NSW Health

Disaster Response and Recovery

An integrated model of care for NSW Health Mental Health Programs

June 2025

NSW GOVERNMENT

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Setting the context

Purpose

The purpose of the document is to provide guidance to local health districts (LHDs) in designing local mental health and wellbeing responses that are evidence-based and delivered across the phases of disaster: prevention and preparedness, response and recovery.

The document outlines the principles to support LHDs to design and deliver coordinated mental health recovery support through three disaster response mental health programs: Disaster Recovery Clinicians (DRCs), Rural Adversity Mental Health Program (RAMHP) and Farm Gate Counsellors and Rural Peer Support Worker Program (Farm Gate).

The principles help support LHDs in providing a flexible response to the diverse needs of local communities and priority population groups.

The guidance provided in this document should be considered within the context of a whole of community and multi-agency approach to disaster response and alongside relevant national, state and NSW Health frameworks and policies.

Methods

The principles and components of care were informed by two main types of evidence (refer to Appendix 1):

- research evidence including peer-reviewed and grey literature identified through PubMed and Google searches
- experiential insights and evidence collected from healthcare providers and community members using a mixed methods consultation approach.[1]

Background

Defining disaster and rural adversity

A disaster is a serious disruption of the functioning of a community or 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.

Rural adversity can be a sudden or slow disruption or difficult situation such as tragedies, droughts, mouse plagues, biosecurity issues, or pandemics.

The effect of the disaster or rural adversity can be immediate and localised 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 require assistance from external sources, which could include neighbouring jurisdictions, or those at the national or international levels.[2]

The effect of the disaster is dependent on individual capacity as well as any objective assessment of community impact. The effect of a disaster may not be felt commonly for all people in the community.

Phases of disaster

The phases of disaster refer to specific timeframes in the cycle of disaster:

- **Prevention and preparedness** occur all the time.
- **Response** occurs at the immediate point of the disaster and up to six months after the disaster.

- **Recovery** may occur for up to 10 years following the response phase of the disaster.

Successive disasters such as sequential fires and floods can have a cumulative impact on individuals and communities and can disrupt the disaster phases.

These phases may not occur in a linear way and could occur simultaneously during various disasters, leading to cumulative impacts on people and communities. [1, 3, 4] The lessons learnt during all phases of disaster create opportunities to transform and strengthen mental health care and community capacity in the long term.[3]

Reactions and support required after disasters

Disasters can impact the physical, social and mental health and wellbeing of affected individuals and communities. Widespread and short-term distress responses are common in the aftermath of a disaster and for most people, the symptoms improve over time and do not progress to severe or clinically significant mental health disorders. However, the effect of cumulative disasters can lead to further distress.

Priority populations and some affected groups can be especially susceptible to adverse mental health outcomes and are more likely to experience prolonged and severe mental health problems needing specialist mental healthcare.[5]

These include:

- those with more severe disaster exposure
- those with pre-existing mental health conditions
- those with coexisting mental health and substance abuse issues
- those with coexisting mental health and physical health issues
- children and young people
- women
- first responders
- those from socioeconomically disadvantaged backgrounds
- LGBTIQ+ people
- those currently suffering financially including farmers coping with cumulative adverse events or disasters
- those with low social support
- culturally and linguistically diverse people
- Aboriginal people.

When considering the impact of disaster through an Aboriginal lens, it must be acknowledged that the destruction of lands, displacement of people, and culturally inappropriate responses have a profound impact on the wellbeing of Aboriginal people.[2] Aboriginal culture, and therefore wellbeing, is tied to Country –traditional medicine/food, birthing and ceremonial sites. Where there is a change in the landscape due to disaster – burning of scarred trees from bush fires, eroding of rock art from floods - elements and history of culture are lost and cannot be rebuilt. [2]

Supporting disaster recovery for Aboriginal people includes the need to listen to key individuals affected by the disaster and elders in those areas.

The impact of experiencing a disaster is complex, combining increased stress on mental health and wellbeing and practical things like finances, and access to food and shelter. Neither occur in isolation, and an individual and community's ability to manage all stress must be supported holistically.

Everyone involved in planning for and responding to disasters including healthcare and other responders, should have knowledge about how people who are affected react to and cope with these events. [6] This includes an understanding of the risk factors that people face and how well they cope, including the importance of social support, relationships, leadership and care. [6] This knowledge should inform multi-agency disaster planning, which should include plans for psychosocial and mental health care. [6] Multiagency planning should also include actions to support and strengthen communities before incidents occur alongside addressing the mental health and well-being needs of people and communities in the response and recovery phases.[6]

Disaster preparation can include building rural partnerships and community and individual resilience. Mental health promotion, participation in community events, community and individual training in psychological first aid and actions to reduce stigma against help seeking and stigmas against priority groups can all be useful actions to build community and individual resilience.

Partnership and community building can include building on partnerships among districts, PHNs, local councils, other Government Agencies, charities, CMOs, and community groups.

Building supports and capacity of first responder organisations to respond to distress in their staff and client groups can help in the preparation stage.

Actions during the preparation stage to implement Closing the Gap commitments to reduce racism and discrimination against Aboriginal people in rural areas, and to build Aboriginal governance into programs and build partnerships and referral pathways with ACCHOs can help with targeted support during the recovery phase.

There are three levels or steps of mental health assistance people may require following a disaster with people progressing to a higher level or step when the need arises. The steps include:[7]

- **Level 1** is general mental health support that most community members find useful. It includes interventions such as psychological first aid and understands that most community members will undergo psychosocial recovery from the event. Social support and connectedness are the highest predictors of psychosocial recovery, and it is in this context that community-led events and connectedness need strong support from services and agencies.

- **Level 2** is a focused level of mental health intervention where people may need more support for disaster-related issues that create distress and disrupt or interfere with normal functioning and day-to-day life. It includes interventions such as Skills for Psychological Recovery (SPR), Skills of Life Adjustment and Recovery (SOLAR), and Problem Management + that are brief, specific and aimed at the main issue. Trained but non-mental health professionals can provide the interventions to people in the community.

- **Level 3** is focused on support for community members identified with low prevalence yet more debilitating mental health issues because of their disaster experience. Illness (including coexisting illnesses) may have been pre-existing and exacerbated by the disaster or as a direct result. Trained mental health professionals would provide therapeutic and evidence-informed inventions based on individual needs and preferences.[7]

Policy context

National frameworks

The Australian Government funded the National Mental Health Commission to develop a National Disaster Mental Health and Wellbeing Framework as part of the response to the 2019-2020 bushfires.[1] The framework aims to improve the coordination of localised mental health and wellbeing responses following natural disasters and outlines tiered levels of care and support:

- Tier 1 (Universal): A whole of population approach
- Tier 2 (Targeted): Interventions for priority populations
- Tier 3 (Indicative): Specialised care for individuals with pre-existing mental health concerns or who experience prolonged or acute symptoms. [2]

The Australian Government released an update of the Australian Government Crisis Management Framework in September 2024. The Framework outlines the Government's approach to preparing for, responding to, and recovering from crisis.

NSW frameworks

The State Emergency Management Plan (EMPLAN) describes NSW's approach to emergency management, governance and coordination arrangements, and roles and responsibilities of agencies.

The NSW Health Services Functional Area Supporting Plan (NSW HEALTHPLAN), a supporting plan to the EMPLAN, describes the strategic emergency management arrangements for providing health services and resources during emergencies in NSW. Under the NSW HEALTHPLAN, each LHD must establish emergency management arrangements across the prevention, preparation, response and recovery phases.

Mental health recovery services (DRCs, RAMHP, Farm Gate): An integrated model of care

Three publicly funded programs that directly support mental health disaster responses have been implemented in NSW as outlined in Table 1. They are:

- Disaster Recovery Clinicians (DRCs)
- Rural Adversity Mental Health Program (RAMHP)
- Farm Gate Counsellors and Rural Peer Support Worker Program (Farm Gate).

Where practicable, LHDs may consider integrating the three programs into a single model of care.

However, it is important to be mindful of the scope of each role and to avoid diminishing any associated programs, branding, or functionality.

As part of an integrated model, the LHD will provide support across the components of care outlined in the National Disaster Mental Health and Wellbeing Framework as defined in Table 2. The components of care include specialised services, focused non-specialised support, community and family support, and practical support and advocacy.

Culturally responsive care and support is included as an additional component to reflect the cultural needs and preferences of Aboriginal people in NSW – and the value of Aboriginal ways of knowing during various phases of a disaster.

An integrated model of care for NSW Health is outlined in Table 3. The core roles of each program are tailored towards the various phases of a disaster – prevention and preparedness, response, and recovery. Guidance on how to set up the integrated model is outlined in Table 4.

LHDs are responsible for determining their local integrated model of care to support communities in preparing for, responding to, and recovering from disasters. When the needs are greater than the resources available in the LHD, there may be a statewide request for appropriately skilled clinicians from other LHDs, resulting in short term deployments to assist the recovery efforts.

Aboriginal-led organisations and traditional knowledge holders can provide appropriate, timely and sustainable support in the context of disaster and enable holistic, culturally safe and sustainable care and support for people in NSW who experience disasters (Supplementary File 1 for Cultural Guidance from the Aboriginal Mental Health Team, Mental Health Branch).

An integrated model of care is designed to facilitate greater teamwork through collaboration, open communication, less program duplication, cross promotion of each program and more efficient networking capabilities with stakeholders and partners.

Table 1: NSW mental health disaster response programs

Program	Description
Disaster Recovery Clinicians – 30 FTE DRCs (clinical positions) across 11 LHDs Funding for the DRCs was initially approved in early 2020 in response to the bushfires. In 2021-22 the program pivoted to provide support through successive disasters and adverse events, including floods.	• Focuses on delivering clinical mental health support to people and communities in regional and rural NSW impacted by disasters. • Leads and coordinates responsive outreach through mental health triage, assessment, direct support, and warm referrals. • Coordinates and provides timely mental health and wellbeing support at evacuation and recovery centres and in the community. • Work within a stepped care framework in collaboration with general practitioners, allied health professionals, schools, public mental health services, and private psychologists and psychiatrists. • Target vulnerable population groups across the district
Rural Adversity Mental Health Program (RAMHP) – 19.5 FTE RAMHP Coordinators (non-clinical) across 9 LHDs RAMHP was established in 2007 as a drought response program but has since expanded focus to encompass the broader mental health and wellbeing of regional, rural and remote people and communities of NSW.	RAMHP uses four strategies to support regional, rural and remote communities: • Link – provide personalised advice to link individuals who need assistance for their mental health to the most appropriate services and resources • Train – deliver standardised and high-quality mental health training to build knowledge and understanding among community members and workplaces • Inform – produce and disseminate information about mental health and available resources • Partner – work in partnership with stakeholders to create pathways to care and flexible interagency response to priority groups and issues.
Farm Gate Counsellor and Rural Peer Support Program (Farm Gate) – 27 FTE counsellors (e.g. psychologists, occupational therapists, or social workers) and/or peer support workers with a lived experience of rural adversity across 8 LHDs Farm Gate was initially funded in 2018 as part of the drought response but has since expanded to respond to all rural adversity.	• Farm Gate can provide support to anyone in regional, rural and remote areas but has a focus on supporting farmers, farming families and local businesses in rural and remote NSW. • Provides free mental health and emotional support and delivers assertive outreach to people at locations of their choice, such as farms. • The outreach aspects of the program for both the rural peer workers and the farm gate counsellors mean many people that would not otherwise access support can access psychological or other understanding support. • Farm gate counsellors and rural peer workers also attend local events and this visibility and interaction with local people encourages more people in distress to reach out for support.

Table 2: Defining the components of care (from the National Disaster Mental Health and Wellbeing Framework)

Culturally responsive care and support	Culturally responsive care and support combines Aboriginal cultural ideals, knowledge, and practices with western practices. It takes a holistic approach to wellbeing across all phases and tiers of disaster, enabling population level and targeted interventions that are culturally safe, locally designed, and adaptable to evolving needs of communities.
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.
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.
Community and family support	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.
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.

Table 3: An integrated model in practice covering the various stages of the disaster

Program	Role in Prevention and Preparedness phase	Role in Response phase	Role in Recovery phase
Disaster Recovery Clinicians	• Provide ongoing education and training to key community groups and individuals (eg. Psychological First Aid) • Develop relationships, referral pathways and communication channels with organisations, agencies and community groups involved in the many aspects of disaster recovery • Develop, implement and evaluate community programs that improve awareness of mental health effects of disaster, identify referral pathways and promote a strengths based approach • Identify and build relationships to support vulnerable communities.	• Coordinate and provide timely mental health and wellbeing support at evacuation and recovery centres and in the community • Deploy clinical staff to acute mental health response in other LHDs • Provide assertive outreach for communities and coordination with local services • Facilitate clinical consultation and act in a liaison role • Provide early interventions (e.g., psychological first aid, self-care, supportive counselling etc) and psychological support • Provide access to self-help and psychosocial support (e.g., web-based interventions) at scale • Increase the capacity of other agencies to support people with acute distress with flexible eligibility criteria across primary and secondary care and referrals to tertiary mental health services • Ensure emergency services staff and volunteers can access appropriate and timely clinical services to deal with mental health needs arising from disasters	• Provide psychological support to people with ongoing mental health concerns related to disaster • Deliver assertive outreach for communities • Coordination of and collaboration with local services • Ensure disaster affected individuals can access appropriate and timely clinical services • Work closely with Primary Health Networks to ensure people can access the right level of mental health care • Maintain high community and service visibility and participation to support communities and assist access to clinical supports
Rural Adversity Mental Health Program (RAMHP)	• Build community preparedness and resilience through increasing mental health literacy through resource distribution and training in various settings (e.g. Mental Health First Aid) • Build community resilience through mental health promotion and information-sharing at community gatherings and incidental	• Link people in with other services to address practical problems (e.g., physical health. housing, financial, legal, as well as other mental health services) • Target harder to reach communities through existing partnerships • As required, deploy staff to acute mental health response and assist in the	• Provide links to care • Deliver mental health promotion and stigma reduction activities • Remain connected and responsive to communities allowing for tailored recovery actions and support, for example, coordinate and/or attend community events to celebrate

Program	Role in Prevention and Preparedness phase	Role in Response phase	Role in Recovery phase
	conversations (e.g., at the cattle stalls and community markets) • Guide and support communities to deliver community-centred wellbeing initiatives to build resilience • Coordinate partnerships that will benefit communities when disasters occur – and attend local interagency meetings to identify community needs and help to identify solutions • Distribute resources to help people talk about and plan for disasters and build awareness of reactions and coping strategies • Partner with the Local Aboriginal Land Council (LALC) to facilitate yarns about the land and the cycle of disaster to build and share knowledge before a disaster • Partner with local ACCHOs to build an understanding of local protocols and context for care • Identify and build relationships to support vulnerable communities.	Evacuation Centre in other LHDs to provide additional capacity • Liaise with, educate and support first responder volunteer services (e.g., SES and RFS) • Distribute resources to help people talk, and build awareness of reactions and coping strategies • Where needed, support the responsiveness and coordination of the broader wellbeing response • Act as a designated key contact for partner agencies and the people they connect with • Work with industry partners to ensure health and wellbeing perspectives are considered within parts of the response that may be occurring independently of the health and wellbeing response.	timepoints since the disaster (e.g., engaging in dance, music, and art as a form of healing with communities) • Guide and support communities to deliver community-centred wellbeing initiatives to build resilience.
Farm Gate Counsellors and Rural Peer Support Worker Program (Farm Gate)	• Build community resilience and reduce stigma through providing support to people who would otherwise not access supports • Deliver assertive outreach health promotion activities, advice and information to communities • Identify and build relationships to support vulnerable communities.	• Deploy clinical staff to acute mental health response and assist in the Evacuation Centre (e.g., assessments, triage) • Provide mental health assessment, support and intervention for individuals and families • Provide information and support about ‘normal’ responses to disaster to people and communities • Provide early interventions (e.g., psychological first aid, self-care, peer support, supportive counselling etc) and practical support	• Provide psychological and/or peer support to people with ongoing mental health concerns related to disaster • Provide ongoing mental health support, education and promotion at community events and gatherings in disaster impacted communities.

Program	Role in Prevention and Preparedness phase	Role in Response phase	Role in Recovery phase
		• Provide access to self-help and psychosocial support (e.g., web-based interventions) at scale • Provide community outreach support for isolated communities that cannot or will not travel to designated Recovery Centres.	

Table 4: How to set up an integrated model of care

Service Elements	Considerations
What are the eligibility requirements?	• Establish eligibility criteria for access to the service may include: — lives in the geographical catchment or is in that catchment at the time of the disaster (prevention/preparedness and recovery) — is displaced as a direct result of disaster and temporarily residing in the geographical catchment (response) — presents with disaster related mental health and wellbeing needs and/or distress (and does not require an acute mental health response) — consents to the referral.
What is the referral process?	• Support a 'single front door' entry point • Establish soft entry referral processes from several access points (e.g. community-based services, interagency partners in the disaster recovery space and self-referral at community and/or disaster related events).
What are the hours of operation?	• Be flexible according to local needs. May include: — locally guided hours of operation during prevention/preparedness and recovery phases of the disaster — access to 24/7 support via the Mental Health Line — when required outside of business hours for community engagement activities — flexible hours in the response phase of the disaster — establish a rotating roster to ensure specific and equitable skill mix and ensure fatigue management.
What specific therapeutic interventions can be provided by the service?	• Provide a range of interventions based on recovery orientated and trauma informed care principles (e.g., psychological first aid, supportive counselling, motivational interviewing etc) • Provide practical support, (e.g. applications for housing support) • Link to other services and supports.
What are the review and discharge/transfer requirements?	• Review every 12 weeks or earlier if risk factors or symptoms intensify in ways that place the person or others at risk • Establish discharge/transfer criteria: — improvements in mental health and wellbeing — changes to needs and preferences that indicate an alternate service may be more appropriate and is available.
What are the documentation requirements?	• Document all contact hours and interventions as required by District/Program processes (e.g., number of mental health promotion and information-sharing activities and number of assertive outreach sessions, including travel time).
What resources and equipment need to be available?	• Ensure access to 4WD vehicles in lieu of standard fleet vehicle options in rural and remote locations for safety reasons. All vehicles need to be self-sufficient with recovery gear (e.g., kinetic recovery ropes and shackles, max Trax, tyre compressor, lithium battery charger etc), tool kit, first aid kit, UHF Radio and other items for safety. Recovery gear should only be used by trained staff

Service Elements	Considerations
	• Provide laptops with remote access capabilities, access to host LHD data collection systems, mobile phone, access to portable printer/scanner and laminator (for resources) and portable power supply: — Satellite phone — Provisions for community event attendance and travel allowances.
What training and support is required?	• Ensure all staff complete 1) Emergency Management Training (or similar) provided by Resilience NSW and 2) Introduction to Health Emergency Management and Emergency Procedures (via My Health Learning-Course Code 133766564) • Provide evidence-based culturally responsive therapeutic training and resources: — the impact of psychological trauma — the principles of Trauma Informed Care — applying Trauma Informed Care principles in your work and organisation — how to assess and talk about trauma safely and sensitively — using brief recovery-focussed interventions — looking after yourself — Psychological First Aid. • Focus on wellbeing and care of workforce.
What about local governance?	• Establish district-wide governance structure for RAMHP, Farm Gate and DRCs to deliver a coordinated stepped care response across the district • Establish a local primary contact for the community and other key service partners where appropriate. One example could be the Rural Adversity Mental Health Program Coordinators, but these roles are not clinical or funded to be 24/7, so LHDs may have other established arrangements for local coordination and contacts • Meet weekly or fortnightly to discuss clinical and community needs in the prevention/preparedness and recovery phase, which may include: — review new referrals — conduct safety huddles — discuss and plan for upcoming meetings and events. • Meet daily during the response phase to discuss community needs and changeable circumstances, which may include: — review new referrals — disaster weather forecast and road conditions — conduct safety huddle. • Integrate governance and all reporting lines (operational and professional) through the Local Health District Mental Health Service (MHS) and the Ministry of Health, in partnership with Aboriginal Community Controlled Health Organisations.

Principles

The principles were informed by the National Disaster Mental Health and Wellbeing Framework[1] and the 2018 Australian National Principles for Disaster Recovery, and then locally and culturally adapted for the NSW Health context, as shown in Table 5. A collection of ASK questions are included to promote reflection, inquiry and action when developing a local response and to help integrate the principles as shown in Appendix 2.

Table 5: Description of principles

Principles	Description
Governance and community leadership	Strengthen local community capability and mobilise workers and community leaders with knowledge and strong interpersonal relationships. Acknowledge that people and communities have lived experience in disaster and knowledge, skills, and existing supports.
Community-centred partnerships	Build collaborative and community-centred partnerships to ensure the design and delivery of services are responsive to the local context and are resourced to meet the needs and preferences of the community.
Holistic and inclusive care	Provide culturally safe and appropriate support – which includes ensuring services are culturally safe for Aboriginal people and are responsive to the needs of all priority population groups. Recognise that health outcomes are intrinsically linked to community recovery including social and economic infrastructure.
Access	Ensure mental health services are easy to access, appropriate and timely. Use clear and simple eligibility requirements and ensure increased flexibility in the response phase. Recognise that psychosocial recovery is multifaceted, and the services people need to alleviate distress include practical support. Plan for specialist mental health input for those with pre-existing trauma and mental illness and those who develop serious mental health conditions in the months and years after the disaster.
Proactive care	Be proactive in thinking about and acting on evolving community needs. Recognise that most people will manage well in the aftermath of the disasters with support and practical assistance; many will benefit from professional mental health support; and some will experience a delayed onset disorder after months or years.
Adaptable	Be adaptable in the moment and ensure the local response is designed in a way that is flexible enough to meet differing needs of priority populations, and whole communities through experiencing different disasters. Consider the community context as well as the nature of the emergency.
Communication	Ensure that communication strategies are established across agencies for clear and consistent messaging to the community. Establish regular communications and disseminate information through a wide variety of channels. Use trusted and established local organisations to support information sharing. Provide information and resources that can be adapted locally and tailored to meet the diverse needs of priority population groups.
Coordination	Ensure a coordinated approach is in place to mitigate stress, reduce duplication and minimise practical difficulties in service delivery. Recognise that people and communities are diverse, and their needs change over time; coordination will help people navigate and access appropriate support.
Workforce, education, and training	Build resilience and enhance capability by providing ongoing education and training to key community groups and individuals.
Planning	Ensure planning has been completed pre-disaster, with all stakeholders, including local communities and organisations. Ensure clarity of roles and responsibilities among stakeholders who will provide support and care to enable rapid mobilisation of resources and timely care.

Appendix 1: Evidence

Methods

The model draws on two main types of evidence:

- research evidence including peer-reviewed and grey literature identified through PubMed and Google searches
- experiential insights and evidence collected from healthcare providers and community members using a mixed methods consultation approach.

PubMed and Google searches were completed in February 2024 using a combination of key terms relating to disaster, mental health, and models of care. Search strings and inclusion and exclusion criteria are available in Box 1 and Box 2, respectively. A total of 792 studies were screened and 46 studies and reports were reviewed and included in the synthesis.

Experiential insights were gathered using connected conversations with health care providers (n=11) and community members in NSW (n=10). The connected conversations used appreciative inquiry as an asset-based approach to dialogue and occurred over four (6 hours) and five (7 ½ hours) days with health care providers and community members, respectively. A 60-minute online group discussion was conducted with community members (n=5) from a disaster-affected area in NSW (Quaama). A two-hour virtual Townhall was held with disaster and recovery healthcare providers (n=37). The Rural Mental Health Partnerships Governance Committee participated in a virtual workshop, and three individual interviews were conducted with stakeholders from partner organisations (e.g., Reconstruction Authority, Healthwise, and Department of Education). Yarning sessions were used to gather cultural insights with Aboriginal health workers (n=30), the Aboriginal mental health workforce (n=40), and with community members (n=8) in Northern NSW and Southern NSW. All consultations were conducted between 29 April 2024 and 10 June 2024. A qualitative analysis approach was used to explore the data gathered from the consultations and generate actionable insights for identified issues and opportunities.

Summary of research evidence

Existing literature on disaster mental health focuses on risk or protective factors, epidemiology, trajectories of mental health problems post-disaster, and preventive or therapeutic interventions for specific conditions or patient populations. Relatively few articles focus on the model of care or delivery of services for prevention and preparedness, response, and recovery. Those that do are largely descriptive with a mix of guidelines, frameworks, and toolkits for implementation, and case reports. There is limited published evaluative evidence for existing models of care, and those available are mostly output-orientated (i.e. processes, and volume of services delivered) rather than outcome-focused.

Following a disaster, people may need to access different layers of mental health and wellbeing support, from informal family and community support to more specialised services.[1] There are challenges for providing these services including:

- planning
- alignment to community needs
- timeliness (e.g. administration and funding processes)
- access (e.g. coordination, eligibility, workforce).[1]

National and international guidelines for mental health service planning mostly recommend a stepped approach to mental health interventions in the event of a disaster. The stepped approach usually starts with universal practical and psychosocial support and advocacy provided by relief workers, volunteers, and other non-clinicians. This escalates to selected and focused non-specialised support (basic mental healthcare provided by primary care providers or community workers), and then to indicative specialised support provided by mental health specialists based on needs.[1, 8] A comprehensive list of enablers and barriers to disaster mental health service implementation and people's access and utilisation of services is outlined in Table 6.

Box 1: Search strings

PubMed search terms

("Mental Disorders"[MeSH Terms] OR "mental health"[Title] OR "mental ill*"[Title] OR "mental disorder*"[Title] OR "behavioral health"[Title] OR "stress disorders, post traumatic"[MeSH Terms] OR "psychosocial"[Title] OR "psycho-social"[Title] OR "psychological"[Title]) AND ("disasters"[MeSH Terms] OR "disaster planning"[MeSH Terms] OR "disaster medicine"[MeSH Terms] OR "disaster*"[Title]) AND ("Delivery of Health Care"[MeSH Terms] OR "intervention*"[Title] OR "model*"[Title] OR "pathway*"[Title] OR "framework"[Title] OR "guidline*"[Title] OR "guidance*"[Title] OR "role*"[Title] OR "care"[Title] OR "service*"[Title] OR "program*"[Title] OR "support*"[Title] OR "response*"[Title] OR "recovery"[Title]) AND ("humans"[MeSH Terms] AND "english"[Language]) AND 2014/01/01:2024/12/31[Date - Publication]

792 hits on 22 February 2024

Google search terms

Mental health disaster response, mental health disaster recovery, disaster response and recovery models of care, disaster response and recovery framework

Note only the first three pages of search results will be screened.

Box 2: Inclusion and exclusion criteria

Inclusion	Exclusion
• Published in English • Published since 2014 • **P**opulation: people affected by disasters such as natural disasters, health pandemics or human-caused disasters such as terrorist attacks, major/mass incidents or crises or conflict, etc • **I**ntervention: mental health models of care covering response and/or recovery • **O**utcomes: implementation outcomes such as effectiveness, timeliness, and people-reported outcomes, facilitators and barriers • **S**tudy types: • Review studies with systematic search strategy and methods • Experimental studies with/without a comparison group • Observational studies with/without a comparison group • Descriptive studies describing models of care or frameworks. • Grey literature such as guidelines and consensus statements • **S**etting: Australian jurisdictions or high-income OECD countries with similar healthcare systems to Australia.	• Not in English • Published prior to 2014 • Studies that do not meet **PICOS** criteria • Studies reporting on only one specific aspect of care delivery without elaborating on the overall organisation of care (i.e. assessment, or a particular therapy, counselling or treatment intervention) • Studies reporting on pre-disposing risk factors, needs or epidemiological impact of disasters.

Pre-identified mental health disaster response and recovery models of care for inclusion

Existing model of care or framework:

- National Disaster Mental Health and Wellbeing Framework
- Hunter New England Local Health District (HNELHD) has developed a draft Disaster Recovery Team Model of Care.

NSW Health funded programs:

- Disaster Recovery Clinicians (DRCs)
- Rural Adversity Mental Health Program (RAMHP)
- Farm Gate Counsellors and Rural Peer Support Worker Program (Farm Gate).

Table 6: Enablers and barriers to disaster mental health service implementation; and people's access and utilisation of services

Enablers	Barriers
Ensuring competency of care[9, 10]	Stigma around mental health[13, 22]
Being sensitive to community features such as assets, vulnerabilities and values[11]	Lack of knowledge about services available or not knowing eligibility criteria[13, 23, 24]
Avoiding harm[9]	Motivational barriers such as avoiding help-seeking due to pessimism or reluctance[22]
Delivering Trauma informed care[12]	Financial difficulties in accessing care[22]
Protecting confidentiality and privacy[9]	Self-reliance or preference to self-manage mental health problems[22]
Respecting autonomy [9]	Lack of time[22]
Promotion of help-seeking behaviour[13]	Not knowing whether their emotional response to disaster is normal or not[24]
Flexible referral pathways[14]	Long waiting list to access support[24]
Taking a strength-based approach[15]	Reluctance to use services due to concerns about taking up resources from someone who needed them more[23]
A work plan for service coordination, roles and responsibilities[16]	
Addressing the psychosocial needs of the responders themselves[15, 16]	
Strong leadership centring around community[15]	
Collaborating and coordinating across sectors and agencies[15]	
Communicating and engaging with community[15, 17]	
Gathering and sharing insights, stories using minimally invasive, community-based, and culturally responsive methods and lessons leant[15]	
Improved preparedness for socioeconomically marginalised groups, young children and their care givers, and other groups that are more susceptible to adverse mental health oucomes[18 19-21]	

Summary of experiential evidence

Findings from the mixed methods consultation approach were categorised into themes, with future-focused actionable insights presented in Table 7.

Table 7: Themes, future-focused actionable insights, and quotes from the consultation

Themes	Future-focused actionable insights	Quotes from the consultations
Resilience at all levels	• Foster strong connections within and between communities and services to build trust. • Shift the focus from trauma to support, growth, and resilience. Draw on the knowledge and wisdom of people in local communities. • Focus on the wellbeing and care across the workforce at every disaster phase. Acknowledge that people live and work in disaster-affected areas, and while they care for others, they may be impacted themselves.	"There is never enough mental health staff - so how might we upskill our community"

Themes	Future-focused actionable insights	Quotes from the consultations
	• Recognise that inequities are exacerbated by disasters. Focus on equitable resource distribution and partner with local leaders and community members.	
Awareness and proactive preparedness	• Provide education at the community level to ensure people are well-equipped before a disaster. • Use early intervention strategies and outreach to ensure psychological safety/defusing and to reduce the risk longer-term impacts. • Establish coordinated emergency plans with clearly defined roles across all services. • Distribute resources to help people talk about disasters and build awareness of reactions and coping strategies.	"Out of three natural disasters in my community, the one where we were called together by the Emergency Services is the one which we had the most connection afterwards. We connected emotionally, gathered information, sought out those who had resources they would share with others, and determined those in need" "Recognise the support for 'men' will likely happen in parallel with there being task-based activities"
Local responses with local communities	• Design the local response to meet the unique needs of each community and leverage local cultural knowledge from within the community. • Leverage community and place-based solutions to build capacity and capability.	"When there are opportunities to come together – it's easier to look after each other"
Partnerships with clear role delineations	• Implement a staggered response to ensure that services and assistance is mobilised and deployed strategically and not all at once. • Plan across organisations and sectors. Establish clear roles and responsibilities to enhance coordination and prevent confusion from the start. • Use available resources to ensure timely, coordinated, and adaptable local responses.	"There used to be a psychologist who came into town and ran a clinic at the hall. Since the floods, we haven't seen her, and some people are really struggling."
Sustained efforts	• Focus on long-term and sustained efforts – rather than short-term or ad hoc disaster responses. • Build into budgets evidence-based therapeutic training and resources and provide assurance around long-term funded positions. • Assess and address disparities in disaster response and recovery efforts to address systemic inequities. • Offer lower-intensity interventions to ensure greater reach across communities.	"When the floods hit, people all helped each other, and the local organisations all worked together to make sure we had what we needed."
Cultural ways	• Address systemic racism by ensuring equitable access to resources and supports that are culturally responsive and safe.	"We need to be coming together to heal. Not just mob. But with everyone. The things we know – our art,

Themes	Future-focused actionable insights	Quotes from the consultations
	• Incorporate traditional Aboriginal knowledge and practices across all disaster phases. • Ensure that disaster response and recovery efforts respect and preserve the cultural heritage of affected communities, including support for traditional practices and languages.	our stories, they'll help everyone get better afterwards"

Appendix 2: ASK questions to integrate the principles in a local response

Principles	ASK questions
Governance and community leadership	• How has the local response been informed by the local community and what partnerships are in place to support implementation? • Are there clear role delineations? • Is there a safe space for community voices to be heard? • Has there been engagement with ACCHOs, NGOs, local Elders and leaders? — contact LHD Aboriginal Clinical Lead.
Community-centred partnerships	• Does the response focus on a coordinated approach to care and support, based on the needs and preferences of the community? • Does the response emphasise high community and service visibility? • Is participation in community events prioritised?
Holistic and inclusive care	• Has cross-service collaboration been established to minimise the need for repeat storytelling? • Is flexibility embedded in the design of service delivery? Including location, length of service and duration of individual occasions of service.
Access	• How does the model address and reduce barriers to enable equitable access to care and support, especially for priority populations? • Is there a single point of entry or 'no wrong door' approach to access and referrals? • Does the level of acuity to access specialised services reflect the complexities of mental wellbeing in the context of disaster?
Proactive care	• Is there a plan in place to provide a fully coordinated psychosocial response to the disaster? Does this include: — immediate practical help? — access to specialist mental health, evidence-based assessment and treatment? — clinical roles? — responsibilities and are clearly articulated?
Adaptable	• Does the response meet the needs of priority population groups or communities who face additional barriers? • How has the Aboriginal world view and concept of health been embedded in the response?
Communication	• Has a communication plan been developed that utilises multiple communication methods, including targeted material for priority population groups?

Principles	ASK questions
	• Is there a single point for communication sharing that is not reliant on technology? • Are there cross-agency communication portals to support the response?
Coordination	• Who is best placed locally to lead coordination across all phases of disaster? • Is coordination being led by a local organisation? • Have existing services been mapped?
Workforce, education, and training	• Has standardised training been tailored to meet the needs of the community? • Have staff been identified who want to be involved in disaster response? • Has psychological first aid training been delivered to key workers and community members? • Are there additional mechanisms for cultural supervision for Aboriginal staff supporting the response? • Has a plan been developed to provide additional training and education for the non-mental health workforce and community?
Planning	• Has a safe space been created for community to express their concerns and preferences to inform the model? • Do all stakeholders understand their roles and responsibilities across all phases and tiers of disaster?

Supplementary File 1: Aboriginal Mental Health Resources

Background

NSW Health recognises the ongoing strength and resilience of Aboriginal people and is committed to working in partnership to ensure they have a genuine say and capacity to lead, design and deliver policies and programs that affect them. NSW Health is committed to improving health outcomes and supporting Aboriginal peoples' right to self-determination. By embedding co-design into service planning, design, delivery and evaluation, NSW Health will ensure knowledge and expertise of the Aboriginal community guides the health system at every level, including identification of key issues. NSW Health recognises that models of culturally safe and appropriate mental health care are critical for ensuring optimal outcomes for Aboriginal people.

Holistic definitions to ground the principles and components of care

An Aboriginal definition of health provides a holistic understanding of health. This definition grounds the principles and care components to meet the needs of whole communities and priority populations.

The National Aboriginal Community Controlled Health Organisation (NACCHO):

"'Aboriginal health' means not just the physical well-being of an individual but refers to the social, emotional and cultural well-being of the whole Community in which everyone is able to achieve their full potential as a human being thereby bringing about the total well-being of their community. It is a whole of life view and includes the cyclical concept of life-death-life."

Culturally responsive care and support

Culturally responsive care and support combines Aboriginal cultural ideals, knowledge, and practices with western practices. It takes a holistic approach to wellbeing across all phases and tiers of disaster, enabling population level and targeted interventions that are culturally safe, locally designed, and adaptable to evolving needs of communities.

Impact of disasters on Aboriginal communities

When considering the impact of disaster through an Aboriginal lens, it must be acknowledged that the destruction of lands, displacement of people, and culturally inappropriate responses have a profound impact on the wellbeing of Aboriginal people. Aboriginal culture, and therefore wellbeing, is tied to Country – traditional medicine/food, birthing and ceremonial sites. Where there is a change in the landscape due to disaster – burning of scarred trees from bush fires, eroding of rock art from floods - elements and history of culture are lost and cannot be rebuilt. Genuine cooperation, consultation and co-design with Aboriginal communities is crucial to providing culturally responsive care and support across all phases and tiers of disaster.

Consultation Learnings

Summary of experiential evidence

During the mixed methods consultation approach, 'Cultural ways' emerged as a theme.

Theme	Future-focused actionable insight	Quotes
Cultural ways	• Address systemic racism by ensuring equitable access to resources and supports that are culturally responsive and safe. • Incorporate traditional Aboriginal knowledge and practices across all disaster phases. • Ensure that disaster response and recovery efforts respect and preserve the cultural heritage of affected communities, including support for traditional practices and languages.	"We need to be coming together to heal. Not just mob. But with everyone. The things we know – our art, our stories, they'll help everyone get better afterwards"

Enablers & Barriers

As part of the consultations in the development of the model of care, ACI conducted yarning sessions. These yarning sessions identified several enablers and barriers for Aboriginal people.

The enablers are also present in the *NSW Aboriginal Mental Health and Wellbeing Strategy 2020-2025* which is being implemented across NSW Health and helps enact the goals of shared governance under the Closing the Gap Agreement.

Some of these enablers are specific to Aboriginal people and communities, such as centring reconciliation and indigenous views of wellbeing. Others are applicable to both Aboriginal and non-Aboriginal communities.

Enablers	Barriers
Providing culturally appropriate and sensitive care	Competing priorities such as seeking basic shelter and food
Centring reconciliation and indigenous views of wellbeing	Deprioritising own health needs in favour of looking after others'
Ensuring competency of care	Lack of financial resources
Being sensitive to community features such as assets, vulnerabilities and values	Lack of transportation resources
Avoiding harm	Medical bureaucracy and processes, i.e. difficulties in making appointments, accessing referrals, and arrangement of imaging and testing
Delivering Trauma informed care	Preference to engage with Aboriginal Community Controlled Health Organisations (ACCHOs) over mainstream services due to poor treatment from medical reception staff, not being able to see a preferred doctor, and lack of Aboriginal staff.
Protecting confidentiality and privacy	
Respecting autonomy	
Promotion of help-seeking behaviour	
Flexible referral pathways	
Taking a strength-based approach	
A work plan for service coordination, roles and responsibilities	

Enablers	Barriers
Addressing the psychosocial needs of the responders themselves	
Strong leadership centring around community	
Collaborating and coordinating across sectors and agencies	
Communicating and engaging with community	
Gathering and sharing insights, stories using minimally invasive, community-based, and culturally responsive methods and lessons learnt	
Improved preparedness for socioeconomically marginalised groups, young children and their care givers, and other groups that are more susceptible to adverse mental health outcomes.	

NSW Health Aboriginal Initiatives

NSW Health plays an important role in the governance of mental health and wellbeing support and responses to disaster in partnership with Aboriginal-led organisations such as the NSW Aboriginal Health and Medical Research Council and Aboriginal Community Controlled Organisations. These partnerships build on funded programs such as the Aboriginal Mental Health and Wellbeing Model of Care, Building on Aboriginal Communities Resilience and Ministerially Approved Grants.

The Model of Care pilots in particular help provide appropriate, timely and sustainable support in the context of disaster and enable holistic, culturally safe and sustainable care and support for people in NSW who experience disasters. They also ensure representation from Aboriginal Community Controlled Organisations, Elders, and other leaders on governance.

NSW Health also funds Aboriginal Clinical Leads, Aboriginal Care Navigators, Aboriginal Peer Workers and the Djirruwang Aboriginal Mental Health Worker Education and Training Program to build capacity in local health districts and specialty health networks and provide culturally safe mental health supports.

The NSW Aboriginal Mental Health and Wellbeing Strategy 2020-2025

The NSW Aboriginal Mental Health and Wellbeing Strategy 2020-2025 was designed to support and assist NSW Health services in delivering respectful and appropriate mental health services in partnership with Aboriginal services, people, and communities. It reflects the NSW Government's commitment to closing the health gap between Aboriginal and non-Aboriginal people in NSW.

Closing the Gap

Funding has been provided to expand the Building on Aboriginal Communities' Resilience initiative to 12 new Aboriginal Community Controlled Health Organisations (ACCHO). The funding will significantly boost access to community-led culturally appropriate suicide prevention activities.

Funding has also been provided to implement Aboriginal mental health models of care across NSW mental health services. The annual grants will be available to local health districts, specialty health networks and Aboriginal Community Controlled Health Organisations.

Aboriginal Mental Health and Wellbeing Models of Care (MOC)

The objective of this initiative is to implement localised, evidence-based, cultural models of mental health and wellbeing care (MOC) that improve the cultural safety, effectiveness and quality of mental health services and care pathways for Aboriginal people and communities. This initiative will enable local health districts, specialty health networks and ACCHOs to assess readiness and identify next steps to

developing a MOC that reflects local context. The initiative aims to remove barriers to access and improve the experience of Aboriginal people, families, and communities who access the mental health system.

MOC will share the values of collaboration, connection and holistic care and support principles such as shared governance, cultural safety and trauma-informed and strengths-focused approaches.

Effective MOC are likely to share the values and related principles of:

Value		Related principle
Collaboration	1	A commitment to shared governance and joint decision-making is evident
	2	Strong partnerships between ACCHOs, Districts, Networks and communities are enabled and empowered
	3	Services and pathways are locally tailored to the needs of the community and connected care is prioritised
Connection	4	Culturally safe care environments are delivered that embrace Aboriginal understandings of social and emotional wellbeing and healing
	5	Outreach to the community, health promotion and improving mental health education and literacy are prioritised
	6	The Aboriginal mental health workforce is recognised as key to the successful delivery of care and services
Holistic Care	7	A person-centred and strengths-focused approach is applied to the delivery of holistic care and support
	8	Work is being undertaken to improve the social determinants of health affecting the individual
	9	Trauma-informed approaches are embraced and employed in the provision of care

Mental Health Recovery Package

NSW Health has also invested in expanding the Aboriginal mental health and suicide prevention workforce. 18 Aboriginal Care Navigators positions have been created across NSW. Each local health district and specialty health network has access to one position. The Aboriginal Care Navigators are responsible for supporting Aboriginal people and their families to connect with the most appropriate service within and outside the local health district or specialty health network.

There are also 18 Aboriginal Mental Health & Wellbeing Peer Worker positions with one position sitting in each local health district and specialty health network. These positions ensure culturally sensitive support, particularly in emergency settings, and provide much needed links to other culturally appropriate services such as suicide prevention services, drug and alcohol services, and Aboriginal community services.

Aboriginal Mental Health and Wellbeing Disaster Recovery Program

The Aboriginal Mental Health and Wellbeing Disaster Recovery Program aimed to support the medium to long term healing of Aboriginal communities impacted by the flood events of February and March 2021. The Program provided funding to enable ACCHOs to design and implement culturally appropriate, locally based solutions to support affected Aboriginal communities. It is expected that the Program will end in 2025.

Glossary

Term, acronym, or abbreviation	Definition
ACCHO	Aboriginal Community Controlled Health Organisation
ACI	NSW Agency for Clinical Innovation
CMO	Community Managed Organisation
DRC	Disaster Recovery Clinicians
EMPLAN	State Emergency Management Plan
LALC	Local Aboriginal Land Council
LHD	Local Health District
NACHHO	National Aboriginal Community Controlled Health Organisation
NGO	Non-Government Organisation
RAMHP	Rural Adversity Mental Health Program
RFS	Rural Fire Service
SES	State Emergency Service
SOLAR	Skills Of Life Adjustment And Recovery
SPR	Skills for Psychological Recovery

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