NDTMS ADULT INTERVENTIONS AID Dataset R

Psychosocial interventions — structured

Motivational interventions

Motivational interventions aim to help service users resolve ambivalence for change, and increase intrinsic motivation for change and self-efficacy through a semi-directive style and may involve normative feedback on problems and progress. They may be focused on substance specific changes and/or on building recovery capital. Motivational interventions can be delivered in groups or one-to-one and may involve the use of mapping tools.
Motivational interventions require competences over and above those required for key working, and delivery within a clinical governance framework that includes appropriate supervision.
Motivational interviewing and motivational enhancement therapy are both forms of motivational interventions.

Contingency management

Contingency management (CM) provides a system of reinforcement or incentives designed to motivate behaviour change and/or facilitate recovery. CM aims to make target behaviours (such as drug use) less attractive and alternative behaviours (such as abstinence) more attractive.
CM requires competences over and above those required for key working, and delivery within a clinical governance framework that includes appropriate supervision.

Family and social network interventions

Family and social network interventions engage one or more of the client's social network members who agree to support the client's treatment and recovery. The interventions use psychosocial techniques that aim to increase family and social network support for change, and decrease family and social support for continuing drug and/or alcohol use. These interventions may involve the use of mapping tools. They require competences over and above those required for key working, and delivery within a clinical governance framework that includes appropriate supervision eg social behaviour and network therapy (SBNT), community reinforcement approach (CRA), behavioural couples therapy (BCT) and formal family therapy.

Evidence-based psychological interventions for coexisting mental health disorders

NICE guidelines for mental health problems generally recommend a stepped care approach. Low intensity psychological intervention for co-existing mental health problems, include guided self-help or brief interventions for less severe common mental health problems.
High intensity psychological therapies (such as cognitive behavioural therapy) are recommended for moderate and severe problems. Typically formulation - based and delivered by clinicians with specialist training who are registered with a relevant professional/regulatory body. They can be delivered in groups or one-to-one.
Both low and high intensity interventions require additional competences for the worker and delivery within a clinical governance framework that includes appropriate supervision.

Psychodynamic therapy

A type of psychotherapy that draws on psychoanalytic theory to help people understand the developmental origins of emotional distress and behaviours such as substance misuse, by exploring unconscious motives, needs, and defences.

12-step work

A 12-step intervention for recovery from addiction, compulsion or other behavioural problems. Interventions are delivered within a clinical governance framework that includes appropriate supervision.

Counselling – BACP Accredited

A systematic process that gives individuals an opportunity to explore, discover and clarify ways of living more resourcefully, with a greater sense of well-being. This requires additional competences for the worker and delivery within a clinical governance framework that includes appropriate supervision.

Cognitive and behavioural based relapse prevention interventions (substance misuse specific)

Cognitive and behavioural based relapse prevention interventions develop the service user's abilities to recognise, avoid or cope with thoughts, feelings and situations that are triggers to substance use. They include a focus on coping with stress, boredom and relationship issues and the prevention of relapse through specific skills eg drug refusal, craving management. They can be delivered in groups or one-to-one and may involve the use of mapping tools. They require competences over and above those required for key working, and delivery within a clinical governance framework that includes appropriate supervision eg CBT based relapse prevention (which may include mindfulness and 'third wave' CBT), behavioural self-control (alcohol)

Client involved in structured community day programme

The client has attended structured community day programme during the last six-month period. These programmes are intensive care-planned community-based treatment interventions, consisting of a combination of evidence based and guideline supported psychosocial and recovery support interventions, but not recovery support interventions only. Clients who attend day programmes may also be receiving pharmacological interventions.
Clients usually attend 3-5 days per week and for a minimum of 10 hours per week. Programmes follow a set structure, with specified attendance criteria, through either a fixed rolling programme or an individual timetable, usually involving group work and supported by regular keywork sessions. Programmes should address drug and alcohol use, health needs, social functioning, offending and life skills. Attendance may be a component of a criminal justice programme supervised by the Probation Service eg an Alcohol Treatment Requirement or a Drug Rehabilitation Requirement. Programmes should be accessible to – and meet the needs of – all, appropriately adapted to meet the needs of people with protected characteristics, and some programmes may specifically target priority groups in line with local needs assessments.

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Pharmacological interventions — structured

Current opioid prescribing intention

Current opioid prescribing intention.
Assessment and stabilisation:
To stabilise the use of illicit drug(s), following and alongside continuing appropriate assessment. It also includes re-induction onto opioid substitution treatment prior to prison release, in the limited circumstances where this is appropriate
Maintenance:
Stable dose regimen to medically manage physiological dependence and minimise illicit drug use. Maintenance prescribing may be provided to support the individual in achieving or sustaining medication assisted recovery.
Withdrawal:
To facilitate medically assisted withdrawal and to manage withdrawal symptoms. This would usually be for up to 12 weeks in the community or 28 days as an inpatient.

Methadone (oral solution)*

Client is prescribed oral methadone, following and alongside continuing appropriate assessment.
It also includes re-induction onto opioid substitution treatment prior to prison release, in the limited circumstances where this is appropriate.

Buprenorphine (tablet/wafer)#

Client is prescribed buprenorphine tablet/wafer (eg mono-buprenorphine), following and alongside continuing appropriate assessment.
It also includes re-induction onto opioid substitution treatment prior to prison release, in the limited circumstances where this is appropriate.
Subutex should be recorded as buprenorphine.

Buprenorphine depot injection (rods or fluid)

Client is prescribed buprenorphine depot injection. This would usually be for up to 12 weeks in the community or 28 days as an inpatient.

Current daily dose of liquid oral methadone medication (ml)*

If any medications indicated with * are prescribed, record the client's current daily dose of oral methadone in millilitres (ml) of 1mg/1ml methadone solution equivalent (in most cases this will be the same as the daily volume prescribed. In the unusual case of a methadone concentrate being prescribed, the 1mg/1ml equivalent will need to be calculated). If client has not been prescribed liquid oral methadone/is no longer being prescribed liquid oral methadone then leave blank

Current daily dose of oral buprenorphine medication (mg)#

If any medications indicated with # are prescribed, record the client's current daily dose of oral buprenorphine in mg. If client has not been prescribed oral buprenorphine/is no longer being prescribed oral buprenorphine then leave blank

Is consumption of OST medication currently supervised?* #

If client's OST medication (indicated with * or #) is currently supervised at every or most dispenses record 'Supervised'.
If client's OST medication is currently taken away to be consumed without supervision at every or most dispenses record 'Unsupervised'.
If client is not prescribed OST record NA (99)

Diamorphine injection – Opioid assessment and stabilisation/opioid withdrawal/opioid maintenance

Client is prescribed diamorphine injection (for instance, injectable ampoules) for opioid assessment and stabilisation, withdrawal or maintenance

Methadone injection – Opioid assessment and stabilisation/opioid withdrawal/opioid maintenance

Client is prescribed methadone injection for opioid assessment and stabilisation, withdrawal or maintenance.

Benzodiazepine – Benzodiazepine maintenance

Client is prescribed benzodiazepine for benzodiazepine maintenance.

Benzodiazepine – Stimulant withdrawal

Client is prescribed benzodiazepine for stimulant withdrawal.

Benzodiazepine – GHB/GBL withdrawal

Client is prescribed benzodiazepine for GHB/GBL withdrawal.

Stimulant (for example, dexamphetamine) – Stimulant withdrawal

Client is prescribed stimulants such as dexamphetamine for stimulant withdrawal.

Pregabalin – Gabapentinoid withdrawal

Client is prescribed pregabalin for gabapentinoid withdrawal.

Gabapentin – Gabapentinoid withdrawal

Client is prescribed gabapentin for gabapentinoid withdrawal.

Naltrexone (oral) – Opioid relapse prevention

Client prescribed oral naltrexone to prevent relapse to opiate use.

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Pharmacological interventions — structured (continued)

Naltrexone (oral) – Alcohol relapse prevention/consumption reduction

Client prescribed naltrexone to prevent relapse to alcohol use or to limit the amount of alcohol a client drinks.

Chlordiazepoxide – Alcohol withdrawal

Client prescribed chlordiazepoxide to treat acute alcohol withdrawal (do not record chlordiazepoxide prescribed to treat anxiety or for any other purpose).

Diazepam – Alcohol withdrawal

Client prescribed diazepam to treat acute alcohol withdrawal (do not record diazepam prescribed to treat anxiety or for any other purpose).

Carbamazepine – Alcohol withdrawal

Client prescribed carbamazepine to treat acute alcohol withdrawal (do not record carbamazepine prescribed for any other purpose).

Other prescribed medication for alcohol withdrawal – Alcohol withdrawal

Client prescribed other medication to treat acute alcohol withdrawal.

Acamprosate – Alcohol relapse prevention

Client prescribed acamprosate to prevent relapse to alcohol use.

Disulfiram – Alcohol relapse prevention

Client prescribed disulfiram to prevent relapse to alcohol use.

Vitamin B and C supplement to prevent/treat Wernicke's encephalopathy/ Wernicke-Korsakoffs

Client prescribed vitamin B and C supplement to prevent or treat Wernicke's encephalopathy/Wernicke-Korsakoffs.

Any other medication for the treatment of drug misuse/dependence/ withdrawal/associated symptoms

Client prescribed other medication for instance, any other medication not listed above but used for the treatment of drug or alcohol misuse or dependence or withdrawal or associated symptoms but not for unconnected illnesses and their symptoms.

Recovery support interventions – non-structured

Peer support involvement

A supportive relationship where an individual who has lived experience of problem drug or alcohol use including affected others may be recruited on a paid or voluntary basis to provide support and guidance to peers. This peer support can be provided by peers volunteering or working in treatment services (peer-delivered) or by peers volunteering or working in peer-led initiatives (peer-led). Peer support can also include less formal supportive arrangements where shared experience is the basis but generic support is the outcome (for example, as a part of a social group). This may include mental health focused peer support where a person has co-occurring mental health conditions. Where peer support programmes are available, staff should provide information on and support access where people express an interest in using this type of support. Any peer support provided or signposted to must be age appropriate.

Facilitated access to mutual aid

Facilitating access to mutual aid (FAMA) is a short, simple and effective method for increasing mutual aid participation (see Facilitating Access to Mutual Aid). Mutual aid groups may be based on 12-step principles (such as Alcoholics Anonymous, Narcotics Anonymous and Cocaine Anonymous) or another approach (such as SMART Recovery). FAMA is a technique that can be used by treatment professionals. It involves using 1 or more one-to-one keyworking sessions to help people to engage with any mutual aid group (12-step and non-12-step).
The FAMA guidance is based on 1-3 sessions. The number of sessions will vary between individuals, depending on each person's experience of engaging with mutual aid. As part of this process, staff introduce mutual aid including discussing any past experience, providing information about mutual aid groups and agreeing goals. This is followed by encouraging the individual to attend a mutual aid group including exploring barriers and solutions and reviewing goals. Where a person wants to try mutual aid, staff should facilitate the initial contact by, for example, arranging for them to meet a mutual aid group member, arranging transport or someone to accompany the person to the first session and dealing with any subsequent concerns. In follow-up sessions, staff take an active interest in the individual's attendance of and engagement with mutual aid. It is not enough to simply provide someone with a leaflet.

Family support

Staff have assessed the family support needs of the individual/family as part of a comprehensive assessment, or on-going review of their treatment package. Agreed actions can include arranging family support for the family in their own right or family support that includes the individual in treatment.

Parenting support

Staff have assessed the family support needs of the individual as part of a comprehensive assessment, or on-going review of their treatment package. Agreed actions can include a referral to an in-house parenting support worker where available, or to a local service which delivers parenting support.

Housing support

Staff have assessed the housing needs of the individual as part of the comprehensive assessment, or on-going recovery care planning process, and has agreed goals that include specific housing support actions by the treatment service, and/or active referral to a housing agency for specialist housing support. Housing support covers a range of activities that either allows the individual to maintain their accommodation or to address an urgent housing need.

Employment support

Staff have assessed the employment needs of the individual as part of the comprehensive assessment, or on-going recovery care planning process, and agreed goals that include specific specialised employment support actions by the treatment service, and/or active referral to an agency for specialist employment support. Where the individual is already a claimant with Jobcentre Plus or the Work Programme, the referral can include a three way meeting with the relevant advisor to discuss education/employment/training (ETE) needs. The referral can also be made directly to an ETE provider.

Education and training support

Staff have assessed the education and training related needs of the individual as part of the comprehensive assessment, or on-going recovery care planning process and agreed goals that include specific specialised education and training support actions by the treatment service, and/or active referral to an agency for specialist education & training support. Where the individual is already a claimant with Jobcentre Plus or the Work Programme, the referral can include a three way meeting with the relevant advisor to discuss ETE needs. The referral can also be made directly to an ETE provider.

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Recovery support interventions – non-structured (continued)

Supported work projects

Staff have assessed the employment related needs of the individual as part of the comprehensive assessment, or on-going recovery care planning process and agreed goals that include the referral to a service providing paid employment positions where the employee receives significant on-going support to attend and perform duties.

Recovery check-ups

Recovery check-ups involve post-treatment monitoring and feedback. It is comprised of a series of planned motivational sessions. The sessions focus on:

- checking in with people to find out how they are
- offering support and encouragement and information and advice to help people to address any needs
- using motivational interviewing techniques to support the person to re-engage in treatment where appropriate
- identifying and addressing barriers to accessing support, including treatment.

These interventions should be informed by national guidance including national clinical guidelines and OHID's recovery support services and lived experience initiatives guidance, and ideally by local protocols.

Evidence-based psychosocial interventions to support relapse prevention

Evidence based psychosocial interventions that support on-going relapse prevention and recovery (including counselling), delivered following successful completion of structured substance misuse treatment. These are interventions with a specific substance misuse focus and delivered within substance misuse services.

Complementary therapies

Complementary therapies aimed at promoting and maintaining change to substance use, for example through the use of therapies such as acupuncture and reflexology that are provided in the context of substance misuse specific recovery support.

Mental health interventions

Evidence-based psychosocial interventions for common mental health problems that support continued recovery by focusing on improving psychological well-being that might otherwise increase the likelihood of relapse to substance use; this would include counselling. These are delivered following successful completion of structured substance misuse treatment and may be delivered by services outside the substance misuse treatment system following an identification of need for further psychological treatment and a referral by substance misuse services.

Smoking cessation

Specific stop-smoking support has been provided by the treatment service, and/or the individual has been actively referred to a stop smoking service for smoking cessation support and take-up of that support is monitored. Suitable support will vary but should be more than very brief advice to qualify as an intervention here. It will most commonly include psychosocial support and nicotine replacement therapy and will be provided by a trained stop smoking advisor.

Client provided with domestic abuse support for victim/survivor

Staff have assessed service user needs in relation to domestic abuse/violence as part of the comprehensive assessment or ongoing recovery care planning process. There are agreed goals that include support actions by the treatment service, and/or active referral to a specialist domestic abuse service. These services may include MARAC; community or refuge support providing safety planning, legal advice, advocacy and therapeutic interventions for victims/survivors and their children.

Client provided with domestic abuse support for perpetrator

Staff have assessed service user needs in relation to domestic abuse/violence as part of the comprehensive assessment or ongoing recovery care planning process. There are agreed goals that include support actions by the treatment service, and/or active referral to a specialist domestic abuse service. Perpetrators of domestic abuse/violence may attend a perpetrator programme.

Has the client been provided prescribing for relapse prevention (post structured treatment only)?

Drug relapse prevention - naltrexone prescribed in line with NICE Technology Appraisal TA115 ('Naltrexone for the management of opioid dependence'). Alcohol relapse prevention - Acamprosate, oral naltrexone, or disulfiram (prescribed in line with NICE Clinical Guidance CG115 'Alcohol Use Disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence').

Referral to peer-led initiatives

People with lived experience leading activities, groups and organisations that provide a range of harm reduction interventions, peer support and recovery support, and help people to access and engage in treatment and other support services. This does not include treatment provider-led initiatives. Peer-led initiatives range from small, unconstituted groups with no formal legal structure to established lived experience recovery organisations (LEROs). A LERO is an independent organisation led by people with lived experience of recovery.

Continuing care

Continuing care involves both post-treatment monitoring and feedback and supportive interventions. It involves treatment services offering lower intensity interventions after a person has met their treatment goals and is in recovery. This intervention offers a more extensive (longer term) form of what has traditionally been called ''aftercare''. Continuing care mainly involves ongoing assessment and psychosocial intervention. Psychological techniques used include:

- motivational interviewing
- individual or group relapse prevention including identifying early warning signs and using mindfulness techniques
- behavioural contracting (where a person agrees in writing to change an identified behaviour within a specified timeframe, often for rewards).

These interventions should be informed by national guidance including national clinical guidelines and OHID's recovery support services and lived experience initiatives guidance, and ideally by local protocols.