**A Call to Action for resetting an optimal balance between face-to-face, assertive outreach and digitally enhanced community focussed mental health services: Telehealth Mental Health Services for and beyond Prolonged Droughts, Extreme Bushfire regions, COVID19 & other likely Climate Change related adverse events.**

Supporting Document for Action Plan: The Need for Fundamental Change in Mental Health, International Mental Health Collaborating Network [ICMHCN].

Professor Alan Rosen, AO, Chair Transforming Australia’s Mental Health Service System, Inc, [TAMHSS]; Institute of Mental Health, University of Wollongong; Brain & Mind Centre, University of Sydney, Australia, October 2020.

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* We welcomed the first waves of mental health responses to the COVID-19 crisis from the National Governments, particularly in higher to middle income countries. Many largely focused upon the whole population through on-line or e-health information, triage, crisis counselling services, and telehealth, but much less so, if at all, on enhancing face-to-face and home visiting services. This resulted on rapidly “pivoting” many primary and specialist mental health care services from face-to-face to telehealth.
* Although telehealth enhancement was often the sole or predominant response, it was often withdrawn too early, or extensions of these arrangements were often brief and discontinuous, or still too expensive and inaccessible for too many.
* We also appreciated the unprecedented steps taken by Governments to preserve livelihoods through the crisis via various economic stimulus packages. The safety nets that have been established are crucial to prevent loss of jobs, which harshly impact on people with more severe forms of mental illness. However, such support was often too restricted or curtailed too rapidly.
* There is now an urgent need to move the focus to people with moderate to severe, persisting and complex mental illness, and suicidality, whose numbers are swelling as further adversities unfold.

**Key issues**

* The needs of people with moderate to severe mental illness were often poorly served prior to the pandemic, as evidenced by the prior low priority for funding of and many inquiries into mental health services. This represents a pre-existing crisis and makes the system in many countries extremely under strain and at risk.
* Many people with mental illness and psychosocial disability were already existing on the margins of the economy and society, and are extremely vulnerable to the pandemic, associated economic recession, and high levels of unemployment. Many are isolated or living with families in need of support themselves and are at high risk of suicidal behaviour.
* At particularly high-risk are isolated or facility-bound aged individuals and those living with disabilities, Indigenous people, homeless people, non-citizens, and international students. Their need for acute care will swell during this crisis. A substantial rise in suicide risk is building, as in all economic recessions, and it will be more severe this time because of the scale and depth of the global disaster of COVID-19, including loss and grief. The suicide prevention field has been rightly emphasising the power of social determinants of suicide. The impact will be difficult to counter or moderate in the medium term. Our response therefore must turn much more strongly to freely accessible expert clinical care.
* In the shock of the initial phases of this pandemic, public, private and many NGO mental health services for people with mental illness saw a sharp drop in face-to-face care, and a withdrawal from home based and assertive outreach modes of providing such care, just when these are most needed for a wider range of service users who were more isolated than ever. In part this is related to a lack of availability of protection equipment and justifiable concerns about service-user and staff safety.
* The system is weakest at a point where it needs to be strongest in the context of COVID-19, namely in its capacity to work upstream with timely community interventions to prevent excessive emergency department presentations, and hospital admissions of acute mental illness.
* As with any disaster, and particularly the pandemic of the huge scale in which we are now immersed, there are emerging several delayed and overlapping surges of increasing demand and need for care.
* Mental health services, including hospital facilities, are being overwhelmed when providers do not intervene early, and intensively, with people we know to be at risk of acute episodes and suicide.
* It is also sometimes due to inconsistencies of clinical leadership and central policy direction, and to failures of role modelling by some senior clinicians, without age or disability related vulnerabilities, who have withdrawn to working digitally only from their homes and offices, and loss of in-person clinical back-up for NGO direct support services in the community.

**Key Solutions**

* The key solution is to urgently deploy evidence based mobile pre-emptive active response community-based mental health teams, including home-based care with dynamic integration with digital on-line and telehealth platforms.
* There are increasing numbers of published studies on telehealth use for mental health in recent disasters, but they are mainly descriptive, and often simplistic, implicitly encouraging public mental health teams to “pivot” almost completely to more sedentary telehealth, without providing rigorous evidence of comparative effectiveness, nor adequate balance with face-to-face and outreach home visiting services, whenever possible and necessary, and with proper safety precautions. Some senior clinical leaders, even those not in designated vulnerable categories, role-modelled this by switching their work attendance to “virtual” only.
* However, we need an optimal and adjustable mix of both, encouraging hybrid digitally enhanced face-to-face services (and vice versa) in all regions. The legacy of evidence and lessons from these disasters, extensive modelling algorithms on the basis of this evidence, and likely exponentially worsening climate change, for mental health services, are that we will need to stabilize and develop this balance further for the future, making these arrangements more equitable and ongoing. Government responses to ameliorating the continuing mental health impacts of trauma & prolonged economic consequences of these disasters, need to be sustained on an ongoing basis, not for just a few months at a time, nor without further and continuous Government commitment for the future.
* We call on all Governments to ensure that national mandated policy guarantees an optimal balance between online and telehealth services, in-person mobile outreach community services, hospital inpatient services, and residential alternatives for community residential care with continuity of support. The focus of the next wave of policy and investment must shift to ensure the safety and optimal care of people with moderate to severe or complex mental illness.
* Service managements must ensure safety and personal support of all service-users, clinical and NGO providers. Mental health providers must be assured that there will be no retractions of community staffing or their outreach capacity, with strong and compassionate management support, thorough safety training, adequate supplies of personal protective equipment, regular supervision and pastoral mentoring, in full consultation with their industrial representatives.
* We must also now re-plan our mental health services for well beyond recent environmental disasters, including the current pandemic, in the light of our experiences of the effectiveness and deficiencies of different nations’ mental health responses to these disasters, We must do this also in anticipation of increasing demand for such services due to further escalation of climate change related environmental adversities, which will affect those with the worst greatest disabilities and social determinants first, but ultimately us all. This entails expanding early intervention and active response community based mental health services, while resetting the balance between more community and less hospital-centric services, as well as between digitally augmented and face-to-face and assertive outreach services.

**References:**

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