

The Treatment Outcomes Profile (TOP)

A guide for keyworkers



National Treatment Agency for Substance Misuse

September 2007

Treatment Outcomes Profile

 / /

Client ID

D.O.B. (dd/mm/yyyy)

Name of keyworker

 / /

Gender: M F

Treatment stage: Modality start Care plan review
Discharge Post-discharge

TOP interview date (dd/mm/yyyy)

Section 1: Substance use

Record the average amount on a using day and number of days substances used in each of past four weeks

	Average	Week 4	Week 3	Week 2	Week 1	Total
a Alcohol	<input type="text"/> units/day	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-28
b Opiates	<input type="text"/> g/day	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-28
c Crack	<input type="text"/> g/day	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-28
d Cocaine	<input type="text"/> g/day	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-28
e Amphetamines	<input type="text"/> g/day	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-28
f Cannabis	<input type="text"/> spliff/day	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-28
g Other problem substance?	<input type="text"/> g/day	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-28

Name.....

Section 2: Injecting risk behaviour

Record number of days client injected non-prescribed drugs in past four weeks (if no, enter zero and go to section 3)

	Week 4	Week 3	Week 2	Week 1	Total
a Injected	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-28
b Inject with needle or syringe used by someone else?	Yes <input type="checkbox"/> No <input type="checkbox"/>				<input type="text"/> Enter 'Y' if any yes, otherwise 'N'
c Inject using a spoon, water or filter used by someone else?	Yes <input type="checkbox"/> No <input type="checkbox"/>				

Section 3: Crime

Record days of shoplifting, drug selling and other categories committed in past four weeks

	Week 4	Week 3	Week 2	Week 1	Total
a Shoplifting	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-28
b Drug selling	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-28
c Theft from or of a vehicle	Yes <input type="checkbox"/> No <input type="checkbox"/>				<input type="text"/> Enter 'Y' if any yes, otherwise 'N'
d Other property theft or burglary	Yes <input type="checkbox"/> No <input type="checkbox"/>				
e Fraud, forgery and handling stolen goods	Yes <input type="checkbox"/> No <input type="checkbox"/>				<input type="text"/> Enter 'Y' or 'N'
f Committing assault or violence	Yes <input type="checkbox"/> No <input type="checkbox"/>				

Section 4: Health and social functioning

a Client's rating of psychological health status (anxiety, depression and problem emotions and feelings)

Poor 0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 Good 0-20

Record days worked and at college or school for the past four weeks

	Week 4	Week 3	Week 2	Week 1	Total
b Days paid work	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-28
c Days attended college or school	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-28

d Client's rating of physical health status (extent of physical symptoms and bothered by illness)

Poor 0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 Good 0-20

Record accommodation items for the past four weeks

e Acute housing problem	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="text"/> Enter 'Y' or 'N'
f At risk of eviction	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="text"/> Enter 'Y' or 'N'

g Client's rating of overall quality of life (e.g. able to enjoy life, gets on well with family and partner)

Poor 0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 Good 0-20

The National Treatment Agency for Substance Misuse

The National Treatment Agency for Substance Misuse (NTA) is a special health authority within the NHS, established by Government in 2001, to improve the availability, capacity and effectiveness of treatment for drug misuse in England.

Treatment can reduce the harm caused by drug misuse to individuals' well-being, to public health and to community safety. The Home Office estimates that there are approximately 250,000–300,000 problematic drug misusers in England who require treatment.

The overall purpose of the NTA is to:

- Double the number of people in effective, well-managed treatment between 1998 and 2008
- Increase the percentage of those successfully completing or appropriately continuing treatment year-on-year.

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Note: This version corrects the following errors in the June 2007 edition: the Timeline Followback calculations on Figure 4 and Figure 7, and the calculation of alcohol units on page 10 under the heading, “A more complicated drinking pattern”. The introduction to “Framing the first TOP interview” on page 5 was amended to reflect guidance from the senior ethics advisor of the British Medical Association.

Introduction

Welcome to the keyworker's guide to the Treatment Outcomes Profile (TOP).

The TOP contains a set of questions that record information about a client's behaviour, health and social situation in the month before treatment. It has been developed as short interview between a keyworker and a client at assessment and the subsequently as part of the care planning and review process. The outcomes from treatment are then seen by looking at changes in the behaviours and other information recorded over time.

The TOP is the NTA's new national outcomes monitoring tool. It is to be used with every client (aged 16 and over) who enters structured (Tier 3 and 4) treatment in England. The TOP assesses outcomes of the following seven modalities: inpatient detoxification; specialist prescribing; GP prescribing; psychosocial intervention; structured day programme; residential rehabilitation; and other structured intervention. The TOP is intended for clients who are seeking a treatment intervention due to problems with one or more illicit psychoactive substances and alcohol. At a national level the TOP dataset is combined with the NDTMS data concerning referral, treatment modality, departure status and time-based information concerning the treatment journey.

We intended this guide to be a work in progress – it will develop and be refined over time from feedback and suggestions received from the field and as NDTMS implementation develops. Your participation in this regard is warmly encouraged.

The purpose of the guide

The NTA recognises that as a key worker in a specialist service you are at the front line when it comes to delivering treatment and the national system for monitoring treatment outcomes. You are the named practitioner responsible for ensuring the client's care plan is delivered and reviewed. Accordingly, this guide has been prepared as an important information resource. It tells you how to complete the TOP and offers suggestions and tips for conducting the interview and using the information in practice.

This guide has several objectives. Foremost among these is to give you the information you need to use the TOP and to record information from your client which is as accurate as possible. As you read the manual you will also find helpful tips for asking the questions and suggestions about handling challenging situations. We have prepared this guide for the standalone paper version of the TOP interview. Database software developers will produce computer-assisted TOP interviews and your service may integrate the TOP questions into broader care plan review paperwork. The same considerations and skills will apply to these applications.

Context

The substance misuse treatment field has grown in recent years. There has been substantial increase in the numbers of people receiving treatment and in the capacity of the treatment system to meet demand. Proxy indicators of the impact of treatment (such as whether a client is retained in treatment) offer some insight into questions of effectiveness. But in themselves they are not enough. It might have seemed logical to have a single outcome measure – change in substance use – but almost all clients present for treatment with problems in other areas as well, such as health and social problems – so several measures are needed to properly evaluate outcome.

From a client's and a worker's point of view it is clear what is happening in treatment. Scheduled keyworking sessions are usually full of discussion surrounding areas of a client's life that are improving as well as a focus on problems that are not improving or, perhaps, getting worse. However, unless there is a summary of this progress or continued problems this knowledge is not shared by anyone else outside the service. The impact of treatment is hidden from view.

So, what is needed is an appropriate and simple way of recording actual change in behaviour during treatment. Much has been learnt about this from cohort follow-up studies. But this sort of research is only done occasionally and generally looks at outcome after someone has left treatment. While answers to questions of medium and long-term effectiveness are important, a 'real time' assessment is needed of outcome during a client's treatment. Some services have made good progress in setting up a procedure to do this. However, they are a minority. Recent audits of the treatment field have found assessment and outcome 'monitoring' to be generally lacking. A standardised approach to assessing problems and recording change will establish a common 'outcome language' across the treatment field. The TOP is designed to fulfil this role.

It is important to appreciate that the TOP is a method for recording information about problems that a person seeking specialist help for drug and alcohol misuse faces. By recording this information repeatedly over the course of treatment as part of the care plan review, a picture can be built of the client's progress and outcome. While each client has their own unique set of problems, the TOP is designed to combine information from clients and across services within a particular modality so that the NDTMS can assess the effectiveness of treatment right across the country.

At its heart, the TOP is a simple tool for use by an individual keyworker working with a client. The questions are clear and straightforward to answer.

However, your skills are needed to frame the questions, provide examples, probing for clarification, offering reassurance about confidentiality and what the information will be used for. Without

leading the client, your task is to help the client recall behaviour and then use this information to build motivation for change. Some of these skills will need practice to master and we will offer suggestions for good practice later on in the guide. Please note that the TOP is not a substitute for comprehensive assessment. It focuses on recent behaviours only and there are many areas of risk and problems that are not recorded by TOP. Please also note that as you are using the TOP keyworkers in other services across the country are doing the same. This effort will now become an integral part of service delivery. It is not an occasional research exercise or something that can be done periodically and then brushed aside. The TOP represents a major shift in the business of treatment in England. Downstream, important questions about the value of treatment services are going to be answered leading to better delivery and commissioning, and ultimately to better services for clients. We see the TOP as an evolving tool and wider applications will follow in the coming months.

Development

There are a good many questionnaires and rating scales in the substance misuse field and most have their supporters. However, many lack clarity, proper research development or fail to directly involve a client in the assessment process. After surveying the existing outcomes tools, the NTA took the view that all of the validated outcomes tools were too long or otherwise inappropriate. What was needed was the briefest possible outcome tool, that would record outcomes in an objective way that could be used for care planning and review and at the same time address the information needs of service managers, treatment commissioners and policy makers. The Treatment Outcomes Profile (TOP) was created to fill this gap. It is the result of a major collaborative effort bringing together a large sample of treatment services, keyworkers, clients and an NTA development team. The TOP has been tried and tested by a group of keyworkers across England in a large sample of Tier 3 and 4 services, with a sample of over 1,000 clients. A much longer list of questions was initially studied and then reduced to the most reliable set. The TOP contains 30 items from which 20 core data items are uploaded to NDTMS for national outcome monitoring (your manager will advise you how the service is communicating this information to the NTA).

Principles

The TOP has been designed with the following principles and requirements in mind:

- It must reflect the main problems (risks and harms) that clients of structured substance misuse interventions experience.
- It must be as brief as possible so as to minimise the time taken to collect the information.

- It must be straightforward to complete and ask questions in an objective manner.
- It should be in a form that is useful to clinical practice and can provide helpful feedback to clients to build and maintain motivation to change.

It must pass stringent reliability and validity criteria.

Framing the first TOP interview

We have designed the TOP to be a practical tool for care planning and review. Yes, it is a form but the way you use it can make all the difference as you build rapport with a client. Our recommended way of introducing the TOP might go like this:

“As part of your assessment today, I’d like to spend a few minutes completing a short interview with you. It’s called the Treatment Outcomes Profile. Your answers will really help me get a picture of your recent problems. The questions look at substance use, health risk, crime, and social aspects and some of them may not be relevant to you. We ask all of our clients who are in treatment here to complete the TOP. We use the information as part of the way we will plan your care and also how we evaluate how well we are providing treatment to our clients. Some of the data is also sent to the National Treatment Agency so that they can monitor the outcomes from services across the country. The information collected by TOP will be reported as part of a wider set of information collected by the National Drug Treatment Monitoring System (NDTMS). NDTMS requires your initials, date of birth and DAT of residence solely to ensure that the same person is not counted twice on the database. The information is used to monitor the effectiveness of treatment across England. The information collected by the NTA is not passed on to police or probation. Some NDTMS data is published on the internet, but this is anonymous data to help monitor how services or areas are performing. No NDTMS data which could be used to identify an individual will be published anywhere in any form. Nevertheless, you do not have to agree to provide data to NDTMS if you do not wish to and this will not affect your treatment in any way. It’s important that you answer as accurately and as truthfully as you can, but if you don’t want to answer any question just say so and I’ll move on. Once we’ve completed your TOP we can look more in-depth at your needs and goals.”

You’ll see that, in this introduction, the worker conveys several key things: the interview is going to be an assessment *with* the client not *of* the client; the worker is positive about the TOP and how it fits into the care planning process; and there is a straight description of the wider purpose of the data and how the full assessment will be done. Naturally, you will use your own wording and style to frame the TOP. The TOP questions could be asked in

a perfunctory, matter-of-fact style, rather like a census. However, this is not the intention. We encourage you to ask the questions in a way that is an “assessment conversation” with your client. You are asking the questions because you want to know the answers not just because the NDTMS requires some of the data.

So, how shouldn't you use the TOP? In this imaginary example a keyworker says the following:

“The management here and the NTA require me to write down your answers to this form before we can plan your treatment. It asks about drug use, crime and other things about your life. You don't have to answer anything if you don't want to. It won't take too long and then we can get on and talk about how we can help you”.

What is the sub-text to this style of introduction? Basically, it conveys to the client that the worker doesn't have any ownership or mistrusts the TOP, that the information is of no value, and he/she offers nothing to the client as to the reason for collecting the information. We think you'll agree that this approach isn't helpful to anyone.

Confidentiality

It is important that you do not assume that clients will be equally concerned or blasé about confidentiality issues. A client who is seeking treatment for the first time may be very different to someone who is familiar with the treatment system. It is ethically important that a statement regarding confidentiality is conveyed to each client at each TOP interview. TOP data submitted via NDTMS will have the same safeguards in relation to confidentiality as any other item within the NDTMS core data set. This should be carefully explained to the client and local confidentiality agreements should be modified as appropriate to take into account the introduction of TOP into clinical and reporting systems. Please refer to the *Confidentiality and information sharing* and *Data protection and record retention* documents available on the NTA website.

The general format of the TOP

The TOP form asks participants to respond in three main ways:

- Some questions ask the client to recall the number of days in each of the past four weeks on which they did or experienced something. You then add these to create a total for the past four weeks in the blue NDTMS box
- Some questions require a simple tick for yes or no and then a “Y” in the blue NDTMS box if yes (or “N” if no)
- Some questions invite a response using a 20-point scale from ‘poor’ to ‘good’. Together with the client, you mark the scale in an appropriate place and then write the equivalent score in the blue NDTMS box.

Note: If a client refuses to answer a question or cannot recall even after assistance enter “NA” (no answer) on the form.

The structure of the TOP

The TOP has four sections:

- Section 1 has seven questions about drugs and alcohol
- Section 2 has three questions about injecting risk behaviour
- Section 3 has six questions about crime
- Section 4 has seven questions about health, work, college/school, and housing.

(There is a copy of the form on the inside back cover)

All of these questions ask about behaviours that may or may not have already occurred in the past month. Many of the questions ask the client to estimate the number of days on which behaviours took place. A day is taken to be a 24-hour period, spanning the morning, afternoon and evening.

A first glance at the TOP's four sections tells you that not all of the questions are going to be relevant to every client you work with. For example, many clients will not be injecting, while others will not be committing any crime. The key point is that a standard set of questions is being used right across the drug treatment system – any question that does not apply is recorded as such and you can move on to the next one. It is also obvious to see that the time needed to complete the TOP is going to vary. A client who is a daily heroin injector with few health problems, no crime involvement and reporting few social functioning problems will be completed in just a few minutes. In contrast a poly-drug using client reporting multiple problems across the four sections will require more time. On average, the TOP takes about 10 minutes after you have framed the assessment and outlined the confidentiality aspects and ethical aspects. You'll find that you need more time to complete the TOP in the first few weeks of use; but after that you will probably become much faster – just remember to complete the TOP as thoroughly as possible.

Recalling behaviour in the past month

Using the TOP is all about helping the client think about the past month and record whether and how often things happened. How best should you approach this task? Let's take the example of alcohol use. You could simply ask “how often did you drink alcohol?” and leave clients free to structure an answer of their own choosing. You might get a response such as “oh, about four times a week”. This is of course fine to open up a general conversation but what about the task of assessing several different types of beverage as well? It starts to get more complicated – and critically, things may become more problematic for the client to remember. Add to that questions about illicit

substances, crime, health, work and so on, and it's clear that we need a consistent and quick method.

A simple calendar method for helping recall

When you use the TOP you are going to be asking clients to think about the previous month and recall how often certain things happened and also general (subjective) evaluations of aspects of their health and quality of life.

If you stop for a moment and consider how you would do this with a client, you might say: "I'd like you to think about last month." This is a simple approach that probably works fine for surveys but we need a little more precision for monitoring treatment outcomes.

There are some commonly encountered patterns of drug and alcohol use among people seeking treatment – for example, daily opiate use, or episodic crack cocaine use or binge drinking. But equally, there are a lot of differences between people too, particularly when you consider polydrug use. Also, while some clients may come to treatment with a fairly consistent pattern of drug taking, this may not continue to be the case. It makes sense, therefore, to think of each client as having a unique pattern.

So, in order to help your client recall the past month – and to help you ask the questions – we have built the TOP as a simple calendar-based interview to help you and your clients summarise their behaviour. This approach works really well for people who have a consistent substance use pattern but it also works really well for people who have an inconsistent pattern.

This approach has been around for a long time in the alcohol and drug field. Developed by two Canadian researchers – Linda and Mark Sobell – the Timeline Followback (TLFB) is a method for organising a discussion with clients and helping them recall their use of substances and other behaviours (Sobell & Sobell, 1996). It was devised specifically to evaluate changes in behaviour before and after treatment. This technique takes a bit of practice to do really well, but once you've mastered it, it is an indispensable way of generating a picture of your client's situation. A summary of the TLFB method is presented in this manual, adapted for the purpose of the TOP.

It's important to stress that in most applications, workers will use the TLFB approach as a basic strategy to organise the collection of information. You will quickly see that you could use the method to collect a very detailed picture, or a more basic snapshot. You will develop your own style as you become more and more expert in interviewing with the TOP. Please note that even very experienced interviewers recognise that a TLFB approach is a very good way of collecting information and the research literature shows that clients respond very well to a calendar method – even those who initially might doubt that they can recall past behaviour with any accuracy.

July/August 2007						
Su	Mo	Tu	We	Th	Fr	Sa
1	2	3	<u>4</u>	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31	1	<u>2</u>	3	4

Figure 1: Calendar showing date of the TOP (underlined) and then the recall period (shaded)

Framing the TOP interview

The first thing to do before getting down to the task of asking questions is to frame the interview. This means clarifying for the client what you mean by the past four weeks. This period is going to be used for the entire TOP assessment – not any time before nor (for now) any time afterwards.

Let's take an example. A client begins treatment on Wednesday 1 August 2007. As it happens, the first TOP assessment is done on Thursday 2 August.

The first TOP records the four weeks (28 days) before the start of the modality, so this means the last day of the four weeks before treatment is Tuesday 31 July and, working back, the beginning of the recall month is 4 July.

The calendar in Figure 1 shows the date of the assessment (underlined) and then the recall period (italicised). As you can see, the four weeks run from Wednesday 4 July to Tuesday 31 July, as follows:

- Week 1 runs from Wednesday 4 July to Tuesday 10 July
- Week 2 runs from Wednesday 11 July to Tuesday 17 July
- Week 3 runs from Wednesday 18 July to Tuesday 24 July
- Week 4 runs from Wednesday 25 July to Tuesday 31 July.

In order to help a client think back across this period – and also help you ask the questions and record the answers – it's a good idea to use a simple calendar as a prompt and recording sheet.

Figure 2 is an example of a simple calendar for the example above with the recall period shaded.

As you can see, the start and end date is marked, as is the date treatment started and the date of the first TOP assessment. This example uses shading, but you could circle the dates or draw a bold line around the four-week block of time. You can also see that we have added some memorable dates – and we will come on to this and other tips about helping recall later on.

	Sun	Mon	Tue	Wed	Thu	Fri	Sat
	1	2	3	4 Start	5	6	7
July	8	9	10	11	12	13	14
	15	16	17	18	19	20	21
	22	23	24	25	26	27	28
	29	30	31 End	1 Started treatment	2 TOP interview	3	4
August	5	6	7	8	9	10	11
	12	13	14	15	16	17	18
	19	20	21	22	23	24 Glastonbury	25
	26	27 Bank holiday	28	29	30	31	1

Figure 2: A simple calendar with the recall period shaded

Instructions at the beginning of the TOP assessment

Until you become familiar with using the TOP, it's a good idea to use or paraphrase the following instructions to your client:

"I am going to ask you to think back over the past month before you started treatment here and tell me about your substance use and about other things we'll come on to in a while. A picture of how often you use and the pattern of your use will help us plan your treatment. To you do this with me, we'll use this calendar. As you can see I've marked out the past four weeks as a block of 28 days from [start] to [end]. I'd like to record if there were any memorable dates for you during this time. You can also see that I've marked 27 August as a Bank Holiday, but what about personal memorable dates – I'm thinking of birthdays; special occasions ..."

Mark any personally memorable dates that the client recalls on the calendar.

Completing the TOP

In this section we will walk you through how to complete the TOP, section by section.

Administrative information

Start the TOP interview by entering:

- Name and identifiers of your client (date of birth and gender)
- Your name
- Date of assessment
- The stage at which the TOP is being completed: assessment, care plan review, discharge or post-discharge.

Note: Remember the TOP is an important entry in your client's clinical record and should be kept on file. Writing your name is important – it links the client to you as their keyworker and shows that the TOP has been completed correctly in the event of a subsequent audit. It also personalises the form when you retrieve this TOP form from the file and compare it to a subsequent TOP assessment.

Section 1: Substance use										
Record the average amount on a using day and number of days substances used in each of past four weeks										
	Average	Week 4	Week 3	Week 2	Week 1	Total				
a Alcohol	<input type="text"/> units/day	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-28			
b Opiates	<input type="text"/> g/day	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-28			
c Crack	<input type="text"/> g/day	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-28			
d Cocaine	<input type="text"/> g/day	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-28			
e Amphetamines	<input type="text"/> g/day	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-28			
f Cannabis	<input type="text"/> spliff/day	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-28			
g Other problem substance?	<input type="text"/> g/day	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-28			
Name.....										

Figure 3: Section 1 of the TOP form

Section 1: Substance use

The first assessment section of the TOP form is shown in Figure 3.

As you can see, it is a concise summary of the use of different substances in the past four weeks. Week four is the last (most recent) week in the block of four and week one is the first. Your task in completing the first section is to help clients think back across the recall period and recall:

- 1 The number of days they used alcohol, each of five illicit substances and (if necessary) one other problem substance in each week (scored 0 to 7)
- 2 The average amount (volume/grams) used on a typical using day during this time.

Note: The name of the “other problem substance” recorded must not include tobacco and must be a non-prescribed or illicit substance that the client cites as causing or related to health and other social and legal problems.

The information you collect about how much each substance is used is not needed at the national outcome monitoring system level. This is in no way to downplay the importance of recording this information. It’s obviously important for your client care plans and is also an important indicator of progress through treatment. It just isn’t critically needed at the national level and there are obvious differences in the content of street level purchases of illicit drugs that make it hard to compare clients and aggregate this information.

How to complete Section 1 – recording days used

Work through the section starting with alcohol and ending with any other problem substance not listed previously. Here’s how you would ask the questions about alcohol, showing the client the calendar:

“First of all, let’s look at how often you had a drink containing alcohol in the past four weeks. Did you use alcohol at any time?”

If the client says no – and you’ve checked that they mean total abstinence – you move on to ask about opiates. But, let’s say the client had been drinking – here’s what you do:

“Let’s then look together at these dates. Maybe we can start with the most recent week. How many days would you say you had a drink during this week?”

Mark on the calendar each day in week four that the client reports having a drink. Use the letter “A” and write this letter in each day. Check that blank days were non-drinking days.

“What about the week before – did you drink then at any time?”

Record drinking days with an “A” as before and continue for the first two weeks. If the client has recalled the same pattern for the first two weeks recorded you might ask: “So was this week pretty much the same?” Remember to probe the memorable dates as these may be more likely to be using days.

Figure 4 is an example of what this record for alcohol might look like and shows the numbers of drinking days that need entering on the TOP form.

We will come on to how to record the average amount used later on, but first here are some suggestions to help to make the interview run smoothly and help the client’s recall.

Tips for completing

We want you to have flexibility in completing the TOP, so feel free to start at the beginning of the recall month (week one) or the middle or end – it’s up to you. People generally find that the most recent weeks are the easiest to recall, but there are no hard and fast rules.

- Some clients will have fairly fixed substance use patterns before starting treatment. For example, a client may say: “I was using every day”. In this situation – in which it is obviously very easy to record “7” for each week – it’s nonetheless important to check by saying: “Can I just check, there were no days at all in the past month that you didn’t use.” There is no value judgement in the tone of this question – just a neutral

Drink	%ABV	Units
Pint ordinary strength lager, beer or cider	3.5	2
Pint strong lager, beer or cider	5	3
440ml can ordinary strength lager	3.5	1.5
440ml can strong lager, beer or cider	5	2
440ml can super strength lager or cider	9	4
1 litre bottle ordinary strength cider	5	5
1 litre bottle strong cider	9	9
Glass of wine (175ml)	12	2
Large glass of wine (250ml)	12	3
Bottle of wine (750ml)	12	9
Single measure of spirits (25ml)	40	1
Bottle of spirits (750ml)	40	30
275ml bottle alcopops	5	1.5

Figure 5: Alcohol units converter:

You then complete the TOP form as shown in Figure 6.

A more complicated drinking pattern

The client reports drinking two pints of ordinary strength lager, two cans of super strength cider and two double measures of spirits. The number of units for this pattern is:

$$2 \times \text{pints lager (4 units)} + 4 \times \text{440ml cans super strength cider (16 units)} + 2 \times \text{doubles of spirits (4 units)} = 24 \text{ units.}$$

The table in Figure 5 should be adequate for most instances. If you encounter a situation where you need to work out the specific units for a beverage type that isn't shown, you're going to need a calculator to hand and to record the millilitre serving size and the estimated %ABV. The formula to work out the number of grams of alcohol is:

$$\text{Volume (ml)} \times \%ABV \times 0.79/100$$

This gives you the number of grams of alcohol drunk so then divide this figure by eight to convert to standard units. Here's an example: The client recalls that she drinks strong red wine (14% ABV) and drinks a bottle each drinking day. This is:

$$750\text{ml} \times 14 \times 0.79/100 = 82.95 \text{ grams}$$

$$\text{Divide this by 8 to get the number of units} = 82.95/8 = 10.4 \text{ units}$$

Tips for completing

As with the question on drinking days, the goal is to be as accurate as possible. Here are some suggestions to help you:

First of all, remember we are talking about the number of whole alcoholic drinks consumed by clients over the course of a typical drinking day. It may be helpful to reassure clients that you are not expecting their estimate to be 100 per cent accurate, but to try to be as accurate as they can.

If clients have difficulty in estimating the number of drinks, go for the mid-point. For example, the client says: "I'm not sure whether it was four, five or six glasses of wine in the local bar," record "5" as the average (5 x 175ml glasses of wine = 10 units).

Completing the remainder of Section 1

Once you have mastered the method for completing the number of drinking days and the average amount drunk, you simply use the same method to complete the number of days of:

- Opiates (heroin, other illicit opium products and pharmaceuticals)
- Crack
- Cocaine
- Amphetamines (including methamphetamine)
- Cannabis.

Let's look at opiates. We are referring here to illicit heroin powder, other illicitly manufactured opium products and any non-prescribed prescription opioid medications (such as methadone and dihydrocodeine (DF118)). The most commonly illicit opiate is obviously heroin, so we suggest you start with that and when you have completed the number of days of heroin, move on to ask about other opiates. When you have completed all of the illicit opiates used, you need to add the days of each type to produce a total out of 28. If two or more opiate drugs are used on a particular day, count this day as one only. Taking the example of heroin, the first thing to do is to look at the calendar with the client and say:

"Now let's move on to look at illicit opiate use – heroin. Did you use heroin at any time in the past four weeks?"

If the client says no – and you've checked that they mean total abstinence – you move on to ask about crack. But, let's say the client has been using heroin, then follow exactly the same procedure that you used for alcohol.

"Let's look again at these dates. Maybe we can start with the most recent week. How many days would you say you had used heroin during this week?"

Mark on the calendar each day in week four that the client reports using heroin. Use the letter "H" and write this letter in each day. Check that blank days were abstinent heroin use days.

Record the average amount on a using day and number of days substances used in each of past four weeks						
	Average	Week 4	Week 3	Week 2	Week 1	Total
a Alcohol	3.5 units/day	5 0-7	2 0-7	4 0-7	5 0-7	16 0-28

Figure 6: Example of a typical drinking pattern recorded on the TOP form

	Sun	Mon	Tue	Wed	Thu	Fri	Sat
				4 Start H	5 A, H	6 A, H	7 A, H
July	8 A, H	9 A, H	9 H	11	12 H	13 A, H	14 A, H
	15 H	16	17 H	18 H	19 A, H	20 A, H	21 Friend's party A
	22 A, H	23 H	24	25 H	26 Boyfriend's b'day A, H	27 Payday A, H	28 A
29 A	30	31 End A					

Record the average amount on a using day and number of days substances used in each of past four weeks

b Opiates Average Week 4 Week 3 Week 2 Week 1 Total

g/day 0-7 0-7 0-7 0-7 0-28

Figure 7: A sample calendar for a heroin and alcohol user, and the corresponding TOP entry

“What about the week before – did you use heroin then at any time?”

Record the heroin use days with an “H” as before and continue for the first two weeks. If the client has recalled the same pattern for the first two weeks recorded you might ask: “So was this week pretty much the same?”

Remember to probe the memorable dates as these may be more likely to be using days. Building on the calendar for alcohol, Figure 7 shows a calendar of what this client’s heroin use might look like and the numbers to be entered on the TOP form are therefore:

After completing the number of heroin days, you need to ask clients to estimate how much heroin they usually used, on an average day, during the past four weeks. Ask this question like this:

“During the past four weeks can you estimate how much heroin you would have used on a typical day when you used?”

This information is not communicated to NDTMS but is obviously an important part of the assessment. It is up to you what sort of unit you wish to record. The best advice is to let the client report this verbatim. Most clients will report in terms of bags, grams or money spent. The usual amount purchased on the street varies quite a lot across the country and it will be necessary for you to use a typical street price for a given amount. As a helpful guide, DrugScope conducted a survey of street prices of heroin (and also crack, cocaine and amphetamines) in 16 English cities in 2006. We have taken the average of these figures that show that a £10 bag of street heroin weighs 0.2 grams. A £20 rock of crack weighs about 0.2 grams.

Record the days and average amounts for crack, cocaine and amphetamines in exactly the same way. It’s entirely up to you but you might use the following letters: Cr (crack), C (cocaine,) Am (amphetamine) and Ca (cannabis). For cannabis, we suggest that the amount is recorded as the number of spliffs (or pipes) smoked, but again it up to you to choose the cannabis consumption unit that is most appropriate.

Section 2: Injecting risk behaviour

Record number of days client injected non-prescribed drugs in past four weeks (if no, enter zero and go to section 3)

a Injected Week 4 Week 3 Week 2 Week 1 Total

0-7 0-7 0-7 0-7 0-28

b Inject with needle or syringe used by someone else? Yes No } Enter ‘Y’ if any yes, otherwise ‘N’

c Inject using a spoon, water or filter used by someone else? Yes No }

Figure 8: Section 2 of the TOP form

Note: Be sure to enter “0” (zero) in each of the week boxes to show abstinence from that substance.

Complete Section 1 by recording the days and amount used for one other problem substance. You should check for this in the following way:

“Was there another illicit drug that you were using in the past four weeks that caused you concerns or problems with your health, or other aspects of your life?”

If the client reports that there was, write the name of this substance in the space underneath question 1(g) as shown on the form and complete the numbers of days used and the average amount used in the usual way.

Section 2: Injection risk behaviour

The second section of the TOP form is shown in Figure 8.

As you can see it is a short set of three questions. It concerns the same four week period as you looked at in Section 1.

If in Section 1 the client has reported only using a non-injectable substance (either alcohol or cannabis) then enter a “0” (zero) in each of the week four, three, two and one boxes and move directly to Section 3.

If the client has reported use of opiates, crack, cocaine or amphetamines, or another problem substance (named), then ask the following:

“I’m now going to ask you about drug injecting. Thinking about the past four weeks we have talking about [remind the client of the start and end day and point out the calendar] did you inject a non-prescribed drug at any time?”

By “inject” we are referring to intravenous (surface or deep venous), subcutaneous and intramuscular injecting into one or more parts of the body.

If the client says no, probe to check that there was not a single day of injecting. If so, enter “0” in each of the boxes across the four-week recall and move to Section 3.

If the client says yes, complete the number of days injected in the usual way. Please note that if a client injects more than one type

of drug on a given day that only counts as one day (i.e. an injecting day). Here’s the sort of instructions you could use:

“Let’s then look together at these dates. Maybe we can start with the most recent week. How many days would you say you injected during this week?”

Mark on the calendar each day in week four that the client reports injecting. Use the letter “I” and write this letter in each day. Then ask:

“What about the week before – did you inject at any time during that week?”

Record the injecting days reported with an “I” as before and continue on to record for the first two weeks. If the client has recalled the same pattern for the first two weeks recorded you might ask: “So was this week pretty much the same?”

Once you have recorded the number of days that the client injected, enter these on the TOP form and add them up to produce the NDTMS total.

Asking about needle and syringe sharing

Sections 2(b) and 2(c) ask about needle and syringe sharing during the past four weeks. These are simple yes or no questions which reflect matters of considerable individual and public health importance.

Question 2(b) records direct sharing – meaning that clients injected themselves (or were injected by someone else, such as a partner) with a needle or syringe that they believed had been used already by someone else. This person is any other user and our definition of direct sharing includes whether or not the works had been flushed out with water or bleach.

Question 2(c) records indirect sharing – meaning that clients injected themselves (or were injected by someone else such as a partner) in a procedure that involved using one or more items of injecting paraphernalia – such as spoons, water or filters – that were known or believed to have been used before by another injector.

Record the client’s answer to questions 2(b) and 2(c) by placing a tick in the box to the right of their answer. In the blue NDTMS box

Section 3: Crime					
Record days of shoplifting, drug selling and other categories committed in past four weeks					
	Week 4	Week 3	Week 2	Week 1	Total
a Shoplifting	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-28
b Drug selling	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-28
c Theft from or of a vehicle			Yes <input type="checkbox"/> No <input type="checkbox"/>		<input type="text"/> Enter ‘Y’ if any yes, otherwise ‘N’
d Other property theft or burglary			Yes <input type="checkbox"/> No <input type="checkbox"/>		
e Fraud, forgery and handling stolen goods			Yes <input type="checkbox"/> No <input type="checkbox"/>		<input type="text"/> Enter ‘Y’ or ‘N’
f Committing assault or violence			Yes <input type="checkbox"/> No <input type="checkbox"/>		

Figure 9: Section 3 of the TOP form

write “Y” if the client answers yes to either or both questions (i.e. any yes). If they answer no to both questions enter an “N”.

Section 3: Crime

The third section of the TOP is shown in Figure 9.

There are six questions in this section, which record information about the most important (and reliably reported) crimes – shoplifting, drug selling, other theft, fraud, forgery and committing acts of violence. The first two questions use the standard TOP days format and the other four have a simple yes or no response format.

Above all the other sections, Section 3 needs special handling concerning confidentiality. You need to reassure the client about this issue and the following introductory words should be paraphrased:

“I’m now going to move on to ask you some questions about things you may have done in the past four weeks that are against the law. Clients have obvious concerns about confidentiality and I want to stress that we ask all our clients these questions – as do treatment services all over the country – and the information is used to help us see what changes happen in this area over time. I am not asking for any details – just general information about how often or whether you did certain things.”

Asking about shoplifting and drug selling

Section 3(a) and 3(b) use the usual days format you are now familiar with.

Here’s how you would ask the questions about shoplifting and then drug selling – again showing the client the calendar...

“First of all, let’s look at shoplifting – stealing something from a shop or a supermarket. Did you do this at any time in the past four weeks?”

If the client says no, you move on to ask about drug selling. If the client answers yes, then use the standard procedure, paraphrasing the following:

“Let’s then look together at these dates. Maybe we can start with the most recent week. On how many days did you steal something from a shop?”

Mark on the calendar each day in week four that the client reports committing shoplifting. You might use the letters “Sh” to indicate this.

“What about the week before – did you do any shoplifting during that week?”

Record the shoplifting days as before and complete the remaining weeks recording the week totals in the four boxes next to Section 3(a) and then add these up to produce the NDTMS total in the blue box.

Section 3(b) should be completed in exactly the same way. We define selling as exchanging drugs for money or other goods and services.

Note: it is important to note that the TOP does not record drug possession – just drug selling.

Section 4: Health and social functioning

a Client’s rating of psychological health status (anxiety, depression and problem emotions and feelings)

Poor 0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 **Good** 0-20

Record days worked and at college or school for the past four weeks

	Week 4	Week 3	Week 2	Week 1	Total
b Days paid work	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-28
c Days attended college or school	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-28

d Client’s rating of physical health status (extent of physical symptoms and bothered by illness)

Poor 0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 **Good** 0-20

Record accommodation items for the past four weeks

e Acute housing problem	Yes <input type="checkbox"/>	No <input type="checkbox"/>	<input type="text"/>	Enter ‘Y’ or ‘N’
f At risk of eviction	Yes <input type="checkbox"/>	No <input type="checkbox"/>	<input type="text"/>	Enter ‘Y’ or ‘N’

g Client’s rating of overall quality of life (e.g. able to enjoy life, gets on well with family and partner)

Poor 0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 **Good** 0-20

Figure 10: Section 4 of the TOP form

Asking about other theft, fraud and violence

The remaining four questions in Section 3 use the simple format yes or no to record information about committing other types of theft, fraud, forgery and handling, and also committing assault or other violence at any time in the past four weeks.

For question 3(c), ask clients if they have stolen something from a vehicle or taken a vehicle and driven away (theft of vehicle) in the past four weeks. Place a tick in the box on the TOP form to show their answer as yes or no.

Question 3(d) asks clients if they have stolen something from a commercial or a residential property or some other type of theft in the past four weeks. Tick yes for any affirmative answer in the box on the TOP form or no as appropriate.

Question 3(e) concerns fraud, forgery and handling stolen goods. Ask the client if they have been involved in any cheque or card fraud or forgery or involved in handling stolen goods at any time in the past four weeks. Place a tick in the box on the TOP form to show if they answer yes or no.

For the coding to NDTMS of these three items, you can see that if the client has answered yes to one or more of questions 3(c), 3(d) or 3(e) then you place a “Y” in the blue box. If the client answered no for all three questions – write “N” in the box.

The last question in Section 3, 3(f), concerns assault or violence. Ask clients if they have committed an act of violence or assault on anyone in the past four weeks. Place a tick in the box on the TOP form to show their answer yes or no.

For the coding of NDTMS, if the client answers yes to 3(f) place a “Y” in the blue box. If the client answers no write “N” in the box. If they can’t or won’t answer, write “NA”.

Section 4: Health and social functioning

The fourth and final section of the TOP is shown in Figure 10.

Section 4 contains a broad set of items about health and health-related quality of life, work or college, and accommodation issues. There is a mix of reporting formats here that need special care in completing. Work, college and school use the familiar days in the past four weeks format and housing uses the simple yes or no format, but the health questions have a different format.

Introducing Section 4

Frame this final section as follows:

“We are nearly finished doing the TOP assessment together on this occasion. I’ve now got a very important group of questions to ask you about which look at your health and your life in general. Answers to these questions will give me an important picture about your situation and what needs to be improved.”

Asking about psychological health:

“As before, please reflect back across the past four weeks. The first thing I’d like you to think about is your emotional health during this time – I mean by that feelings of anxiety, depression or other emotions and feelings that were troubling you – and your overall sense of how you were”.

Note: Show the client the TOP form and point out the rating scale for 4(a).

“How would you rate your psychological health on a scale from nought (“0”) to twenty (“20”), where zero is very poor indeed – the worst it could be – and twenty is very good, pretty much the best it could be. What number would you say comes closest reflecting you have been feeling? As you can see, a lower number means you had greater problems in this area and higher number means you had fewer problems or no problems at all? There’s no right or wrong answer – just your rating.”

Place a circle around one number on the scale for 4(a) and write this number in the NDTMS blue box.

Tips for completing

As you can see this is a very simple subjective rating of psychological health. A long, multiple-item rating scale would have taken up too much time and we have found that this single item does the job adequately. Here are some suggestions to help you:

- If the client is unsure about what you mean, then you should expand on what you mean by feelings of anxiety, depression and other troublesome feelings and emotions. The key point to make is each of us experiences things differently and that these feeling can range from mild, to moderate to severe
 - Anxiety – this is an unpleasant emotional state that can bring about thoughts and feelings as worry, uneasiness or apprehension, fear or panic
 - Depression – this may be experienced as very negative thoughts about yourself as a person with feelings of hopelessness and low self-worth or self-esteem
- It’s important to remember that this question is just a simple subjective rating – it can never take the place of a proper psychological assessment
- If a client says “I really can’t pin-point a single number” ask for their best estimate
- If this is difficult to do, you have another strategy. Paraphrase the following: “Would you say it was above or below the middle of the scale?” Then, according to the answer, break that part of the scale down into two ranges of 5-points, (i.e. “0–4” and “5–9”, or “11–15” and “16–20”). Ask clients if they feel they would score within the upper or the lower range and score them at the mid-point. Here’s an example:

1. A client feels unable to really give a precise number
 2. You ask if feelings are above the middle of the scale (in the “good” range) or below the middle of the scale (in the “poor” range)
 3. If the reply is “in the poor range,” you then say: “Do you think it was towards the bottom end of the scale – towards zero, or towards the top end of the scale towards the mid-point?”
 4. If the reply is towards the bottom of the scale, ask if a score in the middle of the range (“2”) feels about right. If it is towards the top of the range ask if a score in the middle of the range (“7”) feels about right.
- The score ranges and mid-points are therefore as follows:
 - 0–4 (mid-point = 2)
 - 5–9 (mid-point = 7)
 - 11–15 (mid-point = 13)
 - 16–20 (mid-point = 17)

Asking about work and college

Items 4(b) and 4(c) are about work and college or school, and use the standard “days in the past four weeks” format. It might seem odd to have a 0-28 days range for these two items but it is possible for someone to work every day and college attendance might span over a weekend.

Work includes formal paid employment as well as casual work. College and school includes all types of educational course including vocational or other training.

“Let’s now move on to look at work and college. Looking back over the past four weeks did you have any paid work – either a formal job or some casual paid work?”

Note: It’s best to show the calendar again here to remind the client of the start and end days of the past four weeks.

Record the number of days of work on the calendar by week and enter the number of days on the TOP to the right of 4(b) and add these together to get the overall number of days and write this figure in the blue NDTMS box as shown. Record “0” in each week if the client has not had any paid work.

Then ask about college or school:

“What about college or some other training. Looking back over the past four weeks did you attend school, college or a training course?”

Note: Use the calendar again here and note that we are talking about actual days attended school/college.

Record the number of days the client attended college or school on the calendar by week and enter the number of days on the TOP to the right of 4(b). Add these to get the overall number of days and write this figure in the blue NDTMS box as shown.

Asking about physical health

4(d) is a rating scale to record the clients’ ratings of their physical health status over the past four weeks. Frame this question as follows:

“Let me now ask you to give me a rating about your physical health. Can you think in an overall way about physical symptoms or being bothered by illness during the past four weeks – this includes pain, breathing problems, gastric problems, sleep problems and any physical symptoms”.

Note: Show the TOP form and point out the rating scale for 4(d).

“So how would you rate your physical health on a scale from nought (“0”) to twenty (“20”), where zero is very poor indeed, the worst it could be, and twenty is very good – pretty much the best it could be. What number would you say comes closest reflecting you have been feeling physically? As you can see a lower number means you had greater problems in this area and higher number means you had fewer problems or no problems at all? There’s no right or wrong answer – just your rating.”

Place a circle around one number on the scale for 4(a) and write this number in the NDTMS blue box.

Tips for completing

As with 4(a), this is a very simple subjective rating of physical health. There is a constellation of physical symptoms that could be bothering the client. Here are some tips for completing this section:

- The TOP is obviously not a medical examination and you need to avoid getting the client providing a detailed description of their health. Recording a simple rating of physical health is not difficult however – remember that you are simply asking for the client’s own subjective evaluation – there are no right or wrong answers
- We are distinguishing between having a chronic illness and being bothered or troubled by symptoms connected with it. For example, a client might be suffering from an obstructive airway disease (bronchitis) and receiving treatment for this and not be suffering any symptoms
- If a client says “I really can’t pin-point a single number” ask for a best estimate
- If this is difficult to do, you have another strategy and should use the same technique as for psychological health.

Note: Avoid mentioning whether you used this approach for psychological health because this could contaminate the answer for physical health.

Paraphrase the following: “Would you say it was above or below the middle of the scale?” Then, according to the answer, break the scale down into two ranges of five-points

(0–4 and 5–9, or 11–15 and 16–20) and ask clients if they feel they would score within the upper or the lower range and score the client at the mid-point. Here's an example:

1. The client feels unable to really give a precise number.
2. You ask if feelings are above the middle of the scale (in the "good" range) or below the middle of the scale (in the "poor" range).
3. If replying "in the poor range," you then say: "Do you think it was towards the bottom end of the scale – towards zero, or towards the top end of the scale towards the mid-point?"
4. If client feelings are towards the bottom of the scale, ask if a score in the middle of the range ("2") feels about right; if feelings are towards the top of the range ask if a score in the middle of the range ("7") feels about right.

The score ranges and mid-points are therefore as follows:

- 0–4 (mid-point = 2)
- 5–9 (mid-point = 7)
- 11–15 (mid-point = 13)
- 16–20 (mid-point = 17)

Asking about accommodation issues (problems and risks)

Questions 4(e) and 4(f) ask about accommodation issues for the past four weeks. They are simple yes or no questions.

Homelessness

4(e) records whether the client is categorised as having an acute housing problem. What is meant by this? We are talking about people who are homeless using the definition that they do not have accommodation that they have a legal right to occupy and which is available to them and is reasonable to occupy. We are not talking about clients who are living in rented accommodation, those who own their own property, those living at home with parents or relatives or those living in an institution (such as a residential unit, a hospital or a prison).

The TOP therefore defines acute housing problem as one or more of the following:

- The client is of no-fixed-abode and has been sleeping on a night-by-night basis on the streets
- The client has been sleeping in a night shelter on a night-by-night basis
- The client has been sleeping on different friends' floors night-by-night.

This definition does not include people who are:

- Living in temporary accommodation (up to six months) involving staying with friends or family as a guest, living in a B&B; living in a direct access short stay hostel, living in a house of multiple occupancy or squatting
- Living in settled accommodation, that is they are entitled to occupy this for six months or more and have a form of assured or secure tenancy or are an owner occupier. These people would not be considered acutely homeless or of no fixed abode.

So, to ask 4(e), paraphrase the following:

"In the past four weeks have you had no place of your own to stay so that you had to sleep rough on the streets, or staying at a night shelter or hostel, or sleep on different friends' floors each night?"

Record the client's answer to 4(e) by placing a tick in the box to the right of their answer. In the blue NDTMS box write "Y" if clients answer yes or "N" if they answer no.

Risk of eviction

Question 4(f) records whether the client is categorised as having being at risk of eviction. What is meant by this? We are talking here about clients who are living in rented accommodation or those who own their own property.

The TOP defines risk of eviction as follows:

The current status of the client in the past four weeks is that he or she has had either:

- A verbal warning from their landlord (or agency or lender) concerning their tenancy that concerns some infringement of the agreement – such as arrears in housing payments (rent or mortgage)
- A formal written warning, notice seeking possession or court order which may result in their eviction from their rented or owned property.

Note: Technically all drug users who use non prescribed drugs on any rented premises are at risk of eviction but do not use this as evidence or eviction risk.

Ask 4(f) by paraphrasing the following:

"In the past four weeks have you been at risk of eviction from where you are living? By that I mean you had served on you in the past four weeks a verbal warning or a more formal warning from someone such as a landlord or the court concerning arrears in housing payments or something else that could result in you losing the right to continue living in your home?"

Record the clients' answers to 4(f) by placing a tick in the box to the right of their answer. In the blue NDTMS box write "Y" if the client answers yes or write "N" if they answer no.

Asking about quality of life

The final item on the TOP form, 4(g), records the clients' impressions of their overall quality of life over the past four weeks. It uses the 0–20 scored subjective rating scale that you have used already to record psychological and physical health. "Quality of life" is a commonly used phrase, but it means different things to different people.

The TOP defines quality of life as an umbrella term that refers to the clients' overall sense of satisfaction with living conditions and circumstances, family and other relationships, work and financial aspects of their lives and overall social situation.

Frame this question as follows:

"Let me now ask you finally to give me a rating about how you see your overall quality of life. Can you think in an overall way about your living conditions and circumstances, your family and other relationships, work and financial aspects of your life and your overall social situation?"

Note: Show the TOP form and point out the rating scale for 4(d).

"So how would you rate your quality of life on a scale from nought ("0") to twenty ("20"), where zero is very poor indeed, the worst it could be, and twenty is very good – pretty much the best it could be. What number would you say comes closest reflecting your situation. As you can see, a lower number means you feel you had worse quality of life and higher number means you had a better quality of life, all things considered. There's no right or wrong answer – just your rating".

Place a circle around one number on the scale for 4(g) and write this number in the NDTMS blue box.

Tips for completing

As with 4(a) and 4(d) this is a very simple subjective rating of quality of life. Use the same procedure if the client has difficulty choosing a single number. The score ranges and mid-points are therefore as follows:

- 0–4 (mid-point = 2)
- 5–9 (mid-point = 7)
- 11–15 (mid-point = 13)
- 16–20 (mid-point = 17).

Completing the first TOP interview

As you we have seen, the TOP is a brief record of behaviours and other ratings and does not cover all of the topics that a keyworker needs to address in the treatment engagement phase. Once you have completed all the questions, it is advisable to say to the client that you will be looking again at the TOP interview when you review the care plan.

Using the TOP in the treatment delivery phase

In this final section we focus on the use of the TOP as part of the treatment delivery phase. This section should be cross-referenced with the NTA's Care Planning Practice Guide: Update 2007 (NTA 2007). The client's care plan needs to be regularly reviewed (ideally every three months but more or less frequently depending on individual need) with the client and other care providers. As an absolute minimum standard, reviews should be conducted annually. The TOP, however, must be completed every three months and at discharge. This provides a consistent time-frame for monitoring outcomes within your service and at the national level.

Note: When you use the TOP for the first and subsequent reviews you need to be absolutely clear that the questions concern the previous four weeks. Use the calendar based prompt to frame this period as described above.

There is evidence that good care planning improves treatment outcomes and the TOP can assist in setting care plan objectives and goals and charting progress. An example of the connection we have in mind is as follows:

Client intake TOP profile:

The client is a daily heroin injector with episodic heavy alcohol and crack use, in marked ill health and is sleeping rough. The TOP is completed at initial assessment.

Initial care plan objectives:

1. Stop injecting heroin and reduce heroin intake
2. Aim to control drinking and cocaine use that results when intoxicated
3. Access primary care and focus on ways of improving sleep quality
4. Access local authority housing department.

In this example, the worker discusses progress at the regular scheduled keyworking sessions and then formally reviews progress at 12 weeks using the TOP.

TOP changes discussed:

At the 12 week care plan review, the following changes are noted:

1. Days of injecting have reduced from 28 to 0 (100% improvement)
2. Heroin using days have reduced from 28 to 12 (client is smoking heroin 3 days each week and has therefore made encouraging progress)
3. Drinking days have reduced from 14 to 8 and crack using days from 14 to 4

4. Client's physical and psychological scores have improved from 4 to 13 (physical) and from 6 to 14 (for psychological)
5. The client has moved from being acutely homeless to living in local authority accommodation so scores 'no' on Q4e.

These initial changes are important for the client and you can see how further objectives could be included in the reviewed care plan to create further change momentum and recovery.

This is just one example among many. Each client will have their own unique TOP, care plan and change profile. The change in TOP scores for the things that the TOP does measure will help you and your clients clearly see what has improved in the past three months and where further work might be needed to help clients improve things. This feedback of real, measured change can be a real motivational tool in your work with a client. And, as we develop a baseline for TOP scores, you and your clients will also be able to see how they are improving compared to other people in similar situations.

Reviewing TOP scores

We suggest you compare each TOP review form with the previous and with the first TOP. This means all the completed TOP forms need to be kept, probably in the client's file.

There are different ways in which the scores from TOP to TOP could be tracked graphically in a way that makes immediate sense to clients. Your service or partnership may want to look at how this can be done locally. The NTA will be looking at some of the scoring and charting methods that could be used and plans to produce guidance on them.

Looking together at the changes indicated on the forms can be a very illuminating event for the client. You should look at ways of highlighting the positive changes to reinforce progress. Here's an example:

A client has reduced their amphetamine use from 20 days in the month before starting treatment to 5 days in the month before the first care plan review. There is recognition by the client and worker that this is a major achievement after many weeks of regular amphetamine use. The keyworker uses this TOP score change to discuss:

- How the client has felt physically after several days of amphetamine abstinence
- How the client has spent time when not using
- Any 'less good things' that have resulted from cutting back (e.g. not seeing using friends so much)
- The fact that the client has used more alcohol
- The reduced money spent on amphetamine and the increased money spent on alcohol

- Whether the client feels ready to try to stop amphetamine use altogether.

You can see that discussing these and other relevant aspects can serve to build further motivation for further change, identify ambivalence about this as well as identify practical activities to further health gain.

Ultimately, the TOP is simply a set of questions and a method for asking and recording them. But in the hands of a keyworker the TOP can play an important part in building a therapeutic relationship and grounding the care planning and review process.

More information

There is more information and additional TOP resources on the NTA website at www.nta.nhs.uk/TOP.

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