Emergency Preparedness Surveys of Victorian Citizens and Community-Based Service Providers

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Background

Victoria has experienced multiple disaster events in recent decades, including the Black Saturday bushfires in 2009, the current COVID-19 pandemic and the 2022 Murray River floods. These events have resulted in far-reaching devastation for locals, communities, business, ecosystems and infrastructure, disproportionately affecting people with disability and other high-risk groups, such as people with mental health conditions[1, 2]. Under ordinary circumstances, people with disability experience social isolation and discrimination which marginalises them from mainstream social, economic and cultural participation. They are also overwhelmingly excluded from community-level disaster preparedness[3]. During the recent disasters, people with disability found it challenging to respond to emergency situations quickly and effectively[4]. This difficulty was a result not only of their functional limitations, but also inaccessible emergency communication, a lack of evacuation support and poor accessibility among emergency shelters[5, 6]. More generally, people with disability's existing health problems are rapidly aggravated in the aftermath of disasters by a lack of supplies and utilities, as well as disruptions to their routine access of health care and social supports[7]. Physical and mental stress, and the loss of permanent housing and possessions, also contribute to this aggravation[8]. These adverse effects lead to a higher risk of emotional trauma, financial hardship, and decreased quality of life among people with disability[9, 10].

People with disability and other high-risk groups require routine supports from community-based health and social care providers, such as disability support workers, allied health professionals, and general practitioners. However, the needed supports are often abruptly hindered by an emergency or disaster event, as evidenced by the 2019-20 bushfire season and the ongoing COVID-19 pandemic. It is clear to Victorians now that community-based service providers must have an effective plan in place to prepare, prevent, manage, and respond to emergency and disaster situations. Only by doing so can they minimise the likelihood of service disruption, and ensure the safety, health and wellbeing of their staff and the people they support.

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7. Phibbs, S., Good, G., Severinsen, C., Woodbury, E., & Williamson, K. (2015). Emergency preparedness and perceptions of vulnerability among disabled people following the Christchurch earthquakes: Applying lessons learnt to the Hyogo Framework for Action. Australasian Journal of Disaster and Trauma Studies, 19, 37-46.
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9. Quaill, J., Barker, R., & West, C. (2018). Experiences of individuals with physical disabilities in natural disasters: an integrative review. Australian journal of emergency management, 33(3), 58-63.
10. Stough, L. M., Sharp, A. N., Resch, J. A., Decker, C., & Wilker, N. (2016). Barriers to the long-term recovery of individuals with disabilities following a disaster. Disasters, 40(3), 387-410. https://doi.org/10.1111/disa.12161

Another important role of community-based service providers is to enable personal emergency preparedness with high-risk clients. The relationships between service providers and people with disability are a community asset and can be leveraged to increase resilience to disasters[11, 12]. By nature of performing their routine interactions, service providers acquire an intimate knowledge of the capability and support needs of people with disability. In addition, their knowledge of the local disaster risks and community resources places them in an optimal position to aid people with disability in developing personal emergency plans[13].

Community-based service providers are not currently equipped to facilitate emergency preparedness among people with disability, despite the unprecedented need for them to do so[14, 15]. Their incapacity to offer these services is due to several reasons. Firstly, these providers are not integrated into emergency planning at local, state, or national level. Secondly, there is no explicit policy guidance for the development, implementation, and evaluation of their capabilities and capacity to optimise self-resilience among high-risk clients. To further complicate the matter, the roles and responsibilities of service providers in assisting their clients with emergency preparedness are hard to define, since people with disability may receive different levels of support from multiple service providers at once. These levels of support may include private sector entities as well as, or separate from, support from government-funded mainstream services.

Building community resilience is a responsibility shared by all individuals, families, communities, businesses, emergency services, and state and federal governments. Recognising these intersections, in the inquiry into the 2019-20 Victorian Fire Season funded by the Victorian Government, the Inspector-General for Emergency Management (IGEM) outlined a set of actions designed to clarify each group's roles and responsibilities in relation to emergency management[16]. **Before undergoing this clarification process, we must first understand each group's disaster experience and current emergency planning practices, in addition to the opportunities and challenges that individuals in each group face before, during and after a disaster.**

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12. Wyte-Lake, T., Claver, M., Dalton, S., & Dobalian, A. (2015). Disaster planning for home health patients and providers: a literature review of best practices. Home Health Care Management & Practice, 27(4), 247-255. doi:10.1177/1084822314567536

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15. Villeneuve, M. (2019). Increasing involvement of people with disability. Australian Journal of Emergency Management, 34(4), 16–17.

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In collaboration with Victorian State Government Department of Health, The University of Sydney Centre for Disability Research and Policy have conducted survey studies to

- understand the level of personal emergency preparedness among people with disability, carers, general Victorians and frontline workers, as well as their capabilities and support needs before, during and after an emergency;

- understand the role, capacity and willingness of community-based organisations and frontline workers in enabling emergency preparedness with high-risk clients, as well as the tools and training needed to improve their business resilience, ensure continuity of service provision and protect the wellbeing of their staff during an emergency.

This report summarises the findings of our surveys. It can be used to inform the development and implementation of disability inclusive emergency preparedness and disaster recovery planning across the state of Victoria.

Methods

Questionnaire design

Design of the surveys was based on the Person-Centred Emergency Preparedness (P-CEP) framework and principle developed by Villeneuve[17, 18]. To improve the content validity, the design of the questionnaires was further informed by literature review and previous survey studies such as ABS Surveys of Disability, Ageing and Carers, and findings from individual interviews with 18 Australian service providers on their contributions enabling P-CEP in their practices[13]. All questionnaires were reviewed and tested by people with lived experience and service providers to ensure the understanding and appropriateness. All survey studies received ethical approval by the Human Research Ethics Committee at The University of Sydney.

Data collection

Our online, self-administered surveys were rolled out across Australia between October 2020 and June 2022. They targeted five separate study populations: (1) people with disability, (2) informal carers providing regular, unpaid support, (3) the general population without disability and not working in a carer role, (4) community-based health and social care organisations, and (5) frontline workers including volunteers. To improve the external validity of the surveys, invitations were circulated through a wide range of channels, including direct email distribution, social media, and an online panel.

People with disability and informal carers were surveyed at two separate time periods. The first was between October 2020 and March 2021, and the second was in March 2022. Additionally, the second surveys were modified slightly to include questions regarding Aboriginal and Torres Strait identity, culturally and linguistically diverse backgrounds, self-rated mental health and so on.

17. Villeneuve, M., Sterman, J., & Llewellyn, G.L. (2006). Person-Centred Emergency Preparedness: a process tool and framework for enabling disaster preparedness with people with chronic health conditions and disability, vol. 2006, Centre for Disability, Research and Policy, University of Sydney, NSW, 2018.
18. Villeneuve, M., Abson, L., Pertiwi, P., & Moss, M. (2021). Applying a person-centred capability framework to inform targeted action on Disability Inclusive Disaster Risk Reduction. International Journal of Disaster Risk Reduction, 52, 101979–. https://doi.org/10.1016/j.ijdrr.2020.101979

Data analysis

Data of respondents from Victoria was extracted and analysed. Frequency distributions were calculated for categorical data. Means and standard deviations were calculated for continuous data. All responses, including partial responses, were included in the analysis. Missing values were not included in the calculation of percentages. Qualitative data collected via open-ended questions was analysed using a thematic approach.

Survey Findings

The findings from the surveys are presented below in three sections. *Part A* focuses on personal emergency preparedness among people with disability, carers, frontline workers, and the general population of Victorians. *Part B* concentrates on emergency preparedness among community-based health and social care organisations. *Part C* focuses on the facilitation of emergency preparedness with high-risk clients from the perspective of organisations and frontline workers.

Part A. Emergency Preparedness of Victorians

Respondent characteristics

Demographics

In total, 89 people with disability (PWD), 55 informal carers, 25 frontline workers and 54 individuals representing the general population completed the survey. Table 1 summarises the demographic characteristics of respondents. Due to the nature of convenience sampling, the demographic characteristics of the study samples do not necessarily reflect actual distributions of the target populations across the state of Victoria. More females presented in the group of PWD (63%), carers (58%) and frontline workers (88%). The most commonly occurring age group was aged 30-39 among general respondents (30%), aged 40-49 among PWD (22%), and aged 50-59 among carers (24%) and frontline workers (32%). A minority identified themselves as Aboriginal and/or Torres Strait Islander People (PWD: 5%, carers: 2%, frontline workers: 4%, general population: 0%). Among all four groups, frontline workers had the highest level of education, with 84% holding a bachelor's degree or above. It was only among people with disability that the number of unemployed respondents (n = 50, 57%) exceeded those employed. Moreover, respondents with disability reported the lowest household income compared to the other groups, with nearly half (48%) earning $50,000 or less annually.

Self-reported physical and mental health

Respondents with disability, carers and those representing the general population were asked to rate their physical and mental health on a five-point scale, with 1 being poor and 5 being excellent. The majority of respondents with disability rated their physical (40%) and mental (41%) health at the mid-point of the scale. Most of the respondents who identified as carers rated their physical (55%) and mental (41%) health as being 4. Similarly, among respondents representing the general population, most gave a rating of 4 for their physical (56%) and mental (41%) health (Table 2).

Self-reported disability

Of the 89 respondents with disability, the most commonly reported impairments were restriction in physical activities/work (42%), mental illness (40%) and chronic pain/discomfort (37%) (Figure 1). To participate in everyday life more fully, some respondents with disability (44%) required aid, an assistive device or equipment, support from a friend or family member (37%), a paid support worker (25%), and, in some cases, assistance animals (9%).

Table 1. Demographic characteristics of respondents with disability, informal carers, frontline workers and general respondents

|	People with Disability % (n)	Carers % (n)	Frontline Workers % (n)	General population % (n)
Gender				
Female	63% (56)	58% (32)	88% (22)	50% (27)
Male	35% (31)	42% (23)	12% (3)	50% (27)
Other	2% (2)	0% (0)	0% (0)	0% (0)
Aboriginal and Torres Islander*				
Yes	5% (3)	2% (1)	4% (1)	0% (0)
CALD† Background*				
I was born overseas	16% (9)	19% (10)	-	33% (18)
One or both of my parents were born overseas	21% (12)	30% (16)	-	33% (18)
I speak a language other than English at home	4% (2)	11% (6)	-	7% (4)
None of the above	66% (37)	54% (29)	-	46% (25)
Age Groups				
<30	15% (13)	20% (11)	0% (0)	11% (6)
30-39	18% (16)	11% (6)	28% (7)	30% (16)
40-49	22% (19)	15% (8)	20% (5)	11% (6)
50-59	16% (14)	24% (13)	32% (8)	11% (6)
60-69	19% (17)	22% (12)	20% (5)	19% (10)
70-79	9% (8)	7% (4)	-	19% (10)
80+	1% (1)	0% (0)	-	-
Education			-	
Postgraduate/graduate diploma/graduate certificate	17% (15)	25% (14)	40% (10)	17% (9)
Bachelor's degree	21% (19)	25% (14)	44% (11)	24% (13)
Advanced diploma/Diploma	13% (12)	13% (7)	12% (3)	15% (8)
Certificate III/IV	17% (15)	13% (7)	4% (1)	22% (12)
Senior Secondary Education	20% (18)	18% (10)	0% (0)	15% (8)
Junior Secondary Education	8% (7)	5% (3)	0% (0)	7% (4)
Primary Education or below	0% (0)	0% (0)	0% (0)	0% (0)
I am not sure	3% (3)	0% (0)	0% (0)	0% (0)
Employment				
Employed (full-time/part-time/self-employed)	43% (38)	60% (33)	96% (24)	67% (36)
Unemployed	57% (50)	40% (22)	4% (1)	33% (18)
Annual household Income				
$20,000 or less	10% (8)	5% (3)	0% (0)	11% (6)
$20,001 to $50,000	38% (32)	20% (11)	4% (1)	15% (8)
$50,001 to $80,000	23% (19)	22% (12)	17% (4)	17% (9)
$80,001 to $120,000	14% (12)	20% (11)	9% (2)	20% (11)
$120,001 or more	8% (7)	22% (12)	39% (9)	31% (17)
Not sure	5% (4)	5% (3)	4% (1)	4% (2)
Prefer not to say	2% (2)	5% (3)	4% (1)	2% (1)
Dwelling				
A free-standing separate house	73% (65)	92% (33)	-	-
A semi-detached house	8% (7)	0% (0)	-	-
A low-rise unit with no lift	12% (11)	8% (3)	-	-
A medium/high rise unit with a lift	4% (4)	0% (0)	-	-
Other	2% (2)	0% (0)	-	-
Residential Status				
Owned by you or someone in this household	69% (60)	71% (25)	96% (24)	-
Rented as a public housing tenant	5% (4)	9% (3)	0% (0)	-
Rented as a private rental tenant	26% (23)	20% (7)	4% (1)	-
Occupied without payment of rent	0% (0)	0% (0)	0% (0)	-
Household Occupants				
By myself	28% (25)	-	8% (2)	28% (15)
With others (e.g. family, friends, housemates)	72% (69)	-	92% (25)	72% (43)

* Data collected via the 2022 survey only. † Cultural and Linguistic Diversity

Table 2. Five-point scale of physical and mental health reported by respondents with disability (n = 55), carer respondents (n = 53) and general respondents (n = 54)

Self-reported physical health	People with Disability % (n)	Carers % (n)	General Population % (n)
Scale 1	5% (3)	0% (0)	0% (0)
Scale 2	22% (12)	4% (2)	4% (2)
Scale 3	40% (22)	26% (14)	31% (17)
Scale 4	25% (14)	55% (29)	56% (30)
Scale 5	7% (4)	15% (8)	9% (5)
Self-reported mental health			
Scale 1	4% (2)	0% (0)	0% (0)
Scale 2	21% (12)	13% (7)	2% (1)
Scale 3	41% (23)	31% (17)	33% (18)
Scale 4	21% (12)	41% (22)	41% (22)
Scale 5	13% (7)	15% (8)	24% (13)

*Note.* Data collected via the 2022 survey only

Figure 1. Long-term health conditions and impairments reported by respondents with disability (n = 89)
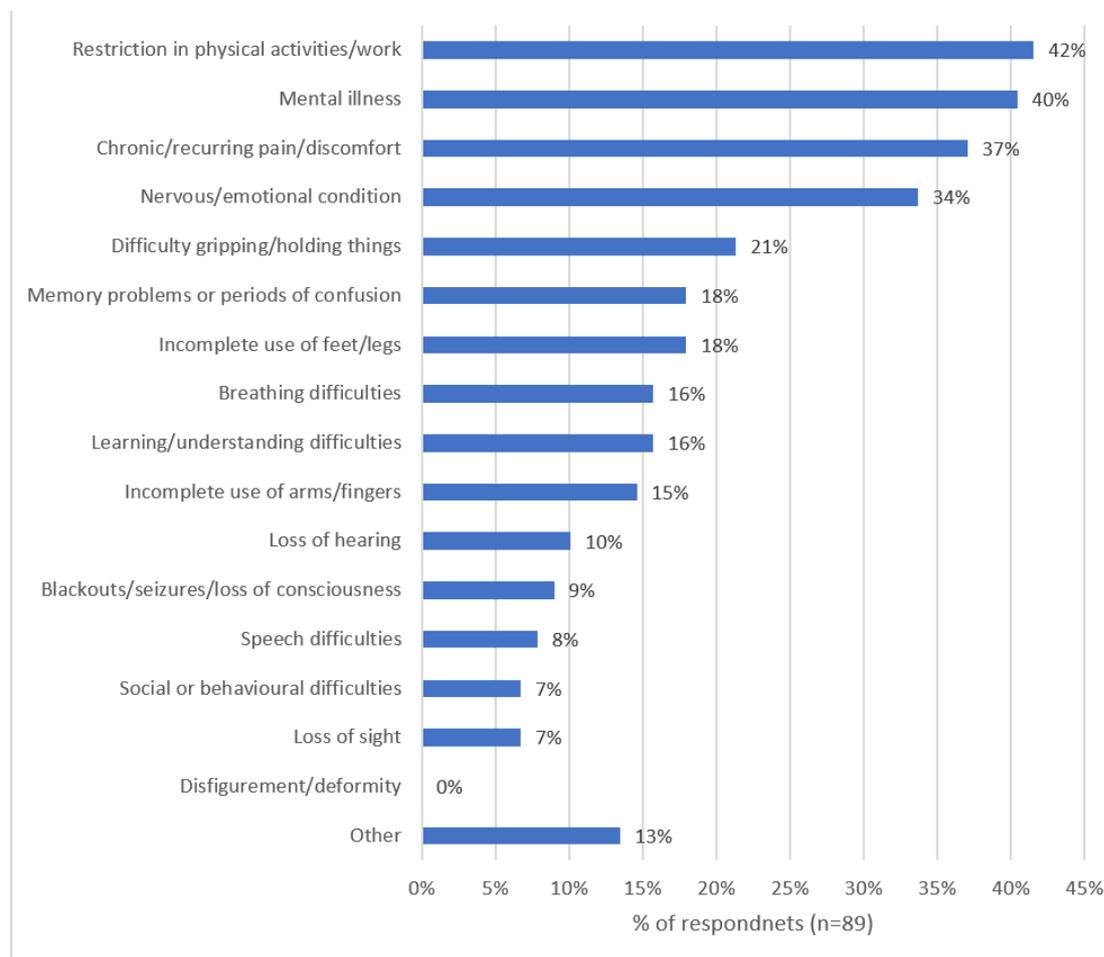
Note. Data collected via a multiple-choice, multiple-response question

The majority of respondents with disability had difficulty in remembering or concentrating (66%), followed by walking or climbing steps (62%), and seeing, even if wearing glasses (33%). Figure 2 provides a comparison of the functional limitations between respondents with and without disability.

Figure 2. Difficulty in daily activities (PWD: n = 89, General respondents: n = 54)
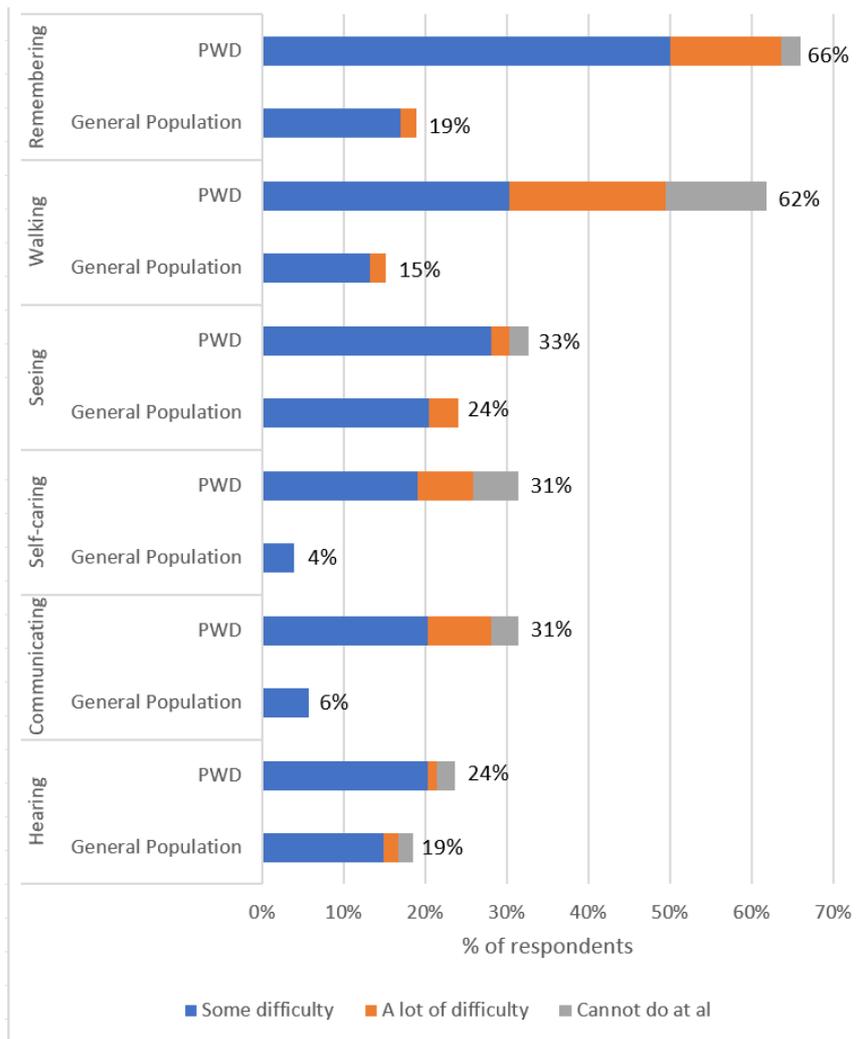
Just over a quarter of respondents with disability were Disability Support Pension recipients (28%) and/or National Disability Insurance Scheme (NDIS) participants (27%). More than a half (57%) reported that they did not receive any disability or aged care support from governments.

Caring role

Of the 53 carer respondents, 77% were primary carers. One in five (20%) carer respondents was the daughter of the recipient of care. Other common relationships to the recipient of care were spouse/partner (18%) and mother (16%) (Figure 3).

The majority of the care recipients (26%) were aged more than eighty years old, followed by aged between 70 and 79 (23%). The most frequently reported condition or disability for which the care recipient required care was frailty due to aging (36%), followed by chronic health conditions (22%) and physical disability (20%) (Figure 4). Notably, around one in every ten care recipients (11%) could not be left alone at all, while 7% of them could be left alone for less than an hour and 35% for a few hours (Table 3).

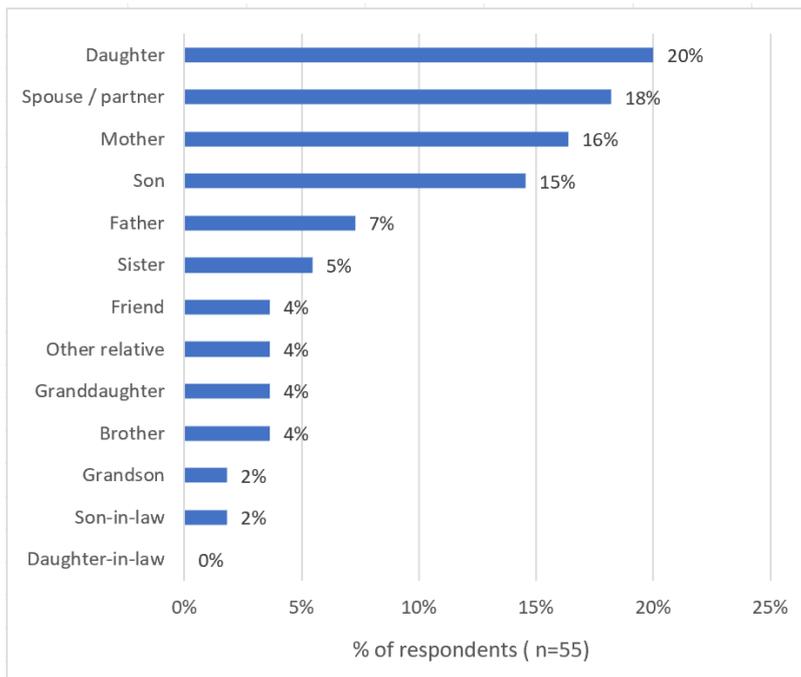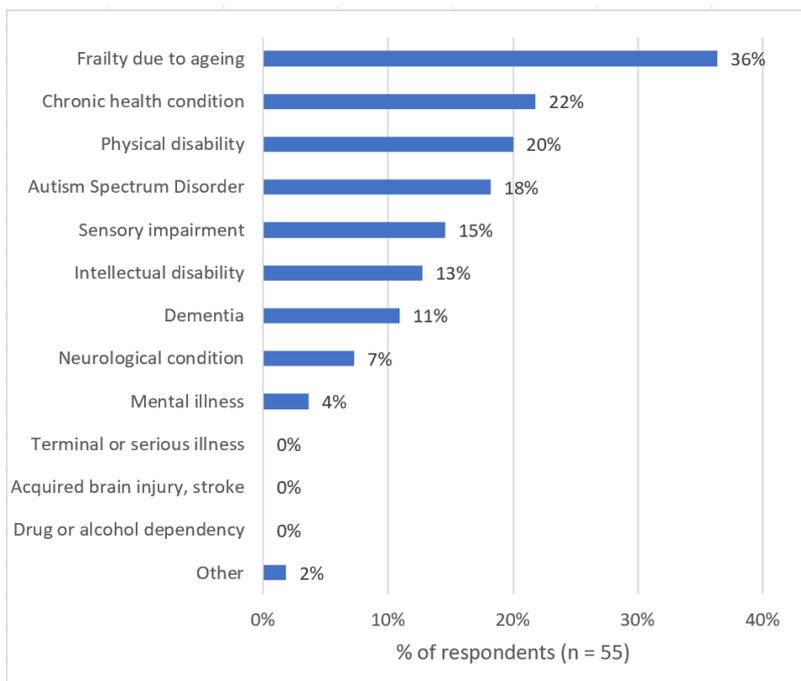Figure 3. Carers' relationship to those they care (n = 55)

Figure 4. Carer recipients' health conditions and disabilities that required care (n = 55)

Note. Data collected via a multiple-choice, multiple-response question

Table 3. The maximum time length that carer recipients could be left alone (n = 55)

Maximum duration	% (n)
Not at all	11% (6)
Less than an hour	7% (4)
A few hours	35% (19)
One day	13% (7)
A few days	13% (7)
More than a few days	22% (12)

Five most common types of assistance provided by carers were: household chores (72%), transport (65%), reading or writing tasks (64%), cognitive or emotional tasks (59%), and property maintenance (59%) (**Error! Reference source not found.**Figure 5). Three-quarters of the carer respondent (75%) reported that they did not receive any allowance from the government for their caring role.

Figure 5. Types of assistance provided by carers (n = 55)
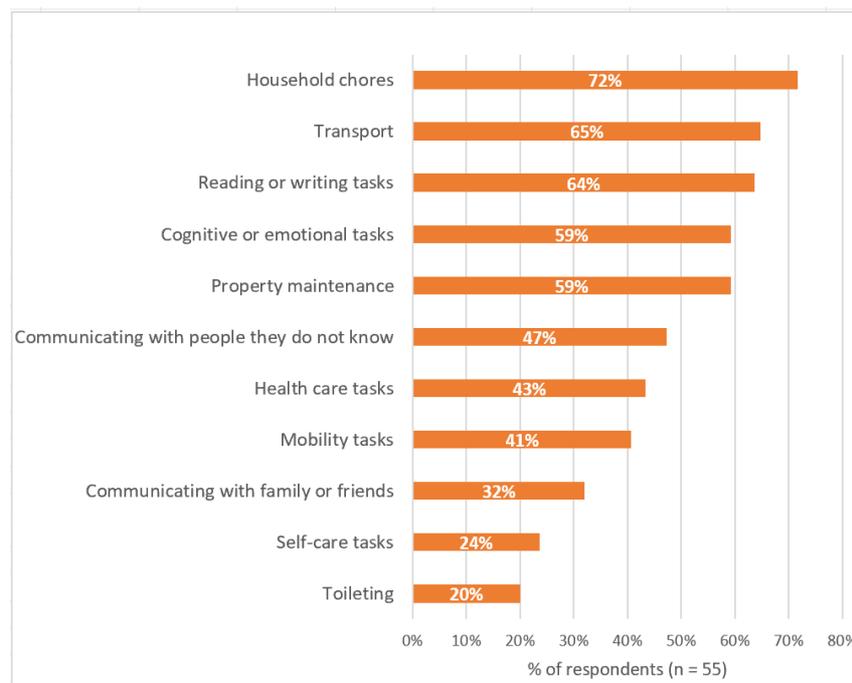
Note. Data collected via a multiple-choice, multiple-response question

Personal Emergency Experience

At this stage of the survey, respondents were asked about their personal emergency experience, where the word "emergency" states an actual or imminent event that endangers or threatens life, property, or environment and requires immediate action, including hazard events like a bushfire, flood, human-made events like a house fire and infectious events like COVID-19.

Emergency concern

Figure 6 illustrates the most concerning emergency events according to respondents with disability, carers, frontline workers and those representing the general population. The pandemic received the highest rating among all four groups, reported as both 'very' and 'extremely' concerning for respondents' respective communities. In particular, concern for pandemic was greater among frontline workers (60%), followed by carers (48%), those in the general population (37%), and lastly

people with disability (32%). Other hazards events, such as droughts, heatwaves and bushfires also received high rating from respondents across all four groups (Figure 6).

Confidence in dealing with emergencies

Respondents with disability and carers were further asked about their level of confidence in dealing with emergencies. The majority of the respondents reported that they were most confident in dealing with heatwaves (PWD: 35%; carers: 33%), but least confident in dealing with housefire (PWD: 33%; carers: 20%).

The most common reasons for being confident were "I can deal with the emotions that arise in this type of emergency" (PWD: 55%, carers: 36%) and "I have plenty of experience in dealing with this type of emergency" (PWD: 35%, carers: 36%). On the other hand, the most common reasons for not feeling confident were "I don't have any personal experience dealing with this type of emergency" (PWD: 52%, carers: 35%), "I don't think I am capable of keeping myself safe when this type of emergency happens" (PWD: 36%, carers: 20%) and "I don't have an emergency plan for this type of emergency (PWD: 35%, carers: 35%) (Table 4).

Emergency information

Across all four groups, State Emergency Service (SES) (PWD: 58%, carer: 70%, frontline workers: 88% general population: 58%) and Fire Services/Rural Fire Service/Fire and Rescue (PWD: 44%, carer: 48%, frontline workers: 60%, general population: 34%) were the most common sources that respondents would go to for reliable information and learn how to prepare for, respond to, and recover from an emergency. Family was another information source commonly accessed by respondents with disability (42%), carers (44%) and general population (38%), whereas Department of Health was the key information source accessed by frontline workers (60%).

Across all four groups, the most common communication mediums/channels that respondents seek for timely information about emergencies or disaster warnings were radio (PWD: 51%, carer: 53%, frontline workers: 68%, general population: 69%), TV (PWD: 50%, carer: 60%, frontline workers: 64%, general population: 59%), and websites of Local Council or Emergency Services (PWD: 45%, carer: 44%, frontline workers: 64%, general population: 39%).

Impact of COVID-19 pandemic

During the height of the COVID-19 pandemic, Victorians endured the longest period of lockdown in the world. Table 4 outlines the issues produced by the pandemic and the duration of their adverse effects. Of the 25 general respondents impacted by the pandemic, 36% reported a new mental health issue or that their mental health had worsened and 18% of these unprecedented issues were ongoing (Table 5). However, it is important to note that this data was collected from a small number of survey respondents in this survey study. A larger scale survey employing a probability sampling method is needed to better understand the full impact of the pandemic on the Victorian population.

Figure 6. Level of concern for emergency events in the community (PWD: n = 55, carers: n = 53, frontline workers: n = 25, general population: n = 54)
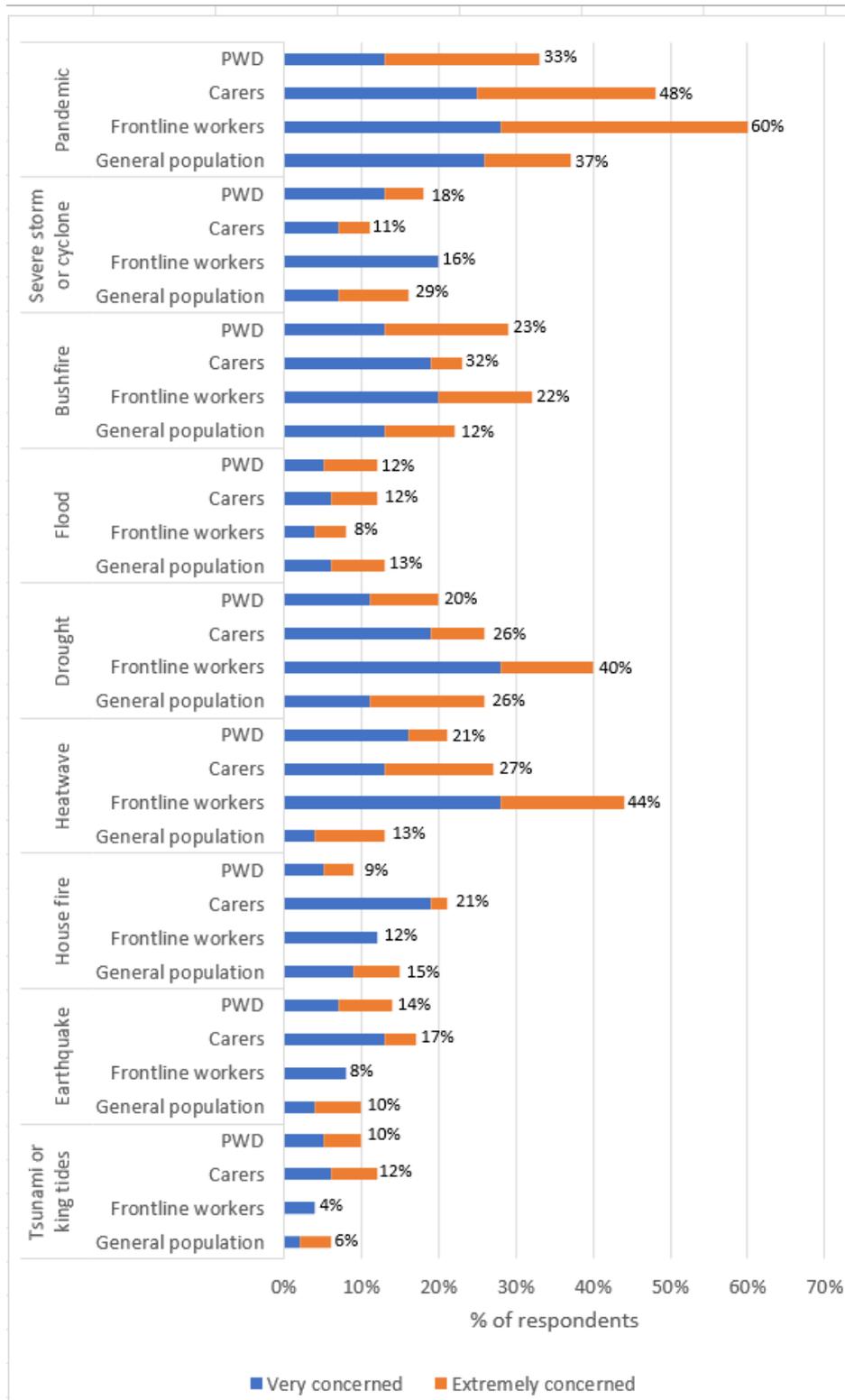
Table 4. Main reasons for feeling most or least confident in dealing with certain emergencies among respondents with disability (n = 89) and carers (n = 55)

	PWD % (n)	Carers % (n)
Reasons for feeling confident		
I can deal with the emotions that arise in this type of emergency	55% (49)	36% (20)
I have plenty of experience in dealing with this type of emergency	31% (35)	36% (20)
I know how to assist the care recipient during this type of emergency	-	31% (7)
I have family/carers with me who will assist me during this type of emergency	25% (22)	
I have an emergency plan in place that would help me in the event of this emergency	21% (19)	16% (9)
My neighbours will check on me	11% (8)	-
The police, emergency personnel or local council would take care of my needs during this type of emergency	6% (5)	13% (7)
I have people to support me or check on me and the care recipient in an emergency	-	11% (6)
I have attended emergency meetings or training on how to be better prepared for this type of emergency	6% (5)	7% (4)
My service providers will check on me	4% (4)	-
I have conducted evacuation drills in the past 12 months	1% (1)	4% (2)
Reasons for NOT feeling confident		
I don't have any personal experience dealing with this type of emergency	52% (46)	33% (18)
I don't think I am capable of keeping myself safe when this type of emergency happens	36% (32)	20% (11)
I don't have an emergency plan for this type of emergency	35% (31)	35% (19)
I don't think I can deal with the emotions that arise in this type of emergency	-	18% (10)
I don't have anywhere to go that is accessible during this type of emergency	27% (24)	16% (9)
I don't have anyone to help or check in on me in this type of emergency	15% (13)	16% (9)
I think there is an emergency plan somewhere, but I don't know the details of the plan	7% (6)	-

Table 5. Issues caused by pandemic in the past three years among the general respondents (n = 25)

Did this pandemic cause you any of the following issues?

	No	Yes. This issue was **short term**	Yes. This issue was **medium-term**, lasting up to 6 months	Yes. This issue has been **longer-term**, lasting up to a year	Yes. This is an **ongoing** issue	Prefer not to say
Physically injured or became physically unwell	73% (16)	9% (2)	5% (1)	0% (0)	9% (2)	5% (1)
Worsening or new mental health issue	64% (14)	9% (2)	0% (0)	5% (1)	18% (4)	5% (1)
Increased drug and/or alcohol intake	82% (18)	9% (2)	5% (1)	0% (0)	0% (0)	5% (1)
Lost or damaged shelter/home	95% (21)	0% (0)	0% (0)	0% (0)	0% (0)	5% (1)
Loss of income	68% (15)	23% (5)	0% (0)	5% (1)	0% (0)	5% (1)
Unable to attend my place of study	86% (19)	5% (1)	0% (0)	0% (0)	5% (1)	5%(1)
Experienced an increase in domestic violence	95% (21)	0% (0)	0% (0)	0% (0)	0% (0)	5% (1)
Involved in more arguments, fights and violence	82% (18)	9% (2)	0% (0)	5% (1)	0% (0)	5% (1)

Personal Emergency Preparedness

Emergency planning

Moving onto our investigation of personal emergency preparedness, we found that 56% of the frontline workers, 38% people with disability, 27% carers and 25% of those within the general population reported having an emergency plan to guide them through all types of hazard events (Table 6). Across all four groups, the most frequently reported motives for planning for emergencies include:

- "By making an emergency plan, I am improving my chances of surviving during an emergency" (PWD: 64%, carers: 57%, frontline workers:85%, general population: 69%), and
- "I am confident that I can actually do something to help myself" (PWD: 48%, carer: 71%, frontline workers: 46%, general population: 69%).

On the other hand, the most common reason among respondents with disability, carers and those within the general population for not making an emergency plan was:

- "I have just never thought about preparing for an emergency at all" (PWD: 43%, carer: 37%, general population: 35%), and
- "I am not sure how to prepare for an emergency" (PWD: 43%, carer: 37%, general population: 35%).

Unlike the other three groups, the most common reason reported by the frontline workers for not creating a plan was

- "I would have plenty of warning prior to the emergency, so I don't need to prepare in advance" (42%).

Another factor that deterred carers and frontline workers from making an emergency plan was

- "I don't have time/I am too busy" (carers: 21%, frontline workers: 25%).

Household emergency preparedness

Table 6 lists the household preparedness actions that respondents, as well as any other members of their household, had completed in the past year. The most implemented actions across four groups were

- Maintaining at least a quarter tank of petrol in the vehicle at all times. (PWD: 52%, carers: 39%, frontline workers:53%, general population: 56%), and

- Reducing home/property damage by either keeping gutter and downpipes clear of leaf and litter, trimming trees, and cutting back overhanging branches, clearing an area around the house, keeping the roof in good condition, installing, and maintaining smoke alarm etc. (PWD: 50%, carers: 37%, frontline workers:65%, general population: 41%).

The least implemented actions across four groups were

- Participating in an evacuation drill in the past 12 months (PWD: 8%, carers: 11%, frontline workers: 24%, general population: 8%), and

- Putting together an easy-to-carry go-bag with critical items, such as mobile phone, medications, flashlight, etc. (PWD: 12%, carers: 18%, frontline workers: 13%, general population: 11%).

On average, frontline workers demonstrated the highest completion rate of household preparedness actions (34%), equally followed by carers (26%) and general population (26%), and people with disability being the lowest (24%).

We observed the greatest difference between groups in relation to "Identifying alternative accommodation for shelter if own home not accessible". Frontline workers were those most likely to implement this measure (50%), while carers were the least likely to do so (11%) (Table 6).

Mental emergency preparedness

Participants were asked to rate how confident they felt in their ability to manage mental stress during a time of uncertainty, with 1 being not confident at all and 5 being extremely confident. As illustrated in the top-2-box bar chart (Figure 7), those representing the general population had relatively higher mental resilience compared to the other groups, while respondents with disability had relatively lower mental resilience.

We then asked the general respondents what strategies they employed to cope emotionally during and after an emergency event, the most frequently reported strategies were "Trying to maintain a normal routine" (33%) and "Occupying myself with recreational activities, exercise, or tasks that need attending to" (31%) (Figure 8).

Table 6. Percentages of household preparedness actions completed by the respondents (or any other household members) in the past year (PWD: n = 56, carers: n = 54, frontline workers: n = 25, general population: n = 54)

	PWD	Carers	Frontline workers	General population
Keeping an updated emergency contact list	20%	35%	38%	30%
Keeping extra prescription medications and copies of prescriptions in a waterproof container	20%	19%	13%	11%
Developing an evacuation plan for where to go if you decide to leave and how to get there	17%	20%	25%	23%
Arranging a family meeting place or reconnection plan	7%	23%	13%	19%
Stocking your house with emergency supplies such as 3-day supply of food and drinking water, a first aid kit, etc.	33%	38%	63%	38%
Getting and reviewing property, vehicle and/or life insurance policies	33%	50%	50%	37%
Making a backup plan for support workers/personal assistants and essential suppliers/agencies	7%	20%	n/a	n/a
Working out how to get timely emergency information and warnings	30%	38%	50%	30%
Getting a home generator or solar panel	13%	23%	13%	33%
Develop strategies to manage stress levels	24%	25%	29%	8%
Writing down your medical information, such as identification, medications, food and drug allergies, health records etc.	23%	30%	18%	22%
Safely storing important documents (e.g., will, power of attorney, passport, banking information, etc)	46%	38%	41%	52%
Making arrangements for short notice/emergency replacement care	4%	15%	29%	11%
Reducing home/property damage by either keeping gutter and downpipes clear of leaf and litter, trimming trees, and cutting back overhanging branches, clearing an area around the house, keeping the roof in good condition, installing, and maintaining smoke alarm etc.	50%	37%	65%	41%
Putting together an easy-to-carry go-bag with critical items, such as mobile phone, medications, flashlight, etc.	12%	18%	13%	11%
Speaking with family, friends and/or personal assistant about what to do during an emergency situation	19%	18%	31%	15%
Knowing the manual operations for your/carer recipient's medical equipment or assistive technology	27%	15%	n/a	n/a
Participating in an evacuation drill in the past 12 months	8%	11%	24%	8%
Maintaining at least a quarter tank of petrol in your vehicle at all times	52%	39%	53%	56%
Identifying alternative accommodation for shelter if own home not accessible	31%	11%	50%	27%

Figure 7. High mental resilience (scale 4 and scale 5 of a five-point scale) during a time of uncertainty among respondents with disability (n = 56), carers (n = 54), frontline workers (n =25), and general respondents (n = 54)
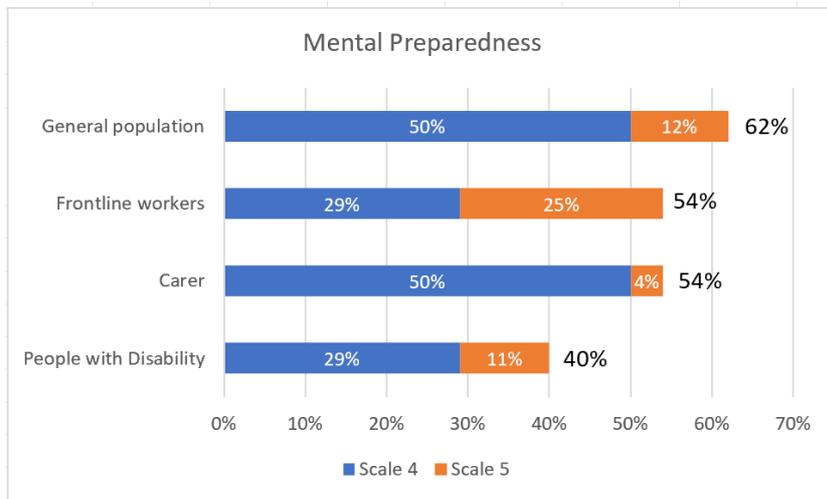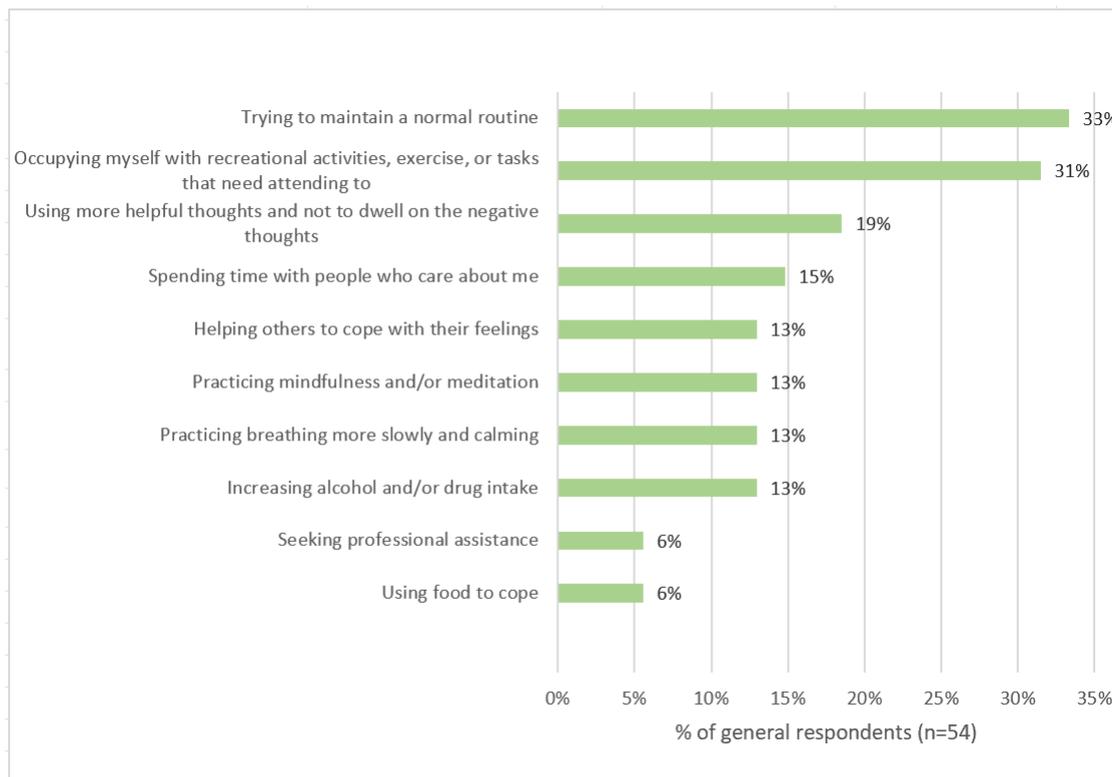

Figure 8. Coping strategies used by the general respondents (n = 54) to cope emotionally during and after an emergency
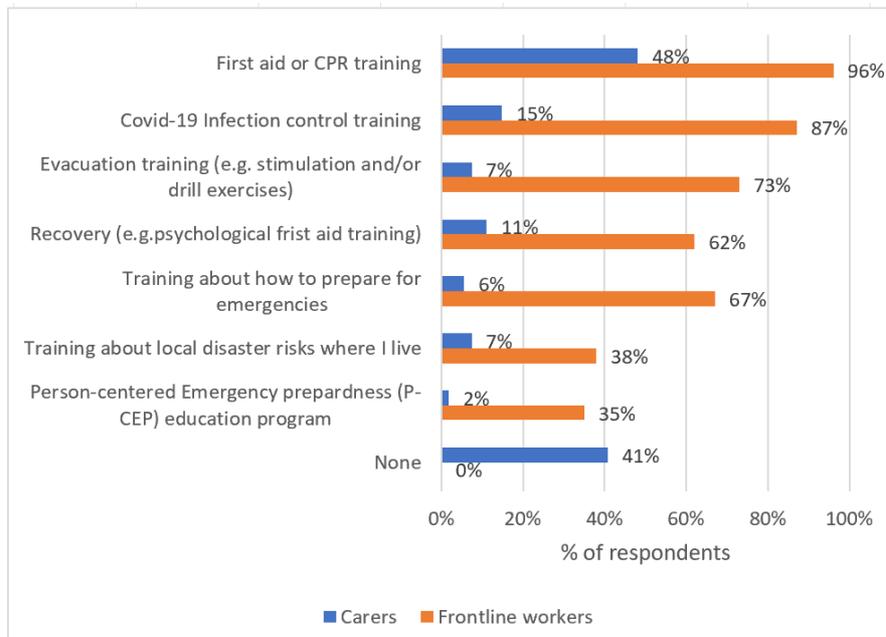

Note. Data collected via a multiple-choice, multiple-response question

Emergency training

Both carer respondents and frontline workers were asked if they had completed any emergency training in their personal and/or professional life. As shown in Figure 9, first aid or CPR training was the most common emergency training completed by carers and frontline workers. It's worthwhile noting that 41% of the carer respondents did not complete any of the listed emergency trainings.

Figure 9. Emergency trainings partaken by care respondents (n = 54) and frontline workers (n = 25)

Note. Data collected via a multiple-choice, multiple-response question

Capabilities and Support Needs

Post-emergency assistance

When respondents with disability, carers and general respondents were asked to rate whom they anticipated to rely on within the first 72 hours after an emergency, fire services (e.g., Rural Fire Service, Fire and Rescue) and SES received the highest rating among all three groups. The Venn diagram below (Figure 10) offers a more detailed illustration of the similarities and differences regarding the sources of assistance that each group anticipated.
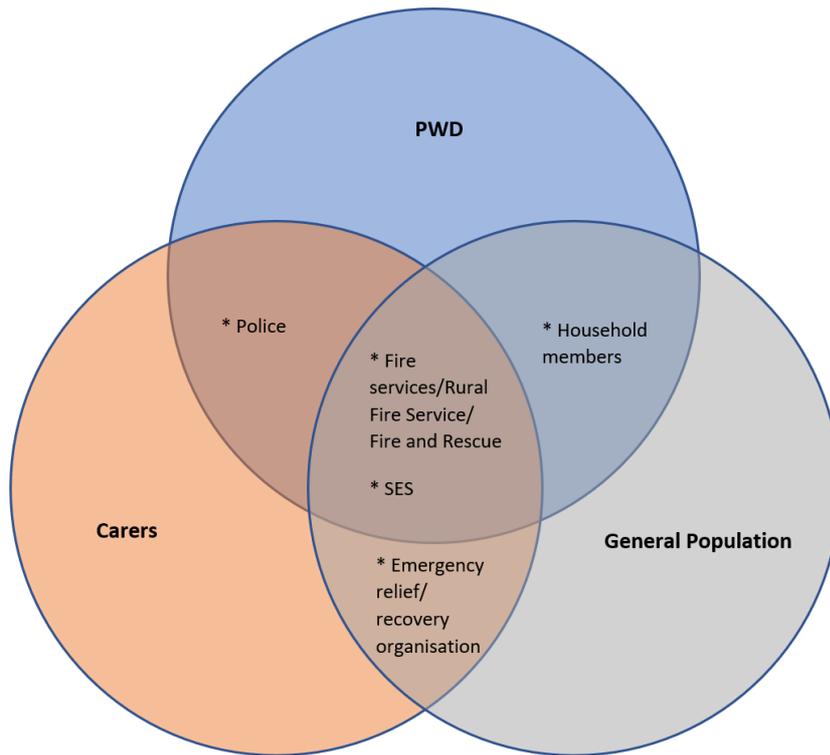
Figure 10. Sources of assistance most commonly anticipated by respondents with disability (n = 89), carers (n = 55) and general respondents (n = 54) within 72 hours following an emergency

Managing emergency situations

At this stage of the survey, respondents with disability and informal carers were asked to imagine themselves in the following hypothetical scenarios:

| **Shelter-in-place scenario:** |
| Following a severe storm in your neighbourhood, the debris from trees and homes has blocked all roads. The State Emergency Services will be supporting clean-up, but it is going to take 7 days before you can get out or any service providers can get to you. You are safe at your home, but services have been shut off (electricity, gas, water) and you cannot buy any water, food, personal hygiene products or some essential supplies that you need to replenish. |
| **Evacuation scenario:** |
| Emergency services have issued an evacuation order and you need to evacuate within 12 hours. Public transportation services have stopped operating and it is difficult to get a taxi or Uber that is accessible. The temporary evacuation shelter that your local council operates is overcrowded, noisy, and not accessible for your level of support needs. |

Respondents were asked to score, on a scale from 1 to 5, how capable they felt they were at managing each scenario. A score of 1 indicated that a participant felt they couldn't manage the scenario at all by themselves and would require a lot of assistance, while a score of 5 indicated that they felt confident handling the scenario without any assistance. Both groups reported similar scores for the evacuation scenario. However, respondents with disability reported a slightly higher score for the shelter-in-place scenario (Table 7).

Table 7. Level of capabilities and support needs during the shelter-in-place and evacuation scenarios among respondents with disability (n = 73) and carers (n = 54)

	Shelter-in-place		Evacuation	
Score	People with Disability % (n)	Carer % (n)	People with Disability % (n)	Carer % (n)
1	12% (9)	19% (10)	17% (12)	16% (8)
2	16% (12)	24% (13)	25% (18)	12% (6)
3	37% (27)	22% (12)	14% (10)	31% (16)
4	22% (16)	31% (17)	22% (16)	31% (16)
5	12% (9)	4% (2)	22% (16)	10% (5)
Average score	3.03	2.77	3.07	3.07

Part B. Emergency Preparedness of Service Providers

This section describes the impact of the recent emergency events on business and clients, the strategies adopted by service organisations to improve business resilience, and the tools and training needed to develop and implement a strong business continuity plan.

Service Profile

Organisation profile

Of 43 responding organisations, the majority of them (62%) were from the private sector; 60% registered as a company, and a third of them in medium sized organisations with employee numbers between 20 and 199 (Figure 11). Just over half of those surveyed (53%) stated that they typically provide direct service delivery to their clients. Disability services (70%) was identified as the most provided service, followed by allied health (28%) and aged care services (23%) (Figure 12).
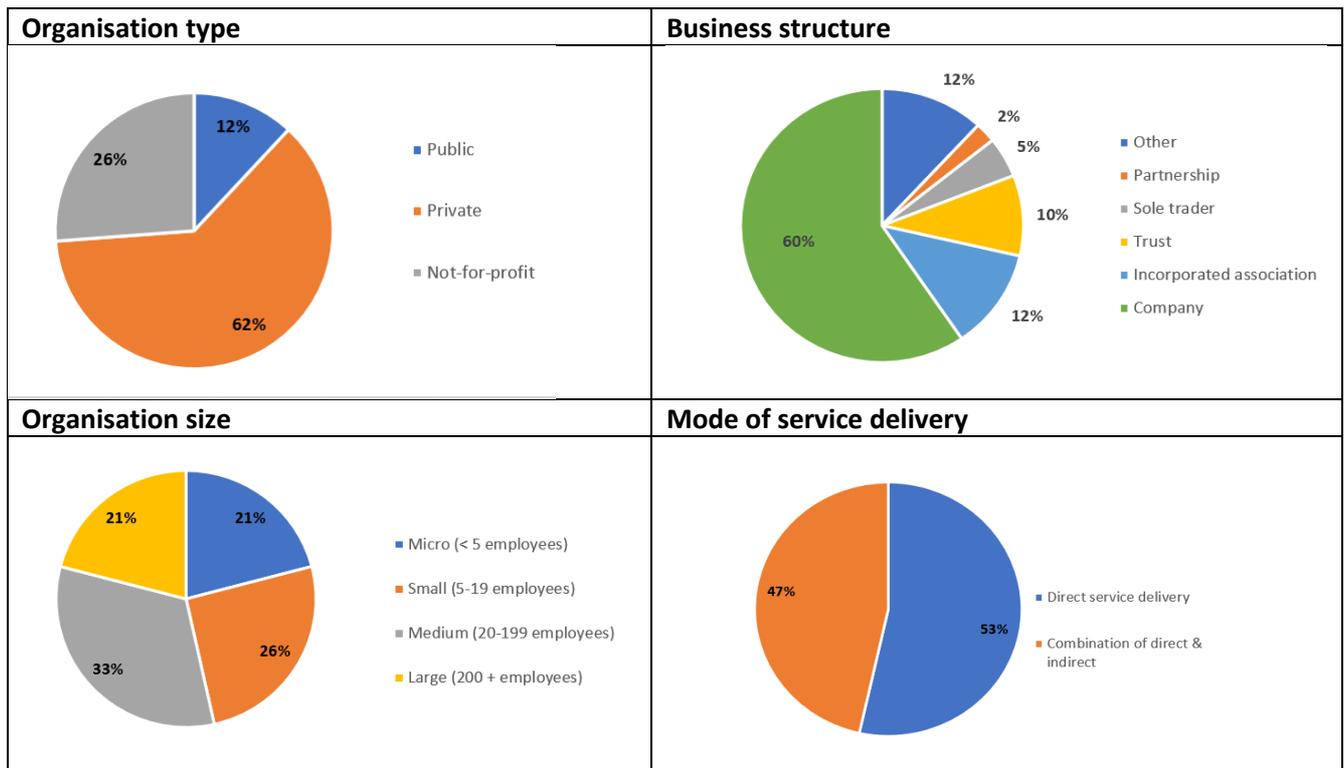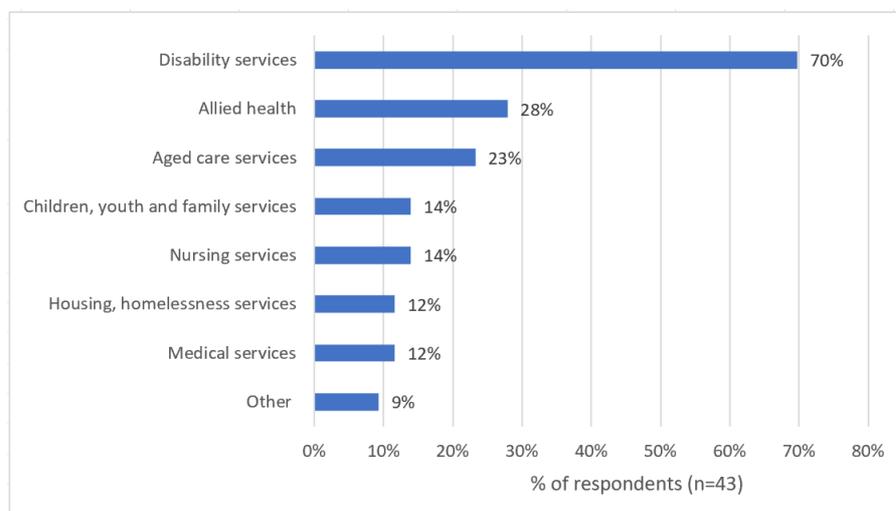
Figure 11. Organisation profile

Organisation type	Business structure

Organisation size	Mode of service delivery

Figure 12. Primary services provided by the organisations surveyed.

| Service	%
Disability services	70%
Allied health	28%
Aged care services	23%
Children, youth and family services	14%
Nursing services	14%
Housing, homelessness services	12%
Medical services	12%
Other	9%

% of respondents (n=43)

Note. Data collected via a multiple-choice, multiple-response question

Professional profile

Of 25 frontline workers, more than a half (56%) belonged to the allied health sector (Figure 13), made up of 4 social workers, 3 physiotherapists, 3 speech pathologists, 2 occupational therapists, 1 psychologist and 1 other. Half of the frontline workers had worked in their professional for more than ten years.

Figure 13. Primary roles of the frontline workers.
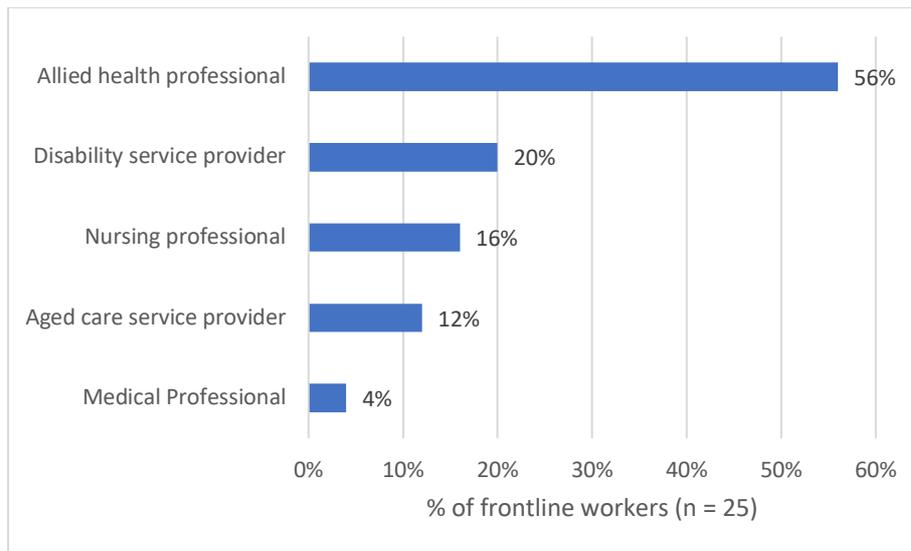
Client profile

The majority of the responding organisations (82%) reported that their main client group was people with disability. Other commonly reported client groups included people with mental health illness (36%), culturally and linguistically diverse clients (26%) and families and informal carers (23%) (Figure 14). Table 8 provides the average number of active clients per organisation, whereas Table 9 presents the caseload of frontline workers at the time of this survey. Most frontline workers (44%) reported to have up to a 20-client caseload.

Figure 14. Main client groups
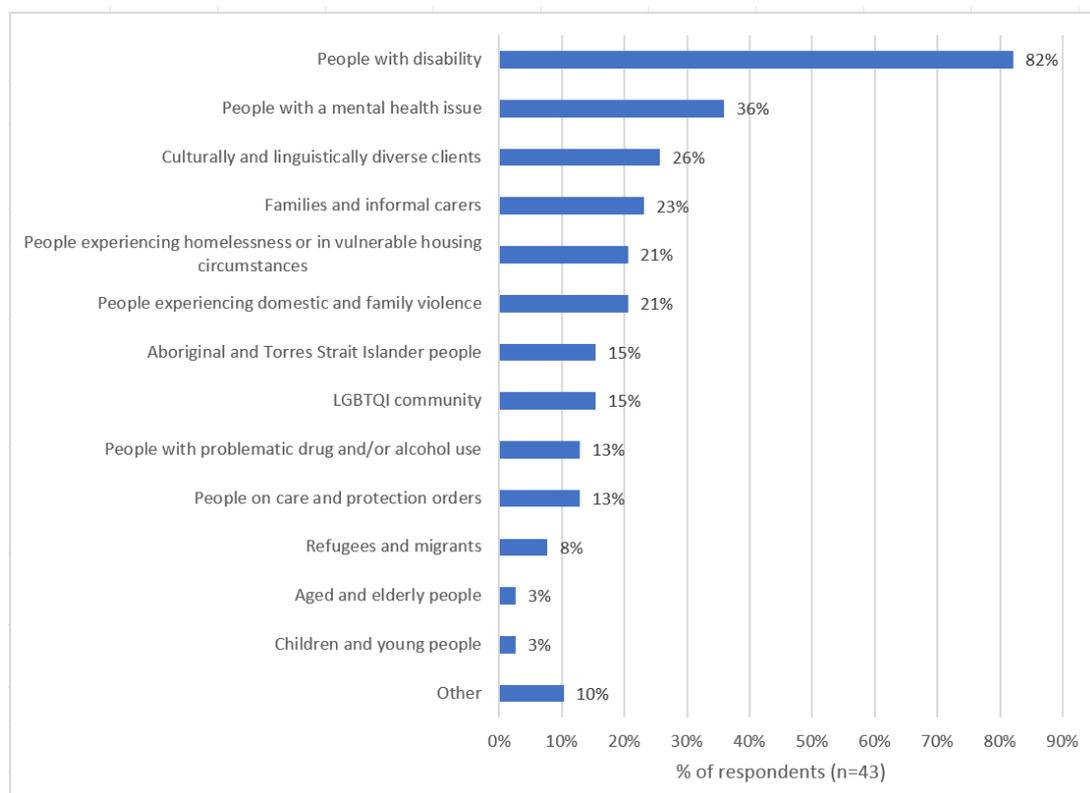
Note. Data collected via a multiple-choice, multiple-response question

Table 8. Number of active clients per organisation

| Organization size	Average client number
Micro (< 5 employees) (n = 9)	27
Small (5-19 employees) (n = 11)	290
Medium (20-199 employees) (n =14)	489
Large (200 or more employees) (n = 9)	710

Table 9. Caseload per frontline worker

Client number	% (n)
0-20	44% (11)
21-40	12% (3)
41-60	16% (4)
61 or more	28% (7)

Impact on business and clients

Of 43 organisations surveyed, 91% had been impacted by natural hazards and/or emergency events in the past ten years. The most reported hazard was pandemic (88%), followed by heatwaves (30%), and bushfires (23%) (Figure 15). On average, these hazards led to 3119 hours business downtime per organisation in financial year 2021/2022.

Figure 15. Types of emergencies impacted the organisations in the past ten years
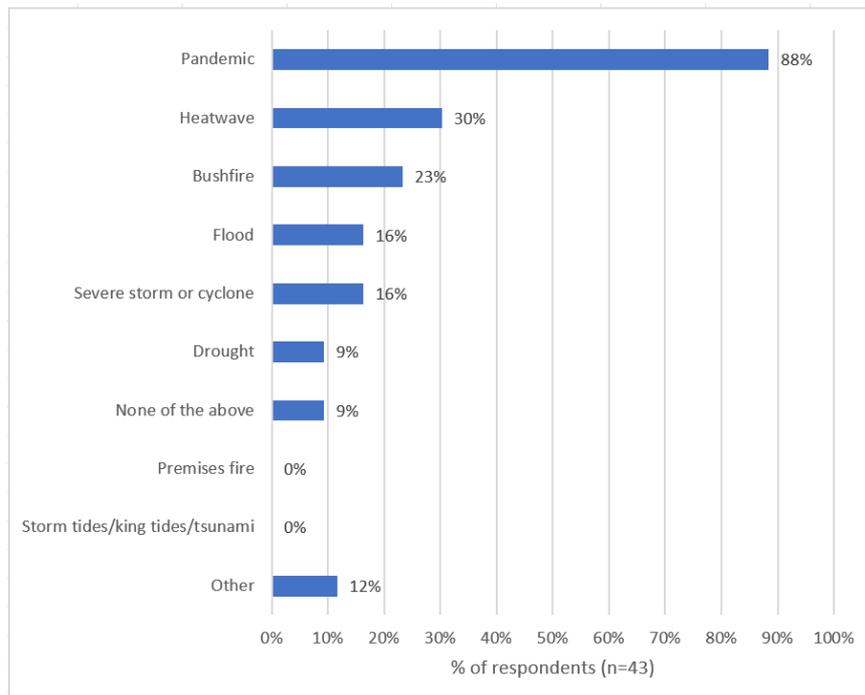
Note. Data collected via a multiple-choice, multiple-response question

When asked <u>how</u> the past emergency events impacted on businesses and clients, the following themes recurred throughout the responses.

- Services to clients were restricted or delayed.

  "Flood closed roads which prevented staff and clients from getting to the facility. Pandemic prevented us from offering Day Respite and increased screening requirements for anyone entering the premises, also limited ability to visit."

- Waiting lists, delays and cancellations were common affecting clients' access to services.

  "Allied Health Supports and pending long waiting lists in the Wimmera, Western Regional Victoria - Our clients are mostly being put on Occupational Therapy waiting lists that are anywhere between 6 - to 18 months long, way too long for some clients."

- Overall services were reduced, e.g. reduced client numbers. Particular service streams may have been cut.

  "There was not much work with the clients we already have and we couldn't get any new clients due to the restrictions."

  "Bushfire limited our support a(t) the time. Pandemic closed down our respite support. Limited our community integration. Unable to provide hours of employment to staff."

- This reduction in services had financial impacts on organisations. Additional financial burden may have also been incurred due to the emergency. Extra funding was rarely available to meet increased need.

  "The COVID-19 pandemic affected our business especially during lockdown. We lost 70% of our business as clients stay home. Mostly we provide community access, short term accommodation, support coordination, supported Independent Living."

  "Loss of Participants. Loss of income. Loss of staff. Near collapse of organisation"

  "None of the above increase in service has been funded in a meaningful way. We have had some access to funds to cover some of these roles, but none is appropriately built into our recurrent funding to enable us to plan effectively for future disaster respond."

- Emergencies and the resulting restriction on services impacted service users, affecting their physical and mental health.

  "For example, about (2) of our clients health conditions/disabilities changed and deteriorated rapidly, one ended up in Hospital and another ended up in Emergency Specialised Disability Accommodation, they needed OT Supports immediately and were put on emergency provider waiting lists instead - un-supported and frustrated…"

  "Clients - directly impacted by events where they live - trauma, AoD, grief and stress - both financial and emotional; health impacts esp of heatwave, services less accessible or suspended therefore risk of negative impact on health esp chronic illness, AoD, FV and mental health. Waitlists grow."

- In some cases, services needed to increase to assist service users to cope with the emergency. While some service streams may have decreased, others experienced a higher demand.

  "Increase in service delivery to include monitoring when experiencing heat waves or periods of heat health alerts"

  "With barely a day between the bushfires and the announcement of the COVID 19 pandemic, our organisation continued to advocate for fire affected locals, undertaking the role of case management in many instances where people were unable to understand the plethora of outside organisations that descended upon us."

  "Increased business to providing supports for self care"

- Staff members were sometimes impacted by the emergency, especially as they tried to continue with service provision. Restrictions in services impacted staff employment. The additional burden caused by emergency-related changes also impacted staff.

  "Impending heatwave means we have increased work in providing education to our community and staff, and responding to increased illness associated with heat. Older local infrastructure is also without efficient cooling, so staff are at risk when working in the

community. Finally, staff called to 000 call out's in heatwave conditions are at increased risk of illness and heat associated injury."

"Availability of workers, due to rostering staff who were also impacted by event/s impacted facilities and property owned by organisation."

- Many organisations reported staffing difficulties as they struggled to recruit and retain trained staff, or experienced staff shortages when staff members were impacted by the emergency.

"We also experienced issues in recruiting and maintaining an adequate staffing profile, attributed to mandates made the Commonwealth and State Governments whereby staff where unable to work at more than 1 location, unable to recruit recently trained staff due to their inability to complete their placement hours. Many of these students chose not to complete their studies and gained employment in other sectors."

- Organisations implemented strategies to manage emergencies, including reviewing and updating procedures, adapting the way they provided services, managing staff shortages.

"With COVID we took our lead from NDIS and continued to provide services in home where possible and cohorted staff around customers to minimize spreading of infection...all community access support was ceased."

" We face bushfire threat each summer, we have stored on site a list of staff available to work on Code Red days, we cease community access and provide minimum in home support as required."

- Telehealth and remote working enabled some services to continue when normal services were disrupted (mostly due to pandemic restrictions). But this was not always ideal or possible. Some services e.g. community access support were not able to be provided via telehealth. Remote working required additional resources and infrastructure, costing money and not always functional during an emergency. Additional administrative burden.

"The Pandemic has required our business to pivot continually from direct face to face services to online telehealth. this has increased the non face to face/ administrative burden immensely. and the stress involved with ensuring the safely of not only our clients but also of the staff. Considerable strain and effort to ensure compliance with the NDIS and other health directives was caused."

"Telehealth is not always appropriate for children, people with intellectual disability or high needs."

"Inability to complete full assessments requiring face to face activities (eg home assessment, equipment trials etc)"

"Staff unable to get to office or unable to work from home if required IT infrastructure damaged"

- Organisations reported supports that helped them manage during emergencies, including government funding for COVID leave etc. These supports helped organisations deal with emergencies, eased financial impacts and enabled continuity of supports.

    "Fortunately, we were supported by the State Government financially and minimally by the NDIS initially and so when staff were required to take leave due to suspected exposure or COVID -like symptoms we felt it was possible and this eased the financial stress."

    "This was all resolved within a day however as locals pitched in and cleaned up. All of the work was done before SES and council arrived."

Service Continuity Planning

The majority of responding organisations demonstrated a high level of organisational emergency preparedness that could minimise the likelihood of service disruption during an emergency. About half of the organisations strongly agreed that

- their organisation was fully insured (55%),
- their services were especially important because many of their clients were beyond the reach of other services in case of emergencies (52%), and
- they had a strong business continuity plan (45%)

Respondents also reported the challenges and facilitators in preparing and implementing a strong business continuity plan:

Challenges

- Lack of funding, time

    "Administrative time to prepare plans, funding models inadequate to support business preparedness, funded face to face/ non face to face contact time insufficient"

    "This is generally well beyond our capabilities and other than a pandemic has normally not been addressed."

- Lack of training, trained staff

    "Sector specific emergency management training for staff"

- Limited access to resources to enact the plan

    "Mobile reception, access to computers, tablets etc for some of our clients to enable telehealth to take place"

- Funder's requirements not proportionate to organisation size, service type and complexity

    "While we have a business continuity plan, the specialist psychological and behavioural assessments and supports we provide are not of an urgent nature... Our business continuity plan meets our client and service needs and it is bureaucratic nonsense to insist that at 2 - 3 person specialist operation needs a continuity plan consistent with, for example, supported accommodation providers and large scale support organisations."

Facilitators

- Guidance, advice about what to include, templates, training, resources

  "Guidance most of all as to what to include in the plan"

  "Sector specific staff training for frontline workers, supported by sector specific resources/templates"

  "I think it would be helpful to have additional resources and tools and perhaps a short online training course that I could roll out to managers / other staff."

- Time, staffing and funding

  "Availability of a skilled workforce to implement planning , administrative support and for a surge workforce to respond"

  "We already have a strong business continuity plan but it took a number of senior workers to develop aspects of it."

  "Funding models that support specific emergency management planning time for our clients including direct / face to face/ indirect/non face to face"

- In compliance with funder's requirement

  "Our service is required to complete annual seasonal preparedness and to maintain a business continuity plan as part of our department of families, fairness and housing funding. This is a priority for our service."

- A flexible workforce to enact the plan

  "We already have a system of providing alternative workers or contracting out work so direct support to clients can continue with minimal disruption. This has worked effectively during the COVID-19 pandemic."

Part C. Enabling Emergency Preparedness with High-Risk Client

This section of the survey sought to investigate respondents' intentions and capacities to facilitate emergency preparedness with high-risk clients through various activities. Table 10 lists the actions that the frontline workers and organisations surveyed had taken, could take in the future, or could not take. To briefly summarise, the most common activities that had been taken fully or partially were:

- **Identifying clients who are at risk in an emergency** e.g., chronic physical and mental health condition affecting mobility, geographical location, barriers to access mainstream sources of information about impending danger (technology, communication, and language barrier). (Organisations: 57% fully done, 37% partially done; frontline workers: 28% fully done, 64% partially done), and
- **Assessing clients to identify their personal strengths and support needs during emergencies to minimise ris**k e.g., communication, technology, transport, living situation, personal

supports, assistance animals, social connectedness, health (medical management) (Organisations: 29% fully done, 51% partially done; frontline workers: 12% fully done, 56% partially done).

On the other hand, the most frequently reported activity that both groups felt they could *not* implement was:

- **practicing emergency drills with clients to increase their familiarity, sense of preparedness and confidence in how to respond effectively in an emergency** e.g., evacuation, access to medication and ongoing care (36% of each group).

Table 10. Intentions and capacities to perform the following activities with high-risk clients (organisations: n = 43, frontline workers: n = 25)

	I/We do all of this already % (n)		I/We do some of this already % (n)		I/We could do this in the future % (n)		I/We could not do this % (n)	
	Organisations	Frontline workers	Organisations	Frontline workers	Organisations	Frontline workers	Organisations	Frontline workers
Identify clients and their families who are at risk in an emergency e.g., chronic physical and mental health conditions affecting mobility, geographical location, and barriers to access mainstream sources of information about impending danger (technology, communication, and language barrier)	59% (24)	28% (7)	37% (15)	64% (16)	2% (1)	4% (1)	2% (1)	4% (1)
Make referrals to community services that can help them to enhance their emergency preparedness e.g., local emergency service personnel and council	40% (17)	32% (8)	33% (14)	12% (3)	24% (10)	40% (10)	2% (1)	16% (4)
Assess clients to identify their level of emergency preparedness e.g., awareness of local hazard risks, access to emergency information and alerts, and understanding their role and responsibility in an emergency.	29% (12)	25% (6)	49% (20)	33% (8)	22% (9)	25% (6)	0% (0)	17% (4)
Assess clients to identify their personal strengths and support needs during emergencies to minimize risk e.g., communication, technology, transport, living situation, personal support, and health (medical management).	29% (12)	12% (3)	51% (21)	56% (14)	17% (7)	24% (6)	2% (1)	8% (2)
Provide emergency planning tools, information, or resources to clients e.g., information on local bushfire or flood risk, and community service resources such as the Australian Red Cross emergency preparedness plan.	19% (8)	16% (4)	38% (16)	36% (9)	36% (15)	40% (10)	7% (3)	8% (2)
Explore preparedness information, tools, and resources WITH clients to encourage them to take steps to prepare e.g., learn together with your client on local disaster risks, recognize gaps in knowledge (yours and theirs), and develop skills to stay informed during an emergency such as how to find information about bushfires and floods, etc.	10% (4)	8% (2)	34% (14)	36% (9)	49% (20)	36% (9)	7% (3)	20% (5)
Develop an emergency preparedness plan for, or with clients that is tailored to their support needs in emergencies e.g., household, or personal emergency checklist and kit, emergency supplies, supported accommodation, and communication strategy (including contact list).	21% (9)	16% (4)	43% (18)	32% (8)	33% (14)	36% (9)	2% (1)	16% (4)
Strengthen support networks of clients, e.g., neighbours, friends, local neighbourhood centres, buddy system that pairs people with trusted local community members who can assist them in an emergency.	21% (9)	20% (5)	50% (21)	36% (9)	19% (8)	28% (7)	10% (4)	16% (4)
Provide formal support or education to clients to increase their active participation in taking steps to prepare for emergencies e.g., helping them with programs such as the Person-Centred Emergency Preparedness (P-CEP) Workbook; using planning guides such as the Australian Red Cross 'REDIPLAN'.	13% (5)	12% (3)	33% (13)	44% (11)	46% (18)	32% (8)	8% (3)	12% (3)
Practice emergency drills with clients, to increase their familiarity, sense of preparedness, and confidence in how to respond effectively in an emergency e.g., evacuation, access to medication, and ongoing care.	14% (6)	12% (3)	17% (7)	32% (8)	33% (14)	20% (5)	36% (15)	36% (9)

The Venn diagram below (Figure 16) illustrates the key barriers to enabling emergency preparedness with high-risk clients, from the perspective of organisations and frontline workers. The key barriers that both groups experienced were insufficient funds (organisations: 72%, frontline workers: 56%) and clients' being unwilling to engage in emergency preparedness planning (organisations: 40%, frontline workers: 44%).
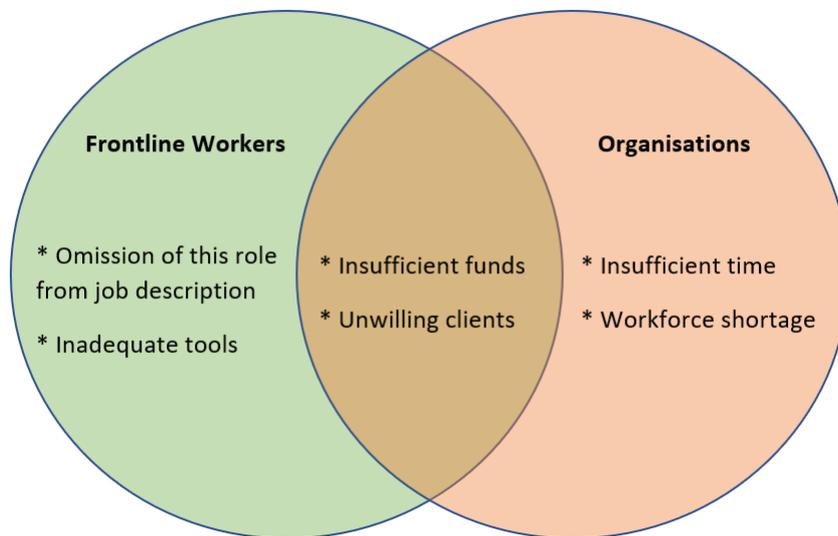

Figure 16. Key barriers to enabling emergency preparedness with risk-clients (organisations: n = 43, frontline workers: n = 25)

Limitations

There are two main limitations to this report. *Firstly,* since the studies employ convenience sampling, the survey samples may not represent the target populations of the studies. As a result, the findings presented in this report may not be applicable to a broader context across Victoria. *Secondly*, due to the relatively small sample sizes for each study, we were unable to conduct inferential statistical analyses, such as regression modelling. Therefore, the predictors for outcomes of interest, such as personal emergency preparedness and enabling emergency planning with high-risk clients, cannot be determined based on the survey data.

While the studies did not produce conclusive results, their findings can help build our understanding of the baseline emergency preparedness among Victorians with disability, carers, frontline workers, and those within the general population. These findings also indicate the capabilities and support needs of these groups before, during and after an emergency. In addition, the studies offer crucial insight into the barriers preventing service continuity among health and social care service providers, as well as what needs to be done to facilitate this continuity. Finally, study findings can be used to provide necessary clarification on the individual roles and capacities of these different groups in sharing the responsibility of disaster preparation and emergency management at the local community level.

Implications

In the survey studies of people with disability, carers, frontline workers, and those within the general population, "possessing an emergency plan" and "implementing household preparedness actions"

were used as proxies for personal emergency preparedness. Frontline workers demonstrated the highest level of self-reported preparedness among all study groups, as they reported the highest completion rate of emergency planning and household preparedness actions. This elevated level of preparation places frontline workers in a suitable position to enable emergency preparedness with the people they support. Their personal experience, knowledge of local disaster risks and community resources, and their attitude toward preparedness can be readily shared with clients and their families. What seems to be missing to make this possible is a tool to guide this knowledge sharing, and to establish this role more clearly in their job description.

To address the first missing facilitator, the award-winning P-CEP tool could easily be adapted to act as a guide for frontline workers to aid emergency preparedness with high-risk clients. Its incorporation into the COVID-19 planning guide for people with disability, endorsed by the Australian Department of Health and distributed nation-wide, attests to its applicability in real-world context. The University of Sydney Centre for Continuing Education now offers a [P-CEP Certificate Course](#) which can be taken up by service providers. This Course focuses on personal emergency preparedness so that providers have their own plan in place before facilitating preparedness in others. Two key features of this course are: (1) incorporation of an implementation planning module so that all learners come out with a plan for how they will implement P-CEP within their role and responsibilities; and (2) multi-stakeholder learning whereby service providers learn alongside government, emergency personnel, and people with disability to support a capability-focused approach to personal emergency preparedness. Co-design and evaluation is supporting the development as a nationally consistent approach to P-CEP education.

Regarding the second missing facilitator, greater accountability is needed to make sure employers in the disability sector update all job descriptions for frontline workers to reflect the requirements of the National Disability Insurance Scheme (NDIS) Quality and Safeguarding Commission Legislation Amendment (15 November 2021). This legislation states that all NDIS registered providers should work with their clients to undertake risk assessments and should include preparedness strategies in their individual support plans[19].

The legislation also establishes the need for service providers to engage in emergency management and disaster recovery planning to ensure continuity of supports and services. It was deeply concerning to learn that less than half (45%) of the organisations surveyed had a strong business continuity plan to support compliance with this requirement. This finding reflects the urgent need for the greater delivery of resources, tools, and training to aid the development and implementation of strong business continuity plans among these organisations. These resources, tools and training must be tailored and specialised to match the types of services or support offered by different health and social care organisations, as well as being proportionate to their size and complexity. In addition, they must facilitate collaborations between providers and emergency personnel to fulfill their shared responsibilities in emergency management and disaster recovery planning.

Identifying factors that could motivate, or alternately might discourage, preparedness behaviour among people with disability, carers, frontline workers and those within the general population is the first step to engaging in conversations about emergency preparedness with these groups. Our survey findings indicate that the most common reason for not making an emergency plan was, "I have just

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[19] National Disability Insurance Scheme Legislation Amendment (Quality Indicators) Guidelines (2021) https://www.legislation.gov.au/Details/F2021N00274

never thought about preparing for an emergency at all". To address this, government agencies could consider implementing an effective, state-wide campaign (similar to the public health campaigns) to improve awareness of the importance of personal emergency preparedness among all Victorians.

Another common reason for not making an emergency plan was the response, "I am not sure how to prepare for an emergency". This can be addressed by promoting and implementing the aforementioned P-CEP tool. Underpinning Sen's capability approach, guided by the DIDRR principles and co-designed with people with disability, the P-CEP tool enables people with disability and other high-risk groups to develop personal preparedness plans tailored to their specific situations and support needs. The P-CEP process can be broken down into smaller, actionable and achievable steps, which can motivate people who reported being too busy to prepare to take actions incrementally.

Our survey findings confirmed that respondents with disability reported lower rates of both material and mental preparedness compared to the other groups. It was alarming to discover that every one in five respondents with disability lacked confidence in their ability to manage mental stress at a time of uncertainty. Our survey findings also revealed that disasters and emergencies can detrimentally impact the mental health of all sectors of the population to a substantial extent. Among the general respondents who were impacted by COVID-19 pandemic, 36% reported that their mental health had worsened or that they had experienced new mental health issues, and nearly a quarter (23%) of those issues were either long term or ongoing. Just under a fifth (18%) of the general respondents reported that they increased drug and/or alcohol intake during the pandemic; while another 18% reported that they participated in more arguments, fights and violent activities. Without a doubt, building mental resilience is vital to improving health and wellbeing for all citizens. Improving this resilience could be achieved by creating a personal emergency preparedness plan, as well as practicing self-care and stress management techniques, strengthening social connectedness, and becoming more involved in community emergency preparedness initiatives.

Conclusions and Recommendations

This project set out to investigate the level of personal emergency preparedness among people with disability, carers, frontline workers and general Victorian, as well as their capability and support needs before, during and after an emergency. In addition, this project was to investigate the role, capacity and willingness of community-based service providers in enabling emergency preparedness with high-risk clients, as well as the tools and training needed to improve business resilience and ensure continuity of service provision.

This project has revealed that Victorian citizens and community-based service providers were deeply concerned about and impacted by emergency events and natural disasters such as pandemic, droughts, heatwaves, and bushfires. Preparedness is one of the most cost-effective strategies to reduce risk and increase resilience to disasters. Yet, the majority of the survey respondents were not adequately prepared due to various individual and environmental factors, such as unclear roles and responsibilities, lack of methods, tools and programmatic guidance to facilitate preparedness behaviours and coordinate preparedness efforts. These findings suggest five courses of actions:

1. Build nationally consistent standards for including disability representation into all emergency management arrangements (policies, practices and activities) at all levels of government.

2. Prioritise collaborative and inclusive disability research that will assist government and emergency personnel to understand and respond to the extra support needs of people with disability in emergencies.
3. Provide person-centred resources, support, and advocacy where needed for people with disability to self-assess their risks and tailor personal emergency preparedness to their support needs and situation.
4. Support capacity development for community and disability service providers and disability advocates in person-centred emergency preparedness and service continuity planning.
5. Provide explicit policy guidance on who takes responsibility for the extra support needs of people with disability in emergency situations including, how that support should be organised and delivered before, during and after disaster, and how the responsibilities of different stakeholders will be guided and outcomes measured.

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