Guideline for the prevention and management of the use of restraint for nutritional delivery in young people with eating disorders at The Royal Children's Hospital

November 2025

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This guideline was developed for use in the medical adolescent ward (Kelpie) at The Royal Children's Hospital, Melbourne, Australia. Other centres are welcome to adapt this guideline for their context with appropriate referencing. This guideline is due for review in November 2026.

1. Aim of guideline

This clinical guideline aims to support clinicians and other professionals working with medically unstable young people (YP) with a diagnosis of an Eating Disorder (ED), including but not limited to: Anorexia Nervosa (AN), Atypical Anorexia Nervosa (AAN), Bulimia Nervosa (BN) and Avoidant Restrictive Food Intake Disorder (ARFID), at The Royal Children's Hospital Melbourne (RCH), to reduce the instances of restraint for nasogastric tube (NGT) feeding and to encourage best practice if restraint is required.

Through utilisation of this guideline, clinicians will promote person-centred, trauma-informed best practice, informed by those with lived experience, and ensure the consistent use of the least restrictive interventions for YP with an ED. The development of this guideline is responsive to the recommendations from the Royal Commission into Victoria's Mental Health System,[1] and congruent with (1) the Mental Health and Wellbeing Act 2022 (Vic),[2] (2) Safer Care Victoria guidance [3] and (3) RCH strategic priorities, which all aim to promote consumer autonomy and consistent, sustainable use of least restrictive interventions.

This guideline includes 3 documents:

1. Main Guideline
2. Appendix A: Checklist prior to restraining a young person at RCH with an ED for delivery of nutrition
3. Appendix B: PEACE sensory screening tool

2. Background to the Guideline

The priority during the admission of YP with EDs to an acute care paediatric service is to achieve medical stability, by delivering adequate nutritional intake. Where there is resistance to nutritional intake by the young person, at times the need for restraint to feed via a nasogastric tube (NGT) is considered. In an audit of YP admitted to the adolescent ward at The RCH from 2021 to the end of 2023, 76/217 (35%) needed a NGT for feeding, and of this group, 23 YP, or 11% of all those admitted required restraint.[4] A small number of

YP experienced repeated and frequent episodes of restraint, over many months. The Royal Commission into Victoria's Mental Health System made clear and definitive recommendations regarding the use of restraint and seclusion, specifically that practices of restraint and seclusion should be eliminated by 2031.[1] While there are statewide efforts to realise this in mental health settings, the population of YP with EDs in paediatric acute care settings requiring restraint for nutritional rehabilitation is somewhat unique and requires particular consideration.

3. Guideline Development

This guideline was developed in conjunction with lived-experience advisors (LEA) – three young adults with lived experience of being restrained during adolescence for nasogastric tube placement and nutritional delivery and two parent/carers of YP who had experienced restraint in this context – and with reference to national and international literature regarding child and adolescent eating disorder treatment protocols, alongside health ethics literature. The research team included expert clinicians from paediatrics, adolescent medicine, mental health, bioethics, and nursing research from The Royal Children's Hospital Melbourne (RCH) and The University of Melbourne.

4. Guideline Funding

The Victorian Nurses and Midwives Trust

Funding for the research and development of this guideline was provided by The Victorian Nurses and Midwives Trust.

5. Who can use this guideline

The intended audience for this guideline is for all professionals working in acute paediatrics and/or adolescent medicine caring for medically compromised YP under the age of 18 with an ED at RCH. The intent is that all involved staff/professionals are familiar with the content and recommendations within this guideline **before** they are involved with a decision to restrain or participate in restraint of a YP for NGT insertion and nutritional delivery. Early and frequent reference to this guideline will support staff at RCH in reducing the instances of restrictive interventions in this patient group.

6. Definition of terms

ABBREVIATION	EXPANSION
AAN	Atypical Anorexia Nervosa
AN	Anorexia Nervosa
ANUM	Associate Nurse Unit Manager
ARFID	Avoidant Restrictive Food Intake Disorder
BSP	Behavioural Support Profile
ED	Eating disorder
EMR	Electronic medical record
LEA	Lived Experience Advisor
LEAG	Lived Experience Advisor Group
MHA	In this guideline referring to Mental Health and Wellbeing Act 2022 (Vic)
NGT	Nasogastric Tube
NUM	Nurse Unit Manager
RCH	The Royal Children's Hospital (Melbourne)
YP	Young person/people
TERMS	DEFINITION
Parent/carer	Anyone in a role as primary caregiver to the young person at the time they were treated for AN/AAN.
Restraint	As per the MHA[2] : (i) The use by a person of their body to prevent or restrict another person's movement (physical restraint); or (ii) The use of a device to prevent or restrict a person's movement (mechanical restraint); or (iii) Giving of a drug to a person for the primary purpose of controlling the person's behavior by restricting their freedom of movement (chemical restraint).

7. Considerations in the use of restraint in paediatric healthcare settings

7.1 Legal considerations: The Mental Health and Wellbeing Act 2022 (Vic)

The use of restraint is regulated in Australia through state and territory laws. In Victoria, restraint and seclusion is governed by **The Mental Health and Wellbeing Act (Vic) 2022 (MHA)**[2] which applies to all medical and mental health settings. The broad values which underpin the MHA seek to balance the freedom and autonomy of individuals with the need to ensure the safety of individuals and the community. Principles of restraint use under the

Act include that restraint must only be used where necessary to prevent serious and imminent harm, that the least restrictive means should be applied with the least force for the least time possible, with all other alternatives to restraint attempted or considered.

To achieve this balance, legislative requirements determine that restrictive practices, including involuntary hospitalisation, seclusion and restraint, should only be used as a last resort, only when necessary to prevent harm, and with the least restrictive method possible. The MHA provides direction to ensure that any decision to restrain is regularly reviewed, and restraint is discontinued as soon as it is no longer clinically indicated. In addition, the MHA includes specific decision-making principles to promote the rights of people subject to compulsory assessment and treatment and restrictive interventions.

This guideline assumes compliance with the specific procedures, processes, and responsibilities as outlined in the MHA below. It is the responsibility of individual clinicians, hospital departments and institution leadership to ensure that all who care for YP with an ED are familiar with, and adhere to, the requirements of the MHA. **This guideline does not in any way supersede the legislative requirements in the MHA.**

See Mental Health and Wellbeing Act 2022 for further information.

7.2 Consent/agreement of the young person

It is established in case law that YP under the age of 18 can give their own informed consent for their medical treatment if they are deemed by the clinician to have the maturity and capacity to understand and weigh up treatment options and the consequences of each (mature minor principle).[5] Where this threshold is not met, either due to developmental immaturity or impaired capacity, ethical best practice is that the YP, as well as their parent/carer, would be fully informed, and the agreement of the YP would be sought in conjunction with parental consent. **The YP should therefore always be given every opportunity, appropriate to the urgency of the clinical decision to be made, to engage in treatment discussions and agree to treatment, regardless of age, developmental stage or illness severity.**

Proceeding with restraint without the YP's agreement can only be justified where significant harm would otherwise result.

7.3 Consent of parent/carer

Unless deemed a mature minor, parent/carer (or other legal guardian where that applies) maintain decision-making authority for their children until the age of 18 years. Thus, parental consent is required for clinical interventions, and this includes NGT insertion and feeding. However, if restraint is deemed necessary, the legal requirement in Victoria is that even when there is parental consent, the MHA must be appropriately invoked. Therefore, all YP requiring restraint for feeding as part of their treatment of an ED must be placed under an Assessment Order through the MHA. The result of this means decision-making regarding clinical care then rests with the treating team in conjunction with an authorised psychiatrist, not the parent/carer. Following the review of an assessment order by a psychiatrist, it may be determined that ongoing care under the MHA is required, and a Temporary Treatment Order is then needed to continue the provision of care directed by the medical team.

Throughout this process, it is legally required, and best ethical practice, that parent/carer (or legal decision maker) are informed and consulted about any treatment decisions, and their views considered. This includes any restrictive interventions.

7.4 Ethical considerations

Decisions to restrain a YP for any acute clinical intervention involves trade-offs between fundamental ethical values.[6] The ethical justification for using restraint is that it facilitates a clinical procedure that will be beneficial or prevent further harm, including death or long-term health complications. However, there are also ethically significant downsides to restraining, including loss of autonomy and deprivation of liberty, development of distrust, ongoing psychological trauma and possibly physical injury.[7-8]

Weighing up the ethical considerations relevant to restraining a medically unstable YP to deliver nutrition is particularly complex, because this situation differs from the use of restraint in other mental health emergencies. In other situations, restraint is typically in response to acute dysregulation that is an immediate threat to self or others. In the context of restraining to feed a medically unstable young person, the risk of harm to the young person from not having nutritional intake is perhaps not immediate but is significant and could occur within a short time. This can make the legal and ethical requirement to use restraint only to prevent immediate harm more difficult to interpret. In addition, in cases of ongoing food refusal, restraint for nutritional delivery is often required at each mealtime (3-

6 times a day), resulting in predictable repeated restraint episodes. The RCH has a Children's Bioethics Centre who can be contacted to support clinicians with these decisions.

7.5 Trauma –informed care principles

The principles of *trauma- informed care*[9] have been adopted to underpin the guideline development, from collaborating with those with lived experience in the research phase, to framing the guideline content. Trauma informed care principles emphasize (1) *Trust*: actioned by transparency and honesty, reciprocity, establishing safe spaces, allowing time; (2) *Understanding and Acceptance*: actioned by actively listening, acceptance of difference, giving agency and choice; (3) *Self-awareness*: actioned by acknowledging others' expertise, practicing critical reflexiveness, respecting boundaries; and (4) *Relationship building*: actioned by open communicating with respect, establishment of shared goals, taking time to understand each other's strengths and limitations.[9]

Practicing with a trauma informed approach is crucial when caring for YP with an ED. For many YP, the experience of trauma is contributing factor in their ED course/journey, Treatment protocols or procedures, including restraint, may trigger or exacerbate a trauma response from the YP.

This approach is congruent with the Melbourne Children's trauma-informed preventative care resources.

8. Relevant ED program considerations

Inpatient ED management at RCH is supported by a comprehensive clinical protocol which is regularly updated. Specific considerations in the ED protocol have been identified by those with lived experience as relevant in working towards preventing the need for restraint for feeding.

Please contact the Eating Disorders Service at RCH for a current version of their clinical protocol: https://www.rch.org.au/adolescent-medicine/eating-disorders-service/

8.1 Flexibility of the protocol to meet individual needs

Flexibility in administering the ED protocol has been identified as one important consideration in avoiding use of restraint to administer nutrition. However, consistency is also important to mitigate anxiety that may arise with unpredictability. **Therefore, the**

preferred approach where feasible and considered appropriate for the YP, is that the existing protocol should be adapted according to each YP's individual needs and this adjusted protocol should be documented and then applied consistently unless and until changes are negotiated between the YP and the treating team.

Information about appropriate adjustments to the protocol in response to neurodivergence and mental health comorbidities is outlined in Appendix 5 of the RCH Eating Disorder Protocol. To further assist in appropriate and effective adjustments, an understanding of the YP, their history, the existence of co-morbidities or neurodivergence, past trauma, likes and dislikes, and motivations is vital. This can be aided by completing a Behaviour Support Profile (BSP) Nursing guidelines : Behaviour Support Profile and a sensory screen (see Appendix B of this document) early in the admission for every young person admitted with an ED.

8.1.1 Behaviour support profile

E**very YP admitted to RCH with an ED should have a BSP completed and flagged for easy reference in the Electronic Medical Record (EMR).** This should be completed as a joint activity between the YP and bedside nurse, nurse coordinator or clinical nurse consultant on Day 3 or 4 of the YP's first admission (allowing for a period of time to settle in and understand the protocol). Other key clinicians and parent/carer may be included in this process where appropriate and with the YP's agreement. For YP who have a planned admission, it may be appropriate to start this in the outpatient setting. For subsequent admissions, the BSP should be updated with the YP's input early in the admission. Ongoing updates can also be added at any time at YP's request or clinical staff's discretion.

The BSP should act as a guide to understand the individual needs of the YP, including sensory sensitivities, language preferences, helpful interventions and responses to challenging situations, which will enable clinicians to promote therapeutic engagement. **It is the responsibility of every health professional to read the BSP of every YP they are directly caring for, and to adjust their interactions and interventions to meet each YP's individual needs as set out in the BSP.**

8.1.2 Sensory sensitivities

Upon admission to the ward, or very early in the admission, all YP should undergo a sensory screen by a bedside nurse, nurse coordinator or clinician nurse consultant, or junior medical team to identify any hyper or hypo sensitivity to external sensations that

may require consideration when planning treatment. The results of this sensory assessment must be clearly documented in the BSP and any considerations flagged on the YP's EMR. Please refer to the following two pathways:

1. Sensory screen undertaken with the YP utilising the PEACE sensory screen (see Appendix B).
    a. If there are no concerns, note this clearly in the BSP. No further action is required.
    b. If there are concerns noted, the YP should be referred to an Occupational Therapist for further assessment. All sensory considerations and adjustments must be reported to the treating team and clearly recorded in the BSP.

8.1.3 Advance statement of preferences

For YP who know they may become dysregulated, or are at risk of requiring restrictive practices, including restraint for feeding for treatment of an ED, offering the option of completing an Advance Statement of Preferences.

Advance statements of preferences are written by a person saying what treatment, care and support they prefer should they become subject to an order under the MHA that authorises compulsory assessment or treatment. An Advance Statement of Preferences allows clinicians to respect the YP's wishes wherever possible in the event they cannot express these at the time. This is a way of ensuring that treatment, care, and support decisions better align with a patient's preferences.

Ideally, Advance Statement of Preferences documentation should be completed with the YP when they are not medically unstable or in an acute mental health crisis. Discussions regarding this for YP admitted with ED at RCH are therefore best commenced at the end of the first admission in which a YP has required restraint. If the YP wishes to utilise this option, discharge plans should include ongoing support (by outpatient ED nurse, paediatrician, GP or peer support worker) to complete this documentation. Subsequent admissions should review the YP's Advance Statement of Preferences alongside their BSP.

8.2 Meal support

Meal support is a crucial part of treatment for YP hospitalised with an ED, and effective support during mealtimes can reduce the escalation that may lead to restrictive

interventions. Training for staff responsible for meal support is important to ensure best practices are adhered to, and a therapeutic approach is maintained.

Staff providing meal support should be well versed in appropriate, person-centered, strengths-based language to reduce stigma and create a safe, non-judgmental environment. Neutral, non-food-related conversation should be used during mealtimes to reduce anxiety and food-related stress. Individual preferences for support during mealtimes as outlined in the YP's BSP should be respected whenever possible, including conversation topics, or other distractions.

A period of intensive 1:1 support during and post meals should be considered before escalating to any restrictive interventions to provide nutrition, unless the YP is critically unwell, and immediate nutritional delivery is considered an emergency. It is strongly recommended that bedside nurses providing direct care to YP with eating disorders particularly when there is a risk of distress or restrictive interventions, possess relevant mental health training and/or demonstrated experience in adolescent or eating disorder care. It is essential that staff assigned to this role have clinical competence, confidence, and therapeutic skillset required to support YP safely and effectively. Staff without this background should not be allocated to these roles without appropriate supervision and support.

8.3 Integrated mental health support

Eating disorders are complex and serious mental health disorders, with significant physical and psychological consequences. Whilst the focus of admission to an acute care paediatric service is to achieve medical stability, it is essential to recognise that mental health support is crucial for all stages of treatment and recovery. Whilst admitted into an acute care setting, the aim should be for YP to have regular contact with mental health professionals. This may include psychiatrists, psychologists, and mental health nurses. Part of the mental health support team may also be peer support workers. **Any request by the YP to meet with a member of the mental health team, or their own community mental health professional, should be honoured whenever possible.**

The integration of mental health support into the treatment of YP can aid in the development of strategies for emotional regulation, which may help prevent escalation to a situation needing restraint. Mental health input is also fundamental in providing the YP with the opportunity to explore the underlying psychological and emotional factors driving the eating disorder, navigate the emotional challenges associated with refeeding and weight

restoration, as well as the impacts of hospitalisation. This helps promote trust and motivation to continue along the challenging path to recovery. Furthermore, the integration of mental health treatment within the hospital setting can help ease the transition home, possibly reducing the risk of readmission.

8.4 Clinician knowledge, skills and experience

8.4.1 Trauma informed care

All staff caring for YP with ED should complete the RCH Trauma-informed care learning package: TIPC eLearn

To adopt a trauma informed approach, clinicians need to recognise the prevalence of trauma, understand its impact on behaviour, and actively seek to avoid re-traumatisation. Trauma informed care is a strengths-based framework grounded in five core principles: safety, trustworthiness, choice, collaboration, and empowerment, as well as respect for diversity. Clinicians should promote safety through the creation of a calm, quiet environment and through the provision of clear and tailored information about procedures and protocols involved in treatment. Consistency in care is the key to fostering a sense of trustworthiness, alongside the creation and maintenance of boundaries and ensuring all commitments made to YP are followed up. Restoring a sense of control for YP can be achieved through the provision of choice wherever possible, including timing of non-critical procedures, environmental choices, distraction techniques used, and the presence of a support person. Collaboration requires the inclusion of the YP in decisions regarding their treatment and recognising the importance of their lived and living experience. Empowerment is continually promoted through a strengths-based, patient-centred approach to care.

For clinicians, a trauma informed approach should be grounded in empathy and the validation of the YP's experiences. Clinical staff should be sensitive to both verbal and non-verbal cues indicating distress. For some YP, utilising a traffic light system to indicate anxiety or arousal state may be helpful. When physical procedures are necessary, clinical staff should explain each step in clear and appropriate language, provide time to process information, and allow the YP to have a trusted person present.

It is critical to note that trauma responses may manifest as challenging behaviours. Rather than reacting punitively, it is important for clinical staff to respond with empathy and compassion whilst seeking to understand the underlying cause.

8.4.2 Eating disorder treatment

Eating disorder specific training should be provided to all clinical staff involved in the care of YP with EDs, to equip them with the appropriate knowledge and skills needed to deliver effective, compassionate care tailored to the unique needs of this patient population. Training should focus on the psychological aspects of eating disorders, including body image distortion, anxiety around food and mealtimes, and the importance of a non-judgmental approach, as well as information regarding the use of strengths-based, consumer focused language. Practical skills should also be developed, such as meal support techniques, strategies for managing challenging behaviours, de-escalation techniques, and strategies for identifying and responding to compensatory behaviours. Furthermore, education should address the importance of collaborating and communicating with parent/carers and other family members if appropriate. The prioritisation of ongoing, eating disorder-specific education for staff is critical to improving patient care, safety, and treatment outcomes in the acute care setting.

8.4.3 De-escalation techniques

De-escalation skills are taught as part of PAUSE training which should be completed by all RCH staff looking after YP with ED. For more information about PAUSE training or to book into the course, email pause.training@rch.org.au.

De-escalation techniques can be key to preventing escalation to a situation of restraint. Potential escalation triggers (such a mealtimes or weight checks) and effective de-escalation techniques can be identified in collaboration with the YP early in the admission; these techniques should be clearly recorded in the patient file and communicated amongst the healthcare team. De-escalation techniques can include:

- distraction to a less stressful topic or activity, such as music, sensory toys, or hobbies
- grounding exercises, such as the 5-4-3-2-1 exercise; breathing exercises, such as box breathing or deep breathing; change of environment
- positive reframing, to help YP challenge eating disorder cognitions
- moving YP to a quiet, safe, private space, and consider involving a staff member with whom they have a good rapport

9. Decisions about restraint for feeding

All decisions about the use of restraint should be made in accordance with the MHA. Specific requirements must be met, relating to authorisation, monitoring, clinical documentation, and data entry when restrictive interventions are used. Staff must also give proper consideration to mental health and decision-making principles defined in the MHA.

9.1 Indications/ rationale

Section 127 of the MHA stipulates that restrictive interventions including physical and mechanical restraint may only be used to prevent serious and imminent harm when all less restrictive interventions have been tried or considered and found unsuitable.

Therefore, restraint for delivering nutrition in a YP with an ED should only occur if:

(1) the young person is medically unstable, or at risk of becoming imminently unstable, as defined by one or more of the following:

- Significant electrolyte disturbance (such as K < 3.0 or hypoglycaemia)
- HR ≤ 50bpm
- Resting systolic BP ≤80 mmHg
- Postural systolic drop ≥ 20mmHg
- Hypothermia <35.5C
- Arrhythmia or prolonged QTc >0.45s
- Moderate to severe dehydration
- Other serious physical health concern resulting from or exacerbated by lack of nutrition, as determined by the Consultant Paediatrician

(2) all other options have been considered or tried and are not effective or feasible. This includes:

- flexibility in the type of foods offered
- adjustments to the protocol
- acceptance of less-than-optimal intake or weight gain
- increased mental health input
- 1:1 meal support,
- the opportunity to trial medications to reduce anxiety

Consideration of some options will be constrained by the urgency of nutritional delivery related to the clinical status of the YP. Any deviation from the individualised protocol for the YP should be discussed with a multidisciplinary group and the YP and parent/carer and documented in the EMR with a clear rationale and limits so that it can be applied consistently and transparently.

Restraint for the delivery of nutrition for YP with ED should be done during daytime working hours if possible, and during times of higher staff ratios. Restraint overnight (8pm – 8am) should only occur in exceptional circumstances where the YP is critically unwell, and it is unavoidable. In all other circumstances, the 12 hours overnight should be a space where the YP can physiologically and psychologically rest.

9.2 Type of restraint offered/used

Prior to any restraint, assessment of whether the YP has a preference for the type of restraint (physical, mechanical, chemical) and specific considerations within that (eg an aversion to a specific medication used for chemical restraint). Where a YP has completed an Advanced Statement of Preferences, this should be referred to.

Where possible, the YP's choice about the type of restraint used should be respected if it is safe and feasible to do so.

Before proceeding to physical restraint, YP should be offered medication to help manage their distress. Consideration should be given to the type of medication the YP identifies as being beneficial to them. If medication is being used for the purpose of sedation and prevention of resisting NGT placement and feeding, this should be documented as chemical restraint as per the MHA.

10. Information and communication

10.1 Clear, individualised goals of admission

The establishment of clear, individualised goals of admission for each young person should be outlined on the day of admission and communicated to the YP, parent/carer, and key clinicians. There should be a collaborative family meeting, within a few days of admission, centred around balancing the wishes and motivations of the YP with the clinical imperatives and resource constraints of the hospital system. Regular review and adjustment of these goals should occur to ensure treatment remains responsive to the

YP's evolving needs and progress. Individualised goals of care are paramount for effective treatment and recovery, providing a sense of autonomy, ownership, and motivation for the YP. It is vital that the goals of care are tailored to each YP's unique history, circumstances, and presentation. These should be verbally discussed and documented with a copy provided to the YP and parent/carer as well as filed in the EMR. Where goals of care differ between clinicians and the YP and/or parent/carer and no resolution can be reached, this is important to clearly document and revisit throughout the admission.

10.2 Information and communication to YP and parent/carer

Information about restraint

Information about restraint should be provided to the YP and parent/carer by a key clinician both verbally and in written form. This should include:

- the possibility of the need for restraint
- the situations where this may arise
- the rationale for restraint
- the type of restraints which may be used
- what is involved in each type of restraint
- potential benefits, risks and burdens from restraint
- how risks and burdens will be minimised
- alternatives to restraint
- who is involved in the decision to restrain and performing any physical restraint

This information must be given **a reasonable time before** restraint occurs. A reasonable time will vary with each individual's situation, but the YP and parent/carer must be given a chance to absorb the information, read written information given, ask questions, and express their preferences. The YP should also have time to talk to their parent/carer or support person if they wish and be given another opportunity to orally eat or drink.

Information about the MHA and YP rights

Alongside information about restraint of the YP and their parent/carer must be provided information about the MHA both verbally and in a written format. This should include:

- Information about the MHA in age and developmentally appropriate language, including the rationale for using the MHA, the way this happens, who makes these decisions, the choices a YP has under the MHA and how they can express that, the

role of the Tribunal and how they can get support while under the MHA. Consumer information produced by Department of Health: Mental Health and Wellbeing Act information for the community

- Statement of rights of the YP: Mental Health and Wellbeing Act Statement of Rights
- Information about the rights of their parent/carer while the YP is under the MHA, including the information they will be given as a matter of course.

Parent/carer notification prior to restraint occurring

The MHA identifies a range of circumstances in which parent/carer of people under the age of 16 years; and guardians must be consulted and notified. One of these is when restrictive interventions are used on a person. **Restraint of a YP for any reason should not be initiated without parent/carer or legal guardian's knowledge except in a situation of significant risk of immediate self-harm or harm to others.** Restraint for nutritional delivery does not meet this threshold of risk and therefore should be delayed until a parent/carer has been notified. **This applies to every instance of restraint for ED, even if the parent/carer expects restraint to occur.**

The person responsible for ensuring a parent/carer is notified of an imminent restraint for their child is the Adolescent Consultant or Fellow on ward service or the NUM or ANUM. Notification must be done verbally by phone or in person; it is not appropriate to notify a parent/carer of an imminent restraint of their child by email, text message or to leave a voicemail. There may be some circumstances where parent/carer distress is such that there is a negotiation to notify a parent/carer by a different route as per Appendix 5 in the Eating Disorder Protocol. However, this should only occur in exceptional circumstances.

Parent/carer presence during restraint

Parent/carer may be a key support for YP during a restraint event. This is a choice that should primarily be within the discretion of the YP, not clinical staff. All YP requiring restraint for nutritional delivery should be asked if they wish a parent/carer to be present, if it is feasible (eg parent/carer able to attend the hospital at the time the feed is planned). Where a YP has expressed this as their preference, the parent/carer should be asked if they are willing to be present, and if so, all attempts should be made to co-ordinate the restraint with the parent/carer attending. If a parent/carer cannot or does not want to be present, every attempt should be made to have a staff member who is familiar to the YP present, with their primary focus to monitor and support the YP during restraint. This person should stay in YP's sight, provide them with reassurance, conversation or distraction as is the YP's preference, and not have any role in performing restraint or the feeding procedure.

If a YP does not wish a parent/carer to be present during the restraint, this should not occur even if the parent/carer wishes to be there.

Where the parent/carer are present for a restraint for the first time, a staff member should be allocated to support them. This includes a pre-brief with the parent/carer, ensuring they understand the plan and process and how the restraint will look, support during the procedure explaining what is happening and follow up after the procedure. For subsequent restraints, a support person should be allocated to parent/carer according to clinical judgement, staff availability, and parental need.

10.3 Communication with staff involved

A **pre-huddle of all staff** who will be involved in the restraint and feeding intervention should occur prior to every restraint episode. This should include clinical staff, security staff and the Code Grey team members. Information discussed in this pre-huddle should include:

- The rationale for use of restraint
- Goals of restraint
- Key aspects of the YP's BSP and Advance Statement of Preferences and any specific considerations to minimise trauma
- Who will lead the restraint
- The role of each staff member during the restraint, including allocating a support person for the YP and the parent/carer if required
- Indications to abort the procedure
- The plan for a post huddle debrief
- The opportunity for anyone to voice concerns or ask questions

If any member of staff in the pre-huddle has questions or concerns which are fundamental to the restraint going ahead safely or ethically, and which cannot be adequately answered immediately, the restraint should not be commenced until these questions or concerns are addressed

11. During restraint

Typically, physical restraint is used when it is necessary to use restraint to administer nutrition to a YP with an ED. As per the MHA this should be undertaken with the minimal

amount of restraint necessary for the shortest amount of time to complete the procedure safely. To facilitate promotion of this:

- If medication is used to reduce anxiety prior to feeds, this should be given adequate time to work before any physical restraint. Clinicians should be alert to the possibility of sensitivity and paradoxical reactions to psychotropic medications.
- All equipment for the procedure should be ready, and all staff involved in the procedure should be assembled before restraint commences.
- NGTs should remain insitu for all YP unless there is risk of self-harm from leaving it in place, or if the YP removes the NGT themselves or requests it to be removed with the knowledge that it may need to be reinserted.
- Feeds should be given via a bolus push, not a pump.
- For YP who have multiple restraints for feeding, dietetic advice should be sought prior to the pre-huddle restraint meeting, to determine whether increased volume or concentration of feeds to reduce the number of restraints is helpful. This should then be discussed with the YP, and their preferences for either more frequent feeds of smaller volume, or less frequent feeds of larger volume, should be taken into consideration.

In addition, ethical and trauma-informed principles apply during restraint. This may include:

- Consideration of the past trauma history of the YP, particularly with respect to the gender of staff performing restraint, parts of the body that will be held, language used and directions to the YP during the restraint.
- Environmental set up, such as low-stimulus room, quiet voices, limiting verbal interaction with the YP to one key person, preference or not for parental presence, familiar staff if possible.
- Maintaining privacy for the YP being restrained. This includes making the best use of the environment to ensure the space in which restraint is performed, specifically that it is not public, nor overlooked by other YP and families. A YP's dignity should be maintained, with all parts of their body they would usually choose to clothe being always covered during the restraint.
- Clear explanations for the restraint based on clinical necessity and positive, non-punitive language during the restraint. Restraint is not a treatment for ED or associated mental health challenges, so these should not be referred to in explanations given to YP about purpose of restraint. The rationale should be clearly communicated to the YP as necessary to prevent serious clinical deterioration.

For more detailed information on the legal obligations under the Mental Health and Wellbeing Act 2022, please see the Chief Psychiatrist's guideline for the use of restrictive interventions.

12. After restraint

12.1 Follow up with YP

Following restraint, it is crucial to provide the YP an opportunity to collaboratively debrief in a non-judgmental manner with a clinical staff member they know and trust. Not all YP's will want to participate in this, however it should be routinely offered. This debrief should explore the YP's understanding and experience of the restraint, whilst providing a safe space for questions and discussion. The debrief should include the identification of emotional triggers, self-regulation techniques, and strategies to help reduce distress. The overall aim is to plan collaboratively with the YP to minimise or eliminate future use of restraint. Debriefings with YP should be documented, including any outcomes, feedback, or recommendations, and shared with the multidisciplinary team. The clinician responsible for debriefing should be allocated in the pre-huddle.

12.2 Follow up with parent/carer

Parent/carers should be contacted as soon as possible following a restraint and a debriefing session offered. If appropriate, this should take place in person in a calm, private environment. Debriefing should include discussion on the rationale for restraint, the events leading up to restraint, the procedure itself, and the immediate aftermath. Parent/carers should be encouraged to express their emotions and/or concerns and ask questions about restraint. The debriefing should validate the emotions of parent/carers whilst explaining the medical necessity of the intervention. A discussion should be included regarding the implications for the YP's physical and mental health, the support being offered to the YP, and the plan moving forward. Parent/carers should be directed to support services, such as Eating Disorders Families Australia and Eating Disorders Victoria.

12.3 Follow up with staff

Post-restraint staff debriefing should occur as soon as practicable following the event, ideally within 24 hours, and involve all staff members who made the decision to restrain, who were involved in the restraint or who witnessed the restraint. The debriefing should

include discussion on the events leading up to restraint, the process of restraint, and the immediate aftermath. Considerations can include:

- evaluating the necessity and appropriateness of the restraint
- identifying alternatives that could be employed to prevent reoccurrence
- assessing the emotional impact on staff, parents and the YP

Debriefing can also identify any policy or procedural issues that may have contributed to the need for restraint. Debriefings should be documented, including any outcomes, feedback or recommendations, and shared with the multidisciplinary team.

In addition, RCH has a number of staff wellbeing services available to access: Wellbeing support links.

12.4 Follow up with other patients and families

In situations where other patients and families are aware of the restraint happening, there should be a check in by their allocated bedside nurse. Should any YP or family appear distressed, further debriefing provided by a senior nurse or senior medical staff should be arranged.

All measures should be taken to ensure the privacy and confidentiality of all admitted YP, including those requiring restraint. In some circumstances, other admitted patients or families may become aware that restraint has occurred. In these circumstances:

- At a suitable time, the YP who has experienced restraint, as well as their parent/carer, should be informed that other patients/families are aware of these elements of their care. Collaborative planning to improve privacy and confidentiality should occur. YP and families should be given the option to discuss this outside the clinical team, such as with the Consumer Liaison Officer (CLO).
- Other admitted YP and parent/carer should be provided with the opportunity to discuss the impact of being aware of and exposed to restraint practices. Structured opportunities for debrief should be provided when needed by the CL Psychiatry team. YP and families should be informed that feedback can also be provided through the CLO.

13. Ongoing use of restraint

Ongoing use of restraint (one episode or more a day over weeks or months) is always concerning even if the indications and rationale are appropriate according to the MHA. Restraint itself has no therapeutic value in treating the ED, and may result in short- and long-term trauma, so the balance of harm versus clinical necessity must be continuously reassessed. Considering suboptimal nutrition to minimise restraint should be part of that discussion with ongoing input from the dietitian. Ongoing use of restraint is an indication for a clinical ethics referral, to ensure a comprehensive ethical discussion of the situation.

13.1 Staff considerations

Ongoing use of restraint is physically, emotionally and morally distressing for staff involved in making decisions about restraint, and involved in restraining, but can also be upsetting for other staff on the ward who have not been involved but are aware of it happening. This may include students, PSAs, volunteers, ward clerks, and cleaners, amongst others. As well as debriefing after restraint episodes, consider the need for whole ward debriefing, particularly in situations where a YP is having ongoing restraint. This can be facilitated jointly by a psychologist or wellbeing support, and clinical ethics.

In addition, other considerations may reduce staff burnout including rotating staff with primary care of a YP with ongoing restraint and referral of individual staff to the Employee Assistance Program.

Linked Resources

- Mental Health and Wellbeing Act 2022: https://www.legislation.vic.gov.au/in-force/acts/mental-health-and-wellbeing-act-2022/001
- RCH Children's Bioethics Centre: https://www.rch.org.au/bioethics/contact_us/
- Melbourne Children's Trauma Informed Care Policy: https://mentalhealth.melbournechildrens.com/resource-hub/clinical-resources/trauma-informed-preventative-care-resources/
- RCH Eating Disorders Service: https://www.rch.org.au/adolescent-medicine/eating-disorders-service/
- RCH Behaviour Support Profile Nursing Guideline: https://www.rch.org.au/rchcpg/hospital_clinical_guideline_index/Behaviour_Support_Profile/
- Vic Health Advance Statement of Preferences: https://www.health.vic.gov.au/mental-health-and-wellbeing-act-handbook/advance-statements-of-preferences
- RCH TIPC eLearn: https://learninghero.rch.org.au/course/view.php?id=1487
- Vic Health Mental Health and Wellbeing Act information for the community: https://www.health.vic.gov.au/mental-health/information-for-the-community-mental-health-and-wellbeing-act-2022
- Vic Heath Mental Health and Wellbeing Act Statement of Rights: https://www.health.vic.gov.au/mental-health-and-wellbeing-act-handbook/statement-of-rights
- Vic Health Chief Psychiatrist's guideline for the use of restrictive interventions: https://www.health.vic.gov.au/sites/default/files/2024-03/restrictive-interventions-chief-psychiatrist-guideline.pdf
- Eating Disorders Families Australia: https://edfa.org.au
- Easting Disorders Victoria: https://eatingdisorders.org.au
- RCH staff wellbeing supports: https://rch0365it.sharepoint.com/:u:/r/sites/WorkplaceHealthandSafety/SitePages/WELLBEING-SUPPORTS.aspx?csf=1&web=1&e=2sTMpx

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Appendix A: Checklist prior to restraining a young person at RCH with an ED for delivery of nutrition

1. Indication/ rationale established

☐ YP is currently medically unstable.

☐ YP is very likely to become medically unstable if nutrition is not imminently given.

If the YP is not currently or imminently medically unstable STOP and reassess need for restraint.

- Ensure consultation with Consultant Paediatrician and Psychiatrist/MH team
- Consider if MDT needed to promote discussion and shared decision making
- Seek ethics advice: +61 478 281 449

2. Optimal communication has taken place

All optimal communication strategies below must be checked prior to the first feeding restraint in each admission; clinician discretion should be used in what is required prior to subsequent restraints in the same admission.

2a. Information and explanation given to YP and parent/carer regarding:

☐ The rationale for using restraint for feeding

☐ The MHA (verbal and written information) and Statement of Rights*

☐ NGT procedure

☐ The process of restraint including the roles of various people in the room

☐ Negotiable and non-negotiable aspects of the process clearly outlined

2b. Opportunities provided for YP and parent/carer to

☐ Ask questions and express preferences*

☐ Absorb information before the restraint proceeds*

2c. YP offered opportunity

☐ To change their mind about trying oral intake before the restraint proceeds

☐ To voice if they would like a parent/carer/other support person to present at restraint

2d. Parent communication

☐ Parent/carer is notified prior to restraint episode*

Date _____ Time _____ Staff in contact _____

Note: a requirement under MHA is parent/carer should be notified prior to each restraint episode.

☐ Parent/carer offered to be present at the restraint if YP has expressed this wish and it is feasible for parents to attend. Parent response _____

If optimal communication has not occurred or parent/carer has not been notified STOP.
- Delay restraint until parent/carer can be contacted

2e. Communication with staff

☐ Authorised psychiatrist (or delegate) has been informed*

Pre-huddle with all staff involved in procedure including Code Grey and Security.

Pre-huddle discussion to include:

☐ Rationale for use of restraint

☐ Indications to stop

☐ YP's BSP and specific considerations to minimise trauma

☐ The role of each staff member: Lead _____

NGT insertion/feeding _____ Key support for YP _____

Key support for parent, if applicable _____ Other_____

☐ Opportunity for questions or concerns to be raised

If questions/concerns of staff are not adequately addressed STOP.
- Pause until questions/concerns are explored and addressed.

3. Restraint follow-up (within 24 hours of restraint)

3a. Administrative

☐ MHA paperwork completed*

☐ Restraint documented in the EMR appropriately

3b. YP

☐ Offered support following restraint by the staff member allocated as key support

☐ Offered 1:1 time to debrief about the experience with a trusting MH staff member

3c. Parent/Carer

☐ Parent/carer have been offered time to debrief following the restraint

3d. Staff

☐ MDT to reflect on the process and identify areas for improvement

**Requirement under MHA act.*

Appendix B: PEACE sensory screen

PEACE
Pathway for Eating disorders and Autism developed from Clinical Experience

Sensory Summary

Mark where you think you are on the below scales. Hypersensitivity means you are highly sensitive to sensations and may try and avoid them where possible; hyposensitivity means you have lower sensitivity and may try to seek out these sensations. There are examples below each scale. If you think you are neither hyper/hyposensitive and have no sensory differences, mark yourself in the middle as a 5.

Taste

0	1	2	3	4	5	6	7	8	9	10

(Hyposensitive) (No sensory differences) (Hypersensitive)

If I am hyposensitive, I might add lots of salt to my food to make it taste stronger. If I am hypersensitive, I might prefer to eat bland foods as I find them too strong.

Smell

0	1	2	3	4	5	6	7	8	9	10

(Hyposensitive) (No sensory differences) (Hypersensitive)

If I am hyposensitive, I might not notice strong smells and enjoy smelling essential oils. If I am hypersensitive, I might dislike smelly places like a canteen and find smells overpowering.

Vision

0	1	2	3	4	5	6	7	8	9	10

(Hyposensitive) (No sensory differences) (Hypersensitive)

If I am hyposensitive, I might really like watching bright light displays. If I am hypersensitive, I might prefer to have lights dimmed or turned off.

Sound

0	1	2	3	4	5	6	7	8	9	10

(Hyposensitive) (No sensory differences) (Hypersensitive)

If I am hyposensitive, I might turn my music up loud and dislike silence. If I am hypersensitive, I might dislike loud spaces and put my hands over my ears.

Touch

0	1	2	3	4	5	6	7	8	9	10

(Hyposensitive) (No sensory differences) (Hypersensitive)

If I am hyposensitive, I might enjoy rubbing my hands on soft fabric or a soft toy. If I am hypersensitive, I might dislike and avoid touching certain fabrics.

Texture

0	1	2	3	4	5	6	7	8	9	10

(Hyposensitive) (No sensory differences) (Hypersensitive)

If I am hyposensitive, I might really enjoy the feeling of certain food textures in my mouth (such as liking crunchy food). If I am hypersensitive, I might strongly dislike and avoid eating certain food textures (such as mashed potato).

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