Extending the Role of Primary Care Agencies in Mental Health Responses to Disaster

Short title: Extending Primary Care Roles in Disaster

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Natural disasters are increasingly affecting individuals, resulting in greater calls on health care services. It is therefore timely to review the traditional roles of different elements of the health system and extend the capacity of agencies involved in mental health service provision. Primary care systems have been recognized as vital components of disaster mental health responses,¹ but the role of primary care services following disasters has traditionally been defined in comparatively narrow terms through the role of family physicians in mental health screening, treatment and referral.²-⁴

We conducted a pilot evaluation of the Australian Government’s mental health response to Australia’s largest wildfire disaster, the Victorian Black Saturday Bushfires of 2009, which highlighted the extended scope for primary care involvement in community disaster recovery.⁵ As part of the response, five federally funded and regionally operating primary care agencies, so-called Divisions of General Practice (or Divisions), provided targeted community capacity-building and mental health promotion initiatives to aid the psychological recovery of affected communities. With limited prior disaster experience, the traditional role of Divisions has centered on family physician workforce support, primary care integration, as well as provision or facilitation of illness prevention, health promotion and primary mental health care programs.

The summative pilot evaluation examined the provision of these initiatives in terms of their nature and scope, their levels of uptake, benefits, disadvantages and issues associated with them. Data sources included five Division program reports and interviews with nine key informants involved in the wildfire response which were analyzed through descriptive and thematic analyses.

Following community stakeholder consultations, Divisions provided 35 initiatives which included locally targeted community events (e.g., health and wellbeing nights), mental
health and resilience training for community leaders and health professionals, provision of service information, support programs for farming families and frontline recovery workers, and replacement funding for school staff. Divisions either directly provided, facilitated, or subcontracted programs to external providers. Well in excess of 7,000 community members participated in the various initiatives.

Program evaluation data, albeit limited in scope, indicated that the initiatives were overwhelmingly positively received by and conducive to the recovery of participants. Participant benefits included normalization of disaster reactions, increased mental health awareness, reduced barriers in access to care, breaks from disaster immersion and opportunities for people and communities to reconnect. Minor disadvantages included limited afterhours access to training and availability of replacement teachers in rural areas.

Postdisaster challenges affecting provision of initiatives included: destroyed infrastructure, community rifts, multiple competing priorities, heightened sensitivities during anniversary periods, fatigue among local agency staff, delayed funding availability, variable Division community profiles and delivery timelines of greater than one year postdisaster.

A strong partnership approach facilitated service provision, as did community engagement and consultation, flexible funding parameters, tailoring of initiatives to local needs, use of existing allied health and drought workers, and integration with local area and disaster response structures.

Evaluation findings highlight the important multiple roles that primary care agencies can play in facilitating community recovery from disaster, including as provider, broker, and facilitator of mental health capacity building initiatives and mitigating existing barriers in access to care.\(^6\) The profile, preparedness and capacity of these agencies to provide disaster recovery services may need to be strengthened further to increase the timeliness and
efficiency of future disaster responses. The integration of climate related primary care response capacities looms as a key consideration for future disaster planning.

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References


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