The National Methamphetamine Symposium

Making Research Work in Practice

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NCETA

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

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

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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

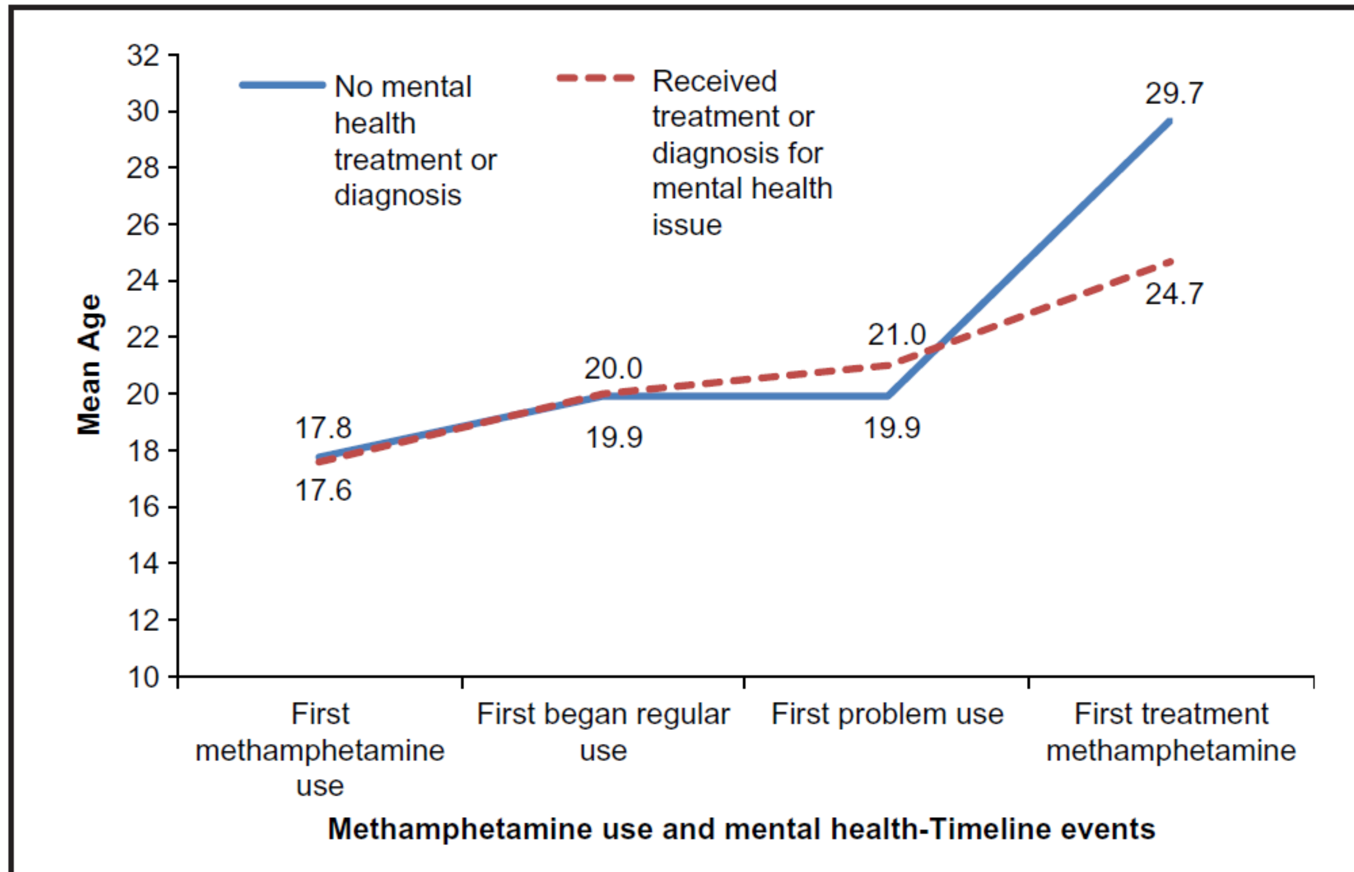
Problems associated with methamphetamine use

- 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)

Quinn et al. Journal of Substance Abuse Treatment 2013;45:235–41; Lee et al Advances in Dual Diagnosis 2012;5(1):23-31; Hillhouse et al. Addiction 2007;102(Sup1):84-95; Darke et al Drug and Alcohol Review 2008;27;253-262; McKetin et al 2007 Drug and Alcohol Review 26, 161-168;

Up to 10 year treatment delay

ST VINCENT'S HOSPITAL SYDNEY



Lee, Harney & Pennay (2012) "Examining the temporal relationship between methamphetamine use and mental health comorbidity", Advances in Dual Diagnosis, 5(1):23 - 31

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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

B. Quinn et al 2013 Journal of Substance Abuse Treatment 45; 235–241; Quinn et al 2013 Int J Drug Policy 24(6) 619–623 ; Lee et al 2012 Advances in Dual Diagnosis 5(1)23-31.

Where is professional support sought?

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

B. Quinn et al 2013 Journal of Substance Abuse Treatment 45; 235–241; Quinn et al 2013 Int J Drug Policy 24(6) 619–623

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

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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

Ali et al 2013 Drug and Alcohol Dependence 132 352– 361

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

Gossop et al 1995. *Addiction 90*(5): 607-614.

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

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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

Calver et al. 2010 BMC Emergency Medicine **10**:14

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Harm reduction

Safe sex/safe use

- Information & education www.avil.org.au, www.acon.org
- 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

Winhusen et al. Drug & Alcohol Dependence 2014;134:391-5

Brief intervention

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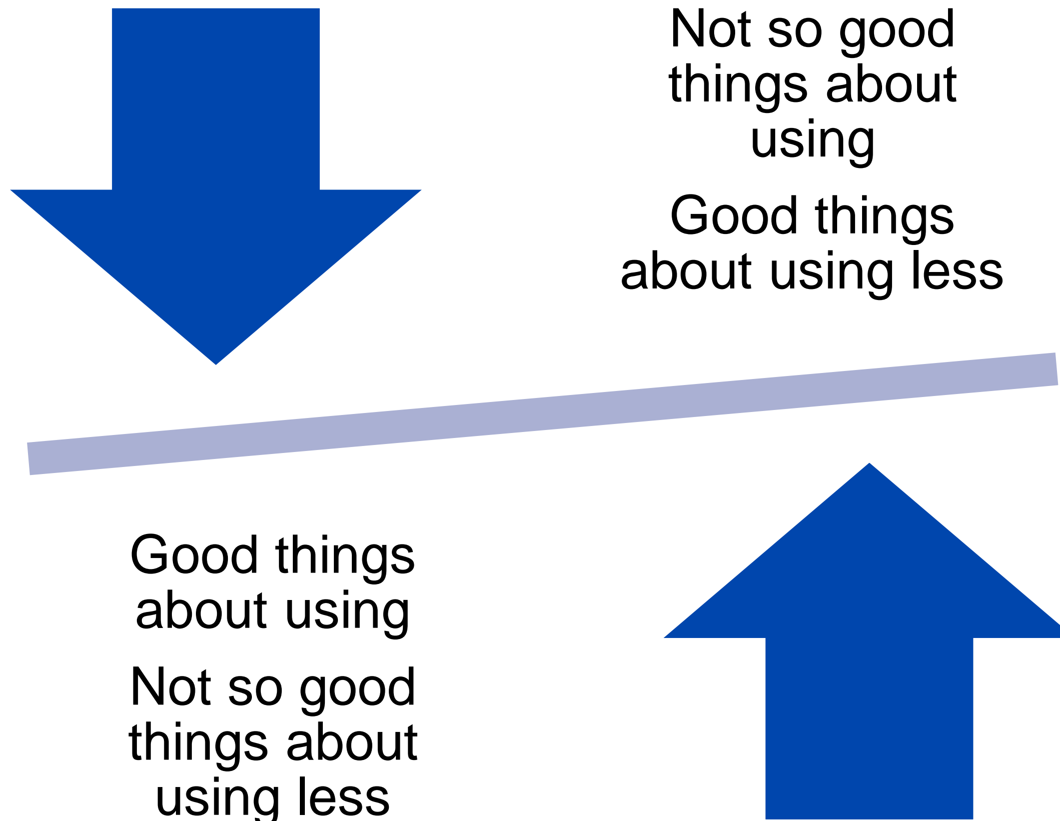
- Engage, retain
- Assess motivation
- 5As
  - Ask, Advise, Assess, Assist, Arrange
- FLAGS
  - Feedback, Listen, Advise, Goal setting, Strategies

Motivational interviewing



Motivation and confidence change over time

Withdrawal Syndrome

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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

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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

Shoptaw 2008 Cochrane Review 2; Pennay & Lee 2001 Drug and Alcohol Review 30, 216–222; Kay-Lambkin et al 2011 MJA 195 (3): 38

Post-withdrawal care

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Withdrawal is not treatment:

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

McKetin et al 2012. Evaluating the impact of community-based treatment options on methamphetamine use: findings from the Methamphetamine Treatment Evaluation Study (MATES). Addiction. 107(11):1998-2008.

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

Colfax et al 2011 Arch Gen Psychiatry 68;1168-1175Heinzerling et al 2014 Addiction online ahead of print; Elkashef et al 2008 Neuropsychopharmacology 33;1162-1170; McCann & Li 2012 CNS Neuroscience & Therapeutics 18 ;414–418 Shoptaw et al 2008 Drug Alc Depend 96;222-232; Das et al 2010 AIDS 24; 991-2000

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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

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★ DO YOU OR SOMEONE YOU KNOW... ★

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SNORT IT
PACK IT, LIGHT IT
BLAST IT?

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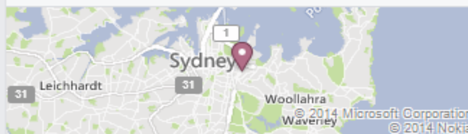
ABOUT



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APPS

About S-Check

PHOTOS

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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.

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Yesterday

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

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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

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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**