SHPA's NSW branch committee submission to Equity, accessibility and appropriate delivery of outpatient and community mental health care in New South Wales Inquiry, September 2023

The Society of Hospital Pharmacists of Australia (SHPA) is the national, professional organisation for the 6,100+ Hospital Pharmacists, and their Hospital Pharmacist Intern and Hospital Pharmacy Technician colleagues working across Australia's health system, advocating for their pivotal role improving the safety and quality of medicines use. Embedded in multidisciplinary medical teams and equipped with exceptional medicines management expertise, SHPA members are progressive advocates for clinical excellence, committed to evidence-based practice and passionate about patient care.

According to the Australian Institute of Health and Welfare's (AIHW) Mental health services in Australia report, 17.2% of the Australian population filled a prescription for a mental health-related medication in 2019- 20, with an average of 9.2 prescriptions per patient.[1] Given the prevalence of mental illness 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.

SHPA convenes a Mental Health Specialty Practice Group, comprising of a network of SHPA members who work in mental health units and any inpatient, outpatient, ambulatory or primary care settings where patients of any age with mental health conditions, receive pharmacy services. These members contribute to safe and appropriate prescribing of antipsychotic medicines, as well providing advice and advocating for the least restrictive treatment options that are not only evidence-based, but in line with consumer preferences. Interventions made in inpatient and outpatient settings can improve adherence to treatment in community, improve medication management and prevent medication-related hospital readmissions.

Due to the critical importance of outpatient and community mental health services to the health and wellbeing of consumers across New South Wales, SHPA NSW branch committee welcomes the opportunity to provide feedback to this Inquiry. If you have any queries or would like to discuss our submission further, please do not hesitate to contact Jerry Yik, Head of Policy and Advocacy on jyik@shpa.org.au.

Recommendations

Recommendation 1: Embed mental health pharmacists into community mental health teams and services through funding and service design to prevent avoidable mental health-related hospital admissions.

Recommendation 2: Enable and provide investment into hospital pharmacy mental health outpatient services through Tier 2 Non-Admitted Services to improve medication management for mental health service consumers, avoiding and preventing medication-related adverse events and hospital admissions.

Recommendation 3: 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 SHPA's Standards of Practice for Clinical Pharmacy Services, which recommends one full-time equivalent pharmacist per 20 acute psychiatric beds.

Recommendation 4: Invest in the current and future mental health pharmacy workforce through scaling up structured workforce development programs such as Mental Health Advanced Training Residency to ensure mental health service consumers have access to expert mental health pharmacist workforce in outpatient and community mental health services.

Terms of Reference (ToR)

Note ToR A, C and E have been grouped together as they cover similar themes.

ToR A: equity of access to outpatient mental health services

ToR C: capacity of State and other community mental health services, including in rural, regional and remote New South Wales

ToR E: appropriate and efficient allocation of mental health care workers, including psychiatrists, nurses, psychologists, GPs, councillors, social workers, allied health professionals and peer workers

Access to Community Mental Health Care

Between 2005–06, almost 5.7 million Community Mental Health Care (CMHC) service contacts took place across Australia. This has almost doubled to around 10.2 million in 2020–21.[2] In the 2022-23 NSW State Budget, $73.3 million was allocated as part of the $700 million Statewide Mental Health Infrastructure Program, to build more contemporary mental health facilities in NSW. However, SHPA's NSW members report that access to CMHC services in NSW has not increased in line with the increased demand, despite the investment seen into further inpatient services.

For some consumers, access to private psychiatrists may be an alternative option in accessing treatment in the community. For others who come from lower socioeconomic backgrounds, this is not a financially or logistically viable option. They must instead be able to access a local CMHC service, which can be challenging for those living in regional and remote areas.

According to the National Rural Health Alliance, overall service provision by all mental health care service providers is 2.7 times less in remote areas and 5.6 times less in very remote areas, with services provided by a psychiatrist reducing dramatically once outside of major cities.[3] Interestingly, community mental health utilisation and emergency department presentations increase with remoteness, indicating presentation later in the course of a mental health disorder and inadequacy of primary mental health services to manage acute presentations.

Hospital re-admissions

Recommendation 1: Embed mental health pharmacists into community mental health teams and services through funding and service design to prevent avoidable mental health-related hospital admissions

Recommendation 2: Enable and provide investment into hospital pharmacy mental health outpatient services through Tier 2 Non-Admitted Services to improve medication management for mental health service consumers, avoiding and preventing medication-related adverse events and hospital admissions

Between 2020-2021, 14.7% of stays in public hospital acute mental health services in Australia resulted in a readmission within 28 days of discharge,[4] above the National Healthcare Agreement Indicator's 12% benchmark. According to this Australian Institute of Health and Welfare (AIHW) data, only 43.6% of admissions to public hospital acute mental health services had a community care service in the 7 days *prior* to the hospital stay. In NSW, this was even lower, at 34.8%. 78.7% of separations from acute hospital services in NSW had a follow-up community care service in the 7 days *after* the hospital stay. It could therefore be determined that although initial follow up appears to be occurring for most consumers in NSW, the data indicates a possible lack of access to services immediately prior to a relapse and subsequent readmission to hospital.

At least 250,000 hospital admissions annually in Australia are medication related, with an estimated cost of 1.4 billion Australian dollars (AUD$).[5] Preventing hospital readmissions therefore is a priority and could be achieved by adequate management of consumers through CMHC services. As described in the introduction, with medicines being one of the primary interventions for this cohort of consumers, adequate medication management is needed to avoid medication-related hospital admissions.

It is often those consumers with the highest acuity and complex needs that present to hospitals for a mental health admission. These consumers are then prescribed equally complex medication regimens for multiple conditions due to the comorbidities inherently seen in this cohort of patients. These medicines may be only intended for short-term use, or may require titration, careful withdrawal and monitoring. When mental health consumers are discharged from hospital inpatient services back to CMHC services, the complex medication management plan and associated monitoring is expected to continue. However, without adequate access to CMHC services, the continuation of the treatment plan and the necessary monitoring may not occur, potentially leading to a relapse and or/ a hospital readmission.

SHPA believes that pharmacists should be embedded into community mental health teams as well as being part of mental health outpatient clinics. The pharmacist's role in these clinics involves a patient-centred approach, discussing goals of treatment with the consumer, providing education around how medicines work, potential side effects and monitoring required. The pharmacist is then able to advise the psychiatrist of potential treatment options preferred by the consumer, as well as any required ongoing monitoring required.

An example of pharmacist interventions working effectively to reduce inappropriate use of antipsychotics and benzodiazepines in aged care settings is the RedUSe project funded by the Department of Health and Aged Care in the ACT. The project involved 150 pharmacists in the initiative and reduced inappropriate prescribing of antipsychotics and benzodiazepines by 13% and 21% respectively. As well as the clear benefit to patients of reducing medication burden and potentially preventing associated adverse effects, interim economic modelling results demonstrated cost effectiveness through medication reduction costs alone.[6] The funding for this initiative was unfortunately not continued and identifies a key action area that NSW could adopt to reduce the use of inappropriate prescribing for mental health consumers in NSW.

Further, a study to evaluate the clinical impact of pharmacist medication reviews in community mental health teams found that the expert team comprising of a psychiatrist and GP, agreed with 76% of pharmacist medication review findings and considered that 81% of recommendations were appropriate. Collectively, 69% of recommendations were considered likely to be implemented, with 77% of reviews deemed potentially to have a positive clinical impact.[7]

Queensland hospital health services have implemented many pharmacist-led outpatient clinics and are responsible for approximately 90% of the national Clinical Pharmacy 40.04 outpatient clinics, a Tier 2 Non-admitted service under Activity Based Funding.

The limitation of the national funding cap in the Commonwealth's contribution of 6.5% each year leads to all hospitals in Australia having to decide between resourcing inpatient services or outpatient clinics rather than taking a person-centred approach and supporting both. SHPA recommends that similar, evidenced based pharmacist-led clinics are also adequately funded to allow safe and effective management of mental health disorders.

SHPA believes that the current singular Tier 2 Clinic 40.04 Clinical Pharmacy should be complemented by other Tier 2 Non-Admitted Services with varying levels of funding, so that the breadth of hospital pharmacy outpatient services can be implemented. Incorporating a tiered level consultation structure for hospital pharmacy mental health outpatient services would support broader utilisation in Australian hospitals, and ultimately provide higher quality and safer care that reduces mental health related admissions.

For outpatient settings, SHPA's Standard of practice in mental health for pharmacy services[8] recommends one full-time equivalent pharmacist to ten outpatients, including participation in outpatient interdisciplinary and pharmacist-led clinics.

Utilisation of the specialist mental health workforce

Recommendation 3: 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 SHPA's Standards of Practice for Clinical Pharmacy Services, which recommends one full-time equivalent pharmacist per 20 acute psychiatric beds.

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 (ED), surgical and medical wards – which could be extended to outpatient and community settings.

Compared to jurisdictions such as Victoria and Queensland, NSW has the poorest hospital pharmacist to bed ratio in Australia.[9] SHPA recommends that the NSW government should address the inadequate ratio of hospital pharmacists to hospital beds in regional and metropolitan NSW health services. In line with the Department of Health's National Mental Health Workforce Strategy 2021- 2031, SHPA commends the NSW government for its development of a Strategic Framework and Workforce Plan for Mental Health[10] which recognises clinical pharmacists as key participants of NSW's mental health service workforce.

However, to achieve the Plan's workforce priority of increasing consumer access to pharmacists, SHPA recommends that NSW hospitals adopt pharmacist-to-bed ratios outlined in SHPA's Standards of Practice for Clinical Pharmacy Services[11] 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 SHPA recommending one full-time equivalent pharmacist per 20 acute psychiatric beds. These pharmacists could be utilised to not only improve inpatient care, but also in outpatient and community mental health services that require specialist medication management services.

Building a sustainable mental health pharmacy workforce

Recommendation 4: Invest in the current and future mental health pharmacy workforce through scaling up structured workforce development programs such as Mental Health Advanced Training Residency to ensure mental health service consumers have access to expert mental health pharmacist workforce in outpatient and community mental health services.

To support early career development in mental health pharmacy, SHPA recommends the allocation of more positions or funding to include a six-month rotation in a mental health setting for Foundation Resident pharmacists. In 2017, SHPA's launched its two-year Foundation Residency Program, designed to develop an early career hospital pharmacist's competence and practice performance to Advancing – Stage I (Transition Level) of the National Competency Standards Framework for Pharmacists in Australia 2016. SHPA's Foundation Residency Program is Australia's first and only structured, formalised, supported and accredited national pharmacy residency program.

To date, 12 NSW pharmacists have completed the Foundation Residency Program. The Residency Program is a formal, structured experiential learning program for pharmacists. Formal experiential training, like that provided by a residency program, consolidates initial education and training, and progresses the early career practitioner towards advanced practice. Theoretical knowledge gained without application in practice is unlikely to develop a competent, flexible pharmacy workforce that can adapt to the changing future needs of consumers and mental health services.

Through the flexible nature of the Foundation Residency Program, pharmacists rotate across different specialities depending on what services the hospital provides. SHPA provides an Advanced Training Residency Program (ATR) in Mental Health, to build on skills and experience gained in the Foundation Residency Program, advancing pharmacist professional practice towards Advancing – Stage II (Consolidation Level) performance in Mental Health.

Currently, NSW has one of the lowest uptakes of SHPA's ATR program compared with other jurisdictions (*see table 1 below*), therefore allocating more positions for this program is required to provide NSW with the highly skilled pharmacist workforce required to provide exceptional mental health care.

Jurisdiction	**Current ATR enrolment**	**Completed ATR residents**
Australian Capital Territory	1	0
New South Wales	**1**	**0**
Northern Territory	0	0
Queensland	24	5
South Australia	9	0
Tasmania	3	1
Victoria	19	9
Western Australia	3	0
Total	**60**	**15**

Table 1: Current and completed SHPA Advanced Training Residency (ATR)

ToR B: navigation of outpatient and community mental health services from the perspectives of patients and carers

Not applicable.

ToR D: integration between physical and mental health services, and between mental health services and providers

Recommendation 1: Embed mental health pharmacists into community mental health teams and services through funding and service design to prevent avoidable mental health-related hospital admissions

Recommendation 2: Enable and provide investment into hospital pharmacy mental health outpatient services through Tier 2 Non-Admitted Services to improve medication management for mental health service consumers, avoiding and preventing medication-related adverse events and hospital admissions

Recommendation 3: 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 SHPA's Standards of Practice for Clinical Pharmacy Services, which recommends 1 full-time equivalent pharmacist per 20 acute psychiatric beds.

People prescribed mental health medications experience double the mortality rate than that of the general population in Australia.[12] About 60% of the excess mortality seen in mental health service consumers is due to physical comorbidities, predominantly cardiovascular disease (CVD).[13]

Hospital mental health pharmacists manage the treatment of consumers who, due to mental illness, are already predisposed to CVD and related conditions such as diabetes and obesity, with some of the medicines used for the treatment of mental health conditions also contributing to an increased risk of disease progression. Chronic mental health conditions can affect a person's ability to take care of their physical health and those with physical health issues may also experience a decline in mental health.[14]

SHPA members report a lack of integration between physical and mental health services in NSW. Some jurisdictions such as Victoria have physical health teams embedded within community mental health teams, who are dedicated sub-teams focusing on physical health issues. As outlined in NSW's Strategic Framework and Workforce Plan for Mental Health[9] objective of improving the physical health care of consumers, this requires the clinical input of pharmacists.

Risks at transitions of care

Communication between hospital, community and GP services is often poor with treatment plans and metabolic monitoring not followed through. Lack of responsibility by clinicians can occur due to the multiple providers involved in a consumer's care, with one assuming the other is completing the required monitoring. GPs may also be hesitant to review or assess mental health medications that have been initiated by a psychiatrist. Equally, community mental health teams may not regularly review medications for the treatment of physical health conditions or prompt a medication review by the consumer's GP or pharmacist.

SHPA believes that a shared-care approach is required across all healthcare providers to ensure that the necessary integration occurs between physical and mental health monitoring. Pharmacists particularly play a vital role in ensuring communication around treatment occurs between transitions of care.

If transitions of care are not undertaken properly, patients are at high-risk of readmission to hospital. Following an inpatient admission, discrepancies in the discharge summary or treatment plan can occur, with the potential for these discrepancies being continued along each step in the transitions of care. An audit at an Australian regional hospital demonstrated that almost half of these discrepancies are attributed to regular medications being omitted.[15] 29% of these had moderate potential clinical significance reiterating that

improved communication around changes to medication regimes at transitions of care is essential in preventing harm to consumers.

Atypical antipsychotics such as clozapine and olanzapine for the treatment of mental health diagnoses such as schizophrenia and bipolar disorder can increase risk of developing diabetes and weight gain. Lack of ongoing metabolic monitoring results in consumers risk of diabetes not identified promptly, further contributing to disease progression. It is vital that these pharmacists are involved in every aspect of treatment selection and providing consumers and carers with the necessary information to make informed decisions about their care.

A further barrier to communication of physical and mental health can be attributed to the lack of interoperability between healthcare digital systems. All clinicians involved in a consumer's care may not have access to the same digital records, relying therefore on the consumer or carer to follow up on any monitoring required. It is vital that these systems are able to integrate with each other to prevent a siloed and fractured approach to a person's mental health care.

NSW Health's Physical Health Care for People Living with Mental Health Issues Guideline[16] outlines many action points and interventions that pharmacists can make, including advice around smoking cessation and lifestyle adjustments as well as reducing polypharmacy by regular medication review. Most vitally, it states that optimising treatment requires involvement of pharmacists in multidisciplinary teams, screening for cardiometabolic risk factors and physical health considerations. The specific action areas state that people taking antipsychotic medication require a comprehensive assessment of cardiometabolic risk at 3-monthly intervals for the first 12 months and every six months thereafter, with routine physical health screening occurring within one month of admission to community care or 24 hours for acute services. SHPA believes that these targets cannot be realistically achieved without multidisciplinary team care and pharmacist intervention in outpatient and community mental health services.

ToR F: the use of Community Treatment Orders under the Mental Health Act 2007

Not applicable.

ToR G: benefits and risks of online and telehealth services

Telehealth services can provide access to specialists for those living in rural and remote areas or those not serviced by community mental health teams or outpatient service linked to a hospital. Virtual Clinical Pharmacy Service (VCPS) models for inpatients have been used in some parts of rural and remote Australia to address the gaps in clinical pharmacist medication reconciliation, management and review. A similar model could be applied to community and outpatient mental health services.

Western NSW Local Health District provides VCPS to patients and staff in rural and remote hospitals in Bathurst, Dubbo and Orange Health Services. The service provides access to clinical pharmacists in these isolated and remote hospitals and clinics, providing high quality medication management and addresses medication safety issues. Prior to implementation of the VCPS, clinical pharmacy services were only available face to face in eight of 47 hospitals in Western NSW and Far West NSW Local Health Districts, which span an area of 450,000 square kilometres.

The VCPS helped to overcome workforce challenges in these areas and supported reduced social contact requirements during the COVID-19 pandemic. Benefits also include equitable access for patients to pharmacy services across Western NSW and Far West LHDs as well as improving continuity of care by providing up to date medication information to prescribers and patients. The Agency for Clinical Innovation has also authored a Spotlight on Virtual Care: Virtual Clinical Pharmacy Service Report[17] which contains more information about the VCPS.

Western NSW has recently undertaken a scalability study[18] across eight of these rural and remote hospitals in NSW, to evaluate if virtual clinical pharmacy services are a feasible option in healthcare delivery and is

expected to show a significant increase in best possible medication histories, medication reconciliation and detection of potential medication-related harms. Rural and remote patients should have the same access to clinical pharmacy services as their metropolitan counterparts and VCPS is a step to providing this.

This would increase the ability for the clinical pharmacist workforce to provide patient counselling and medicines review to optimise the quality use of medicines and achieve positive health outcomes. These virtual services can and should be scaled up more broadly to ensure all hospital inpatients and outpatients have access to clinical pharmacy services, which can be facilitated by remote access to electronic medical records and fit-for-purpose. Key digital enhancements such as high-speed internet and wireless two-way conferencing carts at the bedside have enabled a virtual model of care in these areas. Broad roll out could therefore be challenging due to internet connectivity in remote areas.

Both VCPS and in-person hospital pharmacy services do not have sufficient investment by Local Health Districts and there are still many inpatients that are missing out on clinical pharmacy services that will make their care episode safer and reduce their length of admission.

It is also important to note that the specialist monitoring associated with antipsychotic medications such as metabolic monitoring (weight, waist circumference, blood glucose levels) would be challenging to obtain and record virtually. Strong links with GPs would need to be established to allow metabolic monitoring and assessment of adverse effects to occur. Adverse reactions to some antipsychotic medicines such as movement disorders would be harder to diagnose if physical examination cannot be performed.

In addition, administration of long-acting injections is not able to be completed or the associated monitoring after the injection is given. For example, olanzapine pamoate long-acting injection requires 3-hours post monitoring to occur post-administration to observe for adverse effects such as sedation and delirium caused by post-injection syndrome. For this reason, administration is not authorised outside of clinical areas where an emergency response is available. Other high-risk antipsychotic medicines that require close monitoring (physical monitoring and regular blood tests) such as clozapine would also be limited via virtual services alone. This could limit treatment choice and create and inequity in access for those who are unable to access in-person community services.

From a psychiatric assessment aspect, deterioration in metal state could be challenging via virtual services. Observing home environments as well as physical appearance can also indicate a decline in mental health to clinicians and may prompt referral to inpatient services.

While it is a great benefit to consumers that they can benefit from virtual health services to improve the quality, safety and timeliness of treatment, for mental health service consumers especially, face-to-face care services are ideal, and virtual care models should only be implemented where face-to-face services are unable to be provided due to logistical challenges.

ToR H: accessibility and cultural safety of mental health services for First Nations people, culturally and linguistically diverse (CALD), LGBTQIA+ people, young people, and people with disability

There are higher rates of mental health observed among Australians with a disability, LBTIQA+ and First Nations people - with 24% of the Indigenous Australian population reporting a mental health or behavioural condition.[19] The rate of emergency department presentations for mental health issues in Indigenous people is 4.5 times higher than in non-Indigenous people, which could reflect the inadequacy of access to primary mental health care services in rural Australia relative to population need.[3]

Training all healthcare staff on trauma informed care can assist in understanding consumer's present and future needs, especially in culturally and linguistically diverse (CALD) communities and Aboriginal and Torres Strait Islander populations where intergenerational trauma may be present. Referring to consumer care plans and being aware of consumer early warning signs may prevent non-adherence to treatment and subsequent relapse, as well as acknowledging preferences and empowering consumers in their own treatment.

On top of the existing undergraduate training provided to pharmacy students on mental health conditions and treatment, training around trauma informed care could be integrated into undergraduate training programs and be continued through essential workplace training courses throughout a healthcare professional's career.

ToR I: alternatives to police for emergency responses to people experiencing acute mental distress, psychosis, delirium, dementia or intoxication in the community, including but not limited to Police, Ambulance, Clinical, Early, Response (PACER)

Not applicable.

ToR J: any other related matter

No applicable.

References

[1] Australian Institute of Health and Welfare. (2021). Mental health services in Australia. Prescriptions. Canberra: AIHW
[2] Australian Institute of Health and Welfare. (2021). Mental health. Community mental health care services. Canberra: AIHW
[3] National Rural Health Alliance. (2021). Factsheet: Mental Health in rural and remote Australia. Available at: https://www.ruralhealth.org.au/sites/default/files/publications/nrha-mental-health-factsheet-july2021.pdf
[4] Australian Institute of Health and Welfare. (2021). Mental health performance indicators. Available at: https://www.aihw.gov.au/mental-health/monitoring/performance-indicators#apmhs
[5] Pharmaceutical Society of Australia. (2019). Medicine Safety: Take Care. Canberra: PSA
[6] Wicking Dementia Research and Education Centre. University of Tasmania. (2009). RedUSe: Reducing Use of Sedatives in aged care facilities. Available at: https://www.utas.edu.au/__data/assets/pdf_file/0012/1100172/Reduse-IPA-Westbury-2009.pdf
[7] Gisev, N., Bell, J.S., O'Reilly, C.L., Rosen A., Chen T.F. (2010). An expert panel assessment of comprehensive medication reviews for clients of community mental health teams. Social Psychiatry and Psychiatric Epidemiology 45, 1071–1079. https://doi.org/10.1007/s00127-009-0148-8
[8] Lowy, H., Borja, V., Bailey, S., Bjorksten, C., Kochman, A., Longworth, J., Meldrum, A., Sieff, A., Smith, L., Wisdom, A. and Mellor, Y. (2023), Standard of practice in mental health for pharmacy services. J Pharm Pract Res, 53: 204-225. https://doi.org/10.1002/jppr.1874
[9] Australian Bureau of Statistics. National Health Workforce Data Set.
[10] NSW Government. (2018). NSW Strategic Framework and Workforce Plan for Mental Health 2018–2022 - A Framework and Workforce Plan for NSW Health Services. Available at: https://www.health.nsw.gov.au/mentalhealth/resources/Publications/mh-strategic-framework.pdf
[11] The Society of Hospital Pharmacists Australia. (2013). Standards of Practice for Clinical Pharmacy Services. Journal of Pharmacy Practice and Research Volume 43, No. 2
[12] Australian Bureau of Statistics. (2011). Mortality of People Using Mental Health Services and Prescription Medications, Analysis of 2011 data. Available at: https://www.abs.gov.au/ausstats/abs@.nsf/0/EB5F81AAC6462C72CA2581B40012A37D#:~:text=The%20standardised%20death%20rate%20for%20persons%20aged%2015-74,compared%20with%203.0%20deaths%20per%201%2C000%20population%20respectively%29.
[13] Vancampfort D., Stubbs B., Mitchell A.J., De Hert M., Wampers M., Ward P.B., Rosenbaum S., Correll C.U. (2015). Risk of metabolic syndrome and its components in people with schizophrenia and related psychotic disorders, bipolar disorder and major depressive disorder: a systematic review and meta-analysis. World Psychiatry. 2015 Oct;14(3):339-47. doi: 10.1002/wps.20252. PMID: 26407790; PMCID: PMC4592657.
[14] Canadian Mental Health Association. (2017). Connection between Mental and Physical Health, Available at: https://ontario.cmha.ca/documents/connection-between-mental-and-physical-health/
[15] Wilkin, M. E., Knight, A. T., Boyce, L. E. (2018). An audit of medication information in electronic discharge summaries for older patients discharged from medical wards at a regional hospital. Journal of Pharmacy Practice and Research, 48(1), 76-79. doi:10.1002/jppr.1340
[16] NSW Health. (2021). Physical Health Care for People Living with Mental Health Issues Guideline. Available at: https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/GL2021_006.pdf
[17] NSW Agency for Clinical Innovation.(2022). Spotlight on virtual care: Virtual Clinical Pharmacy Service. Western New South Wales Local Health District (WNSWLHD). Sydney: ACI; 2022. Available at: https://aci.health.nsw.gov.au/__data/assets/pdf_file/0008/724292/Virtual-clinical-pharmacy-service.pdf
[18] Allan, J., Nott, S., Chambers, B., Hawthorn, G., Munro A., Doran C., Oldmeadow C., Coleman C., Saksena T. A stepped wedge trial of efficacy and scalability of a virtual clinical pharmacy service (VCPS) in rural and remote NSW health facilities. BMC Health Serv Res 20, 373 (2020). https://doi.org/10.1186/s12913-020-05229-y
[19] Australian Institute of Health and Welfare. (2021). Mental health - Prevalence and impact of mental illness. Available at: https://www.aihw.gov.au/mental-health/topic-areas/mental-illness