"Ice" (crystal methamphetamine): concerns and responses

There is no cause to feel impotent, despite disturbing media reports about methamphetamine

Methamphetamine has been around for some time. Although it is now available in a crystal form that is more potent and more readily smoked than earlier forms, no-one should feel impotent in the face of widespread alarmist commentary about this drug.

The recent National Ice Taskforce Report[1] describes a pattern of increasing use of methamphetamine over the past decade. Compounding the effect of the shift in use from the older amphetamine sulphate to methamphetamine (in powder or crystal form) is the increase in purity of illicit methamphetamine: the purity-adjusted price (the dose obtained for a given price) is now similar for both methamphetamine forms,[2] so that users obtain much larger doses. This probably underlies the evidence of more regular and greater levels of dependent use among people who use the drug, and also some of the increases in observed harms.[3]

The medical profession is pivotal in responding to these changes, and needs to provide clear, evidence-based responses and care for those affected; it is not "someone else's problem".

People who use methamphetamine come into contact with the general health care system for a number of reasons, ranging from problems directly related to use (eg, insomnia, acute mental health problems) to complications of use (eg, injuries, infections and cardiovascular problems), some of which may be detected while providing other care (eg, during antenatal care). Some users present when seeking treatment from general practitioners, including some requesting benzodiazepines or other sedatives, but methamphetamine use may not be disclosed or the GP may not have asked about it; sometimes it is other members of the family who seek help.

People who use methamphetamine are generally younger (under 40 years of age); more men than women use these drugs, and users commonly experience mental health and other substance use problems.[4] Use is more prevalent among some groups more frequently exposed to health risks, especially Aboriginal and Torres Strait Islander people, and the gay, lesbian, transgender and transsexual communities. Recent use is more common in rural and remote communities. Most people who have used methamphetamine have done so only occasionally; however, the best available data suggest that there are now more regular and dependent users of the drug than at any other time in the past decade.[5]

What would be an appropriate response? There is a pressing need for a flexible and coordinated treatment system that can respond in a timely manner to people who use amphetamines. We need to develop the skills, confidence and capacity to do so. Drug and alcohol specialists, nurses, psychologists and other allied health practitioners all play key roles in partnership with primary and acute care services, including emergency departments and mental health services. Strategies to engage the broader medical workforce are urgently needed. GPs cite a range of reasons for feeling unskilled or unsupported in managing people with substance misuse problems, so that many are reluctant to do so.[6] This situation must be changed if we are to improve our frontline responses to problems linked with methamphetamine use.

"the Final Report of the National Ice Taskforce provides an opportunity for action"

Optimal alcohol and drug-specific treatments incorporate multidisciplinary care that also attends to co-occurring substance use (eg, tobacco), as well as to physical, mental health and social problems. Psycho-social treatment approaches include specific drug counselling and support, withdrawal services, day programs and residential treatment for those who require more intensive support. Assertive follow-up and proactive relapse prevention programs are crucial, as the relapse rate among dependent methamphetamine users is high.

More research is needed to develop methods for better attracting methamphetamine users to treatment, to

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provide brief interventions for those with less severe problems, and to improve treatments for those who need intensive assistance. In addition to ongoing research overseas, a recently announced NHMRC grant to fund research that explores an alternative pharmacotherapeutic approach (application 1109466) and another that will examine the particular needs of Aboriginal communities (application 1100696) are promising starts.[7]

The alcohol and drug treatment sector needs to grow significantly to allow it to respond to those who need intensive treatment and to be available to support primary care. The announced introduction of Medicare item numbers for addiction medicine specialists[8] will facilitate development of the workforce in this area. The use of a national planning model that assesses needs according to population prevalence, estimates the demand for treatment, and calculates the amount of resources required to respond effectively has been used to develop mental health services. A similar plan should be a matter of priority as a blueprint for national drug and alcohol service development.[9] Western Australia has used modelling to develop one version of such an approach, focusing on system integration because this "ensures service delivery is comprehensive, cohesive, accessible, responsive, and optimises the use of limited resources".[10]

The release of the Final Report of the National Ice Taskforce provides an opportunity for action. However, many key issues raised in the report still require adequately resourced strategies; this applies especially to specific plans for Indigenous communities. Mixed funding by the federal and state governments makes it challenging to achieve the necessary coherence of response. The Primary Health Networks will need to rapidly develop the capacity to engage with GPs, and specialist drug and alcohol services if they are to play a key role. Governments, health services and the general community must seize this opportunity to respond to the problems associated with methamphetamine use.

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