NATIONAL INSTITUTE FOR HEALTH AND CLINICAL EXCELLENCE

SCOPE

1 Guideline title

Violence and aggression: the short-term management of violent and physically threatening behaviour in healthcare settings

1.1 Short title

Violence and aggression

2 The remit

This is an update of Violence (NICE clinical guideline 25).

This update is being undertaken because new evidence has emerged on service users' views on the use of physical intervention and seclusion, and the utility, acceptability, and safety of available medicines and their dosages for rapid tranquilisation.

3 Clinical need for the guideline

3.1 Epidemiology

On an average psychiatric ward up to 5 episodes per month of manual restraint of patients might be expected, although there is considerable variation. Around 75% of nursing staff experience violent behaviour such as physical assault every year, more commonly in psychiatric than in other inpatient settings. Episodes of violence and aggression towards staff are also common in community settings, although many go unreported. Such episodes lead to significant morbidity and stress among staff and account for periods of sickness absence, low morale and early retirement.

3.2 Current practice

The management of violence and aggression towards staff, and damage to personal or ward property, varies according to setting. In hospital settings, the most common response is special observation, followed by manual restraint, seclusion and emergency tranquilisation, usually with antipsychotic drugs. In community settings, it is more common for the staff concerned to remove themselves from the scene of violence and ask for police help. Violence is a particular risk when carrying out assessments under the Mental Health Act.

4 The guideline

The guideline development process is described in detail on the NICE website (see section 6, 'Further information').

This scope defines what the guideline will (and will not) examine, and what the guideline developers will consider. The scope is based on the referral from the Department of Health.

The areas that will be addressed by the guideline are described in the following sections.

4.1 Population

4.1.1 Groups that will be covered

a) Adults (aged 18 and over) with mental health conditions who are currently service users within healthcare, social care or community settings.

b) Adults (aged 18 and over) with mental health conditions and co-existing substance misuse (both hazardous use and dependence) or withdrawal.

4.1.2 Groups that will not be covered

a) Children and young people under the age of 18. Although some areas of the guideline may be relevant, the guideline will not address Child and Adolescent Mental Health Services (CAMHS).

b) People whose primary violent behaviour is self-harm. (Self-harm (NICE clinical guideline 16) focuses specifically on short-term management for this population.)

c) People with a primary diagnosis of learning disability. Although the principles of managing threatening behaviour will be relevant to people with learning disability, 'Challenging behaviour in people with learning disability', a NICE clinical guideline currently in development, will specifically address this population (see section 5.2).

4.2 Healthcare setting

a) This guideline will cover the care received, including the management of violence and aggression, from healthcare professionals who have direct contact with and make decisions about the care of NHS service users in any physical health, mental health or social care setting, and how this care may need to be modified in specific health and social care settings, including:

- adult inpatient psychiatric settings (including high-, medium- and low-security psychiatric hospitals and NHS general hospitals)
- emergency and urgent care services
- assertive community treatment teams
- community mental health teams
- primary care.

4.3 Clinical management

4.3.1 Key clinical issues that will be covered

Areas from the original guideline that will be updated

a) Identification of potentially violent and aggressive service users including the identification of risk assessment methods and tools.

b) De-escalation methods and other short-term psychosocial intervention methods.

c) Seclusion.

d) Physical restraint.

e) Pharmacological interventions. Note that guideline recommendations will normally fall within licensed indications; exceptionally, and only if clearly supported by evidence, use outside a licensed indication may be recommended. The guideline will assume that prescribers will use a drug's summary of product characteristics to inform decisions made with individual patients.

f) Staff training or education requirements for the above-mentioned interventions.

Areas not in the original guideline that will be included in the update

a) Anticipation of violence and aggression.

b) Environmental influences and how to alter these.

c) The relationship between smoking and violence and aggression in inpatient settings.

d) Mechanical restraint.

e) The role of advance directives in the management of violence and aggression.

f) Post-incident management for staff, service users and witnesses.

g) Substance misuse.

h) The interface between mental health services and the police in the immediate management of violence and aggression.

4.3.2 Clinical issues that will not be covered

Condition-specific information will not be covered in this guideline.

4.4 Main outcomes

The following outcomes will be considered by the Guideline Development Group when determining 'critical' and 'important, but not critical' outcomes:

a) Rates of seclusion.

b) Rates of manual restraint.

c) Use of antipsychotics.

d) Use of rapid tranquilisation methods.

e) Experience of service users.

f) Rates of injury among service users.

g) Rates of injury among staff.

4.5 Economic aspects

Developers will take into account both clinical and cost effectiveness when making recommendations involving a choice between alternative interventions. A review of the economic evidence will be conducted and analyses will be carried out as appropriate. The preferred unit of effectiveness is usually the quality-adjusted life year (QALY), but different measures may also be used, including staff outcomes, depending on the availability of appropriate clinical data identified for the guideline. The costs considered will usually be only from an NHS and personal social services (PSS) perspective. Further detail on the methods can be found in 'The guidelines manual' (see ‘Further information’).

4.6 Status

4.6.1 Scope

This is the consultation draft of the scope. The consultation dates are 14 December 2012 to 25 January 2013.

4.6.2 Timing

The development of the guideline recommendations will begin in March 2013.

5 Related NICE guidance

5.1 Published guidance

5.1.1 NICE guidance to be updated

This guideline will update and replace the following NICE guidance:

- Violence. NICE clinical guideline 25 (2005).

5.1.2 Other related NICE guidance

- Drug misuse – opioid detoxification. NICE clinical guideline 52 (2007)
- Drug misuse – psychosocial interventions. NICE clinical guideline 51 (2007)
- Self-harm. NICE clinical guideline 16 (2004)

5.2 Guidance under development

NICE is currently developing the following related guidance (details available from the NICE website):

- Smoking cessation in secondary care: mental health services. NICE public health guidance. Publication expected November 2013.
- Psychosis and schizophrenia (update). NICE clinical guideline. Publication expected March 2014.
- Challenging behaviour in people with learning disability. NICE clinical guideline. Publication expected May 2015.

6 Further information

Information on the guideline development process is provided in the following documents, available from the NICE website:

- How NICE clinical guidelines are developed: an overview for stakeholders the public and the NHS

- The guidelines manual.

Information on the progress of the guideline will also be available from the NICE website.