Least restrictive practice

Decision-support flowchart

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Introduction

This decision-support flowchart supports kaimahi to respond safely when a person presents with distress where alcohol or other drug (AOD) use, intoxication, or withdrawal may be involved. It provides a step-by-step guide to safety checks, crisis management, de-escalation, assessment, and least-restrictive care. It is designed to complement existing clinical policies and escalation pathways while supporting trauma-informed and culturally responsive practice.

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START - Person presents with behavioural or psychiatric distress where AOD use / withdrawal / intoxication is suspected.

Step 1

Immediate safety check

(first 0–5 minutes)

- Rapidly assess for immediate life-threatening features: level of consciousness (Alert voice pain unresponsive/Glasgow coma scale), airway compromise, respiratory rate <10 or >30, oxygen saturation <94%, seizures, severe hyperthermia (>38.5–39°C), chest pain, or severe head injury. If present → call emergency/medical team immediately and follow emergency response pathway.
- Simultaneously evaluate risk of imminent harm to self/others (verbally threatening, weapon access, escalating aggression). If high risk, move to Step 2 (Crisis management). If low–moderate risk, move to Step 3 (De-escalation & engagement).

Why: early triage separates physiological emergencies from primarily behavioural presentations and avoids delaying life-saving care. (See clinical escalation guidance below).

Ask the tangata whai ora if there is anyone in their whānau that they would like to contact.

Helpful resource (seclusion / least-restrictive policy): **Ministry of Health Guidance for Reducing and Eliminating Seclusion and Restraint. (Ministry of Health NZ)**

Step 2

Crisis management

(if immediate danger or medical red flags)

Primary objectives: protect life and minimise harm while avoiding unnecessary seclusion wherever possible. Remember, if unsure at any stage, treat as medical red flags – prioritise as medical over behavioural to include the medical team as soon as possible.

Actions in parallel:

Call for medical review immediately: (senior clinician/ward medical officer) If intoxication/withdrawal complication suspected, escalate to ED per local escalation policy.

Monitor and record vitals continuously: Heart rate, blood pressure, respiration rate, oxygen saturation, temperature, Glasgow coma scale. Document frequency (e.g., every 5–15 minutes depending on severity). Tachycardia + hyperthermia + agitation suggests stimulant toxicity — treat as medical emergency.

Immediate medical interventions as advised by the medical team: (Intravenous fluids, cooling, oxygen, naloxone for suspected opioid overdose, benzodiazepines for severe stimulant/agitation where indicated by clinician). Avoid medications that may worsen hyperthermia or heart rhythms unless under medical direction.

Calm, containing presence: assign one calm staff member to maintain rapport (slow voice, validate, offer choice). Ensure environment is low-stimulation (quiet room, minimal staff, remove hazards).

Consider short-term monitored containment options: (one-to-one supervision in a safe area) only if all de-escalation attempts fail and there is immediate risk — document rationale and continue reassessment; seclusion should remain last resort. Follow your national/local seclusion policy.

Key red-flag vitals / signs that trigger immediate medical escalation: Heart rate >120–130, systolic blood pressure >160, Temp ≥38.5°C with agitation, respiration rate >25, decreasing Glasgow coma scale, signs of severe muscle pain, dark urine, and repeated seizures (Local escalation thresholds may vary — follow your organisation's clinical policies).

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Step 3

De-escalation & engagement

(low–moderate risk)

Primary objectives: reduce arousal, meet needs, prevent escalation, and collect useful information to inform care.

Use trauma-informed, strengths-based language: (validate distress, normalise, avoid blaming).
Example: “What are you feeling right now?” [Pause for answer].
“Are you feeling any pain anywhere right now?” [Pause for answer].

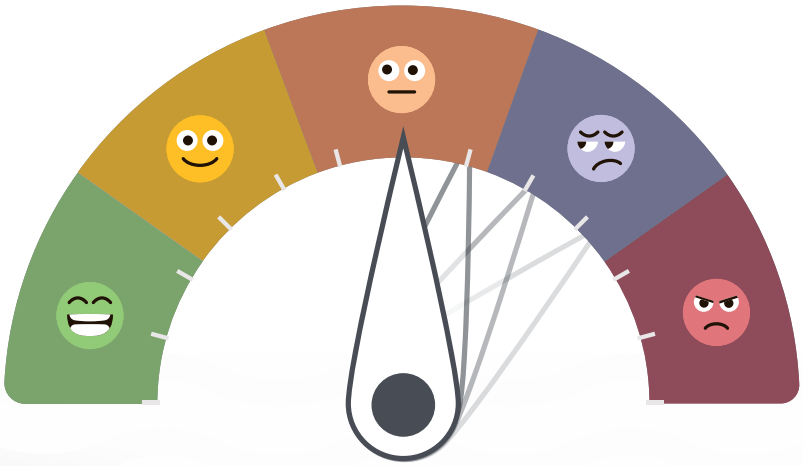
Identify triggers and needs quickly: ask open questions about sleep, last intake, craving, pain, hunger, medication, and recent stressors. Use brief screening tools later when settled (AUDIT-C, ASSIST, DUDIT) and consider screening, brief intervention and referral to treatment.

Comfort and environmental supports: offer hydration, a walk outside if safe, a quiet space, sensory modulation items (earbuds, weighted blanket, comfort object), and peer support where available. Small comforts often lower agitation (document examples in person’s file for normalising patterns).

Bring in specialist AOD or peer support early if available: they add credibility, lived-experience insights and practical harm-reduction strategies.

If the person engages → proceed to Step 4 (Assessment & collaborative planning). If refuses or re-escalates → loop back to Step 2 for crisis management.

For more information about brief screening tools, please see the Mental Health and Addiction Screening and Assessment resource on the **Te Pou website.**



Step 4

Assessment & collaborative planning

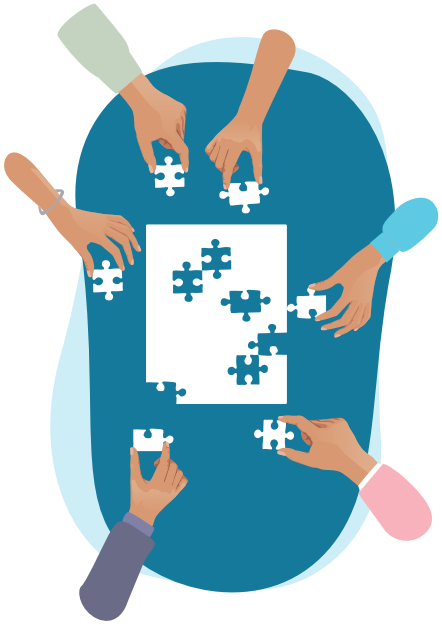
(once stable enough for assessment)

Complete a structured, holistic, person-centred assessment covering mental state, substance use history, physical health, safety, cultural needs and supports, and social determinants. Use validated tools as appropriate:

- **Alcohol withdrawal:** Clinical Institute Withdrawal Assessment for Alcohol - revised (CIWA-Ar) for repeatable objective monitoring. Use local pharmacological protocols for benzodiazepine administration guided by CIWA-Ar scores.
- **Opioid withdrawal:** Clinical Opiate Withdrawal Scale (COWS).
- **Stimulant (meth) withdrawal / intoxication:** use vitals, Abbreviated Cognitive Screening Assessment tool and treat symptomatically; consider cardiovascular and hypothermia risk.

Components of the assessment:

- Brief substance history (last use, quantity, route, time since last use).
- Withdrawal history (previous seizures, delirium tremens), prior patterns in past admissions (document in the person's file).
- Medical review and baseline observations (electrocardiogram if stimulant toxicity suspected, bloods if indicated).
- Mental state exam including suicidality and psychosis.
- Cultural, whānau, and spiritual needs; ask who to involve and how.



Develop a collaborative care plan including: harm reduction strategies, withdrawal symptom plan, medication review, psychosocial supports, monitoring frequency, and follow-up/AOD referral pathways. Record who is responsible for each action and include the person and whānau in planning.

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Step 5

Implementation of least-restrictive interventions & monitoring

Implement scheduled monitoring (e.g., CIWA-Ar every 4 hours or per local protocol; more frequent if score elevated).

- Provide non-pharmacological supports (hydration, nutrition, sleep hygiene, sensory options, whānau contact, peer support).
- Pharmacological management: follow local prescribing protocols and specialist advice for withdrawal (benzodiazepines for severe alcohol withdrawal per CIWA-Ar protocol; opioids; consider opioid substitution treatment; stimulant agitation; benzodiazepines preferred first-line; antipsychotics used cautiously under medical direction).
- If the person stabilises, continue plan and prepare discharge/transfer with AOD link-in. If unstable or deteriorating, return to Step 2.

Step 6

Review, documentation, and continuous improvement

- Document incident, interventions, observations, consent decisions, involvement of whānau and peer supports, and the rationale for any restrictive measures considered or used (including why they were unavoidable).
- Debrief with staff and the person (when appropriate), record learnings, and update care plan. Use data from repeated admissions (clinical record / wellbeing plan) to normalise withdrawal features and guide future care (e.g., “last time you felt better after water and a walk”).
- Feed aggregated learning into team practice reviews and training (e.g., scenario practice, cue cards, posters).

Practical tools and where to find them

A. National seclusion / least-restrictive policy

- Guidelines for Reducing and Eliminating Seclusion and Restraint — New Zealand Ministry of Health (2023).

Use this as the primary policy reference when considering containment or seclusion.

B. Substance withdrawal management (NZ best-practice guideline)

- Substance withdrawal management: Guidelines for medical and nursing practitioners — Te Pou / Ministry-aligned guidance (2021 update).

Includes CIWA-Ar appendix and practical withdrawal management guidance across substances. Use when creating local withdrawal protocols.

C. Alcohol withdrawal tools & guidance

- CIWA-Ar (Clinical Institute Withdrawal Assessment for Alcohol, revised)

Validated tool; available from CIWA publishers, MDCalc, and incorporated into local managed withdrawal workbooks.

Use for scoring and benzodiazepine protocols.

D. Acute behavioural disturbance guidance

- Acute Behavioural Disturbance — St John / NZ clinical practice guidance

Useful for pre-hospital/ED overlap. Also see local Health New Zealand | Te Whatu Ora acute behavioural disturbance clinical pathways.

E. Managed withdrawal & training materials

- Managed Withdrawal Workbook (Blueprint/ Te Pou)

Practical workbook and workshop content for staff managing medically assisted withdrawal across substances. Useful for staff training and local protocol development.

F. Practical frontline resources

- The Level (NZ Drug Foundation)

Plain-language substance information for staff and tāngata whai ora.

Quick reference — which tool when

- CIWA-Ar — use for suspected alcohol withdrawal monitoring and medication decisions.
- COWS — use for opioid withdrawal assessment.
- ACSA / AWQ — consider for amphetamine/ methamphetamine withdrawal symptom assessment if available locally.
- Vital signs & ECG — mandatory when stimulant toxicity suspected.