National Institute for Health and Care Excellence

Violence and aggression (update)
Guideline Consultation Table
19th November 2014 – 14th January 2015

Stakeholder	Order No	Document	Page No	Line No	Comments	Developer's Response
Association for Family Therapy and Systemic Practice	1	NICE	6	29	The NICE version refers to 'young people with mental health problems who are violent or aggressive'. This use of language implies some young people with mental health problems have an inherent disposition to be violent or aggressive. The NICE full guideline raises the concern about how people with mental health problems are subject to stigma that they are likely to be violent. A less stigmatising use of language would be 'young people with mental health problems who may show violent or aggressive behaviour'.	Thank you for your comment and for bringing this to the attention of the GDG. The text has been changed.
Association for Family Therapy and Systemic Practice	2	Full	30	5	(Lines 5-13) Risk assessments can often consist of a checklist of risk factors that may or may not be present. This can give an estimation of future risk of violence or aggression. However the formulation approach, which can take into account a person's past and present experiences and the meaning the person makes of these, can inform a personalised plan to help prevent the occurrence of violence. A psychological and systemic (relational and contextual) formulation would be informative.	Thank you for your comment. We've expanded on these issues in the introduction to Chapter 4 of the full guideline and the subsection introductions
Association for Family Therapy and Systemic Practice	3	Full	76	28	(Lines 28-30) Clinical supervision can provide an important space for staff to reflect on and learn from their work, and thereby support staff to sustain working as a therapeutic team, in the context of frequently complex and demanding work.	Thank you for your comment. The GDG felt that supervision is not relevant to this guideline but down to general practice.

					Clinical supervision could usefully be added to the list in the first point of 4.6.1.1.	
Association for Family Therapy and Systemic Practice	4	Full	76	32	(Lines 32-34) The second point of 4.6.1.1. includes guidance that service users are offered appropriate psychological therapies. If in the assessment a history of violent relationships, or current violence in the family is identified, then psychological or systemic therapy to reduce the violent behaviour could have a helpful effect in reducing violent behaviour in health settings. Systemic Family Therapists are experienced at working with violence in couple relationships and in families, for example, Reading Safer Families. Vetere, A. (2011) Family violence and family safety: An approach to safe practices in our mental health services. Partner Abuse, 2, 246-256. Vetere, A. and Cooper, J. (2001) Working systemically with family violence: risk, responsibility and collaboration. Journal of Family Therapy, 23, 378-396	Thank you for your comment. While the GDG recognises the usefulness of systemic family therapy in other contexts, it would not be appropriate to recommend it in this guideline specifically for the *short-term* management of violence and aggression. This recommendation as it stands is about creating a positive environment for service users so that the risk of violence and aggression will be mimimised, and part of this will be making sure that service users are offered appropriate activities while in hospital, including psychological therapy.
Association for Family Therapy and Systemic Practice	5	Full	77	30	(Lines 30-31) It would seem useful to emphasize the relational and interactional factors in the development and escalation of violence for the service user. The service user's perspective, and the carer's perspective where possible, would be helpful here. This would help to inform a psychological and systemic (relational) formulation. Systemic Family Therapists use attachment theory to help inform assessments and identify triggers in interactional violence. Dallos, R., and Vetere, A. (2009) Emotion regulation: aggression, ADHD and violence in families. In: Systemic Therapy and Attachment Narratives: Applications in a range of clinical settings. London. Routledge. p59-85	Thank you for your comment. The relational and interactional factors in the development and escalation of violence for the service user has been covered in depth throughout the guideline and the resulting recommendations. The book chapter you cite would not meet criteria to be included as evidence in the guideline, as it is not based on a systematic review.

Association for Family Therapy and Systemic Practice	6	Full	109	34	(Lines 34-36) Training for staff should include how to assess relational and interactional factors in the development and escalation of violence.	Thank you for your comment. The GDG reviewed the recommendation but felt that this was sufficiently covered here and in other recommendations.
Association for Family Therapy and Systemic Practice	7	Full	114	1	(Lines 1-4) In discussion with the service user about what their wishes might be should they feel agitated, it would be useful to include how the s-ervice user would prefer staff to interact with them in order to promote de-escalation.	Thank you for your comment. The guideline emphasises engaging service users as early as possible to plan care and responses to violence and aggression – see recommendations 1.1.6-1.1.10.
Association for Family Therapy and Systemic Practice	8	Full	115	4	(Lines 4-5) The service user's cultural experience of observation might be useful to take into account.	Thank you for your comment. The guideline makes several recommendations about taking a service user's culture into account (see section 1.1), but the GDG is not sure how a person's culture would impact on their experience of observation.
Association for Family Therapy and Systemic Practice	9	Full	175	14	(Lines 14-17) In the post-incident review, the opportunity for the service user to discuss the incident in a supportive environment (6.6.2.9.) is important, but work with the service user needs to go beyond this. It is important to consider what reparative work in relationships might be appropriate and help to promote safety in the future, for example, between the service users, or service user and staff involved. As part of work to change violent behaviour, it is enormously important to work on repair and restoration in relationships, which takes time to consolidate, alongside helping people take responsibility for their behaviour that harms others, and helping people take responsibility for safety.	Thank you for your comment. Part of the external post-incident review is for the organisation as a whole to reflect and learn from the experience. Nevertheless the guideline does not cover long-term management so is not able to comment further on the nature of this reparative work as far as it pertains to changing violent behaviour.
Association for Family Therapy and Systemic Practice	10	Full	199	9	(Lines 9-11) Use of seclusion for children and young people, particularly those with attachment disorders, may be experienced as rejection.	Thank you for your comment. The GDG did not agree but have amended the recommendation so that :"Decisions about whether to seclude a child or young person should be approved by a senior doctor and reviewed by a multidisciplinary team at the earliest

						opportunity."
Association for Family Therapy and Systemic Practice	11	Full	199	8	(Lines 8-22) With respect to managing violence and aggression in children and young people (7.8.1): There is some evidence that the non-violent resistance approach (NVR) is helpful for reducing violent behaviour for young people living with their families. There is also some evidence that the non-violent resistance approach is helpful for reducing violent behaviour for young people in inpatient settings, and that this approach could also be used in adult settings. Gieniusz, B. (2014) Examining the evidence for the non-violent resistance approach as an effective treatment for adolescents with conduct disorder, Context, 132, 42-44. Weinblatt, U. and Omer, H. (2008) Non-violent resistance: a treatment for parents of children with acute behaviour problems. Journal of Marital and Family Therapy, 34, 75-92. Ollefs, B., Von Schlippe, A., Omer, H. and Kriz, J. (2009) Adolescents showing externalising problem behaviour. Effects of parent coaching. (German). Familiendynamik, 3, 256-265. Newman, M., Fagan, C. and Webb, R. (2013) The Efficacy of Non-violent Resistance Groups in Treating Aggressive and Controlling Child and Young People: A Preliminary Analysis of Pilot NVR Groups in Kent. (unpublished) Nick Goddard and colleagues in De Bascule Hospital in Amsterdam: Non-violent resistance (NVR) is a technique which can lead to a reduction in aggression whilst still promoting a safe environment, working together with patients, family and staff. In a ward setting staff are trained in the principles of NVR, and in specific techniques to	Thank you for this suggestion. The scope of the guideline covers short-term management. We believe that NVR is more appropriately considered for the longer-term management of violence. Please see the NICE guideline (CG158): http://www.nice.org.uk/guidance/cg158

					help reduce aggression, and specific techniques designed to repair the damage of an aggressive act (reparative act). NVR is a systemic intervention, a whole team approach, and staff are helped to reflect on their own roles in the cycle of aggression. NVR has been used successfully in a psychiatric setting in Amsterdam (de Bascule) to reduce aggressive incidents by over 75% and the use of coercive measures by over 50% - on an acute psychiatric ward for young people. It is also used on other wards for children and adolescents. The principles are transferable to adult settings Jakob, P. (2011). Re-connecting Parents and Young People with Serious Behaviour Problems – Child-Focused Practice and Reconciliation Work in Non Violent Resistance Therapy. New Authority Network International. http://www.newauthority.net/data/cntfiles/146_.pdf	
Black Country Partnership NHS Foundation Trust	1	NICE	37	0	Where did this 15 minute timeframe come from? Is it based on empirical evidence?	Thank you for your comment. Since stakeholder consultation the GDG decided to change this to 10 minutes because restraining for longer 10 minutes is associated with much worse outcomes, including death. Please see chapter 6, section 6.5 for the evidence to support this amendment.
Black Country Partnership NHS Foundation Trust	2	NICE	37	0	Is this 15 minute time frame for all manual restraint positions? Blofeld inquiry 2003 suggested that prone restraints should not exceed 3 minutes.	Thank you for your comment. Since stakeholder consultation the GDG decided to change this to 10 minutes because restraining for longer 10 minutes is associated with much worse outcomes, including death. Please see chapter 6, section 6.5 for the evidence to support this amendment.
Black Country Partnership NHS Foundation Trust	3	NICE	37	0	15 minute timeframe. Will this lead staff to either (a) releasing an intervention too soon or (b) possibly under reporting true timings.	Thank you for your comment. Since stakeholder consultation the GDG decided to change this to 10 minutes because restraining for longer 10 minutes is associated with much worse

						outcomes, including death. Please see chapter 6, section 6.5 for the evidence to support this amendment.
Black Country Partnership NHS Foundation Trust	4	NICE	37	0	IS NICE suggesting that the use of Rapid Tranquillisation and Seclusion is less damaging than manual restraint. Is this based on empirical evidence?	Thank you for your comment. The GDG are not suggesting this or vice versa. We think all these interventions carry significant risks, especially RT and manual restraint and manual restraint. The evidence suggests manual restraint has a stronger correlation with mortality. Please see the full guideline, Chapter 6 for the evidence which references the report that restraining for longer 10 minutes is associated with much worse outcomes, including death(see NICE recommendation 1.4.29)...
Black Country Partnership NHS Foundation Trust	5	NICE	37	0	Manual restraint levels can be classed in many ways. Would a low level intervention warrant the use of seclusion/rapid tranquillisation? I'm conscious the point alludes to the term 'Consider' but interpretations to the need for other interventions will vary from practitioner to practitioner. May generate unnecessary risks.	Thank you for your comment. These are complex situations in which being too rigid or insistent on the use of rapid tranquillisation or seclusion would not be sensible or appropriate. However the GDG did think that when manual restraint is prolonged, clinical teams need to consider bringing it to an end somehow. These are two ways that might happen.
Black Country Partnership NHS Foundation Trust	6	NICE	37	0	If a Manual restraint was in excess of 15 minutes and a high risk scenario how does NICE suggest the person is taken into seclusion and/or given a Rapid Tranquillisation. This is something practitioners struggle with on a day to day basis – risks to the patient and staff are extensive. The safest option at that time may be to stay in situ and continue holding.	Thank you for your comment. Rapid tranquillisation is, in many cases, almost always undertaken while the person is being held, and manual restraint is commonly used to ensure seclusion. These are complex situations in which being too rigid or insistent on the use of rapid tranquillisation or seclusion would not be sensible or appropriate. However the GDG did think that when manual restraint is prolonged, clinical teams need to consider bringing it to an end somehow.(see NICE recommendation 1.4.30)..
Black Country Partnership NHS Foundation Trust	7	NICE	43	0	Would the Service User Experience Monitoring Unit or equivalent be required to hold a post incident review for all incidents of Manual restraint? In some organisations this can be 100+ per month (number based on NHS	Thank you for your comment. The GDG has added a definition for incident to clarify that this would not include use of observation. While the GDG recognises that that this recommendation will take some resources and effort to

					Benchmarking). If this will be the case then how does NICE suggest this can be reasonably implemented. If it is not for all manual restraints which ones should they examine? DoH Positive and Proactive/NHS Benchmarking at present are monitoring all restraints with a special focus being on prone restraints.	implement, it would like to point out that the purpose of the Service User Experience Monitoring Unit is to reduce the use of restrictive interventions across the country.
Black Country Partnership NHS Foundation Trust	8	NICE	43	0	72 hours timeframe. Is this realistic? Would the Service User Experience Monitoring Unit be able to gather information from all individuals involved in a manual restraint. Staff may be on days off/annual leave etc.	Thank you for your comment. The GDG judged that it was important that the external review happened very soon after the event while the event was fresh in people's minds and while the people involved were available.
Black Country Partnership NHS Foundation Trust	9	NICE	43	0	Is it practicable to suggest the Service User Experience Monitoring Unit (SUEMU) or equivalent has access to confidential information?	Thank you for your comment. The GDG has clarified that the Service User Experience Monitoring Unit should have access to the service user's notes relating to the incident rather than their entire health record.
Black Country Partnership NHS Foundation Trust	10	NICE	43	0	72 hours timeframe. Some organisations are geographically extensive, practicably this may not be possible unless there is more than one Service User Experience Monitoring Unit. Cost implications.	Thank you for your comment. The GDG considered that the benefits of improved service user experience and improved data collection would offset the costs required.
Black Country Partnership NHS Foundation Trust	11	NICE	43	0	Is it practicable to train a myriad of service users and staff in investigation skills. Service users and staff would then have to be available within 72hrs to conduct the investigations. Depending on the number of manual restraints this may be impracticable. What are the foreseeable benefits of the SUEMU that an organisations procedure for reporting/ investigating/ sharing do not offer?	Thank you for your comment. The GDG recognises that that this recommendation will take some resources and effort to implement, but that the benefits of improved service user experience and improved data collection would offset this. The GDG would also like to point out that the purpose of the Service User Experience Monitoring Unit is to reduce the use of restrictive interventions across the country.
Black Country Partnership NHS Foundation Trust	12	NICE	45	0	Is it practicable to train all staff (based on a training needs analysis) in disengagement skills. Resources/costs.	Thank you for your comment. The GDG considered that this training is necessary to help protect workers in cases where they find themselves in situations with reduced support.
Black Country Partnership NHS Foundation Trust	13	NICE	45	0	Research suggests teaching staff in disengagement skills is not productive due to deterioration in skill retention (if the skills are	Thank you for your comment. The GDG is not aware of such research, but nevertheless has revised the recommendation to say that

					not used).	provision of training should depend on the incidence of violence and aggression in each setting.
CALM Training	1	NICE	General	General	CALM Training welcomes the increase in scope of client populations this guidance now refers to.	Thank you
CALM Training	2	NICE	5	General	CALM Training is not sure that the use of the word 'common' to describe child maltreatment is appropriate unless it can be contextualised with appropriate references whether the section has been agreed with the relevant professional college or not	Thank you for your comment. This is a standard NICE text which has gone through due consultation and process to be set as template text.
CALM Training	3	NICE	21	0	1.1.13 CALM Training welcomes the clarity expressed in this recommendation	Thank you.
CALM Training	4	NICE	22	0	(Pages 22-23) 1.2.2 & 1.2.3 CALM Training welcomes the recommendations concerning the need for restrictive intervention reduction plans	Thank you.
CALM Training	5	NICE	23	0	CALM Training believes the recommendations regarding collation, analysis and subsequent publication of data concerning the use of restrictive interventions is an essential component of restraint reduction programmes. As a consequence these recommendations are warmly welcomed.	Thank you.
CALM Training	6	NICE	37	0	Whilst recognising that NICE makes recommendations in line with Clinical Effectiveness, IN April of 2014, The Department of Health published guidance which stated that prone restraint must not be used in health and social care settings. Whatever the merits of the ban on prone restraint, CALM Training is concerned that the guidance being commented on is not consistent with Guidance published in 2014 which is potentially problematic and a source of confusion for staff.	Thank you for raising this issue. NICE guidelines are based on the best available evidence and GDG consensus, and therefore it would not be appropriate to simply recommend policy and attempt to align to all DH guidance.
CALM Training	7	NICE	37	0	CALM Training is concerned that specifying	Thank you for your comment. We are grateful

					time limits may not be helpful. E.g. technique A may be safely applied to individual X for a period exceeding 15 minutes whereas technique A may not be safely applied to individual Y under any circumstances and for any period of time. It may be more appropriate to maintain a more generalised warning concerning prolonged restraint which may differ in time length for individuals.	you have brought this to our attention. The intention is to make sure that manual restraint is carried out for no longer than necessary, and the GDG felt that specifying a time limit would therefore be appropriate. Having received a number of comments about the time limit of 15 minutes, the GDG decided to change this to 10 minutes because restraining for longer 10 minutes is associated with much worse outcomes, including death.
CALM Training	8	NICE	46	0	1.7 CALM Training welcomes the inclusion of this section in relation to supporting children and young people. However it may be appropriate to restate the documents definitions in respect of children (aged 12 or under) and young people (aged 13 – 17)	Thank you for your comment. The terms 'children' and 'young people' are hyperlinked to the definitions at the start of the guideline.
CALM Training	9	Full	171	0	CALM training are concerned that the guidance and the deliberations of the group appear to have ignored the serious challenges arising from managing acutely physically ill individuals with concurrent severe mental illness. In such settings mechanical restraint may be significantly safer then neuroleptics or prplonged restraint. To restrict its use to high secure settings only is therefore inappropriate	Thank you for your comment. It was the GDG's considered view that where individuals were sufficiently dangerous to require a period of mechanical restraint, such people would be in a high secure environment. The GDG also understood mechanical restraint for transport of some individuals between secure settings. They did not subscribe to the view that mechanical restraint would be appropriate in any other setting.
CALM Training	10	Full	171	0	Wording of this section with reference to the head. i.e. 'able to protect and support the service user's head and neck, if needed' is helpful	Thank you for your comment.
CALM Training	11	Full	174	0	CALM welcome the suggestions regarding publication of board reports detailing violence and restraint but suggest NICE should consider producing a standard template for such reporting facilitating ready comparison between services	Thank you for your comment. This is an implementation issue which will be taken into consideration.
CALM Training	12	Full	General	General	The document makes no reference to compartment syndrome a potential adverse	Thank you for your comment. This guideline is specifically for the *short-term* management of

					consequence of prolonged restraint?	violence and aggression; prolonged restraint is not recommended.
CALM Training	13	Full	175	0	The guidance regarding conducting a immediate post-incident review to identify and address physical harm to service users or staff, ongoing risks and the emotional impact on service users and staff, including witnesses suggests including a nurse and a doctor. The immediate involvement of a doctor may not always be practicable in some services. A trained nurse practitioner could undertake this role	Thank you for your comment. In physical healthcare, an emergency such as a cardiac arrest would require the presence of nurses and doctors. In the GDG's opinion, parity of esteem between physical and mental health would require that use of a restrictive intervention was taken very seriously.
CALM Training	14	Full	170	0	CALM note the guidance suggesting a doctor trained to use emergency equipment should be immediately available to attend an emergency if restrictive interventions might be used. The immediate availability of a doctor may not always be practicable in all settings.	Thank you for your comment. The GDG felt strongly that restrictive interventions should not be used if there is not at the very least a staff member available who is trained in ILS and a doctor. The recommendation has been amended to say 'staff trained in ILS or a doctor trained in emergency equipment should be immediately available...', see NICE recommendation 1.4.4.
CALM Training	15	Full	170	0	CALM note The guidance suggests that services should not use restrictive interventions to inflict pain. A significant number of services and training providers use pain techniques to facilitate breakway or escape. Nice must express an explicit view on this practice	Thank you for your comment, but the GDG is of the opinion that pain should not be inflicted, and that this is clear in the guideline, as reflected in NICE recommendation 1.4.6.
CALM Training	16	Full	201	0	CALM note he framing of the research question What is the most appropriate physical restraint technique to use should it become necessary for the short-term management of violent and aggressive behaviour in children and young people? The questions suggests one technique may be better than another when techniques are embedded with systems and models. Extracting a single technique for purposes of study may actually contribute little to our understanding of the dynamics of restraint safety. A comparison of models might provide	Thank you for your comment. For the purposes of reviewing the evidence, the GDG agreed to focus on specific techniques before examining the evidence. However, they we aware of the issue you raise and did take this into account when drafting recommendations.

					greater insight and should ne undertaken instead.	
CALM Training	17	Full	General	General	There is a notable paucity of research exploring how staff make decisions to use restraint and /or seclusion. Further research to inform what is a critical aspect of practice is warranted.	Thank you for this suggestion, the GDG agree and made the following recommendation: In what circumstances and how often are long-duration or repeated manual restraint used, and what alternatives are there that are safer and more effective? (NICE recommendation 6.7.1.2)
Cardiff & Vale UHB	1	NICE	40	0	Single dose:Impractical for units that do not have a Dr on site 24/7.	Thank you for your comment. The GDG disagree; if there is no prescriber on site, the safety of the Service User needs to be considered.
Cardiff & Vale UHB	2	NICE	27	General	Daily review by senior doctor is unlikely due to availability	The GDG considered it to be critical that if rapid tranquillisation is being used, as a senior doctor should review all medication daily.
Central & North West London NHSFT	1	NICE	4	0	(Para 3) I do not understand why you have only included patients currently under the care of a MH service. This cannot always be established at the time of an initial presentation. But the presence of an acute psychiatric disturbance is commonly clearly evident when a violent and aggressive circumstance arises. Therefore to exclude such patients from the inclusion in good prescribing and treatment guidelines like this is unnecessary biased.	Thank you for your comment, but as scope sets out and the introduction states, the guideline covers people with mental health problems who access all health services, not just mental health services. The GDG agrees that it is not always possible to establish a mental health problem at the initial presentation and has therefore stated that staff in emergency departments should be trained in mental health triage (see recommendation 1.5.4), and have added that they should also be trained to distinguish between excited delirium states (acute organic brain syndrome), acute brain injury and excited psychiatric states (such as mania and other psychoses) (see new recommendation 1.5.5).
Central & North West London NHSFT	2	NICE	4	0	(Para 3) By omission it currently reads that this guidance – including all the advice about preventing guidance - doesn't touch the medium term	Thank you for your comment, the introduction has been amended to cover the issues you have raised.

					management of violence, e.g. the need to optimise standards psychotropic drug treatment rather than just referring professional to the use of restraint and RT. This is a shame, as it skews the focus to becoming a reaction to an emergency, rather than helping treating teams to avoid such a crisis occurring. If this is to remain the narrow focus of the guidance it would be helpful if this was explicitly stated with the rationale.	
Central & North West London NHSFT	3	NICE	4	0	(Para 3) By omission it currently reads that this guidance doesn't includes patients in prisons, specifically healthcare settings. I am not sure if this is what was intended. Again it would be helpful to explicitly state this as currently it could be interpreted either way.	Thank you for your comment. The prison setting has been excluded as there is a separate guidance looking into mental health of adults within the criminal justice system pathway, including prisons. The 3rd paragraph of the introduction to the NICE guideline has been made clearer to reflect which setting this guideline covers.
Central & North West London NHSFT	4	NICE	11	0	(1st bullet point) Should add that this training (that should be offered) should be specific to the age group of patient being cared for, i.e. different restraint techniques for frail adults, compared to children and adults.	Thank you for your comment. Please see NICE recommendation 1.4.7 has been amended to ensure that when restrictive interventions are used, the service user's physical health, degree of frailty and developmental age is taken into account.
Central & North West London NHSFT	5	NICE	11	0	(Last heading) "Inpatient wards" – but at the beginning the guidance appears to relate to MH in patient services, so please be more specific and change to "Inpatient psychiatric wards"	Thank you for your comment. We have amended the heading in line with your comment.
Central & North West London NHSFT	6	NICE	14	0	(3rd sub heading) This is the first time the phrase "Post incident review" is used yet there is no description or definition here of what constitutes "an incident". This definition is extremely important otherwise we do not know when to follow the related instructions. Is an incident any episode of restraint? Or RT? Or prn? I presume it means any occasion where staff have intervened?	Thank you for your comment. A definition of incident has been added to the guideline – it is any use of a restrictive intervention, except observation.

					A definition needs to be added both here and in the definitions list on page 17& 18.	
Central & North West London NHSFT	7	NICE	14	0	(1st sub-sub heading) "External post incident reviews" - delivering this will have SIGNIFICANT staffing and cost implications.	Thank you for your comment. The GDG considered that the benefits and potential savings of this approach was worth the resources required. Without routine review it is not known to what extent restrictive interventions are being applied.
Central & North West London NHSFT	8	NICE	17	0	Please add in definition for "incident" here.	Thank you for your comment. A definition has been added.
Central & North West London NHSFT	9	NICE	19	0	(Between 1.1.1 and 1.1.4) I cannot see any reference to minimising potential antecedents. For example no reference to physical pain, or communication barriers/explanations about admission, and only minor references to problems when patients are environments that restrict smoking. These omissions need to be added. With specific reference to smoking, there's no emphasis on providing smoking replacement therapies if the restricted access to smoking is leading to anxiety, agitation and increased aggression in nicotine addicted patients. As smoking should be considered as a possible antecedent in some scenarios, and it can be easily addressed by the prescribing and nursing team this should be recommended. None of this is outlined. Rather it seems to imply – contrary to the smoking guidelines – that we should be facilitating smoking. It would be helpful to avoid (even unintended) inconsistencies between guidelines.	Thank you for your comment. The GDG made a number of recommendations relating to prevention please see NICE guideline, section 1.3 for more information. There is a separate Public Health guidance which focuses on smoking cessation in secondary care, see PH48.
Central & North West London NHSFT	10	NICE	21	0	(1.1.13) To balance this whole section please would you add something to state that equally staff have the right not to be physically attacked whilst undertaking their normal work tasks. And doing their jobs. They can/should be encouraged and supported by their managers to all report	Thank you for your comment. This is beyond the remit of the scope and down to local services to support their staff members.

					incidents of serious violence to the police.	
Central & North West London NHSFT	11	NICE	25	0	“Carry out the risk assessment in an interview....” this is frequently not possible as patients are too unwell to speak, or even mute, therefore please reword to “Carry out the risk assessment where possible by interview...”	Thank you for your comment. The wording ‘in an interview’ has been removed from the recommendation
Central & North West London NHSFT	12	NICE	41	0	(Title for 1.4.53) As per comment #6 above, we need a definition here for “incident”.	Thank you for your comment. A definition for ‘incident’ has been added to the start of this section.
Central & North West London NHSFT	13	NICE	41	0	This lists the details that must be reported to the Trust board. Please add: “Use of seclusion” – as this is reported via the MHMDS anyway and it is good to look at the pattern and relationship between number of RT incidents and rate of use of seclusion.	Thank you for your comment. Seclusion is defined as a restrictive intervention in this guideline therefore the GDG did not feel that it was necessary to single out this intervention.
College of Emergency Medicine	1	Full	General	General	This document is very welcome and has more to offer than the previous CG 25 (2005). There are some important general issues and issues relating to Emergency Departments (EDs) that I feel need to be reviewed: General comments - Management of violent and physically threatening behaviour implies that there needs to be staff training in this field but no trainer or training organisation was involved in writing the guidelines. This was a significant omission, the guideline group have no authority to provide advice on training. The draft guideline requires review by a number of trainers from a number of health care settings. Trainers need to comment on staff fitness to train/operate and on the efficacy, role and risks of each intervention. Skills need to be selected specifically for each health care setting as reporting dictates. Need a section on managing the environment in ED – refer to designing out violence – Design Council	Thank you for your comment. Stakeholders were invited to a stakeholder workshop who advised on the key issues which will need to be addressed in this guideline; based on these areas the stakeholders advised us on which professional expertise should form the target constituency. The guideline group was based on this target constituency and on the applications received; the professionals were selected based on their knowledge and experiences they could bring to the overall development of this guideline. This is an evidence-based guideline that focuses on interventions rather than on who provides them. We have addressed the range of interventions and settings which overall were represented in the guideline development group. Furthermore it is part of the guideline process to ensure the recommendations and the evidence is available to all stakeholders during consultation so that they may advise the guideline group further. In response to your comment and those received by other

						stakeholders section 1.5 'Managing violence and aggression in emergency departments' has been expanded to include a section on liaison mental health teams, and two new recommendations on preventing violence and aggression (NICE recommendation 1.58 and 1.5.9). A number of recommendations highlight the training required to ensure the safety of the professionals and the service user, however it is for local health and social care providers to design their appropriate training for their staff.
College of Emergency Medicine	2	Full	12	15	1.2.3. There is no mention of providing staff with physical response to violence – this might represent an unlawful piece of advice - staff have the same rights as anyone else under law to protect themselves and prevent harm.	Thank you for your comment. The NICE guidelines are to provide best practice guidance for healthcare and social care professionals to ensure an optimal quality of care for service users; the recommendations may make reference to legal acts but the level of legal context you are asking for in the NICE recommendations is beyond the remit of the scope. However, the NICE guideline has been revised to highlight that health and social care provider organisations should ensure the safety of staff, particularly in the use of restrictive interventions. This would involve the use of techniques to avoid injuries (see recommendation 1.4.2).
College of Emergency Medicine	3	Full	25	36	2.7 deals with training in general terms and the lack of national curriculum – needs section on training needs analysis, reporting and monitoring of physical interventions. There are no national guidelines for this – this guidance needs to expand to include the principles for this or even deliver such guidelines on physical interventions.	Thank you for your comment. It is beyond the remit of the scope to undertake a national curriculum of training needs analysis.
College of Emergency Medicine	4	Full	76	25	4.6.1.1. Prediction – need to add the value of hospital IT systems in the acute health sector having a red flag system to alert staff of potentially or known violent patients with mechanisms to ensure fairness and review of	Thank you for your comment. GDG considered the current IT systems and agreed that they are not standardised or adequate enough to make such a recommendation. Furthermore there was no evidence to support the IT systems.

					including patients in such a system. Also to recognise the potential stressors and triggers of violent behaviour in the ED setting. Refer to Design Council project to design violence out of ED.	
College of Emergency Medicine	5	Full	79	40	5.1.1 deals with training programmes – very important paragraph – needs to be driven forwards either under this guidance or a separate guidance.	Thank you for your comment. The section of the guideline you are commenting on is an introduction to training programmes. The GDG agree with its importance in managing violence and aggression and there are a number of recommendations which go a long way in emphasising training throughout the guideline.
College of Emergency Medicine	6	Full	80	35	5.1.2 deals with management strategies – this is an under developed area – needs to exclude to include the acute health sector.	Thank you for your comment. The scope covers the short-term management of violence and aggression in people with mental health problems, therefore the introduction to this chapter focuses on this issue in relation to pre- and immediately pre-event. We do not believe it would help the reader if we expanded to include the acute health sector.
College of Emergency Medicine	7	Full	98	2	5.4.3 – vague – needs expansion.	Thank you, but we have followed the approach advised in the NICE guidelines manual. That is, 'Short evidence statements for outcomes should be presented…The evidence statements should include the number of studies and participants, the quality of the evidence and the direction of estimate of the effect.'
College of Emergency Medicine	8	Full	107	27	5.7.1. instructions are given on de-escalation techniques – validated? Why not give instructions on higher level interventions through a recognised training body?	Thank you for your suggestion. The GDG considered this issue carefully and decided that high level principles were more appropriate than naming any one training body.
College of Emergency Medicine	9	Full	116	29	5.7.2. encourages training – there needs to be a good reporting system to define the threat for each location and provide appropriate training dictated by that reporting process. Need to advise ED staff that mental health presentations need to be assessed from a medical perspective – many physical medical problems may present as mental health upset. Specific	Thank you for your comment. The GDG agreed and have expanded recommendations concerning assessments (see NICE recommendation 1.5.1) and concerning improving reporting (see NICE recommendation 1.2.3, 1.4.54, 1.4.55).

					guidance required on this point – happy to help draft it. This often goes wrong in the acute sector.	
College of Emergency Medicine	10	Full	123	2	Table 30 needs to ask the research question whether Ketamine has a role in rapid tranquillisation – advocated by some in America. There has been an almost knee jerk rejection of Ketamine in the rapid tranquillisation role – there is a strong argument for it – seek review of this – happy to get involved in the discussion of this.	We believe there is not a current evidence base for the use of ketamine in the management of violence and aggression as defined within the scope of the current guideline. We accept that ketamine is sometimes used as a short acting anaesthetic in Emergency Department settings but this is a different issue. We do not believe that there are strong grounds to propose a research question regarding the utility of ketamine in the management of violence and aggression in mental health settings, not least because of *a priori* knowledge of it's impact on cortical glutamatergic traffic and pro-psychotic effects.
College of Emergency Medicine	11	Full	133	16	Table 37 needs to ask the research question whether Ketamine has a role in rapid tranquillisation – advocated by some in America. There has been an almost knee jerk rejection of Ketamine in the rapid tranquillisation role – there is a strong argument for it – seek review of this – happy to get involved in the discussion of this.	We believe there is not a current evidence base for the use of ketamine in the management of violence and aggression as defined within the scope of the current guideline. We accept that ketamine is sometimes used as a short acting anaesthetic in Emergency Department settings but this is a different issue. We do not believe that there are strong grounds to propose a research question regarding the utility of ketamine in the management of violence and aggression in mental health settings, not least because of *a priori* knowledge of it's impact on cortical glutamatergic traffic and pro-psychotic effects.
College of Emergency Medicine	12	Full	163	15	Guidance on seclusion room – operation, staffing, training, monitoring, working with the police in particular with patients detained under Section 136 of the Mental Health Act. 6.5.1. The guidance says that seclusion is not good practice in the ED – I say that it might be necessary and is often very useful and some departments have seclusion rooms – it is	Thank you for raising these important issues. The GDG revisited the issue around seclusion in ED and pain compliance, but still maintain that to improve practice, these recommendations are important and justified.

					necessary from time to time as an antecedent to rapid tranquillisation. Pain compliance is rejected out of hand– this is not tactically sound and pain compliance has a role in some situations to prevent escalation and terminate violence and prevent escalation and injury. Supine restraint is preferred over prone restraint – reasonable.	
College of Emergency Medicine	13	Full	170	8	6.6.1.6. restrictive interventions should not – punish (agree), inflict pain (disagree with reservation), suffering (agree) or establish dominance (ridiculous) – of course you're asserting dominance – you're controlling a violent individual.	Thank you for your comment. The GDG is of the opinion that a restrictive intervention is to minimise harm or potential harm to self and others, both staff and other patients. It is not to establish a power relationship even though for a period of time a person's liberty will be restricted. The GDG considered it very important that restrictive interventions should not be used with the aim of establishing a power relationship over the service user.
College of Emergency Medicine	14	Full	170	20	6.6.1.9 – fine	Thank you
College of Emergency Medicine	15	Full	170	34	6.6.1.14 – consider also mechanical restraints – much safer in a prolonged restraint. The GDG need to see modern, less intrusive restraints and review this.	Thank you for your comment, but the GDG judged that mechanical restraint should be reserved for high secure settings only.
College of Emergency Medicine	16	Full	171	1	. staff member supervising restraint needs to be aware of excited delirium/acute behavioural disturbance We NEED to teach staff in management of the acute behavioural disturbance/excited delirium state – a medical emergency that requires rapid termination and not automatically treat as a psychiatric episode. This is a huge omission which must be addressed. Mechanical restraint is recommended only for transport – it can and should be used with less risk to all parties to other situations in which control is required. Manual restraint limited to 15 minutes – sensible but an arbitrary number.	Thank you for your comment and for drawing the GDG's attention to this important point. A recommendation has been added to the guideline (see 1.5.3) about recognition of excited delirium states. However the GDG did not share your view of mechanical restraint; the group considered that mechanical restraint should be reserved for high secure settings and transport between such settings only.

College of Emergency Medicine	17	Full	171	13	6.6.1.19 mechanical restraint has a potential role in the acute setting and is not unlawful and may be necessary – this section is illogical. Consider Ketamine under rapid tranquillisation option.	Thank you for your comment. It was the GDG's considered view that where individuals were sufficiently dangerous to require a period of mechanical restraint, such people would be in a high secure environment. The GDG also understood mechanical restraint for transport of some individuals between secure settings. They did not subscribe to the view that mechanical restraint would be appropriate in any other setting, and certainly not ketamine.
College of Emergency Medicine	18	Full	173	38	6.6.1.38 – seclusion may and does have a role in ED	Thank you for your comment. The GDG is of the opinion that in the emergency department violence and aggression should be managed as a mental health emergency. Therefore seclusion is not appropriate. However the recommendation has been changed to say that service users who become aggressive or violent should not be excluded from the emergency department.
College of Emergency Medicine	19	Full	177	1	Section 7 Mechanical restraint is outlawed in children – has a role in strong adolescents. We need to consider specific physiological and psychological vulnerabilities of children in restraint – by age and maturity.	Thank you for your comment. We believe that the use of mechanical restraint in children has been taken into consideration in NICE recommendation 1.7.18. The importance of tailoring restrictive interventions is also considered in NICE recommendation 1.7.4.
College of Mental Health Pharmacy	1	NICE	12	0	(Last main bullet point) “When prescribing prn medication to prevent violence and aggression”. Again this is very unclear wording. Firstly I think you mean “When prescribing psychotropic prn medication to prevent violence and aggression”. And secondly you do not prescribe it to “prevent violence and aggression”. Otherwise this would suggest it is given to any patients as a preventative. Rather it is used as part of the management of violence and aggression, to prevent escalation of violence and aggression which has already started.	Thank you for your comment. The GDG did not agree that the word psychotropic is needed here however to add clarity, the recommendation has been amended to say ‘when prescribing p.r.n medication *as part of a strategy* to de-escalate or prevent situations that may lead to violence and aggression’ .

College of Mental Health Pharmacy	2	NICE	12	0	(Penultimate sub bullet point) “do not prescribe prn medication routinely or automatically on admission”. Again this is very unclear wording. Firstly I think you mean “do not prescribe prn psychotropic medication for the treatment of violence and aggression routinely or automatically on admission”. And secondly this would not be a safe or advisable practice in a large MH unit where there are several admission a day, and one duty doctor out of hours. This would mean potential delays in patients getting prn medicines which would potentially lead to delays in treatment and therefore escalation of events before the one duty SHO could arrive at the scene to review the unwell disturbed patient for prn psychotropics. Or worse, that doses would be given by nurses who then retrospectively call junior doctors to come and prescribe. The on-call junior doctor may well be less experienced than the usual team of doctors, plus they are unlikely to know the patient and their care plan as well as the regular team. Therefore this would introduce additional risks to optimal patient care. Either way I do not think this is safe advice. This line should be deleted. Please refer to comments on 1.4.44 below.	Thank you for your comment. The GDG considered carefully the issues you raised. They made some changes to the recommendation to improve clarity (particularly to the stem of the rec), but felt that a competent prescriber should be available to individualise the prescribing of prn medication in line with this recommendation. They consider this to be safe advice.
College of Mental Health Pharmacy	3	NICE	12	0	(Final sub bullet point) “tailor prn medication to individual need and include discussion with the service user”. Again this is very unclear wording. Firstly I think you mean “tailor prn psychotropic medication for the treatment of violence and aggression to the individual needs of the service user and, as far as possible, include discussion with the service user”.	Thank you for your comment. The GDG does not feel it is necessary to state that this is ‘psychotropic’ medication but has added that discussion should take place ‘if possible’.

College of Mental Health Pharmacy	4	NICE	13	0	(First bullet point) “ensure that there is clarity about the rationale and circumstances in which prn medication may be used and that these are included in the care plan”. Again this is unclear wording, please could the wording be more specific to clearly refer to the scope of the guidance. e.g. change to “ensure that there is clarity about the rationale and circumstances in which prn psychotropic medication may be used in the treatment and management of violence and aggression and that these are included in the care plan”	Thank you for your comment. The GDG did not see how your suggestion would bring greater clarity to the recommendation and felt it should remain unchanged.
College of Mental Health Pharmacy	5	NICE	13	0	(2nd bullet point) This is the first time the phrase “Rapid tranquillisation” is used yet there is no description or definition here, and it is not included in the definitions list on page 17& 18. The reader has to go all the way on to page 38 to find your new definition. This needs to be added in both here and in the definition list, otherwise it reads very unclearly. It also needs to be clearly highlighted that this NICE definition of RT is different to the 2005 definition. And it needs to give a rationale/explanation. As definitions cannot simply be changed at will.	Thank you for your comment. The definition of rapid tranquillisation has been added to the list of the terms used in this guideline, please see section 1 of the NICE guideline.
College of Mental Health Pharmacy	6	NICE	14	0	(First title) “Using restrictive practices in inpatient settings” Again this is unclear wording, please could the wording be more specific to clearly refer to the scope of the guidance as previously defined, e.g. change to: “Using restrictive practices in inpatient psychiatric settings”.	Thank you for your comment. The heading of section 1.4 has been changed to make it clear that the recommendations pertain to inpatient psychiatric settings.
College of Mental Health Pharmacy	7	NICE	14	0	(2nd bullet point) “together with” – this phrase is extremely unclear when read in this Key Priorities sections. When this wording is read in the context of the rest of the recommendations is clearer. However the reader cannot tell at this	Thank you for raising this, the GDG agree and have amended the recommendation to read ‘combined with’.

					point whether you mean “in combination” or whether you are instructing prescribers to avoid the use of both drugs (used alone).	
College of Mental Health Pharmacy	8	NICE	18	0	(“prn”) This definition is very unclear. Firstly from reading the rest of the document I think that whenever you say “prn” you actually mean “prn psychotropic medicines”. Therefore I suggest throughout the whole document you instead refer to “prn psychotopics”. Otherwise you are inadvertently referring to the as required administration of paracetamol and other medicines for physical health conditions. Secondly the definition of “prn” is already made, and is quoted in the BNF – i.e. prn means pro re nata (Latin) or “as required”. We cannot change that definition. From the context in which your document has used this term I gather that your use in intended to mean “non-parenteral” (i.e. oral, buccal, sublingual) administration of psychotropic medication. If I have understood this correctly, and this is what is intended, please make the definition along these lines.	Thank you for your comment. We recognise that in the majority of cases, where oral medicines used as prn in the context of managing violence and aggression, they will be psychotropic, but the GDG did not consider a change in definition is necessary. Section 1.2.14 highlights the need for multidisciplinary involvement including a psychiatrist and specialist pharmacist to devise an individualised pharmacological strategy including prn. This would include consideration of the pharmacokinetic/pharmacodynamic properties of the pharmacological agent and the use of appropriate formulations of the medicine where appropriate.
College of Mental Health Pharmacy	9	NICE	18	0	Please add in definition for “RT” (as given on page 38) here.	Thank you for your comment. Please see Section 1 of the NICE guideline for the definition of rapid tranquillisation.
College of Mental Health Pharmacy	10	NICE	20	0	(1.1.8) “Ensure that service users understand the side effect profiles of the medicines recommended....” I fully agree and support the idea of informed choices and decisions by patients. But the way this is worded is simply not achievable. “Understand the side effects profiles” is a potentially never-ending amount of information to be understood and digested by someone. In most circumstances when RT is about to be given, the patient is not in the frame of mind to	Thank you for your comment. The recommendation (1.1.8) has been amended to read ‘main side-effect profiles’ to address your concern. The GDG considered your comments about capacity and choice. Recommendation 1.4.38 (NICE) provides guidance on the management of patients where there is insufficient information to guide the choice of medication for rapid tranquillisation.

					consider such information and making such decisions, and would not be considered to have the capacity to make such an informed decision. Furthermore many patients who require RT are treated by services in who do not know them and do not have access to previous records to check if they have ever made any advance decisions/statements/preference in other organisations in which they are known, which they are currently unable to express. This section also reads in a manner that suggests that the patient should be given whatever they choose. Patients don't always selects clinically appropriate treatments. Additionally this doesn't fit very well with your later very limited list of recommended drug options (eg what if the patient says I only want oral aripiprazole?) It would be better to phrase this section something more like it was in the 2005 version. Something along the lines of: "Patients should always be informed that the will be given parenteral medication before this is given. They should always be given the opportunity to accept appropriate prescribed oral medication"	Recommendation 1.4.37 advises that a number of factors should be considered when deciding which medication to use. The service user's preferences or advance statements and decisions are one of these, but others are important too. The GDG considered whether the old wording was better, but decided to keep the new wording (with some amendments for clarity).
College of Mental Health Pharmacy	11	NICE	26	0	"the multidisciplinary team should review the pharmacological strategy and the use of medication at least once per week" Whilst I completely agree with this, if we are (rightly) reviewing all medicines – including psychotropic prn and RT – once each week, this is not "short term" management of violence and aggression which is what the scope of this guidance. I suggest keeping this in but expanding it and emphasising the need to focus on all the patients pharmacological treatments. The following bullet point list doesn't include the	Thank you for your comment. The recommendation has been amended to say 'all medication' should be reviewed by a senior doctor if rapid tranquilisation is being used (see NICE recommendation 1.2.16).

					maintenance psychotropic treatment. Doesn't talk about optimising regular treatment to (hopefully) therefore minimise the use of prn and RT.	
College of Mental Health Pharmacy	12	NICE	28	0	(1.3.1, 7th bullet point) "drugs or alcohol" please change to "drugs, unknown or illicit substances and alcohol"	Thank you for your comment, but the GDG thinks that the wording is clear as it stands
College of Mental Health Pharmacy	13	NICE	30	0	(1.3.10, "Using prn medication" section) Need more explanation of the definition here, otherwise it is not clear to the reader the distinction you have now made between RT and prn, most readers are likely to expect the definition to be as peer your previous 2005 guidance, unless you explicitly state otherwise. "When prescribing prn medication to prevent violence and aggression:" This phrasing suggests a flawed notion. Medication can be prescribed as a long term strategy to (attempt to) prevent episodes of violence – but this is a long term strategy, as such it is outside of the scope of this guidance. Prn psychotropics made be given acutely, but by definition, they are only given "as required", so when nurses see the beginnings of violence and aggression. If they were always used to "prevent violence" this would lead to serious over use of them, and sedating all patients. Please rephrase as I guess you mean prevent the escalation of violence and aggression (ie as part of a management strategy for events that are already developing). Throughout this section rather than saying "prn" please say "prn psychotropic medication" as that is what you mean.	Thank you. We have added an additional section within the glossary to clarify the distinction between the terms RT and PRN when used in this guideline and clarified the use of medication with a plan or strategy for de-escalation.
College of Mental Health Pharmacy	14	NICE	30	0	(1.3.10, 2nd bullet point) "....include discussion with the service user" please change to "....include discussion with the service user whenever possible"	Thank you for your comment, the GDG has made this suggested change.
College of Mental Health	15	NICE	30	0	(1.3.10-11)	Thank you for this suggestion. However, the

Pharmacy					I think this whole section about prn medication should sit after de-escalation, as one would expect de-escalation and attempting to address the cause of the problem to be attempted prior to giving prn psychotropics. De-escalation may even include the use of non-psychotropic medicines – for example if the patient is in pain, or nicotine withdrawal, and in these circumstances the use of prn psychotropics wouldn't be appropriate without first dealing with the cause.	recommendations about p.r.n. are in the context of prevention. De-escalation happens in response to an event, and therefore sits better after p.r.n.
College of Mental Health Pharmacy	16	NICE	30	0	(1.3.12) De-escalation – discusses staff training, but doesn't actually say how this training should be used. Or that this should be used first, before medication, and that teams should work to identify and address any primary cause or concern that led to the events of violence and aggression escalating. This needs to be added.	Thank you for your comment, but the GDG thinks that the subsequent recommendations are clear about how to use de-escalation. The GDG is also of the opinion that the use of medication should be planned in advance, before de-escalation might be needed. Identifying and addressing causes and concerns leading to violence and aggression are covered in section 1.2.
College of Mental Health Pharmacy	17	NICE	32	0	I think you should add the recommendation that any staff prescribing or administering RT, or monitoring patients' physical health after the administration of RT, should be proficient at least in Basic Life Support, if not Intermediate Life Support skills. And that this should be updated annually.	Thank you for your comment. The GDG agreed and have amended recommendation 1.4.4 to reflect that staff members should be trained in ILS if undertaking restrictive interventions.
College of Mental Health Pharmacy	18	NICE	39	0	Why not also include the option of haloperidol AND lorazepam (at the same time) seeing as there was plenty of trial data on this from the TREC trials, and it is currently the most widely used combination in the UK. The current void of not recommending it, and also not giving any advice or guidance about this combination appears to be an omission. If you are not recommending it please advise why, so that clinicians understand WHY they shouldn't do something. Giving just two options is extremely restrictive.	Thank you for your comment. The GDG considered all of the evidence (documented in Section 6.3.4 of the full guideline) and came to the conclusion that that the combination of IM haloperidol and IM lorazepam did not offer benefits that outweighed the risks when compared to IM lorazepam on its own or IM haloperidol combined with IM promethazine. NICE recommendations do not usually give a rationale or evidence in the NICE version of the guideline.

					And not likely to be adhered to without giving readers a rationale. Similarly it would also be helpful to state something along the lines of “aripiprazole IM is not recommended for RT due to paucity of efficacy data, and high NNT from meta-analysis”. Again omitting to comment is extremely unhelpful and not persuasive to stopping a practice. If you are not confident enough in the evidence to recommend that – then please tell us. Alternatively, if there is now new evidence concerning the safety of it, please state.	With regard to aripiprazole IM, recommendations against using an intervention are typically only made if there is clear evidence that harms outweigh the benefits. The GDG felt there was insufficient evidence to make this judgement. Again, this information is provided in the full guideline, not the NICE version.
College of Mental Health Pharmacy	19	NICE	39	0	“If..... no ECG has been carried out avoid IM haloperidol”. I think we need to give readers something more to work with, otherwise this guidance will be considered unrealistic and be ignored. If a patient is clearly psychotic and extremely disturbed (and refusing to have an ECG or it is simply unsafe to do) we need to use IM antipsychotics alongside the sedative. Trials have demonstrated that antipsychotics have an onset of action within a few days, therefore the quicker they are started the quicker the response in psychotic symptoms. If it's untreated psychosis and the patient is medication free (previously defaulted and admitted relapsed), and the TREC combination with haloperidol isn’t appropriate (e.g. cannot get an ECG) then IM olanzapine, or IM aripiprazole might be very sensible and may form the start of an antipsychotic monotherapy treatment plan, but you have not recommended them (by omission). Therefore what should be used for the overtly psychotic patient when lorazepam alone is frequently insufficient? The situation is likely to escalate the longer it is	Thank you for your comment. The GDG considered all of the evidence (documented in Section 6.3.4 of the full guideline) and came to the conclusion that that IM lorazepam on its own or IM haloperidol combined with IM promethazine have sufficient evidence that benefits outweigh the risks. It was the GDG’s view that there is not sufficient evidence to suggest that IM antipsychotics (alongside sedatives) has any benefit with regard to treating psychosis. It is there view that the treatment of psychosis and schizophrenia should be done by following the appropriate NICE guideline (CG178). This guidance doesn’t specifically exclude other options for rapid tranquilisation in situations where a risk-benefit assessment for the individual service user indicates lorazepam or haloperidol/promethazine is not appropriate. Also note recommendation 1.2.15 and 1.2.16 about developing an individualised pharmacological strategy. Regarding IM haloperidol and ECG, the GDG felt that given the risks, IM lorazepam should be

					left which could pose more risks to the patient. It would be helpful to say something like ECG in the last year, or past 6 months. Etc. To aid understanding. It should be noted that haloperidol injection SPCs still only say that “Baseline ECG is recommended prior to treatment” i.e. it is not an absolute requirement as it is in this NICE Guidance. Furthermore you’ve made no reference to bearing in mind the potential risks posed by the current physical health condition and hydration of the patient – only “Pre-existing physical health problem”, so there is no reference to assessing whether they are currently (in the last day or two) eating and drinking. And no reference to drugs/illicit substances used. These points need to be added.	the first-line choice if no ECG had been carried out. Thank you for raising the issue about current physical health, we have updated 1.4.37 to highlight pregnancy and possible intoxication as factors which should be taken into account.
College of Mental Health Pharmacy	20	NICE	39	0	In each of these points where it says “if little/no response” please add here that prescribers and teams should also review ALL treatments regularly including optimise medium term psychotropic medication (oral and depots). Rather than simply telling them what dose to give next. The prn and RT MUST be considered alongside the medium term plan as well.	Thank you for your comment. Please see NICE recommendation 1.2.16. In addition, the GDG has changed recommendation 1.2.15 to say that if rapid tranquillisation is being used, all medication should be reviewed at least once a day. The GDG believe this will address your concerns.
College of Mental Health Pharmacy	21	NICE	39	0	The only (licensed) option given here for a child (i.e. aged under 18 years) for RT is IM lorazepam. Supply issues aside, parenteral benzodiazepines can cause disinhibition and children are more at risk of this than adults. I understand the lack of an evidence base for other interventions but maybe just mentioning that if you give lorazepam IM and it all gets worse, there may be a reason for this. And suggest some alternatives.	Thank you for your comment. Section 7.7.4 in the full guideline highlighted the fact that no evidence was found which enabled the GDG to assess the benefits and harms of pharmacological interventions. Given the paucity of evidence, the GDG felt that IM lorazepam was the only pharmacological intervention that could be recommended. The GDG also recognise that clinical judgement will be required on an individual basis.

College of Mental Health Pharmacy	22	NICE	39	0	Then what? Please advise about reviewing the acute diagnosis, the setting (e.g. should seclusion be used), other physical states (e.g. pain, withdrawal), and consider a second consultant opinion.	Thank you for your comment. The GDG has added to recommendation 1.4.43 that if IM lorazepam has already been used then a team meeting should be convened and a second opinion sought if needed.
College of Mental Health Pharmacy	23	NICE	39	0	As per comment #2 above. Rather as per 1.2.15, the point is that doses and overall treatment plans should be frequently reviewed. Rather than only write up one dose at a time, it would be safer and more pragmatic to also prescribe repeated doses to be prescribed as needed, but that the relevant ward/team doctor should be called to come and see and review the patient as every parenteral dose of RT is given. This gives the protection of timely reviews by a doctor, but doesn't delay nurses giving urgent and necessary treatment whilst they wait for a doctor to be able to attend.	Thank you for your comment. The GDG considered this issue carefully and came to the conclusion that recommendation 1.4.44 was appropriate and would lead to best practice when combined with recommendations 1.2.15 and 1.2.16.
College of Mental Health Pharmacy	24	NICE	40	0	There seems a little inconsistency here as the monitoring advice (which is very pragmatic and sensible) describes the monitoring that should occur if you've exceeded the BNF dose of a drug – in a manner that anticipates that this WILL happen. But this wasn't part of the recommended options. Therefore if you are anticipating this to be the case please at least describe for which drug. As exceeding the BNF limit suggests that your steps described (1.4.40, 41, 42, 43) were insufficient.	Thank you for your comment Recommendation 1.4.45 advises more frequent monitoring (every 15 minutes) if the BNF limit is exceeded . This recommendation is made in acknowledgement of the fact that exceeding BNF limit increases the risk of harm. Recommendation 1.3.10 deals with the issue of intentional exceeding of BNF doses, which should only occur in defined circumstances and carried out under the direction of a senior doctor.
College of Mental Health Pharmacy	25	NICE	40	0	This states that vital signs should be monitored "at least hourly" after RT. "At least" will get lost and it will be interpreted as "hourly", which would miss the point that peak plasma levels after IM medication occur much sooner than at 1hour, and if you only check at 1hour you may miss something that you really should have picked up. Therefore we suggest that it should be re-	Thank you for your comment. The GDG agreed that it should be kept as hourly. These are guidelines but should be tailored to the individual by the healthcare professional. We then continue to specify when checks should be done every 15mins.

					worded to monitoring “every 15 minutes for the first hour” because that way you will pick up an evolving clinical situation and may be able to act to prevent a serious deterioration. thereafter the monitoring frequency can decrease – as stated.	
College of Mental Health Pharmacy	26	NICE	41	0	(1.4.52, 3rd bullet point) “End the seclusion when rapid tranquillisation has taken effect”. Please amend to: “End the seclusion when rapid tranquillisation or other medication has a sufficient calming effect”.	The GDG thinks that the wording is clear as it stands. Recommendation 1.4.52 covers the use of rapid tranquilisation while a service user is secluded. Recommendation 1.4.49 requires that seclusion only lasts for the shortest time possible; this would include consideration of the calming effect of other medication.
College of Mental Health Pharmacy	27	NICE	41	0	(1.4.53 Title) Again needs a definition here for “incident”.	Thank you for your comment. A definition for ‘incident’ has been added to the start of this section.
College of Mental Health Pharmacy	28	NICE	51	0	I think this is too simplistic. People are aggressive/violent for all sorts of reasons and I doubt that any drug treatment would provide a Heineken effect. Research would be good of course but maybe restrict the question to those with obvious psychosis or those who have ingested substances or any other group (but a relatively narrowly defined one).	Thank you for your comment. We do not know enough about medication in the de-escalation phase of management, and this is very important as good treatment could prevent many episodes degenerating into overt violence. This is why we have included the research recommendation (see 3.1): ‘Which medication is effective in promoting de-escalation in people who are identified as likely to demonstrate significant violence?’
College of Mental Health Pharmacy	29	NICE	General	General	In all the instructions that this sets out, nowhere can I see the guidance to advice that giving medication parenterally should not be used as a threat or a coercion to patients. Or that oral medication is the preferred option that should be used whenever reasonable/possible. I think these points should be added.	Thank you. We agree it is important to ensure medication should not be used as a threat or as a coercion. We have added this to NICE recommendation 1.4.6. The GDG agree that the parenteral route for medication should only be considered if urgent sedation is required during an episode of violence or aggression when oral medication is neither possible nor appropriate. This is stated in the NICE guideline within the definition of rapid tranqulisation.
College of Mental Health	30	NICE	General	General	The very narrow recommendation of just 3	Thank you for your comment.

Pharmacy					drugs needs some careful rider added to acknowledge that at times other drugs may be needed, although are not preferred. For example there are frequently times of the past decade (including at the moment) when the only UK manufacturer of licensed lorazepam injection fails to provide stocks nationally. Therefore this leaves organisations with the only recommended option of haloperidol and promethazine – which will not be suitable for all. You need to acknowledge that at such times other less favourable products will need to be considered. It would be helpful to advise - for example – that due to the weight of evidence of efficacy in RT it is more preferable to source suitable (unlicensed) versions of lorazepam injections, rather than use alternative licensed products such as aripiprazole. If you do not issue some guidance then organisations will further vary in the (unwise) use of less suitable options. And the MHRA recommends that we should ALWAYS use licensed medicines over unlicensed ones. Therefore when lorazepam injection is unavailable we are officially advised that we should not use versions unlicensed in the UK. Therefore if a patient refuses an ECG prescribers are left considering aripiprazole and olanzapine IM.	The guidance does not exclude the use of other pharmacological treatments for rapid tranquilisation in situations where a risk benefit assessment for the individual service user indicates lorazepam or haloperidol/promethazine is not possible or appropriate. The general use of medication is covered in the introduction in the subsection on 'medicines.' The GDG felt there was insufficient evidence to make recommendations beyond what is already included, other than to advise that health care professionals should arrange an urgent team meeting to carry out a review and seek a second opinion if needed (see 1.4.43 in the NICE version of the guideline).
Cumbria Partnership NHS Foundation Trust	1	General	General	General	I've been exploring the violence guidance for a while now and I wanted to share my thoughts and consider how/if to feed these back. The full guidance document from section 2.8 onwards, make frequent reference to the use of data collected to develop a risk Formulation (a narrative, predictive tool which identified triggering factors etc. and supports prevention and prediction of violence as well as management). This is all to the good and well evidenced, however in the NICE version of the	Thank you for your comment. The section to which you refer is in the introductory chapter, the aim of which is to provide an overview of the topic and the current provision of services. While the GDG can see the value of developing a formulation in the long-term, the recommendations in the guideline are for short-term management of violence and aggression only. The development and refinement of a formulation would be undertaken during general assessment with a view to long-term

					guidance, which I presume is the one that average person reads, the references to formulation disappear and although it recommends the collection of a lot of information, it does not go on to explicitly note the use of formulation to use this information constructively, instead referring to amorphous 'skills'. I wonder if this might be an issue with the wording and content, since it is accepted best practice in structured clinical judgement of risk to develop risk formulations in order to effectively use the collected data and these skills are not explicit in the NICE version of the document.	management of the mental health problem.
Department of Health	1	Full	8	3	Do community settings include offices occupied by Community Mental Health teams which are frequented by service users who drop in and sometimes receive treatment? If so, are they expected to deal with violent incident or send for the police?	Thank you. The GDG has made the definitions of community settings clearer and has revised a recommendation to say that community mental health teams can consider use of breakaway techniques and de-escalation (see NICE recommendation 1.6.6).
Department of Health	2	Full	24	12	(Lines 12-14) It states that research literature can focus on consequences of staff. Is there no data collected nationally to show the harm or injury caused to service users such as that supplied to the NRS? It seems strange that we collect data on staff injuries but not on the people we look after.	Thank you for your comment. We have checked and there is no such data available.
Department of Health	3	Full	26	18	(Lines 18-41) It is unclear in this paragraph what student mental health nurses are taught re: the short term management of violence and aggression. Since V&A seem to be such a problem and MH nurses seem to deal with most of the incidents, it seems they require consistent quality training in this area. I presume they are not required or expected to aid in the de-escalation and management of violence before being fully	The specific training of student nurses and their preparation of clinical placements, coupled with what they can and cannot so whilst on those placements, are necessarily matters for detailed agreement between Trusts and their education providers. Clearly they are going to depend on the content of local policies and the aggression management training provided to qualified staff in the locality.

					trained to do so.	
Department of Health	4	Full	80	41	(Pages 80-81, Lines 41-42, 29, 37) Deals with PBS. It is an oversimplification of PBS more reflective of its precursor Applied Behaviour Analysis (ABA). It fails to acknowledge that when ABA morphed into PBS it became more person centred, with a primary aim of meeting needs and enhancing quality of life; it was heavily influenced by the social role valorisation theory and concept of social validity; and placed huge emphasis on co-production and long term life planning. PBS uses a system of care planning which calls for primary and secondary preventative strategies, as well as tertiary reactive strategies. Section 5.1.12 states 'It is only now being suggested as applicable to inpatient psychiatry via guidance from the English Department of Health (2014)'. PBS is eclectic – if someone is in pain it would legitimately involve giving pain relief; if someone hears voices it may mean giving them an antipsychotic, if someone has a phobia it might include systematic desensitisation and graded exposer. PBS is a very broad church, it is an orientation or philosophy of care which doesn't locate the problem within a person and which sees behaviour has been indicative of unmet needs and impoverished quality of life. The notion of person centeredness is not new in mental health but has probably been talked about for a decade. PBS seeks to integrate PBS with approaches which enable behaviour to be linked to unmet needs. Much of it would seem to have cross sector transferability. Of the more traditional ABA interventions which may still feature within PBS some have greater and some lesser applicability. We are therefore not advocating wholesale importation of PBS into MH services but calling for greater person	The summary for PBS as given in the guidance clearly indicates it includes many other elements besides Applied Behaviour Analysis, including 'environmental adjustment, skills training for patients, enriching patients quality of life'. The meaning of the term 'person centred' has a long history in psychiatry and is very broad, encompassing nearly every positive aspect of care. No clarity would be achieved by including it within this short summary paragraph. The degree of applicability of PBS to psychiatry is open to argument, and its efficacy within that setting and with those patients unproven

					centeredness, user and family engagement, structured preventative planning and a focus on using patterns of behaviour as a rich source of data by which to identify unmet needs.	
Department of Health	5	Full	95	41	(Pages 95-96, Lines 41-2, 1-3) Is it usual for NICE to quote ministers and shadow ministers – surely the comments should be deleted.	Thank you for your comment. These quotes have subsequently been removed.
Department of Health	6	Full	105	28	(Lines 28-31) Talks about all staff being trained in the risks associated in Restricted Interventions (RI). This should be specific to roles i.e. cleaner, receptionist, nurse, consultant should be with regard to those interventions used to any given member of staff. The range of risks should be specified for example risk of physical harm, psychological trauma, risk of loss of rights etc.	Thank you for your comment. The GDG agreed that all staff being trained in risks associated with restrictive interventions are important however NICE recommendations only specify particular staff roles in exceptional circumstances and the GDG did not think this warranted a change to usual practice.
Department of Health	7	Full	106	3	Psychiatric triage, psychiatric liaison service seen as essential in every emergency dept. This will have large cost implications, which need to be carefully considered.	Thank you for your comment. The GDG considered that the benefits (reduced levels of violence and aggression) and potential savings (through the reduction of repeat admissions) would be worth the cost of the service.
Department of Health	8	Full	108	4	(Lines 4-8) May need expanding for greater clarity about when Restrictive Interventions might amount to a Deprivation of Liberty. Also a DoL can be authorised by a court of protection order.	Thank you for your comment, but the current recommendation was checked by a lawyer and therefore the GDG feels that the wording is sufficient and clear that unless a service user is detained under the Mental Health Act 1983 or subject to a deprivation of liberty authorisation or order under the Mental Capacity Act 2005, no restrictive intervention should amount to a deprivation of liberty.
Department of Health	9	Full	110	20	(Lines 20-21) Refers to exploring the use of technology in reporting however accurate reporting is currently a problem that needs to be improved urgently with or without technology.	Thank you for your comment. The GDG agreed and has made further recommendations about improving reporting in recommendation in 1.2.5 and in recommendation 1.4.54
Department of Health	10	Full	114	20	(Lines 20-24) Again talks about staff training, but needs to be more specific to staff roles.	Thank you for your comment. The GDG felt it was down to local services and protocol to define staff roles.

Department of Health	11	Full	117	5	(Lines 5-7) Refer to psychiatric nurses, this should read mental health nurses.	Thank you for your comment, but the GDG prefers the term 'psychiatric nurse' because it feels it is the term likely to be most recognised by the field.
Department of Health	12	Full	117	19	(Lines 19-22) Given that ambulance service may be involved in transporting detained patients to hospitals, some may need training in manual restraint.	Thank you for your comment. In the NICE guideline the section on restrictive interventions (1.4) is also applicable to ambulance services. The GDG has now made this clearer in the document.
Department of Health	13	Full	167	7	States the requirement for a doc trained in the use of resuscitation equipment but does not mention that nurses should be equally trained in its use.	Thank you. Please see recommendation 1.4.4- the recommendation has been amended to say that all staff trained in immediate life support and a doctor trained to use the emergency equipment should be available to attend to the situation.
Department of Health	14	Full	170	1	(Lines 1-2) Is emergency equipment the same as resuscitation equipment? Why does it only state about doctors being trained in its use – why does it not mention nurses?	Thank you for your comment. Resuscitation equipment is the same as emergency equipment. The GDG felt strongly that restrictive interventions should not be used if there is not at the very least a staff member available who is trained in ILS and a doctor. The recommendation has been amended to say 'staff trained in ILS and a doctor trained in emergency equipment should be immediately available...', see NICE recommendation 1.4.4.
Department of Health	15	Full	170	20	(Lines 20-21) This paragraph is at odds with DH guidance Positive and Proactive Care.	Thank you for your comment. These guidelines are based on the NICE guideline groups' review of the evidence. In our view declaring a complete end to prone restraint, while potentially desirable, is premature and has not been shown to be safe or possible in all circumstances.
Department of Health	16	Full	171	9	(Lines 9-10) Refers to monitoring service users following restraint – shouldn't it state that physical vital signs should be monitored during the restraint?	Thank you for your comment, but monitoring vital signs during manual restraint is covered in recommendation 1.4.32.
Department of Health	17	Full	171	13	(Lines 13-17) Does not acknowledge for a small number of people with severe Learning Disabilities and	Thank you for your comment. The use of restraint in people with learning disabilities is covered in the NICE guideline, that is currently

					high frequency self-injurious behaviour. Mechanical restraint may be used on a long term basis e.g. arm splints, safety helmets (appreciating that the guidance doesn't cover people with LD, but presumably including those who have mental health problems).	in development, on challenging behaviour and learning disabilities: https://www.nice.org.uk/guidance/indevelopment/gid-cgwave0654
Department of Health	18	Full	173	30	(Lines 30-32) There may be exceptional times when community team members may need to undertake restraint pending the arrival of the police. There will likely be situations where they couldn't simply stand back.	Thank you for your comment. The recommendation has been revised to address your concerns.
Department of Health	19	Full	175	35	(Pages 175-6, lines 35-40) Talks about the service user experience monitoring unit of SU group, this needs greater clarity – it sounds like SUs reviewing incidents and having access that involves individual notes. I can't see how this is feasible in all settings.	Thank you for your comment. The GDG has clarified that the Service User Experience Monitoring Unit should have access to the service user's notes relating to the incident rather than their entire health record.
Department of Health	20	Full	201	22	(Lines 22-26) This indicates that for Children & Young People, seclusion should not be in a locked room and should only be in agreement with the Multi-Disciplinary Team (MDT) . In the Code of Practice we are clear that seclusion is not defined as such by a locked door. If seclusion is immediately necessary it will not be timely to include a MBT. In positive and proactive care we are clear that seclusion should be a response to an emergency and not a pre-planned response – as such not sure how the MDT recommendation could work.	Thank you for your comment. The recommendation has been amended to reflect at the earliest opportunity a MDT should review the decision.
Devon Partnership NHS Trust	1	Full	127	27	(Lines 27-32) The consultation refers to the fact that manufacturer of olanzapine IM discontinued the product in the UK and therefore the GDG would not be able to make recommendations for its use. Local Trust guidelines for rapid tranquillisation (	Thank you for your comment. The GDG stand by there decision to not specifically recommend IM olanzapine given the companies decision to stop the manufacture of the formulation for the UK market. Nevertheless, it should be noted that the recommendations do not preclude the use of IM olanzapine.

					where IM route is indicated) use olanzapine as antipsychotic of choice, with haloperidol reserved as a treatment option if preferred and / or clinical reason why olanzapine contra-indicated (pre-treatment ECG also required- therefore risk- benefit decision required where this is not available/ not possible to undertake because of the presentation of the individual). Whilst the company withdrew from actively marketing olanzapine in the UK, it still holds a European marketing authorisation (product licence), therefore is still licensed for use in the UK and is still available. Therefore as this product is still available, and clinically relevant to this guidance, it is requested that olanzapine IM is recognised as a treatment option in the updated NICE guidance.	
Devon Partnership NHS Trust	2	Full	171	31	(Lines 31-2) Please consider including olanzapine IM as a treatment option here. Considered preferable to using a combination of haloperidol and promethazine.	Thank you for this suggestion. As described in section 6.3.2, during the review process it became known that the manufacturer of IM olanzapine had discontinued the product in the UK and so the GDG chose not make recommendations for its use. However, it should be noted that the GDG did not make a recommendation against IM olanzapine.
Devon Partnership NHS Trust	3	Full	171	10	(Lines 10-11) Please consider including olanzapine IM as a treatment option here. Considered preferable to using a combination of haloperidol and promethazine.	Thank you for your comment. Olanzapine is not routinely available in the UK, but the guidance doesn't exclude the use of IM olanzapine as an option for rapid tranquilisation in situations where a risk benefit assessment for the individual service user indicates lorazepam or haloperidol/promethazine is not appropriate. In the full guideline p167 also covers this issue on a case by case basis. We have amended the wording of the guidance to highlight the need to document in the clinical record the basis for using an alternative treatment option - also refer to the addition of 'review' and to get a second opinion (see NICE

						recommendation 1.4.43).
Devon Partnership NHS Trust	4	Full	171	12	(Lines 12-13) Please consider including olanzapine IM as a treatment option here. Considered preferable to using a combination of haloperidol and promethazine.	Thank you for this suggestion. As described in section 6.3.2, during the review process it became known that the manufacturer of IM olanzapine had discontinued the product in the UK and so the GDG chose not make recommendations for its use. However, it should be noted that the GDG did not make a recommendation against IM olanzapine.
Devon Partnership NHS Trust	5	Full	171	14	(14-16) Please consider including olanzapine IM as a treatment option here. Considered preferable to using a combination of haloperidol and promethazine. Concerned that as olanzapine is firmly embedded into practice in many Trusts, in order to reflect evidence based practice (and highlight safety concerned, i.e. avoiding the administration of lorazepam and olanzapine at the same time) olanzapine needs to be referred to and included within these guidance for rapid tranquillisation.	Thank you for this suggestion. As described in section 6.3.2, during the review process it became known that the manufacturer of IM olanzapine had discontinued the product in the UK and so the GDG chose not make recommendations for its use. However, it should be noted that the GDG did not make a recommendation against IM olanzapine.
Devon Partnership NHS Trust	6	Full	172	17	(17-19) Concerns that this statement may have a negative impact on the timely administration of appropriate medication. For example, practice locally allows the clinician to prescribe up to 2 different medications for RT that may be administered up to three times. A doctor is not always present when RT is initially administered, and in cases where someone did not respond to initial dose of RT a Dr would generally be requested to review the individual, there may be cases where this could delay the administration of a second dose resulting in increased risk of harm to the individual and other patients & staff. Our Trust uses a separate prescription chart for RT which restricts the frequency of	Thank you for your detailed response. In the event of non-response to the initial use of rapid tranquillisation, the GDG considered that repeated doses of rapid tranquillisation should not be prescribed until the outcome of the initial dose was known as this should inform the subsequent prescribing and use of rapid tranquilisation.

					administration to 3 doses/ medication per 'episode' or RT. A new RT prescription is required for each episode of RT (this avoids RT medication being prescribed in the 'when required' section of prescription charts which previously resulted in repeated use for separate episodes without review as to whether treatment was still appropriate.  DPT Rapid Tranquillisation Prescr The prescription chart must be used with a Trust protocol for prescribing RT, this requires a period of 1 hour between doses (2 hours for olanzapine) prior to the administration of a second dose to ensure adequate time to observe response to treatment.	
Devon Partnership NHS Trust	7	Full	172	20	(Lines 20-29) Monitoring post RT	Thank you. It appears this comment is incomplete; we are therefore unable to respond.
Devon Partnership NHS Trust	8	Appendix 8	32	0	Unclear whether this is intended to be included in final document/ NICE guidance or whether this is just referring to medication included in this review. Clarity around certain medicines not being appropriate for RT needs to be highlighted (i.e. chlorpromazine IM, zuclopenthixol acetate)	Thank you for your comment. An introduction has been added to explain the reasoning behind this section.
Devon Partnership NHS Trust	9	NICE	19	0	(1.1.5) Full guidance refers to a "Doctor trained to use emergency equipment should be immediately available to attend an emergency if restrictive interventions might be used" It would be helpful to include guidance re. level of training that is reasonable to expect regarding medical emergencies on wards/ units where restrictive/ RT interventions are used (i.e. all clinical staff should be trained to resus council ILS standard)	Thank you for your comment. The GDG felt this recommendation as a general principle of care should not be changed however NICE recommendations 1.4.2 and 1.4.4 have been expanded to reflect the level of training required.

Devon Partnership NHS Trust	10	NICE	27	0	"A senior doctor should review medication used for rapid tranquillisation at least once a day." Is this statement / practice expectation achievable/ approipriate? Where RT is written up in advance IN CASE it is needed, it is appropriate for prescribed medication to be reviewed by a doctor if RT is required/ administered, but otherwise review at least once a week (and more frequently if indicated) would be considered sufficient. Maybe a distinction needs to be made between medication 'prescribed' and medication 'administered for RT rather than just stating 'medication used'	Thank you for your comment. The GDG considered this should be the minimum expectation. However, the recommendation has been revised to make it clear that this review takes place in the context of rapid tranquillisation being used
Devon Partnership NHS Trust	11	NICE	32	0	"define staff:patient ratios for each inpatient ward and the numbers of staff required to undertake restrictive interventions" As staff: patient ratios required in order to undertake restrictive interventions are likely be similar nationally (although may vary depending on security of unit), it would be helpful if NICE guidance could advise on what is considered to be a safe minimum staffing ratio.	Thank you for your comment. NICE is in the process of producing a series of safe staffing which cover staff:patient ratios, there will be one specifically on Inpatient mental health settings which will cover this.
Devon Partnership NHS Trust	12	NICE	33	0	Although this is 'guidance', it is requested that this GDG review this statement. "A doctor trained to use emergency equipment should be immediately available to attend an emergency if restrictive interventions might be used." It is suspected that this may be an impossible target to achieve- given the locality of some MH units- 'immediate availability' of a doctor may not be achievable. It would be helpful for the guidance to define 'immediately available', and also widen the statement to reflect that timely response to medical emergencies should be available if restrictive interventions used- but recognise that	Thank you for your comment. The GDG felt strongly that restrictive interventions should not be used if there is not at the very least a staff member available who is trained in ILS and a doctor. The recommendation has been amended to say 'staff trained in ILS or a doctor trained in emergency equipment should be immediately available...', see NICE recommendation 1.4.4.

					this might not always be provided by a doctor (e.g. could be provided by acute hospital crash team, paramedics via 999, and appropriately training clinicians- e.g trained nursing staff with ILS training. Due to the variation in MH Trusts, locality of units and delivery of services it would be helpful to have some more specific guidance regarding management of medical emergencies where restrictive interventions are used otherwise we are concerned that this will lead to variation in practice (and standards of emergency medical care provided).	
Devon Partnership NHS Trust	13	NICE	38	0	(Pages 38-40) Section on Rapid Tranquillisation: Please see comments referring to FULL guidance above	Thank you, all your comments have been considered and responded to.
Devon Partnership NHS Trust	14	NICE	38	0	It is a positive move in the updated guideline to define Rapid Tranquillisation as parenteral route only – this definition has been use in the Trust for many years and has proved highly beneficial in avoiding confusion and clearly defining the extra cautions/monitoring required when parenteral medication is used. It also provides clarity when monitoring the usage of such interventions across the Trust.	Thank you supporting the GDG definition of RT.
East London Foundation Trust	1	Full	40	0	(1.4.45) If the patient has an unknown physical health risk and or refuses to co-operate to receive monitoring of blood pressure, respiratory rate temperature, level of hydration; we would recommend a RAG rated observational checklist be completed every 15 minutes by a trained member of staff to ensure that the patient is being monitored even if it is by sight, with a view to escalating levels of care as per guidance.	Thank you for your comment, but the GDG could find no evidence for the use of such RAG rated checklists.
East London Foundation Trust	2	Full	40	0	(1.4.46) If a patient not detained under MHA (1983) is	Thank you for your comment and for bringing this to the attention of the GDG. The

					secluded in an emergency situation a Mental Health assessment should be arranged under MHA (1983) immediately.	recommendation has been amended accordingly.
East London Foundation Trust	3	Full	41	1.4.52	(1.4.52) Patients in seclusion following PRN or Rapid Tranquilisation should be specifically monitored for positive and negative effects on physical health for at least an hour of administration of the medication. The monitoring should include, respiration, hydration, posture, skin colour and feedback from the patient. When RT/PRN has taken effect this should not be the only indicator to terminate seclusion, this should lead to a review of seclusion immediately and consider other risk factors that have led to seclusion. When there are physical health concerns raised by the patient or the observing nurse seclusion should be reviewed immediately by the MDT and intervene appropriately or terminate seclusion.	Thank you for your comment. The recommendation has been revised to say that staff should follow the recommendations about rapid tranquillisation (which covers monitoring) in a preceding section and that a risk assessment should be undertaken before considering ending seclusion.
Ferrer Internacional	1	Full	General	General	From our perspective and in order to help potential readers we would like to comment the following: The new version of the guidelines on violence and aggression is based on two concepts, 1) prevention and risk factors (pre and immediately pre-event) and 2) the actual violence and aggression status (during and post-event). Following this structure it is logical to assume that the recommendations on the management of its situation (1 & 2) should be structured at the same level. In the part (2) on actual violence and aggression status (during and post-event), pharmacological management is extensively described. When structuring the part (1) on prevention and risk factors (pre and immediately pre-event), in this section	Thank you for raising this issue. The GDG thought carefully when developing the review questions and concluded that only one question about medication was relevant in the context of prevention (see Table 17, question number 3.6): *Does p.r.n. (pro re nata) medication used to prevent imminent violent and aggressive behaviour by mental health service users in health and community care settings produce benefits that outweigh possible harms when compared to an alternative management strategy?* Based on this review, two recommendations were made (5.7.1.27 and 5.7.1.28).

					management, pharmacological management should be described as in this part as well. Following the part on “Pre-violence and aggression (agitation studies)” and the part “During and after the event (violence/aggression studies)”, both parts would contain a description of pharmacological treatment as well as non-pharmacological interventions. For this purpose, our proposal would be to add an extra table in section 5.6.1 All settings (page 104, line 2) by adding an additional paragraph 5.6.2 which includes a systematic review of the studies on pharmacological management evaluating “agitation” “pre and immediately pre-violence”. Suggested references to be included in the systematic review are enclosed in “our” Annex 1, as well as the indirect analysis between intramuscular (IM) antipsychotics and other formulations (See the EMA CHMP assessment report on inhaled loxapine Available at: http://www.ema.europa.eu/docs/en_GB/document_library/EPAR_-_Public_assessment_report/human/002400/WC500139407.pdf).	We do not believe that adding the review you suggest would be appropriate at this stage of development. The indirect analysis you cite does not appear to follow accepted methods for combining direct and indirect comparisons, and therefore it would not be appropriate to include as evidence.
Ferrer Internacional	2	Full	16	9	For clarification, a suggestion is to add more detail regarding the levels of agitation/violence in this paragraph regarding the definition of violence and aggression. The suggested text to be included in this paragraph is the same as already stated in chapter 5.1 page 79 - Full version of the guideline. The suggested text would be: For the purpose of this guideline, pre- and immediately pre-event is referring to restlessness, escalating to agitation and irritability, through verbal aggression, gestures, threats, damage to objects in the surrounding area and culminating	Thank you for your comment. It is not clear what would be gained by expanding the definition at this point. The provided definition is already broad enough to capture the contents of the proposed extra text.

					in an assault that can escalates into violence or aggression behaviour.	
Ferrer Internacional	3	Full	110	26	Regarding the individualized pharmacological strategy to reduce the risk of violence and aggression, a suggestion is to include more specific recommendations on the pharmacological strategy to reduce the risk of violence and aggression, taking into accounts the review of the studies specifically on "agitation". In the full guideline data is presented on the Cmax and the time to effect of the available pharmacological treatment options that provide evidence on its rapid onset of action. The data, at current is included in appendix 1.8, though due to the importance of the data on the rapid onset of action of the pharmacological treatments, our recommendation is that the data also should be included in paragraph 5.7.1.16. See the suggestion in "our" Annex 2, containing a table with data on peak plasma levels for the different medication and the time of effect.	Thank you for your comment. The GDG considered this issue and decided it is not necessary to include the information from the appendix within 5.7.1.16. As described in the in the introduction to the NICE version of the guideline, 'The guideline will assume that prescribers will use a medicine's summary of product characteristics to inform decisions made with individual service users.'
Ferrer Internacional	4	Full	134	0	*(Pages 134-40, Tables 39-44)* In tables 39 until 44, in the description of the outcomes the reduction of basal PANSS-EC (PEC) scores 2h after administration has not been evaluated as a relevant critical outcome. On the other hand in the objectives of the guideline though it is clearly stated that "The time scale of the evaluation of these interventions has to be a relatively short one" (page 125, line 38). Besides, the guideline defines that "the occurrence of a violent incident is generally the culmination of a gradually escalating behaviour pattern, starting with restlessness, escalating to agitation and irritability, through verbal aggression, gestures, threats, damage to	Thank you raising this issue. The GDG did examine change in behaviour as measured by a scale (see Appendix 15b). However, regarding inhaled loxapine, the GDG considered that a comparison with only placebo made it difficult to establish the value of this medication for the management of short-term violence and aggression, regardless of the outcomes examined. For the purposes of Section 6.5.1, the GDG decided to remove the text about inhaled loxapine and say 'There was insufficient evidence to make a judgement about the use relative risk/benefits of other antipsychotic drugs.'

					objects in the surrounding area and culminating in an assault" (Full, page 79, line 4). In this context, a preventive pharmacological strategy directed "to calm, relax, tranquillise or sedate service users" (Full, page 110, line 30) is recommended as well as a rapid tranquillisation during an event directed to "calm/lightly sedate the service user, ..., and achieve an optimal reduction in agitation and aggression" (Full, page 123, line 2, Table 30). For this purpose, it is important that the European Medicines Agency considers that "Treating patients during the first few hours of agitation is most important in emergency and critical care situations" (Abilify EPAR, Scientific Discussion, EMEA/H/C/000471/II/0015, London, 04 October 2006), and should be considered as "the standard in this field of antipsychotics used for the treatment of agitation in patients with schizophrenia or bipolar I disorder" to evaluate as "primary efficacy measure the mean change from baseline to 2 hours post first intramuscular injection in PEC Score" . Former text provides important evidence to evaluate PEC Score as a critical outcome for the pharmacological treatments evaluated in table 39 to 44. Reassessing the clinical studies included in this guideline, and in specific those related to intramuscular haloperidol, taking into consideration the onset of effects and setting as the main critical outcome of effects 2 h after dosing is recommended.	
Ferrer Internacional	5	Full	140	0	*(Table 44)* Regarding table 44 (Summary of study characteristics for trials comparing inhaled loxapine with placebo) a few suggestions for corrections and inclusion of additional data are recommended.	Thank you for providing this information. We have corrected the errors. Regarding outcomes, two of the published papers did not provide sufficient information for PANSS-EC scores to be entered into the meta-

					Consent gained? In the guideline it is stated that consent gained in the study of Allen (3) is unclear, which is not correct. When reviewing the study of Allen (3) at page 53 in the last paragraph of the publication it says “The study was conducted in compliance with institutional review board requirements, informed consent regulations and the International Conference on Harmonization Good Clinical Practice Guidelines. All participants provided written informed consent.” (See “our” Annex 1 for the full reference of the study of Allen (3)) Outcomes As explained in comment 4 on tables 39-44, it is suggested to add evidence related to the outcome used in other studies on PANSS-EC (PEC) scores 2 hours after administration. In specific for inhaled loxapine the efficacy outcomes extracted from the inhaled loxapine versus placebo studies are very limited, as they include only three different assessments derived presumably for Clinical Global Impression (“Global impression – no improvement”, “Global impression – need for additional medication”, “Global impression – mild to marked agitation”). The main endpoint of inhaled loxapine versus placebo studies was the reduction of basal PANSS-EC (PEC) scores 2 h after administration. Moreover, all three studies showed a very rapid onset of effect for active treatment, which has not been reflected as relevant “critical outcome”. In view of this, our recommendation is to include the primary endpoint results. PANSS-EC (2,3) significantly reduced agitation compared to placebo in patients with schizophrenia and bipolar disorder 10 minutes after dosing. Additionally, as the clinical global impression – improvement (CGI-I) at 2 hours post-dose was the key secondary endpoint and shows clinical	analysis. Given that the GDG felt that a comparison with placebo provided insufficient information to make a recommendation, including the PANSS-EC would not help the GDG reach a decision about the balance between risks and benefits in this context

					relevance, our recommendation is to use these data in place of the global impression data. CGI-I 2 h post-dose (2) – statistically significant decreases in agitation compared with placebo in patients with bipolar disorder were observed (See Kwentus 2012, p.35, 37). (3) CGI-I 2 h post-dose – statistically significant decreases in agitation compared with placebo in patients with schizophrenia (See Lesem 2011, p.55-56) The note at the foot of the table "IM = Intramuscular injection" is not correct and it is suggested to delete the text.	
Ferrer Internacional	6	Full	154	0	*(Pages 154-5, table 54)* In table 54 at the row "Global outcome: Not improved – vs loxapine" and at the row "Adverse effects: 1. General (loxapine) – one or more adverse effect," it is important to clarify that this concerns intramuscular (IM) loxapine, as no mention has been made as to the formulation.	Thank you, this has been amended.
Ferrer Internacional	7	Full	155	1	Please consider changes to the document with respect to introducing pharmacological management in the chapter on prevention and risk factors (pre and immediately pre-event) apart from during an event. Our suggestion would be that the studies on inhaled loxapine in paragraph 6.3.4 (during an event) could be added in an additional table after table 54.This could be table "table 54b" whose proposed title could be "Summary of findings table for intramuscular (IM) or other formulations antipsychotics vs placebo for rapid tranquilisation in agitation" . The purpose of this table would be to summarize the findings of clinical studies for rapid tranquilization regarding just agitation. In this new table (54b), we would also recommend to include the summary of findings of clinical evidence for all	Thank you for making this suggestion. We've considered this, but as described earlier, the GDG felt it was difficult to reach any conclusion about the benefit of using inhaled loxapine given that it has only been compared to placebo.

					formulations of the available drugs, including inhaled loxapine for the management of agitation. For the inclusion of studies in this suggested table on the summary of evidence for rapid tranquilisation in agitation (table 54b) we suggest to refer to the studies included in paragraph 2.5.6.2 of EMA CHMP assessment report on inhaled loxapine, tables 26, 27, 28 and 29 on p. 58-60. (See EMA CHMP assessment report on inhaled loxapine Available at: http://www.ema.europa.eu/docs/en_GB/document_library/EPAR_-_Public_assessment_report/human/002400/WC500139407.pdf).	
Ferrer Internacional	8	Full	165	5	In line 5 it is stated that “There was insufficient evidence to make a judgement about the use of other antipsychotic drugs including inhaled loxapine.” In view of the evidence available and as mentioned in comment 4, the reduction of basal PANSS-EC (PEC) scores at different time points and 2h after administration has not been evaluated here as a relevant critical and clinically meaningful outcome for inhaled loxapine. , The desired outcome is to have the time to a successful intervention be a relatively short one. Importantly, relevant to a desired outcome, inhaled loxapine is able to control agitation in 10 minutes). As this evidence on inhaled loxapine was not included as a critical and clinically meaningful outcome, our suggestion is to include this information regarding the time to effect for control of aggression, patient calming and rapid tranquilisation, as in recommended text in Table 44). As a consequence we would also suggest removing this phrase “There was insufficient evidence to make a judgement about the use of	Thank you for your comment. The reference to the lack of evidence was in relation to the lack of evidence comparing loxapine to other forms of rapid tranquilisation. We have removed the specific reference to inhaled loxapine p165 line 5 to avoid ambiguity. This now reads There was insufficient evidence to make a judgement about the relative risk/benefits of other antipsychotic drugs.

					other antipsychotic drugs including inhaled loxapine." Alternatively, if the phrase is kept please do not refer to inhaled loxapine in specific due to available evidence proposed in comment 4 and related to the benefit of the rapid onset of action that inhaled loxapine provides.	
Ferrer Internacional	9	Full	33	0	*(Full and appendix 8; table "Other medication included in review")* In the table "Other medication included in review" in the row "loxapine inhaled" it is included that it concerns "ADASUVE 4.5 mg inhalation powder" while the authorised presentations for Adasuve in the EU are Adasuve 4.5 mg and 9.1 mg inhalation powder.	Thank you, we decided to remove the dose as this was not consistent with other medication included in the Appendix 8.
Ferrer Internacional	10	Full	49	0	*(Full and appendix 14; table 1.2.1.15, row "Global impression: 2. non-response (CGI-I) – 10 mg",)* There is an error in the number of patients presented in the table; the number of patients with inhaled loxapine should be 79/257 instead of 79/256.	Thank you, this has been corrected.
Ferrer Internacional	11	Full	77	0	(Full and appendix 15b; table "15.2.2 10 mg", row "Kwentus 2012 [M]") There is an error in in the numbers in the figure; the number of events/total should be 27/105 instead of 27/104.	Thank you, this has been corrected.
Ferrer Internacional	12	NICE	17	0	(Section: "Terms used in this guideline") Our suggestion is to include the definition of agitation in "Terms used in this guideline". Our recommended definition of agitation is based on references from published literature (see Annex 3 for full references). Agitation: Agitation is defined as a syndrome of behaviours, such as verbal aggression, physical aggression, purposeless motor behaviours, heightened arousal and disruption of patient functioning (Allen et al. 2005). The time course for agitation escalation can be minutes (Buckley	Thank you for your comment and suggestion. However the GDG chose not to include a definition of agitation because other signs and symptoms are not defined (for example, irritation, anxiety etc) – it was felt that such terms would be understood by the intended audience and their definition is not specific to this guideline.

					1999; Lesem at el. 2011). Agitation can then progress and escalate to an outwardly apparent dysfunctional state manifested by cursing, hostility, difficulty controlling impulses, with uncooperative behaviour and increased potential for violence. When agitation becomes severe it may lead to behavioural dyscontrol where the threat of self-harm or assaultiveness to others become immediate treatment concerns (Battaglia 2005; Mendelowitz 2002).	
Ferrer Internacional	13	NICE	26	0	When describing the individualised pharmacological strategy for using routine and p.r.n. medication to calm, relax, tranquillise or sedate service users who are at risk of violence and aggression as soon as possible after admission to an inpatient unit, our suggestion is to include the following requirements in choosing medication, according to the Expert Consensus Guidelines for Treatment of Behavioural Emergencies by Allen et al.(2001), for an anti-agitation pharmacological treatment: 1) speed of onset, 2) control of aggressive behaviour, 3) patient preference, 4) long-term physician-patient relationship and 5) medication reliability of delivery. Reference: Allen, M.H., Currier, G.W., Hughes, D.H., Reyes-Harde, M., Docherty, J.P. The Expert Consensus Guideline Series. Treatment of behavioral emergencies. Postgrad.Med., 2001; (Spec No) 1-88. Additionally, some recent literature identifies specific guidelines for medication use that may be relevant as well, for example: the use of medication as a restraint should be discouraged; non-pharmacologic approaches, such as verbal de-escalation should be attempted if possible; medication should be used to calm, not to induce sleep; patients should be involved in the process of selecting	Thank you for your comment. The GDG do not feel it necessary to list the factors that should be considered by the multidisciplinary team when developing an individualised pharmacological strategy. Therefore, it is not necessary to cite the consensus guideline you suggested. The GDG approach is covered in Section 1.2.14 (Nice) / 5.7.1.16 (Full). This section highlights the need to include a specialist pharmacist and a psychiatrist within the multidisciplinary team. This should ensure appropriate consideration is made of all the relevant factors that would be needed to individualise the pharmacological strategy in line with our guidance. This would include consideration of the pharmacokinetic properties of the pharmacological agent and the use of appropriate formulations of the medicine where appropriate.

					medications to whatever extent possible; if the patient is able to cooperate with oral medication, these are preferred over IM preparations. See Reference: Wilson, M.P., Pepper, D., Currier, G.W., Holloman, G.H., Feifel, D. The Psychophmacology of Agitation: Consensus Statement of the American Association for Emergency Psychiatry Project BETA Psychopharmacology Workgroup. West J Emerg Med. 2012; 13(1):26-34. (See pages 29-30.)	
Ferrer Internacional	14	NICE	30	0	(Section: “1.3.10”) In accordance with our suggestions for the full guideline, our recommendation would be to add information regarding the use of pharmacological treatments and the importance of the characteristics of these treatments to the short version of the guideline. Our recommendation is to include the following consideration within the guideline when it comes to pharmacological treatment: “When choosing the pharmacological option to intercept the escalation of the behaviour as soon as possible, the pharmacokinetics and pharmacodynamics characteristics of the medication as well as considering patient preferences for non-invsaive routes of administration should be taken into account.” In specific we would recommend to implement the following suggestion in the paragraph on “Using p.r.n. medication (page 30)” as an extra bullet under “When prescribing p.r.n. medication to prevent violence and aggression”.	Thank you for your comment. The GDG do not feel it would be necessary to list the factors that should be considered by the multidisciplinary team when developing an individualised pharmacological strategy in Section 1.2.14 (nice) / 5.7.1.16 (Full). This section highlights the need to include a specialist pharmacist and a psychiatrist within the multidisciplinary team. This should ensure appropriate consideration is made of all the relevant factors that would be needed to individualise the pharmacological strategy in line with our guidance. This would include consideration of the pharmacokinetic properties of the pharmacological agent and the use of appropriate formulations of the medicine where appropriate.
Ferrer Internacional	15	NICE	38	0	(Section: “Rapid tranquillisation”) In the paragraph “Rapid tranquilisation” in the phrase “Rapid tranquilisation in this guideline refers to the use of medication by the parenteral route (usually intramuscular or, exceptionally, intravenous) if oral pharmacotherapy is not	Thank you for your comment. Although medication by inhalation was included in the review, the GDG do not believe the description of RT needs changing at this time.

					possible or appropriate and urgent sedation with medication is needed." Inhaled loxapine is missing as an administration route. In view of the evidence available and clinical features of inhaled loxpaine we suggest to modify the sentence as follows: "Rapid tranquilisation in this guideline refers to the use of medication by inhalation (inhaled loxapine) when urgent calming and control of aggression is desired or by the parenteral route (usually intramuscular or, exceptionally, intravenous) if oral pharmacotherapy or inhalation is not possible or appropriate. "	
Ferrer Internacional	16	General	General	General	Annex 1-3 attached:	Thank you.
Hampshire Constabulary	1	Full	164	37	This goes against all recent Police guidance and direction, including a number of inquests as well as the Adebowale report. Police are only trained in pain compliance. It is not the role of the Police to manage mentally unwell people in their own homes or in a community health care setting. There is also no power in law to enable Police to do this. It is the policy of Hampshire Constabulary that we would therefore decline any such request to attend unless life is immediately at risk. In the setting of a health care provider, HSE have provided clear written guidance that it is the responsibility of the "home" to anticipate any foreseeable eventuality and have sufficient trained staff available to manage it. That cannot be the Police service as we are not trained or legally equipped to do so, and would decline to attend	Thank you for your comment. This section of the guideline has been amended in accordance with a change to the corresponding recommendation (NICE 1.6.6) which now says that the police should only be contacted if there is immediate risk to life.
Hampshire Constabulary	2	Full	167	9	Police officers are ONLY trained in pain compliance techniques. We are not the appropriate service to restrain those who are mentally unwell.	Thank you for your comment. Police techniques are used to gain control; line 9 refers to the use of restraint by NHS staff to inflict pain or to punish as the reason for the use of the restraint. With police techniques, the pain is caused via the non-compliance, and as per the ACPO

						Personal Safety Training manual pain and compliance are not the only restraint techniques taught.
Hampshire Constabulary	3	Full	167	22	As above, the Police are neither trained, legally empowered nor responsible for these incidents. We would decline any such request for restraint and would not attend unless life was immediately at risk.	Thank you for your comment. The GDG agree with you with regards to restraint in relation to medical intervention but again the GDG were discussing 'spontaneous' violence and that rather than try and restrain a violence person themselves they should call the police. The recommendation has been amended to reflect that staff should call the police if there is immediate risk to life(see NICE recommendation 1.6.6)..
Hampshire Constabulary	4	Full	167	25	The only other option that Police have apart from pain compliant restraint, is the use of mechanical restraint in the form of handcuffs and Velcro limb restraints. In addition, the handcuffs that we use also in themselves rely on pain compliance both in the initial application as well as ongoing throughout the entire period that they are applied.	Thank you for your comment. The use of mechanical restraint and type of mechanical restraint are different. Any police attending would have to justify their use of force as necessary and proportionate to the situation they face, and the use of such force would be regularly reviewed as per the national decision making model that police use. As for handcuffs, they are only be used where someone is violent or potentially violent, an escaper or potential escaper and do not necessarily inflict pain throughout the entire period they are applied.
Hampshire Constabulary	5	Full	173	30	As above. Police will not attend to restrain a mental health patient unless life is immediately at risk.	Thank you for your comment. This section of the guideline has been amended in accordance with a change to the corresponding recommendation, which now says that the police should only be contacted if there is immediate risk to life.
Lancashire Care NHS Foundation Trust	1	General	General	General	LCFT agree with the contents and have no further comments.	Thank you.
London Metropolitan Police & Association of Chief Police Officers *(joint submission)*	1	Full	16	9	Could this paragraph be put in bold so those that need to quickly understand the definition know which part of 2.2 to look at. *I would suggest this for all sections as the academic research although interesting is time consuming to read and in some cases not relevant as it is*	Thank you for your comment. The paragraph which you asked to be placed in bold which defines violence and aggression has been moved to the front of the section 2.2 making it much easier to identify. Please see the first paragraph of section 2.2 on p 16 of the full

					out of date from what the summary or definition for this document follow.	guideline. We try to make the full guideline as reader friendly as possible but the purpose of this document is to present the evidence within the context of the subject area. The table of contents displays the headings quite nicely so you should be able to jump to a relevant section quite easily. In the NICE guideline please see Section 1, 'terms used in this guideline' which defines violence and aggression at the forefront of the recommendations.
London Metropolitan Police & Association of Chief Police Officers *(joint submission)*	2	Full	23	4	There is no mention of reporting to police. As we know majority of patients have capacity and therefore should be appropriately dealt with through the criminal justice process.	Thank you for your comment. This section of the introduction to the full guideline is to set the personal consequences of violence and aggression for the individual and for others. The GDG have discussed the role of the police in the prediction and management of violence (pre, during and post event) please see chapters 4, 5 and 6 of the full guideline for more information.
London Metropolitan Police & Association of Chief Police Officers *(joint submission)*	3	Full	26	16	The issue of police being called onto Mental Health wards to restrain patients where staff have lost control, is currently under review by the National Mental Health Policing Lead and College of Policing. The review hopes to identify and clearly specify the circumstances and role of agencies involved, e.g. should police officers restrain whilst tranquilisation is administered? (especially when compared to comments in para 5.7.1.38 on page 114).	Thank you for the information provided.
London Metropolitan Police & Association of Chief Police Officers *(joint submission)*	4	Full	27	22	After the words 'some settings' the words 'and misused and overused in others' should be added. Many health environments inappropriately call for police, this is recognised in the Mental Health Crisis Care Concordat.	Thank you for your comment. The addition of the proposed words would make the sentence difficult to understand. Whether or not the Police are over or under utilised on such occasions is a matter open to further study. We are unaware of any evidence that substantiates either position.
London Metropolitan Police & Association of Chief Police Officers *(joint*	5	Full	30	36	Is that reported incidents internally or reported incidents to police?	Thank you for your comment. The figures reported refer to incidents reported centrally by contractors as part of the standard NHS

submission)						contract. Every incident will not necessarily be reported to the police.
London Metropolitan Police & Association of Chief Police Officers (joint submission)	6	Full	108	10	This training needs to also include an understanding of other agencies powers under these acts. Police are often asked to do things by health professionals which they have no power to do.	Thank you for your comment. The GDG agree with your comment and this is the reason why a multi-agency approach is so appropriate.
London Metropolitan Police & Association of Chief Police Officers *(joint submission)*	7	Full	119	13	Consider adding; Where police are called to render assistance, it is advised that a post-event joint review takes place to understand and maximise opportunity for learning and reducing risk in future incidents.	Thank you this has been added.
London Metropolitan Police & Association of Chief Police Officers (joint submission)	8	Full	169	4	There is barely any mention of police and the involvement they have in incidents of violence and aggression, yet the first recommendation is about working with police. As previously stated, the role and actions of police are currently under review.	Thank you for your comment. This is an acknowledgement of the fact that this guideline is for the NHS but is one where a multi-agency approach is necessary in all aspects as per the 'Mental Health Crisis Care Concordat'.
Mind	1	General	General	General	We welcome this draft guideline, in particular its emphasis on service users' rights, framework for anticipating and reducing violence, and its recommendation for a service user experience monitoring unit or similar.	Thank you for your comment
Mind	2	General	General	General	Title – we are concerned about the impression the title could give that violence and aggression are intrinsic to the person, and to mental health problems, and that the guideline is solely about management and not also prevention. We hope to provide alternatives in the near future if these can be considered.	Thank you for your comment. We believe that the title accurately reflects the scope of the work and does not imply that violence and aggression are intrinsic to people with mental health problems. For example, the title deliberately expands beyond the mental health area to specify '… mental health, health and community settings'. Throughout, prevention is considered as a core component of overall management.
Mind	3	General	General	General	The concepts in the title of NHS Protect's guidance *Meeting needs and reducing distress* could usefully be incorporated into the guideline.	Thank you, the GDG believes that the concepts are already incorporated into the guideline. For example, in the NICE version of the guideline, the GDG were careful to set out principles for improving service user experience and

						involving services users in decision making (see section 1.1).
Mind	4	Full	12	19	(Line 19-27) The way the aims are framed implies that violence and aggression are intrinsic or attached to the person and are a condition to be treated. We think the aims should more closely align with what is actually expressed in the guideline, and recognise the influence of ward culture and environment, the importance of preventing and reducing violence and responding in ways that promote calm, dignity and safety for all concerned.	Thank you for your comment. The language of the aims in section 1.2.3 of the full guideline has been amended to not convey the impression that violence and aggression are innate, and to highlight that prevention is an important part of the guideline.
Mind	5	NICE	25	0	(1.2.10 and elsewhere) We welcome the way that the guideline emphasises at various points person-centredness and the involvement of the person in their own care planning and other decisions (eg 1.3.16). However this could go further in terms of risk assessment which we recommend framing in terms of a collaborative approach (where possible) to personal safety planning in which responsibility is shared. Please see Boardman, J and Roberts G (2014), Risk, safety and recovery. Centre for Mental Health and Mental Health Network, NHS Confederation (http://www.imroc.org/wp-content/uploads/ImROC-Briefing-Risk-Safety-and-Recovery.pdf).	Thank you for your comment. The GDG have considered your comment but felt the recommendations go a long way to emphasise a person-centred approach and ensuring the individual is at the heart of all considerations, this list is not exhaustive but for example please see NICE recommendations 1.1.6, 1.1.7, 1.1.8, 1.2.1, 1.2.15. The briefing paper you cite would not meet criteria to be included as evidence in the guideline, as it is not based on a systematic review. However, we do believe that the recommendations are in line with person-centred safety planning advocated in the paper.
Mind	6	NICE	22	0	(1..2.1) In the light of comment 5 on collaboration, we recommend adding skills in collaborative care/recovery and safety planning to this list	Thank you for your comment. The GDG felt think this is covered in the first bullet point.
Mind	7	NICE	25	0	We welcome the point about the potential for cultural misinterpretations. Further to the point made, ie that practices/customs may be misinterpreted as aggressive, we would add that values and customs that are normal and	Thank you for your comment, but the GDG thinks that your point is adequately covered in the preceding bullet point about not making negative assumptions based on culture, religion or ethnicity.

					acceptable to one person may be unusual and unacceptable to another, thus potentially adding to tensions to be negotiated.	
Mind	8	NICE	37	0	We are concerned about the introduction of a time limit. While there could be a value in setting parameters, this is a blanket prescription and appears to be arbitrary. It could focus attention on the clock rather than the person and lead to the impression that staff 'have got 15 minutes'. In our campaign we heard of staff holding, releasing and holding a person again. Surely body position, the amount of force and other factors would affect the decision of how long to restrain someone and in some cases 15 minutes would be far too long (the Bennett Inquiry report recommended a maximum of three minutes in prone restraint).	Thank you for your comment. We are grateful you have brought this to our attention. The intention is to make sure that manual restraint is carried out for no longer than necessary, and the GDG felt that specifying a time limit would therefore be appropriate. Having received a number of comments about the time limit of 15 minutes, the GDG decided to change this to 10 minutes because restraining for longer 10 minutes is associated with much worse outcomes, including death(see NICE recommendation 1.4.29)..
Mind	9	NICE	37	0	A time limit would provide a prompt to considering rapid tranquillisation or seclusion, but it still appears to be arbitrary and too generalised for this context. On the face of the evidence we recommend not giving a time limit but setting out what the reasons would be for choosing rapid tranquillisation or seclusion in preference to continuing to restrain (eg balancing different safety concerns) and giving guidance to apply that reasoning to the situation. However, it would be helpful to know what the GDG's rationale was for these recommendations and it is difficult to make a judgement without it.	Thank you for your comment. We are grateful you have brought this to our attention. The intention is to make sure that manual restraint is carried out for no longer than necessary, and the GDG felt that specifying a time limit would therefore be appropriate. Having received a number of comments about the time limit of 15 minutes, the GDG decided to change this to 10 minutes because restraining for longer 10 minutes is associated with much worse outcomes, including death(see NICE recommendation 1.4.29)...
Mind	10	NICE	21	0	(1.2.1 and elsewhere) The sections on staff training are very welcome but we suggest adding a point about staff supervision. Clinical supervision and reflective practice are important ways to reinforce positive organisational culture and staff skills, and to support staff development and wellbeing.	Thank you for your comment. The GDG agrees that supervision is important, but it is not a topic that is specific to the topic of the management of violence and aggression.

Mind	11	NICE	23	0	We welcome this recommendation about the collection and use of data. We recognise that the guideline addresses reducing restrictive interventions across the board, but recommend adding a line about being alert to the risk of a reduction in one form of restrictive intervention leading to an increase in the use of another.	Thank you for your comment. The GDG agreed and this is implicit in other recommendations see NICE guideline, section 1.4.
Mind	12	NICE	52	0	We are concerned that this recommendation could be unethical and are not sure what would happen in the light of the results. Everyone has the right and should have the opportunity to make an advance statement about any aspect of their care and treatment; we would also want to see routine co-production of care plans and safety plans. It would be of interest to have a systematic evaluation of what happens when people do make advance statements but essentially this is about people's participation and involvement not an empirical treatment issue and we are not convinced that an RCT is an appropriate methodology.	Thank you for your comment. Our guideline group were very concerned to hear from our service users on the group that the opportunity to make advance statements about management of violence had been seldom offered or discussed, and they were core people in making these recommendations.
Mind	13	Full	26	0	(Lines 38-41) The guideline makes clear the lack of quality control in staff training and it would be helpful to have a recommendation from the GDG on this.	Thank you for your comment. It is beyond the remit of the scope to review staff training quality control.
National Adolescent Forensic Service	1	Full	General	General	These comments are submitted on behalf of the National Secure Forensic Mental Health Service for Young People (NSFMHSfYP). The service is commissioned by NHS England and provides medium secure mental health and learning disability beds for up to 97 young people nationally; the beds are based at six units provided by both NHS and non-NHS organisations. All the provider organisations have submitted comments in their own right; these comments are additional and represent the perspective across the service nationally.	Thank you.
National Adolescent	2	Full	General	General	The service endorses the overall approach of	Thank you for your comment. We hope to have

Forensic Service					the guidance, particularly in relation to person-centred care, reducing restrictive practices, and the importance of de-escalation and staff training. However, there are some general and specific concerns arising from the draft guidance.	addressed your concerns throughout this consultation table.
National Adolescent Forensic Service	3	Full	196	35	(Lines 35-9) We note the discussion regarding the potential prohibition of prone restraint for young people. Bearing in mind the very limited evidence base regarding the relative risks associated with different restraint positions (particularly prone restraint) for young people, on what basis could this be considered? Prone restraint is not the default position within NSFMHSfYP (it is avoided if at all possible, and ended as soon as possible in accordance with recommendation 1.4.24), but it is an integral part of the models used within all the units; all units are using recognised and comprehensive models for the management of violence and aggression, with accredited training etc. Additionally, some young people prefer to be restrained in the prone position if restraint is necessary (see comment 6 below).	Thank you for your comment. The GDG discussed this at length but did not agree; therefore no changes have been made.
National Adolescent Forensic Service	4	NICE	49	0	The use of Emergency Response Belts (a form of mechanical restraint) has been sanctioned by the commissioners for the NSFMHSfYP, and three of the units in the service have operational policies permitting their use for the reasons outlined below. All usage is monitored by the provider organisations, across the service nationally, and reported to the commissioners. Reasons for usage are; • Avoidance of prolonged restraints (including use of prone restraint) • Quicker and safer resolution of	Thank you for your comment. We have made the decision to state that mechanical restraint should not be used with children having given thought to the potential physical and / or psychological harm that the use of mechanical restraint may impose on the child. Furthermore we have considered public acceptability of applying mechanical restraint to children. We have however conceded there may be occasions were mechanical restraint can be justified and have said that children in high-secure settings who are there as a consequence of their behaviour and potential for harming themselves or offers mechanical

					incidents • Avoidance of third-party intervention (i.e. Police, who often use mechanical restraint in these situations anyway) • Safer management of critical escort situations (e.g to A &E departments for emergency treatment) • User preference -see comments below It should also be noted that there is no high secure provision for under-18s; it is only under very exceptional circumstances that they are admitted to the high secure estate. Therefore the medium secure NSFHMSfYP is the most secure provision available. We are also unsure how this aspect of the guidance is consistent with the draft guidance on managing challenging behaviour within LD settings, which also appears to sanction the use of mechanical restraint under certain circumstances – see quote below; 1.8.3 If a restrictive intervention is used as part of a reactive strategy, carry out a thorough risk assessment. Take into account: □ any physical health problems and physiological contraindications to the use of restrictive interventions, in particular manual and mechanical restraint □ any psychological risks associated with the intervention □ any known biomechanical risks, such as cardiovascular and musculoskeletal risks □ any sensory sensitivities, such as a high or low threshold for pain or touch.	restraint may be considered. Also we have said that mechanical restraint may be considered where children are being transported and there is a real risk of the child absconding and / or causing a serious traffic accident for example should they become violent in a vehicle. So having said mechanical restraint is not desirable caveats have been created and the use of mechanical restraint must comply with relevant legislation (Mental Health Act 1983) and be a multidisciplinary team decision where the use of mechanical restraint has been previously discussed and put into the care plan which should cover under what circumstances mechanical restraint might be considered, and clearly state the process of application, monitoring, and removal of the restraint at the earliest opportunity. Please see NICE recommendation 1.7.19 for the clarification of the above and clarifies this should only be carried out when a child or young person is being treated in adult high-secure settings.
National Adolescent Forensic Service	5	NICE	49	0	Mechanical restraint (usually handcuffs) is used by units within NSFMHSfYP in escort situations	Thank you for your comment, however the GDG felt strongly that the use of mechanical

					deemed high-risk, based on individualised risk assessment and care planning. This has significantly reduced the use of external agencies for escorts and improved continuity of care (often at critical times for the young person)	restraint in young people should be restricted to high secure settings and transfer between medium and high secure settings.
National Adolescent Forensic Service	6	NICE	19	0	(Pages 19, 20, 48; sections 1.1.6-8 and 1.7.7) Within the NSFMHSfYP service user views are taken into account as much as possible in care planning, including the prevention, de-escalation and management of critical incidents. This is done when incidents occur and also as part of the care planning process – advance statements. Some young people express a preference for prone rather than supine restraint, and also a preference for mechanical rather than physical restraint, as they experience less re-enactment of previous traumatic events under these circumstances.	Service users were included in the GDG, and there was considerable review of the involvement of service users. In particular advance statements/directives were reviewed (see table 18 in the full guideline), and in spite of insufficient evidence to reach a conclusion, the GDG agreed that it was good practice to involve service users in all decisions about their care, and advance decisions or statements about the use of restrictive interventions should be encouraged (as recommended in 1.1.7 and 1.1.8). These recommendations apply to young people unless otherwise stated.
National Adolescent Forensic Service	7	Full	183	0	(Pages183, 186, 189, 194; sections 7.3.2, 7.4.2, 7.5.2, 7.6.2; lines 12-17, 6-9, 34-38, 21-25) The eligible evidence base for risk factors, prediction and management in young people is extremely weak (a maximum of three out of 528 studies reviewed – none of which was in the UK). We are concerned that evidence relevant to practice with young people may have been excluded by the exclusion criteria used.	Thank you raising this issue. The GDG acknowledge that the evidence base is weak. However, relaxing the eligibility criteria and including even poorer quality evidence would only serve to further reduce the quality of the evidence, and would not help the GDG in making recommendations. Therefore, we believe the right approach has been used.
National Adolescent Forensic Service	8	Full	194	0	(Page 194, 7.7 and general) The weakness of the evidence base is acknowledged in the draft guidance, which makes recommendations based on expert opinion even more important. Bearing in mind the high proportion of restraints that occur in services for young people and services for learning disability (see attached audit from NHS Benchmarking and the audit data in the table below) – and therefore the need for more	Thank you for your comment. This is an evidence-based guideline that focuses on interventions rather than on who provides them. We have addressed the range of interventions and settings which overall were represented in the guideline development group. It is part of the guideline process to ensure the recommendations and the evidence is available to all stakeholders during consultation so that they may advise the guideline group further.

<table>
<tr><td></td><td></td><td></td><td></td><td></td><td>explicit and detailed guidance in these areas – there should have been greater representation from these areas on the GDG and greater attention to these areas in the guideline.

<table><tr><td colspan="2">NHS Benchmarking data August 2014</td></tr><tr><td>Total no of restraints – Adult Acute</td><td>1451</td></tr><tr><td>Total no of restraints – CAMHS</td><td>1411</td></tr><tr><td>Restraints per 10 beds – Adult Acute</td><td>2</td></tr><tr><td>Restraints per 10 beds – CAMHS</td><td>15</td></tr><tr><td>Restraints per 10 beds – Acute LD</td><td>14</td></tr></table></td><td>Lastly, out of 14 professional members on the guideline development group, there were 3 CAMH representatives so we do not agree with your comment. Also there are two NICE guidelines currently in development focusing on challenging behaviour and learning disabilities and learning disabilities with mental health problems.</td></tr>
<tr><td>National Adolescent Forensic Service</td><td>9</td><td>Full</td><td>General</td><td></td><td>A disproportionately high number of incidents within the NSFMHSfYP involve girls. This may parallel experiences in adult secure services that manage female patients. Bearing in mind the prevalence of incidents and the weakness of the evidence base regarding young people (and girls in particular) and learning disability the guidance should make further recommendations regarding future research in these areas.</td><td>Thank you for your comment. The GDG felt the detail of the research will define the subgroups which will need to be covered, this includes the girls. Please note there is a separate guidance in development which address specific considerations for people with learning disabilities.</td></tr>
<tr><td>National Adolescent Forensic Service</td><td>10</td><td>General</td><td>General</td><td>General</td><td>See attached document</td><td>Thank you.</td></tr>
<tr><td>National Association of Psychiatric Intensive Care and Low Secure Units</td><td>1</td><td>NICE</td><td>12</td><td>29</td><td>(Lines 29-30)
We have concerns about not prescribing as required medication routinely on admission. This could mean delays in patients receiving as required medications out of hours, which could lead to a dangerous escalation of agitation before an on call doctor was present to review the patient.
In addition, the on-call junior doctor will almost always be less experienced than the regular inpatient care team, and is less likely to know</td><td>Thank you for your comment. The GDG believe that a competent prescriber should be available to individualise the prescribing of prn medication in line with this recommendation. Recommendation 1.2.15 highlights the need for multidisciplinary involvement in the prescribing plan as soon as possible after admission to an inpatient unit</td></tr>
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					the patient and their care plan. Nursing staff should be trusted to give as required medication only when it is required, and not prescribing routine as required medication suggests their judgement needs limiting in a way that ultimately is more likely to introduce risk to patient care.	
National Association of Psychiatric Intensive Care and Low Secure Units	2	NICE	14	10	(Page 14 Line 10 & page 15 line 6) We have concerns about the concept of organising external post incident reviews. The guidance is not clear as to which restrictive interventions should be subject to these. If all incidents that use a restrictive intervention are subject to it (e.g. including observations) then the practicalities of arranging an external post incident review, especially led by a service user, involving staff from another unit, and that also gets together all the staff involved in the incident would be likely to be impractical to arrange in real world practice.	Thank you for your comment. The GDG has added a definition for incident to clarify that this would not include use of observation. The GDG accepts that this recommendation will take some resources and effort to implement but it is very likely that in doing so there should be reduction in the use of restrictive interventions and the beginning of a much more coherent understanding between service users and staff.
National Association of Psychiatric Intensive Care and Low Secure Units	3	NICE	18	General	We have concerns that the term rapid tranquilisation should also be included in this list of definitions.	Thank you for your comment. Please see the NICE guideline, Section 1 'terms used in this guideline' for a definition of rapid tranquilisation.
National Association of Psychiatric Intensive Care and Low Secure Units	4	NICE	20	12	(Lines 12-15) We have concerns about the clarity of statement in this section. Engaging in a lengthy discussion about the side effect profile of a medication is often impractical in a situation involving rapid tranquilisation. Instead something should be stated here about keeping service users informed of what parenteral medication they are to be given prior to it's administration, and that oral medication should always be offered as an alternative first.	Thank you for your comment. Situations where service users are unwilling or unable to participate in decisions about their care is covered in recommendation 1.1.6. We have amended this recommendation to make it clearer that this includes medication (treatment). We have also amended recommendation 1.1.8 to read 'main side-effect profiles'.
National Association of Psychiatric Intensive Care and Low Secure Units	5	NICE	30	General	We have concerns that the section discussing prn medication comes before the section discussing de-escalation in the guidance. Should de-escalation not come first, as it should in clinical practice?	Thank you for your comment, but the GDG feels that the sections are in the right order. P.r.n would be ideally discussed before situations became violent, whereas de-escalation would be used once a situation

					Perhaps more emphasis in general should be given to de-escalation and even distraction or occupation prior to the need for de-escalation throughout the entire document?	threatened to become violent. The GDG also judges that the emphasis given to de-escalation is sufficient.
National Association of Psychiatric Intensive Care and Low Secure Units	6	NICE	39	General	We have concerns about the very limited number of pharmacological agents mentioned in this guidance. There is no mention of IM olanzapine or aripiprazole for example, which may be suitable alone when sedation is not required, but rapid 'neuroleptisation' is. In addition, undertaking ECGs or other physical health investigations is not always practical or possible when managing very agitated service users. Can wording be altered to suggest recommendation rather than absolute statements on these issues? 'Where possible' or 'When practical' might be considered regarding ECGs for example. Sometimes the risks of omitting medication may outweigh the risks of giving medication without having first undertaken full physical health assessments, and these realities need to be clearly acknowledged within the guidance.	Thank you for your comment. The guidance doesn't specifically exclude the use of other options for rapid tranquilisation in situations where a risk benefit assessment for the individual service user indicates lorazepam or haloperidol/promethazine is not appropriate . Section 6.5 in the full guidelines also covers this issue on a case by case basis. We have amended the wording of the guidance and highlighted the need to document in the clinical record the basis for using an alternative treatment option, also refer to the addition of 'review' and to get a second opinion in recommendation 1.4.43.
National Forensic Psychotherapy Development Group	1	Full	29	30	(Lines 30-39) Relational Security The guidelines refer to "non-patient-related factors". These factors in fact all relate to "relational security". There has been an increasingly emphasis on supporting good practice around relational security in secure and forensic psychiatric services over the past few years (eg see Department of Health guidance "See, Think, Act" (2010) available at: https://www.rcpsych.ac.uk/pdf/Relational%20Security%20Handbook.pdf). We recommend that the concept of "relational security" is included as this is relevant o non-secure/forensic psychiatric settings and the	Thank you for this comment. The GDG agrees that a reference to relational security should be included.

					sharing of learning and good practice could be supported by the guideline referencing the above document and existing practice, which directly relates to the management of aggression and violence.	
National Forensic Psychotherapy Development Group	2	Full	81	17	The above comment links to the "Safewards" initiative discussed in the guideline and this link should be made explicit. This would potentially support the development of integrated training across forensic/secure – non-forensic/secure practitioners and rather than overlapping training being developed separately.	Thank you for your comment. We believe the recommendations about training do not preclude integrated training across settings (see NICE recommendation 1.4.1, 1.5.3-1.5.5, and 1.6.2-1.6.3).
National Forensic Psychotherapy Development Group	3	Full	30	11	(Lines 11-12) We strongly support this approach and think that it has important implications for training, which should be considered by all the relevant training bodies, in particular the Royal College of Psychiatrists. *"Clinicians may be well advised to consider a formulation-based approach which facilitates the prevention and management of aggression and violence, as opposed to an over-reliance on purely predictive methods."*	Thank you for your comment.
National Forensic Psychotherapy Development Group	4	Full	117	26	(Lines 26-8) This is the only reference we could identify relating to supervision of staff. "The risk assessment should be available for case supervision and in community teams it should be subject to multidisciplinary review." We recommend that there is more explicit and detailed guidance on the role of supervision of staff, including team supervision. The function of this is to support good practice, as suggested by the Safer Wards initiative, and as is consistent with a focus on relational security (see comments 1 and 2 above).	Thank you for your comment. The GDG felt that supervision was adequately covered by the current recommendation.
National Forensic Psychotherapy Development Group	5	Full	27	12	Debriefing is mentioned and it is suggested it "may" occur after incidents. This suggests potentially significant variation in	Thank you for your comment. This is a review of current practice as part on an introductory chapter, and does not form part of the

					current practice and a lack of clarity about suggested good practice. Clearer guidance on whether debriefing should occur is indicated and research on whether this is effective, and/or how any effectiveness can be maximised.	recommendations. Specific guidance on debriefing is later provided later in the document.
National Forensic Psychotherapy Development Group	6	Full	General	General	There is no mention in the guidance on the possible role of "reflective practice" or "group supervision", as a necessary and regular activity to support good practice. There is not clear evidence about the effectiveness of this in terms of studies reporting data, but there is evidence in the form of reviews of practice and opinion. Although, in the light of an absence of clear evidence it may not be possible to give clear guidance on this area it should at least be referenced, with a comment that further research is required to determine its potential place and effectiveness. It is already a widespread and existing practice in many services (eg forensic/secure psychiatric services) and this should at least be acknowledged, if only to allow other services to be aware of it and see if it may have a role or to call for greater evaluation of its use. See eg: Campling P, Davies S, Farquharson G (Editors) (2004) From Toxic Institutions to Therapeutic Environments: Residential Settings in Mental Health Services. Royal College of Psychiatrists: London. Gordon J, Kirtchuk G (Editors) (2008) Psychic Assaults and Frightened Clinicians: Countertransference in Forensic Settings. Karnac Books: London.	Thank you for raising this issue. However, the role of 'reflective practice' and 'group supervision' are outside the scope of the guideline, which covers the short-term management of violence and aggression. While the GDG acknowledge that the distinction between short and longer term management is sometimes difficult to define, they focused on those issues specific to short-term management that they felt would provide the biggest improvement in the care of service users.
NHS England	1	NICE	6 & 11	General	(Pages 6 & 11) It may be helpful to make reference to the	Thank you for your comment. We are unable to include these references as the evidence for

					'Positive and Proactive Guidance' (DoH) in the document as other guidelines are mentioned (page 6) and particularly 'A Positive & Proactive Workforce' in the training section as the document highlights a number of helpful strategies relating to workforce development.	these techniques has not been reviewed.
NHS England	2	NICE	General	General	The referrals to different sections are a little confusing throughout and this was less evident in the 2005 version which was easier to follow. However, once the hyperlinks are applied it may be easier to follow. The sentence structures are rather long and complex for front-line staff to follow with ease and clarity. Certain sections seem rather over prescriptive e.g. searching, while others seem relatively sparse eg. manual restraint	Thank you for your comment. We hope the changes made to the NICE guideline make it easier and clearer to follow.
NHS England	3	NICE	6	0	In this section it may be important to highlight the principles of Trauma Informed Care and the impact that previous traumas have on current presentation and risk.	Thank you for your comment. This is a standard NICE text which has gone through due consultation and process to be set as template text.
NHS England	4	NICE	12	0	The impact of trauma from outside and within the Organisation and appropriate support/supervision /reflection for staff could be included here.	Thank you for your comment, although we apologise we are not entirely sure what you mean. If you mean the impact of trauma on staff as a result of violence and aggression, the GDG felt this was adequately covered in NICE recommendation 1.4.55.
NHS England	5	NICE	12	0	The impatient wards section could be structured into: Social/Context: needs/triggers Psychological/Mental Health: needs/triggers Physical: needs/triggers Environment: structure/triggers This section could further clarify the formulative and potential trigger issues. Physical illness/pain and lack of sleep could also be included as precursors and good observations could also be included in the environment. It may also want to highlight positive culture, validation, active problem-solving and service-	Thank you for your comment. The GDG is content with the current structure. In terms of triggers this is referred to in the penultimate bullet point and the final point address the unknown and unseen in the inpatient unit. Your final comment we believe is addressed throughout the entire guideline it is clearly referred to in 1.2.7

					user involvement.	
NHS England	6	NICE	12	0	In the sentence 'Recognise possible teasing, bullying, unwanted physical contact" could sexual be added?	Thank you for your comment. The GDG agrees and has added 'sexual' to the recommendation
NHS England	7	NICE	13	0	De-escalation staff training: General principles could be presented at the beginning with a discussion of preventative strategies such as being recovery-orientated, high levels of engagement, providing meaningful activity, creating validating, containing environments which have active problem-solving by service-users and staff as a key theme. In addition, formulation driven collaborative care planning for the management of future violence could be included and the importance of good relationships and familiar staff could be highlighted.	Thank you for your comment. The GDG felt that the de-escalation techniques described in recommendation 1.3.12 and 1.3.18 provided sufficient advice about the prevention of violence and aggression. Regarding your second point, please see recommendation 1.2.7 for a framework for anticipating and reducing violence and aggression.
NHS England	8	NICE	14	0	The rapid tranquilisation section could add instead after Lorazepam and before (1.4.39), as this makes it easier to understand.	Thank you for your comment. The recommendation wording has been amended to say…a' and use intramuscular lorazepam "instead"'.
NHS England	9	NICE	14	0	(1.4.5 & 1.4.7) Using restrictive interventions as a last resort and proportionality are also key issues and should be included in this section	Thank you for your comment, but the GDG feels that these points are adequately covered in 1.4.5 and 1.4.7.
NHS England	10	NICE	12	0	In the section on preventing violence and aggression, psychosocial/psychological approaches should be included. In the prn section, despite being focused on short-term management, would a review of current medication to prevent future relapse be indicated?	Thank you for your comment. As you point out this guideline is about the *short-term* management of violence and aggression, therefore it would not be appropriate to recommend specific psychosocial/psychological approaches or a review of current medication to prevent future relapse.
NHS England	11	NICE	14	0	Post incident reviews. The length of this section seems inconsistent with other key priorities and is repeated again later in the document.	Thank you for your comment. Recommendations that appear in the Key Priorities section are repeated in the main body of the guideline. The GDG considered post-incident reviews to be a key component in helping t reduce the use of restrictive interventions in the management of violence,

						and therefore gave them some prominence in the guideline.
NHS England	12	NICE	18	0	Terms: In the description of the term observation it misses the vital component of monitoring of the individual and their mental state in order to provide support. Incident debrief is not defined.	Thank you for your comment. Please see the NICE guideline attached for the revised definition which defines incident debrief in section 1, 'terms used in this guidance'.
NHS England	13	NICE	20	0	Ensure risk management plans also identify protective factors and strengths could be added to this section.	Thank you for your comment. The GDG agreed that long term management is outside of the scope.
NHS England	14	NICE	21	1.1.13	Working with the police: It may be helpful to include the maintenance of clinical oversight by mental health professionals in these situations as clarification of the roles and responsibilities is a key issue in these situations. It may be helpful to comment on information to be shared with the police. It may also be helpful to recommend that locally agreed protocols include some training for the police in mental health and the ethos of mental health environments.	Thank you for your comment. The GDG felt they got the balance of this recommendation right between developing joint local policies and what the policies should cover, the operating protocols should be reviewed regularly. If training is required this should be a matter for the individual service providers
NHS England	15	NICE	22	0	1.2.1 "An understanding of the relationship between mental health problems and the risk of violence and aggression" and protective factors could be added. The psychological contributing factors could also be highlighted. In the point about post-incident review it may be helpful to refer to the immediate review with the service user and staff, as well as the external reviews. Staff may find the former more challenging where there may be high expressed emotion. 1.2.3 In the point about leisure activities, would personally meaningful and individually motivating activities be included, as often	Thank you for your comment. The GDG felt that protective and psychological contributing factors were covered by the third bullet point of 1.2.1. The GDG did however agree with your point about undertaking an immediate review (for clarification purposes, now called post incident debrief). An extra bullet point has been added to NICE recommendation 1.2.1. The GDG also agreed with your suggestion of adding 'personally meaningful' to describe the activities in 1.2.3. Please see recommendation 1.2.3, personally meaningful activities has been in light of your comment.

					services provide activities which are service driven and not motivating for service-users and therefore do not promote engagement and recovery.	
NHS England	16	NICE	23	0	"Use de-escalation" - is this part of a reduction programme as the other strategies seem more service orientated requirements? Would effective staff training be added to this section for completeness?	Thank you for your comment. The GDG felt the existing NICE recommendation 1.2.1 goes into sufficient detail regarding staff training to support the reduction in the use of restrictive interventions.
NHS England	17	NICE	24	0	Some discussion of developmental history and experience of trauma would add a broader perspective when discussing the service user's mental health. Psychological therapies could be further developed, for example, to increase coping strategies. In the section on "recognise possible teasing, bullying, unwanted physical (add sexual) contact or miscommunication between service-users". It may also be helpful to add identify vulnerabilities in individuals and power dynamics in the ward environment. On the section on physical environment – good observation should be added as it is a key issue when considering environmental structure.	Thank you for your comment. This recommendation is about a framework for anticipating and reducing violence and aggression by improving the hospital environment – which would include ensuring that psychological therapies (recommended by NICE guideline for the specific mental health problem) are provided. Developmental history and trauma would be part of a broader mental assessment, and therefore not part of the scope of this guideline. Regarding your point about identifying vulnerabilities and power dynamics, the GDG did not consider that this would be appropriate to an anticipatory framework. Observation is covered later in the guideline in section 1.4 (1.4.8-1.4.22).
NHS England	18	NICE	26	0	1.2.10 It would also be helpful to highlight positive and protective factors at the end of this section. 1.2.11 In most settings individual risk formulation using structured clinical judgement e.g. the START, maybe more helpful than actuarial methods to manage risk and develop risk management plans. Some guidance on recording of this information may be helpful.	Thank you, but our focus on short-term management of violence and aggression meant that our review focused on risk factors and tools for predicting imminent violence and aggression.
NHS England	19	NICE	26	0	While this section is on pharmacological strategy, following this it would be appropriate to discuss other therapeutic approaches, which may address long-term risk of violence and	Thank you for your comment, this is beyond the scope's remit on short term management of violence and asking to review the longer term management.

					aggression in order to prevent further short-term relapses?	
NHS England	20	NICE	28	1.3	Preventing violence and aggression: It maybe helpful to think about the overarching headings as there is lots of overlap. For example, searching, while being preventative to a degree in terms of maintaining a safe environment and restricting assess to disinhibiting unhelpful substances, is also a restrictive practice and, as described in 1.3.5, becomes a highly restrictive intervention if the service user refuses. It may also be more helpful to discuss other preventative strategies at the start of this section, such as risk formulation and identification of preventative strategies which are mentioned in the document in 1.2.10.	Thank you for your comment, but the GDG considers the act of voluntary searching to not be a restrictive intervention. If searching is refused, staff may have to undertake a restrictive intervention, but these interventions are covered in section 1.4. The GDG considered risk assessment and other strategies in section 1.2 to be critical to the anticipation and reducing the risk rather than prevention.
NHS England	21	NICE	30	0	1.3.10 Prn medication: While this section is valuable, service user groups such as MIND and WISH have highlighted that service-users require good psychosocial care and time with staff to discuss their anxieties, symptoms and distress, which are often precursors to aggression. Thus it should be highlighted that such interventions should be used as the first line approach prior to de-escalation and medication.	Thank you for your comment, but the GDG feels that precursors to aggression are covered sufficiently in section 1.2.
NHS England	22	NICE	31	0	Negotiation skills and active listening are an essential principle in this section – such as the Behavioural Change Stairway Model (Hasselt, Romano & Vecchi, 2008)	Thank you for your comment. There are numerous models and approaches to de-escalation which all include negotiation skills and effective communication strategies. Although the model you refer to was not specifically reviewed by the GDG the basic elements are covered in the recommendations.
NHS England	23	NICE	32	0	1.3.19 It maybe helpful to remove the word supress as it is very difficult to supress emotional and physical responses. In addition, feedback can be helpful to service-users, as people who are	Thank you for your comment. The term 'suppress' has been removed from recommendation 1.3.19. However the GDG did not think it would be safe to recommend feedback in this context – the group considered

					often in an agitated state lack the awareness of the impact they are having on others and once they realise this, it can lead to a more measured, calmer response. 1.3.20 It may be helpful to add why this should not routinely be a seclusion room e.g. this may increase arousal as it may be perceived as threatening.	it more important that staff understand the need to contain and engage. In recommendation 1.3.20 the rationale for not using a seclusion room has been added to the recommendation. Thank you for this suggestion.
NHS England	24	NICE	33	0	In this section service-users' preferences and advanced decision/statements could be added for completeness.	Thank you for your comment, but the GDG considered that this had been adequately covered in section 1.1.
NHS England	25	NICE	34	0	In this section why are 'observations' in the restrictive intervention section but 'searching' is not? Would both not be in a section on maintaining a safe environment which manages risks as they are both on a spectrum of preventative measures moving to highly restrictive when risks increase?	Thank you for your comment. Observation is a limited and non- physical way of monitoring someone's behaviour and following the person's movement (sometimes very closely) with the explicit aim of being prepared to intervene physically to prevent harm. Searching, on the other hand, is undertaken following a request by staff to look though the possessions or clothing of a patient if they have concerns that they could become violent or aggressive. Observation sometimes restricts a person's freedom of movement, whereas searching does not. Obviously if someone refuses to be searched, staff may then perform a restrictive intervention but searching itself is not one as such.
NHS England	26	NICE	35	0	Levels of observation: Continuous observation: In some services, if there is an immediate risk of violence, they would not put someone on a 1:1 level due to the risk that this staff maybe assaulted. Would it be helpful to consider this risk? Some would argue this level of observation is more relevant for risk of self-harm than violence (unless it is only a specific person who is at risk). With reference to multi-professional observation, is this a different type/ process that	Thank you for your comment. As with any classification there is bound to be some overlap between categories but we have made changes to reflect your concerns. Of course staff have an equal responsibility to protect service users from their own actions (self-harm) but this is covered by a separate guideline.

					is being proposed?	
NHS England	27	NICE	36	0	Not sure of the relevance of self-disclosure and therapeutic silence in this section. A more generic recommendation of being empathic and supportive may be more helpful.	Thank you for your comment. The recommendation has been changed to address your concerns by removing self-disclosure and therapeutic silence.
NHS England	28	NICE	37	0	Obesity is also a factor which also requires extra care in restraint and was a factor in the two most recent deaths under restraint. Does the term physically unwell cover chronic heart/respiratory problems which also increase risks? Also the effects of medication/ intoxication/substances increase risk and there is no guidance on pregnant women. It may be helpful to give more specific details here, given its importance for practice and potential harm.	Thank you for your comment. In response to your comment NICE recommendation 1.4.27 has been amended to reflect extra care should be given if a Service User is pregnant or obese. However, the GDG did not feel it would be necessary to list all the factors or options that should be considered by the multidisciplinary team when developing an individualised pharmacological strategy. This is covered in NICE recommendation 1.2.14. This section highlights the need to include a specialist pharmacist and a psychiatrist within the multidisciplinary team. This should ensure appropriate consideration is made of all the relevant clinical and pharmacological factors that should be considered in order to individualise the pharmacological strategy in line with our guidance.
NHS England	29	NICE	38	0	1.4.33 Would it be helpful to add the review of management plans to determine if such a situation can be avoided in the future? 1.4.34 Mechanical restraint may not always be planned in advance. For example, it maybe used in emergency situations if a person is presenting as high risk, but is injured or in danger, to move them to a place of safety/hospital/ or evacuate in the case of a fire. It may also be considered if a person is being restrained in prone position and needs to be moved to seclusion for example, but is combative and resistant. In such	Thank you for your comment, but the GDG considered that a full review would be conducted by the post-incident debrief and the external post-incident review. The GDG is grateful for your point about mechanical restraint not always being possible to plan in advance and has removed it from the recommendation, although the group stands firm in its belief that mechanical restraint should only be used in high secure settings. In recommendation 1.4.35 the GDG has made it clear that mechanical restraint should be used as a last resort.

					circumstances they may be restrained to a device/stretcher in order to move them without injury, to themselves or others, to quickly end the restraint and thus reduce the risks associated with restraint. Would these issues be considered? 1.4.35 Given the lack of evidence in this area it should be explicit that mechanical restraint is to be used as a last resort when all other management approaches have failed.	
NHS England	30	NICE	39	0	Seclusion rooms: it maybe helpful to add should have a method of communicating with/summoning staff to facilitate needs.	Thank you for your comment. Your suggestion has been added to the recommendation 1.4.46.
NHS England	31	NICE	41	0	In some services such as high secure services, seclusion is not always ended after rapid tranquilisation as the risk of violence continues to be high and chronic. Therefore end seclusion as soon as possible following a risk assessment maybe added	Thank you for your comment. The recommendation has been changed to say that risk assessment should be undertaken before considering ending seclusion.
NHS England	32	NICE	42	0	Post incident review: Would an increase in observations prompt such a review or just manual/pharmacological restraint? If all aspects of restrictive practice are included this would be very time consuming for services, especially when combined with a further external review. In addition would service users feel empowered to lead such reviews? And are there enough service users available who are willing to contribute to these reviews to implement this recommended practice?	Thank you for your comment. The GDG has added a definition for incident to clarify that this would not include use of observation. Regarding the empowerment of service users and availability of service users, the GDG cannot make a judgement about this but believes wholeheartedly that an external review involving service users would lead to a reduction in the use of restrictive interventions.
NHS England	33	NICE	43	0	Same point as above, is this after every restrictive practice? For example, in high secure services some service-users in long-term segregation are fed out of rooms using approved holds for association in the ward/to attend hygiene and this may happen on a daily if not more frequent	Thank you for your comment. A definition of incident has been added to the guideline – it is any use of a restrictive intervention, except observation, therefore in this sense they would be 'grouped together'.

					basis. Would these instances all trigger an external review? Could they be grouped together? In services with high levels of incidents and a small number of challenging high risk individuals this may be hard to achieve in the time frame given.	
NHS England	34	NICE	48	0	This section could also be included in the adult section on assessment also, as it applies equally to all service-users. Psychological may be inserted prior to help to aid clarity.	Thank you for your comment. The GDG agrees and has made the changes you have suggested.
NHS England	35	NICE	49	0	Even in high security to mechanically restrain a young person does not seem appropriate or necessary, to manage the risk of violence. It could be argued that in this instance,both children and young people should be treated with the same level of safeguards. If a young adult is admitted to high security at age 18, or in exceptional circumstances younger, they are still early on in their treatment trajectory. Whereas mechanical restraint may be considered as a last management resort once all other approaches have failed, to improve quality of life. It would be ethically questionable to arrive at this position with someone of such a young age. Mechanical restraint has significant effects on self-esteem, self-image, hope and recovery, which would be highly damaging to a young person.	Thank you for your comment. We agree that the use of mechanical restraint is not desirable with children and it is our hope that this guidance clearly articulates that the use of mechanical restraint should be a rare exception to other skills of managing violence. However we feel that to state mechanical restraint should never be used may remove from those providing care for the most at risk of harming themselves or others the option of mechanical restraint which they may need in an exceptional situation and the mechanical restraint may prevent harm that may of otherwise occurred.
NHS England	36	NICE	50	0	If the room is not locked is this seclusion or isolation? This requires clarification.	Thank you for your comment. The GDG agreed that according to the Mental Health Act and the Code of Practice, the term 'seclusion' is correct. Please see the NCIE guideline for the definition of the terms used in this guideline.
NHS England	37	NICE	51	0	Research recommendations: Positive approaches/alternatives and an investigation of factors which reduce risk could be raised more explicitly as research questions.	Thank you for your comment. The GDG carefully considered which research questions should be prioritised and felt that they were confident with the selection made.
NHS England	38	NICE	General	General	More guidance may be required on what local policy requirements should consist of as a	Thank you for your comment. Local determination is outside of our remit.

					range of areas searching, observation etc., require their development.	
NHS England	39	Full	General	General	The British Psychological Society representative(s) is not indicated. There do not appear to be any psychologists cited on the review team. It would be helpful to include psychological perspectives.	Thank you for your comment. This guideline is about the short-term management of violence and aggression; whilst psychological methods have been recommended the immediate delivery would unlikely come from a psychologist. Stakeholders expressed and confirmed the GDG constituency during the scoping stage of the guideline and psychologist were not considered key to the overall development of this guideline. Also this is an evidence-based guideline that focuses on interventions rather than on who provides them. We have addressed the range of interventions and settings which overall were represented in the guideline development group. Furthermore it is part of the guideline process to ensure the recommendations and the evidence is available to all stakeholders during consultation so that they may advise the guideline group further.
NHS England	40	Full	General	General	There is no attention given to indirect aggression in the document. This is a crucial aspect to consider. It is well recognised as populations age: it deserves a mention even in the definition or it will look like an omission. The overall definition is not very easy to follow.	Thank you for your comment, however indirect aggression was not included in the scope of the guideline.
NHS England	41	Full	14	4	(Lines 4-7) Some of the literature being cited here could be more up to date, particularly when assertions are being made about the current context 'violence and aggression' being relatively common and having serious consequences There is no quantification of the statement 'relatively common'. What type of aggression? This is not a minor point about detail and literature as it needs to be up to date and specific as this document is likely to be recited. It also needs to quote literature more broadly.	We believe that it is appropriate to describe the broad nature of the problem in these general terms in the first few lines of the first paragraph of the introduction to the full guideline. This is intended to be helpful to readers from all backgrounds in framing the rationale for the guideline. The cited literature is consistent with the text. We believe that terms such as 'relatively common' and 'dangerousness' will be understood in their everyday senses rather than in any specific epidemiological or criminological sense, and that this is compatible with the

					This is an issue that noted throughout. It did not appear particularly comprehensive in parts and has focused on the risk assessment literature per se. For example, at line 23 the term 'dangerousness' is used; this is an out-dated term based in legal definition.	intended accessibility of the guideline.
NHS England	42	Full	15	16	(Lines16–28) This section is hard to follow and does not capture motivation as part of the core definition – there is no mention of reactive and proactive aggression. Rather there is a focus on a perception of aggression scale that is not definitional and not well cited. The OAS is presented as a 'well used research instrument'. This is not considered by aggression researchers to be a gold standard tool and including it in this way suggests it is. This could be misleading, as there are more established measures in the field that are more widely published and accepted.	Thank you for your comment. The OAS is the most widely used tool in aggression research in inpatient psychiatry, even more so if its subsequent modifications are included (MOAS, ROAS, SOAS, SOAS-R). The core definitions in the OAS are carried forward into these subsequent versions and the OAS has therefore determined the format and content of much aggression research in psychiatry. The reference to the OAS in any case occurs only in the section on the definition of aggression and nowhere is it said or implied that this tool represents any kind of 'gold standard'.
NHS England	43	Full	16	0	The Di Martino reference is dated. This needs to be a more current citation. There is a considerable amount of work on this topic that could be cited as an alternative.	Thank you for your comment, this section has been updated.
NHS England	44	Full	General	General	There is no mention of aggression motivation or function in the document. To manage aggression effectively you need to capture the motivation. This is a noted omission. Understanding motivation and function is the cornerstone of management and so it needs to be included more explicitly.	Thank you for your comment, however the guideline covers the short-term management of violence and aggression only.
NHS England	45	Full	16	34	(Pages 16-17, Lines 34-22) Some research suggests that violence is higher in secure forensic psychiatric settings.	Thank you for your comment, this section has been updated.
NHS England	46	Full	17	17	Typing error 03	Thank you this has been amended.
NHS England	47	Full	10	37	Is this section really needed? It seems rather dated and linked to the previous section. The reference to heuristics and labelling seems out of place here, it seems unnecessary.	Thank you for your comment. The GDG feels that this section is needed. The purpose of it is to build on the points in the previous section on the relationship between mental health

						problems and violence and aggression, for example perceptions of risk.
NHS England	48	Full	21	0	(Pages 21-22) The work of Bowen and Bowie appears as an important omission in this section.	Thank you for your comment. The following references have now been added: Bowen M, Lovell A. Representations of mental health disorders in print media. British Journal of Mental Health Nursing. 2013;2:198-202. Paterson B, McKenna K, Bowie V. A charter for trainers in the prevention and management of workplace violence in mental health settings. The Journal of Mental Health Training, Education and Practice. 2014;9:101-08.
NHS England	49	Full	23	22	The MHA 1983 is cited here. The new Act really should be covered.	Thank you, this refers to the newer act. We've been advised by NICE's lawyers that while the act was amended in 2007, it is still correct to describe it as the MHA 1983.
NHS England	50	Full	24	19	(Lines 19-20) Where is the reference to sexual aggression? The reference to Ireland 2006 could include more detail on the estimates.	Thank you for your comment. Sexual aggression is referred to in lines 27/28 on page 15 and lines 21-24 on page 24; the GDG felt more detail would not be necessary.
NHS England	51	Full	25	0	(Pages 25-27) Some detail on what is currently available would be useful. The review does not signpost positive practice and is discussing this section as if it applies routinely when it does not at all.	Thank you for your comment. This section is part of a review of current practice, and forms part of an introductory chapter setting the scene. As such it is not part of our positive practice recommendations which follow in subsequent chapters.
NHS England	52	Full	28	22	(LINES 22-28) It maybe unhelpful to suggest unstructured clinical judgement has strong value when the research suggests the opposite. References from 1991 to 1995 are used to support this, but the literature in this area has progressed since then.	Thank you for your suggestion. Having reviewed this section again, we agree that the wording needs amending and have done so based on your comment.
NHS England	53	Full	29	0	There are typing errors on this page.	Thank you for your comment, these have been amended.

NHS England	54	Full	29	44	From a reference 10 years ago to comment on current knowledge, i.e. “it continues to be the case” is questionable.	Thank you for your comment, this reference has been removed and the emphasis of the section changed in a small way.
NHS England	55	Full	30	6	(Lines 6-7) Current applications of structured clinical risk assessments are both to predict and intervene via preventative measures. Structured clinical judgement is also not a ‘purely predictive measure’. The section on risk assessment could be improved. There was fleeting mention to formulation at line 11 and this really should be a key theme throughout.	Thank you for your comment. We’ve expanded on these issues in the introduction to Chapter 4 of the full guideline and the subsection introductions
NHS England	56	Full	30	0	(pages 30-32) Readers should have a clearer idea of current costs and not those from 10 years ago, certainly when inflation estimates are not applied.	Thank you for your comment. The data sources quoted are the most up to date available and have been adjusted for inflation.
NHS England	57	Full	52	8	(Lines 8-10) These are estimates from some time ago. What are the current estimates? This is crucial as mandatory risk assessments in forensic settings, as one example, have been in practice only for just under 10 years.	Thank you for your comment this section has now been updated
NHS England	58	Full	52	0	This section maybe the ideal one for including motivations for aggression as these motivations are the risk elements. There is also nothing on what decreases risk which is an important element – the questions all relate to what increases risk and not what decreases it. This could be explored as aggression research is moving towards what is decreases risk.	Thank you for your comment. We’ve expanded on these issues in the introduction to Chapter 4 of the full guideline and the subsection introductions
NHS England	59	Full	56	0	(Pages 56-64) This review seems rather sparse – 13 included and 528 excluded, reducing further to 7. The space dedicated to this appears questionable. This ‘review’ would not receive a good REF rating and so its value should not be over-focused on. It leaves readers with the impression that there is a very narrow review	Thank you, we agree that the evidence is sparse. However, if NICE guidelines are to be based on the best available evidence, then we believe that focusing on prospective observational studies that used multivariate models to establish unique risk factors was the correct approach in this case.

					and its value is not really clear. However, conclusions within national guidelines are being drawn from it which seems questionable.	When developing recommendations, the GDG recognised the paucity of evidence in this area, and agreed that it was appropriate to create a framework and principles, rather than being too prescriptive.
NHS England	60	Full	64	0	(Pages 64-67) The problems with these high/medium/low prediction tools need to be made very clear and it is not an approach that is promoted within the field. The work of Hart, Cooke & Michie published in 2007 in the British Journal of Psychiatry highlights the real difficulties with this approach. It needs to be very clear that what is not being advocated by these guidelines are actuarial prediction tools (where many problems lie) but structured clinical guidelines. This is not clear in the document currently and in fact as you progress to page 66 it really feels like the guidance is promoting actuarial assessments as they are commenting on psychometric properties. This is problematic and the following paper should be considered as a seminal one: *Hart, S., Michie, C., Cooke, D. (2007). Precision of actuarial risk assessment instruments: Evaluating the margins of error of group v. individual predictions of violence. British Journal of Psychiatry, 109 (supplement 49), s60 – s65.* There has been no reference made in these guidelines to the work of Cooke and his colleagues, or of David Farrington, which seems to be an omission in this area.	Thank you for raising this issue. We agree that risk assessment is complex. However, other commentators have disagreed with Hart and colleagues (e.g., Mossman & Sellke, 2007: doi: 10.1192/bjp.191.6.561; Hanson & Howard, 2010: DOI 10.1007/s10979-010-9227-3). Therefore, rather than attempt a review of this debate, we set out the issues as succinctly as possible in section 4.1. We then review what instruments most reliably predict short-term violence, as specified in the review protocol (Table 8). We believe the GDG took into account the quality of the evidence, and made recommendations which are appropriate given the evidence.
NHS England	61	Full	67	14	(pages 67-73, Line 14 onwards) See previous comments. A review of the paper noted previously will assist here. Also, do the figures add anything?	Thank you, but as noted in the previous response, we do not think that reviewing the issues raised by Hart et al., would add clarity given that others disagree with their views. The figures were presented to the GDG,

						therefore we believe it appropriate to present them here.
NHS England	62	Full	74	0	(Pages 74-76) Does this section add anything to the guidelines?	Thank you, but we consider that it is very important to provide some rationale for the recommendations.
NHS England	63	Full	79	4	(Lines 4-39) Where is the evidence for this section?	Thank you, this has been amended.
NHS England	64	Full	General	General	The section on training programmes only seems to cover MVA. There are a range of de-escalation and positive approach training programmes that are well integrated that have not been captured here. There are also healthy community initiatives and 'anti-bullying' initiatives that are not captured. Readers will be left with a view that focus is on seclusion and management. This seems limited.	Thank you for your comment. Managing Violence and Aggression was intended as a generic term for all such training courses, rather than a reference to a specific type of training.
NHS England	65	Full	96	38	(Lines 38-44) The reviews are very limited and a review of two studies is not a full review. The structure of this section could be improved.	Thank you, but we disagree. We conducted a comprehensive search for existing reviews and more recent primary studies. The fact that there is a paucity of evidence does not invalidate our review, but highlights the need for further research. Also, it should be noted that although there were two studies, one of these was a systematic review that included 14 primary studies. Regarding the structure of the section, we have looked at this an are not convinced that restructuring would help the reader. In addition, we've followed a similar structure in other chapters.
NHS England	66	Full	125	0	(pages 125-6) Some of the evidence for these assertions would be of value. There are a number of typing errors on page 127.	Thank you. The errors have now been corrected.
NHS England	67	Full	General	General	Some caution around pharmacological intervention may be of assistance here – more so it is demonstrated to be virtually a last resort and not a strategy of preference. This is	Thank you for your comment. In the full guideline, Section 6.5, linking evidence to recommendations, the statement about lorazepam being a " first choice option" has

					particularly the case when the review concludes not enough is known to determine the effectiveness of seclusion and restraint (pg. 140). Some readers may consider therefore that pharmacological approaches have increased benefit because the review lacks evidence base for other approaches. This is important as these guidelines will be considered beyond the UK jurisdiction.	been amended to reflect the fact that this is in the context of drug choice – and not as a specific first choice of any intervention .
NHS England	68	Full	155	0	The summary forest plots are presented as a means to aid interpretation, but not sure they achieve this?	Thank you for raising this. The GDG agreed that given the large number of comparisons reported in the GRADE profiles and Appendix 15b, some type of overview was important.
NHS England	69	Full	177	9	(Lines 9-10) The reference for this final sentence needs including.	Thank you for your comment this has been updated.
NHS England	70	Full	177	0	This special considerations section could have included details on positive interventions with children and specific risk assessment approaches e.g. the SAVRY. There has been considerable criticism of the challenges of placing children with mental health problems and the NHS failing to address this sufficiently. A sense of the positive approaches that are being used, and should be used, with this group is required.	Thank you for your comment. Only instruments for the prediction of imminent violence were reviewed; tools such as SAVRY are not designed for this. However the GDG agreed this is a very relevant tool used by professionals working with young people for assessment purposes. Reference to the SAVRY tool (with reference to Bartel and Borum) can be found in the introduction to Chapter 7 of the full guideline.
NHS England	71	Full	178	36	(Lines 36-41) No mention of tools such as the SAVRY. There is a significant research base excluded making the review and conclusions limited. There is no mention of Randy Borum's work which is an omission in this area.	Thank you for your comment. Only instruments for the prediction of imminent violence were reviewed; tools such as SAVRY are not designed for this. However the GDG agreed this is a very relevant tool used by professionals working with young people for assessment purposes. Reference to the SAVRY tool (with reference to Bartel and Borum) can be found in the introduction to Chapter 7 of the full guideline.
NHS England	72	Full	178	43	(Lines 43-46) There is brief comment made to the restraint of children in private providers. NICE could make	Thank you for your comment. NICE is not able to comment on the suitability of private care provision. However, the GDG and other

					a comment on the suitability of this – clearly there are significant issues over the containment of a child physically.	stakeholder comments acknowledged the need to revise the recommendation on staff training programmes and how they should be adapted for the use in children and young people. See NICE recommendation 1.7.1
NHS England	73	Full	196	0	(Pages 196-7) Regarding the sections on restraint, seclusion and pharmacological interventions with children and young adults it may be advisable to invite a view from the Children's Commissioner for England. In general the section regarding children seems like an extension of the guidelines on adults rather than fully conceptualised in its own right, and more specialist advice may be required in this area, given the potential for harm to such a vulnerable group. In the guidance it needs to be fully emphasised that this should be considered as a last resort and the urgency to find more appropriate approaches and interventions with this group should be highlighted. Again positive/ alternative approaches need to be researched more fully.	Thank you for your comment. This is an evidence-based guideline that focuses on interventions rather than on who provides them. We have addressed the range of interventions and settings which overall were represented in the guideline development group. It is part of the guideline process to ensure the recommendations and the evidence is available to all stakeholders during consultation so that they may advise the guideline group further. Lastly, out of 14 professional members on the guideline development group, there were 3 CAMH representatives so we do not agree with your comment. Regarding your point about restrictive interventions only being used as a last resort, the GDG feels that this is sufficiently covered in recommendation 1.7.14: Use restrictive interventions only if all attempts to defuse the situation have failed and the child or young person becomes aggressive or violent." Positive/proactive approaches (which the GDG agrees requires further research in this population) are highlighted prior to the use of restrictive interventions (see recommendations 1.7.8 – 1.7.13). "Use restrictive interventions only if all attempts to defuse the situation have failed and the child or young person becomes aggressive or violent." Positive/proactive approaches (which the GDG agrees requires further research in this population) are highlighted prior to the use of restrictive

						interventions (see recommendations 1.7.8 – 1.7.13).”Use restrictive interventions only if all attempts to defuse the situation have failed and the child or young person becomes aggressive or violent.” Positive/proactive approaches (which the GDG agrees requires further research in this population) are highlighted prior to the use of restrictive interventions (see recommendations 1.7.8 – 1.7.13).
NHS England	74	Full	General	General	The use of the term “trade off” appears a little minimising.	Thank you for your comment. The section you are commenting on is part of the NICE template wording in the Strength of the recommendations section of the guideline. No changes can be made to the template but your comment will be passed onto the relevant people.
NHS Protect	1	NICE	General	General	NHS Protect has responsibility for leading on work to protect the NHS from crime and this responsibility includes tackling violence, harassment, abuse and anti-social behaviour against the NHS. NHS Protect provides policy, guidance and operational support to enable NHS bodies to address their responsibilities in relation to the safety and security of their staff. Local Security Management Specialists (LSMS) are trained and accredited to lead on this at a local level. We *strongly recommend* that this violence guideline references the work of NHS Protect and points staff to their LSMS for violence and aggression issues. We can provide assistance with an insert in the guideline. In terms of auditing these guidelines, as well as the statutory role of the Care Quality Commission, can it include that NHS Protect quality assures an organisation’s methodology, and its practical application, for tackling	Thank you for your comment. We believe that the guideline adequately captures the points about systematic approaches to violence and aggression that are advocated by NHS Protect, including the need for local agreements that would likely involve Local Security Management Specialists (LSMS). Indeed, it might be anticipated that NHS Protect and LSMS will utilise the guideline when defining criteria for the organizational audit of violence and aggression, and when preparing related publications.

					violence and aggression against staff.	
NHS Protect	2	NICE	General	General	NHS Protect put together and managed a clinically led expert group to produce guidance for the prevention and management of challenging behaviour: NHS Protect (2013) *Meeting needs and reducing distress: guidance for the prevention and management of clinically related challenging behaviour in NHS settings*. This guidance provides organisations with practical strategies on how to prevent and manage the risks of challenging behaviour in healthcare settings. This guidance has been very well received and is being implemented in NHS organisations and we recommend that this is at the very least d in this guideline: http://www.nhsprotect.nhs.uk/reducingdistress	Thank you for your comment. We believe that the guideline adequately captures the points about systematic approaches to violence and aggression that are advocated by NHS Protect, including the need for local agreements that would likely involve Local Security Management Specialists (LSMS). Indeed, it might be anticipated that NHS Protect and LSMS will utilise the guideline when defining criteria for the organizational audit of violence and aggression, and when preparing related publications.
NHS Protect	3	NICE	General	General	These guidelines are evidence based, however even without conducting a systematic review, we have identified (below) certain inconsistencies with already recently published guidance. We recommend that this guideline is mapped across to all recent guidance for the prevention and management of challenging behaviour/violence such as NHS Protect's (2013) Meeting needs and reducing distress guidance , the DH (2014) led Crisis Care Concordat, DH (2014) Positive and Proactive Care and Skills for Health and Care (2014) Positive and Proactive Workforce guidance.	Thank you for your comment. We believe that the current guideline will be helpful in resolving inconsistencies and will be a source for the development of related local and national publications.
NHS Protect	4	NICE	General	General	This guideline (along with a lot of other literature on this subject) should move the focus away from controlling a person's behaviour to prevent and manage violence and aggression, and instead place an emphasis on the importance of planning high quality individualised care. The guideline references this, however it could be more strongly emphasised. The approach that we used in	Thank you for your comment. There are a number of recommendations which aim at involving the service user in decision making and in anticipating and reducing the risk of violence via personalised care plans (see NICE rec 1.2.1).

					NHS Protect (2013) *Meeting needs and reducing distress: guidance for the prevention and management of clinically related challenging behaviour in NHS settings* was to shift the emphasis towards meeting needs by designing optimum care and better outcomes for the individual. Managing the risks is only needed when other strategies failed, and only as a way of identifying what is lacking in a person's care. Positive Behavioural Support is based on this approach.	
NHS Protect	5	NICE	General	General	This guideline and training strategies to anticipate and reduce violence and aggression is mental health sector specific and may not sit easily with general nursing staff who have to manage individuals who present with mental health problems, for instance in acute/ED. For instance, acute staff may not have the same opportunities to build rapports and therapeutic relationships with service users and have the training to assess and understand the reason for someone's behaviour. NHS Protect (2013) guidance *meeting needs and reducing distress* is therefore designed to bridge this gap by giving them immediate strategies to prevent and manage behaviours and we recommend that this is referenced for acute/ED staff: http://www.nhsprotect.nhs.uk/reducingdistrsess The logical progression from the NHS Protect's guidance is that where it is recognised that staff are routinely dealing with mental health patients they should have appropriate training to triage and manage the patient until the mental health team can take responsibility.	Thank you for your comment and for bringing this to the attention of the GDG. A new recommendation has been added to section 1.5 to ensure that staff in emergency departments receive training so that they can distinguish between excited delirium states and excited psychiatric states (see NICE recommendation 1.5.5).
NHS Protect	6	NICE	General	General	There is nothing specific in the guideline about the responsibility on staff and organisations for the reporting and recording of all incidents of violence and where restraint has been used for risk management purposes and restraint	Thank you for your comment. For recommendations on reporting to trust board or equivalent governing body please see NICE recommendation 1.4.54

					reduction strategies.	
NHS Protect	7	NICE	3	5	Introduction - Please include the latest Reported Physical Assault figures published by NHS Protect for 2013/14 http://www.nhsbsa.nhs.uk/Documents/SecurityManagement/Reported_Physical_Assaults_2013-14.pdf	Thank you for your comment, the introduction has been amended to cover the issues you have raised.
NHS Protect	8	NICE	24	29	Anticipate that restricting a service user's liberty and freedom of movement (for example, not allowing service users to smoke or to leave the building) can be a trigger for violence and aggression. This is seemingly inconsistent with NICE guideline [PH48] on having smoking cessation within acute, maternity and mental health services, including smoking bans on premises and stop smoking services, and with current developments in that most hospitals, including MH hospitals, are now introducing full smoke free policies. This section could possibly recommend that smoke free policies should enable staff to exercise discretion in exceptional circumstances where there is a high risk of violence.	Thank you for your comment. We have removed the reference to Service Users leaving the building in order to smoke. Please see NICE recommendation 1.2.7 for the revision.
NHS Protect	9	NICE	26	17	The original NICE CG25 (2005) states 1.10.2.1 Emergency units should have a system in place to alert staff to patients known by the unit to pose a risk of disturbed/violent behaviour, so that steps can be taken to minimise risks to staff and other patients. The system should be reviewed at reasonable intervals to avoid stigmatisation. 1.2.13 This requirement is missing from the new guidelines, but it is not clear why. Crucially, if used correctly alert systems are an important way of sharing handling strategies. To avoid stigmatisation this could be changed to a 'meeting needs marker' with clinical	Thank you for your comment. The GDG for this guideline update judged that the recommendation about alert systems in the previous guideline assumed that service users have a natural propensity to violence and aggression, rather than violence and aggression being seen as, at least in part, having an environmental cause. The GDG appreciates that you are aware of the potential stigmatisation of alert systems, but they considered that the current recommendation was sufficient.

					management strategies to meet a person's needs and reduce distress: http://www.nhsbsa.nhs.uk/Documents/SecurityManagement/Reported_Physical_Assaults_2013-14.pdf	
NHS Protect	10	NICE	28	21	Developing a policy of searching 1.3.1 Consider a separate bullet in addition to finding alcohol: how to manage the storage, return and disposal of drugs or other illegal contraband, for example illegal images, including reporting the finding of illegal contraband to the police.	Thank you for your comment, but the recommendation (7th bullet point) covers storage, return and disposal of drugs. It would be the responsibility of trusts to develop policies on managing illegal images, which is outside of the scope of this guideline.
NHS Protect	11	NICE	37	5	The original NICE guideline CG25 (2005) states: 1.10.5.1 Every emergency department should have access to an identified consultant psychiatrist for liaison with providers of local mental health services. 1.10.5.2 Appropriate psychiatric assessment should be available within 1 hour of alert from the emergency department, at all times. 1.10.5.3 In addition to a mental health liaison team, there should be at least one registered mental nurse working with every emergency department. 1.10.5.4 Emergency departments should be encouraged to employ registered mental nurses. This is a requirement of the DH Crisis Care Concordat (2014) however it is omitted from the new guideline. This provision for commissioners and providers will ensure that ED staff can access specialist personnel to advise, liaise with mental health services and ensure that service users in crisis can get assessed as a matter of urgency. It is also an important safeguard for staff and service users.	Thank you for your comment and for bringing this to the attention of the GDG. On reflection the GDG agree that new recommendations based on CG25 should have been included to meet good clinical practice in emergency departments. Two recommendations about liaison mental health have been added (1.5.1 and 1.5.2).
NHS Protect	12	NICE	38	15	Health and social care provider organisations should ensure that mechanical restraint is used only in high-secure settings (except when transferring service users between medium-	Thank you for your comment. The GDG agrees that there needs to be clarity. It was the GDG's considered view that where individuals were sufficiently dangerous to require a period of

					and high-secure settings as in recommendation 6.6.1.21), planned in advance and reported to the trust board. Clarity around this is important. Acute trusts use handcuffs and velcro restraints in ED to protect staff and other service users. Medium and low secure units, especially in forensic services, use velcro straps to help prevent patients from self-harm. Handcuffs are used by Medium secure units to transfer high risk patients to external appointments such as acute hospital, GPs and dentists. To stop this would create a high risk to the public from known sex-offenders and violent offenders. The use of mechanical restraint should be determined by the levels of risk staff face, rather than in which setting or sector an incident takes place. We would advocate that the use of mechanical restraint is available for all staff to use depending on the risks faced and not based on where they work.	mechanical restraint, such people would be in a high secure environment, therefore in this sense the use of mechanical restraint is setting specific. The GDG also understood mechanical restraint for transport of some individuals between secure settings. They did not subscribe to the view that mechanical restraint would be appropriate in any other setting.
NHS Protect	13	NICE	44	1	Healthcare provider organisations should ensure that, at all times, there are sufficient numbers of staff on duty in emergency departments who have training in the management of violence and aggression in line with this guideline. Anecdotally there are very few staff in ED, with training in the prevention and management of violence and aggression, including restraint to safely administer rapid tranquilisation. We are also aware of an anomaly where expert clinical staffs trained in restraint from a mental health trust are unable to restrain violent individuals in ED with the onus falling on security staff (who may or may not have had appropriate training) and general nurses who almost certainly will not be trained. Whilst some security staff are trained in non-	Thank you. The GDG empathise with your comment but as this is a resource issue, this falls outside of the scope's remit.

					clinical physical intervention very few are trained on the clinical side, making their use to restrain very limited. NHS Protect will have to take a position on the published guidelines, as it directly affects the ability of staff and service users to protect themselves.	
NHS Protect	14	NICE	44	22	Section 1.5 managing violence and aggression in emergency departments. The requirement in the original NICE CG25 guideline is that A&E should have at least one designated interview room, dependent on the number of attendees, set aside and available to conduct a mental health assessment of service users. This is also a requirement of the DH (2014) Crisis Care Concordat. This requirement has been dropped from the current draft. Some trusts have already allocated a secure room/area with the same provisions as a place of safety and may subsequently withdraw this facility in light of this new guideline. Plus by removing this requirement, we have concerns about the implications on clinical, non-clinical staff and service user safety, not only from violence and aggression, but the serious risk of a person absconding. This risk was highlighted in a recent case where a service user absconded from an ED, which had failed to have the proper provisions of a secure room/area in place. The service user suffered serious life changing injuries as a result, see WEBLEY V St. GEORGES HOSPITAL AND THE MPS - A High Court judgement on liability following a S2 MH patient absconding from an A&E and suffering life changing injuries following a fall.	Thank you for your comment. The GDG carefully considered your concerns and has reinstated a recommendation about emergency departments having a designated room for mental health assessments and has updated the 'Linking evidence to recommendations' table in the full guideline Chapter 5, section 5.6) accordingly.
NHS Protect	15	NICE	44	44	1.5.1 Healthcare provider organisations should train staff in emergency departments in methods and techniques to reduce the risk of	Thank you for your comment and for bringing this to the attention of the GDG. A new recommendation has been added to section 1.5

					violence and aggression, including anticipation, prevention and de-escalation. 1.5.2 Healthcare provider organisations should train staff in emergency departments in mental health triage. In the original version CG25 (2005) staff were expected to receive training in recognition of acute mental health illness and awareness of organic mental health diagnosis. It is unclear whether mental health triage will include these factors however there is a risk that service users will not receive the appropriate attention, assessment, treatment and care. It is also worth emphasising here or elsewhere in the guideline of the need for ED staff to treat patients with mental health conditions as seriously as those presenting with physical health conditions, in accordance with the DH (2014) Crisis Care Concordant.	to ensure that staff in emergency departments can distinguish between excited delirium states and excited psychiatric states (see NICE recommendation 1.5.5). The GDG feels that throughout the guideline it has upheld the importance of parity of esteem between physical and mental health.
NHS Protect	16	NICE version	45	5	When using manual restraint, avoid taking the service user to the floor, but if this becomes necessary: • use the supine position if possible or • if the prone position is necessary, use it for as short a time as possible. This would seem contrary to the DH (2014) Positive and Proactive Care guidance and current Positive and Safe Work Programme which is looking to minimise the use of restrictive interventions and see an end to the use of prone restraint.	Thank you for your comment. Although the GDG was broadly supportive of Positive and Proactive Care and the Positive and Safe Work Programme, there were some differences of opinion around prone and supine restraint. Nevertheless the overall approach to manual restraint is very similar.
NHS Protect	17	NICE	45	17	If a service user with a mental health problem becomes aggressive or violent, do not remove them from the emergency department. Manage the violence or aggression in line with recommendations 1.4.1–1.4.45 and do not use seclusion. Refer the service user to mental health services urgently for a psychiatric assessment within 1 hour.	Thank you for your comment. The GDG is of the opinion that in the emergency department violence and aggression should be managed as a mental health emergency. Therefore seclusion is not appropriate. However the recommendation has been changed to say that service users who become aggressive or violent should not be excluded from the

					The DH (2014) Crisis Care Concordat states that EDs should have in place suitable facilities for the seclusion of people in a mental health crisis. Here it states that seclusion cannot be used. It also says that they cannot be removed from ED. However if someone is being extremely violent and aggressive and staff are having to restrain in public for an hour whilst they await an assessment this is bound to put staff at significant risk as well as the patient themselves. It is also contrary to ensuring the dignity and respect and safety of service users as set out in the NHS Constitution. It also is distressing for other service users, carers and relatives. There is also an attendant organisational reputational risk.	emergency department. We have also checked the concordat and we were unable to see where seclusion was mentioned.
NHS Protect	18	NICE	45	5	Healthcare provider organisations and commissioners should ensure that every emergency department has a psychiatric liaison service that can provide immediate access to a psychiatric nurse or doctor. This has security management implications. Access to around the clock psychiatric services in ED is unrealistic for many trusts and ties up security staff, and places all staff and other service users at risk. In many instances there is a wait of several hours before any form of psychiatric liaison is available, and we see ever more cases of police bringing mentally unwell people into ED rather than to dedicated s136 facilities. Plus forces are starting to develop policies of having fewer mentally disordered people in police custody and this will bring more people into S136 facilities and into ED. With the increasing pressures on trusts unless this service is properly funded and staffed, trusts will be unable to meet this requirement. In light of the recent Webley v St Georges	Thank you for your comment. The GDG felt that they have to stick to the best available evidence and your comment alone could not justify amending the recommendation

					Hospital incident (see 12 above) clarity would be welcome in the guideline: if a patient presents at ED only with a mental health condition and is being seen by the psychiatric liaison team, is the patient the responsibility of the acute trust or the mental health trust providing the staff? We would also welcome reference to the judge's recommendations in this case regarding the provisions to be made in ED where someone is an absconding risk. This includes the safe number of security staff, the level of observation required, and finally when dealing with a disturbed patient, security staff should adopt the minimum restraint possible whilst balancing the need to prevent the patient from leaving, but that the latter requirement is more important.	
Northamptonshire Foundation NHS Trust	1	Full	General	General	As many of the recommendations were based on the recommendations of the GDG and much of the guidance relates to the actions / interventions / decision making of nursing staff (who are also most likely to be assaulted), it would be appropriate to have greater representation from frontline nursing staff and PMVA trainers in this group.	Thank you for your comment. Stakeholders were invited to a stakeholder workshop who advised on the key issues which will need to be addressed in this guideline; based on these areas the stakeholders advised us on which professional expertise should form the target constituency. The guideline group was based on this target constituency and on the applications received; the professionals were selected based on their knowledge and experiences they could bring to the overall development of this guideline. This is an evidence-based guideline that focuses on interventions rather than on who provides them. We have addressed the range of interventions and settings which overall were represented in the guideline development group. Furthermore it is part of the guideline process to ensure the recommendations and the evidence is available to all stakeholders during consultation so that they may advise the

						guideline group further. It is for local health and social care providers to design their appropriate training for their staff.
Northamptonshire Foundation NHS Trust	2	Full	17	29	Reference is missing a digit as reads Pettit et al (203)	Thank you this has been updated.
Northamptonshire Foundation NHS Trust	3	Full	16	21	(21-25) New data now published (NHS Protect) that shows an increase on these figures	Thank you for your comment, this section has been updated.
Northamptonshire Foundation NHS Trust	4	Full	49	2	(Page 49 Lines 2-39 & Page 50 Lines 1-8) This section is very useful as it clarifies the importance and intent behind the choice of words	Thank you for your comment.
Northamptonshire Foundation NHS Trust	5	Full	80	19	Ministry of Justice have already published work in this area (March 2014) and the High Secure Services are in the process of producing a core manual for physical techniques	Thank you for your comment. The prison manual techniques would not be acceptable in health service settings and some run counter to the content of this guidance, particularly around the use of pain. Whilst the work amongst the high secure hospitals is a welcome attempt to bring some consistency, as a guideline group we are unable to endorse it.
Northamptonshire Foundation NHS Trust	6	Full	108	20	(Lines 20-24) There is also a significant role for community staff in the development of advance statements with service users (either pre or post admission) – the need for this should be highlighted in the guidance.	Thank you for your comment. The recommendations in this section are for all staff including community.
Northamptonshire Foundation NHS Trust	7	Full	109	24	Is the PSTS theory syllabus no longer considered to be the standard in MH and LD services?	Thank you for your comment. The GDG agreed that given the paucity of evidence, it was more appropriate to provide principles by which training can be delivered, rather than naming a particular syllabus.
Northamptonshire Foundation NHS Trust	8	Full	113	15	No mention of the PSTS or Conflict Resolution Training that is designated as mandatory for frontline staff?	Thank you for your comment. The GDG considered your view but confirmed that the current recommendations already cover these kind of issues such as conflict resolution training. This is not mandatory for all Trusts but appears in the NF NHS Trust Policy manual.
Northamptonshire Foundation NHS Trust	9	Full	117	22	Surely the need for Breakaway training should be informed by an assessment of risk that	Thank you for your comment. The GDG considered that this training is

					includes an analysis of previous reported assaults on staff in each setting? When there are few / no reported assaults in the community (for some trusts), it seems to be a poor use of resources to train every member of staff in interventions they may not remember (given the acknowledged poor retention of such skills) and are unlikely to be used in practice. Community / primary care staff should be encouraged to assess the risks and leave the area when aggression / violence seems likely. A recommendation that all community and primary care staff should attend breakaway training will cost a significant amount of money, take staff away from services without any real evidence that the training would prevent harm.	necessary to help protect workers in cases where they find themselves in situations with reduced support but nevertheless has revised the recommendation to say that provision of training should depend on the incidence of violence and aggression in each setting.
Northamptonshire Foundation NHS Trust	10	Full	126	5	(Lines 5-10) A very useful description	Thank you.
Northamptonshire Foundation NHS Trust	11	Full	167	9	Should read ‘used’ rather than ‘users’	Thank you this has been amended.
Northamptonshire Foundation NHS Trust	12	Full	167	13	Can you clarify why the research of Parkes et al (2008, 2001) and Lancaster et al (2008) was not discussed by the GDG when considering the various physical restraint positions? The research by Parkes et al clearly indicated that the hyperflexed position appeared to have even more impact on respiration than the prone position – I am concerned that this has not been discussed in the guidance. I would have also thought that the increased risks to staff when using the supine position (kicking, biting and the strength element) should have also been discussed by the GDG.	Thank you, but these papers are included in the review by Stewart et al. 2009 (in the full guideline the reference ID for this paper is Stewart 2009a), which the GDG did consider.
Northamptonshire Foundation NHS Trust	13	Full	167	19	The recommendation to limit physical restraint to 15 minutes is commendable but may be very difficult to achieve given that RT is not guaranteed to work, many areas do not have access to seclusion facilities and a seated restraint in a de-escalation room can often take	Thank you for your comment. Having received a number of comments about the time limit of 15 minutes, the GDG decided to change this to 10 minutes because restraining for longer 10 minutes is associated with much worse outcomes, including death (see NICE

					longer than 15 minutes. Perhaps the 15 minutes should be a maximum time for floor restraint although this may then increase the use of mechanical restraint / pain compliance techniques and seclusion – the law of unintended outcomes may well come into play here.	recommendation 1.4.29)..
Northamptonshire Foundation NHS Trust	14	Full	167	25	(Lines 25-32) Limiting mechanical restraint use only to high secure services is likely to put staff at significant risk. Although its use should be only in emergency situations, it would certainly be safer than a prolonged physical restraint as that has been associated with serious injury and death. Limiting physical restraint to 15 minutes will also increase the need for alternative approaches as staff will have to be able to quickly and safely relocate very violent / disturbed individuals to eg seclusion rooms. Given the manual handling, safety and dignity issues associated with such a manoeuvre, the closely monitored and regulated use of a restraint stretcher would seem to be a preferable option for use in extreme situations.	Thank you for your comment. The GDG consensus was that mechanical restraint was more restrictive than manual restraint, seclusion or rapid tranquillisation. As such the use should be much more limited than other interventions and this should only be applied in health care and social settings. The GDG felt there was no evidence to suggest there was greater risk to staff than in other lower secure services. The intention is to make sure that manual restraint is carried out for no longer than necessary, and the GDG felt that specifying a time limit would therefore be appropriate. Having received a number of comments about the time limit of 15 minutes, the GDG decided to change this to 10 minutes because restraining for longer 10 minutes is associated with much worse outcomes, including death (see NICE recommendation 1.4.29).
Northamptonshire Foundation NHS Trust	15	Full	170	1	A recommendation with significant financial implications given the use of the word 'might' ("A doctor trained to use emergency equipment should be immediately available to attend an emergency if restrictive interventions might be used"). This seems too vague and seems to infer that Trusts should have a doctor available for each ward area 24 hours a day as violence and physical restraint might happen anywhere and at any time in inpatient services. Perhaps a recommendation that doctors must attend for all floor and prolonged restraints as this would be a more achievable and safer suggestion.	Thank you for your comment. The GDG felt strongly that restrictive interventions should not be used if there is not at the very least a staff member available who is trained in ILS and a doctor. The recommendation has been amended to say 'staff trained in ILS and a doctor trained in emergency equipment should be immediately available...', see NICE recommendation 1.4.4.

Northamptonshire Foundation NHS Trust	16	Full	170	20	(Lines 20-27) See points 11 and 12 above regarding evidence and restraint positions. Although no pressure should be placed onto a service users torso, certain positions (some seated restraints for example) may impact on respiration (inadvertently) especially when applied on those with a high BMI	Thank you for your comment. The GDG agrees – there are some positions where respiration is inadvertently interfered with. However this should never be an intended consequence and should be checked as soon as this is recognised. We have added the concerns you have raised about high BMI to recommendation 1.4.27.
Northamptonshire Foundation NHS Trust	17	Full	171	3	It would be much safer for the service user if there was a requirement for a member of staff to support and control the head during the use of all floor restraint.	Thank you for your comment, but the GDG considers the guideline to be clear about this issue. Recommendation 1.4.23 stipulates that manual restraint should be undertaken by staff who work closely together as a team and have a defined lead. Recommendation 1.4.32 should be understood in this context.
Northamptonshire Foundation NHS Trust	18	Full	171	12	(Lines 12-25) Limiting the use of mechanical restraint only to high secure services may conflict with H&S legislation which requires safe systems of work to manage reasonably foreseeable risk. How should staff relocate someone that is highly resistive from one area of a ward to the seclusion room bearing in mind the recommendation to limit restraint to 15 minutes? Manual handling regulations indicate that where possible staff should use equipment – this would suggest that a type of stretcher would be safer and more dignified.	Thank you for your comment. It was the GDG's considered view that where individuals were sufficiently dangerous to require a period of mechanical restraint, such people would be in a high secure environment. The GDG also understood mechanical restraint for transport of some individuals between secure settings. They did not subscribe to the view that mechanical restraint would be appropriate in any other setting.
Northamptonshire Foundation NHS Trust	19	Full	173	20	“end the seclusion when rapid tranquillisation has taken effect” Seclusion is used to manage seriously disturbed behaviour that presents as a significant risk to others and cannot be managed in another way. Just because RT has taken effect does not automatically mean that the risk will have significantly decreased – that decision must lay with the professionals involved.	The GDG has changed the recommendation to say that risk assessment should be undertaken before considering ending seclusion.
Northamptonshire Foundation NHS Trust	20	Full	173	30-32	(Lines 30-32) Totally agree with this	Thank you.

Northamptonshire Foundation NHS Trust	21	Full	174	7	(Lines 7-10) Service user involvement in monitoring – a very important point.	Thank you.
Northamptonshire Foundation NHS Trust	22	Full	175	2	(Lines 2-4) “Doctor to be involved in an immediate post incident review following the use of physical interventions – whilst it is evident that post incident reviews are crucial, the timing of them is also an important consideration – studies indicate that it may take up to 60- 90 minutes for the levels of adrenaline and cortisol to return to baseline. This would indicate that post incident reviews should be held at least an hour after the incident has finished. This recommendation also is dependent on the availability of the medical staff and they may be unable to attend immediately.	Thank you for your comment, but the GDG thinks that the context is clear (that is, when the risk has subsided, as stated in the recommendation).
Northamptonshire Foundation NHS Trust	23	Full	176	24	(Lines 24-32) Research into the efficacy (and risks) of restraint techniques must be priority. There is currently an unregulated free market where anyone can sell training packages without any proper assessment of the techniques taught – this would be considered unacceptable in any other area of health care.	Thank you for your comment. We agree that this is very important and is addressed in our second research recommendation (3.5, covering a slightly broader area): ‘In what circumstances and how often are long-duration or repeated manual restraint used, and what alternatives are there that are safer and more effective?
Northamptonshire Foundation NHS Trust	24	Full	121	11	(Lines 22-23) “Decision to seclude only to be made by the MDT” seclusion is often not a planned intervention. Nurses are the only staff group that will be with young service users around the clock as other MDT members generally are only available Monday to Friday 9-5. This fact means that the recommendation is unlikely to be followed in practice.	Thank you, but the GDG discussed this at length and decided that best practice dictated that the ultimate decision should be made by a MDT. The recommendation is based on the best available evidence and focus on prospective best practice rather than limit the recommendations to current provision of services.
Partnerships in Care	1	Full	170	0	I have read the guidance from the perspective of managing violent episodes within clinical practice areas especially when catering for patients who from time to time may present high levels of extremely challenging behaviour,	Thank you for your comment. We are grateful you have brought this to our attention. The intention is to make sure that manual restraint is carried out for no longer than necessary, and the GDG felt that specifying a time limit would

					high levels of outward aggression and violence to staff and others. Page 170 (6.6.1.14) references that manual restraint should not be used for more than 15 minutes at a time. Can I suggest that the current wording somewhat offers an absolute although does not offer an alternate option should staff during a period of manual restraint be unable to remove themselves from the situation or use another alternative measure to keep both staff and patient safe within the 15 minute time frame (as noted). Justification: from time to time staff will unfortunately (although this will be dictated by the presenting behaviour and mental state of the patient) be unable to remove themselves from a restraint at a given time or for a given period of time as to do so may pose the patient and staff at a higher risk of danger. I would also question where the evidence and/or research to support 15 minutes of manual restraint has come from? Is this any better than say 10 minutes or indeed a longer time limit of say 20 minutes? Should this not sit in line with staff only using manual restraint for the shortest time possible to gain immediate control?	therefore be appropriate. Having received a number of comments about the time limit of 15 minutes, the GDG decided to change this to 10 minutes because restraining for longer 10 minutes is associated with much worse outcomes, including death(see NICE recommendation 1.4.29)...
Partnerships in Care	2	Full	170	0	Page 170 (6.6.1.19) references that mechanical restraint should be reserved for high secure settings only Can I suggest that the wording of this be changed as the issue of using a mechanical restraint device is not just relevant to high secure settings/environments as this does somewhat allude to the High Secure Estate only? Justification: there are a number of medium secure facilities that from time to time utilise	Thank you for your comment. It was the GDG's considered view that where individuals were sufficiently dangerous to require a period of mechanical restraint, such people would be in a high secure environment. The GDG also understood mechanical restraint for transport of some individuals between secure settings. They did not subscribe to the view that mechanical restraint would be appropriate in any other setting. They have, however, made it clear that mechanical restraint should only be used as a

					mechanical restraint devices for extremely challenging, violent or self-injurious and life threatening type behaviours. I personally feel that any use of a mechanical restraint device should only be considered as an extreme last resort when all other options have been considered and all of the relevant agencies have been notified. In line with this, organisations should be required to evidence and provide a full rationale and justification for use. Terry Heenan Management of Violence and Aggression Director Partnerships in care Email: terry.heenan@partnershipsincare.co.uk	last resort.
Partnerships in Care	3	Full	General	General	This is a very detailed and helpful set of documents. I have read them from the perspective of acquired brain injury and did begin to make detailed notes I could reference, but quickly gave up on this! Despite the burgeoning literature regarding ABI, violence and aggression, there is almost nothing in the document that describes the increasingly important associations that are being made on ABI as a causative factor underlying aggressive behaviour (either individually or in conjunction with other variables, including mental illness). Equally, I can find nothing about ABI in relation to risk assessment/prediction or management/outcomes. Throughout the document I could only find a single reference to 'organic brain syndrome' nested in Table 12. If the scope of the guidelines explicitly excludes ABI then I would be reassured if the GDG can confirm this. However, if ABI is assumed to fall within a very broad definition of 'mental illness' then it is absolutely essential that the	Thank you for your comment. The GDG agree that people with ABIs pose particular clinical difficulties and have added a new recommendation that states that "Healthcare provider organisations should train staff in emergency departments to distinguish between excited delirium states (acute organic brain syndrome), acute brain injury and excited psychiatric states (such as mania and other psychoses)," see NICE recommendation 1.5.5.

					document, advice and recommendations that services will be expected to embrace, properly reflects this clinical condition. If not, specialised neurobehavioural services will be expected to incorporate methods from mainstream and forensic psychiatry into their practice that are not consistent with the needs of the populations they serve. I am concerned regardless that ABI is not – as far as I can see from a first read – discussed as a major causative factor for aggression/violence, a very significant and surprising omission which warrants addressing. I would be happy to provide such input/advice if requested. Professor Nick Alderman BA (Hons) MAppSci PhD CPsychol CSci FBPsS Director of Clinical Services Partnerships in Care - Brain Injury Services Email: nick.alderman@partnershipsincare.co.uk	
Roche Products	1	General	General	General	No comments.	Thank you.
Rotherham Doncaster and South Humber NHSFT	1	NICE	26	0	OPMHS: it would be useful to have some information added regarding the instruments/ models appropriate for use in Dementia care settings	Thank you for your comment. The management of risk in people with dementia is covered in the NICE guideline on Dementia guideline (CG 42).
Rotherham Doncaster and South Humber NHSFT	2	NICE	28	0	(1.3.1) Could guidance be given on the searching of carers?	Thank you for your comment. This recommendation does advise that a health and social care provider should provide an operational searching policy to better inform carers. The searching of carers however is beyond the remit of the scope for this guideline.
Rotherham Doncaster and South Humber NHSFT	3	NICE	33	0	OPMHS: 'a doctor trained to use emergency equipment should be immediately available if restrictive interventions might be used'- comment: Doctors are not present all the time on our units -other staff on the unit/ ward who are present may be trained to use emergency	Thank you for your comment. The GDG felt that at the very least there should be a staff member available who is trained in ILS and a doctor if restrictive interventions are used; please see NICE recommendation for the amendment. See NICE recommendation 1.4.4.

					equipment - so the question is does it have to be a doctor? (this would be unrealistic for many services/ settings) or could the guideline offer some clarity and guidance on what to do in situations where there is no doctor immediately available FORENSICS LD: Services would struggle to have a doctor trained in ILS available immediately, and wonder if it would give assurance that all our staff are trained in ILS. Also is it part of the Junior doctor's contracts here that they should be no more than a 20 minute drive away. If this could be put into consideration also I think it would be more achievable for most NHS hospitals. AMHS: Doctors would not be immediately available – question using other staff appropriately trained in Life Support or use of 999.	
Rotherham Doncaster and South Humber NHSFT	4	NICE	38	0	Resuscitation Service: Rapid Tranquillisation is only described as IM as in previous guidance it was both IM and Oral, patients may choose to have medication via IM route or this may have been a best interest decision to use IM and therefore in both cases the use of IM may only be PRN, we may also miss times when oral medication may still be accepted by the patient but at the height of their escalation and therefore a higher risk.	Thank you for your comment. Although a service user can voluntarily ask for IM lorazepam, in this guideline rapid tranquillisation is defined as a restrictive intervention, which will necessarily take place against a person's will.
Rotherham Doncaster and South Humber NHSFT	5	NICE	38	0	Resuscitation Service: There appears to be a reduction in the physical observations needed after restraint. The sentence that states "for as long as necessary" how do we quantify this? There is no mention of the use of EWS with the physical observations; this is also a change and a concern, moving away from all national drivers for physical observations.	Thank you for your comment. The GDG felt that 'for as long as necessary' should be down to clinical judgement.
Rotherham Doncaster and South Humber NHSFT	6	NICE	40	0	Resuscitation Service -There has been a reduction in the physical observations after	Thank you for your comment. The GDG has changed the recommendation to make it clear

					rapid tranquillisation to once an hour and again no mention of the use of the Early Warning Score, again it states until there are no concerns how do we quantify this?	that it means no 'further concerns about the service user's physical health' after the monitoring of pulse, blood pressure, respiratory rate, and so on (see NICE recommendation 1.4.45).
Rotherham Doncaster and South Humber NHSFT	7	NICE	43	0	OPMHS: External Post incident review: we envisage that carrying out external post incident reviews (as set out in the draft) would be unrealistic in every case – for example a person with dementia may be oppositional to intervention on occasions and staff may need to use permitted restrictive interventions to deliver essential care if no other options possible – if an external review is required in every such instance this potentially would be beyond the capacity of services and would be questionable in its usefulness- we therefore suggest that some clearer criteria/ thresholds are set to differentiate the type and level of incidents requiring an external review. FORENSICS LD: External post incident reviews, these would be unrealistic for our area also, the amount of incidents we have in this area it would need a person to be tasked with co-ordinating this on a daily basis. Also due to us being a specialist service it would need to be an external body that is experienced in dealing with secure care. Again more clarification is needed regarding the level of incidents they are requesting an external post incident review for. There is also a reference to the patient leading the review, unfortunately that would not always be possible in this area as patients at times will lack capacity but also would need lots of support and guidance in leading a de-brief which I feel defeats the object of what they are trying to achieve. Unless they are referring to a patient who is external coming in and leading the review in which case this would need	Thank you for your comment. The GDG considered it to be essential that restrictive interventions should be monitored and analysed to ensure that human rights are upheld and to detect poor practice as quickly as possible. The group also wished to ensure that good practice in the use of restrictive interventions is standardised across England, hence the recommendation for a formal external post incident review. With regard to forensic Learning Disabilities, this is beyond the remit of this guidelines scope, however there is a guideline on mental health and learning disabilities currently in development that should cover your concerns. The GDG accepts that this recommendation will take some resources and effort to implement but it is very likely that in doing so there should be reduction in the use of restrict interventions and the beginning of a much more coherent understanding between service users and staff.

					looking into as it would need to be someone with experience in secure care but at the same time fulfils the requirements of working with patients such as DBS approval and not deemed as a risk to vulnerable patients. AMHS: Unrealistic agree with Forensic and timescale of 72hrs logistically difficult, to release staff. Already have systems in place to scrutinise and RI. Nursing and Partnerships (Listen to Learn): There is no current group established within the Trust that would be able to undertake the external post-incident review. This would therefore need to be established and is likely to impact on workload and capacity for both current staff and service user volunteers, as the Trust is currently reporting circa 800 incidents recorded as violence, aggression and harassment per quarter. The work needs to be linked to the Reducing Restrictive Intervention workstream.	
Rotherham Doncaster and South Humber NHSFT	8	NICE	46	0	CAMHS: Concur with the need for specialist training for CAMHS staff D&A: Concur with need for specialist training for community staff.	Thank you.
Rotherham Doncaster and South Humber NHSFT	9	NICE	47	0	CAMHS: Would welcome training/guidance on the causes of ASB, and techniques for dealing with ASB, concern would be with a policy of non-tolerance that there would be an increased risk of disengagement of children and young peoples from the service	Thank you for your comment. It is beyond the scope's remit to review the causes of ASB however there is a NICE guidance on Antisocial Behaviour and Conduct Disorders which can be referred to for more information.
Rotherham Doncaster and South Humber NHSFT	10	NICE	48	0	CAMHS: Is there any approved training that NICE recognises or would this be for local service to develop.	Thank you for your comment. This is a clinical guideline and the provision of training is a decision for local services. When this guideline goes out for publication NICE will provide implementation tools.
Royal College of General practitioners	1	Full	183	0	7.3 (Page 183 and general) Lack of recommendations regarding management of substance misuse?	Thank you for your comment. A separate NICE guidance has been published on substance misuse. Furthermore, the GDG strongly

					Given that substance misuse appears to be one of the major contributors to violence in in-patient and community settings, it needs greater attention and recommendations. This is an opportunity to improve integrated working across health and social care as drug and alcohol services are commissioned by public health now and appear to be becoming increasingly detached from health settings. (LE)	disagreed; there's no evidence of the association in inpatient care. Repeated studies with large samples have now shown no co-occurring connexion (in inpatient) between substance use and violence. Also goes beyond the short term management of violence and asking to review the longer term management.
Royal College of General practitioners	2	Full	77	0	(4.5.1.33-4.6.1.3) ?Conflicting statements 4.5.1 33 states: In community settings for adults, the only factors demonstrated to be risk 33 factors in both studies were history of being victimised and recent drug use. Other risk factors demonstrated in one study were history of violence – for women only - and conviction for a non-violent offence. In women, African-Caribbean ethnicity was also an independent risk factor for violence. Recommendation - 19 Do not make negative assumptions based on culture, religion or ethnicity. Completely agree shouldn't make assumptions but being an AC woman appears to be a risk factor that should be considered from the evidence above in risk assessment tools? (LE)	Thank you for raising this issue. When we looked at the association between ethnicity and violence, there were potential confounding factors. The GDG felt that because of this it was appropriate to recommend not to make negative assumptions based on ethnicity. We have now provided more information in section 4.5 about this.
Royal College of General practitioners	3	Full	General	General	*'Psychiatrisation'* of criminals A small subset of people with mental illness, those who are actively experiencing serious psychotic symptoms, are more violent than the general population. Research suggests several factors associated with this group's violent behavior, including drug and alcohol abuse, noncompliance with medication requirements, and biological or biochemical disorders. Extrapolating this, does this mean that a large	Thank you for your comment. The GDG felt it is questionable as to whether people with psychosis generally are more likely to be more violent than other people. In fact the evidence suggests that there is no association between substance misuse and heighted risk of violence. Please see the introduction in the full guideline which weighs up these issues at length.

					number of people with mental health problems are therefore being violent with capacity, insight and intent. Should this not be pursued down the normal legal routes? Are mental health problem an excuse for violent behaviour? (LE)	
Royal College of General practitioners	4	Full	200	17	I agree de-escalation skills are useful, can be taught and perhaps should be included as part of mandatory training for the workforce in general. This would be a good skill to have with patients generally whether they have mental health problems or not. So all individuals working in health and social care services should have knowledge of these techniques (obviously different levels of knowledge depending on roles and responsibilities). (LE)	Thank you. We agree with your comment. Each provider of healthcare / social services needs to undertake a risk assessment process and decide upon the level and extent of training required.
Royal College of General practitioners	5	Full	78	15	(4.6.1.8) After a risk assessment has been carried out, staff working in community and primary care settings should: • share the risk assessment with other health and social care services and partner agencies (including the police and probation service) who may be involved in the person's care and treatment, and with carers if there are risks to them • be aware of professional responsibilities in relation to limits of confidentiality and the need to share information about risks. I think the importance of communication needs much greater emphasis as information sharing is poor generally and as a GP I have never received a risk assessment from a secondary care colleague or info about this. Also need to make some recommendations about how primary health care teams can look at predicting/ assessing violence. GPs and many nursing colleagues (district nurses, community matrons) go out on home visits to see patients so what should they do? (LE)	Thank you for your comment. The GDG considers that the issues you have raised about risk assessment and communication are adequately covered in recommendation 1.2.13.

Royal College of General practitioners	6	Full	General	General	In general, there appear to be few recommendations on the management of violence and risk in primary care (and community care- not the CMHT but staff such as district nurses, health visitors etc). The document consistently refers to community within the context of CMHTs. My understanding of community services is broader encompassing practice nurses, district nurses, physios, dietiticians etc Need recommendations on data collection to look at prevalence of violence against the workforce in general and violence in primary care (including wider community team) related to mental health. (LE)	Thank you for your comment. The introduction to the NICE guideline has been revised to make it clear that the recommendations apply to mental health, *health* and community settings. Section 1.6 is specifically for people working in community and primary care, which would include the professionals you mention. Regarding your point about data collection, this is covered in recommendation 1.2.4: "Health and social care provider organisations should collate, analyse and synthesise all data about violent events and the use of restrictive interventions, share this information with the teams and services involved and the trust board or equivalent organisational governing body, and involve service users in the process. They should link the information to the standards set in safeguarding procedures."
Royal College of General practitioners	7	Full	169	19	(6.6.1.2) Staffing recommendations too narrow? In-patient care affected by number of staff on the ward and often because wards are not appropriately staffed additional 'specialing' costs are incurred. There can also be a lack of continuity of care with the use of large numbers of agency nurses in many wards. Wards need to have enough staff to deliver high quality holistic care not just be able to restrain. (LE)	Thank you for your comment. For NICE guidance on general staffing levels please refer to safe staffing guidance.
Royal College of General practitioners	8	Full	106	13	(Page 106 and general) I was so pleased to see an awareness of impact on resources. So often extra layers of obligation are added to already very stretched services without weighing up the time taken for what is new work. When clinical staff have no spare time anyway asking them to do something extra –including record keeping, can have the effect of taking staff away from front-line patient care. As professionals we often have to make a judgement about priority.	Thank you. We believe that ultimately the recommendations will lead to improvements for both service users and staff.

					There is a political culture of being 'risk aware' linked with a general feeling of fear in the health service (re complaints, disciplinary procedures etc) that means at times I have observed staff so busy with protocols and record keeping that they ignore the needs of patients. (DU)	
Royal College of General practitioners	9	Full	106	42	Great care would seem to be needed when altering the use of precious resources such as staff time, on the basis of mainly poor quality evidence. (DU)	Thank you, the GDG were mindful of the potential resource use when developing the recommendations. However, the GDG considered that the benefits (reduced levels of violence and aggression) and potential savings (through the reduction of repeat admissions) would be worth the cost of the service.
Royal College of General practitioners	10	Full	109	29	I agree the bedrock of care and avoiding problems is in an approach that is person centred, positive with continuity of care. Patients really, really appreciate dealing with the same professional- someone who understands them. I have seen this help in a dangerous situation many times- it is central to trust. Continuity of care does cost but is so good for patients also for staff morale and job satisfaction. (DU)	Thank you for your comment. The GDG agree in the importance of person-centred and continuity of care and appreciate your feedback in support of this recommendation.
Royal College of General practitioners	11	Full	200	17	I agree de-escalation skills are useful, can be taught and should be first line. (DU)	Thank you.
Royal College of Nursing	1	Full	General	General	(General principles) It does not seem clear whether the scope of this document is to support/improve patient experiences or to protect the safety of staff. If it is both then there needs to be further context regarding legislation in place to protect the safety of staff (and others such as other service users, contractors and visitors). The guidance refers to the Human Rights Act, Mental Health Act and the Mental Capacity Act but there is no cross reference to the legal obligations on employers to ensure compliance with the Health and Safety at Work Act or Management of Health and Safety Regulations.	Thank you for your comment. The NICE guidelines are to provide best practice guidance for healthcare and social professionals to ensure an optimal quality of care for service users; these are health and social care recommendations they may make reference to legal acts the level of legal context you are asking for in the NICE recommendations as this is beyond the remit of the scope.

Royal College of Nursing	2	Full	General	General	We feel the document is missing a section encouraging the reporting of violent incidents towards staff that did not result in restrictive practices. The early reporting/investigation and follow up/risk assessment review of such events can help prevent further incidents and the need to use restrictive practices. This would fit in with section 1.2	Thank you for your comment. The GDG agreed and has made further recommendations about improving reporting (NICE recommendation in 1.2.3, 1.4.54, 1.4.55) and staff safety (NICE recommendation 1.4.2).
Royal College of Nursing	3	Full	General	General	In terms of the prevention of violence and aggression in emergency departments. We feel some emphasis should be placed upon post-incident analysis as well as post-incident de-brief.	Thank you for your comment. In the NICE guideline the section on post-incident debrief and post- incident review (1.4.53 -1.4.63) is also applicable to emergency departments but the GDG has now made this clearer in the document.
Royal College of Nursing	4	Full	General	General	There is also the need for positive behaviour support. This cannot be emphasised enough; it is usual practice in learning disability service provision.	Thank you for your comment. The National Collaborating Centre for Mental Health is currently reviewing the evidence of Positive Behaviour Support for people with learning disabilities in 2 separate guidelines, the first is challenging behaviour and learning disabilities (the expected publication date is 27 May 2015) and the second is mental health problems in people with learning disabilities (the expected publication date is 14 September 2015).
Royal College of Nursing	5	Full	General	General	We feel that communication should receive high attention as some people will need particular support needs regarding their communication or limitations; i.e. those who cannot speak or communicate verbally very well	Thank you for your comment. Please see NICE recommendations 1.2.1, 1.2.7 and 1.7.10 which all aim at ensuring staff are trained to pick up on the communication needs of the service user.
Royal College of Nursing	6	Full	General	General	In terms of the prevention of violence and aggression in emergency departments, some emphasis should be placed upon post-incident analysis as well as post incident debrief. Any commonalities in terms of the working environment at the time either when it is very busy with long waiting times or not, members of staff involved in any incident, the location of the incident (relative isolation in triage appears a common historical feature) would assist in	Thank you for your comment. In the NICE guideline the section on post-incident debrief and post- incident review **(1.4.53 -1.4.63)** is also applicable to emergency departments but the GDG has now made this clearer in the document.

					future prevention strategies.	
Royal College of Nursing	7	NICE	21	0	(1.1.13) Partnership working with the police and in prisons; Health and nursing requirements and actions will differ from mainstream policing and attention to NMC Professional Code is paramount in these settings.	Thank you for your comment. The GDG felt this issue has been addressed.
Royal College of Nursing	8	NICE	29	0	There is the risk of 'inoculation injury' to staff from medical sharps such as hypodermic needles, this needs to be identified in this section and a safe protocol put in place (e.g. as in 1.3.7).	Thank you for your comment. The GDG has added a bullet point to recommendation 1.4.2 about ensuring safety of staff, including when using hypodermic needles during rapid tranquillisation.
Royal College of Nursing	9	NICE	32	0	We feel that there is the need for some reference to the physical demands of carrying out a restrictive intervention and that staff recovering from injury or illness may not be able to fully support such interventions.	Thank you for your comment. This is a matter for local resourcing which will need to be considered by local services. NICE is producing a series of Safe Staffing guidelines to protect professionals: http://www.nice.nhs.uk/guidance/safestaffing/SafeStaffingGuidelines.jsp
Royal College of Nursing	10	NICE	35	0	There needs to be an acknowledgement that the nurse observer may be a 'lone worker' and will need access to an effective means of raising an alarm/checks (referring to the lessons learnt following the death of nurse Mamade Chattun at St George's Mental Health trust in 2003)	Thank you for your comment. The recommendation has been changed to address your concerns by stating that nurses should have immediate access to other members of staff if needed.
Royal College of Nursing	11	NICE	36	0	We welcome the recognition of fatigue and the need for regular breaks where staff members are observing for longer than two hours.	Thank you.
Royal College of Nursing	12	NICE	37	0	Manual restraint should be the last resort but as in accordance with our comments in (7) above regarding the NMC Professional Code, this will be important to broker a clear pathway and expectations of staff, in terms of what IS and IS NOT acceptable.	Thank you, although the GDG did not specifically mention the NMC Professional Code of Conduct, it believes the point you are making is covered by the principles recommended in the guideline.
Royal College of Nursing	13	Full	38	0	(1.4.37) We understand from our members that such activities present a significant risk of a sharps injury to a member of staff and would want	Thank you for your comment and bringing this to the GDG's attention. The GDG has added a bullet point to recommendation 1.4.2 about ensuring safety of staff, including when using

					organisations to implement 'safer injection devices' to reduce the risk of a post incident inoculation (as required by the Health and Safety (Sharp instruments in health care) regulations 2013.	hypodermic needles during rapid tranquillisation.
Royal College of Nursing	14	NICE	43	0	Is there any clinical evidence on the benefits of a more formal de-brief for staff following such events?	Thank you for raising this issue. As described in the full guideline (section 6.5.2) there was very little empirical evidence, but the GDG felt it was important to make recommendations based on good practice and their expert opinion.
Royal College of Nursing	15	NICE	45	0	The requirement for all patients attending emergency departments (ED) to undergo mental health triage may not be feasible; some EDs have abandoned triage and replaced it with streaming and/or rapid assessment teams. It may be more feasible to require the clinician of first contact to undertake this triage assessment and also to formally document whether the patient appears to be under the influence of drink and/or drugs which poses additional risk. It may also be appropriate to recommend a mental health triage tool such as the Australian MH (Mental Health) triage tool for standardisation of practice.	Thank you for your comment. It is the GDG's experience that most emergency departments still use mental health triage, and that it is an important aspect in the prevention of violence and aggression. The guideline is not able to recommend any specific tools because these were not reviewed.
Royal College of Nursing	16	NICE	46	0	We would like to see more around the personal safety of lone workers in the community (e.g. means of raising the alarm, supervision - particularly out of office hours) see NHS Protect guidance on lone working.	Thank you for your comment. Recommendations in section 1.6 have been revised to take account of your concerns. See revised recommendation 1.6.6 for what CMHTs should do in situations of medium and high risk.
Royal College of Paediatrics and Child Health	1	General	General	General	No comments.	Thank you.
Royal College of Psychiatrists	1	Full	General	General	The use of the MHA is not explicitly mentioned in the section on children and young people. In our opinion there needs to be some discussion about its application to this group and in particular on whether restrictive interventions would fall within the zone of parental control and therefore constitute restriction of liberty or	Thank you for your comment. NICE recommendation 1.7.3 has been revised in light of your suggestion to include reference to the MHA. However it is beyond the remit of the scope to provide more detailed advice on the applicability of legislation.

					whether they amount to deprivation of liberty. The use of restrictions is very different in young children compared to adolescents and adults and this needs to be discussed more. Chapter 36 of the MHA code of Practice can be used to inform these discussions.	
Royal College of Psychiatrists	2	Full	167	19	(Lines 19-20) The recommendation to limit the duration of manual restraint to 15 minutes appears arbitrary and does not reflect practice. What is the evidence base for this recommendation? Furthermore this recommendation appears to be watered down on page 170, line 34 by stating "Do not routinely use manual restraint for more than 15 minutes." (change of format to bold by us). We note that these two somewhat conflicting recommendations are in the general section while the section on manual restraint specific for children and young people remains silent on the duration of the manual restraint (page 200, lines 36-37).	Thank you for your comment. Having received a number of comments about the time limit of 15 minutes, the GDG decided to change this to 10 minutes because restraining for longer 10 minutes is associated with much worse outcomes, including death (see NICE recommendation 1.,4.29). Regarding your point about manual restraint in children and young people, please note that, as stated in recommendation 1.7.4, management of violence and aggression in children and young people, including use of manual restraint, should be in line with the recommendations for adults, adapted for the child's level of maturity.
Royal College of Psychiatrists	3	Full	169	24	(Lines 24-30) While we understand and agree that there is a rational for specialist equipment like "an automatic external defibrillator and a bag valve mask oxygen" to be available given that these are accessible in many public places (e.g. train station etc), we have reservations about the practicability of the other suggested items, namely "cannulas, intravenous fluids, suction and first-line resuscitation medications" to be available and maintained on a weekly basis. It might be worth pointing out that in certain settings these events are extremely rare (e.g. children's inpatient unit) and would suggest that calling emergency ambulance services might be a safer and more realistic option.	Thank you for your comment, but the GDG wished to uphold the principle of parity of esteem between physical and mental health care. Following this principle, they carefully considered that it was of some importance that resuscitation equipment was available immediately, and in good working order. In recommendation 1.7.1 a new bullet point has been added that staff who undertake restrictive interventions should be trained in the use of resuscitation equipment in children. See NICE recommendation 1.4.4.
Royal College of Psychiatrists	4	Full	171	26	(Pages 171-2, lines 26-38; 1-29) Consideration should be given to rephrase	Thank you for your comment. The GDG revisited these recommendations and

					(rewrite) the section on rapid tranquilisation. It does not read well. Adding an algorithm chart would enhance understanding and clarity.	made some adjustment to the wording to add clarity. An algorithm was considered, but it was decided that this would be better done at a local level so that the recommendations are properly incorporated into local protocols..
Royal College of Psychiatrists	5	Full	200	15	(Lines 15-16) The recommendation to "Offer a parent training programme and support to parents of children and young people who are violent or aggressive" needs specifying. What kind of parent programme is the GDG referring to? Where is the evidence base for this rather general recommendation?	Thank you for your comment. The recommendation has been amended in light of your comment.
Royal College of Psychiatrists	6	Full	201	1	(Lines 1-12) There are no high secure settings for under 18s in this country. In extremely rare circumstances older adolescents might be transferred to adult forensic high secure settings. We are concerned about NICE limiting the use of mechanical restraints to high secure settings for adolescents, which do not exist. The use of Emergency Response Belts (a form of mechanical restraint) has been sanctioned by the commissioners for the National Secure Forensic Mental Health Service for Young People, and three of the units in the service have operational policies permitting their use. All usage is monitored by the provider organisations, across the service nationally, and reported to the commissioners. The CQC's review of the MHA nationally in 2013 highlighted positive practice in relation to ERB where they had been consulted in advance.	Thank you for your comment. The recommendation has been amended in light of your comment.
Royal College of Psychiatrists	7	Full	201	13	(Lines 13-15) We suggest that a stepped approach to the psychopharmacological management of violence and aggression is considered. This would involve offering oral medication first, e.g. oral promethazine or lorazepam. This reflects	Thank you for your comment. NICE recommendation 1.7.21 covers rapid tranquillisation. We have amended the section 'terms used in this guideline' to clarify the approach and definitions used in this guideline .

					the practice in child and adolescent psychiatry inpatient settings in UK. A section on the best evidence base for managing aggression with oral medication for adults and a second section for under 18s is missing. Is there a rational for this omission?	Section 7.7.4 (Full) highlighted the fact that no evidence was found which enabled the GDG to assess the benefits and harms of pharmacological interventions. Lorazepam was the only pharmacological intervention agreed by expert opinion and concensus.
Royal College of Psychiatrists	8	Full	201	22	(Lines 22-23) A significant number of seclusions occur outside of working hours when it would be unrealistic, time consuming and adversely affecting the care of the child and young person to convene a full MDT meeting in order to make a decision regarding seclusion. We suggest that such a decision should be sanctioned by senior clinicians and reviewed according to locally agreed protocols.	Thank you for your comment. The GDG agreed and the recommendation on seclusion has been amended to reflect: "Decisions about whether to seclude a child or young person should be approved by a senior doctor and reviewed by a multidisciplinary team at the earliest opportunity."
Royal College of Psychiatrists	9	Full	201	25	(Lines 25-6) Seclusion is defined in the glossary of terms (in the NICE document) as "the supervised confinement of a patient in a room, which may be locked." It would be helpful to have a rational as to why this definition is changed for children and adolescents, i.e. why it is advised not to seclude a child or young person in a locked room?	Thank you for your comment. The GDG felt we should keep the recommendation because of potential safety issues and increased vulnerability of children, but please note this applies to children only (and not young people).
Royal College of Speech and Language Therapists	1	NICE	11	20	Skills, methods and techniques to reduce or avert imminent violence and defuse aggression when it arises- suggest add e.g. verbal de-escalation	Thank you for your comment. This recommendation has been amended in light of your comment.
Royal College of Speech and Language Therapists	2	NICE	12	9	After line 9 add this as a bullet point: 'Recognise the effect of communication difficulties in relation to escalating frustration'. It is important that staff are aware of the effect of such difficulties and the frustration caused when a person is unable to express what they want to say. In such circumstances, service users are more likely to resort to physical violence.	Thank you for your comment. 'Support for communication difficulties' has been added to the recommendation.
Royal College of Speech	3	NICE	23	0	The Service User Experience Monitoring Unit	Thank you for your comment. It is expected that

and Language Therapists					should particularly examine instances where restrictive interventions are used on service users with communication difficulties.	the Service User Experience Monitoring Unit will analyse restrictive interventions in all service users who are violence and aggression and not just in those with communication difficulties.
Royal College of Speech and Language Therapists	4	NICE	24	1	After psychological therapies, 'add support for communication difficulties', physical activities ….	Thank you for your comment. 'Support for communication difficulties' has been added to the recommendation (see NICE recommendation 1.2.7).
Royal College of Speech and Language Therapists	5	NICE	25	0	Within the final bullet point…'such as anxiety, agitation, 'communication difficulties', disappointment…' It should also be explicitly acknowledged in the report that risk assessment primarily involves talking to the person to monitor mood, agitation etc. Where the service user has a communication disorder, risk assessment may be more difficult and the staff may need support from a speech and language therapist to ensure that their assessment is reliable. In some cases non-verbal strategies such as individualised mood charts etc. may be required.	Thank you for your comment. Communication disorders are not specific to people who exhibit violence or aggression and are one of many disorders including thought disorder or symptoms of psychosis, however reference to communication difficulties has been added to recommendation 1.2.7.
Royal College of Speech and Language Therapists	6	NICE	43	27	Staff undertaking investigations of incidents should have training in communicating with service users who have communication difficulties.	Thank you for your comment. The GDG felt NICCE recommendation 1.2.1 covers the assessment of the service users communication needs and it should be that trained staff member who undertakes a post incident debrief.
Royal College of Speech and Language Therapists	7	NICE	47	0	Add to the first bullet point: 'and their ability to communicate effectively'.	Thank you for your comment. NICE recommendation 1.7.10 has been amended to identify the possible communication difficulties which may increase the risk of violence or aggression in a child or young person.
Royal College of Speech and Language Therapists	8	NICE	48	0	Rather than 'language', it would be better to use 'language and communication'. (Language is often interpreted only as non-English language).	Thank you for your comment. The recommendation has been changed according to your suggestion.
Royal College of Speech	9	Full	76	28	This could be achieved through a focus on	Thank you for your comment.

and Language Therapists					attuned communication, see: 'Containing conversations': introducing VERP into a secure forensic service for adolescents. Helen Gibson, Martin Elliot and Emily Archer In VIDEO ENHANCED REFLECTIVE PRACTICE: Professional Development through Attuned Interactions Edited by Hilary Kennedy, Miriam Landor and Liz Todd (in press)	Although a good idea for mental health professionals generally, we found no benefit for its short term management of violence and aggression
Royal College of Speech and Language Therapists	10	Full	77	25	Ensure that staff is alert to potential unrecognised communication difficulties (and EAL). If present these should be considered and accommodated to, in all interactions with the service user.	Thank you for your comment, but communication difficulties are not specific to people who exhibit violence and aggression.
Royal College of Speech and Language Therapists	11	Full	80	20	It seems imperative that there should be quality control on courses about the prevention and control of violence. These should include an awareness of how verbal and non-verbal interaction can escalate or de-escalate violence, including when the service user has a communication difficulty or EAL	Thank you for your comment. This update of the guidance has significantly expanded content on verbal and non verbal de-escalation. These take into account the fact that nearly all disturbed psychiatric patients have a variety of cognitive and communication difficulties.
Royal College of Speech and Language Therapists	12	Full	108	15	'Involving service users in decisions about their care' means they also need to take into account potential unrecognised communication difficulties (and EAL). If present these should be considered and accommodated in all interactions with the service user; including any interventions or treatment	Thank you for your comment. The communication abilities of the service user is integral throughout out, see the definition for de-escalation and NICE recommendations 1.2.1 and 1.2.7 on staff should be skills to assess the communicational needs of the service user.
Royal College of Speech and Language Therapists	13	Full	113	34	These techniques should meet the communication needs of the user. Also a reduction in the use of verbal language may help service users process the situation and calm themselves, saying too much, can increase aggression.	Thank you for your comment. The GDG agreed but felt this issue is not specific to this guideline. There are a number of recommendations on communication already.
Royal College of Speech and Language Therapists	14	Full	199	12	'This needs to include and consider their communication skills and potential unrecognised communication difficulties' – (Alexandra Hollo, Joseph H. Wehby1, Regina M. Oliver2	Thank you for your comment. NICE recommendation 1.7.10 has been amended to identify the possible communication difficulties which may increase the risk of violence or aggression in a child or young person.

					Unidentified Language Deficits in Children With Emotional and Behavioural Disorders: A Meta-Analysis Exceptional Children Volume 80, Number 2 / Winter 2013)	
South Central Ambulance Service NHS Trust	1	Full	General	General	There is not enough practical guidance for front line ambulance staff.	Thank you for your comment. In the NICE guideline parts of the section on restrictive interventions (1.4) are also applicable to ambulance services. The GDG has now made this clearer in the document. The sections on anticipating and preventing violence and aggression (1.2 and 1.3) are also applicable to ambulance staff unless stated otherwise, therefore the GDG has not made the specific changes you have suggested.
South Central Ambulance Service NHS Trust	2	Full	General	General	The guidance appears not to recognise the unique working environment of front line ambulance staff where there may only be one person with the patient and no immediate access to other support.	Thank you for your comment. The GDG recognises the important role played by ambulance staff in preventing and managing violence and aggression. Please note that while section 1.6 of the NICE guideline is specifically for community and primary care staff, parts of sections 1.1-1.4 are also applicable unless stated elsewhere, therefore the GDG has not made the specific changes you have suggested.
South Central Ambulance Service NHS Trust	3	Full	General	General	There doesn't seem to have been anyone from the Ambulance Service involved in the Development Group or Review Team (although the police were included).	Thank you for your comment. This is an evidence-based guideline that focuses on interventions rather than on who provides them. We have addressed the range of interventions and settings which overall were represented in the guideline development group. Furthermore it is part of the guideline process to ensure the recommendations and the evidence is available to all stakeholders during consultation so that they may advise the guideline group further.
South Central Ambulance Service NHS Trust	4	Full	117	18	Staff Training. There is no mention of a requirement to train staff in appropriate restraint techniques. Ambulance staff are trained in de-escalation techniques and risk assessments but if they cannot safely contain aggressive	Thank you for your comment. In the NICE guideline the section on restrictive interventions (1.4) is also applicable to ambulance services. The GDG has now made this clearer in the document.

					behaviour when it occurs, both of the above are useless.	
South Central Ambulance Service NHS Trust	5	Full	117	29	Managing violence and aggression. There is no mention of HOW to manage aggression or type of training which staff require. There is no mention of the ambulance service and although it might be prudent to have a Dr and a Social Worker (would the term Approved Mental Health Professional be more appropriate?) undertaking a community assessment together, they may not be trained to manage any aggression.	Thank you for this comment. The GDG felt that given the current evidence base, provider organisations need to take responsibility for sourcing training that is appropriate for their needs (the ambulance service is specifically mentioned in the training recommendations, and by definition is included in recommendation 1.6.5). The GDG felt that rec 1.6.5 would be understood by professionals working in community settings.
South Central Ambulance Service NHS Trust	6	Full	164	37	(Lines 37-9) It is not a core responsibility of the police to routinely provide restraint in a health care setting where the risk of violence is already known. Service providers should establish appropriate responses as required and police used only in exceptional circumstances.	Thank you for your comment. This section of the guideline has been amended in accordance with a change to the corresponding recommendation, which now says that the police should only be contacted if there is immediate risk to life (see NICE recommendation 1.6.6).
South Central Ambulance Service NHS Trust	7	Full	167	20	(20-3) It is not a core responsibility of the police to routinely provide restraint in a health care setting where the risk of violence is already known. Service providers should establish appropriate responses as required and police used only in exceptional circumstances.	Thank you for your comment. This section of the guideline has been amended in accordance with a change to the corresponding recommendation, which now says that the police should only be contacted if there is immediate risk to life(see NICE recommendation 1.6.6)..
South Central Ambulance Service NHS Trust	8	Full	167	23	Line 23 (“…..to contact the police”) contradicts line 9 (“interventions should not be users to inflict pain”) as police restraint techniques rely on pain compliance.	Thank you for your comment. The GDG felt that we were in fact covering 2 separate issues, the first is covering where the NHS can manage a situation and deploy restraint as one of several techniques available to them to manage a violent event vs a situation that is beyond the ability of the staff and where calling police for assistance is necessary and justified.
South Central Ambulance Service NHS Trust	9	Full	173	32	“…and contact the police.” It is not a core police responsibility to provide restraint for health care settings – as stated above (re p164).	Thank you for your comment. These recommendations are for community settings as opposed to ‘health care setting’ and is not what the GDG envisaged.
South Central Ambulance	10	NICE	46	0	“If manual restraint is needed, staff should	Thank you for your comment. The

Service NHS Trust					remove themselves from the situation and contact the police". It is not a core police responsibility to provide restraint for health care settings – as stated above (re p164 of full version).	recommendation has been revised to address your concerns.
South Eastern Health and Social Care Trust	1	General	General	General	It is encouraging to note that the principals identified for managing violence and aggression including those who present with Mental Health Complications are those which we currently adopt, particularly in relation to Manual Restraint at 1.4.23 and Managing Violence & Aggression in Emergency Departments at 1.5	Thank you for your comment.
South Eastern Health and Social Care Trust	2	General	General	General	This draft for consultation identifies the need for those involved in Manual restraint to work closely together and to that end we as a department are actively considering a model of training which those in Mental Health treatment areas have now adopted.	Thank you for your comment.
South Staffordshire and Shropshire Healthcare NHS Foundation Trust	1	Full	84	0	5.3.1 There is a lot of evidence from the NHS Protect assault statistics, that there are a large number of assaults within Older Adult assessment services	Thank you for your comment. Frequency of aggression statistics are largely uninformative about how such behaviours are to be managed. There are indeed a large number of sources of official statistics and academic research on frequency, but this is not very helpful in terms of giving evidence for practice. Older adult services would be included in the phrase 'some other speciality areas' (84, line 4)
South Staffordshire and Shropshire Healthcare NHS Foundation Trust	2	Full	173	0	The Mental Health Act, Code of Practice talks about a suitably qualified professional should be within sight and sound of the patient. The NICE guideline states Nurse, does 'Nurse' include assistant practitioners and HCSW or just registered nurses. Also legally which would we have to follow the Code of Practice or the NICE guideline	Thank you for your comment. The recommendation has been changed to say 'suitably trained member of staff'(see NICE recommendation 1.4.50).
South Staffordshire and Shropshire Healthcare NHS Foundation Trust	3	Full	173	0	The Mental health Act Code of Practice discusses the use of Anti rip suits being used appropriately within seclusion facilities. The NICE guideline states that patients should be	Thank you for your comment. The Mental Health Act Code of Practice makes it plain that service users should never be deprived of appropriate clothing during the day with the

					maintained in their own clothing. Should the NICE guideline also mention the use of the Anti-rip suits?	intention of restricting their movement. While you are not suggesting anti-rip suits should be used for this purpose there is a danger that service users in seclusion would misinterpret the offer of anti-rip suits. In addition, the GDG thought it was more important to not single people out by changing their clothing.
South Staffordshire and Shropshire Healthcare NHS Foundation Trust	4	Full	171	0	MSU's are routinely handcuffing patients for visits to Acute Healthcare Trusts, Dentists, court appointments and other related appointments. According to the draft guideline this would not be covered, except for transfers to High Secure units. Should the guideline be changed or should the practice of handcuffing be reviewed	Thank you for your comment. It was the GDG's considered view that where individuals were sufficiently dangerous to require a period of mechanical restraint, such people would be in a high secure environment. The GDG also understood mechanical restraint for transport of some individuals between secure settings. They did not subscribe to the view that mechanical restraint would be appropriate in any other setting."
South Staffordshire and Shropshire Healthcare NHS Foundation Trust	5	Full	171	0	Especially in older adult care the choice of Rt will be restricted to Lorazepam, due to the recommended anti psychotics possibly being contra indicated for alder adults with particular conditions. Abilify is widely used in older adult care, why does this not show up in the guideline.	Thank you for your comment. Please see the full guideline, section 6.5 linking evidence to recommendations. We have amended the statement about lorazepam being a 'first choice option' to reflect the fact that this is in the context of drug choice – and not as a specific first choice of any intervention. With regard to aripiprazole (Abilify), this was included in the review of rapid tranquillisation (section 6.3), but there was no evidence regarding older adults specifically.
South West Yorkshire Partnership NHS Foundation Trust	1	NICE	37	0	It is clear that there isn't sufficient evidence to make many specific recommendations in the guidance about restraint but it does seem to contradict Positive and Proactive Care (2014) which may be an issue. "Staff must not deliberately restrain people in a way that impacts on their airway, breathing or circulation, such as face down restraint on any surface, not just on the floor. [Para 70] Positive and Proactive Care (2014)" This could cause difficulties when both sets of	Thank you for your comment. Although the GDG was broadly supportive of Positive and Proactive Care and the Positive and Safe Work Programme, there were some differences of opinion around prone and supine restraint. Nevertheless the overall approach to manual restraint is very similar.

					guidance are enacted.	
South West Yorkshire Partnership NHS Foundation Trust	2	NICE	37	0	Time limiting restraint is new (David Bennett report suggested 3 minutes) and it is also not compatible with Positive and Proactive Care (2014) for reducing all restrictive interventions including rapid tranquillisation and seclusion in that we are swapping one for another.	Thank you for your comment. In light of new evidence the recommendation which you mention (NICE recommendation 1.4.29 and 1.4.30) has been revised; for the evidence please see the full guideline chapter 6, Linking evidence to recommendations.
St John Ambulance	1	General	General	General	The guideline addresses primarily hospital based situations, though there are sections for Ambulance and community services. I feel that there is a significant omission in the Ambulance section (and possibly the community service section) on how to deal with the violent, alcohol intoxicated individuals. The type of recommendation that I would like to see considered includes (for alcohol intoxicated individuals) for example: • Ambulance personnel might undertake a triage at a distance before approaching someone who is potentially or actually violent. • In the absence of a life threatening condition it may be better for the ambulance crew to delay intervention until the individual has decided that he does indeed need assistance a 'wait and see' approach to give the casualty time to 'cool down'. • Ambulance personnel may wish to negotiate with the casualty and the police for the police (and rationale bystanders) to withdraw to a distance that the casualty finds non-provocative whilst treatment is given. An alternative approach is for the ambulance to park a short distance away and invite the casualty to come to the ambulance. • Ambulance personnel also need to consider whether the sex or ethnicity of their team might provoke further violence.	Thank you for your comment and for your suggestions. In the NICE guideline parts of the section on restrictive interventions (1.4) are also applicable to ambulance services. The GDG has now made this clearer in the document. The sections on anticipating and preventing violence and aggression (1.2 and 1.3) contain many of the principles you highlight and are applicable to ambulance staff unless stated otherwise, therefore the GDG has not made the specific changes you have suggested.
Wales Institute of Forensic Medicine	1	Full	General	General	This document is clearly the product of a great deal of detailed study and discussion. I	Thank you for your very thoughtful comments. The GDG were mindful of the issues you raise,

					commend those involved for their application to the task. My concerns arise out of my field of practice – forensic pathology – and the depressing regularity with which I still see cases of death during struggle against restraint. Over the last three years or so I have seen deaths after restraint: • By police, in a general hospital, in natural disease, • By police, and by ambulance staff, in the community, after cocaine, • By police, in the community, after cathinones, • By police and mental health staff, in s136 place of safety, with "psychosis" • By police and mental health staff, on a general psychiatric ward, after chronic drug-induced behavioural abnormality • By security staff, outside a pub, after behavioural disturbance • By police, in custody, after cocaine The common thread in these cases is the emergency management of acute behavioural disturbance where there is a need for multi-agency involvement. I am mindful of the exhortations in paras10.16 – 10.19 of the 2008 Code of Practice to the Mental Health Act 1983 and the onus placed upon LSSAs, hospitals, NHS commissioners, police forces and ambulance services to work together in such situations and to have agreed protocols in place to provide appropriate training for all those involved. Sadly, the cases seen by me do not convince me that these paragraphs are embedded in practice. Whilst, there may be fiscal reasons for this, they will not be regarded by many as adequate excuse.	and have kept this in mind during revision of the guideline. In particular, they were very mindful of the issue of deaths in custody, and invited Lord Adebowale as an expert witness. As you point out, the interface with the Police is complex and there is little evidence to guide practice. The GDG cannot make recommendations for the Police, so ultimately it will require local health and social care provider organisations to develop joint working policies. The GDG hope that this guidance provides the principles to do so.

					I appreciate that the GDG had difficulty finding good published data to inform strategies addressing the immediate management of serious behavioural disturbance in the community, or in health settings where sufficient staff trained in physical and chemical restraint are not available, but these are the contexts in which fatalities occur and where those who have little training and no experience, in the identification of persons in jeopardy of death during restraint, have to act. I feel that this guidance should go further into that evidence that exists around deaths during police restraint in the community and in hospitals. There is, I would suggest, confusion over which agency takes primacy in which location and over the techniques that are employed. Control and restraint techniques developed for the apprehension of the offender resisting arrest differ from tactics employed in health to deal with an acute behavioural disturbance where the well-being of the client is the primary goal and where there is greater emphasis on de-escalation. Those techniques used by police in the control and restraint of the fit young man can be potent triggers in the multi-factorial pathway that leads to death after restraint. We cannot expect people who have never experienced the management of serious behavioural disturbance to anticipate a sudden death during restraint but we can ensure that the danger of restraint is recognised and that the danger need not be obvious– victims may be breathing and talking up to the point of collapse. Deaths from peanut allergy are far less common than deaths during restraint but we have achieved a widespread awareness of the	

					danger – the same needs to happen with the use of restraint with a target audience of police, ambulance staff, psychiatric staff, hospital staff, security staff “bouncers” etc I think that the guidance needs to describe in more detail the emergency management of acute behavioural disturbance. It is not enough to pass this responsibility on to the police when optimum practice dictates the presence of medical assistance or the use of protocols formulated with significant medical input, that address techniques to employ including de-escalation, means of restraint, transportation methods, and where to take patients.	
Wales Institute of Forensic Medicine	2	Full	12	1	If the guidance covers violence and aggression in the community then it has to be more than “relevant” to police and security personnel – it is going to have to form the basis for a multi-agency approach where the actions, roles and responsibilities of co-operating organisations are part of agreed and co-informed protocols	Thank you for your comment, but the remit of the guideline is to cover the work of the police only in so far as this work intersects with the clinical management of violence and aggression. The guideline recommends the development of policies for joint working and operating protocols but it cannot go any further than that.
Wales Institute of Forensic Medicine	3	Full	14	16	(Lines 16-20) I agree – hence need for this guidance to reach into police and security practice.	Thank you for your comment.
Wales Institute of Forensic Medicine	4	Full	26	27	(Lines 27-41) Agree – also true in police and security and army training. Need to produce a standard.	Thank you.
Wales Institute of Forensic Medicine	5	Full	27	20	(Lines 20-22) In fatal death during restraint there is frequently no link between the agency restraining and informed health professionals.	Thank you for your comment. We are not clear what point is being made here. This section is an introduction to give an overall context to the current management of violence and aggression in the NHS as described by the GDG. More detail can be found in the evidence chapters.
Wales Institute of Forensic Medicine	6	Full	28	4	(Lines 4-12) Agree that acut violence and aggression needs psychiatric input at earliest possible time.	Thank You for your comment.
Wales Institute of Forensic	7	Full	65	11	(Lines 11-15)	Thank you for your comment. We appreciate

Medicine					Strongly agree – how is this to happen in the community?	the challenge in the community. However the GDG made this point (about parity) to put forward the concept and a framework within which to consider the psychiatric emergency of violence and aggression.
Wales Institute of Forensic Medicine	8	Full	80	33	But which currently put practitioners of those taught techniques in jeopardy.	Thank you for your comment. Unfortunately there is no evidence on which techniques put practitioners in jeopardy. However some reasonable training is better than offering staff no guidance whatsoever.
Wales Institute of Forensic Medicine	9	Full	105	29	(Lines 29-31) Strongly agree	Thank you
Wales Institute of Forensic Medicine	10	Full	106	6	(Lines 6-12) This needs to go further and cover the multi-agency management of violence and aggression in the community. Techniques to be used by police need to be balanced by risk to community from client and risk to client – which is an assessment that needs medical input.	Thank you for raising this issue. Multi-agency working is covered in the guideline, in particular, (see section 6.5).
Wales Institute of Forensic Medicine	11	Full	127	34	(Lines 34-38) Whilst the quality of literature related to death in restraint is undeniably poor (for obvious reasons) there are nevertheless reports and papers which can help to inform clinical decision-making particularly with regard to balancing the risk of physical restraint to the client against the risk of the client to others, and there is support for attitudes that reduce confrontation and which de-escalate.	Thank you for raising this. Following the approach set out in the review protocol we didn't identify any relevant evidence. We then drew on GDG expert opinion.
Wales Institute of Forensic Medicine	12	Full	164	37	(Lines 37-39) Fine, but only if the police can deal with the situation in a way which has had medical input or which is under health management.	Thank you for your comment. This section of the guideline has been amended in accordance with a change to the corresponding recommendation, which now says that the police should only be contacted if there is immediate risk to life (see NICE recommendation 1.6.6).
Wales Institute of Forensic Medicine	13	Full	165	33	(Lines 33-35) I think this is a cop out. This duty already exists under the CoP to the MHA but it doesn't	Thank you for your comment. This was part of the 'Mental Health Crisis Care Concordat'; given the diverse nature of the area

					happen. It is too much to be left to 43 separate police forces and the health ares they serve – they need national protocols that can be implemented locally with appropriate modification according to local geography etc.	the level of detail being asked would not be possible for national health and social care recommendations.
Wales Institute of Forensic Medicine	14	Full	166	24	(Lines 24-36) An important issue to make security staff and police aware of.	Thank you
Wales Institute of Forensic Medicine	15	Full	166	28	(Lines 28-31) Again, a cop out, - for reasons given above.	Thank you for your comment. The GDG have gone as far as they could in making recommendations for the police given the lack of evidence.
Wales Institute of Forensic Medicine	16	Full	167	21	(Lines 21-23) If the GDG is making judgements without an evidence base on this issue, then it should be prepared to give judgements on ”safe restraint” for police use, despite the problems with the evidence base.	Thank you for your comment. This section of the guideline has been amended, please see NICE recommendation 1.6.6 to reflect techniques to use in situations of medium or high risk.
Wales Institute of Forensic Medicine	17	Full	169	4	(Lines 4-16) Need to include who takes primacy in what settings. Need to have national policies for the actual interaction with the client to ensure a uniform and well-informed standard is developed for local honing and implementation.	Thank you for your comment. This was part of the ‘Mental Health Crisis Care Concordat’; given the diverse nature of the area the level of detail you are asking for would not be possible for national health and social care recommendations.
Wales Institute of Forensic Medicine	18	Full	170	29	(Lines 29-39) Agree. All sensible. Could add some further ones, such as monitor temperature and keep cool; actions to take with particular vital signs etc	Thank you for your comment. Monitoring vital signs is covered in greater detail in 1.4.32.
Wales Institute of Forensic Medicine	19	Full	176	24	Need to look at, say, incidence of use of police restraint (and outcome) before and after policies put in place to reduce confrontational nature of police interaction (such as shouting “Police, Police” and kicking a door down) and use of de-escalation and containment techniques. Need a national log of all uses of prolonged police restraint constructed with medical input for extraction of useful data.	Thank you for your comment. NICE are not in a position to make recommendations or research recommendations directly for the police.

					Where restraint has to be employed by police, what is the best way of carrying it out? (c/w p201 l28)	

Registered stakeholders: http://www.nice.org.uk/guidance/indevelopment/gid-cgwave0619/documents