TREATMENT APPROACHES FOR USERS OF **METHAMPHETAMINE**

a practical guide for frontline workers

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Contents

Introduction

Stimulants such as amphetamine have been used by some people in Australia for many years. However, a more potent form, methamphetamine, has come to dominate the illicit stimulant market over the past decade. Because of its potency, many users have experienced a range of significant physical and psychological health problems.

Alcohol and other drug (AOD) workers from a variety of service settings are now frequently required to respond to methamphetamine users who are experiencing the harmful effects of methamphetamine, going through withdrawal or seeking methamphetamine-specific treatment.

Clinical treatment guidelines that provide a step-by-step guide to structured counselling are available for trained AOD workers such as *A Brief Cognitive Behavioural Intervention for Regular Amphetamine Users* (Baker et al 2003) and *Clinical Treatment Guidelines for Alcohol and Drug Clinicians. No 14: Methamphetamine Dependence and Treatment* (Lee et al, 2007). However, the Australian Government Department of Health and Ageing recognises that clear and up-to-date information is required by all AOD workers, not just those with a clinical or professional background; hence, this publication has been developed to bridge an identified gap in available resources.

The guide is based on recent research, national and international guidelines, and expert opinion. Because a comprehensive review of the research literature was undertaken for the Commonwealth Monograph *Models of Intervention and Care for Psychostimulant Users* (Baker et al 2004) and published in 2004, the literature from 2003 to the present was reviewed for this guide. Databases including PubMed and PsychInfo were used to find studies on relevant topics. Guidelines from Australia and overseas were also consulted and form the basis for a range of topics.

The signs of methamphetamine overdose are now well recognised and frontline workers are advised to familiarise themselves with the emergency management techniques detailed in Chapter 4 *Recognising and managing overdose*.

Best practice in methamphetamine treatment involves a clear, mutually acceptable treatment plan that is designed to meet the needs of the individual. Early engagement, good communication and the development of a strong helping relationship between the worker and service user or client are important to attract methamphetamine users into treatment and to keep them engaged.

Numerous high-quality studies have suggested that psychosocial treatments, especially cognitive behaviour therapy (CBT), should be a standard intervention in methamphetamine treatment. CBT also assists with mental health problems, such as depression and anxiety, which are common among methamphetamine users.

Dependent psychostimulant users experience withdrawal symptoms when they stop using the drug. Although we do not know a lot specifically about methamphetamine withdrawal yet, evidence suggests that, for mild cases of withdrawal, medication is not usually required and most symptoms resolve within two weeks. In contrast, users with more severe dependence might go on to have a longer and more intense withdrawal, and need targeted ongoing support.

In circumstances where a methamphetamine user does not wish to stop using the drug, harm reduction interventions are recommended and a range of suggestions are offered in the guide.

Finally, where research evidence is lacking regarding issues such as methamphetamine use among young people and those from culturally and linguistically diverse backgrounds, the Indigenous community and pregnant women, advice based on good practice and expert opinion is included to provide a starting point to guide workers' responses.

Summary of important points from each chapter

Chapter 1: About methamphetamine (p.13)

- Methamphetamine is a strong **stimulant** that comes in various forms such as 'ice' (a potent, crystal form that can be smoked or injected), base (an oily powder or paste that can be injected), powder ('speed' or 'louie' that can be injected or 'snorted' into the nasal passage) and tablets that are usually swallowed.
- All methamphetamine forms quickly raise and sustain levels of the brain's chemical messengers (**neurotransmitters**), particularly **dopamine**, which is responsible for memory, attention, purposeful behaviour and pleasurable feelings.
- Over time, neurotransmitters become depleted, leading to poor concentration, low mood, lethargy and fatigue, sleep disturbances and lack of motivation.

Chapter 2: Effects, risks and harms, and how these can be reduced (p.19)

- Although there is variation between individuals, **short-term effects** include euphoria, alertness, increased confidence and wakefulness. Higher doses can cause agitation, sweating, tremors, irritability, teeth grinding, anxiety or panic, paranoia and hallucinations (seeing or hearing things that others cannot).
- **Longer-term effects** of regular use can include weight loss; dehydration; poor appetite or malnutrition; kidney problems; mood swings including depression; anxiety; paranoia; chronic sleep disturbance; changes in brain structure and function leading to memory, thinking, and emotional disturbances; disrupted decision making ability; grossly impaired contact with reality (psychosis); and dependence on methamphetamine.
- Due to the high potency of crystal methamphetamine, smoking and injecting ice can rapidly lead to **dependence** in some users.

- **Risks of use** include vein infections from injecting; blood-borne virus (BBV) transmission; heart infection (endocarditis); heart attack; brain haemorrhage; lung and skin infections; poor oral health including tooth decay and gum disease; poor nutrition; psychosis and other mental health problems; and social, occupational and legal problems.
- **Harm reduction approaches** include good diet; regular fluids; adequate rest; regular breaks from using; good oral hygiene (brush and floss regularly); contact with supportive and stable friends and family; education about effects, signs of overdose and psychosis; and advice to seek professional help if psychotic symptoms emerge.
- **Pregnant** methamphetamine users should receive regular antenatal care to reduce risks and to improve outcomes for both mother and baby. Even if psychostimulants have been used in the earlier stages of pregnancy, there are possible benefits of reducing or ceasing use in the later stages. Pregnant users should avoid use of other drugs, such as alcohol and tobacco.

Chapter 3: Recognising and managing intoxication (p.25)

- **Signs of methamphetamine intoxication** can include rapid or difficult-to-interrupt speech; restlessness or agitation; jaw clenching and teeth grinding; sweatiness; large pupils; irritability.
- **An appropriate response** involves sound communication skills; prompt response to a service user's needs; avoidance of lengthy questioning; provision of written materials for later reference; opportunistic brief interventions if possible; and the maintenance of a calm, safe, supportive and helpful environment.
- Do not attempt to interview or counsel an intoxicated client, offer another appointment if required.

Chapter 4: Recognising and managing overdose (p.27)

- Methamphetamine **overdose** (toxicity) is a medical emergency.
- Signs of **toxicity** include hot, flushed or very sweaty skin, which may indicate high fever or overheating; severe headache; chest pain; changes in consciousness; muscle tremor, spasm or fierce jerky movements; severe agitation or panic; difficulty breathing; changes in mental state (eg confusion, disorientation); seizures (fits); and symptoms of psychosis can also occur.
- First aid includes **calling an ambulance immediately** even if unsure of cause; providing a non-stimulating and safe environment; making sure the person can breathe; cooling the body (loosen restrictive clothing, use ice

packs); removal of dangerous objects if the person has a seizure; continual reassurance and waiting with the person until the ambulance arrives.

Chapter 5: Recognising and responding to a person with mental health problems (p.29)

- Methamphetamine users can experience **mental health problems** such as depression, anxiety or psychosis. Symptoms often resolve when the user cuts down or stops using, but some people experience longer-lasting symptoms.
- **Symptoms of psychosis** may be low-grade or 'subacute' and can include: deterioration in general functioning in day-to-day life; expression of unusual thoughts or ideas, strange, inappropriate or out-of-character conversational style; fear or paranoia; a sense of self, others or the world being different or changed in some way; suspiciousness or constant checking for threats in an exaggerated way; over-valued ideas (ordinary events have special significance or are more meaningful than usual); illusions (misinterpretation of surroundings); and erratic behaviour.
- Psychosis in its acute form describes a disorder in which a person's contact with reality is grossly impaired. Symptoms include hallucinations (hearing, seeing or feeling things that other people cannot); delusions (fixed, false beliefs); disordered thought processes; disturbance in mood; and strange, disorganised or bizarre behaviour.
- Methamphetamine can cause a psychotic episode in healthy people with no previous history of mental health problems. It can also trigger a mental health problem such as schizophrenia in vulnerable people, which will endure even after they stop using the drug (for a diagnosis of schizophrenia at least one obvious psychotic symptom must persist for longer than a month in the absence of drug use or withdrawal).
- Psychosis is more likely among dependent methamphetamine users, injectors, and those with other health problems.
- Many people will spontaneously recover from psychosis within hours, as the effects of the drug wear off, while some will go on to experience symptoms for some time.
- **Immediate management of psychosis** includes reducing risk to the person, other workers and bystanders; a calming environment; effective communication (eg never argue, calm voice, repetition of key messages); calling an ambulance to facilitate an emergency assessment if the person remains acutely disturbed; or calling police if risk of harm to self or others is high.

- **Longer-term management of psychosis** includes interventions aimed at discontinued use; education regarding sensitivity to future psychotic episodes; lifestyle management; and harm reduction strategies for those who do not want to stop using (eg regular breaks from using; advice not to use more than small amounts; avoidance of use of multiple drugs; and early intervention should symptoms recur).
- **Depression** commonly occurs among methamphetamine users. Symptoms of depression (eg withdrawal from social contact; negative thoughts; feelings of sadness, guilt, pessimism; changes in appetite, libido and energy) may persist for weeks, months or in some cases even several years after stopping methamphetamine use.
- Workers and clients should regularly review symptoms of depression and seek specialist help if symptoms worsen, especially if suicidal thoughts occur.
- A depressed person might be at high risk for suicide if he or she has tried before; has a clear and lethal plan with the means to carry it out; has a lot of stressors; feels hopeless; has psychotic symptoms; continues to use alcohol and other drugs; or has few or no social supports.
- Clients considered to be at high risk should have an urgent and thorough specialist assessment by mental health services. Workers should keep the contact number for emergency mental health services on hand and refer appropriately.
- **Anxiety** can occur in many forms and usually involves excessive worry. Other features of anxiety can include agitation; racing heart; sweatiness; difficulty breathing; tightness in the chest or chest pain; fear or panic; and sleep disturbance.
- Anxiety symptoms often subside when the drug is no longer used, but if symptoms persist after stopping, a mental health specialist should assess the client. Cognitive behaviour therapy is an effective intervention for anxiety disorders.
- Anxious clients should be provided with a low-stimulus environment and encouraged to take slow, deep, calming breaths. Other relaxation strategies include tensing and relaxing all the large muscle groups in the body; and actively imagining a peaceful, safe place of the client's own choosing.
- Workers should keep the contact numbers for both emergency and non-emergency mental health services on hand at all times and familiarise themselves with procedures for appropriate referral or consultation.

Chapter 6: Helping a person get through withdrawal (p.43)

- Many **recreational users** will experience a 'crash' period after they stop using, which lasts a few days. During this time, they often sleep and eat a lot, can become irritable, and might feel 'flat', tired and lethargic or generally out of sorts. They usually do not require specialist assistance during this 'coming down' period.
- Some **dependent users**, however, will experience full-scale methamphetamine withdrawal, which often lasts for about a week or two. For some people, certain symptoms, such as depression, can linger for several weeks, months or even longer.
- During **withdrawal**, a person can feel depressed; irritable or anxious; be agitated; have difficulty sleeping; be unable to experience pleasure; have poor concentration and memory; have aches and pains; and strong cravings to use methamphetamine.
- Support includes written materials and education about typical length of withdrawal and common symptoms; the need for self-monitoring symptoms of depression and intervention if severe; management of cravings; relapse prevention; and relevant referral to a general practitioner for medical support if insomnia, symptoms of anxiety or depression linger or place the client at risk of relapse.

Chapter 7: Use of other drugs and possible effects of mixing drugs (p.47)

- Use of **multiple drugs** with methamphetamine, particularly **alcohol**, **nicotine**, **cannabis**, **heroin** and **benzodiazepines**, is common.
- Dangerous effects can result when medications for depression (antidepressants) are taken within two weeks of using methamphetamine and can include overheating, high blood pressure, and seizures (serotonin toxicity).
- **Heroin** used in conjunction with methamphetamine increases risk of heroin overdose.
- Methamphetamine can stop people from feeling drunk after drinking alcohol, even when blood alcohol levels are high. Therefore, the risk of accident and injury is increased, as is the potential for driving while intoxicated. Clients with problems related to the use of alcohol need targeted interventions.

- Methamphetamine can also stop people from feeling the full effects of benzodiazepines, leading to increased risk of accident and injury. There is also the potential to take large quantities of benzodiazepine, which increases risk of dependence and subsequent withdrawal. Some people can experience withdrawal symptoms if benzodiazepines are stopped abruptly after just one month. Signs of benzodiazepine withdrawal include sensitivity to loud noises/light/touch; feelings of unreality; numbness; anxiety, fear of open spaces (agoraphobia) and panic states; metallic taste in the mouth; pain, stiffness and muscular spasms resulting in headaches and muscle twitching; and seizures.
- Methamphetamine reduces the effectiveness of **antipsychotic medication** and increases risk of seizures.
- Users should be informed of the potential for harmful effects of mixing methamphetamine and medications and advised to **seek advice from the prescribing doctor**.

Chapter 8: Overview of the range of treatment options (p.53)

- Approaches to methamphetamine users should be individually tailored and match each client's goals for treatment.
- **Cognitive behaviour therapy** has been evaluated most extensively and is effective for a range of problems related to methamphetamine use, including mental health problems such as depression and anxiety. Medicare pays for up to 12 sessions of counselling by a registered psychologist if a general practitioner refers clients.
- Other approaches include brief interventions; counselling (eg narrative therapy, solution-focused therapy); residential rehabilitation; self-help groups; and behavioural therapy.
- Assessments should be offered in the context of a safe, reassuring, supportive, nonjudgemental environment to enhance a client's engagement with the service. In the early stages, this may be more important than the specific drug treatment.
- No medications have yet proven to be more effective than others in treatment (eg for withdrawal or to prevent relapse). However, research is continuing into several medications including dexamphetamine and modafinil. Following a specialist assessment, the appropriate prescription of medications to treat mental health and medical problems is strongly recommended.

- **Young people** can benefit from a thorough assessment of factors such as leisure and social functioning; family relationships; peer interactions; hobbies; and educational history. Intensity of treatment should be matched to the severity of problematic methamphetamine use. Treatment approaches should be youth friendly and include easy access, drop-in capability, follow-up, collaboration between service providers and family therapy.
- Workers should be sensitive to the cultural and social needs of **Indigenous** clients and those from **culturally and linguistically diverse (CALD)** backgrounds. Considerations include the provision of culturally appropriate information including media other than print (eg art or video); role of family in the client's life; need for translation services; outreach service and case management; and culturally appropriate harm reduction messages.
- Services should respond promptly to all clients' requests for help; provide support and assistance with immediate concerns before offering targeted interventions for methamphetamine use; have information readily available; attempt to address a range of user's needs; and actively assist clients to access other services as required.

Chapter 9: Assisting families, carers and significant others (p.71)

- Disruption to **family and other relationships** is common in the context of methamphetamine use.
- Families should be encouraged to access support for their own needs (eg mutual support groups; telephone support and advice; educational materials) and ensure that they continue to live their own lives while they continue to care for their family member.
- Families should be provided with information on how methamphetamine works including the range of possible effects. This should include information about the 'crash' period and withdrawal symptoms, how regular methamphetamine use can adversely affect a person's mood, concentration, and decision-making abilities, and the risks of dependence and psychosis.
- Families require assistance with developing an emergency plan should serious consequences such as hostility or violence, or psychosis arise (see Appendix 2, *Example family emergency plan*).
- Methamphetamine use can sometimes affect the ability to parent, so others might take on the role of caring for a client's children until he or she is better equipped to do so. In this case carers should be encouraged to access ongoing support and practical assistance (eg financial support).

- **Young carers** should also be encouraged to pay attention to their own lives and pursue interests appropriate to their age. They should be encouraged to seek support from appropriate sources (eg school counsellor, teacher, trusted relative, kids help line, or dedicated websites such as http://www.youngcarers.net.au), and to develop an emergency plan (see Appendix 3, *Example young carer's emergency plan*).

Chapter 10: Legal issues (p.79)

- **Interventions** tend to be as effective for people who are pressured to enter treatment (coerced clients) as for those who seek help voluntarily.
- **Coercion** can be formal (eg court ordered) or informal (pressure from a spouse or family).
- Clients who have been formally coerced into treatment should be informed of which agencies and under what circumstances workers are legally obliged to disclose information regarding the client's progress without his or her consent.
- Informally coerced clients should give consent before any information about their progress can be shared with their spouse, family member or significant other.
- **Mandatory reporting** describes legislation that requires some workers to report all cases of suspected or confirmed child abuse and neglect. As legislation varies across each state and territory, workers have a duty to be familiar with mandatory reporting requirements in their own state or territory.
- Although there is a perception that all methamphetamine users are violent, this is not the case. Rates of violent crime, although higher than the general population, tend to be restricted to methamphetamine-dependent, multiple-drugs users with a history of violence. Violence, when it does occur, usually happens when people are paranoid or psychotic. Therefore, hostility and violence is often time-limited, and tends to occur only when symptoms are acute.

Chapter 11: Making links and creating partnerships (p.83)

- **Service partnerships** can help facilitate timely, appropriate and targeted responses to a client's needs, minimise access barriers for clients, and ultimately improve client outcomes.
- Services should identify appropriate or helpful agencies for potential partnerships; decide on the level of cooperation or collaboration that would be useful; initiate contact; agree on a desired outcome for cooperation; ensure regular liaison, prompt responses, support, and ongoing education for partner agencies; and evaluate the effectiveness of partnerships.
- Staff members should learn and use **appropriate terminology** when referring a client to other agencies, particularly mental health services and general practitioners.
- **Referral** can be improved by ensuring that workers address the client's pressing needs first, before suggesting referral to another agency for assistance with less important matters; enhancing awareness of other useful agencies or services including location, hours of opening, cost, who is eligible for assistance, and waiting times for service; understanding the needs of the client (eg financial resources; access to transport; requirement for child care; cultural and social issues; level of ability to advocate for self; literacy level; mental health concerns) prior to making a referral; and matching referral to a client's need.

1
About methamphetamine

What is methamphetamine?

Methamphetamine is a synthetic substance that can come in various forms:

- crystalline ('ice', 'crystal', 'crystal meth', 'shabu', 'glass')
- oily powder or paste ('base')
- coarse or fine powder ('speed', 'louie')
- tablet ('pills')
- oil (base) is the least commonly available form, but it is the purest form that is converted by manufacturers into the other forms; base is stronger than powder forms and nonadulterated crystal is estimated to be about 80% pure.

The chemical structure is similar to amphetamine, but methamphetamine tends to be more potent than amphetamine sulphate and amphetamine hydrochloride (also called 'speed'), which were typically used before the mid-1990s. The stimulant effects of methamphetamine can last from 7 to 24 hours or even longer, depending on the form used (for photographs of methamphetamine forms see the fact sheets at http://ndarc.med.unsw.edu.au).

Methamphetamine can also be mixed with a range of other substances or drugs. For example, methamphetamine is sometimes mixed with ketamine, a powerful anaesthetic, to form a tablet that is then commonly sold to users as *ecstasy* (for information on ecstasy, see http://www.druginfo.adf.org.au/article.asp?ContentID = ecstasy).

How many people use methamphetamine?

Every three years, the Australian Government undertakes a study in which a representative sample of Australians, aged 14 years and over, is asked about

their use of drugs. This survey is known as the National Drug Strategy Household Survey. In 2007:

- meth/amphetamine had been used at some time in the life of 6.3% of those surveyed
- the highest proportion of recent meth/amphetamine users were those in the 20–29-year age group (9% males and 4.8% females)
- two-thirds of injecting drug users identified meth/amphetamine as the drug injected most recently, compared with heroin at 39.7%.

How and why people use methamphetamine

People use methamphetamine for different reasons and in a variety of patterns:

- Experimental — many people, often adolescents and young people, try a range of drugs once or twice out of curiosity.
- Instrumental — some people use methamphetamine for specific purposes, for example, to stay awake (eg long-distance truck drivers), improve concentration (eg students), reduce weight and enhance endurance (eg for sporting events), or boost energy for a range of other activities.
- Recreational — some people use occasionally, for enjoyment or socialising, at private parties, clubs or dance parties.
- Binge — others use moderate to high doses in an on–off pattern.
- Regular — some people use weekly, several times weekly or daily. Regular users are more likely to be dependent on methamphetamine and have problems with their mental health.

The way that people take methamphetamine generally depends on the form used:

- Powder is often 'snorted' into the nasal passage.
- Ice is often smoked by heating the crystal in a pipe until it is vaporised or by mixing it with cannabis and smoking it ('snow cone').
- Ice and base can also be injected or swallowed (known as 'bombing').
- Smoking methamphetamine, although considered less harmful than injecting by some users, has high potential to lead to dependence due to the rapid onset of euphoria (a strong feeling of wellbeing or elation) and subsequent intense cravings for more of the drug. It is also difficult for smokers to know how much they have used, which can lead to toxic (poisonous) effects.
- Bombing and snorting are common among experimental and recreational users; injecting is typically associated with regular users, and both recreational and regular users smoke methamphetamine.

- Methamphetamine powder is typically purchased by gram or half-gram weights, whereas ice and base are usually bought in a much smaller amount, known as a 'point' or one-tenth of a gram, because of their high potency.

People rarely use methamphetamine exclusively, and the use of multiple drugs, known as polydrug use, is common (see Chapter 7, *Use of other drugs and possible effects of mixing drugs*).

How does methamphetamine work?

The way methamphetamine works is complex, but it is extremely important for workers to understand how this drug works in the body so they can help inform their clients. Understanding the mechanism of methamphetamine's actions, the short- and long-term effects of methamphetamine use, and the impact on a person's mental health helps the worker understand the user's behaviour and treatment options. The end of this section contains a suggested plain language explanation that can be used by workers to help clients better understand the effects of methamphetamine.

Information for workers

Methamphetamine disrupts the brain's chemical messengers known as 'neurotransmitters'. The main neurotransmitters involved are *dopamine, noradrenaline* and *serotonin,* which have a broad range of important functions.

Dopamine controls movement, attention and memory, and purposeful behaviour. It is the main neurotransmitter involved in feelings of pleasure and euphoria when a person engages in activities that are essential for human survival, such as eating, drinking, and sexual activity. Dopamine encourages these behaviours by making people feel good so they are motivated to repeat them. This system is referred to as the 'reward pathway' and, because dopamine is also linked to cravings to use all drugs, it is thought to be involved in the development and maintenance of drug dependence in general.

Noradrenaline is involved primarily in preparing individuals to either run away from, or stand and fight against, perceived threats ('fight or flight' response): it stimulates the central nervous system, and is involved in heart function and blood circulation, concentration, attention, learning and memory.

Serotonin is involved in a variety of important activities including control of mood; appetite; sleep; thinking and perception; physical movement; regulation of temperature, blood pressure and pain; and sexual behaviour.

Short-term use

Methamphetamine quickly and substantially raises the levels of these neurotransmitters and stops them from being cleared (known as 're-uptake'), so their levels remain high for a much longer time than usual. (Selective serotonin reuptake inhibitor [SSRI] antidepressants also work in this way, but this is beneficial in depressed people who have low levels of these transmitters without treatment.) Methamphetamine causes the brain cells to be awash with dopamine, which markedly accelerates the normal bodily processes. A person will be alert and energetic, and have an intense feeling of wellbeing (euphoria). The euphoria is usually much more intense and lasts longer than that felt from natural survival behaviours. For example, in animal studies, dopamine level increases by around 50% after eating, but increases tenfold after administration of methamphetamine (see Chapter 2, *Effects, risks and harms, and how these can be reduced*).

After a while, stores of these neurotransmitters peter out, and the levels drop from too high to too low, like overdrawing a savings account. When the level is low, a person can experience a range of symptoms of varying intensity that are mostly the opposite to those of intoxication: low mood, lethargy and fatigue, poor concentration, disturbed sleep, increased appetite, and lack of motivation for daily tasks. It takes some time for the neurotransmitters to be replenished (adequate diet, rest and avoidance of methamphetamine are critical for this), during which time the person might continue to feel out of sorts and have difficulty taking pleasure in normal activities. Recovery or 'coming down' from short-term or binge exposure might take the person a couple of days to a week (see Chapter 6, *Helping a person get through withdrawal*).

Long-term use

Both animal and human studies have shown that long-term exposure to heavy methamphetamine use leads to both short-term neurotransmitter depletion and changes in brain structure and function. To reduce overexposure to neurotransmitters, particularly dopamine, the body responds by reducing both the number of receptors (receivers) and transporters (carriers) of these neurotransmitters in certain parts of the brain. In addition, brain cells themselves can be killed (neurotoxicity) as they struggle to break down excess dopamine. The result is chronic dopamine *underactivity*, resulting in damage to memory, concentration, decision-making, impulse control, and emotional balance.

The recovery period after long-term use, during which complete avoidance of methamphetamine should be maintained, can take many months or even years. Some researchers believe that certain individuals, particularly long-term regular users who began using methamphetamine at an early age, may never recover completely (see Chapter 2, *Effects, risks and harms, and how these can be reduced*).

Information for clients

The following explanation could be helpful for some clients. Workers could also use visual images or drawings to aid understanding:

> Methamphetamine causes the brain to release a huge amount of certain chemical messengers, which, as you probably know, make people feel alert, confident, social, and generally great. Some of these messengers help us to respond to threats by preparing us to either fight or run away, so they increase energy, keep us awake, stop hunger and raise blood pressure and heart rate.
>
> The problem is that there are only so many of these messengers stored at any one time. Think of a glass full of 'happy' messengers, so when people have been using methamphetamine for a while, the glass empties and no matter how much methamphetamine they use, they just can't get the 'rush' they want and will still feel awful. There are just too few messengers left to tell the brain to feel good. It's like overdrawing a bank account — no matter how many times you go back to the bank, the balance is still zero until a deposit is made.
>
> It takes rest, a good diet, and most of all TIME for the glass to become full again. During this period, people can feel flat, moody, irritable, forgetful, and restless, but exhausted, which is opposite to the feelings people have while using. This is when people often get strong cravings to use methamphetamine because these cravings are caused by the same brain chemical messengers, which are being produced, but in only small amounts.
>
> Researchers think that, after using methamphetamine regularly over several years, some people experience a long-term or chronic lack of these 'happy' messengers, which can cause people to feel moody, have trouble concentrating and making decisions, and either lack motivation to do usual things or behave in reckless ways. This can sometimes last for months or even a year or two.
>
> The main issues in treatment are to make sure that your mood doesn't get too low; improve your general health by eating a good diet and getting plenty of rest; manage cravings; and take things day by day so you don't get frustrated with your progress and go back to using.

References Chapter 1: About methamphetamine

Australian Institute of Health and Welfare (2008). *2007 National Drug Strategy Household Survey: First Results*. Drug Statistics Series number 20. Cat. no. PHE 98. AIWH, Canberra.

Davidson C, Gow AJ, Leea TH and Ellinwood EH (2001). Methamphetamine neurotoxicity: necrotic and apoptotic mechanisms and relevance to human abuse and treatment. *Brain Research Reviews* 36:1–22.

Dean A (2004). Pharmacology of Psychostimulants In *Models of Intervention and Care for Psychostimulant Users*, 2nd edition, Baker A, Lee N and Jenner L (eds), Commonwealth of Australia Monograph Series, 35–50. Australian Government Department of Health and Ageing, Canberra.

Dolan K, MacDonald M, Silins E and Topp L (2005). *Needle and Syringe Programs: A Review of the Evidence*. Australian Government Department of Health and Ageing, Canberra.

Jenner L and McKetin R (2004). Prevalence and patterns of psychostimulant use, In *Models of Intervention and Care for Psychostimulant Users*, 2nd edition, Baker A, Lee N and Jenner L (eds), Commonwealth of Australia Monograph Series, 13–34. Australian Government Department of Health and Ageing, Canberra.

Lee N, Johns L, Jenkinson R, Johnston J, Connolly K, Hall K and Cash R (2007). *Clinical Treatment Guidelines for Alcohol and Drug Clinicians. No 14: Methamphetamine Dependence and Treatment*. Turning Point Alcohol and Drug Centre Inc, Fitzroy.

McKetin R, McLaren J and Kelly E (2005). *The Sydney Methamphetamine Market: Patterns of Supply, Use, Personal Harms and Social Consequences*, National Drug and Alcohol Research Centre, Sydney.

National Drug and Alcohol Research Centre (2006). *Methamphetamine: Forms and Use Patterns* http://ndarc.med.unsw.edu.au/NDARCWeb.nsf/resources/NDLERF_Methamphetamine/$file/NDLERF+ICE+FORMS+AND+USE.pdf (Accessed May 2008).

Volkow ND and Li TK (2004). Drug addiction: the neurobiology of behaviour gone awry. *Nature Reviews Neuroscience* 5:963–970. http://www.nature.com/reviews/neuro doi:10.1038/nrn1539 (Accessed January 2008).

2
Effects, risks and harms, and how these can be reduced

What are the short-term effects?

The effects of methamphetamine depend upon a range of factors including the quality and purity of the drug; amount used; how it is used; the person's tolerance to methamphetamine (eg new or regular user); where it is used (eg crowded, hot dance party or person's home); and the person's general physical and mental health. Although there is individual variation in the effects of the drug, the following points serve as a guide:

During intoxication

During *intoxication*, the person usually feels a sense of wellbeing or euphoria and is alert, energetic, wakeful, extremely confident — sometimes invincible— with a sense of heightened awareness and increased concentration. Libido (sex drive) and blood pressure often increase. The person may be talkative and fidgety or restless, and will have large (dilated) pupils. Appetite is reduced. Wakefulness varies, but might continue for 12 hours or more.

At higher doses

At *higher doses*, the person might experience tremors, anxiety, sweating, palpitations (racing heart), dizziness, tension, irritability, confusion, teeth grinding, jaw clenching, increased respirations (breathing); auditory (hearing), visual or tactile (touch) illusions; paranoia and panic state; loss of behavioural control; or aggression.

In overdose

In *overdose* (toxicity), the person can experience intense paranoia involving hallucinations (hearing or seeing things that are not there) and delusions (eg having a fixed false belief often that people or things mean the person harm). The person can also experience chest pain and shortness of breath; severe headache; tremors; hot and cold flushes; dangerously increased body temperature; muscle spasms; brain haemorrhage; heart attack; or seizures (fits) (see Chapter 4: *Recognising and managing overdose*).

What are the long-term effects?

Long-term use of methamphetamine can result in a number of physical and psychological effects, which are often related to poor diet, lack of sleep, dehydration and ongoing (chronic) neurotransmitter disruption including:

- weight loss and dehydration relating to poor nutrition or malnutrition; irregular or absent menstrual periods; renal (kidney) problems caused by the lack of adequate fluid intake; chronic sleeping problems; and probable methamphetamine dependence
- extreme mood swings including depression and possibly suicidal feelings; anxiety; paranoia; and psychotic symptoms including hallucinations and delusions (see Chapter 5: *Identifying and responding to a person with mental health problems*)
- cognitive (thinking) changes including memory loss, difficulty concentrating, and impaired decision-making abilities.

What are the other risks and harms?

Users of methamphetamine are at risk for a range of other potential harms including:

- blood-borne viruses (BBV), including hepatitis B and C and human immunodeficiency virus (HIV) from sharing injection equipment
- infections and damage to veins (cellulitis)
- heart problems such as irregular heart beat, weakened heart muscle (cardiomyopathy), bacterial infections of the lining of the heart (endocarditis), and heart attack (myocardial infarction)
- burst blood vessels in the brain (stroke, ruptured aneurysm, brain haemorrhage)
- shortness of breath and dizziness in smokers of ice
- sexually transmitted diseases including HIV and syphilis linked to sexual risk taking
- poor oral health such as gum inflammation (gingivitis) and cavities caused by methamphetamine-induced dry mouth, and damaged teeth due to grinding and jaw clenching
- feelings that 'bugs' are crawling under the skin (tactile hallucinations)
- compulsive skin picking and scratching, particularly on the face and arms, which can increase vulnerability to skin and other infections
- family and other relationship breakdown; financial problems; loss of employment; and legal problems related to drug driving, dealing, or engaging in other crimes to support continued use.

How can the risks and harms be reduced?

A harm reduction approach should be taken with all methamphetamine users who intend to continue to use and will not consider stopping.

Users come to services with a wealth of knowledge about drug use already, so it is important for workers to ask what clients already know and what they would like to know so harm reduction advice can be tailored, appropriate and engaging.

As well as the usual safer injecting and safer sexual practices advice, which is freely available in a wide range of resources, some harm reduction strategies specifically for users of methamphetamine have been recommended (see http://www.aivl.org.au or http://www.hepatitisc.org.au) or contact the local alcohol and drug information service.

Workers should encourage clients to do the following.

Eat and drink enough

- Drink plenty of water — keep a water bottle handy and take frequent sips because people tend to forget to drink when they are intoxicated and on the go, and can easily become dehydrated.
- Eat a balanced diet including dairy products, meat and fish (or non-animal protein for vegetarians), fruit, vegetables, rice, grains, nuts, etc. Workers can help by checking a client's weight regularly.
- Drink milk, high protein drinks, shakes or fruit smoothies if solid food cannot be tolerated. (*You wouldn't run a long distance marathon without eating or drinking so you need to put some fuel into your body.*)

Rest sufficiently

- Get adequate rest. (*Going more than two nights without sleep isn't good for anyone.*) Encourage regular users to have regular non-using days each week, or plan a 'crash' period when they can rest and sleep undisturbed for several days to 'come down'.
- Get into regular patterns of eating, drinking and resting as detailed above. Even if users do not feel hungry, a little food and good hydration helps.

Understand the actions and effects of methamphetamine

- Understand how methamphetamine works (see Chapter 1 *About methamphetamine*).
- Be clear about individual signs and symptoms of psychosis. If psychotic symptoms are experienced, take a total break from using methamphetamine and seek professional help from the person's GP, local emergency department, or local mental health service (see Chapter 5, Recognising and responding to a

person with mental health problems).

- Call on friends or family who are stable supports in the person's life if he or she is feeling scared, paranoid or panicky. Support people can often help the client calm down or can call for specialist help if needed. Users could make an emergency plan and have names and numbers of support people handy.
- Be clear about signs and symptoms and overdose including advice to call an ambulance immediately if overdose occurs (see Chapter 4, *Recognising and managing overdose*).

Attend to other health and lifestyle issues

- Brush and floss teeth regularly, and chew sugar-free gum to increase saliva and to take some pressure off the enamel if teeth grinding is a problem. Dental health can suffer due to a lack of bacteria-fighting saliva in the mouth.
- Plan for the week ahead and make sure that the person does not use (or be in the middle of 'coming down') just before an important event or commitment (workers might need to assist clients to brainstorm alternatives to using). This will help to keep life a little more on track.
- Consider if the person is doing things that they would not normally do to buy methamphetamines. Sometimes a person does not realise that his or her life is out of control, and a client's own moral compass is a good indicator.
- Avoid discussing sensitive topics or making important decisions if partners are coming down together. Social or romantic relationships can suffer when people are feeling irritable, so encourage partners to be patient with each other.
- Avoid driving when intoxicated or 'coming down', particularly if alcohol has also been consumed.

What about pregnancy?

Workers in the drug and alcohol field are sometimes asked for advice about drug use during pregnancy. There is only limited evidence about the specific effects of methamphetamine on the developing foetus in humans, and most evidence comes from animal studies or is derived from studies on cocaine or 'crack' use.

The most important thing for a pregnant woman is to have regular, supportive antenatal care, which improves outcomes for both the mother and baby. The specialists in the antenatal team can assess each woman and offer individual advice and guidance throughout the pregnancy. It is not uncommon for women to be reluctant to disclose drug use, as they often fear criticism, or dread having the baby removed from their care. However, antenatal teams focus on the best interests of the mother and child, and play a crucial role in improving the likelihood of a healthy pregnancy.

Workers can assist a pregnant user by establishing strong networks and collaborating with specialist antenatal teams who see mothers at risk for complications. Antenatal teams can be contacted through the local hospital. (See Chapter 11, *Making links and creating partnerships* for advice about networking).

Workers could encourage pregnant clients to talk to other mothers who have had a good or positive experience with a local antenatal team to relieve the client's fears.

If the mother declines antenatal support and workers are concerned about the welfare of the baby or other children in the mother's care, workers should consider the role of child protective services. Workers should refer to the guidelines for mandatory reporting and seek advice from a supervisor if in doubt (see Chapter 10 *Legal issues*).

Concerns about foetal development in babies of methamphetamine users

Based on limited research, some of the concerns for pregnant methamphetamine users include the risk:

- that methamphetamine use will affect organ development during the early weeks of the pregnancy, which can cause for example, cleft pallet or heart defects
- that the foetus will not receive the oxygen and nutrients essential for normal growth and development, including brain development (eg risk of premature birth, low birth weight or subtle brain changes)
- of foetal toxicity in the third trimester (weeks 24 to birth) because it takes the developing foetus nearly twice as long as the mother to clear drugs from its system, placing the baby at significant risk for methamphetamine withdrawal after birth
- of other health-related issues linked to the mother's lifestyle such as inadequate rest, nutrition, and hydration; cigarette smoking and use of other drugs including alcohol (which puts the baby at risk for foetal alcohol syndrome[1]); increased maternal blood pressure; exposure to impurities in street methamphetamine; and being a victim of violence.

Concerns for breastfed babies of users

Methamphetamine use reduces quantity of breast milk and methamphetamine can be released into breast milk (methamphetamine has been found in the urine of babies of users). Infants breastfed by methamphetamine-using mothers may experience a range of drug-induced behavioural problems such as irritability,

1 Foetal alcohol syndrome can result in low birthweight, smaller than normal head circumference, small eyes, flattened face and heart defects. Later in life, affected children might experience low IQ, developmental delays, behavioural problems, learning difficulties and memory problems.

poor sleeping patterns, agitation and crying. New mothers who continue to use methamphetamine can often still breastfeed their infants; however, antenatal team specialists are best placed to advise mothers about the best ways to limit risks to the baby.

Advice for pregnant women

Pregnant women and new mothers who use methamphetamine should be encouraged to seek regular, effective health care during and after the pregnancy to improve maternal nutrition, reduce psychological distress and improve outcomes for newborns.

Pregnancy can be a strong motivator for change in some women, and workers can skilfully employ motivational approaches during this time.

Pregnant users should be advised to avoid other substance use; especially nicotine, cannabis and alcohol, as abstaining from these substances can also improve neonatal and early childhood outcomes.

Even if methamphetamine has been used in the earlier stages of pregnancy, there are possible benefits for reducing or ceasing use in the later stages, which should be discussed with specialists in the antenatal team.

References Chapter 2: Effects, risks and harms and how these can be reduced

Dean A (2004). Psychostimulant use in pregnancy and lactation. In *Models of Intervention and Care for Psychostimulant Users*, 2nd edition. Baker A, Lee N and Jenner L (eds), Commonwealth of Australia Monograph Series, 169–187. Australian Government Department of Health and Ageing, Canberra.

Jewell S (2007). Harm reduction for methamphetamine users. Unpublished report. Australian Injecting and Illicit Drug Users League (AIVL).

Lee N (2004). Risks associated with psychostimulant use. In *Models of Intervention and Care for Psychostimulant Users*, 2nd edition. Baker A, Lee N and Jenner L (eds), Commonwealth of Australia Monograph Series, 51–59. Australian Government Department of Health and Ageing, Canberra.

National Drug and Alcohol Research Centre. *On Thin Ice: A User's Guide*. http://ndarc.med.unsw.edu.au/ (Accessed February 2008).

Western Australian Centre for Evidence Based Nursing & Midwifery (2007). *Breastfeeding Guidelines for Substance Using Mothers*, Western Australian Centre for Evidence Based Nursing & Midwifery, Perth.

Wouldes T, LaGasse L, Sheridan J and Lester B (2004). Maternal methamphetamine use during pregnancy and child outcome: what do we know? *New Zealand Medical Journal* 117:1206). http://www.nzma.org.nz/journal/117-1206/1180/ (Accessed February 2008).

3
Recognising and managing intoxication

Intoxication: what to look for

Signs of methamphetamine intoxication vary according to the amount of methamphetamine (and other drugs) taken and can include the following:

- rapid or pressured speech (fast, loud and difficult-to-interrupt speech), or jumping from one topic to another
- restlessness, agitation, pacing
- repetitive movements
- impulsivity or recklessness
- clenched jaw, teeth grinding (bruxism)
- sweatiness
- suspiciousness or paranoia
- large (dilated) pupils
- anger, irritability, hostility, particularly if it is out of character

Responding to an intoxicated person

The aims of responding to a person who is intoxicated are to maintain a calm environment to reduce the chance that the person will become angry or hostile and to promote a positive, helpful interaction. **Remember that an intoxicated person has impaired judgment and will probably see the interaction differently to you.**

What you should do

✔ If other people are present, try to steer the intoxicated person to an area that is less stimulating while ensuring that the client and worker both have an easily accessible exit.

- ✔ Maintain a calm, nonjudgmental, respectful approach.
- ✔ Listen, and respond as promptly as possible, to needs or requests. (*I hear what you are saying, so let me see what I can do to help.*)
- ✔ Allow the person more personal space than usual.
- ✔ Use clear communication — short sentences, repetition, and ask for clarification if you are unsure what is said. (*I really want to help, but I'm not sure what you need. Please tell me again.*)
- ✔ Move around with the intoxicated person to continue communication if necessary.
- ✔ Have written information available for the person to take away.
- ✔ Provide opportunistic, relevant, brief interventions if you are able.

What you should not do

- ✖ Do not argue with the person and do not use 'no' messages. If you cannot provide what they are asking for, be clear about what you *can* provide.
- ✖ Do not take the person's behaviour or any criticisms personally.
- ✖ Do not ask a lot of questions — ask only what is necessary to respond to the situation, as the person will have low tolerance for frustration or questioning.
- ✖ Do not undertake a lengthy interview or try to counsel the person — if the person has presented for assessment or counselling, inform him or her that you cannot continue if he or she is intoxicated and agree to make a future appointment.

References Chapter 3: Identifying and managing intoxication

Lee N, Johns L, Jenkinson R, Johnston J, Connolly K, Hall K and Cash R (2007). *Clinical Treatment Guidelines for Alcohol and Drug Clinicians. No 14: Methamphetamine Dependence and Treatment*. Turning Point Alcohol and Drug Centre Inc, Fitzroy.

Montana Chemical Dependency Bureau (2006). *Best Treatment Strategies for Methamphetamine Treatment Implementation*, Montana Chemical Dependency Bureau, Helena, Montana.

Webber R (2006). *Working with Methamphetamine Abusers: Personal Safety Recommendations and Procedures*, Chestnut Health Systems Lighthouse Institute, Bloomington, Illinois.

4
Recognising and managing overdose

Methamphetamine overdose: what to look for

Methamphetamine overdose (toxicity) is a medical emergency. If untreated, overdose can lead to heart attack, stroke, breakdown of muscle tissue (rhabdomyolysis), kidney failure, and possibly death.

In addition to those listed for intoxication in the previous chapter, signs of toxicity include:

- hot, flushed or very sweaty skin, which may indicate high fever
- severe headache
- chest pain
- unsteady walking (gait)
- muscle rigidity, tremors, spasm, fierce jerking movements of the limbs, seizures
- severe agitation or panic
- difficulty breathing
- altered mental state (eg confusion, disorientation).

Symptoms of psychosis can also occur (see Chapter 5, *Recognising and responding to a person with mental health problems*).

First aid for methamphetamine overdose

✔ **CALL 000 AND REQUEST AN AMBULANCE IMMEDIATELY,** even if you are unsure if methamphetamine is the cause — ambulance officers do not routinely notify police in the event of overdose.

✔ Move the person to a quiet, safe room away from bystanders, noise, excessive light, heat and other stimulation.

- ✔ Remove constrictive or hot clothing; apply icepacks to neck, underarms and groin; or thoroughly wet a towel with cold water and place over the person's body to reduce temperature.
- ✔ If the person is unconsciousness, place him or her on the side with the upper leg bent at the knee to support the body, and tilt the chin upward slightly to maintain a clear airway and avoid any obstruction to breathing.
- ✔ If muscle spasms or seizures occur, remove anything from the immediate environment that might pose risk of injury.
- ✔ Stay with the person until the ambulance arrives and give reassurance that he or she will be attended to as soon as possible.

What not to do

- ✖ Do not attempt to transfer the person to a doctor or hospital yourself or allow others to do so.
- ✖ Do not call a doctor or hospital directly — this simply wastes precious time.
- ✖ Do not leave the person alone.

Recommended service response

It is recommended that each agency or service develop a policy or protocol for identifying and managing overdose in its particular setting. The document should include the signs and management principles listed here, and should incorporate routine staff training and review after an emergency occurs.

References Chapter 4: Recognising and managing overdose

Dean A and Whyte I (2004). Management of acute psychostimulant toxicity. In *Models of Intervention and Care for Psychostimulant Users*, 2nd edition. Baker A, Lee N and Jenner L (eds), Commonwealth of Australia Monograph Series, 85–101. Australian Government Department of Health and Ageing, Canberra.

Jenner L, Spain D, Whyte I, Baker A, Carr VJ and Crilly J (2006). *Management of Patients with Psychostimulant Toxicity: Guidelines for Ambulance Services*. Australian Government Department of Health and Ageing, Canberra. http://www.nationaldrugstrategy.gov.au/internet/drugstrategy/publishing.nsf/Content/publications-psychostimulant-ambulance (Accessed February 2008).

5
Recognising and responding to a person with mental health problems

Background

Users of methamphetamine can experience a range of mental health problems (eg depression, anxiety, psychotic symptoms). Some people experience these as a direct result of using the drug, and the problem will improve or resolve rapidly when people stop using or cut down.

Other people might experiences longer lasting psychosis (weeks to months).

Some people might have had a mental health problem before they started to use methamphetamine, for example, schizophrenia, and are likely to experience relapse of psychotic symptoms following methamphetamine use.

Many diagnostic and screening instruments are available to detect a range of mental health disorders (see http://www.adelaide.edu.au/library/guide/med/menthealth/scales.html).

This chapter describes the symptoms of psychosis, depression and anxiety. It includes tips on how to communicate with a person who is experiencing psychosis; how to respond to a client with depression or who is thinking of self-harm; and how and when to refer a client to mental health services.

What is psychosis?

The term psychosis describes a disorder in which a person's contact with reality is grossly impaired. Symptoms of psychosis include:

- Hallucinations — the person experiences sensations that have no basis in reality such as hearing 'voices' (auditory hallucinations), 'feeling' things on the skin or in the body (tactile hallucinations), or seeing things that others cannot (visual hallucinations). Other hallucinations involve taste (gustatory hallucinations) and smell (olfactory hallucinations).

- Delusions — the person holds fixed, false beliefs that do not shift even when faced with logical evidence to the contrary. For example, a person might believe that he or she is being spied upon by a secret agency, or that his or her thoughts are being controlled by external forces. Beliefs that are part of a person's religion or culture are not considered to be delusions unless those beliefs are not upheld by others in the person's same religious or cultural group.
- Thought disorder — a person's thinking becomes confused, concentration becomes difficult, thoughts may speed up or slow down, or the person will jump from one topic to another with no obvious logical connections.
- Disorganised or bizarre behaviour — a person will respond to strange thoughts or unusual sensory experiences by changing their behaviour to adapt to their beliefs or perceptions. To others, their behaviour may seem disorganised or bizarre, but to the person they make sense. For example, those who fear surveillance might pull down blinds; speak in whispers; disconnect the phone; appear generally anxious, jumpy or afraid; and may even keep a weapon for protection.

Mood swings also commonly occur when a person experiences psychosis.

Note: Mood swings, agitation and irritability *without* the presence of hallucinations or delusions does not mean that the person is psychotic. Workers should respond to these people in the usual way, such as providing a calm environment, using de-escalation techniques, and meeting the person's immediate needs.

About methamphetamine psychosis

Stimulants can bring on a psychotic episode in healthy people with no previous history of mental health problems. Many users report experiencing low-grade or 'subacute' psychotic symptoms such as visual illusions, fleeting hallucinations or odd thoughts that come and go. Other users can experience more severe episodes where they hear or see things that are not there, or they become paranoid and believe that other people are going hurt them. The rate of psychosis among regular methamphetamine users interviewed in Sydney recently was 11 *times* that seen in the general population.

Many people will recover spontaneously from psychotic symptoms within hours as the effects of the drug wear off. These people may benefit from a quiet, low-stimulus environment and will not usually need specialist treatment. On the other hand, psychosis can persist for days, weeks, months or longer in some people. In this case, it is likely that those people were already at risk for developing a psychotic disorder and methamphetamine use triggered it. These people need to have specialist mental health treatment, which usually includes medication (antipsychotic drugs).

Although hospital admissions for amphetamine psychosis have increased over the past decade, only a small percentage of people who experience psychosis actually go to hospital for treatment. When they do, it is usually through the emergency department and only when psychosis is severe. As methamphetamine psychosis is more likely in dependent users, multiple presentations to emergency departments are more common among this group.

Some regular users who have been psychotic might become psychotic again when even small quantities of methamphetamine are used. This is known as 'reverse tolerance' (ie even using *smaller* amounts than before can trigger psychosis). These people can also be sensitive to stressors including the use of other drugs or alcohol, which might also trigger a psychotic episode. Some people can experience fleeting psychotic symptoms or 'flashbacks' even after they stop using.

What is schizophrenia?

Psychosis can be fleeting and last for hours, days or a week or two. On the other hand, according to the International Classification of Diseases-10, schizophrenia is a disorder that is characterised by at least one prominent psychotic symptom (or two symptoms if not clear cut) that last for *more than a month,* and is *not related to drug intoxication or withdrawal*. A person with severe, enduring psychosis or schizophrenia also tends to lack insight into his or her symptoms, which means that the person is unable to recognise that hallucinations or delusions may not be real. People with schizophrenia can be stabilised on medication, which means that psychotic symptoms are much less severe, although some symptoms can persist. People who have a mental health problem like schizophrenia are at greater risk of experiencing psychosis than other methamphetamine users.

Methamphetamine psychosis or schizophrenia?

It is extremely difficult to distinguish between methamphetamine psychosis and schizophrenia, and only a psychiatrist can make a diagnosis, so the important thing is to respond appropriately and skilfully to every person who experiences psychotic symptoms (see *Initial response*, page 29). However, those with methamphetamine psychosis:

- have a history of methamphetamine use or have used methamphetamine recently
- have psychotic symptoms that developed during intoxication, withdrawal or shortly after withdrawal
- have psychotic symptoms that subside and resolve within hours as the methamphetamine effects wear off
- do not fit criteria for a diagnosis of schizophrenia.

Impending or 'subacute' psychosis: what to look for

Acute psychotic symptoms are usually easy to identify, although methamphetamine users may present with a range of low-grade psychotic symptoms that are more difficult to pinpoint. The following are signs of low grade or subacute psychosis:

- Suspiciousness, guardedness, hypervigilance[2] — constantly checking for threats in an exaggerated way.
- Overvalued ideas — ordinary events have special significance or are more meaningful than usual or odd.
- Illusions or misinterpreting the environment — eg a shadow might seem like a person walking into a room, or a random sound might seem like a ringing phone or a police siren; or fleeting, low-level hallucinations.
- Erratic behaviour — often related to overvalued or paranoid ideas and might include accusing others of perceived misdeeds, or arguing with bystanders for no apparent reason.

Acute psychosis: what to look for

The following are signs of acute psychosis:

- Delusions — often people feel persecuted; they may believe that others have malicious intentions or that they are under surveillance.
- Hallucinations — often auditory such as 'voices' or sounds like police car sirens, or tactile such as a feeling that 'bugs' are crawling under the skin, but these can also be visual.
- Erratic, uncontrolled or bizarre behaviour often in response to delusions or hallucinations, for example, talking or shouting in response to 'voices'; unnecessary whispering; barricading a room; checking doors; pulling down blinds; making frantic phone calls; keeping a weapon for protection from perceived threats.
- Illogical, disconnected, or incoherent speech
- Extreme or rapid mood swings that are unpredictable, irrational or erratic.

First steps in response

✔ Quickly scan the immediate vicinity and observe location of exits, bystanders, and potentially dangerous objects to judge immediate risks and decide upon the most suitable approach (leave and call for assistance or respond carefully).

2 Due to some users' lifestyle factors, guarded or vigilant behaviour might be appropriate so enquire about this during assessment.

- ✔ If in a public place, service or treatment setting, move bystanders from the immediate environment to avoid risk of injury or escalation of the situation.
- ✔ If in a nontreatment setting or private home, stay close to the exit and remove yourself from any room that might contain dangerous implements or weapons (eg kitchen, workshop).
- ✔ Try to reduce noise, human traffic or other stimulation within the person's immediate environment.
- ✔ Try to determine if the person has recently used methamphetamine either by direct questioning or by asking companions or family.
- ✔ Observe for any physical signs of methamphetamine overdose and respond promptly (see Chapter 4, *Recognising and managing overdose*).
- ✔ If psychosis is severe, arrange transfer to an emergency department for assessment and treatment by **calling an ambulance on 000**. Give them your exact location and name of the nearest cross street; accurately describe what is happening (say exactly what the person is saying and doing); remain calm and ensure everyone's continued safety until the ambulance arrives.

Communicating with a person who is experiencing psychotic symptoms

A skilled response to a person who is experiencing psychosis will assist him or her considerably.

What the communicator should do

- ✔ Choose one worker who will communicate with the person and feels confident to do so — many communicators increase stress, confuse the person, and escalate the situation.
- ✔ The 'communicator' should place other workers on stand-by so a team approach can be undertaken. Have another staff member present to observe or step in *only if required* (the communicator could use a code word to call for assistance from the 'observer'). The observer should attempt to determine if the client has a known history of aggression or violence and, if so, extra care should be taken and the observer should be ready to call for immediate assistance if required.
- ✔ Allow the person as much personal space as possible.
- ✔ The communicator should be aware of his or her body language — arms should be by the sides with palms out and the communicator should make no sudden movements and should approach slowly from the front so the person is not startled.

- ✔ The communicator should mirror body-language signals from the person — sit with a person who is seated, walk with a person who is pacing —to show that the worker understands what the person is going through (empathy) and to ensure that the worker appears neither threatening, by standing over the person, nor vulnerable by being seated while he or she stands.
- ✔ The communicator should monitor and use appropriate eye contact — not too much (appears threatening) or too little (implies indifference or untrustworthiness).
- ✔ Use a consistently even tone of voice, even if the person's communication style becomes hostile or aggressive.
- ✔ Use the person's name if known or the communicator should introduce him- or herself by name.
- ✔ Carefully call the person's attention to their immediate environment. (*You're in the* [service] *and you're completely safe now*).
- ✔ Offer a glass of juice or water, as this can often help calm the person.
- ✔ Use careful, open-ended questioning to determine the cause of the behaviour or the person's immediate needs and communicate your willingness to help. (*I can see that you are really upset; what can I do to help you?*)
- ✔ Listen attentively and respectfully.
- ✔ Ask the person if he or she would like a minute or two to think and respond — consider stepping back to reduce the stimulus while still actively managing the situation. (*I'll give you a minute or two to think, but I'll be right here.*)
- ✔ Always appear confident — this will increase the client's confidence in the communicator's ability to manage the situation, as he or she will probably be feeling scared or anxious too.

What the communicator should not do

- ✖ Do not laugh at or argue with the person's unusual beliefs, even if they are obviously wrong or make no sense at all.
- ✖ Do not agree with or support the unusual beliefs either, as people can usually tell when workers are not being genuine. It is better to simply say:
  - ✔ *I can see that you're scared, how can I help you?*
- ✖ Do not allow the person to block the worker's exit from the room, and do not block theirs.
- ✖ Do not use 'no' language, which may prompt a hostile outburst; rather, use statements like:
  - ✔ *This is what I CAN do for you…* often encourages further communication and has a calming effect.

Note: Is the person threatening harm to him- or herself or others? If so, call the police on 000 immediately and remove all bystanders or other staff members from the location until police arrive. Workers should be aware that psychostimulant use is a risk factor for sudden death of individuals being physically restrained and if restraint is ever necessary, it should be undertaken for the *shortest possible time* (see *Responding to challenging situations: a practical guide for frontline workers*).

Longer-term management

The preferred goal of treatment for a person who has experienced methamphetamine psychosis is to stop using the drug. Motivational approaches that focus on psychosis as a consequence of methamphetamine use could be helpful in achieving this. If psychotic symptoms persist, the person must be treated by mental health specialists, preferably in conjunction with alcohol and other drugs workers, and workers should encourage the person to take psychiatric medications as prescribed (see *Referring to mental health services* later in this chapter).

It is important to encourage the person to adopt a healthy lifestyle that involves relaxation and adequate diet and sleep, due to the risk of stress-induced relapse of psychotic symptoms. For the same reason, use of other drugs or alcohol should be reduced significantly or stopped altogether.

Regardless of this advice, some people decide to keep using methamphetamine even after they have had a psychotic episode. The following advice could be helpful for such people:

- Avoid injecting or smoking methamphetamine to limit exposure to high doses of the drug.
- Avoid the use of multiple drugs.
- Take regular breaks from using and never use more than twice per week.
- Use no more than a very small amount to limit the chance of another psychotic episode.
- Understand 'reverse tolerance' and the risk of future psychotic episodes.
- Recognise the early warning signs that psychotic symptoms might be returning (eg feeling more anxious, stressed or fearful than usual, hearing things, seeing things, feeling strange or feeling that the world or people have changed in some way etc). If experiencing any of these, immediately stop drug use and seek help to reduce the risk of a severe episode.
- Inform the client that the use of methamphetamine can make prescribed medications for psychosis or schizophrenia ineffective.

Depression

Depression commonly occurs among methamphetamine users, as discussed in previous sections. Symptoms of depression (eg withdrawal from social contact; negative thoughts; feelings of sadness, guilt, pessimism; changes in appetite, libido and energy) may persist for weeks, months or even several years after quitting methamphetamine use.

Encourage clients to be aware of their symptoms and to alert a worker or seek specialist help if depression worsens, particularly if suicidal thoughts occur.

Many workers are reluctant to discuss suicide with clients, but raising the issue will not trigger suicidal ideas in a person who has no intentions. On the other hand, sensitive questioning by a worker can be a relief for clients who have been harbouring thoughts of self-harm, while providing an opportunity for the client to receive the help and support that is urgently required.

A depressed client might be at high risk for suicide if he or she:

- has a clear plan that could cause death and the means to carry it out
- has tried before in the past or recently
- continues to use alcohol and other drugs
- has psychotic symptoms
- has significant life stressors and feels hopeless and helpless to deal with them
- has few or no social supports
- has a family member who has attempted or committed suicide.

The following suggestions from the *PsyCheck* can help guide a worker's response:

Risk level	Action
Low risk: fleeting thoughts of suicide but no risk factors as described above, can guarantee own safety, has supports in place.	• Review frequently. • Identify potential supports or contacts and provide contact details. • Contract with client to seek immediate assistance if fleeting thoughts become more serious or depression deepens.
Moderate risk to high risk: suicidal thoughts present, some or many risk factors, plan has some detail or is very detailed, has means or access to means, poor or no social supports, cannot guarantee safety, feels hopeless.	• Request permission to organise a specialist mental health assessment as soon as possible, continue contract as above, and review daily. • If risk is high and the client has an immediate intention to act, contact the mental health services or emergency mental health team immediately (see *Referral* section below for details) and ensure that the client is not left alone. • Call an ambulance or police if risk is high and the client will not accept a specialist assessment. • Consult with a colleague or supervisor for guidance and support.

Anxiety

Anxiety can occur in many forms and usually involves excessive worry. Other features of anxiety can include agitation, racing heart, sweatiness, rapid breathing or a feeling of breathlessness, tightness in the chest or chest pain, fear or panic, and sleep disturbance.

It is common for methamphetamine users to experience some of these symptoms as a direct effect of the drug. In many cases, anxiety symptoms subside when methamphetamine is no longer used. However, if anxiety symptoms persist after stopping, the client must be assessed by a mental health specialist.

Anxious clients should be provided with a low-stimulus environment and encouraged to take slow, deep, calming breaths. Some useful examples of other relaxation strategies include tensing and relaxing all the large muscle groups in the body; actively imagining a peaceful, safe place of the client's own choosing; taking a warm bath; listening to music; and meditation.

Referring to emergency mental health services

Acute or emergency mental health services usually provide an intake or triage telephone line. Many are staffed on a 24 hours per-day basis in major cities, but in regional areas, emergency treatment is often provided outside of business hours through the emergency department of the local hospital. **Workers should ensure that the emergency telephone number for their most appropriate contacts are on hand at all times.**

A worker should ask the client's permission to contact mental health services. If the client refuses permission, workers can call the local mental health service or the mental health triage worker in the local emergency department and ask for advice about the situation without identifying the client in the first instance.

When contacting a mental health service, give a detailed and accurate summary of the situation and be clear about what the worker's concerns are. Workers should learn to use relevant and appropriate language and only communicate what can be observed. The mental health worker can then offer advice about what to do next.

When a worker telephones an intake officer, the officer will ask for the worker's name, the person's name and the name of the worker's service. The worker will then be asked to describe in detail his or her concerns about the person in question. A worker could state for example:

> *The person is severely agitated, appears to be responding to auditory hallucinations as he is shouting at people who are not present, and he is threatening to harm himself with a knife.*

This will have more impact and convey more information about the situation than for example, *'The guy's going off in the waiting room'***.** In extremely serious situations such as this, the mental health services intake worker will probably instruct the referrer to call the police so the person can be taken to the nearest emergency department or place of safety for an immediate assessment. This is often distressing to both the client and the worker; however, this action is

dictated by the worker's duty-of-care. Workers should also enlist the support and advice of senior staff from their own service in such cases.

Another group of clients might experience serious or lingering symptoms of depression that may lead to thoughts of self-harm or suicide. Workers have a duty-of-care to ensure the safety of clients who disclose thoughts of self-harm. In this case, it is essential to gather as much information as possible before contacting mental health services so the mental health intake worker can make a rapid determination of the client's potential risk and then advise the worker of the best course of action.

Referring for nonemergency mental health assessment

Some clients might have mental health problems that do not appear to pose great risk; however, they may still complicate treatment for methamphetamine use. After gaining consent from the client, the choice of the appropriate contact for a mental health assessment will depend on the location and structure of your service and may include:

- a mental health professional in your own service
- a specialist dual diagnosis consultant
- an intake or triage officer at the client's nearest community mental health service
- a general practitioner or a visiting psychiatrist or clinical psychologist if you are in a rural or remote area where mental health services are not easy to access.

It is important to gather as much information as possible and to use appropriate language when referring clients. Give an accurate description of the person's issues using appropriate language and terms, request an assessment, and indicate what level of involvement in the client's future treatment that you would like to maintain (ongoing contact/counselling, co-case management, etc).

If the client has an established mental health disorder as diagnosed by a psychiatrist, be sure to inform the agency. If not, simply state the client's symptoms or concerns. For example,

> *The client reports feeling anxious and tearful, and her sleeping pattern has been disturbed for several months. She has little appetite, has difficulty managing daily tasks, and although she says she can't imagine going on like this, she says she doesn't have any thoughts of self-harm.*

The assessor or intake worker will then advise the referrer of a course of action, which could include referral to a general practitioner for an assessment or an appointment for an assessment with the mental health service.

Do whatever is reasonable to help the person keep the appointment, but also be sure to maintain professional boundaries with clients. (Also see Chapter 11, *Making links and creating partnerships*).

Recommended service response

It is recommended that each agency or service develop a policy or protocol for identifying and managing mental health problems, including psychosis and suicidal ideation in its particular setting. The document should include the signs, symptoms and management principles listed here, incorporate routine staff education and support, and require prompt debriefing or review should an acute incident occur.

It is recommended that services develop close links with mental health services, ambulance, police and other key agencies so a team approach to response and treatment can be smoothly organised should it be required (see Chapter 11 *Making links and creating partnerships*).

References Chapter 5: Identifying and responding to a person with mental health problems

Barr AM, Panenka WJ, MacEwan W, Thornton AE, Lang DJ, Honer WG and Lecomte T (2006). The need for speed: an update on methamphetamine addiction. *Journal of Psychiatry and Neuroscience* 31(5):301–313.

Dawe S and McKetin R (2004). Psychiatric comorbidity of psychostimulant use. In *Models of Intervention and Care for Psychostimulant Users*, 2nd edition. Baker A, Lee N and Jenner L (eds), Commonwealth of Australia Monograph Series, 154–168. Australian Government Department of Health and Ageing, Canberra.

Degenhardt L, Roxburgh A and McKetin R (2007). Hospital separations for cannabis- and methamphetamine-related psychotic episodes in Australia. *Medical Journal of Australia*, 186(7):342–345.

Jenner L, Baker A, Whyte I and Carr V (2004). *Psychostimulants — Management of Acute Behavioural Disturbances. Guidelines for Police Services*, Australian Government Department of Health and Ageing, Canberra.

Lee N, Johns L, Jenkinson R, Johnston J, Connolly K, Hall K and Cash R (2007). *Clinical Treatment Guidelines for Alcohol and Drug Clinicians. No 14: Methamphetamine Dependence and Treatment*, Turning Point Alcohol and Drug Centre Inc, Fitzroy, Victoria.

Lee NK, Jenner L, Kay-Lambkin F, Hall K, Dann F, Roeg S, Hunt S, Dingle G, Baker A, Hides L and Ritter A (2007). *PsyCheck: Responding to Mental Health Issues within Alcohol and Drug Treatment*, Australian Government Department of Health and Ageing, Canberra..

McIver C, Flynn J, Baigent M, Vial R, Newcombe D, White J and Ali R (2006). *Management of Methamphetamine Psychosis Stage 2: Acute Care Interventions for the Treatment of Methamphetamine Psychosis and Assertive Community Care for the Post-discharge Treatment of Methamphetamine Psychosis*. DASSA Research Monograph No. 21 Research Series. http://www.dassa.sa.gov.au/webdata/resources/files/Monograph_21.pdf (Accessed February 2008).

McKetin R, McLaren J and Kelly E (2005). *The Sydney Methamphetamine Market: Patterns of Supply, Use, Personal Harms and Social Consequences*, National Drug and Alcohol Research Centre, Sydney.

Montana Chemical Dependency Bureau (2006). *Best Treatment Strategies for Methamphetamine Treatment Implementation*, Montana Chemical Dependency Bureau, Helena, Montana.

ORYGEN Research Centre. *Psychosis: Guidelines for Providing Mental Health First Aid.* Department of Psychiatry, The University of Melbourne, Australia. http://www.mhfa.com.au (Accessed February 2008).

6
Helping a person get through withdrawal

About methamphetamine withdrawal

Many methamphetamine users will experience what is commonly referred to as a 'crash' or a brief period of recovery when they stop using, which might last for a few days. During this time, the person is likely to experience periods of prolonged sleep, increased appetite, some irritability and a general sense of feeling flat, anxious or out of sorts (dysphoria). As neurotransmitter stores are replenished, the person improves rapidly. It is like a 'hangover' from alcohol. The crash period is not a clinical methamphetamine withdrawal so specialist intervention is usually not required.

In contrast, some dependent methamphetamine users will experience the full-blown withdrawal syndrome when they stop using, the course of which depends on the person's severity of methamphetamine dependence (see Appendix 1: *Severity of dependence scale*); how long and how often the person has used; the presence of other physical or mental heath problems; and other factors such as the setting in which withdrawal is undertaken and expectations and fears about the course of withdrawal.

Signs and symptoms of withdrawal can include:

- a range of feelings from general dysphoria through to significant, clinical depression
- mood swings
- inability to experience pleasure (anhedonia)
- decreased energy
- irritability or anger
- agitation, anxiety
- aches and pains
- sleep disturbance, lethargy, exhaustion, insomnia

- poor concentration and memory
- cravings to use methamphetamine.

Although this varies between individuals, the acute phase of withdrawal can peak around day two or three after last use and generally begins to ease after a week to 10 days. Low-grade symptoms including mood swings and agitation, cravings, and sleep disturbance can last for a further couple of weeks; however, for some individuals, depression can last from weeks to many months or even a year in severe cases.

Withdrawal is most often undertaken at home, but a specialist hospital or residential setting is more suitable for people who are at heightened risk of severe or lengthy withdrawal, have unstable housing, are exposed to methamphetamine at home, or have complicating medical or psychiatric disorders.

Supported withdrawal should be seen as the first step in a comprehensive treatment plan, including counselling and relapse prevention, rather than a treatment in itself.

Assisting a person who is withdrawing

The following strategies are recommended for helping a person who is withdrawing:

- ✔ Tell the person what to expect during withdrawal, including probable time course, common symptoms particularly agitation, irritability, anger, depression, and cravings and possible consequences such as impact on relationships, work, and other social factors.
- ✔ Determine what was and was not helpful during any previous withdrawals.
- ✔ Identify dependence on other drugs and offer appropriate interventions.
- ✔ Recommend adequate diet, rest, and fluid intake. Encourage the person to prepare by having a supply of nutritious food and drink in the house, taking leave from work, limiting visitors etc.
- ✔ Encourage the person to monitor him or herself for symptoms of depression and, if symptoms persist, become severe or thoughts of self-harm occur, advise the person to seek urgent medical attention.
- ✔ Assist with managing cravings to use, by explaining how cravings occur and by developing an early intervention and relapse prevention plan (see Baker et al 2003, *A Brief CBT Intervention for Regular Amphetamine Users*, and Lee et al (2007) for practical strategies for managing cravings).

- ✔ Identify key social supports and educate the family or carers about withdrawal and what to expect (see Chapter 9, *Assisting families, carers and significant others*).
- ✔ Provide written materials as the person may have difficulty with recall and concentration during withdrawal (eg *On Thin Ice,* http://www.ndarc.med.unsw.edu.au).
- ✔ Refer the person to a medical practitioner if the person experiences sleep disturbance or insomnia for more than a week or two, or the person has ongoing feelings of anxiety, agitation or restlessness, which is increasing the likelihood of relapse. Some people benefit from the prescription of a short course of sedative-hypnotic medications such as temazepam for sleep or diazepam for agitation and anxiety.
- ✔ Encourage the person to seek further support if symptoms such as those listed above are severe and persist beyond a week or two.
- ✔ Recommend ongoing interventions such as counselling to prevent relapse to using. Withdrawal strategies should be the *first step* in a planned, individualised treatment approach to support a client's long-term goals.

References Chapter 6: Helping a person get through withdrawal

Baker A, Kay-Lambkin F, Lee NK, Claire A and Jenner L (2003). *A Brief Cognitive Behavioural Intervention for Regular Amphetamine Users: A Treatment Guide*. Australian Government Department of Health and Ageing, Canberra. http://www.health.gov.au/internet/wcms/publishing.nsf/Content/health-pubhlth-publicat-document-cognitive_intervention-cnt.htm (Note: This website is under review).

Cruickshank C and Dyer K (2006). The nature and temporal profile of the amphetamine withdrawal syndrome among a drug-dependent treatment population. Paper presented at 16th Western Australian Drug and Alcohol Symposium 18–19 September 2006. http://www.dao.health.wa.gov.au/Publications/tabid/99/DMXModule/427/Default.aspx?EntryId=947&Command=Core.Download (Accessed February 2008).

Gossop M, Darke S, Griffiths P, Hando J, Powis B, Hall W, and Strang J (1995). The Severity of Dependence Scale (SDS): Psychometric Properties of the SDS in English and Australian Samples of Heroin, Cocaine and Amphetamine Users. *Addiction* 90(5):607–614.

Jenner L and Saunders S (2004). Psychostimulant withdrawal and detoxification. In *Models of Intervention and Care for Psychostimulant Users*, 2nd edition, Baker A, Lee N and Jenner L (eds), Commonwealth of Australia Monograph Series, 102–118.

Lee N, Johns L, Jenkinson R, Johnston J, Connolly K, Hall K and Cash R (2007). *Clinical Treatment Guidelines for Alcohol and Drug Clinicians. No 14: Methamphetamine Dependence and Treatment*. Turning Point Alcohol and Drug Centre Inc, Fitzroy.

McGregor C, Srisurapanont M, Jittiwutikarn J, Laobhripatr S, Wongtan T, and White JM (2005). The nature, time course and severity of methamphetamine withdrawal. *Addiction* 100(9):1320–1329.

Newton T, Kalechstein A, Duran S, Vansluis N and Ling W (2004). Methamphetamine abstinence syndrome: preliminary findings. *American Journal on Addictions* 13(3):248–255.

Topp L and Mattick RP (1997). Choosing a cut-off on the Severity of Dependence Scale (SDS) for amphetamine users. *Addiction* 92(7):839–845.

7
Use of other drugs and possible effects of mixing drugs

Methamphetamine users often take other drugs in an effort to improve sleep or reduce agitation or anxiety when the person is 'coming down' from methamphetamine. Other combinations provide a pleasurable experience for the user, reflect a dependence on multiple drugs, or are prescribed by a medical practitioner to treat a person's mental health disorder or physical illness.

The risks associated with continued methamphetamine use in combination with prescribed medications **should always be discussed with the prescribing doctor**. However, some clients might be reluctant to disclose methamphetamine use to their doctor for a range of reasons. Workers can assist clients by discussing the issues that are barriers to disclosure and identifying potential solutions together. Sometimes clients need to find a different doctor, with whom he or she can feel comfortable enough to discuss all issues related to their health and wellbeing, including drug use.

Risks associated with prescribed medications

Although the medications described in this section should be prescribed by a doctor, some users obtain antidepressants, antipsychotics and benzodiazepines from other sources such family or friends who have been prescribed these medications, or purchase tablets on the street.

Antidepressants including those that block reuptake of the neurotransmitter serotonin (collectively called selective serotonin reuptake inhibitors or SSRIs), monoamine oxidase inhibitors (MAOI) and tricyclic antidepressants when *used within the same two weeks as methamphetamine* can cause dangerously high blood pressure; increased blood levels of methamphetamine; and serotonin toxicity (overheating, fits, heart attack, stroke, kidney failure).

Antipsychotic medications used to treat psychotic disorders such as schizophrenia can be made ineffective. Methamphetamine can reduce blood

levels of antipsychotic medications, which reduce their effectiveness and lead to relapse of psychotic symptoms. Risk of seizures (fits) also increases.

Benzodiazepines increase the risk of benzodiazepine dependence if large or regular doses are used. Additionally, as methamphetamine use can stop the client from feeling the full effect of benzodiazepines, risk of accident and injury also increases. If clients are injecting methamphetamine, they might also be at risk for injecting benzodiazepines, which can damage veins and cause infections, which can affect the heart (see http://www.druginfo.adf.org.au/article.asp?ContentID = benzodiazepines).

It is important to note that benzodiazepines are very useful in the early stages of methamphetamine withdrawal and are prescribed frequently to reduce agitation and anxiety, and restore sleep. If a client is using benzodiazepines, workers could assist the person to regulate the dosage in the following ways:

- ✔ consider supervised dosing of benzodiazepines (or other medications); for example, a client can receive the prescribed number of tablets each day or once per week from a designated pharmacy, rather than fill a prescription for a month's supply at once
- ✔ reduce the likelihood that the person will obtain multiple prescriptions from more than one doctor (known as 'doctor shopping') by asking him or her to voluntarily complete the *Authority to release personal Pharmaceutical Benefits Scheme (PBS) claims information to a third party* form, which is used to track and monitor prescriptions
- ✔ create a contract stipulating the conditions under which the mediation will be taken (dose, frequency, etc), which the client and worker sign and date.

Blood pressure regulating medication (antihypertensives) can be made ineffective.

HIV medications can result in methamphetamine toxicity (overdose) if taken together.

As new medications are developed and brand names are often subject to change, see the MIMS online website for brand name examples of the medications described in this section http://www.mims.com.au/.

Risks associated with other drugs

Users of methamphetamine typically use a range of other drugs, which is referred to as *polydrug use*.

Alcohol combined with methamphetamine can increase blood pressure, placing greater burden on the heart. It can also stop the person from *feeling* intoxicated or drunk, but the person *is* impaired and blood alcohol levels will still be high. This increases the risk of alcohol poisoning or accidents due to a false sense of feeling sober and in control. (Some people take methamphetamine or other stimulants, because this enables them to drink more alcohol without being sick or passing out.) Use of alcohol and methamphetamine can also place a greater burden on the user's liver, which breaks down alcohol and other drugs for elimination from the body. Careful assessment of a client's use of alcohol will help to identify any problems that the worker should then target specifically (see *Guidelines for the treatment of alcohol problems*, available from http://www.alcohol.gov.au/internet/alcohol/publishing.nsf/Content/AAG07).

Cannabis use has been associated with the worsening of psychotic symptoms in some individuals, particularly those with schizophrenia. People often do not see the relationship as psychotic symptoms tend to worsen a few days after cannabis use. Methamphetamine users with a history of psychosis should be aware of the risks of smoking cannabis.

Opiates increase the risk of heroin overdose, because methamphetamine users may not feel the full effect of heroin and could use considerably more than intended.

Other psychostimulants such ecstasy and cocaine can interact with methamphetamine to increase a user's risk of heart attack, stroke and psychosis.

Tobacco is often smoked in greater quantities when a person is intoxicated with methamphetamine, increasing nicotine-related health risks (eg lung and heart disease, cancer).

Possible interactions with methamphetamine: quick reference list

Drug type	Possible interaction effects
Alcohol	Possible depressed heart and breathing functions
Antidepressants	Possible dangerous rise in blood pressure and body temperature leading to strokes, seizures or heart failure; not to be used within the same 2-week period
Antipsychotic medications	Possible reduced effectiveness of medication, increased risk of seizures
Benzodiazepines	Increased risk of accident and injury and benzodiazepine dependence if taken regularly or in large quantities
Blood pressure medications	Can reduce the effectiveness of medication and increase blood pressure
Cannabis	Linked to worsening of psychotic symptoms in people with psychotic disorders
HIV medications	Increases risk of methamphetamine toxicity (overdose)
Opiates (eg heroin)	Increased risk of opiate overdose
Psychostimulants (ecstasy, cocaine)	Increased risk of heart attack and strokes
Tobacco	Increased risk of lung and heart disease, and cancer

Advice for methamphetamine users

Continuing users of methamphetamine should be provided with the following information:

- ✔ Be aware of the potential interactions of all prescribed medications with methamphetamine, and **always discuss the risks and benefits with the prescribing doctor**.
- ✔ People should not take antidepressants in combination with methamphetamine due to the potential for serious interactions. Users must discuss the dangers with the prescribing doctor.
- ✔ Be aware of the number of benzodiazepine tablets taken as people can lose track. Only take the amount prescribed by the doctor. This will reduce the risk of benzodiazepine dependence and accidents and injuries.
- ✔ Some people can experience withdrawal symptoms if benzodiazepines are stopped abruptly after just one month. Symptoms of benzodiazepine withdrawal can be very similar to methamphetamine intoxication, toxicity or withdrawal (eg anxiety; sleep disturbances; hallucinations; headaches; and depression). The following are hallmarks of benzodiazepine withdrawal and should be attended to immediately if they occur: extreme sensitivity to loud noises, light or touch; feelings of unreality; numbness; fear of open spaces (agoraphobia), a metallic taste in the mouth; pain, stiffness and muscular spasms resulting in headaches and muscle twitching. Untreated benzodiazepine withdrawal can be life threatening because seizures (fits) can occur.
- ✔ Be aware of the amount of other drugs taken (eg heroin) to reduce the risk of overdose. If multiple drugs are taken at once, one drug might 'come one' before another, which can lead to using more of the other drug, possibly taking much more than the person is used to.
- ✔ Be aware of the amount of cannabis used and its effects in combination with methamphetamine, to limit the risk of experiencing or worsening psychotic symptoms.
- ✔ Continuing users of methamphetamine should also be told the following:
  - ✖ Never drive or operate machinery after drinking alcohol and using methamphetamine. Even if the person does not feel drunk after drinking alcohol, he or she is actually drunk, coordination and concentration will be impaired, and the blood alcohol level will reflect this.
  - ✖ Avoid using multiple types of stimulants at once.

References Chapter 7: Use of other drugs and possible effects of mixing drugs

Curran C, Byrappa N and McBride A (2004). Stimulant psychosis: systematic review. *British Journal of Psychiatry* 185:196–204.

Dean A (2004). Pharmacology of psychostimulants. In *Models of Intervention and Care for Psychostimulant Users*, 2nd edition, Baker A, Lee N and Jenner L (eds), Commonwealth of Australia Monograph Series, 35–50.

Lee N, Johns L, Jenkinson R, Johnston J, Connolly K, Hall K and Cash R (2007). *Clinical Treatment Guidelines for Alcohol and Drug Clinicians. No 14: Methamphetamine Dependence and Treatment*. Turning Point Alcohol and Drug Centre Inc, Fitzroy.

White J and Ali R (1995). *A Handbook for General Practitioners and Other Health Professionals to Assist in the Management of Benzodiazepine Withdrawal. H*ttp://aodgp.gov.au/internet/aodgp/publishing.nsf/Content/resource-kit-4/$FILE/handout3_benzos.pdf (Accessed April 2008).

8
Overview of the range of treatment options

This chapter describes the principles of assessment and the range of treatment options available for methamphetamine users including brief interventions, counselling, behavioural approaches, mutual support groups, residential rehabilitation, and medications. Special considerations for Indigenous clients, youth, and those from culturally and linguistically diverse backgrounds (CALD) are highlighted.

About treatment seeking

As most people feel energetic, confident and euphoric when they use methamphetamine, it is not surprising that many users do not identify as a 'drug user' or do not actively seek treatment until the consequences are severe (eg hostility directed towards a loved one, depression or psychosis, physical health concerns).

Users also report that services are often not targeted to their needs. For example, methadone can be prescribed for heroin dependence, but there are no medications available specifically for methamphetamine use and dependence, although medication trials are currently underway in Australia and elsewhere (see *Medications* section in this chapter).

Research suggests that services generally have a poor record of attracting methamphetamine users into treatment in the first place (engagement) and then keeping them in treatment until goals are met (retention). Engagement and overall outcome are improved by establishing a firm helping relationship and by ensuring that treatment is driven by a *client's* goals rather than those of the service and is matched to the information gained from the assessment (see *Assessment* section in this chapter).

When considering appropriate treatment for methamphetamine users, workers often feel at a loss about how to respond. It is important to recognise that many

of the general approaches undertaken with clients who use other drugs are also relevant and effective for users of methamphetamine. Some useful approaches are described below.

Brief interventions

Brief interventions can be as short as a few minutes in a busy needle and syringe program, through to four one-hour counselling sessions in an outpatient treatment setting.

Brief interventions can include:

- screening and assessment
- provision of self-help materials (see *Resource Section*)
- harm reduction advice
- motivational interviewing
- education
- mood monitoring
- counselling.

Australian research has demonstrated the effectiveness of a brief cognitive behavioural intervention for regular amphetamine users to assist in reducing the quantity and frequency of amphetamine use as well as symptoms of depression. The clinical treatment manual used in the study is freely available (see *Resource Section* for download details).

Assessment

A thorough, routine assessment is undertaken for all clients in most service settings with the probable exceptions of needle syringe programs and drop in centres, for example, where only opportunistic screening or brief assessment is provided. Therefore, most workers in the drugs treatment field should be competent in undertaking a thorough assessment.

Assessments should be offered in the context of a safe, reassuring, supportive, nonjudgmental environment to enhance a client's engagement with the service, which in the early stages, is more important than specific drug treatment. Research has shown that a thorough assessment and follow-up by workers helps some users reduce or stop using amphetamines.

Workers should help clients identify their particular treatment goals (eg cut down or stop using; satisfy a court order; resume or gain employment; regain custody of children; improve a strained relationship, etc). This will help strengthen engagement and assist in the development of a treatment plan that is matched

to individual needs. The worker and client can determine collaboratively the progress of treatment against the identified goals, which can sometimes change during the course of treatment. For example, clients who try controlled use of methamphetamine at the beginning of treatment and find it difficult to maintain might choose to stop altogether.

A thorough assessment for methamphetamine treatment should include the following areas:

- current and past methamphetamine use
- other drugs use
- dependence on each drug
- physical and psychological health
- previous methamphetamine withdrawal
- social factors
- trauma history
- readiness to change.

Each of these is discussed in detail below.

Current and past methamphetamine use

History of current and past methamphetamine use should include the following:

- age at first use
- age at first regular use
- type of methamphetamine currently used (crystal, base, powder, pills)
- route of administration (*How do you usually use methamphetamine?*)
- quantity used (*How much are you using? How much do you usually spend? How many points/grams/etc would you use per day/week/fortnight?*)
- frequency of use (*How often are you using?*)
- when the client last used (*Have you used today?*)
- effects of methamphetamine use on the individual (*How does it make you feel?, Are there any effects that are causing difficulties for you?*)
- potency of methamphetamine used (*How long does it usually last*?).

Other drugs use

Using the questions mentioned above for methamphetamine use, workers should question clients about the use of other drugs. Clients might be unaware of the quantities of alcohol and other drugs that they are using, in which case workers should encourage clients to try to keep track of their use over the next week.

Dependence on each drug

Workers should obtain information about the type and severity of dependence on each drug used. The criteria for dependence on each drug should be determined according to the International Classification of Diseases (ICD-10), which state that a person is considered dependent on a drug if *three or more* of the following apply:

- The user has a strong desire or sense of compulsion to take the drug.
- The user has developed tolerance, ie needs to use more of the drug to get the same effect (*Have you found that you need to use more methamphetamine (or other drug) to get the same effect as before?*).
- The person experiences withdrawal symptoms if drug use is reduced or stopped (*Tell me about when you stop using, how do you feel?*; also see Chapter 6, Assisting a person to get through withdrawal for typical symptoms).
- The person is unable to stop using or is using in larger amounts or for longer periods than intended (*Have you ever tried to stop, but found you couldn't?, Have you ever used more than you meant to?, Have you ever used for a longer time than you meant to for example, did a plan to use for a night or two ever turn into a long binge?*).
- A great deal of time is spent acquiring, using or recovering from the drug *(How much time in your day-to-day life is spent on scoring, using or coming down?*), or important activities of life are reduced or neglected because of drug use (*Do you ever skip or miss important things like work, family, or social events due to using or coming down?*).
- The person continues using despite recognition of persistent physical or psychological harms associated with use (*Do you think that any issues that concern you are related to your drug use? Would you consider stopping because of these issues?*).

The **severity** of dependence should also be assessed (see the *Severity of Dependence Scale (SDS*), Appendix 1).

Physical health and psychological health

Workers should ask about the user's physical and psychological health (*Please tell me about your health in general. Do you have any illnesses or injuries? Do you take any prescribed medication?*).

Sometimes methamphetamine users might not be aware that they have physical problems, so workers should recommend a thorough medical checkup if the person has not seen a general practitioner for some time.

A range of screening questionnaires can be used to assess psychological health (see http://www.adelaide.edu.au/library/guide/med/menthealth/scales.html).

The following questions adapted from the *PsyCheck* package can be useful, and if the person answers yes to any question, a detailed assessment should be undertaken:

- Have you ever had emotional problems or problems with your 'nerves'/ anxiety/worries?
- Have you ever seen a GP, psychologist or psychiatrist?
- Have you ever been told that you have a mental health problem?
- Have you ever been in hospital for mental health treatment?
- Do you take medication?
- Do you feel down, sad or blue?
- Has the thought of harming yourself ever been on your mind?
- Are you more jumpy or anxious than usual?
- Do you see or hear things that other people say they can't?

Previous methamphetamine withdrawal or treatment

Workers should ask about the user's previous history of withdrawal or treatment, including its effectiveness and triggers for relapse (*Have you ever received drug treatment before? What prompted you to start using again?*).

Social factors and history of gambling

- Various social factors should be included, such as information about relationships, finances, legal issues, accommodation, social supports (*Please tell me about your life in general. What about friends and family? Are you in contact with your family? Are they supportive? Are you able to manage on the income you receive?*).
- Information about current or previous history of problematic gambling is also helpful (contact alcohol and drug information services (ADIS) for local treatment services).

Trauma history

Assessment should include information about trauma history, including childhood sexual abuse, torture, critical incidents and war experiences. (*Many people who enter drug treatment have suffered traumatic events in their past. May I ask if that is true for you?*)

If a client discloses a history of trauma and is willing, help him or her access help from a specialist because relapse to drug use is high when trauma-related issues are ignored. Be sure to follow-up the client after the assessment if he or she discloses trauma, particularly if it is the first time (contact ADIS for local treatment services).

Readiness to change

Treatment for methamphetamine use should be matched to the client's stage of readiness to change, which can be categorised as follows:

- precontemplation, where the person is not considering change
- contemplation, where the person has not yet cut down or quit, but is considering change
- preparation stage, where the person has made a firm commitment to quit or cut down
- action stage, where the person has recently cut down or quit
- maintenance stage, where the person has cut down or quit for some time
- relapse, where the person has started to use again.

Harm reduction and brief advice are suitable approaches for those not considering change. Those considering change can benefit from motivational enhancement, education, counselling. Those in the preparation or action stage can benefit from structured counselling, and those in relapse can benefit from motivational approaches and skills building.

Counselling

Formal or structured counselling is usually undertaken after withdrawal symptoms subside and should be provided only by workers who have been trained in the approaches described below (see *Making links and creating partnerships* for advice on referral).

Cognitive behavioural approaches

Cognitive behavioural approaches are the most extensively evaluated of the counselling styles and are effective in helping people address problems with meth/amphetamine use. Several clinical treatment manuals are available to guide clinicians in the use of this approach (see *Resources* section for download details).

Cognitive behavioural approaches are short-term, focused, talking therapies that aim to identify and address common errors in thinking and subsequent behaviours that lead to, and maintain, problematic drug use. These approaches include cognitive behaviour therapy (CBT), mindfulness-based cognitive therapy (MBCT), acceptance and commitment therapy (ACT), relapse prevention (RP), and motivational interviewing (MI).

CBT is also very effective for addressing mental health problems such as depression and anxiety.

The Australian Association for Cognitive and Behaviour Therapy can provide details of CBT practitioners in each area (see http://www.aacbt.org/).

Other counselling approaches

Other counselling approaches include:

- narrative therapy, which emphasises the importance of personal life stories and helps clients determine how their stories shape their thoughts and behaviours (see http://www.dulwichcentre.com.au/NC.Australia.htm for a list of therapists)
- solution-focused therapy, which applies a client's strengths to develop solutions to the problems identified(see http://www.goodtherapy.com.au/find_a_therapist.php for a list of therapists).

Randomised controlled trials of these approaches with methamphetamine users have yet to be undertaken, so their effectiveness is not yet known.

Cost of counselling

Medicare will pay for up to 12 counselling sessions by a registered psychologist endorsed by Medicare if the client is referred by a general practitioner. Some private health funds will cover some of the cost of counselling.

Online counselling for drug and alcohol problems can be accessed free of charge from *Counselling Online* 24 hours a day, 7 days a week, across Australia (see http://www.counsellingonline.org.au)

Community Health Centres also often have counsellors available who can be seen free of charge (see local White Pages or call ADIS for contact details).

The rate for counselling from private psychologists vary, but the Australian Psychosocial Society (APS) recommends fees from $100 for a 30-minute session, through to $360 for a session up to 2 hours (see http://www.psychology.org.au/).

Behavioural approaches

Behavioural approaches help clients alter their behaviours and lifestyles to reduce the risk of using drugs. Behavioural approaches can be used alone or in conjunction with CBT. Behavioural approaches include:

- Avoidance of situations, places or people that have been associated with methamphetamine use in the past.
- Adopting new, healthy lifestyle choices, for example, starting a regular exercise program or engaging in activities like dancing, surfing, diving, skiing, golfing; practicing meditation or yoga.

- Use of distraction techniques to deal with cravings to use (eg going for a walk or run, listening to music, taking a shower, calling a friend, gardening).
- Using contingency management (CM), which is based on the theory that behaviour can be shaped by reinforcement, and both positive reinforcement (reward) and negative reinforcement (punishment) will lead to repetition of desirable behaviours.

Contingency management

American studies have examined programs that provide clients with a voucher that can be swapped for goods (eg food), services (eg accommodation) or cash when they provide a urine drug screen that is free from illicit drugs, or engage in other negotiated and contracted desirable behaviours. The approach appears to be useful in the short term to help people stop using, and it is sometimes used in conjunction with CBT to help people maintain abstinence (see *Reference section* for more information on CM).

Even though this type of CM is undertaken rarely in Australia, workers can apply the principles by providing positive feedback about a client's progress and encouraging involved family members to do the same. Workers can help clients identify improvements in his or her overall quality of life. On the other hand, the risk of relapse is high if the client feels that no improvements have been made. In this case, workers can focus on detailed relapse prevention strategies and help clients identify achievable, short-term goals that can signal progress and strengthen retention in treatment.

Residential rehabilitation

Studies have shown that residential treatment is effective for some users.

Residential rehabilitation (RR) is based on the principle that a structured, longer-term, residential setting provides an appropriate environment in which to address the underlying causes of problematic drug use.

The people who are most appropriate for RR are those who have unstable or no accommodation; have poor or absent social supports; have had repeated failed attempts to cease methamphetamine use in the community; and are dependent on multiple drugs.

RR programs usually emphasise abstinence from all drugs as a treatment goal, and some programs exclude prescribed medications as well. RR programs may involve individual and group counselling sessions; and many are based on a 12-step approach (see next section).

Other RR models integrate various treatment approaches and permit the continued use of prescribed medications for mental health symptoms. This

may be important given that many long-term methamphetamine users also have concurrent mental health problems, and this approach may help address the high initial dropout rates. Workers should understand a RR facility's model for treatment and refer clients to the particular program that will best meet their needs.

Self-help or mutual support groups

Most self-help or mutual support groups are based on the 12-step approach of alcoholics anonymous (AA) or narcotics anonymous (NA), which promotes a disease concept that implies recovery from, rather than a cure for, substance dependence.

This approach is based on the '12 steps' to recovery and includes making a personal inventory of the user's life, making restitution to those injured, and assisting and supporting others through disclosure of personal stories at meetings and personal sponsorship of other users in recovery. It also emphasises a spiritual component or 'higher power'.

A specific group exists for users of methamphetamine known as *Crystal Meth Anonymous*, which is running in some areas of Australia such as Sydney (http://www.sydcma.com/index.htm). Methamphetamine users can attend NA meetings in other areas (see http://www.naoz.org.au/community/index.php for meeting details).

Research demonstrates that some people do well with the 12-step approach although dropout rates are high. Outcomes specifically for methamphetamine users have not yet been determined.

An alternative model, recently introduced to Australia, is SMART recovery (Self Management And Recovery Training), which integrates the self-help, mutual support model with elements of CBT.

The four key elements of SMART Recovery include motivational enhancement, coping with cravings to use, problem solving, and developing a balanced lifestyle. SMART recovery does not have a spiritual foundation and emphasises an evidence-based approach to self-help.

Currently, most groups are run in NSW, although new groups are launched regularly throughout Australia, so check the website for details (http://www.smartrecoveryaustralia.com.au/).

Medications (pharmacotherapies)

Three broad categories of medications are relevant to methamphetamine treatment. These are prescribed to:

- ease the symptoms of withdrawal
- help clients stay off methamphetamine (maintenance therapy or drug substitution therapy)
- treat other disorders such as mental or physical health problems.

Research into the effectiveness of a wide range of medications (referred to as pharmacotherapies) to treat methamphetamine withdrawal and to prevent relapse has not yet demonstrated the superiority of one drug over another because the medications may cause uncomfortable side effects, increased cravings, or lack of improvement in general.

Drug substitution therapy aims to replace an illegal, injectable or smokable drug with a legal drug that can be taken by mouth and to provide an opportunity to stabilise a person's lifestyle enough to allow him or her to receive structured counselling. Substitution with dexamphetamine (a central nervous system stimulant) has been available for some time in the United Kingdom and is similar in principle to prescribing methadone for heroin dependence. Substitution therapy is generally reserved for methamphetamine users who experience the most harm from use.

Medication trials of both dexamphetamine and modafinil, which promotes wakefulness and is used to treat the sleep disorder narcolepsy, are currently underway in Australia.

Evidence suggests that appropriate medications are effective and should be prescribed for diagnosed mental health conditions such as enduring depression, anxiety, and psychotic disorders.

Stimulant treatment programs

Several specific stimulant treatment programs are currently being evaluated in NSW. Treatment comprises assessment and counselling, education, support and specialised treatment for clients who also have mental health issues. Call the local ADIS for details of specific services in other areas.

Other supports

Although evidence is lacking on alternatives to those discussed above, users have expressed interest in complementary therapies and other supports

to improve their general physical and mental health. The following general principles apply to most users:

- A good diet is essential for recovery and long-term health.
- Regular exercise alleviates some symptoms of depression, regulates sleep, and boosts the immune system.
- Meditation reduces stress and improves concentration.
- Massage promotes relaxation.

Special considerations for young methamphetamine users

There is some evidence to suggest that drug use at an early age can increase a person's chances of developing dependence later in life, which is thought to be at least partly due to drug exposure before the brain has fully developed.

Methamphetamine use from a young age has been linked to structural and functional changes in the brains of long-term, regular users later in life.

Rates of amphetamine use among those involved with juvenile justice are higher than that of the general population.

Guidance for working with young stimulant users

Evidence regarding effective approaches for young stimulant users is sparse, although the following can be used as a guide:

- Assessment should include domains described in the *Assessment* section plus exploration of leisure and social functioning, family relationships, peer interactions, hobbies and educational history.
- As with adult users, the intensity of treatment should be matched to the severity of problematic methamphetamine use and associated problems, from the least to the most intensive interventions. For example, a recreational methamphetamine user could benefit from harm reduction advice and education about the short- and long-term effects to reduce risk of regular use or of moving on to injecting. A regular ice smoker with a history of psychosis would need more intensive interventions including monitoring for withdrawal and relapse of psychosis. Treatment matching is known as a 'stepped-care' approach.
- Treatment should be 'youth friendly' and include:
  - follow-up for missed appointments
  - ease of access
  - prompt screening and assessment

  - drop-in capability
  - strong links to other relevant agencies to ensure holistic treatment
  - an environment that is able to provide some basic assistance before the young person enters more formal or structured treatment.
- Family therapy is considered essential in the management of adolescent users.
- Mental health disorders should be assessed and treated appropriately, and a co-ordinated approach should be taken by all workers involved in the young person's care (see Chapter 11, *Making links and creating partnerships*).
- Hospital-based detoxification is rarely required for by young people because of a shorter exposure to the drug and because of a young person's capacity to recover rapidly.
- The Australian Government Department of Education Science and Training has produced a resource *Keeping in Touch: The Kit. Working with Alcohol and Other Drug Use. A resource for Primary and Secondary Schools*, which is useful for those whose work involves schools or school-aged children (see http://www.dest.gov.au/).

Special considerations for Indigenous methamphetamine users

The problems associated with the use of methamphetamine can be even more severe in Aboriginal communities where significant social and health problems already exist. Ideally, both Indigenous and non-Indigenous workers would be available so clients can choose the worker with whom they feel most comfortable. If an Indigenous worker is not available, non-Indigenous workers could seek advice, secondary consultation or other support from Indigenous workers from external agencies, in addition to undertaking training in cultural awareness.

In responding to the needs of Indigenous clients, workers should consider the following issues:

- Culturally appropriate assessment for drug use is required when working with Indigenous clients, and assessment can be enhanced by gaining information from a range of sources including the client, family and other service providers.
- Workers should liaise with other services to establish a strong network that can provide support and follow-up for Indigenous clients (see Chapter 11, *Making links and creating partnerships*).

- Indigenous clients should be informed of how to access additional information (*If you want to know more about (*subject*), this is how you can find it*).
- Careful information gathering is also required to determine the presence and content of delusions and hallucinations. When unusual beliefs or sounds (eg spirits) are described by Indigenous people, workers should not make an assumption that such thoughts are part of the person's cultural beliefs and therefore not a cause for concern. The content of the unusual thoughts should be carefully checked with the person's family or significant others to determine if the beliefs are shared by the person's family or tribe. If the beliefs are *not shared* then they could be psychotic in nature. A declining level of functioning in the person's day-to-day life is also a good indicator that the person is experiencing psychosis.
- Indigenous users may have a higher risk of diseases associated with injecting, including hepatitis B and C. Some evidence suggests that needle sharing is more common among Indigenous Australians than non-Indigenous Australians. This could be due to the culture of sharing among close friends and family, lack of access to clean equipment, or lack of awareness of how to obtain clean injecting equipment. Risks of sharing needles and how to access a supply of clean needle and syringes should be discussed with clients who do not intend to stop using methamphetamine. Workers should encourage the client to consider screening and vaccination.
- Some Indigenous clients may have a low level of literacy, and written materials should be appropriate to the reading age of the client. Other media that are culturally appropriate should be used to deliver harm reduction advice or other information (see http://www.adac.org.au for the comic, *Don't mess with meth*).
- The impact of the person's drug use on his or her family including parenting and child protection issues should be considered. Indigenous families require strong support to understand and navigate the range of agencies that might be involved in their care.
- Methamphetamine use may impose a financial burden, particularly on families that are already struggling.
- Methamphetamine use may alienate the person from family life and cultural activities, and this may affect the client's mental, emotional and spiritual health.

Special considerations for methamphetamine users from culturally and linguistically diverse backgrounds (CALD)

- Research into methamphetamine use in CALD communities is sparse, although drug use is less likely in people from CALD backgrounds than in the wider community.
- People from CALD backgrounds often experience difficulties in accessing culturally appropriate information and treatment services because most services have been developed primarily for non-CALD populations.
- The style of individualised counselling that is provided in mainstream alcohol and other drug treatment agencies may be unfamiliar, and the client and family may lack confidence in treatment outcomes. Workers should carefully explain the aims of treatment and encourage the client and family to recognise even small gains made over time.
- In many cases, cultural appropriateness requires workers to include a client's family in treatment planning, although this will vary from client to client.
- Outreach services and case management approaches are often used by specialist services to respond to the needs of clients from a CALD background.
- An interpreter may be required to ensure an accurate assessment and appropriate management strategy. The use of skilled interpreters with the appropriate dialect and of the client's preferred gender is crucial. Even when families are involved in the client's treatment, it is inappropriate to use family members as interpreters.
- Workers should establish what knowledge the client has about methamphetamine use to begin with and use that as a starting point to provide relevant information and enhance the client's engagement with the service.
- As with Indigenous clients, care should be taken when assessing the nature of possible psychotic symptoms to ensure that unusual beliefs or experiences are not related to the person's culture.
- Workers should explore support needs for any resettlement issues clients from CALD backgrounds might have (eg housing, financial, employment, language, social issues) and help the person access help needed to overcome these additional stressors, which could be a barrier to treatment progress.

General tips for agency responses to methamphetamine users

The following tips will help in responding to the needs of methamphetamine users:

- respond promptly and acknowledge the client's effort to ask for assistance
- be open and nonjudgmental
- provide written resources and advise of the availability of treatment options
- consider the appointment of a case manager and follow up missed appointments
- refer when needed
- provide adequate staff training and supervision.

Each of these is explained in more detail below.

Respond promptly and acknowledge the client's effort

- Develop a culture of prompt response, including telephone response. Be sure to schedule initial appointments, without delay, within 24 hours of the call, even if only an intake or assessment can be undertaken.
- Acknowledge the enormous effort the person has made to ask for assistance — methamphetamine users have often reached a crisis point, and feel low and extremely vulnerable at this time. Workers could say something like 'It must have taken a lot of courage and determination to come here and ask for help'. This recognition can help the person engage with the service and establish a helping relationship between the worker and the client.

Be open and nonjudgmental

- Adopt an open, nonjudgmental, nonconfrontational approach. Accept the client as an individual and do not allow any personal beliefs or feelings about methamphetamine use to cloud the helping relationship. Be willing to work with the client's goals for treatment even if they do not match those of the worker.

Provide written resources and advise of the availability of treatment options

- Ensure that a range of written resources are readily available for clients to take away.
- When amphetamine-specific treatment is available (eg CBT), place signs in prominent positions indicating that treatment is available in the service.

Appoint a case manager and follow up on missed appointments

- Appointment of a case manager can strengthen a client's engagement with the service and help maintain the person in treatment. Case managers also help people access a range of important services from other agencies.
- Follow-up for missed appointments (eg telephoning the client) also increases the likelihood that the client will continue to access the service.

Refer when needed

- Referral information should be readily at hand. However, a client in crisis often does not have the resources necessary to access other agencies, and workers should attempt to address as many of the person's needs as possible in the one setting. If this is not possible, workers should actively help the person access other agencies rather than simply providing 'passive' referrals (see Chapter 11, *Making links and creating partnerships* for referral tips).

Provide adequate staff training and supervision

- Workers should receive regular, relevant training from either more experienced workers within the service or specific training organisations. For example, *From go to whoa* is an amphetamine-specific training package that has been developed for frontline workers. Contact Turning Point Alcohol and Drug Centre in Melbourne for details (http://www.turningpoint.org.au).
- Workers should receive regular clinical supervision in addition to that routinely undertaken by line managers. Supervision provides an opportunity for reflective practice; enhancement of clinical skills; debriefing; maintaining professional boundaries; and attention to the management of stress and burnout. It is also useful for workers to clarify complex issues such as mandatory reporting and mental health interventions. A supervision resource kit can be downloaded from the National Centre for Education and Training on Addiction (NCETA) website (http://www.nceta.flinders.edu.au/csrk/).
- Consider involving peer organisations or individual peer support workers or educators in the service's overall response to methamphetamine users.
- The range of skills and knowledge required by workers to respond appropriately to methamphetamine users include:
  - sound communication
  - engagement and retention strategies
  - screening and assessment for methamphetamine use *and* mental health problems
  - brief interventions
  - risk reduction principles
  - motivational interviewing

  - relapse prevention
  - knowledge of treatment options
  - knowledge of appropriate agencies for referral and strong client advocacy skills
  - CBT or an alternative counselling style if structured clinical counselling is to be offered by the worker.
- Awareness and maintenance of professional boundaries that define the relationship between the worker and client. This can include careful consideration as to what, if any, personal information to share with clients, declining to provide personal phone numbers or addresses, and acting within the parameters of a helpful or therapeutic relationship that is in the best interests of the client.

References Chapter 8: Overview of the range of treatment options

Aboriginal Health and Medical Research Council of New South Wales, Mandala Consulting (2004). *Increasing Access to Services in NSW for Aboriginal People at Risk of Contracting or Who Have Blood Borne Infections*. Aboriginal Health and Medical Research Council of NSW, Strawberry Hills, NSW http://www.ahmrc.org.au/Publications.htm (Accessed 26 May 2008).

Alberta Alcohol & Drug Abuse Commission (2004). *Crystal Meth and Youth Effective Treatment and Prevention Practices,* Alberta Alcohol & Drug Abuse Commission, Calgary.

Baker A, Gowing L, Lee NK and Proudfoot H (2004). Psychosocial interventions. In *Models of Intervention and Care for Psychostimulant Users*, 2nd edition. Baker A, Lee N and Jenner L (eds), Commonwealth of Australia Monograph Series, 63–84.

Baker A, Kay-Lambkin F, Lee N, Claire A and Jenner L (2003). *A Brief Cognitive Behavioural Intervention for Regular Amphetamine Users: A Treatment Guide*. Australian Government Department of Health and Ageing, Canberra.

Campos M and Shoptaw S (2005). Evidence-based treatments for methamphetamine abuse. *Focus: A Guide to AIDS Research and Counseling*, 20(6):5–8.

Drug and Alcohol Multicultural Education Centre (DAMEC). (2007). *Submission to the Inquiry into the Impact of Illicit Drug Use on Families*. Submission No: 90. Redfern, New South Wales. http://www.aph.gov.au/house/committee/fhs/illicitdrugs/subs/sub090.pdf (Accessed February 2008)

Drug and Alcohol Office WA. *Illicit Amphetamine Summit* July 2007 Background paper. Drug and Alcohol Office, Perth.

Donovan DM and Wells EA (2007). Tweaking 12-Step: the potential role of 12-Step self-help group involvement in methamphetamine recovery. *Addiction* 102 Supplement 1:121–129.

Gossop M, Darke S, Griffiths P, Hando J, Powis B, Hall W and Strang J (1995). The severity of dependence scale (SDS): psychometric properties of the SDS in English and Australian samples of heroin, cocaine and amphetamine users. *Addiction* 90:607–614.

International Classification of Diseases (ICD-10). *Dependence Syndrome*. World Health Organization. http://www.who.int/substance_abuse/terminology/definition1/en/index.html (Accessed May 2008).

Lee, N.K. & Rawson, R.A. (2008) A systematic review of cognitive and behavioural therapies for methamphetamine dependence. *Drug and Alcohol Review*, 27(3), 309-317.

Lee NK, Johns L, Jenkinson R, Johnston J, Connolly K, Hall K and Cash R (2007). *Clinical Treatment Guidelines for Alcohol and Drug Clinicians. No 14: Methamphetamine Dependence and Treatment*. Turning Point Alcohol and Drug Centre Inc, Fitzroy.

Lee NK, Jenner L, Kay-Lambkin F, Hall K, Dann F, Roeg S, Hunt S, Dingle G, Baker A, Hides L and Ritter A (2007). *PsyCheck: Responding to Mental Health Issues within Alcohol and Drug Treatment*. Commonwealth of Australia, Canberra.

Montana Chemical Dependency Bureau (2006). *Best Treatment Strategies for Methamphetamine Treatment Implementation*. Montana Chemical Dependency Bureau, Helena.

National Drug Research Institute (2001). *The Harm Reduction Needs of Aboriginal People who Inject Drugs*. Community Report. Curtin University of Technology, Perth.

ORYGEN Research Centre. *Psychosis: Guidelines for Providing Mental Health First Aid to an Aboriginal or Torres Strait Islander Person*. Department of Psychiatry, The University of Melbourne AUSTRALIA. http://www.mhfa.com.au (Accessed February 2008).

Roll JM, Petry NM, Stitzer ML, Brecht ML, Peirce JM, McCann MJ, Blaine J, MacDonald M, DiMaria J, Lucero L and Kellogg S (2006). Contingency management for the treatment of methamphetamine use disorders. *American Journal of Psychiatry* 163:1993–1999.

Roll JM (2007). Contingency management: an evidence-based component of methamphetamine use disorder treatments. New information on methamphetamine. *Addiction* 102 Supplement 1:114–120.

Shearer J and Gowing L (2004). Pharmacological interventions. In *Models of Intervention and Care for Psychostimulant Users*, 2nd edition, Baker A, Lee N and Jenner L (eds), Commonwealth of Australia Monograph Series, 120–132.

Shearer J (2007). Psychosocial approaches to psychostimulant dependence: A systematic review. *Journal of Substance Abuse Treatment* 32(1):41–52.

Stubbs M, Hides L, Howard J and Arcuri A (2004). Psychostimulants and young people. In *Models of Intervention and Care for Psychostimulant Users*, 2nd edition, Baker A, Lee N and Jenner L (eds), Commonwealth of Australia Monograph Series, 133–155.

Volkow ND and Li T (2004). Drug addiction: the neurobiology of behaviour gone awry. *Nature Reviews Neuroscience,* 5:963–970. http://www.nature.com/reviews/neurodoi:10.1038/nrn1539.

9
Assisting families, carers and significant others

Families are often a great source of support and encouragement for methamphetamine users and can be a strong foundation for positive change in their lives. However, family dynamics can also be complex and, in some families, drug use or even violence can be a part of the family system. Workers should explore the family dynamics thoroughly with the client and, if the family situation is unhelpful, it is in the best interests of the client to get support from elsewhere such as friends, peers, and treatment or welfare agencies.

Families should also understand that sometimes users are motivated to protect them from the consequences of their drug use by avoiding their family when they are using, withdrawing or receiving treatment.

In considering these issues, a worker might assist a client who has experienced family breakdown or help supportive families strengthen their relationship with a family member who is using methamphetamine. In some cases, the family or carer *is* the client and the drug user might not be seen by the worker at all. Families of methamphetamine users have needs in their own right, and some services now have a family therapist available.

Tips for helping families, carers and significant others

Regular users of methamphetamine can experience mood swings, anxiety, depression, irritability, anger and hostility. Such adverse effects can have a profoundly negative impact on relationships with family and others. It is often difficult for carers to understand why their family member continues to use methamphetamine in the face of often significant problems related to poor mental health, dependence, finances or the law.

Families, carers and significant others need education, support and practical assistance to help them understand the issues and to improve their own

wellbeing as they maintain a relationship or try to repair a relationship with their family member.

The following suggestions might be helpful:

- ✔ Listen to their concerns, help them clarify the major issues and assure them that a range of feelings such as distress, helplessness, embarrassment, fear and anger are shared by other families and are normal feelings in this situation.
- ✔ Explain the different ways in which people use drugs — experimental or recreational use of methamphetamine does not mean that the user is dependent (see Chapter 1, *About methamphetamine*).
- ✔ Briefly and plainly, describe how this drug works in the body and the range of possible effects. Include information about the 'crash' period and withdrawal symptoms and how regular methamphetamine use can adversely affect a person's mood, concentration and decision-making abilities (see Chapter 1, *About methamphetamine*).
- ✔ Explain the concept of 'readiness to change' to promote an understanding of relapse and how some individuals can be in two minds (ambivalent) about changing methamphetamine use; describe suitable approaches for each stage (see Chapter 8, *Overview of the range of treatment options*).
- ✔ Describe symptoms of psychosis and early warning signs, and recommend an effective approach if the user experiences symptoms. Emphasise that an expression of anger or irritability does not mean that a person is psychotic, but can simply be a sign to back off to allow space for everyone to calm down (see Chapter 5, *Recognising and responding to a person with mental health problems).*
- ✔ Help families develop a crisis plan should the user express thoughts of suicide, develop psychosis or become hostile. The crisis plan should include a safety plan; emergency contact numbers; when and how to enlist the help of specialist mental health services; and how to communicate with the user until help is gained (see Appendix 2 for an example).
- ✔ Explain the range of treatment options available and the role of harm reduction for users not considering change.
- ✔ Explain that there are many ways that a person's methamphetamine use can affect a family. Workers can help families recognise even subtle changes and should encourage the family to develop helpful strategies to deal with undesired changes.
- ✔ Determine what strategies have been successful and not so successful; encourage families to change their approach if it is not resulting in the outcomes they seek.

- ✔ Encourage the family members to be clear about what they will and will not tolerate, to maintain their limits and to communicate this calmly and clearly to the user.
- ✔ Remind family members to look after themselves and not to put their own lives on hold. Stress management, adequate diet, rest and exercise, and continuing to enjoy their usual activities will help family members cope and better enable them continue to care for their family member.
- ✔ Provide information about local support services and encourage families to meet or speak to other families in similar situations (see *Supports for families* later in this chapter). Feelings of isolation and stigma or fears of being judged as a poor parent are common and are often involved in a family's reluctance to seek help.
- ✔ If the methamphetamine user is the worker's primary client, provide as much information as possible to the family without breaching client confidentiality or obtain client consent to provide relevant information to the family.

Dependent children of adult methamphetamine users

Family relationships can become even more complex or troubled when young children are involved. Grandparents and other relatives can be caught between trying to repair relationships with their own adult child or sibling and feeling concern for the children's welfare. Grandparents and other relatives might have difficulty seeing the children if the relationship with their own adult child or sibling is strained. In some cases, grandparents, aunts or uncles find themselves being the primary care giver for the children of methamphetamine users.

In addition to the above, the following suggestions might be useful:

- ✔ Encourage family members to talk to each other about their concerns.
- ✔ If access to children is limited or denied, explore other avenues of maintaining a relationship with the children such as through letters, email or phone calls if possible.
- ✔ Grandparents and other relatives should be clear about what their concerns are in regard to the welfare of the children and, if safe to do so, calmly and clearly discuss this with the children's parents.
- ✔ If the concern for the child's welfare is significant, then the grandparent or other relatives can telephone the state child protection agency and either ask for general advice about the situation before making a decision about how to proceed, or formally report their concerns. Families must be reminded that removal of children from parents is the last resort for these departments — methamphetamine users still love their children and can continue to be good parents.
- ✔ Family members caring for children might be entitled to financial assistance, so contact *Centrelink* for advice.

Young carers

Children and young people are sometimes required to care for or support a family member who has a drug, alcohol or mental health problem. The role that the young person plays will vary from family to family, but can include cooking and cleaning, caring for younger siblings, paying bills, shopping, generally supporting the parent and even intervening during a crisis.

The impact of such a great responsibility can significantly affect the young person's school and social life. The young person might feel isolated, embarrassed, fearful, angry, anxious, and a range of other emotions.

Like older carers, young people need to continue to live their own lives and reduce their stress levels. For example, they could draw, write, listen to music, dance, sleep, read, surf the internet, spend time with friends, or do something physical like playing sport, surfing or riding.

Young carers should also be encouraged to develop a crisis plan should an emergency situation arise. This should include making sure there is at least one trusted person they can contact or stay with in an emergency (see Appendix 3, *Example of a young carer's emergency plan*).

They should also be encouraged to talk about their feelings with a trusted relative, teacher or school counsellor. Some schools now have *Young Carer* support workers and programs available.

Alternatively, they can call Kids Help Line, which is an Australia-wide, free, confidential counselling and support service available to children and young people aged 5 to 25 years. Email or web-based counselling is also available. Telephone toll free: 1800 55 1800. Website: http://www.kidshelp.com.au.

There are several other sites for young carers that have useful links, chat rooms, and practical information available for download: http://www.youngcarersnsw.asn.au; http://www.youngcarers.net.au; http://www.reachout.com.au; http://www.headroom.net.au.

Supports for families

Resources

A Guide to Coping. Support for families faced with problematic drug use. This publication contains personal stories and information about a range of drugs, and offers practical advice to assist families of drug users. The book can be purchased from Family Drug Support. http://www.fds.org.au/

Parent Drug Information Service Information and Support Pack for Parents and Families: For those faced with problem drug or alcohol use of a child or family

member, by the Drug and Alcohol Office Western Australia. This publication can be downloaded from the following site: http://www.dao.health.wa.gov.au/

What parents should know about ice. Victorian Government Health Information website. Brochure can be downloaded in pdf format from the following site: http://www.health.vic.gov.au/drugservices/pubs/ice.htm

Contact numbers and websites

Australia-wide

Family Drug Support is a national, nongovernment support and information service with a chapter in each state that provides family assistance 24 hours a day. http://www.fds.org.au/. Helpline: 1300 368 186.

There is an Alcohol and Drug Information Service (ADIS) in each state, which offers confidential telephone information 24 hours, 7 days a week, advice and counselling services for people with problems related to drugs and alcohol. Each ADIS keeps a complete database of treatment agencies in its state. See contact numbers for ADIS in each state below.

Carers Australia website has many useful links and tips for families http://www.carersaustralia.com.au.

Each state has Al-anon, Nar-anon and Families Anonymous groups. Call your ADIS for local information.

ACT

ADIS: (02) 6205 4545, toll free nonmetropolitan: 1800 422 599.

ParentLink provides confidential telephone information, advice, guidance and referral service: (02) 6205 8800 or http://www.parentlink.act.gov.au/.

NSW

ADIS: (02) 9361 8000, toll-free nonmetropolitan: 1800 422 599.

Family and Carers Support Group, Ted Noffs Foundation: 02 9310 0133 or http://www.noffs.org.au/ (Sydney, Wollongong, Canberra, Coffs Harbour and Dubbo). Programs for parents or carers concerned about their child's drug use.

Parent Line, available 9 am to 4.30 pm AEST Monday–Saturday: 13 20 55.

Northern Territory

ADIS Darwin: (08) 8922 8399, Alice Springs: (08) 8951 7580, toll-free nonmetropolitan: 1800 131 350.

Parentline, a confidential telephone counselling service providing professional counselling and support for parents and care givers, available 8 am to 10 pm, seven days a week: 1300 30 1300 (http://www.parentline.com.au).

Queensland

ADIS: (07) 3236 2414, toll-free nonmetropolitan: 1800 177 833.

Family Drug Support: (07) 3252 1735.

Parent, Child and Family Support Program: (07) 3620 8111.

Queensland Injectors Health Network (QuIHN) http://www.quihn.org.

Parentline, a confidential telephone counselling service providing professional counselling and support for parents and care-givers, available 8 am to 10 pm, seven days a week: 1300 30 1300 (http://www.parentline.com.au).

South Australia

ADIS: (08) 8363 8618, toll-free nonmetropolitan: 1300 13 13 40.

Family Drug Support: (08) 8384 4314.

Tasmania

ADIS Hobart: (03) 6222 7511, toll-free nonmetropolitan: 1800 811 994.

Parenting Line Tasmania: 1300 808 178.

Victoria

ADIS: (03) 9278 8100, toll-free nonmetropolitan: 1800 888 236.

Family Drug Help provides support and information to families and friends of drug users by assisting families and agencies to develop self-help and mutual support groups in their local community: (03) 9572 2855.

Western Australia

ADIS: (08) 9442 5000, toll-free nonmetropolitan: 1800 198 024.

The Parent Drug Information Service (PDIS) is a confidential telephone support service that provides support, counselling, information and referral service 24 hours a day to parents and families in Western Australia: (08) 9442 5050, country toll-free: 1800 653 203.

Grand Care is operated by Wanslea Family Services and is designed to support grandparents who care for their grandchildren. The program offers group and individual support, limited individual consultation and an information line staffed by volunteers during business hours: 1800 008 323. http://www.wanslea.asn.au/services/servicesGC.html.

References Chapter 9: Assisting families, carers and significant others

Australian General Practice Network (2007). *Management of Patients with Psychostimulant Use Problems — Guidelines for General Practitioners.* Australian Government Department of Health and Ageing, Canberra.

Department of Health (England) and the devolved administrations (2007). *Drug Misuse and Dependence: UK Guidelines on Clinical Management,* Department of Health (England), the Scottish Government, Welsh Assembly Government and Northern Ireland Executive, London.

Drug and Alcohol Office (2006). *Parent Drug Information Service Information and Support Pack for Parents and Families: For Those Faced with Problem Drug or Alcohol Use of a Child or Family Member*. Drug and Alcohol Office Western Australia, Perth. http://www.dao.health.wa.gov.au/ (Accessed January 2008).

Family Drug Support (2002). *A Guide to Coping: Support for Families Faced with Problematic Drug Use*, Family Drug Support, Leura, NSW.

10
Legal issues

There is a range of legal issues related to methamphetamine use, and key areas are briefly considered here.

Clients who are forced into treatment (coerced clients)

There are times when a person might feel pressured to enter treatment. This is known as *coercion*.

Coercion can be both *formal* and *informal*.

- *Formal coercion* involves treatment that is legally mandated or required to fulfil a court order. The client will be supervised by community corrections, drug courts, diversion programs or similar programs. Clients may also enter treatment to meet requirements of child custody or access rights.
- *Informal coercion* includes pressure to enter treatment from a spouse, parent, carer, other family member, or any significant person in the client's life, and is not bound by legal obligations.

Workers sometimes feel a sense of pessimism about treatment outcomes for coerced clients, particularly those mandated by the courts. However, evidence suggests that treatment is *just as effective for users who are pressured to enter treatment as for those who seek help voluntarily*. Workers must take into consideration that, although the person was coerced to enter treatment, he or she ultimately made the decision to attend.

Careful attention to building rapport, developing an alliance, and enhancing engagement and motivation are important aspects in treatment of the coerced client. Workers should employ a nonjudgmental approach and emphasise that the worker is there to help the client and will respond to his or her needs, and that workers have no role in pressuring or punishing the client in any way.

In responding to the needs of coerced clients, it is important to determine whether the coercion is formal or informal and to target assistance or treatment accordingly. For example, if the coercion is *informal*, client consent is required before any information about his or her progress can be shared with a spouse, family member, significant other or any other party. The extent to which others are involved in a client's care is entirely up to the client even if he or she feels pressured to attend sessions.

If coercion is *formal*, establish a firm working relationship at the outset. Workers should clearly state under what circumstances and to which agencies they are legally obliged to disclose information regarding the client's progress even without client consent (eg diversion programs, community corrections, family services). If workers are unaware of their legal obligations, they should make every effort to find out before the first session is undertaken.

It is also important to note that a longer time in treatment is associated with more positive outcomes for methamphetamine users mandated to treatment; therefore, engaging the coerced client is essential for improving long-term outcomes.

Mandatory reporting

Mandatory reporting relates to legislation specifying who is required by law to report suspected cases of child abuse and neglect.

Every Australian state and territory now has mandatory reporting legislation in place. The information to be reported and the categories of people required by law to report vary across states and territories, so workers have a duty to familiarise themselves with the legislation in their own state or territory. Workplaces should provide an opportunity for workers to understand their responsibilities under this legislation. If ever in doubt about their responsibilities, workers should seek assistance from a supervisor.

Generally speaking, workers are required to report to the relevant state body (eg department of family services, child protection office, department of child safety) if they suspect or confirm that a child or young person is suffering, has suffered or is likely to suffer abuse, neglect or harm. In some states, harm also includes exposure to domestic violence.

Many reports throughout Australia have involved parents who use drugs.

In some states reports can be made before a child is born or shortly after delivery.

For details of specific mandatory reporting legislation, see the Australian Government Institute of Family Studies website for an overview of Australia-wide legislation and for links to each state and territory at http://www.aifs.gov.au.

Crime

A recent survey of Sydney users revealed that many could afford to pay for methamphetamine with a legitimate income, although regular or dependent users were more likely to turn to criminal activity such as drug dealing or stealing to fund continuing methamphetamine use.

There is widespread public perception that all users of methamphetamine are violently out of control. Although methamphetamine users have higher rates of violent offending than the general population, violent crime tends to be limited to a relatively small group of methamphetamine users who are likely to be polydrug users (particularly alcohol and heroin), and who are already inclined toward criminal activity. A single dose of methamphetamine does not inevitably cause a person to become violent.

Violence, when it does occur, is often linked with fear and paranoia associated with regular or dependent methamphetamine use and is frequently triggered in response to a perceived threat, or when a person is paranoid or psychotic. Therefore, hostility and violence are often time limited and tend to occur only when symptoms are acute.

Readers are referred to *Responding to Challenging Situations Related to the Use of Psychostimulants: A Practical Guide for Frontline Workers* at http://www.nationaldrugstrategy.gov.au.

References Chapter 10: Legal issues

Brecht ML, Anglin MD and Dylan M (2005). Coerced treatment for methamphetamine abuse: Differential patient characteristics and outcomes. *American Journal of Drug & Alcohol Abuse* 31(2):337–356.

McKetin R, McLaren J and Kelly E (2005). *The Sydney Methamphetamine Market: Patterns of Supply, Use, Personal Harms and Social Consequences*, National Drug and Alcohol Research Centre, Sydney.

McKetin R, McLaren J, Riddell S and Robins L (2006). *The Relationship Between Methamphetamine Use and Violent Behaviour*. NSW Bureau of Crime Statistics and Research Crime and Justice Bulletin No. 97. NSW Bureau of Crime Statistics and Research, Sydney.

11
Making links and creating partnerships

This chapter provides guidance on developing links and partnerships with a range of agencies and service providers including general practitioners (GPs), mental health services, antenatal teams, police and ambulance services. The different types of referral and tips on improving referral practices are also offered.

Why create partnerships?

Users of methamphetamine are faced with a range of general and mental health concerns, as well as other day-to-day needs. GPs, specialist mental health services (MHS), ambulance services, housing services, employment services, legal aid, and a range of other welfare or support agencies can provide the care and specialist assistance that alcohol and drug treatment services often cannot. The aim of collaboration is to help facilitate timely, appropriate and targeted responses to clients' needs, minimise access barriers for clients, and ultimately improve client outcomes.

Barriers to effective partnerships

Any of the following factors can act as a barrier to developing an effective partnership:

- fear of breaching client confidentiality
- reluctance of some services or agencies to accept or treat known methamphetamine users
- unfamiliarity with the role and function of other service providers or roles in client treatment
- use of different language or jargon

- breakdown of communication or referral pathways, which discourages ongoing collaboration
- workers' lack of awareness of referral pathways and specific roles *within* an organisation.

Tips for developing partnerships

Collaboration can be seen as a continuum, with simple advice or referral at one end to coordinated shared care at the other. Each service should decide the level of collaboration it is hoping to achieve and actively take steps to realise that outcome.

In many cases, collaboration occurs naturally as a consequence of a personal relationship between individual staff members from different services. However, cooperation may stop or change when staff members leave organisations, so formal links are much more likely to last.

Local agencies

The following is a suggested sequence for identifying appropriate local agencies and developing partnerships with them.

1. Identify local agencies

Workers should determine which local agencies could improve their service's response to users of methamphetamine — it is important to find out what potential partners actually offer to make sure the partnership is workable or useful, and that the worker's clients fit the target agency's access criteria before negotiations begin.

2. Meet with the target agency

Workers should approach the target agency with a request for collaboration or cooperation and determine ahead of time how their service could support the partner agency. Workers need to be prepared to outline how their service, the target agency and clients could benefit from a recognised or formal collaboration. Workers might need to challenge some myths that could arise about methamphetamine users (eg all users are violently out of control) and use persuasive client advocacy skills at this stage.

3. Decide on the nature of the collaboration

If the agency is receptive, workers from both services should collaboratively decide on an appropriate level of cooperation, agree on roles, function and outcomes. These might include fast-tracked assessment or access to the other service; reciprocal telephone or face-to-face support or advice; taking turns to provide a regular service to clients in each of the service settings; offers to provide in-service training; sharing of relevant information; co-case management.

4. Consider a joint memorandum of understanding

Consider developing a joint memorandum of understanding (MoU, see Appendix 4 for an example); formal referral pathways; policy and procedures for collaboration including confidentiality and information sharing issues; and timelines for review of effectiveness of collaboration according to the level of cooperation chosen.

The following points relate to developing links with specific services.

Mental health services

The structure of mental health services (MHS) varies across states and territories. Services are provided mainly in the community, and there is now a greater emphasis on collaboration with alcohol and other drug (AOD) services as the overlap between mental health problems and drug use has become increasingly more evident.

Acute MHS undertake assessments of people who are considered a risk to themselves or others. If the risk is high, these people tend to be stabilised in a hospital or acute care setting, whereas those considered less at risk are cared for in the community.

AOD treatment agencies will from time to time contact acute or crisis MHS if workers are concerned about the safety and mental health of a client who is experiencing psychosis or expressing thoughts of self-harm. Similarly, workers will collaborate with community MHS practitioners' if clients with mental health problems receive services from both agencies.

The following steps provide a starting point and an opportunity to develop more formal links.

1. Initiate contact with the MHS

Workers could start by contacting the local MHS with an offer to provide an in-service training session for both community and acute MHS staff members on the topic of methamphetamine use and related problems.

Workers should make contact with the local MHS team that is responsible for assessments (eg crisis team, acute care service, admissions office, etc) and ask for information about their intake procedures, criteria for admission, geographical intake boundaries (usually limited to clients residing in certain suburbs or districts), and office hours, etc so the worker's service can refer clients appropriately.

2. Describe the service offered

Workers could take the opportunity to inform both community and acute MHS staff members of what their service provides; the intake and assessment process; office hours etc, so an understanding of each other's service can be fostered.

3. Develop links with the MHS

If clients with a pre-existing mental health disorder have an MHS case manager, workers should develop cooperative links with the case manager so a collaborative treatment plan can be developed.

In all steps, workers are advised to use appropriate language when referring clients to MHS (see the section *Referring to mental health services* in Chapter 5).

General practitioners

Here are some strategies for establishing links with GPs.

- Start by looking at recent referrals to find which GPs are already accessing the service and who may be willing to become involved in collaboration or shared care.
- Identify whether there is a GP liaison or support person in the local area, because he or she will be working with GPs who are interested in AOD issues. The liaison person might be willing to approach potentially interested GPs on behalf of the service.
- Consider liaising with the local division of general practice to determine if a drug and alcohol or mental health interest group exists and offer to provide an information session on methamphetamine. This is an effective way to make personal contact with GPs to begin a dialogue about cooperation. The publication, *Management of Patients with Psychostimulant Use Problems: guidelines for general practitioners* could be a useful tool (see *Resources* section for download details).

Police and ambulance

The police and ambulance service may be called to provide assistance to workers, so it is helpful to establish a good working relationship with these professionals before a serious situation arises.

- Start by initiating a meeting with representatives from the local ambulance service (some services have paramedics who specialise in drug overdose). This will allow workers to learn about the service; share information; and increase collaboration should an emergency arise.
- If the ambulance workers are not already familiar with resources, introduce them to the publication *Management of Patients with Psychostimulant Toxicity: Guidelines for Ambulance Services*, and offer to provide extra information or support if required (see *Resources* section for download details).
- Contact the community liaison officer of the local police and initiate a meeting to discuss their service, desire for support and prompt response

when required. Offer to provide in-service training or information sessions on methamphetamine or other drugs as required. The publication *Psychostimulants — Management of Acute Behavioural Disturbances, Guidelines for Police Services*, could be helpful as a starting point. (see *Resources* section).

- Consider developing a visiting policy for police to indicate when and where it is acceptable to visit to ensure client confidentiality and continued access of the service. The details could be included in a MoU.

Antenatal teams

- Start by locating antenatal teams by telephoning local hospitals.
- Introduce the workers and the service offered and ask to meet with one or more members of the 'high-risk' team to create a personal link. Inform the antenatal team about what the service offers, and find out what service the antenatal team provides; this information is helpful for both workers and clients.
- Explore the possibility of a shared care role, or at least collaboration, to improve outcomes for pregnant clients.
- Offer to fast-track referrals from the antenatal team to the worker's service for drug counselling/support of pregnant users.
- Offer to provide training for the antenatal teams in methamphetamine or other drug use issues.

Maintaining and improving established links

Workers should establish regular liaison with the target agencies through telephone contact, general practice visits, and informal or formal meetings. This can also include a designated liaison worker if the interaction between agencies is regular.

Offer to provide in-service education to the other agency on topics related to methamphetamine and other drug use, or other topics as required.

Respond promptly to referrals and requests for information or assistance made by the collaborating agency or GP to ensure that communication remains two-way and that collaboration continues uninterrupted and strengthens over time.

Workers should evaluate and revise the partnership if necessary. Evaluation might include the following questions:

- How many clients have been referred to the worker's service by the partner agency? How many clients have actually been seen? Has this number increased or decreased?

- How many clients has the worker's service referred to the partner agency? How many clients have actually been seen? Has this number increased or decreased?
- Have clients of the worker's service experienced reduced waiting time to access the partner agency or otherwise benefited from improved services? Have clients of the partner agency experienced reduced waiting time to access the worker's service?
- Are staff members in both services satisfied with the partnership? Why or why not? Do they have recommendations for improvement?
- Are clients satisfied with the partnership? Why or why not? Do they have recommendations for improvement?

Types of referral

Three different referral practices are outlined below:

- Passive referral — the client is given the name and number of the other agency to make his or her own appointment. This is only suitable for clients who are motivated to ask for help, are not depressed or 'flat', and have the resources to make and keep the appointment.
- Facilitated referral — the worker telephones the other agency, provides basic information, and makes an appointment on behalf of the client. This is probably most suitable for the same group of clients who can receive passive referral.
- Active referral — the worker telephones the other agency in the presence of the client, uses appropriate language to provide detailed information so the client does not have to repeat it at the next appointment, and makes the appointment for the client. This is most suitable for clients who are depressed and or who lack the resources necessary to make an appointment or advocate on their own behalf. Agencies could also facilitate transport to the other service if the resources are available.

Strategies for effective referral

Use of the following strategies can enhance the effectiveness of referrals:

1. Workers address the client's pressing needs first before suggesting referral to another agency for assistance with less important matters.
2. Workers understand the needs of the client, including financial resources; access to transport; requirement for child care; cultural and social issues; level of ability to advocate for self; literacy level; and mental health concerns before making any referral.
3. Workers are aware of agencies that might be of assistance to clients, including location, hours of opening, cost, who is eligible for assistance, and waiting times for access.
4. Workers offer the client a choice of referral points if more than one agency is available to respond to his or her needs.
5. Workers ensure that the type of referral undertaken is the most appropriate for the client, and consent for level of referral is given. The different ways of referring were discussed in *Different referral practices* in Chapter 5.
6. Services involve Indigenous and culturally and linguistically diverse communities in the development of referral practices and pathways.
7. With client consent, workers actively follow up referrals made, to determine if the client kept the appointment and if the agency was able to provide the assistance required. Additional referrals or actions can then be initiated if required.
8. Strong links and partnerships, as described in this section, underpin effective referral processes.

Reference Chapter 11: Making links and creating partnerships

Furler J, Patterson S, Clark C, King T and Roeg S (2000). *Shared Care: Specialist Alcohol and Drug Services and GPs Working Together*. Turning Point Alcohol and Drug Centre Inc, Fitzroy.

Glossary

Abstinence: no longer using a specific drug

Agoraphobia: fear of open spaces

Aneurysm: ballooning of the wall of a blood vessel leading to weakening

Anhedonia: inability to experience pleasure

Auditory: related to hearing (see *Hallucinations*)

Base methamphetamine: 'base' is the street name for methamphetamine that has a damp, oily or paste like appearance

Binge: irregular, on-again, off-again pattern of moderate to heavy drug use

Brain haemorrhage: also known as cerebral haemorrhage, the rupturing of a blood vessel, usually an artery, in the brain (a cause of cerebral vascular accident (CVA), also known as stroke

Bruxism: teeth grinding

Cerebral haemorrhage: the rupturing of a blood vessel, usually an artery, in the brain (a cause of cerebral vascular accident (CVA) — also known as stroke

Coercion: formal (court ordered) or informal (family, spouse, peer, etc) pressure to enter treatment

Cognitive: pertaining to thoughts or thinking processes

Cognitive behaviour therapy: a talking therapy that seeks to modify dysfunctional or distorted thoughts and beliefs

Crystalline methamphetamine: methamphetamine that has a crystalline appearance, which is typically high in purity — street names include ice, crystal and shabu

Depression: a mood disorder or state that meets diagnostic criteria characterised by blunted affect (facial appearance), psychomotor retardation (slowed physical movements and thinking), dysphoria (flat mood) and anhedonia (inability to experience pleasure)

Delusions: fixed, false beliefs that are not amenable to logical challenge

Dependence: characterised by three or more of the following: a strong desire to take the drug, using more than intended, a desire to cut down or quit, using despite harms, increased tolerance, withdrawal

Detoxification: the planned cessation of drug use in someone who is drug dependent

Dexamphetamine: amphetamine that is available on prescription

Dilated: enlarged (eg pupils)

Dopamine: a brain chemical messenger (neurotransmitter) involved in the control of movement, thinking, motivation and perception of reward or pleasure (ie 'reward pathway')

Dysphoria, dysphoric mood: emotional state characterised by discontent, depression, anxiety and malaise

Endocarditis: a bacterial infection of the lining of the heart

Engagement: to attract a person into a service setting; to make a connection with a potential client that will facilitate him or her to actively participate in treatment or the service provided

Euphoria: a strong feeling of wellbeing or elation

Gingivitis: inflammation of the gums

Hallucinations: sensory impression having no basis in external stimulation, can be auditory (hearing), tactile (feeling), olfactory (smelling) or visual (seeing)

Harm minimisation/harm reduction: refers to a range of strategies that aim to reduce harms associated with continued drug use

Hypervigilance: exaggerated preoccupation with external events or people, usually associated with fear of harm

Ice: see *Crystalline methamphetamine*

Illusions: mental impression derived from misinterpretation of an actual sensory event (eg a shadow in a room is perceived as a person)

Insomnia: inability to fall or remain asleep

Intoxication: being affected by a drug

Intranasal: method of administering drugs by sniffing through the nose (snorting)

Lethargy: weariness, lack of energy or stupor

Libido: sex drive

Mandatory reporting: relates to the legislation, which specifies who is required by law to report suspected cases of child abuse and neglect

Methamphetamine, methylamphetamine: amphetamine with the addition of a methyl group on the molecular chain, which gives a potent effect

Motivational interviewing: a non-confrontational cognitive behavioural style of interviewing used to assist clients to recognise and address their health concerns leading to behaviour change

Myocardial infarction: medical term for a 'heart attack', which involves damage to the heart muscle generally through lack of blood supply

Neurotoxicity: injury to the nervous system, death of brain cells

Neurotransmitters: the chemicals that are involved in the transmission of signals from one brain cell (neuron) to the next across a short distance (synapse)

Noradrenaline: a neurotransmitter secreted by the adrenal glands promoting energy and alertness

Over-valued ideas: ordinary events have special significance or are more meaningful than usual

Palpitations: a heartbeat that is unusually rapid, strong or irregular enough to make a person aware of it

Paranoia: mental disorder characterised by delusions of persecution

Pharmacological: relating to the properties or actions of drugs (medications)

Polydrug use: use of multiple drugs

Potency: relating to the level of effect from a specific dose of the drug

Pressured speech: fast, loud and difficult-to-interrupt speech

Psychosis: a mental health disorder characterised by a separation from reality, may include symptoms such as delusions, hallucinations, disorientation and confusion

Psychostimulants: a group of central nervous system stimulants that act to increase the activity of the neurotransmitters dopamine, noradrenaline and serotonin

Recreational use: irregular drug use in a social setting

Regular use: recurring, routine pattern of drug use

Relapse: recurrence of an illness, or return to drug use after a period of abstinence

Residential rehabilitation: medium to long-term treatment option offered in a home-like setting

Respiratory: pertaining to breathing (respirations)

Retention: in this guide retention refers to the maintenance of client engagement with a service, or client participation until identified service or treatment goals are met

Reuptake: reabsorption

Rhabdomyolysis: disintegration of muscle tissue due to very high body temperatures

Route of administration: path into the body by which drugs are used or administered

Seizure: in this guide, a seizure refers to a sudden alteration in motor function, characterised by severe muscle jerking or spasm, and usually involves an alteration in level of consciousness (lay term 'fit')

Serotonin: neurotransmitter involved in complex behaviours such as mood, appetite, sleep, cognition, perception, motor activity, temperature regulation, pain control, sexual behaviour and hormone secretion

Shabu: see *Crystalline methamphetamine*

Sign: behaviour or event that can be seen by an observer

Stepped care: matching the intensity of treatment to the severity of problematic methamphetamine use and associated problems, from the least to the most intensive intervention

Stroke: lay term for cerebrovascular accident involving a blockage of a blood vessel in the brain, which leads to varying degrees of brain damage and possibly death

Subacute: a condition that is not a severe acute condition, and has not progressed to a chronic, long-term state

Substitution therapy: prescription of a drug, which is similar in effects to the illegal drug, which aims to reduce the harms associated with illegal drug use

Suicidal ideation: thoughts or preoccupation with suicide

Symptom: an experience or sensation that is described by the sufferer and often cannot be seen by an observer (contrast with *sign*)

Tactile hallucinations: a hallucination that involves the sensation of touch

Tolerance: a condition in which higher doses of a drug are required to produce the same effect as that experienced when the drug was first used

Toxic: poisonous

Toxicity: the capacity of a substance to produce toxic or poisonous effects

Tremors: shakes, usually of hands, or limbs, can be mild (fine) or severe (coarse)

Urine drug screen: analysis of a specimen of urine to detect the presence of drug metabolites

Withdrawal: the progress and time-course of detoxification

Resources

A wide range of resources about methamphetamine and other psychostimulants are available; the following titles are just a sample:

For workers

Written materials

Australian General Practice Network (2007). *Management of Patients with Psychostimulant Use Problems: Guidelines for General Practitioners.* Australian Government Department of Health and Ageing, Canberra.
http://www.nationaldrugstrategy.gov.au/internet/drugstrategy/publishing.nsf/Content/psychostimulant-gp

Baker A, Kay-Lambkin F, Lee NK, Claire A and Jenner L (2003). *A Brief Cognitive Behavioural Intervention for Regular Amphetamine Users: A Treatment Guide*. Australian Government Department of Health and Ageing.
http://www.health.gov.au/internet/wcms/publishing.nsf/Content/health-pubhlth-publicat-document-cognitive_intervention-cnt.htm (note this website is under review)

Baker A, Lee NK and Jenner L (eds) (2004). *Models of Intervention and Care for Psychostimulant Users — Monograph Series No 51.* Australian Government Department of Health and Ageing, Canberra.
http://www.health.gov.au/internet/main/publishing.nsf/Content/health-pubhlth-publicat-document-mono51-cnt.htm

Beneath the Ice. A CD ROM for workers, teachers, parents. Purchase details:
http://www.adf.org.au/store/article.asp?ContentID = Beneaththeice725

Lee NK, Johns L, Jenkinson R, Johnston J, Connolly K, Hall K and Cash R (2007). *Clinical Treatment Guidelines for Alcohol and Drug Clinicians. No 14: Methamphetamine Dependence and Treatment*, Turning Point Alcohol and Drug Centre Inc, Fitzroy.
http://www.turningpoint.org.au/library/lib_ctgs.html#14

Jenner L, Baker A, Whyte I and Carr V (2004). *Psychostimulants — Management of Acute Behavioural Disturbances: Guidelines for Police Services.* Australian Government Department of Health and Ageing, Canberra.
http://www.nationaldrugstrategy.gov.au/internet/drugstrategy/publishing.nsf/Content/psychostimulant-police

Jenner L, Spain D, Whyte I, Baker A, Carr VJ and Crilly J (2006). *Management of Patients with Psychostimulant Toxicity: Guidelines for Ambulance Services.* Australian Government Department of Health and Ageing, Canberra.
http://www.nationaldrugstrategy.gov.au/internet/drugstrategy/publishing.nsf/Content/publications-psychostimulant-ambulance

McIver C, Flynn J, Baigent M, Vial R, Newcombe D, White J and Ali R (2005). *Management of Methamphetamine Psychosis, Stage 2: Acute Care Interventions for the Treatment of Methamphetamine Psychosis and Assertive Community Care for the Post-discharge Treatment of Methamphetamine Psychosis*, Drug and Alcohol Services South Australia, South Australia.http://www.dassa.sa.gov.au/webdata/resources/files/Monograph_21.pdf

Websites and useful contacts

Australian Drug Information Network: a government-funded, Australia-wide information, referral, and resource site for workers, clients, families and other interested parties.
http://www.adin.com.au

Australian Government Department of Health and Aging: has a wide range of resources available for download by frontline workers.
http://www.health.gov.au

Department of Human Service, Tasmania Alcohol and Drug Service has on-line facts sheets available as well as information on services throughout Tasmania.
http://www.dhhs.tas.gov.au/services/view.php?id = 354

Drug and Alcohol Services South Australia (DASSA) has on-line resources available for frontline workers as well as details of services in SA and relevant training.
http://www.dassa.sa.gov.au/site/page.cfm

Drug and Alcohol Office (DAO) has on-line resources available for frontline workers as well as details of services in Western Australia and relevant training.
http://www.dao.health.wa.gov.au/

National Centre for Education and Training on Addiction (NCETA) has on-line resources available for frontline workers as well as details of relevant training.
http://www.nceta.flinders.edu.au/

National Drug & Alcohol Research Centre (NDARC) has on-line resources available for frontline workers as well as details of relevant training.
http://ndarc.med.unsw.edu.au/

National Drug Research Institute (NDRI) has a range of publications as well as details of training available in Western Australia.
http://www.ndri.curtin.edu.au/

Next Step Drug & Alcohol Services has on-line resources available for frontline workers as well as details of services in WA and relevant training.
http://www.dao.health.wa.gov.au/AboutDAO/DrugAlcoholServices/tabid/60/Default.aspx

Northern Territory Government Alcohol and Other Drugs Program has information available for workers.
http://www.nt.gov.au/health/healthdev/aodp/aodp.shtml.

NSW Government, NSW Health Druginfo has details of relevant services in NSW
http://www.druginfo.nsw.gov.au/treatment

Queensland Alcohol and Drug Research and Education Centre (QADREC) has on-line resources available for frontline workers as well as details of relevant training.
http://www.uq.edu.au/qadrec/

Turning Point Alcohol and Drug Centre has on-line resources available for frontline workers as well as details of relevant training.
http://www.turningpoint.org.au/

For users

Written materials

A user's guide to speed. National Drug and Alcohol Research Centre
Can be ordered from http://ndarc.med.unsw.edu.au/NDARCWeb.nsf/page/Resources

Crystal meth: reducing and quitting. AIDS Council of NSW (ACON)
http://www.acon.org.au/assets/file_library/other/ACON_CRYSTAL.pdf

Crystal Meth — Effects. Health. Sex. Help. AIDS Council of NSW (ACON). An information booklet for the gay, lesbian, bisexual and transgender community.
http://www.acon.org.au/assets/file_library/brochures/Crystal%20Booklet%20Web%20020051213.pdf

Fast facts on ice. National Drug and Alcohol Research Centre
http://ndarc.med.unsw.edu.au/

Ice: crystal methamphetamine fact sheet. Alcohol and Drug Foundation.
http://www.druginfo.adf.org.au/article.asp?ContentID=ice_crystal_methamphetamine_hy

Ice fact sheet. National Drug and Alcohol Research Centre.
http://ndarc.med.unsw.edu.au/NDARCWeb.nsf/resources/NDARCFact_Drugs7/$file/ICE+FACT+SHEET+2.pdf

On thin ice: a user's guide. National Drug and Alcohol Research Centre
http://ndarc.med.unsw.edu.au/

Websites and telephone contacts

Beyondblue: an organisation that helps people to address problems associated with depression.
1300 224 636
http://www.beyondblue.org.au

Counselling online: is a service where people can communicate with a professional counsellor about an alcohol or drug related concern, using text-interaction. This service is free for anyone seeking help with their own drug use or the drug use of a family member, relative or friend. Counselling Online is available 24 hours a day, 7 days a week, across Australia.
http://www.counsellingonline.org.au

Family Drug Support
1300 368 186
http://www.fds.org.au

Headspace: a government funded youth mental health information site.
http://www.headspace.org.au

Kids Help Line: a free, confidential and anonymous, telephone and online counselling service specifically for young people aged between 5 and 25.
1800 551 800
http://www.kidshelp.com.au

Lifeline: free, confidential telephone counselling service available 24 hours per day, anywhere in Australia
13 11 14

Narcotics Anonymous Australia: information on NA groups and help lines in each state.
http://www.naoz.org.au/community/index.php

Reach Out!: a web-based service that aims to improve young people's mental health and wellbeing by providing support information and referrals in a format that appeals to young people.
http://www.reachout.com.au

SANE Australia: promotes understanding of mental illness through a range of education products and services for those affected, their family and friends, health professionals and the general community.
SANE Helpline: 1800 187 263
http://www.sane.org

SMART Recovery Australia: information on the S.M.A.R.T. recovery approach and location of mutual support groups.
http://www.smartrecoveryaustralia.com.au/

Appendix 1
Severity of dependence scale

(Gossop et al 1995)

1. Have you ever thought your [speed] use is out of control?

Never (0) Sometimes (1) Often (2) Always (3)

2. Has the thought of not being able to get any [speed] really stressed you at all?

Never (0) Sometimes (1) Often (2) Always (3)

3. Have you worried about your [speed] use?

Never (0) Sometimes (1) Often (2) Always (3)

4. Have you wished that you could stop?

Never (0) Sometimes (1) Often (2) Always (3)

5. How difficult would you find it to stop or go without?

Not difficult (0) Quite difficult (1) Very difficult (2) Impossible (3)

Total Score:_____

Note: A cutoff score of greater than 4 indicates severe amphetamine dependence (Topp & Mattick 1997)

Appendix 2
Example family emergency plan

Emergency contact names and telephone numbers

_____

_____

_____

Suicidal thoughts	Psychotic symptoms
High risk if: depressed, discloses a plan that is lethal and has the means or access to the means to carry it out; has tried before; feels hopeless; can't guarantee own safety.	Sees things or hears things others can't; is suspicious or paranoid; has odd or unusual beliefs; behaves in strange or bizarre ways; speech might be disconnected or illogical; might also be anxious, panicky or disoriented.
✔ **DO** be calm, listen without judging, acknowledge feelings, express a desire to help, and determine level of risk. ✖ **DON'T** argue, nag, lecture, or tell them how to 'fix it'. Don't assume that he or she will just get over it or that help isn't required. **If risk is not high but thoughts are present**, encourage the family member to see a counsellor or GP, or telephone a dedicated suicide help-line for support if available. **If risk is high**, do not leave the person alone, do not agree to keep his or her plan a secret, contact the emergency mental health team or call an ambulance on 000.	✔ **DO** be calm, talk slowly, reassure and comfort, acknowledge fears, reduce noise and distractions in the room, call attention to familiar surroundings. ✖ **DON'T** argue, threaten, shout, lecture or laugh. Don't play along with unusual beliefs or ideas. Don't attempt restraint, don't block exits. **Settles?** Continue to reassure, watch carefully and call the mental health service for advice. If psychosis persists call the mental health crisis team or take the person to the local emergency department for assessment (call an ambulance if safety is at risk). **Becomes violent?** Call the police on 000 and enact safety plan.

Safety Plan

Person/service to call first if you feel threatened or in danger:

_____

Place that you (and other family members) will go if you need to leave the house in a hurry (eg *neighbour, friend who lives close by, other relative***):**

_____

Location of extra keys to your house and car:

_____

Other actions:

_____

Appendix 3
Example young carer's emergency plan

Name of young carer:

Phone number(s):

Name of parent or family member:

Name and age of other siblings:

Address:

Emergency contact numbers [insert others here eg kids help line, relative]

000 Ambulance or police

What to say to ambulance officers in case of an emergency:

Other things to do in case of an emergency:

First person to contact if your relative goes to hospital or somewhere away from home:

Name and contact details of person you will stay with:

When staying with someone else, things you should take from home (eg clothes, school uniform, toothbrush, schoolbooks, pocket money)**:**

Other things you need when staying with someone else (eg details of sports practice, a letter to your teacher, transport to school)**:**

Things the person should know about you (eg medications? allergies? doctor's appointments? special food?)**:**

Person to look after your pet:

Person to check on the house while you're away:

When staying at home, the details of help you need to manage:

Person/people to give you this help:

Name and phone number of your local doctor:

Medicare number:

Name and contact number of school:

Support person at school:

Adapted from Young Carers Care Plan, http://www.youngcarers.net.au/

Appendix 4
Example Memorandum of Understanding

MEMORANDUM OF UNDERSTANDING

between

(Insert Agency 1 name here)

AND

(Insert Agency 2 name here)

Purpose or statement of intent

This Memorandum of Understanding (MoU) establishes an arrangement between *(first agency name and description of service)* and *(second agency name and description of service)*.

This arrangement establishes a collaborative relationship between the parties. Each agency recognises that the aims and purposes of the MoU are to *(insert purpose here)*.

Both parties have agreed to enter into this MoU on the terms and conditions contained herein.

Objectives of the MoU

List what the MoU is intended to achieve.

In the operation of the partnership, the parties agree to:

Specify the conditions of the MoU here.

1.

2.

3.

Term of MoU

Insert the duration of the MoU, date of expiry, when and how the MoU will be reviewed, and how it can be terminated before the expiration date if necessary.

Contact persons for MoU

Insert title and contact details for both parties.

Signatories

Signed on this *(insert date)* day of *(insert month)* 20XX.

signed_____

Name and position of authorised person, agency 1

signed_____

Name and position of authorised person, agency 2