Australian College of Mental Health Nurses

Inquiry into Rural, Regional and Remote Medicare Access and Funding

Australian College of Mental Health Nurses

19 February 2026

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Cover Letter

Committee Secretary
Senate Standing Committees on Rural and Regional Affairs and Transport
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Dear Rural and Regional Affairs and Transport References Committee,

Re: Rural, regional and remote Medicare access and funding

On behalf of the Australian College of Mental Health Nurses (ACMHN), we submit this consolidated cover statement to accompany contributions from Credentialed Mental Health Nurses (CMHN),

Nurse Practitioners (NP), researchers and rural clinicians contributing to this Inquiry into Rural, Regional and Remote Medicare Access and Funding.

Across all member contributions, a consistent and evidence-informed message emerges. Current Medicare settings are misaligned with the realities of rural mental health need, workforce distribution and contemporary mental health nursing capability. Member reports show practical consequences including cancelled telehealth clinics, disrupted continuity of care, increased travel burden for consumers, financial instability for small community clinics, and predictable escalation to crisis care and avoidable emergency presentations.

We therefore recommend targeted and operational reforms that i) expand MBS and Better Access eligibility to ACMHN-endorsed CMHNs and advanced practice NPs; ii) introduce rural complexity loadings, telehealth top-ups and blended/bundled payments; iii) provide 6–12 month transitional protections for nurse-led and NP-led services; iv) fund dedicated telehealth follow-up for post-ED discharge and high-risk consumers; v) mandate Rural Impact Statements that model provider type, remoteness, lived-experience and cultural responsiveness; vi) invest in credentialing, postgraduate training, structured supervision and rural retention; and vii) require independent evaluation and public reporting of outcomes and policy changes.

The ACMHN Board endorses this consolidated reform platform as essential to ensuring Medicare remains fair, workable, and sustainable for rural Australians. Aligning funding with real-world multidisciplinary practice will strengthen small clinics and community-embedded services, while reducing long-term system costs associated with crisis-driven care.

We thank the Committee for its attention to these matters and stand ready to assist with further evidence, modelling or stakeholder consultation as required.

Yours sincerely,

[redacted]

Emeritus Professor Wendy Cross
Acting Chief Executive Officer
Australian College of Mental Health Nurses

[redacted]

Associate Professor Cathy Daniel
Vice President
Australian College of Mental Health Nurses

About the Australian College of Mental Health Nurses

The Australian College of Mental Health Nurses (ACMHN) is the voice of the mental health nursing profession in Australia. The College is the peak professional mental health nursing organisation and the recognised credentialing body for Australia's mental health nurses. We represent mental health nurses across all levels of government and health service sectors and have local branches across Australia.

The College

- Sets standards for practice and professionalism
- Drives research in the field of mental health nursing
- Communicates the role and benefits of mental health nurses and releases news and current information about the profession
- Formally endorses training programs and supports continued professional development of mental health nurse members
- Promotes the benefits of non-medical approaches to mental health nursing
- Provides a rigorous professional development events schedule and communicates with members regularly about their experiences in their day-to-day work

Membership Profile

Executive Summary

Background

Rural communities experience higher rates of psychological distress, suicide, chronic disease comorbidity and service scarcity. These inequities are compounded for First Nations peoples and for racially, ethnically, culturally and linguistically diverse communities, who face additional barriers relating to cultural safety, language, trust and fragmentation of services. In these settings, Credentialed Mental Health Nurses (CMHNs) are often the most stable and trusted clinicians available. They deliver comprehensive assessment, evidence-based and culturally responsive psychological therapies, risk management, medication liaison, physical health monitoring and multidisciplinary coordination across the full spectrum of need. The 1 November 2025 Medicare changes were designed to strengthen continuity and system efficiency. However, in rural and remote contexts, evidence from our members indicates unintended consequences.

Methods

The ACMHN has collated submissions from CMHNs, Nurse Practitioners (NPs), researchers, and rural mental health nurses via an Expression of Interest (EOI) sent to members. Member submissions were reviewed and thematically analysed to identify recurring issues and key recommendations. Each member contribution is included verbatim, with minor formatting changes, in the submission to ensure that the perspectives and intent of individual contributors are accurately represented.

Key Findings

The key findings from the submissions include:

- The introduction of the MyMedicare alternative pathway has effectively created a two-tier telehealth system. Consumers attached to large, MyMedicare-registered practices experience streamlined eligibility and reduced administrative barriers, while those relying on nurse-led clinics, Aboriginal Community Controlled Health Services, community health services, and visiting NPs face new restrictions. Evidence from rural and remote communities shows this shift

has already disrupted continuity of care, led to cancelled telehealth clinics, and increased travel burdens for consumers, particularly in regions where local service options are limited.

- ACMHN-endorsed CMHNs are structurally excluded from explicit eligibility under the Better Access initiative and many relevant MBS mental health items. This exclusion does not reflect clinical capability as CMHNs already deliver comprehensive assessment, evidence-based and culturally responsive psychological therapies, risk management, medication liaison, physical health monitoring, and care coordination. The exclusion represents a systemic funding misalignment. The impact is most acute for small and community-embedded clinics which face financial vulnerability, reduced service capacity, and challenges maintaining multidisciplinary and culturally safe care.
- Current MBS item structures, including Chronic Disease Management and perinatal mental health session limits, impose consultation durations that are often clinically insufficient for chronic, perinatal, and complex mental health presentations. These limits create practical barriers to providing comprehensive care and make bulk-billing financially unsustainable for small and community-based practices, undermining continuity, preventive intervention, and culturally responsive engagement.
- Regulatory and workforce reforms that formally recognise CMHNs as specialist, place-based clinicians are essential to addressing workforce sustainability challenges in rural, regional, and remote areas. Evidence indicates that investing in CMHNs, funding postgraduate education, providing structured supervision, and offering targeted rural retention strategies improves workforce retention, clinical capability, and the availability of high-quality and locally embedded mental health services.
- Small rural practices operate under complex clinical, administrative, and financial pressures. Reforms including rural loadings, blended or bundled payments, nurse-led MBS items, and mandatory rural impact or stress-testing are required to stabilise community-embedded clinics, support multidisciplinary team models, and mitigate avoidable acute service use. These measures help ensure that Medicare settings reflect the higher clinical complexity, longer consultation times, and coordination demands characteristic of rural mental health care.

Recommendations

The ACMHN requests that the Committee recommend the following changes to Medicare to ensure rural consumers maintain access to locally delivered, culturally and clinically safe mental health care:

1. Expand MBS eligibility and funding to explicitly include ACMHN-endorsed CMHNs and advanced practice Nurse Practitioners as eligible providers under Better Access and relevant MBS telehealth and multidisciplinary items, where scope and governance requirements are met.
2. Introduce complexity loadings, telehealth top-ups, and blended or bundled payment models for services delivered in MM3–MM7 areas to reflect longer consultations, care coordination, and workforce scarcity.
3. Implement 6–12-month exemptions or transitional funding for nurse-led and NP-led services affected by MyMedicare or telehealth rule changes to prevent sudden service loss and preserve continuity.

4. Fund dedicated telehealth follow-up items for post-ED discharge and high-risk mental health consumers in rural and remote areas.
5. Require all future MBS reforms to include Rural Impact Statements with provider-type modelling, remoteness stratification, lived-experience indicators and cultural responsiveness analysis.
6. Invest in credentialing for nurses working in mental health, postgraduate training, protected supervision, and rural retention incentives, including scholarships, relocation support, and defined minimum rural service commitments.
7. Ensure all pilots and policy changes are independently evaluated using indicators of access, continuity, cultural responsiveness, consumer-reported outcomes, and acute service utilisation, with public reporting and predefined triggers for remedial action.

Conclusion

Evidence shows that stabilising funding, recognising specialist mental health nursing capability, and supporting culturally responsive and place-based care prevents avoidable hospitalisations, maintains continuity, and strengthens community trust in rural mental health services.

Suggested citation

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Member submissions

Steve Goldsmith

Submission to the Senate Inquiry on Rural, Regional and Remote Medicare Access and Funding
Steve Goldsmith, ACMHN
Contributor to the Australian College of Mental Health Nurses (ACMHN) Submission
Date: 15 January 2026

Executive Summary

Recent Medicare changes (effective **1 November 2025**) reshape telehealth eligibility for nurse practitioners and reconfigure mental health pathways under Better Access. While designed to promote continuity, these shifts can **reduce practical access** for rural, regional, and remote communities unless **rurally stress-tested** and supported by **team-care funding** that recognizes mental health nursing roles. Evidence from Australian peer-reviewed studies shows telehealth **improves rural access and is clinically effective** when embedded in locally connected, culturally responsive, mixed-team models (Caffery, Muurlink, & Taylor-Robinson, 2022; Speyer et al., 2018; Beks et al., 2023; Mathew et al., 2023). This submission proposes targeted reforms—**rural-appropriate telehealth eligibility**, **blended/rural-loaded incentives**, and **nurse-led MBS items with bundled payments**—to reduce avoidable ED presentations and strengthen continuity of care (AIHW, 2025; Barraclough, Longman, & Barclay, 2016).

Introduction

This submission addresses the effects of recent changes to Medicare access and funding on rural, regional, and remote communities, focusing on mental health nursing, telehealth, and mixed-team models of care. It draws on current government guidance and national health data and includes **de-identified local case vignettes** from rural Victoria (Mallee, Gippsland, Wimmera, Grampians, Hume) to illustrate access and continuity issues and feasible solutions (Parliament of Australia, 2025).

TOR (a)

Term 1: Impact of the 1 November 2025 Medicare changes on access to primary care, including telehealth

Context. From **1 November 2025**, telehealth eligibility requirements were extended to nurse practitioners, aligning with GP telehealth rules and introducing an “eligible practitioner” pathway or exemption (AGDHA, 2025a, 2025b, 2025c). Better Access adjustments (e.g., some review functions shifted to general attendances) may **increase friction** for remote patients reliant on multidisciplinary services (AGDHA, 2025a, 2025b).

Evidence. Telehealth **reduces rural access barriers** and is **as effective as face-to-face care** when delivered by nurses/allied health professionals; retaining pandemic-era gains is crucial for rural equity (Caffery et al., 2022; Speyer et al., 2018). Acceptability rises when providers are **locally connected** and culturally attuned (Moody, Loi, Rock, Usher, & Rice, 2025).

Local Case (Mallee – Mildura/Swan Hill). A grain-farming family relied on mental-health-nurse telehealth every 2–3 weeks. Post-change, an in-person visit was required to maintain rebates; the earliest slot was **6 weeks away**, leading to missed early-warning intervention and symptom escalation (AGDHA, 2025b, 2025c).

Recommendations (with expected outcomes).

- **Expand/clarify rural exemptions** (distance, transport hardship, broadband constraints) under the eligible-practitioner rule for MMM4–7.
  Outcome: Maintains timely telehealth access; prevents disengagement and deterioration (AGDHA, 2025b; Caffery et al., 2022).
- **Align MyMedicare** registration to **facilitate longer telehealth**, reduce administrative friction, and reinforce continuity.
  Outcome: Fewer missed appointments and improved adherence (AGDHA, 2025d; Speyer et al., 2018).

TOR (b)

Term 2: Financial sustainability of independently owned rural general practices

Context. The **BBPIP** expands bulk-billing support (payments from **Jan 2026**), but independent rural clinics continue to face thin margins, constraining non-medical roles (AGDHA, 2025e). The **Effectiveness Review of General Practice Incentives** recommends **blended funding** to enable multidisciplinary hires (KPMG, 2024; RACGP, 2024).

Evidence. Nurse practitioner-led rural mental health services deliver **integration gains** and reduce crisis events—supporting investment in mental health nursing capacity (Barraclough et al., 2016).

Local Case (East Gippsland – Orbost/Lakes Entrance). A small clinic (≤3 FTE GPs) reduced mental-health-nurse capacity due to incentive reform uncertainty and cash-flow lag, extending waits from **2 to 6 weeks** and increasing unplanned GP reviews (KPMG, 2024; RACGP, 2024).

Recommendations (with expected outcomes).

- **Introduce rural loadings (e.g., 20–30%)** within BBPIP/WIP to reflect low patient density and higher fixed costs.
  Outcome: Stabilizes nurse capacity; reduces wait times and crisis escalations (AGDHA, 2025e; Barraclough et al., 2016).
- **Implement blended payments** dedicated to **employing mental health nurses/NPs** in MMM4–7.

Outcome: Sustained team-care roles; fewer avoidable ED presentations (KPMG, 2024; RACGP, 2024).

TOR (c)

Term 3: Current Medicare settings and avoidable ED presentations/preventable hospital admissions

Context. Mental-health-related ED presentations rose **22%** since 2014–15 to **~310,200 in 2023–24**; on-time care fell from **71% to 60%**. Remote/very remote areas show higher rates of **low-urgency ED use** and **potentially preventable hospitalisations** (AIHW, 2025; Burge, 2025).

Evidence. Telehealth embedded in rural ecosystems (including ACCHOs) improves **follow-up**, **access**, and **continuity**, reducing crisis presentations (Beks et al., 2023; Mathew et al., 2023).

Local Case (Wimmera – Horsham & surrounds). An 80-year-old with bipolar disorder and COPD lost weekly telehealth check-ins due to eligibility pathway disruption; transport barriers preceded ED presentation for mood destabilisation and dehydration (AIHW, 2025; Burge, 2025).

Recommendations (with expected outcomes).

- **Create new MBS items** for **proactive relapse prevention and care coordination** by mental health nurses (telehealth + outreach) in MMM4–7.
  Outcome: Fewer crisis escalations; reduced ED load (AIHW, 2025; Mathew et al., 2023).
- **Commission PHN rapid-follow-up bundles** (safety planning, navigation, next-day telehealth).
  Outcome: Faster stabilization post-deterioration; lower readmissions (AIHW, 2025; Beks et al., 2023).

TOR (d)

Term 4: Adequacy of Medicare support for mixed-team models in rural communities

Context. Government policy encourages **multidisciplinary team-based care**, PHN-commissioned teams, and **full scope** practice for non-medical clinicians (AGDHA, 2025f; WA Primary Health Alliance, 2024). Implementation must preserve continuity and avoid fragmentation (Croakey Health Media, 2025).

Evidence. Mixed-team telehealth **enhances access** and coordination when supported by infrastructure and local relationships; acceptability is high in rural contexts (Mathew et al., 2023; Caffery et al., 2022).

Local Case (Hume – Wodonga/Upper Murray). A co-located team (GP, mental health nurse, NP, allied health) runs outreach days; absent **nurse-led MBS items** restricts scale (only **2 days/month**) despite improved continuity (AGDHA, 2025f; WA Primary Health Alliance, 2024).

Recommendations (with expected outcomes).

- **Establish nurse-led MBS items** for mental health consultations and case management.
  Outcome: Scaled outreach and continuity; reduced travel burden (AGDHA, 2025f; Barraclough et al., 2016).
- **Introduce bundled/team payments** for defined rural episodes.
  Outcome: Stable mixed-team delivery; measurable improvements in adherence and symptom control (KPMG, 2024; Mathew et al., 2023).

TOR (e)

Term 5: Impacts of current rules/incentives on corporate providers vs small rural clinics

Context. Practice consolidation and corporatisation can deliver extended hours/co-location but may **undermine local continuity** if incentives favour scale without equity adjustments (de Moel-Mandel & Sundararajan, 2021; Erny-Albrecht & Bywood, 2016; KPMG, 2024).

Local Case (Grampians – Stawell/Halls Gap vs regional hub). A corporate clinic in a regional hub drew clinicians away from a small community clinic 40 km away; waits increased and mental-health-nurse sessions decreased locally (de Moel-Mandel & Sundararajan, 2021; KPMG, 2024).

Recommendations (with expected outcomes).

- **Embed rural equity adjustments** in incentives (e.g., rural loadings, diminishing returns for very high-volume multi-site entities).
  Outcome: Protects small-town access and continuity (KPMG, 2024; de Moel-Mandel & Sundararajan, 2021).
- **Provide stabilization grants** (digital infrastructure, locum pools) for independent rural clinics.
  Outcome: Sustains local services; mitigates recruitment shocks (Erny-Albrecht & Bywood, 2016).

TOR (f)

Term 6: Reforms to ensure Medicare is fair, workable, and sustainably funded (including rural stress-testing)

Context. Telehealth eligibility changes and evolving **MyMedicare** benefits require **formal rural impact assessment and stress-testing** to avoid access shocks (AGDHA, 2025b, 2025d). This aligns with strengthening multidisciplinary primary care (AGDHA, 2025f).

Evidence. Retaining telehealth's rural gains preserves continuity where in-person access is constrained; rural preferences emphasize local connection and culture (Caffery et al., 2022; Moody et al., 2025).

Local Case (East Gippsland – Orbost/Buchan). Confusion about eligibility and MyMedicare alignment caused **6–8 weeks** of dropped telehealth sessions and increased unplanned GP visits (AGDHA, 2025b, 2025d).

Recommendations (with expected outcomes).

- **Legislate a Rural Stress-Test Protocol** (MMM4–7 modelling, communication plan, mitigation funding) for all major Medicare changes.
  Outcome: Smooth transitions; minimized service disruption (AGDHA, 2025f; Caffery et al., 2022).
- **Publish rural impact summaries** (access and continuity metrics) for transparency.
  Outcome: Informed adjustments; accountability to rural communities (Parliament of Australia, 2025).

TOR (g)

Term 7: Other related matters (workforce & hybrid models)

Context. Hybrid models combining **telehealth** and **periodic in-person outreach** are well-suited to dispersed rural populations; stability of teams/funding is essential (AIHW, 2025; Croakey Health Media, 2025).

Evidence. Rural and ACCHO telehealth models are **acceptable**, **improve continuity**, and support culturally responsive care (Beks et al., 2023; Mathew et al., 2023).

Local Case (Latrobe Valley – Traralgon/Moe). Weekly telehealth and monthly nurse-led groups correlated with fewer anxiety-related ED presentations and better adherence (AIHW, 2025; Croakey Health Media, 2025).

Recommendations (with expected outcomes).

- **Fund nurse training/retention pipelines** tied to MMM4–7 service.
  Outcome: Increased local capability; reduced vacancies and wait times (Barraclough et al., 2016).
- **Scale PHN-led hybrid pilots**, evaluated against AIHW ED indicators.
  Outcome: Demonstrated reductions in ED utilization; sustained continuity (AIHW, 2025; Mathew et al., 2023).

Quick-Reference Table of Key Recommendations & Expected Impacts

Term	Key Recommendation	Expected Impact
1	Expand rural telehealth exemptions; align MyMedicare for longer telehealth	Maintains access; prevents disengagement and crises

2	Rural loadings + blended payments for mental health nurses/NPs	Stabilizes workforce; shortens waits; fewer ED visits
3	New MBS items for nurse-led relapse prevention; PHN rapid follow-up	Reduced crisis escalation; lower ED presentations
4	Nurse-led MBS items + bundled/team payments	Scaled outreach; stronger continuity; reduced travel
5	Rural equity adjustments; stabilization grants for small clinics	Protects local access; mitigates corporatisation impacts
6	Legislated Rural Stress-Test Protocol; publish rural impacts	Smooth transitions; transparency and accountability
7	Fund rural nurse pipelines; scale PHN hybrid pilots	Workforce stability; measurable ED reductions

Conclusion

The **1 November 2025** telehealth changes and current funding settings risk **access and continuity impacts** for rural Australians if not **rurally stress-tested** and paired with **team-care funding** that recognizes mental health nursing roles. Evidence supports: (a) **rural-appropriate telehealth eligibility**, (b) **blended, rural-loaded incentives** stabilizing independent practices, and (c) **mixed-team and nurse-led models**—including hybrid delivery—to reduce avoidable ED use and strengthen continuity (AGDHA, 2025a–f; AIHW, 2025; KPMG, 2024; Caffery et al., 2022; Barraclough et al., 2016; Beks et al., 2023; Mathew et al., 2023).

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Susan Glassick

Submission to Medicare Access Inquiry: Call for Contributions

Date: 15 January 2026

Introduction

Practitioner Background:

I am a credentialed mental health nurse with a Master of Nursing, working in private practice across metropolitan and rural areas. My nursing career spans four decades, including qualifications as a midwife and women's health nurse.

My career has included substantial work in perinatal mental health, roles with the Agency for Clinical Innovation (ACI), service as an Official Visitor (OV), service development across the District, Area and the State. I am approaching three decades in the full range of mental health services as a Clinical Nurse Specialist, Clinical Nurse / Midwife Consultant and 6 years as a Credentialed Mental Health Nurse in private practice where in addition to contracting to three Primary Heath Networks, Medical practitioners refer client directly to my practice due to the quality of care provided and my commitment to maintaining no waiting list—a deliberate business decision to ensure timely access to mental health support.

Findings and recommendations

1. Chronic Disease Management Plans: Insufficient Session Allocation

The current limitation of five appointments per calendar year under Chronic Disease Management (CDM) plans is fundamentally inadequate for people with chronic conditions.

In my clinical experience with mental health patients, therapeutic momentum is lost when appointments are spaced more than four weeks apart, significantly diminishing treatment outcomes. This creates an impossible situation for patients with comorbid conditions who must choose between attending a mental health session or a physical health appointment—both of which are essential for managing complex, chronic disease.

Real-world impact: I regularly observe clients attempting to ration their limited sessions by extending time between appointments, trying to stretch their allocation across the calendar year. This approach directly undermines the continuity of care essential for mental health recovery and prevents clients from maintaining therapeutic momentum along their recovery journey.

Recommendation: Increase the minimum number of sessions under CDM plans to at least 12 per year to better reflect the ongoing nature of chronic illness management and enable appointments at therapeutically appropriate intervals.

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2. Perinatal Mental Health: Critical Gap in Care

The allocation of three non-directive pregnancy support sessions is grossly insufficient for addressing perinatal mental health needs. While three sessions may allow for discussing pregnancy choices, they are entirely inadequate for treating pregnancy-related mental health conditions including depression, anxiety, birth trauma, and adjustment disorders.

These conditions have profound implications for maternal-infant attachment and long-term child development. Many pregnant women also present with pre-existing mental health conditions requiring concurrent treatment. The perinatal period represents a critical intervention point that can significantly impact the wellbeing of families for generations—yet we are limited to three sessions.

Real-world impact: Under the current Medicare structure, when I assess pregnant women requiring ongoing mental health support, I am forced to explore alternative referral pathways at the initial assessment rather than providing continuity of care myself. This fragments care during a vulnerable period and delays treatment while women navigate new providers and waiting lists.

Recommendation:

- Establish a dedicated perinatal mental health program with a minimum of 12-15 sessions available from early pregnancy through the first postnatal year
- Make these sessions separate from and additional to standard mental health care plans

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3. Session Duration: Mismatch Between Clinical Need and Medicare Guidelines

A comprehensive mental health assessment incorporating psychological techniques requires 60-90 minutes, depending on clinical complexity. The Medicare-recommended timeframe of 20-30 minutes may be appropriate for some allied health services, but it is impossible to deliver meaningful, therapeutic mental health care within this constraint.

This timing mismatch is particularly problematic for pregnant women and people with chronic diseases who require thorough assessment, psychoeducation, development of safety plans, and treatment planning.

Recommendation: Revise Medicare guidelines to reflect realistic timeframes for mental health consultations, with item numbers that appropriately reimburse for assessments (60-90 minutes) and follow-up sessions (45-60 minutes).

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4. Financial Unsustainability of Bulk Billing

When providing bulk-billed services to vulnerable populations—who are often financially disadvantaged—the current rebate structure is financially unsustainable and threatens access to quality mental health care.

Current rebates of $61.80-$72.55 must cover:

- Consulting room hire: $25-$35 per hour (rural rates)

- Physical resources, assets, equipment, office supplies, and communication devices
- Professional indemnity insurance
- Continuing professional development
- AHPRA registration fees
- Credentialing and accreditation costs
- Time spent on clinical documentation, care coordination, and liaison with other healthcare providers (all unbilled activities)

After expenses, practitioners are left with minimal—if any—financial return, making it economically unviable to continue providing bulk-billed services to those who need them most.

Real-world impact: The inadequate rebate structure forces practitioners to either:

- Charge gap fees that make services unaffordable for disadvantaged populations
- Work at a financial loss, which is unsustainable long-term
- Reduce the quality or duration of consultations to see more clients per day
- Exit Medicare-funded practice entirely

My commitment to maintaining no waiting list and providing quality care means I absorb significant financial losses when bulk billing, effectively subsidizing the healthcare system from my own income.

Recommendation:

- Increase Medicare rebates to sustainable levels that reflect true practice costs
- Create separate item numbers for care coordination and clinical liaison activities (currenty not billable)

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5. A Concerning Observation: The Exodus of Expertise from Public Mental Health Services

From my observations working across both public and private sectors, there is a deeply troubling trend that is directly impacting access to quality mental health care: Local Health Districts are systematically moving on experienced staff.

I have witnessed expert and dynamic nurses with decades of specialized knowledge and youthful committed clinicians leaving the Public Health Services. The senior, and often aging but remaining dynamic staff who hold the expertise and institutional knowledge that takes decades to develop is no longer valued by LHDs. Instead, experienced or innovative practitioners face hostile work environments that effectively force them into leaving the profession, entering private practice or taking early retirement.

This represents a catastrophic loss to the public health system. My transition to private practice was not driven by choice but by necessity—the public system no longer provides a sustainable or respectful environment for experienced clinicians who have dedicated their careers to public health.

The compounding effect on access: This exodus of expertise compounds the Medicare access issues outlined in this submission. We now face a situation where:

- Public mental health services have lost their most experienced practitioners. These expert clinicians now work in private practice, where they could provide high-quality care to vulnerable populations
- Inadequate Medicare rebates and session limitations make it financially impossible to provide this expertise affordably to those who need it most
- Patients are caught between under-resourced public services with long waiting lists and unaffordable private care

The irony is profound: Australia has invested decades and significant resources in developing clinical expertise, only to drive that expertise out of public services and then fail to provide a Medicare framework that enables these skilled practitioners to serve vulnerable populations in private practice.

Recommendation:

- Urgently review workforce retention strategies in public mental health services, particularly for experienced senior clinicians
- Recognize that Medicare rebate structures must reflect the value of clinical expertise and experience
- Consider differential rebate levels that recognize advanced qualifications and decades of specialized experience
- Develop pathways that enable experienced clinicians to work across public and private sectors without facing financial penalties

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Conclusion

These systemic inadequacies create substantial barriers to accessing essential mental health care for Australia's most vulnerable populations: people with chronic diseases, pregnant and postnatal women.

The current structure forces clinically inappropriate compromises—rationing sessions, fragmenting care, and creating artificial treatment endpoints—that directly contradict evidence-based mental health practice. Meanwhile, inadequate rebates make it financially unsustainable for experienced practitioners to provide accessible, quality care to those who need it most.

I can state unequivocally that the current Medicare framework fails to meet the clinical needs of vulnerable populations and threatens the viability of practitioners committed to serving them.

Jan Bradley

Date: 19 January 2026

As someone who has worked within the Medicare scheme for a few years, there is one particular issue I am forced to deal with often, that likely will fall under the category of:

TOR (g): Any other related matters

As a practitioner dealing wth referrals from GPs, the main issue I face is not knowing whether the client is actually eligible for subsidised mental health nursing (counselling) services and if so, how many sessions they are eligible to receive.

A referral and mental heath care plan from a GP entitles the client to several different services, including rebated services for treatments such as a podiatrist.

Nowhere on the medicare receipt, does it indicate how many sessions remain available to the client. There is no online or in-app indicator.

Often, neither the client, the GP or the practitioner can look this up. Quite often I have done a session only to find that the client has used up all of their rebated sessions with another practitioner. Sadly, they had no idea and are either out of pocket or as in most cases, simply can not pay.

Indicating the number of services the client has remaining, similar to what is done with scripts, would be exceptionally helpful to everyone using the system.

Sincerely,

Jan Bradley
Member: 14333

Rowan Hardinge

SUBMISSION TO THE SENATE RURAL AND REGIONAL AFFAIRS AND TRANSPORT REFERENCES COMMITTEE

Inquiry into Rural, Regional and Remote Medicare Access and Funding

From: Rowan Hardinge, Registered Nurse

Date: 21 January 2026

Location: Northern NSW / Gold Coast Region

Thank you for this opportunity to contribute to the ACMHN submission. As a registered nurse with experience in both clinical practice and accessibility support, I'm particularly concerned about how the November 2025 Medicare changes may disproportionately impact vulnerable populations in rural and regional areas.Thank you for this opportunity to contribute to the ACMHN submission. As a registered nurse with experience in both clinical practice and accessibility support, I'm particularly concerned about how the November 2025 Medicare changes may disproportionately impact vulnerable populations in rural and regional areas.

Key concerns I'd like to highlight:

TOR (a) and (d)

Access barriers through telehealth restrictions (Terms of Reference 1 & 4) The proposed changes to telehealth Medicare items risk creating significant barriers for clients who have established therapeutic relationships with mental health nurses. Rural and regional Australians often face substantial travel distances, limited local specialist availability, and the compounding effects of cost and time barriers. Telehealth has proven essential for maintaining continuity of care, particularly for clients managing chronic mental health conditions who require regular, consistent support.

TOR (d) and (f)

Recognition of advanced practice mental health nursing (Terms of Reference 4 & 6)

Advanced practice mental health nurses, particularly those credentialed by the ACMHN, bring highly specialized expertise that is critical yet undervalued in current funding models. These practitioners have invested years in postgraduate education (Masters level or higher), accumulated substantial supervised clinical hours, obtained credentialing, and often completed additional training in evidence-based psychotherapy modalities including CBT, DBT, and EMDR. Credentialing specifically enables mental health nurses to train in EMDR, which directly addresses trauma and PTSD—conditions increasingly prevalent in rural communities. Importantly, EMDR can be effectively delivered via telehealth, making it particularly valuable for reaching geographically isolated clients.

Rural and regional Australians face compounding trauma from climate-related disasters including drought, bushfires, and floods, alongside the psychological burden carried by those who have served in defence or emergency services. With climate change intensifying the frequency and severity of natural disasters, rural communities are experiencing a trauma epidemic that requires sustained, accessible mental health support. Mental health nurses are ideally positioned to address these needs, but only if they can upskill in evidence-based trauma therapies and establish financially viable practices. Current Medicare funding structures make this career pathway unsustainable, forcing experienced practitioners to leave rural areas or abandon the profession entirely at precisely the time their expertise is most needed.

Mental health nurses deliver valuable psychotherapy and can fill vital care gaps in rural communities without depleting the inpatient workforce—these are complementary rather than competing roles. However, without appropriate Medicare support, we face a critical workforce sustainability issue. The nursing profession already struggles with demographic challenges and high attrition rates. When advanced practice mental health nurses cannot establish financially viable private practices or work sustainably in collaborative care models, many leave the profession entirely or retrain in other disciplines where their expertise is better recognized and remunerated.

We need successful mental health nurses in private practice as positive role models to attract and retain the next generation of practitioners. Current Medicare structures actively work

against this.

TOR (c)

Prevention of avoidable emergency presentations and hospital admissions (Terms of Reference 3) Mental health nurses play a crucial role in preventing mental health crises that result in emergency department presentations and preventable hospital admissions. Through early intervention, ongoing therapeutic support, and proactive management of chronic mental health conditions, mental health nurses can identify and address deteriorating mental health before it reaches crisis point. This is particularly critical in rural and regional areas where emergency services and inpatient psychiatric facilities are already stretched thin and often require lengthy transfers to access. When Medicare funding fails to support accessible mental health nursing services, including via telehealth, the result is increased pressure on already overburdened emergency departments and higher costs to the health system overall.

TOR (d)

The value of nurse-led mental health care in mixed-team models (Terms of Reference 4) Mental health nurses bring unique clinical expertise combining comprehensive nursing assessment skills with specialized mental health training and psychotherapeutic capabilities. We're often more accessible and affordable than other mental health professionals, providing crucial early intervention and ongoing support that prevents crisis escalation. Any funding model that doesn't adequately recognize and support mental health nursing roles undermines the mixed-team care approach essential for rural communities.

Recommendations

Recommendations I'd suggest including:

- Maintain equitable telehealth access for mental health nursing services with appropriate MBS items that recognize the value of continuity of care
- Establish Medicare item numbers that appropriately recognize and remunerate credentialed advanced practice mental health nurses delivering evidence-based psychotherapy, including trauma-specific modalities like EMDR

- Acknowledge mental health nurses as essential primary care providers within rural healthcare teams, capable of independent psychotherapeutic practice
- Ensure rural stress-testing is mandatory for all future Medicare changes affecting mental health service delivery
- Develop funding models that support collaborative care between GPs, nurse practitioners, credentialed mental health nurses, and allied health professionals in rural settings
- Address workforce sustainability by creating funding structures that enable viable career pathways for advanced practice mental health nurses, preventing further attrition to other disciplines
- Recognize the cost-effectiveness of mental health nursing services in preventing avoidable emergency presentations and hospital admissions, particularly in rural and regional contexts

Thank you for considering these concerns and recommendations.

Sincerely,

Rowan Hardinge

RN, BN, Masters Mental Health Nursing

Credentialed by Australian College of Mental Health Nurses (CMHN)

Location - Northern NSW / Gold Coast region

Nicole Allen

Submission to the Government Inquiry on Medicare Support for Rural, Regional and Remote Mixed-Team Care Models

From: A Credentialed Mental Health Nurse (CMHN) with over 20 years of frontline experience in Queensland's rural and regional health sectors.

Date: 29/01/2025

Terms of Reference Addressed:

1. The adequacy of Medicare support for the mixed-team models of care needed in rural, regional, and remote communities, including the roles of general practitioners, nurse practitioners, nurses, allied health professionals and visiting specialists
2. The impacts of current Medicare rules and incentive arrangements on large corporate providers compared with small, community-embedded rural clinics
3. Reforms needed to ensure Medicare is fair, workable, and sustainably funded for rural, regional, and remote Australians, including the requirement for rural stress-testing of future changes

Introduction

1. Introduction and Professional Background

I write as a Credentialed Mental Health Nurse (CMHN) with over two decades of clinical practice across acute and community settings in rural and regional Queensland. My submission is informed by direct experience of the potential and profound limitations of current Medicare structures. I have seen firsthand, particularly under the now-ceased Mental Health Nursing Incentive Program (MHNIP), how integrated CMHNs within general practice can dramatically improve mental health access and outcomes. The current MBS rules, however, now prevent this skilled workforce from fulfilling its essential role in the mixed-team model, to the direct detriment of rural communities.

Findings

2. Key Observation: The Systemic Exclusion of a Critical Rural Workforce

The adequacy of Medicare support appears undermined by its inequitable design, which excludes Credentialed Mental Health Nurses from core Medicare funding pathways. This is not merely a professional oversight; it is a critical failure in rural health workforce strategy.

Proven Model, Current Barrier: The MHNIP demonstrated that CMHNs embedded in primary care provide accessible, high-quality, and cost-effective mental health care. Despite this evidence, CMHNs are explicitly excluded as approved providers under the Better Access initiative and for

providing focused psychological strategies under a GP Mental Health Care Plan (GPMHCP), while psychologists and accredited social workers are included (Services Australia, 2025; RACGP, 2025). This creates an illogical and unfair two-tiered system. The MBS rules for the Better Access initiative are set by government policy.

Direct Impact on Rural Access and Affordability: As a CMHN now in private practice, this exclusion forces me to charge full fees, placing comprehensive mental health assessments and ongoing therapy out of reach for many in my community. Meanwhile, patients face prohibitive wait times for the psychologists they can claim a rebate for. This worsens the known crisis in rural mental health access, where people are already more likely to receive medication alone due to therapist shortages (Moody et al., 2025).

The financial disparity is stark: a patient can claim for a clinical psychologist ($145.25), general psychologists ($98.97), and social workers ($87.24) and $0 for an equivalently skilled CMHN such as myself with over 20 years of clinical practice and a Masters of Mental Health qualification.

Under-utilised Skills in a Telehealth Context: CMHNs possess exceptional, specialist skills in comprehensive mental health assessment, risk formulation, and therapeutic intervention. These skills are currently being grossly under-utilised. Within a reformed Medicare framework, CMHNs could provide vital tele-health assessments and support, complementing GPs and other professionals.

This would ensure consumers in remote locations receive prompt care, reduce pressure on overburdened GPs, and create a truly collaborative mixed-team model. GPs, who are often time-poor, could confidently refer to a CMHN for detailed assessment, care planning, and navigation of complex community referral pathways, ensuring best, continuous care.

Recommendations

3. Recommendations for Changes

To build a sustainable, effective mixed-team model for rural Australia, Medicare must see change to use the entire skilled workforce. I urge the Inquiry to recommend the following:

1. Achieve Provider Equity in the Better Access Scheme: Amend the MBS to include Credentialed Mental Health Nurses as approved providers for items under the Better Access initiative (including GPMHCPs and focused psychological strategies). CMHNs must be recognised and remunerated at a level equivalent to other core mental health professionals for equivalent services.
2. Formally Embed CMHNs in Primary Care Telehealth and Mixed-Team Models: Create and fund a new Medicare item or program that enables GPs in rural areas to directly refer to and collaborate with CMHNs. This should explicitly support both in-person and Telehealth delivery, maximising reach, and flexibility to address workforce gaps and long wait times.
3. Apply a Mandatory Rural Impact Assessment: Mandate that any future changes to Medicare-funded mental health services include a formal "Rural and Remote Impact

Assessment." This must evaluate the impact on workforce distribution, service viability, and patient access in non-metropolitan communities, ensuring policy does not inadvertently deepen existing inequities.

Evidence

4. Supporting Evidence for Change

Evidence of the Critical Need to establish CMHN's in Rural & Regional Areas is in the following examples:

Example 1: This workforce inequity worsens a pre-existing crisis in rural mental health access. As the Australian Institute of Health and Welfare reports, people in remote areas have far lower access to Medicare-subsidised mental health services, receiving less than half the annual sessions per capita of those in major cities (AIHW, 2023).

Example 2: Recent research confirms that individuals in rural Australia face a severe shortage of mental health professionals and, as a result, are significantly more likely to receive medication from a GP rather than evidence-based psychological therapy—a situation the full integration of CMHNs into primary care could help rectify (Moody et al., 2025).

Example 3: Current policy creates a two-tiered system. As reflected in the resources of the Royal Australian College of General Practitioners, referrals under Better Access are directed to specific allied health professions, while CMHNs—despite their specialist mental health training—are absent from this pathway (RACGP, 2025)."

Example 4: The shortage of mental health professionals in rural Australia is well-documented, with just 47 psychologists per 100,000 people in remote areas compared to 142 in cities. This makes the under-utilisation of other skilled professionals like CMHNs, due to Medicare barriers, not just an issue of fairness but a critical failure in workforce strategy (AIHW, 2023; Moody et al., 2025)."

Example 5: The current Medicare Benefits Schedule (MBS) framework, as outlined in official guidance for health professionals, creates a clear inequity by excluding Credentialed Mental Health Nurses from the list of approved providers for psychological therapy under a GP Mental Health Care Plan (Services Australia, 2025)."

Example 6: The fiscal impact of excluding CMHN's from claiming MBS items is stark. Where a patient could receive a rebate of $98.97 for a session with a psychologist, they receive no Medicare support to see a CMHN for an equivalent service (example clinic schedule, 2025). This often makes necessary mental health care difficult to access and unaffordable for many regional Australians already facing cost-of-living pressures."

Conclusion:

Medicare's current structure is the single greatest barrier to deploying the proven skills of the Credentialed Mental Health Nursing workforce in rural and regional Australia. This is a fixable policy

failure. Providing equity under Medicare is not a professional privilege; it is a necessary step to unlock a ready, highly skilled cohort that can at once expand access, support GPs, and deliver the integrated, prompt care that rural communities urgently need and deserve.

Thank you for considering this submission.

Yours sincerely,

Nicole Allen CMHN

Credentialed Mental Health Nurse

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Rhonda Wilson

Mental Health Nursing Implications for Improving Rural and Regional Mental Health Outcomes in Australia

Professor Rhonda Wilson RN BNSc MNurs(Hons) PhD FACMHN

Professor of Mental Health Nursing RMIT University

President Australian College of Mental Health Nursing

Cultural affiliation: Wiradjuri yinaar (woman)

[redacted]

Date: 30 January 2026

Consultation submission

Across two decades, Professor Wilson's program of research consistently demonstrates that rural and regional mental health outcomes are shaped by ecological, cultural, workforce, technological, and relational factors, rather than service availability alone. The evidence positions mental health nurses (MHNs) as the most adaptable, trusted, and contextually embedded workforce capable of addressing these intersecting determinants, if their scope, capability, and leadership are fully enabled.

Findings

Key Mental Health Nursing Implications for Rural and Regional Australia

1. Mental Health Nurses as Ecological Navigators of Rural Mental Health Care

Wilson's rural mental health ecology research shows that rural distress emerges within complex social, cultural, environmental, and economic systems, requiring clinicians who can work across boundaries rather than within silos (Wilson & Usher, 2015; Wilson et al., 2015).

Implications

- MHNs should be formally recognised and funded as place-based mental health system navigators, not solely as service-based clinicians.
- Workforce models must enable MHNs to work across health, social care, education, community, and cultural systems, particularly in small communities.
- Policy settings should move beyond fly-in/fly-out psychiatry toward embedded MHN-led continuity models, which are more sustainable and culturally acceptable in rural contexts.

2. Continuity of Care and Trust as Core Rural Mental Health Interventions

Wilson's work consistently demonstrates that trust, continuity, and relational safety are decisive factors in whether rural people engage with mental health care (Ferris-Day et al., 2021; Wilson, 2007; Wilson et al., 2012).

Implications

- Mental health nurses should be resourced to provide longitudinal care, not limited to episodic crisis response.
- Funding mechanisms must reward relationship-based continuity, particularly for people with emerging psychosis, complex distress, or repeated emergency department presentations.
- MHNs are uniquely positioned to reduce avoidable ED use and admissions through early intervention, sustained engagement, and family-inclusive care in rural communities (Higgins et al., 2024).

3. Cultural Safety and Decolonising Practice as Rural Workforce Essentials

Wilson's research on cultural safety, Indigenous health and social and emotional wellbeing, and decolonising ethics demonstrates that culturally unsafe systems directly worsen mental health outcomes, particularly in rural and regional Australia where First Nations peoples are over-represented in acute care pathways (McGough et al., 2022; Rooney et al., 2023; Hiyare et al., 2024).

Implications

- Mental health nursing workforce strategies must embed cultural safety as a core competency, not an optional add-on.
- MHNs should be supported to work in partnership with Elders, Aboriginal Health Workers, and community-controlled organisations.
- Government investment should prioritise MHN-led culturally responsive models, rather than externally imposed programs that fail to gain local trust.

4. Digital Mental Health as an Enabler, Not a Replacement, of Rural Care

Wilson's extensive body of digital mental health research demonstrates that technology improves rural access only when it is nurse-led, relationally anchored, and contextually adapted (Christensen et al., 2021; Wilson et al., 2024; Higgins & Wilson, 2025).

Implications

- Mental health nurses should lead the selection, adaptation, and governance of digital mental health tools in rural settings.
- AI-enabled decision support and telehealth should be used to extend MHN reach, not substitute face-to-face care.
- Investment in digital capability building for MHNs is essential to avoid widening rural inequities through poorly implemented technology.

5. Supported Decision-Making and Human Rights-Based Rural Care

Wilson's work on supported decision-making shows that rural consumers experience higher levels of coercion, repetition, and system fatigue, particularly during crises (Francis et al., 2022; Francis et al., 2024).

Implications

- Mental health nurses should be authorised and supported to lead supported decision-making practices, especially in rural emergency and inpatient pathways.
- Policy reform should enable MHNs to act as champions of person-centred, rights-based care, reducing retraumatisation and disengagement.
- MHN-led models can mitigate workforce shortages by preventing escalation, not merely responding to it.

6. Workforce Sustainability, Recognition, and Scope Optimisation

Wilson's global and national leadership research demonstrates that rural mental health systems fail when mental health nurses are treated as replaceable labour rather than skilled professionals (Wilson et al., 2025; Wilson et al., 2026).

Implications

- Governments must explicitly recognise mental health nursing as a specialist workforce, including advanced and extended scopes of practice.
- Rural workforce retention depends on professional recognition, decision-making authority, and leadership pathways, not incentive payments alone.
- MHNs should be embedded in policy advisory, service design, and governance roles at regional and national levels.

Strategic Policy Message for Government

Improving rural and regional mental health outcomes in Australia requires a decisive shift from service-centric solutions to mental health nurse-led, place-based, culturally safe, and digitally enabled systems of care. The evidence demonstrates that mental health nurses are not an adjunct to rural mental health care, they are its backbone.

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Recommendations

1) Strategic alignment to Commonwealth reform settings

A. National Mental Health and Suicide Prevention Agreement (NMHSPA)

The NMHSPA is explicitly about better outcomes, joint accountability, and service reform across jurisdictions, supported by bilateral schedules and national reporting.

Positioning message: **MHNs are the workforce most capable of delivering visible, measurable improvements under the Agreement, especially in rural/regional Australia, because they provide continuity, navigation, and whole-of-system integration (Wilson & Usher, 2015; Ferris-Day et al., 2021; Higgins et al., 2024).**

B. National Mental Health Workforce Strategy 2022–2032

The Strategy focuses on how governments will attract, train, maximise, support and retain the workforce needed to meet demand.

Positioning message: **"Maximise" must include structural reforms that unlock MHN capability (scope, funding, training pipeline, credentialing, and enabling legislation), rather than treating mental health nurses as residual labour.**

C. Strengthening Medicare and MBS reform momentum

MBS reforms have recently strengthened and restructured nurse practitioner items, demonstrating that Medicare can be redesigned to support contemporary workforce models.

Positioning message: **Rural access and continuity goals won't be met unless Medicare settings actively enable MHN-delivered care (including credential mental health nurses; endorsed mental health nurse prescriber and Credential mental health NP models) in stepped-care and chronic/complex mental health pathways.**

2) Whole-of-system positioning: where MHNs must be embedded (and why)

Across all health service types (public, PHN-commissioned, private, ACCHOs, NGOs)

Reform ask: **Establish MHN-led models as a core rural service architecture:**

- MHN-led continuity and navigation across ED → inpatient → community → primary care (*cf* Wison's rural access/engagement and ED work: Ferris-Day et al., 2021; Higgins et al., 2024; Wilson, 2007)
- rights-based supported decision-making embedded into rural crisis and acute pathways (Francis et al., 2024)
- culturally safe models co-designed with First Nations communities (McGough et al., 2022; Rooney et al., 2023)

Within universities (pipeline + workforce capability)

Reform ask: **Funded postgraduate education is the central lever for building rural mental health capacity, particularly with new prescribing and advanced practice reforms.**

- The Commonwealth workforce strategy intent to "train" and "maximise" cannot be achieved without funded postgraduate MHN pathways into rural practice (National Workforce Strategy).

Across government institutions (policy, commissioning, standards, quality and safety)

Reform ask: **Create formal MHN influence points:**

- MHN representation in national advisory and commissioning structures aligned to NMHSPA reporting and bilateral schedules
- workforce planning and data definitions that count MHNs accurately and usefully (AIHW workforce reporting provides a baseline for MHN workforce visibility).

3) Priority reform package (three headline asks)

1) Commonwealth funding for postgraduate MHN education (rural-focused)

Policy intent: **"Fund the capability that the system is already relying on."**

Minimum features: **Commonwealth-supported postgraduate places/scholarships for MHNs working toward:**

a) ACMHN Credentialed MHN standards,

b) mental health nursing endorsement on Registered Nurse legislation, and

c) RN prescribing education pathways where relevant to mental health service delivery.

- rural education and professional development pipelines (supervision, protected learning time, paid clinical mentorship), aligned to the same logic used in the RN prescribing endorsement rollout (education + governance).
- Rural outcome logic (from Wilson's research): continuity + local trust + earlier intervention reduces escalation and ED dependence (Wilson et al., 2012; Ferris-Day et al., 2021; Higgins et al., 2024).

2) Legislative reform: AHPRA-recognised "Mental Health Nursing" endorsement on the RN register

Right now, NMBA/AHPRA endorsements exist as formal regulatory mechanisms (e.g., NP endorsement), and the NMBA explicitly frames endorsement as identifying additional qualifications and expertise.

Reform ask

- **Establish an NMBA endorsement for "Mental Health Nursing" (parallel regulatory logic to existing endorsements), with:**

- ACMHN accredited postgraduate qualification requirements
- practice standards and continuing professional development expectations
- public register visibility (workforce transparency + commissioning confidence)

Why this matters to government

- Creates a nationally consistent mechanism to identify, deploy, and fund MHN capability, especially in rural services where "who can safely do what" needs clarity.
- Enables service commissioning specifications (PHNs, states/territories) that require endorsed MHNs in key rural roles (navigation, crisis, telehealth triage, supported decision-making).

3) Medicare rebate enhancements: Credentialed MHNs, nurse prescribers, and credentialed mental health nurse practitioners

Recent MBS changes for nurse practitioner items show Medicare can evolve to support contemporary workforce delivery models.

Separately, the RN prescribing endorsement framework now exists nationally, with published standards and an implementation model built on governance + prescribing agreements, explicitly intended to improve access, including in rural areas.

Reform ask **Three-tier Medicare design**

1. **Credentialed Mental Health Nurses (CMHNs):** expand MBS-rebatable MHN consultations for evidence-based, recovery-oriented interventions and structured follow-up (including telehealth), particularly for rural/regional people with complex needs and poor access.
2. **Credentialed MHNs with nurse prescriber endorsement:** add MBS items that recognise the added clinical value of medication initiation/adjustment within governance frameworks—especially where GP/psychiatry access is constrained. (Use the RN prescribing model as precedent for education + governance + supervised practice).
3. **Credentialed MH nurse practitioners:** ensure MBS settings optimise CMHNP contribution in mental health (attendance/telehealth, care planning, continuity), building on current NP item reforms.

Non-negotiable safeguards (policy-ready)

- credentialing/endorsement requirements
- minimum supervision/mentorship and clinical governance
- rural loading or rural access incentives
- outcomes monitoring aligned to NMHSPA reporting

Conclusion

To deliver the National Mental Health and Suicide Prevention Agreement and the National Mental Health Workforce Strategy, governments should ***unlock the full capability of mental health nurses through*** (1) funded postgraduate pathways, (2) AHPRA-recognised mental health nursing endorsement on the RN register, and (3) Medicare rebates for credentialed MHN care, including prescriber endorsement and credentialed mental health nurse practitioner models, especially in rural and regional Australia.

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Tracy Tabvuma

Submission to the Senate Inquiry on Rural, Regional and Remote Medicare Access and Funding

Dr Tracy Tabvuma, *PhD, MMhlthNurs, BN*

Tabvuma Mental Health

Contributor to the Australian College of Mental Health Nurses (ACMHN) Submission
Date: 30 January 2026

Executive summary

Rural Australians experience higher rates of psychological distress, suicide and comorbidity, alongside persistent workforce shortages. These inequities are further compounded for First Nations peoples, racial, ethnically, culturally and linguistically diverse communities, who face additional barriers related to cultural safety, trust, language and service fragmentation. Medicare settings that narrow access pathways in these contexts risk exacerbating unmet need and crisis presentations.

The 1 November 2025 Medicare reforms were intended to strengthen continuity of care and improve system efficiency. In rural, regional and remote Australia, however, the reforms risk entrenching inequity by restricting telehealth access and narrowing the range of clinicians able to deliver Medicare-subsidised mental health services.

The introduction of MyMedicare as an alternative pathway to telehealth eligibility has created a practical two-tier system. Consumers attached to large, MyMedicare-registered practices experience streamlined access. In contrast, communities relying on nurse-led clinics, community health services, Aboriginal Community Controlled Health Services and visiting Nurse Practitioners (NP) face new administrative and eligibility barriers. Early reports indicate cancelled telehealth clinics, disrupted continuity of care, and increased travel burden for consumers in remote areas.

Credentialed Mental Health Nurses (CMHNs) are central to rural mental health delivery. They provide comprehensive assessment, evidence-based and culturally-responsive psychological interventions, risk management, physical health care and advice, medication liaison and complex care coordination across the full spectrum of need including prevention, early intervention through to high-risk and comorbid presentations. In many rural communities, CMHNs are the most stable and trusted clinicians available.

Despite this, CMHNs are not explicitly recognised as eligible providers under the Better Access initiative and have limited access to relevant MBS mental health items. This structural exclusion creates a funding gap. It weakens small community-embedded clinics, advantages larger corporate providers, and undermines multidisciplinary models of care. Most importantly, it reduces access to timely, local and trusted mental health support. This increases the risk of avoidable emergency department (ED) presentations and preventable hospital admissions.

Evidence from nurse-led and NP-led rural models demonstrates improved access, strong consumer satisfaction, enhanced continuity of care and reductions in acute service reliance when

funding is stable and integration is supported. Conversely, abrupt funding or eligibility changes rapidly erode capacity and community trust.

This submission recommends:

- Explicit inclusion of ACMHN-endorsed CMHNs as eligible providers under Better Access and relevant MBS telehealth and multidisciplinary items.
- Rural complexity loadings and telehealth top-ups in MM3–MM7 areas.
- Transitional protections for nurse-led services affected by MyMedicare and telehealth rule changes.
- Mandatory Rural Impact Statements for all future MBS reforms.
- Investment in credentialing, supervision and rural retention to secure the specialist mental health nursing workforce.
- Independent evaluation of reforms using access, continuity, cultural responsiveness and acute service utilisation indicators.

These reforms are not an expansion of scope without safeguards. They align funding with existing clinical practice, use credentialing as a quality gate, and strengthen multidisciplinary care in settings where workforce supply is fragile.

Without targeted adjustment, current Medicare settings risk widening rural mental health inequities. With evidence-informed reform, they can strengthen sustainable, community-embedded models of care.

TOR (a)

TOR (a): Impact of the 1 November 2025 Medicare changes on access to primary care, including telehealth, for rural, regional and remote Australians

The MyMedicare pathway introduced on the 1st of November 2025 creates a practical eligibility shortcut for telehealth but only for consumers formally attached to MyMedicare-registered practices. Many rural communities access care through nurse-led clinics, community health services and visiting nurse practitioners, this change creates a two-tier access system: i) easier telehealth access where large GP practices operate, and ii) reduced access where community-embedded nurse providers operate.

Evidence and lived-experience impact

- The Department of Health clarified MyMedicare provides an alternative pathway for the "established clinical relationship" requirement for telehealth from 1 November 2025. That change reduces administrative friction for consumers attached to MyMedicare practices but leaves many community clinics disadvantaged. [i]
- The ACMHN and other nursing peaks have publicly warned that the new rules constrain nurse practitioners and advanced nursing care, with immediate reports of consumers in remote areas losing access to familiar nurse-led telehealth supports. Press and member reports document cancelled telehealth clinics and consumers forced to travel for repeat face-to-face appointments. [ii]
- Credentialed Mental Health Nurses (CMHN) already hold the specialist skills required under Better Access which include comprehensive assessment, evidence-based and culturally-responsive psychological interventions, risk management and care coordination. Yet they are not named as eligible providers under the current Better Access items.[iii] Excluding CMHNs creates a practical barrier to subsidised therapy and follow-up for many rural consumers who receive their care from nurse-led clinics. This has led to service cancellations and consumer travel when local clinicians cannot claim rebates. To prevent immediate service loss, Better Access eligibility should be amended to explicitly include ACMHN-endorsed CMHNs, or equivalent credential holders, where governance and supervision arrangements are in place.[iv]

Recommendations

1. Amend MBS and Better Access guidance so that endorsed Nurse Practitioners and ACMHN-credentialed mental health nurses are explicitly listed as eligible telehealth practitioners and eligible Better Access providers where scope and governance permit. Explicit access to Better Access Scheme items and relevant MBS telehealth items is a critical step toward equitable Medicare access for diverse rural populations.
2. Allow PHN-endorsed community clinics, Aboriginal Community Controlled Health Services and nurse-led practices to register as MyMedicare-equivalent entities for telehealth eligibility.

3. Institute an immediate 6–12-month exemption so existing nurse-led telehealth services are not interrupted while registration and rule changes are implemented.

TOR (b)

TOR (b): Financial sustainability of independently owned rural general practices under current Medicare funding and incentive structures

Current incentive realignment and bulk-billing changes advantage providers that can scale administration and billing. Small independent practices and community nurse-led clinics face administrative burden and rebate structures that do not reflect the time and complexity of rural mental health care.

Evidence and lived-experience impact

- Evaluations and PHN summaries show rural consultations are longer and clinically complex. Additionally, community clinics serving ethnically and culturally diverse populations often provide culturally tailored care that builds trust and improves utilisation. [v] Rebates that fail to recognise complexity and multidisciplinary input threaten the viability of small clinics that keep care local, undermine culturally responsive care and widen health inequities for racialised groups. This drives closures or consolidation, which communities repeatedly describe as loss of safe and trusted local care. [vi, vii, viii]
- CMHNs cannot currently claim Better Access rebates for many therapy items, nurse-led clinics have fewer viable billing options for longer, complex rural consultations. This revenue gap undermines financial sustainability and incentivises consolidation toward larger providers with broader billing capability. Addressing eligibility for CMHNs is therefore a direct financial stability measure for small rural clinics. [ix, xxvi]

Recommendations

1. Introduce telehealth top-ups or complexity loadings for mental health consultations delivered in Modified Monash (MM) 3–7 areas to reflect longer consults and care coordination.
2. Provide PHN-admin onboarding grants for small practices to meet MyMedicare or equivalent registration requirements without absorbing unsustainable admin costs.
3. Ensure MBS does not cannibalise existing small-clinic funding (PHN or state grants) or create a “small clinic viability” safeguard that provides transitional payments if revenue falls after policy change.

TOR (c)

TOR (c): The extent to which current Medicare settings contribute to avoidable emergency presentations and preventable hospital admissions in rural, regional and remote areas

When primary and community mental health access is constrained, rural consumers present more frequently to EDs. Flexible telehealth and nurse-led outreach have been shown to prevent escalation, but only when telehealth is accessible through local trusted providers.

Evidence and lived-experience impact

- Systematic reviews and rural virtual ED evidence show telehealth reduces unnecessary ED use and speeds appropriate care when integrated with local teams.[x] For behavioural health and suicidality, virtual support models have reduced delays and improved management in rural ED networks. Conversely, removing local telehealth options forces consumers to travel or wait until crisis. [vii]
- Case studies of nurse-led and NP-led services in rural NSW report improved integration with local services and fewer avoidable escalations when nursing clinicians are empowered to lead follow-up and liaison. Consumers consistently value continuity and the trust established with local nursing teams.[xi]
- If CMHNs had explicit access to Better Access rebates or equivalent MBS telehealth items, rural services could sustain timely post-ED follow-up and high-risk outreach without placing additional billing burden on small clinics. This would support measurable reductions in avoidable ED presentations.[xii]

Recommendations

1. Fund nurse-led telehealth follow-up items specifically for post-ED discharge and high-risk mental health follow-up in rural areas.
2. Commission and independently evaluate NP/nurse-led rural ED liaison pilots with clear targets for reduced re-presentations and admission avoidance.
3. Require PHNs to track ED mental health presentations by remoteness and provider type and trigger a rapid response when nurse-delivered telehealth volumes fall.

TOR (d)

TOR (d): The adequacy of Medicare support for the mixed-team models of care required in rural, regional and remote communities, including the roles of general practitioners, nurse practitioners, nurses, allied health professionals and visiting specialists

Rural mental health care depends on mixed teams with GPs, nurse practitioners, credentialed mental health nurses, allied health and visiting specialists. Current MBS settings are fragmented. They insufficiently fund team coordination, nurse-led clinics and telehealth participation by non-GP clinicians.

Evidence and lived-experience impact

- A national scoping review found several evaluated nurse-led models in regional, rural and remote Australia. Outcomes show improved access, adherence to guidelines and high consumer satisfaction, but the evidence base is inconsistent because funding pathways are unpredictable and evaluation scarce. That fragility reflects a funding system that under-recognises nurse-led and team-based delivery.[xiii]
- The Productivity Commission and other program evaluations such as the Mental Health Nurse Incentive Program (MHNIP) show well-designed nurse-led programs reduce hospital use and improve continuity when supported by sustainable funding and integration.[xiv] Consumers and carers report better experiences when nurse clinicians lead coordination and follow-up. [xv]
- Scoping reviews and MHNIP evaluations demonstrate that nurse-led and NP-led services provide care across the low-to-high need spectrum and function effectively within mixed teams; however, MBS and Better Access exclusion prevents CMHNs from being formally funded as part of multidisciplinary referrals or as lead providers for care-coordination items. Explicitly enabling CMHNs to claim or be named within multidisciplinary Better Access arrangements would align funding with real-world team practice and improve continuity. [xiii]

Recommendations

1. Introduce MBS and Better Access items that fund multidisciplinary case conferencing and care coordination where a CMHN or NP can be the lead claimant, and explicitly list CMHNs as eligible Better Access providers for individual and group psychological treatment where credentials and governance are met.
2. Permit allied clinicians and credentialed mental health nurses to claim telehealth participation in multidisciplinary items, with payments apportioned for each provider's contribution.
3. Protect existing PHN-commissioned nurse programs with matched MBS top-ups for a two-year transition to integrated mixed-team MBS items.

TOR (e)

TOR (e): The impacts of current Medicare rules and incentive arrangements on large corporate providers compared with small, community-embedded rural clinics

Administrative complexity and economies of scale advantage large corporate providers. Small and community-embedded clinics provide culturally safe and place-based care but cannot easily absorb new registration and compliance costs. The result is an erosion of locally trusted services and greater centralisation.

Evidence and lived-experience impact

- Multiple medical and nursing organisations have reported that the new telehealth administration and MyMedicare processes advantage organisations with dedicated billing teams. [xvi, xvii, xviii, xix] Excluding CMHNs from Better Access rebates increases the incentive for service consolidation into larger providers who can supply the full suite of MBS-rebated services, accelerating loss of community-embedded and culturally safe clinics that rely on nurse-led models.
- Communities note that when local clinics close or are acquired, continuity, cultural safety and trust fall. These effects are especially damaging in First Nations, racially, ethnically, culturally and linguistically diverse communities.[xx] Without culturally responsive providers supported through Medicare funding, these communities experience further marginalisation, reduced continuity of culturally appropriate care and increased risk of poor outcomes.[xxi, v]

Recommendations

1. Create an administrative exemption and financial support package for community-embedded clinics to maintain service continuity and retain local staff.
2. Where government contracts are offered, include criteria that favour local community-embedded providers and penalise monopoly behaviour that reduces local access.

TOR (f)

TOR (f): Reforms needed to ensure Medicare is fair, workable and sustainably funded for rural, regional and remote Australians, including the requirement for rural stress-testing of future changes

Medicare changes must be accompanied by mandatory rural impact assessment, targeted rural loadings, and transparent monitoring. Without this, reforms intended to improve efficiency will widen gaps in access and outcomes.

Evidence and lived-experience impact

- Reviews of telehealth implementation repeatedly call for local engagement, digital support and rural-specific impact assessment.[xxii] Rural communities are heterogeneous. One-size-fits-all policy decisions cause harm in places with fragile services.[xxiii]

Recommendations

1. Require every Rural Impact Statement to model the effect on Better Access eligibility and MBS claiming for provider types such as GP, NP, CMHN, allied health, and include scenario testing for small nurse-led clinics and Aboriginal Community Controlled Health Services.
2. Require a formal Rural Impact Statement for any MBS change that affects telehealth, workforce eligibility or bulk-billing incentives. Stress-tests must model provider-type impacts such as GP vs NP vs CMHN and MM remoteness strata.
3. Require all Rural Impact Statements to include cultural responsiveness and equity analyses, including modelling how changes to telehealth, Better Access and MBS eligibility affect ethnically and culturally diverse and First Nations consumers, and whether culturally safe service provision is supported.
4. Establish an independent panel including rural CMHNs, PHN representatives, consumers, carers and digital health experts to review proposed telehealth reforms before implementation.
5. Fund quarterly public dashboards that publish telehealth volumes by item, provider type and remoteness. Create pre-defined triggers to pause or adapt policy if negative trends are detected.

TOR (g)

TOR (g): Any other related matters.

1. **Credentialing of mental health nurses matters and is under pressure.**
   The CMHN credential signals specialist capability, clinical governance and consumer confidence. Recent workforce surveys and peer-reviewed work indicate that credentialing is highly valued by clinicians, strengthens professional identity, clinical confidence and employer recognition. Declining credentialing numbers therefore translate into fewer clinicians formally recognised to provide advanced, specialist mental health assessment, risk management and care coordination which are skills vital to rural practice where specialist back-up is limited. The declining numbers credentialing signal vulnerability to disproportionate funding, under-recognition and system change.[xxiv]
2. **Mental health nurse-led and NP-led models deliver measurable clinical and system benefits in rural settings.**
   Evaluations and scoping reviews consistently show nurse-led services improve access, care coordination and consumer satisfaction in regional, rural and remote Australia. These benefits were contingent on sustained funding, clear clinical governance and integration with primary care and local services. Where funding or integration was absent, effects were weaker or unsustained. This explains why abrupt funding or administrative shifts such as tightening telehealth eligibility, can quickly erode service capacity and community trust. [xiii, xi]

3. **Lived-experience integration and continuity are central to recovery and avoidance of acute care.**
   Consumers repeatedly report that continuity of relationship, culturally safe and trusted local clinicians (often nurses) are the primary drivers of engagement and recovery factors that reduce avoidable ED presentations and admissions. MHNIP program evaluations report increased continuity of care and reduced reliance on inpatient services in participating sites. These recorded outcomes reverse when programs are removed or destabilised. Losing locally-embedded credentialed mental health nurses therefore causes immediate dislocation, disengagement from consumers, relapse risk rises, and ED presentations increase. MHNIP demonstrates improved continuity and reduced acute utilisation where nursing roles are embedded and sustained.[xxv, xxvi]

4. **Workforce retention and transition challenges are well documented.**
   Retention of mental health nurses in rural practice depends on supervision, role clarity, professional development and local career pathways. Gaps in these supports drive attrition and reduce the pipeline of credentialed clinicians. [xxvii] Credentialing should be used as the quality gate for expanded Better Access eligibility. Only ACMHN-endorsed CMHNs or equivalent recognised credential holders with supervised scope, should be permitted to claim Better Access-equivalent rebates or specified MBS telehealth items. This approach preserves clinical safety while opening funding to clinicians who already provide complex and evidence-based care in rural settings. The ACMHN credential is an auditable standard used by PHNs and commissioners and provides the clinical governance required for Medicare recognition.

Recommendations

1. **Invest Credentialed Mental Health Nurses and rural retention**

   - The ACMHN requests that the Committee amend Better Access rules to explicitly list ACMHN-endorsed CMHNs as eligible providers for individual psychological treatment items and group therapy items where clinicians meet credential and governance requirements.

   - Extend existing mental-health telehealth item eligibility to CMHNs or create new CMHN-led MBS telehealth and care-coordination items with MM remoteness loadings.

   - Fund CMHN placements and supervision, subsidise postgraduate placements and protected supervision time for nurses undertaking CMHN credentialing in rural PHN catchments. Credentialing increases clinical capability and retention.

   - Targeted scholarships and relocation/retention allowances for CMHN who commit to minimum rural service term addresses pipeline and distribution challenges.

2. **Embed lived experience and co-design in all pilots and funding reforms**

   - Mandate consumer and carer co-design for any rural telehealth or nurse-led pilot, with lived-experience representation on steering committees and evaluation frameworks.

Consumers consistently cite continuity and relationships as critical. Co-design ensures cultural safety and relevance.

- Fund peer or consumer workforce positions alongside CMHN roles in funded models to strengthen engagement and recovery pathways. Integrated peer support improves uptake and outcomes.

3. **Require independent evaluation with lived-experience and cultural responsiveness indicators**

   - Every pilot or funding change must include pre-specified and independent evaluation measures covering access by remoteness and provider type, continuity of care, cultural safety indicators, ED presentations and consumer-reported outcomes. Scoping review and program evaluations show benefits only where evaluation and integration exist.

   - Results should be published quarterly and trigger remediation if key indicators such as decline in nurse-led telehealth volume or rise in ED presentations breach thresholds.

4. **Protect existing community nurse-led and NP-led capacity during transition**

- Provide 6–12 month protected funding or exemptions for existing CMHN or NP-led services at risk from administrative or telehealth rule changes to avoid sudden service loss. Case studies show abrupt withdrawal causes immediate harm.

Conclusion

Rural, regional and remote Australians already face higher mental health need and reduced service availability. Medicare reforms must not deepen these inequities. Credentialed Mental Health Nurses are core clinical providers in rural systems, delivering comprehensive, culturally responsive and evidence-based care across levels of acuity, coordinating multidisciplinary responses, and sustaining the trusted relationships that prevent crisis escalation. Current eligibility settings, particularly the exclusion of CMHNs from explicit Better Access and relevant MBS mental health items, weaken small community-embedded clinics, advantage larger providers, and risk increased emergency presentations and preventable hospital admissions.

By formally recognising ACMHN-endorsed CMHNs within Better Access and appropriate MBS items, applying rural loadings, protecting nurse-led services during transition, and mandating rural impact assessment for future reforms, Government can align funding with real-world practice, strengthen mixed-team care, and ensure Medicare remains fair, workable and sustainable for rural Australians.

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