UCPM

# How to Act in Emergencies

## Guidelines for First Responders

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# About these Guidelines

**These Guidelines support first responders across Europe to better prepare for and act during emergencies in order to support persons with disabilities according to their requirements, needs, and preferences.** They contribute to the objectives of the Preparedness Union Strategy, particularly Action 33. They are grounded in the United Nations Convention on the Rights of Persons with Disabilities (CRPD), with focus on Article 11 on situations of risk and humanitarian emergencies, Article 9 on accessibility, Article 19 on independent living, and Article 21 on access to information and communication.

**Preparedness is most effective when everyone has the tools, knowledge and opportunity to act confidently in an emergency.** Accordingly, two complementary Guidelines were created:

1. **Guidelines for Persons with Disabilities:** Guidelines to support persons with disabilities to prepare, act, and recover in any emergency, and to guide the caregivers and other persons and institutions to support these activities.
2. **Guidelines for First Responders:** A guide to help emergency services support persons with disabilities.

**Both guidelines will also be available in more accessible formats,** including Easy-to-Read.

**These Guidelines are currently being reviewed and updated through two rounds of consultations taking place between May and June 2026.** The process includes online meetings and written feedback from civil protection authorities, emergency response personnel, as well as organizations of and for persons with disabilities.

### Who These Guidelines are For

**These Guidelines are written for first responders across Europe, aimed at the five response roles most likely to encounter persons with disabilities in an emergency.** The mandates, roles, and responsibilities of these responders differ, however, not only among UCPM Member States and Participating States but also across different types of emergencies and crises, such as everyday emergencies, disasters, and armed conflict. The Guidelines are therefore kept broad enough to be adapted to each context, and the guidance per mandate is kept deliberately general to fit all these different roles and responsibilities.

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# Glossary of Terms

**Accessibility:** The condition where persons with disabilities can access places, services, information, and transportation on an equal basis with others.

**Active listening:** A way of listening where you give the person your full attention, reflect back what they say, and show understanding without judgment.

**Agitation:** A state of heightened distress where a person may pace, move repeatedly, speak loudly, or be unable to stay still. Agitation means the person needs space and calm, not force.

**Aggression:** Behavior directed toward people, objects, or the environment that carries a risk of immediate physical harm. Different from agitation and requires backup support.

**Assistive technology:** Any device, equipment, or tool that helps a person with a disability maintain or improve their abilities. Examples include wheelchairs, hearing aids, white canes, and communication devices.

**Augmentative and Alternative Communication (AAC):** Methods and tools used by persons who cannot rely on speech. This includes pictograms, communication boards, pictograms, and speech-generating devices.

**Autonomy:** The right of persons with disabilities to make decisions about their own lives, including during emergencies. It means asking before acting and following the person's instructions.

**Barriers:** Physical, communication, social, or system factors that prevent persons with disabilities from participating equally. In emergencies, this includes inaccessible exits, lack of accessible information, or discriminatory attitudes.

**Disability:** The interaction of long-term physical, mental, intellectual, or sensory impairments and environmental or attitudinal barriers that may hinder full, equal participation in society. Disability does not require a formal diagnosis or visible signs.

**Disability inclusion:** The meaningful participation of persons with disabilities and the consideration of their perspectives in all areas of policy and operations.

**Echolalia:** A communication pattern where a person repeats words or phrases spoken to them, either immediately or after a delay. Common in persons on the autism spectrum.

**Emergency:** A situation that threatens life, safety, health, or property and requires immediate response. For persons with disabilities, emergencies create greater risks due to existing barriers.

**Functional requirements:** The specific conditions, adjustments, or support that a person with a disability requires to participate safely and effectively. Used instead of "special needs."

**Independence:** The physical ability to complete daily tasks and activities without physical assistance from others. A person can be independent in some areas and require support in others.

**Informed consent:** Agreement given freely by a person based on sufficient information. In emergencies, consent must be sought before any physical contact or intervention.

**Mobility aid:** Any device that supports a person's ability to move, including wheelchairs, crutches, walking frames, canes, and prosthetic limbs. A mobility aid is an extension of the person's independence.

**Organisation of Persons with Disabilities (OPD):** An organisation led and governed by persons with disabilities that represents their interests and advocates for their rights.

**Personal emergency plan:** A document developed by or with a person with a disability that describes their specific needs, preferred assistance, medication, devices, emergency contacts, and instructions for responders.

**Preparedness:** The capacities established before emergencies to ensure effective response. This includes risk awareness, planning, accessible warnings, and trained response.

**Psychological First Aid (PFA):** An approach to supporting persons in acute distress following a crisis. It follows three actions: Look (observe and ensure safety), Listen (make contact and attend to needs), and Link (connect to services and support).

**Reasonable accommodation:** Necessary modifications made in a specific case to ensure a person with a disability can exercise their rights equally with others. Denying reasonable accommodation represents discrimination.

**Referral:** The active connection between a person and a specialist service or agency better suited to meet their needs.

**Resilience:** The ability of a community or system to resist, absorb, and recover from hazards. For persons with disabilities, resilience depends on whether they are included in preparedness and can access support.

**Response:** Actions taken directly before, during, or immediately after an emergency in order to save lives, reduce health impacts, ensure public safety, and meet the basic needs of the people affected.

**Support network:** A group of trusted people, including family, friends, neighbors, and personal assistants, who know a person's requirements and can provide assistance before, during, and after an emergency.

# Introduction: Preparing Together

**Europe is facing a new reality, marked by increased risk and deep uncertainty**. Climate change is increasing the frequency and severity of floods, wildfires, heatwaves, droughts, and other extreme weather events. At the same time, new threats such as cyberattacks and disinformation can disrupt essential services, spread confusion, and affect daily life. These challenges are becoming more frequent, more complex, and more interconnected, making preparedness and resilience increasingly important for everyone.

**These events hit some groups harder than others.** Persons with disabilities, women, children, and older persons are often the most affected. Too often, these persons are left behind in the response.

**As a first responder, you are often the first person to meet persons with disabilities when an emergency happens, but you may not always know how to assist and support them.** Different persons need different levels and kinds of support. Being ready to provide it must be part of your everyday work, including your training and your plans.

**Persons with disabilities should be seen as active agents of resilience with resources and strengths.** Persons with disabilities know best what is right for them and can help you assist them effectively. With this in mind, support should increase autonomy, not dependency. These guidelines show you how to act in order to respect people's requirements, needs, and choices in emergency situations, honoring their rights and dignity.

# What These Guidelines Contain

**These Guidelines walk you through an intervention from start to finish: how to prepare yourself and your community before any intervention, how to act on the scene, and how to close the intervention and learn from it.** The "How to Act in Emergencies" part contains guidance by type of disability. It addresses seven main types: visual, hearing and speech, psychosocial, autism spectrum, intellectual, locomotor and mobility, and complex medical dependencies. These are not intended as labels or diagnoses, but rather as entry points to help you find guidance quickly.

**Self-Check on Your Beliefs.** Before you begin, take a moment to check your beliefs and assumptions about persons with disabilities. The Guidelines position persons with disabilities as active agents of resilience, with their own resources, expertise, and knowledge of their disability. They can guide you to offer support that respects their rights and dignity, according to their requirements, needs, and preferences.

**The Guidelines follow the natural flow of an intervention.** You do not need to read everything at once. Start with the part that matches what you need right now.

- **Part 1. Preparing Before the Intervention** contains guidance on how to know and engage your community, check your beliefs, make first contact, work together with caregivers, always ask before you act, listen actively, and understand what the person needs by focusing on function rather than diagnosis.

- **Part 2. How to Act in Emergencies** shows you what to do on the scene. This is the largest part of the Guidelines. It gives you specific actions for the seven types of disability listed above. For each one, you get a Quick Reference, how to communicate, and how to act according to your role.
- **Part 3. Closing the Intervention** shows you what to do before you leave and after the intervention ends. It covers key checks before leaving, how to leave the person more prepared for next time, how to take care of yourself, when to ask for help, what to do after a difficult call, and how to reflect and learn so the next intervention goes better.

**Use the Toolbox for the Guidelines that accompany these guidelines**. It's the actionable part of the guidelines and offers practical advice for speaking with persons with disabilities in an intervention and about them in institutional communication, techniques for grounding people and for staying calm, and quick reference cards on what to do and what to avoid on the scene and explore the subjects of disability and inclusion. Keep it on your phone or tablet and share it with your colleagues.

# Part 1. Preparing Before the Intervention

## Know and Engage Your Community

**Build relationships with your community, including persons with disabilities and their organisations, before any emergency.** Knowing your area, its services, organisations, groups at risk, and informal support networks, helps you be more prepared, respond faster and with more dignity.

**Persons with disabilities and their organisations should lead inclusive planning, preparedness, and response.** Include them in drills, consult them during interventions, ask for feedback, and use it to do better next time.

**This matters beyond work too.** Time spent with people different from you builds empathy and chips away at bias. Empathy is a skill, built through curiosity and exposure.

**Personal experience with disability is useful but not enough for skilled interventions.** No two persons with disabilities are the same, even within the same disability group. You cannot guess what someone requires and needs in an emergency from a label.

### How to Engage Your Community

**As a person in your community:**

- **Identify and contact local OPDs.** They know who is in the community, what functional requirements exist, what services are available, and where the gaps are.
- **Learn the specific barriers OPDs and disability organisations face.** Knowing this in advance means you arrive informed, not improvising.
- **Volunteer at and participate in activities organised by or for persons with disabilities.** Low-stakes contact builds trust, exposes you to the full diversity of

disability, and develops the mutual recognition that makes emergency collaboration work.
- **Invest in ongoing relationships, not transactional contacts.** Trust takes time.

**As a professional within your institution:**

- Engage disability services, social services, and specialist providers before an emergency, including mental health crisis teams, rehabilitation services, and supported living. Know who they are, what they cover, and how to reach them outside standard hours.
- Where registers of persons with disabilities or groups at risk exist, know how to access them and understand the legal framework, including GDPR data protection obligations.
- Include persons with disabilities and OPD representatives in planning, exercises, and debriefs as active contributors. Ensure the diversity of the disability population is represented, including persons with intellectual and psychosocial disabilities, women and girls with disabilities, older persons, and migrants with disabilities.
- In needs assessments, use both quantitative and qualitative evidence to identify barriers and risks. Response plans should reflect that evidence, and avoid general assumptions.
- Establish intersectoral referral pathways linking emergency response with health, social, and community services. Pathways that ignore disability leave persons with the highest functional requirements without a route to support.
- Build coordination personnel's capacity on disability inclusion through trainings and other preparedness activities, and include OPDs in capacity-building.
- Establish an annual calendar of training, simulations, and awareness activities to keep engagement continuous rather than one-off.
- Document interested organisations and formalise relationships with simple tracking, collaboration protocols, and clear roles. Test these through joint exercises.
- Share the outcomes of exercises and activities online, institutionally, and in local media where appropriate. Real stories and accessible materials reach further than formal reports and draw new participants in.

## Check Your Beliefs

**As a first responder, you may not always have much time during an intervention.** You often need to act quickly. In these situations, it can be easy to make assumptions about the person in front of you. If those assumptions are wrong, they may unintentionally cause more harm than good.

**Below you have you six rules to remember.** Each rule has a question to ask yourself. Use these questions now to check your ideas. Use them again when you help a person with a disability in an emergency. This way you can make sure you do not do more harm and that you help persons with disabilities feel respected and supported.

### Box 1. Check Your Beliefs: Questions to Ask Yourself

1. **Dignity**

Am I talking to the person? Or am I talking to their caregiver or friend because it feels easier?

2. **Choice**

Do I start with what the person can do and what the person wants? Or do I start with their disability and what I think they need?

3. **Asking First**

Did I ask the person before I acted, touched, or helped? Or did I think it was OK because the emergency is urgent?

4. **Equal Treatment and Changes to Help**

Can I remove things that make this situation hard for the person? Or am I leaving the person to deal with the problem alone?

5. **Safety and Choice**

Is the person's wheelchair, cane, or caregiver staying with them? Or am I taking them away when I do not need to?

6. **Do No Harm and Protect**

Am I doing what is best for the person? Or am I doing what is faster and easier for me?

## How to Make First Contact

**How you first talk to a person with a disability in an emergency shapes everything that follows.** A calm, clear and respectful start helps the person feel less afraid and builds trust. Check their communication preferences and adapt. Make sure they know who you are and that you are there to help.

**Always respect the person's culture.** When working with children, women, or families from different cultures, think about gender with care. In some cultures, there are strong rules about who can give care. A first responder of a certain gender may build trust more easily. When possible, have a colleague of a different gender close by.

**How to act:**

- **Keep the person safe.** Move the person away from danger when it is safe. Find a quiet place to talk and keep the person away from media and people watching.
- **Always come to the person from the front, at a calm and steady pace.** Speak calmly or wave your hand where they can see it so they notice your presence.
- **Face the person and get down to their level.** Crouch or sit down when the person is on the ground, sitting or in a wheelchair. Do not force eye contact.

- **First, check how the person communicates, if they understand verbal communication, and adapt your approach accordingly.** Use speech, writing, gestures, pictograms, or a translation app as needed.
- **Keep your voice calm, low and steady.** Be gentle. Be respectful. Be considerate.
- **Say your name and where you work.** Show your badge or ID. If the person seems unsure or wary, encourage them to call 112 to verify your identity. This can help build trust.
- **Ask for information in a gentle way.** Do not push for answers.
- **Stay at a good distance and always leave a clear way out.** When you block the way out, the person can feel more afraid. Some people may have strong reactions when they feel trapped. They might get upset or even aggressive.
- **When two or more helpers are there, only one should talk to the person.** Many voices at the same time cause confusion and distress. The other helpers should stay close but at a distance.

### Box 2. What to Say First

1. **Check how the person communicates and adapt your approach.**
2. **Say your name and where you work in simple words.** Show your badge or ID.
3. **Reassure the person.** Let them know they are safe and you are there to help.

**You can say:**

*“Can you hear me?” (point to your ear) “My name is Vlad. I am a firefighter. You are safe now. I am here to help you. You are not alone.”*

## How to Spot Non-Visible Disabilities

**Not every disability is visible.** The seven response sections that follow often overlap, and the people you meet may have co-occurring conditions even if they show no outward signs.

**Look for signs that the disability may not be visible.** The person may avoid eye contact, take longer to answer, repeat words or movements, cover their ears, freeze, seem confused by simple instructions, or carry a Sunflower lanyard, pin, or card (see below). A family member or companion may also tell you. Even without these signs, always check when approaching whether the person understands verbal communication, and always ask how they prefer to be helped.

### The Hidden Disabilities Sunflower

**The Hidden Disabilities Sunflower is an internationally recognised symbol for non-visible disabilities.** It is a green lanyard, wristband, pin, or card with yellow sunflowers, worn voluntarily by people who may need more time, patience, or a different kind of support (see Figure 1. Hidden Disabilities Sunflower below**).** The wearer does not have to explain their condition, and many also carry a Sunflower card with information about their needs, medication, or emergency contacts. You can find more information at [hdsunflower.com](hdsunflower.com).

**Figure 1. Hidden Disabilities Sunflower**

**Source:** The Hidden Disabilities Sunflower. University of Sydney, Students share their experience of the Hidden Disabilities Sunflower initiative (2023).

## How to Work Together with Caregivers

**In an emergency, when a caregiver, support person or communication facilitator (such as a sign language interpreter) is there, greet them and talk to them from the start.** They know how the person prefers to talk, what upsets the person, what support tools the person uses, and what works well. When you talk to them at the right time and in the right way, your work is safer and the person is treated with more dignity.

**However, always talk to the person with a disability first and in a direct way.** Caregivers and Interpreters facilitate your communication but they should not take the place of the person as they know their own life and requirements best.

**Other people can also help you, not just the caregiver.** In a building, the building manager may know which floors have persons with disabilities and what they need. In a community disaster, the mayor, local social services or community leaders may know where persons with disabilities live and what support they need. In hospitals and care homes, social workers and case officers know the persons in their care well. In all cases, the rule is the same: find the people who know and talk to them before or together with the person with a disability.

**You should pay more attention to these four situations:**

1. **Children with disabilities:** A caregiver or trusted adult should always be there when you talk to a child with a disability. When no caregiver is there, find one before you go on when time allows. Do not talk to a child alone unless there is an urgent safety reason.
2. **Persons with autism, intellectual disabilities or big communication needs:** When you can, talk to the caregiver first. Find out the best way to talk, what things

upset the person, and what helps the person stay calm. The goal is to make your direct talk with the person work better, not to skip it.

3. **Persons in hospitals or care homes:** When time allows, check with the social worker, case officer or staff member before you talk to the person. They know the person and their history better than anyone. This makes your work safer, faster and better.
4. **Deaf and Hard of hearing persons:** When the person uses sign language and a sign language interpreter or another communication support is available (family member, colleague, app), engage them so the conversation can happen directly with the person. The interpreter or support relays the conversation but they do not replace the person or speak for them. If no interpreter is available, agree on another method together with the person, such as text on a phone or clear face-to-face speech for lip-reading.

> ### Box 3. Questions to Ask Caregivers Before or During the Talk
>
> - **How does the person talk or understand speech?** Is there a different way to communicate needed?
> - **What causes the person stress or strong reactions?** (sounds, touch, other)
> - **What usually helps the person stay calm?**
> - **Are there body handling or medical requirements I should know about?**
>
> Ask these questions early. The caregiver knows the person well. Use this knowledge.

### When to Separate a Person from Their Caregiver

**As a rule, do not separate a person with a disability from their caregiver, unless there is a danger.** The caregiver helps the person to communicate, to move around safely, and to feel safe. When you take the caregiver away, even for a short period, the person can feel scared or lost. In the eventuality that **the caregiver is dangerous for the person with a disability,** you must separate them to keep the person safe and explain clearly why you do this.

**Make sure the person gets help from someone else during this time.** Never leave the person alone without support. Only separate them for as long as needed.

## Always Ask Before You Act

**In an emergency, always ask the person with a disability what they need** unless their life is in immediate danger. Remember that people with disabilities are not all the same. Never assume. Always ask.

**Accept what the person tells you.** You do not need to look for medical papers or a diagnosis. If a person says they have a disability or functional limitation, believe them. Make it safe for them to ask and receive support.

**Box 4. Always Ask: "How Would You Like Me to Help You?"**

Before you do anything, check if the person understands verbal communication and ask:

***“How would you like me to help you?”***

This question shows that you respect the person. It shows that the person can make their own choices. It opens a real conversation. It makes sure that you help the person in the way they want. The person with disability always knows what is best for them.

**If the person cannot answer with words, give them other ways to answer**, such as gestures, pictograms or ask their caregiver to help them answer.

**In an emergency, unless life is in immediate danger, there is always time to ask.** Ask these questions:

- **Ask what the person needs and wants.** Do not tell them what you think they need.
- **Ask what is most important to them right now.** Support them to make their own decisions.
- **Ask if there is a person they trust who should be with them.** This can be a caregiver, a personal assistant, a family member, or another support person who knows them well.
- **Ask how they want to communicate with you.** Ask if there are things that upset them, so you can avoid them.
- **Ask if they have a health condition or take medicine that you need to know about.**
- **Do not act before** you ask and before the person answers.

## How to Understand What the Person Needs

### How to Listen Actively

To understand the person, you have to listen. Good listening works in 3 ways:

- **with the eyes:** by giving the person your full attention;
- **with the ears:** by truly hearing what the person says;
- **with the heart:** by showing real care and no judgment.

**This is called active listening.** When you listen this way, the person feels understood, is more likely to share their needs, work with you, and stay calm. It also helps you understand information better and avoid mistakes.

**With persons with disabilities, you may need to change how you listen.** Give the person more time to answer. Stay calm and do not judge. Use your presence, your face, and simple body language to make them feel heard.

Table 1. How to Listen Actively

| Skills | How to Listen Actively |
|---|---|
| Pay Attention | Give the person your full focus. Look at them. Watch their words and body. Do not interrupt. Use a calm, warm voice. |
| Hold Judgment | Do not solve or advise right away. Stay open. Listening does not mean you agree. |
| Encourage | Show it is safe to speak. Nod. Show warmth. Never rush the person.<br>Say "Yes." or "I see." |
| Reflect | Say the main points back in your own words. Name the feeling you see. Do not guess.<br>Say "It sounds like this has been very frightening for you." |
| Clarify | Ask open questions that cannot be answered with yes or no. Do not lead the person.<br>Say "Can you tell me more about what happened?" |
| Summarise | Say the main points and feelings back. Confirm you understood.<br>Say "So what you are telling me is… and what you require right now is…" |
| Share Next Steps | Once the person feels heard, give information. Be clear about what happens next. |

## Focus on Function, Not on Diagnosis

**A medical diagnosis does not tell you what a person needs or how to support them.** People with disabilities have different levels of autonomy and independence: some need no support, some need specific support, others need full support with daily tasks. Whatever their level of support, they can always tell you what they prefer. Disabilities also vary greatly, even within the same type. Ask these five questions and use the answers to guide your assistance:

- What can the person do on their own?
- What do they need help with?
- What barriers are in their way right now?
- What would make them safe and comfortable?
- How can I support them to decide what they want?

**Do not ask for proof of disability or medical documents.** If a person tells you they have a disability or functional limitation, believe them. Some people have no official diagnosis. Some disabilities are invisible. Their needs are still real and urgent. Never make them prove their disability is real. Make it safe for them to tell you their requirements and needs.

## How to Support a Person Take Their Own Decisions

**In an emergency, once you have made contact, your main concern is to support the person in making their own decisions about their body, movement, care, and the items they rely on for assistance.** Making one's own decisions is a legal right and must be respected at all times, including in crisis situations. When interacting with persons with disabilities, it is important that you do not take this right away from them. Instead, help them reach their own decision. This is called supported decision-making.

**Ask the person directly what they want, and use whatever communication method works for them.** Persons with disabilities are experts in their disability and in their own lives and know best what they require, need and prefer. Do not assume a person cannot make their own decisions because of their disability. Remember that a person who needs support to decide is not the same as a person who cannot decide.

**Practical steps to support a person with disabilities in making their own decisions:**

- **Communicate in the person's way.** Verbal, written, signed, device-based, gestures, behaviour. All are valid. Arrange an interpreter or trusted supporter if needed; do not skip this because it takes longer. No understanding means no consent.
- **Speak to the person, not the companion.** The person with the disability is the rights holder. A companion can help communicate, but should not decide for them.
- **Give time.** Wait for an answer before rephrasing. Slower replies are still answers.
- **Offer real choices.** A choice is only real if more than one option is genuinely available.
- **If their choice cannot be known, follow their will and preferences.** Use prior wishes, or what someone who knows them well says they would want. Not your view of their best interest.
- **Always seek consent.** Explain what you will do and why, before you act. There is always time for consent. Check they have understood and agreed.
- **Act without consent only if life is at immediate risk and consent cannot be obtained.** Return decision-making to them as soon as it is safe.

# Part 2. How to Act in Emergencies

## 5 Rules for Everyone

**These 5 rules apply in every interaction with a person with a disability.** They apply no matter your role, the type of disability, or the type of emergency. Remember them. Apply them every time.

**Box 5. 5 Rules for Everyone**

1. **Relate to the person, not to the disability.**

   Treat the person behind the disability with respect and compassion. Persons with disabilities are active agents of resilience. They have knowledge, valuable capacities, and resources.

2. **Ask before acting and accept what they tell you.**

   A person with a disability knows what they require and how they prefer to be assisted. For non-visible disabilities, look for a Sunflower lanyard, pin, or card. Always start with checking how they communicate and ask: How can I help you?

3. **Speak directly to the person and support them to take their own decision.**

   If a caregiver or interpreter is present, speak directly to the person with the disability. Do not talk about the person in the third person while they are present.

4. **Do not separate or leave behind assistive devices.**

   Treat assistive devices as part of the person. They help the person manage on their own. Always try to save the assistive devices or animals, unless your life is in danger. Make sure the person always has access to what they require.

5. **Never leave a person alone.**

   Always link the person with the next service or first responder. Leave them more connected than you found them.

## Respond to Visual Disabilities

**Visual disability is on a spectrum, from partial sight to full blindness.** Many persons with visual disability do not use a cane, do not identify as disabled, and are not known to any service. This makes the disability often invisible to first responders.

### Quick Reference

| Category | Key Points |
|---|---|
| **Main Risks** | › Person can walk into danger before sensing it. |

| Category | Key Points |
|---|---|
| | › Loss of cane, guide dog, or phone removes mobility, orientation, and ability to call for help.<br>› Without a clear introduction, the person cannot judge whether to trust or follow you. |
| **What To Look For** | › White cane, plain or with a red tip.<br>› Guide dog wearing a harness.<br>› Sunglasses worn indoors.<br>› Person moving by touching walls, furniture, or surfaces. |
| **Adapt Your Approach** | › **Born with visual disability:** Often move with more confidence than persons who lost sight later in life. Handle clear spoken instructions well. May not have the same understanding of the world as you do. Explain thoroughly. Ask questions to verify.<br>› **Lost sight later in life:** May not carry a cane. May not identify as disabled. More likely to feel disoriented and more cautious. Give extra time and patient support.<br>› **Low vision:** Keep some sight, but it changes with light, stress, or tiredness. Can behave as a blind person in some contexts, like in smoke, dust, or low light.<br>› **Visual disability with other disabilities (including older persons):** Require a combined approach. Check the other relevant sections. |

## How to Communicate

**Your voice is the main tool:**

- Introduce yourself clearly with your name, role, uniform, and reason you are there.
- Keep talking throughout the intervention because silence is disorienting.
- Anchor your words to the person's body or to sounds and objects they can touch, and never say left, right, or over there.
- Describe obstacles and next steps before they happen.
- Say out front before you touch the person or any object near them.
- Do not hand over written information. Read it out loud, type it into their phone for the screen reader, or send a voice message.
- For persons who are deafblind, spoken communication does not work, so keep any specialist interpreter with the person at all times.

See the **Toolbox** for more on the Sighted Guide Technique and verbal guidance.

## How to Act by Role

### 112 Operators

**You are the first point of contact. You are the only first responder who is not physically there. You work only through voice.**

- Keep talking. Say what is happening, what help is coming, and what the person should do while they wait.
- Anchor your words to what the person can touch or hear around them. Do not say left, right, or over there.
- Give first aid guidance if needed. Walk the person through it as you would with any caller. Describe every step clearly. Do not assume the person can see anything.
- Brief the field units before they arrive. Tell them the person has a visual disability. Tell them where the cane or guide dog is, if you know. Tell them to announce themselves out loud before they approach.
- If the call is silent or has no voice, do not dismiss it. A person with a visual disability under stress may not be able to find or use their phone. Follow the standard silent call and callback steps.

### Firefighters / Mountain Rescuers

**You are often first on scene. Your time with the person is short and intense. Smoke, poor lighting, bad weather and debris have often already removed the person’s main sight cues.**

- Look for signs of a visual disability: a white cane, a guide dog, sunglasses indoors, or a person feeling their way by touch.
- Look for dangers in the person's path that they cannot see. Remove them. Move the person along a safe route, using the way of guiding they prefer. Move at their pace. Say what is happening as you move.
- Announce yourself out loud before you approach. Do not rely on the person seeing your uniform.
- Keep talking to the person. Always narrate what you are doing. Tell them what you will do before doing it.
- If you wear a breathing mask, helmet, or full protective gear, describe yourself: “I am wearing a helmet and a breathing mask. I am a firefighter and I am here to help you.”
- If you put a mask, oxygen, or any device on the person’s face or body, say so first: “I am going to place a mask over your nose and mouth now.”
- Offer your elbow. Do not grab the person’s arm. Talk as you move. Describe obstacles and distances based on the person’s body. Ask what the person needs and how they want to be helped or guided. Do not assume.
- If you evacuate or rescue a group, form a single-file chain. Each person holds the shoulder of the person in front.

- Keep the cane, phone and guide dog with the person at all times, whenever possible. If they get lost during the evacuation, they must be searched for and returned.

### Police

**You may be the first uniformed first responder on scene. Visual disability is invisible most of the time.**

- A person who does not respond to a wave, a gesture, or a hand signal is not being uncooperative. They may simply not see it.
- Say your name and role out loud before you approach. Do not shout. Keep you normal tone of voice.
- Do not read hesitation, confusion, or slow response as refusing to cooperate.
- Do not startle the person. Make verbal contact before you move toward them. Do not touch without announcing.
- If the person seems reluctant to follow, give them time. They cannot check who you are by looking. Trust must be built through your voice and your behaviour first. Find ways to assure them.
- Offer your elbow. Do not grab the person's arm. Talk as you move. Describe obstacles and distances based on the person's body. Ask what the person needs and how they want to be helped or guided. Do not assume.

### Medical Assistance Personnel

**You have the longest clinical contact with the person. You are responsible for consent, clinical assessment, and handover to the receiving facility.**

- Describe every clinical step before you do it. Do not touch the person without saying what you are about to do.
- Get verbal consent. Do not decide for the person, assuming they cannot decide.
- Speak directly to the person with a visual disability, not to the caregiver.
- Keep the cane, guide dog, and personal phone with the person during transport. If you must separate them, reunite the person with their device as soon as possible. Assure them.
- Write down the visual disability, preferred guiding method, and assistive device details in the handover. Make sure the receiving team knows before handover is complete.

### Social Workers

**You are usually called in later than the other first responders. Or you might already be with the person in a care center. You often know the most about orientation, mobility, assistive devices, and community contacts. Your role continues after the emergency is over.**

- Help the person decide on their preferred guiding method, device arrangements, and community contacts. Pass this on to the field units before or during the intervention.

- Help the person build a mental map of any new place they will stay in. Describe the layout clearly. Guide the person through the main routes so they can learn the space in their head.
- After the emergency, reconnect the person with their cane, guide dog, and phone. Reunite them with family and support network.
- Link the person to information they can use. Read all printed papers out loud. Arrange Braille materials or volunteer readers in the shelter, hospital, or care place where you can.
- Before closing, check if the person has a personal emergency plan, is known to a disability service, or is connected to a support network. If not, help them register with the local civil protection authority.
- Do not close the intervention until at least one connection is in place or formally recorded.

## Respond to Hearing and Speech Disabilities

**Hearing and speech disabilities affect how a person receives information and communicates with others.** They cover a wide range of conditions: mild hearing loss, total deafness, speech impairments, complete absence of spoken language, acquired language disorders such as aphasia and deafblindness. Hearing loss can be invisible. Persons with significant hearing loss may not use visible aids, lip-read, or self-identify. In an emergency, audio-only warnings do not reach this population, and standard verbal interaction does not work.

### Quick Reference

| Category | Key Points |
|---|---|
| **Main Risks** | › Audio-only warnings do not reach the person; they may not know an emergency is occurring.<br>› Non-response to verbal commands is easy to misread as non-compliance or confusion.<br>› Lip-reading can be unreliable; eye contact does not confirm understanding.<br>› Deafblind persons face compounded isolation; neither verbal nor visual channels work.<br>› Loss of hearing aids and implants, AAC device, or interpreter removes the person’s main way of communicating.<br>› Cochlear implant users may not be able to undergo certain emergency imaging procedures, particularly Magnetic Resonance Imaging (MRI), without prior clearance from their clinic. |

| Category | Key Points |
|---|---|
| **What To Look For** | › Red and white striped cane (deafblind); distinct from the plain white cane.<br>› Hearing aids or cochlear implants behind one or both ears.<br>› Person pointing to their ears or from ears to mouth.<br>› Loud vocalisations, urgent gestures, or arms waving to get attention.<br>› Visible effort to speak without producing clear words.<br>› No response to any verbal instruction or called name.<br>› Person trying to write on your palm or reaching for a phone or paper.<br>› AAC device nearby: communication board, pictograms, tablet, or phone with a communication app open.<br>› Membership card, bracelet, or personal emergency plan from a national Deaf association. |
| **Adapt Your Approach** | › **Deaf:** Significant or total hearing loss, usually from birth or early life. Sign language is the primary language; written text is a second language for many. Use visual and light-based alerts and sign language interpretation. Writing is a valid field tool but does not replace them.<br>› **Hard of hearing:** People with hearing loss whose main way of communicating is speech. May use lip-reading, hearing aids, or cochlear implants. Cannot hear well in noise or at distance. Cochlear implants can be disturbed by electromagnetic interference from emergency equipment and MRI. Loss can be one-sided; check which side you speak from. Capacity can worsen under stress. Confirm understanding continuously.<br>› **Sound sensitivity (tinnitus, hyperacusis, sensory processing differences, many autistic persons):** Sirens and alarms can cause pain, disorientation, or panic. May present as freezing, covering ears, or apparent non-compliance. Reduce noise and move the person away from the source.<br>› **Speech impairment:** Can hear you but may not produce clear speech, especially under stress. Often misread as cognitive impairment. Use patience, writing, and yes/no questions.<br>› **Deafblind:** Both verbal and visual channels are inaccessible. Communication relies on tactile methods.<br>› **Deaf and non-speaking:** Significant hearing loss with little or no spoken language. Communication capacity is intact. Use sign language, writing, AAC device, or tactile methods. |

## How to Communicate

- **Get visual attention before speaking.** Move into the person's field of vision, wave in their peripheral vision, or lightly touch the shoulder or upper arm. Never call out from behind or from the side.
- **Position face to face at eye level, within 1.5 metres, in good light.** Keep your face visible and your mouth uncovered. Remove a standard mask if safe, or use a transparent one.
- **Ask how the person prefers to communicate:** lip-reading, writing, sign language, AAC device, gesture, or a combination. Follow their lead and stay consistent. Designate one responder to communicate.
- **Use multiple channels:** speech, writing, pictograms, gesture, and pointing are all valid. Carry paper and pen as standard field equipment, and switch to writing or drawing without hesitation if speech is not working.
- **Never pretend to have understood.** If unclear, write: "I did not understand. Can you write it or show me?" Confirm understanding with yes or no questions and physical signals such as thumbs up or thumbs down. Looking at you is not confirmation.
- **If a sign language interpreter is present, speak directly to the person, not to the interpreter.** Maintain eye contact with the person. Do not say "tell them" or "ask them". Never position yourself between the person and the interpreter. If no interpreter is on scene, ask whether the person has a remote video relay service contact and facilitate the call.

## How to Act by Role

### 112 Operators

**First point of contact, and the only responder without physical presence. The caller may not be able to use voice. Short message service, real-time text, email, video relay, and silent or dropped calls can all be real emergency contacts.**

- Do not dismiss a call that arrives as silence, text only, or broken speech.
- Treat silent or dropped calls as priority until proven otherwise. A deaf person under stress may have called for help but cannot speak.
- If the person is injured and you can reach them by text or relay, give pre-arrival first aid in short, numbered steps. Confirm each step before the next.
- If the person can hear but cannot speak, talk to them normally.
- Give time. Do not rush.
- Ask again if something is not clear. Repeat and rephrase without getting frustrated. Never pretend you understood.
- Brief field units before arrival. Flag the hearing or speech disability and the communication mode. Tell field units not to rely on voice alone and to have paper and pen ready.

## Firefighters / Mountain Rescue

**First on scene, usually for a short and intense window focused on safety and evacuation, often in loud and chaotic settings.**

- Watch for signs the person is trying to communicate: strong lip movements, pointing to the ears, urgent hand movements, trying to write on your palm, torch signals, fabric hung in a window, or a written message held up.
- Switch off sirens before reaching the scene, or as soon as they are no longer needed. Use visual alerts. Keep service radios away from hearing devices. Radios can cause noise in the hearing device.
- If a person does not answer when you call, think of hearing or speech disability first. Go closer, make eye contact, and try writing or hand signs before you do anything else.
- For persons with speech impairments or non-speaking persons, use yes or no questions with a physical signal, such as thumbs up or a nod, to confirm consent.
- If the alarm at the scene is only sound, a person with a hearing disability has had no warning. Treat this as a safety gap. In search and rescue, actively check for persons who did not respond to calls. Use cues other than sound. Silence is not proof no one is there.
- Remove anything that blocks the view between you and the person. The person needs to see your face. Make eye contact before you do anything. Wave or lightly touch the arm to show you are there.
- Carry paper and pen as standard field gear. Use them from first contact. You can also use you phone to type in.
- Check for member cards, cochlear implants, bracelets, or personal emergency plans. Members of Deaf associations often carry these, with their communication preferences and interpreter contacts.
- Only one responder should talk to the person at a time. Take turns if needed. Never speak at the same time.
- Ask for a sign language interpreter.

## Police

**You may be first or second on scene. You might have to talk to the person as part of larger group of persons or individually. You might need to ask them to follow instructions.**

- A person who seems unresponsive, non-compliant, or confused may have a hearing or speech disability. Do not escalate before checking if the person can hear or speak.
- For persons with speech impairments or non-speaking persons, use yes or no questions with a physical signal, such as thumbs up or a nod, to confirm consent.

- Switch off sirens before reaching the scene, or as soon as they are no longer needed. Use visual alerts. Keep service radios away from hearing devices. Radios can cause noise in the hearing device.
- Identify yourself visually. Hold up your badge and point to it.
- Remove anything that blocks the view between you and the person. The person needs to see your face. Make eye contact before you do anything. Wave or lightly touch the arm to show you are there.
- Carry paper and pen as standard field gear. Use them from first contact. You can also use you phone to type in.
- Check for member cards, bracelets, or personal emergency plans. Members of Deaf associations often carry these, with their communication preferences and interpreter contacts.
- Only one responder should talk to the person at a time. Take turns if needed. Never speak at the same time.
- Ask for a sign language interpreter.

### Medical Assistance Personnel

**Often the longest clinical contact before handover. Responsible for consent, assessment, and information transfer to the receiving facility.**

- Get consent and explain every step through writing or visual cues when voice does not work.
- Ask the person how they want to communicate. Follow their answer: lip-reading, writing, sign language, communication device, or a mix. They know best what they need.
- For persons with speech impairments or non-speaking persons, use yes or no questions with a physical signal, such as thumbs up or a nod, to confirm consent.
- Do not assume non-speaking means unable to decide.
- Do not remove or switch off augmentative and alternative communication devices. They are the person's voice.
- In the handover, record the disability, the existence of cochlear implants, communication mode, device details, and interpreter contacts. Confirm the receiving team has this before leaving.

### Social Workers

**Usually activated later, but holds the deepest knowledge of the person's communication profile and the longest mandate, through the aftermath phase. They can also be caregivers in a care center.**

- Pass on communication preferences, sign language use, augmentative and alternative communication device details, interpreter contacts, and home sign contacts to field units before or during the response.
- On scene, take over communication coordination from field responders as soon as possible.

- Make sure an interpreter or video relay service is in place before leaving.
- Find a known person first. Ask if a family member, caregiver, neighbour, or known support person is there or can be reached. A family member may share the person's family signs. A caregiver may know the person's communication device.
- Ask for a sign language or spoken language interpreter straight away. Speak to the person, not to the interpreter.
- Before leaving, check whether the person has a personal emergency plan, is known to a disability service, is on a groups-at-risk registry, or is linked to a support network or organisation of persons with disabilities. Do not close without at least one connection in place. Leave them more connected than you found them.

## Respond to Psychosocial Disabilities

**Psychosocial disabilities affect how a person experiences, processes, and responds to reality, emotion, and their environment.** They include a wide range of conditions, including but not limited to schizophrenia, bipolar disorder, and dementia. Conditions vary widely and are almost entirely invisible. A person in acute psychosocial crisis may appear agitated, still, repetitive, elated, or entirely disengaged. Each of these is easy to misread. In an emergency, the environment itself, including noise, crowding, unfamiliar persons, and loss of routine, may be disturbing for persons with psychosocial disabilities.

### Quick Reference

| Category | Key Points |
|---|---|
| **Main Risks** | › Misreading the person: thinking that agitation means aggression, or that mania points to drug or alcohol use.<br>› They may have real cause to worry but not be taken seriously, because they are seen as delusional and dismissed.<br>› Crisis or worsening state because they cannot access medication or continue treatment.<br>› Instability, especially without proper treatment.<br>› Fast shift from agitation to aggression.<br>› Exploitation or abuse when cut off from caregiver and family. |
| **What To Look For** | › Pacing, loud or fast speech, big gestures, or being unable to stay still.<br>› Standing completely still, not responding to their name, or seeming cut off from what is around them.<br>› Repeating the same words or questions over and over.<br>› Reacting to things you, yourself, cannot see or hear: a sign of hallucination or delusion. |

| Category | Key Points |
|---|---|
| | › A strong or sudden reaction to a specific trigger: noise, touch, a command, or a blocked exit.<br>› Very high mood, fast speech, grandiose beliefs, or risky impulsive behaviour: signs of a manic episode.<br>› Saying they want to harm themselves or someone else. |
| **Adapt Your Approach** | › **Persons with schizophrenia or conditions involving hallucinations and delusions:** May be reacting to voices, threats, or beliefs you cannot see or hear. They may be frightened, or convinced of a danger no one else can sense.<br>› **Persons with dementia or Alzheimer's disease:** May not recognise where they are, may ask the same question over and over, and may try to return to a place they feel safe in, even if it no longer exists. They may believe things that are not true today, such as that a deceased family member is still alive.<br>› **Persons in a manic episode:** May be very energetic, talk fast, hold grandiose beliefs, and act on impulse. They may look fine on the surface but cannot judge risk or recognise danger. They can shift quickly to agitation or aggression if they feel challenged or blocked. |

## How to Communicate

**Help the person feel calmer before you ask them to do anything.** In a crisis, a person cannot follow instructions or make decisions until their distress has eased. Lower your voice before you are within speaking distance. Move slowly and predictably.

- Designate only one person to speak. More than one voice increases confusion and escalation risk.
- Lower your voice, speak slowly and respectfully, use title and surname, stay in the present tense.
- Do not use first name without permission, and do not speak informally or use infantilising, colloquial, or undignified terms.
- Address the emotion before anything else: *"I can see you are frightened"* before any instruction or question.
- Do not argue, correct, contradict, use humour. Do not keep lectures or give orders.
- When the person describes a delusion or hallucination, do not argue with the content, confirm it as real, or dismiss it. Acknowledge the emotion behind it: *"That sounds very frightening"* . The emotion is always valid even if the reality is not.

## How to Act by Role

## 112 Operators

**You are the only remote responder. The briefing you give shapes what happens on scene.**

- Do not dismiss calls that are incoherent, repetitive, or unclear. These are often signs of acute distress, not pranks.
- Stay on the line. Your presence stabilises. Keep talking to them.
- Do not dismiss delusional content. Redirect to what the person can see and hear now.
- Ask if a caregiver, family member, or neighbour is present. If so, speak with them for diagnosis, medication, and support for calming them down.
- Ask what the person is afraid of and what to avoid. More actionable than asking what happened.
- Answer repeated questions directly and simply, every time. Repetition tells you what the person is most worried about.
- Do not correct false beliefs or things the person sees or hears that are not real. Do not argue. Do not mock. Do not engage with it.
- Stay calm if the person becomes louder. Do not match their energy.
- Brief field units with the full communication profile: incoherent, non-speaking, repetitive, agitated, time-disoriented, or potentially aggressive. Knowing beforehand can make a difference in the field.
- Be aware of signs that the person wants to harm themselves or others. Dispatch EMS alongside other units if the person expresses intent to harm self or others, or shows complete loss of contact with the environment.

## Firefighters / Mountain Rescue

**You are the first on scene, in a short intense window. Your focus is on physical safety, rescue and evacuation.**

- Watch the person from a safe distance before you go close. Look for signs like walking back and forth, talking loud or fast, standing very still, looking far away, repeating the same words or movements, reacting to things you cannot see, or strong sudden reactions.
- Say your name and your role. Your uniform alone can look like a police uniform and scare the person.
- Make the place quiet before you go close. Turn off loud sounds and move bright lights if you can. Move other people away. Take the person to a quiet place if you can.
- Lower your voice and speak slowly. Use the person's title and surname, and do not use the first name without asking.
- Slow your movements. If the person is sitting, go down to their level and make yourself smaller if you can.
- An agitated person can become aggressive. Do not trap the person in a corner. Always leave a clear way out and do not stand between the person and the door.

- Stay 1.5 metres away. Do not turn your back and do not work alone. Ask for help from the police or from a mental health crisis team.
- Do not show fear, even if you feel afraid. Fear makes the situation worse.
- Tell the person what you are going to do before you do it, and do not touch the person without asking.
- Ask about medication and make sure it goes with the person.
- Help the person stay in the present. Name things in the room and say what you see around you.
- Offer choices when you can. This helps the person feel more in control and calmer.
- Give short, clear information about the emergency and why you suggest this action.
- Do not move closer until the person has seen you. Keep your safe distance.

## Police

**First or second on scene.**

- Do not read non-response, erratic behaviour, disconnection, or manic presentation as resistance. Treat as crisis. Learn to make the difference between agitation and aggression. Act accordingly.
- Slow your voice and movements. Do not close distance without permission. Do not move to physical intervention unless safety requires it.
- Be aware that an agitated person might become aggressive. Do not corner them. Always leave a clear way out; don’t stand between the person and the exit.
- Hold 1.5 meters distance, do not turn your back, do not work alone.
- Move bystanders away. Take the person to a quiet place, if possible.
- Offer choices when you can. This helps the person feel more in control and calmer.
- Give short, clear information about the emergency and why you suggest this action.
- Do not move closer until the person has seen you. Keep your safe distance.
- If the person refuses to engage, step back and request specialised support.
- If restraint is unavoidable, never use face-down positioning. It can be life-theartening to some persons. Change positions frequently.

## Medical Assistance Personnel

**You spend the most time with the person before handing them over to the hospital or back to their home or care facility.**

- If someone has already held the person down before you arrive, check how the person is lying straight away. Never leave a person face-down.
- Check how the person is feeling and if their condition is getting worse. Check if they need medication. Do this first.
- Tell the person what you are going to do before you do it. Surprise actions can upset the person.
- Do not take the person's phone away. Do not cut them off from family, friends, or caregivers.
- Offer small acts of care, like a blanket or some water.

- Make sure the person can get their treatment and see a doctor. The medication goes with the person.
- Call mental health crisis services and emotional support early, before the person gets worse again.
- When you hand the person over to the hospital team, tell them: how the person is acting, what medication the person takes, what condition the person has, if you know. Make sure the hospital team has this information before you leave.

### Social workers

**You come in later in an emergency. But you often know the persons' requirements and needs best and will stay with them the longest.**

- On scene, take over talking to the person and calming them down as soon as you can.
- Find a known person first. Ask if a family member, caregiver, neighbour, or known support person is there or can be reached. Check the personal emergency plan if one exists.
- Work together with family and caregivers. Link the person to people who support them.
- Stay with the person until a family member or caregiver they know arrives. Or arrange for a trusted person to take your place.
- Help the person get back to their mental health service and their medication. Help them get what they need. Help them get more medication if supplies are low. Help them continue their treatment.
- If the person is from a residential facility or hospital, get in touch with staff they know. Ask staff how to support this person. If the person needs a place to stay in a residential facility, start the process before you leave.
- If the person has no plan and no connection, support them in developing a plan with at least one trusted contact. Do not leave them without at least one connection in place. Leave the person more connected and prepared than you found them.

## Respond to Autism Spectrum Disorders

**Autism spectrum disorders (ASD) are a group of conditions that change the way a person communicates, takes in sensory input, and behaves.** In an emergency, persons with ASD may react in ways that look unusual like a sensory meltdown, crying or screaming as well as hurting themselves repeatedly (e.g., hitting their head, biting). They may not respond to spoken commands. Others may rock or flap their hands. Some may react to pain in ways you do not expect, like laughing when they are hurt or in pain. They may hide or wander off after rescue.

### Quick Reference

| Category | Key Points |
|---|---|
| **Main Risks** | › Sirens, uniforms, touch, and changes in routine can upset them and cause a meltdown.<br>› They may have paradoxical reactions: they may smile or laugh when they are hurt or in pain.<br>› They may repeat words over and over. They may not reply to your questions but repeat what you say. Always check their answers in more than one way.<br>› During a meltdown, they may hurt themselves (e.g., hitting their head, biting). Protect them from harm without restraining unless necessary.<br>› After rescue, they may walk toward water, train tracks, or traffic. This can put their life at risk. |
| **What To Look For** | › No response to their name, to "stop," or to any command, even though the person is awake and present.<br>› Repeating words, phrases, or sounds. This is called echolalia.<br>› Rocking, hand-flapping, spinning, or flicking fingers. These are self-calming movements called stimming.<br>› Noise-cancelling headphones, communication devices, pictograms, or fidget toys.<br>› Hiding in a closet, under a bed, behind furniture, or in any small closed space.<br>› Moving toward water, train tracks, traffic, or firetrucks after rescue, without noticing the danger.<br>› No sign of pain even with a clear injury. Or the opposite: laughing or smiling when badly hurt.<br>› Sensory meltdown from noise: covering ears, freezing, rocking, flapping, shouting, or other strong movements. |
| **Adapt Your Approach** | › **Persons with ASD who do not speak:** They communicate through devices, gestures, or behaviour. No speech does not mean no understanding. Find their communication device first, after physical safety. If there is no device, use pictograms or gestures. Do not force them to speak. Do not read silence as refusal.<br>› **Persons with ASD and intellectual disability:** They may find it hard to follow instructions, say what they want, or manage stress. |

| Category | Key Points |
|---|---|
|  | Give them more time, simpler words, and closer support. Also read the section on Intellectual Disabilities.<br>› **Persons with ASD who have average or high intelligence:** They may seem fluent, calm, and in control. This can hide real distress. They may be masking, which means hiding their stress to cope. Masking has a limit. When it breaks, it breaks fast. Check in with them directly, offer support, and reduce noise and crowding, no matter how capable they look. |

## How to Communicate

**To communicate well with a person with ASD, it is important to keep them calm.** Turn off sirens or keep them away. Keep the number of people on scene low. Avoid sudden moves and loud commands. Some persons with ASD are non-speaking. They may use other ways to communicate, like signs, a communication device, pictograms, or a communication board.

**If a caregiver is there, ask them about how the persons prefers to communicate, what triggers them, what calms them down before you approach.** However, remember, the person with a disability is always the primary rights-holder.

- Approach slowly and from the front. Say who you are before you are close enough to touch
- Do not touch without permission
- Use short, clear, direct sentences. Do not use figures of speech or hints. Give 1 instruction at a time. Wait. Then give the next one,
- Give time for answers. Some persons need more time to process. Do not raise your voice. Do not hurry them
- Ask simple, closed questions. For example: "Does your arm hurt or your leg?" instead of "Where does it hurt?" Always check the answer by asking again in a different way. If the person repeats the last word of your question (echolalia), swap the order of the options and ask again before you trust the answer.
- If words are not working, try gestures, pointing, drawing, or showing pictograms.
- Allow self-calming movements like rocking, flapping, or stimming. If you try to stop them, this can trigger a meltdown. The person can become aggressive.

## How to Act by Role

### 112 Operators

**You are the first point of contact. You also are the only first responders without physical presence on scene. The caller may not always be the person with ASD.**

- Do not dismiss a call with repeating speech or unusual communication. It can be a sign, not a prank. Stay on the line.
- Use short, clear, direct sentences. Do not use figures of speech or hints. Give 1 instruction at a time. Wait. Then give the next one.
- Give time for answers. Some persons need more time to process. Do not raise your voice. Do not hurry them
- Ask simple, closed questions. Always check the answer by asking again in a different way. If the person repeats the last word of your question (echolalia), swap the order of the options and ask again before you trust the answer.
- Ask if a caregiver or family member is there and ask to speak with them.
- If the caller is a caregiver or family, ask them about how to person communicates, what upsets them and what calms them down, before units arrive. Pass the answers to the field units.
- Tell the field units before they arrive that verbal commands may not work. Tell them to turn off sirens on approach.
- Ask if the person has a personal emergency plan, a tracking app on their phone, or is in a groups-at-risk registry.
- If the person is missing, send units to check nearby water and train tracks. Also, check with the caregiver if the person has other favorite places.

## Firefighters / Mountain Rescuers

**First on scene during the loudest, busiest part of the emergency. You also cover search and rescue.**

- Turn off sirens before you reach the person where you can. Noise is a trigger and upsets them.
- Check all hiding places: closets, under beds, small closed spaces, and vehicles.
- If the person is missing, go straight to nearby water or train tracks.
- Approach slowly, at eye level, with open hands. Say your name and role once. Then wait.
- Do not separate the person from a service dog.
- Find a caregiver or family member as fast as you can. Ask them about how the persons prefers to communicate, what triggers them and what calms them down.
- Always try to save their communication devices. Give the person back their communication device and comfort object as soon as physical safety is in place.
- Show equipment before you use it. Let the person touch it first if it is safe.
- Secure the environment after rescue or evacuation. Make sure the person does not wander way towards water, traffic, train tracks.
- Do not leave the person alone after rescue. Hand them over to a caregiver, family member, or specialist.

## Police

**You may be first or second on scene. You are the most likely to be called when a person with ASD is missing or wandering.**

- If the person is missing, ask the caregiver if a tracking app is on the phone before starting a physical search. You can start the search near water sources and rain tracks.
- Search all hiding places: small closed spaces, vehicles, behind buildings. Do not read silence as absence. The person may not speak.
- Sometimes they will not respond, or they will repeat your words. Do not consider this as refusal to cooperate.
- Use pictograms, ask for a caregiver, or call a sign language interpreter, if needed. Some persons with ASD are non-speaking.
- When you approach, slow your body and your voice. Always tell them you are approaching.
- Use short, clear, direct sentences. Do not use figures of speech or hints. Give 1 instruction at a time. Wait. Then give the next one.
- Allow self-calming movements like rocking, flapping, or stimming. If you try to stop them, this can trigger a meltdown. The person can become aggressive.
- Find a caregiver or family member as fast as you can. Ask them about how the persons prefers to communicate, what triggers them and what calms them down.
- Do not leave the person alone. Hand them over to a caregiver, family member, or specialist.

### Medical Assistance Personnel

**You meet persons with ASD mostly in a crisis. You are also the one who finds injuries the person may not be showing. Check the body for injuries step by step, even if the person shows no pain. Paradoxical reactions are common such as laughing when they are badly hurt.**

- Find a caregiver or family member as fast as you can. Ask them about how the persons prefers to communicate, what triggers them and what calms them down.
- Take care of the sensory state before the emotional state. Lower the input first: less noise, less movement, fewer people. Watch if the person settles before you try more communication.
- Allow self-calming movements like rocking, flapping, or stimming. If you try to stop them, this can trigger a meltdown. The person can become aggressive.
- Ask for consent with yes/no questions or thumbs up or down. Confirm with a physical sign if the person does not speak.
- Show equipment before you use it. Let the person touch it first if it is safe.
- Check for swallowed objects, self-injury wounds, or objects in the mouth. Check for pica. Some persons with ASD might like swallowing things that are not food.
- Watch for non-speaking signs of pain: body posture, face, changes in behaviour. Check the body step by step whatever the person says.

- Check for self-injury and for other medical problems that you cannot see and the person may not tell you. Do not assume the clear problem is the only one.
- Do not take away communication devices, boards, or comfort objects.
- Write communication profile, triggers, calming strategies, comfort objects, and caregiver contacts into the handover. Confirm the next team has this before you leave.

### Social workers

**Your priority is to keep them safe and calm. You also have to reconnect them to routine, familiar environment, and their caregivers.**

- Find out who their caregiver is and how to contact them. Look for emergency information on the back of the front door, near the fridge, in a bag or wallet, on a mobility aid or communication device, or with a neighbour.
- Connect them with their caregiver as fast as possible.
- Ensure their routine as much as possible.
- Make sure they have access to their assistive devices.
- Provide them with sensory and calming objects, if needed.
- Check if the person has a personal emergency plan, is registered with a disability service or groups-at-risk registry, or is linked to an OPD, community network, or trusted neighbour. Do not close the intervention until at least 1 connection is in place. Leave the person more connected and prepared than you found them.

## Respond to Intellectual Disabilities

**Intellectual disability affects how a person understands information, communicates, and manages daily life.** Some persons may have other health conditions at the same time that you cannot see. Persons with intellectual disability are very different from one another. Some speak well. Others speak very little or not at all. Many find it hard to follow instructions when they are under stress. Some might nod or say yes but they may not have understood you.

### Quick Reference

| Category | Key Points |
|---|---|
| **Main Risks** | › The person may nod or agree without understanding what you said.<br>› The person may not be able to tell you about pain, injury, or illness.<br>› The person is at higher risk of harm or exploitation when away from their caregiver. |

| Category | Key Points |
|---|---|
|  | › The person may have other health conditions at the same time that you cannot see, like epilepsy or heart conditions.<br>› A seizure can look like a behaviour problem and be misread.<br>› Missing medication causes a second crisis in the hours and days after.<br>› All these risks grow when the person is separated from their caregiver, and are highest when the person is moved from a residential home. |
| **What To Look For** | › The person has trouble understanding or following what you say, but nods or agrees.<br>› The person gives short, unclear, or no answers when asked what happened.<br>› The person looks confused or does not seem to follow what is happening.<br>› The person comes close, touches your equipment, or reaches for objects. This is curiosity or a way to communicate, not aggression.<br>› The person looks away, walks unsteadily, or speaks in an unclear way. Do not assume this is alcohol or low blood sugar. |
| **Adapt Your Approach** | › **Persons with mild intellectual disability:** May seem to follow the conversation well. This can hide real trouble with complex language and decisions under stress. Check understanding at every step, not only at the start.<br>› **Persons with moderate or severe intellectual disability:** May have little or no speech and strong reactions to unfamiliar people, places, or equipment. Give more time, use simpler language, and keep the caregiver close. Allow time for the caregiver to interpret or translate.<br>› **Persons with Down syndrome and other genetic conditions:** May have intellectual disability together with heart, thyroid, or breathing conditions. Ask about other health conditions before you move the person.<br>› **Persons with intellectual disability who do not speak:** Use the same tools as for non-speaking persons on the autism spectrum. This includes pictograms, picture exchange cards, and communication devices. See the autism section for details. |

## How to Communicate

**Remember, the person may not understand what you say, even if they nod or agree.** The person may not be able to tell you what is wrong, give them time. Speak to the person as you would speak to any adult, avoid baby talk or talking down to them. Keep your voice calm and your words simple. If words are not working, use pictograms, gestures, or objects.

**If a caregiver is present, they are a resource for information, but you speak to the person, not about them.** Remember, the person with a disability is always the primary rights-holder.

- Say your name, your role, and why you are there. Show your identification card and point to it. If you wear protective gear, describe it in simple words.
- Use short sentences and simple words. Give one instruction at a time. Wait for the person to finish one step before you give the next.
- Do not use baby talk. Do not talk down to them.
- Never treat nodding or saying yes as proof of understanding. Ask the person to show you or tell you in their own words what they will do next.
- Ask one question at a time. Offer a choice of two options rather than an open question. Point to each option as you say it.
- Tell the person what to do, not what not to do. Say "Walk with me" instead of "Do not run."
- Give the person time. Wait at least 3 seconds after you speak. Do not fill the silence. Do not interrupt.
- If words are not working, switch to pictograms, gestures or pointing. Do not keep repeating the same words louder.
- Speak directly to the person, not to their caregiver.

## How to Act by Role

### 112 Operators

**You are the first point of contact. You cannot see the person. The caller may be the person with intellectual disability, a caregiver, or a bystander. The call may be hard to follow.**

- Do not dismiss a call that sounds unclear, repetitive, or hard to understand. Stay on the line.
- Ask if a caregiver or personal assistant is with the person. Ask to speak with them.
- Do not accept yes or no answers as confirmed. Persons with intellectual disability may agree with questions they have not understood. Ask open questions and listen for consistency.

- Brief the field units before they arrive. Tell them the person may have an intellectual disability. Share the communication profile and any known other health conditions or medication requirements.

## Firefighters / Mountain Rescuers

**You are often first on scene, during the most confusing moment of the emergency. You carry out search, rescue, and evacuation. Your protective gear can frighten the person, or, on the contrary, interest them.**

- Before you approach, scan for signs of intellectual disability. The person may have trouble following what is happening, may look confused, or may look to others for cues on how to behave. Check for communication aids, pictograms, communication devices, or Easy Read materials. Their presence tells you that pictograms or symbols are the way to communicate.
- Check if the person is alone or with a caregiver. A person found alone is a sign the person may be at risk of harm. If the person is alone, do not leave them with unknown persons.
- Introduce yourself fully before anything else. Say your name, your role, and why you are there. Describe your gear: "I am wearing a helmet and a mask. I am a firefighter. I am here to help you." Let the person touch the gear if it helps.
- Use short, concrete sentences. One instruction at a time. Wait for the person to finish one step before you give the next. Move slowly and say each action before you do it.
- Redirect the person gently if they come close, touch your equipment, or reach for objects. This is curiosity, not aggression or obstruction.
- Do not read silence or no response as refusal.
- Ask about medication. Make sure it goes with the person during evacuation or transport.
- Keep the person with their caregiver whenever possible. If the caregiver is not on scene, find them before you close the intervention.
- If the person has fled or is hiding, search in small enclosed spaces.

## Police

**You may be first or second on scene. In this category, the risk of misreading the person is highest. Looking away, not following commands, or unusual behaviour are often wrongly read as non-compliance, alcohol, or suspicious behaviour.**

- Watch for signs that the person has understood nothing, even if they seem to agree. Nodding, smiling, and going along with you are not proof of understanding. Watch for repeated glances at others, delayed responses, or actions that do not match what you asked.
- Check for signs of neglect, injury, or exploitation when the person is found alone or in circumstances that do not make sense. This group is at higher risk, and the signs may not be clear at first.

- Flag as priority any person who is alone, without medication, without a caregiver, without identification. The person may be at risk of harm. Find a caregiver or personal assistant as fast as possible.
- Do not read agreement as a confession or as real consent. Search for the caregiver. Make sure the person can take their own decisions will full consent.
- Do not read trouble following instructions as resistance. Give time and offer support. Work with caregivers or social workers.
- Slow down your voice and your movements before you approach.
- Ask the person to show or tell you in their own words what happened. Do not rely on yes or no answers. Ask questions to verify answers.
- Speak as you would to any adult. No baby talk. No exaggerated slow speech.

### Medical Assistance Personnel

**You stay with the person for the longest time before you hand them over. You check for health problems the person may not be able to tell you about. The person may react strongly to your equipment, to what you do, and to being touched.**

- Identify other health conditions that may not be visible: signs of seizure, breathing difficulty, signs of pain that are not spoken, or physical signs of a condition the person cannot describe. Do not treat intellectual disability as the only clinical consideration.
- Check if the person came from a residential or institutional setting. These persons may arrive with no identification, no medication, no record of their medical history, and no way to name their support worker or facility. Flag this gap to social workers without delay.
- Describe every piece of equipment before you use it. Let the person touch safe items if it helps reduce fear.
- Redirect calmly if the person reaches for equipment or moves toward dangerous areas. This is curiosity, not deliberate obstruction. Involve the caregiver in managing the interaction whenever possible.
- Speak directly to the person, not to the caregiver. Use the person's name.
- Do not rely on standard pain scales or on what the person says. Do a full physical examination regardless of what the person communicates.
- Assess for other health conditions in a systematic way: epilepsy, heart conditions, breathing conditions, swallowing difficulties.
- Ask the caregiver about medication, medical history, and known conditions.
- Offer food and water once the person is physically safe and the environment is calm. Check with the caregiver before you offer solid food or liquids. Swallowing difficulties are common and may not be visible. If no caregiver is there, offer small amounts of water first and watch.
- Ask about medication. Make sure it travels with the person. Make sure they can continue their treatment.

- Document intellectual disability, communication profile, other health conditions, and medication in the handover. Confirm that the receiving team has this before you leave.

### Social Workers

**You usually arrive later than other first responders. You are the most likely to already know the person. You may know how they communicate, what medication they take, what other health conditions they have, who supports them, and their legal status.**

- Share any prior information you hold with the field units before or during the intervention, not after, if applicable. On scene, take over communication from field responders as soon as possible.
- Talk slowly, use simple words, short sentences. Give enough time for reply. If words are not working, shift to gestures, pointing, drawing, pictograms, picture exchange cards, or Easy Read materials. Do not keep repeating the same words louder.
- Find out more information about the person, if needed. Check if the person has a personal emergency plan, is registered with a disability service or groups-at-risk registry, or is connected to an organisation of persons with disabilities, a community network, or a trusted neighbour. Emergency information may be stored inside the front door, near the refrigerator, in a bag or wallet, on a medical alert card, on a mobility aid or communication device, or held by a neighbour.
- For persons from residential facilities, contact the facility as soon as possible. Find out what the person requires, what their communication profile is, and whether known staff can be reunited with them.
- Make sure other health conditions, communication profile, medication details, and caregiver contacts transfer clearly at every handover.
- Reconnect the person with their caregiver, support network, and medication supply before you close the intervention.
- If the person has no plan and no connection, flag this in the handover. Support them in developing a plan with at least one trusted contact. Do not close without at least one connection in place or formally recorded. Leave the person more connected and prepared than you found them.

## Respond to Locomotor and Mobility Disabilities

**Locomotor and mobility disabilities affect how a person moves, walks, stands, or manages their body and surroundings.** Some persons have partial or temporary limitations. Others fully depend on a wheelchair or assistive device. In an emergency, the person and the device cannot be separated: one without the other leaves the person fully dependent.

### Quick Reference

| Category | Key Points |
|---|---|
| **Main Risks** | › Injury from moving the person without asking or proper technique.<br>› Harm from hidden conditions you cannot see.<br>› Power loss for persons who use powered devices.<br>› Being separated from the mobility aid. |
| **What To Look For** | › Wheelchair, manual or powered.<br>› Crutches, walking frame, walker, cane, or prosthetic limb.<br>› Person moving slowly or with clear physical effort.<br>› Person who cannot stand, cannot get up from a chair, or cannot use stairs without help.<br>› Person sitting on the floor or next to a wall because they cannot move on their own.<br>› Medical equipment with the person or attached to the mobility aid: oxygen tanks, catheters, IV lines, ventilators, or feeding systems.<br>› Person signalling from a fixed position. They may wave from a window, use a torch, or hang fabric to show they cannot move to you.<br>› Person without a mobility aid who is moving with clear difficulty. Their aid may have been lost or broken in the emergency. |
| **Adapt Your Approach** | › **Manual wheelchair user:** The person is the expert on their own chair. The chair may be set up for their body in ways you cannot see. They can often move on flat ground on their own. They need help for stairs and uneven ground. Ask before you touch the chair.<br>› **Powered wheelchair or scooter user:** The chair is much heavier than a manual chair. It cannot be folded. The battery may need to be removed before you move it. Medical equipment such as a ventilator, oxygen, or a feeding device may be connected to the chair. Do not handle it like a manual chair. You can harm the person and the chair.<br>› **Partial mobility:** The person can walk short distances and move between seats. They may need help only for stairs, uneven ground, or long distances. The level of help they need is not the same for every person and you cannot tell from looking.<br>› **Temporary mobility impairment:** The person may have had a recent injury, surgery, pregnancy, or acute illness. They may not see themselves as having a disability. They may not ask for help. They may |

| Category | Key Points |
|---|---|
|  | be in a building with no accessible exit and no emergency plan. Offer help to anyone moving with pain or clear difficulty. |

## How to Communicate

**The most important thing for persons with mobility disability is consent before contact**. This disability changes the physical side of every interaction. The person is often seated and lower than you. They depend on their equipment. They may not be able to follow you without assistance.

- Approach from the front.
- Crouch or sit so your eyes are at the same level as the person's eyes.
- Do not lean on the wheelchair or mobility aid. It is part of the person's body space.
- Speak directly to the person, not to a companion or a colleague.
- Do not talk about the person with a colleague while the person is there.
- Ask how you can help before you offer specific help.
- Ask what the person can do on their own.
- Ask if there is anything you should know before you move them.

## How to Act by Role

### 112 Operators

**You are the first point of contact. You are not on scene. Your job is to ask the right questions and brief the field units before they arrive.**

- Ask if the person uses a wheelchair. Ask if it is manual or powered.
- Ask what floor or location they are on. Ask if the exit route is accessible.
- Ask if any medical equipment is attached to the device.
- Ask if the person uses any device that needs electricity.
- Brief field units before they arrive. Tell them the wheelchair type, the floor, the attached equipment, and any co-occurring conditions.
- If the person is alone on an upper floor with no accessible exit, flag this as an immediate priority.
- Do not accept a yes or no answer on whether the person is safe. Ask more questions. Ask what help they need. What they can do on their own. And if there is anything the field units should know in advance.

### Firefighters / Mountain Rescuers

**You are first on scene. You have the broadest physical role: search, rescue, and evacuation. You are most likely to find the person in a place with no accessible exit. You will often face the decision of whether and how to move them.**

- Scan before you approach. Look for mobility aids. A wheelchair, walker, crutches, cane, prosthesis, or scooter tells you what help the person may need. Look for a person moving with difficulty but no visible aid. Their aid may have been lost in the emergency.
- Assess the environment for barriers: stairs, narrow doorways, debris, uneven ground, no accessible exit.
- Search actively for persons signalling from a fixed position. They may wave from a window, use a torch, or hang fabric. They cannot come to you. Do not wait.
- Ask before you touch or move anything. Check if the wheelchair is manual or powered before any action.
- Ask about co-occurring conditions. Ask if there is any equipment attached to their chair you should not disconnect. This change how the person can be moved.
- Move the person to an area of refuge first where you can. Do not try to evacuate them down the stairs without trained people, except in immediate life-threatening danger.
- If the person is in immediate danger, move them to safety. Keep them in their wheelchair or mobility aid unless there is absolutely no other option. Taking a person out of their wheelchair without knowing their condition is itself a source of serious harm. Ask first if you have any time at all.
- Keep the mobility aid with the person wherever possible.
- Report the location of any person waiting for evacuation to incoming units straight away.

### Police

**You may be first or second on scene. You will usually not do physical evacuation. But you may need to coordinate it or stay with the person until the firefighters and Emergency Medical Services arrive.**

- Do not move a person in a wheelchair without their consent and clear guidance.
- Make sure the scene is accessible for incoming emergency vehicles and evacuation equipment.
- If the person is in a place with no accessible exit, stay in contact with them. Relay the location to Emergency Medical Services, firefighters or other units.
- Do not leave the person alone.
- If the person is alone and without their mobility aid, treat this as a possible safeguarding concern. Ask if the aid was lost or taken.
- Identify isolated persons. A person with significant mobility limitation who is alone, has no personal emergency plan, and has no known support person is a priority. Do not assume someone else will find them.

### Medical Assistance Personnel

**You have the longest sustained clinical contact before handover. You are responsible for assessment, treatment, and transport. You are most likely to encounter co-occurring medical conditions attached to or depending on the mobility aid.**

- Ask about co-occurring conditions before any physical intervention: catheters, spinal cord injury, pressure vulnerability, respiratory equipment, cardiac conditions, spasticity, and pain on movement of specific limbs.
- Ask if the person's device or any medical equipment needs electricity or battery power before you decide on transport. A person who depends on a ventilator, oxygen concentrator, or powered wheelchair cannot wait in a place without power or charging.
- Do not remove or disconnect medical equipment from a mobility aid without understanding what it does.
- Do a full physical check no matter what the person tells you. Pain may be atypical or absent.
- Confirm that the receiving facility can meet the person's mobility needs before transport.
- Document the mobility aid type, co-occurring conditions, power dependency, and specific handling requirements in the handover. The next responder cannot safely care for the person without this information. Document all of it every time.

### Social Workers

**You are usually activated later. You hold knowledge of the persons condition and disability type. Your role continues through the aftermath phase.**

- Reunite the person with their mobility aid. A person separated from their wheelchair, crutches, or prosthesis is fully dependent. Note where any aid was left and treat its return as the first step after safety.
- Make sure they receive proper fitting and training for their new aid when applicable.
- Confirm the person has been placed in an accessible location. Check that the facility is accessible and that the toilets are accessible. For women with mobility disability, inaccessible toilets in shelters, for example, are a known source of protection risk. Raise this as a safety concern.
- Check that specific supply needs are being met. Generic shelter provision often does not cover catheters, air mattresses, silicone cushions, diapers, or charging for powered devices. Check these items directly.
- If the person has been separated from their support network or residential setting, reconnect these before you close the intervention. For persons from residential facilities, find the originating facility and make contact with known staff.
- Before closing the intervention, check if the person has a personal emergency plan, is known to a disability or social protection service, is registered in a groups-at-risk registry, or is connected to an Organisation of Persons with Disabilities, a community network, a caregiver, or a trusted neighbour. Do not close the case until at least one connection is in place. Leave the person more connected and prepared than you found them.

## Respond to Complex Medical Dependencies

**Persons with complex medical dependencies need medicine, medical equipment, or regular treatment to stay alive.** This group is often hard to spot as their disability might not be visible. The greatest danger often comes after the emergency when treatment is interrupted and the medicine runs out or their medical equipment is disconnected from power sources.

### Quick Reference

| Category | Key points |
|---|---|
| **Main Risks** | › Treatment stops and the person gets worse fast. This can happen with dialysis, insulin, oxygen, chemotherapy, and rare disease medicine.<br>› Power goes off. This is an emergency for persons who use a ventilator, oxygen machine, or feeding pump.<br>› Medicine is left behind. Some medicine cannot be replaced from standard emergency supplies.<br>› The shelter is not safe. Standard shelters often have no fridge, no steady power, no clean space, and no specialist medicine.<br>› Persons with rare diseases are often not known to local services.<br>› The person gets worse after the emergency because no one is watching them. |
| **What To Look For** | › Medical equipment in the home: oxygen machines, ventilators, drip lines, feeding systems, dialysis machines, insulin storage, monitors.<br>› A person who cannot sit up or get out of bed, with no mobility aid in sight, or who shows severe intolerance to effort or debilitating exhaustion.<br>› Medicine storage, needle containers, pumps, or monitors that show the person is on a treatment plan.<br>› A person who talks and looks well but has a lot of medical equipment around them.<br>› Medical alert bracelets, treatment cards, or emergency plans in the home.<br>› Extension leads, backup batteries, or generators near medical machines. |

| Category | Key points |
|---|---|
| **Adapt Your Approach** | › **Persons on dialysis or chemotherapy:** Ask when they had their last treatment and when they need the next one. Missing treatment is dangerous.<br>› **Persons with diabetes who use insulin:** Ask about insulin storage, monitoring equipment, and when they last ate or took medicine. Insulin may need a fridge.<br>› **Persons who use oxygen or breathing machines:** Ask if they have a backup battery. Never move them to a place without power. Power is a medical need from the first moment.<br>› **Persons with rare diseases:** Their medicine is often special. It has no replacement. It must go with the person.<br>› **Persons in cancer treatment:** Their body may not fight infection well. Standard shelters are not safe for them. They may be tired or in pain even if they do not show it.<br>› **Persons who are bed-bound:** Move them with care. Watch for pressure on the skin, pain, and tubes. |

## How to Communicate

**The person might be unable to speak properly or understand, due to pain or medication, or other conditions.** They might be in bed or, often, seated and lower than you. They depend on their equipment. They may not be able to move without assistance.

- Approach from the front.
- Crouch or sit so your eyes are at the same level as the person's eyes.
- Do not lean on the wheelchair or mobility aid. It is part of the person's body space.
- Speak directly to the person, not to a companion or a colleague.
- Do not talk about the person with a colleague while the person is there.
- Ask how you can help before you offer specific help.
- Ask what the person can do on their own.
- Ask if there is anything you should know before you move them.
- Ask the person about their treatment before you move them or their equipment.
- If the person cannot speak, ask the caregiver first. If no caregiver is there, look for a written plan or medical card.
- Tell the person what will travel with them, where they are going, and who has been told.

## How to Act by Role

### 112 Operators

**You are the first point of contact. You are not on the scene. Your job is to brief the field units before they arrive and to activate the right resources.**

- Ask if the person uses any medical equipment.
- Ask if the equipment needs power.
- Ask if the person has a treatment schedule that has stopped or will stop soon.
- Ask about medicine and if it needs a fridge.
- Pass this information to all field units before they arrive.
- If the person has a rare disease or a condition that local services do not know, activate specialist medical support.

### Firefighters

**You are often first on the scene. You may find the person before any medical check has been done. You may not know the full picture of their condition. You might need to evacuate the person or rescue them.**

- Ask about medical equipment and power needs before you touch or move anything.
- Do not disconnect or move medical devices if you do not know what they do.
- Check for oxygen tanks, gas cylinders, and pressurised medical equipment. Secure these before any fire or heat source gets close. Treat them as a scene safety priority.
- If equipment cannot travel with the person, note where it is. Report this to Emergency Medical Services when they arrive, if applicable.
- Look for a personal emergency plan or medical information document. Check inside the front door, on the equipment, or in a bag. These papers will tell you what to take, how to move the person, and who to contact.
- If a caregiver or support person is there, ask them before you touch the person or the equipment.
- Call Emergency Medical Services early. Ask for clinical support to manage the evacuation together.
- Tell all incoming units that the person is medically complex. Confirm that specialist transport is on the way before you move the person.

### Police

**You may be first or second on the scene. Your role is, most likely, to manage the scene and coordinate the flow of persons.**

- Do not move or disconnect medical equipment.
- Check for oxygen tanks, gas cylinders, or pressurised medical devices. Keep them away from heat, flame, and impact.
- Keep the scene clear and access routes for Emergency Medical Services vehicles and specialist transport.
- If the person cannot be safely evacuated without specialist support, stay with them. Do not leave the person alone. Tell incoming units the location and the medical situation.

- If a caregiver or support person is there, keep them with the person. They know that person best and hold the medical history, the equipment and treatment knowledge.
- Look for a personal emergency plan or medical information document before you make any decision about moving the person.

### Medical Assistance Personnel

**You have the longest clinical contact with the person. You are responsible for assessment, treatment, and transport. You are the main clinical actor for this group.**

- Do a full assessment before transport. Check the condition, current medicine and storage needs, devices and power needs, treatment schedule, time since last treatment, and the name of the specialist or treating facility.
- Do not transport before you confirm that the receiving facility can meet the person's specific needs. Check power supply, fridge, clean conditions, and specialist availability.
- Make sure medicine, devices, and supplies travel with the person.
- For persons on oxygen or breathing support, confirm supply is continuous through transport.
- For persons with rare diseases or conditions you do not know, contact the specialist directly before or during transport if possible.
- If a caregiver is there, involve them throughout. They are a clinical resource.
- Document all medical dependencies in full in the handover. Confirm the receiving team has read and understood before you close.

### Social Workers

**You are usually activated later. You have the most important role in the aftermath phase. Your work goes beyond the immediate emergency.**

- Confirm that the person's treatment is continuing without interruption.
- Confirm that medicine supply is accessible, stored correctly, and being taken.
- Confirm that the person has not been placed in a facility that does not meet their medical needs. A place with no fridge, no steady power, no clean space, and no specialist supply can cause rapid deterioration.
- Reconnect the person with their specialist or treating facility as the first priority after immediate safety.
- For persons with rare diseases, connect with the relevant patient advocacy organisation or Organisation of Persons with Disabilities. These organisations hold clinical knowledge, specialist contacts, and peer support networks.
- Check if the person has a personal emergency plan, is known to a disability service, is on a groups-at-risk registry, or is connected to a support network or specialist organisation. If not, help them build this plan and connect them with the right actors.
- Do not close the intervention until treatment continuity is secured, the person is in a suitable environment, and at least one medical contact or specialist support has been told of their location and situation.

# Part 3. Closing the Intervention

**After you have assisted a person with a disability, do not leave the person on their own.** Make sure they have support, know what happens next and how to manage in their new place. Confirm that the staff or caregiver know what happened and the person's requirements, needs, and preferences.

## Key Checks Before You Leave

- Check that the person has their assistive devices and technologies, so they can stay safe and independent.
- Check that the person has their medicine and medical equipment, and brief the receiving staff on what is required to continue treatment.
- Guide a person who is blind or has low vision through the new space, so they can move around on their own.
- Hand every child over to a trusted adult. Never leave a child alone.
- Refer a person who was alone before the emergency to social services. Do not send them back to being alone.
- Prepare a person who feels fear or anxiety for the new place. Tell them who will be there and what will happen.
- Remind the person they can speak up, ask for support, and contact someone they trust in the new place.

## Leave the Person More Prepared

**Closing your part is also a chance to leave the person more connected and prepared than before.** This check takes a few minutes. It can stop the next emergency from being worse. Before you leave, ask:

- Does the person have family or friends who help them?
- Does the person have a personal emergency plan?
- Is the person on a list of persons at risk?
- Does a social worker or support group know this person?
- Is the person in contact with a group of persons with disabilities, a community group, a neighbour they trust, or the people in their building?

**If none of these apply, connect the person with a social service, an organisation of persons with disabilities, or the local firefighters.** They should help the person make a personal emergency plan. They should also connect the person to at least one support group or specialist medical service. They should map this person and make this person known to emergency services. A person who faced an emergency alone and with no plan should not leave it with no plan.

The companion guide **How to Act in Emergencies: Guidelines for Persons with Disabilities**, offers step-by-step advice on how to prepare. Give it to the person with disabilities, their caregiver or support staff who will follow up.

# Take Care of Yourself

**First responders face risks that go beyond physical danger.** Repeated exposure to trauma, hard decisions, and human suffering can be challenging. Anxiety, depression, and burnout are common. Across Europe, stress and mental health problems are the second most common work-related health issue, and response personnel are hit harder than most.

## When to Ask for Help

**Stress in this line of work often goes unnoticed.** First responders see people in their homes, at their lowest, in crisis, in distress, sometimes dying. The calls that weigh heaviest tend to involve multiple casualties, children, failed resuscitations, injury to a colleague, or a bad outcome despite your best efforts.

**Watch for these signs, in yourself and in your colleagues:**

- Trouble concentrating or making decisions;
- Tiredness that sleep does not fix;
- Guilt, self-blame, or feeling helpless after a call;
- Feeling numb, low, or cut off from work and colleagues;
- Anger, irritability, or acting out of character;
- Reliving events: unwanted thoughts, images, or memories;
- Avoiding anything that reminds you of a specific call;
- Constant dread or being on edge;
- Changes in appetite or sleep;
- Dizziness, racing heart, shortness of breath;
- Drinking more, or using other substances more;
- Losing empathy, or becoming cynical about the people you help.

**Not all of these signs are equally serious.** Some are normal short-term reactions and fade with rest, talking it through, and support from colleagues. Others stick around or get worse, and need professional help. Remember, they can be prevented, managed, and treated, if they are caught in time and met with the right support.

## Build Habits That Help

**Taking care of yourself has to be a daily practice.** Build healthy habits now, learn how to pace yourself, and know what to reach for when a call hits hard.

**Day to day:**

- Eat well, sleep enough, move your body.
- Have a life outside work: hobbies, people, rest.
- Know your stress level and your limits.
- Take breaks during your shift. Use whatever helps you wind down.
- Mix up your tasks when you can. A change of focus helps.

**After difficult calls:**

- Talk to a colleague, supervisor, or peer support contact. Do not carry it alone.
- Talk openly with colleagues about how the work affects you. It helps everyone.
- Get professional support if sign of severe distress stick around. Asking for help is part of doing the job well.

**Know what helps you:**

- Know how you react to stress and have a plan for when things get hard.
- Find out what support your organisation offers before you need it.

### What to Do After a Difficult Call

**What works is different for everyone.** Therapy and mindfulness training have been shown to reduce traumatic symptoms, depression, and anxiety in response personnel.

The **Tools to Stay Calm and Present** in the Toolbox of these Guidelines are a good place to start.

**If you are struggling, reaching out is the right call.** Find a therapist or mental health service in your country. Some institutions offer this for free through their own therapists, so check what is available to you before you need it. In emergency services, worrying about how it will be seen is often the biggest barrier, and the best thing an organisation can do is make support visible, confidential, and free of stigma.

## Reflect, Learn and Improve

**Every intervention teaches you something.** Taking a few minutes to reflect on your own, with your team, or across your organisation is how inclusive response gets better over time. The steps below show you how to turn each experience into learning, both for yourself and for the people you will assist in the future.

### Reflect After Each Intervention

**Ask yourself:**

- Did I have the knowledge and tools to help this person well?
- Did I communicate in a way the person understood?
- Did I ask for consent before acting?
- Did I assume something instead of asking?
- Did I know where to refer the person next? If not, what was missing?
- What would I do differently next time?

**Ask as a team:**

- Did we miss anything important, like equipment, clear steps, or the right contacts?
- Did we reach every person who needed help, including children, women, older persons, migrants, and persons with no one to support them?
- Did we respect the rights and dignity of the persons we assisted?
- What would we do differently next time?

## Build a Learning Culture in Your Team

When your team shares, listens, and includes the voices of persons with disabilities, the whole organisation gets better at its work.

- Talk to your colleagues about what you learned. If something is missing or not working, tell the people who can fix it.
- Ask persons with disabilities and their organisations to join the review after an emergency. They will tell you what worked and what did not.
- Keep notes of what worked, what did not, and what was missing. Over time, these notes help the whole team.
- Make disability inclusion part of your normal reviews after interventions. If it is not in there yet, ask for it.
- Bring persons with disabilities and their organisations into planning meetings and drills. They make the work better. And when something happens, you already know each other. This way you will be more prepared to assist them based on their requirements, needs and preferences.

# Toolbox for the Guidelines

## How to Use This Toolbox

**This Toolbox gives you practical tools to support persons with disabilities in an emergency.** It works together with the Guidelines above on **How to Act in Emergencies: Guidelines for First Responders.**

**Keep the Guidelines and Toolbox contents where you can reach them fast: in your vehicle, at your station, in your kit, or on your phone or tablet.** Share them with your colleagues. Use them alongside your training and your team's procedures.

### What's Inside

1. **Communication Basics:** Practical advice on how to speak with persons with disabilities during an emergency, and how to talk about persons with disabilities.
2. **Keeping People Calm:** Short guidance on how to reduce fear and stress during an emergency and support persons who may be frightened, confused, or in shock. Along with wellbeing and mindfulness tools to manage stress and calm others on the scene.
3. **Quick Cards: Do and Don't:** Quick reference tables that show you what to do and what to avoid when responding to persons with different disabilities. Review them before a call or use them on the scene.
4. **Keep Learning:** Extra resources to go further, including training platforms on inclusive emergency response and films and documentaries to build empathy and understanding of disability.

## Communication Basics

**In an emergency, how you communicate is as important as what you do.** The words you use and the way you speak shape how a person feels, how much they trust you, and whether they can follow your instructions. The wrong words can exclude, hurt, or discriminate, even when you do not mean to. The right words show respect, build trust, and protect the person's rights and dignity.

**This section shows you how to talk about persons with disabilities in a way that respects their rights, and how to speak with them during an emergency using practical techniques for different disabilities.** Use this section before a call, on the scene, and in training with your team.

### How to Speak with Dignity

**The words you use matter.** They shape how a person feels and how much they trust you. The table below shows you which words to avoid, which to use instead, and why. Use it to speak with and about persons with disabilities in a way that respects their rights and their dignity.

Table 2. How to Talk About and With Persons with Disabilities

| Avoid | Use Instead | Why |
|---|---|---|
| *“Suffers from schizophrenia”* | **Person with schizophrenia** | “Suffers from” victimises; neutral phrasing reduces stigma |
| *“Normal / healthy / able-bodied people”* | **Persons without disabilities** | “Normal” implies inferiority; the alternative is neutral and inclusive |
| *“Handicapped”* | **Person with a mobility impairment / wheelchair user / person with limited mobility** | Outdated and pejorative; alternatives are respectful and descriptive |
| *“Mentally ill / crazy / lunatic”* | **Person with a psychosocial disability / person with a mental health condition** | Stigmatising and offensive; use language that respects human rights and dignity |
| *“Retarded / slow”* | **Person with an intellectual or cognitive disability** | Offensive; the current term respects the person’s dignity and aligns with human rights standards |
| *“Blind / partially sighted”* | **Person who is blind / person with a visual impairment / person with low vision** | Negative connotations; alternatives are rights-based, neutral, and person-centred |
| *“Deaf-mute”* | **Deaf person / person with a hearing impairment / hard-of-hearing person / person with a speech impairment** | Using “deaf-mute”, unless referring to someone who has a co-occurring hearing and a speech impairment, is inaccurate and stigmatising, as Deaf persons have a voice. Communication varies from person to person |
| *“He is autistic / schizophrenic”* | **He is a person with autism / schizophrenia** | Avoids defining identity exclusively through diagnosis; uses person-centred language |
| *“Invalid” / “Has problems”* | **Has a disability / requires support with…** | “Invalid” implies lack of worth; the alternative is centred on support and respects human rights |

| Avoid | Use Instead | Why |
|---|---|---|
| *“The disabled” / “Those with disabilities”* | **Persons with disabilities** | Avoids generalisation; puts the person before the disability |
| *“Special child” / “Special needs”* | **Child with a disability / adapted support / functional requirements** | “Special” is often used as a euphemism and considered a form of ableism; it does not make rights or adaptations explicit |

## How to Communicate with Everyone

**Every person communicates differently.** Your job is to find the way that works for the person in front of you. This section gives you the basics. It covers how to speak with persons with different disabilities during an emergency.

*Table 3. How to Adjust Your Speech Across Disabilities*

| Disability Type | Before You Speak | How To Speak | How To Adapt | Do Not |
|---|---|---|---|---|
| **Persons with Visual Disabilities** | Say you are there before you come close. Tell the person your name and your job. Never come close without speaking first. | Describe everything in words. When you give directions, use the person’s body as the starting point. Keep talking while you move. | To guide the person, offer your elbow. Do not grab them. Read out loud any written information. For persons who are deafblind, write letters on the palm of their hand. | Do not use words like “over there” or “look at this.” Do not walk away without telling the person first. Do not take the person’s phone away. |
| **Persons with Hearing Disabilities** | Move into the person’s field of vision before you speak. To get their attention, wave. Do not shout. | Speak clearly and at a normal volume. Speak a little slower than usual. Keep your face visible so the | Always carry paper and a pen. You can also use your phone screen, pictograms, gestures, or a text-to-speech app. Ask for a | Do not shout. Do not turn your back to the person. Do not exaggerate your mouth movements. Do not speak in a slow, childish |

| Disability Type | Before You Speak | How To Speak | How To Adapt | Do Not |
|---|---|---|---|---|
| | | person can read your lips. | sign language interpreter if one is available. | voice. Do not assume the person understands just because they are looking at you. |
| **Persons with Speech Disabilities** | Give the person time to speak at their own pace. Do not interrupt. Do not finish their sentences for them. | If the person has trouble speaking, ask questions they can answer with "yes" or "no." | Use the person's communication device, communication board, or pictograms. You can also ask them to write, type, point, or draw. | Do not take away or turn off the person's communication device. Do not speak for the person. |
| **Persons with Psychosocial Disabilities** | Lower your voice and slow down before you speak. Choose one person in your team to speak to the person. Ask other people to step back. | Talk about how the person feels before you give any instruction. Use short, calm sentences. | Only one person should speak. Offer simple choices. Stay about 1.5 metres away, unless the person invites you closer. | Do not argue, correct, mock, or contradict. Do not raise your voice. Do not block the exit. Do not turn your back to the person. Do not touch the person without asking first. |
| **Persons on the Autism Spectrum** | Make the area quieter first. Turn off sirens if you can. Ask people to step back. Avoid sudden movements. If | Use short, clear, direct sentences. Do not use figures of speech. Give one | If the person repeats your words, use this to check their understanding. Keep their communication device, | Do not try to stop the person from rocking, flapping, or repeating movements. Do not give more than one |

| Disability Type | Before You Speak | How To Speak | How To Adapt | Do Not |
|---|---|---|---|---|
| | a caregiver is there, ask them the five key questions from the caregiver protocol. | instruction at a time. | pictograms, or comfort objects with them at all times. | instruction at a time. Do not use expressions or jokes. Do not touch the person without asking first. |
| **Persons with Intellectual Disabilities** | Check if a caregiver is there. Ask if the person has their own way of communicating. If yes, use it. | Use short sentences of three to five words. Use simple, everyday words. Pause after each sentence. Speak to the person as you would to any adult. | Use gestures or pictograms. Offer two choices at a time. Ask the same question in different ways to check understanding. | Do not rely on just one answer. Do not ask two questions at the same time. Do not use baby talk. Do not speak in a slow, childish voice. |
| **Persons with Mobility Disabilities** | Ask before you touch the person. Ask what the person can do on their own. Ask about their mobility aid and about any other health conditions. | Speak directly to the person, not to the caregiver. Get down to eye level. Tell the person what you are going to do before you do it. | The person knows their body and their mobility aid best. Follow their lead. | Do not stand over the person for a long time. Crouch down or sit. Do not lean on the wheelchair. The wheelchair is part of the person's body. |

### Box 6. Sighted Guide Technique

1. Introduce yourself and describe to the person what you look like. Tell the person you are there to help.

2. Ask the person which guiding style they prefer. They can take you by the arm, shoulder, or elbow; they can walk in front of you, behind you, or side by side.
3. Agree on the pace and distance as you move, so you do not step on each other.
4. Clearly say which steps come next before you take them, and describe any obstacles, so the person is prepared.

**Say:**

“Hello! My name is Hélène and I work on the ambulance. I am wearing a uniform and I have a mask over my mouth. I am here to help you.”

“We need to go outside the house. Would you like to take me by the arm or by the shoulder? Would you like to walk in front of me or behind?”

### Box 7. Verbal Guidance

1. Introduce yourself and describe to the person what you look like. Tell the person you are there to help.
2. Give as many spoken cues as possible about direction, size, shape, distance, and the surroundings.
3. Set clear cues such as the length of each step and landmarks for changing direction (the clock-face method). Use the other person’s body as the reference point, not your own.
4. Avoid vague words like “here” or “there.”

**Say:**

“Hello! My name is Paweł and I am a firefighter. I am wearing a uniform with a mask. I have a gas thank on my back and thick gloves on my hands. I am here to help you get out of the house.”

“Listen to my voice and come towards it. Put one foot in front of the other and take 10 steps forward.”

### Box 8. Four-Step Protocol for Communicating with Deaf Persons

Use this as your default opening sequence before attempting any other method.

1. **Attract attention.** Wave in the person’s field of view, or lightly touch their arm. Never call out from behind or from the side.

2. **Position face to face.** Stand directly in front of the person at eye level, within 1.5 metres, in good light. Keep your face visible. Remove a mask if safe to do so.
3. **Speak clearly, not loudly.** Use normal volume at a slightly slower pace. Keep your head still and your mouth uncovered. Shouting distorts lip patterns and does not help. Do not exaggerate mouth movements.
4. **Use natural body language.** Gesture, facial expression, and movement carry meaning independently of words. They support understanding even when spoken communication does not land.

### Box 9. 5 Questions to Ask Caregivers of Persons with ASD

**If a caregiver, family member, or teacher is there, ask these 5 questions before you go up to the person.** They take less than 2 minutes and give you information you cannot learn on your own: how the person communicates, what upsets them, and what calms them.

1. **How does the person communicate?** Do they use speech, sign language, an AAC device, pictograms, or gestures? Do they repeat words or sounds (echolalia)? This helps you avoid mistakes at first contact.
2. **Is their communication device with them?** If the person uses an AAC device, tablet, or communication board, where is it? Without it, they cannot express themselves. Find it right away.
3. **What upsets them or causes strong reactions?** Certain sounds, touch, people, changes, or uniforms can set off a meltdown. Some triggers cause fast and strong reactions. Knowing them keeps both of you safe.
4. **What helps them calm down?** A special object, phrase, activity, or sensory input can reduce distress. This is your best tool for calming them on scene.
5. **What are their favourite things?** Games, films, objects, characters, topics. Favourite things can focus, distract, and calm the person. They can also open a way to communicate when nothing else works.

## Keeping People Calm

### Agitation versus Aggression

**Calming a person only works if they are agitated, not aggressive.** Learning to tell the two apart keeps you, the person, and everyone around safe.

### Box 10. Recognise Agitation vs Aggression

Learn to make a difference between agitation and aggression. They look similar but require very different responses.

#### Agitation

Agitation is distress without a clear target. Signs include:

- Walking back and forth
- Talking loudly
- Repeating the same movement, such as searching their pockets over and over
- Not being able to stand or sit still

Agitation shows the person needs space and help to calm down. It does not mean they are dangerous. But agitation can grow into aggression, so stay alert.

#### Aggression

Aggression is directed toward persons or objects. It is dangerous.

**Warning signs that agitation is shifting toward aggression:**

- Staring hard at one person or object
- Direct verbal threats
- Moving towards one person or object
- Faster breathing, tight fists

#### What To Do If Aggression Develops

- Call for backup and specialist support right away. Do not try to handle it alone.
- Move bystanders away.
- Keep your safety distance of approximately 1.5 metres.
- Keep your exit route clear. Never turn your back to the person. Never corner or block their exit.
- If you must use physical restraint, use as little force as possible. Keep speaking calmly, use the person's name, and explain what is happening, even while restraining them.

## How to Calm A Person Down

**When a person feels lost, scared, or overwhelmed, grounding helps them come back to the present moment through their senses and their body.** Slow breathing helps them calm down. These are some of the simplest tools you have as a first responder. They need no equipment and no special training. They need only your calm presence, your patience, and your willingness to stay with the person.

**The exercises below work for different ages and different abilities.** Older children and teenagers can follow the adult exercises, but use simpler words. Always involve a caregiver or a trusted adult if one is there. Their calm presence is the best grounding tool for a child in distress. Not every exercise works for every person, so always adapt.

Box 11. How to Calm A Person Down

### Exercise 1: The Five Breaths

**Works for:** Most persons, including children over 5 · **Do not use for:** Hyperventilating, breathing difficulty, or respiratory conditions

A rapid self-regulation technique that uses the breath to align the nervous system and return to the present moment.

*Ask the person to:*

1. Take a deep breath in
2. Breathe out slowly, making the exhale slightly longer than the inhale
3. Repeat five times, extending the exhale a little more with each breath
4. Keep eyes open if they can and if others are present; they may also keep them closed

*Plum Village. Mindful Breathing Practice. [Link](#).*

### Exercise 2: The Candle and the Flower

**Works for:** Children with disabilities aged 5 and under · **Do not use for:** Children showing signs of respiratory distress

For the youngest children, counting and structured breathing can feel overwhelming. This visualisation uses familiar, comforting images to guide the breath naturally and gently.

*Ask the person to:*

1. Hold both hands out in front of them
2. Imagine a sweet-smelling flower in one hand and a small candle in the other
3. Close their eyes if they feel comfortable doing so
4. Breathe in slowly through the nose to smell the flower
5. Breathe out slowly and gently toward the other hand to blow out the candle
6. Repeat, and when finished, ask them to notice how they feel

*STEM-ful. Mindful Breathing for Kids. [Link](#).*

## Tools to Stay Calm and Present

**Helping others starts with looking after yourself. When you are calm, you can help others stay calm too.** These short resources are for you in two ways: for yourself, to manage stress, slow down your breathing and your heart rate, and recover after a hard call;

and for your work, to learn new exercises and techniques you can use to ground a person, bring them back to the present moment, and help them feel safe. The resources also help you understand more about mental health, stress, and how to stay grounded in difficult moments.

**Use them when you need a quick reset, as part of your daily routine, in training with your team, or share them with your colleagues.**

**Breathing and Grounding**

- Mindful Breathing Exercise — simple diaphragmatic breathing for immediate stress relief https://www.youtube.com/watch?v=O_iDaIAPrGo
- Box Breathing — structured breathing technique widely used for immediate stress relief phttps://www.youtube.com/watch?v=a7uQXDkxEtM
- 5-4-3-2-1 Grounding Technique — sensory grounding exercise to anchor attention in the present moment https://www.youtube.com/watch?v=zilmlTO5i9Q
- Mindful Breathing for Kids — illustrated breathing technique designed for children https://sf-stemful.com/mindful-breathing-for-kids/
- Feeling Overwhelmed? Try This Quick Meditation.https://www.youtube.com/watch?v=HrZT-KxWc-U
- 3 Minutes to Calm Your Mind: An SOS Breathing Practice for Stress & Burnout https://www.youtube.com/watch?v=y7u5-YBgmQ4
- 10 Minutes Reset: Decompress Your Body and Mind https://www.youtube.com/watch?v=QHkXvPq2pQE
- Panicking? Try This Super Short Meditation For Coming To The Present.https://www.youtube.com/watch?v=-bibn6Y7vCk
- Mindfulness Made Easy: 8 Meditation Techniques You Can Learn in 10 Minutes https://www.youtube.com/watch?v=xT9wAhLLj5E

**Mental Health Resources**

- Mindfulness-based Cognitive Therapy for Depression by Zindel Segal, Mark Wiliams, and John Teasdale https://www.youtube.com/watch?v=u7J_VKqB3hc
- Full Catastrophe Living by Jon Kabat-Zinn https://www.youtube.com/watch?v=rJsqhOu2u0Q
- Exploring Life's Biggest Questions with Andy Puddicombe: Why Meditate https://www.youtube.com/watch?v=8XItP4XVbIA
- How to Live without Regret and Guilt? https://www.youtube.com/watch?v=woio0Fayza4
- What is Loneliness? https://www.youtube.com/watch?v=nO6JIoGILP8
- How Do We Deal with Change https://www.youtube.com/watch?v=JRTEAwYaHC4
- How Do We Cope with Fear? https://www.youtube.com/watch?v=EUA5siagejA
- How to be at Peace with the Unknown | Andy Crisis Wisdom https://www.youtube.com/watch?v=5XTNG5ujvk4

- A Four-Step Approach to Working with Anger – with Ron Siegel, PsyD https://www.youtube.com/watch?v=ouVM_5-8I9A
- How To Cope With Depression https://www.youtube.com/watch?v=8Su5VtKeXU8
- 12 signs you might be suffering from PTSD https://www.youtube.com/watch?v=qOibW5LXt3w
- How the body keeps the score on trauma – Bessel van der Kolk https://www.youtube.com/watch?v=iTefkqYQz8g

**Platforms for Deeper Exploration**

- **Mental Health Europe** The main independent European non-governmental network organisation committed to the protection of the rights of persons with psychosocial disabilities, the promotion of positive mental health, the prevention of mental distress, and the improvement of mental health care and social inclusion. https://www.mentalhealtheurope.org/; https://www.mentalhealtheurope.org/library/mhevideopresentation/
- **TED Talks** Short, accessible talks by leading thinkers and practitioners on disability, inclusion, empathy, belonging, mental health, and human behaviour. Particularly useful for awareness-raising and pre-training preparation. https://www.ted.com/
- **Headspace** Structured mindfulness and meditation platform covering stress, anxiety, sleep, and focus. https://www.youtube.com/@headspace
- **The School of Life** Psychology and emotional intelligence content for self-understanding and reflective practice. https://www.youtube.com/@theschooloflifetv

## Quick Cards: Do and Don't

**These Quick Cards show you what to do and what to avoid when responding to persons with different disabilities**. Each card focuses on one type of disability. Use them before a call to refresh your approach or check them on the scene when you need a fast reminder.

**Table 4. Do/ Don't: Visual Disabilities**

| DO | DO NOT |
|---|---|
| ✓ Announce yourself by name and role before approaching. | ✗ Do not approach silently or touch without warning. |
| ✓ State what you are about to do before doing it, and confirm understanding before moving on. | ✗ Do not begin acting before the person is aware of your presence, and do not assume silence means the person has understood. |

| DO | DO NOT |
|---|---|
| ✓ Ask how the person prefers to be guided. Offer your bent elbow or your shoulder and let them follow your body movement. | ✗ Do not grab the person’s arm or assume maximum assistance is required. |
| ✓ Describe the route and environment using the person’s body as the reference point: “5 steps ahead of you,” “wall to your right.” Replace alarm words with direct commands: “Stop. Obstacle ahead.” | ✗ Do not use vague spatial terms (“over there,” “this way”), gestures, or exclamations that carry no directional information. |
| ✓ Keep the cane, guide dog, and personal phone with the person at all times. Document their location in every handover. | ✗ Do not move or separate assistive devices without asking, and do not leave them behind. |
| ✓ If you have to take the person to another space, orient them on arrival to the nearest wall, exit, seating, and other people present. Announce when you leave, who replaces you, and what happens next. | ✗ Do not walk away without warning or without handover. |
| ✓ Treat the guide dog as working equipment. Inform bystanders and other first responders that the dog is working. If asked to hold the dog, hold the lead, never the harness. | ✗ Do not pet, feed, or speak to the dog directly. Do not deny the dog transportation or access. Do not separate the dog from the person. Do not take or handle the dog unless the person asks you to or is unable to do it themselves. |
| ✓ Communicate all written or printed information verbally. Arrange Braille materials or volunteer readers in the shelter phase. | ✗ Do not provide written information without a verbal equivalent. |
| ✓ When guiding a group, form single file with each person holding the shoulder of the person in front. | ✗ Do not leave persons with visual disabilities behind thinking they will find their way out only by voice commands. |

### Table 5. Do/ Don’t: Hearing and Speech Disabilities

| DO | DO NOT |
|---|---|
| ✓ Get visual attention first: wave or lightly touch the arm. | ✗ Do not call out from behind or the side, or speak before the person sees you. |
| ✓ Use a transparent mask, or write key information. | ✗ Do not keep a standard mask on, and do not start shouting if the person does not hear you. |
| ✓ Designate one responder to communicate and stay consistent. | ✗ Do not have several responders speak or sign at once. |
| ✓ Ask which communication mode the person prefers and act on it. | ✗ Do not impose a method without asking. Writing is not accessible for everyone. |
| ✓ Speak at normal volume and pace, head still, face visible. | ✗ Do not shout, over-enunciate, turn away while speaking, or stand with the light behind you. |
| ✓ If an interpreter is present, speak directly to the person. | ✗ Do not speak to the interpreter or look at them instead of the person. Do not stand between the person and the interpreter. |
| ✓ Keep hearing aids and communication devices with the person. | ✗ Do not remove, store, or switch off any assistive device. Consider turning off any equipment that might interfere with their devices. |
| ✓ For speech impairments, use yes or no questions with thumbs up or down. | ✗ Do not assume inability to speak means inability to understand or decide. Find a way to communicate. |
| ✓ Speak directly to the person by name, in adult language. | ✗ Do not speak about the person to a companion as if they are not there. |

### Table 6. Do/ Don’t: Schizophrenia and Conditions Involving Hallucinations/ Delusions

| DO | DO NOT |
|---|---|
| ✓ Lower and slow your voice. Speak respectfully at normal volume. | ✗ Do not raise your voice, speak rapidly, or use an authoritative, condescending, or ironic tone. |
| ✓ Acknowledge the experience directly. Normalise and reassure: “I can hear that something very frightening is happening for you. I would feel the same if I were seeing or hearing this. I am here to help.” | ✗ Do not argue about what is real, dismiss what the person reports, or try to reason them out of the delusion. |
| ✓ Validate that the emotion is real even when the content is not. | ✗ Do not make jokes, use sarcasm, or reference hallucinations dismissively. |
| ✓ Ask permission before any physical contact. Wait for a response before touching. | ✗ Do not touch without explicit permission, and do not handle or restrict movement. |
| ✓ Anchor in shared present reality. Name objects in the room and describe what is visible around you. | ✗ Do not debate what is real or not real, and do not try to prove the delusion wrong. |
| ✓ Ensure the person always has a visible route out. Position yourself to the side. | ✗ Do not stand between the person and the exit, and do not corner them in any space. |
| ✓ Stay calm and still if the person becomes louder or more agitated. | ✗ Do not escalate your own tone, volume, or physical presence in response to theirs. |

### Table 7. Do/ Don’t: Dementia Including Alzheimer’s Disease

| DO | DO NOT |
|---|---|
| ✓ Use formal address. Use title and surname at all times. Use “we,” “our,” and “together” language to create a sense of shared safety. | ✗ Do not use first name without permission, and do not speak informally or use infantilising, colloquial, or undignified terms. |
| ✓ Stay in the present tense. Focus on what is happening now and what happens next. | ✗ Do not ask about memories, probe, or make reference to the past. |
| ✓ Give short, clear information about the emergency and why you are recommending this course of action. Say: “We need to evacuate now. There is a fire in the near building.” | ✗ Do not explain the broader emergency or overwhelm the person with information. |
| ✓ Offer choices rather than commands: “Would you like to take this jacket with you, or the other?” | ✗ Do not say “You need to leave now” without explanation. |
| ✓ Redirect gently toward the present moment when the person holds a false belief. | ✗ Do not correct, contradict, or argue with what the person believes to be true, even if the belief is significant (for example, the person believes a deceased family member is still alive). |
| ✓ Stay with the person until a known family member or caregiver arrives, or arrange for a trusted contact to replace you. | ✗ Do not leave the person with an unknown person, or alone in an unfamiliar space, because your mandate is over and you need to leave the scene. |
| ✓ Keep communication simple, calm, and sequential. One step at a time. Stay patient. | ✗ Do not give multiple pieces of information at once. Do not show impatience at repeated questions or statements. |

Table 8. Do/ Don’t: Autism Spectrum Disorders

| DO | DO NOT |
|---|---|
| ✓ Turn off sirens and lower noise before you reach the person where you can. | ✗ Do not use loud sounds, alarms, speakers, or shouting. |
| ✓ Ask the caregiver about how the person communicates, what upsets them, and what calms them down, before units arrive. | ✗ Do not skip the caregiver. They hold the information you need. |
| ✓ Approach slowly with open hands. Keep your moves predictable. Say before you touch. | ✗ Do not make sudden moves, reach for the person without warning, restrict their movement, or touch without warning. |
| ✓ Use short, clear, direct sentences with one idea at a time. | ✗ Do not use figures of speech, hints, sarcasm, or jokes. |
| ✓ Accept repeated words (echolalia) as a try to communicate. Check the answer by asking again in a different way. | ✗ Do not try to stop or correct echolalia. Do not trust the first answer without checking. |
| ✓ Check the body for injuries step by step, even if the person shows no pain. | ✗ Do not assume no pain means no injury. Persons with ASD may laugh or smile when badly hurt. |
| ✓ Keep communication devices, comfort objects, and familiar items with the person at all times. | ✗ Do not take away or leave behind communication devices or comfort items. |
| ✓ Show equipment before you use it. Let the person touch it first if it is safe. | ✗ Do not use equipment on the person without warning or explanation. |
| ✓ Allow self-calming movements like rocking, flapping, or stimming. | ✗ Do not try to stop self-calming movements by force or command. This can trigger a meltdown. |
| ✓ Check all hiding places during search: under beds, in closets, in small closed spaces. | ✗ Do not assume no response to calls means the person has left or is not there. |

| DO | DO NOT |
|---|---|
| ✓ If the person is missing, check water, train tracks, and roads first. | ✗ Do not leave these areas for last. |
| ✓ Stay with the person after rescue. Hand them over to a known caregiver or specialist. | ✗ Do not leave the person alone after rescue or with strangers in a busy environment. |
| ✓ Write the communication profile, triggers, calming strategies, and caregiver contacts into every handover. | ✗ Do not assume the next team will spot ASD and adapt on their own. |

**Table 9. Do/ Don't: Intellectual Disabilities**

| DO | DO NOT |
|---|---|
| ✓ Introduce yourself fully: your name, your role, and why you are there. Describe your gear if you wear protective equipment. Show your identification card and point to it. | ✗ Do not assume the person knows your uniform or understands that you have authority. |
| ✓ Use short, simple, concrete sentences. Give one instruction at a time. Support your words with gestures, pictograms, or objects when words are not working. | ✗ Do not use complex language, metaphors, or several instructions at once. Do not assume that clear speech means the person has understood. |
| ✓ Speak to the person as you would to any adult. Use their name. Keep eye contact. Treat them with the same dignity as any other person in a crisis. | ✗ Do not use baby talk. Do not talk down to the person. Do not use exaggerated slow speech. Do not praise simple actions as if they were exceptional. |
| ✓ Check understanding at every step. Ask open questions like “Can you show me what you will do next?” | ✗ Do not treat nodding, saying yes, or going along with you as proof the person has understood. |

| DO | DO NOT |
|---|---|
| ✓ Give the person time to think and respond before you repeat or move to the next step. | ✗ Do not rush. Do not interrupt. Do not read silence as refusal. |
| ✓ Speak directly to the person, not to their caregiver or companion. | ✗ Do not speak to the caregiver instead of the person. Do not talk about the person as if they are not there. |
| ✓ Keep the person with their caregiver whenever possible. | ✗ Do not separate the person from their caregiver, unless there is an immediate safety reason. |
| ✓ Ask about medication. Make sure it travels with the person during evacuation. | ✗ Do not leave medication behind. Do not treat it as a secondary concern. |
| ✓ Ask about other health conditions before you move the person. | ✗ Do not treat intellectual disability as the only clinical concern. |
| ✓ Check for pain and injury in a systematic way, no matter what the person tells you. | ✗ Do not rely only on standard pain scales or on what the person says. |
| ✓ Use visual communication tools when words are not working: pictograms, picture exchange cards, drawing, gesture, or pointing. Use Easy Read materials if you have them. | ✗ Do not keep repeating words when they are clearly not being understood. Do not raise your voice. |
| ✓ Redirect the person calmly if they reach for your equipment or move toward dangerous areas. | ✗ Do not read curiosity about your equipment or surroundings as aggression or deliberate obstruction. |
| ✓ Treat any person with intellectual disability found alone as a sign the person may be at risk of harm. | ✗ Do not assume a person found alone is simply lost or confused. |

| DO | DO NOT |
|---|---|
| ✓ Record the communication profile, other health conditions, medication, and caregiver contacts in every handover. | ✗ Do not assume the next first responder will work out the person’s requirements on their own. |

**Table 10. Do/ Don’t: Locomotor and Mobility Disabilities**

| DO | DO NOT |
|---|---|
| ✓ Ask before you touch, push, lift, or move the person or their equipment. Ask what they can do on their own and what they need help with. | ✗ Do not touch, move, or handle the person or their mobility aid without asking. Do not assume the level of help needed from how the person looks. |
| ✓ Check if the wheelchair is manual or powered before you act. Ask about co-occurring conditions, catheters, pain, spasticity, and attached medical equipment before any movement. | ✗ Do not treat all wheelchairs the same. Do not move the person without checking for co-occurring conditions or attached medical equipment. |
| ✓ Move the person to an area of refuge and wait for trained help. | ✗ Do not try to carry a wheelchair with a person in it down the stairs, unless immediate life-threatening danger leaves no other option. |
| ✓ Ask if any device needs electricity or battery power. Treat power continuity as a clinical priority where this applies. | ✗ Do not assume that power loss is not a clinical issue. |
| ✓ Keep the mobility aid with the person at all times. If the aid was lost or broken in the emergency, ask what happened and flag the need for a replacement. | ✗ Do not separate the person from their mobility aid without a plan to reunite them. Do not assume a person without a visible aid does not need one. |
| ✓ Approach from the front. Put yourself at eye level. Report the location of any | ✗ Do not stand over the person. Do not leave them alone in a place with no |

| DO | DO NOT |
|---|---|
| person waiting for evacuation to incoming units straight away. | accessible exit without telling incoming units. |
| ✓ Before shelter placement, confirm the sanitary facilities are accessible. Ask about specific supply requirements. Ask if the support systems they had before the emergency are still in place. | ✗ Do not assume generic shelter provision meets the needs of persons with mobility disability. Do not assume support systems from before the emergency are still in place. |

Table 11. Do/ Don't: Complex Medical Dependencies

| DO | DO NOT |
|---|---|
| ✓ Ask about treatment schedules, medicine, devices, and power needs before you move anyone with complex medical needs. | ✗ Do not assume the person is stable just because they can walk and talk. |
| ✓ Look for a personal emergency plan, medical document, or treatment summary before you decide how to move or place the person. If you have time, search for it. | ✗ Do not assume there is no information just because you cannot see any. |
| ✓ Ask if there is medical equipment in the home that could be dangerous, such as oxygen tanks or gas cylinders. | ✗ Do not ignore dangerous medical equipment. It can harm the person, the caregiver, and you. |
| ✓ Keep the caregiver or support person with the medically dependent person at all times. They know the medical history, the equipment, and how to handle the person. | ✗ Do not separate the person from their caregiver. Do not try to handle the evacuation without medical advice. |
| ✓ Make sure medicine, devices, and supplies go with the person during evacuation. | ✗ Do not leave medicine behind. Do not treat it as less important. |

| DO | DO NOT |
|---|---|
| ✓ Before transport, check that the receiving place can meet the person's needs: steady power, a fridge, and the right specialists. | ✗ Do not move a person who depends on power or has complex medical needs before you check the receiving place can meet those needs. |
| ✓ If the person has a rare disease, contact the right patient advocacy organisation for urgent medical advice if normal procedures do not apply. | ✗ Do not assume normal emergency procedures cover rare disease medicine and treatment. |
| ✓ Write down the person's condition, medicine, devices, power needs, treatment schedule, specialist contacts, and transport needs at every handover. | ✗ Do not just write "has medical needs" and assume the next responder will work out the details. |

## Keep Learning

**This is a list of EU platforms where you can find training materials, good practice examples, and online courses.** They cover inclusive emergency response and disability inclusion. You can use them on your own to learn at your own pace. You can also use them with your team as part of training.

- **EU Civil Protection Knowledge Network** European Commission Good practices, training materials, and case studies on inclusive emergency response across EU Member States and Participating States. https://civil-protection-knowledge-network.europa.eu.
- **EU Academy** European Commission Online courses on inclusion, fundamental rights, and related topics, available to anyone across EU Member States. https://academy.europa.eu/.
- **EDF Resource Portal** European Disability Forum Policy updates, good practice examples, and resources on disability inclusion, including the Annex of training initiatives from across the EU. https://www.edf-feph.org.