Management of Stimulant Use

OVERVIEW

TIMELINE	COMMON PRESENTATIONS
Acute withdrawal Onset: Within 24 hrs of last use Duration: 7–10 days, with "crash" first 1–2 days	**Stimulant overuse/psychosis** Nausea/vomiting, aches/pains, tremors, fever, hypertension, tachycardia, panic, extreme agitation, paranoia, hallucinations, skin-picking
Post-acute withdrawal Can last weeks to months	**Stimulant withdrawal** Fatigue, depressed mood, anxiety, sleep disturbance, increased appetite *Psychosis can continue into withdrawal

ASSESSMENT

- Intake & vital signs
  - Complete substance use history will guide monitoring and treatment
  - Polysubstance use increases OD risk and concurrent withdrawal syndromes may be present
  - Wake clients for assessment during their first 6h of their WMS stay
- Monitor for suicidal ideation
- Monitor with **Level of Agitation (LOA) Scale** q2h while awake days 1 to 3:

LOA 1–2	LOA 3–4 +/- PSYCHOSIS	LOA 5 +/- AGITATED DELIRIUM
No treatment required Continue to monitor	See treatment options for agitation and drug-induced psychosis below	Transfer to ED

TREATMENT OF WITHDRAWAL

- Minimize stimuli throughout withdrawal (e.g., dim lights, quiet setting)
- Treat based on the client's LOA scoring +/- presence of psychosis
- Discuss long-term treatment options (see below)

TREATMENT OF AGITATION

- Diazepam 5 mg PO q2–6h PRN (ED transfer if no improvement after 40 mg)
- Lorazepam 0.5 mg PO q2–6h PRN (ED transfer if no improvement after 4 mg)

TREATMENT OF DRUG-INDUCED PSYCHOSIS*

- Olanzapine 5 mg PO q2h PRN (max 20 mg/day)
- Risperidone 1 mg PO q1h PRN (max 4 mg on day 1)
- Quetiapine 12.5–25 mg PO TID PRN + 50 mg PO hs PRN or standing

*Combination antipsychotic-benzodiazepine therapy may be required. For clients on opioids or opioid agonist treatment, dual therapy requires additional caution and medical monitoring.

WHEN TO SEND TO THE EMERGENCY DEPARTMENT

- No improvement after max day 1 dosing
- Escalating LOA and declining oral meds
- Escalation to LOA 5
- **Any of** SBP > 180, DBP > 120, HR > 120, T > 37.5°C, chest pain, shortness of breath

LONG-TERM TREATMENT OPTIONS

- First line: **Contingency management**
- Limited evidence for medication, and all medications are off-label for stimulant use disorder

MEDICATION	DOSING AND TITRATION	CONSIDERATIONS
Bupropion	150 mg PO once daily x 3 days, then 150 mg PO twice daily *or* XR 150 mg PO once daily, titrate over 3 days to 450 mg PO once daily	Useful for concurrent ADHD Useful for desired smoking cessation Useful with symptoms of low energy, low mood
Naltrexone	25 mg PO hs x 4 days, then 50 mg PO once daily Increase by 25–50 mg weekly as needed Max 150 mg PO once daily	Useful for concurrent stimulant/alcohol use Cannot be used with opioid or opioid agonist treatment on board
Mirtazapine	15–30 mg hs Can increase to 45 mg hs	Useful for sleep assistance and low mood
Disulfiram	125 mg PO once daily Can increase to 250 mg PO once daily	Complete abstinence from alcohol required Compounding required Complete labs before starting, hepatic risk
Topiramate	25–50 mg PO qhs, then increase by 25–50 mg weekly as needed, dividing doses BID, to a max 300 mg/day	Useful for concurrent stimulant/alcohol use Pregnancy category D