Caring for people displaying acute behavioural disturbance

Clinical guidance to improve care in emergency settings
# Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Introduction</strong></td>
<td>2</td>
</tr>
<tr>
<td>1. Assessment</td>
<td>4</td>
</tr>
<tr>
<td>Where to get assessment information</td>
<td>4</td>
</tr>
<tr>
<td>Where to assess</td>
<td>4</td>
</tr>
<tr>
<td>How to assess level of distress and sedation</td>
<td>5</td>
</tr>
<tr>
<td>Underlying causes of acute behavioural disturbance</td>
<td>6</td>
</tr>
<tr>
<td>2. Transition from prehospital care</td>
<td>7</td>
</tr>
<tr>
<td>Pre-arrival notification</td>
<td>7</td>
</tr>
<tr>
<td>Preparing for arrival</td>
<td>7</td>
</tr>
<tr>
<td>Handover and transfer of care</td>
<td>8</td>
</tr>
<tr>
<td>3. De-escalation</td>
<td>9</td>
</tr>
<tr>
<td>How to de-escalate</td>
<td>9</td>
</tr>
<tr>
<td>Verbal de-escalation</td>
<td>10</td>
</tr>
<tr>
<td>4. Sedation and ongoing care post-sedation</td>
<td>11</td>
</tr>
<tr>
<td>When to give sedation</td>
<td>11</td>
</tr>
<tr>
<td>How to give sedation</td>
<td>12</td>
</tr>
<tr>
<td>Post-sedation care</td>
<td>14</td>
</tr>
<tr>
<td>5. Physical and mechanical restraint and ongoing care while restrained</td>
<td>15</td>
</tr>
<tr>
<td>When to restrain</td>
<td>15</td>
</tr>
<tr>
<td>How to restrain</td>
<td>16</td>
</tr>
<tr>
<td>Post-restraint care</td>
<td>18</td>
</tr>
<tr>
<td>6. Transition from the emergency care setting</td>
<td>19</td>
</tr>
<tr>
<td>Debriefing and feedback</td>
<td>19</td>
</tr>
<tr>
<td>Admission</td>
<td>19</td>
</tr>
<tr>
<td>Transfer considerations</td>
<td>20</td>
</tr>
<tr>
<td>Discharge</td>
<td>20</td>
</tr>
<tr>
<td>7. Staff support and case review</td>
<td>22</td>
</tr>
<tr>
<td>Staff support</td>
<td>22</td>
</tr>
<tr>
<td>Case review</td>
<td>22</td>
</tr>
<tr>
<td>Glossary of terms and abbreviations</td>
<td>23</td>
</tr>
</tbody>
</table>
Introduction

Everyone deserves to feel safe in emergency care settings, but this can be challenging when caring for people experiencing acute behavioural disturbance. This clinical guidance aims to support emergency care clinicians to provide person-centred, evidence-based care for some of our most vulnerable Victorians.

How to use this clinical guidance

This guidance provides advice for emergency clinicians caring for a person displaying acute behavioural disturbance. Assessment is an ongoing and repeating core component of care, so is presented first alongside six other possible moments:

1. assessment
2. transition from prehospital care
3. de-escalation
4. sedation and ongoing care post-sedation
5. physical and mechanical restraint and ongoing care while restrained
6. transition from the emergency care setting
7. staff support and case review.

This clinical guidance applies to adults aged 16–65 years of age, with acknowledgement that some concepts may apply to people outside this range. It applies to people in emergency departments and urgent care centres and may be adapted for prehospital care such as ambulance services. It does not apply to people with a clear organic cause for their acute behavioural disturbance such as a closed head injury, dementia or delirium.

We have also developed an A3 size quick reference visual summary (Appendix 1) to use with this guidance.

Key principles

The key principles that underpin this guidance are:

- safety for all
- provide the least restrictive care possible
- value and partner with the person and their networks
- reduce unwarranted variation in care
- practical and evidence-based guidance
- effective communication.

1For guidance on managing children displaying acute behavioural disturbance see the Royal Children’s Hospital guidelines.
Guidance development

This guidance was developed by experts including clinicians and healthcare consumers and underwent public consultation. You can read about our development method and supporting evidence in the clinical guidance supplement.

Acknowledgements

The ‘Physical and mechanical restraint and ongoing care while restrained’ section of this clinical guidance has been adapted with permission from the Alfred Health 2019 guideline ‘Physical and mechanical restraint: assessment and application’.
1. Assessment

Assessment is the interpretation of all information available at that moment in time. The aim is to learn how a person displaying acute behavioural disturbance can be best supported, including identifying any underlying causes of the behaviour and the most appropriate care.

Assessment is an ongoing and repeating process. Frequent engagement with the person can help you learn more about them and prevent escalation. The clinical condition of people displaying acute behavioural disturbance can change quickly, so regular reassessment is very important.

WHERE TO GET ASSESSMENT INFORMATION

Be aware of the past experiences and individual needs of the person such as cultural identity, gender identity, trauma history and preferred language.

Seek assessment information from many sources, for example:

- the person
- family, carers, friends of the person while respecting the person’s right to privacy
-prehospital care staff handover
- previous medical records, including electronic medical records
- emergency department management plans
- My Health Record
- advance statements and wellness plans
  – access these on the client management interface (CMI)
- community treatment team
- behavioural support plans.

Maintain safety for all: know when to call for help

Do not attempt to care for a person displaying acute behavioural disturbance without adequate support or resources. Emergency care settings with fewer resources may have lower thresholds for escalation and referral.

Activate your health service’s emergency response procedures if you feel unsafe, including code grey or code black. The Department of Health and Human Services (DHHS) has also prepared some weapons management principles and guidelines.

WHERE TO ASSESS

Assess the person in a safe space where distractions are minimised and you can give your full attention. Remove bystanders and unnecessary staff, acknowledging that family and carers may be important during assessment.

Use a behavioural assessment room (BAR) if available, adhering to the DHHS ‘Guidelines for behavioural assessment rooms in emergency departments’. If unavailable, assess the person in the highest acuity area possible, such as a resuscitation bay.
HOW TO ASSESS LEVEL OF DISTRESS AND SEDATION

Use the sedation assessment tool (SAT) in Table 1 to measure and describe the person’s level of distress and sedation throughout the care episode.

Table 1: Sedation assessment tool (SAT)

<table>
<thead>
<tr>
<th>Score</th>
<th>Responsiveness</th>
<th>Speech</th>
</tr>
</thead>
<tbody>
<tr>
<td>+3</td>
<td>Combative, violent, out of control</td>
<td>Continual loud outbursts</td>
</tr>
<tr>
<td>+2</td>
<td>Very anxious and agitated</td>
<td>Loud outbursts</td>
</tr>
<tr>
<td>+1</td>
<td>Anxious/restless</td>
<td>Normal/talkative</td>
</tr>
<tr>
<td>0</td>
<td>Awake and calm/cooperative</td>
<td>Speaks normally</td>
</tr>
<tr>
<td>−1</td>
<td>Asleep but rouses if name is called</td>
<td>Slurring or prominent slowing</td>
</tr>
<tr>
<td>−2</td>
<td>Responds to physical stimulation</td>
<td>Few recognisable words</td>
</tr>
<tr>
<td>−3</td>
<td>No response to stimulation</td>
<td>Nil</td>
</tr>
</tbody>
</table>

While not always present, increased frequency or intensity of behaviours described by the STAMP framework in Table 2 may indicate increasing distress and predict behavioural escalation.

Table 2: STAMP framework of behaviours that may indicate increasing distress

<table>
<thead>
<tr>
<th>Staring</th>
<th>Tone and volume of voice</th>
<th>Anxiety</th>
<th>Mumbling</th>
<th>Pacing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prolonged glaring at staff</td>
<td>Sharp retorts</td>
<td>Flushed appearance</td>
<td>Talking under their breath</td>
<td>Walking around confined areas</td>
</tr>
<tr>
<td>Absence of eye contact (culture and disability dependent)</td>
<td>Sarcasm</td>
<td>Hyperventilation</td>
<td>Criticising care just loud enough to be heard</td>
<td>Walking back and forth to staff station</td>
</tr>
<tr>
<td></td>
<td>Increased volume</td>
<td>Rapid speech</td>
<td>Repetition of same or similar phrases</td>
<td>Flailing around in bed</td>
</tr>
<tr>
<td></td>
<td>Demeaning inflection</td>
<td>Expressed lack of understanding about care processes</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
UNDERLYING CAUSES OF ACUTE BEHAVIOURAL DISTURBANCE

Consider the underlying causes of acute behavioural disturbance in Table 3. Some underlying causes can be serious and possibly life threatening.

These require immediate intervention and can be identified by these ‘red flag indicators’:

- first episode of acute behavioural disturbance in a person aged 45 years or older
- abnormal vital signs
- evidence of a head injury
- focal neurologic findings
- decreased awareness with difficulty paying attention
- substance withdrawal or intoxication
- no clear trigger for behaviour in people with intellectual disability or autism
- exposure to toxins.

Medical investigations are not routinely indicated. However, when safe and appropriate always obtain a:

- detailed history
- physical examination, at an appropriate and safe time
- set of vital signs (heart rate, respiratory rate, blood pressure, temperature, conscious state)
- blood sugar level.

Table 3: Possible underlying causes of acute behavioural disturbance

<table>
<thead>
<tr>
<th>Non-medical</th>
<th>General medical</th>
<th>Psychiatric</th>
<th>Intoxication or withdrawal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relationship conflict</td>
<td>Head trauma</td>
<td>Psychotic disorders</td>
<td>Alcohol</td>
</tr>
<tr>
<td>Anniversaries of past traumatic events</td>
<td>Encephalitis, meningitis or other infection</td>
<td>Mania</td>
<td>Nicotine</td>
</tr>
<tr>
<td>Interactions with police or security staff</td>
<td>Encephalopathy, particularly from liver or renal failure</td>
<td>Agitated depression</td>
<td>CNS stimulants e.g. cocaine, amphetamine-type substances</td>
</tr>
<tr>
<td>Distress experienced by people with intellectual disability or autism</td>
<td>Toxins, including prescription medication</td>
<td>Anxiety disorders</td>
<td>CNS depressants e.g. GHB, benzodiazepines, opioids</td>
</tr>
<tr>
<td>Family violence</td>
<td>Metabolic derangement e.g. hyponatraemia</td>
<td>Personality disorders</td>
<td>Novel psychoactive substances e.g. synthetic cannabinoids</td>
</tr>
<tr>
<td>Prehospital care</td>
<td>Hypoxia</td>
<td></td>
<td>Hallucinogens and dissociatives e.g. LSD, magic mushrooms</td>
</tr>
<tr>
<td></td>
<td>Thyroid disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Seizures or postictal</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Pain, especially in people with intellectual disability or autism</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
2. Transition from prehospital care

This section applies if the person displaying acute behavioural disturbance has received prehospital care such as from paramedics, police or a community treatment team.

**PRE-ARRIVAL NOTIFICATION**
Anticipate pre-arrival notification from prehospital care providers if the person they are transporting is:

- agitated, with a SAT score above zero
- escorted by police
- sedated with parenteral medication
- physically or mechanically restrained.

**PREPARING FOR ARRIVAL**

- Allocate a safe and private care space that minimises interruptions. Use a BAR if available.
- Assemble a team of adequately skilled and trained staff to receive care of the person. This will vary with local resources but may include:
  - staff who are part of your health service’s code grey response
  - senior medical staff
  - senior nursing staff
  - nursing staff
  - mental health clinicians
  - security staff.
- Allocate roles for team members, including one person as lead communicator.
- Discuss and prepare de-escalation strategies.
- Discuss and prepare to meet the person’s unique needs such as sensory items, gender identity, cultural identity and language preference.
- Prepare any medications that might be needed for urgent sedation after clinical assessment.
- Ensure that emergency resuscitation equipment is readily available and in working order.
- If you reasonably think it may be required, ensure equipment for physical or mechanical restraint is available and in working order. Do not have this visible to the person.
- Access medical records, advance statements and wellness plans, including from external systems such as the CMI and My Health Record.
- Consider if a planned code grey response is needed, according to your health service’s procedures.
HANDOVER AND TRANSFER OF CARE

When safe to do so, explain the handover process to the person displaying acute behavioural disturbance and invite them to share information at the end of handover.

Use a structured handover tool to communicate information between care teams. Include information about:

- the precipitating event
- the person’s wishes for care
- de-escalation techniques used
- the effects of medication given, including SAT score
- the social situation
- members of the person’s network who may positively or negatively affect care
- medical, drug and alcohol, mental health and any other relevant history.

Do not share information with members of the person’s network without consent.
De-escalation is the combination of strategies, techniques and methods to reduce a person’s agitation or aggression. It involves verbal and non-verbal communication, environmental modification and working with the person to find solutions. Begin de-escalation early to have the best chance of success.

The aim is to support the person displaying acute behavioural disturbance to calm their behaviour and regain control. Assign only one clinical staff member as the lead communicator to guide de-escalation.

### De-escalation training resources
- The Safewards model is designed to improve safety in mental health services. It has been implemented in Victorian inpatient services and an adapted version is being piloted and tested in emergency departments. [Training resources](#) are available from the DHHS website.
- DHHS has four free e-learning modules to reduce violence and aggression in health services.
- The DHHS ‘Guide for violence and aggression training in Victorian health services’ describes best-practice training principles for different staff groups.

### HOW TO DE-ESCALATE
Consider the impact of gender identity, cultural identity, language, trauma history, medical conditions and the individual needs of the person.

If you feel unsafe at any time, activate your health service’s emergency response procedures, including [code grey or code black](#).

Approach de-escalation with respect and empathy. Try to manage your emotions. Anticipate any potential triggers for conflict and plan your de-escalation according to the principles in Table 4.

### Table 4: Principles of de-escalation

<table>
<thead>
<tr>
<th>Non-verbal communication</th>
<th>Verbal communication</th>
<th>Environment</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Allow time for open communication. Don’t rush.</td>
<td>- Keep the conversation centred on the person’s needs.</td>
<td>- Remove bystanders and unnecessary staff from the view of the person.</td>
</tr>
<tr>
<td>- Move slowly and gently.</td>
<td>- Have a concerned and interested tone of voice.</td>
<td>- Consider the impact of sensory needs e.g. lighting, noise, sensory items.</td>
</tr>
<tr>
<td>- Use culturally appropriate eye contact.</td>
<td>- Ask open questions to build discussion.</td>
<td>- Ensure the person’s privacy.</td>
</tr>
<tr>
<td>- Relax your body.</td>
<td>- Do not shout or raise your voice.</td>
<td>- Keep exits clear and accessible.</td>
</tr>
<tr>
<td>- Do not place hands on hips or in pockets, finger wag or prod, cross arms or clench fists.</td>
<td>- Do not give threats, orders or advice.</td>
<td>- Remove potentially dangerous items.</td>
</tr>
<tr>
<td>- Give at least two arms’ length of personal space.</td>
<td>- Avoid ‘If I were you…’ or ‘You’d better stop that right now or…’</td>
<td>- Make available food, drink, toilet, bedding and appropriate access to phone calls.</td>
</tr>
<tr>
<td>- Consider alternative forms of communication e.g. communication boards, symbols or signs.</td>
<td>- Do not argue the point. You don’t need to defend or justify yourself.</td>
<td>- Consider nicotine replacement therapy.</td>
</tr>
</tbody>
</table>
VERBAL DE-ESCALATION

Conversation is the safest and most common form of de-escalation. After considering the principles of de-escalation in Table 4, follow the stages of verbal de-escalation in Figure 1.

Figure 1: Stages of verbal de-escalation

- **Get started**
  - Assess the need for support or back-up.
  - Tell another team member where you are going.
  - Create a safe and helpful communication space.
  - Introduce yourself.
  - Invite a conversation.
  - Explain that you are here to help and that you will work together to make the person feel safe.

- **Listen. Work out what the problem is**
  - Speak clearly.
  - Use each other’s names.
  - Ask open-ended questions to learn what is happening.
  - Use simple words.
  - Speak in short sentences.
  - Repeat, paraphrase and check understanding.
  - Answer questions.
  - Clarify misunderstandings.

- **Find solutions**
  - Work together to compromise and problem solve.
  - Be flexible.
  - Offer realistic choices and options.
  - Explain and give reasons for rules and decisions.
  - Ask: ‘Is there anything I can do to help us work through this together?’
  - Ask: ‘What can I do to help you feel safe here?’
4. Sedation and ongoing care post-sedation

WHEN TO GIVE SEDATION

A person displaying acute behavioural disturbance may be sedated with medication only when de-escalation and all reasonable, less restrictive methods have been unsuccessful or are found to be unsuitable by clinical staff because of the person’s acute behavioural disturbance or clinical condition.

Sedation is not the first-line treatment for people displaying acute behavioural disturbance. Give sedation to prevent serious and imminent harm to the person or others and to facilitate assessment and management of the person’s underlying condition.

Aim for the person to be drowsy but rousable with a SAT score of −1 or 0.

Legal requirements for urgent sedation

Always try to obtain informed consent before giving sedation. Everyone has a human right to decide what happens to their own body. The care you provide must adhere to the Victorian Charter of Human Rights and Responsibilities.

When informed consent cannot be obtained from the person, try to get consent from a substitute decision-maker. In exceptional cases and when this is not reasonably possible, the law supports clinicians to treat a person displaying acute behavioural disturbance without their informed consent if you reasonably believe that:

- you need to act immediately due to a sudden or extraordinary emergency and it is not practical to obtain consent
- urgent care is required to prevent serious and imminent harm to the person or others.

The care you provide must be:

- the least restrictive care possible, after trying or considering all other less restrictive options
- a reasonable response to the emergency
- what a reasonable clinician would do acting in the best interests of the person.

Document your decision-making process and how you have considered these points.
People at high risk of harm from sedation

People displaying acute behavioural disturbance may have experienced trauma that may increase psychological harm from sedation. Minimise this through effective communication and sensitivity to issues such as gender identity and cultural identity.

Gather relevant information from multiple sources as listed in the assessment section to make an informed clinical decision about giving sedation. There is a higher risk of adverse physical effects from sedation if the person is:

- obese
- pregnant
- in general poor health
- intoxicated with alcohol.

HOW TO GIVE SEDATION

All medications in this guidance have the potential for adverse effects. Use clinical decision making to determine if the need for sedation outweighs any potential adverse effects.

Ensure monitoring and resuscitation equipment is readily available before giving sedation.

This sedation guidance applies to adults aged 16–65 years.

Oral sedation

Offer oral sedation according to Table 5 as the first option.

Table 5: Oral sedation for adults aged 16–65 years

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dose</th>
<th>Onset time</th>
<th>Adverse effects</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oral diazepam</td>
<td>5–20 mg</td>
<td>30–60 minutes</td>
<td>• Drowsiness</td>
</tr>
<tr>
<td></td>
<td>and/or</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oral olanzapine</td>
<td>5–10 mg</td>
<td>30–60 minutes</td>
<td>• Extrapyramidal reactions</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Hypotension</td>
</tr>
</tbody>
</table>
Parenteral sedation

Give parenteral sedation according to Table 6 if sedation is required but oral sedation is refused or considered inappropriate by clinical staff because of the person’s acute behavioural disturbance or clinical condition.

Do not get intravenous (IV) access just to give sedation. Intramuscular (IM) administration is at least as effective, faster and has less risk of needlestick injury.

Assemble a team of adequately skilled and trained staff to give parenteral sedation. This may include:

- a clinical leader to monitor the patient, order medications and give direction
- clinical staff to give the medication
- one clinical staff member assigned as the lead communicator with the person
- security staff.

Table 6: Parenteral sedation for adults aged 16–65 years

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dose</th>
<th>Onset time</th>
<th>Adverse effects</th>
</tr>
</thead>
</table>
| IM droperidol  | 5–10 mg. Repeat in 15 minutes. Maximum total dose 20 mg. | 3–10 minutes | • Extrapyramidal reactions  
|                |                    |            | • QT segment prolongation (minimal clinical significance) |
| IM midazolam   | 5–10 mg. Repeat in 15 minutes. Maximum total dose 20mg. | 2–15 minutes | • Respiratory depression  
|                |                    |            | • Oxygen desaturation  
|                |                    |            | • Airway obstruction  
|                |                    |            | • Hypotension |
| IM ketamine    | 4–5 mg/kg          | 3–4 minutes | • Hypertension  
|                |                    |            | • Emergence reactions  
|                |                    |            | • Tachycardia |

Seek specialist advice about additional sedation options if:

- the sedation in Table 6 has not been effective
- the person continues to display ‘red flag indicators’, especially abnormal vital signs
- the person already has IV access and you want to give IV sedation
  - suggested IV doses: droperidol 5–10 mg, maximum total dose 60 mg; midazolam 2.5–5 mg, maximum total dose 20 mg; ketamine 1 mg/kg.
POST-SEDATION CARE

Clinical monitoring
The person should be monitored by a clinician able to recognise and manage:

- an obstructed airway
- inadequate oxygenation
- inadequate ventilation
- hypotension
- cardiac arrhythmias.

Determine the level of post-sedation monitoring based on clinical judgement. Table 7 describes suggested frequency of clinical assessment and documentation in relation to SAT score.

For people who received parenteral sedation, in addition to Table 7 perform a clinical assessment at least every 15 minutes for the first hour after parenteral sedation is given.

If obtaining vital signs will compromise safety, continue to visually observe the person until vital signs can be obtained.

Table 7: Post-sedation clinical assessment in relation to SAT score

<table>
<thead>
<tr>
<th>SAT score</th>
<th>Minimum clinical assessment</th>
<th>Minimum frequency of clinical assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>If the person received parenteral sedation, perform a clinical assessment at least every 15 minutes for the first hour</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0 or +1</td>
<td>Standard clinical assessment</td>
<td>Standard frequency of assessment</td>
</tr>
<tr>
<td>−1</td>
<td>SAT score, blood pressure, heart rate, respiratory rate, oxygen saturation</td>
<td>Every 30 minutes until SAT score increases</td>
</tr>
<tr>
<td>−2</td>
<td>SAT score, blood pressure, heart rate, respiratory rate, oxygen saturation, ECG</td>
<td>Every 15 minutes for 1 hour or until SAT score increases, then every 30 minutes until SAT score increases</td>
</tr>
<tr>
<td>−3</td>
<td>Continuous visual observation Clinical assessment every 15 minutes until SAT score increases</td>
<td></td>
</tr>
</tbody>
</table>

Admission or discharge
Refer to Section 6 of this guidance when considering admission or discharge of the person.
Physical and mechanical restraint is not a therapeutic intervention and is always a last resort after all other options have been tried or considered. Revisit Section 3 De-escalation for some less restrictive options.

Physical and mechanical restraint can be traumatising and dangerous for a person displaying acute behavioural disturbance and staff providing care. Minimise this by considering the impact of gender identity, cultural identity, trauma history, medical condition and the individual needs of the person.

Consider this guidance alongside the Victorian Chief Psychiatrist’s guideline ‘Restrictive interventions in designated mental health services’. It describes quality care for all people who are restrained, not just people receiving mental healthcare.

WHEN TO RESTRAIN

A person displaying acute behavioural disturbance may be restrained as a last resort only after all less restrictive options have been tried or considered and found to be unsuitable by clinical staff because of the person’s acute behavioural disturbance or clinical condition. Use restraint only to prevent immediate harm to the person or others and for the shortest time possible. The care you provide must adhere to the Victorian Charter of Human Rights and Responsibilities.

Legal requirements for a person not subject to an order under the Mental Health Act 2014

Always try to obtain informed consent before restraining a person. Everyone has a human right to decide what happens to their own body.

When informed consent cannot be obtained from the person, try to get consent from a substitute decision-maker. In exceptional cases and when this is not reasonably possible, the law supports clinicians to restrain a person displaying acute behavioural disturbance without their informed consent if you reasonably believe that:

- you need to act immediately due to a sudden or extraordinary emergency and it is not practical to obtain consent
- urgent restraint is required to prevent serious and imminent harm to the person or others
- all less restrictive options have been tried or considered and found to be inappropriate
- the care you are providing is in line with what a reasonable clinician would do acting in the best interests of the person displaying acute behavioural disturbance.

Document your decision-making process and how you have considered these points.
**Legal requirements for a person subject to an order under the Mental Health Act 2014**

This **does not** include people brought by police using their apprehension powers under section 351 of the Mental Health Act 2014.

Physical or mechanical restraint of this person must be authorised by an authorised psychiatrist or, if they are not immediately available, a medical practitioner or the senior registered nurse on duty, who must seek retrospective authorisation from an authorised psychiatrist. They must reasonably believe:

- all less restrictive options have been tried or considered and found to be unsuitable because of the person’s acute behavioural disturbance or clinical condition
- restraint is necessary to prevent serious and imminent harm to the person or others.

Document your decision-making process and how you have considered these points. You must inform the psychiatrist, complete the [MHA 140](#) or [MHA 141](#) form to authorise restraint, and record observations on the [MHA 142](#) form.

**HOW TO RESTRAIN**

Continue de-escalation and communication throughout the restraint. Explain what is happening, why, and how the person can help.

Physical and mechanical restraint is invasive and restrictive. Never use it simply for convenience. You must stop physical or mechanical restraint as soon as it is no longer required to prevent serious and imminent harm to the person or others.

**Physical restraint**

This is the skilled, hands-on immobilisation or physical restriction of a person. Assemble a team of adequately skilled and trained staff, including:

- a clinical leader to provide direction and monitor the person’s head, neck, airway and chest
- four staff members to each restrain one of the person’s limbs
- additional clinical staff for any procedures or medication administration.

Physical restraint can be very high risk for all involved. There are no completely safe techniques. To make it as safe as possible:

- avoid prone (face-down) restraint. Prone restraint has caused deaths from respiratory restriction and is the subject of a [DHHS Chief Psychiatrist’s clinical practice advisory notice and guideline](#). If in the course of a restraint the person is put in a prone position, keep it to an absolute minimum and no more than **three minutes**. Assign one staff member to actively time this
- **never** use techniques or positions that restrict breathing or circulation. Do not compress the chest or abdomen, block the nose or mouth, or flex the head towards the knees
- use the least amount of force required and do not apply pain
- do not prevent the person from communicating – for example, by blocking their mouth or ears.

If physical restraint is required for longer than 10 minutes, consider alternative strategies such as sedation or mechanical restraint.
Legal requirements for a restrained person subject to an order under the Mental Health Act 2014

- Complete the MHA 140 or MHA 141 form to authorise restraint.
- A registered nurse or medical practitioner must continuously observe the person.
- Document a clinical assessment every 15 minutes, including whether restraint is still needed.
- Complete the MHA 142 form to record observations while the person is restrained.
- The psychiatrist or medical practitioner must review the person at least every four hours.
- Preserve dignity and meet basic needs by providing access to food, water, toilets, bedding and so on.
- Notify the nominated person, guardian or carer if you think restraint will affect the care relationship.

Mechanical restraint

This is the application of devices, such as belts or straps, to restrict a person’s movement.

- Only use mechanical restraint devices and techniques authorised by your health service.
- Avoid restraining the person with one arm above their head and one arm by their side.
- Elevate the bedhead slightly to avoid lying the person completely flat.
- Document a clinical assessment every 15 minutes, including:
  - breathing
  - vital signs (heart rate, temperature, respiratory rate)
  - movement and level of agitation, including SAT score
  - skin integrity and neurovascular assessment of restrained limbs
  - drink, food and toilet needs
  - whether restraint is still needed. Prepare to stop restraint now if it is no longer needed.
- Consider venous thromboembolism (VTE) prophylaxis.
- Release each limb from mechanical restraints at least once per hour to prevent injury and allow repositioning.
  - Release one limb at a time while maintaining safety.
- Unless required by law, only share information with members of the person’s network if they have given consent.
  - If consent is given, consider discussing the restraint technique used, duration, risks, care plan and how they can help the person.
- Remove mechanical restraints from the care environment if they are not being used.

You must stop mechanical restraint as soon as it is no longer required to prevent serious and imminent harm to the person or others.
POST-RESTRAINT CARE

■ Perform a dedicated clinical assessment for any injuries caused by restraint. Consider repeating this assessment multiple times to check for emerging injuries.
■ Offer the person to walk, move all their limbs, drink and eat.
■ Offer the person counselling and support from an appropriate staff member.
■ Frequently monitor the person according to your health service’s guidelines and processes.
■ If sedation was given, refer to Table 7 for ongoing clinical monitoring requirements.

Admission or discharge

Refer to Section 6 of this guidance when considering admission or discharge of the person.
6. Transition from the emergency care setting

Emergency departments and urgent care centres are usually not the appropriate place for definitive care of a person displaying acute behavioural disturbance. Use clinical decision making and your health service’s policies to guide whether it is in the best interest of the person to be admitted to the short stay unit, inpatient unit, or another health service.

When planning admission or discharge consider the:

- wishes of the person, carer or guardian
- person’s clinical condition, after discussion with senior clinical staff
  - ensure the person can walk, talk and drink fluids before discharge
- effects of all medications and substances, including alcohol
- likely underlying cause of the behavioural disturbance to guide admitting specialty
- clinical specialities and services at your health service to guide the need for admission to another health service.

DEBRIEFING AND FEEDBACK

Care provided during an episode of acute behavioural disturbance can be traumatising for the person. Give the person options for debrief and feedback such as:

- debrief at the time of presentation by a skilled staff member able to listen to the person’s experiences and discuss care decisions (this staff member may be external to your emergency care team)
- contact details of a staff member the person can debrief with after discharge
- contact details of your health service’s consumer liaison department or equivalent
- contact details for the Health Complaints Commissioner (1300 582 113) if they want to escalate their feedback
- for people who received mental healthcare, contact details for the Mental Health Complaints Commissioner (1800 246 054) if they want to escalate their feedback.

ADMISSION

Follow your health service’s guidelines and processes.

When determining clinical appropriateness for admission consider your health service’s escalation and transfer policy, or equivalent policy related to National Safety and Quality Health Service standard 8 ‘Recognising and Responding to Acute Deterioration’.
TRANSFER CONSIDERATIONS
A person displaying acute behavioural disturbance should be escorted by suitably skilled and trained clinicians with appropriate:

- airway management skills
- ability to recognise and respond to cardiovascular instability
- plans for adverse events, including written orders for further sedation
- communication and de-escalation skills.

If the person was given sedation, the transfer should be authorised by the clinical leader who ordered the medications or equivalent.

Sedation for transporting people subject to an order under the Mental Health Act 2014
A medical practitioner can administer sedation to a person without their consent for safe transport to a mental health service. **Only do this after consulting with the psychiatrist at the receiving mental health service.**

DISCHARGE
When the person is clinically stable and able to engage with staff, obtain their consent and consider referring them to:

- a social worker
- a care coordination team
- a drug and alcohol team
- a mental health team
- pastoral care
- any other relevant services in your health service.

Make sure you follow the appropriate referral pathway if it is outside business hours. Use telehealth if available.

Share information about the person’s presentation with their support network only if they give consent or if the information directly affects the care relationship after discharge. Their support network may include their:

- general practitioner
- case manager
- housing support worker
- carer
- family.
Discharging a person who was given sedation

The clinical leader who ordered the medications or equivalent should authorise discharge.

Inform the person about:

- their clinical condition including any medications given
- the risks of driving, operating machinery, physical activity and making legally binding decisions
- any signs and symptoms of potential side effects or complications and to re-present if concerned.
Caring for people displaying acute behavioural disturbance can be clinically, ethically and emotionally challenging. Staff support and review of care episodes can improve care, decrease restrictive interventions and maintain staff wellbeing. Consider the distress staff may have experienced when planning staff support or a case review.

**STAFF SUPPORT**

- Consider offering psychological support to staff, ideally with a senior staff member.
  - Psychological support can reduce initial distress, address basic needs, promote adaptive coping, and encourage engagement with existing supports. There is no set formula for psychological support. Use readily available strategies and resources that suit the staff member.
- Share the contact details of your health service’s employee assistance program.
- Taking part in psychological support should not be mandatory because it may hinder individual coping strategies.

**Staff support resources**

DHHS has four e-resources to support effective response to episodes of violence or aggression:

- managing incidents in public health services
- post-episode support guides that provide tips and advice on looking after yourself and others. There are three separate guides, one each for health service staff, managers and leaders.

**CASE REVIEW**

- If the care episode involved violence or aggression, report it to your health service as both a clinical and occupational health and safety incident, even if there is no physical injury.
  - Use your health service’s incident management system such as VHIMS or RiskMan.
  - Your health service must report to Safer Care Victoria if the use of physical or mechanical restraint resulted in serious harm or death. This is a sentinel event category.
- Reviewing care episodes can identify opportunities for systemic improvement. Possible review questions:
  - What was done well?
  - What can be learned, and what can be done to avoid repeating mistakes?
  - What policy or system revisions are required?
- Communicate review outcomes with the level of health service governance that can take action.
- Communicate the outcomes of the review with the care team involved in the episode.
- Consider creating or updating the person’s behavioural support or emergency department management plan.
# Glossary of terms and abbreviations

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Full Form</th>
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<tbody>
<tr>
<td>BAR</td>
<td>Behavioural assessment room</td>
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<tr>
<td>CMI</td>
<td>Client management interface</td>
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<tr>
<td>CNS</td>
<td>Central nervous system</td>
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<tr>
<td>DHHS</td>
<td>Victorian Government Department of Health and Human Services</td>
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<tr>
<td>ECG</td>
<td>Electrocardiograph</td>
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<td>IM</td>
<td>Intramuscular</td>
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<td>IV</td>
<td>Intravenous</td>
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<td>kg</td>
<td>Kilogram</td>
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<td>mg</td>
<td>Milligrams</td>
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<td>QT segment</td>
<td>The time from the start of the Q wave to the end of the T wave on an ECG</td>
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<tr>
<td>SAT</td>
<td>Sedation assessment tool</td>
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<tr>
<td>VHIMS</td>
<td>Victorian Health Incident Management System</td>
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Caring for people displaying acute behavioural disturbance in emergency settings

A3 visual summary to be used with Safer Care Victoria’s clinical guidance Caring for people displaying acute behavioural disturbance

**Assessment**
- Consider past experiences and individual needs of the person

**Transition from prehospital care**
- Pre-arrival notification

**De-escalation**
- Apply principles of de-escalation
- Follow the stages of verbal de-escalation

**Sedation and ongoing care**
- Consider less restrictive options and legal requirements
- Aim for the person to be drowsy but responsive with a SAT score of 1 or 0
- Oral sedation 5-20 mg diazepam and/or 5-10 mg chlorpromazine
- Parenteral sedation
  - For most people: 5-10 mg IM droperidol + 2
  - For people with psychotomimetic toxicity or alcohol withdrawal: 5-10 mg IM midazolam + 2
  - When safety is of extraordinary and immediate risk: 4-5 mg/kg IM temazepam
- Safe and vigilant post-sedation care
  - 15-minute clinical assessment for the person, guided by SAT score

**Physical and mechanical restraint**
- Optimize safety for all
- Preserve dignity and maintain safety
- Document a clinical assessment every 15 minutes
- Continuously observe the person’s vital signs, head, neck, arms and chest
- Stop restraint as soon as no longer required to prevent serious and imminent harm
- Perform a post-restraint assessment; offer counselling

**Handover**
- Use a structured handover tool
- Communicate key information

**Ongoing and repeat assessment**
- When the situation changes or with new information, identify how to best support the person

**Maintain safety for all**
- Know when and how to call for help

**Initial assessment**
- Basic information from many sources
- Assess underlying cause; consider red flag indicators
- Use the SAT and STAMP framework

**Transition from emergency care**
- Offer the person options for feedback and debrief

**Staff support and case review**
- Consider psychological support for staff