A Review of Australian Clinical Guidelines for Methamphetamine Use Disorder

June 2019
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Acknowledgements

This document was written by Ann M Roche, Kirsten Ryan, Jane Fischer and Roger Nicholas of The National Centre for Education and Training on Addiction (NCETA) for The National Centre for Clinical Research on Emerging Drugs (NCCRED).

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- Dr Krista Siefried, Clinical Research Lead
- Ms Florence Bascombe, Knowledge Translation Lead
- Mr Quoc Nguyen, Project Officer

and from NCETA;

- Mr Allan Trifonoff
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About NCETA

The National Centre for Education and Training on Addiction (NCETA) is based at Flinders University in South Australia and is an internationally recognised research and training centre that works as a catalyst for change in the alcohol and other drug (AOD) field. NCETA’s areas of expertise include training needs analyses, the provision of training and other workforce development approaches. We have developed training curricula, programs and resources, and provided training programs, to cater for the needs of: specialist AOD workers; frontline health and welfare workers; Indigenous workers; community groups; mental health workers; police officers; and employers and employee groups. The Centre focuses on supporting evidence-based change and specialises in change management processes, setting standards for the development of training curriculum content and delivery modes, building consensus models and making complex and disparate information readily accessible to workers and organisations.

Contact us

National Centre for Education and Training on Addiction

Flinders University
GPO Box 2100
Adelaide SA 5001
Australia

www.nceta.flinders.edu.au
nceta@flinders.edu.au
nceta@facebook
@NCETAFinders

About NCCRED

The National Centre for Clinical Research on Emerging Drugs (NCCRED), was established by the Commonwealth Government in 2018 as part of the National Ice Action Strategy, recognising the need for improved treatments for methamphetamine, as well as more prompt detection and response to emerging drug threats.

NCCRED aims to support clinicians to detect and respond to new drug health problems by developing innovative and evidence-based new treatments for drug dependence; building clinical research capacity in the Australian AOD workforce; and the rapid translation of research findings into clinical practice.

The Centre was formed as a consortium between St Vincent's Health Australia (SVHA); The National Centre for Education and Training on Addiction (NCETA, Flinders University); The National Drug Research Institute (NDRI, Curtin University); and The National Drug and Alcohol Research Centre (NDARC, The University of New South Wales).

Contact us

National Centre for Clinical Research on Emerging Drugs
(02) 8382 1531
info@nccred.org.au
nccred.org.au @NCCREDNews
Biographies

Professor Ann Roche

Professor Ann Roche has over 30 years’ experience in public health. She has worked as a policy analyst, researcher, and educator. For the past 18 years she has been the Director of NCETA. Previously, she was Director of the Queensland Alcohol and Drug Research and Education Centre (QADREC). She has held academic posts at several universities, and has worked in clinical, public health and community settings. Ann’s professional activities have primarily focused on alcohol and other drug issues, particularly policy development, best practice, workforce development, research translation and dissemination.

Ms Kirsten Ryan

Kirsten Ryan (BBSC) (MSW) is a Project Officer at NCETA. Kirsten has extensive clinical experience working in the alcohol and other drug sector in South Australia. Prior to commencing at NCETA, Kirsten was employed as a senior social worker by Drug and Alcohol Services South Australia (DASSA). As part of this role, Kirsten was the senior social worker (Team Coordinator) at South Australia’s therapeutic community program ‘The Woolshed’. This included overseeing the assessment, admission, treatment and discharge planning for the 24-bed residential facility and accompanying halfway program.

Dr Jane Fischer

Dr Jane Fischer is a Research Fellow at NCETA. Prior to her NCETA appointment, Jane was the program manager for the Centre of Alcohol and Drug Studies (CDAS), located at ‘Biala’ Alcohol and Drug Services, Queensland Health. At CDAS she conducted translational AOD research and delivered AOD-related training to generalist (e.g. social workers, psychologists, nurses) and specialist AOD workers. Jane has also been a Research Officer at QADREC. She has also worked as a Needle and Syringe Program Worker and as an AOD Outreach Worker for Queensland Health.

Mr Roger Nicholas

Roger Nicholas is a Senior Project Manager at NCETA. He holds a Masters Degree in Public Administration (Policy) and his research and policy interests include regulatory and law enforcement responses to alcohol-related crime and disorder, drug misuse, and law enforcement and drug harm reduction. He is experienced in dealing with drug affected clients, law enforcement and methamphetamine use. Prior to his current appointment, Roger was employed in various clinical roles such as inpatient alcohol and drug detoxification, methadone programs and outpatient counselling services. He has also had experience as a clinical educator and in the policy environment.
# Table of Contents

ABBREVIATIONS AND DEFINITIONS .................................................................................. 8

EXECUTIVE SUMMARY .................................................................................................. 9
  Guidelines identified ..................................................................................................... 9
  Guideline coverage ..................................................................................................... 9
  Guideline appraisal ..................................................................................................... 10
  Gap analysis ................................................................................................................ 10
  Future guideline development ...................................................................................... 10

1. INTRODUCTION ......................................................................................................... 11
  1.1 Methamphetamine Use in Australia ....................................................................... 11
      1.1.1 Prevalence and harms .................................................................................... 11
      1.1.2 Treatment settings ....................................................................................... 12
  1.2 Role of Clinical Guidelines .................................................................................... 12
  1.3 Defining Clinical Guidelines .................................................................................. 13

2. METHOD ....................................................................................................................... 13
  2.1 Identifying Australian Methamphetamine Clinical Guidelines ........................... 13
      2.1.1 Search strategy ............................................................................................ 13
      2.1.2 Inclusion criteria .......................................................................................... 13
  2.2 Mapping Treatment Settings and Populations Covered ....................................... 14
  2.3 Guideline Appraisals ............................................................................................. 15
  2.4 Gaps and Implications for Future Guideline Development ................................... 15

3. KEY FINDINGS ............................................................................................................ 16
  3.1 Identified Clinical Guidelines ............................................................................... 16
  3.2 Guideline Concordance with AGREE Criteria ..................................................... 16
  3.3 Guideline Content .................................................................................................. 17
      3.3.1 Assessing guideline coverage ...................................................................... 17
  3.4 Future Guideline Development ............................................................................. 20
      3.4.1 Potential process enhancements for future guideline development .......... 20
      3.4.2 Priority treatment settings for inclusion in future guidelines .................... 21
      3.4.3 Priority population groups for inclusion in future guidelines .................... 21
      3.4.4 How should future guidelines be structured? ............................................. 21
4. DISCUSSION AND CONCLUSION ................................................................. 22
REFERENCES .................................................................................................. 24
APPENDICES .................................................................................................. 26
  Appendix A: Review search strategy ............................................................. 26
  Appendix B: Full list of methamphetamine-related clinical guidelines .......... 27
  Appendix C: Other Australian methamphetamine-related resources .......... 34
  Appendix D: International methamphetamine-related resources ............... 38
  Appendix E: Assessing Guideline Concordance with AGREE Criteria .......... 41
  Appendix F: Detailed assessment of guidelines against AGREE Criteria ....... 49

Tables

Table 1 - Summary of guideline coverage ...................................................... 9
Table 2 - Analytic Framework ....................................................................... 14
Table 3 - Identified methamphetamine-related clinical guideline ............... 18
Table 4 - Treatment settings and population groups addressed by methamphetamine-related clinical guidelines. .................................................. 19
ABBREVIATIONS AND DEFINITIONS

<table>
<thead>
<tr>
<th>Abbreviations</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIHW</td>
<td>Australian Institute of Health and Welfare</td>
</tr>
<tr>
<td>AOD</td>
<td>Alcohol and Other Drugs</td>
</tr>
<tr>
<td>AGREE GRS</td>
<td>Appraisal of Guidelines for Research and Evaluation Global Rating Scale</td>
</tr>
<tr>
<td>IOM</td>
<td>Institute of Medicine</td>
</tr>
<tr>
<td>NCCRED</td>
<td>National Centre for Clinical Research on Emerging Drugs</td>
</tr>
<tr>
<td>NCETA</td>
<td>National Centre for Education and Training on Addiction</td>
</tr>
<tr>
<td>NHMRC</td>
<td>National Health and Medical Research Council</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Definitions</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical guidelines</td>
<td>Statements that include recommendations intended to optimise patient care that are</td>
</tr>
<tr>
<td></td>
<td>informed by a systematic review of evidence and an assessment of the benefits and</td>
</tr>
<tr>
<td></td>
<td>harms of alternative care options (IOM, 2011).</td>
</tr>
<tr>
<td>Clinical practice</td>
<td>The performance of health professionals within any health care setting (NHMRC, 2011).</td>
</tr>
<tr>
<td>Companion document</td>
<td>A secondary publication directly adapted or derived from a clinical practice guideline</td>
</tr>
<tr>
<td></td>
<td>for a particular group (e.g., patients or a particular health professional discipline</td>
</tr>
<tr>
<td></td>
<td>(NHMRC, 2011)).</td>
</tr>
<tr>
<td>Health professionals</td>
<td>Any health worker who provides health care and related medical services, including</td>
</tr>
<tr>
<td></td>
<td>doctors, nurses, Aboriginal health workers and allied health professionals (NHMRC, 2011).</td>
</tr>
</tbody>
</table>
EXECUTIVE SUMMARY

The National Centre for Clinical Research on Emerging Drugs (NCCRED) commissioned the National Centre for Education and Training on Addiction (NCETA), Flinders University to undertake a review of Australian methamphetamine-related clinical guidelines.

The project comprised four stages:

1. Identifying Australian methamphetamine clinical guidelines
2. Mapping guideline content for treatment settings and populations covered
3. Assessing guidelines against contemporary guideline criteria
4. Identifying gaps and implications for future guideline development.

Guidelines identified

Twenty-seven methamphetamine-related clinical guidelines were identified (see Section 3.1). Many of the guidelines were generic but contained sections relevant to methamphetamine.

Guideline coverage

Guidelines were mapped according to the treatment setting and population groups that they covered. An overview of guideline coverage is presented in Table 1 (see Table 4 for mapping in detail).

Table 1 - Summary of guideline coverage

<table>
<thead>
<tr>
<th>Treatment Setting</th>
<th>Generic</th>
<th>Young People</th>
<th>Rural &amp; Remote</th>
<th>Aboriginal</th>
<th>LGBTIQa</th>
<th>Families &amp; Children</th>
<th>Perinatal</th>
<th>Othersb</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol and other drug (AOD) Specialist</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Hospital</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Primary and community care</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Telephone/Online</td>
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<td>No</td>
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<td>No</td>
<td>No</td>
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</tr>
<tr>
<td>Corrections</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Not Defined</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

aLesbian, gay, bi-sexual, trans-gender, intersex, queer; bfor example, culturally and linguistically diverse (CALD), mental health, coerced.

1Treatment setting categories and population risk groups were adapted from the Final Report of the National Ice Task Force (Department of Prime Minister and Cabinet, 2015).
**Guideline appraisal**

Guidelines were assessed against an NCETA-modified version of the Appraisal of Guidelines for Research and Evaluation (AGREE) instrument (Brouwers et al., 2010). While current guidelines were not developed to explicitly meet the AGREE criteria, the assessment nonetheless provides a benchmark for future guideline development.

Fifteen of the 27 guidelines scored >70%, the AGREE threshold recommended by Brouwers et al. (2010) (see Appendix E for assessment details). Most guidelines did not meet the AGREE assessment criteria regarding:

- Adequate detail on processes by which they were developed
- Inclusion of target clinicians'/workers' or patients'/public views in the guideline development.

A number of guidelines used stigmatising and judgemental language that could undermine effective therapeutic relationships between patients and care providers.

**Gap analysis**

It was generally difficult to ascertain the processes by which guidelines were developed and the evidence base used to inform the guidelines. Limited research was available to inform guidelines and the need to strengthen the evidence base is highlighted as a priority.

While the available guidelines covered most of the relevant treatment settings and target population groups there were some notable gaps. In relation to treatment settings, clinical guideline gaps were identified in relation to primary and community care, telephone / online settings, correctional settings and general hospitals. In terms of population groups, lesbian, gay, bi-sexual, trans-gender, intersex, queer (LGBTIQ), Aboriginal, and rural and remote populations warranted further tailored guidelines.

**Future guideline development**

It is recommended that the AGREE Framework (or other guideline development standards as recommended by the National Health and Medical Research Council) is used to inform the development of future guidelines to address methamphetamine and other emerging drugs.

**Guideline implementation**

Future guidelines should comprise two components:

1. Desktop resource: A concise document that provides guidance for busy frontline clinicians which briefly addresses each of the treatment areas and population groups.

2. Bookshelf resource: A comprehensive companion document detailing the guideline development process and including:
   - A systematic literature review of the evidence base
   - Coverage of all main treatment approaches
   - Detailed implications for each of the treatment settings and population groups.
1. INTRODUCTION

The National Centre for Clinical Research on Emerging Drugs (NCCRED) commissioned The National Centre for Education and Training on Addictions (NCETA) to identify Australian clinical guidelines available to support clinical interventions for methamphetamine use disorders and identify gaps and strategies to inform future development in this area. This report presents the projects’ key findings.

1.1 Methamphetamine Use in Australia

There is widespread concern in Australia regarding increased use of methamphetamine, particularly the potent crystalline form of the drug known as ‘ice’. A wide range of problems and harms associated with crystal methamphetamine use have been identified (Goldsmid et al., 2017).

Australia’s National Ice Action Strategy (2015) (Department of Prime Minister and Cabinet, 2015) highlighted five priority areas for action:

1. Support for families and communities
2. Targeted prevention
3. Investment in treatment and workforce
4. Focused law enforcement
5. Better research and data.

The present examination of clinical guidelines is intended to support the Strategy by identifying gaps in resources to support the workforce, how these gaps could be addressed and where further research may be required to support future guideline development.

1.1.1 Prevalence and harms

While prevalence of recent methamphetamine use at the general population level decreased significantly between 2013 and 2016 (from 2.1% to 1.4%) (AIHW, 2017), the proportion of people using crystal methamphetamine (i.e., ‘ice’) had already increased significantly between 2010 and 2013; with crystal methamphetamine displacing powder as the preferred form of the drug (AIHW, 2017).

Methamphetamine-related harm, including deaths2 and demand for treatment, has increased as a result of the shift to the crystallised form of methamphetamine.

An elevated risk of harm exists among population groups with a high prevalence of use and/or disproportionate vulnerability relative to their use level. These groups include young people aged 20-29, regional and rural communities, Indigenous communities, and lesbian, gay, bi-sexual, transgender, intersex and queer (LGBTIQ) communities (Goldsmid et al., 2017; AIHW, 2017; Roche et al., 2015).

---

2 In 2016 the death rate from psychostimulants with abuse potential, including methamphetamine, was four times higher than in 1999 (ABS, 2017).
For example:

- **Aboriginal and Torres Strait Islander**: populations are 2.2 times more likely to use methamphetamine than non-Indigenous Australians (AIHW, 2017)
- **Regional and rural Australians**: lifetime and recent methamphetamine and recent crystal methamphetamine use is significantly higher among rural Australians compared with those living in major cities (Roche and McEntee, 2017). Similarly, the National Drug Strategy Household Survey found those living in remote/very remote areas were 2.5 times more likely to use methamphetamine than Australians living in major cities (AIHW, 2017)
- **LGBTIQ communities**: use of methamphetamine was 5.8 times higher in Australian homosexual and bisexual populations than among heterosexual people (AIHW, 2017). Lea et al. (2016) found that amongst bi-sexual men, rates of both crystal methamphetamine and speed use were consistently higher than among heterosexual groups
- **Young people**: Degenhardt et al. (2016) reported increases over the past 12 years in the numbers of regular and dependent methamphetamine users in Australia, an increase which has been most marked among young adults (i.e., those aged 15-34 years). Data from the NDSHS (2016) also indicate that the highest rates of methamphetamine use are found amongst those aged 20-29 (AIHW, 2017).

### 1.1.2 Treatment settings

Methamphetamine use can lead to complex physical, mental health and social problems. The role of treatment and other interventions is crucial in addressing methamphetamine-related problems. In Australia, publicly funded treatment episodes where the primary drug problem was meth/amphetamine use doubled between 2011 and 2016 (AIHW, 2018).

Treatment for methamphetamine-related problems occurs in a diverse array of settings, including hospitals, Alcohol and Other Drug (AOD) specialist services, primary and community care and correctional services; and involves a wide range of health and human services professionals. Emergency department staff, nurses, general practitioners, AOD workers, police, social workers and psychologists may all be pivotally involved with different types of problem presentations and at different levels of problem severity.

It is recognised that these different professional groups and the various settings in which they work require appropriate evidence-based support tools and clinical guidelines.

### 1.2 Role of Clinical Guidelines

Clinical guidelines inform individual workers’ practice and the treatment services available to people with methamphetamine-related health problems. High quality and appropriately targeted clinical guidelines are essential to ensure safe, effective, evidence-based and evidence-informed treatment and service delivery.
1.3 Defining Clinical Guidelines

The Institute of Medicine (IOM, 2011) defined clinical guidelines as:

“statements that include recommendations, intended to optimize patient care, that are informed by a systematic review of evidence and an assessment of the benefits and harms of alternative care options.”

This definition, if strictly applied, would have excluded many guidelines from this review. This, in turn, would have led to a less comprehensive overview of resources currently available. Instead, clinical guidelines that possessed at least some of requisite features identified in the IOM definition were included.

2. METHOD

The project comprised four components:

1. Identifying Australian methamphetamine clinical guidelines
2. Mapping treatment settings and populations covered
3. Assessing guidelines against contemporary guideline criteria
4. Identifying gaps and implications for future guideline development.

2.1 Identifying Australian Methamphetamine Clinical Guidelines

2.1.1 Search strategy

A comprehensive Internet search for Australian methamphetamine clinical guidelines was undertaken (see Appendix A for details).

2.1.2 Inclusion criteria

Guidelines that met the following criteria were included in the review:

- Produced in Australia after 2000
- Specifically addressed methamphetamine, in full or in part
- Were produced for health and welfare professional groups (e.g., medical officers, nurses, pharmacists, Indigenous alcohol and other drug workers)
- Were publicly available.

The full references for included guidelines, with brief descriptions of their content, are provided in Appendix B.

The following were excluded:

- Australian reference materials (see Appendix C)
- Clinical guidelines produced for audiences outside of Australia (due to the differences in service delivery models) (see Appendix D).
2.2 Mapping Treatment Settings and Populations Covered

A purpose-developed analytic framework (see Table 2) was used to map each guideline according to the treatment setting and population addressed.

Table 2 - Analytic Framework

<table>
<thead>
<tr>
<th>Treatment Setting</th>
<th>Population Group Addressed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Generic</td>
</tr>
<tr>
<td>AOD Specialist Outreach</td>
<td></td>
</tr>
<tr>
<td>Counselling services</td>
<td></td>
</tr>
<tr>
<td>At-home withdrawal</td>
<td></td>
</tr>
<tr>
<td>Withdrawal Service</td>
<td></td>
</tr>
<tr>
<td>Residential rehabilitation</td>
<td></td>
</tr>
<tr>
<td>Other/not specified</td>
<td></td>
</tr>
<tr>
<td>Hospital</td>
<td></td>
</tr>
<tr>
<td>Emergency department</td>
<td></td>
</tr>
<tr>
<td>General ward</td>
<td></td>
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<tr>
<td>Perinatal</td>
<td></td>
</tr>
<tr>
<td>Mental health</td>
<td></td>
</tr>
<tr>
<td>AOD withdrawal (inpatient)</td>
<td></td>
</tr>
<tr>
<td>Other/not specified</td>
<td></td>
</tr>
<tr>
<td>Primary and Community Care</td>
<td></td>
</tr>
<tr>
<td>General practice</td>
<td></td>
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<tr>
<td>Mental health</td>
<td></td>
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</tr>
</tbody>
</table>

\(^a\) Lesbian, gay, bi-sexual, trans-gender, intersex, queer.
\(^b\) For example, culturally and linguistically diverse, mental health, coerced

The guidelines were mapped against treatment settings and population groups by KR, JF & RN, and confirmed through group consensus.

\(^3\) Population categories were adapted from groups identified at particular risk of methamphetamine-related harm in the Final Report of the National Ice Task Force (Department of Prime Minister and Cabinet, 2015).
2.3 Guideline Appraisals

Identified guidelines were assessed for concordance with contemporary standards for clinical guidelines. To assess for concordance, an NCETA-modified version of the Appraisal of Guidelines for Research and Evaluation (AGREE) instrument (Brouwers et al., 2010) was used. The AGREE is an international tool designed to assist the development of methodologically rigorous and transparent guidelines (see Appendix D for further information).

The AGREE appraisals identified a range of gaps in the processes used to develop and present the currently available guidelines and provided valuable pointers to recommended approaches to future guideline development.

The NCETA-modified instrument comprised 22 items organised within five domains:

1. Process of development (7 items)
2. Presentation style (3 items)
3. Completeness of reporting (6 items)
4. Clinical validity (3 items)
5. Quality & utility (3 items).

All items were scored on a 7-point scale (1 = lowest level of concordance with AGREE criteria and 7 = highest). A non-applicable option allowed items to be omitted from the scoring procedures. Scores were obtained for each domain and overall and transformed into total scores out of 100 (see Appendix E).

Guidelines with appraisal scores >70% met the concordance threshold level of the AGREE criteria recommended by Brouwers et al. (2010).

Scores for the ‘process of development’ domain consistently fell below 50%, hence overall scores were recalculated excluding that domain.

Appraisal assessments were undertaken by three assessors (KR, JF & RN) (unless otherwise indicated) with divergent views resolved by consensus.

2.4 Gaps and Implications for Future Guideline Development

Findings were synthesised to inform the gap analysis and recommendations for future guideline development. Treatment settings and population groups not addressed by existing guidelines or provided limited/incomplete coverage were identified, together with ways in which future guideline development processes could be enhanced.
3. KEY FINDINGS

3.1 Identified Clinical Guidelines

Twenty-seven methamphetamine-related clinical guidelines were identified (see Table 3). Some guidelines solely addressed methamphetamine (or stimulants) specifically, while others were generic but contained component parts of relevance.

3.2 Guideline Concordance with AGREE Criteria

Guideline appraisal scores for each AGREE domain were:

- **Process of development:** none scored >70%
- **Presentation style:** 24 scored >70%
- **Completeness of reporting:** 3 scored >70%
- **Clinical validity:** 23 scored >70%
- **Quality and utility:** 19 scored >70%.

Methamphetamine-related clinical guidelines that scored >70% in their overall appraisal are identified with an asterisk (*) in Table 3. Overall, most guidelines were well organised and well written. Presentation styles generally produced clear, specific and unambiguous guidelines with easily identified recommendations. However, most guidelines did not accord with AGREE quality assessment criteria in relation to:

- How they were developed. It was often unclear whether they had been developed following a systematic review of available literature. Most guidelines also relied on the work of a few authors and/or used other guidelines as their basis.
- Consumer and/or target group involvement. Most guidelines did not report whether the views of target clinicians/workers or patients/public had been incorporated into guideline development.

While these features do not necessarily impact the overall clinical utility of the guidelines, they can make it difficult to assess whether the guidelines:

- Are consistent with the available evidence
- Accord with the consensus views of relevant groups.

A small number of guidelines used stigmatising and judgemental language that could undermine effective therapeutic relationships between patients and care providers.
3.3 Guideline Content

3.3.1 Assessing guideline coverage

The guidelines were mapped against the treatment settings and population groups they addressed (see Table 4).

In identifying coverage gaps in the available guidelines, it is important to be mindful that it is not necessarily practical (or desirable) to have guidelines available for every population group in every treatment setting. In addition, many of the guidelines included in the:

- *Other/not specified* treatment setting category could be valuable in treatment settings for which gaps currently exist
- *Generic* population category would have utility in the population categories for which gaps currently exist.4

For AOD specialist treatment settings, guidelines had most commonly been developed for withdrawal settings. AOD specialist treatment setting guidelines tended to be written with general and perinatal populations in mind. One methamphetamine-related clinical guideline (No. 7) addressed at-home withdrawal for rural and remote populations, while another guideline (No. 11) addressed perinatal concerns in all AOD specialist treatment settings.

For each hospital treatment setting included in the framework there was at least one methamphetamine-related clinical guideline. Clinical guidelines most commonly addressed the generic or perinatal population groups. One methamphetamine-related clinical guideline (No. 7) addressed at-home withdrawal for rural and remote populations, while another (No. 11) addressed the perinatal population group in all settings.

Methamphetamine-related clinical guidelines have been written for general practice, mental health, and a range of unspecified primary care settings. All primary care methamphetamine-related clinical guidelines most commonly addressed generic population concerns. However, one general practice treatment setting guideline addressed families and children (No. 16), a mental health guideline addressed perinatal populations (No. 11) whilst an unspecified primary care treatment setting guideline addressed rural and remote and Aboriginal population groups (No. 25; Aboriginal only: No. 6).

The treatment setting was not defined in 12 guidelines, eight of which addressed generic methamphetamine-related concerns. Five of the 12 guidelines addressed young people and perinatal population groups. Four addressed children and families, whilst two each addressed Aboriginal and LGBTIQ populations. One guideline addressed rural and remote population groups.

---

## Table 3 - Identified methamphetamine-related Clinical Guidelines

<table>
<thead>
<tr>
<th>No.</th>
<th>Methamphetamine-related Clinical Guideline</th>
</tr>
</thead>
<tbody>
<tr>
<td>3*</td>
<td>De Crespiigny, C. &amp; Talmet, J. Eds. (2012). Alcohol, tobacco and other drugs: Clinical guidelines for nurses and midwives. Adelaide, South Australia: The University of Adelaide School of Nursing and Drug and Alcohol Services South Australia.</td>
</tr>
<tr>
<td>15*</td>
<td>St Vincent's Hospital Melbourne, NEXUS and VDDI (2014). Guidelines for the acute assessment and management of methamphetamine-type stimulant intoxication and toxicity. Melbourne: St Vincent's Hospital Melbourne.</td>
</tr>
</tbody>
</table>

* scored >70% on the AGREE overall quality appraisal
<table>
<thead>
<tr>
<th>Treatment Setting</th>
<th>Population Group Addressed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Generic</td>
</tr>
<tr>
<td>AOD Specialist</td>
<td></td>
</tr>
<tr>
<td>Outreach</td>
<td>21</td>
</tr>
<tr>
<td>Counselling services</td>
<td>21</td>
</tr>
<tr>
<td>At-home withdrawal</td>
<td>7</td>
</tr>
<tr>
<td>Withdrawal service</td>
<td>7</td>
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<tr>
<td>Residential rehabilitation</td>
<td>7</td>
</tr>
<tr>
<td>Other/not specified</td>
<td>12</td>
</tr>
<tr>
<td>Hospital</td>
<td></td>
</tr>
<tr>
<td>Emergency department</td>
<td>3</td>
</tr>
<tr>
<td>General ward</td>
<td>22</td>
</tr>
<tr>
<td>Perinatal</td>
<td>3</td>
</tr>
<tr>
<td>Mental health</td>
<td>10</td>
</tr>
<tr>
<td>AOD withdrawal (inpatient)</td>
<td>7</td>
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<tr>
<td>Other/not specified</td>
<td>3</td>
</tr>
<tr>
<td>Primary and Community Care</td>
<td></td>
</tr>
<tr>
<td>General practice</td>
<td>10</td>
</tr>
<tr>
<td>Mental health</td>
<td>3</td>
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<tr>
<td>Other/not specified</td>
<td>3</td>
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<tr>
<td>Telephone/Online</td>
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</tr>
<tr>
<td>Corrections</td>
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<td>Not defined</td>
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<td></td>
<td>14</td>
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<tr>
<td></td>
<td>20</td>
</tr>
<tr>
<td></td>
<td>24</td>
</tr>
</tbody>
</table>

†Numbers correspond to the guidelines listed in Table 3.

*lesbian, gay, bi-sexual, trans-gender, intersex, queer;

*b for example, non-English speaking background, mental health, coerced
The gap analysis identified several treatment settings and population groups where opportunities exist to enhance guideline coverage.

3.3.2 Treatment setting gaps

While several guidelines provide evidence informed generic guidelines that would have applicability in a range of settings, no guidelines were found that directly supported telephone / online settings. Coverage was also limited for general hospital wards and correctional settings.

The results presented in Table 4 are discussed in more detail below.

3.3.3 Population group gaps

Of all population groups, LGBTIQ populations had the least number of clinical guidelines (n=2) that had been developed to meet their specific needs. For both guidelines, the treatment setting was not specified, meaning that this population group had large gaps across treatment settings.

The needs of Aboriginal populations were addressed in four guidelines; of these, two were for undefined treatment settings and two were for unspecified primary health care settings. There were gaps in guidelines designed for hospital, AOD specialist service, telephone / online and correctional settings.

Rural and remote populations were also not well served by current guidelines. Only four guidelines addressed the specific needs of rural populations; of these 2 focussed on withdrawal settings (hospital inpatient and at home), one was for unspecified treatment settings and one for an unspecified primary care setting.

3.4 Future Guideline Development

3.4.1 Potential process enhancements for future guideline development

It is recommended that the AGREE Framework (or other guideline development standard as recommended by the National Health and Medical Research Council) is used to shape the development of future guidelines to address methamphetamine and other emerging drugs.

The AGREE Framework is highly regarded and is likely to provide an appropriate level of transparency concerning the extent to which guidelines:

- Are evidence-based
- Represent the consensus views of key stakeholders.

Guidelines examined here were not developed in accordance with the AGREE Framework as many pre-dated its availability. A high degree of concordance with AGREE criteria could

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not therefore be expected. While many of these guidelines have considerable clinical utility, future guideline development would be enhanced by a greater degree of concordance with AGREE criteria, or similar standards.

The use of the AGREE Framework is likely to bring to light gaps in available evidence to support guideline development. In this guideline examination, it became apparent that the evidence base to support methamphetamine treatment was not strong. In addition, it was often difficult to ascertain the extent to which guidelines were evidence based, or to determine the quality of evidence that informed them. It is critically important that identified evidence gaps inform the future research agendas in this area to ensure that practitioners have access to guidelines with robust links to sound evidence.

### 3.4.2 Priority treatment settings for inclusion in future guidelines

The treatment settings not adequately covered by the current methamphetamine related clinical guidelines were:

- Telephone/online
- Corrections
- General hospital wards.

### 3.4.3 Priority population groups for inclusion in future guidelines

LGBTIQ and Aboriginal populations are the top priorities for future guideline development. These groups are closely followed by rural and remote populations.

### 3.4.4 How should future guidelines be structured?

It is critically important that clinicians have access to guidelines that address the methamphetamine treatment settings and population groups identified in this review.

The challenge will be to develop guidelines which contain broadly applicable core information with sufficient supplementary information to allow them to be adapted to individual population groups and treatment settings.

While busy clinicians require a “how to” resource, they also need the capacity to refer back to source research if need be.

Attempting to achieve this in a single document or online resource is likely to result in a very large / lengthy resource which may be inaccessible for busy clinicians. For example, the National Guidelines for Medication-Assisted Treatment of Opioid Dependence (Gowing et al., 2014), while very comprehensive, it is over 200 pages long.

It is therefore recommended that future guidelines comprise two components:

1. Desktop resource: A concise document that provides guidance for busy frontline clinicians which addresses each of the treatment areas and briefly addresses the needs of all population groups.
2 Bookshelf resource: A comprehensive companion document that details the guideline development process. This should include:

- A systematic literature review of the evidence base
- Coverage of all main treatment approaches
- Detailed implications for each of the population groups.

4. DISCUSSION AND CONCLUSION

Australia has produced a substantial number of good quality methamphetamine-related clinical guidelines. Most guidelines are useful resources with valuable clinical utility and serve the needs of a wide range of treatment settings and population groups. There are however gaps and limitations in the guidelines currently available and there is scope for the production of a comprehensive guideline to inform consistent quality practice nationally.

The current guidelines largely pre-date the emergence of NHMRC, or similar gold standards to inform the development of high-quality clinical guidelines. Moreover, there is a relatively limited evidence base available to inform methamphetamine-related clinical guidelines. The current review highlights the pressing need for further clinical research to be undertaken to build the evidence-base required for future guidelines.

Important gaps in the extant guidelines were identified in both the coverage of specific treatment settings and particular population groups. In terms of treatment settings, guidelines relevant to telephone / online settings general hospital wards and correctional settings warrant future attention. In terms of population groups, LGBTIQ and Aboriginal people are the top priorities for future guideline development. These groups are closely followed by rural and remote populations.

In moving towards the future development of high-quality guidelines, it is imperative that they are written in non-stigmatising, non-judgemental language. This is central to fostering effective therapeutic relationships between patients and care providers and for achieving positive treatment outcomes.

It is possible that some clinical guidelines were inadvertently missed in this review. In addition, assessing the guidelines in terms of their AGREE scores and coverage of treatment settings and populations is by necessity a subjective process. Nevertheless, using three independent assessors minimised risk of significant scoring variations.

The tool used to assess the guidelines was an NCETA-modified version of the Appraisal of Guidelines for Research and Evaluation (AGREE) instrument (Brouwers et al., 2010). There was a variable degree of concordance with the AGREE criteria. This is unsurprising given that the guidelines were not developed with the AGREE criteria in mind.

It is recommended that the AGREE tool (or a similar replacement) should be the benchmark to inform the development of future guidelines.

At the time that this project was conducted, the NHMRC was working with an Expert Advisory Committee to develop a new online resource for guideline developers that will supersede its current Standards. This new resource will be published in self-contained modules on the NHMRC ‘Guidelines for Guidelines’ website.
While NHMRC-led advances in guideline development should inform future work in this area, it is important to note that NHMRC frameworks and approaches to guideline development address issues well beyond clinical practice. As such, they may not be a 'perfect fit' for the development of future methamphetamine-related clinical guidelines.

Nonetheless, ensuring that future methamphetamine-related guidelines reflect NHMRC standards will likely produce stronger, more reliable and evidence-based clinical support tools.
REFERENCES


APPENDICES

Appendix A: Review search strategy

The search for Australian methamphetamine clinical guidelines comprised the following activities:

- Google and Google Scholar searches using the following terms: clinical guidelines for methamphetamine, amphetamine type stimulants; clinical treatment guidelines to assist health and medical professionals treat people with alcohol and other drug problems; guidelines for the management of amphetamine misuse and dependence; psychostimulant guidelines; managing amphetamine intoxication
- An examination of the resources and guidelines for health professionals located in the Cracks in the Ice online toolkit
- An examination of the references and resources in NCETA’s online resource Ice: Training for Frontline Workers, cross-checked with the list of resources and references from NCETA’s 2015 National Methamphetamine Symposium
- An examination of policies and procedures located on:
  - The Australian Government Department of Health’s website – using the following search terms: guidelines, amphetamine, amphetamine-type, methamphetamine, psychostimulant
  - All state and territory Health Department and AOD government services websites using the following search terms: guidelines, methamphetamine, amphetamine, psychostimulants
  - An examination of references and resources on the Indigenous AOD Knowledge Centre website using the following search terms: guidelines, methamphetamine, amphetamine, psychostimulants.
## Appendix B: Full list of methamphetamine-related clinical guidelines

<table>
<thead>
<tr>
<th>Full Guideline Citation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>de Crespigny, C., &amp; Talmet, J. (Eds.). (2012).</strong> Alcohol, tobacco and other drugs: clinical guidelines for nurses and midwives (3 ed.). Adelaide, South Australia: The University of Adelaide School of Nursing &amp; Drug and Alcohol Services South Australia.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Focus</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>CBT Treatment</td>
<td>This is a project evaluating the effectiveness of two and four session cognitive behavioural interventions developed specifically for people who use amphetamines. Context and background into how the study was developed are included in section 1 and 2. Guidelines for how to use the intervention and tools to apply the intervention are provided in section 3 and 4. This is a systematic study.</td>
</tr>
<tr>
<td>Withdrawal and clinical interventions Australia-wide</td>
<td>This is a 270 page document. It includes 3 main sections and is part of an Australian Government Department of Health and Ageing monograph series. The introduction, provides background to the Monograph. Section 2, discusses prevalence effects and risks. Section 3 provides clinical considerations. Information on amphetamines is embedded throughout the entire document, mostly under the broader heading of psychostimulants. The systematic review methods for developing the guidelines are included.</td>
</tr>
<tr>
<td>Nurses and Midwives SA</td>
<td>This is a 427 page guideline is an SA Health document developed for nurses and midwives. Psychostimulants are covered in section 3.3.2 (p. 262). Methamphetamine is covered in section 3.4.5 (p. 299). There is a table titled symptoms and effects of drugs, which includes amphetamines on page 66. Table 6, (p. 94) has a table called harm and risk of withdrawal for drug use during pregnancy. Amphetamine withdrawal assessment charts are included in the Appendix section. These guidelines aim to provide a benchmark for quality intervention assessment and referral by nurses.</td>
</tr>
<tr>
<td>Frontline workers Australia-wide</td>
<td>This is a 115 page document, published by the National Drug Strategy. It was based on contemporary research at the time, national and international guidelines and expert opinion. There are 11 chapters and a summary of the important aspects of each chapter. Chapter 1, provides a background to methamphetamine. Chapter 2 describes the effects, risks and harms as well as harm reduction strategies. Chapter 3 provides information on recognising and managing intoxication. Chapter 4 provides information on how to recognise</td>
</tr>
<tr>
<td>Full Guideline Citation</td>
<td>Focus</td>
</tr>
<tr>
<td>---------------------------------------------------------------------------------------</td>
<td>--------------------------------</td>
</tr>
<tr>
<td>5 Jenner, L., Spain, D., Whyte, I., &amp; Baker, A. (2006). *Management of patients with</td>
<td>Emergency Departments</td>
</tr>
<tr>
<td>psychostimulant toxicity: guidelines for emergency departments. Canberra: Australian</td>
<td>Australia-wide</td>
</tr>
<tr>
<td>Government Department of Health and Ageing.</td>
<td></td>
</tr>
<tr>
<td>6 Lee, K., Freeburn, B., Ella, S., Miller, W., Perry, J., &amp; Conigrave, K. (2012).</td>
<td>Aboriginal Health Workers</td>
</tr>
<tr>
<td><em>Handbook for Aboriginal alcohol and drug work</em>. Sydney: University of Sydney.</td>
<td>NSW</td>
</tr>
<tr>
<td>7 Grigg J., Manning V., Arunogiri S., Volpe I., Frei M., Phan V., Rubenis A., Dias S.,</td>
<td>Variety of Practitioners</td>
</tr>
<tr>
<td>Practice Guidelines for Health Professionals (Second Edition). Richmond, Victoria:</td>
<td></td>
</tr>
<tr>
<td>Turning Point.</td>
<td></td>
</tr>
<tr>
<td>8 Manning, V., Arunogiri, S., Frei, M. R., K., Mroz, K., Campbell, S., &amp; Lubman, D.</td>
<td>Variety of Practitioners</td>
</tr>
<tr>
<td>(2018).</td>
<td></td>
</tr>
<tr>
<td>Full Guideline Citation</td>
<td>Focus</td>
</tr>
<tr>
<td>----------------------------------------------------------------------------------------</td>
<td>-------------</td>
</tr>
<tr>
<td><em>Alcohol and other drug withdrawal: practice guidelines</em>, Richmond, Victoria: Turning</td>
<td>VIC</td>
</tr>
<tr>
<td>Point.</td>
<td></td>
</tr>
<tr>
<td>9 Stone, J., Bennetts, A., Cleary, L., Ditchburn, S., Jacobson, H., Rea, R., Aitken,</td>
<td>Counselling</td>
</tr>
<tr>
<td>10 Mental Health Alcohol and Other Drugs Directorate. (2012). *Queensland alcohol and</td>
<td>Withdrawal</td>
</tr>
<tr>
<td>drug withdrawal clinical practice guidelines*, Brisbane: Queensland Health.</td>
<td>QLD</td>
</tr>
<tr>
<td>11 NSW Ministry of Health. (2014). *Clinical guidelines for the management of substance</td>
<td>Nursing and</td>
</tr>
<tr>
<td>use during pregnancy, birth and the postnatal period*, North Sydney: NSW Ministry of</td>
<td>Midwifery</td>
</tr>
<tr>
<td>Health.</td>
<td>NSW</td>
</tr>
<tr>
<td>12 SA Health. (2017). *Management of acute presentations related to methamphetamine use:</td>
<td>Adults and</td>
</tr>
<tr>
<td>Clinical guideline for adults and adolescents*, Adelaide: SA Health.</td>
<td>Adolescents</td>
</tr>
<tr>
<td>SA</td>
<td></td>
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<td>Full Guideline Citation</td>
<td>Focus</td>
</tr>
<tr>
<td>-------------------------</td>
<td>-------</td>
</tr>
<tr>
<td>15 St Vincent's Hospital Melbourne, NEXUS, &amp; VDDI. (2014). <em>Guidelines for the acute assessment and management of amphetamine-type stimulant intoxication and toxicity</em>, Melbourne: St Vincent’s Hospital Melbourne.</td>
<td>Emergency Department St Vincent Specific VIC</td>
</tr>
<tr>
<td>16 Australian General Practice Network. (2007). <em>Management of patients with psychostimulant use problems – guidelines for general practitioners</em>, Canberra: Australian Government Department of Health and Ageing.</td>
<td>GPs Australia-wide</td>
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<tr>
<td>Full Guideline Citation</td>
<td>Focus</td>
</tr>
<tr>
<td>-------------------------</td>
<td>-------</td>
</tr>
<tr>
<td>17 Cementon, E. (2011). <em>Alcohol and other drug withdrawal practice guidelines: acute inpatient and residential services</em>. Melbourne: Substance Use and Mental Illness Treatment Team, North Western Mental Health.</td>
<td>Inpatient and Residential withdrawal North Western Mental Health, VIC</td>
</tr>
<tr>
<td>18 Drug and Alcohol Clinical Advisory Service. (2011). <em>Fact Sheet: management of stimulant use</em>. Victoria: Drug and Alcohol Clinical Advisory Service.</td>
<td>GPs</td>
</tr>
<tr>
<td>19 Insight Clinical Support Services. (2016). <em>Psychostimulant early intervention flow chart: combined</em>. Brisbane: Queensland Health.</td>
<td>Frontline workers QLD</td>
</tr>
<tr>
<td>21 Mental Health and Drug and Alcohol Office. (2008a). <em>Drug and alcohol psychosocial interventions professional practice guidelines</em>. Sydney: Ministry of Health, New South Wales.</td>
<td>Psychosocial Interventions NSW</td>
</tr>
<tr>
<td>Full Guideline Citation</td>
<td>Focus</td>
</tr>
<tr>
<td>-------------------------</td>
<td>-------</td>
</tr>
<tr>
<td>22 Mental Health and Drug and Alcohol Office. (2008b). Drug and alcohol withdrawal clinical practice guidelines - New South Wales. Sydney: Ministry of Health, New South Wales.</td>
<td>Withdrawal NSW</td>
</tr>
<tr>
<td>24 New South Wales Health. (2007). Clinical guidelines for nursing and midwifery practice in NSW: identifying and responding to drug and alcohol issues. North Sydney: NSW Department of Health.</td>
<td>Nursing and Midwifery NSW</td>
</tr>
<tr>
<td>25 Remote Primary Health Care Manuals. (2017). CARPA standard treatment manual. Alice Springs, Northern Territory: Centre for Remote Health.</td>
<td>Indigenous communities in Northern and Central Australia</td>
</tr>
<tr>
<td>Full Guideline Citation</td>
<td>Focus</td>
</tr>
<tr>
<td>-------------------------</td>
<td>-------</td>
</tr>
<tr>
<td>26 Royal Women’s Hospital. (2017). <em>Drug and alcohol management of methamphetamine dependence in pregnancy</em>. Parkville, Victoria: The Royal Women's Hospital.</td>
<td>Nursing Midwifery/ WCH Hospital Specific VIC</td>
</tr>
</tbody>
</table>
Appendix C: Other Australian methamphetamine-related resources

During the process of identifying clinical guidelines for methamphetamine use disorder for this project, a range of other methamphetamine-related resources were located. While these resources could not be regarded as clinical guidelines, they do contribute to the evidence base concerning effective responses to methamphetamine-related issues. For this reason, they have been listed below.

<table>
<thead>
<tr>
<th>No.</th>
<th>Title</th>
<th>Focus</th>
<th>Description</th>
<th>Link</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.</td>
<td>Allsop, S., &amp; Lee, N. (2012). <em>Perspectives on amphetamine type stimulants.</em> East Hawthorn, Victoria: IP communications.</td>
<td>Amphetamine Type Stimulants and approaches to care</td>
<td>This is a book which includes an introduction to amphetamine type stimulants and influences on their actions and effects. The book includes consumer and front line worker perspectives and discusses evidence to inform responses to harm related to amphetamine type substances.</td>
<td>Book. No link available.</td>
</tr>
<tr>
<td>4.</td>
<td>Dawe, S., Atkinson, J., Frye, S., Evans, C., Best, D., Lynch, M., Moss, D., &amp; Harrett, P. (2006). <em>Drug use in the family impacts and implications for children.</em> Canberra: Australian National Council on Drugs.</td>
<td>Parental substance misuse and children between 2 and 12 years old.</td>
<td>This is a research paper focusing on drug use in the family context. There are nine chapters which include prevalence of use amongst parents and the impact this has on children. The impact in Indigenous communities is discussed along with policy and legal frameworks. Principles of best practice are also addressed. Responses to Hidden Harm in the UK is also included. Specific information on methamphetamine is included throughout the paper.</td>
<td><a href="https://www.researchgate.net/publication/37358668_Drug_Use_in_the_Family_Impact_s_and_Implications_f">https://www.researchgate.net/publication/37358668_Drug_Use_in_the_Family_Impact_s_and_Implications_f</a> or_Children</td>
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<tr>
<td></td>
<td>Reference</td>
<td>Description</td>
<td>URL</td>
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<td>-----------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td>Insight Clinical Support Services (2016). Meth Check: Ultra-Brief Intervention Tool Aboriginal and Torres Strait Islander Version. Brisbane: Queensland Health.</td>
<td>QLD front line workers</td>
<td>This is a brief intervention tool for health practitioners to use with Aboriginal or Torres Strait Islander populations. This is approximately a 5 to 10-minute intervention.</td>
<td><a href="https://insight.qld.edu.au/shop/aboriginal-&amp;-torres-strait-islander-meth-check-ultra-brief-intervention-tool">https://insight.qld.edu.au/shop/aboriginal-&amp;-torres-strait-islander-meth-check-ultra-brief-intervention-tool</a>.</td>
</tr>
<tr>
<td>17.</td>
<td>Uniting Care ReGeN. (2014). <em>Methamphetamine Treatment: Building in successful strategies to build outcomes</em>. Melbourne Victoria: Uniting Care ReGeN.</td>
<td>Program and Strategic</td>
<td>This is an eight page document created by the ReGen Uniting Care service. It provides background information on methamphetamine. It describes the ReGen experience of a stepped care clinical trial conducted to improve service delivery.</td>
<td><a href="https://www.regen.org.au/images/Meth_Tr">https://www.regen.org.au/images/Meth_Tr</a> eatment_-_Building_on_successful_strategies_to_enhance_outcomes_v1.0.pdf</td>
</tr>
</tbody>
</table>
Appendix D: International methamphetamine-related resources

A range of international methamphetamine-related resources were identified during this project. These were not appraised in this review due to the differences in service delivery models. However, they do contribute to the evidence base concerning effective responses to methamphetamine-related issues. For this reason, they have been listed below.

<table>
<thead>
<tr>
<th>No.</th>
<th>Title</th>
<th>Focus</th>
<th>Description</th>
<th>Link</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.</td>
<td>Gouzoulis-Mayfrank, E., Hartel-Petri, P., Hamdorf, W., Havemann-Reinecke, U., Muglig, S., Wodarz, N. (2017). Methamphetamine-related disorders. <em>Deutsches Arzteblatt</em></td>
<td>Development of methamphetamine- related guidelines.</td>
<td>This is a 10 page document. The method section on page 4 states that it is a clinical guideline. This was developed following a systematic review. Treatment recommendations are included in the</td>
<td><a href="https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5523799/">https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5523799/</a></td>
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<td></td>
</tr>
<tr>
<td><strong>6.</strong> Braunwarth, W., Christ, M., Dirks, H., Dyba, J., Hartel-Petri, Drug Commissioner of the German Federal Government. (2016). Making evidence-based statements on the Efficacy of pharmacological and psychotherapeutic interventions for patients with <em>Making evidence-based statements on the Efficacy of pharmacological and psychotherapeutic treatment.</em> This is a 219 page document with 10 sections. Its goal was to provide evidence-based medical treatment / interventions for patients with <a href="https://www.aezq.de/mdb/edocs/pdf/literatur/s3-gil">https://www.aezq.de/mdb/edocs/pdf/literatur/s3-gil</a></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Practice guideline: Methamphetamine related disorders. Berlin: Drug Commissioner of the German Federal Government.</td>
<td>Interventions. End user not stated.</td>
<td>methamphetamine-related disorders in Germany. Statements were voted on by experts and consensus ranking. Methamphetamine-related key words are embedded throughout the document.</td>
<td>methamphetamine-related-disorders-long.pdf</td>
<td></td>
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<tr>
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</tr>
</tbody>
</table>
Appendix E: Assessing Guideline Concordance with AGREE Criteria

The National Health and Medical Research Council (NHMRC, 2011) endorsed the Appraisal of Guidelines for Research and Evaluation (AGREE) (Brouwers et al., 2010), an international tool designed to assist the development and evaluation of guidelines. The AGREE formed the basis of the quality appraisal process used for this project.

The AGREE quality assessment tool was designed to assist researchers and clinicians to develop and appraise clinical guidelines (Woolf, Grol, Hutchinson et al., 1999). It was updated to the AGREE II in 2009. An AGREE II Reporting Checklist was created in 2016 to enhance completeness of reporting on guidelines (Brouwers et al., 2016). A shortened version, the AGREE GRS, was subsequently produced A copy of the AGREE GRS is provided below.

Although the AGREE GRS is a shorter appraisal tool, it proved to be a viable alternative when use of AGREE II was not feasible and resources were sparse (Brouwers et al., 2012).

NCETA staff piloted the AGREE GRS and found this shortened assessment tool to be unsuitable for some aspects of methamphetamine guidelines. It was determined that a modified version of the AGREE GRS was required for the purposes of this review.

The NCETA-modified tool was subsequently developed based upon the following principles:

- The revised instrument would not compromise AGREE GRS principles
- It would be appropriate for the broad range of candidate methamphetamine-related clinical guidelines
- It needed to include a ‘not applicable’ option to account for irrelevant items
- It would more precisely reflect the focus of each domain being assessed.
- It would reflect guideline concordance with AGREE GRS principles

The AGREE GRS was modified by refining some items and including other items from the AGREE II Reporting Checklist, to form stand-alone questions. The NCETA-modified instrument comprised 22 items organised within five domains (see 2):

1. Process of development (7 items)
2. Presentation style (3 items)
3. Completeness of reporting (6 items)
4. Clinical validity (3 items)
5. Quality & utility (3 items).

The NCETA-modified AGREE GRS tool retained the existing AGREE GRS domains, items and 7-point scoring scales (with 1 indicating lowest level of concordance with AGREE criteria and 7 indicating highest level of concordance with AGREE criteria). The domains and items that were common to the AGREE GRS and the NCETA-modified tool are presented in Table E1. The NCETA-modified version of AGREE GRS also included a score per item (as used in AGREE II), rather than by each domain only (as used in AGREE GRS) is presented in Table E2. A full copy of the NCETA-modified instrument is also provided below.
Table E1: Changes made to the AGREE GRS to create the NCETA-modified AGREE

<table>
<thead>
<tr>
<th>Domain</th>
<th>Original Items</th>
<th>Additional Items</th>
</tr>
</thead>
<tbody>
<tr>
<td>Process of Development</td>
<td>• Were the appropriate stakeholders involved in the development of the guideline?</td>
<td>• To what extent were the views of the target population (patients, public) sought?</td>
</tr>
<tr>
<td></td>
<td>• Was the evidentiary base developed systematically?</td>
<td>• To what extent were the views of the target clinicians/workers sought?</td>
</tr>
<tr>
<td></td>
<td>• Were recommendations consistent with the literature?</td>
<td>• To what extent were the views of experts included in the guideline?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• To what extent does the guideline include a description about when the guideline will be reviewed and updated?</td>
</tr>
<tr>
<td>Presentation Style</td>
<td>• Was the guideline well organised?</td>
<td>• To what extent are the recommendations specific and unambiguous?</td>
</tr>
<tr>
<td></td>
<td>• Were the recommendations easy to find? (revised as: Were the recommendations easily identifiable).</td>
<td></td>
</tr>
<tr>
<td>Completeness of reporting</td>
<td>• Was the guideline development process transparent and reproducible? (revised as two questions: 1. Was the process transparent? 2. Was the process reproducible?)</td>
<td>• Where evidence is incomplete, to what quality has this been stated?</td>
</tr>
<tr>
<td></td>
<td>• How complete was the information to inform decision-making?</td>
<td>• To what extent have the health benefits, side effects and risks been considered in formulating the recommendations?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• To what quality is the tool supported by tools for application? For example, specific assessment tools like the ASSIST, or flow chart decision making tools.</td>
</tr>
<tr>
<td>Clinical Validity</td>
<td>• Are the recommendations clinically sound?</td>
<td>• To what extent are the recommendations appropriate for the intended clinician/AOD worker?</td>
</tr>
<tr>
<td></td>
<td>• Are the recommendations appropriate for the intended patients?</td>
<td></td>
</tr>
<tr>
<td>Overall assessment*</td>
<td>• Rate the overall quality of this guideline.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• I would recommend this guideline for use in practice.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• I would make use of a guideline of this quality in my professional decisions.</td>
<td></td>
</tr>
</tbody>
</table>

* Renamed as ‘Quality and utility’ to differentiate it from the final overall appraisal score included in the NCETA-modified tool
Table E2: NCETA-modified clinical guideline assessment tool: domains, assessment criteria and associated items

<table>
<thead>
<tr>
<th>Domain</th>
<th>Items</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Process of development</td>
<td>1.1 To what extent was the evidentiary base developed systematically? 1.2 To what extent were recommendations consistent with the literature? 1.3 Was the population (target users, patients, public etc.) to whom the guideline is meant to apply adequately described? 1.4 To what extent were the views of the target population (patients, public) sought? 1.5 To what extent were the views of the target clinicians/workers sought? 1.6 To what extent were the views of experts included in the guideline? 1.7 To what extent does the guideline include a description about when the guideline will be reviewed and updated?</td>
</tr>
<tr>
<td>2. Presentation style</td>
<td>2.1 To what extent was the guideline well organised? 2.2 To what extent the recommendations easily identifiable? 2.3 To what extent are the recommendations specific and unambiguous?</td>
</tr>
<tr>
<td>3. Completeness of reporting</td>
<td>3.1 To what extent is the guideline development process transparent? 3.2 To what extent is the guideline process reproducible? 3.3 How complete was the information to inform decision making? 3.4 Where evidence is incomplete, to what quality has this been stated? 3.5 To what extent have the health benefits, side effects and risks been considered in formulating the recommendations? 3.6 To what extent is the guideline supported with tools for application? e.g., screening instruments, flowcharts to aid decision-making</td>
</tr>
<tr>
<td>4. Clinical validity</td>
<td>4.1 To what extent are the recommendations clinically sound? 4.2 To what extent are the recommendations appropriate for the intended patients? 4.3 To what extent are the recommendations appropriate for the intended clinician/AOD worker?</td>
</tr>
<tr>
<td>5. Quality &amp; utility</td>
<td>5.1 Rate the overall quality of this guideline. 5.2 I would recommend this guideline for use in practice. 5.3 I would make use of a guideline of this quality in my professional decisions.</td>
</tr>
</tbody>
</table>

Every included guideline was appraised by three reviewers.

A spreadsheet was developed to standardise scoring procedures across reviewers and minimise scope for error. Each item within the five domains was assigned a score between 1 and 7 (with 1 indicating the lowest level of concordance with AGREE Criteria quality and 7 indicating the highest, plus a non-applicable option). Items considered not applicable to a given guideline were omitted from the scoring procedures. The scoring system allowed for discrepancies between appraisers.

For each domain, the item scores were summed to provide a composite domain score. The number of relevant items was then calculated (i.e., excluding those designated as not applicable) as well as the maximum and minimum possible score for that domain. When the non-applicable option was nominated, the corresponding maximum and minimum scores were adjusted accordingly. This process was repeated for each domain, and for each of the three reviewers’ scores.
A total domain score was calculated by summing the composite domain score for each of the three reviewers. Similarly, the total maximum and minimum score for each domain was calculated by summing the maximum/minimum number of items in each domain for each reviewer.

To obtain an overall percentage score for each domain, the total minimum score possible was subtracted from (a) the total domain score and (b) the total maximum score possible. The two resultant numbers were then divided (i.e., $\frac{a}{b}$) and multiplied by 100. As recommended by Brouwers et al. (2010) a nominal threshold of ≥70% was set as the quality guideline for each respective domain.

To calculate a single final score for the guideline, the total scores for each domain were summed. These scores were then subjected to the same procedure as above to calculate the final overall percentage score for each guideline.
### AGREE GRS INSTRUMENT

**Process of development**

1. Rate the overall quality of the guideline development methods.
   
   **Consider:**
   - Were the appropriate stakeholders involved in the development of the guideline?
   - Was the evidentiary base developed systematically?
   - Were recommendations consistent with the literature?

<table>
<thead>
<tr>
<th>Lowest Quality</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>Highest Quality</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Highest Quality</td>
</tr>
</tbody>
</table>

**Presentation Style**

2. Rate the overall quality of the guideline presentation.
   
   **Consider:**
   - Was the guideline well organised?
   - Were the recommendations easy to find?

<table>
<thead>
<tr>
<th>Lowest Quality</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>Highest Quality</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Highest Quality</td>
</tr>
</tbody>
</table>

**Completeness of Reporting**

3. Rate the completeness of reporting.
   
   **Consider:**
   - Was the guideline development process transparent and reproducible?
   - How complete was the information to inform decision-making?

<table>
<thead>
<tr>
<th>Lowest Quality</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>Highest Quality</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Highest Quality</td>
</tr>
</tbody>
</table>

**Clinical Validity**

4. Rate the overall quality of the guideline recommendations.
   
   **Consider:**
   - Are the recommendations clinically sound?
   - Are the recommendations appropriate for the intended patients?

<table>
<thead>
<tr>
<th>Lowest Quality</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>Highest Quality</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Highest Quality</td>
</tr>
</tbody>
</table>
### NCETA-MODIFIED AGREE GRS INSTRUMENT

**Methamphetamine Clinical Guideline:** [Insert Author. Year. Title. Publisher. Place of Publication]

<table>
<thead>
<tr>
<th>1. PROCESS OF DEVELOPMENT</th>
<th>LOWEST CONCORDANCE</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>HIGHEST CONCORDANCE</th>
<th>NA¹</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. To what extent was the evidentiary base developed systematically?</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>2. To what extent were recommendations consistent with the literature?</td>
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</tr>
<tr>
<td>3. Was the population (target users, patients, public etc.) to whom the guideline is meant to apply adequately described?</td>
<td></td>
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<tr>
<td>4. To what extent were the views of the target population (patients, public) sought?</td>
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<tr>
<td>5. To what extent were the views of the target clinicians/workers sought?</td>
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<tr>
<td>6. To what extent were the views of experts included in the guideline?</td>
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<tr>
<td>7. To what extent does the guideline include a description about when the guideline will be reviewed and updated?</td>
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</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2. PRESENTATION STYLE</th>
<th>LOWEST CONCORDANCE</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>HIGHEST CONCORDANCE</th>
<th>NA¹</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. To what extent was the guideline well organised?</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>2. To what extent the recommendations easily identifiable?</td>
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<td></td>
</tr>
<tr>
<td>3. To what extent are the recommendations specific and unambiguous?</td>
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<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3. COMPLETENESS OF REPORTING</th>
<th>LOWEST CONCORDANCE</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>HIGHEST CONCORDANCE</th>
<th>NA¹</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. To what extent is the guideline development process transparent?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>2. To what extent is the guideline process reproducible?</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>3. How complete was the information to inform decision making?</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>4. Where evidence is incomplete, to what extent has this been stated?</td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
5. To what extent have the health benefits, side effects and risks been considered in formulating the recommendations?

6. To what extent is the guideline supported with tools for application? e.g., screening instruments, flowcharts to aid decision-making.

<table>
<thead>
<tr>
<th>4. CLINICAL VALIDITY</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>LOWEST CONCORDANCE</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>1. To what extent are the recommendations clinically sound?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. To what extent are the recommendations appropriate for the intended patients?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. To what extent are the recommendations appropriate for the intended clinician/AOD worker?</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>5. QUALITY &amp; UTILITY</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>LOWEST CONCORDANCE</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>1. Rate the overall quality of this guideline.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. I would recommend this guideline for use in practice.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. I would make use of a guideline of this quality in my professional decisions.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Key: 1 Not Assessable
SCORING

Formula for calculating domain scores:

Domain scores were calculated by summing all the scores of the individual items in a domain and by scaling the total as a percentage of the maximum possible score for that domain.

<table>
<thead>
<tr>
<th>Appraiser</th>
<th>Item Scores</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2.1 2.2 2.3</td>
<td></td>
</tr>
<tr>
<td>Appraiser 1</td>
<td>5 6 6</td>
<td>17</td>
</tr>
<tr>
<td>Appraiser 2</td>
<td>5 5 6</td>
<td>16</td>
</tr>
<tr>
<td>Appraiser 3</td>
<td>5 5 6</td>
<td>16</td>
</tr>
<tr>
<td>Total</td>
<td>15 16 18</td>
<td>49</td>
</tr>
</tbody>
</table>

Minimum possible score = 1 (lowest quality) x 3 (items) x 3 (appraisers) = 9
Maximum possible score = 7 (highest quality) x 3 (items) x 3 (appraisers) = 63

The scaled domain score would be calculated as follows:

\[
\frac{\text{Obtained score} - \text{minimum possible score}}{\text{Maximum possible score} - \text{minimum possible score}} \times 100
\]

\[
\frac{49-9}{63-9} \times \frac{40}{54} \times 100 = 0.74 \times 100 = 74\%
\]
Appendix F: Detailed assessment of guidelines against AGREE Criteria

Those 15 are the guidelines shown above that are numbered 1 to 15 (the remainder, numbered 16 to 27, scored below 70% in their quality appraisal) (see Table F1). Specific AGREE scores by domain are also shown in Table F1.

Table F1: Identified Australian methamphetamine-related clinical guidelines, associated domain scores concerning their concordance with AGREE criteria and overall appraisals.


<table>
<thead>
<tr>
<th>No.</th>
<th>Methamphetamine-related Clinical Guideline</th>
<th>Domain Scores</th>
<th>Overall Appraisals</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>1</td>
<td>Brief cognitive behavioural intervention for regular amphetamine users</td>
<td>56%</td>
<td>76%</td>
</tr>
<tr>
<td>2</td>
<td>Models of intervention &amp; care for psychostimulant users</td>
<td>66%</td>
<td>83%</td>
</tr>
<tr>
<td>3</td>
<td>ATOD clinical guidelines for nurses &amp; midwives</td>
<td>33%</td>
<td>83%</td>
</tr>
<tr>
<td>4</td>
<td>Practical guide for frontline workers</td>
<td>68%</td>
<td>100%</td>
</tr>
<tr>
<td>5</td>
<td>Guidelines for emergency departments</td>
<td>46%</td>
<td>85%</td>
</tr>
<tr>
<td>6</td>
<td>Handbook for Aboriginal alcohol &amp; drug work</td>
<td>44%</td>
<td>85%</td>
</tr>
<tr>
<td>7</td>
<td>Methamphetamine Treatment Guidelines: Practice Guidelines for Health Professionals (Second Edition)</td>
<td>36%</td>
<td>81%</td>
</tr>
<tr>
<td>8</td>
<td>AOD withdrawal practice guidelines</td>
<td>33%</td>
<td>81%</td>
</tr>
<tr>
<td>9</td>
<td>Counselling guidelines: alcohol &amp; drug issues</td>
<td>60%</td>
<td>92%</td>
</tr>
<tr>
<td>10</td>
<td>QLD alcohol &amp; drug withdrawal clinical practice guidelines</td>
<td>27%</td>
<td>89%</td>
</tr>
<tr>
<td>11</td>
<td>Management of substance use during pregnancy, birth &amp; postnatal period</td>
<td>44%</td>
<td>96%</td>
</tr>
<tr>
<td>12</td>
<td>Management of acute presentations related to methamphetamine use: Clinical guideline for adults and adolescents</td>
<td>58%</td>
<td>86%</td>
</tr>
<tr>
<td>No.</td>
<td>Methamphetamine-related Clinical Guideline</td>
<td>Domain Scores</td>
<td>Overall Appraisals</td>
</tr>
<tr>
<td>-----</td>
<td>----------------------------------------------------------------------------------------------------------</td>
<td>---------------</td>
<td>-------------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>13</td>
<td>Psychotherapy … treatment manual &amp; response</td>
<td>59%</td>
<td>94%</td>
</tr>
<tr>
<td>14</td>
<td>QUICKFIX: Identify &amp; Intervene … in primary health care</td>
<td>51%</td>
<td>83%</td>
</tr>
<tr>
<td>15</td>
<td>Acute assessment &amp; management of ATS intoxication &amp; toxicity</td>
<td>29%</td>
<td>83%</td>
</tr>
<tr>
<td>16</td>
<td>Guidelines for general practitioners</td>
<td>41%</td>
<td>85%</td>
</tr>
<tr>
<td>17</td>
<td>AOD withdrawal practice guidelines: acute inpatient &amp; residential services</td>
<td>19%</td>
<td>69%</td>
</tr>
<tr>
<td>18</td>
<td>Fact Sheet: management of stimulant use</td>
<td>13%</td>
<td>46%</td>
</tr>
<tr>
<td>19</td>
<td>Psychostimulant early intervention flow chart</td>
<td>24%</td>
<td>78%</td>
</tr>
<tr>
<td>20</td>
<td>Responding to challenging behaviour</td>
<td>31%</td>
<td>74%</td>
</tr>
<tr>
<td>21</td>
<td>Psychosocial interventions professional practice guidelines</td>
<td>48%</td>
<td>87%</td>
</tr>
<tr>
<td>22</td>
<td>Drug &amp; alcohol withdrawal clinical practice guidelines: NSW</td>
<td>37%</td>
<td>89%</td>
</tr>
<tr>
<td>23</td>
<td>AOD handbook for health professionals</td>
<td>48%</td>
<td>87%</td>
</tr>
<tr>
<td>24</td>
<td>Nursing &amp; midwifery practice: identifying &amp; responding to drug &amp; alcohol issues</td>
<td>32%</td>
<td>78%</td>
</tr>
<tr>
<td>25</td>
<td>CARPA standard treatment manual</td>
<td>37%</td>
<td>80%</td>
</tr>
<tr>
<td>26</td>
<td>Drug &amp; alcohol: management of methamphetamine dependence in pregnancy</td>
<td>18%</td>
<td>76%</td>
</tr>
<tr>
<td>27</td>
<td>Assessment &amp; management of psychostimulant users</td>
<td>24%</td>
<td>67%</td>
</tr>
</tbody>
</table>

* 'Process of development' domain scores excluded in overall appraisal scores.

^ Assessed by only two assessors