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Out of the Ashes: Ashcroft Indian Band and the Elephant Hill Wildfire Insights for Public Health Responses to Long-term Evacuation

The National Collaborating Centres for Public Health (NCCPH) led a project to explore knowledge gaps and inform priorities for public health responses to long-term evacuations due to natural disasters. This included identifying issues related to the impact of natural disasters on First Nations communities. The long-term evacuees project led to the development of three knowledge products for public health professionals. See page 11 for more detail.

HOW CAN EVACUEES' STORIES INFORM PUBLIC HEALTH?

Individuals or entire communities may be evacuated from their homes in the event of an emergency triggered by a natural disaster. The protection of life is of paramount importance in emergency management.[1] Public health officials issue emergency evacuation orders to protect the health and safety of people, but the process can be disruptive, and the period of evacuation can continue for a long time. Extended displacement can have devastating long-term health implications, particularly for more vulnerable populations and communities.

Evidence shows that First Nations peoples are disproportionately affected by natural disasters and emergency evacuations, which can be exacerbated by longstanding systemic and structural inequities.[2-5] However, the evidence falls short when it comes to determining how and to what extent First Nations peoples cope and recover after disasters and emergency evacuations.[2,6] For public health at all levels, questions also remain about their role, how best to support long-term recovery, and where improved coordination with local and other levels of emergency management or response may be required.

Understanding the priorities for emergency management and public health roles in long-term evacuation circumstances must begin with listening to those most affected and honouring the knowledge that comes from the lived experience of disaster evacuation. Stories from the evacuation experiences of First Nations peoples can provide greater understanding of the long-term impacts of evacuation on health and well-being and raise important implications for public health practice.

Through a narrative approach, this case study explores the effects of evacuation on the Nlaka'pamux people of the Ashcroft Indian Band following the Elephant Hill wildfire in the summer of 2017. The setting and circumstances of the Elephant Hill wildfire, described in the text box on page 2, help to characterize the severity of the disaster and duration of the evacuation. The following accounts of these events from community members illustrate the depth and complexity of impacts, building insight on factors that may contribute to, or mitigate, long-term effects of evacuation from natural disasters, and identifying priorities for public health.

ASHCROFT INDIAN BAND AND THE ELEPHANT HILL WILDFIRE

The Elephant Hill wildfire was one of the most destructive fires in British Columbia's history,[7] resulting in 211 homes and structures destroyed, more than 50,000 people evacuated from their homes, and almost 200,000 hectares of land burned.[8]

Less than 10 km from where the fire started is the Ashcroft Indian Band, a small First Nations community with a registered population of 333 members, the majority of whom live off reserve.[9] The community is located within the unceded lands of the Nlaka'pamux traditional territory in BC's south-central interior.[10]

The Ashcroft Indian Band was hard-hit by the Elephant Hill wildfire, which left 12 families homeless and most of the 77 on-reserve community members evacuated for 18 months. Nine single-family dwellings, a triplex unit, two maintenance buildings filled with equipment, and historical documents were destroyed. As well, numerous vehicles and other community infrastructure like power poles and fences were lost, and there was extensive damage to the Reserve land, including a historic cemetery.[11,12]

EVACUATION EXPERIENCES FROM THE NLAKA'PAMUX PEOPLE OF ASHCROFT

The following narrative provides first-hand accounts of evacuation experiences from the Nlaka'pamux people of the Ashcroft Indian Band. The stories were gathered as part of a community-based research project that invited community leaders and members to contribute to and share benefits from knowledge created about experiences of natural disaster, evacuation and long-term displacement. Ethics approval was provided by the Health Research Ethics Board of the University of Manitoba. With participants' consent, interviews and small group discussions were held with seven Ashcroft evacuees, including four Band members and three Band administrators, who shared memories and reflections on their evacuation experiences and paths of recovery. Their stories were collected by researchers who drew from their relationships and familiarity with the community, as well as skills in Indigenous-centred research practices.[13] Although the stories are anonymous, the words of individuals are quoted verbatim to help retain the meaning and authenticity of lived experiences.

Evacuees' stories are laid out in several themes that follow a rough chronology, beginning with initial experiences of the disaster and evacuation of the Ashcroft Band, and continuing with experiences of resettlement and longer-term challenges. Some added information is provided from published accounts of the disaster to give context to the evacuees' statements.

Confusion and Lack of Emergency Preparedness

On July 7, 2017, when a brush fire escaped established control lines and began to burn the lower plateaus of the Ashcroft Indian Band,[8] an immediate evacuation order was issued for the community.[14] Extremely hot, dry and windy environmental conditions caused the fire to escalate more quickly than expected. Within 30 minutes, the entire community experienced thick smoke, the smell of burning materials, whirring helicopters, intense heat, fire, ash and destruction all around.[8] This wildfire, now known as the Elephant Hill wildfire, would become one of the most destructive in British Columbia's history.[7]

Ashcroft evacuees recalled having little or no warning to escape the wildfire by whatever means necessary and with nothing more than *"the clothes on [their] backs."* One evacuee remembered the feeling of confusion, *"I didn't know where to go, what to do, or who to ask."* This sentiment was echoed by other evacuees who reported feeling *"anxious"* and fearful at the time of the emergency evacuation. They further described the evacuation process as being *"chaotic"*, *"stressful"*, *"terrifying"* and *"traumatic."*

Evacuees talked about the lack of preparedness that was felt at the individual and community levels. At the time of the evacuation, all cell service was cut off and the surrounding highways were closed, so there was no communication between Ashcroft residents and people from outside the community.[11] With unclear lines of communication and no procedural and risk-based information about the event from the Band office or provincial emergency service agencies, evacuees acknowledged that the community had lacked an emergency plan. At an individual level, interviewees noted they had not given much personal consideration to their own preparedness in the event of disasters and emergencies.[13]

Amidst the *"chaos"*, evacuees recalled seeing community members fleeing in many different directions. One evacuee remembered, *"Everybody was all scattered around, and I couldn't find my kids, and the kids couldn't find me."* With no evacuation plan in place, family reunification and keeping families together proved difficult for evacuees. By all accounts, the initial separation from their family members and the rest of the community was the *"scariest"* and most unsettling part of the evacuation process.

Source: iStock

Stress and Mistrust during Emergency Operations

Within a couple days of the evacuation, an emergency operations centre and emergency social services were established. The centre was managed by staff of the Ashcroft Indian Band who had limited experience or training on how to deliver emergency services. Ad hoc training had included instruction on tasks related to finances, logistics, operations and planning.[12] One of the evacuees, who also served as an emergency responder, reflected on the stress of this new and demanding role: *"We didn't even know what time of the day it was until somebody says, you know, 'It's time to get off the clock.'"*

Evacuees who also had a role in emergency response talked about the emotional difficulties they experienced in providing emergency support to family members, as well as to community members whom they had known for a very long time. One evacuee sympathized: *"[Emergency responders] have their own trauma issues to deal with, so they're not always able to provide the best help."* Evacuees disclosed that they struggled with feelings of isolation and neglected self-care while working to provide support to other evacuees. One evacuee noted that there was no opportunity to debrief at the end of the day as a way to relieve some of the stress they endured while providing emergency support services to evacuees: *"Nobody ever approached us and said, 'You know what? When you get off the clock, let's go have a coffee.' You know, 'Let's go have a chat. I'm here for you.' Nobody ever did that. Nobody at all."*

Evacuees expressed strong feelings of mistrust, especially toward government involved in emergency operations. Although a sense of mistrust existed long before the wildfire, it appeared to worsen after the disaster, mainly because of the way the evacuation was managed. Several evacuees conveyed that government's inability to provide clear and timely information during the emergency, and decisions made that did not reflect the best interests of the community, reduced their confidence in government. Federal, provincial and territorial governments were seen to be inadequately prepared to respond to disastrous events affecting First Nations communities. This decreased trust in government leadership appeared to negatively influence how evacuees transitioned through the response and recovery phases of emergency management.[13]

Onerous Administrative Processes

When the emergency operations centre was up and running, evacuees began to register for access to emergency support services. All of the evacuees interviewed expressed appreciation for the emergency supports they received, and several evacuees reported having positive interactions while receiving services. However, some evacuees also talked about feeling judged or mistreated when attempting to access services. One evacuee shared, *"People in there was trying to ask for help, and [the emergency responder] was denying, denying. Like, you know, you're there to help people. You're not there to judge them."*

Evacuees described a very burdensome registration process to access emergency support, which required them to repeatedly re-register for continued access to these services. They commonly reported having to self-advocate and *"fight"* for support through the emergency services program, which resulted in an unequal and inequitable distribution of services to evacuees.

Evacuees talked about an unsettling feeling that came with receiving emergency support services: *"Sometimes, it was overwhelming. It was, like … you can do this. You can do that … you can go here, go there, go wherever. Like, everything was at my beckoning, but I didn't want to go to those places. It was too much."* Several evacuees maintained that, as a result of feeling overwhelmed, they were unable to make informed decisions.

"People in there was trying to ask for help, and [the emergency responder] was denying, denying. Like, you know, you're there to help people. You're not there to judge them."

Worsening Health & Lack of Continuity in Health Care

The Elephant Hill wildfire caused significant health and health services concerns for evacuees. All of the evacuees reported experiencing some type of respiratory illness, such as bronchitis or pneumonia, following the disaster. One evacuee explained, *"My lungs got beat up a little bit from the smoke … I had pneumonia and bronchitis this year. I didn't know. I thought I just had a cold, until I started coughing up blood for two months."* Some evacuees believed their respiratory symptoms were made worse by their subsistence lifestyle and strong relationships with the land, as they went about their often strenuous daily activities in excessively smoky conditions outdoors. It is unclear whether community members were assessed for symptoms of emerging health conditions or cautioned about the health risks that some of their routine activities posed.

Lack of continuity for health care services was a key concern identified by evacuees. As a result of the urgent evacuation and having to quickly flee the community, one evacuee inadvertently left behind prescribed medications. In addition to a several-day delay in seeing a medical specialist for a prescription refill, the evacuee encountered challenges in accessing the federal health program (Non-Insured Health Benefits) to cover the costs of these medications.

Unacknowledged Vulnerability and Increased Risk

Some evacuees felt their vulnerability went unnoticed in the emergency response. Although Elders are commonly seen as highly vulnerable and a top priority for emergency support services, evacuees of other ages talked about their own vulnerability in the aftermath of evacuation. One evacuee remembered looking for, but not receiving, mental health support: *"I tried to get help. I think I phoned three or four times because I was so depressed. I was scared I might do something. She never returned my call. I was, like, 'what the hell?'"* Feelings of isolation and overwhelming sadness developed as a result of not receiving proper support when needed.

Source: iStock

Unreliable Lodging and its Effects

As part of the evacuation process, some evacuees were placed in motels, while other evacuees were billeted by families.[11] For most evacuees, lodging arrangements were short-term and unsuitable, and evacuees often had to go through burdensome processes to access their temporary accommodations. One evacuee remembered, *"They didn't have space in motels for us. They wanted to put us in stalls, I guess, in a gym somewhere. And I have arthritis and was sick. They wanted to take me to a hospital, and I said, 'No, I'm not going to a hospital because I have all kinds of diseases, and if I get sick, I'll get worse. So, they finally got us a motel room. So then, we got in there for three days, and the horrible thing about it was you had to pack all the stuff that you had and move, go stand in the lineup again, in order to get another room. And you might not get that same place. You get put somewhere else, every three days."*

For evacuees who lost their homes to the wildfire, finding suitable accommodations was especially stressful. It took several weeks for evacuees to transition from their temporary motel or billet placement to more suitable interim housing options, which included either longer-term motel accommodations or short-term apartment rentals. The uncertainty of their temporary lodging caused several evacuees to experience sleep deprivation and physical exhaustion, which, in some cases, worsened pre-existing physical and mental health conditions. One evacuee spoke of the concern she felt regarding her daughter's health and well-being as they awaited more secure accommodations: *"She was looking after kids, and looking after me. And it just drained her. All she did was sleep, work, sleep, work, sleep. Now that we are home, it feels like going from dark to sunlight."* Another evacuee, with complex health challenges, tearfully spoke of the exhausting disruption caused by uncertain accommodations: *"For a while, I think I went about a week without. I couldn't sleep. I couldn't eat. Well, I'll eat but, you know, just tears and tears and tears."*

Lingering Grief from Loss

Evacuees who lost their home spoke of their grief and a deep sense of loss. They talked about their emotional attachment to their house as a home, not just a property: *"It was just a tiny box, but it was my home."* Evacuees said they felt depressed, anxious and angry about losing their home. One evacuee expressed, *"My heart was empty and cold, kind of mad … really mad. I lost my home. How did this happen to us? I was very upset."* Another evacuee described the physical and mental costs of the experience: *"Like, I wasn't eating. I wasn't sleeping. I was drinking lots … yeah, but I didn't give a shit."* Even eighteen months after being evacuated and having seen their home re-built, evacuees reported lingering feelings of grief and sadness from losing their home. As one respondent explained, *"This is part of my journey here. I'm glad I'm home, but it's not my home. Now, we've got these houses here, and I am not comfortable with it."*

Evacuees talked about the devastating toll of losing their pets. For several evacuees, their pet served as a source of resilience and helped them to cope with crises. One evacuee recalled that the loss of home and community was further compounded by the grief of losing a pet as a result of being evacuated: *"I had to give my dog away. It was so sad. That really got me down mentally, and I think that dropped my health down a lot."*

"My heart was empty and cold, kind of mad … really mad. I lost my home. How did this happen to us? I was very upset."

Source: iStock

Trauma and Isolation

The Elephant Hill wildfire was viewed by evacuees not as a stand-alone event, but as one of many recurring and compounding traumas. One evacuee asserted that *"the fire was just another layer on top of all the trauma."* Some of the evacuees who lost their home to the wildfire were residential school survivors. They spoke of parallels between two traumas—their evacuation experiences and their childhood experiences of being taken away from their home communities and interned in residential schools. For these evacuees, the institutional-like lodging, seemingly endless waiting lines, and complicated registration processes were reminiscent of their time spent in residential schools.

Emotional trauma was also seen to carry over into evacuees' social interactions. In response to the trauma of the disaster and emergency evacuation, some evacuees remembered projecting anger and aggression onto family, community members and emergency responders. One evacuee acknowledged, *"[The mental health worker] would come and visit me in my room and, you know, I took it out on her… I don't know why I took it out on her, but I apologized to her."*

A couple of evacuees talked about how, after their evacuation, they felt emotionally detached and cut off from social gatherings, which left them feeling isolated and excluded. One evacuee disclosed, *"We used to all hang out. We went swimming. We took the kids to the park. Then after the fire, 'No. I'll just stay in my room.' And not, 'Come on. Let's go.' You know? I just wanted to be alone."*

Limited Transportation Options and Challenges for Daily Activities

After being evacuated, particularly to places located at greater distances from their home communities, many evacuees found it difficult to attend work, mainly because of transportation challenges. In fact, finding safe and reliable transportation to carry out daily activities proved to be quite challenging. One evacuee explained, *"If I got to work, I had to hitchhike every morning. My garden's up here, but I'm down there. Now, you go look. You can work at eight o'clock. That's when [Band office staff] go to work, eight o'clock. It's, like, freaking hot out there. I can't work in that heat."* Another evacuee expressed similar frustration with transportation constraints: *"Well, getting around was one difficult part that was frustrating because I wanted to do things, activities, or go here and there, but couldn't go because you're on foot. But, if I wanted to go to the community, I had to wait for the Band office to open so I could get a ride."*

Increased Substance Use and Addictions

All of the evacuees who were interviewed reported noticeable increases in the use of alcohol and other substances by evacuated community members, especially among those who lost their homes to the wildfire and were evacuated for longer periods of time. Attributing the increased use of alcohol to being isolated from family and the community, and to being temporarily housed near a pub, one evacuee shared a personal reflection, *"I had a hotel that was really good to me, except the food part. I drank a lot. So, the bar was right down the stairs. I had a tab and, you know, everything was at my beckoning."*

For evacuees who provided services to the community, the increased use of alcohol and other substances by fellow evacuees merely added to the complexity of their emergency management work. One evacuee described the difficulty from their perspective as a service provider: *"A prominent disaster response organization gave everybody in the community, including my household, money cards. As soon as some of our community members got those money cards, they were selling them and bought different, other cards. And they were using those cards to purchase drugs of some sort."* Another evacuee remembered, *"All of a sudden, the drug-dealing started happening, alcohol consumption … and we're like, 'Okay. We need to deal with this in our community?' … We don't have adequate training to deal with this."* Reflecting on the long-term effects of evacuation, one evacuee commented, *"We are now seeing an increased need for addictions counselling and trying to manage people through the challenges of addictions."*

Unhealthy Environmental Conditions

Several evacuees maintained that, upon returning to the community, their needs for resettlement supports intensified. Evacuees expressed concerns for increased risks of exposure to toxins and other environmental contaminants as a result of disruptions to power and water supply systems caused by the wildfire. Some evacuees identified a need for extensive restorative cleaning and specialized inspections to ensure that their homes met public health standards for environmental health and safety. One evacuee spoke of the unsanitary conditions of her daughter's home: *"When my daughter got back, her house stunk of smoke, and all the mice had gone in there, chewed through the food, and left a mess."* Other evacuees shared similar experiences of returning home to find rodent infestation, along with rotten food in their fridge and freezer, and homes filled with ash, soot and the smell of smoke.

Source: iStock

CRITICAL INSIGHTS FOR PUBLIC HEALTH

Two years after the Elephant Hill wildfire, memories of the emergency evacuation remained vivid and impacts persisted. Many of the experiences shared by evacuees focused on the disaster—the initial threat it posed and the emotional trauma that ensued. However, even after returning to their home community, evacuees continued to struggle with consequences of the disaster and dislocation. Some of their comments have suggested risks for longer-term health concerns that often go unaddressed for First Nations peoples and communities. These experiences raise several insights about impacts of disaster and evacuation, factors that may influence the severity or duration of impacts, and opportunities for public health to support improved recovery.

First Nations Insights

First Nations peoples place great value on family, community, land and resources rather than material possessions. Their lands and waters, and the cultural and spiritual interconnections with the land and water, are invaluable. They represent subsistence and quality of life. Given the devastating impact of loss on mental health and well-being of First Nations peoples, a meaningful understanding of concepts such as value and loss from a First Nations perspective will help identify suitable approaches to best support evacuees and communities.

The same holds true for the concepts of risk and vulnerability. First Nations leadership are best positioned to identify the needs of their community, including which evacuees require priority services, what services would best support their unique needs and how services should be rolled out to sustain the health and well-being of evacuees amidst the stresses of evacuation and displacement. Public health plays a key role to engage with First Nations communities and liaise with partner organizations to develop effective emergency management protocols and practices, positioning First Nations knowledge and cultural expertise as central in all decision-making processes.

Psychological Well-being and Health Effects

Mental health is a public health issue of primary concern for long-term evacuees, as the Ashcroft evacuees' experiences suggest. The evacuees talked about intense emotional distress during and continuing long after the disaster. They described terror, confusion, and unsettling feelings having to locate family members separated in the chaos. The evacuation created conditions that disrupted their families' daily routines, activities and work, and left them with chronic uncertainty about their lodging. The loss of their homes, personal belongings, and pets removed sources of security and resiliency. Long after returning to their home community, they continued to experience anxiety and discomfort, and some struggled with addiction. Local emergency support workers experienced distinct sources of distress, having to deliver emergency services with minimal training and limited capacity to provide effective support in the wake of trauma. They, too, were personally affected by the disaster, but lacked supports to maintain self-care. Through the course of evacuation and resettlement, evacuees' needs grew, while significant needs remained unaddressed, which intensified stress and increased their risks for compounded mental, physical and social problems.

These concerns demonstrate the need for enhanced prevention, early intervention and continued mental health and social supports for evacuees. A priority area for public health involvement is to ensure not only that the immediate needs of evacuees are met, but also that there is ongoing follow-up with evacuees to effectively support their emotional health and psychological well-being after their resettlement or return to community.

Preparedness and Recovery Planning

The Ashcroft evacuees' experiences suggest that emergency preparedness planning may be a key priority area for First Nations communities, although response and recovery efforts may also require increased public health attention. For the Ashcroft Band, with no formal emergency plan in place, neither the community nor its residents were prepared to deal with a disaster. When the wildfire struck, families were separated, community connections were strained, and community members lost confidence in disaster management teams. Evacuees expressed concerns with the way vital information was shared, services were rolled out, and temporary placements were determined. Complicated processes and burdensome requirements presented barriers to service access. As well, the type, distribution and accessibility of services provided created problems or caused harm to evacuees. Evacuees raised numerous health, social and safety concerns with temporary and interim accommodations, and with the unhealthy conditions of their homes upon their return. Even newly built homes and their environments raised significant concerns for the physical health and safety of evacuees.

These issues suggest the need for emergency management policies and practices that address the kinds of local conditions, resource and capacity constraints, and systemic barriers that persist for First Nations communities. As a start, there is a need for community-based evacuation plans to include ongoing orientation and refresher training, with annual reviews and updates of evacuation guidelines. As well, there is need for regular public presentations of community emergency plans to ensure community members are aware and understand the plans and procedures that are in place. Emergency management guidelines developed with First Nations communities should include streamlined administrative processes, key contact organizations that provide required and elective support services at different stages of emergency management, and self-care policies and practices for local emergency support workers. Greater support for local responders could add value to the role and help minimize staff burnout and turnover while increasing service effectiveness and trust with evacuees. Although costly and labour-intensive, there may be long-term benefit in public health taking a lead role to establish appointed emergency management teams to liaise between public health and First Nations communities, assess the immediate and ongoing needs of evacuees, help evacuees navigate through available resources, and follow-up with them to ensure their continued health and well-being.

Public health could also take the lead on engaging with First Nations peoples and communities to build stronger relationships with them before disaster strikes. Evacuees talked about feeling judged, ignored and mistreated, which in turn, influenced their use of—or unwillingness to use—available resources. Part of building stronger relationships with First Nations communities is ensuring that public health personnel and staff of partner departments involved in emergency planning and response have at least basic awareness and understanding of First Nations cultures and historical influences on current Indigenous-Canadian relations. It is particularly important to develop emergency response strategies with greater understanding that ongoing, systemic harms are layered with and exacerbate harms from evacuation, which may be addressed through cultural sensitivity, anti-racism and trauma-informed training and practice.

ADDED INSIGHTS AND MORE TO LEARN

The experiences of several individuals, a single First Nations community, and one disaster cannot be generalized to build conclusions about First Nations experiences of long-term evacuation. Rather, each First Nation and context builds added insights and shows what can be learned from the lived experiences of an evacuation, and through reflection on different sources of knowledge.

This case study set out to explore the effects of evacuation and prolonged displacement on the health and well-being of the Nlaka'pamux people of the Ashcroft Indian Band, a First Nations community that suffered significant damage and harm from the Elephant Hill wildfire of 2017. Reflecting on the experiences shared by Ashcroft's evacuees led to several critical insights on the potential health effects and social impacts of disaster and evacuation, factors that influence and mitigate harms, and opportunities for public health to support improved recovery of First Nations peoples and communities affected by natural disasters and displacement.

Added insights are shared through stories of evacuees from the Siksika First Nation, a community evacuated during the 2013 Bow River flood, which can be found in: *Case Study 2. From the Floodwaters: Siksika Nation and the Bow River Flood*.[15] A third companion document draws on findings from the community-based research, the research literature, and consultations with public health decision-makers to further explore the potential role that public health may play in this work.[16]

ABOUT THE LONG-TERM EVACUEES PROJECT

The National Collaborating Centres for Public Health (NCCPH) led a project to explore knowledge gaps and inform priorities for public health responses to long-term evacuations due to natural disasters. This included identifying issues related to the impact of natural disasters on First Nations communities, which are often hardest hit by such events. As well, the project sought to establish evidence needs and identify public health roles and emergency management practices that can improve recovery for communities and individuals affected by natural disasters, long-term evacuation and extended displacement. As a reflection of the growing public health significance of natural disasters and the complexities of recovery, all NCCs supported the project, each contributing distinct expertise on the topic area.

The Long-term Evacuees Project exploration of communities' experiences was led by Dr. Lilia Yumagulova, a Bashkir woman from the Ural Mountains, Darlene Yellow Old Woman-Munro, a member of the Siksika First Nation, and Dr. Emily Dicken, a researcher-practitioner of Cree descent. The research team formed strong relationships with the people and leaders of Ashcroft Indian Band and the Siksika First Nation. Through dialogue, researchers and community members established mutual trust and created space for participants to be central to the development of knowledge. From their work together comes a series of knowledge products for public health professionals, which include:

- ***Case Study 1: Out of the Ashes: Ashcroft Indian Band and the Elephant Hill Wildfire.***
- ***Case Study 2: From the Floodwaters: Siksika Nation and the Bow River Flood.***
- ***Health and Social Impacts of Long-term Evacuation Due to Natural Disasters in First Nations Communities: A Summary of Lessons for Public Health.***

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