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Importance of training in de-escalation techniques for the prevention and management of agitation☆

Importancia de la formación en técnicas de desescalado para la prevención y tratamiento de los episodios de agitación

Dear Editor,

Psychomotor agitation is a nonspecific syndrome of multifactorial aetiology that entails impaired motor behaviour and a state of uncontrolled and unproductive physical and mental hyperactivity, associated with internal stress.[1] Agitation can lead to violent,[2] verbal or physical behaviour towards the person themselves or their families, healthcare personnel and the environment. This frequent clinical picture, which is extremely serious, most often presents in a rapidly progressive manner. It should be noted that there are warning signs or prodromal signs, which usually precede agitation.[3] These symptoms include hostile or suspicious discourse, a disproportionate approach to a context or tense and angry facial expression.

Assessing the severity of agitation and predicting possible aggressive behaviour[2] by detecting and addressing alarm signals, could enable control of potentially dangerous behaviour.[4] Therefore, this assessment must guide therapeutic decisions,[2] attempting to promote the use of tools that could be beneficial for the patient. However, there are coercive measures such as mechanical restraint and seclusion that are potentially negative for the therapeutic relationship and harmful to both patients and healthcare personnel,[5] although they are used when the patient's life is at risk and while awaiting therapeutic response.

The treatment of agitation includes the use of drugs and non-pharmacological techniques. It could be said that enough has been studied on psychopharmacological treatment in agitated patients. On the contrary, to date there has been little discussion about verbal de-escalation techniques, despite the increasing evidence of their efficacy, throughout health training in our environment, we have no regulated learning on de-escalation techniques or on the management of agitated patients beyond pharmacological treatment.

The guidelines of the Best Practices in Evaluation and Treatment of Agitation project, seek to standardise verbal de-escalation techniques and ensure that they are undertaken with the best safeguards,[6] and in the best possible way. These techniques have the potential to reduce levels of restlessness and agitation, and to reduce the potential for associated violence.[7] In addition, they provide benefits in terms of safety, outcomes and patient satisfaction,[7] and are clearly beneficial for the doctor-patient relationship, among

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other things, because they lead to a reduction in the number of mechanical restraints.

It has been seen that the decreased use of mechanical restraint on its own without specific training can lead to an increase in attacks against patients and staff.[8] In this regard, specific training in the different units and health centres to increase knowledge of the factors that lead to agitation, teaching the least restrictive interventions possible and learning safe reactions to patient violence are necessary for application of the technique to be effective.

It is recommended that training in behavioural emergency management and agitation, analogous to advanced training in cardiovascular life support, should be regular,[7] on an annual basis if possible. This should include not only learning in a classroom or from a book, but also putting skills into practice. In this sense, de-escalation techniques can be learned through role play or simulated encounters with patients.[7] It should be noted that all members of hospital staff, not just health workers in psychiatry, can learn de-escalation techniques and use them successfully if they are well trained and gain a certain skill set.

In conclusion, clinical staff in emergency departments and other health network facilities should be trained in de-escalation techniques, and in the prevention and management of agitated and aggressive behaviour,[7,9] therefore we recommend implementing training programmes in verbal de-escalation. We consider that this training is applicable in our environment and has the potential to improve how episodes of agitation are handled, while increasing user satisfaction with the entire therapeutic process.

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Clozapine and acute hepatitis☆

Clozapina y hepatitis aguda

Dear Editor,

Clozapine is an atypical antipsychotic introduced into clinical practice in the early 1970s and indicated in patients with schizophrenia resistant to other antipsychotics and in psychotic disorders occurring in Parkinson's disease where conventional therapy has failed.

Given the severity of the haematological (neutropenia/agranulocytosis), with incidences of 3 and .7%, respectively, and cardiovascular (pericardiomyocarditis, thromboembolic disease, arrhythmias or sudden death)side effects included in its technical data sheet,[1] its use as first line therapy is not widespread, despite its proven efficacy in resistant schizophrenia. This has probably led to less attention being paid to other side effects. This is the case with acute hepatitis, which is predominantly cytolytic and, although very rarely, can lead to fatal fulminant hepatic necrosis.

We performed a review of the medical literature (MEDLINE, PubMed; keywords: *clozapine and hepatotoxicity*

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