Amphetamine Withdrawal Management

These toolkits are derived from the QLD Alcohol and Drug Withdrawal Clinical Practice Guidelines 2012.
Medical Addiction specialists will be able to offer additional expert opinion based upon current evidence.

insight
Alcohol and other drug training and workforce development Queensland

1 SCREENING

Severity of Dependence Scale (SDS)

Record the answer that best represents the consumer's personal feelings towards their amphetamine use over the previous twelve months.				
Did you ever think your amphetamines use was out of control?	Never or almost never (0)	Sometimes (1)	Often (2)	Always or nearly always (3)
Did the prospect of not using amphetamines make you anxious or worried?	Never or almost never (0)	Sometimes (1)	Often (2)	Always or nearly always (3)
How much did you worry about your use of amphetamines?	Never or almost never (0)	Sometimes (1)	Often (2)	Always or nearly always (3)
Did you wish you could stop using amphetamines?	Never or almost never (0)	Sometimes (1)	Often (2)	Always or nearly always (3)
How difficult would you find it to stop or go without amphetamines?	Never or almost never (0)	Sometimes (1)	Often (2)	Always or nearly always (3)
Amphetamines > 4 indicates dependence (Topp L, Mattick R. 1997).				Total /15

2 ASSESSMENT

Perform Comprehensive Assessment

1. **Consumption History:** Type of amphetamine, average daily intake (higher doses increase severity of dependence), frequency of use (number of doses per day), duration of use - months or years, history of severity of withdrawal symptoms, other drug use, day/time of last use, other serotonergic agents e.g. SSRIs, some opioids and MDMA
2. **Biopsychosocial history:** Medical and psychiatric conditions, social history and collateral relating to presentation
3. **Investigations:** Bloods (eLFTS, FBC), ECG, Urine Drug Screen, Blood Born Virus Screen, STI check, Malnutrition screening tools
4. **Physical examination:** Neurological observations, mental state examination, assess for IV use (patentcy and health of veins - assess for cellulitis/ infected access sites)

Consider additional investigations if patient presents with chest pain (Troponin), or if patient is intoxicated (CK)

3 MONITORING

Amphetamine Withdrawal Scale AmWS

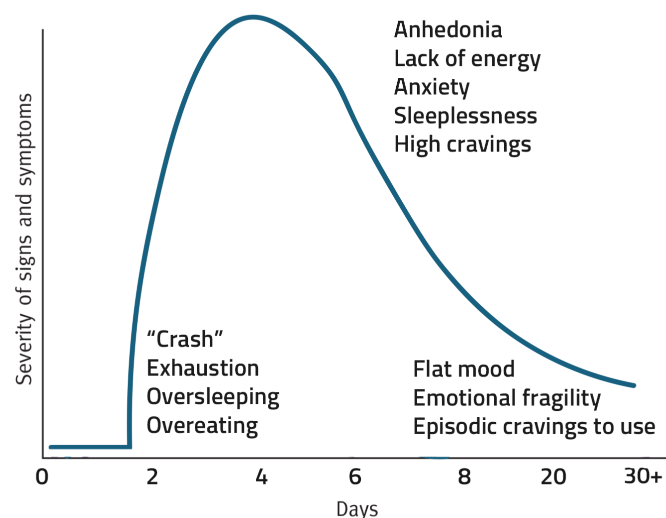
- Implement and monitor AmWS, using as a guide to monitor withdrawal trends
- Commence twice daily and reduce as scores settle (*inpatient only*)
- Use objective data and clinical judgement to guide management

Withdrawal Symptoms

ACUTE PSYCHOTIC SYMPTOMS: At risk and vulnerable with unstable mental state; Fearful, agitated and labile mood; repetitive, compulsive, meaningless behaviour (scratching, foraging for rubbish, cleaning for hours over and over, dismantling objects, etc.); paranoid delusions with clear consciousness may be very frightened, panicky, aggressive, can result in violence; hallucinations: auditory, tactile (typically formication – bugs are crawling under the skin), visual, gustatory or olfactory

COMMON SYMPTOMS: Strong cravings; mood changes, irritability, agitation, anxiety; low mood, depression and risk of suicidality; increased sleep, vivid dreams, appetite; poor memory / concentration; fatigue, lack of energy, generalised aches and pains

Course of Withdrawal



Supportive Therapies

<table>
<tr><th>Symptoms</th><th>Supportive Pharmacotherapies</th><th>Brief interventions</th></tr>
<tr><td>Sleep problems</td><td>Promethazine

Diazepam (low dose e.g. 5mg twice daily reducing over 3-7 days)</td><td rowspan="5">• Progressive muscle relaxation
• Relaxation (app or CD)
• Sensory approaches
• Challenging irrational beliefs
• Physical activity/exercise
• Relaxation strategies
• Breathing and meditation techniques
• CBT and mindfulness approaches
• Stress management
• Mood management
• Coping strategies
• Activity scheduling
• Timetabling pleasant activities
• Anger management
• Sleep hygiene
• Solution-focused brief therapies
• Motivational interviewing techniques
• Decisional balance
• Readiness /confidence to change ruler
• Psychoeducation
• Goal-setting
• Diet high in tryptophan (protein-based foods or dietary proteins)</td></tr>
<tr><td>Restlessness; anxiety; irritability</td><td></td></tr>
<tr><td>Hallucinations
Mood disturbances</td><td>Olanzapine (low dose e.g. 2.5mg while symptoms persist titrated against symptoms)</td></tr>
<tr><td>Stomach pains
Physical pain
Muscle cramping
Nausea</td><td>Hyoscine butylbromide
Paracetamol, NSAIDS
Magnesium supplementation
Metoclopramide, promethazine</td></tr>
<tr><td>Vitamin and electrolyte disturbance</td><td>Multivitamin and dietary supplements</td></tr>
</table>

Integrated withdrawal and post-withdrawal services are required to manage the protracted nature of the extinsion phase of stimulant withdrawal.

Variances to Standard Withdrawal Protocols

- Do not prescribe benzodiazepines for patients on methadone or buprenorphine programs without consultation with treating physician.
- Caution diazepam use in severe hepatic/renal dysfunction. Consider oxazepam as alternative

Alcohol and Drug Clinical Advisory Service: 1800 290 928

Post-Withdrawal Treatment Options

Relapse Prevention	Adis 24/7 Alcohol and Drug Support 1800 177 833 adis.health.qld.gov.au Individual counselling Self-help groups (AA, NA, Smart Recovery) Residential rehabilitation Family Drug Support (FDS) - 1300 368 186