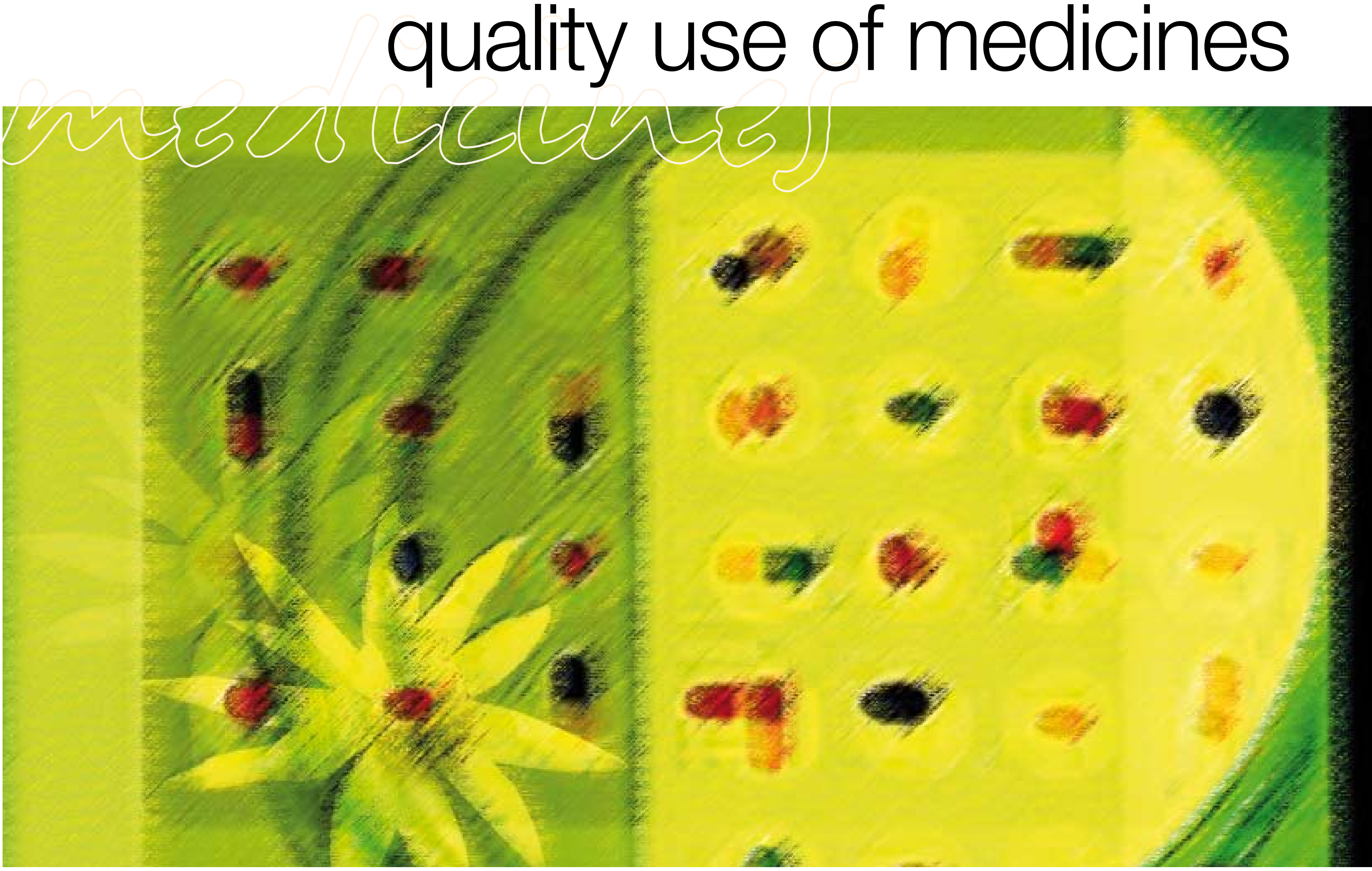
MENTAL
HEALTH
COUNCIL OF
AUSTRALIA

Mental health and quality use of medicines



Report of the National Stakeholder Workshop
concrete ideas for practical action

Melbourne: 27 June 2006

Foreword

The quality use of medicines (QUM) seems an ethereal concept in that it is oft-quoted but rarely put into practice. The Council's goal in holding the workshop that is the basis for this report was anything but ethereal. The workshop's title, 'Concrete Ideas for Practical Action', bears this out. Medicines are a critical element for many people with a mental illness and are often the key to living better and more stable lives. Making sure people have every opportunity to use these medicines appropriately is vital and yet this issue has been largely ignored, particularly across the mental health sector. Many other areas have investigated the quality use of medicines in greater detail than mental health; for example both the areas of asthma and heart disease have done significant work in this area acknowledged in this report.

But there is no mention at all of the quality use of medicines in Australia's National Mental Health Strategy. Nor is there any link between this Strategy and the National Strategy for the Quality Use of Medicines. Given the significance of the issue of medicines for many people with a mental illness, this seems a serious deficiency in existing policy approaches.

This workshop was designed partly as a first step to building some bridges between the mental health sector and the field of quality use of medicines. In this regard, the involvement of the Consumers' Health Forum as part of the Workshop Steering Committee was invaluable as this organisation has done considerable work in the area of QUM from which the Council could draw.

It is also worth noting that this workshop was organised under the auspices of the Pharmaceutical Collaboration, a group of seven companies and the Mental Health Council, working together to address issues of common interest. For people who need medicine, the Collaboration is most concerned to promote the quality use of those medicines. The findings and recommendations arising from this workshop will be used by the Collaboration to direct future activity in this important area.

For example, one of the key issues arising is the inconsistency in current arrangements for people being discharged from acute hospitals to home. While some places appear to provide a good level of support and information regarding medicines, many others provide little or no help to people going home. One suggestion for possible future QUM-related activity would be a project to identify for best practice in QUM for people with a mental illness discharged from care into the community. The aim of this project would be not only to identify good practice but then to see it replicated elsewhere.

Another key area is in relation to Consumer Medicines Information (CMI). The MHCA website contains little if any reference to QUM and the QUM workshop raised several familiar criticisms of CMI. Another project which could be considered to make real progress in this area was to establish the Council website as a site of excellence for QUM in mental health and a point of reference for these matters for members and the general community. The type of information to be provided could include:

- Material on QUM as auspiced by independent agencies in Australia (the PHARM committee, the National Prescribing Service etc);
- CMIs on all medicines relevant to mental illness, enabling consumers and others to compare and contrast different medications;
- Links to relevant other sites and organisations, including sites offering peer support.

These are just a couple of the suggestions arising from the workshop which would be of practical benefit to improving the quality use of medicines for people with a mental illness.

QUM is an area ignored for too long whose time has now come.

Rob Knowles
Chair
October 2006

Contents

Overview of the workshop

Goals

The workshop originated with research and concerns that, while medicines are an important part of treatment for most people living with mental illness, many of these people are not getting the best outcomes. The workshop brought together stakeholders and experts working 'at the coalface' of mental health and Quality Use of Medicines (QUM) to explore:

- *selecting* good management options for mental health
- *choosing* suitable medications—if medicine is an appropriate treatment option
- *using* medicines in ways that are safe and effective.

The specific goals of the workshop were:

- to map the main stages and parts of QUM in mental health
- to review QUM in other chronic disease areas for actions or approaches relevant to mental health
- to map out areas for research and pilot projects
- to begin building a network of people and organisations that can contribute to QUM in mental health.

The workshop was held at the Melbourne Town Hall on 27 June 2006.

Support

The event was supported by a collaboration between the Mental Health Council of Australia (MHCA) and seven pharmaceutical companies: AstraZeneca, Bristol–Myer Squibb, Eli Lilly Australia, GlaxoSmithKline, Lundbeck, Pfizer Australia and Wyeth.

Participants

The workshop was attended by 43 people. They included:

- consumers, carers and their advocates
- general practitioners, psychiatrists and psychologists
- nurses
- hospital and community pharmacists
- mental health service providers
- State and Federal Government departments of health
- researchers
- educators
- experts in mental health and the law
- QUM experts
- pharmaceutical manufacturers.

A list of all the participants is included at the end of this report.

Program

The workshop was divided into four parts:

1. presentations by three speakers:
    - Ian Hickie—research on medicines for treating mental illness
    - Ric Day—Quality Use of Medicines in Australia
    - Kathryn Weedon—an insider's perspective on medicines and mental health.
2. mapping the consumer's journey through mental illness—focussing on consumer's use of medicines
3. reviewing suggestions for QUM in other chronic disease areas
4. outlining priorities for action in mental health and QUM.

About this report

This report summarises the notes taken by participants on the day, as well as responses to the Background Readings. Because it reflects contributions from a diverse range of stakeholders made in just one day, this report is not a comprehensive portrait of QUM in mental health, nor an exhaustive, systematic exploration of areas for improvement. Some of the issues raised by participants fall outside of the formal definition of Quality Use of Medicines, and some are not concerned with medicines at all — although they are important in treating people with mental illness. This report tries to impose some order on the great volume of contributions, but preserve the variety of participants' views, suggestions and priorities.

Quality use of medicines

The *National Strategy for the Quality Use of Medicines* defines QUM as:

1. *Selecting* management options wisely by:
   - considering the place of medicines in treating illness and maintaining health, and
   - recognising that there may be better ways than medicine to manage many disorders.
2. *Choosing* suitable medicines if a medicine is considered necessary so that the best available option is selected by taking into account:
   - the individual
   - the clinical condition
   - risks and benefits
   - dosage and length of treatment
   - any co-existing conditions
   - other therapies
   - monitoring considerations
   - costs for the individual, the community and the health system as a whole.
3. *Using* medicines safely and effectively to get the best possible results by:
   - monitoring outcomes
   - minimising misuse, over-use and under-use, and
   - improving people's ability to solve problems related to medication, such as negative effects or managing multiple medications.

Speakers

The following is a summary of the main points presented to the workshop by Ian Hickie, Ric Day and Kathryn Weedon.

Ian Hickie

Executive Director, Brain and Mind Research Institute
Professor of Psychiatry, The University of Sydney

Community attitudes to mental illness are changing. For example, studies have found increasing recognition of depression as a major mental health problem, as well as a growing ability of community members to recognise depression in themselves or family members. But, while there is increasing support for people with mental illnesses, this often does not extend to treatment. The public media in particular is still negative about medicines for mental illness.

Even with changing public attitudes, many people are still not diagnosed until many years after the onset of illness. The onset of most mental illnesses occurs in people aged in their twenties but, on average, people are not diagnosed for another 15–20 years. In this period, many people will ‘self-medicate’. People with depression, for example, are more likely than the general population to smoke, drink heavily, and use marijuana.

Even once a person has been diagnosed, the basic problem remains that there simply are not services to refer them to. While existing tools are sufficient for GPs to identify people with mental disorders, there is little point screening without a commitment to treatment or enhanced care. Currently the number of people identified with mental illness far exceeds the number receiving formal care. GPs in particular have not been supported by adequate professional training; remuneration; logistical, professional and specialist support; or access to specialist treatment systems. New mental health systems are needed which provide:

- more flexible entry points
- greater use of appropriate assessment and monitoring technologies
- rapid access to specialised services
- continuous monitoring
- social and vocational recovery rather than occasions of service.

In the case of medicines, there is evidence that increased prescribing has produced benefits. In depression, for example, the decreasing number of suicides reported in the last decade has been in proportion to increasing antidepressant prescribing. (This, however, most benefits those who can access primary care and receive treatment —the greatest reductions have been seen in women and older people. Young people by contrast are more likely to turn to their friends or families than a GP.)

Despite such improvements, there is a continuing belief in the community of the harmfulness of antidepressant medicines, particularly that they increase the risk of suicide. Research shows in fact that risk of suicide precedes treatment. Other public concerns include the perceived harmfulness of medicines (from addiction, personality change and side effects) as well as other concerns about mental illness (such as stigma, discrimination in the workplace, and worries about insurance).

Recent focus groups of people receiving ongoing care has found that such negative attitudes — from family, friends, carers and even some health professionals — are a barrier to accessing and benefiting from medicines. Other significant problems identified by consumers include:

- lack of access to information on medicines

- lack of understanding about medicines
- lack of interest by the treating doctor.

Such problems can lead to relapse, illness, and poor social and work outcomes.

Suggestions for improving QUM in mental health include:

- providing information resources from independent sources
- increasing the use of web-based resources (for some mental illnesses, such as depression, online educational and information resources like the BeyondBlue and MoodGYM websites have been shown to deliver clinical benefits)
- developing and using tools to enable consumers to share their experiences of medicine use with their peers
- providing medicine-specific helplines
- providing self-monitoring methods, such as mood charts.

A model for QUM in mental health needs to incorporate:

- new information systems
- new consumer systems
- new Primary Care systems
- new continuity systems.

Ric Day

Professor, Clinical Pharmacology, University of New South Wales
St Vincent's Hospital, Sydney
Chair, PHARM Committee

The development of Australia's Quality Use of Medicines strategy grew out of efforts by the consumer movement in the late 1980s to develop a National Medicines Policy. Concerns — then as now — included under-use, overuse and inappropriate use of medicines, along with adverse events.

The National Medicines Policy addresses these issues with four strategies:

- ensuring medicines are of high quality, safety and efficacy (a task overseen by the Therapeutic Goods Administration)
- providing equitable access to necessary medicines (secured through the Pharmaceutical Benefits Scheme)
- Quality Use of Medicines (QUM)
- supporting a viable and responsible pharmaceutical industry.

The goal of QUM is to optimise medicinal drug use (prescription, over-the-counter and complementary) to improve health outcomes for all Australians. It involves:

- selecting management options wisely
- choosing suitable medicines, if a medicine is considered necessary
- using medicines safely and effectively.

Achieving QUM is approached through changing behaviour and developing partnerships. It involves all groups who influence medicine use; includes all stages of learning; and includes all relevant settings where medicine is used. QUM draws together health practitioners, regulators, the pharmaceutical industry and consumers.

QUM provides:

- an evidence-based, collaborative, systems approach to optimising clinical and resource outcomes, wherever medicines are used
- an evidence-based set of resources and tools for use by all stakeholders to improve the use of medicines
- an evaluation framework for feedback and continuous quality improvement in medicines policy, strategy and use.

Through the PHARM Committee (Pharmaceutical Health and Rational Use of Medicines), QUM has been integrated into the National Health Priorities. The following are some areas of action by PHARM in the past five years.

1. A joint workshop in 2002 with the National Asthma Reference Group and a follow-up workshop held in 2004.
2. A joint workshop with the National Diabetes Strategies Group held in 2004, which lead to:
   - a QUM-in-Diabetes paper, which is currently available for comment and available on the PHARM website
   - contributions to QUM for diabetes educators
3. Participation in the National Heart Foundation's Quality Use of Cardiovascular Medicines workshop in November 2005.
4. Involvement in the National Service Improvement Frameworks.

Kathryn Weedon

St Vincent's Mental Health, Melbourne

Kathryn spoke as a person who has lived with a psychotic disorder for more than two decades — undiagnosed for nineteen of those years, despite repeatedly seeking help from psychiatry. Before her diagnosis, she experienced homelessness, poverty, despair and social isolation. She was first prescribed an antipsychotic medicine eight years ago. Since then, she has felt the benefits of less confusion, paranoia, isolation and poverty — but for her, these are only just outweighed by the physical problems that have accompanied medicine use: back and foot pain, muscular spasms, migraines, loss of libido, and excessive weight gain.

Her key experience has been learning to balance the harms associated with side effects against the benefits of symptom reduction. Her journey has involved three prescribers in the last eight years — encountering health professionals who expected her to endure chronic disability and side effects, while giving little advice or other medications to help cope. Her view is that much of what consumers report to health professionals — particularly about side effects — is taken as delusions or imaginings.

She has experienced great difficulty accessing good information about her medicines. She finds that CMI sheets in particular are poor, and many pharmacists are not prepared to provide them at all.

People with psychosis disorders can expect to take medications for decades, but there are no clear, comprehensive information services or advice lines appropriate to their specific needs. Kathryn emphasised that consumers need information about the risks and harms of their medicines, as well as the benefits.

Two of the biggest barriers to recovery faced by people with severe mental illnesses — apart from side effects — are stigma and hatred. Kathryn reported a recent American study showing that people with severe mental illnesses were likely to suffer 6–23 times more violent crime (rape, sexual assault, robbery, assault) than the general population. This had been matched by her own personal experience. Kathryn urged the workshop to confront such myths and prejudices about people with mental illness.

Mapping QUM in mental illness

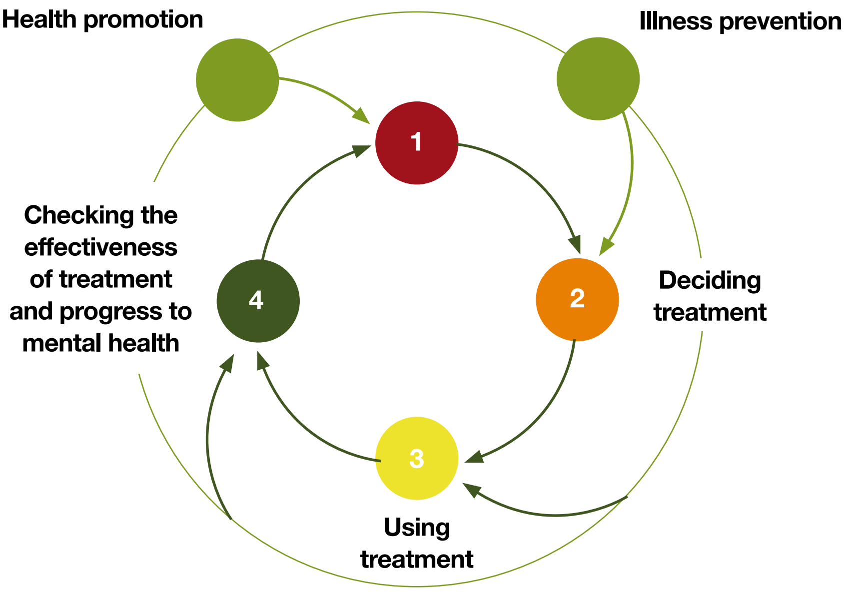
Medicines are only one option for treating mental illnesses. As stakeholders in previous QUM projects have insisted, the use of medicines has to be put into the larger context of the patient's journey through their disease — from onset, through treatment, to recovery and good health. To establish what the journey is in the case of mental health, workshop participants were given a schematic diagram of possible stages, based on work in other chronic diseases (diabetes, asthma and cardiovascular disease), and asked to correct it so that it reflected the experience of those dealing with mental illnesses.

A number of issues emerged in these discussions, which illustrated that the original, rather linear approach was not appropriate for mental illness. Important differences included:

- unlike cardiovascular diseases and diabetes, some mental illnesses — such as depression and anxiety — are curable and not permanent conditions
- the distinction between acute episodes and preventative care — taken from diabetes, asthma and cardiovascular disease — is often not appropriate for mental illnesses
- the use of medicines has to be closely integrated with other interventions — lifestyle, psychological and support— as the success of one depends on the contributions of the others
- any model needs to cover both self-management and treatments involving health professionals within the health system
- participants felt that good feedback was essential to good outcomes — a fact not reflected in the linear outline provided.

The diagram (below) better summarises the basic stages of treating mental illness described by the workshop participants. Each of the four main phases can, in turn, be broken down into different contributions. These are summarised in the next three pages. To succeed, this cycle needs to operate in an environment that:

- promotes good mental health
- helps prevent the incidence of mental illness in the first place, and
- creates access and reduces barriers to people seeking treatment.



Health promotion and illness prevention

For many participants, a key task of health promotion needs to be the reduction of stigma about mental illnesses and their treatments (including medicines). Activities that this will require include:

- community education
- raising community awareness
- addressing trans-cultural issues and needs.

Health promotion also needs to address misinformation about mental illnesses and treatments—particularly by the popular press and by extreme interest groups.

Identification of need

A person may have broadly two types of need:

- they may be at risk of developing a mental illness
- they have been diagnosed with a mental illness.

Participants repeatedly stressed the importance of early intervention, as many mental illnesses are not diagnosed for many years after onset.

Identifying those at risk

Individuals and agencies that participants said could identify those at risk of mental illness include:

- carers
- colleagues
- school teachers
- general practitioners
- community nurses
- police
- government agents, such as Centrelink
- social workers
- clergy.

Diagnosing a mental illness

People who may diagnose mental illness include:

- the person with the illness themselves (informal self-diagnosis and self-treatment is common for many mental illnesses)
- informal diagnosis by family, friends or work colleagues
- a formal diagnosis by a GP or another health professional.

Assessment and diagnosis by a health professional may take place in a number of settings, and will depend on how the person (or their carer) seeks help. Settings may include:

- general practices
- hospital emergency departments

- community health services
- residential care (if the person is already receiving treatment).

Participants said that a major barrier to medical diagnosis and treatment — apart from stigma of mental illness, which may prevent people seeking medical attention — is getting timely access to a GP or specialist. For people being admitted in emergency circumstances, good interfaces between health professionals, police and ambulance services are also important. There was also some concern that GPs in regional and remote areas may lack resources and appropriate tools for diagnosis and treatment. Resources that participants felt may help include:

- telepsychiatry
- internet-based service delivery.

Deciding on treatments

Exactly how treatment plans are developed will depend on the path by which the consumer seeks or enters into care. Workshop participants stressed the importance of health professionals involving both consumers and carers in exploring treatment options and agreeing to a management strategy. This demands consultation, good dialogue, provision of tailored information, and discussion of risks and benefits.

A number of participants underlined the need for these discussions to be informed by accurate, accessible information from an independent source. Pharmacogenomics may also increasingly play a role in selection of medications.

For some participants, the goal of these discussions is the formation of a ‘therapeutic alliance’ between consumer, carer and health professionals — a partnership that works together to stabilise the illness and help restore the consumer to health.

A number of participants noted that many consumers self-prescribe ‘treatments’ without consulting a health professional. These commonly include alcohol, cigarettes, over-the-counter painkillers, vitamins, minerals, and complementary therapies.

Parts of the formal health system that workshop participants said may deliver treatments include hospitals, general practices, community-based care, and residential care. Treatments will commonly include medicines, psychotherapy or psycho-education, social and domestic support and lifestyle interventions — although as many participants stressed, these need to be closely integrated, as each supports the others. Several participants said treatment plans should also incorporate relapse planning.

Lifestyle modifications mentioned by participants included:

- diet and exercise
- managing alcohol and cigarette use
- reducing illicit drug use
- education and vocational support
- helping people manage the side effects of medicines.

Support that participants said is important to medicine use include:

- peer and mutual support
- housing
- improved socio-economic status
- employment

- community involvement
- overcoming social isolation
- reducing stigma.

Psychological contributions that participants mentioned included raising self-esteem.

Participants wanted to see less use of both chemical and physical restraints of hospital in-patients.

As well as the therapeutic outcomes of treatments, an important issue identified by participants is the cost of treatment — to the individual, to their families, and to the community as a whole. Costs and financial support relevant to treating mental illness include:

- PBS
- MBS Items (especially newer items for psychologists and nurses)
- case conferencing
- carer support and respite care
- Home Medicines Reviews[1]
- GP–psychiatrist support.

Using treatments

Prescription, over-the-counter and complementary medications may all be part of treatments for mental illness. Issues in the prescribing and dispensing of medicines raised by participants were:

- side effects
- inappropriate polypharmacy
- off-label prescribing
- generics versus brand-name medicines
- access and affordability — especially PBS access — and the cost to the community and to the individual.

Health professionals and others who participants said may provide counselling and education about medicines for mental illness include:

- the prescriber and other health professionals
- support groups
- rehabilitation services
- the consumer and carer
- employers
- school teachers.

There was some difference amongst participants on the appropriateness of the terms compliance, adherence or concordance.

---

[1] A 'Home Medicines Review' or HMR is ordered by a general practitioner and conducted by a pharmacist, normally for patients using a large number of medicines. The review is done at the consumer's home and includes a review of all medicines they are taking (prescription, over-the-counter and complementary), interactions, correct use of medicines, storage, expired medicines, and the correct functioning of equipment (such as asthma inhalers).

Treatment may take place across a number of healthcare settings. And, over the period of treatment, consumers may move between settings. An issue raised by some participants was the importance of continuity of care, and hence good communication between different care settings and health teams. The case manager has a particularly important role.

Checking outcomes and progress

Processes that participants said were important for checking the effectiveness of treatments included:

- formal review mechanisms
- quality assurance
- accountability mechanisms
- complaint mechanisms
- Home Medicines Reviews for people with mental illnesses.

Participants said that reviews need to cover not just adherence to medicines and other treatments, but also the consumer's progress towards wellness and their quality of life. Consumers need to feel they are being heard, and that their concerns are being taken into account and responded to.

Since a health review may lead to changes in treatment, two issues of importance to QUM in mental health include having processes for:

- early discontinuation of medication
- adding new medicines to treatment.

As well as reviewing and providing feedback at an individual consumer level, several participants emphasised the need for system-wide review, for overall monitoring of treatments and interventions. This would require the linking of prescribing data with the MBS and PBS datasets.

Suggestions from previous QUM projects

To help participants identify areas for action and further development, they were given a list of 73 suggestions. These were drawn from previous work for the Heart Foundation Pharmaceutical Roundtable and were intended as a starting point for discussions — to explore what ideas could be extrapolated from QUM work in other chronic disease areas, and identify what was specific to mental health.

A copy of the list was incorporated into the Background Readings distributed to all participants before the workshop. Each person was asked to record whether they agreed or disagreed with each suggestion, or felt it needed more work. 16 of the 43 participants provided their completed answer sheets for analysis at the end of the workshop. Over two-thirds of responses agreed with the suggestions as presented — even though they had been formulated for quite a different group of illnesses. Participants disagreed with, on average, only 2 of the 73 suggestions. Participants felt that the remaining one third of suggestions required further work.

The number of responses is shown in the middle three columns of the following table. (Because not every person gave feedback, the figures do not always sum to the 16 respondents. Also, some people gave two responses or ambiguous answers — the number of these is shown following the + sign. So, for example, a response of 3+1 disagreeing means three people disagreed and one person was divided in their views.)

At the workshop, participants were asked to discuss a selection of these same 73 suggestions, but in small groups, so they could hear and respond to other peoples' views. Participants were asked to record whether the group agreed or disagreed with suggestions, whether they felt more work was required, or else whether the group was divided in its views (unfortunately, one group did not provide this last piece of information: their entries have been marked with a dash in the following table). Each group was also asked to rate how important they felt each suggestion was (from ★ to ★★★★★), and provide comments. Each group's responses is shown in the left column of the following table. The comments have been edited for sense. Some suggestions were discussed by more than one group and some were not discussed at all.

Suggestion	Agree	Disagree	Needs Work	Agreement	Comments
Identifying risks and diagnosing illness					
1. screen people in groups vulnerable to various mental disorders.	2	2	11	divided ★★★	• When a health professional has screened and identified a person, what do they do? • Which health professionals are doing the screening and what is the purpose of screening?
2. develop practical tools for GPs to assess risk and diagnose mental illnesses.	8	2+1	5+1	agree ★	• There are enough tools already available. There is no need to develop more. • Make tools accessible and embed in them in GPs software.
3. accelerate training of GPs in mental illness risk assessment and diagnosis — through initiatives such as the Better Outcomes in Mental Health program.	11	1+1	3+1	agree ★	• If this suggestion means 'streamline training', then the group agrees. And make training more accessible.
Prescribing appropriate treatments					
4. develop and maintain a central repository of: • educational materials • clinical evidence • clinical practice guidelines • research • projects underway and completed • health services • support groups • balanced information on benefits and harms of medicines.	10	0	6	agree ★★★★	• Achieving this suggestion would need collation, consolidation and analysis. • The information has to be reviewed and be accessible to consumers and health professionals. • This resource needs to be for everyone. • This should not involve 're-inventing the wheel'.
5. develop treatment guidance for GPs on appropriate use of medicines for mental illnesses.	9	2	5	disagree	• There are already enough clinical guidelines. What is needed are strategies to get them into practice.
6. encourage consumers to discuss the following with health providers before they make treatment decisions: • their health, medical history and illnesses with prescribers • options for treatment • benefits and risks of each treatment option • concerns about side effects and how to respond to them • constraints on treatments — such as cost, lifestyle, family support and willingness.	14	0	2	agree ★★★★★	• Achieving this suggestion requires empowering consumers to ask. • Educate health professionals to respond to consumers appropriately.

Suggestion	**Agree**	**Disagree**	**Needs Work**	**Agreement**	**Comments**
7. inform doctors of prescribing and dispensing options that help consumers manage the cost of medicines and treatment.	10	0	6	agree ★★★	• Change 'doctors' to 'practices' in order to encompass the other professions who could prescribe and dispense (eg. pharmacists). • It is important for this activity to happen. • 'Informing' does not change behaviour — systematic changes would be required.
8. include information on cost, cost-effectiveness and consumer choices in clinical practice guidelines.	10	3	3	—	• This is not a practical suggestion.
9. increase community understanding of mental illnesses and treatments to permit a balanced discussion of benefits and harms of medicine use.	11	0	5	agree ★★★★★	• This suggestion should have the goal of reducing stigma and prejudice.
10. for GPs and specialists: • specifically ask consumers about all the medicines they are using—prescription, OTC and complementary — before prescribing • document this use and make sure consumers have their own record • advise consumers on possible adverse reactions and interactions.	14	0	2	agree ★★★★★	• Change this suggestion from 'GPs and specialists' to 'practice staff'. • This action needs to be accompanied by new guidelines, multilingual resources and appropriate multimedia.
11. educate consumers to inform all of their health care providers about all of the medicines they are using.	14	0	2	agree ★★★	• Change 'educate' to 'encourage'.
12. provide all consumers with a medicine record to keep, and encourage them to keep it up-to-date.	11+2	0	3+2	agree ★★★	• This involves the risk of consumers having an out-of-date list. • Increase consumer empowerment.
13. for prescribers: use existing facilities in prescription software to print a medicine record for consumers.	11+1	0	4+1	agree ★★★	• The group agrees — if the prescriber's own records are up-to-date and comprehensive (this depends on them maintaining their software and records). • This suggestion is already happening for those prescribers who use relevant software.

Suggestion	Agree	Disagree	Needs Work	Agreement	Comments
Dispensing medicines					
14. for pharmacists: • specifically ask consumers about complementary, OTC and prescription medicines they are using before dispensing • advise consumers on possible adverse effects and interactions.	11+1	0	4+1	agree ★★★★★	• Pharmacists should be skilled at doing this — they may need education and support. • Include 'benefits of taking medications' along with adverse effects and interactions. • This should be part of the pharmacist's role at the moment. • For some consumers, this may need to be done in the context of a multidisciplinary team and/or specialist.
15. develop guidance for pharmacists on appropriate use of drug administration aids (DAAs) for people with mental illnesses living in residential facilities.	10	0	5	—	• This suggestion forms part of pharmacy standards that should already be followed.
Counselling and education					
16. revise the design of CMI to make it: • shorter and easier for consumers to use and more relevant to their needs, and • more attractive for health professionals to use as a counselling tool.	9+1	0	6+1	agree ★★★★★ needs work —	• Agree with this suggestion as a research priority. • There needs to be research about what consumers want and need at different stages of their journey.
17. for pharmacists: adhere to current professional guidelines on providing CMI to consumers and carers when dispensing medicines.	11	0	4	agree — agree —	
18. Broaden the distribution of CMI beyond pharmacies.	9	2	5	agree — needs work —	• The group has concerns about broadening the supply of CMI beyond dispensing pharmacists—but recognises that it may be available on the internet.
19. Review and improve processes for informing GPs and specialists of mental health materials.	8+1	0	7+1	agree —	
20. Encourage consumers and carers to ask for written information about their medicines and conditions.	12	0	4	agree ★★★★★	
21. for general practices: make greater use of practice nurses to educate consumers about medicines and lifestyle interventions.	8	1	7	agree ★★★★★	

Suggestion	Agree	Disagree	Needs Work	Agreement	Comments
22. Review all existing mental health information and programs for: • consistency with QUM principles • relevance to readers at the time they are provided • useability by readers in the circumstances they receive the material • practicality—how well people can act on the advice they are given • how materials are provided • overlap between different publications	11+1	0	4+1		
Beginning to take medicines					
23. educate consumers about how to use medicines and other treatments effectively. In particular: • how to take medicines correctly • what results to expect • when to expect results • how to monitor the effects, and • what to do if treatment does not work as expected.	12	0	4	agree ★★★★★	
24. for prescribers: before commencing medicine, explain why switching and changing doses is often necessary initially, and how long it may take to find a medicine or combination of medicines that will suit the individual.	14+1	0	1+1	agree ★★★★★	• This type of explanation by prescribers needs to be consistent and on-going.
25. develop protocols to help prescribers reduce frequent swapping, and help consumers manage change better.	9	2	4	disagree	
26. before commencing use, provide consumers with information on side effects they may experience, how long they might last, and how to respond.	13	0	1	needs work ★★★★★	• GPs may minimise side effects.
27. provide training and support to GPs to help them titrate medicines safely and effectively.	11	1	4	agree ★	

Suggestion	Agree	Disagree	Needs Work	Agreement	Comments
Monitoring use and effectiveness					
28. provide consumers with tools and training on how to monitor their treatments and experiences.	10	0	6	agree ★★★★★	• Include 'personal subjective observation' rather than 'monitor' (as this term implies detachment). Observations should also include positive outcomes.
29. develop tools to help health professionals track: • the patient's own experiences of treatment • adherence to treatments • mental health outcomes.	11	0	5	agree	
Adhering to treatment					
30. develop a resource kit and training for general practices to help GPs improve adherence to treatments.	7+1	0	7+1	needs work ★★	• Change 'adherence' to 'concordance'.
Getting people to hospital or care					
31. educate patients and carers to: • recognise acute mental illness events • know what action to take in response • know how promptly action is required.	12	0	3	agree ★★★★★ agree ★★★★★	• Develop an action plan/ advance directive (this requires a team approach, done with consumer control). • Develop protocols for advance directives.
Medicines at admission					
32. suggestion: • develop standard procedures and a standard sheet for recording peoples' medicine details at admission • disseminate the recording sheet and protocols nationally, and provide training in their use.	4+1	1	10+1	divided ★ agree ★★★★★	• The pharmacist should keep this list. • Need to be aware of privacy laws and Mental Health Act.
Medicines in acute intervention					
33. develop better alignment between hospital formularies and PBS Schedule.	13	0	3	agree ★★★★ agree ★★★★★	• The group thought this suggestion should be automatic.
34. make specialists aware of medicines available on the PBS, and the cost implications of their prescribing. Encourage specialists to select medicines that will minimise the need for changes after discharge. recovery	10	1	4	agree ★★★★ agree ★★★★★	• Recovery is a process, not a point. It may be better to use the term 'functionality' or 'quality of life and wellness'.

Suggestion	Agree	Disagree	Needs Work	Agreement	Comments
35. for hospitals: counsel patients and carers about the importance of continuing medicines and other treatments.	12	0	4	agree ★★★★ agree ★★★★★	• Counselling should be done in consultation with the consumer's GP and other professions. • Change 'counsel' to 'educate' or 'engage with the consumer'. • Educate consumers and carers about medicines and provide them with information on alternatives.
Discharge					
36. develop standard discharge documents (or templates) and discharge procedures for use in all hospitals to achieve better transition from hospital to general practice and home care settings.	11	1	4	agree — agree ★★★★★	• Make the discharge documents electronic for ease of sending and transferring information.
37. ensure relevant health providers receive a copy of the discharge plan.	14+1	0	1+1	agree — agree ★★★★★	• Make the discharge plan an electronic record. • Best practice — work towards having the person's consent for transfer of information. • The discharge plan must be ready at the point of discharge.
38. provide patients with a detailed discharge plan including: • appointments with GPs and specialists • medicines to be taken after discharge (and a list explaining any medicines changed during treatment).	12	0	3	agree — agree ★★★★★	• Providing patients with a plan is essential. • The plan should be in writing and should be developed in partnership with the patient. • A plan is a good accountability tool. • This is the consumer's plan and their story. • Carers need to be involved in developing the plan because (a) it relieves stress and (b) it provides prompts.
39. for hospitals—arrange an appointment with the patient's GP or health centre before the patient is discharged.	15	0	1	agree — agree ★★★★★	• There are problems with doing this. For example: is the appointment kept? • The systems to achieve this need integrating with hospitals, community, the GP and other health care professionals.

Suggestion	Agree	Disagree	Needs Work	Agreement	Comments
40. develop and publicise a directory of secondary prevention service providers—for consumers, carers and health care professionals.	14	0	2	agree ★★★★★ agree/ needs work	• There needs to be a booklet on all available services and contact details. Keep it simple, but back it up with more detailed information. • Peer support should start before discharge.
41. for hospitals: as appropriate to patients' conditions and needs, organise a home visit within 5–10 days after discharge to: • check the patient's and carers' progress • provide counselling (both to the patient and their carers) • check the patient understands their condition and what they need to do to recover • check the patient has a recovery plan • check the patient knows what to do to reduce risks of further events, and prevent further damage • check the patient has all the medicines prescribed • check medicine use • check the patient's links with doctors, pharmacists, nurses, rehabilitation, physiotherapists and specialists.	11+1	0	4+1	needs work ★★★★★ agree/ needs work ★★★★★	• This is only relevant where these services are not already provided. • 5–10 days is far too long — there is a high risk of suicide. • People's memory is better immediately after discharge. • Carers need more support immediately after discharge. • Someone should go with the consumer to settle them in at home and follow up with a daily visit. • Give the consumer printed information at discharge. • There needs to be a Home Medicine Review within 48 hours by a qualified and informed Mental Health worker,ideally a trusted person. • Develop peer support network for referral.
Carers					
42. for carer groups and hospitals: • engage carers — particularly at diagnosis and discharge • inform carers on what they can expect while providing care • inform carers on risks they need to manage: social, financial, emotional and psychological • inform carers of the support and resources available • provide carers with psychological support.	10+2	0	3+2	—	• One gap is young people as carers. • Sort out privacy issues. • Train professionals to deal better with carers.

Suggestion	Agree	Disagree	Needs Work	Agreement	Comments
Support groups, consumer organisations					
43. for support groups: teach and encourage consumers to question their doctors and take responsibility for their health and long-term management.	11+1	1	3+1	—	• Use of support and peer groups for carers. • Carers have a problem with stigma as well as people with mental illness. • Encouragement needs to be broader than just the stated aim. • Train support groups in group skills, such as work skills, basic counselling skills, and good psycho-education • There need to be more support groups in regional and remote areas. • A patient-held record should be supported.
44. build links between support groups, prevention programs and rehabilitation programs.	14+1	0	1+1	—	• This suggestion needs rewording.
Specialists and general practitioners					
45. for professional bodies — find ways to improve communication between general practitioners and specialists, and promote these methods in the profession.	13		3	—	• MBS Item 291 needs promoting for greater uptake. • Psychiatrists need to behave more as consultants. • Need to look at broader models of care — shared care — and add allied health as well.
46. implement strategies already developed to reduce the administrative burden on general practices.	11	0	4	—	• Expand the role of the practice nurse. • Authority scripts for people on long-term antipsychotics; doing a care plan should be the gateway to medication, not just needing the medicine and getting the Authority. • There is the problem of starting a patient on medicine in hospital when they can't continue using it in the community.

Suggestion	Agree	Disagree	Needs Work	Agreement	Comments
Nursing					
47. encourage general practice to adopt practice nurses—in particular, for: • health assessments • preparing medication records • organising multidisciplinary health teams • educating patients and carers about medicines and lifestyle changes • counselling patients — particularly when prescribing medicines and lifestyle changes • medicine reviews • providing CMI.	8+2	1+1	4+3	—	• Need to invest in affordable training in mental health for practice nurses.
Professional education					
48. for medical courses: provide training courses where all health students work together, so young medical professionals accept working in cross-disciplinary teams as normal and desirable practice.	12	1	2	—	• Do problem-based learning with medical students and other disciplines, as well as in postgraduate and specialty training.
49. for medical courses: get consumer input into the design and presentation of courses so that students have a first-hand knowledge of consumers' needs.	12	1	2	—	• This suggestion should also include carers.
Pharmaceutical industry					
50. continue research to find medicines that are better tolerated by patients.	14	0	2		
51. design clinical trials to reflect real use of medicines.	11+1	0	4+1		
52. encourage adverse events reporting—by both consumers and health professionals and use this information in the design of new medicines.	12+1	0	2+1	—	• There should also be post-marketing surveillance.
53. find ways to reduce the number of medicines and doses that consumers have to take; for example, by developing 'poly-pills' and slow-release tablets.	8+1	0	7+1		
54. ensure packet information and labels for medicines can be read easily.	15	0+1	1+1		

Suggestion	Agree	Disagree	Needs Work	Agreement	Comments
55. overcome consumers’ confusion between generic and brand names.	10+1	0	4+1		
56. conduct research into complementary, herbal and alternative medicines in order to develop a rigorous evidence base for their use (or non-use).	12	0	3		
57. continue to develop information and educational materials for consumers and health professionals on medicines and their use in the larger treatment of disease.	13	0	2+1		
Mass media					
58. engage the media in health education. In particular, make them aware of: • the impact the media has on the lives of consumers and health professionals • their responsibilities reporting treatments, and • appropriate ways of reporting medical evidence, risks and benefits.	11	1	4		
Data to help improve practice					
59. where under or over-prescribing is detected in PBS data: • advise the doctor using the personalised NPS Prescriber Feedback • ask the doctor to review their prescribing practices, and explain good practice • give advice on alternatives to medicines and the use of lifestyle prescriptions.	7	2+1	6+1		
Clinical practice and advice					
60. reduce reliance on published guidelines to change the behaviour of health professionals, and use more effective educational methods.	7+1	0	8+1	needs work ★★★★	• Guidelines are necessary but not sufficient for clinical decision-making. • Reduce the rigidity of guidelines.
61. suggestion for software developers: further develop and implement decision support systems for health professionals.	9+1	0	6+1	needs work	

Suggestion	Agree	Disagree	Needs Work	Agreement	Comments
Continuity of care					
62. develop materials, training and incentives to implement the APAC Continuity of Medication Management Guidelines.	10+1	0	3	divided —	• The group does not understand the concept.
63. for health departments: develop ways to ensure continuity of funding when patients transfer between different health care settings in order to ensure financial support for continuity of care.	13+1	0	1	agree ★★★★★	
64. for departments of health: develop a whole-of-life health policy to integrate currently fragmented health policies.	15	0	1	agree ★★★★★	• This suggestion is probably impossible to implement.
65. for government: develop and promote a better understanding of the impacts of mental disorders on government portfolios outside health.	16	0	0	agree ★★★★★	
66. for departments of health: develop measures to break down internal policy silos, particularly at the project level.	12+1	0	3+1	agree ★★★★★	• If silos exist.
Medical records, IT and privacy					
67. for DoHA and Medicare Australia: develop and implement electronic health records for all Australians, along with appropriate privacy and confidentiality controls.	3	3	9	needs work —	• Confidentiality and discrimination could be a huge problem in developing e-health records. The principle is good, the issue is privacy. • In principle, this is urgent; in practice, it is not urgent.
68. make privacy policies easy for consumers, carers and health professionals to access, understand and act on.	13	0	3	agree ★★★★★	
69. ensure all patients are provided with consent forms and supporting information on the use and constraints on information gathered about them.	7	0	8	agree ★★★★★	• Consent forms should be provided in a manner consumers understand. There are issues regarding consent in languages other than English and low literacy.
70. develop and roll out infrastructure, software and training necessary to support e-health records and connectivity between health care providers.	8	1	6	needs work —	• If e-records are accessible across the community, this suggestion is urgent. Otherwise, it is a low priority.

Suggestion	Agree	Disagree	Needs Work	Agreement	Comments
Information, communication & promotion					
71. to help health professionals, researchers and funders avoid 're-inventing the wheel', develop and make public an inventory of mental health programs already in place for: • exercise • healthy eating • quitting smoking • medicine use • school programs • workplace programs • peer education programs • professional development courses • community programs.	11+1	0	3+1	agree/ needs work ★★★	• This material needs to be culturally appropriate and accessible in the users' preferred medium. • Resources must be developed in collaboration with consumers.
72. develop an easily-searchable portal or website of all medical evidence, guidelines and treatment options for health professionals.	9	0	7	needs work ★★★	• This is a huge task. Guidelines etc require interpretation. Need to provide education on how to use these. • Find out what materials and resources are already out there.
73. Review and improve processes for disseminating information on mental disorders in hospitals and support groups, and getting them used by consumers and carers.	8+2	0	5+2	needs work ★★★★★	• There are issues with consumers and carers having access to these resources. • Consumers and carers want and seek information actively — there is concern that it is not being provided.

Priorities for QUM in mental health

In the final session of the Workshop, participants were asked to discuss and nominate areas where they felt action is needed to achieve QUM in mental health. Because of the many potential topics, participants decided to focus on four areas that were of importance to them:

- access
- system integration
- mental health literacy
- information technology.

In developing their suggestions, participants were asked to bear in mind the six 'building blocks' of QUM:

1. policy development and implementation
2. provision of services and interventions
3. facilitation and coordination of services
4. education and training
5. objective information about, and ethical promotion of, medicines
6. research, evaluation and data collection.

Access

Wise selection of medicines

For the first discussion group, the two key issues to be addressed were access and knowledge—for consumers, their carers and health professionals. Areas that this group saw for developing understanding and knowledge were:

- for consumers and carers — knowledge of the disease
- what lack of treatment will result in
- long-term issues for the progress of the disease and of treatments
- an understanding of risks versus benefits, particularly of medicines
- side effects
- cost of medicines (and other treatments)
- for doctors and pharmacists: access to and use of online tools like MoodGYM (and extending such tools from depression to other mental illness areas and treatments, such as psychotropics).

Developing this knowledge requires access to:

- information technology
- networks.

Other access issues the group discussed were:

- 'step-up' and 'step-down' procedures
- access for prisoners to mental health services and medicines.

Selecting medications

A core problem seen by this group was ‘silo’ funding of shared services — particularly the split between the Australian Government for the PBS and the State governments for hospitals. The group felt that increased spending on medications would reduce the number of people being admitted to hospital — at a net saving to the community. The group suggested that funds saved this way should be returned to the PBS and used to pay for medicines that are currently not subsidised.

Another problem discussed by this group was the need to obtain an authority to prescribe many medicines, even when the consumer is stabilised on long-term medication. They made two suggestions to overcome this:

- develop a formal Mental Health Plan with the patient—which could include an on-going authority to prescribe
- have special funding arrangements under Section 100 for people on Compulsory Treatment Orders, to reduce the cost of treatment and the risk of polypharmacy.

Finally, the group suggested accrediting selected prescribers for prescribing in mental health — although participants recognised that this may lead to greater off-label and non-PBS use and problems with authorities.

Safety and assessment

The group wanted to see national data used to track access to medicines and health outcomes, and to improve therapies. Better use of data would allow tracking of concordance and the amount of on-and off-label prescribing. Once gathered, this data could be fed back to prescribers to improve therapy (just as the NPS currently provides feedback to prescribers). The group understood that this kind of feedback to prescribers had changed prescribing patterns and treatment outcomes in a number of other disease areas.

The group wanted to see eligibility for HMRs extended to all people on long-term psychotropic medicines.

The group felt that if a person is re-admitted to hospital or care within 28 days of discharge, they should qualify for a case manager or case management protocol.

Finally, the group wanted to see partnership agreements being developed between consumers, prescribers and psychiatrists to work on relapse prevention (particularly through reviewing the side effects of medicines).

System issues

The second discussion group explored existing programs and resources that could be adapted or adopted by mental health in three areas: peer support, action in the home, and professional development.

1. Existing peer support
    - the Council on the Ageing (COTA) already runs successful peer education which could be extended to mental health
    - support groups for both consumers and carers
    - Carers Associations in each State provide large amounts of education and training for carers.
2. In-home support
    - Practice Nurses — under the direction of GPs — could visit consumers’ homes to do work around medicines (extending programs that currently focus on the elderly)
    - health teams could do home visits after people are discharged, to do follow-ups and help the person maintain treatments established in care
    - Home Medicines Reviews, specifically for people with mental illnesses.

3. Professional development — the group used this term broadly to cover not only education within particular health professions, but also in building health teams and linking interest groups. Areas identified were:
   - development and use of in-patient medication groups
   - Primary Dispute Resolution (PDR) services
   - better discharge planning and transfer of information to GPs
   - more involvement of case managers in QUM
   - involvement of Centrelink, social workers and other government agencies that deal with the mentally ill
   - more meetings between GPs and psychiatrists
   - greater use of psychiatric nurses in general practice
   - greater development of Advance Directives about treatment—in the context of wellness planning.

Mental health literacy

This third discussion group started by recognising that there is substantial stigma attached to mental illness, medicines and treatments, and this needs to be broken down if consumers are to be treated effectively. The group pointed to the success of the New Zealand anti-stigma campaign in talking about people's medication experiences.

The group wanted to examine the way mental illness is portrayed, particularly in the media. Participants wanted to see guidelines developed for journalists writing about:

- mental illness
- treatments.

The group wanted to look at how information can be made interesting and balanced. Participants were concerned with the way the media can report a person taking medicine and becoming suicidal — such accounts need to be reported in a balanced way.

Health professionals need to understand the fear around medicines for some people — for example, about possible changes to their personality, or anatomical changes, or addiction. Consumers need to be informed about treatment options—including medicines. Both health professionals and consumers need to understand that medicines are not necessarily the only way of improving health and well-being. This requires not only a pharmacological understanding of medicines, but also a social and behavioural understanding. Guidelines are also needed on when to provide information.

The group felt that too much focus was going to GPs and this could be creating undue pressure on them. Participants wanted better involvement of other health professions. For example, nurses could be given training in providing information to consumers.

Finally, the group wanted more research on complementary treatments for mental illnesses — about what works and what does not.

Information technology

This fourth discussion group began by affirming the value of the internet as an information tool for consumers. But participants also felt that it is hard for consumers to find and access information and to distinguish between reliable information and ‘propaganda’. One suggestion was for the MHCA to put links on its website to the Therapeutic Goods Administration (TGA) so that consumers could know:

- what medicines are available
- what medicines are on the PBS and for what conditions.

Recognising that is not possible for such information or links to be on every mental health website, the group suggested that the MHCA develop an equivalent of the Heart Foundation’s ‘Heart Tick’. Website operators could apply to the MHCA and, if the information is judged sufficiently balanced and scientific, the MHCA could issue a tick so that consumers could know that the information is reliable.

Other ways that this group saw the internet being used included:

- for conducting distant consultations — potentially useful for people in remote areas. This could also be used to give GPs support from psychiatrists (extending existing programs which work well)
- e-prescribing — in particular, checks can be built into software which could decrease the number of prescribing mistakes made
- a common electronic care plan — accessible by the consumer, their GP, allied health professionals and psychiatrists. Internet access would mean that, when the plan is updated, everyone involved would be informed of what changes have been made. It could also incorporate a follow-up plan, like the system for Pap smears, which the group felt works very well. (Follow-up is very poor for mental health.)
- data linkage — for example, between hospitals, MBS and PBS, so that a consumer can be tracked from hospital to hospital to allow greater continuity of care and better health outcomes. In Western Australia, some datasets are already linked.

The group felt that research was still needed into electronic care plans and possible follow-up tools, to check whether they have value and clinical benefit. People also stressed that, if there is such research, consumer’s identities need to be protected — they should be informed about the research and should give consent.

Finally, this group underlined that doctors are not IT experts. They felt that, instead of expecting doctors getting their heads around complicated computer programs, it was better to give them expert IT support (which, in turn, will require funding).

Participants

Gillian Adamson	*Pfizer Australia*
John Aloizos	*APAC*
Douglas Bell	*Victorian Institute of Forensic Mental Health (Forensicare)*
Peggy Brown	*ACT Health*
Melanie Cantwell	*Consumers Health Forum*
Michael Cassar	*Psychiatric Disability Services of Victoria*
Christine Culhane	*Psychotropic Drug Advisory Service*
Ric Day	*PHARM*
Sophie Delaney	*Mental Health Legal Centre*
Danielle Elisha	*Beyond Blue*
Mary Emanuel	*Australian Self Medication Industry*
George Fink	*Mental Health Research Institute*
David Grainger	*Eli Lilly Australia*
Meg Griffiths	*Multicultural Mental Health Australia*
Ian Hickie	*Brain and Mind Research Institute*
Toni Higgins	*Victorian Law Institute Health Law Committee*
Cayte Hoppner	*Peninsula Health Psychiatric Service*
Caroline Johnson	*RACGP*
Penny Lewisohn	*The Network for Carers*
Tania Lim	*RACGP*
Gillian Malins	*NSW Consumer Advisory Group for Mental Health*
Grant Martin	*Pharmaceutical Society of Australia*
Jo-Anne Mazzeo	*Mental Health Review Board of Victoria*
Chris McAuliffe	*Australian Divisions of General Practice*
Ian McKnight	*Wyeth*
Monique McLaughlin	*AstraZeneca*
Micheal Moore	*Bristol–Myers Squibb*
Rob Ramjan	*Schizophrenia Fellowship of NSW*
Richard Reed	*Primary Mental Health Care Australian Resource Centre*
Sebastian Rosenberg	*Mental Health Council of Australia*
Yvonne Santen	*SANE Australia*
Gwen Scotman	*Mental Health Coordinating Council NSW*
Danielle Sellick	*Beyond Blue*
Margaret Springgay	*Mental Illness Fellowship of Australia*
Michael Summers	*Carers Victoria*
Sarah Tennant	*GlaxoSmithKline*
Julie Thompson	*Better Outcomes Implementation Advisory Group*
Patrick Tollen	*Peninsula Health Psychiatric Service*
Michelle Toner	*Faculty of Education*
Tori Wade	*SA Divisions of General Practice*
Katey Weedon	*University of Melbourne*
Lynn Weekes	*National Prescribing Service*
Neil Wildman	*Eli Lilly Australia*