2019 Submission - Royal Commission into Victoria's Mental Health System

Organisation Name
N/A

Name
Mr Brett McKinnon

What are your suggestions to improve the Victorian communitys understanding of mental illness and reduce stigma and discrimination?
"Overall when one looks at the trajectory of mental health care in an Australian context and specifically since the early 1990's and the start of the National Mental Health Planning process under the National Mental Health Commissions Guidance, we can see that there has been significant progress towards the de stigmatisation of mental illness. One only has to look at the volumes of people attending for services to see that inroads have been made. However, having said this, and with a realist hat on, I can also add that despite such efforts stigma still affects many and impedes overall engagement, help seeking and outcomes. In my experience, I have witnessed the great benefits in targeted education and awareness programs delivered in a variety of settings and across a variety of mediums. I wish to specifically highlight a couple that I believe have held maximum benefit in the bigger picture outcomes vs Stigma. The first one relates to an in school programs designed to demystify and destigmatise mental illness and showcase the pitfalls of recreational drugs and the importance of making healthy choices in life. I have had the privilege to be involved in the setting up and management of such programs whilst working both in Acute Care and now in Primary Health. In the Acute Care sector whilst working with Dandenong Area Mental Health Services, I had the pleasure of managing a Schools Project for a couple of years with Michael Sillekens (a fellow MHN Colleague) The program saw the coming together of the Acute Service Sector, the local Business Community, the Education Sector and the Youth of the day making their way through the education sector. The buy in for each party was for the Acute Service Sector to co-ordinate the delivery of a contextualised mental health education package delivered over a 2 week period and covering topics such as Good Mental health vs Mental illness, depression, anxiety, psychosis / schizophrenia, self-care and making healthy choices, negatives of illicit drug use, suicide and supporting each other to access assistance. The Education Sector engaged via providing approved access to year 11 and 12 students to participate in the training and its associated competition. Some of the participating colleges even factored in some advance standing against curriculum for the program. The business sector assisted with sponsorship which allowed for a competition to be held whereby students who participated in the program had an opportunity to submit a piece of artwork, essay or other like representation of key learnings achieved within the program. Prizes were awarded for the most dynamic and appropriate entries and the school that submitted the best quality of entries were given a grand prize. An awards ceremony that had guest speakers (celebrity and or sports stars) was the culmination of the program. The Prizes at the time circa 2003-6 saw the best student entry given a $500 Myer Voucher and the College winner's prize was sponsored by Holden Australia and the winner received approx. 3-4k of funding to put towards computers or other like equipment of their choosing. The upshot of this program saw the coming together of communities, Education was provided by clinical experts who additionally held capacity to be the first port of call for immediate referrals of which there were several including young persons and their significant others referred by participants. Connections between all parties to identify opportunities for awareness and help

were established and mental illness was demystified thus assisting stigma goals. Since leaving the Acute Sector and establishing services in Primary Care with Tristar Medical Group, we have rolled out an in schools' model of service delivery that is akin to the school's project minus the competition aspect. The model has Tristar Medical Group GPs, Mental health Clinicians including Mental Health Nurses, Mental Health Nurse Practitioners, Psychologist and Psychiatrist all contributing to the in school wellbeing services. We operationalise under the school umbrella as a wellbeing team extension and not as Tristar Medical Group, we have accessed buckets of funding including MBS, MHNIP and PTS/ATAPS to deliver these services as a cost neutral opportunity for service users. We provide education and training for the teaching cohort, we offer opportunities for parents and significant other to be involved as well in education and clinical service delivery. We have achieved significant success in the application of this program and are keen to extend it moving forward but obviously limited by funding availability. (Please see attached references that show case outcomes). As a side note, I have been emailing the Education Minister James Merlino since 2013 to advise of the program and outcomes and had often delayed responses to emails and after a couple of years had passed the Victorian Government introduced the GP in Schools program which strangely enough has provision for a GP and practice nurse to attend local secondary colleges but not necessarily mental health clinicians. My sources inform me that a large amount of services provided in this realm relate to Mental Health conditions, hence I hope over time extra consideration is given to including provision for mental health clinical expertise to be added to the mix. Other effective strategies for improving understanding and reducing stigma have been targeted education to workplaces, sporting clubs and other like environments where masses of individuals may populate themselves. Such training provides for a united approach to asking questions and supporting each other and essentially provides such groups a means to open discussions and define specific pathways that each organisation can monitor members both as a group and or individually. Beyond Blue strategies (many and varied) and RU OK day processes and campaigns also value add I also believe that targeted training for General Practitioners (GPs) and specifically relating to Patient and Carer education and engagement are important. The capacity for front end service providers to normalise symptoms, their prevalence and the prognostic picture up front may hold for better outcomes. The GP is often the first point of call for patient presentations and their role is integral to the efficacy of the service system, hence having dynamic, informative and holistic care in the first instance is highly valuable. "

What is already working well and what can be done better to prevent mental illness and to support people to get early treatment and support?

"Throughout my career, I have had the privilege of working across the entire service sector and can strongly attest that the greatest impact that can be had lies in primary care and to this end I believe that as a Health System we need to do better in this space and particularly around Education and Training, Funding and Systems of Practice. I will expand this assertion later in the submission. I firmly believe that sorting the system starts from the top and that Government Ministers need to be commanding value for money and progressive outcomes from services and governing bodies (E.g. PHNs) etc. The amount of wasted investment in non-clinical positions and other associated ancillary processes that do little to value add is frustrating. I have numerous examples of complete wastage and we are not talking small dollars. When you conceptualise the amount of investment in the sector vs in some areas, declining outcomes, it's easy to see that we need to review focus points and processes. One needs to look only as far as the increasing burden of illness along with suicide rates, despite all the awareness campaigns, training opportunities and funding etc, then it's not hard to assert that we need to take a more detailed look. This Royal Commission itself, would not be occurring if our systems were delivering upon

intended aspirations and outcomes. The Primary Care Argument: As I have previously alluded, the GP sits at the heart of the service sector and at the coalface of Primary Care. The GP role is integral to early detection, intervention and the reduction in the burden of illness being experienced. Current statistics reflect that 90% of patients with mental health related challenges will attend their GP as a first port of call as it is less stigmatising attending GP first, plus may already have a trusting relationship with the GP. Across Victoria in the 2017/18 financial year, Medicare derived statistics indicated that 498,744 individual patients were afforded a GP prepared mental health care plan. Beyond this many others would have presented needing assistance for Mental Health related symptomatology, but not requiring a mental health plans. These numbers represent a significant uptake of services. The questions I pose are; Are they getting the right services? Does the system structure lend itself to best outcomes? The challenge has been that despite nearly half a million individual patients starting care pathways, only 29% of those patients were ever subjected to a formal review of those care pathways using the Government coined Medicare Benefits Scheme (MBS) item numbers and processes. What is even more tragic is that such item numbers and pathways of care have been around for a decade now and millions of plans have crafted yet the best rates of review sit no greater than 42% per year and such results don't even reflect a pass mark. (DHS Australia Medicare statistics 2019). What this essentially means is that the formal processes that guide thorough and thoughtful service provision under the MBS are being underutilised and it is only possible to postulate what outcomes have been achieved for those 71% of plans that have been not formally reviewed under this system. If MBS coined processes are enacted effectively, then the GP will assess for mental health symptomatology, once a reliable working diagnosis is formulated, then a plan can be crafted to address the health related challenges being experienced by the patient. The GP may refer patients on to ancillary specialist mental health allied health and nursing services under the auspices of the plan. Allied health professionals under the MBS are capped at 10 sessions per calendar year and there is fee for service and other grant related funding pools that allow patient access to care. The MBS has provision for the plan of care to be reviewed every 90 days to determine efficacy, however as mentioned stats hold for very poor outcomes and I wonder how many plans have hit their target and enhanced health and wellbeing. What I can advise in reference to the above is that in a Tristar context we are very cogniscent to the benefits of utilising the above model of care and we have achieved some outstanding patient care outcomes from being thorough in this space. Our plan review rates are still not perfect at just over 70% overall, but what I can advise is that we have had no patient suicides under our care. We hold and deliver upon specific suicide prevention funding, meaning we are readily working with and adequately servicing patients with suicidal ideation. Our overall outcome measures datasets reveal excellent progress against recovery variables meaning our planned care has both managed risks and provided measurable patient benefit and all within the primary care space. The system we have created at Tristar Medical Group has mental health clinical staff members working alongside GPs in clinic and provides for a one stop shop. We believe that co locating mental health services augers well for positive outcomes, shared learnings and collegial partnerships that benefit the patient. Our services have capacity to provide interventions across the entire stepped care continuum as propagated by PHNs as a new idea, but it is really an old concept rehashed under their auspices. All our GPs are put through RACGP accredited Mental Health Skills training at the point of their orientation and inception into our program. We are a provider of such training under our training arm Kure Medical Training and as I mentioned previously this training has been ratified by the RACGP and ACRRM as being suitable for GPs. We have extensive data mining capacity engrained within our organisation and use such data to assist quality improvement strategies. Our internal stats give rise to impressive outcomes with examples provided in

subsequent answers to the Commissions questions. The main selling / showcase points for our Models are, no suicides, patient recovery outcomes and minimal referrals to acute services being required. Basically our patients receive high quality, dynamic and cost effective services across the entire stepped care continuum in a one stop shop equation in essentially a primary care space, thus alleviating systemic burden across multiple touchpoints in the sector. Sadly, due to recent funding cuts in Primary Mental health care and associated interesting decisions being made in relation to tendering of services through the PHNs that have impacted communities (please see attached formal complaints letters to the Department of Health and Minister Foley), our highly effective services have been decimated to the point where our impact is minimised. The ripple effect has seen significant reduction in capacity, and in Victoria alone we as an individual organisation have lost over 10 senior highly experienced (20 years +) Mental Health Nurses and Mental Health Nurse Practitioners. Such losses of staff have occurred in communities that could ill afford to lose such resource. The new landscape under current funding and beyond PHN tendering, has led to under skilled / underqualified clinicians taking their place, ballooning waiting times, service establishment, inception and access delays of up to 4 months in one case and now extensive delays in accessing services. In one of our centres in rural Victoria, our organisation and the community have lost a local based Mental Health Nurse and Nurse Practitioner (2 staff) who were delivering 60-80 consults per week between them and buffering acute services etc; and had them replaced by a fly in fly out type arrangement provided by a metro based provider. This was brought about by Federal Government funding shifts that while many in industry could easily see that this equation was illogical for this local community, when such argument was pitched to local and national members it was hardly going to get much mileage given that these local members were all part of the same political party as the Federal Government. In this space I again need to reference the importance of Government ministers being fully aware of the impact that the decisions they are taking and supporting are having at the coalface of care. In closing of this section I reiterate that I firmly believe that making funding available to allow for General Practices to have clinical mental health professionals working alongside GPs at the coalface of primary care holds for insurmountable benefits, our models of care vs outcomes achieved are a testament to this. Effective early detection and intervention at this point may prevent patient decline that would necessitate acute services involvement impacting overall costs and community burden of illness. As an individual practitioner, I personally have kept hundreds away from acute services through effective management of presenting symptoms and problems, yet as an organisation despite having access to available staff, excellent outcomes and well appraised services, I struggle to find funding to materialise a more comprehensive impact. The now disbanded Mental Health Nurse incentive program evaluation specifically highlighted the immense value that such GP based services held and its impact is now lost to communities. In comparison we see huge buckets of money afforded to downstream services who are effectively playing catch up roles to address symptoms that could have been short circuited effectively in primary care. In many cases, the individual burden of illness has progressed to the point where there is an enormous amount of work to do to address problems that have now spiralled out of control, yet could have been sorted much earlier. This situation effectively impacts overall costs. Having worked across the entire sector, I can strongly assert that the clinical role I am enacting in primary care is fact more impactful than any role I have ever occupied in the acute care sector. I am pleased to be assisting patients well enough that they will never require acute care, however without such interventions being available one can easily see that many of the patients I am seeing will end up in acute care if not intervened with earlier. "

What is already working well and what can be done better to prevent suicide?

"The fact that there has been significant focus and investment into suicide awareness and prevention strategies, yet we have ballooning rates of suicide is quite alarming in itself. The fact it has to be listed as a key target of our 5th National Mental Health Plan highlights that the problem is unacceptable and this is one thing that I think all persons involved in the industry can agree upon. From my experiences, I offer the following appraisals of potential gaps. Firstly, I agree that we need to raise awareness, provide focus for communities and services providers to come together to support those who are having challenges relating to suicidal ideation. Multiple opportunities exist and we are only confined by our imagination regarding ways and means to showcase and remedy this problem. I recall reading some more recent articles that assert, that over 70% of individuals at some stage throughout their lives will harbour suicidal ideation. This is quite alarming; however it is ultimately what individuals do with such thoughts that will result in any outcome against suicide rates. The key ingredient here is about raising awareness that such thoughts are commonplace in society. That they are unhelpfully prominent in those that are experiencing significant life challenges, and that in most part they are transient in nature, meaning that there are multiple opportunities for them to be addressed along with life challenges to assist the individual to regain composure in life. The importance of highlighting the plethora of supportive options available should be highly factored into any intervention strategy. Adequate education and training for frontline staff is integral to better outcomes, with many such training programs being afforded to acute staff being great in identifying signs and symptoms including high risk factors and tipping points etc; but sometimes lacking in content as to how to achieve meaningful information and what to do with the information gleaned. This becomes even more concerning in the hands of junior inexperienced practitioners working in acute care as I have personally witnessed and reported to the Office of the Chief Psychiatrist and Coroner. Even as I type I hold concerns for one such Area Mental Health Service who have 1st year social work graduates enacting roles as front end crisis intervention staff and with limited supervision and service leadership being provided. It is of no coincidence for mine that this region has possibly the worst track record in the state for death by way of suicide. I personally have raised concerns with Service managers and Clinical directors within this service to see little to no overt change occurring. Further the same service and their decision makers have recently won a PHN Tender to deliver essentially an extension of already funded Continuing Care services and are utilising a senior staff member who was previously providing acute care services thus detracting from the acute services capacity leaving staffing gaps and junior staff to deliver acute care. No other Acute Service would have bid for this funding. It's no surprise that this service did however, as they are privately owned publicly funded, so only benefactors are company shareholders. I reference this to showcase the importance of adequate leadership and decision making to better place the system. In this case the referenced service could ill afford to lose such acute care expertise. Training of GPs and Frontline Primary Care staff is also important and as mentioned with 90% of patients attending GP as first point of enquiry, the GP role is integral and may essentially be the difference between life and death. I personally believe that all GPs should be exposed to comprehensive suicide risk assessment and management and crisis theory training. Such training leaves the GP hyper aware of the importance of the first interactions and laying the foundations in terms of education pertaining to overcoming symptoms, challenges and opportunities for support. Delivered effectively Crisis theory strategy can leave the patient feeling hopeful that options exist for regrouping and recovery to ensue. Both of these training opportunities are afforded to our GPs within the Tristar Context and as mentioned we have had no suicides under our care. As a case example in one of our Victorian regions where suicide rates for the community are nothing short of horrible (at approx. 90 over the last seven years and 5 in the last month), we hold suicide prevention funding and exceed our funded targets. We have had no patients under our care end

their lives through this means in the 7 years we have held such funding. Our services provide between 1-2k individual funded suicide consults per annum and readily see approx. 5,000 patients per year which is equivalent to acute services. Sadly no one is coming to explore what we do and how we do it to achieve such great outcomes despite us putting it out there to PHN and suicide prevention PHN programs   The next point I wish to raise relates to the need for better communication between services and particularly between the GP and Acute Services. In many regions that we provide services, and despite our best efforts and advice, there is a disconnect between acute services and the GP and I think that Ego and naivety plays a big part in this equation. What we are finding challenging in most areas is a lack of dynamic service provision from acute care providers. I am acutely aware and have been guilty of this myself when working in acute care in thinking that Acute care services by virtue of the work they do are the Kings of the Jungle' so to speak. Reality is that while such roles and services are integral to the industry and outstanding work is occurring, the gaps created by less than dynamic application of roles can effectively sabotage patient care outcomes. On many occasions in the past and including in more recent times, Acute services have had contact from patients who also receive care from our GPs and Mental Health Clinicians. What is lacking is that the Acute service provider has failed to contact the usual treating team of GP and Mental health clinicians and as such have missed a vital opportunity to gain a deeper understanding of the patients care, interventions that have been tried and additionally the opportunity to engage in a shared care pathway to enhance early discharge management back to the GP. In some cases we have seen medication regimes changed to reflect medications already tried and proven ineffective and mis diagnosis occurring thus exposing patients to inappropriate regimes of care and time lags against recovery. We have had patients discharged back to our care with no discharge summaries from acute care and in some cases, we have not even been advised of attendance at acute care until we see our patients again and sometimes that is weeks down the track. There have been cases whereby we have made referrals of highly at risk patients who despite raft of information and contacts being provided ensuring that acute services attend to patient needs, the patient has not been serviced and effectively an incident reportable miss for their organisation. Again this points back to adequate leadership and supervision in the acute care space to make this aspect of service delivery work.   Other factors that may give rise to increased Suicide rates and risk management include that the Primary care system has some interesting nuances that perhaps do not place risk management and suicide prevention that well. Firstly Psychologists are the mainstay of the primary care system and well looked after by the MBS, but in the majority of cases have little to no acute care experience. Acute care is at the pointy end of psychiatry where managing acute risks are a day to day challenge where in many cases the way in which care is applied may be the difference between life and death. This is by no means being disrespectful to psychologists as a profession but more a representation of the elitism that they propagate in distancing themselves from being heavily engrained within Acute crisis teams and in lieu of this I would propose that all Psychologists working in Primary Care equally need to have attended Comprehensive suicide prevention and Crisis theory training. Lastly, GP Treatment plan review rates as mentioned previously, we need to be doing better across the board to ensure that planned care is effective and this facet is already funded under the MBS. In one PHN region where suicide rates are higher than the norm, the GPMHCP review rate was until recently sitting at only 8% which is not good enough and perhaps correlatable against wider mental health statistics including burden of illness and suicide.
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What makes it hard for people to experience good mental health and what can be done to improve this? This may include how people find, access and experience mental health

treatment and support and how services link with each other.

"In responding to this question, achieving good mental health outcomes across community can be influenced by many factors both individual in terms of decision making at key choice points in a person's life and relating to their education and understanding about managing their health and wellbeing and additionally relating to societal factors including, stigmatisation, access and equity of services and availability of resources in line with stepped care goals of right support at right time provided by right providers etc. In my opinion there are too many touch points for system entry and too many silos of service provision. I believe, and in line with almost all aspects of the health care system, that care should be streamlined through the GP (who is the heart of the system) and inclusive of GP, as this will already form the start of a formative discharge management plan. Acute Mental Health services could and should be linked with GP to reconcile the current disconnect and the tragic state of affairs that see the Acute service sector fall short in terms of truly dynamic service provision and associated information sharing inclusive of the primary care providers. After all, the aim of the Acute Service is to discharge their patients and most commonly back to GP and Primary care providers, so wouldn't it make sense to have a system that was inclusive of all. Other primary care providers can be factored into the body of work being completed by the GP and through direct referral and case conferencing type arrangements as an example of one such means of inclusivity. Perhaps now is the time to be bold and overhaul the system, be proactive rather than reactive. The current models aren't completely working, they aren't reducing numbers attending for acute health, suicide rates despite the intense focus are still increasing. Creating opportunities through the GP based services could prove a game changer and as I have mentioned I have data to support this. Further I have attached a document that was submitted by Tristar Medical Group in relation to the recent review of MBS Item numbers for Mental Health Care and specifically arguing upon the value of Mental Health Nurses (MHN) in relation to them being an essentially untapped resource under the MBS that if a service provision pathway could be created, then this group by sheer numbers may be able to address the workforce shortages in regional, rural and remote areas. On the back of the MHNIP, we certainly value the role of the MHN in delivering comprehensive BIOPSYCHOSOCIAL care opportunities for patients as a superior option to their other allied health counterparts in terms of comprehensive coverage. In synergy with the GP we have achieved significant outcomes utilising MHNs in addressing both the mental and physical health challenges being experienced. We have also developed a Mental Health Nurse Practitioner program and have added 8 Mental Health Nurse Practitioners to our team to provide expert and timely input into patient care. This Program has shown great impact in terms of outcomes in areas whereby access to, and or availability of Psychiatrists is a challenge. Again, I have program statistics and outcome measures that inform the efficiency of this aspect of our services. "

What are the drivers behind some communities in Victoria experiencing poorer mental health outcomes and what needs to be done to address this?

"The largest drivers behind poorer mental health outcomes relate to access and equity of services available to support community needs and ideally as a face to face entity. We have noticed already the burden of illness increases in our patient cohort due to funding cuts and the loss of mental health clinicians in clinic. Access to specialist MH services in primary care is integral to overall community mental health and wellbeing. Opportunity and incentive needs to be provided for clinicians who work in regional rural and remote settings above and beyond what their well-resourced metro counterparts receive. Funding restructuring proportionate to system outcomes and impact should be considered. There seems excessive funding being provided to downstream services in contrast to primary care services. Funding made available for private organisation or

staff who work in private practice who make a difference should be considered. I reference recent nurse practitioner grants that were only available to public sector entities etc, yet our service would have had 4 applicants who if successful would have completed studies and been able to make a measurable impact in primary care. See attached letter addressed to Dept of Health In some regions we have ineffective acute services that miss targets, are difficult to access and with lack of leadership evident, in terms of decisions being made that reflect poor outcomes. Having worked in acute services, I am aware that stats are fudged, including contacts and outcome measures to reflect uptake and efficacy of services and to receive recognition against funding but may be inconsistent against reality. I have already alerted Dept of Health IT Team of the gaps in a previous employment life. Finally, Poor PHN decision making without fully exploring the local landscape has hurt communities in which we provide services. I have attached complaint letters to Dept of Health Australia and Minister Foley Victoria outlining concerns in this space. "

What are the needs of family members and carers and what can be done better to support them?

"The bottom line in relation to this question is that there is enormous benefit in having carers and or significant others involved in the care of our patients. After all, they are often the travelling companions of patients and assist to buffer patient challenges. They can be cast in integral roles beyond our infrequent consult time being spent. There is great value in ensuring that carers are well educated and supported to enact whatever role they occupy within the care journey. Opportunities for carers to be involved in the various feedback loops to review service efficacy is also valuable as they too are living the decisions being taken by service providers to address challenges being faced. Offering shared learning opportunities with carers and service providers in our experience has been highly useful. "

What can be done to attract, retain and better support the mental health workforce, including peer support workers?

"Akin to most industries, there are many facets that will entice and retain a mental health workforce including but not limited to: Better conditions under relevant awards (remuneration, leave entitlements, super rates, salary packaging etc.) both for public and private system employees including salary packaging for non-public sector clinical staff. Availability of more dynamic Career pathway opportunity for Nurses in Particular. MHNs are largest part of workforce but markedly under utilised and remembering they have efficacy and efficiency against the entire BIOPSYCHOSOCIAL Model. NB# they are often the mainstay of Acute Services and Crisis Teams but not given parity of opportunity under the MBS. Funding grants for ongoing education and training Creating Safe workplaces as Occupational Violence is one detractor from enjoying the body of work being completed The above may be all value adds in relation to recruitment and retention strategy. Remember we have an ageing workforce so we need to be dynamic now to ensure greater longevity. "

What are the opportunities in the Victorian community for people living with mental illness to improve their social and economic participation, and what needs to be done to realise these opportunities?

Perhaps greater opportunities for employment and incentives for employment agencies and employers who find and or offer sustainable ongoing employment for those afflicted with mental illness. Employment is one such mechanism to enhance quality of life and social and psychological value beyond financial value may also be significant. Subsidised training

opportunities for those experiencing mental illness to learn new employability skills and participate in training to ultimately make them employable may also prove useful.

Thinking about what Victorias mental health system should ideally look like, tell us what areas and reform ideas you would like the Royal Commission to prioritise for change?

"As I have mentioned previously, I think there is distinct advantage in situating the System around the GP who is the main central point of entry to the health care system. When 90% of patients attend their GPs first and with many people in the community not even being aware that acute services exist then it seems to be a logical start point. How the commission and relevant entities achieves this outcome will be up to you. As also previously mentioned, I am happy to assist and have expertise of all systems that places me well to participate. Focussed strategy and funding that prioritises primary prevention strategy e.g. early detection and intervention to prevent future waves of patients requiring downstream and costly acute care alternatives would also value add Education and Training of all front end clinical staff is integral to enhancing outcomes. Minimum training requirements in and around suicide prevention and crisis theory is important for all. Ensuring that all GPs have attended GP Mental Health Skills training auspiced by the RACGP / ACRRM is also important given their roles and responsibilities in this system. Finding ways to better operationalise Mental Health Nurses as an essentially untapped resource in Primary care may prove highly successful across the BIOPSYCHOSOCIAL continuums of care but additionally as a means to address workforce shortages in regional rural and remote locations. Incentivising Mental Health care for clinical staff to assist recruitment and retention strategy in public and private system is also of benefit, especially with our aging workforce. Challenging services to deliver outcomes and addressing funding wastage into non clinical programs could also be addressed. "

What can be done now to prepare for changes to Victorias mental health system and support improvements to last?

"An urgent review / audit of all funding to determine service efficacy, requirements , wastage of $$ and potential benefits if such wastage was directed into clinical care. When we are talking about millions of dollars, that's a lot of primary care subsidised consults as one such impact. Reviewing processes that make services more accountable for under performance and adverse outcomes to ensure that we don't see consistent poor outcomes being achieved. Depending on choices taken and on system redesign, amendments to the Mental Health Act may require drafting and submitting for authorisation. Associated training would need to ensue regarding such change. Funding to support General Practice to prepare for changes would need to be provided and including specific training for GPs, reception and Mental Health staff In terms of Mental Health Nurses being better utilised I would suggest some collaborative work with the Australian College of Mental Health Nurses to create a better career pathway may prove to be a ground breaking adventure that allows for service gaps and outcomes including access to services to be addressed Making Available a bucket of funding for General Practice to employ in house mental health clinical staff would be useful as an early detection and intervention strategy. Extending the GP in schools program to make provision for Mental Health Nurses to participate and value add into the care package. "

Is there anything else you would like to share with the Royal Commission?

"Given that this submission is already quite long, I will dot point some following items for consideration I have a body of evidence that showcases how Federal Government funding shifts

operationalised by PHNs has hurt communities. Especially in terms of access and outcomes (see attached Dept of Health Appeal) I believe that the current landscape being experienced in the sector is a bi product of poor system redesign, too great a focus on the Acute Care Sector and Chronic Conditions at the expense of Primary Care. Without wanting to shoot Bambi (sic), I believe that the money being afforded the Headspace Model is disproportionate to outcomes it is delivering in many regions. While I believe that their services are an excellent value add overall, I think that it should not be at the expense of other well credentialed providers. There are many individuals that do not wish to utilise the Headspace model for many reasons (including stigma and clinical outcomes) who are either falling through the cracks and or being serviced by other providers of their choosing. We have a significant number on our books and I have written to the Headspace CEO advising of same. A system that also allocates appropriate funding outside of Headspace would also be advantageous. I believe gaps exist in the application of comprehensive mental health care particularly in parts of the acute sector. I believe that gaps in accountability for sound ethical practice for many services exist and with limited leadership being shown to address these problems in some services. As a wider system example, One only has to look back to the complete overhaul of the last Mental Health Act to see that services and leaders within services, failed to deliver upon the aspirations of the former Act Circa 1986 with amendments in and around 2010-12. In essence the leaders and the educators had significant accountability for the operationalising of this former Act yet many did not know and could not even indicate what the first few sections outlining the spirit of the Act were about (I validated these assertions in a Victorian Senior Psychiatric Nurse Collaborative Forum). What they could tell me was the more punishing / punitive sections were (E.g. Restraint, Seclusion, Police Powers, Recommendation, CTO's etc and that I was the exception to the norm in terms of applying the spirit of the Act in my day to day practice. Educators and university Sector teachings would also focus on these sections as well thus creating a negative focus as opposed to the sections relating to the spirit of the Act. I recall now that MHA 1986 Victoria was changed to stop punitive care occurring which was not surprising given that the Act was effectively sabotaged through the intense focus upon the punitive aspects by leaders and educators. Think of the money invested to make such changes and overhauling of the Act. Imagine how many extra services could have been delivered with the same amount. I hope that the leaders of today are more dynamic in realising the impact that they are having or can have on making this system truly deliver upon its intentions. "

Submission to the MBS Review Taskforce – Mental Health

TRISTAR MEDICAL GROUP

Review of MBS Items for the comprehensive management of patients afflicted with Mental Illness and suggestions that allow for more appropriate treatment enhancing approaches under the MBS.

Prepared by: Brett McKinnon
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Organisational Overview

Introducing Tristar Medical Group which is an expanding organisation that currently has 65 General practices across 6 states and Territories of Australia (Victoria, New South Wales, South Australia, Queensland the Australian Capital Territory and the Northern Territory). Current internal data from Tristar Medical Group suggests that the clinics provide medical and ancillary services to approximately 2.7 percent of the Australian population across the network.
With an initial business model that centered around identifying growth areas and areas identified to be in high need of medical practitioners, coupled with a GP recruitment arm that sourced, trained and accredited general practitioners from across the globe to match into the desired positions, the business has gone from strength to strength.
The Tristar Model has its Head Office in Mildura, Victoria, where a 50+ strong team comprising of 7 Executive Managers (including CEO, Managing Director, and Managers of Programs, Mental Health, Workforce, Human Resources, Finance, Information Technology and Projects all officiate roles) plus 45+ support staff provide overarching structure, governance, leadership and support to the clusters of clinics across the geographical spaces we occupy. We operationalise the same successfully proven business model across all our locations which operate in a pseudo franchise like format.

Tristar Medical Group employs (500) Staff across the 65 clinics and all positions aside from the General Practitioners have come from the local communities from where the clinics operate. It is this additional career opportunity facet for local citizens that value adds to the otherwise excellent medical and ancillary services that Tristar provides.
Tristar Medical Group employees fulfil a multitude of professional roles across a broad spectrum of disciplines including but not limited to,

- General practitioners
- Specialists including
    - Urological Surgeon/ Urologic Oncologist
    - Urologist
    - Respiratory and Sleep Disorders Physician
    - Endocrinologist
    - Neurosurgeon and Spinal Surgeon
    - Paediatrician
    - Oral Surgeon
    - Cardiac and Thoracic Surgeon
    - Pain Specialist/Anaesthetist
    - Neurologist / Neurophysiologist
    - Ear, Nose and Throat Surgeon
    - Psychiatrists
- Allied Health (Psychologists, Social Workers, Podiatrists, Diabetes Educators Physiotherapists, Exercise Physiologists to name a few)
- Nursing (including Generalist, Mental Health and Nurse Practitioners)
- Administration and Program Management
- Human Resources
- Information Technology
- Finance
- Importing and Warehousing and Supply chain

Introduction:

Tristar Medical Group acknowledges the Medicare Benefits Scheme (MBS) Review Taskforce has been asked by Minister Greg Hunt MP, Commonwealth Health Minister, to review the current approaches to treatment of individuals experiencing Mental Illness and specifically in relation to this submission, those 47 MBS Items being targeted by the Mental Health Reference Group.
This submission seeks to identify and explore the key issues for consideration relating to the efficacy of the current MBS Items pertaining to the comprehensive treatment of individuals experiencing mental illness. Specifically, we feel well placed to advise upon those MBS items that assist patients whom are receiving Mental Health Services in Primary Care via their General Practitioner and associated Allied Health Treating Teams.

Current Evidence Base: Relevant to the 47 MBS Items under review

Mental health services in Australia (MHSA) authored by the Australian Institute of Health and Welfare (AIHW) provides a picture of the national response of the health and welfare service system to the mental health care needs of Australians.

A recent Web Report updated 3 May 2018 from MHSA indicated the following.

General Practitioners (GPs) are often the first port of call for people seeking help with a mental illness. GPs provide a variety of services, including referral of the patient on to specialised services. GPs play an integral role in this realm and across the entire Primary Care Sector

The Bettering the Evaluation and Care of Health (BEACH) survey of general practice activity, which provides detailed information about GP encounters (Britt et al. 2016) based on data collected from a sample of GPs, is one source of reliable information that informs burden of disease and apportioning of funding, to list only a couple of value adds.

Analysis of Mental health-related Medicare Benefits Schedule (MBS) items provided by GPs (throughout this section referred to as Medicare-subsidised mental health-specific services), are another source of information to draw upon to understand service trends and community needs.
These 2 data sources provide complementary insights into mental health-related GP care. Not all mental health-related GP encounters are billed using mental health-specific Medicare Benefits Schedule (MBS) item numbers. Consequently, the number of estimated GP encounters from the BEACH survey deemed to be mental health-related are greater than the number of Medicare-subsidised mental health-specific services.

In relation to this submission, the above-mentioned resources yielded the following information relevant to General Practice:

- According to the BEACH data, just under 18.0 million estimated GP encounters were mental health-related in 2015–16, equating to around 12.4% of all GP encounters.
- There has been an annual average increase of 4.7% in the number of estimated GP encounters that were mental health-related since 2011–12.
- *Depression* was the most commonly managed problem during a mental health-related estimated GP encounter (about one-third, or 32.1%).
- The most common management of mental health-related problems was for the GP to prescribe, supply or recommend medication (61.6 per 100 mental health-related problems managed).

- According to the MBS data, there were about 3.2 million Medicare-subsidised mental health-specific services provided by GPs in 2015–16.

Medicare-subsidised mental health-specific services are provided by psychiatrists, general practitioners (GPs), psychologists and other allied health professionals.

Medicare-subsidised general practitioner (GP) services	**Medicare-subsidised general practitioner (GP) services** are services provided by medical practitioners who are vocationally registered under Section 3F of the Health Insurance Act 1973 or are Fellows of the Royal Australian College of General Practitioners or trainees for vocational registration.
Medicare-subsidised other allied mental health services	**Medicare-subsidised other allied mental health services** are services provided by other allied mental health professionals such as occupational therapists, social workers and mental health nurses. These services cover focussed psychological strategies—allied mental health (occupational therapist and social worker items) and enhanced primary care—allied health (mental health worker item). Mental health workers include Aboriginal health workers, mental health nurses, occupational therapists and some social workers as well as psychologists. Although some psychologists are covered by this item they cannot be readily separated from the other mental health workers covered, so this item is counted under the heading of other allied mental health services. For Medicare payments to be made on these items the provider (occupational therapist, social worker or other appropriate provider) must be registered with Medicare Australia as meeting the credentialing requirements for provision of the service.
Medicare-subsidised psychologist services	**Medicare-subsidised psychologist services** are services provided by psychologists that are rebatable by Medicare through psychological therapy services, focussed psychological strategies and enhanced primary care items. The data source section lists these item groups with the relevant MBS item numbers. For these items to be eligible for Medicare rebates, the provider must meet the following eligibility requirements and be registered with Medicare Australia. Medicare rebates for psychological therapy services are only available for services provided by clinical psychologists who are fully registered in the relevant jurisdiction and are members of, or eligible for membership with, the Australian Psychological Society's College of Clinical Psychologists. Clinical membership is only available for registered psychologists who have completed the standard 4 years of study in psychology and attained an accredited doctorate degree in clinical psychology or master's degree in clinical psychology with 1 year of supervised post-masters clinical psychology experience. Medicare rebates for focussed psychological strategies and enhanced primary care are available for services provided by psychologists who are fully registered in the relevant jurisdiction regardless of any specialist clinical training. Registered psychologists must complete the standard 4 years of study in psychology with an additional 2 years of supervised practice, postgraduate coursework or a research degree, and meet any

	other jurisdiction-specific requirement for registration.

The services described here are provided in a range of settings, for example hospitals, consulting rooms, home visits, over the phone, and online videoconferencing as defined in the Medicare Benefits Schedule (MBS).

- **2.4 million Australians** (9.8% of Australians) received Medicare-subsidised mental health-specific services in 2016–17.
- **9.8%** of Australians received Medicare-subsidised mental health-specific services in 2016–17, an increase from **5.7%** in 2008–09.
- **11.7%** of Australian females accessed Medicare-subsidised mental health-specific services compared to 7.9% of Australian males in 2016–17.
- **11.1 million** Medicare-subsidised mental health-specific services were provided by psychiatrists, GPs, psychologists and other allied health professionals in 2016–17.
- **GPs** provided the most Medicare-subsidised mental health-specific services during 2016–17.

Historical MBS Structures

Since 2002, several additional mental health specific items have been included on the MBS to provide support to GPs coordinating the treatment needs of patients with mental health related problems:

- The 2002 Better Outcomes in Mental Health Care initiative was designed to improve community access to quality primary mental health services by providing better education and training for GPs and more support for them from allied health professionals and psychiatrists; and introduced new MBS items for eligible GPs under the headings '3 Step Mental Health Process' and 'Focussed Psychological Strategies'.
- The November 2006 Better Access initiative was designed to improve access to, and better teamwork among, psychiatrists, clinical psychologists, GPs and other allied health professionals; and introduced the GP Mental Health Care items as well as psychiatrist and allied health worker MBS items that are linked to these plans.

- From 1 January 2010 4 new items (items 2700, 2701, 2715 and 2717) were introduced to replace items 2702 and 2710 for the development of a GP Mental Health Treatment Plan. Items 2700 and 2701 have a lower schedule fee for GPs who have not undertaken accredited Mental Health Skills Training. The schedule fees for the review consultation items 2712 and 2713 were reduced. Allied health services were capped at ten services per patient per calendar year, and the provision for an additional six services under exceptional circumstances was removed.
- From November 1 2017, MBS funding was extended for Psychologists and to provide telehealth services for patients in applicable telehealth regions Monash Modified Model (MMM) 4-7 with a blending of telehealth up to 7 sessions per calendar years interspaced with 3 face to face (1 in the first 4 sessions) assisting GPs and health services to provide care to rural and remote centres.
- From July 1 2018, Additional MBS Items allowing Medical Practitioners (non GP) to craft Mental Health Care Plans and provide Focussed Psychological Therapies under items 272 – 287

A number of different health care and community welfare professionals, such as psychiatrists, psychologists, nurses, general practitioners and social workers, provide a range of mental health-related services to Australians. The workforce data for this section is sourced from the National Health Workforce Data Set (NHWDS), which comprises data about employed health professionals collected through annual registration surveys administered by the Australian Health Practitioners Regulation Agency (AHPRA) since 2010.

In 2015, there were an estimated 3,131 Psychiatrists, 20,834 Mental health nurses and 24,522 registered psychologists (not exclusive to MH Services) and 2260 Mental Health Social Workers in Australia.

Current Approaches to Treatment:

The MBS in its current form provides a framework from which General Practitioners (GPs) may assess for underlying psychopathology, diagnose mental illness and commence treatment under the auspices of a General Practitioner Mental Health Care Plan (GPMHCP). Such plans are the conduit for GPs to provide a raft of care options that they may provide themselves, but additionally refer onwards to ancillary service providers including Psychologists, Social workers and Mental Health Nurses. In a Tristar Medical Group context, we are acutely aware of this landscape. We have 200 GPs across our network we have approx. 30 Psychologists and 3 Social Workers plus 4 Psychiatrists and 12 Mental Health Nurses including 6 Nurse Practitioners on our books. We have access to another 120 Psychologists through partnership arrangements with other service providers. We have all disciplines working in synergy under the governance of the MBS and other funding streams (including the former MHNIP (now Stepped Care Transition Funding) Psychological Therapy Services (PTS) under the remit of the Primary Health Networks to achieve the best possible outcomes for our patients.
In line with the MBS, we exercise 90-day cycles of multidisciplinary care under an in house Mental Health Program Guide and Associated Models of Care attached to Mental Health Nurse Practitioners (AHPRA Endorsed) and Managing the Physical Needs of the Mental Health Patient. All care within our context assimilates to key deliverables under the 5th National Mental Health and Suicide Prevention Plan.
We recognise the importance of adequately preparing our GP cohort for playing an integral role in the patient care journey, thus all of our doctors have completed the RACGP endorsed MHST and few have additionally completed Focussed Psychological Skills (FPS) training. (Both of these courses we have been a RACGP Certified trainer for).

Limitation of MBS with regards to Servicing the comprehensive needs of those affected with Mental Illness:

Unfortunately, the changing landscape with the winding down of the highly effective and proven MHNIP and minimal opportunity for Mental Health Nurses to access the MBS, the limited capacity of only 10 sessions per Allied Health clinicians are limiting the impact for our teams to deliver tangible longer term efficacious outcomes under the MBS. In a Tristar context we adopt multidisciplinary approaches to care with services provided through a combination of General Practitioners, Psychiatrists, Psychologists, Mental Health Nurses and Social Workers. GPs are at the heart of primary care and hold a generalist not specialist knowledge of all health conditions. While they have capacity to craft GPMHCP and linkages for service, often they report themselves to be **lacking in;**

- required time to be completely thorough in terms of assessment and planning;
- complete understanding of diagnostic specifiers;
- full awareness of the various psychological treatment modalities
- and reluctant to commence treatment without Psychiatrist review.

The problem we have identified is the often-lengthy delays in being able to access Psychiatrists in some of our contexts do not bode well for timely treatment enhancing decision making.
Tristar Medical Group feels that while having access to Psychiatrists is advantageous, there is options to commence early interventions (beyond initial GP Assessment) through Mental Health Nurse Practitioners and Psychologists which can commence whilst patients are on waiting lists for Psychiatrist review.
Our service has witnessed first hand the benefits of utilising MHNs and MHNPs for comprehensive coverage and or Psychologists for diagnostic clarification and Psychological therapies in support of the GP +/- Psychiatrist Review if complexity necessitates.

Options for Changing the MBS to provide greater coverage for those affected with Mental Illness:

Tristar Medical Group as a significant provider of General Practice Mental Health Care Services suggest the following options may prove helpful including:

Better Utilisation of Credentialed Mental Health Nurses and Mental Health Nurse Practitioners under Better Access and MBS

Before we start highlighting the benefits it is important to understand the various qualifications on offer in the MH Nursing realm as in our experience, many are still unaware.

- RN - RNs have undergraduate range of biosciences and human sciences including social science and psychology and a very small proportion have post graduate MH qualifications. A RN working in public MH are required to undertake MH post graduate qualifications to work in MH. *"Practice Nurses"* who are RNs (often confused with *'Nurse Practitioner'* which is a protected title and endorsed by AHPRA which is a different scope of practice) have a role in medical clinics with assisting with preparation of MHTPs.

- Credentialed MHN - undertake further credentialing CPD and supervision to become Credentialed as a MH specialist. The Mental Health Nurse Incentive Program allowed GPs to recruit and refer under a MHTP for chronic, persistent and severe mental illness with flexible number of contacts and reviews every 90 days. It was reviewed under the HMA report 2012 with very favourable outcomes for Primary MH clients. Is was the only bulk billed MH services service under Medicare that was cashed out to PHNs over 2 years ago which officially closed in June 2018. This is a big loss to consumers who are not eligible to Public MH and unable to access NDIS. CMHN skills and qualification needs to be considered under Better Access and important for Step care models.

- Nurse Practitioner - MH/Psychiatry - are endorsed beyond RN and specialise in MH/Psychiatry and mostly unknown and many health professionals are unfamiliar with the scope of practice. They have extension to practice that allow them to engage with a client without a referral, advance assessment, diagnosis, clinical investigations including pathology, a range of talk based psychological treatments, pharmacology prescribing, referral to medical specialist and writing sick certificates. Focus of MHNP is to fill gaps in service so would be ideally placed to assist GPs with the predicted increase

in managing people living with Mental Illness and provide advance clinical expertise in MH consultations and referral to medical specialist such as Psychiatrist when necessary.

The findings of the MBS Review Taskforce Interim Report (2016) highlighted a number of key areas based on the feedback received from the sector which are relevant to nursing and mental health:

- Nursing services are one of the most underutilised services under the MBS.
- Available items often did not support nurses to work to their full scope of practice, particularly where nurses had post-graduate qualifications in an area of specialty (e.g. mental health), generating an increased burden on GPs and psychiatrists to fill the gap, or creating large gaps in services and unmet need in areas where GPs, psychiatrists and allied health professionals are unavailable or in short supply.
- Access to affordable mental health treatment under the MBS was limited, particularly for those with more chronic mental health conditions requiring access to more intensive and prolonged treatment.
- Unfortunately, much of the community's current access to mental health nursing services occurs through the crisis-driven and overburdened acute mental health service setting, rather than alongside Psychiatrists and GPs in primary care where there are substantially greater opportunities for prevention and early intervention. Interestingly Mental Health Nurses are entrusted with the care of the most significantly unwell in the acute sector, yet their advanced skillsets are not fully recognised in the MBS and Better Access landscape. We see immense value in Nurses achieving greater recognition under these programs. Especially in Case Management, managing the physical health care needs and suicide prevention.
- Mental health nurses are the largest and most geographically accessible clinical mental health workforce, creating enormous potential to increase access to mental health services across Australia, including in rural and remote locations (AIHW, 2017).
- Despite credentialed mental health nurses having specialist qualifications in mental health and many with specific training in particular therapy modalities (e.g. family therapy, CBT, DBT, MI, psychotherapy), and specialising in identified high need areas (e.g., older adults, child and youth, eating disorders, perinatal and managing physical health needs), Psychiatrists and GPs continue to experience funding barriers to engaging highly skilled and qualified MHN to support the patients in their practice. This directly contributes to barriers to access and service gaps experienced by Australian consumers for specialist mental health services.
- Tristar Medical Group believe Credentialed Mental Health Nurses and Mental health Nurse Practitioners provide the maximum value for clinical care across the entire BIOPSYCHOSOCIAL Model. If funding allowed then we would recruit mental health nurses before any other clinical discipline. Sadly, funding for nurses has been very limited to those fortunate to receive PHN Tender related funding under the stepped care model, thus limiting the full potential of this workforce in comparison to facilitating greater access to MBS items for their services.

- Evidence of effectiveness of the MHNIP model of service delivery whereby MHNs were actively providing clinical interventions and co-ordinating care for patients has been well documented by a number of reviews (HMA 2012).
- Clients receiving treatment and support under MHNIP experienced improved outcomes through increased continuity of care- including through home visits, follow up and care co-ordination, access to support and greater compliance with their treatment plans.
- Of note that in a Tristar Context whereby we readily use MHNs to both provide and co-ordinate care, our completion rates of complete 90-day cycles of care and review of GPMHCPs sits at approximately 70%. Medicare database statistics and reporting indicates, that Nationally (and after a decade), the best review rates achieved have been no greater than 42% with Victoria tracking close to a bare pass mark of 50% at 46% last year. This score is the closest any state has got to achieving a bare pass since the introduction of the MBS 2712 billing item. This item itself is integral in demonstrating effectiveness in reviewing planned care. The role of the MHN in our context has been vital to achieving excellent patient care outcomes in this domain.
- Under the MHNIP, there was evidence of an overall reduction in average hospital admission rates and lengths of stay in hospital where admission occurred; increased levels of employment; improved family and community connections; and positive impacts on GP workloads to list a few.
- MHNs value add into Primary Care and General Practice by offering
    - Advanced assessment and diagnosis of Mental Health Issues
    - Physical health monitoring and reporting to the GP
    - Medication monitoring and reporting to the GP
    - Medication psychoeducation
    - Psychotherapy / Psychological Interventions

- Changes could be made to the current item structure to improve care collaboration and integration, particularly given the direction and priorities arising from the recent primary care and mental health reform.
- Mental health Nurses have proven themselves very effective in the Primary Care landscape and evidenced by the treatment successes noted under the now de funded MHNIP Program. To extend their impact, Mental Health Nurses require better recognition under the MBS and Better Access schemes
- With the exception of telepsychiatry, the existing item structure does little to assist in improving access to mental health care in outer regional, rural and remote Australia. Telepsychiatry is still less than optimal as it does not provide a clinician with in-depth working knowledge of the issues faced by the rural community/ies they are providing services to, nor does it provide the community with full time access to mental health care. As mentioned previously the Mental Health Nursing workforce is the largest in Mental health care and essentially untapped yet proven effective when operationalised. It may prove beneficial to extend their scope to assist into regional and rural communities. Tristar Medical Group would certainly welcome their greater scope as we have many clinics in regional and rural Australia.
- The limited time available for consultations continues to pose a problem. Communicating and identifying key issues reflective of the person's mental wellbeing as well as their physical health. Consumers often report that

psychiatric consultations of less than 15-30 minutes provide little opportunity to achieve more than a medication review and a very brief discussion relating to their mental state.

- Effective utilisation of the mental health nursing workforce working in collaboration with psychiatrists and GPs offers a way of increasing access to collaborative, integrated mental health care under the MBS. Furthermore, the entire BIOPSYCHOSOCIAL model is catered to and especially when Managing Physical Health Needs and Suicide Prevention are highlighted in the 5th National Mental health and Suicide Prevention plan.

- Mental health nurses have demonstrated great aptitude for facilitating strong outcomes for people experiencing severe and complex mental illness and this has been recognised by the National Mental Health Commission in its 2014 Report and in the literature (McLeod, 2017; Lakeman, 2013; Richards, 2013). As registered nurses, mental health nurses are also well placed to support patients with co-occurring chronic physical health conditions, including monitoring and responding to the adverse impact of psychotropic medications on physical health in collaboration with the patient's psychiatrist and/or GP.

- All Credentialed Mental Health Nurses complete their formative years in Acute Care and other like settings whereby the management of risk and suicide prevention strategies training and interventions are strong hallmarks of their daily roles. With these facts in mind Mental Health Nurses are often better placed than their GP and Allied Health colleagues in the identification and effective management of suicidal and / or at-risk behaviours. Targeted measures are a key thrust of the 5th National Mental Health and Suicide Prevention Plan. Funding Nurses into the mix under the MBS and Better Access may prove beneficial in delivering upon the intentions of the Plan.

- Psychiatrists and GPs who have utilised mental health nursing services have viewed those services as an important adjunct to the services they provide (HMA, 2012). Some psychiatrists and GPs have offered credentialed mental health nurses free room rent because of the range of benefits the service brings to the practice and its patients.
- The MBS should deliver values-based incentives, connect primary health care to other sectors of the health care system and facilitate innovation, collaboration and fully integrated mental health care. Psychiatry items should be reviewed in light of these principles, particularly in terms of how the MBS could better support psychiatrists and GPs who are keen to engage mental health nurses to provide integrated mental health care to the patients in their practice.
- Consideration should also be given to mental health nurses being supported under the MBS to deliver mental health care to people in rural and remote communities where there is no psychiatrist available, in collaboration with telepsychiatry services as required.
- Given the growing need in the community, effectively harnessing the currently underutilised mental health nursing workforce represents an opportunity for improving access to specialist mental health care for Australians with mental health issues, mental disorder or mental illness, and

improving mental health outcomes for all Australians. Tristar Medical Group Supports the ACMHN recommendations that consideration be given to:

- Establishing an MBS item number to support psychiatrists and GPs to engage mental health nurses to deliver mental health services within their scope of practice.
- Establishing a mechanism to support MHN working collaboratively with psychiatrists via telepsychiatry in regional, rural and remote areas where psychiatry services are unavailable.
- In the care of a mental health nurse working in collaboration with psychiatrists and GPs, people with moderate and severe mental illness have access to further care from a clinician who is specially trained to consider and contribute to their mental, physical and social wellbeing within the care team.

Increased Session Numbers for Psychologists and Clinical Psychologists:

As an employer of and referrer to Psychologists and Clinical Psychologists, Tristar Mental Health Services inclusive of our GPS and Psychiatrists are aware of the valuable work that Psychologists complete to assist patient recovery. We feel however that the MBS needs to be reconfigured back to historical numbers to allow for Psychologists to provide up to 18 individual patient sessions, as many cases require and benefit from having more extensive treatment packages to remove longer standing challenges (E.g. those with complex trauma, Borderline Personality Disorder etc.). Tristar Medical Group would support such changes in the MBS to accommodate these needs as a more significant buffer for the GP and Acute Services.

Parity for Multidisciplinary Professionals under the MBS

Tristar Medical Group is aware that disparity exists within the MBS in recognition of clinical roles and skillsets held. Tristar Medical Group believes parity measures that group funding in tiers of clinical importance may prove highly relevant in assisting GPs and Psychiatrists to recruit a skilled workforce to assist them to manage patient care. Tristar would suggest a tier parity funding structure that groups the following.

1. Clinical Psychologists and Mental Health Nurse Practitioners (higher rates as greater impact)
2. Psychologists, Social Workers, Credentialed Mental Health Nurses, MH Occupational Therapists.

Please see attached table (Comparison in Mental Health Service Funding) that highlights disparity variables.

Thank you again for the opportunity to provide feedback. We are happy to be contacted should the Committee require further information.

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Comparison Mental Health Service funding in Primary Care

Nurse Practitioner SoP Mental Health/ Psychiatry	MHNIP Program Closed June 2018	Better Access NB: excludes MH Nurses while they provide FPS under ATAPS, CDMP, PSC	PHN Psychological Services (ATAPS)	Chronic Disease Management Plan (CDMP)	Pregnancy Support Counselling (PSC)	General Practitioner providing Focus Psychological Strategies (FPS)	General Practitioner Standard Consult	Consultant Psychiatrist
10 min 82205 **$17.85** 20 min 82210 **$33.80** ≥ 40 mins 82215 **$49.80**	One session of 3.5 hours with 2 - 3 pt contacts. Often a % paid MHN by the eligible organisation @ **average $45/hr**	At least 50 mins Clinical Psychologist **$124.50** Gen Psychologist **$84.80** Allied Health **$74.80**	At least 50 mins **$125.00** **CMHN Clin Psych Gen Psych MHSW MHOT**	At least 20 mins **$52.95** **Inc CMHN Allied Health**	MBS 81000, 81005, 81010 At least 30 mins **$62.20**	MBS 2721 30-40 mins **$92.75** MBS 2725 40+ mins 2725 **$132.75**	B consult -20 min **$37.60** C consult 20+ consult **$72.80** D consult ≥ 40 min **$103.50**	MBS items 296 ≥ 45 mins **$221.30** 302 15–30 min **$73.50** 304 30 + **$113.15** 306 45–75 min **$156.15**
No. of Sessions unlimited	NOS unlimited	NOS 10 sessions	NOS 12 sessions	NOS 5 sessions	NOS 3 sessions	NOS 12 sessions	NOS unlimited	NOS unlimited

Comparison of scope of practice	**Clinical Psychologist**	**Gen Psychologist MH SW MH OT**	**Credentialed Mental Health Nurse**	**MH Nurse Practitioner**	**Psychiatrist**	**General Practitioner**
Referral is ***not*** required for a client to engage & initiate service				✓		✓
Care Plan				Health Care Homes		✓ 6 hour MH training
Assessment						
Biological systems assessment			✓	✓	✓	✓
Medication assessment & monitoring			✓	✓	✓	✓
Social assessment	✓	✓	✓	✓	✓	✓
Psychological assessment	✓	✓*	✓	✓	✓	✓
Clinical investigations and pathology				✓	✓	✓
Diagnosis	✓			✓	✓	✓
Treatment						
Advance psychotherapeutic skills	✓*	✓*	✓*	✓*	✓*	
Focused psychological strategies (FPS)	✓*	✓*	✓*	✓*	✓*	✓* 20 hours CPD FPS
MH Counselling	✓	✓	✓	✓	✓	✓
Outcome measures	✓	✓	✓	✓	✓	✓
Psychometric testing	✓			✓	✓	
Prescribe medication				✓	✓	✓
Referral to medical specialist				✓		✓
Write sick certificates				✓	✓	✓
Admission rights				✓	✓	✓
Unlimited number of sessions	10 BA 12 ATAPS	10 BA 12 ATAPS	✓ **MHNIP (ceased)** 12 ATAPS	✓	✓ 306 – 50 319 - 160	✓ FPS 12 sessions

*Note: the HC professional can provide service with extra training and credentialing
NP Legislation was implemented in 2000. In 2010 the MBS items and PBS authorisations were established for NP. Both require updating to allow full implementation of NP authorisations.

MHN Response to priority areas on 5th National Mental Health and Suicide Plan

1. Achieving Integrated regional planning and service delivery – MHN demonstrated close working relationships with GPs and medical clinic based care, liaison with all other health care professionals, collecting collateral information to coordinate and plan care. MHN have demonstrated skills with working across a range of mental health issues including moderate to severe mental illness, drug dependence, forensic care, family violence, suicide prevention, acute and emergency response. The most significant gap in services for people living with mental health is in primary care. They are the highest number of people receiving disability support pension and cannot afford to use private psychology and psychiatry services. MHN and MHNPs are able to fill the gap between State Public Mental Health Services and Private Mental Health Services in Primary Care to be able to offer consultation liaison to GPs for psychiatry. The MHNIP, now closed in June 2018, was the only fully bulk billed clinical Primary Mental Health service available to people living with persistent, chronic and severe mental illness.

2. Suicide Prevention – MHN have professionally developed through acute and emergency service response and well equipped to provide accessible and advanced practice while understanding service systems to manage suicide presentations.

3. Coordinating treatment & support for people with severe and complex mental illness – demonstrated efficacy and efficiency with providing coordination of care and psychotherapeutic interventions for patient living with mental illness and complex comorbid health conditions.

4. Improving Aboriginal and Torres Strait Islander Mental Health and suicide prevention – MHN workforce are the most accessible group of MH providers and proven efficacy with diverse groups and cultures

5. Improving physical health of people living with mental illness and reducing early mortality – demonstrated skills and qualified to provide biological assessment, monitoring and liaison with primary health professionals, private and public health sectors.

6. Reducing Stigma and discrimination – MHN have demonstrated skills and training to respond to diversity, developing effective rapport, success with assisting MH clients to engage in work and vocational opportunities and community participation.

7. Making safety and quality central to mental health service delivery – MHN demonstrated vigilance in recalling client when they don't attend booked appointments and fall out of treatment, don't present for clinical review under MHTP which can indicate disengagement in treatment and increased risk.

8. Ensuring that the enablers of effective system performance and system improvement are in place – MHN have exceptional skills in assisting clients to navigate the health care system for all sectors of health including mental health, drug and alcohol and physical health services.

MHA report 2012
2018 – 19 Victorian Budget Submission, AMA