GOVERNMENT OF WESTERN AUSTRALIA

DFES Department of Fire & Emergency Services

FOR A SAFER STATE

# ROYAL COMMISSION INTO NATIONAL NATURAL DISASTER ARRANGEMENTS

## Priority Action XIII: Prioritisation of Mental Health and Inclusion of Primary Healthcare Providers in Disaster Management

Australian, State and Territory Governments Survey Results

December 2023

# **About this** Document

This report was produced by the Department of Fire and Emergency Services (DFES) Western Australia (WA), on behalf of the Priority Action XIII Working Groups (PAXIIIWG) 15.2 and 15.3.

The report was developed with the assistance and input of the PAXIIIWG 15.2 and 15.3 and consultation with external agencies.

The following people and organisations were consulted in the development of this document:

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- Mr Matt McNally, Director Emergency Relief and Support, Community Services, Department of Communities (WA) – Chair of PAXIIIWG 15.3
- Dr Penny Burns, General Practitioner and Disaster and Emergency Management Consultant (NSW)
- Australian Government Department of Health and Aged Care
- National Emergency Management Agency (NEMA)
- NSW Health
- Tasmanian Government Department of Health
- Department of Health (WA)
- NT Health
- SA Health
- Queensland Health
- Emergency Management Victoria (EMV)
- ACT Emergency Services Agency
- Department of Fire and Emergency Services (WA)
- NSW Reconstruction Authority
- Department of the Premier and Cabinet (WA)
- Department of Communities (WA)
- Mental Health Commission (WA)
- Royal Australian College of General Practitioners (RACGP)
- Various Primary Health Networks (PHNs), nationally
- Disaster and Emergency Management Primary Care Special Interest Group
- Australian National University (ANU)
- Australian Medical Association (AMA)
- Western Sydney University (WSU)

# **Executive** Summary

It was agreed at the National Emergency Management Ministers Meeting (NEMMM) in July 2022, that Western Australia (WA) would lead the Royal Commission into National Natural Disaster Arrangements (Royal Commission) Priority Action XIII: Prioritisation of mental health and inclusion of primary healthcare providers in disaster management.

**Recommendation 15.2 Inclusion of primary care in disaster management**

- Australian, state and territory governments should develop arrangements that facilitate greater inclusion of primary healthcare providers in disaster management, including representation on relevant disaster committees and plans and providing training, education and other supports.

**Recommendation 15.3 Prioritising mental health during and after natural disasters**

- Australian, state and territory governments should refine arrangements to support localised planning and the delivery of appropriate mental health services following a natural disaster.

To support the progression of these recommendations, WA established two time-limited National Priority Action XIII Working Groups (PAXIIIWG) in late 2022.

The working groups consisted of representatives from all Australian states, territories and the Commonwealth. Representatives were invited to complete a survey (Appendix 1) to develop a holistic understanding of the activities that the Commonwealth and jurisdictions were already undertaking to progress the implementation of the recommendations and identify any gaps.

Due to the diverse range of professional groups providing primary healthcare, the working group focused primarily on General Practitioners (GPs) where more substantive evidence and research exists.

## Survey results

This report was developed using the information provided by Australian, state and territory government representatives in response to the survey. It sought to identify opportunities to progress the implementation of the Royal Commission Recommendations 15.2 and 15.3.

The survey results confirmed the PAXIIIWG members' perception that Australian, state and territory governments are already undertaking numerous projects, activities and programs that are considered to facilitate the prioritisation of mental health and inclusion of primary healthcare providers in disaster management.

The key themes that emerged from the survey were:

- funds and funding models
- the role of primary healthcare
- education and training
- importance, utilisation and involvement of Primary Health Networks
- inclusion of GPs in disaster healthcare
- the role of GP organisations in disaster education, training and guidelines e.g. Royal Australian College of General Practitioners (RACGP), Australian College of Rural and Remote Medicine (ACRRM), Australian Medical Association (AMA), National Aboriginal Community Controlled Health Organisation (NACCHO), Aboriginal Health and Medical Research Council of New South Wales (AHMRC)
- resources
- community pharmacy sector
- coordination, collaboration and communication between agencies, the community and healthcare providers
- developing relationships and engagement including sustained collaboration written into systems and processes such as standing positions on committees etc
- liaison officers and networks
- policies, strategies, procedures and arrangements in place and some with active reviews
- emergency management frameworks, arrangements and committees
- national frameworks and plans (mental health)
- project and program reporting
- committees and governance
- post-disaster and program reviews
- grant funding requirements
- importance of specialist and special interest disaster management groups within primary healthcare
- legislation, rules and regulations
- jurisdictional differences and harmonization
- youth mental health programs and support
- social support (mental health)
- models of care (mental health)
- mental health programs and preparedness.

The most significant themes and topics raised in the survey results are discussed below.

Following the compilation and analysis of the survey responses, Dr Penny Burns, a GP and Disaster and Emergency Management Consultant from NSW shared the lessons learned from her research and experiences in primary healthcare and GP involvement in disasters and planning for disaster management.

The insights Dr Burns provided are included in this report and form part of the recommendations.

## Funds and funding models

The key to including primary care in activities relating to the disaster cycle and prioritising mental healthcare during and after natural disasters is access to funds and sustainable funding models. This also includes sustaining General Practice in disaster management, which can be difficult to navigate due to the complexity of having the public health system funded by states and territories and the primary health system funded by the Commonwealth. The GP model of payment is a fee for service model which complicates the situation further.

The commentary about funding was multi-faceted, including funds being a barrier for jurisdictions and the lack of financial support for healthcare providers to attend planning meetings – and the work that ensues – means that there is little or unsustained involvement of primary healthcare providers in disaster planning meetings and other related activities.

Where funding does exist, it is accessible through funded programs. Ad hoc, time-limited funding has also been made available for Primary Health Networks (PHN) to assist with primary healthcare responses, including mental health supports, to specific disaster events. However, funding consists largely of one-off grants in response to specific disaster events, based on need, that do not allow for sustained and sustainable disaster planning, education, preparedness and training. PHNs are only part of the GP Disaster Healthcare Management (DHM) system and GP professional groups also need funding to provide sustained guidance education and training for GPs in DHM.

GP professional groups (e.g. RACGP, AMA etc) have played an important role in providing additional support in areas where local PHNs have limited capacity, and have also contributed to strengthening the national voice for GPs in DHM.

There is a disparity between funding arrangements at the Commonwealth and jurisdictional levels which limit the visibility, accessibility, transparency and sustainability of primary healthcare engagement in the emergency management and disaster medicine space. This results in a lack of end-to-end solutions to disaster planning, mitigation, response and recovery challenges.

It is acknowledged that funded organisations are typically flexible and agile in supporting the implementation of measures and respond to delivering services in innovative ways. This expertise should be leveraged in any future funding arrangements to allow for sustained continuity of health services over the longer term (if practices close due to financial impact of the disaster, this impacts future healthcare in that community - especially rural/regional areas) in the rapidly changing environment of a disaster response.

For mental health, the availability of additional funding and the timely provision of this funding, means the ability to scale up mental health services following a disaster event. Flexibility in reporting and inclusions and exclusions in funding agreements are required to enable pivoting from business as usual during a disaster response.

In relation to timeframes for funding for additional mental health recovery programs through locally based services, these often do not align with community needs, which results in services reducing at a time of critical need. It also puts unsustainable demands on the services when they transition back to business as usual.

Overall, existing funding arrangements are identified as barriers to inclusion, scalability and adaptability of work that could be considered to facilitate the prioritisation of mental health and inclusion of primary healthcare providers in disaster management. In the same vein, some government processes are identified as an inhibitor to the timeliness of funding and often funding and grants have end dates, which can mean the cessation of a program or role. As a result, the short-term nature of these funds has impacts on staff retention and wellbeing.

## The role of primary healthcare

Primary healthcare is recognised as an essential and critical part of the health system and emergency planning, response and recovery. However, it is not embedded formally and sustainably as a part of emergency preparedness and response structures at regional, state and national levels.

Primary healthcare also faces challenges based on long-standing arrangements, such as the differences between Commonwealth and jurisdictional responsibilities and funding arrangements.

Primary healthcare recorded some successes in disaster management such as rapid credentialling of primary healthcare providers so they can work in hospital facilities where local infrastructure is compromised, shared staffing arrangements for isolated communities and supporting local primary healthcare providers when communities are isolated.

Respondents emphasised the value that PHNs contribute during disasters, highlighting their flexibility and adaptability to support primary care responses to disaster events. Respondents pointed to the COVID-19 pandemic as a key example of the value of systematically integrating PHNs into preparedness and response planning frameworks.

An example of the broad base of organisations that support primary care in disasters and their roles was witnessed during COVID where the major roles, guidelines, authority and support for GPs came from State and National GP professional and advocacy groups (RACGP/AMA/ACRRM/NACCHO/AHMRC), while the operational activities were supported well by the PHNs.

Aboriginal Community Controlled Health Organisations (ACCHOs) are also valuable contributors to the delivery of primary healthcare to displaced residents in a disaster, as they promote continuity of care, maximise trust and effectively deliver healthcare.

## Education and training

Investment in training and education is critical in order to enable jurisdictions to effectively prioritise mental health and include primary healthcare providers in the disaster management cycle.

Training needs to be primary healthcare specific, nationally consistent and incorporate the essential evidence-based knowledge and skills relevant to each primary healthcare professional stakeholder group e.g. GPs and Pharmacists. Professional bodies (such as the Royal Australian College of General Practitioners (RACGP)) have substantial disaster educational resources that are rolled out and disseminated in disasters, while the PHNs support presentations and webinars approved by the professional colleges.

However, existing training does not seem to cover the aspects and roles of primary healthcare and does not explain how primary healthcare providers link to the bigger disaster management picture. In addition, the availability of training resources does not equate with dissemination and/or intake as the end-users (primary healthcare workers) are not funded to attend these courses.

Survey respondents reported there is training and professional development for their primary healthcare and allied health providers that includes mental health training. There are also tailored courses and programs that have been developed such as a blended psychological first aid training course for pharmacists and pharmacy staff and other education and training projects, including for local community agencies and collaborative training with GPs.

However, the offer of training activities does not address the financial burden for GPs to attend, nor the loss of income should these activities occur during working hours.



## Primary Health Networks

Primary healthcare is the entry point to the health system and, is usually a person's first encounter with the broader healthcare system. It includes a broad range of services and programs; from health promotion and prevention to treatment and management of acute and chronic conditions. This is supported by a diverse primary healthcare workforce consisting of a range of professions and specialisations. As such, these workers and the sector at large are not represented by a single professional representative body. Further, each individual profession may have multiple representative bodies, which do not capture the entire workforce, nor work in synchronicity from a common agenda.

A suitable surrogate for such a representative body at the local level are the 31 Primary Health Networks (PHN) across Australia. Each PHN is considered a local conduit for primary healthcare to be incorporated into disaster management, as they contribute to recovery arrangements, including commissioning of appropriate services for their community. The survey respondents suggested that PHNs should assist with primary healthcare response and training, communicate updates and issues to their members and with other GP and primary healthcare groups and maintain a register of GPs who are trained and prepared to contribute to a funded emergency response. PHNs' working arrangements can vary to suit local conditions. PHNs – not surprisingly – are considered an integral part of the primary healthcare ecosystem. The Royal Commission highlighted the importance of integrating primary healthcare into disaster preparedness and response and PHNs are a valuable way to achieve this, as they have already demonstrated their flexibility and adaptability to mobilise primary healthcare into disaster response. They are also a source of real-time information, including signalling where there is an adverse effect on primary healthcare service delivery, healthcare impacts and identifying emerging needs and challenges.

PHNs hold several formalised, other ad-hoc or responsive roles depending on the issues. These roles include collaboration on regional planning and coordinated service provision in response to natural disasters and membership of planning committees, advisory groups and forums. It is crucial that consistent disaster management functions are developed for PHNs, that include role descriptions and outputs.

Additionally, as part of their core business, all PHNs are expected to maintain a capacity to integrate with jurisdictional disaster preparedness and response planning frameworks. This will be formalised and aligned with the Commonwealth's forthcoming Primary Health Network Strategy.

Close collaboration is undertaken with PHNs and their commissioned primary mental healthcare service providers in the planning, development, commissioning and coordination of mental health services and response. PHNs are integral in prioritising youth mental health by facilitating access and improving pathways to care such as headspace and through services that build resilience and growth and for rural and regional youth.

Overall, rapidly engaging with PHNs in shared planning in a disaster helps develop a consistent and integrated response and ensures services are complementary, rather than duplicating or leaving service gaps in the community.

## Inclusion of General Practitioners (GP) in disaster healthcare

An outcome of the Royal Commission was the acknowledgement that GPs are willing to provide healthcare in disasters. There was also acknowledgment that there is a need for GPs to provide healthcare during disasters but that most GPs had little training in disaster management or understanding of disaster concepts and linkages they could tap into.

For GPs assisting in disasters, they have encountered issues including accessing rebates for billed services at evacuation centres and location-based arrangements, which need to be fit for purpose when services are disrupted.

Addressing these issues will enhance the strengths of GPs and enable them to bring proven and sustained benefits to healthcare during and post disaster.

In the development of training for GPs, there are reported educational successes. Disaster-related educational activities are available for medical students, scenario workshops and lectures are conducted in various Australian medical schools and GP Colleges offer disaster management teaching during registrar training. GP Colleges have conducted numerous training and disaster-focused scenarios for interested GPs, but these are often delivered at conferences and the reach is low.

Engagement of GPs in disaster activities appears to reflect a personal special interest rather than a cohort-led activity, i.e. it is an opt-in process and can be summarised as a coalition of the willing. Even so, this has the potential to encourage the growth of disaster management expert GPs. The group's potential to deliver further education and training is undermined by its critically endangered sustainability.

A few PHNs have developed, and continue to develop, disaster educational activities specifically for GPs. While still under development, these educational activities are aimed at training interested GPs on how to be involved in emergency response in evacuation centres. The courses also aim to support GPs who remain working in their practices to maintain the continuity of healthcare, which reduces the burden on other emergency services, local hospitals and emergency departments. As noted elsewhere, from the provider's perspective, these courses are not mandatory, nor subject to credentialling or to competency review. From the recipient's perspective, attendance at these courses is largely un-funded.

While there is a growing number of GPs who have been involved personally in disaster response, it must be noted that this does not necessarily equate with formal or accredited disaster education or competency.

The common view is that GPs must be included in the larger multi-agency healthcare response and, to help increase the understanding of the value of GP inclusion,

greater visibility of primary healthcare resources during response is required. While some local resources with this intent seem to exist, they must be generalised, integrated, publicised and consistent.

It is also important that the inclusion of GPs in disaster healthcare is informed by existing and evolving evidence. GP contributions and roles are based largely on academic research on disaster healthcare needs, as well as interviews with GPs who have experienced disasters.

The key role of GPs in disasters is to keep their practice doors open and redirect patients away from the emergency department, which is often achieved by extending operating hours. It is essential that General Practices in disaster areas are prioritised for re-establishment, as GPs cannot operate where there is no infrastructure. There is anecdotal evidence that GPs in these situations have worked in evacuation centres while seeing their usual patients, who could not access their GP in their usual location.

Support for primary healthcare business continuity should be a top priority in a disaster, as well as ongoing continuity after the disaster. This will enable General Practices to continue to operate once the community has recovered, ensuring communities do not lose their local GP. Business continuity should be based on a scalable and proportional model, in line with emergency management doctrine, starting with local arrangements between primary care provider businesses themselves and then between them and public and private healthcare facilities.

## Resources

The survey responses indicated human resources remain a significant challenge, with recruitment delays and a low number of applicants for leadership roles a recurring issue. Community organisations face chronic workforce shortages alongside a surge in demand for services, which is directly linked to short-term funding models resulting in insecure tenure. This lack of sustainable employment often results in higher staff turnover in many programs.

Respondents reported that recruitment for allied health professionals is difficult. In addition, large scale and protracted events such as bushfires, floods and pandemics do interrupt business continuity; redeployed staff are absent from their normal workplaces and regular client appointments deferred unpredictably.

On the other hand, request for staff to deploy in disaster affected areas deplete an already thinned workforce and often cannot be authorised due to loss of business continuity and the need to maintain front line healthcare operations.

Some work has been undertaken to address the mismatches of supply and demand in primary healthcare that could be provided out of hospital but those could not be resourced by private primary healthcare practitioners.



There is also a lack of available funding to employ additional specialist resources. Additionally, at a practitioner level, there is an absence of funding for emergency management training, professional development, personal protective equipment and other necessary equipment.

Similarly, in mental health, there is a lack of qualified psychologists and allied health workers available to work in schools and who are specially trained to support children, adolescents and their families.

## Community pharmacy sector

The community pharmacy sector is an important component of primary healthcare. They are a nationwide network that remain open and provide access to vital lifesaving medications and other professional services in times of bushfires, floods and pandemics and can provide extended and continued dispensing under Controlled Substances/ Emergency Management Provisions in disasters.

Community Pharmacy should be considered a frontline asset to be either deployed, or maintained functional, early in any emergency response and be included as a standing member on the various state, local and national emergency planning forums. Linkages between GPs and pharmacists are important in expediting access to regular medications in disasters.

## Coordination and collaboration between agencies, the community and healthcare providers

Integral to a process-driven healthcare system is collaboration and unrestricted sharing of relevant information. This includes collaboration with other local and regional teams, community partners, services, clinicians and support staff when engaged in disaster response.

Respondents indicated that regular engagement and communication is underway nationally across the healthcare sector, in the form of information sharing via regular working groups, meetings and forums. As well, assurance mechanisms are in place to capture lessons identified and enable continuous improvement by embedding these lessons in future activities and programs.

This raises the issue of a consistent system of GP disaster management (DM) planning and communication nationally. The GP working groups and the DM working groups don't regularly overlap though the GP discussion table set up for disaster planning with the Department of Health (DoH) and peak GP groups in 2009 by Chris Baggoley worked very well.

It was restricted to a very tight invite of one representative (rep) only of the key GP groups including a national PHN peak rep (in 2009 it was a national Medical Local rep), RACGP/ ACRRM/AMA/NACCHO etc - the key idea was to keep the membership tight and limited, with occasional special guests due to their special knowledge for the particular discussion.

This worked well for discussion planning and dissemination of consistent, accurate and timely information back to individual GPs. The addition of State Disaster Managers would work well here – to keep consistent known peak planning and communication groups representing General Practice Disaster Management for the planning (albeit, the directive is primary care, initially it could just include GP and pharmacy). This group would be the conduit for GP/Pharm/disaster consultation - currently there is no cohesive system of GP planning and discussion.

Business-as-usual is always disrupted during disasters and in the post-disaster period. Adequate planning and testing of alternative operating procedures need to be undertaken, focusing on coordination, communication, ongoing and/ or new partnerships, relevant MOUs, understanding current capacities and available capabilities, as well as referral pathways between primary and clinical and mental health services. These are essential to meet the community requirements at times of need and severely limited resources.

Therefore, the importance of developing strong and effective relationships, and collaborating with partner agencies, service providers, PHNs and across government prior to activation cannot be emphasised enough. To augment these partnerships, it is essential that clear and well-understood communication and activation protocols are in place, which are forged during peacetime and are exercised regularly.

Early engagement is a key to success, for example, between primary and available mental health services to make sure services are accessible, resources are mobilised to the right areas, and pathways of care are easily navigable and responsive.

ACCHOs are another good example where early engagement is beneficial, as they assist with reviewing and refining emergency responses and provide essential local knowledge and relationships. Further, the inclusion of ACCHOs on regional medical groups ensures effective and timely communication, planning and response.

Collaboration and mutual understanding between disaster managers and primary healthcare providers in exercises, planning and review meetings supports networking and helps with the shared development of resources.

## National Disaster Mental Health and Wellbeing Framework

The *National Disaster Mental Health and Wellbeing Framework* (the Framework) was released by the Australian Government in May 2023. This survey and its responses preceded the release of the Framework.

The Framework provides guiding principles for governments, communities and multisector recovery partners to work together towards the same goals, using the same language, in a coordinated and consistent manner. While states and territories were supportive of the aims and principles of the Framework, they had yet to consider how it would be implemented in their jurisdictions.

States and territories noted that once the Framework was released, work would be undertaken to identify gaps that are needed to support their roles and responsibilities.

Jurisdictions anticipated that the Framework, and its implementation, would be considered in the context of developing new policies or proposals targeting mental health responses to all hazards, including natural disasters.

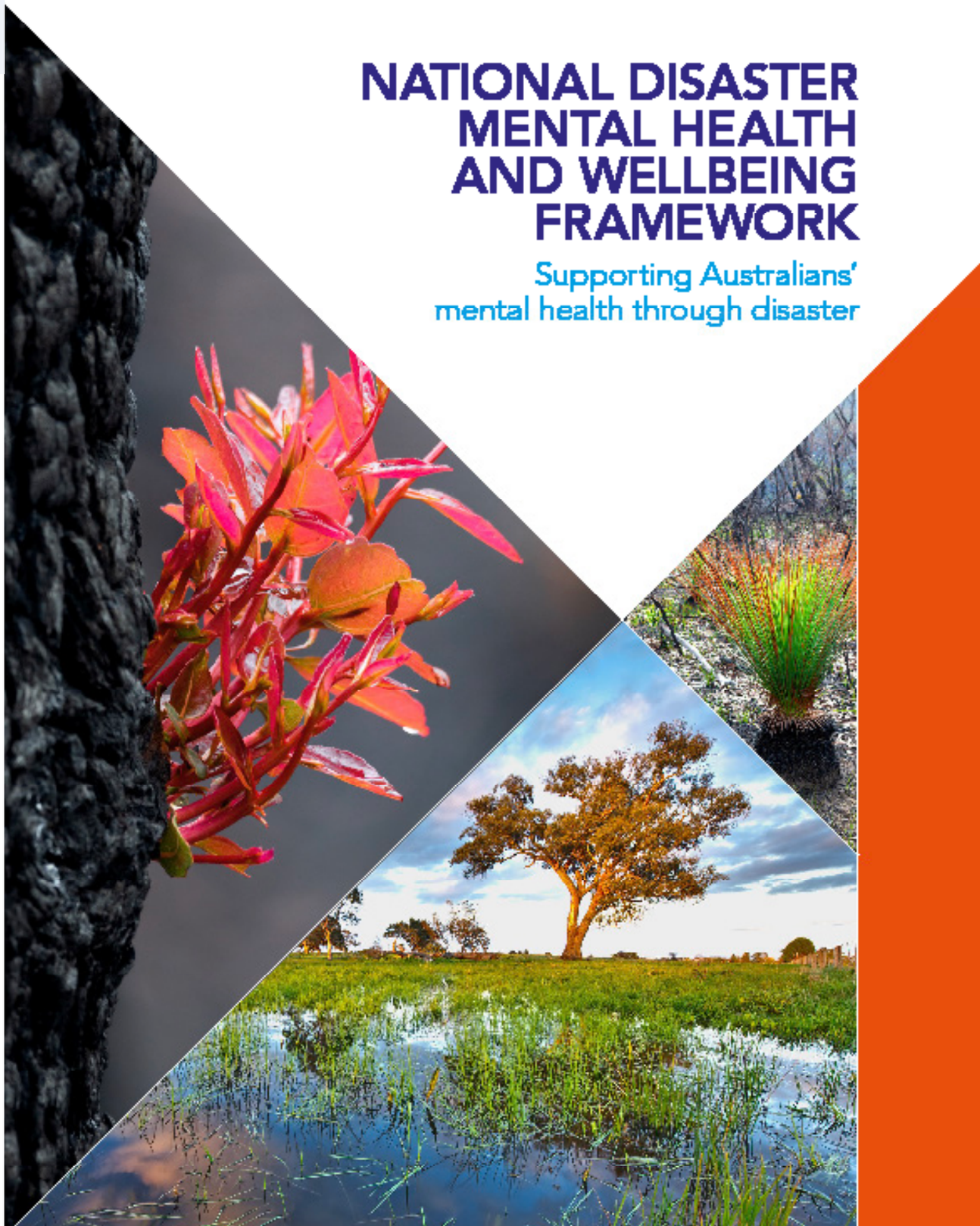
Skills for Psychological Recovery (SPR) were used by GPs and others post Victorian bushfires 2009 as the next step after PFA to support individuals: https://www.ptsd.va.gov/professional/treat/type/skills_psych_recovery_manual.asp

Respondents noted that a community psychology response is required in the initial phase following a disaster, to enable community resilience and cohesion through wellness and mental wellbeing activities in addition to psychological first aid. The referral pathways that provide continued support after the initial psychological first aid is provided are vital. Pragmatic and simple solutions – such as a flyer or business card that provides this information for use when the patient is ready – would achieve the intent.

In the initial phase, the most valuable support is from those that have connections to the community and utilising a stepped care mental health approach, with the ability to provide continuity of care past the first weeks and months following the disaster. More intensive, individualised counselling support and intervention from a specialised mental health professional should only be made available significantly further down the track.

The PAXIIIWG 15.3, which is focused on prioritising mental health during and after natural disasters, acknowledged that in many cases, the guiding principles of the framework are already consistent with state and territory responses to mental health and wellbeing following disaster events. This includes prioritising mental health responses during and after disasters and applying the three-tiered disaster mental health response matrix.

In response to the Framework, it has been proposed that the PAXIIIWG 15.3 will convert into a national Senior Officials Group (SOG), to oversee and continue the implementation of the Framework and provide opportunities to include disaster response in mental health initiatives and policies.




# Contents

# Recommendations

The following recommendations are derived from the responses to the survey received from the Australian Government and state and territory primary healthcare stakeholders, in relation to Primary Healthcare.

## Recommendation 1
## Funding

**1.1 Develop a transparent funding model for primary healthcare providers in disaster planning and during response.**

1.1.1 To support and fund the participation of primary healthcare providers in disaster planning and establish a funding model applicable during disaster response.

**1.2 Allocate funding to PHNs nationally to develop and maintain their critical role in disaster planning and response.**

1.2.1 To develop funding arrangements that could be employed at each network level for planning activities, training, professional development.

1.2.2 To develop the position of a national Emergency Management Officer to coordinate and contribute to national planning and oversight of training and collaboration within PHNs.

**1.3 Allocate suitable sources of funding to academic GP departments and other GP/primary care profession-led research to capture, document and evaluate the activities of GPs and other primary healthcare providers during disasters.**

1.3.1 To increase the profile and understanding of the roles and contributions of GPs and other primary care professionals in a disaster and enable lessons identified to be implemented, published, and disseminated.

**1.4 Allocate dedicated funding to GP professional bodies (including RACGP, ACCRM, AMA) and NACCHO.**

1.4.1 To support and increase their roles in providing national guidance on disaster planning and response and setting relevant national training standards.

**1.5 Implement outcomes and recommendations from the Disaster Recovery Funding Arrangements (DRFA) review.**

1.5.1 To improve reporting, data sharing, monitoring and evaluation arrangements.

## Recommendation 2
## Primary Health Networks

**2.1 Formally integrate Primary Health Networks (PHNs) into disaster planning and response frameworks in each jurisdiction.**

2.1.1 To establish specialist primary healthcare disaster management advisory groups.

2.1.2 To ensure PHNs regularly exercise disaster planning and response frameworks and arrangements.

**2.2 Support PHNs to develop internal and external facing disaster plans.**

2.2.1 To increase the knowledge of the primary healthcare providers in Emergency Management Arrangements.

2.2.2 To establish clear lines of authority and communication channels to the PHN through the local health district.

2.2.3 To include PHN representation within the local recovery committee to foster overall coordination of care and reduced duplication.

## Recommendation 3
## Community Pharmacy

**3.1 Include community pharmacy representatives on emergency planning committees.**

3.1.1 To ensure community pharmacy involvement in emergency planning arrangements.

**3.2 Enable the community pharmacy network to continue dispensing medications during disasters.**

3.2.1 To provide for the dispensing of medications remotely and for extended periods.

3.2.2 To ensure adherence to the continuity in medication management guiding principles.

3.2.3 To ensure the utilisation of the existing wholesaler network in emergency response.

## Recommendation 4
## Legislation

**4.1 Amend legislation to facilitate access to medicines and healthcare during disasters.**

4.1.1 To enable telehealth legislation to ensure access to healthcare in disasters and other emergencies.

4.1.2 To establish adequate professional indemnity and personal insurance coverage for primary healthcare providers when working in disaster response.

## Recommendation 5
## State health departments

**5.1 Strengthen state health departments' primary healthcare response during disasters.**

5.1.1 To integrate lessons learned from previous responses into emergency management frameworks.

5.1.2 To build strong relationships with partner agencies during disaster planning and response.

5.1.3 To ensure seamless communication between healthcare providers and local councils during and after disasters.

The primary aim of these recommendations is to improve disaster planning and response within the primary healthcare sector in Australia.

The implementation plan will need to identify the appropriate leads for the action(s), following consultation. Suggested agency leads are provided in the table below.

**Suggested role allocations**

**Recommendation 1: Funding**
Commonwealth

**Recommendation 2: Primary Health Networks**
Commonwealth and States / Territories

**Recommendation 3: Community Pharmacy**
Commonwealth and States / Territories

**Recommendation 4: Legislation**
Commonwealth and States / Territories

**Recommendation 5: State health departments**
States / Territories

## Recommendation 6
## Services and Programs

6.1 **Implement nationally the National Disaster Mental Health and Wellbeing Framework** (the Framework) that will support cross-jurisdictional efforts to ensure appropriate mental health services are delivered in disasters, a proactive and pre-agreed approach to funding mental health programs through the DRFA and improved monitoring and evaluation to ensure mental health services are timely and effective.

6.2 **Ensure the provision of mental health services in disasters is timely, flexible and available for at least five years post-disaster** to meet evolving needs that may emerge over time.

6.3 **Enable the scalability and adaptability of mental health recovery programs**, through long-term and strategic planning.

6.4 **Improve the coordination of mental health services on the ground** to ensure that those in need are aware of the support available and can easily access them.

6.5 **Develop a specifically designed and focused clinical intervention program**, to deliver mental health treatments more effectively, compared to conventional approaches.

6.6 **Improve the monitoring and evaluation of mental health programs**, including data collection and sharing of consistent data across governments and agencies.

6.7 **Tailor services for children and young people** when addressing the psychological and mental health impacts of natural disasters.

6.8 **Factor the impact that COVID has had and update programs and services as appropriate**, as psychosocial risks and impacts are becoming more prominent as people are seeking assistance from their GP's and workplaces due to delayed reactions.

## Recommendation 7
## Funding and Investment

7.1 **Review the Australian Government investment policies and frameworks to enable a longer-term, consolidated and strategic approach to mental health support in disasters.**

There should be a nationally consistent approach to mental health investment in disasters, including a commitment to the implementation of the Framework.

The approach should also leverage existing mechanisms such as the DRFA and be integrated into the health system.

7.2 **Align the off-the-shelf DRFA package development with the Framework.**

7.3 **Enable additional funding for mental health services following a disaster** so they can be scaled up as needed and provide further flexibility for service delivery of Mental Health Commission-funded providers.


## Recommendation 8
## Preparedness

8.1 **Develop resources, training, therapeutic materials for children and a communications plan** when undertaking preparedness for a disaster, to enable effective stand-up.

8.2 **Improve longer-term mental health disaster preparedness initiatives.**

## Recommendation 9
## Community Pharmacy Network

9.1 **Enable mental health medications to be accessed and dispensed** via the community pharmacy network as a part of disaster management.

9.2 **Implement nationally a psychological first aid training program** in pharmacies as a first-line contact and referral pathway.

## Recommendation 10
## Governance and Policy

10.1 **Establish a Senior Officials Group (SOG)** to implement the Framework.

10.2 **Provide additional information and clarity on the expectations of agencies** when implementing a disaster response, including leadership, funding, communications and responsibilities at an operational level.

# Glossary

## AAPM

Australian Association of Practice Management

Is a not-for-profit, national peak association recognised as the professional body dedicated to supporting effective Practice Management in the healthcare profession.

## ACCHO

Aboriginal Community Controlled Health Organisations

Is a primary health care service initiated and operated by the local Aboriginal community to deliver holistic, comprehensive and culturally appropriate health care to the community which controls it, through a locally elected Board of Management.

## ACRRM

Australian College of Rural and Remote Medicine

Is accredited by the Australian Medical Council (AMC) for setting professional medical standards for training, assessment, certification and continuing professional development in the specialty of General Practice.

## Activation

The shift into emergency response operation. A successful activation phase will allow for quick mobilisation of funding and deployment of resources into the emergency response.

## AHMRC

Aboriginal Health and Medical Research Council of New South Wales

Institution whose principal activity is to promote the prevention or control of diseases in human beings (Health Promotion Charity) (HPC).

## Allied health

Allied health includes a broad range of health professionals who can treat conditions and illnesses and is provided by trained professionals with university qualifications. They use practices with good evidence of effectiveness to prevent, diagnose and treat various conditions and illnesses.

Note that there is no one definition of allied health. Different definitions are used internationally and across Australia.

## Allied health practitioners or professionals

Types of allied health professions include physiotherapy, psychology, pharmacy, occupational therapy and social work.

## AMA

Australian Medical Association

The peak professional body for doctors in Australia. The AMA promotes and protects the professional interests of doctors and the healthcare needs of patients and communities.

## ANU

Australian National University

An Australian university located in the Australian Capital Territory (ACT)

## ANZEMC

Australia-New Zealand Emergency Management Committee is responsible for influencing and advocating for national policies and capabilities that reduce disaster risk, minimise the potential for harm and uphold public trust and confidence in emergency management arrangements. The Committee consists of senior officials from each Australian, state and territory government, plus a member from New Zealand and the Australian Local Government Association.

## APNA

Australian Primary Health Care Nurses Association

Is the peak professional body for nurses working in primary health care.

## Australian Child and Adolescent Trauma Loss and Grief Network

Is a network that works with a team of experts to bring together evidence-based resources and research in order to make them more accessible to those working with, or interested in, children and young people who have been affected by trauma and grief.

## Commonwealth

Relating to the Australian nation.

## Disaster and emergency planning

Involves a coordinated, co-operative process of preparing to match urgent needs with available resources.

## Disaster and emergency response

Refers to the actions taken directly before, during or in the immediate aftermath of a disaster. The objective is to save lives, ensure health and safety and to meet the subsistence needs of the people affected.

## DRFA

Disaster Recovery Funding Arrangements

Under the joint Australian Government-State Disaster Recovery Funding Arrangements 2018, assistance is provided to alleviate the financial burden on states and territories. It also supports the provision of urgent financial assistance to disaster-affected communities.

Under these arrangements, the state or territory government determines which areas receive assistance and what assistance is available to individuals and communities.

Where the arrangements have been activated, the Australian Government may fund up to 75 per cent of the assistance available to individuals and communities. This contribution is delivered through a number of assistance measures.

## Emergency plan

(See also disaster and emergency planning and disaster and emergency response)

A living document that is periodically adapted to changing circumstances and that provides a guide to the protocols, procedures and division of responsibilities in emergency response.

## Emerging Minds

An organisation that develops mental health policy, interventions, in-person and online training, programs and resources in response to the needs of professionals, children and their families. We partner with family members, national and international organisations to implement evidence-based practice into the Australian context.

# Glossary

## GP/ GPs

General Practitioner/s

A physician who treats acute and chronic illnesses and provides preventive care and health education to patients of all ages. GPs' duties are not confined to specific fields of medicine, and they have particular skills in treating people with multiple health issues.

## Headspace

The National Youth Mental Health Foundation, founded in 2006 that provides early intervention mental health services to 12-25-year-olds.

headspace services are in over 154 communities across Australia, providing online and phone counselling services, vocational services and a presence in schools.

## HealthPathways

HealthPathways is an online manual used by clinicians to help make assessment, management and specialist request decisions for over 550 conditions.

Rather than being traditional guidelines, each pathway is an agreement between primary and specialist services on how patients with particular conditions will be managed in the local context. Each health jurisdiction tailors the content of HealthPathways to reflect local arrangements and opinion and deploys their own instance of HealthPathways to their clinical community.

The target audience for HealthPathways is the primary care clinicians responsible for managing patients in the community and for initiating requests (including referrals to hospital) for specialist assistance.

## Jurisdictions/jurisdictional

The terms used to encompass all the states and territories of Australia, including New South Wales, Australian Capital Territory, Queensland, South Australia, Tasmania, Victoria, Western Australia and the Northern Territory.

## KPI

Key Performance Indicator

Refers to a set of quantifiable measurements used to gauge a company or individual's overall long-term performance.

## Medicare

Australia's universal health insurance scheme. It guarantees all Australians (and some overseas visitors) access to a wide range of health and hospital services at low or no cost.

## Mental Health Practitioners Network

An organisation that supports practitioners to work together better to improve referral pathways and consumer outcomes through two core programs: the national networks program and the online professional development program, working with member and partner organisations, professional associations and other like-minded organisations within the mental health sector.

## Mental health services (primary)

Focuses on the prevention of mental health disorders and issues before they occur. Examples include youth groups and clubs to increase community bonds and support, parenting classes and education to prevent substance abuse.

## Mental health services (secondary)

Services aimed at detecting the mental health disorder early and intervening promptly. An example is a hotline or crisis centre where mitigation is possible before the disorder escalates.

## Mental health services (tertiary)

Specialised services for people with serious and long-lasting mental illness. Tertiary services can include outpatient support following a hospitalisation related to a mental health disorder or crisis, support groups and pharmacological therapy.

## MIMMS

Major Incident Medical Management and Support

A training provider that teaches a systematic approach to disaster medical management. This approach can be applied to any major incident. The emphasis is on the scene management and the majority of the medical management courses are based on practical skills.

## NACCHO

National Aboriginal Community Controlled Health Organisation

Is the national leadership body for Aboriginal and Torres Strait Islander health in Australia.

## National Disaster Mental Health and Wellbeing Framework

Is a new framework that will guide how governments and recovery partners can consistently support the mental health and wellbeing of communities before, during and after disaster events. The framework provides guidance to recovery workers to support disaster-affected communities' mental health and wellbeing.

## National Infant and Child Disaster Mental Health Advisory Committee

Formed in 2021 as a collective of people who work in infant and child mental health, disaster and emergency management and policy, practice and research.

## National Mental Health and Suicide Prevention Agreement

Sets out the shared intention of the Commonwealth, state and territory governments to work in partnership to improve the mental health of all Australians, reduce the rate of suicide toward zero and ensure the sustainability and enhance the services of the Australian mental health and suicide prevention system.

## National Mental Health Plan for Emergency Services Workers: 2023-2026

A national plan that has been designed to work within the broader system of mainstream health and mental health care and services. The Plan acknowledges the specific challenges faced by emergency services workers and identifies specific support for emergency service workers in the context of the National Disaster Mental Health and Wellbeing Framework.

## NEMA

National Emergency Management Agency

A merger of the National Recovery and Resilience Agency and Emergency Management Australia to create a single, enduring, end-to-end agency to better respond to emergencies, help communities recover and prepare Australia for future disasters.

# Glossary

## NEMMM

National Emergency Management Ministers' Meeting Facilitates emergency management portfolio ministers from their respective jurisdictions to work collaboratively to drive national cooperation and consistency on enduring strategic issues in emergency/disaster management and resilience.

NEMMM also address emerging issues requiring cross-border collaboration and perform policy and standard setting functions. This may include cross-portfolio issues, such as building, planning, land management, infrastructure, communications, data and digital, health, science, research, environment and education. NEMMM reports to National Cabinet.

## PAXIIIWG

Priority Action XIII: *Prioritisation of mental health and inclusion of primary healthcare providers in disaster management*.

## Phoenix Australia

An independent not-for-profit organisation and Australia's National Centre of Excellence in Posttraumatic Mental Health, working on understanding, prevention and recovery from trauma.

## PPRR

Prevention, Preparedness, Response and Recovery

Is a theoretical framework used to explain the work of emergency management.

PPRR provides a means of situating the work of different agencies and authorities within emergency management phases but provides no guidance as to operational practice.

## PSA

Pharmaceutical Society of Australia

Is the peak national professional pharmacy organisation, representing Australia's 32,000 pharmacists in all sectors and across all locations.

## PHN/ PHNs

Primary Health Network/s

Are independent organisations working to streamline health services – particularly for those at risk of poor health outcomes – and to better coordinate care so people receive the right care, in the right place, at the right time.

## Primary health/ Primary healthcare

is the healthcare that people seek first in their community, such as GPs, pharmacies and allied health professionals.

## RACGP

Royal Australian College of General Practitioners

Australia's largest professional General Practice organisation and represents urban and rural GPs.

See also 'Resources' section.

## Royal Commission

See Royal Commission into National Natural Disaster Arrangements (the Royal Commission).

## Royal Commission into National Natural Disaster Arrangements

(the Royal Commission)

Also referenced as RCNNDA and the Bushfires Royal Commission.

Was established on 20 February 2020 in response to the extreme bushfire season of 2019-20 which resulted in loss of life, property and wildlife and environmental destruction.

The Commission examined coordination, preparedness for, response to recovery from, disasters as well as improving resilience and adapting to changing climatic conditions and mitigating the impact of natural disasters. The inquiry also considered the legal framework for Commonwealth involvement in responding to national emergencies.

## Royal Commission Implementation Time-limited Working Group

A working group that brings together working-level officials from all Australian jurisdictions to enable national-level coordination, collaboration and consistency in the implementation and reporting of recommendations by the Royal Commission into National Natural Disaster Arrangements (the Royal Commission)

## Survey

Refers to the survey (at Appendix 1) sent to all Australian states and territories that sought to identify opportunities to progress the implementation of the Royal Commission Recommendations 15.2 and 15.3 and develop a holistic understanding of the activities that Australian, state and territory governments are undertaking in pursuit of the implementation of the recommendations. The responses to the survey formed the basis of this report.

## WA

Western Australia.

# Resources

This section includes examples of resources identified on disaster management for GPs.

## Royal Australian College of General Practitioners (RACGP)

The RACGP has a growing number of disaster management resources on disaster management available for members. It is currently working on national Guidelines for GPs working in evacuation centres at the request of SNHN and Healthy North Coast PHN.

**Emergencies and pandemics**

Providing care and support during disasters:
https://www.racgp.org.au/running-a-practice/practice-management/managing-emergencies-and-pandemics/naturaldisasters

Emergency Response Planning Tool:
https://www.racgp.org.au/running-a-practice/practice-management/managing-emergencies-and-pandemics/emergency-response-planning-tool

Managing emergencies in General Practice:
https://www.racgp.org.au/running-a-practice/practice-management/managing-emergencies-and-pandemics/managing-emergencies-in-general-practice

Emergency planning and response factsheets:
https://www.racgp.org.au/running-a-practice/practice-management/managing-emergencies-and-pandemics/fact-sheets

Resources to support General Practices prepare and respond to emergencies:
https://www.racgp.org.au/running-a-practice/practice-management/managing-emergencies-and-pandemics/resources-to-support-general-practices

Managing pandemics:
https://www.racgp.org.au/running-a-practice/practice-management/managing-emergencies-and-pandemics/managing-pandemics

Summer Planning Toolkit Modules:
https://www.racgp.org.au/running-a-practice/practice-resources/practice-tools/summer-planning-toolkit/summer-planning-toolkit-modules

https://www.racgp.org.au/getattachment/683349f5-dcc5-4382-ac40-7db3790a8fc0/Summer-Planning-Toolkit-modules.aspx

**Disasters and Emergencies Working Group and RACGP disaster team.**

- Disasters and Emergencies Working Group meets monthly.
  - During COVID, the group met weekly and as needed.
- The group sits under one of the RACGP Expert Committees, Practice Technology and Management.
- The disaster team at the RACGP work on disaster matters and stand up to assist the state RACGP faculties when a disaster occurs.

The team responds to submissions in disaster management, including the 2019 Bushfire Royal Commission.

- Most recently the team is developing a response to the Department of Home Affairs and the National Emergency Management Agency's consultation on 'Alternative Commonwealth Capabilities for Crisis Response'.
  * https://www.homeaffairs.gov.au/reports-and-publications/submissions-and-discussion-papers/alternative-commonwealth-capabilities-for-crisis-response-discussion-paper
  * Alternative Commonwealth Capabilities for Crisis Response, Discussion Paper – August 2023: https://www.homeaffairs.gov.au/reports-and-pubs/files/alternative-clth-capabilities-crisis-response.pdf
- Both groups readily provide representation for GPs on disaster related matters when requested.

**Position Statements and Media Releases**

Position Statement, Provision of mental health services in rural Australia:
https://www.racgp.org.au/advocacy/position-statements/view-all-position-statements/clinical-and-practice-management/mental-health-services-in-rural-australia

**To be published soon** Position Statement, General practitioners in disasters
https://www.racgp.org.au/advocacy/position-statements

Media Release, GPs and other essential health services must be supported in times of disaster.
https://www.racgp.org.au/gp-news/media-releases/2022-media-releases-1/september-2022/gps-and-other-essential-health-services-must-be-su

## RACGP Standards

https://www.racgp.org.au/FSDEDEV/media/documents/Running%20a%20practice/Practice%20standards/5th%20edition/Standards-for-general-practice-5th-edition.pdf

The RACGP has developed the Standards for General Practices (5th edition) (the Standards) with the purpose of protecting patients from harm by improving the quality and safety of health services.

The Standards support General Practices in identifying and addressing any gaps in their systems and processes.

See C3.3 A Our practice has an emergency response plan for unexpected events, such as natural disasters, pandemic diseases, or unplanned absences of clinical team members. Including:

To help reduce the impact of an emergency, complete appropriate emergency planning and preparation and frequently identify, review and update the actions that need to be completed before and during an emergency.

These actions may include:

- having a documented emergency response plan
- appointing an emergency management coordinator Standards for General Practices 5th edition 44
- undertaking research to identify key information (e.g. emergency services, the local geography and previous events that have affected the community)
- providing the practice team with education and training that will help them effectively prepare for and respond to emergencies
- testing components of the emergency response plan (e.g. evacuation drills) once a year
- reviewing, monitoring and updating the emergency response plan every three months
- keeping the emergency kit fully stocked
- The emergency response plan could contain:
  - information on how to communicate with patients and other services
  - contact details of all members of the practice team
  - contact details for response agencies and other health services
  - details about the practice such as accounts, service providers (e.g. insurers, lawyers, providers of telephone, internet and utilities) and insurance policy numbers
  - information on how the practice will triage and run clinical sessions during an emergency
  - details about where practice staff will work from in the case of an emergency
  - information on how the practice can provide telehealth services during an emergency, including the locations from which your practice will facilitate telehealth, as per the above item
  - the practice's policy on infection control
  - details of equipment needed to manage an emergency
  - information on how to manage unplanned absenteeism of multiple practice team members (including succession planning)
  - the practice's policy on the management of patients' health information in computer and paper-based systems.

Must also have a recovery plan that details what the practice team could do to re-establish the practice's operations, when appropriate, if your practice needs to close due to an emergency.

# Resources

## Australian Medical Association (AMA)

**Position Statements and Media Releases**

Position Statement, Primary Health Care – 2021:

https://www.ama.com.au/sites/default/files/2021-09/Primary%20Health%20Care%20-%202021%20-%20Final_0.pdf

Position Statement, Local Hospital Networks and GP-led Primary Care Services Designed to Reduce Potentially Preventable Hospitalisations 2020:

https://www.ama.com.au/position-statement/local-hospital-networks-and-gp-led-primary-care-services-designed-reduce

Position Statement, Ethical Considerations for Medical Practitioners in Disaster Response in Australia 2022:

https://www.ama.com.au/sites/default/files/2022-11/Position%20Statement%20on%20Ethical%20Considerations%20for%20Medical%20Practitioners%20in%20Disaster%20Response%20in%20Australia%202022.pdf

Media Release, AMA calls for greater role for doctors in disaster planning and management:

https://www.ama.com.au/media/ama-calls-greater-role-doctors-disaster-planning-and-management

Related news, ABC delves into AMA position statement on doctors in disasters:

https://www.ama.com.au/ama-rounds/17-june-2022/articles/abc-delves-ama-position-statement-doctors-disasters

Position Statement, Ethical Considerations for Medical Practitioners in Disaster Response in Australia:

https://www.ama.com.au/sites/default/files/2022-05/Position%20Statement%20on%20Ethical%20Considerations%20for%20Medical%20Practitioners%20in%20Disaster%20Response%20in%20Australia%202022.pdf

Media Release, AMA (NSW) calls for immediate grant funding to health services in response to flood report:

https://www.amansw.com.au/ama-nsw-calls-for-immediate-grant-funding-to-health-services-in-response-to-flood-report/

Related media release, Lismore GPs finally get flood recovery support:

https://www.rdaa.com.au/common/Uploaded%20files/_NSW/Media%20releases%2023/RDANSW%20Lismore%20funding%20announcement%2023-2-23.pdf

Related news, Flood Funding for Lismore Primary Care Providers:

https://www.nswrdn.com.au/site/index.cfm?module=news&pagemode=indiv&page_id=1848857

Related news, RDN Supports Call for Emergency Health Funding:

https://www.nswrdn.com.au/site/index.cfm?module=news&pagemode=indiv&page_id=1711006

## Australian College of Rural and Remote Medicine (ACRRM)

**Natural Disaster Readiness and Recovery webpage:**

https://www.acrrm.org.au/support/clinicians/community-support/natural-disaster-readiness-recovery

- Advises to link with local authorities and networks.
- Contains communication on information, alerts and warnings.
- Lists resources:
  - Online Course: Approach to Care - Natural Disasters which is designed to introduce some of the public health and psychosocial issues associated with environmental disasters and the role that can be played by primary health practitioners in responding to individual and community impact.
  - Online Course: Supporting Children and Families in General Practice After a Natural Disaster or Community to assist GPs working with families and children affected by natural disasters such as fire, floods, or storms, or by community trauma events.
  - A Flood Action Plan for after the flood.
  - Webinars on rebuilding after floods Rural health Webinars - Rural Doctors Foundation.

**Joint media release with Rural Doctors Association of Australia (RDAA), 20 May 2020:**

https://www.acrrm.org.au/about-us/news-events/media-releases/2020/05/19/joint-release-covid-19-shows-gps-essential-in-disaster-response

## Rural Doctors Network (RDN)

**Annual Reports**

https://www.nswrdn.com.au/site/index.cfm?display=78980&pageReload=yes

# Introduction

It was agreed at the National Emergency Management Ministers' Meeting (NEMMM) in July 2022, that Western Australia (WA) would lead the Royal Commission into National Natural Disaster Arrangements (Royal Commission) Priority Action XIII: Prioritisation of mental health and inclusion of primary healthcare providers in disaster management.

**Recommendation 15.2 Inclusion of primary care in disaster management**

- Australian, state and territory governments should develop arrangements that facilitate greater inclusion of primary healthcare providers in disaster management, including representation on relevant disaster committees and plans and providing training, education and other supports.

**Recommendation 15.3 Prioritising mental health during and after natural disasters**

- Australian, state and territory governments should refine arrangements to support localised planning and the delivery of appropriate mental health services following a natural disaster.

To support the progression of these recommendations, WA established two time-limited National Priority Action XIII Working Groups (PAXIIIWG). The working groups consist of representatives from all Australian states, territories and the Commonwealth.

This report was developed using the information provided by Australian, state and territory government representatives in response to a survey, located at Appendix 1. The survey sought to identify opportunities to progress the implementation of the Royal Commission Recommendations 15.2 and 15.3 and develop a holistic understanding of the activities that Australian, state and territory governments are undertaking in pursuit of the implementation of the recommendations.

Responses to the survey questions have been summarised under key themes. The summation is an issue or key theme that was recognised by one or more states and jurisdictions but should not be taken to mean that it has been identified by all states and territories.

For the purposes of this report, primary healthcare providers work in local communities typically providing first contact care with the health system. They include GPs, nurses and allied health providers. Allied health providers include disciplines such as pharmacists, dentists, physiotherapists, psychologists, Aboriginal health practitioners, occupational and other therapists and social workers.

Primary health is addressed in Section 1 of this report and mental health in Section 2. Due to the close alignment of these health areas, there is some overlap between the two and information may be repeated in each section.


# Section 1

## Inclusion of Primary Care in Disaster Management

# Survey Question 1

*Projects, activities, or programs that could be considered to facilitate the prioritisation of mental health and inclusion of primary healthcare providers in disaster management as per Recommendations 15.2 and 15.3*

## Key Themes | Primary Healthcare

### Funds and funding models

Funds and funding models are an important and key barrier for jurisdictions. The lack of financial support for healthcare providers to attend planning meetings – and the work that ensues – means that there is little and unsustained involvement of healthcare providers in disaster planning meetings and other related activities. Not only are healthcare providers not compensated for their attendance, but they also incur a loss of income as the meetings and activities are often held during business hours.

Although it is not commonplace, there is a small, uncentralised pool of funding to reimburse Royal Australian College of General Practitioners (RACGP) to enable them to be involved in working groups, provide advice, or review policies and programs.

Where it does exist, funding is accessible through programs such as Disaster Recovery Funding Arrangements (DRFA), Black Summer Bushfire Recovery Program, National Bushfire Recovery Fund, and other funded programs. Limited and irregular funding is available for Primary Health Networks (PHNs) to assist with primary healthcare response however, funding consists largely of one-off grants in response to events that may not allow for sustained and sustainable disaster planning, education, preparedness and training.

Respondents also noted that human resources are spread thinly and there is a lack of funding to employ additional specialist resources. Additionally, at a practitioner level, there is an absence of funding for emergency management training, professional development, personal protective equipment and other equipment. Also lacking is the funding to recompense for loss of income and damage to infrastructure and equipment during disasters. Whether due to volunteering for unpaid disaster response, providing free medical treatment including provision of free dressings and medical supplies, damage to the practice, or due to reducing consultation fees to the minimum bulk billed level (for an undefined period), all relating to a very unsustainable business model.

### Education and training

Training and education are integral components in prioritising mental health and including primary healthcare providers in the disaster management cycle. Providing mental and physical healthcare in the austere circumstances of a post-disaster environment mandates participation in relevant professional development for primary healthcare and allied health providers. GPs must also be included in the larger multi-agency healthcare response.

Any training that is developed needs to be primary healthcare specific. Professional bodies (such as RACGP) have substantial disaster educational resources that are rolled out and disseminated in disasters, while the PHNs support presentations and webinars approved by the professional colleges. However, existing training does not seem to cover the aspects and roles of primary healthcare and doesn't explain how primary healthcare providers link to the bigger disaster management picture. In addition, the availability of training resources does not equate with dissemination and/or intake as the end-users (primary healthcare workers) are not funded to attend these courses.

### Utilisation of Primary Health Networks

Primary healthcare 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. This also translates into a primary healthcare workforce which is represented by many professions (GPs, pharmacists, allied health, etc.) that do not enjoy a single representative body, either by profession or within the profession itself. The best current surrogate for such a representative body is the Primary Health Networks (PHN). Each of the 31 PHNs is considered a (not the) local conduit for primary healthcare, as they contribute to recovery arrangements including commissioning services, and should assist with primary healthcare response

and training, communicate updates and issues to their members and with other GP and primary healthcare groups and maintain a register of GPs who are trained and prepared to contribute to a funded emergency response. There are historical communication and support interlinking between the PHNs and the various professional bodies (including the AMA, RACGP, ACRRM and PSA), however the lack of widespread representativity of these bodies for the primary healthcare workforce dilutes every aspect of the desired interventions such as education, training, preparedness, funding and accessibility.

PHNs hold several formalised, other ad-hoc, or responsive roles depending on the issues. These roles include collaboration on regional planning and coordinated service provision in response to natural disasters and membership of planning committees, advisory groups and forums. It is crucial that consistent disaster management functions are developed for PHNs, that include role descriptions and outputs.

**Liaison officers and networks**

Respondents indicated that regular engagement and communication occurs in the pharmacy sector, in the form of meetings between the Chief Pharmacist and the community pharmacy sector and related organisations, on a range of issues including emergency supply.

Primary Health Liaison Officers are engaged by many, but not all, of the PHNs, although the role may be undertaken under a different title. Identifying in detail their role was outside the scope of the survey, however, their generic responsibilities are to establish a working liaison relationship with the Department of Health and key community and primary health stakeholders, including but not limited to, state RACGP, ACRRM and AMA.

With large jurisdictional and local variability and representativity, there exist GP liaison officers located in some hospitals and health services, GP forums and the development of an ongoing robust and representative General Practice or primary healthcare disaster network that involves peak bodies, GP liaison officers and other representatives has been highlighted as an ongoing challenge. While these networks are concerned largely with business-as-usual matters, they should also include a standing disaster medicine and emergency management agenda.

Local initiatives have seen successful General Practice and pharmacy disaster management roundtables organised with representation from each GP professional group (i.e. AMA, ACRRM, RACGP, Medicare, Pharmacy Guild of Australia, PSA, APNA, AAPM and invited experts). However, what the end effect of such initiatives has had at the grassroots has not been quantified.

**Implemented strategies, policies, procedures and arrangements, some with active reviews.**

It is recognised that as there is no single representative body for each of the professions captured under the primary healthcare umbrella, the implementation of strategies and tactics is piecemeal and uncoordinated. As a result, the penetration and buy-in of initiatives within primary healthcare lacks visibility and proof of completion.

**Coordination and collaboration between agencies, the community and healthcare providers**

Coordination and collaboration within and between the sector are vital for systems to run in an integrated, effective and process-driven manner. This includes collaboration with regional teams and community partners, services, clinicians and support staff when engaged in response to natural disasters.

Business-as-usual will be disrupted during and after the post-disaster period. Adequate planning and testing of alternative operating procedures need to be undertaken, focusing on coordination, communication, ongoing and/ or new partnerships, relevant memorandums of understanding (MOUs), understanding current capacities and available capabilities, as well as referral pathways between primary and tertiary clinical and mental health services. These are essential to meet the community requirements at times of need and severely limited resources.

**Emergency Management Frameworks, Arrangements and Committees**

Underpinning the points above is the requirement to facilitate involvement to enable the contribution of PHN, GP and organisation involvement, empowerment, linkages and procedures and create an authorising environment for immediate activation and operational readiness. This formalisation could be included in the following documents and arrangements:

- Agency Commissioning Plans that outline commissioning intentions and areas of focus in response to emerging government priorities and community need
- Community Recovery Arrangements and Frameworks
- Emergency Management Plans and Frameworks
- Emergency Planning Committees and Public Health Committees, including Terms of Reference
- Disaster Management Arrangements and State Emergency Management Arrangements
- MOUs
- Disaster Recovery Committees.

## Suggestions and Improvements
## Primary Healthcare

1. Funded engagement. To ensure the participation of primary healthcare providers in disaster planning, a sustained, transparent and accessible funding model must be developed that compensates these providers for their time, commensurate with their salary. Funding should be made widely available and not conditional to membership of professional bodies.

   Engagement in disaster medicine and emergency management during business hours for most primary healthcare providers requires absence from their primary business and loss of income as they are private business operators or require cessation of services. This also extends to the additional time required to progress the working groups' agendas. Therefore, planning meetings and communication involving primary care tend to be conducted with primary care organisations, peak bodies and/or with Gps, pharmacists and other allied health professionals employed within the state service. In the absence of national representative authorities and organisations, they represent a very small minority of the group.

   A standing invitation for PHNs, primary healthcare representatives and/or GPs on local health districts' disaster committees, on (determined) state disaster committees and on national disaster planning committees.

2. Preparedness. Standing invitations to PHNs to include GPs or PHN staff in disaster exercises and relevant training.

3. Response. PHN support and direction to develop internal and external facing disaster plans. This would include establishment of lines of authority and clear communication channels to the PHN through the local health district, with names and contact details. Such plans should observe extant emergency management doctrine and integrate seamlessly within a larger health response to a disaster, in a proportional and scalable manner. All plans should be tested upon design and at regular intervals.

4. Recovery. Inclusion of PHN representation on the local recovery committee so communication can go to frontline clinicians on the numerous recovery resources available, thus groups involved in the disaster response are encouraged to feedback patient contact to the GPs, contributing to the overall coordination of their care and duplication is reduced.

5. PHN and primary healthcare engagement in disaster management. Encourage a disaster management advisory group for each PHN to provide input and support for the PHN disaster coordinators and increase primary healthcare engagement in processes.

6. Education. Funding to the GP professional bodies such as RACGP/ACRRM/NACCHO for joint development and publication of a 'roles for GPs in disaster guidelines that outline the roles GPs could and should play, the lines of communication through the PHNs and with the colleges, as well as the existing resources (including funding) available to support GPs. This should be developed in collaboration with emergency management experts. Additional clinical guidelines should also be developed in relation with clinical practice interventions in austere/ disaster environments, including, for example, triage and ethical decision making in such circumstances. Minimum knowledge of emergency management doctrine requirements and the clinical guidelines would underpin the minimum training required and will set the standards for GPs in disaster cycle (mitigation, preparedness, response, recovery).

7. Primary healthcare (PHN and/or GPs and community pharmacy, as a minimum) should be represented as a standing member on local, regional and state-wide emergency planning committees.
8. PHNs should be integrated into disaster preparedness and response frameworks in each jurisdiction as the two-way channel for mobilising primary care response and involving primary healthcare in the disaster cycle activities.
9. Promotion of a specialist group of disaster management GPs or primary care experts to support the PHN disaster management role. PHN staff in disaster management roles also need training in GP and primary healthcare disaster management.
10. Primary healthcare advisory groups should be established to support DHM planning and decision-making.
11. To have national authority and credibility, the healthcare response and training delivered by PHNs will need support and collaboration from peak bodies such as the RACGP and the Australian College of Rural and Remote Medicine (ACRRM).
12. Continued dispensing and maintaining access to mental health and other chronic disease medications via the community pharmacy network must be a priority as part of disaster management. Provisions need to be made for the dispensing of medications for those that normally need to present in person but cannot do so at the time. In addition, provisions need to be made for the dispensing of medications for longer periods.
13. The medications continuation program conducted through community pharmacy ensures maintenance of vital services to isolated and quarantined vulnerable cohorts and should continue.
14. The COVID-19 antiviral program was initially poorly implemented resulting in blockage and delay and in the future utilisation of the existing wholesaler network in emergency response should occur.



# Survey Question 2

*Monitoring or tracking implementation of the previously identified projects, activities, or programs*

## Key Themes
## Primary Healthcare

### Project and program reporting

Reporting is an essential tool for project management, undertaken at regular intervals or as needed, which communicates the status, performance, effectiveness of the project or program and whether it is progressing on time and in accordance with the original plan. It can also provide information on how the budget is tracking and allows a means to identify issues early and take corrective actions.

In the case of PHNs, monitoring and tracking of their activities is undertaken using mandated project reporting tools and regular discussions. This process can be used to monitor compliance within program guidelines and evaluation of performance and outcomes against KPIs.

### Committees and governance

Respondents advised that they are members of, and participate in, various committees that meet regularly, such as the Royal Commission Implementation Time-limited Working Group (RCI TLWG).

### Post-disaster and program reviews

Following natural disaster events and at the conclusion of programs, it is common for a debrief, evaluation and/or review to take place, which results in collecting and analysing experiences from the event or program. This lessons management process is beneficial for future planning and development, identifying what was done well and where improvements are needed, so errors are not repeated and processes and outcomes are improved.

### Grant funding requirements

For programs or projects that are awarded grant funding, appropriate administration requires expenditure to be tracked and outcomes and KPIs to be evaluated, according to the conditions of the grant.

For example, DRFA assistance should be used to complement and promote disaster resilience outcomes for affected individuals and communities and assistance should provide value-for-money outcomes for all levels of government. Hence, reporting of assistance under the DRFA occurs on a regular basis.

Where services are provided through funding mechanisms and monitored and reported according to the mechanisms defined by the program.

For natural disasters, monitoring and tracking is undertaken through the National Emergency Management Agency (NEMA) tracking system.

## Suggestions and Improvements | Primary Healthcare

1. Work is being undertaken through the DRFA Review to improve reporting, data sharing, monitoring and evaluation arrangements. States and territories should consider implementing the recommendations from the DRFA Review.
2. PHNs to conduct an after-action review post-disaster documenting and reporting on primary healthcare contributions to the disaster response activities, strengths and opportunities for improvement. This should be made publicly available on the respective PHN website.
3. Dedicated funding should be allocated to capture and document the activities of GPs and primary healthcare providers during disasters, which will increase the profile and understanding of what has occurred and enable lessons learned to be implemented. These publications should be published in journals so the successes and lessons identified can continue to be disseminated.

# Survey Question 3

*Successes or improvement opportunities that can be shared.*

## Key Themes | Primary Healthcare

### The role of primary healthcare

Primary healthcare is recognised as an essential and critical part of the health system and emergency planning response and recovery. However, it is not embedded as a part of emergency preparedness and response structures at regional, state and national levels. The sector also faces challenges based on long-standing arrangements, such as the differences between Commonwealth and jurisdictional responsibilities and funding arrangements. For example, the governance and funding of primary care is predominantly a Commonwealth responsibility, while states and territories are responsible for governance and allocation of funding for public health and hospital services.

For GPs opting to assist in disasters, issues they have encountered include billing services at evacuation centres and that strict location-based arrangements are not fit for purpose when services are disrupted.

Conversely, there were some successes identified such as rapid credentialling of primary healthcare providers so they can work in hospital facilities where local infrastructure is compromised, shared staffing arrangements for isolated communities and supporting local primary healthcare providers when communities are isolated. However, sustainable arrangement for jurisdiction-wide credentialling versus just-in-time, fixed location, credentialling continue to be a significant time and financial burden. One of the key roles of GPs in disasters is to keep their practice doors open or to provide a surge capacity to redirect patients away from the emergency departments. This is often achieved by extending opening hours. It is essential that General Practices affected by disasters are prioritised for re-establishment, as GPs cannot operate where there is no infrastructure. There is anecdotal evidence that GPs in these situations have worked in evacuation centres while seeing their usual patients, who couldn't access their usual GPs' location.

> An example of this is in local evacuation centres as locums to assist the local GPs, support between neighbouring General Practices when one is compromised e.g. sharing of vaccine fridges, offering space to continue seeing patients when a neighbouring GP's practice has been damaged, or in seeing another practices' patients where that GP is unable to see patients due to injury etc.

Support for primary healthcare business continuity should be a top priority in disaster planning and response, as well as ongoing continuity in the recovery phase to ensure that General Practices continue to operate once the community has recovered and communities don't lose their local GP.

Respondents shared the value that PHNs provide during disasters, saying that their flexibility and adaptability to support primary care responses to disaster events and the COVID-19 pandemic, highlighted the value of systematically integrating them into preparedness and response planning frameworks.

Aboriginal Community Controlled Health Organisations (ACCHOs) are also valuable contributors to the delivery of primary healthcare to displaced residents in a disaster, as they promote continuity of care, maximise trust and effectively deliver healthcare.

### Inclusion of GPs in disaster healthcare

It is important that the inclusion of GPs in disaster healthcare is informed by contemporaneous evidence. GP contributions and roles are based on academic research on disaster healthcare needs, as well as interviews with GPs who have experienced disasters over the last 15 years.

The publication of detailed guidelines on the health effects of disasters relevant to GP practice would support them to understand what health effects they will address in the short, medium and longer term, by type of disaster. This should be part of their emergency management education and disaster medicine and it will also assist in defining the added value of GPs for other emergency responders.

### GP and PHN involvement

There needs to be clarity in the systems where there is GP and PHN involvement, with consistency across the different PHNs, including the planning, response and recovery roles and communication channels and systems.

An example of this is the planning and guidelines for the roles of GPs and PHNs in disasters that were developed, along with lessons identified from the 2013 Blue Mountains bushfires. These were tested in subsequent disasters, including the 2019 bushfires and various floods and were evaluated as useful in improving the response. Other examples are the internal and external plans that were developed for the Healthy North Coast PHN from the lessons identified following the response to the Lismore floods.

Dissemination, sharing of resources and presentation of disaster management activities have been attempted through the establishment of the New South Wales (NSW) PHN Disaster Management group which shares what PHNs are doing, the successes and the gaps. This group has supported collaboration between PHNs.

To help increase the understanding added value of GP inclusion, greater visibility of primary healthcare resources during response is required. While some local resources with this intent seem to exist, they must be generalised, integrated and consistent. This could be through emergency online mapping and traffic light system of functioning practices and their hours of availability, as was used after the 2010and 2011 Christchurch earthquakes. Red dots signified a non-functional General Practice or pharmacist, green indicated full functionality (including the number of GPs at the practice, opening hours and other relevant information) and orange denoted partial functionality (no consultations, only the provision of prescriptions).

This real-time mapping system has now been developed by the Sydney North PHN (SNHN) in 2023 and is available to be shared with other PHNs. It is to be activated via the PHN website during and after the disaster and be available to both the public and emergency responders.

### Funding and resources

Respondents noted that primary healthcare encounters several fundamental, activity and development limiting challenges, including the disparity between funding arrangements at the Commonwealth and jurisdictional levels which limit the visibility, accessibility, transparency and sustainability of primary healthcare engagement in the emergency management and disaster medicine space, throughout the entire disaster cycle. This results in absent end-to-end solutions to disaster planning, mitigation, response and recovery activities.

Another challenge is the divergent trend between workforce shortages that community organisations face and the increase in demand for services; jurisdictions report that recruitment and retention of allied health professionals is a constant pressure.

In addition, bushfire, flood and pandemic responses – which are often a large scale and protracted events – often mean the interruption of business continuity, redeployment of staff thus absents from their normal workplaces and regular patient appointments cancelled or deferred. On the other hand, request for staff to deploy in disaster affected areas deplete an already thinned workforce and often cannot be authorised due to loss of business continuity and the need to maintain front line healthcare operations.

However, some work has been undertaken to address the mismatches of supply and demand in primary healthcare that could be provided out of hospital but could not be resourced by private primary healthcare practitioners.

For GPs responding to a disaster, there are unresolved procedural aspects in relation to Medicare rebates for the ability to bill for their medical services provided at other locations than their normal place(s) of work (for example at evacuation centres). In these circumstances, the current Medicare arrangements of a unique provider number linked to a specific healthcare location is a hindrance and a not-fit-for-purpose arrangement.

In recognition of the expected disaster pathology differing from that seen in day-to-day practice, as well as the time required to ascertain the new patient's background, adequate standards of care will be reflected in longer consultation times. This should be recognised through appropriate rebates for these consultations. Alternatively, a fixed hourly or daily rate should be considered, in line with other publicly employed medical practitioners deployed to disaster zones.

In a similar vein, insurance arrangements and professional indemnity coverage must be clearly outlined for healthcare providers when working during a disaster response and recovery phase. There arrangement need to meet current Work Health and Safety (WHS) legislation requirements.

Funded organisations are typically flexible and agile, can support the implementation of measures and respond to delivering services in innovative ways, based on local circumstances. This expertise should be leveraged in any future funding arrangements to allow for continuity of health services in the rapidly changing environment of a disaster response.

**Developing relationships, collaboration and engagement**

The importance of developing and maintaining strong and effective relationships and collaborating with partner agencies, service providers, PHNs and across government prior to activation cannot be overemphasised. To augment these partnerships, it is essential that clear and well-understood communication and activation protocols are in place that are exercised regularly. Additionally, previous successes should be used to build future planning, with ongoing engagement and regular forums with partners. Functional alliances are to be explored to maximise resources during times of need, as well as mutual understanding of roles and responsibilities.

Early engagement is another key to success; for example, between primary and specialist mental health services to make sure services are accessible, resources are mobilised to the right areas and pathways of care are easily navigable and responsive. The ACCHOs are another good example where early engagement is beneficial, as they assist with reviewing and refining emergency responses and provide essential local knowledge and relationships.

Further, the inclusion of ACCHOs on regional medical groups ensures effective and timely communication, planning and response.

Collaboration and mutual education between staff with disaster management responsibilities and primary healthcare providers in exercises, planning and review meetings, supports networking and can help to enhance the joint development of resources.

As outlined above, greater visibility of primary healthcare resources during response is also required.

**Educational successes**

*Medical students*

Disaster management and disaster medicine educational activities for medical students is currently ad hoc and developed by academic GPs with a special interest in the topic. Scenario-based workshops and lectures are already being conducted by GP departments in Australian medical schools such as Western Sydney University (WAU) Australian National University ANU) and James Cook University. For these activities to reach their full potential, they need to be embedded in the formal training of all medical students, in all universities involved in the training of the future healthcare workforce, not only medical schools.

*GP registrars*

Nationally, there is a severe shortage of GP registrars, and even more so, those with disaster medicine and/or emergency management education. While GP Colleges offer some disaster management teaching during GP registrar training, these courses are not part of the mandatory curriculum and they are conducted when a suitable trainer or educator is sourced.

Following the increase in the number of disasters there has been a natural increase in the number of GPs who have been involved personally in disaster response; however, this does not necessarily equate with formal or accredited disaster education or competency.

*General Practitioners*

GP Colleges have conducted numerous training and disaster-focused scenarios for interested GPs. However, these are often delivered at conferences as satellite activities. While the reach is low, these activities do encourage the growth of GPs exposed to disaster management and disaster medicine, with the hope that they will help disseminate the training.



*Disaster educational activities*

Primary healthcare education, on specific disaster management basics, requires more than attending a Major Incident Medical Management and Support (MIMMS) or disaster education activity developed for other groups. While these courses do contain the minimum, generally accepted, emergency management and disaster medicine principles required to be observed by all, most courses do not focus on primary healthcare, thus additional targeted educational activities are required.

The RACGP has a disaster management special interest advisory group that has been instrumental in approving disaster medicine resources developed by the RACGP.

Also, some PHNs have developed, and continue to develop, disaster educational activities specifically for GPs. An example is the Sydney North Health Network (SNHN) which developed a course consisting in the following educational sessions, of 2.5 hours each session:

**First session**

1. Disaster Planning & Local Hazard Risk Assessment
2. Disaster Systems overview
3. Command & Control & Communication
4. Disaster Skills Triage
5. SNHN Primary Health Network Disaster Involvement and Response
6. Disaster Skills Psychological First Aid & Skills for Psychological Recovery

**Second session**

1. Health effects of disasters and what health conditions are exacerbated by disasters in the first days, months and years after disasters
2. Disaster Response within the Practice
3. Evacuation centres - GPs roles and involvement
4. Practice business continuity and recovery
5. Cyber security and data breach response
6. Selfcare

This has been piloted twice to date and is currently undergoing minor revision to improve the content and delivery following feed-back with the aim of sharing amongst all PHNs.

While still under development, these educational activities are aimed at training interested GPs on how to be involved in emergency response in evacuation centres. The courses also aim to support GPs who remain working in their practices to maintain the continuity of healthcare, which reduces the burden on other emergency services, the local emergency departments and hospitals. As noted elsewhere, these courses are not mandatory, nor subject to credentialling or to competency review.

Other examples of disaster educational activities that have been developed include:

- Disaster Mental Health (developed by non-governmental organisations in collaboration with the GP Colleges)
- Physical health effects of disasters by hazards
- Roles of GPs in evacuation centres
- Position statements of roles of GPs in disaster response.

These educational activities are aimed at training interested GPs on how to be involved in emergency response in evacuation centres. The courses also aim at supporting GPs who remain working in their practices to maintain the continuity of healthcare, which reduces the burden on other emergency services, the local emergency departments and hospitals.

As noted elsewhere, these courses are not mandatory, not subject to credentialling or to competency review, nor sustainably funded for the developers and the primary healthcare participants.

*Disaster management resources for GPs*

There are a growing number of GP-focused disaster management educational resources, position statements guidelines. These are predominantly created by the GP Colleges and professional bodies, but the ongoing development and updating of the HealthPathways guidelines is undertaken by GPs working for the local PHNs.

HealthPathways is a web-based resource designed and written for use during a primary care consultation. Each pathway provides clear and concise guidance for assessing and managing a patient with a particular symptom or condition in primary care. Pathways also include information about making requests to services in the local health system. Content is developed collaboratively by GPs, hospital clinicians and a wide range of other health professionals. Each pathway is evidence-informed, but also reflects local reality and aims to preserve clinical autonomy and patient choice.

HealthPathways for disaster pathways were developed in August 2019 due to the concern of severe fires in the summer of 2019 and available just in time for the bushfires. The six disaster-related pathways were developed initially by the local Nepean Blue Mountains PHN HealthPathways team, who then disseminated them across other PHNs nationally. These pathways were rapidly disseminated to GPs across the country. As noted elsewhere in this report, this demonstrates the ability and willingness of the PHNs to rapidly share resources if needed, however the process is not consistent across jurisdictions. For example, accessing the HealthPathways in NSW requires registration and is password protected, while the one in Western Australia is open access.

Access to disaster planning through subsidy of the Emergency Response Planning Tool (ERPT) is variable across to PHNs and jurisdictions; for example, Sydney North Health Network (SNHN) is one PHN offering fully subsidised access for General Practices in 2023/24.

### Importance of Primary Health Networks

States and territories again noted the importance of PHNs in the delivery of primary healthcare. When utilised at their full potential, they can be the best source of real-time information, including for example, early warning or actual adverse effects on primary healthcare service delivery, healthcare impacts, identifying emerging needs and challenges and potential solution. PHNs are generally fast and adaptable, acknowledging that not all organisations are educated in disaster management and finding their way. PHN may also be the best environment to conduct functional alliances between providers at times of disasters and increased need.

Overall, on the one hand, rapidly engaging with PHNs in shared planning in a disaster helps develop a consistent and integrated response, within the PHN and ensures services are complementary, rather than duplicating or leaving service gaps in the community; on the other hand, replicating the process between PHNs across the country will contribute to national consistency.

### Community pharmacy sector

The community pharmacy sector is an important component of primary healthcare and open and transparent discussions with this group should continue. They are a nationwide network that remained open and provided access to vital lifesaving medications and other professional services in times of bushfires, floods and pandemics and can provide extended and continued dispensing under Controlled Substances/Emergency Management Provisions in disasters.

### Specialist and special-interest disaster management groups within primary healthcare

While disaster medicine and emergency management do require formal qualifications to obtain 'specialist' status, specialist and special-interest disaster management groups within primary healthcare would be required to progress the Recommendations 15.2 and 15.3. This includes special interest groups, which exist in the RACGP, those that exist at an international level such as the World Association for Disaster and Emergency Medicine (WADEM), and in a lesser manner, with the world organisation of family doctors (WONCA). WADEM is a growing network that facilitates the sharing of ideas internationally and has facilitated many lessons identified sessions by Australian GPs from New Zealand.

## Suggestions and Improvements | Primary Healthcare

1. Funding mechanisms should be reviewed and refined to expedite the distribution of funds in time-critical emergency contexts and to build in flexibility to increase or decrease funding amounts in response to changing circumstances.
2. Lessons identified from the bushfire and flood responses should be widely and formally integrated into the emergency management framework.
3. Legislation should be amended to facilitate timely access to medicines during any disaster.
4. Enablement of telehealth legislation to ensure continued access to medical consults and medicines in an emergency.
5. The Victorian Government funds the Emergency Response Tool in Victorian GPs since 2019, which could support the Department of Health responsibilities under the State Emergency Management Plan Health Emergency Subplan and strengthen the department's primary care response in emergencies. A similar model could be adopted in other states and territories.
6. All PHNs should be sustainably resourced with employed staff with roles and responsibilities in Emergency management. This will be formalised and aligned in the forthcoming Commonwealth Primary Health Network Strategy. The resourcing model should also allow for seamless inter-organisational cooperation and resource sharing during disasters.
7. Implementation of a consistent, integral position of a primary healthcare disaster management coordinator, with defined roles for all PHNs in disaster planning, preparedness, response and recovery. Key outputs such as, but not limited to:
   - the PHN role incorporated into the equivalent local health district/ local health network plans
   - development, rehearsal and review of PHN internal and external disaster plans
   - primary healthcare disaster medicine advisory group
   - Primary care services capacity mapped by a traffic light system to show operational status during disasters (red-closed, orange – partially functional, green – fully functional)
   - development and regular scheduling of training and preparedness activities for local primary healthcare professionals in their area
   - register of trained primary care providers for response to evacuation centres and
   - regular meetings and ongoing engagement with jurisdictional emergency management services, with an annual report of activities.

   These outputs are needed to ensure that, based on locally conducted risk assessments, PHNs are disaster prepared, helping to better integrate primary care into emergency planning. This will be formalised and aligned in the forthcoming Commonwealth Primary Health Network Strategy.
8. Noting that not two disasters are the same, PHNs must consider integrating the lessons identified from each disaster. Investment should be made in consistently and sustainably elevating all PHNs and their staff to the same level of disaster awareness and preparedness, along with disaster-educated local primary care practitioners.
9. Community Pharmacy should be considered a front-line asset of which business continuity and early deployment in any emergency response is essential and should be a mandatory requirement in any disaster plans. They should be included as a standing member on the various state, local and national emergency planning forums.
10. Strong and effective relationships, MOUs and functional alliances must be built with partner agencies and across government ideally during the planning phases and not during the response.
11. Clear and well understood communication and activation protocols must be embedded in disaster plans that are tested and exercised regularly.

# Survey Question 4

*Identified barriers that prevent the scalability or adaptability of the work (identified in Survey Question 1) for national adaptation.*

## Key Themes | Primary Healthcare

### Funding

The principal barrier that prevents the opt-in, scalability and adaptability for the inclusion of primary healthcare providers in disaster management and disaster medicine, including the prioritisation of mental health management, is the absence of sustainable funding and a fit-for-purpose funding model. This includes remuneration for primary healthcare providers – including GPs – to attend planning meetings and ensuing out-of-session work and the funds required to reimburse private primary healthcare providers so they can be involved in planning activities, training, professional development, post-deployment leave, responding to emergencies and to acquire specific specialist equipment and supplies.

Existing funding arrangements act as barriers to the inclusion of private (self-employed) GPs in the provision of emergency response and arrangements and Medicare rebates cannot, or are slow to adapt, which limit both the workforce buy-in as well as the delivery of primary healthcare services.

Current financial and accountability processes and requirements may act as an inhibitor to the timeliness of funding. Further, funding and grants often are time-limited which can mean the cessation of a program or role, for example, that of a community pharmacy liaison position. As a result, the short-term nature of these funds has impacts on both staff retention, as well as program development, delivery and sustainability.

### Legislation, rules, and regulations

Legislation varies across each state and territory, which can lead to inconsistencies in requirements and processes across Australia.

Regulatory and legal barriers prevent practice at top of scope, whereby practitioners are limited in what they are permitted to do and may be restricted from acting to the full extent of their skill set and training.

The rules of the Medicare Benefit Schedule were acknowledged as not fit-for-purpose in delivering primary healthcare in a disaster as they do not allow for special provisions for disaster situations compared to business as usual.

### Resources

As previously noted, workforce shortfall is a continuing multifactorial challenge relating, not exclusively, to limited resources, recruitment bureaucracy and the low number of applicants for some roles. Linked to funding uncertainty and program tenure, staff often leave the program before it ends.

Regarding PHNs, it was identified that there is a need for a disaster response coordinator to maintain engagement and review plans with primary care providers.

### Jurisdictional differences and harmonisation

There are significant differences between the legislative environment in which each state and territory is operating, with unique procedures and clearances between jurisdictions. This can cause obstacles, such as the access and availability of national data. As legislation varies in each state and territory, so do cross-border challenges, which were exacerbated during COVID but persist nonetheless despite lessons identified.

## Suggestions and Improvements | Primary Healthcare

1. Streamline government funding processes to execute necessary contractual arrangements to ensure funding reaches the communities quicker.
2. Better joint planning of utilisation of resources to help maximise deployment of valuable staff and resources.
3. Funding arrangements are developed that could be employed at each divisional level for planning activities, training, professional development and obtaining the adequate equipment and supplies during any emergency for GPs and other primary care providers.
4. PHN NT would benefit from a disaster response coordinator to maintain engagement and review of emergency plans with primary care providers, noting that all PHNs are expected to have this capacity as part of their core business. PHNs will need to be integrated into each state and territory planning and response frameworks.
5. Clarification of professional indemnity and personal insurance cover when primary care providers provide healthcare in a disaster.
6. Further development of social recovery resourcing especially in small/remote communities after an emergency, e.g. how to provide and pay for locums or additional primary care practitioners during the recovery period.
7. Address communication issues between healthcare providers and the local council during and after an emergency.
8. A gap analysis and implementation plan of solutions is required, following the outcomes of the review of each jurisdiction COVID response.
9. Inclusion of GP colleges (RACGP/ACRRM/NACCHO/AMA/AHMRC)/primary healthcare groups would support greater consistency in roles, systems and outputs (allowing for minor variations for local context).

# Survey Question 5

*National or jurisdictional forums that support the projects, programs, or activities identified in the survey.*

## National or Jurisdictional Forums | Primary Healthcare

The forums identified by states and territories that support projects, programs, or activities include:

- Royal Commission Implementation Time-limited Working Group
- Australia New Zealand Emergency Management Committee (ANZEMC)
- National Emergency Management Ministerial Meeting (NEMMM)
- Disaster Recovery Funding Arrangements (DRFA) Working Group
- Community Outcomes and Recovery Subcommittee (CORS)
- Social Recovery Reference Group
- National Chief Pharmacists Forum
- National Mental Health and Suicide Prevention Agreement Bilateral meetings between the Commonwealth Government and each jurisdiction
- Funded programs that convene their own forums to support the projects
- Monthly meetings with PHNs.

# Survey Question 6

*Programs, activities, or projects identified in the survey that are directly, in part or solely, considered to have contributed to the completion of a Royal Commission recommendation.*

## Key Themes | Primary Healthcare

**Primary Health Networks (PHNs)**

PHNs are of key importance, as they operate throughout all jurisdictions and are well placed to develop and maintain a primary healthcare involvement in the disaster cycle. They are also involved at the front line, supporting the community following disaster events.

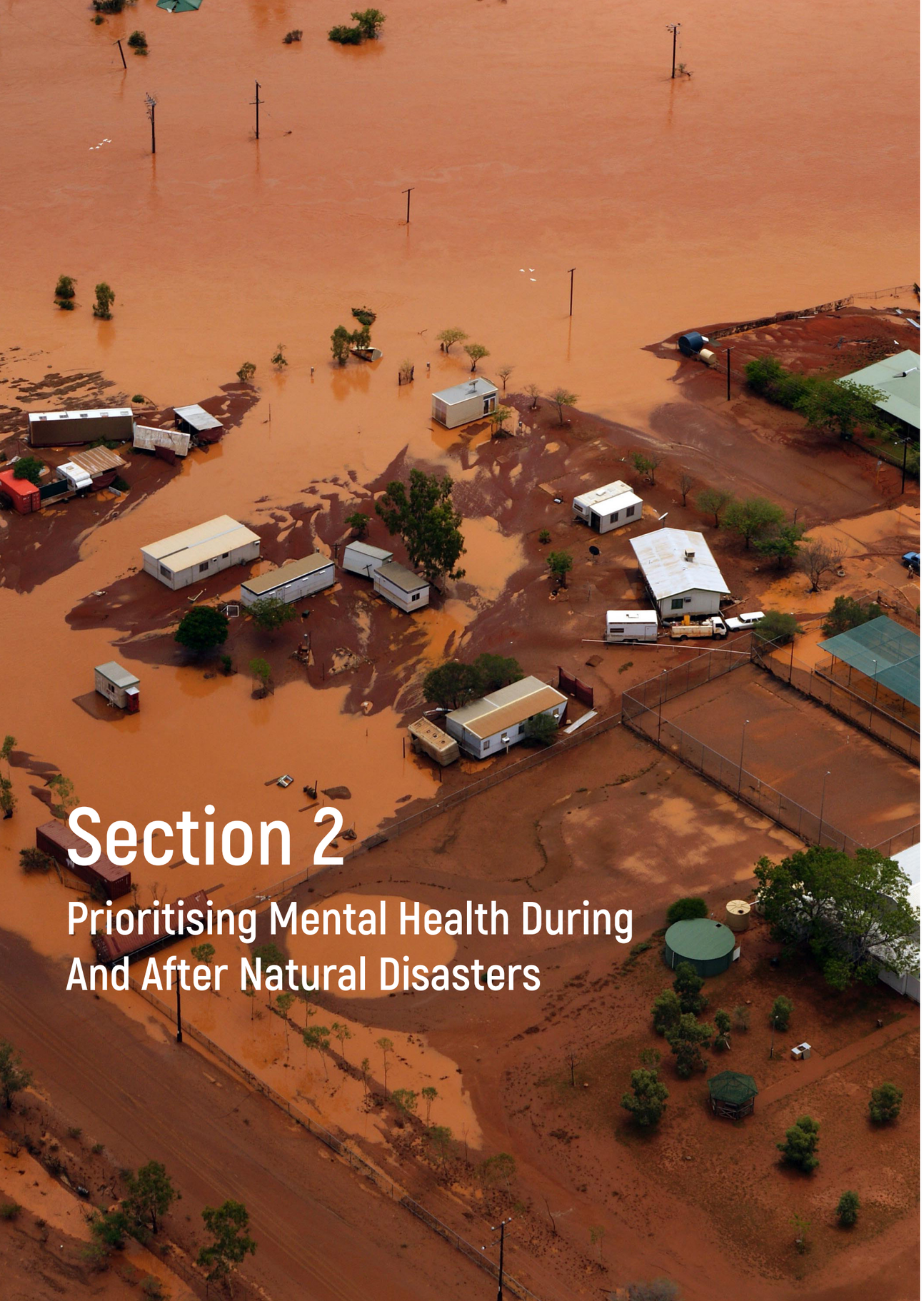
## Suggestions and Improvements | Primary Healthcare

1. **Funding should be provided to PHNs nationally** to develop and maintain their critical role. Funding through the PHNs for disaster related activities has contributed to some, albeit very isolated, yet very active engagement of PHNs in this space and development of planning and resources mentioned in Survey Question 3.
2. **Noting the absence of sole representative organisations,** at least peak organisations such as the RACGP, ACRRM, Australian Medical Association (AMA) and Pharmaceutical Society of Australia (PSA) **should be engaged in jurisdictional and nation-wide emergency response planning processes** as well as providing expert advice in relation to their respective subject matter expertise and responsibilities. Sustainable funding models should exist for these organisation to continue their engagement in disaster management and medicine.

# Survey Question 7

*How jurisdictions intend to apply the National Mental Health Commission's National Disaster Mental Health and Wellbeing Framework to assist with, or support the implementation of Recommendation 15.3*

Refer to Section 2, Prioritising mental health during and after natural disasters in this report, for information relating to this survey question.



# Section 2

## Prioritising Mental Health During And After Natural Disasters

# Survey Question 1

*Projects, activities, or programs that could be considered to facilitate the prioritisation of mental health and inclusion of primary healthcare providers in disaster management as per Recommendation 15.2 and 15.3*

## Key Themes | Mental Health

### Funds and funding models

Funds and funding models are an important and key barrier for jurisdictions. However, there are funds and programs available to support the mental health of the workforce and mechanisms in place to monitor psychological hazards in the workplace.

At a national level, the Commonwealth Government has a range of digital mental health services available during and after emergency periods including Lifeline Australia's 13 11 14 phone line, Kids Helpline, ReachOut, Mindspot (online clinic), and SANE Australia's online community forums are also available in supporting communities after a disaster event.

The Head to Health phone service is available for all Australians on 1800 595 212 (8.30am - 5pm weekdays) to be assessed and connected to mental health services in their region that best meets their individual needs.

The Head to Health digital platform (www.headtohealth.gov.au provides information, advice and links to free and low-cost phone, online and face to face mental health services and supports.

Medicare also provides access to a range of mental health supports, including via telehealth.

headspace provides free, telephone and web-based support services to young people aged 12-25 years with, or at risk of developing mental illness.

The DRFA provides financial support to states and territories for expenditure on relief and recovery measures for natural disasters. The DRFA covers specific mental health support programs, mental health support services for individuals and families including family violence and youth mental health due to bushfires and other disasters and other funded programs to help communities to recover and build resilience. The Australian Government, in consultation with state and territory governments, is developing an off-the-shelf package for mental health and wellbeing.

### Education and training

Training and education are integral components in prioritising mental health and including primary healthcare providers in the disaster management cycle. Survey respondents reported there is training and professional development for their primary healthcare and allied health providers that includes mental health training.

There are tailored courses and programs that have been developed such as a blended mental health first aid training course for pharmacists and pharmacy staff and other education and training projects, including for local community agencies and collaborative training with GPs.

### Utilisation of Primary Health Networks

PHNs are funded to commission mental health services tailored to their communities. Close collaboration is undertaken with PHNs and their commissioned primary mental health service providers in the planning, development, commissioning and coordination of mental health services and response. Some PHNs also have representation on planning committees, advisory groups and forums.

PHNs are integral in prioritising youth mental health by facilitating access and improving pathways to care such as headspace and through services that build resilience and growth and for rural and regional youth.

### Coordination and collaboration between agencies, the community and healthcare providers

Coordination and collaboration within and between the sector are vital for systems to run in an integrated, effective process-driven manner. This includes collaboration with regional teams and community partners, services, clinicians and support staff when engaged in response to natural disasters.

In disaster-affected areas, coordination, ongoing partnerships, understanding capacities and capabilities and referral pathways between primary

and tertiary mental health services is essential to meet community needs. For example, including primary healthcare services in clinical review and referral meetings aids the referral process between these services.

Survey respondents noted that for the provision of mental health services, clinicians and support are engaged where needed, including suicide prevention coordinators and mental health clinicians who are contracted across each region in response to natural disasters. Treatment services are purchased for the provision of public inpatient and non-admitted mental health and alcohol and other drug services.

In other examples provided by states and territories, evacuation centres are supported by community partners that respond to mental health needs of the people attending and work is undertaken with regional teams to develop community profiles which includes documenting mental health services in a location, as well as reviewing local welfare committee representation and functioning to expand to include mental health providers.

**National Frameworks and Plans**

Implementation of all components of the National Disaster Mental Health and Wellbeing Framework will contribute significantly to the completion of Recommendation 15.3 of the Royal Commission.

States and territories are committed to implement the principles of the National Disaster Mental Health and Wellbeing Framework, that provides guidance to recovery workers to support disaster-affected communities' mental health and wellbeing. It also guides governments, communities and multisector recovery partners to work together towards the same goals, using the same language, in a coordinated and consistent manner.

In the same vein, the National Mental Health Plan for Emergency Services Workers: 2024—2027 will be released in the near future, which aims to lower the rates of suicide and improve mental health outcomes among Australia's current and former emergency services workers including volunteers.

Jurisdictions will undertake a review of the policies and procedures in light of the National Disaster Mental Health and Wellbeing Framework, to ensure that the approaches to providing referrals and services in a disaster is consistent.

**Youth mental health programs and support**

Survey respondents indicated that there are several ways in which youth mental health is supported, such as the proactive building and supporting the capacity of the 'informal front lines', which includes teachers, childhood educators, youth workers and leaders and embedding psychology services in schools. One jurisdiction discussed an initiative that promotes and disseminates resources on prevention, early intervention and treatment to schools, childcare centres and libraries.

The Australian Government, through PHNs has prioritised mental health and inclusion of primary healthcare providers in disaster management, through the provision of additional funding to undertake disaster response activities through the headspace program.

headspace is the primary national platform to provide support to young people aged 12-25 experiencing, or at risk of, mild to moderate mental illness. headspace services provide holistic support across four key streams – mental health, related physical and sexual health, alcohol and other drug support and vocational services. These streams are delivered by primary and mental healthcare providers.

In response to various natural disasters, the Commonwealth has provided additional funding to specific PHNs/headspace services to boost access to vital mental health support. Funding has been used to support necessary capital works, additional/ surge staffing arrangements, or to establish and provide interim outreach services to disaster-impacted services.

The Australian Government engages with headspace National and PHNs to implement these measures.

Funding is contingent on the type and severity of the incident. Some packages have been provided to deliver regional responses and others to undertake localised initiatives. Funding is not necessarily intended to compensate primary and allied healthcare providers, but this may occur indirectly.

Activities, milestones and deliverables, are at various stages (contingent on activity start date and measure through which funding was provided).

## Suggestions and Improvements | Mental Health

1. Continued dispensing and maintaining access to mental health and other chronic disease medications via the community pharmacy network must be a priority as part of disaster management.
2. Some States have implemented mental health first aid training programs in pharmacies as a first-line contact and referral pathway, which should be implemented nationally.



# Survey Question 2

*Monitoring or tracking implementation of the previously identified projects, activities, or programs*

## Key Themes | Mental Health

**Committees and governance**

Respondents advised that they are members of, and participate in, various committees that meet regularly, such as the Royal Commission Implementation Time-limited Working Group and the Bushfire Mental Health Multiagency Coordination Committee.

**Post-disaster and program reviews**

Following natural disaster events and at the conclusion of programs, it is common for a debrief, evaluation and/ or review to take place, which results in collecting and analysing experiences from the event or program. This lessons management process is beneficial for future planning and development, identifying what was done well and where improvements are needed, so mistakes are not repeated and processes and outcomes are improved.

Survey respondents noted that their program plans include timeframes for reviews. Evaluation and analysis of programs and measures that address and support mental health and wellbeing are informed by the collection and analysis of data, surveys and information from service provider contract reporting and agreed milestones. An example of this is monitoring community access to mental health services in collaboration with the PHN.

When undertaking a debriefing of disaster response, primary healthcare providers and mental health support and response are included and considered.

**Project and program reporting**

It is acknowledged that reporting is an essential tool for project management. Reporting is undertaken at regular intervals, which communicates the status, performance and effectiveness of the project or program, and whether it is progressing on time and in accordance with the original plan. It can also provide information on how the budget is tracking and allows a means to identify issues early and take corrective action.

For PHN activities, monitoring and tracking of implementation is undertaken using the Commonwealth Department of Health and Aged Care's mandated project reporting tool and in the case of natural disasters, by the National Emergency Management Agency tracking system.

Overall, monitoring of the actions and outcomes of mental health programs is undertaken through internal performance reporting mechanisms and by regular reporting to the program managers through the committees that oversee the governance of the programs, to track expenditure, outcomes and key learnings.

**Grant funding requirements**

For programs or projects that are awarded grant funding, appropriate administration requires expenditure to be tracked and outcomes and KPIs to be evaluated, according to the conditions of the grant. This includes monitoring and reporting of assistance that is received under the DRFA, funded service provision and other grant programs.

# Survey Question 3

*Successes or lessons learned that can be shared.*

## Key Themes | Mental Health

### Funding and resources

Survey respondents noted that mental healthcare encounters several challenges, including the surge in demand for care at a time when there are also critical workforce shortages and, in an environment where allied health professionals are extremely hard to recruit. Adding to this pressure is that bushfire, flood and pandemic responses – which are often at a large scale and for lengthy periods of time – mean the interruption of business continuity, that redeployed staff are absent from their normal workplaces and regular client appointments deferred. It is not easy to manage deployment appeals, with a real risk of needing to decline these requests to maintain front line healthcare operations.

Organisational restructures have also changed priorities and responsibilities therefore, this makes it difficult to coordinate a disaster mental health and wellbeing response.

To be able to fulfill state and territories commitment to the implementation of the National Disaster Mental Health and Wellbeing Framework, secure funding for a coordinator is required to provide a whole of government, coordinated response. This role would respond to the Framework and focus on proactive preparedness.

### Developing relationships, collaboration and engagement

The importance of developing strong and effective relationships and collaborating with partner agencies, service providers, PHNs and across government must not be downplayed. Early engagement is a key to success, for example, between primary and tertiary mental health services in disaster-affected areas to make sure services are accessible to the community, resources are mobilised to the right areas and pathways of care are easily navigable and responsive. Further, a team with a mix of clinical and community engagement skills and experience is better for the program than just one with only clinical staff.

### Social support

Respondents noted that social support contributes to psychological health and that community members from disaster-affected areas have acquired knowledge and developed skills to assist in their psychological recovery, as well as accessed psychological support and mental health services appropriate to their needs. This means they are better equipped to respond to future disasters in ways that are more protective of their mental health and wellbeing.

### Models of care

It is acknowledged that a focused and bespoke clinical intervention program can be a more effective way of delivering mental health treatment compared to conventional approaches. This is especially true for children and young people, as they need to be understood and treated differently when addressing the psychological and mental health impacts of natural disasters.

Similar to this, in the mental health context, implementing a stepped care model that links community engagement and development, low-intensity psychological interventions and trauma-specific treatment, works well to address a range of issues across the life spectrum.

A successful example here was the implementation of therapeutic play kits for children in evacuation centres, which helped them work through emotions and experiences during difficult times.

### Collaboration on education

Mental health education collaboration is occurring between the GP Colleges and non-governmental organisations working in the disaster mental health space. For example, the longstanding work of the Australian Child and Adolescent Trauma Loss and Grief Network (ACATLGN) at the Australian National University (now part of Emerging Minds and Phoenix Australia).

The collaborative work by the RACGP, Emerging Minds and Phoenix has contributed to the development of GP-specific trauma-informed disaster care educational modules and GP checklist and advice information sheets for patients. These materials were developed with GP and mental health collaboration, and most crucially, disseminated through the RACGP networks.

The Mental Health Practitioners Network has also collaborated on webinars for mental health and GP audiences. The webinars served to present hypothetical case presentations to educate GPs and mental health clinicians on how they work together in disaster health management. Emerging Minds and ACATLGN are now leading the National Infant and Child Disaster Mental Health Advisory Committee as an outcome of the Royal Commission recommendations.

## Suggestions and Improvements | Mental Health

1. **There is a need for a longer-term, consolidated and strategic approach to Australian Government investment in mental health support** in disasters.
2. **Improvements can be made in monitoring and evaluation of mental health programs**, including data collection and sharing of consistent data across governments and agencies.
3. Need **improved coordination of services on the ground** to ensure that those in need of mental health services are aware of the support available and can easily access them.
4. Ensure the **provision of mental health services in disasters is timely, flexible and available for at least five years post-disaster** to meet evolving needs that may emerge over time.
5. Develop a **focused clinical intervention program that is tailored to the various cohorts and is fit for purpose**. This is a more effective way of delivering mental health treatment compared to more conventional approaches.
6. The **impact that COVID has had on people should not be underestimated and should be factored into programs and services**, both in their workplaces and private lives. Psychosocial risks and impacts are becoming more prominent as people are seeking assistance from their GP's and workplace and be attuned to delayed reactions that may be masked by tiredness, sickness and other factors not linked to the workplace.
7. **Children and young people need to be understood and treated differently** when addressing psychological and mental health impacts of natural disasters.
8. **Preparedness** including resources, training, therapeutic materials for children and a communications plan **is required for effective stand up in a disaster.**

# Survey Question 4

*Identified barriers that prevent the scalability or adaptability of the work (identified in Survey Question 1) for national adaptation.*

## Key Themes | Mental Health

### Funding

One of the principal barriers that prevent the scalability or adaptability of work that could be considered to facilitate the prioritisation of mental health and inclusion of primary healthcare providers in disaster management is funding. This includes the availability of additional funding and the timely provision of this funding or other resources to be able to scale up mental health services following a disaster event. This means that flexibility in reporting and inclusions and exclusions in funding agreements are required to enable pivoting from business as usual during a disaster response.

In relation to timeframes for funding for additional mental health recovery programs through locally based services, these often do not align with community needs, which results in services reducing at a time of critical need. It also puts unsustainable demands on the services when they transition back to business as usual.

Compounding this issue is the capacity and timeframes of service providers, the location of the disaster and the availability and accessibility of services in regional, remote, and isolated areas. One jurisdiction noted that commissioned mental health service providers expressed concern that involvement in disaster response may be in breach of their funding agreements.

Regarding funding rounds, the two- to three-year cycles are not best placed to assist with disaster recovery as it can take many years, and noting that mental health requirements, sometimes, do not emerge until after an event. Relatedly, Australian Government investment in mental health support in response to disasters has often been reactionary and ad hoc in nature and does not provide long-term certainty of funding.

### Mental health programs and preparedness

First and foremost, it is vitally important that the Framework informs approaches at all levels of government to mental health investment in disasters.

Barriers that are contributing to the achievement of the prioritisation of mental health in disaster management is a misunderstanding of the mental health needs of the community in the context that a current or recent large-scale disaster can occur. Due to the complex nature of recovery and the cumulative impact of stress from many associated factors, there is serious concern that mental health and wellbeing will continue to be severely impacted.

### Resources

Survey respondents noted workforce supply as an issue, citing limited resources, recruitment delays and the low number of applicants for some roles. Specifically, mental health programs can be expected to scale up rapidly which is very challenging to achieve with chronic workforce shortages, as well as the difficulty to fill time-limited employment contracts. There is a lack of qualified resources in schools for psychologists and allied health workers who are specially trained to support children, adolescents and their families and an overall number of available psychologists due to these workforce shortages.

Regarding the scalability and adaptability of mental health services, the capacity and timeframes of services providers could limit the ability to meet increased demand. An additional barrier is the location of the disaster event and the availability and accessibility of services in regional or remote areas.

## Suggestions and Improvements | Mental Health

1. The successful implementation of the Framework will require buy-in from relevant Ministers and state and territory governments. This nationally consistent approach should also leverage existing mechanisms, e.g. the DRFA and other mainstream mental health support services.
2. **Long-term planning** to benefit the scalability and adaptability of mental health recovery programs.
3. **The development of longer-term mental health disaster preparedness initiatives.**



# Survey Question 5

*National or jurisdictional forums that support the projects, programs, or activities identified in the survey.*

## National or Jurisdictional Forums | Mental Health

The forums identified by states and territories that support projects, programs, or activities include:

- Royal Commission Implementation Time-limited Working Group
- Chief Psychiatrist Forums
- Disaster Recovery Funding Arrangements Review working group
- National Mental Health and Suicide Prevention Agreement bilateral meetings
- Funded programs that convene their own forums to support the projects
- Australia New Zealand Emergency Management Committee
- National Emergency Management Ministerial Meeting
- Mental Health Forums, facilitated by Primary Health Networks and Mental Health Australia.

# Survey Question 6

*Programs, activities, or projects identified in the survey that are directly, in part or solely, considered to have contributed to the completion of a Royal Commission recommendation.*

## Key Themes | Mental Health

**National Disaster Mental Health and Wellbeing Framework**

States and territories expressed their firm commitment to implement all components of the National Disaster Mental Health and Wellbeing Framework and the National Mental Health Plan for Emergency Services, noting that this will contribute significantly to the completion of Royal Commission Recommendation 15.3. In doing this, an emphasis should be placed on the need for preparedness.

One jurisdiction outlined its mental health response to incidents, which provides evidence that simply by responding to the event and ensuring the appropriate mental health services are delivered to the community following a disaster, that jurisdictions are contributing to the completion of the Royal Commission recommendation.

## Suggestions and Improvements | Mental Health

1. Workers should **contribute to implementing Royal Commission recommendation 15.3,** which will support cross-jurisdictional efforts to ensure appropriate mental health services are delivered during and after disasters, a proactive and pre-agreed approach to funding mental health programs through DRFA and other funding mechanisms and improved monitoring and evaluation to ensure mental health services are timely and effective.
2. A **gap analysis** needs to occur to determine progress related to the Royal Commission's recommendations.



# Survey Question 7

*How jurisdictions intend to apply the National Mental Health Commission's National Disaster Mental Health and Wellbeing Framework to assist with, or support the implementation of Recommendation 15.3*

As the National Disaster Mental Health and Wellbeing Framework was not released at the time of the survey, while states and territories are supportive of the aims and principles of the Framework, they have yet to consider how it would be implemented in their jurisdictions. In many cases, the guiding principles of the Framework are already consistent with responses to mental health and wellbeing following disaster events, including prioritising mental health responses during and after disasters and applying the three-tiered disaster mental health response matrix.

In practice, there are several business-as-usual programs and initiatives that contribute towards this recommendation, such as state-provided mental health services, funded service provision, focused clinical intervention and resilience programs, screening and psychological first aid and stepped care approaches. It is noted that many community members from disaster-affected areas have acquired knowledge and developed skills to assist in their psychological recovery from the disaster event.

Other initiatives include state governments developing longer-term mental health hazard-preparedness measures and ensuring that those wishing to study mental health and practice in the system, are supported to do so to help build a contemporary mental health workforce. Under the National Mental Health and Suicide Prevention Agreement, governments have agreed to work together to build a mental health and suicide prevention workforce that is culturally safe and responsive to changing needs, while ensuring current shortages and maldistribution are addressed.

States and territories have noted that once the framework is released, work will be undertaken to identify gaps that are needed to support their roles and responsibilities as set out in the Framework. The Framework and its implementation, will be considered in the context of developing new policies or proposals targeting mental health responses to all hazards, including natural disasters.

Participation in meetings and appropriate and relevant working groups to oversee the implementation of the Framework will continue to occur nationally, as will regular, collaborative forums with partners to improve access to community mental health services, that will provide opportunities to include disaster response.

## Suggestions and Improvements | Mental Health

1. Where natural disasters have occurred, mental health service providers have been flexible with service delivery to meet community needs but were limited by existing funding arrangements. **Mental health services following a natural disaster can be scaled up if additional funding is provided.**
2. **Additional information and clarity are required on the expectations of agencies when implementing a disaster response,** including leadership, funding, communications and responsibilities at an operational level.
3. **Recommend the establishment of a Senior Officials Group (SOG) to implement the National Disaster Mental Health and Wellbeing Framework.** The group would include representation from all levels of government and both health and emergency management agencies and would drive and sustain long-term collaboration and reform in this area.
4. **The off-the-shelf DRFA package development should be aligned with the National Disaster Mental Health and Wellbeing Framework.**

# Appendices

# Appendix 1 - Jurisdictional Survey Questions

*Prioritisation of mental health and inclusion of primary healthcare providers in disaster management – [Insert Your Agency] Response.*

Western Australia is the lead for Priority Action XIII: Prioritisation of mental health and inclusion of primary healthcare providers in disaster management; and is seeking to engage with jurisdictions to identify opportunities to progress the implementation of recommendations 15.2 and 15.3 of the Royal Commission into National Natural Disaster Arrangements (Royal Commission).

**Recommendation 15.2 Inclusion of primary care in disaster management**

- Australian, state and territory governments should develop arrangements that facilitate greater inclusion of primary healthcare providers in disaster management, including representation on relevant disaster committees and plans and providing training, education and other supports.

**Recommendation 15.3 Prioritising mental health during and after natural disasters**

- Australian, state and territory governments should refine arrangements to support localised planning and the delivery of appropriate mental health services following a natural disaster.

The information provided in response to this survey will develop a holistic understanding of the activities that the Commonwealth and jurisdictions are undertaking to progress recommendations 15.2 and 15.3 of the Royal Commission.

The information provided in response to this survey will be submitted to the Priority Action XIII cross jurisdictional working group and inform reporting to the Commonwealth and other relevant forums including ANZEMC, NEMMM and NFRC. The Priority XIII working group will work towards:

1. Understanding jurisdictional approaches to the implementation of the Royal Commission recommendations 15.2 and 15.3 and
2. Implementing and achieving the Priority Action XIII Project Management Plan.

Questions

**1. What projects, activities, or programs are being undertaken in your jurisdiction currently that could be considered to facilitate the prioritisation of mental health and inclusion of primary healthcare providers in disaster management as per recommendation 15.2 and 15.3?**

We are specifically interested in understanding:
- Each project, activity, or program objectives.
- How agencies are liaising and collaborating with primary healthcare providers to define, plan and implement the project or activity?
- Is compensation being offered to primary or allied healthcare providers for their contribution to disaster management projects or activities?
- The level of funding committed to the project, activity and or compensation.
- What are the milestones and timeframes for each project or activity?
- What is the status of the project or activity?

**2. How are you monitoring or tracking implementation previously identified projects, activities or programs?**

**3. Are there any successes or lessons that can be shared here?**

**4. Have you identified barries that prevent the scalability, or adaptability, of this work for national adaptation**

Please consider barriers at all stages of a project, including:
- Stakeholder consultation and/or participation
- Planning
- Capacity and capability
- Legislation
- Implementation
- Research, data, and information
- Mainstreaming /BAU – what inhibits broader adoption?

**5. Are there national or jurisdictional forums that you are involved with that support the projects, programs or activities discussed in this survey?**

**6. Are any of the programs, activities or projects in this response directly, in part or solely, considered to have contributed to the completion of a Royal Commission recommendation? Please identify why the recommendation is considered completed, providing detail around the completion criteria.**

**7. The National Mental Health Commissions National Disaster Mental Health and Wellbeing Framework was developed in response to the severity of the 2019 / 2020 season. The Framework supports the implementation of Priority Action XIII – 15.3. How does your jurisdiction intend to apply The Framework to assist with, or support, the implementation of Priority Action XIII – 15.3?**

Please consider the following when developing your answer:
- How is The Framework being applied in your jurisdiction?
- What is required in your jurisdiction to apply The Framework?
- Identify some strategies that have assisted with the implementation of The Framework.
- What you can you share about the success and barriers to implementing The Framework.



**Nominated representatives**

1. Jurisdiction:

2. Department or Agency:

3. Contact officer: .....

   a) Work Number: .....

   b) Mobile: .....

   c) Email: .....

4. Clearance Officer: .....
   (if required to allow sharing with other jurisdictions)

Date: .....