Section 3:
Priority areas

Reducing suicide and deliberate self-harm in mental health services and related health service settings

Rationale

Suicides in mental health service settings may indicate a catastrophic system failure and can undermine public confidence in the mental health care system. They are tragic events that cause much grief and distress for families and friends, as well as for mental health professionals and other workers involved in their care, and for other consumers within the **mental health service**. Although suicides of people in the care of mental health services are not always preventable, it is acknowledged that there is scope for reducing some of these tragic events through improved systems of care.

Health Ministers agreed that 'suicide of a patient in an inpatient unit' is a **sentinel event** in health care, to be publicly reported by jurisdictions as one of a number of nationally agreed core sentinel events (see Appendix 8). This data will be included in the National Sentinel Event Report due to be released by the Australian Council for Safety and Quality in Health Care by the end of 2005.[11]

In addition to suicides in inpatient units, **adverse events** also include suicides occurring while mental health consumers are on day leave, or are absent without leave, and in the days and weeks immediately following discharge. This recognises that preventable suicides can occur as the result of omissions in care, for example as a result of lack of follow-up and continuity of care post-discharge. It is also argued that suicides occurring for periods up to a year following discharge from an inpatient unit are also serious events, particularly where consumers are in the care of community mental health services. Such suicides are commonly perceived by members of the community as a failure of the health care system.

Suicides are often preceded by suicide attempts and/or other acts of deliberate self-harm. However, not all self-harm behaviour is suicidal behaviour or related to suicidal thinking. Improved systems of assessment and management of deliberate self-harming behaviours may help to reduce suicides. A systems oriented approach to reducing suicides, suicide attempts and deliberate-self harm is needed, along with a non-punitive culture that rewards incident reporting and supports its use in continuous quality improvement.

The consultation (refer Appendix 4) indicated that improved suicide assessment and management was a shared safety priority across the range of stakeholders consulted.

Strategies developed for this action plan have been conceived to be complementary to efforts under the National Suicide Prevention Strategy and State and Territory suicide prevention policies.

11 All jurisdictions have commenced to collect sentinel event data. Two jurisdiction have publicly reported – Department of Human Services (2004) *Sentinel Events Program: Annual Report 2002-03*, Victorian Government Department of Human Services, Melbourne, May 2004 and NSW Health (2005) *Patient Safety and Clinical Quality Program: First report on incident management in the NSW public health system 2003-2004*, Sydney, January 2005.

TABLE 1:

Reducing suicide and deliberate self-harm in mental health services and related health service settings

Objectives	Reduced suicide in **mental health services**.
	Reduced suicide in acute health care services.
	Reduced suicide in the days immediately following discharge from inpatient care.[12]
	Reduced suicide within 28 days following discharge from inpatient care.[13]
	Reduced instances of suicide attempts in mental health services.
	Reduced instances of deliberate self-harm in mental health services.
	Reduced instances of suicide attempts within 28 days following discharge from inpatient care.
	Routine suicide risk assessment and management, and post-discharge follow-up within existing policies, protocols and clinical guidelines.
	Routine consideration of Coroner's recommendations for improving systems of care in mental health services to reduce suicides.
Priority settings	**Mental health services** (including the interface with public and private facilities).
	Acute care services outside mental health services, particularly emergency departments.
	Interface between mental health services and **primary care sector**, such as general practitioners, and non-government organisations.
	Other relevant settings as applicable, such as ambulance services and other approved transport providers and police services.
Known problem areas	Specialised mental health services (first days of admission, periods of leave, **discharge planning**, follow-up post-discharge, continuity of care between hospital and community based services and primary care services such as general practitioners and non-government organisations).
	Issues specific to accident and emergency hospital-based settings (triage, discharge planning, timely access to mental health assessments and staffing/resources/ workflow issues).
	Appropriate information and support for consumers and carers post-discharge, especially when current hospitalisation involves suicide attempt in care or prior to care, or where it is the first diagnosis of mental illness for a consumer.
	Absence of identified good practice in suicide risk assessment. Variability in protocols and application of protocols across hospitals/services and jurisdictions.
	Communication across the jurisdictions.
	Over-reliance on junior/trainee clinicians in emergency departments and mental health services.
	Risk factors related to the health service environment such as access to hanging points and belts, and other well documented risk factors.[14]

12 Jurisdictions have differing protocols and information collection requirements. There is consensus that monitoring is needed but the time period for monitoring varies across jurisdictions from 5-28 days post discharge.

13 Agreed Phase 1 KPIs for public specialised mental health services include '28 day readmission'.

14 Refer to National Suicide Prevention Strategy documents and other evidence-based sources.

TABLE 1: *(continued)*

Reducing suicide and deliberate self-harm in mental health services and related health service settings

Strategies	Identify and disseminate good practice in suicide risk assessment and management, and review existing protocols and clinical guidelines of mental health services and related health services. This will include examining good discharge planning, risk assessment, and outcomes measurement. This will include consideration of variations in good practice related to particular settings, eg child and adolescent mental health services. Identify good practice services/leaders and facilitate their role in influencing clinical and service management change system-wide. Implement and use **incident monitoring and management systems** for monitoring instances of deliberate self-harm, suicide attempts and suicides. If a sentinel event of 'suicide in an inpatient unit' occurs ensure that the relevant service policy on **open disclosure** is followed and post suicide bereavement information resources are available to families and significant others[15] Ensure appropriate processes are in place to support staff. Investigate, using tools such as **root cause analysis**, all suicides that occur whilst consumers are in the care of hospitals (mental health services and other parts of the hospital) and community components of public specialist mental health services. Investigate, using tools such as **root cause analysis**, all suicides that are known to have occurred within one year post-discharge from acute care or specialist mental health service care. Develop education and training strategies for supporting services to use tools such as **root cause analysis** after suicides. Develop nationally consistent measures for recording, classifying and reporting of all suicides of mental health consumers in the care of mental health services and acute care, as well as for reporting of suicides within one year of discharge. Implement existing clinical practice guidelines for the management of deliberate self-harm.[16] Ensure that systems are in place to automatically consider Coroner's findings, disseminate lessons, and ensure appropriate changes to systems. Evaluate changes in practice and outcomes.

15 Some resources have been prepared under the National Suicide Prevention Strategy that may be appropriate here. See www.community-life.org.au for information support packs for suicide and sudden death. This web site also provides information on training and education opportunities for carers and others who want to be able to assist their loved ones who are suicidal, for example ASSIST training (LivingWorks) that is specifically targeted at carers.

16 Australasian College for Emergency Medicine, *Guidelines for the management of deliberate self-harm in young people* and Royal Australian and New Zealand College of Psychiatrists, Guidelines for the management of deliberate self-harm in adults.

TABLE 1: *(continued)*

Reducing suicide and deliberate self-harm in mental health services and related health service settings

Complementary/ linked strategies/ activities	National Suicide Prevention Strategy. Existing State and Territory suicide prevention strategies. *National Action Plan for Promotion Prevention and Early Intervention in Mental Health 2000.* Australian Council for Safety and Quality in Health Care, particularly national sentinel event reporting, Open Disclosure Standard. Existing State/Territory initiatives targeting areas identified in the above strategies, for example South Australian guidelines for reporting and managing sentinel events that include compulsory root cause analysis for suicide within 28 days of discharge. Implementation of Royal Australian and New Zealand College of Psychiatrists (RANZCP) Clinical Practice Guidelines for management of deliberate self-harm (adults). Australasian College for Emergency Medicine *Guidelines for the management of deliberate self-harm in young people.* Existing non-government initiatives, for example Lifeline's 'buddy' program to support consumers post-discharge from mental health services.

Reducing use of, and where possible eliminating, restraint and seclusion

Rationale

The United Nation's *Principles for the protection of people with mental illness and the improvement of mental health care* states that:

> *'Physical restraint or involuntary seclusion of a patient shall not be employed except in accordance with the officially approved procedures of the mental health facility and only when it is the only means available to prevent immediate or imminent harm to the patient or others. It shall not be prolonged beyond the period which is strictly necessary for this purpose. All instances of physical restraint or involuntary seclusion, the reasons for them and their nature and extent shall be recorded in the patient's medical record. A patient who is restrained or secluded shall be kept under humane conditions and be under the care and close and regular supervision of qualified members of the staff. A personal representative, if any and if relevant, shall be given prompt notice of any physical restraint or involuntary seclusion of the patient.'*[17]

This Plan endorses the United Nation Principle and supports the enactment of the Principle in domestic legislation.

There is considerable variation in the clinical **standards** governing the use of **restraint** and **seclusion** in mental health services and guiding the appropriate use of the interventions or the use of alternative strategies. The goal of the Plan is to reduce the use of these interventions, and the **adverse events** that accompany them. However, it is acknowledged that there are situations where it is appropriate to use interventions such as restraint and/or seclusion but only as a safety measure of last resort. It is clear that restraint and seclusion are not a substitute for inadequate resources and are not to be used as a method of punishment, and if used in either of these ways is a serious contravention of consumer rights.

A systems oriented approach to reducing restraint, seclusion and associated adverse events is needed, along with a non-punitive culture that rewards incident reporting and supports its use in continuous quality improvement.

There is a close relationship between the use of restraint and seclusion and serious adverse events. The known adverse events associated with use of restraint and seclusion include dehydration, choking, circulatory and skin problems, loss of muscle strength and mobility, pressure sores, incontinence and injury from associated physical/mechanical restraint, injury from other patients, increased psychological distress and, in rare circumstances, death. It is essential that restraint and seclusion be used in a manner consistent with defined protocols for safe management of the consumer.

Rapid sedation, where it is used in mental health emergency situations as an alternative to mechanical/physical restraint, is considered restraint by consumers, carers and others, and carries its own risk of adverse events. However, at this time there is no definitive agreed definition of restraint that includes rapid sedation. Incidents and adverse medication events related to sedation, however, are considered adverse drug events.

Currently States and Territories and mental health services have a range of documented policies and/or protocols for use of these interventions. State and Territory mental health legislation includes specific requirements related to use of these interventions. The *Model Mental Health Legislation* funded under the National Mental Health Strategy for use by States and Territories when reviewing their mental health legislation, included model clauses on seclusion and restraint.

The consultation (refer Appendix 4) indicated that the safety of consumers, staff and others in situations related to restraint use was a high safety priority across sectors.

17 UN principles for the protection of people with a mental illness, Principle 11, paragraph 11.

TABLE 2:

Reducing use of, and where possible eliminating, restraint and seclusion

Objectives	Reduced use of, and where possible elimination of, restraint in mental health emergency situations. Reduced use of, and where possible elimination of, restraint in **mental health services.** Reduced use of, and where possible elimination of, seclusion in mental health services. Reduced adverse events associated with use of **restraint.** Reduced adverse events associated with use of **seclusion.** Clear protocols guiding the use of restraint are in use in mental health services and other health services. Clear protocols guiding the use of seclusion are in use in mental health services and other health services.
Priority settings	Mental health services (particularly inpatient settings). Acute care services outside mental health services, particularly emergency departments. Any setting in which restraint and seclusion of consumers is practiced based on a view that they are suffering from a mental heath problem.
Known problem areas	Lack of identified good practice/agreed clinical standards for the use of restraint. No national standards on appropriate use of restraint currently exist. Lack of identified good practice/agreed clinical standards for the use of seclusion. No national standards on appropriate use of seclusion currently exist. Inappropriate use of interventions and variation in practice, for example using threat of restraint or seclusion to coerce particular behaviour. Known adverse events associated with use of restraint and seclusion. Lack of staff knowledge or skills to prevent use and identify and use alternative interventions or to safely use restraint and seclusion interventions in emergency situations. Lack of staff knowledge or skills regarding appropriate triaging of mental health presentations, particularly in emergency departments. Despite restraint being commonly practised in emergency departments, there is a lack of training about restraint practices and a lack of documentation and **clinical audit** of restraint practices. Aggressive and violent behaviours are common triggers for the use of restraint and seclusion. Lack of staff training and knowledge about early warning signs of agitation and aggression and effective interventions to prevent the use of seclusion and restraint.

TABLE 2: *(continued)*

Reducing use of, and where possible eliminating, restraint and seclusion

Strategies	Implement and use **incident monitoring and management systems** for quality improvement by monitoring and managing: • instances where restraint is used; • instances where seclusion is used; • adverse events that occur whilst a consumer is restrained (whether the injury is to consumer or other); and • adverse events that occur whilst a consumer is secluded (whether injury to consumer or other). Investigate adverse events proximal to restraint and seclusion using known tools/methodologies such as **Root Cause Analysis**. Ensure that outcomes of such analysis are fed into quality improvement processes. Propose that the Australian Council for Safety and Quality in Health Care support the inclusion of all deaths in acute health care that are proximal to use of restraint and seclusion in the national set of core sentinel events. Develop national **standards** for the use of restraint. Identify good practices in the prevention, reduction and, where possible, elimination of restraint that are applicable across jurisdictions and settings. Develop standards for the monitoring and reporting of restraint and identifying alternatives to the use of restraint that are applicable across settings and jurisdictions. Develop national standards for the use of seclusion. Identify good practices in the prevention, reduction and, where possible, elimination of seclusion that are applicable across jurisdictions and settings. Develop standards for the monitoring and reporting of seclusion and identifying alternatives to the use of seclusion that are applicable across settings and jurisdictions. Develop an education and training strategy for management of aggression including techniques for prevention and de-escalation as an alternative to using restraint and seclusion. Consumer and carer experiences and participation are integrated into education and training strategies, products and activities. Implementation and staff education about the national triage guidelines for emergency departments and the Mental Health Triage Scale. Ensure mental health services and related health services (especially emergency departments and other acute care services) have in place policies and procedures for use of restraint and seclusion and consider **clinical audits** of restraint and seclusion as part of quality improvement processes. Evaluate changes in practice and outcomes.
Complementary/ linked strategies/ activities	Existing State/Territory initiatives (such as mandatory reporting of use of mechanical restraint in some States, existing legislation, protocols and policies). Australian Council on Healthcare Standards (ACHS) **Clinical Indicators** for Mental Health include seclusion indicators.

Reduce adverse drug events in mental health services

Rationale

The primary focus of this priority area is to reduce **adverse drug events** in a mental health service delivery context. **Medicines** are a critical element in the treatment of many mental health disorders. However, it is essential that medicines are administered in accordance with evidence based guidelines and closely monitored. **Medication errors** can lead to serious consequences for mental health consumers, including death. Health Ministers have agreed that 'Medication error leading to death of a patient reasonably believed to be due to incorrect administration of drugs' is a publicly reportable sentinel event. The consultation indicated that medication prescribing and administering errors were a high safety priority.

Psychotropic medicines have well known side-effects and contraindications, some of which are associated with serious adverse medication reactions if not adequately monitored. There are also a range of other adverse drug events that occur in mental health care, such as medication errors, which can be reduced through enhanced monitoring and management of psychotropic medicines. Consumers can be on psychotropic medications for long periods of time and may also be taking other medications for other conditions (eg concurrent physical illness or concurrent substance use disorders) or may be under the care of multiple health care professionals.

Mental health professionals are well aware of the occurrence of **adverse drug reactions**, however, adverse drug events in mental health service settings, including medication errors, are not well researched. A systems oriented approach to reducing adverse drug events is needed, along with a non-punitive culture that rewards error reporting and supports its use in continuous quality improvement.

The *National Mental Health Plan 2003-2008* identifies the safe and **quality use of medicines** as a key action towards improving safety. The *National Standards for Mental Health Services* state that medicines and other medical technologies are provided in a manner that promotes choice, safety and the best possible quality of life for the consumer. Standard 11.4.C specifically states that mental health services must ensure a system exists for monitoring medicines and properly treating any adverse drug events.

There are a range of initiatives in the area of quality use of medicines and medication management that are complementary to the focus of this Plan and that aim to improve the safe and quality use of psychotropic and other medicines.

TABLE 3:

Reduce adverse drug events in mental health services

Objectives	Reduced **adverse drug events** (ADEs) in mental health services. Reduced **medication errors** involving psychotropic medicines within mental health services and other health services. Increased safe and quality use of psychotropic medicines in mental health services and other health services.
Priority settings	**Mental health services.** Hospital pharmacy services. Other settings, such as primary care settings and mental health consumer home/community settings (see linked strategies below).
Known problem areas	Known side-effects of common psychotropic medicines (such as the anti-psychotic clozapine and movement disorders). Contraindications. Problems related to concurrent medicines (**polypharmacy**) and comorbidities, for example with depression and diabetes. Problems related to concurrent drug and alcohol use and medicine use. Problems with identifying and recording all medicines that may have contributed to an adverse drug event, including prescribed medicines, illicit drugs, over-the-counter drugs and complementary medicines. Non-oral sedation, particularly when used in emergency psychiatric care. **Medication error** (dosage, dispensing, prescription, wrong person). Problems related to changing medicines, such as switching between antidepressants particularly those within the Selective Serotonen Reuptake Inhibitors (SSRI) group. Overdose, both intentional and accidental. Consumer concerns about side-effects of medicines and their impact on quality of life. Lack of clear mechanisms for consumers and carers to: report adverse drug events; to input into quality improvement in the use of medicines; and to provide information on their perceptions of care in relation to medicines. Lack of information provided to consumers about their medicines. Lack of information provided to carers about medicines and changes to medicines, affecting their ability to support consumers. Lack of knowledge of the effects of psychotropic medicines, particularly antidepressants and antipsychotics for which there is a high demand for information. Differing effects of prescription medicines on people from differing gender, cultural and linguistic groups, including Aboriginal and Torres Strait Islander peoples, and the need for further work to identify appropriate and safe use of prescription medicines for specific populations, such as children and adolescents, where needed. Related adverse events such as injury through falling. People on psychotropic medicines are at increased risk of falls. Weight gain as a side effect of antipsychotic medicines.

TABLE 3: *(continued)*

Reduce adverse drug events in mental health services

Strategies	Identify good practice in prescribing and monitoring psychotropic medicines and other evidence-based medicines in mental health services, including specific protocols to document variance from recommended prescribing guidelines, lessons and principles with potential application in other settings, consumer and carer input into decision-making and monitoring processes, communication between different treatment services, and the use of new technologies, such as electronic/computerised prescribing tools. Develop and implement medication monitoring protocols, electronic systems and documentation practices to flag safety and quality issues and improve medication management systems in mental health services. Include decision support algorithms in such electronic systems. Establish information management systems to detect and report adverse drug events in mental health services at a national level. Such systems to be integrated within existing information management systems and processes. Raise awareness of medication errors in mental health care delivery, drawing on lessons from other areas of health care in regards to systems changes and improvements. Identify good practice services/leaders and facilitate their role in influencing clinical and service management change. Include consumer and carer perspectives in clinical and service management change processes. Implement clinical practice guidelines in public and private specialised mental health services and other related services, such as primary care, hospital pharmacies, and private office-based psychiatric services. Develop information packages on the use of medicines that are designed for use by consumers and carers as part of individual care planning and integrated into **discharge planning** and practice. Use existing information packages where available and where they match the consumer and carer information needs. Ensure provision of accurate information to consumers, and where appropriate their carers, about the safe and quality use of their medicines. Ensure such information is integrated into the routine care planning and monitoring. This may require education of health professionals about the need to communicate with consumers about matters of concern to them, such as adverse medicine events. Evaluate changes in practice and outcomes.

TABLE 3: *(continued)*

Reduce adverse drug events in mental health services

Complementary/ linked strategies/ activities	The **Quality Use of Medicines** in Mental Health Subgroup of the Better Outcomes Implementation Advisory Group was established to work collaboratively with the Pharmaceutical Health and Rational Use of Medicines Committee (PHARM) to improve quality use of medicines in primary mental health care through the Better Outcomes in Mental Health Care initiative. Mainstream health policies and strategies such as National Medicines Policy, National Strategy for Quality Use of Medicines and the activities of bodies such as the Adverse Drug Reactions Advisory Committee (ADRAC), PHARM, the Australian Pharmaceutical Advisory Council (APAC), National Prescribing Service, *HealthConnect*, and the Therapeutic Good's Administration. Professional practice standards for the provision of **Consumer Medicine Information** (CMI) by pharmacists. Australian Council for Safety and Quality in Health Care initiatives, eg such as the national medication alert system, national sentinel event reporting, Medication **Breakthrough Collaboratives**, Medication Safety Innovation Awards Program, development of a common inpatient medication chart, *10 tips for safer health care.* Implementation of RANZCP Clinical Practice Guidelines for: major depression; schizophrenia; anorexia nervosa; bipolar disorder; and panic disorder and agoraphobia. Improved use of existing information products and services, for example CMI, ***Medimate,*** *Medicines Line, Adverse Medicine Events (AME) Line, Australian Adverse Drug Reactions Bulletin,* SANE Australia's information for consumers and carers on antipsychotic and antidepressant medicines. National Institute of Clinical Studies (NICS) projects and initiatives. Existing State and Territory initiatives, such as the Queensland Health Medication Management Service, and information pamphlets. ACHS **Clinical Indicators** for Mental Health include indicators related to prescribing patterns of psychotropic medicines.

Safe transport of people experiencing mental disorders

Rationale

A range of agencies have statutory or service responsibility for providing transport of people experiencing mental disorders, or suspected of experiencing mental disorders. Arrangements vary across jurisdictions. Frequently transport of mental health consumers, when it is not provided by carers, families or consumers themselves, is organised and undertaken by community mental health professionals. Ambulance services, police services, air services, and occasionally private companies, may also play a role in transporting mental health consumers to treatment and assessment services. While generally the transport of mental health consumers by service providers is **incident** free, it is apparent that incidents are more likely to arise in **mental health crisis situations**.

Clearly mental health consumers have the right to safe transport that minimises interference with their rights, dignity and self-respect and that avoids traumatising family members, particularly children. This right, however, needs to be balanced with the safety of the transport provider.

In the consultation (refer Appendix 4) transport providers indicated that transportation of people experiencing mental disorders is a high priority, both in terms of the safety of mental health consumers and the personal safety of staff and others. The use of **restraint**, including sedation, during transportation was also a high priority issue for transport providers.

Mental health consumers are frequently sedated and/or restrained by service providers during transportation. They may also experience significant stigma that adds to psychological distress and creates a negative perception of care.

A systems oriented approach to reducing adverse events and overly restrictive interventions during transportation is needed, along with a non-punitive culture that rewards incident reporting and supports its use in continuous quality improvement.

The least restrictive safe transport of people experiencing mental disorders cannot be achieved without considerable partnership activity between all services involved and processes that include consumer and carer participation. As many transport provider services are outside the governance structures of mental health services, developing strategies for improving safety needs to occur in consultation with the police services, ambulance services and other transport services.

TABLE 4:
Safe transport of people experiencing mental disorders

Objectives	Mental health consumers are safe during transportation. Staff involved in transportation are safe. Reduced adverse events associated with transport of people experiencing mental disorders. Clear policies and protocols to ensure that the least restrictive safe transport of people experiencing a mental illness are used.
Priority settings	**Mental health services.** Ambulance services. Air services, for example the Royal Flying Doctor Service. Police services. Other services, such as private contractors that provide transport of mental health consumers.
Known problem areas	Emergency transportation in **mental health crisis situations.** Restraint use during transport. Routine use of sedation during transportation regardless of circumstances. Heavy sedation that requires consumers to be intubated is a major medical intervention that carries its own risks of adverse drug events. Reliance on police to apprehend and transport consumers known to mental health services when alternative means are available. Police transporting consumers without the support of clinical staff. Adverse events associated with transport with or without restraint use, including adverse drug events. Stigma experienced by consumers from emergency care providers. Transport from and within rural/remote settings. Timeliness of transport between hospitals, particularly between private and public mental health services.

TABLE 4: *(continued)*

Safe transport of people experiencing mental disorders

Strategies	Convene a cross-sector workshop to develop common directions in identifying best practice in the safe transport of people with mental illness. Identify good practices and policies for the safe transport of people with mental disorders, in consultation with mental health consumers and carers, mental health services and emergency services, such as emergency departments, police, ambulance, air ambulance/Royal Flying Doctor Service. Assessment/review of the suitability and design of vehicles used in transportation, including air and road ambulance and police vehicles. Best practices and innovations are identified and disseminated. This includes staff education and training being provided where required. Monitor and report instances of incidents during transportation between services and use this information for quality improvement. Identify good practice services/leaders and facilitate their role in influencing clinical and service management change across the services that provide transport. Mental health services develop protocols about working with other agencies and training staff in transporting mental health consumers. Clarify legislative issues in existing and future protocols about working with emergency services. Implement existing recommendations for joint information sharing protocols and practices in mental health crisis situations.[18] Ensure clear joint protocols and practices for sharing information in mental health crisis situations between mental health services and relevant emergency services are in place.[19] Develop mechanisms to improve skills, competence and confidence of mental health professionals in engaging with their consumers and carers. Identify and/or develop models of transportation practice where mental health consumer or carer advocates/representatives are involved in supporting mental health consumers and carers during, or prior to, transportation. Evaluate changes in practice and outcomes.
Complementary/ linked strategies/ activities	Existing State/Territory initiatives, such as the South Australian policy on emergency transport of mental health consumers from country locations.

18 Recommendations regarding establishing such information sharing protocols can be found in – Expert Advisory Committee on Information Sharing in Mental Health Crisis Situations (2000) *Toward a national approach to information sharing in mental health crisis situations*, Commonwealth Department of Health and Aged Care, February 2000.

19 ibid.