Submission to the Independent Review of Commonwealth Disaster Funding

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Q1. What experience have you had with Commonwealth disaster funding support?

Wentworth Healthcare (WHL), provider of Nepean Blue Mountains Primary Health Network (NBMPHN), received Commonwealth disaster funding through Department of Health and Aged Care (DoHAC) since 2018 to address the mental health impacts of successive natural disasters such as drought, bushfire and flood as well as specific funding to assist healthcare providers across the region to respond to disasters.

Generally the funding was for:

* Providing immediate counselling

* Assisting with increased demand for headspace services by young people

* Providing navigation to appropriate mental health supports and promote a joined-up approach to the mental healthcare system

* Providing small community grants to strengthen social connectedness and resilience as well as reduce suicide and identify PTSD

* Expanding low-intensity, short to medium term mental health services to provide tailored support based on the needs of the local communities.

* Infrastructure grants to General Practices affected by floods to support them to continue to provide services and immunisation to the community.

The NBM region is vulnerable to natural disasters. It features a unique world heritage area which is regarded as one of the most bushfire prone areas in the World and the Hawkesbury Nepean Valley has been described as having the highest single flood exposure in NSW and possibly Australia. Wide geographical diversity and varied weather conditions makes the region vulnerable to natural disasters and adverse weather conditions such as bushfires, floods, droughts, heatwaves and landslides. The region ranks 2nd highest across all NSW PHNs for persons reported with high or very high psychological distress. The region is also home to tourists, seasonal workers, people who voluntarily live 'off grid' and a higher than average Aboriginal and Torres Strait Islander population.

In our experience, the funding is provided for specific natural disasters and despite the best of intentions it is delayed in reaching the PHN which inhibits a timely response especially if recruitment is required.

Funding is often prescriptive and does not provide enough flexibility for a tailored response to meets the needs of our region. For example, considerable funds are provided for Psychological Therapies which has been challenging to utilise as trauma affected individuals don't always identify with having 'traditional' mental health issues, so do not seek out 'traditional' support. Additionally, in our region considerable distances are required to attend appointments, public transport is limited, internet connectivity is poor and further undermined by disaster impacts and there are shortages of mental health providers. Alternative funding sources were used to commission outreach Wellbeing Workers that were embedded in the state designated recovery service to provide outreach mental health check ins and navigation to stepped up support (consistent with the effective responses noted in the National Mental Health Commission's National Disaster Mental Health and Wellbeing Framework).

The funding period is usually 2-3 years which is not consistent with widely accepted evidence that the minimum timeframe for disaster funding should be 5-10 years. Additionally, there is often the expectation that the funding will be committed within 3-6 months during the 'flurry' of disaster aftermath.

Q2. How could Commonwealth funding support communities to reduce their disaster risk?

* The increasing frequency of disasters requires a cohesive approach between healthcare providers and stakeholders. Ongoing funding is needed to build and maintain capacity of primary healthcare, mental health providers and community stakeholders that find themselves on the frontline as 'accidental counsellors'. If funded appropriately PHNs can bring their infrastructure and capacity to coordinate localised planning and delivery to ensure the joined-up system stands up to the crisis and evolving needs that disaster brings. Without adequate preparedness work and capacity building, an uncoordinated response becomes a burden on current systems during the critical response phase. As stated in National Mental Health Commission's National Disaster Mental Health and Wellbeing Framework "a poor disaster response can be as traumatic as the disaster itself and this short-term thinking should be avoided".

* It is important that sustainability, scalability, and ongoing support is considered. Primary healthcare providers and community stakeholders are constantly changing and these networks need to be maintained to ensure there is a coordinated and integrated response. There has been much criticism from both community and primary healthcare providers about the 'fly in and fly out' nature of support providing no continuity and a fractured approach.

* Whilst a mobilised response is needed during and immediately following a disaster, there must be consideration in providing ongoing care and support that meets the needs of a community. The workforce assisting people impacted by disasters have particular support needs. This includes those working in mental health and wellbeing roles as well as other roles in direct contact with community members, such as tradespeople or retail staff.

* Commonwealth funding should allow for purpose-built and community-led mental health supports that utilise clinical and/or non-clinical services and be open to innovative and creative solutions driven by local initiatives which feature community connection, shared meaning and wellbeing. It is

important to recognise that disaster impacted individuals do not see themselves as having mental health issues so trauma informed practices which prioritise soft entry, non- clinical and informal wellbeing assistance are supported with proactive automatic funding after a disaster. The Journal of Social Work cites that "the four most useful supports were family, friends, rebuilding resources, and their community".

* Funding timeframes should recognise the delayed response and account for the delay in individuals affected by trauma seeking assistance and long-term clinical support. We concur with the approach of the National Mental Health Commission's National Disaster Mental Health and Wellbeing Framework that the Australian Government adopts a 'five-year planning timeframe for mental health recovery following major disasters to allow for extended and delayed mental health impacts'.

* Acknowledge that disasters will keep happening and that a community may be engaged in simultaneous actions for disaster prevention, preparedness, response and recovery as cascading and concurrent events occur, such as flooding after a drought or bushfire during a heatwave. Specifically named disaster funding ("Flood Funding" or "Bushfire Funding") prevents natural synergies that can be enhanced as a result of relationships developed during cumulative and often successive disasters.

Q3. Please describe your understanding of Commonwealth disaster funding processes.

* While the importance of supporting people's health and wellbeing following disasters is well documented and recognised, it is not supported by ongoing funding but rather it is reactively enacted after specific disasters and focused on recovery rather than preparedness and risk mitigation. Funding is mostly narrow in scope and does not allow for a tailored non-clinical approach that acknowledges the layers of informal support with family and community and pre-existing relationships with community services. Much work needs to happen when there is not a disaster, at a time when it isn't 'sexy' to invest in this work. PHNs are key to integrating the primary healthcare providers, mental health professionals and community stakeholders to prepare and respond to emergencies and disasters efficiently and effectively.

* PHNs should be provided with dedicated ongoing base funding for disaster management work which can support preparedness, immediate response and recovery, with additional funding provided on an as needs basis in the height of a disaster.

Q4. Are the funding roles of the Commonwealth, states and territories, and local government, during disaster events clear?

The multilayered system is exposed during disaster and can result in some ambiguity on the roles of the Commonwealth, states and territories, and local government during disaster events. Confusion also arises from a plethora of well-intentioned agencies such as Lifeline, Vinnies, Red Cross, CatholicCare etc that have been activated to provide wellbeing support.

WHL was provided with funding for community grants by both Commonwealth and State government, which initially had different funding timeframes, that required developing new systems for reporting to each funding agency.

Clearly delineated roles that is recognised by all levels of government and stakeholders will assist with coordination and collaboration. As noted in National Mental Health Commission's National Disaster

Mental Health and Wellbeing Framework "people's mental health and wellbeing following disasters is dependent on collaboration and well-coordinated action by all recovery partners".

Q5. Is there any further information you would like to provide?

* Whilst PHNs have been funded by the Commonwealth Government to provide mental health support post disaster events, there has been no funding for PHNs to undertake preparedness activities with General Practice and the broader primary care sector, which PHNs support.

* The Australian Government should fund PHNs and primary healthcare providers to undertake regional emergency planning and preparedness work, including developing primary health preparedness and response plans, and related communication, training and trialing.

* National disaster preparation, response, and recovery initiatives must be systematically integrated with the local community responses to ensure local coordination and ongoing support after an event. In a healthcare context, primary care is well-suited to provide this support given its interaction with 85% of the population annually. PHNs, as experts in regional primary care coordination, have essential skills, capabilities, and existing local relationships to support the integration of the primary care into coordinated disaster preparedness, response and recovery efforts.

* PHNs offer the opportunity to coordinate a strong primary health care response that will deliver care where and when it is needed. PHNs can enable primary care providers to continue delivering primary care to their local communities and effectively contribute to the local health response. This can be achieved in a cost effective and rapidly scaled manner ensuring access to primary health care services at a time when acute health services are stretched.

* Primary health care is an important part of Australia's healthcare system but while there is much goodwill and commitment from primary care providers, they are not able to maximise existing capabilities for response, relief and recovery, without coordination, leadership and support. Please see A white Paper: The role of Primary Health Networks in natural disasters and emergencies. https://www.nbmphn.com.au/Resources/About/The-Role-of-Primary-Health-Networks-in-Natural-Dis

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