NICE National Institute for Health and Care Excellence

Appendix B: Stakeholder consultation comments table

2019 surveillance of Violence and aggression: short-term management in mental health, health and community settings (2015)

Consultation dates: Thursday, 19 September to Wednesday, 2 October 2019

1. Do you agree with the proposal to not to update the guideline?			
Stakeholder	**Overall response**	**Comments**	**NICE response**
University hospitals Leicester NHS trust	Yes	Not answered	
Elysium Healthcare	No	We feel some fundamental aspects may be missed if the current guidance is not updated.	Thank you for your comment. The guideline will now be fully updated.
Central & North West London NHS Foundation Trust	No	Not answered	
Royal College of Nursing	Yes	The Guideline is still relevant to today's practice and does not need updating at present.	Thank you for your comment. Due to the concerns raised by other stakeholders we have decided that the guideline will now be fully updated to ensure that it continues to remain relevant to today's practice. The scoping process will determine the exact parameters, but a number of areas may

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			be considered in scoping including: the perspective of longer term care and trauma informed care; the care of children and young people and the treatment of patients with learning difficulties; and revising the use of pharmacological interventions.
Mind	Yes	We agree on the basis of the proposed refresh and further comments below We strongly agree that the Mental Health Units (Use of Force) Act 2018 should be referenced in the guideline **Comment on rapid tranquillisation (RT)** Zuclopenthixol acetate / clopixol acuphase injection – in a baseline audit of rapid tranquillisation in mental health services carried out by the Prescribing Observatory for Mental Health, in 11 per cent of the cases where an intramuscular injection of an antipsychotic drug was used, the drug used was zuclopenthixol acetate (Clopixol Acuphase). This is very concerning as this drug is not recommended for rapid tranquillisation due to delayed onset of its sedative and, particularly, antipsychotic actions and lack of evidence to support its use for RT. Reference for the audit - https://journals.sagepub.com/doi/full/10.1177/0269881118817170 Other recent guidelines which re-state that there is no role for ZA in RT - https://www.bap.org.uk/pdfs/BAP_Guidelines-RapidTranquillisation.pdf	Thank you for your comment. The guideline will now be fully updated. Thank you for your comment. The guideline will be fully updated, and the Use of Force Act 2018 may be relevant. Thank you for your comment. The guideline will be fully updated. The scoping process will determine the exact parameters, but rapid tranquilisation is an area that has been identified for consideration in scoping.

		While the guideline does not mention this drug in its recommendations, given that acuphase has been so widely used as to be part of the language ('being acuphased'), and that individual clinicians may still favour it, we think that direct advice against its use should be provided (potentially with limited exceptions for example where an individual has previously found it helpful). **Comment on trauma** While the guideline refers to trauma in the context of assessment and post-incident debrief, it does not convey the importance of care being trauma-informed, the risk of harm from re-traumatisation or the potential for this harm to intersect with protected characteristics. We recommend that the guideline includes a statement on these aspects.	Thank you for your comment. This guideline will now be fully updated. The scoping process will determine the exact parameters, but trauma informed care is an area that has been identified for consideration in scoping.
South London and Maudsley NHS Foundation Trust	No	Not answered	
British Geriatrics Society	No comment	Not answered	
NHS England	No	This guideline should have a full update, a change in title, a much better focus on children and a full review of the role of trauma informed care. (TK)	Thank you for your comment. This guideline will now be fully updated. The scoping process will determine the exact parameters, but the care of children and young people and the role of trauma informed care are areas that have been identified for consideration in scoping.

		The guidance is applicable to AHPs working across health, social care education and criminal justice within adult and CAMHs service (for service users aged 12 year and over) and provides helpful guidance (SC) I don't find the name of this guidance to be acceptable. The description of 'violence and aggression' to describe what is often a reaction by the person to poor care, psychological triggering, deprivation of liberty, poor communication, pain or distress places blame and judgement with the person as opposed to understanding it as behaviour which challenges others. I believe the title of the guidance should change. (LD)	Thank you for your comment. Thank you for your comment. This guideline will be fully updated. The scoping process will determine what the final title will be.
The Royal College of Psychiatrists	Yes	We agree that update of the proposed sections e.g. • Restraint positions • Post-incident debriefs • Liberty protection safeguards • Pharmacological methods for rapid tranquilisation Will be sufficient and not the update the whole guideline.	Thank you for your comment. The guideline will be fully updated and new evidence and intelligence regarding restraint positions, post-incident debriefs, liberty protection safeguards and pharmacological methods for rapid tranquilisation may be considered during its development.

2. Do you have any comments on areas excluded from the scope of the guideline?			
Stakeholder	**Overall response**	**Comments**	**NICE response**

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University hospitals Leicester NHS trust	Yes	Health and social care provider organisations support for staff who have been directly implicated within incident 1. Staff who undertake community home visits are more likely to not report such incidences 2. Health and social care provider organisations-need to consider: a. If they provide regular team meetings that one of the standing items should be have there been any incidences since the last team meeting that need to be highlighted for the team b. where incidences have been reported in this forum then they can be further examined as part of a post incident debriefs learning opportunity	Thank you for your comment. This guideline will be fully updated. The scoping process will determine the exact parameters, but protection and support for staff is an area that has been identified for consideration in scoping.
Elysium Healthcare	Yes	The new Restraint Reduction Network (RRN) Standards – April 2019 have not been considered as a supportive documents/standards base for this consultation. We feel a number of best practice standards elements within this document would support safer practices across healthcare, social care and educational settings. Moreover we feel the trainer standards and the course delivery/programme standards within the RRN standards would support improved practice and should be included within any updated or reviewed guidance.	Thank you for your comment. This guideline will be fully updated and the Restraint Reduction Network (RRN) Standards may provide relevant and useful support. We will pass this information to the scoping team for consideration
Central & North West London NHS Foundation Trust	Yes	**Haloperidol monotherapy:** one of the TREC trials was stopped early due to ADRs with this treatment option. Other guidelines actively do not recommend this option. Please add active recommendations	**Haloperidol monotherapy** Thank you for your comment. The guideline will be fully updated. The scoping process will determine the exact

		regarding options that are being used nationally (see POMH RT data) but are not safe as concluded by safety measures in robust RCTs such as this. Please see the recent BAPRT Guidelines. **Inhaled Loxapine**: this is not included in the current guideline, and you state in your consultation that this is because the "*NICE Technology appraisal guidance TA286 states that NICE is unable to recommend the use in the NHS of loxapine inhalation*". However within that 2013 publication you stated that this did not proceed on a technicality for data submission around costing models, as opposed to lack of clinical efficacy or safety data: "*The manufacturer stated that there is insufficient evidence available to develop the appropriate analytical model required to estimate cost effectiveness in line with NICE single technology appraisal procedures. NICE has therefore terminated this single technology appraisal*." NICE guidelines should look more widely than just precis drugs that manufactures have pushed through TAs. None of the other recommended RT options have approved TAs. Please see the recent BAPRT Guidelines. **Midazolam IM and buccal**: there is no reference to either of these in the current guidance. Clinicians require guidance; these options are being used (see POMH RT data), especially in sub-populations e.g. LD. and especially as there is an ongoing intermittent national shortage of IM lorazepam for the past decade.	parameters, but rapid tranquilisation is an area that has been identified for consideration in scoping. **Inhaled loxapine** Thank you for your comment. The guideline will be fully updated. The scoping process will determine the exact parameters, but rapid tranquilisation is an area that has been identified for consideration in scoping. **Midazolam IM and buccal** Thank you for your comment. The guideline will be fully updated. The scoping process will determine the exact parameters, but rapid tranquilisation is an area that has been identified for consideration in scoping.

		Lack of comment on a drug can be misconstrued, and appears as an oversight. If there is active evidence to suggest a lack of safety (as with IM midazolam in non acute trust hospital settings), this should be stated. Please see the recent BAPRT Guidelines. **Haloperidol with lorazepam** – POMH data says that this is the most widely used combination nationally. This may not be RCT data as you require, but that is data, and at a very significant level. Therefore it is an oversight not to address that treatment option in the revised edition. Furthermore other data is available e.g. includes through NRLA, MHRA Yellow Card monitoring etc. these can all be triangulated. Conversely, one could ask why clinicians should be forced to cease using this option in the absence of comment from NICE, and in the absence of safety concerns. Please see the recent BAPRT Guidelines. **Promethazine** with **lorazepam:** again another widely used combination for which there is no efficacy or safety data and no comment to this effect from NICE. An absence of such guidance leads to its use proliferating. Please see the recent BAPRT Guidelines. There is no reference to how to proceed if a patient has just been **tasered**. This is becoming more common, therefore national guidance is required. Even if it is not based on RCTs, but based on theoretical knowledge of how the technology and drugs work.	**Haloperidol with lorazepam** Thank you for your comment. The guideline will be fully updated. The scoping process will determine the exact parameters, but rapid tranquilisation is an area that has been identified for consideration in scoping. **Promethazine with lorazepam** Thank you for your comment. The guideline will be fully updated. The scoping process will determine the exact parameters, but rapid tranquilisation is an area that has been identified for consideration in scoping. **Taser** Thank you for your comment. The guideline will be fully updated; the new scope may consider the use of tasering.

		The current guidance gives a very limited list of options, and not alternatives to IM lorazepam with the ongoing intermittent national shortages of IM lorazepam of the past decade. **Olanzapine IM:** the current guidance omits any reference to this treatment option which is not helpful as it is widely available (despite not being marketed in the UK). Your consultation states: "*During development of NG10, the manufacturer of intramuscular (IM) olanzapine discontinued the product in the UK and so the Guideline Development Group was not able to make recommendations for its use. This product is not routinely available for use in the UK*." But then chooses not to add such an explanation into the guidelines, leaving readers guessing as to why it is omitted. Omission of comment/advice about a drug options makes it hard for clinicians to interpret for practice. It doesn't help to drive up poor practice. It undermines the message of NICE by appearing to be an omission/oversight. **Aripiprazole IM** – as above. A licensed option available in the UK, for which there is no reference of explanation of omission. It is used. In the context of Winterbourne View of other similar tragedies, more support for the message of **least restrictive option**, proportional levels of forced	Thank you for your comment. We have been informed of the intermittent shortages of IM lorazepam. The guideline will be fully updated. The scoping process will determine the exact parameters, but rapid tranquilisation is an area that has been identified for consideration in scoping. **Olanzapine IM** The guideline will be fully updated. The scoping process will determine the exact parameters, but rapid tranquilisation is an area that has been identified for consideration in scoping. **Aripiprazole IM** The guideline will be fully updated. The scoping process will determine the exact parameters, but rapid tranquilisation is an area that has been identified for consideration in scoping. **Least restrictive option**

		intervention, and not abusing professional rights and authorities, i.e. greater emphasis on **offering oral medicines first** – wherever possible, and optimising the regular treatment plan so as to avoid the need for IM RT. Surprisingly there is only <u>one</u> reference to oral medication in the whole of the current guideline. **Pregnancy:** there is no active advice about the use of RT medicines in **pregnancy**, in the current guideline. Just two covering statements around "take into account" or take "extra care" if the person is pregnant. These scenarios happen, and guidance is needed – even if there are no RCTs. Please see BAP guidelines on RT. Without the above amendments the revised NICE NG10 guidelines with be seen as obsolete next to the more realistic and detailed recent BAP RT evidence based guidelines which do address all these issues – and more.	Thank you for your comment. NG10 recommends that the least restrictive intervention is used in order to respect service users' human rights. NG10 also recommends that techniques and methods used to restrict a service user are the least restrictive option to meet the need. NG10 recommends rapid tranquilisations only if oral medication is not possible or appropriate and urgent sedation with medication is needed. The guideline will be fully updated. The scoping process will determine the exact parameters, but restrictive interventions is an area that has been identified for consideration in scoping. **Pregnancy** Thank you for your comment. It was noted during the surveillance process that there is a lack of information in the guideline regarding the use of rapid tranquilisation medicines in pregnancy and that CG192 Antenatal and postnatal mental health: clinical management and service <u>Recommendation 1.8.23</u> provides more information. The guideline will be fully updated. The scoping process will determine the exact parameters, but patients within the Equality Act's protected characteristics will be identified for consideration in scoping. Thank you for your comments. The guideline will now be fully updated and will consider the amendments that you have suggested during its development.
Royal College of Nursing	No	N/A	
Mind	Not answered	Not answered	

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South London and Maudsley NHS Foundation Trust	Yes	The current guideline recommends that emergency departments should follow the recommendations outlined in 1.4.37 – 1.4.45 for rapid tranquilisation. These recommendations for IM lorazepam or IM haloperidol +/- IM promethazine do not take into account the specific environmental factors involved in decision making regarding pharmacological treatment in A&E. These areas of acute hospitals cannot safely manage patients who are continuously violent, when considering the safety of the environment for other patients, staff, and equipment. This medical environment differs vastly from psychiatric unit environments, and the guideline does not reflect the impact of this on drug choice. Practical experience, as well as expert consensus guidelines and published evidence (Patel et al (2018), Joint BAP NAPICU evidence-based consensus guidelines for the clinical management of acute disturbance: De-escalation and rapid tranquillisation, J Psychopharmacol) support the use of IV diazepam. This produces a more predictable and rapid response than IM options. Intravenous benzodiazepines can be safely used in acute medical settings, where rapid access to ventilatory support and reversal agents, as well as the ability to site IV access is readily available. A recognition in the NICE guideline that drug choice for rapid tranquilisation in these acute medical settings may be different to psychiatric settings would be welcome.	Thank you for your comment. The guideline will be fully updated. The scoping process will determine the exact parameters, but rapid tranquilisation, including its use and settings, is an area that has been identified for consideration in scoping.

British Geriatrics Society	Yes	There is no explicit coverage of delirium as covered in the NICE Guideline "Delirium: prevention, diagnosis and management" CG103. The term "excited delirium" is used twice in the guideline. This is not directly relevant. It is not clear why there is no coverage of delirium as such in NG10. Delirium affects about 20% of patients in acute hospitals, and also occurs commonly in community settings, especially care homes. Delirium is a relatively common cause of 'violence and aggression', especially in older people in acute hospitals (though it also causes such behaviours in younger adults and children). Central to the effective management of delirium is (a) recognition that it is delirium (this is not covered using the correct term delirium in NG10), (b) a thorough assessment of the causes, and (c) appropriate treatment. Agitation and aggression in people with delirium may commonly be caused by pain (which may not be articulated by the patient) or other physical symptoms. It is a concern that NG10 does not direct staff to the possibility that violence and aggression may be occurring in the context of delirium, especially in acute settings (eg. Emergency Departments), and that the assessment and treatment will thus potentially be inappropriate. It is notable that delirium continues to be under-diagnosed, that alternative and outdated terms such as 'acute confusional state' or 'acute on chronic	Thank you for your comment. The guideline will be fully updated. The scoping process will determine the exact parameters, but delirium is an area that has been identified for consideration in scoping. NICE recognises the importance of appropriate diagnosis and management of patients with delirium and notes that NICE guideline CG103 already covers how to prevent, diagnose and manage Delirium.

		confusion' continue to be used, and that drug treatment of agitation, etc., in the context of delirium is used more than is recommended by experts or is based on evidence. It is our view that it is essential that NG10 explicitly covers delirium, using the standard term 'delirium' – not 'excited delirium' or 'acute organic brain syndrome' (not a standard diagnostic term), as is covered in CG103 and also the 2019 Scottish Intercollegiate Guidelines Network (SIGN) guideline on 'Risk reduction and management of delirium' SIGN 157. This is essential because person-centered care requires accurate diagnoses and targetted treatment. We note that dementia is considered out of scope. Although delirium commonly complicates dementia, it is a separate condition with different assessment and treatment. Also, a substantial proportion of delirium occurs in people without dementia. Therefore, delirium should be included in NG10 – it should be within scope.	
NHS England	Yes	From the children and young people's mental health perspective we recommend extension of these guidelines to substantially increase the sections relating to CYP as this is written very much from an adult perspective. Although this may reflect an absence of evidence as is often the case for CYP it is particularly relevant because management of	Thank you for your comment. The guideline will be fully updated. The scoping process will determine the exact parameters, but the care of children and young people and patients with learning disabilities are areas that have been identified for consideration in scoping. According to the current scope of NG10 "people with a primary diagnosis of learning disability" are outside of the remit of the guideline.

		violence and aggression and use of restraint is proportionately much more of an issue in CYPMH. There is no specific consideration of the impact of learning disabilities and autism – despite the recent serious incidents affecting CYP with these challenges. There is recent government guidance that regarding CYP with ASD/LD which references updating the legal framework (changes to Mental Capacity Act), adding chemical restraint rather than referring to rapid tranquilization, tightening CYP elements including for CYP with ASD/LD and for services to be aware of the NHSE requirements for monitoring restrictive practice within inpatient settings – really helpful if NICE guidelines were consistent.	NICE has created a guideline on challenging behaviour and learning disabilities which recommends interventions and support for children, young people and adults with a learning disability and behaviour that challenges however if this behaviour becomes violent or aggressive this guideline refers to NG10. It is noted that NG10 does not contain specific recommendations for those with learning disabilities and the scope of NG10 will be reconsidered.
		The current approach is 'reactive' management and does little to reduce the incidence, failing to reflect more 'preventative' approaches driven by a shared psychological formulation, and Positive Behaviour Support (as developed by LD colleagues) and more recent CYP interventions such as Secure STAIRS (KP)	Thank you for your comment. The guideline will be fully updated. The scoping process will determine the exact parameters, but reactive management is an area that has been identified for consideration in scoping.
		There is no mention of Trauma informed Care and Trauma informed principles which should be understood within any framework seeking to reduce restrictive practices. There should be reference to the potential harm caused by laying hands on any person who has a history of trauma and the possibility for re-traumatisation.	Thank you for your comment. The guideline will be fully updated. The scoping process will determine the exact parameters, but trauma informed care is an area that has been identified for consideration in scoping.
			Thank you for your comment. The guideline will be fully updated. The scoping process will determine the exact

		There is limited reference to positive and proactive care and government recommendations about reducing restrictive practices. (LD)	parameters, but positive and proactive care and reducing restrictive practices are areas that have been identified for consideration in scoping. Thank you for your comment. The guideline will be fully updated. The scoping process will determine the exact parameters, but the care of children and young people is an area that has been identified for consideration in scoping.
		Endorse the use of risk formulation and management plan informed by this which includes robust preventative approaches, it would also be helpful for clinicians and CYP and their carers to include in the guidance support for any evidence around consideration by clinicians with carers and yp as far as possible, of the appropriateness of ongoing use of the particular restrictive settings especially in-pt setting for CYP presenting with difficulties lending themselves to restrictive approaches (although this may be not be the sole reason for use of such approaches) (SI)	Thank you for your comment. The guideline will be fully updated. The scoping process will determine the exact parameters, but the care of children and young people and patients with learning disabilities is an area that has been identified for consideration in scoping. According to the current scope of NG10 "people with a primary diagnosis of learning disability" are outside of the remit of the guideline. NICE has created a guideline on challenging behaviour and learning disabilities which recommends interventions and support for children, young people and adults with a learning disability and behaviour that challenges however if this behaviour becomes violent or aggressive this guideline refers to NG10. It is noted that NG10 does not contain specific recommendations for those with learning disabilities and the scope of NG10 will be reconsidered.
		The guidance needs to be updated to focus on / provide significant additional best practice related to children and young people who may require management under this protocol. There needs to be a better focus on human rights, rights of the child and disadvantaged groups for example children with autism or learning disabilities.	

		The use of mechanical restraint is rising in CYP populations which appears to be proceeding unchecked, in addition there is an increasing array of new products being introduced to support physical restraint (Pods and beanbags) which lack an evidence base All age groups require focus on best practice in relation to NG feeding under restraint and the distinctive and unique risks posed by this group. Focus on trauma informed, rights, consideration of how debriefs may not be helpful for some CYP (autism and LD) and how to adapt the process. Bring up to date with other guidance that has been recently updated. (SM)	Thank you for your comment. The guideline will be fully updated. The scoping process will determine the exact parameters, but restriction in children and young people is an area that has been identified for consideration in scoping. Thank you for your comment. The guideline will be fully updated. The scoping process will determine the exact parameters, but restrictive practices, trauma informed care and debriefing are areas that have been identified for consideration in scoping.
The Royal College of Psychiatrists	Yes	The guidelines mentions about types of incidents related to mental health patients but does not mention about the deaths caused by mental health patients. I agree that we do not want to cause undue scare in relation to risks posed by mental health patients to others, but data suggests that one death a week is caused by people suffering from mental illness. The risks posed by mental health patients is not discussed, but this has a bearing on how risk assessment and management of mental health patients are carried out and if they are being prematurely discharged from psychiatry wards or prematurely discharged from Mental health act. This	Thank you for your comment. The guideline will be fully updated. The scoping process will determine the exact parameters, but risk assessment and management of mental health patients are areas that have been identified for consideration in scoping. The guideline is, however, and will remain focused on violence and aggression. Violence and aggression is defined as a range of behaviours or actions that can result in harm, hurt or injury to another person, regardless of whether the violence or aggression is physically or verbally expressed, physical harm is sustained or the intention is clear.

		also has bearing on people with mental illness and their timely access to suitable mental health care.	
3. Do you have any comments on equality issues?			
Stakeholder	**Overall response**	**Comments**	**NICE response**
University hospitals Leicester NHS trust	No	Not answered	
Elysium Healthcare	No	Not answered	
Central & North West London NHS Foundation Trust	Not answered	Not answered	
Royal College of Nursing	No	N/A	
Mind	Not answered	We welcome consideration of the EHRC's Human Rights Framework for Restraint, and the addition of age to the factors to be considered. In addition to age, the document draws attention to duties towards disabled people under the Equality Act and states (p.9): "2. Any anticipated use of restraint must be planned and regularly reviewed. This must include active consideration of: • reasonable adjustments, or other measures that could be taken, to avoid or minimise the use of restraint and the risk of harm resulting for the individual or others in their situation, and	Thank you for your comment. The guideline will be fully updated and, during its development, will ensure that specific areas from the Equality Act, in particular those around protected characteristics such as age, disability, gender, sexuality and race, have been fully considered and the guideline reflects service users' human rights.

		• the risks to the person's physical and mental well-being, taking into account matters such as disability and age." While the recommendation at 1.1.11 on Equality Act duties covers disability, we recommend an explicit mention of active consideration of reasonable adjustments. While the principles section contains key overarching recommendations and positive statements, it is important that the guideline speaks to the reality of people's experience of coercive environments and practices. These can focus on or disproportionately impact on people in relation to their protected characteristics – for example the more negative and coercive experience of black and minority ethnic people as inpatients, the disproportionate use of face down restraint on women and girls, and the significance of gender, race and sexuality in people's experience of trauma and re-traumatisation. Stereotypical thinking, prejudiced attitudes and biased decision-making will play a part in the disproportionate use of coercion as well as lack of attention to the specific needs of different groups. Therefore we think that it would be helpful for the guideline to address equalities in a more specific way.	
South London and Maudsley NHS Foundation Trust	No	Not answered	

British Geriatrics Society	Yes	Not including delirium in NG10 potentially discriminates against older people, because in general settings, violence and aggression in older people is mostly commonly caused by delirium, dementia or delirium superimposed on dementia; this is much more common than mania or other psychoses.	Thank you for your comment. The guideline will be fully updated; the scoping process will consider the issue around age that you have highlighted.
NHS England	Yes	There is no mention of the specific inequalities faced by particular patient types. For example, we know that women are more likely to be restrained than men, children more likely to be restrained than adults and there are specific inequalities experienced by people from minority backgrounds and with Learning Disabilities and Autism. (LD)	Thank you for your comment. The guideline will be fully updated and, during its development, will ensure that specific areas from the Equality Act, in particular those around protected characteristics such as age, disability, gender, sexuality and race, have been fully considered and reflect service users' human rights.
The Royal College of Psychiatrists	Not answered	Not answered	

4. NICE are aware of the important differences between post-incident debriefs and psychologically focused debriefs. Evidence shows that post-incident debriefs can be safe and effective for service users and staff after violent or aggressive events have taken place. However, evidence shows that psychologically focused debriefs can be harmful after traumatic incidents for those suffering with post-traumatic stress disorder and should not be used. NICE have suggested adding "debrief" to the "Terms used in this guideline" section in order to clarify how a debrief should be conducted. Could you please provide feedback on the clarification of "debrief" within this guideline?

Stakeholder	Overall response	Comments	NICE response
University hospitals Leicester NHS trust	Not answered	Occupational health perspective on what constitutes a debrief -entirely agree that Health and social care provider organisations actively "pushing" a member of staff to	Thank you for your comment. The guideline will be fully updated. The scoping process will determine the exact parameters, but debriefing is an area that has been identified for consideration in scoping.

		undertake psychologically focused debriefs focusing on the traumatic incident are likely to be harmful -staff prefer to talk to their own colleagues within their team to discuss the post incident debrief about lessons that could be learned in a confidential and sensitive manner-the individual leading this needs to have some basic mediation skills -a potential useful strategy as a personal self-help initiative will be to offer the attached booklet/worksheet on trauma focused CBT for the staff member to have access to as a reference point-then it is their decision to use it or not https://www.psychologytools.com/worksheet/what-is-tf-cbt/ -where Health and social care provider organisations have access to occupational health the line manager should offer the staff member an opportunity to be referred and also provide them with details of a commissioned counselling service that is available to them	
Elysium Healthcare	We agree with what has been suggested here.	No comment	
Central & North West London NHS Foundation Trust	Not answered	This review is essential as the current terminology is confusing, and not clearly described. The "formal external post-incident review (see recommendations 1.4.62–1.4.63) with the service user that includes a visit from an advocacy service or hospital manager" needs completely reviewing.	Thank you for your comment. The guideline will be fully updated. The scoping process will determine the exact parameters, but debriefing is an area that has been identified for consideration in scoping.

		Unlike the rigid approach taken to the medication sections, there is no robust evidence behind these recommendations. They are neither realistic nor achievable, and debatably not even desirable. They and are not concerned with the patients treatment care, and not being practiced nationally.	
Royal College of Nursing	Yes	The clarification of 'debrief' is useful because it helps to distinguish the type of debrief that should and should not be used for patients with Post Traumatic Stress Disorder (PTSD). It also allows clinicians to find alternate methods of debriefing patients with PTSD.	Thank you for your comment. The guideline will be fully updated. The scoping process will determine the exact parameters, but debriefing is an area that has been identified for consideration in scoping.
Mind	Not answered	We agree that the use of the term debrief in this context is problematic without further clarification. Rather than defining debrief, we recommend changing the terminology. The Restraint Reduction Network's training standards 2019 (standard 2.13) make a helpful, evidence-based distinction between 1) post-incident support and 2) post-incident reflection and learning review. We think it would be useful to reflect this in the guideline. The proposed wording to explain 'debrief' focuses on the reflection and learning component of what should happen post-incident. However, use of the term 'debrief' in the guideline covers recommendations relating to both support and reflection/learning. We think it would be helpful to replace the term 'debrief' with language taken from the training standards. This would both avoid confusion with a psychologically focused debriefing technique and convey directly what is meant rather than needing necessarily to link to a definition. This is an extremely	Thank you for your comment. The guideline will be fully updated. The scoping process will determine the exact parameters, but debriefing is an area that has been identified for consideration in scoping.

		important part of the guideline, and one which we believe services can struggle with, so the clearer it can be the better. If the term stays in the guideline, then the definition and the ways in which the term is used need to align. **Additional comment on post-incident debriefing** In addition, the proposed wording suggests a single discussion involving the staff team and service user, when the approach to learning from the service user should be based on their needs and wishes and what they would find most supportive.	
South London and Maudsley NHS Foundation Trust	No	Not answered	
British Geriatrics Society	No comment.	Not answered	
NHS England	Not answered	We have heard evidence from CYP with autism and LD that the use of debrief adds pressure to their recovery and care We need alternatives to the debriefing process that does not subject a CYP to having to demonstrate remorse or learning from the incident when this may not be possible. Debrief as a whole needs to be person centred and trauma informed, linked to the ability of the person	Thank you for your comment. The guideline will be fully updated. The scoping process will determine the exact parameters but the care of children and young people and patients with learning disabilities is an area that has been identified for consideration in scoping. According to the current scope of NG10 "people with a primary diagnosis of learning disability" are outside of the remit of the guideline. NICE has created a guideline on challenging behaviour and learning disabilities which recommends interventions and support for children, young people and adults with a learning

		and their desire to discuss the event and whether they have anything to share with the staff about learning for the future rather than being a tick box exercise that has to be completed. (SM)	disability and behaviour that challenges however if this behaviour becomes violent or aggressive this guideline refers to NG10. It is noted that NG10 does not contain specific recommendations for those with learning disabilities and therefore there is a gap in NICE guidelines. The scope of NG10 will be reconsidered and amended as necessary during this update.
The Royal College of Psychiatrists	Yes	Debrief can mean different thing to different people. The description and process of debrief is inadequate on page 209 and beyond in the existing guideline (NG10). It needs some case studies, example and clarity around framework of debrief for different group of people. Some clarity on psychological processes which should be used and who should be included and excluded from debrief process should be clarified. There is some evidence to suggest that clarity around debrief process and timely availability of debrief process to affected people can help with prevention of emotional difficulties and potential sickness among staff. Hence updating this section of the current guideline will be useful.	Thank you for your comment. The guideline will be fully updated. The scoping process will determine the exact parameters, but debriefing is an area that has been identified for consideration in scoping.