B: Attachment: 13 Suggested Provisional Guidelines

Re: Beyond the Commonwealth of Australia Government Mental Health Package

(as announced by Prime Minister of Australia 12 January 2020) of National Bushfire Recovery Agency to complement State mental health enhancement strategies: 13 suggested provisional guidelines. Vn 1.3

Appended: Tables differentiating between Crisis, Emergency and Disaster

To: Hon **Greg Hunt,** Minister for Health, and Dr.**Michael Gardner,** Ministerial Mental Health Advisor, Hon **Gladys Berejiklian**, Premier of NSW, Hon **Brad Hazzard,** NSW Minister for Health, Hon **Bronnie Taylor,** NSW Minister for Mental Health
Mr**. Frank Quinlan,** Federation National Director, Royal Flying Doctor Service, Canberra .
Dr **Anthony Bartone**, President & Mr **Simon Tatz**, Director of Public Health, Federal AMA
A/Prof **John Allan**, President, Dr **Siva Bala**, Dr **Peter Jenkins**, Dr **Nick O'Connor**, Dr **Victor Storm**, RANZCP Head Office, Dr **Angelo Virgona**, Chair, Dr **Loy McLean**, Dr **Ralf Ilchef,** NSW Branch Committee, RANZCP.
Ms **Lucinda Brogden**, Chair, and Ms **Christine Morgan**, CEO, National Mental Health Commission,
Ms **Catherine Lourey,** Commissioner MH Commission of NSW, Deputy Commissioners Messrs **Tom Brideson, Tim Heffernan, Daniel Angus**, Mr. **Tim Marney**, NOUS Australia, formerly Commissioner, WA Mental Health Commission.
Ms. **Irene Gallagher,** CEO, Being, NSW, Ms. **Fay Jackson,** formerly Deputy Commissioner & Flourish Australia, Mr **Peter Gianfrancesco,** NEAMI Australia, Mr **Doug Holmes,**TAMHSS.
Ms **Melanie Cantwell,** Acting CEO, Mental Health Australia.
Dr **Paul Fanning**, National MHS Advisor, St Vincent's de Paul, Australia.
Ms **Viv Miller,** Executive Director, The Mental Health Services Conference of Australia & NZ
Professors **Pat McGorry, Ian Hickie**, **Maree Teesson, Luis Salvador-Carulla, Roger Gurr, Katherine Boydell, Kathy Eager, Marie Bashir, Alan Fels, Ross Garnaut, Ellie Fossey, Ernest Hunter, Graham Meadows, Gordon Parker, Helen Christiansen, Garry Walter, Michael Robertson, Louise Newman, Phillip Mitchell, Max Bennett, Helen Milroy, Pat Dudgeon, David Perkins, Tim Carey,** Doctors' **Michael Dudley, Peter McGeorge, Claire O'Reilly, Sebastian Rosenberg, John Farhall, Elsa Bernardi, Louise Nash.**

From: Alan Rosen
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Date: 13 Jan 2020.

Introduction:

The provisional guidelines below were developed as a response over a week ago, after having some concerns being sent personally to me for comment by the federal office of a major national health organisation, providing advice to government and the sector, about the forthcoming mental health package of

the national bushfire recovery effort. They were concerned about the lack of balance in the preponderance of potentially pathologizing clinical interventions being floated for the mental health package, without sufficient regard for encouraging and supporting spontaneous individual, family and community recovery and resilience. Yesterday, the Federal government announced funding of an initial mental health services package with some commendable components, including psychological first aid, mental health (including telehealth) counselling, telepsychiatry, headspace enhancements in affected areas, and supporting local community initiatives, cohesion and resilience, providing in particular for first-responders, young people and badly affected rural families and their communities.

However, they are doing nothing to stop many of the states' health systems from continuing to allow regional health districts to shift resources dedicated for rural mental health services, into covering their regional overspends on technical, medical and surgical procedures. This has **resulted in the continual depletion and gradual dismantling of local and familiar rural community mental health teams, ironically, often in the very locations and communities which are suffering most from the bushfires.**

Telepsychiatry, telehealth counselling, e-health on-line interventions, and fly-in/fly-out locum practitioners increasingly should be included in the spectrum or mixed economy of service delivery sub-systems. Overreliance on them, however, may oblige affected communities to rely excessively on a transient and interchangeable influx of strangers and distant on-line counselling rather than restoring more familiar and engaging in-person services. This may dash communal expectations of consistent continuity of care and support where needed for severe, persistent and complex problems, like severe trauma.

At the RANZCP branch level, in at least some instances, requests for registration to be available for paid telepsychiatry clinical assessments and reviews, has been the only way Fellows of the College have been asked so far to contribute to the mental health package effort. Overbalancing in this direction could provide a skewed, unstable, fragmentary and expensive service.

A. The **individual and family mental health & wellbeing priorities** at this stage should be: ensuring the meeting of practical needs (safety, food, water, fuel, clothing, money, accommodation, etc) , service navigation & coordination, integrated teamwork. and psychological first aid or skilled active listening. This includes trustworthy and culturally safe supported ventilation and ensuring family involvement, rather than formal psychiatric interventions. However expert mental health professionals are needed in such teams as well as lay and peer support workers, and indigenous mental health workers, all of whom will need thorough training, supervision, mentoring and pastoral care.

Much of this is best done by rebuilding, re-stabilising and sustaining depleted community health and community mental health teams with a substantial proportion of local and familiar service providers, wherever possible, who are prepared to build a commitment on a persisting residential basis or required

professionals at least to make an ongoing regular visiting commitment to each region or key township. **Rural/remote LHD's should stop relying on a jury-rig of transient fly-in professional cover arrangements, often devaluing all mental health and other clinical specialists by treating them all as interchangeable agency locums**, chewing them up and spitting them out with discourtesies, disrespect, shifting responsibility and blame, and unsafe clinical governance, resulting in unfilled, unstable and un-collegiate rosters. Rather, LHD's should be rebuilding stable rosters of expert clinicians, and strongly supporting them to demonstrate a commitment to the region and to close supervision and care of junior staff.

The irony is that many affected rural/remote mental health services, particularly their community mental health components, are ill-prepared as they have been allowed to become eroded, depleted and virtually dismantled in many rural regions of several state and territory jurisdictions, as mental health resources are still being shifted overtly or tacitly by LHD CEO's to meet shortfalls due to overspends on medical and surgical technical procedures etc. CEO's have been permitted to do so for years with impunity and without external scrutiny.

This mirrors our governments' neglect and complacency which led to the lack of preparation of the rural fire services for the fires and under-resourcing of the rural fire brigades and their equipment, including inadequate fire-bombing aircraft, etc.

So this emergency should be operationalised as a timely opportunity to restore resource depleted community mental health services on an ongoing continuity of care basis, for the long haul, via cooperative arrangements between Commonwealth and States. The Commonwealth effort, including the National Bushfire Recovery Agency Mental Health Package should provide financial incentives for states and territories to rebuild and sustain these facilities to provide a stable presence and ongoing continuity of care as required (see 6.1). This would be far preferable than just importing a transient bunch of clinicians &/or support workers undertrained for this purpose, funded only to provide services for the short-term, whether on an overly intrusive clinicalizing or superficial gestural counselling basis, dashing expectations and betraying needs to deal with ongoing disaster sequelae of loss, grief, long-term trauma, anxiety, depression and suicidality.

B. The **communal priorities** should include encouraging, fostering and supporting communities to generate and sustain their own communal resilience, cohesion and reciprocal support networks, to find their own solutions and take credit and ownership for these solutions, and to be in the driving seat to steer and drive these solutions. Outsiders, whatever their expertise, should not just bowl up into town and just take over,or dominate these community efforts, which would deskill and disempower the locals and derail their attempts to take the initiative.

Evidence and rationale to support this broad but integrated range of strategies includes studies of disaster responses, studies of critical incident

debriefing vs psychological first aid, Khmer & Pinochet Chile torture & trauma Survivors, genocide and holocaust survivors, response to initial counselling methods soon after 9/11 (S. Goldfinger et al), the learnings from developmental trauma delayed debriefing and 1st person accounts by the Royal Commission on Institutional Child Abuse (H Milroy), Justification for not separating children (S. McFarlane et al), acknowledging and managing environmental grief and Solastalgia (Albrecht G et al, see 5.6 below), relevance of a blueprint for nationally consistent mental health workforce training, supervision, pastoral care and qualifications (Teesson M, Rosen A et al, 2019) Commonwealth Integrated Mental Health Projects (Perkins D, Eager K et al), RFDS experience, and Urban or Rural Alliances of all Mental Health, Trauma and Homelessness related agencies (C Moore, P McGeorge et al) and different mental health needs in rural settings (Orange Declaration, 2017).

Provisional Guidelines (suggested amendments welcome)
Check-List of 13 Do's & Don't's

1. DO: Plan appropriate differing levels of services for the whole spectrum of outcomes: resilient and functional, vulnerable, or functional impairment and disability outcomes.
Requirements: Carefully calibrated balance and combined integrated teamwork between service navigators, practical service brokerage and support services, physical care, well-trained counsellors, including well trained local lay peer counsellors and indigenous mental health workers, together with critical mass of mental health professionals (see 3.) .

2. DO: provide a well trained core workforce. Counsellors need to be trained to know how to do non-intrusive active listening, family & communal cohesion work, encouraging resilience and helping with practical problem solving. They also need sound training so they will know how to draw on team support, off-load to defray vicarious trauma and how to recognise over-involvement, over-intrusiveness and exhaustion in themselves.

2.1 DO: Ensure **nationally consistent mental health workforce qualifications, training, supervision, mentorship of, and pastoral care** for all mental health professionals, trauma counsellors, support and peer workers. Ref: invited Ministerial Submission & Blueprint coordinated by Maree Teesson & Alan Rosen, University of Sydney and University of Wollongong.

2.2 DO: Train up culturally familiar people as local voluntary support and resource people in small townships, which are often without resident health professionals, and with substantial Aboriginal populations. A model for this can be provided by the results of the Commonwealth Integrated Mental Health Project in remote NSW, and Royal Flying Doctor Service, Federation office.

3. DO: provide balance between professionals, non- and para-professionals. These teams will need specialist mental health professionals input and supervision to recognize more severe and dangerous conditions, to triage and escalate them to more specialized mental health services if they have severe, complex and symptomatic crises, to provide expert supervision,

to provide pastoral care & mentorship for counsellors and support staff. A solely non- or para-professional team may not detect complex and/or severe disorders or may not know how to protect themselves from becoming overburdened and exhausted by them. A totally professional workforce may overly “clinicalize” & overtreat, and not directly address practical stressors.

4, DO: Meet need for team mobility, dedicated vehicles & adequate travel time. This workforce should not be sedentary, but able to work on the “turf and terms” of those whose wellbeing and mental health have been affected. These teams will need to mobilise & base selves in primary health centres, going for a quiet walk together (not down the main street) in serene and familiar (hopefully non-retraumatising) settings, and “home delivery” or home visits (for those who still have homes or at substitute accommodation, or witnessing impact of loss of homes) as non-stigmatising settings. This will ensure that they will be well engaged if they need further help, but they may well need secondary expert mental health services input at home too (see 3.).

5. DO: Address needs of & work with whole community, and communal components, eg Different age, cultural and interest groups, Aboriginal & Refugee communities.

5.1 Do take joint responsibility for mental health and wellbeing needs of your whole catchment or community.

5.2 **Do: form a coordinating, collaborative and trouble-shooting partnership or network of all health, mental health, welfare and support agencies** serving each affected community or region. (eg P McGeorge et al, Urban Mental Health Alliance, King’s Cross, NSW, C Moore, Mayor’s Alliance). Are these envisaged roles for the PHN’s “bushfire trauma response coordinators” or by subsidiaries of the “National Cross-Services Framework”?

5.3 Provide communal, family & individual wellbeing input and dynamic continuing co-design and evolution of regional services (via public meetings, workshops) affirming communal response so far and providing input re sustaining relationships, watching out for emotional needs of kids, and their need for their parents to be reassuringly nearby, resilience and communal involvement, inclusion and reciprocity. Local communities may be weary and emotionally depleted. or well ahead of transregional services in organising these in the short term. They should be encouraged in such communally developed and owned self- and mutual-help initiatives.

5.4 Main problems to deal with are:
a) shortterm when all in the community are badly affected by disaster, and need influx of strangers to take over for a short while, and
b) longterm exhaustion and loss of ability to sustain local communal effort, if emergency carries on for too long.

5.5 Do separately consult **indigenous and refugee communities.**
Don’t split them up. Don’t separate their kids from parents, elders, or extended family and friends [See also 8.].

5.6 **DO: encourage and facilitate structured, safe and respectful discussion of the wide range of communal beliefs, attitudes and knowledge regarding causality** of the extraordinary ferocity, ubiquity and persistence of this catastrophic bushfire season**.** Do consider this in terms of how those affected make sense of what has happened and develop a sense of agency in a time of crisis and recovery.
Do acknowledge the need to develop causal understandings while supporting individual, family and community agency in the short and longer term. **Beliefs and attitudes regarding climate change in this disaster will vary and at times be divisive.** Do support and enable constructive discussion drawing on reliable evidence leading to increasing agency in the short and long term. This should include acknowledgement of communal existential concerns and anxieties. Do **enable** open discussion of **climate change anxiety** and acknowledge any communal existential concerns, including of collective pain and grief for actual and anticipated loss of accustomed habitat (**Solastalgia**, Albrecht G et al, 2007) and of anxiety arising from uncertainty and fears for the future, and for their future as a community, and as a habitable planet for future generations.

5.7 Do also acknowledge and remind affected communities of their strengths, social cohesion and inclusivity, resilience, courage and determination to regroup and rebuild their lives and communities, in the face of such overwhelming threats.

6. DO: Operationalise this emergency response as a timely opportunity to restore resource-depleted community mental health services on an ongoing continuity of care basis, for the long haul, via a cooperative arrangement and financial incentives between Commonwealth and State Governments. (Mr Tim Marney, Nous, and Dr. Paul Fanning, former Regional Director of Health, can provide current details, effective monitoring mechanisms and well-tested solutions).

6.1 A subsequent wave of Commonwealth funding could be employed as leverage for or a strictly dedicated monetary signal to the states, to restore stably funded, fully staffed community mental health teams with evidence based components in vulnerable Australian townships and regions.

7. DO: Be inclusive of and work with families of all ages or their proxies of confidantes, wherever possible, not just 1-to-1 with individuals on an ongoing basis if possible.Do keep families together if possible. **Don't separate children from parents**, or send kids away if avoidable, as they will worry about the safety of their parents. Do encourage parents to keep talking with kids, reassuring them that they are now safe, explaining what they are doing as a family to come through this, and try to discourage or distract kids from watching news on TV, as they need to be reassured of their own safety now, rather than reliving others' terror (S McFarlane et al).

8. DO: make appropriate cultural provisions for members of Aboriginal & Torres Strait Islander communities who are caught up in bushfire emergency, whether as victims, threatened residents or responders.

8.1. Do include Aboriginal Elders and Aboriginal Mental Health workers in service planning and everyday service delivery.

8.2. Ensure, for better outcomes, that Aboriginal MH Professionals are appointed to both specialty mental health teams and in primary health teams run by AMS Aboriginal controlled programs, but also need Aboriginal people involved on staff and on boards running other agencies, including police, corrections, family & housing services, fire & ambulance etc
Evidence eg Chandler & Lalonde 2013, British Columbia
Expert/Authorities:
Prof Pat Dudgeon, Director of the Univ West Australia Centre of Best Practice in Aboriginal and Torres Strait Islander Suicide Prevention (CBPATSISP), Dept Indigenous Studies, UWA, W A.
A/Prof Christopher Lalonde, University of Victoria, British Columbia , Canada.

8.3. Ensure training, supervision and Aboriginal Mental Health Workers.(AMHW)
Durrawang Program, Charles Sturt University, Wagga Wagga has been the only University degree program to qualify Aboriginal mental health worker (AMHW) professionals in Australia. It had been envisaged that Edith Cowan University in WA would be the 2nd hub location for this course in the future. Restore the AMHW Mentorship Program which in NSW was successfully run for 10 years by Western NSW LHD and Far West LHD MHS, but was then defunded despite a 5 year evaluation demonstrating its effectiveness. Mentorship was shown to contribute to course retention and completion at degree level. Expert /Authority: Mr Tom Brideson, NSW Aboriginal MHS Coordinator, NSW MHCommission Deputy Commissioner, Chair National Mental Health Leadership Group.

8.4. Ensure provision for uninterrupted ventilation, personal narratives and story-telling, rather than rapid-fire clinical questioning as a means of assessment and trauma debriefing.
Authority: Prof Helen Milroy, UWA, Commissioner, Royal Commission on Institutional Child Abuse.

8.5. Do routinely involve either Aboriginal Traditional Healer or Aboriginal Mental Health Worker in determining any safe alternative to involuntary orders, before resorting to an involuntary order with Aboriginal people in crisis.
Precedent: as per provisions in the WA Mental Health Act.

9. DO NOT: Displace or remove citizens far away from their neighbours & communities, wherever possible. Have regard for and encourage natural processes of resilience, reciprocity, mutual support and cohesion occurring in neighbourhoods & communities, with loss of orientation to place and community being dis-spiriting.

9.1 Attend to the practical and emotional needs of now **newly homeless individuals and families,** who cannot be taken in by family, neighbours or friends, for refuge, temporary accommodation and permanent resettlement within their communities, close to their neighbours, mindful of their need for orientatation to familiar place and community.

10. DO NOT: Just rely on temporary militaristic raids of acute services, to be withdrawn too soon, without building up depleted critical mass and continuity of community mental health services for the long term. This will just dash expectations and leave community feeling abandoned and angry again. This package has been offered by the Prime Minister as initial funding with his public undertaking that if more is needed, more funding will be provided. This undertaking must be honoured.

11. DO NOT: Just temporarily flood, eclipse and take over from local professional and voluntary services, which may devalue or deskill them. Unobtrusively encourage, support and complement their efforts rather than bossing them around. Do not allow Commonwealth mental health workers to work separately or in isolation from State mental health workers. Do not create organizational vacuums or ambiguities which will result in competition or battles over which level of government is in charge. They should form a unitary cohesive team. Their ability to pull together, cohere and bounce back, may inspire the whole community to do likewise. Support locals to take over leadership and ownership again as soon as they feel up to it and are capable of doing so, and support them being in charge from then onwards.

12.DO NOT: Allow agencies, whether private, public or NGO, seeking to empire build on the back of a disaster, to provide suites of naive, futile or fashionable strategies which have not been subject to extensive evidence-based testing and expert and communal consultation.

13. **DO NOT: Just rely mainly on telepsychiatry, other telehealth counselling and e-Health strategies, individual allied professional counselling, or support workers <u>in isolation</u> for help with mental health related issues** for individuals, families and communities that are affected by disaster like these devastating bushfires, who are facing complex issues of trauma and loss, and possibly other complicating physical and mental health issues.

Mild disorders may respond well to e-health websites, checklists, subjective ratings and therapies, especially with young people, people who are more comfortable seeking services via internet, and those who are shy or wary of personal engagement with service providers. Individuals with **Moderate** disorders may need “hybrid combinations” of in-person, telehealth and on-line mental health services (Yellowlees P & Shore JH, APA, 2018) while individuals and Families with Acute, **Severe and Complex** psychiatric disorders usually respond best to inclusive in-person engagement and interdisciplinary teamwork (eg. Hickie I, ABC-RN, 1 April 2019) with well coordinated and integrated division of labour, and high level ongoing team support.

Psychiatrists and other clinicians offering telehealth consultations and advice are best provided in combination and balance with intermittent in-person psychiatric consultations and reviews, optimally by the same psychiatrist or by the same rostered and collegiate group of psychiatrists, providing local team and GP consultation, and clinically hand over to each other. Such a combination should provide better engagement, greater accuracy of assessment and review, better appraisal of physical health needs, better communication and clinical supervision with local gp's and community mental health teams, and better peer review. While telepsychiatry and telehealth counselling are now becoming a highly valued component of mental health services for rural and remote communities, it should be part of a mixed and balanced economy or well integrated spectrum of mental health services. It should not be offered as a stand-alone service, particularly in rural settings, without firm Commonwealth, Medicare and RANZCP requirements to act in close and regular clinical communication with gp's, community mental health teams, and families, especially if agreed by the initial service-user. It is often community mental health teams who have to deal with ensuing crises and acute admissions, sometimes by complete surprise, as telehealth practitioners are not required to do nor are they separately reimbursed for such regular communications.

Rapid access to automated email escalation of e-health clientele from on-line assessment and interventions to urgent in-person services, may be intended by e-health designers and operators, based on the on-line appraisal of high severity, worsening symptoms or potential lethality. This fails when in-person services are not prepared for such waves of electronic referrals, or particularly when the in-person services have been depleted of resources and staffing. Such escalation may depend on direct communication, formal acceptance of hand-over, continuing and often enhanced resourcing and availability of in-person services, particularly as e-health strategies can generate or tap increased demand for mental health services. [See footnote (1) below].

In-person psychiatric services, telepsychiatry, other telehealth and e-health strategies, all medicare rebatable allied professional counselling services, and NGO support services should operate in a complementary, cooperative, carefully integrated and balanced manner with public mental health services. They should also be reciprocally communicative when imminent danger looms, as public psychiatry is obliged to provide a safety-net for the individual service-user when such danger is perceived by their families and chosen service-providers. Such chosen services should operate without gap payments, lengthy waiting lists before triage, or other obstacles or impediments to easy access and engagement. It appears from the on-line documentation that "free" services in this package only apply to "front-line" first responders and their families, with others affected being entitled to a "medicare rebate", indicating the possibility of demands for substantial gap payments.

Resources for public in-person community mental health services should not be compromised or sacrificed for telepsychiatry, other telehealth and e-health

programs, which may ultimately increase case-finding and demand for in-person services. Some governments and mental health administrations may be tempted or persuaded to incrementally or rapidly replace in-person community mental health services mainly with telehealth services and e-health facilities. We need both, and a well-integrated and carefully monitored balance between them. It is probable that both components will require further government enhancements.

Hope this is useful.
Best Wishes,

Alan

Professor Alan Rosen, AO.

Appendices (pages 10-13)
Table 3: Differentiating Crisis from Disaster Response
Table 4: Differentiating Crisis from Emergency Response
[Many service providers, planners and managers confound these terms or use them interchangeably, yet the responses required for each may be very different].
Footnotes

Appendices

Table 3: Differentiating Crisis from Disaster Response
From: Rosen A, Mezzina R, Miller V, Conceptual Confusions in Mental Health Crisis Intervention, in preparation, 2020. Rosen A, Clenaghan P, Emerton F, Richards S. Integration of the Crisis Resolution function within community mental health teams in Johnson S, Needle J, Bindeman JP, Thornicroft G (eds). Crisis Resolution and Home Treatment in Mental Health. Cambridge: Cambridge University Press, 2008.

Differentiating between:	Crisis	Disaster
Incidence and Character:	* Normative event; common; * Ordinary; familiar * Part of our shared everyday experience. * Most people do experience them in their lifetimes. * Crises can become complex & unfamiliar if associated with an acute mental illness	* Extreme event; uncommon; * Extraordinary; unfamiliar, * Not part of our collective experience * Most people do not personally experience them in their lifetimes
Socio-Cultural Response:	* Mobilised familiar interpersonal resources: evokes close family and local communal support.	* Often depletes or exhausts intimate interpersonal resources, as familiar support people are often caught up in the disaster too, so evokes wider but less personal societal response

Differentiating:	**Crisis**	**Disaster**
Professional Response:	* Active Listening * No unnecessary "clinicalising". * Timely skilled intervention if needed * Assess and empathise with the meaning for the individual and family * Assist to Identify trustworthy resource & support people among family & friends * If isolated, Crisis team temporarily becomes proxy for extended support network * Grief and loss or conflict resolution counselling * Explore practical choices & ways of dealing with losses &/or problems of living &/or interpersonal issues & work in parallel with acute psychiatric illness if both are co-existing	* Psychological First Aid"/ immediate low-key listening & support as alternative to Critical Incident Debriefing. * Requires particular skills in managing and special understanding of disaster as unfamiliar experience for both victims and helpers. * Involve family & do not separate kids from parents * Encourage & foster local communal initiatives and leadership fostering cohesion, resilience and reciprocal support. * help navigating/ integrating all needed services
Possible Risks & Sequelae of Non-Intervention:	* Non-adaptation, or symptomatic pseudo-adaptation. * Chronic sick role inviting excessive medical and psychiatric inputs * Poorly developed skills for resolving the next crisis. * Self-harm risk	* Acute Stress Disorder * Post Traumatic Stress Disorder for both victims and helpers. * Long-term Bereavement Disorders. * Self-harm risk * Unaddressed Developmental Traumas load children for lifelong future vulnerabilities and disorders.
Differentiating:	**Crisis**	**Disaster**

Table 4: Differentiating Crisis from Emergency Response

From: Rosen A, Clenaghan P, Emerton F, Richards S. Integration of the Crisis Resolution function within community mental health teams in Johnson S, Needle J, Bindeman JP, Thornicroft G (eds). Crisis Resolution and Home Treatment in Mental Health. Cambridge: Cambridge University Press, 2008.
Rosen, A. Crisis Management in the Community, Med. J. Aust., 167: 11/12: 633-638, 1/14 December. l997.

Differentiating between	**Crisis**	**Emergency**
Key Characteristic	Intensely Stressful Turning Point	Immediately Life-Threatening Situation
Appropriate Personnel to Call: (eg's)	* General Practitioner * Community Mental Health Professional * Department of Community Services Officer	* Police * Ambulance * Fire Station * State or Territory Emergency Services * Hospital Emergency Department
Appropriate Response Timing	* Timely eg Phone back within 15 minutes of call, and arrange crisis visit as soon as possible, and strategically timed to include all participants and personal supports.	* Immediate eg Dial emergency phone number and expect immediate connection and urgent action on 24 hour basis, subject to triage arrangements on the basis of assessed level of urgency and emergency resources available.
	Crisis	**Emergency**
Appropriate Response Type	* Crisis assessment and support * Defusing stress and interpersonal strife * Harness emotional arousal – use as opportunity for new solutions * Practical assistance with pressing problems of living * Low key physical or psychiatric assessment and treatment if necessary.	* Life-preserving: secure physical safety * Defusing violence or potential violence * Psychological First Aid as alternative to Critical Incident Counselling * Urgent physical or psychiatric assessment and treatment

Footnotes

(1) **e-health mental health interventions.** Automated digital services can provide a much larger scale of reach at the population level, and can be most effective as

primary screening & secondary prevention strategies, and can be very effective as interventions alone, particularly for milder to moderate disorders. This may lower demand for in-person services for milder disorders by GP's, community mental health teams, and private psychiatric and psychology services. But it could also uncover latent population demand for in-person services for moderate to severe disorders, which cannot be met with existing workforces.

When individuals accessing e-health mental health hubs need escalation for higher severity and acuity, and/or perceived danger of harm, automated escalation is not sufficient nor always reliable or safe. Explicit protocols need to be systematically applied to ensure formal confirmation of acceptance of hand-over of duty of care, at an appropriate level of urgency. This needs to be assured and communicated both ways, verbally and with documentation, between identifiable service provider persons. Monitoring and management of this and of peak flows of demand for escalation are issues for integration mechanisms between services, including formal service agreements. Public mental health services, and particularly Community mental health staffing levels and mobility, should be reviewed to ensure that sustained increases in demands via these portals can be met.