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Providing a model of health care service to stimulant users in Sydney

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Abstract

Despite the harms associated with stimulant use, treatment options for stimulant users are limited. Psychosocial interventions are the mainstay of treatment, with greater effectiveness among people with less severe use. As many stimulant users delay treatment seeking, St Vincent's Hospital Stimulant Treatment Programme in Sydney established a check-up programme to attract stimulant users. The model, termed the S-Check Clinic, is a four-session brief intervention with psychosocial and medical components. An evaluation of S-Check was conducted to describe service users', assess retention and establish perceptions of the service. A mixed methods approach was used consisting of assessing clinical records of 186 clients attending at least one session and qualitative interviews with 10 clients. Eighty-one percent attended two sessions and 59% attended all four. Just over half (52.2%) reported previous experience with drug treatment. Participants rated each session favourably, with median scores of above 90 out of 100. In interviews clients' reported on the benefits of a service designed for stimulant users and delivered within a non-judgmental, harm reduction framework. The findings suggest the attractiveness of this dedicated service offering brief psychological and medical interventions to stimulant users. Further translational research is required to scale up this promising service delivery model.

Keywords

Australia, brief interventions, drug services, drug use, healthcare

History

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Introduction

The use of stimulants such as methamphetamine, cocaine and MDMA/ecstasy is associated with physical, psychological and social harms and the potential for dependence on these drugs (Darke, Kaye, McKetin, & Dufrou, 2008; Romanelli & Smith, 2006). Stimulant-related health problems are on the rise in Australia, largely due to the increased use of the potent crystalline form of methamphetamine. Data from the 2013 National Drug Strategy Household Survey showed that while the prevalence of past-year methamphetamine use was relatively stable at around 2% of population (similar to the use of cocaine MDMA/ecstasy) and, among existing methamphetamine users the self-reported use of crystalline methamphetamine more than doubled from the 2010 (22%) to 2013 (50%) survey, as did the number of people reporting daily or weekly use (Australian Institute of Health and Welfare, 2014). In the Illicit Drug Reporting System, an annual surveillance survey of people who regularly inject drugs, the number of participants who reported crystal methamphetamine use in the preceding 6 months increased from 39% in 2010 to 61% in 2014 (Stafford & Burns, 2015).

Stimulants have been linked to a range of mental health issues, such as psychosis and schizophrenia; with a high number of methamphetamine users presenting to needle and syringe programmes with primarily substance-induced psychotic disorders (Hides et al., 2015). 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 (McKetin, Lubman, Baker, Dawe, & Ali, 2013). Long-term use of stimulants can also result in memory loss and other cognitive deficits (Belcher, Feinstein, O'Dell, & Marshall, 2007; Rippeth et al., 2004; Woods et al., 2005). People who use stimulants have been found to be more likely to participate in violent and criminal behaviours as well as increased sexual risk practices (Brecht, Lovinger, Herbeck, & Urada, 2013; McKetin et al., 2014). Harms associated with stimulant use also present a public health burden, with significant costs to health care to treat people presenting with problems associated with stimulant use (Bunting, Fulde, & Forster, 2007; McKetin & Kelly, 2007). Australia has one of the highest rates of methamphetamine dependence in the world (Degenhardt et al., 2014).

Treatment demand for stimulant use disorders is increasing, more than doubling from 2009 to 2014 (Australian Institute of Health and Welfare, 2015); methamphetamine-related hospital presentations and admissions have also substantially increased (Roxburgh & Burns, 2015).

Psychosocial interventions, and cognitive behavioural therapy (CBT) in particular, are currently regarded as the most effective treatments for methamphetamine users (Baker, Boggs, & Lewin, 2001), with modest effectiveness in reducing or ceasing methamphetamine use and improved psychosocial functioning (Jenner & Lee, 2008; Lee & Rawson, 2008). While a number of pharmacotherapies have been investigated in clinical trials, there are currently no approved medications for methamphetamine withdrawal or dependence (Brensilver, Heinzerling, & Shoptaw, 2013; Courtney & Ray, 2014). People who use stimulants often show low treatment utilisation (Brecht et al., 2013), with poor treatment engagement and retention. (McKetin & Kelly, 2007; Pennay & Lee, 2009; Quinn, Stoové, & Dietze, 2013). Furthermore, a dominant perception that drug treatment services are oriented towards people with opioid dependence may present a barrier to treatment for people experiencing problems with stimulants. Heroin use is heavily stigmatised and opioid treatment centres are commonly freighted with the same meaning. Among those using other drugs, there is often a desire to create a social distance from those who use heroin and from their associated services (Radcliffe & Stevens, 2008).

Consequently, the development and evaluation of alternative, stimulant-focussed treatment model based on existing evidence-based interventions and designed to attract a range of people who use stimulants was considered critical, both in response to the needs of individual users and to address growing community and public health concerns. In November 2011, the St Vincent's Hospital Stimulant Treatment Programme in Sydney, Australia, established a brief intervention programme for stimulant users. The design of the Sydney service, known as the S-Check Clinic, was informed by an intervention developed by Smout et al. (2010) in South Australia which consisted of a single 30-minute psychosocial screening and motivational interviewing session. Smout et al. (2010) found that those who attended reduced their stimulant intake and reported engaging in less harmful drug related behaviours. The aim of the S-Check Clinic was to provide strengths-based, bio-psycho-social assessments for people who use stimulants who would otherwise not engage in drug treatment. The S-Check model expands on the one session programme offered by the South Australian intervention (Smout et al., 2010) and comprises four sessions held close together with both medical and psychosocial elements. The four sessions consist of a psychosocial assessment, a medical assessment, a medical feedback and a psychosocial feedback session. In an attempt to reduce harms associated with drug use, information about stimulant use, counselling and referral services is also provided.

Given the novel approach of S-Check's model of care, it was important to evaluate the service. The evaluation aimed to describe the characteristics of service users, assess their retention across the four appointments and establish their perceptions and experiences of the service. Taking a translational research approach, service success was not based on particular service-user health outcomes but rather that attendance is understood as having a beneficial effect in and of itself (Smout et al., 2010).

Methods

Design

A mixed methods research design was adopted, consisting of (1) data extraction from existing clinical records collected at the clinic during client visits and (2) semi-structured qualitative interviews with clients. Clients participating in the S-Check Clinic consented to be involved in the evaluation and have their clinical records accessed by an independent researcher. The study received ethics approval from the Human Research Ethics Committees of St Vincent's Hospital and UNSW Australia.

Measures

Over a 2–3 month period, an independent researcher based on-site at the S-Check Clinic was granted access to clinical records. During the four sessions, the following information was routinely collected, assessed and entered into a database: demographic characteristics, source of referral, number of sessions attended, ratings of the service, substance use and treatment history, severity of stimulant dependence, drug-related risk practices and psychological distress.

Stimulant dependence was assessed with the Severity of Dependence Scale (SDS) (Gossop, Griffiths, Powis, & Strang, 1992). Participants with an SDS score of at least 4 were categorised as stimulant dependent (Topp & Mattick, 1997). Participants were also asked to indicate for each stimulant drug whether this drug was currently a “problem” for them (yes, no). Psychological distress in the previous four weeks was assessed during session 1 with the Kessler Psychological Distress Scale (K10) (Kessler et al., 2002). Participants with a total K10 score of 22 or above were categorised as experiencing high levels of distress (Australian Bureau of Statistics, 2007).

Participants were asked to rate each session immediately following the session in terms of the relationship with the clinician, the goals and topics covered, the approach used by the clinician, and an overall session rating. Participants rated each aspect of the session by placing an X on a 100 mm ruler scale, with responses closest to 0 equating to an unfavourable rating and responses closest to 100 equating to a favourable rating.

Each client was given a unique random identification number and no names or addresses were extracted from the clinic records. The data-reporting period is from the clinic's inception until the end of May 2015, and includes all clients who attended S-Check during this period. All data were entered into a database and analysed using Stata v13.0 (StataCorp, College Station, TX).

Semi-structured interviews

Semi-structured interviews were also undertaken with 10 clients to assess in more detail their perceptions and experiences of the service. These data serve to complement and provide more description to the data from the clinical records. Purposive sampling was used to recruit a diverse range of clients. Staff approached clients regarding their interest in participating in an interview. In accordance with ethics protocol, interested clients passed on their contact

details to the researcher via staff. The researcher then contacted the client to organise an interview. Interview themes included the following: how clients heard about clinic, whether they would refer friends or family to the clinic, how many sessions they had attended, their experiences at each session, the perceived benefits/limitation of clinic, future engagement with the clinic and with other drug treatment services, satisfaction with the services and their perceptions of staff. Participants were reimbursed with an AUD\$25 super-market voucher for their participation. Interviews lasted approximately 45–60 min and were conducted over the phone, audiotaped and transcribed verbatim. Data were analysed thematically.

Results

Quantitative data from clinical records

Participants were referred to S-Check from a variety of sources, most commonly self-referral, a family member or a friend (33.9%), or a general practitioner, psychiatrist or psychologist (18.8%). Just over half (52.2%) of participants who attended S-Check reported any previous alcohol and/or other drug treatment.

One hundred and eighty-six participants attended S-Check for at least one appointment. Seventy-five percent ($n = 139$) identified as male and 25% ($n = 47$) as female, with median age of 36 years. Additional demographics are shown in Table 1. Data on educational attainment, cultural background and sexual identity were not collected. Eighty-one percent of participants ($n = 151$) who attended session 1 were retained at session 2, 56.5% ($n = 105$) were retained at session 3 and 58.6% ($n = 109$) were retained at session 4. The median number of days that elapsed between session 1 and

other sessions was 11 d (interquartile range [IQR] 1–13) for session 2, 20 d (IQR 7–21) for session 3 and 29 d (IQR 13–30) for session 4. Hence for the average participant, all four sessions were completed with a period of 1 month.

The majority of participants reported having ever used methamphetamine (speed and/or crystal methamphetamine) (90.3%), ecstasy (88.2%) and cocaine (87.1%). 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 an average, when they reported first using methamphetamine, but were younger when they first used cocaine ($M = 24$ years) and MDMA/ecstasy ($M = 23$ years). More than two-thirds of participants (69.4%) reported methamphetamine use in the month prior to attending the service. The majority of participants self-reported that they had a problem with stimulant use (76.9%) and 25.3% reported a current problem with other illicit drugs. The median SDS score was 8 (interquartile range 5–11) and 82.3% of participants were categorised as stimulant dependent. Participants who self-reported that they had a current ‘‘problem’’ with stimulant use had significantly higher SDS scores compared with participants who did not report having a current problem (median: 9 versus 5; $z = -4.40$, $p < 0.001$). More than half of the 43 participants who reported that they did not have a problem with stimulants (55.8%) had SDS scores indicative of stimulant dependence.

Table 2 shows self-reported risk practices and harms associated with stimulant 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%). A small number of participants reported having ever shared equipment used to snort stimulants (4.3%) or needles, syringes and other injecting equipment (3.8%). Six in 10 participants (59.7%) reported that they had ever driven a vehicle while under the influence of stimulants, and almost half of participants had engaged in crime or had contact with the police while using stimulants (45.2%). ‘‘Unprotected’’ sex or other ‘‘risky’’ sexual practises were reported by six out of 10 participants (60.2%) while using stimulants. One in five participants (19.4%) reported

Table 1. Demographic characteristics of S-Check participants.

	<i>n</i> (%)
Age (<i>M</i> , <i>SD</i>)	36.4 (10.0)
Gender	
Male	139 (74.7)
Female	47 (25.3)
Accommodation	
Rented house or unit	113 (60.8)
Privately owned house or unit	43 (23.1)
Hostel/supported accommodation	14 (7.5)
Homeless	7 (3.8)
Other	5 (2.7)
Data not available	4 (2.2)
Living arrangement	
Alone	62 (34.4)
Spouse/partner	39 (21.0)
Friends	35 (18.8)
Parents	25 (13.4)
Other arrangement	19 (10.2)
Data not available	6 (3.2)
Income	
Full-time employment	61 (32.8)
Part-time employment	19 (10.2)
Temporary benefit/no income	47 (25.3)
Pension/retirement fund	27 (14.5)
Student allowance	8 (4.3)
Dependent on others	5 (2.7)
Other	15 (8.1)
Data not available	4 (2.2)

Table 2. Risk practices and harms associated with stimulant use.

	<i>n</i> (%)
Ever shared drug equipment	
Yes	117 (62.9)
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 stimulants	
Yes	111 (59.7)
Ever engaged in crime or had contact with the police	
While using	84 (45.2)
While not using	26 (14.0)
Ever engaged in unprotected sex or other risky sexual behaviours	
While using	112 (60.2)
While not using	69 (37.1)
Ever engaged in sexual activity in exchange for money or drugs	
While using	36 (19.4)
While not using	20 (10.8)

Table 3. Participants' ratings of each S-Check session.

Aspect of session	Session			
	1 (n = 170) Med (IQR)	2 (n = 88) Med (IQR)	3 (n = 52) Med (IQR)	4 (n = 80) Med (IQR)
Relationship with clinician	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 100 mm ruler response scale was used for each item. Possible scores range from 0 to 100 with higher scores indicating a more positive rating.

having ever engaged in sexual activity in exchange for money or drugs while they were using stimulants (see Table 2).

Almost three-quarters of participants (72%) 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 one in seven participants (15.6%) reported having current suicidal thoughts or thoughts of self-harm.

Table 3 shows participants' ratings of each S-Check session out of 100, including the relationship with the clinician, the goals and topics covered, the approach or method of the clinician, and an overall rating. On the whole, participants rated each session favourably, with median scores of above 90 for the overall ratings of each session.

Semi-structured interviews with service users

Ten participants were recruited for qualitative interviews: five males and five females. The qualitative data below outline service users' experiences and perceptions of the S-Check Clinic, along with their views on the benefits and drawbacks of this service model

For the interview sample, the majority of participants, S-Check was their first engagement with a health service for their stimulant use. The interview data suggest that prior to attending S-Check participants had limited knowledge of existing support options. Participants typically described reaching a defining moment when they realised that they needed help with their stimulant use and only then were they prompted them to look for an appropriate support services.

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)

Client participants almost uniformly described their overall experience of S-Check and the support they had

received in strongly positive terms. 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 an assessment is particularly significant in light of stimulant users being able to identify a 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 regard discussing stimulant use with their general practitioner. Often contrasting their experiences with other drug intervention programmes, participants believed S-Check provided therapeutic support without necessarily impacting negatively on their careers and/or personal lives. Participants commented on S-Check's commitment to fostering a welcoming and accepting service, underpinned by a harm reduction philosophy:

Definitely harm reduction ... I actually managed to fall asleep behind the wheel of my 4-wheel drive doing 100km an hour on the M5 in the fast lane ... [T]hey helped me to identify that driving and using was a major risk, not only to me, but in terms of putting other people in danger ...

I: And I guess they were able to help you with your injecting in the leg as well?

R: Yes, yes definitely and even just advice about not shooting up in my feet, for example, because I could barely even walk at one point ... [T]hose types of supports as well, were really, really helpful (Client 5)

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 being both thorough and generous with their time; flexible when it 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:

“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)

The stimulant-specific nature of the service was also valued, particularly given the perception some participants held that their drug use was different from those who used other drugs. For example, one participant felt that the effects of stimulant use could lead to awkward or stressful social encounters; and two others considered their general level of social functioning and engagement as higher relative to ‘other’ drug users, especially those who use heroin. A stimulant specific service was seen as providing a more honed and focussed service better able to engage with any of issues that may be particular to stimulant use.

...there is no other service and that they are so fabulous that they really do provide that sense of family and that sense of connection in a really positive way to people and I think it can be a very isolating experience and like I say, in terms of heroin use, a lot of people do end up on maintenance programmes, so they know other people and yeah, but I don’t really see that with methamphetamine use... but what I see is people’s behaviour because of the increase of – symptoms like paranoia and you know maybe being manic, being awake all through the night and things like that, that people really isolate a lot more with their use and don’t end up wanting to be around other people, that it creates more social tensions, because the scattered kind of “off the air” behaviour that it can lead to because of the lack of sleep mean that people clash more. Whereas with heroin use, you kind of all on the nod and normally happy, so there’s less kind of social challenges with heroin than with methamphetamine use from my observation as well (Client 5)

I did ask them a few times, you know because I’m 34, 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 or not like I’ve got a drug problem, (Client 10)

Given participants’ widespread and consistent positivity towards S-Check they were typically reticent to identify any service limitations and/or challenges. When pushed, however, several of the participants mentioned delays and/or waiting lists as issues of concern. Among some participants, there appeared to be confusion distinguishing between the initial “intake” session and their first “formal” session (the psychosocial session). Participants suggested a need for greater clarity in terms of what happens at the end of the

S-Check programme, 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 prompted by someone other than the stimulant user. Overall, however, most participants reported that four sessions were sufficient to either provide adequate reassurance or enable advice on future options and direction:

“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)

Minor concerns or criticisms notwithstanding, participants overwhelmingly endorsed the positive impact their S-Check sessions had on not only their stimulant use but 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)

Discussion

The data from this study illustrate the value and the benefit of providing an accessible and low-threshold service model for stimulant users. Participants routinely reported the appeal of an intervention which is brief yet addresses both psychosocial and health aspects of stimulant use. While S-Check clients may choose to attend just one session, the intervention is designed around four sessions, and retention in treatment is associated with decreases in harmful drug use and better psychosocial outcomes (Moos, 2003). A model of service provision such as S-Check, one not based on an expectation of attendance, may be suitable to attract these stimulant users. Additionally, the data on retention across the four sessions suggests that session retention is good, and that once they access one session the overwhelming majority go on to session two and over half of the sample appear to complete all four sessions. S-Check’s flexible approach to session attendance and the time between sessions may attract those who would not otherwise identify their stimulant use as “problematic” or who see their drug use as somehow different from others and hence not seek assistance for it. Data from this study indicated that more than half of the participants who did not identify their stimulant use as problematic were dependent on stimulants. This finding is similar to that reported from a non-treatment using population in Melbourne, Australia where perceived need was identified as an important barrier to service access (Quinn, Stoové, Papanastasiou, & Dietze, 2013). Our findings suggest that the S-Check service may assist in overcoming this barrier.

The service was credited by participants for being non-judgmental, especially in comparison with general practitioners, where stimulant users’ report that their experience has generally been one of stigma and judgment. Experiences of

stigma and discrimination are known to act as a barrier to health care (Pascoe & Smart Richman, 2009), and may even increase risk-taking behaviour (Guthrie, Young, Williams, Boyd, & Kintner, 2002; Preston, D'Augelli, Kassab, & Cain, 2004) and other harms associated with drug use (Wilson et al., 2014). S-Check's non-judgmental focus and harm reduction approach was clearly welcomed by participants. Such a framework doubtless ensured that the service was not only accessible but is also highly likely to have also played a role in the good retention rates found across the four sessions.

S-Check's inclusion of both a psychological assessment and a medical check-up to assess possible drug-related harms was important for participants. While some clients may not identify their drug use as "problematic" or "harmful", it is evident from both the qualitative and quantitative data that participants reported engaging in risky behaviours. Although sharing of injecting equipment and related risks were of low prevalence (less than 5%) the majority (60%) reported HIV/STI sexual risk behaviours while using stimulants, this is similarly found in other studies (Brecht et al., 2013; McKetin et al., 2014), and points to the importance of accessible medical services for check-ups to reduce these stimulant-related harms. Additionally, the majority (60%) reported driving a vehicle while under the influence of stimulants, and close to half (45%) reported criminal activities (other than drug use). This finding is supported by the existing literature (see, e.g. McKetin et al., 2014). The sample also reported a high level of psychological distress, with almost three-quarters of participants having ever been diagnosed with a mental illness. Indeed, the rates of mental health diagnoses and current psychological distress are considerably higher than reported among adults in the general Australian population (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 stimulant use (McKetin et al., 2012). Severity of dependence scores among this sample is high, with 82% of participants categorised as stimulant dependent, suggesting a greater level of use and dependence than is reported by clients themselves. Again, the data reinforce the need for stimulant specific services able to respond effectively to the complexities of this population.

The original idea behind S-Check was to attract people either at an early point in their treatment history or treatment naïve. This was achieved for around half of the S-check clients – many of the remaining clients had long histories of illicit drug use involving a range of substances. Hence while there may be a popular perception of stimulant uses as a "niche" market, our interview data suggest a more complex and nuanced picture. Nearly half of those interviewed were dependent on social security and/or left high school early. Participants' average age was 36 years, more than 10 years after commencing stimulant use (with an even earlier reported age of commencement of drug use for some class of stimulants). Several participants reported histories of injecting drug use and/or self-described "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 – while still functioning in their employment and personal lives – our participants suggested a demographic more firmly entrenched or experienced in their drug use. This does not detract from the value of S-Check as a health service with a specialised understanding of and focus on stimulant use and modelled around the principle of harm reduction, hence making it unique in a number of ways from other services and attractive to a range of people at different points in their drug use trajectories. However, it does suggest that alternative delivery strategies – such as through primary care rather than a specialist drug and alcohol service – should be explored to attract a younger age group and to promote earlier intervention.

This research has evaluated a model of health service delivery specifically focussed on catering for people who primarily use stimulants. Clearly there were some initial problems, including client confusion about how the programme unfolds and the function of the initial intake. Similarly, there were some limitations with the data collected which consequently impacted on our evaluation. No data were collected about sexual identity; conclusions cannot be made on accessibility for potential target populations which is unfortunate given the high rates of use in some populations and the high number of LGBTI residents in the local area (mostly gay men) (Lea et al., 2016; Roxburgh, Lea, De Wit, & Degenhardt, 2016). Furthermore, data were not collected about referrals to other services after completing S-Check or was a structured follow up conducted a few months after completing the intervention. Hence, no conclusions can be drawn about the longer-term stimulant-related and other health outcomes for this group. Future research should address referrals and drug use pathways to assess the long-term health implications and service usage among stimulant users who access such brief interventions. Additionally, while stimulant use in Australia is nearing parity between men and women (Stafford & Burns, 2015), our findings suggest that the service attracted a majority (75%) of men. Without a non-service engaged comparison group, we cannot explain this observation.

Nonetheless the data from the clinic records as well as clients reports about the clinic are positive and encouraging, and indicate that a dedicated service for stimulant users based on a similar model to S-Check is valuable in attracting and retaining clients over a short period of time and has reported benefits for participants in relation to their drug practises. It would be useful to investigate alternative venues to deliver such a service model, for example, in community settings or through primary and sexual health services. This may make the service more accessible to people than a hospital-based clinic and may assist in improving service reach and in attracting treatment naïve people. This evaluation has shown that the S-Check model, with both medical and psychological components, enables the provision of at least some measure of all round health and well-being assessment along with information on how to manage harms associated with drug use to this group of stimulant drug users.

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Declaration of interest

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