National Treatment Agency for Substance Misuse

National Alcohol Treatment Monitoring System (NATMS)

NATMS Data Set

Business Definition for Adult Alcohol Treatment Providers

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Revision History

Version	Author	Purpose/Reason	Date
5.0	A. Cooper	New business definition for providers of specialist treatment services for adult alcohol misusers Version 5 refers to NDTMS Data Set E	21/01/2008
5.3.0	G. Scott	Update external references	02/07/08
6.0.0	J. Knight	Discharge Codes added, Parental Status Definitions Added	02/02/2009
6.1.0	R. Bull	Consolidation of earlier changes	16/02/2009
6.1.1	R. Bull	Miscellaneous non-substantive changes to eliminate inconsistencies and increase document usability	23/03/2009

External References

Ref No	Title	Version
1	NDTMS Data Set - Technical Definition	6.1.1
2	NDTMS Data Set - Reference Data	6.1.2
3	NDTMS Data Set – Business Definition for Young People's Treatment Providers	6.1.0
4	2006-07 WT guidance	Nov 20005
5	Models of Care for Alcohol Misusers (MoCAM)	Jun 2006
6	The Review of the effectiveness of treatment for alcohol problems	2006

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

Contents

1 INTRODUCTION

Specialist alcohol treatment data was incorporated into the National Drug Treatment Monitoring System (NDTMS) from 1st April 2008. This document sets out, at a business level, the set of performance data items (known as the National Alcohol Treatment Monitoring System (NATMS) Data Set) collected and utilised by the NDTMS, and the specific items from the full NDTMS data set that are required from alcohol treatment providers.

The NATMS Subset of the NDTMS Data Set consists of 28 data items. The full NDTMS Data Set (see APPENDIX A) for completion by Adult Drug Treatment Providers is a larger dataset and contains a number of additional data items that are collected for regional purposes.

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

This version (commonly referred to as the NDTMS Data Set 'F') will come into effect for national data collection from April 2009.

This document contains definitions that are primarily applicable to use with clients aged 18 or over, more relevant definition and revisions for use with Young People are available in Ref [3].

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

This document should not be interpreted as a technical statement - it is intended to serve the business perspective of what data will be so managed. From this document, the technical specification[1] will be derived and established as described in Ref [1]. Code sets for the data items listed in this document are provided in Ref [2]. Both documents are available from the NTA web site:

http://www.nta.nhs.uk/areas/ndtms/core_data_set_page.aspx

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

2 REQUIREMENTS

The collection of data on specialist treatment for alcohol misuse enables national, regional and local-level reporting on alcohol treatment to support the National Alcohol Strategy and needs analysis. Data reporting facilitates policy formulation and supports the development of efficient commissioning systems at a local level.

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

- Numbers in treatment
- Waiting times
- Successful completions of treatment.

3 CARERS, RELATIVES AND CONCERNED OTHERS REPORTING THE NATMS DATA SET TO THE NDTMS

NDTMS is currently designed only to receive details of the treatment episodes of problematic drug and alcohol users. Some providers have been reporting work that they have been doing with carers/parents (commonly coding it as Other Structured Intervention). Details of carer interventions should not be reported to NDTMS and providers should remove any such records at the next opportunity.

4 DATA ENTITIES

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

Client details	Section No 1
Episode details (including client details which may vary over time)	Section No 2
Treatment modality/intervention details	Section No 3
TOP	Section No 4
Local/Regional Fields	Section No 5

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

5 TREATMENT OUTCOME PROFILES (TOP)

It is not mandatory for Adult Alcohol Treatment Providers to collect TOP data items. However, providers may choose to collect these items if they have had the adequate training to do so. TOP has been validated for alcohol clients.

6 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 sex that the client was at birth
	Ethnicity	The ethnicity that the client states as defined in the Office for National Statistics (ONS) 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.

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.
	Agency Code	An unique identifier for the Treatment provider (agency) that is defined by the regional NDTMS centres – for example L0001
	Consent for NDTMS	Whether the client has agreed for their data to be shared with regional NDTMS teams and the NTA. Informed consent must be sought from all clients and this field needs to be completed for all records triaged after 1st April 2006. It does not need to be completed for clients triaged before this date (it is assumed that all records previously returned have been consented for).
	Postcode	The postcode of the client's place of residence. Depending upon regional preference regarding client confidentiality, this postcode may or may not be truncated, by removing the final two characters of the postcode (fore example 'NR14 7UJ' would be truncated to 'NR14 7'). If a client states that they are of No Fixed Abode (denoted by having an Accommodation Need of NFA) the postcode should be left blank.
	Parental Status	The parental status of the client – whether or not the client has children, whether none of, some of or all of the children live with the client. A child is a person who is under 18 years old. See APPENDIX D for revised data items and definitions.

Sect No	Item	Description
2	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.
	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) the PCT of the treatment provider should be used as a proxy. Note although the Accommodation Need is the status at the start of the episode, the PCT is the current situation)
	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.
	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.
	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.
	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

Sect No	Item	Description
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 re-engage the client with treatment may occur.
	Discharge Reason	The reason why the client's episode of structured treatment (Tier 3/Tier 4) was ended. A valid discharge reason code should be used as defined in APPENDIX C .

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 Ref [5]. A valid treatment modality code should be used as defined in Ref [2]. Reference [2] contains two sets of reference data for Treatment modality, to cater for those providing services to Adults and Young Persons. A client may have more than one treatment modality running sequentially or concurrently within an episode. Current definitions and name changes for all the Tier 3/4 modalities/interventions can be found in APPENDIX B .
	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 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.
	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
	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 B 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 with the client should be used.
	Modality Exit Status	Whether the exit from the treatment modality was planned or unplanned.

APPENDIX A WHAT DATA ITEMS SHOULD BE UPDATED AS AN 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	Should not change
	11	Episode ID	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)
	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)

Sect No	No	Field Description	Rules & Guidance
2	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	✓ MUST be completed. If not data may be excluded from performance monitoring reports. May change (i.e. current living situation)
	19	Problem Substance No 1	✓ MUST be completed. If not, record rejected. Not expected to change (i.e. as at start of Episode)
	20	Age of first use of Problem Substance No 1	Not expected to change (i.e. as at start of Episode)
	21	Route of Administration of Problem Substance No 1	Not expected to change (i.e. as at start of Episode)
	22	Problem Substance No 2	May be left blank if client has no second drug Not expected to change (i.e. as at start of Episode)
	23	Problem Substance No 3	May be left blank if client has no third drug Not expected to change (i.e. as at start of Episode)
	24	Referral Source	Not expected to change (i.e. as at start of Episode)
	25	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)
	26	Care Plan Started Date	MUST be completed when Modality Start Date given. Not expected to change (i.e. as at start of Episode)
	27	Injecting Status	Not expected to change (i.e. as at start of Episode)
	28	Children	Not expected to change (i.e. as at start of Episode).
	29	Pregnant	May change (i.e. current situation)
	30	Drinking Days	Not expected to change (i.e. as at start of Episode)
	31	Units of Alcohol	Not expected to change (i.e. as at start of Episode)

Sect No	No	Field Description	Rules & Guidance
2	32	Dual Diagnosis	Not expected to change (i.e. as at start of Episode)
	33	Hep C – Latest Test Date	May change (i.e. current situation)
	34	Hep C - Intervention Status	May change (i.e. current situation)
	35	Hep B Vaccination Count	May change (i.e. current situation)
	36	Hep B Intervention Status	May change (i.e. current situation)
	37	TOP Care Coordination	May change (i.e. current situation)
	38	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
	39	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	40	Treatment Modality	Required as soon as modality is known. Should not change – otherwise the regional NDTMS team should be formally advised
	41	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
	42	Modality Id	Should not change
	43	Date of First Appointment Offered for Modality	Waiting times calculated from this field. Should not change
	44	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
3	45	Modality End Date	Required when client completes modality or is discharged. Should only change from 'null' to populated as episode progresses
	46	Modality Exit Status	Required when client completes modality or is discharged. Should only change from 'null' to populated as episode progresses

Sect No	No	Field Description	Rules & Guidance
4	47	Treatment Outcomes Profile (TOP) date	Not expected to change (i.e. as at TOP date)
	48	TOP ID	Not expected to change (i.e. as at TOP date)
	49	Treatment Stage	Not expected to change (i.e. as at TOP date)
	50	Alcohol use	Not expected to change (i.e. as at TOP date)
	51	Opiate use	Not expected to change (i.e. as at TOP date)
	52	Crack use	Not expected to change (i.e. as at TOP date)
	53	Cocaine use	Not expected to change (i.e. as at TOP date)
	54	Amphetamine use	Not expected to change (i.e. as at TOP date)
	55	Cannabis use	Not expected to change (i.e. as at TOP date)
	56	Other drug use	Not expected to change (i.e. as at TOP date)
	57	IV drug use	Not expected to change (i.e. as at TOP date)
	58	Sharing	Not expected to change (i.e. as at TOP date)
	59	Shop theft	Not expected to change (i.e. as at TOP date)
	60	Drug selling	Not expected to change (i.e. as at TOP date)
	61	Other theft	Not expected to change (i.e. as at TOP date)
	62	Assault/violence	Not expected to change (i.e. as at TOP date)
	63	Psychological health status	Not expected to change (i.e. as at TOP date)
	64	Paid work	Not expected to change (i.e. as at TOP date)
	65	Education	Not expected to change (i.e. as at TOP date)
	66	Acute housing problem	Not expected to change (i.e. as at TOP date)
	67	Housing risk	Not expected to change (i.e. as at TOP date)
4	68	Physical health status	Not expected to change (i.e. as at TOP date)
	69	Quality of Life	Not expected to change (i.e. as at TOP date)

Sect No	No	Field Description	Rules & Guidance
5	70	Injected in last 28 days?	Not expected to change (i.e. as at start of Episode)
	71	Ever Shared?	Not expected to change (i.e. as at start of Episode)
	72	Previously Hep B Infected?	May change (i.e. current situation)
	73	Hep C Positive?	May change (i.e. current situation)
	74	Referred for Hepatology?	May change (i.e. current situation)
	75	Sex Worker Category	May change (i.e. current situation)
	76	Local Authority	May change (i.e. current living situation)
	77	Sexuality	Not expected to change (i.e. as at start of Episode)
	78	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 DEFINITIONS OF INTERVENTIONS

See Ref[5] for further key definitions.

B.1 ALC - Inpatient treatment – Definition of intervention

Inpatient treatment interventions usually involve short episodes of hospital-based (or equivalent) alcohol medical treatment. This normally includes 24-hour medical cover and multidisciplinary team support for alcohol treatment interventions such as:

- comprehensive assessment of complex cases
- care planning
- prescribing interventions for medically assisted alcohol withdrawal
- prescribing interventions to reduce the risk of relapse
- evidence-based psychosocial therapies and support to address alcohol misuse.

Inpatient treatment should be provided within a care plan with an identified keyworker. The care plan should address alcohol (and other substance) misuse, health needs and social functioning.

The three main settings for inpatient alcohol treatment are:

- specialised statutory, independent or voluntary sector inpatient facilities for medically assisted alcohol withdrawal, stabilisation and assessment for complex cases
- dedicated specialised inpatient alcohol units
- residential rehabilitation units for alcohol misuse
- general psychiatric wards for patients with co-morbid mental illness where alcohol withdrawal is overseen by an addiction specialist.

Research evidence has demonstrated that clients who receive treatment in dedicated units are more likely to have better outcomes than those who receive treatment in general psychiatric wards.

Those with complex alcohol and other needs requiring inpatient interventions may require hospitalisation for their other needs (e.g. liver problems, pregnancy) and this may be best provided for in the context of those hospital services (with specialist alcohol liaison support). Inpatient treatment provided for secondary complications arising out of the misuse of alcohol, or other needs, are not to be reported to NDTMS.

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

B.2 ALC - Residential rehabilitation – Definition of intervention

Alcohol residential rehabilitation consists of a range of treatment delivery models or programmes to address alcohol misuse, including medically assisted alcohol withdrawal, prescribing for relapse prevention and abstinence-oriented interventions within the context of residential accommodation.

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

- Alcohol (and drug) residential rehabilitation services whose programmes 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 alcohol (and drug) crisis intervention services (in larger urban areas).
- Inpatient treatment directly attached to residential rehabilitation programmes.
- Residential treatment programmes for specific client groups (e.g. women).
- 'Second stage' rehabilitation in alcohol-free supported accommodation where a client may move after completing an episode of care in a residential rehabilitation unit, and where they will continue to have a care plan, and receive keyword and a range of alcohol and non-alcohol-related support.
- Other supported accommodation, with the rehabilitation interventions (therapeutic alcohol-related and non-alcohol-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.

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

B.3 ALC - Community Prescribing – definition of intervention

Community prescribing involves the provision of care-planned specialised alcohol treatment, which includes the prescribing of drugs to treat alcohol misuse. Ref [6] identifies three classes of pharmacotherapy that are effective in the treatment of alcohol misusers:

- medications to promote abstinence or prevent relapse, including sensitising agents
- medications for treating withdrawal symptoms during community-based medically assisted alcohol withdrawal
- nutritional supplements as a harm reduction measure for heavy drinkers and high-dose parenteral thiamin for the treatment of Wernicke's encephalopathy and its prevention.

There is significant research evidence and consensus on the most appropriate medications to use in managing the side effects of withdrawal from alcohol and these conventions should be followed. Typically the medications of choice will be benzodiazepines, such as chlordiazepoxide or diazepam. Medications for reducing craving for alcohol should only be prescribed alongside psychosocial treatment and not as a stand-alone intervention, and use of sensitising medications requires continuing support from professionals and from families or social networks.

Pharmacological therapies should be delivered in the context of structured care-planned treatment and are not a stand-alone treatment option (there is some evidence that multiple episodes of assisted withdrawal can be associated with increased harmful outcomes). Pharmacological therapies are most effective when used as enhancements to psychosocial therapies as part of an integrated programme of care.

Medically assisted withdrawal from alcohol using prescribed medication can often be safely carried out in the home or other community settings, such as day centres.

Whatever delivery mechanism and settings are chosen to meet local needs, local commissioners and providers should ensure evidence-based practice is underpinned by good clinical governance and audit mechanisms.

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

B.4 ALC – Structured Psychosocial Intervention

Structured psychosocial interventions are clearly defined, evidence-based psychosocial interventions, delivered as part of a client's care plan, which assist the client to make changes in their alcohol (and drug) misuse. These interventions are normally time limited and should be delivered by competent practitioners. Competent practitioners will have adequate training, regular clinical supervision to ensure adherence to the treatment model and be able to demonstrate positive client outcomes.

Structured psychosocial interventions should be identified within a care plan. These interventions can be delivered in individual or group settings, and by any practitioners who have appropriate training and supervision

Ref [6] identifies a wide range of treatments shown to be effective in research studies, including cognitive-behavioural therapy, motivational enhancement therapy, 12-step facilitation therapy, coping and social skills training, a community reinforcement approach, social behaviour and network therapy, behavioural self-control training, and cognitive-behavioural marital therapy.

Psychosocial treatment skills (e.g. particular relapse prevention techniques) may be used in face-to face sessions (e.g. by a keyworker), but this would not reach the threshold to be considered a 'structured psychosocial intervention'. If such a skill were used as part of a clearly defined, consistent and evidence-based package of psychological treatment, especially when delivered by a demonstrably competent practitioner, it would then be part of a 'structured psychosocial intervention'. Examples of structured psychosocial interventions could include four sessions of family therapy, or a manualised relapse prevention package.

In this definition, psychosocial interventions are to be differentiated from a number of other interventions:

- While psychosocial interventions may be delivered by a keyworker, this activity is not part of the keyworking process *per se*. The keyworker may provide a level of ongoing face-to-face therapeutic support involving the use of some psychological techniques. If keyworkers do not deliver complete and consistent psychological treatment packages as part of their work with individual clients, it does not constitute a 'structured psychosocial treatment'. For example, a keyworker helping a client draw up a list of pros and cons is not delivering a full motivational interviewing intervention, merely using one technique commonly associated with the approach. Where keyworkers do deliver a planned, structured and coherent evidence-based psychosocial intervention (for which they have received training and supervision) this is likely to comprise a number of sessions and this constitutes a structured psychosocial intervention.
- The difference between psychosocial interventions for problem substance misuse and formal psychological therapies targeting a client's co-morbid mental health problems is that the latter interventions are specialist psychological treatments (such as cognitive-behaviour therapy for depression or anxiety, cognitive-analytic therapy, dialectical behaviour therapy, or schema-focused therapy for personality disorders) aimed primarily at the non-substance psychological problem. Such interventions should only be delivered by specialist practitioners such as clinical and counselling psychologists, suitably trained psychiatric staff or other specialist therapists with relevant training, qualifications and supervision in the therapy model being offered. This would be delivered as part of the care plan but would not constitute a 'structured psychosocial intervention' for problem alcohol use itself.
- Psychosocial interventions also differ from advice, information, simple psycho-education or other low-threshold support, which may be provided by a range of practitioners in a range of treatment settings.

An additional category of 'other structured treatment' is provided for less clearly defined counselling in the context of a structured care plan (see section B.6 for further discussion).

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

B.5 ALC - Structured Day Programmes – Definition of Intervention

Structured alcohol 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 alcohol (and any drug) misuse, health needs and social functioning.

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 B.6 for further discussion).

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 community rehabilitation.

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 substance misuse treatment services if they are part of a larger treatment provider.

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

B.6 ALC – Other Structured 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 substance misuse worker. The care plan should address alcohol (and any drug) misuse, health needs and social functioning. 'Other structured treatment' describes structured therapeutic activity not covered under the alternative specific intervention categories set out above.

The creation of this 'other' category of intervention reflects the evidence base that treatment consisting of individually tailored packages of care, in the context of a therapeutic relationship, is beneficial. 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 alcohol misuse and support to address needs in other domains. This intervention may be particularly relevant for alcohol misusers who are receiving community-based structured, care-planned treatment in the absence of prescribing interventions or psychosocial interventions. For example:

- Regular sessions with a keyworker to address a range of social and health-related needs
- Ongoing support following alcohol withdrawal to maintain abstinence as part of the care plan
- A short period of care-planned regular brief interventions to address problem alcohol misuse.

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.

'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. residential rehabilitation), 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 C DISCHARGE CODES FROM APRIL 1ST 2009

Data item name: Treatment completed – Alcohol free

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

Data item name: Treatment Completed - Occasional user

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

Data item name: Transferred – Not in custody

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

Data item name: Transferred – In custody

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

Data item name: Incomplete – Dropped Out

Data item definition: The treatment provider has lost contact with the client without a planned discharge and activities to get 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 in another secure setting. While the treatment provider has confirmed this, there has been no formal two-way communication between the treatment provider and the criminal justice system care provider leading to continuation of the appropriate assessment and care-planned structured alcohol treatment.

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

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

Data item name: Incomplete – Client died

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

APPENDIX D PARENTAL STATUS CODES 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 and all the client's children reside with them full time.

Data item name: Some of the children live with client

Data item description: The client is a parent and some of the client's children 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 but none of the client's children reside with them, they all live in other locations full time.

Data item name: Not a parent

Data item name: Client declined to answer.

Note: A child is a person who is under 18 years of age.