Violence and aggression: prevention and management

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Association of Ambulance Chief Executives	General	General	Pharmacological restraint / sedation is used in the ambulance / emergency community care setting by trained ambulance personnel and its use should follow the Joint Royal Colleges Ambulance Liaison Committee Guidelines (JRCALC)	Thank you for your comment. When making recommendations the committee will consider implementation factors and the interface between services and with other guidance.
Association of Ambulance Chief Executives	General	General	There is currently limited consistency in the use of terminology around conflict management / resolution, de-escalation, disengagement / breakaway techniques / restraint, safe holding, restrictive interventions it would be beneficial to work towards standardisation of terminology to aid understanding of what this constitutes	Thank you for your comment. The scope has been amended to include the categories of restrictive practices as outlined by the Restraint Reduction Network, as follows: physical restraint (including breakaway techniques that have a restrictive component); surveillance; mechanical restraint; blanket restrictions; environmental restraint (including seclusion or segregation); cultural restraint; psychological restraint. The guideline will also be consistent in the use of terminology around de-escalation and non-restrictive breakaway techniques.
Association of Ambulance Chief Executives	General	Draft Question 11	What are the signs of a physical health emergency in people who are being restrained? • Changes to breathing pattern such as becoming weaker / irregular or the absence of breathing • Changes in skin tone to become lighter / pale / blue	Thank you for your comment. This review question will identify and review evidence on the early identification of a physical health emergency in order to signal that restraint should be stopped. It is anticipated that the recommendation will include a list of signs, but these will be based on the evidence reviewed and the clinical knowledge and experience of the committee.

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			• Patient reporting that they are struggling to breath or can't breathe • Pain on breathing or chest pain • Fatigue, weakness, cessation of movement • Confusion, dizziness, feeling light headed • Pain, loss of sensation • Passivity or reduced consciousness • Non responsive • Blocked airway / vomiting	
Association of Ambulance Chief Executives	020	1.1.5	The Mental Health (Use of Force) Act 2018 should also be considered / cited for inclusion here	Thank you for your comment. Recommendations on staff training in legislation will be reviewed and updated based on committee consensus and this process will include updating the recommendations so that they are in line with current legislation. In response to your comment this section of the table has been amended to make it clearer that these recommendations will be updated in line with the Mental Health Units (Use of Force) Act 2018.
Association of Ambulance Chief Executives	021	1.1.13	Working with the police – in the ambulance / emergency community care setting the impact of the Right Care Right Person implementation needs to be	Thank you for your comment. The recommendation around working with the police will be updated as part of this guideline update. A

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			evaluated to inform this current guideline. From an ambulance perspective this has resulted in a significant change / reduction in operational response. A more collaborative approach to this initiative needs to be explored within this guideline. In addition, we suggest that the responsibilities of joint attendance at incidents where violence and aggression is involved within the ambulance / emergency community care setting is made clear, ambulance crews are responsible for the health, welfare and monitoring of the patient and those involved in any restrictive interventions / restraint	review question was not included on this area as no evidence was identified that would address these issues. However, the committee will update recommendations based on their clinical knowledge and experience and the wider context of related guidance, for example, from the College of Policing.
Association of Ambulance Chief Executives	022	1.2.1	Staff training for the ambulance / emergency care setting should also include; • an in depth focus on dynamic risk assessment and situational awareness to aid the anticipation and reduction of the risk of violence and aggression. • skills, methods and techniques to undertake restrictive interventions safely when these are required – this should also include to	Thank you for your comment. The effectiveness of organisational level interventions targeted at reducing aggressive behaviour and the use of restrictive practices will be examined in this update. In response to your comment, structured risk assessment to inform clinical decision-making has been added as an example of an organisational intervention or component of a multicomponent intervention. The table in the scope and the 'Activities, services or aspects of care this update covers' section have been

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			undertake restrictive interventions within the legal framework • an understanding of the relationship between mental health problems and the risk of violence and aggression – this should also include a focus on trauma informed practice • understanding of personal awareness, emotional regulation and self-management techniques to control verbal and non-verbal expressions of anxiety or frustration (for example, body posture and eye contact) when carrying out de-escalation. • Identification / treatment of potentially modifiable or reversable pathologies of violence and aggression • Effective recording and reporting of incidents of violence and aggression	amended to make it clear that principles for anticipating, understanding and responding to aggressive behaviour will be included in the update. Recommendations on staff training in legislation, involving service users in decision-making, advance decisions, and preventing violations of service users' rights will also be reviewed and updated based on committee consensus and this process will involve updating the recommendations (including recommendations around recording and reporting on the use of force) to ensure that they are in line with current legislation and best practice. In response to your comment, the table in the scope has been amended to make it clearer that these recommendations will be updated in line with the Mental Health Units (Use of Force) Act 2018.

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			In the absence of other guidance, it would be prudent to establish recommendations for training contact time and recommendations for a refresher training schedule to ensure maintenance of knowledge, best practice and appropriate skill retention. Guidance on delivery of this should also be considered for example, scenario based learning and practical sessions	
Association of Ambulance Chief Executives	024	1.2.4	The collation, analysis and synthesis of all data about violent events and the use of restrictive interventions should also be used to inform the development and delivery of training	Thank you for your comment. Recommendations on staff training in legislation, involving service users in decision-making, advance decisions, and preventing violations of service users' rights will be reviewed and updated based on committee consensus and this process will include updating the recommendations (including recommendations around recording and reporting on the use of force) so that they are in line with current legislation. The table in the scope has been amended to make it clearer that these recommendations will be updated in line with the Mental Health Units (Use of Force) Act 2018 and the Restraint Reduction Network (RRN) Training Standards 2019.

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Association of Ambulance Chief Executives	038	1.4.29	Every situation is different, some restraint by ambulance personnel may last longer than 10 minutes in the ambulance / community care setting due to being used for the purpose of providing immediate and necessary treatment and protecting people from imminent danger when lacking mental capacity. Resources for rapid tranquillisation are not always readily available or appropriate. Where it is not achievable to resolve a situation after 10 minutes the importance and requirement of monitoring / continuous review should be highlighted and outlined In addition, many medical conditions may cause patients to display violence and aggression these are referred to as "potentially modifiable" or "reversable pathologies" in the Joint Royal Colleges Ambulance Liaison Committee Guidelines (JRCALC). These should be considered as a possible factor driving any behaviour and appropriate treatment provided to reduce the need for restraint	Thank you for your comment. Although the amended review questions in the scope are not specific to a particular setting, when reviewing the evidence and making recommendations the committee will consider implementation factors and that it may be necessary to write different sets of recommendations for different types of settings.
Association of Ambulance Chief Executives	038	1.4.33	Monitor the service user's physical and psychological health for as long as clinically necessary after using manual restraint – for ambulance / emergency care	Thank you for your comment. There is a review question in the scope that examines the safety of restrictive practices. The committee will consider

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			setting it should be detailed that where a form of restraint has been used, this needs to be reported to the place of definitive care during the medical handover of the patient to ensure this monitoring is continued	this evidence in the context of their clinical knowledge and experience and will make recommendations that take implementation factors and the interface between services into account. Recommendations on staff training in legislation, involving service users in decision-making, advance decisions, and preventing violations of service users' rights will also be reviewed and updated based on committee consensus and this process will involve updating the recommendations (including recommendations around recording and reporting on the use of force) to ensure that they are in line with current legislation and best practice.
Association of Ambulance Chief Executives	047	1.6.2	In the absence of other guidance, it would be prudent to establish recommendations for training contact time and recommendations for a refresher training schedule to ensure maintenance of knowledge, best practice and appropriate skill retention Data on the type of incidents, the frequency and predictive risk assessments should be used to inform this training and the skills taught. Frequent training	Thank you for your comment. There is a review question in the scope that examines the effectiveness of organisational interventions, including staff training, that are targeted at reducing aggressive behaviour and the use of restrictive practices. Where possible, this review will also include subgroup analysis and/or meta-regression to explore differences in effectiveness associated with components of multicomponent

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			review is required to ensure that it remains relevant, appropriate and effective in meeting the needs of the staff who care for patients	organisational interventions. The committee will also consider the delivery of training when making recommendations. Recommendations on staff training in legislation, involving service users in decision-making, advance decisions, and preventing violations of service users' rights will be reviewed and updated based on committee consensus and this process will include updating the recommendations so that they are in line with current legislation. The table in the scope has been amended to make it clearer that these recommendations will be updated in line with the Mental Health Units (Use of Force) Act 2018 and the Restraint Reduction Network (RRN) Training Standards 2019.
Association of Ambulance Chief Executives	047	1.6.3	Predictive and Dynamic Risk Assessments should be utilised	Thank you for your comment. The effectiveness of organisational level interventions targeted at reducing aggressive behaviour and the use of restrictive practices will be examined in this update. In response to your comment, structured risk assessment to inform clinical decision-making has been added as an example of an organisational intervention or component of a

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				multicomponent intervention. The table in the scope and the 'Activities, services or aspects of care this update covers' section have been amended to make it clear that principles for anticipating, understanding and responding to aggressive behaviour will be included in the update.
Association of Ambulance Chief Executives	047	1.6.6	The Association of Ambulance Chief Executives supports the training in and use of restrictive interventions, where staffing levels are appropriate to; • Facilitate urgent clinical interventions in a medical emergency where immediate and necessary clinical procedures / interventions are required • Protect vulnerable patients from immediate risks of harm when lacking capacity and placing themselves in danger / further danger • Maintain personal safety where there is no viable alternative	Thank you for your comment. Recommendations on staff training in legislation, preventing violations of service users' rights, and working with the police will be reviewed and updated based on committee consensus and this process will involve updating the recommendations to ensure that they are in line with current legislation and best practice. The effectiveness of organisational level interventions targeted at reducing aggressive behaviour and the use of restrictive practices will be examined in this update. In response to your comment, structured risk assessment to inform clinical decision-making has been added as an example of an organisational intervention or component of a multicomponent intervention. The

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			The use of de-escalation and disengagement techniques should be prioritised and if the level of risk exceeds that of the safe use of restrictive interventions delivered in training staff are advised to contact the police for assistance and exit the situation. As stated above the implementation of Right Care Right Person should be considered to inform this guidance	table in the scope and the 'Activities, services or aspects of care this update covers' section have been amended to make it clear that principles for anticipating, understanding and responding to aggressive behaviour will be included in the update.
Buckinghamshire, Oxfordshire, Berks West Integrated Care Board BOB ICB	EIA	2.2	Can this section also include - needs to include consideration for people with protected characteristics who may not have family as carers, in particular people who are LGBT+ or experienced domestic abuse - the scope should build in next of kin (friends, support network reps etc).	Thank you for your comment. This will be added as a new equality and health inequality consideration in the EHIA update.
Buckinghamshire, Oxfordshire, Berks West Integrated Care Board BOB ICB	EIA comments	2.2	To the phrase Consider disproportionate use of restraint in young males, particularly with learning disabilities, please add and who are Black and from Minority Ethnic Communities.	Thank you for your comment. This population will now be added in the EHIA update when considering disproportional use of restraint.

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Buckinghamshire, Oxfordshire, Berks West Integrated Care Board BOB ICB	EIA	004	For this point Implementation considerations: • Consider how guidance on violence and aggression across different health and care settings might be tailored or implemented differently to address the needs of different groups (for example, those with learning disabilities, children and young people, settings with limited resources). Please add all 9 protected characteristics and health inequalities.	Thank you for your comment. We will consider all protected characteristics and health inequalities when tailoring or implementing guidance and this has been reflected in the EHIA update.
Buckinghamshire, Oxfordshire, Berks West Integrated Care Board BOB ICB	009	002	We applaud this process and suggest that Safeguarding reviews in both the Child and Adult will be considered as part of the evidence base, specifically when they mention violence/aggression and how this was managed in a clinical setting or by other agencies for example Police forces using spit hoods and cuffs. Understanding that this is clinical guidance perhaps mention of inter-agency work with cover off our suggestion.	Thank you for your comment. Recommendations on staff training in legislation, involving service users in decision-making, advance decisions, preventing violations of service users' rights, and working with the police will be reviewed and updated based on committee consensus and this process will involve updating the recommendations (including recommendations around safeguarding) to ensure that they are in line with current legislation and take into account other guidance, for instance, the College of Policing (2021) guidance on 'The police use of restraint in mental health & learning disability settings'.

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Buckinghamshire, Oxfordshire, Berks West Integrated Care Board BOB ICB	009	009	This process needs greater scrutiny, we understand that on occasion clinicians have used this method when there was no suitable bed for a young person. The young person was kept sedated and ventilated when capacity assessments had not taken place. This was reported via a Safeguarding Adult Review.	Thank you for your comment. The committee will consider the evidence for the benefits, harms and experience of rapid tranquillisation in the context of their clinical knowledge and experience and will make recommendations that take into account ethical considerations and implementation factors. Recommendations on staff training in legislation, involving service users in decision-making, advance decisions, and preventing violations of service users' rights will also be reviewed and updated based on committee consensus and this process will involve updating the recommendations (including recommendations around safeguarding) to ensure that they are in line with current legislation and best practice.
Buckinghamshire, Oxfordshire, Berks West Integrated Care Board BOB ICB	010	005	This scope should also include CYP who reside in un-regulated health care placements.	Thank you for your comment. This section of the scope summarises the scope for the current (2015) guideline which we are updating. We cannot accept consultation comments on this section.
Buckinghamshire, Oxfordshire,	011	005	Can consideration be made for in-patients who are regularly secluded in these places.	Thank you for your comment. This section of the scope summarises the scope for the current

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Berks West Integrated Care Board BOB ICB				(2015) guideline which we are updating. We cannot accept consultation comments on this section.
Care Quality Commission	001	002	We request that the language and terminology used to describe people in this document is reviewed, to reflect an understanding of best practice in relation to trauma-informed practice, relational support, dignity, respect, and emphasising preventative approaches. For example: • labelling people as 'violent and aggressive' can objectify people and feed into negative stereotypes and assumptions as well as issues with epistemic justice. These terms fail to represent human-rights based values and do not reflect that in certain circumstances people are displaying distress and emotional reactions that may be related to external and internal triggers (poor staff skills, unsuitable	Thank you for your comment. In response to your comment, we have replaced 'violence and aggression' with 'aggressive behaviour'. We acknowledge that 'aggressive behaviour' is used in the absence of a better description and is recognised as not implying deliberate intention. We are not able to adopt your suggestion of 'preventing and managing the risk of harm to self and others' as it does not clearly differentiate this guideline from the NICE self-harm guideline which would cause confusion.

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			environments, unmet needs, trauma). • 'Aggression' can be an ambiguous term – it does not tell us enough about the person's needs/risk or how to support and reduce risk. • Neither 'violence' nor 'aggression' adequately reflect psychological harm. For example, 'violence and aggression – prevention and management', could be replaced with 'preventing and managing the risk of harm to self and others'.	
Care Quality Commission	002	014	We are concerned about the exclusion of sheltered housing, shared lives schemes and children's homes for looked after children. Will these settings be covered in another document/update?	Thank you for your comment. The 'Settings this update covers' section of the guideline has now been simplified and includes all settings in which NHS care or social care is provided.
Care Quality Commission	002	018	'Blanket restrictions' and 'psychological coercion' should be considered in the update	Thank you for your comment and suggestion. The scope has been amended to include the categories of restrictive practices as outlined by

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				the Restraint Reduction Network which includes blanket restrictions and psychological restraint.
Care Quality Commission	008	010	It would be helpful if terminology was aligned between this document and others e.g. use of "physical restraint" rather than "manual restraint");	Thank you for your comment and helpful suggestion. The scope has been amended to include the categories of restrictive practices as outlined by the Restraint Reduction Network and manual restraint has been replaced with physical restraint.
Care Quality Commission	008	014	It would be helpful to further define the use of products to support restraint: would it be considered a form of mechanical restraint or something completely different? It is difficult to know without a detailed description of what is meant	Thank you for your comment. Examples (tasering, pods or bean bags) have been added to the 'Activities, services or aspects of care this update covers' section of the scope.
Care Quality Commission	008	021	Post-incident debriefing or formal review after using a restrictive intervention: there is a Mental Health Services Data Set item recording whether a Restrictive Intervention Post-Incident Review was held, for the patient and for staff, as well as a marker for "An indication of whether a Restrictive Intervention Post-Incident Review for Care Personnel was held within 24 hours of the incident of a Restrictive Intervention.";	Thank you for your comment. This review question focuses on the experience of post-incident debriefing or formal review after using a restrictive practice from the perspective of people who use services, their parents and carers, and staff. However, recommendations on staff training in legislation, involving service users in decision-making, advance decisions, and preventing violations of service users' rights will

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				be reviewed and updated based on committee consensus and this process will include updating the recommendations (including recommendations around recording and reporting on the use of force) to ensure that they are in line with current legislation and best practice. In response to your comment, the table in the scope has been amended to make it clearer that these recommendations will be updated in line with the Mental Health Units (Use of Force) Act 2018.
Care Quality Commission	008	021	We would like the reason for the use of restraint to be recorded, again this is included in the Mental Health Services Data Set. Better exploration of items recorded within the Mental Health Services Data Set is advisable, ditto Use of Force Act 2018 which is not mentioned.	Thank you for your comment. This review question focuses on the experience of post-incident debriefing or formal review after using a restrictive practice from the perspective of people who use services, their parents and carers, and staff. However, recommendations on staff training in legislation, involving service users in decision-making, advance decisions, and preventing violations of service users' rights will be reviewed and updated based on committee consensus and this process will include updating the recommendations (including recommendations around recording and reporting

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				on the use of force) to ensure that they are in line with current legislation and best practice. In response to your comment, the table in the scope has been amended to make it clearer that these recommendations will be updated in line with the Mental Health Units (Use of Force) Act 2018.
Centre for Mental Health	General	General	**General comment**: We also think that there should be more of a specific focus on the specific needs of neurodiverse children and people and those with learning disabilities or brain injuries. For example, the need for reasonable adjustments, the invaluable advice on adjustments from Speech and Language therapists and occupational therapists. The need for sensory modifications and sensory supportive spaces and strategies – as well as the importance of staff training and integrated working	Thank you for your comment. There are some areas that are covered in other NICE guidelines (for instance, anticipating, preventing and managing behaviour that challenges in people with learning disabilities) and this update will not include specific evidence reviews on these areas, although recommendations in these other NICE guidelines may be cross-referred to. The scope has been amended to make this clearer.
Centre for Mental Health	General	General	**General comment**: We would like to see separate NICE guidance looking at effective practice when working with children with complex needs and supporting effective practice in integrated working.	Thank you for your comment. Suggestions for topics for future NICE guidance can be made here: **Topic suggestion | Prioritising our guidance topics | What we do | About | NICE**
Centre for Mental Health	002	014	I understand from Amber that the Children and Young People Secure Estate (which also includes secure children homes holding children entering	Thank you for your comment. The 'Settings this update covers' section of the guideline has now

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			under child protection and justice legislation) are excluded due to concerns of a) scope and b) already established protocols and practices for managing violence and aggression in this sector. In a task and finish group of clinical leads responding to the current consultation, clinical leads from our Children and Young People Secure Estate network had significant concerns about this exclusion for the following reasons: a) Health workers are embedded/work in these settings are **subject to CQC inspections.** b) **The decision to exclude risks undermining the key principle of equivalence** which refers to ensuring that individuals receive the same standard of care and support across different settings and environments. It means providing consistent, high-quality, safe, consistent care regardless of the specific context, whether it's a secure setting, community placement, or home environment. a. Equivalence also helps health professionals maintain professional accountability. Clinicians consistently	been simplified and includes all settings in which NHS care or social care is provided.

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			implemented guidelines to maintain accountability, justify decisions, and **support professional competence**. b. **Lack of equivalence, and this planned exclusion, would also contribute potentially to deepening health inequalities experienced by these children.** By ignoring the rights and needs of children in these settings, we risk further undermining their already pronounced health inequalities**.** c) NICE guidance acts as an important **clinical safety net** across these secure estates in terms of clinical safety of children in these settings There are often cultural differences in approaches taken by operational/residential staff versus health staff in such settings and NICE guidance is an important reference point for holding everyone to account in an integrated way of working for children's best health and social outcomes. For example,	

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			operational staff can often be responsible for constant observation in these settings but had no guidance and training (despite comprehensive ACCT processes) on how to manage this safely. Clinical staff and NICE guidance have helped create a reference point for best practice. Baseline NICE guidelines are thus crucial for secure settings to support decisions against inappropriate measures and ensure safe clinical care in these settings. d) NICE guidance is generally **an important reference point** and authority for clinical safety and excellence in these settings and helps promote **integrated working** across disciplines. e) Not including the Children and Young People Secure Estate in these NICE guidance would also result in a lack of consistency in care across **transitions** (as children come in and as they transfer out). Good transitions for children are already one of the biggest	

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			challenges faced by children in these settings based on our networks' feedback, our Young Advisors' feedback, and NHS Health and Justice intelligence. This exclusion will create yet another barrier to consistency. f) The Children and Young People Secure Estate settings work closely with many community services and particularly community Health and Justice Vanguards for children with high risk, high needs and high harm needs delivering trauma informed care and are involved in offering support to these children in the community. Clinicians had concerns about how the current exclusion of the Children and Young People Secure Estate might affect Vanguard programmes which work across local authorities, police, and community children's homes. g) Exclusion would also mean that health staff working in the Children and Young People	

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			Secure Estate settings would also be working with different NICE reference points which would be confusing for children, families, and professionals. h) Many health staff in the Children and Young People Secure Estate settings also work in community and inpatient settings as well. Having some settings where guidance does apply and some where it wouldn't, would be very confusing and professionally unhelpful. Clinical leads involved in this consultation felt strongly that NICE guidance should be focused on the patient/child/person and their outcomes and on integrated working and professional consistency rather than switching from setting to setting. i) There was a suggestion that the Children and Young People Secure Estate might not need this guidance as they already had processes in place. If this is the case, it would be better to **build on what positive learning there is**	

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			in these settings rather than exclude this estate. As a solution, we would advise that Children and Young People Estate children are included in this new guidance on the short-term management of violence and aggression but with a qualification that guidance may need to be adapted (underpinned with a rationale) to the children and processes in these settings	
Centre for Mental Health	002	024	j) Children and Young People In the Secure Estate hold some of the most vulnerable children in the country with significantly higher chance of having gone through trauma compared with their peers in the community (Baglivio, 2014). Outbursts of violence and aggression (sometimes directed at themselves, sometimes directed towards others can be one way in which children with these histories seek to take back control and externalise extreme distress over past upsetting experiences. **Evidence based and trauma informed support and management** of children presenting with	Thank you for your comment. The 'Settings this update covers' section of the guideline has now been simplified and includes all settings in which NHS care or social care is provided. The review question on organisational level interventions targeted at reducing aggressive behaviour and the use of restrictive practices includes trauma-informed care, and the committee will consider implementation factors and the interface between services, when making recommendations.

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			these difficulties is something that staff in these settings are committed to improving – they would welcome evidence-based support for these approaches via NICE guidance. Here is a link to emerging evidence clarifying the model of implementation of trauma informed care in the Children and Young People In the Secure Estate. This is a way of working that has been in place for some time in the CYPSE to support children's outcomes and to de-escalate and manage outbursts of violence and aggression and repetitive self harm. However, a challenge has been consistently implementing, integrating and maintaining the programme and approaches across different disciplines – particularly when staff-child ratios are low, in larger settings and where institutional pressures are high. We would like to see the emphasis and focus on trauma informed care enhanced in this new proposed guidance. These ways of working do not have a high profile in the current consultation document. Anything that this	

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			guidance could do to stress the importance of such approaches and the need for multidisciplinary, consistent, and integrated working based on the child's story and formulation would be helpful.	
Centre for Mental Health	002	025	• Emphasis on tranquillisation was of some concern to those feeding into this consultation. It is not used in Children and Young People In the Secure Estate settings and clinical leads would have some concerns about its use. PRN (as-needed) medication is preferred. On a practical level, there is a lack of availability of psychiatrist capacity to facilitate rapid tranquillisation, Furthermore scrutiny regarding vulnerable children's rights, and the rights of girls, for example, who might already have experienced traumatic abuse often going hand in hand with grooming via substances, would make this a highly contentious and potentially unethical area of practice. There were some concerns about	Thank you for your comment. The use of p.r.n. (as needed) medication (administered orally) to prevent the onset of aggressive behaviour was considered to be best covered by condition-specific guidelines for people who are already known by the health or care provider and care is already managed in the context of their circumstance, condition and co-morbidities. Oral antipsychotic medication to prevent the onset of aggressive behaviour has been added as an exclusion for this update. Although the review question on rapid tranquillisation is not differentiated by setting, when reviewing the evidence and making recommendations, the committee will consider whether different

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			the unintended knock-on effects of introducing rapid tranquillisation into Children and Young People In the Secure Estate. Although we recognise that it is intended to be used as a last resort, there was concern that if it was used, it would be easy to avoid critical post incident debriefs to learn from potential missed opportunities in terms of de-escalation (see six core strategies approaches). If rapid tranquillisation is introduced into other settings, it must be a last resort and must be accompanied by post-incident debriefing for learning and integrating support plans and informing the formulation.	recommendations are needed for different settings
Centre for Mental Health	008	007	Our group saw few benefits of rapid tranquillisation of children and young people and felt that prn and trauma informed approaches were a more ethical and effective way to manage such situations. They saw many downsides of the use of rapid tranquillisation with children including re-	Thank you for your comment. The review questions include adults and children within the same review questions. However, when reviewing the evidence and making recommendations, the committee will consider whether different recommendations are needed

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			traumatisation of girls who may have been groomed and sexually abused using substances, the fact that having this option available might shift the system into using it at points of behavioural crisis (and not thinking about all of the important escalation options that should come first), the ethical dimensions of drugging vulnerable children without their consent, the fact that many settings won't have access to a psychiatrist for the administration of such interventions, the fact that there are risks of less post incident debriefing and learning. It was not felt to be an appropriate course of action with vulnerable and traumatised children.	for children and young people, based on implementation factors, ethical considerations and the principle of using the least restrictive intervention possible. The use of p.r.n. (as needed) medication (administered orally) to prevent the onset of aggressive behaviour was considered to be best covered by condition-specific guidelines for people who are already known by the health or care provider and care is already managed in the context of their circumstance, condition and co-morbidities. Oral antipsychotic medication to prevent the onset of aggressive behaviour has been added as an exclusion for this update. The effectiveness of organisational level interventions targeted at reducing aggressive behaviour and the use of restrictive practices, including training in de-escalation and trauma-informed care, will be examined in this update.
Centre for Mental Health	010	013	There should be a separate section considering children but also considering girls and women (for	Thank you for your comment. This section of the scope summarises the scope for the current (2015) guideline which we are updating. We

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			whom experiences such as restraint, and particularly restraint or rapid tranquillisation by men, may be particularly re-triggering in terms of historic trauma). NICE guidance would ideally highlight gender responsive awareness and consider and detail effective gender responsive approaches supporting girls and women in this and in each new guidance produced. See here and here	cannot accept consultation comments on this section. However, girls and women have been considered in the EHIA as people with protected characteristics when considering restraint methods and searching.
Centre for Mental Health	010	015	**Exclusions 14 • People who do not have a mental health condition and who are not carers 15 of people with a mental health condition** This statement about excluding people without mental health conditions is problematic for children in that, at their age and stage, they are much less likely to present with clear cut mental health presentations. These often emerge as they reach adulthood. What you often see during childhood and teenage years are complex behaviours. Children communicate psychological and social and neurodiverse distress through their behaviour. This exclusion should either be qualified or removed.	Thank you for your comment. This section of the scope summarises the scope for the current (2015) guideline which we are updating. We cannot accept consultation comments on this section. However, the update extends the guideline beyond only those with diagnosed mental health conditions.

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Centre for Mental Health	010	016	In 2022, The NHSE Children and Young People Health and Justice Team commissioned an internal review of constant supervision/observation in the children and young people estate which had many recommendations for improved integrated working and improved experiences for children. Young People provided their ideas for improvement based on consultation with them for this Review. 1. **Reduce isolation:** enhanced supervision shouldn't mean segregation or isolation. There is a need to provide more channels for communication and support to reduce isolation – e.g. phone calls to family carers and other trusted people. 2. **Reduce stigma:** Have a more discreet way of staff keeping records on observations to reduce stigma; Hold mental health awareness days for children in the settings. 3. **Peer support:** CYPSE settings should establish peer support schemes and provide resource and time for peers to support each other.	Thank you for your comment. This section of the scope summarises the scope for the current (2015) guideline which we are updating. We cannot accept consultation comments on this section. However, in the update we are including a review question that examines the qualitative experience of restrictive practices (including surveillance) from the perspective of people who use services, their parents and carers, and staff.

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			4. **Better information:** CYPSE settings should provide young people with better information about enhanced supervision and about the secure estate more generally. These materials should be co-designed with children who have experienced enhanced observation. 5. **Improve staff engagement (as part of enhanced supervision):** CYPSE staff should increase engagement and interaction - ask young people how they are, how they feel and what they need. 6. **Staff training:** CYPSE settings should provide more training for staff in neurodiversity; there should be more staff training in building trusting relationships and how to engage children effectively. 7. **Changes to procedure:** Less frequent and more individualised observations (particularly for lower risk children in SCHs) and less intrusive observations; Conduct enhanced supervision for shorter time periods to reduce isolation.	

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			8. **Give young people more choice and control:** CYPSE settings should give young people more choice and control in the process; have a choice of staff to talk to; have a choice over distractions when children are in their room; give young people the ability to reduce enhanced supervision if they are showing stable behaviour. 9. **Provide things to do**: CYPSE settings should facilitate more activities and distractions for children; this guards against them 'just going over everything mentally' which further undermine their mental health. Don't empty young people's rooms altogether and ensure they have something to occupy them. Staff also strongly supported this call for more distractions. This review recommends that work is completed with children in the estate to co-produce and creatively extend the range of distractions available to them when on enhanced supervision. What is offered should be personalised to each child.	

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			10. **CYPSE settings should provide children with more support to check up on them after constant supervision has finished**. Some said they struggled with their mental health after constant observations and particularly found it difficult to re-integrate back to normality afterwards. 11. **Children wanted workers to understand the back story to the crisis leading to constant supervision and separation events**.	
Decently	007	022	The draft scope references the use of 'structured assessment instruments' but does not reference what these assessment instruments are, nor whether they are within the scope for the review. For example, will there be a recommended set of assessment instruments for standardisation of risk assessments?	Thank you for your comment. The effectiveness of organisational level interventions targeted at reducing aggressive behaviour and the use of restrictive practices will be examined in this update. Structured risk assessment to inform clinical decision-making has been added as an example of an organisational intervention or component of a multicomponent intervention. The committee will consider this evidence and existing recommendations on risk assessment,

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				including the use of structured assessment instruments, will be replaced
East Midlands Ambulance Service George Reid Violence Prevention Reduction Lead	002	020	De-escalation needs to start at EOC the RAPPORT approach needs to be taken to keep crews mindful of all of the skills taught in training	Thank you for your comment. The 'Settings this update covers' section of the guideline has now been simplified and includes all settings in which NHS care or social care is provided. When making recommendations the committee will also consider implementation factors and that it may be necessary to write different sets of recommendations for different types of settings.
East Midlands Ambulance Service George Reid Violence Prevention Reduction Lead	002	022	Training needs to be updated using a risk-based approach locally as opposed to nationally to capture local trends etc.	Thank you for your comment. The effectiveness of organisational level interventions targeted at reducing aggressive behaviour and the use of restrictive practices, including training, will be examined in this update. The committee will consider the evidence in the context of their clinical knowledge and experience and treatment recommendations will be structured to take implementation factors into account. Implementation issues will be considered by NICE across the guideline and relevant support activity will be planned where appropriate.

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East Midlands Ambulance Service George Reid Violence Prevention Reduction Lead	002	022	Training in this area should be yearly with emphasis on skill acquisition, practiced in a safe environment.	Thank you for your comment. The effectiveness of organisational level interventions targeted at reducing aggressive behaviour and the use of restrictive practices, including training, will be examined in this update. The committee will consider the evidence in the context of their clinical knowledge and experience and treatment recommendations will be structured to take implementation factors into account. Implementation issues will be considered by NICE across the guideline and relevant support activity will be planned where appropriate.
East Midlands Ambulance Service George Reid Violence Prevention Reduction Lead	002	025	Restrictive interventions are too dangerous for 1-1 which is where ambulance staff find themselves, crews need dynamic breakaway techniques rather than restrictive interventions.	Thank you for your comment. The effectiveness of organisational level interventions targeted at reducing aggressive behaviour and the use of restrictive practices will be examined in this update. In response to your comment, training in non-restrictive breakaway techniques has been added as an example of an organisational intervention or component of a multicomponent intervention. The committee will consider the evidence in the context of their clinical knowledge and experience and treatment recommendations

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				will be structured to take implementation factors into account.
East Midlands Ambulance Service George Reid Violence Prevention Reduction Lead	003	001	Risk assessments for ambulance crews need to also follow the THRIVE model to align with the need to police support around RCRP	Thank you for your comment. The effectiveness of organisational level interventions targeted at reducing aggressive behaviour and the use of restrictive practices will be examined in this update. In response to your comment, structured risk assessment to inform clinical decision-making has been added as an example of an organisational intervention or component of a multicomponent intervention. The table in the scope and the 'Activities, services or aspects of care this update covers' section have been amended to make it clear that principles for anticipating, understanding and responding to aggressive behaviour will be included in the update.
East Midlands Ambulance Service George Reid Violence Prevention Reduction Lead	007	018	By not training restrictive interventions crews are not inclined to lay hands on and therefore reduce the risk of harm to themselves. The rationale being that staff are often in a 1-1 setting in the back of an ambulance where interventions would lead to more harm to the patient or staff or both.	Thank you for your comment. Although the amended review questions in the scope are not specific to a particular setting, when reviewing the evidence and making recommendations the committee will consider implementation factors and that it may be necessary to write different

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				sets of recommendations for different types of settings.
East Midlands Ambulance Service George Reid Violence Prevention Reduction Lead	007	024	Ambulance crews should understand the THRIVE model coupled with other risk assessment models to ensure that they are better able to inform support of their needs.	Thank you for your comment. The effectiveness of organisational level interventions targeted at reducing aggressive behaviour and the use of restrictive practices will be examined in this update. In response to your comment, structured risk assessment to inform clinical decision-making has been added as an example of an organisational intervention or component of a multicomponent intervention. The table in the scope and the 'Activities, services or aspects of care this update covers' section have been amended to make it clear that principles for anticipating, understanding and responding to aggressive behaviour will be included in the update.
East Midlands Ambulance Service George Reid Violence Prevention Reduction Lead	008	021	Reviews Debriefing relies on managers being able to support crews as soon as possible to gain clear understanding of an incident, it also relies on an incident being reported so that checks and support can be given as soon as practicable to support staff wellbeing etc.	Thank you for your comment. This review question focuses on the experience of post-incident debriefing or formal review after using a restrictive practice from the perspective of people who use services, their parents and carers, and staff. The committee will interpret the evidence

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				and take into account implementation factors when making recommendations.
General Pharmaceutical Council	General	General	The General Pharmaceutical Council (GPhC) is the regulator for pharmacists, pharmacy technicians and registered pharmacy premises in Great Britain. Our role is to protect, promote and maintain the health, safety and wellbeing of patients and the public who use pharmacy services in England, Scotland and Wales. We have a statutory role in relation to 'system' regulation (as we regulate registered pharmacies) as well as 'professional' regulation of individual pharmacists and pharmacy technicians. Our main work includes: • • setting standards for the education and training of pharmacists, pharmacy technicians and pharmacy support staff, and approving and accrediting their qualifications and training • • maintaining a register of pharmacists, pharmacy technicians and pharmacies	Thank you for your comment. The 'Settings this update covers' section of the guideline has now been simplified to clarify that all settings in which NHS care or social care is provided will be covered. Although the amended review questions in the scope are not specific to a particular setting, when reviewing the evidence and making recommendations the committee will consider implementation factors and that it may be necessary to write different sets of recommendations for different types of settings.

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			• • setting the standards that pharmacy professionals have to meet throughout their careers • • investigating concerns that pharmacy professionals are not meeting our standards, and taking action to restrict their ability to practise when this is necessary to protect patients and the public or to uphold public confidence in pharmacy • • setting standards for registered pharmacies which require them to provide a safe and effective service to patients • • inspecting registered pharmacies to check if they are meeting our standards. We welcome the opportunity to respond to the consultation on short-term management of violence and aggression in mental health, health and community settings. We have limited our response to where we feel our work is directly relevant. We support the extension of the guidelines to cover all health, mental health and social care settings including community care settings. The GPhC	

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			recently published a joint statement with other pharmacy organisations sharing the widespread view that there should be zero tolerance for any abuse or violence against pharmacy staff. Our full statement can be found **here.** We have also provided advice in response to issues raised with us, including advising that pharmacy staff should not be asked to work alone because of potential risks to their safety. Our regulatory approach, standards and guidance are there to help safeguard pharmacy staff, as well as patients and members of the public. Our full statement on violent disorder and its impact on pharmacy services can be found **here.** We recognise that employers have a duty of care to keep their staff safe at work. Our guidance on ensuring pharmacies have a safe and effective team states that pharmacy owners and pharmacy professionals are best placed to identify training needs regarding staff and must provide staff with necessary training appropriate to their roles. Training and development for pharmacy teams should be flexible and should respond to the changing needs of	

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			the business and environment. The full guidance can be found **here.**	
Mencap	General	General	We do not think this guideline should cover people with a learning disability at all. Currently the exclusion is for 'people with a primary diagnosis of learning disability'. However, if a person with a learning disability is receiving treatment in hospital for a mental health condition we would still not want this guideline to be used. It should also be noted that not everyone who has a learning disability has a formal diagnosis. Therefore, we suggest the wording of the exclusion is 'people with a learning disability'.	Thank you for your comment. The wording referred to is based on the current (2015) guideline and we cannot accept consultation comments on this section. However, there are some areas that are covered in other NICE guidelines (for instance, anticipating, preventing and managing behaviour that challenges in people with learning disabilities) and this update will not include specific evidence reviews on these areas, although recommendations in these other NICE guidelines may be cross-referred to. The scope has been amended to make this clearer.
Mencap	General	General	We believe that the NICE guidance on Challenging behaviour and learning disabilities should be followed where someone with a learning disability is displaying behaviour that challenges (which may include behaviour experienced by others as 'violent and aggressive'). The NICE guidance on Challenging behaviour and learning disabilities is understanding of the needs of	Thank you for your comment and helpful suggestion. We agree that these areas are better covered by the NICE guideline on Challenging behaviour and learning disabilities NG11. The scope has been amended to make it clearer that for areas covered by other NICE guidelines (in this case, anticipating, preventing and managing behaviour that challenges in people with learning

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			people with a learning disability and what good support looks like in relation to preventing and managing behaviour that challenges. We think it is the appropriate guidance to be followed in this situation. At specific points in the Draft Scope, there are references to following condition-specific guidance instead of the 'violence and aggression' guidance (e.g. Pg 5, 1.4, 'These recommendations will cover all settings and all populations except people with dementia because the pharmacological management of aggression and agitation is covered in the NICE guideline on dementia'). We would like the condition-specific NICE guidance on Challenging behaviour and learning disabilities to be used for people with a learning disability displaying behaviour that challenges in all cases instead of the NICE Violence and aggression guidance.	disabilities), this update will not include specific evidence reviews, but recommendations in these other NICE guidelines may be cross-referred to.
Mencap	General	General	We would like the Draft Scope to make it clear that those following it must consider the specific needs of people with protected characteristics and, as stated	Thank you for your comment. The EHIA for this update outlines how consideration of protected characteristics will be taken into account. In

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			above, where people have a learning disability, that the NICE guidance on Challenging behaviour and learning disabilities should be followed instead. It will be important for the workforce trained in the Violence and aggression guidance to also be trained in the guidance on Challenging behaviour and learning disabilities so that they are able to use the correct guidance in relation to the population of people with a learning disability who they may come into contact with. We are concerned that because it is not always immediately obvious that someone has a learning disability, someone with a learning disability may be responded to and treated under this guidance as opposed to the condition-specific guidance developed to meet their needs. It is important that in this guideline there is an emphasis on considering protected characteristics and the needs that people have by: looking at relevant information and documentation that outlines their needs e.g. hospital passports and care plans	response to your comment, the scope has been amended to make it clearer that for areas covered by other NICE guidelines (in this case, anticipating, preventing and managing behaviour that challenges in people with learning disabilities), this update will not include specific evidence reviews, but recommendations in these other NICE guidelines may be cross-referred to.

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			and importantly, listening to the person and their families and other professionals who know the person well and understand their needs and how to support them. Once it is understood that the person has a learning disability then staff will know to follow the condition-specific guidance.	
Mencap	General	General	The Draft Scope states that some settings including people's own homes are excluded. We think it should be clear that this means supported living and supported housing are excluded as well.	Thank you for your comment. The 'Settings this update covers' section of the guideline has now been simplified to clarify that all settings in which NHS care or social care is provided will be covered.
Mencap	General	General	There must be an ongoing interrogation of the possibilities that may lead to people with a learning disability falling into the scope of this guideline due to their needs, circumstances or settings they are in, so that this can be avoided.	Thank you for your comment and helpful suggestion. In response to your comment, the scope has been amended to make it clearer that for areas covered by other NICE guidelines (in this case, anticipating, preventing and managing behaviour that challenges in people with learning disabilities), this update will not include specific evidence reviews, but recommendations in these other NICE guidelines may be cross-referred to.
Midlands Partnership	General	General	New evidence should be sourced to support the use of non-pharmacological interventions – through the use of engagement in occupations, experts in the	Thank you for your comment. There is a review question in the scope that will examine the effectiveness of organisational interventions

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University NHS Foundation Trust			use of non-verbal and verbal communications including trauma informed language training in DMI practice, sensory integration and sensory approaches.	targeted at reducing aggressive behaviour and the use of restrictive practices. Training in verbal and non-verbal de-escalation, communication practices, psychologically informed environments and trauma-informed care are included as examples of interventions, or intervention components in a complex intervention, for this review.
Midlands Partnership University NHS Foundation Trust	Recruitment of consultation panel		Expert recruitment for the consultation excludes Allied health professionals that utilise effective interventions in the management of violence and aggression specifically Occupational Therapists Speech & Language Therapists	Thank you for your comment. We appreciate the valuable contributions that Occupational Therapists and Speech & Language Therapists can make to situations where aggressive behaviour may occur. After careful consideration, however, it was determined that the scope does not include a dedicated section on aggressive behaviour that specifically refers to the expertise of these roles. As a result, we have not added an Allied Health Professional position to the committee constituency.
National Federation for Personal Safety	General	General	**Response – General Comments** The following constitutes the National Federation for Personal Safety's (NFPS) response to NICE's	Thank you for your comment. Recommendations on staff training in legislation, involving service users in decision-making,

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			scoping document for amendments and changes to NICE Guidance 10 – Violence and Aggression Prevention and Management (NG10). The National Federation for Personal Safety welcomes both the opportunity to provide input into the proposed updated NICE Guideline 10, as well as the long-overdue recognition that the issues, risks, and dangers posed by violence and aggression within healthcare organisations extend beyond the previous narrow focus on those organisations and facilities responsible for providing care and treatment to mental health patients and for mental health conditions. It is encouraging that the proposed new guidance intends to address these previous shortfalls. Unfortunately, since the demise of NHS Protect in April 2017, and with it the cancellation of the requirement to record and report incidents of violence perpetrated against staff (VAS Stats) at a national level, there is no way of evidencing the	advance decisions, and preventing violations of service users' rights will be reviewed and updated based on committee consensus and this process will include updating the recommendations (including recommendations around recording and reporting on the use of force) to ensure that they are in line with current legislation and best practice**.** The table in the scope has been amended to make it clearer that these recommendations will be updated in line with the Mental Health Units (Use of Force) Act 2018 and the Restraint Reduction Network (RRN) Training Standards 2019. The scope has been amended to include the categories of restrictive practices as outlined by the Restraint Reduction Network, including physical restraint, surveillance, mechanical restraint, blanket restrictions, environmental restraint (seclusion or segregation), cultural restraint, and psychological restraint**.**

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			extent of the problem across the whole of the healthcare spectrum. This has been exacerbated by the failure to replace and/or introduce, at a national level, a valid alternative to VAS Stats (preferably expanded to include information relating to all violent incidents occurring within healthcare organisations, not just violence perpetrated against staff). Additionally, there is a known issue of many healthcare organisations, either by design or out of ignorance, under-reporting these types of incidents to regulatory organisations and/or other national bodies. This has led to a dearth of evidence regarding the seriousness, implications, and consequences of failing to address both violence and the connected necessity of engaging in and/or using physical interventions within healthcare settings. The evidence that does exist, therefore, is both localised, partial, and anecdotal at best.	The 'Settings this update covers' section of the scope has now been simplified to clarify that all settings in which NHS care or social care is provided will be covered. Although the amended review questions in the scope are not specific to a particular setting, when reviewing evidence and making recommendations the committee will consider implementation factors and that it may be necessary to write different sets of recommendations for different types of settings. The term rapid tranquillisation has been retained in order to align with other NICE guidance. However, the wording in the review question has been amended to 'medication in the acute management of aggressive behaviour'. The effectiveness of organisational level interventions targeted at reducing aggressive behaviour and the use of restrictive practices will be examined in this update. In response to your comment, structured risk assessment to inform clinical decision-making has been added as an

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			Areas for Consideration It is the view of NFPS that due consideration should be provided within the new guidance to the following areas: **Terminology** The current NG10 is replete with terminology and concepts that specifically apply to mental health settings and practices while giving the impression that they are universal and practicable across all healthcare settings—for example, terms such as 'observation,' 'seclusion,' and 'rapid tranquillisation.' In the absence of any other guidance, this can and does lead to confusion within other healthcare settings that do not possess direct experience, knowledge, resources, or competency in the subject matter. This mental health-centric perspective has previously ignored the availability, viability, and logistics of alternative approaches outside mental health settings, as well as valid options available in other healthcare settings to manage violent and volatile	example of an organisational intervention or component of a multicomponent intervention. The table in the scope and the 'Activities, services or aspects of care this update covers' section have been amended to make it clear that principles for anticipating, understanding and responding to aggressive behaviour will be included in the update. There is a review question in the scope that will examine the qualitative experience of post-incident debriefing and formal review from the perspective of people who use services, their parents and carers, and staff, and the barriers that you mention may emerge as themes from this review.

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			behaviour. One such example is the use of 'Procedural Sedation' in Acute Emergency Medicine [refer to the Royal College of Emergency Medicine Best Practice Guidance on Procedural Sedation in the Emergency Department]. NFPS would urge that strong consideration is given to expand the remit of the guideline to include the many areas in primary, acute and sub-acute care facilities where patients/service users display aggression and violence. We have provided a list from **our** substantial operational and training experience of such areas. Appendice 1 Therefore, it would be advantageous for the new guidance to reflect these alternatives and acknowledge that the term 'Rapid Tranquillisation' is, in many cases, both practically inaccurate and would benefit from being amended in the guidance to a more appropriate and accurate term, such as 'Emergency Sedation.'	

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			Risk Assessments A key aspect of identifying and understanding the nature, extent, and specific dangers relating to violence and aggression within any healthcare organisation is the ability to design, introduce, and implement appropriate measures to mitigate the risks involved. This requires the ability to conduct and analyse an appropriate and effective suite of risk assessments (RAs), applicable to the specific organisation. To be effective in reducing both violence and the concurrent requirement for physical interventions, these should include: • **Strategic Violence Risk Assessment (SVRA)** – Required to identify issues and inform a healthcare organisation's overall Violence Reduction Strategy (and by default, its Restraint Reduction Strategy). • **Operational Violence Risk Assessment (OVRA)** – Required to identify and inform individual divisions, teams, wards, and specialities of the specific requirements within their areas of responsibility.	

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			• **Tactical Risk Assessment (TRA)** – Used to determine the specific requirements for an individual patient and/or pre-planned event or intervention. • **Dynamic Risk Assessment (DRA)** – Used to immediately assess the risks involved in no-warning/volatile incidents. • **Role Risk Assessment (RRA)** – Used to determine who requires specialised training and (just as importantly) who does not within a specific staff group. **Training** NFPS advocates that the new guidance should stipulate that suitably qualified and experienced personnel, using a combination of the aforementioned RRA and a Training Needs Analysis (TNA), should identify the appropriate training model required to minimise and mitigate the previously identified risks. Further, the training requirement	

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			should be conducted by qualified and experienced sector-specific trainers. The training requirements set out in the current guidance should be expanded to include: • National Decision-Making Model • Conducting Tactical Risk Assessments • Conducting Dynamic Risk Assessments – should form an integral part of any effective (and mandatory) Conflict Management Training. • Expanded legal knowledge (the current requirements are too narrow), including but not limited to details on an individual's lawful authority to detain a person, an individual's lawful authority to restrain a person, and their specific legal rights and responsibilities during an aggressive and/or violent incident. • Recognition of the presentation features of Acute Behavioural Disturbance (ABD).	

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			Physical & Mechanical Restraint While it is appreciated that, in an ideal world, alternative methods should be used to prevent, mitigate, or reduce the risk of incidents escalating into violence, outside of mental health settings, the reality of dealing with aggressive and violent behaviour often means such opportunities are greatly reduced or even removed. Therefore, the review should consider the following: • The restrictions and control measures that mental health organisations can place on access to their facilities, thereby reducing the potential for violent and aggressive behaviour, are not available in all other healthcare settings, including Acute, Emergency Medicine, and Primary Care settings. • Violent conduct in healthcare settings is not restricted to just patients but often involves others—such as relatives, other service users, or criminals—who pose significant risks to staff, patients, and service users.	

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			• Violent conduct is not confined to traditionally high-risk areas like mental health and emergency medicine but occurs across the entire healthcare estate, including presumed low-risk areas. • The appropriate and lawful use of mechanical restraint systems can reduce the risk of serious injuries to all involved in a physical intervention. Increasing evidence suggests that their appropriate use can prevent injuries and fatalities by reducing both the number of individuals involved in a physical intervention and the duration of restraint. • The current '10-minute' rule for manual restraint is practically ineffective and potentially dangerous. Instead, restraint duration should be determined by dynamic risk assessments and effective observation rather than an arbitrary timescale. **The Structured Professional Judgement (SPJ) paradigm (decision theory) could be mentioned here, as it contains similar elements to the more familiar 'National**	

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			Decision Making Model' (NDMM), which all restraint practitioners should be familiar with; as we have stated. **Healthcare Security** Outside of specialised mental health organisations, the responsibility for managing physical interventions in healthcare settings, particularly in Emergency Medicine and Acute settings, does not typically lie with either the police, or clinical/medical staff, but is often delegated to relevent healthcare security teams. However, the roles, competencies, and training of these teams vary significantly due to the absence of national or sector standards. Given the increasing reliance on security teams to manage violence and aggression, the new guidance should acknowledge and reflect this reality.	

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			Policies & Procedures **While it is generally accepted that healthcare organisations should have appropriate policies and procedures related to violence and aggression, there are concerns about the competency of those drafting such documents. Therefore, NFPS believes the new guidance should stipulate that individuals responsible for writing these policies meet statutory definitions of competence and fitness for the role. Such defintions, for example can be found in sections 5 and 19 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014** **Post-Incident Reporting & Review** While formal post-incident reviews and timely reporting of incidents are best practices, practical limitations—such as clinical workload and multiple simultaneous incidents—mean that they are not always consistently applied, particularly in Emergency Medicine and Acute Healthcare settings.	

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			NFPS believes the guidance should acknowledge these limitations and propose viable alternatives to improve reporting and reviews. *Appendice 1* List of other areas within Primary, acute and sub-acute settings where aggression and violence is prevalent. Wards Major Trauma Burns Intensive Care Units Infectious diseases General Medicine Elderly general Medicine Acquired Brain Injury Neuro -Surgery/Epilepsy Surgical recovery Theatres Pharmacy Out-Pa Car Pa No Sm Main re Cafes	

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			Phlebotomy services	
National Mental Health, Learning Disability and Autism Quality Transformation Team. NHS England.	General	General	We welcome the update to this guidance that we feel is long overdue and that this will compliment and support with our current National work to reduce restrictive practices and align with the Use of Force Act.	Thank you for your comment in support of this work.
National Mental Health, Learning Disability and Autism Quality Transformation Team. NHS England.	General	General	Consider the language and terminology used within the scope to describe, to reflect an understanding of best practice in relation to trauma-informed practice, relational support, dignity, respect, and emphasising preventative approaches. For example: labelling people as 'violent and aggressive' can objectify people and feed into negative stereotypes and assumptions as well as issues with epistemic justice. These terms fail to represent human-rights based values and do not reflect that in certain circumstances people are displaying distress and emotional reactions that may be related to external and internal triggers (poor staff skills, unsuitable environments, unmet needs, trauma).	Thank you for your comment. In response to your comment, we have replaced 'violence and aggression' with 'aggressive behaviour' in this update. We acknowledge that 'aggressive behaviour' is used in the absence of a better description and is recognised as not implying deliberate intention. Unfortunately, we were not able to adopt your suggestion of 'preventing and managing the risk of harm to self and others' as it does not clearly differentiate this guideline from the NICE self-harm guideline, but we hope that the changes we have made address your concerns.

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			'Aggression' can be an ambiguous term – it does not tell us enough about the person's needs/risk or how to support and reduce risk. Neither 'violence' nor 'aggression' adequately reflect psychological harm. For example, 'violence and aggression – prevention and management', could be replaced with 'preventing and managing the risk of harm to self and others'. Please see NHSE Culture of Care Standards 2024 re Use of Language.	
National Mental Health, Learning Disability and Autism Quality Transformation Team. NHS England.	General	General	Consent and legal frameworks should be within the scope of this update. The previous guide NG10 Violence and Aggression was published in 2015 and although it did include reference to consent and Deprivation of Liberty, there has been developing caselaw around this since 2015, especially as the new guide will be all-age. CQC has published Restrictive practices - Care Quality Commission which may need to be dovetailed accordingly.	Thank you for your comment. Recommendations on staff training in legislation, involving service users in decision-making, advance decisions, and preventing violations of service users' rights will be reviewed and updated based on committee consensus and this process will include updating the recommendations (including recommendations around recording and reporting on the use of force) to ensure that they are in line with current legislation and best practice. In response to your comment, the table in the scope

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				has been amended to make it clearer that these recommendations will be updated in line with the Mental Health Units (Use of Force) Act 2018.
National Mental Health, Learning Disability and Autism Quality Transformation Team. NHS England.	General	General	There is separate guidance (condition specific guidelines) for people who have a primary diagnosis of a learning disability. "Challenging Behaviour and Learning Disabilities: prevention and interventions for people with learning disabilities whose behaviour challenges". This guidance is equally relevant for people who do not have a learning disability (autistic people in particular – but certainly wider that just this as well). Some of the Learning Disability specific guidance needs to go into the 'generic' one.	Thank you for your comment. The scope has been amended to make it clearer that for areas covered by other NICE guidelines (for instance, anticipating, preventing and managing behaviour that challenges in people with learning disabilities or anticipating, preventing and managing behaviour that challenges in people with autism spectrum disorder), this update will not include specific evidence reviews. However, recommendations in these other NICE guidelines may be cross-referred to.
National Mental Health, Learning Disability and Autism Quality Transformation Team. NHS England.	General	General	Why limit restrictive interventions considered to just restraint, rapid tranquillisation, or seclusion? The Restraint Reduction Network (RRN) have published guidance on 8 different types of restraint which the Welsh Government have supported and aligned to in their cross-Government Strategy.	Thank you for your comment and helpful suggestion. The scope has been amended to include the categories of restrictive practices as outlined by the Restraint Reduction Network, including physical restraint, surveillance, mechanical restraint, blanket restrictions, environmental restraint (seclusion or segregation), cultural restraint, and psychological

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				restraint. Rapid tranquillisation has been retained as a term and not completely replaced by chemical restraint in order to align with other NICE guidance. However, the scope has been amended so that as well as benefits and harms of rapid tranquillisation, the qualitative experience of chemical restraint (from the perspective of people who use services, their parents and carers, and staff) will also be examined.
National Mental Health, Learning Disability and Autism Quality Transformation Team. NHS England.	General	General	Consider rethinking the approach to prevention. Seems a little negative in the way it is phrased. Broaden the approach from e.g. using medication to prevent violence which seems a little downstream of where we would like to go on prevention. One of the most positive moves we have had is the 4 steps to safety programme which is much more proactive (DASA scoring/zoning, patient engagement, intentional rounding, teamwork/SBARD and the safe environment). Consider the interface with wider safety planning e.g. new guidance re suicide prevention. This NICE guidance covers short term safety planning in small groups (in patients) in relation to risk to others where	Thank you for your comment. There is a review question in the scope that will examine the effectiveness of organisational level interventions, including psychologically-informed environments, that are targeted at reducing aggressive behaviour and restrictive practices. The table in the scope and the 'Activities, services or aspects of care this update covers' section have been amended to make it clear that principles for anticipating, understanding and responding to aggressive behaviour will be included in the update.

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			the evidence base re predicting risk is quite good as against the prediction of self harm/ suicide in large populations assessed in a variety of settings.	
National Mental Health, Learning Disability and Autism Quality Transformation Team. NHS England.	002	003	There seems to be a disconnect between what is included and what is excluded in this guidance for instance: Care homes for older adults have 70-80% of residents with dementia and yet whilst care homes are included, pharmacological treatment in people with dementia is not. Consider including people's own homes where regulated care is being provided. Specifically, consideration of supported living settings. Professionals, Children Young People and families refer to children's homes in different ways such as residential unit and care unit, children's setting. If these are being excluded (we don't agree they should be) this may need to be defined by the regulator rather than the name of the service e.g. all Ofsted services are out of scope.	Thank you for your comment. In response to your comment, the 'Settings this update covers' section of the guideline has now been simplified and includes all settings in which NHS care or social care is provided.

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			It would also be helpful to separate out inpatient hospitals (line 7) for clarity. For mental health hospitals it would be helpful to align with NHSE guidance to say something like 'mental health inpatient settings including acute inpatient mental health services for adults and older adult acute mental health inpatient services for adults with a learning disability and autistic adults, adult mental health rehabilitation inpatient services, secure provision and services for children and young people. We would urge this includes the use of 'Secure Transport'.	
National Mental Health, Learning Disability and Autism Quality Transformation Team. NHS England.	003	005	Consider adding segregation as well as seclusion	Thank you for your comment and helpful suggestion. The scope has been amended to include the categories of restrictive practices as outlined by the Restraint Reduction Network including environmental restraint (seclusion or segregation)

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National Mental Health, Learning Disability and Autism Quality Transformation Team. NHS England.	004	1.2 1.3 1.4 1.6	Consider that links to other guidance re: prn is not helpful, and a note re: caution re dosages is valuable to include. under de-escalation will need to take into account any sensory impairment. Consider how the practitioner giving rapid tranquilization will know if the person has delirium or dementia or both. A note re: caution re: dosages in older adults is valuable to include. Evidence review on restraint should specifically consider issues around older adults	Thank you for your comment. The use of p.r.n. (as needed) medication (administered orally) to prevent the onset of aggressive behaviour was considered to be best covered by condition-specific guidelines for people who are already known by the health or care provider and care is already managed in the context of their circumstance, condition and co-morbidities. Oral antipsychotic medication to prevent the onset of aggressive behaviour has been added as an exclusion for this update. Organisational level interventions targeted at reducing aggressive behaviour and the use of restrictive practices includes training in verbal and non-verbal de-escalation as examples of interventions, or components in a complex intervention. In response to your, and other stakeholder, comments training in communication practices have also been added to the list of examples of organisational interventions. Where possible, this review will also include subgroup

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				analysis and/or meta-regression to explore differences in effectiveness associated with components of multicomponent organisational interventions. For the rapid tranquillisation review question, trials that specifically recruit participants with dementia will be excluded. This is because the guiding principle of this update is to make general recommendations on the management of aggressive behaviour, and specific adaptations based on condition are better dealt with in condition-specific guidelines. There is existing NICE guidance that covers the management of agitation or aggression in dementia. The recommendations in this update will cover, or signpost to relevant recommendations in other guidance, to inform the most appropriate person-centred management of aggressive behaviour. As outlined in the EHIA for this update, consideration of protected characteristics, including age, will take the form of subgroup

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				analyses wherever possible. We will add sensory impairment to our list of EHIA considerations for de-escalation.
Queen's University Belfast	004	1.1	This text was identified as confidential and has been removed	Thank you for your comment. The organisational level interventions targeted at reducing aggressive behaviour and the use of restrictive practices includes methods of observation as an example of an intervention, or component in a complex intervention, where findings from relevant evidence such as the study you describe may be captured. In response to your comment, training in communication practices have also been added to the list of examples of organisational interventions. Where possible, this review will also include subgroup analysis and/or meta-regression to explore differences in effectiveness associated with components of multicomponent organisational interventions.
Queen's University Belfast	004	1.2	This text was identified as confidential and has been removed	Thank you for your comment. The effectiveness of organisational level interventions targeted at reducing aggressive behaviour and the use of restrictive practices, including methods of observation, will be examined in this update.

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				Although the list of interventions is illustrative rather than exhaustive, we have added training in communication practices as an example of an intervention or component in a complex intervention. Where possible, this review will also include subgroup analysis and/or meta-regression to explore differences in effectiveness associated with components of multicomponent organisational interventions
Restraint Reduction Network	General	General	Definitions – any guidance should be careful not to conflate description of the phenomenon (e.g., what the thing is) with goal, purpose or function (e.g., what the restraint does or is used for). Meaningful restraint reduction initiatives require that the phenomenon of restraint be identified and measured etc. This means that conceptual definitions must move away from those that accommodate an inherent variation of certain kinds of phenomena by implicating it with goal and/or purpose.	Thank you for your comment and helpful suggestion. The scope has been amended to include the categories of restrictive practices as outlined by the Restraint Reduction Network, including physical restraint, surveillance, mechanical restraint, blanket restrictions, environmental restraint (seclusion or segregation), cultural restraint, and psychological restraint. Rapid tranquillisation has been retained as a term and not completely replaced by chemical restraint in order to align with other NICE guidance. However, the scope has been amended so that as well as benefits and harms of rapid tranquillisation, the qualitative experience

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			Relevant paper: Hibberd, F. J. (2019). What is scientific definition?. *The Journal of Mind and Behavior*, *40*(1), 29-52.	of chemical restraint (from the perspective of people who use services, their parents and carers, and staff) will also be examined.
Restraint Reduction Network	General	General	The definition of 'breakaway' across guidance on restrictive practices and use of force is problematic. This is because most breakaways by their very nature use an element of force to enable the removal of a grip. As such, the various techniques can be experienced as limiting autonomy, highly restrictive and/or risky. As physical force is used, there is (some) resistance and so this meets the definition of restraint. While the restraint might be justifiable, it meets the definition of restraint. We therefore urge you to consider making breakaways a form of restraint explicitly mentioned within the guidance as, if they are not recognised as such, they cannot come under the same scrutiny as other restrictive interventions in terms of risk, impact and recording.	Thank you for your comment and helpful suggestion. The scope has been amended to include the categories of restrictive practices as outlined by the Restraint Reduction Network, as follows: physical restraint (including breakaway techniques that have a restrictive component); surveillance; mechanical restraint; blanket restrictions; environmental restraint (including seclusion or segregation); cultural restraint; psychological restraint. The examples of organisational interventions to reduce the use of restrictive practices has also been expanded to include training in non-restrictive breakaway techniques. The guideline will be consistent in the use of terminology and the distinction between non-restrictive breakaway techniques, and breakaway techniques that include a restrictive component will be recognised.

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Restraint Reduction Network	General	General	Regarding what is considered a restrictive practice, we suggest broader consideration should be given to both formal coercion (e.g., physical, mechanical and environmental restraint) and informal coercion (psychological restraint). We have outlined 8 different ways people's agency and human rights might be restricted in the Restraint Reduction Network's '8 types of restraint' document at https://restraintreductionnetwork.org/resource/8-types-of-restraint/. Informal coercion can have a disruptive and cumulative effect on the psychological and physical integrity of a person, impacting relational working by fracturing trust, self-determination and treatment compliance. Recent evidence on informal coercion: - Andersson, U., Fathollahi, J., & Gustin, L. W. (2020). Nurses' experiences of informal coercion on adult psychiatric wards. *Nursing ethics*, *27*(3), 741-753.	Thank you for your comment, helpful suggestion and references provided. The scope has been amended to adopt and use the categories of restrictive practices that you outline: physical restraint (including breakaway techniques that have a restrictive component); surveillance; mechanical restraint; blanket restrictions; environmental restraint (including seclusion or segregation); cultural restraint; psychological restraint. Rapid tranquillisation has been retained as a term and not completely replaced by chemical restraint in order to align with other NICE guidance. However, the scope has been amended so that as well as benefits and harms of rapid tranquillisation, the qualitative experience of chemical restraint (from the perspective of people who use services, their parents and carers, and staff) will also be examined.

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			- Valenti, E., Banks, C., Calcedo-Barba, A., Bensimon, C. M., Hoffmann, K. M., Pelto-Piri, V., ... & Priebe, S. (2015). Informal coercion in psychiatry: a focus group study of attitudes and experiences of mental health professionals in ten countries. *Social psychiatry and psychiatric epidemiology*, *50*, 1297-1308. - Yeeles, K. (2016). Informal coercion: Current evidence. *Coercion in community mental health care. International perspectives*.	
Restraint Reduction Network	General	General	We found that much of the guidance was based on management rather than prevention. Arguably the emphasis should be at the very least balanced. We felt that the guidance was written in a way that unreflexively situated violence and aggression as originating in the person as innate characteristics, rather than seeing it as relationally constructed e.g., as a product of unmet need from inadequate environment/staff.	Thank you for your comment. In response to your comment, we have replaced the terms violence and aggression' with 'aggressive behaviour' in this update. We acknowledge that 'aggressive behaviour' is used in the absence of a better description and is recognised as not implying deliberate intention. There is a review question in the scope that examines organisational level interventions that are targeted at reducing aggressive behaviour and restrictive practices that will examine the effectiveness of these prevention approaches, and a qualitative review

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				question has been added to explore facilitators and barriers to the implementation of these organisational level interventions. The table in the scope and the 'Activities, services or aspects of care this update covers' section have been amended to make it clear that principles for anticipating, understanding and responding to aggressive behaviour will be included in the update.
Restraint Reduction Network	007	001	The best evidence based approach to reducing reliance on restrictive practices is the 6 core strategies (https://restraintreductionnetwork.org/wp-content/uploads/2023/09/Consolidated-Six-Core-Strategies-Document.pdf)	Thank you for your comment. The effectiveness of organisational level interventions targeted at reducing aggressive behaviour and the use of restrictive practices will be examined in this update. Where possible, this review will also include subgroup analysis and/or meta-regression to explore differences in effectiveness associated with components of multicomponent organisational interventions.
Restraint Reduction Network	007	009	It is vital that training in the use of restrictive practices is quality assured. The RRN Training Standards have a clear evidence base through independent evaluation by Manchester	Thank you for your comment. Recommendations on staff training in legislation, involving service users in decision-making, advance decisions, and preventing violations of service users' rights will be reviewed and updated based on

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			Metropolitan University and a requirement through Mental Health Units (Use of Force) Act 2018 statutory guidance; Scottish schools guidance 2024, Security Industry Authority 2022 guidance, Local Government Association 2024 guidance.	committee consensus and this process will include updating the recommendations so that they are in line with current legislation. In response to your comment, the table in the scope has been amended to make it clearer that these recommendations will be updated in line with the Mental Health Units (Use of Force) Act 2018 and the Restraint Reduction Network (RRN) Training Standards 2019.
Restraint Reduction Network	007	011	Prevention is described as intervention which it is not. Most distress results from unmet needs. Prevention therefore focuses on meeting needs.	Thank you for your comment. The evidence review on organisational level interventions (including structured risk assessments to inform clinical decision-making) to reduce aggressive behaviour and the use of restrictive practices aims to examine the effectiveness of prevention approaches that have been implemented in the context of intervention effectiveness studies. However, we anticipate that the unmet needs that you refer to are likely to emerge as a theme in the qualitative review questions on facilitators and barriers to implementing these organisational interventions, on the experience of restrictive

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				practices, and on the experience of post-incident debriefing and formal review.
Restraint Reduction Network	008	005	Support for pregnant people should emphasise de-escalation and non-pharmacological and restraint/seclusion methods as there is little/no research on their safety for the parent or developing foetus. We find this paper wholly inadequate and based on little actual research evidence: Powell, J., Taylor, D., & Manoharan, M. (2024). The pharmacological management of acute behavioural disturbance in pregnancy. *BJPsych Advances*, *30*(1), 67–70. doi:10.1192/bja.2023.7	Thank you for your comment. There are some areas that are covered in other NICE guidelines (for instance, rapid tranquillisation in pregnant people is covered in the NICE Antenatal and postnatal mental health guideline CG192) and this update will not include specific evidence reviews on these areas. However, recommendations in these other NICE guidelines may be cross-referred to. The scope has been amended to make this clearer. For other areas of the guideline, for example the safety of non-pharmacological restraint, consideration of protected characteristics will take the form of subgroup analyses wherever possible, and this is outlined in the EHIA for this update.
Restraint Reduction Network	008	005	Support for pregnant people should emphasise de-escalation and non-pharmacological and restraint/seclusion methods as there is little/no research on their safety for the parent or developing foetus.	Thank you for your comment. There are some areas that are covered in other NICE guidelines (for instance, rapid tranquillisation in pregnant people is covered in the NICE Antenatal and postnatal mental health guideline CG192) and this update will not include specific evidence

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			We find this paper wholly inadequate and based on little actual research evidence: Powell, J., Taylor, D., & Manoharan, M. (2024). The pharmacological management of acute behavioural disturbance in pregnancy. *BJPsych Advances*, *30*(1), 67–70. doi:10.1192/bja.2023.7	reviews on these areas. However, recommendations in these other NICE guidelines may be cross-referred to. The scope has been amended to make this clearer. For other areas of the guideline, for example the safety of non-pharmacological restraint, consideration of protected characteristics will take the form of subgroup analyses wherever possible, and this is outlined in the EHIA for this update.
Restraint Reduction Network	008	010	Greater emphasis is needed on psychological impact/trauma involved in restraint for staff and people in the service. At present there is a heavy weighting towards physical impact/injury. Evidence to inform this: - Bonner, G., Lowe, T., Rawcliffe, D., & Wellman, N. (2002). Trauma for all: a pilot study of the subjective experience of physical restraint for mental health inpatients and staff in the UK. *Journal of psychiatric and mental health nursing*, *9*(4), 465-473. - Hamid, M. A. Y. S., & Daulima, N. H. C. (2018). The experience of restraint-use among patients	Thank you for your comment and for providing these references. There is a review question in the scope that will examine the qualitative experience of restraint (and other restrictive practices) from the perspective of people who use services, their parents and carers, and the staff implementing these measures. In response to your comment, post-traumatic stress disorder (PTSD) and self-harm have also been added to the list of main outcomes for this update and will be considered for the review question on the safety of restrictive practices for the short-term management of aggressive behaviour.

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			with violent behaviors in mental health hospital. *Enfermería Clínica*, *28*, 295-299. - Cusack, P., Cusack, F. P., McAndrew, S., McKeown, M., & Duxbury, J. (2018). An integrative review exploring the physical and psychological harm inherent in using restraint in mental health inpatient settings. *International journal of mental health nursing*, *27*(3), 1162-1176. - Douglas, L., Donohue, G., & Morrissey, J. (2022). Patient experience of physical restraint in the acute setting: A systematic review of the qualitative research evidence. *Issues in Mental Health Nursing*, *43*(5), 473-481. - Holmes, D., Kennedy, S. L., & Perron, A. (2004). The mentally ill and social exclusion: a critical examination of the use of seclusion from the patient's perspective. *Issues in mental health nursing*, *25*(6), 559-578. - Muskett, C. (2014). Trauma-informed care in inpatient mental health settings: A review of the literature. *International journal of mental health nursing*, *23*(1), 51-59.	

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			- Frueh, B. C., Knapp, R. G., Cusack, K. J., Grubaugh, A. L., Sauvageot, J. A., Cousins, V. C., ... & Hiers, T. G. (2005). Special section on seclusion and restraint: Patients' reports of traumatic or harmful experiences within the psychiatric setting. *Psychiatric services*, *56*(9), 1123-1133. - Peterson, H. L. (2017). Patient abuse and trauma: A policy analysis of the regulation of seclusion and restraint in mental health care. *Journal of policy practice*, *16*(2), 187-204.	
Restraint Reduction Network	008	013	The guidance should make the distinction between seclusion (e.g., enforced isolation lasting less than 48hrs) and Long-Term Segregation (e.g., enforced isolation which extends beyond 48hrs) – see CQC ICETR definitions on LTS - https://www.cqc.org.uk/sites/default/files/20200824_9001307_brief-guide_long-term-segregation_v3_0.pdf The psychological and physical impact of isolation practices are very different and so the delineation of	Thank you for your comment. The scope has been amended to include the categories of restrictive practices as outlined by the Restraint Reduction Network, including environmental restraint (seclusion or segregation). The guideline will be clear on the distinction between seclusion and segregation.

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			short term and extended isolation are warranted. Additionally, Baroness Hollins' report 'My Heart Breaks' (2023) and HOPE(S) data have identified that, at a national level, it is notoriously difficult for staff to identify when they are using seclusion and LTS. This has meant that staff are too often unable to enact the appropriate safeguards and national processes (e.g., reporting occurrences of LTS to the CQC) – clarity would be helpful.	
Restraint Reduction Network	008	013	The destructive impact of enforced isolation (both seclusion and long-term segregation) requires expanding. At present, incorrect beliefs about the therapeutic benefit of isolation are pervasive, which in turn mean staff are more likely to use the practice. Enforced isolation has been shown to have significant effects on people's physical and psychological well-being and result in irreversible damage. Almost all research advocates for the avoidance of its use and the implementation of relational working as a proactive strategy.	Thank you for your comment. There is a review question in the scope that will examine the qualitative experience of restrictive practices, including enforced isolation from the perspective of people using services, their parents and carers, and the staff implementing these measures. In response to your comment, post-traumatic stress disorder (PTSD) and self-harm have also been added to the list of main outcomes for this update and will be considered, alongside adverse physical events, for the review question on the safety of restrictive practices for

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			Relevant research to consider: - Chieze, M., Hurst, S., Kaiser, S., & Sentissi, O. (2019). Effects of seclusion and restraint in adult psychiatry: a systematic review. *Frontiers in psychiatry*, *10*, 491. - Haney, C. (2018). The psychological effects of solitary confinement: A systematic critique. *Crime and Justice*, *47*(1), 365-416.	the short-term management of aggressive behaviour.
Restraint Reduction Network	008	013	We urge you to highlight surveillance as a restrictive practice as it inherently rights restricting e.g., peoples article 8 right to privacy and when applied in a blanket fashion (e.g., too all bedrooms) it can constitute a blanket restriction and touch on article 14 (e.g., surveillance is being used because the psychiatric population are considered as inherently risky). There is considerable evidence demonstrating the harmful impact of surveillance. The Desai (2021) work is especially comprehensive in showing the rights restricting harms of surveillance which include	Thank you for your comment and for the references provided. The scope has been amended to include the categories of restrictive practices as outlined by the Restraint Reduction Network, including surveillance and blanket restrictions. Review questions in the scope will examine the safety and experience of restrictive practices.

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			disrupting the therapeutic alliance, predisposing people to voyeuristic gaze, violation of privacy and greater instances of power-induced/laden conflict. Relevant papers on surveillance include: - Desai, S. (2021). *Surveillance Practices and Mental Health: the impact of CCTV inside mental health wards*. Routledge. - Simpson, A. (2023). Surveillance, CCTV and body-worn cameras in mental health care. *Journal of Mental Health*, *32*(2), 369-372. - Griffiths, J. L., Saunders, K. R., Foye, U., Greenburgh, A., Regan, C., Cooper, R. E., ... & Simpson, A. (2024). The use and impact of surveillance-based technology initiatives in inpatient and acute mental health settings: a systematic review. *BMC medicine*, *22*(1), 564. - Foye, U., Wilson, K., Jepps, J., Blease, J., Thomas, E., McAnuff, L., ... & Simpson, A. (2024). Exploring the use of body worn cameras in acute mental health wards: a mixed-method	

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			evaluation of a pilot intervention. *BMC Health Services Research*, *24*(1), 681.	
Restraint Reduction Network	008	021	There is evidence that post incident debriefing should be divided into a support phase (e.g., to re-establish psychological and physical safety) and a learning phase (e.g., to find ways to reduce the likelihood to the restraint being required again). The Restraint Reduction Network Post Incident Debriefing Explainer for staff in inpatient settings and Post Incident Debriefing Explainer for staff working with autistic people or people with learning disabilities Further evidence: Baker, PA. (2017) Attending to debriefing as post-incident support of care staff in intellectual disability challenging behaviour services: An exploratory study. *International Journal of Positive Behavioural Support,* 7(1), 38-44.	Thank you for your comment. This review question focuses on the experience of post-incident debriefing or formal review after using a restrictive practice from the perspective of people who use services, their parents and carers, and staff. Benefits of a phase-based approach may emerge as a theme from this analysis, but it was not considered appropriate to pre-specify this in the review question.

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			King, J., Baker, P. and Gore, N. (2022) Psychological wellbeing and support of staff in a specialist residential school for children with intellectual and developmental disabilities. *International Journal of Positive Behavioural Support*, 12(1), 46-52. McKenna, K., Paterson, B., Hallett, N., & Berring, L. L. (2024). Post-occurrence Review. In *Coercion and Violence in Mental Health Settings: Causes, Consequences, Management* (pp. 405-428). Cham: Springer Nature Switzerland.	
Restraint Reduction Network	010	022	We suggest referring to pregnant people rather than pregnant women as some people that are pregnant are nonbinary/transgender.	Thank you for your comment. This wording will be used going forward in the update.
Restraint Reduction Network	010	023	We also think you should reconsider the guidance in relation to autism and learning disability. With the closure of many learning disability hospitals, the exclusion of this population can impact support provision negatively, notably where dual diagnosis of	Thank you for your comment. This section of the scope summarises the scope for the current (2015) guideline which we are updating. We cannot accept consultation comments on this section. However, there are some areas that are covered in other NICE guidelines (for instance,

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			learning disability and a mental health condition may exist.	anticipating, preventing and managing behaviour that challenges in people with learning disabilities) and this update will not include specific evidence reviews on these areas, although recommendations in these other NICE guidelines may be cross-referred to. The scope has been amended to make this clearer.
Royal College of Nursing	General	General	We don't have any comments to add at this stage but look forward to getting information regarding the full consultation in due course.	Thank you.
Royal College of Speech and Language Therapists	General	General	As new recommendations will be formed on the activities of care including management, training and trauma informed approaches it would be worth re-visiting the core staffing model in mental health. Dedicated access to speech and language therapy in the multidisciplinary mental health inpatient and community mental health hospital settings is crucial. When any person experiences a mental health need, the processing of language diminishes to some degree. All mental health conditions have a detrimental effect on communication, interaction, language and processing. Communication	Thank you for your comment. In response to your comment, training in communication practices have been added to the list of examples of organisational level interventions, or intervention components, targeted at reducing the use of restrictive practices. Although the amended review questions in the scope are not specific to a particular setting, when reviewing evidence and making recommendations the committee will consider implementation factors and that it may be necessary to write different sets of recommendations for different types of settings.

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			breakdown often leads to patients being put in seclusion, put in holds and long unneeded stays in hospital. Speech and language therapists make a huge impact on access to services, engagement in treatment, access and response to mental health talking therapies, reduction in seclusion, reduction in holds, safe discharge planning, fewer re-admissions and diagnosis. Speech and language therapists support the MDT to understand a person's communication, understanding and interaction level when mentally unwell. We recommend that speech and language therapists are added as a core part of the healthcare workforce.	
Royal College of Speech and Language Therapists	001	021	Can you confirm that the scope will include older people using mental health and social care services as this is not specifically mentioned.	Thank you for your comment. The scope will include older people and the 'Populations this update covers' section of the scope has been amended to make this clearer.
Royal College of Speech and	007	011	Draft review question 1	Thank you for your comment. In response to your comment, training in communication practices have been added to the list of examples of

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Language Therapists			We recommend that this is expanded as below to include communication and emphasise its role in the interventions being discussed. What are the benefits and harms of organisational interventions for reducing the use of restrictive interventions in children and adolescent inpatient and residential settings, and how does communication play a role in these interventions?	organisational level interventions, or intervention components, targeted at reducing aggressive behaviour and the use of restrictive practices. Where possible, this review will also include subgroup analysis and/or meta-regression to explore differences in effectiveness associated with components of multicomponent organisational interventions.
Royal College of Speech and Language Therapists	007	014	Draft review question 2 We recommend that this is expanded as below to integrate communication into the context, emphasizing its role in the interventions being discussed. What are the benefits and harms of organisational interventions for reducing the use of restrictive interventions in inpatient and residential settings for adults, and how is communication integrated into these interventions?	Thank you for your comment. In response to your comment, training in communication practices have been added to the list of examples of organisational level interventions, or intervention components, targeted at reducing the use of restrictive practices. Where possible, this review will also include subgroup analysis and/or meta-regression to explore differences in effectiveness associated with components of multicomponent organisational interventions.
Royal College of Speech and Language Therapists	007	017	Draft review question 3 We recommend expanding this to include communication, highlighting its role in the interventions being discussed.	Thank you for your comment. In response to your comment, training in communication practices have been added to the list of examples of organisational level interventions, or intervention components, targeted at reducing the use of

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			What are the benefits and harms of organisational interventions for reducing the use of restrictive interventions in emergency care, outpatient care, primary care, and community settings, and how does communication impact the effectiveness of these interventions?	restrictive practices. Where possible, this review will also include subgroup analysis and/or meta-regression to explore differences in effectiveness associated with components of multicomponent organisational interventions.
Royal College of Speech and Language Therapists	008	007	The scope states that staff training will be addressed in questions 1 and 3. However, the review questions do not specifically mention staff training or de-escalation techniques. We recommend that this is added. By not explicitly incorporating staff training into the review questions, there may be a missed opportunity to assess the impact of proper training on outcomes such as the reduction of restrictive interventions, the prevention of violence and aggression, and overall safety. De-escalation strategies are often the first line of defense in managing violence or aggression, and their effective implementation can reduce the need for restrictive interventions like seclusion or restraint.	Thank you for your comment. Examples of organisational interventions, including training in verbal and non-verbal de-escalation, are included in the 'Activities, services or aspects of care' section of the scope and will be outlined in the review protocol that is drafted for this review question.

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			The omission of de-escalation techniques from the review questions may limit a comprehensive assessment of how these strategies contribute to improving care, reducing incidents, and promoting a safer environment for both service users and staff.	
Royal College of Speech and Language Therapists	008	010	Draft review question 9 We recommend that this is expanded to integrate communication, which could be related to both the interaction with service users during restraint and seclusion and the exchange of information among staff. What is the safety of observation, manual restraint (including prone and supine restraint positions, and the use of products to support restraint), mechanical restraint, seclusion, and communication strategies during these practices?	Thank you for your comment. In response to your comment, training in communication practices has been added to the list of examples of organisational level interventions, or intervention components, targeted at reducing the use of restrictive practices. Where possible, this review will also include subgroup analysis and/or meta-regression to explore differences in effectiveness associated with components of multicomponent organisational interventions. Communication has not been added to the review question about the safety of restrictive practices as it was not considered appropriate to include here.
Royal College of Speech and Language Therapists	008	013	Draft review question 10 We recommend that this is expanded to integrate communication, which could be related to both the interaction with service users during restraint and	Thank you for your comment. This review question will examine the qualitative experience of restrictive practices. Communication may emerge as a theme from this analysis, but it was

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Stakeholder	Page no.	Line no.	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
			seclusion and the exchange of information among staff What is the experience of observation, manual restraint (including prone and supine restraint positions, and the use of products to support restraint), mechanical restraint, or seclusion from the perspective of service users, staff who are implementing these measures, and how communication is managed in these situations?	not considered appropriate to add this to the review question.
Royal College of Speech and Language Therapists	008	018	Draft review question11 We recommend expanding this to include communication, which could relate to both the interaction with service users during restraint and seclusion, as well as the exchange of information among staff. What are the signs of a physical health emergency in people who are being restrained, and how is communication with them handled during such events?	Thank you for your comment. This review question is focused on early identification of a physical health emergency in order to signal that restraint should be stopped and it was not considered appropriate to add communication to this review question.
Royal College of Speech and Language Therapists	008	020	Draft review question 12 We recommend that this is expanded to focus on how communication plays a role in the post-incident support and review process.	Thank you for your comment. This review question will examine the qualitative experience of post-incident support. Communication may emerge as a theme from this analysis, but it was

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			What is the experience of post-incident debriefing or formal review after using a restrictive intervention from the perspective of service users and staff, and how is communication facilitated during these processes?	not considered appropriate to add this to the review question.
Royal College of Speech and Language Therapists	009	Section 1-14	Main outcomes for this update We recommend that the last bullet is expanded to include communication as a key aspect in the experience of service users and staff, particularly in how communication does impact and relate to the outcomes mentioned. Experience of service users and staff, including communication during and after interventions	Thank you for your comment. Communication may emerge as a theme from the qualitative review questions, but it was not considered appropriate to add this to the outcomes in the scope.
Royal College of Speech and Language Therapists	011	Section 11-20	Activities, services or aspects of care Communication can certainly play a key role in each of these areas, especially in preventing and managing violence and aggression. However, it is not directly referenced in the text. Communication is essential in all of these contexts. We recommend expanding the following points: • Anticipating and reducing the risk of violence and aggression - the role of	Thank you for your comment. This section of the scope summarises the scope for the current (2015) guideline which we are updating. We cannot accept consultation comments on this section.

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			communication in early identification and de-escalation. - Preventing violence and aggression - focus on effective communication strategies to manage challenging situations. - Using restrictive interventions in inpatient psychiatric settings - communication can help to reduce the need for these interventions, good communication for de-escalation. - Managing violence and aggression in emergency departments - emphasis on communication between staff and service users. - Managing violence and aggression in community and primary care settings – good communication can help prevent escalation. Managing violence and aggression in children and young people - communication techniques tailored to this population.	

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South Western Ambulance Service NHS Foundation Trust	General	General	As restrictive interventions is such a broad topic, does this need to be considered as separate guidance altogether?	Thank you for your comment. The use of restrictive practices in some areas was considered to be best covered by condition-specific guidelines for people who are already known by the health or care provider and care is already managed in the context of their circumstance, condition and co-morbidities. The scope has been amended to make it clearer that for areas covered by other NICE guidance, there will not be specific evidence reviews for this update, although relevant recommendations in other NICE guidelines may be cross-referred to as appropriate.
South Western Ambulance Service NHS Foundation Trust	002	013	Working with police should be expanded broader to consider 'other services' noting that police and criminalisation is not always the best approach under the public health framework to prevent and reduce violence.	Thank you for your comment. Working with the police is singled out as this area is covered by the current guideline and will be updated based on committee expertise. It may be that other services might be included in the updated recommendations, or that the interface with other services might be captured by other review areas, but it was not considered appropriate to add this to the scope as this is a reference to the area that was focused on in the current guideline

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South Western Ambulance Service NHS Foundation Trust	002	014	Peoples own homes and other settings we believe should be considered within this guidance. As this guidance is expanded to include emergency care (including ambulance settings) and community settings, the nature of urgent and emergency care is largely in individual's homes. The most common location for violence and aggression to occur for ambulance services is individual's homes, as it's where the majority of our service provision is undertaken.	Thank you for your comment. The 'Settings this update covers' section of the guideline has now been simplified and includes all settings in which NHS care or social care is provided.
South Western Ambulance Service NHS Foundation Trust	004	General	It states no new evidence surrounding the 'working with the police' section. The Right Care, Right Person initiative has significantly changed some of the operational response around individuals with mental health needs so I think this would be worth looking into as well (https://www.college.police.uk/guidance/right-care-right-person-toolkit) . This is probably worth considering as part of the scope as operationally services have seen a move to less police attendance.	Thank you for your comment. The recommendation around working with the police will be updated as part of this guideline update. A review question was not included on this area as no evidence was identified that would address these issues. However, the committee will update recommendations based on their clinical knowledge and experience and the wider context of related guidance, for example, from the College of Policing.
South Western Ambulance	004	General	The review mentions excluding staff training in legislation. We feel as though this should be	Thank you for your comment. These recommendations will be included in the update

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Service NHS Foundation Trust			considered for review due to the enactment of the Mental Health Units (Use of Force) Act 2018, which is one of the closest pieces of primary legislation for other services, as well as mental health providers surrounding legislation behind use of force.	but there will not be an evidence review on these areas. Recommendations in the current guideline will be reviewed and updated based on committee consensus and this process will include updating the recommendations so that they are in line with current legislation. In response to your comment this section of the table has been amended to make it clearer that these recommendations will be updated in line with the Mental Health Units (Use of Force) Act 2018.
South Western Ambulance Service NHS Foundation Trust	009	004	We feel as though there needs to some consistency surrounding terminology utilised in types of restrictive interventions, as policy and guidance do not always align and NICE guidance would be a good way to encourage standardisation of terminology. We'd suggest the following: - Physical (use of force from a person) - Mechanical (use of restrictive intervention tools such as handcuffs, seat belts etc) - Chemical (including rapid tranquillisation)	Thank you for your comment and helpful suggestion. The scope has been amended to include the categories of restrictive practices as outlined by the Restraint Reduction Network, including physical restraint, surveillance, mechanical restraint, blanket restrictions, environmental restraint (seclusion or segregation), cultural restraint, and psychological restraint. Rapid tranquillisation has been retained as a term and not completely replaced by chemical restraint in order to align with other NICE guidance. However, the scope has been

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			- Psychological (threats of use of restrictive interventions) Environmental (seclusion etc)	amended so that as well as benefits and harms of medication for the acute management of aggressive behaviour, the qualitative experience of chemical restraint (from the perspective of people who use services, their parents and carers, and staff) will also be examined.
South Western Ambulance Service NHS Foundation Trust	009	008	Clearly defined scope of what will be looked at under 'rapid tranquillisation' as we feel as though this should be broadened to consider wider chemical restraint (i.e. a patient with cocaine toxicity who is presented as violent and aggressive may be administered diazepam to alleviate symptoms which would also be considered a restrictive intervention).	Thank you for your comment. The review protocol for rapid tranquillisation will outline in more detail the areas that will and will not be covered by this review question. It is considered likely that the protocol may include the broader use of chemical restraint provided in your example where medication is used for the acute management of agitated or aggressive behaviour. Rapid tranquillisation is regarded as a restrictive practice in this guideline, and the review questions in the scope have been amended so that as well as benefits and harms of medication for the acute management of aggressive behaviour, the qualitative experience of chemical restraint (from the perspective of people who use services, their parents and carers, and staff) will also be examined.

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The Association of Clinical Psychologists UK	General	General	ACP-UK would like consideration given to the expression of anger and violence in people who have cognitive limitations, be that dementia or a brain injury, and a non-pharmacological way of managing their needs, which does not seem to be included in the current scope.	Thank you for your comment. There are some areas that are covered in other NICE guidelines (for instance, management of aggression or agitation in dementia) and this update will not include specific evidence reviews on these areas, although recommendations in these other NICE guidelines may be cross-referred to. The scope has been amended to make this clearer. There is a review question in the scope that will examine the effectiveness of organisational level (non-pharmacological) interventions targeted at reducing aggressive behaviour and the use of restrictive practices.
The Association of Clinical Psychologists UK	General	General	ACP-UK acknowledges that the scope guidance excludes learning disability and dementia, however, there are still many conditions where people have reductions in cognition – does the scope include ways of adapting the environment and/or supporting communication specifically to support those with cognitive difficulties?	Thank you for your comment. There is a review question in the scope that will examine the effectiveness of organisational level interventions, including psychologically-informed environments, targeted at reducing aggressive behaviour and the use of restrictive practices. In response to your comment, training in communication practices has also been added as an example of an organisational intervention or component of a complex intervention.

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The Association of Clinical Psychologists UK	General	General	The scope seems primarily aimed at the management of violence and aggression once it occurs (although it does say prevention in the title), rather than talking about steps taken to reduce occurrence. ACP-UK feels that there should be more emphasis on reducing the occurrence of violence. For example, having an assessment of a person's cognition or language to help healthcare providers meet the person's needs.	Thank you for your comment. There is a review question in the scope that examines organisational level interventions that are targeted at reducing aggressive behaviour and restrictive practices that will examine the effectiveness of these prevention approaches, and a qualitative review question has been added to explore facilitators and barriers to the implementation of these organisational level interventions. The table in the scope and the 'Activities, services or aspects of care this update covers' section have been amended to make it clear that principles for anticipating, understanding and responding to aggressive behaviour will be included in the update.
The Association of Clinical Psychologists UK	General	General	In relation to reducing the risk of aggression, there should be recommendations around appropriate physical health checks needed to understand increased agitation. For example, whether there is delirium and/or other identifiable medical causes? ACP-UK is concerned that there appears to be no reference to physical health review when the scope covers a lot of different care settings.	Thank you for your comment. General principle recommendations in the current guideline around training staff in skills to assess why behaviour is likely to become violent or aggressive will be updated based on committee consensus and may be informed by the evidence review on organisational level interventions targeted at reducing the use of restrictive practices. The

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				table in the scope and the 'Activities, services or aspects of care this update covers' section have been amended to make it clear that principles for anticipating, understanding and responding to aggressive behaviour will be included in the update.
The Association of Clinical Psychologists UK	General	General	ACP-UK generally feels that there should be more emphasis on trying to understand, and therefore reduce violent and aggressive behaviour.	Thank you for your comment. General principle recommendations in the current guideline around training staff in skills to assess why behaviour is likely to become violent or aggressive will be updated based on committee consensus and may be informed by the evidence review on organisational level interventions targeted at reducing the use of restrictive practices. The table in the scope and the 'Activities, services or aspects of care this update covers' section have been amended to make it clear that principles for anticipating, understanding and responding to aggressive behaviour will be included in the update.
The National Association of	General	General	**Update to include two significant guidance published.**	Thank you for providing these references. The committee will consider the interface with other guidance when making recommendations.

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Psychiatric Intensive Care			• Joint British Association of Psychopharmacology (BAP) NAPICU evidence-based consensus guidelines for the clinical management of acute disturbance: De-escalation and rapid tranquillisation.
			• Royal College of emergency medicine (RCEM) acute disturbance behaviour in Emergency departments.
			
			Include evidence from other key sources
			• The Prescribing Observatory for Mental Health (POMH) data
			• Care Quality commission reviews
			  ○ Both have found key areas of concerns regarding restrictive practices including
			  ▪ Haloperidol being used as monotherapy.
			  ▪ Rapid tranquillisation being automatically prescribed.
			  ▪ Lack of rapid tranquillisation monitoring and/or recording.	

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			▪ De-brief of patients and staff not being recorded and/or learning documented. Evidence from the British Association for Psychopharmacology (BAP) and the National Association of Psychiatric Intensive Care and Low Secure Units (NAPICU) highlights: • Evidence based guidelines on de-escalation • The need for individualised rather than standardised RT protocols. • Improved drug safety monitoring. • Avoidance of pharmacological overuse and greater emphasis on de-escalation strategies. **Recommendation:** • Integrate BAP/NAPICU guidelines into NICE standards. • Integrate RCEM guidelines into NICE standards. • Integrate POMH UK data • Integrate CQC recommendations	

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			• Include post-administration monitoring protocols as mandatory in all settings covered by the guidance. • Include de-brief strategies as standard in all settings • Enhance guidance on non-pharmacological interventions before the use of restrictive practices including rapid tranquillisation.	
The National Association of Psychiatric Intensive Care	001	121	**Specific Guidance for CAMHS (Child and Adolescent Mental Health Services)** • The draft scope extends coverage to children and young people but does not differentiate management approaches from adult settings. • There are significant concerns on the emerging treatment of children and adolescents in acute hospitals, including restrictive practices such as mechanical restraints and the use of ketamine. . Recommendation: • Tailor recommendations for age-appropriate de-escalation techniques and review	Thank you for your comment. The 'Settings this update covers' section of the guideline has now been simplified to clarify that all settings in which NHS care or social care is provided will be covered. The review questions include adults and children within the same review questions. When reviewing the evidence and making recommendations, the committee will consider whether different recommendations are needed for children and young people, and implementation factors will also be considered for different types of settings.

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			CAMHS-specific approaches to aggression management. • Include physical and environmental aspects.	
The Prescribing Observatory for Mental Health, Centre for Quality Improvement, Royal College of Psychiatrists	002	007	The scope covers a broad range of clinical settings. The guideline would need to take account of differences in the clinical presentation of violence/aggression, the skill mixes of the clinical team members, and access to relevant facilities (e.g. resuscitation facilities, availability of seclusion rooms, laboratory facilities, safety pods, etc.) in these different care settings and specify the interventions that would be most appropriate, feasible, and safe in each particular setting.	Thank you for your comment. Although the amended review questions in the scope are not specific to a particular setting, when making recommendations the committee will consider implementation factors and that it may be necessary to write different sets of recommendations for different types of settings.
The Prescribing Observatory for Mental Health, Centre for Quality Improvement, Royal College of Psychiatrists	008	003, point 3	The acronym 'ABD' is mentioned, but this is a controversial term that is not accepted across all healthcare settings. It may be advisable to avoid the use of this term.	Thank you for your comment. We agree and have tried to avoid the term acute behavioural disturbance (ABD) due to the absence of a clear definition and because this is not a diagnostic category. However, given that there is guidance that uses this term, e.g. the Royal College of Emergency Medicine 'Acute Behavioural Disturbance in Emergency

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				Departments', we aimed to make it clear that this acronym was sometimes used.
The Prescribing Observatory for Mental Health, Centre for Quality Improvement, Royal College of Psychiatrists	010	017	The omission of 'people in whom the primary behaviour is self-harm' should be reconsidered, as such an exclusion will mean that the guideline will not be applicable in a large proportion of episodes of acutely disturbed behaviour. Data from a clinical audit recently conducted nationally by the Prescribing Observatory for Mental Health in inpatient mental health services revealed that a quarter of all those patients involved in an episode of acutely disturbed behaviour that had been treated with additional medication had a diagnosis of personality disorder and a common feature of such episodes was deliberate self-harm. This is consistent with the data contained in the restrictive interventions dashboard from NHS England, which shows that one of the main incident reasons for restrictive intervention incidents is to 'prevent a patient causing serious intentional harm to themselves': https://app.powerbi.com/view?r=eyJrIjoiN2JkMDY	Thank you for your comment. This section of the scope summarises the scope for the current (2015) guideline which we are updating. We cannot accept consultation comments on this section. However, there are some areas that are covered in other NICE guidelines (for instance, the assessment, management and prevention of recurrence of self-harm) and this update will not include specific evidence reviews on these areas, although recommendations in these other NICE guidelines may be cross-referred to. The scope has been amended to make this clearer.

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			yMWEtYzgxMC00YjZjLTg1YjktMDAyODEzMDdlOTg5IiwidCI6IjM3YzM1NGIyLTg1YjAtNDdmNS1iMjIyLTA3YjQ4ZDc3NGVlMyJ9	
TULLY FORENSIC PSYCHOLOGY LTD	General	General	Existing guidelines state at 1.2.11 Consider using an actuarial prediction instrument such as the BVC (Brøset Violence Checklist) or the DASA-IV (Dynamic Appraisal of Situational Aggression – Inpatient Version), rather than unstructured clinical judgement alone, to monitor and reduce incidents of violence and aggression and to help develop a risk management plan in inpatient psychiatric settings. I agree that any structured approach is better than unstructured clinical judgment alone, based on the literature. However, this part of the guidance limits suggestions to actuarial risk assessment methods. There is a lot of evidence of the effectiveness of structured professional judgment (SPJ) based violence risk assessment approach (see Singh et al, 2011 for a start) using tools like the HCR-20v3 (Webster et al., 2013), and although tool choice is helpfully left to the clinician, I wondered whether	Thank you for your comment. The effectiveness of organisational level interventions targeted at reducing aggressive behaviour and the use of restrictive practices will be examined in this update. In response to your comment, structured risk assessment to inform clinical decision-making has been added as an example of an organisational intervention or component of a multicomponent intervention. The table in the scope and the 'Activities, services or aspects of care this update covers' section have been amended to make it clear that principles for anticipating, understanding and responding to aggressive behaviour will be included in the update.

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			mention of this approach or examples being provided of structured professional judgment tools for violence (such as HCR-20v3) may help clinicians become aware that there are varied approaches. However, it should probably be acknowledged that violence risk assessment using the SPJ approach takes longer to complete than actuarial risk assessment and so may not be feasible in some acute contexts. Singh, J. P., Gann, M., Fazel, S. (2011). A comparative study of violence risk assessment tools: A systematic review and metaregression analysis of 68 studies involving 25,980 participants. *Clinical Psychology Review 31(*3), 499-513 Webster, C. D., Douglas, K. S., Eaves, D. & Hart, S. D. (2013). *HCR-20: Assessing Risk for*	

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			Violence Version 3. Mental Health, Law and Policy Institute, Simon Fraser University: British Columbia	