Effective strategies to address methamphetamine problems in primary care, emergency departments and hospital settings

Nadine Ezard
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Stimulant use disorders largely untreated

Prevalence stimulant use disorders >3x opiate use disorders

Treatment seeking late, retention poor

Outcomes poorer among those with higher baseline use

Problems associated with methamphetamine use

- psychosis, depression, anxiety
- blood-borne virus transmission, sexually transmitted infections
- cardiovascular & cerebrovascular events
- dependence/severe substance use disorder (compulsive use, tolerance, withdrawal, loss of control, narrowing of repertoire, persistent use despite recognised harm)

Treatment seeking

• More likely to see treatment if:
  • Riskier use (eg IV)
  • Mental health diagnosis (commonly anxiety and depression)
  • Seeking support for other problems (eg mental health)

• Less likely to seek treatment if
  • Women, born outside Australia, full-time employed
  • Non-injectors
  • Perception of use as non-problematic even if dependent and experiencing MA-related harm

Where is professional support sought?

- GPs most common source (24%)
- ED / hospital presentations while common under-exploited opportunity

Spectrum of Psychoactive Substance Use

**Non-problematic**
- recreational, casual or other use that has negligible health or social impact

**Beneficial**
- use that has positive health, spiritual or social impact: e.g. pharmaceuticals; coffee/tea to increase alertness; moderate consumption of red wine; ceremonial use of tobacco

**Problematic**
- potentially harmful
  - use that begins to have negative health consequences for individual, friends/family, or society: e.g. impaired driving; binge consumption; routes of administration that increase harm

- Substance Use Disorders
  - Clinical disorders as per DSMV/ICD10 criteria

Reference: Adapted from Government of BC, Canada, *Every door is the right door: a planning framework to address problem substance use and addiction*, 2004, p8
Tiered intervention framework

Population impact

Treatment

Early intervention

Prevention

Promotion

Severity of use disorder

ED

GP
Actions

Detection (screening)
Management of intoxication
Harm reduction
Brief intervention (occasional users)
Motivational interviewing
Withdrawal management (daily users)
Counselling
Referral to specialist services
Support groups and residential rehabilitation
Screening – Assist lite

In the past 3 months

1. Did you use an amphetamine-type stimulant, or cocaine, or a stimulant medication not as prescribed? Yes [1] No [0]. If Yes:

2. Did you use a stimulant at least once each week or more often? Yes [1] No [0]

3. Has anyone expressed concern about your use of a stimulant? Yes [1] No [0]

2 +: positive for stimulant use disorder

Severity of dependence scale (SDS)

In the past month

(i) Have you ever thought your speed use is out of control?
   Never (0)   Sometimes (1)   Often (2)   Always (3)

(ii) Has the thought of not being able to get any speed really stressed you at all?
   Never (0)   Sometimes (1)   Often (2)   Always (3)

(iii) Have you worried about your speed use?
   Never (0)   Sometimes (1)   Often (2)   Always (3)

(iv) Have you wished that you could stop?
   Never (0)   Sometimes (1)   Often (2)   Always (3)

(v) How difficult would you find it to stop or go without?
   Never (0)   Sometimes (1)   Often (2)   Always (3)

Total Score: ____________

Score 4+: positive

Assessment

Intoxication/withdrawal
Duration of use and problem use
Route of administration
Risks and harms
Periods of abstinence, previous interventions
Other substance use
Co-existing problems
  Internet use disorders
  Gambling
  High risk sexual practices
  Substance use disorders – eg BZD, GHB
  Mental illness
Management of intoxication

• Assess risk of harm to self and others
• Exclude other organic causes
• Monitoring of vital signs
• Verbal de-escalation if necessary
• Sedation as required: BZD’s, if fail then oral sedating atypical antipsychotic (olanzapine wafer)
• ED local sedation protocols for the management of acute behavioural disturbance
  • Nurse initiated IM protocols simple, more effective (shorter duration of behavioural disturbance, fewer requiring further sedation) and as safe as medical IV protocols (DORM protocol, Newcastle)
• Regular hydration
• Feedback, information when settles, harm reduction, referral
Harm reduction

Safe sex/safe use

- Peer education
- Planning ahead
- Supplies and equipment
- Condoms lube
- NSPs (not pipes in current Australian context)
- Play packs/blood play packs (MSM, SSAW)

PEP/PrEP

HIV/STI/HCV/HBV testing, HBV vaccination

Avoid/manage BZD dependence

Smoking harm reduction
Brief intervention

- Engage, retain
- Assess motivation
- 5As
  - Ask, Advise, Assess, Assist, Arrange
- FLAGS
  - Feedback, Listen, Advise, Goal setting, Strategies
Motivational interviewing

Motivation and confidence change over time

Good things about using
Not so good things about using less

Not so good things about using
Good things about using less
Withdrawal Syndrome

Arises from:
- Depletion of pre-synaptic monoamine stores
- Down regulation of receptors
- Neurotoxicity

Characterised as:
1. Crash (1-3 days) – excessive sleepiness
2. Acute phase (7-10 days) – fatigue, depression/anhedonia, hyperphagia, in/hypersomnia, irritability, cravings, anxiety, poor concentration
3. Subacute phase (2 weeks +) - sleep disturbance (less restorative), cravings, dysphoria, appetite disturbance

Cruickshank & Dyer, 2009 A Review of the Clinical Pharmacology of Methamphetamine, Addiction
Withdrawal - treatment

Location – ambulatory, residential, inpatient

Information

Supportive counselling

No evidence-based pharmacotherapy

Diazepam low dose for agitation for 3 days (max)

Antipsychotics (eg olanzapine wafer) as indicated

Post-withdrawal care

Withdrawal is not treatment:

“Detoxification alone did not change methamphetamine use at any follow-up relative to no treatment”

Post – withdrawal care

Depression

Mostly resolved by end of 2 weeks of abstinence

May persist for several months or longer (? neurotoxic component)

?May be a place for mirtazapine

Address smoking

?Buproprion 300mg / d

Benefits of exercise

Cognitive retraining

Post-withdrawal care

**Self-help/Peer support groups**
Narcotics Anonymous
SMART Recovery
Crystal Meth Anonymous

**Carer support groups**
Family Drug Support Australia

**State Alcohol and Drug Information Services** for 24hr info. & referral advice for patients, carers, and clinicians.
Specialist services, counsellors (trauma treatment)
Residential Rehabilitation
**DO YOU OR SOMEONE YOU KNOW...**

S-Check Clinic
Clinic

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**S-Check Clinic**
Yesterday 🕒

2122 FB Likes Thanks every Like Post and Tweet helps, we really want everyone to know about Stimulant Checkups to head off the risky end of meth use.

Like · Comment

S-Check Clinic likes this.

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**S-Check Clinic**
Yesterday 🕒

Do you know someone who uses crystal, meth or ice? Suggest a Stimulant Checkup at St Vincent’s Hospital Sydney. Free and confidential.

Like · Comment

S-Check Clinic likes this.

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**S-Check Clinic**
July 21 🕒

Hi to all our new FB fans. You can send us a private message if you want more info on free stimulant checkups for partners, friends, family, colleagues or yourself. Confidential, friendly service.

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SCheck

Risk based physical health screen
  STI / HIV / BBV
  Cardiovascular
  Mental illness

Mental health screen
  K10
  SDS
  DASS21

Feedback
Referral
Conclusion

• MA use disorder growing public health problem
• Psychosocial interventions with moderate efficacy treatment mainstay of treatment
• Treatment coverage low, treatment seeking late
• Enhance primary care and hospital role in detection, early intervention and harm reduction