



Methamphetamine: Primary Care Dilemma

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Objectives of this talk:

- ◆ To introduce a “toolkit” for primary care clinicians who have patients using methamphetamine
- ◆ To demonstrate how to apply primary care evidence-based guidelines for risky behaviors
- ◆ To describe what primary care clinicians need to know to care for patients who want to quit meth

Problems assoc with meth use

- ◆ Interpersonal violence
- ◆ Injection Drug Use
- ◆ Risky Sex—STD's
- ◆ Child abuse and neglect
- ◆ Self-destructive behaviors

We're seeing more of it in the ED

Pregnant women are using it

Drug-exposed infants

Local drug labs

Dilemma: What can we do?

Is it a primary care problem?

Compulsive Meth Use

- ◆ Results in greatest behavioral pathology
- ◆ Most serious medical consequences
- ◆ Present to ED
- ◆ Medical and psych emergencies

Compulsive Use

- ◆ Bingeing, high doses
- ◆ or daily use
- ◆ Smoked or injected
- ◆ 5-10% of MA users

Methamphetamine Users

- ◆ U.S. as a whole, 70% users are employed
- ◆ Seek treatment after average 8 yrs use
- ◆ Not a homogeneous population
- ◆ Different patterns of use

It's not easy to treat since:

- ◆ "They don't want to stop
- ◆ When they try to stop, they fail
- ◆ There's nowhere for them to go to treatment
- ◆ They can't afford treatment
- ◆ MA causes brain damage
- ◆ Whole families use together"

Proposal: Use Primary Care Behavioral Interventions

- ◆ Evidence-based
- ◆ US Preventative Task Force
- ◆ Feasibility has been studied with tobacco, sedentary lifestyle, unhealthy diet, and alcohol abuse
- ◆ Common, persistent, harmful behaviors

Why aren't we applying these guidelines to meth use?

- ◆ No research in primary care setting
- ◆ Risk vs benefit unclear
- ◆ Any evidence it might work?
- ◆ Cost-effective in our busy clinics?
- ◆ Patients don't tell us they're using

“Be prepared to intervene for patients who are willing to change their behavior.”

Paul Strange, M.D.
Coshocton, N.Y.
US Preventive Task Force

. AHRQ and CDC recommend:
Every patient who uses tobacco should be offered at least a brief tobacco dependence treatment.

Lessons from STEP-UP: Randomized Clinical Trial of Preventive Service Delivery

Evidence to support recommendations to change physicians' approaches and office system organizations to promote healthy changes with minimal disruption of other aspects of primary care delivery.

Jaen, 2003

AAFP CME Bulletin

Meth Treatment Research “Best Practice”

CSAT Methamphetamine Treatment
Project 1998-2001 identified
Motivational Interviewing model as a
Best Practice

Behavioral Interventions: The 5 A's

ASSESS

ADVISE

AGREE

ASSIST

ARRANGE

USPSTF, 2003

Step #1: ASSESS

Do not need to ask every patient if they use meth.

First step is to prepare clinicians to deal with meth issues.

They will start identifying the non-emergent cases.

When word gets out that a provider at your clinic is interested in helping people get off meth,

They will come.

Step #1: Recommendations on how to assess

- ◆ Detailed enough to ID the risky behavior
- ◆ Short enough to be feasible

Jaen, 2003

Assess for risk behavior. (real cases)

- ◆ Patient on meds for psychosis, comes for Pap test. Says she's one month off meth, trying to get custody of her child back.
- ◆ Tribal CD counselor refers client to primary care clinic because he screens positive for depression on intake for meth treatment
- ◆ 16 yo patient presents with amenorrhea. Her mother arrives and says her daughter is injecting meth and is court-ordered to treatment.

When to assess for meth?

- ◆ Prenatal
- ◆ Well woman
- ◆ New Patient
- ◆ Adolescent
- ◆ Visits for depression, insomnia, anxiety
- ◆ Chronic pain
- ◆ Dental
- ◆ Incarcerated patient

Tips on assessing behavior that is illegal

- ◆ Similar to assessing stigmatized behavioral risk factors for HIV/STD
- ◆ Explicit admission of behavior not necessary to deliver first level of intervention
- ◆ Non-judgmental
- ◆ Least intrusive
- ◆ Give general info appropriate for community members

Patient with positive drug screen who denies use

Your message:

“Methamphetamine is dangerous to people’s health,
and it is possible to stop.”

IDEA

Pre-printed info for patients

“Want to get off meth? Think you can’t do it? Ask your healthcare provider.”

similar to:

“PIMC CARES! Get on the path of sobriety today....” calling cards

If Patient admits to use

- ◆ Question is willingness to stop using
- ◆ Use same questions you have been using for years with tobacco users
- ◆ "Are you interested in stopping meth?"
- ◆ "Have you tried to stop?"
- ◆ Non-judgemental

Step #2: ADVISE

Advice should be:

Clear

Strong

Personalized

1-ASSESS

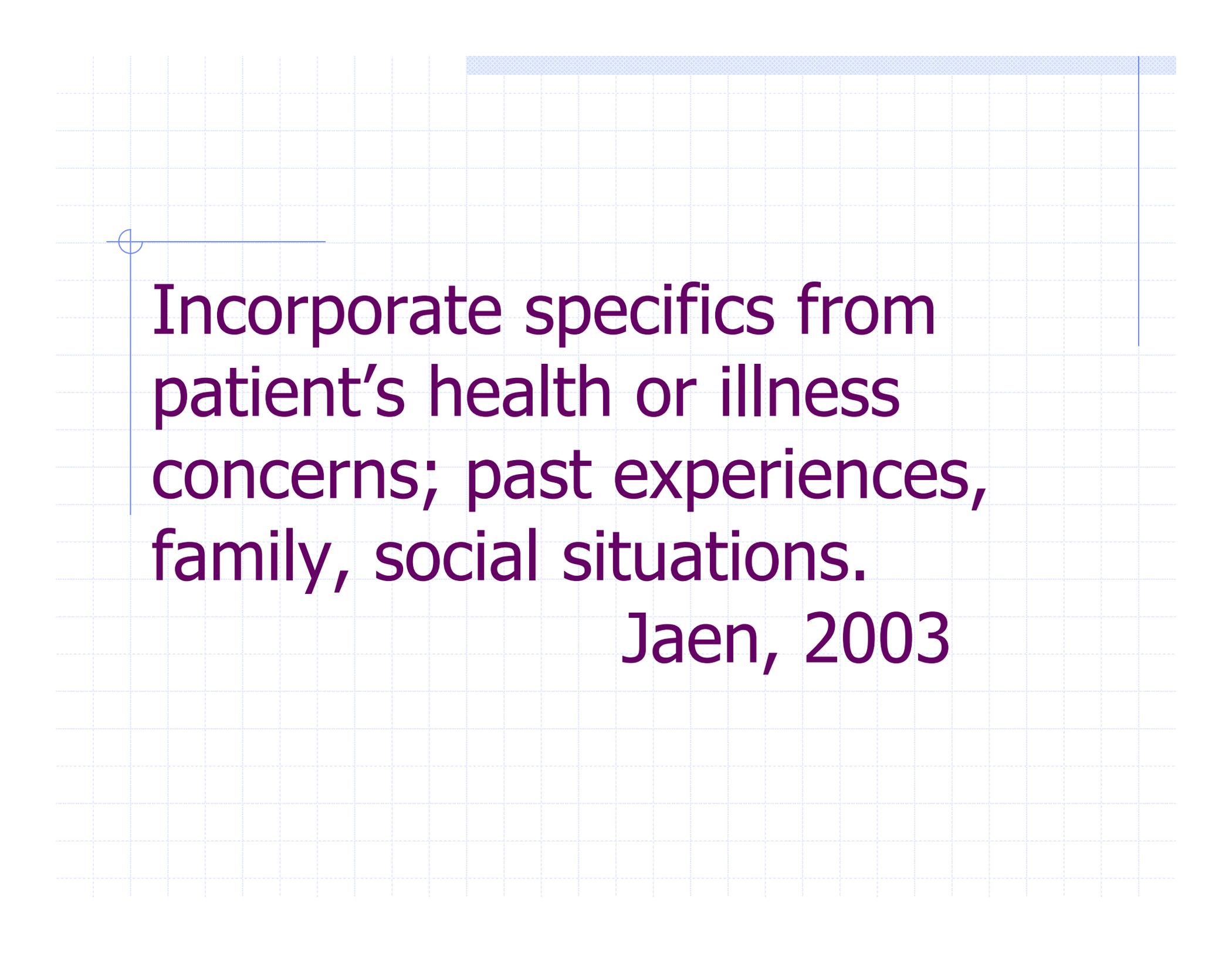
2-ADVISE

Jaen, 2003

Advice on stopping meth

- ◆ “As your clinician, I believe that you should stop using (meth.)”
- ◆ “Quitting (meth) is the best thing you can do for now and the future.”
- ◆ “The (Behavioral Health, CD Program) and I are prepared to help you.”

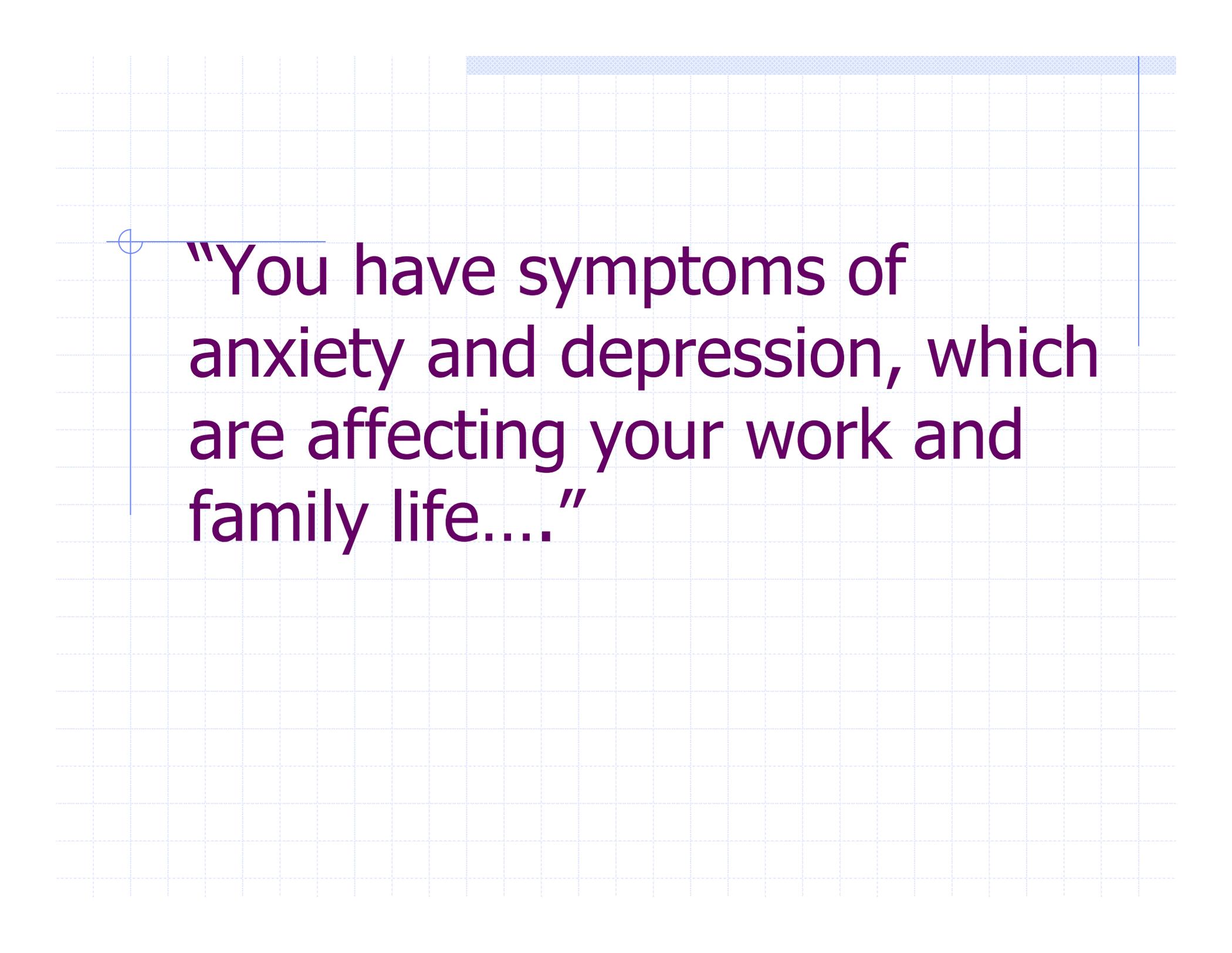
from Jaen, 2003



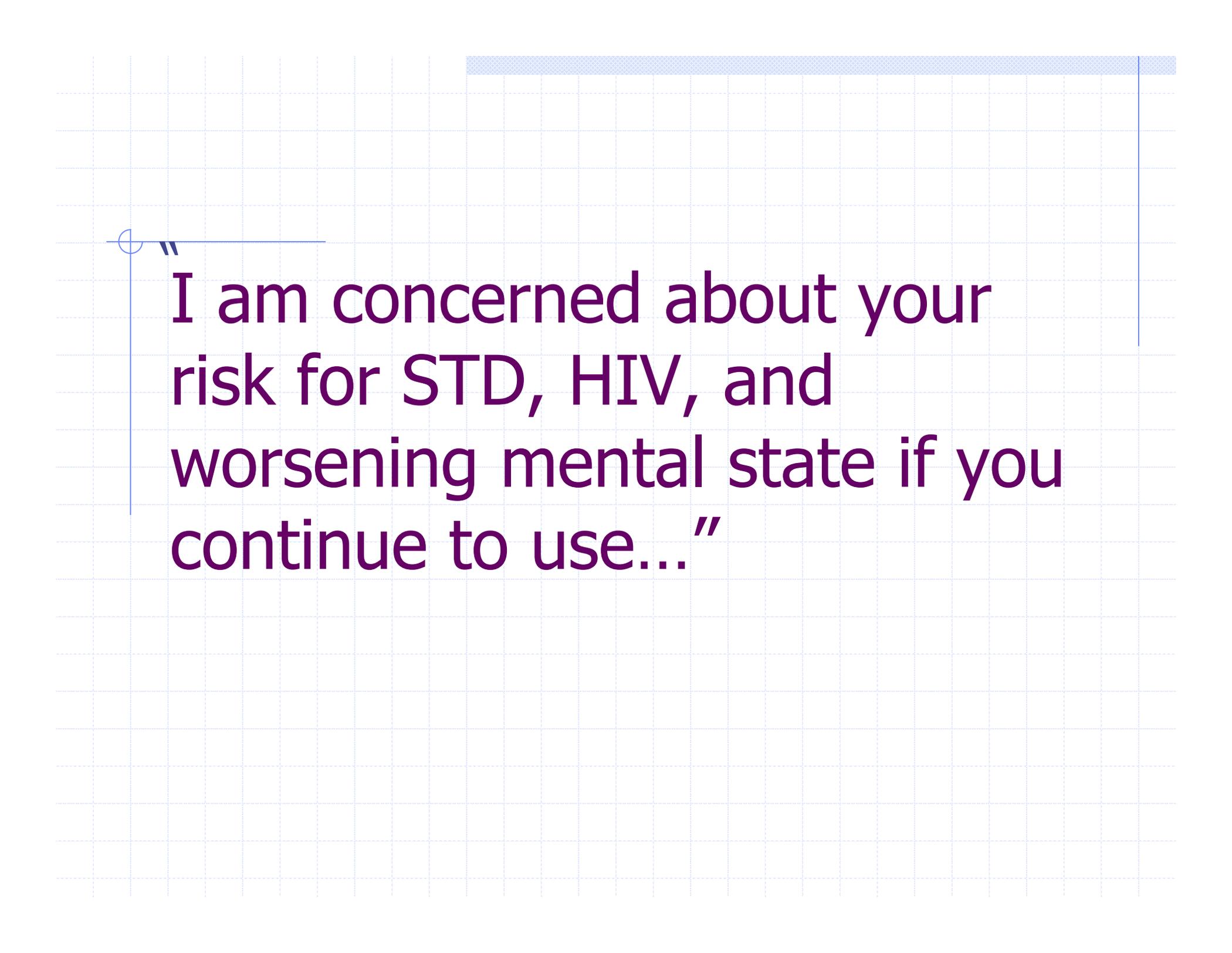
Incorporate specifics from patient's health or illness concerns; past experiences, family, social situations.

Jaen, 2003

“You told me that you have used meth for a year, and injected meth only one time, which was last week. You never shared needles with anyone else....”



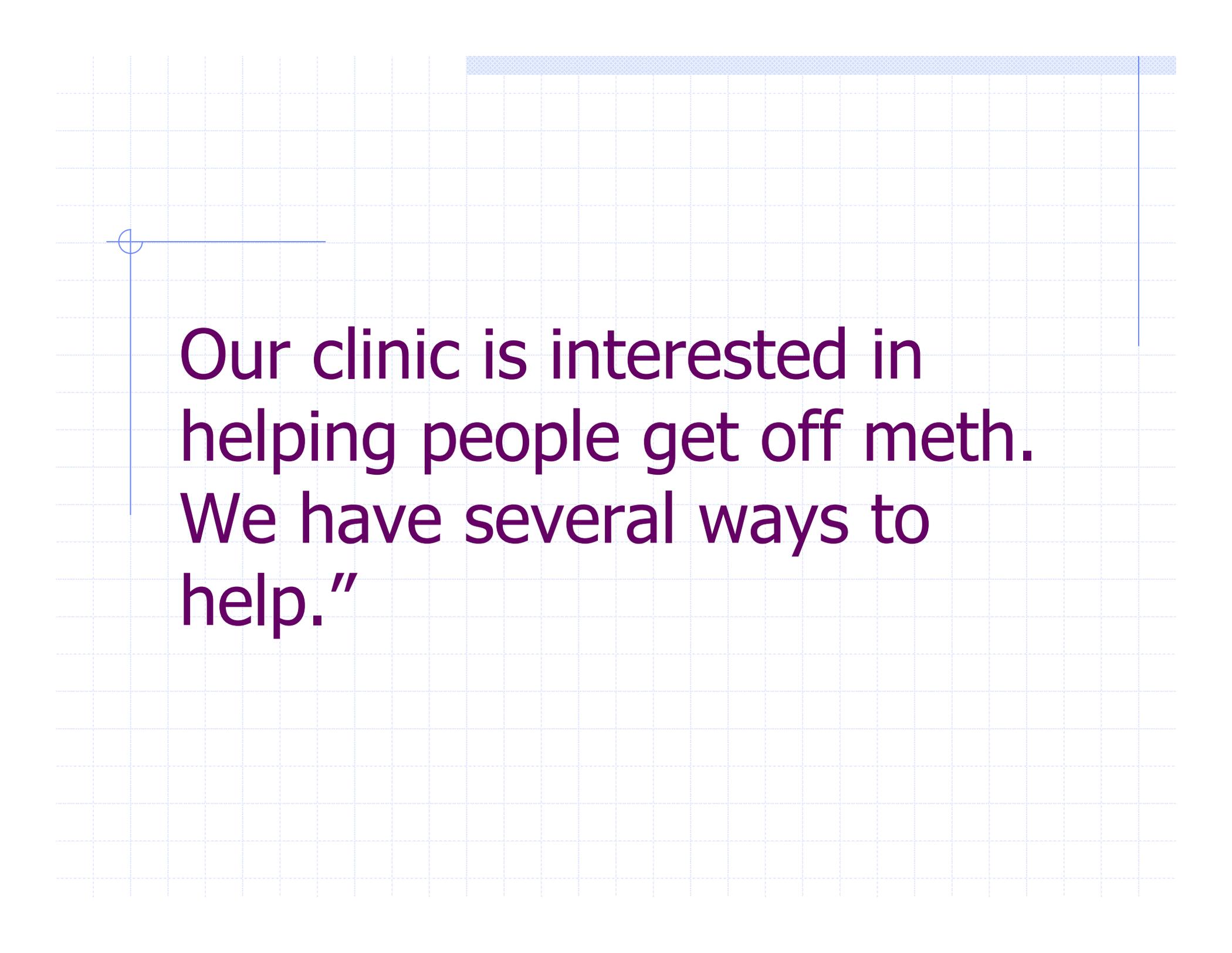
“You have symptoms of anxiety and depression, which are affecting your work and family life....”



“
I am concerned about your
risk for STD, HIV, and
worsening mental state if you
continue to use...”

“As your (health care provider), I can tell you that the most important thing you can do for your physical and mental health is to stop using methamphetamine...”

“Now. Because sharing needles and other risky behaviors are common among meth users. So is a lack of awareness or even memory of what a person does while they are high on meth...”



Our clinic is interested in helping people get off meth. We have several ways to help.”

Task of Step #3: AGREE on a course of action

- ◆ The patient is the only factor that can change a risk behavior.
- ◆ The health care provider is a facilitator.

1-Assess

2-Advise

3-Agree

Jaen, 2003

AGREE = Negotiate

- ◆ Negotiate the risk behaviors to target
- ◆ Negotiate the intensity
- ◆ Negotiate the timing

Jaen, 2003

Negotiating with meth user:

◆ Case #1:

“I wish I could stop using, but I have to work and I would have to stop working to go to treatment.”

Negotiating with meth user

◆ Case #2:

“ I think my depression is my real problem, and if that was taken care of I could stop using meth.”

Task of Step #3: AGREE

◆ Case #1:

“It sounds like you want to stop using but can’t see that happening since you work...If that is the case, then your plan for getting off meth will need to start without interfering with your getting to work....”

Step #3: AGREE

◆ Case #2:

“It sounds like you want to get your depression under control, in order to stop using meth. I am willing to work with you on both depression and meth issues. I suggest we start by assessing both problems and coming up with a plan for each.”

Task of Step #4: ASSIST

We need to know:

what is indicated

what is feasible locally

1-ASSESS

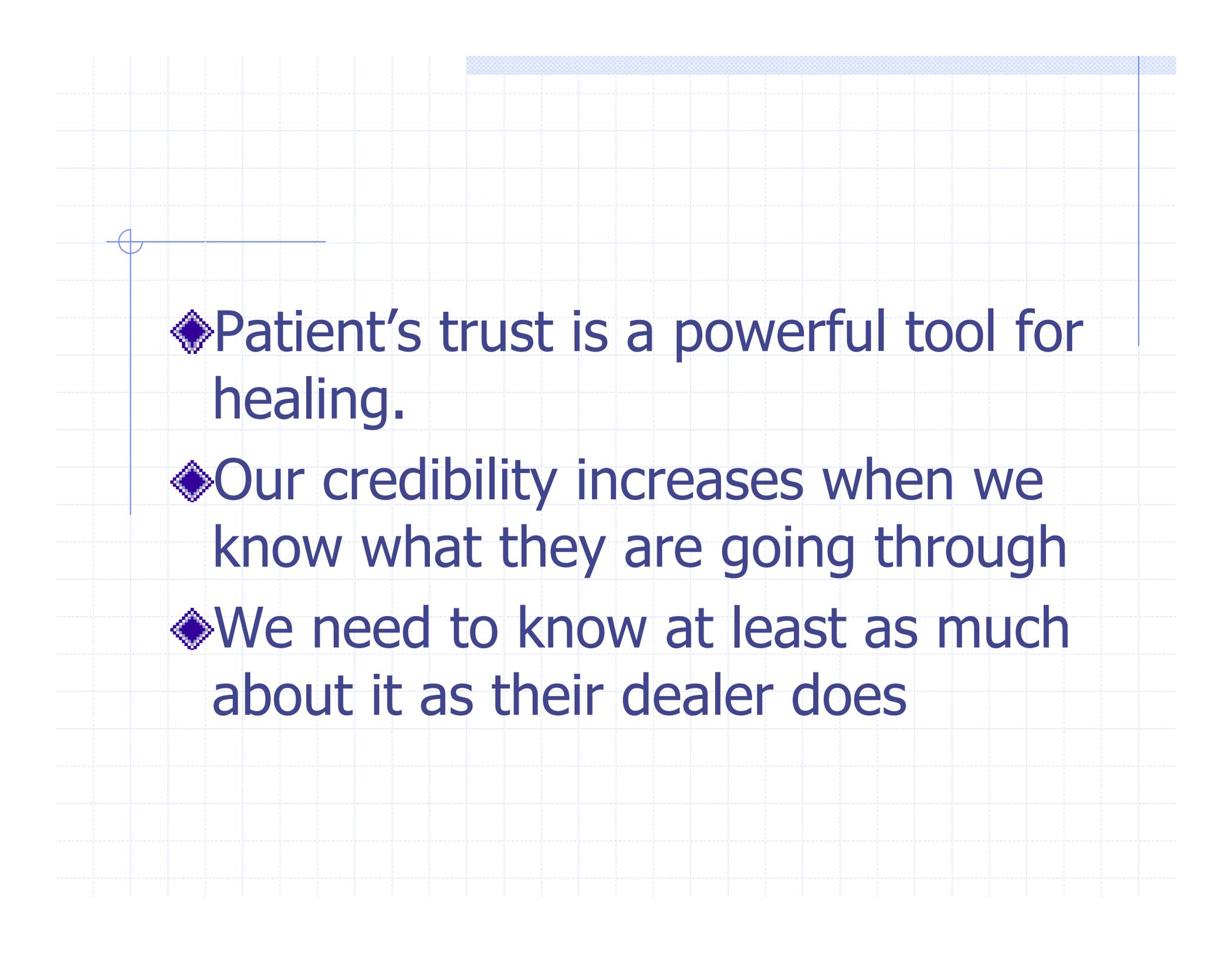
2-ADVISE

3-AGREE

4-ASSIST

Step #4: ASSIST

- ◆ We need specific knowledge about the course of withdrawal from meth
- ◆ In order to inform the patient (and family) about what to expect
- ◆ And when to seek medical help
- ◆ If we are not admitting the patient

- 
- ◆ Patient's trust is a powerful tool for healing.
 - ◆ Our credibility increases when we know what they are going through
 - ◆ We need to know at least as much about it as their dealer does

Tips from tobacco cessation

- ◆ Strong dose-response relationship between intensity of counseling and its effectiveness
- ◆ Many attempts to quit are common before success
- ◆ Have direct knowledge of community resources
- ◆ Encourage patient to enlist support from non-using friends and family

Jaen, 2003

Stages of “withdrawal” or what to expect when you stop using

- ◆ Early crash
- ◆ “Tweaking”
- ◆ Middle crash
- ◆ Late crash
- ◆ Protracted withdrawal

CSAT, 1999

Methamphetamine Early Crash

Days 1-4: decreased norepinehrine

- ◆ Fatigue
- ◆ Low stimulant craving
- ◆ High CHO craving

Days 4-10

- ◆ Anxiety
- ◆ Agitation
- ◆ Drug craving
- ◆ Euphoric dreams

CSAT, 1999

Nuchols, 2005

"Tweaking"

- ◆ Repetitive cycle of bingeing with intervening crash
- ◆ Can result in protracted withdrawal
- ◆ Can appear early or later
- ◆ Irritability
- ◆ Jittery state ("He's tweaking")
- ◆ Brisk, jerky movements, quivery speech
- ◆ Thinking scattered, paranoid delusions

CSAT, 1999

Middle Crash

- ◆ Sleep for 24-36 h.
- ◆ Or desire for sleep with insomnia
- ◆ Fatigue
- ◆ Depression
- ◆ Anhedonia
- ◆ Decreased mental, physical activity
- ◆ Use alcohol, benzos, opioids to self-medicate

CSAT, 1999

Early recovery craving management

Situational triggers

Avoid people, places and things associated with their use

Emotional triggers

HALT: don't get too hungry, angry, lonely, or tired

Nuchols, 2005

Late Crash

- ◆ Awake
- ◆ Hungry

CSAT, 1999

Protracted Withdrawal

- ◆ Fatigue
- ◆ Depression
- ◆ Anhedonia
- ◆ Loss of physical, mental energy
- ◆ Lack of interest in surroundings

CSAT, 1999

Protracted Withdrawal

- ◆ Symptoms opposite to meth intoxication
- ◆ May increase over 12-96 h
- ◆ May wax and wane for several weeks
- ◆ Severe, persistent depression risk for suicidal behavior
- ◆ Anhedonia and dysphoria last 6-18 weeks

CSAT, 1999

Protracted Withdrawal

- ◆ This is why people say “withdrawal from meth takes months.”
- ◆ Trying to stay “clean” is discouraging
- ◆ The patient “knows” that using would “cure” the symptoms
- ◆ That may not be true anymore.
- ◆ Brain is dopamine-depleted.

Later recovery craving management: Behavioral

- ◆ Structure
- ◆ Cognitive rehabilitation=repertive recovery-oriented behaviors
- ◆ Schedule to include: CD treatment, nutrition, physical exercise, fun, spirituality,AA/NA, work/school, medical,
- ◆ Change old habits, patterns
- ◆ Avoid triggers
- ◆ Develop a “safety plan” if triggered to use

Nuchols, 2005

Back to the clinic:

- ◆ We have a patient who has indicated he/she wants to quit
- ◆ We have negotiated which behaviors they are willing to change
- ◆ We have offered to help
- ◆ What can we do for him/her?

Primary Care “Toolbox”

- ◆ Pharmacotherapy for depression, dysthymia, anxiety
- ◆ Assess and advise on nutrition, exercise
- ◆ Refer or treat chronic psychosis
- ◆ Address concurrent medical issues
- ◆ Educate patient and family
- ◆ Refer to CD/BH treatment

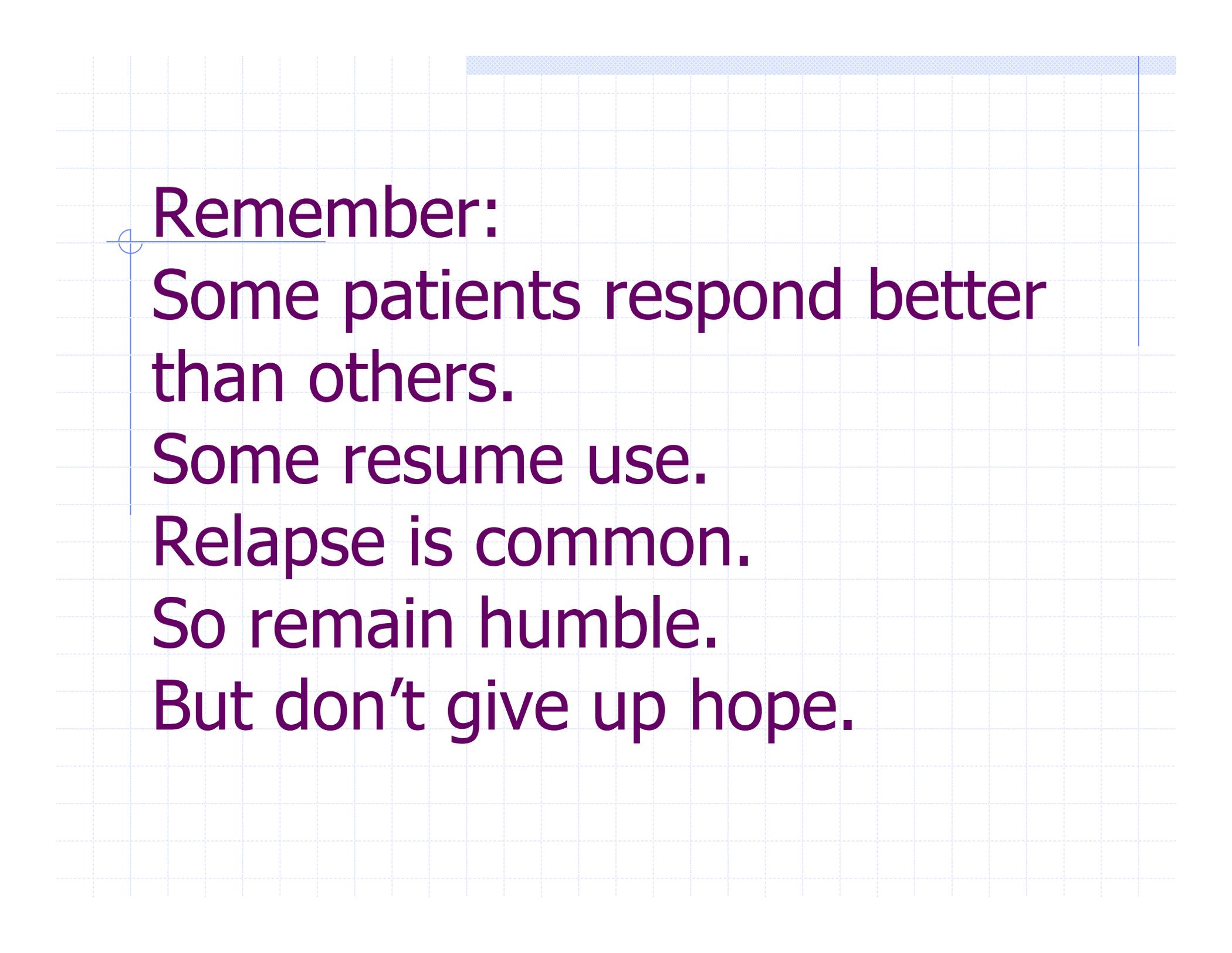
Step #5: ARRANGE follow-up

- ◆ Get started following these patients
- ◆ Treat their primary care symptoms: learn from your patients
- ◆ Assess brain recovery each visit
- ◆ Reassure: "Your brain is healing."
- ◆ Remind of improvements: "A couple of months ago, you couldn't hardly get out of bed in the morning."
- ◆ Address system issues discouraging continuity of care

Evidence for welcoming, empathic continuum of care

Keeping patients in treatment longer
improves outcomes for
methamphetamine dependence

- 1-Assess
- 2-Advise
- 3-Agree
- 4-Assist
- 5-Arrange



Remember:

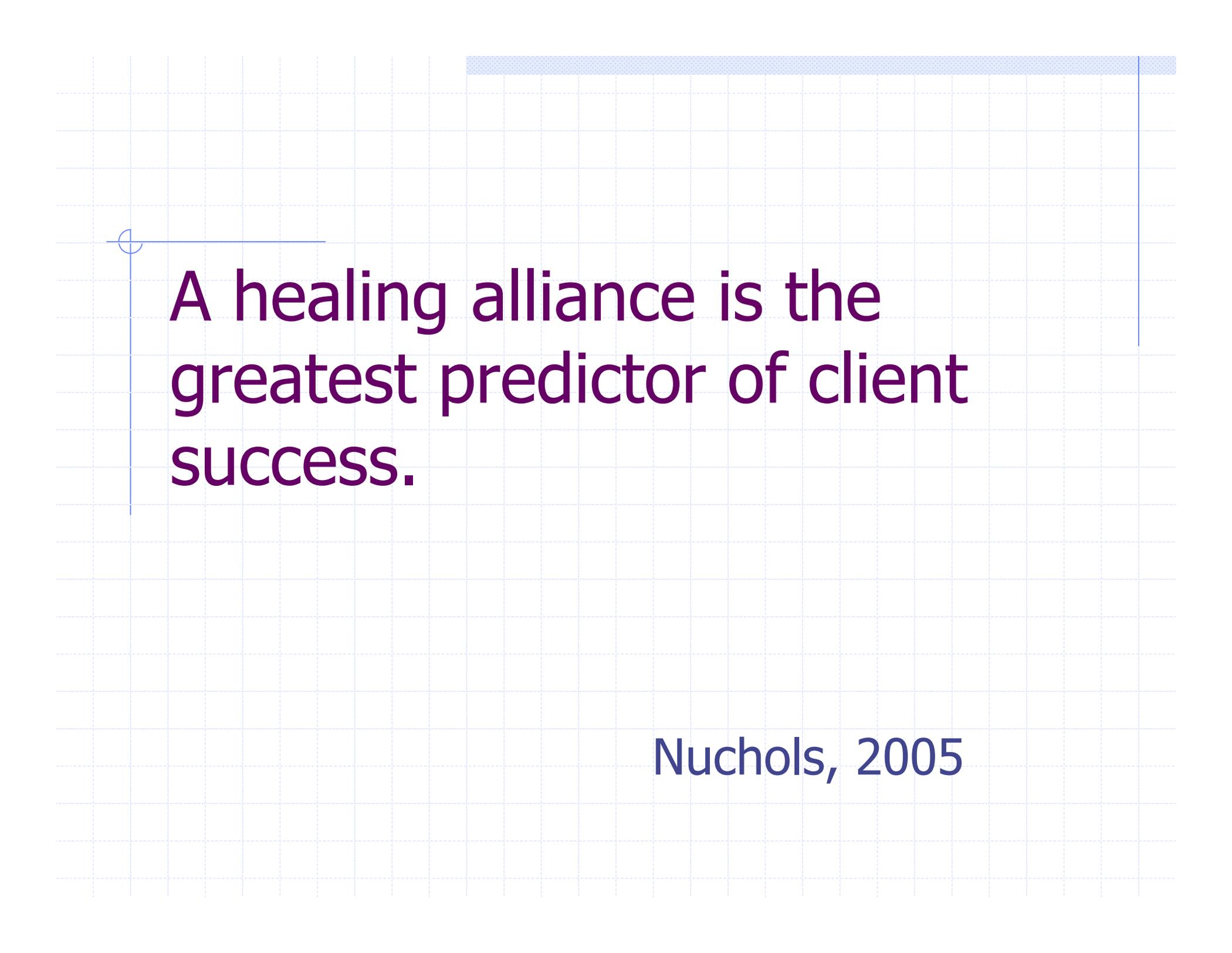
Some patients respond better than others.

Some resume use.

Relapse is common.

So remain humble.

But don't give up hope.

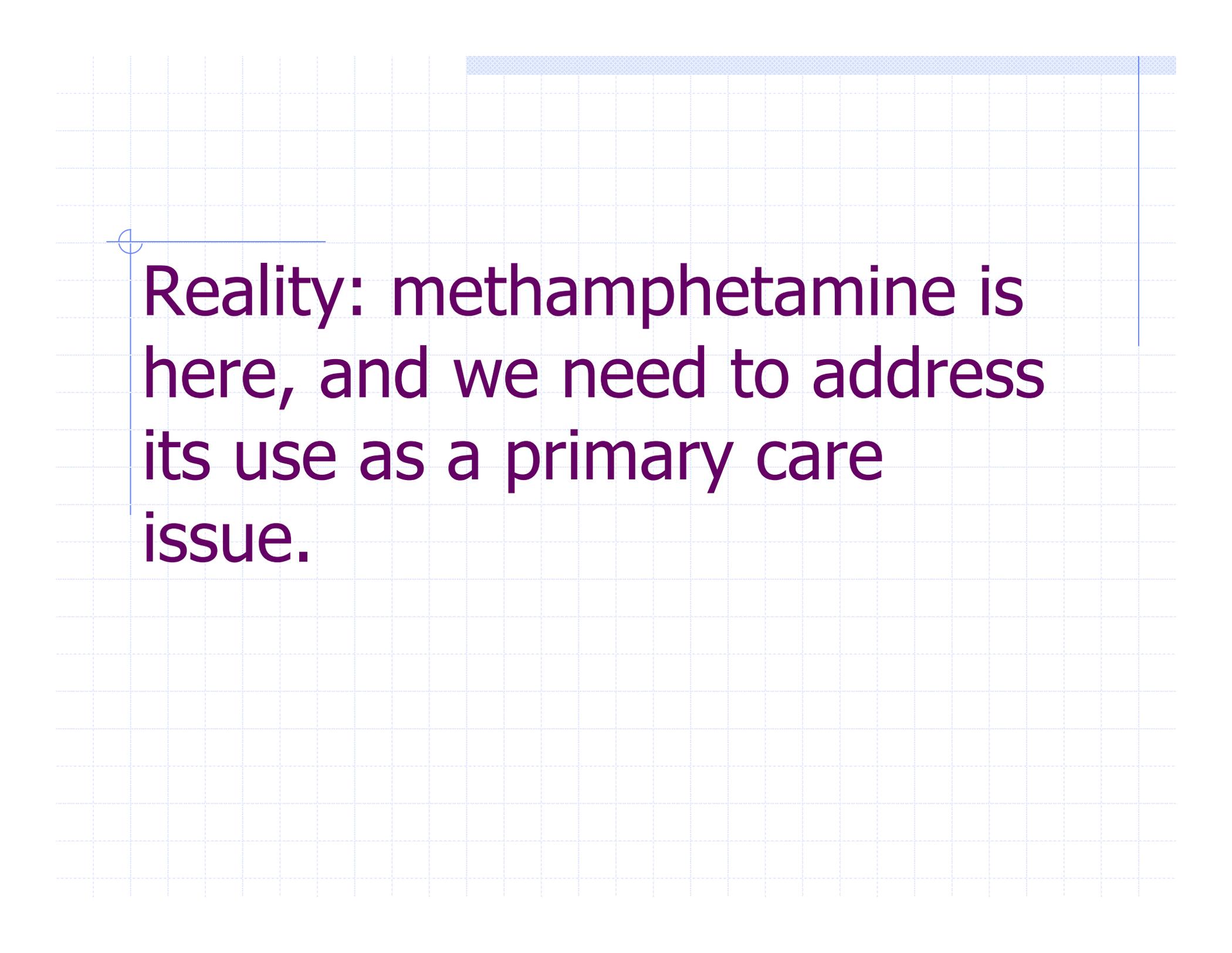


**A healing alliance is the
greatest predictor of client
success.**

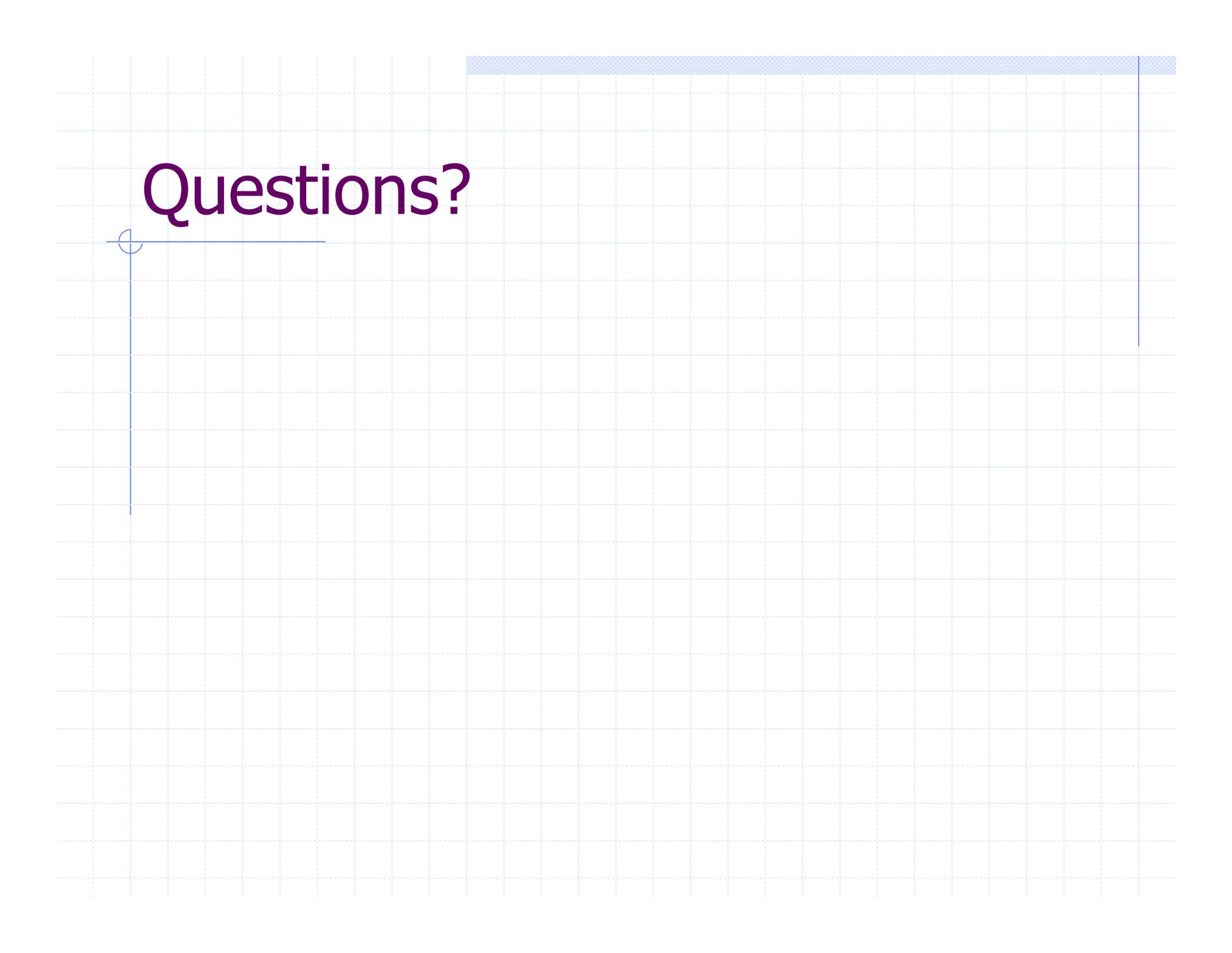
Nuchols, 2005

Primary Care Behavioral Intervention for Meth Use

- ◆ Assess use
- ◆ Advise to stop
- ◆ Agree—negotiate what they are willing to do
- ◆ Assist-pharmacotherapy, behavioral therapy, craving management, educate on what to expect
- ◆ Arrange follow up



Reality: methamphetamine is here, and we need to address its use as a primary care issue.



Questions?



Resources

- ◆ UCLA Integrated Substance Abuse Program
- ◆ Cardwell Nuchols PhD
- ◆ Matrix Institute
- ◆ Indian Health Service Chief Consultant in Addiction Medicine, PIMC
- ◆ Indian Health Service Behavioral Health Program, Rockville, MD
- ◆ Substance Abuse and Mental Health Administration, Centers for Substance Abuse Treatment (CSAT) and Substance Abuse Prevention (CSAP)