

## EDITORIAL

# Multidisciplinary management of acute disturbance

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The drive to reduce restrictive interventions over the past decade has reinvigorated the debate around the therapeutic, safe and effective ways of managing acute disturbance associated with underlying mental or physical disorder. The National Association of Psychiatric Intensive Care and Low Secure Units (NAPICU) has worked hard over the years to develop and advance clinical practice in this area.

Assessing, understanding, and managing the immediate and longer term impact of acute disturbance is one of the most challenging areas in clinical practice; de-escalation and rapid tranquillisation (RT) are core interventions in this respect.

In this Journal issue, Patel, Sethi et al. (2018a) present the Joint BAP NAPICU Evidenced-Based Consensus Guidelines for the Clinical Management of Acute Disturbance: De-escalation and Rapid Tranquillisation. The guideline supports clinicians in determining the most appropriate clinical intervention for the right clinical scenario at the right time, and is co-published in the *Journal of Psychopharmacology* (Patel, Sethi et al. 2018b). It takes a multidisciplinary approach, including the patient perspective.

Past guidelines in this clinical area have generally been short of a wide variety of interventional options due to the relative lack of high level evidence base. In Patel, Sethi et al. (2018), this guideline achieved consensus recommendations by reviewing a wide range of evidence categories; steered by a diversity of perspective within a strong multidisciplinary authorship.

The guideline is based on the seven fundamental principles of a *multidisciplinary approach, effectiveness of intervention, proportionality, treatment individualisation and choice, treatment optimisation of the underlying disorder, with continuous monitoring and review of the clinical state*. It clearly outlines three components of the manage-



ment of acute disturbance. The pre-RT phase describes de-escalation and/or the use of non-parenteral (oral/oral-inhaled/buccal) medications. The RT phase describes the use of intramuscular medications or intravenous medications. The third phase considers strategies for when pre-RT and RT interventions are not working.

The guideline highlights the central position of de-escalation in the management of acute disturbance, and is a unique evaluation of the process and active components of de-escalation. The approach used to consider de-escalation as an intervention, may well provide a way to critically evaluate other restrictive interventions in the management of acute disturbance.

In terms of the pharmacological management of acute disturbance, based on the available evidence base, this guideline provides a wider set of interventions across all formulations. Clinical protocols in this area have sometimes paid less attention to oral pre-RT and intravenous RT, as they are often focused on what is perceived as important in inpatient psychiatric settings. Yet, the manage-

ment of acute disturbance presents challenges in many diverse health and social care settings; oral pre-RT and intravenous RT are presented as key components of the algorithm in this guideline (with the caveat that intravenous RT must only be used in settings where resuscitation equipment and trained clinicians are available to manage medical emergencies).

The guideline looks at effectiveness and safety of interventions, and presents a framework for physical health monitoring following the use of medications pre-RT and RT. Given the evidence of poor documented physical health monitoring in the hour following RT (POMH-UK 2017) improvement in this area of practice is critical.

Patel, Sethi et al. hope to re-frame the way in which we think about managing acute disturbance, with a focus on the interplay between pharmacological and non-pharmacological multidisciplinary interventions.

Sticking with the theme of complex clinical challenges in acute psychiatry, in this issue of *JPI*, Henry et al. (2018) present a review of possible associations with the eleva-

tion of the enzyme creatine kinase in psychiatric inpatients. Engelbrecht et al. (2018) examine the common side-effect of clozapine-induced sialorrhoea and highlights standard and alternative management strategies.

## References

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