S-Check: an innovative service model to attract stimulant users

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Outline

• Background
• Project
• Results
• Next steps
Stimulant use in Australia

Cocaine, MDMA, MA (2-3% adults used in the last 12 months)
MA most important from public health perspective
One of the highest rates of MA use in the world
No significant change since 1993
Form changed and frequency significantly increased compared with 2010
• Increase in the proportion of users daily or weekly (from 9.3% to 15.5%)
• Among crystal meth users (from 12.4% to 25.3%)
• Crystalline form (more concentrated) “ice” “crystal” more than doubled
Majority < once a month (70% MA –all forms, >80% for cocaine, MDMA)

Increased MA-related harms

- psychosis, depression, anxiety
- memory loss, cognitive deficits
- acute cardiovascular & cerebrovascular events
- cardiomyopathy, heart failure
- social, occupational, financial impacts
- associated risk behaviours: HIV, other blood-borne virus transmission, sexually transmitted infections
  - NSP data: HIV + 4% MA (1% heroin); 1/3 GBM HIV+
  - methamphetamine dependence – Australia one of the highest in the world
  - increased hospitalisations

Treatment

• Increased treatment demand (doubling from 2009 to 2014)
• Psychosocial interventions (CBT) modest effectiveness in reducing use and improving health and wellbeing
• No approved medications for methamphetamine withdrawal or dependence
• Low treatment utilisation
• Poor treatment engagement and retention
• Treatment seekers more likely to have riskier use, more severe use disorder and harms related to use
• Poorer treatment outcomes with higher baseline frequency of use
• Late treatment seeking
Up to 10 year treatment delay

Example of typical treatment seeker

Adapted from Lee et al 2012 Advances in Dual Diagnosis, 5(1):23-31
Tiered intervention framework


Population Impact

Severity of Disorder

Treatment

Early Intervention

Prevention

Promotion
S-Check Project

Time limited pilot

  Extends Smout (2010)

Advisory group

  consumer, sexual health, LGBTI, service providers, advocacy groups

Early intervention / harm reduction

  attract people not engaged in AOD treatment

Bio-psycho-social health ‘check-up’

  client-centred strengths & evidence-based

Target populations

  LGBTIQ communities, professional business, commercial transport

Smout et al DAR 2010 29(2); 169-176
S-Check Intervention

Session 1
Counsellor
- Psycho-social assessment
- K10, SDS

Session 2
Doctor
- Risk screen
- Pregnancy/BBVs/HIV/STIs, ECG etc
- Harm minimisation education

Session 3
Doctor
- Results
- Treatment / Referral

Session 4
Counsellor
- Feedback
- Goal Setting
- Information & Referral

Option for ongoing 3-month follow-up
Evaluation

April 2013 – May 2015

186 clients

36
years

(Median age)

Range

19 - 73

Male 75%

Female 25%

Employed

38%

43% 😊

25% 😞 p=0.005

Stable Accommodation

78%

83% 😊

64% 😞 p<0.001

32% self-referred

16% GP/psychologist

54%

no previous drug and alcohol treatment

Brener, Lea, Rance, Wilson, Bryant, Ezard, DEPP (in press)
Baseline use

<table>
<thead>
<tr>
<th>Current Problem Use</th>
<th>69% MA (69%) 9% Cocaine (9%) 9% MDMA (9%) 1% NPS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dependence</td>
<td>79% dependent (SDS ≥ 4) Median SDS = 8</td>
</tr>
<tr>
<td>No Problem Use</td>
<td>23% reported no problem use 51% of whom dependent using SDS</td>
</tr>
<tr>
<td>Use in last month</td>
<td>70% used in last month Median 12 days/last month (IQR 4 -20)</td>
</tr>
<tr>
<td>Primary Route</td>
<td>MA: smoke (64%) inject (33%) Cocaine: snort (92%)</td>
</tr>
</tbody>
</table>

## Baseline mental health & psychological distress

<table>
<thead>
<tr>
<th></th>
<th>n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ever diagnosed with mental health disorder(^a)</td>
<td>134 (72.0)</td>
</tr>
<tr>
<td>Current psychological distress</td>
<td></td>
</tr>
<tr>
<td>K10 score (M, SD)</td>
<td>27.8 (8.7)</td>
</tr>
<tr>
<td>High K10 score(^b)</td>
<td>62 (33.3)</td>
</tr>
<tr>
<td>Very high K10 score(^b)</td>
<td>77 (41.4)</td>
</tr>
<tr>
<td>Current suicidal thoughts or thoughts of self-harm</td>
<td>29 (15.6)</td>
</tr>
</tbody>
</table>

\(^a\)Excludes substance use disorders. \(^b\)K10 scores: high distress (score of 22-29), very high distress (score of 30-50).

## Risk behaviours

<table>
<thead>
<tr>
<th>Risk behaviour</th>
<th>n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ever shared drug equipment</td>
<td>117 (62.9)</td>
</tr>
<tr>
<td>Pipe</td>
<td>54 (29.0)</td>
</tr>
<tr>
<td>Snorting equipment (note, straw)</td>
<td>8 (4.3)</td>
</tr>
<tr>
<td>Injecting equipment (needle, syringe, ancillary equipment)</td>
<td>7 (3.8)</td>
</tr>
<tr>
<td>Ever driven while under the influence of psychostimulants</td>
<td>111 (59.7)</td>
</tr>
<tr>
<td>Ever engaged in crime or had contact with the police</td>
<td></td>
</tr>
<tr>
<td>While using</td>
<td>84 (45.2)</td>
</tr>
<tr>
<td>While not using</td>
<td>26 (14.0)</td>
</tr>
<tr>
<td>Ever engaged in unprotected sex or other risky sexual behaviours</td>
<td></td>
</tr>
<tr>
<td>While using</td>
<td>112 (60.2)</td>
</tr>
<tr>
<td>While not using</td>
<td>69 (37.1)</td>
</tr>
<tr>
<td>Ever engaged in sexual activity in exchange for money or drugs</td>
<td></td>
</tr>
<tr>
<td>While using</td>
<td>36 (19.4)</td>
</tr>
<tr>
<td>While not using</td>
<td>20 (10.8)</td>
</tr>
</tbody>
</table>
## Results

- **Participants (n)**

<table>
<thead>
<tr>
<th>Session 1</th>
<th>Session 2</th>
<th>Session 3</th>
<th>Session 4</th>
<th>3 or 6 month Follow-up</th>
</tr>
</thead>
<tbody>
<tr>
<td>186</td>
<td>151</td>
<td>105</td>
<td>109</td>
<td>14</td>
</tr>
</tbody>
</table>

Up to 30 days between Session 1 and Session 4

- **Retention**

- **58% attended all 4 sessions**
  - Older (median age 38 vs 34, p=0.01)
  - Lower self-report of problem use at BL (72% vs 84%, p=0.04)
  - Lower daily tobacco (46% vs 61%, p=0.04)

- **Participant ratings >90/100 for all sessions**
  - Relationship with clinician
  - Goals and topics covered
  - Approach or method of the clinician
  - Overall rating
Qualitative interviews with clients

Client feedback – harm reduction, non-judgmental

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

• “[not] just trying to tell me to stop” or “without it having to be well it’s illegal, so it shouldn’t be done” (Client 1)

• “you are not being told you are a f*cking idiot, stop taking drugs, it’s going to wreck your life” (Client 2)
Case study - Janos

Source: https://pixabay.com/
Case study - Cindy

Source: https://pixabay.com/
Case study - Adam

Source: https://pixabay.com/
Discussion

- Translational research approach – service success not based on health outcomes but on attendance
- Population similar to national population of at least weekly MA users in age, gender, employment status
- Half of participants were treatment naïve
- More than half of those who didn’t recognise problem use were dependent, similar to Melbourne out of treatment cohort

Smout et al DAR 2010; 29, 169-176. ; Lee DAR 2014; 33(S1),1–67;McKetin DAR 2013; 32. 80-87; Quinn et al IJDP 2013 24, 619-623.
Conclusions

Need for earlier intervention as part of spectrum of intervention options

- S-Check easy to administer, attractive and useful for clients and service providers.
- Delivered at scale, potential for value-for-money population level impact
Future directions

Adapt delivery model to address

• single session /modular approach
• promote earlier presentation
• risk reduction (eg sexual, crime)
• measure outcomes and cost-effectiveness
• expand coverage
• increase accessibility (geographic, cultural – diversity)
• increase uptake
Next steps

New technologies (scheck app)

Partnerships

- Sexual health / HIV services
- Primary care (PHNs)

Evaluation framework

- Process and outcome measures (substance use, risks, wellbeing, target populations)
- Cost-effectiveness
- Consumer engagement
Acknowledgements

Participants

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Brian Francis and the Scheck team

Centre for Social Research in Health UNSW - Loren Brener, Joanne Bryant, Hannah Wilson, Toby Lea, Jake Rance

Brendan Clifford
LIVE HARD?
LIVE FAST?
Live long...

...with a Regular Health Check specifically designed for people who use crystal and other stimulants (cocaine, speed, ice, ecstasy, MDMA)

SCheck: Stimulant Check-up
• PHYSICAL HEALTH • MENTAL HEALTH • SOCIAL & EMOTIONAL WELLBEING
Call 9361 8078 to make an appointment for a free, confidential check up with our specialist doctors and qualified clinicians.

NO REFERRAL NECESSARY

ST VINCENT’S HOSPITAL STIMULANT CHECK UP CLINIC IS A GLBT AFFIRMATIVE SERVICE
Feel free to pass this card on to partners, friends, family and colleagues who may benefit from a health check.