Where to people go when they are on ice?

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“Out of control ... sedated and restrained, a man is taken to an ambulance after a psychotic episode believed to involve methamphetamine use in Darlinghurst” SMH, July 9, 2007
Why should we care?

• To make contact
  – Provide information and help – don’t always present saying “I’m on meth”

• Plan services
  – Understand how services are affected by increases in meth use

• Ultimately design more efficient and effective services
  – Both for consumers and for the health sector
Aim for today

• When someone is using meth, how does this change how they interact with the health sector?
  – Where do they go?
  – Where don’t they go?
• What net impact does this have on our health sector?

Method

• 486 people dependent on methamphetamine (DSM-IV)
• Interview them and also follow them up a few times
• Each time ask them about contact with health services in the past year
• Correlated this with frequency of meth use in the past year
What did we measure?

- General hospital admissions
- Psychiatric hospital admissions
- Emergency department presentations
- Ambulance attendance
- General practice visits
- Psychiatrist visits
- Counsellor/psychologist sessions
- Dentist visits

→ Regardless of reason for attendance
→ Excluded services provided for drug treatment

Who where they?

- Drug treatment exposure (¼ recruited from treatment)
- Polydrug use: mostly tobacco, cannabis, alcohol; ¼ using heroin
- Most male, unemployed, single with low-average education
- High rates of comorbidity (esp. depression)

– Adjusted for these things in our statistical analysis
% who used service in the past year

Mean rate of use per person year
HOW DOES THIS CHANGE WITH METH USE?

Change in use of health services ($\ln(\text{OR})$) during periods of meth use

- General hospital
- Psychiatric hospital
- Emergency department
- Ambulance
- General practice
- Psychiatrist
- Counsellor or psychologist
- Dentist

Legend:
- $<\text{weekly}$
- Weekly $+$

**$p < 0.05$**
***$p < 0.001$***
Change in use of health services (ln[OR]) with meth use
(adjusted for other substance use, comorbidity and demographics)

Number of additional events during meth use per
(100 person years)
At a national level?

• Multiply by the number of people using methamphetamine in the 2013 NDSHS – by frequency of use:
  – 54,700 (28,400 – 80,900) psychiatric hospital admissions
  – 90,800 (29,700 – 151,800) emergency department admission

Other predictors of ED/Psychiatric admissions

• Alcohol and opioid use
• Comorbid mental health disorders
• Unemployment, unstable housing, low income, low education
• Attending drug treatment
Considerations

• Ignores any chronic health effects of methamphetamine
  – E.g. strokes would have lasting health effects beyond use
• Based on a heavy meth users mostly from treatment
  – Likely to be more engaged with services, and also more marginalised,
    than the average person using meth
• Direction of effects and mechanisms unclear
  • Self-medication, referral between services, avoidance cf. need for health care

Implications

• Brunt of impact on acute care (ED/psych wards)
  – Need to resource appropriately
• Disengagement with voluntary services (dentists, GPs, counsellors)
  – Stigma/confidentiality?
  – Drug-using lifestyle? (lack of money, other concerns)
  – Reduced perceived need? (self-medicating symptoms)
  “Crisis” approach to health care?
• Potential benefit in addressing multiple needs and improving
  pathways between services (e.g. housing, mental health)
Credits

501 people who volunteered to participate

41 treatment agencies and various other health services

Researchers: Erin Kelly, Shelley Cogger, Rachel Sutherland, Grace Ho, Cathie Sammut, Kate Hetherington, Sagari Sarkar, Julia Rosenfeld and Miriam Wyzenbeek

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Credits