T R A N S C R I P T

LEGISLATIVE COUNCIL ENVIRONMENT AND PLANNING COMMITTEE

Inquiry into the 2022 Flood Event in Victoria

Melbourne – Wednesday 6 December 2023

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WITNESS

Jane Nursey, Head, Clinical Services, Phoenix Australia.

The CHAIR: Welcome back to the final session of the day for the committee's public hearing for the Inquiry into the 2022 Flood Event in Victoria. Thanks very much for coming.

I will just read out our standard statement about your evidence. All evidence taken is protected by parliamentary privilege as provided by the *Constitution Act 1975* and the provisions of the Legislative Council standing orders. Therefore the information you provide to us during the hearing is protected by law. You are protected against any action for what you say during the hearing, but if you go elsewhere and repeat the same things, those comments may not be protected by privilege. Any deliberately false evidence or misleading of the committee may be considered a contempt of Parliament.

All evidence is being recorded. You will be provided with a proof version of the transcript following the hearing. Transcripts will ultimately be made public and posted on the committee's website.

I might ask the members of the committee to introduce themselves.

Wendy LOVELL: I am Wendy Lovell, Member for Northern Victoria Region.

David ETTERSHANK: I am David Ettershank, from the Western Metropolitan Region.

The CHAIR: I am Ryan Batchelor, from the Southern Metropolitan Region and Chair of the committee. We may be joined shortly by our colleague Jacinta Ermacora from Western Victoria – she will be with us in a moment.

Thanks very much for coming in, Ms Nursey. I invite you to make an opening statement, should you choose to do so, and for the Hansard record could you state your name and the organisation you appear on behalf of when you commence your statement. Over to you.

Jane NURSEY: Thank you. My name is Jane Nursey. I am Head of Clinical Services for Phoenix Australia, which is a not-for-profit organisation based at the University of Melbourne, with specialists in psychological trauma, and has been a centre of excellence in Australia really for trauma for the last 25 years, so our mission is to improve the lives of people who get impacted by trauma no matter what the cause of that trauma is. I would just have an opening premise that I am a late stand-in for this delivery. I was advised last week that a colleague was unwell and unable to attend, so I have had only a few hours to prepare really.

The CHAIR: That is okay. We appreciate you coming in.

Jane NURSEY: I will cover what I can.

The CHAIR: That is fine.

Jane NURSEY: I also should make the point that I was not actually involved in this flood response. I have been involved in other disaster responses and recoveries. My understanding is that you are interested in understanding about the impacts on mental health of disasters and how they might impact the responses to disasters and this flood emergency in particular, so what I thought I would do is just give you a general overview of what we know from the research in terms of disaster impacts and also what I know from 30 years of clinical experience and then sort of relate it to the terms of reference perhaps as I go through.

I guess to start off with we have had an explosion of evidence happening over the last 15, 20 years in terms of being able to run good trials and literature reviews on understanding the impacts, and we do know and have strong evidence for the fact that mental health and wellbeing are significantly impacted by disasters. It impacts individuals, it impacts families and it impacts communities. Everyone is going to have their own individual response. There is no such thing as a normal response. Every response is normal is another way of putting it, so we can expect a whole range of different reactions in people and in communities.

It is important to state outright that we know that the majority of people are resilient. They might have initial reactions, and we would expect most people, particularly in a disaster event as significant as this one, to have some early perhaps significant reactions. They might be strong, intense emotional reactions in terms of fear, sadness, anger, grief, shame, guilt – whatever the situation might have caused. They are likely to have sleeping difficulties and some medical physical issues in terms of pain, nausea, headaches and those sorts of things. They are likely to have significant problems with concentration for a period of time and difficulties getting their thinking organised and retrieving information and are also likely to have changes in behaviour, and that will vary depending on the age of the person, their background and what is going on for them. But it can include things like becoming very withdrawn, whereas usually they are quite social and outgoing, or it might be that they become quite impulsive or it might be that they become quite disorganised. It might be that they throw themselves into work and will not stop. For children and young people it can be tantrums, regression in skills and those sorts of things. It does impact people across the age range. Even infants can experience some reaction depending on the level of intensity of the reaction in their parents, so no-one is immune to that.

The majority of people will recover fairly quickly from that over a period of weeks or months, particularly if they have got good social support and good support around them and the community response is well organised and gives them direction on where to go and seek support. We know that following disaster there can be a significant increase in anger in the community, and that often translates into higher levels of domestic violence in families in those communities. That differentially impacts women in particular and children, and that has been shown in number of studies both in Australia and overseas. Recovery will be different for everyone. As much as the reactions might look different in everyone, the recovery trajectory will look different in everyone as well. As I said, the majority of people by far will slowly recover from those initial reactions. But there is likely to be at least 25 to 30 per cent of the population who will demonstrate some ongoing distress that will interfere with their ability to sort of cope with the recovery process and perhaps go on to develop a mental health disorder, and that would include things like depression and anxiety, PTSD, substance abuse problems and those sorts of things.

An interesting finding that is beginning to emerge in the literature is the impact of compounding events. We know that in Victoria, particularly at the time of these floods, our rural and regional communities were suffering a sort of three-pronged natural disaster event in terms of floods and fires and the pandemic as well. The compounding nature of those disasters means that individuals do become more vulnerable and particularly if they have had other trauma exposure in their life and other events that they have been exposed to. Social connectedness and community connectedness are really very good predictors of recovery and probably the best support that people can have. Those that are perhaps living alone or are more isolated within their communities or even within their families might be more likely to struggle than those who are well connected. We also know that there are multiple risk factors though for perhaps having a less favourable recovery, and they can happen at an individual level. It depends on the nature of their disaster experience, what they witnessed, how soon help was available, whether or not they thought they were going to die, whether or not they witnessed other people being harmed or injured and what their own coping skills are but also what their experience of the response was for them as an individual.

That I guess brings me to one of the key points that perhaps is relevant to most of your terms of reference really in that the nature of the emergency response can have a significant impact on the level of recovery of individuals and the community as a whole. What we have noticed is as a state, as a government and as a community we are getting much better at providing systematised approaches to emergency response and recovery, but in the past that has definitely not been the case. What happens is that you get very fragmented responses. You get multiple agencies coming in with no understanding of how trauma and disaster might impact on individuals and how they might respond to direction or to what they are saying. It is very difficult for the members of the public to actually find out where to go and get help, how to access help and what that help might provide for them, and if there is no good infrastructure in terms of providing that support, if there are people waiting days or hours for support and safety, then that is definitely going to have an impact on their recovery as well.

So I think in terms of thinking about how to improve and learn from experiences in each disaster we need to be taking an all-hazards approach. We do not just go from one disaster to the next, but we are taking an overall approach that says we are preparing for disaster, because it is potentially going to happen very regularly in our communities from now on. But we are also thinking about, for each agency that might come in to help in that response, (a) there is communication between agencies, and (b) there is a common understanding about trauma

and its impacts, so those responders actually get training in understanding trauma impacts, in things like psychological first aid, which I will talk about in a minute, and in a trauma-informed care approach to supporting the community. What I mean by that is that it is coordinated, that it is done with the view of trying to do it in the safest way possible and in the most inclusive and respectful way possible and that it is done informed by knowing the impacts on trauma.

I think that is enough on mental health impacts. I guess just one last word on the impact on communities – we know that what happens, particularly in regional communities where most of these disasters are happening, is that you get an immediate coming together of community to help each other, and that is incredibly helpful in terms of that initial response. People understand that there is help there, and it is help that they know and are comfortable with. But what you can see over time is some fragmentation of the communities as the recovery process goes on. Difficulties in terms of accessing support are variable. Then those sorts of things can start to eat into relationships and into how the community is responding, and those sorts of things need to be taken into account.

In terms of how we respond and support people who might be impacted by disasters, we do have, just recently made available, the Victorian disaster and mental health framework through the Department of Health, which I would suggest is probably a good resource document if you are not familiar with it. By and large that initial response is just about providing safety for people, practical support, ensuring that they are meeting their basic needs in terms of shelter, food, water and those sorts of things, but also in general support. If we think about the approach to recovery, it really is what we call a stepped care approach, so the idea that at different stages of the recovery process, different people will have different needs, and we need to be able to match those needs for each of those individuals as it goes on. Really initially it is a universal approach where we can provide basic psychological and wellbeing support to everyone through something like psychological first aid, which is meeting those practical needs and ensuring that they are safe, helping them to calm down, providing them with some strategies to do that and linking them in to the various agencies that might be there that can meet the immediate needs that they have. That is really important, and the evidence would suggest that it is really important that everyone who is working in that flood response, actually, is aware of how to access those different resources, because we cannot guarantee that everyone is going to hear about them if it is just one or two people that have that knowledge. So we really want everyone who is working in the area to be aware of where to find those supports and how to support the individual that is in front of them at the time. So that is a level 1 intervention.

Perhaps at a level 2 it is still universal, but it is about really drawing on that self-help and community support – so the idea that you are using the resources that are lying within the community, the strengths that that community has to support each other, which will have happened naturally, but really bedding that in, I guess. I guess a primary aim of that is that connectedness, you know. Families that get displaced, that get separated, are much more vulnerable and particularly young children but even adults and the elderly. If they are getting displaced, then that becomes a very high-risk factor.

The next level, level 3, is what we call focused or non-specialised support, and that is perhaps more targeted psychological support, but still it is just for people who have some ongoing distress; it is not for people who have significant mental health disorders. It can be provided by GPs, primary healthcare workers, trained community workers, and it is about being able to skill up people in those resilience skills like problem-solving, emotional regulation, stress management, managing sleep, those sorts of things. Then the final one is much more specialised help, where people who are developing mental health disorders are getting referred.

There is really strong evidence for community-led recovery programs. Communities that do best are those where the community are actually the ones involved in developing that and leading that and implementing that. It is not to say that they will not benefit from input from special advisers and experts, but that advice and input needs to be provided by people who are trauma-informed, who are culturally informed of the different cultures within the community and the culture of the community itself and respectful of those differences and able to help the community navigate how to implement things for those differences.

The CHAIR: Ms Nursey, we might just stop the opening statement. It has been very, very useful evidence, but I have got a few questions that I want to ask.

Jane NURSEY: Can I just put one last thing?

The CHAIR: Yes, please.

Jane NURSEY: Disaster recovery capital is really important, by that I am talking about the idea that there are a range of different resources every community has that can be drawn upon to support recovery. And in disaster and emergency planning it is really important to pay attention to those. So it includes things like, you know, the buildings around you, the human resources, the capability of the humans in the community, the natural environment and what it has got to offer, finance, housing, those sorts of things, so there are about seven different disaster capitals that we could talk about. I will stop there.

The CHAIR: Thank you. I have got a few questions, and I am sure the others do too. One of the things I am interested in is – you touched on it briefly and the Minister for Emergency Services made a similar comment earlier – about some of the differences in the temporal aspects of the support that people might need. It might not be straightaway; it might come a long time afterwards. I am wondering if you have got any insights you can share with us about what your practice experience or the literature tells us about how needs change over time and what government and community need to be thinking about in terms of supporting people's mental health post disasters?

Jane NURSEY: First of all, again, that idea that everyone is going to be different, but it is possible that the needs are going to extend across 10, 20, 30 years. A disaster at one point in time is not necessarily just going to be contained within a one, two or three-year period. In those first initial days and weeks, that universal support is really important, but it is something that needs to be available and openly available without it necessarily being pushed upon individuals.

Some months into the recovery process you will begin to see people who are not following that trajectory of resilience so much, that have got some ongoing distress, some ongoing difficulties, maybe irritability, anger, difficulty making decisions, accessing supports. That is where you really want that second tier of supports available, the primary healthcare workers with good training in level-two supports. You might have, from six weeks post, people presenting with frank mental health problems. But there are other people who might do really well, not even show many signs initially on; maybe they are involved in the recovery and that engagement really helps to provide them with support. But 15 years down the track – maybe there is something else that happens to them, maybe there is a significant event in their life even if it is not traumatic – that then their coping and resources suddenly break down and they actually begin to get some re-experiencing symptoms of the disaster or some depression and anxiety PTSD emerges.

What we have learned from the research is that PTSD is quite prevalent following disasters but usually has a fairly good recovery trajectory, and most people will recover from that. There will be a percentage that do not. But depression and anxiety hang around and can be problematic over a long period of time. Most often what we will see is that there will be peaks and troughs. Symptoms of those sorts of disorders will come and go, but even symptoms of distress will come and go, so things like anniversaries and memorials or similar events happening in other towns in Australia are all going to be triggers –

The CHAIR: So triggering events, yes, okay. Interesting.

Jane NURSEY: triggering events. And they might need to then go and seek more support than they did when they experienced their own event. So it does depend on how well they have coped, what resources they have around them, what their own mental health history and what their physical health are like, what are the other stressors in their life and how well they are getting managed, what that recovery trajectory for them has been like. We know from the 2019 bushfires at least a third of the community is impacted by that, say at the 10 to 15-year mark that things still are not back to normal. I am still trying to work on recovery and get this community back to normal or my idea of this community back to normal and contribute to that. So it can be very long, I think, and I think the message in that is that we cannot just say, 'All right, we're providing support in these initial months, or for the first two, three, four, five years.' We need to have supports available.

The CHAIR: That brings me to just one more question, and then I will pass to my colleagues, about your view of the adequacy of the current response support arrangements for these sorts of issues both in the immediate response and then in the extended recovery period?

Jane NURSEY: I think, as I say, it is significantly improving. My experience in the Black Saturday bushfires being in on day one in many of those communities was that it was pretty chaotic. You did have lots of

different providers coming in from afar, and so it was very disorganised. People just wanted to come together with people they knew; they did not really want to speak to strangers. There were people coming in that really did not understand how to set up support services, and certainly the other emergency response agencies had very little understanding of how to work with people who were in high states of adrenaline and trauma.

I think now we are much better and I think the Red Cross does an amazing job in terms of going in and providing that support, and there are other agencies that do that as well. But I think the government as well has got a much better handle on the need for coordination of those responders. I think the biggest issue is finding access to that higher level support for people who do have trauma-related mental health problems. Finding providers – psychologists, mental health workers – who are well trained in trauma treatments is difficult. But again, the recent Victorian review into mental health services and setting up a statewide trauma service should hopefully address some of that.

The CHAIR: Great. I will pass over to whichever of my colleagues wishes to go next. I am in your hands. You can go, Deputy Chair.

Jane NURSEY: I should say more training of GPs and primary healthcare workers.

The CHAIR: Yes. Getting the primary healthcare interface better. Yes, sure.

David ETTERSHANK: I think Mr Batchelor covered the major issue I wanted to get to there. Can I firstly thank you for a very comprehensive introduction.

Wendy LOVELL: Yes, it was great.

David ETTERSHANK: And if you did not have time to prepare – I mean, heaven help us if you had. That really was terrific. Thank you for that. We tend to like to simplify these things as much as possible. Recognising you were not involved in the Maribyrnong directly, if you were to do a gap analysis of what ideally would be in place, as opposed to what is in place, what would be at the top of the list there in terms of gaps in service provision and delivery?

Jane NURSEY: A centralised communication port for every agency that is going to go in and play a role. I think we are getting close to that, but there has to be an immediate briefing, I think, of all of those agencies, about the situation. You would potentially want all of the staff in those agencies trained in those three things: psychological first aid, mental health literacy and trauma-informed care. I think that is a gap. The people who go in – we do not expect them to be counsellors, but we do expect them to be able to know how to communicate and interact with people who are in a state of high distress and trauma. You do find that many of the financial counsellors, the engineers and the plumbers that go in often say, 'Well I'm not a plumber, I'm a counsellor,' because they are the only person that the community member has found to actually talk to. So I think an upskilling of our community generally in those sorts of things is a gap, and one that we need to address.

David ETTERSHANK: Upskilling in terms of psychological first aid?

Jane NURSEY: Psychological first aid and mental health literacy also. I think our understanding of mental health more broadly in the community is quite low. The terminology is quite well-known, but the deeper understanding is perhaps less well-known. Again, we do not expect them to be therapists or counsellors but to actually understand how it works, because that then feeds into the willingness to go and seek help and support, because they do not actually understand what the problem is or what the support might offer. That is the second thing, really; the barriers and access to care is the gap. Particularly in regional and remote communities there are very few trained mental health providers capable of providing the resources. I would argue that even in cities and regional areas we have got many providers but not necessarily all competent and capable of providing the right level of support. So that is another gap and I think resourcing those communities with the appropriate level of mental health support is really important.

David ETTERSHANK: Can I perhaps pick you up on the first one about the central point for all people going in to provide support. Is that the sort of function you would see being performed by organisations like Emergency Recovery Victoria? Is that who you would be thinking might be trying to do that coordination, or who would otherwise?

Jane NURSEY: Yes, I think so – the lead agency, I guess, so yes, Emergency Management Victoria would be the key one. I think they do do that, and they have done that in the past, but I think there is still a lack of knowledge. I think there is assumed knowledge, perhaps, in all agencies about what to expect and how to respond. If we think about emergency services workers, for instance, police and SES and those people, first of all, many of them are volunteers – not police, but others – and are perhaps working in their own communities, so they are going to be impacted and traumatised by the experience themselves. They are going in without an awareness of what those impacts are for them and how to manage those. They are perhaps going in without an awareness of what might be happening in the other community members as well, in terms of general knowledge about that, and I think also how the work that they are doing is going to impact them over time. We do have a large percentage of mental health disorders occurring in those first responders following disaster because they are not necessarily correctly prepared for it.

David ETTERSHANK: Lots of areas have disaster recovery plans. In your experience, do they address these sorts of mental health issues, or are they more about getting rid of the mud and getting people into shelter?

Jane NURSEY: Traditionally they have not, and to some extent even your terms of reference do not really actually refer to mental health. It is assumed in there. It is sort of something that sits there underneath always for different agencies, but there is no overt training. There are no objective measures to look at it and evaluate it. There is no training. It is improving, and I know that police and emergency services are now getting much better at promoting mental health within their organisations, training them in understanding mental health literacy and those sorts of things. But there will be other agencies, whether it be financial counsellors, whether it be animal rescue agencies and those sorts of things, and it sort of applies to everyone, not just the main ones. I think it is just that we need to understand that we are now in an era where emergencies are part of our life, and if we want to be able to minimise the compounding risks of exposure over time and support communities, then we need to upskill everyone in our community to understand the impacts and what helps recovery.

David ETTERSHANK: Excellent. Thank you, that is outstanding. Thank you, Chair.

The CHAIR: Ms Lovell.

Wendy LOVELL: Thank you very much. It was a really comprehensive report. You have talked a lot about community response, which I will come back to in a minute. Last Thursday I celebrated 21 years as a member of Parliament. My entire career being a country representative, particularly for Northern Victoria, has been marked by disasters: the millennium drought for the first 10 years of the century; we had within days of my being elected in 2022 my electorate up in the High Country up around Mitta Mitta ablaze throughout the summer of 2002 and 2003; we had the great alpine fires in 2006; Black Saturday in 2009; fires again in the 2019–20 summer season; we had floods in 2010, 2011, 2016 and 2022. So I have been through this post-traumatic stress and the community response and the government response for natural disasters a number of times.

I think there is only so much governments can ask of a community-led response. For instance, in Murrindindi in the 2009 fires, the vast majority of the local government employees had lost their own homes. In Rochester everyone was affected – they had lost homes, and they were expected to then step up and help their communities. It just strikes me that there needs to be some better framework around this. Yes, communities want to do everything they possibly can. Rochester have done a sensational job. I called into the recovery centre in March and I have a very good relationship with Amanda, who is the Neighbourhood House coordinator there, and she just unloaded on me. I was happy for her to unload on me because that was therapy for her. We have since had lots of laughs and lots of hugs about it, but she was just finding it overwhelming that day. We have got nine weeks wait for financial counselling, there have been times in Rochester where we have had zero mental health workers available. You have got a lot going on for people in their communities. What does your report say about government response and how prepared government should be for this response? Because we all know that there is a shortage of these specialist workers, but we need to have them come in and help those communities.

Jane NURSEY: I am not an author of the report, I will just say that on the outset. But I think what is important is having a framework, having a good plan. What is required is surge capacity, so what we need is the capacity to bring in support, and that has been what has happened in the past. But it is giving guidelines about what that support should look like and how much of it needs to come in. We know that in bushfires,

firefighters from all over Australia and overseas will come and support local agencies to fight fires. We need something similar in terms of supporting the mental health of affected communities.

I worked at the Austin Hospital psychological trauma service during the 2009 bushfires and headed up the outpatient service there, and we set up a bushfire recovery service across the state at that time, funded by the department of health. Really one of the key things was providing someone for the local area mental health services and community mental health services to provide supervision to them, to provide support to them, to provide support to the local government workers who were working, so opportunities to have some counselling support, opportunities to get some education around what was required, providing education to the case managers that were brought in at that time to deal with the response.

I think it is agencies like universities and specialist academic institutions and mental health provider institutions that have expertise in what is required being brought into really upskill community. I think it is about having a plan to upskill and build capacity over time so that communities can become self-reliant and that there are opportunities to keep that training going. But regardless, each time you are going to have to bring in some expertise to build that capacity, and understanding how to do that for each community so that the community is able to engage with those outsiders, not feel threatened by them and not resist that support in and of itself is something that requires planning and thinking through and training.

Wendy LOVELL: I understand what you are saying about building skills within community, but as I have just pointed out, it is often the whole of community that is affected, and to build skills within community really does not help if you have got a whole of community affected. It is also about –

Jane NURSEY: But it is working alongside those affected.

Wendy LOVELL: Yes, but also some people in the community do not feel comfortable talking to someone they know. They are going to feel much better talking to someone who is not someone that they are going to be seeing down the street every day for the next 10 years, for instance, particularly if they are having some stress or particularly mental health issues et cetera. We need outside support; we cannot do it all ourselves. You talk about our local CFA volunteers: every time they go to a fire, it is someone's house who they know, who is losing everything they own. As they are putting out the fire, they are dealing with their friends going through the most traumatic event they have had in their lives. My own brother does road rescue – he has cut his best mate's mother out of a car that she has just died in, when his best mate is sitting on the side of the road crying, and Gary is dealing with both of these things. This is what we deal with in country communities, we know each other.

Jane NURSEY: Yes. And that is where that surge capacity comes in – the idea that you are bringing in outside support that works within the community for a period of time but alongside the community, so it is building capacity at the same time as it is providing direct support and serving the community's needs. There are differential impacts in those communities. Again using the Black Saturday bushfires, going in and supporting Goulburn Valley Area Mental Health, for instance. Most of those staff were impacted directly by the bushfires, but being able to go in and provide some supervision support, some training, some education, doing some of the work alongside them as well, meant that (a) they felt supported, (b) they felt upskilled and able to manage better and (c) they were able to get some support and management of their own issues. And so they came out the other end hopefully in a better position to be able to go into the next disaster knowing what to do and how to manage – not saying that they will not need support again, but you can learn from each of those experiences, and you can recover from each of those experiences as well. I think it is about people recognising what their capabilities are within that and opting out if they are not in the right position to be doing that work and there being a system where we can call on other providers to be coming in and providing that support.

I do think with mental health – and it does not have to be mental health workers necessarily in those initial phases, primary care workers as well – part of the problem at the moment is our healthcare system is also under a huge amount of pressure, particularly from COVID, and so the capability of our healthcare system to provide that extra support, drawing on it from other regions, is limited.

I do not think there are clear, simple solutions to these problems, but I think what we know about what helps recovery is about connecting people and providing that support and upskilling. And I think if we have a model about how we go about doing that, even if it is a model that is sort of permanently there – maybe it is a

Commonwealth issue in terms of that coordination between states as well. You know, who do we bring in from what state to help with mental health? If it operates at a first responder level, why couldn't it work at a mental health level as well?

Wendy LOVELL: I think that is a good idea.

The CHAIR: I might bring your evidence to a conclusion there. Thank you so much for coming in. I think having heard a lot of hydrology, engineering, sandbags – all important – it is good to finish on people and how they respond and to think about that, so I really appreciate the time you have taken to actually come in and give us that very, very comprehensive and useful evidence. You will receive a copy of the transcript of today to review before it is made public. With that today's committee hearings are concluded.

Committee adjourned.