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Communities in crisis

LIFELINE QLD SUPPORTING THOSE IN NEED

MARCH 2023

ABOUT THE MCKELL INSTITUTE

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ACKNOWLEDGEMENT OF COUNTRY

This report was written on the lands of the Darug and the Eora Nations. The McKell Institute acknowledges Aboriginal and Torres Strait Islander peoples as the Traditional Owners of Country throughout Australia and their continuing connection to both their land and seas.

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EXECUTIVE SUMMARY

Poor mental health and suicide are significant public health issues. Australians have had an exceptionally challenging past few years, facing numerous waves of the COVID-19 pandemic and increasingly frequent extreme weather patterns and intense natural disasters. These difficulties have had serious direct and indirect consequences for the mental health of the nation.

Thus, the services that Lifeline provides are seeing an increase in demand and usage, especially those around disaster events. Lifeline is a national charity that runs 24-hour crisis support and suicide prevention services for Australians experiencing emotional distress, and they have been operating in Australia since 1963. Their national network consists of over 40 centres, includes 10,000 volunteers, 4,500 crisis supporters, and 1,000 employees. The Queensland network consists of 10 centres and 6000 volunteers, and 593 full time paid employees.

In addition to its crisis line services, Lifeline Queensland also runs a Community Recovery and disaster relief program that has been supporting the communities of QLD since 1996. The teams are most frequently activated at the request of local or state government authorities after events such as floods, bushfires, cyclones, major health emergencies, road accidents, or other community crises.

Lifeline provides invaluable services that address the needs of the 'missing middle' within the mental health and suicide prevention ecosystem. Their crisis lines, community recovery programs, and resilience work with 'at risk' communities helping those people in crisis who might otherwise fall through the cracks. While the Queensland government recognises the need to support those categorised as the missing middle, other than the funding they provide for Community Recovery services, they do not fund Lifeline services in a direct or consistent way, unlike some of the other states and territories. Given the increasing need for Lifeline's services, and the irreplaceable value they provide to Australians in crisis, this needs to change.

This report uses Lifeline call data and UnitingCare QLD CrisisWorks data to explore the state of mental health and community recovery needs nationally

and in Queensland. What we found is that there is an increasing and consistently high need for dedicated disaster lines and Community Recovery services. Yet, to run these programs more efficiently and sustainably, there is a need for a standardised funding model that provides for a regular workforce and proactive crisis management. Instead of something that is activated as an afterthought in the wake of community crises, Community Recovery needs to be built into the system.

Part 1 of this report focuses on the mental health services landscape in Australia and QLD, and Lifeline's place within that landscape. Part 2 explores the relationship between climate change, COVID-19, and natural disasters on mental health. Part 3 specifically examines and analyses Lifeline's call data and CrisisWorks disaster data, and Part 4 of the report provides general recommendations for long term resilience, which needs to be proactively funded.

KEY FINDINGS

Demand for Lifeline's services is on the rise. Nationally, from 2013-2022, there has been a **31.6 per cent** increase in service usage.

The 62 busiest days on record all occurred within the last 18 months, with a maximum of **3,726** calls on Jan 1st 2022

Throughout 2020 and 2021, when working hours logged were comparably higher than they have been before or since, the median call answer rate (CAR) was **90 per cent,** whereas in 2018 and 2019 it was **81 per cent**

> In 2022, working hours dipped by 4.4 per cent, and while correlation does not equal causation, you can see that there has also been a fall of 7.1 per cent in the per centage of calls answered nationally, with an overall CAR of 82 per cent.

Nationally, since being introduced in Jan 2020, a total of **332,452** calls (or 10 per cent) have been made to the specific bushfire/natural disaster helpline 13HELP

> In Queensland 14.5 per cent of all calls since then have been made through this number, the most of any state

Since 2019, the Community Recovery program has made almost **68,000** referrals to support services, there have been almost **45,000** instances of practical support, over **18,000** instances of reconnection to social supports, almost **19,000** cases that required stabilisation or grounding, and almost **16,000** properties visited

The funding model for community disaster events needs to move from a 'crisis response' model to one that is proactive and regularised

PART 1:

THE CONTEXT AND LANDSCAPE OF AUSTRALIA'S MENTAL HEALTH SERVICES, SYSTEMS, AND INFRASTRUCTURE

Mental health is a vital part of health and wellbeing, however, health systems around the world are yet to sufficiently or satisfactorily respond to the burden of mental health disorders. As such, the gap between the need for treatment and its delivery is widening. For example, in higher income countries, between 35 and 50 per cent of people with severe mental disorders receive no treatment for their condition. The increasing frequency of community disasters (pandemics and natural hazards) serves to increase the mental health burden on the system, as sustained and chronic disasters have a detrimental impact on mental health and wellbeing.

Lifeline is a national charity that runs 24-hour crisis support and suicide prevention services for Australians experiencing emotional distress, and they have been operating in Australia since 1963. They are available 24 hours a day to listen, without judgement, to any person in Australia who is feeling overwhelmed, experiencing crisis, or yearns to be heard. Their national network consists of over 40 centres, includes 10,000 volunteers, 4,500 crisis supporters, and 1,000 employees.

They fulfil a vital role within the mental health and suicide prevention ecosystem, in that they address the needs of those who otherwise might not be able to access mental health services when they need them the most. The Productivity Commission, as well as other organisations, describe people who fall within the 'missing middle' category as those who need intensive community support to recover and carry on with their lives. These people tend to fall between inpatient hospital services, and services for people with mild to moderate mental health problems, those who struggle

to access and navigate Australia's mental health services, and who often go untreated, and uncared for.

Not only does Lifeline cater to those who are overwhelmingly underserviced within the mental health landscape, but Lifeline QLD also offers services that support individuals and communities during and after natural disasters. These types of programs work with at risk communities, building disaster and mental health resilience in a time when extreme weather events are only going to increase. Thus, there is a need to future-proof mental health disaster crises with more consistent and stable funding from the QLD government, building resilience into the system rather than relying on recovery mechanisms and actions.

In Australia, the mental health system is complicated and fragmented, with roles and responsibilities divided and overlayed across a variety of government, non-government, and private stakeholders and entities. Within the Australian mental health system, the division of roles and responsibilities exists across legislative bodies, policies, funding mechanisms, and service delivery programs. These are further divided among the Australian Government, state and territory governments, Primary Health Networks (PHNs), Local Health Networks (LHNs), and the private and non-government sectors. As many of these roles and responsibilities overlap and intersect with each other, there exists a level of uncertainty and complexity for service providers, consumers, and carers.

The national government has both funding and policy responsibilities. The Australian Government, among their other funding streams, contributes funds to the non-government sector, both directly and indirectly through PHNs. The state and territory governments are responsible for enacting mental health legislation, guiding policies and funding frameworks, and providing public mental health services that give specialised care to those in need. This includes state and territory community mental health care services. The non-government sector consists of private organisations, both not-for-profit and for-profit, including charities such as Lifeline. Non-government mental health organisations may receive funding from the national government, state or territory governments, PHNs, LHNs, or private entities. In general, these services focus on delivering non-clinical support, advocacy, and assistance to people who live with mental illness, rather than the assessment, diagnostic, and treatment plans undertaken by clinical programs.

The Australian mental health context and recent national developments

In any given year, approximately one in five people in Australia aged between 16-85 will experience a mental health disorder. Mental health is affected by a myriad of socioeconomic factors, including an individual's access to services, living conditions, and employment status. Poor mental health impacts not only the individual, but their families, carers, and the community. A variety of mental health services are provided by various levels of government, and in addition to the specialised services offered by each state and territory, both levels of government provide support to population mental health crisis and support services. However, historically, that support has not been regularised or proactively planned to provide long term resilience.

The latest figures on mental health from the Australian Bureau of Statistics (ABS) show that 20 per cent of Australians registered as having a mental or behavioural condition, which was an increase from 18 per cent from the previous reporting period in 2017. This increase, both nationally and in QLD, was predominantly due to an increase in the number of people reporting anxiety-related conditions and depression or feelings of depression. When looking at the states and territories separately, QLD had the highest percentage of those with mental health or behavioural conditions (22.7 per cent).

In 2020, the Productivity Commission published its final report on the Mental Health Inquiry. The Commission found that Australia's current mental health system does not sufficiently cater to those in need, and that reform of the system would engender significant benefits in the quality of life for those suffering from mental illness valued at up to $18 billion per annum, with the added yearly benefit of $1.3 billion due to increased economic participation. The final report focused on early intervention, support, and prevention, emphasising the need for a person-centred mental health system.

The Royal Commission into the Victorian Mental Health System released its report in 2021, which included a reform agenda to redesign the Victorian mental health and wellbeing system. The Commission found that the current Victorian system was not equipped to support the diverse needs of individuals living with mental illness or psychological distress, noting the pressure placed on the system by the COVID-19 pandemic as well as the severe 2019-20 bushfire season.

Due to system constraints, services are often inaccessible at those times when they would make the most impactful difference for those in crisis. Additionally, the system largely operates in crisis mode, meaning it is more reactive than proactive when it comes to dealing with mental health crises and supporting the mental health system. The report also stated that good mental health and wellbeing had historically been a relatively low priority for all levels of government as well as for the community itself. As it stands, the system primarily focuses on those with severe and persistent mental health issues, which fosters a system that is reactive, crisis-driven, and shaped by a clinical model of care and administration.

In response to the recommendations put forth in the Productivity Commission's report and the Royal Commission into the Victorian Mental Health System, the 2021-22 Federal Budget allocated $2.3 billion over four years to the National Mental Health and Suicide Prevention plan. A further $547 million was allocated in the 2022-23 budget.

In the 2022-23 Budget collection of fact sheets addressing the prioritisation of mental health, preventative health, and sport, the government organises around five main pillars:

1. Prevention and early intervention,
2. Suicide prevention,
3. Treatment,
4. Supporting the vulnerable, and
5. Workforce and governance.

Mental health services in QLD

The 2022 parliamentary inquiry into improving mental health outcomes found that for over a decade, Queensland's expenditure on mental health services has been lower than the national average. And in 2019-20, it had the lowest per capita expenditure on mental health services across Australia.

Looking specifically at the social and economic impact of mental health in QLD, mental illness is the highest contributor (at 20 per cent) to the Indigenous burden of disease in the state, impacting family and community cohesion. In 2019, there were approximately 45,000 informal mental health carers in QLD. They provided the equivalent of 34, 600 FTE formal support workers, with a total annual replacement cost of $3.3 billion. Yet, many mental health carers have insufficient support, resulting in high levels of isolation and loneliness, anxiety, reduced income and poverty, and their own mental health challenges.

The Report on Government Services 2022 shows that between 2010-11 and 2019-20, there was a 52 per cent increase in per capita expenditure on public hospital and health services as provided by Hospital and Health Services in QLD, while for mental health services, there was only a five per cent increase over that same period. In the non-government mental health sector, the impact of piecemeal, inconsistent, and ad hoc funding has a negative impact on service delivery and workforce planning.

Funding mechanisms are a key lever and control point for improving service capacity and development. The effectiveness of funding as a lever of improvement and reform requires clarity and agreements about intergovernmental and cross-sectional responsibilities for funding as well as decision-making about what should be funded.

The total expenditure on mental health services in QLD has not increased proportionately with its population. According to the Productivity Commission report, expenditure on mental health services accounts for 7.8 per cent of government health expenditure even though mental health and substance abuse disorders account for the fourth largest contributor to the total disease burden.

Further, those people struggling with early signs of illness or distress, those dubbed the 'missing middle', are often provided with little to no support. The term 'missing middle' has been prominent in discourse relating to the provision of mental health care in Australia, particularly by advocates of non-governmental youth mental health services such as headspace as well as related adult services. The term has been used to describe people 'whose needs are not met by current mental health services'. In somewhat more detail, Petrie et al stated that the term refers to patients who are moderately unwell, but partly functioning, who do not meet the criteria for crisis services and who require ongoing treatment and therapy, which is often out of their financial means.

There are approximately 150,000 Queenslanders who would be classified as being part of the missing middle, with the Productivity Commission stating the existence of a missing middle reflects a lack of community mental health services. The 2022 inquiry into the QLD mental health system found that there were several reasons for the emergence of this under-serviced group, one of which being that the system is designed to respond to crisis rather than invest in and support long term resilience and those showing early signs of distress.

Lifeline's role in the mental health service landscape

One of Lifeline's primary access points is its crisis lines, providing individuals with a phone number to call (or online chats or text message options) when they are experiencing distress or suicidal ideation, where they can talk to a trained volunteer or employee without fear of judgement or derision.

Difficulties navigating the mental health system, or instances of not quite meeting diagnosis or support eligibility requirements, are major reasons that consumers do not receive the care they need. This leaves those struggling with early signs of illness or distress, those dubbed the 'missing middle', with little to no support. Lifeline helps to plug this gap.

Further, with suicide being the leading cause of death for Australians aged 15 to 44, the ongoing, and indeed increased, support of mental health services and crisis lines such as those provided by Lifeline, are essential for a functioning society. Beyond the immediate and devastating loss of life of individual life, each incident results in the impact of at least 135 people who may require clinical services or support following the event. Evidence shows that exposure to the suicide of a relative increases the risk for depression, admission to psychiatric facilities, and suicide, as well as there being demonstrable risks for non-family members who have been exposed to suicide attempts or death.

Throughout the 2021 financial year, Lifeline saw unprecedented demand, with over 1,000,000 calls answered, three times more calls to the dedicated bushfire crisis support service accessible through 13HELP, and over 58,000 safety plans created. In 2021, across all Lifeline's phone services, the call answer rate (CAR) was 90.34 per cent. By August 2021, the volume of incoming calls reflected a 40 per cent per cent increase compared to pre-pandemic levels, with the 13 11 14 crisis line receiving a call every 30 seconds.

The cumulative effects of Australia's recent natural disasters, be they droughts, bushfires, global pandemics, or floods, have driven unprecedented demand for Lifeline's crisis support and suicide prevention services. 13HELP was established in February 2020, with the crisis supporters managing the service having completed specialised online training designed to equip them for managing bushfire-related trauma. Throughout 2021, they continued to field record monthly call volumes to the 13HELP service.

The funding mechanisms available for not-for-profits like Lifeline are quite ad hoc and complicated, making workforce planning and long term community resilience a challenge. The services that Lifeline provides are seeing an increase associated with disaster events (including both natural disasters and the pandemic). These disasters are increasing on a frequency, duration, and intensity basis. As the Community Recovery service will see, and indeed is already seeing, increased demand due to the more frequent disaster events, investment in these services needs to be proactive rather than reactive as these crises occur.

Lifeline (UnitingCare) is a vital community support service in QLD

As part of UnitingCare, Lifeline Queensland runs Lifeline crisis support services, crisis lines, and community recovery services in QLD. Crisis lines provide a critical first line of mental wellbeing support for communities in distress and have done so for over half a century. Crisis lines aim to reduce and contain help seekers' emotional or physical crises, promoting coping mechanisms, and broadening internal resources and external supports, including pathways to more specialised services. Support is usually delivered by way of an immediate, anonymous, confidential, single session intervention that is low or no cost. Crisis support services feature in national suicide prevention and mental health strategies the world over. In Queensland, they run a 24-hour Lifeline Crisis Support Line through 10 Lifeline centres, as well as offering test messages and online chat services 24 hours a day.

They also provide a range of other services in the community, such as the Lifeline Community Recovery service, which ensures that there are teams ready and available to provide face-to-face support in the wake of

natural disasters. At the request of state or local government authorities or community groups or organisations, the Lifeline Community Recovery team is deployed to a specified community to provide practical support, counselling, and psychological first aid (PFA) in the weeks and months following bushfires, droughts, cyclones, pandemics, floods, and tragedies.

The Recovery teams support people and communities as they go through shock and begin to process their experiences. This process takes time, with the Lifeline teams often continuing to support communities in the years following a crisis. This support is extended to those both directly and indirectly affected by events. This service has been supporting Queensland communities since 1996, drawing on the expertise of a range of professionals from social workers, Lifeline Crisis Support workers, and specialist volunteers. Beyond the PFA duties and activities run by the Community Recovery Teams, they also partner with local agencies and governments to manage evacuation centres and support hubs during events to ensure a coordinated community outreach.

The program also supports long term strategies to assist recovery, through community-led activities, collaborative practice, case management, community education, and capacity building.

Primarily funded by the Department of Communities, Housing, and Digital Economy, the service embodies the six human services quality framework compliance (HSQF) standards set out by the department. The HSQF standards constitute the department's framework for assessing and promoting improvement in the quality of the services that are provided under their funding. The six standards are as follows:

1. Governance and management,
2. Service access,
3. Responding to individual need,
4. Safety, well-being, and rights,
5. Feedback, complaints, and appeals, and
6. Human resources.

The Community Recovery program will be discussed in more detail in Part 3 of the report.

That said, apart from funding the Community Recovery team through Standing Offer Arrangement (SOA) orders and emergency funding (such as the $3.5 million provided in 2020 to cope with COVID-related usage increases), the QLD government (unlike NSW and Victoria) provides no consistent baseline funding to Lifeline. Although, during the midst of the pandemic in June 2020, when many of the retail stores had to be closed, there was a one-off donation of $3 million from the QLD Government. In general, however, for Lifeline QLD, approximately 70 per cent of its funding comes through retail sales and fundraising.

Here, it would be instructional to pose a simple thought experiment: what would happen if Lifeline QLD didn't exist?

What would happen to the almost 12,000 callers in QLD who required safe plans in 2021 (which is an increase of 52.9 per cent from the year before)? What of the 78.6 per cent of calls deemed 'crisis calls' in QLD that have come through since 2013, or the approximately 180,000 calls a year? In 2019 in QLD, almost 30,000 calls in QLD involved safety issues, in 2021, this number saw an increase of 16.7 per cent, resulting in over 34,000 callers presenting with a safety issue.

Without those safe plans, volunteers to advise on safety issues, or just having someone to talk to, callers may have suicided, self-harmed, or been unable to help someone else and subsequently needed to present themselves or others to emergency departments.

Those with suicidal thoughts and those classified as the missing middle, which the QLD government has recognised as an underserviced section of the population, would be left floundering, without recourse, without hope.

PART 2:

THE IMPACT OF COVID-19, CLIMATE CHANGE, AND NATURAL DISASTERS ON COMMUNITY MENTAL HEALTH AND WELLBEING

Over the past couple of years, Australia has faced a multitude of challenges to its collective mental health. A global pandemic and multiple, successive, intense natural disasters have pushed people to their limits.

The increasing frequency of community disaster events means that the funding mechanisms hitherto employed to deal with said crises are no longer efficient or sustainable. Natural hazards and disasters are becoming the norm, and the mental health system must respond to the changing times and opt for funding and service infrastructure models that focus on long term resilience, building Community Recovery into the system, rather than activating these types of services after the fact.

COVID-19 has exacerbated mental health issues

When it comes to the COVID-19 pandemic, the current focus of countries and global organisations (such as the WHO) is on controlling and mitigating the spread and impact of the virus by identifying, testing, treating infected people, and developing drugs, vaccines, and treatment protocols. Throughout the pandemic, the WHO have expressed concerns over the mental health and psychosocial implications of the outbreak, as the mental health and wellbeing of individuals and populations can be undermined by macroeconomic forces or by emergency public health measures taken to contain disease outbreaks.

Along with the anxiety and widespread concern associated with the fear of becoming infected, as well as the fear of long lasting outcomes or even death for those already ill, the public health measures enacted to curb the further spread of the disease only served to exacerbate or even trigger mental illness. Mandatory quarantine, self-isolation, lockdowns, gathering bans, and associated closures of schools and workplaces have had a unique (read adverse) effect on mental health for many people. The impact was compounding for those who already had existing mental and physical health conditions or difficulties.

As we have seen throughout this report, mental health issues and suicide are significant public health issues for Australia, and these have only been amplified during the COVID-19 pandemic. When the pandemic first made its way to Australia in early 2020, psychological distress levels in adults were significantly higher than pre-pandemic levels, with 10.6 per cent of Australian adults experiencing severe psychological distress, as opposed to 8.4 per cent in February 2017.

Social distancing restrictions, which placed limits on an individual's activities outside the home to those that were considered absolutely essential, were found to increase social isolation and loneliness, alcohol abuse, and domestic violence. In April 2020, a survey of over 1,500 Australians found that 22.1 per cent of respondents reported symptoms of anxiety, and 21.9 per cent reported symptoms of depression.

A later survey of 14,000 adults in Australia investigated whether the high prevalence of mental health problems in April 2020 was related more to the fear of contracting COVID-19 or to the impact of restrictions. It found that while both were linked to mental health issues, experiencing the restrictions as having an extremely negative effect on daily life was associated with much higher odds of clinically significant depressive and anxiety symptoms than those associated with the fear of contracting COVID-19.

In this way, the global pandemic and the restrictions implemented to halt the spread of the disease are associated with an increased population burden of moderate to severe symptoms of depression and anxiety.

Climate change threatens our mental health and wellness

According to the International Disasters Database, natural hazards and extreme climate events are on the rise. In 2021, a total of 432 catastrophic events were recorded the world over, which is significantly higher than the average of 357 annual disaster events between 2001-2020. Floods dominated these events, with 223 on record, up from an average of 163 annual flood occurrences between 2001-2020.

Climate change is exacerbating extant public mental health challenges and will continue to do so over the coming decades. Climate change aggravates risks to mental health and wellbeing when the frequency, duration, intensity, and unpredictability of weather-related hazards change. The subsequent weather impacts increase the number of people (re)exposed to extreme events and their resulting psychological issues, with suicide an extreme manifestation of trauma. Less apparent consequences of weather-related disasters can be particularly hazardous, such as the creation of food shortages, homelessness and displacement, and the damaging of public infrastructure, power and connectivity, agricultural land, and sacred places.

Natural disasters don't just threaten our physical world, they impact our mental health and wellbeing as well

Australia has been increasingly exposed to a range of natural disasters which impact the health and wellbeing of its population. Natural hazards common to Australia include floods, bushfires, cyclones, severe storms, droughts, heatwaves, and to a lesser extent, earthquakes and tsunamis. In view of the increasing impacts of global warming and climate change on the frequency and intensity of natural and extreme weather disasters, there is a growing need to assess and compensate for the burden that exposure to natural disasters has on the mental health of the population.

Natural disasters threaten and impact the lives of millions of people each year. Anyone experiencing a disaster may experience measurable financial costs, such as loss of home and personal property, and potentially face life-long non-monetary costs. Dealing with the danger of death or physical injury, the loss of loved ones, and financial stressors can trigger depression, anxiety, and numerous other emotional and physical health problems.

These effects may reduce individuals' labour potential and productivity, as well as increase the risk of falling into poverty.

Climatically, Queensland experiences both tropical and subtropical conditions and is subject to intense tropical cyclones and periods of heavy rainfall caused by tropical lows, which can trigger substantial wind and flooding events. As such, Queenslanders are susceptible to a wide range of natural disasters, possibly facing catastrophic bushfires one month and then unyielding and relentless flooding the next. Since 2011, QLD has been hit by more than 80 significant natural disaster events, resulting in the tragic loss of life, and incurring a recovery and reconstruction bill of more than $16.1 billion.

When examining certain types of disasters, or extreme environmental occurrences, several studies have noted a negative effect on subjective wellbeing, life satisfaction, and happiness. The rise in climate-related disasters has prompted the growth of empirical literature and studies into the psychological problems and crises brought about by natural disasters. In 2009, Carroll et al found that droughts in Australia decrease life satisfaction in rural areas. Also in 2009, Luechinger and Raschky identified the negative effects of flood disasters on life satisfaction and subjective wellbeing.

When it comes to natural disasters and community-wide trauma, research distinguishes between several phases of psychological responses. Pasnau and Fawzy (1989) presented five key stages, which have been adapted and refined over the decades:

1. The impact phase or actual onset of the disaster can induce a range of emotions from shock to overt panic. Initial confusion and disbelief are often followed by a focus on self-preservation and family protection.

2. The heroism (or rescue) phase is characterised by a time of altruism, where many survivors exhibit adrenaline-induced rescue behaviour and high activity. This includes intervention activities from various government and non-government organisations.

3. The honeymoon (or remedy) phase is where people collaborate actively for the collective good, communities pull together, and there is a feeling of hope and elation.

4. Disillusionment is the phase where people are disappointed in resource allocation, and there is a rising sense of injustice as some people appear to be more fortunate. Distress rises, and there is potential for mental health problems to increase during this time.

5. The reorganisation (or recovery and/or reconstruction) phase sees people start to rebuild their lives and begin to depend on themselves again. People begin adjusting to new circumstances. That said, failure to do so may cause long-term bitterness and animosity.

A 'pre-disaster' phase was later added to the list, where disasters with no warning can cause feelings of vulnerability, fear of the future, lack of security, and a loss of control. Natural hazards with warnings can cause feelings of guilt or self-blame for failure to heed warnings.

As previously mentioned, traumatic events, such as natural disasters and disease outbreaks have a physical, social, and emotional impact on those directly and indirectly affected. Additionally, research has shown that successive disasters have a compounding effect on people's mental health. This is particularly relevant for the state of QLD, as over the past two years, there have only been approximately three months where Lifeline QLD's Community Recovery support team has not been stood up by the Government.

Australia's mental health is in jeopardy

Even prior to the COVID-19 pandemic, the country was already experiencing some of the largest bushfires, in both scale and duration, in Australian history. As bushfires raged, many communities were also in the midst of extended severe droughts. And following the bushfires, much of Australia was impacted by hailstorms and once-in-200-year floods in January 2022, only to be followed by a once-in-500-year flood event in Bulga NSW in July 2022. The impact of acute natural disasters on mental health has become an increasingly prominent area of study, but the impact of chronic natural disasters brings unique challenges.

The 2020 summer bushfires caused significant damage to life, homes, businesses, and natural bushland. The financial impacts of the bushfires were estimated to exceed $10 billion, however, the mental health impacts on communities were more difficult to quantify.

Evidence from previous fires in Australia indicates that a range of psychological factors result from the processing of trauma after bushfires, particularly for those directly impacted, such as first responders and communities living in fire damaged areas. Some of the more common mental health issues resulting from natural disaster induced trauma include anxiety, depression, substance abuse, and post-traumatic stress disorder. Others may also experience increased suicidal ideation, acute stress, or poor sleep quality.

The 'Beyond Bushfires Study' was led by the University of Melbourne over a period of six years, investigating the longitudinal impacts of the 2009 Victorian bushfires. It found that at five years post bushfires, 22 per cent of people in high impact areas reported symptoms of mental health disorders at approximately twice the rate evident in low impact communities. A decade after the 2009 bushfires, the study found that there was still clear evidence that exposure to the fires increased the risk of experiencing mental health issues. After ten years, the likelihood of people in the most impacted areas reporting mental illness was still more than twice as high as those from low/no impact communities.

It wasn't just the experience of the bushfires themselves that impacted people's mental health and wellbeing. Subsequent life changes undermined their ability to return to their everyday lives. Major stressors included loss of income and accommodation, and relationship breakdowns in the years following the disaster were associated with poorer mental health outcomes and were a predictor of persistent or emerging mental health issues over the next ten years. Additional pressure points identified by the study participants included the practical aspects of managing the post-disaster clean-up and rebuilding, mental health challenges, family related concerns, and the perception of injustice.

Research has found that social networks and community groups are significant and important influences on wider group resilience and recovery. Disaster studies found that support from community organisations and financial and practical support for rebuilding played positive roles in community recovery and the ability to cope with the aftermath of the event. These are precisely the services that Lifeline provides via their Community Recovery program - psychological support, practical support, reconnection to social and community groups and ties, as well as post-event follow ups and property visits.

In addition to those who reported symptoms of specific mental illnesses, many individuals had moderate to high levels of exposure who, although they did not quite meet the threshold of a diagnosable condition, still had trouble with adjustment in the post disaster period and were significantly more likely to develop PTSD or depression at a later point. Further, heightened emotions, including anger, are common in post disaster communities. However, that anger can manifest in different ways, be it immediate, intense and frequent, prolonged, or destructive.

Research shows that sudden explosive anger three-four years after a disaster can be a risk factor for mental health problems. Five years after the fire, approximately 10 per cent of respondents from high impact areas reported significant anger issues three times higher than moderate to low impacted areas. These anger problems frequently occurred simultaneously with other post-disaster mental health issues and were strongly associated with an increased risk of suicidal ideation and adverse aggressive behaviour.

The Royal Commission into National Natural Disaster Arrangements states that the mental health response to natural disasters requires effective planning and those of national scale or consequence need to be supported by national coordination mechanisms. The report also found that there was scope to improve the coordination and delivery of mental health services. The experience of the 2019-20 bushfires, floods, and pandemic highlights the need to clarify the governmental roles and responsibilities relating to the delivery of emergency health responses. The long lasting trauma of disaster events over the last decade underscores the need for greater planning for the delivery of proactive long term locally based and appropriate mental health services.

PART 3:

ANALYSIS AND DISCUSSION OF NATIONAL AND QLD LIFELINE DATA

Lifeline call data and Community Recovery data tells us that demand is increasing and that it will continue to do so. That said, there is high variability in daily service needs, increasing need for adequate staffing, hours, and funding to support training, deployment, staff development, and crisis line service.

This requires more secure and regularised funding to create a mental health system and infrastructure that proactively guards against the worst mental health outcomes in crises, rather than reacting to what will only be more frequent, intense, and longer community disasters. Intervention, crisis lines, and face-to-face services such as Community Recovery matters and should be funded accordingly.

To maintain high levels of service, there needs to be a stable, secure workforce. Instead of disaster recovery support being invoked after a crisis, it needs to be built into the mental health service infrastructure.

National and QLD call data and general service demand is consistently increasing

While the data shows that there is a randomness and a certain unpredictability to the daily usage of Lifeline's services and community recovery outreach, the overarching trend shows a clear upward demand and a consistent need over time.

From the 1st of January 2013 to the end of December 2022, 9,719,393 calls were offered, with 19 per cent of those calls being in QLD. From 2019 to 2021, national crisis calls increased by 37 per cent, and by 16 per cent in QLD. Between 2013 and 2022, there has been a 39.6 per cent increase in calls to Lifeline crisis services. Even more startling, the 62 busiest days on record all occurred within the last 18 months, with a maximum of 3,726 calls on the 1st of January 2022.

Nationally, 77.2 per cent of all calls answered were classified as 'crisis calls', in QLD, it was 78.5 per cent. Across Australia, 19.1 per cent of callers cited safety issues, QLD callers were at 18.9 per cent. Additionally, 5.1 per cent of callers required safe plans nationally, with QLD virtually matching that percentage at 5.2 per cent.

In terms of variability, from one day to the next, the total call numbers regularly vary by more than 500. And while the call volume trend over time is clearly increasing, the day to day variability is significant. Two per cent of days covered by the 2013-22 data have over 1000 more or fewer calls nationally than the previous day. This daily difference was over 800 on 17.2% of days. Thus, as service needs fluctuate daily and are hard to predict, it is vitally important to staff generously if peak service levels are to remain high.

Nationally, days with over 3000 calls are on the rise

As can be seen in Figure 1, prior to 2020, it was extremely rare to have over 3000 calls per day, occurring 0.7 per cent of the time, or, approximately once every 142.86 days. Over the course of three years, between 2016-2019, very few days received over 3000 calls. However, since the beginning of 2020, exceptionally busy days have become the norm, with days with 3000 or more calls occurring 49.0 per cent of the time (in the preceding 2.5 years), or, once every 2.04 days.

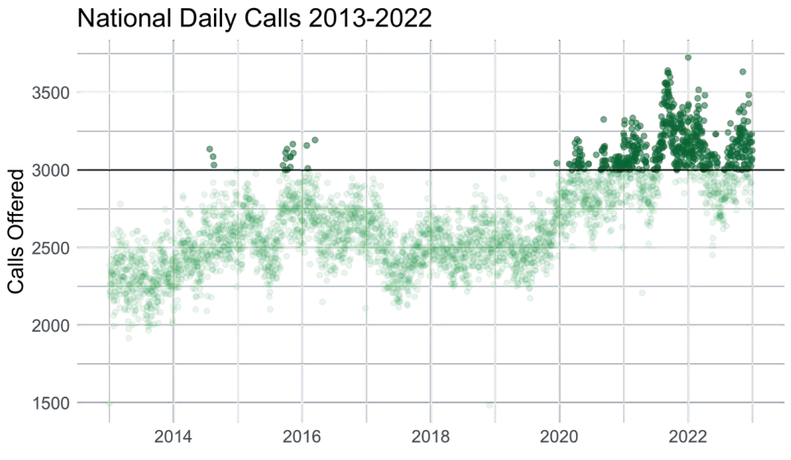

Figure 1: Number of calls offered from 2013-2022

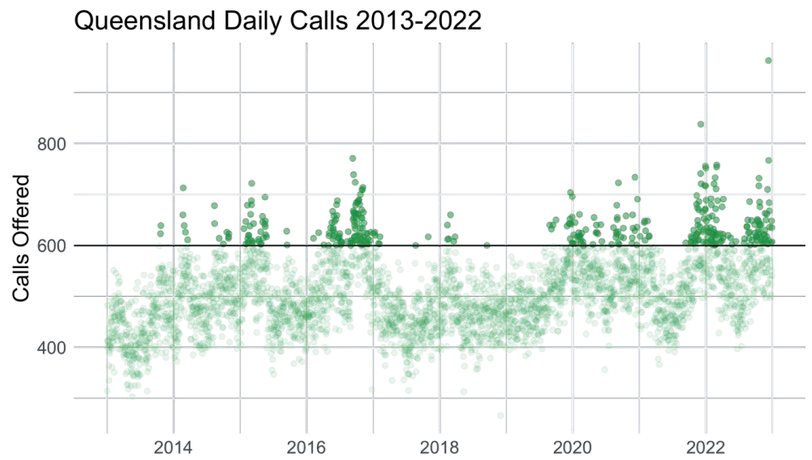

Figure 2: Number of calls offered in Queensland from 2013-2022

QLD follows the same general trend, where prior to 2020, it was rare to have over 600 calls in a day, only 1 in every 6.1 days. Yet, since 2020, those days have become more common, now occurring 35.6 per cent of the time, or once every 2.4 days (Figure 2). QLD's busiest day was recorded on the 11th of December 2022, with 963 calls coming through.

More resources mean better service

In terms of service needs, hours worked, and the resulting performance, we can see from Figure 3 that throughout 2020 and 2021, there was a clear increase in hours logged, where the median call answer rate increased to 90 per cent, whereas in 2018 and 2019, it was 81 per cent. Further, you can see that hours worked decreased by 4.4 per cent between 2022 and 2021, which corresponds with a more dramatic drop in the per centage of calls answered (falling by 7.1 per cent).

During the pandemic, extra resources were allocated for mental health support, which helped more people because it meant that more calls were answered. However, we also see that as those resources have tapered off, without the additional capacity that was previously in the system, the call answer rate has also declined. Yet the number of incoming calls has yet to return to pre-pandemic levels and are unlikely to do so (see Figure 1 and 2).

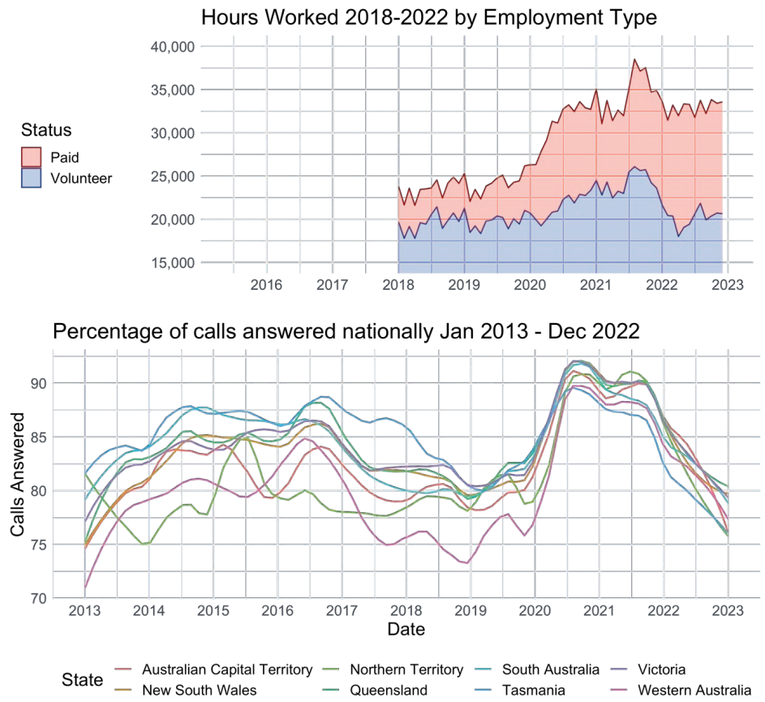

Figure 3: Comparison of call answer rates and number of hours worked (paid and volunteer)

If there had not been an increase in the number of employed hours that enabled the call answer rate (CAR) to rise, the calls answered may have remained at 81 per cent. If that were the case, the 9 per cent fewer calls would have been answered over the period between 2020-2021, representing 196,169 calls that could have been missed. In QLD, a 9 per cent difference in answer rate over 2020-21 represents 34,985 calls that may have been missed.

Dedicated disaster crisis lines are being utilised more heavily

When examining the call service usage data in more detail, we see that the 13HELP line which was set up in February 2020 for bushfire related trauma, and was later used for more general community disasters, the line is heavily utilised, particularly in QLD (see Figure 4).

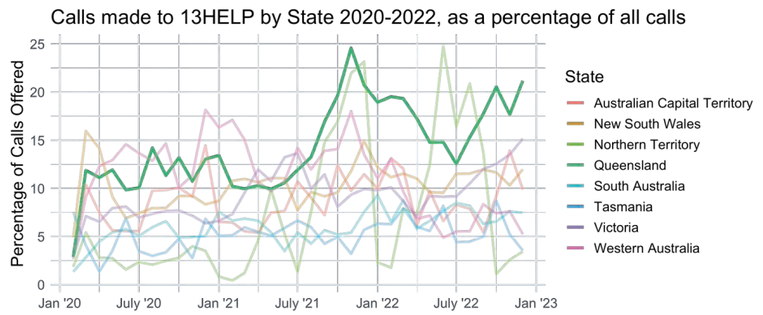

Figure 4: Calls made to 13HELP by state

Nationally, since its inception, a total of 332,452 calls (or 10.4 per cent of all calls) have been made to the specific bushfire helpline 13HELP. In QLD, 14.5 per cent of all calls since then have been made specifically to this number, which is the most of any state (as can be seen in Figure 5). In QLD, it's not a question of if a natural disaster will occur, but when.

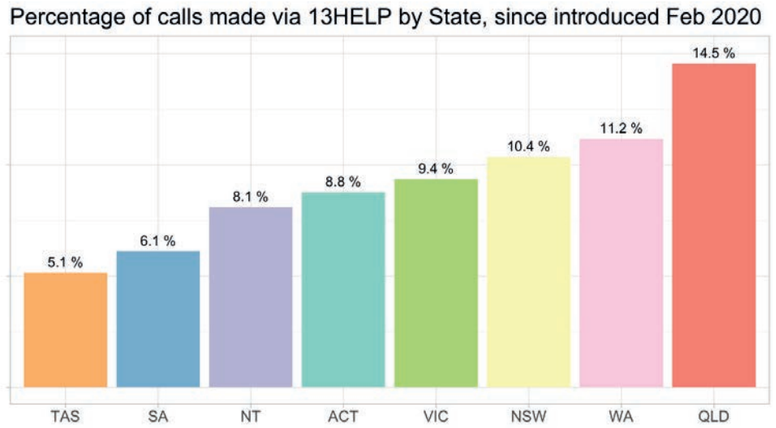

Figure 5: Percentage of calls made to 13HELP by state

Additionally, when, on a call, the Lifeline volunteer or employee records a particular topic as the reason for an individual's call, COVID-19 and community disasters are often cited as the specific trigger or stressor. Of the pre-2022 calls that recorded a topic, 85 per cent of those noted COVID. In addition to calls marked as being pandemic-related, in 2020, there was

a large spike in calls received, and it is reasonable to assume that much of that increase could be attributed to the arrival of the virus in Australia. Of the calls that cited flooding as the reason for the call, 58% of those came from QLD.

Further, we know that Lifeline QLD not only runs these crisis and disaster service lines, but their Community Recovery program also enables them to go out into impacted communities and provide on-the-ground, face-to-face support for those in dire need.

Lifeline Queensland's Community Recovery services are in increasingly high demand

Lifeline Queensland's Community Recovery service has been in increasingly high demand since it began over 25 years ago. Between mid 2020 and mid 2022, their crisis works team has been deployed approximately 86.8 per cent of the time. That said, this includes the administrative burden that goes along with each deployment, as there is much organisation and follow-up on either side of an event, with an estimated two weeks prior to an event and four weeks post.

The team is activated using an escalation model based on the four distinct stages of Alert, Lean Forward, Stand Up, and Stand down. Alert covers the pre-disaster period, when said disaster presents as a likely risk. Lean forward occurs when the threat of the impacts and consequences of a disaster event is imminent. The completion of these first two stages may not be possible if the community disaster occurs without warning. Next, the stand up phase covers the formation of the appropriate level of response, development of specific operational plans, deployment of staff, and the provision of community recovery services. Finally, the stand down stage is based on the completion of main activities and agreed recovery milestones. In this phase, longer term strategies to support the ongoing needs of the community will be considered. In some cases, depending on funding and approval, following the final phase, a case management team may be established to liaise with clients after the initial psychological first aid and practical support.

There is a range of crisis, support, and information services such as Lifeline, Beyond Blue, Kids Helpline, Head to Health, and ReachOut. That said, Lifeline is the only provider that deals primarily in providing PFA.

PFA consists of a systematic set of helping actions aimed at reducing initial post-trauma distress, supporting short and long term adaptive functioning, and minimising the risk of further harm. PFA is comprised of eight core components which are as follows:

1. Contact and engagement. Here, the goal is to initiate contact in a non-intrusive, compassionate, and helpful manner.

2. Safety and comfort. This component focuses on practical help and aims to enhance immediate and ongoing safety, as well as provide physical and emotional comfort.

3. Stabilisation (if necessary). Here, the individual administering the PFA needs to calm and orient emotionally-overwhelmed/ distraught survivors, grounding them if they seem out of touch with their surroundings.

4. Information gathering aims to identify immediate needs and concerns, gather general information, and tailor PFA interventions to the individual in question.

5. Practical assistance. The goal of this core principle is to offer practical help to the survivor in addressing the already identified immediate needs and concerns.

6. Connection with social supports is meant to reduce distress by helping structure opportunities for brief or ongoing contacts with primary support persons (family and significant others) or other sources of support, including friends, and community helping resources.

7. Coping information gathering is meant to provide the individual with information (including education about stress reactions and coping) that may help them deal with the event and its aftermath.

8. Linkage with collaborative services. This step links survivors with needed services and informs them about available services that may be needed in the future.

Throughout the engagement, Lifeline's CrisisWorks database is used to collect and store information. It is a relatively new platform where

information about natural disaster deployments, field closure reports, and the number and types of engagements are recorded. The types of events recorded range from natural hazards (for example, bushfires or floods) to community incidents (car accidents, domestic violence, homicides).

While PFA is the community recovery team's primary purpose, their remit in so far as providing community support in post-disaster communities is broad. For example, this may include case management and counselling as well. Since 2019, there have been almost 45,000 instances of practical support given, almost 19,000 instances of stabilisation and grounding, over 18,000 cases of reconnecting people to social support, almost 16,000 properties visited, and almost 68,000 referrals made.

Breaking those numbers down further, and only looking at some of the larger deployments in 2020-21, during the Springfield Lakes Hailstorm, there were 1,267 client contacts, 249 properties visited, 1,656 referrals made, 644 cases of reconnecting people to their social supports, 212 instances of stabilisation and grounding, 78 suicide assessments, and 996 instances of practical support given. During the Townsville floods, there were approximately 26,881-27,042 client contacts, 1,647 staff days recorded, 23, 916 referrals made, 694.5 hours of outreach worked, and approximately 5.996.5 hours worked in crisis hubs. Over the course of the Eastern Queensland fires, there were 3, 585 instances of PFA, 1,751 referrals, and 747 properties visited. The Southern Queensland fires elicited 3,007 cases of PFA, 1,984 referrals, and a total of 341 visited properties.

Behind the scenes of these deployments, there is the development of the CrisisWorks database, with the team working to improve its functionality, make the user experience easier, and ensure more accurate data and reporting. There are the follow-up client welfare and anniversary checks, the running and management of community engagement programs (such as Get Ready QLD and the Community Recovery Forum), the delivery of post event crisis supporter surveys, specialist debriefing and supervision sessions, the writing of closure reports, and these are just a few examples of what is required on either side of community recovery deployments.

In 2020, there were over nine events, in over seven locations, where 46 workers of the Community Recovery team were mobilised by either the Department of Communities, local councils, or relevant community organisations. In

2021, there were over 12 events, in over 12 locations, with over 53 workers deployed. That said, these numbers also include community incidents (which include homicides and domestic violence occurrences), as well as community disaster recovery events.

During the North Queensland monsoonal trough of 2019, there were more than 160 crisis supporters and team leaders engaged to support impacted communities, $90,000 worth of food vouchers distributed to those in need (provided by GIVIT), and over 620,000 km travelled to get to communities in need. Additionally, there were over 32,000 PFA client contacts, over 27,000 referrals to support services, over 20,000 properties visited, and over 2,500 suicide assessments. The Crisis Recovery team also accompanied the Queensland Reconstruction Authority, QLD Fire and Emergency Services, and the Department of Communities for over 3,400 post-event damage assessments.

To fund these deployments, the government engages Lifeline Queensland through SOA orders. These SOAs are used for the supply of extraordinary human and social Disaster Relief and Recovery Services in communities impacted by disaster events.

The SOA orders also specify that all expenditures must be event/crisis related and cannot be expended on pre-existing unmet needs. This reinforces a reactive rather than proactive model of community recovery funding, precluding the development of a more stable and regularised funding model that provides for the ongoing administrative burden that is required to support emergency disaster recovery services and teams. Additionally, while SOAs encompass personal support services and community support services, they do not cover the administrative work and general work input that covers organising deployment and the wind-up after the event. The work that is required on either side of disaster deployments accounts for a significant amount of time and effort by the Lifeline Community Recovery Team.

Staffing is impacted by numerous floods, pandemics, and ad hoc funding

Given the predictable unpredictability of natural disasters, there has been a significant loss of volunteers, both paid and unpaid, for the Community Recovery program. COVID, bushfires, hailstorms, and floods (as well as the vaccine mandate) have resulted in the number of logged hours in QLD decreasing, after a spike in 2021, most likely a result of an infusion of COVID-related funds. What this indicates is that the model needs to have longer term employment and funding resilience built into the system.

The consequences of the surge capacity burden highlight the insufficient structure and funding modelling for the Community Recovery teams. In this case, surge capacity is understood as being the ability to expand capacity rapidly and obtain adequate staff, supplies, and equipment and for structures and systems to provide sufficient care to meet the immediate needs of an influx of needs following a large scale incident or disaster.

As being part of the Community Recovery team offers paid work, volunteers often want to transition over to disaster recovery and crisis work. Further, given that the Community Recovery team are operating consistently, not just in terms of the number of deployments but in the administrative and

organisational work that each deployment requires on their side of the fieldwork, the operating model and framework would benefit more from a permanent funding model rather than ‘crisis mode’ funding.

While Community Recovery has been operating for over a decade, the operation model and data collection frameworks are not ideal. The CrisisWorks data highlights the gaps in the ability to capture ‘hours worked’, as much of the work that gets done isn’t registered. Before and after deployments, team members are on call 24 hours a day, 7 days a week, organising and wrapping up deployments and following up with those in need. However, to address these issues, there needs to be adequate time and funding set aside for system and infrastructural upgrades and developments.

Given the increasing occurrence and intensity of natural disasters, programs such as this need to be sufficiently funded on a standardised and ongoing basis to serve the community with the necessary capacity. This includes staff training and leadership development which, as it stands with the reactive funding model, is not possible. As ad hoc funding mechanisms do not allow for employee development or planned and thoughtful system upgrades, there needs to be a more sophisticated disaster response funding mechanism that facilitates a consistent funding stream to enable workforce planning and growth.

RECOMMENDATIONS

RECOMMENDATION 1

There should be a more regularised funding program for non-governmental mental health service organisations, such as Lifeline. This would help move from a reactive crisis funding model and infrastructure, to a proactive one.

This would ensure that funding streams wouldn't come in bursts, as crisis events happen, or when particular interest groups manage to attract public attention. Thus, adequately funding new service streams and weaving together comprehensive service packages to meet the needs of those who are struggling with mental health (both from disaster recovery and mental illness) would enable the mental health system to build long term resilience and service the changing needs of Australians.

RECOMMENDATION 2

Formalise the integration of Lifeline into the national and state mental health landscape by establishing interagency referral agreements between government bodies and other mental health service providers.

This would ensure that people calling through and attempting to navigate the mental health and crisis line system would be directed to the appropriate agency, making it easier for the missing middle to access the services they need, when they need them.

RECOMMENDATION 3

Reassess and define clear roles and responsibilities between various funding bodies and their service delivery arms.

THE McKell Institute

REFERENCES

1. World Health Organization. (2021). Comprehensive Mental Health Action Plan 2013-2030. *WHO*. Accessed online: https://apps.who.int/iris/bitstream/handle/10665/345301/9789240031029-eng.pdf
2. World Health Organization. (2021). Comprehensive Mental Health Action Plan 2013-2030. *WHO*. Accessed online: https://apps.who.int/iris/bitstream/handle/10665/345301/9789240031029-eng.pdf
3. Lifeline. (n.d.). Who we are. *Lifeline*. Accessed online: https://www.lifeline.org.au/about/who-we-are/
4. Lifeline. (n.d.) About Us. Who we are. *Lifeline*. Accessed online: https://www.lifeline.org.au/about/who-we-are/
5. Swerissen, H &. Duckett, S. (2020). A Primary Health Network redesign to address the 'missing middle' in health. *Croakey Health Media*. Accessed online: https://www.croakey.org/a-phn-redesign-to-address-the-missing-middle-in-mental-health/#:~:text=The%20missing%20
6. National Mental Health Commission. (2019). Monitoring mental health and suicide prevention reform. National report 2019. *National Mental Health Commission*. Accessed online: https://apo.org.au/sites/default/files/resource-files/2019-09/apo-nid260121.pdf
7. National Mental Health Commission. (2019). Monitoring mental health and suicide prevention reform. National report 2019. *National Mental Health Commission*. Accessed online: https://apo.org.au/sites/default/files/resource-files/2019-09/apo-nid260121.pdf
8. National Mental Health Commission. (2019). Monitoring mental health and suicide prevention reform. National report 2019. *National Mental Health Commission*. Accessed online: https://apo.org.au/sites/default/files/resource-files/2019-09/apo-nid260121.pdf
9. National Mental Health Commission. (2019). Monitoring mental health and suicide prevention reform. National report 2019. *National Mental Health Commission*. Accessed online: https://apo.org.au/sites/default/files/resource-files/2019-09/apo-nid260121.pdf
10. National Mental Health Commission. (2019). Monitoring mental health and suicide prevention reform. National report 2019. *National Mental Health Commission*. Accessed online: https://apo.org.au/sites/default/files/resource-files/2019-09/apo-nid260121.pdf
11. Australian Bureau of Statistics. (2008). National Survey of Mental Health and Wellbeing: Summary of Results. Accessed online: https://www.abs.gov.au/statistics/health/mental-health/national-study-mental-health-and-wellbeing/2007
12. Slade, T., Johnston, A., Teesson, M., Whiteford, H., Burgess, P., Pirkis, J., & Saw, S. (2009). The mental health of Australians 2: report on the 2007 National Survey of Mental Health and Wellbeing.
13. Australian Institute of Health and Welfare. (2022). Mental Health Services in Australia. *AIHW*. Accessed online: https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-content/summary-of-mental-health-services-in-australia/overview-of-mental-health-services-in-australia
14. Australian Institute of Health and Welfare. (2022). Mental Health Services in Australia. *AIHW*. Accessed online: https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-content/summary-of-mental-health-services-in-australia/overview-of-mental-health-services-in-australia
15. Australian Bureau of Statistics. (2018). Mental Health. *ABS*. Accessed online: https://www.abs.gov.au/statistics/health/mental-health/mental-health/2017-18
16. Australian Bureau of Statistics. (2018). Mental Health. *ABS*. Accessed online: https://www.abs.gov.au/statistics/health/mental-health/mental-health/2017-18
17. Australian Institute of Health and Welfare. (2022). Mental Health Services in Australia. *AIHW*. Accessed online: https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-content/summary-of-mental-health-services-in-australia/overview-of-mental-health-services-in-australia; Productivity Commission. (2020). Mental Health. Productivity Commission Inquiry Report. Vol. 1. *Productivity Commission*. Accessed online: https://www.pc.gov.au/inquiries/completed/mental-health/report/mental-health.pdf
18. Productivity Commission. (2020). Mental Health. Productivity Commission Inquiry Report. Vol. 1. *Productivity Commission*. Accessed online: https://www.pc.gov.au/inquiries/completed/mental-health/report/mental-health.pdf
19. Australian Institute of Health and Welfare. (2022). Mental Health Services in Australia. AIHW. Accessed online: https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-content/summary-of-mental-health-services-in-australia/overview-of-mental-health-services-in-australia; Royal Commission into Victoria's Mental Health System. (2021). Final Report. *Victorian Government Printer*. Accessed online: https://finalreport.rcvmhs.vic.gov.au/download-report/
20. Australian Institute of Health and Welfare. (2022). Mental Health Services in Australia. *AIHW*. Accessed online: https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-content/summary-of-mental-health-services-in-australia/overview-of-mental-health-services-in-australia; Royal Commission into Victoria's Mental Health System. (2021). Final Report. *Victorian Government printer*. Accessed online: https://finalreport.rcvmhs.vic.gov.au/download-report/
21. Royal Commission into Victoria's Mental Health System. (2021). Final Report. *Victorian Government printer*. Accessed online: https://finalreport.rcvmhs.vic.gov.au/download-report/
22. Royal Commission into Victoria's Mental Health System. (2021). Final Report. *Victorian Government printer*. Accessed online: https://finalreport.rcvmhs.vic.gov.au/download-report/
23. Anglicare Southern Queensland. (2022). Inquiry into the opportunities to improve mental health outcomes for Queenslanders' submission. Mental Health Select Committee. *Queensland Mental Health Commission*. Accessed online: https://documents.parliament.qld.gov.au/com/MHSC-1B43/IQ-5DEF/submissions/00000041.pdf
24. Australian Institute of Health and Welfare. (2022). Mental Health Services in Australia. *AIHW*. Accessed online: https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-content/summary-of-mental-health-services-in-australia/overview-of-mental-health-services-in-australia
25. Department of Health and Aged Care. (2022). Budget 2022-23: Prioritising mental health, preventative health and sport. Australian Government. Accessed online: https://www.health.gov.au/resources/collections/budget-2022-23-prioritising-mental-health-preventive-health-and-sport
26. Mental Health Select Committee. (2022). Inquiry into the opportunities to improve mental health outcomes for Queenslanders. *Parliamentary Committees*. Accessed online: https://documents.parliament.qld.gov.au/tp/2022/5722T743-64F1.pdf
27. Queensland Government. (2016). Queensland Health Aboriginal and Torres Strait Islander Mental Health Strategy 2016-2021. *Brisbane Queensland Health*. Accessed online: https://www.health.qld.gov.au/__data/assets/pdf_file/0030/460893/qhatsi-mental-health-strategy.pdf
28. Anglicare Southern Queensland. (2022). Inquiry into the opportunities to improve mental health outcomes for Queenslanders' submission. Mental Health Select Committee. *Queensland Mental Health Commission*. Accessed online: https://documents.parliament.qld.gov.au/com/MHSC-1B43/IQ-5DEF/submissions/00000041.pdf
29. Anglicare Southern Queensland. (2022). Inquiry into the opportunities to improve mental health outcomes for Queenslanders' submission. Mental Health Select Committee. *Queensland Mental Health Commission*. Accessed online: https://documents.parliament.qld.gov.au/com/MHSC-1B43/IQ-5DEF/submissions/00000041.pdf
30. Diminic, S., Hielscher, E., Lee, Y. Y., Harris, M., Schess, J., Kealton, J., & Whiteford, H. (2017). The economic value of informal mental health caring in Australia. Accessed online: http://helpingminds.org.au/wp-content/uploads/2017/03/Mind_Value-of-Informal-MH-Caring_Full-Report_v7.pdf
31. Queensland Health. (2022). Submission – Inquiry into the opportunities to improve mental health outcomes for Queenslanders. *Queensland Mental Health Commission*. Accessed online: https://documents.parliament.qld.gov.au/com/MHSC-1B43/IQ-5DEF/submissions/00000150.pdf
32. *Queensland Mental Health Commission*. (2022) Inquiry into the opportunities to improve mental health outcomes for Queenslanders' submission. Mental Health Select

Committee. *Queensland Mental Health Commission*. Accessed online: https://documents.parliament.qld.gov.au/com/MHSC-1B43/IQ-5DEF/submissions/00000151.pdf

33. *Queensland Mental Health Commission*. (2022) Inquiry into the opportunities to improve mental health outcomes for Queenslanders' submission. Mental Health Select Committee. *Queensland Mental Health Commission*. Accessed online: https://documents.parliament.qld.gov.au/com/MHSC-1B43/IQ-5DEF/submissions/00000151.pdf
34. Stephen, R. K., Stephen, A., & Tarun, B. (2021). Is there a missing-middle in Australian mental health care?. *Australasian Psychiatry: Bulletin of Royal Australian and New Zealand College of Psychiatrists*, 10398562211057069-10398562211057069. Accessed online: https://journals.sagepub.com/doi/pdf/10.1177/10398562211057069
35. Stephen, R. K., Stephen, A., & Tarun, B. (2021). Is there a missing-middle in Australian mental health care?. *Australasian Psychiatry: Bulletin of Royal Australian and New Zealand College of Psychiatrists*, 10398562211057069-10398562211057069. Accessed online: https://journals.sagepub.com/doi/pdf/10.1177/10398562211057069
36. Petrie, K., Baldwin, P., Crawford, J., & Harvey, S. B. (2021). The voice of mental health practice in Australia: a mixed-method cross-sectional study of gaps and areas of need. *Australian and New Zealand Journal of Public Health, 45*(4), 318-324. Accessed online: https://onlinelibrary.wiley.com/doi/pdfdirect/10.1111/1753-6405.13078
37. Mental Health Select Committee. (2022). Inquiry into the opportunities to improve mental health outcomes for Queenslanders. *Parliamentary Committees*. Accessed online: https://documents.parliament.qld.gov.au/tp/2022/5722T743-64F1.pdf
38. AIHW. (2022). Deaths in Australia. *AIHW*. Accessed online: https://www.*AIHW*.gov.au/reports/life-expectancy-death/deaths-in-australia/contents/leading-causes-of-death
39. Cerel, J., Brown, M. M., Maple, M., Singleton, M., Van de Venne, J., Moore, M., & Flaherty, C. (2019). How many people are exposed to suicide? Not six. *Suicide and Life- Threatening Behavior, 49*(2), 529-534. Accessed online: https://losscs.org/wp-content/uploads/2018/05/Cerel_et_al-2018-Suicide_and_Life-Threatening_Behavior.pdf
40. Cerel, J., Brown, M. M., Maple, M., Singleton, M., Van de Venne, J., Moore, M., & Flaherty, C. (2019). How many people are exposed to suicide? Not six. *Suicide and Life- Threatening Behavior, 49*(2), 529-534. Accessed online: https://losscs.org/wp-content/uploads/2018/05/Cerel_et_al-2018-Suicide_and_Life-Threatening_Behavior.pdf
41. Lifeline. (2021). Annual Report. *Lifeline*. Accessed online: https://www.lifeline.org.au/media/vwop50aj/lifeline-annual-report-2021-v2.pdf
42. Lifeline. (2021). Australians reaching out for help in record numbers – media release. *Lifeline*. Accessed online:
43. Lifeline. (n.d.). Data and Statistics. *Lifeline*. Accessed online: https://www.lifeline.org.au/resources/data-and-statistics/
44. Lifeline. (2021). Annual Report. *Lifeline*. Accessed online: https://www.lifeline.org.au/media/vwop50aj/lifeline-annual-report-2021-v2.pdf
45. Ma, J. S., Batterham, P. J., Kõlves, K., Woodward, A., Bradford, S., Klein, B., ... & Rickwood, D. J. (2021). Community expectations and anticipated outcomes for crisis support services—Lifeline Australia. *Health & Social Care in the Community*.
46. Ma, J. S., Batterham, P. J., Kõlves, K., Woodward, A., Bradford, S., Klein, B., ... & Rickwood, D. J. (2021). Community expectations and anticipated outcomes for crisis support services—Lifeline Australia. *Health & Social Care in the Community*.
47. Ma, J. S., Batterham, P. J., Kõlves, K., Woodward, A., Bradford, S., Klein, B., ... & Rickwood, D. J. (2021). Community expectations and anticipated outcomes for crisis support services—Lifeline Australia. *Health & Social Care in the Community*.
48. Lifeline QLD. (n.d.). Disaster Relief and community recovery. *Lifeline QLD*. Accessed online: https://www.lifelineqld.org.au/get-help/disaster-relief-and-community-recovery#:~:text=At%20the%20request%20of%20authorities,%2C%20cyclones%2C%20pandemics%20and%20tragedy.
49. UnitingCare. (2021). Community Recovery – In Field Practice Manual. *UnitingCare*.
50. The Hon Greg Hunt MP. (2022). New agreement to deliver more mental health and suicide prevention services for Queensland. *Department of Health and Aged Care*. Accessed online: https://www.health.gov.au/ministers/the-hon-greg-hunt-mp/media/new-agreement-to-deliver-more-mental-health-and-suicide-prevention-services-for-queensland
51. Kumar, A., & Nayar, K. R. (2021). COVID 19 and its mental health consequences. *Journal of Mental Health, 30*(1), 1-2. Accessed online: https://www.tandfonline.com/doi/pdf/10.1080/09638237.2020.1757052
52. World Health Organisation. (2022). European framework for action on mental health 2021-2025. *WHO*. Accessed online: https://www.who.int/europe/publications/i/item/9789289057813
53. World Health Organisation. (2022). European framework for action on mental health 2021-2025. *WHO*. Accessed online: https://www.who.int/europe/publications/i/item/9789289057813
54. National Mental Health Commission. (2021). Monitoring mental health and suicide prevention reform. National report 2021. *National Mental Health Commission*. Accessed online: https://www.mentalhealthcommission.gov.au/getmedia/095abc13-4f0a-4244-a648-f2eb9e18f938/National-Report-2021.pdf
55. National Mental Health Commission. (2021). Monitoring mental health and suicide prevention reform. National report 2021. *National Mental Health Commission*. Accessed online: https://www.mentalhealthcommission.gov.au/getmedia/095abc13-4f0a-4244-a648-f2eb9e18f938/National-Report-2021.pdf
56. Zhang, W. R., Wang, K., Yin, L., Zhao, W. F., Xue, Q., Peng, M., ... & Wang, H. X. (2020). Mental health and psychosocial problems of medical health workers during the COVID-19 epidemic in China. *Psychotherapy and psychosomatics, 89*(4), 242-250. Accessed online: https://www.karger.com/Article/FullText/507639
57. Wu, P., Liu, X., Fang, Y., Fan, B., Fuller, C. J., Guan, Z., ... & Litvak, I. J. (2008). Alcohol abuse/dependence symptoms among hospital employees exposed to a SARS outbreak. *Alcohol & Alcoholism, 43*(6), 706-712. Accessed online: https://academic.oup.com/alcalc/article/43/6/706/250093
58. Galea, S., Merchant, R. M., & Lurie, N. (2020). The mental health consequences of COVID-19 and physical distancing: the need for prevention and early intervention. *JAMA internal medicine, 180*(6), 817-818. Accessed online: https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2764404
59. Czeisler, M. É., Wiley, J. F., Facer-Childs, E. R., Robbins, R., Weaver, M. D., Barger, L. K., ... & Rajaratnam, S. M. (2021). Mental health, substance use, and suicidal ideation during a prolonged COVID-19-related lockdown in a region with low SARS-CoV-2 prevalence. *Journal of psychiatric research, 140*, 533-544. Accessed online: https://www.sciencedirect.com/science/article/pii/S0022395621003563
60. Fisher, J. R., Tran, T. D., Hammarberg, K., Sastry, J., Nguyen, H., Rowe, H., ... & Kirkman, M. (2020). Mental health of people in Australia in the first month of COVID-19 restrictions: a national survey. *Medical journal of Australia, 213*(10), 458-464. Accessed online: https://onlinelibrary.wiley.com/doi/pdfdirect/10.5694/mja2.50831
61. Fisher, J., Tran, T., Hammarberg, K., Nguyen, H., Stocker, R., Rowe, H., ... & Kirkman, M. (2021). Quantifying the mental health burden of the most severe covid-19 restrictions: a natural experiment. *Journal of Affective Disorders, 293*, 406-414. Accessed online: https://www.sciencedirect.com/science/article/pii/S0165032721006467?casa_token=Mbam_0RqeSAAAAAA:T3sqXv3xM3ReAF54E96VBo4LnQBlcnXRJPy08JHpXIbSFozmthnJW-11xYsfNoyIFhzDBPtKvj8o
62. Fisher, J., Tran, T., Hammarberg, K., Nguyen, H., Stocker, R., Rowe, H., ... & Kirkman, M. (2021). Quantifying the mental health burden of the most severe covid-19 restrictions: a natural experiment. *Journal of Affective Disorders, 293*, 406-414. Accessed online: https://www.sciencedirect.com/science/article/pii/S0165032721006467?casa_token=Mbam_0RqeSAAAAAA:T3sqXv3xM3ReAF54E96VBo4LnQBlcnXRJPy08JHpXIbSFozmthnJW-11xYsfNoyIFhzDBPtKvj8o
63. EM-DAT. (2022). Disasters. Year in Review 2021. *Centre for Research on the Epidemiology of Disasters*. Accessed online: https://cred.be/sites/default/files/CredCrunch66.pdf
64. EM-DAT. (2022). Disasters. Year in Review 2021. *Centre for Research on the Epidemiology of Disasters*. Accessed online: https://cred.be/sites/default/files/CredCrunch66.pdf
65. Watts, N., Amann, M., Ayeb-Karlsson, S., Belesova, K., Bouley, T., Boykoff, M., ... & Costello, A. (2018). The Lancet Countdown on health and climate change: from 25 years of inaction to a global transformation for public health. *The Lancet, 391*(10120), 581-630.

66. Padhy, S. K., Sarkar, S., Panigrahi, M., & Paul, S. (2015). Mental health effects of climate change. *Indian journal of occupational and environmental medicine*, 19(1), 3; Majeed, H., & Lee, J. (2017). The impact of climate change on youth depression and mental health. *The Lancet Planetary Health, 1*(3), e94-e95.
67. Berry, H. L., Waite, T. D., Dear, K. B., Capon, A. G., & Murray, V. (2018). The case for systems thinking about climate change and mental health. *Nature climate change, 8*(4), 282-290.
68. Reifels, L., Mills, K., Dückers, M. L. A., & O'donnell, M. L. (2019). Psychiatric epidemiology and disaster exposure in Australia. *Epidemiology and psychiatric sciences, 28*(3), 310-320. Accessed online: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7032773/pdf/S2045796017000531a.pdf
69. Reifels, L., Mills, K., Dückers, M. L. A., & O'donnell, M. L. (2019). Psychiatric epidemiology and disaster exposure in Australia. *Epidemiology and psychiatric sciences, 28*(3), 310-320. Accessed online: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7032773/pdf/S2045796017000531a.pdf
70. Baryshnikova, N. V., & Pham, N. T. (2019). Natural disasters and mental health: *A quantile approach. Economics letters, 180*, 62-66. Accessed online: https://pdf.sciencedirectassets.com/271682/1-s2.0-S0165176519X00051/1-s2.0-S0165176519301387/main.pdf
71. Cummings, W. B. (2021). The Economic Impact of National Disaster Relief and Recovery Funding for Local Government Infrastructure in Tropical North Queensland. In *Economic Effects of Natural Disasters* (pp. 1-9). Academic Press.
72. Queensland Government. (2019). Get Ready Queensland. *The State of Queensland (Queensland Reconstruction Authority)*. Accessed online: https://www.getready.qld.gov.au/understand-your-risk/types-disasters
73. Kõlves, K., Kõlves, K. E., & De Leo, D. (2013). Natural disasters and suicidal behaviours: a systematic literature review. *Journal of affective disorders, 146*(1), 1-14. Accessed online: https://pdf.sciencedirectassets.com/271035/1-s2.0-S0165032713X00059/1-s2.0-S016503271200568X/main.pdf
74. Carroll, N., Frijters, P., & Shields, M. A. (2009). Quantifying the costs of drought: new evidence from life satisfaction data. *Journal of Population Economics, 22*(2), 445-461. Accessed online: https://link.springer.com/article/10.1007/s00148-007-0174-3
75. Luechinger, Simon, and Paul A. Raschky. "Valuing flood disasters using the life satisfaction approach." *Journal of Public Economics* 93.3-4 (2009): 620-633. Accessed online: https://www.sciencedirect.com/science/article/pii/S0047272708001539
76. Kõlves, K., Kõlves, K. E., & De Leo, D. (2013). Natural disasters and suicidal behaviours: a systematic literature review. *Journal of affective disorders, 146*(1), 1-14. Accessed online: https://www.sciencedirect.com/science/article/pii/S016503271200568X; Nebraska Strong (n.d.). Phases of Disaster. *Nebraska Strong Recovery Project*. Accessed online: https://region4bhs.org/Portals/0/Stages%20of%20Disaster%20NE%20Strong%20Flyer%202.pdf
77. Nebraska Strong (n.d.). Phases of Disaster. *Nebraska Strong Recovery Project*. Accessed online: https://region4bhs.org/Portals/0/Stages%20of%20Disaster%20NE%20Strong%20Flyer%202.pdf
78. World Health Organisation. (2016). Psychological First aid For All – Supporting People in the Aftermath of Crisis Events. *World Mental Health Day WHO*. Accessed online: https://www.europsy.net/app/uploads/2022/03/Psychological-first-aid-WHO-presentation.pdf
79. Reifels, L., Spittal, M. J., Dückers, M. L., Mills, K., & Pirkis, J. (2018). Suicidality risk and (repeat) disaster exposure: findings from a nationally representative population survey. *Psychiatry, 81*(2), 158-172. Accessed online: https://www.tandfonline.com/doi/pdf/10.1080/00332747.2017.1385049
80. National Mental Health Commission. (2020). Monitoring mental health and suicide prevention reform. National report 2020. *National Mental Health Commission*. Accessed online: https://www.mentalhealthcommission.gov.au/getmedia/6be640dd-5d7e-48ae-b18b-0ed64a9f2bef/National-Report-2020.pdf
81. Minister for Transport, Planning, and Ports. (2022). Media statement: Cruicial east-west rail line re-opened after emergency repairs. *Government of Western Australia*. Accessed online: https://www.mediastatements.wa.gov.au/Pages/McGowan/2022/02/Crucial-east-west-rail-line-re-opened-after-emergency-repairs.aspx
82. Deacon, B. (2022). Rain and flood records fall across New South Wales as temperatures in Queensland plummet. *ABC News*. Accessed online: https://www.abc.net.au/news/2022-07-08/weather-records-fall-across-eastern-australia/101192232
83. National Mental Health Commission. (2020). Monitoring mental health and suicide prevention reform. National report 2020. *National Mental Health Commission*. Accessed online: https://www.mentalhealthcommission.gov.au/getmedia/6be640dd-5d7e-48ae-b18b-0ed64a9f2bef/National-Report-2020.pdf
84. National Mental Health Commission. (2020). Monitoring mental health and suicide prevention reform. National report 2020. *National Mental Health Commission*. Accessed online: https://www.mentalhealthcommission.gov.au/getmedia/6be640dd-5d7e-48ae-b18b-0ed64a9f2bef/National-Report-2020.pdf
85. National Mental Health Commission. (2020). Monitoring mental health and suicide prevention reform. National report 2020. *National Mental Health Commission*. Accessed online: https://www.mentalhealthcommission.gov.au/getmedia/6be640dd-5d7e-48ae-b18b-0ed64a9f2bef/National-Report-2020.pdf
86. The University of Melbourne. (2019). The Beyond Bushfires Study. Why was it needed? *The University of Melbourne*. Accessed online: https://mspgh.unimelb.edu.au/__data/assets/pdf_file/0008/2976020/Beyond-bushfires-2019-update-Feb.pdf
87. The University of Melbourne. (2019). 10 years Beyond Bushfires Report. *The University of Melbourne*. Accessed online: https://mspgh.unimelb.edu.au/__data/assets/pdf_file/0009/3645090/BB-10-years-report_spread.pdf
88. The University of Melbourne. (2019). 10 years Beyond Bushfires Report. *The University of Melbourne*. Accessed online: https://mspgh.unimelb.edu.au/__data/assets/pdf_file/0009/3645090/BB-10-years-report_spread.pdf
89. The University of Melbourne. (2019). 10 years Beyond Bushfires Report. *The University of Melbourne*. Accessed online: https://mspgh.unimelb.edu.au/__data/assets/pdf_file/0009/3645090/BB-10-years-report_spread.pdf
90. The University of Melbourne. (2019). 10 years Beyond Bushfires Report. *The University of Melbourne*. Accessed online: https://mspgh.unimelb.edu.au/__data/assets/pdf_file/0009/3645090/BB-10-years-report_spread.pdf
91. The University of Melbourne. (2019). 10 years Beyond Bushfires Report. *The University of Melbourne*. Accessed online: https://mspgh.unimelb.edu.au/__data/assets/pdf_file/0009/3645090/BB-10-years-report_spread.pdf
92. The University of Melbourne. (2019). 10 years Beyond Bushfires Report. *The University of Melbourne*. Accessed online: https://mspgh.unimelb.edu.au/__data/assets/pdf_file/0009/3645090/BB-10-years-report_spread.pdf
93. The University of Melbourne. (2019). 10 years Beyond Bushfires Report. *The University of Melbourne*. Accessed online: https://mspgh.unimelb.edu.au/__data/assets/pdf_file/0009/3645090/BB-10-years-report_spread.pdf
94. The University of Melbourne. (2019). 10 years Beyond Bushfires Report. *The University of Melbourne*. Accessed online: https://mspgh.unimelb.edu.au/__data/assets/pdf_file/0009/3645090/BB-10-years-report_spread.pdf
95. Royal Commission into the National Natural Disaster Arrangements. (2020). The Royal Commission Report. *The Royal Commission into National Natural Disaster Arrangements*. Accessed online: https://naturaldisaster.royalcommission.gov.au/publications/html-report/chapter-15
96. Royal Commission into the National Natural Disaster Arrangements. (2020). *The Royal Commission Report. The Royal Commission into National Natural Disaster Arrangements*. Accessed online: https://naturaldisaster.royalcommission.gov.au/publications/html-report/chapter-15
97. Royal Commission into the National Natural Disaster Arrangements. (2020). The Royal Commission Report. *The Royal Commission into National Natural Disaster Arrangements*. Accessed online: https://naturaldisaster.royalcommission.gov.au/publications/html-report/chapter-15
98. UnitingCare. (2021). Community Recovery – In Field Practice Manual. *UnitingCare*.
99. Ruzek, J. I., Brymer, M. J., Jacobs, A. K., Layne, C. M., Vernberg, E. M., & Watson, P. J. (2007). *Psychological first aid. Journal of Mental Health Counseling, 29*(1), 17-49. Accessed online: https://www.researchgate.net/profile/Patricia-Watson-3/publication/277775039_Psychological_First_Aid/links/5a73d98ea6fdcc53fe148cd3/Psychological-First-Aid.pdf
100. Ruzek, J. I., Brymer, M. J., Jacobs, A. K.,

Layne, C. M., Vernberg, E. M., & Watson, P. J. (2007). Psychological first aid. *Journal of Mental Health Counseling, 29*(1), 17-49. Accessed online: https://www.lifeline.org.au/resources/news-and-media-releases/media-releases/https://www.researchgate.net/profile/Patricia-Watson-3/publication/277775039_Psychological_First_Aid/links/5a73d98ea6fdcc53fe148cd3/Psychological-First-Aid.pdf; UnitingCare. (2021). Community Recovery – In Field Practice Manual. *UnitingCare*.

101. Lifeline QLD. (2021). Community Recovery Recruitment Roadshow Presentation. *Lifeline & UnitingCare*.
102. Lifeline QLD. (2021). Service Leaders Conference Presentation. *Lifeline & UnitingCare*.
103. Lifeline QLD (2019). NQ Monsoonal Trough – Community Recovery Presentation. *Lifeline & UnitingCare*.
104. Lifeline QLD (2019). NQ Monsoonal Trough – Community Recovery Presentation. *Lifeline & UnitingCare*.
105. UnitingCare Queensland. (n.d.). Standing Offer Arrangement (SOA) Details. Disaster Relief and Recovery Support Services. *Department of Communities, Child Safety and Disability Services & UnitingCare*.

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