

Stimulant-induced psychosis requires the same clinical priority as other psychotic disorders

Stimulant-induced psychosis is a severe psychotic disorder with a potentially poor prognosis and should be given the same clinical priority as other psychotic disorders.

The statement by Bouthillier *et al.* [1] on stimulant-induced psychosis (StIP) is warmly welcomed. With the current increasing trend [2], StIP is likely to become a more common complication of stimulant use. Yet, clinical practice is poorly supported by evidence-based knowledge.

The authors note that current diagnostic distinctions often fail in real-world settings, where abstinence is difficult to achieve. StIP is frequently managed as a substance-use complication than seen as a severe mental illness, despite the poor outcomes the authors highlight. Discrepancies in diagnostic frameworks further complicate this problem. International Classification of Diseases (ICD) classifies substance-induced psychosis (SIP) under substance use disorders, whereas Diagnostic and Statistical Manual of Mental Disorders places SIP within psychotic disorders, implying closer phenomenological overlap with, for example, schizophrenia [3, 4]. These diagnostic differences are problematic, as they shape clinical intuitions how StIP should be managed. This inconsistency is not merely semantic, it widens evidence gaps by excluding StIP from psychosis treatment guidelines, further reinforcing fragmented care.

We also need better understanding of SIP subtypes and their relationship to other psychotic disorders. SIPs represent a heterogeneous group with divergent trajectories rather than uniformly transient phenomenon associating with substance use [5, 6]. Cannabis-induced psychosis, for example, may reflect a continuum with emerging primary psychotic disorders including schizophrenia [3, 7]. In turn, StIP may be more of a toxicity-related syndrome induced by stimulant exposure [8]. However, even among heavy stimulant users, not all experience psychotic symptoms [5, 9]. Therefore, the etiology of StIP is more complex than stimulant exposure alone [3].

First-episode StIP can be difficult to distinguish from the schizophrenia-spectrum psychosis [10, 11]. Therefore, more knowledge is needed how to distinguish 'pure StIP' from cases in which stimulant use relates with underlying psychotic disorder. In our recent study, 14% of persons with incident StIP received an ICD-10 F20–F29 diagnosis already within 1 year follow-up, indicating that a proportion of amphetamine-related first-episode psychoses are

initially misclassified [12]. Understanding StIP requires research on pre-morbid risk factors, genetics and other biological underpinnings, acute and subacute presentation and clinical trajectories.

Bouthillier *et al.* [1] propose that StIP management requires phase-specific approaches. The knowledge gap is most pronounced in StIP prevention among stimulant-using populations as well as management beyond the acute phase. Preventing psychosis onset and relapse should be most important in care, as in any psychotic disorder. Relapsing to SIP is a significant clinical burden: one in five people with StIP are rehospitalized within 2 years of their first StIP admission [13]. Despite uncertainty about whether antipsychotics should be used for relapse prevention in StIP, antipsychotics are commonly prescribed in outpatient treatment [12]. Better evidence is needed on antipsychotics for StIP psychosis relapse prevention, for instance, which patients benefit, which agents to use, whether long-acting injectables have a role and what the longer-term risks are. As high quality randomized controlled trials (RCT) are challenging to conduct in this hard-to-reach population, register studies can help answer questions that conventional trials may struggle to address [14, 15]. Such data are not a substitute for RCTs, but they are crucial for generating testable hypotheses and informing treatment planning.

Improving outcomes in StIP requires a broader approach than stimulant use cessation and psychosis relapse prevention. For example, attention-deficit/hyperactivity disorder (ADHD) is common among those presenting with StIP [16] and is associated with a higher risk of recurrent SIP [13]. This raises questions about prescribing ADHD stimulants in people with StIP and ADHD: do they increase relapse risk or reduce it by stabilizing ADHD symptoms and lowering illicit stimulant use? Recent studies suggest ADHD stimulants do not increase psychotic events in adults with prior psychosis [17], but StIP-related studies are needed. In parallel, active efforts to implement suicide and overdose prevention for people with StIP are an imperative to improve their long-term prognosis.

There is also a pressing need to make efforts to minimize harms related to novel synthetic cathinone use, as they appear to be associated with more severe psychotic symptoms than conventional stimulants [18]. Current evidence links synthetic cathinone use also to increased violent behavior, greater risk of stimulant overdose, and potential long-term somatic health problems [18]. However, clinical

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research on their management and longer-term course, including risks of chronic psychotic states, remains so far very limited.

In sum, Bouthillier *et al.* [1] justifiably argue that StIP requires greater attention. Indeed, the current knowledge gap leaves clinicians in an enduring limbo, relying on assumptions rather than empirical findings. StIP should be seen as a severe mental disorder with potentially poor prognosis, requiring treatment guidelines and evidence-based care rather than the reactive and fragmented approaches that still dominate clinical practice. Without these efforts, prevention, treatment and services will continue to fall short for people with StIP.

KEYWORDS

amphetamine, cocaine, evidence-based treatment, psychosis, stimulants, substance-induced psychosis, synthetic cathinones, treatment guideline

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Solja Niemelä: Conceptualization; writing—original draft; writing—review and editing.

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