the Australian College of Mental Health Nurses Inc.

ACMHN response to:

Report from the Mental Health Reference Group to the MBS Review Taskforce 2018

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Introduction

The Australian College of Mental Health Nurses (ACMHN) welcomes the opportunity to provide feedback to the MBS Review Taskforce, regarding the *Report from the Mental Health Reference Group to the MBS Review Taskforce 2018.*

The ACMHN acknowledges the Medicare Benefits Scheme (MBS) Review Taskforce was asked by Minister Greg Hunt MP, Commonwealth Health Minister, to review the existing MBS items, with a primary focus on ensuring that individual items and usage meet the definition of best practice.

We note that the Primary Care Reference Group focused on items that are primarily or exclusively provided by non-doctor health professionals, and which have a close relationship to primary care and in some instances, to mental health nursing.

The ACMHN also notes that a number of ACMHN Members have been involved as participants to the MBS Review process:

> Ms Sonia Miller - Mental Health Nurse Practitioner and Credentialed Mental Health Nurse; Director, MHNP Consulting; Chair, Australian College of Mental Health Nurses (ACMHN) Mental Health Nurse Practitioners (MHNP) Special Interest Group (**Appointed to Mental Health Reference Group**)
>
> Ms Peta Marks – RN, BN, MPH, MCFT, Credentialed Mental Health Nurse; Director, Australian Health Consulting; Professional Development Manager Australian College of Mental Health Nurses (ACMHN) (**Appointed to Mental Health Services Clinical Committee (Eating Disorders)).**

The ACMHN made a number of submissions to the MBS Review Taskforce:

1. Feedback to the MBS Review Taskforce: Primary Mental Health Review Committee.
2. Submission to the review of MBS items for the treatment of people with eating disorders.

The Australian College of Mental Health Nurses

The Australian College of Mental Health Nurses (ACMHN) is the peak professional organisation representing mental health nurses in Australia. A primary objective of the ACMHN is to enhance the mental health of the community through the pursuit of efforts to improve service and care delivery to those affected by mental illness and disorder. The ACMHN also sets standards of practice for the profession and promotes best practice in mental health nursing.

Mental Health Nurses

Mental Health Nurses, Credentialed MHNs and Mental Health Nurse Practitioners (hereafter MHNs), work with people across the mental health spectrum - who experience crisis and psychological distress, mental disorder and mental illness; across all clinical settings – primary care, community and outpatient, inpatient and specialist/tertiary services; across the age spectrum from the perinatal period, to babies, children and young people, to adults and older adults. Among other things, MHNs provide evidence-based psychological therapy, mental health assessment and risk assessment, care coordination and monitoring.

General Comments

The ACMHN acknowledges the work of the Mental Health Reference Group and the clinical committees in what appears to have been a comprehensive exploration of the key issues and considerations impacting on access to treatment for people experiencing mental health concerns.

In particular, the ACMHN appreciates that the goals of the review recommendations were to provide:

- Affordable and universal access
- Best-practice health services
- Value for the individual patient
- Value for the health system

We note with concern that:

- *despite increases in the specialist workforce over the last decade, access to many specialist services remains problematic, with some rural patients being particularly under-serviced* (p12)

And agree with the following statements:

- The MBS should *support the delivery of services that are appropriate to the patient's needs, provide real clinical value and do not expose the patient to unnecessary risk or expense* (p13)
- The MBS should *reduce the volume of services that provide little or no clinical benefit, enabling resources to be redirected to new and existing services that have proven benefit and are underused, particularly for patients who cannot readily access those services currently* (p13)

- The MBS needs to ensure that *consumers have adequate access to mental health services through the MBS*, that consumers have a right to *choice in mental health provision to promote a strong therapeutic alliance*, and that *commercial interests of health professionals should not influence this choice.*
- Issues that relate to *access, proximity and affordability of services and the complexity of the referral process* need to be addressed.
- A stepped care approach provides matched services to the level of intervention that most suits a person's current need.

Nurses from all clinical settings and all specialty areas have a role to play in the provision of stepped mental health care. Please see Appendix A for a description of the role nurses play across the stepped care continuum.

At present, there is limited access to mental health nurses through primary health care – there are a range of reasons for this including workforce shortages, however, lack of recognition as an eligible provider under the MBS is a major contributing factor. This also affects MHN ability to act as providers of psychological therapy to other programs including NDIA, WorkCover, Victims of Crime etc. Not only is this inequitable and could be considered professional bias, it is illogical given that MHNs have the knowledge, skills and experience to provide comprehensive mental health treatment and management to people across the spectrum of mental illness, and are the most well-distributed of all mental health professionals.

Response to Recommendations

Recommendation 1 – Expand the Better Access Program to at-risk patients

The ACMHN supports the expansion of Better Access program to people who are at risk of developing a mental health disorder, in order to support those who present with early symptoms, and to those who are recovered but remain at risk of relapse.

Mental health nurses working in primary care and private practice with people who have recovered from an acute episode of mental illness recognise the value, to the individual and their support system as well as to the community and the health system more broadly, of maintaining contact with the person who may be at risk of relapse. The focus of care at this time is on relapse prevention and maintenance of good mental health, as well as physical health promotion and the maintenance of good physical health. In addition, supporting the person to re-establish connections and activities that may have been disrupted through the period of mental ill health, such as social/family/community connections, work/education/leisure activities, and engaging with other support and community services as required are essential.

Recommendation 2 – Increase the maximum number of sessions per referral

The ACMHN supports the increase of the maximum number of sessions per referral to avoid unintentionally inhibiting access to care for some people or disrupting the flow of treatment with an unnecessary review session.

Recommendation 3 – Introduce a 3-tiered system for access to Better Access sessions for patients with a diagnosed mental illness

1. The ACMHN strongly supports the introduction of a 3 tiered system, whereby people with diagnosed mental illness can access treatment based on their individual need, over a 12 month period relevant to them (i.e. commencing from the date of the initial referral) and on the severity of symptoms, duration of mental health disorder, impact on functioning, treatment response and complexity; rather than on arbitrary session limits.

2. The ACMHN would also recommend including a person's carer/family in the decision to identify clinical need wherever possible and relevant, as carer/family are a vital important element of the team. We recommend that the wording in the report is restructured to include carer/family: 'clinical need is collaboratively established with the referrer, mental health provider, consumer *and carer/family,* rather than setting a number determined prescriptively' (p36).

3. The ACMHN has a number of comments in regard to the observations by the committee regarding people who experience moderate to severe mental health disorders accessing appropriate mental health treatment, in particular, issues of relevance to mental health nursing includes:
    - *Patients with moderate to severe mental health disorders, a small cohort with the highest mental health illness burden, do not currently receive the treatment they need through the MBS*
    - *The Mental Health Nurse Incentive Program (MHNIP) provided support in this area, but the program was discontinued in June 2018. While the Reference Group is not aware of data collected on the impact of this change, clinical experience suggests that many MHNIP clients did not fully transition to PHN funding.*
    - *The short-lead funding cycle for PHNs affects staff quality and turnover and makes it difficult for the PHN system to consistently promise continuity of care.*
    - *The MBS model enables more consumer choice and has fewer access limitations than services commissioned by PHNs (where patients and GPs are restricted to the staff of providers commissioned by the PHN).*
    - *Appropriate treatment would result in optimal outcomes for these patients. With long-term care, this group of patients gets better over time. This reduces hospital admissions, reduces the use of other health services, and improves community and workforce engagement.*
    - *When patients with moderate – severe mental illness do not receive adequate treatment, costs increase for the rest of the health system—for example, through emergency department presentations and hospital admissions*
    - *Under the MHNIP, providing flexible and unlimited contacts for clients reduced emergency department presentations, hospitalisations and length of stay in hospital; allowed for early discharge management; and prevented relapse overall. Twenty-six per cent of emergency presentations and 25 per cent of inpatient admissions to mental health beds were for people with personality disorders, when measured over four years for one local health district in New South Wales.*

There has been much reform in the mental health and primary health care sectors since 2016 and despite the opportunities these reforms provide, some issues have arisen which continue to be of significant concern to the ACMHN and which are relevant to the MBS Review process.

The Mental Health Nurse Incentive Program (MHNIP) was funded through Medicare from 2007-2016 and was designed to provide people with moderate-severe & complex mental illness access to mental health nurses, providing care and treatment in collaboration with general practitioners and/or psychiatrists based in primary care.

There were a range of positive findings from external evaluation of MHNIP including (but not limited to):

- Patients supported under MHNIP benefitted from improved levels of care in the form of greater continuity of care, greater follow-up, timely access to support, and increased adherence with treatment plans
- Treatment and support provided by mental health nurses improved the mental health and wellbeing of patients under the program
- Mental health hospital admissions decreased by 13.3% for a sample of MHNIP patients in the 12 months following their involvement in the program
- When they were admitted to hospital following their engagement in MHNIP, there was on average a reduction in their total number of admission days by 58% and the average length of stay fell from 37.2 days to 17.7 days
- Cost analysis suggest savings on hospital admissions alone attributable to MHNIP was around $2,600 per patient involved in the program per annum
- A large number of un-costed and intangible benefits associated with MHNIP included the impacts of improved patient outcomes, enhanced relationships with carers and family members, and the effects on carer social security outlays.
    - There was some evidence of increased patient employment
    - MHNIP encouraged and facilitated increased involvement in social and educational activities
    - MHNIP had positive flow on benefits to some carers
    - MHNIP had other positive impacts on patients, including improved family interactions and reductions in the number of emergency department presentations
    - MHNIP had a positive impact on medical practitioner workloads by increasing their time available to support other patients and improve patient throughput.

Credentialed mental health nurses working under the MHNIP were impacted by funding suspensions applied to MHNIP from 2012-2016, leading to ongoing uncertainty about their future and tenuous work arrangements, often reduced session allocations, and a lack of capacity to build their practice. Then, transfer of funding for mental health nursing services from Medicare (MHNIP) to PHNs in 2016 created substantial disruption to the workforce and has impacted significantly on continuity of patient care – particularly where nursing services were withdrawn, not filled or re-distributed.

The ACMHN can report that recent work undertaken during a Commonwealth Funded Mental Health (Nurse) Workforce Development project (2016-2018) which found that 73% (n=19) of PHNs (total n=26) identified that there was a shortage of MHNs in their region. PHNs have reported difficulties in recruiting MHNs impacting their ability of PHNs to provide equitable geographic access to services. In oorder manage demand, some PHNs have imposed a range of restrictions on referral criteria (and therefore, on the mental health nurses' scope of practice) such that the ACMHN would consider risk of 'intention to leave' primary care for specialist MHNs whose practice is inhibited would be significant – particularly as the type of work/roles undertaken by MHNs represented an important consideration for MHNs when considering their role in the primary health care sector. Some PHNs have looked at employing other health professionals to ensure geographic access to the service. However, this raises questions over the trade-off between providing any service and providing a quality service.

Since the 2016 transition the College has continued to receive calls from nurses leaving primary care to work back in the acute care hospital setting, or to leave the mental health sector all together, due to the uncertainty surrounding the ongoing commissioning of their services and the impact of this on their ability to provide a quality service to clients as well as their own employment security. Many MHNs have been frustrated by limitations being placed on their practice by commissioning arrangements and their disenchantment at having the valuable work that they do so under-valued.

The very effective MHNIP program that was built up from 2007-2016 and which the 2014 Review of Mental Health Services by the NMHC recommended be *expanded* has effectively been *dismantled*.

The focus of Primary Health Networks on regional solutions to local health care problems, is a principal which everyone supports. However, the lack of clear guidelines that each PHN is to follow and implement according to local needs has resulted in a disparate approach to the provision of mental health nursing services and significant disruption to mental health nursing service delivery and continuity of care in some areas. This means that people with moderate-severe & complex mental illness do not have access to mental health nursing services in many areas.

Recommendation 4 – Establish a new working group or committee to review access to, and rebates for, Better Access sessions delivered by different professional groups.

The ACMHN strongly supports this recommendation and agrees this is a critical issue to improving access and equity of service to people with mental illness.

As a key provider of specialist mental health treatment and support to people with mental illness in the Australian community, the ACMHN respectfully requests representation on this new working group.

In relation to the MBS, the ACMHN draws the attention of the committee and the Minister to the recommendations of the National Mental Health Commission's National Review of Mental Health Programmes and Services – 30 November 2014– Volume 1, recommendation 21 which states:

> **Recommendation 21:**
> *Improve supply, productivity and access for mental health nurses and the mental health peer workforce.*
>
> How this will be achieved:
> *#5. Examine the cost-effectiveness of including extension of Better Access to nurses with postgraduate qualifications in mental health.*
> (see Appendix 3 for all elements of Recommendation 21)

It is the ACMHN position that Credentialed Mental Health Nurses and Mental Health Nurse Practitioners, who have been demonstrated to provide effective, cost effective and accessible mental health treatment to people with moderate – severe/complex mental illness in primary care, should be included as eligible providers to the Better Access program. MH nurses have the specialist skills, knowledge and experience required to be a part of the solution to the growing mental health need of the community – particularly in support of people with moderate to severe and complex mental illness.

MHNs comprise the largest group of professionals working clinically in the mental health workforce and are a critical component in mental health service provision. MHNs are more geographically dispersed than any other health professional (see Table below), creating enormous potential for increasing access to specialist mental health services across Australia, including in rural and remote locations.

Professional group	Number	FTE per 100,000	Major city FTE/% per 100,000	Very Remote FTE per 100,000	Average hrs worked per week	Average clinical hours per week
Mental Health Nurses (MHN)	21,500	85.1			36.3	
MHN working clinically		**78.1**	**90.8**	**31.1**		**33.3**
Registered Psychologists (RP)	24,500	88.1				
RP working clinically		63.9	82.7%	23.2	32.4	23.5
Psychiatrists	3200	13			36.3	
Psychiatrists working clinically		10.8	13.2	3.3		33.3

(AIHW, 2018)

Despite having the greatest geographical coverage and greatest potential to respond to needs in rural and remote Australia, the lack of access to mental health items available to the mental health nursing workforce under the MBS acts as a strong disincentive to highly skilled and qualified mental health nurses living in rural and remote Australia considering employment in primary mental health care; where MBS access is very limited and the only alternative funding source is limited and uncertain program based funding that often may not be adequate to support full time employment.

A three-tiered MBS system as recommended by the committee in Recommendation 3, which included mental health nurses as eligible providers would:

- Provide ***greater access*** to specialist mental health treatment and support to consumers with a diagnosed mental illness – including across rural, regional and remote areas where mental health nurses practice.
- Provide consumers with mental illness with ***greater choice*** around demonstrably effective treatment and support in primary care.
- It has been demonstrated that mental health nurses working in primary care achieve ***good clinical outcomes*** for consumers, benefits to carers and to other health professionals. There is ***demonstrated economic benefit*** associated with mental health nurses in primary care, through the reduction of presentations to emergency department, reduced frequency and duration of admissions and the un-costed benefits associated with improved social, educational, relational and vocational activity.

- Inclusion of Credentialed Mental Health Nurses and Mental Health Nurse Practitioners, at rates commensurate with similarly qualified mental health professionals (e.g. clinical psychologists) would enable mental health nurses to work to their full scope of practice and ***support retention and increase recruitment*** of mental health nurses in primary care settings.

Recommendation 5 – **Reduce minimum number of participants in group sessions**

The ACMHN supports the recommendation that the minimum number of participants in a group session be reduced to four, to enable better access to evidence-based treatment for people, particularly in rural, regional and remote areas where group numbers may be less than the current requirement of 6-10 participants.

Recommendation 6 – Add a new group item for therapy in larger groups

The ACMHN supports the recommendation that group therapies which have found to be demonstrably effective in larger cohorts, should be able to be delivered to larger groups.

Recommendation 7 – Enable family and carers to access therapy

The ACMHN strongly supports the recommendation that family and carers be eligible to access therapy and support, which relates to the consumer/identified patient, but where the consumer/identified patient need not be physically present. Families and carers are vital to the recovery of many individuals with mental health issues and the impact of caring has been demonstrated to be detrimental to the physical and mental health of carers.

Recommendation 8 – Measure Better Access outcomes

The ACMHN supports the recommendation that consistent, comprehensive, flexible and carefully implemented outcome measures for Better Access be established. Evidence of effectiveness of treatment impact is essential to providing better care to all Australians with mental health issues. It is important though, that administrative burden and cost for individual providers does not become onerous and is considered and included in remuneration.

Recommendation 9 – Update treatment options

The ACMHN supports the recommendation that the MBS should be aligned with current evidence, and that the list of therapies covered under the MBS should be based on evidence of effectiveness and that approved psychological interventions be frequently reviewed, in order that current evidence is reflected and the MBS sbetter meets contemporary evidence and patient needs.

Recommendation 10 – Unlink GP focused psychological strategy items from M6 and M7

The ACMHN supports the recommendation.

Recommendation 11 – Encourage coordinated support for patients with chronic illness and patients with mental illness

The ACMHN strongly supports the recommendation.
People with mental illness experience high rates of physical illness and chronic disease – including diabetes, metabolic syndrome, cancer and other chronic health conditions.

- Given the priority area of physical health issues for people experiencing mental illness (evidence states people experiencing mental illness die up to 25 years earlier than the average population, mostly as a result of chronic physical disease); and the commitment of Australian governments to improving the physical health of people experiencing mental illness (as outlined in the 5th National Mental Health & Suicide Prevention Plan and the NMHC Equally Well Consensus Statement), MHNP are well placed to provide physical and mental health assessment and treatment.

- Even though MHNP have the skills to provide this service, the ACMHN has heard from its MHNP members that the existing MBS items for MHNP pose a barrier to conducting a full assessment in practice, as this typically requires a 60-90 minute consultation to cover both mental and physical health assessment and MHNP report that this is not supported by the existing item structure.

- NP items have very low remuneration across all other MBS items ($/min) and existing items do not allow for implementation of full scope of practice. **The fee for MHNP items should be increased to match GP mental health items.** The

equivalent items for MHNP are much lower, despite MHNP holding (at minimum) a post graduate Masters level qualification in Mental Health.
- NP need to be able to refer to allied health professionals – such as under a MHCP/CDMP. This would greatly improve care integration and responsiveness to individual needs.

Recommendation 12 – Promote the use of digital mental health and other low-intensity treatment options

The ACMHN supports the recommendation.

Recommendation 13 – Support access to mental health services in residential aged care

The ACMHN supports the recommendation.

The National Mental Health Commission (2014) recommended that the Mental Health Nurse Incentive Program be expanded to provide mental health nursing services to residential aged care facilities (RACFs).

It is the position of the ACMHN that all RACFs should have access to a Credentialed Mental Health Nurse or a Mental Health Nurse Practitioner, who could:
- Provide cost effective, accessible mental health assessment, risk assessment, care planning and behavior management planning for consumers with mental illness
- Provide mentoring and support to Registered Nurses and Enrolled Nurses working in RACFs, to better identify and plan care for residents with mental health care needs.
- Mental Health Nurse Practitioners could also provide physical and mental health treatment in RACF settings.

Investment in workforce development will be required and should be the focus of the government's approach to improving mental health care and outcomes for residents with mental illness residing in RACFs.

Recommendation 14 – Increase access to telehealth services
The ACMHN supports the recommendation.

Appendix A:

Nursing & MH Stepped Care

The stepped care model requires that all nurses provide mental health care relevant to their scope of practice and their clinical setting. The table below demonstrates the key nursing workforce involved in mental health service delivery and where they work.

LEVEL OF DISTRESS	LEVEL OF NEED FOR SUPPORT	FOCUS OF CARE	CARE SETTING	KEY NURSES IVOLVED
STEP 5 **Severe distress**	***Very High Level of Need*** (Risk to life; Severe self-neglect)	**Mental Health Assessment** **Risk assessment** **Management of critical incidents** **Medication** **Treatment**	**Emergency Departments**	**Consultation-Liaison Mental Health Nurses** **MH Nurse Practitioners (MHNP)** **Emergency Department (ED) Nurses**
			Acute MH Services **Acute Care MH Teams**	**MHN/CMHN/MHNP**
			Acute AOD Services	**Alcohol & Other Drug (AOD) Nurses**
		Mental Health Assessment **Risk assessment** **Acute MH care** **Medication**	**Acute MH** **Acute Care MH Teams**	**MHN** **Credentialed MHN** **MH Nurse Practitioners**
STEP 4 **Moderate to severe distress**	***High level of need for support*** (Recurrent, atypical and those at significant risk)	**Mental Health Assessment** **Brief psychological interventions** **Medication Education & Management** **Social support & referral**	**Emergency Departments**	**Consultation-Liaison MHN** **Credentialed MHN** **MH Nurse Practitioners**
		Mental Health Assessment **Brief psychological interventions** **Complex psychological interventions** **Medication** **Social support & care coordination**	**Inpatient MH** **Community MH**	**MHN**
			Primary health care	**MH Nurse Practitioners** **Credentialed MHN**
STEP 3 **Moderate distress**	***Moderate level of need for support*** (Moderate or severe mental health problems)	**Mental Health Assessment** **Psychological interventions** **Medication Education & Management**	**Medical settings** **Community MH & Primary health care**	**Consultation Liaison MHN** **MH Nurse Practitioners** **MH Nurse Practitioners** **Credentialed MHN** **MHN**
		Identifying distress **Appropriate Referral** **Social support**	**Medical settings** **Primary health care**	**Emergency Department (ED) Nurses** **Alcohol & Other Drug (AOD) Nurses** **Nurses working in Chronic Disease settings** **GP nurses** **Primary Care Nurses**
STEP 2 **Mild to moderate distress**	***Low level of need for support*** (Mild mental health problems)	**Guided Self Help** **Brief psychological interventions**	**Primary health care**	**MH Nurse Practitioners** **Credentialed MHN** **MHN**
		Identifying distress **Raising awareness** **Flagging risk** **Watchful waiting**	**Medical settings** **Primary health care**	**Emergency Department (ED) Nurses** **Nurses & midwives in all settings** **Consultation Liaison MHN** **Alcohol & Other Drug (AOD) Nurses** **Nurses working in Chronic Disease settings** **GP nurses** **Primary Care Nurses** **MHN/CMHN in primary care**
STEP 1 **Minimal to mild distress**	***Relapse prevention for those with Dx mental illness***	**Maintenance of mental health** **Monitoring for signs of relapse**	**Primary Health Care** **Community Mental Health**	**MH Nurse Practitioners** **Credentialed MHN** **MHN**
	Need for wellbeing and resilience promotion	**Recognition of risk** **Mental health literacy** **Mental health promotion**	**All health care settings** **Primary health care**	**All nurses & midwives in all settings** **GP Nurses** **Nurses working in primary care**

Appendix B:

National Review of Mental Health Programmes and Services – 30 November 2014 – Volume 1

Recommendations specific to the Mental Health Nurse Incentive Program (MHNIP), to mental health nurses and to the nursing workforce in relation to mental health more broadly.

Recommendation 21:

Improve supply, productivity and access for mental health nurses and the mental health peer workforce.

How this will be achieved:

1. Pay a proportion of the Mental Health Nurse Incentive Programme (MHNIP) funding as a loading on top of the Practice Nurse Incentive Programme (PNIP) to attract more mental health nurses into general practice.

2. Retrain registered general nurses as mental health nurses: in the short term the projected shortage of mental health nurses in 2016 of just over 1,000 (or approximately seven per cent of the workforce demand) is best reduced by a stop-gap training intervention that can deliver supply quickly. The only way that is possible is to train current registered nurses to become mental health nurses, which in theory requires only one year. Transferring 1,000 nurses from the general to the mental health workforce will have limited impact on the general registered nurse population (less than 0.5 per cent) but will dramatically impact on the number of mental health nurses.

3. End the freeze on the MHNIP as an identified priority for more equitable access to mental health services.

4. Commit to at least maintaining the existing level of funding for the programme: when funding permits, it should grow from its allocation of $41.7 million in 2014–15 to $72 million a year to enable an equitable distribution of funds for the target population.

5. Examine the cost-effectiveness of including extension of Better Access to nurses with postgraduate qualifications in mental health.

6. Extend MHNIP eligibility to include residential aged care facilities and

Multipurpose Services.

7. Promote the uptake of the programme by Indigenous Primary Health Care Organisations including Aboriginal Community Controlled Health Services, including opportunities for MHNIP-funded nurses to be a part of the proposed mental health and social and emotional wellbeing teams.

8. Remove the requirement for GPs to write a mental health care plan for referral to mental health nurses under MHNIP where a comparable health plan has been prepared by a specialist mental health professional.

9. Enable PMHNs to contract directly with mental health nurses instead of through an "eligible organisation" to provide greater flexibility across multiple settings.

10. Train practice nurses to develop their mental health skills and provide scholarships which enable them to train to become mental health nurses.

· Practice nurses should be trained to take more responsibility for people with moderate and episodic illness and to assist in meeting the gap which is arising from the looming shortage of mental health nurses.

11. Build the capacity of the primary health care sector to significantly and pragmatically increase service access to a greater proportion of persons with a mental health problem and improve the delivery of mental health promotion and the likelihood of earlier intervention. Develop the mental health competence of GPs and collaborative teams to provide them with appropriate support services and decision-making tools to assess and manage the mental health needs of their patients.

12. PMHNs and LHNs should work together to create a primary health care mental health consultancy team in each LHN to support general practices, provide second opinions, support assessment practice and provide opportunistic training of GPs and practice nurses.

13. Include a mandated amount of mental health curricula content and assessed mental health competencies for undergraduate nurse preparation.

14. Develop a more generalist workforce to provide services in areas of greatest need.

· Continue promotion, implementation and evaluation of recruitment, retention and incentive mechanisms, in both generalist and specialist mental health career pathways. This should target particular areas and communities that need it most (e.g. socio-economically disadvantaged, recovering from natural disasters)

· Expand rural health education initiatives to include a focus on supporting the generalist workforce to respond to mental health emergencies as well as working with people with comorbidities, and conduct further research and evaluation of how health and welfare workers may augment traditional categories.

15. Establish National Mental Health Peer Workforce Development Guidelines for use in a range of settings including: agreed definitions, key roles and functions, guiding principles and a code of ethics, national capabilities for peer workers and supervisors (including diversity), principles for employment and reasonable adjustment, training and support, practical resources, supervision, coaching and mentoring and a dissemination/ implementation approach.

16. Develop a national mental health peer workforce data set, data collection and public reporting approach across employment sectors to measure progress and support evaluation.

17. Grow the Aboriginal and Torres Strait Islander workforce in social and emotional wellbeing: set a target of growing the workforce at least proportionate to their three per cent presence in the population.

Issues:

· Just as with the mental health system overall, the mental health workforce needs to be demand-driven. Demand for workforce is derived from the work performed, which in turn is determined by demand for services.

· There is an immediate priority to address current shortfalls in supply: in particular the mental health nurse workforce numbers constitute the most immediate threat to both short and long-term service ambitions. The projected shortage of mental health nurses in 2016 of just over 1,000 (or approximately seven per cent of the workforce demand) is best reduced by a stop-gap training intervention to deliver supply quickly.81

· The Commission also supports ending the freeze on the MHNIP programme, indexing sessional payments and aiming for a long-term commitment in the regional funding arrangements for PMHNs.

· Even though it is called an incentive payment, the MHNIP in fact is a fee-for-service payment—a full payment for sessions of services provided. The PNIP, on the other hand, is a true incentive payment: it provides a contribution towards the cost of employment of a practice nurse.

· In 2013–14 about 300 FTE mental health nurses provided services to about 45,000 people with severe mental health problems at a cost of about $100,000 per nurse.

· The PNIP, which had a budget of $330 million in 2013–14, involves payments to eligible general practices, Aboriginal Medical Services and Aboriginal Community Controlled Health Services, of an incentive to offset the costs of employing a practice nurse. This incentive is up to $25,000 for each nurse, with a cap of $125,000 for each practice, and a rural loading of up to 50 per cent. About 4,100 practices receive funding.

It is proposed that a proportion of the MHNIP budget should be reallocated as a substantial payment on top of the PNIP payments as an incentive to be able to attract mental health nurses into general practice.

· Not all of the MHNIP should be paid in this way. There are other services which are eligible for the MHNIP payment but not eligible for the practice nurse payment. In addition, there is widespread inequity in use of the MHNIP.

· The 2012 MHNIP evaluation found broad support for the programme with the model of care—involving flexible, one-on-one clinical treatment and support provided by credentialed mental health nurses working with eligible medical practitioners—receiving strong endorsement from GPs, psychiatrists and mental health nurses, as well as people with lived experience, their families and other support people and relevant peak bodies.

· The evaluation identified scope for improvement in a number of areas, including addressing current inequity in the distribution of MHNIP services across jurisdictions (this was an application-based programme where those who applied first were funded, and when the programme was capped other “eligible organisations” could not get access, so the inequity now is built in to existing arrangements).

· The current inequitable distribution of the MHNIP means that simply sharing the existing funding equitably across Australia will result in many areas which currently receive services facing substantial reductions in access to nurses.

· Payment of a proportion of the MHNIP as a loading on the PNIP will enable some of that inequity to be addressed.

· The Commission considers that, under the current funding model, payments into the MHNIP need to be at least maintained at its existing level of about $40 million a year. It would need to be increased to about $72 million a year to enable equitable access to mental health nurses in the private sector for those with severe and persistent mental illness.

· Until such time as there is a more equitable distribution of funding and services across

Australia, and a mechanism for bringing together MHNIP payments (which are specific to mental health) with PNIP payments (which apply more broadly to general practice), MHNIP should not be included in the regional bundling of funds to PMHNs. However, PMHNs should be involved in decisions on eligibility for combined MHNIP/PNIP payments to general practices as an important factor in planning and setting regional priorities.

· To better equip areas of need, particularly in rural and remote Australia, to deliver mental health services, we need to look at innovative ways of ensuring they still have access to a fit-for-purpose workforce.

· Peer support workers are a key component of recovery-oriented mental health services as they illustrate to others the possibility of recovery and participation in social and employment activities, and provide support for their own recovery. Increasing the number of peer workers in mental health services nationally is an immediate priority that will be sustained over the Commission's 10-year implementation strategy.