

# Where to people go when they are on ice?

Rebecca McKetin, BSc (Psychol) PhD  
Curtin Senior Research Fellow  
National Drug Research Institute  
Curtin University

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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



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## 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

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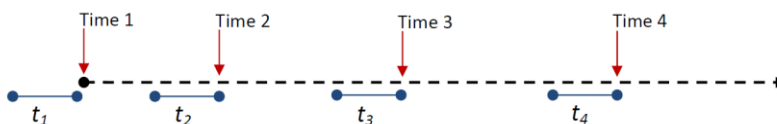
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## Aim for today

- 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

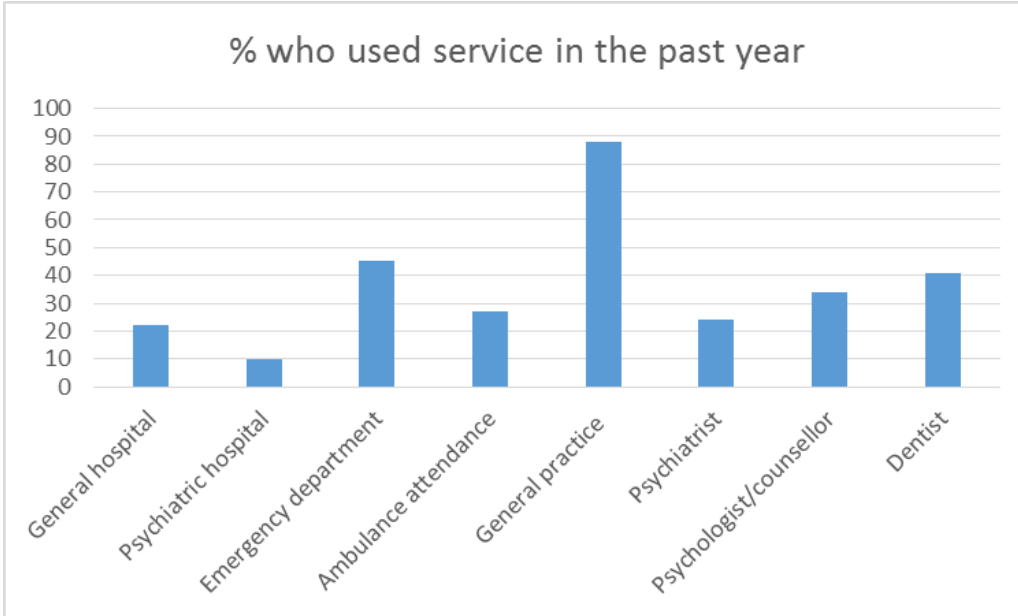
→ Regardless of reason for attendance

→ Excluded services provided for drug treatment

## Who where they?

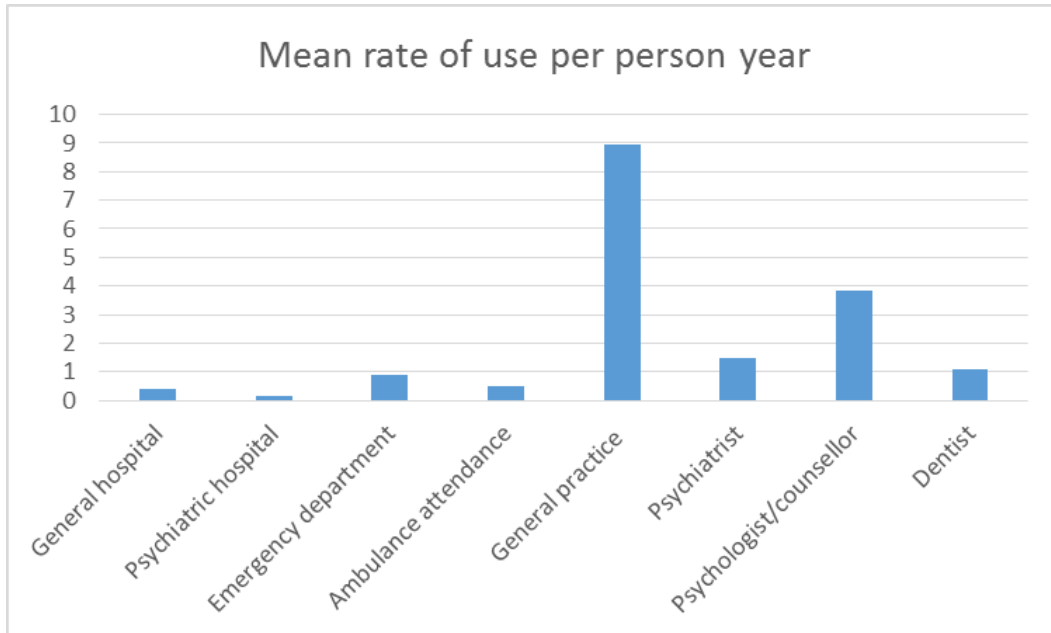
- Drug treatment exposure ( $\frac{3}{4}$  recruited from treatment)
- Polydrug use: mostly tobacco, cannabis, alcohol;  $\frac{1}{4}$  using heroin
- Most male, unemployed, single with low-average education
- High rates of comorbidity (esp. depression)

– Adjusted for these things in our statistical analysis



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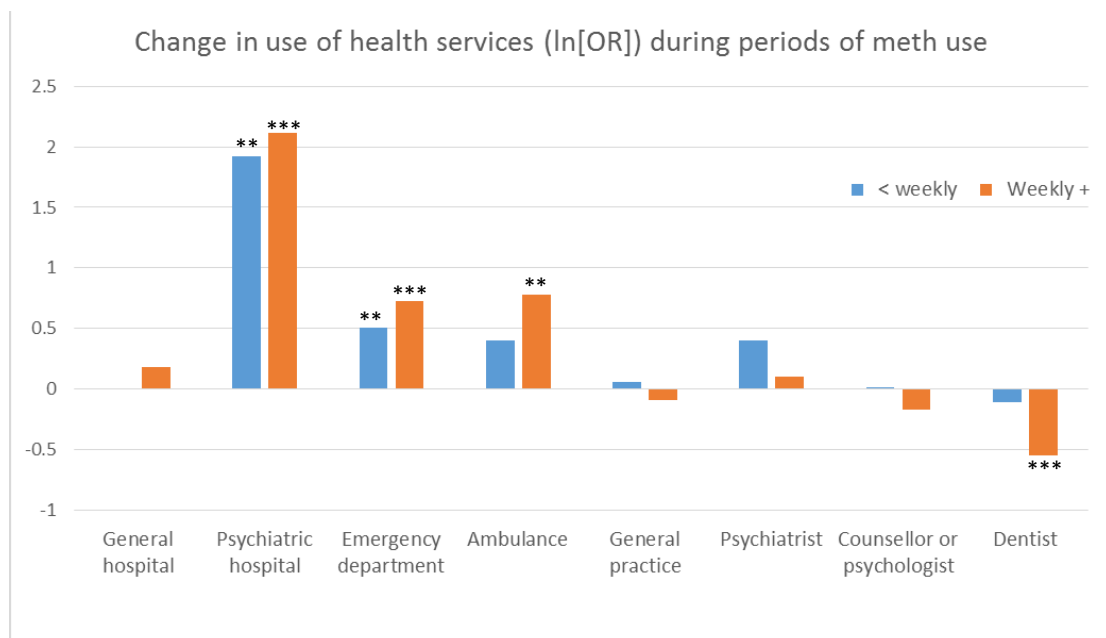
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## HOW DOES THIS CHANGE WITH METH USE?

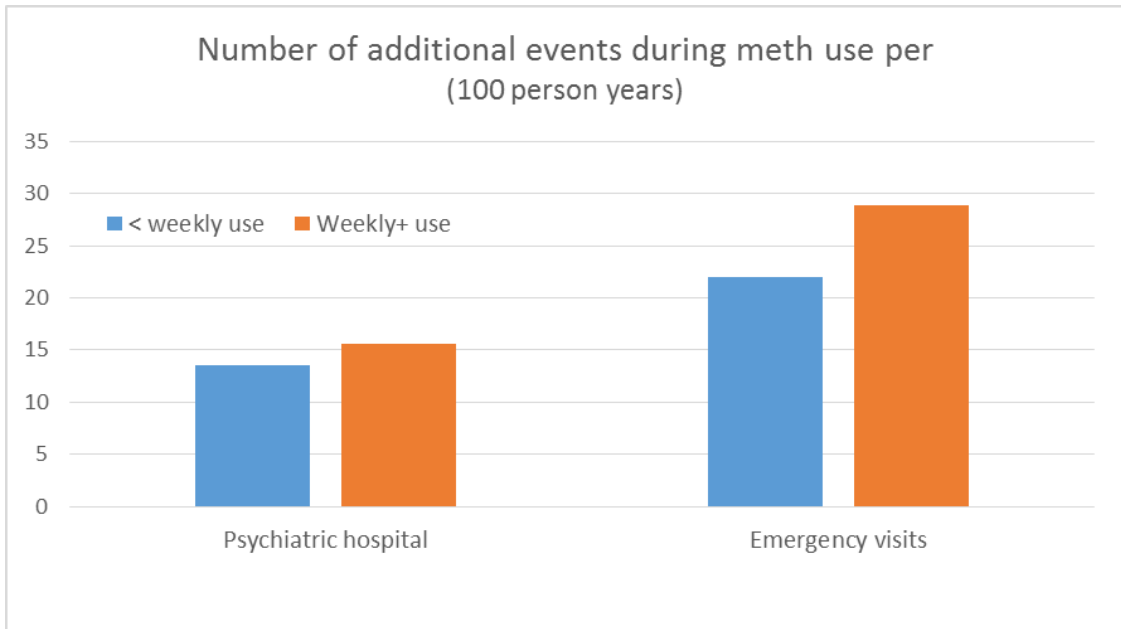
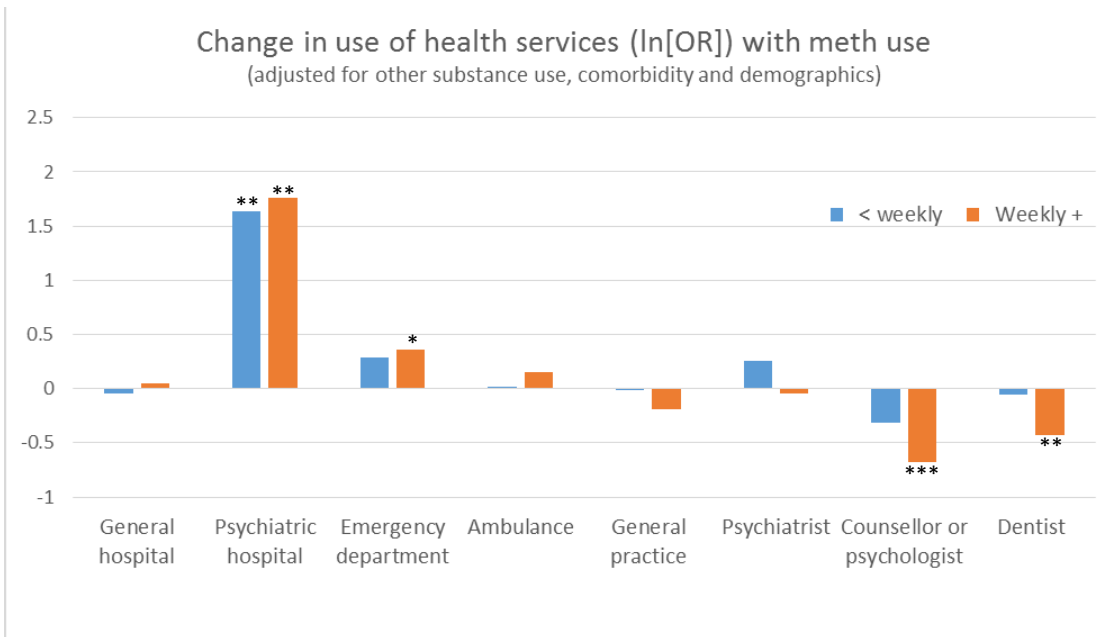
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## At a national level?

- 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)
  - Potential benefit in addressing multiple needs and improving pathways between services (e.g. housing, mental health)
- “Crisis” approach to health care?**



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## 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

My co-authors: Louisa Degenhardt, Marian Shanahan, Amanda Baker, Nicole Lee and Dan Lubman

The Methamphetamine Treatment Evaluation Study (MATES) investigators:

Me, Jake Najman, Dan Lubman, Richard Mattick, Jo Ross, Robert Ali, Sharon Dawe

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## Credits

McKetin R, Degenhardt L, Shanahan M, Baker AL, Lee NK, Lubman DI. Health service utilisation attributable to methamphetamine use in Australia: patterns, predictors and national impact. **Drug and Alcohol Review**. In Press.