



## **Emergency Preparedness for Persons with Disabilities – Emergency Planners**

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### **Background**

Disasters – natural (e.g., hurricane, earthquake, etc.) or human involved (e.g., terrorist attack) (McClure et al., 2011) – can happen anywhere at any time. You may have advance warning, or not. Some geographic locations more at risk for certain types of natural disasters (Baker & Cormier, 2013). For example, in BC we may experience earthquakes. Other natural disasters can strike anywhere. For example, storms, flooding, and power outages can happen regardless of location.

### Persons with Disability

Persons with disabilities tend to be more vulnerable, along with older adults and medically dependent individuals (Levac et al., 2012), to disproportionately adverse consequences of emergencies (Fox et al., 2007). This is because they may be unable to take protective action (Murray, 2011); it is too dangerous to evacuate, they are more affected by unfamiliar surroundings and change of routine, and/or their support systems fall apart (Rothman & Brown, 2007). Other factors include that their needed assistive devices may be left behind (Rooney & White, 2007) and a lack of access to medical records (Jan & Lurie, 2012). Most shockingly, persons with disabilities may be left behind/abandoned (Rushford, 2015)

Among persons with disabilities, the most vulnerable include children (Murray, 2011); those with the lowest functional level and/or the most severe disability (Tomio et al., 2012); those who live in social isolation (Al Rousan et al., 2015), and those with cognitive impairment (Rothman & Brown, 2007).

Persons with disability are often less prepared (Levac et al., 2012; Tomio et al., 2012) due to a combination of factors., including lack of time or money to purchase supplies, lack of information, disbelief in risk (Levac et al., 2012), or trust in authorities and expectation of rescue (Hogaboom et al., 2013). Some may be unable, due to disability, to engage in preparedness activities (Tomio, et al., 2012). Even worse, some may feel prepared but are not adequately prepared (Hogaboom et al., 2013).

Persons with disability may say they can evacuate but have no actual plan (McClure et al., 2011). In fact, persons with disabilities are less likely to have evacuation plans (Spence et al., 2007). The one area in

with persons with disabilities may be more prepared than persons without disabilities is in terms of medical preparation, such as stockpiling medications (Tomio et al., 2012).

Persons with disabilities and informal caregivers are less likely to evacuate, even under mandatory evacuation orders, because they are unable physically, there is a lack of accessible transportation (Brodie et al., 2006; Rooney & White, 2007; Smith & Notaro, 2009), and elevators shut down and there is no alternative way out (Rooney & White, 2007). Persons with disabilities who have not evacuated state that they did not learn about the evacuation order, did not know how or to where to evacuate, or they chose to stay (Brodie et al., 2006). People with disabilities chose to stay because they were unable to leave due to disability or were the carer of a person with disability who was unable to leave (Brodie et al., 2006).

### **Recommendations for Community Emergency Planning**

*If planning does not embrace the value that everyone should survive, they will not* (Federal Report, 2006, p. 1350).

#### Overall Approach

Rushford (2015) proposed a “twin track” approach to emergency preparedness planning for persons with disabilities – disability inclusive and disability specific. Being Disability Inclusive means involving persons with disabilities in emergency planning, and this is widely recommended (Fox et al., 2007; Jan & Lurie, 2012; Rushford, 2015; Rooney & White, 2007; Smith & Nataro, 2009), including persons with mental health disabilities (Federal Report, 2006). Being Disability Specific means empowering persons with disabilities and their families through education about emergency preparedness specific to their needs. Baker and Cormier (2013) found that even a short educational intervention significantly increases preparedness among persons with disabilities. However, it is important not to put all responsibility for emergency preparedness on individuals, but to also ensure that the build environment and policies address needs of persons with disability (Christensen et al., 2007).

#### Know the Need

- Know the number and location of persons with disabilities in your region (Fox et al., 2007; Spence et al., 2007).
  - Encourage self identification by persons with disabilities, including the services they need (Fox et al., 2007).
- GIS (geographic information systems) technology could be useful for emergency planning, IF agencies collaborate and the data sets available include disability information (Enders & Brandt, 2007).
- Maintain a priority list for utility reconnection for those using medical devices (Al Rousan et al., 2015).

- Plan priority distribution of food, water, etc. for persons with disabilities who cannot get to distribution points or stand or wait in line (Rooney & White, 2007).

### Preparation and Training

- Participate in training about emergency preparedness for persons with disabilities (Roland et al., 2007).
- Ensure function-based scenarios are used in all drills (Kailes & Enders, 2007).
- Work with businesses and nursing homes to be sure they are prepared (Jan & Lurie, 2012), including evacuation of employees and visitors with disabilities (Loy et al., 2006).
- Ensure alternative power sources for medical facilities and nursing homes (Jan & Lurie, 2012).
- Public Education:
  - Design awareness campaigns for how social media can and should be used in emergency situations (Bricout & Baker, 2010)
- Train peer counsellors to provide support to persons with mental health disabilities in emergencies (Hardiman & Jaffee, 2008).

### Triage

- Use a C-MIST approach to emergency planning and triage for persons with disabilities (Kailes & Enders, 2007). This includes:
  - Communication – use multiple methods, post written copy of verbal messages, establish locations and times when translation (including sign translation) will be available, use community organizations to get credible interpreters.
  - M – train Medical response personnel.
  - I – Identify and screen functional needs early.
    - Follow up within 48 hours to - replace medications and assistive technology, orient the visually impaired, replace essential consumable medical supplies (e.g., dressings, ostomy supplies, etc.), and arrange assistance as needed (e.g., toileting, dressing, feeding, etc.).
  - S – Arrange Supervision as needed (e.g., for dementia, intellectual disability, trauma, children, mental health).
  - T – Ensure transportation for everyone, including paratransit options (Kailes & Enders, 2007)
- Use the Chronic Care Triage Scale to determine where to send people as rescued – general shelter, general shelter with functional needs supports, or a medical station (Fannin et al., 2015).
- Differentiate between dementia and delirium and respond appropriately (support for former, treatment for latter) (Rothman & Brown, 2007).
- Assess for dehydration and malnutrition as part of triage (Rothman & Brown, 2007).

## During the Emergency

- Have a Disability Services Coordinator position within the command post (Jan & Lurie, 2012).
- Communications:
  - Communication must be timely, clear, concise, comprehensive, and action oriented (what should people do?) (Bricout & Baker, 2010; Levac et al., 2012; Smith & Nataro, 2009).
  - Encourage people to assist neighbours with disabilities (Spence et al., 2007).
  - When identifying shelter locations, specifically identify accessibility and care available as well as accessible transportation to get there (Fox et al., 2007; Rutkow et al., 2015; Spence et al., 2007).
  - Have language interpretation for communications (Smith & Nataro, 2009).
  - Have alternative communication methods for persons with sensory disabilities (e.g., sign language interpreters, large print/high contrast and Braille signage, etc.) (Bloodworth et al., 2007; Campbell et al., 2009; Rutkow et al., 2015).
  - Gear communications to low literacy levels (Campbell et al., 2009; Smith & Nataro, 2009).
  - Consider alternative communication strategies (e.g., text messaging, social media) (Bricout & Baker, 2010; Campbell et al., 2009).
  - Communicate how to evacuate from home community if no personal transportation, limited financial resources, or no place to stay outside home community, especially if self or family member has a disability (Brodie et al., 2006).
  - Credibility of messaging to persons will be enhanced if use persons with disability to deliver the message (Brodie et al., 2006; Fox et al., 2007).
  - Do not just communicate on website – older adults and persons with disability less likely to have computer access (Smith & Nataro, 2009).
  - If using web site, ensure accessible web design (Campbell et al., 2009).
  - Keep health and social service agencies in the communications loop (White et al., 2006).
- Collaboration:
  - Work with rehabilitation personnel to learn about assistive devices, what questions to ask persons with disability, and how to use the equipment (Roland et al., 2007).
  - Work with health care professionals (MDs, home care workers, etc.) to get information to their patients (Smith & Nataro, 2009).
  - Collaborate with advocacy groups, community mental health services, and independent living centres to get information to their members (Person & Fuller, 2007; Smith & Nataro, 2009).
  - Enlist durable medical equipment suppliers to provide assistive devices for persons with disabilities in shelters who had to be evacuated without their devices (Bloodworth et al., 2007).

- Enlist pharmacies near shelters to provide emergency prescription refills (Bloodworth et al., 2007).
- Use social services volunteers to assist with reuniting families, discharge planning, etc. (Bloodworth et al., 2007).
- Use mental health service agencies to reach out to known individuals with mental health disabilities (Hardiman & Jaffee, 2008).
- Consider the role of the military, should they be deployed to assist with a disaster (Brodie et al., 2006).
- Evacuation/Rescue:
  - Purchase specialized evacuation equipment (Roland et al., 2007).
  - If possible, take mobility devices with the person (Bloodworth et al., 2007; Public Safety Canada, 2010; Rooney & White, 2007; Rothman & Brown, 2007).
  - Send accessible methods of transportation in locations where persons with disability live to facilitate evacuation (Brodie et al., 2006; Rutkow et al., 2015).
  - If unable to evacuate, have system to deliver supplies to persons with disabilities and their families (Brodie et al., 2006).
- Shelters:
  - Have Functional Support Coordinators at shelters to screen at intake to shelters and to track that needed services are available or if relocated, to orient shelter personnel, and to train shelter personnel in “quick fixes” (e.g., temporary ramps, time and place for interpreter services, etc.) (Kailes & Enders, 2007).
  - Designate accessible shelters and a way to supply them (Brodie et al., 2006; Rooney & White, 2007).
  - Ensure accessibility to entry, washrooms, and food distribution area (Rutkow et al., 2015).
  - Ensure accessible communication within shelters, including sign language, Braille, and language interpretation (Rutkow et al., 2015).
  - Have beds in shelters for persons with disabilities who cannot transfer to cots (Rothman & Brown, 2007).
  - Position persons with disabilities near services (e.g., washrooms, food, etc.) (Rothman & Brown, 2007).
  - Maintain supplies of medications in shelters, including mental health medications (Federal Report, 2006; Person & Fuller, 2007).
  - Ensure needed assistance with ADLs is available (Rothman & Brown, 2007).
  - Use rehabilitation and social service workers and volunteers in shelters to assess persons with disabilities, to train volunteers to assist in ADLs, and to support persons with disabilities (Bloodworth et al., 2007; White et al., 2006).
  - Allow mental health workers and peer support counsellors to work in shelters (Federal Report, 2006; Hardiman & Jaffee, 2008; Person & Fuller, 2007).
  - Do not refuse persons with mental health disabilities in shelters, nor segregate them within the shelters (Federal Report, 2006; Person & Fuller, 2007).

- Establish regular meal times, and maintain supplements for those malnourished (Rothman & Brown, 2007).

### **Additional Resources for Community Emergency Planners**

A Shared Responsibility: The Need for an Inclusive Approach to Emergency Planning for People with Disabilities

<http://www.disabilityalliancebc.org/docs/asharedresponsibility.pdf?LanguageID=EN-US>

Training and resources (BC)

<http://www.disabilityalliancebc.org/ourwork/emergency.htm>

Checklist to Facilitate Health Emergency Planning for At-Risk People

[http://www.disabilityalliancebc.org/docs/emergprepchk1stattriskpeople\\_2colour.pdf?LanguageID=EN-US](http://www.disabilityalliancebc.org/docs/emergprepchk1stattriskpeople_2colour.pdf?LanguageID=EN-US)

On-line training re Serving People with Disabilities (US)

<http://www.nisonger.osu.edu/odhp/emergencyplanners>

ADA Accessibility Checklist for Emergency Shelters (US)

<https://www.ada.gov/pcatoolkit/chap7shelterchk.htm>

Resources on Including Persons with Disabilities in Emergency Planning (US)

<https://www.disability.gov/can-emergency-planners-include-people-disabilities-planning-emergencies-ensure-emergency-services-accessible/>

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