

Vn 5: 23 Aug 20.

Telehealth Services for Fireground regions & COVID related mental health services:

Additional Submission following testimony to the SENATE FINANCE AND PUBLIC ADMINISTRATION REFERENCES COMMITTEE, July 29, 2020:

Inquiry into lessons to be learned in relation to the preparation and planning for, response to and recovery efforts following the 2019-20 Australian bushfire season

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**Re: Mental Health Panel, 29 July 2020:
Professor Alan Rosen AO (Submission 4) (via videoconference)**

Summary:

We may have an unbalanced over-reliance on and possibly only transient provision of telehealth for extreme bushfires and COVID19 by the Commonwealth Government mental health response plans, without adequate operational or ethical guidelines nor adequate investment for parallel provision of local in-person services required for an effective mental health response to these circumstances.

There are now concerns, shared by at least some Senators on this Senate Committee, that the temporary implementation of these telehealth provisions could now be followed by downgrading, curtailing or withdrawal of Commonwealth mental health telehealth Medicare arrangements in vulnerable regions where the prolonged depletion of familiar local mental health services still has not been addressed.

Introduction:

Many mental health practitioners and some service users have found telehealth consultations helpful during the COVID 19 Pandemic. Together with colleagues Dr Dorothy Kral, and Professor Peter Yellowlees (subsequently, Professor of On- line Health, University of Queensland, & then at University of California, at Davis, Sacramento) I was among the very early adopters of telepsychiatry and mental health telehealth in remote Australia and with Aboriginal communities from the 1980's. I have always favoured the practical, ethical, integrated and expanded use of these tools to augment our clinical practices, and still do so.

My most recent concerns are for the potential for withdrawal of these concessional COVID 19 arrangements by 30 Sept 2020 for psychiatrists and other mental health professionals doing telehealth consultations in parallel with the precedent set earlier this week by the Commonwealth Government in curtailing GP Medicare arrangements for Telehealth. Also, it is clear that A substantial proportion of fee-for-service psychiatrists doing telehealth now, intend or are likely to revert to their more habitual urban local practices in their rooms when the COVID19 separation requirements recede and their own usual clientele return.

There are parallel concerns with the possible transience of the recent belated replacement of local familiar public mental health professionals on the ground, whose positions have been depleted by the jurisdictions over some years, (including and especially in many of the extreme bushfire areas) by distant

stranger mental health professionals working by telehealth. The current subsequent risk of having the latter telehealth services withdrawn by the possible curtailing Commonwealth Medicare arrangements, while the long-term impact of trauma will carry on for many years, may disrupt any prospect of any expert ongoing continuity of care (see my attached statement on deficient arrangements for the firegrounds, prepared for the Royal Australian & NZ College of Psychiatry, which informed my testimony to the Senate Committee on learnings from the bushfires: Rosen A, 2020b).

For example, when do assured rather than discretionary bulk-billing arrangements end for telepsychiatry/mental health professional telehealth sessions for those individuals and families affected by fires and the fire-fighters and their families?

1. Crucial Role of the Commonwealth Government

The Commonwealth Government should urgently take an active role in working with, provide financial assistance to and incentivize the states & territories, to replenish the depleted family care teams, restructuring them in more evidence-based ways. This should be done especially in regions with most vulnerable populations affected by prolonged droughts and floods, extreme bushfires and COVID 19, by providing enabling financial incentives, offers that they can't refuse to meet half-way. This would offer immediate relief for the firegrounds and most vulnerable pandemic-affected regions, as well as providing timely pilots for coherent, cost-effective services for the future.

Professor Hickie stated recently (Hickie I, 2020): "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".

The Commonwealth Government needs to urgently take an active role in working with the states and territories, ensuring a balance between enhancing evidence-based in-person mobile outreach community mental health services and enhancing telehealth services to minimize unnecessary person-to-person contact on safety grounds. At the same time, they should ensure the safety of all clinical and support workers. [See the Expert Clinicians Call for Action attached].

2. Achieving a balance between Telehealth & In-Person Mental Health consultations

RANZCP Telepsychiatry guidance needs to promote a balance with in-person engagement, assessment & review and home-based care when needed, including doing this with safety in fireground regions and throughout the Covid pandemic era. One core problem is that RANZCP Position Statement on telehealth is still silent on many of these issues, as are the Australian Psychological Society guidelines. [Note attached: Call 4 action with presidents of AMA and RANZCP also being signatories]. Also, we need to compare solely digital practice with digitally enhanced or digitally augmented in-person community mental health practices (See sections 5 and 6 below, plus attached: Rosen A, Gill N, & Salvador-Carulla L, 2020a, and Gurr R. Rosen A et al, 2020, Productivity Commission draft report response-see telehealth sections of both).

As ever, and as with the national mental health response for both Covid 19, the extreme bushfires, prolonged droughts and further inevitably ongoing and compounding climate change emergencies (see invited US psychiatric news articles attached) we will continue to need a careful balance between familiar in-person and outreach home visiting services, delivered with proper safety precautions and equipment, and digital & telehealth services in regional mental health provision.

A message in a recent mass email notification to all health practitioners via AHPRA (10 August 2020) from Professor Michael Kidd AM, the Commonwealth Deputy Chief Officer, states: "Telehealth items are provided on the basis that if a face-to-face attendance with a patient is clinically indicated during a telehealth attendance, then this can be arranged. The face-to-face attendance does not need to be performed by the same practitioner who provided the telehealth service, but providers should ensure that they can arrange a face-to-face attendance if required." This message is encouraging and

welcomed by many concerned expert health and mental health practitioners who sent the Call-For-Action document to the Commonwealth on their concerns to re-establish this balance. However, this advice becomes ambiguous, as it is not followed up with any related firm recommendation in the accompanying COVID19 Telehealth Items Guide itself. One partial exception may be the Guide Section 3.4, "In the case of patients living in remote locations, some components could be performed by another service provider (such as a remote area nurse or Aboriginal health practitioner). This might include observing the patient's vital signs, such as pulse, blood pressure and temperature, which could be communicated to the medical practitioner responsible for the service". This is important to state, although it still has too many "could" and "might" qualifiers [See 6.j & 6.k below]. Another promising sign has occurred with the Prime Minister's very recent announcement (Morrison S, 2020) of Commonwealth funding for a new range of clinics and multidisciplinary teams in Victoria, both urban and regional, during the COVID spike there. It includes an undertaking that affected individuals (including Aged Care facility residents) and "their families and carers, will be able to access mental health workers, including psychologists, at these clinics either in person, or via telephone or digital services where needed." Hopefully, their additional capacity to do home visits with safety precautions and equipment, as necessary, will be clearly mandated and properly exercised.

3. Telehealth Services required for Fireground regions and COVID 19 related mental health services.

My current concerns are for the potential for curtailing or complete withdrawal of these concessional COVID 19 arrangements by 30 September 2020 for psychiatrists and other mental health professionals doing telehealth consultations in parallel with the precedent set last week by the Commonwealth Government withdrawal of nationwide GP Medicare billing arrangements for Telehealth consultations. Also, it is clear that a substantial proportion of fee-for-service psychiatrists doing telehealth now, intend or are likely to revert to their more habitual urban local practices in their rooms when the Covid distancing requirements recede and their own usual clientele return. Also, as stated by Senator Watt in this Senate Hearing 29 July 2020: "One of the things that concerned us was that we were told that, while mental services had been provided on the ground in the early stages after the bushfires—and people were very grateful for that—with the COVID restrictions and the limitations on people's travel, a lot of that face-to-face and on-the-ground service had actually been withdrawn."

There are parallel concerns regarding our prolonged season of extreme bushfires: In particular, the possible transience of the belated replacement of familiar local public mental health professionals on the ground (whose positions have been depleted by the jurisdictions over years, especially in many of the extreme bushfire-ground regions) by distant telehealth mental health professionals. The consequent risk of having these telehealth arrangements withdrawn by the possible curtailing Commonwealth Medicare arrangements, while the long-term impact of trauma will carry on for many years, may disrupt any prospect of any expert continuity of care.

Several Senators at our hearing expressed similar concerns regarding the uncertainty of Commonwealth telehealth funding arrangements in fireground areas beyond 30 September 2020. However Ms Alison Verhoven, CEO of the Australian Hospitals & Healthcare Association (AHHA) states that: "Health Minister Greg Hunt has also indicated support in principle for telehealth consultations to continue beyond September when the current arrangements expire" (<https://protect-au.mimecast.com/s/GEqSCWLVXkUAAZ6pip5Hze?domain=ahha.asn.au>).

I recently asked Dr Ruth Vane, the Deputy Chief Medical Officer (Mental Health), Commonwealth Dept Health, the following questions:

1. Can you possibly indicate what mental health telehealth and telepsychiatry Commonwealth billing arrangements are being considered for beyond Sept 30th?
2. When do assured rather than discretionary bulk-billing arrangements end for telepsychiatry/mental health professional telehealth sessions for those individuals and families who have been "affected" by the fires and for the fire-fighters and their families?

3. How much utilization has there been of these arrangements in the different fire-ground regions?

Dr Vine replied that while discussions are ongoing, and she is actively seeking further information re issue 3, issues 1. & 2. are yet to be determined.

The Commonwealth should still prioritize taking an active role in providing financial signals to work with and incentivize the states & territories to replenish those familiar local teams in more evidence-based and cost-effective ways. This would offer immediate relief for the fireground and badly pandemic affected regions, as well as providing timely pilots for coherent services for the future.

4. Issues for mental health service-users and mental health professions.

a) MH Service Users & Peer Workers:

From: Many Voices, Many Needs: Consultations with people living with mental health issues at the onset of the COVID-19 crisis, Being, April, 2020.

Adapting to new technology: A significant proportion of peer workers expressed a level of difficulty with the move to telephone and online support. Whilst most peer workers are trained to provide face to face support, many are unsure of how to provide such sort through technological methods. Similarly, some peer workers identified that their services were not equipped to provide peer support through digital platforms, leaving many peer workers unable to work in ways other than contact by phone. Further, a number of peer workers were being called on to provide tech support to some of their clients as an added service, despite not feeling comfortable themselves with technology. Some also expressed that they found it difficult to juggle the work of looking after their clients' mental health whilst also providing skills develop in the IT area. Peer workers suggested that some peer workers would benefit from additional IT education themselves if they are expected to provide technical support and/or assist their clients to establish digital and online platforms.

Not being able to provide person-to-person support: This is an area that peer workers are finding particularly challenging when trying to support their clients in relation to accessing services to meet their clients' needs, such as such as Centrelink, safe housing, and shopping. These kinds of supports are particularly important at a time when so many changes are occurring so rapidly and peer workers felt it important for them to be considered in the same vein as essential clinical services.

Consumer access to technology: Where social groups are moving online, peer workers have experienced challenges because some consumers do not have access to technology, and many peer workers are not trained in such ways of working. Perhaps in some cases, consumers could be subsidised to access technology that would allow them to maintain some level of social interaction during the COVID-19 pandemic. Recommendations for subsidised phones and plans, as well as it equipment and internet plans were highly recommended.

b) MH Professionals:

We mental health professionals, our clinical services and professional organisations need to regain a balance between telehealth /telepsychiatry services and in-person engagement, assessment, outreach & review, with home-based care when needed, including doing the latter with safety in Covid 19 era. [See attached: Call 4 action]. We also need to liaise with the person's clinicians and family. One core problem is that the RANZCP Position paper and other available clinical professional guidance on telehealth are still silent on many of these issues. This may well pertain also to other professional organisations. See also sole digital practice Vs digitally enhanced or digitally augmented comprehensive community mental health practice (Rosen et al, Future of Community Psychiatry 2020 & Gurr R et al, 2020). TAMHSS response to Productivity Commission draft report 2019).

c) Special Needs populations and culturally appropriate adaptations

For all these levels of service for rural-remote, indigenous, transcultural, refugee/asylum seeker, LGBTI, forensic and aged care institutions and co-occurring mental health and

substance using populations and communities, a combination of some in-person and e-health/telehealth “hybrid” services can also provide a range of on-line interim or temporarily bridging partial proxies for the wider spectrum of therapeutic options for rural/remote/indigenous or transcultural populations, which would otherwise only be available in-person at urban or regional centres. (The Orange Declaration, Perkins D et al, 2019, Aust. J. Rural Health).

Indigenous communities are particularly vulnerable to outside visitors or service-providers inadvertently infecting and decimating their elders and others living with physical disabilities, so extra-rigorous precautions must be invoked, favouring a balance of indigenous community controlled telehealth services and familiar, well-monitored, trusted health and mental health providers for in-person services, wherever possible.

The Drought Mental Health Adversity Project [DMHAP] report 2008-9, under the leadership of Assoc Professor Paul Fanning, and of which I co-authored the study and sections on impact on Aboriginal communities, was endorsed by government and morphed into a multimillion dollar Rural Adversity Mental Health Program [RAMHP] throughout NSW. Our findings remain relevant that rural and regional Australia required innovative mental health service models to cope with rural adversity from drought/fires/climate change, macro-economic reform and rapidly changing population demographics. A bespoke service model would have incorporated a network of service agencies including local well trained MH responders, general practitioners backed up by regular and familiar (not interchangeable agency locum) visiting specialists, with access to 24 hour telehealth or telepsychiatry assessments and advice. This could be titrated according to need and locality.

Complementary findings can be found in the COAG funded Murdi Paaki (2009) and Farm Link (2009) reports that aimed to reduce morbidity and mortality from mental health and drug and alcohol disorders for rural and remote communities, including Aboriginal populations. These initiatives were endorsed by government but not operationalised, despite the overwhelming evidence and support from national advocacy groups (P Fanning, pers.comm.2020, Hart C et al, 2011).

5. Lack of professional organisations providing sufficient routine training and guidance re ethical and more effective practices

All mental health professionals organisations (eg Royal ANZ College of Psychiatry-RANZCP, Australian Psychologists’ Society-APS, the Agency for Clinical Innovation and others) need to update their formal advice to all mental health professions on these issues. They variably provide some sound advice on practical matters, including clinical risk and maintaining boundaries, which may also defray some risks for the organisations or professions as well. There are no or very few recommendations on practitioners trying their best to see ongoing clientele in person from time to time (growing literature on “Hybrid Care” Yellowlees P. et al 2018), nor any insistence on practitioners liaising with the persons’ g.p. and with families or local mental health workers or units who/which may be involved, even in crisis, largely because they don’t get a fee for these. So local workers may cop a surprise unheralded emergency presentation because of failure of the telehealth practitioner to communicate such concerns. Some practitioners do try to communicate systematically, but many don’t, and there is no formal requirement, nor any real financial incentive, certainly not for psychiatrists, and possibly for other professions. The Commonwealth need to provide financial incentives, ethical standard practices & regulatory requirements to ensure that they do so.

6. Mental Health Professionals need guidance & training on how to conduct telehealth, including:

- a. Checking privacy, including who else is in the room or in earshot.

b. Welcoming the presence as appropriate, of an existing mental health care coordinator, Aboriginal or transcultural mental health worker or interpreter, primary health practitioner, as well as a family carer or a confidante, if the service-user agrees to or requests it, unless that other person is actively abusive, threatening or controlling, in a way that would effectively restrict the service user from expressing their concerns.

c. Seeking or welcoming co-lateral account or complementary viewpoint from confidante of service user's choice, with permission of service user.

d. Routinely consulting and communicating with person's g.p., family or carers, local mental health care coordinator.

e. Need to eliminate and/or regulate discretionary or arbitrarily set and charged substantial gap payments.

f. If telehealth is employed for ongoing care, it is important whenever practicable, to see them in person, especially in crisis, for initial assessment and annual or comprehensive review, or second opinion. It will usually be understandable if this is not always possible, but it is rarely offered even when it is possible.

g. It is preferable for mental health by telehealth practitioners to practice regionally if possible, rather than nationally or beyond, so that periodic in-person reviews become achievable, or so that telehealth practitioners can fruitfully join local team case conferences or reviews.

h. Mental health needs in a disaster are often not apparent to some victims until well after the emergency phase and early physical recovery phase, and they may not be ready to reach out or to be receptive to mental healthcare until some months after the height of the disaster, but by that time they often find that the initially responding and offering mental health resource people have left the field and returned to their urban practices.

i. While it is appreciated when mental health professionals become willing telehealth practitioners, often from a distance, during national emergencies, it is essential that they make a commitment to continue this service on the same payment basis (eg. bulk-billing) for a considerable time (eg at least for 1 year if necessary with following review) , as trauma precipitated disorders take a long time and consistent treatment to improve and heal. A common complaint in our recent disasters has been warm short-term engagement by professionals who then retract their services and commitment to people from that region. This can feel like a breach of promise, or re-abandonment.

j. Services must provide training, updating, up-skilling and regular individual or group supervision sessions for telehealth practitioners, to be arranged and funded via their professional organisation or on an interdisciplinary basis, funded by government.

k. Overall, the vast majority of telehealth consultations, particularly by GP's, are by telephone. Practitioners need to ensure that the person is seen in-person if a more comprehensive specialist examination or interactive assessment is required, and if it is too complex to delegate to a primary health care professional. So practitioners must overcome any natural tendency to extrapolate or to resort to their imagination to "fill-in-the gaps" from the limited information or the lack of information available on a telephone or screen. This could occur either in or out of the practitioner's awareness. In extreme form, this could be considered to be professional negligence or could appear to constitute a dysfunctional iatrogenic equivalent of "practitioner confabulation".

l. For telepsychiatry/telehealth consultations with rural/remote/indigenous/transcultural communities and populations:

- a. the practice should be sensitive of the impact of witnessing and recording disclosures made during comprehensive assessment by telehealth and/or emergency management when assessing mental health, sexual & general health and substance issues on patient confidentiality and relationships and fear of public shaming via gossip networks in small communities, and

- b. practitioners should be familiar with local resources for mental health, sexual & general health and substance use assessment and treatment, and be willing to actively liaise and to arrange referral to and appointments with these services as needed.

7. Bulk-billing Medicare rebates and gap fees for vulnerable & disaster affected people

We draw on the example of Psychiatry here. Bulk-billing for telehealth and general psychiatric consultations, especially for fireground victims, vulnerable and pandemic affected individuals and families should be encouraged so they will seek mental health services when timely, rather than waiting until they are desperate or actively suicidal. However, the Medicare Schedule needs to be totally revamped if we want to encourage bulk billing, though of course it would cost more and the federal government usually wants Medicare costs to be contained or diminished. We already have the highest out of pocket costs of any OECD country including the USA (for those with insurance) and these services are out of reach for those people with insurance with little disposable income, or those who cannot afford insurance at all.

A problem with advocating for more bulk-billing in psychiatry is that it is so biased towards brief appointments, [maximizing Medicare payment at 4 appointments per hour] and at diminishing comparative rates with less than inflation increases over time. If you only see one or two patients per hour, which may be much more clinically effective, you earn less than if you were salaried in public practice, where you would be paid more per hour plus holidays, benefits and no practice costs. To see a new patient for ongoing care, bulk-billing pays a low fee which is not commensurate with the extra assessment, thinking and writing time required, so private psychiatrists may stick to seeing their habitual clientele or to charging high gap fees, especially for new assessments. While there is a higher paying item (Medicare item 291) for seeing a person for an assessment and preparation of a care plan for the GP to implement, that does not solve the problem for referrals of people likely to need the ongoing skilled care of the psychiatrist (nor the ongoing need to review needs with their family carers). This is not to minimize the problem that, as in other specialties, some practitioners are still allowed to charge exorbitant gap fees on the basis of what the market will bear. Bulk-billing new patients is also problematic, due to the high no-show/last minute cancellation rates, often by those most in need of psychiatric care, which amounts to a waste of time and a loss of income. Medicare should also provide incentives and pay for time spent liaising with the person's gp, family (with permission, currently only in the initial assessment phase at a lower fee), and mental health care coordinator if they have one. Thus, the current Medicare payment system does not effectively shape psychiatrist behaviours in the most desirable and effective directions.

8. Privacy of Personal Information, Security of & Investment in Information Platforms.

As Rosen A, Gill N & Salvador-Carulla L, 2020a, state: There are also concerns on the quality and transparency of the information available to consumers. As stated in a recent Lancet editorial, "without a clear framework to differentiate efficacious digital products from commercial opportunism, the companies, clinicians and policy-makers will struggle to provide the required level of evidence to realize the potential of digital medicine". Unlike pharmaceutical research, there is little disclosure vigilance regarding financial ties and partnership bias in digital health research and it is still possible for researchers, clinicians, and health officers to be investors in the digital products that they are researching and promoting. An improvement of methods of analysis and conflict disclosure is even more pertinent in mental health, where it is necessary to clearly define what kind of players and partners the new digital health companies will be for the mental health community, and how they will 'ensure that mental health data are secure and patient consent for their use and reuse is transparent' without unauthorized disclosure, especially for service users, who are vulnerable and easy prey to public shaming, stigma and discrimination.

9. Current Knowledge & Developments of digital mental health services

9.1. 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 (Chistiansen H,pers comm). But it could also uncover latent population demand for in-person services for moderate to severe disorders, which cannot be met with existing facilities and workforces.

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). Whereas, on the basis of intricate modelling algorithms, individuals and families with Acute, **Severe and Complex** psychiatric disorders and severe suicidality usually respond best to inclusive in-person engagement, interpersonal re-connection, interdisciplinary teamwork and assertive outreach (Hickie I, ABC-RN, 1 April 2019, Atkinson J-A, Hickie I et al 2020) with well-coordinated and integrated division of labour, and high level ongoing team support. However, to confidently recommend these pathway distinctions, requires much more empirical evidence.

Rather than the above implicitly stepped-care model, planning for real-world mental health ecosystems requires a more complexity encompassing framework, allowing for multiple variants of face-to-face and digital interactions and settings, with hopefully person-centered clinical and support services (Rosen et al 2020a, Rock D et al 2020). Widening the range of optimal combinations of mental health service experiences for different individuals can be planned for with blended scenarios, rather than "abandoning" mild and common disorders almost solely to e-Health interventions and triage, which may disrupt therapeutic relationships and interactions at and between primary and secondary care levels (Salvador-Carulla L et al, forthcoming study of blended systems). For instance, it is not clearly established that e-health self-help interventions for all mild disorders are superior to and would not be synergised by an in-person therapeutic component if available. For example, on the basis of systematic reviewing of numerous rigorous studies, Cognitive Behavioural Therapies, e.g. for anxiety disorders, delivered by automated computerized delivery service systems may not be as effective as compared with in-person professional CBT services (O Kearney R et a , 2019), so caution should be exercised before large-scale implementation.

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 and enhanced to ensure that sustained increases in demands via these portals can be met without being swamped or overwhelmed.

9.2. Telepsychiatry and other Telehealth mental health services

Psychiatrists and other clinicians offering telehealth consultations and advice are best provided in combination and balance with an activated capacity for in-person psychiatric consultations and reviews as necessary, with proper safety precautions. Optimally, the in-person consultations should be provided by the same clinician or team, or by the same rostered and collegiate group of expert clinicians, 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 GPs and community mental health teams, and better peer review. While telepsychiatry and telehealth counselling are now becoming highly valued components of mental health services for rural and remote communities, they 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 GPs, 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 so, and nor are they separately reimbursed for such regular communications.

9.3. Limits to our Knowledge and Understanding, or “Known Unknowns”:

We are beginning to know how much we don't know in the fields of applying e-health and telehealth. We are realizing that clinicians conducting telehealth practices need to acquire different skill-sets for:

- competence and reliability in early prevention and detection, triage, referral, assessment, clinical advice, counselling, treatment, and review via e-Health and Telehealth, and/or in their use in augmenting in-person practice,
- establishing organisational or business models to sustain them, and
- anticipating and understanding the many complexities, including transience of services and variable equity of access for and use by vulnerable populations, of e-Health and Telehealth service delivery, as demonstrated by the rapid shifts to digital services, accelerated by the sudden demands of the extreme bushfires and the pandemic (Taksa L, pers.comm.2020, Erfani S S, et al 2016).

10. Conclusions & Recommendations: On-line Mental Health, Telepsychiatry & Telehealth In Balance with Local Mental Health Services:

- a) e-Health:** Judicious bringing to scale and use of firmly evidence-based e-Health initiatives, especially for the growing more receptive segments of Australia's population, should be planned for as part of a blended mental health ecosystem framework, in balance with in-person services. However, we must not generate demands, nor raise expectations that we can't meet via on-line mental health portals or by any other means.

For escalation or urgent triage of symptoms rated as severe and risking life by on-line scales from automated e-health systems, it is unacceptable to escalate or refer such individuals by automated call, text or email, lest the receiving service is depleted and way behind in opening messages. 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. Such referral needs to be assured, confirmed and communicated both ways, verbally and with documentation, in-person between identifiable human service providers.

- b) Telehealth:** Medicare subsidized telepsychiatry and mental health professional telehealth, where needed for the regional mix of clinical mental health services, could be jointly monitored and regulated between the Commonwealth and State or Territory Governments via a jurisdictional budget-holding and “Commissioning” Mental Health Commission (eg W.A.), or Regional Commissioning Authorities. These could protect and pool mental health service

funding from all public sources, as recommended by the Productivity Commission [Gurr R et al, response to draft Productivity Commission report, Jan 2020]. Under these provisions, telehealth practitioners should be obliged and incentivized to:

- encourage longer consultations where needed, and regular liaison with the person's GP, with their families (with permission of the service-user), and with Community Mental Health teams, especially if there is any risk of presentation to public services.
- be governed by a single or unitary and widely agreed regional MHS plan integrating all public, NGO and any privately contracted MHS. This plan should have some formal obligation status such as strictly operated contracting, with clear sanctions, rather than just a loose in-principle service agreement.

These arrangements could underlie a regional "arm's-length" commissioning method of ensuring delivery of contracted services, whether from public, NGO, private institutional or fee-for-service sectors, with monitoring and auditing of both budgets and expenditure acquittals to ensure that no shifting of resources to non-contracted or non-MHS services, or funding will be promptly withdrawn.

2. The Commonwealth should provide more easily accessed e-Health portals and telehealth augmented services which have been fully determined to be cost-effective, to help to meet the growing surges of demand for mental health services generated by recent prolonged disasters, and beyond.
3. As digital communication and telehealth are used more by clinical, rehabilitation and support services, service users, peer workers and families need technical education and support for less technologically literate individuals and families, to ensure that lack of familiarity with technology does not exclude them from online clinical and social support services and opportunities for sustained social contact. The latter is therapeutic in itself. Provision of funds is needed to purchase hardware and connectivity for people living with mental health issues who are not currently able to afford them. Provision of IT familiarization and ongoing technical support is also required (Being, 2020). However, service users who are isolated, whether due to their disabilities or environmental adversities and disasters or both, will need all this in balance with safe and regular in-person contact.
4. Finally, the Commonwealth Government has a crucial role and an overarching responsibility to ensure a fully functional balance between distal digital, office based and local familiar in-person and assertive outreach services for all vulnerable Australian populations, whether their vulnerability and adversity is due to extreme bushfires, prolonged drought, floods or pandemics, climate change, and other social and cultural determinants, including indigenous, rural-remote, migrant and forensic communities.
 - The Commonwealth government needs to work with the states and territories to enhance funding, not just for e-Health, telehealth and for increasing the number of Better Access sessions, but also for adequate provision of local, familiar, in-person, community outreach, inpatient and hospital-in-the-home alternatives and other community-based rehabilitation and supported residential facilities.
 - The Commonwealth should urgently take an active role in work with, provide financial signals to and incentivize the states and territories to replenish depleted local community mental health teams, restructuring them in more evidence-based ways of operation. This would offer immediate relief for the most vulnerable fireground communities and both badly and as yet only moderately pandemic-affected regions, as well as providing timely pilots for coherent, cost-effective services for the future.

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