Publication withdrawn

This guidance was withdrawn in April 2024.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

Adult and young people's drug and alcohol secure settings business definitions

Core data set O

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Revision history

Version	Author	Purpose/reason
5.03	L Hughes	**Minor amendments:** • Clarified which exit fields are to be populated on exit from current secure setting and which are to be populated on release from all secure settings. • Clarified secure setting exit date, exit reason and exit destination guidance on P.27 • Appendix D – clarified recording of transfers to secure hospitals • 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 • Repaired hyperlinks
5.02	L Hughes	**Minor amendments:** • Revision history pre CDS-O moved to 'Revision History Pre CDS-O' document
5.01	L Hughes	**Minor amendments:** • Updatability table - 'DAT of residence' amended to show that it is not updateable and should be recorded as the situation prior to custody • Appendix C - 'No' added to early help table • Appendix D – added 'or a community provider' to 'Onward referral offered and refused'
5.0	L Hughes	**CDS O** **New reference data items:** • ETHNIC – 'value is unknown' added • PC – default code for NFA added – ZZ99 3VZ • EHCSC – 'Client declined to answer' added • MODEXIT – 'Released from court' added • DISRSN – 'Onward referral offered and refused' added **Amendments:** • AGNCY, CLIENT and CLIENTID moved to 'client' section rather than 'episode' • Postcode (PC) amended to clarify that the postcode should be truncated • INJSTAT definition clarified to confirm that it refers to the 28 days prior to custody • Added to Appendix D guidance for transfers to secure hospitals

Version	Author	Purpose/reason
		• MODAL – Appendix E clarified to confirm that naltrexone pre-release should be used to record naltrexone prescribing at any point during the custodial stay • LEHIGSYP – field description changed from 'Legal highs (NPS)' to 'New psychoactive substances' • AFULHU - field description changed from 'Age substance first used: legal highs (NPS)' to 'Age substance first used: New psychoactive substances (NPS)' • YPOR age first used questions – clarified how to record 'never used' • SENTENCED – amended definition to clarify that this needs to be completed for all clients on release • REFHEPCTX - amended definition to clarify that this needs to be completed for all clients on release • Links to NTA website updated to: gov.uk

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

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1. Introduction

The National Drug Treatment Monitoring System (NDTMS) data helps drug 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.

This document contains definitions that are primarily applicable to use with both adult and young people who are drug and alcohol clients in secure settings. Secure settings include prisons, immigration removal centres, secure children's homes, welfare only homes, youth offender institutions and secure training centres. Information and definitions relating to data collection from adults and young people in the community 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 Public Health England (PHE) systems
- suppliers of systems to PHE
- suppliers of systems that 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 which defines the format of the CSV file used as the primary means of inputting the core dataset into NDTMS
- NDTMS technical definition which provides the full list of fields that are required in the CSV file and the verification rules for each item
- NDTMS geographic information which provides geographic information including DAT of residence and local authority codes
- NDTMS reference data which 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 Core Dataset O (CDS-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 provide measurements to support:

- the Public Health Outcomes Framework (PHOF) as appropriate
- the NHS outcomes framework as appropriate
- the Section 7A agreement as appropriate
- the government's drug strategy in relation to young people which states: "The aim of specialist substance misuse interventions is to stop young people's drug and alcohol use from escalating, to reduce harm to themselves or others and to prevent them becoming drug or alcohol-dependent adults. Specialist substance misuse interventions should be delivered according to a young person's age, their levels of vulnerability and the severity of their substance misuse problem, and should help young people become drug and alcohol-free" [Ref 5]

3. Data entities

The data items listed in this document may be considered as belonging to 1 of 4 different sections which are used throughout this document.

Client details

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

Episode details

Details pertaining to the current episode of treatment including information gained at reception in to custody and triage such as geographic information, protected characteristics information, problem substance/s, parent and child status, BBV, among others. A treatment episode includes time spent engaged in treatment at 1 secure setting, made up of 1 triage date and 1 discharge date but can (and in most circumstances will) include multiple treatment interventions. Multiple treatment episodes can be recorded at each estate at different times to record clients who may complete or drop out of treatment but represent later in their custodial stay.

Treatment intervention details

Details regarding which intervention/s the client has received, their outcomes and the relevant start and end dates.

Outcomes Profile

Either the Treatment Outcomes Profile (TOP) or the Young People's Outcomes Record (YPOR). The TOP & YPOR should be completed at treatment start ideally by the first custodial estate to receive the client. These should be completed by the keyworker with the client to review their substance use behaviour and health and social functioning in the 28 days prior to custody. TOP or YPOR is not required to be completed by immigration removal centres.

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 of this document).

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 NDTMS Confidentiality Toolkit: https://www.gov.uk/government/publications/confidentiality-guidance-for-drug-and-alcohol-treatment-providers-and-clients

4. 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's sex at registration of birth.
Ethnicity	ETHNIC	The ethnicity that the client states as defined in the Office of Population Censuses and Surveys (OPCS) census 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.
NDTMS secure setting code (Agency code)	AGNCY	A unique identifier for the secure setting that is defined by the regional NDTMS team – for example A0001.
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.
Client reference	CLIENT	The unique number allocated to the individual. This should be the NOMS ID if applicable. (NB: this field must not hold or be composed of attributers, which might identify the individual).

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 DET2 V1.0 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 in which the client was residing prior to entering custody (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 (NFA) record the Partnership (DAT) where the benefits office from which the client last claimed is located. See NDTMS Geographic Information document for a list of DAT codes: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/669776/Geographic_information_for_the_National_Drug_Treatment_Monitoring_System__NDTMS_.pdf
Postcode	PC	The postcode of the client's place of residence prior to entering custody. 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.
Initial reception date	INTRCPTD	The date that the client was received into the first secure setting where they began their current continuous period in custody.
Reception date	RECPTD	The date that the client was received into the current secure setting.
Transferred from (other secure estate)	PRISON	The previous secure setting from which the client has transferred from into the current secure setting (if applicable). If this is the first secure setting the client has entered during this custodial period this field can be left blank.

2. Episode details		
Field description	**CSV Header**	**Definition**
Triage date	TRIAGED	The date that the client made a first face to face presentation to a substance misuse worker (this includes healthcare staff who initiated substance misuse treatment for the client).
Sexual orientation	SEXUALO	The sexual orientation that the client states. If a client declines to answer, then 'not stated' should be used. **This field only needs to be completed by adult secure settings (including YOIs with 18-21 populations).**
Religion or belief	RELIGION	The religion or belief of the client. If a client declines to answer, then 'not stated' should be used. **This field only needs to be completed by adult secure settings (including YOIs with 18-21 populations).**
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 B for disability definitions. **This field only needs to be completed by adult secure settings (including YOIs with 18-21 populations).**
Disability 2	DISABLE2	Whether the client considers themselves to have a secondary 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 B for disability definitions. **This field only needs to be completed by adult secure settings (including YOIs with 18-21 populations).**
Disability 3	DISABLE3	Whether the client considers themselves to have a third 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 B for disability definitions. **This field only needs to be completed by adult secure settings (including YOIs with 18-21 populations).**
Time since last paid employment	TSLPE	How long has it been (in years) since the client was last in (legal) paid employment? This can include cash in hand work but doesn't include paid work since the client has been in custody. The time in years should be calculated from the date the question is asked (at triage). For example, if the client has been in custody for 2 years prior to triage and was unemployed for 1 year prior to custody then 2-3 years should be recorded. If the client declines to answer use 'client declined to answer' option. **This field only needs to be completed by adult secure settings (including YOIs with 18-21 populations).**
Pregnant	PREGNANT	Is the client pregnant at triage?
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 lived with the client in the 28 days prior to entering custody. A child is a person who is under 18 years old. See Appendix C for data items and definitions.

2. Episode details		
Field description	**CSV Header**	**Definition**
Children	CHILDWTH	The number of children under 18 that lived in the same household as the client at least 1 night a week in the 28 days prior to custody. 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. Record zero here if the client was under 18 and living in care with other children prior to custody.
Early help or in contact with social care	EHCSC	Are the client's children/any children that were living with the client prior to entering custody, in touch with early help services or children's social care? This includes children aged under 18 only. If more than 1 option applies, then please select the 1 considered to be the priority from the perspective of the treatment service/keyworker. If client declines to answer record 'client declined to answer'. See Appendix C 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(s) is/are responsible for clinically deciding which substance is primary.
Problem substance number 2	DRUG2	An additional substance that brought the client into treatment at the point of triage/initial assessment, even if they are no longer actively using this substance. If no additional substance 'no second drug' should be recorded.
Problem substance number 3	DRUG3	An additional substance that brought the client into treatment at the point of triage/initial assessment, even if they are no longer actively using this substance. If no 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	In the 28 days prior to custody was the client injecting? Record 'C - currently injecting' if the client was injecting in the 28 days prior to custody. Record 'P - previously injected' if the client has previously injected but not in the 28 days prior to custody. Record 'N - never injected' if the client has never injected. Record 'Z - client declines to answer' if the client declines to answer.
Drinking days	ALCDDAYS	Number of days in the 28 days prior to custody that the client consumed alcohol.
Units of alcohol	ALCUNITS	Typical number of units consumed on 1 drinking day in the 28 days prior to custody.

2. Episode details		
Field description	**CSV Header**	**Definition**
AUDIT score (alcohol use disorders identification test)	AUDIT	What was the client's AUDIT score on reception? This should be the client's score on the full AUDIT (10 questions) completed during the initial healthcare screening and/or the substance misuse assessment. The score should be between 0 and 40. AUDIT-C scores should not be recorded here, only the full 10-question AUDIT score. See https://www.gov.uk/government/publications/alcohol-use-screening-tests for more information. If a full AUDIT has not been completed for the client, leave this field blank. AUDIT scores should be recorded for all individuals coming into contact with substance misuse treatment services, including those not requiring structured alcohol treatment but accessing treatment to address their drug misuse.
Dual Diagnosis	DUALDIAG	Does the client have need of a mental health intervention for reasons other than substance misuse? See appendix G for definitions.
Hep B intervention status	HEPBSTAT	Whether the client was offered a vaccination for hepatitis B within the current episode at the secure setting, 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://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/669749/Guidance_for_recording_data_about_blood-borne_virus_interventions_on_the_NDTMS.pdf
Hep B vaccination count	HEPBVAC	The number of hepatitis B vaccinations given to the client within the current episode at the secure setting, or if the course of vaccinations was completed. Where the healthcare provider provides 1 or more vaccinations to a client that completes the course, then 'course completed' should be recorded rather than the number of vaccinations. For example, if course started in the community but is completed in the secure setting**. This field only needs to be completed by adult secure settings (including YOIs with 18-21 populations).** For further information on recording BBV details please refer to the Recording NDTMS data about blood-borne virus interventions document: https://assets.publishing.service.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 intervention status	HEPCSTAT	Whether the client was offered a test for hepatitis C within the current episode at the secure setting, 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://assets.publishing.service.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 episode or previous to this stay (for example, in the community or in another secure setting). If the response is 'Yes' the 'Hep C – latest test date' should be completed. **This field only needs to be completed by adult secure settings (including YOIs with 18-21 populations).** For further information on recording BBV details please refer to the Recording NDTMS data about blood-borne virus interventions document: https://assets.publishing.service.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	The date that the client was last tested for hepatitis C. This test may be within the current episode or previous to this stay (having either been tested in the community or in another secure setting). 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. **This field only needs to be completed by adult secure settings (including YOIs with 18-21 populations).** For further information on recording BBV details please refer to the Recording NDTMS data about blood-borne virus interventions document: https://assets.publishing.service.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**
Discharge date	DISD	The date that the client stopped receiving structured treatment in the secure setting (even if they remain in the same secure setting). If a client has had a planned discharge from treatment, then the date agreed within this plan should be used. If a client's discharge was unplanned then the date of the last face to face contact with the treatment provider should be used. 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.
Discharge reason	DISRSN	The reason why the client's episode of structured treatment was ended. For discharge codes and definitions see Appendix D.
Sentenced	SENTENCED	Whether or not the client was sentenced for some or all of the duration of this custodial stay - record 'yes' if sentenced and 'no' if on remand. This field should be completed for all clients when they leave their current establishment. **This field only needs to be completed by adult secure settings (including YOIs with 18-21 populations).**
Take home naloxone and training	THNALOX	Whether or not the client was provided with a take home naloxone kit and training on its use on release from custody. This field should be populated if the client's exit status is 'released'. **This field only needs to be completed by adult secure settings (including YOIs with 18-21 populations).**
Referred to hep C treatment	REFHEPCTX	Whether or not the client has been referred for hepatitis C treatment; either treatment has been delivered in-house within the establishment (as in-reach or GP-led) or the client is being referred to secondary care in the community if they are being released before treatment can be initiated in custody. This field should be completed for all clients when they leave their current establishment. **This field only needs to be completed by adult secure settings (including YOIs with 18-21 populations).**
Secure setting exit date	EXITD	The date that the client left the secure setting (or died).
Secure setting exit reason	EXITRSN	The reason that the client left the secure setting. For detailed definitions see Appendix D.

2. Episode details

Field description	CSV Header	Definition
Secure setting exit destination	EXITDEST	The Partnership area to which the client was released or the secure setting that the client was transferred to. Use 'outside UK' option if client is deported or leaving the country on release. Most IRCs report to NDTMS and can be found in the exit destination list. For any services that do not report to NDTMS (for example, secure hospitals) record 'non NDTMS reporting secure setting'.
Referral on release status	RTOAGNCY	If the reason for the exit from the secure setting is 'released', record whether a referral was made to a recovery support provider (or YOT if under 18), or to a structured treatment provider in the community, or to both a recovery support provider (or YOT if under 18) and a structured treatment provider, or if no onward referral was made for the client.
Pre-release review date	PRERREVD	If the reason for the exit from the secure setting is 'released' then the date of the pre-release review, or discharge plan if under 18 should be recorded.

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 E of this document. There are different interventions for adult and YP clients. A client may have more than 1 treatment intervention running sequentially or concurrently within an episode.
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).
Intervention start date	MODST	The date that the stated treatment intervention commenced, ie the client attended for the appointment.

3. Treatment intervention details		
Field description	**CSV Header**	**Definition**
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). Current definitions for the intervention exit status codes can be found in Appendix F.

4. Outcomes profile – TOP/YPOR			
Field description	**CSV Header**	**Definition**	**Outcome record**
Treatment Outcomes Profile (TOP or YPOR) date	TOPDATE	Date of the outcomes review. This should be on or up to 2 weeks after the client's initial reception into the establishment. All outcomes data should reflect the 28 days prior to custody. See Appendix H for recording outcomes information.	TOP, YPOR
TOP ID	TOPID	A mandatory, unique technical identifier representing the TOP/YPOR, 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).	TOP, YPOR
Treatment stage	TRSTAGE	Stage of treatment that the TOP/YPOR data relates to – for secure settings this should always be recorded as 'Start'.	TOP, YPOR
Alcohol use	ALCUSE	Number of days in the 28 days prior to custody that the client has used alcohol.	TOP, YPOR
Consumption (alcohol)	CONSMP	Typical number of alcohol units consumed on a drinking day in the 28 days prior to custody.	TOP, YPOR
Opiate use	OPIUSE	Number of days in the 28 days prior to custody that the client has used opiates.	TOP. YPOR

4. Outcomes profile – TOP/YPOR			
Field description	**CSV Header**	**Definition**	**Outcome record**
Crack use	CRAUSE	Number of days in the 28 days prior to custody that the client has used crack.	TOP, YPOR
Cocaine use	COCAUSE	Number of days in the 28 days prior to custody that the client has used powder cocaine.	TOP, YPOR
Amphetamine use	AMPHUSE	Number of days in the 28 days prior to custody that the client has used amphetamines.	TOP, YPOR
Cannabis use	CANNUSE	Number of days in the 28 days prior to custody that the client has used cannabis.	TOP, YPOR
Cannabis average use per day	CAUSPD	Typical number of grams of cannabis used on a typical using day in the 28 days prior to custody.	YPOR
Other substance use	OTRDRGUSE	Number of days in the 28 days prior to custody that the client has used other problem drugs that are not listed on the TOP/YPOR form.	TOP, YPOR
Other substance 2 use	OTHR2YP	Number of days in the 28 days prior to custody that the client has used a second other problem drug that is not listed on the YPOR form.	YPOR
Other substance 3 use	OTHR3YP	Number of days in the 28 days prior to custody that the client has used a third other problem drug that is not listed on the YPOR form.	YPOR
Tobacco use	TOBUSE	Number of days in the 28 days prior to custody that the client smoked tobacco, in whatever form (ready-made cigarettes, hand-rolled cigarettes, cannabis joints with tobacco, cigars, pipe tobacco, shisha/water pipes, among others), but not including nicotine replacement therapy and e-cigarettes.	TOP
Injected	IVDRGUSE	Number of days in the 28 days prior to custody that the client has injected non-prescribed drugs.	TOP
Sharing	SHARING	Has client shared needles or paraphernalia (spoon, water or filter) in the 28 days prior to custody? On the TOP form this is displayed as 2 questions, but only 1 response is used for NDTMS. See NDTMS reference data document.	TOP
Shoplifting	SHOTHEFT	Number of days in the 28 days prior to custody that the client has been involved in shop theft.	TOP

4. Outcomes profile – TOP/YPOR

Field description	CSV Header	Definition	Outcome record
Selling drugs	DRGSELL	Number of days in the 28 days prior to custody that the client has been involved in selling drugs.	TOP
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 the 28 days prior to custody? On the TOP form this is displayed as 3 questions, but only 1 response is used for NDTMS. See NDTMS reference data document.	TOP
Assault/violence	ASSAULT	Has client committed assault/violence in the 28 days prior to custody?	TOP
Psychological health status	PSYHSTAT	Self-reported psychological health (anxiety, depression, problem emotions and feelings) score in the 28 days prior to custody of 0-20, where 0 is poor and 20 is good.	TOP
Paid work	PWORK	Number of days in the 28 days prior to custody that the client has had paid work. Includes legal work only.	TOP
Unpaid work	UPDWORK	Number of days in the 28 days prior to custody 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 organisation.	TOP
Days volunteered	DAYSVOLN	Number of days in 28 days prior to custody 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 organisation.	TOP
Education	EDUCAT	Number of days in the 28 days prior to custody that client has attended for education. For example, school, college, university.	TOP
Physical health status	PHSTAT	Self-reported physical health (extent of physical symptoms and bothered by illness) score in the 28 days prior to custody of 0-20, where 0 is poor and 20 is good.	TOP
Acute housing problem	ACUTHPBM	Has client had an acute housing problem (been homeless) in the 28 days prior to custody?	TOP
Housing risk	HRISK	Has client been at risk of eviction within the 28 days prior to custody?	TOP

4. Outcomes profile – TOP/YPOR

Field description	CSV Header	Definition	Outcome record
Unsuitable housing	UNSTHSE	Has the client been in unsuitable housing in the 28 days prior to custody? 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.	TOP, YPOR
Quality of life	QUALLIFE	Self-reported quality of life score (able to enjoy life, gets on with family and partner, etc) in 28 days prior to custody of 0-20, where 0 is poor and 20 is good.	TOP
Tobacco/nicotine	TOANIC	Number of days in the 28 days prior to custody that the YP has smoked tobacco/nicotine.	YPOR
Ecstasy	ECSTSYYP	Number of days in the 28 days prior to custody that the YP has used ecstasy.	YPOR
Solvents	SOLVYP	Number of days in the 28 days prior to custody that the YP has used solvents.	YPOR
Ketamine	KETAMNYP	Number of days in the 28 days prior to custody that the YP has used ketamine.	YPOR
GHB	GHBYP	Number of days in the 28 days prior to custody that the YP has used GHB.	YPOR
New psychoactive substances (NPS)	LEHIGSYP	Number of days in the 28 days prior to custody that the YP has used new psychoactive substances (NPS).	YPOR
Tranquilisers (including benzodiazepines)	TRANYP	Number of days in the 28 days prior to custody that the YP has used tranquilisers (including benzodiazepines).	YPOR
Age substance first used: cannabis	AFUCAN	What age did the YP first ever use cannabis? If substance has never been used record 0.	YPOR
Age substance first used: alcohol	AFUALC	What age did the YP first ever consume alcohol? If substance has never been used record 0.	YPOR
Age substance first used: tobacco/nicotine	AFUTOBN	What age did the YP first ever use tobacco/nicotine? If substance has never been used record 0.	YPOR

4. Outcomes profile – TOP/YPOR			
Field description	**CSV Header**	**Definition**	**Outcome record**
Age substance first used: opiates (illicit)	AFUOOL	What age did the YP first ever use opiates? If substance has never been used record 0.	YPOR
Age substance first used: crack	AFUCRACK	What age did the YP first ever use crack? If substance has never been used record 0.	YPOR
Age substance first used: cocaine	AFUCOC	What age did the YP first ever use powder cocaine? If substance has never been used record 0.	YPOR
Age substance first used: ecstasy	AFUEST	What age did the YP first ever use ecstasy? If substance has never been used record 0.	YPOR
Age substance first used: amphetamines	AFUAMP	What age did the YP first ever use amphetamines? If substance has never been used record 0.	YPOR
Age substance first used: solvents	AFUSLV	What age did the YP first ever use solvents? If substance has never been used record 0.	YPOR
Age substance first used: ketamine	AFUKET	What age did the YP first ever use ketamine? If substance has never been used record 0.	YPOR
Age substance first used: GHB	AFUGHB	What age did the YP first ever use GHB? If substance has never been used record 0.	YPOR
Age substance first used: new psychoactive substances (NPS)	AFULHU	What age did the YP first ever use new psychoactive substances (NPS)? If substance has never been used record 0.	YPOR

4. Outcomes profile – TOP/YPOR			
Field description	**CSV Header**	**Definition**	**Outcome record**
Age substance first used: tranquilisers (including benzodiazepines)	AFUTQL	What age did the YP first ever use tranquilisers (including benzodiazepines)? If substance has never been used record 0.	YPOR
Alcohol use – Binge drinking	AAUSFWK	In the previous 28 days, has the YP drunk more than 8 units of alcohol (males) or more than 6 units of alcohol (females) in a single drinking episode?	YPOR
Ever injected	LINSTUS	Has the YP ever injected a substance?	YPOR
Current injecting drug use	YPIVDRGU	Has the YP injected a substance in 28 days prior to custody?	YPOR
Alc using behaviour: On a weekday during daytime	PTEDAWDD	In the 28 days prior to custody, has the YP consumed alcohol on a weekday during the daytime?	YPOR
Alc using behaviour: On a weekday during the evening	PTEDAWDE	In the 28 days prior to custody, has the YP consumed alcohol on a weekday during the evening?	YPOR
Alc using behaviour: On a weekend during the daytime	PTEDAWED	In the 28 days prior to custody, has the YP consumed alcohol on a weekend during the daytime?	YPOR
Alc using behaviour: On a weekend during the evening	PTEDAWEE	In the 28 days prior to custody, has the YP consumed alcohol on a weekend during the evening?	YPOR

4. Outcomes profile – TOP/YPOR			
Field description	**CSV Header**	**Definition**	**Outcome record**
Alc using behaviour: On their own	PTEDOYO	In the 28 days prior to custody, has the YP consumed alcohol on their own?	YPOR
Substance using behaviour: On a weekday during daytime	PTEUSWDD	In the 28 days prior to custody, has the YP used substances (excluding tobacco) on a weekday during the daytime?	YPOR
Substance using behaviour: On a weekday during evening	PTEUSWDE	In the 28 days prior to custody, has the YP used substances (excluding tobacco) on a weekday during the evening?	YPOR
Substance using behaviour: On a weekend during daytime	PTEUSWED	In the 28 days prior to custody, has the YP used substances (excluding tobacco) on a weekend during the daytime?	YPOR
Substance using behaviour: On a weekend during evening	PTEUSWEE	In the 28 days prior to custody, has the YP used substances (excluding tobacco) on a weekend during the evening?	YPOR
Substance using behaviour: On their own	PTEUSOYO	In the 28 days prior to custody, has the YP used any substances (excluding tobacco) on their own?	YPOR
Life satisfaction	LISREDYS	How satisfied is the YP with life today?	YPOR
Life worthwhile	LWWAS	To what extent does the YP feel that the things they do in life are worthwhile?	YPOR
Anxiety	ANSTS	How anxious did the YP feel yesterday?	YPOR
Happiness	HAPSTYS	How happy did the YP feel yesterday?	YPOR

4. Outcomes profile – TOP/YPOR			
Field description	**CSV Header**	**Definition**	**Outcome record**
Family/Friends relationships	FMCRCOH	How well does the YP get on with family/friends?	YPOR

5. Data collection guidance and field updateability

1. Client details	
Field description	**Guidance**
Initial of client's first name	MUST be completed. If not, record rejected. Should not change, 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, 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. If changed will create a validation mismatch.
Client sex at registration of birth	MUST be completed. If not, record rejected. Should not change. If changed will create a validation mismatch.
Ethnicity	Should not change.
Nationality	Should not change.

2. Episode details	
Field description	**Guidance**
NDTMS secure estate code (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.
Software system and version used	MUST be completed. If not, record rejected. This is populated by your software system. May change (ie update as at current situation).

2. Episode details	
Field description	**Guidance**
Consent for NDTMS	Client must give consent before their information can be sent to NDTMS. May change (ie update as at current situation).
DAT of residence	MUST be completed. If not, record rejected. Should not change (ie prior to custody).
Postcode	May change (ie current living situation). Can be left blank if NFA.
Client ID	MUST be completed. If not, record rejected. This is populated by your software system. Should not change.
Client reference	Should not change and should be consistent across all episodes of treatment in the secure setting.
Episode ID	MUST be completed. If not, record rejected. This is populated by your software system. Should not change.
Initial reception date	MUST be completed. If not, record rejected. Should not change
Reception date	MUST be completed. If not, record rejected. Should not change
Transferred from	Should not change. Can be blank if client hasn't been transferred in.
Triage date	MUST be completed. If not, record rejected. 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).

2. Episode details	
Field description	**Guidance**
Time since last paid employment	Should not change (ie as at start of episode).
Pregnant	Should not change (ie as at start of episode).
Parental status	Should not change (ie as at start of episode).
Children living with client	Should not change (ie as at start of episode).
Early help or in contact with social care	Should not change (ie as at start of episode).
Problem substance number 1	MUST be completed. If not, record rejected. 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).
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).
AUDIT score	Should not change (ie as at start of episode).
Dual diagnosis	Should not change (ie as at start of episode).
Hep B intervention status	May change (ie update as at current situation).
Hep B vaccination count	May change (ie update as at current situation).
Hep C intervention status	May change (ie update as at current situation).
Hep C tested	May change (ie update as at current situation).

2. Episode details	
Field description	**Guidance**
Hep C latest test date	May change (ie update as at current situation).
Discharge date	Discharge date required when client is discharged from treatment. Prior to discharge ALL interventions MUST have end dates and exit statuses. If discharge date is populated then discharge reason MUST also be populated. Should only change from 'null' to populated as episode progresses.
Discharge reason	Discharge reason required when client is discharged from treatment. Prior to discharge ALL interventions MUST have end dates and exit statuses. If discharge reason is populated then discharge date MUST also be populated. Should only change from 'null' to populated as episode progresses.
Sentenced	Required when the client leaves their current secure setting. Should not change (ie as at exit from current secure setting).
Take home naloxone and training	Required when the client is released. Should not change (ie as at release from secure setting).
Referred to hep C treatment	Required when the client leaves their current secure setting. Should not change (ie as at exit from current secure setting).
Secure setting exit date	Secure setting exit date required when client exits current secure setting. Prior to exit all episodes MUST have discharge dates and discharge reasons. If exit date is populated exit reason MUST also be populated. Should only change from 'null' to populated as episode progresses.
Secure setting exit reason	Secure setting exit reason required when client exits current secure setting. Prior to exit all episodes MUST have discharge dates and discharge reasons. If exit reason is populated exit date MUST also be populated. Should only change from 'null' to populated as episode progresses.
Secure setting exit destination	Required if secure setting exit date is populated and exit reason is recorded as 'transferred to another secure setting', or if the client is 'released' and referred to a structured treatment service or recovery support service, then the treatment service partnership/ local authority should be recorded. Should not change (ie as at exit from secure setting).
Referral on release status	Required when the client leaves the secure setting and exit reason is released. Should not change (ie as at release from secure setting).

2. Episode details	
Field description	**Guidance**
Pre-release review date	Required when the client leaves the secure setting and exit reason is released. Should not change (ie as at release from secure setting).

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.
Intervention ID	MUST be completed. If not, record rejected. This is populated by your software system. Should not change.
Intervention start date	Required when client starts intervention. Should only change from 'null' to populated as episode progresses. If changed will create a validation mismatch.
Intervention end date	Required 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. Outcomes profile – TOP/ YPOR	
Field description	**Guidance**
Treatment Outcomes Profile (TOP or YPOR) date	Not expected to change (ie as at TOP/YPOR date). If changed will create a validation mismatch.
TOP ID	MUST be completed if any items in this section (TOP/YPOR) are not null. If not, record rejected. Should not change.
Treatment stage	Should not change (ie as at TOP/YPOR date).
Alcohol use	Should not change (ie as at TOP/YPOR date).
Consumption (alcohol)	Should not change (ie as at TOP/YPOR date).
Opiate use	Should not change (ie as at TOP/YPOR date).
Crack use	Should not change (ie as at TOP/YPOR date).
Cocaine use	Should not change (ie as at TOP/YPOR date).
Amphetamine use	Should not change (ie as at TOP/YPOR date).
Cannabis use	Should not change (ie as at TOP/YPOR date).
Cannabis average use per day	Should not change (ie as at YPOR date).
Other substance use	Should not change (ie as at TOP/YPOR date).
Other substance 2 use	Should not change (ie as at YPOR date).
Other substance 3 use	Should not change (ie as at YPOR 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).

4. Outcomes profile – TOP/ YPOR	
Field description	**Guidance**
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).
Days volunteered	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/YPOR date).
Quality of life	Should not change (ie as at TOP date).
Tobacco/nicotine	Should not change (ie as at YPOR date).
Ecstasy	Should not change (ie as at YPOR date).
Solvents	Should not change (ie as at YPOR date).
Ketamine	Should not change (ie as at YPOR date).
GHB	Should not change (ie as at YPOR date).
New psychoactive substances (NPS)	Should not change (ie as at YPOR date).
Tranquilisers	Should not change (ie as at YPOR date).
Age first used: cannabis	Should not change (ie as at YPOR date).

4. Outcomes profile – TOP/ YPOR	
Field description	**Guidance**
Age first used: alcohol	Should not change (ie as at YPOR date).
Age first used: tobacco/nicotine	Should not change (ie as at YPOR date).
Age first used: opiates (illicit)	Should not change (ie as at YPOR date).
Age first used: crack	Should not change (ie as at YPOR date).
Age first used: cocaine	Should not change (ie as at YPOR date).
Age first used: ecstasy	Should not change (ie as at YPOR date).
Age first used: amphetamines	Should not change (ie as at YPOR date).
Age first used: solvents	Should not change (ie as at YPOR date).
Age first used: ketamine	Should not change (ie as at YPOR date).
Age first used: GHB	Should not change (ie as at YPOR date).
Age first used: new psychoactive substances (NPS)	Should not change (ie as at YPOR date).
Age first used: tranquilisers	Should not change (ie as at YPOR date).
Alcohol use – binge drinking	Should not change (ie as at YPOR date).
Ever injected	Should not change (ie as at YPOR date).
Current injecting drug use	Should not change (ie as at YPOR date).
Alc using behaviour: On a weekday during daytime	Should not change (ie as at YPOR date).
Alc using behaviour: On a weekday during the evening	Should not change (ie as at YPOR date).
Alc using behaviour: On a weekend during the daytime	Should not change (ie as at YPOR date).

4. Outcomes profile – TOP/ YPOR	
Field description	**Guidance**
Alc using behaviour: On a weekend during the evening	Should not change (ie as at YPOR date).
Alc using behaviour: On their own	Should not change (ie as at YPOR date).
Substance using behaviour: On a weekday during daytime	Should not change (ie as at YPOR date).
Substance using behaviour: On a weekday during evening	Should not change (ie as at YPOR date).
Substance using behaviour: On a weekend during daytime	Should not change (ie as at YPOR date).
Substance using behaviour: On a weekend during evening	Should not change (ie as at YPOR date).
Substance using behaviour: On their own	Should not change (ie as at YPOR date).
Life satisfaction	Should not change (ie as at YPOR date).
Life worthwhile	Should not change (ie as at YPOR date).
Anxiety	Should not change (ie as at YPOR date).
Happiness	Should not change (ie as at YPOR date).
Family/Friends relationships	Should not change (ie as at YPOR date).

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.

Appendices

Appendix A – Definition of structured treatment

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 and family support services according to need. In addition to pharmacological and psychosocial interventions that are provided alongside, or integrated within, the key working or case management function of structured treatment, service users should be provided with the following as appropriate: • harm reduction advice and information • BBV screening and immunisation • advocacy • appropriate access and referral to healthcare and health monitoring • crisis and risk management support

Appendix B – 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 C – Safeguarding 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 was living 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) resided with them full time in the 28 days prior to custody.
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) resided with them in the 28 days prior to custody, 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) resided with them in the 28 days prior to custody, 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 social care

Are the client's children or any of the children that were 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 one that is considered 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 Government).
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.

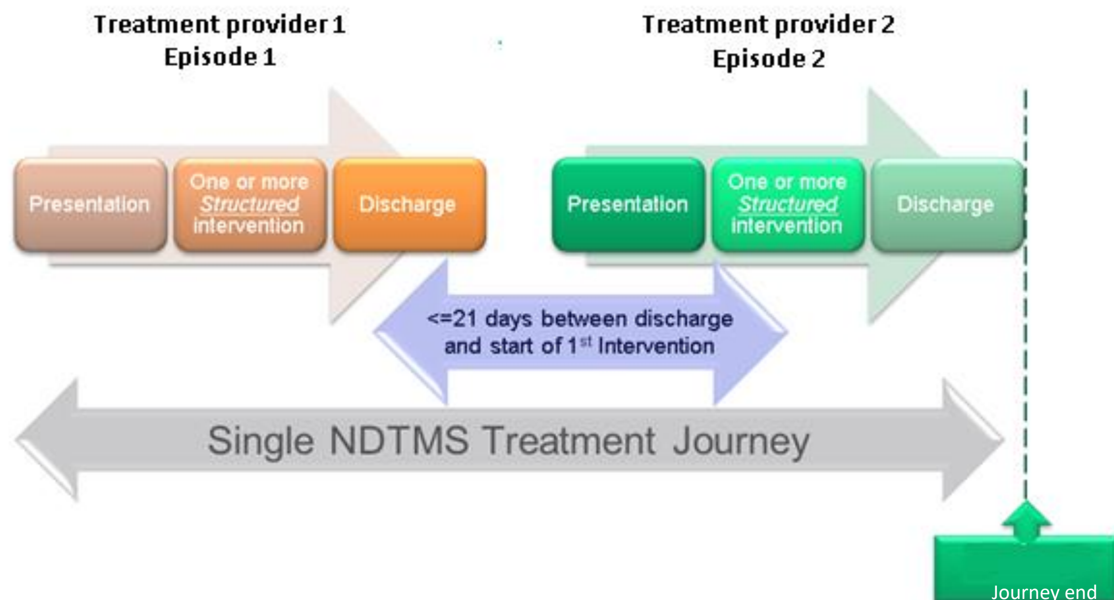
Appendix D – Discharge reason and exit reason definitions

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 or alcohol 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 treatment interventions and the individual has been referred to an alternative non-prison provider for this. This code should only be used if there is an appropriate referral path and care-planned structured drug treatment pathways are available.
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 2-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 has finished treatment at this secure setting provider but still 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 – 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 drug treatment intervention.
Incomplete – client deported	Without completing their episode of structured treatment, the client has been deported to another country.
Incomplete – client released from court	The treatment provider has been unable to continue the client's treatment due to the client being released from court.
Incomplete – client died	During their time in contact with structured treatment the client died.

Discharging clients as 'transferred'

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



Transferring clients to a secure hospital

When a client is transferred to substance misuse treatment within a secured hospital (involving 2-way communication to ensure continuity of care) you should record the transfer as:

- Discharge Reason – Transferred not in Custody
- Exit Status – Released
- Exit Destination – non NDTMS reporting secure setting

If the client has not been referred for ongoing structured treatment (for example there has been no 2-way communication) then the discharge should be recorded as 'dropped out'.

Below are the current secure setting exit statuses and their definitions:

Data item name	Definition
Transferred	The client has been transferred to another secure setting.
Released	The client is no longer in a secure setting and has been released.
Absconded	The client has escaped from the secure setting without permission.
Died	During their time in the secure setting the client has died.

Appendix E – Definitions of interventions

The substance misuse treatment interventions to be captured for NDTMS are defined below. There are separate NDTMS intervention categories for the adult secure settings and for the children and young people's secure settings (YOIs for under 18s, secure training centres, secure children's homes and welfare only homes).

Adult secure settings, immigration removal centres (IRCs) and young offender institutions (YOIs) with no juvenile (under 18s) population should only use the adult treatment interventions for recording the interventions they deliver. YOIs that have a juvenile population (under 18s) should use the young persons (YP) interventions for any clients they treat.

Adult clinical interventions

E.1 Benzodiazepines detoxification

Withdrawal prescribing should be initiated on the day of admission where there is a history of benzodiazepine dependence (either prescribed or regular illicit use) and the presence of objective symptoms and signs of withdrawal already present. Benzodiazepine dependence requiring treatment is not common in polydrug users and does not normally need pharmacological treatment in those using benzodiazepines in the context of heroin or crack dependence.

Where clinical assessment does, however, indicate a previous history of regular benzodiazepine use that suggests substantial dependence that could require treatment of withdrawals (for example, use of sufficiently high doses over a long duration, and/or with previous withdrawals requiring treatment such as fits), a benzodiazepine assisted withdrawal regimen should be prescribed. The intervention start is the date of dispensing the first dose of medication.

E.2 Lofexidine

Lofexidine is a non-opioid alpha-adrenergic agonist authorised for the management of opioid withdrawal. It is most likely to be successful for patients with uncertain dependence, young people and shorter drug and treatment histories. NICE's guidance (NICE 2007b) states that lofexidine may be considered for those who have decided not to use methadone or buprenorphine for detoxification, have decided to detoxify within a short time period or have mild or uncertain dependence.

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

E.3 Naltrexone pre-release

Naltrexone provided prior to release from prison for users abstinent from opiates and committed to abstinence may be a useful adjunct to psychosocial treatment. However, it is not generally recommended where psychosocial support cannot be secured as dropout from such treatment is associated with a heightened risk of drug-related death [Ref 4].

The intervention start is the date of dispensing the first dose of medication. If naltrexone is prescribed during the custodial stay at any time other than pre-release then it should be recorded as 'Naltrexone pre-release'.

E.4 Opioid re-induction

Prior to release some patients request re-induction onto opiate substitution treatment. Re-induction should be considered for patients who are about to leave prison and for whom there is a clearly identifiable risk of overdose. Re-induction may be offered after the patient has been offered and has declined relapse prevention interventions, and once the implications of restarting opiate misuse have been explained [Ref 4].

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

E.5 Opioid reduction – methadone or buprenorphine

The intervention recorded should reflect the medication prescribed; the 2 options are:

- opioid reduction – methadone
- opioid reduction – buprenorphine

The 'opioid reduction' intervention should be used where the client is receiving substitute opioid prescribing (methadone or buprenorphine) and the client's care plan objective is reduction with a commitment to becoming drug free. Every review of the client's care plan should indicate that the substitute dosage is being reduced. Where it has not been possible to reduce the dosage over successive reviews (2 or more) the client is effectively being maintained and, therefore, this intervention should be ended and a subsequent 'opioid maintenance' intervention opened.

Opioid detoxification may also be recorded under this intervention. Following a stabilisation, detoxification should routinely be for a minimum of 14 days if withdrawing from a short-acting opiate but longer if withdrawing from methadone. Detoxification will often need to be for 21 days or more if methadone has been used regularly prior to arrest. [Ref 2].

It is important that the right balance be achieved in determining whether a detoxification, gradual reduction or maintenance regime is the appropriate approach

when prescribing for those who are opiate dependent. DH guidance sets out parameters for the use of substitute prescribing. [Ref 1, Ref 2]

There is a requirement that all periods of extended prescribing, whether maintenance or gradual reduction regimes, are reviewed every 3 months as a minimum. The review will have input from the multi-disciplinary team including the patient, prescriber, other members of the substance misuse team and where their involvement is incorporated within an agreed clinical governance framework, a senior officer and/or offender supervisor.

The client will also be expected to participate in the psychosocial, educational and rehabilitation opportunities available to them whilst in custody to assist them with achieving abstinence. The intervention start is the date of dispensing the first dose of medication where reduction is the aim.

E.6 Opioid maintenance – methadone or buprenorphine

The intervention recorded should reflect the medication prescribed; the 2 options are:

- opioid maintenance – methadone
- opioid maintenance - buprenorphine

The option of methadone (first line) or buprenorphine maintenance after stabilisation should be considered where:

- a chronic opiate user is received into custody on remand to enable them to engage in treatment upon release
- an opiate-dependent client is received into custody for a period of less than 26 weeks, to enable them to engage in treatment upon release where, based on a full clinical assessment, it is considered necessary to protect the client on release from the risks of opiate overdose upon release [Ref 1]

There is a requirement that all periods of extended prescribing whether maintenance or gradual reduction regimes are reviewed every 3 months as a minimum. The review will have input from the multi-disciplinary team including the patient, prescriber, other members of the substance misuse team and where their involvement is incorporated within an agreed clinical governance framework, a senior officer and/or offender supervisor.

Where longer term prescribing is offered to those whose sentence exceeds 26 weeks, it should be explained that at an appropriate time, there will be an expectation that the client works towards reducing their dose of opiate substitute medication, and that abstinence remains the ultimate goal.

When a client moves from a maintenance to a reduction regime, the maintenance intervention should be ended and a new intervention of 'opioid reduction' be opened to indicate the change in treatment goal.

The client will also be expected to participate in the psychosocial, educational and rehabilitation opportunities available to them whilst in custody to assist them with achieving abstinence.

The intervention start is the date of dispensing the first dose of medication on a maintenance script.

E.7 Alcohol – prescribing

Prescribing involves the provision of care planned specialised alcohol treatment, which includes the prescribing of drugs to treat alcohol misuse. This intervention should be used to capture the 3 classes of pharmacotherapy that are effective in the treatment of alcohol misusers:

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

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

Pharmacological therapies should be delivered in the context of structured care planned treatment and are not a stand-alone treatment option (there is some evidence that multiple episodes of assisted withdrawal can be associated with increased harmful outcomes).

Pharmacological therapies are most effective when used as enhancements to psychosocial therapies as part of an integrated programme of care. The intervention start is the date of dispensing the first dose of medication.

Adult psychosocial interventions

E.8 Psychosocial intervention mental disorder

Many users of drugs and/or alcohol also have considerable co-morbid problems, particularly common mental health problems such as anxiety and depression. There is evidence that a range of evidence - based psychosocial interventions can be beneficial for a wide range of mental disorders. Such disorders may include: depression (NICE, 2007b); anxiety (NICE, 2007c); post-traumatic stress disorder (NICE, 2005a); eating disorders (NICE, 2004); obsessive compulsive disorder (NICE, 2005b); antenatal and postnatal mental health (NICE, 2007d).

Psychosocial interventions to address these disorders range from, for example, guided self-help and brief interventions for mild forms of problems to cognitive behavioural therapy and social support for more moderate forms. All psychosocial interventions to address common mental disorders should be recorded using this code regardless of their intensity.

The difference between psychosocial interventions for problem substance misuse and formal psychological therapies targeting a client's co-morbid mental health problems is that the latter interventions are specialist psychological treatments (such as cognitive-behaviour therapy for depression or anxiety, cognitive-analytic therapy, dialectical behaviour therapy, or schema-focused therapy for personality disorders) aimed primarily at the non-substance psychological problem. Such interventions should only be delivered by specialist practitioners such as clinical and counselling psychologists, suitably trained psychiatric staff or other specialist therapists with relevant training, qualifications and supervision in the therapy model being offered.

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

E.9 Other structured psychosocial intervention

This intervention category includes other psychosocial therapies that are used in drug and alcohol treatment and that are beneficial for some clients as they are practical and broad-based techniques. Psychosocial therapies recorded under this category will include the Community Reinforcement Approach and Social Behaviour Network Therapy. Structured psychosocial interventions are clearly defined, evidence-based psychosocial interventions, delivered as part of a client's care plan, which assist the client to make changes in their drug and /or alcohol misuse. These interventions are normally time limited and should be delivered by competent practitioners. Competent practitioners will have adequate training, regular clinical supervision to ensure adherence to the treatment model and be able to demonstrate positive client outcomes.

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

E.10 Structured day programme

The structured day programmes category should be used to record a range of programmes where a client must attend for a fixed period. Interventions tend to be either via a fixed rolling programme or a fixed individual timetable, according to client need. In either case, the programme includes the development of a care plan and regular key working sessions. The care plan should address drug and alcohol misuse, health needs, offending behaviour and social functioning.

Clients will usually attend the programme according to specified attendance criteria, and follow a set timetable that will include group work, psychosocial interventions, educational and life skills activities.

In secure settings, the majority of drug and alcohol treatment programmes would fall into this category, including 12-Step programmes and therapeutic communities.

The category of 'other structured intervention' should be used for less extensive or less structured 'day care' provided in the context of a structured care plan.

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

E.11 Other structured intervention

'Other structured intervention' describes a package of interventions set out in a client's care plan which includes as a minimum, regular planned therapeutic sessions with the keyworker or other substance misuse worker. The care plan should address drug and alcohol misuse, health needs, offending behaviour and social functioning.
This intervention category reflects the evidence base that drug treatment consisting of individually tailored packages of care, in the context of a therapeutic relationship, is beneficial.

This intervention may be particularly relevant for non-opiate drug misusers and clients who are receiving criminal justice treatment interventions. Most clients receiving 'other structured intervention' will receive a range of interventions to meet needs identified in their care plan. These will involve a range of interventions to address their substance misuse and support to address needs in other domains.

Examples of these may include:

- a crack user who is receiving regular sessions with a keyworker and attending 'day care' sessions to address a range of social and health-related needs
- an opiate user who has been through detoxification and is receiving ongoing support to maintain abstinence as part of the care plan (prior to referral on or

provision of aftercare arrangements), and is also receiving harm reduction interventions and help to deal with health needs

- an uncomplicated problem cannabis user who is receiving a short period of care-planned regular brief interventions to deal with problem cannabis use clients who are not receiving a structured psychosocial intervention for their problem drug or alcohol use, but who receive regular sessions with keyworkers to address their social and/or health-related needs and offending behaviour
- an alcohol client who is receiving ongoing support following alcohol withdrawal to maintain abstinence as part of the care plan
- a short period of care-planned regular brief interventions to address problem alcohol misuse

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

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

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

E.12 Alcohol – brief intervention

This intervention should be used for recording brief interventions with alcohol clients, should secure settings wish to record these on NDTMS. Brief interventions for hazardous and harmful drinkers include:

- a session of structured brief advice on alcohol for adults who have been identified via screening as drinking a hazardous or harmful amount
- an extended brief intervention for adults who have not responded to structured brief advice or who may benefit from an extended brief intervention for other reasons [Ref 3]

Further definitions are provided in the 2011 NICE alcohol commissioning guidance [Ref 3] as follows:

- brief intervention: This can comprise either a short session of structured brief advice or a longer, more motivationally based session (that is, an extended brief intervention) – both aim to help someone reduce their alcohol consumption or abstain, and can be carried out by non-alcohol specialists
- extended brief intervention: this is motivationally based and can take the form of motivational-enhancement therapy or motivational interviewing – the aim is to motivate people to change their behaviour by exploring with them why they behave the way they do and identifying positive reasons for making change; in this guidance, all motivationally based interventions are referred to as 'extended brief interventions'

The intervention start is the date of the first face-to-face contact where a simple or extended brief intervention has been provided.

Young persons (YP) treatment interventions

Treatment providers should be delivering specialist treatment interventions for young people in secure settings. The definition that has been agreed across government departments, and should be used in this context, is that young people's specialist substance misuse treatment is a care-planned medical, psychosocial or specialist harm reduction aimed at alleviating current harm caused by a young person's substance misuse.

Universal, targeted or early intervention substance misuse activity for young people should not be reported to NDTMS. Any treatment providers providing universal, targeted and/or early intervention services for substance misuse should ensure they report only substance misuse activity for young people receiving specialist treatment to NDTMS.

Young people (under 18s) must be able to access each of the young people's specialist substance misuse treatment interventions described below. Interventions include social and health care interventions, all of which are important and complement each other in reducing harm caused by a young person's substance misuse.

Young people's structured specialist substance misuse treatment interventions require additional competencies for the worker and delivery within a governance framework including appropriate supervision.

Psychosocial interventions are structured treatment interventions that encompass a wide range of actions. Key working is the basic delivery mechanism for a range of

key components including the review of care plans and goals, provision of substance including alcohol related advice and information, and interventions to increase motivation and prevent relapse. Help to address social problems, for example peer relationships, family relationships and education. In addition, a range of formal psychosocial interventions may be provided by key workers or others with the appropriate competences.

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

- to treat substance misuse including alcohol or co-occurring mental health disorders
- alone or in addition to harm reduction or pharmacological interventions

Formal psychosocial interventions should be provided in accordance with Drug Misuse and Dependence: UK guidelines on clinical management (DH and devolved administrations, 2007), also known as the 'clinical guidelines' or 'orange book' and relevant NICE clinical guidelines.

The type of psychosocial intervention should be selected on the basis of the problem and treatment need of the specific young person guided by the available evidence base of effectiveness.

This intervention has been broken down into 5 psychosocial intervention types:

E.13 Specialist pharmacological intervention

These are substance misuse specific pharmacological interventions, which include prescribing for detoxification, stabilisation and symptomatic relief of substance misuse as well as prescribing of medications to prevent relapse.

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

E.14 Counselling

Counselling is a process in which a counsellor holds face-to-face talks with young person to help him or her solve a problem, or help improve that person's attitude, behaviour (substance misuse).

E.15 Cognitive behavioural therapy

Cognitive behavioural therapy is a psychotherapeutic, talking therapy that aims to solve problems concerning dysfunctional emotions, behaviours and cognitions through a goal oriented, systematic procedure.

E.16 Motivational interviewing

Motivational interviewing is a brief psychotherapeutic intervention. For substance misusers, the aim is to help individuals reflect on their substance use in the context of their own values and goals and motivate them to change.

E.17 Relapse prevention

Relapse-prevention CBT focuses on helping drug users to develop skills to identify situations or states where they are most vulnerable to drug use, to avoid high-risk situations, and to use a range of cognitive and behavioural strategies to cope more effectively with these situations.

E.18 Family work

Interventions using psychosocial methods to support parents, carers and other family members to manage the impact of a young person's substance misuse and enable them to better support the young person in their family. This includes work with siblings, grandparents, foster carers, for example, and can be provided even if the young person misusing substances is not currently accessing specialist substance treatment.

Note: family work should only be reported to NDTMS if, and when, a young person who is a member of the family receiving family work, is currently accessing specialist substance misuse young people's treatment services and should be reported using the young person's attributors.

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

E.19 YP harm reduction service (specialist)

Care-planned substance misuse specific harm reduction is not brief advice and information. This intervention must be delivered as part of a structured care plan and after a full assessment of the young person's substance misuse and risks. Specialist harm reduction interventions should include services to manage those at risk of, or currently involved in:

- injecting - these treatment services could include needle exchange, advice and information on injecting practice, access to appropriate testing and treatment for blood borne viruses
- overdose - advice and information to prevent overdose, especially overdose associated with poly-substance use, which requires specialist knowledge about substances and their interactions

- risky behaviour associated with substance use - advice and information to prevent and/or reduce substance misuse related injuries and substance misuse related risky behaviours

The intervention start is the date of the first appointment where specialist harm reduction interventions were provided.

Appendix F – Intervention exit status definitions

Data item name – mutually agreed planned exit.
Data item definition – when a client has ended a treatment intervention in agreement with their keyworker. This should include any clients that are transferred or released, including those released direct from court or deported where the substance misuse team have not known in advance.

Data item name – client’s unilateral unplanned exit.
Data item definition – when the client has refused or dropped out of the treatment intervention after commencement. This can also be used if the client dies whilst in custody.

Data item name – intervention withdrawn.
Data item definition – when the service provider chooses to withdraw the treatment intervention from the client. This can be used in cases where the client has been violent towards staff.

Data item name – released from court.
Data item definition – where the client has been released from court without completing their treatment intervention.

Appendix G – Dual diagnosis

Data item – "Does the client have need of a mental health intervention for reasons other than substance misuse?"
Data item definition – identification of the need for a current or future mental health intervention could be based on information obtained from community services (for example, GP, community mental health service) or could be a need newly identified by healthcare staff in the secure setting.

Where and when the intervention is delivered will depend on the level of need, the time the client spends in the secure setting and/or access to appropriate services.

The mental health intervention can include a wide range of recognised specific interventions provided by primary care (including IAPT) and by a variety of secondary mental health services. But it can also include interventions, such as individual or group counselling or specific reflective support, provided commonly by voluntary and non-mental health service providers, aimed at meeting mental health needs. For example, through giving specific support for surviving sexual, physical and/or emotional abuse, or to address issues related to domestic violence (and when the identified need extends beyond just practical and legal support from such services).

The need for such specific mental health support/intervention may be clear even if it may not involve diagnosis of a specific mental disorder, or a particular structured specialist mental health intervention required (such as CBT).

Appendix H – Recording outcomes profiles (TOP/YPOR) in secure settings

Both the Treatment Outcomes Profile (TOP) and the Young People's Outcomes Record (YPOR) are used as national outcomes monitoring tools for client's receiving substance misuse treatment. The TOP is used for clients in adult services and the YPOR for those in young people's services. They both consist of a simple set of questions that can aid improvements in clinical practice by enhancing assessment and care plan reviews. It can also help to ensure that each service user's recovery care plan identifies and addresses his or her needs and treatment goals.

There are 4 different areas covered by the TOP/YPOR – substance use, substance risk behaviours, offending behaviour (TOP), and health and social functioning. The latter includes information on psychological health, physical health, work and education, housing and overall quality of life. Outcomes reports are compiled centrally within Public Health England (PHE) via NDTMS.

In April 2014, establishments in the North West that were part of the 'Gateways' project piloted the use of TOP in secure settings, but as of 1 April 2017 all establishments are to record a TOP or YPOR (depending on the age of their population) for any detainees who have started a new custodial stay and are assessed by a substance misuse worker. The TOP/YPOR should be completed within2weeks of initial reception, ideally when the detainee is being assessed for their treatment need. This may be on the date of initial reception into custody or shortly thereafter.

The TOP/YPOR should reflect the 28 days before entering custody. This will provide a baseline record of behaviour in the month leading up to the custodial stay and commencement of a new secure setting treatment journey. If a detainee has transferred from another establishment, and was assessed in the sending secure setting, a TOP/YPOR does not need to be completed by the receiving establishment – the establishment where they were first received into custody should already have completed the TOP/YPOR. If a detainee is assessed more than 2 weeks after initial reception, for example, because they chose not to engage with treatment when they first came into custody, a TOP/YPOR does not need to be completed. This is because it will not be possible to robustly capture behaviour in the 28 days before entering custody.

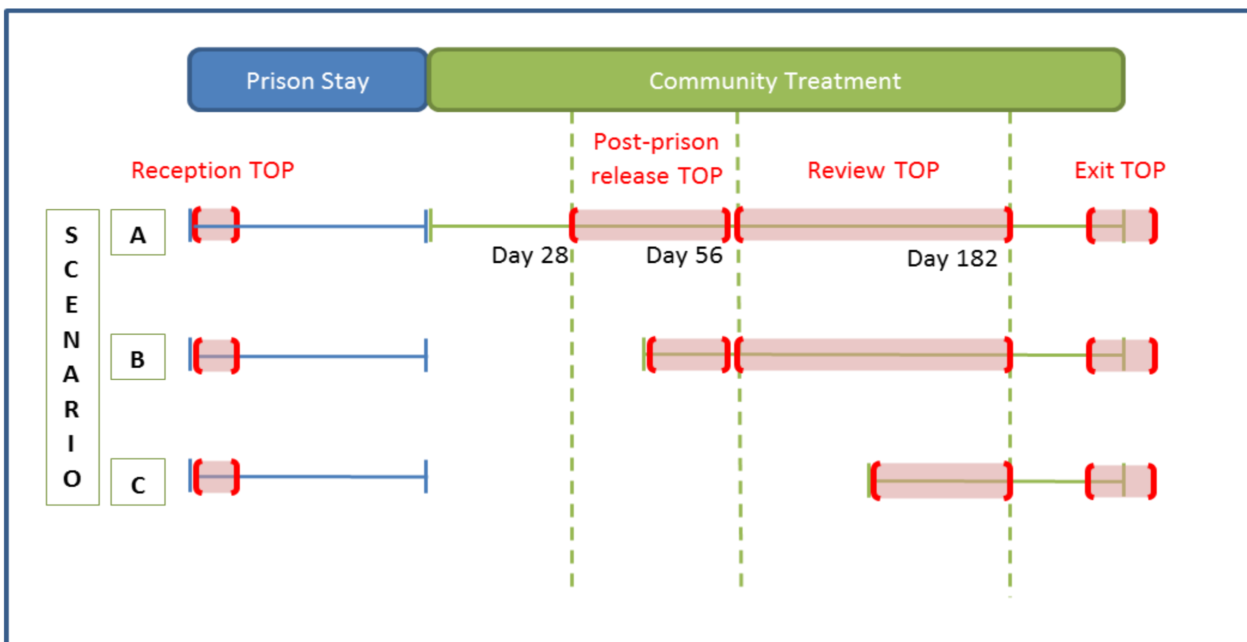
The TOP/YPOR should be used for all structured substance misuse clients except those being treated in Immigration Removal Centre's (IRC's). All questions on the forms should be answered; zero should be recorded where the client does not use that particular substance and NA used when the question has not been answered.

In the community, treatment providers record TOP and YPOR with clients at treatment start and at regular review points (reviews are optional for YPOR), as part

of a review of the service user's recovery care plan. Community treatment providers also complete the TOP/YPOR at treatment exit. Following release from custody, post-release TOP/YPOR reviews will also be completed by community providers, where the client has been referred to and engaged with treatment and/or taken onto a CJIT caseload. Community providers will complete a post-release TOP/YPOR at least 28 days after the client leaves custody (and within 56 days of release). To support this, please ensure that the secure setting release date is shared with the community provider.

By collecting TOP/YPOR information at secure setting entry, NDTMS will be able to monitor treatment outcomes post-release and across a client's entire treatment journey, for example, from secure setting treatment to community treatment and at treatment completion.

Secure setting TOP/YPOR scenarios



Scenario A – The secure setting completes the reception TOP/YPOR within 2 weeks of the client entering custody. Following custody, the client immediately presents to treatment in the community (the community provider may complete a start TOP/YPOR within 2 weeks of the community treatment start date) but the community provider will need to wait until the client has been out of custody for at least 28 days to complete the post-prison release TOP/YPOR. Review and exit TOP/YPOR will continue to be completed by the community provider as normal after this.

Scenario B – The secure setting completes the reception TOP/YPOR within 2 weeks of the client entering custody. Following custody, the client does not present to community treatment until they have been out of custody for between 28-56 days.

The community provider can complete just 1 TOP/YPOR in this period that will count as both their community start TOP/YPOR and their post-prison release TOP/YPOR. Review and exit TOP/YPOR will continue to be completed by the community provider as normal after this.

Scenario C – The secure setting completes the reception TOP/YPOR within 2 weeks of the client entering custody. Following custody, the client doesn't present to community treatment until after the 28-56 day post-prison release window. In this situation the post-secure release TOP/YPOR is not required and the community provider would complete start, review and exit TOP's/YPOR's as normal.

Appendix I – External references

Ref No.	Title	Version
1	Updated guidance for prison-based opioid maintenance prescribing, Department of Health	2010
2	Clinical Management of Drug Dependence in the Adult Prison Setting, Department of Health file:///S:/Downloads/UK21_management%20in%20prison%20setting.pdf	2006
3	Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence, NICE guidelines (CG115), NICE 2011 https://www.nice.org.uk/guidance/cg115	2011
4	Drug misuse and dependence: UK guidelines on clinical management, Department of Health. https://www.gov.uk/government/publications/drug-misuse-and-dependence-uk-guidelines-on-clinical-management	2017
5	Drug Strategy 2010: Reducing Demand, Restricting Supply, Building Recovery: Supporting People to Live a Drug Free Life. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/98026/drug-strategy-2010.pdf	2010

In this document, any external references are indicated by square brackets, for example [Ref 1].