Psychiatric emergencies: Detection and treatment

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Lets start with a case

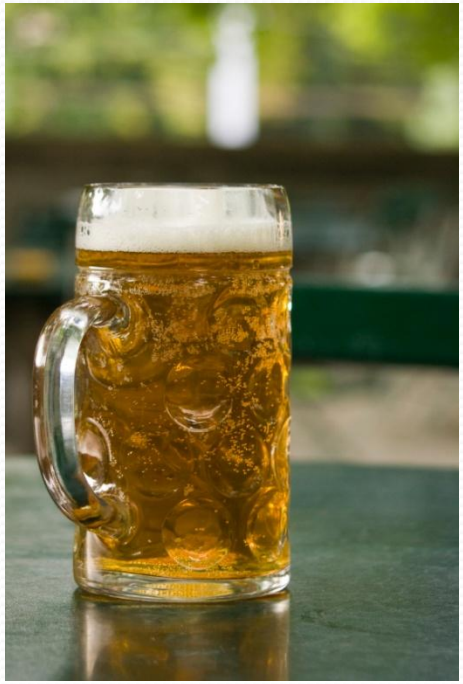
- Male brought in as a John Doe found wandering in the city appearing disoriented. Appears to be in mid 40s, mildly disheveled.
- That's all the information you have….so what could be going on with him and what you want to do next?

So this is what we get

- Utox + ETOH,
- Na: 140 K+: 3.1 Mg: 2.0 Creat:1.0 BUN: 14 ALT 218 AST 210 ALK phos 78
- WBC:10.8, MCV:99, Hct:36
- BP:120/84 HR:94 temp:37.2
- PE: remarkable for mild tremor
- So what are you thinking?
- How to you want to manage this patient?

Dx: Tx

- Acute alcohol intoxication



- Given Lfts, CBC results appears to be a chronic ETOHic
- Either- get out of ED before starts going through DT or consider initiation of BZ

Several hours pass, pt indicated he wants to get clean and was beginning to sober up then…

- You notice he actually seems less with it than an hour ago and in fact appears to not know where he is.
- VS now BP: 142/90, HR:118, temp:38.9, RR:18
- What do you think is going on?
- What do you want to do?

Things that come to mind

- Acute ETOH WD
- If acute DT- initiate BZ

- Delirium due to infectious process-? Find out source and tx accordingly

Through your excellent care the patient is stabilized but what if…

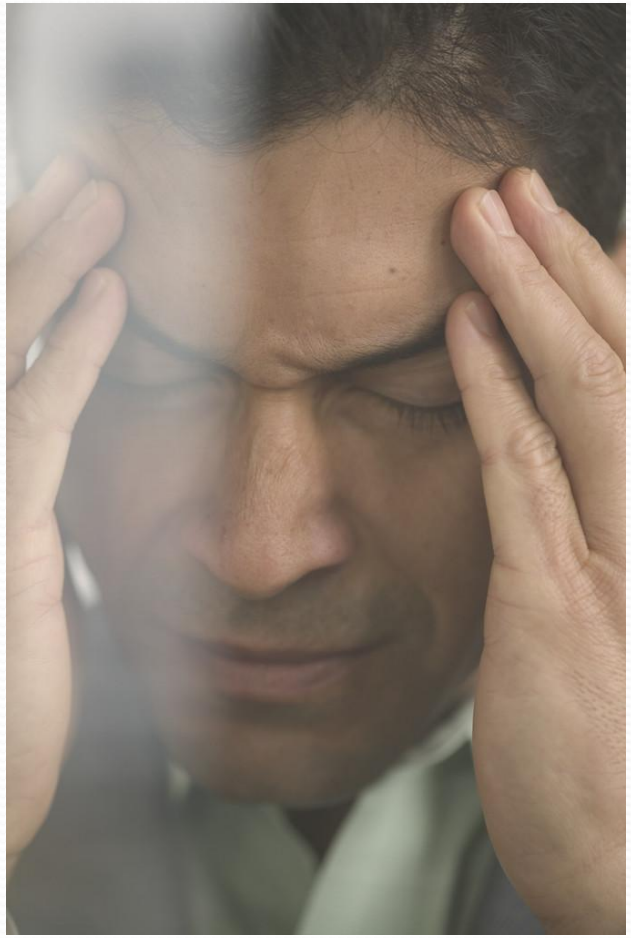
The results are as follows:

- Utox + cocaine
- Na: 140 K+: 3.9 Mg: 2.2 Creat:1.0 BUN: 14 ALT 33 AST 49 ALK phos 43
- WBC:10.8, Hct:44
- BP:130/94 HR:108 temp:37.1
- Psychomotor agitated appearing paranoid
- So what are you thinking?
- How to you want to manage this patient?

- Acute cocaine intoxication

- Check EKG to make sure not having an MI!
- Tx with nothing, BZ, or antipsychotics depending on level of agitation and paranoia

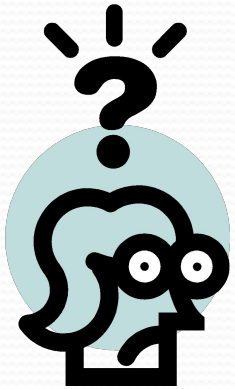
- Could also be an exacerbation of a primary psychotic illness such as schizophrenia
- Tx with antipsychotics or BZ depending on level of agitation and paranoia



So our patient story evolves

- When the nurse attempts to get the ECG the patient jumps up and starts screaming “Get away from me! You are trying to stop my heart! Get away from me!!!”
- When you enter the room he is standing next to his gurney looking at the door like he is getting ready to bolt

- So what are you thinking?
- How to you want to manage this patient?



Emergency Dept. (ED) Presentations

- An equal number of men and women attend the ED with a mental health emergency
- More single people present than married people
- About 20% of these people are suicidal and approx. 10% are violent
- About 40% of ED presentations require hospitalization
- Most visits occur during the night hours
- Contrary to popular belief studies have found there to be no increase in mental health presentations during a full moon.

ED Presentations

Emergency presentations may include:

People with suicidal ideation
People experiencing psychosis
People in situational crisis
People with a delirium
People Intoxicated with Substances
Aggression and Violence
Mood disorders – mania and depression
Personality disorders in crisis
Major disasters
Neuroleptic Malignant Syndrome
Serotonin syndrome
Lithium toxicity

Recognition of distress

Situations which may cause distress:

- Relationship issues
- Conflict
- Trauma
- Bereavement
- Loss of friends, job, home or health

People react differently to stressors and may present as

- Anxious
- Depressed
- Suicidal
- Angry
- Tearful
- Agitated
- Aggressive
- Confused

Signs of acute distress

- Highly aroused
- Wide eyed, agitated
- Tearful
- Wringing hands
- Hysterical
- Screaming
- Yelling
- Frightened
- Frantic

Signs of acute distress

OR

- Pale
- Feels faint
- Weak
- Jelly-legged
- Looks blankly
- Seems unable to comprehend circumstances
- Shivering
- Feelings of numbness and emptiness

Respond appropriately

- Always assess the risk to yourself and others
- If able to do so ask the person how you can help them
- If they are very disturbed, agitated summon help as the person can be very unpredictable

Safety issues

Work in pairs

Risk assessment prior to visit, if necessary police in attendance

Weapons

Ensure front door not deadlocked

Adequate personnel to respond if help is needed including trained security personnel

Method to call for help

Assessment

The most important question is:

Is this presentation due to a primary or secondary psychiatric condition?

diabetes mellitus, thyroid disease, acute intoxications, withdrawal states, head traumas and infection can present with prominent changes to mental status that mimic psychiatric illness.

These conditions may be life threatening if not treated promptly

Physical Examination

- Vital Signs
- Finger-prick blood glucose level
- Dipstick urinalysis
- Urine drug screen
- Look for any obvious signs of injury or illness
- Laboratory Tests i.e.

  CBE, TFT, EUC, LFTs
- CT head

Mental State Exam

- Appearance
- Behaviour
- Conversation / speech
- Affect / mood
- Perception
- Cognition
- Insight / Judgement
- Rapport

Risk Assessment

- Risk of harm to self
- Risk of harm to others
- Level of problem with functioning
- Level of support available
- History of response to treatment
- Attitude and engagement to treatment

Risk of harm to self
What are the static factors

- Previous suicide attempt
- Previous high lethality suicide attempt
- Family history of suicide
- Long term unemployment
- Long standing physical illness or pain
- Male – under 35 years

Risk of harm to self
What are the dynamic factors

- Intent / plan / thoughts
- Current suicide attempt
- Distress or anger
- Isolated / lonely
- Hopelessness / perceived lack of control over own life
- Stressors over the last six months
- Psychotic symptoms
- Command hallucinations
- Content of delusional belief

Risk of harm to others What are the static factors

- Under 25 years of age
- History of violence
- Criminal history
- Conduct disorder
- History of substance abuse

Vulnerability/Exploitation/Self Neglect

- At risk of being sexually abused by others
- At risk of domestic/family violence
- At risk of being financially abused by others
- Cognitive / intellectual disability
- History of absconding
- Refusal of treatment
- Frustration regarding hospitalisation
- Breach of limited community treatment order

Violence and Aggression

Aggression: Hostile or destructive behaviour or actions

Violence: Physical force exerted for the purpose of violating, damaging, or abusing

Contemporary concerns

- Unprovoked, haphazard violence
- Violence by people suffering from mental illness
- Terrorism

Biological

- Amygdala, hypothalamus, prefrontal cortex, limbic system
- Cortical dysfunction e.g. abnormal EEG in antisocial personality disorder
- Genetic e.g. sex chromosome abnormalities
- Hormonal
- Neurotransmitters
  - ↓ GABA, ↓ serotonin, ↑ noradrenalin and ↑ dopamine are associated with increased aggression
- Alcohol, substance abuse

Developmental Factors Associated with Adult Violence

- Abuse by parents
- Truancy, school failure, lower IQ
- Delinquency as an adolescent
- Arrest for prior assaults
- Childhood hyperactivity
- First psychiatric hospitalization by age 18 years
- Fire setting and animal cruelty

Risk Factors for Aggression or Violence

- young, male
- developmental factors
- less education
- lack of sustained employment
- lower socioeconomic status
- history of substance abuse
- acute intoxication with alcohol and / or psychoactive substances
- past history of violence, aggression
- violent fantasies

Risk Factors for Aggression and Violence (continued)

- chronic anger towards others
- recent sense of being unfairly treated
- residential instability – homeless mentally ill more likely to offend
- antisocial / borderline personality disorder
- Mania
- acute psychosis – delusional beliefs involving particular individuals
- command hallucinations
- Delirium

Predictors of Impending Violence Include:

- Refusal to cooperate
- Intense staring
- Motor restlessness, akathysia
- Purposeless movements
- Labile affect
- Loud speech
- Irritability
- Intimidating behavior
- Damage to property

Management

- Establish differential diagnosis
- Attempt where possible to initiate treatment with medication to treat underlying illness
- Assess risk to others (specific threats) – duty to warn
- Weapons – firearms notification
- Where to treat? Voluntary or detained?
- Use verbal strategies initially; if necessary use restraint, emergency medication, seclusion
- Liaise with treating team/clinicians (if any)
- If no evidence of psychiatric or medical illness -consider involving the police

Choice of Medication

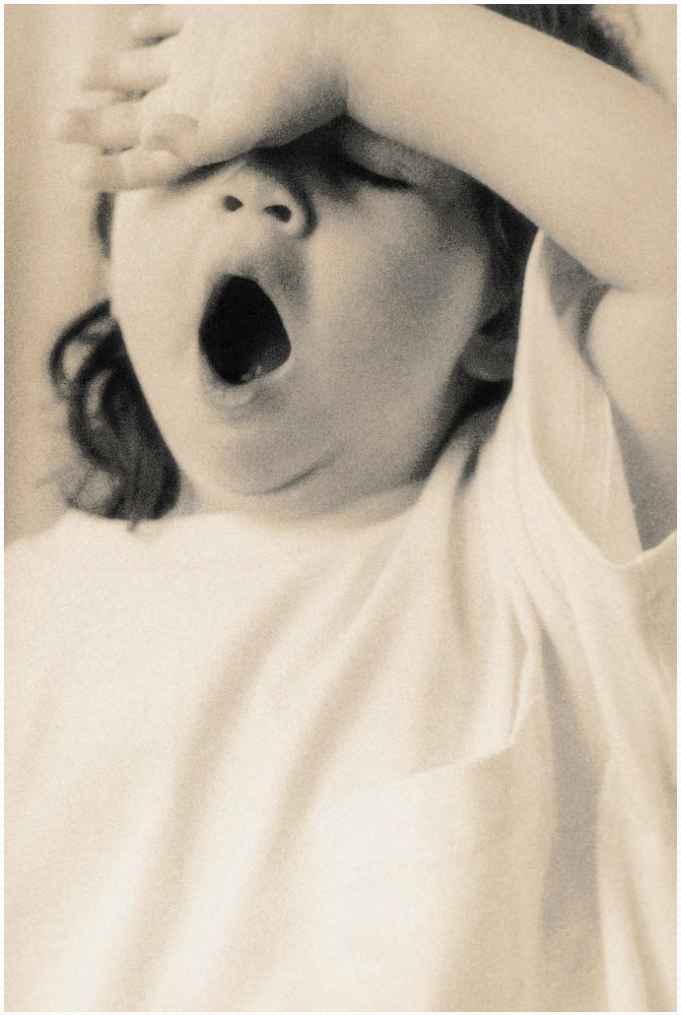
Consider:

- **speed of onset**
- **oral vs IM**
- **duration of action**
- **side effects**
- **past response**
- **patient preference**

Pharmacologic Support: Benzodiazepines

- Lorazepam - inthe first 24 hours agitation is as effectively addressed with lorazepam as antipsychotics even if psychosis is present.
- Usual dose 1-2mg IM, IV or po q 1-2 hours

- sedative hypnotic effect which can be additive with other such agents (ex. Alcohol) resulting in excessive sedation and respiratory depression
- risk of an allergic reaction -rare for benzodiazapines
- paradoxical reaction and actually become more agitated. about 5% of the population



Benzodiazepines

Exercise caution in the use of BZ:

- Elderly
- patients with respiratory disease
- acute intoxication with alcohol
- severe impairment of hepatic or renal function
- depressed level of consciousness
- patients using
- “organic” brain conditions

Midazolam

- Midazolam 2 – 10 mg (IM/IV) for agitated, aggressive patients
- Risk of respiratory depression – requires close monitoring and ideally pulse oximetry
- Onset of action 1 – 15 minutes (depending on route of administration)
- Half life 1 – 2.8 hours

Clonazepam

- Clonazepam (0.5 – 2 mg) is a longer acting IM alternative to midazolam – but risks associated with excessive sedation, ataxia
- Onset of action 5 – 15 minutes
- Peak plasma levels in less than 4 hours
- Half life 20 – 40 hours

Lorazepam

- Lorazepam (0.5 – 2.5 mg) -shorter half life
- Onset of action 5 – 15 minutes
- Peak plasma levels in 2 hours (oral and IM have a similar absorption profile)
- Half life 10 – 20 hours
- Less respiratory depression than Diazepam and Midazolam

Diazepam

- Diazepam (2.5 – 10 mg) is well absorbed orally
- IM absorption is erratic
- IV excellent but dangerous
- Onset of action (oral) up to 30 minutes
- Half life 14 - 60 hours (has multiple active metabolites

Pharmacologic support: Antipsychotics

- effective in reducing agitation
- There are options in the following forms:
  - PO, IM, Quick dissolving tabs

IM Antipsychotics

- Ziprasidone (Geodon) 20mg IM q 4 hours or 10mg q 2 hours not to exceed (NTE) 40mg/24 hours
- Olanzapine (Zyprexa) 5-10mg IM NTE 20mg/24 hours (caution with the elderly)
- Haloperidol (Haldol) 1-5mg IM q 1 hour NTE 20-30mg/24 hours

Haloperidol (oral / IM)

- Time of Onset of action depends on route of administration
  - IV – immediate
  - Oral - up to 60 minutes
- Half life 24 hours

Zuclopenthixol

- Zuclopenthixol HCl (Clopixol) 10, 25mg tablets
- Onset of action 10-30 minutes
- Peak plasma levels in less than 4 hours
- Half life 24 hours

Acuphase (Zuclopenthixol acetate)

- Acuphase (Zuclopenthixol acetate) – short acting depot used when IM medication is required, with tranquilization lasting 24 to 72 hours
- Onset of action 4 to 6 hours
- Monitor for EPS and hypotension. Hydrate
- Exercise caution in treatment naive patients

Second Generation Antipsychotics (SGAs)

Risperidone (tablets, depot)

Paliperidone (tablets, depot)

Olanzapine (tablets, short-acting IM)

Amisulpride (tablets)

Aripiprazole (tablets, long-acting IM)

Quetiapine (tablets)

Ziprasidone (tablets, short-acting IM)

Clozapine (tablets)

Second Generation Antipsychotics

For tranquilization and to reduce hostility in agitated patients

In mania and depression

As mood stabilizers

In anxiety disorders including GAD and social anxiety disorder

As augmentation treatments in OCD and treatment-resistant depression

As monotherapy / augmentation in PTSD and borderline personality disorder

Medication for agitated, psychotic patients

Generally involves a combination of:

- Oral atypical antipsychotic
- Oral benzodiazepine in the first instance

Parenteral Medication

If patient more agitated or unwilling to accept oral medication:

- **IM olanzapine or IM haloperidol plus**
- **IM lorazepam / clonazepam /midazolam**

If patient extremely agitated and presents an ongoing threat to self or others or has not responded to IM olanzapine / IM haloperidol consider use of:

- **zuclopenthixol acetate plus**
- **IM lorazepam / clonazepam / midazolam**

Monitor level of sedation, respiration. Ideally pulse oximetry if using midazolam.

Extrapyramidal symptoms

- Haldol is the most likely to cause extrapyramidal symptoms (eps) followed by risperidone with the other atypicals having less eps risk
- EPS is most likely to occur in young males and older women
- EPS is usually noted as muscle tightness in limbs, tongue thickness and neck tightness. More rarely laryngeal and pharyngeal spasm and a sense of choking

EPS treatment

- Be ready to give O2 if breathing problems develop
- PO or IM Dekinet 5 mg + PO diazepam 10 mg
- Repeat after 30 min.
- If not effective- use benadryl

Our patient story evolves

- On interview pt stated he took “a bunch of meds because I’m tired…just worn out.”
- So what are you thinking?
- How to you want to manage this patient?

First things first

- Make sure he is safe in the current setting i.e. is he still actively suicidal or can he be safe while you are evaluating him. ALWAYS ERR ON THE SIDE OF SAFETY!

- Find out what this guy took and determine if he is going to need a lavage vs supportive tx, ECG, labs etc

Suicidality and suicide

Suicide- the act of self- murder

Suicidality- thoughts, preoccupations, drives and preparations

Epidemiology

completed suicede: 25 attempts 1

Males are X4 successful than females, use mor lethal means

Females:X3 attempts than males

Peak age- M 45, F 55

have psychiatric diagnosis 95%

Leading means- hanging, firearms, jumping

reported suicidality 1 month prior to the attempt 2/3

Most visited GP 1 week prior to the attempt and a psychiatrist 2 months prior

Self harm

- X38 risk after any previous attempt
- Mainly ½ year after
- 1% of the attempters will succeed within 1 y
- 15% will aventually succeed

Risk factors

M
>45y
A letter
Previous attempts
lonely
In conflict
Any psychiatric diagnosis
Chronic pain and disability
Cancer, epilepsy, HIV
Abusers
Genetic factors
Cultural factors
Sexual identity
Secular
Unemployment an financial difficulty
Immigrants
Personality disorders
Early loss of parents

Psychiatric factors

- At least 1 ps. diagnosis
- 22% in the first year after receiving the DX
- Most cases after hospital release, most cases within 2 weeks
- Any drug abuse and especially alcohol abuse+M+over 45y+lonely and unemployed

Suicide

Genetics

Molecular genetic studies have mixed results…stay tuned!

- Among 590 **suicide attempt** polygenes implicated
- Several developmentally important functions (cell adhesion/migration, small GTPase and receptor tyrosine kinase signaling),
- 16 of the **suicide attempt** polygenes have previously been studied in SB (BDNF, CDH10, CDH12, CDH13, CDH9, CREB1, DLK1, DLK2, EFEMP1, FOXN3, IL2, LSAMP, NCAM1, nerve growth factor (NGF), NTRK2 and TBC1D1).
- **Single-nucleotide proteins (SNPs)** from MRAP2 (melanocortin 2 receptor accessory protein 2) - a gene expressed in brain and adrenal cortex and involved in neural control of energy homeostasis, - appear to provide susceptibility to **suicidality**.
- These suggested the importance of a **polygenic neurodevelopmental etiology** in **suicidal** behavior, even in the absence of major psychiatric diagnoses.

Suicide

CRH

Expression of corticotropin releasing hormone receptors type I & type II mRNA

- **Corticotropin-releasing hormone (CRH)** is a key neuroendocrine factor implementing endocrine, immune and behavioral responses to stress.
- CRH exerts its action through **two major receptors**, **CRH-R1** and **CRH-R2**.
- Strong expression of **CRF-R2** in human pituitaries and the **ratio** of **CRH-R1/R2** in the pituitary appears to be protective

A Blood Test for Suicide

SKA2 methylation

- **SKA2** is expressed in the brain's **prefrontal cortex** and involved in **cortisol suppression** and is linked to **stress reactions** via **glucocorticoid receptor** transactivation.
- There are **significantly reduced levels of the product of gene SKA2 in people with mental illness.**
- In a subset of subjects who died by suicide, researchers found an epigenetic modification that caused **higher levels of methylation at the SKA2 gene.**

A Blood Test for Suicide

SKA2 methylation

- The test (looking for **methylation** at the **SKA2** gene) was used to predict which patients had thought about or attempted **suicide**, and accuracy rate was **80%**.
- Among people with **more severe risks of suicide**, the test's accuracy rate jumped to **90%**.

Protective factors

- **Faith**
- **Parenthood, family**
- **Responsibility**
- **Optimism**
- **Fear**
- **Social embarassement**
- **Morality**
- **Support**
- **Plans for future**

Suicide assessment

- Ideation- acute vs. chronic, passive vs. active- if active is there a plan, If there is a plan ? lethality of method, intent.

- Demographic/Environmental: Risk factors include
- Caucasian or Native American, male, >65, unmarried, living alone, unemployed, family history of suicide of first degree relative, recent interpersonal loss, lethal means available (particularly firearms)

Suicide assessment cont.

- Clinical factors: Personal history of suicide attempt, substance use, chronic medical illness, agitation,

- Psychiatric illnesses/Sx including severe anxiety, schizophrenia, depression, Bipolar disorder, Borderline or antisocial personality disorder.

- H/o TBI, current hopelessness, anhedonia or apathy, current sleep disturbance, social isolation, recent psychiatric hospitalization

Is it possible to predict suicide?

- **Impossible!**
- **Possible to access the immediate risk factors**
- **Impossible to access the potential future risk**
- **Treatment plan decreases the risk**

Managing the suicidal patient

- **Ensure safety**
- **Anamnesys and collateral hystory**
- **Don't afraid to directly ask**
- **Past HX**
- **Physical and lab**
- **Support system**
- **Exact details of the attempt, current plans and intentions and methods**

Acute management

- **Treatment plan**
- **Remove the means**
- **Address the crisis**
- **Treat intoxication**
- **Relieve pain**
- **If suicidal but not psychotic- try to convince to get admitted. If refuses- F/U closely**
- **If psychotic and suicidal- compulsory hospitalization**

Serotonin syndrome

- Rapid onset of symptoms
-
- 60% present within 6 hours after initial use of medication, an overdose, or a change in dosing
- 14 to 16 % overdoses on SSRIs

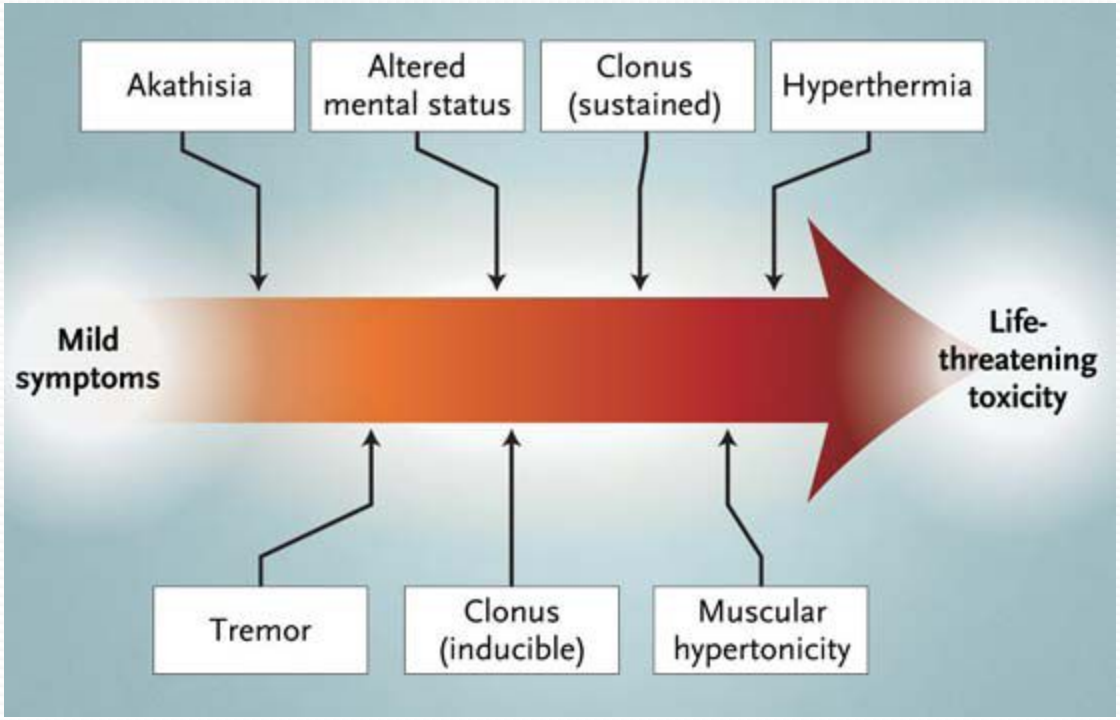
Drug interactions associated with severe serotonin syndrome

- Phenelzine and meperidine
- Tranylcypromine and imipramine
- Phenelzine and SSRI
- Paroxetine and buspirone
- Linezolide and citalopram
- Tramadol, venlafaxine, and mirtazapine

Diagnosis : Classic triad

- Mental status changes: confusion, restlessness, **agitation**, anxiety, decreased level of consciousness
- Neuromuscular abnormalities: **tremor**, rigidity, **clonus**, myoclonus, **hyperreflexia**, ataxia
- Autonomic hyperactivity : **diaphoresis**, hyperthermia, shivering, mydriasis, nausea, diarrhea
- Vital signs: tachycardia, labile BP changes

Spectrum of Clinical Findings.



Edward W. Boyer, M.D The serotonin syndrome .N Engl J Med 2005

Treatment

- Discontinuation of all serotonergic agents
-
- Supportive care, many do not require tx
- Consult with a medical toxicologist, clinical pharmacologist, or poison control center
- Cyproheptadine (serotonin antagonist)
- Intubation and ventilation : severe syndrome with hyperthermia (a temp.> 41.1°C)

Sexual abuse- PREVALENCE

- Sexual assault is one of the most under reported crimes, with 60% still being left unreported.
- Males are the least likely to report a sexual assault, though they make up about 10% of all victims.
- **Approximately 2/3 of rapes** were committed by someone known to the victim.
- **73% of sexual assaults** were perpetrated by a non-stranger.

  38% of rapists are a friend or acquaintance.
  28% are an intimate.
  7% are a relative.

Victims of sexual assault are:

- **3 times** more likely to suffer from depression.
- **6 times** more likely to suffer from post-traumatic stress disorder.
- **13 times** more likely to abuse alcohol.
- **26 times** more likely to abuse drugs.
- **4 times** more likely to contemplate suicide.

1 out of every 6 American women has been the victim of an attempted or completed rape in her lifetime.

About **3% of American men** — or **1 in 33** — have experienced an attempted or completed rape in their lifetime.

Rape is NEVER the victim's fault!

Rape is an act of violence and aggression and is usually about power and control over another person. Sex is the weapon!

Sometimes people make poor safety choices…. That does not give someone else the right to hurt them!

VIOLENCE IS ALWAYS A CHOICE

- ***The victim's only goal is to survive.***
  Sometimes cooperation is required for survival.

Cooperation to survive does NOT equal consent

-

UNIQUENESS OF SEXUAL VIOLENCE AS A CRIMINAL VIOLATION

- The violation of "self" that causes trauma in crime victims is a subjective injury, unique to each individual.
- The majority of victims are in fear for their life, even if they know the assailant.
- The crime is often intended to be as degrading and dehumanizing as possible, and that has a lasting negative effect.
- Due to the nature of the trauma, most survivors will remember more about the attack ***next week, next month***….etc.

TWO MOST COMMON RESPONSES IMMEDIALEY FOLLOWING RAPE

Expressed

demonstrating anger, fear, and anxiety through restlessness, crying or sobbing, tense posture and other signs such as hand wringing, and seemingly inappropriate smiling or laughing. ***Inappropriate laughter or smiling is common…it is an automatic response to trauma.***

Controlled

hiding or masking feelings. Exterior pose is calm, composed or subdued. Survivor may appear very deliberate in every action. Someone has just had complete control of their body…their main goal is to regain control. ***This survivor mechanism may "look" as if the rape was "no big deal".***

EITHER ONE OF THESE REACTIONS CAN CONFUSE THOSE TRYING TO HELP INCLUDING FAMILY AND FRIENDS.

Symptoms of Survivors (both female and male)

- Nightmares / sleep disturbances
- Substance Abuse
- Panic Attacks
- Irritability/Anger
- Difficulty Concentrating and focusing
- Impaired memory/Memory loss
- Sexual dysfunction
- Phobic / Compulsive behaviors
- Hyper-vigilance (always being "on your guard"
- Exaggerated "startle response"
- Depression

- Disassociation (zoning out)
- Anorexia / Bulimia / Overeating (Eating disorders)
- “Cutting” / Self-mutilation
- Anger: distance = safety
- Difficulty with relationships- triggers
- Flashbacks
- Promiscuity , Risky behavior/poor safety choices
- Distorted Thinking patterns to regain control
- Engage in sex very soon after rape
- Don’t want sex, be uncomfortable with sex (even with someone they trust)

- guilt – confusion – sexual identity issues
- Extreme independence/isolation
- Triggers / Sights, sounds, smells, feelings:
  Re-experiencing sensations, feelings from the assault
- Doubt one's own judgment, feel responsible
- Feeling dirty, humiliated, devalued
- Self-blame and shame
  Based on misconceptions about rape

- Numbing/Apathy (detachment, loss of caring)
- Social Withdrawal
- Restricted affect (inability to express emotions)
- Loss of security, trust in others and the world
- Suicidal ideation

Is alcohol a date rape drug?

Any drug that can affect judgment and behavior can put a person at risk for unwanted or risky sexual activity.

Alcohol is one such drug. In fact, alcohol is the drug most commonly used to help commit sexual assault. When a person drinks too much alcohol:

- It's harder to think clearly.
- It's harder to set limits and make good choices.
- It's harder to tell when a situation could be dangerous.
- It's harder to say "no" to sexual advances.
- It's harder to fight back if a sexual assault occurs.
- It's possible to blackout and to have memory loss.

ROHYPNOL a.k.a. "roofies"

Rohypnol (roh-HIP-nol). Rohypnol is the trade name for flunitrazepam (FLOO-neye-TRAZ-uh-pam). Abuse of two similar drugs appears to have replaced Rohypnol abuse in some parts of the United States. These are: clonazepam (marketed as Klonopin in the U.S.and Rivotril in Mexico) and alprazolam (marketed as Xanax). Rohypnol Rohypnol is 7 - 10 times stronger than Valium.

- Muscle relaxation or loss of muscle control
- Difficulty with motor movements
- Drunk feeling
- Problems talking
- Nausea
- Can't remember what happened while drugged
- Loss of consciousness (black out)
- Confusion
- Loss of consciousness (black out)
- Confusion
- Problems seeing
- Dizziness
- Sleepiness
- Lower blood pressure
- Stomach problems
- Death

GHB - GAMMA HYDROXY BUTYRATE

GHB is a central nervous system depressant that is illegally manufactured in the U.S.

GHB is a clear liquid or a sticky white powder. GHB can be tasteless, odorless, colorless, but more often has a slight tinge of brown or yellow and can make a drink taste slightly metallic. Effects include:

- feelings of extreme intoxication
- nausea and dizziness
- vomiting
- intense drowsiness
- tremors
- unsteady balance and slurred speech
-antereograde amnesia (memory loss for events following ingestion)
-Problems seeing
-Loss of consciousness (black out)
-Seizures Problems breathing
-Tremors
-sweating
-Vomiting
-Slow heart rate
-Dream-like feeling
-Coma
-Death

ECSTASY

While not classified as a “date rape drug”, many survivors were raped while using ecstasy.

Psychological difficulties:

- Confusion
- Depression
- Sleep problems
- Severe anxiety
- Paranoia (during & sometimes weeks after use)

Physical Symptoms:

Muscle tension	Involuntary teeth clenching
Nausea	Faintness
Blurred vision	Rapid eye movement
Chills or sweating	Rash that looks like acne

SUBSTANCE ABUSING SURVIVORS

- 75% of men and 55% of women involved in acquaintance rapes reported using alcohol or other drugs prior to the incident. As a result…

- AUTOMATICALLY DISTRUSTFUL OF LAW ENFORCEMENT BECAUSE OF THEIR DRUG/ALCOHOL USE.

- MORE LIKELY TO LIE ABOUT DRUG USE

- SUBSTANCE ABUSERS ARE MORE LIKELY TO END UP IN SITUATIONS "OUT OF THEIR CONTROL"
  - STRANGE PEOPLE
  - STRANGE PLACEs
  - UNSUBSTANTIATED TRUST IN INDIVIDUALS

MANY PEOPLE, *PARTICULARLY THOSE USING SUBSTANCES*, *MAY* MAKE POOR SAFETY CHOICES.

REGARDLESS OF THE SITUATION AND THE SUBSTANCE USE,
NO ONE DESERVES TO BE RAPED.

Substance Abuse

Two to three times more common among those with psychiatric illness than in general population.

Negative attitudes towards this subset of the population hinders the provision of effective care.

Urine drug screening helpful

Common Substances of Abuse

- Alcohol
- Cocaine
- Amphetamine
- Methamphetamine
- MDMA (3,4 methylene dioxymethamphetamine), (ecstasy)
- Ketamine
- Cannabis
- Opiates

The Drug Abusing Patient

- Patient may present with intoxication or withdrawal symptom
- Stimulant intoxication may induce paranoid symptoms, delirium
- Opiate withdrawal marked by pupillary dilatation, lacrimation, diarrhoea, cramping
- Patient may present with physical symptoms and demand opiates for pain relief

Amphetamine – Methamphetamine Abuse

- **Clinical Presentation:**
  - Acute anxiety
  - Paranoid ideation
  - Loud, demanding behaviour
  - Motor agitation, aggression
  - Stereotypic behaviours –sniffing, teeth clenching, purposeless searching, picking of skin
  - May be evidence of needle marks
  - Pulse, BP, respiration rate, increased and dilated pupils
    Exacerbation, precipitation of mania/psychosis
  - Persisting delusional state

Treatment

- Support, verbal de-escalation
- Safety first – potential for aggression
- Benzodiazepines – to reduce arousal
- Second generation antipsychotics
  - i.e. Olanzapine - Quetiapine
- Monitor for orthostatic hypertension with SGAs
- ECG – QTc
- General medical including hydration, malnutrition
- Routine screens including Biochemistry, CBP, Hep screens, HIV
- Assess need for inpatient treatment
- Referral to specialist drug, alcohol service where appropriate