National Treatment Agency for Substance Misuse

National Drug Treatment Monitoring System (NDTMS)

NDTMS DATA SET H

BUSINESS DEFINITION FOR ADULT DRUG TREATMENT PROVIDERS

Author	**M. Hinchcliffe**
Approver	**M. Roxburgh**
Date	**01/03/2011**
Version	**8.03**

REVISION HISTORY

Version	Author	Purpose / Reason	Date
4.00	M. Roxburgh	New items added for 2007-08 data collection Nationality Accommodation Need Frequency of use of problem substance No.1 Children Pregnant Drinking days Units alcohol Dual diagnosis Hep C – Intervention Status Modality Exit Status Sexuality (regional item) Items removed Accommodation Status (replaced by accommodation need) Postcode Incode (technical change to existing postcode field will enable this to be captured by regional NDTMS centres without requiring a separate data item) Parental Status (replaced with no. of children and pregnancy)	04/10/2006
4.10	M Roxburgh	Parental Status reinstated, in order to ensure that existing DH and NTA commitments to Hidden Harm data monitoring are not discontinuous. The wider YP treatment monitoring requirements are currently being reviewed. This will probably lead to further YP specific changes being announced as part of NDTMS Data Set E (April 07) Employment Status moved from Regional data items to National data item	26/10/2006
4.20	G Scott	Description of Client Reference correct (field may contain attributable information)	03/11/2006
4.30	G Scott	Update following review by external parties Clarification of guidance relating to clients that are NFA Clarification of definition of Nationality	09/11/2006
4.40	G Scott	Clarify all references to "last month" or "four weeks" to 30 days	12/02/2007
5.00	G Scott	Update for CDS-E (inclusion of Treatment Outcomes Profile (TOP) New Fields Treatment Outcomes Protocol (TOP) date Treatment Stage Alcohol use Opiate use Crack use Cocaine use Amphetamine use Cannabis use Other drug use	29/05/2007

Version	Author	Purpose / Reason	Date
		IV drug use Sharing Shop theft Drug selling Other theft Assault/violence Psychological health status Paid work Education Acute housing problem Housing risk Physical health status Quality of Life Fields Changed Injected in the last 28 days (was injected in the last 30 days) Field Deleted Parental Status Frequency of use of Problem Substance No 1 Employment Status	
5.10	G Scott	Update for CDS-E (inclusion of Treatment Outcomes Profile (TOP) New Fields Treatment Outcomes Protocol (TOP) date Treatment Stage Alcohol use Opiate use Crack use Cocaine use Amphetamine use Cannabis use Other drug use IV drug use Sharing Shop theft Drug selling Other theft Assault/violence Psychological health status Paid work Education Acute housing problem Housing risk Physical health status Quality of Life Fields Changed Injected in the last 28 days (was injected in the last 30	29/05/2007

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		days) Field Deleted Parental Status Frequency of use of Problem Substance No 1 Employment Status	
5.20	G Scott	Reclassification of Parental Status as NDTMS Data Set	30/08/2007
5.30	M Kozikova	Uplifting external references	02/07/2008
6.00	J. Knight	Update for CDS F New Discharge coding (see Appendix F) New Parental Status Coding see (Appendix G) New TOP care coordination field Revised definition of Children data item	28/01/2009
6.01	R. Bull	Discharge Date restored	16/02/2009
6.10	R. Bull	Consolidation of 6.0.0, 6.0.1 changes	16/02/2009
7.01	J. Jaswani	CDSG Modality Code Definitions ***Inpatient treatment*** • Inpatient treatment assessment only • Inpatient treatment stabilisation • Inpatient treatment detoxification (assisted withdrawal) ***Psychosocial Interventions*** • Behavioural couples therapy • Family therapy • Contingency management (drug specific) • Psychosocial intervention to address common mental disorders • Other formal psychosocial therapy (e.g. community reinforcement approach or social behaviour network therapy)	01/03/2010
7.02	M. Hinchcliffe	Appendix A: No 29 – 'Pregnant' Updated to 'Not expected to change (i.e. as at start of Episode)' inline with YP and Adult Alcohol Business Definitions.	21/04/2010
7.03	M. Hinchcliffe	Client Reference definition updated with clarification "(NB: this must not hold or be composed of attributers which might identify the individual)" Change to 'PCT of residence' data item description.	11/05/2010
7.04	M. Hinchcliffe	Appendix A; No. 22 & 23 – "May be left blank if client has no second drug" removed for 'Problem Substance No 2' and 'Problem Substance No 3'.	03/09/2010

Version	Author	Purpose / Reason	Date
7.05	M. Hinchcliffe	Sex Worker Category data item removed. Item removed. This item was previously included within the data set for collection and use at regional level only. Following consultation, this data item will be removed from the data set at the next revision in April 2011. In the interim, the NDTMS systems will be amended to exclude any data submitted in this field and cease any entries from being uploaded onto the database.	14/10/2010
8.00	M. Hinchcliffe	The following fields have been updated to be mandatory and must be completed in all records: • Client ID • Episode ID • Modality ID[1] • TOP ID[1] [1]MUST be completed if any items in this section above are not null. If not, record rejected '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. 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. New fields added to Core Data Set - 'Hep C Tested'. Permissible values: • No • Yes • Not asked	04/01/2011
8.02	M. Hinchcliffe	Updated external references Section C.5.1 - Tier 4b services removed.	24/01/2011
8.03	M. Hinchcliffe	Definition of Local Authority updated as below: 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.	01/03/2011

EXTERNAL REFERENCES

Ref No	Title	Version
1	NDTMS Data Set - Technical Definition	8.02
2	NDTMS Data Set - Reference Data	8.03
3	2006-07 WT guidance	Nov 05
4	Models of Care for Treatment of adult drug misusers:	Update 2006

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

CONTENTS

1 INTRODUCTION

This document establishes, at a business level, the set of performance data items (known as the NDTMS Data Set) to be collected and utilised by the NDTMS.

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

This version (commonly referred to as the NDTMS Data Set 'H') will come into effect for national data collection from 1st April 2011.

This document contains definitions that are primarily applicable to use with clients aged 18 or over. Information and definitions relating to data collection from the Young Peoples treatment system can be found 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 agency 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 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 above.

2 REQUIREMENTS

The data items contained in the NDTMS Data Set are intended to address the following critical requirements:

- Provide measurements to support the NHS outcomes framework as appropriate
- Provide measurements NTA Key Performance Indicators and elements of the drug strategy, for example:
    - Waiting times
    - Access for Parents/Crack clients and BME groups
    - Housing and Employment
    - Proportion of clients successfully completing treatment
    - Unit cost of treatment (met by providing related factors only)

3 CARERS, RELATIVES AND CONCERNED OTHERS REPORTING TO NDTMS

NDTMS is currently designed only to receive details of the treatment episodes of problematic drug 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 five different entities or groups. These are:

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

5 DATA ITEMS

Sect No	Item	Description
1	Initial of client's first name	The first initial of the client's first name – for example Max would be 'M'
	Initial of client's surname	The first initial of the clients surname – for example Smith would be 'S', O'Brian would be 'O' and McNeil would be 'M'.
	Date of birth of client	The day, month and year that the client was born.
	Sex of client	The client gender at registration
	Ethnicity	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.
	Nationality	Country of nationality at birth

Sect No	Item	Description
2	Referral Date	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 date is used in waiting times calculations please see APPENDIX B .
	Agency Code	An unique identifier for the Treatment provider (agency) that is defined by the regional NDTMS centres – for example L0001
	Client Reference	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 attributers which might identify the individual)
	Client ID	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 attributers, which might identify the individual.). A possible implementation of this might be the row number of the client in the client table.

Sect No	Item	Description
2	Episode ID	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 hold or be composed of attributers, which might identify the individual). A possible implementation of this might be the row number of the episode in the episode 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).
	Previously treated	Has the client ever received structured drug treatment at this or any other treatment provider?
	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 (i.e. '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 Post Code should be left blank.
	Accommodation Need	The accommodation need refers to the current situation (28 days prior to treatment start) of the client with respect to housing need. The NDTMS Data Set - Reference Data [2] contains two sets of reference data for Accommodation Need, to cater for those providing services to Adults and Young Persons Appendix E and the NDTMS Data Set - Reference Data [2] gives some guidance as to the use of this field for Adult Services
	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.
	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

Sect No	Item	Description
2	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.
	Local Authority	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.
	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.
	Problem Substance No. 1	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.
	Age of first use of Problem Substance No. 1	The Age (in years) that the client recalls first using the Problem Substance No. 1
	Route of Administration of Problem Substance No. 1	The route of administration of Problem Substance No. 1 recorded at the point of triage / initial assessment
	Problem Substance No. 2	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.
	Problem Substance No. 3	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.

Sect No	Item	Description
2	Referral Source	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].
	Triage Date	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.
	Care Plan Started Date	Date that a care plan was created and agreed with the client for this treatment episode.
	Injecting Status	Is the client currently injecting, have they ever previously injected or never injected?
	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.
	Pregnant	Is the client pregnant?
	Drinking days	Number of days in the 28 days prior to initial assessment that the client consumed alcohol
	Units of alcohol	Typical number of units consumed on a drinking day in the 28 days prior to initial assessment
	Dual Diagnosis	Is the client currently receiving care from mental health services for reasons other than substance misuse?
	Hep C Tested	Has the client been tested for Hep C? This test may be within the current treatment episode or previously to the episode. If the response is 'Yes' the 'Hep C – Latest Test Date' should be completed.
	Hep C – Latest Test Date	Date that the client was last tested for Hepatitis C. This test may be within the current treatment episode or previously to the episode. If the exact date is not known then the 1st of the month should be used if that is known. If only the year is known then the 1st of January for that year should be used.
	Hep C – Intervention Status	Within the current treatment episode, whether the client was offered a test for Hepatitis C, and if that offer was accepted by the client.
	Hep B Vaccination Count	Within the number of Hepatitis B vaccinations given to the client within the current treatment episode, or if the course of vaccinations was completed. Vaccinations can be provided by the treatment agency or elsewhere, such as in Primary Care. Where this or a partner treatment provider provides one vaccination to a client but this actually completes the course, then 'course completed' should be recorded rather than 'one vaccination'.
	Hep B Intervention Status	Within the current treatment episode, whether the client was offered a vaccination for Hepatitis B, and if that offer was accepted by the client.

Sect No	Item	Description
	Drug treatment health care assessment date	The date that the initial healthcare assessment was completed in accordance to defined local protocols. The full scope and depth of the assessment will vary according to the presenting needs of the client, but should include an initial assessment of the client's physical health and mental health needs. Any arising needs should form part of the care plan and would be directly responded to by the drugs agency itself or, where health needs are more specialised (e.g. dental care, sexual health) a formal referral is made to an appropriately qualified professional and followed up and reviewed by the drugs worker as part of the on-going delivery of the care plan.
	TOP Care Coordination	Does the treatment provider currently have care coordination responsibility for the client in regards to completing the TOP information when appropriate during the client's time in structured treatment.
2	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 reengage the client with treatment may occur. Note: This process should be used for clients triaged after 1st April 2006 and records should not be amended retrospectively.
	Discharge Reason	The reason why the client's episode of structured treatment (Tier 3/Tier 4) was ended. For discharge codes and definitions see APPENDIX F

Sect No	Item	Description
3	Treatment Modality	The treatment modality / intervention a client has been referred for / commenced within this treatment episode as defined in models of care. A valid treatment modality code should be used as defined in the NDTMS Data Set - Reference Data [2]. The NDTMS Data Set - Reference Data [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. Current definitions and name changes for all the Tier 3 / 4 modalities / interventions can be found in appendix C.
	Date Referred to Modality	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 tier 3 / 4 modality/intervention. For subsequent modalities it should be the date that both the client and the keyworker agreed that the

Sect No	Item	Description
3		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.
	Modality ID	A mandatory, technical identifier representing the modality, as held on the clinical system used at the agency. (NB: this should be a technical item, and should not hold or be composed of attributers, which might identify the individual). A possible implementation of this might be the row number of the modality in the modality table. This field is mandatory if any items in this section (Modality) are not null.
	Date of First Appointment Offered for Modality	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 appendix C of this document.
	Modality Start Date	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 C of this document
	Modality End Date	The date that the stated treatment modality/ intervention ended. If the modality has had a planned end then the date agreed within the plan should be used. If it was unplanned then the date of last face to face contact date within the modality should be used.
	Modality Exit Status	Whether the exit from the treatment modality was planned or unplanned

Sect No	Item	Description
4	Treatment Outcomes Profile (TOP) date	Date of most recent care plan review. All outcome status submitted in this section of the data-set will be associated and stored as being the status as of this date.
	TOP ID	A mandatory, technical identifier representing the TOP, as held on the clinical system used at the treatment provider. (NB: this should be a technical item, and should not hold or be composed of attributers, which might identify the individual). A possible implementation of this might be the row number of the TOP in the TOP table. This field is mandatory if any items in this section (TOP) are not null.
	Treatment Stage	Stage of treatment that the TOP data relates to
	Alcohol use	Number of days in previous 28 days that client has used
	Opiate use	Number of days in previous 28 days that client has used opiates
	Crack use	Number of days in previous 28 days that client has used crack

Sect No	Item	Description
4	Cocaine use	Number of days in previous 28 days that client has used powder cocaine
	Amphetamine use	Number of days in previous 28 days that client has used amphetamines
	Cannabis use	Number of days in previous 28 days that client has used cannabis
	Other drug use	Number of days in previous 28 days that client has used other problem drug
	IV drug use	Number of days in previous 28 days that client has injected non prescribed drugs
	Sharing	Has client shared needles or paraphernalia in last 28 days?
	Shop theft	Number of days in previous 28 days that client has been involved in shop theft
	Drug selling	Number of days in previous 28 days that client has been involved in selling drugs
	Other theft	Has client has been involved in theft from or of vehicle, property or been involved in fraud in last 28 days
	Assault/violence	Has client committed assault/violence in last 28 days
	Psychological health status	Self reported score of 0-20.
	Paid work	Number of days in previous 28 days that client has had paid work
	Education	Number of days in previous 28 days that client has attended college/education system
	Acute housing problem	Has client had acute housing problem (been homeless) in last 28 days
	Housing risk	Has client been at risk of eviction within past 28 days
	Physical health status	Self reported score of 0-20.
	Quality of Life	Self reported score of 0-20.

Sect No	Item	Description
5	Injected in last 28 days?	Has the client injected in the last 28 days?
	Ever Shared?	Has the client ever shared injecting paraphernalia?
	Previously Hep B Infected?	Has the client ever had a previous hepatitis B infection?
	Hep C Positive?	Is the client Hep C positive?
	Referred for Hepatology?	Has the client been referred to a hepatology unit?
	Sexuality	Clients self defined sexuality. A valid sexuality code should be used as defined in the NDTMS Data Set - Reference Data [2].
	Employment Status	The client's current employment status

APPENDIX A - WHAT DATA ITEMS SHOULD BE UPDATED AS EPISODE OF TREATMENT PROGRESSES

Sect No	No	Field Description	Rules & Guidance
1	1	Initial of Client's First Name	✓ MUST be completed. If not, record rejected. Should not change – otherwise the regional NDTMS team should be formally advised
	2	Initial of Client's Surname	✓ MUST be completed. If not, record rejected. Should not change – otherwise the regional NDTMS team should be formally advised
	3	Date of birth of client	✓ MUST be completed. If not, record rejected. Should not change – otherwise the regional NDTMS team should be formally advised
	4	Sex of client	✓ MUST be completed. If not, record rejected. Should not change – otherwise the regional NDTMS team should be formally advised
	5	Ethnicity	Should not change
	6	Nationality	Should not change
2	7	Referral Date	✓ MUST be completed. If not data may be excluded from performance monitoring reports. Should not change – otherwise the regional NDTMS team should be formally advised
	8	Agency Code	✓ MUST be completed. If not, record rejected. Should not change – otherwise the regional NDTMS team should be formally advised
	9	Client Reference	Should not change and should be consistent across all episodes at the Agency.
	10	Client ID	✓ MUST be completed. If not, record rejected Should not change
	11	Episode ID	✓ MUST be completed. If not, record rejected Should not change
	12	Consent for NDTMS	Client must give consent before their information can be sent to NDTMS May change (i.e. current situation)

Sect No	No	Field Description	Rules & Guidance
	13	Previously treated	Not expected to change (i.e. as at start of Episode)
	14	Post Code	May change (i.e. current living situation)
	15	Accommodation Need	Not expected to change (i.e. as at start of Episode)
	16	Parental Status	Not expected to change (i.e. as at start of Episode)
	17	DAT of residence	✓ MUST be completed. If not data may be excluded from performance monitoring reports. May change (i.e. current living situation)
	18	PCT of residence	May change (i.e. current living situation)
	19	GP Practice Code	May change (i.e. current living situation)
	20	Problem Substance No 1	✓ MUST be completed. If not, record rejected. Not expected to change (i.e. as at start of Episode)
	21	Age of first use of Problem Substance No 1	Not expected to change (i.e. as at start of Episode)
	22	Route of Administration of Problem Substance No 1	Not expected to change (i.e. as at start of Episode)
	23	Problem Substance No 2	Not expected to change (i.e. as at start of Episode)
	24	Problem Substance No 3	Not expected to change (i.e. as at start of Episode)
	25	Referral Source	Not expected to change (i.e. as at start of Episode)
	26	Triage Date	✓ Trigger to submit record and MUST be completed. If not, record rejected Not expected to change (i.e. as at start of Episode)
	27	Care Plan Started Date	MUST be completed when Modality Start Date given. Not expected to change (i.e. as at start of Episode)
	28	Injecting Status	Not expected to change (i.e. as at start of Episode)
	29	Children	Not expected to change (i.e. as at start of Episode).

Sect No	No	Field Description	Rules & Guidance
	30	Pregnant	Not expected to change (i.e. as at start of Episode)
	31	Drinking Days	Not expected to change (i.e. as at start of Episode)
	32	Units of Alcohol	Not expected to change (i.e. as at start of Episode)
	33	Dual Diagnosis	Not expected to change (i.e. as at start of Episode)
	33	Hep C Tested	May change (i.e. current situation)
	34	Hep C – Latest Test Date	May change (i.e. current situation)
	35	Hep C - Intervention Status	May change (i.e. current situation)
	36	Hep B Vaccination Count	May change (i.e. current situation)
	37	Hep B Intervention Status	May change (i.e. current situation)
	38	Drug Treatment Health Care Assessment Date	Not expected to change (to be completed when initial health care assessment is completed)
	39	TOP Care Coordination	May change (i.e. current situation)
	40	Discharge Date	✌ Discharge date required when client is discharged. ALL modalities MUST now have end date. Discharge reason MUST be given. Should only change from 'null' to populated as episode progresses
	41	Discharge Reason	✌ Discharge reason required when client is discharged. Discharge date MUST be given. Should only change from 'null' to populated as episode progresses
3	42	Treatment Modality	✌ Required as soon as modality is known. Should not change – otherwise the regional NDTMS team should be formally advised
	43	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
	44	Modality Id	✓ MUST be completed. If not, record rejected Should not change

Sect No	No	Field Description	Rules & Guidance
	45	Date of First Appointment Offered for Modality	🕑 Waiting times calculated from this field. Should not change
	46	Modality Start Date	👌 Required when client actually starts modality 🕑 Trigger for Waiting Time to be calculated Should only change from 'null' to populated as episode progresses
	47	Modality End Date	👌 Required when client completes modality or is discharged. Should only change from 'null' to populated as episode progresses
	48	Modality Exit Status	👌 Required when client completes modality or is discharged. Should only change from 'null' to populated as episode progresses
4	49	Treatment Outcomes Profile (TOP) date	Not expected to change (i.e. as at TOP date)
	50	TOP ID	✓ MUST be completed if any items in this section above are not null. If not, record rejected Should not change
	51	Treatment Stage	Not expected to change (i.e. as at TOP date)
	52	Alcohol use	Not expected to change (i.e. as at TOP date)
	53	Opiate use	Not expected to change (i.e. as at TOP date)
	54	Crack use	Not expected to change (i.e. as at TOP date)
	55	Cocaine use	Not expected to change (i.e. as at TOP date)
	56	Amphetamine use	Not expected to change (i.e. as at TOP date)
	57	Cannabis use	Not expected to change (i.e. as at TOP date)
	58	Other drug use	Not expected to change (i.e. as at TOP date)
	59	IV drug use	Not expected to change (i.e. as at TOP date)
	60	Sharing	Not expected to change (i.e. as at TOP date)

Sect No	No	Field Description	Rules & Guidance
	61	Shop theft	Not expected to change (i.e. as at TOP date)
	62	Drug selling	Not expected to change (i.e. as at TOP date)
	63	Other theft	Not expected to change (i.e. as at TOP date)
	64	Assault/violence	Not expected to change (i.e. as at TOP date)
	65	Psychological health status	Not expected to change (i.e. as at TOP date)
	66	Paid work	Not expected to change (i.e. as at TOP date)
	67	Education	Not expected to change (i.e. as at TOP date)
	68	Acute housing problem	Not expected to change (i.e. as at TOP date)
	69	Housing risk	Not expected to change (i.e. as at TOP date)
	70	Physical health status	Not expected to change (i.e. as at TOP date)
	71	Quality of Life	Not expected to change (i.e. as at TOP date)
5	72	Local agency details	May change (Local modality item)
	73	Injected in last 28 days?	Not expected to change (i.e. as at start of Episode)
	74	Ever Shared?	Not expected to change (i.e. as at start of Episode)
	75	Previously Hep B Infected?	May change (i.e. current situation)
	76	Hep C Positive?	May change (i.e. current situation)
	77	Referred for Hepatology?	May change (i.e. current situation)
	78	Local Authority	NOW PART OF CORE DATA SET ✓ MUST be completed. If not, record rejected May change (i.e. current living situation)
	79	Sexuality	Not expected to change (i.e. as at start of Episode)
	80	Employment Status	Not expected to change (i.e. as at start of Episode)

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.

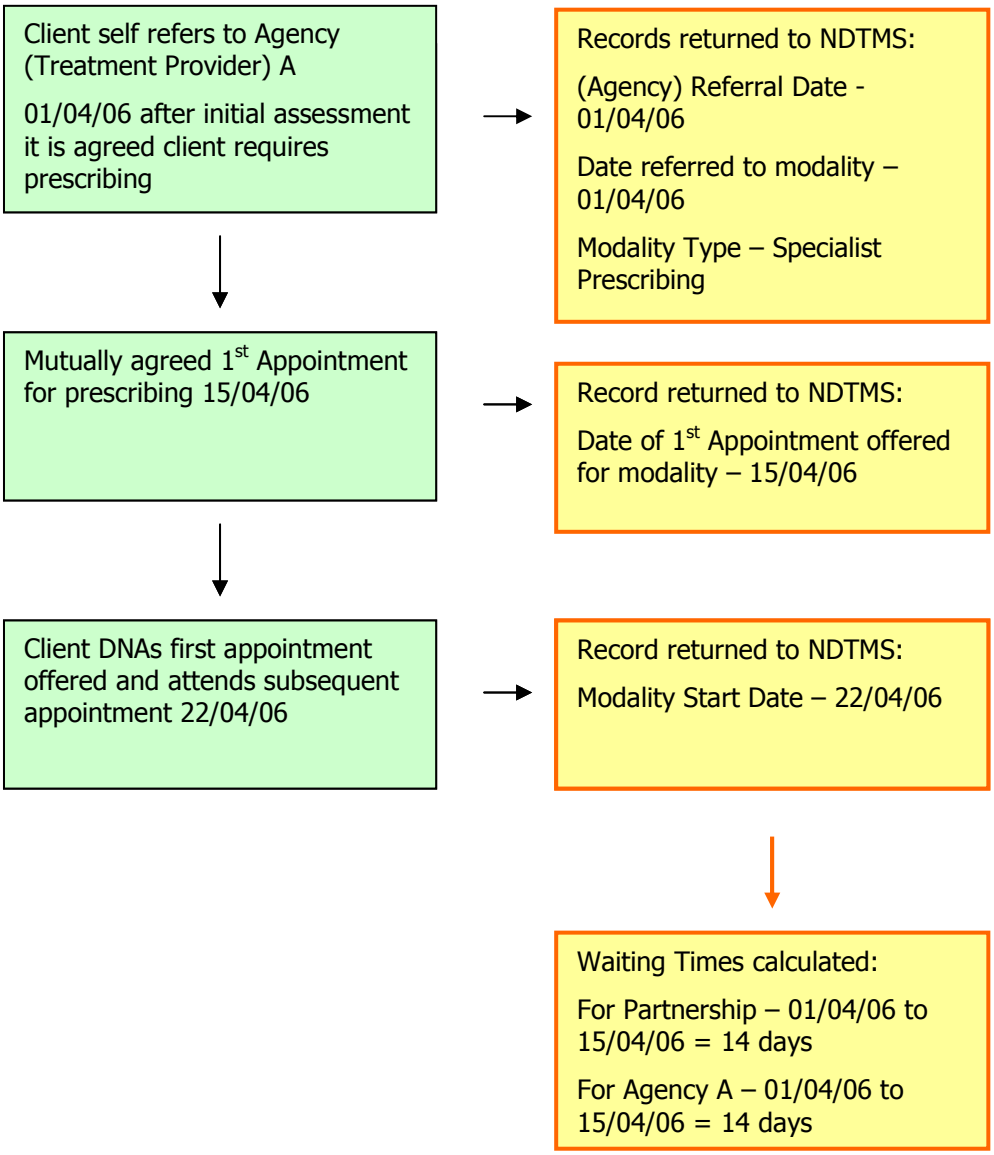
APPENDIX B - SCENARIOS AND EXAMPLES [3]

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.

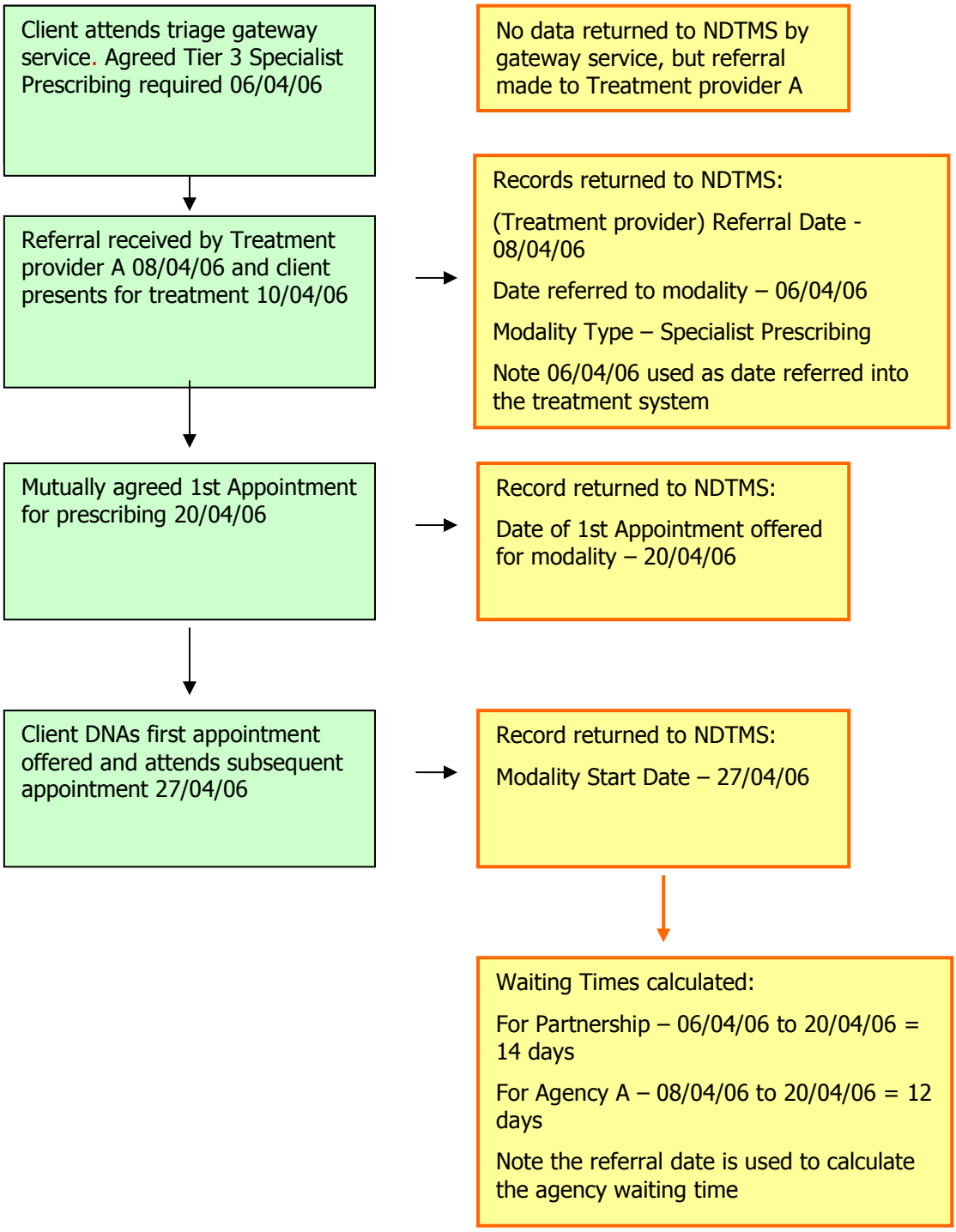
B.2 WAITING TIMES SCENARIO 1 – SELF REFERRAL

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



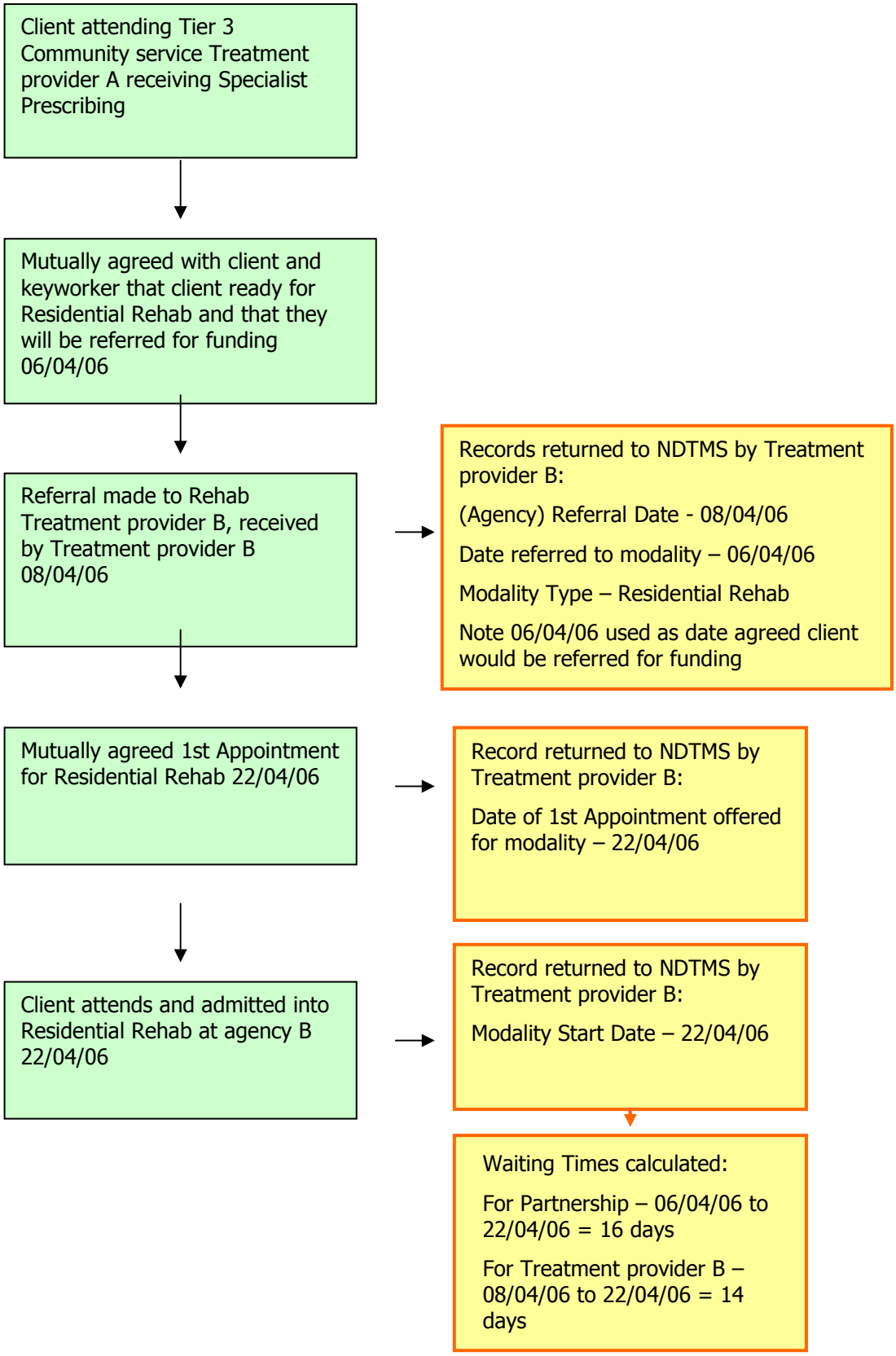
B.3 WAITING TIMES SCENARIO 2 – REFERRAL FROM A THIRD PARTY TREATMENT PROVIDER

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.



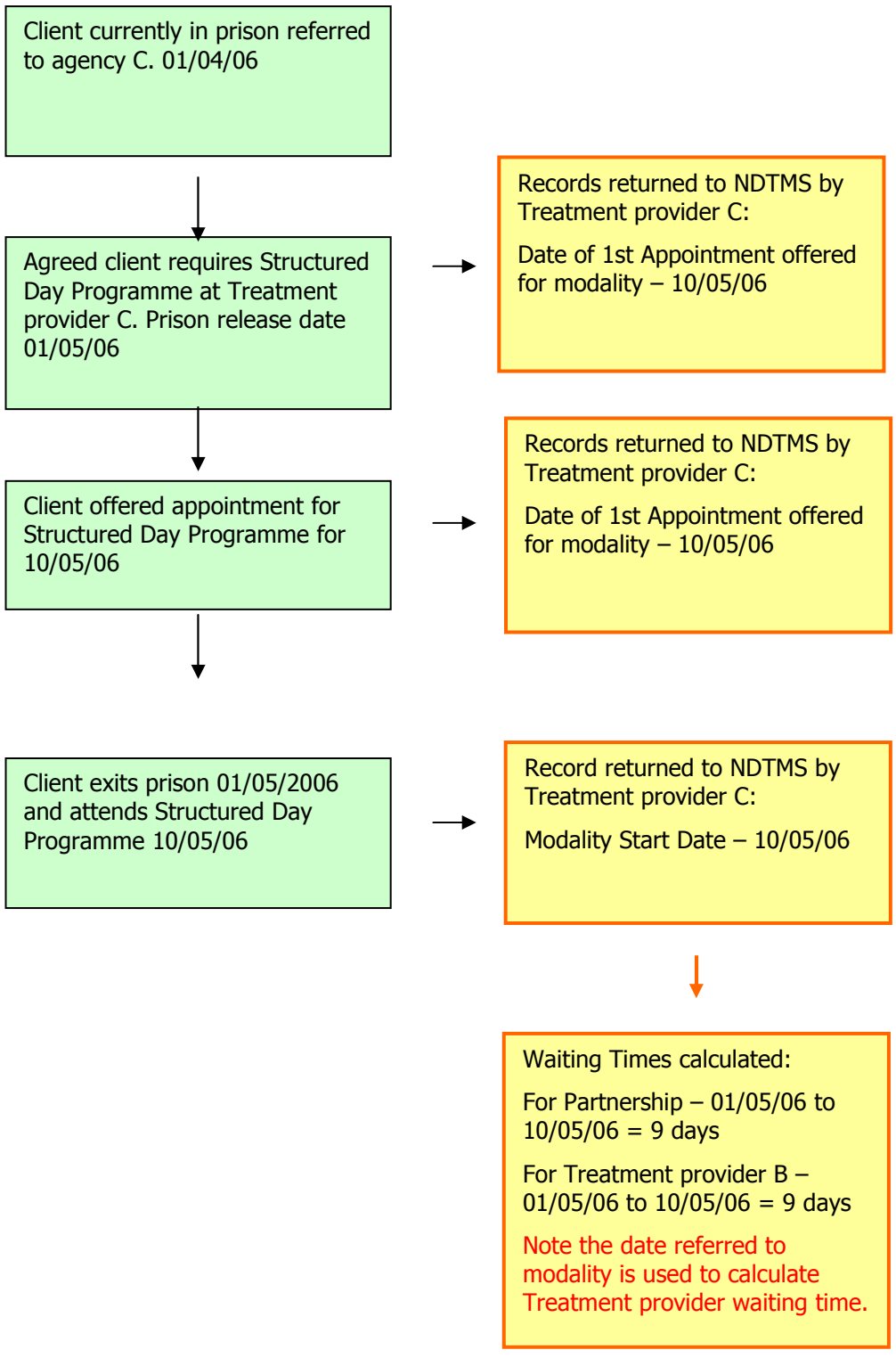
B.4 WAITING TIMES SCENARIO 3 – TIER 4

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



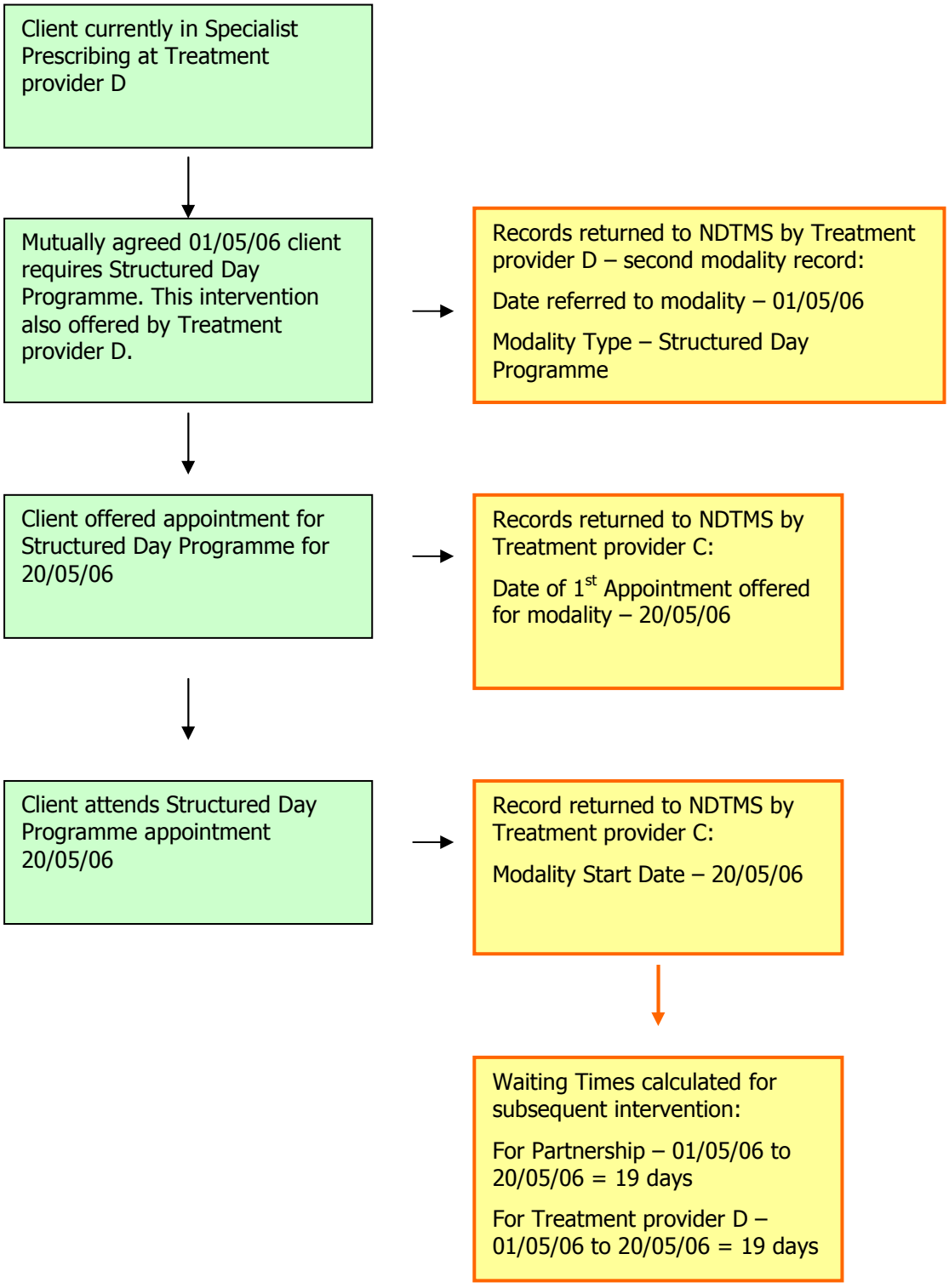
B.5 WAITING TIMES SCENARIO 4 – PRISON REFERRALS

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

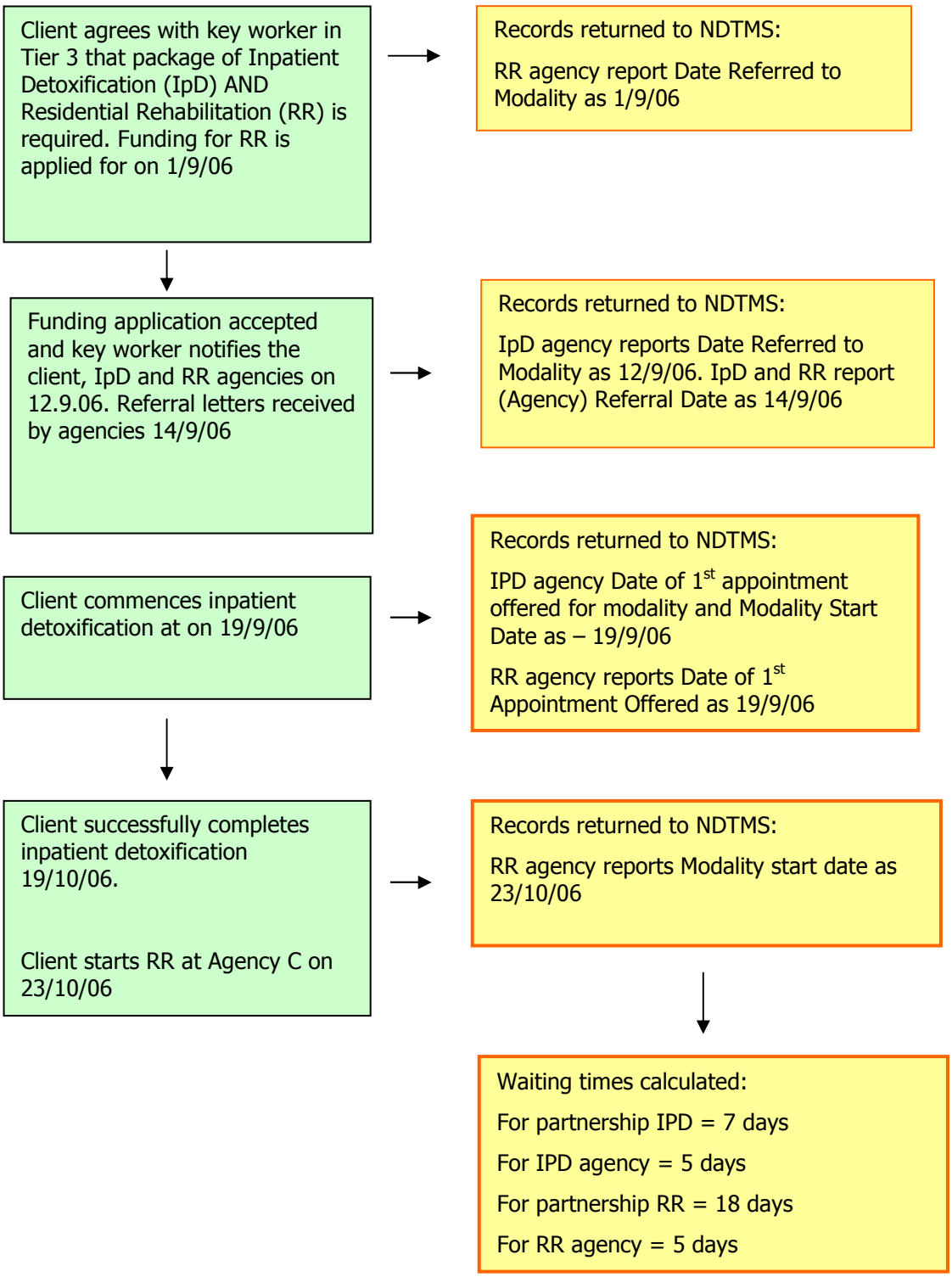


B.6 WAITING TIMES FOR SCENARIO 5 – SUBSEQUENT WAIT WITHIN AN EPISODE

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



B.7 WAITING TIMES SCENARIO 6 – MEASURING INPATIENT DETOXIFICATION AND RESIDENTIAL REHABILITATION AS A PACKAGE



APPENDIX C - DEFINITIONS OF INTERVENTIONS

See Models of Care: Updated 2006 [4] for further key definitions.

C.1 INPATIENT TREATMENT – DEFINITION OF INTERVENTIONS

An Inpatient Unit (IPU) provides care to service users with substance-related problems (medical, psychological or social) that are so severe that they require medical, psychiatric and psychological care. The key feature of an IPU is the provision of these services with 24-hour cover, 7 days per week, from a multidisciplinary clinical team who have had specialist training in managing addictive behaviours.

Treatment in an inpatient setting may involve one or more of the following interventions

1. Assessment
2. Stabilisation,
3. Assisted withdrawal (detoxification)

A combination of all three may be provided or, one followed by the other.

IPU treatment is based on a plan of care, developed prior to admission, and should encompass relevant preparatory work and a seamless transition to on-going treatment after discharge.

The three main settings for inpatient treatment are:

- General hospital psychiatric units
- Specialist drug misuse inpatient units in hospitals
- Residential rehabilitation units (usually as a precursor to the rehabilitation programme)

The modality/intervention start date is the date of admission to the inpatient facility.

C.1.1 Client choice – accessing a service with longer waiting times

Some clients choose to attend a service with longer waiting times than the service recommended by the referrer.

C.2 INPATIENT TREATMENT ASSESSMENT ONLY – DEFINITION OF INTERVENTION

Individuals with drug and alcohol dependence present with a wide range of psychiatric, physical and social problems.

Substance misuse services provide a comprehensive assessment of these needs and formulate a treatment care plan to tackle them.

A hospital setting permits a higher level of medical observation, supervision and safety for service users needing more intensive forms of care. Specific tasks of the IPU may include:

• Assessment of substance use
• Assessment of mental health
• Assessment of physical health
• Assessment of social problems

These should be undertaken as described in the *Inpatient Treatment of Drug and Alcohol Misusers in the National Health Service – Scan consensus project* (2006).

This document is available at using the following link.
http://www.scan.uk.net/docstore/SCAN_Inpatient_Consensus_project_document_FINAL.pdf

C.3 INPATIENT TREATMENT STABILISATION – DEFINITION OF INTERVENTION

There is considerable evidence that the number of service users with more complex problems (co-existing physical and mental illness, dependence on more than one substance) is increasing. Such cases can be managed in a community setting, but the IPU setting permits a high level of medical observation, supervision and safety for service users needing more intensive forms of care.

The IPU should have care pathways, clinical protocols, and sufficient human and physical resources to offer the following range of stabilisation procedures:

1. Dose titration

Admission to an IPU with staff skilled in monitoring the effects of methadone and the opioid withdrawal syndrome may prevent the individual dropping out of treatment, or else continuing to supplement their prescribed methadone or buprenorphine dose with illicit opioids

2. Dose titration on injectable opioid medication

IPU admission allows interventions to optimise the service user's injection technique, and 24 hour monitoring allows safer and more efficient calculations of dosage

3. Stabilisation on maintenance therapy

Use of heroin on top of a prescription of methadone can be problematic, and attempts to tackle it in the community may lead to increasing doses of methadone and rising opioid tolerance without the desired break from the illicit drug market

A short (one or two week) admission to an IPU may be an effective way of breaking this cycle, particularly when followed up by day care or intensive community support

4. Combination assisted withdrawal/stabilisation

A period of IPU treatment may allow assessment and treatment of the withdrawal symptoms from stimulant drugs, alcohol or benzodiazepines, and in doing so facilitate stabilisation on opioid maintenance treatment. Such individuals can then continue to receive Tier 3 interventions in a community setting

C.4 INPATIENT TREATMENT DETOXIFICATION (ASSISTED WITHDRAWAL) – DEFINITION OF INTERVENTION

Assisted withdrawal should only be encouraged as the first step in a longer treatment process, and needs to be integrated with relapse prevention or rehabilitation treatment programmes which can be provided in the NHS or independent/non-statutory sector

Withdrawal in an IPU setting offers better opportunities for clinicians to ensure compliance with medication and to manage complications. IPU admission also offers a major opportunity to recruit service users into longer-term treatment to reduce the risk of relapse back into regular drug or alcohol use

The IPU should have care pathways, clinical protocols, and sufficient human and physical resources to offer assisted withdrawal for a wide range of single and poly-drug and alcohol misuse problems.

C.5 RESIDENTIAL REHABILITATION – DEFINITION OF INTERVENTION

Drug residential rehabilitation consists of a range of treatment delivery models or programmes to address drug and alcohol misuse, including abstinence orientated drug interventions within the context of residential accommodation.

There is a range of residential rehabilitation services, which include:

- Drug and alcohol residential rehabilitation services whose programmes to suit the needs of different service users. These programmes follow a number of broad approaches including therapeutic communities, 12-Step programmes and faith-based (usually Christian) programmes
- Residential drug and alcohol crisis intervention services (in larger urban areas)
- Inpatient detoxification directly attached to residential rehabilitation programmes
- Residential treatment programmes for specific client groups (e.g. for drug-using pregnant women, drug users with liver problems, drugs users with severe and enduring mental illness). Interventions may require joint initiatives between specialised drug services (Tier 3 or 4, depending on local arrangements) and other specialist inpatient units
- Some drug-specific therapeutic communities and 12-Step programmes in prisons
- 'Second stage' rehabilitation in drug-free supported accommodation where a client often moves after completing an episode of care in a residential rehabilitation unit, and where they continue to have a care plan, and receive keywork and a range of drug and non-drug-related support
- Other supported accommodation, with the rehabilitation interventions (therapeutic drug-related and non-drug-related interventions) provided at a different nearby site(s)

Residential rehabilitation programmes normally combine a mixture of group work, psychosocial interventions and practical and vocational activities. These components are also used in specialist residential programmes for particular client groups (e.g. parent and child programmes).

The modality/intervention start is the date of admission to the residential establishment or the date on which the detoxification element is started (if detox and rehab are being provided in one package).

C.6 COMMUNITY PRESCRIBING – DEFINITION OF INTERVENTION

Community prescribing involves the provision of care-planned specialised drug treatment, which includes the prescribing of drugs to treat drug misuse. The range of community prescribing interventions can include the following:

- Stabilisation on substitute opioids, including dose titration
- Prescribing for a sustained period to substitute illicit drugs such as methadone and buprenorphine (maintenance prescribing)
- Prescribing for withdrawal from opioids with opioid or non-opioid medications such as buprenorphine or lofexidine (community detoxification)
- Prescribing to prevent relapse
- Stabilisation and withdrawal from sedatives, such as benzodiazepines
- Prescribing for assisted withdrawal from alcohol where appropriate
- Treatment for stimulant users, which may include symptomatic prescribing
- Non-medical prescribing (by nurses or pharmacists)

All prescribing interventions must be carried out in line with Drug Misuse and Dependence: UK guidelines on clinical management, 2007 also known as the 'clinical guidelines' or the 'orange book'.

Substitute prescribing alone does not constitute drug treatment (NTA expert prescribing group, 2002). A community prescribing intervention should be provided within a care-planned package of care with an identified keyworker. It should be aimed at addressing the range of identified needs. The care plan should address drug and alcohol misuse, health needs, offending behaviour and social functioning.

The modality/intervention start is the date of dispensing the first dose of medication.

C.6.1 Specialist prescribing

Specialist prescribing is community prescribing for drug misuse in a specialist drug service setting, which normally comprises a multidisciplinary substance misuse team. Specialist prescribing interventions normally include comprehensive assessments of drug treatment need and the provision of a full range of prescribing treatments in the context of care-planned drug treatment. The specialist team should also provide, or provide access to, a range of other care-planned healthcare interventions including psychosocial interventions, a wide range of harm reduction interventions, BBV prevention and vaccination, and abstinence-oriented interventions.

The client group should be comprised of drug misusers whose problem level is mostly moderate to severe.

The teams include specialist doctors who are usually consultant addiction psychiatrists 'with a Certificate of Completion of Training (CCT) in psychiatry, with endorsement in substance misuse working exclusively to provide a full range of services to substance misusers'. Such teams sometimes have other specialists including:

- Consultants in general psychiatry with a special interest in addiction
- Consultants in general psychiatry
- Other doctors on the specialist register (associate specialists)
- Senior clinical medical officers (see Roles and Responsibilities)
- Doctors in training.

Since the specialist team should provide or enable access to other drug-related interventions identified in the client's care plan, the team may contain a range of staff including clinical psychologists, counselling psychologists, general and psychiatric nurses, pharmacists, social workers and drug workers.

Specialist prescribing services may also be supported by non-medical prescribers, such as nurses and pharmacists). For more information on nurse prescribing, see Nurse Prescribing in Substance Misuse (NTA, 2005)52 – this was updated in 2006 to include pharmacists and will issued as guidance on non-medical prescribing in substance misuse. Further guidance on prescribing for pharmacists is available in the RPSGB's Clinical Governance Framework for Pharmacist Prescribers and Organisations Commissioning or Participating in Pharmacist Prescribing.

C.6.2 GP Prescribing

GP prescribing is community prescribing for drug misuse which may be carried out in a primary care setting through a primary healthcare team, consisting of GPs and other primary care staff (depending on contractual arrangements). This is normally assisted or supported by a specialist drug team. The clinical guidelines advise against GP prescribing without such support.

A number of models of primary care drug treatment have evolved in the context of local resources and identification of need. These models include various types of shared care services in which GP services are supported by more specialist service provision, and primary care-led drugs services which do not have shared care arrangements with a secondary care provider.

GP prescribing should be provided within a care plan with regular keyworking, and provision of appropriate psychosocial or other interventions as required. Different degrees of care planning may be appropriate in different primary care arrangements (NTA/RCGP 2004). The care plan should also address drug and alcohol misuse, health needs, offending behaviour and social functioning. In some practices, the GP will assume the keyworker role, but more commonly the shared care or primary care worker will take on this responsibility in collaboration with the GP.

GP prescribing should be guided by the Department of Health's clinical guidelines. These cover arrangements for daily dispensing, for shared care support and for the provision of supervised consumption through community pharmacies.

The client group in primary care has traditionally been drug users who are stable on substitute medication or whose problem level is mild to moderate. However, the exact nature of the clients treated and how the prescribing takes place will depend on the skills and competences of the GP and the degree of skilled multidisciplinary support. The guidance document Roles and Responsibilities of Doctors in the Provision of Treatment for Drug and Alcohol Misusers (2005) specifies a hierarchy of roles for GPs, with increasing competency levels:

- GPs providing core services
- GPs providing enhanced services
- GPs with special clinical interest (GPwSI) providing enhanced services
- Substance misuse specialist (primary care).

GP prescribing services may also be supported by non-medical prescribers, such as nurses and pharmacists, as well as other staff who are competent to provide drugs interventions, such as harm reduction, interventions for blood-borne viruses and psychosocial interventions.

C.7 STRUCTURED PSYCHOSOCIAL INTERVENTION - DEFINITIONS

Psychosocial interventions are structured treatment interventions that encompass a wide range of actions. Key working is the basic delivery mechanism for a range of key components including the review of care or treatment plans and goals, provision of drug-related advice and information, harm reduction interventions, and interventions to increase motivation and prevent relapse. Help to address social problems, for example housing and employment, is also important. In addition, a range of formal psychosocial interventions may be provided by key workers or others with the appropriate competences.

Formal psychosocial interventions may be provided alone or in combination with other interventions and should be targeted at addressing assessed need.
They may be provided:

- To treat drug misuse or co-occurring mental disorders
- Alone or in addition to pharmacological interventions

Formal psychosocial interventions should be provided in accordance with Drug Misuse and Dependence: UK guidelines on clinical management (DH & devolved administrations, 2007), also known as the 'clinical guidelines' or 'orange book' and relevant NICE Clinical Guidelines.
The type of psychosocial intervention should be selected on the basis of the problem and treatment need of the specific client, guided by the available evidence base of effectiveness.

The modality/intervention start is the date of the first formal and time-limited appointment.

C.7.1 Behavioural Couples Therapy

- Behavioural couples therapy is a specific psychosocial intervention that should only be available for use with clients who have an established relationship and a drug-free partner willing to engage in treatment.

- The focus is on the client's drug use and should consist of at least twelve weekly sessions.

C.7.2 Family Therapy

- Family therapy is a structured psychosocial intervention that is delivered by a competent clinician.

- The focus is on discussion with families relating to the sources of stress associated with drug misuse and aims to support and promote the family in developing more effective coping behaviours.

- Family therapy should only be recorded under this code when the client is actively involved in the intervention. This does not reflect family work that is done where the service user is not engaged in the intervention.

C.7.3 Contingency Management (drug specific)

- Structured behavioural programmes using incentives to reinforce changes in behaviour.

- Behaviour changes incentivised for people receiving methadone maintenance treatment include reduced illicit drug use and/or increased engagement with services.

- Behaviour changes incentivised for people who primarily misuse stimulants include reduced illicit drug use, abstinence and/or increased engagement with services.

C.7.4 Psychosocial Intervention to address common mental disorders

- Many drug users also have considerable co-morbid problems, particularly common mental health problems such as anxiety and depression.

- There is evidence that a range of evidence-based psychosocial interventions can be beneficial for a wide range of mental disorders.

- Such disorders may include: depression (NICE, 2007b); anxiety (NICE, 2007c); post traumatic stress disorder (NICE, 2005a); eating disorders (NICE, 2004); obsessive compulsive disorder (NICE, 2005b); antenatal and postnatal mental health (NICE, 2007d)

- Psychosocial interventions to address these disorders range from, for example, guided self-help and brief interventions for mild forms of problems to cognitive behavioural therapy and social support for more moderate forms.

- All psychosocial intervention to address common mental disorders should be recorded using this code regardless of their intensity.

C.7.5 Other formal psychosocial therapy (e.g. community reinforcement approach or Social behaviour network therapy)

- This includes other psychosocial therapies that are used in drug treatment and beneficial for some clients as they are practical and broad-based techniques.

- Psychosocial therapies recorded under this category will include the Community Reinforcement Approach and Social Behaviour Network Therapy.

C.8 STRUCTURED DAY PROGRAMMES – DEFINITION OF INTERVENTION

The term 'structured day programmes' replaces the old term 'structured day care' and will be the intervention name used for NDTMS monitoring from April 2006. Introduction of an additional category of 'other structured treatment' can be used for less extensive or less structured 'day care' provided in the context of a structured care plan (see section 9.7 for further discussion).

Structured day programmes (SDPs) provide a range of interventions where a client must attend 3–5 days per week. Interventions tend to be either via a fixed rolling programme or an individual timetable, according to client need. In either case, the SDP includes the development of a care plan and regular keyworking sessions. The care plan should address drug and alcohol misuse, health needs, offending behaviour and social functioning.

SDPs usually offer programmes of defined activities for a fixed period of time. Clients will usually attend the programme according to specified attendance criteria, and follow a set timetable that will include group work, psychosocial interventions, educational and life skills activities. Some clients may be attending the SDP as a follow-on or precursor to other treatment types, or may be attending as part of a criminal justice programme supervised by the probation service (e.g. DRR), or community rehabilitation.

Settings: SDPs are normally community-based services, set in centres that have been specifically designated for the programme (purpose-built or converted) and have rooms designated for specific parts of the programme (e.g. group work and life skills).

SDPs may be attached to other drug treatment services if they are part of a larger treatment provider. Structured day programmes are also used in prisons, and in prisons the majority of drug treatment programmes would fall into this category.

The modality/intervention start is the date of the start of the programme.

C.9 OTHER STRUCTURED DRUG TREATMENT – DEFINITION OF INTERVENTION

'Other structured treatment' describes a package of interventions set out in a client's care plan which includes as a minimum regular planned therapeutic sessions with the keyworker or other drugs worker. The care plan should address drug and alcohol misuse, health needs, offending behaviour and social functioning. 'Other structured treatment' describes structured therapeutic activity not covered under the alternative specific intervention categories set out in Models of Care: Update 2006.

The creation of this 'other' category of intervention reflects the evidence base that drug treatment consisting of individually tailored packages of care, in the context of a therapeutic relationship, is beneficial. This intervention may be particularly relevant for non-opiate drug misusers and clients who are receiving criminal justice treatment interventions.

Clients in receipt of community prescribing interventions, residential rehabilitation, inpatient treatment, structured day programmes or structured psychosocial interventions should not be additionally recorded as receiving 'other structured treatment'. Care-planned support usually provided by the keyworker is integral to all such interventions anyway.

Most clients receiving 'other structured treatment' will receive a range of interventions to meet needs identified in their care plan. These will involve a range of interventions to address their drug misuse and support to address needs in other domains. Examples of these may include:

- A crack user who is receiving regular sessions with a keyworker and attending 'day care' sessions to address a range of social and health-related needs
- An opiate user who has been through community detoxification and is receiving ongoing support to maintain abstinence as part of the care plan (prior to referral on or provision of aftercare arrangements), and is also receiving harm reduction interventions and help to deal with health needs
- An uncomplicated problem cannabis user who is receiving a short period of care-planned regular brief interventions to deal with problem cannabis use
- Clients who are not assessed as needing 'structured psychosocial interventions' for their problem drug use, but who receive sessions with keyworkers to address their social needs and offending behaviour.

'Other structured treatment' can describe regular sessions with a keyworker, delivered in order to keep a client engaged in the treatment system while they are waiting to start receiving another care-planned intervention (e.g. GP prescribing), if the structured interventions are outlined in an initial care plan following a triage assessment.

Clients receiving 'day care' rather than a structured 'day programme', as part of a care plan, may be recorded as 'other structured treatment'. Day care is distinct from structured day programmes, because it has a lower requirement to attend than structured day programmes (usually 1–2 days). Some clients may have a care plan that specifies regular attendance at day care with regular sessions with keywork. As part of the care-planned day care they may receive a range of interventions and support including emotional and psychological support, educational and life-skills work and related activities, advice and information, harm reduction support, further assessment and subsequent referral to alternative structured treatment. This may be particularly relevant for clients who have co-existing mental health problems.

The modality/intervention start is the date of the first formal and time-limited key worked appointment.

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 tier 3 and 4 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

Data item name - Treatment completed – Drug free

Data item definition – The client no longer requires structured drug treatment interventions and is judged by the clinician not to be using heroin (or any other opioids) or crack cocaine or any other illicit drug.

Data item name – Treatment Completed - Occasional user (not heroin and crack)

Data item definition – The client no longer requires structured drug treatment interventions and is judged by the clinician not to be using heroin (or any other opioids) or crack cocaine. There is evidence of use of other illicit drug 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 drug 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 drug 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 drug treatment intervention.

Data item name – Incomplete – Client died

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

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