Methamphetamine clinical guidelines: current state of play

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The National Centre for Clinical Research on Emerging Drugs (NCCRED) was established by the Commonwealth Government in 2018 as part of the National Ice Action Strategy, recognising the need for improved treatments for methamphetamine, as well as more prompt detection and responses to emerging drug threats.

NCCRED aims to support clinicians to detect and respond to new drug health problems by:

- developing innovative and evidence-based new treatments for drug dependence;
- building clinical research capacity in the Australian AOD workforce;
- the rapid translation of research findings into clinical practice.
Knowledge generation & dissemination

Lag between generation of new evidence & its application (UNODC; Fixsen et al., 2005)

AOD sector especially prone to evidence gap (Miller et al., 2007), partly due to diverse views on:

• etiology and conceptualisation of AOD problems/addiction,
• who is best placed to provide treatment/support,
• how to prioritise interventions and service delivery models (Klingemann & Hunt, 1998; Room, 2010)

Various factors inhibit new responses, including resistance to innovation and new research evidence (Rush & Urbanoski, 2019)

The evidence-gap presents significant challenges for planners and funders to develop evidence-informed systems (Rush & Urbanoski, 2019).
Making sense of conflicting evidence, the role of clinical guidelines

Evidence in the field of substance use treatment is often contested. It typically requires contextualisation to make sense of seemingly conflicting research findings (Rush & Urbanoski, 2019). Clinical guidelines are one mechanism by which to reconcile evidence and inform best practice.
NCETA was commissioned by NCCRED to:

1: **Identify high quality, evidence-based**
Australian methamphetamine-related clinical guidelines.

2: **Map** guideline content against treatment settings and populations covered.

3: **Appraise** guidelines against contemporary guideline criteria.

4: Identify **strengths & gaps** for future guideline development.
Assessing Clinical Guidelines

Extensive research over past 30 years on methods underpinning Clinical Practice Guidelines (CPGs), including:

• their development,
• updating,
• reporting,
• tailoring for specific purposes,
• implementation and evaluation.

Increasing number of terms, tools and acronyms.

Over time, CPGs have shifted from opinion-based to evidence-informed, including increasingly sophisticated methodologies and implementation strategies.
NHMRC Selection Criterion

Selection criteria:

• Is the guideline evidenced based?
• Is the guideline Australian?
• Is the guideline current?
• Is the guideline freely available?
• Was the guideline developed in a transparent manner with potential conflicts of interest stated?
• Was the guideline developed under the auspices of a professional college or association?
Clinical guidelines were defined as those met some of the following features:

* Statements that include recommendations, intended to optimize patient care, that are informed by a systematic review of evidence and an assessment of the benefits and harms of alternative care options (Institute of Medicine, 2011).

Additional inclusion criteria were:
* Produced in Australia after 2000
* Addressed methamphetamine, in full or in part
* Produced for health and welfare professional groups
* Publicly available
Exclusion criteria

**Australian reference materials** (but were documented and uploaded to the NCCRED and NCETA website for information).

**Clinical guidelines produced for audiences outside of Australia** (due to differences in service delivery models).
Guidelines were assessed against an NCETA-modified version of the Appraisal of Guidelines for Research and Evaluation (AGREE) instrument (Brouwers et al., 2010).

The NCETA-modified instrument comprised 22 items organised in 5 domains:

1. Process of development (7 items)
2. Presentation style (3 items)
3. Completeness of reporting (6 items)
4. Clinical validity (3 items)
5. Quality & utility (3 items).

Items were scored on a 7-point scale (1 = low level of concordance with AGREE criteria and 7 = highest). A non-applicable option allowed items to be omitted from the scoring procedures. Scores were obtained for each domain and overall and transformed into total scores out of 100.

Appraisal assessments were undertaken by three assessors (KR, JF & RN), with divergent views resolved by consensus.
FINDINGS

1: Identification

2: Map of treatment settings & populations covered

3: Appraisal

4: Strengths and gaps
27 methamphetamine-related clinical guidelines identified.

Most were generic but contained sections relevant to methamphetamine.
## Mapping

<table>
<thead>
<tr>
<th>Treatment Setting</th>
<th>Generic</th>
<th>Young People</th>
<th>Rural &amp; Remote</th>
<th>Aboriginal</th>
<th>LGBTIQ&lt;sup&gt;a&lt;/sup&gt;</th>
<th>Families &amp; Children</th>
<th>Perinatal</th>
<th>Other&lt;sup&gt;b&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol and other drug (AOD) Specialist&lt;sup&gt;1&lt;/sup&gt;</td>
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<td>No</td>
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<td>Primary and community care&lt;sup&gt;3&lt;/sup&gt;</td>
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<td>Yes</td>
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<td>No</td>
<td>No</td>
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<td>Corrections</td>
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<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

<sup>a</sup> Lesbian, gay, bi-sexual, trans-gender, intersex, queer; <sup>b</sup> for example, culturally and linguistically diverse (CALD), mental health, coerced.

<sup>1</sup> AOD Specialist: outreach, counselling services, at-home withdrawal, withdrawal service, residential rehabilitation and other/not specified; <sup>2</sup> Hospital: emergency department, general ward, perinatal, mental health (inpatient), AOD withdrawal (inpatient) and other/not specified; <sup>3</sup> Primary and community care: general practice, mental health and other/not specified. Not all population groups were addressed in all primary and community care settings.
Appraisal scores for each AGREE domain

CAVEAT: Current guidelines were not developed to explicitly meet the AGREE criteria, the assessment nonetheless provides a benchmark for future guideline development.

1. Process of development: none scored >70%

2. Presentation style: 24 scored >70%

3. Completeness of reporting: 3 scored >70%

4. Clinical validity: 23 scored >70%

5. Quality and utility: 19 scored >70%
Guideline strengths

The available guidelines covered most relevant treatment settings and target population groups.

Most guidelines were well organised and written.

Presentation styles generally produced clear, specific and unambiguous guidelines with easily identified recommendations.
Guideline gaps & limitations

Population and treatment setting coverage.

Accordance with AGREE quality assessment criteria.
Treatment Setting Gaps

- Primary and community care
- Telephone / online settings
- Correctional settings
- General hospitals.

Several guidelines provided evidence-informed generic guidelines that would have applicability in a range of settings.
Population coverage gaps

Aboriginal populations
Addressed in 4 guidelines.
2 for undefined treatment settings
2 for unspecified primary health care settings.
There were gaps in guidelines designed for hospital, AOD specialist service, telephone / online & correctional settings.

LGBTIQ
Addressed in only 2 guidelines.
Neither specified the treatment setting. Hence, this population group had large gaps across treatment settings.

Rural and remote
4 guidelines specifically addressed needs of rural populations.
2 focussed on withdrawal settings (hospital inpatient & at home)
1 was for unspecified treatment settings
1 for an unspecified primary care setting.
AOD specialist treatment settings and associated population group addressed:
An example of populations coverage gaps

<table>
<thead>
<tr>
<th>Treatment Setting</th>
<th>Generic</th>
<th>Young People</th>
<th>Rural &amp; Remote</th>
<th>Aboriginal</th>
<th>LGBTIQs</th>
<th>Families &amp; Children</th>
<th>Perinatal</th>
<th>Others</th>
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<td>11</td>
</tr>
</tbody>
</table>

Note: Table cell numbers are the reference for each included methamphetamine-related clinical guideline
Little detail on how they were developed.

The processes by which guidelines had been developed.

Whether they had been developed following a systematic review of available literature.

Most guidelines also relied on the work of a few authors and/or used other guidelines as their basis.
Clinicians, workers or patients perspectives not included.

Most guidelines did not report whether the views of target clinicians or clients had been incorporated into guideline development.
A small number used stigmatising and judgemental language that could undermine effective therapeutic relationships between patients & care providers.
Limited research available to inform guidelines. Need to strengthen the evidence base is a priority. Clinical guideline development standards applied in future.

Priority treatment settings
- Telephone/online
- Corrections
- General hospital wards

Priority population groups
- Aboriginal people
- LGBTIQ
- Rural and remote
Where to access the review and resources


NCETA.flinders.edu.au/
NCETA’s new 6-page meth resource:
Outlines prevalence & impact of methamphetamine use among Aboriginal & Torres Strait Islander people.
Provides intervention options for workers.
Available for download from NCETA:
Thank you