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

This resource was developed by Sydney South West Area Drug Health Services
Intoxicated?
Symptoms include euphoria, agitation, hypervigilance, rapid speech, paranoia

Yes

Major symptoms of toxicity
• Chest Pain
• Fever
• Hypertension
• Psychotic features
• Severe behavioural disturbance

Yes

No

Major symptoms of toxicity

No

Refer for medical assessment or Emergency Department

Yes

Attend Drug Health Services for assessment after 24-72 hours

No

Assessment
(Use Standard Assessment Form)

Ready to Change?

Consider

Dependent?

Dependence: 3 or more
Tolerance, withdrawal syndrome, uses more than intended, difficulty cutting down, significant time spent using, impact on lifestyle, uses despite harm

Yes

No

Consider
Drug Withdrawal Service (Inpatient or Outpatient)

Offer CBT and/or other psychosocial intervention

Harm minimisation, brief intervention and follow-up

Special needs

Young People
Focus on engagement and family involvement then proceed as for adults.
Use youth specific D&A services if available

Pregnancy
Refer to drugs in pregnancy service and/or obstetrics and gynaecology

Polydrug use
Consider all drug use in assessment and treatment planning

Injecting drug use
Screen for blood-borne viruses. Consider vaccination if applicable

Mental health symptoms
Consider safety of client or others and determine need for urgent referral to Emergency Department or Crisis Team.
If currently known to Mental Health, liaise with case worker. If not, consider need to refer for specialist assessment and proceed with integrated treatment, shared care arrangements as appropriate and follow-up

Flowchart for Assessment and Management of Psychostimulant Users

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