National Institute for Health and Clinical Excellence

Violence and Aggression
Scope Consultation Table
14/12/12-25/01/13

Type (NB this is for internal purposes – remove before posting on web)

SH = Registered Stakeholders. These comments and responses will be posted on the NICE website after guideline development begins.
NICE = Comments from NICE. These are added to this table for convenience but will not be posted on the web.
Non Reg = Comments from organisations and people who have not registered as stakeholder. These are added for convenience but will not be posted on the web.

No.	Type	Stakeholder	Order No	Section No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
1.	SH	Health and Safety Executive		4.1.1	Is the guidance being limited to adults with mental health conditions only? NICE 25 was not limited to mental health conditions only. It is not only mental health patients and those who have learning difficulties that may present a risk of violence. It is important that this is not overlooked (given that confused patients on elderly care wards, with infections, reactions to drugs and post anaesthesia, may become violent). Should it not be adults who present clinically related challenging behaviour?	Thank you for raising the issues however, as stated in 4.1.1, the guideline will look only at people with mental health conditions.
2.	SH	Health and Safety Executive		4.1.2	Groups that will not be covered include 'People with a primary diagnosis of self harm / learning disability' and links to NICE 16 and guidance being developed for 2015. – Surely, the overall management of a violent incident will be the same and should these not be linked. Staff may not know whether someone has a mental health condition or learning disabilities – in this case which guidelines would they follow?	Thank you for your comment. This will be a matter for clinical judgement, and several other relevant guidelines have been listed in 5.1.2 and 5.2.
3.	SH	Health and Safety Executive		4.3.1.h	Is it just the interface between mental health services and the police when the application of the guidance is to all healthcare settings? It maybe a district nurse visiting a community setting (not linked to a mental health service). Arrangements for liaison with the police should be covered, both in respect of places of safety for patients (the police often complain that hospitals are unwilling to take violent patients and they are therefore kept in police cells) and for communication when police are called in to a healthcare setting	Thank you for your comment. This is covered in 4.3.1 (n)
4.	SH	British Association for Counselling & Psychotherapy		General	BACP welcomes this draft scope for the development of an updated guideline on the short term management of violent and physically threatening behaviour in healthcare settings.	Thank you for your comment.
5.	SH	British Association for Counselling & Psychotherapy		General	BACP would suggest that service users, carers, their families and friends are consulted on the development of this scope	Thank you for your comments. Service user and carer stakeholder organisations are welcomed and

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						encouraged to respond.
6.	SH	British Association for Counselling & Psychotherapy		General	Although the guideline's remit is on the short term management of violent and physically threatening behaviour, greater emphasis on the prevention of violence, as well as ensuring the therapeutic management of violence, should reduce the number of violent incidents, the severity of injuries to staff and service users and the amount of money spent in the rehabilitation of staff and service users.	Thank you for your comment.
7.	SH	British Association for Counselling & Psychotherapy		4.3	The key clinical issues that will be covered in the current scope are strongly focussed on service users and violent and aggressive behaviours. There is very little mention of staff who may be impacted by the experience of violence and aggression from patients and/or relatives, other than in 4.4 g (Rates of injury among staff), where the main outcomes are cited. This also implies only physical injury. BACP would suggest the inclusion of the rates of emotional/psychological harm to staff and recommend the addition of scope for the development of processes for assessing emotional/psychological harm, including PTSD and access to these.	Thank you for your comment. We agree that this is a key outcome and believe this is covered by 4.3.1 l).
8.	SH	British Association for Counselling & Psychotherapy		4.3.1 f	In relation to staff training or education requirements, whether working in the community or in inpatient settings, staff may need to receive appropriate training so they feel confident in their skills to prevent and manage violent and physically aggressive behaviour. Staff may need to be sensitive to the needs of all the users of such services including violent or potentially violent service users drawn from BME Groups, service users expressing differing sexualities and female service users. Staff also need to be able to develop positive on-going collaborative professional relationships with the service users carers, family and friends and also with social services and primary health care services - so they can work effectively together to prevent and manage potentially violent situations.	Thank you for your comment. Training and carers will be included in the guideline.
9.	SH	British Medical Association		General	We believe that the scope currently focuses on in-patient settings and the advice included in the final guideline should be extended to include primary care settings as well, particularly as GP surgeries are not recognised in the English Mental Health Act as a public place which causes problems with police attendance at incidents	Thank you for your comment. We believe these settings are covered in section 4.2. (a) which is not an exhaustive list.
10.	SH	Cheshire and Wirral Partnership NHS Trust		4	All settings must be covered i.e. adult/CAMHS/LD	Thank you for your comment. The remit of the scope has been expanded and will now also include children and young people, however it is still outside

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						of the limits of the scope of this guideline to look at learning disabilities.
11.	SH	Cheshire and Wirral Partnership NHS Trust		4	Age range from 13 - death	Thank you for your comment. The remit of the scope has been expanded and will now also include children and young people.
12.	SH	Cheshire and Wirral Partnership NHS Trust		4	Debriefing must include time scales and risk factors for doing so	Thank you for your comment.
13.	SH	Cheshire and Wirral Partnership NHS Trust		4	Information sharing must include NHS Protect/Police	Thank you for your comment.
14.	SH	Cheshire and Wirral Partnership NHS Trust		4	Learning Disabilities must include reference to Behavioural Support Planning and post incident support	Thank you for your comment. Learning disability will not be covered in this guideline; NICE are currently developing the "Challenging behaviour in people with learning disability" guideline.
15.	SH	Cheshire and Wirral Partnership NHS Trust		4	Interventions to cover must include seclusion/segregation/isolation and other behavioural interventions.	Thank you for your comment. We will look for all relevant evidence during development of the guideline.
16.	SH	Cheshire and Wirral Partnership NHS Trust		4	Guidance must include the use of 'body belts' which the police use as these types of mechanical restraints can be less traumatic for both staff and service users and is used by the Police which would be a valuable tool for continuity of practice.	Thank you for your comment.
17.	SH	Cheshire and Wirral Partnership NHS Trust		6	The term violence is not acceptable to all service user groups. Need to reflect the criminal law act definition as violence indicates capacity and must be acted on if reported to the Police. But the vast majority of incidents involve service users with a lack of capacity but there still needs to be some direction to staff when reporting incidents to the Police. The compensation pathway would mean that all incidents have to have Police incident number assigned to them. Preferred term ; Violence and Aggression; managing incidents that involve challenging behaviour, violence and aggression in health and social care settings.	Thank you for your comment. We have added a paragraph to section 3 explaining the definition of violence in this guideline.
18.	SH	Cheshire and Wirral Partnership NHS Trust		4	Deescalation needs to be the introduction to any guidance document. Non-physical skills training must be mandatory into any health training plan e.g. level one – Deescalation skills, level 2 Breakaway/basic physical skills [guiding/holding/leading where only two staff are required. Does not involve prone or supine restraint only seated or standing], level 3 Team Restraint [last resort more than two staff involves prone and supine restraint. Clear roles for the management of air ways with the aim of returning autonomy/hands off a priority for	Thank you for your comment. The evidence for de-escalation will be evaluated during development of the guideline.

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					all staff]	
19.	SH	Cheshire and Wirral Partnership NHS Trust		5	Training by health or social care staff, qualified trainers with evidence of a health or a social care qualification. No non health or social care trainers. A register of trainers who meet a minimum standard of training e.g. NICE/NHSLA and trainers have to re register every three years.	Thank you for your comment. As per 4.3.1 (f), training will be included in the guideline.
20.	SH	Cheshire and Wirral Partnership NHS Trust		4	Pain compliance techniques must not be taught as a intervention but rather the consequences of pain within physical intervention incidents for staff and service users; and only used where there are significant risks of harm.	Thank you for your comment. The evidence for different models of physical intervention will be evaluated during development of the guideline
21.	SH	Cheshire and Wirral Partnership NHS Trust		4	All training must be annual. Physical and non-physical courses must be kept separate and not taught together. For staff to access the physical skills training courses they must have first attended a non-physical skills course within the last year. For physical skills initially a minimum of 3 days and then one day annually.	Thank you for your comment. The evidence for different models of training will be evaluated during development of the guideline.
22.	SH	Cheshire and Wirral Partnership NHS Trust		5	PMVA [incorporating challenging behaviour]	Apologies but it is not clear what section you are referring to, therefore we are not able to respond.
23.	SH	Cheshire and Wirral Partnership NHS Trust		7	B Local Security Management Specialist	Apologies but it is not clear what section you are referring to, therefore we are not able to respond.
24.	SH	Cheshire and Wirral Partnership NHS Trust		6	Mental health including LD	Apologies but it is not clear what section you are referring to, therefore we are not able to respond.
25.	SH	College of Mental Health Pharmacy		4.1	The College agrees that the population groups suggested are appropriate	Thank you for your comment.
26.	SH	College of Mental Health Pharmacy		4.2	The College agrees that the Healthcare settings proposed are appropriate	Thank you for your comment.
27.	SH	College of Mental Health Pharmacy		4.3.1e	The College accepts that where medicines are used this should be within the licensed indications and doses where possible. However, we would point out that there are a limited number of licensed medicines in this area and that one (olanzapine IM) has recently been withdrawn from the UK market. In addition licensed doses, especially for example lorazepam, may be insufficient to manage some patients effectively. Supply problems with lorazepam injection for the past two years have highlighted the problems where a key medicine is marketed by a sole supplier, leading to significant use of unlicensed imports or the use of other medicines with no licensed indication e.g. midazolam. The College would welcome a full assessment of all the medicines currently used in the UK for rapid tranquillisation in order to guide practitioners on choices when standard approaches fail or are unavailable. The review by James Innes DOI:	Thank you for your comments. We will be reviewing rapid tranquillisation and will have a senior pharmacist in the Guideline Development Group.

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					http://dx.doi.org/10.1017/S174264641200026X highlights that 16 medicines and four routes of administration are recommended in UK Trusts Rapid tranquillisation protocols	
28.	SH	College of Mental Health Pharmacy		General	The Colleges notes that the STA for Loxapine inhalation (ID479) which was suspended to align the review with the licensing timeline has now restarted. The College would strongly endorse the inclusion and incorporation of the Loxapine STA within the Scope of the Violence and Aggression guideline. This holistic approach ensures that the place of loxapine inhalation in therapy can be determined and included in the Guideline and not as an add on in a different document. This approach ensures all the available treatments are considered together and simplifies implementation of the Guideline in clinical practice	Thank you for your comment, this is being considered.
29.	SH	College of Mental Health Pharmacy		General	The College notes the Scope does not include a specific section on physical health monitoring post Rapid Tranquillisation (RT). RT is a high risk procedure but research shows wide variation in monitoring practice (DOI: http://dx.doi.org/10.1017/S1742646411000057) The College strongly endorses a review of the evidence for post RT monitoring and inclusion of recommendations on required monitoring in the final guideline	Thank you for your comment. The evidence for rapid tranquilisation including any benefits and harmful effects will be reviewed as part of this guideline.
30.	SH	Department of Health		General	Since health care services are provided to people in prison and other places of detention, such as immigration and removal centres and police stations, I would be grateful if all these settings (and hence patients in these settings) could be in scope for this review.	Thank you for your comment, however it is outside of the NICE remit to cover prisons, detention centres, immigration and removal centres and police stations.
31.	SH	Health and Safety Executive		**General**	How do NICE link with NHS Protect who have been set up to take national responsibility for tackling violence in the NHS	Thank you for your comment. NICE's remit is set by Department of Health. NHS Protect are registered as stakeholders and will therefore be invited to comment on the draft guideline.'
32.	SH	Health and Safety Executive		General	The safety of staff needs to be considered alongside the health and safety of patients - not as a bolt-on afterthought - when developing policies, training and arrangements to deal with violence	Thank you for your comment.
33.	SH	Health and Safety Executive		General	Are you aware of the guidance currently being developed by NHS Protect called ' Clinically Related Challenging Behaviour – The Prevention and Management' and how does this link to that?	Thank you for your comment. This guideline will not be addressing challenging behaviour.
34.	SH	Humber NHS Foundation Trust		General	Senior clinicians in Humber NHS feel that the scope of this guideline is too broad for x1 document, covering High Security to Primary care.	Thank you for your comment.
35.	SH	MIND		General	Mind is the leading mental health charity in England and Wales. We provide advice and support to empower anyone experiencing a	Thank you for your comment.

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					mental health problem. We campaign to improve services, raise awareness and promote understanding. We work in partnership with 158 independent local Minds to provide a range of services tailored to the needs of their local community. Services on offer include supported housing, crisis help lines, drop-in centres, counselling, befriending, advocacy, and employment and training schemes. Last year our network provided direct support to over 285,000 people. Mind wants to ensure that people with mental health problems have their voices heard, and are treated fairly, positively and with respect.	
36.	SH	MIND		1.1.2	Mind represents the views and experiences of people with mental health problems and as such many of our members have had contact with mental health and social care services, both at a primary and secondary care level. From our research and ongoing engagement with people who use mental health services, we know that people with mental health problems regularly face both explicit or latent stigma and discrimination within the healthcare system. Users of services, people detained under the Mental Health Act and people in acute and secondary settings, are often very unwell and need to recover in a safe and compassionate environment where they are treated with dignity and respect. The symptoms of some mental health conditions will have implications for people's behaviour and can cause severe distress when coupled with unfamiliar surroundings and healthcare professionals in an often non-therapeutic environment. This is compounded by the inherent power imbalances created by the existence of the Mental Health Act and the threat, or in many cases reality, of compulsion. **The context in which people are treated is a critical consideration in the management of challenging behaviour and should be fully considered in the scope of this guideline.** We know from our research that people with mental health problems are more likely to experience abuse within both healthcare and community settings than the general population, and that the reality of treatment for many is experienced as abusive. For example, people tell us about forced administration of medication which often involves violence, either from heavy-handed physical restraint by staff, or because the forced nature of the intervention triggers violence by the patient. Due to the stigma and discrimination faced by people with mental health problems in secondary care settings, we know that users of	Thank you for your comment. We will take all of these issues into consideration in the development of the guideline and will be including at least two service users and a carer of someone who has been restrained or subject to coercion. While we agree that the Mental Health Act is, it itself, discriminating, we cannot address these legal issues in this guideline.

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					services find the term 'violence' unpalatable because of the negative connotations associated with mental health and dangerousness. While we accept that the guideline title is explicit so that staff are able to immediately recognise its applicability, we feel that for users of services the term 'violence' is disempowering and assumes implicit judgement about the intention behind the behaviour. **We recommend that the title be changed to 'Preventing and managing challenging behaviour in health and social care'**. We know from our research that people from Black and minority ethnic communities are most likely to access mental health services via secondary care settings and the use of compulsion for this group, especially for young African Caribbean men, is higher than the rest of the population. The 'Violence' guidelines will apply mainly in secondary care settings therefore as mentioned above, there is an implicit reinforcement of negative racial association between BME groups and violence.	
37.	SH	MIND		2	For mental health patients, too often poor accommodation and security; safety concerns; insufficient staffing levels and intense boredom exacerbate existing difficulties and create new ones. Patents residing in healthcare settings which are not conducive to their recovery mean they experience worsening mental, and often physical, health. The CQC has described a "culture of physical restraint" where social and environmental factors can be triggers for unsettled behaviour that engenders restraint and in turn further distress/agitation. Mind's *'Listening to Experience'* report found that in many areas there continues to be major problems with acute care, with people describing difficulties getting help when they need it and wards that are not safe or therapeutic. Rates of detention under the Mental Health Act have continued to increase. In particular, and despite a five-year plan to deliver race equality in England, some BME groups are still significantly over-represented in compulsory detention and coercive treatment in England and Wales. **The remit of this guideline must cover all mental health settings including community settings and some primary care pathways.** It is not sufficient to cover only clinical settings but should also encompass other health and social care environments. The guidelines must also cover people from all protected characteristics and especially those marginalised groups in our society who have increased contact with mental health services because of	Thank you for your comment. This guideline will cover a range of settings as specified in the scope and will be of relevance to other populations and settings, also specified in the scope. The guideline will also refer to the existing guideline and quality standards on service user experience which covers many of the point you raise.

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					undiagnosed conditions and cultural or lifestyle history. **The remit of the scope must also make clear that people with mental health problems more often experience violent behaviour *towards* them rather than being the aggressor, as suggested by the scope guidelines.** As discussed above, we know people with mental health problems disproportionately experience abuse, which is often sexual or physical assault, sometimes from other patients and even in some case from staff. **The scope should also consider the implications when police are brought into healthcare settings to assist with challenging behaviour and how this is experienced by patients as stigmatising and criminalising, which in turn can trigger increased distress and agitated behaviour, manifesting itself in further violence.**	
38.	SH	MIND		3 3.1 3.2	From our research for 'Listening to experience', some people emphasised wanting someone else to take control in crisis, while others focused on ways to maintain some control over what happened to them. People wanted their wishes about how they were treated to be respected; for example, through advance directives, agreed care plans, or the involvement of a trusted family member or friend. True shared decision-making lies not merely, or even primarily, in provider choice, but in enabling patients and clinicians to work together to select treatments, devise joint care plans and identify desired outcomes, which are specific to each individual. **As the CQC has recommended, this should involve including possible responses to challenging behaviour in joint care plans, which have been discussed and agreed by both patient and staff. We would like to the see the guideline explore this and other de-escalation techniques, which are critical in the prevention and supportive management of challenging behaviour.** Last year, Mind supported the inclusion of the indicator - reported incidents of physical assaults on users of specialised mental health services – in the Commissioning Outcomes Framework. We believe the indicator must include assaults by staff as well as by other patients, as from our *Listening to experience* report, we know that use of control and restraint is a critical issue within secondary mental health services, in terms of both safety and dignity. In particular, physical restraint has strong resonance with the BME community, given disproportionality in police restraint, the wider issue of deaths in custody and the tragic deaths of David 'Rocky' Bennett and others following restraint by healthcare staff. Restraint was the	Thank you for your comments. The guideline will cover anticipating, preventing and managing both aggressive behaviour and violence. We have modified the scope to situate violence within the treatment service users receive. We have also included BMS groups. The specific issue of violence by staff is outside the remit of this guideline.

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					top issue coming out of Maat Probe Group's research into African-Caribbean people's experience of mental health services. In our acute care inquiry, we heard about restraint being used on individuals from BME groups that was physically aggressive where people talked about being pinned to the floor, having a knee on the back of the neck, feeling violated, "Go in for recovery…come out injured." We also heard about other people being restrained and injured by staff, including for example by security staff in A&E. We are disappointed that this crucial indicator has not been included in the current CCOIS consultation. **NICE's guideline should cover use of restraint, aggression towards patients by staff and the disproportionalities people from BME groups face.**	
39.	SH	MIND		4.1	The treatment of people from BME communities remains poor in mental healthcare settings, with people still more likely to experience detention, compulsion and high doses of medication, while being less likely to access primary and community care services. Social Action for Health (2010) highlighted in their report that men tended to stay longer on wards and were less included in ward life. The involvement of lay people acting as 'health guides' made a big impact, simply through relating to the men in an ordinary way, and taking an interest in their health and wellbeing.	Thank you for your comment. We agree that these are important issues and BME groups have been added to the scope.
40.	SH	MIND		4.2	**We believe this guideline should cover all healthcare settings, including and not limited to the list supplied. As discussed earlier, it should also include aspects of the early stages of the primary care pathways.**	Thank you for your comment. The guideline is already quite large and cannot cover all settings.
41.	SH	MIND		4.3.1	Members of the African Caribbean service user group Maat Probe told us about staff culture and approach needing to change and a lack of respect towards people with mental health problems staying on wards – especially men from BME communities (Listening to Experience, 2011). The Maat Probe Group told us about their approach to influencing practice and by influencing their Trust to adopt Respect Solutions training instead of control and restraint, which showed how practice can improve when the decision is made to start from a position of respect. Another technique for de-escalating situations and reducing anxiety was to offer the person a phone call before using physical restraint. We also heard about face-to-face safe holding which can be critical in maintaining communications to safely de-escalate situations.	Thank you for your comment. Specific methods, such as Respect, will be addressed where evidence permits evaluation.

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42.	SH	NHS Direct		1	The guideline title specifically states violent and **physically** threatening behaviour in healthcare settings. Will there be further guidance relating to threatening behaviour in remote assessment health care, and if not, should this expanding area of care be included within this guideline or elsewhere?	Thank you for your comment. As set out in 4.2, the guideline will look at violence and physically threatening behaviour in all physical health, mental health and social care settings.
43.	SH	NHS Direct		4.2	As comment above - Healthcare setting does say "...care of NHS service users in **any** physical health, mental health or social care setting,…" Verbal abuse can be very challenging for front line telephone staff to deal with and may impact on any other care that the patient receives.	Thank you for your comment. The guideline cannot easily cover all forms of abuse and is restricted to physical forms.
44.	SH	NHS Direct		4.3.1b	I do realise that this guideline is aimed at face to face care but how a threatening call is dealt with may be something that could be clarified for remote assessment when considering the overall care of the patient.	Thank you for your comment. The problem is the size of the scope which needs to be limited to ensure it is manageable.
45.	SH	NHS Protect		1	We welcome NICE extending the scope of the existing CG25 to include the management of violence and aggression which is committed by adults with mental health conditions in any healthcare setting. This seems logical as the problems of violence and aggression and the associated prevention and management strategies can apply irrespective of the health and social care setting and in this sense the existing CG25 is too narrowly focused. • The terminology is problematic. Violence and aggression suggests a deliberate, malicious act which carries criminal culpability. Although we acknowledge that even where an adult has an underlying mental health problem, behaviours can still be deliberate and prosecutable, we need to be careful not to stigmatise vulnerable adults whose behaviour is often as a result of a mental ill health and, or combined with other progressive illness such as dementia. Indeed low level violence and aggression is prevalent on psychiatric elderly wards. NHS Protect is leading a national project involving twenty-two clinical and security experts and is currently developing guidance titled: Clinically Related Challenging Behaviour: The Prevention and Management. [**I can forward more details of this project on request**]. We put a lot of time and effort into choosing a suitable terminology and whilst acknowledging that it is not perfect, the term challenging behaviour is consistent with other guidance in this area and fits better for incidents that are clinically related, that pose a safety risk to staff and patients and that require a clinical care solution.	Thank you for your comment. We have added a paragraph to section 3 explaining the definition of violence in this guideline. The term "challenging behaviour" does not encompass all the forms of Violence and Aggression that this guideline will cover.

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46.	SH	NHS Protect		2	We would support an emphasis on continuous de-escalation and strategies to prevent of challenging behaviour. A starting point for this review MUST be to achieve a reduction in the use of all forms of physical interventions, seclusion and sedation (including anti-psychotics), except for the short term management of emergency situations.	Thank you for your comment. The evidence for de-escalation will be evaluated during development of the guideline.
47.	SH	NHS Protect		3.1	• NHS Protect collates national statistics around violence and aggression and latest figures highlight that 69% of all nationally reported physical assaults occur in mental health and learning disability settings in 2011-12. http://www.nhsbsa.nhs.uk/Documents/SecurityManagement/2011-12_NHS_Violence_Against_Staff.pdf • In terms of epidemiology, the picture is not clear or consistent in terms of the cause and effects of challenging behaviour. In mental health hospital settings, challenging behaviour tends to occur in low risk areas such as acute inpatients, especially older persons (dementia) services and acute admissions. Secure settings, e.g. forensic services may have a higher risk of challenging behaviours due to the adult's mental state, but can have a comparatively low level of incidents due to better management, although when incidents do occur they tend to be more serious in nature. Psychiatric Intensive Care Units (PICU) can have a high level of incidents due to adults' being in crisis, however the effects are mitigated by higher staffing ratios, observations and one-to-one nursing. • However although this sector has the greatest incidence of challenging behaviour, mental health hospitals generally have well established arrangements for conducting risk assessments on admission and throughout an adult's stay and staff are generally skilled at preventing and managing the risks of challenging behaviour. All front line clinical staff in mental health organisations receive de-escalation and physical intervention training as standard. • It is in the acute sector, particularly A&E, where we would suggest that there is still a risk, particularly to general nursing staff who are not trained to monitor, assess and identify mental illness, to risk assess for challenging behaviour and conduct physical interventions. We acknowledge that if there are risks they hand over to psychiatric liaison teams although we recommend that this risk area particularly needs to be addressed in the guidelines. We acknowledge that community staff are particularly vulnerable to challenging behaviour and welcome any additional support for this	Thank you for your comments

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					group of staff in the guidelines.	
48.	SH	NHS Protect		3.2	•See comments above. •Depending on the type of hospital settings, the most common response may not always be special observation, followed by restraint. This depends on the hospital setting and the different risk levels and the adult group. In psychiatric settings this may be the approach where staff are restraint trained, however in acute hospitals and community settings staff are more likely to call for a response team/security/police help. •Although we would agree that challenging behaviour is a risk factor when carrying out assessments under the MHA, staff are better skilled and trained to assess and manage patients safely in crisis in psychiatric settings. Furthermore, where patients are brought in under s.136, and a MHA assessment needs to take place, the police should not leave until it is safe to do so. If this is not happening and the risks remain, we would argue instead that there needs to be stronger emphasis on protocols between the police and NHS to manage s.136 patients requiring a MHA section safely. •We recognise that community colleagues are vulnerable to challenging behaviour and welcome any guidelines aimed at improving their safety and security. One issue is that there needs to be robust information sharing arrangements in place between the hospitals and community services, to ensure that the risks of challenging behaviour and management strategies are shared by the hospital to better protect community colleagues. We would argue that management strategies need to be different dependent on setting. Community colleagues are far more vulnerable to different types of challenging behaviour. We would always advocate that they withdraw and call the police in any situation where they feel threatened. However in psychiatric hospital settings staff should manage incidents themselves and only when they fail to control a situation should the police be called. In acute hospitals staff will need guidance to be able to assess suspected mental illness and know when to call specialist mental health teams/security/police. This guideline should therefore not try and recommend a standardised management approach across community and hospital settings.	Thank you for your comments. There will be a member of the police force on the Guideline Development Group. Violence and aggression management strategies and information sharing are important issues for the Guideline Development Group to consider.
49.	SH	NHS Protect		4.1	• Although we acknowledge that the DH set the priorities for this guideline review, it is unclear as to why the scope of this guideline covers adults with mental health conditions only. The strategies for the prevention and management of challenging behaviour could and should apply equally to any patient group in any health and social care setting. • The guideline will need to be clear as to why it does not apply	Thank you for your comment. The remit of the scope has been expanded and will now also include children and young people.

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					to Child and Adult Mental Health Services (CAMHS). It is stated that some areas of the guideline may be relevant to these settings and organisations may look to adapt aspects of this guideline for CAMHS services when it is not appropriate to do so. We would also wish for it to signposted as to which guidelines are applicable for CAMHS.	
50.	SH	NHS Protect		4.2	• We welcome the extension to the existing CG 25 to include any care setting. Just to reiterate the prevention and management decisions will be very different in secure settings, in A&E, and in community services , dependent on the different levels of risks, the level of illness, and the skills of staff to deal with the challenging behaviour. For example in older person's wards, primacy should always be placed on de-escalation/communication, however it may be necessary for high secure units to control a dangerous situation first through sedation to enable medical control and stabilisation of an ill adult. • It will be a particular challenge to design one guideline and it should be clear that approaches will vary dependent on the risks faced in different healthcare settings when managing adults with a range of mental health conditions.	Thank you for your comment. We agree and the needs of each group will be carefully reviewed in the guideline.
51.	SH	NHS Protect		4.3.1	• Under the DH Care Programme Approach, adults generally go through a detailed tier 1 / 2 risk assessment. This is established practice, so is there need for further guidelines in this area? Furthermore, there are a range of risk assessment tools that are already widely in use, with HCR20 being possibly the most widely used for assessing challenging behaviour. Also, if the group is going to identify risk assessment methods and tools, without a formal process of validation by this group it may be hard to recommend specific ones. • Caution should be addressed when trying to base reliance on risk processes and tools to predict challenging behaviour, physical signs may be recognisable, psychological/emotional signs may be less visible, unless looked for. • We welcome the emphasis on de-escalation being the preferred approach, the key message should be on continuous de-escalation to minimise the type and duration of any physical intervention and the counter therapeutic consequences of using physical interventions. • The guideline must be clear that physical interventions should only ever be used to manage an emergency situation. The use of medication should only be considered when it is in	Thank you for your comment. We are keen to evaluate predictive factors and tools. We agree with many of your comments which will, no doubt, be a part of discussions in the Guideline Development Group.

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					everyone's best interests: in the interests of the safety of the adult and staff. • There is still a lack of national guidance on physical interventions involving the police and those adults with mental health conditions. This work will need to link to the Independent Advisory panel (IAP) which is developing a common set of principles for custody sectors on the use of restraint, including where police use restraint in mental health settings, see http://iapdeathsincustody.independent.gov.uk/work-of-the-iap/working-groups/use-of-restraint/ • The key in terms of interface between the police and NHS organisations is development of agreements/protocols between the two to say who has primacy in an emergency situations and when attending, when the police should stand off or respond. In all emergency situations a responsible clinician should always take the lead in decision making before any form of physical intervention is considered and any police action should be continuously clinically supervised. • NHS Protect has a national memorandum of understanding (MoU) agreement between the NHS, ACPO and CPS to facilitate joint working to progress cases for prosecution where appropriate: Tackling violence and antisocial behaviour in the NHS Joint Working Agreement between the Association of Chief Police Officers, the Crown Prosecution Service and NHS Protect [I can forward more details of this agreement on request]. This agreement makes it clear that a mental health condition is not a bar to prosecution through the courts. NHS Protect would welcome discussions about how the NHS, police and CPS should work together to progress cases involving adults with mental health conditions. •	
52.	SH	NHS Protect		4.4	• NHS Protect would expect that any guidelines that place an emphasis on de-escalation, will inevitably lead to reduction in the use of physical interventions, antipsychotics and rapid tranquilisation. There is however a general absence of national reporting data in these areas and it will be in interesting to see which sources of information the guideline group base reliance on. • NHS protect recognises that there is still a general underreporting of incidents of challenging behaviour especially for low level incidents in some mental health services e.g. dementia services where they are still considered 'part of the job' and in community services where	Thank you for your comment. All available and relevant evidence will be reviewed as part of the guideline.

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					underreporting is problematic. • Without reliance on incident reporting, it is unclear what alternative sources of data will be available to measure the rates of different types of physical interventions that are used	
53.	SH	NHS Protect		4.5	• The true economic costs and benefits of challenging behaviour is extremely hard to quantify accurately. It is relatively easy to quantity the costs and benefits of preventing challenging behaviour that is attributable to staff sickness and absence cover. It is much harder to make a link between the different interventions that are used and the economic benefits that each brings. • This is an important incentive for NHS organisations and commissioners alike to be able to demonstrate the economic costs and benefits of different strategies to prevent and manage challenging behaviour. We also welcome further evidence of the link between interventions to prevent and manage challenging behaviour and better outcomes for staff and adults with mental health conditions.	Thank you for your comments.
54.	SH	Nottinghamshire Healthcare NHS Trust		1	Should the word "physically" be removed as this doesn't capture Verbal abuse etc.	Thank you for your comment. The guideline cannot address verbal abuse as this may or not lead to or be connected with violence.
55.	SH	Nottinghamshire Healthcare NHS Trust		4.3.1 (second "a)" bullet)	Should this read "Anticipation of *imminent* violence and aggression"	Thank you for your comment. We do not feel the addition of the word imminent is helpful.
56.	SH	Nottinghamshire Healthcare NHS Trust		4.3.1 ("h)" bullet)	Indicates only "immediate police action" is required though we feel that this may be more on going in some cases.	Thank you for your comment. This will be reviewed as part of the guideline.
57.	SH	Nottinghamshire Healthcare NHS Trust		4.1.2	Why not include young people sub 18 yrs. This surely leaves a very vulnerable group at risk.	Thank you for your comment. The remit of the scope has been expanded and will now also include children and young people.
58.	NICE	Public Health		4.3.1	Page 4 of the draft scope states that the update of CG25 will include the following area that was not in the original guideline: "c) The relationship between smoking and violence and aggression in inpatient settings". The Centre for Public Health Excellence at NICE is developing guidance on '**Smoking cessation in secondary care**' using the NICE public health programme process. The Programme Development Group (PDG) will be meeting on 30th/31st January 2013 to finalise the	Thank you for your comments. The clinical guidelines programme is there to provide guidance to improve clinical and social care practice based on evidence derived from the study of clinical and social care practices. Public Health Guidance should not

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					draft guidance prior to consultation from 5th April 2013 to 5th June 2013. The scope for this guidance includes the following: smoking cessation and temporary abstinence support for mental health service users; and, smoke-free strategies and interventions in mental health settings. For further information, see: http://guidance.nice.org.uk/PHG/54 As smoking rates are much higher among people with mental health problems than in the general population, people with mental health problems are at greater risk of smoking-related disease. A third (33%) of people with mental health problems and more than two-thirds (70%) of patients in psychiatric units smoke tobacco. This compares with one in five adults (20%) in the general population. The PDG is aware that in some mental health settings smoking is almost accepted and in cases supported through smoking breaks for patients. Acceptance, however justified (whether as patient choice, promoting sociability between staff and patient or to relax) presents a unique barrier to promoting smoking cessation support, reduces the productivity and effectiveness of health services, and helps to perpetuate health inequalities. The PDG has considered evidence from the UK and elsewhere for a range of smoke-free interventions in mental health settings; they have also considered the unintended consequences of adopting interventions. The PDG was reassured by the evidence, that interventions in inpatient settings do not adversely affect aggression, disruptive behaviour or non-compliance with smoke-free legislation. In making draft recommendations the PDG has considered the relationship between smoking and violence in inpatient settings. Draft recommendations are being developed to support practical and effective smoke-free interventions. The PDG recognise there is need for strong leadership, clear procedures that support smoke-free policies, training and education for staff and better hospital-based advice and support to enable smoking abstinence and quit attempts. In CPHE's view, to avoid overlaps with the public health guidance on '**smoking cessation in secondary care**', we recommend that the "relationship between smoking and violence and aggression in inpatient settings" is removed from the final scope for the update of CG25.	infringe on this domain of NICE's activity and therefore we believe that the work on violence smoking cessations and restrictions should be undertaken within the context of the violence and aggression guideline.

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59.	SH	Rotherham Doncaster and South Humber NHS Foundation Trust		General	Our comments are as follows, the new guideline is welcomed as it will cover a raft of services, for example, specific guidance for LD services, and not just inpatient areas.	Thank you for your comment. Learning disability will not be covered in this guideline; NICE are currently developing the "Challenging behaviour in people with learning disability" guideline.
60.		Royal College of Nursing		General	The Royal College of Nursing welcomes proposals to update this guideline. It is timely	Thank you for your comment.
61.		Royal College of Nursing		1	Title – This is a good opportunity to consider the title of this NICE guideline If one labels individuals in an inpatient service who may have a learning disability, mental health problem and are frightened, worried, stressed or confused as 'Violent and Aggressive' then one is starting with a negative connation with handling this issue and may be destined to fail them right from the outset. Violence is defined by the World Health Organization as the intentional use of physical force or power, threatened or actual, against a person, or against a group or community that either results in or has a high likelihood of resulting in injury, death, psychological harm, mal-development or deprivation. This definition associates intentionality with the committing of the act itself, irrespective of the outcome it produces. Aggression is an intention to cause harm or an act intended to increase relative social dominance. In comparison would one label someone with say a heart condition using similarly pejorative terms such as wastrel, slacker, malingerer because they want to rest? One would hope not. We would ask the group to consider a more positive title, for example 'Supporting people who are at risk of injuring themselves or others' OR 'Supporting Positive Behaviour in health care settings' OR 'Supporting people who are stressed, confused, upset or worried' We acknowledge that these titles are a bit long winded but hopefully should help to clarify our standpoint.	Thank you for your comment. We have added a paragraph to section 3 explaining the definition of violence in this guideline.
62.		Royal College of Nursing		1	Title — if this guideline is specifically about use in the mental health service user group, then it should be explicit in the title.	Thank you for your comment, however we feel this is addressed in 4.1.
63.		Royal College of Nursing		1.1	As above, if this is a guideline specific to mental health it should be clear in the title	Thank you for your comment, however we feel this is addressed in 4.1.
64.		Royal College of Nursing		2	We would welcome the service user's input regarding the use of seclusion.	Thank you for your comment. We agree and service users and carers play a key

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						role in the Guideline Development Group as well as in stakeholder consultation.
65.		Royal College of Nursing		3.1	The current title would make this seem like a generic violence and aggression guideline, but this section (and the population), makes this seem to be related to mental health patients/service users. If this is a generic guideline the introduction needs to be more balanced. If not, the title and context should reflect this.	Thank you for your comment, however we feel this is addressed in 4.1.
66.		Royal College of Nursing		3.1	Epidemiology mentions violence in psychiatric wards and community settings but does not discuss violence in emergency or urgent care areas.	Thank you for your comment. The guidelines will address violence in Accident and Emergency departments.
67.		Royal College of Nursing		3.2	In hospital settings' – is this just mental health facilities?	Thank you for your comment. As set out in 4.2, the guideline will look at violence and physically threatening behaviour in all physical health, mental health and social care settings.
68.		Royal College of Nursing		4.1.1	As per our earlier comments, is this guidance only about mental health service users? Much of the 'violence and aggression' experienced across acute settings is not related to mental health service users but involves service users and their families – this is not mentioned anywhere in this document.	Thank you for your comment. As stated in 4.1.1, the guideline will look only at people with mental health conditions and their carers. It is outside the limits of the scope of this guideline to look at the entire population.
69.		Royal College of Nursing		**4.1. 2 c)**	We note the statement that principles of managing threatening behaviour will be relevant to people with learning disability or older people. This is a key area for both Learning Disability (LD) nursing and Criminal Justice Service (CJS) nursing. LD (specific) CQC and DH are working on collaboration with guidance around this - Positive behavioural support. There is a need to support staff through training and ongoing professional development when working in challenging situations and settings. Likewise for healthcare support workers. We would like to draw attention to the recently published Winterbourne View Report from DH and the serious case review.	Thank you for your comments.
70.		Royal College of Nursing		**4.2a**	Will older people's settings be covered?	Thank you for your comment. Older people's settings will be covered, however the Dementia NICE clinical guideline 42, referred to in 5.1.2 will be

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						of particular relevance.
71.		Royal College of Nursing		**4.2a**	Mentions settings of emergency and urgent care and primary care will be discussed - will it cover guidelines and relevant information for these areas where service users will be cared for by non-mental health teams as all others on the list are mental health services	Thank you for your comment. As set out in 4.2, the guideline will cover the care received from all healthcare professionals within physical health, mental health and social care settings, in the management of violence and aggression of service users with a mental health conditions.
72.		Royal College of Nursing		4.3.1	We are surprised to note that special observation is not being covered in this important and welcome review of Guideline 25. Some organisations are departing from the types of observation set out in the original guideline. Worse still, reverting to numbered 'levels' of observation, which have caused problems in the past where staff have muddled the levels, some believing level 1 to be the closest level of observation and 4 the lowest - and vice versa – resulting in poor patient outcomes, episodes of AWOL and even death. We would urge that the opportunity to reconsider and include observation in the review process is not lost.	Thank you for your comment. The evidence for different models of observation will be evaluated during development of the guideline.
73.		Royal College of Nursing		4.3.1	Restrictive practice: It may be worth noting that CQC is in the process of developing a report on the 'Use of Restrictive Practices' which would capture their evidence, and feedback from a recent symposium discussion. The report will signpost towards guidance material that already exists in this area. This might be a useful resource for the guideline. They are looking to publish this in January 2013	Thank you for your comment.
74.		Royal College of Nursing		4.3.1a	Risk assessment tools and the need for a comprehensive, individual risk management plan is necessary – we are aware of some medium secure service, where they currently use the START risk assessment tool; this does not include a risk management strategy nor a specific domain for violence	Thank you for your comment. The evidence for risk assessment tools will be evaluated during development of the guideline.
75.		Royal College of Nursing		4.3.1b	Environmental issues - the evidence base behind improving the aesthetic of inpatient wards and the importance of providing meaningful activities and a therapeutic environment is necessary	Thank you for your comment. As per 4.3.1 (h), the guideline will evaluate evidence around environmental influence/impact and how to alter these.
76.		Royal College of Nursing		4.3.1c	The effect of smoking bans related to violence is welcomed. Hope it would include cancelling access to cigarettes as a risk management strategy and increasing risk of violence as well as the use of smoking/nicotine as a de-escalation technique.	Thank you for your comment.
77.		Royal College of Nursing		4.3.1d	Note that mechanical restraint would be included. It would be helpful to clarify when and where the use of this acceptable.	Thank you for your comment.

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78.		Royal College of Nursing		4.3.1d	Physical restraint- will the guideline give guidance regarding what appropriate training to perform this should look like?	Thank you for your comment. This is covered in 4.3.1 (d).
79.		Royal College of Nursing		4.3.1d	It would also be necessary to look at restraint reduction options.	Thank you for your comment. The evidence will be evaluated during development of the guideline.
80.		Royal College of Nursing		General	With regards to CJS – it is worth noting that nurses do work in police custody settings and this presents additional challenges when dealing with detainees.	Thank you for your comment.
81.		Royal College of Nursing		General	Consideration to PACE is essential. Likewise in prison services there are systems and policies that can compromise a registered nurse's registration and clear guidance in these areas is essential in order that nurses retain compliance with their professional code (NMC). Independent Advisory Panel (IAP) for Deaths in custody led by Lord Toby Harris will report in Spring 2013 and there is a cross connection to this work	Thank you for your comment.
82.		Royal College of Nursing		General	We are concerned that there is no mention of prisons, police custody suites and immigration removal centres! If this is covered or to be covered by another guideline, it would be good to clarify in this document and cross reference.	Thank you for your comment, however prisons, prison custody suites and immigration removal centres are outside of the remit of this scope.
83.		Royal College of Nursing		General	One of the most worrying omissions is the lack of mention on training and regulation. This definitely needs to be reviewed.	Thank you for your comment. Please see 4.3.1 (f)
84.		Royal College of Nursing		General	Also need to review staff attitudes, organisational cultures and evolving preventative strategies such as advanced directives	Thank you for your comment.
85.	SH	Royal College of Psychiatrists		General	The CAHMS faculty were disappointed to have been excluded for the SCOPE of this consultation. CAMHS services also need to manage violence and aggression in the under 18 year olds. Thus, we wish to express the most serious concern that under 18s are not involved in this scope. Especially as we understand this guidance will include physical restraint of individuals. If children are not included this will leave provider services that have child and adolescent units in an invidious and untenable situation. Additionally much of the recent "evidence" in the field of restraint is to be found in the children's literature. We would therefore ask you to reconsider. We also believe failure to include children is likely to lead to questions being asked by the children's commissioner and others with statutory responsibility for the	Thank you for your comment. The remit of the scope has been expanded and will now also include children and young people.

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					welfare of children (any person under the age of 18 years).	
86.	SH	Royal Society of Psychiatrists		General	This "draft scope" specifically excludes Intellectual Disability [ID] (as does the previous Guidance (although I note that Sue Johnston, then psychiatrist for people with learning disability at Rampton Hospital, was part of the Guideline Development Group). People with a primary diagnosis of ID are excluded seemingly on the basis that there is going to be (2015) a guideline for challenging behaviour in PLD, but this leaves a significant gap, as some patients with mild ID, for instance those who have offended, have been admitted to secure hospitals, do not have "challenging behaviour" as it is usually defined, but can still be violent in the absence of clearly defined mental illness such as psychotic disorders such as schizophrenia or mood disorders such as major depression or bipolar illness. With the current scope of the guidance, there is therefore a risk that many people with (mostly mild) ID fill fall outside the recommendations of both the proposed Violence and Aggression Guidance and the Challenging Behaviour Guidance.	Thank you for your comment. People with Learning Disability will be covered in the NICE guideline "Challenging behaviour in people with learning disability", which is currently under development.
87.	SH	Sheffield Health & Social Care NHS Foundation Trust		General	Consideration of pharmacological treatments - CHMP recently announced that Alexza pharmaceuticals are likely to receive a marketing authorisation for their new formulation of loxapine adasuve for the management of agitation in patients with schizophrenia or bipolar disorder. The NICE forward work program also includes consideration of loxapine adasuve (loxapine inhalation [ID479]) as a single technology appraisal. Given the likely association between agitation and violence or aggression it would be preferable for the place of loxapine adasuve to be considered within the overall context of this clinical guideline – rather than as a separate entity within the single technology assessment programme. The management of violence and aggression is complex, therefore it would be difficult to frame a dichotomous outcome from ID479 to fit seamlessly within this clinical guideline. Clearly it would be possible to create a "mini guideline" to support the context of use (or not) of loxapine adasuve in the management of agitation and how this could translate into the possible management of violence, from a clinical management perspective it would be preferable to incorporate ID479 into the scope of this violence clinical guideline. As part of the national medicines optimisation agenda, when NHS trusts are considering local availability of drug treatments we (the NHS) is required to "ensure there is no further duplication of the NICE evidence assessment, or challenge to an appraisal recommendation	Thank you for your comments. Loxapine inhalation has already been commissioned into the TA programme and cannot therefore be removed from the TA programme, however, the chair and facilitator will be involved in the TA and thereby able to influence the precise wording to help with later integration of the TA into the guideline.

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					… where there is a NICE technology appraisal". Therefore if loxapine adasuve is considered as a TA, local NHS communities would be required to either adopt – or reject loxapine adasuve onto their formularies , with no opportunity to determine the use of this drug within the context of local circumstances , facilities or available expertise. The current NICE guidance (CG25) recognises the importance of creating local "individualised" plans for the use of rapid tranquilisation, therefore if loxapine adasuve were to be approved within the technology appraisal process this would present practical difficulties for organisations to construct treatment algorithms in a way which ensured best fit for local circumstances. If loxapine adasuve is assessed as a separate single technology appraisal – and outside of the clinical guideline process (where considerations of all other drug and non drug interventions are to be assessed) this could create an unintended skewed environment where this novel formulation attains a particular "NICE status" which is beyond that available for alternative agents. This in turn could create a greater (or lesser) focus on the product simply because of the context within which the product is reviewed. Given the likely cost of loxapine adasuve and any associated safety considerations, it is reasonable to assume that without NICE guidance, there would be a significant variation in the availability of loxapine adasuve to treat NHS patients, therefore it is right that the overall place of the drug is considered under a NICE umbrella, but as stated previously this should be within the clinical guideline process, rather than the technology assessment area of NICE. Previous clinical guidelines (for example schizophrenia) were strengthened substantially by the decision to incorporate the former TA43 for atypical antipsychotics into the clinical guideline process. May I therefore request that the proposed ID479 be incorporated into the scope of the NICE clinical guideline for the management of violence and is not considered as a single technology appraisal.	
88.	SH	South West Yorkshire Partnerships NHS Foundation		General	Would it be possible for the scope to cover both the short term management of violence and aggression and the longer term management of those service users with persistent violent / aggressive behaviour	Thank you for your comment, however it is outside the limits of the scope of this guideline to look at longer term management.

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89.	SH	South West Yorkshire Partnerships NHS Foundation		4.1.1	Will the guideline consider the use of the interventions in adults with mental health conditions and significant physical co-morbidity?	Thank you for your comment. The guideline will not look at interventions for people with mental health conditions and comorbid physical conditions as this is outside of the remit.
90.	SH	Sussex Partnership NHS Foundation Trust		4.1	The scope of the guidance states mental health conditions. It is not clear if this includes those with personality disorder as well or just mental health illness. Violence and aggression occurs in both situations.	Thank you for your comment. As stated in 4.1.1, all mental health conditions, including personality disorders, will be covered apart from those listed in 4.1.2.
91.	SH	Sussex Partnership NHS Foundation Trust		4.1	Would this include later life dementia service, I feel we should be specific as this national carries a high rate of violence against staff	Thank you for your comment. The specific management of dementia including challenging behaviour is dealt with in the dementia guideline, which is now referenced in the scope.
92.	SH	Sussex Partnership NHS Foundation Trust		4.3.1e	Pharmacological interventions should highlight the risk to those on high dose antipsychotic treatment and managing violence and aggression using antipsychotic drugs in this group.	Thank you for your comment. The risks and benefits of any intervention that is recommended will be considered in the guideline.
93.	SH	Sussex Partnership NHS Foundation Trust		4.3.1e	Personal and lone working safety requirements. An area that has never really been governed but yet carries a high risk to it.	Thank you for your comment. Personal and lone working safety requirements are intrinsic to community settings, which will be covered in the guideline.
94.	SH	Sussex Partnership NHS Foundation Trust		1	Short term – this needs to be defined.	Thank you for your comment. This will be defined by the Guideline Development Group.
95.	SH	Sussex Partnership NHS Foundation Trust		4.2	Clarification of MHA status. If the patient is informal, detained, or emergency. Issues of consent may need to be addressed.	Thank you for your comment. This will be addressed by the Guideline Development Group.
96.	SH	Sussex Partnership NHS Foundation Trust		4.1.2	Management of Violence and Aggression in dementia patients. Are they to be excluded or included?	Thank you for your comment. The management of behaviour that challenges in dementia care is dealt with in the Dementia guideline.
97.	SH	Sussex Partnership NHS Foundation Trust		4.2a	Are those patients managed in prison healthcare units to be included? A lot of violence and aggression occurs in prisons (and also within substance misuse services) where many patients present with psychotic symptoms but may not have a diagnosis of mental illness.	Thank you for your comment. The guideline will be of direct relevance to all parts of the NHS, although we will not be specifically addressing the evidence developed within other services such as prisons.
98.	SH	WEST LONDON		3.2	Comment on current practice: in hospital settings a common response	Thank you for your comment. The

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		MENTAL HEALTH NHS TRUST			is to monitor/observe, attempt verbal de-escalation in situations where violence is threatened but not (yet) physical and only manually restrain/move the individual out of association as a last resort.	Guideline Development Group will address current practice.
99.	SH	WEST LONDON MENTAL HEALTH NHS TRUST		4.1.2	Whilst it is appreciated that the guidance will be limited to groups who are aged 18 years and over we would recommend that we (as guideline stakeholders) proactively lobby for the development of guidance for the management of aggression and violence in children and young people. The Trust have a CAMHS service and have developed CAMHS specific PMVA, de-escalation and other psycho-social interventions to prevent and manage challenging behaviour in this population - so we have some experience which we could contribute to the development of this type of guidance.	Thank you for your comment. The remit of the scope has been expanded and will now also include children and young people.
100.	SH	WEST LONDON MENTAL HEALTH NHS TRUST		4.3.1	It would be helpful to include in the update the link between mental state and violence: where arousal escalates, how to support de-escalation without exacerbating the risk to staff; this requires capacities for mentalising (being able to imagine the motives for action of others and their feeling states) from both parties: staff and patients. Also under point f) there are instances, particularly in forensic services of trauma (in the form of flashbacks and avoidance of similar situations) connected to the witnessing of incidents in units that are under-acknowledged for their impact on patients	Thank you for your comment. We will look for all relevant evidence during development of the guideline.
101.	SH	WEST LONDON MENTAL HEALTH NHS TRUST		4.4	Other outcomes might include: unresolved incompatabilities within services (and management of this); psychological intervention to resolve trauma/establish mediation processes between staff and patients or patients and fellow patients.	Thank you for your comment. We believe that psychological intervention is covered under 4.3.1 (l)
102.	SH	WEST LONDON MENTAL HEALTH NHS TRUST		4.4	The Trust has prioritised and made considerable investment in work to develop user/carer involvement and recovery approaches in all of it's services; I am sure therefore that we would want to welcome the focus for this review. Areas from the original guidance that will be updated include; Identification of risk methods and tools Psycho-social intervention methods Staff training Whilst all areas for update (as outlined in the scope) are relevant the above are particularly resonant for us; they will hopefully address issues around; Dynamic risk assessment to better target preventative interventions Increase patient specific options and opportunities to de-escalate (improved care planning and interventions) and finally guidance on staff training to support violence and	Thank you for your comment. All available and relevant evidence will be reviewed as part of the guideline.

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					aggression interventions (including use of assessment tools, psycho social methods, advanced directives). Evidence should cover following issues: Prone restraint (that there is no good position for restraining and all restraint should be minimum time, put pressure should not be applied to main organs and across back and diaphragm). Length of restraint (short as possible) Training should be locally regulated, and managed under a clinical framework. Minimum standards should be explicit in each service.	
103.	SH	WISH		General	The guidelines need to recognise that the potential for Retraumatisation is immense in a number of the standard responses to violent/aggressive incidents. Wish works with women in the community, hospital settings and healthcare settings within prisons, a large percentage of whom have disclosed abuse, particularly sexual abuse. Women inform us that being observed not only impacts on dignity but can also recreate experiences of being observed by perpetrators of abuse. Likewise, restraint, seclusion and rapid tranquilisation can recreate experiences of being overpowered and removal of control. Wish would like to see specific consideration given to responding to people who may have experienced abuse/sexual violence.	Thank you for your comment. We will cover these issues in the guidance.
104.	SH	WISH		1.2.1.1	The Quality Networks Forensic Mental Health Services: Standards and Criteria for Women in Medium Secure Care (CTRU 061) should be adhered to.	Thank you for your comment, however NICE do not refer to policy.
105.	SH	WISH		1.2.1.2	The need for Gender Specific approaches to working with women should be recognised both generally and specifically. Triggers for violence and aggression in women in inpatient settings can be subtle and in many situations could be avoided. Research should be carried out to identify key situations where a lack of gendered approach triggers violence and aggression in women; and approaches changed to preventative gendered approaches and ways of working. There should be specific awareness of child and family contact, and dates in relation to past trauma and abuse, acting as triggers.	Thank you for your comment. We agree that this is an important issue and the Guideline Development Group will specifically address the situation and needs of women.

No.	Type	Stakeholder	Order No	Section No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					Wish provides a Gender Specific model of advocacy based on relational security, and on many occasions the Wish advocate is aware of issues and triggers which the clinical team and/or staff should be aware of but it transpires that they are not; and this lack of insight and understanding can lead women, to what is commonly termed by unit staff to "kick off". These situations could be avoided.	
106.	SH	WISH		1.2.1.4	Add: or Gender – Women (mad and bad) not fitting staff's perception of acceptable female stereotype, which can lead to extremely negative attitudes and behaviour towards women; and a lack of understanding/recognition of the how women's past experience of trauma, violence and abuse impacts on their current situation and diagnosis. Linked into this is the need for staff awareness of women's need for relational security, validation, trust, respect, not to be judged and to be believed. Wish is currently carrying out research to bring life to and understand the importance of these issues to women. In terms of treatment and care there is the need for a great bias to psychological and other therapies, as opposed to an over-reliance on medication; especially when women have experienced a negative incident relating to their past or other trigger; not to mix a different drug cocktail but to address supporting the issue in a more therapeutic way.	Thank you for your comments. These are all important issues which the Guideline Development Group will consider.
107.	SH	WISH		1.2.1.9	Add: Staff shortages: repeated demands when needs cannot be met for women can	Thank you for your comment, however it is beyond the remit of this scope to look at staff shortages.
108.	SH	WISH		1.3.1.5	Add: Gender	Thank you for your comment. We have chosen to add specific issues for women which covers this.
109.	SH	WISH		1.3.1.15	And in relation to searches to be aware of the potential impact of flashbacks for women	Thank you for your comment. The scope will address issues specific to women.
110.	SH	WISH		1.7.1.17	Add: significant dates or recent (but not part of on-going, normal) contact with family or children	Thank you for your comment. This is too detailed for a scope. Carers are however addressed in the scope.

These organisations were approached but did not respond:
2gether NHS Foundation Trust
Addaction
ADFAM
Adolescent Forensic Service
Alder Hey Children's NHS Foundation Trust
All Wales Senior Nurses Advisory Group
Allocate Software PLC
Alzheimer's Society
Anglesey Local Health Board
ASSIST Trauma Care
Association for Dance Movement Psychotherapy UK
Association for Family Therapy and Systemic Practice in the UK
Association for the advancement of meridian energy techniques
Association of Anaesthetists of Great Britain and Ireland
Association of British Neurologists
Association of Paediatric Emergency Medicine
Association of Professional Music Therapists
Association of Therapeutic Communities
Astrazeneca UK Ltd
Autism Treatment Trust
Avon and Wiltshire Mental Health Partnership NHS Trust
Barnet Primary Care Trust
Barnsley Hospital NHS Foundation Trust
Bath Spa University
Bipolar UK
Birmingham and Solihull Mental Health NHS Foundation Trust
Birmingham City Council
Bradford and Airedale Primary Care Trust
Bradford District Care Trust
British Association for Psychopharmacology
British Association of Art Therapists
British Association of Behavioural and Cognitive Psychotherapies
British Association of Skin Camouflage
British Association of Social Workers
British Geriatrics Society
British HIV Association
British Medical Journal
British National Formulary
British Psychological Society
Calderdale and Huddersfield NHS Trust

Calderstones Partnerships NHS Foundation Trust
Camden and Islington NHS Foundation Trust
Camden Link

Capsulation PPS
Care Quality Commission (CQC)
Central & North West London NHS Foundation Trust
Central and North West London Mental Health NHS Trust
Central London Community Health Care NHS Trust
Central Manchester and Manchester Children's Hospital NHS Trust
Centrepoint
Challenging Behaviour Foundation
Changed to British Paediatric Mental Health Group ..British Paediatric Psychology & Psychiatry Group
Children England
Children, Young People and Families NHS Network
CIS' ters
Clarity Informatics Ltd
Cochrane Developmental, Psychosocial and Learning Problems
College of Emergency Medicine
College of Occupational Therapists
Community Psychiatric Nurses' Association
Contact
Co-operative Pharmacy Association
Council for Involuntary Tranquilliser Addiction
Crisis
Critical Psychiatry Network
Croydon Health Services NHS Trust
Cygnet Health Care
Cygnet Hospital Harrow
Department of Health, Social Services and Public Safety - Northern Ireland
Derbyshire Healthcare NHS Foundation Trust
Devon Partnership NHS Trust
Dorset Primary Care Trust
Drinksense
East Midland Ambulance Services NHS
East Midlands Ambulance Service NHS
Eastbourne District General Hospital
Eli Lilly and Company
Equalities National Council
ESyDoc
Faculty of Public Health
Fair Play for Children
Family Futures
Fens Unit
Five Boroughs Partnership NHS Trust

Forum for Advancement in Psychological Intervention
General Medical Council
George Eliot Hospital NHS Trust
Glencare
Great Western Hospitals NHS Foundation Trust
Greater Manchester West Mental Health NHS Foundation Trust
Hafal
Hafan Cymru
Hammersmith and Fulham Primary Care Trust
Hampshire Partnership NHS Trust
Health Quality Improvement Partnership
Healthcare Improvement Scotland
Hertfordshire Partnership NHS Trust
Hindu Council UK
Hiraeth Services Ltd
Hockley Medical Practice
holistic family care
Human Givens Institute
Independent Healthcare Advisory Services
Institute of Conflict Management
Integrity Care Services Ltd.
Janssen
Kent and Medway NHS and Social Care Partnership Trust
King's College Hospital NHS Foundation Trust
Lancashire Care NHS Foundation Trust
Leeds and York Partnership Foundation Trust
Leeds Teaching Hospitals NHS Trust
Leicestershire Acute Trust
Leicestershire Partnership NHS Trust
Lesbian, gay, bisexual and trans domestic abuse forum
Liverpool Community Health
Liverpool Primary Care Trust
Lundbeck UK
Medicines and Healthcare products Regulatory Agency
Mental Health Act Commission
Mersey Care NHS Trust
Middlesex University
Midlands Physical Intervention Network
Mild Professional Home Ltd
Ministry of Defence
National Association for Gifted Children
National Association of Psychiatric Intensive Care and Low Secure Units
National Association of Psychiatric Intensive Care Units

National Autistic Society
National Clinical Guideline Centre
National Collaborating Centre for Cancer
National Collaborating Centre for Mental Health
National Collaborating Centre for Women's and Children's Health
National Control and Restraint General Services Association
National Institute for Health Research Health Technology Assessment Programme
National Institute for Health Research
National Institute for Mental Health in England
National Patient Safety Agency
National Public Health Service for Wales
National Treatment Agency for Substance Misuse
National Voices Forum
National Youth Advocacy Service
National Youth Agency
Neurolink
NHS Bristol
NHS Confederation
NHS Connecting for Health
NHS County Durham and Darlington
NHS Herefordshire
NHS Norfolk Primary Care Trust
NHS Plus
NHS Sheffield
NHS Trafford
Norfolk Suffolk & Cambridgeshire Strategic Health Authority
North Essex Mental Health Partnership Trust
North Staffordshire Combined Healthcare NHS Trust
North Yorkshire & York Primary Care Trust
Northamptonshire Foundation NHS Trust
Northumberland County Council
Northumberland, Tyne & Wear NHS Trust
Northumberland, Tyne and Wear NHS Trust
Nottinghamshire Acute Trust
Novartis Pharmaceuticals
Nursing and Midwifery Council
Office of the Children's Commissioner
Oxford Health NHS Foundation Trust
Partneriaeth Prifysgol Abertawe
Partnerships in Care
Partnerships in Care Ltd
Patient Assembly
PERIGON Healthcare Ltd

Pfizer
Pilgrim Projects
Prospect PBS Training Ltd
Public Health Wales NHS Trust
Respect
Respond
Rethink Mental Illness
Robert Jones & Agnes Hunt Orthopaedic & District Hospital NHS Trust
Rotherham Primary Care Trust
Royal Berkshire NHS Foundation Trust
Royal College of Anaesthetists
Royal College of General Practitioners
Royal College of General Practitioners in Wales
Royal College of Midwives
Royal College of Obstetricians and Gynaecologists
Royal College of Paediatrics and Child Health
Royal College of Paediatrics and Child Health , Gastroenetrology, Hepatology and Nutrition
Royal College of Pathologists
Royal College of Physicians
Royal College of Psychiatrists in Wales
Royal College of Radiologists
Royal College of Speech & Language Therapists
Royal College of Surgeons of England
Royal Pharmaceutical Society
Royal Society of Medicine
Sainsbury Centre for Mental Health
SANE
Scottish Intercollegiate Guidelines Network
Sheffield Childrens Hospital
Sheffield Teaching Hospitals NHS Foundation Trust
SIFA Fireside
Social Care Institute for Excellence
Society for Existential Analysis
South East Coast Ambulance Service
South London & Maudsley NHS Trust
South Staffordshire and Shropshire Healthcare NHS Foundation Trust
South Western Ambulance Service NHS Foundation Trust
Southern Health Foundation Trust
Southport and Ormskirk Hospital NHS Trust
St Andrews Healthcare
St Mary's Hospital

St Mungo's
Staffordshire Ambulance Service NHS Trust
Sussex Ambulance Services NHS Trust
Tees, Esk and Wear Valleys NHS Trust
The Association of the British Pharmaceutical Industry
The College of Social Work
The Neurological Alliance
The Princess Alexandra Hospital NHS Trust
The Relatives and Residents Association
The Rotherham NHS Foundation Trust
The Samaritans
The Survivors Trust
The University of Glamorgan
Trafford Healthcare NHS Trust
Trauma Audit & Research Network
Triangle
Tunstall Healthcare UK Ltd
Turning Point
UK Pain Society
Unison
United Kingdom Council for Psychotherapy
University Hospital Birmingham NHS Foundation Trust
university hospital southampton
University of Bristol
User Voice
VIDA
Warrington and Halton Hospitals NHS Foundation Trust
Welsh Government
Welsh Scientific Advisory Committee
West Sussex Public Health
Western Cheshire Primary Care Trust
Westminster Local Involvement Network
Wirral Primary Care Trust
Worcestershire Acute Hospitals Trust
Worcestershire Health and Care NHS Trust
York Hospitals NHS Foundation Trust
YoungMinds