Managing Acute Stimulant Intoxication and Withdrawal

Note: This document provides information on managing stimulant intoxication and withdrawal. Regional health authorities may opt to develop relevant pre-printed orders (PPOs), decision support tools (DSTs), workflows, or other tools to support implementation

Preamble

Managing stimulant intoxication and withdrawal is necessary to:

Prioritize the safety of the patient

- Support the patient while their primary medical condition is treated
- Help prevent self-iniated discharge
- Minimize agitation and possible injuries
- Minimize self-management of withdrawal (e.g., unregulated substance use) and risks and harms related to the toxic drug supply

Provide comfort

- Stimulant withdrawal can be a severely uncomfortable and distressing syndrome
- Address any concerns the patient may have from past experiences managing intoxication and withdrawal
- Manage stimulant withdrawal as soon as possible

Reduce barriers to meeting other treatment, harm reduction, and self-defined recovery and wellness goals.

Each patient requires an individualized care plan to manage stimulant intoxication and withdrawal.

- Clinical discretion must be used to prioritize client safety
- Use shared decision-making to create care plan that aligns with the patient's goals and preferences

Assessment

The initial clinical examination should include:

1. A clinical interview (as feasible)
   a. Screen for substance use and understand the patient's relationship with substances
   b. Assess for conditions that can present similarly to stimulant intoxication (e.g., mania, sleep deprivation)

   The effects of intoxication and sleep deprivation are usually short-term, psychiatric disorders may have longer lasting symptoms
2. Physical examination, with consent
3. Observation of signs and patient-reported symptoms
4. Review of any available collateral information
5. A safety assessment of the patient's risk of harm to self and others
6. Consult the local inpatient consult team, 24/7 Addiction Medicine Clinician Support Line, RACE app, or other regional addiction medicine supports as needed

Identifying Stimulant Intoxication

Recognizing the presence of stimulant intoxication, stimulant-induced agitation, and/or stimulant-induced psychosis is key when determining an approach to management.

- ☐ These presentations occur on a spectrum and may be overlapping, which has implications for treatment considerations.
- ☐ In the presence of agitation and/or psychosis, identify potential causal factors other than stimulant intoxication (e.g., sleep deprivation, underlying psychiatric disorder); treatment should address all underlying causes.
- ☐ Consult the local inpatient consult team, 24/7 Addiction Medicine Clinician Support Line, or RACE app to support diagnostic clarity of stimulant-induced psychosis versus primary psychotic disorder.
- ☐ If stimulant-induced psychosis is suspected, refer to psychiatry.

Stimulant Intoxication Signs & Symptoms

Physical Symptoms	Psychiatric Symptoms
• Chest pain • Sweating • Abnormal movement (ataxia, choreoathetosis) • Elevated blood pressure • Skin picking • Dilated pupils **Hyperadrenergic Symptoms** (may require a higher level of care) • Tachycardia • Hypertension • Hyperthermia • Agitation	• Agitation • Mania • Paranoia • Severe delirium • Other features of psychosis

Stimulant-induced Agitation Signs & Symptoms

Physical Symptoms	Psychiatric Symptoms
• Motor and verbal hyperactivity • Inability to remain still • Hyperresponsiveness • Communication impairment	• Racing thoughts • Emotional tension • Inability to remain calm

Stimulant-induced Psychosis Signs & Symptoms

Physical Symptoms	Psychiatric Symptoms
• Auditory and visual hallucination • Unpredictability, which may manifest as hostility and violence, as a stress response	• Delusions of persecution • Agitation and anxiety • Compulsive thoughts

Identifying Stimulant Withdrawal

Physical Signs & Symptoms	Psychiatric Signs & Symptoms
• Fatigue • Pain • Hypersomnia • Insomnia • Craving • Psychomotor agitation or impairment • Increased appetite	• Depressed mood • Vivid, unpleasant dreams • Anxiety • Cognitive impairment • Agitation and irritability • Self-stigmatizing thoughts

Management of Stimulant Intoxication and Withdrawal

Focus care on comfort and de-escalation. Symptoms of intoxication and withdrawal should be managed using supportive care.

There are no specific or targeted medications approved for treating stimulant withdrawal.

Support that should be offered during active stimulant intoxication and withdrawal:

Minimize stimuli

- Respect personal space
- Offer a quiet, low-lit room
- Provide a comfortable place to sit or lie down
- Provide a clear and open exit

Provide comfort

- Speak in a calm voice
- Introduce yourself
- Ask what they need to feel more comfortable
- Reassure them
- Affirm and normalize feelings of distress in distressing situations
- Offer a cool cloth
- Meet the patient where they are at
  - Follow their lead
  - Mirror language
  - Give space
  - Allow safe self-soothing behaviours (e.g., rocking, repeating words or mantras)
  - Do not take their experience personally
- If they are confused, tell them what happened
- Promote autonomy by giving options wherever possible (e.g., if they want to stand or sit, where to sit, if they want to be called by their first or last name)
- Offer to connect them with a peer navigator, if available

Concise and repeated communication that allows the patient time to process and understand

- Orient to time and place
- Provide reassurance
- Communicate what they can expect while in acute care

Follow best practices for general substance toxicity:

- Provide vitamins, fluids, and nutritional support, including thiamine and dextrose
- Correct electrolyte and fluid imbalances
- Provide adequate nutrition

Support that should be offered after the patient's condition has improved:

- Address sleep deprivation by supporting re-establishing sleep/wake cycles
- Conduct a mental health assessment

Managing Stimulant-induced Agitation

Supportive care is the first-line treatment for intoxication and withdrawal (listed above).

Offer to connect patient to peer navigators, where available.

Benzodiazepines may be used to treat stimulant-induced agitation if distressing symptoms persist despite supportive care.

- Initial dosing:
  - **Lorazepam 1–2mg IV/PO/IM** based on clinical signs and symptoms and duration of effects
  - **Midazolam 5mg IM or 0.01-0.05mg/kg** IV for acute, severe agitation in adult patients
- The clinical effect of the initial dose should guide the timing and amount of subsequent doses
- Hold subsequent doses if signs of respiratory depression are observed

Limit use of restraints to manage stimulant-induced agitation, as it can cause harm to the patient (e.g., invoking anger, triggering past trauma).

- Use the least invasive methods possible when necessary to protect the safety of patients and/or staff
- Avoid use of physical restraints and chemical restraints, unless absolutely necessary

If agitation and/or psychosis do not respond to the setting's available de-escalation and/or medication management interventions, coordinate transition to a more intensive level of care.

Management of Stimulant-induced Psychosis

Management of stimulant-induced psychosis is beyond the scope of this document.

Consult with psychiatry to determine management for patients with features of psychosis including hallucinations, delusions, delirium, or other significant features of mental illness.

Consultations may include a psychiatrist, mental health nurse, or the Rapid Access to Consultative Expertise (RACE) app.

Monitoring

- Symptoms may change as intoxication subsides and withdrawal symptoms begin to develop.
  - Stimulant intoxication can subside after a few minutes (e.g., cocaine) up to 12 hours (e.g., methamphetamines, extended-release amphetamine/dextroamphetamine), depending on which stimulant is used
  - Acute withdrawal symptoms typically begin within 24 hours of last use of stimulants and can last for 3–5 days
- Continue monitoring symptoms that require supportive care.
- Monitor for suicidal ideation and explain this is to help them stay safe because people may experience suicidal thoughts during stimulant withdrawal.
- Continue to monitor for escalating or new symptoms.
- Development of psychiatric symptoms or abnormal vitals should be monitored especially closely

Ongoing Treatment

- Collaboratively develop a treatment plan based on patient-identified goals.
- **The standard of care for stimulant use disorder is psychosocial treatment**.
  - Refer to psychosocial interventions available in your region, such as counselling, cognitive behavioural therapy, or contingency management
  - See the BCCSU's *Stimulant Use Disorder Practice Update* for more information on psychosocial interventions
- Ask the patient if they are interested in working with peer navigators or Indigenous patient navigators, where possible, to facilitate ongoing treatment.

How to Help – Practical Strategies to Keep You and Your Patients Safe

☐ It is important to create a space for discussion about substance use that aims to be culturally safe, free of stigma, and anti-racist so that patients feel safe enough that they do not leave before their care is completed.

☐ Signal safety to people who use substances by using person-centred and trauma-informed principles of care, which:

- Reduce stigma
- Increase access to care
- Reduce conflict

☐ Ask how the patient keeps themself safe when they use substances and discuss an overdose prevention plan.

☐ Clinicians are responsible for making decisions based on the patient's presentation and with the consent of the patient.

- Decisions to provide or administer medications should be based on whether the patient meets the clinical indication for that medication at the time of assessment

☐ Develop a plan to reduce harm if the patient continues to use substances or returns to use.

Encourage the use of harm reduction services in the local area, such as:

Drug checking services

- Drug Checking BC provides a list of local drug checking services
- Get Your Drugs Tested offers testing by mail and is available to all Canadians
- Substance Drug Checking offers testing by mail for people on Vancouver Island, by drop in in Victoria, and at a number of sites across Vancouver Island

Supervised consumption sites or overdose prevention services

- Patients may access support related to safer use strategies and linkages to addiction care
- Some existing overdose prevention services and supervised consumption sites do not allow substances to be smoked due to ventilation restrictions
- Discuss potential alternate routes of administration and safety with the patient
- Offer harm reduction supplies

Offer education on overdose prevention, recognition, and response

Discuss strategies to prevent overdose:

- Using with others when possible
- The Brave app or Lifeguard app
- National Overdose Response Service
- Starting with a small amount of substance, especially after a period of abstinence or decreased use (i.e., a "test dose")
- Share safety concerns and harms (e.g., sedation, overdose) related to co-occurring substance use
  - Increased risk of overdose when using more than one CNS depressant (e.g., benzodiazepines, alcohol, opioids)

Review signs and symptoms of an overdose to ensure the patient can recognize an overdose

Discuss how to respond to an overdose

- There is no medication to reverse a stimulant overdose
- Seek immediate medical attention for the following symptoms:
  - Seizures
  - Loss of consciousness
  - Chest pain or fast pulse
  - Agitation, hallucinations, or paranoia
  - Increasing temperature
- If an opioid overdose is suspected due to stimulants contaminated with opioids:
  - Naloxone administration
    - Provide take-home naloxone kits early in admission in case the patient self-initiates discharge
    - Review how to use naloxone with the patient, if the patient is interested
    - First Nations patients may access nasal naloxone without a prescription through FNHA at pharmacies across the province

Discharge Planning

☐ Discuss discharge plans as soon as possible and on an ongoing basis before anticipated discharge (e.g., determine the patient's pharmacy in case of abrupt discharge).

☐ Provide discharge prescriptions based on patient presentation and primary medical condition.

- Benzodiazepines should not be prescribed long-term

☐ Continuity of care

- Offer the patient resources to support continuity of care
- Contact the community pharmacist and/or prescriber directly, when possible, before the patient is discharged
  - Send relevant information to the community prescriber, including a discharge summary and pertinent investigations, procedures, consultations, and dosage of continuing prescriptions
- Provide linkages or referrals to psychosocial interventions such as counselling, cognitive behavioural therapy, or contingency management, and inform patients about what to expect if waitlisted
  - Be familiar with which services are available locally or virtually

☐ Consider referral to an outreach team, if available in the region.

☐ Provide information on community supports such as harm reduction services (e.g., overdose prevention sites), community-based health care clinics, psychosocial supports, Indigenous cultural supports, and educational materials, in alignment with patient goals.

☐ Discuss with the patient if any support people should be alerted of the treatment plan (e.g., family members, friends, staff at supportive housing, etc.).

- Offer to give a copy of important paperwork to a friend of family member, if helpful

Consultation

Consult with an addiction specialist, such as the local inpatient addiction medicine consult team (available at some acute care sites), for any questions or concerns.

24/7 Addiction Medicine Clinician Support Line

- Consult with an addictions medicine specialist 24 hours a day, 7 days a week
- Available to physicians, nurse practitioners, nurses, midwives, and pharmacists who are involved in addiction and substance use care and treatment in BC
- 778-945-7619

Rapid Access to Consultative Expertise (RACE)

- Online application where primary care providers (physicians and nurse practitioners) can receive specialist advice

Resources

BCCSU: *Stimulant Use Disorder Practice Update*

ASAM/AAP: *The ASAM/AAAP Clinical Practice Guideline on the Management of Stimulant Use Disorder* (American guideline)

Patient Resources

Rapid Access to Addiction Care (RAAC) Clinics

Providence Health Care, St. Paul's Hospital, Vancouver

Fraser Health Authority

- Fraser East RAAC
  - Abbotsford, Abbotsford ACT Building
  - Chilliwack, Chilliwack General Hospital
  - Mission, Mission MHSU Centre
- Fraser North RAAC
  - New Westminster, MHSU Centre, RCH
- Fraser South RAAC
  - Surrey, Creekside Withdrawal Management Centre

Island Health, Pembroke St, Victoria

Virtual Addictions Medicine Services

Vancouver Coastal Health Lighthouse Virtual Substance Use Care Clinic

- Free virtual clinic that uses telephone appointments to provide medical treatments and short-term stabilization for people who use substances
- Available 7 days per week including statutory holidays (604-806-8223 or toll-free 1-877-842-8884)

Interior Health Virtual Addiction Medicine (VAM)

- Provides urgent care and medical support for those with substance use disorder

Northern Health Virtual Substance Use Clinic

- Offers substance use support to residents of Northern Health 1-844-645-781

Opioid Treatment Access Line

- 1-833-804-8111
- People with opioid use disorder can access care from clinicians, including physicians and nurses
- Prescriptions for opioid agonist treatment medications
- Covered by PharmaCare

First Nations Virtual Doctor of the Day

- Virtual appointments available to all First Nations people and their families living in BC (1-855-344-3800)