
Caring for people displaying acute behavioural disturbance

Clinical guidance to improve care
in emergency settings





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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.¹ 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)

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
<ul style="list-style-type: none"> • Prolonged glaring at staff • Absence of eye contact (culture and disability dependent) 	<ul style="list-style-type: none"> • Sharp retorts • Sarcasm • Increased volume • Demeaning inflection 	<ul style="list-style-type: none"> • Flushed appearance • Hyperventilation • Rapid speech • Expressed lack of understanding about care processes 	<ul style="list-style-type: none"> • Talking under their breath • Criticising care just loud enough to be heard • Repetition of same or similar phrases 	<ul style="list-style-type: none"> • 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
<ul style="list-style-type: none">• 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	<ul style="list-style-type: none">• 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	<ul style="list-style-type: none">• Psychotic disorders• Mania• Agitated depression• Anxiety disorders• Personality disorders	<ul style="list-style-type: none">• 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 dissociatives 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
- 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.

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.

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.

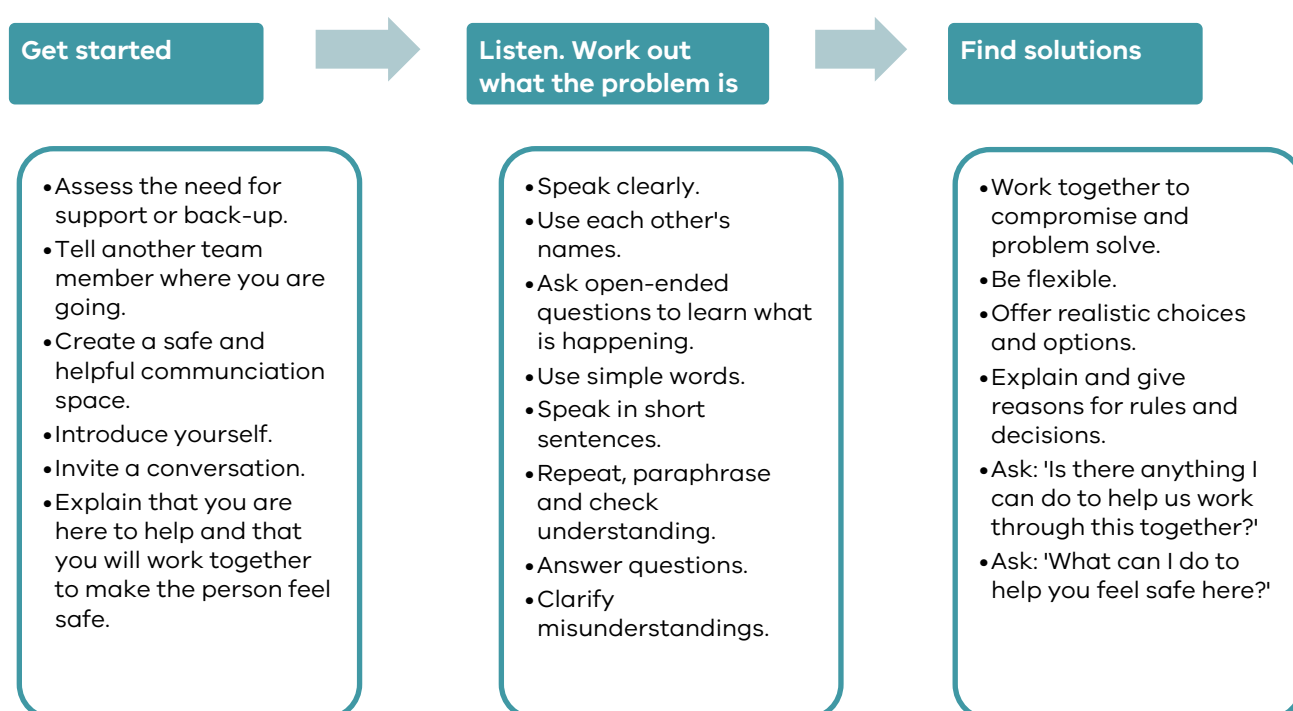
Table 4: Principles of de-escalation

Non-verbal communication	Verbal communication	Environment
<ul style="list-style-type: none">• Allow time for open communication. Don't rush.• Move slowly and gently.• Use culturally appropriate eye contact.• Relax your body.<ul style="list-style-type: none">– 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.	<ul style="list-style-type: none">• Keep the conversation centred on the person's needs.• 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.<ul style="list-style-type: none">– 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.	<ul style="list-style-type: none">• 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. 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

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	• Extrapyrarnidal reactions • Hypotension

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

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	<ul style="list-style-type: none">• Extrapyramidal reactions• QT segment prolongation (minimal clinical significance)
For people with suspected psychostimulant toxicity or alcohol withdrawal			
IM midazolam	5–10 mg. Repeat in 15 minutes. Maximum total dose 20mg.	2–15 minutes	<ul style="list-style-type: none">• Respiratory depression• Oxygen desaturation• Airway obstruction• Hypotension
When safety is at extraordinary and immediate risk			
IM ketamine	4–5 mg/kg	3–4 minutes	<ul style="list-style-type: none">• 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

SAT score	Minimum clinical assessment	Minimum frequency of clinical assessment
If the person received parenteral sedation, 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 and 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](#) 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.

7. Staff support and case review

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

BAR	Behavioural assessment room
CMI	Client management interface
CNS	Central nervous system
DHHS	Victorian Government Department of Health and Human Services
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*

