



Stimulant Use Disorder

A VA Clinician's Guide

Stimulant use disorder is defined in the DSM-5 as
“a pattern of amphetamine-type substance, cocaine, or other stimulant use
leading to clinically significant impairment or distress, from mild to severe.”

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Common Myths/Misconceptions: *Dive in to learn more*

- 1. Myth:** The majority of stimulant overdose deaths occur from prescription stimulants.
- 2. Myth:** Stimulants prescribed for ADHD (Attention-Deficit/Hyperactivity Disorder) increase the development of stimulant use disorder.
- 3. Myth:** Patients with stimulant use disorder should either be offered harm reduction or standard interventions for substance use disorders, but not both.
- 4. Myth:** Providing items such as sterile needles and fentanyl test strips enable and encourage the use of illicit substances like methamphetamine and cocaine.
- 5. Myth:** By providing external rewards for abstinence, contingency management reduces patients' internal motivation for recovery.

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Raising awareness

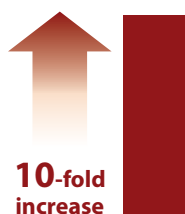
- **Drug overdose is the leading cause of accidental death** in the United States.¹
- **Drug overdose deaths in the United States were up 30%** in 2020.²
- Amphetamine-related hospital costs totaled \$436 million in 2003 and increased to **\$2.17 billion in 2015**.³



died every day in the United States due to stimulants in 2019.⁴

Stimulant overdose deaths are rising primarily due to the co-involvement of synthetic opioids, increased availability, higher potency, and lower cost.

While synthetic opioids still account for most overdose deaths, from 2009 through 2019 there have been:



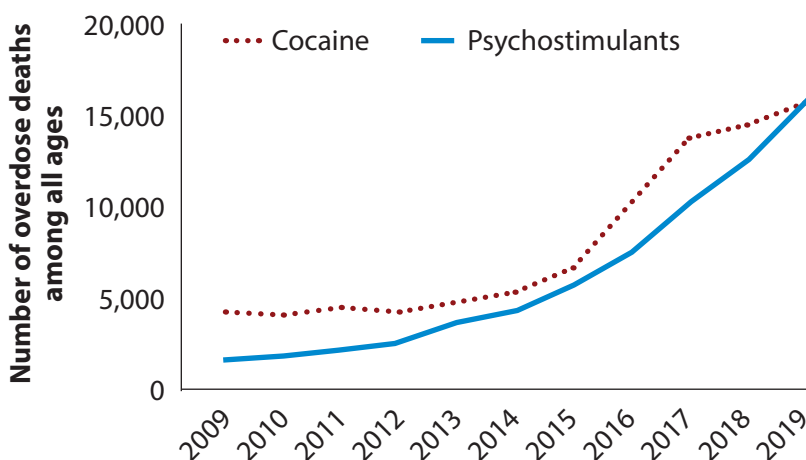
10-fold increase in deaths involving psychostimulants^{5,*}

5.5-fold increase in deaths involving cocaine and opioids; after 2012: **9-fold increase** in deaths involving psychostimulants and opioids^{5,*}

In 2019, **3 out of every 4** cocaine related deaths involved opioids and **1 out of every 2** psychostimulant related deaths involved opioids^{5,*}

*Psychostimulants are primarily methamphetamine.

National drug overdose deaths involving cocaine or psychostimulants with abuse potential (primarily methamphetamine),[‡] from 2009-2019⁴



Over half of all stimulant overdoses involved an opioid, often due to the presence of fentanyl or other synthetic opioids.

[‡] Among deaths with drug overdose as the underlying cause, the cocaine category was determined by the T40.5 ICD-10 multiple cause-of-death code. The psychostimulants with abuse potential (primarily methamphetamine) category was determined by the T43.6 ICD-10 multiple cause-of-death code. Source: www.drugabuse.gov/drug-topics/trends-statistics/overdose-death-rates.

Veterans using illicit stimulants are at a higher risk for overdose.

Offer overdose education and naloxone to Veterans with a stimulant use disorder.



Myth versus truth



Myth: The majority of stimulant overdose deaths occur from prescription stimulants.



Truth: Illicit stimulants (cocaine and methamphetamine) account for more than 90% of deaths related to stimulants.^{6,7}



Prevalence of stimulant use and stimulant use disorder in adults in 2019

- Out of 7.4 million adults who used cocaine or methamphetamine, 27% (2 million) reported having a cocaine or methamphetamine use disorder.
- Out of 16 million adults who used prescription stimulants, 3.1% (0.5 million) reported a stimulant use disorder.

Data highlights from the 2019 National Survey of Drug Use and Health (NSDUH) for adults 18 and over in the general population.⁸



Myth: Stimulants prescribed for Attention-Deficit/Hyperactivity Disorder (ADHD) increase the development of stimulant use disorder.



Truth: Use of stimulants for ADHD does not appear to increase the risk of developing a stimulant use disorder, having either no effect or reducing risk.^{9,10,11,12}



No clear relationship exists between prescription stimulants and the development of a stimulant use disorder.⁹

Sticking it to stigma

Stimulant use and stimulant use disorder are highly stigmatized. Stigma remains a major barrier to mental health and substance use disorder treatment, as they tend to be more highly stigmatized than other health conditions. Stigma can come from multiple sources—from within the person, from interpersonal relationships and the community, and from institutions and society.

Because of the prevalence of stigma, **substance use disorders are often treated as moral and criminal issues, rather than a health concern.**¹³

Stigma can lead to the following:^{14,15}

Feeling guilt, shame, worthless, resignation, embarrassment



Fear of being labeled and judged



Concealing substance use to avoid losing things that are important (e.g., job, child custody, housing)



Avoidance of and reduced access to quality healthcare



Ensure you are using non-stigmatizing language when talking to Veterans about substance use, just as you would for other chronic medical conditions like diabetes and hypertension.¹⁶

Say this:

Urine test was “positive for cocaine.”

“Person who uses methamphetamine.”

“Person with stimulant use disorder.”

“In recovery from stimulants but recently reported use.”

Not this:

Urine was “dirty.”

“Meth head.”

“Addict.”

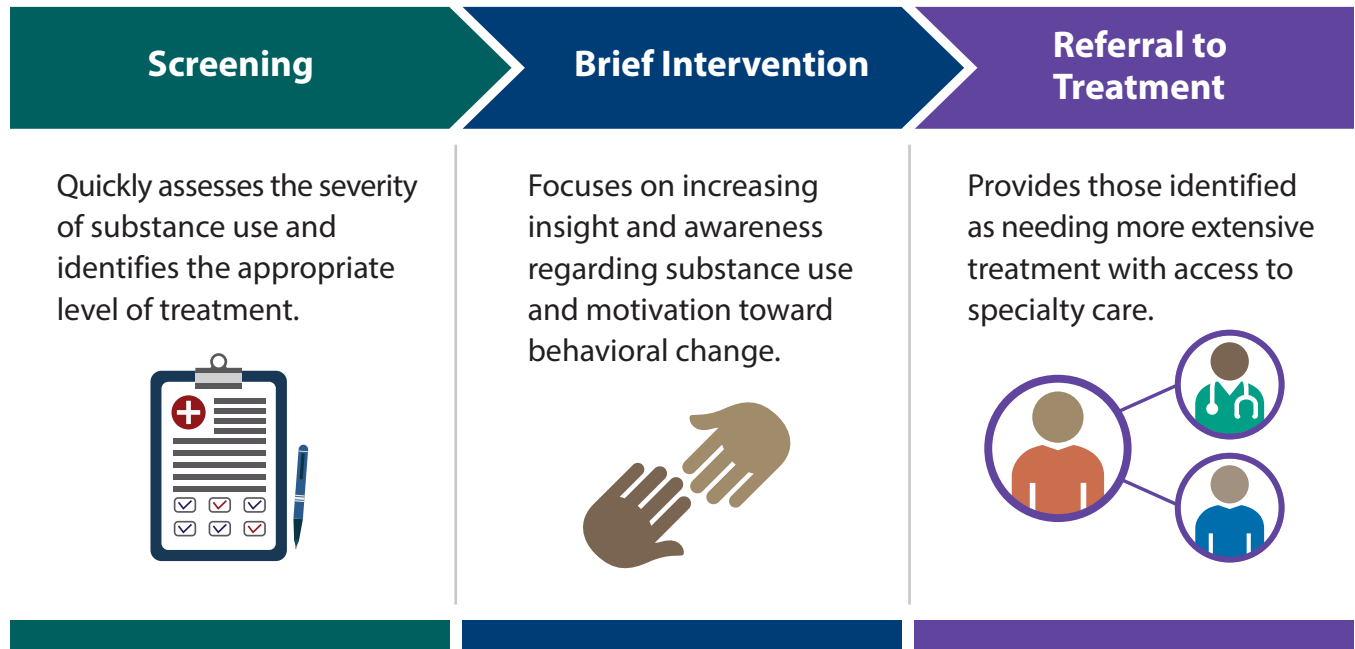
“Relapsed.”



Screening and diagnosis of stimulant use disorder

Screening Veterans for substance use disorder is an important part of providing comprehensive care in any healthcare setting. Providers should use SBIRT when substance use disorder is suspected.

SBIRT = Screening, Brief Intervention, and Referral to Treatment



Identifying and treating patients with stimulant use disorder is important. There are various screening tools available (ASSIST, DAST-10, CAGE-AID, TAP) that may be used based on clinical preference, practice setting, and co-occurring substances.

Use strategies from brief intervention when starting the conversation surrounding substance use.

See page 5 for strategies.



Brief intervention strategies and examples¹⁷

Raise the subject

Ask about substance use in a non-judgmental, open manner

- Where they use and who they use with: *"In the last six months, which of these substances have you used? Do you typically use these with other people or alone?"*
- Routes of use, including supplies: *"Please tell me how you use the substance."*
- Why they use and perceived benefits (e.g., euphoria, increased attention, energy, to stay awake, sex work, sexual desire): *"What are benefits you feel from using the substance?"*
- Negative experiences: *"Have you ever had a negative experience or side effect from using? Can you share with me what happened? Have you ever used too much? How did you realize it was too much?"*

Provide feedback

- *"As your provider I want to make you aware of how using stimulants can impact your health and possibly contribute to the health problem you came in for today."*
- Stimulant use disorder is associated with cardiovascular risks (e.g. stroke, myocardial infarction), seizures, paranoia and hallucinations, and anxiety.
- Other unintended consequences can be sexually transmitted diseases or skin infections.

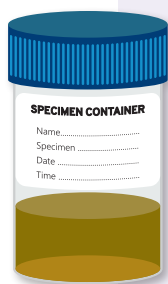
Enhance motivation

- *"What changes are you willing to make?"*
- *"What do you see as possible benefits to reducing your use of stimulants?"*
- If patient indicates no changes, *"What might make you think that reducing your stimulant use would be worth considering?"*

Negotiate plan

- *"How might you make your substance use safer?"*
- With the patient's permission or invitation, provide a menu of harm reduction options, i.e., using Syringe Service Programs (SSPs), using fentanyl test strips, not using alone, carrying naloxone, not sharing injection equipment. *"How many times do you use needles? How often do you share needles?"*
- *"What would make you consider changing how you use stimulants?"*

Urine Drug Testing (UDT)



When ordering urine drug tests, **consider asking patients prior to the test what substances they expect to appear in the results.**

This can provide an opportunity to engage the patient in a discussion around risk reduction and offer appropriate treatment if indicated.



UDT monitoring with immediately available results is a core component of contingency management. *See the treatment section (pages 10-11) for more information.*

Interpreting urine drug testing results¹⁸

	Cocaine metabolites	Amphetamine & methamphetamine	Methylphenidate
Detection period after last dose	1-3 days (7-12 days with repeated high doses)	1-3 days (3-4 days for methamphetamine products)	Not detected on amphetamine screen
Expected results*	Immunoassay: benzoylecgonine (BZE)	Immunoassay: amphetamine	N/A: requires confirmatory testing
Agents potentially causing false positives	Coca leaf tea Topical anesthetics containing cocaine	Bupropion, chlorpromazine, desipramine, fluoxetine, labetalol, promethazine, ranitidine, pseudoephedrine, trazodone, and methylphenidate	N/A
Interpretation of results	A positive UDT for cocaine is highly indicative of use	Recommend confirmatory testing: results should be interpreted with caution due to many false positives	Requires confirmatory testing

*Confirm with local lab for additional details.

Making the diagnosis

Diagnostic criteria for stimulant use disorder can be linked to example questions that can help inform your clinical assessment of the Veteran.^{19,20}

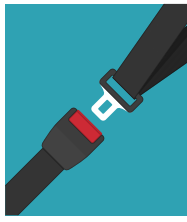
Mild: 2-3 symptoms, **Moderate:** 4-5 symptoms, **Severe:** ≥6 symptoms occurring within a 12-month period

DSM-5 stimulant use disorder symptoms	Questions to consider asking to gauge behaviors:
1. Using larger amounts and/or over a longer period than intended	<i>"What difficulties have you had difficulties limiting stimulant use?"</i>
2. Unable to cut down or control use	<i>"What happened when you tried to cut down or stop using stimulants?"</i>
3. Spending a lot of time in activities necessary to obtain, use or recover from effect of the stimulant	<i>"To what extent has obtaining stimulants and getting over their effects occupied your time?"</i>
4. Craving stimulants	<i>"How would you describe the feelings you get when you want to use stimulants?"</i>
5. Stimulant use interferes with taking care of responsibilities at work, school, or home	<i>"In what ways has your use of stimulants led to difficulties with your ability to keep up with your job, housework, or paying bills?"</i>
6. Continued use despite stimulants causing persistent social or interpersonal problems	<i>"In what ways has your use of stimulants led to problems with family or friends?"</i>
7. Giving up previously enjoyed activities because of use	<i>"What effect has your stimulant use had on how often you pursue other activities that you used to enjoy?" (e.g., exercising, painting, hiking)</i>
8. Recurrent use in situations that increases chances of getting hurt	<i>"In what ways has your use of stimulants put you in situations that increase your chances of getting hurt?" (e.g., theft, prostitution, drug dealing)</i>
9. Continued use despite persistent physical or psychological problems caused by stimulants	<i>"What health problems do you have that are made worse by your stimulant use?" (e.g., chest pain, stroke, seizures, tooth decay)</i>
10. Tolerance*	<i>"How has the amount and how often you use stimulants changed over time?"</i>
11. Withdrawal*	<i>"What happens to you when the effects of the stimulants wear off?" (e.g., depression, bradycardia, hypersomnia, cravings)</i>

*Tolerance and withdrawal do not count for the DSM-5 diagnosis if taken as prescribed under medical supervision.

Providing harm reduction for stimulant use disorder

Harm reduction is a set of practices to reduce harms. Everyday examples of harm reduction include:



Goals and principles of harm reduction, in the context of substance use:

- ✓ Keep people alive (reduce overdose).
- ✓ Prevent diseases and infection.
- ✓ Recognize an individual's autonomy as the expert of their own experience.
- ✓ Acknowledge that a life of abstinence may not be realistic at this time.



Myth: Patients with stimulant use disorder should either be offered harm reduction or standard interventions for substance use disorder, but not both.



Truth: Harm reduction is NOT an alternative to treatment. Harm reduction should be part of a continuum of treatment goals for all patients with stimulant use disorder.

Data has indicated that 85-90% of adults with substance use disorder are NOT in treatment due to various reasons, which include cost and accessibility.

Effective harm reduction strategies can reduce the risks of morbidity and mortality in patients with substance use disorder—regardless of treatment status.²¹



Please reach out to your local substance use disorder specialty leads for more information on harm reduction.

Harm reduction resources: what to know and offer

Harm reduction strategy	Key components	Evidence statistics	What can you do?
Drug overdose	Co-involvement of stimulants and opioids is increasingly common in overdose deaths. ⁵	Nationally, opioids are involved in 76% of deaths attributable to cocaine and 54% of deaths attributable to methamphetamine. ⁵	Provide overdose education and naloxone distribution (OEND) , free for at-risk Veterans with no copay.
Safer use equipment and education*	Syringe Services Programs (SSP) provide sterile syringes and supplies, along with other services (e.g., infectious disease screenings, safe disposal, and linkage to substance use treatment). ²²	Use of SSP results in 50% decline in HIV transmission. Users of SSPs are 3x more likely to stop injecting drugs and 5x more likely to enter treatment. Providing syringes does NOT increase illegal drug use or crime. ²²	Prescribe syringes , provided no local legal restrictions. Check with your Regional Counsel. Refer to community SSP if one exists locally. Find more information and trainings: Syringe Services Programs SharePoint.
Testing drugs for contaminants*	Fentanyl Test Strips (FTS) detect the presence of fentanyl in drugs and drug containers. They are inexpensive, easy to use, and produce results in minutes. ²³	Studies have found high rates of fentanyl mixed with stimulants. ²⁴ When test strips are positive, patients can use strategies to stay safe (e.g., use a test dose, have naloxone on hand) which can reduce the risk of overdose and death. ^{25,26,27}	FTS may be available from a community SSP or even your VA. Ask Veterans to talk with others about the risks of fentanyl and share test strip results to reduce community harm.
Routine testing and vaccines	HIV and HCV risk increases when syringes, needles, mixing cups, and drug solutions are shared.	HIV diagnoses are rising among persons who inject drugs, reversing long-term declines in national HIV trends. ²⁸	Testing: HIV, HCV antibody, sexually transmitted infection testing Vaccinations: Tdap, HPV, Hepatitis A & B Pre-exposure prophylaxis (PrEP)
Sexual health	Stimulants are often used to enhance sexual experiences.	Persistent use of methamphetamine is the biggest risk factor for HIV seroconversion among gay and bisexual men. ²⁹	Offer condoms, birth control, and PrEP.

*State or local laws may limit options. Please confirm laws before making recommendations.



Myth

Myth: Providing items such as sterile needles and fentanyl test strips enable and encourage the use of illicit substances such as methamphetamine.



Truth

Truth: Users of Syringe Services Programs (SSPs) are three times more likely to stop injecting drugs and five times more likely to enter treatment.²²



Consider offering pre-exposure prophylaxis (PrEP)

PrEP is the use of antiretroviral medication to prevent acquisition of HIV infection in appropriate persons (e.g., people who inject drugs or engage in risky sexual behavior). For more information, see the Quick Reference Guide for OUD (pages 22-23).

Provide harm reduction strategies to Veterans with a stimulant use disorder.

Referral and treatment of stimulant use disorder

- Stimulant use disorder poses a significant public health problem in addition to the adverse effects on the physical and mental health of individuals using cocaine and amphetamines.
- Motivational interviewing techniques can be used across all treatment settings and disciplines to address stimulant use by:
 - Helping patients address ambivalence
 - Engaging patients more successfully in treatment



Referral to treatment

Refer patients who have stimulant use disorder concerns to specialty care substance use disorder services for additional evaluation and treatment. Please work with your local mental health and/or substance use disorder healthcare teams to find out what treatment options are available and how to refer Veterans to those services.

Collaborate with patients to assess status of their recovery

- Collaborate with patients to determine how ready they are to make a change in their lives and address stimulant use.
- Use compassion and meet the patient where they are on the spectrum of recovery.

Respect patient preference

- Consider the patient's prior treatment experience, respect patient preference, and engage in shared decision-making.

Emphasize that options will remain available

If unwillingness to initiate treatment remains:

- Do NOT argue with the patient.
- Maintain open communication.
- Determine where mental/psychiatric diagnoses are managed.
- Offer follow-up and continue to look for opportunities to engage.
- Provide reassurance to support recovery.
- Always offer OEND and other harm reduction strategies.
- Regularly assess housing status and refer to local Housing and Urban Development–VA Supportive Housing (HUD-VASH) Program services.

In addition to providing harm reduction, refer Veterans with a stimulant use disorder to specialty care.



Myth

Myth: By providing external rewards for abstinence, contingency management (CM) reduces internal motivation for recovery.



Truth

Truth: Immediate and escalating positive reinforcement of intended behavior (negative UDT for target substance) encourages sustainable abstinence even after the incentives are withdrawn.

- CM can be delivered by both licensed independent practitioners (LIPs) and non-LIPs.
- CM programs are low cost, brief, and can be supported by VHA resources such as VA Canteen Services.
- For more information, please see Contingency Management SharePoint.

Psychosocial interventions

Intervention	Description	Benefits
Contingency Management <i>Most evidence to support³⁰</i>	<ul style="list-style-type: none"> • Uses positive reinforcement to encourage abstinence by incentivizing abstinence verified by negative UDTs for the target substance. • Point of Care UDT facilitates timely use of incentives. • Reinforce desired behaviors with incentives (e.g., gift cards or vouchers). 	Associated with reductions in: <ul style="list-style-type: none"> • Number of days of stimulant use • Stimulant cravings • New stimulant use • Risky sexual behaviors
Cognitive Behavioral Therapy: Substance Use Disorder³¹	Short-term, goal-oriented intervention that enables individuals to understand their current problems, challenges, and experiences to change their behaviors and patterns of thinking.	Associated with reductions in: <ul style="list-style-type: none"> • Quantity of stimulants consumed per week • Frequency of stimulant use per week • Risky sexual behaviors
Individual Drug Counseling (IDC)³¹	Manualized approach that includes patient education about a biopsychosocial and spiritual approach to recovery, attention to building a therapeutic alliance, monitored UDT, and encouragement of 12-step participation (e.g., Alcoholics Anonymous, Narcotics Anonymous).	Patients in IDC plus group drug counseling (GDC) were found to reduce their cocaine use more than patients who received cognitive therapy plus GDC, supportive-expressive psychodynamic therapy plus GDC, or GDC alone. ³²
Community Reinforcement Approach (CRA)³¹	Behavioral intervention that focuses on environmental contingencies that impact and influence the patient's behavior. CRA includes analyzing clients' substance use, relationship counseling, and job skills training.	Associated with reductions in: <ul style="list-style-type: none"> • Addiction severity • Substance use Associated with: <ul style="list-style-type: none"> • Cocaine abstinence

Pharmacotherapy: Currently there are no FDA-approved medications for stimulant use disorder.

- There is insufficient evidence to recommend for or against the use of any pharmacotherapy for the treatment of cocaine use disorder or amphetamine/methamphetamine use disorder.³³
- Refer to substance use disorder specialty care for more information on pharmacotherapy options.

Use psychosocial and behavioral interventions as first-line treatments for stimulant use disorder.³¹

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This reference guide was created to be used as a tool for VA providers and is available from the Academic Detailing SharePoint.

These are general recommendations only; specific clinical decisions should be made by the treating provider based on an individual patient's clinical condition.

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