Australasian College
for Emergency Medicine

# Statement on the use of restrictive practices in emergency departments

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## Document review

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## 1. Purpose and Scope

This document is a position statement of the Australasian College for Emergency Medicine (ACEM) and relates to the application of restrictive practices in the context of people with an acute behavioural disturbance from any cause.

The statement is applicable to emergency departments (EDs) in Australia and Aotearoa New Zealand. It should be read in concert with the College's Position Statement on Violence in the ED.
In addition to this statement, clinicians should be aware of the relevant mental health statutory provisions in their jurisdiction.

The statement is applicable to all people attending an ED. This can include patients experiencing a variety of health problems in a range of situations, not just those experiencing psychiatric symptoms. The application of the statement should be tailored to the specific circumstances of an individual.

This document does not apply to restraint used by law enforcement, corrective services. or other similar government officials where restraint of the person remains under their legal responsibility.

## 2. Position

ACEM acknowledges that the personal experience of restraint is confronting. An empathetic, trauma-informed approach should be employed. It is acknowledged that there is potential for harm when employing restrictive practices through physical injury, pharmacological complications, and/or psychological trauma.

Alongside these personal experiences, we must balance the fact that that the ED is a workplace, with a duty of care to all its staff, patients, and family members/carers. Staff also have a responsibility to keep people safe during assessment and treatment, as well as ensuring the safety of other staff, other patients, and their families/carers. The decision to employ restrictive practices is a balance of that duty of care with the human rights of the individual.

Emergency physicians must be aware of the capacity of the patient to make an informed decision about their health care prior to the implementation of any restrictive practices. Lack of capacity is a pre-requisite for the use of restrictive practices and Emergency Physicians must be aware of their legal and ethical obligations in their jurisdictions.

All six criteria below must be met for use of restrictive practices:

1. Failure of other lower risk attempts to de-escalate the behaviour of the person.
2. The person is experiencing acute behavioural disturbance, and this is precluding safe care.
3. The person is of significant imminent risk of harm to self or others.
4. The person lacks the capacity to make informed decisions about their health.
5. There is a need for ongoing assessment and/or treatment in the ED.
6. A proportionate, graded team-based approach should be utilised aiming to use least-restrictive practices.

ACEM acknowledges that an experienced Emergency Physician has the capability to make a rapid assessment of the above six criteria in order to apply appropriate restraint in dangerous situations. The ED is not a suitable environment for the longitudinal management of people with any health condition. After initial assessment and management, people requiring further care should be transferred expediently to an appropriate site for ongoing care by the appropriate health service once behaviour and processes allow. Lengthy waits in the ED for admission to an in-patient unit may adversely impact patients and increase the risk of escalating behaviour, violence, and the requirement for repeated restraint.

Temporary restrictive practices may be required for the initial stabilisation of acute behavioural disturbance in order to facilitate an ED assessment to differentiate organic or co-existent medical concerns, such as overdose/poisoning, delirium, or head injury. Mental and physical health assessment and a decision to admit should run concurrently or immediately after an episode of restraint or sedation.

It is recognised that management of acute behavioural disturbance is resource-intensive, and that EDs must be adequately resourced to ensure that restrictive practices are minimised, and when necessary, are safely and appropriately applied. Acute behavioural disturbance can follow an unpredictable course and there is a need for ongoing reassessment and recognition of a fluctuating need for intervention.

## 3. Definitions

Restrictive practices are by their nature involuntary. The involuntary treatment of patients can involve complex medical and ethical decision-making and has a differing legal framework across jurisdictions.

Restrictive practices include:

a) Restraint: the restriction of an individual's freedom of movement both physical/manual (hands on immobilisation techniques) or mechanical (using devices such as belts or straps). Restraint may also involve the use of medication when administered to a person without their explicit, free, informed consent with the purpose of reducing the movement of a patient or activity that is otherwise preventing their safe care. The choice of agent may also have a role in providing treatment for the distressing symptoms of the underlying illness.
b) Seclusion: the involuntary confinement of a patient at any time alone in an enclosed environment from which free exit is prevented.

The term chemical restraint refers to the administration of medication for the primary aim of controlling behaviour, rather than providing safe care. Chemical restraint should not be occurring in the ED. The use of medication to allow the safe assessment and treatment of the patient in the ED is not considered chemical restraint.

## 4. Background

Restrictive practices occur within legal frameworks, which vary between jurisdictions. Clinicians should acquaint themselves with the ACEM policy on violence in the ED, the legal requirements of their jurisdiction with respect to restrictive practices, and the policies and procedures within their workplaces.

The management of agitated or violent individuals in the ED can be challenging and poses a safety risk to the individual, staff, and other patients and the people accompanying them.[1,2,3,4] In cases where de-escalation and less restrictive practices such as oral anxiolytics have failed, restrictive practices may be required to manage behaviour that poses an immediate threat to the person themself or to others.

The use of restrictive practices in many circumstances is a result of system failure. In particular, access block and unreasonable and excessively long waits for definitive care and disposition can aggravate patient distress, necessitating the use of restrictive practices where EDs are not staffed and resourced to provide clinical supervision and non-restrictive de-escalation of patients over prolonged periods of time.[1]

The use of restrictive practices in the ED may also be predicated on their use in the pre-hospital environment. Australian Institute for Health and Welfare (AIHW) data shows that people requiring mental health care are more likely to arrive via ambulance (50.5 per cent) or police/correctional vehicles (6.0 per cent) compared to other people seeking care in the ED (26.9 per cent and 0.6 per

cent respectively).[5] Therefore, the use of restrictive practices in the pre-hospital environment may impact the behaviour of the patient on arrival in the ED.

The use of restrictive practices has been shown to exacerbate symptoms of mental illness and lead people to avoid care in the future.[3,6] However, there is a lack of research exploring peoples' experiences of restrictive practices in the ED. For example, one American study of the use of physical restraint found negative experiences from patients including isolation, distrust, and feeling violated.[7] In comparison, an Australian study of patients who had been sedated to manage behavioural disturbance in the ED showed that despite the use of sedation, most patients understood that it had been for the benefit of both themselves and staff, and had considered the use of such practices as appropriate or their only option.[8]

## 5. Recommendations

### 5.1 Pre-hospital

Behavioural disturbance is primarily a health issue. Therefore, transport should ideally be via a health service / ambulance, with police used in a support role where required for safety of emergency service providers.

ACEM recognises that innovative approaches to mental health assessments in the community have the potential to reduce the risk of acute behavioural assessment escalating.

### 5.2 De-escalation

People presenting to ED with acute behavioural disturbance should be treated with empathy and respect. Basic comforts such as food, drink, a warm blanket or change of clothes can assist de-escalation measures greatly. A graded, collaborative approach is required utilising verbal de-escalation, trauma-informed communication, stimulus reduction, and where appropriate anxiolytic medication voluntarily taken before application of a restrictive practice. Restrictive practices are a last option after initial approaches are unsuccessful and there is ongoing risk to the safety of patients or staff. De-escalation training should be provided as part of an essential emergency competency. Open, honest communication with patients and their carers or families is important.

### 5.3 The use of medications for safe assessment

The use of medications as a form of restrictive practice should only be used where it is allowed under jurisdictional guidelines. When undertaking this approach, a minimally restrictive approach should be maintained. Where possible, a person should be invited to consent to administration of medication, in a manner without pressure or coercion. Staff should aim to collaborate with the person where possible.

When a decision has been made that medication must be administered despite a lack of consent; a minimal-harm approach should be undertaken. The type and route of sedative chosen will be affected by many factors (patient, staff, departmental) but should prioritise patient and staff safety, and follow pre-determined local policy based on the best available evidence

The aim of safe assessment is never to render the patient unconscious, but to reduce their level of arousal in order to safely assess and care for them. The person must be placed in an area of the department with access to appropriate staffing, monitoring, and resuscitation equipment to maintain a safe level of sedation.

### 5.4 Physical or mechanical restraint

ACEM advocates that physical or mechanical restraint may only be used if it is necessary to prevent imminent and serious harm to the patient or to another person, where all reasonable and less restrictive options have been tried or considered, and where it is allowed under jurisdictional guidelines. Physical restraint may be used to administer medical treatment including to facilitate safe assessment. Any physical or mechanical restraint however should be used for as short a duration possible, and only as a bridge to effective de-escalation.

Restraint carries both immediate and delayed risks to the patient, both psychological and physical, and significantly impacts upon any therapeutic relationship between staff and patient.

The use of restraint on a patient subject to mental health legislation will vary between jurisdictions. ED staff should follow guidance provided by their jurisdiction.

Though it is noted that pre-hospital personnel may need to utilise restraint to facilitate transport of a patient to the ED, it is expected that the ED will reassess as soon as possible after arrival whether continued restraint is required as well as plan to bridge to effective behavioural sedation. Ideally, jurisdictions will ensure consistent guidance in the pre-hospital and ED environments.

### 5.5 Seclusion

ACEM regards seclusion as a practice that has no therapeutic benefit and can disrupt therapeutic relationships between clinicians and the patient. EDs have significant differences in resources including number and ability of security personnel, senior medical and nursing staff, and high acuity bed availability. Despite this every effort should be made for the safe, timely and dignified treatment of people experiencing acute severe behavioural disturbance. This is not achieved though seclusion.

In line with this ACEM has a published a minimum standard for safe assessment rooms within EDs. It states that these rooms are to be used for 'rapid assessment and containment only' and are 'not designed for longer term seclusion'. The aim of the room is to provide a safe area that maintains a patient's privacy and dignity while their agitation is managed. Once a decreased state of agitation is achieved, the patient should be moved into a suitable treatment space for ongoing care. If seclusion is permitted under jurisdictional guidelines and is to be used, it should be used for the minimal amount of time, as a bridging event, until safe assessment has occurred.

### 5.6 Debriefing

Where possible, a patient should be debriefed following an instance of restrictive practice use. Debriefing can take a number of forms depending on staff capacity. This may be with or without a member of the ED care team but should ideally involve a member of staff trained and resourced for this purpose.

Debriefing for the patient and the family/carers provides a non-punitive, trauma-informed opportunity to review the incident involving the restrictive practice, identify possible triggers and may provide alternative measures for de-escalation should further need occur. It should acknowledge the traumatizing effect of the restrictive practice itself on all involved and provide honest communication regarding proportionality and intentions of beneficence.

ACEM supports a review of the episode by the care team to reflect and identify opportunities for systemic improvement with the overarching aim that restrictive practices should be minimised wherever possible.

### 5.7 Documentation and reporting

There is a lack of data regarding the use of restrictive practices. Use of restrictive practices in EDs should be governed by clear clinical governance frameworks, standardised documentation tools that include patient discharge summaries, and clear reporting pathways. This will allow:

1) Auditing to identify and monitor the impact on patient outcomes and the relationship with ED length of stay, and the availability and accessibility of acute or community-based services and support.
2) Monitoring oversight to ensure practice of least restrictive principles with proportionality and intentions of beneficence are adhered to.
3) Benchmarking at a national level to identify any possible local systems or resourcing issues.
4) Determination of a framework under which the restraint occurred i.e. Mental Health Act or Duty of Care principles. This will help inform further policy recommendations and legal reform.

The minimum data recorded for each restrictive practice event should include:

- The reason/s for using the restrictive practice. Multiple reasons may apply, including but not limited to:
    - Prevention of serious harm to the patient.
    - Prevention of serious harm to another person.
    - Facilitation of medical assessment and / or treatment.
    - Facilitation of mental health assessment and / or treatment.
- The measures used prior to the restrictive practice being utilised.
- The type of restrictive practice.
- The time of initiation and time of cessation of each restrictive practice used.
- The legal framework used (Mental Health Act or Duty of Care principles).

This should be documented in the clinical notes as well as a local centralised repository whether that be the electronic medical record, local risk registers, and/or a register as determined by jurisdictional Mental Health Acts. Reporting responsibilities should be rationalised to decrease disruption to clinical work.

### 5.8 Design principles and alternative models of emergency care

Collaborative, multidisciplinary, and timely care in a low-stimulus and safe environment can decrease the number of security calls, the use of restrictive practices and patient length of stay. ACEM encourages the further development and adoption of innovative and alternative models of emergency care for acute behavioural disturbance that embraces these principles.

ACEM also encourages all new EDs to incorporate specific design principles to ensure low-stimulus and safe environments are provided to remove potential triggers for acute behavioural disturbance, as well as to provide sensory means for de-escalation and remove the need for restrictive practices. ACEM also encourages existing departments to adopt any measures they can within their current design to decrease restrictive practices, such as sensory boxes, decreasing harsh lighting, or placement in a quieter treatment space.

### 5.9 Staffing requirements and training

It is recognised that verbal de-escalation techniques should be considered a core capability of all ED staff with training encouraged in improving those skills. Likewise, security personnel and/or orderlies are an important staffing resource in the management of acute behavioural disturbance who should also be appropriately resourced and trained in de-escalation techniques as an integrated part of the ED clinical team. Well-trained, experienced hospital security personnel/orderlies with strong physical presence, excellent communication skills, an aptitude for learning, a solid understanding of cultural safety, and a positive 'customer service' attitude can be successfully utilised in the ED to problem solve and eliminate unnecessary conflict.[9]

ACEM acknowledges that rural and remote EDs are often not resourced to contract after-hours security personnel and instead rely on the on-call use of private security firms and/or local police. In these contexts, specific local arrangements should be in place, preferably with memorandums of understanding, to ensure the safety of patients and staff.

### 5.10 Clinical governance

EDs and mental health services should establish functional, co-operative relationships. Concurrent assessments by the ED team and the psychiatry team should occur wherever possible for those patients who have acute behavioural disturbance or are escalating. This is to improve access to timely definitive decisions and minimise repetition as a trigger for patient escalation.

For patients who require restrictive practices more frequently, management plans collaboratively authored by the ED team and the psychiatry/mental health team (community and inpatient) or other relevant inpatient units (such as Alcohol and Other Drugs or acute medicine), as well as police and paramedics, should be developed to minimise the use of restrictive practices.

ACEM believes that the ED is an unsuitable environment for the longitudinal management of admitted mental health patients and contributes to escalation, absconding, and the use of restrictive

practices. An inpatient bed should be made available at a delegated receiving unit as soon as possible. Regular liaison meetings to collaboratively evaluate performance and quality issues, engage other relevant stakeholders, review local communication processes; allow benchmarking of data and activity, and development of site-based local service agreements will underpin this relationship.

## 6. Related Documents

ACEM Policy on Violence in Emergency Departments

ACEM/RANZCP Policy on the Medical Assessment of Patients with a Mental Health Condition in the ED

ACEM Emergency Department Design Guidelines

## 7. References


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Australasian College for Emergency Medicine
34 Jeffcott St
West Melbourne VIC 3003
Australia
+61 3 9320 0444

acem.org.au