ACUTE CARE INFO BRIEF

Acute Stimulant Withdrawal

Significance

Stimulant withdrawal occurs after cessation or reduction of heavy, prolonged stimulant use (methamphetamine, cocaine, amphetamines). Stimulant withdrawal carries significant psychiatric risk, especially during the acute phase. Recognition and appropriate support in acute care settings can prevent adverse outcomes.

KEY TERMS:

StUD – Stimulant Use Disorder

MOUD – Medications for Opioid Use Disorder

COWS – Clinical Opiate Withdrawal Scale

Clinical presentation

- **Acute phase (hours to 4-7 days after last use):** Profound exhaustion, peak depression, hypersomnia, anhedonia, anxiety, increased appetite, physical discomfort/pain, irritability, craving, and poor concentration. Suicidal ideation risk is highest during this phase. May have prominent psychotic symptoms.
- **Early protracted phase (2-3 weeks):** Initial reduction of symptoms and improvement in mood. May still have persistent fatigue, anhedonia, difficulty concentrating, intense cravings, dysphoria, and sleep disturbances. Suicide risk remains elevated. Psychotic symptoms often abate during this time.
- **Late protracted phase (1-6 months):** Cognitive dysfunction, anhedonia, cravings, mood instability, including depression and anxiety. While protracted withdrawal symptoms are managed in outpatient settings, it may be beneficial to communicate this expectation with patients.[1]

Symptoms of stimulant withdrawal

- **SLEEP:** Hypersomnia initially (patients may sleep 12-24+ hours); later insomnia and vivid or disturbing dreams
- **MOOD:** Depression, anhedonia, irritability, anxiety, emotional lability
- **COGNITION:** Difficulty concentrating, slowed thinking, impaired memory; paranoia, delusions, and persistent psychotic symptoms may occur
- **PHYSICAL:** Fatigue, increased appetite, psychomotor retardation, generalized aches, headache
- **BEHAVIORAL:** Social withdrawal, decreased motivation, intense cravings[1,2,3]

Management

There is no pharmacotherapy specific to stimulant withdrawal, though, medications to treat stimulant use disorder should be considered.[1] See Emergency Department Care of Stimulant Use Disorder. Management is primarily supportive and focused on safety, comfort, and linkage to ongoing care.

DOMAIN	INTERVENTION
Environment	Quiet, low-stimulation setting; allow rest and sleep
Hydration and nutrition	Encourage oral fluids and regular meals; patients are often dehydrated and nutritionally depleted. Provide IV fluids as indicated.
Sleep	Allow sleep; avoid unnecessary interruptions
Safety monitoring	Suicide risk assessment
Symptom management	Consider medications for severe anxiety, agitation, and insomnia, (hydroxyzine, lorazepam) and persistent psychotic symptoms (olanzapine, ziprasidone, haloperidol)
Psychosocial support	Validate distress. For psychosis, validate the underlying feeling, not the delusional content; calmly acknowledge their fear, anxiety, or pain, while maintaining reality and without directly challenging the delusion. Offer peer support, social work, and psychiatry if available.
Discharge planning	Warm handoff to outpatient treatment and mental health care; ensure follow-up appointments are scheduled before discharge[4]

Suicide risk

Suicidality is the primary safety concern in acute stimulant withdrawal. Risk is highest in the first 1-7 days.

Risk factors

- History of prior suicide attempts or self-harm
- Co-occurring psychiatric disorders (depression, bipolar disorder, PTSD)
- Concurrent opioid or alcohol use disorder
- Recent psychosocial stressors (housing loss, relationship breakdown, child custody and other legal issues)
- Prolonged or high-dose stimulant use
- Social isolation or lack of support
- Access to lethal means

Clinical approach

- **Screen every patient** with stimulant intoxication/withdrawal for suicidal ideation; use direct, non-judgmental questions (e.g., "Are you having thoughts of hurting yourself or ending your life?").
- **Assess risk level** by asking about intent, plan, access to means, timeline, and protective factors.
- **Do not dismiss ideation as "just withdrawal."** Withdrawal-related suicidality is a real risk.
- **Implement appropriate precautions:**
  - Implement institutional protocols for suicide risk.
  - For patients with passive ideation but no plan/intent: increase monitoring frequency, remove access to means, involve social work/behavioral health, ensure safe discharge plan including a safety plan.
  - For patients with active ideation, plan, or intent: initiate 1:1 observation, psychiatry consult, consider involuntary hold if appropriate.[4]
- **Involve psychiatry early** for any patient with elevated risk; do not wait for escalation.
  If these resources are not available on site, consult the Washington Psychiatry Consultation Line: 877-927-7924.
- **Document** risk assessment, protective factors, safety plan, and clinical rationale.
- **Discharge:** Avoid premature discharge; confirm suicidal ideation has improved and ensure patient has a safety plan. Provide crisis resources and arrange follow-up within 24-72 hours for high-risk patients.
  Crisis resources:
  - Text or call 988
  - Crisis Connections 24 hour crisis line: 866-427-4747 (866-4CRISIS)
  - Tailored to patient: care team members, nearby hospital

Peer support

If your facility has peer support services, engage them early on. Peers can:

- **Normalize the experience:** Patients may feel ashamed or alarmed by suicidal thoughts. A peer who has been through withdrawal can validate that these feelings are common, expected, and temporary.
- **Have honest conversations:** Peers often build rapport quickly and can discuss withdrawal and suicidality in a less clinical way, opening doors that formal screening may not.
- **Set expectations:** Peers can help patients understand what to expect over the coming days to months, related to protracted withdrawal and treatment.
- **Provide hope:** Connection with someone who has survived withdrawal and built a life in recovery can be profoundly reassuring during a moment of despair.[4]

Other stimulant use related conditions

- **Overamping (stimulant overdose):** Manage psychiatric and hyperadrenergic symptoms and treat cardiovascular complications. Benzodiazepines are first-line treatment. See Emergency Department Care of Stimulant Overamping/Acute Intoxication.
- **Stimulant use disorder (StUD):** No FDA-approved medications exist for StUD. Off-label pharmacotherapy (e.g., extended-release naltrexone + bupropion, mirtazapine) may be considered. See Emergency Department Care of Stimulant Use Disorder.

Key takeaways

- Stimulant withdrawal carries high risk for suicidality. Risk is highest in the acute phase (1-7 days).
- Take suicidal ideation seriously and create a safety plan.
- If available, engage peers early on; they can normalize suicidal thoughts, set expectations, and provide hope.
- Implement safety precautions based on risk level; involve psychiatry early for high-risk patients.
- Management is supportive: rest, nutrition, hydration, safety monitoring, symptom-directed treatment.
- Avoid premature discharge; ensure safety plan and follow-up in place.
- Offer treatment initiation and referral for stimulant use disorder. See Emergency Department Care of Stimulant Use Disorder.

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