The National Centre for Clinical Research on Emerging Drugs

St. Vincent's S-Check Clinic

Model of Care

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Acknowledgements

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Acronyms and Abbreviations

AOD	Alcohol and Other Drugs
ATSI	Aboriginal and Torres Strait Islander peoples
ATOP	Australian Treatment Outcomes Profile
BBV	Blood Borne Virus
BMI	Body Mass Index
CBT	Cognitive Behaviour Therapy
GHB	Gamma-hydroxybutyrate
K-10	Kessler Psychological Distress Scale
LGBTI+	Lesbian, Gay, Bisexual, Transgender, Intersex and others of diverse sexual and gender identities
MDMA	Methylenedioxymethamphetamine
MoC	Model of Care
NGO	Non-Government Organisation
NDSHS	National Drug Strategy Household Survey
PrEP	Pre-Exposure Prophylaxis
PWI	Personal Wellbeing Index
S-Check	Stimulant Check-up Clinic
SDS	Substance Dependence Scale
SMART	(Goal setting): Specific, Measurable, Achievable, Realistic, Time-bound
SMART	(Group therapy): Self-Management And Recovery Training
STI	Sexually-Transmitted Infection
WHO	World Health Organisation

Executive Summary

Stimulant use disorder is on the rise in Australia, representing a significant public health burden. Treatment seeking, however, remains low and late. St. Vincent's Hospital Sydney consequently developed a stimulant-specific brief intervention program designed to enhance engagement and foster harm reduction in those not accessing traditional drug and alcohol services. This program, the Stimulant Check-up Clinic (S-Check), builds on an earlier model from South Australia (Smout et. al., 2010) and consists of four sessions: a biopsychosocial assessment; physical health assessment; physical health feedback; and a biopsychosocial feedback, goal setting and care planning session. Initial evaluation by the University of New South Wales demonstrated the success of the model in attracting stimulant users who have not sought treatment before and argued for scaling up the intervention. To support the dissemination of this low-threshold intervention, this document has been published to demonstrate the model used in the St Vincent's Hospital, Sydney context. The authors encourage clinicians in primary care, sexual health, community mental health and drug and alcohol services to use this as a framework of a stimulant-specific brief intervention, elements of which may require adapting to suit the needs of the client population or resources available, so as to improve wider access to care and reduce the impact of methamphetamine use on the population of Australia.

Section 1 - Introduction

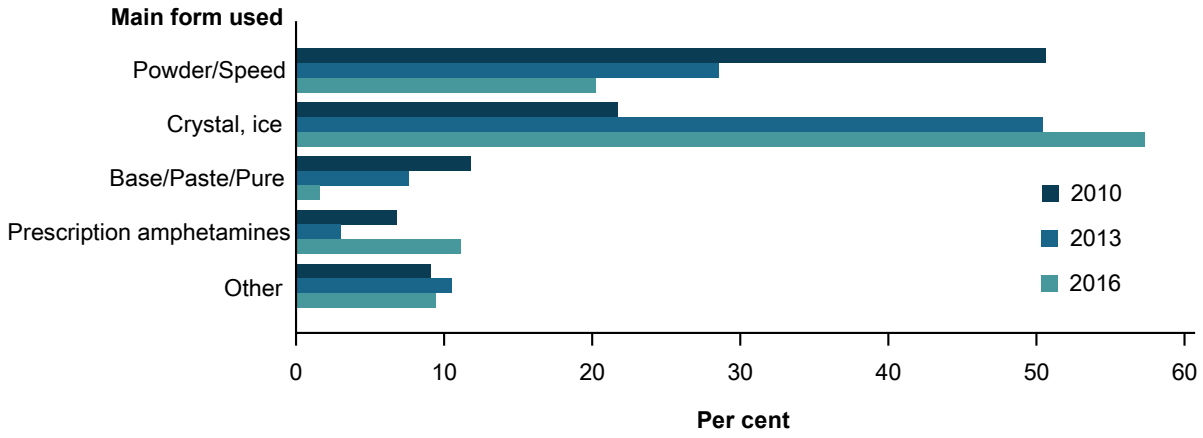
1. Background

1.1 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 (Romanelli & Smith, 2006). Illicit stimulants include amphetamine (including speed, base and crystal forms), cocaine and methylenedioxymethamphetamine (MDMA).

Methamphetamine is a more potent form of amphetamine. The addition of a methyl group to the amphetamine compound protects the drug from breakdown by the body, effectively increasing its half-life and length of intoxicating effect (Romanelli & Smith, 2006). Data from the 2016 National Drug Strategy Household Survey (NDSHS) demonstrated that meth/amphetamines are the most frequently used illicit stimulants (Australian Institute of Health and Welfare, 2017). Although population prevalence had remained stable since the 2010 NDSHS, there has been a shift amongst people who currently use meth/amphetamine and specifically among people who inject drugs away from powder forms to the more potent crystalline form of meth/amphetamine.

Figure 1 – Main form of meth/amphetamines used in the last 12 months 2010-2016%



1.2 Impacts of stimulant use

Stimulant use is associated with a number of significant harms including stimulant use disorder or dependence. Psychologically, methamphetamine use is associated with acute anxiety and chronic depression (Romanelli & Smith, 2006). Further, an Australian study demonstrated that users with no history of psychosis were five times more likely to suffer from psychotic symptoms as compared to when they were abstinent (McKetin et al. 2013). More recently it has been reported that almost one-quarter of regular methamphetamine users will suffer from a symptom of psychosis in any given year (McKetin et al. 2005). Physically, long-term use can result in brain damage leading to memory loss and other cognitive deficits (Belcher et al. 2007; Rippeth et al. 2004; Woods et al. 2005), cardiomyopathy and heart failure (Yeo et al. 2007; Kiel et al. 2015; Kaye et al. 2007), and stroke (McKetin & Lubman, 2014). There is also evidence of increases in stimulant-related hospitalisation (NSW Department of Health, 2018). Despite the above, the majority of people who use methamphetamine reported their health to be ‘very good’ or ‘excellent’ in the most recent NDSHS. The majority similarly reported a low level of psychological distress (Australian Institute of Health and Welfare, 2017).

Methamphetamine use is associated with violent behaviour in some people (McKetin et al. 2014; Brecht & Herbeck, 2013). There is also evidence of an association between stimulants and blood borne virus (BBV) transmission among people who inject drugs (Halkitis et al. 2009), and participation in behaviours that risk sexually transmitted infection (STI), including among men who have sex with men (Green & Halkitis, 2006; Hopwood et al. 2015).

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. Economist Tim Moore estimated that the cost to the Australian Government of illicit drug use amounted to approximately $3.2 Billion per annum, an estimate which has significantly grown since its calculation in 2002 (Collins, 2007; Dunlop, 2008). Further evidence of stimulant-related harms include increases in arrests for methamphetamine related offences (McKetin et al. 2006), treatment admissions (Ridley & Coleman, 2015) and hospital separations (Roxburgh et al. 2013).

2. Rationale

2.1 Current treatment options

The evidence base for stimulant-specific interventions is modest, though building. Current treatment options include withdrawal management, residential rehabilitation, and counselling. Of these, psychosocial interventions such as Cognitive Behavioural Therapy (CBT) have developed the strongest evidence-base, with an Australian systematic review finding that CBT can be effective in reducing methamphetamine use and other positive changes in as few as two sessions (Lee & Rawson, 2008).

2.2 Limitations in treatment access

As a whole, Alcohol and other Drug (AOD) treatment options have traditionally focused on opiate and alcohol dependence, resulting in models of engagement which are not suited to the needs of people who use stimulants. Whilst there are a number of specialised stimulant treatment services, these struggle to keep up with demand. Further, remote and rural areas may not be equipped with sufficient resources to respond to the growing rates of methamphetamine use (Wallace et al. 2009).

2.3 Limitations in treatment seeking

People who use stimulants have been found to have a pattern of low treatment utilisation (Brecht et al. 2013), with poor treatment engagement and retention associated with a range of factors, such as female gender, greater socio-economic disadvantage, mental health issues, greater severity of stimulant use, and greater experience of harms associated with use (McKetin & Kelly, 2007; Quinn et al. 2013; Pennay & Lee 2011; Brecht et al. 2013). Many individuals 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 (Wallace et al. 2009). Moreover, a recent Australian meta-analysis found that internal client factors such as embarrassment, stigma, privacy concerns, and belief that treatment is unnecessary were significant barriers to treatment seeking across international studies (Cumming et al. 2016).

Of those presenting for treatment, there is typically a substantial temporal lag in approaching services. Findings from a Turning Point Alcohol and Drug Centre study (Lee & Pennay, 2012) indicated that individuals delayed treatment seeking by up to approximately ten years despite experiencing problematic drug use.

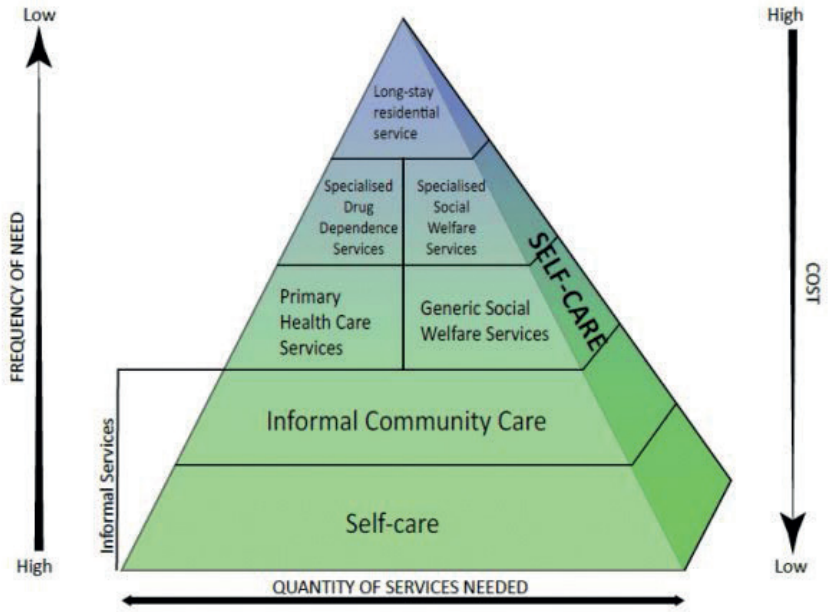
3. Development

To address these issues, St. Vincent's Hospital Stimulant Treatment Program received funding from the Commonwealth Department of Health and Ageing to develop a program aimed at improving access to stimulant treatment, and promoting treatment seeking for people who use stimulants. The Stimulant Check-up Clinic (S-Check) was developed to present opportunities for an early intervention to reduce the escalation of stimulant use, reduce health and social harms, and facilitate appropriate entry into other treatment options if necessary.

S-Check was informed by a Psychostimulant Check Up model piloted in South Australia (Smout et al. 2010) which provided a single-session 30-minute semi-structured psychosocial screening and motivational interviewing intervention. S-Check enhanced this original intervention and sought to provide biopsychosocial assessments, brief intervention, information and referrals for people who use stimulants, and to provide a novel approach to engaging those who are treatment naïve.

The development of the S-Check intervention was further influenced by the World Health Organization (WHO) Pyramid Framework for Service Organisation:

Figure 2 - Service organization pyramid for substance use disorder treatment and care.



The model calls for an increase in services at the lower intensity spectrum of service type. S-Check has thus been developed so as to be implemented as a low threshold intervention from primary health care services, generic social and welfare services, through to specialised drug services. As depicted in the WHO pyramid framework, the earlier the intervention, the less costly and the greater the scope for harm reduction. The existence of a brief intervention model also ensures that the intensity of treatment matches the severity of substance use issue, maximising treatment outcomes for the client.

4. Objectives

The primary objective of S-Check is to provide a stimulant-specific brief intervention for individuals who are treatment naïve. The barriers to users accessing treatment are deeply considered in the provision of S-Check, such as promoting the program as a more generalised physical and mental health check-up, and by couching the program in a strengths-based, affirming, confidential model.

As an early intervention model, S-Check functions as a motivational tool by providing an opportunity to explore impacts of drug use on physical, psychological, social and spiritual

wellbeing in a non-judgemental setting. The aims of S-Check can therefore be summarised as:

- Provision of strengths-based assessments regarding physical health, psychological health, social wellbeing and spiritual wellbeing
- Attracting those who may have concerns about the effect their use of stimulants is having on their wellbeing into accessing support
- Provision of information and education on ways to reduce the harms associated with their use of stimulants and other drugs
- Provision of referrals to appropriate services such as drug and alcohol treatment agencies, sexual health clinics, general practitioners and mental health services as required.

5. Preliminary Outcomes

In 2016, an evaluation of S-Check was conducted to describe service users, assess retention and establish perceptions of the model of care. The full paper for this evaluation can be accessed at: “Brener et al. (2018). Providing a model of health care service to stimulant users in Sydney. *Drugs: Education, Prevention and Policy.* 25(2), 130-137.”

The clinical records of 186 clients were reviewed, and ten in-depth interviews were conducted. The following findings were made:

- Engagement: The majority of interview participants described S-Check as their first general health service contact. They described the service as friendly, supportive, understanding and non-judgmental. This finding directly addresses the barrier to treatment of perceived stigma and judgement.
- Retention: The majority of clients completed all four sessions of S-Check: Eighty-one percent of participants were retained at session 2, 56.5% were retained at session 3 and 58.6% were retained at session 4.
- Stimulant-specific: Participants described their stimulant use as different from other drug group users, and S-Check as being focused on supporting them individually.
- Biopsychosocial focus: The breadth of assessment appears to be a strength of the model. For example, approximately three quarters of participants had received a mental health diagnosis in their lifetime, over half reported health risks such as equipment sharing and unprotected sex, and a number faced social issues such as homelessness and unemployment.
- Harm reduction: Rated in interview as one of most helpful aspects of the model. Sharing of drug equipment, driving under the influence and engaging in unprotected sex were amongst the risks most commonly discussed in session.

- Low threshold: Participants favoured the brief, low-threshold approach of S-Check in contrast to higher threshold interventions which may impact education/vocation responsibilities and/or personal lives. Further, more than half of participants who denied their drug use was problematic were classified as dependent following an evidence-based screener, the Substance Dependence Scale (SDS). The low threshold nature of a “checkup” is of value for these individuals.
- Aftercare: The care planning was seen as imperative to the program, with participants seeking referrals to other services and additional support options for family and friends.

The value of programs such as S-Check was supported by the findings of the 2015 report from the National Ice Taskforce. The report highlights both the need for prevention and early intervention models of care, and for services which are methamphetamine-specific and tailored to the needs of this client group (Commonwealth of Australia, 2015).

6. Who should read this document?

The current document is intended to support health professionals in responding to stimulant use in an evidence-informed manner. In considering that people who use methamphetamine who are not accessing specialised drug treatment, the S-Check Clinic model has the potential to increase treatment reach across a broad range of healthcare sectors. This document may then be of interest to clinicians (allied health, doctors and nurses) and service managers. Health services include, but are not limited to, inpatient alcohol and drug and mental health services, general practice, outpatient mental health, drug and alcohol, sexual health, youth, and prison health services.

Existing drug and alcohol services may consider incorporating the S-Check model as an engagement and brief intervention tool. Similarly, mental health services could consider the present document, given the significant intersect in client groups amongst mental health and drug and alcohol services. Primary care practices are presented with a unique opportunity for screening, assessment and motivational intervention, and could consider the relevance of the document to their practice.

As recommended by the National Ice Taskforce (Commonwealth of Australia, 2015), consideration should be given to the regions in Australia bearing the most need for services, including remote and Aboriginal communities. Adaptation of the S-Check program into these settings may be of value.

The tools used in the model were developed for use in one population and may need to be adapted to suit the needs of another. It is acknowledged that elements of this model may need to be modified depending on the resources available, therefore the authors encourage clinicians to view this as a framework for a client-centered, stimulant-specific biopsychosocial, strengths based brief intervention.

Section 2 – Implementation

1. How does S-Check fit with your service

The S-Check has been designed to be delivered by health professionals from a range of backgrounds including medical, nursing and allied health. The model requires a lead clinician who will be the point of contact and support for the client. Clinical governance processes should be in place to ensure this clinician is appropriately skilled and trained in counselling assessment and brief interventions, and that processes are in place to support and supervise this clinician to ensure quality of service delivery.

The complete S-Check model comprises of four sessions – two psychosocial, and two health-related. Clinicians are thus able to deliver all four sessions where their training and practice allows, whilst some members of the multi-disciplinary team may be able to deliver the psychosocial sessions only. Forging a link or partnership with appropriate allied health team members will enable the full model to be delivered, however there is value in delivering the two psychosocial sessions, or two physical health sessions, in isolation. Where there are two clinicians delivering the S-Check, effective clinical information sharing is vital to ensure a holistic intervention for the client. This may be facilitated through brief meetings between clinicians at the completion of the biopsychosocial and physical health assessments, so as to generate an integrated picture of the client's health and wellbeing.

Each organisation or practitioner should also have in place a risk assessment and response protocol, which is to be followed for identification of any client risk around suicidality, unsafe drug or equipment use (e.g. overdose risk), domestic violence, child protection, mental state (e.g. psychosis), pregnancy or physical health risk (e.g. cardiac, BBV).

The S-Check program should have in place a robust registration or intake process. The purpose of intake is to assess suitability of the client/patient for S-Check, assess current risk factors, discuss confidentiality and collect demographic details. Collecting several forms of contact details is recommended, e.g. phone; email; next of kin.

2. Referral pathways and linkages

A key focus of the S-Check model of care is supported referrals and the identification of linkages into the community that will assist in sustaining protective factors, reducing stimulant-related risk and improve wellbeing. The aim of effective referral processes is to ensure the safe and effective transfer of care of clients who attend S-Check and enhance continuity of care with the clients ongoing care provider(s).

Well-documented support networks and referral pathways are highly recommended and will assist with ensuring high quality outcomes for clients in the delivery of transfer of care.

In order to support this aspect of S-Check, dissemination and transmission of accurate and appropriate clinical information in accordance with confidentiality and privacy policy is essential.

Whilst they may occur at any point of S-Check, referrals and linkages typically form part of S4. As part of any referral and/or transfer of care, the client should be provided with all literature required prior to their transfer of care, including plans for follow-up care and contact details of relevant service providers. Some key principles to consider when making referrals for clients include:

- Proximity to where the client lives
- Minimal disruption to employment, social and other protective activities
- Provision of evidence-based interventions
- A respectful approach to substance users
- A recovery perspective

Key service types to consider when making referrals include:

- Specialist AOD treatment services (National Alcohol and Other Drug Hotline 1800 250 015)
- Sexual Health Clinic in area
- Legal support services (www.legalaid.nsw.gov.au)
- Indigenous organisations (www.naccho.org.au)
- Lesbian Gay Bisexual Transgender and Intersex (LGBTI+) support services (www.lgbtihealth.org.au)
- Men's/women's support services (www.mensline.org.au; www.1800respect.org.au)
- Young person support services (www.kidshelpline.com.au)
- Community drug and alcohol such as Narcotics Anonymous or SMART Recovery
- Local community Non-Government Organisations (NGO's) or neighbourhood groups
- Education and vocation opportunities

3. Assertive follow-up

In opposition to many drug and alcohol programs which require clients to maintain close contact to secure a position in treatment or waiting list, S-Check has an in-built assertive follow up protocol. This is in recognition of the cyclical nature of motivation to change as detailed by Prochaska and DiClemente (1982), and aims to support clients as much as possible to build and maintain this motivation.

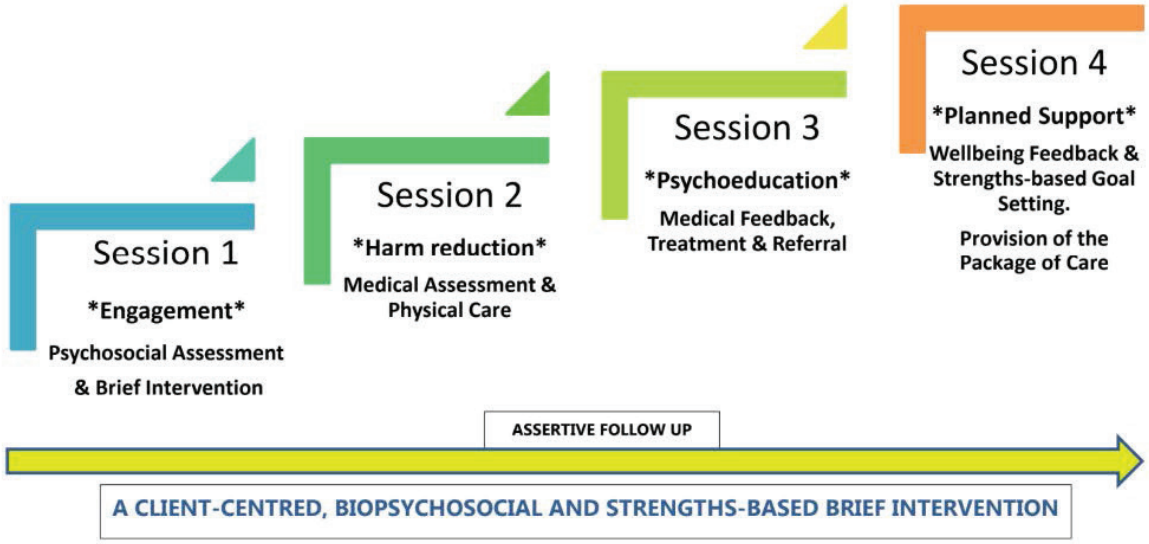
The following protocol may be adapted to suit any service: If a client misses a session,

then the S-Check clinician will attempt two contacts via telephone, text message or email to assess their welfare and reschedule the appointment. If the content of a client's session has indicated that there are risk issues such as physical health risk, mental state, pregnancy etc, then the S-Check clinician will make three attempts to contact via any method the consumer has identified, before attempting to contact the next of kin any other relevant organisations the client is linked with. A police welfare check may be arranged should the client not be contactable at all. Each of these decisions should be discussed amongst team members in an appropriate setting, such as a clinical review.

3.1 Client journey

The following diagram has been developed to highlight the key theme for each session, and the activities therein:

Figure 3 – Key elements of the S-Check Model of Care



4. Monitoring and evaluation

An evaluation framework including defined data collection should be considered from the outset. There are a number of key issues to consider:

1. Collection of demographic details: In understanding the community specific to a service, the service can be better tailored to their needs. Suggested minimum elements include age, gender, sexual orientation and Aboriginal and Torres Strait Islander status. Drug use information is also of value including duration of use, route of administration and first treatment episode. *For demographic analysis example see "Brener et al. (2018). Providing a model of health care service to stimulant users in Sydney. Drugs: Education, Prevention and Policy. 25(2), 130-137."*

2. Choice of outcome framework: evidence-based outcome measures are advised. New South Wales (NSW) clinical guidelines are often based on the Australian Treatment Outcomes Profile (ATOP), a validated instrument for measuring treatment outcomes in the substance using population. Readers are also directed to revisit S4 and the follow-up screening using the PWI. Retention rate and satisfaction per session are also useful outcomes to collect. *For further information on the ATOP see "Ryan et al. (2014). Validation and implementation of the Australian Treatment Outcomes Profile in specialist drug and alcohol settings. Drug and Alcohol Review, 33(1), 33-42."*

3. Consumer input: a rich source of feedback to ensure quality and suitability of the intervention to the issues facing the service population. Examples may include anonymous survey, one-to-one interviews or an advisory group.

5. Concluding remarks

As a sector, we are striving to better respond to the needs of people who use stimulants. Stimulant-specific, low-threshold brief interventions are believed be of particular value, and S-Check may function well in this context. Ultimately, this model aims to develop health awareness, build motivation and reduce harms in the stimulant-using population. It must be emphasised that S-Check does not constitute treatment, and that high-quality assessment and referral processes may ensure that levels of intervention are tailored to the needs of the presenting individual.

For further information, support or feedback, you are invited to contact the Stimulant Treatment Services Manager at St Vincent's Hospital Drug and Alcohol Service: svhs.stp@svha.org.au

Section 3 - Model of Care

Articulated in this section is the S-Check model of care that encapsulates the core elements of the intervention. As a whole, the intervention consists of four sessions – biopsychosocial assessment; physical health assessment; physical health feedback; wellbeing feedback.

With the progression of sessions, the clinician is able to build information for the client regarding their overall health and wellbeing, accompanied by strengths-based strategies for increasing sustainable supports in the community and reducing stimulant-related harms. Each of the sessions is explored in detail below, and module documentation can be found in appendices.

Session 1 (S1): Biopsychosocial Assessment

The comprehensive biopsychosocial assessment is designed to establish a whole picture of the individual's drug and alcohol use, with a particular focus on stimulant use and its relationship with health, wellbeing, and day to day functioning.

The session is composed of four clinician-administered scales (A), and a biopsychosocial interview (B). These are explored in more detail below:

A) Scales

S-Check clinical staff are responsible for administering several scales, designed to develop an overview of wellbeing. The battery is composed of:

1. Personal Wellbeing Index (PWI): This is a tool to measure subjective Quality of Life. It contains seven questions which constitute the minimum set of domains representing the first level deconstruction of 'Life as a whole'. The seven domain scores can be summed to yield an average score which represents 'Subjective Wellbeing'. Alternatively, each of the domains can be analysed as a separate variable. *Further information: "Cummins et al. (2003). Developing a National Index of Subjective Wellbeing: The Australian Unity Wellbeing Index. Social Indicators Research, 64:2, 159-190."*

2. Strengths assessment: A self-assessment tool of a range of character strengths. Based on the strengths-based theory of recovery which emphasises an individual's capacity to overcome problems by engaging strengths. *Further information: "Rapp, R. C. (2002). The Strengths Perspective and Persons with Substance Abuse Problems. The Strengths Perspective in Social Work Practice, 77-96"*

3. Kessler-10 (K-10): A ten-item scale capturing the level of distress experienced by an individual over the past four-week period. Each item is scored from one ‘none of the time’ to five ‘all of the time’. Scores of the 10 items are added together, yielding a minimum score of 10 and a maximum score of 50. A score under 20 denotes the likely absence of depression or anxiety. *Further information and scoring: “Andrews, G. & Slade, T. (2001). Interpreting scores on the Kessler Psychological Distress Scale (k10). Australian and New Zealand Journal of Public Health, 25, 494-497.”*

4. Severity of Dependence Scale (SDS): a five-item scale concerned with the psychological components of dependence. Each of the five items is scored on a 4-point scale (0-3). The total score is obtained through the addition of the 5-item ratings. A score 4 and above has been shown to be indicative of clinically significant dependence (Lawrinson et al. 2007). *Further information: “Gossop et al. (1995). The Severity of Dependence Scale (SDS): psychometric properties of the SDS in English and Australian samples of heroin, cocaine and amphetamine users. Addiction, 90(5):607-14.”*

The clinician delivers a brief explanation of each scale before providing the client with paperwork. The client is provided enough time and space to complete the scales, with clinician assistance where necessary. Where client literacy may prevent understanding of terminology related to personal strengths, it may be useful to provide examples e.g. compassion can be thought of as feeling sympathy or concern for someone else.

After all are complete, the clinician discusses the outcomes with the client. For instance; reflecting on the PWI score; key strengths; provide an explanation of the K-10 score or SDS score.

B) Biopsychosocial interview

S-Check clinical staff are responsible for completing the biopsychosocial interview. The S1 assessment template provides an overview of what is to be covered in the assessment, including social situation and lifestyle, psychological wellbeing, sexual functioning, details of substance use, past treatment for substance use, stimulant use and effects and a strengths discussion.

The S-Check clinical staff role is to provide, where required, advice, information, encouragement, support and brief interventions. This may include, for example, a discussion of the strengths engaged to quit smoking in the past; providing education regarding the risks associated with sharing drug equipment; providing supportive counselling in relation to client’s relationship difficulties.

Where appropriate, referrals may be made at this point, and not delayed until the

completion of S-Check. This may be due to a current mental health issue or urgent need for accommodation, for example. If any significant clinical risks are identified, then appropriate referrals and notifications should be made.

Session 2 (S2): Physical Health Assessment

S-Check clinicians may complete the physical health check-up, designed to screen for adverse impacts of stimulant use, and provide opportunities for education and treatment. For those non-medical practitioners, completing the S2 and S3 components of the S-Check may require forging links with a general practice or other appropriate medical staff.

The S2 screens cardiac/respiratory health, mental health, sexual health, neurological health and dental health. It is a health and systems screen targeted at common co-morbidities associated with methamphetamine use disorder. Physical examinations include heart rate, blood pressure, body mass index (BMI), and a range of pathology screening for STIs and BBVs. This session thus assumes capacity to take basic physical measurements, and to access lab investigations.

This session is viewed as an opportunity to provide specialist harm minimisation education. This may include, for example, dental hygiene, safer injecting practices and drug interactions. Referrals may be made at this point in S-Check, such as to a general practice in the community where the client currently lacks one, or for further specialised intervention such as HIV pre-exposure prophylaxis (PrEP).

Session 3 (S3): Physical Health feedback

This session is an opportunity for the medical professional to reflect back an overview of the client's current health, and invite the client to consider the role their stimulant use may play. Additionally, as a result of the medical assessment, specific medical treatment may need to be provided in S3. Examples of S3 interventions may include treatment for STIs or brief intervention around nutrition. This is also an opportunity to discuss and make formal referrals for issues that arose during S2. Further assessment and treatment, such as psychiatric or cardiac, can then be delivered via a partner service.

It is important that medical feedback is similarly provided to the counsellor leading the S-Check, so as to ensure a holistic health review may be provided in the final session.

Session 4 (S4): Wellbeing Feedback

In the final session of S-Check, the client meets with the initial counsellor. There are a number of small components to this session:

Scales

The clinician explains that the PWI scale from the first session will be completed again, to allow the client to reflect on changes in their wellbeing over the course of S1-4. Any change in score is discussed with the client: explore higher scores from a strengths-perspective; provide support and referral where necessary for a reduction in score. If your organisation is choosing to capture data from these scales for evaluation purposes, this must be discussed with the client and consent sought.

Biopsychosocial assessment review

The clinician provides feedback around wellbeing, and reviews any key issues addressed throughout the sessions. This is thus a key area for targeted brief interventions. For instance, providing support for STI diagnosis and discussion of safe sex practices; re-visit the client's relationship issue with their partner and explore communication styles.

Goal setting exercise (example: Appendix D)

The clinician invites the client to participate in a goal-setting exercise. This goal is generally informed by the biopsychosocial assessment, and may or may not be AOD-related. Examples include developing a fitness regime, changing jobs, engaging with spirituality, learning mindfulness, transitioning from injecting to smoking amphetamine, or quitting nicotine. Clinicians are invited to utilise their individual goal-setting practices. An example worksheet is also provided in Appendix D. To utilise this sheet, a specific goal statement is placed in the centre of a page. Above the goal, the clinician explores with the client the value of this goal. Key questions include "why is this goal important to you?" "what would this mean to you, to achieve this goal?" "what would this say about you, to achieve this goal?". These are written at the top of the page. At the bottom of the page, the clinician explores with the client the steps that are necessary to take to work towards the goal. Clinicians are reminded of the SMART theory of goal setting (Simple, Measurable, Achievable, Realistic, Time-bound). Steps are placed on the page sequentially. The client takes this structured plan with them from the session.

Strengths-based care plan

The clinician summarises the outcomes of the S-Check. This includes changes the client has decided to make during discussion with the clinician (e.g. access needle and syringe program) and referrals that have been made (e.g. to a specialised drug and alcohol treatment service). Together these form the strengths-based care plan – a summary of aftercare. To support engagement, it is useful to write down the summary and provide to the client, or to make referrals on the client's behalf (with permission). For more information refer back to 'referral pathways and linkages'.

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Appendices

Appendix A: S1 Assessment scales

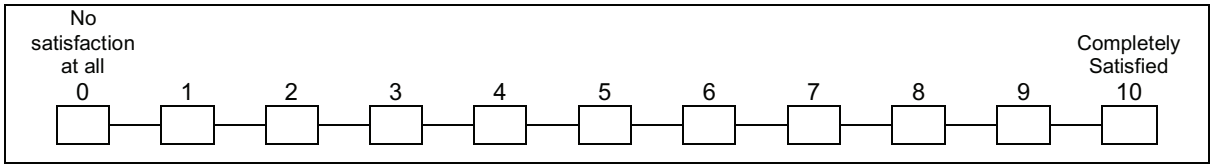
Appendix B: S1 Biopsychosocial Interview

Appendix C: S2 Physical Health Assessment

Appendix D: S4 Goal-setting exercise

Question 1 - Personal Wellbeing Index Scale (Verbal Format)

"(On this scale,) **Zero** means you feel no satisfaction at all. **10** means you feel completely satisfied."



"Would you like me to go over this again for you? [If "yes", repeat the above. If "no", proceed to next statement].

"How satisfied are you with...?"	Respondent's Rating (0-10)
1. ...your standard of living?	
2. ... your health?	
3. ... what you are achieving in life?	
4. ... your personal relationships?	
5. ... how safe you feel?	
6. ... feeling part of your community?	
7. ... your future security?	

Question 2 - Strengths Assessment

You have many personal strengths and abilities. The following scale rates how frequently you connect with each of the below strengths. Place a tick in the appropriate box.				
	4. Very Often 4	**3. Often** 3	**2. Sometimes** 2	**1. Rarely** 1
Spiritual				
Enthusiastic				
Compassionate				
Confident				
Patient				
Trustworthy				
Courageous				
Creative				
Self-reliant				
Optimistic				
Considerate				
Friendly				
Artistic				
Insightful				
Broad-minded				
Determined				
Good-natured				
Flexible				
Calm				
Humble				
Tolerant				
Grateful				
Organised				

Question 3 - K10

For the following questions, please think about the average number of times across the past 4 weeks.

In the past 4 weeks:	None of the time (score 1)	A little of the time (score 2)	Some of the time (score 3)	Most of the time (score 4)	All of the time (score 5)
1. About how often did you feel tired out for no good reason?	☐	☐	☐	☐	☐
2. About how often did you feel nervous?	☐	☐	☐	☐	☐
3. About how often did you feel so nervous that nothing could calm you down?	☐	☐	☐	☐	☐
4. About how often did you feel hopeless?	☐	☐	☐	☐	☐
5. About how often did you feel restless or fidgety?	☐	☐	☐	☐	☐
6. About how often did you feel so restless you could not sit still?	☐	☐	☐	☐	☐
7. About how often did you feel depressed?	☐	☐	☐	☐	☐
8. About how often did you feel that everything is an effort?	☐	☐	☐	☐	☐
9. About how often did you feel so sad that nothing could cheer you up?	☐	☐	☐	☐	☐
10. About how often did you feel worthless?	☐	☐	☐	☐	☐
(Office use only)TOTAL Score:					

Re-produced from: Kessler, R.C., Barker, P.R., Colpe, L.J., Epstein, J.F., Gfroerer, J.C., Hiripi, E., Howes, M.J, Normand, S-L.T., Manderscheid, R.W., Walters, E.E., Zaslavsky, A.M. (2003). Screening for serious mental illness in the general population *Archives of General Psychiatry.* 60(2), 184-189.

Question 4 - Severity of Dependence Scale

For the following questions please circle the response that is closest to your experience with stimulants (cocaine, amphetamines/ methamphetamines, or ecstasy) in the past month.

i. Do you think your stimulant use was out of control during the past month?

Never or almost never (0)	Sometimes (1)	Often (2)	Always or nearly always (3)

ii. During the past month, did the prospect of not having or going without stimulants make you anxious or worried?

Never or almost never (0)	Sometimes (1)	Often (2)	Always or nearly always (3)

iii. Did you worry about your use of stimulants in the past month?

Not at all (0)	A little (1)	Quite a lot (2)	A great deal (3)

iv. Did you wish you could stop using stimulants in the past month?

Never or almost never (0)	Sometimes (1)	Often (2)	Always or nearly always (3)

v. How difficult would you find it to stop or go without stimulants during the last month?

Not difficult (0)	Quite difficult (1)	Very Difficult (2)	Impossible (3)

(Office use only) **Total: /15**

Re-produced from: Gossop, M., Darke, S., Griffiths, P., Hando, J., Powis, B., Hall, W., Strang, J. (1995). The Severity of Dependence Scale (SDS): psychometric properties of the SDS in English and Australian Samples of heroin, cocaine and amphetamine users. *Addiction* 90(5); 607-614

S1 Biopsychosocial interview

Client Name:	**Contact Number:**
Assessment conducted by:	**Date of assessment:**
PWI Score:	**SDS Score:**

Summary of S-Check session:

Appendix B: S1 Biopsychosocial interview

1. Introduction

S-Check is a comprehensive assessment designed to establish a whole picture of your drug and alcohol use, in particular your stimulant use and its relationship with your health, well being, and day to day functioning.

S-Check consists of four sessions:

- ☐ Session 1 – Psychosocial Assessment
- ☐ Session 2 – Physical Health Assessment
- ☐ Session 3 – Physical Health Feedback
- ☐ Session 4 – Psychosocial Feedback and Care Plan

CONFIDENTIALITY: All information you share with S-Check is confidential and will not be released without your permission except as required by law (as per the Mental Health Act and Child Protection Act). If you have any questions about confidentiality, please speak with your counsellor.

Reason for Presentation:

What are your hopes and expectations from completing an S-Check?

2. Social Situation and Lifestyle

Relationships and Social Supports:
Who are your main social supports? Are your social supports aware of your drug use? Do you usually use drugs alone or with others? (include details of current relationships, family situation, relationship status, dependents, any carer duties)

Domestic Violence Screening:
Have you ever experienced any type of abusive behaviour (e.g physical violence, sexual assault, emotional abuse or social or financial control) from a current or previous partner, family member or friend?

☐ Yes ☐ No (If yes, provide details: _____)

Child Protection:
If carer for children, how has your parenting been impacted by your drug use?

Mandatory Child Protection Required: ☐ Yes ☐ No If yes, Outcome:_____

Professional Supports:
Are you currently involved with any other services? (include details of frequency of support, duration of relationship with service, contact details of key worker)

Living Situation:
What is your current accommodation? Do you feel safe where you are living? (include details of living arrangements e.g. alone or with others, any tenancy issues, if homeless, ask whether a client is engaged with any homelessness services)

2. Social Situation and Lifestyle (cont.)

Financial Situation:
What is your source(s) of income? How has your drug use impacted your financial/work/ study commitments? (include details of any financial issues, e.g. significant debts, ability to manage finances, persons assisting)

_____

_____

_____

Gambling:

Frequency: _____ Amount: _____

Do you consider gambling a problem? If yes, why and how long have you considered it a problem?

_____

_____

Legal Situation:
Do you have any current legal issues? Have you had any contact with Police or legal trouble when using drugs? (if relevant, include details of forensic history current reporting conditions, legal representation)

_____

_____

_____

Lifestyle and Daily Functioning:

What are your usual daily activities? Are drugs a sole or main form of enjoyment in your life? How has your drug use impacted ability to perform day-to-day tasks? (include details of ADLS, sleep patterns, nutritional intake, social engagement, personal hygiene)

2. Social Situation and Lifestyle (cont.)

Mental Health History

Have you ever been given a formal mental health diagnosis by a health professional? (e.g. Depression, Anxiety, Mania or Bipolar, ADHD, Personality Disorder, PTSD, Schizophrenia) If no formal diagnosis, do you have any current concerns regarding your mental health?

Have you ever experienced a drug induced psychotic episode? ☐ Yes ☐ No

If yes, provide details of episode (s): _____

Past or Current Treatments

Are you currently prescribed any medications for your mental health or have you been prescribed any in the past? Have you ever been hospitalised for a mental health concern? (include details of dosage and prescriber of medications, details of any other mental health treatments)

Self Harm/Suicide Assessment and Management Planning

i. How would you rate your current mood on a scale of 0 to 10, with 0 being extremely depressed and 10 being extremely happy? How typical is this mood of recent times? If low rating, ensure (ii) suicide risk is completed.

ii. When you feel this way, have you ever had thoughts of harming or killing yourself? Review lethality of method, time frame for plan and accessibility.

4. Sexual Functioning

Do you use stimulants or 'chems' to have sex? (include details of what substances, frequency, first used)

☐ Yes ☐ No *If yes, provide details of episode (s)*: _____

_____

_____

_____

How has your sexual functioning been impacted by your drug use? (include details of any sexual dysfunction issues, impacts on intimacy, experiences of sexual violence)

_____

_____

_____

Have you ever engaged in unprotected sex or any other risky sexual behaviours when using drugs? (e.g. sex for favours, group sex, multiple sexual partners)

☐ Yes ☐ No *If yes, provide details of episode (s)*: _____

_____

_____

_____

When was your most recent sexual health or blood borne virus check-up?

_____

_____

_____

5. Details of Substance Use ***(re-produced with permission from New South Wales Health Drug and Alcohol Service Assessment form, 2017).***									
Drug Please circle relevant drug if options available	**Ever Used**	**Frequency** Number of days used in the last month	**Mode of Use** 1: injecting, 2: smoking/ inhaling, 3: snorting 4. swallowing	**Amount** Number times used on a typical day	**Amount used** - weight/cost	**Last Used** Time/day	**Do you consider this drug to be a problem?**		**Age first used**
Methamphetamines (e.g. Speed, Crystal Meth)	☐	/28					☐ **Yes**	☐ **No**	
Cocaine	☐	/28					☐ **Yes**	☐ **No**	
Ecstasy/MDMA	☐	/28					☐ **Yes**	☐ **No**	
Alcohol	☐	/28					☐ **Yes**	☐ **No**	
Benzodiazepines	☐	/28					☐ **Yes**	☐ **No**	
Cannabis	☐	/28					☐ **Yes**	☐ **No**	
Synthetic Drugs	☐	/28					☐ **Yes**	☐ **No**	
GHB/GBL	☐	/28					☐ **Yes**	☐ **No**	
Inhalants (e.g. Poppers, Glue, Petrol)	☐	/28					☐ **Yes**	☐ **No**	
Hallucinogens: LSD, Magic Mushrooms	☐	/28					☐ **Yes**	☐ **No**	

5. Details of Substance Use ***(re-produced with permission from New South Wales Health Drug and Alcohol Service Assessment form, 2017). Cont.***									
Heroin	☐	/28					☐ **Yes**	☐ **No**	
Methadone / Buprenorphine / Suboxone Film	☐	/28					☐ **Yes**	☐ **No**	
Other Opiates (Including oxycodone, opium, fentanyl, morphine)	☐	/28					☐ **Yes**	☐ **No**	
Ketamine	☐	/28					☐ **Yes**	☐ **No**	
Steroids	☐	/28					☐ **Yes**	☐ **No**	
Tobacco/Nicotene	☐	/28					☐ **Yes**	☐ **No**	
Other drugs (including prescription medications)	☐	/28					☐ **Yes**	☐ **No**	

5a. Injecting Drug Use:	
☐ Never Injected	☐ Last injected > 3 months but < 12 months
☐ Last Injected within the past 3 months	☐ Last Injected > 12 months
☐ Not stated	☐ If never, do you think you would inject?

Have you ever shared drug equipment? (e.g. injecting equipment, pipe, spoons, tourniquet) If yes, provide details (e.g. frequency, awareness of safe injecting practices):

6. Past Treatment for Substance use		
Have you ever used a service for support of past drug or alcohol use?	☐ Yes	☐ No
☐ Counselling ☐ Inpatient/residential withdrawal management ☐ Outpatient withdrawal management ☐ Residential rehabilitation activities	☐ Day program rehabilitation activities ☐ Buprenorphine ☐ Methadone ☐ Other maintenance pharmacotherapy ☐ Inpatient consultation	☐ Outpatient consultation ☐ Support and case management only ☐ Assessment only ☐ Other ☐ No previous service received
Details of past treatment(s): *Which of any of these services were helpful?*		
Periods of Abstinence: *How long? How was this achieved? Were there any benefits?*		

7. Stimulant Use and Effects

Benefits: *Are there any benefits of using stimulants for you? What do you find attractive about it?*

Disadvantages: *Are there any disadvantages of using stimulants for you?*

Withdrawal: *What is your come down like?*

Prompt: sleep, fatigue, concentration, stomach pains, headaches, frequent illness, issues relating to route of administration, grind teeth, pick at skin, reduced appetite

What are your moods and thinking like:

On stimulants	Withdrawing	Not using stimulants

Prompt: euphoric, confident, anxious, restlessness, self-conscious, concentration, attention span, short term memory, racing thoughts, paranoid, aggressive, energy levels, flat

8. Strengths Discussion
What activities do you find enjoyment in? (include details of interests, hobbies, passions) _____ _____ _____ _____ _____
Discuss the strengths that the client indicated as a 5 or 4 in the Strengths Assessment <u>Comments:</u> _____ _____ _____ _____ _____

S2 Physical Health Assessment

1. Introduction

This consultation is an opportunity to review how stimulant use may have affected the health of your client, possible risks they may have encountered or may encounter if use continues. This will cover all aspects of the clients health, however the client reserves the right not to answer a question if requested.

The questions below are to be used as a guide and should not preclude clinical judgement.

2. Current Medical Concerns

Does the client have any specific health concerns? Are there any health concerns that prompted them to access S-Check? Include details of general health concerns and concerns specifically related to drug use…

Does the Client have a GP that they normally see?	☐ Yes ☐ No
If yes: Does the client feel they can discuss their drug use with their GP?	☐ Yes ☐ No

3. Past Medical History

Any history of:	Diabetes	☐ Yes ☐ No
	Hypertension	☐ Yes ☐ No
	High Cholesterol	☐ Yes ☐ No
	Smoking	☐ Yes ☐ No
	Epilepsy	☐ Yes ☐ No
	Hepatitis A	☐ Yes ☐ No
	Hepatitis B	☐ Yes ☐ No

Any other pre-existing medical conditions/medical history:

Family History of:	Sudden death	☐ Yes ☐ No
	Cardiac Problems	☐ Yes ☐ No
	Stroke	☐ Yes ☐ No
	Hypertension	☐ Yes ☐ No

Any other relevant family history:

Appendix C: S2 Physical Health Assessment

Medications		
Drug name	Dose	Indication

Contraception and Pre-Exposure Prophylaxis	
Is the client on any long-acting contraception? Details:	☐ Yes ☐ No ☐ N/A
Does your client take Pre-Exposure Prophylaxis?	☐ Yes ☐ No ☐ N/A

Allergies
None Known ☐ List:

Immunisations	
Human Papillomavirus (HPV)	☐ Yes ☐ No
Hepatitis A (HAV)	☐ Yes ☐ No
Hepatitis B (HBV)	☐ Yes ☐ No
If yes to any of the above provide details of when immunised:	☐ Yes ☐ No

Hospital Presentations/Admissions related to stimulant-use	
Drug-induced psychosis	☐ Yes ☐ No
Cellulitis	☐ Yes ☐ No
Post-exposure prophylaxis	☐ Yes ☐ No
Sexual health issues	☐ Yes ☐ No
Details:	

4. Stimulant Related Health Screening/Systems Review

Current Stimulant Use (Refer to detailed substance use completed by counsellor for extensive substance use history)

Cardiac Screen

Any recent	chest pain?	☐ Yes ☐ No
	palpitations?	☐ Yes ☐ No

Any other cardiac symptoms:

Respiratory Screen

Any recent	chest infections?	☐ Yes ☐ No
	wheeze?	☐ Yes ☐ No
	problems with nasal passageways (if snorts)	☐ Yes ☐ No

Any other respiratory symptoms:

Psychiatric Screen

Any	auditory or visual hallucinations?		☐ Yes ☐ No
	paranoia?		☐ Yes ☐ No
Are symptoms:	Only present with use ☐	in withdrawal ☐	When not using drugs ☐

Any other psychiatric symptoms:

Appendix C: S2 Physical Health Assessment

Neurological		
Any	concentration problems	☐ Yes ☐ No
	memory problems	☐ Yes ☐ No
	headaches	☐ Yes ☐ No
Any other neurological symptoms:		
Blood Borne Viruses and Sexual Health		
Does the client inject drugs?		☐ Yes ☐ No
Are they known to reuse injecting equipment?		☐ Yes ☐ No
How many sexual partners have they had in the past 12 months (male or female)		
Have they had a previous or current STI diagnosis?		☐ Yes ☐ No
Any STI/BBV symptoms ie:	Unusual discharge from the penis, vagina or anus	☐ Yes ☐ No
	Pain during sex or urination	☐ Yes ☐ No
	Itchiness in the genital area	☐ Yes ☐ No
	Irritation in the genital area	☐ Yes ☐ No
	Sores in the genital area	☐ Yes ☐ No
	Blisters in the genital area	☐ Yes ☐ No
	Ulcers in the genital area	☐ Yes ☐ No
	Warts in the genital area	☐ Yes ☐ No
	Rashes in the genital area	☐ Yes ☐ No
Any problems related to injection sites?		☐ Yes ☐ No
Any other symptoms:		
Oral and Dermatological Health		
Any	Mouth ulcers	☐ Yes ☐ No
	Gingivitis	☐ Yes ☐ No
	Teeth grinding	☐ Yes ☐ No
	Dental abscess	☐ Yes ☐ No
	Dental pain	☐ Yes ☐ No
	Loose or chipped teeth	☐ Yes ☐ No
	Skin picking	☐ Yes ☐ No
When was the last time your client saw a dentist?		
Any other oral or dermatological symptoms:		

Appendix C: S2 Physical Health Assessment

5. Physical Examination			
HR	BP	Weight	Height
Cardiac:			
Respiratory:			
Neurological:			
Genitourinary:	*If applicable - if asymptomatic, nil exam needed*		
Dermatological:			
Oral:			
Other			
6. Issues and Recommendations			

7. Pathology		
Test	Ordered	Result
Urine Chlamydia PCR		
Urine gonorrhoea PCR		
Urine MCS		
HBV serology		
HCV serology		
HIV serology		
Syphilis serology		
Gonorrhoea swab (throat)		
Gonorrhoea swab (anus)		
Gonorrhoea swab (vaginal)		
Chlamydia swab (vaginal)		
HSV swab		
Syphilis swab		
Confirmation of contact details - compulsory for pathology samples: Name: _____ Mode of contact 1: _____ Date of birth: Mode of contact 2: _____		

8. Referrals	
General Practitioner	
Sexual Health	
Dental	
Mental Health	

Bottom-Up Goal Setting Exercise

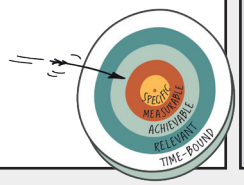
3. WHAT DOES THAT MEAN FOR YOU? WHY IS IT IMPORTANT?

2. WHY DO YOU WANT THAT? WHY IS IT IMPORTANT TO YOU? WHAT IS STOPPING YOU FROM DOING IT?

Ways to achieve this/Other options

Ways to achieve this/Other options

1. WHAT DO YOU WANT or HOPE TO ACHIEVE?



Long term goal/"Passion" statement

MEASURABLE SHORT TERM GOALS / TASKS:

1.

2.

3.