UNSW AUSTRALIA

St Vincent's Hospital Sydney, Drug and Alcohol Service, S-Check Clinic

Evaluation Report

Never Stand Still | Art & Social Sciences | Centre for Social Research in Health

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December 2015

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Suggested citation: Brener, L., Bryant, J., Wilson, H., Lea, T., & Rance, J. (2016). ***St Vincent's Hospital Sydney, Drug and Alcohol Service, S-Check Clinic: Evaluation report***. Sydney: Centre for Social Research in Health, UNSW Australia. http://doi.org/10.4225/53/57AA8C9E4A664

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1 Introduction

Stimulant Use in Australia

Stimulants refer to psychoactive substances that elevate heart rate, blood pressure and respiration, with the impact of increasing alertness and energy[1]. Stimulants may be used in the treatment for health conditions where traditional treatments have failed, such as attention-deficit disorder. Although there is some evidence that prescription stimulant use among children and adolescents may protect against later substance dependence[2, 3], there is some concern about the potential for misuse of medications[4, 5]. Illicit stimulants include methamphetamine (including speed, base and crystal), cocaine and MDMA. In recent years, there has been an increasing trend in non-prescription use of stimulants. In 2013-2014, the number of detections of amphetamine-type stimulants at the Australian border increased, such that it was the highest number on record[6]. Data from the 2013 National Drug Strategy Household Survey showed that about 2% of the total Australian population reported using methamphetamine in the preceding 12 months[7]. Although population prevalence has remained stable, there has been a shift among current methamphetamine use, specifically injecting drug users, away from powder forms to the crystalline form of methamphetamine[7]. In 2005, researchers estimated that there were 17,700 regular methamphetamine users and 14,700 dependent methamphetamine users in Sydney alone[8]. More recently, the 2013 National Drug Strategy Household Survey showed that self-reported use of crystal methamphetamine among methamphetamine users more than doubled from the 2010 to 2013 survey, (from 22% to 50%) as did the proportion of people reporting daily or monthly use[7]. In the Illicit Drug Reporting System 2014 survey, the number of current injecting drug users reporting use of crystal methamphetamine in the preceding six months increased by 6% (from 61% to 67%)[9].

Adverse Impacts of Stimulant Use

Increases in non-prescription stimulant use are concerning, given the potential for dependence and associated harms. There is the potential for adverse and unwanted effects of stimulant use, including anxiety, aggression and depression[1]. An Australian study recently reported high levels of depression among methamphetamine users entering treatment, however distinguishing a diagnosis of depression from substance-induced depression can be problematic[10]. Stimulants have been linked to a range of mental health issues, including psychosis and schizophrenia, with a high number of methamphetamine users presenting to needle and syringe programs with primarily substance-induced psychotic disorders[11]. In a recent Australian study, users of crystal methamphetamine with no history of psychosis were

five times more likely to suffer from psychotic symptoms while taking the drug as compared to when they were abstinent[12]. Psychosis among people who use methamphetamine has been found to be linked with family history of schizophrenia, pre-morbid schizoid/schizotypal personality, as well as frequent and early onset of methamphetamine use[13, 14]. Long-term use of stimulants can also result in memory loss and other cognitive deficits[15-17], cardiomyopathy and heart failure[18-20], and stroke[21]. People who use stimulants have been found to be more likely to participant in violent and criminal behaviours[22, 23]. There is also evidence of an association between stimulants and participation in risky sexual practices[24, 25], particularly among men who have sex with men where substances are used to enhance sexual experiences[26, 27]. There is a high risk of transition to heroin injection and polydrug use[28], which may exacerbate the harms associated with stimulant use.

Harms associated with stimulant use also present a public health burden, with significant costs to health care to treat people presenting with stimulant use problems. In the United States, estimates as of 2005 indicated that the economic burden of methamphetamine was between $16.2 and $48.3 billion, accounting for criminal justice, treatment and health care costs[29]. No such estimates are available for Australia, however there is evidence of increases in indicators of stimulant-related harm. These include increases in stimulant-related arrests[30], treatment admissions[31] and hospital separations[32, 33]. There is also evidence of harm to frontline health workers; in a study comparing methamphetamine and other toxicology-related emergency department presentations, methamphetamine users were found to be more agitated, aggressive and violent[34], therefore posing greater risk to health care workers. In Australia, much of the stimulant use reported is via injection, hence people who use stimulants may experience a range of injecting-related harms, such as cutaneous injection-related infection (e.g. abscesses, cellulitis)[35, 36]. Though not life threatening, these infections present serious health complications, with substantial costs to health care to treat them[35, 37].

Treatments for Stimulant Use

In Australia, treatment options for stimulants remain limited, as treatment approaches for substance abuse have traditionally focused on opiates and alcohol. This is despite the fact that stimulants are becoming an increasing problem in Australia, and are receiving significant media attention, particularly methamphetamine (see [38-40] for examples). Treatment options for substance abuse include detoxification, pharmacotherapy, outpatient and community-based services, and residential rehabilitation. Some of these treatments have been largely ineffective among stimulant users. In a study evaluating community-based treatment for methamphetamine users in Sydney and Brisbane, researchers found that detoxification had no effect in reducing methamphetamine use over time[41]. This could be explained by the longer withdrawal period for stimulants such as amphetamine, compared to opiates, suggesting that detoxification could be better suited in a community-setting where other monitoring could be implemented[42]. Indeed, there is a lack of knowledge around stimulant withdrawal syndrome; symptoms may include depression and agitation, and these may last for a few days up to a few months[43]. Further, in one study, residential rehabilitation was found to have a significant effect in reducing methamphetamine use at 3-month follow-up, however this affect attenuated over time[41]. This is not to say that

the treatments themselves are ineffective, just that poor engagement and retention limits their ability to significantly reduce stimulant use[44]. People who use stimulants have been found to have a pattern of low treatment utilisation[45], with poor treatment engagement and retention associated with a range of factors, such as female gender, greater socio-economic disadvantage, mental health issues (including depression), greater severity of stimulant use, and greater experience of harms associated with use[44, 46-48]. Many stimulant users may also not identify that they have a problem with their use, while others may be concerned about confidentiality, particularly in rural or remote areas[49]. Although strategies to overcome barriers to treatment among stimulant users have been suggested, such as provision flexibility, multi-focused intervention packages and use of new technologies, these are yet to be introduced and evaluated among this population[50]. Where stimulant users have engaged in available treatment, there is evidence of lower frequency of methamphetamine use[45]. Psychosocial interventions, namely cognitive behavioural therapy (CBT) are regarded as the most effective treatment available for stimulant users[51-54].

There have been efforts to develop pharmacotherapy suitable for administration to stimulant users, such as psychostimulant replacement. Pharmacotherapies for opiate dependence have been found to be effective in reducing use, as well as the drug-related harms, including overdose risk and HIV risk behaviours[55-58]. However, no suitable pharmacotherapy for treatment of stimulant users has been found[59, 60]. Randomised controlled trials have produced promising results for methylphenidate, naltrexone, bupropion and mirtazapine in reducing stimulant use, however replicable efficacy has not been established[59]. The lack of effective pharmacotherapy means that the medical profession may not be as involved in the treatment of stimulants, and may therefore not perceive stimulant use to be as serious as other drug dependence, such as opioid dependence[47]. Efforts to introduce web-based interventions have also been unsuccessful with no evidence of reduction in stimulant use[61]. In one study, researchers used a real-time text messaging intervention to reduce use of methamphetamine and engagement in sexual risk behaviours, as well as increase adherence to HIV treatment[62, 63]. Findings indicated that the intervention decreased frequency of use and unprotected sex[62, 63]. There is some evidence of effectiveness of alternative treatments in reducing harms associated with stimulant use. For example, in China, treatment programs have used traditional Chinese herbal approaches and acupuncture, in combination with medications (such as fluoxetine for depression associated with stimulant use) to treat stimulant abuse. These approaches have had some success in reversing cardiac arrhythmia associated with stimulant intoxication, while acupuncture has been successful in treatment of depressive symptoms associated with stimulant withdrawal[64].

Given that many stimulant users do not access conventional treatments, development and evaluation of alternative treatment and service models is imperative.

2 The Program

In November 2011 the St Vincent's Hospital Stimulant Treatment Program successfully applied to the Commonwealth Department of Health and Ageing under the Non-Government Treatment Organisation Grants Program (NGTOGP) to develop an early intervention program for stimulant users.

While the core business of the program is to conduct a 3-year pilot Stimulant Check-up Clinic, S-Check has three distinct key performance areas:

1. *Clinical Practice*
2. *Community Development*
3. *Sector Development.*

The aim of the clinic is to provide strengths-based, bio-psycho-social assessments for people who use stimulants such as methamphetamine, cocaine and ecstasy, who would otherwise not engage in drug and alcohol treatment (***Clinical Practice***).

Clients participating in the Check-up Clinic are consented to be involved in research and evaluation. The Check-up Clinic comprises:

- Session 1 Psychosocial Assessment
- Session 2 Medical Assessment (data not included in evaluation)
- Session 3 Medical Feedback (data not included in evaluation)
- Session 4 Psycho-social Feedback
- On going 3 month follow up.

The clinic offers Assessment, Information, Brief Intervention, and Referral services. Patients may elect to attend two Stimulant Check-up consultations and will be encouraged to attend 3, 6 or 12 monthly checkups as appropriate.

The project includes conducting a Social Marketing Campaign (***Community Development***) to introduce 'Stimulant Check-ups' into the vocabulary and mindset of people who use stimulants and their associates.

It is hoped that the experience of the clinic and this evaluation will help develop a clinical model of care to be distributed to services around Australia to adapt according to the individual needs of their area and target population groups (***Sector Development***).

3 Study Objectives

3.1 Primary Objective

The focus of the evaluation is to assess the following objectives:

- Assess the utilisation of the clinic among people who use non-prescribed psycho-stimulants who are in early stage drug use and who have not previously sought treatment for psycho-stimulant use disorders.
- Assess the demographic distribution of people attending the clinic.
- Assess retention of client group through the four appointments and to longer terms follow up.
- Assess perceptions and experiences of clients utilising this service.
- Assess staff experiences of working at this clinic (including perceived benefits and limitations).
- Assess stakeholder perceptions of the clinic (including perceived benefits and limitations).

4 Study Design

The evaluation is a mixed methods design consisting of the following:

1. Data extraction from clinical records (n=186) and participants who contacted S-Check via phone for information or referral but did not attend the service in person (n=80)
2. Semi structured interviews with clients (n=10)
3. Semi structured interviews with staff and key stakeholders (n=10).

4.1 Data extraction from clinical records

Over a 2-3 month period, clinic records were assessed by a research officer based on site at St Vincents hospital. The aim was to establish the following from information collected routinely at the 4 clinic sessions.

- No. of people attending the service
- Engagement of treatment naïve people early in drug us history
- No. of sessions most commonly attended
- If any clients attend longer term follow up at 3, 6 or 12 months
- Any de-identified demographic information to describe clinic attendees, including age, gender, ATSI, language spoken at home, employment status, sexuality
- Substance use and intervention history
- Psychosocial assessments at baseline and at later sessions.
- Source of referral
- Previous service utilisation
- Substance use
- Psychological distress (K10)
- Severity of dependence (SDS)
- Risk questionnaire
- Stimulant use and effects.

In order to obtain this data, clinical files data were analysed for descriptive statistics of the client population, completion rates, and changes in self-reported substance use, risk behaviours, psychological distress, and severity of dependence and outcome rating scale.

Measures used for data extraction to address each research question were agreed upon by the research team. Data extraction occurred on site at the S-Check Clinic. Each client was given a unique random identification number and no personal information was extracted from the clinic records. The first period of data extraction occurred between February and March 2015. In July 2015 the researcher returned to S-Check to extract new data between the period of March until the end of May 2015. Hence the data reporting period is from the start of the clinic data collection until the end of May 2015 and includes all clients who attended the S-Check Clinic during this period.

All data were entered into an SPSS database. Both hard copy clinic evaluation data and CHIME records for each client was assessed by the research officer. Records were also obtained for clients who had called in and completed an intake assessment via telephone but had never come in for a first appointment. Demographic data from this group was entered into SPSS so as to assess whether any differences existed in these characteristics between those clients who only do telephonic intake and those who actually come in to the clinic.

4.2 Semi structured interviews with clients

Semi-structured interviews were undertaken with 10 clients to assess their perceptions of the service offered by the S-Check clinic in more detail. Initially it was hoped that 15 clients interviews would be undertaken, but due to a range of circumstance including ethical constraints in recruiting clients and both clinic and researcher staff turnover, it was difficult to recruit clients into the study. Nevertheless, attempts were made to sample a range of clients to reflect different demographic profile of the clinic including male versus female. Areas addressed in the interview included: how clients heard about clinic, whether they would refer friends or family to the clinic, how many session they had attended, their experiences at each session, the perceived benefits/limitation of clinic, future clinic usage, satisfaction with the services, perceptions of staff and so on. Participants were reimbursed $25 in the form of a supermarket vouchers for their participation in the interview. Interviews lasted approximately 45 min-1 hour and were conducted over the phone, audiotaped and transcribed.

4.3 Semi structured interviews with staff and key stakeholders

Semi-structured interviews were conducted with 6 current/ previous clinic staff members. The staff was asked questions about their perceptions of the service, the perceived benefits and limitations of the clinic, the marketing of the service and their experiences with clients.

Six key stakeholders were also interviewed from key groups identified by the Clinic Advisory group. These key people involved in the establishment of the clinic were asked their views on the importance of S-Check service along with ideas about the practicalities of establishing such a service, benefits and limitations, marketing of the service and expected outcome of the service.

5 Quantitative Data Analysis

5.1 Statistical analyses

Proportions were calculated for all categorical variables, the mean and standard deviation for continuous variables that were approximately normally distributed, and the median and interquartile range (smallest and largest values in the middle 50% of the data) for variables that were not normally distributed. Statistical comparisons between participants who completed phone intake only and participants who attended the S-Check service were conducted where comparable data were available (e.g. demographic characteristics, source of referral, alcohol and other drug treatment history) using two-sample t-tests and Pearson's chi square tests. Other statistical comparisons examining factors associated with participant retention and psychostimulant dependence used chi-square tests for categorical variables, t-tests for normally distributed continuous variables and Mann-Whitney U tests for non-normally distributed continuous variables. Statistical significance was set at $p < 0.05$. Stata Version 13 was used to conduct these analyses.

6 Results

6.1 Retention of participants

Two hundred and sixty-six participants made contact with the S-Check service during the study period. This included 186 participants (69.9%) who attended S-Check for at least one appointment, and 80 participants (30.1%) who contacted S-Check via phone for information or referral but did not attend the service in person. Some of these 80 participants may have intended to attend the service but did not, although this information was not collected at intake and therefore cannot be reported.

Retention of participants who attended S-Check in person is shown in Table 1. Eighty-one percent of participants who attended session 1 were retained at session 2, 56.5% were retained at session 3, and 58.6% were retained at session 4. The median number of days that elapsed between session 1 and other sessions was 11 days for session 2, 20 days for session 3 and 29 days for session 4. This means that for the average participant, all four sessions were completed with a period of one month.

Table 1 Retention of participants at S-Check session

	Attended	Days elapsed from session 1
	n (%)	Median (IQR)
Session 1 – Psychosocial assessment	186 (100)	-
Session 2 – Medical assessment	151 (81.2)	11 (1-13)
Session 3 – Medical feedback	105 (56.5)	20 (7-21)
Session 4 – Psychosocial feedback	109 (58.6)	29 (13-30)
Completed 3 or 6 month follow-up	14 (7.5)	-

IQR, interquartile range.

6.2 Participant evaluations of each session

Table 2 shows participants ratings of each S-Check session, including the relationship with the clinician, the goals and topics covered, the approach or method of the clinician, and an overall rating. Participants responded to each item by placing an X on a 100mm ruler scale, with responses closest to 0 equating to an unfavourable rating and responses closest to 100 equating to a favourable rating.

On the whole participants rated each session favourably, with median scores of above 90 for overall ratings of each session. For each aspect of the session, including the relationship with the clinician, the goals and topics, and approach or method of the clinician, median scores of above 90 were found for each session (see Table 2).

Table 2 Participants' ratings of each S-Check session

	Session			
	1 (n=170)	2 (n=88)	3 (n=52)	4 (n=80)
Aspect of session	Med (IQR)	Med (IQR)	Med (IQR)	Med (IQR)
Relationship	97 (90-100)	93 (85-98)	93 (86-98)	96 (91-100)
Goals and topics	93 (83-99)	94 (85-98)	94 (85-98)	96 (89-99)
Approach or method	95 (88-100)	95 (86-99)	94 (88-98)	97 (91-100)
Overall rating	95 (88-100)	94 (87-98)	95 (85-99)	96 (91-100)

IQR, interquartile range; Med, median.

Note. A 100mm ruler response scale was used for each item. Possible scores range from 0-100 with higher scores indicating a positive rating.

6.3 Demographic characteristics

Table 3 compares the demographic characteristics of participants who attended S-Check (n=186) with those who only made phone contact (n=80). The mean age of participants was 36 years (range 19-73). The majority of participants were men (74.4%), were living in stable accommodation (e.g. rented or privately owned dwelling; 77.8%), and lived alone or cohabited with a spouse or partner (48.9%). Most participants were not in paid employment (62.4%) and more than one-quarter were receiving a temporary benefit or had no income (30.2%). Four participants reported sex work as their primary source of income. Data on sexual identity, education attainment, country of birth and cultural background were not collected.

Participants who attended S-Check in person were significantly more likely than participants who only made phone contact to be living in stable accommodation (83.9% vs. 63.8%; $p < 0.001$), and to be in paid employment (43.0% vs. 25.0%; p=0.005). There were no significant differences between in-person and phone participants in terms of age, gender, and whom they lived with.

Participants who attended S-Check in person were also asked about their occupation. Those who reported being in paid employment were employed in a range of different professions, including labour/trade (10.8%), health (8.1%), business/management (7.5%), sales/retail (6.5%), hospitality (6.5%), self-employment (4.8%), art/media (4.3%) and accounting/finance (2.7%) (professions with fewer than 5 participants are not reported).

Among participants who only completed phone intake, the majority reported methamphetamine as their principal stimulant drug of concern (91.3%, n=73).

Table 3 Comparison of demographic characteristics of participants

	All participants (n=266)	Phone assessment only (n=80)	S-Check participants (n=186)
	n (%)	n (%)	n (%)
Age (M, SD)	36.3 (10.1)	36.0 (10.3)	36.4 (10.0)
Gender			
Male	198 (74.4)	59 (73.8)	139 (74.7)
Female	67 (25.2)	20 (25.0)	47 (25.3)
Transgender[a]	1 (0.4)	1 (1.2)	-
Accommodation			
Rented house or unit	147 (55.3)	34 (42.5)	113 (60.8)
Privately owned house or unit	60 (22.6)	17 (21.3)	43 (23.1)
Hostel/supported accommodation	14 (5.3)	3 (3.8)	11 (5.9)
Homeless	13 (4.9)	6 (7.5)	7 (3.8)
Boarding house	4 (1.5)	1 (1.2)	3 (1.6)
Other	12 (4.5)	7 (8.8)	5 (2.7)
Data not available	16 (6.0)	12 (15.0)	4 (2.2)
Living arrangement			
Alone	79 (29.7)	21 (26.3)	58 (31.2)
Spouse/partner	51 (19.2)	12 (15.0)	39 (21.0)
Friends	47 (17.7)	12 (15.0)	35 (18.8)
Parents	40 (15.0)	15 (18.8)	25 (13.4)
Alone with children	5 (1.9)	1 (1.3)	4 (2.2)
Other arrangement	26 (9.8)	7 (8.8)	19 (10.2)
Data not available	18 (6.8)	12 (15.0)	6 (3.2)
Income			
Full-time employment	73 (27.4)	12 (15.0)	61 (32.8)
Part-time employment	27 (10.2)	8 (10.0)	19 (10.2)
Temporary benefit/no income	75 (28.2)	28 (35.0)	47 (25.3)
Pension/retirement fund	41 (15.4)	14 (17.5)	27 (14.5)
Student allowance	9 (3.4)	1 (1.3)	8 (4.3)
Dependent on others	5 (1.9)	-	5 (2.7)
Other	18 (6.8)	3 (3.8)	15 (8.1)
Data not available	18 (6.8)	14 (17.5)	4 (2.2)

M, mean; SD, standard deviation.

[a] Information about whether this participant identified as a trans man or a trans woman was not available

6.4 Sources of referral

Table 4 shows how participants were referred to S-Check. Participants were referred to S-Check from a variety of sources, most commonly via self-referral, a family member or a friend (32.0%), or a general practitioner, psychiatrist or psychologist (15.8%). There were no significant differences in sources of referral between participants who completed phone intake only and participants who attended the service in person.

Fifty-five percent of participants who completed phone intake only and 52.2% of participants who attended S-Check in person reported any previous alcohol and/or other drug treatment.

Table 4 Sources of referral to S-Check

	All participants (n=266)	Phone assessment only (n=80)	S-Check participants (n=186)
	n (%)	n (%)	n (%)
Self/family member/friend	85 (32.0)	22 (27.5)	63 (33.9)
GP/psychiatrist/psychologist	42 (15.8)	7 (8.8)	35 (18.8)
Outpatient AOD service	29 (10.9)	10 (12.5)	19 (10.2)
Health service (e.g., clinic, hospital)	27 (10.2)	9 (11.3)	18 (9.7)
Court diversion (e.g., MERIT)	19 (7.1)	8 (10.0)	11 (5.9)
Community mental health unit	18 (6.8)	9 (11.3)	9 (4.8)
Residential AOD treatment agency	16 (6.0)	6 (7.5)	10 (5.4)
Other non-health agency	7 (2.6)	2 (2.5)	3 (1.6)
Police diversion (Probation and Parole)	2 (0.8)	1 (1.3)	1 (0.5)
Other criminal justice setting (e.g., Connections)	10 (3.8)	1 (1.3)	9 (4.8)
Data not available	11 (3.0)	5 (6.3)	6 (3.2)

AOD, alcohol and other drug; MERIT, Magistrates Early Referral Into Treatment.

6.5 Psychostimulant use

6.5.1 Patterns of use

Table 5 shows patterns of psychostimulant use reported at the commencement of the intervention among participants who attended the S-Check service in person. The majority of participants reported having ever used methamphetamine (speed and/or crystal) (90.3%), cocaine (87.1%) and ecstasy (88.2%). One in eight participants (12.4%) reported having ever used synthetic stimulants (e.g. mephedrone, other novel psychoactive substances).

Participants were 27 years of age, on average, when they reported first using methamphetamine and synthetic stimulants, but were younger when they first used cocaine (M=24 years) and ecstasy (M=23 years). More than two-thirds of participants (69.4%) reported methamphetamine use in the month prior to attending the service, and

approximately 1 in 7 participants reported use of cocaine (15.1%) or ecstasy (14.5%) in the previous month (see Table 4). Among participants who reported any methamphetamine use in the past month (n=129), 17.1% had used ecstasy in the past month, 13.2% had used cocaine and 2 participants had used synthetic stimulants.

Participants used methamphetamine on a median of 12 days in the month prior to first attending S-Check. Psychostimulants other than methamphetamine were used on fewer days in the previous month compared to methamphetamine; cocaine was used on a median of 2 days, and ecstasy and synthetic stimulants each on a median of 1 day (see Table 5).

Table 5 Patterns of psychostimulant use at baseline assessment

	Ever used	Age at initiation	Used in past month	Days used in past month[a]
	n (%)	M (SD)	n (%)	Med (IQR)
Methamphetamine (speed, crystal)	168 (90.3)	26.7 (9.5)	129 (69.4)	12 (4-20)
Cocaine	162 (87.1)	24.2 (7.6)	28 (15.1)	2 (1-4.5)
Ecstasy / MDMA	164 (88.2)	22.6 (7.5)	27 (14.5)	1 (1-3)
Synthetic stimulants	23 (12.4)	27.1 (5.6)	2 (1.1)	1.5 (1-2)

IQR, interquartile range; M, mean; MDMA, 3,4-methylenedioxy-methamphetamine; Med, median; SD, standard deviation.

[a] The denominator for each cell in this column is the number of participants who used the drug in the corresponding row in the past month.

6.5.2 Route of administration

Table 6 shows the primary route of administration of different psychostimulant drugs reported by participants. Among participants who reported methamphetamine use, the primary route of administration was smoking (63.5%), followed by injecting (33.1%). Among respondents who reported cocaine use, almost all participants reported primarily snorting cocaine (92.0%). Among respondents who reported ecstasy use, all but one participant reported primarily ingesting ecstasy. Among the small number of participants who had used synthetic stimulants, ingesting and snorting were most commonly reported (see Table 6).

Table 6 Primary route of psychostimulant use at baseline assessment

n (%)[a]	Inject	Smoke	Snort	Ingest
Methamphetamine (speed, crystal) (n=148)	49 (33.1)	94 (63.5)	2 (1.4)	3 (2.0)
Cocaine (n=75)	4 (5.3)	2 (2.7)	69 (92.0)	-
Ecstasy / MDMA (n=71)	1 (1.4)	-	-	70 (98.6)
Synthetic stimulants (n=11)	-	1 (9.1)	4 (36.4)	6 (54.5)

MDMA, 3,4-methylenedioxy-methamphetamine.

[a] The denominator for each cell is the number of participants who reported ever using the drug in the corresponding row.

6.5.3 Self-reported problem with use

Table 7 shows the number of participants who reported that they had a 'problem' with psychostimulants, as well as the number of participants who reported a problem with each psychostimulant expressed as a proportion of participants who reported use of that drug in the previous month.

The majority of participants reported that they had a problem with methamphetamine use (68.8%). Almost 1 in 10 participants reported having a problem with cocaine use (9.1%), and a small number of participants reported a problem with ecstasy use (n=6) and synthetic stimulants (n=1; see Table 7). Twenty-three percent of participants reported having a problem with no psychostimulant drugs when they first attended S-Check, 72.6% reported a problem with one psychostimulant (primarily methamphetamine), and 4.3% reported a problem with more than one psychostimulant.

Participants were asked to report any unwanted effects from psychostimulant use. The median number of unwanted effects was 4 (interquartile range 3-6).

Table 7 Participants who reported having a current problem with psychostimulant

	All participants	Participants who used that drug in the past month
	n (%)	n (%)
Methamphetamine (speed, crystal)	128 (68.8)	110 (85.3)
Cocaine	17 (9.1)	10 (35.7)
Ecstasy / MDMA	6 (3.2)	4 (14.8)
Synthetic stimulants	1 (0.5)	-

6.5.4 Dependence

The Severity of Dependence Scale (SDS) was used to measure psychostimulant dependence. Questions in this scale were asked in reference to any psychostimulant use rather than a specific psychostimulant drug. The median SDS score was 8 (interquartile range 5-11) and 82.3% of participants were categorised as psychostimulant dependent using a cut-off score of 4 or greater (Topp & Mattick, 1997).

Among participants who reported methamphetamine use in the past month and use of no other psychostimulants (n=94), the median SDS score was 9 (interquartile range 7-11). A score of at least 4 is indicative of methamphetamine dependence (Topp & Mattick, 1997), and 96.8% (n=91) of these participants were categorised as methamphetamine dependent using this cut-off score.

Participants who reported that they had a current problem with psychostimulant use had significantly higher SDS scores compared to participants who did not having a current problem (median: 9 vs. 5). More than half of the 43 participants who reported that they did not have a problem with psychostimulants (55.8%) had SDS scores indicative of

psychostimulant dependence.

6.5.5 Risk practices and harms from use

Table 8 shows self-reported risk practices and harms associated with psychostimulant use. Close to two-thirds of participants (62.9%) reported having ever shared drug equipment with another person, most commonly pipes used to smoke methamphetamine (29.0%). A small number of participants reported having ever shared equipment used to snort psychostimulants (4.3%) or needles, syringes and other injecting equipment (3.8%).

Six in 10 participants (59.7%) had ever driven a vehicle while under the influence of psychostimulants, and almost half of participants had engaged in crime or had contact with the police while using psychostimulants (45.2%). Smaller proportions of participants reported engaging in crime or having contact with the police while withdrawing from or not using psychostimulants (see Table 8).

'Unprotected' sex or other risky sexual practices were reported by 6 out of 10 participants (60.2%) while using psychostimulants, and by approximately one-third of participants while withdrawing or not using. One in five participants (19.4%) reported having ever engaged in sexual activity in exchange for money or drugs while they were using psychostimulants, while approximately 1 in 10 respondents had done so while withdrawing or not using (see Table 8).

Table 8 Risk practices and harms associated with psychostimulant use

	n (%)
Ever shared drug equipment	
Yes	117 (62.9)
No	69 (37.1)
Type of equipment that was shared	
Pipe	54 (29.0)
Snorting equipment (note, straw)	8 (4.3)
Injecting equipment (needle, syringe, ancillary equipment)	7 (3.8)
Ever driven while under the influence of psychostimulants	
Yes	111 (59.7)
No	75 (40.3)
Ever engaged in crime or had contact with the police	
While using	84 (45.2)
While withdrawing	37 (19.9)
While not using	26 (14.0)
Ever engaged in unprotected sex or other risky sexual behaviours	
While using	112 (60.2)
While withdrawing	64 (34.4)
While not using	69 (37.1)
Ever engaged in sexual activity in exchange for money or drugs	
While using	36 (19.4)
While withdrawing	16 (8.6)
While not using	20 (10.8)

6.6 Other illicit and prescription drug use

Table 9 shows patterns of illicit drug use and prescription drug use other than psychostimulants. Lifetime use of drugs other than psychostimulants was commonly reported, most commonly cannabis (81.2%), benzodiazepines (61.3%), gamma-hydroxybutyrate (GHB; 57.5%) lysergic acid diethylamide (LSD; 51.6%) and ketamine (43.5%). The most commonly used drugs in the month prior to attending S-Check were cannabis (33.9%), benzodiazepines (25.3%) and GHB (17.7%). More than 1 in 10 participants reported a current problem with cannabis use (11.3%), and 1 in 20 participants reported a current problem with GHB use (4.8%).

Table 9 Other illicit drug use at baseline assessment

	Ever used	Age at initiation	Used in past month	Self-reported problem with use
	n (%)	M (SD)	n (%)	n (%)
Cannabis	151 (81.2)	17.6 (5.0)	63 (33.9)	21 (11.3)
Synthetic cannabis	32 (17.2)	29.5 (10.2)	1 (0.5)	-
Benzodiazepines	114 (61.3)	26.4 (8.1)	47 (25.3)	4 (2.2)
GHB	107 (57.5)	29.7 (9.4)	33 (17.7)	9 (4.8)
LSD	96 (51.6)	21.9 (6.7)	5 (2.7)	-
Ketamine	81 (43.5)	26.2 (7.3)	6 (3.2)	-
Heroin	42 (22.6)	23.2 (7.8)	3 (1.6)	1 (0.5)
Methadone / Buprenorphine	19 (10.2)	23.5 (10.0)	2 (1.1)	-
Other opioids	29 (15.6)	29.9 (8.9)	3 (1.6)	-
Steroids	33 (17.7)	27.6 (6.0)	2 (1.1)	-

GHB, gamma-hydroxybutyrate; LSD, lysergic acid diethylamide; M, mean; SD, standard deviation.

6.7 Alcohol and tobacco use

Table 10 shows participants patterns of alcohol and tobacco use as reported at their first visit to S-Check. The majority of participants had ever consumed alcohol (92.5%), and less than 6 in 10 participants had consumed alcohol in the preceding month (57.0%). Following the Australian guidelines to reduce health risks from drinking alcohol, participants' alcohol risk was calculated according to the average number of standard drinks they consumed per week in the previous month (low risk: 0-14 standard drinks; medium risk: 15-28 drinks; high risk: >28 drinks). The majority of participants were categorised as drinking at low-risk levels or did not consume alcohol (88.7%), while 7.0% were drinking at medium-risk levels, and 4.3% at high-risk levels. More than 1 in 10 participants reported that they had a problem with alcohol use (12.4%).

Eight in 10 participants reported having ever used tobacco (80.6%) and approximately half of participants reported currently using tobacco daily (52.2%). One-third of participants reported that their tobacco use was a problem (33.3%; see Table 10).

Table 10 Alcohol and tobacco use at baseline assessment

	n (%)
Alcohol	
Ever used	172 (92.5)
Age at initiation (M, SD)	15.3 (3.3)
Used in past month	106 (57.0)
Days used in past month (M, SD)[a]	10.1 (9.3)
Alcohol risk in past month[b]	
Low (0-14 standard drinks per week)	165 (88.7)
Medium (15-28 standard drinks per week)	13 (7.0)
High (> 28 standard drinks per week)	8 (4.3)
Self-reported problem with use	23 (12.4)
Tobacco	
Ever used	150 (80.6)
Age at initiation (M, SD)	16.5 (4.4)
Daily tobacco use	97 (52.2)
Self-reported problem with use	62 (33.3)

M, mean; SD, standard deviation.

[a] The denominator is the number of participants used alcohol in the past month.

[b] Alcohol risk categories based on Australian guidelines to reduce health risks from drinking alcohol (National Health and Medical Research Council, 2009).

6.8 Injecting drug use

Table 11 shows the injecting drug use history of participants. Half of participants (51.1%) reported having ever injected drugs, and 32.8% had injected in the three months prior to their first S-Check visit.

Table 11 Injecting drug use at baseline assessment

	n (%)
Injected in past 3 moths	61 (32.8)
Injected 3 to 12 months ago	10 (5.4)
Injected more than 12 month ago	24 (12.9)
Never injected	85 (45.7)
Did not respond	6 (3.2)

6.9 Mental health and psychosocial functioning

Table 12 shows participants history of diagnoses with mental health disorders and current levels of psychological distress. Almost three-quarters of participants reported having ever been diagnosed with a mental health disorder (excluding substance use disorders), and three-quarters of participants (74.7%) reported high or very high levels of current psychological distress according to the K10. More than 1 in 7 participants reported having current suicidal thoughts or thoughts of self-harm.

The rates of mental health diagnoses and current psychological distress are considerably higher than reported among adults in the general Australian population. For example, in the 2007 National Survey of Mental Health and Wellbeing, the prevalence of any lifetime mental health disorder was 45.5% (Slade, Johnston, Oakley Browne, Andrews & Whiteford, 2009). However, the findings reported here are consistent with the high rates of mental health disorders reported among people seeking treatment or other support for their psychostimulant use (McKetin et al., 2012).

Table 12 Mental health and psychological distress at baseline assessment

	n (%)
Ever diagnosed with mental health disorder[a]	134 (72.0)
Current psychological distress	
K10 score (M, SD)	27.8 (8.7)
High K10 score[b]	62 (33.3)
Very high K10 score[b]	77 (41.4)
Current suicidal thoughts or thoughts of self-harm	29 (15.6)

K10, Kessler Psychological Distress Scale; M, mean; SD, standard deviation.

[a] Excludes substance use disorders.

[b] K10 scores: high distress (score of 22-29), very high distress (score of 30-50).

6.10 Factors associated with participant retention

A series of analyses were conducted to characterise and compare the sociodemographic profile, drug use history, and mental health of participants who were retained at session 4 with participants who did not complete session 4.

Participants who were retained at session 4 were significantly older than participants who did complete session 4 (M=37.9 vs. M=34.2; p=0.01) and were less likely to self-report that they had a problem with any psychostimulant at baseline (71.6% vs. 84.4%; p=0.04), and less likely to report daily tobacco use at baseline (45.9% vs. 61.0%; p=0.04). Retention at session 4 was not related to gender, previous experience of alcohol and/or other drug treatment, severity of psychostimulant dependence at baseline, recent injecting drug use at baseline, previous diagnosis with a mental health disorder, psychological distress at baseline, and ratings of S-Check sessions.

6.11 Factors associated with psychostimulant dependence

Participants were categorised as psychostimulant dependent if their SDS score at baseline was 4 or greater, consistent with the cut-off used for methamphetamine dependence (Topp & Mattick, 1997). A series of bivariate analyses were then conducted to examine factors associated with psychostimulant dependence, and statistically significant results ($p < 0.05$) are shown in Table 13. Participants who were categorised as psychostimulant dependent at baseline were significantly more likely than other participants to have been referred to S-Check via self-referral or family member / friend, or via a health professional (e.g., GP, psychiatrist, psychologist), and less likely to have been referred via criminal justice settings. Participants who were categorised as psychostimulant dependent rated the first S-Check session significantly less favourably than other participants, and were also significantly more likely to report a current problem with psychostimulant use, a higher number of unwanted stimulant effects, to have previous experience of alcohol and/other drug treatment, to have ever engaged in unprotected sex or other risky sexual practices while using psychostimulants, and to have experienced high or very high levels of psychological distress in the 4 weeks prior to attending S-Check. While not statistically significant, participants categorised as psychostimulant dependent were more likely to report having injected drugs in the 3 months prior to attending S-Check and to have ever shared any equipment used for taking psychostimulants (see Table 13).

Table 13 Characteristics of participants categorised as psychostimulant dependent at baseline

	Psychostimulant dependence		
	No (n=33)	Yes (n=153)	p-value
Session 1 overall rating (median, IQR)	98 (93-100)	95 (87-99)	0.03
Source of referral (%)			
Self / family / friend	24.2	35.9	0.02
GP / psychiatrist / psychologist	9.1	20.9	
Criminal justice setting	24.2	8.5	
Other	42.4	34.6	
Previous AOD treatment (%)			
No	63.6	44.4	0.04
Yes	36.4	55.6	
Self-reported problem with stimulant use (%)			
No	57.6	15.7	< 0.001
Yes	42.4	84.3	
Number of unwanted stimulant effects (median, IQR)	3.0 (2-5)	5 (3-7)	0.002
Injected drugs in the past 3 months (%)			
No	78.8	64.7	0.12
Yes	21.2	35.3	
Ever engaged in unprotected sex or other risky sexual behaviours while using			
No	60.6	35.3	0.007
Yes	39.4	64.7	
Ever shared any drug equipment used for taking psychostimulants			
No	51.5	34.0	0.06
Yes	48.5	66.0	
High or very high K10 score (%)			
No	60.6	17.6	< 0.001
Yes	39.4	82.4	

7 Main Summary Points from the Quantitative Data

- Retention in initial session appears to be is good from session 1-2, but less so in relation to session 3 and session 4.
- Client ratings of sessions high – above 90 (out of 100) on all ratings – relationship, goals and topics, approach/method, which indicates that clients were very satisfactions with most aspects of the S-Check sessions and in terms of the care provided to them.
- There are few differences between the group who only phone in but never attend for the first session and those who actually attend.
- Those who attend S-Check are more likely to be employed in stable housing than those who phone in for intake but do not actually come in to S-Check. However there no other significant differences between participants who only phone in and those who actually attend on age, gender, who they live with etc.
- Participants were referred to S-Check from a variety of sources, most commonly via self-referral, a family member or a friend, or a general practitioner, psychiatrist or psychologist.
- Approximately half of the sample appeared to be treatment naive. Fifty-five percent of participants who completed phone intake only and 52.2% of participants who attended S-Check in person reported that they had previous had alcohol and/or other drug treatment.
- The main drugs that the majority of participants reported having ever used were methamphetamine (most common), cocaine and ecstasy
- Participants were 27 years of age, on average, when they reported first using methamphetamine and synthetic stimulants, but were younger when they first used cocaine (M=24 years) and ecstasy (M=23 years).
- More than two-thirds of participants (69.4%) reported methamphetamine use in the month prior to attending the service.
- Participants used methamphetamine on a median of 12 days in the month prior to first attending S-Check.
- Among participants who reported methamphetamine use, the primary route of administration was smoking, followed by injecting. Among respondents who reported cocaine use, almost all participants reported primarily snorting cocaine. Among respondents who reported ecstasy use, all but one participant reported primarily ingesting ecstasy.

- 23% of participants reported having a problem with no psychostimulant drugs when they first attended S-Check, 72.6% reported a problem with one psychostimulant (primarily methamphetamine), and 4.3% reported a problem with more than one psychostimulant.
- The median SDS score was 8 (interquartile range 5-11) and 82.3% of participants were categorised as psychostimulant dependent using a cut-off score of 4.
- Participants who reported that they had a current problem with psychostimulant use had significantly higher SDS scores compared to participants who did not having a current problem (median: 9 vs. 5).
- Sharing of equipment for drug use was not uncommon in among this group. Close to two-thirds of participants reported having ever shared drug equipment, most commonly pipes used to smoke methamphetamine . A small number of participants reported having ever shared equipment used to snort or needles, syringes and other injecting equipment.
- 6 in 10 participants had ever driven a vehicle while under the influence of psychostimulants, and almost half of participants had engaged in crime or had contact with the police while using psychostimulants.
- 'Unprotected' sex or other risky sexual practices were reported by 6 in 10 participants while using psychostimulant. One in five participants reported having ever engaged in sexual activity in exchange for money or drugs while they were using psychostimulants.
- Half of participants reported having ever injected drugs, and 32.8% had injected in the three months prior to their first S-Check visit.
- Almost three-quarters of participants reported having ever been diagnosed with a mental health disorder, and three-quarters of participants reported high or very high levels of current psychological distress according to the K10.
- More than 1 in 7 participants reported having current suicidal thoughts or thoughts of self-harm.
- In relation to retention in the four S-Check sessions, those participants who were retained at session 4 were significantly older than participants who did complete session 4, were less likely to self-report that they had a problem with any psychostimulant at baseline. Retention at session 4 was not related to gender, previous experience other drug treatment, severity of psychostimulant dependence at baseline, recent injecting drug use at baseline, previous diagnosis with a mental health disorder, psychological distress at baseline, and ratings of S-Check sessions.
- Participants who were categorised as psychostimulant dependent rated session 1 less favourably than other participants, and were significantly more likely to report a current problem with psychostimulant use, a higher number of unwanted stimulant effects, to have previous experience of other drug treatment, to have ever engaged in unprotected sex or other risky sexual practices while using psychostimulants and to have experienced high/ very high levels of psychological distress in the 4 weeks prior to attending S-Check.
- It appears that this group of clients attending S-Check while possibly not having much

prior contact with drug treatment facilities do have long and complex drug taking histories which also involve use of more than one substance as well as engagement in increased risk practices, (sharing of injecting equipment, unprotected sex and driving while under the influence of drugs). Additionally while approximately 37 % of the sample do hold either full time or part time employment, 28% are on benefits. Close to 40% of the sample are injecting drug users. Approximately seventy two percent have been diagnosed with a mental health disorder at some point and almost 77% have a high or very high K10 score.

- Whilst S-Check may not be attracting only the young treatment niave users, it very important to note that this type of low thresh hold service is well regarded by clients as evidenced in the high ratings given by clients across the sessions and the good retention across session 1 and 2,despite it being less so for sessions 3 and 4.

8 Qualitative Data

8.1 Demographics

8.1.1 Staff and stakeholder

- 10 participants ranging in age from 26 to 60 years
- Equal representation of men and women
- Occupations represented included counselors, clinicians and managers.

8.1.2 Clients

- 10 participants ranging in age from 25 to 64
- Equal representation of men and women
- Four receiving social welfare benefits; five employed fulltime or self-employed; one self-funded retiree
- Six attended university and/or completed forms of further education and training; the remainder completed between 4 to 6 years of high school.

8.2 Work history: staff and stakeholders

Among participants, experience in the AOD sector ranged from 3 to 20 years. Among S-Check staff, involvement with the clinic ranged from 1-3 years. This included both those involved from the outset in establishing the clinic, along with those employed subsequently. Staff participants covered a range of experience, from supervision and management to strategic planning and development, and service promotion.

Several S-Check staff members had prior experience working in various roles within SVH's AOD services, including drug helpline, referral and advice services, telephone counselling. Stakeholder participants typically learnt about S-Check through their current workplace. As one community based sex worker explained:

> We hold addiction seminars and someone from St Vincent's came and spoke on stimulants and the service being offered and that clarified for me what S-Check does. (Stakeholder 3)

A number of staff participants emphasised being drawn to S-Check specifically because of the type of service and philosophical approach it offered:

> When S-Check came on my radar, I was interested in their non judgmental attitude, we

are not going to push you into any sort of rehab counseling or tell you to stop using the drug. (Staff 3)

I remember landing up in the same room as the S-Check manager and taking issue with a couple of things that weren't peer-based and the next thing I had an invite to be on the advisory committee. (Staff 4)

8.3 Drug use history: clients

All client participants reported using drugs for a number of years, including some for over 20 years. Most described their initial use as 'social' and/or 'recreational':

I started in a recreational way at parties … I started with cannabis, then moved to ecstasy, then acid, cocaine and finally ice. (Client 4)

I've pretty much always dabbled on the odd weekend here or parties for probably 20 odd years. About 2½ years ago, I tried ice and became addicted to it. I stopped using it … but I just didn't feel like I was moving on from there so that's when I approached the stimulant clinic to help. (Client 7)

I'm a social drug user, so sometimes I might do cocaine or MDMA, that's very social for me, so that might happen four or five times a year, but ice is something that I've been using on a very regular basis and that's the reason I went to the clinic. (Client 10)

Two participants reported injecting as their preferred route of administration; the remainder as either oral or nasal. Nonetheless, a theme noted in several client interviews was their perception of themselves as somehow 'separate' and 'different' from other drug users. Such a distinction was evident, for example, when participants discussed their association between routes of administration and types of drug use(r):

I've got a full time job, I've travelled around the world, like I'm bit more of a – I don't know, different class of drug user. (Client 10)

There was a time where I felt that I had hit rock bottom, that I was going to die in the gutter. All I could think of was heroin and junkies, that's what syringes meant to me. (Client 1)

I've never injected. I've always thought that that was for heroin and that was always really unattractive, strangely enough it still is, so cocaine I snort, dope you smoke, but ice has only ever been something that I inhale. (Client 2)

8.4 Stimulant treatment history and experiences: clients

For the majority of client participants, S-Check was their first experience of treatment for their stimulant use. The interview data suggest that participants had limited awareness or knowledge of available treatment options for stimulant use prior to attending S-Check.

Participants reported reaching a defining moment in relation to their stimulant use where they recognised they needed help:

I got to a point where I realised that I had reached the limit of my ability to manage by

> myself. (Client 2)
>
> I desperately needed help because I was just going out of control … I sourced what options are out there that are available to help me if needed, because at that time I didn't think I was capable of doing it by myself. (Client 5)
>
> When I was high I was doing things that are very risky and things that could hurt close people to me. You know I just had a button that would switch on and then I would just go on this binge and spend all this money and do all these things that were wrong and that made me think, "fuck I need to get some help or I'm going to end up like one of those people on the street". I don't know, I just got scared. (Client 10)

Most participants reported researching options for external help online. In some instances, however, participants sought support from local primary health care services with which they had pre-existing relationships, such as the Kirketon Road Center or the Albion Street Centre. For those participants involved in court cases, their lawyer or court-based social worker provided referral advice.

Several participants indicated that the initial push to seek assistance came from family members, partners or friends:

> My family got alarmed at my weight loss … [They] did this like mini intervention at home and they were like, right, we are concerned. (Client 2)

For these participants attending S-Check was in part at least about appeasing others. As these two participants recall:

> I was like ok, I'll just get a full test so that everyone is comfortable and there is no damage as a result. (Client 2)
>
> Someone who hadn't seen me for a couple of months was shocked so I wanted to make sure and thought it would be a good time to sort of just get a bit straight on the whole thing. (Client 3)

While several participants also reported attending S-Check as part of preparing for court, this did not appear to detract from the therapeutic value of their treatment experience.

Participants reported learning about S-Check from various sources, including family, friends, Lifeline and so forth. One participant mentioned coming across the information about relevant agencies while studying for her Certificate IV in AOD. Several participants noted that S-Check was preferable to formal detoxification or rehabilitation services, in part because of the different type of commitment required and/or the expense involved.

8.5 Treatment options: staff and stakeholders

Staff and stakeholders were asked about their understanding of the treatment options available to stimulant users. Generally the response was that stimulant users are able to access a range of drug and alcohol services; specifically, private and psychiatric hospitals, detox and rehabilitation units, community and helpline counseling. These options cover a spectrum of possibilities: from the contained and intentionally isolated world of rehabilitation (allowing a slow and staged entry back into the general community) to information and

assistance via telephone helplines.

Participants cited a number of barriers to S-Check access. These included the often long waiting lists and the challenge of getting stimulant users to identify as someone who might benefit from attending treatment and support services. Participants universally described stimulant users as a niche target market, distinct from 'typical' drug and alcohol users, particularly those publicly visible and street-based. While this is borne out to some extent by some of our client participants who remained employed and engaged with other aspects of their personal lives, this was not universally the case. Four client participants received Disability Support Pensions via Centrelink; two reported injecting drug use; several were in contact the criminal justice system; and a number reported quite profound forms of social isolation. While S-Check is envisaged as an early intervention service that ideally encourages stimulant users to increase their knowledge and information around stimulants – whilst simultaneously still functioning in their careers and personal lives – the client participants interviewed for this report suggest a demographic more firmly entrenched or experienced in their drug use.

8.6 Client experience of S-Check and treatment

Client participants almost uniformly described their overall experience of S-Check and the treatment provided as strongly positive. As these participants testified:

> I really think it's a good service and I hope other people get to benefit from it and that these guys get a good amount of recognition that they are doing a really fine job. (Client 2)

> They are very welcoming, they are great, they are there for you, if you need anything you can turn up to their centre anytime … Every time I went there and walked out, I did feel a whole lot better. (Client 7)

S-Check staff members were consistently described as friendly, understanding, supportive and non-judgmental; the service as accessible and approachable. Such as assessment is particularly significant in light of stimulant users being able to identify a treatment and support service where they could feel comfortable discussing their concerns. This was in sharp contrast to the apprehension and fear of judgement participants reported feeling with regards discussing stimulant use with their GP.

Here participants celebrated S-Check's commitment to fostering a welcoming and accepting service, underpinned by a harm reduction philosophy, in contrast to a punitive, zero-tolerance approach:

> Just trying to tell me to stop. (Client 1)

> You are not being told you are a fucking idiot, stop taking drugs, it's going to wreck your life. (Client 2)

While participants praised S-Check's 'down-to-earth' and helpful staff – "from the one who buzzed me in to reception, to the doctor" (Client 2) – they also noted their professionalism. Staff were described as both thorough and generous with their time; flexible when came to

changing appointments and encouraging when making follow-up appointments. Participants invariably recalled feeling welcomed and respected when attending the clinic.

Importantly, and in keeping with this sense of welcoming acceptance and respect, participants acknowledged the therapeutic benefits of attending S-Check:

> You can sort of psychologically just be sure that you are in check which is important. (Client 4)

> It was incredibly therapeutic and a way to calibrate myself, because I really lost track of whether I was doing ok. (Client 2)

> I love it. There's nothing that I would change, absolutely nothing right here and now and definitely not in hindsight. It's all positive. Yeah, there's nothing I've reflected and gone away and gone, "oh that was or that could have been". (Client 6)

Participants, particularly those on limited incomes, acknowledged and appreciated that S-Check was a free service. Participants remarked that while the program is short it nonetheless feels substantial. And, as noted earlier, the stimulant-specific nature of the service was also highly valued – particularly given the perception some participants held that their drug use was somehow different from others who used drugs.

Participants' widespread and consistent positivity towards S-Check meant identifying clinical limitations and/or challenges often required cajoling. When pushed, however, several of the participants mentioned delays and/or waiting lists as a matter of concern:

> After giving my details I didn't hear from them for 3 months, they then called out of the blue, they'd lost my details, found them and were now calling … if I have the courage to ask for help they need to get back to me very quickly. (Client 1)

> They are very time poor though … I had to wait 5 weeks for my first appointment … That's honestly my only criticism of the whole program. (Client 7)

Among some participants there appeared to be confusion distinguishing between the initial 'intake' session and their first 'formal' session (the psychosocial session). This confusion is worth noting to ensure that all future participants are fully appraised of how the program unfolds, including the function of the initial intake.

Participants also indicated a need for greater clarity in terms of what happens at the end of the S-Check sessions, especially regarding referrals to other support services. Participants similarly noted the need for additional support and further education for family members and friends – perhaps reflecting that contact with S-Check was initiated by someone other than the stimulant user. Overall, however, most participants reported that four sessions were sufficient to either provide adequate reassurance or enable advise on future options and direction:

> I don't want to be over tested and waste any resources, but I wanted to be sure I was having all the tests that I needed. (Client 4)

> The first session they get to know you, the second they start to unravel stuff and after a few sessions I felt so much better, I can't explain the lightness that came into my system. (Client 3)

Participants stated that they would definitely recommend S-Check to a friend, with one participant noting that they had already done so. Another participant emphasised the importance of 'indirectly' recommending S-Check by way of example rather than word of mouth. This perhaps highlights the sensitivities that potential service providers need to negotiate within this target population who may feel more comfortable with 'indirect' rather than direct forms of referral or treatment recommendation:

> I am trying not to prophesise, not to go out with a flag saying come all ye hopeless people, this is where you will be saved, because that is counter productive. I know that they are watching me and I just want them to see the results, to see for themselves what a difference it's made in me and hopefully that will speak for itself. (Client 1)

Minor concerns or criticisms notwithstanding, participants overwhelmingly endorsed the positive impact their S-Check sessions had had on other aspects of their life:

> The overall message I took away was that this is bigger than me, that I am not weak because I can't manage it, it's just stronger than I am and I need help, that all the other assessments and judgments I've made in other areas of my life are probably okay as well. (Client 1)

> They take a pretty personal approach with you and they seem to take a lot of interest in things in your life, which other counselling places don't. (Client 5)

8.7 Staff and stakeholder experience of the S-Check clinic

In line with client participants' enthusiastic assessment of S-Check, staff participants also highlighted the positive feedback they received from clients of the clinic:

> I'm getting only good feedback informally from clients. I've only heard positive stuff, I've never heard anything negative to be honest. (Staff 4)

Although the retention rate across the four sessions was considered to have been largely successful, concerns were raised regarding the possible adverse effects of limiting the service's opening hours to 8:30am-5pm, especially given many stimulant users were in full time employment. As this staff member noted:

> This makes four appointments spread across a few weeks tricky for people who work full time. (Staff 1)

This sentiment was reinforced by several client participants, including Client 7 who worked fulltime:

> I was lucky, because I get Friday afternoon's off work because I work Saturday mornings. If that wasn't the case, I probably wouldn't have been able to even use this service and it is a very valuable.

8.8 Set-up of S-Check

Staff participants were asked to comment on their experience of the initial establishment of the clinic. There was overall agreement that internal administrative barriers meant that

the initial phase was slower than expected and that clients had also been slow to begin using the service. Internal politics was identified as one of the factors that had hindered the establishment of the clinic: "You can't do this, you can't do that, all that passive aggressive stuff" (Staff 3).

Participants also cited the high turnover of staff, along with concerns about insufficient staff numbers, as contributing to 'start-up' issues. Participants felt that the implementation of the project suffered as a result of these staff changes. Participants also recalled the initial difficulties they had experienced trying to recruit clients from the specified 'target market'. As a result, the decision was made to draw a number of clients from the STP waiting list and support them via the S-Check program. These clients were seen by an S-Check counselor and doctor before being returned to the STP list.

8.9 Strengths and benefits

S-Check's design as a service specifically for stimulant users emerges as one of the primary benefits of the clinic. As noted earlier, some participants perceived stimulant users as somehow different to other drug users. Stakeholder and staff participants noted too that stigmatisation and 'othering' is commonplace across different drug using communities:

> I am not an opiate user, I am not a drinker, I'm not like one of those people. (Staff 3)
>
> I don't see myself as a drug addict. I have a job, most of my friends do not use. (Staff 4).
>
> They don't see it as a problem because it is so integrated with their socialising, you know, party drugs, dancing, clubs and hanging out with friends. (Stakeholder 1)

Some stimulant users considered their general level of social functioning and engagement as higher relative to 'other' drug users. Several clients also reported that stimulants enhanced their ability to function and perform better at their job. Staff noted that stimulant users were also less likely to consider themselves as living with an 'addiction':

> They think they could take it or leave it and that's the challenge that we have, is to actually get people to say that leaving it is not such an easy thing to do. (Stakeholder 1)

As such, staff participants believed that a stimulant specific service provides a more honed and focused service – one better able to engage at a deeper level with these issues:

> Stimulant users themselves find it a huge relief to talk to someone who understands stimulants and stimulant use and the lives that people lead. (Staff 4)

Having access to a GP was identified as another particular benefit of the clinic:

> The GP is one of the biggest selling points of the model. As wonderful as is, the doctor that they know isn't going to judge them is a crucial part of the model. (Stakeholder 2)

In keeping with the appeal and advantage of being able to offer a service-specific GP, promoting S-Check as a health 'check-up' was seen as attractive to clients. Participants praised the client-focused, individualised and responsive nature of the service. Staff and stakeholder participants clients' sentiments regarding the importance of a harm reduction

approach:

> They think poorly of themselves for what they are doing and their fear is that they are going to come in here and be told that they are worthless and useless, so to come in and be heard and understood and cared for, gives them a different experience of themselves and often a bit of confidence to then make some changes. (Staff 1)

> It is straight down pure harm reduction, we weren't there to change people's use, we weren't there to stop them … Working down the harm minimisation tree is really powerful because a GP may simply just say, STOP. (Staff 3)

While some staff highlighted the benefits of being located within a hospital – including improved access to a range of diagnostic and referral facilities, and adding credibility to the medical screening – the prevailing sense was that S-Check's hospital location actually created additional challenges for the service (discussed in more detail below).

Staff noted that one of S-Check's strengths is its aim to attract treatment naïve individuals, including those who may not ordinarily seek out drug treatment services. S-Check, they believed, provided a solid stepping stone which opened up possibilities and opportunities to take things further (or not):

> It's an opportunity for people to analyse their own use, get a feedback assessment to take away with them. (Staff 4)

The non-judgmental attitude referred to by client participants was also highlighted by staff and stakeholder participants. The SMS system used for appointment reminders and as a way of communicating with clients was singled out as a strength of S-Check. Staff felt that use of SMS helped to maintain a positive but confidential means of communication with clients:

> Inviting rather than demanding … [the SMS] comes up as a private number which is important for people who are ambivalent about their use and accessing services. (Staff 4)

9 Limitations and Challenges

Issues around staffing emerged as the most prominent concern or 'limitation' reported by staff and stakeholder participants. In particular, the high turnover of staff (general, managerial and medical) meant that S-Check clients were not always offered an ideal continuity of care. With regards to medical practitioners specifically, this inconsistency of availability reflects a widespread over-demand for AOD doctors generally. As a result, "clients see kind of whichever medical staff is on call at a particular time" (Staff 6). The 'rotation system' for doctors meant that "every six months we've had a change of doctors … As soon as they get a handle on it, they rotate" (Staff 3). Staff also noted that not all the doctors had been sufficiently trained to deal with stimulant use. As one staff member put it, what they really need is "an expert with stimulant experience" (Staff 3) to be allocated specifically to work with S-Check.

Two other main issues were noted by staff: the administrative workload and the clinic's hospital location. The 'administratively heavy' workload was performed by clinicians in addition to their work with clients. Staff felt that this was not only at the expense of time that could be spent working with existing clients but potentially restricted the number of new clients that could be taken on. This administrative burden was further exacerbated by the requirement to maintain two recording systems: Chime (electronic) and S-Check (paper). As these staff members put it:

> For every 2½ hours with a client there is about 7 hours' worth of admin. (Staff 1)
>
> An administrative nightmare … Admin time and actual client time are totally out of whack. (Staff 6)

Allied to staff concerns regarding S-Check's over-administrative is its location within a large, tertiary hospital system. While participants acknowledged that such a location had some benefits (such as the smooth referral pathways noted earlier) the overriding sense was that S-Check would be better situated elsewhere:

> Everything in and about a hospital is an administrative nightmare because you have to work within the parameters of the hospital's systems. (Staff 3)
>
> There's a lot of kind of top-down hospital pressure that was preventing us from actually opening the doors and seeing the clients. (Staff 6)

A further if lesser issue noted by staff participants involved S-Check's shift in target population. Staff were concerned that data for the evaluation would be skewed because the target market initially set out in the proposal was different to the group who ended up attending S-Check:

> The initial proposal says that we are targeting commercial transport workers and business people but we didn't make any connections into those sectors. The group we were funded to attract wasn't the group we ended up seeing. (Staff 3)

More specifically there was concern among staff participants that S-Check had failed to attract stimulant users who were not seeking formal treatment. This was particularly in the context of those who came to S-Check via the STP waiting list. Participants identified the challenge of attracting stimulant users to S-Check who were not treatment-seeking but were nonetheless experiencing problems with their drug use.

10 Marketing of S-Check

Staff were overwhelmingly positive regarding S-Check's promotion as a 'check-up' as opposed to a 'treatment' clinic:

> Marketing it as a short term check-up is what draws people in. (Staff 3)

> The use of the terminology 'stimulant check-up' into the broader community worked well. It also gave family, friends and partners an opening of – 'go and get a check-up'. (Staff 5)

Nonetheless, the overriding sentiment among stakeholder and staff participants was that the social media marketing had not been successful, particularly relative to the focus it was given in the initial proposal:

> All we did was set up a Facebook site when we should have trialed different mechanisms … We should have explored beyond just Facebook. (Staff 2)

Once again, S-Check's location within an unwieldy and hierarchical hospital bureaucracy, with its inevitable internal politics, was seen as part of the problem:

> In the beginning I said we need a Facebook page but STP management said no, it took about a year for everyone to agree. (Staff 6)

Similarly, the lack of administrative support was also identified:

> We've had to pull time away from clients so in effect it would be better to have a dedicated admin person who could look after marketing and social media. (Staff 5)

11 Main Summary Points from the Qualitative Data

- Overall, based on the qualitative reports, the concept of the S-Check Clinic and the service it provides was very well received by clients, staff and stakeholder participants.
- S-Check's provision of a stimulant-specific service was considered a primary benefit for a number of reasons:
  - Medically and psychologically focused and equipped to meet the particular needs of stimulant users
  - Being a stimulant-specific clinic affords its clients separation from other drug-using demographics, particularly those more readily stereotyped as 'injecting drug users'.
- The service was credited for being non-judgmental, especially in comparison to GPs, where stimulant users' experience has generally been one of stigma and judgment. (There are indications here of a need to up-skill GPs in identifying and treating stimulant use).
- Despite just under 50% of clients identifying as treatment naïve, many had long histories of recreational and/or social drug use involving a range of substances. While there may be a popular perception of stimulant uses as a 'niche' market, our qualitative data suggests a more complex and nuanced picture. Nearly half of those interviewed were dependent on social security and/or left high school early. Several participants also reported histories of injecting drug use and/or 'problematic' experiences with other drugs.
- Hence, while S-Check is envisaged as an early intervention service that ideally encourages stimulant users to increase their knowledge and information around stimulants – whilst still functioning in their careers and personal lives – the client participants interviewed suggest a demographic more firmly entrenched or experienced in their drug use.
- Particularly among staff, but among clients too, S-Check's harm reduction based approach was very positively received.
- Staff noted difficulties around their workload especially that it was administratively heavy and there are strong indications of the need for dedicated administrative staff to avoid the current situation where administrative work is being done by clinicians. This would also free up the health care staff so that they have more time for their clinical work.
- This above issue is related to a need for stream lining of paperwork and administration, staff noted duplicated systems of paperwork which increased the administrative load of

their work.

- Difficulties in ensuring continuity were noted because of the high staff turnover. This was raised by clients particularly in relation to a lack of continuity among the medical staff attending to them.
- Despite some positive comments about the S-Check clinics location within a hospital, there was an overriding sense it should be removed from the overly-bureaucratic hospital environment.
- Stimulant users often fail to identify their need for help and are usually encouraged to do so by family members or friends. This has important implications for how S-Check is marketed, including forms of 'indirect' appeal: "do you know someone who uses?" etc.
- In line with the above sentiments, participants endorsed the marketing of S-Check as a 'check-up' clinic as opposed to a 'treatment' clinic.
- Unlike other drug intervention programs, client and staff participants believed S-Check provided therapeutic support without necessarily impacting negatively on clients' careers and/or personal lives.

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