MANAGEMENT OF ACUTE INTOXICATION FOR EMERGENCY DEPARTMENT
MA & healthcare system

- MA may account for up to 3% of all ED attendances.
- Despite modest proportion, impact could be high due to several factors:
  - High acuity psych/med/behaviour issues
  - Overstretched system
  - Crowded environment


Methamphetamine

Common features

- Increases
  - Heart rate
  - Blood pressure
  - Pupil size
  - Respiration
  - Sensory acuity
  - Energy

- Decreases
  - Appetite
  - Sleep
Organ Toxicity from MA

- Stroke
- Seizures
- Mood & anxiety
- Impaired cognition
- Psychosis

- Pulmonary hypertension

- Hypertension
- Tachycardia
- Myocardial Infarct
- Arrhythmia
- Cardiomyopathy

- Hepatic toxicity

- Renal toxicity
Acute MA mental effects

- Hallucinations
- Delusions
- Disorganized thought process
- Disorganized behavior
- Panic, extreme fearfulness, hypersensitivity to stimuli
- Potential for violence
Study of 309 regular methamphetamine users (used at least monthly)

☐ 13% of participants screened positive for psychosis

☐ 23% had experienced a clinically significant symptom of suspiciousness, unusual thought content or hallucinations in the past year

☐ Dependent = 3 X more likely to experience psychosis


Risk increased by regular use, rapid route of drug administration, sleep deprivation, underlying vulnerability
Meth psychosis vs primary psychotic illness

- Important to consider, as Mx differs.
- Could be difficult to distinguish
- Some studies: meth psychosis = more likely to have VH, less likely to have thought disorder, shorter duration of psychosis
- Diagnosis of primary psychotic illness should not be made if there is evidence that meth is involved
- MA could exacerbate pre-existing illness

Overview of management

- General approach to agitated patient
- Risk assessment
- Manage psychosis / agitation
- Exclude other drug use issues
- Evaluate and manage medical issues
- Evaluate and manage mental health issues
- Blood borne virus
- Harm reduction strategies
- Post discharge management
General approach to agitated patient

- Keep safe distance, don’t sneak, avoid physical contact
- Reassure & explain reason for assessment
- Consider offering basic needs (water, food)
- Speak in calm & inviting manner
- Consistent staffing
- Quiet, dimly lit room (low stimulus)
- Easy observation
- Consider nicotine replacement

1st hour of care critical
Assessment & Investigations

Assessment

- Vital signs, blood sugar level, oximetry
- Orientation
- Insight
- Delusional thinking
- Types and nature of any hallucinations
- History of psychiatric illness
- Medical history
- Current medications
  - Drug use history, specifically:
    - number and types of different drug types used (both licit and illicit)
    - changes in recent use patterns, particularly escalation
    - time and amount of most recent use of each drug
    - route of administration
    - presence of injection sites or ‘track marks’
- Recent sleep patterns

Investigations

- Organic screening tests for medical illness
- Drug screen
Limited research

2 general groups: antipsychotics (e.g. olanzapine, risperidone, quetiapine) & benzodiazepines (e.g. diazepam, lorazepam, midazolam)

Oral agents generally preferred over IM / IV

Agitation: benzodiazepine 1st line

Psychosis & agitation: benzodiazepine + antipsychotics

Physical restraint (last resort)

Examples:

Oral agents: lorazepam (initial) + olanzapine / risperidone / quetiapine

Parenteral agents: midazolam + olanzapine / haloperidol

References:


## Level of Agitation Scale

<table>
<thead>
<tr>
<th>Item</th>
<th>Score</th>
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<tbody>
<tr>
<td>Patient is asleep.</td>
<td>1</td>
</tr>
<tr>
<td>Patient is awake but calm, without verbal aggression or agitation.</td>
<td>2</td>
</tr>
<tr>
<td>Patient is angry, but this is primarily focused on the situation, and requests are not delivered in an obviously threatening or aggressive manner.</td>
<td>3</td>
</tr>
<tr>
<td>Patient is awake and agitated with some verbal outbursts but no physical aggression.</td>
<td>4</td>
</tr>
<tr>
<td>Patient is severely agitated with extreme verbal outbursts and/or physical aggression.</td>
<td>5</td>
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</tbody>
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Reproduced from the Royal Adelaide Hospital Emergency Department *Policy and Protocol for the Use of the Safe/Seclusion Rooms* form.
Where to from ED?

- Discharge from hospital
- Overnight / short-term ED stay
- Referral to medical / psychiatry for admission
- Referral to Alcohol & Drug Information Service / DASSA CL
GETTING THROUGH AMPHETAMINE WITHDRAWAL

A guide for people trying to stop amphetamine use

CONTENTS

About this book
Making the decision to stop using amphetamines
Amphetamine withdrawal
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  What kinds of symptoms will I have?
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- Post discharge management
Matrix Model
An Integrated, Empirically-based, Manualized Treatment Program

- Relapse Prevention
- Motivational Interviewing
- Psychoeducation
- Social Support

- Family and Group Therapy
- 12-Step Involvement
Summary

- Risk assessment
- Manage agitation
- Comprehensive assessment
- Take opportunity to educate / give info, brief intervention, harm minimization
- Referral VS discharge from ED
- Post discharge care
Impending or ‘subacute’ psychosis: what to look for

Acute psychotic symptoms are usually easy to identify, although methamphetamine users may present with a range of low-grade psychotic symptoms that are more difficult to pinpoint. The following are signs of low-grade or subacute psychosis:

- Suspiciousness, guardedness, hypervigilance — constantly checking for threats in an exaggerated way.
- Overvalued ideas — ordinary events have special significance or are more meaningful than usual or odd.
- Illusions or misinterpreting the environment — e.g. a shadow might seem like a person walking into a room, or a random sound might seem like a ringing phone or a police siren, or feeling, low-level hallucinations.
- Erratic behaviour — often related to overvalued or paranoid ideas and might include accusing others of perceived meadows, or arguing with bystanders for no apparent reason.

Acute psychosis: what to look for

The following are signs of acute psychosis:

- Delusions — often people feel persecuted, they may believe that others have malicious intentions or that they are under surveillance.
- Hallucinations — often auditory such as ‘voices’ or sounds like police car sirens, or tactile such as a feeling that ‘bugs’ are crawling under the skin, but these can also be visual.
- Erratic, uncontrolled or bizarre behaviour often in response to delusions or hallucinations, for example, talking or shouting in response to ‘voices’, unnecessary whispering, barricading a room, checking doors, pulling down blinds, making frantic phone calls, keeping a weapon for protection from perceived threats,
- Rigid, disinterested, or incoherent speech
- Extreme or rapid mood swings that are unpredictable, irrational or erratic.

First steps in response

- Quickly scan the immediate vicinity and observe location of exits, bystanders, and potentially dangerous objects to judge immediate risks and decide upon the most suitable approach (leave and call for assistance or respond carefully).

1 Due to the acute nature of the symptoms, be aware of the possibility of sudden change in behavior.
Thank you

Questions?