



Our Stories

Beyond the Disaster

2021



Australian Government
National Mental Health Commission



National Disaster
**Mental Health and
Wellbeing Framework**

About this Report

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ISBN: 978-0-646-83581-5

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Suggested citation

National Mental Health Commission.

Our Stories: Beyond the Disaster. Sydney: NMHC; 2021.

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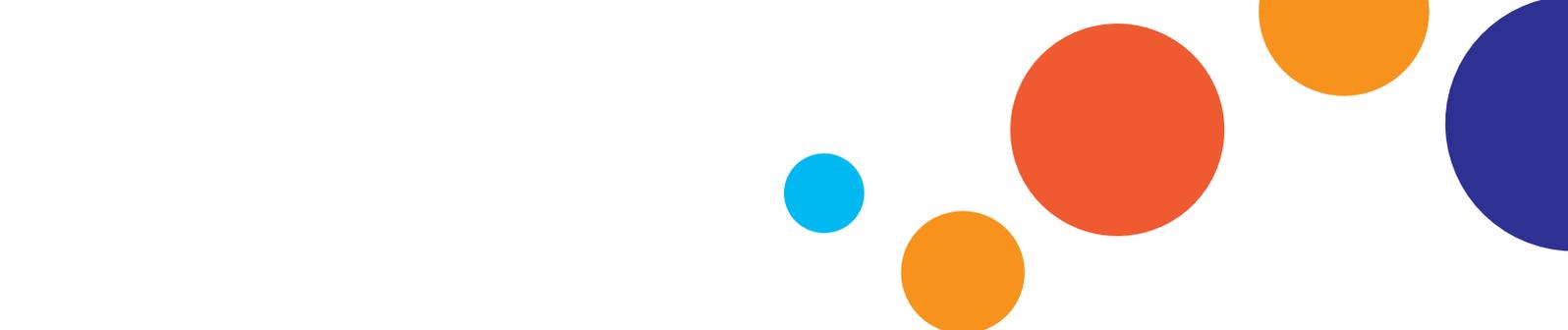
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Key findings

- In addition to stressors related to exposure to a disaster event, aftermath stressors have significant detrimental impacts on the mental health and well-being of those affected by disasters. These stressors may include things such as disruptions to housing, managing insurance claims, experiencing subsequent health issues and struggling to access support services.
- Addressing practical issues before they escalate into compounding stressors reduces post disaster stress.
- The post disaster environment may cause strain on relationships for those affected.
- The workforce assisting people impacted by disasters have particular support needs. This includes those working in mental health and well-being roles as well as other roles in direct contact with community members, such as trades people or retail staff.
- People exposed to multiple disasters can experience accumulative stress, and may perceive a sense of inequity or abandonment when services 'move on' to more recent disasters.
- Not implementing lessons learned from previous disasters is a cause of significant frustration to those affected by new disasters.
- The mental health and well-being of people affected by disasters is often dynamic and may fluctuate over time.
- Many people affected by disasters who require assistance will delay seeking support for a wide variety of reasons. Where services do not anticipate or plan for a delay in uptake of services, those who do not seek immediate assistance may be disadvantaged.
- People affected by disasters may experience multiple barriers to accessing support from services. These barriers may include not knowing what services are available, having competing needs to manage, being overwhelmed by the disaster related workload, perceiving services as unsuitable, waitlists, physical barriers to accessing services, being unsure if eligible for support, and being worried that other people need the services more than they do.
- A range of things were identified as helpful to people impacted by disasters in relation to mental health and well-being support. These included practical support, access to appropriate, flexible, supportive and consistent services and feeling understood.
- The way services are delivered (i.e. care, communication, flexibility) is just as important as what is delivered.
- Providing practical support with small barriers to progress can remove a sense of powerlessness (rather than encourage learned helplessness) and allow people to progress.



Recommendations for organisations supporting disaster affected people

1. A human centred, trauma informed approach to all disaster support should be used.
2. Recognise that aftermath stressors can be a source of trauma or distress which significantly diminishes the mental health and well-being of those impacted. These stressors are often interconnected and compounding. Addressing aftermath related stressors should be considered as both a mental health and well-being intervention and a prevention strategy for future mental health issues.
3. Proactive, flexible, context appropriate and coordinated service delivery should be a priority to ensure that the wide range of issues that people experience in the aftermath of disasters can be addressed.
4. Eligibility for support should be as clear and simple as possible to understand.
5. Entry to services should be designed to be frictionless. This may include multiple entry pathways, minimising needs for secondary referrals where possible.
6. All services should be supported to understand the importance of coordination within and between services as a way of minimising stressors for those affected.
7. Organisations should plan for long-term service provision, and anticipate delays in help seeking from those affected.
8. Using a wide range of communication channels is important to ensure that those impacted are aware of support available and have access to services. Ideally, an up to date 'one stop information shop' should be available to those impacted, promoted through multiple communication channels.
9. Workforce support and training in trauma-informed practice should be available for workers who interact with disaster affected communities in a wide range of sectors.

Background to project

The National Mental Health Commission (the Commission) requested a research consultancy from the University of Melbourne to support their efforts to capture community stories to inform the development of the National Disaster Mental Health and Wellbeing Framework (the framework).

The Commission specified a qualitative research methodology, with a focus on two disaster events:

- 2019/2020 bushfires in southern New South Wales, focusing on the Bega Valley and surrounding areas, and
- 2019 monsoon events impacting Townsville and Westerns surrounds in Queensland.

NMHC recruited community-based researchers in New South Wales and Queensland to collect stories from community members in these locations. The University of Melbourne team provided project guidance, support to the community-based researchers, analysis of data and presentation of findings.

Project aims

The objective of this research was to inform the Commission framework by capturing examples of lived experience from those who have been impacted by disasters.

The aims of the framework are to:

- Create an agreed, coordinated approach between levels of government to respond to psychosocial and mental health needs in the context of natural disasters.
- Identify responses at an individual, family and community level.
- Grapple with current problems and challenges, and feature ways that current arrangements are working well and local adaptations that could be scaled up nationally.

This research will contribute to the development of the framework by capturing the insights of people with lived experience of disasters and the mental health and well-being impacts they experienced.

Methodology

Settings

2019–2020 bushfires areas, New South Wales

Eurobodalla and Bega Valley communities were significantly impacted by the 2019/20 bushfires. The threat to the region started on Tuesday 26 November 2019 with the Currowan Fire burning through Shoalhaven and into Eurobodalla. Bushfires in the region still posed a risk until March 2020. The fires burnt 65 per cent of the Far South Coast and claimed several lives. The impacted area covered 401,000ha in the Bega Valley and 270,000ha in the Eurobodalla. This equated to nearly 60 per cent of the Bega Valley's land mass and almost 80 per cent of the Eurobodalla. In the Bega Valley, 448 homes were lost and 126 were damaged, but 1344 were saved. In the Eurobodalla, 501 homes were destroyed, 274 were damaged and 1716 saved.

2019 monsoon and flood event, Queensland

In late January / early February 2019, a large, slow moving monsoon rain and flood event affected a large area of northern Queensland, first affecting the Townsville region and then moving west to areas such as Julia Creek, Richmond, Winton and Cloncurry. The extensive rainfall and flood events were largely unexpected, especially in communities which had been experiencing sustained drought for some years.

In the Townsville region, much of the direct damage was to residences and small businesses, while in the northern interior region, livestock, farming infrastructure, mining operations and transport corridors were heavily impacted. Public infrastructure was also affected in both areas¹.

Sampling and recruitment

The Commission identified demographic groups they especially wanted to ensure were represented in the participant sample. These included people with pre-existing mental health conditions, single parents, carers and Aboriginal and Torres Strait Islander people.

A purposive sampling approach was identified as a suitable strategy in the initial stages of this study. Purposive sampling is widely used as a qualitative research sampling technique. It allows the researcher to identify information rich participants who have particular experience or knowledge about the phenomena being investigated². This strategy is useful when there are limited resources or there are a number of identified perspectives that are required to be included in a study.

The community-based researchers connected with community leaders, community based organisations and recovery committees to recruit participants who had particular experiences and knowledge of the disasters of interest to the Commission. From here, the community-based researchers used a snowball recruitment approach where participants identified others in their community who had relevant experience.

¹ (Queensland Health, 2019; Simikic, 2020)

² (Palinkas et al., 2015; Patton, 2002)

Data collection

Personal stories were collected through semi-structured interviews conducted by the community-based researchers. Interviews were conducted in person, except for one undertaken via phone. In semi-structured interviews the researcher has a list of general queries about topics of interest but they are conducted as free-flowing conversations, to allow space for new, unanticipated issues to be raised and discussed. The focus of the interviews was their experience following the disaster (rather than the disaster event itself). Interviews were conducted between July and November 2020.

All of the interviews were audio-recorded and transcribed by a professional transcription service to provide a written record of the discussion.

Data analysis

The research team used an abductive process when analysing the written record of the interview discussions. Abductive analysis refers to a process of moving back and forward between inductive (bottom-up) and deductive (top-down) approaches in order to identify emergent themes, 'check hunches' and look for particular themes of interest (Charmaz, 2008, 2014; G. R. Gibbs, 2007; Shank, 2008).

The lead researcher from the academic team undertook a preliminary inductive review of the earliest received interview transcripts, developing high-level thematic codes. These codes were then used to start analysing the next wave of interview transcripts received, with other thematic codes included as needed. Following review from the project academic team and discussion with the community-based researchers, these emergent themes were further refined. A deductive approach was then used to analyse data for themes of particular interest identified by the Commission.

Anonymisation

Efforts were made to de-identify participants when using quotes in this report.

Project limitations

The skew to older female participants, with no representation from children and young people and all interviews being conducted in English are acknowledged as limitations of the study. Participant recruitment was time restricted and researchers relied on known networks to promote participation. Broader study limitations include a study focus on two common hazard types and two case study locations (which provided rich data, but may limit generalisability).

Who participated in the interviews?

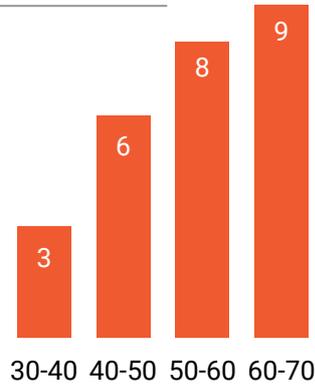
Participant ages

There were **3** participants aged between **30** and **40**

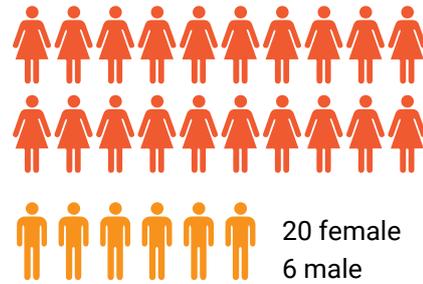
6 participants aged between **40** and **50**

8 participants aged between **50** and **60** and

9 participants aged between **60** and **70**



Gender



There were **20** female and **6** male participants.

Location

There were **6** participants from North Western Queensland

8 participants from Townsville and

12 participants from Bega/Eurobodalla



Characteristics



7 participants identified they had a **pre-existing mental health condition**



2 participants identified they were in a **carer role** for another adult



3 participants identified they were **Aboriginal and / or Torres Strait Islander**



3 participants identified that they were **not born in Australia**



6 participants identified they were a **single parent**



18 participants identified they either **lost their home** or their home was significantly **impacted by the disaster event**

Representation of existing evidence

A snapshot of existing literature relating to disaster mental health and well-being are presented below in story form as 'character vignettes'. Presenting an overview of existing evidence in this way provides a context-rich, narrative account of common disaster experiences that is congruent with the disaster literature and can serve as a useful tool to facilitate the exploration and identification of suitable mental health, psychosocial and practical support options for people with diverse life experiences affected by disaster. The character vignettes were designed to explicitly reflect some of the key characteristics and experiences the Commission identified as being of particular interest.

A number of excellent traditional academic reviews of existing literature on disaster mental health exist, and we encourage readers who would like to read more about the existing evidence base to consult these. Examples are listed below (full references are listed at the end of this report).

Beyond Bushfires longitudinal research study³

Beaglehole et al., 2018: Psychological distress and psychiatric disorder after natural disasters: systematic review and meta-analysis.

Bonanno, Brewin, Kaniasty, & La Greca, 2010: Weighing the costs of disaster: Consequences, risks, and resilience in individuals, families, and communities.

Eyre, 2006: Literature and best practice review and assessment: Identifying peoples needs in major emergencies and best practice in humanitarian response.

Gibbs, 2020: Expert witness statement to the Royal Commission into Natural Disaster Arrangements.

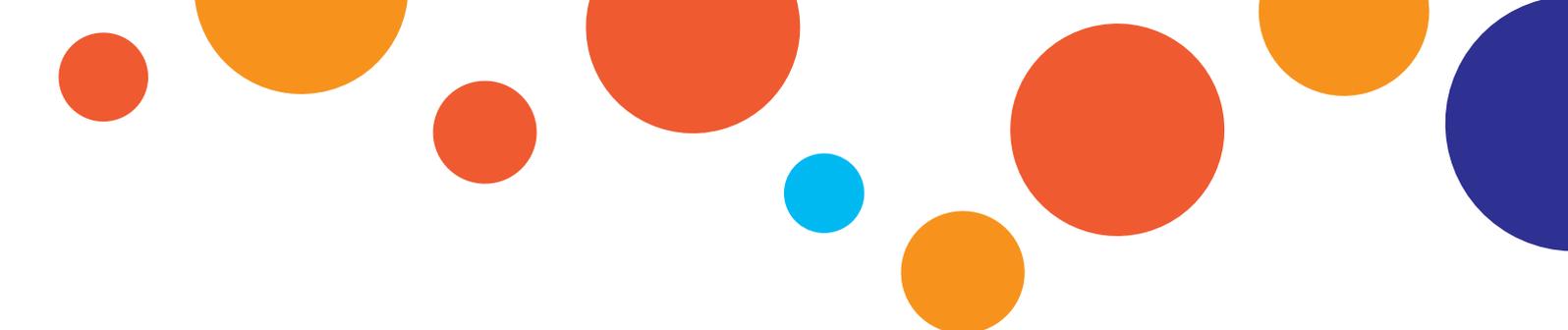
Inter-Agency Standing Committee Taskforce, 2008: IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings

Norris et al., 2002: 60,000 disaster victims speak: Part I. An empirical review of the empirical literature, 1981–2001.

North & Pfefferbaum, 2013: Mental health response to community disasters: A systematic review.

Reifels, Lennart et al., 2013: Lessons learned about psychosocial responses to disaster and mass trauma: An international perspective

³<https://mispgh.unimelb.edu.au/centres-institutes/centre-for-health-equity/research-group/beyond-bushfires>



Our Stories

Vignettes

Adam

Before the disaster event

Adam is a 39 year old proud Aboriginal man who lives in a regional centre. Adam and his wife have three children. Their youngest child has an intellectual and physical disability and requires a high level of care and a wheelchair. Adam and his wife used to find the demands of caring for their youngest child incredibly stressful⁴, but for the last two years have engaged the support of a wonderful carer who has a deep and caring connection with their child and has come to feel like part of the family. Since then, life has seemed much more manageable. His wife returned to work part-time, which reduced the financial pressure their household was facing on one income. Adam enjoyed his work. Both work and the school his older children attend are within walking distance. Adam was very involved in his community – he was on the parent committee for the school, and coached his older children’s sport teams. He played football with a group of friends once a week and had a great relationship with the neighbours in his street – they all helped each other out.

Eight years ago, Adam was diagnosed with depression after struggling for some time. He actively managed his condition with the support of his GP, with whom he has a strong, trusting relationship. He knows his mental health is closely linked to his stress levels and sleep hygiene. For some years he was successfully maintaining a healthy regime of exercise, sleep, good food, limited alcohol and deliberately made time to spend quality time with his family. Whenever Adam started feeling any concerns about his mental health, he was pro-active about going back to his GP and they discussed options, made a plan together and closely monitored the situation until Adam felt confident again.

After the disaster event

Six months ago, Adam’s town experienced a major flood event. Adam’s home was significantly damaged. He and his family had to move out for the duration of the repairs, but due to skyrocketing rents and limited housing suitable for a wheelchair, they had to temporarily move approximately 50km out of town⁵. They anticipate this will be for at least six more months. Adam now has to drive to work and drive his older children to school. Due to road repairs from the flood impacts, this can be anywhere from an hour and a half to two hours each day. By the time they get home, it’s dark. Their youngest child’s carer lost her home in the flood, and can’t afford the new rent levels so has had to move to a different city and can no longer provide any support⁶. Adam’s wife has had to resign from her job to take care of their youngest child full-time⁷, which she finds incredibly stressful⁸, especially as she no longer has access to a car.

Everything feels very stressful for Adam at the moment⁹. The family relies on his income now that his wife can no longer work, and there are a lot of extra expenses between the repairs and travel costs¹⁰. He isn’t getting enough sleep¹¹. There is a lot of extra work for the parents’ committee at the school because of the floods¹², though the sports teams have temporarily stopped playing due to extensive damage to the sports fields so Adam is not coaching at the moment. He is no longer seeing friends socially¹³ and he feels like there is no time for exercise. Mentally, Adam is feeling like things are starting to get bad¹⁴.

Adam’s GP’s clinic was also extensively damaged in the floods¹⁵. His GP has decided to retire a few years earlier than planned, as the prospect of reopening the clinic seemed too overwhelming¹⁶. There is another GP clinic in town, but Adam and his family have previously been made to feel unwelcome there, and he doesn’t feel comfortable making an appointment¹⁷.

Adam feels overwhelmed and scared about where this is all heading.

Links to existing literature

⁴ Parents and carers of people with a disability are more likely to experience financial stress, depression and poor physical health than the general population in Australia. Aboriginal and Torres Strait Islander people are more likely to experience difficulties in social and economic outcomes than the general population in Australia, resulting in a 'double disadvantage' (DiGiacomo et al., 2017).

⁵ Disaster events may impact housing in a range of ways, and these impacts are experienced differently across the community. The existing evidence regarding housing impacts in developed countries largely stems from research in the United States and New Zealand. Many communities experience increased demand and competition for available housing stock after disasters, and rising costs associated with scarcity (Eves & Wilkinson, 2014; Graham & Rock, 2019; Hallegatte & Przulski, 2010; Rodriguez-Dod & Duhart, 2006; Rowlands, 2013) Pre-existing housing inequality and housing instability influence the way that people can access housing after a disaster (Bidwell & Dell, 2012; Peacock, Dash, & Zhang, 2007; Peacock, Zandt, Zhang, & Highfield, 2014).

⁶ Feeling close to people who have left the community after a disaster has been identified as a predictor of depression in people who stay in the community (Bryant et al., 2017, 2014). Interruptions to social resources as a result of disaster can have a negative impact on people affected by disasters and the supports they can draw on (Norris, Friedman, Watson, et al., 2002).

⁷ Changes to infrastructure, social networks and housing have a disproportionate impact on women after disasters, often resulting in increased unpaid caring roles while decreasing capacity for paid employment (Enarson, 2000; Morrow, 1999; Peek & Fothergill, 2008).

⁸ Parents with children who have disabilities, particularly severe disabilities, routinely report higher levels of stress than parents of typically developing children (Hayes & Watson., 2013; Hsiao, 2018; Jones & Passey, 2004; Rivard, Terroux, Parent-Boursier, & Mercier, 2014).

⁹ Mental health impacts at 3, 5 and 10 years post Black Saturday were exacerbated by major life stressors including change of accommodation, change of income and relationship strain (Bryant et al., 2020). There is an increasing body of evidence demonstrating that people who experience life stress are at a greater risk for developing depression (Caspi et al., 2003; Tafet & Nemeroff, 2016). Combinations of stressful events can trigger depression for people who are already at risk (Beyond Blue, 2020).

¹⁰ Current financial hardship has been strongly associated with depression (Butterworth, Rodgers, & Windsor, 2009; Handley, Rich, Lewin, & Kelly, 2019).

¹¹ Poor sleep hygiene is associated with moderate – severe depression. Insomnia is highly prevalent in people who have depression and is one of the most commonly presenting symptoms for people who seek help from GPs (Berk, 2009; Vandeputte & Weerd, 2003).

¹² Involvement in community groups is generally protective for well-being. However, the relationship is nuanced. The Beyond Bushfires longitudinal study into the 2009 Black Saturday bushfires identified that there was a curvilinear relationship between group membership and well-being; while being a member of groups was generally positive, at a certain point, membership to additional groups became detrimental to mental health (Gallagher et al., 2019; L. Gibbs, 2020).

¹³ Interpersonal relationships and perceived social support after disasters are an important predictor of coping success and resilience (Bonanno et al., 2010; Norris, Friedman, Watson, et al., 2002).

¹⁴ Self-perceptions of coping abilities are an indicator of wellbeing after disasters (Benight & Harper, 2002; Hobfoll et al., 2007; Norris, Friedman, Watson, et al., 2002). Prolonged exposure to secondary stressors after a disaster are associated with adverse mental health outcomes (Bonanno et al., 2010; Jermacane et al., 2018; Kessler et al., 2012; Lock et al., 2012).

¹⁵ Primary health care has been recognised as a key strategy to increasing mental health care access in the general population (Reifels et al., 2015). GPs are often the first point of contact for people with concerns about their mental health and act as brokers to psychosocial and specialist care services (Buszewicz, Pistrang, Barker, Cape, & Martin, 2006; Fleury, Imboua, Aubé, Farand, & Lambert, 2012; Reifels et al., 2015; Stone, 2019)

¹⁶ Disruptions to health services and facilities, displacement of health personnel and increased demand for services after disasters can have detrimental health outcomes, including the exacerbation of pre-existing conditions and escalation of preventable conditions (Picou & Marshall, 2007). Investigations into the capacity of the Australian community sector to withstand the impact of disasters found that approximately 25% of community sector organisations would not be able to reopen, mirroring similar estimates for small to medium enterprises (Mallon, Hamilton, Black, Beem, & Abs, 2013).

¹⁷ There is a significant body of research indicating that Aboriginal and Torres Strait Islander people may experience discrimination and additional barriers to accessing appropriate medical care, or may find it difficult to find culturally appropriate services (Durey, 2010; Freeman et al., 2014; Kelaher, Ferdinand, & Paradies, 2014; Markwick, Ansari, & Clinch, 2019; Senate Community Affairs Committee Secretariat Australia, 2018). Existing barriers to mental health care are often amplified in post disaster settings (Reifels et al., 2015).

Indie

Before the disaster event

Indie is 17 and about to enter her final year of high school. She was a consistently high academic achiever and loved going out with her friends to the movies, playing netball and hockey, and playing the piano. At the end of year 11, she was voted onto the school council and was excited about being part of the year 12 formal committee and the inter-school sports representative team. Indie was pretty sure year 12 was going to be the best year ever.

Indie lives with her mum and older brother in a rural interface community. Their house backs onto a reserve which then goes into state forest. When she was a little kid, she and her friends used to build forts in the bush, and in recent years Indie loved going for walks there with her dog.

After the disaster event

Over the summer and into February, there was a series of ferocious fires around the area where Indie lives, which resulted in multiple fatalities. Indie and her family had to evacuate six times over six weeks, the shortest time being for one night and the longest time for four days. The summer was marked by a lot of uncertainty and fear for Indie – she'd never thought much about bushfires in her area before, but now all she can see is the danger of where they live. Nothing feels safe anymore¹⁸. Indie starts culling her possessions, so that what she has in her room can be easily packed into a bag. When she is away from her mother and brother she has started texting them so she knows where they are at all times.

It's been a month since the fires stopped burning. Indie always feels anxious now¹⁹. She finds it hard to pay attention in school and her memory is completely unreliable – it's like she's forgotten how to retain any information²⁰. She fails her first school assessment of the year, which is the first time that's ever happened. She bites her nails down to the quick and it now takes her hours to get to sleep. Even when she does sleep, she wakes suddenly, multiple times a night, her heart racing²¹.

Indie quits the school formal planning committee and tells her mum she doesn't want to play netball or hockey this year. It all seems quite silly now, she can't see the point of it²². She resists the urges of her friends to come out – it's like they just don't get it²³. In frustration, one of her friends tells her that she isn't even one of the bushfire affected people and that's she's playing a fake victim card. When she vents to another friend about it, the friend shrugs and says she agrees. Indie is pretty sure that her friends have started a new group chat on Snapchat and have excluded her²⁴.

Indie feels wretched and can't help but wonder how her life changed so fast.



Links to existing literature

¹⁸ A perceived sense of control over one's life and perception of self-efficacy, self-esteem, mastery, hope and optimism is generally linked to lower levels of distress after disasters. Many people affected by disasters report losses that include perceived control over their life (Norris, Friedman, Watson, et al., 2002). Hyperarousal can have a significant effect on risk perception (Hobfoll et al., 2007). When an individual's sense of safety and security has been threatened this can have a negative impact on mental health and may be a significant predictor for mental health concerns (Bryant et al., 2014).

¹⁹ Experiencing some distress including hypervigilance and feeling overwhelmed is a normal and common reaction to a disaster. If this persists or starts to interfere with normal life rhythms, more assistance may be needed (Hobfoll et al., 2007; Phoenix Australia, Australian Centre for Grief and Bereavement, Australian Red Cross, & Beyond Blue, 2009). Some teenagers will experience mental health difficulties following disaster exposure. The nature and extent of impacts will vary and is likely to be influenced by personal, family, and school characteristics (Barrett, Ausbrooks, & Martinez-Cosio, 2012; La Greca et al., 2013; Norris, Friedman, Watson, et al., 2002; Peek, 2008; Peek & Richardson, 2010).

²⁰ Stress symptoms such as trouble concentrating and sleeping are commonly experienced, but may have longer term consequences such as impacting academic performance and school adjustment (Bonanno et al., 2010) Exposure to trauma has the potential to affect

students' concentration, memory, processing of information, planning and problem solving (Barrera-Valencia, Calderón-Delgado, Trejos-Castillo, & O'Boyle, 2017; Parslow & Jorm, 2007; Samuelson, Krueger, Burnett, & Wilson, 2010; Turley & Obrzut, 2012).

²¹ Trouble sleeping and hyperarousal are common distress symptoms in the short-term following a potentially traumatic event, but often decrease to a manageable level in the days and weeks following a disaster. Where this starts to interfere with normal life rhythms, more assistance may be needed (Hobfoll et al., 2007).

²² Anti-social behaviour, isolation and loss of interests are common stress reactions in children and young people after disasters (Pfefferbaum, Houston, North, & Regens, 2008; Pfefferbaum, Jacobs, Houston, & Griffin, 2015; SAMHSA, 2018).

²³ Research into the 2009 Victorian Bushfires identified that children (younger and older) experienced upheavals and stressors in the home, school, sport, community and friendship groups (L. Gibbs, 2015)

²⁴ Disruptions to social networks or perceived lack of social support can negatively influence post-disaster well-being (Gordon, 2004; Pfefferbaum et al., 2008)

Anna

Before the disaster event

Anna is a 65 year old woman living in an outer metropolitan area with her wife. Over the last 18 months, her wife experienced rapid onset dementia. Twelve months ago, Anna quit her job to become her full-time carer. With neither of them working, Anna had to sell their house as they still had a considerable mortgage. They have been renting a house for the last two years. While it is much smaller than their old house, it has a beautiful tree-lined outlook and lots of native birds that her wife enjoys watching and listening to. Anna had to manage their money very carefully but they were ok. It worried her a bit knowing they didn't have much of a buffer.

Anna was raised in a religious family and had a strong connection to her faith community. When she came out in her 30's, she was rejected by both her family and community. This was an incredibly distressing and traumatic experience for Anna.

Over the last year, Anna had been seeing a psychologist in a private practice fortnightly. Originally it was to seek help with the grief and stress of becoming her wife's carer, but they started exploring her family relationships. Anna had a strong rapport with the psychologist and invested a lot of trust in her. She found the sessions insightful and incredibly helpful. Having someone she trusted to speak to confidentially who had excellent insight and strategies improved her quality of life immensely.

After the disaster event

A cyclone and flood event impacted the town Anna lives in. While a large number of homes were destroyed or damaged, the house Anna lives in is fine. However, the shed containing most of their photos and sentimental items was badly damaged and flooded²⁵. It is heartbreaking, and fills her with grief, but she feels silly talking about it when so many people have lost so much.

Anna's wife was very scared during the cyclone and the change to the landscape makes her even more disoriented and distressed²⁶. She begs to go 'home' most days. She doesn't sleep at night much anymore. Anna is exhausted and exasperated and cries most days²⁷.

A month after the cyclone and floods, the rental agent wrote to inform them that their rent will be increasing. When Anna calls to request reconsideration, the agent points to the dramatic demand in rental properties and the corresponding prices²⁸. He tells Anna she should be grateful they weren't evicted.

As a way to reduce her household expenditure, Anna cancels her private health insurance, and reduces her home and contents insurance amongst other things²⁹. She wishes she could go back to the psychologist but knows she can't afford the payments³⁰. There is a free counseling service available for people affected by disasters, but it is being run by a religious organisation³¹ and Anna feels too anxious to contact this service.

Anna is feeling overwhelmed and grief stricken.



Links to existing literature

²⁵ The impact of loss of irreplaceable / sentimental items as a result of a disaster can be substantial (Lock et al., 2012). Loss of sentimental items in disasters events is associated with adverse mental health outcomes (Lowe, Joshi, Pietrzak, Galea, & Cerdá., 2015; Paul et al., 2014; Tempest, Carter, Beck, & Rubin., 2017; Tracy, Norris, & Galea, 2011).

²⁶ The Beyond Bushfires longitudinal research study into the impacts of the 2009 Victorian Black Saturday bushfires indicated that connection to the natural environment had a deep, personal significance and that the fire impacts to the natural environment was a source of grief to some community members. However, strong attachment to the natural environment was also associated with better mental health and wellbeing outcomes 3-5 years after the event (Block et al., 2019).

²⁷ Carers for people with dementia experience high rates of depression and anxiety (Watson, Tatangelo, & McCabe, 2019). Older people experiencing cognitive, physical and financial challenges may face difficulties in relation to disaster resilience (Astill & Miller, 2018a, 2018b)). Caregivers during disasters may face additional stressors and require multifaceted support (Vaiitheswaran, Lakshminarayanan, Ramanujam, Sargunan, & Venkatesan, 2020).

²⁸ Many communities experience increased demand and competition for available housing stock after disasters, and rising costs associated with scarcity (Eves & Wilkinson, 2014; Graham & Rock, 2019; Hallegatte & Przulski, 2010; Rodriguez-Dod & Duhart, 2006; Rowlands, 2013). Pre-existing housing inequality and housing instability influence the way that people can access housing after a disaster (Bidwell & Dell, 2012; Peacock et al., 2014).

²⁹ Australians with low or erratic incomes are the least likely people to hold insurance. Research from the Brotherhood of St. Laurence (BSL) indicates that low income Australians are largely aware of the importance of insurance but affordability is prohibitive (Banks & Bowman, 2017; Collins, 2011). Investigations by BSL indicate that low income Australians juggle risks and costs associated with insurance, and where they hold insurance often forego essential items to meet insurance premium payments (Banks & Bowman, 2017).

³⁰ Affordability of mental health services can be a barrier to accessing services. Public mental health care services are often difficult to access for all but the most serious cases. Mental health services often require private health insurance to be affordable and accessible, which may act as a barrier for access to services for people who cannot afford private health insurance, or for people who find it difficult to access insurance due to pre-existing conditions (Senate Community Affairs Committee Secretariat Australia, 2018).

³¹ Provision of post disaster services by faith based organisations is embedded in current Australian emergency management arrangements. Considering current exemptions to anti-discrimination legislation for some religious organisations relating to LGBTIQ issues, and persistent discrimination against the LGBTIQ community by some religious organisations, services being contracted to religious third party organisations may act as a barrier to support for some people in the LGBTIQ community (Dominey-Howes, Gorman-Murray, & McKinnon, 2014, 2016).

David

Before the disaster event

David is a 42 year old man who lived with his wife and two primary school aged children. They moved to a regional town seven years ago to get away from the city traffic and city house prices so they could buy a bush block and give their kids space to run around.

David worked hard to build their home and recently completed the renovations. Finally, it felt like the house was nearly what he had in mind when he started, just a few bits to add here and there but all the big stuff was done. He was really proud of what they had made.

David owns a small plumbing business, just him and an apprentice. He built up a good network of other tradesmen in the area, and while they're not super close, some of them became friends who he had a drink with on a Friday night or occasionally went fishing with.

After the disaster event

A fire burns through David's town suddenly and with little notice. David and his family don't have time to enact their fire plan, and hastily evacuate with a few possessions to the local cricket oval and wait out the fire there with some other people from town. It is very frightening for everyone, but thankfully there is no loss of life. David thought he and his family were going to die³².

The damage to the town is significant. David and his family lose their home to the fire and they are devastated³³.

While his wife wants to rent a place closer to her mother's house in the city, David insists that they will live on the block in a donated portable donga and rebuild³⁴. He can't see how she could think

that being away from the block could work – there is so much to do to get it ready to rebuild and he works and works at clearing the block every evening using portable lights from a building site until he's so tired he can barely keep his eyes open³⁵.

David feels a rage that seems uncontrollable³⁶. He is so angry that the fire happened, that the mitigation hadn't been done properly, that no one gave them warning and that the fire brigade mishandled the event. He is also incensed at the bureaucracy that is stopping the things he wants to do to fix everything so they can just get back to normal³⁷, and the way the media are portraying the event. Between the insurer, the council, the do-gooders that just want to talk about feelings instead of getting things done, the grants paperwork and the announcements from the politicians, he is outraged. He is furious that his wife wants to delay the process even further – she says she doesn't know if they should rebuild here and wants some time to think about it³⁸. His kids seem to cry all the time. Everything feels out of control and he feels like roadblocks are in front of him at every turn³⁹.

To make things harder, he knows that people don't want to be around him anymore⁴⁰. After a confrontation at the pub, his mates are avoiding him. His apprentice has resigned after a few tense weeks ended in a shouting match. He has been blocked from coming to the recovery centre after a few discussions became more heated than he'd intended. He knows that he's being angrier than normal but there is so much to rage and his fuse feels shorter than it ever has.

The worst bit is at home. For the first time ever, his wife looks scared of him, as do his kids⁴¹. It's never been like this before. In truth, he's scaring himself a bit. He has no idea what to do, and that fuels the feeling of being out of control.

David tries to stay away from the donga as much as he can. When he's at home, he works on the block. He tries to take on as much work as he can so he is busy, but he keeps making silly mistakes on the job⁴² and to top it off, he's slower now he's working by himself. Clients are complaining about his work. David is so angry he could explode.



Links to existing literature

³² An individual's belief that they were at risk of dying during a disaster is associated with high incidence of negative mental health impacts (Brewin, Andrews, & Valentine, 2000; Bryant et al., 2014)

³³ Home loss as a result of disaster is associated with greater trauma exposure and poorer mental health outcomes (Bonanno et al., 2010; Bryant et al., 2020).

³⁴ Housing related decision making post disaster is an under-researched area. There is some evidence from Hurricane Katrina that there may be disagreements within households when deciding to rebuild, stay in the area or relocate (Henry, 2013; Peek, Morrissey, & Marlatt, 2011).

³⁵ Prolonged experience of secondary stressors after disasters are associated with adverse mental health outcomes (Bonanno et al., 2010; Jermacane et al., 2018; Kessler et al., 2012; Lock et al., 2012). In their systematic review of disaster related secondary stressors, Lock et al. (2012) identify a typology of secondary stressors, which include stressors related to economic hardship, compensation, recovery and rebuilding, loss of physical possessions, health issues, education and schooling, family, social life, loss of leisure and recreation time and changes to the view of the world or oneself. In this example, David is experiencing many of these stressors simultaneously.

³⁶ Anger and major life stressors have been identified as a significant predictor of poor mental health outcomes after disasters. (Forbes et al., 2015). Anger problems post disaster have also been associated with lower life satisfaction, increase in suicidal ideation, and a nearly 13-fold increase in hostile aggressive behaviour (Cowlshaw et al., 2020) .

³⁷ See footnote 33

³⁸ Decisions about rebuilding and relocating following disasters are complex, and affected people may need time to make decisions that are right for them and their families (L. Gibbs et al., 2016; Peek et al.,

2011) Research has shown that the decision about whether and where to rebuild is highly emotional. The recovery experiences are very different but the wellbeing outcomes three years after the disaster are similar for those who stay in the community and those who relocate.

³⁹ The importance of individuals having a sense of control and a belief in their own ability to cope with adversity and take actions that will likely lead to positive outcomes are well established in psychology and trauma literature. Following trauma events, people may be at a heightened risk of losing their sense of control and competency. Where people believe in their own capacity to cope with trauma related events, they are more likely to experience beneficial outcomes (Hobfoll et al., 2007).

⁴⁰ Social isolation is associated with poor mental health outcomes (Inoue, Matsumoto, Yamaoka, & Muto, 2014; Sone et al., 2016). Disaster related social stressors are recognised as a form of secondary stress (Lock et al., 2012).

⁴¹ There is growing empirical evidence of experiences of intimate partner violence following disasters. Disaster related experiences of property damage, job loss and financial hardship have been associated with increases in post-disaster interpersonal violence. Research following 2009 Black Saturday bushfires demonstrated higher rates of interpersonal violence in communities which experienced the highest levels of disaster impact compared to communities with lower levels of affectedness. Where disaster affected women also experienced violence, there was an increased presentation of PTSD and depression symptoms (Molyneaux et al., 2020; Parkinson D., 2019; Schumacher et al., 2010; Sety, 2012).

⁴² Concentration and memory may be impaired following traumatic events and protracted stress (Bell et al., 2018; Bisby, Burgess, & Brewin, 2020)

Maria

Before the disaster event

Maria is a single mother to three small children, and a widow. She arrived in Australia as an asylum seeker three years ago. When she was granted refugee status, she and her children settled in a rural community where there were other newly arrived migrant families. She can speak two languages fluently, but her spoken English is limited and she struggles to read in all the languages she can speak. Maria missed her family at home but knew that it would be some time before she saw them again, so tried to be satisfied with regularly talking to them on the phone instead.

Maria had been making friends in the community and had a job as a cleaner at the local high school. Maria was happy with the simple but peaceful life she had been able to create for her family. After years of turmoil, things are settling down. They have a nice place to live, and friendly neighbours. One of her children attended the pre-school and she had been making an effort to get to know the other parents and volunteer her time.

After the disaster event

A flooding event hits the town Maria lives in. Maria didn't know about any emergency warning messages⁴³, and may not have acted at all except that her neighbours came to tell her what she needed to do and drove her and her children to the evacuation centre where they stayed overnight⁴⁴. The centre was full of people and smells and noise and food they had never eaten, and the noise of the storm was amplified in the building they were in. Maria did her best to reassure her children that they were safe, but it was an overwhelming and uncomfortable experience, especially as she only understood a little of what was being announced.

Maria's neighbours drove them home the next day. Their flat was ok, just minor water damage. Maria couldn't believe how lucky they had been. She went to the school where people had gathered and tried to find a way that she could help others, and was able to help sort clothes and household items and food for those who needed it⁴⁵.

From that time, however, her second child seemed to undergo a personality change. Usually a vivacious and cheeky child, he has become quiet and more reserved. Maria notices him sucking his thumb, which he hasn't done since he was a baby. Despite being toilet trained for some time, he has started to wet the bed again, and have accidents in the day. He always wants to be by her side, clinging to her dress or her leg, and cries when she leaves for work⁴⁶. This is most unusual for him, and she worries. Did something happen in the evacuation centre that she didn't see? Has someone hurt him? When she asks, he just cries and tells her he's scared.

Maria knows that there is a lot of information around, she sees posters and booklets in the street and at the school. She understands some of the words, and knows they are about floods, and knows some of the information is about children, but can't understand the material⁴⁷. She wants someone to check her son and find out what is wrong and how she can fix it but she's not sure what to do. Maria is worried and unsure of who can help.



Links to existing literature

⁴³ Language and cultural differences can present communication barriers between emergency management agencies and multicultural and linguistically diverse communities, especially when official information is only made available in one language. Despite recognition from governments and emergency management agencies of the importance to ensure that everyone has access to information, there are often inadequate structures in place to ensure this happens (Ogie & Perez, 2020).

⁴⁴ Relationships with neighbours and nearby friends are important during and after disasters. Neighbours are often 'zero responders' – those on the scene before emergency services worker. Local, trusted networks provide information and immediate and practical support during disasters (Aldrich, 2010, 2012).

⁴⁵ The emergence of 'spontaneous volunteers' is a common occurrence in the immediate aftermath of disasters. These volunteers may include disaster affected people, people who are local to communities impacted, and others. Spontaneous volunteers may include people who are linked to existing community organisations and people who are not affiliated with any group (Australian Institute of Disaster Resilience, 2018; Twigg & Mosel., 2017).

⁴⁶ Regressive behaviours in children following trauma events (including disasters) are well documented in existing literature. These reactions may include increased crying, sleep disturbances and behaviours such as returning to bed-wetting, thumb sucking or being particularly clingy to parents. These responses are common following disasters and usually diminish with time and support from caregivers (Smilde-van den Doel et al., 2006; Walker et al., 2012)

⁴⁷ Disaster recovery guidelines from Australia, the United States and other countries reinforce the need for recovery programs to take into account the diverse needs of multicultural communities following disasters, particularly in relation to the language information is presented in and the way people access services. The US Surgeon General's office has published recommendations for the support of refugee groups after disasters, which notes the importance of public education to be tailored to the cultural and linguistic needs of those affected, programs which use persistence and proactive outreach approaches and services which make particular efforts to be welcoming (Australian Institute of Disaster Resilience, 2018; Norris & Alegría, 2008).

Alison

Before the disaster event

Alison is a 55 year old woman who lives with her mother in a suburban rural interface area in public housing. She was diagnosed with a severe and persistent mental health condition with multiple comorbidities in her early 20s. Since then, Alison has experienced a wide range of treatments and health management strategies, including a significant amount of time in extended inpatient care and acute inpatient care over the years.

Alison's mother is 85 years old and is her full time carer, despite her own chronic health problems. Alison attended a day clinic three times a week and has regular appointments at a hospital with a health care team, including her psychiatrist and social worker. Alison's mother drove her to all of these appointments; there were no public transport options where they lived that would get them into the hospital in time for the clinic.

Having a routine helped Alison. Alison had friends she has met through the clinic and mostly looked forward to going. She attended on Monday, Wednesday and Friday. She enjoyed going to the movies with her mum every Tuesday, and going to the library on Thursday, where she knew the librarians and they recommended books and DVDs for her. She loved reading, taking care of her pets, and helping her neighbor in the garden on the weekends.

After the disaster event

A bushfire was been burning through the areas surrounding Alison's home. It was quite scary for a number of weeks – the smoke was thick, and they were told to leave home on high temperature days a number of times. Alison's mum tried to keep as much to their routine as she could even on these days – they went to the clinic, and they went to the movies in town on those days instead of their closest cinema. Then, one day there was another evacuation warning that was more serious. Alison's mum had already had things packed for a few weeks, and they drove to her aunt's house in town. Alison's home was badly damaged and they were informed that they would not be able to live there anymore. There is uncertainty from the public housing office when and where they will be able to get a new home, but they were provided short-term accommodation in the interim⁴⁸.

The short-term accommodation is more than an hour and a half drive from the hospital and day clinic. In a case of spectacularly bad timing, Alison's mum's car stops working. The mechanic advises that they're not able to fix it within their budget, and Alison's mum can't afford to buy a new car⁴⁹. Alison isn't able to get to the clinic or her appointments⁵⁰.

Alison is very scared and not feeling well.



References

⁴⁸ Concerns about health, reduced access to medical services and accessing stable and suitable housing are all recognised as secondary stressors (Lock et al., 2012). Pre-existing housing inequality and housing instability influence the way that people can access housing after a disaster (Bidwell & Dell, 2012; Peacock et al., 2007, 2014).

⁴⁹ One in three people in Australia cannot find \$500 to deal with unexpected events (Banks & Bowman, 2017). Loss of physical possessions is recognised as a secondary stressor following disaster events (Lock et al., 2012).

⁵⁰ People with pre-existing mental health conditions are at a greater risk of negative mental health outcome following a disaster (Beaglehole et al., 2018; Bonanno et al., 2010; Norris, Friedman, Watson, et al., 2002). Breakdown in household daily activity that ordinarily provide stability and routine are recognised as post disaster secondary stressors (Lock et al., 2012). Existing barriers to mental health care may be amplified in post-disaster environments (Reifelsz et al., 2015).

Study findings

1. Aftermath related stressors

The stressors most commonly reported by participants came after the disaster events – ‘aftermath stressors’. The endless, overwhelming and relentless workload of managing the aftermath of disasters, and the interconnected and compounding effects of the various disruptions and challenges had a significant negative impact on mental health and well-being for many.

While the term ‘secondary stressors’ is commonly used to describe stressors for disaster affected people which are subsequent to the immediate hazard impacts, we refer to them here as ‘aftermath stressors’ so as to not diminish their significance. While these stressors are ‘secondary’ in the sense that they come after the disaster they are not secondary in terms of impact. They are potentially traumatic, significant, burdensome issues in their own right with complex and profound consequences for those affected⁵¹.

Reports of aftermath related stressors were the most common thread throughout the interviews.

Two main points were highlighted throughout the interviews:

- Aftermath stressors can be a source of trauma or distress in and of themselves, and significantly diminish the mental health and well-being of those impacted. These stressors are often interconnected and compounding.
- Addressing aftermath related stressors should be considered as both a mental health and well-being intervention and prevention strategy for mental health issues. By addressing many of the practical issues that people faced, negative impacts on mental health and well-being could be significantly reduced or prevented⁵².

“ And, I – and I believe the majority of a lot of the mental health issues that come on properties is purely financial. Not purely, but the majority. A big factor. It – it’s – there’s a lot of debt out there on properties. And, it – it, you know, banks haven’t been – they’ve been a bit savage in the past and I think that plays on people’s minds... You know, most people when they lie down in bed at night, it’s either you’re thinking about drought or an adverse – something that’s just happened, but adverse. Normally it means it’s something from left-field. But it’s – they’re lying there. How we going to make our budget? How we going to do this? How we going to feed these cattle? Sheep?... How we going to pay for our kids boarding school fees? How we going to get these dead cattle off this lawn at our house, around the shed when you can’t pay someone to do it and your husband shouldn’t have to do it, because he’s just lived there and watched them die. To me that grant saved a lot of lives.”

⁵¹ For further discussion of secondary stressors following disaster events, see (Bonanno et al., 2010; Erikson, 2014; Kessler et al., 2012; Lock et al., 2012; Tempest et al., 2017; Whittle et al., 2010)

⁵² (Forbes et al., 2015; Tempest et al., 2017)



Aftermath related stressors continued

Aftermath stressors were presented as having a profound, burdensome and heavy impact on participants' fatigue levels. Participants frequently described being overwhelmed by the volume, complexity and effort related to the things they had to address following the disaster events. This was an issue because it led to:

- **Reduced capacity to cope with small challenges before they escalated to big issues:** Many participants reported 'small things becoming big things'. These were issues, which, by themselves, may have ordinarily been dealt with relatively easily but became insurmountable.

“ When we lost our house, we also lost one of our cars. Right? And, when we lost our house, we actually lost absolutely everything. You know, you – there – there was – there was nothing left and when I say nothing, there was nothing left. The car you couldn't even recognise that the car was – was a [car model]. It was insured so, you know, in – in – in normal times, that's not a hard thing, you know. You go out – the insurance company pays you, you go out and you find yourself a car. I could not cope with the fact I was looking for a car. I could not do it. It was a – and the length of time it took me even just to muck around to about even thinking about it, I couldn't even do that.”

- **Reduced resilience to non-disaster related life stressors:** A number of participants reported a reduced capacity to cope with non-disaster related life events, such as the death of loved ones or a diagnosis of serious illness. These events would have ordinarily been very difficult, but in the context of the aftermath of the disaster, they became overwhelming.

“ You're dealing with everyday life all through your life. And, part of that everyday life is you're dealing with births, deaths, marriages in your family, you're dealing – and your friends and that. You're dealing with, you know, losing jobs or – you know changing employment. Life. And then, you have this massive disaster on top of everyday life. It's too much.”

- **The disaster related workload became a barrier to help seeking:** In an attempt to grapple with the overwhelming workload that came after the disaster, a number of participants were not able to sufficiently prioritise their own well-being. Effectively, the disaster related workload became a barrier to seeking help related to mental health and well-being, which in turn made the workload more difficult to cope with.

“ During the time, and especially, I suppose, six months after there was – yeah, like, people were still losing stock, you know, weeks, months after with the disease and nobody really had time, I feel, in their eyes, to go and talk to somebody. They're just trying to make do with what they've got and get their head around everything. So, they might have been reluctant anyway just because of cultural reasons, but it – was it the fact that they were preoccupied.”

Participants identified a range of aftermath related stressors. Four stressors emerged as especially pervasive across many of the interviews:



Insurance



Housing & living conditions



Subsequent health issues



Service access and attitudes



Insurance

Insurance emerged as one of the most frequently identified stressors for participants. While some participants were not insured due to unaffordable insurance premiums, for most participants who had insurance, negotiating with insurers was described as a frustrating, consuming, exhausting and unjust experience that dragged on, diminished their sense of wellbeing and affected their relationships.

“ [It was] probably April – April, I had the breakdown, and I – and I did the screenshot to the assessor about what the medical report was. “Insurance had driven her to a breakdown, she’s to be left alone.” So, insurance left me alone for two months.”

Insurance processes were described as inconsistent and burdensome. Most participants expressed frustration that they had paid insurance premiums for years but struggled with claims being processed because of difficulty proving losses to insurers.

“ You have to provide proof of everything. So, you’ve got to do a detailed inventory of your contents to be able to claim them. Yeah. You can’t just say “I lost everything”, and therefore claim the maximum amount. No. You have to prove to them. Yeah. Yeah. Photographs and descriptions of the product, and how old it was, and “where was it bought?” You’re told to do this on a computer, but, you know, your computer’s gone in the flood.”

Some participants described the insurance related stress as having a negative impact on their relationships. The pervasive nature of the stress associated with the insurance claims and disputes process became consuming and affected relationships with partners and children.

“ You know? And, [my oldest son] made the comment one day “it doesn’t matter which house we go to, it’s the same – the same – same – same, same.” And, I said “what do you mean same, same?” He said “well, I – I walk into [girlfriend’s] mother’s house and her mother’s screaming at insurance. I walk into our house, and you’re screaming at insurance... So, he said “no matter where we go we can’t escape.”

Additional stresses related to insurance included being asked to sign incorrect documents; being caught in between insurers and the trades people they had engaged and being required to attend the property to repeatedly provide access to assessors and trades people with little or no notice.

With few exceptions, participants described anger and a strong sense of injustice at the approach insurers took. Examples included being made to engage in complicated administrative processes to negotiate offers, excessive red tape, insurers making deceptive or excessively low offers or not explaining what was available to clients until they were forced to.



Insurance continued

Participants who struggled with insurance processes made comments that their frustrations went beyond an administrative burden. They described feeling lied to, bullied, coerced, diminished, betrayed and accused of lying. For some participants, the strong emotions connected to the disaster event were also tied into their experience with the insurer; having to repeat what had happened was too hard to revisit.

“ It is – and that... That’s part of why – my insurance company is waiting on me, you know, you produce papers. And, it’s not actually that extreme, but that – to do that brings up everything. I can’t separate it from any of it.”

Timeframes presented by insurance companies for repairs and rebuilding were often unrealistic or unrealised. This resulted in compounding stressors, such as leases for interim accommodation expiring or needing to be extended beyond the reimbursement period for policies, or extended separation from pets.

“ We’d phone our insurance if the claim had started, we didn’t know what the process was for a claim, so we had no idea that, you know, we wouldn’t get a scope of works. We were told by the insurance assessor, “You’ll only be able to get home in three to five months.” ... So, we got our first scope of work at the end of April. That’s February, March – three months. So, we should be at the point of moving back into the house, according to the assessor in February. Since the insurance scope came through, it was all incorrect, and I don’t sign any document that’s not correct, so I went back to the insurance company and – it’s classic. I went to the insurance company who sent me the document, “No. We don’t look at that. You have to go back to the panel builder.” “Well, you sent me the document.” “Yeah. But, we don’t deal with it.” You know, this is silly little things when you look back at it, but in my mind I’m like, “Geez” – you know, why – and, then I had to phone them, and then there was no answer, he’s busy, blah, blah, blah, for 10 – 10 days it was. And, so I just left it.”

Some participants were able to identify things that eased friction related to their interactions with insurers. These included previous experience managing insurance claims, having access to expert advice and having someone else act on their behalf to resolve their claim. In one location, an emergent group of affected people was able to come together to compare experiences with other people in their communities going through similar scenarios. Not only did this provide moral support and a sense of normalising the experience, but it also provided practical support like being able to compare claims and assessors’ reports and use each others’ cases as precedents.

“ It was a, “It’s not just me”, that’s what everyone [thinks]. “It’s just me, it’s only me having problems with my scope of works, it’s only me having issues with my insurance company, it’s only me having issues with trades coming and going”, and everyone’s in their own little bubble and they don’t realise that no, it’s not you, it’s the lady three doors up, it’s the guy around the corner, it’s the lady in front of you at the supermarket. I mean, the stories that we all – you stand in aisle five and you just cry when you see cleaning products. I do that. People don’t realise, and it was nice to sort of know that it’s – you know, I’m not going mental or insane, I’m not – you know, someone else is dealing with the same issue. So, it’s not only the financial support and being able to have the knowledge to go to your insurance company and deal with all the paperwork and everything, because this – I’m entitled to this, it’s the whole, “I’m not alone” attitude.”



Housing / living conditions

Housing emerged as another significant influence of the well-being of participants. Some participants had their homes destroyed entirely by the disaster event, while others had to relocate because of damage from the event.

Participants experienced prolonged instability, uncertainty and vulnerability while their housing situation was precarious or unsustainable. This was a major stressor in and of itself, and had significant impacts on participant well-being.

“ It was hard, really hard. And, you’re panicking because you don’t know if you’re going to get a place to live. And, that’s your biggest thing. You – you need that stability, without the support of it, you’re just lost.”

Some participants experienced significant difficulties in securing suitable housing after the disaster event and had to move multiple times in a short period. This exacerbated other stressors they were experiencing. Relocating was not only exhausting, but exposed inconsistencies in the support available to people impacted.

“ The only other thing I really had problems with was the mail redirections. Because, they offered free mail redirection for a year but when you’re going from place to place to place, they only – that free mail redirection’s only the once. And, like, yeah, the other few I had to pay for. You’ve – you’ve just got to – yeah, every four to six weeks changing address again, and that’s annoying, that really is, and half of my mail got lost.”

Participants who relied on housing provided by community services or government reported stressful and complex processes that reduced their sense of control and exposed them to convoluted and difficult bureaucratic processes.

“ There was other things like housing and – and housing that’s a, bloody, nightmare too. I mean, you’re going from temporary, temporary, temporary until they get you a place, but when you normally apply for housing you’ve got – you can choose so many areas, that sort of thing. After the flood, because of the big need you weren’t allowed to choose, you just got what you got. And – because, you know, I – I have health ailments, I don’t drive so I need to be near transport, and I had to get to and from work. I actually – I broke down in housing and they ended up giving me this place. Where they were going to put me, there was no buses from there to [name of suburb], well, that’s only a ten-minute drive (but) there’s no buses. So, I wouldn’t have been able to get to and from work. But housing were going, ‘tough’. There’s a bus stop near the house, yes, there was, but it doesn’t go to where I needed to be. And, yeah, they were really narky about it. And, the temporary places you stay all – you have to sign a lease, because the lease says “duration of need” and the conditions of that duration of need was you had to take the first offer from housing and if you knocked it back, you still - you couldn’t even stay in the temporary accommodation. You had to get out. Okay. So, like, we were scared of being homeless. We really were. And, then we finally got this place in October and - we’re still trying to make a home out of it. Well, that’s a good – you know eight months from [when the disaster destroyed their home]. And, when you’re not getting mental health help going through all that, it’s... well, I was so close to a breakdown.”



Housing / living conditions continued

For some participants, traumatic experiences of the disaster event influenced their future housing priorities. They expressed being fearful of finding themselves in a situation where they may be exposed to another disaster, and were basing housing decisions on trying to avoid this. This was described as being a fear-driven, exhausting process.

“ So, we just feel so powerless over finding a – a – a new place to live and we’ve – we’ve totally narrowed our scope of where we can live so that’s – you know, that’s our doing ‘cause we don’t want to live in the trees anymore. And, I’ll tell you how we did it. The [state government] has a geospatial mapping thing. And – and in there, they have a hazard. When you put in an address, it has a hazard. One – one Saturday, there were 25 properties... and I put each address into the geospatial mapping and guess how many weren’t in a acute fire zone? One.”

Participants living in unsuitable conditions reported their environment as not only having a detrimental effect on their mental health and well-being but also on their physical health. For these participants, the housing situation following the disaster posed a threat to their safety and sense of security. For some, it was the physical living conditions that were a threat (e.g. mould, exposure to parasitic infection, cramped living conditions, housing not able to accommodate medical aids). For others, it was the complex situations they faced as a result of not being able to quickly secure accommodation after the disaster (e.g. living with an ex-partner, being isolated or not having any stability).

“ And, that was for us, wasn’t it? I mean we waited for so long. Eighteen – eighteen months I think by the time they [helped]. We didn’t have hot water for six months. No shower. No hot water. The shower went through the floor. I tried to pull – pull it out and try and patch it up and I had nothing to patch it up with. You stand in the shower and it’s like it was on a lean. Like a fishing boat under the jetty. You had to lean forward. I thought it’s going to go through the floor. It’s just on the panel. But, we – we got through it though. We got through it. But, the hole in the floor because the doors all swelled up - we had to get rid of the doors. So – and I – I couldn’t sleep and thinking, god, there’s going to be a crawler come up through there, you know. Like a crawler. Maybe a snake. It was horrible. was horrible.”

Some participants reported unsuitable and unstable housing having negative impacts on family dynamics. Some examples that participants reported included increased exposure to family violence, diminished ability to care for their loved ones, and family separation due to cramped conditions. These situations were all described in the context of longer-term strain on relationships.



Housing / living conditions continued

“ ... it’s pretty dire because my partner couldn’t come home [from hospital] because they wouldn’t let her out until she had somewhere to go and things like that. She didn’t have a bed – like, she sleeps in a recliner chair and she actually needs one of the – the only time she hasn’t been in pain for that has been in the hospital with the hospital bed. So, we’re – we’re chasing down a hospital bed. It won’t fit in the [temporary accommodation] however. So, there has to be – so, she’s sleeping in a recliner chair but at the time the chair... the chair was here in [the temporary accommodation] but it was too cold so she slept in the car... The cramped confined – it’s really – it’s difficult living on top of each other so closely especially when we’re – I mean we get on all right but, you know, at tense moments when things are going wrong it’s – it is – it’s much – it’s heightened because there’s no – there’s no space... And, I don’t have anywhere to sit in it. So, I’ve got like just a bunk bed and she’s got a chair and there’s nowhere for me to sit. So, I just basically sit on the bed. And, I did my back last week so that’s not a good thing to be sitting on the bed... it’s not right.”

When participants were able to move into secure or permanent housing, they described an enormous relief to their stress. Having secure housing provided a sense of stability which had a positive impact to their mental health and well-being, though some participants noted that feeling settled in their new home took longer.

“ And, you know, I guess I’m like, “Wow, we have come through at this end.” You know, we’re not – you know, we’re – we’re not normal, but, you know, we’re – we’re so much better than what we were.”

One participant described having to move back in with an abusive ex-partner, who threatened loss of access to their children if she tried to leave because she had no stable accommodation after her home was damaged in the disaster event.

“ [I’d say] No, this is my ex-partner. We are not – because I’d already had the big dramas with Centrelink because, like, we weren’t divorced – formally divorced. So, now we were living together in the one house, we had to fill in all the different forms. He refused to. (He’d say) If that’s the case, I can get out. He’ll keep my [children] because, you know – and it was just like – and so, I had all that as well going, you know?”



Subsequent health impacts

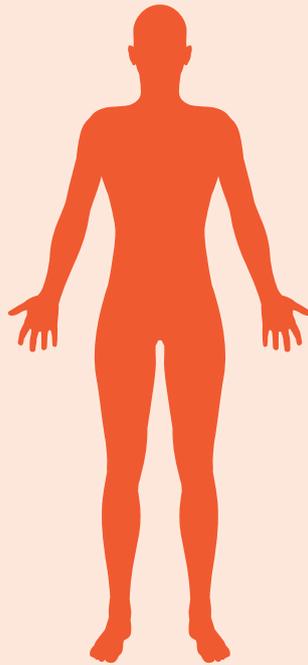
Participants identified a range of other health problems that were attributed to disaster related stress and living conditions which impacted their mental health and well-being.

Participants identified an array of health conditions including:

Respiratory and cardiovascular issues such as pneumonia, asthma and heart palpitations which were linked to both stress and post disaster environment, especially mould.

Neurological disorder exacerbated by stress.

Sleep disturbances.



Parasitic infection.

Significant **changes to weight** (gain and loss).

Injury from clearing debris which required surgery.

Increased use of **alcohol**.

For some participants, an additional stressor to these disaster-related health impacts was being told they had insufficient proof these health impacts were linked to the disaster. Struggling to provide proof further diminished their sense of well-being and support, and in some cases had practical implications for breaking leases and insurance claims.

“ So, [months after the disaster, a doctor] put me on the strongest medications for pneumonia he could put me on. I came back here, and that process continued. And, now I’m on an antibiotic every day, and he thinks it probably will be for years... And, those things wear you down psychologically. Okay. Initially, we – you know, the comment was made “you can’t really say that came from the flood.” But - you know, being left in the house I can, because my children have got the same cough. And, I noticed my cough stopped, because I’ve been to the respiratory specialist and I’m on an antibiotic. But, my [child] has got it. Right. Okay. You know, it just sounds like a whinge fest sitting here telling you this.”

Service access and attitudes

Stress related to administrative processes or 'red tape' was identified by many participants and was described as having a negative impact on mental health and well-being. Examples given included:

- Complex referral processes to access services.
- Arduous negotiation processes with local councils and insurance companies.
- Unclear eligibility criteria for assistance.

The experiences of trying to negotiate through red tape or the feeling of being let down when eligibility for support was rejected on a technicality were described as frustrating, exhausting and demoralising. Conversely, where participants had positive experiences of seamless administration processes, or interacted with a service representative who navigated the complex process on their behalf, they described not only the absence of stress, but relief and empowerment.

“ Okay. So, probably one of the main things I came – that I’ve noticed, personally to start with. From the monsoon, the biggest mental health help that I believe we’ve received, was that \$75,000 grant that was given. No frills. Right. Four pages. Tick and flick. It doesn’t happen ever. That... that you’ll see some form of assistance to be done that easily.”

Some of the participants highlighted that individual workers had inconsistent approaches and could act as gatekeepers to services. Some participants described experiences where one worker in a service advised that they were ineligible for support while another worker assessed their situation differently and was able to find ways to get them help. While the participants appreciated the efforts of the second worker, they expressed frustration at the inconsistency and the element of 'chance' that seemed to exist when it came to accessing support. Examples included eligibility to accessing housing support and financial aid, and inconsistency with insurance assessors from the same company.

“ And then, another lady rang and said, “Well, you know what? I actually don’t think you’re flood-affected at all. You chose to leave the house you were in”... and, it was like, “What?” Like, who in their right mind would do that? And so, we really – I – I battled between going to places and being – one person going, “Yep,” you know, “Totally. You – you fit the bill. Like, we can help you.” Others are like, “Well, no.” And - you felt – it sounds like it was like you were making a fuss when you shouldn’t have been.”



Service access and attitudes continued

While some participants noted that they were aware of processes to renegotiate or challenge decisions from services that rejected or reduced their access to support, they described feeling too depleted to be able to fight back. The process of challenging decisions was arduous, time consuming and energy sapping at a time when participants didn't feel they had capacity.

“ On the Sunday, I got a phone call that said, “We’re running your car up for market value with the kilometres, with the condition of the car”, blah, blah, blah, “This is the amount that will be in your account. Are you happy with that? It’ll be there in two to three days.” Then, I hear through the [community support] group, “No. They said no, because that was wrong.” And, other people just – you know, like – one – they were offered – the son’s car was \$19,000 for a Jeep. I mean, I don’t know what the price of cars are anymore. He got \$43,000. So, when you think – you’re an insurance – you’re – you’re an expert, this is your field, why are you being dishonest to me as your customer? Why aren’t you just offering me that \$43,000 to start with? So, I’m thinking well hang on, you know, we had a [model of car] – yeah. It was nine years old, it’d done 35,000 kilometres. Nothing. It went to the tip, and that was it. It had one scrape on it, and a brand new set of tyres were put on it, so we spent – you know, there’s nearly \$1,500 on tyres, it’d been serviced every year, and we got \$7,000 for it. Were we done by? I could have contested it, because I had 12 months to do it, and I was like, “You know what? I just” – I was still dealing with the house, we hadn’t even got the house started yet, and here we are – you know, we... there’s so much to do.”

2. Relationship related stressors

Some participants described their partners, family members, friends and colleagues as being their biggest supports in the post-disaster environment. Where people described this, they identified both emotional and practical supports provided by the people around them, and identified that this was incredibly helpful.

“ My husband has been absolutely amazing. He’s been like a rock.”

However, a number of participants identified the stress relating to their close relationships as particularly difficult and burdensome. Some participants described an increase compared with pre-disaster caring responsibilities and found this difficult to cope with at a time where they were already feeling stretched and depleted:

“ She loses it a lot with me because it’s sort of like, well you know... I mean she needs more help. It’s not just the [disaster]. I mean the [disaster events] have made it harder – if it was just dealing with health. I mean health’s difficult to deal with but with the [disaster impacts] and living how we’re living it’s just – it’s, you know? It’s hard.”

Others attributed negative changes in their relationships to the disaster events and subsequent impacts. They described struggling with caring for their loved ones while struggling themselves, feeling helpless to help their family members, and as though they were on the receiving end of their loved one’s pain, anger and frustration in addition to their own stress(Harms et al., 2020).

“ I think – I think the one thing that is helplessness. Also understand too, within – within a relationship too, it’s even worse because I – and this is – this is my stuff, I’m suddenly – find I need to be the one who’s stronger. Now, whether that’s a real or perceived but it doesn’t matter. That’s the truth... You know, and her pain is anger and unfortunately what happens is, in a relationship, the only person who’s there is me, so I’m the one that wears the brunt of the anger. That in itself wears you down in some regards so when you’re starting to talk about trauma and all of these things, you – you understand that in a family, you know, you’re – you’re enclosed in a situation...”

Some participants voiced concern that the strain in their relationships stemming from the stress and tension linked to trauma, and aftermath stressors such as cramped living conditions would have long-term impacts on their relationships.

Two participants referred to experiences of family violence in their interviews. The experiences described were illuminating in relation to how disasters can force women and children who have previously left situations of family violence back into these environments, how a fragmented service system may exacerbate the difficulties faced by women in post-disaster settings who are vulnerable to family violence and the importance of family violence services being enhanced after disasters and included in disaster plans. Issues identified included disaster affected women’s vulnerability to job loss, inability to secure housing, fear of losing custody of their children because of precarious housing, having legal documents and accounts in joint names (requiring ex-partners signatures) and services being physically inaccessible to attend without exclusive access to a car.

3. Impacts on workforce

A need for professional support for workers in disaster affected communities emerged as a theme from the interviews. This was reported as being a gap not only for those working in mental health and well-being support roles, but also for workers in client facing positions who found themselves in the role of 'accidental counsellor'.

“ So, my [son]... he's a tradesman. So, he's – he said – came home – came home one day and he said “I'm – I'm not – I'm not an electrician anymore.” And, I said “sorry?” He said “I'm a social worker.” And, I said, I said “what do you mean?” He said “well, I walk in to every job site now, I've got lollipops for the kids to stop them screaming and to give their mother a bit of a break, a bit of a break. I spend the first 15 minutes of every job site to do with the flood where I'm holding a woman while she – while she sobs.” He said “I'm not - - -” No. “I'm not an electrician anymore, I'm a social worker.”»

Emergency service and disaster recovery workers expressed frustration about the disconnect between the understanding of the situation by their head office colleagues and the reality in their communities. A number of participants who were in professional roles involved in the disaster response or recovery efforts and were also personally impacted reported feeling disappointed and let down that their organisations had not been more supportive. They described difficulties in accessing appropriate support, and eventually having to go around their organisation's policies to organise support for themselves and their colleagues.

“ But, I have to say it's only been this week that my employer has provide – it was last week actually [eight months after the event], was the first time I got any profession support– like, formal debriefing or supervision provided to me and we've had to fight tooth and nail so my team that I looked after have had nothing until this week.”»

The impact on mental health workers who were also personally affected was apparent to some of their clients. One participant described the burden of feeling like they had to support their counsellor who was also personally affected. They described receiving inadequate and unprofessional assistance due to the strain on the mental health worker, but also feeling like they couldn't provide the feedback.

“ I found it really difficult because I'm suddenly now placed in a position where I've got to speak to her [mental health counsellor] and what, do I tell her the truth or do I not? Do you understand? I end up having to carry more – I know this sounds – sounds... It's an issue – it's like suddenly I've got to turn around, take on – I take on board the fact that I have a counsellor who is struggling herself and it means suddenly, I've got to take that on board as well. And – and – and it's – I suppose it's our age group, you know. It's – it's like we were raised to try to make sure we don't hurt other people's feelings. Dalai Lama's argument is that sometimes a lie is – a lie is justifiable because, you know, you look at it – what's the truth – the truth hurts and it – and if there is no point at the end of it and if the person's struggling who's the counsellor, I mean she needs to understand that herself but is it her role then to – to tell her. I mean, I find that so hard.”»

4. Compounding disasters

All participants were impacted by more than one disaster, to a greater or lesser extent. In addition to the monsoon / flood or bushfire events (the focus of this study) all participants were impacted by COVID-19 restrictions. On top of this, some participants had experienced other disasters, including prolonged drought, fire events in recent years and one participant noted being impacted by a disaster earlier in their life.

While some participants described minimal, manageable disruptions as a result of COVID-19, for others it was particularly grueling. Strategies participants had been using to engage their natural support systems when recovering from the monsoon / flood or fire event, such as seeing friends, attending recovery related social events, continuing to participate in group activities such as sports teams and bands, and doing things they enjoyed such as seeing live music or getting away to have a break from being surrounded by the disaster impacted area, were all removed by pandemic restrictions.

Some participants described the isolating effects of COVID-19 restrictions as even more distressing than other impacts of the disasters they had experienced. There were descriptions of compounding effects – as though COVID-19 had removed all of the remaining normal or positive parts of their life post-disaster which they had been relying on.

“ [COVID-19 restrictions] has been shocking. That it is worse – that is worse emotionally for us than the bushfires. The bushfires, we – the bushfires, you coped with it because it’s – you just have to and you have supportive people around you. You – you can go and visit people, you can – bit of normality back in your life, given the fact that you’ve lost all the normality that you can possibly have... We – we’ve been hit with everything, you know. Not only do we get hit with the bushfires, people losing homes, but we also got hit with bushfires which meant economically, we’ve been devastated. Then we get hit with COVID which is even worse... I suppose, you know... there’s an – you – you can – [with the fires] you’ve lost your house but at least you can get back into your life... [With the pandemic restrictions] we’ve lost our normality of our life.”

A number of participants reported that COVID-19 restrictions meant they lost access to information and services they felt comfortable using, especially where there was a reluctance or inability to engage with online support. Further to this, some participants described feeling abandoned by services.

“ I think that when COVID arrived I felt – we felt pretty – we felt dumped and – and just not, I suppose, forgotten I think we – we felt and I think if it hadn’t been for our local community fire bush recovery centre and the person that’s working so hard there, without that person, I don’t know. But, then she eventually had to close and restrict it too because she was bound by – bound by the – the rules that govern that too. So – but, yeah. At that time we felt everyone went away. [Demolition and clearing services] went away. All the help, all the support, everything went away. Everyone just gravitated to their homes and, yeah, it was pretty – a pretty – quite distressing in a way. It just felt like well, here we are and there’s no one around anymore.”

In addition to the impacts of COVID-19, a number of participants referred to other disaster events, mostly in frustration. These participants described mistakes and stressors that they attributed to poor coordination, planning and workforce preparedness, and which should have been avoidable if lessons from previous disasters had been implemented.

4. Compounding disasters continued

- “ What surprises me too is that this kind of community development stuff and the models and all that kind of stuff, they’ve been around for decades. It’s not rocket science but it’s, you know. There’s a whole lot of kerfuffle and like, people look at me and think sometimes, “How did you know that?” I mean, the World Health Organisations have had these models out for decades. They’re in our national mental health plans. You know, Maslow’s hierarchy of needs has been around forever. And the Social determinants of health. It’s just not... it’s not rocket science.”
- “ I’m – it would be good – at what level of Government, I have – no, it has to be at the top and then work down, that you have a process – I’m sorry but recovery after a disaster should be pretty much down pat by now and yet every time it happens, the wheel is reinvented and I can’t see why it has to be like that... And, you know, they say this happened at the Black Saturday– the fires in Victoria. Well, actually, yes, it did so what was learnt from that and what has been put in place so that when the next one happens, this is what the people who are impacted need from the people who are impacted, not from someone sitting in an office thinking this is what we think they need.”

Some participants also expressed a sense of perceived injustice at the inequity of support provided to those affected by different disaster events. Bewilderment and frustration were apparent when the differences in financial support and other services between recent events in the same region were described.

- “ I feel a lot of frustration now, looking what people are going through, like – and my understanding was that, after [2018 Tathra] fire, it’s been a really disorganised recovery process – at the recovery process for this current fire – the 2019/20 fire – I thought it was going to be a lot smoother, but that’s not actually what I’m hearing, and – and there’s really no reason that it shouldn’t be a smooth-sailing process for everyone, after what we’ve been through. The other thing is the – the other frustrating thing that I have as well is that, you know, we’re still currently in exactly the same situation as a lot of the people that are in the 2019/20 fire, yet we’re not entitled to anything flowing from this 2019/20 fire. I mean, that’s any bushfire grants, monetary grants, physical assistance grants – even the building support grant... It’s like – I – I can’t see the difference between, you know, the fires only – you know, it was only 12 months before, you know, being any different to – to the current fire. If you’re in that situation, the assistance should be there for you.”

How participants described mental health and wellbeing and navigating support pathways

Participants described their mental health in the years and months after the disaster events in a range of ways. Some participants focused on discussing the state of their mental health explicitly, and described specific symptoms.

“ I’d reached my full-on breaking point... and I was – I was a mess. I wasn’t – I wasn’t leaving the property we were on [much]...and then I’m in Bunnings with two friends and I had a panic attack in Bunnings.”

Most participants described their mental health in non-specific, broad terms relating to the interconnected psychosocial impacts of the disaster and how it affected their lives generally.

“ We’re, like, every day you get up and you think... And, then something goes wrong. Right. And, then you do it again every day. And, then something’s wrong again. That’s exhausting. It is exhausting. Mentally exhausting. It is huge. And, we get to a stage where we – we are both frustrated. Yeah. You know, and stuff it... I’m not doing anymore... The hell with anything.”

Participants described their mental health as fluctuating over a prolonged period of time. When there was uncertainty in their environment there was a sense of instability in their own mental health and well-being.

Most participants referred to being emotionally and physically depleted.

This made tasks feel harder and more overwhelming and reduced feelings of positive emotions and experiences such as joy and humour.

“ I’m very conscious of rebuilding my mental energy reserves and moving – moving past this... I did notice the more I became exhausted, emotionally I was just bankrupt. And, nothing I did could change that. I just had to chug along.”

Suicide attempts and suicidal ideation

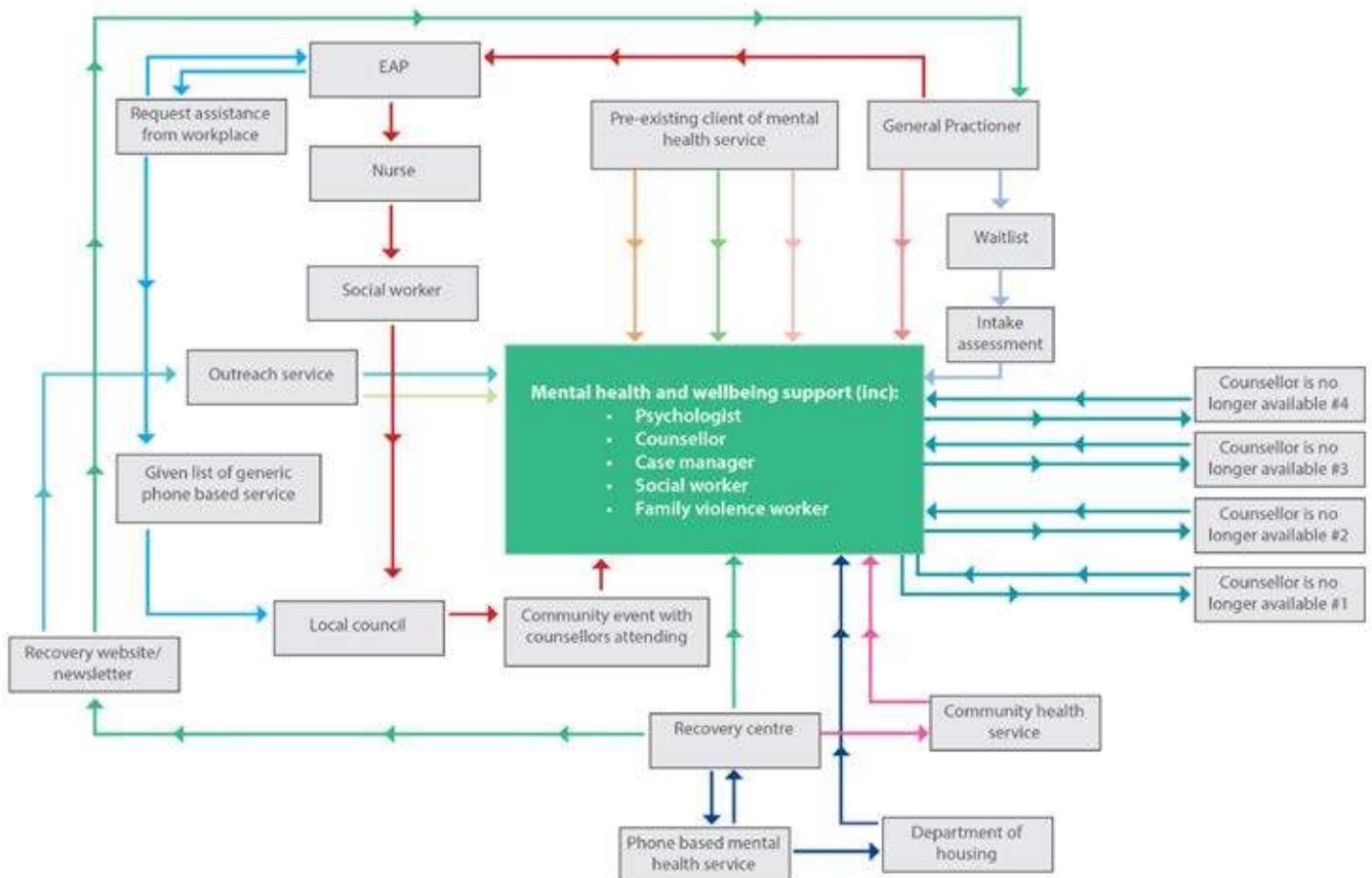
Three participants raised that they had either attempted suicide or thought about suicide in the post disaster period. All three participants who discussed suicidal ideation referred to feeling exhausted, worn down and helpless.

“ ... there were cases in the early days that all I wanted to do is swim out from the beach and not come back and I actually tried once except God had a different plan and he had a bloody swell coming in. It kept knocking me back to the beach which I wasn’t impressed with.”

Help-seeking and navigating support services

The participants who identified they had sought assistance for post disaster mental health and wellbeing described a wide range of ways they accessed help. Their descriptions highlighted the importance of a coordinated service system and multiple entry points to accessing assistance. Some participants described a straightforward pathway, while for others, accessing support was a complex process that involved 'false starts'.

Below is a diagram depicting the steps participants took when accessing mental health and well-being supports.



Delays and barriers to seeking help

Delays in seeking help

Some participants accessed mental health and well-being services reasonably soon after the disaster event, but many participants discussed a wide range of reasons for delays in seeking help for both practical and mental health support.

Delays in accessing services had practical implications for participants trying to get help in the months after the disaster event. Some services had a finite amount of resources which they allocated on a 'first come, first served' basis, which meant that anyone who either waited to access support missed out. Other organisations based their operational plans for long-term service provision on the initial demand and did not account for delays in requests for help. This resulted in organisations either assuming their services would not be required in the longer term or having insufficient levels of support available.

“ And towards the end of that week [approximately one month after the event] they'd [city based FIFO (fly-in fly-out) mental health team] decided that there wasn't a need here [rural farming community]. Because of course they weren't going out of town. Well they probably couldn't get out of town. And people from around here couldn't get into town. They had carcasses at their back door. Blocking the exits.”

Barriers to seeking help

Participants identified a range of barriers to accessing assistance for health and well-being in the period after the disaster.

Not knowing what services were available

Some participants noted in their interviews that they were unaware of the services available or where to look for support. Even once they had identified a service, some participants were unclear how to get access to them.

“ We didn't know it was there, we didn't receive any information. I looked it up. I said to [family member] “There's got to be somebody that can help us, you know” There's got to be someone who can give us a hand. [I borrowed] someone's laptop and I brought it up on that. And, I actually looked and I thought these people can help... By the time we go there it was too late anyway. But, we – we started from that point on.”

Barriers to seeking help continued

Competing needs

Many participants described competing needs following the disaster event which forced them to prioritise some needs over others. This resulted in a delay to access some types of services while addressing other issues first.

“ ... I wasn't happy that four months after, we're throwing out our own contents, and I'm paying \$16 a ute at the tip. I couldn't tell – it went on credit card. I couldn't tell you how many trips we've made. Hundreds and hundreds of dollars. So, I asked for tip relief. And, I was told, well, we should have got it done in the couple of weeks that we had for free tipping. But, we were busy helping everybody else.”

Overwhelming disaster related workload

Many participants described the overwhelming workload related to the disaster as a barrier to accessing help. Even where they knew they needed assistance, going to get help felt like another burdensome item on their list of things to do.

Perceiving services as unsuitable

Some participants identified services as unsuitable for a range of reasons, including being culturally inappropriate, being offered at the wrong time in the recovery process, being a fly-in, fly-out service or having insufficient or erratic staffing levels.

“ They [fly-in, fly-out government mental health service] had very strict boundaries about who they could see. Very strict boundaries. And, then these people weren't so rigid about it. They would tell me “I can't go off road. They have to come in to see me, I can't go off the highway”. And, I'm like, are you for serious? And, he was like, “Yep.”

Waitlists or complex processes to access services

Waitlists and complex intake processes presented a barrier to some participants accessing the services they needed, when they needed them.

“ My biggest thing is it took me eight months to find help. Because everyone was told right from the start, “You need a mental health plan and a referral from a doctor.” There were so many people in waiting lists, it was months and months for an appointment just to see the nurse for that initial interview. Nobody was getting the help, because there was too much need and no one knew where to get it, and I didn't know about the Recovery Services.”

Physical barriers to accessing services

Participants identified physical barriers to accessing services included disaster affected infrastructure, such as damage to roads, cars and public transport, and either no access to or disrupted access to technology. Participants also reported that pandemic restrictions also impacted access.

Uncertainty regarding eligibility

Eligibility criteria for services that was not clear, or was interpreted differently by different staff was a barrier to participants accessing support.

Concerned that 'other people' needed help more

Concern for other people impacted by the disaster event emerged as a concern for participants, who described being reluctant to use services in case they were taking it away from someone who needed it more.

What helped?

1. Practical support

Practical assistance which met the direct issues and stressors facing participants was not only a source of support but also reduced escalating, compounding stress.

Some examples of practical support identified by participants included acts by family, friends and neighbours such as helping to organise accommodation, finding a replacement car, and replacing fencing to keep animals in, and meals.

Practical support from service providers was highly valued. Examples included accommodation services, financial assistance and assistance with completing paperwork and other complex administration processes. An important benefit of service providers being able to provide practical support was that it met the immediate needs facing those affected. Once these immediate needs were addressed, participants described being able to move past these issues, to tackle bigger or more complex issues they were confronting.

“ ... you're dealing with people who are traumatised and it's very hard for them to – to say what they need because they're only looking to the end of their nose. They're – they're – they're going to give you their immediate need and that might be food, a lot of it would be a roof over their head.”

Rather than an indication of learned helplessness from having services undertake tasks, participants who received practical, flexible support expressed how much easier it then became to do other things, as though they had been energised or given a 'boost'. Having their needs addressed in a proactive, coordinated and effective manner reduced a sense of paralysis from the overwhelming nature of the aftermath workload they were trying to manage, and reduced a sense of helplessness and isolation and helped reestablish a sense of self-efficacy and control.

“ And, there was a – a case worker. She was amazing. And, she's just like, “Whatever you need. You know, I'm here to listen to what you need.” Not telling me what, you know? And it was also – “What do you need today, right here, now?”... And, that was just huge, because you know, I guess [other services say]– “Okay, well, I can do this, this, this – which one?” You know, you – you'd – you – if you didn't fit into those... they go, “Sorry, can't help you.” So, [caseworker] had done a referral to [housing assistance agency] for me, and in between, she – she also started dealing with my insurance company. She goes, “Sign a release. I can call them.”... She just said “You know what? Sign it over. I'll call him for you.” And, that was just so – it – believe it – it was, like, so empowering that I didn't have to fight everything on my own.”

2. Appropriate, supportive and consistent services

Services that were considered helpful by participants were:

- Welcoming and approachable.
- Flexible.
- Proactive.
- Well integrated / connected with other services, including non-disaster services.
- Easy to access.
- Made people feel validated and cared for.

Proactive services

The need for proactive, context appropriate, well-coordinated, connected, flexible services was highlighted repeatedly. Where services were coordinated and proactive, this was highly valued, not only because it addressed the participants' needs and eased the burden of their aftermath related workload, but the proactive connected nature of it made the participants feel validated, supported, understood and cared for.

A number of participants recommended proactive services as a way to promote access to services before issues escalated, and as a way to ensure people knew there was help available.

“ I think it would have been good right from the start to – and, you know, with future things that happen to have like a case worker right – right from the beginning to be guiding people and be able to go through that process with them. And, maybe if you could not have to go through your story so many times to different people. And, if it was just one person and that you were their case so – and they – they had all of your information and then they could follow up things or they could put you onto say, right, your next step is you need to ring this person or – not saying they do it all for you because I think that there's some – I think to be able to take some control and do things for yourself is good too. But, I think just in guiding, because it just – it just – it looks insurmountable from this point.”

“ ...the mental health people when they did their regular call, and I wouldn't talk to them. And then, they came to our house. And then, asked – asked me if they could go then. I – actually, when they came to my house, I didn't open the door for them, but took a long time for them to leave. So, I – I thought, “I'll just open.” And then, they asked me to – that I – if they could come back to the house. And, I said, “No. No. No.” And then, eventually, we decided to meet at the café. That was with the counsellor. I said, “Okay.” And, I – I just said okay just to tell them, “Okay.” And then, I – I was thinking I was – I wouldn't go there anyway. But then that's also the time when I thought, “I'll probably go then.” Because, you know, I was already not functioning well at the time, and I felt sorry for my daughter. So, I went to that. And then, since then, I realised that that was a big help for me. And – and, I – yeah. The – the support from the mental health was the biggest help that I got.”

2. Appropriate, supportive and consistent services continued

Coordinated and flexible services

Participants rarely described seeking a particular service – rather they described more generally looking for some ‘help’.

A number of participants identified roles of ‘brokers’ or ‘fixers’ as invaluable. In some cases, these were people in service coordination roles, social workers, recovery centre managers, case managers or insurance brokers. They were people who were able to provide practical support, ease administrative burdens, solve escalating issues and connect participants to the range of services that met their needs. People in these roles had flexibility to address a wide range of issues rather than being confined to only addressing one facet of the participants’ needs. The people in these roles were described as being proactive, warm, empathic, kind, welcoming and efficient. Even where the service system was not especially well coordinated, these individuals were able use their knowledge of the available supports to navigate barriers and make the most of the help available for the people they helped.

“ I put the applications in only because [government agency] were amazing. Right? And [name of government agency worker] was the most amazing person I’ve – and if anybody was to get an award – you know, Australian of the Year, she’s – she’s up there in my opinion. She certainly needs an – an AO because of her compassion, her dedication and her dogmatic approach to just getting stuff done for you, ... So, what happened was, putting it in, she – she generated me enough to go and get it – put the insurance – ‘cause just did it.”

Looking for help, rather than a specific service

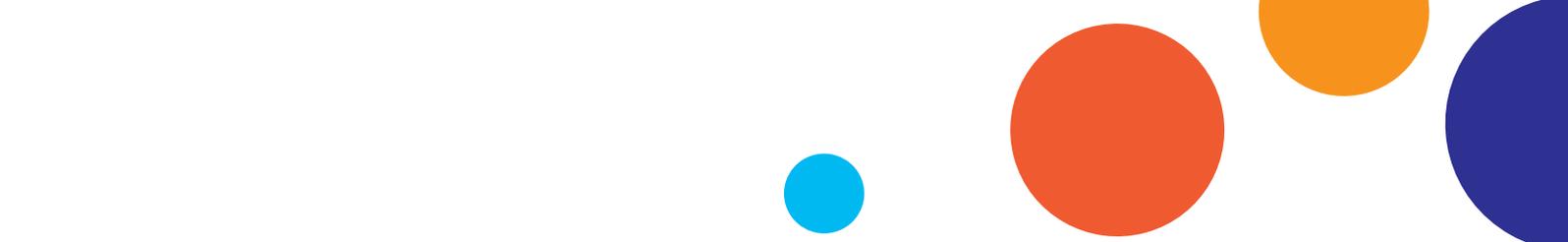
Some participants, particularly those who were not experienced service users or service providers themselves, struggled to differentiate between different organisations and departments and did not understand how services were connected. This was a significant point for a number of participants as their experience with one organisation could influence whether they felt supported or felt as though there were no suitable supports.

This is important for organisations to understand. While services may be separate, most participants viewed them as being bundled together; a good experience could lead to positive overall assumptions about support available, as could a negative experience. It is imperative that support is coordinated as people who have been affected may not be able to distinguish between individual services.

Participant A: “You know, [I want to give] – a plug too from Salvos in [town name]. I – they gave us something and I can’t remember everything they gave us now. Whatever – whatever you could get from them, we got. I think it was a – a grant.

Participant B: “It may have been Vinnies you’re thinking of.”

Participant A: “Or maybe it’s Vinnies.”



2. Appropriate, supportive and consistent services continued

2.2. Coordinated and flexible services

When participants found a point of support that was a 'good fit' for them, they tended to go back to that service for multiple needs. This included non-disaster related services such as community houses or GPs. Where participants were able to return to a single point for a range of needs, their access to services was often smoother and more efficient.

A significant point of frustration for some participants was where services were not connected together, or where the services were too inflexible to adapt to the need of the participant. This lack of coordination and adaptation created administrative burdens and deep frustrations for those affected.

“ So even when I approached [government housing department], they said – “Okay, well, hang on a sec. We can get you a couple of nights somewhere.” And I said “Great. Then what?” And they said “I’m not sure.” It’s like, you know, for us, I couldn’t do that. And, it – and, it is – it’s – it – it comes down to – there’s no – there’s no central anything. And, even then, when we moved, they [community housing organisation] told me, if I can find a place that they can give me a week’s rent. I’m like, “Awesome.” So, we found a place [through a different organisation] and went, “Hey, can I get that funding.” They went, “No, they’re community housing like us, and we’re not paying another organisation.” ...What if that was the difference between me getting the house or not? They didn’t care. And then, the other thing was, again, government guidelines. So, when I was moving into here, because all my stuff was in storage, [community organisation] could pay for two movers for something like six hours to move my stuff in [up to \$800]. But they couldn’t do it ‘til the Monday. That was the day I was starting the new job, and to me, the job was really important. And, I’m thinking, “Well, how bad is that on your first day?” And so, I said, “Look, I can’t do that, but, hey, I can get some people to help. We’ve paid \$400 to rent the truck. Can you reimburse that?” “No.” Because they’ve got strict rules.”

Appropriate services for the community context

A number of participants highlighted a need for services to be context appropriate. Some participants acknowledged that there were a number of disaster recovery mental health and well-being services available, but they described them as unsuitable and not fit for the community need. This was especially apparent in communities which had struggled to access services prior to the disaster event. Services which were not culturally appropriate or those with rotating fly-in-fly-out health workers, especially those with little to no experience in the communities they were being sent to were mostly described as unhelpful and a lack of flexibility from state level coordinating bodies was described as frustrating.

“ The Aboriginal community is [faring] worse. There are those of us who are comfortable using mainstream services and there’s those of us who would prefer to use a more culturally appropriate service. One of the things that we saw, a lot of services came from out of town, well-meaning, well-intentioned, but they were not local, they were not culturally appropriate, they were – they were non-Aboriginal and a – and while they – they meant well, not being a localised service, not being from here, I don’t think people were comfortable to approach them. So, some were, but not everyone.”

Where existing services were able to be enhanced, this was generally seen as positive; it meant service providers had existing trusted relationships within the community and understood the context.

2. Appropriate, supportive and consistent services continued

Welcoming approach

The approach of services, be they private companies, government agencies, not for profit organisations or community sector organisations, had a significant impact on whether participants felt like they would return to the service, recommend others use a service, or consider pursuing help-seeking.

Where services were welcoming, participants reported a broader sense of feeling supported.

Participant A “But, anyway, they helped us out. They helped us out. They do. They have a fabulous service. Right. Right. For everybody.

Participant B: “And, not – you could not fault one of them. No. And, they were – there are a lot of people that. As soon they see you – if I pull up and I – I start walking into there they come straight out.”

Participant A: “[and say] “How you going?” “Good to see you.” You know, I’m popping in - They just make you feel so welcome. They have a chat with you.”

Participant B: “No, they were brilliant. They’re so friendly.”

However, when participants perceived services as unwelcoming or judgmental, they described a sense of diminishment.

“ It was – it was just hard, and not having somewhere to go – and, I’m – you know, there – there are so many people needing help at the same time, and I felt like, well, I’m being selfish if I’m trying to push that I need help, because there are people in worse situations. And then – I said, then, sometimes, you – it’s almost like you swallow your pride and just go, “Look, I’m going to go in there,” and some of the people are just - You know, they make you feel like crap, and you walk away going, “Well, I’m not doing that again.” Just the way – as I said, I – I was sick of hearing, you know, “Well, you know, you seem pretty articulate. You can explain this. You know, you’re capable. You know, there are other people who – who aren’t.” And, you just go, “Yeah, but now – right now, I’m not functioning.” You know, I was just getting by.”>>

It is important for services to meet the most pressing needs identified by those affected.

The perception that participants had of services was important in how supported they felt, both in whether they felt like support was available, and whether they perceived they would be helped. An interesting, paradoxical theme emerged whereby some participants were simultaneously adamant that services weren’t available while also naming / identifying services available. Our analysis of these interviews led us to surmise that for participants who were feeling overwhelmed and distressed, unless it felt like there was a service accessible to them that met their specific / particular need/s at that time, it felt like there was ‘nothing’ there. While their own transcripts show this is probably not the case, it is important for services to understand that this perception of support can be as important as receiving support. Where participants perceived there was no support, even if they could identify services, they described feeling misunderstood, invalidated, powerless, angry and isolated.

3. Feeling understood

One of the themes that strongly emerged was how helpful it was to connect with people who 'got it', be they representatives of formal services or being around others who had also experienced the disaster event and the subsequent impacts. Participants explained that people who 'got it' understood that life had been dramatically altered by the disaster and did not require participants to explain the impacts to their living situations, practical issues or their emotional fluctuations. When participants described people who 'got it', they expressed a feeling of being understood and validated. Interactions with people who 'didn't get it' were described as exhausting, frustrating, diminishing and maddening.

“ ... it's interesting because you don't relive it with people who've lost everything. And, I think people looking in from the outside would argue the opposite. Their perception would be, "Look at all these people in there. They're – they're there feeding off each other's loss." The truth is, we – we aren't. The truth is that people who haven't are actually feeding off our loss because they want to know what it feels like. They want to know what our journey's doing. They want to know what it's like and that's just a human nature, but what they don't understand is – is that by that position, they're the ones that are feeding off what we've lost. So, if you imagine that when you give away your feelings – right? There's – there's a cost. So, suddenly you – you know, you give something away, you always have to pay a price. So, every time you tell your story, you're giving a – you're giving away a bit of your story but what's happening is you've got to then relive it.”

Participants noted that not only did some people not understand the experience of the disaster, but they also had a misunderstanding of what could be expected to come after. Examples included 'outsiders' not understanding:

- How long recovery took.
- Assuming that if you had insurance you would have all the money you needed.
- Items of importance could not all be replaced.
- Experiencing significant loss extended beyond bereavement.

“ [Soon after the event] there's still adrenalin going and it's like, you know? And, people say, "Sorry, you lost your house." And, you go, "Oh well." You know? People say things like, "Oh well, you know, you made it out. That's good." And, you go, "Yeah, yeah. Yeah, that's – that's true. And, then later on you – and – and you believe that and then later on you think yeah, but you know, I lost my birth certificate or I lost this or I lost that or I lost that. That is important to me. Not – not my surfboard or my kayak but those other things are important to me. And – and, people still keep saying, "But, you" you know? "And, you're insured so you'll be okay." And – and, they don't realise that we're under insured and that the pain of rebuilding and the pain of the house block is cleared now... It's a different kind of – if it's depression or grief, yeah.”

Participants explained the relief in a 'shorthand' that could be used with people who did understand what it was like. The relief was particularly welcome at a time that they felt overburdened. This sense of feeling understood could come from other community members, but also services.

“ Flood people, I said to you, you don't have to explain to each other. They don't have to say how they feel. Yeah. We use the word "I'm flood." Sort of like a little... It's a – it's a code. "I'm flood." Are, you flood?" "yeah, I'm flood." Right. Or – or they look at you like you've got two heads. Right. They've got no idea what you're talking about. But, flood people, they get it. It's an immediate understanding. And then, if you stand there and you start crying and you're angry or whatever your emotion is, it's accepted.”

3. Feeling understood continued

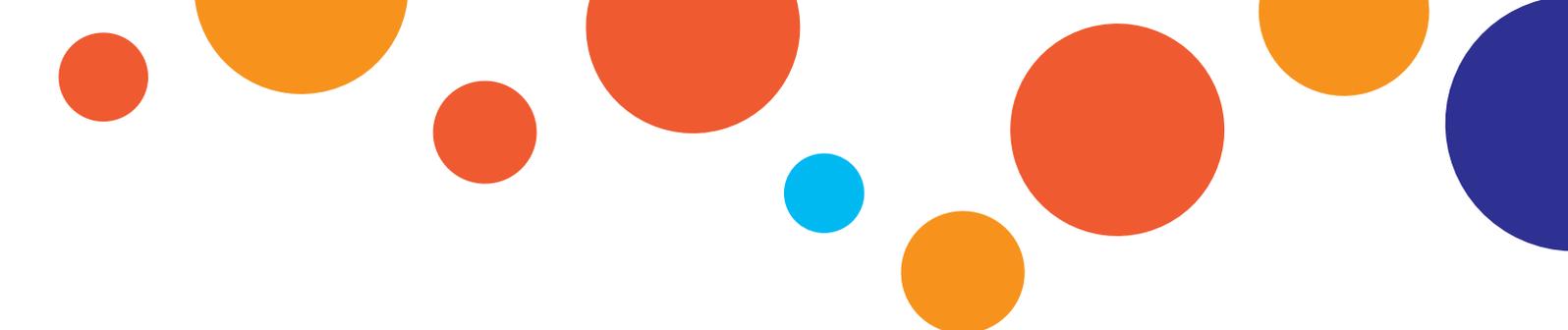
In addition to feeling understood, participants identified that connecting with people who were also impacted provided an opportunity for information sharing and support to navigate services. In addition to emotional support and normalising their situation, these connections provided information about services, practical support and shortcuts through red tape.

“ And, we were just a little group, and we would meet regularly, and it wasn't a pity party. It was, “I've had this issue. This is what I'm working with. I haven't got anywhere with this. What did you find?” So, we were sharing, and – and helping each other out. So – and, you know, different people would come and go, as they needed help, they'd come, and not come twice, and then not come back, or keep coming. So, we found that very helpful. So, there's, sort of, some practical benefits. Just in terms of knowledge, or information. In terms of benefit that people would get from it? I think meeting with like-minded people. So, you didn't have to explain – there was no one saying to you, “Well, you're lucky. Your house is going to get all fixed, you know?” Or – or, “Well, you shouldn't complain. It's happened now and you just need” There was – you didn't have to worry about – you didn't want pity from anyone, but you didn't have to worry, people understood. And, they met where you were, and no one had to say anything.”

Reflections by participants indicated that some services had been able to better understand the context and practical implications of the disaster affected communities than others. Services which did not take steps to ensure that their offerings were appropriate for the context were either dismissed as unsuitable or became a barrier to accessing support. Where service providers were dismissive of a specific impact, participants expressed a broader sense of feeling like their experience and subsequent impacts had been diminished. However, where participants felt recognised and heard on a specific issue, they felt validated more broadly. Participants described feeling validated or diminished as having an impact on their broader well-being.

“ The other thing I think that probably helped people cope, was actually the recognition that come out of the Federal Government about what – what actually had happened up here. Acknowledging that we are a contributor to the economy of Australia. A huge – a huge... you know. We – we contribute a fair bit of money through farming to the – to the overall [economy]. So, it sort of validated - - - Validated us, because we've been kicked in the guts a fair bit. You know, greenies are in to us all the time. It's looked upon us as if we're probably poor cousins, just living on properties. From that you get that feeling from metropolitan Australia. A lot of them don't have understanding of – of farming, or grazing or any of that. And, to us, I think it validated that we are actually important... So, I think a big thing, I believe, was the acknowledgment from the Federal Government in that there was assistance provided.”

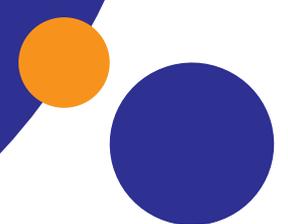
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Conclusion

People impacted by disasters may experience diminished mental health and well-being for a range of reasons. Disasters often result in complex, burdensome impacts for those affected and may exacerbate pre-existing issues.

Human centred supports which are responsive to the range of complex and intersecting challenges people may face after a disaster are important. Highly connected, flexible, proactive, context appropriate service systems will reduce adverse impacts to mental health and well-being after disasters.



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