Vancouver team uncovers self-medication with crystal meth

Selected highlights from the XVI International AIDS Conference, Toronto, Canada, 13-18 August 2006

A major health issue for some people at risk for or who have HIV infection is substance use. This behaviour can lead to addiction and, in the long-term, reduce overall health as well as weaken the immune system. The following is a short list of some commonly used substances in high-income countries:

- alcohol
- cocaine
- codeine
- crystal methamphetamine (crystal meth or meth)
- ecstasy
- heroin
- marijuana
- morphine

Crystal meth is a major problem on the Pacific coast of North America; in Canada, particularly in Vancouver. It is also a problem among some men who have sex with men (MSM). Initially, users may try an occasional dose of this substance, but this can quickly turn into an addiction. A major issue for community groups in Vancouver is to find out why people use meth. Preliminary results from a study sponsored by the British Columbia Centre for Excellence in HIV/AIDS suggest that meth is often used in an apparent attempt to self-medicate underlying mental health conditions.

Study details

Between December 2005 and March 2006 the research team recruited 25 former meth users with whom they conducted interviews. The profile of the study participants, all male, was as follows:

- average age – 36 years
- 20% were Aboriginal; 80% were White
- almost half were HIV positive
- meth was used for an average of five years
- the drug was smoked, snorted or injected

The mental health disorders disclosed to the team were as follows:

- depression
- bipolar disorder
- attention deficit/hyperactivity disorder
- obsessive compulsive disorder
- anxiety
- post-traumatic stress disorder

Statements made by participants with each of the following diagnoses illustrate how they become involved with meth:

**Depression:**
“I think atypical depression is highly under-diagnosed among the HIV positive population...and they are self-medicating with a stimulant. Amphetamines are the treatment of choice for atypical depression.”

Another participant revealed that he “[stopped taking antidepressants] right when I started with the drugs [and] stopped seeing my psychiatrist. The [antidepressants] work for 6 to 12 months then lose their ability to do what they’re supposed to.”

**Bipolar disorder:**
“[At the time I began using meth]...I was finding it very difficult to get used to taking these drugs to treat bipolar disorder.”

**Attention deficit/hyperactivity disorder:**
“[Meth] leveled me out. I could concentrate at work better...it helped me slow down so that I could concentrate better, so I could complete a task.”

The research team summarized its findings by noting that “previously diagnosed mental health disorders are common among problematic meth users.” They also found that for many men in the study, “the initiation and escalation of meth use was linked to their previously diagnosed but poorly controlled mental health disorder.” Also, the study team found that among MSM “interferon therapy–associated depression may cause the initiation or progression of meth use.”

According to the team, its findings have implications for health care providers who need to anticipate that their MSM patients may use or increase their exposure to meth in order to deal with “poorly controlled mental health disorders.” Counseling for MSM with these disorders is needed to steer them toward healthy choices.

The team also suggested that MSM should be “strongly encouraged” to disclose their use of meth, even if it is only occasional, to their primary health care providers.

**REFERENCE:**
Lampinen TM, Greatheart MS, Schilder A, et al. Medicinal crystal methamphetamine: self-medication of poorly controlled health conditions and progression to problematic use among MSM. Abstract ThPe0722.
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