Public Health England

Protecting and improving the nation's health

National Drug Treatment Monitoring System (NDTMS)

Adult drug and alcohol treatment business definitions

Core dataset P

V14.3

About Public Health England

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Revision history

Version	Author	Change
14.3	J Palmer	Updates made since V14.2 CRTMHN - added 'If the client has a mental health treatment need (MTHTN = 1 'Yes') please record whether they are receiving treatment for their mental health needs' CIRCRTMHN - added 'If the client has a mental health treatment need (CIRMTHTN = 1 'Yes') please record whether they are receiving treatment for their mental health needs' CRTMHN & CIRCRTMHN – removed 'Is the client receiving treatment for their mental health needs?'
14.2	L Hughes	Updates made since V14.1 LA – added 'If the DAT code is 'Out of England' (Z00B) the LA field should be left blank'. 'Religion or belief' changed to 'Religion' so consistent with technical definitions and reference data. PREGNANT & CIRPREGNANT – added 'required for female clients only' LIVSCRN & CIRLIVSCRN – added 'The referral does not necessarily have to have been made by the treatment provider, for example, the service user could have been referred by a GP who has already carried out an initial test and referred to a liver specialist'. LIVSCRN – clarified that this applies to referrals made in the 4 weeks prior to triage HCVPCR & CIRHCVPCR - added 'If the client has cleared the virus naturally this should be recorded as 'negative - never infected'.' REFHEPCTX – clarified that this applies to 'at treatment start' CIRREFHEPCTX – clarified that this applies to 'in the last 6 months'

Version	Author	Change
		CIRHEPBSTAT – definition updated CIRHEPBCSTAT – definition updated CIRLIVSCRN – clarified that this applies to referrals made in the last 6 months CIREHCSC, CIREHCSC2 & CIREHCSC3 – definitions amended to remove reference to the data item at triage/ on the latest CIR changing. HIVSTAT & CIRHIVSTAT – expanded definition. Amended field description to 'Is client HIV positive?' as per reference data. REFLDSERV – added to revision history for V14.1 and field description changed to 'Referred to service date' so consistent with technical definitions. Clarified that this relates to structured or non structured treatment. Added '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.' REFLD – clarified that this relates to structured treatment. PRNTSTAT, CIRPRTST & Appendix F updated to state 'the majority of the time'. CHILDWTH & CIRCLDWT amended to state 'at least one night a fortnight' OTRDRGUSE corrected to OTDRGUSE NALOXISS & CIRNALOXISS – definition clarified regarding when to record 'no – client already in possession of adequate naloxone'. TSLPE – added 'This field should be populated if EMPSTAT is not 'regular employment'. CIRHEPBSTAT, CIRHEPCSTAT, CIRREFHEPCTX, CIRHIVSTAT, CIRLIVSCRN, CIRNALOXAD, CIRPARENT, CIRCLDWT, CIRMTHTN – added 'must be completed each time a **full** client information review is completed' to updatability column. Revised Appendix B Appendix C – some definitions updated to keep consistent with reference data document.

Version	Author	Change
		Appendix I – 'Incomplete' added before 'Onward refusal offered and refused'. Appendix L updated to remove references to 'post prison exit TOP' as this has been dropped in CDS-P. Added Appendix N Added Appendix O
14.1	L Hughes	CDS-P New headers UTLA – Upper tier local authority LTLA – Lower tier local authority REFLDSERV – Referral date to service VETERAN – Is the client a veteran of the British Armed Forces? PARENT and CIRPARENT – Does the client have parental responsibility for a child aged under 18? EHCSC2, EHCSC3, CIREHCSC2 and CIREHCSC3 – added to enable providers to record up to 3 forms of help being received. Definition of EHCSC and CIREHCSC amended accordingly. REFHEPCTX and CIRREFHEPCTX– has the client been referred for Hep C treatment? HIVSTAT and CIRHIVSTAT – is the client HIV positive? LIVSCRN and CIRLIVSCRN – has the client been referred to GP, alcohol nurse or specialist in liver disease for an investigation for alcohol-related liver disease? NALOXISS and CIRNALOXISS – has the client been issued with naloxone at episode start/in the last 6 months? NALOXAD and CIRNALOXAD - has the client ever been administered with naloxone to reverse the effects of an overdose/has the client been administered with naloxone to reverse the effects of an overdose in the last 6 months?

Version	Author	Change
		PHDOSMET - Current daily dose of liquid oral methadone medication (ml)*
		PHDOSBUP - Current daily dose of oral buprenorphine medication (mg)#
		PHOSTSPVD - Is consumption of OST medication currently supervised?* #
		PHMETSTBL – Methadone (oral solution)* - Opioid assessment and stabilisation
		PHMETWTH – Methadone (oral solution)* - Opioid withdrawal
		PHMETMAIN – Methadone (oral solution)* - Opioid maintenance
		PHBUPSTBL – Buprenorphine (tablet/wafer)# - Opioid assessment and stabilisation
		PHBUPWTH – Buprenorphine (tablet/wafer)# - Opioid withdrawal
		PHBUPMAIN – Buprenorphine (tablet/wafer)# - Opioid maintenance
		PHBUNASTBL – Buprenorphine (tablet/wafer) with naloxone# – Opioid assessment and stabilisation
		PHBUNAWTH – Buprenorphine (tablet/wafer) with naloxone# – Opioid withdrawal
		PHBUNAMAIN – Buprenorphine (tablet/wafer) with naloxone# – Opioid maintenance
		PHBUDIWTH – Buprenorphine depot injection (rods or fluid) – Opioid withdrawal
		PHBUDIMAIN – Buprenorphine depot injection (rods or fluid) – Opioid maintenance
		PHDIAINJ – Diamorphine injection – Opioid assessment and stabilisation/opioid withdrawal/opioid maintenance
		PHMETHINJ – Methadone injection – Opioid assessment and stabilisation/opioid withdrawal/opioid maintenance
		PHBENMAIN – Benzodiazepine – Benzodiazepine maintenance
		PHBENSWTH – Benzodiazepine – Stimulant withdrawal

Version	Author	Change
		PHBENGWTH – Benzodiazepine – GHB/GBL withdrawal PHSTIMWTH – Stimulant (such as, dexamphetamine) – Stimulant withdrawal PHPREGWTH – Pregabalin – Gabapentinoid withdrawal PHGABAWTH – Gabapentin – Gabapentinoid withdrawal PHNALTRLPR – Naltrexone (oral) – Opioid relapse prevention PHNALTALC – Naltrexone (oral) – Alcohol relapse prevention/consumption reduction PHCHLORALC – Chlordiazepoxide – Alcohol withdrawal PHDIAALC – Diazepam – Alcohol withdrawal PHCARBALC – Carbamazepine – Alcohol withdrawal PHOTHALCW – Other prescribed medication for alcohol withdrawal – Alcohol withdrawal PHACAMALC – Acamprosate – Alcohol relapse prevention PHDISUALC – Disulfiram – Alcohol relapse prevention PHVITBC – Vitamin B and C supplement to prevent/treat Wernicke's encephalopathy/Wernicke-Korsakoffs PHOTHMED – Any other medication for the treatment of drug misuse/dependence/withdrawal/associated symptoms CIRSTAGE – CIR stage CIRHEPCTSTD – Hep C test date added to CIR and definition of HEPCTSTD amended accordingly CIRHLCASSDT – Health care assessment date added to CIR and definition of HLCASSDT amended accordingly New reference data items RFLS • 39 – Adult treatment provider • 38 – Adult mental health service • 40 – Young people's structured treatment provider • 75 – Recommissioning transfer • 76 – Hospital alcohol care team/liaison nurse • 77 – Housing/homelessness service • 74 – Domestic abuse service

Version	Author	Change
		• 37 – Relative/peer/concerned other • 59 – Employment or education service DISRSN – 74 – Transfer – recommissioning transfer Dropped headers ROUTE – Route of administration of problem substance number 1 CPLANDT – Care plan start date ALCDAYS – Drinking days ALCUNITS – Units of alcohol HEPBVAC and CIRHEPBVAC – Hep B vaccination count HEPCTD and CIRHEPCTD – Hep C tested RECHEPC – Referred to hep C treatment (recovery support sub intervention) RECTHNAL – Client provided with take home Naloxone and training information MODEXIT – Intervention exit status TITDATE – Time in treatment assessment date TITREAT – Time in treatment TITID – Time in treatment ID SHOTHEFT – Shoplifting (TOP) DRGSELL – Selling drugs (TOP) OTHTHEFT – Other theft (TOP) ASSAULT – Assault/violence (TOP) PHSTBL – Client's prescribing intention is assessment and stabilisation PHMAIN – Clients prescribing intention is maintenance PHWTH – Clients prescribing intervention is withdrawal PHRELPR – Clients prescribing intention is relapse prevention APHWITH – Clients alcohol prescribing intention is withdrawal APHREPR – Clients alcohol prescribing intention is relapse prevention PHUSMET – Client prescribed unsupervised methadone

Version	Author	Change
		PHSUPMET – Client prescribed supervised methadone PHUSBUP – Client prescribed unsupervised buprenorphine PHSUPBUP – Client prescribed supervised buprenorphine PHUSBUNAL – Client prescribed unsupervised buprenorphine/naloxone (such as, Suboxone) PHSUPBUNAL – Client prescribed supervised buprenorphine/naloxone (such as, Suboxone) PHDIAM – Client prescribed diamorphine PHNALT – Client prescribed naltrexone PHCHLOR – Client prescribed chlordiazepoxide PHACAMP – Client prescribed acamprosate PHNALME – Client prescribed nalmefene PHDISULF – Client prescribed disulfiram PHOTHER – Client prescribed other medication Dropped reference data items RFLS: • 1 – drug service statutory • 65 – criminal justice other • 2 – drug service non-statutory • 11 – psychiatry services • 16 – education service • 18 – connexions • 73 – children's social services • 20 – CLA – children looked after • 21 – sex worker project • 23 – psychological services • 24 – relative • 25 – concerned other • 32 – community alcohol team • 53 – job centre plus • 58 – peer • PRNTSTAT and CIRPRTST – 14 – not a parent as field only required if new field PARENT is 'yes' • MODAL – 76 – ALC brief intervention

Version	Author	Change
		Amendments CIR requirements changed – all CIR fields to be reviewed with the client every 6 months and a full CIR submitted to NDTMS. BBV information can be submitted on a partial CIR in between full CIRs. Reporting alcohol treatment to NDTMS refreshed SEX – field description 'Client sex' changed to 'Client sex at registration of birth' NATION – field description 'Nationality' changed to 'Country of birth' SEXUALO – field description 'Sexual orientation' changed to 'Client stated sexual orientation' CONSENT – definition amended to state that informed consent must be gained rather than explicit consent DISABLE2, DISABLE3, DRUG2 and DRUG3 – guidance changed so that these fields can be left blank PRNTSTAT – field description changed from 'Parental status' to 'If parental responsibility is 'yes', how many of these children live with the client?' PRNTSTAT and CIRPRTST – definition amended so field only needs populating if new field PARENT is 'yes' CHILDWTH and CIRCLDWT – field description & definition amended to be explicit that this relates to the total number of children living in the same house as the client. EHCSC and CIREHCSC – field description changed to 'What help are the client's children/children living with the client receiving?' and reference data item 5 changed from 'No' to 'None of the children are receiving any help'. Definition amended to cover how to complete EHCSC2 and EHCSC3/CIREHCSC2 and CIREHCSC3. HEPCTSTD – 'Hep C latest test date' changed to 'Hep C test date' and new CIR field added to record subsequent dates. RFLS: • 22 – hospital – definition amended so this now includes A & E • 56 – employer – removed 'applicable to primary alcohol clients only'

Version	Author	Change
		• EMPSTAT – definitions of reference data items clarified • CRTMHN/CIRCRTMHN – definition of 'receiving mental health treatment from GP' clarified. • HLCASSDT – changed from 'Drug treatment healthcare assessment date' to 'Healthcare assessment date' • PREGNANT – now only required for female clients • All references to AOR and alcohol minimum dataset removed • Appendix B – waiting times guidance reviewed and refreshed • Appendix G – Healthcare assessment date guidance reviewed and refreshed • Section 4 and Appendix M – brief interventions guidance reviewed and refreshed • Field updatability incorporated into main table

Contents

Introduction

The National Drug Treatment Monitoring System (NDTMS) data helps drug and alcohol treatment demonstrate the outcomes it achieves for the people it treats, and in doing so aids accountability for the money invested in it. NDTMS is a national standard and is applicable to young people and adults within community and secure setting based treatment providers. The dataset is accredited by NHS Digital and the Information Standard is published under section 250 of the Health and Social Care Act 2012. Relevant documentation in relation to this can be found here.

This document contains definitions that are applicable to both drug and alcohol clients in community adult treatment services. Information and definitions relating to data collection applicable to young people and secure settings can be found at: https://www.gov.uk/government/collections/alcohol-and-drug-misuse-treatment-core-dataset-collection-guidance

This document is intended to be a definitive and accessible source for use. It is not intended to be read from end to end, rather as a reference document, which is utilised by a variety of readers, including:

- interpreters of data provided from PHE systems
- suppliers of systems to PHE
- suppliers of systems which interface to PHE systems
- PHE/National Drug Treatment Monitoring System (NDTMS) personnel

This document should not be used in isolation. It is part of a package of documents supporting the NDTMS dataset and reporting requirements.

Please read this document in conjunction with:

- NDTMS CSV File Format Specification – defines the format of the CSV file used as the primary means of inputting the core dataset into NDTMS
- NDTMS technical definition – provides the full list of fields that are required in the CSV file and the verification rules for each item
- NDTMS geographic information – provides locality information, for example DAT of residence and local authority codes
- NDTMS reference data – provides permissible values for each data item

To assist with the operational handling of CSV input files, each significant change to the NDTMS dataset is allocated a letter.

The current version (commonly referred to as the NDTMS dataset P) for national data collection will come into effect on 1 April 2020.

NDTMS is a consented to dataset meaning that all clients should give informed consent for their information to be shared with NDTMS. For further details, please refer to the NDTMS consent and confidentiality guidelines.

Purpose of NDTMS

The data items contained in the NDTMS dataset are intended to:

1. provide measurements that support the outcome and recovery focus of the government's drug strategy, such as:
    - proportion of clients successfully completing treatment
    - proportion of clients that do not return to treatment following a successful completion
    - value for money
    - housing and employment
    - health and quality of life outcomes
    - support for children and families of drug and alcohol dependent people

2. provide information which can be used to monitor how effective drug and alcohol treatment services are and help to plan and develop services that better meet local needs

3. produce statistics and support research about drug and alcohol use treatment

4. provide measurements to support the Public Health Outcomes Framework

Data entities

The NDTMS dataset consists of fields that are updateable (such as the client's postcode) and fields that should not change and should be completed as per the start of the episode (such as the client's sexuality). For some episode fields we require the most up to date information and these updates should be made on the CIR form, so that the episode field can give us a baseline to monitor change. The NDTMS dataset fields table (below) details for each data item the question, the definition and whether it is updateable during the episode of treatment or whether the information reported should be as per the start of the episode. In general, all data is required.

The data items listed in this document may be considered as belonging to 1 of 6 different sections, which are used throughout this document.

Client details

Details pertaining to the client including initials, date of birth, gender, ethnicity and country of birth.

Episode details

Details pertaining to the current episode of treatment including information gained at triage such as geographic information, protected characteristic information, problem substance/s, parent and child status, BBV, etc. A treatment episode includes time spent in treatment at one provider, where they record one triage date and one discharge date but can (and in most circumstances will) include multiple treatment interventions. Multiple treatment episodes make up a treatment journey (see Appendix I for treatment journey definition).

Treatment intervention details

Details regarding which high-level intervention/s the client has received and the relevant dates.

Sub Intervention Review (SIR)

Details regarding which sub interventions the client has received since treatment start or since the last SIR. SIRs should be completed at least every 6 months (but can be completed more frequently if this would be of use locally) and at discharge from treatment. They should be completed retrospectively and can be completed by the keyworker without the client present.

See Appendix J for definitions of the different sub interventions.

Treatment Outcomes Profile (TOP)

The Treatment Outcome Profile (TOP) should be completed with all clients in adult services. It should be completed at treatment start, every 6 months during treatment and at discharge. It can be completed more frequently if deemed of use locally. TOP should be completed by the keyworker with the client to review their substance use behaviour and thoughts in the last 28 days.

See Appendix L for more information on completing TOP.

Client Information Review (CIR)

The CIR contains updateable information for some of the episode level questions, including parental status and children information, BBV information and mental health. CIR questions should be reviewed with the client every 6 months and a full CIR should be returned to NDTMS. One should also be completed on discharge. Updates to the BBV fields may be returned to NDTMS as and when they occur on a partial CIR, but the latest information should also be populated on the full CIR when it is completed.

Together, the TOP, SIR and CIR form the Combined Review Form (CRF). See Appendix P for more information on completing the CRF.

Reporting alcohol treatment to NDTMS

Structured alcohol treatment

Structured alcohol treatment consists of a comprehensive package of concurrent or sequential specialist alcohol-focused interventions. It addresses multiple or more severe needs that would not be expected to respond, or have already not responded, to less intensive or non-specialist interventions alone.

Structured treatment requires a comprehensive assessment of need, and is delivered according to a recovery care plan, which is regularly reviewed with the client. The plan sets out clear goals which include change to substance use, and how other client needs will be addressed in one or more of the following domains: physical health; psychological health; social well-being; and, when appropriate, criminal involvement and offending. All interventions must be delivered by competent staff, within appropriate supervision and clinical governance structures.

Structured alcohol treatment provides access to specialist medical assessment and intervention, and works jointly with mental and physical health services and safeguarding and family support services according to need.

In addition to pharmacological and psychosocial interventions that are provided alongside, or integrated within, the key working or case management function of structured treatment, service users should, as appropriate, be provided with:

- information and immunisation
- advocacy
- appropriate access and referral to healthcare and health monitoring
- crisis and risk management support
- referral to homelessness and housing support
- education
- training and employment support
- family support
- mutual aid/peer support

Brief interventions – what to report to NDTMS

One-off brief interventions or extended brief interventions for alcohol use should not be reported to NDTMS.

Extended brief interventions should only be reported to NDTMS where the service has provided an assessment and care plan followed by brief treatment comprising multiple

planned Extended Brief Intervention (EBI) sessions with a treatment goal of abstinence or reducing consumption. This can be recorded under the psychosocial sub-intervention ‘motivational interventions (see Appendix M for further information on brief interventions and what can be reported to NDTMS).

NDTMS dataset fields

1. Client details			
Field description	CSV file header	Definition	Field updatability
Client ID	CLIENTID	A mandatory, unique technical identifier representing the client, as held on the clinical system used by the 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.	**Must be completed. If not, record rejected.** This is populated by your software system. Should not change.
Initial of client's first name	FINITIAL	The first initial of the client's first name – for example Max would be 'M'. If a client legally changes their name this should be updated on your system. This will create a mismatch at your next submission for which you should select 'replace' or 'delete'.	**Must be completed. If not, record rejected.** Should not change (record as per start of episode), unless client legally changes their name. If changed will create a validation mismatch.
Initial of client's surname	SINITIAL	The first initial of the client's surname – for example Smith would be 'S', O'Brian would be 'O' and McNeil would be 'M'. If a client legally changes their name this should be updated on your system. This will create a mismatch at your next submission for which you should select 'replace' or 'delete'.	**Must be completed. If not, record rejected.** Should not change (record as per start of episode), unless client legally changes their name. If changed will create a validation mismatch.
Client birth date	DOB	The day, month and year that the client was born.	**Must be completed. If not, record rejected.** Should not change (record as per start of episode). If changed will create a validation mismatch.

1. Client details			
Field description	CSV file header	Definition	Field updatability
Client sex at registration of birth	SEX	The client's sex at registration of birth.	**Must be completed. If not, record rejected.** Should not change (record as per start of episode). If changed will create a validation mismatch.
Ethnicity	ETHNIC	The ethnicity that the client states as defined in the Office of Population Censuses and Surveys (OPCS) categories. If a client declines to answer, then 'not stated' should be used. If client does not know then 'Value is unknown' should be used.	Should not change (record as per start of episode).
Country of birth	NATION	Country of birth. Kosovo should be recorded as Serbia as per NHS data dictionary.	Should not change (record as per start of episode).
Agency code	AGNCY	A unique identifier for the treatment provider that is defined by the regional NDTMS team – for example L0001.	**Must be completed. If not, record rejected. This is populated by your software system.** Should not change. If changed file will fail on validation.
Client reference	CLIENT	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).	Should not change and should be consistent across all episodes at the treatment provider.

2. Episode details			
Field description	CSV file header	Definition	Field updatability
Episode ID	EPISODID	A mandatory, unique 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.	**Must be completed. If not, record rejected. This is populated by your software system.** Should not change.
Software system and version used	CMSID	A mandatory, system identifier representing the clinical system and version used at the provider, for example, agencies using the data entry tool would have DET V8.0 populated in the field.	**Must be completed. If not, record rejected. This is populated by your software system.** May change (record as per current situation).
Consent for NDTMS	CONSENT	Whether the client has agreed for their data to be shared with PHE. Informed consent must be sought from all clients. For further information on obtaining NDTMS consent please see NDTMS consent and confidentiality guidelines.	**Client must give consent before their information can be sent to NDTMS.** May change (record as per current situation).
Postcode	PC	The postcode of the client's place of residence. The postcode should be truncated by your system when extracted for NDTMS (the final 2 characters of the postcode should be removed, for example, 'NR14 7UJ' would be truncated to 'NR14 7'). If a client states that they are of no fixed abode or they are normally resident outside of the UK then the default postcode ZZ99 3VZ should be recorded (and truncated on extract).	May change (record as per current living situation).

2. Episode details			
Field description	CSV file header	Definition	Field updatability
DAT of residence	DAT	The partnership area or upper tier local authority in which the client normally resides (as defined by the postcode of their normal residence). If the client is resident in Scotland, Wales, Northern Ireland or outside of the UK record the code that reflects this. If a client states that they are of No Fixed Abode (denoted by having an accommodation need of NFA) then for a structured community provider the partnership (DAT) of the treatment provider should be used as a proxy and for residential 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. See NDTMS Geographic Information document for a list of DAT codes.	**Must be completed. If not, data may be excluded from performance monitoring reports.** May change (record as per current living situation).
Local Authority	LA	The local authority in which the client currently resides (as defined by the postcode of their normal residence). If the client is resident in Scotland, Wales, Northern Ireland or outside of the UK record the code that reflects this. If a client states that they are of No Fixed Abode (denoted by having an accommodation need of NFA) then for a structured community provider the local authority of the treatment provider should be used as a proxy and for residential 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. If the DAT code is 'Out of England' (Z00B) the LA field should be left blank. See NDTMS Geographic Information document for a list of LA codes.	**Must be completed.** May change (record as per current living situation).

2. Episode details			
Field description	CSV file header	Definition	Field updatability
Upper tier local authority	UTLA	**This field will be electronically mapped by software providers based on the DAT of residence field. Treatment providers do not need to complete this field.** The upper tier local authority (UTLA) in which the client normally resides (as defined by the postcode of their normal residence). If the client is resident in Scotland, Wales, Northern Ireland or outside of the UK record the code that reflects this. If a client states that they are of No Fixed Abode (denoted by having an accommodation need of NFA) then for a structured community provider the UTLA of the treatment provider should be used as a proxy and for residential treatment providers the UTLA 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 UTLA is the current situation. See NDTMS Geographic Information document for a list of UTLA codes and how they should be mapped from DAT codes.	**Should be completed by software provider based on DAT of residence field.** May change (record as per current living situation).

2. Episode details			
Field description	CSV file header	Definition	Field updatability
Lower tier local authority	LTLA	**This field will be electronically mapped by software providers based on the LA field. Treatment providers do not need to complete this field.** The lower tier local authority (LTLA) in which the client currently resides (as defined by the postcode of their normal residence). If the client is resident in Scotland, Wales, Northern Ireland or outside of the UK record the code that reflects this. If a client states that they are of No Fixed Abode (denoted by having an accommodation need of NFA) then for a structured community provider the local authority of the treatment provider should be used as a proxy and for residential 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 LTLA is the current situation. See NDTMS Geographic Information document for a list of LTLA codes and how they should be mapped from LA codes.	**Should be completed by software provider based on Local Authority field.** May change (record as per current living situation).
Referred to service date	REFLDSERV	Date client was initially referred to this service for **structured or non structured** 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 please see Appendix N.	Should not change (record as per start of episode).
Referral date	REFLD	The date that the client was referred for this episode of **structured** 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.	**Must be completed. If not data may be excluded from performance monitoring reports.** Should not change. If changed will create a validation mismatch.

2. Episode details			
Field description	CSV file header	Definition	Field updatability
Referral source	RFLS	The source or method by which a client was referred for this treatment episode. See Appendix C for a list of referral sources and definitions.	**Must be completed. If not data may be excluded from performance monitoring reports.** Should not change.
Triage date	TRIAGED	The date that the client made a first face-to-face presentation to this treatment provider for structured treatment. If the client is in non-structured treatment and during this time, it is established that there is a requirement for structured treatment, the non-structured episode should be closed, and a new structured episode should be opened in which the triage date should be recorded as the date that it was agreed that they require structured treatment. This will ensure that waiting times for structured treatment can be accurately calculated. For scenario examples see Appendix B.	Should not change (record as per start of episode).
Previously treated	PREVTR	Has the client ever received structured drug or alcohol treatment at this or any other treatment provider?	Should not change (record as per start of episode).
TOP care coordination	TOPCC	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? If the client is being treated at more than one provider then the services must decide which one completes the TOP.	May change (record as per current situation).
Client stated sexual orientation	SEXUALO	The sexual orientation that the client states. If a client declines to answer, then 'not stated' should be used.	Should not change (record as per start of episode).
Pregnant	PREGNANT	Is the client pregnant? Required for female clients only.	Should not change (record as per start of episode). Updates to this field should be made on Client Information Review.

2. Episode details			
Field description	CSV file header	Definition	Field updatability
Religion	RELIGION	The religion or belief of the client. If a client declines to answer, then 'not stated' should be used.	Should not change (record as per start of episode).
Disability 1	DISABLE1	Whether the client considers themselves to have a disability. If a client declines to answer, then 'not stated' should be entered and DISABLE2 and DISABLE3 should be left blank. If the client has no disability, then 'no disability' should be entered and DISABLE2 and DISABLE3 should be left blank. Refer to Appendix E for disability definitions.	Should not change (record as per start of episode).
Disability 2	DISABLE2	Whether the client considers themselves to have a second disability. If the client has no second disability then this field should be left blank. Refer to Appendix E for disability definitions.	Should not change (record as per start of episode).
Disability 3	DISABLE3	Whether the client considers themselves to have a third disability. If the client has no third disability then this field should be left blank. Refer to Appendix E for disability definitions.	Should not change (record as per start of episode).
Accommodation need	ACCMNEED	The accommodation need refers to the housing need of the client in the 28 days prior to treatment start. Appendix D within this document describes the reference data for this item and the relevant definitions for adult services.	Should not change (record as per start of episode).
Employment status	EMPSTAT	The current employment status of the client. If a client declines to answer, then 'not stated' should be used.	Should not change (record as per start of episode).
Time since last paid employment	TSLPE	How long has it been (in years) since the client was last in paid legal employment (not including any paid work whilst in custody)? This can include cash in hand work. This field should be populated if EMPSTAT is not 'regular employment'. If a client declines to answer then 'client declined to answer' should be used.	Should not change (record as per start of episode).

2. Episode details			
Field description	CSV file header	Definition	Field updatability
British Armed Forces veteran	VETERAN	Is the client a veteran of the British Armed Forces? Veterans have a higher incidence of substance misuse (and mental health) than the general population. The purpose of this question is to better understand the needs of British veterans with respect to substance misuse and their engagement in treatment and subsequent outcomes. British armed forces include: Royal Navy, Royal Marines, British Army, Royal Air Force, Regular Reserve, Volunteer Reserves or Sponsored Reserves.	Should not change (record as per start of episode).
Parental responsibility	PARENT	At treatment start, does the client have parental responsibility for a child aged under 18? A child is a person who is under 18 years of age. Parental responsibility should include biological parents, step-parents, foster parents, adoptive parents and guardians. It should also include de facto parents where a client 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. Parental responsibility as used here is wider than the legal definition of parental responsibility.	Should not change (record as per start of episode). Updates to this field should be made on Client Information Review.
Do any of these children live with the client?	PRNTSTAT	If the client has parental responsibility (PARENT = yes), please record whether none of, some of or all of the children they are responsible for live with the client the majority of the time. A child is a person who is under 18 years old. See Appendix F for data items and definitions.	Should not change (record as per start of episode). Updates to this field should be made on Client Information Review.
How many children under 18 in total live in the same house as the client?	CHILDWTH	The total number of children under 18 that live in the same household as the client at least one night a fortnight. The client does not necessarily need to have parental responsibility for the children. Due to this being a numerical field please record code ‘98’ as the response if the client has declined to answer.	Should not change (record as per start of episode). Updates to this field should be made on Client Information Review.

2. Episode details			
Field description	CSV file header	Definition	Field updatability
What help are the client's children/children living with the client receiving? (1)	EHCSC	What help are the client's children/children living with the client receiving? This question only applies to the client's children aged under 18 (regardless of whether this child lives with the client or not) and to children aged under 18 living with the client (regardless of whether this is the child of the client or not). If more than one option applies then please complete EHCSC2 and EHCSC3 as appropriate. If none of the children are receiving any helpcir record 'None of the children are receiving any help' and leave EHCSC2 and EHCSC3 blank. If client declines to answer record 'client declined to answer' and leave EHCSC2 and EHCSC3 blank. See Appendix F for data items and definitions.	Should not change (record as per start of episode). Updates to this field should be made on Client Information Review.
What help are the client's children/children living with the client receiving? (2)	EHCSC2	What further help are the client's children/children living with the client receiving? This question only applies to the client's children aged under 18 (regardless of whether this child lives with the client or not) and to children aged under 18 living with the client (regardless of whether this is the child of the client or not). If more than 2 options apply then please complete EHCSC3 as appropriate. If client declines to answer or if no help is being received then this field should be left blank. See Appendix F for data items and definitions.	Should not change (record as per start of episode). Updates to this field should be made on Client Information Review.

2. Episode details			
Field description	CSV file header	Definition	Field updatability
What help are the client's children/children living with the client receiving? (3)	EHCSC3	What further help are the client's children/children living with the client receiving? This question only applies to the client's children aged under 18 (regardless of whether this child lives with the client or not) and to children aged under 18 living with the client (regardless of whether this is the child of the client or not). If client declines to answer or if no help is being received then this field should be left blank. See Appendix F for data items and definitions.	Should not change (record as per start of episode). Updates to this field should be made on Client Information Review.
Problem substance number 1	DRUG1	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 provider is responsible for clinically deciding which substance is primary.	**Must be completed. If not, record rejected.** Should not change (record as per start of episode).
Age of first use of problem substance number 1	DRUG1AGE	The age (in years) that the client recalls first using the problem substance number 1.	Should not change (record as per start of episode).
Problem substance number 2	DRUG2	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. If no second problem substance then leave this field blank.	Should not change (record as per start of episode).
Problem substance number 3	DRUG3	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. If no third problem substance then leave this field blank.	Should not change (record as per start of episode).
Injecting status	INJSTAT	Is the client currently injecting, have they ever previously injected or never injected?	Should not change (record as per start of episode).

2. Episode details			
Field description	CSV file header	Definition	Field updatability
SADQ score	SADQ	The Severity of Alcohol Dependence Questionnaire (SADQ) is a short, self-administered, 20-item questionnaire designed by the Addiction Research Unit, Maudsley Hospital to measure severity of dependence on alcohol and recommended in NICE Clinical Guideline CG115.The score of the questionnaire (0 to 60) should be recorded if the service uses this tool. If the score is unknown or another tool is used please complete with 98 information not available and use 99 when a client declines to answer.	Should not change (record as per start of episode).
Health care assessment date	HLCASSDT	The date that the initial health care 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 treatment provider itself or, where health needs are more specialised (for example, dental care, sexual health), a formal referral is made to an appropriately qualified professional and followed up and reviewed by the drug or alcohol worker as part of the ongoing delivery of the care plan. See Appendix G for further information on drug and alcohol treatment health care assessment.	Should not change (record as per start of episode – to be completed when initial health care assessment is completed). Dates of subsequent health care assessments should be recorded on the Client Information Review.
Hep B intervention status	HEPBSTAT	Within the current treatment episode, whether the client was offered a vaccination for hepatitis B, whether that offer was accepted by the client and whether they have commenced/completed vaccinations. For further information on recording BBV details please refer to the Recording NDTMS data about blood-borne virus interventions document.	Should not change (record as per start of episode). Updates to this field should be made on Client Information Review.
Hep C intervention status	HEPCSTAT	Within the current treatment episode, whether the client was offered a test for hepatitis C, whether that offer was accepted by the client and whether they have had a test. For further information on recording BBV details please refer to the Recording NDTMS data about blood-borne virus interventions document.	Should not change (record as per start of episode). Updates to this field should be made on Client Information Review.

2. Episode details			
Field description	CSV file header	Definition	Field updatability
Hep C test date	HEPCTSTD	Date that the client was last tested for hepatitis C (at/prior to episode start). If the exact date is not known then the first of the month should be used if that is known. If only the year is known then 1 January for that year should be used. Subsequent hepatitis C test dates should be recorded on the CIR. For further information on recording BBV details, please refer to the Recording NDTMS data about blood-borne virus interventions document.	Should not change (record as per start of episode). Test dates post episode start should be recorded on Client Information Review.
Hep C antibody test status	HCVAS	What is the result of the client's hepatitis C antibody test? This is the first test (before PCR test) which looks for hepatitis C antibodies in the client's blood. For further information on recording BBV details, please refer to the If the client has never had a test this field should be left blank. Recording NDTMS data about blood-borne virus interventions document.	Should not change (record as per start of episode). Updates to this field should be made on Client Information Review.
Hep C PCR test status	HCVPCR	What is the result of the client's hepatitis C PCR test? The PCR test is usually the second test (after antibody test) which looks at whether the hepatitis C virus is reproducing in the client's body. If the client has cleared the virus naturally this should be recorded as 'negative - never infected'. If the client has never had a test this field should be left blank. For further information on recording BBV details, please refer to the Recording NDTMS data about blood-borne virus interventions document.	Should not change (record as per start of episode). Updates to this field should be made on Client Information Review.
Has the client been referred for hep C treatment?	REFHEPCTX	Has the client been referred for Hep C treatment at treatment start? Whether or not the client has been referred for hepatitis C treatment; either in-house or the client has been referred to secondary care.	Should not change (record as per start of episode). Updates to this field should be made on Client Information Review.

2. Episode details			
Field description	CSV file header	Definition	Field updatability
Is client HIV positive?	HIVSTAT	Is the client HIV positive? This can either be self reported or based on evidence of a test result. Record the most recent test result, regardless of when that test was. If the client has never been tested record 'unknown'.	Should not change (record as per start of episode). Updates to this field should be made on Client Information Review.
Referral for alcohol related liver disease	LIVSCRN	Has the client been referred to GP, alcohol nurse or specialist in liver disease for an investigation for alcohol-related liver disease in the 4 weeks prior to triage? A referral for an investigation for alcohol-related liver disease could include: A referral for initial tests including liver blood tests or a fibroscan (transient elastography) delivered by a GP surgery or an alcohol nurse A referral to a specialist doctor in liver disease for diagnosis and treatment in a hospital outpatient or an in-patient setting. The referral does not necessarily have to have been made by the treatment provider, for example, the service user could have been referred by a GP who has already carried out an initial test and referred to a liver specialist.	Should not change (record as per start of episode). Updates to this field should be made on Client Information Review.
Has the client been issued with naloxone at episode start?	NALOXISS	Whether the client has been issued with either injectable or nasal naloxone (or both) by provider at treatment start. If the client is already in possession of naloxone record ‘No – already in possession of adequate naloxone’.	Should not change (record as per start of episode). Updates to this field should be made on Client Information Review.
Has the client ever been administered with naloxone to reverse the effects of an overdose?	NALOXAD	At treatment start, has the client ever been administered with naloxone (either injectable or nasal) to reverse the effects of an overdose?	Should not change (record as per start of episode). Updates to this field should be made on Client Information Review.

2. Episode details			
Field description	CSV file header	Definition	Field updatability
Mental health treatment need	MTHTN	Does the client have a mental health treatment need? Mental health treatment need includes: common mental illness (for example, anxiety, depression) either current diagnosis or currently experiencing symptoms/behaviours consistent with (where the symptoms are not considered to be simply due to acute psychoactive effects of substances consumed or due to current withdrawals) serious mental illness (for example, psychosis, schizophrenia, personality disorder) – either current diagnosis, or currently experiencing symptoms/behaviour consistent with (where the symptoms are not considered to be simply due to acute psychoactive effects of substances consumed or due to current withdrawals) mental health crisis (person is currently suicidal or indicating a risk of harm to self or others). This is determined either by the client's self-report or by formal assessment. If client declines to answer, then record 'Client declined to answer'.	Should not change (record as per start of episode). Updates to this field should be made on Client Information Review.
Receiving treatment for mental health need	CRTMHN	If the client has a mental health treatment need (MTHTN = 1 'Yes') please record whether they are receiving treatment for their mental health needs. This could include pharmacological and/or talking therapies/psychosocial support. See Appendix H for options and definitions. If more than one treatment option applies, then please select the one that is considered the priority from the perspective of the treatment service/keyworker.	Should not change (record as per start of episode). Updates to this field should be made on Client Information Review

2. Episode details			
Field description	CSV file header	Definition	Field updatability
Discharge date	DISD	The date that the client was discharged ending the current structured 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 2 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. If a client is discharged from treatment and then represents for further treatment at a later date, the expectation is that the client should be reassessed and a new episode created with a new triage date. If this proves burdensome, we can accept the re-opening of the client's previous episode (by removing discharge date and discharge reason) **as long as the gap between discharge from the old episode and representation is less than 21 calendar days. In this scenario, the previous modalities should remain closed and new mod**alities should be opened.	Discharge date required when client is discharged. ALL structured modalities must now have end dates. Discharge reason must be given.
Discharge reason	DISRSN	The reason why the client's episode of structured treatment was ended. For discharge codes and definitions see Appendix I.	Discharge reason required when client is discharged. Discharge date must be given. Should only change from 'null' to populated as episode progresses.

3. Treatment intervention details			
Field description	CSV Header	Definition	Field updatability
Intervention ID	MODID	A mandatory, unique technical identifier representing the intervention, as held on the clinical system used at the treatment provider. (Note: 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 intervention in the modality table.	**Must be completed. If not, record rejected. This is populated by your software system.** Should not change.
Date referred to intervention	REFMODDT	The date that it was mutually agreed that the client required this intervention of treatment. For the first intervention in an episode, this should be the date that the client was referred into the treatment system requiring a structured intervention. For subsequent interventions, it should be the date that both the client and the keyworker agreed that the client is ready for this intervention. For scenario examples and how this date is used in waiting times calculations please see Appendix B of this document.	Waiting times calculated from this field. Must be completed for all interventions. Should not change. If changed will create a validation mismatch.
Date of first appointment offered for intervention	FAOMODDT	The date of the first appointment offered to commence this intervention. This should be mutually agreed to be appropriate for the client.	Waiting times calculated from this field. Should not change.
Treatment intervention	MODAL	The treatment intervention a client has been referred for/commenced within this treatment episode as defined in Appendix J of this document. A client may have more than one treatment intervention running sequentially or concurrently within an episode and may have more than one of the same type running concurrently as long as the setting in each are different.	Required as soon as intervention is known. Should not change (record as per intervention start). If changed will create a validation mismatch.
Intervention setting	MODSET	Each provider has their own default setting. If a client is being treated in a setting other than their default then this field should be populated. This could include where treatment is being delivered by a provider that does not normally report to NDTMS. If this field is left blank the default setting will be assumed. See Appendix K for a definition of the different setting types.	Can be left blank for default setting. Should not change (record as per intervention start).

3. Treatment intervention details			
Field description	CSV Header	Definition	Field updatability
Intervention start date	MODST	The date that the stated treatment intervention commenced, for instance, the client attended for the appointment.	Required field when client starts intervention. Trigger for waiting times to be calculated. Should only change from 'null' to populated as episode progresses. If changed will create a validation mismatch.
Intervention end date	MODEND	The date that the stated treatment intervention ended. If the intervention 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 intervention should be used.	Required field when client completes intervention or is discharged. Should only change from 'null' to populated as episode progresses.

4. Sub intervention review (SIR) details			
Field description	CSV Header	Definition	Field updatability
Sub intervention ID	SUBMID	A mandatory, unique technical identifier representing the sub intervention, 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.	**Must be completed if any items in this section (SIR) are not null. If not, record rejected. This is populated by your software system.** Should not change.
Sub intervention assessment date	SUBMODDT	The date that the sub intervention review was completed.	**Must be completed each time a sub intervention review is completed.** Should not change. If changed will create a validation mismatch.

4. Sub intervention review (SIR) details			
Field description	CSV Header	Definition	Field updatability
Sub interventions received	Various headers (see Appendix J)	The sub interventions that have been received since the previous review was completed. If it is the first review then it will be the sub interventions since the client commenced their latest treatment episode. Sub interventions should be submitted at a minimum of every 6 months while a client remains in one or more of the 3 high-level intervention types (psychosocial, pharmacological or recovery support). When a client finishes structured treatment, a sub-intervention review should be completed to cover the period since the start of treatment or last review (whichever is the latter). See Appendix J for the sub intervention types.	Should not change (record as per sub intervention review date).

5. Outcomes profile – TOP			
Field description	CSV Header	Definition	Field updatability
TOP ID	TOPID	A mandatory, unique 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.	**Must be completed if any items in this section (TOP) are not null. If not, record rejected. This is populated by your software system.** Should not change.
Treatment Outcomes Profile (TOP) date	TOPDATE	Date of most recent outcome review. All data within this TOP should reflect the 28 days prior to this TOP date. See Appendix L for further details and outcomes process maps.	Should not change (record as per TOP date). If changed will create a validation mismatch.
Treatment stage	TRSTAGE	Stage of treatment that the TOP data relates to, for example, start, review, exit, post-exit	Should not change (record as per TOP date).
Alcohol use	ALCUSE	Number of days in previous 28 days that client has used alcohol.	Should not change (record as per TOP date).

5. Outcomes profile – TOP			
Field description	CSV Header	Definition	Field updatability
Consumption	CONSMP	Typical number of alcohol units consumed on a drinking day in the last 28 days.	Should not change (record as per TOP date).
Opiate use	OPIUSE	Number of days in previous 28 days that client has used opiates.	Should not change (record as per TOP date).
Crack use	CRAUSE	Number of days in previous 28 days that client has used crack.	Should not change (record as per TOP date).
Cocaine use	COCAUSE	Number of days in previous 28 days that client has used powder cocaine.	Should not change (record as per TOP date).
Amphetamine use	AMPHUSE	Number of days in previous 28 days that client has used amphetamines.	Should not change (record as per TOP date).
Cannabis use	CANNUSE	Number of days in previous 28 days that client has used cannabis.	Should not change (record as per TOP date).
Other drug use	OTDRGUSE	Number of days in previous 28 days that client has used another problem drug.	Should not change (record as per TOP date).
Tobacco use	TOBUSE	Number of days in previous 28 days that the client smoked tobacco, in whatever form (ready-made cigarettes, hand-rolled cigarettes, cannabis joints with tobacco, cigars, pipe tobacco, shisha/water pipes, etc.), but not including nicotine replacement therapy and e-cigarettes.	Should not change (record as per TOP date).
Injected	IVDRGUSE	Number of days in previous 28 days that client has injected non-prescribed drugs.	Should not change (record as per TOP date).
Sharing	SHARING	Has client shared needles or paraphernalia (spoon, water or filter) in previous 28 days? On the TOP form, this is displayed as 2 questions, but only one response is used for NDTMS. See NDTMS reference data document.	Should not change (record as per TOP date).

5. Outcomes profile – TOP			
Field description	CSV Header	Definition	Field updatability
Psychological health status	PSYHSTAT	Self-reported psychological health (anxiety, depression, problem emotions and feelings) score in previous 28 days of 0 to 20, where 0 is poor and 20 is good.	Should not change (record as per TOP date).
Paid work	PWORK	Number of days in previous 28 days that client has attended paid work. Includes legal work only.	Should not change (record as per TOP date).
Days volunteered	DAYSVOLN	Number of days in previous 28 days that the client has volunteered. Volunteering is engaging in any activity that involves spending time, unpaid, doing something that aims to benefit another person, group or organization.	Should not change (record as per TOP date).
Unpaid work	UPDWORK	Number of days in the previous 28 days that the client has participated in unpaid work as part of a structured work placement. Structured work placements provide experience in a particular occupation or industry for people facing barriers to employment and are part of an education or training course, or package of employment support. Unpaid work differs from volunteering in that the client is the main beneficiary. If volunteering, the main beneficiary it is another person, group or organization.	Should not change (record as per TOP date).
Education	EDUCAT	Number of days in previous 28 days that client has attended for education – for example, school, college, university.	Should not change (record as per TOP date).
Physical health status	PHSTAT	Self-reported physical health (extent of physical symptoms and bothered by illness) score in previous 28 days of 0 to 20, where 0 is poor and 20 is good.	Should not change (record as per TOP date).
Acute housing problem	ACUTHPBM	Has client had an acute housing problem (been homeless) in previous 28 days?	Should not change (record as per TOP date).
At risk of eviction	HRISK	Has client been at risk of eviction within previous 28 days?	Should not change (record as per TOP date).

5. Outcomes profile – TOP			
Field description	CSV Header	Definition	Field updatability
Unsuitable housing	UNSTHSE	Has the client been in unsuitable housing in the previous 28 days? Unsuitable housing includes where accommodation may be overcrowded, damp, inadequately heated, in poor condition or in a poor state of repair. Unsuitable housing is likely to have a negative impact on health and wellbeing and /or on the likelihood of achieving recovery.	Should not change (record as per TOP date).
Quality of life	QUALLIFE	Self-reported quality of life score (able to enjoy life, gets on with family and partner, etc.) in previous 28 days of 0 to 20, where 0 is poor and 20 is good.	Should not change (record as per TOP date).

6. Client information review (CIR)			
Field description	CSV Header	Definition	Field updatability
CIR ID	CIRID	A mandatory, unique technical identifier representing the CIR, 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).	**Must be completed if any items in this section (CIR) are not null. If not, record rejected.** Should not change.
Client information review (CIR) date	CIRDT	The date that the most recent client information review took place. **ALL questions on the client information review should be reviewed with the client every 6 months and a full CIR returned to NDTMS. If BBV information changes in between reviews then a partial CIR may be returned with just the BBV information contained therein.**	**Must be completed each time a client information review is completed.** Should not change – if changed will create a validation mismatch.
CIR Stage	CIRSTAGE	A full CIR should be completed for each client every 6 months. Partial CIRs should be completed in between full CIRs to update BBV information.	**Must be completed each time a client information review is completed.** Should not change – if changed will create a validation mismatch.

6. Client information review (CIR)			
Field description	CSV Header	Definition	Field updatability
CIR Hep B intervention status	CIRHEPBSTAT	Within the current treatment episode, whether the client was offered a vaccination for hepatitis B, whether that offer was accepted by the client and whether they have commenced/completed vaccinations. Once a vaccination course has been completed and recorded as 'Offered and accepted – completed vaccination', the client's hep B status on subsequent CIRs should be recorded as 'Immunised already'. If it is later established that hep B immunity levels have fallen and vaccinations were once again required record the new offer on subsequent CIRs. For further information on recording BBV details please refer to the Recording NDTMS data about blood-borne virus interventions document.	Must be completed each time a **full** client information review is completed. Should not change (record as per client information review date). If information changes a new partial/full CIR should be completed.
CIR Hep C intervention status	CIRHEPCSTAT	Within the current treatment episode, whether the client was offered a test for hepatitis C, if that offer was accepted by the client, and whether they have had a test. Once a test has been done and recorded as 'Offered and accepted – had a hep C test', the client's hep C status on subsequent CIRs should be recorded as 'Assessed as not appropriate to offer'. If the client's risky behaviour continues and they are subsequently offered another test it should be recorded as either 'Offered and accepted' or 'Offered and refused' as appropriate. For further information on recording BBV details please refer to the Recording NDTMS data about blood-borne virus interventions document.	Must be completed each time a **full** client information review is completed. Should not change (record as per client information review date). If information changes a new partial/full CIR should be completed.
CIR Hep C test date	CIRHEPCTSTD	Date that the client was last tested for hepatitis C. If the exact date is not known then the first of the month should be used if that is known. If only the year is known then 1 January for that year should be used. For further information on recording BBV details please refer to the Recording NDTMS data about blood-borne virus interventions document.	Should not change (record as per client information review date). If information changes a new partial/full CIR should be completed.

6. Client information review (CIR)			
Field description	CSV Header	Definition	Field updatability
CIR Hep C antibody status	CIRHCVAS	What is the result of the client's hepatitis C antibody test? This is the first test (before PCR test) which looks for hepatitis C antibodies in the client's blood. If the client has never had a test this field should be left blank. For further information on recording BBV details please refer to the Recording NDTMS data about blood-borne virus interventions document.	Should not change (record as per client information review date). If information changes a new partial/full CIR should be completed.
CIR Hep C (PCR) RNA status	CIRHCVPCR	What is the result of the client's hepatitis C PCR test? The PCR test is usually the second test (after antibody test) which looks at whether the hepatitis C virus is reproducing in the client's body. If the client has cleared the virus naturally this should be recorded as 'negative - never infected'. If the client has never had a test this field should be left blank. For further information on recording BBV details please refer to the Recording NDTMS data about blood-borne virus interventions document.	Should not change (record as per client information review date). If information changes a new partial/full CIR should be completed.
CIR Has the client been referred for hep C treatment?	CIRREFHEPCTX	Has the client been referred for hepatitis C treatment in the last 6 months? For further information on recording BBV details please refer to the Recording NDTMS data about blood-borne virus interventions document.	Must be completed each time a **full** client information review is completed. Should not change (record as per client information review date). If information changes a new partial/full CIR should be completed.

6. Client information review (CIR)			
Field description	CSV Header	Definition	Field updatability
CIR Is the client HIV positive?	CIRHIVSTAT	Is the client HIV positive? This can either be self reported or based on evidence of a test result. Record the most recent test result, regardless of when that test was. This field should always be populated, even if the response is the same as at episode start/ on the previous CIR. If the client has never been tested record 'unknown'.	Must be completed each time a **full** client information review is completed. Should not change (record as per client information review date). Information should be reviewed with the client at least 6 monthly and a new full CIR completed.
CIR Referral for alcohol related liver disease	CIRLIVSCRN	Has the client been referred to GP, alcohol nurse or specialist in liver disease for an investigation for alcohol-related liver disease in the last 6 months? A referral for an investigation for alcohol-related liver disease could include: • a referral for initial tests including liver blood tests or a fibroscan (transient elastography) delivered by a GP surgery or an alcohol nurse • a referral to a specialist doctor in liver disease for diagnosis and treatment in a hospital outpatient or an in-patient setting The referral does not necessarily have to have been made by the treatment provider, for example, the service user could have been referred by a GP who has already carried out an initial test and referred to a liver specialist.	Must be completed each time a **full** client information review is completed. Should not change (record as per client information review date). Information should be reviewed with the client at least 6 monthly and a new full CIR completed.

6. Client information review (CIR)			
Field description	CSV Header	Definition	Field updatability
CIR health care assessment date	CIRHLCASSDT	The date that the latest health care assessment was completed in accordance to defined local protocols. The full scope and depth of the assessment will vary according to the needs of the client, but should include an assessment of the client's physical health and mental health needs. Any arising needs should form part of the ongoing care plan, and would be directly responded to by the treatment provider itself or, where health needs are more specialised (for example, dental care, sexual health) a formal referral is made to an appropriately qualified professional and followed up and reviewed by the drug or alcohol worker as part of the ongoing delivery of the care plan. See Appendix G for further information on drug and alcohol treatment health care assessment.	Should not change (record as per client information review date). Information should be reviewed with the client at least 6 monthly and a new full CIR completed.
Has the client been issued with naloxone in the last 6 months?	CIRNALOXISS	Whether the client has been issued with either injectable or nasal naloxone (or both) by the provider in the last 6 months. If the client is already in possession of naloxone (either previously issued by the provider or from elsewhere) record 'No – already in possession of adequate naloxone'.	Should not change (record as per client information review date). Information should be reviewed with the client at least 6 monthly and a new full CIR completed.
Has the client been administered with naloxone to reverse the effects of an overdose in the last 6 months?	CIRNALOXAD	In the last 6 months has the client been administered with naloxone (either injectable or nasal) to reverse the effects of an overdose?	Must be completed each time a **full** client information review is completed. Should not change (record as per client information review date). Information should be reviewed with the client at least 6 monthly and a new full CIR completed.

6. Client information review (CIR)			
Field description	CSV Header	Definition	Field updatability
CIR Pregnant	CIRPREGNANT	Is the client pregnant? Required for female clients only.	Should not change (record as per client information review date). Information should be reviewed with the client at least 6 monthly and a new full CIR completed.
CIR Parental responsibility	CIRPARENT	Does the client have parental responsibility for a child aged under 18? A child is a person who is under 18 years of age. Parental responsibility should include biological parents, step-parents, foster parents, adoptive parents and guardians. It should also include de facto parents where a client 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. Parental responsibility as used here is wider than the legal definition of parental responsibility.	Must be completed each time a **full** client information review is completed. Should not change (record as per client information review date). Information should be reviewed with the client at least 6 monthly and a new full CIR completed.
CIR Do any of these children live with the client?	CIRPRTST	If the client has parental responsibility (PARENT or CIRPARENT = yes), please record whether none of, some of or all of the children they are responsible for live with the client the majority of the time. A child is a person who is under 18 years old. See Appendix F for data items and definitions.	Should not change (record as per client information review date). Information should be reviewed with the client at least 6 monthly and a new full CIR completed.
CIR How many children under 18 in total live in the same house as the client?	CIRCLDWT	The total number of children under 18 that live in the same household as the client at least at least one night a fortnight. The client does not necessarily need to have parental responsibility for the children. Due to this being a numerical field please record code '98' as the response if the client has declined to answer.	Must be completed each time a **full** client information review is completed. Should not change (record as per client information review date). Information should be reviewed with the client at least 6 monthly and a new full CIR completed.

6. Client information review (CIR)			
Field description	CSV Header	Definition	Field updatability
CIR What help are the client's children/children living with the client receiving? (1)	CIREHCSC	What help are the client's children/children living with the client receiving? This question only applies to client's children aged under 18 (regardless of whether this child lives with the client or not) and to children aged under 18 living with the client (regardless of whether this is the child of the client or not). If more than one response applies then please also complete CIREHCSC2 and CIREHCSC3 as appropriate. If none of the children are receiving any help record 'None of the children are receiving any help' and leave CIREHCSC2 and CIREHCSC3 blank. If client declines to answer record 'client declined to answer' and leave CIREHCSC2 and CIREHCSC3 blank. See Appendix F for definitions of the different responses.	Should not change (record as per client information review date). Information should be reviewed with the client at least 6 monthly and a new full CIR completed.
CIR What help are the client's children/children living with the client receiving? (2)	CIREHCSC2	What further help are the client's children/children living with the client receiving? This question only applies to client's children aged under 18 (regardless of whether this child lives with the client or not) and to children aged under 18 living with the client (regardless of whether this is the child of the client or not). If more than 2 responses apply then please also complete CIREHCSC3. If no help is being received or if the client declines to answer then this field may be left blank. See Appendix F for definitions of the different responses.	Should not change (record as per client information review date). Information should be reviewed with the client at least 6 monthly and a new full CIR completed.

6. Client information review (CIR)			
Field description	CSV Header	Definition	Field updatability
CIR What help are the client's children/children living with the client receiving? (3)	CIREHCSC3	What further help are the client's children/children living with the client receiving? This question only applies to client's children aged under 18 (regardless of whether this child lives with the client or not) and to children aged under 18 living with the client (regardless of whether this is the child of the client or not). If no help is being received or if the client declines to answer then this field may be left blank. See Appendix F for definitions of the different responses.	Should not change (record as per client information review date). Information should be reviewed with the client at least 6 monthly and a new full CIR completed.
CIR Mental health treatment need	CIRMTHTN	Does the client have a mental health treatment need? Mental health treatment need includes common mental illness (for example, anxiety, depression) either current diagnosis or currently experiencing symptoms/behaviours consistent with (where the symptoms are not considered to be simply due to acute psychoactive effects of substances consumed or due to current withdrawals) It also includes serious mental illness (for example, psychosis, schizophrenia, personality disorder) – either current diagnosis, or currently experiencing symptoms/behaviour consistent with mental health crisis (person is currently suicidal or indicating a risk of harm to self or others, history of self-harm/suicide attempts/harm to others) This is determined either by the client's self-report or by formal assessment. If client declines to answer, then record 'Client declined to answer'.	Must be completed each time a **full** client information review is completed. Should not change (record as per client information review date). Information should be reviewed with the client at least 6 monthly and a new full CIR completed.

6. Client information review (CIR)			
Field description	CSV Header	Definition	Field updatability
CIR Receiving treatment for mental health need	CIRCRTMHN	If the client has a mental health treatment need (CIRMTHTN = 1 'Yes') please record whether they are receiving treatment for their mental health needs. This could include pharmacological and/or talking therapies/psychosocial support. See Appendix H for options and definitions. If more than one treatment option applies, then please select the one that is considered the priority from the perspective of the treatment service/keyworker.	Should not change (record as per client information review date). Information should be reviewed with the client at least 6 monthly and a new full CIR completed.

Appendix A: definition of structured treatment and recovery support

If one or more pharmacological interventions and/or one or more psychosocial interventions are selected then the treatment package is a structured treatment intervention, if the following definition of structured treatment also applies.

Structured treatment definition
Structured drug and alcohol treatment consists of a comprehensive package of concurrent or sequential specialist drug- and alcohol-focused interventions. It addresses multiple or more severe needs that would not be expected to respond, or have already not responded, to less intensive or non-specialist interventions alone. Structured treatment requires a comprehensive assessment of need, and is delivered according to a recovery care plan, which is regularly reviewed with the client. The plan sets out clear goals which include change to substance use, and how other client needs will be addressed in one or more of the following domains: physical health; psychological health; social well-being; and, when appropriate, criminal involvement and offending. All interventions must be delivered by competent staff, within appropriate supervision and clinical governance structures. Structured drug and alcohol treatment provides access to specialist medical assessment and intervention, and works jointly with mental and physical health services and safeguarding and family support services according to need. In addition to pharmacological and psychosocial interventions that are provided alongside, or integrated within, the key working or case management function of structured treatment, service users should be provided with the following as appropriate: • harm reduction advice and information • BBV screening and immunisation • advocacy • appropriate access and referral to healthcare and health monitoring • crisis and risk management support • referral to homelessness and housing support • education • training and employment support • family support and mutual aid/peer support

Definition of recovery support

Recovery support definition
Recovery support covers a range of non-structured interventions that run alongside or after structured treatment and are designed to reinforce the gains made in structured treatment and improve the client's quality of life in general. Recovery support can include mutual aid and peer support, practical help such as housing or employment support and onward referrals to services such as smoking cessation or domestic violence services.

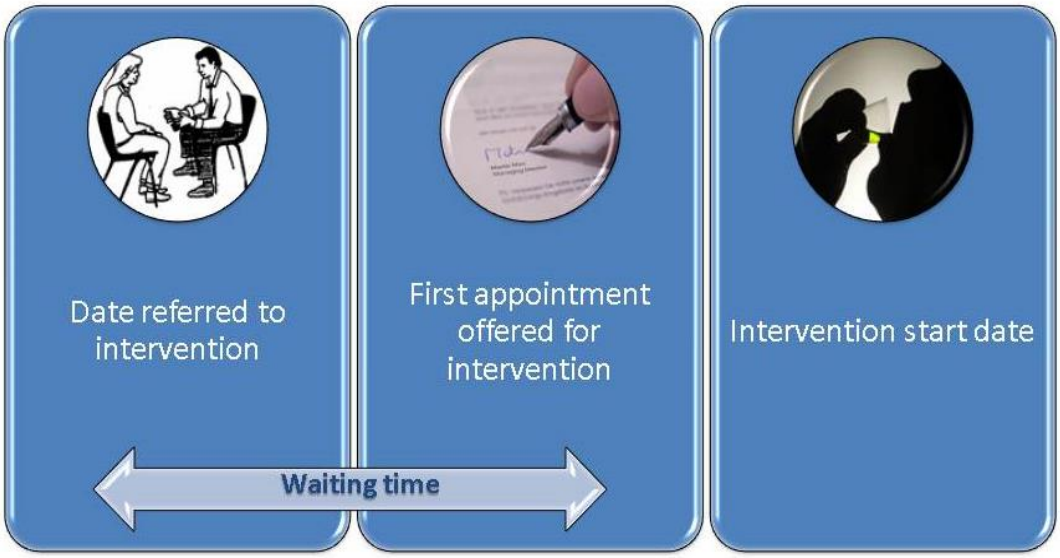
Appendix B: waiting times

A waiting time is the period from the date a person is referred for a specific treatment intervention to the date of the first appointment offered. Referral for a specific treatment intervention typically occurs within the treatment provider at, or following, assessment.

This is measured to ensure that clients are being offered treatment in a timely fashion and to ensure that there is sufficient access to treatment. Long waiting times may indicate a lack of capacity in the treatment system.

When measuring waiting times for partnerships, they will be calculated as the difference in days between the ‘Date referred to Intervention’ and the ‘Date of first appointment offered for intervention’. If the ‘Date of first appointment offered for intervention’ is not present then the ‘Intervention start date’ is used instead.

When measuring waiting times for treatment providers, they will be calculated from the ‘Referral date’ or ‘Date referred to Intervention’ (whichever is later) at that specific treatment provider, to the ‘First appointment offered for intervention’ at that treatment provider.



N.B. if first appointment offered date is left blank the waiting time will be calculated to the intervention start date which can cause longer waiting times to be generated.

Waiting times will only be calculated when a client actually commences an intervention, for instance, when the intervention start date is present in the data.

Waiting times are calculated for the first intervention and for subsequent interventions.

First intervention

At a partnership level, if the ‘Intervention start date’ and the ‘Referral date’ are the same as the earliest in a client’s treatment journey, the waiting time will count as a first intervention.

At provider level, if the ‘intervention start date’ is the earliest ‘intervention start date’ of the episode then it is a first intervention,

All other interventions will count as a subsequent intervention.

Waiting times scenario 1: self-referral

Key point: the ‘referral date’ and the ‘date referred to intervention’ are the same.

Key dates

Referral date = 1 April 2019.

Date referred to intervention = 1 April 2019.

Date of first appointment offered for intervention = 15 April 2019.

Intervention start date = 22 April 2019.

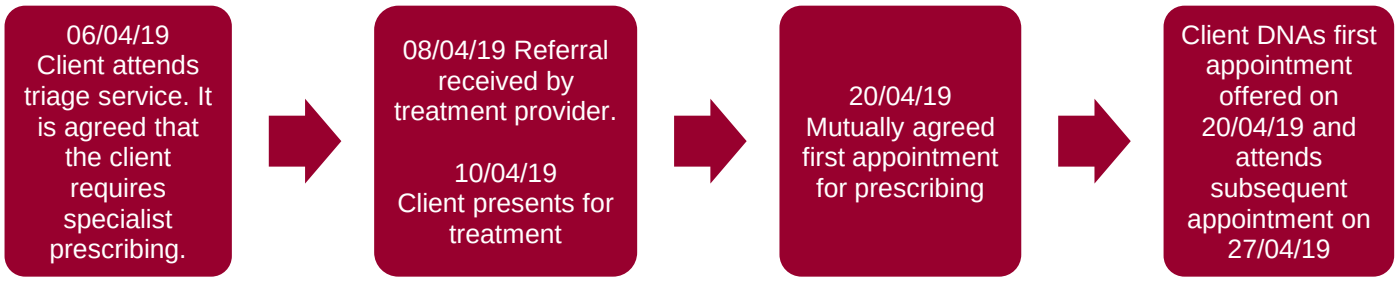
Waiting times calculations

Partnership: Date of first appointment offered for intervention (15 April 2019) – Date referred to intervention (1 April 2019) = 14 days.

Provider: Date of first appointment offered for intervention (15 April 2019) – Referral date/Date referred to intervention (1 April 2019) = 14 days.

Scenario 2: referral from an external organisation

Key point: the ‘referral date’ is after the ‘date referred to intervention’, therefore the ‘referral date’ is used.



Key dates

Referral date = 8 April 2019.

Date referred to intervention = 6 April 2019.

Date of first appointment offered for intervention = 20 April 2019.

Intervention start date = 27 April 2019.

Waiting times calculations

Partnership: Date of first appointment offered for intervention (20 April 2019) – Date referred to intervention (6 April 2019) = 14 days.

Provider: Date of first appointment offered for intervention (20 April 2019) – Referral date (8 April 2019) = 12 days (NOTE: as the referral date is later than the referred to intervention date the referral date is used to calculate the provider waiting time).

Appendix C: referral sources for adults

The referral source is the source or method by which a client was referred for this treatment episode.

Definitions of each referral source are provided below. Treatment providers reporting to the NDTMS should select the code that best reflects the service, which referred the client into treatment. For example, for a young person who is a child looked after and has mental health needs, and is referred to treatment by a crime prevention service, 'crime prevention' should be used as the referral source.

Code	Reference data	Definition
4	Self	Self-referral by client.
69	Self-referred via health professional	Self-referred following advice from a health professional.
3	GP	Referrals from general medical practitioners.
63	Arrest referral	Arrest Referral services engage with clients whose offending is linked to drugs or alcohol misuse at the point of arrest.
70	Community Rehabilitation Company (CRC)	A Community Rehabilitation Company (CRC) is the term given to a private-sector supplier of Probation and Prison-based rehabilitative services for offenders in England and Wales. A number of CRCs were established in 2015 as part of the Ministry of Justice's (MoJ) Transforming Rehabilitation (TR) strategy for the reform of offender rehabilitation.
6	DRR	Drug Rehabilitation Requirement – formally Drug Treatment and Testing order (DTTO).
57	ATR	Alcohol treatment requirement (applicable to primary alcohol clients only)
71	National Probation Service	
72	Liaison and Diversion	From https://www.england.nhs.uk/commissioning/health-just/liaison-and-diversion/ Liaison and Diversion (L and D) services identify people who have mental health, learning disability, substance misuse or other vulnerabilities when they first come into contact with the criminal justice system as suspects, defendants or offenders. The service can then support people through the early stages of criminal system pathway, refer them for appropriate health or social care or enable them to be diverted away from the criminal justice system into a more appropriate setting, if required.
19	Social Services	

Code	Reference data	Definition
10	Syringe exchange	
13	Prison	
22	Hospital	Referrals from hospitals (including A and E departments).
36	Outreach	Referrals from services which provide active outreach to address homelessness, anti-social behaviour, child exploitation or other issues
56	Employer	
39	Adult treatment provider	Services providing structured drug or alcohol treatment services predominantly for those aged 18 years or older. This includes needle exchange programmes and other services to address adult substance misuse.
38	Adult mental health service	Referrals from mental health services such as adult psychiatric and psychological services; private psychiatric and psychological services and third sector mental health or advocacy services for people with mental health needs.
40	Young people's structured treatment provider	Services providing specialist substance misuse treatment services pre-dominantly for those under 18.
75	Recommissioning transfer	For use when clients have been referred from a decommissioned service for further structured drug or alcohol treatment
76	Hospital alcohol care team/liaison nurse	
77	Housing/ homelessness service	
74	Domestic abuse service	
37	Relative/ peer/ concerned other	Including parents, siblings and other relatives, carers, friends, boyfriends or girlfriends, other service user.
59	Employment or education service	
15	Other	

Appendix D: accommodation need guidance for adult services

The accommodation need for adult clients has been defined with high-level reference data. The following provides guidance as to the sub-categories that make up the high- level view:

Code	Reference data	Definition
1	NFA – urgent housing problem	Lives on streets/rough sleeper Uses night shelter (night-by-night basis)/emergency hostels Sofa surfing/sleeps on different friend's floor each night
2	Housing problem	Staying with friends/family as a short-term guest Night winter shelter Direct Access short stay hostel Short term B and B or other hotel Placed in temporary accommodation by Local Authority Squatting
3	No housing problem	Owner occupier Tenant – private landlord/housing association/Local Authority/registered landlord/arm's length management Approved premises Supported housing/hostel Traveller Own property Settled mainstream housing with friends/family Shared ownership scheme

Appendix E: disability definitions

Code	Reference data	Definition
1	Behaviour and emotional	Should be used where the client has times when they lack control over their feelings or actions.
2	Hearing	Should be used where the client has difficulty hearing, or need hearing aids, or need to lip-read what people say.
3	Manual dexterity	Should be used where the client experiences difficulty performing tasks with their hands.
4	Learning disability	Should be used where the client has difficulty with memory or ability to concentrate, learn or understand which began before the age of 18.
5	Mobility and gross motor	Should be used where the client has difficulty getting around physically without assistance or needs aids like wheelchairs or walking frames; or where the client has difficulty controlling how their arms, legs or head move.
6	Perception of physical danger	Should be used where the client has difficulty understanding that some things, places or situations can be dangerous and could lead to a risk of injury or harm.
7	Personal, self-care and continence	Should be used where the client has difficulty keeping clean and dressing the way they would like to.
8	Progressive conditions and physical health	Should be used where the client has any illness which affects what they can do, or which is making them more ill, which is getting worse, and which is going to continue getting worse (such as HIV, cancer, multiple sclerosis, fits etc.)
9	Sight	Should be used where the client has difficulty seeing signs or things printed on paper, or seeing things at a distance.
10	Speech	Should be used where the client has difficulty speaking or using language to communicate or make their needs known.
XX	Other	Should be used where the client has any other important health issue including dementia or autism.
NN	No disability	
ZZ	Not stated	Client asked but declined to provide a response.

Appendix F: safeguarding questions' definitions

If parental responsibility is 'yes', how many of these children live with the client? (PRNTSTAT)

The question only needs to be completed if the response to PARENT is 'yes'.

Code	Reference data	Definition
11	All the children live with client	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 the majority of the time.
12	Some of the children live with client	The client is a parent of children under 18 and some of the client's children (who are under 18) reside with them the majority of the time, others live in other locations for the majority of the time.
13	None of the children live with client	The client is a parent of one or more children under 18 but none of the client's children (under 18) reside with them, they all live in other locations the majority of the time.
15	Client declined to answer	Only use where client declines to answer.

If the response given at episode start changes then the new response should be recorded on the 6 monthly CIR update.

What help are the client's children/children living with the client receiving? (EHCSC1/2/3)

If either parental responsibility is 'yes' or there are children under the age of 18 living in the same house as the client then this field should be completed. If more than one option applies, then please complete EHCSC2/EHCSC3 as appropriate.

Code	Reference data	Definition
1	Early Help	The needs of the child and family have been assessed and they are receiving targeted Early Help services as defined by Working Together to Safeguard Children 2015 (HM Govt.)
2	Child in Need	The needs of the child and family have been assessed by a social worker and services are being provided by the local authority under Section 17 of the Children Act 1989

Code	Reference data	Definition
3	Has a Child Protection Plan	Social worker has led enquiries under Section 47 of the Children Act 1989. A child protection conference has determined that the child remains at continuing risk of 'significant harm' and a multi-agency child protection plan has been formulated to protect the child
4	Looked after Child	Arrangements for the child have been determined following statutory intervention and care proceedings under the Children Act 1989. Looked after children may be placed with parents, foster carers (including relatives and friends), in children's homes, in secure accommodation or with prospective adopters
5	None of the children are receiving any help	None of the children are receiving early help nor are they in contact with children's social care.
99	Client declined to answer	Question was asked but client declined to answer.

If the response given at episode start changes then the new response should be recorded on the 6 monthly CIR update.

Appendix G: alcohol and drug treatment healthcare assessment

There is an expectation that all service users within specialist drug and alcohol treatment providers receive a general healthcare assessment at treatment start. This should be reviewed at regular intervals during the client's treatment. The aims and expected content of such an assessment for people who use drugs are described in the latest version of the clinical guidelines, Drug misuse and dependence: UK guidelines on clinical management, but are also summarised below. The aims and expected content of such an assessment for people who drink harmfully or dependently are outlined in NICE Clinical Guidelines Alcohol Use Disorders:CG115

Purposes/aims

These include:

- to identify unmet health needs and address these through care planning
- to ensure account is taken of health problems which could interact with drug or alcohol treatment
- as a means of attracting and retaining patients into drug and alcohol treatment
- to improve 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 and alcohol users.

All drug and alcohol users presenting to specialist drug and alcohol agencies should receive as part of their healthcare assessment:

Verbal health assessment

General

Health questions should address, for example:

- current and previous illnesses/symptoms particularly epilepsy, asthma, liver disease
- prescribed/OTC (over the counter) drugs
- cigarette smoking
- sexual health (risks and STD history)

- current use of/need for contraception
- dental health
- diet and weight loss
- allergies (including to medication)

Drug and alcohol-related

Health questions should address the following:

For all clients taking drugs:
- blood-borne virus testing and results (HIV, HBV, HCV)
- hepatitis immunisation status (HBV, HAV) and other immunisations (tetanus, TB)
- TB screening
- history of seizures/blackouts
- history of overdose

Current and former tobacco and drug smokers:
- smoking methods
- wheezing/breathlessness/coughing/sputum/haemoptysis/chest pain

For past and current injectors:
- injecting status and problems
- history of skin infection/cellulitis/ulcer/abscess
- history of septicaemia/endocarditis
- history of DVT/PE/other thrombosis

For people drinking harmfully/dependently:
- acute alcohol withdrawal
- history of seizures, black-outs or delirium tremens
- alcohol-related liver disease
- risk of/suspected Wernicke’s encephalopathy
- alcohol-related pancreatitis
- cardiovascular disease

Appendix H: mental health treatment definitions

Code	Reference data	Definition
1	Already engaged with the community mental health team/other mental health services	To include secondary mental health services (CMHT, Inpatient mental health services) or other mental health service (for example, other NICE recommended treatment delivered in third or private sector).
2	Engaged with Improved Access to Psychological Therapy (IAPT)	To include IAPT or other primary care based mental health service.
3	Receiving mental health treatment from GP	Only select this option if the only treatment for a mental health condition that the client is receiving is GP prescribing of psychiatric medicines. If they are also receiving another MH intervention (such as IAPT), please select that option instead.
4	Receiving any NICE-recommended psychosocial or pharmacological intervention provided for the treatment of a mental health problem in drug and alcohol services	This refers to mental health treatment provided in drug and alcohol services and can include pharmacological interventions (for the mental health problem), or existing psychosocial interventions and recovery support interventions: • existing psychosocial sub- intervention 'Evidence-based psychological interventions for co-existing mental health problems' • existing recovery support sub-intervention 'Evidence-based mental health focused psychosocial interventions to support continued recovery' NB: this as currently defined should follow completion of structured substance misuse treatment
5	Has an identified space in a health-based place of safety for mental health crises	Section 136 of the Mental Health Act allows for someone believed by the police to have a mental disorder, and who may cause harm to themselves or another, to be detained in a public place and taken to a safe place where a mental health assessment can be carried out. A place of safety could be a hospital, care home, or any other suitable place. Further information and a map of health based places of safety can be found here: http://www.cqc.org.uk/help-advice/mental-health-capacity/map-health-based-places-safety

Code	Reference data	Definition
6	Treatment need identified but no treatment being received	
99	Client declined to commence treatment for their mental health need	Client was referred for treatment but treatment commencement was declined by client.

If more than one treatment option applies, then please select the one that is considered to be the priority from the perspective of the treatment service/keyworker.

Appendix I: adult discharge codes and discharge scenarios

Code	Reference data	Definition
80	Treatment completed – drug free	The client no longer requires structured drug (or alcohol) treatment interventions and is judged by the clinician not to be using heroin (or any other opioid, prescribed or otherwise) or crack cocaine or any other illicit drug.
81	Treatment completed – alcohol free	The client no longer requires structured alcohol (or drug) treatment interventions and is judged by the clinician to no longer be using alcohol.
82	Treatment completed – occasional user (not heroin and crack)	The client no longer requires structured drug or alcohol treatment interventions and is judged by the clinician not to be using heroin (or any other opioid, prescribed or otherwise) 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.
83	Transferred – not in custody	The client has finished treatment at this provider but still requires further structured drug and/or 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 drug and/or alcohol treatment pathways are available.
84	Transferred – in custody	The client has received a custodial sentence or is on remand and a continuation of structured drug and/or alcohol treatment has been arranged. This will consist of the appropriate onward referral of care planning information and a 2-way communication between the community and prison treatment provider to confirm assessment and that care planned treatment will be provided as appropriate.
74	Transferred – recommissioning transfer	Client has been transferred for further structured drug and/or alcohol treatment as a result of the service being decommissioned.
71	Incomplete - onward referral offered and refused	The client requires further structured drug and/or alcohol treatment interventions. A referral to another secure setting provider or a community provider was offered but client refused the transfer.
85	Incomplete – dropped out	The treatment provider has lost contact with the client without a planned discharge and activities to re-engage the client back into treatment have not been successful.

Code	Reference data	Definition
86	Incomplete – treatment withdrawn by provider	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'.
87	Incomplete – retained in custody	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 2-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/alcohol treatment.
88	Incomplete – treatment commencement declined by the client	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 treatment intervention.
89	Incomplete – client died	During their time in contact with structured treatment the client died.

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

The dataset includes 4 'transferred' discharge codes for use by residential rehabilitation and inpatient detox providers only in order for NDTMS to more accurately record the discharge status of clients leaving a residential or inpatient facility.

Residential and inpatient providers should use these codes instead of the 'transferred' codes above. Unlike the above 'transferred' discharge codes that record the status of a client within the treatment system at the point of discharge from a provider, the residential and inpatient codes additionally record the outcome of the residential programme and where further structured treatment is required.

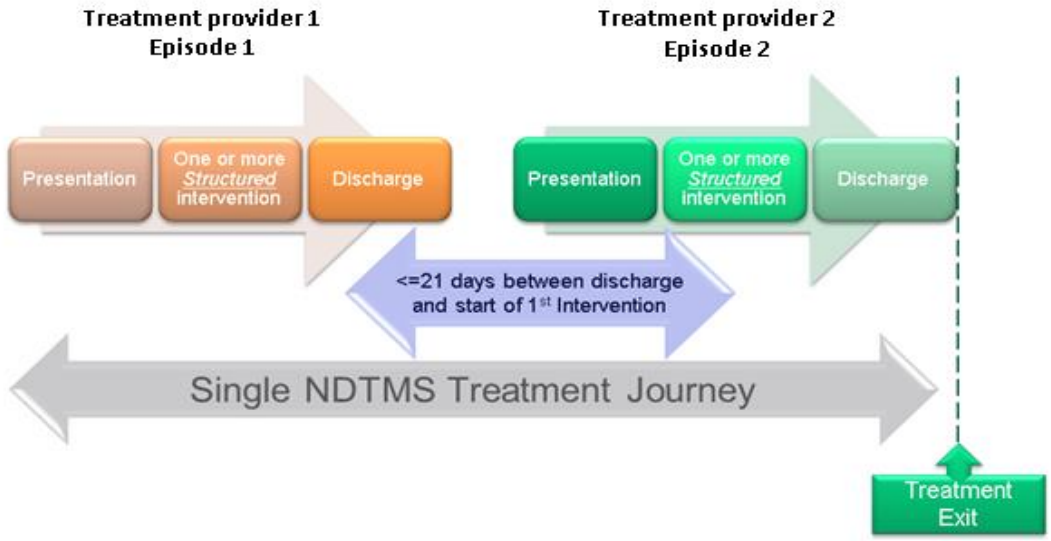
This allows residential and inpatient providers to record where clients have successfully completed the treatment programme and have been transferred for continued structured treatment either at a second stage residential provider or at a community provider.

Code	Reference data	Definition
93	Transferred – treatment programme completed at the residential/inpatient provider – additional residential treatment required	The client has completed the structured treatment programme at the provider by meeting the goals of their care plan. Although they have finished treatment at this provider, they still require continued structured treatment interventions and have been transferred to another residential provider for this. This code should only be used if there is an appropriate referral path and care planned structured treatment pathways are available.
94	Transferred – treatment programme completed at the residential/inpatient provider – additional community treatment required	The client has completed the structured treatment programme at the provider by meeting the goals of their care plan. Although they have finished treatment at this provider, they still require continued structured treatment interventions and have been transferred to a community provider for this. This code should only be used if there is an appropriate referral path and care planned structured treatment pathways are available.
95	Transferred – treatment programme not completed at the residential/inpatient provider – additional residential treatment required	The client has not completed the structured treatment programme at the provider because they have not met the goals of their care plan. They require continued structured treatment interventions and have been referred to another residential provider for this. This code should only be used if there is an appropriate referral path and care planned structured treatment pathways are available.
96	Transferred – treatment programme not completed at the residential/inpatient provider – additional community treatment required	The client has not completed the structured treatment programme at the provider because they have not met the goals of their care plan. They require continued structured treatment interventions and have been referred to a community provider for this. This code should only be used if there is an appropriate referral path and care planned structured treatment pathways are available.

Discharging clients as ‘transferred’

When a discharge reason of ‘transferred’ is selected, the expectation is that there should be 2-way communication between the transferring provider and the receiving provider to ensure continuity of the client’s care. If the client commences a structured treatment intervention at the receiving provider within 21 days of their discharge date from the transferring provider then NDTMS count this as a successful transfer and the client continues their treatment within the same treatment journey. If they do not start a structured treatment intervention elsewhere within 21 days of their discharge date they will be recorded as an unsuccessful transfer and their treatment journey will end. If the

client should represent for treatment after more than 21 days then they will be deemed to have started a new treatment journey. Please see diagram below.



Treatment journey

A treatment journey consists of one or more episodes of structured treatment, at one or more providers, where there has been less than 21 days break between treatment episodes. A treatment journey ends once a client has been exited entirely from structured drug/alcohol treatment once all structured interventions and the episode have been closed. A client may be discharged from one provider but if they continue structured treatment (within 21 days of discharge) at another provider, their NDTMS treatment journey is continued.

If a client is discharged from treatment with a discharge reason of ‘treatment completed’ this indicates that the client has no further structured treatment need. Therefore, this should only be used at the end of a client’s treatment journey when they have completed structured treatment at all providers.

Transfers to secure hospitals (Broadmoor, Rampton and Ashworth)

Secure hospitals are not part of the secure estate, as overseen by HMPPS, rather they are overseen by the NHS. Therefore, clients transferred to secure hospitals should have their discharge reason recorded as ‘Transferred not in Custody’.

Appendix J: definitions of interventions and sub interventions

There are 3 high-level intervention types. For adults these are:

- pharmacological interventions
- psychosocial interventions
- recovery support interventions

Each high-level intervention has a number of sub-interventions that will explain the detail of what has been delivered while the client is in the high-level intervention (described below).

The intervention types and sub-interventions are not mutually exclusive and should be used in combination to describe the full package of treatment and care being provided to a client.

Data will be collected retrospectively on what interventions have been provided in the last 6 months. However, the return is not limited to once every 6 months and may be updated more frequently. It should also be made on discharge. Providers may wish to integrate the collection of sub intervention information into the regular care plan review process so that, where the information is known, it can be returned alongside the TOP data.

J.1 Pharmacological sub interventions

CSV file header	Pharmacological sub intervention	Definition
PHMETSTBL	Methadone (oral solution)* – Opioid assessment and stabilisation	Client is prescribed oral methadone 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.
PHMETWTH	Methadone (oral solution)* – Opioid withdrawal	Client is prescribed oral methadone 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.

CSV file header	Pharmacological sub intervention	Definition
PHMETMAIN	Methadone (oral solution)* – Opioid maintenance	Client is prescribed oral methadone under a stable dose regimen to medically manage physiological dependence and minimise illicit drug use. Maintenance prescribing may be provided to support the individual in achieving or sustaining medication assisted recovery.
PHBUPSTBL	Buprenorphine (tablet/wafer)# – Opioid assessment and stabilisation	Client is prescribed buprenorphine tablet/wafer (for instance, mono-buprenorphine) 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. Subutex should be recorded as buprenorphine.
PHBUPWTH	Buprenorphine (tablet/wafer) # – Opioid withdrawal	Client is prescribed buprenorphine tablet/wafer (for instance, mono-buprenorphine) 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. Subutex should be recorded as buprenorphine.
PHBUPMAIN	Buprenorphine (tablet/wafer) # – Opioid maintenance	Client is prescribed buprenorphine tablet/wafer (for instance, mono-buprenorphine) under a stable dose regimen to medically manage physiological dependence and minimise illicit drug use. Maintenance prescribing may be provided to support the individual in achieving or sustaining medication assisted recovery. Subutex should be recorded as buprenorphine.
PHBUNASTBL	Buprenorphine (tablet/wafer) with naloxone# – Opioid assessment and stabilisation	Client is prescribed buprenorphine tablet with naloxone (for instance, Suboxone) 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.
PHBUNAWTH	Buprenorphine (tablet/wafer) with naloxone# – Opioid withdrawal	Client is prescribed buprenorphine tablet with naloxone (for instance, Suboxone) 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.
PHBUNAMAIN	Buprenorphine (tablet/wafer) with naloxone# – Opioid maintenance	Client is prescribed buprenorphine tablet with naloxone (for instance, Suboxone) under a stable dose regimen to medically manage physiological dependence and minimise illicit drug use. Maintenance prescribing may be provided to support the individual in achieving or sustaining medication assisted recovery.

CSV file header	Pharmacological sub intervention	Definition
PHBUDIWTH	Buprenorphine depot injection (rods or fluid) – Opioid withdrawal	Client is prescribed buprenorphine depot injection 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.
PHBUDIMAIN	Buprenorphine depot injection (rods or fluid) – Opioid maintenance	Client is prescribed buprenorphine depot injection under a stable dose regimen to medically manage physiological dependence and minimise illicit drug use. Maintenance prescribing may be provided to support the individual in achieving or sustaining medication assisted recovery.
PHDIAINJ	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.
PHMETHINJ	Methadone injection – Opioid assessment and stabilisation/opioid withdrawal/opioid maintenance	Client is prescribed methadone injection for opioid assessment and stabilisation, withdrawal or maintenance.
PHBENMAIN	Benzodiazepine – Benzodiazepine maintenance	Client is prescribed benzodiazepine for benzodiazepine maintenance.
PHBENSWTH	Benzodiazepine – Stimulant withdrawal	Client is prescribed benzodiazepine for stimulant withdrawal.
PHBENGWTH	Benzodiazepine – GHB/GBL withdrawal	Client is prescribed benzodiazepine for GHB/GBL withdrawal.
PHSTIMWTH	Stimulant (for example, dexamphetamine) – Stimulant withdrawal	Client is prescribed stimulants such as dexamphetamine for stimulant withdrawal.
PHPREGWTH	Pregabalin – Gabapentinoid withdrawal	Client is prescribed pregabalin for gabapentinoid withdrawal.
PHGABAWTH	Gabapentin – Gabapentinoid withdrawal	Client is prescribed gabapentin for gabapentinoid withdrawal.
PHNALTRLPR	Naltrexone (oral) – Opioid relapse prevention	Client prescribed oral naltrexone to prevent relapse to opiate use.
PHNALTALC	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.

CSV file header	Pharmacological sub intervention	Definition
PHCHLORALC	Chlordiazepoxide – Alcohol withdrawal	Client prescribed chlordiazepoxide to treat acute alcohol withdrawal (do not record chlordiazepoxide prescribed to treat anxiety or for any other purpose).
PHDIAALC	Diazepam – Alcohol withdrawal	Client prescribed diazepam to treat acute alcohol withdrawal (do not record diazepam prescribed to treat anxiety or for any other purpose).
PHCARBALC	Carbamazepine – Alcohol withdrawal	Client prescribed carbamazepine to treat acute alcohol withdrawal (do not record carbamazepine prescribed for any other purpose).
PHOTHALCW	Other prescribed medication for alcohol withdrawal – Alcohol withdrawal	Client prescribed other medication to treat acute alcohol withdrawal.
PHACAMALC	Acamprosate – Alcohol relapse prevention	Client prescribed acamprosate to prevent relapse to alcohol use.
PHDISUALC	Disulfiram – Alcohol relapse prevention	Client prescribed disulfiram to prevent relapse to alcohol use.
PHVITBC	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.
PHOTHMED	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.

In addition to the above sub-interventions we also ask the following questions in relation to pharmacological sub-interventions:

CSV file header	Question	Definition
PHDOSMET	Current daily dose of liquid oral methadone medication (ml)*	If any medications indicated with an * are prescribed record the client's current daily dose of oral methadone in milliliters (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 record 0.
PHDOSBUP	Current daily dose of oral buprenorphine	If any medications indicated with an # are prescribed record the client's current daily dose of oral

CSV file header	Question	Definition
	medication (mg)[#]	buprenorphine in mg. If client has not been prescribed oral buprenorphine/is no longer being prescribed oral buprenorphine record 0.
PHOSTSPVD	Is consumption of OST medication currently supervised?*[#]	If client's OST medication (indicated with a * 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).

J.2 Psychosocial sub interventions

CSV File Header	Psychosocial sub intervention	Definition
PSYMOTI	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.
PSYCNMG	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.
PSYFSNI	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. Examples: social behaviour and network therapy (SBNT), community reinforcement approach (CRA), behavioural couples therapy (BCT) and formal family therapy.

CSV File Header	Psychosocial sub intervention	Definition
PSYCGBH	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, for example, 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. Examples: CBT based relapse prevention (which may include mindfulness and 'third wave' CBT), behavioural self-control (alcohol).
PSYMNTH	Evidence-based psychological interventions for co-existing 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.
PSYDNMC	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. Psychodynamic therapy requires additional competences for the worker and delivery within a clinical governance framework that includes appropriate supervision. Therapists should be registered with an appropriate professional/regulatory body.
PSYSTP	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. The aim of 12-step work is to facilitate service users to complete some or all of the 12 steps.

CSV File Header	Psychosocial sub intervention	Definition
PSYCOUN	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.

J.3 Recovery support sub interventions

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

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

CSV File header	Recovery support sub intervention	Definition
RECPEER	Peer support involvement	A supportive relationship where an individual who has direct or indirect experience of drug or alcohol problems may be specifically recruited on a paid or voluntary basis to provide support and guidance to peers. Peer support can also include less formal supportive arrangements where shared experience is the basis but generic support is the outcome (for example, as a part of a social group). This may include mental health focused peer support where a service user has co-existing mental health problems. Where peer support programmes are available, staff should provide information on access to service users, and support access where service users express an interest in using this type of support.
RECMAID	Facilitated access to mutual aid	Staff provide a service user with information about mutual aid groups and facilitate their initial contact by, for example, making arrangements for them to meet a group member, arranging transport and/or accompaniment to the first session and dealing with any subsequent concerns (see Facilitating Access to Mutual Aid). These groups may be based on 12-step principles (such as Alcoholics Anonymous, Narcotics Anonymous and Cocaine Anonymous) or another approach (such as SMART Recovery). It is not sufficient to simply provide a client with a leaflet.

CSV File header	Recovery support sub intervention	Definition
RECFMSP	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.
RECPRNT	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.
RECHSE	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.
RECEMP	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 Job Centre Plus or the Work Programme, the referral can include a 3-way meeting with the relevant advisor to discuss education/employment/training (ETE) needs. The referral can also be made directly to an ETE provider.
RECEDUT	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 and training support. Where the individual is already a claimant with Job Centre Plus or the Work Programme, the referral can include a 3-way meeting with the relevant advisor to discuss ETE needs. The referral can also be made directly to an ETE provider.

CSV File header	Recovery support sub intervention	Definition
RECWPRJ	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.
RECCHKP	Recovery check-ups	Following successful completion of formal substance misuse treatment there is an agreement for periodic contact between a treatment provider and the former participant in the structured treatment phase of support. The periodic contact is initiated by the service, and comprises a structured check-up on recovery progress and maintenance, checks for signs of lapses, sign posting to any appropriate further recovery services, and in the case of relapse (or marked risk of relapse) facilitates a prompt return to treatment services.
RECRLPP	Evidence-based psychosocial interventions to support relapse prevention	Evidence based psychosocial interventions that support on-going relapse prevention and recovery, delivered following successful completion of structured substance misuse treatment. These are interventions with a specific substance misuse focus and delivered within substance misuse services.
RECCMPT	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.
RECGNH	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. 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.
RECSMOC	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.

CSV File header	Recovery support sub intervention	Definition
RECDOMV	Domestic abuse/violence support	Staff have assessed service user needs in relation to domestic abuse/violence as part of the comprehensive assessment or on-going 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. Perpetrators of domestic abuse/violence may attend a perpetrator programme.
RECMEDRLP	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')

Appendix K: setting

Each provider has their own default setting. If a client is being treated in a setting other than their default then the 'setting' field should be populated. This could include where treatment is being delivered by a provider that does not normally report to NDTMS. If this field is left blank the default setting will be assumed.

Code	Reference data	Definition
1	Community	A structured drug and alcohol treatment setting where residence is not a condition of engagement with the service. This will include treatment within community drug and alcohol teams and day programmes (including rehabilitation programmes where residence in a specified location is not a condition of entry).
2	Inpatient unit	An inpatient unit provides assessment, stabilisation and/or assisted withdrawal with 24-hour cover from a multidisciplinary clinical team who have had specialist training in managing addictive behaviours[1]. In addition, the clinical lead in such a service comes from a consultant in addiction psychiatry or another substance misuse medical specialist. The multi-disciplinary team may include psychologists, nurses, occupational therapists, pharmacists and social workers. Inpatient units are for those alcohol or drug users whose needs require supervision in a controlled medical environment.
3	Primary care	Structured substance misuse treatment is provided in a primary care setting with a General Practitioner, often with a special interest in addiction treatment, having clinical responsibility.
4	Secure setting	Structured drug and alcohol treatment delivered by a locally commissioned substance misuse team within the prison establishment providing the full range of drug and alcohol interventions in line with the evidence base articulated in the Patel Report[2].
5	Residential	A structured drug and alcohol treatment setting where residence is a condition of receiving the interventions. Although such programmes are usually abstinence based, prescribing for relapse prevention or for medication assisted recovery are also options. The programmes are often, although not exclusively, aimed at people who have had difficulty in overcoming their dependence in a community setting. A residential programme may also deliver an assisted withdrawal programme. This should be sufficiently specialist to qualify as a 'medically monitored' inpatient service – and it should meet the standards and criteria detailed in guidance from the Specialist Clinical Addictions Network[1]. This level of support and monitoring of assisted withdrawal is most appropriate for individuals with lower levels of dependence and/or without a range of associated medical and psychiatric problems. Within the residential setting, people will receive multiple interventions and supports (some of which are described by the intervention codes) in a

[1] SCAN (2006). Inpatient Treatment of Drug and Alcohol Misusers in the National Health Service

[2] Patel K (2010) Reducing Drug-Related Crime and Rehabilitating Offenders – Recovery and rehabilitation for drug users in prison and on release: recommendations for action. London: House of Lords

Code	Reference data	Definition
		coordinated and controlledenvironment. The interventions and support provided in this setting will normally comprise both professionally delivered interventions and peer-based support, as well as work and leisure activities.
6	Recovery house	A recovery house is a residential living environment, in which integrated peer-supportand/or integrated recovery support interventions are provided for residents who wherepreviously, or are currently, engaged in treatment to overcome their drug and alcoholdependence. The residences can also be referred to as dry-houses, third-stage accommodation or quasi-residential. Supported housing that does not provide such integrated substance misuse peer orrecovery support as part of the residential placement is not considered a recoveryhouse for this purpose. Recovery houses may be completely independent, or associated with a residentialtreatment provider or housing association. Some will require 'total abstinence' as acondition of residence whereas others may accept people in medication assistedrecovery who are otherwise abstinent.

Appendix L: recording outcomes

The Treatment Outcomes Profile (TOP) is a national outcomes monitoring tool for clients receiving substance misuse treatment. The TOP must be used for clients in adult services and consists of a simple set of questions that can aid improvements in clinical practice by enhancing assessment and care plan reviews. It can also help to ensure that each service user's recovery care plan identifies and addresses his or her needs and treatment goals. Young persons services use a similar record called the Young Persons Outcome Record (YPOR).

There are 3 different areas covered by the TOP – substance use, substance risk behaviours and health and social functioning. The latter includes information on psychological health, physical health, work/education, housing and overall quality of life. Outcomes reports are compiled centrally within Public Health England (PHE) via NDTMS.

The start TOP should be completed for all adult clients 2 weeks either side of their first intervention start date and reflect upon the previous 4 weeks. This will provide a baseline record of behaviour in the month prior to the client starting treatment.

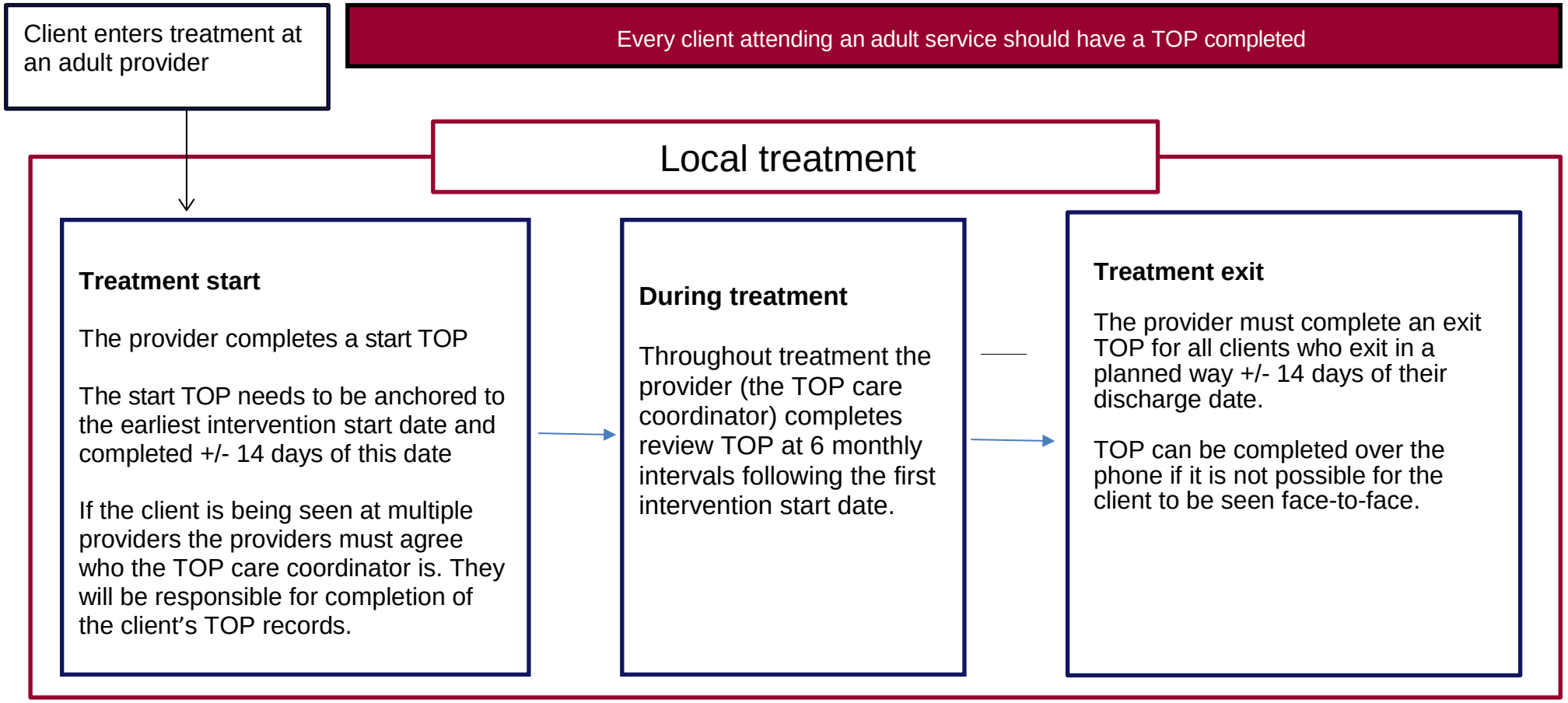
All questions on the form should be answered; zero should be recorded where the client does not use that particular substance and NA used when the question has not been answered.

Review TOP should be undertaken at 6 monthly intervals following the first intervention start date and a final TOP should be completed on discharge from treatment for all planned exits. If the provider is not able to see the client face-to-face then TOP can be done over the phone if necessary.

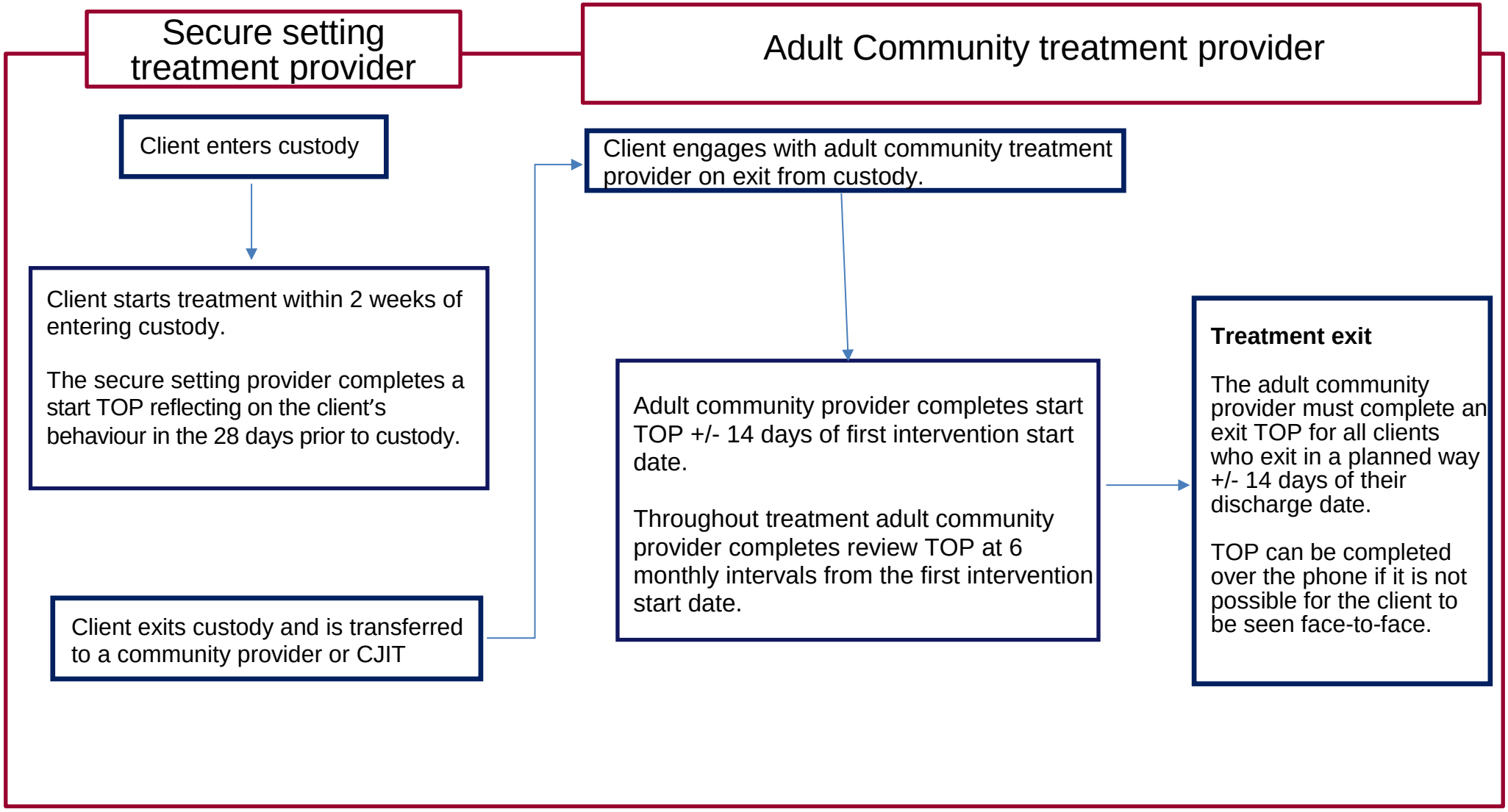
The following pages contain process maps for clients:

- in adult services
- transferred to an adult service from a secure setting
- transferred to an adult service from a YP service

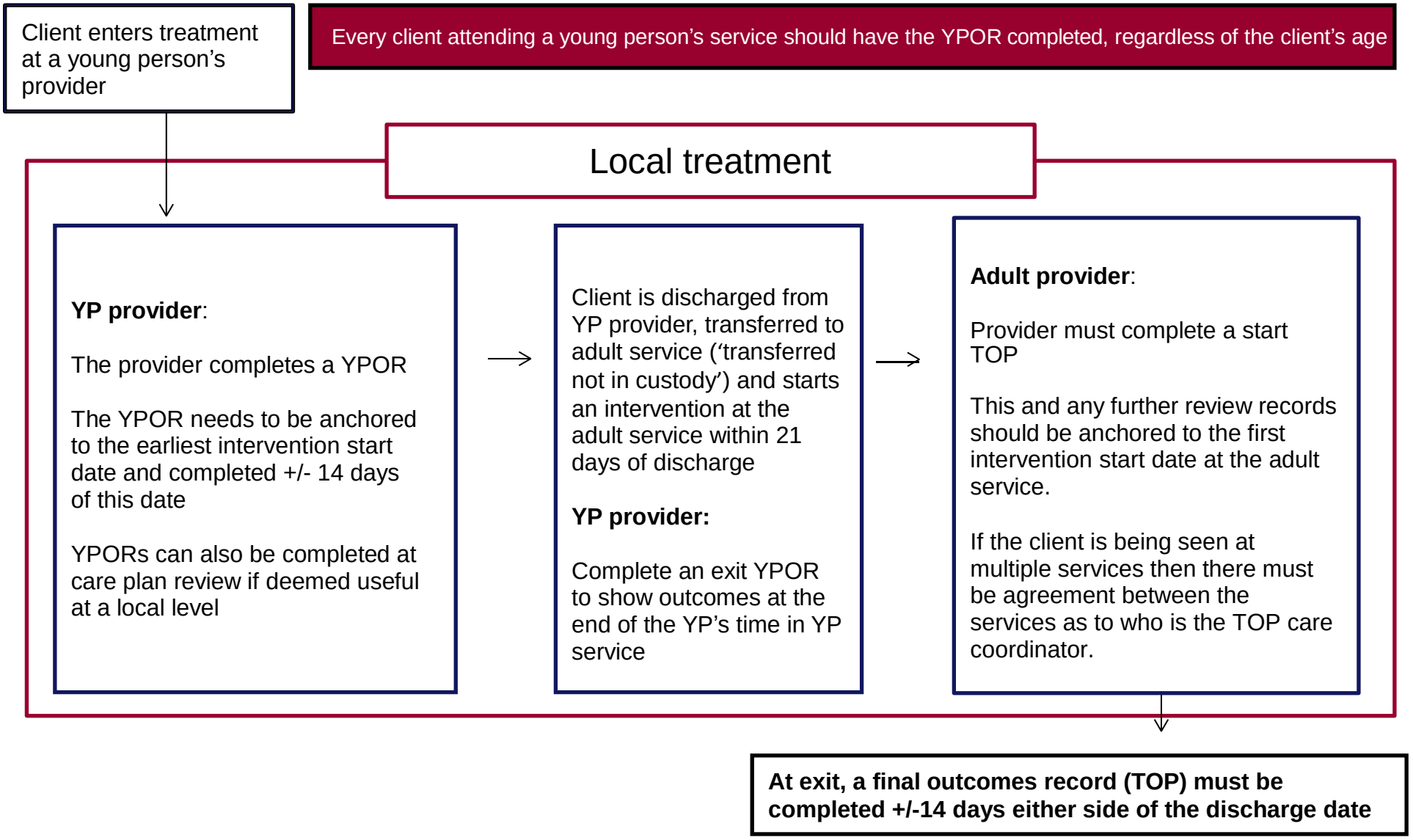
L.1 TOP process map for clients in treatment at an adult service



L.2 TOP process map for clients transferred into a community service from a secure setting



L.3 TOP/YPOR process map for clients being transferred from a YP service to an adult service



Appendix M: brief interventions

NICE PH24 describes Extended Brief Interventions (EBIs) for alcohol use as follows.

Who is the target population?

Adults who have not responded to structured brief advice on alcohol and require an extended brief intervention or would benefit from an extended brief intervention for other reasons.

Who should take action?

NHS and other professionals in the public, private, community and voluntary sector who are in contact with adults and have received training in extended brief interventions techniques.

What action should they take?

Offer an extended brief intervention to help people address their alcohol use. This could take the form of motivational interviewing or motivational-enhancement therapy. Sessions should last from 20 to 30 minutes. They should aim to help people to reduce the amount they drink to low-risk levels, reduce risk-taking behaviour as a result of drinking alcohol or to consider abstinence.

Follow up and assess people who have received an extended brief intervention. Where necessary, offer up to 4 additional sessions or referral to a specialist alcohol treatment service.

What to report to NDTMS?

One-off brief interventions or extended brief interventions for alcohol use should not be reported to NDTMS.

Extended interventions should only be reported to NDTMS where the service has provided an assessment and care plan followed by brief treatment comprising multiple planned Extended Brief Intervention (EBI) sessions with a treatment goal of abstinence or reducing consumption. This can be recorded under the psychosocial sub-intervention ‘motivational interventions

See table below for further information:

Identification and Brief Advice (IBA)/Screening and Brief Intervention (SBI) IBA and SBI refer to an AUDIT screen followed by an explanation of the results and 5 or so minutes of brief lifestyle advice or (as a minimum) an information leaflet.	Commissioners may wish to record IBA/SBI locally but they **should not be recorded on NDTMS.**
A single Extended Brief Intervention (EBI) A single 20 to 30 minute session as described by NICE	Commissioners may wish to record single EBIs locally but they **should not be recorded on NDTMS.**
Multiple planned Extended Brief Interventions (EBIs) should be considered brief treatment More than one and up to 4 additional sessions are planned. It is expected that: 1. treatment is based on a comprehensive assessment of need 2. treatment is delivered according to a recovery care plan, which sets out clear goals which include change to substance use and is regularly reviewed with the client 3. the recovery care plan sets out clear goals for other needs of the client which address one or more of the domains that form part of the Treatment Outcome Profile 4. all interventions must be delivered by competent staff	This would constitute structured treatment and **should be reported to NDTMS** under the psychosocial sub intervention 'motivational interventions'.

Appendix N: referral date to service

In CDS-P (April 2020) a new field was introduced ‘referral date to service’ to give a better understanding of the full client pathway. This should be used to record the date that the client was initially referred to the service, this would include any non-structured treatment that is undertaken prior to structured treatment.

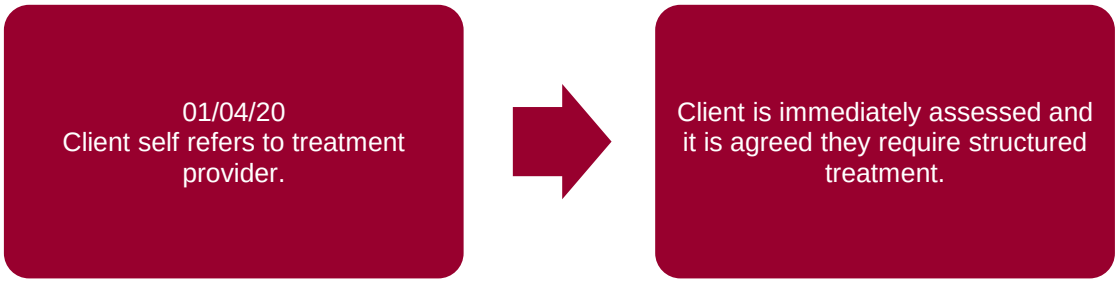
For clients released from the secure estate this would be the date they initially engaged with the community service post release.

Treatment providers should continue to record all other dates (including referral date, triage date etc) as before, as per the NDTMS business definitions.

The following scenarios illustrate how the referral date to service should be recorded.

Scenario 1: self-referral

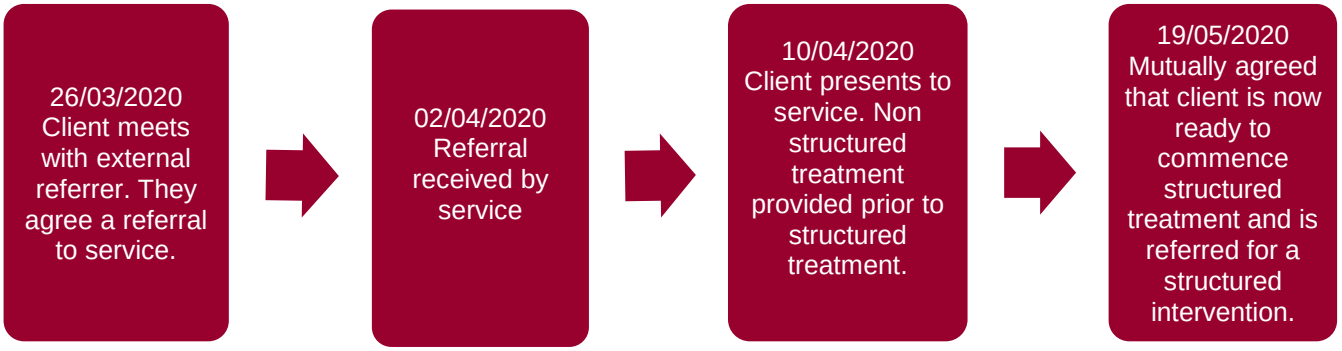
Scenario: the client presents to the treatment service, is immediately assessed and it is agreed that they should enter structured treatment.



Referral date to service = 1 April 2020
Referral date = 1 April 2020

Scenarios 2: a period of non-structured treatment before structured treatment

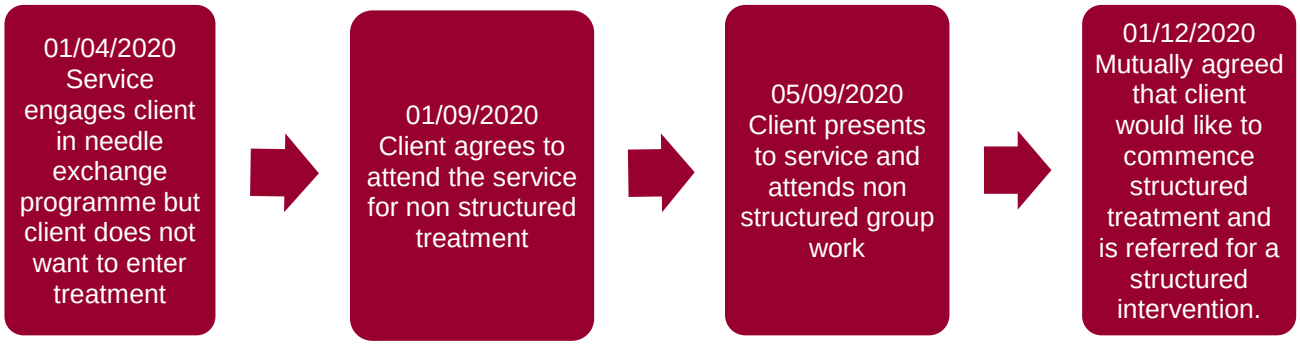
Scenario: the client engages in a mutually agreed period of non structured treatment prior to structured treatment.



Referral date to service = 2 April 2020
Referral date = 19 May 2020

Scenario 3: outreach work followed by a period of non-structured treatment before structured treatment

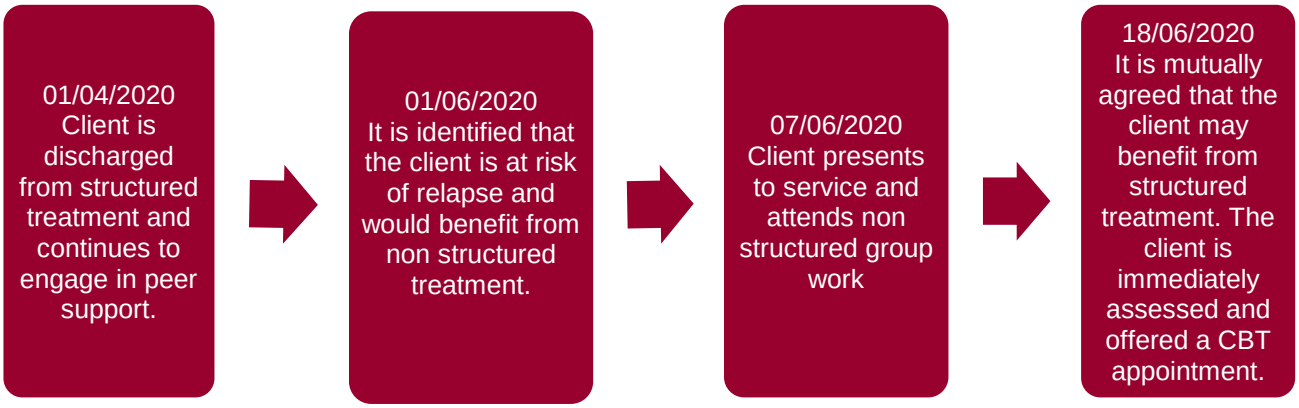
Scenario: The service is working with the client in an outreach capacity for several months before the client agrees to come to the service for non structured treatment. After several months of non structured treatment the client agrees to enter structured treatment.



Referral date to service = 1 September 2020
Referral date = 1 December 2020

Scenario 4: discharged from structured treatment, received recovery support, re-engaged with treatment

Scenario: The client has received structured treatment and has been discharged. After discharge the client engages in recovery support (after care). During this time the client relapses and it is agreed that the client should attend the service for non-structured treatment. After a period of non-structured treatment the client agrees to re-enter structured treatment.



Referral date to service = 1 June 2020
Referral date = 18 June 2020

Appendix O: recording short residential rehab or secure setting stays

This appendix details how a client being transferred into a secure setting or residential rehab should be recorded on NDTMS, and what should happen if/ when they return to the community service at a later date.

Discharging a client from a community service and transferring them to residential rehab or a secure setting

If a client with an ongoign structured treatment need is transferred to a residential rehab or a secure setting from a community treatment provider the community provider should:

1. close all interventions by populating the intervention end date
2. enter the date that the client is discharged (likely to be the date that they enter the residential rehab or the secure setting)
3. record a discharge reason of either ‘Transferred – Not in Custody’ or ‘Transferred – in Custody’ as appropriate
4. complete a combined review form (CRF) including SIR, CIR and TOP.

The client re-presents to the community service within 21 days of discharge

If the client comes back to the community treatment provider within 21 days of being discharged from that provider the service may reopen the previous episode of treatment by:

1. removing the discharge date
2. removing the discharge reason
3. changing the exit TOP to a review TOP

It is imperative that the closed interventions are not reopened but new interventions are started to indicate that the client has re-engaged. Without this the client will not be picked up as a successful transfer for reporting purposes.

The client re-presents to the community service after 21 days or more

If the client comes back to the community treatment provider after 21 days or more the previous episode must remain discharged and closed and a new episode will need to be opened. The service will need to recapture the NDTMS information required at presentation.

Where the community treatment provider has open recovery support intervnetions for ongoing recovery check-ups or other ongoing non-structured support provided whilst the client was in residential rehab/ the secure setting, then these non-structured interventions will need to be closed and reopened in the new structured episode.

Appendix P: Combined Review Form (CRF)

The Combined Review Form (CRF) combines the following dataset entities into one form and one process:

- Treatment Outcome Profile (TOP)
- Client Information Review (CIR)
- Sub Intervention Review (SIR)

It should be completed at treatment start, at least every 6 months and on discharge.

The TOP section should be completed at treatment start, at least every 6 months and on discharge for planned exits. The client needs to be present when the TOP is completed.

The CIR section should be fully completed at least every 6 months and on discharge for planned exits. All data items should be reviewed and completed to reflect the latest status. A partial CIR should be completed on discharge for unplanned exits. A partial CIR can also be completed more frequently to notify us of changes to data, such as BBV information. The client needs to be present for the majority of the CIR to be completed.

The SIR should be completed at least every 6 months and on discharge. This information should be reported retrospectively to notify us of the interventions the client has received since treatment start or since their last SIR. The client does not need to be present when the SIR is completed.

The flowchart below will help to understand which parts of the CRF need to be completed and when: