Queensland Health

Mental Health Sub-plan

A Sub-plan of the Queensland Health Disaster and Emergency Incident Plan

November 2018

Queensland Government

Mental Health Sub-plan 2018

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An electronic version of this document is available at
https://publications.qld.gov.au/dataset/queensland-health-disaster-management-plans

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Authorisation

The Queensland Health Mental Health Sub-plan is issued under the authority of the Director-General, Queensland Health and is a functional health plan that supports the *Queensland Health Disaster and Emergency Incident Plan.*

The Mental Health Sub-plan is to be read in conjunction with the *Queensland Health Disaster and Emergency Incident Plan* and *Queensland Health Incident Management System Guideline*.

The Executive Director, Mental Health Alcohol and Other Drugs Branch, on behalf of the Director-General, maintains the Mental Health Sub-plan for the Department of Health.

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Version control

This document is uncontrolled when printed.

This plan will be updated electronically and available on the Queensland Health website. The electronic copy is the master copy and, as such, is the only copy which is recognised as being current.

Version	Date		
0.1	November 2018		

1. Introduction

1.1 Purpose

The purpose of the Mental Health Sub-plan (the Sub-plan) is to provide direction for the mental health response to disasters and emergency incidents in Queensland.

1.2 Scope

The Sub-plan describes the working arrangements between the Department of Health and Hospital and Health Services (HHSs) to minimise adverse mental health consequences of a disaster or emergency incident by:

- operating within the broader disaster and emergency incident management response
- managing local mental health service responses with coordinated state-wide support, when required
- continuing to provide essential mental health services during an event
- deploying mental health staff capable of assisting in the response and recovery phases of a disaster or emergency incident
- supporting psychosocial and primary care providers with specialised mental health information and advice
- informing individuals and communities affected by events on recovery strategies
- providing evidence-based treatment of trauma-related mental health conditions in the recovery phase
- reviewing involvement in disaster or emergency incident activations and preparedness exercises.

1.3 Context

The *Disaster Management Act 2003* defines a disaster as “a serious disruption in a community, caused by the impact of an event that requires a significant coordinated response by the state and other entities to help the community recover from the disruption”. See glossary for definitions of emergency incident, “serious disruption” and “event”.

The psychological impact of disasters on communities can be widespread and enduring. They cause psychological distress amongst a large proportion of those directly affected; and to a lesser degree result in mental disorders for some of those affected, for which sustained intervention is required. About one third of people exposed to a major disaster experience a mental health disorder, of which around 20% are new disorders[1]. Post-traumatic Stress Disorders and Major Depressive Disorders

[1] North C. (2014) *Current Research and Recent Breakthroughs on the Mental Health Effects of Disasters* Current Psychiatry Reports 16:481 Published on-line 20 August 2014

are the most prevalent conditions and, while a significant proportion of these will be resolved within months, some can develop a chronic course and continue for years.

Emergency incidents, especially when they are unexpected traumatic events, involving personal threat, and which evoke extreme stress, fear or injury[2], also exact a substantial psychological toll on those directly affected. Even though they don't typically involve the widespread disruption experienced with disasters, the intensity of the experience may result in adverse mental health effects as high as or even higher than in some larger-scale disasters.

1.4 Principles

The Sub-plan adopts the following principles to guide the use of specialist mental health staff in post-disaster or emergency incident situations (see definitions in Glossary).

- Psychological recovery is enhanced by using a stepped model of psychosocial and mental health care.
- It begins with interventions applied universally to those who are psychologically affected through to services for those individuals who are struggling to recover, and then to specialised mental health services, where necessary.
- It involves a shift from high coverage, low intensity interventions to low coverage, high intensity interventions, the timing of which is determined by active monitoring of people's responses over time.

An elaboration of these principles, as they apply to the response, relief and recovery stages following a disaster or emergency incident, is presented in Appendix 2 and 3.

[2] This definition of an emergency event is a modified definition derived from terminology for emergencies and critical incidents produced by the Mental Health Coordinating Council (NSW).

1.5 Plan hierarchy

Figure 1 shows how the Sub-plan sits within the Queensland Health Disaster and Emergency Incidents Plan (QHDISPLAN) and broader disaster management plans.

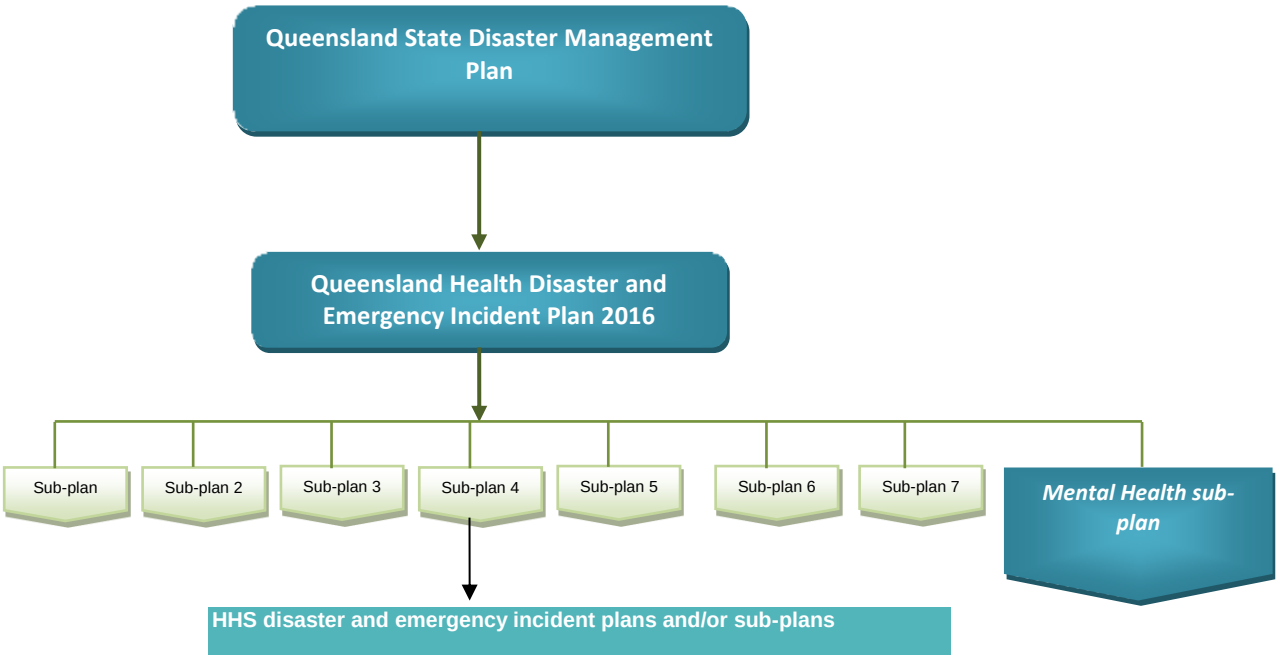

Figure 1 Hierarchy of disaster management plans

As illustrated in Figure 1, the Queensland *State Disaster Management Plan* is supported by state agency plans, including the QHDISPLAN. The QHDISPLAN is supported by agency hazard-specific sub-plans for example the *Queensland Health Heatwave Response Plan*; the *Queensland Health Mass Casualty Incident Plan* etc.

HHSs have individual disaster plans and sub-plans, and are responsible for managing the health response to disasters and emergency incidents at a local level.

The QHDISPLAN and its designated sub-plans address the function of disaster management where Queensland Health is the lead agency.

The QHDISPLAN and its designated sub-plans apply to the department and all HHSs.

The Sub-plan is a subordinate plan of QHDISPLAN. It describes the mechanisms to arrange mental health support for individuals and communities during and following these events.

The Sub-plan also forms part of a broader human social recovery response as defined in the *State Disaster Management Plan* and its sub-plan, the *Queensland Recovery Plan*. The Department of Communities, Disability Services and Seniors (DCDSS) is the lead agency for Human and Social Recovery in Queensland and it coordinates the State Human and Social Recovery Group (SHSRG) and District Human and Social Recovery Groups.

DCDSS contracts with non-government agencies to provide:

- psychosocial support
- identification of immediate, medium and long-term recovery needs
- referral
- community recovery
- Psychological First Aid and counselling support to individuals and communities.

This Sub-plan is developed with the recognition that coordination is required with DCDSS and that provision of psychosocial support and Psychological First Aid to communities immediately following a disaster or emergency incident is primarily the responsibility of organisations it funds for this purpose.

1.6 Review requirements

The Sub-plan will be reviewed at least every two years or:

- following structural or organisational changes impacting on Queensland Health operations;
- legislative changes affecting Queensland Health operations;
- changes to state or federal nomenclature or arrangements;
- or following activation or implementation of the sub-plan resulting in identified improvements.

2. Legislative and policy context

2.1 Legislation

The *Disaster Management Act 2003* provides the legislative basis for disaster management arrangements in Queensland. It makes provision for the establishment of disaster management groups for state, districts and local government areas and provides the legislative basis for the preparation of disaster management plans and guidelines including the *Queensland State Disaster Management Plan* and the QHDISPLAN.

2.2 Supporting documents

Relevant and related policies and directives which may apply during the phases of disaster and emergency incident management include:

- *Emergency Management Assurance Framework*
- *Health Service Directive QH-HSD-003: series – Disasters and emergency incidents.*
- *Queensland Counter-Terrorism Plan*
- *Queensland Health Disaster and Emergency Incident Policy (2018)*
- *Queensland Health Disaster and Emergency Incident Standard (2018)*
- *Queensland Health Disaster and Emergency Incident Plan (2016) and sub-plans*
- *Queensland Health Disaster and Emergency Incident Training Framework (2016)*
- *Queensland Health Incident Management System Guideline (2016)*

- *Queensland Health Operational Briefing and Debriefing Guideline (2016)*
- *Queensland State Disaster Management Plan (2018)*
- *Queensland Recovery Plan (2017).*

3. Incident management functions, structures and roles

The Queensland Health disaster and emergency incident management arrangements (including incident management functions, coordination structures and roles) are detailed in the QHDISPLAN and *the Queensland Health Incident Management System Guideline*.

3.1 Incident management coordination and operations structures

3.1.1 State structures

State Human Social Recovery Group

The SHSRG is the principal body for coordinating human social recovery functions during disasters and emergency incidents. It operates under the direction of the Queensland Disaster Management Committee.

See the QHDISPLAN (Section 4.2 Hierarchy of plans and legislation) for further information about disaster management plans and sub-plans.

3.1.2 State health structures

State Health Emergency Coordination Centre

The State Health Emergency Coordination Centre (SHECC) is the peak emergency coordination centre for state health response to a disaster, emergency incident, or public health incident of state significance.

The SHECC is activated by the State Health Coordinator (SHC), ordinarily the Chief Health Officer & Deputy Director-General Prevention Division (CHO & DDG) as delegate of the Director-General. If required, the SHC will also authorise activation of an incident management team to manage the necessary functions within the SHECC.

The incident management team operating from SHECC is scalable to the needs of the event (or incidents). Staffing and operation of SHECC may vary from small scale monitoring operations, through to fully resourced 24/7 operations.

The SHECC operates at the state level and works with HHS Health Emergency Operations Centres (HEOCs), Queensland Ambulance Service, State Incident Management Room (SIMR) and the State Disaster Coordination Centre (SDCC) as required.

For further information about SHECC see the QHDISPLAN (Section 6).

3.1.3 HHS structures

HHS Health Emergency Operation Centre

Each HHS will have a HEOC that can rapidly stand up to provide incident management support structures and functions for emergency incidents or disaster events that are expected to be prolonged, protracted and require additional resources above and beyond what an individual hospital or business unit (or potentially multiple hospitals) can provide.

See Table 5, Queensland Health activation levels of the QHDISPLAN, for a definition of Levels 1-3 (Emergency Incident and Disaster Events).

The HHS Chief Executive, or authorised delegate, is responsible for authorising the activation of the HEOC.

For further information about HEOCs, see Section 5 of the *Queensland Health Incident Management System Guideline.*

3.2 Roles and responsibilities

3.2.1 State mental health structures

The Executive Director, MHAODB (or delegate) acts as the ***State Mental Health Coordinator*** (SMH Coordinator) and clinical advisor to the State Health Coordinator and the SHECC.

The SMH Coordinator (and identified officers with-in MHAODB) and the SHECC, are responsible for:

- ensuring the adequacy of mental health service support in a disaster or emergency incident following an assessment of needs, in consultation with the HHS Health Incident Controller and HHS Executive Director), Mental Health, Alcohol and Other Drugs Services (or equivalent).
- ensuring coordination of arrangements of state-wide resources to support local efforts
- coordinating provision of public information on mental health implications of disasters and emergency incidents.

The ***SHECC Mental Health Liaison Officer*** (MHLO) is a specialist mental health team member whom acts as a point of contact between the SHECC, and mental health services both at state and HHS level.

This officer:

- coordinates requests for mental health assistance from HHS HEOCS or affected mental health services, actioned by the SHECC.
- may be required to provide specialist mental health advice to SHECC and HHS incident management teams, in consultation with the State Mental Health Coordinator (or delegate).

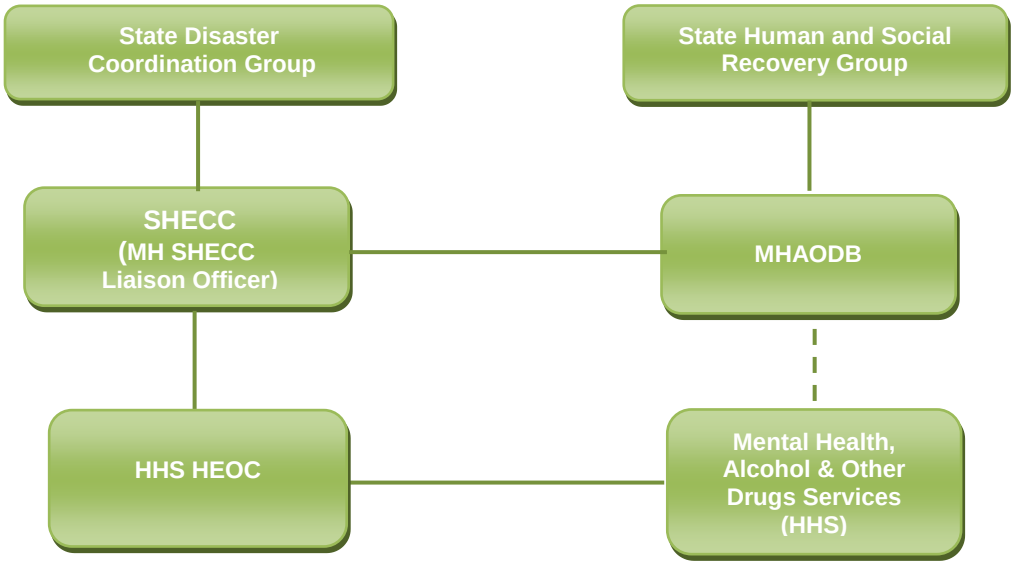

Figure 2 Disaster management reporting arrangements

The **Mental Health Alcohol and Other Drugs Branch** is responsible for:

- providing representation on the SHSRG for disaster-related mental health issues
- supporting a network of disaster mental health coordinators throughout the state
- maintaining a state-wide register of mental health clinicians prepared to assist in response and early recovery phases of disasters and emergency incidents throughout Queensland
- monitoring and analysing research on mental health disaster and emergency incident response and recovery measures
- communicating with HHS concerning training and local response readiness exercises
- reviewing state level mental health aspects of disasters and emergency incidents
- ensuring this plan is reviewed and updated based on research findings and lessons from reviews of disaster responses.

3.2.2 HHS mental health structures

During and/or in the aftermath of a disaster or emergency incident the **Executive Director (or equivalent)** of the relevant HHS Mental Health and Alcohol and Other Drugs Services (or a delegate) coordinates the mental health service response and oversees the operation of multidisciplinary teams for this purpose. During an event or incident this officer operates under the direction of the local Health Incident Controller, if appointed.

A network of **HHS Mental Health Disaster Coordinators** (MHDC) is responsible for:

- maintaining local registers of mental health staff prepared to assist in response and early recovery phases of disasters and emergency incidents throughout Queensland
- ensuring that staff on these registers are prepared for the work they will undertake through orientation and training initiatives

- ensuring necessary resources are available future events.

During an event the MHDC in an affected HHS:

- briefs incoming mental health clinicians deployed to disaster-affected areas
- ensures that local Community Recovery Hubs are informed about the deployment of mental health staff and the role they will perform
- communicates with the HHS HEOC, SHECC and SHECC MHLO about matters relating to the deployments
- participates in post-event or emergency incident debriefing to assist in the emotional and psychological recovery of health staff involved in traumatic events.

4. Activation of sub-plan

4.1 Authority to activate

At a state level, sub-plans of the QHDISPLAN cannot be activated without the initial activation of QHDISPLAN. HHS sub-plans can be activated without the activation of their disaster plan, at the discretion of the Health Incident Controller.

As a sub-plan of the QHDISPLAN, the CHO & DDG has the authority to activate the Mental Health Sub-plan. The ED MHAODB may recommend to the CHO & DDG that the Sub-plan be activated.

The principles of the Sub-plan are both scalable and interoperable and may be followed in circumstances in which a HEOC is not activated and the QHDISPLAN is not activated (see Section 5.1 and Appendix 1).

4.2 Rationale for activation

The Sub-plan may be activated in the case of a disaster or emergency incident in which a mental health response is required.

Requests for activation of the Sub-plan may be received from many sources including but not limited to Ministers, HHSs, DCDSS, or Local Disaster Management Groups (through the HHSs).

5. Communication arrangements

5.1 Overview

On activation of the Sub-plan, and wider disaster and emergency incident management arrangements, clear command and coordination lines need to be established to support the response.

These arrangements are scalable and interoperable and are consistent with the incident management reporting structures described in the QHDISPLAN (Section 5.8).

If a HHS HEOC activates to Lean Forward or Stand Up, the HHS Executive Director, Mental Health, Alcohol and Other Drugs Services (or equivalent, or delegate), through the HEOC, liaises with the SHECC and SHECC MHLO.

A request for assistance may be made by the HEOC for additional mental health assistance when the demands of the situation are beyond the capacity of local resources. For more information on deployments, see Section 6.2.

If a HHS HEOC has not activated, the Executive Director Mental Health, Alcohol and Other Drugs Services (or equivalent, or delegate) will contact the MHAODB and will continue communication and situational awareness with the MHAODB.

In instances where the SHECC has activated but a HHS HEOC has not, the Executive Director), Mental Health, Alcohol and Other Drugs Services (or equivalent, or delegate) will provide situational awareness to the SHECC MHLO.

The SHECC (or the MHAODB, when the SHECC has not activated) will advise if the DCDSS is deploying Psychological First Aid providers and a Community Recovery Team.

Refer to Appendix 1 for a flowchart outlining the processes for activation and requests for assistance during disaster events and emergency incidents.

5.2 Situation reports

Situation reports (SITREPs) and incident action plans are used to manage information and ensure actions meet the overall incident/event management objectives. A SITREP provides clear, concise, consistent, regular updates on the incident and the incident response to inform decision makers.

HHS Mental Health staff may be required to provide information into HEOC SITREPS using the following formats.

Consistent with the QHDISPLAN, the initial SITREP can be provided as an ETHANE:

- **E**xact location
- **T**ype of incident
- **H**azards
- **A**ccess and egress
- **N**umber of people/patients
- **E**mergency services at scene or required

Additional information may include whether a HEOC has been activated and name of the HIC and primary contact number.

As more information is available and additional detail is provided to form a SMEACS-Q briefing (refer to Appendix 1 of the QHDISPLAN for further information).

- **S**ituation **(ETHANE)**
- **M**ission
- **E**xecution
- **A**dministration
- **C**ommunications
- **S**afety
- **Q**uestions (allows for clarification or confirmation of information)

During state-led events, where the SHECC is activated, SITREPs are provided as directed. When the SHECC is not activated, SITREPs may be requested by the MHAODB.

5.3 Documentation and record keeping

A full record of activities, decisions and actions taken is essential for managing an incident, including handover between teams, debriefing, and state government directed requests.

At field response level, mental health staff need to record interventions through a mobile/online platform, where possible, to capture data on services provided to those affected by the disaster or emergency incident. This can occur either in business as usual capacity, or in other activities, such as deployment to a Community Recovery Hub or outreach visits.

Various quantitative data are requested from DCDSS through the SHSRG to the MHAODB throughout the response and recovery phases following an event. As a member of SHSRG, MHAODB is obligated to provide this data when requested. Requests may continue for an extended period long after the HHS HEOC or incident management team has stood down. This data is often used to determine which Local Government Areas are eligible for Category C recovery funding from the State and Commonwealth Governments.

HHS Mental Health, Alcohol and Other Drug services need to collect the requested information and report it directly to MHAODB to meet the SHSRG-directed timeframe. The HHS Emergency Coordinator needs to be included in any correspondence with MHAOCB on these matters. MHAODB collates information from the various HHSs and provides a final statistical report to SHSRG and SHECC.

5.4 Staff briefing and debriefing

Details regarding the briefing and debriefing of all staff involved in a disaster or emergency incident can be found in the *Queensland Health Operational Briefing and Debriefing Guideline*.

For further information also see the QHDISPLAN.

6. Mental health disaster and emergency incident management

Queensland Health adopts an all-agencies and all-hazards approach to disaster and emergency incident management across the prevention, preparedness, response, relief and recovery phases.

The priority for Queensland Health in the response phase of disaster management is on actions to reduce loss of human life, illness or injury resulting from the disaster event or emergency incident, such as providing emergency medical assistance. In the relief and recovery phases the priority shifts to a range of social and health, including mental health, measures to assist individuals, families and communities to regain a proper level of functioning following a disaster. By necessity, the recovery phase requires a coordinated approach with the DCDSS and other government and non-government organisations.

These phases can overlap in time as optimal recovery begins with measures taken during the response phase.

6.1 Prevention and preparedness phases

The level of preparedness of mental health staff from HHSs and MHAODB will directly influence their performance during response, relief and recovery phases of a disaster or emergency incident.

Planning and training should:

- be coordinated with other health services within a HHS and relevant government and non-government agencies engaged in human social recovery activities
- include lessons learnt from previous disasters and emergency incidents
- include participation in planning exercises and joint disaster response training and associated activities with partner agencies to provide understanding and clarity about different roles and responsibilities during events.

HHS mental health services should participate in broader community resilience development activity, including social and demographic profiling of potential disaster-affected areas. Existing mental health consumers who might be especially vulnerable in a disaster event should be identified in advance and provided with information about preparing for and coping with disasters.

For information about approved disaster and incident risk management frameworks and resources see Section 4.5 of the QHDISPLAN.

6.2 Response phase

Mental health workers can operate in evacuation and recovery centres or on outreach visits in the delivery of post-disaster care. They will often be based in Community Recovery Hubs established by DCDSS in disaster-affected communities. These hubs will have a range of social support services from government and non-government agencies such as Red Cross and Uniting Care Queensland (Lifeline Community Recovery).

Psychological First Aid (PFA) is the important initial psychosocial measure for people who are distressed in the immediate aftermath and continuing into the early recovery phase following a disaster or emergency incident. PFA is based around four key components. These are the promotion of: safety, calm and comfort, connectedness

and self-empowerment. DCDSS provides funding to agencies like Uniting Community Care and the Australian Red Cross to provide PFA. DCDSS and the organisations providing Psychological First Aid liaise with Queensland Health as required during these phases.

Mental health care is usually required by a smaller proportion of people psychologically affected by disasters. Specialist mental health support may be called on at evacuation centres and community recovery hubs, or on outreach visits, to assess and support individuals or to provide advice to other support staff. Local knowledge is important in assisting community members in evacuation and recovery centres. As a general principle, HEOCs would firstly deploy local mental health staff to those centres, if available, and then people from supporting HHSs, if needed.

The key roles for mental health staff deployed to work with disaster-affected people in the initial response and transition to recovery phases of a disaster or emergency incident are to:

- respond to individuals with acute stress reactions or exacerbations of pre-existing mental disorders
- assist first responders and psychosocial service providers to identify people at higher risk of experiencing psychological distress
- provide support to Community Hub workers and volunteers on dealing with their own responses to people's distress, where required
- where necessary, liaise with other services to ensure that people requiring treatment are able to receive it in a timely manner.

There is no reliable way to predict those who will develop disaster or emergency incident-related mental health disorders (e.g. PTSD). In the early stages it is prudent to identify those who experience an intense reaction after the event and to monitor their progress over the following weeks or months, if possible.

Particular attention should be given to:

- directly affected individuals who have had a mental disorder, were previously exposed to a major traumatic event, or experience any of the following:
  - were injured
  - experienced disproportionate distress or dissociation at the time of the event
  - were faced with unpredictable circumstances over which they had little control
  - were exposed to highly distressing scenes or extreme life threat
  - suffered the loss of a relative or close friend
  - suffered significant loss of possessions (for example, home, pets, family memorabilia)
  - perceive they have limited social support.
- children who experienced any of the following:
  - separation from parents/caregiver
  - death of parents/caregivers, family members, or friends
  - significant injury to parents/caregivers
  - parents/caregivers are missing.

Health staff or volunteers who assist individuals directly impacted by the disaster or emergency incident may also be adversely affected and attention should be given to their possible needs for mental health assistance.

Alongside giving attention to individual need there is a role for mental health services to provide information about managing psychological recovery to those affected by disasters or emergency incidents in the form of helplines, leaflets, websites, and through social media.

Deployment of mental health staff from outside the disaster-affected areas

In disasters affecting whole communities, mental health staff from outside the HHS may be required to keep essential mental health services operating when local staff have been directly affected, or to assist with managing fatigue of over-stretched staff. Deployed staff may also be needed to replace local staff drawn into disaster-related recovery activity; or to supplement these emergency incident teams with additional personnel; or to provide specialised expertise, if local sources of this expertise are unavailable.

The SMH Coordinator (or delegate) arranges the deployment of additional staff and resources when required, in consultation with other HHSs and SHECC. Depending on the site and circumstances of the disaster, selection of staff for work in post-disaster situations may need to include those with knowledge and experience in working with the following population groups:

- children and young people
- Aboriginal and Torres Strait Islander people and communities
- people from culturally diverse communities.

Refer to Appendix 1 for a flowchart outlining the processes for activation of mental health staff in disaster events and emergency incidents.

6.3 Recovery phase

In a disaster, a District Human and Social Recovery Committee, comprising relevant agencies as a sub-group of the District Disaster Management Group, may be activated. This committee may include representative(s) from HHS mental health services.

Organisations represented in this committee combine to provide personal support and information; physical and mental health; emotional, psychological, spiritual, cultural and social wellbeing; public safety and education; temporary accommodation; and financial assistance to meet immediate individual needs and uninsured household loss and damage.

Recovery plans, at all levels of Queensland's disaster management arrangements, should promote community and self-sufficiency. People benefit in the early stages of recovery by:

- being informed about expected reactions to disaster or emergency incident-related experiences and how to manage stress
- being encouraged to use whatever support networks are available to them
- knowing how and when to get further assistance when needed.

It is important to avoid actions that inadvertently undermine resilience, including pressuring people into dealing with their emotional needs before they are ready or able; or communicating directly or indirectly that people need professional mental health care as a matter of course.

In the early recovery phase, the role of mental health staff is largely a continuation of the work described above for the response and relief phase. Staff deployed from outside the disaster-affected area will be withdrawn once the need for their continuing involvement is no longer required. The responsibility for attending to the mental health needs of disaster-affected individuals will rest on the local mental health services, unless the circumstances warrant the establishment of dedicated Post-Disaster Mental Health Recovery staff.

Decisions regarding providing specialised mental health care require careful consideration and may not be appropriate until sometime after the event when it is clear other means of support are not sufficient to enable psychological recovery from the event.

To the extent that is possible, there should be ongoing monitoring of disaster or emergency incident survivors in the months after the event to determine how they are adapting to their changed circumstances, rather than simply relying on efforts at early identification[3] in the immediate aftermath of an event. In many instances this may only be achieved by educating primary health care and community support organisations who may be in contact with affected individuals and families about the indicators for further assessment and possible treatments. Service providers should be alert to the findings that older adults (in natural disasters)[4] and school aged children[5] are likely to have high rates of post-traumatic disorder symptoms. The education system provides the opportunity for more systematic screening of school aged children, which is more difficult to replicate for a post-school adolescent or adult population.

Monitoring efforts that may eventuate in treatments should take the following form[6]:

- Those with high levels of distress during the first month following a disaster or emergency incident should be identified and encouraged to keep in contact with services.
- Beyond this time contact should be offered and maintained, if accepted, for those continuing to experience high levels of distress, particularly if they are dysfunctional as a result of the distress.
- Assessments can be offered at any point where it seems warranted, but a formal assessment should be offered if these incapacitating distressed states persist for longer than three months or if incapacitation or dysfunction related to the event appears to develop after this time.
- Mental health interventions, such as Trauma-focused Cognitive Behavioural Therapy for those with Post-Traumatic Stress Disorders, may be required.

Following broad scale or high intensity disasters, or high intensity emergency incidents a long-term comprehensive mental health recovery plan with dedicated resources may be developed, drawing in external expertise as required.

Depending on the circumstances this may involve establishing such services as:

- 24-hour access helpline
- Post-disaster Mental Health Recovery Teams
- Web-based information programs on strategies for psychological recovery
- Trauma-focused Cognitive Behaviour Therapy or other evidence-based treatments for those who meet diagnostic criteria for Post-Traumatic Stress Disorders
- Loss and bereavement services.

Specific programs for school-aged children can be developed incorporating:

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[3] Bryant R (2009) *The impact of natural disasters on mental health* InPsych, Australian Psychological Society

[4] Georgina Parker, David Lie, Dan J Siskind, Melinda Martin-Kahn, Beverley Raphael, David Crompton and Steve Kisely (2015*) Mental health implications for older adults after natural disasters – a systematic review and meta-analysis* International Psychogeriatrics, 28:1, 11-20

[5] McDermott BM & Cobham VE (2014) *A stepped-care model of post-disaster child and adolescent mental health service provision,* European Journal of Psychotraumatology, 5:2494 – http://dx.doi.org/10.3402/ejpt.v5.24294

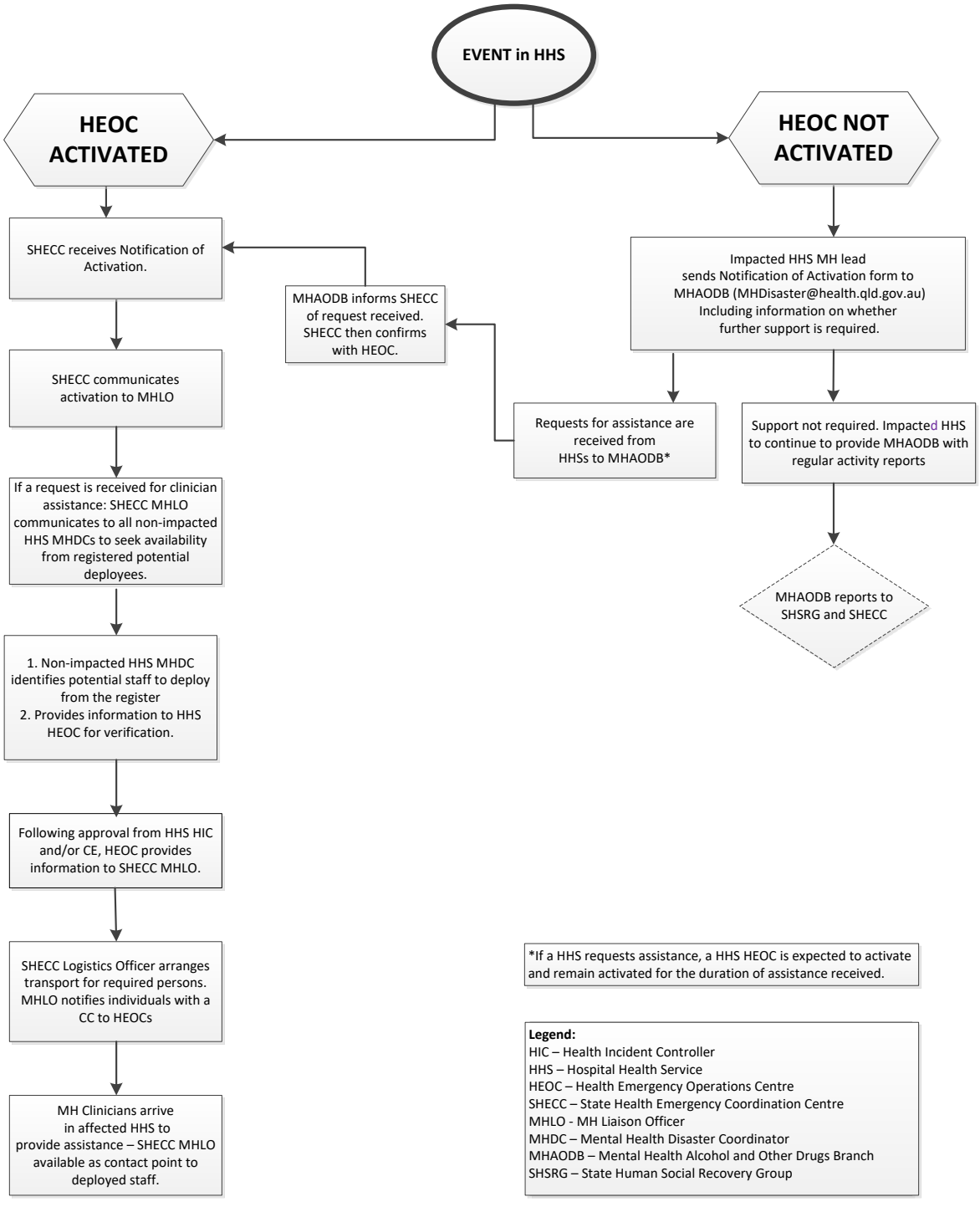
[6] These measures are consistent with the TENTS Guidelines for Psychosocial Care following Disaster and Major Incidents (2008) TENTS (The European Network for Traumatic Stress) www.tentsproject.eu

- An information guide for teachers, parents and clinicians on understanding child and adolescent responses in a post-disaster environment.
- A communication strategy for parents/carers on PTSD and helping children cope with emotional stress; and tip sheets and information booklets.
- A Teacher Training Package to assist with identifying emotional and behavioural difficulties.
- A Disaster Recovery Triple P Program (an early intervention strategy to improve parent confidence and competence in managing children's post-disaster responses).
- School-based screening of disaster-affected children.
- Trauma-focused Cognitive Behaviour Therapy, where indicated.

Depending on the disaster or emergency incident location and/or the experience of the local service providers, delivery of these interventions may require training for teachers, parents, primary care clinicians, community health workers and local mental health service workers (e.g. Skills for Psychological Recovery training programs for local primary care clinicians).

Appendices

Appendix 1 Flowchart for activation and requests for assistance



Please note this does not include overall information flows or SITREP requests. See Section 5 of this Sub-plan, as well as the QHDISPLAN, for further information.

Appendix 2 Mental health role in relief and early recovery

Role for mental health services in the relief and early recovery stages

Psychosocial care and mental health care should be clearly distinguished as types of care, for whom they are intended, and when and by whom they are delivered. Clear roles and responsibilities should be agreed in advance by the different organisations providing psychosocial and mental health services in the field. The former needs to be initiated in the immediate aftermath of an event, and is best performed by individuals and teams specifically trained in Psychological First Aid. This approach involves the provision of advice, information, and support by non-clinical workers and is aimed at providing reassurance, reducing anxiety, assisting with current needs, and promoting adaptive functioning[7].

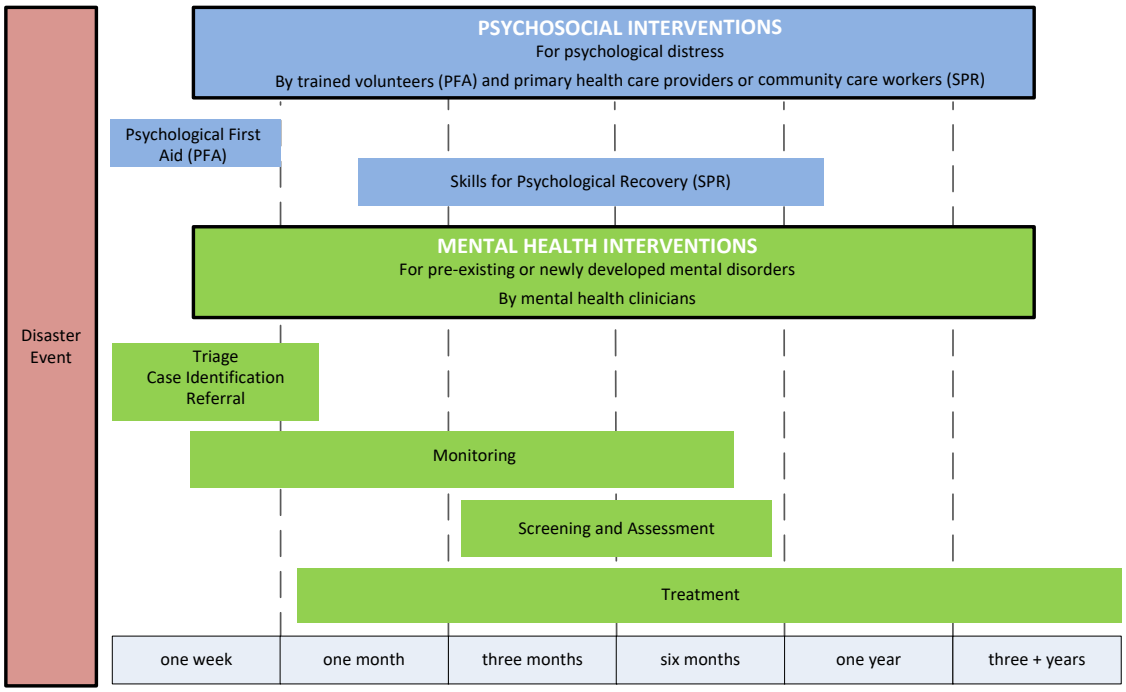


Figure 3 Psychosocial and mental health interventions

Providing mental health counselling as a routine measure in the immediate aftermath of a disaster or emergency incident has not been shown to be effective[8]. In the early recovery stages, the efforts of mental health staff are best directed at:

- providing or organising assistance for those individuals exhibiting an acute stress reaction or for people with an exacerbation of pre-existing mental disorders
- advising psychosocial care providers or other response agency staff on mental health-related reactions to traumatic experiences, and when to call in specialist mental health assistance

[7] *Psychological First Aid: Quick Reference for deployed staff*, Queensland Government
Psychological First Aid: An Australian guide to supporting people affected by a disaster, Australian Psychological Society
[8] McFarlane AC and Williams R (2012) op cit

- providing support, where required, to psychosocial care providers to assist with managing their own reactions to the distress of survivors
- identifying people at higher risk of needing mental health care at a later stage. While there is no validated community wide screening tool for predicting who is likely to require mental health care resulting from a disaster or emergency incident, mental health staff can work in conjunction with psychosocial care providers to observe responses and ensure that services remain in contact with individuals, where indicated and accepted by those individuals.

Mental health staff should be ready to have an elevated role in the immediate aftermath of an emergency incident if there are conditions that may produce higher than usual acute stress reactions, and long-term distress or mental disorders, in particular, events involving high casualties resulting from deliberate human actions.

Psychosocial Recovery and Disaster-related Mental Health Services

- The next step, in the weeks and months following an event, is services for those with persisting mild to moderate distress delivered by practitioners with basic counselling skills working in primary care and community-based services. It involves teaching strength-based skills to improve coping and promote psychological recovery.
- Mental health staff can be usefully engaged working with GPs and other primary health care providers to inform them of potential mental health consequences for people who may present to them at some later point in time, and when to enlist specialist mental health services to assist.
- They can also provide public information on the effects on individuals of trauma and pathways to mental health care for those who might need it in the future.
- Mental health services are required by a smaller proportion of people psychologically affected by the disaster or emergency incident. This is usually provided later in the recovery process once it is clear other interventions will not be sufficient, but should be provided at any stage where a person's presentation warrants it.
- This may include specific interventions for post-traumatic stress disorder and other stress related syndromes (Trauma Focused Cognitive Behaviour Therapy and interventions for complex grief and trauma presentations), as well as treatments for other anxiety, mood or addiction disorders.
- These services are best provided by either primary care or specialist mental health services, depending on the circumstances and the severity of the condition.

Appendix 3 Evidence base for mental health role

The Sub-plan is premised on the following understanding of post-disaster psychosocial and mental health impacts drawn from a review of published research and post-disaster reports:

The general pattern of psychological reactions to and recovery from disasters

- Disasters and emergency incidents can be sudden or anticipated in onset; brief or prolonged in duration; and will vary in scale and intensity.
- They result in transient or enduring psychological ill-effects.
- The impact differs according to the severity of the event, degrees of individual exposure to trauma, and preceding levels of resilience.
- In response to any disaster or emergency incident stress-related reactions such as fear, uncertainty, and insecurity, or mood effects such as sadness and grief are to be expected, and are not necessarily indicative of an impending mental disorder.
- The experience of emotional distress is common during or immediately after a disaster or emergency incident, but most people who are psychologically affected recover without interventions from mental health care providers.
- For most people this distress reduces over time through community involvement, and with support from friends, relatives, and informal support providers.

Persistent psychological distress and acute or ongoing mental health disorders

- Nevertheless, some individuals will experience:
  - persistent and incapacitating disaster or emergency-induced distress, or
  - disaster or emergency-induced mental disorders, such as depressive and anxiety disorders (including Acute Stress Disorder (ASD) and Post-Traumatic Stress Disorder (PTSD), or
  - exacerbation of pre-existing mental health disorders of various kinds, including alcohol or other substance use disorders.
- The groups of people with mental health service needs following disasters are listed in the following table.

Table 1 Groups with different mental health needs following disasters

1. People who are at risk of distress, mental health problems and mental disorders, principally anxiety, depressive, and substance use disorders, consequent on their direct and indirect involvement in events and who present new and additional demands on mental health services.
2. People who have continuing needs for mental health services for pre-existing conditions, but whose care is threatened by challenges to the "business continuity" of pre-existing mental health services consequent on network and community dislocation.
3. People whose involvement in an emergency provokes or precipitates the relapse of a pre-existing mental disorder.
4. People who are responders and whose mental health might be put at risk consequent on their work.

AC McFarlane and R Williams (2012)[9]

The degree of psychological distress and mental health disorders associated with disasters and emergency incidents

- It is not possible to generalise about the extent of adverse psychological outcomes of disaster events due to differences in scale and intensity.
- It is more useful to consider the range of potential outcomes. Based on findings in the post-disaster literature, the North Atlantic Treaty Organisation (NATO[10]) estimates that:
  - up to 80% of people directly or indirectly affected may experience at least short-term mild distress
  - 15-40% may experience medium term, moderate or more severe distress
  - 20-40% may have a mental disorder or other psychological morbidity associated with dysfunction in the medium term
  - 0.5% to 5% may develop a long-term disorder.
- A review of research into major disasters found that on average about one third of people exposed to a major disaster had a mental health disorder afterward, of which around 20% were new disorders, with the remaining representing a continuation of a pre-existing disorder[11].
- When an event results in significant death and injury, and is caused by deliberate human actions, those needing mental health care could increase up to 40%[12] for those exposed to disaster-related trauma.

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[9] McFarlane AC and Williams R (2012) *Mental Health Services Required after Disasters: Learning from the Lasting Effects of Disasters* Depression Research and Treatment, Vol 2012 Article ID 970194

[10] North Atlantic Treaty Organisation (NATO) (2009) *Psychological care for people affected by disasters and major incidents: a model for designing, delivering and managing psychosocial services for people involved in major incidents, conflict, disasters and terrorism,* Brussels

[11] North C. (2014) *Current Research and Recent Breakthroughs on the Mental Health Effects of Disasters* Current Psychiatry Reports 16:481 Published on-line 20 August 2014

[12] Ursano R, Fullerton C, and Benedek D (2009) *What is psychopathology after disasters? Considerations and behavioural consequences of disasters,* in Neria Y, Galea S & Norris F (eds.) *Mental health and Disasters,* Cambridge, Cambridge University Press

Prevalence of post-disaster mental health disorders

- PTSD is usually found to be the most prevalent disorder in research of disaster-affected populations with on average 20% prevalence in trauma-exposed survivors of major disasters, and an upper limit of around 35% in especially severe disasters[13].
- Major depressive disorder is the second most prevalent disorder found in post-disaster studies with an average of 14% in major disasters and an upper limit of around 25% in especially severe disasters[14].
- Increased alcohol and drug consumption is commonly reported in post-disaster studies, but there is little evidence of the occurrence of new substance use disorders.
- Comorbidity involving PTSD, depression and/or substance use disorders is common after disaster-trauma exposure[15].

The major contributing factors to development of disaster-related mental health disorders

- The severity of the event and the degree of exposure to trauma are the factors most commonly associated with higher adverse mental health effects, especially post-traumatic stress disorders.
- Secondary stresses flowing on from the originating event, such as the disruptions in people's lives caused by relocation or financial and work interruptions, may also contribute to a need for mental health services, in particular for depressive disorders.
- These factors appear to account for findings that there are higher rates of mental disorders resulting from many human-caused incidents, especially if intentional, and natural disasters destroy large parts of a community's infrastructure and disperse its population[16].

The differential effects on gender, age and social groups

- Research has consistently identified higher rates of PTSD and depressive disorders amongst female disaster survivors and a higher prevalence of alcohol and other substance use disorders amongst males[17].
- Cross-sectional research following a range of disasters indicates approximately 5 to 15% of children experience significant mental health symptoms following exposure to a disaster[18].
- Rates of mental disorders in older adults exposed to disasters vary according to the type of disaster. Following exposure to natural disasters of sudden onset, older adults (age more than 60 years) were found to be 2.11 times more likely to experience post-traumatic stress disorder symptoms and 1.73 times more likely to

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[13] North C (2014) op cit
[14] North C (2014) ibid
[15] North C (2014) ibid
[16] Norris F. H., & Elrod, C. (2006). Psychosocial consequences of disaster: A review of past research. In F. H. Norris, S. Galea, M. Friedman, & P. Watson (Eds.), Methods for disaster mental health research (pp. 20_44). New York: Guilford and Galea S., Brewin, C., Gruber, M., Jones, R., King, D., King L., et al. (2007). Exposure to hurricane-related stressors and mental illness after Hurricane Katrina. Archives of General Psychiatry, 64, 1427_1434
[17] Goldmann E and Galea S (2014) *Mental Health Consequences of Disasters* Annual Review of Public Health, 35
[18] McDermott BM & Cobham VE (2014) *A stepped-care model of post-disaster child and adolescent mental health service provision,* European Journal of Psychotraumatology, 5:2494 – http://dx.doi.org/10.3402/ejpt.v5.24294

experience adjustment disorder symptoms than younger adults[19]. However, people in the same age group fare better than younger adults in human-induced disasters.

- Middle aged adults are generally at greatest risk of developing mental disorders[20].
- A greater risk of mental health disorders has also been associated with low socioeconomic status, minority ethnic status and those with low social support[21].

The enduring nature of adverse psychological and mental health impacts for some people

- There is considerable variation in the courses of disaster-related mental health disorders.
- Over two thirds of those with PTSD experienced symptoms on the day of the disaster and virtually all experience them within one month of the disaster[22].
- Longitudinal studies suggest that post-disaster psychological symptoms reach their peak in the year following the disaster and then improve, but it has been reported in many studies, symptoms persist for years for some people[23].
- The prevalence of PTSD diagnoses in people affected by disasters compared with those unaffected is about four times higher and prevalence of depression diagnoses is about five times higher around ten years post-disaster[24].
- There is also evidence that there is an adverse effect on long term mental health for a broader group of people affected in major disasters (i.e. including those who would not meet diagnostic thresholds for mental disorders).
- Those affected by disasters have more post-traumatic stress symptoms and poorer mental health at both twelve months and four to seven years post-disaster in comparison to unaffected people[25].
- While treatment is effective in resolving disaster-related mental health disorders, some people will need access to mental health services over an extended period.

Help seeking patterns

- Only a small minority of individuals with disaster-related mental health disorders, especially with PTSD, initiate contact with mental health treatment services, unless they've had prior experience with those services[26].

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[19] Georgina Parker, David Lie, Dan J Siskind, Melinda Martin-Kahn, Beverley Raphael, David Crompton and Steve Kisely (2015*) Mental health implications for older adults after natural disasters – a systematic review and meta-analysis* International Psychogeriatrics, 28:1, 11-20

[20] Norris F, Friedman M, Watson P, Byrne C, Kaniasty K (2002) *60,000 disaster victims speak: Part One. An empirical reviewof the empirical literature: 1981-2001,* Psychiatry, 65

[21] Goldmann E and Galea S (2014) *op cit*

[22] North C & Oliver J (2013) *Analysis of the longitudinal course of PTSD in 716 survivors of 10 disasters* Social Psychiatry Psychiatric Epidemiology 48

[23] Goldmann E and Galea S (2014) *op cit*

[24] Juen B et al. (2016) *Handbook on Mental Health and Psychosocial Support Planning Tools* Operationalising Psychosocial Support in Crisis (OPSIC)

[25] Ajdukovic D et al (2015) ibid

[26] Brewin C et al (2010) *Outreach and Screening following the London bombings: Usage and outcomes* Psychological Medicine 40 (12)

Abbreviations

AIIMS	Australasian Inter-service Incident Management System
CE	Chief Executive
CED	Clinical Excellence Division
CHO & DDG	Chief Health Officer and Deputy-Director General Prevention Division
DCDSS	Department of Communities, Disability Services and Seniors
DDMG	District Disaster Management Group
HEOC	Health Emergency Operations Centre
HHS	Hospital and Health Service
HIC	Health Incident Controller
IMT	Incident Management Team
LDMG	Local Disaster Management Group
MHAODB	Mental Health Alcohol and Other Drugs Branch
QDMC	Queensland Disaster Management Committee
QHDISPLAN	Queensland Health Disaster and Emergency Incident Plan
SDCC	State Disaster Coordination Centre
SHC	State Health Coordinator
SHECC	State Health Emergency Coordination Centre
SHSRG	State Human and Social Recovery Group
SITREP	Situation Report
SMEACS-Q	Situation, Mission, Execution, Administration, Communications, Safety, Questions

Glossary

Disaster	A disaster is a serious disruption in a community, caused by the impact of an event that requires a significant coordinated response by the state and other entities to help the community recover from the disruption.
Emergency Incident	Any emergency incident that is not considered a disaster under the *Disaster Management Act 2003*, but that: • is confined to activation of a single Health Emergency Operations Centre in a single Hospital and Health Service • results in moderate or medium impact on normal operations • is able to be resolved through the use of local or first response resources • may involve the State Health Emergency Coordination Centre moving to 'alert' or 'lean forward' level of activation, dependent on situation reporting. The type of emergency incident where a mental health response is required is an unexpected traumatic event, involving personal threat, which evokes extreme stress, fear or injury.
Event	"An event means a cyclone, earthquake, flood, storm, storm tide, tornado, tsunami, volcanic eruption or other natural happening; an explosion or fire, a chemical, fuel or oil spill, or a gas leak; an infestation, plague or epidemic; a failure of, or disruption to, an essential service or infrastructure; an attack against the state, or an event similar to these" (*Disaster Management Act 2003,* s. 16).
Preparedness	The taking of preparatory measures to ensure that, if an event occurs, communities, resources and services are able to cope with the effects of the event. (2016 State Disaster Management Plan Glossary.
Psychological First Aid	This includes provision of information, comfort, emotional and instrumental support to those seeking help provided in a stepwise fashion tailored to the person's needs. It is the preferred intervention strategy used to reduce distress in the immediate aftermath of a disaster event.

Psychological and Counselling Services	These services may be required for a small percentage of the affected population, whose suffering is intolerable and who may have significant difficulties in basic daily functioning. Care pathways should include general practitioners and other health professionals such as psychologists, social workers, occupational therapists, community and mental health nurses.
Recovery	The taking of preventative measures to recover from an event, including action taken to support disaster-affected communities in the reconstruction of infrastructure, the restoration of emotional, social, economic and physical wellbeing, and the restoration of the environment (2016 State Disaster Management Plan Glossary).
Relief	Efforts to meet the needs of persons affected by a disaster, to minimise further loss through the provision of immediate shelter and basic human needs.
Response	The taking of appropriate measures to respond to an event, including action taken and measures planned in anticipation of, during, and immediately after an event to ensure that its effects are minimised and that persons affected by the event are given immediate relief and support. (2016 State Disaster Management Plan Glossary)
Social Support	This includes family tracing and reunification services, assistance with mourning and communal healing ceremonies, mass communication on constructive coping methods, supportive programs such as loss and grief, formal and non-formal educational activities, screening and treatment programs for children, livelihood activities and the activation of social networks.
Serious Disruption	“Serious disruption means loss of human life, illness or injury to humans, widespread or severe property loss or damage, widespread or severe damage to the environment” (*Disaster Management Act 2003*, s. 13).