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Our current knowledge base is insufficient to ascertain Victoria’s state-wide and regional capacity to respond to the mental health consequences of major natural disasters. While considerable advances were made in relation to recent disaster responses, existing knowledge gaps and workforce shortages still risk undermine the resilience and efficiency of the Victorian response system, thus delaying the delivery of vital mental health and support services and leading to reactive attempts at building community and service provider capacity.

In view of the recent Australian consensus on what constitutes best-practice disaster mental health support in the wake of natural disasters, such a situation could be greatly improved. In fact, what is needed to overcome reactive response patterns is detailed knowledge about the kinds of capacities that already exist in various professional and paraprofessional groups across Victoria. It is precisely a comprehensive examination of these capacities which the current survey project is seeking to deliver. Knowledge and a better understanding of Victoria’s mental health response capacity will in turn enable a more proactive approach to disaster mental health workforce planning and capacity building and thus enhance service provision in the event of future natural disasters.

As a joint initiative between the University of Melbourne (represented by the Centre for Health Policy, Programs and Economics, the Australian Health Workforce Institute and the Melbourne Sustainable Society Institute) and Strategic Data Ltd Pty, the Victorian Disaster Mental Health Workforce Capacity Survey was designed to examine the current state (i.e., the nature, scope, profile and capacity) of the disaster mental health workforce in Victoria. The 12 month study was conducted with wide ranging stakeholder support between the months of November 2011 and October 2012.
METHOD

The study aimed to examine the current state (i.e., the nature, scope, profile and capacity) of the Victorian disaster mental health workforce and to inform the following four research questions:

- **Research Question 1**: What is the profile of the Victorian disaster mental health workforce at state, regional and municipal levels (in terms of key professional groups, qualifications, work contexts and roles)?

- **Research Question 2**: What is the current capacity of this workforce to provide best-practice disaster mental health and support services in the event of future natural disasters (i.e., in terms of disaster mental health training and experience at the three levels outlined in the framework)?

- **Research Question 3**: What is the capacity of the workforce to participate in future disaster mental health responses (including via face to face, telemental health services, and ability to relocate)?

- **Research Question 4**: What are the existing key strengths and strategic development requirements for a resilient Victorian workforce in view of the best-practice framework?

Following a comprehensive initial workforce scoping exercise, an online survey module comprising 19 items was developed and disseminated to relevant workforce groups through existing networks of key stakeholders such as professional associations, Victorian departments and non-government organisations. Drawing on data from this purpose-designed online survey, the study examined a range of indicators of disaster mental health workforce capacity including: the current profile of the Victorian disaster mental health workforce; existing capacity to provide best-practice disaster mental health support and participate in future disaster responses; as well as workforce strengths and strategic development requirements.
KEY FINDINGS

PROFILE OF THE VICTORIAN DISASTER MENTAL HEALTH WORKFORCE

At Victorian state-level, the demographic respondent profile portrayed a comparatively mature aged, largely female, tertiary qualified and professionally organised workforce which mainly operated in direct service roles of relevance to disaster and across a variety of settings.

Key demographic characteristics of the workforce sample \( n=791 \) highlighted that a majority of respondents were female (72%) and the overall mean age was 52 years. Eighty-two percent of respondents were tertiary qualified, with 64% holding postgraduate qualifications. Ten percent of respondents were able to conduct their day to day work in languages other than English. The majority of respondents had professional backgrounds as: psychologists (25%), nurses (19%), counsellors (15%), social workers (14%), pastoral care workers (13%) or teachers (7%). Most eligible respondents were professionally registered and / or holding membership of professional associations. Most respondents had either one (72%) or two roles (24%) of relevance to disaster, with most roles involving direct service delivery (79%). Eighty-six percent of respondents were working in paid and 37% in volunteering capacities. Overall, respondents provided a total of 20,731 weekly working hours in roles of relevance to disaster. Service provision contexts primarily included: independent private practice (27%), not-for profit organisations (21%) and pastoral care services (17%) and a range of other settings. Respondents were most experienced in working with people with mental illness, children and or families, and youth and adolescents, and least experienced in working with displaced people and Aboriginal and Torres Strait Islanders.

The majority of respondents (63%) were operating from metropolitan regions, with about one-third (34%) evenly spread across regional locations. By comparison to their regional counterparts, metropolitan respondents were more likely to be: slightly younger; female; postgraduate-level qualified; psychologists; and less likely to be: pastoral care workers, or involved in volunteering. The scope of the survey data and associated need to maintain respondent anonymity did not permit municipal-level data analysis on this occasion.

CURRENT CAPACITY TO PROVIDE BEST-PRACTICE DISASTER MENTAL HEALTH SUPPORT

At Victorian state-level, key indicators of disaster mental health capacity highlighted a workforce with: a good understanding of disaster aspects; varying levels of experience, training and confidence; and a high level of interest in providing best-practice disaster mental health interventions.

More specifically, respondents indicated a good understanding of the disaster impact on affected individuals, communities and mental health, whereas local area and state emergency plans were less understood. The level of respondent experience in working with disaster survivors varied considerably, with 52% at least ‘quite’ experienced and 48% with either ‘little’ or ‘no’ experience. Current best-practice interventions in disaster mental health examined by this study included: Psychological First Aid (Level 1), Skills for Psychological Recovery (Level 2) and Intensive Mental Health Treatments following Trauma and Disaster (Level 3). Respondents were most likely to be trained in Level 1 (36%), followed by
Level 2 (26%) and Level 3 interventions (22%), but more likely to have provided either Level 1 (27%) or Level 3 (26%) than Level 2 (17%) interventions. Of those trained in Level 1, 2 or 3 interventions, 45%, 53% and 32%, respectively had not provided these interventions. While the majority of respondents indicated that they were ‘not at all’ confident to provide Level 1-3 interventions, confidence levels were considerably higher among those with prior training or provider experience. Overall, the percentage of respondents with at least a ‘moderate’ level of interest in providing Level 1-3 interventions by far exceeded the percentage of respondents trained in these interventions. Key patterns of disaster mental health capacity observed at Levels 1-3 were mirrored for additional disaster mental health interventions, with levels of training, experience, confidence and interest overall highest for interventions dealing with grief and loss.

The majority of respondents with training and experience providing Level 1-3 interventions were based in metropolitan regions. However, the largest proportion of respondents with at least a ‘considerable’ level of understanding of disasters aspects was generally found in regional Victoria.

CAPACITY TO PARTICIPATE IN FUTURE DISASTER MENTAL HEALTH RESPONSES

Overall, respondents had the greatest capacity to participate in disaster mental health responses via face-to-face service delivery and one-off visits to affected areas (with 75% and 63% indicating at least a ‘moderate’ level of capacity) and the least capacity for temporary relocation (30%). About one half of respondents had at least ‘moderate’ capacity to provide services via outreach to affected areas (51%) and telemental health (47%). The maximum reach of service delivery indicated a considerable level of geographical mobility. More than 70% of respondents had at least a ‘state-wide’ reach for telemental health and temporary relocation whereas 36% had the same reach for face-to-face service delivery.

Metropolitan regions generally had the largest number of respondents with at least a ‘high’ level of capacity to participate in disaster mental health responses across all modes of service provision and also the largest number and proportion of respondents with at least a ‘state-wide’ reach.

The key barriers to participation in disaster mental health responses raised by 41%-35% of respondents were: a lack of disaster mental health training, loss of income, limited scope within existing roles, lack of time and lack of experience delivering disaster mental health services. Most frequently mentioned key enablers of effective participation in disaster mental health responses were: Level 3, 2 and 1 type training, supervision and opportunities for involvement.
EXISTING WORKFORCE STRENGTHS AND STRATEGIC DEVELOPMENT REQUIREMENTS

Existing workforce strengths highlighted by the survey data included:

1. the multifaceted nature of the workforce comprising multiple professional and paraprofessional groups operating across a wide range of settings;
2. the overall good level of respondent understanding of aspects of relevance to disasters and high level of interest in providing disaster mental health interventions;
3. the fact that the overall numbers and spread of respondents across Victorian regions (as an indicator of regional disaster mental health capacity) were proportionate to broader Victorian population statistics;
4. the fact that metropolitan regions had a relatively higher level of disaster mental health capacity than regional Victorian locations in terms of the number of people trained in and providing interventions and also the maximum reach of service provision;
5. the finding that between one-fifth and one-third of survey respondents had been trained in current best-practice disaster mental health interventions at Levels 1-3;
6. the greater likelihood of people being trained at Level 1, than Level 2 or Level 3 being congruent with the relative expected demand for these interventions following disaster;
7. a high level of confidence to provide Level 1-3 interventions evident among workforce segments with previous training and or provider experience;
8. evidence of respondent training and provider experience in relation to a variety of additional interventions of relevance to disaster mental health; and
9. a considerable level of geographical provider mobility evident across various modes of service provision.

Strategic development requirements highlighted by the survey data included:

1. the great diversity of providers in the field which warrants a concerted approach to disaster mental health workforce planning;
2. a substantial lack of work experience in disaster contexts on the part of almost one half of survey respondents;
3. the fact that 45%, 53% and 32% of respondents respectively trained at Levels 1, 2 and 3 had not provided these interventions indicated benefits of targeting training resources more strategically;
4. the high level of interest in Level 1-3 interventions as well as key barriers and enablers of effective response participation indicating an existing demand for further disaster mental health training;
5. the evident demand for disaster mental health practice opportunities;
6. strategies to increase provider capacity to engage in telemental health based service provision which may warrant consideration;
7. some gaps in relation to the understanding of emergency plans and management frameworks which may deserve to be strengthened in the future;
8. the incorporation of structural mechanisms for workforce support into future disaster mental health workforce planning and capacity building.

The strategic development requirements highlighted above have implications for policy (1, 2, 8), practice (3, 4, 5, 7) and research (4, 6, 8).
CONCLUSIONS

The current report indicates that the Victorian disaster mental health workforce is multifaceted, comparatively mature aged, largely female, tertiary qualified, professionally organised and mainly operating in direct service delivery roles across varied settings. Study findings demonstrate that this workforce has an encouraging level of understanding of disaster aspects, a high level of interest but variable levels of training, experience, confidence and capacity to provide best-practice disaster mental health interventions. While Metropolitan regions had the greatest number of disaster mental health providers, key indicators of disaster mental health capacity varied between Victorian regions and across provider groups. Key findings of the study including existing workforce strengths and strategic development requirements give rise to a number of recommendations which can inform a more strategic approach to disaster mental health workforce planning and sustainable capacity building in the future.
CHAPTER 1: BACKGROUND

Recent history provides ample evidence of Victoria’s risk status and profile as a state prone to severe natural disasters, including major floods, storms and bushfires. These have affected a large number of Victorians.\textsuperscript{1,2}

The existing research literature demonstrates that natural disasters of this magnitude can significantly affect the mental health of impacted individuals and communities.\textsuperscript{3,4} The impact of exposure to disasters can be mild, moderate or severe, short-term, or enduring and also variable over time.\textsuperscript{5,6} The importance of disaster resilience, preparedness and the capacity to provide timely and quality mental health support at various levels of emerging need has increasingly become recognised as key to mitigating the adverse impacts of disasters on the mental health of affected populations.

While the response to the February 2009 Black Saturday bushfires represented a major advance in the provision of comprehensive and multilevel mental health support services to disaster affected Victorians, it simultaneously highlighted the need and an opportunity for a more concerted and strategic approach to disaster mental health workforce planning. To date, very little systematic data is available on the nature, scope and capacity of the multi-faceted workforce which provides mental health support services to disaster affected Victorians. This situation threatens to severely limit the ability of emergency management agencies to strategically plan and conduct efficient mental health responses to major natural disasters.

Recent Australian expert consensus on current best-practice in disaster mental health support has led to the development of a three-tiered disaster mental health response framework (Table 1) which has been employed in response to both the 2009 Victorian bushfires and the 2010-11 Queensland floods.\textsuperscript{7,8} Within this framework a broad notion of the mental health provider workforce is central which importantly includes both paraprofessionals and professionals. At Level 1, Psychological First Aid (or PFA) is recognised as the primary prevention approach of choice and delivered by disaster relief workers, volunteers, community leaders and general workers to community members experiencing some level of distress in the immediate disaster aftermath. At Level 2, allied and general health professionals offer secondary prevention type support in relation to mild-moderate ongoing mental health problems on the basis of the Skills for Psychological Recovery (or SPR) approach. Finally, at Level 3, specialist mental health practitioners and psychiatrists provide more intensive therapeutic interventions to individuals experiencing more severe and persistent posttraumatic distress. In their entirety, these three evidence-informed interventions represent current best-practice in disaster mental health care and comprise the whole spectrum from primary and secondary prevention to more intensive treatments. Service provision on the basis of this framework is ideally operationalised through a resource-efficient stepped care model which matches appropriate service responses over time to the nature and level of emerging mental health need.
Table 1: The three-tiered disaster mental health response framework

<table>
<thead>
<tr>
<th>PFA (Level 1)</th>
<th>SPR (Level 2)</th>
<th>Intensive MH Treatments (Level 3)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Purpose</strong></td>
<td><strong>Purpose</strong></td>
<td><strong>Purpose</strong></td>
</tr>
<tr>
<td>Population level support of common distress responses in the immediate aftermath</td>
<td>Support of individuals with mild to moderate sub-clinical levels of distress</td>
<td>Treatment of minority experiencing significant mental health conditions</td>
</tr>
<tr>
<td><strong>Core Principles:</strong></td>
<td><strong>Modules:</strong></td>
<td><strong>Evidence-based Interventions:</strong></td>
</tr>
<tr>
<td>1. Promote Safety</td>
<td>1. Gathering information and prioritising assistance</td>
<td>1. Exposure treatments</td>
</tr>
<tr>
<td>5. Promote Hope</td>
<td>5. Promoting helpful thinking</td>
<td>5. Treatment of complicated grief</td>
</tr>
<tr>
<td><strong>Providers</strong></td>
<td><strong>Providers</strong></td>
<td><strong>Providers</strong></td>
</tr>
<tr>
<td>Disaster relief workers, volunteers, community leaders, generic workers</td>
<td>Primary care providers incl.: GPs, allied health professionals, counsellors, welfare staff</td>
<td>Specialist MH care staff incl.: Psychologists, Psychiatrists</td>
</tr>
</tbody>
</table>

Adapted from: Bryant et al. (2009) and Australian Psychological Society (2010)

As a note of clarification, in accordance with the above framework the current study subsumes psychosocial support strategies and other interventions of relevance to disaster mental health under the broader heading of disaster mental health.

As part of the mental health response to the Victorian bushfires of 2009, dedicated training programs in regards to each of the three levels were implemented in order to support relevant practitioners involved in the disaster response.

In order to ensure that Victorians affected by future disasters have ready access to quality mental health support at the three levels of intensity outlined in the framework, it is crucial that the capacity of the Victorian disaster mental health workforce to provide these services be more systematically assessed, understood and developed. The Victorian Disaster Mental Health Workforce Capacity Survey aimed to lay the foundation for this work through compilation of a comprehensive state-wide and regional profile of this workforce in relation to its capacity to provide best-practice mental health support in the event of future natural disasters.

Systematic data on the nature, scope and capacity of this workforce and a better understanding of related workforce challenges are pivotal to strengthening Victoria’s disaster resilience and capacity for a more strategic approach to disaster mental health and response planning. A brief synopsis of the current study is provided in Table 2.
## Table 2: Project synopsis

<table>
<thead>
<tr>
<th><strong>Aim</strong></th>
<th>To examine the current state (i.e., the nature, scope, profile and capacity) of the disaster mental health workforce in Victoria</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Scope</strong></td>
<td>A Victorian state-level initiative addressing disaster mental health capacity in relation to the full range of natural disaster risks including in particular large scale natural disasters such as floods, bushfires, severe storms and earthquakes</td>
</tr>
</tbody>
</table>
| **Partner agencies** | Centre for Health Policy, Programs and Economics (CHPPE), The University of Melbourne  
Australian Health Workforce Institute (AHWI), The University of Melbourne  
Melbourne Sustainable Society Institute (MSSI), The University of Melbourne  
Strategic Data Ltd Pty (WebSurvey) |
| **Chief investigators** | Mr Lennart Reifels (CHPPE)  
Dr Lucio Naccarella (AHWI)  
Ass/Prof Grant Blashki (MSSI)  
Prof Jane Pirkis (CHPPE) |
| **Timeframe** | 12 months study conducted between November 2011 and October 2012 |
| **Funding** | The study was funded through the Natural Disaster Resilience Grant Scheme (NDRGS) of the Office of the Emergency Services Commissioner in Victoria and the Australian Government Attorney-General’s Department. |
| **Expert Reference Group** | The study was endorsed by thirteen key agencies of relevance to disaster mental health in Victoria (see acknowledgement section) and supported through an Expert Reference Group which provided invaluable advice and guidance on the project throughout all its stages. |
CHAPTER 2: METHOD

RESEARCH QUESTIONS

This study sought to examine the current state (i.e., the nature, scope, profile and capacity) of the Victorian disaster mental health workforce and to inform the following four research questions:

*Research Question 1:* What is the profile of the Victorian disaster mental health workforce at state, regional and municipal levels (in terms of key professional groups, qualifications, work contexts and roles)?

*Research Question 2:* What is the current capacity of this workforce to provide best-practice disaster mental health and support services in the event of future natural disasters (i.e., in terms of disaster mental health training and experience at the three levels outlined in the framework)?

*Research Question 3:* What is the capacity of the workforce to participate in future disaster mental health responses (including via face to face, telemental health services, and ability to relocate)?

*Research Question 4:* What are the existing key strengths and strategic development requirements for a resilient Victorian workforce in view of the best-practice framework?

DATA SOURCE

All research questions were addressed using data from a purpose-designed online survey which was administered between 1 March 2012 and 8 June 2012 and targeted at a sample of relevant Victorian disaster mental health provider groups (including both potential professional and volunteer providers). The online survey was constructed by the project team with input from the Expert Reference Group, and developed and hosted by WebSurvey (Strategic Data Ltd Pty). A copy of the survey template can be found in Appendix A. The survey which comprised 19 items gathered information regarding the following content areas:

- Workforce profile (including age, gender, professional background, membership and qualification)
- Participant role, location and context (including paid or volunteering capacity, key role activities, workplace location and setting)
- Current disaster mental health workforce capacity (including level of understanding, experience, training, interest, confidence, and capacity to provide disaster mental health services)
- Key barriers, enablers and future development requirements (including barriers to participation in disaster responses and key future training and support requirements)

Following survey completion, participants were given the opportunity to follow a link to a separate survey which allowed them to provide their contact details to nominated emergency management agencies and professional associations in order to be added to a list of Victorian disaster mental health providers and contacted by those agencies in the event of a future natural disaster. Since this external survey did not form part of the research itself it is only mentioned here for completeness.
RECRUITMENT

WORKFORCE SCOPING

During the initial project stage, the project team with input from an Expert Reference Group conducted a comprehensive workforce scoping exercise in order to identify relevant Victorian disaster mental health provider groups. This exercise built on the strong cross-professional approach that underpinned the psychosocial response to the Victorian Black Saturday bushfires and in particular the role and composition of the Victorian Bushfire Cross-Professional Working Group. Comprised of key government, non-government, professional and expert mental health agencies, the working group provided guidance on the psychosocial response to the bushfires. Beyond these existing agencies and associated provider groups, additional professional and volunteer groups were identified and targeted for participation in the survey. The resulting disaster mental health provider groups identified as part of the scoping exercise included:

(1) Psychologists;
(2) Social workers;
(3) Occupational therapists;
(4) Psychiatrists;
(5) General practitioners;
(6) Nurses;
(7) Midwives;
(8) Counsellors;
(9) Disaster case managers;
(10) Disaster response volunteers;
(11) Clerical and pastoral care workers;
(12) Disaster mental health training facilitators; and
(13) Wider health and community sector workers.

AGENCY BASED RECRUITMENT

The potential provider groups were primarily targeted through agency based recruitment involving dissemination of the study invitation through professional associations and other relevant agencies. An overview of the recruitment strategy can be found in Appendix B. Study invitations were circulated through existing agency networks including via email lists, newsletters, bulletins and in a few instances through additional web links on agency homepages. In order to target particularly hard-to-recruit general practitioners, recruitment through professional associations and local GP networks was complemented with an advertisement in a professional journal. Where ever possible, the initial study invitation was generally followed up with one survey reminder. The recruitment approach involved twelve separate survey links which enabled the tracing of agency-based responses rates. The survey generally aimed to target the entirety of Victorian provider groups or agency membership bases, with the exception of the recruitment of nurses which specifically focussed on selected specialty groups whose work role or context deemed them to be most likely to be involved in disaster responses. While the scope of recruitment was hitherto unprecedented, certain practical, resource and time constraints associated with the research put inevitable restrictions on the recruitment process.
DATA ANALYSES

Data analyses involved a combination of basic descriptive analyses (frequencies, percentages, cross-tabulations) of quantitative survey data using SPSS and limited thematic analysis of open text survey responses.
CHAPTER 3: RESULTS

Chapter 3 describes the results of the Victorian Disaster Mental Health Workforce Capacity Survey with particular reference to the respondents’ demographic profile; current levels of disaster mental health capacity; capacity to participate in future disaster mental health responses; and key training and support requirements. In addition to state-level results, findings of relevance to the disaster mental health capacity of Victoria’s geographical regions and specific provider groups are presented in Appendices D, E and F.

SAMPLE SIZE

The survey yielded a total of 806 responses. Following exclusion of 15 respondents who had submitted reasons for survey non-completion, the resulting sample size and denominator for analysis was n=791.

DEMOGRAPHIC PROFILE

The following section describes the overall demographic profile of survey respondents (n=791). Table 3 provides an overview of selected key respondent demographics.

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Demographics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean age (range, SD) years</td>
<td>51.7 (22-82, 11.7)</td>
</tr>
<tr>
<td>Gender</td>
<td>71.6% Female</td>
</tr>
<tr>
<td>Qualification</td>
<td>82% Undergraduate</td>
</tr>
<tr>
<td></td>
<td>64% Postgraduate</td>
</tr>
<tr>
<td>Languages other than English</td>
<td>10%</td>
</tr>
</tbody>
</table>

MEAN AGE

The respondent mean age was 51.7 (SD 11.7, range 22-82) years. This comparatively high mean age was largely attributable to the big proportion of volunteer respondents who with a mean age of 57.4 (SD 11.8) years were approximately seven to eight years older than respondents in paid employment.

GENDER

Female respondents made up the majority of respondents (566, 71.6%) while male respondents accounted for less than one-third (225, 28.4%) of participants. However, gender ratios such as the one observed here are not uncommon in the mental health field and among the ‘caring’ professions.
REGIONAL LOCATION

The majority of the respondents (500, 63.1%) were either working or volunteering in metropolitan Victoria, with about one-third (268, 33.9%) of respondents evenly spread across regional Victorian locations (Table 4). Of the remaining respondents, twenty indicated being based in Victoria without providing regional information, whereas three respondents were either based interstate or overseas. Overall, the regional representation of survey respondents appeared to be proportionally well aligned with broader population statistics for Victorian regions.

Table 4: Regional location of respondents (n=791)

<table>
<thead>
<tr>
<th>Location</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barwon South West</td>
<td>50</td>
<td>6.3</td>
</tr>
<tr>
<td>Gippsland</td>
<td>54</td>
<td>6.8</td>
</tr>
<tr>
<td>Grampians</td>
<td>43</td>
<td>5.4</td>
</tr>
<tr>
<td>Hume</td>
<td>61</td>
<td>7.7</td>
</tr>
<tr>
<td>Loddon Mallee</td>
<td>60</td>
<td>7.6</td>
</tr>
<tr>
<td>Eastern Metropolitan</td>
<td>126</td>
<td>15.9</td>
</tr>
<tr>
<td>North &amp; West Metropolitan</td>
<td>251</td>
<td>31.7</td>
</tr>
<tr>
<td>Southern Metropolitan</td>
<td>123</td>
<td>15.5</td>
</tr>
<tr>
<td>Vic other</td>
<td>20</td>
<td>2.5</td>
</tr>
<tr>
<td>ACT</td>
<td>1</td>
<td>0.1</td>
</tr>
<tr>
<td>Qld</td>
<td>1</td>
<td>0.1</td>
</tr>
<tr>
<td>Overseas</td>
<td>1</td>
<td>0.1</td>
</tr>
<tr>
<td>TOTAL</td>
<td>791</td>
<td>100.0</td>
</tr>
</tbody>
</table>

LANGUAGES

Seventy-nine (or 10.0%) of the 791 respondents indicated that they were able to conduct their day-to-day work in a language other than English. Among the additional languages spoken, Italian, Greek, German and Mandarin were the most common.
PROFESSIONAL BACKGROUND

Table 5 outlines the professional background of survey respondents (n=791). Twenty-five percent of respondents indicated having a professional background as psychologists, 18.5% as nurses, 14.5% as counsellors, 14.3% as social workers, 13.4% as pastoral care workers, and 6.7% as teachers, with a variety of other professional backgrounds mentioned less frequently. While the majority of respondents had only one professional background (669, 84.6%), a small proportion of respondents indicated having two (94, 11.9%), three (21, 2.7%), or four or more (7, 0.9%) professional backgrounds.

Table 5: Professional background of respondents (n=791)

<table>
<thead>
<tr>
<th>Professional Background</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychologist</td>
<td>200</td>
<td>25.3</td>
</tr>
<tr>
<td>Nurse</td>
<td>146</td>
<td>18.5</td>
</tr>
<tr>
<td>Counsellor</td>
<td>115</td>
<td>14.5</td>
</tr>
<tr>
<td>Social worker</td>
<td>113</td>
<td>14.3</td>
</tr>
<tr>
<td>Pastoral care worker</td>
<td>106</td>
<td>13.4</td>
</tr>
<tr>
<td>Teacher</td>
<td>53</td>
<td>6.7</td>
</tr>
<tr>
<td>Community worker</td>
<td>25</td>
<td>3.2</td>
</tr>
<tr>
<td>Midwife</td>
<td>19</td>
<td>2.4</td>
</tr>
<tr>
<td>Welfare worker</td>
<td>17</td>
<td>2.1</td>
</tr>
<tr>
<td>Business person a</td>
<td>16</td>
<td>2.0</td>
</tr>
<tr>
<td>Psychiatrist</td>
<td>12</td>
<td>1.5</td>
</tr>
<tr>
<td>Youth worker</td>
<td>10</td>
<td>1.3</td>
</tr>
<tr>
<td>Occupational therapist</td>
<td>7</td>
<td>0.9</td>
</tr>
<tr>
<td>Health worker b</td>
<td>6</td>
<td>0.8</td>
</tr>
<tr>
<td>GP</td>
<td>4</td>
<td>0.5</td>
</tr>
<tr>
<td>Lawyer</td>
<td>2</td>
<td>0.3</td>
</tr>
<tr>
<td>ATSI health worker</td>
<td>1</td>
<td>0.1</td>
</tr>
<tr>
<td>Other c</td>
<td>100</td>
<td>12.6</td>
</tr>
</tbody>
</table>

NB. Multiple responses permitted; a Included business owners, managers, entrepreneurs; b Included public and other health backgrounds; c Most frequently included: volunteers (10x), specialty therapists (10x), specialty nurses (9x), pastoral care workers (7x), students (6x) and engineers (5x)
FIELD OF HIGHEST QUALIFICATION

Table 6 outlines the fields in which survey respondents had acquired their highest qualification. Qualification fields were closely aligned with respondents’ professional backgrounds.

<table>
<thead>
<tr>
<th>Field of qualification</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychology</td>
<td>208</td>
<td>26.3</td>
</tr>
<tr>
<td>Nursing</td>
<td>97</td>
<td>12.3</td>
</tr>
<tr>
<td>Counselling</td>
<td>92</td>
<td>11.6</td>
</tr>
<tr>
<td>Social work</td>
<td>77</td>
<td>9.7</td>
</tr>
<tr>
<td>Pastoral Care</td>
<td>72</td>
<td>9.1</td>
</tr>
<tr>
<td>Education</td>
<td>51</td>
<td>6.4</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>25</td>
<td>3.2</td>
</tr>
<tr>
<td>Business</td>
<td>25</td>
<td>3.2</td>
</tr>
<tr>
<td>Community work</td>
<td>15</td>
<td>1.9</td>
</tr>
<tr>
<td>Medicine</td>
<td>12</td>
<td>1.5</td>
</tr>
<tr>
<td>Midwifery</td>
<td>10</td>
<td>1.3</td>
</tr>
<tr>
<td>Welfare work</td>
<td>8</td>
<td>1.0</td>
</tr>
<tr>
<td>Health work</td>
<td>7</td>
<td>0.9</td>
</tr>
<tr>
<td>Occupational therapy</td>
<td>6</td>
<td>0.8</td>
</tr>
<tr>
<td>Law</td>
<td>3</td>
<td>0.4</td>
</tr>
<tr>
<td>Youth</td>
<td>1</td>
<td>0.1</td>
</tr>
<tr>
<td>ATSI health work</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>Other *</td>
<td>82</td>
<td>10.4</td>
</tr>
<tr>
<td>TOTAL</td>
<td>791</td>
<td>100.0</td>
</tr>
</tbody>
</table>

* Most frequently included: specific therapy orientations (14x), counselling specialties (4x) and IT (4x)
HIGHEST QUALIFICATION TYPE

Table 7 outlines the highest type of qualification held by survey respondents. The overall picture emerging is that of a highly qualified workforce sample, with 82.2% of respondents having a qualification at undergraduate degree level or higher, and 64.1% of respondents having a qualification at postgraduate level. Sixteen percent of respondents had a qualification at Diploma or Certificate level and the remaining 2.3% were accounted for by other qualifications.

Table 7: Highest qualification type (n=791)

<table>
<thead>
<tr>
<th>Qualification Type</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>PhD (or equivalent)</td>
<td>61</td>
<td>7.7</td>
</tr>
<tr>
<td>Masters</td>
<td>218</td>
<td>27.6</td>
</tr>
<tr>
<td>Postgraduate Diploma</td>
<td>198</td>
<td>25.0</td>
</tr>
<tr>
<td>Postgraduate Certificate</td>
<td>30</td>
<td>3.8</td>
</tr>
<tr>
<td>Undergraduate Degree with Honours</td>
<td>33</td>
<td>4.2</td>
</tr>
<tr>
<td>Undergraduate Degree</td>
<td>110</td>
<td>13.9</td>
</tr>
<tr>
<td>Diploma</td>
<td>88</td>
<td>11.1</td>
</tr>
<tr>
<td>Certificate</td>
<td>35</td>
<td>4.4</td>
</tr>
<tr>
<td>Other</td>
<td>18</td>
<td>2.3</td>
</tr>
<tr>
<td>TOTAL</td>
<td>791</td>
<td>100.0</td>
</tr>
</tbody>
</table>

PROFESSIONAL MEMBERSHIP AND REGISTRATION

Table 8 outlines the professional registration status of respondent groups eligible for registration with the Australian Health Practitioner Regulation Agency (AHPRA) at the time of data collection. Registration levels were generally high among eligible professional groups, ranging from 73.3% for nurses and midwives to 100% for GPs and psychiatrists.

Table 8: Professional registration with AHPRA for eligible groups

<table>
<thead>
<tr>
<th>Professional Group</th>
<th>No. registered</th>
<th>No. with background</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>GPs</td>
<td>4</td>
<td>4</td>
<td>100.0</td>
</tr>
<tr>
<td>Psychologists</td>
<td>190</td>
<td>200</td>
<td>95.0</td>
</tr>
<tr>
<td>Nurses / Midwives</td>
<td>121</td>
<td>165</td>
<td>73.3</td>
</tr>
<tr>
<td>Psychiatrists</td>
<td>12</td>
<td>12</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Similarly, the overwhelming majority of respondents held membership of relevant professional associations, which is consistent with the agency-based recruitment approach which drew heavily upon professional associations.
ROLES OF RELEVANCE TO DISASTER

Survey respondents had the opportunity to provide information on up to three different work or volunteering roles of relevance to disaster. The majority of respondents provided information on only one role (566, 71.6%), while others provided information on two (186, 23.5%) and three (39, 4.9%) roles. Specific characteristics of these roles are outlined in the following.

Table 9 provides a breakdown of all disaster relevant roles in terms of paid work or volunteering status. The majority of the 791 respondents were working in a paid capacity either on a part-time (308, 38.9%), full-time (304, 38.4%) or casual (72, 9.1%) basis, whilst 296 (37.4%) respondents were involved in volunteering and 51 (6.4%) respondents were not presently working.

<table>
<thead>
<tr>
<th>Table 9: Paid work or volunteering role (n=791)</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paid (full-time)</td>
<td>304</td>
<td>38.4</td>
</tr>
<tr>
<td>Paid (part-time)</td>
<td>308</td>
<td>38.9</td>
</tr>
<tr>
<td>Paid (casual)</td>
<td>72</td>
<td>9.1</td>
</tr>
<tr>
<td>Volunteering</td>
<td>296</td>
<td>37.4</td>
</tr>
<tr>
<td>Not presently working</td>
<td>51</td>
<td>6.4</td>
</tr>
<tr>
<td>Not applicable</td>
<td>24</td>
<td>3.0</td>
</tr>
</tbody>
</table>

NB. Multiple responses permitted

Table 10 describes the key activities involved in roles of relevance to disaster in terms of the total weekly working hours spent on each of these activities. Participants were asked to select for each applicable role the one key activity which best described the nature of the work involved. The vast majority of roles involved direct service delivery to community members, clients or patients (78.6%) amounting to a total of 16,293 weekly working hours among the entire respondent group. Management (5.5%), program coordination (4.5%) and consulting (4.4%) were the next highest ranking activities accounting for 1,138, 928, and 915 weekly working hours respectively. Overall, the 791 survey respondents provided a total of 20,731 weekly working hours in activities and roles of relevance to disasters.

<table>
<thead>
<tr>
<th>Table 10: Key role activities and associated weekly working hours</th>
<th>Weekly working hours</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Direct service delivery</td>
<td>16,293</td>
<td>78.6</td>
</tr>
<tr>
<td>Management</td>
<td>1,138</td>
<td>5.5</td>
</tr>
<tr>
<td>Program coordination</td>
<td>928</td>
<td>4.5</td>
</tr>
<tr>
<td>Consulting</td>
<td>915</td>
<td>4.4</td>
</tr>
<tr>
<td>Other</td>
<td>573</td>
<td>2.8</td>
</tr>
<tr>
<td>Teaching</td>
<td>403</td>
<td>1.9</td>
</tr>
<tr>
<td>Research</td>
<td>328</td>
<td>1.6</td>
</tr>
<tr>
<td>Administration</td>
<td>153</td>
<td>0.7</td>
</tr>
<tr>
<td>TOTAL</td>
<td>20,731</td>
<td>100</td>
</tr>
</tbody>
</table>

NB. Multiple responses permitted
Table 11 outlines the work or volunteering contexts (settings) in which respondents were primarily operating in their roles of relevance to disaster. For each applicable role respondents were asked to nominate the one work context which best reflected their setting of operation. Respondents (n=791) were operating most frequently in independent private practice (212, 26.8%), not for profit organisations (166, 21.0%) and pastoral care services (133, 16.8%) and less frequently across a wide range of other contexts.

**Table 11: Work or volunteering contexts (n=791)**

<table>
<thead>
<tr>
<th>Context</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Independent private practice</td>
<td>212</td>
<td>26.8</td>
</tr>
<tr>
<td>Not for profit / Non-government organisation</td>
<td>166</td>
<td>21.0</td>
</tr>
<tr>
<td>Pastoral care service</td>
<td>133</td>
<td>16.8</td>
</tr>
<tr>
<td>Hospital – psychiatric</td>
<td>53</td>
<td>6.7</td>
</tr>
<tr>
<td>Area-based clinical mental health service</td>
<td>52</td>
<td>6.6</td>
</tr>
<tr>
<td>Hospital – general health</td>
<td>42</td>
<td>5.3</td>
</tr>
<tr>
<td>Schools</td>
<td>36</td>
<td>4.6</td>
</tr>
<tr>
<td>Primary care / GP clinic</td>
<td>35</td>
<td>4.4</td>
</tr>
<tr>
<td>State government department</td>
<td>30</td>
<td>3.8</td>
</tr>
<tr>
<td>Area-based health service</td>
<td>27</td>
<td>3.4</td>
</tr>
<tr>
<td>Tertiary education</td>
<td>24</td>
<td>3.0</td>
</tr>
<tr>
<td>Private company / business</td>
<td>23</td>
<td>2.9</td>
</tr>
<tr>
<td>Division of general practice / Medicare local</td>
<td>18</td>
<td>2.3</td>
</tr>
<tr>
<td>Disability service</td>
<td>14</td>
<td>1.8</td>
</tr>
<tr>
<td>Statewide and specialist mental health service</td>
<td>13</td>
<td>1.6</td>
</tr>
<tr>
<td>Justice / Corrective services</td>
<td>12</td>
<td>1.5</td>
</tr>
<tr>
<td>Local government department</td>
<td>11</td>
<td>1.4</td>
</tr>
<tr>
<td>Drug / alcohol treatment service</td>
<td>10</td>
<td>1.3</td>
</tr>
<tr>
<td>Psychiatric disability rehabilitation and support service</td>
<td>6</td>
<td>0.8</td>
</tr>
<tr>
<td>Housing service</td>
<td>3</td>
<td>0.4</td>
</tr>
<tr>
<td>Other a</td>
<td>84</td>
<td>10.6</td>
</tr>
</tbody>
</table>

NB. Multiple responses permitted; * Most frequently including: Federal Government agencies such as Centrelink, DVA, DHS or Disability services (9x), Country Fire Authorities (4x) and Defence agencies (4x).
EXPERIENCE WORKING WITH POPULATION GROUPS

Figure 1 shows the level of specialist expertise in working with population groups of particular relevance to disasters. Respondents (n=791) appeared to be most experienced in working with people with mental illness, children or families, and youth and adolescents (with 73.5%, 71.3% and 69.5% of respondents respectively indicating being at least ‘quite’ experienced). Respondents appeared to be least experienced in working with displaced people and Aboriginal and Torres Strait Islanders (with only 35% and 28.4% of respondents respectively indicating equivalent experience levels).

DEMOGRAPHIC RESPONDENT PROFILE BY REGION AND ORGANISATION

Tables D1 and D2 in Appendix D provide breakdowns of the demographic respondent profile by Victorian regions and in terms of affiliation with recruiting organisations. The demographic profile of respondents appeared to vary slightly between Victorian regions. By comparison to their regional counterparts, metropolitan respondents were on average more likely to be: slightly younger; female; postgraduate-level qualified; psychologists; as well as less likely to be: pastoral care workers, or involved in volunteering. The scope of the survey data and related need to maintain respondent anonymity did not permit municipal-level data analysis on this occasion.
CURRENT DISASTER MENTAL HEALTH CAPACITY

Several indicators of respondents’ disaster mental health capacity were examined, including existing levels of: experience in working with disaster survivors, understanding of disaster aspects, as well as training, experience, confidence and interest in providing disaster mental health interventions.

EXPERIENCE WORKING WITH DISASTER SURVIVORS

Figure 2 shows the level of respondent experience in working with disaster survivors. Respondents (n=791) were roughly split in half, that is, into one group of respondents (413, 52.2%) who were at least ‘quite’ experienced and another group (378, 47.8%) with either ‘little’ or ‘no experience’ in working with disaster survivors.

Figure 2: Level of experience working with disaster survivors (n=791)
UNDERSTANDING OF DISASTER ASPECTS

Figure 3 displays the level of understanding of a range of aspects of relevance to disasters. Overall, respondents (n=791) appeared to have the greatest understanding of the impact of disasters on affected individuals, disaster mental health consequences, and the impact on affected communities (with 88.9%, 87.7% and 83.7% respectively indicating at least a ‘reasonable’ understanding). Respondents appeared to have the least understanding of local area and regional and state emergency plans (with only 39.6% and 33.6% respectively indicating at least a ‘reasonable’ level of understanding).

Figure 3: Level of understanding of disaster aspects (n=791)
DISASTER MENTAL HEALTH TRAINING, EXPERIENCE, CONFIDENCE AND INTEREST (LEVELS 1-3)

Figure 4 shows the percentage of respondents (n=791) with training, experience, confidence and interest in providing Level 1-3 disaster mental health interventions. Training and experience levels varied between interventions. Respondents were most likely to have been trained in Level 1 (281, 35.5%), followed by Level 2 (209, 26.4%) and Level 3 (171, 21.6%) interventions, but more likely to have provided either Level 1 (211, 26.7%) or Level 3 (206, 26.0%) than Level 2 (134, 16.9%) interventions.

Overall, the percentages of respondents with at least a ‘moderate’ level of confidence to provide interventions were fairly well aligned with and only marginally higher than the respective percentages of respondents trained in these interventions. By contrast, the percentages of respondents with at least a ‘moderate’ level of interest in providing interventions by far exceeded the percentages of respondents either trained in or providing interventions, in some instances by a factor of two or more.

Overall, more than half of the respondents (56.5%, 65.1% and 67.1%) indicated being ‘not at all confident’ to provide Level 1, 2 and 3 interventions. Closer examination of the links between training, experience and confidence revealed that 44.5%, 53.1% and 31.6% of respondents trained at Levels 1, 2 and 3 had never provided these interventions. However, of those trained in Level 1, 2 and 3 interventions the vast majority (91.1%, 90.0% and 87.7%) indicated having at least a ‘moderate’ level of confidence to provide these interventions, contrasting with 10.5%, 8.8% and 12.5% of those who had not been trained. Similarly, the majority of respondents with prior experience providing Level 1, 2 and 3 interventions (79.0%, 79.7% and 74.6%) indicated at least a ‘moderate’ level of confidence to provide these interventions, contrasting with 24.8%, 20.4% and 12.9% of those without prior provider experience.
For respondents with experience providing Level 1, 2 or 3 interventions for whom this data was available (n=190, n=117, n=185), Figure 5 shows the number of people that these interventions had been provided to. Within this group, the level of experience varied considerably between a majority who had provided interventions to 20 or less people and a more experienced provider group who had delivered interventions to more than 100 people. Excluded from this figure is the large group of respondents who indicated having provided interventions to zero people, which respectively accounted for 601 (76.0%), 673 (85.1%) and 602 (76.1%) of respondents.

Figure 5: Number of people Level 1, 2 and 3 interventions provided to (for respondents with experience providing interventions and available data; n=190, n=117, n=185)
DISASTER MENTAL HEALTH TRAINING, EXPERIENCE, CONFIDENCE AND INTEREST (ADDITIONAL INTERVENTIONS)

In addition to intervention Levels 1-3 outlined in the disaster response framework, respondents were asked about other common interventions of relevance to disaster mental health. These additional interventions included specific therapeutic techniques (such as trauma-focussed cognitive behaviour therapy, exposure treatment, eye movement desensitisation and reprocessing [or EMDR] and pharmacotherapy), support strategies provided by non-government disaster response volunteers (such as personal and outreach support), as well as community recovery and capacity building initiatives, emergency preparedness and management.

Figure 6 shows the percentage of respondents (n=791) with training, experience, confidence and interest in providing additional disaster mental health interventions. Training and experience levels varied considerably between interventions. Overall, respondents were most likely to have been trained in interventions dealing with grief and loss (404, 51.1%) and personal support in emergencies (299, 37.8%), whereas training levels were lowest for EMDR (71, 9.0%) and pharmacotherapy (64, 8.1%). Similarly, respondents were most likely to have provided interventions dealing with grief and loss (446, 56.4%) and personal support in emergencies (288, 36.4%) and least likely to have provided EMDR (50, 6.3%) and pharmacotherapy (45, 5.7%).
As with Level 1-3 interventions, there appeared to be fairly good alignment between the percentages of respondents with at least a ‘moderate’ level of confidence in providing interventions and those with either training or experience. The percentages of respondents with at least a ‘moderate’ level of interest in providing interventions again by far exceeded those with training or experience.

Figures 7 and 8 provide summary overviews of the respondent confidence and interest levels for all interventions. Across all interventions, the biggest segment of respondents was ‘not at all confident’ to provide interventions (ranging from 37.9% for dealing with grief and loss to 92.5% for EMDR). The level of respondent interest in providing interventions was overall greatest in relation to dealing with grief and loss, Level 1 Psychological First Aid and Level 2 Skills for Psychological Recovery (with 75.1%, 69.9% and 65.6% respectively indicating at least a ‘moderate’ level of interest) and lowest for EMDR and pharmacotherapy (with only 18.8% and 17.8% respectively indicating the same interest level).

**Figure 7: Levels of confidence to provide interventions (n=791)**
Patterns in the level of provider experience, as defined by the number of people that additional interventions had been provided to, generally mirrored those reported at Levels 1-3. By far the largest segment of respondents indicated having provided interventions to zero people (ranging from 50.7% for interventions dealing with grief and loss to 95.4% for pharmacotherapy). Among the group with experience of providing interventions, experience levels varied considerably between a majority who had provided interventions to 20 or less people and a more experienced group who had delivered interventions to more than 100 people.
CAPACITY TO PARTICIPATE IN DISASTER MENTAL HEALTH RESPONSES

An important and often overlooked dimension of disaster mental health capacity (beyond existing levels of respondent understanding, training and experience, etc.) is the capacity of providers to become involved in disaster mental health responses. Therefore current levels of respondent capacity to participate in disaster mental health responses were examined in relation to different modes of service delivery (displayed in Figure 9).

Figure 9: Capacity to participate in disaster mental health responses via different modes of service delivery (n=791)

Overall, respondents (n=791) had the greatest capacity to participate in disaster responses via face-to-face service delivery and one-off visits to affected areas (with 590, 74.6% and 496, 62.7% of respondents respectively indicating at least a ‘moderate’ level of capacity). Capacity levels were lowest in regards to the ability to relocate temporarily (240, 30.3%). About one half of respondents indicated at least a ‘moderate’ level of capacity to deliver services via outreach to affected areas (403, 50.9%) and telemental health (375, 47.4%).
MAXIMUM REACH OF SERVICE DELIVERY

As an indicator of geographical mobility, Figure 10 shows the maximum reach of service delivery relative to respondents’ primary work location, ranging from the respective local government area (or LGA) to interstate service provision.

Figure 10: Maximum reach for different modes of service delivery

Overall, the vast majority of respondents indicated having capacity to provide services beyond the confines of the local government area of their primary work location. The maximum reach of service delivery was greatest for telemental health and the ability to relocate temporarily (with 376, 70.5% and 320, 72.4% of respondents for whom this data was available indicating at least a ‘state-wide’ maximum reach). The number of respondents with at least a ‘state-wide’ reach was lowest for face-to-face service delivery (254, 35.9%) and outreach to affected areas (262, 45.5%), with related figures for one-off visits to affected areas (384, 60.1%) in the midrange.
A variety of factors (including personal, professional, logistic and situational) can determine the level and extent to which existing or potential disaster mental health workforce capacity may be become mobilised in the disaster context. Therefore both existing barriers to and enablers of effective provider participation in future disaster mental health responses were examined.

**BARRIERS TO EFFECTIVE PARTICIPATION**

Table 12 outlines key barriers to effective provider participation in future disaster mental health responses, selected by respondents (n=791) from a list of potential barriers.

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of dedicated disaster mental health training</td>
<td>320</td>
<td>40.5</td>
</tr>
<tr>
<td>Loss of income</td>
<td>319</td>
<td>40.3</td>
</tr>
<tr>
<td>Limited scope or flexibility within existing role</td>
<td>293</td>
<td>37.0</td>
</tr>
<tr>
<td>Lack of time</td>
<td>287</td>
<td>36.3</td>
</tr>
<tr>
<td>Lack of experience delivering disaster mental health services</td>
<td>274</td>
<td>34.6</td>
</tr>
<tr>
<td>Lack of familiarity with disaster mental health interventions</td>
<td>232</td>
<td>29.3</td>
</tr>
<tr>
<td>Geographical barriers / distance</td>
<td>187</td>
<td>23.6</td>
</tr>
<tr>
<td>Lack of back-fill</td>
<td>161</td>
<td>20.4</td>
</tr>
<tr>
<td>Lack of logistic support / resources</td>
<td>160</td>
<td>20.2</td>
</tr>
<tr>
<td>Lack of leave</td>
<td>142</td>
<td>18.0</td>
</tr>
<tr>
<td>Lack of opportunity</td>
<td>129</td>
<td>16.3</td>
</tr>
<tr>
<td>Lack of employer support</td>
<td>116</td>
<td>14.7</td>
</tr>
<tr>
<td>Lack of confidence to work in a disaster context</td>
<td>109</td>
<td>13.8</td>
</tr>
<tr>
<td>Lack of interest</td>
<td>11</td>
<td>1.4</td>
</tr>
<tr>
<td>Other a</td>
<td>80</td>
<td>10.1</td>
</tr>
<tr>
<td>Not applicable</td>
<td>44</td>
<td>5.6</td>
</tr>
</tbody>
</table>

NB. Multiple responses permitted; * Most frequently including: family commitments (26x), health issues (11x), work commitments (10x), lack of linkage or invitation (9x), old age (8x) and financial barriers (5x).

Among the top ranked barriers to participation in future disaster mental health responses were: a lack of dedicated disaster mental health training, loss of income, limited scope or flexibility within existing role, lack of time and lack of experience delivering disaster mental health services. Other notable barriers included: a lack of familiarity with disaster mental health interventions, geographical barriers / distance, lack of back-fill, lack of logistic support / resources, lack of leave and lack of opportunity. Interestingly, a lack of interest on the part of respondents was among the least mentioned barriers.
ENABLERS OF EFFECTIVE PARTICIPATION

In addition to barriers, respondents (n=791) were asked about a variety of potential enablers (such as training and support measures) that would enhance their capacity to effectively participate in future disaster mental health responses. Following selection of relevant enablers from a list of items, respondents indicated on a five-point scale how much of a priority each of these were (ranging from 'not a priority' to a 'very high priority'). Table 13 summarises the data on the key enablers (including the training and support requirements) that were rated to be at least a 'moderate' or higher level priority.

Table 13: Key enablers of effective participation in future disaster mental health responses (n=791)

<table>
<thead>
<tr>
<th>Enabler</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>At least moderate priority</td>
<td>At least moderate priority</td>
</tr>
<tr>
<td>Level 3 type training</td>
<td>448</td>
<td>56.6</td>
</tr>
<tr>
<td>Level 2 type training</td>
<td>421</td>
<td>53.2</td>
</tr>
<tr>
<td>Supervision</td>
<td>411</td>
<td>52.0</td>
</tr>
<tr>
<td>Level 1 type training</td>
<td>405</td>
<td>51.2</td>
</tr>
<tr>
<td>Opportunities for involvement</td>
<td>372</td>
<td>47.0</td>
</tr>
<tr>
<td>Peer support</td>
<td>329</td>
<td>41.6</td>
</tr>
<tr>
<td>Employer support</td>
<td>321</td>
<td>40.6</td>
</tr>
<tr>
<td>Logistic support / resources</td>
<td>311</td>
<td>39.3</td>
</tr>
<tr>
<td>Paid leave</td>
<td>305</td>
<td>38.6</td>
</tr>
<tr>
<td>Back-fill</td>
<td>177</td>
<td>22.4</td>
</tr>
<tr>
<td>Unpaid leave</td>
<td>115</td>
<td>14.5</td>
</tr>
<tr>
<td>Other training a</td>
<td>29</td>
<td>3.7</td>
</tr>
<tr>
<td>Other b</td>
<td>22</td>
<td>2.8</td>
</tr>
</tbody>
</table>

NB. Multiple responses permitted; a Most frequently including: refresher training (4x); b Most frequently including: finances (4x) and training (4x).

Among the key enablers of effective participation in future disaster mental health responses were: Level 3, 2, 1 type training and supervision (with more than half of respondents rating each of these at least a 'moderate' priority) and opportunities for involvement. Other notable enablers included: peer support, employer support, logistic support / resources, paid leave and back-fill.
REGIONAL DISASTER MENTAL HEALTH CAPACITY

In order to provide an indication of the level of existing disaster mental health capacity throughout Victoria’s eight geographical regions (Figure 11) region-level analyses were conducted. Region-level analyses particularly focussed on levels of respondent: experience in working with disaster survivors, understanding of disaster aspects, as well as training, confidence, interest and capacity to provide disaster mental health interventions. Figures E1-24 in Appendix E provide overviews of regional-level findings for consideration. However, due to lower response numbers, region-level findings should be interpreted with considerable caution. The scope of the existing survey data and related need to maintain respondent anonymity did not permit municipal-level data analysis on this occasion.

Figure 11: Victoria’s eight geographical regions

Source: Department of Human Services

DISASTER MENTAL HEALTH CAPACITY OF SPECIFIC PROVIDER GROUPS

In order to provide an indication of the existing disaster mental health capacity of specific Victorian provider groups, organisation-level analyses of the survey data were conducted with particular attention to levels of respondent: experience in working with disaster survivors, understanding of disaster aspects, as well as training, confidence, interest and capacity to provide disaster mental health interventions. An overview of organisation-level findings is presented in Figures F1-24 in Appendix F. Due to highly variable response rates, organisation-level findings will need to be interpreted with considerable caution.
SUMMARY OF FINDINGS AND DISCUSSION

The Victorian Disaster Mental Health Workforce Capacity Survey sought to examine the current state (i.e., the nature, scope, profile and capacity) of the disaster mental health workforce in Victoria and to inform the following four research questions. Key findings in relation to each research question are summarised and then discussed below.

*Research Question 1:* What is the profile of the Victorian disaster mental health workforce at state, regional, and municipal levels (in terms of key professional groups, qualifications, work contexts and roles)?

*Research Question 2:* What is the current capacity of this workforce to provide best-practice disaster mental health and support services in the event of future natural disasters (i.e., in terms of disaster mental health training and experience at the three levels outlined in the framework)?

*Research Question 3:* What is the capacity of the workforce to participate in future disaster mental health responses (including via face to face, telemental health services, and ability to relocate)?

*Research Question 4:* What are the existing key strengths and strategic development requirements for a resilient Victorian workforce in view of the best-practice framework?

**WHAT IS THE PROFILE OF THE VICTORIAN DISASTER MENTAL HEALTH WORKFORCE?**

At Victorian state-level, the demographic respondent profile portrayed a comparatively mature aged, largely female, tertiary qualified and professionally organised workforce which mainly operated in direct service roles of relevance to disaster and across a variety of settings.

Key demographic characteristics of the workforce sample (n=791) highlighted that a majority of respondents were female (72%) and that the overall mean age was 52 years. Eighty-two percent of respondents were tertiary qualified, with 64% holding postgraduate qualifications. Ten percent of respondents were able to conduct their day to day work in a language other than English. The majority of respondents had professional backgrounds either as: psychologists (25%), nurses (19%), counsellors (15%), social workers (14%), pastoral care workers (13%) or teachers (7%), with a variety of other backgrounds mentioned. The vast majority of eligible respondent groups were professionally registered with the Australian Health Practitioner Regulation Agency and or currently holding membership of relevant professional associations. Most respondents had either one (72%) or two roles (24%) of relevance to disaster, with most roles involving direct service delivery (79%), management (6%) or program coordination (5%). Eighty-six percent of respondents were working in paid and 37% in volunteering capacities. Overall, respondents provided a total of 20,731 weekly working hours in roles of relevance to disaster. Service provision contexts predominantly included: independent private practice (27%), not-for profit organisations (21%), pastoral care services (17%) and various other settings. Respondents were most experienced in working with people with mental illness, children and
or families, and youth and adolescents, and least experienced in working with displaced people and Aboriginal and Torres Strait Islanders.

The number and demographic profile of respondents varied slightly between Victorian regions. The majority of respondents (63%) were operating from metropolitan regions, with about one-third (34%) evenly spread across regional locations. By comparison to their regional counterparts, metropolitan respondents were on average more likely to be: slightly younger; female; postgraduate-level qualified; psychologists; and less likely to be: pastoral care workers, or involved in volunteering. The scope of the survey data and associated need to maintain respondent anonymity did not permit municipal-level data analysis on this occasion.

WHAT IS THE CURRENT CAPACITY OF THIS WORKFORCE TO PROVIDE BEST-PRACTICE DISASTER MENTAL HEALTH SUPPORT?

At Victorian state-level, key indicators of disaster mental health capacity highlighted a workforce with: a good understanding of disaster aspects; varying levels of experience, training and confidence; and a high level of interest in providing best-practice disaster mental health interventions in the event of future natural disasters.

Respondents indicated a good level of understanding of disaster aspects, which was particularly evident in relation to the impact of disasters on affected individuals and communities and disaster mental health consequences, whereas local area and state emergency plans were less understood. Respondents’ level of experience in working with disaster survivors varied considerably, with 52% being at least ‘quite’ experienced and 48% with either ‘little’ or ‘no’ experience. Respondents were most likely to be trained in Level 1 (36%), followed by Level 2 (26%) and Level 3 interventions (22%), but more likely to have provided either Level 1 (27%) or Level 3 (26%) than Level 2 (17%) interventions. Of those trained in Level 1, 2 or 3 interventions, 45%, 53% and 32%, respectively had not provided these interventions. While the majority of respondents indicated being ‘not at all’ confident to provide Level 1-3 interventions, confidence levels were considerably higher among those with prior training or provider experience. Overall, the percentage of respondents with at least a ‘moderate’ level of interest in providing Level 1-3 interventions exceeded the percentage of respondents trained in these interventions by a factor of two or more. Key patterns of disaster mental health capacity observed at Levels 1-3 were mirrored for additional disaster mental health interventions, with levels of training, experience, confidence and interest overall highest for interventions dealing with grief and loss.

The majority of respondents with training and experience providing Level 1-3 interventions were based in metropolitan regions. However, the largest proportion of respondents with at least a ‘considerable’ level of understanding of disasters aspects was generally found in regional Victoria.

WHAT IS THE CAPACITY OF THE WORKFORCE TO PARTICIPATE IN FUTURE DISASTER MENTAL HEALTH RESPONSES?

Overall, respondents had the greatest capacity to participate in future disaster mental health responses via face-to-face service delivery and one-off visits to affected areas (with 75% and 63% indicating at least a ‘moderate’ level of capacity) and least capacity for temporary relocation (30%). About one half of respondents had at least ‘moderate’ capacity to provide services via outreach to affected areas (51%) and telemental health (47%). The maximum reach of service delivery, whilst variable between different modes of service provision, indicated a considerable level of geographical mobility. Seventy-one and
72% of respondents for whom this data was available indicated at least a ‘state-wide’ reach for telemental health and temporary relocation whereas 36% had a similar reach for face-to-face service delivery.

Metropolitan regions generally had the largest number of respondents with at least a ‘high’ level of capacity to participate in disaster mental health responses across all modes of service provision and also the largest number and proportion of respondents with at least a ‘state-wide’ reach.

The key barriers to participation in disaster mental health responses raised by 41%-35% of respondents were: a lack of disaster mental health training, a loss of income, limited scope within existing roles, a lack of time and a lack of experience delivering disaster mental health services, whereas other notable barriers included a lack of familiarity with disaster mental health interventions, geographical barriers / distance, a lack of back-fill, a lack of logistic support / resources, a lack of leave and a lack of opportunity. Most frequently mentioned key enablers of effective participation in disaster mental health responses were: Level 3, 2 and 1 type training and supervision (each rated by more than half of respondents at least a ‘moderate’ priority) and opportunities for involvement. Other notable enablers included: peer support, employer support, logistic support and resources, paid leave and back-fill.

WHAT ARE EXISTING KEY WORKFORCE STRENGTHS AND STRATEGIC DEVELOPMENT REQUIREMENTS?

The survey data highlighted several workforce characteristics that can be seen to reflect existing workforce strengths and which included in particular:

(1) the multifaceted nature of the workforce comprised of multiple professional and paraprofessional groups operating across a wide range of settings;

(2) the overall good level of respondent understanding of aspects of relevance to disasters and high level of interest in providing disaster mental health interventions;

(3) the fact that the overall numbers and spread of respondents across Victorian regions (as an indicator of regional disaster mental health capacity) were proportionate to broader Victorian population statistics;

(4) the fact that in line with the former finding, metropolitan regions had a relatively higher level of disaster mental health capacity than regional Victorian locations in terms of the number of people trained in and providing interventions and also the maximum reach of service provision;

(5) the finding that between one-fifth and one-third of survey respondents had been trained in current best-practice disaster mental health interventions at Levels 1-3;

(6) the greater likelihood of people being trained at Level 1, than Level 2 or Level 3 being congruent with the relative expected demand for these interventions following disaster;

(7) a high level of confidence to provide Level 1-3 interventions evident among workforce segments with previous training and or provider experience;

(8) evidence of respondent training and provider experience in relation to a variety of additional interventions of relevance to disaster mental health;

(9) a considerable level of geographical provider mobility evident across various modes of service provision.
In addition, the survey data highlighted a number of key areas and development requirements vis-à-vis the best-practice disaster mental health framework which are of direct relevance to a more strategic and sustainable approach to building Victoria’s disaster mental health capacity.

1. The great diversity of providers in the field (including professionals and volunteers from a variety of backgrounds and with varying levels of experience) warrants a concerted approach to disaster mental health workforce planning. Currently, existing mental health policies and workforce planning frameworks at state and national levels remain ominously silent on disaster mental health as an important area of expertise. However, in view of the anticipated consequences of climate change and increasing likelihood of extreme climatic events, this expertise is increasingly likely to be called upon in the future.

2. The overall level of experience in working with disaster survivors (presented in Figure 2) indicated a substantial lack of work experience in disaster contexts on the part of almost one half of survey respondents. While subjective interpretations of response categories may vary, this finding appeared to be particularly pertinent since survey respondents likely constituted providers with a keen interest in the area.

3. The fact that 45%, 53% and 32% of respondents respectively trained at Levels 1, 2 and 3 had not provided these interventions (whilst indicating a level of untapped existing provider capacity) also directly speaks to the benefits of targeting training resources more strategically.

4. The overall high level of interest in providing Level 1-3 interventions as well as top-rated barriers and enablers of effective response participation indicate a clear existing demand and thus a mandate for further disaster mental health training. While many respondents also showed a similar level of interest in psychological debriefing and critical incident stress management, neither of these interventions is considered to be current best-practice for people affected by disasters. Therefore this latter finding further highlights the need for disaster mental health training in evidence-informed interventions.

5. The evident lack of work experience in disaster contexts as well as key barriers (such as lack of experience delivering disaster mental health services) and enablers of effective response participation (e.g., opportunities for involvement) indicate a considerable level of demand for disaster mental health practice opportunities. The inherent complexity of disaster contexts and time it may take for prospective providers to develop higher level intervention skills would further attest to this finding.

6. While telemental health and temporary relocation were evidently the modes of service delivery with the greatest maximum reach, both of these avenues (and in particular telemental health) appeared to be slightly underutilised by survey respondents. In view of common logistic challenges inherent in large-scale disaster responses, strategies to enhance provider capacity to engage in telemental health service provision and thus to increase provider mobility in a broader sense may warrant closer consideration.

7. Levels of understanding of disaster aspects, whilst overall encouraging, also highlighted gaps in relation to a broader contextual understanding of the disaster response context, including of relevant emergency plans and management frameworks. As these aspects form an important part
of a broader educational agenda for the disaster mental health workforce they may deserve to be strengthened further in the future.

(8) Several key barriers (such as loss of income, limited scope or flexibility within existing role, geographical barriers / distance) and enablers of effective response participation (e.g., supervision, peer support, employer support, logistic support and resources) highlighted the importance of structural support mechanisms as facilitators of disaster mental health capacity at individual, organisational and system levels. While disaster responses are often heavily reliant on the good will and benevolence of providers, a systematic analysis of opportunities for bolstering structural provider support at each of these levels would be warranted in order to strengthen Victoria's overall levels of disaster mental health preparedness and response capacity.

The strategic development requirements highlighted above have implications for policy (1, 2, 8), practice (3, 4, 5, 7) and research (4, 6, 8).
LIMITATIONS

Some caution should be exercised in interpreting the above findings. Firstly, survey findings are inevitably based and thus reliant on the accuracy of respondent self-report data. Secondly, the survey response likely represents an underestimate of the true number of Victorian disaster mental health providers. This is mainly due to two reasons: firstly, the relatively low response rates for some of the targeted provider groups; and secondly, the existence of potential provider groups that were not specifically targeted for this research (e.g., teachers, child care staff, pharmacists, general nurses, other non-government providers, or registered professionals who were not members of professional associations). Thirdly, participant self-selection is commonly observed in survey research.

SURVEY RESPONSE

Due to varying recruitment strategies employed in relation to different provider groups it is impossible to estimate the overall survey response rate. As outlined in Appendix B, a number of agencies were able to target prospective participants directly through email invitations whereas other agencies issued more generic invitations that were either embedded in newsletters, bulletins or on agency homepages.

For agencies directly targeting prospective participants via email, which included the DH/DHS (n=105), APS (n=5,816), ANF (n=8,106), VCC (n=1,150), Red Cross (n=550), AASW (n=1,640), ACMHN (n=711), ACA (n=700) and beyondblue (n=8), agency-based response rates varied between 26.7% for the DH/DHS and 0.9% for the ANF.

For agencies recruiting participants through more generic invitations, which included OTA, GP networks, RANZCP, VCOS, VICSERV and AHWI, it was not possible to determine agency-based response rates as the respective denominators of potential participants accessing study invitations were unknown.

A number of factors either evident at the time of recruitment or more general in nature were further likely to have impacted on the survey response, including:

- The concurrent transition in professional registration for occupational therapists from state bodies to the Australian Health Practitioner Regulation Agency (AHPRA);
- Victorian nurses were in the midst of enterprise bargaining agreement negotiations;
- General practitioners are known to be over-researched and therefore hard-to-recruit;
- Direct recruitment strategies typically yielding better results than generic invitations.

In addition, participant self-selection on the basis of the personal relevance of or interest in an area under study is commonly observed in survey research. An examination of the reasons for survey non-completion provided by 15 respondents highlighted further considerations which may have impacted on the decision to participate in the survey. These included:

- Lack of personal relevance or the area not being a primary concern 3x
- Confidentiality concerns (not wanting to divulge personal details) 3x
- Lack of experience in regards to disasters 2x
- Lack of experience in mental health 2x
• Old age precluding further involvement 2x
• Student status precluding workforce participation 1x
• Having already completed the survey 1x
• Time constraints 1x

REPRESENTATIVENESS OF THE SURVEY SAMPLE

As disaster mental health service provision likely constitutes an area of practice in which only certain types of providers may get actively involved, it is not necessarily reasonable to assume that demographic characteristics of respondents would be representative of the broader professional cohorts from which they were drawn. However, in order to better characterise survey respondents comparisons of key demographic data from the sample and corresponding membership bases of participating agencies were conducted. Demographic comparison data mainly relating to the mean age and gender of Victorian membership bases were available for the APS, Red Cross, ACA, RANZCP, AASW and VCC. For the majority of these agencies, the gender distribution and mean age in the survey sample (Table D2 in Appendix D) was roughly equivalent to that of respective Victorian membership bases (Table D3). For example, the mean age of APS respondents (49 years), as the largest respondent group, was in between that of Victorian APS members (45 years) and Victorian members of the APS Disaster Response Network (52 years), and perhaps slightly closer to the latter. The level of postgraduate qualification, however, appeared to be significantly higher for APS survey respondents (91%) than for either Victorian APS members (56%) or Disaster Response Network members (51%).

Notwithstanding the above limitations, the existing survey data provides to best available approximation of the profile and capacity of the multifaceted disaster mental health workforce in Victoria.
RECOMMENDATIONS

Key findings of the Victorian Disaster Mental Health Workforce Capacity Survey gave rise to a number of recommendations which can inform a more strategic approach to workforce planning and sustainable capacity building and thus enhance Victoria’s overall level of disaster preparedness.

(1) MINIMUM STANDARDS FOR DISASTER MENTAL HEALTH PROVIDERS

In order to ensure the quality of service provision in disaster contexts and in view of the ‘tsunami of goodwill’ or influx of spontaneous volunteers following disasters with highly variable levels of understanding of disaster mental health, it would be advisable to define minimum standards for the deployment of disaster mental health providers that can guide capacity building into the future. These minimum standards could specify amongst others basic training and role requirements for providers involved in emergencies at various levels. The three-tiered disaster mental health response framework already provides a sound evidence-informed basis to guide the definition of such standards. Based on an agreement between relevant authorities and stakeholders, these minimum standards could be implemented through a decentralised process of credentialing whereby relevant professional associations, non-government agencies and Victorian departments engaged in disaster recovery work take responsibility for ensuring that relevant prospective providers are suitably qualified, trained and prepared to work in disaster contexts. This process could further be supported through expert agencies with disaster mental health and training expertise as well as departments with designated responsibility for emergency management. Over time, these minimum standards could be further elaborated to articulate skills, competencies and capabilities of the disaster mental health workforce by alignment with existing national training and qualification frameworks.\textsuperscript{9,10}

In addition, the development of a nationally consistent training curriculum for the disaster mental health workforce looms as a key consideration for the future. At its core, this curriculum could incorporate existing content from disaster mental health training courses at Levels 1-3. This could further be complemented with a variety of content areas such as in relation to: the broader disaster response context, emergency management concepts, inter-professional, -agency and -sectorial collaboration, working with specific populations, and provider self-care. A national disaster mental health curriculum would need to ensure broad applicability of skills and content areas and allow for different articulation pathways and levels. The curriculum could be developed on a standalone basis and/or benefit from varying degrees of integration with broader national frameworks for disaster health education\textsuperscript{11} as well as existing training curricula for emergency management and mental health education. The interface of disaster response and climate change adaptation capabilities in mental health care may warrant particular consideration in this context.
(2) STRATEGIC DISASTER MENTAL HEALTH WORKFORCE PLANNING

The evident diversity and current stage of development of the field of disaster mental health clearly warrant a more concerted and strategic approach to disaster mental health workforce planning. To this end, existing concepts and approaches from health workforce planning can provide useful guidance on future workforce planning in disaster mental health.

It has become widely accepted and recognised that workforce planning needs to be part of a planning process.\(^1\) Health workforce planning has traditionally and narrowly been defined as the forecasting of health workforce demand and supply in order to determine the appropriate numbers of health care workers required.\(^15\)

In 2005, the Australian Health Workforce Advisory Committee\(^16\) advocated the use of a ‘models of care approach’ to health workforce planning, which involved taking a specific care group (e.g., mental health) and identifying a best practice model of care designed to meet the needs of consumers (not demands) and the required workforce supply and skill mix is then determined. Planning actions include: identifying and describing the care group; identifying a best-practice care model to meet existing needs; and defining skills and capabilities required to provide the model of care.

Broader conceptualisations of health workforce planning also exist. The WHO (2010) describe it as referring to the range of approaches to health workforce policy, including: regulation, education/training content and infrastructure, incentives, role changes, provision of appropriate and accessible care; and ensuring that an appropriate health workforce exists to meet health care needs.\(^17\)

Successful health workforce planning has been found to require accurate data, modelling, continuous and iterative planning, workforce planning skills, scenario building and input from stakeholders.\(^13\) Furthermore, workforce planning should answer questions regarding desired workforce characteristics now and in the future, and how organisational practices can support, authorise, sustain or develop such workforce characteristics.

Newer approaches of health workforce planning further emphasise the need to focus on the capacity of the health workforce to support the delivery of effective and efficient services into the future.\(^15,16\) For example, in the health promotion arena, capacity building has been conceptualised as a process that enhances the ability of individuals, organisations or systems to perform effectively in the functions for which they exist, identify and address new challenges or improve control over practices in a sustainable manner within dynamic contexts.\(^18\)

A capacity building approach also recognises that five key components need focussing on: organisational development, workforce development, resource allocation, partnerships and leadership, and three dimensions: infrastructure development, program sustainability, and enhanced problem solving capacity.\(^19\)

A capacity building perspective on workforce planning may provide a useful framework to build the capacity of the broader system to support the future disaster mental health workforce. This approach recognises that simply focusing on appropriate workforce roles, skill mix, competencies is not sufficient, but that supportive environments will need to be created which enable such workforce roles/skill sets to be developed, supported (e.g., authorised) and sustained.
From a disaster preparedness perspective, the existing workforce data provide a useful aid to inform a more strategic approach to disaster mental health workforce planning and targeting of capacity building resources at state, regional and organisational levels. While workforce demand in disaster contexts is inevitably determined by a number of factors (including the scope, severity and population impact of a disaster), future disaster workforce planning can draw upon varied data sources in order to strategically raise levels of preparedness in identified priority areas. Such data sources include amongst others: a) regional disaster risk profiles (i.e., indicating the type and likelihood of disasters to occur); b) population density maps (indicating the number of people likely to be affected by a disaster); as well as c) disaster workforce data (indicating existing disaster mental health capacity and development requirements at various levels).

(3) SYSTEMATIC DISASTER MENTAL HEALTH WORKFORCE DATA COLLECTION

A more concerted approach to workforce planning in disaster mental health inevitably requires that data on the number, profile and capacity of relevant provider groups be more systematically gathered, synthesised and kept up to date. Currently, the nature, scope and quality of data kept among participating agencies on constituents with potential for disaster involvement varied considerably, with often the most basic demographic indicators missing. However, in order to facilitate future disaster mental health workforce planning, it would be essential for agencies to more systematically collect and maintain data in relation to the profile and capacity of their respective disaster mental health providers. At a state-level, this process could be greatly facilitated through resource-efficient repeat administration of the current survey on a three- to four-yearly basis as this approach would simultaneously ensure broad coverage and consistency of data collection. In addition, the analysis, synthesis and utilisation of data would ideally require a level of departmental leadership and a collaborative effort with input from relevant stakeholders with expertise in disaster mental health, emergency management, research and workforce planning.

(4) MECHANISMS TO ENHANCE DISASTER MENTAL HEALTH CAPACITY AND STRUCTURAL WORKFORCE SUPPORT

Overall survey findings provide a broad based mandate for strengthening Victoria’s disaster mental health capacity, while state-, regional- and organisation-level survey data can assist to inform the setting of priorities and targeting of resources. On the basis of survey findings, it would be recommended that further disaster mental health training at Levels 1, 2 and 3 be provided in identified priority areas in order to boost disaster mental health capacity and preparedness in regions most prone to experiencing natural disasters.

This capacity building effort could draw upon the input of designated expert agencies with training expertise such as the Australian Centre for Posttraumatic Mental Health, the state-wide trauma service at the Austin Hospital and the Australian Psychological Society. Disaster mental health training and support programs need to be evidence-based (in content and delivery), scalable and continuously available for widely-dispersed provider groups. Online-based and blended learning models (such as already exist in the USA for Level 1 PFA) can enhance access to disaster mental health training particularly in rural and remote areas. In addition, it would be desirable for professional associations and non-government agencies more actively engaged in this arena, to build up a level of in-house expertise and provider support capacity over time. Existing examples of disaster specific agency-based networks such the APS Disaster Response Network, the RANZCP disaster referral register or the VCC
emergency ministry provide useful models for provider engagement, support and capacity development.

The creation of disaster mental health practice opportunities and establishment of ongoing support mechanisms (such as supervision, mentoring and peer support) need to form key aspects of future workforce planning and capacity building. Since disasters may only provide infrequent practice opportunities, the mainstreaming of disaster mental health interventions and potential integration of providers within more generic existing trauma services could provide practice opportunities in relation to a broader range of small-scale traumatic events and thereby assist to develop and maintain provider capacity over time. Finally, whether these are provided face-to-face or remotely, by experts or peers, individually- or group-based, access to models of supervision, mentoring and peer support is absolutely vital in that such processes assist providers to acquire the necessary skills and confidence to operate in challenging disaster contexts.
CONCLUSIONS

The current report indicates that the Victorian disaster mental health workforce is multifaceted, comparatively mature aged, largely female, tertiary qualified, professionally organised and mainly operating in direct service delivery roles across varied settings. Study findings demonstrate that this workforce has an encouraging level of understanding of disaster aspects, a high level of interest but variable levels of training, experience, confidence and capacity to provide best-practice disaster mental health interventions. While Metropolitan regions had the greatest number of disaster mental health providers, key indicators of disaster mental health capacity varied between Victorian regions and across provider groups. Key findings of the study including existing workforce strengths and strategic development requirements give rise to a number of recommendations which can inform a more strategic approach to disaster mental health workforce planning and sustainable capacity building in the future.
ACKNOWLEDGEMENTS

The project team wishes to sincerely thank the following agencies for their generous support of the study.

FUNDING BODIES

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PROJECT ENDORSEMENT

The Victorian Disaster Mental Health Workforce Capacity Survey was officially endorsed by the following agencies:

- Victorian Departments of Health & Human Service
- Australian Centre for Posttraumatic Mental Health
- Australian Association of Social Workers
- Australian Psychological Society
- Occupational Therapy Australia
- Royal Australian & New Zealand College of Psychiatrists
- Australian College of Mental Health Nurses
- Australian Nursing Federation (Victoria Branch)
- General Practice Victoria
- Australian Counselling Association
- Victorian Council of Churches
- Australian Red Cross
- Beyondblue

PROJECT EXPERT REFERENCE GROUP

The following agencies represented on the projects’ Expert Reference Group provided invaluable input, support and guidance on the project:

- Victorian Departments of Health & Human Service
- Australian Centre for Posttraumatic Mental Health
- Australian Association of Social Workers
- Australian Psychological Society
- Occupational Therapy Australia
- Royal Australian & New Zealand College of Psychiatrists
- Australian College of Mental Health Nurses
- Australian Nursing Federation (Victoria Branch)
- General Practice Victoria
- Australian Counselling Association
- Australian Red Cross
- Beyondblue

In addition, we wish to thank survey participants and key staff from above agencies who greatly facilitated the conduct of the study.
REFERENCES


GLOSSARY

- MH – Mental Health
- DMH – Disaster Mental Health
- The Survey – The Victorian Disaster Mental Health Workforce Capacity Survey
- ERG – Expert Reference Group
- CHPPE – Centre for Health Programs, Policy and Economics
- AHWI – Australian Health Workforce Institute
- MSSI – Melbourne Sustainable Society Institute
- NDRGS – Natural Disaster Resilience Grants Scheme
- OESC – Office of the Emergency Services Commissioner Victoria
- DH / DHS – Victorian Departments of Health and Human Service
- APS – Australian Psychological Society
- OTA – Occupational Therapy Australia
- ANF – Australian Nursing Federation (Victoria Branch)
- VCC – Victorian Council of Churches
- Red Cross – Australian Red Cross
- AASW – Australian Association of Social Workers
- RANZCP – Royal Australian and New Zealand College of Psychiatrists
- RACGP – Royal Australian College of General Practitioners
- ACRRM – Australian College of Rural and Remote Medicine
- GP Networks – Divisions of General Practice; Medicare Locals
- ACMHN – Australian College of Mental Health Nurses
- ACA – Australian Counselling Association
- Beyondblue – Beyondblue: the national depression initiative
- VICSERV – Psychiatric Disability Services of Victoria
- VCOSS – Victorian Council of Social Service
- PFA – Psychological First Aid
- SPR – Skills for Psychological Recovery
APPENDIX A: SURVEY TEMPLATE

The VIC DMH Workforce Capacity Survey

INTRODUCTION

This section incorporates general information:

- Invitation to Participate
- Plain Language Statement
- Informed Consent
- Request to complete the survey only once
- Brief item exploring reasons for non-completion

WORKFORCE PROFILE

1. **What is your year of birth?**
   [ ] Drop down menu

2. **What is your gender?**
   [ ] Male
   [ ] Female

3. **What is your professional background?**
   [ ] General Practitioner
   [ ] Psychologist
   [ ] Social Worker
   [ ] Occupational Therapist
   [ ] Nurse
   [ ] Midwife
   [ ] Psychiatrist
   [ ] Counsellor
   [ ] Aboriginal and Torres Strait Islander Health Worker
   [ ] Community Worker
   [ ] Welfare Worker
   [ ] Youth Worker
   [ ] Health Worker
   [ ] Pastoral Care Worker
   [ ] Teacher
   [ ] Business Person
   [ ] Lawyer
   [ ] Other (please specify)
3a) Please indicate your current professional membership and registration status by ticking relevant boxes below. (Depending on items selected in Q3 only relevant sections of this submenu will appear)

**General Practitioner**

[ ] Registered with AHPRA / Medical Board of Australia
[ ] Member of Royal Australian College of General Practitioners (RACGP)
[ ] Member of Rural Doctors Association (RDA)
[ ] Member of Australian College of Rural and Remote Medicine (ACRRM)
[ ] Member of Division of General Practice / Medicare Local

**Psychologist**

[ ] Registered with AHPRA / Psychologists Board of Australia
[ ] Member of Australian Psychological Society (APS)
[ ] Registered Medicare provider (please indicate level):
  [ ] General
  [ ] Clinical

**Social Worker**

[ ] Member of Australian Association of Social Workers (AASW)
[ ] Member of Australian College of Social Work (ACSW)
  [ ] Clinical Division (please select if applicable)
  [ ] Mental Health sub-speciality
[ ] Accredited Mental Health Social Worker

**Occupational Therapist**

[ ] Registered with OT State Body
[ ] Member of Occupational Therapy Australia (OTA)
[ ] OTA Specialty Area (please select if applicable)
  [ ] Counselling
  [ ] Mental Health
  [ ] Wellbeing & Psychotherapy
Nurse / Midwife
[ ] Registered with AHPRA / Nursing and Midwifery Board of Australia
  [ ] Nurse
[ ] General Registration with AHPRA / Nursing and Midwifery Board of Australia
  [ ] Registered Nurse
  [ ] Enrolled Nurse
[ ] Endorsement of Registration
  [ ] Scheduled Medicines
  [ ] Nurse Practitioner
  [ ] Midwife
  [ ] Endorsement of Registration
    [ ] Scheduled Medicines
    [ ] Eligible Midwife
[ ] Member of Australian College of Mental Health Nurses (ACMHN)
[ ] Member of Australian Nursing Federation (ANF)
[ ] Speciality Area (please select if applicable)
  [ ] Mental Health
  [ ] Community Health
  [ ] Primary Healthcare
  [ ] Family Health
  [ ] Rehabilitation

Psychiatrist
[ ] Registered with AHPRA / Medical Board of Australia
  [ ] Member of Royal Australian and New Zealand College of Psychiatrists (RANZCP)

Counsellor
[ ] Member of the Australian Counselling Association (ACA)
  Membership Level (please select)
    [ ] Level 1
    [ ] Level 2
    [ ] Level 3
    [ ] Level 4
    [ ] Student
    [ ] Associate
[ ] Member of other Professional Counselling Body (please specify)

Aboriginal and Torres Strait Islander Health Worker
[ ] Registered with State Board
  [ ] Member of National Aboriginal and Torres Strait Islander Health Worker Association (NATSIHWA)
  [ ] Member of other relevant Professional / Paraprofessional Organisation (please specify)

Other
[ ] Professional Registration (please specify body)
  [ ] Member of other relevant Professional / Paraprofessional Organisation (please specify)
4. **What is your highest qualification (Type)?**
   [ ] PhD
   [ ] Doctorate
   [ ] Masters
   [ ] Postgraduate Diploma
   [ ] Postgraduate Certificate
   [ ] Undergraduate Degree with Honours
   [ ] Undergraduate Degree
   [ ] Diploma
   [ ] Certificate
   [ ] Other

5. **What is your highest qualification (Area)?**
   [ ] Medicine
   [ ] Psychology
   [ ] Social Work
   [ ] Occupational Therapy
   [ ] Nursing
   [ ] Midwifery
   [ ] Psychiatry
   [ ] Counselling
   [ ] Aboriginal and Torres Strait Islander Health
   [ ] Community Work
   [ ] Welfare Work
   [ ] Youth Work
   [ ] Health Work
   [ ] Pastoral Care
   [ ] Education
   [ ] Business
   [ ] Law
   [ ] Other (please specify)

6. **Are you able to conduct your day to day work in a language other than English?**
   [ ] Yes (please select)
   [ ] Language(s) (Drop down menu)
   [ ] No
7. Please indicate your level of experience in working with the following groups of people:

   [ ] Children and or Families (Rating scale)
   [ ] Youth and Adolescents (Rating scale)
   [ ] Elderly People (Rating scale)
   [ ] People with Mental Illness (Rating scale)
   [ ] People with Disabilities (Rating scale)
   [ ] People from Culturally and Linguistically Diverse Backgrounds (Rating scale)
   [ ] Aboriginal and Torres Strait Islanders (Rating scale)
   [ ] People in Rural and Remote Communities (Rating scale)
   [ ] Faith-based Communities (Rating scale)
   [ ] Disaster Survivors (Rating scale)
   [ ] Displaced People (Rating scale)
   [ ] Volunteers (Rating scale)
   [ ] Emergency Personnel (Rating scale)

Rating scale: [Very experienced, Considerably, Quite, A little, No experience]
YOUR ROLE, LOCATION AND CONTEXT

Please answer the following questions in relation to your work or volunteering role which is potentially of greatest relevance in a disaster.

8. Do you work in this role in a paid or volunteering capacity?
   [ ] Paid (Full-Time) - Please indicate your weekly working hours (drop down)
   [ ] Paid (Part-Time) - Please indicate your weekly working hours (drop down)
   [ ] Paid (Casual) - Please estimate your average weekly working hours (drop down)
   [ ] Volunteering - Please estimate your average weekly volunteering hours (drop down)
   [ ] Not presently working
   [ ] Not applicable

9. Does this role primarily involve the following activities? Please select the one category which best describes your primary role of relevance to disasters
   [ ] Direct Service Delivery (to community members, clients or patients)
   [ ] Consulting
   [ ] Research
   [ ] Teaching
   [ ] Administration
   [ ] Program Coordination
   [ ] Management
   [ ] Other (please specify)
   [ ] Not applicable

10. What is the primary geographic location of your workplace or volunteering role? If not presently working, please indicate your primary place of residence.
    [ ] Drop down list (of 79 Victorian Local Government Areas)
    [ ] Other (please select if applicable)
        [ ] Interstate (Drop down)
        [ ] Overseas
    [ ] Victorian postcode

11. In which of the following contexts do you work or volunteer primarily in this role (Setting)? Please estimate your weekly working hours for your most applicable role context.
    [ ] Primary care / GP Clinic
    [ ] Independent Private Practice
    [ ] Division of General Practice / Medicare Local
    [ ] Hospital – General health
    [ ] Hospital – Psychiatric
    [ ] Area-based Health Service
    [ ] Area-based Clinical Mental Health Service
    [ ] Statewide and Specialist Mental Health Service
    [ ] Psychiatric Disability Rehabilitation and Support Service
    [ ] Drug/Alcohol Treatment Service
[ ] Disability Service
[ ] Justice/Corrective Services
[ ] Pastoral Care Service
[ ] Housing Service
[ ] Not for profit / Non government organisation (not listed elsewhere)
[ ] Private Company / Business (not listed elsewhere)
[ ] State Government department (not listed elsewhere)
[ ] Local Government department (not listed elsewhere)
[ ] Tertiary Education (other than as a student)
[ ] Schools
[ ] Other (please specify)

12. Do you have another role of relevance to disasters that you would like to tell us about?
[ ] Yes
[ ] No

If yes, please specify:
Paid or volunteering capacity (Drop down menu from Q8; including work hours)
Key activity involved (Drop down menu from Q9)
Your work context(s) (Drop down menu from Q11; excluding work hours)
CURRENT DISASTER MENTAL HEALTH CAPACITY

The next questions will ask you about your current level of understanding, experience, training, interest, and capacity in relation to the provision of disaster mental health services.

13. How would you rate your current understanding of the following aspects:

[ ] Consequences of disasters on affected individuals (Rating scale)
[ ] Consequences of disasters on affected communities (Rating scale)
[ ] Mental health consequences of disasters (Rating scale)
[ ] Disaster Preparedness (Rating scale)
[ ] Disaster Recovery (Rating scale)
[ ] Emergency Management (Rating scale)
[ ] Organisational Emergency Plan (Rating scale)
[ ] Local Area Emergency Plan (Rating scale)
[ ] Regional and State Emergency Plans (Rating scale)

Rating scale: [Excellent, Considerable, Reasonable, A little, Hardly any]

In the wake of the Victorian Black Saturday Bushfires dedicated disaster mental health training programs were provided in support of practitioners involved in the disaster response. These training programs primarily focussed on three levels:

Level 1: Psychological First Aid (PFA) or Community Support Training provided by Beyondblue. For further information visit: http://www.psid.org.au/response (select ‘Psychological First Aid’)

Level 2: Skills for Psychological Recovery (SPR) provided by the Australian Psychological Society, the Australian Centre for Posttraumatic Mental Health and Austin Health. For further information visit: http://www.psid.org.au/recovery (select ‘Moderate Distress’)

Level 3: Treatment of Common Mental Health Problems after Trauma and Disaster provided by the Australian Psychological Society, the Australian Centre for Posttraumatic Mental Health, Austin Health, and the Royal Australian and New Zealand College of Psychiatrists. For further information visit: http://www.psid.org.au/recovery (select ‘Significant mental health problems’)

14. Do you have experience providing the following disaster mental health interventions?

Please indicate the number of people you have provided these services to.

[ ] Level 1: Psychological First Aid (PFA) or beyondblue Community Support
[ ] Level 2: Skills for Psychological Recovery (SPR)
[ ] Level 3: Treatment of Common Mental Health Problems after Trauma and Disaster
[ ] Other relevant experience (please select)

[ ] Assessment and Treatment Planning
[ ] Dealing with Grief and Loss
[ ] Trauma focussed Cognitive Behaviour Therapy
[ ] Exposure Treatment (In-vivo or Imaginal)
15. Have you completed the following disaster mental health training? And how would you rate your current level of confidence to provide these interventions in a disaster context?

**Level 1:** Psychological First Aid or beyondblue Community Support (Rating scale)

**Level 2:** Skills for Psychological Recovery (Rating scale)

**Level 3:** Treatment of Common Mental Health Problems after Trauma and Disaster (Rating scale)

Other relevant interventions:
- Assessment and Treatment Planning
- Dealing with Grief and Loss
- Trauma focussed Cognitive Behaviour Therapy
- Exposure Treatment (In-vivo or Imaginal)
- EMDR (Eye Movement Desensitization and Reprocessing)
- Pharmacotherapy
- Psychological Debriefing
- Critical Incident Stress Management
- Personal Support (in Emergencies)
- Outreach Support (in Emergencies)
- Community Recovery / Capacity Building
- Emergency / Disaster Preparedness
- Emergency / Disaster Management
- Other (please specify)

[ ] Not applicable

**Rating scale:** [Extremely confident, Considerably, Moderately, Slightly, Not at all confident]
16. How would you rate your current level of interest to provide disaster mental health services to affected Victorians in the event of future natural disasters?

**Level 1**: Psychological First Aid (Rating scale)

**Level 2**: Skills for Psychological Recovery (Rating scale)

**Level 3**: Intensive Mental Health Treatments (Rating scale)

Other relevant services:
- [ ] Assessment and Treatment Planning
- [ ] Dealing with Grief and Loss
- [ ] Trauma focussed Cognitive Behaviour Therapy
- [ ] Exposure Treatment (In-vivo or Imaginal)
- [ ] EMDR (Eye Movement Desensitization and Reprocessing)
- [ ] Pharmacotherapy
- [ ] Psychological Debriefing
- [ ] Critical Incident Stress Management
- [ ] Personal Support (in Emergencies)
- [ ] Outreach Support (in Emergencies)
- [ ] Community Recovery / Capacity Building
- [ ] Emergency / Disaster Preparedness
- [ ] Emergency / Disaster Management
- [ ] Other (please specify)
- [ ] Not applicable

**Rating scale**: [No interest, Limited, Moderate, High, Very high interest]

17. Overall, how would you rate your current capacity to participate in disaster mental health responses via the following modes of service provision? And what is your maximum reach?

- [ ] Face-to-Face Service Delivery (Rating scale)
- [ ] Telemental Health (Telephone, internet, etc) (Rating scale)
- [ ] Outreach to Affected Areas (Rating scale + Maximum Radius)
- [ ] Visiting Affected Areas on a one-off basis (Rating scale + Maximum Radius)
- [ ] Ability to Relocate Temporarily (Rating scale + Maximum Radius)
- [ ] Not applicable

**Rating scale**: [No capacity, Slight, Moderate, High, Very high capacity]

**Maximum Reach**: [Local LGA, Neighbouring LGA, Local Region, Neighbouring Region, State-wide, Interstate]
KEY BARRIERS, ENABLERS AND FUTURE DEVELOPMENT REQUIREMENTS

18. What would you see as the key barriers to your participation in future disaster mental health responses?

- Lack of familiarity with disaster mental health interventions
- Lack of experience delivering disaster mental health services
- Lack of dedicated disaster mental health training
- Lack of confidence to work in a disaster context
- Limited scope or flexibility within existing role
- Lack of employer support
- Lack of time
- Lack of leave
- Lack of back-fill
- Loss of income
- Lack of interest
- Lack of opportunity
- Geographical barriers / distance
- Lack of logistic support / resources
- Other (please specify)
- Not applicable

Multiple responses permitted

19. What are your key training and support requirements in order to enhance your capacity to effectively participate in future disaster mental health responses?

Please indicate how much of a priority these are for you.

- Disaster mental health training
- Level 1 type training (Rating scale)
- Level 2 type training (Rating scale)
- Level 3 type training (Rating scale)
- Other training (please specify) (Rating scale)
- Peer support (Rating scale)
- Supervision (Rating scale)
- Employer support (Rating scale)
- Unpaid leave (Rating scale)
- Paid leave (Rating scale)
- Back-fill (Rating scale)
- Opportunities for involvement (Rating scale)
- Logistic support / resources (Rating scale)
- Other (please specify) (Rating scale)
- Not applicable

Multiple responses permitted

Rating scale: [Not a priority, Low, Moderate, High, Very high priority]
This marks the end of the Victorian Disaster Mental Health Workforce Capacity Survey.

In order to submit your responses now, please click [Submit] below.

In order to review your responses please click [Prev]

[Prev] [Submit]

Thank you very much for your contribution to this important project.

The Victorian Disaster Mental Health Providers List

Should you wish to be included on a list of Victorian Disaster Mental Health Providers please follow the link [Proceed to List] below. This will lead you to a separate survey which does no longer form part of the research and which will ask you to provide your preferred contact details in order to be included on a list of willing disaster mental health providers. The list will be made available to relevant emergency management agencies and professional associations for the purpose of facilitating future workforce and disaster response planning.

If you do not wish to be included on this list, simply click on [Exit] now or close your browser.

[Exit] [Proceed to List]

Once again thank you for your time.
By consenting to be included on the Victorian Disaster Mental Health Providers List, I acknowledge that I understand that:

- My decision to participate is entirely voluntary;
- The information I provide will be provided only to relevant emergency management agencies and professional organisations as specified below;
- These agencies will be using the information solely for the purpose of facilitating future workforce and disaster response planning;
- I may be contacted by these agencies in the event of future Victorian disasters;
- My inclusion on the list does not entail any obligation or entitlement on my part or on the part of these agencies;
- I am free to withdraw my details from the list at any stage without adverse consequences;
- I can withdraw my details simply by emailing ‘support@websurvey.com.au’ (until October 2012) after which period I will need to contact relevant agencies directly;
- I freely consent to the inclusion of my contact details on the list as indicated below;
- Survey data linked to the list will not be anonymous to the agencies.

Please provide Your Name and Preferred Contact Details:

Your Name: 
Email: 
Work phone: Private phone: Mobile phone: 
Fax: 
Street address: Suburb: State: Postcode: 

Please select the Agencies you would like your details be made available to:

[ ] Victorian Departments of Health and Human Service  [ ] Australian Psychological Society
[ ] Australian Association of Social Workers  [ ] Occupational Therapy Australia
[ ] Royal Australian & NZ College of Psychiatrists  [ ] General Practice Victoria
[ ] Australian College of Mental Health Nurses  [ ] Australian Nursing Federation
[ ] Australian Counselling Association  [ ] Victorian Council of Churches
[ ] Beyondblue  [ ] Australian Red Cross

Please select if you wish your data from the Vic Disaster Mental Health Workforce Capacity Survey to be linked to the providers list: Yes [ ] No [ ]

Once you have checked your details above, click [Submit] to be included on the providers list. To exit this process simply click [Cancel] or close your browser.

[Submit]  [Cancel]
## APPENDIX B: RECRUITMENT STRATEGY

<table>
<thead>
<tr>
<th>Target group</th>
<th>Key agency</th>
<th>Strategy</th>
<th>Target estimate</th>
<th>URL Link</th>
<th>Date circulated</th>
<th>Date reminded</th>
<th>Response by URL Link</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychologists</td>
<td>APS</td>
<td>Email List</td>
<td>5,816</td>
<td>2</td>
<td>21/3</td>
<td>–</td>
<td>190</td>
</tr>
<tr>
<td></td>
<td></td>
<td>DRN List</td>
<td></td>
<td></td>
<td>21/3</td>
<td>–</td>
<td></td>
</tr>
<tr>
<td>Social Workers</td>
<td>AASW</td>
<td>Email List</td>
<td>1,640</td>
<td>8</td>
<td>21/3</td>
<td>30/4</td>
<td>90</td>
</tr>
<tr>
<td>MH Nurses</td>
<td>ACMHN</td>
<td>Email List</td>
<td>711</td>
<td>10</td>
<td>15/3</td>
<td>10/4; 1/6</td>
<td>58</td>
</tr>
<tr>
<td>Nurses &amp; Midwives a</td>
<td>ANF</td>
<td>Email List</td>
<td>8,106</td>
<td>5</td>
<td>2/4</td>
<td>–</td>
<td>77</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Web link NL</td>
<td></td>
<td></td>
<td>2/4</td>
<td>–</td>
<td></td>
</tr>
<tr>
<td>Counsellors</td>
<td>ACA</td>
<td>Email List</td>
<td>700</td>
<td>11</td>
<td>16/3</td>
<td>19/4</td>
<td>100</td>
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<tr>
<td>Pastoral Care Workers b</td>
<td>VCC</td>
<td>Email List</td>
<td>1,150</td>
<td>6</td>
<td>4/4</td>
<td>30/4</td>
<td>145</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Mail out</td>
<td></td>
<td></td>
<td>4/4</td>
<td>30/4</td>
<td></td>
</tr>
<tr>
<td>Volunteers c</td>
<td>Red Cross</td>
<td>Email List</td>
<td>550</td>
<td>7</td>
<td>26/3</td>
<td>27/4</td>
<td>76</td>
</tr>
<tr>
<td></td>
<td></td>
<td>NL</td>
<td></td>
<td></td>
<td>16/3</td>
<td>–</td>
<td></td>
</tr>
<tr>
<td>MH Training Facilitators d</td>
<td>Beyondblue</td>
<td>Email List</td>
<td>8</td>
<td>12</td>
<td>23/3</td>
<td>15/5</td>
<td>2</td>
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<tr>
<td>Bushfire Case Managers e</td>
<td>DH / DHS</td>
<td>Email List</td>
<td>105</td>
<td>1</td>
<td>19/3</td>
<td>26/4</td>
<td>28</td>
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<tr>
<td>Psychiatrists</td>
<td>RANZCP</td>
<td>E-bulletin Branch NL</td>
<td>Not known</td>
<td>9</td>
<td>14/3 March</td>
<td>April</td>
<td>12</td>
</tr>
<tr>
<td>GPs</td>
<td>RACGP</td>
<td>E-bulletin Branch NL</td>
<td>Not known</td>
<td>4</td>
<td>23/4</td>
<td>–</td>
<td>16 (incl. 3 GPs)</td>
</tr>
<tr>
<td></td>
<td>ACCRM</td>
<td>E-bulletin E-NL</td>
<td>Not known</td>
<td>4</td>
<td>16/3</td>
<td>–</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Medical Observer Journal Ad</td>
<td>Various</td>
<td>3</td>
<td>16/3</td>
<td>18/4</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>Occupational Therapists</td>
<td>OTA</td>
<td>E-bulletin Web link</td>
<td>Not known</td>
<td>13</td>
<td>23/3</td>
<td>20/4</td>
<td>5</td>
</tr>
<tr>
<td>Health &amp; Community Sector Workers</td>
<td>VICSERV</td>
<td>E-NL</td>
<td>Not known</td>
<td>13</td>
<td>23/3</td>
<td>–</td>
<td></td>
</tr>
<tr>
<td></td>
<td>VCOSS</td>
<td>E-NL</td>
<td>Not known</td>
<td>13</td>
<td>23/3</td>
<td>–</td>
<td></td>
</tr>
<tr>
<td></td>
<td>AHWI</td>
<td>Web link</td>
<td></td>
<td>13</td>
<td>23/3</td>
<td>–</td>
<td></td>
</tr>
</tbody>
</table>

a Targeted speciality groups included: Community Health Nurses, Practice Nurses, Mental Health Nurses, Midwives, Nurse Practitioners and School Nurses; b Victorian Council of Churches Emergency Ministry volunteers; c Australian Red Cross disaster response volunteers based in Victoria; d Beyondblue training facilitators involved in Level 1 Community Support Training; e Former Victorian Bushfire Case Management Service workers

E-NL – Electronic newsletter; APS – Australian Psychological Society; AASW – Australian Association of Social Workers; ACMHN – Australian College of Mental Health Nurses; ANF – Australian Nursing Federation (Victoria Branch); ACA – Australian Counselling Association; VCC – Victorian Council of Churches; Red Cross – Australian Red Cross; Beyondblue – beyondblue: the national depression initiative; DH/DHS – Victorian Departments of Health and Human Service; RANZCP – Royal Australian and New Zealand College of Psychiatrists; RACGP – Royal Australian College of General Practitioners; ACRRM – Australian College of Rural and Remote Medicine; GP Networks – Divisions of General Practice and Medicare Locals; OTA – Occupational Therapy Australia; VICSERV -Psychiatric Disability Services of Victoria; VCOSS – Victorian Council of Social Service; AHWI – Australian Health Workforce Institute.
## APPENDIX C: PROJECT TIMEFRAMES

<table>
<thead>
<tr>
<th>Project Stages and Activities</th>
<th>Start Date</th>
<th>End Date</th>
<th>Major Milestones</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Stage 1: Establishment &amp; Scoping</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Establishment of Expert Reference Group</td>
<td>Nov 2011</td>
<td>Nov 2011</td>
<td>Terms of reference and regular meeting schedule enacted</td>
</tr>
<tr>
<td>Scoping the Disaster Mental Health Workforce</td>
<td>Nov 2011</td>
<td>Nov 2011</td>
<td>Key workforce groups identified</td>
</tr>
<tr>
<td>Key Stakeholder Consultations</td>
<td>Nov 2011</td>
<td>Dec 2011</td>
<td>Level of stakeholder input and involvement specified</td>
</tr>
<tr>
<td>Finalising Project Scope</td>
<td>Nov 2011</td>
<td>Dec 2011</td>
<td>Refined project proposal</td>
</tr>
<tr>
<td>Ethics Application</td>
<td>Nov 2011</td>
<td>Dec 2011</td>
<td>Ethics approval</td>
</tr>
<tr>
<td><strong>Stage 2: Survey Design &amp; Development</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Refining Survey Methodology and Specifications</td>
<td>Jan 2012</td>
<td>Feb 2012</td>
<td>Survey methodology finalised</td>
</tr>
<tr>
<td>Development of Online Survey Module</td>
<td>Feb 2012</td>
<td>Feb 2012</td>
<td>Operational survey module</td>
</tr>
<tr>
<td>Finalising Dissemination Strategy</td>
<td>Feb 2012</td>
<td>Feb 2012</td>
<td>Final dissemination plan</td>
</tr>
<tr>
<td><strong>Stage 3: Data Collection</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Survey Administration</td>
<td>Mar 2012</td>
<td>Mar 2012</td>
<td>Survey disseminated to key workforce groups</td>
</tr>
<tr>
<td>Data Collection</td>
<td>Apr 2012</td>
<td>May 2012</td>
<td>Data collated in central data file</td>
</tr>
<tr>
<td><strong>Stage 4: Data Analysis</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Data analysis</td>
<td>Jun 2012</td>
<td>Jul 2012</td>
<td>Relevant statistical analyses performed</td>
</tr>
<tr>
<td><strong>Stage 5: Preparation of Report</strong></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Preparation of final report</td>
<td>Aug 2012</td>
<td>Sep 2012</td>
<td>Final project report available</td>
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<tr>
<td><strong>Stage 6: Dissemination of Findings</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dissemination of findings</td>
<td>Oct 2012</td>
<td>Oct 2012</td>
<td>Final report disseminated to stakeholders and key findings presented in relevant forums</td>
</tr>
</tbody>
</table>
### APPENDIX D: DEMOGRAPHIC RESPONDENT PROFILE BY REGION AND ORGANISATION

#### Table D1: Demographic respondent profile by Victorian region

<table>
<thead>
<tr>
<th>Region</th>
<th>Barwon South West (n=50)</th>
<th>Gippsland (n=54)</th>
<th>Grampians (n=43)</th>
<th>Hume (n=61)</th>
<th>Loddon Mallee (n=60)</th>
<th>Eastern Metro (n=126)</th>
<th>North West Metro (n=251)</th>
<th>South Metro (n=123)</th>
<th>Total (n=791)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean age (SD) years</td>
<td>57.1 (9.5)</td>
<td>54.0 (9.9)</td>
<td>50.5 (12.9)</td>
<td>53.0 (10.9)</td>
<td>54.6 (12.2)</td>
<td>49.8 (11.9)</td>
<td>50.1 (11.8)</td>
<td>51.3 (11.7)</td>
<td>51.7 (11.7)</td>
</tr>
<tr>
<td>Gender female (%)</td>
<td>60.0</td>
<td>81.5</td>
<td>67.4</td>
<td>65.6</td>
<td>63.3</td>
<td>76.2</td>
<td>72.1</td>
<td>77.2</td>
<td>71.6</td>
</tr>
<tr>
<td>Gender male (%)</td>
<td>40.0</td>
<td>18.5</td>
<td>32.6</td>
<td>34.4</td>
<td>36.7</td>
<td>23.8</td>
<td>27.9</td>
<td>22.8</td>
<td>28.4</td>
</tr>
<tr>
<td>Tertiary qualified (%)</td>
<td>64.0</td>
<td>77.8</td>
<td>81.5</td>
<td>83.6</td>
<td>81.6</td>
<td>81.8</td>
<td>87.8</td>
<td>79.7</td>
<td>82.2</td>
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<tr>
<td>Postgraduate qualified (%)</td>
<td>54.0</td>
<td>55.6</td>
<td>53.6</td>
<td>60.6</td>
<td>64.9</td>
<td>58.0</td>
<td>71.4</td>
<td>66.7</td>
<td>64.1</td>
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<td>7.4</td>
<td>0.0</td>
<td>3.3</td>
<td>3.3</td>
<td>9.5</td>
<td>15.5</td>
<td>14.6</td>
<td>10.0</td>
</tr>
<tr>
<td>Paid full-time (%) a</td>
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<td>33.3</td>
<td>41.9</td>
<td>34.4</td>
<td>25.0</td>
<td>35.7</td>
<td>39.0</td>
<td>35.8</td>
<td>35.5</td>
</tr>
<tr>
<td>Paid part-time (%) a</td>
<td>26.0</td>
<td>24.1</td>
<td>18.6</td>
<td>31.1</td>
<td>33.3</td>
<td>33.3</td>
<td>29.9</td>
<td>28.5</td>
<td>29.0</td>
</tr>
<tr>
<td>Paid casual (%) a</td>
<td>4.0</td>
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<td>9.3</td>
<td>0.0</td>
<td>0.0</td>
<td>6.3</td>
<td>4.0</td>
<td>5.7</td>
<td>4.7</td>
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<td>Volunteering (%) a</td>
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<td>27.8</td>
<td>18.6</td>
<td>31.1</td>
<td>35.0</td>
<td>17.5</td>
<td>22.7</td>
<td>19.5</td>
<td>23.9</td>
</tr>
<tr>
<td>Direct service delivery (%) a</td>
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<td>79.1</td>
<td>78.7</td>
<td>78.3</td>
<td>81.0</td>
<td>78.5</td>
<td>78.0</td>
<td>77.6</td>
</tr>
<tr>
<td>Psychologists (%) b</td>
<td>22.0</td>
<td>24.1</td>
<td>27.9</td>
<td>18.0</td>
<td>11.7</td>
<td>27.8</td>
<td>27.1</td>
<td>31.7</td>
<td>25.3</td>
</tr>
<tr>
<td>Nurses (%) a</td>
<td>16.0</td>
<td>18.5</td>
<td>11.6</td>
<td>24.6</td>
<td>20.0</td>
<td>18.3</td>
<td>19.5</td>
<td>17.1</td>
<td>18.5</td>
</tr>
<tr>
<td>Counsellors (%) b</td>
<td>10.0</td>
<td>11.1</td>
<td>14.0</td>
<td>6.6</td>
<td>16.7</td>
<td>20.6</td>
<td>13.5</td>
<td>17.1</td>
<td>14.5</td>
</tr>
<tr>
<td>Social workers (%) b</td>
<td>12.0</td>
<td>5.6</td>
<td>20.9</td>
<td>19.7</td>
<td>20.0</td>
<td>15.9</td>
<td>13.5</td>
<td>8.9</td>
<td>14.3</td>
</tr>
<tr>
<td>Pastoral care workers (%) b</td>
<td>22.0</td>
<td>24.1</td>
<td>11.6</td>
<td>14.8</td>
<td>16.7</td>
<td>11.1</td>
<td>12.0</td>
<td>7.3</td>
<td>13.4</td>
</tr>
<tr>
<td>Teachers (%) a</td>
<td>6.0</td>
<td>9.3</td>
<td>4.7</td>
<td>4.9</td>
<td>18.3</td>
<td>2.4</td>
<td>7.6</td>
<td>4.1</td>
<td>6.7</td>
</tr>
<tr>
<td>Community workers (%) a</td>
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<td>5.6</td>
<td>2.3</td>
<td>8.2</td>
<td>3.3</td>
<td>1.6</td>
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<td>3.2</td>
</tr>
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<td>Midwives (%) b</td>
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<td>1.9</td>
<td>0.0</td>
<td>6.6</td>
<td>1.7</td>
<td>4.0</td>
<td>1.2</td>
<td>1.6</td>
<td>2.4</td>
</tr>
<tr>
<td>Welfare workers (%) b</td>
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<td>0.0</td>
<td>2.3</td>
<td>4.9</td>
<td>3.3</td>
<td>1.6</td>
<td>1.2</td>
<td>2.4</td>
<td>2.1</td>
</tr>
<tr>
<td>Business persons (%) b</td>
<td>0.0</td>
<td>5.6</td>
<td>7.0</td>
<td>4.9</td>
<td>0.0</td>
<td>0.8</td>
<td>2.0</td>
<td>0.0</td>
<td>2.0</td>
</tr>
<tr>
<td>Psychiatrists (%) b</td>
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<td>0.0</td>
<td>0.0</td>
<td>1.6</td>
<td>0.0</td>
<td>0.8</td>
<td>2.4</td>
<td>3.3</td>
<td>1.5</td>
</tr>
<tr>
<td>Youth workers (%) a</td>
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<td>1.9</td>
<td>2.3</td>
<td>1.6</td>
<td>5.0</td>
<td>0.8</td>
<td>0.4</td>
<td>1.6</td>
<td>1.3</td>
</tr>
<tr>
<td>OTs (%) b</td>
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<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>1.7</td>
<td>3.2</td>
<td>0.0</td>
<td>1.6</td>
<td>0.9</td>
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<td>Health workers (%) b</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>4.9</td>
<td>0.0</td>
<td>0.8</td>
<td>0.4</td>
<td>0.8</td>
<td>0.8</td>
</tr>
<tr>
<td>GPs (%) b</td>
<td>0.0</td>
<td>0.0</td>
<td>2.3</td>
<td>0.0</td>
<td>0.0</td>
<td>0.8</td>
<td>0.4</td>
<td>0.0</td>
<td>0.5</td>
</tr>
<tr>
<td>Lawyers (%) a</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.4</td>
<td>0.8</td>
<td>0.3</td>
<td>0.3</td>
</tr>
<tr>
<td>ATSI Health workers (%) b</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>1.7</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.1</td>
</tr>
<tr>
<td>Other backgrounds (%) b</td>
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<td>9.8</td>
<td>16.7</td>
<td>10.3</td>
<td>11.6</td>
<td>13.0</td>
<td>12.6</td>
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</table>

NB. Excluding Vic (other), interstate and overseas respondents; a relating to the primary role of relevance to disasters; b relating to professional backgrounds.
Table D2: Demographic respondent profile by organisation

<table>
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<tr>
<th></th>
<th>1 n=28</th>
<th>2 n=189</th>
<th>3 n=7</th>
<th>4 n=16</th>
<th>5 n=75</th>
<th>6 n=144</th>
<th>7 n=72</th>
<th>8 n=87</th>
<th>9 n=12</th>
<th>10 n=58</th>
<th>11 n=96</th>
<th>12 n=2</th>
<th>13 n=5</th>
<th>Total N=791</th>
</tr>
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<tbody>
<tr>
<td>Mean age (SD) years</td>
<td>49.0</td>
<td>49.3</td>
<td>41.6</td>
<td>52.3</td>
<td>45.4</td>
<td>58.4</td>
<td>54.7</td>
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<td>51.1</td>
<td>48.6</td>
<td>51.8</td>
<td>47.5</td>
<td>58.2</td>
<td>51.7 (11.7)</td>
</tr>
<tr>
<td></td>
<td>(9.6)</td>
<td>(12.0)</td>
<td>(11.7)</td>
<td>(12.9)</td>
<td>(11.5)</td>
<td>(10.7)</td>
<td>(12.7)</td>
<td>(10.4)</td>
<td>(9.1)</td>
<td>(8.0)</td>
<td>(9.9)</td>
<td>(5.0)</td>
<td>(15.4)</td>
<td></td>
</tr>
<tr>
<td>Gender female (%)</td>
<td>82.1</td>
<td>79.4</td>
<td>100</td>
<td>50.0</td>
<td>80.0</td>
<td>43.8</td>
<td>80.6</td>
<td>86.2</td>
<td>25.0</td>
<td>74.1</td>
<td>74.0</td>
<td>50.0</td>
<td>80.0</td>
<td>71.6</td>
</tr>
<tr>
<td>Gender male (%)</td>
<td>17.9</td>
<td>20.6</td>
<td>0</td>
<td>50.0</td>
<td>20.0</td>
<td>56.2</td>
<td>19.4</td>
<td>13.8</td>
<td>26.0</td>
<td>26.0</td>
<td>50.0</td>
<td>20.0</td>
<td>28.4</td>
<td></td>
</tr>
<tr>
<td>Tertiary qualified (%)</td>
<td>78.5</td>
<td>98.4</td>
<td>100</td>
<td>93.8</td>
<td>85.3</td>
<td>70.3</td>
<td>48.6</td>
<td>97.4</td>
<td>83.3</td>
<td>69.5</td>
<td>100</td>
<td>80.0</td>
<td>82.2</td>
<td></td>
</tr>
<tr>
<td>Postgraduate qualified (%)</td>
<td>42.8</td>
<td>90.5</td>
<td>57.2</td>
<td>81.3</td>
<td>61.3</td>
<td>43.2</td>
<td>34.7</td>
<td>69.9</td>
<td>83.3</td>
<td>82.7</td>
<td>53.1</td>
<td>100</td>
<td>40.0</td>
<td>64.1</td>
</tr>
<tr>
<td>Language other than English (%)</td>
<td>7.1</td>
<td>8.5</td>
<td>14.3</td>
<td>31.2</td>
<td>13.3</td>
<td>9.0</td>
<td>11.1</td>
<td>3.4</td>
<td>16.7</td>
<td>6.9</td>
<td>14.6</td>
<td>0</td>
<td>20.0</td>
<td>10.0</td>
</tr>
<tr>
<td>Paid full-time (%) *</td>
<td>57.1</td>
<td>50.8</td>
<td>14.3</td>
<td>56.2</td>
<td>52.0</td>
<td>18.1</td>
<td>4.2</td>
<td>39.1</td>
<td>58.3</td>
<td>46.6</td>
<td>22.9</td>
<td>0</td>
<td>20.0</td>
<td>35.5</td>
</tr>
<tr>
<td>Paid part-time (%) *</td>
<td>32.1</td>
<td>36.0</td>
<td>71.4</td>
<td>25.0</td>
<td>28.0</td>
<td>9.7</td>
<td>2.8</td>
<td>46.0</td>
<td>16.7</td>
<td>39.7</td>
<td>39.6</td>
<td>50.0</td>
<td>40.0</td>
<td>29.0</td>
</tr>
<tr>
<td>Paid casual (%) *</td>
<td>0</td>
<td>5.8</td>
<td>0</td>
<td>6.2</td>
<td>10.7</td>
<td>0.7</td>
<td>1.4</td>
<td>3.4</td>
<td>0</td>
<td>5.2</td>
<td>7.3</td>
<td>50.0</td>
<td>20.0</td>
<td>4.7</td>
</tr>
<tr>
<td>Volunteering (%) *</td>
<td>0</td>
<td>1.6</td>
<td>14.3</td>
<td>6.2</td>
<td>2.7</td>
<td>68.8</td>
<td>88.9</td>
<td>1.1</td>
<td>8.3</td>
<td>3.4</td>
<td>15.6</td>
<td>0</td>
<td>0</td>
<td>23.9</td>
</tr>
<tr>
<td>Direct service delivery (%) *</td>
<td>82.1</td>
<td>82.5</td>
<td>42.9</td>
<td>87.5</td>
<td>81.3</td>
<td>82.6</td>
<td>72.2</td>
<td>74.7</td>
<td>66.7</td>
<td>74.1</td>
<td>70.8</td>
<td>0</td>
<td>40.0</td>
<td>77.6</td>
</tr>
</tbody>
</table>

NB. Organisation codes represent: 1 – DH/DHS Victorian bushfire case managers; 2 – Australian Psychological Society; 3 – Occupational Therapy Australia; 4 – Royal Australian College of General Practitioners / Australian College of Rural and Remote Medicine / General Practice Networks / Medical Observer; 5 – Australian Nursing Federation; 6 – Victorian Council of Churches; 7 – Australian Red Cross; 8 – Australian Association of Social Workers; 9 – Royal Australian and New Zealand College of Psychiatrists; 10 – Australian College of Mental Health Nurses; 11 – Australian Counselling Association; 12 – Beyondblue; 13 – Victorian Council of Social Service / VICSERV / Australian Health Workforce Institute; * relating to the primary role of relevance to disasters
Table D3: Demographic Victorian membership profiles of participating organisations (available comparison data)

<table>
<thead>
<tr>
<th></th>
<th>APS</th>
<th>APS DRN *</th>
<th>ACA</th>
<th>RANZCP b</th>
<th>AASW</th>
<th>Red Cross c</th>
<th>VCC d</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean age (years)</td>
<td>45.1</td>
<td>52</td>
<td>45-50</td>
<td>54</td>
<td>50.2</td>
<td>60</td>
<td>48-58</td>
</tr>
<tr>
<td>Gender female (%)</td>
<td>78.7</td>
<td>81.5</td>
<td>75</td>
<td>38</td>
<td>80.6</td>
<td>85</td>
<td>44</td>
</tr>
<tr>
<td>Gender male (%)</td>
<td>21.3</td>
<td>18.5</td>
<td>25</td>
<td>62</td>
<td>19.4</td>
<td>15</td>
<td>56</td>
</tr>
<tr>
<td>Postgraduate qualified (%)</td>
<td>55.6</td>
<td>43.0</td>
<td>-</td>
<td>100</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

*Victorian members of the APS Disaster Response Network; bVictorian members of the RANZCP Disaster Referral Directory; cVictorian Red Cross Emergency Services volunteers; dVictorian Council of Churches Emergency Ministry volunteers
APPENDIX E: REGIONAL DISASTER MENTAL HEALTH CAPACITY

EXPERIENCE WORKING WITH DISASTER SURVIVORS (BY REGION)

Figure E1: Level of experience working with disaster survivors (by region)
UNDERSTANDING OF DISASTER ASPECTS (BY REGION)

Figure E2: Level of understanding of disaster impact on individuals (by region)

Figure E3: Level of understanding of disaster impact on communities (by region)
Figure E4: Level of understanding of disaster mental health consequences (by region)

- Barwon South West (n=59)
- Gippsland (n=54)
- Gippsland (n=42)
- Hume (n=63)
- Loddon Mallee (n=60)
- Eastern Metropolitan (n=216)
- North & West Metropolitan (n=251)
- Southern Metropolitan (n=129)

- Hardly any understanding
- A little
- Reasonable
- Considerable
- Excellent understanding

Figure E5: Level of understanding of disaster preparedness (by region)

- Barwon South West (n=59)
- Gippsland (n=54)
- Gippsland (n=42)
- Hume (n=63)
- Loddon Mallee (n=60)
- Eastern Metropolitan (n=216)
- North & West Metropolitan (n=251)
- Southern Metropolitan (n=129)

- Hardly any understanding
- A little
- Reasonable
- Considerable
- Excellent understanding
Figure E6: Level of understanding of disaster recovery (by region)

Figure E7: Level of understanding of emergency management (by region)
Figure E8: Level of understanding of organisational emergency plan (by region)

Figure E9: Level of understanding of local area emergency plan (by region)
Figure E10: Level of understanding of regional and state emergency plans (by region)
Figure E11: Number of respondents trained at Levels 1-3 (by region)

Figure E12: Number of respondents providing Level 1-3 interventions (by region)
CONFIDENCE TO PROVIDE INTERVENTIONS (BY REGION)

Figure E13: Level of confidence to provide Level 1-3 interventions (by region)

INTEREST IN PROVIDING INTERVENTIONS (BY REGION)

Figure E14: Level of interest in providing Level 1-3 interventions (by region)
Figure E15: Capacity to participate in disaster mental health responses - Face-to-face service delivery (by region)

Figure E16: Capacity to participate in disaster mental health responses - Telemental health (by region)
Figure E17: Capacity to participate in disaster mental health responses - Outreach to affected areas (by region)

Figure E18: Capacity to participate in disaster mental health responses - One-off visits to affected areas (by region)
Figure E19: Capacity to participate in disaster mental health responses - Ability to relocate temporarily (by region)
Figure E20: Maximum reach of service provision - Face-to-face service delivery (by region)

Figure E21: Maximum reach of service provision - Telemental health (by region)
Figure E22: Maximum reach of service provision - Outreach to affected areas (by region)

Figure E23: Maximum reach of service provision - One-off visits to affected areas (by region)
Figure E24: Maximum reach of service provision - Ability to relocate temporarily (by region)
Organisation codes represent:
1 – DH/DHS Victorian bushfire case managers; 2 – Australian Psychological Society; 3 – Occupational Therapy Australia; 4 – Royal Australian College of General Practitioners / Australian College of Rural and Remote Medicine / General Practice Networks / Medical Observer; 5 – Australian Nursing Federation (Victoria Branch); 6 – Victorian Council of Churches; 7 – Australian Red Cross; 8 – Australian Association of Social Workers; 9 – Royal Australian and New Zealand College of Psychiatrists; 10 – Australian College of Mental Health Nurses; 11 – Australian Counselling Association; 12 – Beyondblue; 13 – Victorian Council of Social Service / VICSERV / Australian Health Workforce Institute.

The respective denominator for each organisation is listed in Table D2 in Appendix D.
Figure F2: Level of understanding of disaster impact on individuals (by organisation)

Figure F3: Level of understanding of disaster impact on communities (by organisation)

Organisation codes represent:
1 – DH/DHS Victorian bushfire case managers; 2 – Australian Psychological Society; 3 – Occupational Therapy Australia;
4 – Royal Australian College of General Practitioners / Australian College of Rural and Remote Medicine / General Practice Networks / Medical Observer; 5 – Australian Nursing Federation (Victoria Branch); 6 – Victorian Council of Churches;
7 – Australian Red Cross; 8 – Australian Association of Social Workers; 9 – Royal Australian and New Zealand College of Psychiatrists;
10 – Australian College of Mental Health Nurses; 11 – Australian Counselling Association; 12 – Beyondblue;
13 – Victorian Council of Social Service / VICSERV / Australian Health Workforce Institute.

The respective denominator for each organisation is listed in Table D2 in Appendix D.
Organisation codes represent:
1 – DH/DHS Victorian bushfire case managers;  2 – Australian Psychological Society;  3 – Occupational Therapy Australia;
4 – Royal Australian College of General Practitioners / Australian College of Rural and Remote Medicine / General Practice Networks / Medical Observer;  5 – Australian Nursing Federation (Victoria Branch);  6 – Victorian Council of Churches;
7 – Australian Red Cross;  8 – Australian Association of Social Workers;  9 – Royal Australian and New Zealand College of Psychiatrists;
10 – Australian College of Mental Health Nurses;  11 – Australian Counselling Association;  12 – Beyondblue;
13 – Victorian Council of Social Service / VICSERV / Australian Health Workforce Institute.
The respective denominator for each organisation is listed in Table D2 in Appendix D.
Figure F6: Level of understanding of disaster recovery (by organisation)

Figure F7: Level of understanding of emergency management (by organisation)

Organisation codes represent:
1 – DH/DHS Victorian bushfire case managers; 2 – Australian Psychological Society; 3 – Occupational Therapy Australia; 4 – Royal Australian College of General Practitioners / Australian College of Rural and Remote Medicine / General Practice Networks / Medical Observer; 5 – Australian Nursing Federation (Victoria Branch); 6 – Victorian Council of Churches; 7 – Australian Red Cross; 8 – Australian Association of Social Workers; 9 – Royal Australian and New Zealand College of Psychiatrists; 10 – Australian College of Mental Health Nurses; 11 – Australian Counselling Association; 12 – Beyondblue; 13 – Victorian Council of Social Service / VICSERV / Australian Health Workforce Institute.

The respective denominator for each organisation is listed in Table D2 in Appendix D.
Figure F8: Level of understanding of organisational emergency plan (by organisation)

Figure F9: Level of understanding of local area emergency plan (by organisation)

Organisation codes represent:
1 – DH/DHS Victorian bushfire case managers;  2 – Australian Psychological Society;   3 – Occupational Therapy Australia;
4 – Royal Australian College of General Practitioners / Australian College of Rural and Remote Medicine / General Practice
Networks / Medical Observer;  5 – Australian Nursing Federation (Victoria Branch);  6 – Victorian Council of Churches;
7 – Australian Red Cross;  8 – Australian Association of Social Workers;  9 – Royal Australian and New Zealand College of Psychiatrists;
10 – Australian College of Mental Health Nurses;  11 – Australian Counselling Association;  12 – Beyondblue;
13 – Victorian Council of Social Service / VICSERV / Australian Health Workforce Institute.

The respective denominator for each organisation is listed in Table D2 in Appendix D.
Figure F10: Level of understanding of regional and state emergency plans (by organisation)

Organisation codes represent:
1 – DH/DHS Victorian bushfire case managers; 2 – Australian Psychological Society; 3 – Occupational Therapy Australia; 4 – Royal Australian College of General Practitioners / Australian College of Rural and Remote Medicine / General Practice Networks / Medical Observer; 5 – Australian Nursing Federation (Victoria Branch); 6 – Victorian Council of Churches; 7 – Australian Red Cross; 8 – Australian Association of Social Workers; 9 – Royal Australian and New Zealand College of Psychiatrists; 10 – Australian College of Mental Health Nurses; 11 – Australian Counselling Association; 12 – Beyondblue; 13 – Victorian Council of Social Service / VICSERV / Australian Health Workforce Institute.

The respective denominator for each organisation is listed in Table D2 in Appendix D.
TRAINING AND INTERVENTION LEVELS (BY ORGANISATION)

Figure F11: Number of respondents trained at Levels 1-3 (by organisation)

![Graph showing number of respondents trained at Levels 1-3 by organisation]

Figure F12: Number of respondents providing Level 1-3 interventions (by organisation)

![Graph showing number of respondents providing Level 1-3 interventions by organisation]

Organisation codes represent:
1 – DH/DHS Victorian bushfire case managers; 2 – Australian Psychological Society; 3 – Occupational Therapy Australia; 4 – Royal Australian College of General Practitioners / Australian College of Rural and Remote Medicine / General Practice Networks / Medical Observer; 5 – Australian Nursing Federation (Victoria Branch); 6 – Victorian Council of Churches; 7 – Australian Red Cross; 8 – Australian Association of Social Workers; 9 – Royal Australian and New Zealand College of Psychiatrists; 10 – Australian College of Mental Health Nurses; 11 – Australian Counselling Association; 12 – Beyondblue; 13 – Victorian Council of Social Service / VICSERV / Australian Health Workforce Institute.

The respective denominator for each organisation is listed in Table D2 in Appendix D.
CONFIDENCE AND INTEREST IN PROVIDING LEVEL 1-3 INTERVENTIONS (BY ORGANISATION)

Figure F13: Level of confidence to provide Level 1-3 interventions (by organisation)

Figure F14: Level of interest in providing Level 1-3 interventions (by organisation)

Organisation codes represent:
1 – DH/DHS Victorian bushfire case managers; 2 – Australian Psychological Society; 3 – Occupational Therapy Australia; 4 – Royal Australian College of General Practitioners / Australian College of Rural and Remote Medicine / General Practice Networks / Medical Observer; 5 – Australian Nursing Federation (Victoria Branch); 6 – Victorian Council of Churches; 7 – Australian Red Cross; 8 – Australian Association of Social Workers; 9 – Royal Australian and New Zealand College of Psychiatrists; 10 – Australian College of Mental Health Nurses; 11 – Australian Counselling Association; 12 – Beyondblue; 13 – Victorian Council of Social Service / VICSERV / Australian Health Workforce Institute.

The respective denominator for each organisation is listed in Table D2 in Appendix D.
CAPACITY TO PARTICIPATE IN DISASTER MENTAL HEALTH RESPONSES (BY ORGANISATION)

Figure F15: Capacity to participate in disaster mental health responses - Face-to-face service delivery (by organisation)

![Bar chart showing the capacity of organisations to participate in disaster mental health responses - Face-to-face service delivery.](chart1)

- **No capacity**
- **Slight capacity**
- **Moderate capacity**
- **High capacity**
- **Very high capacity**

Figure F16: Capacity to participate in disaster mental health responses - Telemental health (by organisation)

![Bar chart showing the capacity of organisations to participate in disaster mental health responses - Telemental health.](chart2)

- **No capacity**
- **Slight capacity**
- **Moderate capacity**
- **High capacity**
- **Very high capacity**

Organisation codes represent:

1 – DH/DHS Victorian bushfire case managers; 2 – Australian Psychological Society; 3 – Occupational Therapy Australia; 4 – Royal Australian College of General Practitioners / Australian College of Rural and Remote Medicine / General Practice Networks / Medical Observer; 5 – Australian Nursing Federation (Victoria Branch); 6 – Victorian Council of Churches; 7 – Australian Red Cross; 8 – Australian Association of Social Workers; 9 – Royal Australian and New Zealand College of Psychiatrists; 10 – Australian College of Mental Health Nurses; 11 – Australian Counselling Association; 12 – Beyond Blue; 13 – Victorian Council of Social Service / VICSERV / Australian Health Workforce Institute.

The respective denominator for each organisation is listed in Table D2 in Appendix D.
Figure F17: Capacity to participate in disaster mental health responses - Outreach to affected areas (by organisation)

Figure F18: Capacity to participate in disaster mental health responses - One-off visits to affected areas (by organisation)

Organisation codes represent:
1 – DH/DHS Victorian bushfire case managers; 2 – Australian Psychological Society; 3 – Occupational Therapy Australia; 4 – Royal Australian College of General Practitioners / Australian College of Rural and Remote Medicine / General Practice Networks / Medical Observer; 5 – Australian Nursing Federation (Victoria Branch); 6 – Victorian Council of Churches; 7 – Australian Red Cross; 8 – Australian Association of Social Workers; 9 – Royal Australian and New Zealand College of Psychiatrists; 10 – Australian College of Mental Health Nurses; 11 – Australian Counselling Association; 12 – BeyondBlue; 13 – Victorian Council of Social Service / VICSERV / Australian Health Workforce Institute.

The respective denominator for each organisation is listed in Table D2 in Appendix D.
Figure F19: Capacity to participate in disaster mental health responses - Ability to relocate temporarily (by organisation)

Organisation codes represent:
1 – DH/DHS Victorian bushfire case managers; 2 – Australian Psychological Society; 3 – Occupational Therapy Australia; 4 – Royal Australian College of General Practitioners / Australian College of Rural and Remote Medicine / General Practice Networks / Medical Observer; 5 – Australian Nursing Federation (Victoria Branch); 6 – Victorian Council of Churches; 7 – Australian Red Cross; 8 – Australian Association of Social Workers; 9 – Royal Australian and New Zealand College of Psychiatrists; 10 – Australian College of Mental Health Nurses; 11 – Australian Counselling Association; 12 – Beyondblue; 13 – Victorian Council of Social Service / VICSERV / Australian Health Workforce Institute.

The respective denominator for each organisation is listed in Table D2 in Appendix D.
Figure F20: Maximum reach of service provision - Face-to-face service delivery (by organisation)

Figure F21: Maximum reach of service provision - Telemental health (by organisation)

Organisation codes represent:
1 – DH/DHS Victorian bushfire case managers; 2 – Australian Psychological Society; 3 – Occupational Therapy Australia;
4 – Royal Australian College of General Practitioners / Australian College of Rural and Remote Medicine / General Practice Networks / Medical Observer; 5 – Australian Nursing Federation (Victoria Branch); 6 – Victorian Council of Churches;
7 – Australian Red Cross; 8 – Australian Association of Social Workers; 9 – Royal Australian and New Zealand College of Psychiatrists;
10 – Australian College of Mental Health Nurses; 11 – Australian Counselling Association; 12 – Beyondblue;
13 – Victorian Council of Social Service / VICSERV / Australian Health Workforce Institute.

The respective denominator for each organisation is listed in Table D2 in Appendix D.
Figure F22: Maximum reach of service provision - Outreach to affected areas (by organisation)

Figure F23: Maximum reach of service provision - One-off visits to affected areas (by organisation)

Organisation codes represent:
1 – DH/DHS Victorian bushfire case managers;  2 – Australian Psychological Society;  3 – Occupational Therapy Australia;
4 – Royal Australian College of General Practitioners / Australian College of Rural and Remote Medicine / General Practice Networks / Medical Observer;  5 – Australian Nursing Federation (Victoria Branch);  6 – Victorian Council of Churches;
7 – Australian Red Cross;  8 – Australian Association of Social Workers;  9 – Royal Australian and New Zealand College of Psychiatrists;
10 – Australian College of Mental Health Nurses;  11 – Australian Counselling Association;  12 – BeyondBlue;
13 – Victorian Council of Social Service / VICSERV / Australian Health Workforce Institute.

The respective denominator for each organisation is listed in Table D2 in Appendix D.
Figure F24: Maximum reach of service provision - Ability to relocate temporarily (by organisation)

Organisation codes represent:
1 – DH/DHS Victorian bushfire case managers; 2 – Australian Psychological Society; 3 – Occupational Therapy Australia; 4 – Royal Australian College of General Practitioners / Australian College of Rural and Remote Medicine / General Practice Networks / Medical Observer; 5 – Australian Nursing Federation (Victoria Branch); 6 – Victorian Council of Churches; 7 – Australian Red Cross; 8 – Australian Association of Social Workers; 9 – Royal Australian and New Zealand College of Psychiatrists; 10 – Australian College of Mental Health Nurses; 11 – Australian Counselling Association; 12 – Beyondblue; 13 – Victorian Council of Social Service / VICSERV / Australian Health Workforce Institute.

The respective denominator for each organisation is listed in Table D2 in Appendix D.