Mental Health and Suicide Prevention Agreement Review

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ADVANCED PHARMACY AUSTRALIA

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Introduction

Formerly known as the Society of Hospital Pharmacists of Australia (SHPA), Advanced Pharmacy Australia (AdPha) is the progressive voice of Australian pharmacists and technicians, built on 80 years of hospital innovation that puts people and patients first. AdPha supports all practitioners across hospitals, transitions of care, aged care and general practice clinics to realise their full potential. We are the peak body committed to forging stronger connections in health care by extending advanced pharmacy expertise from hospitals to everywhere medicines are used.

According to the Australian Institute of Health and Welfare's (AIHW) Mental health services in Australia report, 45.6 million mental health-related medications were dispensed in 2022-2023 with 18% of the Australian population filling a prescription for a mental health-related medication.[1] Given the prevalence of mental health conditions amongst Australians reported by the AIHW, it is clear that medications are one of, if not, the most common treatment interventions for mental health service consumers. Medications are an important treatment modality for many mental illnesses and the specialised management of them is provided by hospital pharmacists.

AdPha convenes a Mental Health Specialty Practice Group, comprising of over 700 members who work in mental health units and any inpatient, outpatient, ambulatory or primary care settings where consumers of any age with mental health conditions, receive pharmacy services. These members contribute to safe and appropriate prescribing of medicines such as antipsychotics, provide specialist advice to colleagues and advocate for the least restrictive treatment options that are not only evidence-based, but in line with consumer preferences.

Interventions made by pharmacists may be around facilitating choice of medications for consumers, education around cardiometabolic side effects and their management, as well as lifestyle interventions. These interventions aim to improve adherence to treatment, improve medication management and prevent medication-related hospital readmissions and suicide. At transitions of care, hospital pharmacists liaise closely with primary care clinicians to ensure treatment plans are carried out such as titration of new medications or weaning doses of antidepressants or antipsychotics. They also ensure on going medication supply is arranged to prevent relapses or representation to emergency departments due to missed medication doses or diminished medication supply.

The National Mental Health Workforce Strategy 2022–2032[2] acknowledges the key role pharmacists play in providing mental health care to consumers. This specialist area of practice requires equally specialised training for pharmacists. To support early career development in mental health pharmacy and to ensure mental health patients receive safe, quality, and specialised mental health medication management and clinical pharmacy services, AdPha offers Resident and Registrar Training Programs (previously known as the Foundation Residency and Advanced Training Residency Programs) which are structured, formalised, supported and accredited national pharmacy training

programs. The Resident Training Program equips early career pharmacists with foundation clinical skills whilst the Registrar Training Program offers a pathway for specialty development for pharmacists with three to five years of foundation hospital experience, seeking to advance their practice towards ANZCAP Registrar status. AdPha's Registrar Training Program offers a range of specialty Practice Area Pathways including a Mental Health pathway for pharmacists keen to expand their scope in this field of practice.

AdPha also produces the Standards of Practice for Clinical Pharmacy Services[3] and the Standards of Practice for Mental Health in Pharmacy Services[4] which outline the entitlement of consumers with mental illness to levels of pharmacy care aligned with other key patient groups.

AdPha therefore welcomes the opportunity to provide recommendations and address the following Terms of Reference in this submission to the National Mental Health and Suicide Prevention Agreement Review:

b) the effectiveness of reforms to achieve the objectives and outcomes of the National Agreement including across different communities and populations
c) the opportunities under the National Agreement to adopt best practice approaches across Australia, particularly where productivity improvements could be achieved
d) the extent to which the National Agreement enables the preparedness and effectiveness of the mental health and suicide prevention services to respond to current and emerging priorities
e) whether any unintended consequences have occurred such as cost shifting, inefficiencies or adverse consumer outcomes
h) applicability of the roles and responsibilities established in the National Agreement

If you have any queries or would like to discuss our submission further, please contact Jerry Yik, Head of Policy and Advocacy at jyik@adpha.au.

Recommendations

Recommendation 1

Establish bilateral Pharmaceutical Reform Agreements (PRAs) with New South Wales and the Australian Capital Territory to deliver equitable access for mental health consumers to PBS medicines, support safer discharges and transitions of care, and ease reliance on overstretched primary healthcare systems.

Recommendation 2

Mental health service consumers in inpatient settings should have access to high quality, safe and comprehensive medication management and pharmacy care. This is enabled by health services adhering to pharmacist-to-patient ratios in AdPha's Standards of Practice for Clinical Pharmacy Services, which recommends **one full-time equivalent pharmacist per 20 acute psychiatric beds**.

Recommendation 3

Invest in the current and future mental health pharmacy workforce through **scaling up structured workforce development programs such as Mental Health Registrar Training Program for pharmacists** to ensure mental health service consumers have access to expert mental health pharmacist workforce in outpatient and community mental health services.

Recommendation 4

Embed mental health pharmacists into community mental health teams and services through funding and service design to prevent avoidable mental health-related hospital admissions.

Terms of reference

b) the effectiveness of reforms to achieve the objectives and outcomes of the National Agreement including across different communities and populations

e) whether any unintended consequences have occurred such as cost shifting, inefficiencies or adverse consumer outcomes

Recommendation 1

Establish bilateral Pharmaceutical Reform Agreements (PRAs) with New South Wales and the Australian Capital Territory to deliver equitable access for mental health consumers to PBS medicines, support safer discharges and transitions of care, and ease reliance on overstretched primary healthcare systems.

Equitable access to healthcare regardless of location, is one of the principals of the National Medicines Policy.[5] Truly equitable healthcare cannot be achieved without established PRA arrangements in all states and territories in Australia. The expansion of the Pharmaceutical Benefits Scheme (PBS) into public hospitals through PRAs in all six other jurisdictions has enabled hospital doctors to prescribe and pharmacists to dispense PBS-subsidised medicines to patients upon discharge from hospital, outpatients and patients receiving care from day treatment services. They have been effective to achieve '*Ongoing access to medicines*,' Guiding Principle 10 of the Guiding Principles to Achieve Continuity in Medication Management document.

The PRAs support access to mental health medications in states that are signatories to the PRAs. However, access to PBS-subsidised quantities of medicines is not afforded to Australians being discharged from public hospitals in NSW and ACT. In the absence of bilateral PRAs in NSW and ACT, 8.9 million Australians receive only 3-7 days' supply of discharge medicines when discharging from a public hospital, compared to 30 days' supply in other states.

This means that for patients being discharged from mental health units requiring medicines for depression, psychosis, schizophrenia and other mental health conditions, they receive just up to one weeks' worth of medicines on discharge.

This forces consumers to urgently visit a GP to access more medicines essential for recovery and preventing hospital readmission, placing an unnecessary financial burden on consumers who may already be from a lower socio-economic background, and further strain on the primary healthcare system that could be avoided with 30 days' worth of medicines supply on discharge.

Both NSW and ACT governments expressed their desire to have PRAs with the Commonwealth, and have been recommended publicly in the ACT's Health Services Plan

2022-2030 and the NSW Government's Response to the Inquiry into Public Hospital Access Block and Ambulance Ramping.

With the Closing the Gap (CTG) PBS Co-payment Program extending to public hospitals from 1 January 2025, unfortunately without a PRA in ACT and NSW – the jurisdiction which has the largest indigenous population – indigenous consumers will not be able to access the medication access benefits of this policy change.

Inequities in treatment

Certain inequities in access to mental health treatment can occur depending on available local service funding and the consumer's access to a hospital and associated community mental health services. For example, two Section 100 (S100) Highly Specialised Drug (HSD) PBS streamline codes exist for clozapine tablets for the treatment of Schizophrenia – streamline code 5015 for 'Initial Treatment' phase for the first 18 weeks of treatment, and streamline code 4998 for Continuing Treatment' phase. Due to this restriction, consumers being discharged from hospital before 18 weeks of clozapine treatment are completed, as most are, are unable to have their clozapine dispensed at their local community pharmacy. They must collect clozapine from the hospital pharmacy weekly due to the weekly blood monitoring requirements for clozapine for the initial 18 week period. A co-payment fee for every clozapine dispensing for the first 18 weeks also applies, unless the hospital is able to fund this independently.

Some hospital services may have special contractual arrangements with community pharmacies where the community pharmacy dispenses the script as a private non-PBS prescription, the prescription is then claimed by the hospital pharmacy and the community pharmacy is then reimbursed by the hospital.

However. depending on where they reside, this cannot be arranged for every consumer and their preferred community pharmacy and is also dependent on the hospital paying for the copayment fee for each dispensing. This limits choice for consumers around where they prefer to receive their medication from.

AdPha proposes that the two different S100 HSD streamline codes for clozapine are consolidated to the 4998 streamline code as 'Continuing Treatment' only for all patients regardless of whether or not they have completed 18 weeks of clozapine treatment.

Case scenario: Clozapine in the community

Consumer A has treatment resistant Schizophrenia and is admitted to a hospital inpatient unit to initiate clozapine treatment. Once the initial stages of titration of clozapine are complete after 8 weeks, Consumer A is discharged back to the community. Consumer A is given a prescription for clozapine with a PBS streamline code of 5015.

However, when Consumer A attempts to get their clozapine prescription filled by their local community pharmacy post-discharge, the pharmacist tells them that their prescription is not eligible for PBS subsidy as they are still in the initial 18-week treatment phase. She tells them that they must get this medication from the hospital.

Consumer A walks away without their medication and misses two days of treatment.

Due to the weekly blood monitoring requirements for clozapine, they need to go back to the hospital pharmacy every week to collect clozapine supplies for the initial 18-week period. They find this challenging and stop taking their medication. They experience symptoms of relapse, present to the emergency department and are readmitted to the inpatient unit to be re-titrated.

In ideal cases, a community mental health team and hospital pharmacist will liaise with the hospital and consumer to ensure clozapine supplies and ongoing blood monitoring occurs post discharge. However, this may not be the case for those consumers without strong transitions of care supports in place, especially outside of metro areas. Further, some hospital mental health inpatient units may not be serviced by a clinical pharmacist at all. Consumers being treated in private hospitals with private prescriptions for clozapine initiation would not be limited by the same restrictions, causing further inequities across mental health consumers in Australia.

Although a rare occurrence, cost-shifting can also occur where a treatment is ineligible for PBS subsidy as an inpatient. As demonstrated in the case study below, although clinically safe and appropriate to do so, an incentive exists for the hospital to delay the administration of medicines.

Case scenario: Antipsychotic long-acting injection

Consumer B has been admitted to an inpatient mental health unit with a relapse in schizophrenia. During their admission, they have successfully responded to paliperidone tablets, an oral antipsychotic medication, and subsequently prescribed an antipsychotic modified release injection preparation of paliperidone to aid in adherence and long-term management of their schizophrenia. The consumer receives both of the required loading doses of paliperidone modified release injection in hospital. Close to the expected date of discharge, the consumer will require their next monthly maintenance dose of paliperidone.

Depending on the dose, each paliperidone modified release injection costs the hospital service up to $280 per injection, and if administered as an inpatient, is ineligible for PBS subsidy, such that the hospital service has to cover the entire cost. However, if the medicine is administered when the consumer is no longer classified as a hospital inpatient, then it is eligible for PBS subsidy, thus reducing the cost to the hospital service.

To utilise the PBS streamline code and claim the medication on the PBS, the outcome of a multidisciplinary team meeting results in adjusting the administration of paliperidone modified release injection by a couple of days to coincide with the consumer's discharge date. The psychiatrist writes a prescription so that the injection may be given after discharge.

c) the opportunities under the National Agreement to adopt best practice approaches across Australia, particularly where productivity improvements could be achieved

Recommendation 2

Mental health service consumers in inpatient settings should have access to high quality, safe and comprehensive care by health services adhering to pharmacist-to-patient ratios in AdPha's Standards of Practice for Clinical Pharmacy Services, which recommends **one full-time equivalent pharmacist per 20 acute psychiatric beds**.

Recommendation 3

Invest in the current and future mental health pharmacy workforce through **scaling up structured workforce development programs such as Mental Health Registrar Training Program for pharmacists** to ensure mental health service consumers have access to expert mental health pharmacist workforce in outpatient and community mental health services.

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Access to clinical pharmacy services

Attracting and retaining a specialist workforce is essential in providing rural and remote consumers with the same access to treatment as their metropolitan counterparts. However, consumers in rural and remote areas are unlikely to receive specialist mental health care due to the lack of specialists practicing in these areas, with 2.2 times as many psychiatrists employed in major cities as there are in remote areas and 5.3 times more than in very remote areas. This inequity extends to access of other healthcare professionals such as psychologists and pharmacists.

In inpatient settings, mental health pharmacists already play a large role in antipsychotic stewardship. Antipsychotic stewardship involves the deprescribing of inappropriate combinations of medicines and/or high dose antipsychotic therapy, which are often associated with risks such as obesity, diabetes and unacceptable side effects. These

factors can affect adherence to treatment, leading to multiple hospital readmissions and poor health outcomes. Hospital pharmacists provide antipsychotic stewardship roles in not only mental health settings but across varied settings such as emergency departments, surgical and medical wards – which could be extended to outpatient and community settings.

AdPha recommends all hospitals adopt pharmacist-to-bed ratios outlined in AdPha's Standards of Practice for Clinical Pharmacy Services[3] to maintain equitable and evidence-based quality of care to all mental health consumers. This includes ensuring that mental health consumers have access to the same clinical pharmacy services as provided in other hospital settings, with AdPha recommending one full-time equivalent pharmacist per 20 acute psychiatric beds. Equal consideration should be given to inclusion of pharmacist in outpatient and community mental health services that require specialist medication management services.

Missed medication doses are of particular significance to mental health service consumers. Missed does in many cases can result in relapses of schizophrenia or require re-titration that may need to be carried out under hospital supervision. Non-adherence to medication is associated with a three-fold increase in risk of relapse, with those missing doses having a significantly higher risk of a hospital admission and symptom worsening.[6,7,8]

This makes the role of the pharmacist vital in ensuring that not only are doses not missed once the consumer is discharged, but also on admission to hospital.

Pharmacist expanded scope of practice

One method of ensuring doses are not missed in the early stages of a hospital admission is ensuring that a consumer's regular medicines are prescribed promptly. With nursing and medical workforce shortages across Australia, this can be challenging.

Pharmacists undertaking collaborative prescribing, including the ordering and reviewing of medication-related baseline investigations, can significantly improve efficiencies in the healthcare system. This has been well established in literature on Partnered Pharmacist Medication Prescribing (PPMP), the first iteration of collaborative prescribing in Australia.

With the complexities of mental health medication regimes, pharmacists are able to determine which medications are urgently required and which may need to be reviewed by a psychiatrist or prescribing doctor.

A Deakin University health economic evaluation[9] of PPMP involving more than 8,500 patients found that it:

- decreased the proportion of patients with at least one medication error from 19.2% to 0.5%
- reduced patient length of stay from 6.5 days to 5.8 days
- saved $726 per hospital admission

Pharmacists working to their full scope of practice are instrumental in alleviating pressures on medical colleagues, while pharmacy technicians, through efficient medication

management and clinical support, enable pharmacists and nurses to dedicate more time to direct patient care and other clinical activities. Services include tech-check-tech, completing Best Possible Medication Histories (BPMH) for newly admitted consumers, and Bedside Medication Management (BMM) supply.

Pharmacy technicians must also be supported to evolve their practice. In addition to developing the Pharmacy Technicians Competency Standards, AdPha has designed ANZCAP recognition of pharmacy technician career progression and specialty skills, formed a Technician and Assistants Specialty Practice Group with over 200 active members, and developed a Standard of Practice for Pharmacy Technicians to support Clinical Pharmacy Services[10], setting the benchmark for the profession across all sectors.

As well as aligning with the focus of the *Unleashing the Potential of our Health Workforce – Scope of Practice Review*, empowering healthcare professionals such as pharmacists and pharmacy technicians to work to their full scope of practice not only improves patient outcomes but also enhances healthcare system efficiency.

Training and workforce development

The National Mental Health Workforce Strategy 2022–2032[2] outlines in Strategic Pillar 1: 'Attract and Retain', to enhance training pathways, increasing access to supervision, and supporting skills transfer amongst healthcare professionals. To develop highly skilled roles in mental health pharmacy, equally specialised training is required to ensure pharmacist are equipped with the clinical skills to provide quality use of medicines to this consumer cohort. Medication regimes are often complex and the use of some medicines may be off-label. Pharmacists working in this highly specialised field must also be aware of the potential adverse effects of antidepressants and antipsychotics, such as the cardio-metabolic risks linked to second-generation antipsychotics, along with strategies for their effective management.

To support early career development in mental health pharmacy and to ensure mental health consumers receive safe, quality, and specialised mental health medication management and clinical pharmacy services, AdPha offers Resident and Registrar Training Programs (previously known as the Foundation Residency and Advanced Training Residency Programs) which are structured, formalised, supported and accredited national pharmacy training programs.

The Resident Training Program equips early career pharmacists with foundation clinical skills whilst the Registrar Training Program offers a pathway for specialty development for pharmacists with three to five years of foundation hospital experience, seeking to advance their practice towards ANZCAP Registrar status.

AdPha's Registrar Training Program offers a range of specialty Practice Area Pathways including a Mental Health pathway for pharmacists keen to expand their scope in this field of practice.

d) the extent to which the National Agreement enables the preparedness and effectiveness of the mental health and suicide prevention services to respond to current and emerging priorities

Emerging priorities

With Australia's ageing population there is likely to be an increased prevalence of dementia and the associated Behaviours and Psychological Symptoms of Dementia (BPSD). This will require a collaborative approach and skilled medication management by pharmacists to assess and adjust medicines that could be contributing to the clinical presentation, deprescribing, optimising current treatments as well as non-pharmacological strategies to reduce severity of BPSD. Inappropriate chemical restraint can also be reduced and prevented by pharmacist-led medication reviews.

Conversely, the prevalence of paediatric diagnosis of mental health conditions including ADHD, will require a highly skilled workforce in mental health and paediatrics.

Pharmacogenomics in mental health

AdPha's annual publication of *Pharmacy Forecast Australia* is a strategic thought leadership piece on emerging trends and phenomena forecasted to impact pharmacy practice and the health of Australian patients in the near future. It is intended to help equip hospital pharmacy departments to proactively position themselves and their teams for potential emerging trends and focus on healthcare that may inform future research, in most recent years identifying trends in pharmacogenomics and precision medicine.

Optimisation of treatments such as antipsychotics are enabled by assessing variation in the CYP450 enzymes in individuals, predicting if consumers may benefit from an antipsychotic medication or likely to experience side effects or a limited response. However, this is largely dependent on the funding provided by the hospital service.

Digital tools

With digital tools at consumers fingertips, there is an alarming trend in access to misinformation around healthcare. A key role of pharmacists is to provide evidenced-based information to consumers to ensure they can make informed decisions around their treatment.

Other tools such as My Health Record (MHR) enable clinicians to share healthcare information between transitions of care. For mental health consumers who may often present to hospital with limited capacity, this digital tool is vital in obtaining GP and community pharmacy details. It is equally vital at transitions of care to ensure highly complex treatment regimens are adhered to by primary care teams, however this remains limited by the capabilities of MHR in accepting uploaded discharge information.

h) applicability of the roles and responsibilities established in the National Agreement

Discrepancies in funding

AdPha notes the discrepancies and lack of coordination between state and government funded mental health services. For example, there is limited rural remote access to government funded services such as subsidised psychology sessions. In addition, rural remote areas have limited mental health service infrastructure, limited specialised healthcare professionals and long wait lists.

This leads to inconsistent mental health service delivery, with some models utilised integrated care and others with fragmented services. Each jurisdiction manages its own mental health programs, which may differ in quality, types of service available as well as treatment options or crisis intervention services. The differing availability of mental health professionals as well as their training and development opportunities also results in an uneven standard of care across Australia.

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