

Consultation on draft guideline – deadline for comments 5pm on 16/09/26

email: violenceandaggression@nice.org.uk

Checklist for submitting comments

- Use this comments form and submit it as a **Word document (not a PDF)**.
- **Do not submit further attachments** such as research articles, or supplementary files. We return comments forms that have attachments without reading them. You may resubmit the form without attachments, but it must be received by the deadline. You are welcome to include links to research articles or provide references to them
- Complete the disclosure about links with, or funding from, the tobacco industry.
- Include **document name, page number and line number** of the text each comment is about.
- Combine all comments from your organisation into 1 response form. **We cannot accept more than 1 comments form from each organisation.**
- **Do not** paste other tables into this table – type directly into the table.
- Ensure each comment stands alone; **do not** cross-refer within one comment to another comment.
- **Clearly mark any confidential information or other material that you do not wish to be made public with underlining and highlighting.** Also, ensure you state in your email to NICE, and in the row below, that your submission includes confidential comments.
- **Do not name or identify any person or include medical information about yourself or another person** from which you or the person could be identified as all such data will be deleted or redacted.
- Spell out any abbreviations you use.
- **We do not accept comments submitted after the deadline stated for close of consultation.**

Note: We reserve the right to summarise and edit comments received during consultations, or not to publish them at all, if we consider the comments are too long, or publication would be unlawful or otherwise inappropriate. Where comments contain confidential information, we will redact the relevant text, or may redact the entire comment as appropriate.

Comments received during our consultations are published in the interests of openness and transparency, and to promote understanding of how recommendations are developed. The comments are published as a record of the comments we received, and are not endorsed by NICE, its officers or advisory Committees.

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	Please read the checklist above before submitting comments. We cannot accept forms that are not filled in correctly. We would like to hear your views on the draft recommendations presented in the guideline, and any comments you may have on the rationale and impact sections in the guideline and the evidence presented in the evidence reviews documents. We would also welcome views on the Equality Impact Assessment. In addition to your comments below on our guideline documents, we would like to hear your views on these questions. Please include your answers to these questions with your comments in the table below. 1. Would it be challenging to implement any of the draft recommendations? Please say why and for whom. Please include any suggestions that could help users overcome these challenges (for example, existing practical resources or national initiatives). 2. Would implementation of any of the draft recommendations have significant cost implications? 3. [Insert any specific questions about the recommendations from the Developer, or delete if not needed] See Developing NICE guidance: how to get involved for suggestions of general points to think about when commenting.
Organisation name (if you are responding as an individual rather than a registered stakeholder please specify).	Royal College of Occupational Therapists
Disclosure (please disclose any past or current, direct or indirect links to, or funding from, the tobacco industry).	Not applicable
Confidential comments (Do any of your comments contain confidential information?)	No
Name of person completing form	Lauren Walker – Professional Practice Manager

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Comment number	Document [e.g. guideline, evidence review A, B, C etc., methods, EIA]	Page number 'General' for comments on whole document	Line number 'General' for comments on whole document	Comments - Insert each comment in a new row. - Do not paste other tables into this table, because your comments could get lost – type directly into this table. - Include section or recommendation number in this column.
1	Committee member list	General	General	We note that the membership of the NICE guideline committee does not include an occupational therapist. We recognise that no guideline committee can include every relevant profession. However, the omission is particularly important here because occupational therapists work across nearly all the populations and settings covered by the guideline, including acute and forensic mental health services, community mental health teams, learning-disability services, neurodevelopmental services, dementia care, care homes, local-authority social care, supported living and children and young people's services. Additionally, research indicates that the role of occupational therapists and other allied health professionals (AHPs) is routinely marginalised and misunderstood within inpatient mental health settings, resulting in avoidable patient safety incidents. Omitting occupational therapy expertise from the development of this guideline risks further compounding this issue. Occupational therapists bring expertise that is directly relevant to preventing and managing aggressive behaviour. This includes analysing how a person's health, abilities, communication, sensory processing, emotional state, occupations and physical and social environment interact. This expertise is relevant because the draft guideline identifies boredom, restricted environments, sensory overload and loss of choice or control as possible contributors to agitation and aggressive behaviour. It also recommends sensory modulation, distraction, quiet spaces, sensory rooms, gyms, play spaces and access to outdoor environments. These areas fall directly within occupational therapy expertise, including occupational analysis, sensory assessment, environmental adaptation, activity grading and the therapeutic use of occupation.

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				Evidence reviews of occupation-based interventions also identify positive effects on mental health, positive behaviour and social participation, while emphasising the need for better intervention definition, controlled evaluation and consistent outcome measurement. The absence of occupational therapy input creates a risk that occupation and activity will be understood narrowly as diversion or recreation, rather than as assessable and modifiable determinants of health, wellbeing, emotional regulation and behaviour. Occupational therapy representation would strengthen the guideline’s multidisciplinary credibility and help ensure that its preventive and least-restrictive ambitions are translated into practical interventions that can be implemented across both health and social-care services. • https://doi.org/10.1136/bmjgs-2024-017746 • https://doi.org/10.5014/ajot.2020.038687 • https://doi.org/10.1177/03080226221110391 • https://doi.org/10.1177/1744629512473557
2	Guideline	General	General	Although the guideline’s scope covers a broad range of NHS and social-care settings, its framing appears predominantly oriented towards acute and institutional care. We recommend a more systematic consideration of community mental health, primary care, social care, supported living and care delivered in people’s own homes. Aggressive behaviour is context dependent. Evidence from intellectual disability services shows that challenging behaviour arises through interactions between the person, relationships, support arrangements and the wider environment. Organisational culture, staffing resources, stability and the quality of support can influence whether behaviour is prevented or intensified. Home and community services present different risks. Practitioners may work alone, have limited control over the environment and lack immediate access to colleagues or emergency assistance. Systematic reviews report that violence towards home-care workers is common and underreported, and that hospital-focused training does not adequately address home-specific risks. Reviews call for tailored approaches incorporating advance assessment, situational awareness, de-escalation, safe withdrawal, reporting and organisational support.

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				Community care also offers distinctive preventive opportunities through assessment of ordinary routines, meaningful occupations, sensory environments, family relationships and unmet social or psychological needs. Evidence concerning community-dwelling people with dementia identifies loneliness, lack of social support, lack of daytime activity and unmet environmental needs as significant concerns. We recommend that community and home-based care considerations are integrated throughout the guideline. Recommendations should address lone working, family and carer involvement, multidisciplinary crisis planning, information-sharing, occupational and environmental interventions, respect for autonomy within the person's home, safe withdrawal and post-incident support. NICE should also consider a research recommendation on effective and acceptable approaches to preventing and managing aggression in home and community settings, as the evidence is currently much less developed than for inpatient care. • https://doi.org/10.1111/jar.12797 • https://doi.org/10.1192/apt.bp.113.011577 • https://doi.org/10.1111/jar.12555 • https://doi.org/10.1097/NHH.0000000000001407 • https://doi.org/10.1002/ajim.23351 • https://doi.org/10.1111/inr.12822 • https://doi.org/10.1002/gps.70066 • https://doi.org/10.1080/13607863.2025.2534406 • https://doi.org/10.3389/fpsy.2022.935821
3	Guideline	General	General	We recommend that the guideline gives greater prominence to occupational therapists and other allied health professionals (AHP), as evidence shows that their role is often overlooked and undervalued within mental health services. This is directly linked to the occurrence of patient safety incidents. A rapid review of 115 quality and safety reports concerning inpatient mental health, learning-disability and autism services found that poor understanding and marginalisation of AHP roles contributed to gaps in multidisciplinary working, risk assessment, care planning, discharge planning and access to

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				specialist input. It also identified insufficient occupational therapy provision and lack of meaningful activity, particularly at weekends, with boredom associated with increased incidents. NICE should explicitly recognise AHPs as integral to preventing and managing aggressive behaviour and recommend their timely involvement in assessment, risk management, care planning and incident review. Services should ensure an appropriate multidisciplinary skill mix and consistent access to meaningful occupation across seven days, while recognising that an occupationally supportive environment is a shared team responsibility rather than the responsibility of occupational therapists alone. • https://doi.org/10.1136/bmjgs-2024-017746
4	Guideline	General	General	We recommend that the guideline explicitly recognises access to meaningful occupation and therapeutic activity as part of the prevention and early management of agitation and aggressive behaviour. The draft identifies boredom, lack of autonomy, restrictive environments and sensory overload as potential contributors to agitation and aggression. However, it does not provide a recommendation that services ensure access to a varied, structured and person-centred programme of meaningful occupations and therapeutic activities. A systematic review of aggression on psychiatric wards identified lack of structure in the day and restrictive ward environments as modifiable risk factors. Evidence from dementia care also indicates that person-centred non-pharmacological interventions, including music, touch-based interventions and recreation therapy, can reduce agitation or aggression, although the magnitude and certainty of effects vary. • https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0258346 • https://pubmed.ncbi.nlm.nih.gov/31610547/ • https://www.frontiersin.org/journals/neurology/articles/10.3389/fneur.2026.1850987/full

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5	Guideline	General	General	Meaningful occupation may support prevention by reducing boredom and occupational deprivation, providing structure and predictability, strengthening identity and agency, enabling safe emotional expression and supporting sensory, physiological and emotional regulation. This is consistent with evidence showing an association between emotion-regulation difficulties and aggression, particularly reactive aggression, and with emerging evidence for sensory modulation in reducing restrictive interventions. • https://pubmed.ncbi.nlm.nih.gov/41424362/ • https://pmc.ncbi.nlm.nih.gov/articles/PMC10680857/ • https://pubmed.ncbi.nlm.nih.gov/28719249/
6	Guideline	General	General	Activities should not be prescribed generically or used simply to occupy time. They should be selected collaboratively, informed by the person's interests, culture, roles, communication needs, sensory preferences, abilities and current level of arousal, and adjusted in response to risk and changing need. Services should consider access throughout the day and evening, including at times when boredom, distress or escalation commonly occurs.
7	Guideline	General	General	We suggest adding the following recommendation: Ensure that people have timely access to a choice of personally meaningful, culturally relevant and developmentally appropriate occupations and therapeutic activities as part of an individual plan to prevent distress, support emotional and sensory regulation, reduce boredom and maintain wellbeing. Identify with the person which occupations or activities are calming, regulating, expressive or energising, and how these should be offered when early signs of distress or agitation occur. Occupational therapists should contribute where needs are complex, including through occupational and sensory assessment, activity analysis, environmental adaptation, graded engagement and evaluation of how occupational participation affects distress, arousal and behaviour.
8	Guideline	Section 1.10	General	Section 1.10 We support the focus on risk assessment. We recommend adding wording that risk assessment and management should be collaborative and proportionate, balancing safety with the person's participation, choice and independence.

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				People using mental health services are not always meaningfully involved in risk assessment. Professional power, perceptions of best interests and organisational responsibility can act as barriers to shared decision making. Research in restrictive settings also indicates that risk-management decisions and environmental restrictions can limit access to meaningful occupations, while graded and adapted occupational approaches can support engagement alongside risk management. Risk-management plans should therefore consider the potential benefits as well as harms of proposed restrictions, including their impact on daily activities, social relationships and community participation, and should use the least restrictive approach consistent with safety. • https://doi.org/10.1186/s12888-021-03304-0 • https://doi.org/10.1192/bjp.bp.114.152447 • https://doi.org/10.1177/03080226241295606
9	Guideline	Section 1.11	General	Section 1.11 We recommend that personalised care plans record, where relevant, the person's meaningful activities and interests, usual routines, sensory preferences and sensitivities, environmental and situational triggers, early signs of distress, and coping or self-regulation strategies that they find helpful. Functional-assessment research supports identifying the antecedents, environmental variables and functions associated with behaviour that challenges so that preventive interventions can be individualised. Evidence from sensory-modulation and activity-based interventions also suggests that adapting sensory input, activities and environments can support emotional regulation, reduce distress and improve engagement. Recording this information would help practitioners use consistent, person-centred preventive strategies and respond before distress escalates. • https://doi.org/10.1007/s40474-019-00180-y • https://doi.org/10.1177/1090198114531782 • https://doi.org/10.1111/inm.13065

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				https://doi.org/10.1177/15691861231204896 https://doi.org/10.1080/01612840.2024.2341034
10	Guideline	Section 1.12	General	Section 1.12 We recommend acknowledging that shared participation in personally meaningful activities can provide an important context for developing positive engagement, communication and therapeutic relationships. Occupation-based and sensory approaches can also support choice, social participation and self-regulation. Evidence from mental health settings indicates that occupational therapy interventions can enable activity engagement and choice, while qualitative research in restrictive inpatient settings suggests that continued therapeutic activity can help maintain relationships, routine and engagement. These approaches may form part of a wider person-centred strategy to address distress early and reduce escalation. Services should therefore consider access to occupational therapy expertise when planning approaches to positive engagement and the prevention of aggressive behaviour. https://doi.org/10.1111/1440-1630.70032 https://doi.org/10.1177/03080226241295606 https://doi.org/10.1177/15691861231204896 https://doi.org/10.5014/ajot.2020.038687 https://doi.org/10.1155/2022/7418667
11	Guideline	Section 1.7	General	Section 1.7 In line with the recommendations and evidence provided above, we suggest including awareness of sensory processing differences, environmental contributors to distress and occupation-focused preventative approaches within training programmes where relevant to the setting and population.
12	Guideline	110	14	We recommend that NICE develops a research question evaluating the clinical and cost-effectiveness of co-produced, personalised occupation-based interventions for preventing and reducing agitation, aggressive incidents and restrictive practices across mental health, intellectual-disability, neurodevelopmental, dementia and social-care settings.

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				Reviews in dementia care suggest that activities tailored to a person's interests and preferences may reduce agitation or behaviour that challenges, while evidence in intellectual disability indicates that skilled and structured engagement in meaningful occupation may be beneficial. However, the available studies are heterogeneous, frequently small, variably reported and concentrated in particular populations. Future studies should distinguish personalised meaningful occupation from generic activity provision and clearly describe how interventions are selected, graded and adapted to the person's interests, identity, culture, sensory profile, abilities, communication needs and current level of arousal. Outcomes should include agitation and aggressive incidents, restraint, seclusion, rapid tranquillisation, injuries, occupational participation, quality of life, autonomy and adverse effects. Studies should also examine mechanisms, implementation, equity, intervention fidelity and cost-effectiveness. Research should be co-produced with people who have lived experience, families, carers and practitioners. It should include pragmatic controlled trials supported by process and qualitative evaluation, with sufficiently powered population-specific analyses. This would establish whether occupation-based interventions reduce restrictive practices directly, indirectly through improved emotional and sensory regulation, or through changes in staff relationships, organisational culture and the care environment.
13	Guideline	General	General	Would implementation be challenging? Implementation may be challenging where services lack sufficient multidisciplinary capacity and access to occupational therapy expertise for environmental assessment, sensory-informed intervention and personalised occupation planning. Implementation requires occupational therapists' contributions to be recognised and incorporated into care planning and risk management, alongside sufficient capacity, training, professional leadership and regular profession-specific supervision. A rapid review of 115 quality and safety reports and publications found that poor understanding and marginalisation of allied health professional roles, limited involvement in care and risk planning, failure to act on recommendations and understaffing contributed to safety incidents. UK research also identifies autonomy, management communication, training and high-quality supervision as important to mental health occupational therapist retention.

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Aggressive behaviour in people receiving NHS or social care: prevention and management

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				NICE should emphasise adequately resourced multidisciplinary teams, explicit recognition of occupational therapy expertise, and access to occupational therapy professional supervision. • https://doi.org/10.1136/bmjgs-2024-017746 • https://doi.org/10.1080/0164212X.2024.2423811 • https://doi.org/10.1177/03080226231174102
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Insert extra rows as needed

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