Methamphetamine (Ice) Use and Dependence

Disclaimer

Contents

Background **1**
About methamphetamine (ice) use and dependence 1
Assessment **2**
Complexity factors 2
Physical health 2
Mental health 3
Drug use history and risk factors 3
Problem gambling risk 3
Dependent children 4
Management **4**
Acutely agitated, or psychotic patients (intoxicated or affected at the time of visit) 4
Drug and Alcohol Clinical Advisory Service (DACAS) 4
Experimental, recreational, or occupational users (low-to-moderate risk) 4
Regular users and dependent users (moderate-to-high risk) 5
Referral **5**
Information **6**
For health professionals 6
For patients 6
Sources **6**

Background

About methamphetamine (ice) use and dependence

- *Methamphetamine belongs to the psychostimulant class of drugs and is commonly available in a powder or crystal form.*
- *Use of crystal methamphetamine, otherwise known as ice, has become more common due to an increase in purity, availability and affordability. 50.4% of methamphetamine users report ice as main form of the drug used.*[1]
- *Methamphetamine may be swallowed, snorted, smoked, or injected and often is used in conjunction with a range of other drugs.*

- *The occasional user will often use with little risk of harm when harm reduction practices are followed. The risk of harm is increased if users become dependent, with an increase in social isolation and health problems, and can lead to financial and criminal problems.*

Assessment

1. If the patient is displaying marked agitation, overheating, sudden onset of headache, difficulty swallowing, sudden weakness, paralysis, psychosis, or aggressive behaviour, further assessment may be impossible.
2. Establish reason for presentation and consider methamphetamine use in patients presenting for benzodiazepines.
3. Determine risk:
    - Low risk – social user
    - Moderate risk – functional user with one to two ***complexity factors***

Complexity factors

Complexity factor	*Definition*
Poor mental health	▪ *Kessler Psychological Distress Score (K10) ≥ 30, or* • *presence of serious mental health diagnoses e.g., bipolar disorder, schizophrenia, borderline personality disorder*
Lack of meaningful activity	*Unemployed and not studying or performing home duties*
Housing insecurity	*Homeless or at risk of eviction*
Pregnancy	*Pregnant*
Serious criminal justice involvement	*E.g. on a court order or on parole*
Multiple previous AOD treatment episodes	*> 5 AOD treatment episodes (lifetime)*
Children potentially unsafe	*Clinician concern about parenting capacity*
Significant or serious physical health issue	*Serious physical illness (e.g. liver, cardiovascular, respiratory, neurological disease) that significantly impacts on wellbeing and functioning.*

    - High risk – dependent user with ≥ 3 complexity factors

4. If cooperation and rapport is obtained, consider assessing:

- ***Physical health***
- ***Mental health***
- ***Drug use history and risk factors***
- **Problem gambling risk**

Physical health

➢ *Pulse, blood pressure, BGL, oximetry*

- *Respiratory examination*
- *Prescribed medications*
- *Recent sleep patterns*

Mental health

- *Mental state examination*
- *Kessler Psychological Distress Score (K10)*
- *Depression, Anxiety and Stress Scale (DASS21)*
- *Engagement with mental health services*
- *Social circumstances*
- *Readiness to change*

Drug use history and risk factors

- *Type of psychostimulant used e.g., methamphetamine (powder, base, or crystal) amphetamines, cocaine, MDMA, prescription drugs*
- *Amount of psychostimulant used e.g., dosage or cost of dose*
- *Potency of psychostimulant used – ask "how long did it last?", "was it strong?"*
- *Route of administration e.g., intranasal, intravenous, oral, inhalation, rectal*
- *Frequency of use:*
    - *Regular daily use and number of times per day*
    - *Binge pattern e.g., use on several consecutive days followed by abrupt withdrawal*
    - *Recreational*
- *Duration of current use, age of first use, and when last used – required to give an indication of how presentation relates to intoxication or withdrawal, and the pattern of use*
- *Use of other drug classes, particularly alcohol, benzodiazepines, cannabis, and opioids – including criteria above*
- *Associated risks:*
    - *Sexual*
    - *Financial e.g., gambling*
    - *Legal*
    - *Relationships*
    - *Reputation*

Problem gambling risk

Consider problem gambling risk.

5. Consider investigations:
    - LFTs
    - Blood-borne viruses (BBV) serology – HBV, HCV, and HIV
    - STI testing
6. Consider the risks of family violence and the needs of any ***dependent children*** of the patient.

Dependent children

- *Children of parents with mental illness and addiction are a vulnerable group. See factsheet.*
- *Follow mandatory assessment and reporting process for child abuse and neglect.*

Management

Acutely agitated, or psychotic patients (intoxicated or affected at the time of visit)

1. Use a calm approach to de-escalate fear. Many acutely affected patients are calm, rational, and aware they need help.
2. If floridly psychotic patient and at significant risk to self or others, contact the police to arrange transfer to the Emergency Department.
3. If significantly intoxicated and concerned for the patient's well-being, arrange referral to the Emergency Department.
4. If significant psychotic illness, refer for urgent mental health assessment.
5. Consider seeking advice:
   - ***Drug and Alcohol Clinical Advisory Service (DACAS)*** – for clinical advice.

   Drug and Alcohol Clinical Advisory Service (DACAS)

   Free 24-hour addiction medicine specialist advice line for healthcare professionals
   - *Phone:* ***1800-812-804***
   - *Website*

   - Ice Advice Help Line – **1800-ICE-ADVICE**

Experimental, recreational, or occupational users (low-to-moderate risk)

1. Assess motivation to change. Consider asking:
   - What do you know about the effects of methamphetamine?
   - How concerned are you by your methamphetamine use?
   - What are some of the good or bad things about using methamphetamine?
2. Offer hepatitis B vaccination and HCV and HIV serology if indicated.
3. Use ***harm reduction strategies.***

Harm reduction strategies

- *Advise patient to:*
  - *eat before using.*
  - *have water available.*
  - *set limits of how much and for how long to use.*
  - *try a small amount of a new batch first and wait before having more.*
  - *use around people they trust and in a safe place.*
  - *be safe sex ready with condoms and lube.*
  - *have a buddy system – look after each other and keep each other safe.*
  - *plan to not drive.*
  - *know the signs of overdose and call* ***000*** *if worried about someone. Tell the ambulance officers what has been taken and how much.*

- *Provide patient with Local NSP services for provision of sterile injecting equipment.*

4. Manage associated medical conditions e.g., hepatitis B, hepatitis C, STI.
5. Offer to refer all patients for management, counselling, and support via Low risk alcohol and drug treatment assessment.

Regular users and dependent users (moderate-to-high risk)

1. If patient is:
   - motivated to cease their use, advise there are a variety of options available. Many patients can be safely managed in the community with their regular general practitioner.
   - not motivated to cease their use, build motivation to initiate a desire to reduce use by using motivational interviewing techniques and goal setting.

2. If patient has short-term insomnia or anxiety:
   - assist initiation of abstinence by alleviating distressing withdrawal symptoms.
   - consider short courses of ***benzodiazepines*** for no longer than 2 weeks. This can assist in restoring sleep.

   Benzodiazepines

Symptom	*Medication*
Agitation	*Diazepam 5 to 10 mg every 6 to 8 hours for 3 to 7 days*
Insomnia	• *Temazepam 10 to 20 mg at night for 3 to 7 days, or* • *Oxazepam 30 to 60 mg at night for 3 to 7 days*

3. If paranoia or other drug-induced psychotic symptoms are prominent, consider short-term prescription of an anti-psychotic e.g., Olanzapine 10 mg at night (continued for several weeks to months with ongoing monitoring).
4. Educate the patient regarding the possible lengthy withdrawal process with protracted periods of:
   - mood fluctuations
   - irritability
   - sleep disorders.
5. If not at risk to self or others, monitor patient's mood for 2 to 4 weeks after cessation before commencing any antidepressant treatment. Avoid initiating treatment for depression during the withdrawal period as accurate mood assessment is difficult during this time.
6. If injecting or part-taking in risky sexual behaviour, offer hepatitis B vaccination and HCV and HIV serology.
7. Offer referral to alcohol and other drug services to ensure that coping strategies are implemented (alcohol and other drug use may mask trauma and other issues.) The service can further assess the patient and decide whether a detox program is beneficial.
8. If patient refuses to see a drug and alcohol service, recommend psychological therapies, such as cognitive behavioural therapy (CBT), dialectal behavioural therapy (DBT), and motivational approaches.
9. Provide patient information for strategies to cope with cravings.

Referral

- If floridly psychotic patient and at significant risk to self or others, contact the police to arrange transfer to the Emergency Department.

- If significantly intoxicated and concerned for the patient's well-being, arrange referral to the Emergency Department.
- If significant psychotic illness, refer for urgent mental health assessment.
- Offer to refer all patients for management, counselling, and support to either of:
    - Low risk alcohol and drug treatment assessment
    - Moderate to high risk alcohol and drug treatment assessment
- If patient refusing to see a drug and alcohol service, recommend adult psychological therapy and counselling.
- For advice, phone:
    - Drug and Alcohol Clinical Advisory Service (DACAS) for clinical advice.
    - Ice Advice Help Line – **1800-ICE-ADVICE**.

Information

For health professionals

Education

ThinkGP – Active Learning Module and Allied Health Skills: Alcohol and Other Drugs and Sexual Health in Young People

Further information

- Australian Family Physician – Motivational Interviewing Techniques
- National Drug Strategy – Treatment Approaches for Users of Methamphetamine: A Practical Guide for Frontline Workers

For patients

- BreakThrough
- Ice Advice Help Line – 1800-ICE-ADVICE

Sources

References

1. Australian Institute of Health and Welfare (AIHW). National Drug Strategy Household Survey detailed report: 2013. Canberra: AIHW; 2014. p. 1-161.

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