A: Submission from Alan Rosen 3 March 2020

To: THE SENATE FINANCE AND PUBLIC ADMINISTRATION REFERENCES COMMITTEE

Lessons to be learned in relation to the preparation and planning for, response to and recovery efforts following the 2019-20 Australian bushfire season inquiry to the Senate Finance and Public Administration References Committee (committee) for inquiry and report by the last sitting day in 2021.

Addressing: Term of Reference 8. An examination of the physical and mental health impacts of bushfires on the population, and the Federal Government's response to those impacts;

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Date: 3 March 2020.

Beyond the Prime Minister's Bushfire Response Mental Health Package: Some Concerns and Opportunities.

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Some National Medical and Mental Health organisations were concerned about the lack of balance in the preponderance of potentially pathologizing clinical interventions being floated for the National Bushfire Recovery Agency mental health package, without sufficient regard for encouraging and supporting spontaneous

individual, family and community recovery and resilience (1). On 12th January, the Federal government announced funding of an initial mental health services package belatedly but then hurriedly patched together. It had 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 still largely fragmentary, lack coordination, potentially expensive to both government and service-users, and to be conducted largely by strangers. Moreover, the Commonwealth Government is 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 could be included in the spectrum or mixed economy of service delivery sub-systems, if rigorously applied. Over-reliance on them, however, may oblige affected communities to rely excessively on a transient and interchangeable influx of strangers and distant on-line counselling, with variable expertise in disaster response, rather than restoring and upskilling 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. There are few financial incentives for telehealth practitioners to communicate directly with local primary health and/or community mental health teams, who are too often caught by surprise by acute exacerbations which they have to suddenly manage without warning, or by a belated referral for acute admission, which might have been avoided by timely cooperative teamwork. Moreover, Medicare subsidized psychiatric and allied health mental health services are so maldistributed, overconcentrating in the most affluent urban suburbs, and much harder to find, when needed, in regional, rural, remote and indigenous communities.

At both the Royal Australian & New Zealand College of Psychiatrists' [RANZCP] national (2) and branch level (3), requests for registration to be available for paid telepsychiatry clinical assessments and reviews, with at least some urgent appointments and some bulk billing, has been the main way Fellows of the College have been asked so far to contribute to the mental health package effort. Overbalancing in this direction in isolation from local Primary Health and/or Community Mental Health Services on the ground could provide a skewed, unstable, poorly communicative, transient, fragmentary and expensive service.

Professor Hickie wrote recently (4) : "Unfortunately, some of those areas most affected by the fires have very low access to these services. Traditional Medicare-based mental health initiatives have never delivered in these regions and they won't get the job done now. Governments will need to look at other higher quality and

more effective options. This is a time for the nation to act on evidence and not just rush to well-meaning but often misguided responses".

However, they could well be part of an effective mix, particularly in rural and remote Australia, if properly evaluated and regulated to be inexpensive to service-users, and closely integrated with local mental health services, GP's and support services.

We (1,5.), Dr Virgona (3.) and others (eg 4.) have all called for the Commonwealth Government via the Minister for Health Hon Greg Hunt, to implement a mechanism to correct these structural inequities on a population basis, with weightings for social determinants, just as the state governments should do with inequities between public mental health service-rich and poor districts.

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, child support, etc) , service navigation & coordination, integrated teamwork. and psychological first aid or skilled active listening. This includes trustworthy and culturally safe, supported unprompted 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.

The RANZCP NSW Branch Chair, Dr Virgona, has noted that GP's from the South Coast were on ABC local radio concerned about lack of access to face-to-face psychiatry (3).
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 requiring 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 psychiatric and other clinical specialists by treating them all as a "passing parade" of 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 resident or visiting psychiatrists into their teams, and strongly supporting them managerially**, to demonstrate a commitment to the region, and to supervision as a peergroup and for 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 this for many years with impunity and without close external scrutiny.

This mirrors our federal 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 consultation with the fire control experts and lack of enough fire-bombing aircraft, etc.

So this emergency response 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 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. This would be far preferable than just importing well-meaning but transient clinicians &/or support workers, some undertrained for this purpose, funded only to provide services for the short-term. Whether on an overly intrusive clinicalizing or superficial counselling basis, these could dash expectations and betray needs to deal with ongoing disaster sequelae of loss, grief, long-term trauma, anxiety, depression and suicidality.

The **communal mental health 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 (1, 2). Outsiders, whatever their expertise, should not be expected to just bowl up into town and take over, nor should they dominate these community efforts, which would deskill and disempower the locals and derail their attempts to take the initiative.

We acknowledge, as the PM has done, that there is a lot more to be done beyond this first announcement and first tranche of mental health resources. This should include fixing the persisting main impediments to conducting integrated mental health services in many of the affected regions, to adequately address the needs of those affected adversely by these ferocious fires and ongoing continuity of care where needed.

Particularly worrying has been the depletion and dismantling of many evidence based aspects of community mental health teams, including the erosion of a familiar skilled in-person mobile workforce, and haphazard fragmentary patching with transient locums, telepsychiatry, other telehealth and digital services, rather than applying all these important innovations in integrated ways, with specific and consistent retraining.

There is a **back-handed and timely opportunity** in this ferocious escalation of our bushfire season, and the likely inevitability of worsening climate change events. In the next phase of the mental health response package, pilot programs in all bushfire-prone regions should be funded to provide the required spectrum of integrated mental health and wellbeing services for those individuals, families and communities affected, if these gaping holes in integrated service delivery are corrected with further Commonwealth-State cooperation. This emergency response should be **operationalised to:**

1) **restore resource depleted community mental health services with expertise on an ongoing continuity of care basis,** for the long haul, via cooperative arrangements between Commonwealth and States.
2) Rather than using a passing parade of agency locums as an interchangeable commodity, **LHD's should be rebuilding stable rosters of expert resident or visiting psychiatrists into their teams, and strongly supporting them managerially**, to demonstrate a commitment to the region, and to supervision as peers and for junior staff.
3) Co-design, develop and implement via the Commonwealth Government a mechanism to **correct the structural inequities in Medicare subsidized fee-for-service on a population basis, with weightings for social determinants(5,6).** Concurrent incentives should be provided to encourage bulk-billing, rational curbing of gap payments, and such practitioners to communicate with GP's, families and rural community mental health services. In parallel, the state governments should be provided with incentives to eliminate inequities between public mental health services which are near-adequate, and those, particularly in rural , drought and fire afflicted areas, which are often utterly inadequate.
4) Consider **integrating the mix of mental health services by evidence - based purchasing through nationally regulated and monitored Regional Commissioning Authorities** (1, 5, 7, 8), which could also stop the continuing siphoning of mental health resources to favour general health services.

As to our communal and public roles as psychiatrists: Like the AMA, and our most distinguished scientists and economists (9), RANZCP should unambiguously and publically acknowledge the strong scientific evidence for our being in the midst of a predictably escalating climate change emergency (9), with many concomitant adverse mental health impacts. These require anticipation, effective mitigation and adaptation, whether symptomatic or functional. This demands our strong advocacy for investment in bolstering the resources and resilience of our poorest and most vulnerable communities, especially remote, indigenous and refugee populations. It also entails training up many multiskilled and mobile mental health workers to work in advance to help build resilience inside these communities.

We should 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, and all should be heard respectfully. We should 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.

We should 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. We psychiatrists, need to consider this in terms of how those affected make sense of what has happened, and help them to develop a sense of agency in a time of crisis and recovery.

RANZCP should encourage us as collegiate psychiatrists, among other mental health professionals, to support each-other in working with affected individuals families and communities, while enabling open discussion about growing and pervasive anxiety about climate change, and acknowledge any communal existential concerns. This could include the collective pain and grief for actual and anticipated loss of familiar and accustomed habitat ("Solastalgia")(10.) and of "eco-anxiety" arising from uncertainty and fears for the future, for ourselves, our children, their children and our communities, and as a habitable planet for future generations.

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B: Attachment: 13 Suggested Provisional Guidelines to Hon Greg Hunt et al for Mental Health Services Package in Federal Government response to 2019-20 Bushfires, 13 January 2020.

See attached.