The National Methamphetamine Symposium

Making Research Work in Practice

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Build it and they will come: What works in treatment and how to apply it in everyday practice

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Build it and they will come:
What works in treatment and how to apply it in everyday practice

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METH

BEFORE

AFTER
2.1% Last 12 months

Purity of speed and ice increasing

Increase in weekly or daily users

50% Crystal meth

Smaller price difference

Increased harms
Occasional users
(< once a month)

Not dependent
Swallowing, snorting
Working
Young
Mild mental health issues
Sleep problems

Secondary interventions:
Reduce harms, prevent riskier use

Regular users
(once a month or more)

Dependent or other problems
Smoking or injecting
Mental health issues
Sleep, nutrition issues
Risky activities

Tertiary interventions:
Reduce harms, treat dependence and risky use
Dopamine

Frontal lobe (thinking, planning decision making)

Limbic system (emotional, social and memory)

Dopamine pathways
Focus, attention and concentration

- Memory
- Energy levels
- Impulse control
- Planning ability
- Flexible thinking
- Mood
- Decision making
- Emotion regulation
- Memory
- Energy levels
- Impulse control
- Planning ability
- Flexible thinking
- Mood
- Decision making
- Emotion regulation
Getting to appointments (memory, planning)
Completing tasks (focus, planning)
Taking on new information (attention, memory)
Thinking about consequences (planning, decision making)
Goal setting and working towards goal (planning)
Stopping inappropriate behaviour (impulsivity)
Switching from one topic to another (flexible thinking)
Unexpected outbursts (emotion dysregulation, impulsivity)
What works in treatment

- ✔ Relapse Prevention (CBT) & Motivational Interviewing
- ✔ Residential rehabilitation (long term benefits unclear)
- ❓ Pharmacotherapy
- ❌ Withdrawal
  (no short or long term benefits without further treatment)

McKetin et al. 2012
Protracted withdrawal

Acute methamphetamine withdrawal

Protracted methamphetamine withdrawal

Alcohol/heroin withdrawal
Outpatient preferred option

Except in cases of...

*Severe dependence (risk of medical complications)*
  *Polydrug dependence*
  *Partner or friends using*
  *Homelessness*
  *Failed previous attempts*

Psychoeducation about what to expect

*Food – Fluids – Forty winks*

Daily monitoring
No medicine has been approved for the treatment of withdrawal

Modafinil, mirtazapine, and dexamphetamine appear to offer some benefits during ATS withdrawal and may also assist with relapse prevention
Pharmacotherapy

No medicine has been approved for the treatment of dependence, some show promise

Dexamphetamine, modafinil, bupropion, naltrexone and methylphenidate have some benefits for some people

Baclofen, gabapentin, ondansetron, amlodipine, aripiprazole, vigabatrin, sertraline, ‘prometa protocol’ showed no benefit or unacceptable adverse effect profile

Mirtazapine, fluoxetine, topiramate, risperidone, varenicline not enough evidence
Psychological interventions
Significant brain changes that result in:

- Strong cravings
- Variable motivation
- Impaired ability to manage emotions
- Impaired thinking processes
- High risk of relapse
- Long recovery/withdrawal time
- Mental health (depression, anxiety)
Flexibility with appointments and systems

Flexibility with format

Shorter more frequent

Written materials

Help plan for homework, appointments

Memory aids

Assertive follow-up
Relapse rates from treatment

88%

McKetin et al 2012
Methamphetamine users in treatment

Access Point Centre

53% treatment completed
(v. 54% for heroin)

39% dependent
63% dependent

64% Injecting 16% smoking
42% injecting 48% smoking

27% employed
54% employed

55% completed within a month

Median length of treatment was 48 days
Average length of treatment 132 days

Most common age group is 20-29 yo, mean age 30 years
Mean age 34 years

25% attended more than one session
85% attended more than one session