Australian Red Cross

Submission on the NSW Mental Health and Wellbeing Strategy

August 2025

About us – Australian Red Cross

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

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

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

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

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

Highlights from our 2023-24 Annual Report:

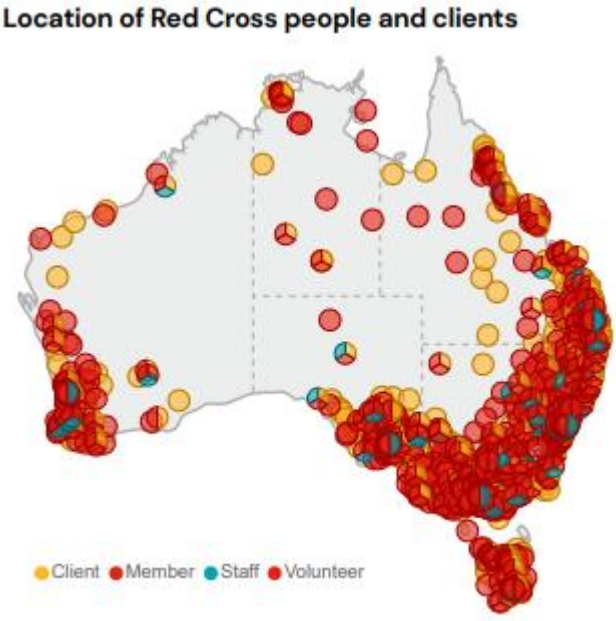
18,300+
members and volunteers acting for humanity

213,000+
Australians supported during **70** emergency activations

5.8 million+
people accessed information from disaster preparedness campaigns

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

Location of Red Cross people and clients



Purpose

Drawing on more than 110 years of expertise in disaster recovery, trauma-informed support, and psychosocial service delivery, Australian Red Cross is committed to highlighting how disasters - including those driven by climate change and other natural and human-induced hazards - are increasingly shaping the mental health and suicide prevention landscape in Australia.

To that end, Australian Red Cross is making the below submission in response to the New South Wales Government's consultation process on the new ten-year Strategy for Mental Health and Wellbeing. While our recommendations apply across several of the eight key questions raised by the consultation process, we will primarily respond to questions five and six, noting that we will raise other intersecting concerns.

Summary of recommendations

Australian Red Cross recommends that the NSW Government and the Mental Health Commission of NSW ensures that the new Mental Health and Wellbeing Strategy (the Strategy):

Recommendation 1
Explicitly acknowledges disasters and climate change as social and environmental determinants of mental health and suicide risk. This should be reflected in the objectives and guiding principles of the next NSW Mental Health Strategy, and embedded in performance and outcome frameworks, aligned with the National Disaster Mental Health and Mental Wellbeing Framework.

Recommendation 2
Enables the funding of psychosocial support as an essential service stream within the mental health system, supported by consistent governance, commissioning and reporting arrangements, a trained, surge-capable psychosocial workforce, and dedicated investment in prevention and resilience-building programs.

Recommendation 3
Promotes social capital and social connectedness as a core objective, by supporting place-based, community-led models. This can be enacted through dedicated funding for community resilience programs that focus on building local networks, leadership, and participation.

Recommendation 4
Recognises and embeds lived experience leadership in the governance of psychosocial and disaster-related supports, including through participatory co-design and peer-informed recovery models.

Recommendation 5
Ensures cross-departmental governance mechanisms integrate mental health and psychosocial support within health, emergency management, youth and community service planning. This may include the establishment of an interagency taskforce or formal coordination structure that includes emergency management agencies and community partners, aligned with the principles of the Glasser Review and the National Disaster Mental Health and Wellbeing Framework.

Recommendation 6
Addresses the compounded vulnerabilities of people at higher disaster and psychosocial risk, including First Nations communities, culturally and linguistically diverse communities, people in rural and remote areas, people with disability, people who are LGBTIQ+ and people experiencing socioeconomic disadvantage, homelessness or housing instability through tailored supports and equity-focused governance.

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

1.1 Disasters are increasingly frequent and complex - driven by climate change as well as other natural and human-induced hazards. They are significant contributors to distress, psychological injury, and increased risk of suicide. Research shows that between 25–50% of people affected by disasters experience elevated psychological distress, with up to 40% developing post-traumatic stress symptoms (Black Dog Institute, 2020; Goldmann & Galea, 2014).

1.2 The Australian Government's *National Suicide Prevention Strategy 2025-2035* recognises disasters and climate change as risks to personal safety that may contribute to suicidal distress. It would be beneficial for the Strategy to **explicitly acknowledge the need to address the mental health and suicide risks associated with disasters and climate change**. Importantly, it should do so while recognising the differentiated impacts of sudden-onset disasters and slow-onset climate change, acknowledging that the latter may unfold gradually, incrementally, and cumulatively over time, and may at times be intangible or slow to perceive. This nuance may be reflected in the nature, timing, and visibility of associated mental health impacts.

1.3 The National Disaster Mental Health and Wellbeing Framework (2024), led by the National Emergency Management Agency (NEMA), provides a national vision for a coordinated, trauma-informed approach to disaster-related mental health and wellbeing. It explicitly recognises disaster exposure as a critical determinant of mental health, and underscores the importance of psychosocial support, community engagement, and lived experience. This could be used as a model for development of the new Strategy, so long as there is acknowledgement of the value of psychological preparedness and preventative strategies in disaster contexts.

1.4 Young people exposed to multiple disasters are up to 2.5 times more likely to experience suicidal ideation or self-harm (Carmen et al., 2024). Eco-anxiety – feelings of helplessness and worry related to anticipated climate impacts - and solastalgia – emotional distress caused by environmental changes in a person's home or local area - are affecting a growing portion of the population, particularly youth, with up to 80% reporting some level of distress (Hickman et al., 2021).

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

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

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

Recommendation 1
That the new Mental Health and Wellbeing Strategy:

Explicitly acknowledge disasters and climate change as social and environmental determinants of mental health and suicide risk. This should be reflected in the objectives and guiding principles of the next NSW Mental Health Strategy, and embedded in any performance and outcome reporting frameworks, aligned with the National Disaster Mental Health and Mental Wellbeing Framework.

2. Psychosocial support as core health infrastructure

2.1 Psychosocial support is distinct from clinical mental health care. It addresses the relational, emotional, and practical aspects of wellbeing and recovery that clinical models often overlook - especially vital in disaster contexts. Psychosocial support refers to non-clinical, community-based assistance that promotes safety, connection, hope, and functioning. It includes psychological first aid, peer support, and community recovery services. Embedding psychosocial support within the Strategy would ensure people receive help earlier, in community settings, rather than only at the point of clinical crisis.

2.2 Psychosocial support is protective against escalating mental health needs and supports long-term recovery. These supports also play a critical role in suicide prevention by reducing isolation, promoting connection, and addressing distress before it escalates to crisis. Evidence from COVID-19 and recent disaster responses shows its effectiveness in reducing distress and improving outcomes (Reifels et al., 2024).

2.3 There is wide agreement that existing mental health supports do not sufficiently elevate psychosocial support as a distinct and essential service stream within the mental health system. This is articulated in the Productivity Commission's Review of the National Mental Health and Suicide Prevention Agreement (2025) and aligns with findings from the Royal Commission into National Natural Disaster Arrangements (2020) and the Inspector-General for Emergency Management Victoria (2020), which highlight gaps in coordination, sustainability and quality control of psychosocial recovery efforts across jurisdictions.

2.4 Prevention and resilience-building must also be prioritised. Dedicated investment in community-based psychosocial initiatives strengthens protective factors, enables earlier intervention, and reduces the long-term social and economic costs of poor mental health. The consultation paper for the NSW Mental Health and Wellbeing Strategy recognises that prevention and protective factors are critical but frequently underfunded, and that early, community-level investment is essential to sustaining wellbeing. Programs that build capacity and connectedness before disaster strikes help ensure communities are better prepared, recover faster and requires less intensive clinical intervention afterwards.

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

Recommendation 2
That the new Mental Health and Wellbeing Strategy:

> Enables the funding of psychosocial support as an essential service stream within the mental health system, supported by consistent governance, commissioning and reporting arrangements, a trained, surge-capable psychosocial workforce, and dedicated investment in prevention and resilience-building programs.

3. Social capital and place-based resilience

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

3.2 People in communities with high levels of social capital experience better mental health outcomes following disasters, independent of socioeconomic status. These communities are more likely to activate informal support networks, maintain trust in services, and engage in collective recovery actions – all of which contribute to resilience (Wubbenberg et al., 2024; Cuthbertson et al., 2023).

3.3 Building social capital is a proven, cost-effective way to boost resilience – yet it is often overlooked in funding and measurement frameworks. Recent evidence from Australian Red Cross (2024) highlights that different forms of social capital – bonding (close relationships), bridging (across communities), and linking (with institutions) – all play distinct roles in supporting resilience. The impacts of low social capital are particularly severe for certain groups, including older adults, those who are unemployed or single, and people in remote areas. In these contexts, higher social capital has been shown to deliver wellbeing gains **equivalent to thousands of dollars in income annually per person**, with significant cumulative returns at the community level (Australian Red Cross, 2024). The final report on of the NSW Parliamentary Inquiry into the Prevalence, Causes, and Impacts of Loneliness (2024) also called for greater investment in community connection programs, underscoring that stronger networks are central to mental health and wellbeing. Social capital should be a core outcome in the new Strategy, supported through investment in local, community-led models.

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

3.5 Among migrants and refugee communities, family ties are a critical source of resilience and driver of social capital. Evidence from Australian Red Cross and Phoenix Australia's work with migrants experiencing vulnerability affirms that strong family connections serve as lifelines – providing emotional stability, cultural support, and practical assistance that enables people to heal from trauma, adapt to new environments, and begin the process of rebuilding their lives (Liddell et al. 2020). The research emphasised the protective role of social capital, including social group membership in the mental health and wellbeing of those on insecure visas. Embedding these insights aligns with the NSW Multicultural Principles, which recognise diversity as a strength and call for equitable access to services. The Principles also complement commitments under the Closing the Gap NSW Implementation Plan and the NSW Disability Inclusion Plan 2021–25, which emphasise community-driven, inclusive approaches to resilience and wellbeing.

Recommendation 3
That the new Mental Health and Wellbeing Strategy:

> Promotes social capital and social connectedness as a core objective, by supporting place-based, community-led models. This can be enacted through dedicated funding for community resilience programs that focus on building local networks, leadership, and participation.

4. Lived experience and community leadership

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

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

4.3 Unfortunately, mechanisms for integrating lived experience input are often informal, time-limited or inconsistently resourced. This undermines their influence and sustainability.

4.4 Strengthening governance arrangements to include lived experience roles - such as dedicated advisory bodies, peer workforce pathways, and funded participation in planning processes - is essential to ensure policies and programs are grounded in real-world experience and tailored to diverse community needs. This is particularly important in disaster recovery governance, where lived experience voices remain less visible in existing frameworks despite being critical to trust, accessibility, and long-term recovery. For example, a recent review of disaster recovery approaches found that peer-informed models increase trust, improve service uptake, and contribute to sustained engagement over time (Reifels et al., 2024). Lived experience models can be especially valuable in supporting culturally safe and accessible responses for First Nations peoples and other groups that experience barriers to conventional services. Clear frameworks and resourcing are needed to ensure meaningful participation across all stages of planning, delivery, and evaluation.

Recommendation 4
That the new Mental Health and Wellbeing Strategy:

> Recognises and embeds lived experience leadership in the governance of psychosocial and disaster-related supports, including through participatory co-design and peer-informed recovery models.

5. Governance and cross-sector integration

5.1 Disasters frequently expose structural weaknesses across different levels of government, and across sectors, including health, housing, emergency management and social service systems. These structural weaknesses result in fragmented responsibilities and siloed approaches that can delay or duplicate care.

5.2 Mental health is not the sole responsibility of health portfolios. Disaster recovery, housing, education, immigration, and community services all play roles. There is a need for cross-government coordination and joint accountability.

5.3 Best practice would be to ensure governance of the Strategy includes representatives from emergency management, local government, and across state and federal agencies – Department of Communities and Justice, NSW Reconstruction Authority, Homes NSW, Multicultural NSW, Aboriginal Affairs NSW, NSW Ambulance, Home Affairs, the National Indigenous Australians Agency, NEMA and Department of Social Services - with mechanisms for participatory decision-making including the involvement of Community Support Organisations. Multiple inquiries into bushfires and floods have found that poor coordination between mental health and recovery systems leads to fragmented services, duplicated efforts, and critical delays in support reaching communities when it is needed most. Notably, the Royal Commission into National Natural Disaster Arrangements (2020), the NSW Independent Flood Inquiry (2022), and reports by the Victorian Inspector-General for Emergency Management have all highlighted the need for improved integration of mental health services within disaster recovery frameworks.

5.4 In New South Wales, there are existing mechanisms that can provide this foundation. The State Emergency Management Plan (EMPLAN) and State and Regional Recovery Committees already bring together health, emergency management and community services in disaster contexts. Explicitly embedding mental health and psychosocial support roles within these structures would ensure the Strategy has a clear operational pathway for cross-sector governance.

5.5 In addition, the newly published Disaster Adaptation Plan (DAP) Guidelines (July 2025) mandate a collaborative, regional and community focused approach to disaster adaptation planning — engaging local government, First Nations peoples, councils and community organisations in setting priorities and actions.

5.6 Leveraging these established mechanisms avoids duplication, reinforces accountability, and aligns with the recommendations of recent inquiries calling for integrated recovery systems.

5.7 The Glasser Review (2025), commissioned by NEMA, further reinforces the need for strengthened cross-sector governance and investment in community-based psychosocial support. It highlights gaps in coordination across levels of government, identifies the limitations of relying solely on clinical mental health interventions, and recommends more structured collaboration between emergency management, health, and community sectors.

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

Recommendation 5
That the new Mental Health and Wellbeing Strategy:

> Ensures cross-departmental governance mechanisms integrate mental health and psychosocial support within health, emergency management, youth and community service planning. This may include the establishment of an interagency taskforce or formal coordination structure that includes emergency management agencies and community partners, aligned with the principles of the Glasser Review and the National Disaster Mental Health and Wellbeing Framework.

6. Equity for priority populations

6.1 The consultation paper for the NSW Mental Health and Wellbeing Strategy explicitly identifies Aboriginal people, culturally and linguistically diverse (CALD) communities, people in rural and remote areas, people with disability as well as people who are LGBTIQ+ and people experiencing socioeconomic disadvantage, homelessness or housing instability as some of the groups facing heightened risks of poor mental health and wellbeing outcomes. These risks are compounded in the context of disasters, where structural inequities can amplify exposure to trauma, isolation, and barriers to accessing support.

6.2 Addressing these compounded vulnerabilities requires a deliberate equity lens in the Strategy. This aligns with NSW's commitments under Closing the Gap, the Disability Inclusion Plan, and refugee and migrant health initiatives, all of which emphasise the importance of culturally safe, accessible, and community-led supports.

6.3 Aboriginal communities, both regional and urban, experience disproportionately higher exposure to disaster risk and systemic barriers to recovery (Royal Commission into National Natural Disaster Arrangements, 2020). Embedding self-determination and community governance into psychosocial and mental health responses is essential to ensure services are culturally safe and grounded in local knowledge.

6.4 CALD communities and people from refugee and migrant backgrounds often experience linguistic, cultural, and systemic barriers to accessing support. Investment in bicultural workers, community navigators, and peer-led models can improve access and trust, and ensure services are responsive to diverse needs.

6.5 People living in rural and remote areas face limited access to both clinical and non-clinical supports, and are more vulnerable to service disruptions during disasters (NSW Independent Flood Inquiry, 2022). Strengthening place-based, community-led resilience initiatives, and investing in local psychosocial workforces, are critical to closing these gaps.

6.6 People with disability are at heightened risk in disaster contexts due to pre-existing social and physical vulnerabilities, and gaps in inclusive planning. Accessible service design, proactive identification of needs, and integration with the NSW Disability Inclusion Plan are necessary to address these risks.

6.7 Existing vulnerabilities and marginalisation faced by people in LGBTIQ+ communities as a part of pre-disaster life are further exacerbated during emergencies (Gourman-Murray et al, 2018). Emergency management workforces often lack awareness and training, resulting in increased social stigma, discrimination and violence toward LGBTIQ+ communities, as well as a loss of trust and lack of engagement for many LGBTIQ+ people (Parkinson et al, 2018). Prioritising psychosocial wellbeing, enhancing social cohesion, as well as ensuring a diversity of experiences and voices are included in consultation, response and recovery planning processes will reduce the humanitarian harm.

6.8 The increasing severity of emergencies and disasters is creating further pressure on an already strained housing sector, and exacerbating existing socioeconomic inequalities (Lee et al., 2018). Approximately 23,000 Australians over the age of 15 have been displaced either temporarily or permanently each year due to housing damage caused by floods, bushfires, and cyclones since 2009, with this number expected to rise due to climate change and population growth (University of Queensland, 2024). Addressing the housing and socioeconomic needs of everyone affected by disasters requires a coordinated, cross-sector approach, including alignment and engagement with the *NSW Homelessness Strategy, 2025-2035*.

6.9 Inspector General for Emergency Management (IGEM) Victoria (2020) and associated regional Disaster Adaptation Plans already include actions focused on enhancing community awareness, preparedness, and social infrastructure, particularly for communities facing greater exposure and vulnerability. Embedding psychosocial equity priorities within these existing mechanisms can enhance both feasibility and coordination. For example, ensuring that community-centred risk reduction actions explicitly consider psychosocial wellbeing and equity across priority populations would strengthen the Strategy's implementation pathways.

Recommendation 6
That the new Mental Health and Wellbeing Strategy:

> Addresses the compounded vulnerabilities of people at higher disaster and psychosocial risk, including First Nations communities, culturally and linguistically diverse communities, people in rural and remote areas, people with disability, people who are LGBTIQ+ and people experiencing socioeconomic disadvantage, homelessness or housing instability through tailored supports and equity-focused governance.

Conclusion

It is clear that mental health is a priority for the New South Wales Government. There is a breadth of programs, service options, referral pathways, monitoring systems and resources for mental health professionals and the wider community.

Despite these measures, mental health challenges continue to escalate however (NSW Ministry of Health, 2023). With more than 110 years of experience in standing with communities through crisis, Australian Red Cross knows that one of the missing pieces, which is often undervalued and overlooked, is social connection. With technology, the recent COVID-19 pandemic, the cost-of-living crisis and an increasingly hyper-individualised society, people are more disconnected from one another and the communities in which they live.

Everyday social connectedness enables proactive cooperation in times of crisis and strengthens everyday community life. It plays a central role in community resilience by fostering trust, social equity, and a sense of shared identity. When people feel connected, included and valued, they are more likely to engage, volunteer, and support each other, turning passive populations into active agents of recovery and wellbeing.

Social connectedness is closely linked to public health, civic participation, and social inclusion. Addressing social inequalities—such as poor mental health, housing insecurity, communication barriers, or race- and gender-based discrimination—improves cohesion and overall wellbeing, which can be leveraged in times of crisis (Dadich, 2025). When social justice is increased, populations unify over shared values and are able to collaborate across the sector towards collective goals (Anderson, 2024). Empirical evidence consistently shows that communities with stronger social capital experience faster recovery and reduced long-term harm compared to those with fragmented or weak networks (Aldrich, 2015).

Australian Red Cross knows that psychosocial wellbeing and social connectedness play a vital role in building resilient communities. Across our programs, **practices that build trust as infrastructure, shift power to communities, remove access barriers and provide trauma-informed, inclusive caring systems and spaces** have impact. By building and focusing on social cohesion, as a way to strengthen overall mental health, the NSW Mental Health Strategy can create strong and resilient communities.

Australian Red Cross welcomes the opportunity to support the Mental Health Commission of New South Wales in building social connectedness and resilient communities in the development of this new Strategy.

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Australian Red Cross

Contact Details

Joel MacKay
Head of External Engagement, Australian Red Cross
Email: jmackay@redcross.org.au