NATMS DATA SET K
BUSINESS DEFINITION FOR ADULT ALCOHOL TREATMENT PROVIDERS

Author J. Knight
Approver M. Roxburgh
Date 01/01/2013
Version 10.03
## REVISION HISTORY

<table>
<thead>
<tr>
<th>Version</th>
<th>Author</th>
<th>Purpose/Reason</th>
<th>Date</th>
</tr>
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<tr>
<td>5.00</td>
<td>A. Cooper</td>
<td>New business definition for providers of specialist treatment services for adult alcohol misusers Version 5 refers to NDTMS Data Set E</td>
<td>21/01/2008</td>
</tr>
<tr>
<td>5.30</td>
<td>G. Scott</td>
<td>Update external references</td>
<td>02/07/2008</td>
</tr>
<tr>
<td>6.00</td>
<td>J. Knight</td>
<td>Discharge Codes added, Parental Status Definitions Added</td>
<td>02/02/2009</td>
</tr>
<tr>
<td>6.10</td>
<td>R. Bull</td>
<td>Consolidation of earlier changes</td>
<td>16/02/2009</td>
</tr>
<tr>
<td>6.11</td>
<td>R. Bull</td>
<td>Miscellaneous non-substantive changes to eliminate inconsistencies and increase document usability</td>
<td>23/03/2009</td>
</tr>
<tr>
<td>7.01</td>
<td>J. Jaswani</td>
<td>Changes around Core Data Set ‘G’ – Additional items to be collected during the client’s treatment episode at triage: AUDIT Score Smoking Status Treatment Goal Days drinking more than binge limit</td>
<td>09/02/2010</td>
</tr>
<tr>
<td>7.02</td>
<td>J. Jaswani</td>
<td>Changes around Core Data Set ‘G’ – Removal of previously introduced data items to be collected during the client’s treatment episode at triage: AUDIT Score Smoking Status Treatment Goal Days drinking more than binge limit</td>
<td>01/03/2010</td>
</tr>
<tr>
<td>7.03</td>
<td>J. Jaswani</td>
<td>Local Agency Details – New local/regional field</td>
<td>05/03/2010</td>
</tr>
<tr>
<td>7.04</td>
<td>M. Hinchcliffe</td>
<td>Clarifying statement added to section 5 regarding Treatment Outcome Profile (TOP) and Alcohol Treatment Providers. Change to ‘PCT of residence’ data item description.</td>
<td>11/05/2010</td>
</tr>
<tr>
<td>7.05</td>
<td>M. Hinchcliffe</td>
<td>Appendix A; No. 22 &amp; 23 – “May be left blank if client has no second drug” removed for ‘Problem Substance No 2’ and ‘Problem Substance No 3’. ‘Children’ field added to data items with clarification: ‘The NTA understands that the children field is not part of the NATMS core data set, however it is expected that if a service’s clinical case management system supports the population of the field, then a response is provided if appropriate.’</td>
<td>03/09/2010</td>
</tr>
<tr>
<td>7.06</td>
<td>M. Hinchcliffe</td>
<td>Updated external links</td>
<td>14/10/2010</td>
</tr>
<tr>
<td>Section</td>
<td>Date</td>
<td>Author</td>
<td>Details</td>
</tr>
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<td>---------</td>
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<td>--------</td>
<td>-------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| 8.00    | 04/01/2011 | M. Hinchcliffe | The following fields have been updated to be mandatory and must be completed in all records:  
  - Client ID  
  - Episode ID  
  - Modality ID  
  - TOP ID  

  1 MUST be completed if any items in this section above are not null. If not, record rejected  

  New field added to Core Data Set for ‘GP Practice Code’. This field has been added to the data-set in order to support potential future reporting requirements from the NDTMS. Should this be required, further information regarding the validation and submission of GP practice codes will be issued. |
| 8.02    | 24/01/2011 | M. Hinchcliffe | Updated external references  
  1 ‘Local Authority’ field (previously a local field) is now part of the Core Data Set and is mandatory. ‘Local Authority’ must be completed in all records. |
| 8.03    | 01/03/2011 | M. Hinchcliffe | Definition for ‘Local Authority’ updated to:  
  The local authority in which the client currently resides (as defined by their postcode of their normal residence).  

  If a client states that they are of No Fixed Abode (denoted by having an Accommodation Need of NFA) then for Tier 3 agencies the Local Authority of the treatment provider should be used as a proxy; and for Tier 4 treatment providers the Local Authority of the referring partnership should be used as a proxy. |
| 10.01   | 6.07.12    | N. Ramnarine | Updated external links  
  Definitions of Interventions and Sub-Interventions added  
  Definitions of Time in Treatment added |
| 10.02   | 10.07.12   | N. Ramnarine | Updated following review |
| 10.03   | 31.01.2013 | D. Mhambi | CDS - K Benchmark update  
  6. Data Items, Sect No 2:  

  Discharge Reason  

  New discharge codes have been added to core dataset K specifically for residential rehabilitation and inpatient detox providers. These codes are to be used on or after the 1st April 2013.
Appendix F:

**Additional ‘transferred’ discharge codes for use by residential rehabilitation and inpatient detoxification providers only**

4 new ‘transferred’ discharge codes have been added to the dataset for use by residential rehabilitation and inpatient detox providers only in order for NDTMS to more accurately record the discharge status of clients leaving a residential or inpatient facility.

Residential and inpatient providers should use these codes instead of the ‘transferred’ codes above. Unlike the existing ‘transferred’ discharge codes, that record the status of a client with the treatment system at the point of discharge from a provider, the residential and inpatient codes additionally record the outcome of the residential programme and what further structured interventions are required.

This allows residential and inpatient providers to record where clients have successfully completed the treatment programme and have been transferred for continued structured treatment at another provider at either at a second stage residential provider or at a community provider.

This may be the case for clients at residential and inpatient services that have been commissioned to provide treatment as a part of a longer treatment journey. The previous datasets recorded this as a ‘transferred on’, which did not capture information that the client has successfully completed that part of their treatment journey at the residential or inpatient provider.

**Data item name** – Transferred – treatment programme completed at the residential/inpatient provider - additional residential treatment required

**Data item definition** – The client has completed the structured treatment programme at the provider by meeting the goals of their care plan. Although they have finished treatment at this provider they still require continued structured treatment interventions and have been transferred to an alternative residential provider for this. This code should only be used if there is an appropriate referral path and care planned structured treatment pathways are available

**Data item name** – Transferred – treatment programme completed at the residential/inpatient provider – additional community treatment required

**Data item definition** - The client has completed the structured treatment programme at the provider by meeting the goals of their care plan. Although they have finished treatment at this provider they still require continued structured treatment interventions and have been transferred to an alternative community provider for this. This code should only be used if there is an appropriate referral path and care planned structured
Data item name – treatment programme not completed at the residential/inpatient provider – additional residential treatment required

Data item definition - The client has not completed the structured treatment programme at the provider because they have not met the goals of their care plan. They require continued structured treatment interventions and have been referred to an alternative residential provider for this. This code should only be used if there is an appropriate referral path and care planned structured treatment pathways are available

Data item name – treatment programme not completed at the residential/inpatient provider – additional community treatment required

Data item definition - The client has not completed the structured treatment programme at the provider because they have not met the goals of their care plan. They require continued structured treatment interventions and have been referred to an alternative community provider for this. This code should only be used if there is an appropriate referral path and care planned structured treatment pathways are available
### EXTERNAL REFERENCES

<table>
<thead>
<tr>
<th>Ref No</th>
<th>Title</th>
<th>Version</th>
</tr>
</thead>
<tbody>
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<td>1</td>
<td>NDTMS Data Set - Technical Definition</td>
<td>10.04</td>
</tr>
<tr>
<td>2</td>
<td>NDTMS Data Set - Reference Data</td>
<td>10.08</td>
</tr>
<tr>
<td>3</td>
<td>An Implementation Guide to Core Dataset J</td>
<td>1.00</td>
</tr>
<tr>
<td>4</td>
<td>2006-07 WT guidance</td>
<td>Nov 2005</td>
</tr>
</tbody>
</table>

This document uses the convention that any external references are indicated by square brackets e.g. [3].
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1 INTRODUCTION

Specialist alcohol treatment data was incorporated into the National Drug Treatment Monitoring System (NDTMS) from 1st April 2008.

This document sets out, at a business level, the set of performance data items (known as the National Alcohol Treatment Monitoring System (NATMS) Data Set) collected and utilised by the NDTMS, and the specific items from the full NDTMS data set that are required from alcohol treatment providers.

In support of evolving business requirements, the data items collected by the NDTMS Programme are reviewed on an annual basis.

This version (commonly referred to as the NDTMS Core Data Set 'K') will come into effect for national data collection from 1st April 2013.

This document contains definitions that are primarily applicable to use with clients aged 18 or over, more relevant definition and revisions for use with Young People are available at http://www.nta.nhs.uk/core-data-set.aspx.

The NDTMS itself is scoped at capturing performance data on clients who reach the assessment/triage stage at the treatment provider which generates the report.

This document should not be interpreted as a technical statement - it is intended to serve the business perspective of what data will be so managed. From this document, the technical specification\(^1\) will be derived and established as described in Ref [1].

Code sets for the data items listed in this document are provided in Ref [2]. Both documents are available from the NTA web site, see link above.

A companion document – 'An implementation guide to core dataset J' Ref [3] has been produced to explain in more detail the significant changes that have been introduced in this dataset change. It also contains various implementation examples and scenarios.

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\(^1\) The technical specification extends the scope of the data beyond that referenced in this document, to include items of a purely technical nature, which may be used to support operational and/or qualitative requirements.
2 REQUIREMENTS

The collection of data on specialist treatment for alcohol misuse enables national, regional and local-level reporting on alcohol treatment to support the National Alcohol Strategy and needs analysis.

Data reporting facilitates policy formulation and supports the development of efficient commissioning systems at a local level.

It is anticipated that performance measures for alcohol treatment will be developed once comprehensive data collection has been implemented across England, for example:

- Numbers in treatment
- Waiting times
- Successful completions of treatment
3 CARERS, RELATIVES AND CONCERNED others
REPORTING THE NATMS DATA SET TO THE NDTMS

NDTMS is currently designed only to receive details of the treatment episodes of problematic drug and alcohol users. Some providers have been reporting work that they have been doing with carers/parents (commonly coding it as Other Structured Intervention).

Details of carer interventions should not be reported to NDTMS and providers should remove any such records at the next opportunity.
4 DATA ENTITIES

The data items (listed later in this document) may be considered as belonging to one of seven different entities or groups. These are:

- Client details
- Episode details (including client details which may vary over time)
- Time in treatment
- Treatment intervention (modality) details
- Sub intervention details
- Treatment Outcomes Profile (TOP) details
- Local (i.e. regional) fields whose usage will depend on regional requirement

The following section lists all data items in the NATMS Data Set. Adult Alcohol Treatment Providers new to NDTMS should collect at least the Alcohol Subset (i.e. the data items listed in this document) and are encouraged to collect the other data items (listed in Ref[2]) where relevant.

Providers currently reporting to the NDTMS should continue to provide all items of the NDTMS Data Set for their alcohol clients.
5 TREATMENT OUTCOME PROFILES (TOP)

The TOP was developed as a clinical outcome monitoring tool suitable for drug misuse treatment.

Because there is not the same professional consensus that TOP is an equally suitable clinical outcome tool for alcohol treatment, TOP returns have never been required within the NATMS guidance, even though the option to provide such returns was made available to practitioners.

The data that has been provided at a national level to date will be analysed to make use of any learning from the returns, although this dataset cannot be validly analysed down to a local level.
## DATA ITEMS

<table>
<thead>
<tr>
<th>Sect No</th>
<th>Item</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Initial of client’s first name</td>
<td>The first initial of the client’s first name – for example Max would be ‘M’</td>
</tr>
<tr>
<td></td>
<td>Initial of client’s surname</td>
<td>The first initial of the client’s surname – for example Smith would be ‘S’, O’Brian would be ‘O’ and McNeil would be ‘M’.</td>
</tr>
<tr>
<td></td>
<td>Date of birth of client</td>
<td>The day, month and year that the client was born.</td>
</tr>
<tr>
<td></td>
<td>Sex of client</td>
<td>The client gender at registration</td>
</tr>
<tr>
<td></td>
<td>Ethnicity</td>
<td>The ethnicity that the client states as defined in the OPCS census categories. If a client declines to answer then ‘not stated’ should be used, if a client is not asked then the field should be left blank.</td>
</tr>
<tr>
<td>2</td>
<td>Referral Date</td>
<td>The date that the client was referred to the agency for this episode of treatment – for example it would be the date a referral letter was received, the date a referral phone call or fax was received or the date the client self-referred. For Scenario examples and how this data is used in waiting times calculations please see APPENDIX B.</td>
</tr>
<tr>
<td></td>
<td>Agency Code</td>
<td>An unique identifier for the Treatment provider (agency) that is defined by the regional NDTMS centers – for example L0001</td>
</tr>
<tr>
<td></td>
<td>Client Reference</td>
<td>A unique number or ID allocated by the treatment provider to a client. The client reference should remain the same within a treatment provider for a client during all treatment episodes. (NB: this must not hold or be composed of attributors which might identify the individual)</td>
</tr>
<tr>
<td></td>
<td>Client ID</td>
<td>A mandatory, technical identifier representing the client, as held on the clinical system used at the agency (treatment provider). (NB: this should be a technical item, and must not hold or be composed of attributors, which might identify the individual). A possible implementation of this might be the row number of the client in the client table.</td>
</tr>
<tr>
<td></td>
<td>Episode ID</td>
<td>A mandatory, technical identifier representing the episode, as held on the clinical system used at the treatment provider (NB: this should be a technical item, and should not be composed of attributors, which might identify the individual). A possible implementation of this might be the row number of the episode in the episode table.</td>
</tr>
</tbody>
</table>
### Consent for NDTMS
Whether the client has agreed for their data to be shared with regional NDTMS teams and the NTA. Informed consent must be sought from all clients and this field needs to be completed for all records triaged after 1st April 2006. It does not need to be completed for clients triaged before this date (it is assumed that all records previously returned have been consented for).

### Postcode
The postcode of the client’s place of residence. Depending upon regional preference regarding client confidentiality, this postcode may or may not be truncated, by removing the final two characters of the postcode (for example ‘NR14 7UJ’ would be truncated to ‘NR14 7’).

If a client states that they are of No Fixed Abode (denoted by having an Accommodation Need of NFA) the postcode should be left blank.

### Parental Status
The parental status of the client – whether or not the client has children, whether none of, some of or all of the children live with the client.
A child is a person who is under 18 years old. See APPENDIX G for revised data items and definitions.

### Children
The number of children under 18 that live in the same household as the client at least 1 night a week. The client does not necessarily need to have parental responsibility for the children. Where the client declined to answer, code ‘98’ is used.

The NTA understands that the children field is not part of the NATMS core data set, however it is expected that if a service’s clinical case management system supports the population of the field, then a response is provided if appropriate.

### DAT of residence
The Drug Action Team (or partnership area) in which the client normally resides (as defined by their postcode of their normal residence).

If a client states that they are of No Fixed Abode (denoted by having an Accommodation Need of NFA) then for Tier 3 agencies the Partnership (DAT) of the treatment provider should be used as a proxy; and for Tier 4 treatment providers the DAT of the referring partnership should be used as a proxy.

Note - although the Accommodation Need is the status at the start of the episode, the DAT of Residence is the current situation.

### PCT of residence
The Primary Care Trust in which the client normally resides (as defined by their postcode of their normal residence). (A DAT partnership area sometimes spans more than one PCT area, also a PCT area may span more than one DAT area.)

If a client states that they are of No Fixed Abode (as denoted by having an Accommodation Need of NFA) then, for tier 3 agencies, the PCT of the treatment provider should be used as a proxy and, for tier 4 treatment providers, PCT can be left blank. Note although the Accommodation Need is the status at the start of the episode, the PCT is the current situation.
<table>
<thead>
<tr>
<th>GP Practice Code</th>
<th>This field has been added to the data-set in order to support potential future reporting requirements from the NDTMS. Should this be required, further information regarding the validation and submission of GP practice codes will be issued.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Local Authority</td>
<td>The local authority in which the client currently resides (as defined by their postcode of their normal residence). If a client states that they are of No Fixed Abode (denoted by having an Accommodation Need of NFA) then for Tier 3 agencies the Local Authority of the treatment provider should be used as a proxy; and for Tier 4 treatment providers the Local Authority of the referring partnership should be used as a proxy. Note - although the Accommodation Need is the status at the start of the episode, the Local Authority is the current situation.</td>
</tr>
<tr>
<td>Problem Substance No. 1</td>
<td>The substance that brought the client into treatment at the point of triage/initial assessment, even if they are no longer actively using this substance. If a client presents with more than one substance the agency is responsible for clinically deciding which substance is primary. ‘Poly drug’ should no longer be used in this field; instead the specific substances should be recorded in each of the problem substance fields.</td>
</tr>
<tr>
<td>Problem Substance No. 2</td>
<td>An additional substance that brought the client into treatment at the point of triage/initial assessment, even if they are no longer actively using this substance. ‘Poly drug’ should no longer be used in this field; instead the specific substances should be recorded in each of the problem substance fields.</td>
</tr>
<tr>
<td>Problem Substance No. 3</td>
<td>An additional substance that brought the client into treatment at the point of triage/initial assessment, even if they are no longer actively using this substance. ‘Poly drug’ should no longer be used in this field; instead the specific substances should be recorded in each of the problem substance fields.</td>
</tr>
<tr>
<td>Referral Source</td>
<td>The source or method by which a client was referred for this treatment episode. A valid referral source code should be used as defined in the NDTMS Data Set - Reference Data [2].</td>
</tr>
<tr>
<td>Triage Date</td>
<td>The date that the client made a first face to face presentation to this treatment provider. This could be the date of triage/initial assessment though this may not always be the case.</td>
</tr>
<tr>
<td>Care Plan Started Date</td>
<td>Date that a care plan was created and agreed with the client for this treatment episode.</td>
</tr>
<tr>
<td>Drinking days</td>
<td>Number of days in the 28 days prior to initial assessment that the client consumed alcohol</td>
</tr>
</tbody>
</table>
Units of alcohol | Typical number of units consumed on a drinking day in the 28 days prior to initial assessment

Discharge Date | The date that the client was discharged ending the current structured (Tier 3/Tier 4) treatment episode. If a client has had a planned discharge then the date agreed within this plan should be used. If a client’s discharge was unplanned then the date of last face-to-face contact with the treatment provider should be used. If a client has had no contact with the treatment provider for two months then for NDTMS purposes it is assumed that the client has exited treatment and a discharge date should be returned at this point using the date of the last face-to-face contact with the client. It should be noted that this is not meant to determine clinical practice and it is understood that further work beyond this point to re-engage the client with treatment may occur.

Discharge Reason | The reason why the client’s episode of structured treatment was ended. A valid discharge reason code should be used as defined in APPENDIX C.

New discharge codes have been added to core dataset K specifically for residential rehabilitation and inpatient detox providers.

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<table>
<thead>
<tr>
<th>Sect No</th>
<th>Item</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>Time in Treatment Assessment date</td>
<td>The date that the Time in Treatment will commence from. Where this is a first occurrence, the date field should be populated with the modality start date of the first structured intervention, all subsequent occurrences should capture the date at which there was a change in the time in treatment threshold.</td>
</tr>
<tr>
<td></td>
<td>Time in Treatment</td>
<td>The time per week that the client will be spending in the entire treatment episode, while the client remains in structured treatment. This will take into account the time receiving any combination of pharmacological, Psychosocial and Recovery Support interventions. If a client is only receiving recovery support then the time in treatment is not expected to be returned. See Appendix I for the definitions of Time in Treatment</td>
</tr>
<tr>
<td>4</td>
<td>Treatment Modality</td>
<td>The treatment modality/intervention a client has been referred for/commenced within this treatment episode as defined in appendix C of this document and as explained in more detail in the Implementation Guide to Core Dataset J document [Ref 3] A valid treatment modality code should be used as defined in Ref [2]. The NDTMS Data Set - Reference [2] contains two sets of reference data for Treatment modality, to cater for those providing services to Adults and Young Persons. A client may have more than one treatment modality running sequentially or concurrently within an episode and may have more than one set of the same type running concurrently as long as the setting in each are different Current definitions and name changes for all structured modalities/interventions can be found in APPENDIX B .</td>
</tr>
<tr>
<td>Sect No</td>
<td>Item</td>
<td>Description</td>
</tr>
<tr>
<td>---------</td>
<td>-----------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td>Setting</td>
<td>The setting that this intervention is being provided in, if the setting differs from the one that the treatment provider is registered under in the agency table. If the setting of the intervention is the same as that registered then this field must be left blank. See Appendix H for a definition of the different setting types.</td>
</tr>
<tr>
<td></td>
<td>Date Referred to Modality</td>
<td>The date that it was mutually agreed that the client required this modality/intervention of treatment. For the first modality/intervention in an episode, this should be the date that the client was referred into the treatment system requiring a structured modality/intervention. For subsequent modalities, it should be the date that both the client and the keyworker agreed that the client is ready for this modality/intervention. For scenario examples, and how this date is used in waiting times, calculations please see appendix B of this document.</td>
</tr>
<tr>
<td></td>
<td>Date of First Appointment Offered for Modality</td>
<td>The date of the first appointment offered to commence this modality/intervention. This should be mutually agreed to be appropriate for the client. The current definition of when a modality commences can be found in Error! Reference source not found.</td>
</tr>
<tr>
<td></td>
<td>Modality Start Date</td>
<td>The date that the stated treatment modality/intervention commenced i.e. the client attended for the appointment. The current definition of when a modality commences can be found in APPENDIX B of this document</td>
</tr>
<tr>
<td></td>
<td>Modality Exit Status</td>
<td>Whether the exit from the treatment modality was planned or unplanned.</td>
</tr>
<tr>
<td>5</td>
<td>Sub Intervention Assessment Date</td>
<td>The date that the Sub Intervention Review was completed</td>
</tr>
<tr>
<td></td>
<td>Sub Interventions Received</td>
<td>The Sub Interventions that have been received since the previous review had been completed. If it is the first review then it will be the sub interventions since the client commenced their latest treatment journey. If is the first review for a client already in treatment on the 1st November 2012, then it will be the Sub Interventions that have been received since then. Sub Interventions should be submitted at a minimum of every six months while a client remains in one or more of the three high level intervention types. If a client ends any of the three high level interventions before six months then the sub interventions should be returned at the time of them finishing. See Appendix C for the Sub Intervention Types</td>
</tr>
</tbody>
</table>
## APPENDIX A  WHAT DATA ITEMS SHOULD BE UPDATED AS AN EPISODE OF TREATMENT PROGRESSES

<table>
<thead>
<tr>
<th>Sect No</th>
<th>No</th>
<th>Field Description</th>
<th>Rules &amp; Guidance</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1</td>
<td>Initial of Client’s First Name</td>
<td>✓ MUST be completed. If not, record rejected. Should not change – otherwise the regional NDTMS team should be formally advised</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>Initial of Client’s Surname</td>
<td>✓ MUST be completed. If not, record rejected. Should not change – otherwise the regional NDTMS team should be formally advised</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>Date of birth of client</td>
<td>✓ MUST be completed. If not, record rejected. Should not change – otherwise the regional NDTMS team should be formally advised</td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>Sex of client</td>
<td>✓ MUST be completed. If not, record rejected. Should not change – otherwise the regional NDTMS team should be formally advised</td>
</tr>
<tr>
<td></td>
<td>5</td>
<td>Ethnicity</td>
<td>Should not change.</td>
</tr>
<tr>
<td>2</td>
<td>6</td>
<td>Referral Date</td>
<td>✓ MUST be completed. If not data may be excluded from performance monitoring. Should not change – otherwise the regional NDTMS team should be formally advised</td>
</tr>
<tr>
<td></td>
<td>7</td>
<td>Agency Code</td>
<td>✓ MUST be completed. If not, record rejected. Should not change – otherwise the regional NDTMS team should be formally advised</td>
</tr>
<tr>
<td></td>
<td>8</td>
<td>Consent for NDTMS</td>
<td>✈ Client must give consent before their information can be sent to NDTMS. May change (i.e. current situation)</td>
</tr>
<tr>
<td>3</td>
<td>9</td>
<td>Post Code</td>
<td>May change (i.e. current living situation).</td>
</tr>
<tr>
<td>4</td>
<td>10</td>
<td>Local Authority</td>
<td>NOW PART OF CORE DATA SET ✓ MUST be completed. If not, record rejected. May change (i.e. current living situation)</td>
</tr>
<tr>
<td>5</td>
<td>11</td>
<td>Parental Status</td>
<td>Not expected to change (i.e. as at start of Episode)</td>
</tr>
<tr>
<td>6</td>
<td>12</td>
<td>DAT of residence</td>
<td>✓ MUST be completed. If not data may be excluded from performance monitoring. May change (i.e. current living situation)</td>
</tr>
</tbody>
</table>
### Business Definition for Adult Alcohol Treatment Providers

<table>
<thead>
<tr>
<th>Column 1</th>
<th>Column 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>13</td>
<td>PCT of residence</td>
</tr>
<tr>
<td></td>
<td>✓ MUST be completed. If not data may be excluded from performance monitoring. May change (i.e. current living situation)</td>
</tr>
<tr>
<td>14</td>
<td>GP Practice Code</td>
</tr>
<tr>
<td></td>
<td>May change (i.e. current living situation)</td>
</tr>
<tr>
<td>15</td>
<td>Problem Substance No 2</td>
</tr>
<tr>
<td></td>
<td>Not expected to change (i.e. as at start of Episode)</td>
</tr>
<tr>
<td>16</td>
<td>Problem Substance No 3</td>
</tr>
<tr>
<td></td>
<td>Not expected to change (i.e. as at start of Episode)</td>
</tr>
<tr>
<td>17</td>
<td>Referral Source</td>
</tr>
<tr>
<td></td>
<td>Not expected to change (i.e. as at start of Episode)</td>
</tr>
<tr>
<td>18</td>
<td>Triage Date</td>
</tr>
<tr>
<td></td>
<td>✓ Trigger to submit record and MUST be completed. If not, record rejected</td>
</tr>
<tr>
<td></td>
<td>Not expected to change (i.e. as at start of Episode)</td>
</tr>
<tr>
<td>19</td>
<td>Care Plan Started Date</td>
</tr>
<tr>
<td></td>
<td>✓ MUST be completed when Modality Start date is given. Discharge date MUST be given.</td>
</tr>
<tr>
<td></td>
<td>Not expected to change (i.e. as at start of Episode)</td>
</tr>
<tr>
<td>20</td>
<td>Children</td>
</tr>
<tr>
<td></td>
<td>Not expected to change (i.e. as at start of Episode)</td>
</tr>
<tr>
<td>21</td>
<td>Drinking Days</td>
</tr>
<tr>
<td></td>
<td>Not expected to change (i.e. as at start of Episode)</td>
</tr>
<tr>
<td>22</td>
<td>Units of Alcohol</td>
</tr>
<tr>
<td></td>
<td>Not expected to change (i.e. as at start of Episode)</td>
</tr>
<tr>
<td>23</td>
<td>Discharge Date</td>
</tr>
<tr>
<td></td>
<td>☀ Discharge date required when client is discharged. Discharge date MUST be given.</td>
</tr>
<tr>
<td></td>
<td>Should only change from 'null' to populated as episode progresses.</td>
</tr>
<tr>
<td>24</td>
<td>Discharge Reason</td>
</tr>
<tr>
<td></td>
<td>☀ Discharge reason required when client is discharged. Discharge date MUST be given.</td>
</tr>
<tr>
<td></td>
<td>Should only change from 'null' to populated as episode progresses.</td>
</tr>
<tr>
<td>25</td>
<td>Time in Treatment Assessment Date</td>
</tr>
<tr>
<td></td>
<td>Must be completed for each time in treatment return. Should not change – otherwise the regional NDTMS team should be advised</td>
</tr>
<tr>
<td>26</td>
<td>Time in treatment</td>
</tr>
<tr>
<td></td>
<td>Not expected to change (i.e. as at Time in Treatment date)</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
</tbody>
</table>
| 4 | 27 | Treatment Modality | Required as soon as the modality is known.  
Should not change – otherwise the regional NDTMS team should be formally advised |
| 28 | Date Referred to Modality | Waiting times calculated from this field. MUST be completed for new presentations/modalities.  
Should not change – otherwise the regional NDTMS team should be formally advised |
| 29 | Setting | Not expected to change (i.e. as at Modality Start date) |
| 31 | Date of First Appointment Offered for Modality | Waiting times calculated from this field.  
Should not change |
| 32 | Modality Start Date | Required when the client actually starts the modality.  
Trigger for waiting time to be calculated  
Should only change from 'null' to populated as episode progresses |
| 33 | Modality End Date | Required when the client completes a modality or is discharged.  
Should only change from 'null' to populated as episode progresses |
| 34 | Modality Exit Status | Required when client completes a modality or is discharged.  
Should only change from 'null' to populated as episode progresses |
| 5 | 35 | Sub Intervention Assessment Date | Must be completed each time a Sub Intervention Review is completed. Should not change – otherwise the regional NDTMS team should be informed. |
|     | 36 | Sub Interventions Received | Not expected to change (i.e. as at Sub Intervention Review date) |

Where items are designated as ‘not expected to change’ this does not include corrections or moving from a null in the field to it being populated.
APPENDIX B  SCENARIOS AND EXAMPLES

B.1 WAITING TIMES MEASUREMENT WITHIN NDTMS – KEY POINTS

- All waiting times are measured in calendar days
- The agency referral date’ recorded by a treatment provider may be later than the ‘date referred to modality’ if the initial contact of a client entering the treatment system is a third party treatment provider. This is because the wait for the client is now being measured across the treatment system.
- The date of ’1st appointment offered for modality’ may be a future date, but the waiting times will only be calculated when a client actually commences a modality i.e. when the modality start date is present in the data.
- Waiting times will be reported at both a treatment system and treatment provider level. For the treatment system it will be calculated from the ‘date referred to modality’ to the ’1st appointment offered for modality’ for all modalities/ interventions. For a treatment provider it will be the ’(agency) referral date’ / ‘date referred to modality’ (whichever is later) to the ’1st appointment offered to modality’ for the earliest modality/ intervention in an episode and then the ‘date referred to modality’ to the ’1st appointment offered for modality’ for all subsequent modalities/ interventions.
B.2 WAITING TIMES SCENARIO 1 – SELF REFERRAL

Key point – the ‘agency referral date’ and the ‘date referred to modality’ are the same.

Client self refers to Agency (Treatment Provider) A
01/04/06 after initial assessment it is agreed client requires prescribing

Mutually agreed 1st Appointment for prescribing 15/04/06

Client DNAs first appointment offered and attends subsequent appointment 22/04/06

Records returned to NDTMS:
(Agency) Referral Date - 01/04/06
Date referred to modality – 01/04/06
Modality Type – Specialist Prescribing

Record returned to NDTMS:
Date of 1st Appointment offered for modality – 15/04/06

Record returned to NDTMS:
Modality Start Date – 22/04/06

Waiting Times calculated:
For Partnership – 01/04/06 to 15/04/06 = 14 days
For Agency A – 01/04/06 to 15/04/06 = 14 days
B.3 WAITING TIMES SCENARIO 2 – REFERRAL FROM A THIRD PARTY TREATMENT PROVIDER

**Key point** – the agency ‘referral date’ is after the ‘date referred to modality’. The ‘date referred to modality’ that is used reflects the clients experience of when the wait started.

Client attends triage gateway service. Agreed Tier 3 Specialist Prescribing required \(06/04/06\)

Referral received by Treatment provider A \(08/04/06\) and client presents for treatment \(10/04/06\)

Mutually agreed 1st Appointment for prescribing \(20/04/06\)

Client DNAs first appointment offered and attends subsequent appointment \(27/04/06\)

No data returned to NDTMS by gateway service, but referral made to Treatment provider A

Records returned to NDTMS:
(Treatment provider) Referral Date - 08/04/06
Date referred to modality – 06/04/06
Modality Type – Specialist Prescribing
Note 06/04/06 used as date referred into the treatment system

Record returned to NDTMS:
Date of 1st Appointment offered for modality – 20/04/06

Record returned to NDTMS:
Modality Start Date – 27/04/06

Waiting Times calculated:
For Partnership – 06/04/06 to 20/04/06 = 14 days
For Agency A – 08/04/06 to 20/04/06 = 12 days
Note the referral date is used to calculate the agency waiting time
B.4 WAITING TIMES SCENARIO 3 – TIER 4

Key point – the wait for residential rehab begins when it has been agreed that the client will be referred for funding.

Client attending Tier 3
Community service Treatment provider A receiving Specialist Prescribing

Mutually agreed with client and keyworker that client ready for Residential Rehab and that they will be referred for funding
06/04/06

Referral made to Rehab
Treatment provider B, received by Treatment provider B
08/04/06

Records returned to NDTMS by Treatment provider B:
(Agency) Referral Date - 08/04/06
Date referred to modality – 06/04/06
Modality Type – Residential Rehab
Note 06/04/06 used as date agreed client would be referred for funding

Mutually agreed 1st Appointment for Residential Rehab 22/04/06

Record returned to NDTMS by Treatment provider B:
Date of 1st Appointment offered for modality – 22/04/06

Client attends and admitted into Residential Rehab at agency B
22/04/06

Record returned to NDTMS by Treatment provider B:
Modality Start Date – 22/04/06

Waiting Times calculated:
For Partnership – 06/04/06 to 22/04/06 = 16 days
For Treatment provider B – 08/04/06 to 22/04/06 = 14 days
B.5 WAITING TIMES SCENARIO 4 – PRISON REFERRALS

Key point – the waiting time begins once the client has been released and is available for treatment.

Client currently in prison referred to agency C. 01/04/06

Agreed client requires Structured Day Programme at Treatment provider C. Prison release date 01/05/06

Client offered appointment for Structured Day Programme for 10/05/06

Record returned to NDTMS by Treatment provider C:
- Referral date 1/4/06
- Referred to Modality date 1/5/06

Records returned to NDTMS by Treatment provider C:
- Date of 1st Appointment offered for modality – 10/05/06

Client exits prison 01/05/2006 and attends Structured Day Programme 10/05/06

Record returned to NDTMS by Treatment provider C:
- Modality Start Date – 10/05/06

Waiting Times calculated:
For Partnership – 01/05/06 to 10/05/06 = 9 days
For Treatment provider C – 01/05/06 to 10/05/06 = 9 days

Note the date referred to modality is used to calculate Treatment provider waiting time.
B.6 WAITING TIMES FOR SCENARIO 5 – SUBSEQUENT WAIT WITHIN AN EPISODE

Key point – the wait for a subsequent intervention within an episode should begin when both the client and keyworker agree that client is ready.

Client currently in Specialist Prescribing at Treatment provider D

Mutually agreed 01/05/06 client requires Structured Day Programme. This intervention also offered by Treatment provider D.

Records returned to NDTMS by Treatment provider D – second modality record:
- Date referred to modality – 01/05/06
- Modality Type – Structured Day Programme

Client offered appointment for Structured Day Programme for 20/05/06

Records returned to NDTMS by Treatment provider C:
- Date of 1st Appointment offered for modality – 20/05/06

Client attends Structured Day Programme appointment 20/05/06

Record returned to NDTMS by Treatment provider C:
- Modality Start Date – 20/05/06

Waiting Times calculated for subsequent intervention:
- For Partnership – 01/05/06 to 20/05/06 = 19 days
- For Treatment provider D – 01/05/06 to 20/05/06 = 19 days
B.7 WAITING TIMES SCENARIO 6 – MEASURING INPATIENT DETOXIFICATION AND RESIDENTIAL REHABILITATION AS A PACKAGE

Client agrees with key worker in Tier 3 that package of Inpatient Detoxification (IpD) AND Residential Rehabilitation (RR) is required. Funding for RR is applied for on 1/9/06

Funding application accepted and key worker notifies the client, IpD and RR agencies on 12.9.06. Referral letters received by agencies 14/9/06

Client commences inpatient detoxification at on 19/9/06

Client successfully completes inpatient detoxification 19/10/06. Client starts RR at Agency C on 23/10/06

Waiting times calculated:
For partnership IPD = 7 days
For IPD agency = 5 days
For partnership RR = 18 days
For RR agency = 5 days

Records returned to NDTMS:
RR agency report Date Referred to Modality as 1/9/06

Records returned to NDTMS:
IpD agency reports Date Referred to Modality as 12/9/06. IpD and RR report (Agency) Referral Date as 14/9/06

Records returned to NDTMS:
IPD agency Date of 1st appointment offered for modality and Modality Start Date as – 19/9/06
RR agency reports Date of 1st Appointment Offered as 19/9/06

Records returned to NDTMS:
RR agency reports Date Referred to Modality as 1/9/06

Records returned to NDTMS:
IpD agency reports Date Referred to Modality as 12/9/06. IpD and RR report (Agency) Referral Date as 14/9/06
APPENDIX C  DEFINITIONS OF INTERVENTIONS AND SUB INTERVENTIONS


C1 - Pharmacological

The psychosocial interventions that are integral to a service user’s pharmacological intervention are now reported separately from the pharmacological intervention itself - as interventions within the psychosocial intervention type. This should not be taken to suggest that these are not still core elements of the pharmacological interventions.

This change does enable the basis of the pharmacological intervention to be reported for the pharmacological intervention – as defined below.

It also means that the psychosocial returns will include all psychosocial interventions provided, whether integral to the pharmacological intervention, additional to the pharmacological intervention, or provided in the absence of a pharmacological intervention.

Therefore, in addition to completing Section 3 concerning pharmacological interventions, all specific structured psychosocial intervention(s) delivered as integral to or alongside prescribing should be reported through Section 4 ‘psychosocial’ returns. Recovery support interventions which are integral to or alongside pharmacological and/or psychosocial interventions should also be recorded, through section 5, ‘recovery support’.

<table>
<thead>
<tr>
<th>Basis of pharmacological intervention</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessment &amp; Stabilisation</td>
<td>Prescribing of a receptor agonist (such as methadone), or partial agonist (such as buprenorphine), or other pharmacotherapy specific to substance misuse, to stabilise use of illicit drug(s), following and alongside continuing appropriate assessment. It also includes re-induction onto opioid substitution treatment prior to prison release, in the limited circumstances where this is appropriate.</td>
</tr>
<tr>
<td>Maintenance</td>
<td>Prescribing of substitute medications under a stable dose regimen to medically manage physiological dependence and minimise illicit drug use. Maintenance prescribing may be provided to support the individual in achieving or sustaining medication assisted recovery.</td>
</tr>
<tr>
<td>Withdrawal</td>
<td>Prescribing of an agonist or partial agonist or other medication, usually up to 12 weeks and 28 days as an inpatient, to facilitate medically-supervised assisted withdrawal and to manage withdrawal symptoms. Prescribing of benzodiazepines and/or other medication for the management of alcohol withdrawal.</td>
</tr>
<tr>
<td>Relapse prevention</td>
<td>Prescribing medication for drug and/or alcohol relapse prevention support (such as naltrexone as part of opioid relapse prevention therapy; or naltrexone, acamprosate or disulfiram as part of alcohol use disorder relapse prevention therapy).</td>
</tr>
</tbody>
</table>
C2 - Psychosocial

The psychosocial intervention field and its sub-interventions should be used by both prescribing and non-prescribing services. They should be used to report structured psychosocial interventions delivered alone, as well as psychosocial interventions integrated with or additional to a pharmacological modality/intervention.

Recovery support interventions that are integral to or provided alongside a pharmacological intervention and/or psychosocial interventions should also be recorded using recovery support intervention codes.

<table>
<thead>
<tr>
<th>Type</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Motivational interventions</td>
<td>Motivational interventions aim to help service users resolve ambivalence for change, and increase intrinsic motivation for change and self-efficacy through a semi-directive style and may involve normative feedback on problems and progress. They may be focused on substance specific changes and/or on building recovery capital. Motivational interventions can be delivered in groups or one-to-one and may involve the use of mapping tools. Motivational interventions require competences over and above those required for keyworking, and delivery within a clinical governance framework that includes appropriate supervision. Motivational interviewing and motivational enhancement therapy are both forms of motivational interventions.</td>
</tr>
<tr>
<td>Contingency management</td>
<td>Contingency management (CM) provides a system of reinforcement or incentives designed to motivate behaviour change and/or facilitate recovery. CM aims to make target behaviours (such as drug use) less attractive and alternative behaviours (such as abstinence) more attractive. CM requires competences over and above those required for keyworking, and delivery within a clinical governance framework that includes appropriate supervision.</td>
</tr>
<tr>
<td>Family and social network interventions</td>
<td>Family and social network interventions engage one or more of the client’s social network members who agree to support the client’s treatment and recovery. The interventions use psychosocial techniques that aim to increase family and social network support for change, and decrease family and social support for continuing drug and/or alcohol use. These interventions may involve the use of mapping tools. They require competences over and above those required for keyworking, and delivery within a clinical governance framework that includes appropriate supervision. Examples: social behaviour and network therapy (SBNT), community reinforcement approach (CRA), behavioural couples therapy (BCT) &amp; formal family therapy.</td>
</tr>
<tr>
<td>Cognitive and behavioural based relapse prevention interventions (substance misuse focused)</td>
<td>Cognitive and behavioural based relapse prevention interventions develop the service user’s abilities to recognise, avoid or cope with thoughts, feelings and situations that are triggers to substance use. They include a focus on coping with stress, boredom and relationship issues and the prevention of relapse through specific skills, e.g. drug refusal, craving management. They can be delivered in groups or one-to-one and may involve the use of mapping tools. They require competences over and above those required for keyworking, and delivery within a clinical governance framework that includes appropriate supervision.</td>
</tr>
<tr>
<td><strong>supervision.</strong> Examples: CBT based relapse prevention (which may include mindfulness and ‘third wave’ CBT), behavioural self control (alcohol).</td>
<td></td>
</tr>
<tr>
<td>Evidence-based psychological intervention for co-existing mental health problems</td>
<td>NICE guidelines for mental health problems generally recommend a stepped care approach. Low intensity psychological intervention for co-existing mental health problems, include guided self-help or brief interventions for less severe common mental health problems. High intensity psychological therapies (such as cognitive behavioural therapy) are recommended for moderate and severe problems. Typically formulation-based and delivered by clinicians with specialist training who are registered with a relevant professional/regulatory body. They can be delivered in groups or one-to-one. Both low and high intensity interventions require additional competences for the worker and delivery within a clinical governance framework that includes appropriate supervision.</td>
</tr>
<tr>
<td>Psychodynamic therapy (substance use focused)</td>
<td>A type of psychotherapy that draws on psychoanalytic theory to help people understand the developmental origins of emotional distress and behaviours such as substance misuse, by exploring unconscious motives, needs, and defences. Psychodynamic therapy requires additional competences for the worker and delivery within a clinical governance framework that includes appropriate supervision. Therapists should be registered with an appropriate professional/regulatory body.</td>
</tr>
<tr>
<td>12-step work</td>
<td>A 12-step intervention for recovery from addiction, compulsion or other behavioural problems. Interventions are delivered within a clinical governance framework that includes appropriate supervision. The aim of 12-step work is to facilitate service users to complete some or all of the 12 steps.</td>
</tr>
<tr>
<td>Counselling – BACP Accredited</td>
<td>A systematic process which gives individuals an opportunity to explore, discover and clarify ways of living more resourcefully, with a greater sense of well-being. This requires additional competences for the worker and delivery within a clinical governance framework that includes appropriate supervision.</td>
</tr>
<tr>
<td>Other</td>
<td>An intervention based on established psychological models/theories that have an evidence base, and that is undertaken by a worker with the required competences with adequate supervision and clinical governance arrangements This category can only be used where an intervention is not covered by individual, or a combination of, categories above. It is anticipated that use of this category would be relatively uncommon.</td>
</tr>
</tbody>
</table>
C3 - Recovery Support

During structured treatment, recovery support interventions should be recorded for interventions delivered alongside and/or integrated with a psychosocial or pharmacological intervention.

Recovery support interventions can also be delivered and recorded outside of structured treatment, following the recording of an exit from structured treatment.

<table>
<thead>
<tr>
<th>Recovery support type</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Peer support involvement</td>
<td>A supportive relationship where an individual who has direct or indirect experience of drug or alcohol problems may be specifically recruited on a paid or voluntary basis to provide support and guidance to peers. Peer support can also include less formal supportive arrangements where shared experience is the basis but generic support is the outcome (e.g. as a part of a social group). This may include mental health focused peer support where a service user has co-existing mental health problems. Where peer support programmes are available, staff should provide information on access to service users, and support access where service users express an interest in using this type of support.</td>
</tr>
<tr>
<td>Facilitated access to mutual aid</td>
<td>Staff provide a service user with information about self-help groups. If a service user has expressed an interest in attending a mutual aid group, staff facilitate the person’s initial contact with the group, for example by making arrangements for them to meet a group member, arranging transport, accompanying him or her to the first session and dealing with any concerns. These groups may be based on 12-step principles (such as Alcoholics Anonymous, Narcotics Anonymous and Cocaine Anonymous) or another approach (such as SMART Recovery).</td>
</tr>
<tr>
<td>Family support</td>
<td>Staff have assessed the family support needs of the individual/family as part of a comprehensive assessment, or ongoing review of their treatment package. Agreed actions can include: arranging family support for the family in their own right or family support that includes the individual in treatment.</td>
</tr>
<tr>
<td>Parenting support</td>
<td>Staff have assessed the family support needs of the individual as part of a comprehensive assessment, or ongoing review of their treatment package. Agreed actions can include a referral to an in-house parenting support worker where available, or to a local service which delivers parenting support.</td>
</tr>
<tr>
<td>Housing support</td>
<td>Staff have assessed the housing needs of the individual as part of the comprehensive assessment, or on-going recovery care planning process, and has agreed goals that include specific housing support actions by the treatment service, and/or active referral to a housing agency for specialist housing support. Housing support covers a range of activities that either allows the individual to maintain their accommodation or to address an urgent housing need.</td>
</tr>
<tr>
<td>Employment support</td>
<td>Staff have assessed the employment needs of the individual as part of the comprehensive assessment, or on-going recovery care planning process, and agreed goals that include specific specialised employment support actions by the treatment service, and/or active referral to an agency for specialist employment support.</td>
</tr>
<tr>
<td>Section</td>
<td>Description</td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Where the individual is already a claimant</td>
<td>Where the individual is already a claimant with Jobcentre Plus or the Work Programme, the referral can include a three way meeting with the relevant advisor to discuss education/employment/training (ETE) needs. The referral can also be made directly to an ETE provider.</td>
</tr>
<tr>
<td>Education &amp; training support</td>
<td>Staff have assessed the education and training related needs of the individual as part of the comprehensive assessment, or ongoing recovery care planning process and agreed goals that include specific specialised education &amp; training support actions by the treatment service, and/or active referral to an agency for specialist education &amp; training support. Where the individual is already a claimant with Jobcentre Plus or the Work Programme, the referral can include a 3 way meeting with the relevant advisor to discuss ETE needs. The referral can also be made directly to an ETE provider.</td>
</tr>
<tr>
<td>Supported work projects</td>
<td>Staff have assessed the employment related needs of the individual as part of the comprehensive assessment, or ongoing recovery care planning process and agreed goals that include the referral to a service providing paid employment positions where the employee receives significant on-going support to attend and perform duties.</td>
</tr>
<tr>
<td>Recovery check-ups</td>
<td>Following successful completion of formal substance misuse treatment there is an agreement for periodic contact between a service provider and the former participant in the structured treatment phase of support. The periodic contact is initiated by the service, and comprises a structured check-up on recovery progress and maintenance, checks for signs of lapses, sign posting to any appropriate further recovery services, and in the case of relapse (or marked risk of relapse) facilitates a prompt return to treatment services.</td>
</tr>
<tr>
<td>Evidence-based psychosocial interventions to</td>
<td>Evidence based psychosocial interventions [as described in Section 4. Psychosocial] that support on-going relapse prevention and recovery, delivered following successful completion of the formal phase of structured substance misuse treatment. These are interventions with a specific substance misuse focus and delivered within substance misuse services.</td>
</tr>
<tr>
<td>support substance misuse relapse prevention</td>
<td></td>
</tr>
<tr>
<td>Evidence-based mental health focused</td>
<td>Evidence based psychosocial interventions (as described in section 4) that support on-going relapse prevention and recovery, delivered following successful completion of structured substance misuse treatment. These are interventions with a specific substance misuse focus and delivered within substance misuse services.</td>
</tr>
<tr>
<td>psychosocial interventions to support</td>
<td></td>
</tr>
<tr>
<td>continued recovery</td>
<td></td>
</tr>
<tr>
<td>Complementary therapies</td>
<td>Complementary therapies aimed at promoting and maintaining change to substance use, for example through the use of therapies such as acupuncture and reflexology that are provided in the context of substance misuse specific recovery support.</td>
</tr>
<tr>
<td>Other</td>
<td>A recognised recovery activity or support intended to promote and maintain a service user’s recovery capital, which is not captured by an individual type or combination of types above.</td>
</tr>
</tbody>
</table>
APPENDIX D  GENERAL HEALTHCARE ASSESSMENT

There is now a requirement that all service users within specialist drug treatment providers receive a general healthcare assessment. This will be monitored within updated NDTMS reporting mechanisms for structured treatment services and will be measured against local standards.

The NTA has defined the healthcare assessment as follows:

'As part of their assessment and care plan, all drug users require a general healthcare assessment, which appraises and responds to (by direct intervention or referral) their risk of, for example, injecting-related wound infection, blood borne viruses, overdose (accidental or intentional), sexually transmitted disease or poor dental health, and will also include a basic health screen carried out by a trained professional.'

Adult Treatment Plan Guidance Notes 2006-07

Purposes/Aims

- To identify unmet health needs and address these through care planning
- To ensure account is taken of health problems which could interact with drug treatment
- As a means of attracting and retaining patients into drug treatment
- To improve drug treatment outcomes such as abstinence and relapse prevention in line with current evidence
- To create opportunities for harm minimisation interventions

The intention is first to define a universal healthcare assessment, which should be carried out by all agencies on all drug users. DANOS competencies required are: AF3 'Carry out comprehensive substance misuse assessment')

In the future, the NTA intends to issue further guidance on incremental health assessment according to drug worker competencies, service amenities and drug user needs.

Therefore, as a first stage towards this goal, the minimum definition is as follows:

All drug users presenting to specialist drug agencies will receive as part of their assessment:

A. Verbal health assessment

   General health questions should address:

   - Current illnesses/symptoms particularly epilepsy, asthma, liver disease
   - Prescribed/OTC (over the counter) drugs
   - Cigarette smoking
   - Sexual health (risks and STD history) including smear status in women age 25-64
   - Current use of/need for contraception
   - Dental health
   - Diet and weight loss

   Drug-related health questions should address:

   a) All patients

   - Blood-borne virus testing and results (HIV, HBV, HCV)
   - Hepatitis Immunisation status (HBV, HAV) and other immunisations (Tetanus, TB)
   - History of fits/blackouts
   - History of overdose

   b) Drug smokers

   - Smoking methods
   - Wheeze/breathlessness/cough/sputum ('are you coughing anything up?)/ haemoptysis ('are you coughing up any blood?')/chest pain
c) Past and current injectors

- Injecting status and problems
- History of skin infection/cellulitis/ulcer/abscess
- History of septicaemia ('blood poisoning') /endocarditis (infection in your heart valves or the lining of your heart?)
- History of DVT/PE/other thrombosis ('blood clot in your leg/lung/anywhere else?')

B. Basic physical health assessment by examination

a) All patients should be offered examination of

- Injection sites
- Any current concerns related to wound infections and skin swellings
APPENDIX E  ACCOMMODATION NEED GUIDANCE FOR ADULT SERVICES

The Accommodation Need for Adult Services has been defined with high-level reference data. The following provides guidance as to the sub-categories that make-up the high-level view.

- **NFA – urgent housing problem**
  - Live on streets
  - Use night hostels (night-by-night basis)
  - Sleep on different friend’s floor each night

- **Housing problem**
  - Staying with friends/family as a short term guest
  - Night winter shelter
  - Direct Access short stay hostel
  - Short term B&B or other hotel
  - Squatting

- **No housing problem**
  - Local Authority (LA)/Registered Social Landlord (RSL) rented
  - Private rented
  - Approved premises
  - Supported housing/hostel
  - Traveller
  - Own Property
  - Settled with friends/family
APPENDIX F  ADULT DISCHARGE CODES FROM APRIL 1ST 2009

When the current NDTMS discharge codes were defined, a scenario that described a need for treatment for alcohol dependence following the completion of drug treatment was not included. However, the expectation then, as now is that if a client has completed drug treatment but still requires a structured alcohol intervention then, depending where the alcohol treatment is provided, the following processes should be followed:

**Data item name** - Treatment completed – Alcohol free

**Data item definition** – The client no longer requires structured alcohol treatment interventions and is judged by the clinician to no longer be using alcohol.

**Data item name** – Treatment Completed - Occasional user

**Data item definition** – The client no longer requires structured alcohol treatment interventions; there is evidence of alcohol use but this is not judged to be problematic or to require treatment.

**Data item name** – Transferred – Not in custody

**Data item definition** – A client has finished treatment at this provider but still requires further structured drug treatment interventions and the individual has been referred to an alternative non-prison provider for this. This code should only be used if there is an appropriate referral path and care planned structured alcohol treatment pathways are available.

**Data item name** – Transferred – In custody

**Data item definition** – A client has received a custodial sentence or is on remand and a continuation of structured treatment has been arranged. This will consist of the appropriate onward referral of care planning information and a two-way communication between the community and prison treatment provider to confirm assessment and that care planned treatment will be provided as appropriate.

**Data item name** – Incomplete – Dropped Out
Data item definition – The treatment provider has lost contact with client without a planned discharge and activities to re-engage the client back into treatment have not been successful.

Data item name – Incomplete – Treatment withdrawn by provider

Data item definition – The treatment provider has withdrawn treatment provision from the client. This item could be used, for example, in cases where the client has seriously breached a contract leading to their discharge; it should not be used if the client has simply ‘Dropped out’.

Data item name – Incomplete – Retained in custody

Data item definition – The client is no longer in contact with the treatment provider as they are in prison or another secure setting. While the treatment provider has confirmed this, there has been no formal two-way communication between the treatment provider and the criminal justice system care provider leading to continuation of the appropriate assessment and care-planned structured alcohol treatment.

Data item name – Incomplete – Treatment commencement declined by the client

Data item definition - The treatment provider has received a referral and has had a face-to-face contact with the client after which the client has chosen not to commence a recommended structured alcohol treatment intervention.

Data item name – Incomplete – Client died

Data item definition – During their time in contact with structured alcohol treatment the client died.

Additional ‘transferred’ discharge codes for use by residential rehabilitation and inpatient detoxification providers only

4 new ‘transferred’ discharge codes have been added to the dataset for use by residential rehabilitation and inpatient detox providers only in order for NDTMS to more accurately record the discharge status of clients leaving a residential or inpatient facility.

Residential and inpatient providers should use these codes instead of the ‘transferred’ codes above. Unlike the existing ‘transferred’ discharge codes, that record the status of a client with the treatment system at the point of discharge from a provider, the residential and inpatient codes additionally record the outcome of the residential programme and what further structured interventions are required.

This allows residential and inpatient providers to record where clients have successfully completed the treatment programme and have been transferred for continued structured treatment at another provider at either at a second stage residential provider or at a community provider.

This may be the case for clients at residential and inpatient services that have been commissioned to provide treatment as a part of a longer treatment journey. The previous datasets recorded this as a ‘transferred on’, which did not capture information that the client has successfully completed that part of their treatment journey at the residential or inpatient provider.

Data item name – Transferred – treatment programme completed at the residential/inpatient provider - additional residential treatment required

Data item definition – The client has completed the structured treatment programme at the provider by meeting the goals of their care plan. Although they have finished treatment at this provider they still require continued structured treatment interventions and have been transferred to an alternative residential provider for this. This code should only be used if there is an appropriate referral path and care planned structured treatment pathways are available

Data item name – Transferred – treatment programme completed at the residential/inpatient provider – additional community treatment required
**Data item definition** - The client has completed the structured treatment programme at the provider by meeting the goals of their care plan. Although they have finished treatment at this provider they still require continued structured treatment interventions and have been transferred to an alternative community provider for this. This code should only be used if there is an appropriate referral path and care planned structured treatment pathways are available.

**Data item name** – treatment programme not completed at the residential/inpatient provider – additional residential treatment required

**Data item definition** - The client has not completed the structured treatment programme at the provider because they have not met the goals of their care plan. They require continued structured treatment interventions and have been referred to an alternative residential provider for this. This code should only be used if there is an appropriate referral path and care planned structured treatment pathways are available.

**Data item name** – treatment programme not completed at the residential/inpatient provider – additional community treatment required

**Data item definition** - The client has not completed the structured treatment programme at the provider because they have not met the goals of their care plan. They require continued structured treatment interventions and have been referred to an alternative community provider for this. This code should only be used if there is an appropriate referral path and care planned structured treatment pathways are available.
APPENDIX G  PARENTAL STATUS FROM APRIL 2009

Parental status should include biological parents, step parents, foster parents, adoptive parents and guardians. It should also include *de facto* parents where an adult lives with the parent of a child or the child alone (for example, clients who care for younger siblings or grandchildren) and have taken on full or partial parental responsibilities.

The minimum period of cohabitation would be one month.

**Data item name** – All the children live with client

**Data item description** – The client is a parent of one or more children under 18 and all the client’s children (who are under 18) reside with them full time.

**Data item name** – Some of the children live with client

**Data item description** – The client is a parent of children under 18 and some of the client’s children (who are under 18) reside with them, others live full time in other locations.

**Data item name** – None of the children live with client

**Data item description** – The client is a parent of one or more children under 18 but none of the client’s children (who are under 18) reside with them, they all live in other locations full time.

**Data item name** – Not a parent

**Data item description** – The client is not a parent of any children under 18

**Data item name** – Client declined to answer
APPENDIX H  SETTING

The settings below should be recorded in the intervention / modality record where the intervention being delivered is at a different setting to the one the provider is registered as.

<table>
<thead>
<tr>
<th>Setting</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community</td>
<td>A structured drug and alcohol treatment setting where residence is not a condition of engagement with the service. This will include treatment within community drug and alcohol teams and day programmes (including rehabilitation programmes where residence in a specified location is not a condition of entry).</td>
</tr>
<tr>
<td>Inpatient unit</td>
<td>An in-patient unit provides assessment, stabilisation and/or assisted withdrawal with 24-hour cover from a multidisciplinary clinical team who have had specialist training in managing addictive behaviours. In addition, the clinical lead in such a service comes from a consultant in addiction psychiatry or another substance misuse medical specialist. The multi-disciplinary team may include psychologists, nurses, occupational therapists, pharmacists and social workers. Inpatient units are for those alcohol or drug users whose needs require supervision in a controlled medical environment.</td>
</tr>
<tr>
<td>Primary care</td>
<td>Structured substance misuse treatment is provided in a primary care setting with a General Practitioner, often with a special interest in addiction treatment, having clinical responsibility.</td>
</tr>
<tr>
<td>Prison</td>
<td>Structured drug and alcohol treatment delivered by a locally commissioned substance misuse team within the prison establishment providing the full range of drug and alcohol interventions in line with the evidence base articulated in the Patel Report.</td>
</tr>
<tr>
<td>Residential</td>
<td>A structured drug and alcohol treatment setting where residence is a condition of receiving the interventions. Although such programmes are usually abstinence based, prescribing for relapse prevention prescribing or for medication assisted recovery are also options. The programmes are often, although not exclusively, aimed at people who have had difficulty in overcoming their dependence in a community setting. A residential programme may also deliver an assisted withdrawal programme. This should be sufficiently specialist to qualify as a “medically monitored” inpatient service – and it should meet the standards and criteria detailed in guidance from the Specialist Clinical Addictions Network. This level of support and monitoring of assisted withdrawal is most appropriate for individuals with lower levels of dependence and/or without a range of associated medical and psychiatric problems. Within the residential setting, people will receive multiple interventions and supports (some of which are described by the intervention codes below) in a coordinated and controlled environment. The interventions and support provided in this setting will normally comprise both professionally delivered interventions and peer-based support, as well as work and leisure activities.</td>
</tr>
<tr>
<td>Recovery house</td>
<td>A recovery house is a residential living environment, in which integrated peer-support and/or integrated recovery support interventions are provided for residents who were previously, or are currently, engaged in treatment to overcome their drug and alcohol dependence. The residences can also be referred to as dry-houses, third-stage accommodation or quasi-residential. Supported housing that does not provide such integrated substance misuse peer or recovery support as part of the residential placement is not considered a recovery house for this purpose. Recovery houses may be completely independent, or associated with a residential facility.</td>
</tr>
</tbody>
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| treatment provider or housing association. Some will require ‘total abstinence’ as a condition of residence whereas others may accept people in medication assisted recovery who are otherwise abstinent. |
APPENDIX I  TIME IN TREATMENT

Time in treatment covers the time spent in an average week in structured treatment on one or more of the interventions defined above. The time will usually be that actually spent but may include service user absence, within the programme’s stipulated attendance requirements.

Interventions included in calculating the time should be exclusively made up of the pharmacological, psychosocial and recovery support interventions defined earlier, but not only recovery support interventions. A client receiving only recovery support interventions would not be in structured treatment.

In deciding which threshold to record for a fractional time spent in treatment, the actual time should be rounded up to the nearest whole hour, e.g. 14.5 hours rounds up to 15 hours so would be recorded as ‘High’.

<table>
<thead>
<tr>
<th>Threshold</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standard</td>
<td>One or more of the interventions defined above is received by, or made available to, the service user for 14 hours or less per week. This can include service user absence, within the programme’s stipulated attendance requirements. Interventions should be exclusively made up of a combination of pharmacological, psychosocial and recovery support interventions, as defined here, but not only recovery support interventions.</td>
</tr>
<tr>
<td>High</td>
<td>One or more intervention types defined above is received by, or made available to, the service user for more than 14 and less than 25 hours per week. This can include service user absence, within the programme’s stipulated attendance requirements. This could include non-residential or residential rehabilitation programmes, including services previously recorded as structured day programmes. Interventions should be exclusively made up of a combination of pharmacological, psychosocial and recovery support interventions, as defined here, but not only recovery support interventions.</td>
</tr>
<tr>
<td>Very high</td>
<td>One or more intervention types defined above is received by, or made available to, the service user for 25 or more hours per week. This can include service user absence, within the programme’s stipulated attendance requirements. This could include non-residential or residential rehabilitation programmes, including services previously recorded as structured day programmes. Interventions should be exclusively made up of a combination of pharmacological, psychosocial and recovery support interventions, as defined here, but not only recovery support interventions.</td>
</tr>
</tbody>
</table>