Managing methamphetamine use

Evidence review summary | July 2019

This evidence review was commissioned by the Alberta Health Services Provincial Addiction & Mental Health team in preparation for creating an AHS Action Plan for Crystal Methamphetamine to address the rise of methamphetamine use in Alberta.

SETTINGS CONSIDERED

Emergency services

Community-based care

Primary care

Supervised consumption services

EVIDENCE SOURCES

Literature review + synthesis

Rapid review and qualitative synthesis of **53 relevant publications** from 2009-19

Environmental scan of best practices

Interviews with **11 service providers in 6 jurisdictions** in Canada and the U.S.

(British Columbia, Saskatchewan, Manitoba, Ontario, Arizona, New York)

For more information or to request the full report, contact the Addiction & Mental Health Knowledge Exchange Team at amh.knowledgeexchange@ahs.ca

Alberta Health Services

Key findings

Emergency services

Staff safety

- Keep an escape route in the patient room.
- Ensure a second person is available to assist if necessary.
- Develop appropriate de-escalation protocols.
- Security or law enforcement officers may need to assist with aggressive patients. However, uniformed officers should not be visible to patients unless necessary for staff or patient safety, as their presence may further agitate patients.

Pharmacological interventions

- Meth-induced psychosis may be managed with benzodiazepines as a first-line therapy. Atypical antipsychotics may be used if these are insufficient.
- The majority of interview respondents reported that first responders use olanzapine as a first-line therapy for individuals intoxicated with meth who are being transported to the emergency department.

Non-pharmacological measures

- De-escalate mild to moderate agitation and aggression through non-medical techniques such as a quiet treatment environment and a consistent care provider who is calm, empathetic, and nonjudgmental.
- Restraint should be used as a last resort and be as least restrictive as possible.

Community care

Pharmacological interventions

The evidence for pharmaceutical therapies to supplement meth addiction treatment is not strong enough nor consistent enough to be introduced as a standard of practice.

- Benzodiazepines or atypical antipsychotics are useful for reducing psychotic symptoms and anxiety associated with meth use.
- The evidence is mixed for pharmacotherapy for mitigating cravings and withdrawal symptoms, but there is some evidence that acetylcysteine, bupropion, and imipramine are effective.
- Sertraline was contraindicated for achieving abstinence.

Psychosocial interventions

The evidence for psychosocial interventions for meth addiction treatment is mixed: No psychosocial modality is clearly better or worse.

- Contingency management combined with cognitive behavioural therapy may help with abstinence.
- One clinical guideline recommended self-help groups, family support, social work support, needs- and motivation-centred psychotherapy, and sports therapy. However, the evidence for these therapies is mixed.

Key findings
(continued)

Primary care

Note: In general, very little primary evidence exists for managing meth addiction in a primary care setting.

Staff safety

Staff should be trained in:

- empathy
- de-escalation techniques
- nonviolent crisis intervention

Supporting patients

- Patients who are ready to stop using meth should be offered immediate preliminary counselling services and referred to treatment services.
- Patients who are not ready to stop using meth should be offered harm reduction support and resources.

Referring patients

Patients should be referred to acute care if they experience:

- paranoia and psychotic symptoms that present a danger to themselves or others; or
- severe physical symptoms of meth intoxication.

Supervised consumption services (SCS)

Staff safety

- Staff should be vaccinated against Hepatitis B, educated on proper handling of used equipment, and have ready access to safety devices, first aid equipment, and post-exposure prophylaxis.
- Staff should be trained in client engagement, de-escalation techniques, and nonviolent crisis intervention.
- The physical space should emphasize safety, including multiple exits and locked inner doors and entry areas.
- Staff may benefit from debriefing sessions after violent incidents.

Issues facing SCS

- There was no conclusive evidence linking SCS with an increase in drug use or public disorder. Some evidence suggested that extended operating hours may in fact reduce public consumption.
- Homelessness was found to be very common among SCS clients using meth, and contributes to a variety of health concerns.
- Health services (including treatments, referrals, and resources) should be embedded into SCS.
- A positive working relationship with local law enforcement is essential for the service to function.

Reaching clients

- Peer workers are a key resource for improving the reach and quality of services.
- Homelessness is strongly associated with reduced engagement with harm reduction services; mobile outreach services may help address this.