Standard of practice in mental health for pharmacy services

Running heading: Standard of practice in mental health

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[HEAD 1] ACKNOWLEDGMENT OF COUNTRY

The authors acknowledge the Traditional Custodians of Country of the lands on which our members meet, work and live, including the Wurundjeri people of the Kulin Nation, Traditional Custodians of Naarm where the Society of Hospital Pharmacists of Australia (SHPA) is based. We thank Elders past and present, and emerging leaders of these lands. We celebrate Aboriginal and Torres Strait Islander Peoples as the first pharmacists, bush medicine practitioners and doctors who practised on these lands.

[HEAD 1] PREFACE

In Australia, everyone shares a fundamental right to safe and high-quality healthcare. This is defined in the Australian Charter of Healthcare Rights,(1) which all healthcare systems must strive to uphold. The Charter summarises the basic rights of patients and consumers when accessing healthcare services including access, safety, respect, partnership, information, privacy and the ability to give feedback. The provision of pharmacy services must encompass the Charter to deliver effective, efficient, timely and equitable patient-centred care.

This Standard references and relies upon SHPA Standards of Practice for Clinical Pharmacy Services(2) as the foremost Standard. This Standard supersedes the previous Standards of Practice for Mental Health Pharmacy(3) and may overlap with others. Depending on the area of specialty practice it may be advisable to refer to additional Standards of Practice.

The use of the word ‘specialisation’ in this Standard is in line with the National Competency Standards Framework for Pharmacists in Australia(4) where ‘specialisation’ refers to the scope of practice rather than the level of performance. ‘Specialisation’ of itself does not confer additional expertise.

The National Competency Standards Framework for Pharmacists in Australia(4) complements the underpinnings of the Charter across five domains of competency for the pharmacy profession, namely: 1. professionalism and ethics; 2. communication and collaboration; 3. medicines management and patient care; 4. leadership and management; and 5. education and research.

This Standard is for professional practice and is not prepared or endorsed by Standards Australia. It is not legally binding.

[HEAD 1] INTRODUCTION

Mental health, an integral component of overall health and well-being, is experienced subjectively; mental ill health is often experienced in response to trauma.(5) Trauma-informed, culturally responsive, family/carer inclusive and patient-centred care are key principles to optimising mental health pharmacy services. Equitable access to evidence-informed practices that facilitate supported decision making, enable least restrictive, best patient care. This is supported by: the pharmacist’s participation in interdisciplinary teams at organisational (health service), government (policy, funding, systems) and national (advocacy) levels (see Figure 1); and integrated policies, procedures and quality improvement activities. Further, the provision of mental health pharmacy services will depend on a skilled and well-resourced pharmacy workforce.(6)
Figure 1 – Role of the mental health pharmacist

[HEAD 1] PURPOSE AND DEFINITIONS

The purpose of this Standard is to describe current best practice for the provision of mental health pharmacy services (Box 1) by mental health pharmacists.

This Standard is intended to be used by pharmacy services in Australia, irrespective of the service type (private or public) or location (metropolitan, regional, rural or remote). The principles and aspects of patient management discussed herein can be applied to all settings.

This Standard refers to both the role of the pharmacy service and the pharmacist’s practice in mental health. It is intended for both pharmacists who provide mental health pharmacy services and pharmacists who specialise in mental health; for this Standard, both will be referred to as mental health pharmacists. This Standard predominantly refers to pharmacists but does not intend to exclude suitably qualified pharmacy technicians where appropriate. SHPA supports both pharmacists and pharmacy technicians to operate at their full scope of practice to achieve optimal patient and pharmacy outcomes.

'A mental illness, [sometimes referred to as a mental disorder], is a medical condition that is characterised by a clinically significant disturbance [in an individual’s]...thought, mood, perception or memory .(7) It is usually associated with distress or impairment in important areas of functioning.’(8)

Mental health conditions is a broader term that encompasses mental disorders, psychosocial disabilities, and other mental states associated with impaired functioning, significant distress or risk of self-harm.(8)
Those who receive mental health services can be referred to as clients, consumers or patients. For this Standard, patient describes anyone who receives mental health services.

This Standard describes essential and emerging services. Essential services demonstrate the full scope of current pharmacy practice. Emerging services are innovative and future focused. SHPA encourages all pharmacy services to strive to provide emerging services wherever possible, in addition to essential services.

The authors acknowledge that there are significant variations in pharmacy services that are dependent on organisational capacity, patient population, pharmacy department and mental health service priorities, and availability of mental health pharmacists. All of these may influence the scope of pharmacy services provided.

Box 1 - Mental health pharmacy services

Clinical mental health pharmacists contribute to medicines management in the following mental health settings, including via telehealth where appropriate:

- Acute inpatient units across the age spectrum (child and youth, adolescents, adults and older persons)
- Specialist inpatient units (e.g. eating disorders, parent and infant program, trauma, brain injuries, addiction medicine, other state-wide referral services)
- Emergency departments, including psychiatric emergency centres
- Consultant liaison psychiatry
- Extended inpatient service (mental health rehabilitation)
- Step-up/step-down services
- Community care units
- Community pharmacy (Opioid Replacement Therapy, Home Medicines Review)
- Outpatient/ambulatory mental health clinics
- Prevention and recovery care
- Forensic psychiatry

Mental health clinical pharmacy services may contribute to the management of mental health symptoms associated with a diagnosis of:

- Schizophrenia and related psychoses
- Bipolar disorder
- Depression and anxiety disorders/affective disorders
- Personality disorders
- Eating disorders
- Post-traumatic stress disorder (PTSD)
- Physical health, including metabolic monitoring
- Neurodevelopmental disorders (e.g. autism spectrum disorder, attention deficit hyperactivity disorder)
- Addictions and substance misuse (e.g. alcohol, opioids)
- Psychotropic medicines overdose (e.g. toxicity profiles)
- Agitation, acute behavioural disturbance and/or behaviours of concern
- Comorbidities, (e.g. physical illness, other neurodevelopmental disorders)
In addition to services described in the *Standards of Practice for Clinical Pharmacy Services*,(2) essential and emerging mental health pharmacy services are listed in Table 1.

\*Consideration should be given to the Power Threat Meaning Framework(9-11)

[head 2] Power Threat Meaning Framework

Traditional models of care (e.g. *Diagnostic and Statistical Manual of Mental Disorders*) are based on diagnoses of mental disorders according to a predetermined set of symptoms and criteria, which then inform treatment. (12) The *Power Threat Meaning Framework* (the Framework) is an alternative to traditional models of care, emphasising ‘why’ people sometimes experience a range of behaviours. For example, threat that misuses of power pose and learnt responses to these threats; threat responses are sometimes referred to as symptoms in traditional mental health practice.(13)

In addition to obvious threat responses (e.g. to trauma and violence), the Framework acknowledges an association between wider social factors (e.g. poverty, discrimination, inequality) and subsequent emotional distress and/or troubled behaviour. Interventions, ‘a path forward’, can include standard pharmacological interventions and/or practical help and resources (e.g. art, music, exercise, nutrition, community activism).(13)

The aim of the Framework is to support and strengthen current good practice and provide alternatives to traditional interventions, service design, professional training, research, collaborative care and social policy, equality and justice. (13)

An awareness of the framework will allow pharmacists to adopt language, mindset and behaviours that are respectful, supportive and empowering for the patient, including during patient/family counselling and interprofessional collaboration. The Framework promotes patient oriented principles that observe the fundamental human right to self-determination through supported decision making. And provision of trauma-informed, culturally responsive care, including least restrictive interventions, that is family inclusive when and as appropriate.

[HEAD 1] THE PREVALENCE OF MENTAL HEALTH CONDITIONS

Data from the Australian Bureau of Statistics(14) indicate that rates of mental health and behavioural conditions in Australia are increasing.

According to the Australian Institute of Health and Welfare,(15) in 2018, mental and substance use disorder was the second highest disease group contributing to non-fatal burden of disease and the fourth highest group contributing to total burden of disease. Additionally, in 2011, for Aboriginal and Torres Islander Peoples in Australia, the years of healthy life lost per 1000 people due to mental and substance use disorders was 2.4 times that of non-Indigenous Australians.

The latest National Survey of Mental Health and Wellbeing in 2021(16), revealed that 43.7% of Australians aged 16-85 had experienced a mental disorder in their lifetime and 1 in 5 Australians aged 18-85 experienced a mental disorder in the previous 12 months. Anxiety disorders (e.g. social phobia), affective disorders (e.g. depressive episodes) and substance use disorders (e.g. harmful alcohol consumption) were the most prevalent mental disorders recorded. Females, compared to males, were more likely to have experienced a mental disorder in their lifetime (44.6% and 42.7% respectively), and were also more likely to have experienced symptoms in the previous 12 months.
Younger survey participants (16-24 years) and people with severe disabilities were also more likely to have had symptoms in the previous 12 months. In children and adolescents (4-17 years), 14% experienced a mental disorder in the previous 12 months, according to the Australian Child and Adolescent Survey of Mental Health and Wellbeing 2013-2014. Prevalence was higher in males compared to females (16% and 12% respectively). Attention deficit hyperactivity disorder (7.4%), anxiety disorders (6.9%), major depressive disorder (2.8%) and conduct disorders (2.1%) were most frequently recorded.

Further, four out of five people living with mental disorders have physical comorbidities; they are twice as likely to have cardiovascular disease, respiratory disease, metabolic syndrome and diabetes, compared to the general population. They are also five times more likely to smoke, six times more likely to die from cardiovascular disease, four times more likely to die from respiratory disease, and have a life expectancy that is 14-23 years less than the general population. (17)

**[HEAD 1] EVIDENCE OF PHARMACIST IMPACT IN MENTAL HEALTH**

Recent evidence suggests that pharmacist intervention can improve treatment adherence and optimise treatment outcomes for patients discharged from mental health inpatient care. Although, this did not appear to reduce readmission rates resulting from medicine-related problems. (18)

Systematic reviews have found that when pharmacists are part of the multidisciplinary care team, mental health clinical outcomes in people with depression and PTSD were improved. (19) Further, pharmacists can improve physical health outcomes (e.g. screening for cardiometabolic risk factors and metabolic syndrome) in people with severe mental disorders by targeting other healthcare professionals with educational material and meetings; and audit and feedback. (20)

The Australian Commission on Safety and Quality in Health Care 2017 report on Medication Safety in Mental Health, stated that clinical pharmacy services improve medication safety in mental health units. (21) The report further stated that a pharmacist home medicines review within seven days of discharge was effective in reducing medicine-related problems; discharge liaison services in mental health care were also effective.

Recommendations from the report to improve medication safety in mental health care include:

- clinical pharmacy services
- medication reconciliation services
- electronic medication management, bar code scanning and individualised patient supply systems
- improvements to the monitoring of long-term medication side effects, including metabolic monitoring.

**[HEAD 1] OBJECTIVES OF THE PHARMACY SERVICE**

It may be difficult to obtain an accurate medication history directly from patients who are acutely unwell when admitted. Additionally, patients with mental health conditions are at risk of adverse drug reactions (ADRs) and medicine-related problems; pharmacists can be pivotal in obtaining complete and accurate medication histories and preventing, detecting and managing adverse effects. (22-25)

The objective of the mental health pharmacy service, as part of the interdisciplinary team, is to optimise medicines management in collaboration with patients and carers. Mental health
pharmacists must deliver the service within a framework of evidence-informed and patient-centred health care. This enables the optimisation of medication regimens that are safe, efficacious, and cost-effective and encourage supported and shared decision-making, including dignity of risk (e.g. right to refuse medicines when not under a compulsory treatment order), consistent with the patient’s recovery preferences.

**[HEAD 1] SCOPE**

This Standard applies to all pharmacists working in mental health, irrespective of service type and location, see Box 1. Various and/or smaller organisations may not have the resources or requirement to provide full mental health pharmacy services. They may choose to implement specific aspects of this Standard to facilitate best possible patient and clinical outcomes.

The scope of services provided by mental health pharmacists will depend on the setting, patient population, funding models and governance structures. In addition to services provided by the hospital or health service; organisational priorities; pharmacy department priorities; and the scope of practice of the individual pharmacist. Although the range of services provided in mental health is primarily delivered by pharmacists, it may be supported by pharmacy technicians and assistants in clinical and non-clinical roles.

An interdisciplinary approach to mental health pharmacy services and mental health care must support patient collaboration and facilitate patient/carer supported decision making: self-determination is a fundamental human right. The role of the mental health pharmacist includes, but is not limited to: delivery of pharmacy services that add value to healthcare systems and improve patient outcomes; the development of and input into policies, procedures, guidelines and resources; advice on medication formulary decisions with relevance to mental health; the provision of educational programs and training for healthcare professionals and students; in addition to quality improvement activities and research related to mental health.

The mental health pharmacist is a point of contact for other pharmacists and health professionals within the health service, for medicines information enquiries related to mental health.

**[HEAD 1] OPERATION**

A contemporary and adaptable framework that continues to engage and strengthen relationships with stakeholders and service users is required when providing mental health pharmacy services. Services need to align with changing patient and carer needs; trends and emerging challenges; and be informed by contemporary and evolving legislation, best practice guidance, and national standards and recommendations (e.g. Royal Commission into Victoria’s Mental Health System (27)).

Mental health pharmacists, ideally embedded within the mental health interdisciplinary team, demonstrate expertise in medicines relevant to mental health. Additionally, knowledge and expertise in general medicine relative to the patients’ comorbidities, and the subsequent impact on mental and physical health, is also required.

Mental health pharmacists, intern pharmacists, early career pharmacists and pharmacists with an interest in mental health should have the opportunity to participate in mental health pharmacy services. Supervision and mentorship by a specialist mental health pharmacist will strengthen the development of the pharmacy workforce to ensure high-quality care for mental health patients.
Mental health pharmacists care for patients across the age spectrum, from childhood through to older persons; mental health pharmacy services are outlined in Table 1. The traditional model of care which focuses on clinical service provision to hospital inpatients, has evolved and expanded to include other practice settings, see Box 1.

The extent of mental health pharmacy services available to support patients managing mental health conditions is dependent on accessibility and availability of pharmacists. Clinical pharmacy services in mental health include the core activities described in the Clinical Pharmacy Standards,2 in addition to essential and emerging services listed in Table 1.

The role of the mental health pharmacist can be challenging due to factors unique to mental health, which may affect both short- and long-term medicines management. These factors may include, but are not limited to, the following:

- Patients’ inability to provide an accurate medication history on admission, especially when acutely unwell
- Incomplete documentation of reasons for ceasing or altering medicines, which can inadvertently affect future prescribing decisions
- Patients’ varying capacity to comprehend consent to have medicines administered
- Undiagnosed and/or undertreated comorbidities
- Off-label prescribing
- High-risk medication protocols
- Inadequate medicines optimisation following discharge when symptoms may have diminished
- Missed opportunities to deprescribe.

Table 1 – Essential, emerging and specialist centre services

<table>
<thead>
<tr>
<th>Service details</th>
<th>Essential</th>
<th>Emerging</th>
</tr>
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<tbody>
<tr>
<td>Document best medication history, clinically review and reconcile medicines, and ensure continuity of psychotropic medicines management at care transitions (e.g. admission, discharge)</td>
<td>✓</td>
<td></td>
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<tr>
<td>Assess and monitor medicines adherence and facilitate a medicines management plan that incorporates shared decision making</td>
<td>✓</td>
<td></td>
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<tr>
<td>Partnered pharmacist medication charting(28)</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Ensure documented indication, dose, dose frequency and maximum daily dose for as required psychotropic medicines</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Advise on:</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>• the pharmacological management of patients with identified behaviours of concern and/or aggression</td>
<td>✓</td>
<td></td>
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<tr>
<td>• optimal acute sedation practices (e.g. reduce and where possible eliminate restrictive interventions, including chemical restraint)</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>• complex medicines management (i.e. Complex Medicines Management Reviews)</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>• Participate in pharmacist-initiated pathology ordering</td>
<td>✓</td>
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</table>
Monitor and advise on psychotropic medicines management (e.g. lithium, carbamazepine, valproate, clozapine):
- efficacy
- dose
- inappropriate polypharmacy
- adverse effects (monitoring, management, reporting)
- interactions (e.g. via CYP450, UDP-glucosyltransferase, P-glycoprotein; and with comorbidities, illicit drugs, cigarette smoking, over the counter medicines, complementary and alternative medicines)
- cross titration plans
- therapeutic drug monitoring
- haematological and cardiac monitoring
- treatment failure/non-responsiveness
- pharmacogenomic considerations
- reduction and where elimination of chemical restraint for the management of acute behavioural disturbance
- clozapine-specific monitoring and advice (e.g. work up and initiation, re-titration, adverse effects, monitoring and recording requirements for supply, participation in Clozapine clinics)

<table>
<thead>
<tr>
<th>Medicines management of long-acting injectable (LAI) depot antipsychotics</th>
</tr>
</thead>
<tbody>
<tr>
<td>• initiation and cessation</td>
</tr>
<tr>
<td>• washout periods</td>
</tr>
<tr>
<td>• missed doses</td>
</tr>
<tr>
<td>• concurrent use</td>
</tr>
<tr>
<td>• acute arousal</td>
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</tbody>
</table>

Review and advice on medicines needing to be withheld or ceased during electroconvulsive therapy (ECT), then recommenced afterwards

Advise on and support the psychopharmacological aspects and interventions for neurodevelopmental and mental disorders in children and young people

Advise on the management of psychotropic medicines in special populations (e.g. children, adolescents, older persons and people who are pregnant or breastfeeding)

Engage in pharmacist consultation-liaison psychiatry by providing review and advice on medicine usage and mental health comorbidities to, for example, Allied Health and/or Clinical Nurse Specialist/Medical Interventions clinics

Monitor and advise on the ‘off-label’ prescribing of psychotropics

Explain toxicity profiles and support the management of psychotropic medicines overdose by:
- Advising on psychotropic medicine toxicity thresholds and pharmacology
- Collaborating with the interdisciplinary team and consumers/carers regarding risks and benefits of therapy in this context

✓
• Providing advice to support management in the event of a psychotropic medicine overdose, including but not limited to medicine recommencement or changes
• Making practical recommendations such as staged supply post-discharge and appropriate immediate and ongoing clinical monitoring

<table>
<thead>
<tr>
<th>Action</th>
</tr>
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</table>
| Advise on the monitoring and management of alcohol and/or opiate and other drug withdrawal | ✓
| Advise on the initiation and/or maintenance of opioid-replacement-therapy, including methadone, buprenorphine/naloxone and long-acting injectable buprenorphine | ✓
| Advise on the pharmacological management of patients on complex opioid replacement therapy, as well as direct patient care for people with complex addiction issues including patterns of high-risk alcohol, methamphetamine or other substance misuse; psychiatric or medical comorbidities (e.g. withdrawal management, take home naloxone) | ✓
| Pharmacist-led evaluation of benzodiazepine appropriateness (de-escalation and initiation) | ✓
| Pharmacist-initiated nicotine replacement therapy and management of nicotine withdrawal | ✓
| Attending codes/callouts for psychiatric behaviours of concern | ✓
| Participate in community, ambulatory, residential rehabilitation or custodial (e.g. Forensicare) interdisciplinary team and case meetings, contributing to psychotropic medicines management, including monitoring, safety, efficacy and tolerability | ✓
| Participate in clinical handover, liaising with other care providers: community mental health teams (e.g. GPs, community pharmacists) and carers | ✓
| Act as a point of contact and liaise with relevant clinicians and units regarding pharmacy related mental health issues, including resolution of complex professional practice problems | ✓
| Act as a point of contact or, with reproductive clinicians, advise on the efficacy and safety of treatment for people in the perinatal period and the potential harms to the fetus or infant | ✓
| Advise on suitable contraceptive methods to reduce the risk of unintended pregnancies | ✓
| Respond to psychotropic medicines information queries from patients, carers and healthcare staff | ✓
| Enable collaborative patient care (i.e. shared/supported decision making, patient self-determination) | ✓
| Provide culturally responsive care for Aboriginal and Torres Strait Islander Peoples and other CALD groups | ✓
| Ensure patient access to written and verbal mental health medicines information commensurate with literacy and health literacy and is appropriate for CALD groups | ✓
| Optimise patient medicines management (e.g. organise dose administration aids or staged supply) | ✓
Facilitate psychotropic education sessions and forums for patients and/or their families/carers; and other healthcare professionals ✓

Contribute to the development of local policies, procedures and guidelines relevant to mental health ✓

Contribute to and/or membership of mental-health-related committees and working groups (e.g. formulary working parties, drugs and therapeutics committees, medication safety expert advisory groups) ✓

 Participate in the dissemination and publication of mental health clinical and scientific information, strategic frameworks, standards, policies, procedures and guidelines ✓

CALD = culturally and linguistically diverse

Applicability will depend on the setting, patient population, funding models, governance structures, services provided by the hospital or health service, organisational priorities, pharmacy department priorities and the scope of practice of the individual pharmacist.

through Partnered Pharmacist Medication Charting (28) or advice to prescribers.

May fall under a different clinical specialty (e.g. addiction medicine)

Pharmacogenomic considerations may be either essential or emerging depending on available evidence and resources for therapeutic drug classes.

Mental health is responsible for 10% of the health gap between Aboriginal and Torres Strait Islander Peoples and non-Indigenous Australians (29).

This may be emerging service for general pharmacists providing mental health pharmacy services.

[head 2] Aboriginal and Torres Strait Islander Peoples and mental health

Improving Aboriginal and Torres Strait Islander Peoples’ mental health and suicide prevention is a priority area in the Fifth National Mental Health and Suicide Prevention Plan (30). Cycles of disadvantage exacerbate physical and mental health conditions. Mental health conditions contribute to suicide risk, high rates of obesity and substance abuse, including alcohol and smoking, leading to and the progression of chronic conditions (31).

For Aboriginal and Torres Islander Peoples, there are associations between mental health and a sense of belonging, strong cultural identity, positive interpersonal relationships, and a feeling of purpose (15, 32). Mental health conditions can be impacted by or be a result of removal from family, incarceration, death of a family member or close friend, discrimination and unemployment (15).

Further, dispossession from land, forced removal of children from Aboriginal and Torres Strait Islander Peoples, family violence, institutional racism and experiences from colonisation are sources of trauma, including intergenerational trauma, that can have ongoing effects on the mental health of Aboriginal and Torres Strait Islander Peoples (15, 32, 33).

[HEAD 1] POLICIES, PROCEDURES, AND GOVERNANCE

Mental health pharmacists must have knowledge of the most current versions of the following documents, as they provide a framework that pharmacists should practise within:

- Australian Charter of Healthcare Rights (1)
- National Quality Use of Medicine Indicators for Australian Hospitals (34)
- National Medicines Policy (35)
- National Safety and Quality Health Service Standards (36) including the National Model Clinical Governance Framework (37)
Mental health pharmacists must be familiar with relevant policies and procedures from their local hospital and health service. These may include, but are not limited to:

- Clozapine prescribing, dispensing and monitoring
- Acute behavioural disturbance management, including rapid tranquillisation, in different patient settings (e.g. emergency department, acute and subacute inpatient, rehabilitation, transport)
- Managing medicines associated with electroconvulsive therapy
- Dispensing, administering and monitoring of long-acting injectable antipsychotics
- Medication management, including patient self-administration in subacute settings
- Restrictive interventions (e.g. reduction and elimination of restrictive interventions, including chemical restraint)

Mental health pharmacists should also be familiar with the most current version of relevant Australian and international clinical guidelines such as:

- Therapeutic Guidelines: Psychotropic
- The Maudsley Prescribing Guidelines in Psychiatry
- The Maudsley Practice Guidelines for Physical Health Conditions in Psychiatry
- The Maudsley Guidelines on Advanced Prescribing in Psychosis
- British Association of Psychopharmacology (BAP) Consensus Guidelines
- Stahl Essential Psychopharmacology: The Prescribers Guide
- National Institute for Health and Care Excellence (NICE) Guidelines
- Psychotropic Drug Directory

Additional policies, procedures, guidelines and standards that may be considered at the level of individual services include, but is not limited to most current version of the following:

- Australian Commission on Safety and Quality in Health Care:
  - National Safety and Quality Mental Health Standards for Community Managed Organisations
  - National Safety and Quality Health Service Standards User Guide for Acute and Community Mental Health Services
  - National Safety and Quality Health Service Standards User guide for health services providing care for people with mental health issues
  - National Consensus Statement: Essential elements for recognising and responding to deterioration in a person’s mental state
• Royal Australian and New Zealand College of Psychiatrists (RANZCP) Clinical Practice Guidelines(52):
  o Anxiety disorders
  o Deliberate self-harm
  o Eating disorders
  o Mood disorders
  o Schizophrenia

• Other RANZCP guidelines and resources(52):
  o Aboriginal and Torres Strait Islander mental health – principles and guidelines
  o Benzodiazepines – guidance for use in psychiatric practice
  o Delirium Clinical Care Standard
  o Diagnostic manuals
  o ‘Off-label’ prescribing in psychiatry
  o Recognising and reducing alcohol related harm
  o Illicit drug policy

• Therapeutic Guidelines(53):
  o Psychotropic
  o Developmental Disability
  o Toxicology and Toxinology
  o Addiction medicine

**[HEAD 1] RECOMMENDED STAFFING**

As per the Clinical Pharmacy Standards,(2) there are three major factors that drive staffing levels for clinical pharmacy services. These include the range of clinical pharmacy services, the complexity of care required and hospital throughput.

Recommended staffing levels for mental health pharmacists (Table 2 and 3) are informed by the Clinical Pharmacy Standards(2). This should be interpreted with consideration for the health service, activities performed by the mental health pharmacist and those that are undertaken by other pharmacists and pharmacy technicians.

Additionally, individual health service organisations may need to consider the following when determining staffing ratios:

- role of the mental health pharmacist
- patient population (e.g. age, social determinants, comorbidities)
- patient length of stay in the hospital or within the health service organisation
- size of the health service
- mode of service delivery (e.g. telehealth, face to face)
- location of service provision (e.g. metropolitan, regional, rural and remote)
- organisational and pharmacy department and mental health service capacity and priorities
- model of care (i.e. team-based versus ward-based mental health pharmacy services).

The traditional model of care has been ward-based pharmacists who are wholly responsible for an individual inpatient. Pharmacists, however, are now increasingly practising in team-based models, with specialisation and consultant-type roles. As the model of care changes and the role of the pharmacist grows, the provision of advanced pharmacy care for an individual patient may not be the sole responsibility of a ward pharmacist. An example is a mental health pharmacist working in an...
interdisciplinary team-based role where patients with mental health conditions and physical comorbidities are co-managed by pharmacists based with different medical teams. Authors of this Standard consider a ratio of 20 patients to 1 full-time equivalent (FTE) pharmacist to be appropriate in an acute adult inpatient unit.

There should be at least one senior clinical pharmacist responsible for the coordination of all aspects of the mental health pharmacy service. Components of this may be delegated to other pharmacists and support staff. Intern and early career pharmacists should be supported by a senior pharmacist who is preferably based within the mental health team.

Table 2 - Recommended pharmacist staffing levels for provision of clinical pharmacy services based on ‘overnight beds’. Adapted from Table 9.1 Staffing Levels and Structure for the Provision of Clinical Pharmacy Services(2)

<table>
<thead>
<tr>
<th>Categorya</th>
<th>Service-related group/bed type</th>
<th>Patients to 1 FTE b pharmacist for clinical pharmacy services 5 days / weekc</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 Medical bed type</td>
<td>Acute mental health inpatient bed</td>
<td>20</td>
</tr>
<tr>
<td>6 Longer stay admissions</td>
<td>Addiction medicine (e.g. drug and alcohol), psychiatric rehabilitation</td>
<td>30</td>
</tr>
</tbody>
</table>

aCategory numbers are from SHPA Standards of Practice for Clinical Pharmacy Services(2)  
bFTE = Full Time Equivalent  
cThe proposed recommendations cover a 5-day/week service. A weekend service or discharges over the weekend would require increased pharmacist services; a discussion at an executive level and consideration of pharmacy resources would be required.

Table 3 - Recommended pharmacist staffing levels for provision of clinical pharmacy services. Adapted from Table 9.2 Staffing Levels and Structure for the Provision of Clinical Pharmacy Services based on the number of patients per day(2)

<table>
<thead>
<tr>
<th>Categorya</th>
<th>Patient/service type</th>
<th>Patients to 1 FTEb pharmacist for clinical pharmacy services per day</th>
</tr>
</thead>
<tbody>
<tr>
<td>9 Review and advise on medicine usage – consultancy service (e.g. for inpatients, outpatients, and community mental health)</td>
<td>Pharmacists providing review and advice on medicine usage in Allied Health and/or Clinical Nurse Specialist/Medical Interventions clinics</td>
<td>5</td>
</tr>
<tr>
<td>10 Outreach services</td>
<td>Pharmacists reviewing and advising on medicines use in the home setting (including residential care)</td>
<td>3</td>
</tr>
</tbody>
</table>
[HEAD 1] TRAINING AND EDUCATION

It is essential to develop the pharmacy workforce through the training and education of pharmacists and technicians to enable the delivery of advanced pharmacy care in mental health services. Pharmacists commencing practice in mental health should undertake relevant orientation at their local site including de-escalation strategies for behavioural management and duress alarm training as required. Another avenue for specialisation is SHPA’s Advanced Training Residency. Further, to facilitate equitable access to mental pharmacy services for Aboriginal and Torres Strait Islander Peoples, training and education to ensure cultural responsiveness is required. Providing culturally responsive care is stipulated in the Australian Health Practitioner Regulation Agency’s Code of conduct(38) and the National Competency Standards Framework for Pharmacists in Australia.(4)

Mental health pharmacists should have a scope of practice competency profile with a continuing professional development (CPD) plan that covers the five domains of professional performance in accordance with the National Competency Standards Framework for Pharmacists in Australia 2016.(2) Although the framework itself is not tied to any area of specialisation, for mental health pharmacists, there are qualifications, educational activities, knowledge, and skills that are recommended in addition to those of a general clinical pharmacist.

A holistic approach to CPD for mental health pharmacists is required. It is not uncommon for patients with mental health conditions to have physical comorbidities. Additionally, antipsychotics have adverse metabolic effects and there are higher rates of smoking in patients with mental health conditions compared to the general population.(54) Mental health pharmacists will therefore need to maintain current knowledge in general medicine in addition to specialised knowledge in mental health pharmacy.

[head 2] Credentialing and Qualifications

The following is a non-exhaustive list of desirable certification, credentialing and qualifications for mental health pharmacists and does not represent endorsement of any provider:

- A relevant post-graduate certification including but not limited to –
  - Certificate, Diploma or Master of Clinical Pharmacy
  - Post Graduate Certificate in Mental Health
  - A Master or Doctor of Philosophy (PhD) for research relevant to mental health
  - Post Graduate Diploma in Psychiatric Pharmacy (e.g. offered by Aston University)
- Completion of Advanced Training Residency in Mental Health (offered by SHPA for approved hospital sites)
- Credentialing as an Advanced/Advancing Practice Pharmacist
- Credentialling pathway offered by the College of Mental Health Pharmacy (CMHP), UK
• Certification from the Board of Pharmacy Specialties of the American Pharmacists Association

[head 2] Educational Activities

Further to the Pharmacy Board of Australia Guidelines on CPD,(55) mental health pharmacists should have a significant proportion of their CPD, per year, tailored to mental health medicine, relevant to their current practice.

[head 3] Continuing professional development.

Recommended CPD for mental health pharmacists include attending the following local, national or online activities:

• SHPA Seminars and CPD activities
• SHPA Medicines Management annual conference
• Royal Australian and New Zealand College of Psychiatrists annual conference
• State-wide (or territory-wide) and national forums and groups with a focus on mental health services (e.g. SHPA’s Mental Health Interest Group, Practice Group and Leadership Committee)
• Mental Health First Aid e.g. Youth Aboriginal and Torres Strait Islander Mental Health First Aid,(56) Aboriginal and Torres Strait Islander Mental Health First Aid.(57)

[head 3] Journals

Mental health pharmacists should also subscribe to specialist journals to maintain currency with the most recent developments in mental health, for example:

• JAMA Psychiatry
• The American Journal of Psychiatry
• The Australian and New Zealand Journal of Psychiatry
• The British Journal of Psychiatry.

In addition to broader journals including, but not limited to:

• Journal of Pharmacy Practice and Research
• Medical Journal of Australia
• The Lancet
• The New England Journal of Medicine
• The British Medical Journal.

[head 3] Professional organisations

The authors recommend joining relevant professional organisations such as:

• The Society of Hospital Pharmacists of Australia (SHPA)
• SHPA Mental Health Specialty Practice program at the Interest Group, Practice Group or Leadership Committee level
• College of Mental Health Pharmacy, UK (CMHP)
• State-based mental health pharmacist organisations.
Knowledge, skills and experiential learning

The role of a mental health pharmacist requires a strong clinical knowledge of general pharmacy with the later addition of specialty-specific experience. Pharmacists working in this area will have high levels of interpersonal skills, confidence, compassion, and effective communication. Underpinning knowledge related to key areas of pharmacy practice in mental health are the skills and application of clinical pharmacy, which will be advanced by experiential learning (Table 4). This Standard does not list the competencies that the individual pharmacist should address, which will be dependent on their scope of practice.

Table 4 – Essential and desirable knowledge and skills and experiential learning for mental health pharmacists

<table>
<thead>
<tr>
<th>Knowledge and Skills</th>
<th>Essential</th>
<th>Desirable</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Knowledge of common mental health presentations and treatment algorithms (e.g. schizophrenia, bipolar affective disorder, depression, anxiety and personality disorders)</td>
<td>Ability to synthesise evidence-based recommendations in the absence of published guidelines, especially in mental health conditions with comorbidities</td>
</tr>
<tr>
<td></td>
<td>Knowledge of substance-related and addictive disorders and treatment algorithms</td>
<td>Ability to synthesise evidence-based recommendations in the absence of published guidelines</td>
</tr>
<tr>
<td></td>
<td>Knowledge of the side effects, including metabolic side effects, for medicines commonly used in mental health and strategies to mitigate risks (e.g. monitoring and early pharmacological and non-pharmacological intervention)</td>
<td>Contribute to policies and guidelines specific to the pharmacological management of mental health conditions</td>
</tr>
<tr>
<td></td>
<td>Knowledge of medicines’ safety and efficacy for people during the perinatal period, including potential harms for the fetus or infant</td>
<td>Participate in interdisciplinary preconception planning and facilitate patient collaborative care (e.g. shared/supported decision making)</td>
</tr>
<tr>
<td></td>
<td>Knowledge of available resources for Aboriginal and Torres Islander Peoples e.g. 13 Yarn(58)</td>
<td>Contribute to relevant legislation and regulations governing the mental health care of involuntary patients</td>
</tr>
<tr>
<td>Registration to clozapine monitoring websites and databases relevant to the principal place of practice (e.g. Clozaril Patient Monitoring System, ClopineCentral)</td>
<td>Contribute to local and national standards, guidelines, and policies relevant to the supply of high-risk medicines in mental health, including clozapine</td>
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</tr>
<tr>
<td>Effective discharge counselling to promote medicines adherence, including identifying and mitigating risks for non-adherence</td>
<td>Contribute to local and national standards, guidelines, policies, education and research relevant to medicines adherence</td>
<td></td>
</tr>
<tr>
<td>Effective communication to enable continuity of care by liaising with carers and other healthcare professionals where appropriate</td>
<td>Provide education and guidance on effective communication specific to patients with mental health conditions and their carers</td>
<td></td>
</tr>
<tr>
<td>Work as an effective member of the interdisciplinary team (e.g. medical officers, nurses, social workers, occupational therapists, other pharmacists)</td>
<td>Collaborate with interdisciplinary team members to develop and present patient education and quality improvement activities</td>
<td></td>
</tr>
<tr>
<td>Skills to enable supported decision making and collaborative care</td>
<td>Influence practice to ensure/facilitate supported decision making and collaborative care</td>
<td></td>
</tr>
<tr>
<td>Participate in pharmacist-led education sessions for nurses, medical officers, patients and carers</td>
<td>Prepare and present education to nursing staff, medical officers, patients and carers</td>
<td></td>
</tr>
<tr>
<td><strong>Experiential Learning</strong> (includes training)</td>
<td><strong>Experiential Learning</strong> (includes training)</td>
<td></td>
</tr>
<tr>
<td>Completion of an evaluation of clinical skills using <strong>Clinical Competency Achievement Tool</strong>(59)</td>
<td>Completion of SHPA Advanced Training Residency where available at approved sites.</td>
<td></td>
</tr>
<tr>
<td>Completion of <strong>Mini Clinical Evaluation Exercise</strong> and <strong>Mini-PAT</strong> (peer assessment)</td>
<td>Completion of post graduate qualifications that have a focus on learning in practice.</td>
<td></td>
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</table>

*Substance-related and addictive disorders may be a clinical specialty independent of mental health services in some health service organisations*

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Larger public health service organisations may operate a network of metropolitan and regional mental health facilities throughout their state or territory. Where possible, the mental health pharmacist should seek clinical placements at different facilities to further their professional and clinical development and gain multi-site experience. The authors consider the ability to undertake preceptorships and/or site visits to health services in geographically diverse areas or areas of diverse
practice to be a useful way of expanding knowledge and skills, particularly for mental health
pharmacists practising alone or at smaller sites.

Training and education will predominantly be work-based education and should follow adult
learning principles. Further information can be found in Chapter 10 of the SHPA Standards of
Practice for Clinical Pharmacy Services.(2)

[HEAD 1] QUALITY IMPROVEMENT

The Australian Commission on Safety and Quality in Health Care defines ‘quality as the degree to
which health services for individuals and populations increase the likelihood of desired health
outcomes and are consistent with current professional knowledge.’(60)

Quality and safety improvement activities should be embedded within mental health clinical
pharmacy practice. Mental health pharmacists, preferably within an interdisciplinary team, should
consistently strive for best patient outcomes, prioritising patients at greatest risk of medication
misadventure.

Quality improvement activities should incorporate principles of improvement science to
methodically and accurately measure, monitor and evaluate progress(61); effectively performing
Plan-Do-Study-Act (PDSA) cycles.

Tools are available from the NSW Clinical Excellence Commission to support incorporation of
improvement science (PDSA cycles) into quality improvement activities.(62) Quality improvement
action plans, initiatives and results should be reported to the health service organisation’s clinical
governance framework (e.g. Drug and Therapeutics Committee) and presented to staff.

Examples of quality improvement activities where improvement science methodology can be
applied include but are not limited to the following:

- Continually reviewing current practice to identify and meet requirements specified in the
  National Safety and Quality Health Service Standards,(63) specifically, the Medication Safety
  Standard.
- Continually reviewing and evaluating medication-management-related workflows and
  processes to optimise safety and efficiency.
- Continually reviewing patient experience of mental health pharmacy services to identify
  areas for improvement as required.
- Ongoing clinical auditing, including the use of established and validated audit tools (e.g.
  National Quality Use of Medicines Indicators for Australian Hospitals (National QUM
  indicators),(64) to monitor and report:
  - Percentage of as required (PRN) psychotropic medication orders with documented
    indication, dose (or dose range), frequency and maximum daily dose (National QUM
    indicator 7.1)
  - Percentage of patients taking lithium who receive appropriate monitoring during
    their inpatient episode (National QUM indicator 7.2); and compliance to clinical
    guidelines for high-risk psychotropic medicines (e.g. clozapine, lithium)
  - Percentage of patients who receive written and verbal information on regular
    psychotropic medicines initiated during their admission (National QUM indicator
    7.3)
Percentage of patients taking antipsychotic medicines who receive appropriate monitoring for the development of metabolic side effects (National QUM indicator 7.4)

Percentage of patients prescribed two or more regular antipsychotic medicines at hospital discharge (National QUM indicator 7.5)

Percentage of best possible medication history documentation and medication reconciliation

Percentage of allergy and adverse drug reaction review

Smoking cessation interventions

Rates of ECG monitoring for mental health inpatients receiving medicines with known QT prolongation risks

Rates of physical and cardiometabolic health monitoring for patients taking regular psychotropic medicines, especially those who have an intellectual disability, are culturally or linguistically diverse or identify as Aboriginal and Torres Strait Islander people.

- Conducting interdisciplinary quality improvement projects following significant adverse medication events and sharing project outcomes at mortality and morbidity meetings.
- Baseline and yearly reports on the number of staff education sessions, conference presentations and published manuscripts provided by mental health pharmacists, including their impact on practice.

Further information on quality improvement can be found in Chapter 14 of SHPA Standards of Practice for Clinical Pharmacy Services. For further reading, the following texts may also be helpful:


[HEAD 1] RESEARCH

Research is vital for developing the pharmacy profession and may inform pharmacy services’ current level of and future contributions to advancing pharmacy practice and patient care. Mental health pharmacists should support, participate in, initiate, conduct, lead and supervise research that contributes to optimal use of medicines and advanced mental health pharmacy practice. Cross sector, inter-sectorial and interdisciplinary research is advocated to ensure input of key stakeholders and relevance of research in the Australian context. Collaborations with universities, research institutes and other groups are also encouraged.

Mental health pharmacists could consider completing part-time postgraduate studies focusing on research (e.g. Master, Doctorate) relevant to their current area of mental health practice. Or collaborate with local research institutes and universities to develop clinician- or practice-oriented research grant applications specific to mental health pharmacy. Engaging with universities to support pharmacy Honours students’ research projects may also be an option.

A research gap must be identified. The research question and study design must benefit patients and be of interest to the mental health team. For example, research may result from clinical questions or...
recurring issues observed during clinical practice that pertain to quality use of medicines or patient related outcomes. These may include managing and minimising adverse effects associated with psychotropic medicines; and reviewing operational systems and processes related to clozapine supply.

The 2017 Australian Commission on Safety and Quality in Health Care report on Medication Safety in Mental Health found significant gaps in the literature related to mental health inpatient units and medication history accuracy; prescribing errors at discharge; and the extent of medication administration errors and adverse events.\(^{(21)}\)

Examples of mental health pharmacy research have included:

- Adverse medication events in mental health\(^{(65)}\)
- Mental illness and opioid use\(^{(66)}\)
- Evaluation of a clozapine decision support tool\(^{(67)}\)
- Administration processes and clozapine\(^{(68)}\)
- Psychotropic medicine use in pregnancy\(^{(69)}\)

Quantitative and qualitative data collection, to prove or disprove a hypothesis or to answer a clinical question, for any research should be achievable within a reasonable timeframe. There should be clearly defined outcomes with objective measures where possible. Data integrity and management must align with protocol requirements, health service guidelines and human research and ethics committee approval to, for example, ensure informed or capacity to consent. Pharmacists should ideally engage with research committees, prospectively and proactively, regarding any potential research to ensure appropriate study design and academic and ethical rigour.

External funding enables larger multi-centre studies to be conducted. Grants are available from organisations including the National Health and Medical Research Council (NHMRC).

Presentation of research at relevant conferences and seminars as referenced in the section on Training and Education is highly recommended. The choice of journal for publication depends on the best audience for the study results. The *Journal of Pharmacy Practice and Research* (JPPR) has a readership of primarily Australian pharmacists. Journals specific to mental health that may be appropriate are listed in Appendix 2: Resources. Presentation and publication of studies by Australian mental health pharmacists are imperative to aid others in the implementation of mental health pharmacy services and to demonstrate how mental health pharmacists contribute to and improve patient care.

Further information on research can be found in Chapter 11 of SHPA Standards of Practice for Clinical Pharmacy Services.\(^{(2)}\)

ACKNOWLEDGEMENTS

SHPA would like to acknowledge the former SHPA Committee of Specialty Practice in Mental Health Pharmacy for their work on the previous Standard: Standards of Practice for Mental Health Pharmacy.

CONFLICTS OF INTEREST STATEMENT

SHPA to add later
AUTHORSHIP STATEMENT
SHPA to add later

REFERENCES

[HEAD 1] APPENDICES

[head 2] Appendix 1. Mental Health Glossary

<table>
<thead>
<tr>
<th>ECT</th>
<th>Electroconvulsive Therapy</th>
</tr>
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<tbody>
<tr>
<td>LAI</td>
<td>Long-acting injection. Also referred to as depot injection.</td>
</tr>
<tr>
<td>ORT/OST</td>
<td>Opioid Replacement (Substitution) Therapy</td>
</tr>
<tr>
<td>PTSD</td>
<td>Post-Traumatic Stress Disorder</td>
</tr>
</tbody>
</table>

[head 2] Appendix 2. Resources

Recommended texts for Mental Health

- Maudsley Prescribing Guidelines in Psychiatry
- Psychotropic Drug Handbook, Steven Bazire
- Stahl’s Essential Psychopharmacology
- Diagnostic and Statistical Manual of Mental Disorders (DSM-5)

Discretionary texts

- The Maudsley Practice Guidelines for Physical Health Conditions in Psychiatry
- Stahl’s The Clozapine Handbook

Key journals specific to Mental Health

- Australian & New Zealand Journal of Psychiatry
- Australasian Psychiatry
- JAMA Psychiatry
- Lancet Psychiatry
- American Journal of Psychiatry
- The British Journal of Psychiatry
- European Neuropsychopharmacology
- Bipolar Disorders
- Schizophrenia Research
- Journal of the Academy of Consultation-Liaison Psychiatry
- Journal of the American Academy of Child and Adolescent Psychiatry

Treatment Guidelines or Clinical Guidelines

- Therapeutic Guidelines, Psychotropic
- Royal Australian and New Zealand College of Psychiatrists statements and guidelines including clinical practice guidelines
  - Schizophrenia
  - Mood disorders
  - Anxiety disorders
  - Eating disorders
- Mental Health First Aid clinical guidelines
- Orygen Clinical Practice Guide Treating Depression in young people
- National Collaborating Centre for Mental Health (NCCMH) clinical guidelines
- British Association of Psychopharmacology Consensus guidelines
- American Psychiatric Association clinical guidelines

### Useful websites

<table>
<thead>
<tr>
<th>Website</th>
<th>URL</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Royal Australian and New Zealand College of Psychiatrists</td>
<td><a href="https://www.ranzcp.org/home">https://www.ranzcp.org/home</a></td>
</tr>
<tr>
<td>American Psychiatric Association</td>
<td><a href="https://www.psychiatry.org/">https://www.psychiatry.org/</a></td>
</tr>
<tr>
<td>- Mental health and young people: opportunities to empower and engage</td>
<td></td>
</tr>
<tr>
<td>British Association of Psychopharmacology</td>
<td><a href="https://www.bap.org.uk">https://www.bap.org.uk</a></td>
</tr>
<tr>
<td>Australian Prescriber</td>
<td><a href="https://www.nps.org.au/australian-prescriber/articles/antipsychotic-switching-tool">Antipsychotic Switching Tool</a></td>
</tr>
<tr>
<td>Dynamed</td>
<td>An electronic evidence-based database <a href="https://www.dynamed.com/">https://www.dynamed.com/</a></td>
</tr>
<tr>
<td>Select Australian Prescriber Podcasts</td>
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<tr>
<td>PPP124: ADHD with Prof Dave Coghill</td>
<td></td>
</tr>
<tr>
<td>PPP107: Mental Health in 2020 with Dr Mark Cross</td>
<td></td>
</tr>
<tr>
<td>PPP069: Best practice use of antipsychotics in aged care with Juanita Westbury</td>
<td><a href="https://www.purplepenpodcast.com">https://www.purplepenpodcast.com</a></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Select Purple Pen Podcasts</th>
<th></th>
</tr>
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<tbody>
<tr>
<td>21/6/21: Opioid and antidepressant combinations</td>
<td><a href="https://ajp.psychiatryonline.org/audio">https://ajp.psychiatryonline.org/audio</a></td>
</tr>
<tr>
<td>14/2/21: How to choose an antidepressant</td>
<td></td>
</tr>
<tr>
<td>14/9/20: Stopping and switching antipsychotic drugs</td>
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</tbody>
</table>

JAMA Psychiatry author interviews

American Journal of Psychiatry audio

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3. SHPA Committee of Specialty Practice in Mental Health Pharmacy. Standards of Practice for Mental Health Pharmacy. 2012;42(2).


56. Mental First Aid Australia. Youth Aboriginal and Torres Strait Islander Mental Health First Aid.


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