Safer Care Victoria

Caring for people displaying acute behavioural disturbance (ABD)

Clinical guidance to improve care in emergency settings

To receive this publication in an accessible format phone 03 9096 1384, using the National Relay Service 13 36 77 if required, or email info@safercare.vic.gov.au

Authorised and published by the Victorian Government, 1 Treasury Place, Melbourne.

ISBN 978-1-76131-569-5 (pdf/online/MS Word)

Available at www.safercare.vic.gov.au

VICTORIA State Government

CENA College of Emergency Nursing Australasia Ltd

Contents

Introduction

Everyone should expect 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 everyone, including people with acute behaviours of concern.

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 dynamic core component of care, so is presented first alongside six other possible moments:

1. assessment
2. transition from prehospital care
3. de-escalation
4. pharmacotherapy and ongoing care requirements
5. physical, 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[1]. It applies to people in emergency departments and urgent care centres and may be adapted for prehospital care such as ambulance services.

We have also developed an A3 size quick reference visual summary to use with this guidance *(See attachment end of document)*.

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.

[1]For guidance on managing children displaying acute behavioural disturbance see the Royal Children's Hospital guidelines <https://www.rch.org.au/clinicalguide/guideline_index/Acute_behavioural_disturbance__Acute_management/>

Guidance development

This initial guidance was developed in 2020 by experts including clinicians, healthcare consumers and underwent public consultation.

The new Mental Health and Wellbeing Act 2022 (MHW Act) came into effect on 1 September 2023, replacing the Mental Health Act 2014 (MHA). There was a time limited regulation (expiring on 31 March 2024) to exempt emergency departments and urgent care centres of designated mental health services from the obligations of the MHW Act in relation to restrictive interventions provided to a person under the MHW Act. This guidance has been reviewed and updated to reflect this change from 1st of April 2024, by experts including clinicians and a mental healthcare consumer.

Please note, that the provisions of the MHW Act apply in designated mental health services. Refer to the Office of the Chief Psychiatrist (OCP) Factsheet – Restrictive interventions in emergency departments and urgent care centres of designated mental health services <https://www.health.vic.gov.au/sites/default/files/2024-03/factsheet-restrictive-interventions-in-emergency-departments-and-urgent-care-centres.pdf>

Acknowledgements

Parts of the original 2020 Acute Behavioural Disturbance guidance were 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.

From a person-centred care perspective, the consumer will value 'connection before content'. Communicating in this way allows for a calmer and more supportive tone of conversation before introducing a clinical assessment. Please consider that as the person's distress levels rise, their ability to communicate may decrease. Emotions such as frustration can become increasingly apparent.

Assessment is an ongoing and dynamic process. Open communication and frequent engagement with the person can support building a trusting and respectful relationship, helping you to learn more about them, responding to their identified needs and prevent escalation. The clinical condition of people displaying acute behavioural disturbance can change quickly, so regular re-assessment 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, supporters, 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
- advance statement of preferences (MHW Act)
- My Health Record
- advance care directives
- wellness plans
- community treatment team
- behavioural support plans (including safety plans)

Ensure access to these are available on the client management interface (CMI) where applicable.

Maintain safety for all: know when to call for help

Do not attempt to care alone 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 <https://www2.health.vic.gov.au/health-workforce/worker-health-wellbeing/occupational-violence-aggression/code-grey-black>. The Department of Health (DH) has also prepared some weapons management principles and guidelines <https://www.health.vic.gov.au/sites/default/files/migrated/files/collections/policies-and-guidelines/w/weapons-management-in-victorian-health-services.docx>

WHERE TO ASSESS

Assess the person in a safe space where distractions are minimised, and you can give your full attention and will reduce stimuli for the person. Ask bystanders and unnecessary staff to move to another area, acknowledging that family, carers, and supporters (including nominated support persons (NSP), NDIS, or other psychosocial supports) may have a supportive and helpful role for both the person and the assessment. Consider mental health peer support workforce as a support during this time – if your service has this available.

Use a behavioural assessment room (BAR) if appropriate and available, adhering to the DH 'Guidelines for behavioural assessment rooms in emergency departments' <https://www.health.vic.gov.au/sites/default/files/migrated/files/collections/policies-and-guidelines/b/behavioural-assessment-rooms-emergency-depts-guide-june-2017-pdf.pdf>. If unavailable, assess the person in the highest acuity area possible, such as a resuscitation bay. Consider the person's needs for cultural (including translators), gender and disability or access supports at this time.

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)

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

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

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

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

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

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
- under 'care and control' as per s232 of the MHW Act
- physically or mechanically restrained.

PREPARING FOR ARRIVAL

- Allocate a safe and private care space that minimises interruptions. Use a BAR if appropriate and 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
  - mental health peer support workforce
- Allocate roles for team members, including **one person (a clinical colleague)** as lead communicator. Every effort is to be made by the lead communicator to discuss the steps that will be taken.
- 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 care directives, advance statement of preferences 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 their accompanying carer or supporter. This can include nominated support persons, NDIS, other psychosocial supports and mental health peer support workforce, or advocates (if a service has these available and also present) 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 person's wishes and preferences for care
- the precipitating event
- de-escalation techniques used
- the effects of medication given, including SAT score
- the social situation
- members of the person's supporters who may positively or negatively affect care
- medical, drug and alcohol, mental health, and any other relevant history.

As a general rule, do not share information with members of the person's support network without consent.

3. De-escalation

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 in supporting the person.

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.

The first step of de-escalation is to ask the person displaying acute behavioural disturbance if they have their own de-escalation plan, or techniques that have worked for them in the past.

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 <https://www.health.vic.gov.au/practice-and-service-quality/safewards-training-resources> are available from the DH website.
- DH has four free e-learning modules <https://www.health.vic.gov.au/worker-health-wellbeing/occupational-violence-and-aggression-training> to reduce violence and aggression in health services.
- The DH 'Guide for violence and aggression training in Victorian health services' <https://www.health.vic.gov.au/sites/default/files/migrated/files/collections/policies-and-guidelines/v/violence-aggression-training-guide-health-services-doc.docx> describes best-practice training principles for different staff groups.

HOW TO DE-ESCALATE

Consider the impact of gender identity, cultural identity, spiritual beliefs, 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.

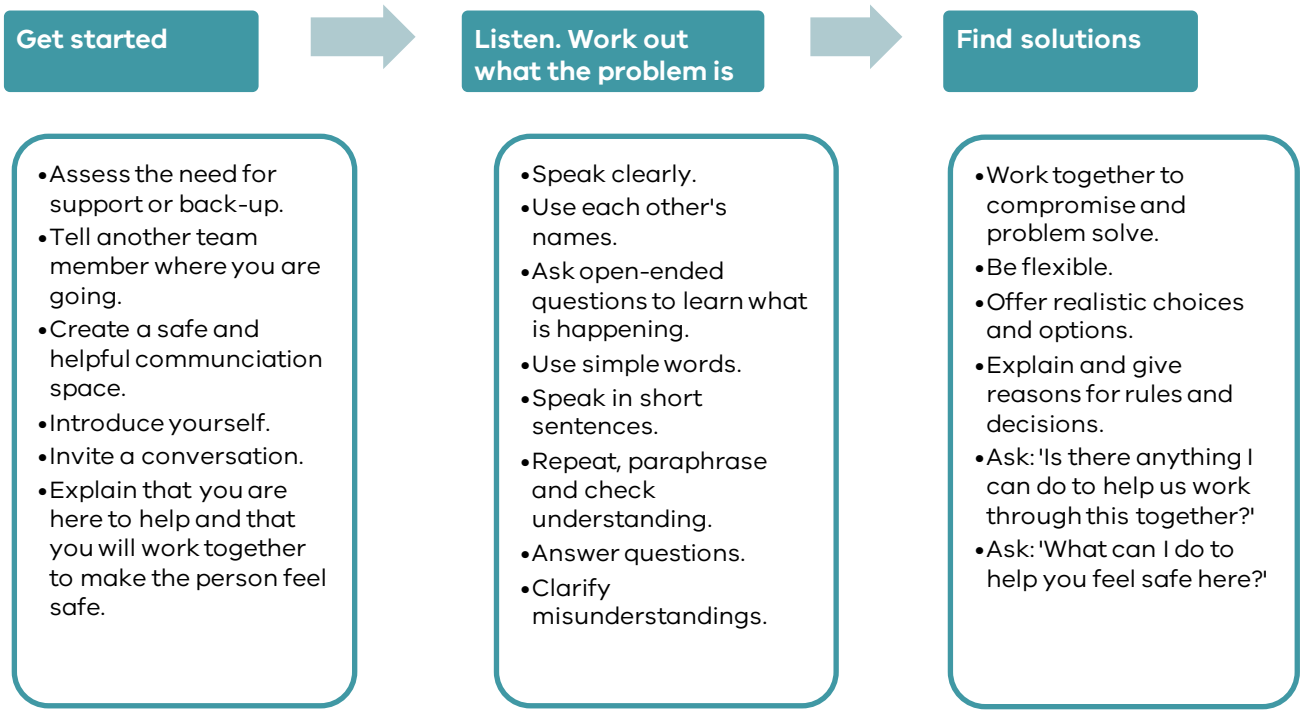
Table 4: Principles of de-escalation

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

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



4. Pharmacotherapy and ongoing care requirements

WHEN TO GIVE PHARMACOTHERAPY

A person displaying acute behavioural disturbance may be prescribed and administered sedative medications only when suitable sensory modulation, 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.

Pharmacotherapy is not the first-line treatment for people displaying acute behavioural disturbance. Give medication with sedative properties 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.

Requirements for urgent pharmacotherapy resulting in sedation where the MHW Act does not apply

Always try to explain in simple, kind terms the reason behind the sedation – then move on to obtain informed consent before providing treatment that can result in sedation. It is important for clinicians when making decisions regarding care requirements, that they consider the Victorian Charter of Human Rights and Responsibilities <https://www.humanrights.vic.gov.au/for-individuals/human-rights/>.

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

- you need to act immediately, 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:

- communicated to the person in the most concise and easy-to-understand terms
- the least restrictive care possible, after trying or considering all other less restrictive options
- a reasonable response to the risk of harm
- what a reasonable clinician would do acting in the best interests of the person and others at risk of harm.

Document your decision-making process and how you have considered these points.

Chemical Restraint under the MHW Act

As of **1 April 2024**, all emergency departments and urgent care centres of a designated mental health service must comply with the obligations in the Act regarding restrictive interventions, including chemical restraint, in relation to a person receiving mental health and wellbeing services. This includes reporting chemical restraint episodes within the meaning of the MHW Act to the Office of the Chief Psychiatrist.

Chemical restraint means 'the giving of a drug to a person for the primary purpose of controlling the person's behaviour by restricting their freedom of movement but does not include the giving of a drug to a person for the purpose of treatment or medical treatment'.

When determining what is chemical restraint within the meaning of the MHW Act and is therefore reportable to the Chief Psychiatrist, consider these 3 questions:

1. Is this practice taking place in a designated mental health service?
2. Is the person receiving a mental health and wellbeing service? Refer to the OCP Factsheet – Restrictive interventions in emergency departments and urgent care centres of designated mental health services <https://www.health.vic.gov.au/sites/default/files/2024-03/factsheet-restrictive-interventions-in-emergency-departments-and-urgent-care-centres.pdf>
3. Is the primary purpose of the 'giving of a drug' to control behaviour by restricting freedom of movement?

If the answer to all these questions is 'yes', the practice constitutes as chemical restraint under the MHW Act and is therefore reportable to the Chief Psychiatrist.

Legal requirements for the use of chemical restraint for a person subject to the *Mental Health and Wellbeing Act 2022*

- Chemical restraint must be authorised by an authorised psychiatrist or delegate; or if an authorised psychiatrist or delegate is not reasonably available, a registered medical practitioner or nurse practitioner acting within their ordinary scope of practice.
- Once a decision is made that chemical restraint is to be authorised, the prescriber of the medication must complete the relevant MHW Act 143 <https://www.health.vic.gov.au/mental-health-and-wellbeing-act-handbook/forms> (authority form for use of chemical restraint) to authorise restraint.
- Considerations, reasons and why the chemical restraint was necessary must be documented.
- Document all other less restrictive options tried or considered and explain why they were unsuitable.
- A registered nurse or medical practitioner must continuously observe the person subject to chemical restraint for not less than **one hour** after it is administered.
- A registered nurse or medical practitioner must also continuously clinically review the person subject to the restrictive intervention as often as is appropriate, having regard to the person's condition, but not less frequently than every **15 minutes,** for the duration of the restraint.
- The authorised psychiatrist must examine the person as soon as practicable after authorising the chemical restraint (or being notified that it has been authorised) and determine if the continued use of the restrictive intervention is necessary to prevent serious and imminent harm, then as often as appropriate in the circumstances but at least every **four hours**.
- If it is not practicable for the authorised psychiatrist to conduct the examination at the frequency that the authorised psychiatrist is satisfied is appropriate, the person must be examined by a registered medical practitioner when so directed by the authorised psychiatrist.
- Complete the form MHW Act 142 <https://www.health.vic.gov.au/mental-health-and-wellbeing-act-handbook/forms> to record observations while the person is restrained.
- Preserve dignity and meet basic needs by providing access to food, water, toilets, bedding and so on.
- Notify the nominated person, guardian, carer if you think restraint will affect the care relationship, parent if person under 16 years, DFFH if a relevant child protection order and the primary non-legal mental health advocacy service provider.
- Review use of restrictive intervention, extend opportunity for the person and their carer or support person to be involved in the review and report to chief psychiatrist.

People at high risk of harm from pharmacotherapy that results in 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 medication causing sedation. There is a higher risk of adverse physical effects from sedation if the person is:

- obese
- pregnant
- in poor health, in general
- intoxicated with alcohol
- affected by drug overdose.

HOW TO PRESCRIBE PHARMACOTHERAPY

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

Ensure monitoring and resuscitation equipment is readily available **before** giving sedative medication.

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

Oral pharmacotherapy

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

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

Medication	Dose	Onset time	Adverse effects
Oral diazepam	5–20 mg	30–60 minutes	• Drowsiness
		and/or	
Oral olanzapine	5–10 mg	30–60 minutes	• Extrapyramidal reactions • Hypotension

Parenteral pharmacotherapy

Give parenteral medication according to Table 6 if sedation is required but oral medication 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 medication. Intramuscular (IM) administration is as effective, faster and has less risk of needlestick injury.

Assemble a team of adequately skilled and trained staff to give parenteral medication. 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.

Where there has been chemical restraint used, clinical documentation for all patients, plus mental health and wellbeing documentation where indicated must be completed (i.e., chemical restraint): MHW Act 143 (authorisation form) and MHW Act 142 (observation form).

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

Medication	Dose	Onset time	Adverse effects
	Aim for the person to be drowsy but rousable with a SAT score of –1 or 0		
For most people requiring parenteral sedation			
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)
For people with suspected psychostimulant toxicity or alcohol withdrawal consider adding			
IM midazolam	5–10 mg. Repeat in 15 minutes. Maximum total dose 20mg.	2–15 minutes	• Respiratory depression • Oxygen desaturation • Airway obstruction • Hypotension
When safety is at extraordinary and immediate risk consider as first line or rescue therapy			
IM ketamine	4–5 mg/kg	3–4 minutes	• Hypertension • Emergence reactions • Tachycardia

Seek specialist advice about additional medication options if:

- the medication 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 30 mg; midazolam 2.5–5 mg, maximum total dose 20 mg; ketamine 1 mg/kg.

POST PHARMACOTHERAPY CARE REQUIREMENTS

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 care monitoring based on clinical judgement. Table 7 describes the suggested frequency of clinical assessment and documentation in relation to the SAT score.

If chemical restraint has been authorised for a person under the MHW Act, the requirements for monitoring must be met as per the MHW Act. This will include a **minimum of one hour of continuous observation**.

For people who received parenteral medication, as per Table 7, perform a clinical assessment **at least every 15 minutes for the first hour** after parenteral medication is given.

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

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

SAT score	Minimum clinical assessment	Minimum frequency of clinical assessment
If the person received parenteral medication, perform a clinical assessment at least every 15 minutes for the first hour		
0 or +1	Standard clinical assessment	Standard frequency of assessment
–1	SAT score, blood pressure, heart rate, respiratory rate, oxygen saturation	Every 30 minutes until SAT score increases
–2	SAT score, blood pressure, heart rate, respiratory rate, oxygen saturation, ECG	Every 15 minutes for 1 hour or until SAT score increases, then every 30 minutes until SAT score increases
–3		Continuous visual observation Clinical assessment every 15 minutes until SAT score increases

Admission or discharge

Refer to Section 6 of this guidance when considering admission or discharge of the person.

5. Physical, mechanical restraint and ongoing care while restrained

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 in this document, 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 disability, gender identity, cultural identity, spirituality, 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' <https://www.health.vic.gov.au/chief-psychiatrist/chief-psychiatrists-restrictive-interventions> as updated from time to time.

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 physical, mechanical, and chemical restraint only to prevent immediate harm to the person or others and for the shortest time possible. It is important for clinicians when making decisions regarding care requirements, that they consider the Victorian Charter of Human Rights and Responsibilities <https://www.humanrights.vic.gov.au/for-individuals/human-rights/>.

Legal requirements for a person not receiving mental health and wellbeing services under the *Mental Health and Wellbeing Act 2022*

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

- you need to act immediately, and it is not practical to obtain consent; and
- urgent care is required to prevent serious and imminent harm to the person or others.

The care you provide must be:

- in line with creating a safe space for everyone when providing care for the person displaying acute behavioural disturbance.
- communicated to the person in the most concise and easy-to-understand terms
- the least restrictive care possible, after trying or considering all other less restrictive options
- a reasonable response to the risk of harm
- what a reasonable clinician would do acting in the best interests of the person and others at risk of harm.

Document your decision-making process and how you have considered these points.

Legal requirements for a person subject to the *Mental Health and Wellbeing Act 2022*

All persons in emergency departments and urgent care centres, which have been deemed as receiving a mental health and wellbeing service will be subject to the restrictive intervention provisions under the Mental Health and Wellbeing Act 2022, irrespective of whether or not their status is as a compulsory patient.

This includes people brought by police or paramedics using their care and control powers under section 232 or 241 of the MHW Act.

Physical and mechanical restraint of this person must be authorised by an authorised psychiatrist or, if they are not reasonably available, a medical practitioner or nurse in charge.

A registered nurse may also authorise the use of physical restraint, but only circumstances where an authorised psychiatrist, registered medical practitioner or nurse in charge is not immediately available to authorise the use of physical restraint; and the registered nurse must reasonably believe that:

- all less restrictive options have been tried or considered and found to be unsuitable
- And that bodily restraint is necessary to;

    (a) prevent imminent and serious harm to that person or another person;

    (b) in the case of bodily restraint—to administer treatment or medical treatment to the person.

A registered nurse who authorises the use of physical restraint must notify the authorised psychiatrist, a registered medical practitioner, or a nurse in charge as soon as practicable after it is authorised. The notified clinician must then either authorise the continued use of the restraint or release the person from the restraint.

Document your decision-making process including:

- the reason why the restrictive intervention is necessary; and
- all the other less restrictive means tried or considered; and
- the reasons why those less restrictive means were found to be unsuitable.

You must inform the authorised psychiatrist, complete the MHW Act 140 or MHW Act 141 form to authorise restraint, and record observations on the MHW Act 142 form < https://www.health.vic.gov.au/mental-health-and-wellbeing-act-handbook/forms>.

HOW TO RESTRAIN

Continue de-escalation and communication throughout the restraint. Explain in a calm and easy to understand way what is happening, why, and regularly ask the person what they need or how the person can help.

Physical and mechanical restraint is invasive and restrictive. Never use it simply for convenience. You must stop any form of 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. However, to make it as safe as possible:

- avoid prone (face-down) restraint at all costs. Prone restraint has caused deaths from respiratory restriction and should be avoided where possible. If in the course of a restraint the person is put in a prone position, keep it to an absolute minimum and for **no more than three minutes**. Assign one staff member to actively time the duration of physical restraint.
- **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 pharmacotherapy or mechanical restraint.

Legal requirements for a person subject to restraint under the *Mental Health and Wellbeing Act 2022*

- Complete the relevant form MHW Act 140 or MHW Act 141, to authorise restraint.
- Considerations and reasons for using restrictive intervention must be documented.
- A registered nurse or medical practitioner must continuously observe the person.
- A registered nurse or medical practitioner must clinically review the person as often as appropriate, having regard to the person's condition, but not less than every **15 minutes**, including whether restraint is still needed.
- The authorised psychiatrist must examine the person as soon as practicable after authorising the restraint (or being notified that it has been authorised) and determine if the continued use of the restrictive intervention is necessary to prevent serious and imminent harm, then review the person as often as appropriate in the circumstances but at least every **four hours**.
- If it is not practicable for the authorised psychiatrist to conduct the examination at the frequency that the authorised psychiatrist is satisfied is appropriate, the person must be examined by a registered medical practitioner when so directed by the authorised psychiatrist.
- Complete the MHW Act 142 form to record observations while the person is restrained.
- Preserve dignity and meet basic needs by providing access to food, water, toilets, bedding and so on.
- Notify the nominated person, guardian, carer if you think restraint will affect the care relationship, parent if person under 16 years, DFFH if a relevant child protection order and the primary non-legal mental health advocacy service provider.
- Review use of restrictive intervention, extend opportunity for the person and their carer or support person to be involved in the review and report to chief psychiatrist.

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 review every 15 minutes, including:
  - whether restraint is still needed. Prepare to stop restraint now if it is no longer needed
  - 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.
- 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 the opportunity to walk, move all their limbs, drink and eat.
- Offer the person counselling and support from an appropriate staff member, including support person, nominated support person, advocate, carer, or mental health peer support worker if available.
- Frequently monitor the person according to your health service's guidelines and processes.
- If pharmacotherapy 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 ongoing 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 transfer or discharge consider the:

- wishes of the person
- wishes of the carer or guardian
- person's clinical condition, after discussion with senior clinical staff
  - ensure the person's function is consistent with their baseline function e.g.: 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, consider the mental health peer support workforce if available
- 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 < https://hcc.vic.gov.au/contact> (1300 582 113) if they want to escalate their feedback
- for people who received mental health and wellbeing service, contact details for the Mental Health & Wellbeing Commission <https://www.mhwc.vic.gov.au/contact-us-or-make-complaint> (1800 246 054) if they want to escalate their feedback.
- Independent Mental Health Advocacy (IMHA) is an opt out non legal agency that functions as a safeguard to support people who are receiving or at risk of receiving compulsory mental health treatment. Patients can be encouraged to contact IMHA (1300 947 820). Additional information and resources can be found at IHMAhttps://www.imha.vic.gov.au/ < https://www.imha.vic.gov.au/>.

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 medication
- communication and de-escalation skills.

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

If the person is administered medication, at the ED or UCC of a designated mental health service, for the purposes of chemical restraint for transporting them from that designated mental health service to any other place, then the provisions of the MHW Act apply as per Part 5.2 (mental health crisis) and 5.3 (transport required under the MHW Act).

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:

- nominated support persons
- psychosocial supports (NDIS support coordinators, hospital outreach post-suicidal engagement (HOPE) services, the way back support service (TWBSS) for post-suicide referrals)
- general practitioner
- case manager
- housing support worker
- carer
- family.

Discharging a person who was given medication causing 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.

7. Staff support, case review and governance

Caring for people displaying acute behavioural disturbance can be clinically, ethically, and emotionally challenging. Colleague 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.

WORKFORCE SUPPORT

- Consider offering psychological support to colleagues, ideally with a senior staff member, a line manager or a professional leader.
  - 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.
- Clinical supervision is a confidential space for the workforce to provide a space for reflection on clinical practice.
- Taking part in psychological support should not be mandatory because it may hinder individual coping strategies.

Staff support resources

DH has four e-resources <https://www.health.vic.gov.au/worker-health-wellbeing/occupational-violence-and-aggression-post-incident-response> 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

- All restrictive interventions under the MHW Act are required to be reviewed as soon as practicable after the episode.
- A person who was subjected to the restrictive intervention, should have the opportunity to be involved in the review process.
- Staff should consider the following when conducting a review of the restrictive intervention:
  - most appropriate staff to lead this review process
  - an appropriate time, place, and for the person to be involved
- The person is to be encouraged to have peer support or a nominated support person accompany them.

- 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 a restrictive intervention resulted in serious harm or death. This is a sentinel event category <https://www.safercare.vic.gov.au/report-manage-issues/sentinel-events/what-to-report>.
- Reviewing care episodes can identify opportunities for systemic improvement. Possible review questions may include:
  - What was done well?
  - What did the person suggest could be done differently?
  - 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 the actions required.
- 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.

LOCAL AND ORGANISATIONAL GOVERNANCE

Both qualitative and quantitative data should be collated and presented at local and organisational governance committees that are responsible for the oversight, monitoring and reporting of restrictive interventions.

This will ensure that any key improvement opportunities are identified and actioned accordingly.

It is important to ensure that local staff and team members are receiving appropriate feedback and identifying further learning opportunities from the review of restrictive interventions.

Additional resources

Resources currently being updated:

- Chief Psychiatrist's clinical guideline and reporting directive for restrictive interventions
- Restrictive Interventions in Emergency Departments and Urgent Care Centres of DMHS factsheet

Glossary of terms and abbreviations

BAR	Behavioural assessment room
CMI	Client management interface
CNS	Central nervous system
DH	Victorian Government Department of Health
ECG	Electrocardiograph
IM	Intramuscular
IV	Intravenous
kg	Kilogram
mg	Milligrams
QT segment	The time from the start of the Q wave to the end of the T wave on an ECG
SAT	Sedation assessment tool
VHIMS	Victorian Health Incident Management System

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 (ABD)*

Maintain safety for all: Know when and how to call for help

Ongoing and repeat assessment: When the situation changes or with new information. Identify how to best support the person

Assessment
Pages 4-6

Consider past experiences and individual needs of the person

Optimise assessment environment
- A safe space with minimal distractions
- Use a BAR if available, or high-acuity space
- Know when to call for help

Initial assessment
- Seek information from many sources
- Assess underlying cause, consider 'red flag indicators'
- Use the SAT and STAMP framework

Transition from prehospital care
Pages 7-8

Pre-arrival notification

Prepare for arrival
- Assemble a team
- Allocate a care space
- Discuss possible support and de-escalation strategies

Handover
- Use a structured handover tool
- Communicate key information

De-escalation
Pages 9-11

- Consider the impact of gender identity, cultural identity, language, trauma history and individual needs
- Assign **one** staff member as the lead communicator

Apply principles of de-escalation
- Non-verbal communication
- Verbal communication
- Environment

Follow the stages of verbal de-escalation
- Get started
- Listen. Work out what the problem is
- Find solutions

Pharmacotherapy
Pages 12-16

- Consider less restrictive options and legal requirements
- If authorising chemical restraint, adhere to requirements of the MHW Act '22
- Aim for the person to be **drowsy but rousable** with a SAT score of –1 or 0

Oral pharmacotherapy
5–20 mg diazepam and/or 5–10 mg olanzapine

Parenteral pharmacotherapy
- For most people: 5–10 mg IM droperidol × 2
- For people with psychostimulant toxicity or alcohol withdrawal consider adding: 5–10 mg IM midazolam × 2
- When safety is at extraordinary and immediate risk consider as first line or rescue therapy: 4–5 mg/kg IM ketamine

Safe and vigilant post-pharmacotherapy care
- 15-minutely clinical assessment for 1hr, then guided by SAT score
- Minimum 1 hour of continuous observation if chemical restraint is authorized

Physical and mechanical restraint
Pages 17-20

- Not a therapeutic intervention; always a **last resort**
- Consider legal requirements, inclusive of MHW Act
- Always for the shortest time possible

Optimise safety for all
- Assemble a team
- Consider individual needs of the person
- Use the safest techniques possible
- Assign **one clinical staff member** to monitor the person's vital signs, head, neck, airway and chest

Preserve dignity and maintain safety
- Document a clinical assessment every 15 minutes
- **Continuously** observe. Offer food, water, toilet, etc.
- Stop restraint as soon as no longer required, to prevent serious and imminent harm
- Perform a post-restraint assessment.
- Offer counselling, feedback and involve support persons where available

Transition from emergency care
Pages 21-23

Offer the person options for feedback and debrief, inclusive of available carer, support person or advocate.

Admit to the appropriate specialty and health service

Discharge with referrals and advice

Staff support and case review
Pages 24-25

Consider psychological support for staff

Review the care episode
Communicate review findings and take action

To receive this publication in an accessible format phone 03 9096 1384, using the National Relay Service 13 36 77 if required, or email info@safercare.vic.gov.au

Authorised and published by the Victorian Government, 1 Treasury Place, Melbourne.

ISBN 978-1-76131-569-5 (pdf/online/MS Word)

Available at www.safercare.vic.gov.au

VICTORIA State Government

Safer Care
Victoria