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Including People with Disabilities in Disaster Preparedness and Response

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Executive summary

People with disabilities constitute a very large minority that consists of between one sixth and one fifth of the general population of most countries. When major incidents and disasters occur, people with disabilities face hardship that is potentially greater than that of the majority population, and they can suffer additional forms of discrimination or neglect. The moral and ethical case for an inclusive approach that guarantees the right of people with disabilities to adequate care in disasters is unassailable. Thus, warning, evacuation, shelter, transitional housing and other emergency provisions are services that need to be fully accessible and usable by a wide range of people with disabilities. Whereas measures for the general population are generally created for groups, a certain number of persons with disabilities require individual assistance, which may involve a fundamental reorientation in the way that civil protection services are planned and delivered.

It is vitally important to understand the needs of people with disabilities during the exceptional circumstances created by major incidents and disasters. It is also essential not to subsume these needs among those pertaining to minorities and disadvantaged groups in general. Emergency measures should seek to preserve the dignity and (where possible) the autonomy of people with disabilities. Academic and practical studies of disability and disaster reveal that there is a significant shortfall between the recognition of these principles and their implementation in practical programmes of action. The shortfall includes failure to design programmes and plans, implement them and monitor their effectiveness.

Planning is an essential part of preparing for emergencies. In order to ensure that resources, manpower and organisation are in place, plans and preparations need to be made at the national level, which should also be the level at which plans and measures are promoted and harmonised at the intermediate and local levels of public administration. Healthcare institutions, social services, and voluntary organisations in the fields of disability and civil protection need to work together at in both the planning and response modes to create viable programmes of emergency care for people with disabilities. Coordination by a single, responsible government entity should nevertheless involve all the organisations involved in responding to emergencies on behalf of people with disabilities. It is important to note that all plans to assist people with disabilities are local in their implementation and outcome, and hence attention needs to be devoted to this level. Plans must be consolidated by frequent updating and testing, which should be complemented by programmes of training designed to ensure that all emergency responders are fully familiar with their roles, responsibilities and the procedures they will need to employ in a crisis or disaster.

In Europe and the Mediterranean area, countries are striving to improve their emergency preparedness. However, little has been done to include people with disabilities into practical programmes of action in civil protection. However, some examples of good practice do exist. These include the creation of specific offices to run programmes for protecting people with disabilities in disaster, ensuring that the problem is adequately dealt with in national disaster response legislation, finding innovative and alternative ways of disseminating warnings to people with cognitive problems, hearing impairments, or who do not understand the local language (for example, tourists, visitors and workers from other countries).

Examples of good practice from around the world highlight the importance of translating it to new situations and ensuring that lessons are learned by implementing them into improved outcomes. For example, evacuation needs require attention to accessibility issues and forms of alerting that take account of people's disabilities. It also requires

accessible transportation and shelter. Occupant emergency plans (OEPs) should be written for key buildings, and such instruments should take account of the needs of people with disabilities.

In conclusion, people with disabilities, and the organisations that represent them, need to be drawn into the civil protection preparedness process. Policies and plans need to be inclusive, but the particular needs of people with disabilities should not be subsumed in a "compromising manner" into wider amalgamations of disadvantaged groups.

Preparing for disaster with and on behalf of people with disabilities requires political commitment, national and local co-ordination, strategic planning, networking, knowledge management, optimisation of resources and the development of good communication strategies. With this in view the Council of Europe, through the EUR-OPA Major Hazards Agreement and its member countries[1], has developed pertinent Guidelines and a Recommendation.

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[1] The member States of EUR-OPA are: Albania, Armenia, Azerbaijan, Belgium, Bosnia and Herzegovina, Bulgaria, Croatia, Cyprus, Georgia, Greece, Luxembourg, Malta, Republic of Moldova, Monaco, Portugal, Romania, Russia, San Marino, Serbia, Spain, "the former Yugoslav Republic of Macedonia", Turkey, Ukraine, and three Mediterranean countries which are not member States of the Council of Europe: Algeria, Lebanon, Morocco.

1. Introduction

With the gradual development of more enlightened attitudes, and the growing popularity of Paralympic athletics, movie actors with learning disabilities or autism, or with sensorial impairments, persons with Down's Syndrome working as teachers, and many other examples where persons with disabilities have reached international recognition, disability has begun to shed some of its stigma and people with disabilities are at last beginning to be more accepted into the mainstream of European society. Although this recognition has been very valuable for showing a new picture of disability, it must be admitted that the people involved are exceptional and not representative for the large majority of people with disabilities.

In parallel, thanks to the impressive lobby work of disability organisations worldwide, the process of overall inclusion of people with disabilities has been helped by legislation that requires property owners, the managers of public amenities and local administrations to provide better facilities and access for people with disabilities, who are no longer "invisible citizens" and fight for their right to be present at all levels of social life.

Discrimination is still common enough to be a serious problem, and physical barriers to accessibility are still a long way from being abolished. According to a report by the BBC,[2] the 2012 London Paralympics had a positive effect on public attitudes in the United Kingdom to disability, but it remains difficult to assess whether the impact is profound and enduring. Hostility to people with disabilities remains a serious problem, including attacks on individuals and guide dogs. In a difficult economic context, people with disabilities enter into competition with other groups of potentially disadvantaged individuals who are looking for jobs or attempting to remain in work (such as people from difficult social backgrounds, workers of a mature age and the long-term unemployed). Moreover cuts to disability benefits associated with the recession have caused serious hardship among those who depend on state funding to survive.

People with disabilities are numerous enough in society to constitute a very large minority. They are probably in the region of 15 per cent of the population of most countries,[3] although any assessment of numbers depends upon the system of definition, registration and counting. In fact, it may be that with the inclusion of people who are not registered the figure rises to one in five of the general population. The forms of disability, and the degrees to which a person may be disabled, are extremely varied, and hence a true count of the numbers involved is difficult. Nevertheless, people with disabilities may suffer, not only widespread discrimination, but also unnecessary restrictions in what they can do, amounting to a form of social exclusion. In addition, they may be economically disadvantaged relative to other members of society through the difficulty of finding adequate employment, assuming that they are able to work at all. Moreover, they may find it more difficult to manage their daily routine than do people who do not live with disability.

One field in which progress is still very slow is the care of people with disabilities in disasters, and their protection against disaster risk. Emergencies, crises and other civil contingencies tend to distort or interrupt the pattern of everyday life and hence are fertile occasions for the resurgence of prejudice, discrimination and neglect. The excuse that "resources are insufficient" (including time and manpower) is not particularly valid as, with proper planning and organisation, it is perfectly possible to redress the balance in favour of caring for and protecting people with disabilities against disasters.

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[2] BBC News, 29 August 2013. 'Jury is out' on Paralympics legacy, charities warn.' www.bbc.co.uk/news/uk-23860821.

[3] WHO 2011. *World Report on Disability*. World Health Organization, Geneva; World Bank, New York, 325 pp.

This report provides an overview of the state of the art in emergency preparedness and disaster risk reduction for people with disabilities. It asks whether an adequate level of resilience has been achieved by and on behalf of people with disabilities. The report begins by defining disability and clarifying questions of ethics regarding the right of people with disabilities to an acceptable level of protection in situations of high disaster risk. In considering the institutional framework for achieving such protection, the report considers the implementation shortfall, in which established principles have not been sufficiently activated. Planning, training and exercising need to be improved, and examples of good practice adapted to new environments and circumstances. The report shows that there is much potential to improve emergency preparedness for people with disabilities, and the arguments for doing so are indisputable.

2. People with disabilities – definitions, facts and figures

The UN Convention on the Rights of Persons with Disabilities (UNCRPD) promotes the following definition: [people] "who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others". Disability can be physical or mental, partial or well-nigh total, temporary or permanent, and constant or fluctuating. Hence it covers a multitude of different conditions which represent a set of restrictions that may reduce a person’s ability to participate fully in the regular activities of normal life, or at least to do so without significant help from equipment, medication or carers.

The World Health Organization's *International Classification of Functioning, Disability and Health (ICF18)* adopts a broad approach in which impairment or restriction of functioning is seen in relation to contextual factors related to a person's life and environment:

> "Functioning is an umbrella term encompassing all body functions, activities and participation; similarly, disability serves as an umbrella term for impairments, activity limitations or participation restrictions. ICF also lists environmental factors that interact with all these constructs. In this way, it enables the user to record useful profiles of individuals’ functioning, disability and health in various domains."[4]

The broadest possible range of human conditions is taken into account in the classification, which assesses what a person can do in both a standard environment and in that person's specific circumstances. Nevertheless, Paralympic athletics and other examples have shown that people with disabilities are not necessarily frail, and many people with disabilities have excelled in a wide range of activities or have taken important leadership roles. This leads to the conclusion that the “normal person” does not really exist and neither does the typical person with a disability. Implicitly, the same human diversity must be taken into consideration in strategies, concepts and solutions to be developed in any field.

The following list illustrates the variety of forms of disability:

- restricted mobility
- blindness or partial sight (possibly requiring the use of guide dogs)
- deafness and hearing impairment
- difficulties of cognition, communication and expression

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[4] WHO 2001. *International Classification of Functioning, Disability and Health (ICF18)*. World Health Organization, Geneva, 299 pp: WHO 2002. *Towards a Common Language for Functioning, Disability and Health: ICF, The International Classification of Functioning, Disability and Health*. WHO/EIP/GPE/CAS/01.3, World Health Organization, Geneva, 22 pp.

- medical problems
- use of support systems to maintain vital functions
- psychiatric disturbances and panic attacks
- infirmity associated with old age.

The categories are not necessarily comprehensive or mutually exclusive.

It should also be noted that major incidents and disasters can create disability. In most cases, paraplegia and permanent physical impairment represent, thankfully, a small proportion of disaster-related injuries, but earthquakes, structural collapses and bombings can all cause lasting physical damage to people that in a minority of cases cannot be healed. In addition, although disaster does not usually increase the number of serious, long-term mental health cases, it does cause large rises in short- to medium-term psychological suffering that can disable people with respect to their normal mental state.

One common problem with institutional arrangements for dealing with people with disabilities is that as a category they may be lumped together with other disadvantaged, or potentially disadvantaged, groups. These may include pregnant women, children, people with disabilities, elderly persons, the sick, the wounded, indigenous populations, environmentally displaced persons, and ethnic and religious minorities.[5] These groups may be the recipients of neglect, discrimination, racism, hostility, violence or repression, or they may simply be more at risk of these things than are members of the general population. While it is important to ensure that measures are taken to fight prejudice, unfairness or victimisation in society, it is also important that the specific needs of people with disabilities as a very heterogeneous, group are not neglected in the process.

3. Ethics

It is a general ethical principal that people with disabilities should be encouraged and helped to live independently and to play a full a role in mainstream society. While severe forms of mental or physical disability might preclude that, many people with disabilities have a good ability to participate strongly in a wide range of activities in regular society, and some are able to live autonomously. They should not be discouraged or prevented from doing so. The UN Convention on the Rights of Persons with Disabilities (UNCRPD) goes further and stresses the importance of respecting human rights.[6] It points out the responsibility of society to support the inclusion of people with disabilities.

People who live with severe disabilities have an ethical right to assistance from the rest of society that enables them to live their lives as fully as possible. In close-knit societies in which family sizes are large, most people with disabilities are cared for en famille. However, many others are not the beneficiaries of sufficient family resources and so require to be cared for by the state and civil society. State or charitable assistance may need to be financial, administrative, logistical, medical and social. Moreover, they need to respect the increasing wish and right of people with disabilities for autonomy and self-determination.

When disaster strikes, or a major incident occurs, people with disabilities have a right to receive the same level of protection as is given to the rest of society. In other words, disaster should not be the occasion to suspend fundamental human rights. This may require that people with disabilities receive a greater level of assistance than at other

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[5] Prieur, M. 2012. *Ethical Principles on Disaster Risk Reduction and People's Resilience*. European and Mediterranean Major Hazards Agreement, Council of Europe, Paris, 37 pp.

[6] See: European Union 2000. *Charter of Fundamental Rights of the European Union* (Document 2007/C 303/01). European Parliament and Council of Ministers of the European Union, Strasbourg.

times. The help that is given should ensure that they are not put into a position of disadvantage with respect to vulnerability reduction, warning, evacuation, shelter, recovery, reconstruction, or any of the other fundamental actions associated with risk reduction and disaster response. Their basic human rights to privacy, courtesy, impartiality and measures to ensure their safety should not be infringed because they live with disability.

In many countries, these ethical goals are far from being achieved: however, they remain essential goals and no government, society, organisation or community should be deterred from striving to attain them. Disasters and emergencies represent a particular class of adversity. This should not be used as an excuse to reduce the level of attention, the magnitude of resources, or the strength of safeguards regarding the position and care of people with disabilities in society. In other words, there is no justification for relaxing either ethical or moral standards, or human rights, during a major incident or disaster.

4. The implementation shortfall

Failure to make any provision for people with disabilities, including failure to appreciate the nature of their special needs, is still endemic in the modern world, including in parts of Europe. Lack of a registration system for people with disabilities is one of the most basic shortcomings and it is still widespread. This is a question of understanding the magnitude of the task, and it is of fundamental importance, because knowing who needs to be assisted, where they are located, what disabilities are involved and how many individuals will require helping is essential basic information that will underpin any viable programme of assistance.

There is a significant number of academic studies of disability and there are some academic centres that have developed expertise in the study of people with disabilities in relation to disaster, notably at the Universities of Kansas in the USA and Leeds in the UK. However, systematic data on people with disabilities are lacking, academic theory has seldom been applied to the problem of protecting people with disabilities against disaster, and it is not common to include people with disabilities in evaluation methodologies and procedures. Hence, the implementation shortfall begins with a deficiency in data and analysis, or in other words in attaining a precise understanding of the issues at hand.

The wide range of political systems, cultural differences and standards of living, combined with geographic and climatic differences, and diverse likelihoods for particular kinds of disasters, makes it very hard to develop a common set of criteria. Hence the approach must be based on a common means of identifying the challenges that must be faced in each context. The very first step is to collect reliable data, which at present are largely absent. Article 31 of the UNCRDP, which deals with statistics and data collection, stresses the importance of respecting the privacy of people with disabilities.

Many countries do not have a register of people with disabilities. This requires that a formal definition of disability be adhered to and people who fall within it be required to register with health and social security authorities, and to maintain a record of their home addresses. The register needs to be available to local authorities and to be kept up to date. In normal times, registers are used to determine who receives living allowances from the state, if such exist. They also serve to identify needs that health authorities and social services can satisfy. If such provisions are lacking among state provisions, there is little incentive to compile the register. However, it is something that can be used to good effect when disaster strikes, and during the formulation of emergency plans, as it will represent an inventory of special needs and the location of people who may be in need of assistance.

Unfortunately, allowances or similar benefits are very often provided by different kinds of administrative unit and are based on different definitions of who are the potential beneficiaries. The result can be a different definition of disability for the same person, depending on the kind of allowance for which he or she may apply.

The WHO International Classification of Functioning, Disability and Health (ICF18),[7] which is endorsed by many states, endeavours to distinguish between the medical and social approaches to disability. However, it is a complicated tool that has not gained much popularity among people and organisations that work in the disability field. In contrast, the "Design for All" approach is becoming more popular, and it evolves in a completely opposite direction. Instead on disability, it focusses on human diversity, but this could make it even more difficult to ascertain who is to be considered a person with a disability. Moreover, in some countries the mobility limitations of citizens over 65 are linked purely to their age, and these persons are thus not defined as living with disabilities.

People with disabilities are not mentioned in a number of key legal instruments and policy declarations. For example, they are absent from the UN Millennium Declaration. In many countries they are not specifically mentioned in national disaster management laws. Even the landmark Americans with Disabilities Act (ADA, 1991) does not include any legislation regarding the evacuation of people with disabilities. Moreover, the 2004 ADA Guide for Local Governments, which is supposed to help city authorities to establish evacuation plans for individuals with disabilities, lacks enforcement.

The following are common aspects of the 'implementation shortfall':

- There is a tendency to subsume provisions for people with disabilities in an inefficient or compromising way into other forms of legislation, such as disaster response acts, health and safety legislation and general legislation on social welfare provisions. In order to honour the provision of European and UN conventions, arrangements for assisting people with disabilities in emergencies and disasters should not disappear in the general legislation--i.e. they should be specific in each country. However, specific measures should not over-concentrate responsibility in single organisation, leading others to relinquish their roles in caring for people with disabilities. The approach must remain holistic and must involve full collaboration between organisations.

- There may be failure to implement legislation, guidelines and organisational arrangements. This is usually attributed to lack of financial resources, but it can also mean a lack of political or administrative motivation to find and use the resources, or indeed to face up to the problem at all. Decentralised organisation of competencies has the merit of bringing services closer to the beneficiaries, but it may result in incomplete responses to need, as well as the division of those responses into highly separate sectors, the enemy of a holistic approach. The effect of such systems may be lack of completeness in the calculation of what resources are needed in order to help people with disabilities.

- Failure to monitor and develop programmes for the protection of people with disabilities in disaster is still common. This includes failure to inform and train emergency responders. This problem is increased by decentralisation of responsibility and lack of concerted action among services.

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[7] WHO 2001. *International Classification of Functioning, Disability and Health*. World Health Organization, Geneva: http://apps.who.int/classifications/icfbrowser/ (accessed 3 October 2013).

- Failure to apportion responsibilities among the various organisations and institutions involved in the care of people with disabilities during disasters is also a widespread deficiency. Either the responsibilities remain undefined, or they are not allotted in an efficient and functional manner. Hence, it is common for planning to assist people with disabilities in disaster to "fall down the cracks" and disappear into bureaucratic limbo. This risk looms even larger when large institutions that house people with disabilities set up their own emergency programs, unless these are competently and rigorously formulated and practised. However, demographic change and the trend to deinstitutionalise people with disabilities mean that such people increasingly do not live in institutions but in their own homes.

- Failure to ensure capillarity in national programmes is another problem. The legislation and organisational arrangements may be exemplary at the national level, but people with disabilities need to be assisted at the local level: hence, arrangements need to be securely in place at the intermediate and local tiers of government. Another case concerns of particular relevance in Europe is that of people who live in border regions, with a high probability of being dependent on foreign emergency system and on communicating their needs in a foreign language.

- Conflicts may arise from different interpretations of disability policies. While the organisations that work on behalf of people with disabilities insist on policies of inclusion, with the right to access any level of any building, fire fighters could usefully promote the view that, in order to avoid evacuation problems, wheelchair users should be allowed to work only at the lower levels of tall buildings.

- Lastly, there may be a funding shortfall. Disability organisations may lack access to mainstream funding connected with disaster mitigation, response and recovery. Civil protection agencies and local governments may be reluctant to devote funds destined for emergency preparedness to a single sector of the population, no matter how demonstrable are its needs. This problem can only be remedied by a serious rethink of priorities when defining the policies which govern the allocation of public or civil society (NGO) funds.

During the recovery phase after a disaster, people with disabilities may endure discrimination, which may be intensified by scarcity of resources, deprivation or deterioration of life choices. Those who previously lived independently may find themselves moved to nursing homes, and more generally their degree of choice about living arrangements may be curtailed. Moreover, major disasters kill or injure the carers of people with disabilities. On the other hand, recovery and reconstruction can offer the opportunity to improve disability standards and inaugurate more inclusive forms of emergency planning. Article 32 of the UN Convention on the Rights of Persons with Disabilities (CRPD) promotes cooperation at the international level and can stimulate exchange of expertise in this field.

5. Institutional framework

In order to ensure fairness and equity governments must have policies that:-

- guarantee and safeguard the fundamental rights of people with disabilities
- promote the inclusion of people with disabilities into mainstream society
- seek actively to prevent discrimination against people with disabilities
- create legal and administrative mechanisms to achieve these goals

- identify exactly which organisations are responsible for implementing and enforcing the policy
- are subject to impartial scrutiny and are regularly monitored with respect to their ethics, effectiveness and level of implementation.

Once again, the particular needs of people with disabilities should not be subsumed as some kind of compromise into general policies designed to ensure the rights of disadvantaged groups.

The deficiencies and failures listed in the previous section may add up to a failure to connect organs of central government, and tiers of government. Registries of people with disabilities are usually managed by a Ministry of Health or Social Services. Emergency planning and management may be a jurisdiction of, for example, the Ministry of the Interior (or Home Office). In countries (such as Sweden, Italy and the UK) in which emergency responses are a dependency of the national Cabinet, there may be more opportunity to connect the different competencies, but there is no inherent reason why that should occur automatically. Nor does such an arrangement guarantee liaison with outside organisations such as NGOs and voluntary associations, which may be necessary at the operational level in order to provide services for people with disabilities.

Answering the needs of people with disabilities in disaster requires a concerted effort by government at all levels, together with civil society in the form of families and voluntary associations. Institutionally there need to be strong links in several directions, as follows:-

- between the national, intermediate and local tiers of government
- between healthcare, social services and other ministries, such as those that deal with emergency response (usually a Ministry of the Interior or Home Office)
- between the forms of public administration listed above and voluntary associations, and
- between civil protection organisations and the associations that care for people with disabilities or defend their rights (Figure 1).

Figure 1. Working together to produce plans for assisting people with disabilities in emergency situations.

Ideally, government provisions for people with disabilities will be coordinated and managed by a single entity that has a department or unit which deals with planning for emergencies. This agency would need to ensure capillarity throughout the system of public administration, or in other words that arrangements are implemented at the local level and fully backed by local administrations. As envisaged in article 33, concerning national implementation and monitoring of the UN Convention on the Rights of People with Disabilities, the organisational format includes focal points and monitoring entities that promulgate clear rules for coordinating, reporting and controlling. It seems to be a model with considerable promise for sharing and exchanging expertise at both the national and international levels.

One very important aspect of the institutional arrangements is to encourage civil protection forces to work together with associations that work on behalf of people with disabilities (see Figure 1, above). This is one way of connecting two sets of institutions with different competencies and agendas, and also of connecting public administration with the civil society organisations on which it depends to carry out tasks that are either outside the domain of the state or have been ceded to the voluntary sector, usually through lack of public resources.

In addition to fostering bilateral relationships, for example, between a civil protection agency and a voluntary organisation, there are other key players that need to be drawn into the process of preparing to assist people with disabilities in disaster. These include disability advocates and legal rights lawyers, experts in disability access, assisting technology experts and the managers of personal assistance services. All have a role to play and all need to know how that role will change during the straightened circumstances of a major incident or disaster.

The relationships described in this section should be implemented at the emergency planning stage, which is described in the next section of this report.

6. Planning

In responding to public emergency situations (major incidents, disasters, contingencies, crises, etc.), there are three elements to programmed activities: plans, procedures and improvisation. Procedures, or protocols, are a form of guidance for conducting particular activities. Planning is the orchestration of procedures and activities into a concerted, multi-disciplinary approach to the process of emergency response (or, in other phases, mitigating risks or recovering from disaster). Most successful planning is based on one or more master documents that are periodically updated and are shared between the people who will use them. The 'bedrock' level of emergency planning is the local level, as this is always the "theatre of operations" when an emergency occurs. The essence of emergency planning is to predispose things (personnel, supplies, vehicles, communications, fuel, equipment, and so on) so that urgent needs can be met in the most efficient way possible.

Hence, planning should continue after the start of the emergency, and into the recovery from it, as the changing pattern of resources requires flexibility in how they can be applied to emerging needs. Throughout this process it will be necessary to improvise when particular contingencies have not been foreseen. However, avoidable improvisation is a form of inefficiency that, at its worst, can lead to unnecessary loss of life or destruction of property. Thus, the purpose of planning is to reduce improvisation to a necessary minimum by foreseeing needs that can be fulfilled in advance of the moment when they become imperative. Many forms of emergency intervention cannot easily be improvised as they require the acquisition of equipment and supplies, the training of personnel and the organisation of forces to carry out specific tasks. An additional element in the scheme can be information and training activities addressed directly to people with disabilities and the staff members who care for them.

This, then, is the matrix in which planning to cater for the emergency needs of people with disabilities should take place. The main difference between 'standard' emergency planning and that required for people with disabilities is that the former can be carried out on behalf of undifferentiated groups of people, while the latter has to take into consideration a range of supplemental and diverse needs. This adds up to a need for individual attention in each case.

It is a reasonable assumption that if emergency plans for the general population are inadequate or missing, planning for people with disabilities is unlikely to be successful. On the other hand, well-thought emergency plans based on the diverse needs of people with disabilities will work with the general population as well and will add better preparedness for unexpected situations. Hence, the one is a prerequisite for the other. However, emergency planning arrangements for the general population should not be allowed to subsume those for people with disabilities.

The first stage of all emergency planning is to collect data on hazards and vulnerability. Notwithstanding the growing number of persons with disabilities who exercise their right to autonomy and self-determination, and thus do not appear in any official data, wherever possible, planners should acquire adequate information on people with disabilities in the planning jurisdiction, including their addresses, ages, types of disability, and probable requirements during an emergency. At the same time, an assessment needs to be made of the nature of hazards that threaten the community and the probable local impacts of an extreme event. Obviously it will be impossible to have absolute numbers or absolutely complete information: therefore local emergency plans should not be designed in a rigid way, and all stakeholders must learn to cope with unforeseen situations.

The next stage is to design measures to safeguard the community, including people with disabilities, in relation to the inventory of resources (personnel, vehicles, equipment, supplies, communications, buildings and expertise) that will be available at any given time during an emergency. Where hazard impacts can be forecast with enough time to react, plans should make provision for warning and evacuating people with disabilities, with careful consideration as to what is involved in these processes. Where shelter is designated in advance, care should be taken to ensure that it is accessible to people with disabilities and meets their needs for privacy and functionality. For those people with disabilities who depend on medicines or medical equipment, arrangements need to be made to ensure continuity of supply and availability during an emergency and its aftermath. Meticulous planning may be required if there is any likelihood that electricity supplies will be interrupted, and there are people with disabilities who depend on medical or living aids that require electricity. Provisions may also need to be made to ensure that working animals such as guide dogs are properly accommodated and cared for in an emergency. The prevailing policy must be one of inclusion, not exclusion, of people with disabilities in emergency arrangements.

The rights of people with disabilities to be rescued and cared for after disaster are explained and codified in the Verona Charter.[8]

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[8] ULSS20 Verona 2007. *Verona Charter on the Rescue of Persons with Disabilities in Case of Disasters.* Unità Locale di Servizi Sanitari no. 20, Verona, Italy, 17 pp. www.eena.org/ressource/static/files/Verona%20Charter%20approved.pdf

7. Training and exercising

All emergency personnel need to be sensitive to the needs of people with disabilities. Hence, it is a good idea to provide a general training course that explains the issues. In most cases, courses should be preceded with some general diversity training. Once that has taken place, the relevant issues include the following:-

- the prevalence of disability in modern society and the diversity of forms that it takes
- the moral and ethical case for inclusiveness
- legal and jurisdictional responsibilities of care
- planning provisions for people with disabilities
- scenarios for action when incidents occur or disaster strikes
- practical matters connected with first response to an incident or disaster.

The last of these issues may require its own specific training course for first responders in the emergency services, relevant branches of public administration and voluntary organisations. These courses should teach a combination of general principles and matters that are specific to local circumstances. Among the former are how to work with people with disabilities, how to lift and transfer bedridden individuals, how to ensure that warnings are disseminated to people who cannot hear or see adequately, and how to ensure that people with disabilities are able to maintain their dignity when evacuated to unfamiliar surroundings. Persons with disabilities and their organisations should be involved as teachers in the practical organisation of such training activities. On the one hand, this would allow participants to understand better the challenges and, on the other hand, it would enhance the level of commitment within disability communities.

Simulation exercises are an important extension of both planning and training. They can be carried out at three levels: by discussion (table-top exercise), as a command-post or command centre exercise, or in the field. Simulation of emergency and disaster conditions is one of the ways in which preparedness to meet civil contingencies can be increased. A simulation should be backed by adequate planning, both of the simulation event itself and of the emergency responses required—i.e. by creating and using viable emergency plans that remain as "standing orders" for future contingencies. In many countries such exercises are mandatory in institutions, and they allow one to “test” the effectiveness of practical co-operation with local emergency services.

The advantages of simulation exercises in the field are as follows:-

- they sensitise the local population and participants to the need to prepare for disaster
- they help familiarise participants with the procedures they need to use during a major emergency
- they help organisations to work together under unfamiliar circumstances and under pressure
- they may reveal deficiencies of organisation, resources or preparation for a real emergency
- they can offer an opportunity to introduce the question of how to care for and assist people with disabilities during emergencies.

However, there are also drawbacks to simulation exercises:-

- they tend to be expensive and require considerable organisation, a process that generally takes 6-12 months of preparation, meetings and planning
- simulations tend to be artificial situations and to lack the urgency, spontaneity and realism of genuine emergencies

- the more realistic a simulation is, the more disruptive to normal life and the more it incurs potential safety risks
- usually, only part of the emergency arrangements can be tested in a simulation and
- there is a tendency not to repeat exercises, or not to do so on a regular basis or with any degree of frequency: hence, the experience acquired may gradually be lost afterwards.

Nevertheless, simulation exercises are valuable means of testing elements of the emergency response system, highlighting areas that need improvement, and raising awareness of issues. They present the opportunity to mobilise disability organisations in the cause of civil protection, train emergency responders in dealing with people with disabilities, and identify deficiencies in arrangements for rescuing, accommodating and assisting them when disaster strikes. The wise use of simulation is coupled with substantial efforts to observe and record processes in the field, and to match the experience with training initiatives. This "lessons-learning" approach can furnish valuable information about difficulties that would be encountered in a real emergency and how to anticipate them by designing an a priori solution.

8. Examples of good practice

The Council of Europe’s Disability Action Plan 2006-2015[9] promotes the rights of people with disabilities and aims to help them improve their quality of life by “meeting country-specific conditions as well as transition processes that are taking place in various member states […] and is intended to serve as a roadmap for policy makers, to enable them to design, adjust, refocus and implement appropriate plans, programmes and innovative strategies.”

In 2013 the Council of Europe began an initiative which involved sending a questionnaire on disaster risk reduction and emergency preparedness for people with disabilities to all 26 member countries of the European and Mediterranean Major Hazards Agreement (EUR-OPA) and other members of the Council of Europe.[10] Twenty countries and two organisations responded. The result is a snapshot of the level of preparedness in European and Mediterranean countries.

Some responses were remarkably candid. Although it can be said that the responding nations are striving to improve their emergency preparedness, the level of provision for people with disabilities is relatively low and is also uneven from one country to another. There is little or no uniformity in the measures adopted and these are highly variable in their reach, effectiveness and level of implementation. Although the questionnaire did not enquire into the level of enforcement of government provisions, it can be assumed that there were many cases in which this was low as well.

Overall, there is a tendency to subsume measures for people with disabilities into general provisions for managing emergencies. There is also a tendency for responsibilities to be split between ministries and agencies, and for there to be no guarantee that communication and collaboration will be sufficient to produce viable measures.

Nevertheless, there are some examples of good practice that may serve as a beacon for other countries to emulate and adapt to their own circumstances and needs.

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[9] Council of Europe 2006. Council of Europe Action Plan to promote the rights and full participation of people with disabilities in society: improving the quality of life of people with disabilities in Europe 2006-2015. Strasbourg, 44 pp.

[10] EUR-OPA 2013. *Questionnaire on Disability Inclusive Disaster Risk Reduction*. APCAT 2013(03). European and Mediterranean Major Hazards Agreement (EUR-OPA), Council of Europe, Strasbourg, 83 pp.

Various countries have organised psychological care in disasters at the national level, notably Austria, Bulgaria, Croatia, the Czech Republic, Italy, Latvia, Slovakia and Ukraine. Examples of emergencies in which the psychologists have intervened in an organised manner include floods, earthquakes, transportation crashes, and episodes of mass violence. Moreover, a European Commission-funded project, EUNAD, is designed to promote the integration of psycho-social care into disaster management on behalf of people with disabilities. This is very necessary, as, although the services are potentially very valuable to people with psychologically-related disabilities, they have seldom been used in this context and have mostly been treated as services for the general population.

Bulgaria has identified a senior member of government who is responsible for coordinating policy, plans and measures in favour of people with disabilities in emergency and disaster situations. Measures for people with disabilities are an extension of the national Disaster Protection Act, which covers risk assessment, planning, risk reduction, resources, warning, emergency response and rescue procedures. The Bulgarian Government has a policy on the Integration of People with Disabilities, which is designed to take account of the special needs of people with disabilities and assist them actively. Measures for people with disabilities in the workplace are an extension of the national Health and Safety at Work Act, which, however, is primarily designed to reduce the incidents of accidents at work. EU funding was used to create a register of people with disabilities in Bulgaria. Although the structure of disaster planning is well developed in Bulgaria, the provisions do not make specific provision for people with disabilities.

Miscellaneous limited examples of good practice in Europe include the following. In Belgium and other countries, text messages have been used to alert deaf people to emergency situations. In Norway, hospitals, nursing homes, and home care assistants have a general obligation to evacuate persons with reduced mobility in an emergency. In Greece people with special needs in schools are given an e-lesson under the programme "E-learning about earthquake protection for people with disabilities" of the European Centre on Prevention and Forecasting of Earthquakes. The Republic of Serbia has designed a pilot project to enable people with hearing and speech impairments to contact the emergency services on emergency numbers in case of need. The project was inaugurated in Belgrade in September 2013, and will gradually be expanded to the rest of the country.

Meanwhile, practical research is being conducted in Europe. A Centre for Disability Studies exists at the University of Leeds in the United Kingdom, and its researchers have conducted studies related to disaster preparedness. In the European Union, an Academic Network of European Disability Experts (ANED) has been created. With regard to specific disabilities, the "European Network for Psychosocial Crisis Management - Assisting Disabled in Case of Disaster" (EUNAD) project aims to help the disabled survivors of disasters. The project is designed to evaluate networks of associations for people with disabilities in terms of their levels of preparedness for disasters, to conduct further studies and to organise workshops. EUNAD will produce recommendations, a taskforce, and pilot training courses for different groups.

There have been significant developments outside Europe from which member countries of the EUR-OPA Agreement could derive inspiration. In New Zealand, for example, disaster services such as emergency call centres have been made accessible to persons with disabilities. Firefighters have created a unit in which officers speak sign language. During the aftermath of the Christchurch earthquake of February 2011, sign language interpreters were used in all television information sessions. A specific call centre was set up for persons with disabilities with the ability to address their needs or refer them to appropriate services. In the United States, the Federal Emergency Management Agency (FEMA) has dedicated part of its website to information resources for people with disabilities.[11] The documentation offers advice and know-how to such people and explains projects connected with improving the access and support for disabled survivors of Hurricane Katrina.

The theme of the UNISDR 2013 International Day for Disaster Reduction is "living with disabilities and disasters". This global initiative, which is centred on 13th October each year, is designed to promote resilience. UNISDR argues that solutions to the disasters problem must be fully inclusive. Moreover, decisions and policies to reduce disaster risks must reflect the needs of persons living with disabilities. Finally, investment in disaster risk reduction must satisfy the needs of persons who live with disabilities.

An EUR-OPA meeting also recorded the views of experts in the field.[12] This enabled examples of good practice to be noted from further afield. For example, fire services in New Zealand have created a unit consisting of sign language interpreters. American practice recommends tailoring emergency access and egress routes of each building to its occupants, with the following provisions:

- shelter in place (SIP) plans
- buddy systems (although these are not to be relied upon solely, they are a good starting point)
- descent devices that will continue to operate in an emergency, including one in which electrical power is lost
- elevator (lift) policies
- the inclusion of service animals in emergency plans and drills
- multiple forms of communication and alert systems for the visual and hearing impaired.

For the safe, successful evacuation of people with disabilities, more attention should be given to the installation and use of guidance systems, to planning alternative accessible exits (when lifts are inoperative), to the installation of visual and acoustic alarms, to special signage for visually impaired persons and to ensuring that obstacles are not present along evacuation routes. Moreover, these provisions need to be robust so that they function during the early stages of a developing disaster impact. In countries such as the USA, these provisions are mandated by Occupational Health and Safety requirements for local governments, as these require an Occupant Emergency Plan (OEP) to be drawn up for major buildings.

In this regard, it is important to seek standardisation at the international level. Unfortunately, accessibility standards, guidance systems, pictograms, and other such measures are not yet harmonised, at either the European or the international levels. In view of this lack of standardisation, training activities can unfortunately be based only on local schemes.

9. Conclusions

The degree of civility in a society can be gauged by the way in which it treats disadvantaged people, including those who have disabilities. In this report we have argued that, although people with disabilities are part of a larger constituency of disadvantaged groups and individuals, they are one that is remarkably heterogeneous in terms of both the range of disability and the needs it generates during emergencies and disasters.

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[11] www.disasterassistance.gov/disaster-information/disabilities-access-and-functional-needs/disabilities-access-and-functional-needs-online-resources (accessed 3 October 2013).

[12] EUR-OPA 2012. *Improving Disaster Risk Reduction in Certain Vulnerable Groups*. APCAT 2012(16). European and Mediterranean Major Hazards Agreement (EUR-OPA), Council of Europe, Strasbourg, 7 pp.

Providing an adequate level of protection is a matter of taking the problem seriously, ensuring that the available structures, organisation and resources are adequate to cope with it, and vigorously promoting an active approach to the promotion of programmes designed to assist people with disabilities with reducing disaster risk and coping with emergencies. There also needs to be a process of monitoring and improvement, in order to adapt programmes to changes in society and to take advantage of potential innovations.

One key to the success of programmes is the inclusion of people with disabilities, and their representatives, in the decision-making process. Another is the inclusion of the programmes as an essential component of government policy-making and legislative processes. Providing greater safety for people with disabilities should be neither optional nor something that can be "left until later". It is a matter of basic rights. Planning, training and the provision of information are activities that are essential in order to ensure that those rights are guaranteed. So are the processes of sharing information, learning from good practice and standardising approaches between European countries. With sufficient motivation and collaboration, the large minority of people in society who have disabilities can be protected in line with human rights obligations and basic ethical imperatives.

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