Department of Public Health
Bureau of Substance Addiction Services

Practice Guidance

Integration of Care for People who Use Stimulants into Substance Use Treatment Services

BSAS
Prevent • Treat • Recover • For Life

Rationale and Considerations

Recognizing the challenge that stimulant use poses to many individuals and that care for stimulant use disorders lags behind compared to care for other substance use disorders. (1)

What are stimulants? (2,3)

- **Stimulant types include :**
  - cocaine
  - methamphetamine
  - prescriptions stimulants (amphetamine, methylphenidate)
  - caffeine
- **National Survey on Drug Use and Health in Massachusetts (2019)** (4)
  - 3.1% of adults used cocaine
  - 0.3% of adults used methamphetamine

Clinical Care and Support

Stimulant Overdose/Intoxication:

- The syndrome of stimulant intoxication and overdose results from a large quantity or potent dose of stimulants and presents differently depending on the substance used.
- Intoxication can result in behavioral symptoms like confusion, paranoia, irritability, hypersexuality, and hypervigilance.
- Physiologic signs and symptoms can include elevated body temperature, rapid heart rate, elevated blood pressure, chest pain, and neurologic problems.
- Both cocaine and methamphetamine acute intoxication and overdose can lead to heart attack, stroke, and seizure, while chronic use is a cause of cardiovascular disease. (5)
- Stimulants are commonly present during opioid, alcohol, and benzodiazepine overdoses as well.

Clinical Care and Support

De-escalating intoxication, agitation, and psychosis:

- Psychosis symptoms include auditory, visual, and tactile hallucinations, delusions (an unshakable belief in something untrue), and paranoia.
- Care should focus on comfort and de-escalation.
- De-escalation starts with ensuring a safe, calming personal space and safety.
- Designate one care provider at a time to interact calmly and reassuringly with the patient, explaining who they are and their role in keeping the patient safe.
- Communication should be concise and repeated, allowing the patient time to process and understand.
- Provide the patient control and reassurance, by offering choices and optimism.

Clinical Care and Support

Ten Domains of De-escalation:

1. Respect personal space
2. Do not be provocative
3. Establish verbal contact
4. Be concise
5. Identify wants and feelings
6. Listen actively and respond appropriately
7. Agree or agree to disagree
8. Lay down the law and set clear limits
9. Offer choices and optimism
10. Debrief the patient and staff.

Source: Richmond JS, Berlin JS, Fishkind AB, et al. Verbal De-escalation of the Agitated Patient: Consensus Statement of the American Association for Emergency Psychiatry Project BETA De-escalation Workgroup. *West J Emerg Med*. 2012;13(1):17-25. Available at: https://pubmed.ncbi.nlm.nih.gov/22461917/

Clinical Care and Support

De-escalating intoxication, agitation, and psychosis:

- Medical providers may offer medications for symptoms and should offer the patient some choice of the timing of the medication.
- If these de-escalation techniques do not de-escalate, then intoxication, agitation, and psychosis symptoms can be managed using anti-psychotic medications during an acute crisis.
- When danger to self or others persists despite de-escalation efforts, engage psychiatric crisis services, and transfer the patient to an emergency or hospital setting for psychiatric care.
- After the intoxication, agitation, or psychosis resolves, debrief with the patient, so they understand what happened and consider how to prevent a future episode.

Clinical Care and Support

Stimulant withdrawal symptoms:

- The frequency and intensity of stimulant use will determine the risk and intensity of withdrawal symptoms, with withdrawal being more common in severe use disorder.
- Stimulant withdrawal is typically characterized by depressed mood, low energy, and irritability. There can be both intense exhaustion and insomnia.
- Other symptoms include agitation and irritability, increased appetite, muscle aches, stimulant cravings, and auditory and visual hallucinations.
- Symptoms typically begin within 24 hours of last use of stimulants and can last for 3-5 days.
- Acute stimulant withdrawal may be followed by protracted withdrawal symptoms of 1-2 months duration, characterized by lethargy, anxiety, unstable emotions, erratic or disturbed sleep patterns, and intense cravings for stimulant drugs.

Clinical Care and Support

Observation and monitoring :

- No withdrawal scale has been validated for widespread use.
- The mainstay of treatment for stimulant withdrawal is monitoring and supportive care to relieve symptoms.
- The patient's mental state should be monitored to detect complications such as psychosis, suicidal ideation, depression, and anxiety.
- Patients who exhibit severe symptoms, such as abnormal vital signs, psychosis, or panic.
- Unresolved de-escalation techniques or withdrawal symptom management should be transferred to a medical or psychiatric hospital where these severe symptoms can be monitored and managed.

Treatment and Harm Reduction

Engagement and retention in treatment:

- The most common evidence-based treatment for stimulant use disorder is cognitive behavioral therapy-based counseling (CBT).
- Offered individually, in groups via an intensive outpatient treatment program, or through residential treatment programs.
- Contingency management (CM) has been shown to be effective in multiple studies.
- The Matrix Model places an intense focus on the use of therapy sessions with a professional therapist and addresses relapse prevention, family education, and peer support groups. (6,7)
- Recent studies have shown some benefit of medications like mirtazapine and bupropion for the treatment of methamphetamine or other stimulant disorders, though these medications have not been FDA approved for these indications. (8)

Treatment and Harm Reduction

Stimulants and other substance use:

- Stimulants are frequently used in conjunction with other substances.
- In order to balance the sedating effects of opioids and alcohol.
  - For example, people who use stimulants often couple it with a sedating substance to counteract the agitation and difficulty sleeping that occurs as a stimulant binge goes on.
  - Benzodiazepines can mellow out the highs of stimulant use.
- In 2018, 86% of deaths involving stimulants also involved opioids. (9-10)
- Users should be aware of the risk of unintentional overdose when using stimulants and or opioids, especially heroin and fentanyl.
- Providers should be aware of and assess for concurrent substance use disorders and offer appropriate, evidence-based treatment whenever necessary.

Treatment and Harm Reduction

Stimulants and harm reduction:

- Stimulants are frequently used through snorting and smoking which are less likely to result in infections.
- Intravenous injection of cocaine and methamphetamine are the highest risk behaviors for overdose; the development of skin, soft tissue, and systemic bacterial infections; and the transmission of HIV and hepatitis C infection. (11)
- Individually tailored harm reduction counseling should accompany all use disorder treatment.
- Persons who inject stimulants or other drugs should be considered for the appropriate HIV prophylaxis. (12)
- Enhancing harm reduction practices during and after the COVID-19 pandemic deserves focus. (13)

Treatment and Harm Reduction

Stimulants and treatment of co-occurring mental illness, including trauma:

- Stimulant use disorder is highly prevalent among adults with mood disorders, ADHD, suicidality, PTSD, or psychotic disorders. (14)
- Difficulty distinguishing primary psychiatric symptoms from substance use disorder intoxication or withdrawal is common.
- Treatment is often challenging and should include psychiatric evaluation and treatment.
- Individuals with multiple psychiatric disorders and co-occurring substance use have lower mental and psychiatric functioning, which may complicate treatment plans. (15)

Treatment and Harm Reduction

Stimulants and pregnancy:

- Cocaine use during pregnancy increases the risk of preterm delivery, low birth weight (< 2500 g), small for gestational age infants, earlier gestational age at delivery, and reduced birth weight.
- There is no compelling evidence that prenatal cocaine exposure is associated with adverse outcomes that cannot be attributed to gestational age at delivery, caregiver psychiatric comorbidities, other prenatal exposures (tobacco, marijuana, or alcohol), or quality of postnatal environment. (16)
- Women who are pregnant should receive the appropriate care to abstain from or decrease stimulant use and other substance use. (17)
- Pediatric guidelines recommend against breastfeeding in the setting of active stimulant use.

Treatment and Harm Reduction

Stimulants and transactional sex:

- Transactional sex (trading money, substances, housing, or safety for sex) can occur among people who use stimulants.
- Awareness of the high-risk sexual behaviors associated with methamphetamine and cocaine use are important for harm reduction and treatment. (18)
- Staff and programs providing care for people who use stimulants should be trained in trauma-informed care and prepared to refer to those with histories of sexual trauma for counseling and support.
- Pre-or post-exposure HIV prophylaxis and should be counseled on safer sex practices and birth control. (19)

Summary

Key Takeaways:

- In the Commonwealth of Massachusetts, there is increasing stimulant use and demand for treatment access.
- The treatment of stimulant use disorders involves a careful assessment of patient needs in order to provide a therapeutic environment.
- Managing withdrawal and planning treatment goals for reducing stimulant use can be done in any treatment setting.
- Patients with stimulant disorders may have other substance use disorders or co-occurring mental illnesses, which are important factors in case management.

Discussion Points & Questions

- How are we currently serving individuals with stimulant use disorders in our program(s) ?
- Are our practices aligned with the guidance presented?
- What could we improve on in each area?
  - Knowledge of stimulant use
  - Policies
  - Organizational operations
  - Service delivery and treatment
  - Support and information for caregivers
  - Other ?

Stimulant Use Disorders Specific Resources

- **SAMHSA Resource:** Substance Abuse and Mental Health Services Administration (SAMHSA): Treatment of Stimulant Use Disorders. SAMHSA Publication No. PEP20-06-01-001 Rockville, MD: National Mental Health and Substance Use Policy Laboratory. Substance Abuse and Mental Health Services Administration, 2020.

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