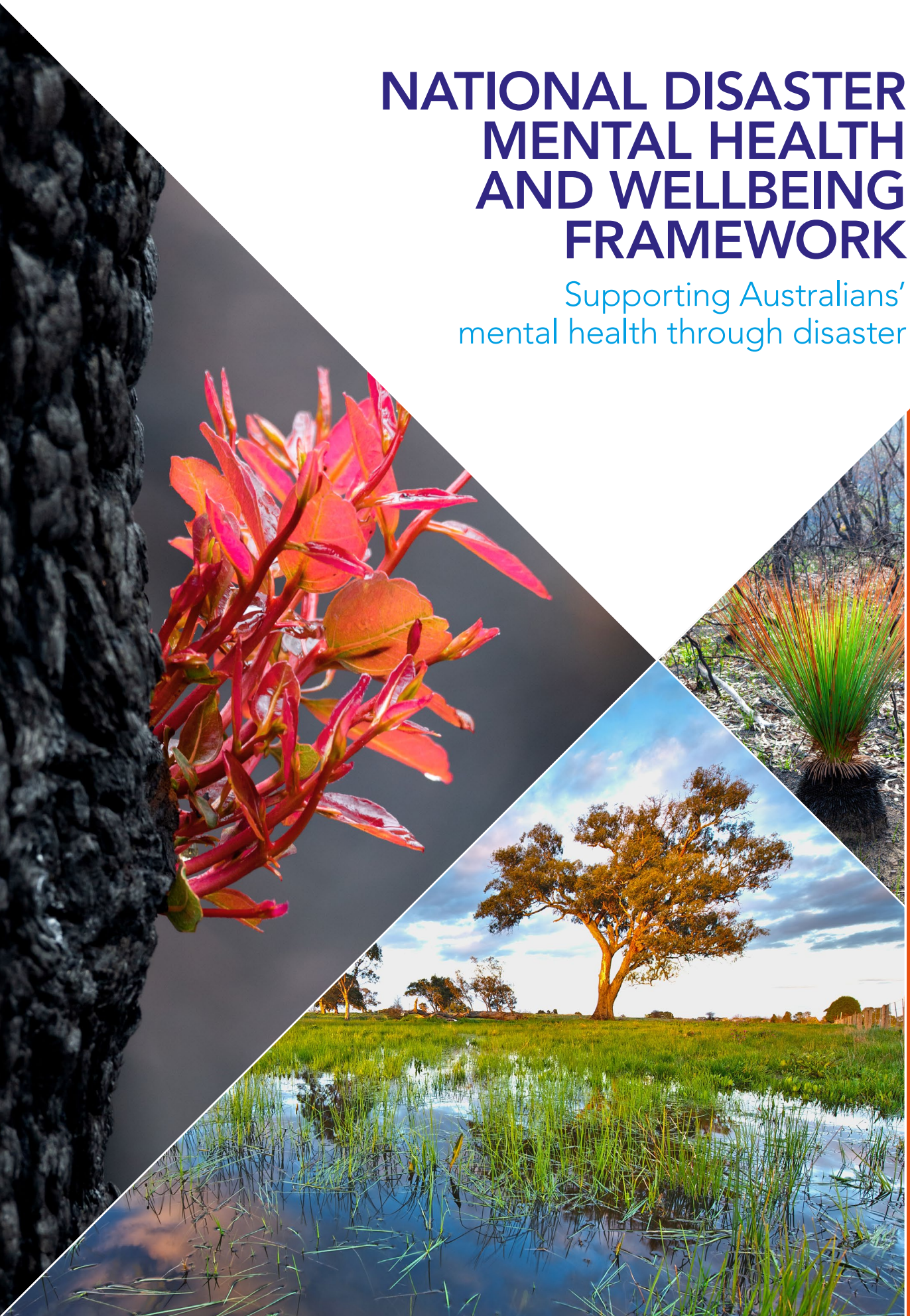
Australian Government
National Mental Health Commission

National Disaster
Mental Health and
Wellbeing Framework

NATIONAL DISASTER MENTAL HEALTH AND WELLBEING FRAMEWORK

Supporting Australians' mental health through disaster



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1. FRAMEWORK PURPOSE

To guide how governments and recovery partners can consistently support mental health and wellbeing before, during and after disasters

2. FRAMEWORK IN CONTEXT

2.1 INTRODUCTION

The Australian Government announced the development of a ***National Disaster Mental Health and Wellbeing Framework*** (the Framework) on 12 January 2020, as part of a package of mental health measures responding to the widespread and destructive 'Black Summer' bushfires in 2019-20. As in many parts of the world, Australia is experiencing an increased frequency, severity, and impact of climate-influenced disasters.[1] Catastrophic fires, floods, cyclones, droughts, heat waves, landslides, hailstorms, plagues and the current pandemic have all occurred recently. Rural and remote communities with limited services have been harshly affected. The Framework helps prepare Australia for this changing environment.

In an emergency, many people and organisations rush to assist; but assisting can be complex, with different levels of government and communities working across state and regional boundaries, in settings where transport and communications are damaged and people are experiencing multiple adversities. Often the aftermath of a disaster, including the economic and social disruption and the stress associated with locating help, can be as challenging as the impact of the disaster itself.

People's mental health and wellbeing following disasters is dependent on collaborative and well-coordinated action by all recovery partners. While it is well-recognised that social factors can strengthen or undermine people's health, including mental health, this is particularly evident following a disaster where so many people are affected. This Framework focuses on action to support individuals as well as action to strengthen families and communities given the evidence clearly indicating that community connections are vital to recovery, adaptation, and resilience in the future.

The Framework takes forward the ***Royal Commission into National Natural Disaster Arrangements*** (the Royal Commission) Recommendation 15.3, which seeks refined cross-jurisdictional arrangements to support localised planning and delivery of mental health services before, during and after a disaster.

It takes as a starting point the influential United Nations Inter-Agency Standing Committee (UN IASC) intervention pyramid, and adapts this for the Australian context where distance and remoteness make the planning and prevention phase particularly important.

The Framework recognises the centrality of land, culture and environment to Aboriginal and Torres Strait Islander people's wellbeing and drives towards genuine partnerships between Aboriginal and Torres Strait Islander people, organisations and all recovery partners. It acknowledges that Indigenous-led approaches should be integrated into collaborative responses to mental health and wellbeing following disasters.

People's mental health and wellbeing following disasters is dependent on collaborative and well-coordinated action by all recovery partners.

2.2 USING THE FRAMEWORK

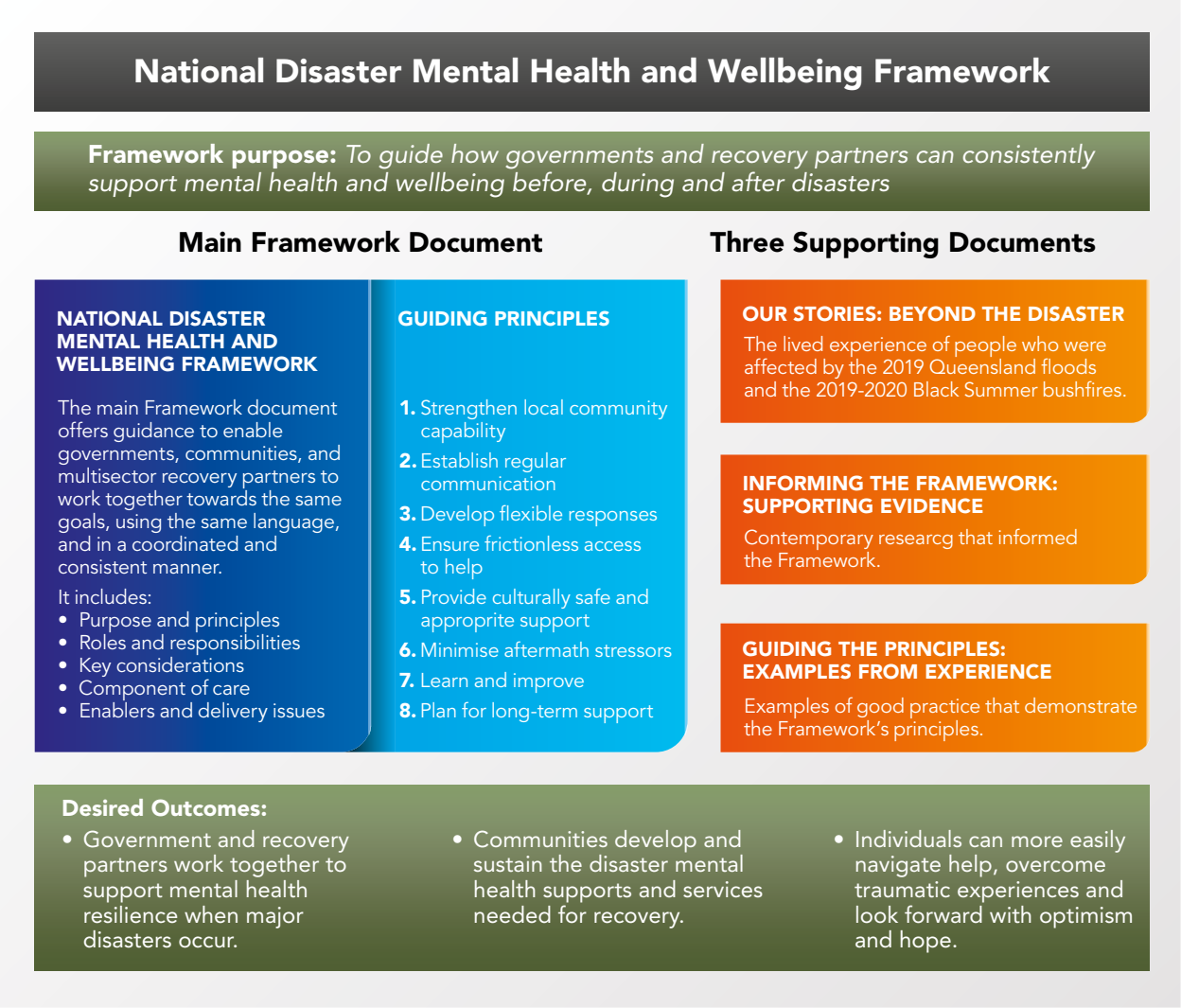
The Framework is designed to provide succinct guidance and useful reference material to support recovery workers in the context of a disaster. This document is accompanied by three others as shown in Figure 1. The supporting documents summarise the evidence base which, along with direct input from recovery organisations and experts, shaped the Framework.

Implementation requires a joint and collaborative approach by all levels of government and communities:

- The Australian Government can use the Framework in planning for and managing emergencies.
- State and territory governments can integrate the Framework in their own policies and plans.
- Local governments and regional bodies such as Primary Health Networks and recovery committees can adopt Framework elements into their own strategies.
- Community-based organisations, charities and the private sector can use the Framework as guidance.

Over time, it is hoped the Framework will become a touchstone for governments and all recovery partners in preparing for and supporting mental health and wellbeing in the context of disasters. It is designed to be deployed, adapted and built on by all.

FIGURE 1 THE FRAMEWORK AND SUPPORTING DOCUMENTS



2.3 LEGISLATIVE AND POLICY CONTEXT

The *National Disaster Mental Health and Wellbeing Framework* has been endorsed by the Australian, state and territory governments and operates within Australia's existing system of legislative and regulatory governance, which includes international agreements that Australia has signed.

Responsibility for all aspects of emergency management and recovery is shared between governments, individuals, industry, non-government organisations and communities. A 'collaborative governance' approach informs the many flexible ways these partners work together.

The Australian Government Crisis Management Framework (AGCMF) outlines the Australian Government's approach to preparing for, responding to and recovering from crisis events. It provides ministers and senior officials with guidance on their respective roles and responsibilities. It also sets out the arrangements that link ministerial responsibility to the work of key officials, committees and facilities. Other relevant frameworks include the *National Disaster Risk Reduction Framework*, the *Australian Disaster Preparedness Framework*, and the forthcoming *National Recovery Framework*.

States and territories have the lead role in emergency planning and coordination, but have recourse to national support on a cost-sharing basis for financial and non-financial assistance. Each state and territory has different emergency management arrangements for relief and recovery. These span multiple departmental structures and including a range of capabilities.

The Framework also aims to guide good practice in any disasters, large or small.

Within health, cross-jurisdictional agreements such as the National Health Emergency Response Arrangements 2011 (NatHealth Arrangements) and the National Health Security Agreement 2011 direct how the Australian health sector collaborates to prepare and respond to emergencies of national consequence. The Framework is consistent with these agreements. States and territories have their own detailed legislation governing decision-making in a health emergency, and it is expected that they would adapt and integrate the Framework in a manner that suits their context.

Key agreements such as the Closing the Gap Agreement which mandates partnership with Aboriginal and Torres Strait Islander community organisations are also relevant to the Framework's implementation. They need to be reflected in place-based responses, including engagement with Aboriginal and Torres Strait Islander communities and community controlled organisations in developing and delivering mental health and wellbeing supports following a disaster.

2.4 FRAMEWORK SCOPE

2.4.1 NATIONAL

The Framework's scope is 'national disasters'. It applies to any disaster that triggers national coordination mechanisms, including response or recovery assistance, under existing nationally agreed plans in the health and emergency management sectors. This includes but is not limited to incidents coordinated under the NatHealth Arrangements, when the Australian Disaster Response Plan (COMDISPLAN) is activated or when Disaster Recovery Funding Arrangements (DRFA) are activated.

The Framework also aims to guide good practice in any disaster, large or small. A key purpose of the Framework is to achieve consistent responses for all Australians who experience a major emergency or hazard, including disasters managed by a single state or territory, or a local event, that do not trigger national coordination mechanisms.

2.4.2 ALL-HAZARDS

The all-hazards approach means the focus is on the impact of an incident, hazard or emergency, rather than being limited to a specific type of event (such as natural hazards). In other words, it is applicable to the full spectrum of emergencies or disasters. This scope is consistent with contemporary Australian and international disaster frameworks, such as the ***Australian Government Crisis Management Framework*** whose scope includes (but is not limited to):

> terrorist incidents, cyber incidents, health pandemics, animal diseases, natural disasters and incidents affecting Australians and/or Australian interests overseas.[2]

2.4.3 RECOVERY PHASES

In recent years the concept of 'recovery as restoration' has been supplemented by a focus on the opportunities disasters may create for communities to 'build back better'. The World Health Organisation (WHO) notes that in developing countries:

> *The surge of aid, combined with sudden, focused attention on the mental health of the population, creates unparalleled opportunities to transform mental health care for the long term.*[3]

FIGURE 2 COMMUNITY CAPACITY BUILDING OVER TIME

The lessons learned in a disaster or emergency situation will ideally build community capability over time. ***Not*** learning such lessons was a frustration highlighted in the National Mental Health Commission's research.

At the same time, research also indicates that individual and community experiences of a disaster vary greatly and progress differently.

At an individual level, recovery is not linear and can be a lengthy process. Some people feel they never recover. Successive or simultaneous disasters can act as triggers, create fears about the future and amplify adverse effects. And individual and community recovery can take different trajectories.

Alternatively, some people describe their experiences post-disaster as ones of evolution or transformation, both for themselves and their community. The Framework often uses the language of 'before; during; and after' a disaster in order to respect people's varied experiences.[4] Alternative language is relevant to other contexts.

2.5 CONSIDERATIONS IN PROVIDING DISASTER MENTAL HEALTH AND WELLBEING SUPPORT

2.5.1 PSYCHOLOGICAL IMPACTS OF DISASTER

People show considerable resilience in the face of potentially traumatic events, especially when they are able to meet basic needs, access social supports and re-establish community networks quickly. In Australia, a major study found that one decade after the 2009 Black Saturday bushfires nearly two-thirds of people felt that they were 'fully' or 'mostly' recovered.[5] Some reported stronger relationships and had experienced a positive transformation in their lives.

However, Australian and international research also shows how disasters and their aftermath can erode mental and emotional health and wellbeing. Short-term distress responses are common, and long-term and severe mental health problems are experienced by a significant minority.[6] See *Informing the Framework - Supporting Evidence*.

For people who already experience mental ill-health (one in five of the population aged 16 years and over), the stress of the disaster and disruption to usual support can lead to a worsening of symptoms.

The Framework addresses services and supports for distress, anxiety and grief as well as for clinically diagnosable mental illness.

Everyone's response to traumatic incidents, such as a disaster, is unique and influenced by their personal history, their context and the protective factors in their life. Exposure to historical, repeat and successive trauma events as experienced by refugees, survivors of family violence, and emergency services workers can be particularly challenging. Population groups such as Aboriginal and Torres Strait Islander people may experience cumulative impacts due to previous exposure to trauma, as well as unique vulnerabilities arising from loss of cultural heritage and social disadvantage.

In short, the Framework addresses the mental health and wellbeing needs of individuals, families and communities who, because of exposure to a hazard with potentially disastrous impacts, are exposed to severe stress and/or who face a crisis outside the bounds of their everyday coping strategies.

Everyone's response to traumatic incidents such as a disaster is unique and influenced by their personal history, their context and the protective factors in their life.

2.5.2 MENTAL HEALTH AND WELLBEING RESPONSE CHALLENGES DURING DISASTERS

People experiencing crisis situations need the opportunity to access several layers of support, from informal family and community support to more specialised services. Formal services and supports available during and following a disaster are not always planned in advance or are well-aligned to community needs. The timeliness of services is critical. Administration and funding processes can mean services are available too late or for too short a period, with people on long waiting lists. Access challenges can arise from poor planning and coordination, inconsistent funding, eligibility barriers, and workforce shortages. Services may not be sufficiently tailored to the local geographic, economic and social context or the preferences and needs of people affected by the disaster.

For this reason, local services with an existing client base and pre-existing relationships within the service ecosystem are favoured, if available, and assuming a surge in demand can be handled. Both local government staff and other local workers may be dealing personally with the same disaster which can limit their capacity to help others (although their first-hand experiences can also allow them to connect strongly with those in need).

Proactive outreach is necessary since stigma remains a barrier to people accessing support and treatment for mental ill-health. People may be distressed but reluctant to seek help because of how this may be perceived by friends and workmates, or because they feel others are more deserving. Many people deal first with their and their families' physical health issues, and for some groups (e.g. emergency workers) mental health challenges are commonly uncovered this way. Upskilling community members to identify common stress reactions, signs and symptoms of mental ill-health is beneficial on an ongoing basis since mental health challenges can emerge a long time after the initial event.

Finally, it is important to minimise the secondary stress that comes from repeated efforts to navigate complicated sources of help. Services that are welcoming, non-judgmental, flexible and able to connect with an individual's needs at the right time can be a major boost and help people re-establish a sense of efficacy and control.

2.5.3 POTENTIAL DISASTER-RELATED MENTAL HEALTH SUPPORT NEEDS OF SPECIFIC POPULATIONS

It is well-known that different population groups are likely to experience disasters differently. This can be for historical, cultural and social reasons, because they are more or less socially isolated, or alternatively, are better protected by strong social ties, good access to economic resources and family support. The Framework emphasises flexible, tailored responses at every point of planning, implementation and delivery to reach all people in need.

Research (see *Informing the Framework - Supporting Evidence*) indicates certain characteristics, context and experiences may put specific groups at greater risk of experiencing mental ill-health related to a disaster. These include people with:

- severe or repeated exposure to a disaster and related traumatic events
- prior mental ill-health and/or disability
- female gender
- Aboriginal and Torres Strait Islander people ethnic minority status
- lower socio-economic status
- certain ages (specifically infants, children and young people, and adults of middle age)

All groups need to be carefully included in planning and preparation to make sure effective communication, service capacity, training of recovery personnel and their specific experience of a disaster event are well-understood prior to a disaster and don't become barriers to access and support.

People experiencing crisis situations need the opportunity to access several layers of support, from informal family and community support to more specialised services.

2.6 GUIDING PRINCIPLES

The Framework has eight Guiding Principles. These align to the 2018 Australian National Principles for Disaster Recovery (shown in the left-hand column) but are more specific to mental health service provision. Below the principles are highlighted, together with explanation of what they mean in practice.

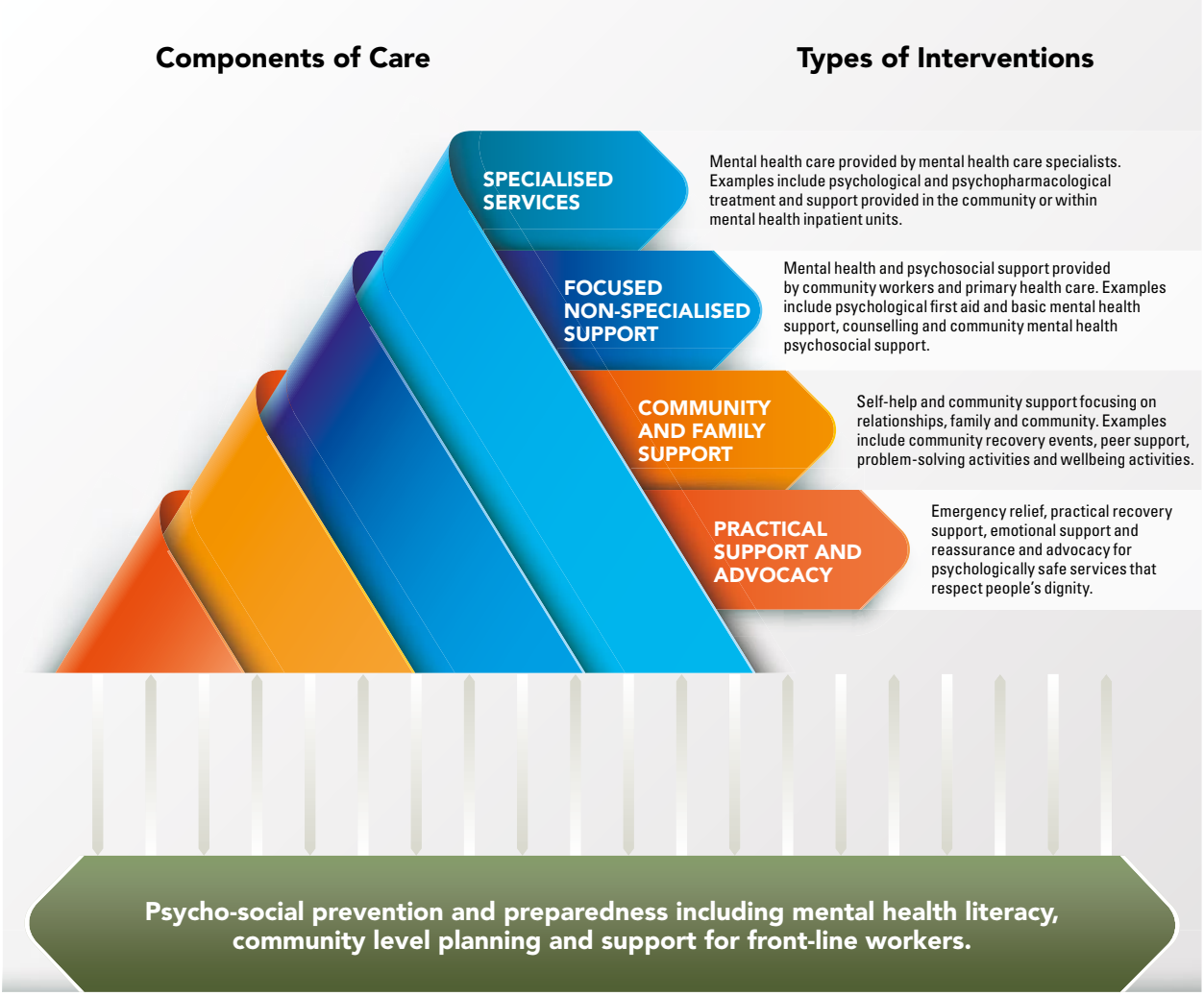
Alignment to National Principles for Disaster Recovery	National Disaster Mental Health and Wellbeing Framework Guiding Principles
Acknowledge and build capacity	1. **Strengthen local community capability:** Develop and strengthen local community capability for mental health and wellbeing preparedness, response and recovery. Workers and community leaders with local knowledge and strong inter-personal relationships are vital to this.
Communicate effectively	2. **Establish regular communication:** Regular communication (via multiple means) from a trusted source of information is essential to reduce confusion. Information and resources that can be adapted locally should be provided in a coordinated way for tailoring by each community. Both physical and mental health needs should be considered to ensure an integrated approach. Exaggerated and emotive imagery should be avoided in public communication.
Use community-led approaches	3. **Develop flexible mental health and wellbeing responses:** Mental health and wellbeing responses must be adapted to local and emerging conditions and be able to integrate flexibly with the wide range of businesses and services people use.
Coordinate all activities	4. **Ensure frictionless access to help:** Services should be welcoming and easy to access, particularly for those unsure of where to go. Eligibility should be clear and simple, and cross-service collaboration adopted widely to minimise the need for repeat story-telling and to ensure people can seamlessly access the most appropriate service for them.
Understand the context	5. **Provide culturally safe and appropriate support:** Recognise the cultural diversity within communities and prepare responses that are understandable, relatable and culturally respectful. Recognise the cumulative trauma and cultural impact of disaster on Aboriginal and Torres Strait Islander peoples, and ensure culturally safe and appropriate support is available.
Recognise complexity	6. **Minimise the impact of aftermath stressors:** Reducing the impact of aftermath stressors on people's mental health and wellbeing helps to improve recovery outcomes and reduce a person's risk of experiencing long-term mental ill-health. Coordination functions are essential to mitigate stress, duplication and practical difficulties in service delivery.
Acknowledge and build capacity	7. **Learn and improve:** What has been learned from previous disasters should guide community preparedness ahead of, during and after disasters. Ways to record lessons and share experiences with broad community involvement need to be agreed and publicised.
Recognise complexity	8. **Plan long-term following the disaster:** Planning and funding for the preparation, response and recovery from disasters, especially in relation to mental health and wellbeing, needs a long-term horizon, that is, over five to ten years.

3. RESPONDING TO NEED

3.1 KEY COMPONENTS OF CARE

'Components of care' refer to the main service types required in an integrated approach to mental health and wellbeing before, during and after disasters. The widely accepted four-component model of care developed by the UN IASC Reference Group on Mental Health and Psychosocial Support in Emergency Settings has been adapted, with the addition of psychosocial prevention and preparedness as a fifth component. Australia's vast distances, and the multi-level nature of its mental health governance make this fifth component particularly relevant in an Australian Framework.

FIGURE 3 THE UN IASC INTERVENTION PYRAMID FOR MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT IN EMERGENCIES (ADAPTED)



In considering components of care in a disaster it is important to note that:

- Psychosocial support including emotional and coping support and reassurance, self-help resources, peer support and community development are the foundational service types.
- Services become more focused, specialised and costly towards the tip of the pyramid
- A person's individual mental health response – and the type of support needed – will depend on the impact of the disaster event, their social networks, natural supports and individual circumstances.
- A service response is needed at all levels from the outset but immediately following a disaster it is likely that people will be mainly occupied with assistance at the pyramid's base.
- During their recovery process, people need to be able to step up or down their supports as needed, or they may need supports at several levels simultaneously.
- The role of mental health workers varies. At the preparedness and practical relief stages they collaborate with others to provide advice, training and advocacy, as well as emotional support and reassurance. At the pyramid's tip, they are the main providers and offer a specialised service response.

Evidence indicates dedicated psychological prevention and preparedness strategies can lessen the toll of major disasters on people's mental health and wellbeing.

The five levels of intervention are briefly described below.

3.1.1 PREVENTION AND PREPAREDNESS

Evidence indicates dedicated psychological prevention and preparedness strategies can lessen the toll of major disasters on people's mental health and wellbeing. For individuals and families this means equipping them with the ability to appropriately adjust response strategies through psychological preparedness activities that enable a better understanding of the impact of disasters and the potential psychological responses they may experience.

At a community and systems level, the following actions have been shown to strengthen individual and community resilience:

- community education to prepare people for disasters and share information about coping strategies
- local and regional planning for mental health responses to disasters including the needs of people with disabilities and existing mental health illnesses
- mapping help-seeking journeys post-disaster to provide insights that optimise service access and linkages
- establishing training and support systems for emergency services workers,[7] health care providers, local government and community service workers
- including community services and volunteer groups in multiagency disaster drills and exercises
- actively engaging young people as leaders in local psychosocial risk planning; and
- building mental health literacy among priority sections of the population with specific needs.

Psychological preparedness is particularly important in communities which are at risk of disaster due to social and environmental factors.[8] In Australia for example, droughts affect everyone but create more immediate and intense challenges for rural communities which experience water stress, and stock and financial losses. The above measures can build cooperation between services and increase everyone's knowledge of the local mental health and wellbeing ecosystem. Training and community education will also strengthen the community's ability to support people experiencing violence or trauma prior to a disaster.

3.1.2 PRACTICAL SUPPORT AND ADVOCACY

Practical support and advocacy following a disaster ensures people's basic needs are met and safety is maintained. It includes a range of disaster relief services, such as disaster evacuation and recovery centres, housing, food and urgent financial support. Such services are the first point of contact for emotional and mental health support. Providing smooth and efficient practical support is an important part of a mental health response.

The manner in which such services are designed and delivered to meet the needs of individuals, especially in priority groups, is critical. Careful consideration should be given to how people with disability will access services (including virtual services) following a disaster, how children and young people will be supported, and how communication with people whose digital access is limited or who communicate best in a language other than English.

Mental health worker involvement is critical in planning and participating in disaster relief services. The UN IASC identifies advocacy for 'safe, dignified, culturally and socially appropriate assistance' as a key responsibility for mental health-trained staff. Such staff can:

- highlight the social context of service provision
- advocate for and assist to establish child-friendly spaces in evacuation and recovery centers
- ensure people receive a caring, empathetic connection in a time of crisis
- identify ways to overcome barriers to help-seeking; and
- share the principles of trauma-informed care with those providing disaster relief.

Emotional support, reassurance and early intervention should be provided at this level, rather than through formal comprehensive debriefing or interviewing, which evidence indicates is not beneficial and should be avoided.[9] Emergency services workers need the skills to assist people in coping with stresses they are likely to feel following a disaster—as advocated in the IASC's 10-step stress reduction protocol.[10]

3.1.3 SUPPORT TARGETING COMMUNITIES AND FAMILIES

Community and family support focuses on rebuilding and strengthening relationships, and using the resources of people's immediate peer and community networks to help people recover together. The aim is to assist people to navigate and access formal support, build resilience, reconnect, and encourage each other's recovery efforts.

Research shows that people often seek help from volunteers, family or friends and encounters with people they trust who have had similar experiences and 'get it'.[11]

Evidence-informed considerations are:

- Building the capacity of existing community organisations and informal groups can be more effective than establishing new services. The former are well-placed to deal with the downstream impacts of disaster such as drug and alcohol issues and family violence, and are likely to have expertise in providing tailored help to different parts of the population.
- Topping up existing grants to local organisations makes planning, training, infrastructure changes and the employment of recovery workers happen faster and is more likely to build long-term capability.
- Where a community grants program is offered, a community co-design and decision-making process has been found to minimise community division, maximise inclusion, and streamline administration.
- Liaising with existing organisations also serves to keep government agencies connected to community needs as they change over time after the disaster event.

Research shows that people often seek help from volunteers, family or friends and encounters with people they trust who have had similar experiences and 'get it'.

3.1.4 FOCUSED NON-SPECIALISED SUPPORT

Focused non-specialised services utilise trained and supervised workers to provide support to individuals and families. Focused non-specialised services work to enhance collective and individual resilience in a disaster setting, as research indicates both are critical to buffering the mental health impacts of disasters.[12]

In Australia, General Practitioners and primary health care providers play a critical role in providing this type of support, and are a gateway to more specialised mental health support providers. Mental healthcare practitioners who are experienced at working with survivors of other trauma, such as motor vehicle accidents and violence, are also an important community resource for this component of care.

The emotional support, reassurance and early intervention provided through Psychological First Aid is an important distress response, highly valuable in addressing coping and short-medium term needs, while also preventing the escalation of psychological states to the point where longer term and clinical impacts occur.

Services such as counselling and psychotherapy also provide a mixture of emotional support and practical assistance in non-confronting community environments. Services suited to children and young people include family-centred interventions and play therapy, school interventions, cognitive behavioural therapy and use of therapeutic animals. Access to traditional and contemporary healing practices should be an option for Aboriginal and Torres Strait Islander people.

Peer or lived experience workers can also be a valuable component of psychosocial support as they offer a unique style of support based on the sharing of personal lived experience.

3.1.5 SPECIALISED SERVICES

Specialist clinical support involves targeted, specialist mental health care, delivered by mental health professionals to a small section of the population for whom mental health challenges have become persistent or acute.

These may include people with:

- emergency-induced mental ill-health: depression and anxiety disorders, (including acute stress disorder and PTSD), substance misuse, and sustained personality changes
- emergency-induced social problems (e.g., family separation; disruption of social networks; destruction of community structures, resources and trust; family violence); and
- people with pre-existing mental ill-health especially if the continuity of care provided by usual services and supports is disrupted[13]

It is important to note that the need for specialised mental health support can emerge many months or years following a disaster, emphasising the need for long-term funding horizons.

The emotional support, reassurance and early intervention provided through Psychological First Aid is an important distress response, highly valuable in addressing coping and short-medium term needs, while also preventing the escalation of psychological states to the point where longer term and clinical impacts occur.

3.2 STEPPED CARE AND THE UN IASC GUIDELINE

Stepped care is the nationally adopted model that informs mental health planning and service provision in Australia. Like the UN IASC guideline it is based on the idea that people's needs and preferences vary and the type of service provision should vary accordingly. The principles informing both stepped care and the UN IASC mental health and psychosocial support pyramid used in this Framework are similar. Both models:

- propose low-intensity supports as an early 'step', and then successively more intensive interventions and treatment if a person requires them; and
- emphasise that people need to be able to increase or reduce their level of support as their needs change.

However, specific to a disaster, the UN IASC guideline:

- has a large base, as the majority of the population is likely to need low intensity services following a significant crisis or trauma
- emphasises community, as well as individual and family, recovery, noting that in emergencies community connections (sometimes called 'social capital') are a critical resource which need to be nurtured and strengthened.

The following three-tiered matrix of psychological intervention and skills was developed through expert consensus to accompany the stepped care model of treatment and support following the Black Saturday bushfires.[14] It has been updated for this Framework to reflect emerging evidence on recent Level 2 interventions. The UN IASC pyramid and levels in the matrix align as follows:

- Levels 1 and 2 align with focused non-specialised support
- Levels 3 aligns with specialised services.

A three-tiered matrix of psychological intervention and skills was developed through expert consensus to accompany the stepped care model of treatment and support following the Black Saturday bushfires.

TABLE 1 THE THREE TIERED DISASTER MENTAL HEALTH RESPONSE MATRIX

PFA (Level 1)	SPR (Level 2)	SOLAR (Level 2)	PM+ (Level 2)	Intensive MH Treatments (Level 3)
Psychological First Aid	Skills for Psychological Recovery	Skills for Life Adjustment and Resilience	Problem Management Plus	Intensive Mental Health Treatments
Purpose Population level support of common distress responses in the immediate aftermath	**Purpose** Support of individuals with mild to moderate sub-clinical levels of distress	**Purpose** Support of individuals with ongoing distress, adjustment issues and sub-clinical mental health problems	**Purpose** Support of individuals with symptoms of common mental health problems and self-identified practical problems	**Purpose** Treatment of minority experiencing significant mental health conditions
Core Principles **1.** Promote safety **2.** Promote calming **3.** Promote self-efficacy **4.** Promote connectedness **5.** Promote hope **6.** Promote help	**Modules** **1.** Gathering information and prioritising assistance **2.** Problem-solving skills **3.** Promoting positive activities **4.** Managing reactions **5.** Promoting helpful thinking **6.** Rebuilding healthy social connections	**Modules** **1.** Healthy living **2.** Managing strong emotions **3.** Getting back into life **4.** Coming to terms with the disaster **5.** Managing worry and rumination **6.** Maintaining healthy relationships	**Strategies** **1.** Understanding adversity **2.** Managing stress **3.** Managing problems **4.** Get going, keep doing **5.** Strengthening social support **6.** Staying well and looking forward	**Evidence-based Interventions** **1.** Exposure treatments **2.** Cognitive therapy **3.** Goal setting/ activity scheduling **4.** Managing anger **5.** Treatment of complicated grief **6.** Managing comorbidity **7.** Pharmaco-therapy
Providers Disaster relief workers, volunteers, community leaders, generic workers	**Providers** Primary care providers including: General Practitioners, allied health professionals, counsellors, welfare staff	**Providers** Community-based or frontline health or disaster workers	**Providers** Community workers, health workers, lay helpers, mental health professionals	**Providers** Specialist mental health care staff including: psychologists, psychiatrists

4. ROLES AND RESPONSIBILITIES

The *Royal Commission into National Natural Disaster* Arrangements noted:

> *There is clearly an opportunity to refresh and strengthen national disaster arrangements… Despite the goodwill of all parties, there is variability in the level of collaboration and coordination in the delivery of recovery programs and services across jurisdictions.*[15]

Strengthening cooperation on mental health and wellbeing disaster responses between all levels of governments, recovery partners and communities is a key goal of the Framework. The Framework works to achieve this by clearly outlining roles and responsibilities to increase shared understanding and suggests opportunities for coordination.

The underlying approach is to distinguish between ***what*** all Australians can expect, whilst maximising the scope for regional and local customisation (the '***how***').

4.1 CURRENT ARRANGEMENTS

The Australian Government funds:

- mental health-related services through Medicare and the Pharmaceutical Benefits Scheme
- Primary Health Networks (PHNs) to work closely with state and territory Local Hospital Districts (LHDs) on regional planning and service provision; and
- community programs which support people experiencing mental illness as well as those grappling with other life challenges affecting personal and family wellbeing. These include telephone and digital crisis lines, crisis support services and regionally specific and/or innovative services focused on specific populations or needs, plus income support, social and community support and disability services.

State and territory governments:

- deliver public acute and psychiatric hospital services or specialist units as well as a wide range of community and public mental health services
- provide general health care that people with mental illness need (including hospitals); and
- fund community and social programs such as supported accommodation, domestic and family violence services and children's services.

Local governments:

- have responsibilities for public health.

The private sector:

- provides services funded in part by government and in part through private health insurance. These include clinically focused services such as the provision of assessment, diagnosis and treatment, and counselling and psychotherapy.

The non-government sector:

- provides services funded through government or privately. These range from general social support and well-being programs, such as neighbourhood centres and family support services, to community-based support for people who live with a mental illness.

4.2 RESPONSIBILITY FOR MENTAL HEALTH AND WELLBEING SERVICES DURING TIMES OF DISASTER

As noted, following a major disaster, a large proportion of the population will require some emotional or psychosocial support to cope with potentially traumatic events. Mainstream mental health services are typically supplemented by additional disaster-related services funded on a cost-share basis between the Commonwealth and state governments through the DRFA. The DRFA also funds local community-based and enabling supports that strengthen social connections. Whether delivered through existing or standalone services, capacity to meet demand will be a challenge. Service continuity and access to pharmaceuticals need to be assured for people with existing illnesses, while new issues arise including emergency-induced social and psychological problems.

All states and territories either set out their mental health and wellbeing response to disasters in a specific plan or a more general disaster-related document (see ***Guiding the Principles: Examples from Experience***). Implementation of the Framework needs to be tailored to each state, regional and local context and take into account both health systems and disaster response and recovery systems. Operationalising the Framework in a way that aligns with these plans and the local context is essential.

Roles and responsibilities consistent with the Framework are suggested in Figure 4. Some of these are dependent on funding.

FIGURE 4 KEY ROLES AND RESPONSIBILITIES FOR IMPLEMENTATION

Level of government	Key roles and responsibilities
Local Government **Local intelligence, mapping and coordination**	• Identify features that support a tailored disaster mental health response including local population profiles; components of the current service system, including current strengths and gaps; places to best situate community gatherings and drop-ins; groups at risk of being physically or socially isolated. • Engage with local and regional services to integrate mental health and wellbeing actions into disaster planning, working with emergency services bodies, local businesses, charities and community organisations. • Focus on the accessibility of recovery and evacuation centres to meet the widest range of community needs including young children, older people and people with a disability, and to cater for individual needs, including households with pets. • Encourage local services to plan for transport and communications disruption, evacuation and continuity of support in the face of disruption. • Facilitate networks of local mental health and wellbeing services before, during and after a disaster to ensure there is coordination, functions are clear, relationships are strong and simple referral channels exist.
Regional bodies (Primary and Local Health Districts or Networks) **Regional planning and coordination**	• Ensure that joint regional mental health plans include disaster mental health measures needed before, during and after disasters. Consider social and cultural factors and geography. • Participate in state Recovery Committees and emergency response planning. • PHNs undertake comprehensive and integrated primary health response plans for emergencies. • Put in place or consolidate regional disaster mental health coordination. • Agree on a plan for community upskilling in mental health awareness, in collaboration with other levels of government and key recovery partners. • Contribute to a disaster mental health workforce plan for the region that considers the capability and capacity of current services; where surge workforces will be needed; and how these will 'fade in' and 'fade out' to ensure local capability is developed; and training, including orientation to local conditions. • Facilitate regional mental health-related intelligence from multiple sources during disasters and share widely with recovery partners.

Level of government	Key roles and responsibilities
State & Territory governments **Service provision and service navigation assistance, regular information**	• Adopt a five-year planning time frame for mental health recovery following major disasters to allow for extended mental health impacts and recovery needs. • Ensure that future state and territory mental health plans (including clinical services plans) address mental health concerns arising from disasters. • Integrate mental health considerations into preparation, relief and recovery planning including in emergency management frameworks, ensuring proactive outreach to first responders, volunteers and their families. • Contribute to regional disaster mental health workforce arrangements and planning including agreements with other levels of government to provide additional workers where needed. • Work with other levels of government to plan which services will conduct proactive outreach and navigation assistance. • Ensure hospitals and state-funded mental health services, and other community services, can ensure continuity of support to people with pre-existing conditions. • Where possible provide additional support by augmenting existing and well-established services. This maximises community trust in, and engagement with, services and maintains long-term continuity of care. • Clarify and communicate in advance the primary communication strategy to be used for social recovery information to the public and what material will be available on it. • Work with Australian Government to develop strategies to improve collecting and sharing of consistent data across governments and agencies to support mental health disaster responses and resilience.
Australian Government **Integrate disaster mental health into national funding agreements & emergency arrangements**	• Establish a standing Senior Officials Group to implement the Framework. Include representation from all levels of government and both mental health and emergency/recovery agencies. • Adopt a five-year planning time-frame for mental health recovery following major disasters to allow for extended and delayed mental health impacts. This is relevant to mental health response and recovery initiatives, including enhanced flexibility under Medicare for providers and patients to allow easier access to providers with reduced costs for individuals. • Where possible, fund PHNs to commission services that align with priorities in regional plans while also allowing flexible responses to local disaster-related needs. • Work with states and territories to identify opportunities to improve workforce sharing and training in the event of a major disaster. • Work with states and territories to agree on a streamlined approach to disaster digital and telephone support service which refers people to assistance following triage, and offers referral to local services where available. • Work with state and territory, regional and local governments to develop strategies to improve collecting and sharing of consistent data across governments and agencies to support mental health disaster responses and resilience. • Work with state governments to implement a communication strategy on disaster mental health to guide media coverage. This will reinforce good practice in relation to where to find help, and appropriate language, images and commemorations.

5. ENABLING EFFECTIVE RESPONSES

The difficulties people and services face following a major disaster mean that even when help is available people may not find it easy to access. Factors that can enable effective responses include those discussed below.

5.1 COORDINATION OF SERVICES

People affected by disasters are confronted by multiple services, offering similar-sounding types of help. To increase communities' ease of recovery, it is important services and recovery workers are well-equipped and informed with knowledge of the local context and available services. Long-term funding is important to avoid a cycle of new services overwhelming the local system and then leaving abruptly – a 'fade in, fade out' approach to allow surge responses to be carefully integrated into the local service system is advisable.

Specific coordination issues arise for individuals and families who need to relocate, cross state borders or have pharmaceutical needs met during an emergency.

Good coordination occurs through both formal and informal mechanisms, through:

- locals who become informal 'system experts' and then act as referral advisers for others
- community services which operate flexibly, according to the 'no wrong door' principle, so that people have only to interface with one service to access different types of help
- trusted advisers outside the health sphere such as accountants, stock agents, or veterinarians who become 'accidental counsellors,' listening and referring as needed
- primary health care providers (e.g. doctors, nurses, community health service staff and pharmacists) who coordinate care for their patients/customers
- local service networks and inter-agencies that meet regularly to understand the role each service plays in the local ecosystem plays and to strengthen connections between them
- professional or cross-professional communities of practice who meet to engage with best practice and to foster coordination and quality of support; and
- regional recovery officers who help with local coordination and feed intelligence to state and federal agencies so programs can be responsively modified.

The mechanisms below are particular aspects of good coordination that help in a disaster.

5.2 PEOPLE WHO PROVIDE NAVIGATION AND CONNECTION ASSISTANCE

> And, there was a – a case worker. She was amazing…she's just like, 'Whatever you need. You know, I'm here to listen to what you need.' Not telling me what, you know? …it was also 'What do you need today, right here, now?'[16]

The type of care and support people receive has an impact on their journey to recovery. The National Mental Health Commission's (NMHC) ***Our Stories: Beyond the Disaster*** research found:

- what helped people was connecting with people who made them feel understood and who provided direct assistance. This assistance was energising, not debilitating.
- If this didn't happen, mental health support was often pushed to last on a long list of challenges disaster-affected people were tackling. Practical issues such as insurance, housing, and supporting family inevitably rose to the top.

The navigation and connection role (currently performed by a variety of case managers and other intermediaries)[17] is crucial to ensuring people receive the help they need. The people affected by a disaster may be quite unfamiliar with using welfare-related services. Practical assistance with paperwork and complex administrative processes, letting people know of opportunities over time, and people who listen, check in and help those with similar experiences connect are highly valued. Evidence is varied but suggests that roles which proactively support people to navigate the service system should ideally be available for up to five years following a major event, depending on need and workforce availability.

A clear, national commitment to funding the functions following disasters will benefit help-seekers and make planning easier.

5.3 COORDINATED INFORMATION AND DATA COLLECTION AND SHARING

Having to tell one's story repeatedly to access support can be frustrating, stressful and a barrier to seeking help. Being questioned multiple times about basic information or documentary evidence while struggling to cope may result in people feeling doubted or re-traumatised.

The Royal Commission recommended that Australian, state and territory governments should agree to:

1. develop consistent and compatible methods and metrics to measure health impacts related to natural disasters, including mental health, and
2. take steps to ensure the appropriate sharing of health and mental health datasets.[18]

Methods to enable joint collection and the sharing of baseline information and mental health outcomes data about people affected by disasters across agencies and sectors are needed. These could be as simple as organisations collaborating locally to jointly interview people, to more advanced digital strategies such as deployment of an app that allows for information sharing and provides user updates.

A collaborative approach to sharing health data and information can assist cross agency collaboration and support and will ultimately contribute to Australia's ability to build resilience on a national level.

5.4 WORKFORCE PLANNING, DEVELOPMENT AND SUPPORT

Ensuring an appropriately located and skilled workforce is one of the main challenges in disaster-affected communities. This includes the permanent and any surge workforce needed, and both volunteer and paid staff. Pressing health workforce shortages often exist in rural and remote areas where the majority of natural disasters occur.[19] Given the increasing frequency and scale of major disasters, coordinating the sharing of temporary workers to go where needed and operate safely and effectively has become an increasingly important function. Consequently disaster-related workforce management is complex and an area where advance planning is highly beneficial.

Disaster mental health workforce planning needs to consider:

- the capability and capacity of existing services and providers
- surge workforces (where needed) and how they 'fade in' and 'fade out' of disaster-affected regions
- training, including orientation to local conditions.

The following tasks need to be part of mental health disaster workforce planning:

- identifying areas of workforce capacity and gaps for all components of care
- planning for the deployment of the local primary health care workforce
- where surge workforces will be needed and from where they will be sourced, e.g. recently retired professionals or students and staff at rural and regional tertiary educational institutions
- considering the needs for specialised surge workforces, e.g. for Aboriginal and Torres Strait Islander workers or speakers of certain languages
- universal and specialised training
- measures to attract and retain new staff for longer-term positions.

Some capabilities are needed by all workers. This includes orientation to the local situation and population needs, understanding emergency arrangements, ability to work cross-culturally and use digital health technology. Psychological First Aid training will also be widely needed. Other specialised skills need to be learned or reinforced. See Table 1 above.

Housing, employment conditions, insurance and schooling arrangements for children also need to be addressed in order to attract and retain temporary staff, along with Medicare Benefits Schedule (MBS) flexibility for registered providers and for service users (see Roles and Responsibilities).

5.5 MAPPING MENTAL HEALTH AND WELLBEING SERVICES

Service mapping, conducted in advance of a disaster, can be a valuable way to improve coordination and service provision. Its benefits include:

- an understanding of capacities and gaps
- lead roles for different functions being established
- improved referrals and a 'no wrong door' approach
- clarity around who to include in forums, inter-agency networks and training
- greater trust between services
- any new funds being used more efficiently

Mapping help-seeking journeys post-disaster can also provide vital insights to the specific needs of groups in the population, as it can uncover transport, telecommunication, financial, social and cultural issues that may affect access.

The perspective of the service-user needs to be at the centre of the service mapping exercise, starting with profiles of those relevant to the local government area.[20] When new formal and informal services enter the community following a disaster, or service disruption occurs, changes can be integrated into the existing service map in a timely manner.

5.6 DELIVERY CONSIDERATIONS

Following a disaster, a wide range of delivery mediums are needed to suit the varied needs and preferences of people as well as the post-disaster environment. These include early childhood and aged care centres, workplaces, mobile delivery, schools and digital health.

Service mapping, conducted in advance of a disaster, can be a valuable way to improve coordination and service provision.

The challenges a region or community faced prior to the disaster can be exacerbated afterwards. Both specialised and non-specialised services need to adapt to the needs of disaster-affected communities, flexing-up at time of greater need and engaging proactively using mobile teams, pop-up services and door-knocking to reach people who are reluctant to seek help.

People's ability to access services needs ongoing monitoring as conditions on the ground change. Considerations include:

- blocked transport routes
- changed access to media or other communications
- damaged or unusable ICT infrastructure
- disruption to economic activities or education that affects people's ability to travel to services
- financial constraints that limits access to allied health or medical practitioners
- the stigma surrounding mental health
- the social and cultural appropriateness of service offerings

Five delivery considerations are discussed below in more detail.

5.6.1 ASSESSMENT AND SCREENING

Effective assessment and screening are important in mental health care following disasters. For many reasons people's distress and impact of trauma can be missed or not dealt with, delaying treatment. Children and adolescents often do not articulate how trauma has impacted them, and in small communities in the wake of the disaster, others may hold back, reluctant to seek help and use scarce resources.

Good practice in assessment and screening that is supported by evidence includes:

- community upskilling to ensure people are aware of signs of impact in others
- providing emotional support and referral with the use of Psychological First Aid[21]
- specialised mental health assessment and referral to support, required for people with acute symptoms when mental ill-health doesn't improve with non-clinical interventions.

Queensland Health notes:

> *assessments can be offered at any point where it seems warranted, but a formal assessment should be offered if these incapacitating distressed states persist for longer than three months or if incapacitation or dysfunction related to the event appears to develop after this time.*[22]

5.6.2 USE AND EFFICACY OF DIGITAL SERVICE PROVISION

Technology-enabled mental health services such as digital apps, telehealth, and online treatment have emerged as a strong complement to face-to face assessment and treatment, with unique benefits such as confidentiality and 24-hour access. During the 2019-20 Black Summer bushfires and the COVID19 global pandemic digital and telehealth services were effectively used in health care, including mental health.[23] People made good use of dedicated disaster helplines for telephone and online support as well as assessment and ongoing support.[24]

This trend is convenient and reduces pressure on face to face services. Good practice digital service provision is incorporated into disaster mental health and wellbeing planning at the local level, ensuring that local primary health care providers are kept informed about and involved in on-line clinical care if the service-user authorises this.

However, technology-enabled solutions should be seen as complementing rather than replacing face to face help. Connectivity problems, damaged ICT infrastructure, users' comfort with the technology and gaps in local knowledge are limiting factors when services are provided digitally and remotely. Some populations, such as people in rural, remote and very remote areas, including Aboriginal and Torres Strait Islander people may not have consistent access to digital tools due to physical infrastructure issues. These are groups disproportionately affected by disasters.

5.6.3 PROACTIVE OUTREACH

At times of disasters, practical assistance and engagement across the community is important to ensure connection, encourage support and offer assistance when needed.

Proactive outreach can overcome access barriers by meeting people at home or other easy to reach locations and by offering mental health check-ins in combination with practical help and health checks.

The characteristics of each community and the nature of the disaster determines the most appropriate methods. These may include home and farm visits (actively listening to concerns expressed around kitchen tables), information sessions, town hall meetings, community barbecues, neighbourhood drop-in centres, workshops and meetings, field days, or creative arts events and workshops.

Proactive outreach is effective when:

- many services work together to triage and refer, and people only need to register once
- informal support is given priority as well as comprehensive referral options being available for specialised services
- the specific cultural, social and economic context of service-users is attended to.

5.6.4 STREAMLINED PROVISION OF DISASTER MENTAL HEALTH SUPPORT AND INFORMATION

Following a disaster, people can find it difficult to navigate the services and assistance available at a time and in a manner right for them. The differentiation between various services may not be obvious. Support may be provided by local, state and territory, and Australian governments as well as through private or philanthropic grants. The types of support range from specific mental health and wellbeing support to practical recovery supports – all of which may come with different eligibility requirements. Finding assistance following a disaster can be extra challenging due to the stress caused by the disaster itself, the overwhelming nature of the aftermath workload and in some cases, a sense of paralysis and isolation.

> *You're dealing with people who are traumatised and it's very hard for them to say what they need because they're only looking to the end of their nose. They're only going to give you their immediate need and… it might be a roof over their heads.*[25]

A single streamlined source of practical mental health and disaster support information will assist communities affected by disaster and enable quicker and more efficient access to mental health support. Such a portal could be managed nationally, with strong regional connections, and include information to educate people about mental health and wellbeing in a disaster context as well as where to find help.

5.6.5 SCHOOL AND WORKPLACE DELIVERY

Providing support at the local workplace and school level is an important strategy to assist community recovery. In schools, education about the disaster and access to psychological support is vital for recovery of children and young people.[26] Psychological First Aid and trauma informed care training can be valuable for teachers and workplaces. Education programs utilising story telling are proving effective in supporting and educating children following disasters (see Examples from Experience).

Workplaces should also ensure accessible support is available through regular check-ins and that Employee Assistance Programs can cater for disaster-related mental health.[27]

5.6.6 TRACKING MOBILE POPULATIONS

Certain population groups which are at risk of experiencing heightened stress and possibly trauma following a major disaster are also ones that are at risk of falling through service provision cracks. These include:

- tourists and other non-residents who leave the area, and then cannot access services because eligibility is based on living in the disaster zone
- seasonal workers whose whereabouts and needs are not known to local authorities; or who are ineligible for MBS or postcode-based health assistance, or face language challenges
- people who voluntarily live 'off the grid' outside mainstream settlements, who may not be known to authorities, may live in dwellings not known to Councils, and who - such as people of no fixed address - may not have personal details be up to date
- people who do not return to, or move away from their disaster affected community or region and may not have access to the same level of funded mental health care as a result of relocation
- Aboriginal and Torres Strait Islander people who live on traditional lands in rural and remote Australia and whose lives feature marked inter- and intra-community mobility, with circular movements within a 'mobility region', and a high rate of travel to places (including regional centres) within the region for relatively short periods of time
- those who are experiencing homelessness or are of no fixed address in a disaster-affected area.

Disaster health registers can also be helpful for keeping track of mobile populations affected by disasters that lead to population dispersals.

5.6.7 TRAUMA-INFORMED SERVICE PROVISION

Trauma-informed care aims to look beyond the person's symptoms, changing the question from 'what's wrong with you?' to 'what happened to you?'

It is a delivery approach that acknowledges and recognises the impact of a trauma experience, including its impact on mental health and wellbeing. In a disaster or emergency situation, people are likely to be living with the disaster aftermath for a long period, and several family members may be experiencing undue levels of fear and worry. This means many practitioners (and especially General Practitioners) will need a skill base that equips them to deal with the broad range of traumatic events.

The Australian Guidelines for the Prevention and Treatment of Acute Stress Disorder, Post-traumatic Stress Disorder (PTSD) and Complex PTSD provide general and mental health practitioners, policy makers, industry, and people affected by trauma with access to recommendations reflecting current evidence on how to better respond to the needs and preferences of people living with these conditions.[28]

Given Aboriginal and Torres Strait Islander peoples' lived experiences with intergenerational trauma, it is important culturally safe services and trauma-informed service provision for Aboriginal and Torres Strait Islander people and communities and available - including a trained and resourced workforce.

Trauma-informed care aims to look beyond the person's symptoms, changing the question from 'what's wrong with you?' to 'what happened to you?'

6. CONCLUSION

Australians will continue to face serious hazards in the coming years, that are increasingly simultaneously or in quick succession. In contrast to other parts of the world where war or civil conflict is present, the majority of these are environmental events or processes. As a result, they disproportionately affect people living in rural and remote areas, and those in certain demographic groups (such as Aboriginal and Torres Strait Islander people).

Research on how people cope in such crises has blossomed in the last decade, including longitudinal or tracking studies which tell us about the varied patterns that occur over time. Such research is reassuring in that resilience is the most common response people manifest in the face of potentially traumatic experiences. However, severe stress reactions followed by recovery, delayed onset reactions, and chronic conditions, also occur.

This Framework sets out actions that strengthen individual, family and community resilience, make recovery more likely, and treat delayed reactions and chronic conditions. Many of these relate to the disaster planning and preparation needed at a community level, and ways to reduce 'aftermath stress' which can be more debilitating and stressful than the disaster itself. In the context of mental health and wellbeing, acknowledging that the impacts of a traumatic event can appear months or years afterwards, and accommodating for this, is critical. Similarly, the Framework emphasises that the way services and supports are delivered is as important as the type of support. Local planning and, where possible, delivery being tailored to local needs is therefore important.

For this reason, the Framework is not designed for standardised implementation but for all recovery partners to use to enhance current arrangements. Its goal is greater consistency in what all Australians can expect in support of their mental health and wellbeing in the context of disasters, while recognising that how this is achieved will require collaborative, tailored solutions involving all levels of government, other recovery partners and the community.

GLOSSARY

Disaster	A serious disruption of the functioning of a community or a society at any scale due to hazardous events interacting with conditions of exposure, vulnerability and capacity, leading to one or more of the following: human, material, economic and environmental losses and impacts. The effect of the disaster can be immediate and localized, but is often widespread and can last for a long period of time. It may test or exceed the capacity of a community or society to cope using its own resources, and therefore may require assistance from external sources, which could include neighbouring jurisdictions, or those at the national or international levels.
Hazard	A process, phenomenon or human activity that may cause loss of life, injury or other health impacts, property damage, social and economic disruption or environmental degradation. Hazards may be natural, anthropogenic (human-caused) and/or socio-natural in origin.
UN Inter-Agency Standing Committee	The Inter-Agency Standing Committee (IASC) was established by the United Nations in 1992 in response to UN General Assembly Resolution 46/182, which called for strengthened coordination of humanitarian assistance. The resolution set up the IASC as the primary mechanism for facilitating inter-agency decision-making in response to complex emergencies and natural disasters. The IASC is formed by the heads of a broad range of UN and non-UN humanitarian organisations. See www.humanitarianinfo.org/iasc
Mental health	Having good mental health or being mentally healthy involves a state of wellbeing. The World Health Organization defines this as a state in which every individual realises their own potential, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community.
Mental illness	A clinically diagnosable disorder that significantly interferes with a person's cognitive, emotional or social abilities. Examples include anxiety disorders, depression, bipolar disorder, eating disorders, and schizophrenia.
Mental ill-health	A broader term encompassing both mental illness and other mental health difficulties.
Peer-worker or lived experience worke	Workers who have a lived experience of mental illness and who provide valuable contributions and support to people who experience mental-ill health by sharing their experience of mental illness and recovery.
Prevention (mental illness)	Action taken to prevent the development of mental illness, including action to promote mental health and wellbeing and action to reduce the risk factors for mental illness.
Primary care or primary health care	Primary health care is the entry level to the health system and, as such, is usually a person's first encounter with the health system. It includes a broad range of activities and services, from health promotion and prevention, to treatment and management of acute and chronic conditions.

Recovery	Recovery is the process of coming to terms with the impacts of a disaster and managing the disruptions and changes caused, which can result, for some people, in a new way of living. For individuals, recovery is being able to create and live a meaningful and contributing life, with or without the presence of mental illness. It incorporates social, personal, clinical and functional domains. Recovery involves hope, self-determination, self-management, empowerment and advocacy. For communities, recovery can mean rebuilding social connections and trust as well as the natural, social and physical infrastructure.
Resilience	For individuals, resilience is the process of adapting well in the face of adversity, trauma, or other significant sources of stress including family and relationship problems, serious health problems, or disasters and their aftermath. For communities, it is the ability to resist, absorb, accommodate to and recover from the effects of a hazard in a timely and efficient manner, including through the preservation and restoration of its basic structures and functions.
Stepped care	An evidence-based staged system comprising a hierarchy of interventions, from the least to the most intensive, matched to a person's needs. Within a stepped care approach, a person is supported to transition up to higher-intensity services or transition down to lower intensity services as their needs change.
Stigma	A negative opinion or judgment that can exclude, shame or devalue a person or group of people on the basis of a particular characteristic, such as their perceived ability to cope.
Potentially traumatic event	Any event that involves exposure to actual or threatened death, serious injury, or sexual violence has the potential to be traumatic. Almost everyone who experiences trauma will be emotionally affected, but not everyone will respond in the same way.

For a comprehensive glossary of disaster-related terms, see AIDR Australia Disaster Resilience Glossary at **knowledge.aidr.org.au/glossary**

ENDNOTES

1 Australian Government (2018) State of the Climate 2018, CSIRO and the Bureau of Meteorology.

2 Commonwealth of Australia (2020) Australian Government Crisis Management Framework, Version 2.3, p. 7.

3 World Health Organization (2013) Building back better: sustainable mental health care after emergencies. WHO: Geneva.

4 'After' also means 'ongoing' in the context of the Framework.

5 Gibbs L, Molyneaux R, Harms L, Gallagher H C, Block K, Richardson J, Brandenburg V, O'Donnell M, Kellett C, Quinn P, Kosta L, Brady K,
Ireton G, MacDougall C, Bryant R. (2020) 10 Years Beyond Bushfires Report. University of Melbourne, Melbourne, Australia.

6 Beaglehole and others, (2018) 'Psychological Distress and Psychiatric Disorder after Natural Disasters: Systematic Review and Meta-Analysis.', The British Journal of Psychiatry, 213.6 pp 716–22.

7 Emergency services workers and volunteers are the focus of a dedicated mental health National Action Plan (2021-2024) to be published by National Emergency Management Agency, and also the focus of some state plans such as Emergency Management Victoria's Resilient Recovery Strategy 2019 **www.emv.vic.gov.au/how-we-help/resilient-recovery-strategy**

8 The Bushfire and Natural Hazards CRC has created a disaster resilience index based on social, economic and environmental factors that can help (prior to disaster) to identify vulnerable communities. **www.bnhcrc.com.au/research/resilienceindex**

9 McFarlane, A. C., & Williams, R. (2012) Mental Health Services Required after Disasters: Learning from the Lasting Effects of Disasters in Depression Research and Treatment.

10 IASC (2020) Basic Psychosocial Skills, a Guide for COVID-19 First Responders, produced by the IASC Reference Group for Mental Health and Psychosocial Support, p. 10.

11 The NMHC's Our Stories research contains vivid accounts by disaster survivors of how they or others close to them became accidental 'social workers' as well as undertaking their normal occupations.

12 McFarlane, A. C., & Williams, R. (2012) Mental Health Services Required after Disasters: Learning from the Lasting Effects of Disasters.

13 MacFarlane, C. and R. Williams (2012) p. 4.

14 See Wade D et al (2012) A multi-level framework to guide mental health response following a natural disaster. Bereavement Care; 31(3) pp 109-13.

15 Royal Commission into Natural Disaster Arrangements (2020) Interim Observations, 31 August 2020 pp. 7, 22.

16 NMHC (2021) Our Stories: Beyond the Disaster, p. 42, at **www.mentalhealthcommission.gov.au**

17 Several terms can be used to refer to the intermediary function and these names are not meant to exclude others.

18 Commonwealth of Australia (2020) Royal Commission into Natural Disaster Arrangements Report. p. 351

19 The Australian Government is developing a National Mental Health Workforce Strategy to conclude in 2021. It will consider the quality, supply, distribution and structure of the mental health workforce and 'consider appropriate access to the mental health workforce for the specific needs of regional, rural, remote and very remote communities.' See **www.health.gov.au/resources/collections/national-mental-health-workforce-strategy**

20 Examples of how 'constructed consumer profiles' can usefully be created to allow consideration of the service ecosystem and the relationships and links with in it are found in NMHC (2021) Our Stories – Beyond the Disaster.

21 McFarlane, A. C. and Williams, R. (2012).

22 Queensland Government (2018) Queensland Health Mental Health Sub-plan: A Sub-plan of the Queensland Health Disasters and Emergency Incident Plan.

23 Australian Government, Department of Health (2020) Management and Operational Plan for People with Disability and (2021) Providing health care remotely during COVID-19. Accessed on 30 March 2021.

24 AIHW (2020) 'How COVID-19 changed the way Australians used health services in 2019-20'. During September 2020 Lifeline saw a 15.6% increase from the same time in 2019, Kids Helpline received a 14.3% increase and Beyond Blue's general phone service 21.3%. Between 16 March 2020 and 27 September 2020, 7.2 million Medicare-subsidised mental health related services were delivered nationally of which over one-third were delivered via telehealth.

25 Our Stories: Beyond the Disaster.

26 Gibbs L, et al (2020).

27 Paul, R. and Thompson, C., 2006. Employee assistance program responses to large scale traumatic events: Lessons learned and future opportunities. Journal of Workplace Behavioral Health, 21(3-4), pp.1-19.

28 The guidelines, approved May 2020, can be found at Phoenix Australia **www.phoenix.org**

NEMA.GOV.AU