Safer Care Victoria

Caring for people displaying acute behavioural disturbance

Clinical guidance supplement
DRAFT FOR CONSULTATION

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Guidance production process

TOPIC SELECTION

In 2018 Safer Care Victoria's (SCV) Emergency Care Clinical Network (ECCN) hosted a strategy day attended by more than 160 clinicians from across the emergency care sector. Attendees at this day identified improving the care of people displaying behaviours of concern as a priority focus area.

We subsequently formed a phase one expert working group to scope and prioritise improvement ideas. After reviewing literature, collecting data and consulting with Victorian healthcare stakeholders, one of the recommendations was to develop statewide evidence-based clinical guidance. The purpose of this guidance is to support person-centred, evidence-based practice and reduce unwarranted variation in care.

Scope

The guidance is intended for use by emergency care clinicians in Victoria. Table 1 describes the scope of the guidance.

Table 1 Scope of the clinical guidance

In scope	Out of scope
Adult patients (16–65 years of age)	Paediatric patients
Urgent care centres	Clear organic cause for acute behavioural disturbance (e.g. dementia, delirium, closed head injury)
Emergency departments	Care after discharge or transfer from an emergency department or urgent care centre
Transitions of care in and out of emergency departments or urgent care centres	Providing clinical guidance to Victoria Police
	Prehospital care*

* While out of scope, our guidance may be suitable to adapt.

EXPERT WORKING GROUP

We formed a phase two expert working group to develop the clinical guidance. The group, listed in Table 2, consisted of three healthcare consumer representatives, 13 clinical experts and two SCV staff members.

The ECCN Governance Committee appointed the chair of the expert working group, and all other members were selected through an expression of interest process open for three weeks. Applicants were asked to submit one paragraph outlining why they were interested in being involved and any relevant experience or skills. All expressions of interest were reviewed by SCV staff and final membership of the group was endorsed by the working group chair and the ECCN clinical lead.

Table 2: Expert working group membership

Name	Role	Affiliation
Thomas Chan (chair)	Emergency Physician Director of Emergency Department	Austin Health
Kristy Austin	National Standards Accreditation Lead	Ambulance Victoria
Shaun Baxter	Emergency Physician Retrieval Physician	Alfred Health Adult Retrieval Victoria
Scott Bennetts	Manager, Clinical Practice Guidelines	Ambulance Victoria
Simon Craig	Emergency Physician	Monash Health
Sim Crawford	Consumer representative	Community
Jo Colvin	Emergency Department Alcohol and Other Drug Nurse Practitioner	Latrobe Regional Hospital
Dan Crompton	Emergency Physician Director of Emergency Services Retrieval Physician Director of Education and Training	Bass Coast Health (Wonthaggi hospital) Adult Retrieval Victoria
John Cunning	Clinical Nurse Specialist (Psychiatry) Associate Director of Nursing	Benalla Health
Cathy Daniel	Consultation Liaison Nurse Coordinator of Postgraduate Mental Health Nursing	Royal Melbourne Hospital University of Melbourne
Claire Doherty	Project Lead, Emergency Care Clinical Network	Safer Care Victoria
Daniel Eltringham	Emergency Department Drug and Alcohol Care Coordinator	Bendigo Health
Liz Flemming-Judge	Consumer representative	Community
James Fowler	Clinical Fellow, Emergency Care Clinical Network	Safer Care Victoria
Kate James	Emergency Department Clinical Nurse Specialist	Werribee Mercy
Cristina Roman	Emergency Department Pharmacist	Alfred Health
Frances Sanders	Consumer representative	Community
Penny Whelan	Emergency Department Nurse Unit Manager	Goulburn Valley Health

Healthcare consumer involvement

Healthcare consumers are people, families and carers who are current or potential users of health services. All consumers included in our group have lived experience of behaviours of concern in emergency care settings.

All consumers were offered orientation to SCV and the ECCN and were reimbursed for their time and travel expenses. To support safe participation, consumers were given access to the Department of Health and Human Services employee assistance program. Consumers were also offered the opportunity to debrief with SCV staff and the working group chair after every meeting.

Conflicts of interest

Expert working group members were required to declare any conflicts of interest in a formal declaration when joining the group. No relevant conflicts were identified.

METHODOLOGY TO PRODUCE THE GUIDANCE

Production timeline

May 2019 – April 2020

Decision to endorse, adapt or develop

In line with SCV's evidence-based guidance strategy, we evaluated existing guidance relating to people displaying acute behavioural disturbance for applicability and methodological rigour. Shortlisted guidance was evaluated by at least two expert working group members. High-scoring guidance was evaluated by at least three members, including one consumer representative.

After evaluation we decided to adapt, with permission, the Alfred Health *Physical and mechanical restraint: assessment and application* guideline for our 'physical and mechanical restraint and ongoing care while restrained' section only.

Search method to review the evidence

We developed the guidance using a basic search strategy involving both a formal and informal approach. Evidence sources included academic literature, legislation, government documents and grey literature.

Databases searched

- EbscoHost: Academic Search Complete; Psych & Behavioral Science Collection; SocIndex
- OVID: MEDLINE; PsychInfo
- Scopus
- Cochrane Library
- INFORMIT: Health Collection; CINCH (Australian Institute of Criminology); FAMILY (Australian Institute of Family Studies); Humanities and Social Science Collection; Australian Policy Observatory
- Google Scholar

Keywords

Keywords used in the basic search strategy included: acute behavioural disturbance, aggression, agitation, assessment, behaviour of concern, behavioural escalation, best practice, clinical guidance, continuing care, critical care, debrief, de-escalation, difficult behaviour, discharge, distress, emergency, emergency department, framework, guideline, handover, incident, mental health, oncall GP, paramedic, policy, post-discharge, post-incident, post-sedation, prehospital, psychomotor agitation, referral, restraint, risk assessment, sedation, situational crisis, transfer, urgent care and violence.

Reviewed evidence

A bibliography of evidence the expert working group reviewed is included in Appendix 1. Not all reviewed evidence directly informed our guidance. We graded reviewed evidence according to the levels of evidence described in Table 3. These are based on the National Health and Medical Research Council's (NHMRC) 2009 levels of evidence and grades for recommendations for developers of guidelines. Note that the definitions for level V and consensus differ from that proposed by the NHMRC. The expert working group decided to introduce these levels of evidence to reflect the importance of lived experiences of care and consensus statements from respected authorities.

Table 3: Levels of evidence

Level	Description
I	Evidence obtained from a systematic review of all relevant randomised controlled trials
II	Evidence obtained from at least one properly designed randomised controlled trial
III-1	Evidence obtained from well-designed pseudo randomised controlled trials
III-2	Evidence obtained from comparative studies with concurrent controls, including reviews of such studies. Examples include cohort studies, case-control studies, non-randomised experimental trials, interrupted time series with a control group
III-3	Evidence obtained from comparative studies without concurrent controls, including reviews of such studies. Examples include historical control studies, two or more single arm studies, interrupted time series without a parallel control group
IV	Evidence obtained from case series with either post-test or pre-test/post-test outcomes
V	Evidence obtained from single descriptive or qualitative studies, including reports of lived experiences of care
Consensus	Expert opinions based on respected authorities or reports of expert committees
N/A	Evidence that cannot be graded, such as legislation

Table 4 summarises the levels of evidence for each section of our guidance as an indication of what type of evidence was identified and reviewed.

Table 4: Level of evidence summary for each guidance section

	Level I	Level II	Level III-1	Level III-2	Level III-3	Level IV	Level V	Con-sensus	N/A
Assessment	1	0	0	6	2	0	8	18	0
Transition from prehospital care	0	0	0	0	0	0	1	0	1
De-escalation	5	0	0	0	2	0	6	8	0
Sedation and ongoing care post-sedation	1	6	0	6	1	4	0	6	0
Physical and mechanical restraint and ongoing care while restrained	3	0	0	2	10	1	10	3	0
Transition from the emergency care setting	0	0	0	0	0	0	1	0	1
After the person has left the emergency care setting	0	0	0	0	0	0	2	3	1

REACHING CONSENSUS

Consensus was reached among expert working group members through discussion, as summarised by the chair. Where consensus could not be reached on a matter, the chair could choose for it be decided by a simple majority vote, or by referral to the ECCN Governance Committee for determination.

SCV staff members were responsible for the guidance creation process and for preparing the guidance supplement. They did not have casting votes for the purposes of consensus building or decision making in the group

CONSULTATION

Public consultation

We are performing a four-week open public consultation on our guidance in February 2020. This is an opportunity for individuals and organisations to have input into the content and structure of the guidance. Feedback is being collected through an electronic survey accessible via the SCV website. A public consultation report will be completed.

REVIEW

The review period for this guidance will be determined after public consultation. More frequent reviews may be required to reflect any changes in evidence and best practice.

Feedback received in between scheduled revisions may prompt changes to the guidance. The decision to update the guidance in between scheduled review cycles will be made by the ECCN Governance Committee in collaboration with previous expert working group members or topic experts as required.

Appendix 1: Reviewed evidence

Table A1: Levels of evidence

Level	Description
I	Evidence obtained from a systematic review of all relevant randomised controlled trials
II	Evidence obtained from at least one properly designed randomised controlled trial
III-1	Evidence obtained from well-designed pseudo randomised controlled trials
III-2	Evidence obtained from comparative studies with concurrent controls, including reviews of such studies. Examples include cohort studies, case-control studies, non-randomised experimental trials, interrupted time series with a control group
III-3	Evidence obtained from comparative studies without concurrent controls, including reviews of such studies. Examples include historical control studies, two or more single arm studies, interrupted time series without a parallel control group
IV	Evidence obtained from case series with either post-test or pre-test/post-test outcomes
V	Evidence obtained from single descriptive or qualitative studies, including reports of lived experiences of care
Consensus	Expert opinions based on respected authorities or reports of expert committees
N/A	Evidence that cannot be graded, such as legislation

Assessment

Table A2: Level of evidence summary: assessment section

	Level I	Level II	Level III-1	Level III-2	Level III-3	Level IV	Level V	Consensus	N/A
Total number	1	0	0	6	2	0	8	18	0

Alam A, Rachal J, Tucci VT, Moukaddam N. Emergency department medical clearance of patients with psychiatric or behavioral emergencies, Part 2: Special Psychiatric Populations and Considerations. Psychiatric Clinics of North America [Internet]. 2017 [cited 2019];40(3):425–33.

Calver LA, Stokes B, Isbister GK. Sedation assessment tool to score acute behavioural disturbance in the emergency department. Emergency Medicine Australasia [Internet]. 2011 [cited 2019];23(6):732-40.

Considine J, Berry D, Johnson R, Sands N. Vital signs as predictors for aggression in hospital patients (VAPA). Journal of Clinical Nursing [Internet]. 2017 [cited 2019];26(17-18):2593–604.

Cowling SA, McKeon MA, Weiland TJ. Managing acute behavioural disturbance in an emergency department using a behavioural assessment room. Australian Health Review [Internet]. 2007 [cited 2019];31(2):296–304.

Douglass AM, Luo J, Baraff LJ. Emergency medicine and psychiatry agreement on diagnosis and disposition of emergency department patients with behavioral emergencies. Academic Emergency Medicine [Internet]. 2011 [cited 2019];18(4):368–73.

Downes MA, Healy P, Page CB, Bryant JL, Isbister GK. Structured team approach to the agitated patient in the emergency department. Emergency Medicine Australasia [Internet]. 2009 [cited 2019];21(3):196–202.

Garriga M, Pacchiarotti I, Kasper S, Zeller SL, Allen MH, Vazquez G, et al. Assessment and management of agitation in psychiatry: expert consensus. World Journal of Biological Psychiatry [Internet]. 2016 [cited 2019];17(2):86–128.

Goldberg RJ, Dubin WR, Fogel BS. Behavioral emergencies: assessment and psychopharmacologic management. Clinical Neuropharmacology. 1989;12(4):233–48.

Gottlieb M, Long B, Koyfman A. Approach to the agitated emergency department patient. Journal of Emergency Medicine [Internet]. 2018 [cited 2019];54(4):447–57.

Group PEW. Behavioural emergencies. Therapeutic guidelines: Psychotropic 7th edn. Melbourne: Therapeutic Guidelines Limited; 2013.

Hew R. Altered conscious state (Chapter 8.4). In: Brown AFT, Cameron P, Jelinek G, Kelly A-M, Little M, editors. Textbook of adult emergency medicine. Edinburgh; New York: Churchill Livingstone/Elsevier; 2015.

Holloman GH, Jr., Zeller SL. Overview of project BETA: best practices in evaluation and treatment of agitation. The Western Journal of Emergency Medicine [Internet]. 2012 [cited 2019];13(1):1–2.

Jensen L, Clough R. Assessing and treating the patient with acute psychotic disorders. Nursing Clinics of North America [Internet]. 2016 [cited 2019];51(2):185–97.

Kleissl-Muir S, Raymond A, Rahman MA. Analysis of patient related violence in a regional emergency department in Victoria, Australia. Australasian Emergency Care [Internet]. 2019 [cited 2019];22(2):126–31.

Knott JC, Bennett D, Rawet J, Taylor DM. Epidemiology of unarmed threats in the emergency department. Emergency Medicine Australasia [Internet]. 2005 [cited 2019];17(4):351–8.

Luck L, Jackson D, Usher K. STAMP: components of observable behaviour that indicate potential for patient violence in emergency departments. Journal of Advanced Nursing [Internet]. 2007 [cited 2019];59(1):11–19.

Lagomasino I, Daly R, Stoudemire A. Medical assessment of patients presenting with psychiatric symptoms in the emergency setting. Psychiatric Clinics of North America [Internet]. 1999 [cited 2019];22(4):819–50.

Lim M, Weiland T, Gerdtz M, Dent A. Expectations of care, perceived safety, and anxiety following acute behavioural disturbance in the emergency department. Emergency Medicine International [Internet]. 2011 [cited 2019];2011:165738.

Lindenmayer JP. The pathophysiology of agitation. Journal of Clinical Psychiatry [Internet]. 2000 [cited 2019];61 Suppl 14:5–10.

McCoy C, Johnson K. Behavioral emergencies: a closer look. Journal of Emergency Nursing [Internet]. 2011 [cited 2019];37(1):104–8.

McKenna B, Furness T, Oakes J, Brown S. Police and mental health clinician partnership in response to mental health crisis: a qualitative study. International Journal of Mental Health Nursing [Internet]. 2015 [cited 2019];24(5):386–93.

Molyneaux E, Turner A, Candy B, Landau S, Johnson S, Lloyd-Evans B. Crisis-planning interventions for people with psychotic illness or bipolar disorder: systematic review and meta-analyses. BJPsych Open [Internet]. 2019 [cited 2019];5(4):e53.

Niedermier J, Kasick D. Maintaining personal safety: understanding and addressing aggression and violence in the health care setting [Internet]. MedEdPORTAL [Internet]. 2018 [cited 2019];14:10722.

Nordstrom K, Zun LS, Wilson MP, Stiebel V, Ng AT, Bregman B, et al. Medical evaluation and triage of the agitated patient: consensus statement of the American Association for Emergency Psychiatry project BETA medical evaluation workgroup. The Western Journal of Emergency Medicine [Internet]. 2012 [cited 2019];13(1):3–10.

Phillips S. Countering workplace aggression: an urban tertiary care institutional exemplar. Nursing Administration Quarterly [Internet]. 2007 [cited 2019];31(3):209–18.

Ryan CJ, Callaghan S. The impact on clinical practice of the 2015 reforms to the New South Wales Mental Health Act. Australasian Psychiatry [Internet]. 2017 [cited 2019];25(1):43–7.

Smart D, Pollard C, Walpole B. Mental health triage in emergency medicine. Australian and New Zealand Journal of Psychiatry [Internet]. 1999 [cited 2019];33(1):57–66.

Sood TR, McStay CM. Evaluation of the psychiatric patient. Emergency Medicine Clinics of North America [Internet]. 2009 [cited 2019];27(4):669–83.

Stowell KR, Florence P, Harman HJ, Glick RL. Psychiatric evaluation of the agitated patient: consensus statement of the American Association for Emergency Psychiatry project BETA psychiatric evaluation workgroup. The Western Journal of Emergency Medicine [Internet]. 2012 [cited 2019];13(1):11–6.

Tucci V, Siever K, Matorin A, Moukaddam N. Down the rabbit hole: emergency department medical clearance of patients with psychiatric or behavioral emergencies. Emergency Medicine Clinics of North America [Internet]. 2015 [cited 2019];33(4):721–37.

Tucci VT, Moukaddam N, Alam A, Rachal J. Emergency department medical clearance of patients with psychiatric or behavioral emergencies, part 1. Psychiatric Clinics of North America [Internet]. 2017 [cited 2019];40(3):411–23.

Wong AH, Wing L, Weiss B, Gang M. Coordinating a team response to behavioral emergencies in the emergency department: a simulation-enhanced interprofessional curriculum. The Western Journal of Emergency Medicine [Internet]. 2015 [cited 2019];16(6):859–65.

Zeller SL, Holloman Jr GH, Wilson MP. Management of agitation. In: Tasman A, Kay J, Lieberman JA, First MB, Riba MB, editors. Psychiatry. 2015: 2479–86.

Zeller SL, Rhoades RW. Systematic reviews of assessment measures and pharmacologic treatments for agitation. Clinical Therapeutics [Internet]. 2010 [cited 2019];32(3):403–25.

Transition from prehospital

Table A3: Level of evidence summary: transition from prehospital section

	Level I	Level II	Level III-1	Level III-2	Level III-3	Level IV	Level V	Consensus	N/A
Total number	0	0	0	0	0	0	1	0	1

Australian Commission on Safety and Quality in Health Care [Internet]. Sydney: ACSQHC; 2017. Communication at clinical handover; 2019 [cited 2019]. Available from: https://www.safetyandquality.gov.au/standards/nsqhs-standards/communicating-safety-standard/communication-clinical-handover

Australian Charter of Healthcare Rights [Internet]. 2nd edn. Sydney: ACSQHC; 2019. 1 p. Available from: https://www.safetyandquality.gov.au/your-rights

De-escalation

Table A4: Level of evidence summary: de-escalation section

	Level I	Level II	Level III-1	Level III-2	Level III-3	Level IV	Level V	Consensus	N/A
Total number	5	0	0	0	2	0	6	8	0

D'Ettorre G, Pellicani V, Mazzotta M, Vullo A. Preventing and managing workplace violence against healthcare workers in emergency departments. Acta Bio-Medica: Atenei Parmensis [Internet]. 2018 [cited 2019];89(4–S):28–36.

Deal N, Hong M, Matorin A, Shah AA. Stabilization and management of the acutely agitated or psychotic patient. Emergency Medicine Clinics of North America [Internet]. 2015 [cited 2019];33(4):739–52.

Du M, Wang X, Yin S, Shu W, Hao R, Zhao S, et al. De-escalation techniques for psychosis-induced aggression or agitation. Cochrane Database of Systematic Reviews [Internet]. 2017 [cited 2019];(4).

Edward K, Giandinoto J-A, Weiland TJ, Hutton J, Reel S. Brief interventions to de-escalate disturbances in emergency departments. British Journal of Nursing [Internet]. 2018 [cited 2019];27(6):322–7.

Gaynes BN, Brown CL, Lux LJ, Brownley KA, Van Dorn RA, Edlund MJ, et al. Preventing and de-escalating aggressive behavior among adult psychiatric patients: a systematic review of the evidence. Psychiatric Services [Internet]. 2017 [cited 2019];(8):819.

Hallett N. Preventing and managing challenging behaviour. Nursing standard [Internet]. 2018 [cited 2019];(26):51.

Harwood, RH. How to deal with violent and aggressive patients in acute medical settings. The Journal of the Royal College of Physicians of Edinburgh [Internet]. 2017 [cited 2019];(2):176.

Richmond JS, Berlin JS, Fishkind AB, Holloman GH, Zeller SL, Wilson MP, et al. Verbal de-escalation of the agitated patient: consensus statement of the American Association for Emergency Psychiatry project BETA de-escalation workgroup. The Western Journal of Emergency Medicine [Internet]. 2012 [cited 2019];(1):17.

Lavelle M, Stewart D, James K, Richardson M, Renwick L, Brennan G, et al. Predictors of effective de-escalation in acute inpatient psychiatric settings. Journal of Clinical Nursing [Internet]. 2016;25(15-16):2180–8.

McGonigle JJ, Venkat A, Beresford C, Campbell TP, Gabriels RL. Management of agitation in individuals with autism spectrum disorders in the emergency department. Child and Adolescent Psychiatric Clinics of North America [Internet]. 2014 [cited 2019];23(1):83–95.

Miner JR, Klein LR, Driver B, Minder ID, Cole JB, West JR. Success rate of verbal de-escalation in the treatment of agitated patients in the emergency department in SAEM annual meeting abstracts. Academic Emergency Medicine [Internet]. 2019 [cited 2019];26(S1):S172.

Mitra B, Nikathil S, Gocentas R, Symons E, O'Reilly G, Olaussen A. Security interventions for workplace violence in the emergency department. Emergency Medicine Australasia [Internet]. 2018 [cited 2019];(6):802.

New A, Tucci VT, Rios J. A modern-day fight club? The stabilization and management of acutely agitated patients in the emergency department. Psychiatric Clinics of North America [Internet]. 2017 [cited 2019];40(3):397–410.

Raveel A, Schoenmakers B. Interventions to prevent aggression against doctors: a systematic review. BMJ Open [Internet]. 2019 [cited 2019];9(9):e028465.

Roberton T, Daffern M, Thomas S, Martin T. De-escalation and limit-setting in forensic mental health units. Journal of Forensic Nursing [Internet]. 2012 [cited 2019];8(2):94–101.

Spencer S, Johnson P, Smith IC. De-escalation techniques for managing non-psychosis induced aggression in adults. Cochrane Database of Systematic Reviews [Internet]. 2018 [cited 2019];(7).

The Joint Commission Division of Healthcare Improvement. Quick Safety 47: de-escalation in health care [internet]. Washington, DC: The Joint Commission; 2019 [cited 2019]. 5p. Available from: https://www.jointcommission.org/assets/1/23/QS_Deescalation_1_28_18_FINAL.pdf

Touzet S, Occelli P, Denis A, Cornut PL, Fassier JB, Le Pogam MA, et al. Impact of a comprehensive prevention programme aimed at reducing incivility and verbal violence against healthcare workers in a French ophthalmic emergency department: an interrupted time-series study. BMJ Open [Internet]. 2019 [cited 2019];9(9):e031054.

Victorian Government Department of Health and Human Services. Code grey standards [Internet]. Melbourne: Department of Health and Human Services. Available from: https://www2.health.vic.gov.au/health-workforce/worker-health-wellbeing/occupational-violence-aggression/code-grey-black

Victorian Government Department of Health and Human Services. Guide for violence and aggression training in Victorian health services [Internet]. Melbourne: Department of Health and Human Services. Available from: https://www2.health.vic.gov.au/about/publications/policiesandguidelines/violence-aggression-training-guide-health-services

Victorian Government Department of Health and Human Services. Safewards handbook [Internet]. Melbourne: Department of Health and Human Services. Available from: https://www2.health.vic.gov.au/mental-health/practice-and-service-quality/safety/safewards/training-resources

Weiland T, Ivory S, Hutton J. Managing acute behavioural disturbances in the emergency department using the environment, policies and practices: a systematic review. The Western Journal of Emergency Medicine [Internet]. 2017 [cited 2019];18(4):647–61.

Sedation

Table A5: Level of evidence summary: sedation section

	Level I	Level II	Level III-1	Level III-2	Level III-3	Level IV	Level V	Consensus	N/A
Total number	1	6	0	6	1	4	0	6	0

ACEM, ANZCA, CICM, RANZCP. Guidelines for safe care for patients sedated in health care facilities for acute behavioural disturbance [Internet]. Melbourne: ANZCA; 2018 [cited 2019]. Available from: http://www.anzca.edu.au/documents/ps63-2018-guidelines-for-safe-care-for-patients-se.pdf

Barbic D, Andolfatto G, Grunau B, Scheuermeyer FX, MacEwan W, Honer WG, et al. Rapid agitation control with ketamine in the emergency department (RACKED): a randomised controlled clinical trial protocol. Trials [Internet]. 2018 [cited 2019];19(1):651.

Calver L, Isbister GK. High dose droperidol and QT prolongation: analysis of continuous 12-lead recordings. British Journal of Pharmacology [Internet]. 2014 [cited 2019];77(5):880–6.

Calver L, Page CB, Downes MA, Chan B, Kinnear F, Wheatley L, et al. The safety and effectiveness of droperidol for sedation of acute behavioral disturbance in the emergency department. Annals of Emergency Medicine [Internet]. 2015 [cited 2019];66(3):230–8.

Calver L, Stokes B, Ibister GK. Sedation assessment tool to score acute behavioural disturbance in the emergency department. Emergency Medicine Australasia [Internet]. 2011 [cited 2019];23(6):732–40.

Castle D, Chan E, Karro J, Knott, J Kong D, Phillips G, et al. Midazolam-droperidol, droperidol, or olanzapine for acute agitation: a randomized clinical trial. Annals of Emergency Medicine [Internet]. 2017 Mar [cited 2019];69(3):318–26.

Chan EW, Taylor DM, Knott JC, Phillips GA, Castle DJ, Kong DCM. Intravenous droperidol or olanzapine as an adjunct to midazolam for the acutely agitated patient: a multicenter, randomized, double-blind, placebo-controlled clinical trial. Annals of Emergency Medicine [Internet]. 2013 [cited 2019];61(1):72–81.

Cohen S, Bhatia A, Buvanendran A, Schwenk E, Wasan A, Hurley R et al. Consensus guidelines on the use of intravenous ketamine infusions for chronic pain from the American Society of Regional Anesthesia and Pain Medicine, the American Academy of Pain Medicine, and the American Society of Anesthesiologists. Regional Anesthesia and Pain Medicine [Internet]. 2018 [cited 2019];43(5):521–46.

Cole JB, Klein LR, Martel ML, Heard KJ. Parenteral antipsychotic choice and its association with emergency department length of stay for acute agitation secondary to alcohol intoxication. Academic Emergency Medicine [Internet]. 2019 [cited 2019];26(1):79–84.

Downes MA, Calver LA, Page CB, Bryant JL, Isbister GK. The impact of a standardised intramuscular sedation protocol for acute behavioural disturbance in the emergency department. BMC Emergency Medicine [Internet]. 2010 [cited 2019];10(1):14.

Hopper AB, Vilke GM, Castillo EM, Campillo A, Davie T, Wilson MP. Ketamine use for acute agitation in the emergency department. Journal of Emergency Medicine [Internet]. 2015 [cited 2019];48(6):712–9.

Ibister GK, Calver LA, Page CB, Stokes B, Bryant JL, Downes, MA. Randomized controlled trial of intramuscular droperidol versus midazolam for violence and acute behavioural disturbance: the DORM study. Annals of Emergency Medicine [Internet]. 2010 [cited 2019];56(4):392–401.

Isbister GK, Calver LA, Downes MA, Page CB. Ketamine as rescue treatment for difficult-to-sedate severe acute behavioral disturbance in the emergency department. Annals of Emergency Medicine [Internet]. 2016 [cited 2019];67(5):581–7.

Khokhar M, Rathbone J. Droperidol for psychosis-induced aggression or agitation. Cochrane Database of Systematic Reviews [Internet]. 2016 [cited 2019];12.

Knott JC, Taylor DM, Castle DJ. Randomized clinical trial comparing intravenous midazolam and droperidol for sedation of the acutely agitated patient in the emergency department. Annals of Emergency Medicine [Internet]. 2006 [cited 2019];47(1):61–7.

Le Cong M, Ellis D, Finn E, Hill M, Johnson R, Langford S, Parsch C, Setchell J. The acutely agitated patient in a remote location assessment and management guidelines a consensus statement by Australian aeromedical retrieval services [internet]. 2015.

Lebin JA, Akhavan AR, Hippe DS, Gittinger MH, Pasic J, McCoy AM, et al. Psychiatric outcomes of patients with severe agitation following administration of prehospital ketamine. Academic Emergency Medicine [Internet]. 2019 [cited 2019];26(8):889–96.

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Riddell J, Tran A, Bengiamin R, Hendey GW, Armenian P. Ketamine as a first-line treatment for severely agitated emergency department patients. The American Journal of Emergency Medicine [Internet]. 2017 [cited 2019];35(7):1000–4.

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Taylor DM, Yap CYL, Knott JC, Taylor SE, Phillips GA, Karro J, et al. Midazolam-droperidol, droperidol, or olanzapine for acute agitation: a randomized clinical trial. Annals of Emergency Medicine [Internet]. 2017 [cited 2019];69(3):318–26.

Wilson M, Pepper D, Currier G, Holloman G, Feifel D. The psychopharmacology of agitation: consensus statement of the American Association for Emergency Psychiatry project BETA psychopharmacology workgroup. The Western Journal of Emergency Medicine [Internet]. 2012 [cited 2019];13(1):26–34.

Yap CYL, Taylor DM, Kong DCM, Knott JC, Taylor SE, Bird SB. Risk factors for sedation-related events during acute agitation management in the emergency department. Academic Emergency Medicine [Internet]. 2019 [cited 2019];26(10):1135–43.

Yap CYL, Taylor DM, Kong DCM, Knott JC, Taylor SE, Graudins A, et al. Management of behavioural emergencies: a prospective observational study in Australian emergency departments. Journal of Pharmacy Practice & Research [Internet]. 2019 Aug [cited 2019];49(4):341–8.

Physical and mechanical restraint and ongoing care while restrained

Table A6: Level of evidence summary: physical and mechanical restraint section

	Level I	Level II	Level III-1	Level III-2	Level III-3	Level IV	Level V	Consensus	N/A
Total number	3	0	0	2	10	1	10	3	0

Beysard N, Yersin B, Carron P. Mechanical restraint in an emergency department: a consecutive series of 593 cases. Internal and Emergency Medicine [Internet]. 2017 [cited 2019];13(4):575–83.

Chapman R, Ogle K, Martin C, Rahman A, McKenna B, Barnfield J. Australian nurses' perceptions of the use of manual restraint in the emergency department: a qualitative perspective. Journal of Clinical Nursing [Internet]. 2016 [cited 2019];25(9-10):1273–81.

Considine J, Berry D, Johnson R, Sands N. Vital signs as predictors for aggression in hospital patients (VAPA). Journal of Clinical Nursing [Internet]. 2017 [cited 2019];26(17-18):2593–604.

Cowling S, McKeon M, Weiland T. Managing acute behavioural disturbance in an emergency department using a behavioural assessment room. Australian Health Review [Internet]. 2007[cited 2019];31(2):296–304.

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Transition from the emergency care setting

Table A7: Level of evidence summary: transition from emergency care setting section

	Level I	Level II	Level III-1	Level III-2	Level III-3	Level IV	Level V	Consensus	N/A
Total number	0	0	0	0	0	0	1	0	1

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After the person has left the emergency care setting

Table A8: Level of evidence summary: after the person has left the emergency care setting section

	Level I	Level II	Level III-1	Level III-2	Level III-3	Level IV	Level V	Consensus	N/A
Total number	0	0	0	0	0	0	2	3	1

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