39 - Overview of treatment

Overview of treatment

532 The Maudsley® Prescribing Guidelines in Psychiatry CHAPTER 4 Stimulant use disorder (SUD) Stimulants, as a group, encompass a wide range of synthetics (amfetamine, methamphetamine, methylphenidate, mephedrone) and naturally derived substances (cocaine and crack, ephedrine, khat) broadly described as sympathomimetic. Ingestion creates characteristic euphoric effects thought to be mediated by release of the monoamines norepinephrine, serotonin and dopamine.1 Cocaine and amfetamine use are the most common with a global prevalence rate of 0.4% and 0.7%, respectively. It is estimated that dependence will develop in 16% of people using cocaine and 11% of those who use amfetamines.2 Acute intoxication and chronic use of these substances can present with cardiovascular symptoms, movement disorders and a range of psychiatric symptoms including agitation, enhanced anxiety, paranoia, panic attacks and psychosis. Associations with violent behaviour, high-risk sexual activity and the injecting of stimulants further underline the implications of stimulant use at the public health level.2–4 Tolerance and dependence can be expected to develop following regular, long-term use. For patients dependent on stimulants, a withdrawal syndrome of approximately 1 week’s duration marked by craving, fatigue, agitation, insomnia and increased appetite can follow on from abstinence.5,6 Recreationally, patterns of SUD vary from use of a single stimulant, several different stimulants and simultaneous or sequential use of drugs from different classes. Combinations of different drugs may be explored by patients as a means of shaping the overall psychoactive experience.3 Stimulant use among people with opiate use disorder is common and linked to poor engagement with opiate agonist therapy and the increased risk of overdose that follows.7,8 Overview of treatment After decades of research there are, at the time of writing, no pharmacological agents approved in the treatment of SUD.9–12 It is worth mentioning explicitly that there is also limited evidence to support the prescribing of stimulants themselves (so-called agonist replacement therapy) for patients with SUD.10,13 There is a need for rigorous, high-quality clinical trials that can overcome the historical methodological challenges.11 Stimulant use for many will be self--limiting without treatment beyond the provision of harm minimisation advice and psychoeducation. For those who use stimulants in combination with alcohol, heroin or GBL, effective treatment of the co-occurring dependency may enable reductions in stimulant use. Successful care of patients dependent on stimulants should involve a comprehensive treatment approach that includes psychosocial interventions that reflect the complexity of factors behind SUD. While a range of therapeutic modalities are recommended, there is particularly good evidence for contingency management.2,11 For many the route to abstinence is through mutual aid and peer support such as Cocaine Anonymous, Crystal Meth Anonymous or Rational Recovery. Further information on the treatment of cocaine dependence can be found in UK clinical guidelines.14 The limited effective interventions available for SUD have prompted the exploring of other treatment modalities.

Revision #1
Created 2026-01-04 20:16:11 UTC by Omar Ayman
Updated 2026-01-04 20:16:11 UTC by Omar Ayman