

Clinical Guidelines for Assessment and Management of Psychostimulant Users

Assessment

- Complete core assessment as per usual with special attention paid to current level of psychostimulant and other drug use, severity of dependence, mental health status, pregnancy, route of administration and stage of change.
- Differentiate between intoxication and withdrawal, as there may be common features.

Intoxication

Increased confidence, excitement, euphoria, anxiety, agitation, reduced need for sleep, reduced appetite, rapid speech, hypervigilance, increased body temperature and blood pressure, dry mouth, paranoia, psychotic features.

Withdrawal

not life-threatening. May exacerbate pre-existing psychiatric symptoms.

Crash phase: excessive sleeping, eating and mood irritability. Lasts hours to 2-3 days.

Acute phase: emotional lability, mood swings, anger, aggression, intense cravings. Lasts 5-7 days.

Chronic protracted phase: depression/dysphoria, lethargy and cravings. Can last months.

Management

Psychostimulant psychosis: Admit if severe, unsafe to self or others, or unsupported. Observe closely.

Sedate only if needed. Use benzodiazepines. Antipsychotics lower seizure threshold and are used sparingly (eg risperidone or olanzepine).

Cardiovascular toxicity: Hydration, sedation. consider α - or β - blockers.

Harm Minimisation: Consider route of administration. Arrange screening for blood borne viruses and HBV vaccination. Offer brief psycho-social education, intervention and follow-up.

Management of withdrawal: The evidence base is inconsistent for the use of medications (including antidepressants) in the treatment of psychostimulant withdrawal management/maintenance. Symptomatic medication may be considered on an individual basis.

Consider inpatient treatment when one or more of the following is present:

- Simultaneous dependence on alcohol or other drugs
- Severe dependence where complicated withdrawal is expected
- Serious medical complications requiring observation
- Significant psychiatric complications eg stimulant induced psychosis
- Multiple failed attempts at outpatient withdrawal
- A poor home environment or lack of support network.

Motivational Interviewing and Cognitive Behaviour Therapy (CBT): CBT is more enduring than other psychotherapies and protective against relapse. A CBT treatment manual for psychostimulants is available for use by all Drug Health Services counselling staff and consists of motivational interviewing, coping with cravings/lapses, managing thoughts about use and relapse prevention.

Comorbidity: Assess for depression or other mental health disorder after 2 weeks. Consider referral and/or antidepressant. Consider follow-up BBV tests as seroconversion may be delayed for 3 months.

References

- Models of intervention and care for psychostimulant users, Monograph 51, 2nd Edition, Baker, Lee and Jenner 2004. National Drug Strategy, Department of Health and Ageing, Australian Government.
- CBT Treatment Manual available at: www.nationaldrugstrategy.gov.au/pdf/cognitive.pdf
- Information for clients at: www.druginfo.nsw.gov.au/illicit_drugs/amphetamines

Flowchart for Assessment and Management of Psychostimulant Users

