Publication withdrawn

This guidance was withdrawn in April 2024.

For up-to-date information about the National Drug Treatment Monitoring System (NDTMS), see core data set documentation on the NDTMS website.

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 O

About Public Health England

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Revision history

Version	Author	Purpose/reason
13.03	L Hughes	**Minor amendments:** • CIRHCVAS & CIRHCVPCR - updatability amended from 'If information changes a new CIR should be completed' to 'If a test is done during the treatment episode a CIR should be completed to show the result of the most recent test, even if the result is the same as a previous test'. • 'Referred to hep C treatment' definition clarified in appendix J.3 • Added that client name should be updated if the client legally changes their name • NATION – clarified that Kosovo should be recorded as Serbia as per NHS data dictionary • Recovery support intervention – take home naloxone and training – clarified definition to explain that this should only be recorded when naloxone is issued.
13.02	L Hughes	**Minor amendments:** • Revision history pre CDS-O moved to 'Revision History Pre CDS-O' document
13.01	L Hughes	**Minor amendments:** • 'No' added to 'early help' table in appendix F • 'Facilitated access to mutual aid' definition clarified in appendix J.3
13.0	L Hughes	**CDS O** **New reference data items:** • ETHNIC – 'value is unknown' added • PC – default code for NFA added – ZZ99 3VZ • EHCSC & CIREHCSC – 'Client declined to answer' added • MTHTN & CIRMTHTN – 'Client declined to answer' added • CRTMHN & CIRCRTMHN – 'Client declined to commence treatment for their mental health need' added • DISRSN – 'Onward referral offered and refused' added **Dropped headers:** • PSYOTHR (Client involved in other treatment sub interventions related to psychosocial)

Version	Author	Purpose/reason
		• RECOTH (Client provided with any other recovery support elements) **Dropped reference data items:** • RFLS – 'PRU' removed as this is covered by 'Alternative education' **Amendments:** • AGNCY, CLIENT and CLIENTID moved to 'client' section rather than 'episode' • Postcode (PC) amended to clarify that the postcode should be truncated • MTHTN – amended to reflect that suicide risk refers to current risk only • MTHTN – definition of 'Identified space in a health-based place of safety' added • Appendix C added • Added to Appendix I guidance for transfers to secure hospitals • Links to NTA website updated to gov.uk • Expanded accommodation need examples

Revision history prior to CDS-O can be found in the Revision History Pre CDS-O document available from your regional NDTMS team.

Contents

1. 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.

This document defines the items to be collected and utilised by the NDTMS.

Previously drug and alcohol business definitions have been provide in separate documents. For the first time, this document contains definitions that are applicable to both drug and alcohol clients aged 18 or over in community treatment. Information and definitions relating to data collection from 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 O) for national data collection will come into effect on 1 April 2018.

2. Purpose of NDTMS

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

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 dependents

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

3. Data entities

The data items listed in this document may be considered as belonging to 1 of 7 different sections, which are used throughout this document. These are:

1. **Client details** – details pertaining to the client including initials, date of birth, gender, ethnicity and nationality.
2. **Episode details** – details pertaining to the current episode of treatment including information gained at triage such as geographic information, protected characteristics information, problem substance/s, parent and child status, BBV, etc. A treatment episode includes time spent in treatment at 1 provider, where they record 1 triage date and 1 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).
3. **Treatment intervention details** – details regarding which high-level intervention/s the client has received and the relevant dates.
4. **Sub intervention details (SIR)** – details regarding which sub modalities 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/admin without the client present.
5. **Time in treatment** – information relating to the time the client spends in treatment. A new time in treatment record should be completed when this information changes during the episode of treatment.
6. **Outcomes Profile** – either the Treatment Outcome Profile (TOP), Young Person Outcome Profile (YPOR) or the Alcohol Outcomes Profile (AOR). The TOP should be completed at treatment start, every 6 months during treatment and at discharge. The AOR and the YPOR should be completed at treatment start and at discharge. All outcomes profiles can be completed more frequently if deemed of use locally. These should be completed by the keyworker with the client to review their substance use behaviour and thoughts in the last 28 days.
7. **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. As this information changes, it should not be updated in the episode but a CIR should be completed with all relevant fields updated as and when required.

In general, all data is required. Some fields are required at treatment start others should be provided as and when the client progresses through their treatment (see section 5).

NDTMS is a consented to dataset meaning that all clients should give explicit consent for their information to be shared with NDTMS. For further details, please refer to the NDTMS confidentiality guidance: https://www.gov.uk/government/publications/confidentiality-guidance-for-drug-and-alcohol-treatment-providers-and-clients

4. Reporting alcohol treatment to NDTMS

Alcohol dataset

Services that treat both drug and alcohol clients are required to collect and report to NDTMS the full adult community dataset. Services that deliver only alcohol treatment are permitted to submit just the alcohol dataset if they choose to (although are encouraged to submit the full dataset). The alcohol dataset is a subset of the full dataset and is listed in full in Appendix O.

Alcohol Outcomes Record (AOR)

The AOR was developed after consultation with the alcohol treatment field as the minimum dataset for measuring outcomes for alcohol clients in structured treatment. All items on the AOR should be completed for alcohol clients at both treatment start and exit. Localities may also complete outcomes information at care plan review to monitor progress if they wish. All of the items on the AOR are also included on the TOP and should localities wish to complete TOP for alcohol clients this will be accepted in place of an AOR.

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 1 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 be provided with the following as appropriate:

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

Brief interventions – what to report to NDTMS

One-off brief interventions for alcohol use should not be reported to NDTMS, but, brief treatment comprising multiple planned Extended Brief Intervention (EBI) sessions can be recorded under the psychosocial sub-intervention ‘motivational interventions’. It is expected that an assessment of need and a care planned approach is undertaken, as a precursor to any series of sessions with a treatment goal of abstinence or reducing consumption. See Appendix N for further information on brief interventions and what can be reported to NDTMS.

5. NDTMS dataset fields

1. Client details		
Field description	**CSV Header**	**Definition**
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'.
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'.
Client birth date	DOB	The day, month and year that the client was born.
Client sex	SEX	The client sex at registration of birth.
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.
Nationality	NATION	Country of nationality at registration of birth. Kosovo should be recorded as Serbia as per NHS data dictionary.
Agency code	AGNCY	A unique identifier for the treatment provider that is defined by the regional NDTMS team – for example L0001.
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).
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.

2. Episode details		
Field description	**CSV Header**	**Definition**
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 V7.0 populated in the field.
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 and this field needs to be completed for all records triaged after 1 April 2006. It does not need to be completed for clients triaged before this date (it is assumed that all records previously returned have been consented for).
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: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/669776/Geographic_information_for_the_National_Drug_Treatment_Monitoring_System__NDTMS_.pdf
Local Authority	LA	The local authority in which the client currently resides (as defined by the postcode of their normal residence). If a client states that they are of No Fixed Abode (denoted by having an accommodation need of NFA) then for 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. See NDTMS Geographic Information document for a list of LA codes: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/669776/Geographic_information_for_the_National_Drug_Treatment_Monitoring_System__NDTMS_.pdf

2. Episode details		
Field description	**CSV Header**	**Definition**
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).
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.
Referral date	REFLD	The date that the client was referred to the service for this episode of treatment. For example, it would be the date a referral letter was received, the date a referral phone call or fax was received or the date the client self-referred. For scenario examples and how this date is used in waiting times calculations please see Appendix B.
Referral source	RFLS	The source or method by which a client was referred for this treatment episode.
Triage date	TRIAGED	The date that the client made a first face-to-face presentation to this treatment provider for treatment. This could be the date of triage/initial assessment though this may not always be the case. 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 reflect the date that they are starting their structured treatment. This will ensure that waiting times for structured treatment can be accurately calculated.
Previously treated	PREVTR	Has the client ever received structured drug or alcohol treatment at this or any other treatment provider?
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.
Sexual orientation	SEXUALO	The sexual orientation that the client states. If a client declines to answer, then 'not stated' should be used.
Religion or belief	RELIGION	The religion or belief of the client. If a client declines to answer, then 'not stated' should be used.

2. Episode details		
Field description	**CSV Header**	**Definition**
Disability 1	DISABLE1	Whether the client considers themselves to have a disability. If a client declines to answer, then 'not stated' should be used. If the client has no disability, then 'no disability' should be entered. Refer to Appendix E for disability definitions.
Disability 2	DISABLE2	Whether the client considers themselves to have a second disability. If a client declines to answer, then 'not stated' should be used. If the client has no second disability, then 'no disability' should be entered. Refer to Appendix E for disability definitions.
Disability 3	DISABLE3	Whether the client considers themselves to have third a disability. If a client declines to answer, then 'not stated' should be used. If the client has no third disability, then 'no disability' should be entered. Refer to Appendix E for disability definitions.
Employment status	EMPSTAT	The current employment status of the client. If a client declines to answer, then 'not stated' should be used.
Time since last paid employment	TSLPE	How long has it been (in years) since the client was last in paid legal employment? This can include cash in hand work. If a client declines to answer then 'client declined to answer' should be used.
Pregnant	PREGNANT	Is the client pregnant?
Parental status	PRNTSTAT	The parental status of the client – whether or not the client is a 'parent' and whether none of, some of or all of the children they are responsible for live with the client. A child is a person who is under 18 years old. See Appendix F for data items and definitions.
Children	CHILDWTH	The number of children under 18 that live in the same household as the client at least 1 night a week. The client does not necessarily need to have parental responsibility for the children. Due to this being a numerical field please record code '98' as the response if the client has declined to answer.

2. Episode details		
Field description	**CSV Header**	**Definition**
Children receiving early help or in contact with children's social care	EHCSC	Are the client's children/ any children living with the client receiving early help or in contact with children's social care? This question 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 1 option applies, then please select the 1 that is considered the priority from the perspective of the treatment service/keyworker. If client declines to answer record 'client declined to answer'. See Appendix F for data items and definitions.
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 1 substance the provider is responsible for clinically deciding which substance is primary. 'Poly drug' should no longer be used in this field. Instead, the specific substances should be recorded in each of the problem substance fields.
Age of first use of problem substance number 1	DRUG1AGE	The age (in years) that the client recalls first using the problem substance Number 1.
Route of administration of problem substance number 1	ROUTE	The route of administration of problem substance Number 1 recorded at the point of triage/initial assessment.
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. 'Poly drug' should no longer be used in this field. Instead, the specific substances should be recorded in each of the problem substance fields. If no additional substance, 'no second drug' should be recorded.

2. Episode details		
Field description	**CSV Header**	**Definition**
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. 'Poly drug' should no longer be used in this field. Instead, the specific substances should be recorded in each of the problem substance fields. If no additional substance, 'no third drug' should be recorded.
Care plan start date	CPLANDT	Date that a care plan was created and agreed with the client for this treatment episode.
Injecting status	INJSTAT	Is the client currently injecting, have they ever previously injected or never injected.
Drinking days	ALCDDAYS	Number of days in the 28 days prior to initial assessment that the client consumed alcohol.
Units of alcohol	ALCUNITS	Typical number of units consumed on a drinking day in the 28 days prior to initial assessment.
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. The score of the questionnaire (0-60) 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. For further information on SADQ please see: https://www.alcohollearningcentre.org.uk/Topics/Latest/Severity-of-Alcohol-Dependence-Questionnaire-SADQ/
Hep B intervention status	HEPBSTAT	Within the current treatment episode, whether the client was offered a vaccination for hepatitis B, and if that offer was accepted by the client. For further information on recording BBV details please refer to the 'Recording NDTMS data about blood-borne virus interventions' document: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/669749/Guidance_for_recording_data_about_blood-borne_virus_interventions_on_the_NDTMS.pdf

2. Episode details		
Field description	**CSV Header**	**Definition**
Hep B vaccination count	HEPBVAC	The number of hepatitis B vaccinations given to the client within the current treatment episode, or whether the course of vaccinations was completed. Vaccinations can be provided by the treatment provider or elsewhere, such as in primary care. Where the treatment provider completing NDTMS, or a partner treatment provider, provides 1 or more vaccinations to a client that actually completes the course, then 'course completed' should be recorded rather than the number of vaccinations. For further information on recording BBV details please refer to the 'Recording NDTMS data about blood-borne virus interventions' document: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/669749/Guidance_for_recording_data_about_blood-borne_virus_interventions_on_the_NDTMS.pdf
Hep C intervention status	HEPCSTAT	Within the current treatment episode, whether the client was offered a test for hepatitis C, and if that offer was accepted by the client. For further information on recording BBV details please refer to the 'Recording NDTMS data about blood-borne virus interventions' document: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/669749/Guidance_for_recording_data_about_blood-borne_virus_interventions_on_the_NDTMS.pdf
Hep C tested	HEPCTD	Has the client been tested for hepatitis C? This test may be within the current treatment episode or previously to the episode. If the response is 'Yes' the 'Hep C – latest test date' should be completed. For further information on recording BBV details, please refer to the 'Recording NDTMS data about blood-borne virus interventions' document: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/669749/Guidance_for_recording_data_about_blood-borne_virus_interventions_on_the_NDTMS.pdf
Hep C latest test date	HEPCTSTD	Date that the client was last tested for hepatitis C. This test may be within the current treatment episode or previously to the episode. If the exact date is not known then the 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: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/669749/Guidance_for_recording_data_about_blood-borne_virus_interventions_on_the_NDTMS.pdf

2. Episode details		
Field description	**CSV Header**	**Definition**
Hep C antibody test status	HCVAS	What is the result of the client's hep C antibody test? This is the first test (before PCR test) which looks for hep C antibodies in the client's blood. For further information on recording BBV details, please refer to the 'Recording NDTMS data about blood-borne virus interventions' document: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/669749/Guidance_for_recording_data_about_blood-borne_virus_interventions_on_the_NDTMS.pdf
Hep C PCR test status	HCVPCR	What is the result of the client's hep C PCR test? The PCR test is usually the second test (after antibody test) which looks at whether the hep C virus is reproducing in the client's body. For further information on recording BBV details, please refer to the 'Recording NDTMS data about blood-borne virus interventions' document: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/669749/Guidance_for_recording_data_about_blood-borne_virus_interventions_on_the_NDTMS.pdf
Drug treatment 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 (eg 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 on-going delivery of the care plan. See Appendix G for further information on drug treatment health care assessment.
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 1 provider then the services must decide which 1 completes the TOP.

2. Episode details		
Field description	**CSV Header**	**Definition**
Mental health treatment need	MTHTN	Does the client have a mental health treatment need? Mental health treatment need includes: • common mental illness (eg 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 (eg 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'.
Receiving treatment for mental health need	CRTMHN	Is the client 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 1 treatment option applies, then please select the one that is considered the priority from the perspective of the treatment service/keyworker.
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. Note: this process should be used for clients triaged after 1 April 2006 and records should not be amended retrospectively. 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 modalities should be opened.

2. Episode details		
Field description	**CSV Header**	**Definition**
Discharge reason	DISRSN	The reason why the client's episode of structured treatment was ended. For discharge codes and definitions see Appendix I.

3. Treatment intervention details		
Field description	**CSV Header**	**Definition**
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 1 treatment intervention running sequentially or concurrently within an episode and may have more than 1 of the same type running concurrently as long as the setting in each are different.
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.
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.
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.

3. Treatment intervention details		
Field description	**CSV Header**	**Definition**
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.
Intervention start date	MODST	The date that the stated treatment intervention commenced, ie the client attended for the appointment.
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.
Intervention exit status	MODEXIT	Whether the exit from the treatment intervention was planned (mutually agreed), unplanned (client dropped out) or withdrawn (service withdrawn by provider).

4. Sub intervention review (SIR) details		
Field description	**CSV Header**	**Definition**
Sub intervention assessment date	SUBMODDT	The date that the sub intervention review was completed.
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 1 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.
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.

5. Time in treatment details		
Field description	**CSV Header**	**Definition**
Time in treatment assessment date	TITDATE	The date that the time in treatment will commence from. Where this is a first occurrence, the date field should be populated with the intervention start date of the first structured intervention, all subsequent occurrences should capture the date at which there was a change in the time in treatment threshold.
Time in treatment	TITREAT	The time per week that the client will be spending in structured treatment. This will take into account the time receiving any combination of pharmacological, psychosocial and recovery support interventions. If a client is only receiving recovery support then the time in treatment is not expected to be returned. See Appendix K for the definitions of time in treatment.
Time in treatment ID	TITID	A mandatory, unique technical identifier representing the time in treatment, 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).

6. Outcomes profile – TOP/ AOR		
Field description	**CSV Header**	**Definition**
Treatment Outcomes Profile (TOP or AOR) date	TOPDATE	Date of most recent outcome review. In each review all outcomes data should reflect the 28 days prior to this date. See Appendix M for further details and outcomes process maps.
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.
Treatment stage	TRSTAGE	Stage of treatment that the TOP data relates to eg start, review, exit, post-exit
Alcohol use	ALCUSE	Number of days in previous 28 days that client has used alcohol.
Consumption	CONSMP	Typical number of alcohol units consumed on a drinking day in the last 28 days.
Opiate use	OPIUSE	Number of days in previous 28 days that client has used opiates.
Crack use	CRAUSE	Number of days in previous 28 days that client has used crack.
Cocaine use	COCAUSE	Number of days in previous 28 days that client has used powder cocaine.
Amphetamine use	AMPHUSE	Number of days in previous 28 days that client has used amphetamines.
Cannabis use	CANNUSE	Number of days in previous 28 days that client has used cannabis.
Other drug use	OTRDRGUSE	Number of days in previous 28 days that client has used another problem drug.
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.
Injected	IVDRGUSE	Number of days in previous 28 days that client has injected non-prescribed drugs.
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 1 response is used for NDTMS. See NDTMS reference data document.
Shoplifting	SHOTHEFT	Number of days in previous 28 days that client has been involved in shop theft.
Selling drugs	DRGSELL	Number of days in previous 28 days that client has been involved in selling drugs.

6. Outcomes profile – TOP/ AOR		
Field description	**CSV Header**	**Definition**
Other theft	OTHTHEFT	Has client has been involved in: theft from or of a vehicle, property theft or burglary or been involved in fraud, forgery or handling stolen goods in previous 28 days. On the TOP form, this is displayed as 3 questions, but only 1 response is used for NDTMS. See NDTMS reference data document.
Assault/violence	ASSAULT	Has client committed assault/violence in previous 28 days?
Psychological health status	PSYHSTAT	Self-reported psychological health (anxiety, depression, problem emotions and feelings) score in previous 28 days of 0-20, where 0 is poor and 20 is good.
Paid work	PWORK	Number of days in previous 28 days that client has attended paid work. Includes legal work only.
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.
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.
Education	EDUCAT	Number of days in previous 28 days that client has attended for education eg school, college, university.
Physical health status	PHSTAT	Self-reported physical health (extent of physical symptoms and bothered by illness) score in previous 28 days of 0-20, where 0 is poor and 20 is good.
Acute housing problem	ACUTHPBM	Has client had an acute housing problem (been homeless) in previous 28 days?
At risk of eviction	HRISK	Has client been at risk of eviction within previous 28 days?
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.

6. Outcomes profile – TOP/ AOR		
Field description	**CSV Header**	**Definition**
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 0-20, where 0 is poor and 20 is good.

7. Client information review (CIR)		
Field description	**CSV Header**	**Definition**
Client information review (CIR) date	CIRDT	The date that the most recent client information review took place. **The client information review should be completed at least annually but is recommended to be completed following each care plan review and any information updates reported to NDTMS.**
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).
CIR Pregnant	CIRPREGNANT	Is the client pregnant? **This should be recorded if the client's pregnancy status has changed since it was recorded at treatment start or since their last client information review.**
CIR Parental Status	CIRPRTST	The parental status of the client – whether or not the client is a 'parent' and whether none of, some of or all of the children they are responsible for live with the client. A child is a person who is under 18 years old. See Appendix F for data items and definitions. **This should be recorded if the client's parental status has changed since it was recorded at treatment start or since their last client information review.**
CIR Children living with client	CIRCLDWT	The number of children under 18 that live in the same household as the client at least 1 night a week. The client does not necessarily need to have parental responsibility for the children. Due to this being a numerical field please record code '98' as the response if the client has declined to answer. **This should be recorded if the number of children living with the client has changed since it was recorded at treatment start or since their last client information review.**

7. Client information review (CIR)		
Field description	**CSV Header**	**Definition**
CIR Children receiving early help or in contact with children's social care	CIREHCSC	Are the client's children/ any children living with the client receiving early help or in contact with children's social care? See Appendix F for definitions of the different responses. This question 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 1 option applies, then please select the one that is considered the priority from the perspective of the treatment service/keyworker. If client declines to answer record 'client declined to answer'. **This should be recorded if the situation has changed since it was recorded at treatment start or since their last client information review.**
CIR Mental health treatment need	CIRMTHTN	Does the client have a mental health treatment need? Mental health treatment need includes: • common mental illness (eg 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 (eg 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'. **This should be recorded if the client's mental health need has changed since it was recorded at treatment start or since their last client information review.**

7. Client information review (CIR)		
Field description	**CSV Header**	**Definition**
CIR Receiving treatment for mental health need	CIRCRTMHN	Is the client 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 1 treatment option applies, then please select the 1 that is considered the priority from the perspective of the treatment service/keyworker. **This should be recorded if the client's situation has changed since it was recorded at treatment start or since their last client information review.**
CIR Hep B intervention status	CIRHEPBSTAT	Within the current treatment episode, whether the client was offered a vaccination for hepatitis B, and if that offer was accepted by the client. **This should be recorded if the client's hep B status has changed since it was recorded at treatment start or since their last client information review.** For further information on recording BBV details please refer to the 'Recording NDTMS data about blood-borne virus interventions' document: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/669749/Guidance_for_recording_data_about_blood-borne_virus_interventions_on_the_NDTMS.pdf
CIR Hep B vaccination count	CIRHEPBVAC	The number of hepatitis B vaccinations given to the client within the current treatment episode, or whether the course of vaccinations was completed. This should be recorded if the number of vaccinations received by the client has changed since it was recorded at treatment start or since their last client information review. Vaccinations can be provided by the treatment provider or elsewhere, such as in primary care. Where this, or a partner treatment provider, provides 1 vaccination to a client but this actually completes the course, then 'course completed' should be recorded rather than 'one vaccination'. **This should be recorded if the number of vaccinations received by the client has changed since it was recorded at treatment start or since their last client information review.** For further information on recording BBV details please refer to the 'Recording NDTMS data about blood-borne virus interventions' document: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/669749/Guidance_for_recording_data_about_blood-borne_virus_interventions_on_the_NDTMS.pdf

7. Client information review (CIR)		
Field description	**CSV Header**	**Definition**
CIR Hep C intervention status	CIRHEPCSTAT	Within the current treatment episode, whether the client was offered a test for hepatitis C, and if that offer was accepted by the client. **This should be recorded if the client's hep C status has changed since it was recorded at treatment start or since their last client information review.** For further information on recording BBV details please refer to the 'Recording NDTMS data about blood-borne virus interventions' document: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/669749/Guidance_for_recording_data_about_blood-borne_virus_interventions_on_the_NDTMS.pdf
CIR Hep C tested	CIRHEPCTD	Has the client been tested for hepatitis C? **This should be recorded if the client's hep C tested status has changed since it was recorded at treatment start or since their last client information review.** If the response is 'Yes' the 'Hep C – latest test date' should be completed. For further information on recording BBV details please refer to the 'Recording NDTMS data about blood-borne virus interventions' document: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/669749/Guidance_for_recording_data_about_blood-borne_virus_interventions_on_the_NDTMS.pdf
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 hep C antibodies in the client's blood. **This should be recorded if the client's (PCR) RNA status has changed since it was recorded at treatment start or since their last client information review.** For further information on recording BBV details please refer to the 'Recording NDTMS data about blood-borne virus interventions' document: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/669749/Guidance_for_recording_data_about_blood-borne_virus_interventions_on_the_NDTMS.pdf

7. Client information review (CIR)		
Field description	**CSV Header**	**Definition**
CIR Hep C (PCR) RNA status	CIRHCVPCR	What is the result of the client's hepatitis C PCR test? The PCR test is the second test (after antibody test) which looks at whether the Hep C virus is reproducing in the client's body. **This should be recorded if the client's (PCR) RNA status has changed since it was recorded at treatment start or since their last client information review.** For further information on recording BBV details please refer to the 'Recording NDTMS data about blood-borne virus interventions' document: www.gov.uk/government/uploads/system/uploads/attachment_data/file/669749/Guidance_for_recording_data_about_blood-borne_virus_interventions_on_the_NDTMS.pdf

6. Data collection guidance and field updateability

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 tables below detail for each data item whether it is updateable during the episode of treatment or whether the information reported should be as per the start of the episode.

1. Client details	
Field description	**Guidance**
Initial of client's first name	MUST be completed. If not, record rejected. Should not change (ie as at start of episode), unless client legally changes their name. If changed will create a validation mismatch.
Initial of client's surname	MUST be completed. If not, record rejected. Should not change (ie as at start of episode), unless client legally changes their name. If changed will create a validation mismatch.
Client birth date	MUST be completed. If not, record rejected. Should not change (ie as at start of episode). If changed will create a validation mismatch.
Client sex at registration of birth	MUST be completed. If not, record rejected. Should not change (ie as at start of episode). If changed will create a validation mismatch.
Ethnicity	Should not change (ie as at start of episode).
Nationality	Should not change (ie as at start of episode).
Agency code	MUST be completed. If not, record rejected. This is populated by your software system. Should not change. If changed will create a validation mismatch.

1. Client details	
Field description	**Guidance**
Client reference number	Should not change and should be consistent across all episodes at the treatment provider.
Client ID	MUST be completed. If not, record rejected. This is populated by your software system. Should not change.

2. Episode details	
Field description	**Guidance**
Software system and version used	MUST be completed. If not, record rejected. This is populated by your software system. May change (ie current situation).
Consent for NDTMS	Client must give consent before their information can be sent to NDTMS. May change (ie current situation).
DAT of residence	MUST be completed. If not, data may be excluded from performance monitoring reports. May change (ie current living situation).
Local authority	MUST be completed. May change (ie current living situation).
Postcode	May change (ie current living situation).
Episode ID	MUST be completed. If not, record rejected. This is populated by your software system. Should not change.
Referral date	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	**Guidance**
Triage Date	MUST be completed. If not data may be excluded from performance monitoring reports. Should not change.
Previously treated	Should not change (ie as at start of episode).
Accommodation need	Should not change (ie as at start of episode).
Sexual orientation	Should not change (ie as at start of episode).
Religion	Should not change (ie as at start of episode).
Disability 1	Should not change (ie as at start of episode).
Disability 2	Should not change (ie as at start of episode).
Disability 3	Should not change (ie as at start of episode).
Employment status	Should not change (ie as at start of episode).
Time since last paid employment	Should not change (ie as at start of episode).
Pregnant	Should not change (ie as at start of episode). Updates to this field should be made on Client Information Review.
Parental status	Should not change (ie as at start of episode). Updates to this field should be made on Client Information Review.
Children living with client	Should not change (ie as at start of episode). Updates to this field should be made on Client Information Review.
Children receiving early help or in contact with children's social care	Should not change (ie as at start of episode). Updates to this field should be made on Client Information Review.
Problem substance number 1	MUST be completed. If not, record rejected. Should not change (ie as at start of episode).

2. Episode details	
Field description	**Guidance**
Age of first use of problem substance number 1	Should not change (ie as at start of episode).
Route of administration of problem substance number 1	Should not change (ie as at start of episode).
Problem substance number 2	Should not change (ie as at start of episode).
Problem substance number 3	Should not change (ie as at start of episode).
Referral source	Should not change (ie as at start of episode).
Care plan started date	MUST be completed when intervention start date given. Should not change (ie as at start of episode).
Injecting status	Should not change (ie as at start of episode).
Drinking days	Should not change (ie as at start of episode).
Units of alcohol	Should not change (ie as at start of episode).
What is the client's SADQ score?	Should not change (ie as at start of episode).
Hep B intervention status	Should not change (ie as at start of episode). Updates to this field should be made on Client Information Review.
Hep B vaccination count	Should not change (ie as at start of episode). Updates to this field should be made on Client Information Review.
Hep C intervention status	Should not change (ie as at start of episode). Updates to this field should be made on Client Information Review.
Hep C tested	Should not change (ie as at start of episode). Updates to this field should be made on Client Information Review.

2. Episode details	
Field description	**Guidance**
Hep C latest test date	May change (ie current situation).
Hep C antibody test status	Should not change (ie as at start of episode). Updates to this field should be made on Client Information Review.
Hep C PCR test status	Should not change (ie as at start of episode). Updates to this field should be made on Client Information Review.
Drug treatment health care assessment date	Should not change (to be completed when initial health care assessment is completed).
TOP care coordination	May change (ie current situation).
Does the client have a mental health treatment need?	Should not change (ie as at start of episode). Updates to this field should be made on Client Information Review.
Is the client receiving treatment for their mental health need?	Should not change (ie as at start of episode). Updates to this field should be made on Client Information Review
Discharge date	Discharge date required when client is discharged. ALL structured modalities MUST now have end dates. Discharge reason MUST be given.
Discharge reason	Discharge reason required when client is discharged. Discharge date MUST be given. Should only change from 'null' to populated as episode progresses.

3. Treatment intervention details	
Field description	**Guidance**
Treatment intervention	Required as soon as intervention is known. Should not change (ie as at intervention start). If changed will create a validation mismatch.

3. Treatment intervention details	
Field description	**Guidance**
Intervention ID	MUST be completed. If not, record rejected. This is populated by your software system. Should not change.
Intervention setting	Can be left blank for default setting. Should not change (ie as at intervention start).
Date referred to intervention	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	Waiting times calculated from this field. Should not change.
Intervention start date	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	Required field when client completes intervention or is discharged. Should only change from 'null' to populated as episode progresses.
Intervention exit status	Required field when client completes intervention or is discharged. Should only change from 'null' to populated as episode progresses.

4. Sub interventions review (SIR) details	
Field description	**Guidance**
Sub intervention assessment date	Must be completed each time a sub intervention review is completed. Should not change. If changed will create a validation mismatch.
Sub interventions (various headers)	Should not change (ie as at sub intervention review date).
Sub intervention ID	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.

5. Time in treatment details	
Field description	**Guidance**
Time in treatment assessment date	Must be completed for each time in treatment return. If not, record rejected. Should not change. If changed will create a validation mismatch.
Time in treatment	Should not change (ie as at time in treatment date).
Time in treatment ID	MUST be completed if any items in this section above are not null. If not, record rejected. Should not change.

6. Outcomes profile – TOP/ AOR/ YPOR	
Field description	**Guidance**
Treatment Outcomes Profile (TOP) date	Should not change (ie as at TOP date). If changed will create a validation mismatch.
TOP ID	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 stage	Should not change (ie as at TOP date).
Alcohol use	Should not change (ie as at TOP date).
Consumption (Alcohol)	Should not change (ie as at TOP date).
Opiate use	Should not change (ie as at TOP date).
Crack use	Should not change (ie as at TOP date).

6. Outcomes profile – TOP/ AOR/ YPOR	
Field description	**Guidance**
Cocaine use	Should not change (ie as at TOP date).
Amphetamine use	Should not change (ie as at TOP date).
Cannabis use	Should not change (ie as at TOP date).
Other drug use	Should not change (ie as at TOP date).
Tobacco use	Should not change (ie as at TOP date).
IV drug use (Injected)	Should not change (ie as at TOP date).
Sharing	Should not change (ie as at TOP date).
Shoplifting	Should not change (ie as at TOP date).
Selling drugs	Should not change (ie as at TOP date).
Other theft	Should not change (ie as at TOP date).
Assault/violence	Should not change (ie as at TOP date).
Psychological health status	Should not change (ie as at TOP date).
Paid work	Should not change (ie as at TOP date).
Unpaid work	Should not change (ie as at TOP date).
Volunteering	Should not change (ie as at TOP date).
Education	Should not change (ie as at TOP date).
Physical health status	Should not change (ie as at TOP date).
Acute housing problem	Should not change (ie as at TOP date).
Housing risk	Should not change (ie as at TOP date).
Unsuitable housing	Should not change (ie as at TOP date).

6. Outcomes profile – TOP/ AOR/ YPOR	
Field description	**Guidance**
Quality of life	Should not change (ie as at TOP date).

7. Client information review (CIR) information	
Field description	**Guidance**
Client information review (CIR) date	Must be completed each time a client information review is completed. Should not change – if changed will create a validation mismatch.
CIR ID	MUST be completed if any items in this section (CIR) are not null. If not, record rejected. Should not change.
CIR Pregnant	Should not change. (ie as at client information review date). If information changes a new CIR should be completed.
CIR Parental Status	Should not change. (ie as at client information review date). If information changes a new CIR should be completed.
CIR Children living with client	Should not change. (ie as at client information review date). If information changes a new CIR should be completed.
CIR Children in contact with early help or children's' social care	Should not change. (ie as at client information review date). If information changes a new CIR should be completed.
CIR Mental health treatment need	Should not change. (ie as at client information review date). If information changes a new CIR should be completed.
CIR Receiving help for mental health treatment need	Should not change. (ie as at client information review date). If information changes a new CIR should be completed.

7. **Client information review (CIR) information**	
Field description	**Guidance**
CIR Hep B intervention status	Should not change. (ie as at client information review date). If information changes a new CIR should be completed.
CIR Hep B vaccination count	Should not change. (ie as at client information review date). If information changes a new CIR should be completed.
CIR Hep C intervention status	Should not change. (ie as at client information review date). If information changes a new CIR should be completed.
CIR Hep C tested	Should not change. (ie as at client information review date). If information changes a new CIR should be completed.
CIR Hep C antibody status	Should not change. (ie as at client information review date). If a test is done during the treatment episode a CIR should be completed to show the result of the most recent test, even if the result is the same as a previous test.
CIR Hep C (PCR) RNA status	Should not change. (ie as at client information review date). If a test is done during the treatment episode a CIR should be completed to show the result of the most recent test, even if the result is the same as a previous test.

Where items are designated as ‘should not change’ this does not include corrections or moving from a null in the field to it being populated.

Appendix A

Definition of structured treatment and recovery support

If 1 or more pharmacological interventions and/or 1 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 1 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 & 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 • 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

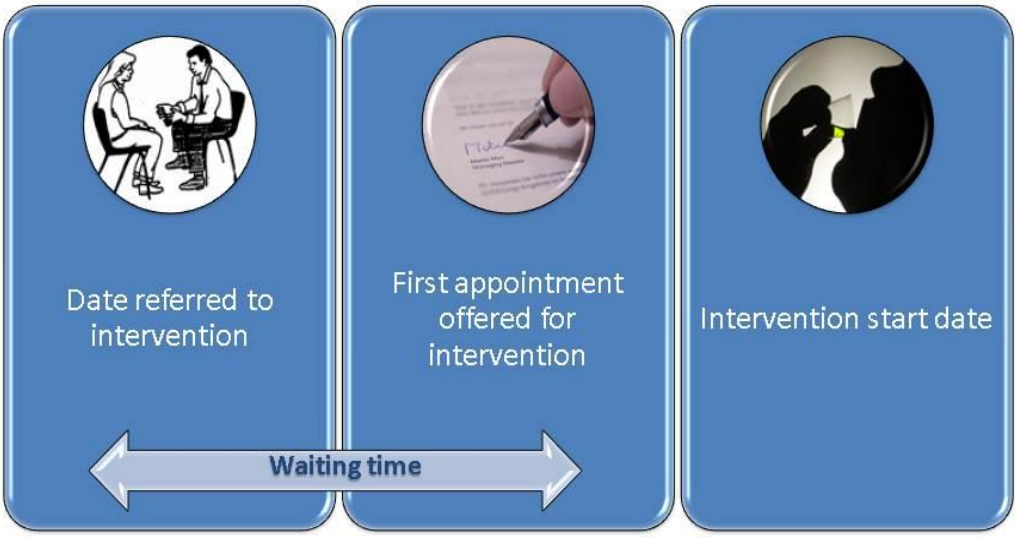
A waiting time is the period from the date a person is referred for a specific treatment intervention and the date of the first appointment offered. Referral for a specific treatment intervention typically occurs within the treatment provider at, or following, assessment.

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. Any waits over 3 weeks are reported in performance reports. Waiting times are calculated in days.

Waiting times are measured 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, it 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.

The ‘Referral date’ recorded by a treatment provider may be later than the ‘Date referred to Intervention’ if the initial contact of a client entering the treatment system is an external organization such as GP, criminal justice system, mental health service (please see scenario 2 below).



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, ie when the intervention start date is present in the data.

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.

If the ‘Intervention start date’ is greater than the earliest ‘Intervention start date’ in the client’s treatment journey, or the ‘Intervention start date’ is equal to the earliest ‘Intervention start date’ in the client’s treatment journey but the ‘Referral date’ is greater than the earliest ‘Referral date’, the waiting time will count as a subsequent intervention.

At provider level, if the intervention start date is the earliest intervention start date of the episode then it is a first intervention, otherwise it is a subsequent intervention.

Waiting times scenario 1: self-referral

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

Referral date = 1 April 2016.

Date referred to intervention = 1 April 2016.

Date of first appointment offered for intervention = 15 April 2016.

Intervention start date = 22 April 2016.

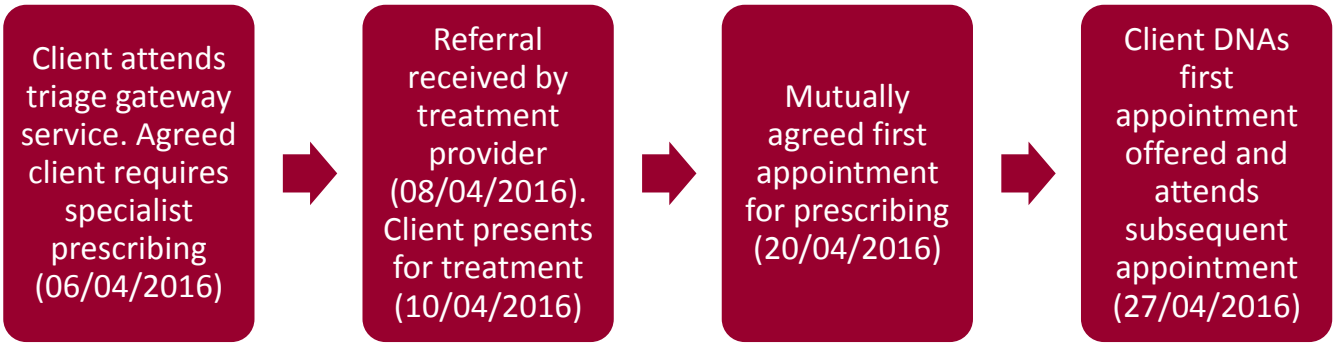
Waiting times calculations:

Partnership = Date of first appointment offered for intervention (15 April 2016) - Date referred to intervention (1 April 2016) = 14 days.

Provider = Date of first appointment offered for intervention (15 April 2016) - Referral date/Date referred to intervention (1 April 2016) = 14 days.

Waiting times scenario 2: referral from an external organisation

Key point – the agency 'referral date' is after the 'date referred to intervention', therefore the 'referral date' is used.



Referral date = 8 April 2016.

Date referred to intervention = 6 April 2016.

Date of first appointment offered for intervention = 20 April 2016.

Intervention start date = 27 April 2016.

Waiting times calculations:

Partnership = Date of first appointment offered for intervention (20 April 2016) - Date referred to intervention (6 April 2016) = 14 days.

Provider = Date of first appointment offered for intervention (20 April 2016) - Referral date (8 April 2016) = 12 days. NOTE: As the referral date is later than the referred to intervention date. Then 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	Text	Comments
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.
1	Drug service statutory	A statutory drug service will normally be a National Health Service (NHS) service but can also be a treatment service provided by social care, the local authority, probation or police.
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.
65	Criminal justice other	Any other criminal justice pathway not covered by the other options provided.
2	Drug service non-statutory	These may be private treatment companies, charities or voluntary organisations.
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&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
11	Psychiatry services	
19	Social Services	
16	Education service	
12	Community care assessment	
9	A&E	Accident and Emergency services
14	Employment service	
10	Syringe exchange	
18	Connexions	Connexions was a UK governmental information, advice, guidance and support service for young people aged 13 to 19 (up to 25 for young people with learning difficulties and/or disabilities), created in 2000 following the Learning and Skills Act.[1] There were Connexions Centres around the country - usually several in each county - which offered support and advice on topics including education, housing, health, relationships, drugs, and finance.
13	Prison	
73	Children's Social Services	Where Social Services are in contact with a child and subsequently refer an adult for treatment.
20	CLA - Children Looked After	Any referrals from services designated to ensure the needs of children and young people who are registered as 'looked after child' are met.
21	Sex worker project	
22	Hospital	Referrals from hospitals (not including A&E departments).
23	Psychological services	
24	Relative	Parents, siblings and other relatives.
25	Concerned other	Carers, friends, boyfriends or girlfriends who are connected to the client in a personal rather than a professional capacity and have referred the client to treatment.
32	Community alcohol team	
36	Outreach	Referrals from services which provide active outreach to address homelessness, anti-social behaviour, child exploitation or other issues

53	Job centre plus	
56	Employer	Applicable to primary alcohol clients only
58	Peer	ie other service user (applicable to primary alcohol clients only)
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	Text	Comments
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&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	Text	Comments
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

Parental status

Parental status 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.

Data item name	Definition
All the children live with client	The client is a parent of 1 or more children under 18 and all the client's children (who are under 18) reside with them full time.
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, others live full time in other locations.
None of the children live with client	The client is a parent of 1 or more children under 18 but none of the client's children (under 18) reside with them, they all live in other locations full time.
Not a parent	The client is not a parent of any children under 18.
Client declined to answer	Only use where client declines to answer.

Early help or in contact with children's social care

Are the client's children or any of the children living with the client receiving early help or in contact with children's social care? If more than 1 option applies, then please select the 1 that is considered to be the priority from the perspective of the treatment service/ keyworker.

Data item name	Definition
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.)
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
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
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
No	Children are not receiving early help nor are they in contact with children's social care.
Client declined to answer	Question was asked but client declined to answer.

Appendix G – Drug treatment healthcare assessment

There is an expectation that all service users within specialist drug treatment providers receive a general healthcare assessment. The aims and expected content of such an assessment are described in the latest version of the clinical guidelines, Drug misuse and dependence: UK guidelines on clinical management, but are also summarised below.

Purposes/aims:

- to identify unmet health needs and address these through care planning
- to ensure account is taken of health problems which could interact with drug treatment
- as a means of attracting and retaining patients into drug treatment
- to improve drug treatment outcomes such as abstinence and relapse prevention in line with current evidence
- to create opportunities for harm minimisation interventions

The intention is first to define a universal healthcare assessment, which should be carried out by all agencies on all drug users.

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

Verbal health assessment

General – health questions should address, for example:

- current 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

Drug-related – health questions should address, for example.

For all clients:

- blood-borne virus testing and results (HIV, HBV, HCV)
- hepatitis immunisation status (HBV, HAV) and other immunisations (Tetanus, TB)
- history of fits/blackouts
- history of overdose

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 septicemia/endocarditis
- history of DVT/ PE/other thrombosis

Basic physical health assessment by examination

All clients should be offered examination of:

- injection sites
- any current concerns related to wound infections and skin swellings

Appendix H – Mental health treatment definitions

Code	Text	Comment
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 (eg 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	To include any pharmacological treatment for mental health condition received from GP.
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
6	Treatment need identified but no treatment being received	
99	Client declined to commence	Client was referred for treatment but treatment

	treatment for their mental health need	commencement was declined by client.

If more than 1 treatment option applies, then please select the 1 that is considered to be the priority from the perspective of the treatment service/keyworker.

Appendix I – Adult discharge codes and discharge scenarios

Below are the current discharge reasons and their definitions.

Data item name	Definition
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.
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.
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.
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.
Transferred – in custody	The client has received a custodial sentence or is on remand and a continuation of structured treatment has been arranged. This will consist of the appropriate onward referral of care planning information and a two-way communication between the community and prison treatment provider to confirm assessment and that care planned treatment will be provided as appropriate.
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.
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.
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’.
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 two-way communication between the treatment provider and the criminal justice system care provider leading to continuation of the appropriate assessment and

	care- planned structured drug/alcohol treatment.
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.
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.

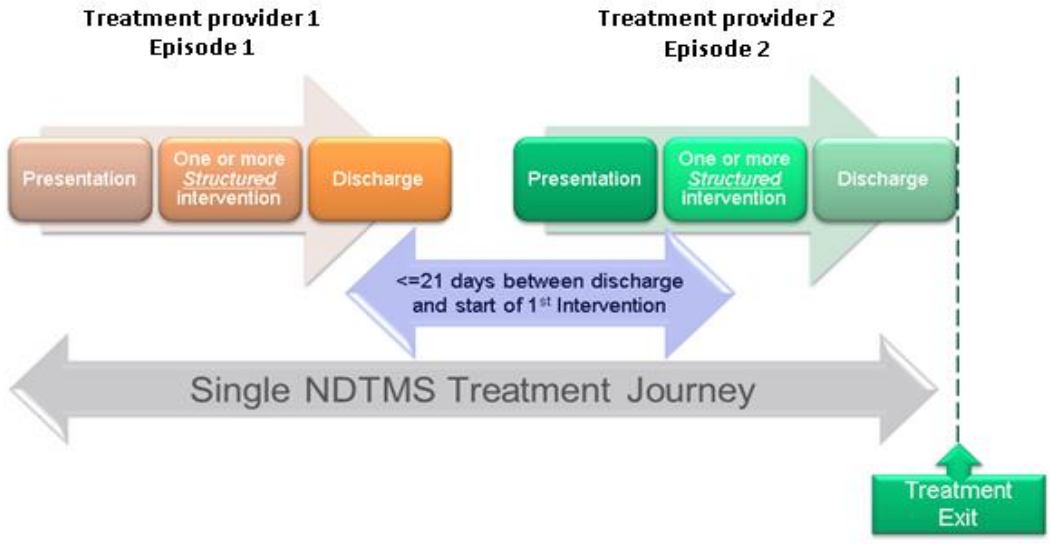
This allows residential and inpatient providers to record where clients have successfully completed the treatment programme and have been transferred for continued structured treatment either at a second stage residential provider or at a community provider.

Data item name	Definition
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.
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.
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.
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 two-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 1 or more episodes of structured treatment, at 1 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 1 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

Basis of pharmacological intervention	Definition	CSV File Header
Assessment and stabilisation	Prescribing of a receptor agonist (such as methadone), or partial agonist (such as buprenorphine), or other pharmacotherapy specific to substance misuse, to stabilise 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.	PHSTBL
Withdrawal	Prescribing of an agonist or partial agonist or other medication, usually up to 12 weeks in the community and 28 days as an inpatient, to facilitate medically assisted withdrawal and to manage withdrawal symptoms.	PHWTH

Maintenance	Prescribing of substitute medications 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.	PHMAIN
Relapse prevention	Prescribing medication for drug and/or alcohol relapse prevention support (such as naltrexone as part of opioid relapse prevention therapy).	PHRELPR
Alcohol withdrawal	Client's alcohol prescribing intention is withdrawal.	APHWITH
Alcohol relapse prevention	Client's alcohol prescribing intention is relapse prevention	APHREPR
Unsupervised methadone	Client prescribed unsupervised methadone ie methadone that is taken away to be consumed without supervision at every dispense or most dispenses in the week. Physeptone should be recorded as methadone.	PHUSMET
Supervised methadone	Client prescribed supervised methadone ie methadone consumption is supervised at every dispense or most dispenses in the week. Physeptone should be recorded as methadone.	PHSUPMET
Unsupervised buprenorphine	Client prescribed unsupervised buprenorphine ie mono-buprenorphine that is taken away to be consumed without supervision at every dispense or most dispenses in the week. Subutex should be recorded as buprenorphine.	PHUSBUP
Supervised buprenorphine	Client prescribed supervised buprenorphine ie mono-buprenorphine consumption is supervised at every dispense or most dispenses in the week. Subutex should be recorded as buprenorphine.	PHSUPBUP
Unsupervised buprenorphine/ naloxone	Client prescribed unsupervised buprenorphine/naloxone (eg Suboxone) ie buprenorphine-naloxone combined product that is taken away to be consumed without supervision at every dispense or most dispenses in the week.	PHUSBUNAL
Supervised buprenorphine/ naloxone	Client prescribed supervised buprenorphine/naloxone (eg Suboxone) ie buprenorphine-naloxone combined product consumption is supervised at every dispense or most dispenses in the week.	PHSUPBUNAL
Diamorphine	Client prescribed diamorphine ie injectable ampoules to be taken away or injected under supervision.	PHDIAM
Naltrexone	Client prescribed naltrexone to prevent relapse to either alcohol or opiate use (or, rarely, both) or to limit the amount of alcohol a client drinks.	PHNALT
Chlordiazepoxide	Client prescribed chlordiazepoxide to treat acute alcohol withdrawal (do not record chlordiazepoxide prescribed to treat anxiety or for any other purpose).	PHCHLOR
Acamprosate	Client prescribed acamprosate.	PHACAMP
Nalmefene	Client prescribed nalmefene.	PHNALME

Disulfiram	Client prescribed disulfiram.	PHDISULF
Prescribed other medication	Client prescribed other medication ie 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.	PHOTHER

J.2 Psychosocial sub interventions

Psychosocial sub intervention	Definition	CSV File Header
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.	PSYMOTI
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.	PSYCNMG
Family and social network interventions	Family and social network interventions engage 1 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.	PSYFSNI
Cognitive and behavioural based relapse prevention interventions (substance misuse specific)	Cognitive and behavioural based relapse prevention interventions develop the service user's abilities to recognise, avoid or cope with thoughts, feelings and situations that are triggers to substance use. They include a focus on coping with stress, boredom and relationship issues and the prevention of relapse through specific skills, eg drug refusal, craving management. They can be delivered in groups or one-to-one and may involve the use of mapping tools. They require competences over and above those required for key working, and delivery within a clinical governance framework that includes appropriate	PSYCGBH

Psychosocial sub intervention	Definition	CSV File Header
	supervision. Examples: CBT based relapse prevention (which may include mindfulness and 'third wave' CBT), behavioural self-control (alcohol).	
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.	PSYMNTH
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.	PSYDNMC
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.	PSYSTP
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.	PSYCOUN

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.

Recovery support sub intervention	Definition	CSV File header
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 (eg 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.	RECPEER
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.	RECMAID
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.	RECFMSP
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.	RECPRNT
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	RECHSE

Recovery support sub intervention	Definition	CSV File header
	service, and/or active referral to a housing agency for specialist housing support. Housing support covers a range of activities that either allows the individual to maintain their accommodation or to address an urgent housing need.	
Employment support	Staff have assessed the employment needs of the individual as part of the comprehensive assessment, or on-going recovery care planning process, and agreed goals that include specific specialised employment support actions by the treatment service, and/or active referral to an agency for specialist employment support. Where the individual is already a claimant with Jobcentre Plus or the Work Programme, the referral can include a three-way meeting with the relevant advisor to discuss education/employment/training (ETE) needs. The referral can also be made directly to an ETE provider.	RECEMP
Education and training support	Staff have assessed the education and training related needs of the individual as part of the comprehensive assessment, or on-going recovery care planning process and agreed goals that include specific specialised education and training support actions by the treatment service, and/or active referral to an agency for specialist education & training support. Where the individual is already a claimant with Jobcentre Plus or the Work Programme, the referral can include a three-way meeting with the relevant advisor to discuss ETE needs. The referral can also be made directly to an ETE provider.	RECEDUT
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.	RECWPRJ
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.	RECCHKP
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.	RECRLPP

Recovery support sub intervention	Definition	CSV File header
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.	RECCMPT
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.	RECGNH
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.	RECSMOC
Referred to Hep C treatment	Client referred to a specialist (directly or through a GP) for treatment of hepatitis C, ideally supported to attend appointment(s) but regardless of whether treatment is agreed and provided. 'Referred' should be interpreted broadly here and does not necessarily require a formal, documented process, especially where hepatology doctors and/or nurses are working within the drug service and contact between them and service users might be direct. However, there should still be some assurance that the client has been properly linked to potential hepatitis treatment and, if agreed and provided, will be supported in it – whether by hepatologists, drug workers or peers.	RECHEPC
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.	RECDOMV
Take home	Provision of take home naloxone and training to reduce	RECTHNAL

Recovery support sub intervention	Definition	CSV File header
Naloxone and training information	overdose deaths from heroin and similar drugs. This should be used to record that the client has been issued with Naloxone (eg if the client still has previously issued naloxone when the SIR is completed it should not be endorsed).	

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.

Setting	Definition
Community	A structured drug and alcohol treatment setting where residence is not a condition ofengagement with the service. This will include treatment within community drug andalcohol teams and day programmes (including rehabilitation programmes where residence in a specified location is not a condition of entry).
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 comesfrom a consultant in addiction psychiatry or another substance misuse medical specialist. The multi-disciplinary team may include psychologists, nurses, occupationaltherapists, pharmacists and social workers. Inpatient units are for those alcohol or drugusers whose needs require supervision in a controlled medical environment.
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 clinicalresponsibility.
Secure setting	Structured drug and alcohol treatment delivered by a locally commissioned substancemisuse 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].
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 SpecialistClinical Addictions Network[1]. This level of support and monitoring of assisted withdrawal is most appropriate for individuals with lower levels of dependence and/orwithout a range of associated medical and psychiatric problems. Within the residential setting, people will receive multiple interventions and

[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 usersin prison and on release: recommendations for action. London: House of Lords

Setting	Definition
	supports (some of which are described by the intervention codes) in a 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.
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 – Time in treatment

Time in treatment covers the time spent in an average week in structured treatment on 1 or more of the interventions defined above. The time will usually be that actually spent but may include service user absence, within the programme's stipulated attendance requirements.

Interventions included in calculating the time should be exclusively made up of the pharmacological, psychosocial and recovery support interventions that are delivered alongside structured treatment (as defined earlier), but not recovery support only interventions. A client receiving only recovery support interventions would not be in structured treatment.

In deciding which threshold to record for a fractional time spent in treatment, the actual time should be rounded up to the nearest whole hour, for example,14.5 hours rounds up to 15 hours, so would be recorded as 'high'.

Threshold	Definition
Standard (14 hours or less per week)	One or more of the interventions defined above is received by, or made available to, the service user for 14 hours or less per week. This can include service user absence, within the programme's stipulated attendance requirements. Interventions should be exclusively made up of a combination of pharmacological, psychosocial and recovery support interventions, as defined here, but not recovery support only interventions.
High (More than 14 hours and less than 25 hours)	One or more intervention types defined above is received by, or made available to, the service user for more than 14 and less than 25 hours per week. This can include service user absence, within the programme's stipulated attendance requirements. This could include non-residential or residential rehabilitation programmes, including services previously recorded as structured day programmes. Interventions should be exclusively made up of a combination of pharmacological, psychosocial and recovery support interventions, as defined here, but not recovery support only interventions.
Very high (25 or more hours per week)	One or more intervention types defined above is received by, or made available to, the service user for 25 or more hours per week. This can include service user absence, within the programme's stipulated attendance requirements. This could include non-residential or residential rehabilitation programmes, including services previously recorded as structured day programmes. Interventions should be exclusively made up of a combination of pharmacological, psychosocial and recovery support interventions, as defined here, but not recovery support only interventions.

Appendix M – Outcomes process maps for TOP and AOR

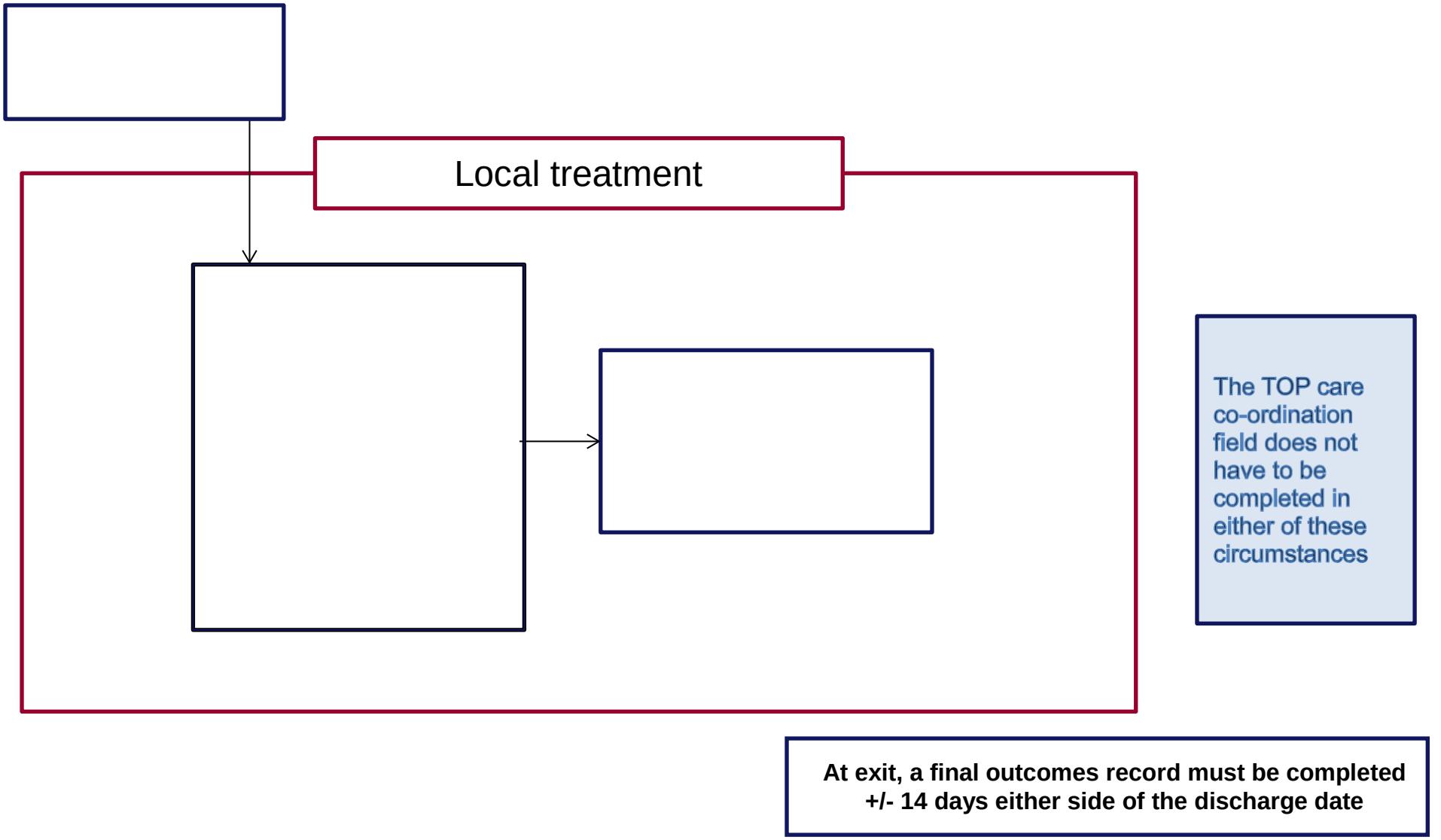
The following process maps outline the steps for recording outcomes information for alcohol clients via the Treatment Outcomes Profile (TOP) and the Alcohol Outcomes Record (AOR).

Each client attending an adult service with a primary problem substance of alcohol should have either a TOP or an AOR completed depending on the outcome record of choice for the service.

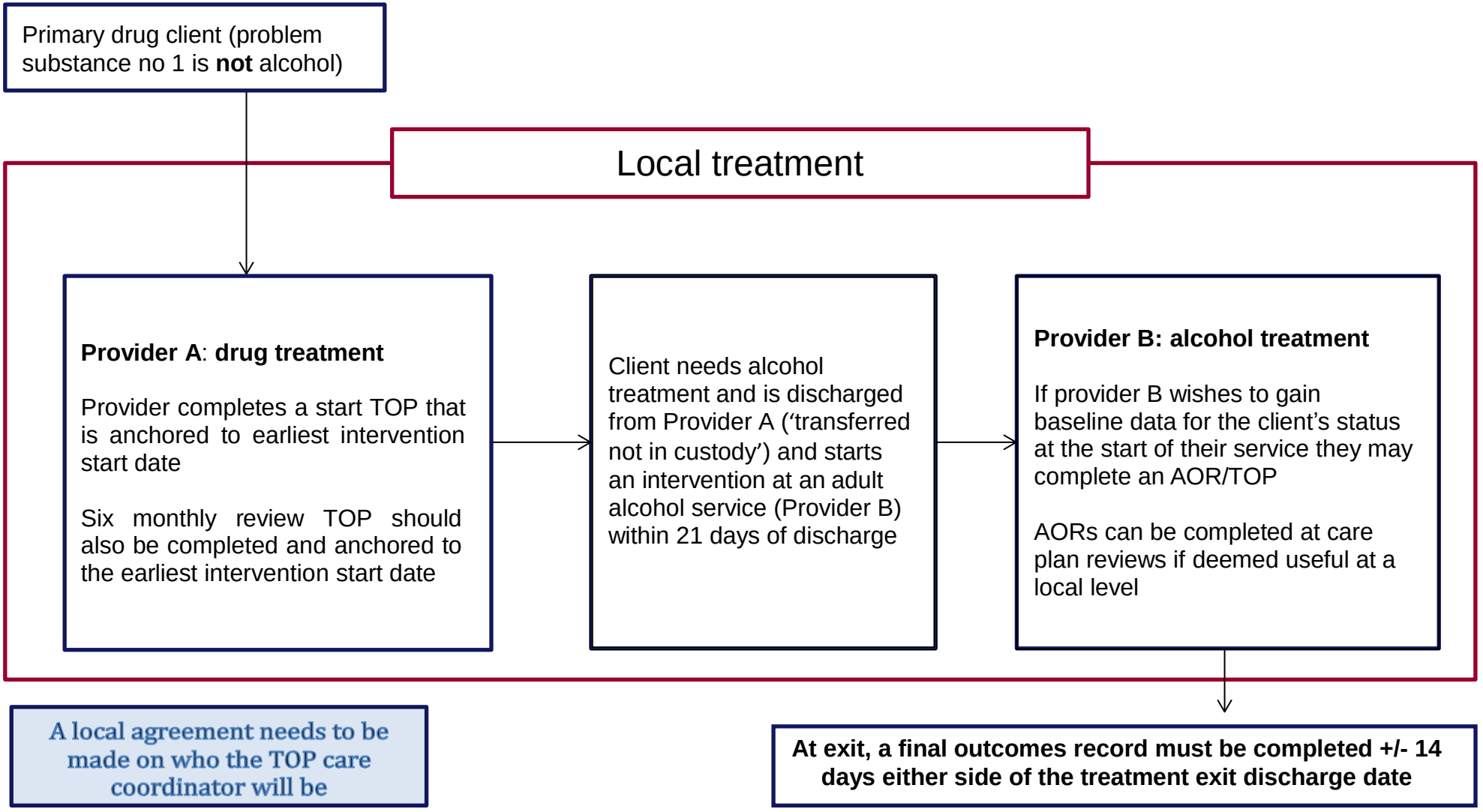
All drug clients at adult services should have a TOP completed.

Examples are provided below for clients who are transferring between alcohol and drug treatment episodes and between adult and young people's services.

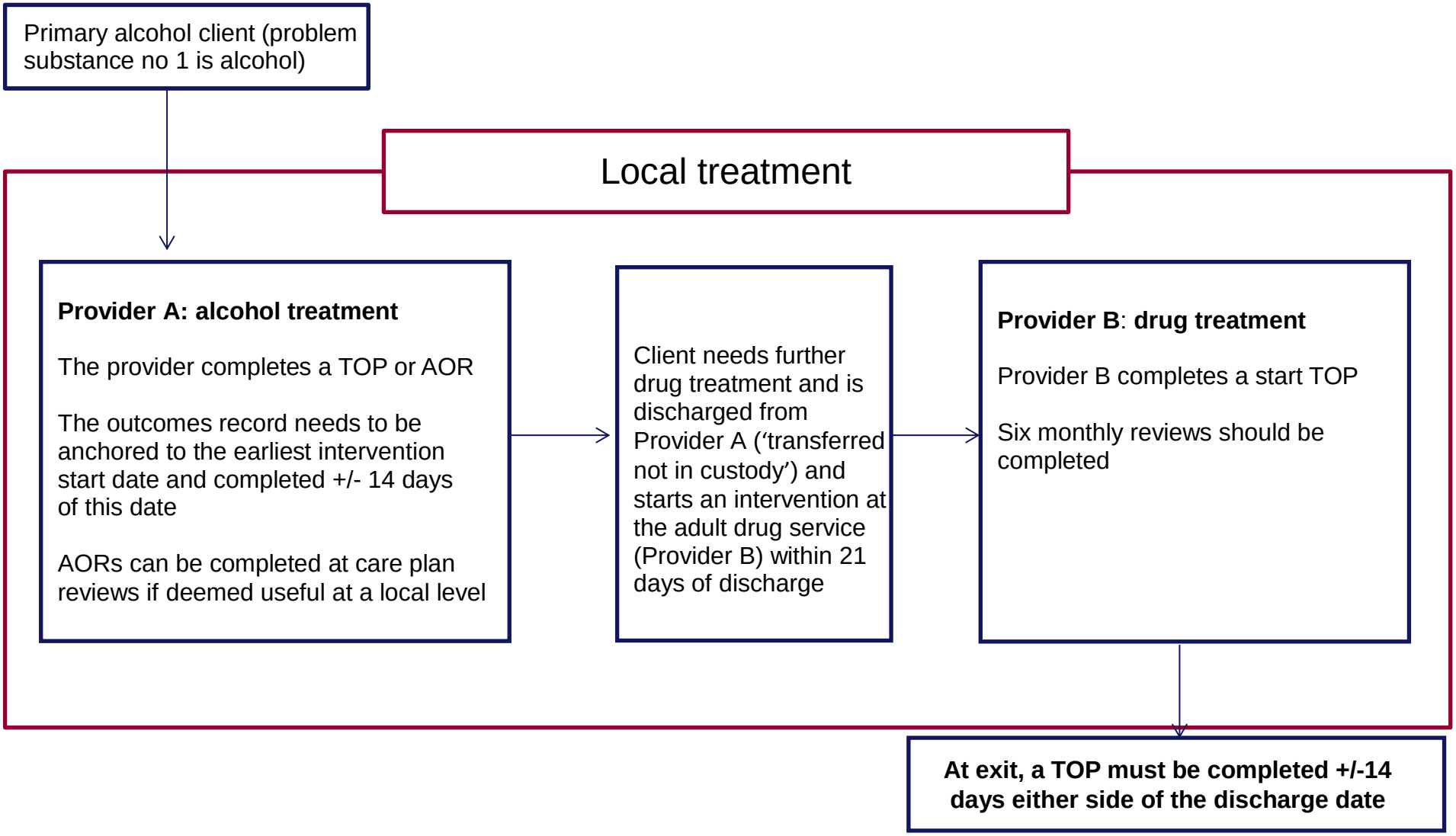
M.1 Process map for completing Alcohol Outcome Record (AOR)



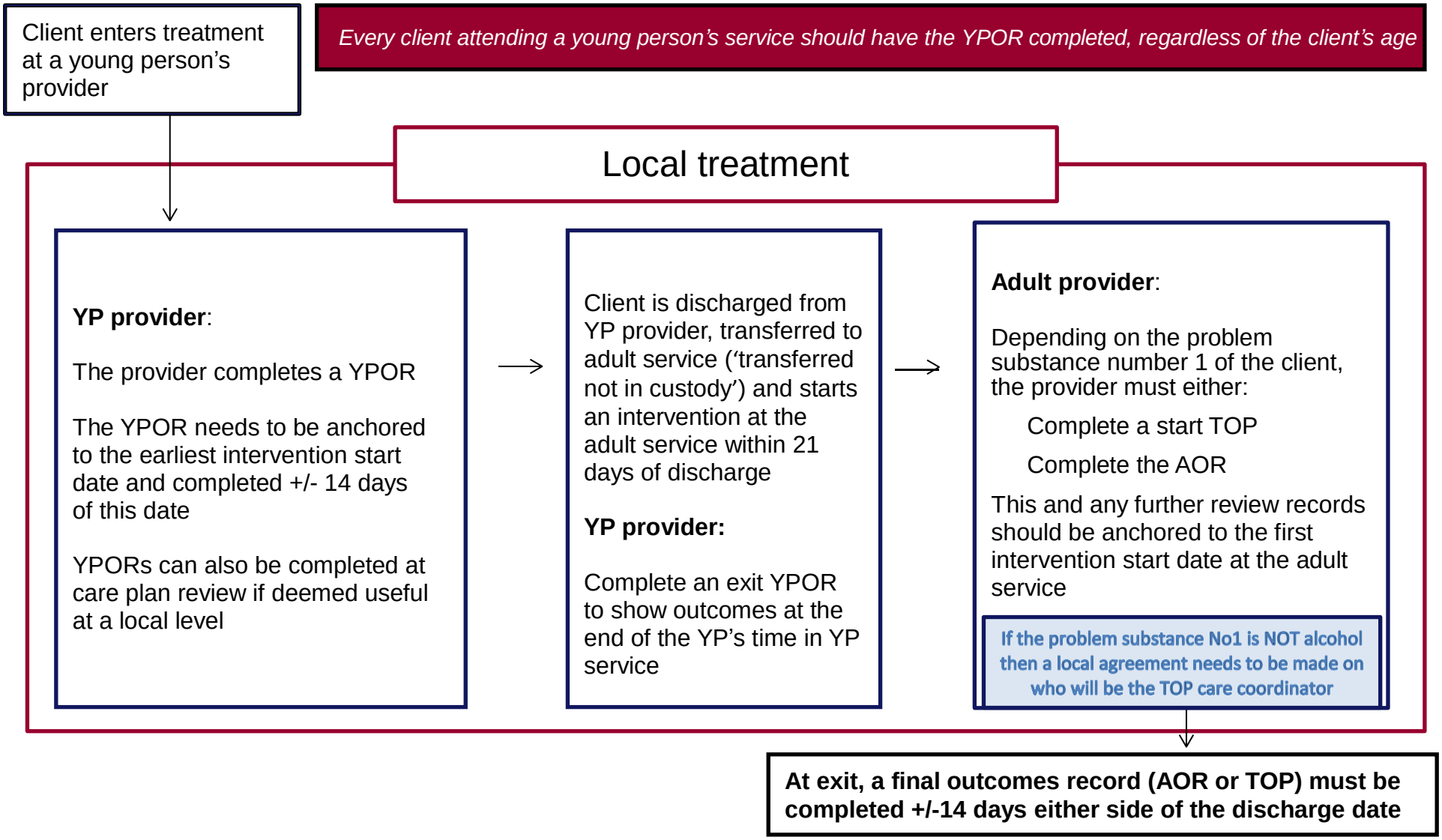
M.2 Process map for clients transferring between adult services and changing problem substance from drug to alcohol



M.3 Process map for clients transferring between adult services and changing problem substance from alcohol to drug



M.4 Process map example for clients being transferred from a YP service to an adult service



Appendix N – Brief interventions

NICE PH24 (www.nice.org.uk/guidance/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 should not be reported to NDTMS, but, brief treatment comprising multiple planned Extended Brief Intervention (EBI) sessions can be recorded under the psychosocial sub-intervention ‘motivational interventions’. It is expected that an assessment of need and a care planned approach is undertaken as a precursor to any series of sessions with a treatment goal of abstinence or reducing consumption.

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 20-30 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 1 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 O - Alcohol dataset data items

Services that treat alcohol clients only are permitted to collect only the alcohol dataset should they choose to do so. Should alcohol services decide that they would prefer to submit this minimum dataset rather than the full NDTMS dataset they should include all of the data items listed below:

Field description	CSV file header
Initial of client's first name	FINITIAL
Initial of client's surname	SINITIAL
Client birth date	DOB
Client sex at registration of birth	SEX
Ethnicity	ETHNIC
Nationality	NATION
Agency code	AGNCY
Software system and version used	CMSID
Consent for NDTMS	CONSENT
DAT of residence	DAT
Local authority	LA
Postcode	PC
Client ID	CLIENTID
Client reference number	CLIENT
Episode ID	EPISODID
Referral date	REFLD
Triage date	TRIAGED
Accommodation need	ACCMNEED
Sexual orientation	SEXUALO
Religion	RELIGION
Disability 1	DISABLE1
Disability 2	DISABLE2
Disability 3	DISABLE3
Employment status	EMPSTAT
Time since last paid employment	TSLPE
Pregnant	PREGNANT
Parental status	PRNTSTAT

Field description	CSV file header
Children living with client	CHILDWTH
Are any of the client's children (biological, step, foster, adoptive, guardian) or any of the children living with the client receiving early help or are they in contact with children's social care?	EHCSC
Problem substance No 1	DRUG1
Age first use of problem substance No 1	DRUG1AGE
Problem substance No 2	DRUG2
Problem substance No 3	DRUG3
Referral source	RFLS
Care plan started date	CPLANDT
Drinking days	ALCDDAYS
Units of alcohol	ALCUNITS
What is the client's SADQ score?	SADQ
Does the client have a mental health treatment need	MTHTN
Is the client receiving treatment for their mental health need(s)	CRTMHN
Discharge date	DISD
Discharge reason	DISRSN
Treatment intervention	MODAL
Intervention ID	MODID
Intervention setting	MODSET
Date referred to intervention	REFMODDT
Date of first appointment offered for intervention	FAOMODDT
Intervention start date	MODST
Intervention end date	MODEND
Intervention exit status	MODEXIT
Sub intervention assessment date	SUBMODDT
Sub intervention ID	SUBMID
Client's prescribing intention is assessment and stabilisation	PHSTBL
Client's prescribing intention is maintenance	PHMAIN
Client's prescribing intention is withdrawal	PHWTH
Client's prescribing intention is relapse prevention	PHRELPR
Client's alcohol prescribing intention is withdrawal	APHWITH
Client's alcohol prescribing intention is relapse prevention	APHREPR
Client prescribed unsupervised methadone	PHUSMET

Field description	CSV file header
Client prescribed supervised methadone	PHSUPMET
Client prescribed unsupervised buprenorphine	PHUSBUP
Client prescribed supervised buprenorphine	PHSUPBUP
Client prescribed unsupervised buprenorphine/naloxone (eg Suboxone)	PHUSBUNAL
Client prescribed supervised buprenorphine/naloxone (eg Suboxone)	PHSUPBUNAL
Client prescribed diamorphine	PHDIAM
Client prescribed naltrexone	PHNALT
Client prescribed chlordiazepoxide	PHCHLOR
Client prescribed acamprosate	PHACAMP
Client prescribed nalmefene	PHNALME
Client prescribed disulfiram	PHDISULF
Client prescribed other medication	PHOTHER
Client involved with motivational interventions	PSYMOTI
Client involved with contingency management (drug focused)	PSYCNMG
Client involved with family and social network interventions	PSYFSNI
Client involved with cognitive and behavioural based relapse prevention interventions (substance misuse specific)	PSYCGBH
Evidence-based psychological intervention for co-existing mental health disorders	PSYMNTH
Client involved with psychodynamic therapy	PSYDNMC
Client involved with 12-step work	PSYSTP
Client involved in counselling – BACP accredited	PSYCOUN
Client provided with peer support involvement	RECPEER
Client provided with facilitated access to mutual aid	RECMAID
Client provided with family support	RECFMSP
Client provided with parenting support	RECPRNT
Client provided with housing support	RECHSE
Client provided with employment support	RECEMP
Client provided with education and training support	RECEDUT
Client provided with supported work projects	RECWPRJ
Client provided with recovery check ups	RECCHKP
Client provided with evidence-based psychosocial interventions to support relapse prevention	RECRLPP
Client provided with complementary therapies	RECCMPT
Client provided with mental health interventions	RECGNH
Client provided with smoking cessation interventions	RECSMOC

Field description	CSV file header
Client referred to Hep C treatment	RECHEPC
Has there been facilitation to domestic abuse/violence support?	RECDOMV
Client provided with take home Naloxone and training information	RECTHNAL
Time in treatment assessment date	TITDATE
Time in treatment ID	TITID
Time in treatment	TITREAT
Treatment Outcomes Profile (TOP) date	TOPDATE
TOP ID	TOPID
Treatment stage	TRSTAGE
Alcohol use	ALCUSE
Consumption (alcohol)	CONSMP
Tobacco use	TOBUSE
Psychological health status	PSYHSTAT
Physical health status	PHSTAT
Client information review date	CIRDT
CIR ID	CIRID
CIR Pregnant	CIRPREGNANT
CIR Parental status codes	CIRPRTST
CIR Children living with client	CIRCLDWT
CIR Are any of the client's children (biological, step, foster, adoptive, guardian) or any of the children living with the client receiving early help or are they in contact with children's social care?	CIREHCSC
CIR Does the client have a mental health treatment need?	CIRMTHTN
CIR Is the client currently receiving treatment for their mental health need(s)?	CIRCRTMHN