Australian Red Cross

Joint submission from Australian Red Cross and Phoenix Australia to the Productivity Commission's Review of the National Health and Suicide Prevention Agreement

July 2025

About us – Australian Red Cross

Established in 1914 and by Royal Charter in 1941, Australian Red Cross is auxiliary to the public authorities in the humanitarian field. We have a unique humanitarian mandate to respond to disasters and emergencies. This partnership means governments can benefit from a trusted, credible, independent and non-political partner with local to global networks, who will work to implement humanitarian goals in a way that maintains the trust of government and Australian society.

Australian Red Cross is one of 191 Red Cross or Red Crescent National Societies that, together with the International Committee of the Red Cross (ICRC) and International Federation of Red Cross and Red Crescent Societies (IFRC), make up the International Red Cross and Red Crescent Movement (the Movement) – the world's largest and most experienced humanitarian network.

The Movement is guided at all times and in all places by seven Fundamental Principles: Humanity, Impartiality, Neutrality, Independence, Voluntary Service, Unity and Universality. These principles sum up our ethics and the way we work, and they are at the core of our mission to prevent and alleviate suffering.

We remain neutral, and don't take sides, including in politics; enabling us to maintain the trust of all and to provide assistance in locations others are unable to go. Volunteering is in our DNA, and thousands of volunteers and members support us every day, helping solve social issues in their own communities. All our work is inspired and framed by the principle of Humanity: we seek always to act where there is humanitarian need.

Core areas of expertise for Australian Red Cross include Emergency Services, Migration, International Humanitarian Law (IHL), International Programs, Community Activities and Programs.

Highlights from our 2023-24 Annual Report:

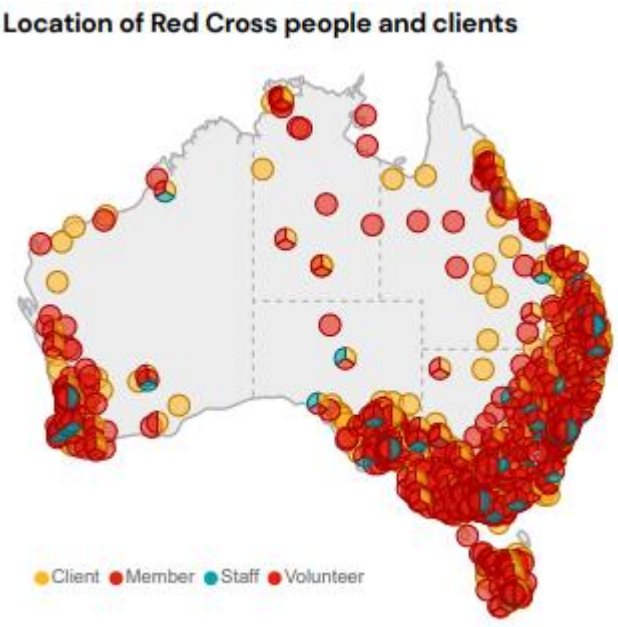
18,300+
members and volunteers acting for humanity

213,000+
Australians supported during 70 emergency activations

5.8 million+
people accessed information from disaster preparedness campaigns

23,600+
people from 129 countries supported through migration programs

Location of Red Cross people and clients



About us – Phoenix Australia – Centre for Posttraumatic Mental Health

Phoenix Australia is expert in trauma and adversity related mental health and wellbeing. For 30 years, it has been Australia's National Centre of Excellence in Posttraumatic Mental Health and an internationally recognised leader in its field. It is committed to driving forward the mental health agenda both at home and abroad. Our overarching mission is to understand trauma and renew lives of those impacted by trauma. Phoenix Australia has extensive experience supporting communities, organisations, workforces (including volunteers) and government departments within the disaster context, from preparedness through to long-term recovery, including research and evaluation, policy development, and development and delivery of training and resources. Underpinning all our work is our leadership of the National Health and Medical Research Council (NHMRC) Guidelines for the prevention and treatment of acute stress disorder (ASD), posttraumatic stress disorder (PTSD) and complex PTSD.

Our role as a national leader has been one of system improvement through research, collaboration, and a commitment to codesign, with a particular emphasis on resilience and recovery from the impacts of trauma and disaster. While we originally built our expertise and international standing in military and veteran mental health and recovery, we have expanded our expertise into emergency and disaster both nationally and internationally. Since the Victorian 2009 Black Saturday bushfires we have had a key role in understanding, developing and delivering best practice initiatives to meet the needs of communities impacted by all forms of disasters across Australia, as well as the health, emergency service and other workforces that support them. Over this period, we have also provided advice and support internationally, for example, to New Zealand in the aftermath of earthquakes, Hong Kong during COVID-19, Norway after the mass shooting, USA after hurricanes, and Japan after their cascading disasters.

We have been key partners of the Australian and Victorian Departments of Health, Primary Health Networks, various disaster response agencies and the National Mental Health Commission as they strive to support disaster resilience and recovery. Since 2020, we have helped communities by building the trauma-related capabilities of more than 8,000 emergency service personnel, community leaders, health, and other recovery workers across Australia, and by developing the highly accessed Disaster Mental Health Hub in partnership with Primary Health Networks. We have also successfully developed, researched and implemented interventions to support the psychosocial needs of disaster impacted regions, and have been engaged by the National Mental Health Commission to investigate the impacts of the pandemic on disaster impacted communities and workforces.

Our international reputation is recognised through our leadership of the International Clinical Practice Treatment Guidelines for PTSD; the World Health Organization (WHO) guidelines for treatment of PTSD; WHO funded research on disaster psychosocial interventions, our internationally awarded clinical trauma treatment programs, and a number of national and international roundtables around improving mental health in the context of disaster.

Through these initiatives, Phoenix Australia has met, and continues to meet, an urgent need for developing and delivering evidence-based and consistent mental health responses to disaster-affected communities across Australia, and the workforces that support them.

Highlights from our 30th Anniversary Impact Statement.

Purpose

This joint submission responds to the Productivity Commission's Review of the National Mental Health and Suicide Prevention Agreement (the Agreement). Drawing on the combined expertise of Australian Red Cross and Phoenix Australia in disaster recovery, trauma-informed support, and psychosocial service delivery, it highlights how disasters - including those driven by climate change and other natural and human-induced hazards - are increasingly shaping the mental health and suicide prevention landscape in Australia.

While the Agreement was designed to promote better coordination and outcomes across the mental health system, it has not adequately addressed the growing impacts of disasters, nor the importance of psychosocial support, lived experience, or community resilience in recovery. As the risks facing communities continue to evolve, the next iteration of the Agreement must better recognise and respond to these drivers of distress and trauma.

This submission outlines six key recommendations to improve national preparedness, prevention and recovery. These include recognising disasters and climate change as social determinants of mental health, strengthening the role and funding of psychosocial support, embedding community leadership, and measuring social capital as a critical driver of resilience. Together, these changes will build a more inclusive, connected, and responsive system to protect wellbeing across all communities - particularly those most at mental health and suicide risk.

Summary of recommendations

Australian Red Cross and Phoenix Australia recommend that the Productivity Commission to:

Recommendation 1
Strengthen draft recommendation 4.1 of the Interim Report by explicitly acknowledging disasters and climate change as social and environmental determinants of mental health and suicide risk. This should be reflected in the objectives and guiding principles of the next Agreement and the renewed National Mental Health Strategy, and embedded in performance and outcome frameworks, aligned with the National Disaster Mental Health and Mental Wellbeing Framework.

Recommendation 2
Call for the funding and governing of psychosocial support as an essential service stream within the mental health system, as reflected in draft recommendation 4.4 of the Interim Report. The recommendation should be strengthened to include a dedicated national funding stream outside of the NDIS for community-based psychosocial support, supported by consistent governance, commissioning, data and reporting arrangements, and development of a trained, surge-capable psychosocial workforce.

Recommendation 3
Build on draft recommendation 4.2 by calling to embed broader psychosocial indicators into performance frameworks. For example, social infrastructure and resilience indicators could be included. This could be achieved by adopting or adapting validated measurement tools within the Agreement's monitoring and evaluation frameworks.

Recommendation 4
Strengthen draft recommendation 4.3 of the Interim Report by strengthening cross-sectoral and intergovernmental governance mechanisms to integrate mental health and psychosocial support within health, emergency management, youth, migration and community service planning. This may include the establishment of an interagency taskforce or formal coordination structure that includes emergency management agencies and community partners, aligned with the principles of the Glasser Review and the National Disaster Mental Health and Wellbeing Framework.

Recommendation 5
Add a new recommendation, that expands on draft recommendation 3.5, to extend lived experience inclusion to non-clinical supports and recovery models to recognise and embed lived experience leadership in the governance of psychosocial and disaster-related supports, including through participatory co-design and peer-informed recovery models. This should be embedded through formal representation mechanisms and decision-making roles in Agreement governance bodies.

Recommendation 6
Add a new section to the report that positions the promotion of social capital and connectedness as a core objective of the Agreement, by supporting place-based, community-led models. This can be enacted through dedicated funding for community resilience programs that focus on building local networks, leadership, and participation.

1. Climate and disasters as determinants of mental health and suicide risk

1.1 The Agreement does not currently recognise disasters, climate change or other large-scale emergencies as drivers of poor mental health or suicide risk. The Productivity Commission's 2025 Mental Health and Suicide Prevention Agreement Review Interim Report (Interim Report) makes only passing reference to disasters and no mention of climate change, despite growing evidence of their impacts.

1.2 Disasters are increasingly frequent, severe and complex - driven by climate change as well as other natural and human-induced hazards. The Australian Government's *National Health and Climate Strategy* (2023) recognises climate change as a critical health challenge and calls for its integration into national health planning. Yet this approach is not reflected in the current Agreement, which omits climate-related drivers of distress and suicide risk. They are significant contributors to distress, psychological injury, and increased risk of suicide. Research shows that between 25–50% of people affected by disasters experience elevated psychological distress, with up to 40% developing post-traumatic stress symptoms (Black Dog Institute, 2020; Goldmann & Galea, 2014). There is also growing evidence that repeated exposure to disasters increases severity of mental health impacts, including suicide risk (Li & Leppold, 2025, Reifels et al., 2018).

1.3 The Australian Government's *National Suicide Prevention Strategy 2025-2035* recognises disasters and climate change as risks to personal safety that may contribute to suicidal distress. While the Interim Report recommends that a renewed National Mental Health Strategy be developed in alignment with the Strategy's objectives and actions, it should also explicitly acknowledge the need to address the mental health and suicide risks associated with disasters and climate change. Importantly, it should do so while recognising the differentiated impacts of sudden-onset disasters and slow-onset climate change, acknowledging that the latter may unfold gradually, incrementally, and cumulatively over time, and may at times be intangible or slow to perceive. This nuance may be reflected in the nature, timing, and visibility of associated mental health impacts.

1.4 The *National Disaster Mental Health and Wellbeing Framework* (2024), led by the National Emergency Management Agency (NEMA), provides a national vision for a coordinated, trauma-informed approach to disaster-related mental health and wellbeing. It explicitly recognises disaster exposure as a critical determinant of mental health, and underscores the importance of psychosocial support, community engagement, and lived experience. While it acknowledges the value of psychological preparedness and preventative strategies in disaster contexts, the Framework does not substantively engage with the broader mental health impacts of climate change - those that extend beyond preparing for an impending disaster or responding to its immediate aftermath. Despite the recognition of disaster exposure as a critical determinant of mental health, these priorities are not embedded within the current Agreement, and there is limited alignment between health and emergency management strategies at the national level.

1.5 Young people exposed to multiple disasters are up to 2.5 times more likely to experience suicidal ideation or self-harm (Carmen et al., 2024). Eco-anxiety – feelings of helplessness and worry related to anticipated climate impacts - and solastalgia – emotional distress caused by environmental changes in a person's home or local area - are affecting a growing portion of the

population, particularly youth, with up to 80% reporting some level of distress (Hickman et al., 2021).

1.6 Disasters can also intensify family and domestic violence, social isolation and community disruption. Droughts and extreme heat increase suicide risk in rural areas, particularly for men (Hanigan et al., 2012; Kelly et al., 2021).

1.7 These disaster-related impacts are not short-term. Longitudinal studies show mental health harms can persist for years if unaddressed, especially among First Nations peoples, older adults, and those with limited support networks (Brockie & Miller, 2017; Loughnan & Brimblecombe, 2023).

1.8 Among First Nations peoples, the mental health and suicide risks associated with disasters are compounded by a complex web of personal, social, and historical factors - including the impacts of colonisation, systemic disadvantage and intergenerational trauma (Dudgeon et al., 2017). These dimensions must be considered in the development of inclusive, culturally responsive disaster and mental health policy.

Recommendation 1

Strengthen draft recommendation 4.1 of the Interim Report by explicitly acknowledging disasters and climate change as social and environmental determinants of mental health and suicide risk. This should be reflected in the objectives and guiding principles of the next Agreement and the renewed National Mental Health Strategy, and embedded in performance and outcome frameworks, aligned with the National Disaster Mental Health and Mental Wellbeing Framework.

2. Psychosocial support as core health infrastructure

2.1 Psychosocial support is distinct from clinical mental health care. It addresses the relational, emotional, and practical aspects of recovery that clinical models often overlook - especially vital in disaster contexts. Psychosocial support refers to non-clinical, community-based assistance that promotes safety, connection, hope, and functioning. It includes psychological first aid, peer support, and community recovery services.

2.2 Psychosocial support is protective against escalating mental health needs and supports long-term recovery. These supports also play a critical role in suicide prevention by reducing isolation, promoting connection and social capital, and addressing distress before it escalates to crisis. Evidence from COVID-19 and recent disaster responses shows its effectiveness in reducing distress and improving outcomes (Reifels et al., 2024). Psychosocial support services also have the potential to reduce the burden on specialist mental health care systems and services and are part of the stepped care approach to support mental health and wellbeing after disaster recommended by the *National Disaster Mental Health and Mental Wellbeing Framework*.

2.3 Despite its recognised importance, the Agreement currently provides insufficient governance, funding, and performance measures for psychosocial support. Implementation has largely been inconsistent and dependent on bilateral arrangements.

2.4 The 2025 Interim Report echoes these concerns, citing under-delivery on commitments and the need for a national framework to coordinate funding, quality and outcomes. Draft recommendation 4.4 of the Interim Report acknowledges the importance of community-based psychosocial supports. However, further action is needed to elevate psychosocial support as a distinct and essential service stream within the mental health system, with dedicated funding and governance structures that ensure national consistency.

2.5 The Interim Report identifies within draft recommendation 4.5 that community and peer-led organisations remain underutilised. This aligns with findings from the Royal Commission into National Natural Disaster Arrangements (2020) and the Inspector-General for Emergency Management Victoria (2020), which highlighted gaps in coordination, sustainability and quality control of psychosocial recovery efforts across jurisdictions.

2.6 There are proven models that work. For example, coordinated responses involving Australian Red Cross, Primary Health Networks and local organisations during COVID-19 provided timely and integrated psychosocial care. They also demonstrated the need for a dedicated national workforce trained to deliver psychosocial support before, during and after disasters. This need grows as the severity of disasters increases. A sustainable, skilled, culturally safe and supported workforce is essential to ensuring consistent, quality psychosocial care, particularly during surge events and in communities with limited access to clinical mental health services.

Recommendation 2

Call for the funding and governing of psychosocial support as an essential service stream within the mental health system, as reflected in draft recommendation 4.4 of the Interim Report. The recommendation should be strengthened to include a dedicated national funding stream outside of the NDIS for community-based psychosocial support, supported by consistent governance, commissioning, data and reporting arrangements, and development of a trained, surge-capable psychosocial workforce.

Recommendation 3

Build on draft recommendation 4.2 by calling to embed broader psychosocial indicators into performance frameworks. For example, social infrastructure and resilience indicators could be included. This could be achieved by adopting or adapting validated measurement tools within the Agreement's monitoring and evaluation frameworks.

3. Governance and cross-sector integration

3.1 Disasters frequently expose structural weaknesses across health, emergency management and social service systems, where fragmented responsibilities and siloed approaches can delay or duplicate care.

3.2 Mental health is not the sole responsibility of health portfolios. Disaster recovery, housing, education, immigration, and community services all play roles in influencing and addressing risk and protective factors related to mental health and suicide risk. Improved coordination is needed both across sectors and between levels of government, supported by joint planning and shared accountability mechanisms.

3.3 Governance mechanisms under the Agreement must be expanded to include representatives from all levels of government, emergency management, Immigration and Multicultural Affairs, the National Indigenous Australians Agency, and Social Services, with mechanisms for participatory decision-making including the involvement of Community Support Organisations. Multiple inquiries into bushfires and floods have found that poor coordination between mental health and recovery systems leads to fragmented services, duplicated efforts, and critical delays in support reaching communities when it is needed most. Notably, the Royal Commission into National Natural Disaster Arrangements (2020), the NSW Independent Flood Inquiry (2022), and reports by the Victorian Inspector-General for Emergency Management have all highlighted the need for improved integration of mental health services within disaster recovery frameworks.

3.4 The Independent Review of National Natural Disaster Governance Arrangements (Glasser Review) (2025), commissioned by NEMA, further reinforces the need for strengthened cross-sector governance and investment in community-based psychosocial support. It highlights gaps in coordination across levels of government and recommends more structured collaboration. These findings provide clear guidance for reforming governance under the next iteration of the Agreement.

3.5 Coordination failures have real-world impacts: individuals may fall through service gaps, supports may be delayed, and community recovery efforts may be duplicated or uncoordinated. The Royal Commission into National Natural Disaster Arrangements (2020) and Inspector General for Emergency Management (IGEM) Victoria (2020) both identified that the absence of shared governance frameworks undermines consistency and equity in disaster-related mental health responses. Strengthening interagency governance is essential to ensure timely and coordinated psychosocial and mental health support when communities need it most.

Recommendation 4

Strengthen draft recommendation 4.3 of the Interim Report by strengthening cross-sectoral and intergovernmental governance mechanisms to integrate mental health and psychosocial support within health, emergency management, youth, migration and community service planning. This may include the establishment of an interagency taskforce or formal coordination structure that includes emergency management agencies and community partners, aligned with the principles of the Glasser Review and the National Disaster Mental Health and Wellbeing Framework.

4. Lived experience and community leadership

4.1 Recovery is not just a clinical process – it is social, emotional, and relational. People with lived experience of trauma and disaster bring critical insights to service design and system accountability. This includes those who have experienced intersecting forms of disadvantage, such as First Nations peoples, culturally and linguistically diverse communities, people with disability, young people, and those in rural and remote areas.

4.2 Participatory co-design and peer-led models are now widely recognised as best practice, helping to build trust, relevance and long-term engagement (Reifels et al., 2024; Slattery et al., 2020). For First Nations communities, this requires strengths-based, community-led approaches that are grounded in self-determination, cultural safety and local knowledge.

4.3 Current mechanisms under the Agreement lack dedicated structures to enable community input into disaster-related supports. Mechanisms for lived experience input are often informal, time-limited or inconsistently resourced. This undermines their influence and sustainability.

4.4 Strengthening governance arrangements to include lived experience roles – such as dedicated advisory bodies, peer workforce pathways, and funded participation in planning processes – is essential to ensure policies and programs are grounded in real-world experience, tailored to diverse community needs and are responsive to changes in community needs over time. For example, a recent review of disaster recovery approaches found that peer-informed models increase trust, improve service uptake, and contribute to sustained engagement over time (Reifels et al., 2024). Phoenix Australia has developed co-design principles tailored to trauma-exposed populations, which provide a useful model for inclusive disaster mental health planning. Lived experience models can be especially valuable in supporting culturally safe and accessible responses for First Nations peoples and other groups that experience barriers to conventional services. Clear frameworks and resourcing are needed to ensure meaningful participation across all stages of planning, delivery, and evaluation.

Recommendation 5

Add a new recommendation, that expands on draft recommendation 3.5, to extend lived experience inclusion to non-clinical supports and recovery models - to recognise and embed lived experience leadership in the governance of psychosocial and disaster-related supports, including through participatory co-design and peer-informed recovery models. This should be embedded through formal representation mechanisms and decision-making roles in Agreement governance bodies.

5. Social capital and place-based resilience

5.1 Social capital - the connections, trust and reciprocity within and between communities - is a core determinant of resilience and mental wellbeing.

5.2 People in communities with high levels of social capital experience better mental health outcomes following disasters, independent of socioeconomic status. These communities are more likely to activate informal support networks, maintain trust in services, and engage in collective recovery actions - all of which contribute to resilience (Wubbenberg et al., 2024; Cuthbertson et al., 2023). Promisingly, there is also emerging evidence that social support may be the key protective factor for mental health in the context of multiple disaster exposures (Li & Leppold, 2025).

5.3 Building social capital is a proven, cost-effective way to boost resilience - yet it is often overlooked in funding and measurement frameworks. Recent evidence from Australian Red Cross (2024) highlights that different forms of social capital - bonding (close relationships), bridging (across communities), and linking (with institutions) - all play distinct roles in supporting resilience. The impacts of low social capital are particularly severe for certain groups, including older adults, those who are unemployed or single, and people in remote areas. In these contexts, higher social capital has been shown to deliver wellbeing gains equivalent to thousands of dollars in income annually per person, with significant cumulative returns at the community level. Improved social capital should be a core outcome in the Agreement, supported through investment in local, community-led models.

5.4 Social capital also enables communities to mobilise their own resources and support systems during times of crisis, reducing pressure on formal services and accelerating recovery. However, many communities - particularly those that are remote, marginalised or newly arrived through humanitarian resettlement, migration or internal displacement - face systemic barriers to building and sustaining these networks. Dedicated localised investment and capacity-building are required to address these inequities and ensure all communities benefit from stronger local connections (Cuthbertson et al., 2023).

5.5 Among migrants and refugee communities, family ties are a critical source of resilience and driver of social capital. Evidence from Australian Red Cross and Phoenix Australia's work with migrants experiencing vulnerability affirms that strong family connections serve as lifelines – providing emotional stability, cultural support, and practical assistance that enables people to heal from trauma, adapt to new environments, and begin the process of rebuilding their lives

(Liddell et al. 2020). Findings from the Refugee Adjustment Study, a longitudinal investigation of refugee settlement and wellbeing in Australia, involving more than one thousand participants highlight the link between family separation and mental health symptoms (Liddell et al. 2020). The research emphasised the protective role of social capital, including social group membership in the mental health and wellbeing of those on insecure visas.

Recommendation 6

Add a new section to the report that positions the promotion of social capital and connectedness as a core objective of the Agreement, by supporting place-based, community-led models. This can be enacted through dedicated funding for community resilience programs that focus on building local networks, leadership, and participation.

Conclusion

Disasters - including those driven by climate change and other natural and human-induced hazards - are growing contributors to mental distress, trauma, and suicide risk. Despite this, the current National Mental Health and Suicide Prevention Agreement does not adequately address their impacts or integrate disaster-related needs into system design, funding, and governance.

This submission identifies six key areas for reform to ensure the next iteration of the Agreement is better equipped to prevent harm and support recovery. It calls for stronger recognition of disasters and climate change as determinants of mental health; investment in psychosocial support as a distinct service stream; and integration of social infrastructure, such as social capital, into performance frameworks. It also highlights the need for cross-sector governance, meaningful inclusion of lived experience and community leadership, and support for place-based, community-led models that foster resilience.

Together, these reforms reflect the combined expertise of Australian Red Cross and Phoenix Australia in supporting communities before, during and after crises. With clear commitments and coordinated action, the next Agreement can strengthen the foundations of mental health and suicide prevention across Australia.

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Contact Details

Joel MacKay

Head of External Engagement, Australian Red Cross

[redacted]

Alexandra Howard

Director, Disasters and Public Health Emergencies, Phoenix Australia

[redacted]