Office for Health Improvement & Disparities

National Drug Treatment Monitoring System (NDTMS)

Adult drug and alcohol secure settings business definitions (dataset Q)

V7.3

Contents

Introduction

We are the Office for Health Improvement and Disparities (OHID) in the Department of Health and Social Care. We have a database called the National Drug Treatment Monitoring System (NDTMS), which we use to collect information about drug and alcohol treatment in England.

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. The dataset is accredited by NHS Digital and the Information Standard is published under section 250 of the Health and Social Care Act 2012.

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

This document contains definitions that are primarily applicable to use with adult drug and alcohol clients in secure settings. Adult secure settings include prisons, immigration removal centres and young offender institutions with populations aged 18 and over. Further information and definitions relating to data collection for adults and young people in the community and under 18s in secure settings is available.

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 OHID systems
- suppliers of systems to OHID
- suppliers of systems that interface to OHID systems
- OHID/National Drug Treatment Monitoring System (NDTMS) personnel

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

Please read this document in conjunction with:

- NDTMS CSV File Format Specification – defines the format of the CSV file used as the primary means of inputting the core dataset into NDTMS

- NDTMS technical definitions – provides the full list of fields that are required in the CSV file and the verification rules for each item

- NDTMS geographic information – provides geographic information including DAT of residence and local authority codes

- NDTMS reference data – provides permissible values for each data item

These definitions and guidance documents can be found on the NDTMS.net website.

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 Q (CDS-Q) for national data collection, will come into effect on 1 April 2022.

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

Purpose of NDTMS

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

- provide measurements that support the outcome and recovery focus of the government's drug strategy, such as:
    - proportion of clients successfully completing treatment
    - proportion of clients that do not return to treatment following a successful completion
    - value for money
    - housing and employment
    - health and quality of life outcomes
    - support for children and families of drug and alcohol dependent people
- provide information which can be used to monitor how effective drug and alcohol treatment services are and help to plan and develop services that better meet local needs
- produce statistics and support research about drug and alcohol use treatment
- provide measurements to support the Public Health Outcomes Framework

Data entities

The NDTMS dataset consists of fields that are updateable (such as the client's postcode) and fields that should not change and should be completed as per the start of the episode (such as the client's ethnicity). The NDTMS dataset fields table details for each data item the question, the definition and whether it is updateable during the episode of treatment or whether the information reported should be as per the start of the episode. In general, all data is required.

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

Client details

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

Episode details

Details pertaining to the current episode of treatment including information gained at reception into 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 one secure setting, made up of one triage date and one 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 re-present later in their custodial stay.

Treatment intervention details

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

Treatment Outcomes Profile (TOP)

Adult secure settings should utilise the Treatment Outcomes Profile (TOP). The TOP 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. A TOP is not required to be completed by immigration removal centres. See Appendix G.

NDTMS dataset fields

Note: 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.

1. Client details

Field description	CSV header	Definition	Field updatability
Client ID	CLIENTID	A mandatory, unique technical identifier representing the client, as held on the clinical system used by the treatment provider. This should be a technical item and must not hold or be composed of attributors which might identify the individual. A possible implementation of this might be the row number of the client in the client table.	Must be completed. If not, the record will be rejected. This is populated by your software system. Should not change.
Initial of client’s first name	FINITIAL	The first initial of the client’s first name eg Max would be ‘M’. If a client legally changes their name this should be updated on your system. This will create a mismatch at your next submission for which you should select ‘replace’ or ‘delete’.	Must be completed. If not, the record will be rejected. Should not change (record as per start of episode). If changed will create a validation mismatch.
Initial of client’s surname	SINITIAL	The first initial of the client’s surname eg Smith would be ‘S’, O’Brian would be ‘O’ and McNeil would be ‘M’. If a client legally changes their name this should be updated on your system. This will create a mismatch at your next submission for which you should select ‘replace’ or ‘delete’.	Must be completed. If not, the record will be rejected. Should not change (record as per start of episode). If changed will create a validation mismatch.
Client birth date	DOB	The day, month and year that the client was born.	Must be completed. If not, the record will be rejected.

Field description	CSV header	Definition	Field updatability
			Should not change (record as per start of episode). If changed will create a validation mismatch.
Client stated sex	SEX	The sex as stated by the client on their birth certificate or gender recognition certificate.	Must be completed. If not, the record will be rejected. Should not change (record as per start of episode). If changed will create a validation mismatch.
Ethnicity	ETHNIC	The ethnicity that the client states as defined in the Office of Population Censuses and Surveys (OPCS) categories. If a client declines to answer, then ‘not stated’ should be used. If client does not know then ‘Ethnicity is unknown’ should be used.	Should not change (record as per start of episode).
Country of birth	NATION	Country of birth. Kosovo should be recorded as Serbia as per NHS data dictionary.	Should not change (record as per start of episode).
Agency code	AGNCY	A unique identifier for the treatment provider that is defined by the regional NDTMS team eg L0001.	Must be completed. If not, the record will be rejected. This is populated by your software system. Should not change. If changed file will fail on validation.
Client reference	CLIENT	A unique number or ID allocated by the treatment provider to a client - this should be the NOMS ID if applicable. The client reference should remain the same within a treatment provider for a client during all treatment episodes. This must not hold or be composed of attributors which might identify the individual.	Should not change and should be consistent across all episodes at the treatment provider.

2. Episode details

Field description	CSV header	Definition	Field updatability
Episode ID	EPISODID	A mandatory, unique technical identifier representing the episode, as held on the clinical system used at the treatment provider. This should be a technical item and should not hold or be composed of attributors which might identify the individual.	Must be completed. If not, the record will be rejected. This is populated by your software system. Should not change.
Software system and version used	CMSID	A mandatory, system identifier representing the clinical system and version used at the provider.	Must be completed. If not, the record will be rejected. This is populated by your software system. May change (record as per current situation).
Consent for NDTMS	CONSENT	Whether the client has agreed for their data to be shared with NDTMS. Informed and evidenced consent must be sought from all clients. Further information on obtaining NDTMS consent, is available in the NDTMS consent and privacy notices.	Client must give consent before their information can be sent to NDTMS. May change (record as per current situation).
Postcode	PC	The postcode of the client's place of residence 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, eg '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).	Should not change (record situation prior to custody).
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	Must be completed. If not, the record will be rejected. Should not change (record situation

Field description	CSV header	Definition	Field updatability
		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.	prior to custody).
Upper tier local authority	UTLA	This field will be electronically mapped by software providers based on the postcode of the client. Treatment providers will not need to complete this field. The upper tier local authority (UTLA) in which the client normally resides (as defined by the postcode of their normal residence). If the client is resident in Scotland, Wales, Northern Ireland or outside of the UK record the code that reflects this. If a client states that they are of no fixed abode (NFA) record the partnership UTLA where the benefits office from which the client last claimed is located. See NDTMS Geographic Information document for a list of UTLA codes	Should be completed by software provider based on DAT of residence field. Should not change (record situation prior to custody).
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.	Must be completed. If not, the record will be rejected. Should not change
Reception date	RECPDT	The date that the client was received into the current secure setting.	Must be completed. If not, the record will be rejected. Should not change
Transferred from (other secure estate)	PRISON	The previous secure setting 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 should be left blank.	Should not change. Should be blank if client hasn’t been transferred in.

Field description	CSV header	Definition	Field updatability
Triage date	TRIAGED	The date that the client made a first face-to-face (or equivalent) presentation to a substance misuse worker (this includes healthcare staff who initiated substance misuse treatment for the client).	Must be completed. If not, the record will be rejected. Should not change (record as per start of episode).
Client stated sexual orientation	SEXUALO	The sexual orientation that the client states. If a client declines to answer, then ‘not stated’ should be used.	Should not change (record as per start of episode).
Pregnant	PREGNANT	Is the client pregnant at triage?	Should not change (record as per start of episode).
Religion	RELIGION	The religion or belief of the client. If a client declines to answer, then ‘Declines to disclose’ should be used.	Should not change (record as per start of episode).
Disability 1	DISABLE1	Whether the client considers themselves to have a disability. If a client declines to answer, then ‘not stated’ should be entered and DISABLE2 and DISABLE3 should be left blank. If the client has no disability, then ‘no disability’ should be entered and DISABLE2 and DISABLE3 should be left blank. Refer to Appendix B for disability definitions.	Should not change (record as per start of episode).
Disability 2	DISABLE2	Whether the client considers themselves to have a second disability. If the client has no second disability then this field should be left blank. Refer to Appendix B for disability definitions.	Should not change (record as per start of episode).
Disability 3	DISABLE3	Whether the client considers themselves to have a third disability. If the client has no second disability then this field should be left blank. Refer to Appendix B for disability definitions.	Should not change (record as per start of episode).
What is the client’s current housing situation?	HOUSING	The client's current housing situation refers to the 28 days prior to entering custody. Appendix I within this document describes the reference data for this item and the relevant definitions for adult secure estates.	Should not change (record as per start of episode).

Field description	CSV header	Definition	Field updatability
Has the client ever been the victim of domestic abuse*?	DOMVIC	The Domestic Abuse Act 2021, for the first time, introduced a statutory definition for domestic abuse. The behaviour of one person towards another is considered domestic abuse if it is “abusive”, and both are aged 16+ and are “personally connected” to one another, irrespective of where they live. The Act recognises children as victims if they “see, hear or otherwise experience the effects of abuse” and are related to either the abuser or abused. The term “Abusive” can refer to: physical or sexual abuse; violent or threatening behaviour; controlling or coercive behaviour and gaslighting; economic abuse; psychological abuse; female genital mutilation (FGM); 'honour-based' violence and more. Clients may be reluctant to disclose that they have been the victim of domestic abuse when they start treatment. In order to get a true reflection, this item should be updated if being the victim of domestic abuse prior to entering the secure estate is disclosed during treatment. If the client disclosed being the victim of domestic abuse at the start of the episode, this should not be updated even if they report that they are no longer the victim of domestic abuse. Record 'Not appropriate to ask' if you are not alone, there is a language barrier or staff are not confident to ask this question etc.	This item should be updated if being the victim of domestic abuse prior to entering the secure estate is disclosed during treatment.
Has the client ever abused* someone close to them?	DOMPER	The Domestic Abuse Act 2021, for the first time, introduced a statutory definition for domestic abuse. The behaviour of one person towards another is considered domestic abuse if it is “abusive”, and both are aged 16+ and are “personally connected” to one another, irrespective of where they live. The Act recognises children as victims if they “see, hear or otherwise experience the effects of abuse” and are related to either the abuser or abused. The term “Abusive” can refer to: physical or sexual	This item should be updated if being the victim of domestic abuse prior to entering the secure estate is disclosed during treatment.

Field description	CSV header	Definition	Field updatability
		abuse; violent or threatening behaviour; controlling or coercive behaviour and gaslighting; economic abuse; psychological abuse; female genital mutilation (FGM); 'honour-based' violence and more. Clients may be reluctant to disclose that they have ever abused someone close to them when they start treatment. In order to get a true reflection, this item should be updated if the client discloses during treatment that they have ever abused someone close to them prior to entering the secure estate. If the client disclosed having ever abused someone close to them at the start of the episode, this should not be updated even if they report that they are no longer abusing someone close to them. Record 'Not appropriate to ask' if you are not alone, there is a language barrier or staff are not confident to ask this question etc.	
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 one year prior to custody then 2 to 3 years should be recorded. If the client declines to answer use 'client declined to answer' option.	Should not change (record as per start of episode).
British Armed Forces veteran	VETERAN	Is the client a veteran of the British Armed Forces? Veterans have a higher incidence of substance misuse (and mental health issues) than the general population. The purpose of this question is to better understand the needs of British veterans with respect to substance misuse and their engagement in treatment and subsequent outcomes. British armed forces include: Royal Navy, Royal Marines, British	Should not change (record as per start of episode).

Field description	CSV header	Definition	Field updatability
		Army, Royal Air Force, Regular Reserve, Volunteer Reserves or Sponsored Reserves.	
Parental responsibility	PARENT	In the 28 days prior to custody did the client have parental responsibility for a child aged under 18? A child is a person who is under 18 years of age. Parental responsibility should include biological parents, step-parents, foster parents, adoptive parents and guardians. It should also include de facto parents where a client lives with the parent of a child or the child alone (eg clients who care for younger siblings or grandchildren) and have taken on full or partial parental responsibilities. Parental responsibility as used here is wider than the legal definition of parental responsibility.	Should not change (record as per start of episode).
If client has parental responsibility, do any of these children live with the client?	PRNTSTAT	If the client has parental responsibility (PARENT = yes), record whether none of, some of or all of the children they are responsible for lived with the client the majority of the time 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.	Should not change (record as per start of episode).
How many children under 18 in total live in the same house as the client?	CHILDWTH	The total number of children under 18 that lived in the same household as the client at least one night a fortnight 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, record code ‘98’ as the response if the client has declined to answer. For children living in care with other children prior to custody this should be recorded as 0, unless the young person was living with other siblings. In this case the number of siblings should be recorded.	Should not change (record as per start of episode).

Field description	CSV header	Definition	Field updatability
If client has parental responsibility and/or children living with them, what help are the children receiving? (1)	EHCSC	Prior to entering custody, what help are the client's children and/or any other children living with the client receiving? This question only applies to the children aged under 18 for which the client has parental responsibility (regardless of whether this child lives with the client or not) and to children aged under 18 living with the client (regardless of whether the client has parental responsibility or not). If more than one option applies, then complete EHCSC2 and EHCSC3 as appropriate. If none of the children are receiving any help record 'None of the children are receiving any help' and leave EHCSC2 and EHCSC3 blank. If the client declines to answer record 'client declined to answer' and leave EHCSC2 and EHCSC3 blank. See Appendix C for data items and definitions.	Should not change (record as per start of episode).
If client has parental responsibility and/or children living with them, what help are the children receiving? (2)	EHCSC2	Prior to entering custody, what help are the client's children and/or any other children living with the client receiving? If more than two options apply, then complete EHCSC3 as appropriate. If the client declines to answer or if no help is being received then this field should be left blank. See Appendix C for data items and definitions.	Should not change (record as per start of episode).
If client has parental responsibility and/or children living with them, what help are the children receiving? (3)	EHCSC3	Prior to entering custody, what help are the client's children and/or any other children living with the client receiving? If the client declines to answer or if no help is being received then this field should be left blank. See Appendix C for data items and definitions.	Should not change (record as per start of episode).
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	Must be completed. If not, the record will be rejected.

Field description	CSV header	Definition	Field updatability
		this substance. If a client presents with more than one substance the provider(s) is/are responsible for clinically deciding which substance is primary.	Should not change (record as per start of episode).
Problem substance number 2	DRUG2	An additional substance that brought the client into treatment at the point of triage/initial assessment, even if they are no longer actively using this substance. If no second problem substance then leave this field blank.	Should not change (record as per start of episode).
Problem substance number 3	DRUG3	An additional substance that brought the client into treatment at the point of triage/initial assessment, even if they are no longer actively using this substance. If no third problem substance then leave this field blank.	Should not change (record as per start of episode).
Injecting status	INJSTAT	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.	Should not change (record as per start of episode).
AUDIT score (alcohol use disorders identification test)	AUDIT	What was the client's AUDIT score on initial reception? This should be the client's score on the full AUDIT 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. 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	Should not change (record as per start of episode).

Field description	CSV header	Definition	Field updatability
		not requiring structured alcohol treatment but accessing treatment to address their drug misuse.	
Hep B intervention status	HEPBSTAT	Within the current treatment episode, whether the client was offered a vaccination for hepatitis B, whether that offer was accepted by the client and whether they have commenced/completed vaccinations. For further information on recording BBV details, refer to the Recording NDTMS data about blood-borne virus interventions document.	May change (record as per current situation).
Hep C intervention status	HEPCSTAT	Within the current treatment episode, whether the client was offered a test for hepatitis C, whether that offer was accepted by the client and whether they have had a test. For further information on recording BBV details, refer to the Recording NDTMS data about blood-borne virus interventions document.	May change (record as per current situation).
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. For further information on recording BBV details, refer to the Recording NDTMS data about blood-borne virus interventions document.	May change (record as per current situation).
Is the client HIV positive?	HIVSTAT	Is the client HIV positive? This can either be self-reported or based on evidence of a test result. Record the most recent test result, regardless of when that test was.	May change (record as per current situation).

Field description	CSV header	Definition	Field updatability
		If the client has never been tested record 'unknown'.	
HIV latest test date	HIVTESTDT	The date that the client was last tested for HIV. 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. For further information on recording BBV details, refer to the Recording NDTMS data about blood-borne virus interventions document.	May change (record as per current situation).
Referral for alcohol related liver disease	LIVSCRN	Has the client been referred to GP, alcohol nurse or specialist in liver disease for an investigation for alcohol-related liver disease since their reception at the current secure estate? This could be an investigation that was delivered in-house within the establishment (as in-reach or GP-led) or where the client was referred to secondary care in the community if they were released before investigation could be initiated in custody. A referral for an investigation for alcohol-related liver disease could include: • a referral for initial tests including liver blood tests or a fibroscan (transient elastography) delivered by a GP surgery or an alcohol nurse • a referral to a specialist doctor in liver disease for diagnosis and treatment in a hospital outpatient or an in-patient setting	Required when the client leaves their current secure setting. Should not change (record status as at exit from current secure setting).

Field description	CSV header	Definition	Field updatability
		This field may be updated to 'yes' at any point during the client's custodial stay but should be reviewed at exit for all clients where 'yes' is not already recorded.	
Dual diagnosis	DUALDIAG	Does the client have need of a mental health intervention for reasons other than substance misuse? See Appendix F for definitions.	Should not change (record as per start of episode).
Mental health interventions prior to custody	MHTINT	In the 28 days prior to custody was the client engaged in any mental health interventions outside of substance misuse treatment? This includes interventions delivered by secondary care (CMHT, inpatient mental health services) or interventions delivered in primary care (IAPT, pharmacological treatment prescribed by GP) or any NICE-recommended psychosocial or pharmacological intervention provided for the treatment of a mental health problem by drug and alcohol services.	Should not change (record as per start of episode).
Has the client ever received money or goods in exchange for sex?	SEXWORK	Goods can include accommodation, shelter, substances, food and others. Sexual services can include sexual intercourse, webcamming, erotic massage, on the street, on premises, among others. This can be done independently or controlled by someone else.	Should not change (record as per start of episode).
Use of Psychoactive Substances (PS) during treatment	NPSUSE	Has the client used Psychoactive Substances (PS) during their episode of treatment? The Psychoactive Substances Act 2016 defines a psychoactive substance (PS) as any substance which: • is capable of producing a psychoactive effect in a person who consumes it, and	Required when the client is discharged from treatment. Should not change (record status as at discharge from treatment).

Field description	CSV header	Definition	Field updatability
		• is not an exempted substance (as listed in Schedule 1 but broadly: drugs already controlled under the Misuse of Drugs Act, medicines, alcohol, nicotine and tobacco, caffeine and food and drink). A substance produces a psychoactive effect in a person if, by stimulating or depressing the person's central nervous system it affects the person's mental functioning or emotional state and references to a substance's psychoactive effects are to be read accordingly. A person consumes a substance if the person causes or allows the substance, or fumes given off by the substance, to enter the person's body in any way. The overwhelming majority of PS used in the prison system are synthetic cannabinoids, generally referred to as 'spice'. For further information on PS in prisons, see the toolkit. This field should be regularly reviewed and updated to 'yes' at any point during the client's episode of treatment but must be asked at discharge for all clients where 'yes' is not already recorded. For very short stays, where there has not been an opportunity to ask the question at discharge, leave the answer blank.	
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-	Discharge date required when client is discharged from treatment. Prior to discharge all interventions must have end dates. If discharge date is populated then discharge reason must also be populated.

Field description	CSV header	Definition	Field updatability
		to-face (or equivalent) contact with the treatment provider should be used. If a client is discharged from treatment and then re-presents 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 reopening 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 re-presentation is less than 21 calendar days. In this scenario, the previous interventions should remain closed and new interventions should be opened.	Should only change from 'null' to populated as episode progresses.
Discharge reason	DISRSN	The reason why the client's episode of structured treatment was ended. For discharge codes and definitions see Appendix D.	Discharge reason required when client is discharged from treatment. Prior to discharge all interventions must have end dates. If discharge reason is populated then discharge date must also be populated. Should only change from 'null' to populated as episode progresses.
Has the client been provided with Reconnect support?	RECONNECT	The care after custody service, RECONNECT, starts working with people before they leave prison and helps them to make the transition to community-based health services. This field should be populated if the client's exit reason is 'released'.	Required when the client is released. Should not change (record as at release from secure setting).
Mental health treatment during stay	MHTXEXIT	Did the client receive treatment for their mental health during the current stay? 'Yes' should be recorded if the client was under the care of the prison mental health team and received appropriate	Required when the client leaves their current secure setting. Should not change (record status as at exit from current secure setting).

Field description	CSV header	Definition	Field updatability
		pharmacological and/or psychosocial interventions to address their mental health concern. This field should be completed for all clients when they leave the current establishment.	
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.	Required when the client leaves their current secure setting. Should not change (record status as at exit from current secure setting).
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 reason is ‘released’.	Required when the client is released. Should not change (record as at release from secure setting).
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.	Required when the client leaves their current secure setting. Should not change (record status as at exit from current secure setting).
Is the client threatened with homelessness in the 56 days (8 weeks) following exit from secure estate?	HOMELESSEXIT	Homelessness Reduction Act 2017 places a duty on housing authorities to work with people who are threatened with homelessness within 56 days to help prevent them from becoming homeless. This field should be populated if the client’s exit reason is ‘released’.	Required when the client is released. Should not change (record as at release from secure setting).
Secure setting exit date	EXITD	The date that the client left the secure setting (or died).	Secure setting exit date required when client exits current secure setting. Prior to exit all episodes must have discharge dates and

Field description	CSV header	Definition	Field updatability
			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	EXITRSN	The reason that the client left the secure setting. For detailed definitions see Appendix D.	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	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 (eg secure hospitals) record ‘non-NDTMS reporting secure setting’. See NDTMS Geographic Information document for a list of DAT codes.	Required if secure setting exit date is populated and exit reason is recorded as ‘transferred', 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 (record status as at exit from secure setting).
Referral on release status	RTOAGNCY	If the clients exit reason is ‘released’, record whether a referral was made to a recovery support provider or to a structured treatment provider in the community, or to both a recovery support provider and a structured treatment provider, or if no onward referral was made for the client.	Required when the client leaves the secure setting and exit reason is released. Should not change (record status as at release from secure setting).

3. Treatment intervention details

Field description	CSV header	Definition	Field updatability
Intervention ID	MODID	A mandatory, unique technical identifier representing the intervention, as held on the clinical system used at the treatment provider. This should be a technical item and should not hold or be composed of attributors which might identify the individual.	Must be completed. If not, the record will be rejected. This is populated by your software system. Should not change.
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. A client may have more than one treatment intervention running sequentially or concurrently within an episode.	Required as soon as the intervention is known. Should not change (record status at intervention start). If changed, it will create a validation mismatch.
Intervention start date	MODST	The date the treatment intervention commenced eg date the client attended their first appointment.	Required when client starts intervention. Should only change from ‘null’ to populated as episode progresses.
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 (or equivalent) contact date within the intervention should be used.	Required when client completes intervention or is discharged. Should only change from ‘null’ to populated as episode progresses.

4. Outcome record – TOP

Field description	CSV header	Definition	Field updatability
TOP ID	TOPID	A mandatory, unique technical identifier representing the TOP, as held on the clinical system used at the treatment provider. This should be a technical item and should not hold or be composed of attributors which might identify the individual.	Must be completed if any items in this section are not null. If not, the record will be rejected. This field is populated by your software system. Should not change.
Treatment Outcomes Profile (TOP) date	TOPDATE	Date of the TOP review. This should be on or up to 2 weeks after the client's initial reception into the establishment. All TOP data should reflect the 28 days prior to custody. See Appendix G for further information on TOP recording.	Not expected to change. If changed, it will create a validation mismatch.
Alcohol use	ALCUSE	Number of days in the 28 days prior to custody that the client has used alcohol.	Should not change (record as per TOP date).
Consumption (alcohol)	CONSMP	Typical number of alcohol units consumed on a drinking day in the 28 days prior to custody.	Should not change (record as per TOP date).
Opiate use	OPIUSE	Number of days in the 28 days prior to custody that the client has used opiates.	Should not change (record as per TOP date).
Crack use	CRAUSE	Number of days in the 28 days prior to custody that the client has used crack.	Should not change (record as per TOP date).
Cocaine use	COCAUSE	Number of days in the 28 days prior to custody that the client has used powder cocaine.	Should not change (record as per TOP date).
Amphetamine use	AMPHUSE	Number of days in the 28 days prior to custody that the client has used amphetamines.	Should not change (record as per TOP date).
Cannabis use	CANNUSE	Number of days in the 28 days prior to custody that the client has	Should not change (record as per

Field description	CSV header	Definition	Field updatability
		used cannabis.	TOP date).
Other substance use	OTDRGUSE	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 form.	Should not change (record as per TOP date).
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.	Should not change (record as per TOP date).
Injected	IVDRGUSE	Number of days in the 28 days prior to custody that the client has injected non-prescribed drugs.	Should not change (record as per TOP date).
Sharing	SHARING	Has client shared needles or paraphernalia (spoon, water or filter) in the 28 days prior to custody? On the TOP form this is displayed as 2 questions, but only one response is used for NDTMS. See NDTMS reference data document.	Should not change (record as per TOP date).
How often has the client had 6 or more units if female, or 8 or more if male, on a single occasion in the last 28 days	BINGEDRINK	Binge drinking usually refers to drinking lots of alcohol in a short space of time or drinking to get drunk. In the UK, binge drinking is drinking more than: 8 units of alcohol in a single session for men 6 units of alcohol in a single session for women Examples: 6 units is 2 pints of 5% strength beer or 2 large (250ml) glasses of 12% wine. 8 units is 5 bottles (330ml) of 5% strength beer or 5 small (125ml) glasses of 13% wine Unit information is found on the NHS website	Should not change (record as per TOP date).
Psychological health status	PSYHSTAT	Self-reported psychological health (anxiety, depression, problem emotions and feelings) score in the 28 days prior to custody of 0 to 20, where 0 is poor and 20 is good.	Should not change (record as per TOP date).

Field description	CSV header	Definition	Field updatability
Paid work	PWORK	Number of days in the 28 days prior to custody that the client has had paid work. Includes legal work only.	Should not change (record as per TOP date).
Days in volunteering or unpaid structured work placement	VOLNPWORK	Number of days in the 28 days prior to custody that the client has volunteered or participated in unpaid work as part of a structured work placement. Volunteering is engaging in any activity that involves spending time (unpaid) doing something that aims to benefit another person, group or organisation. 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.	Should not change (record as per TOP date).
Education	EDUCAT	Number of days in the 28 days prior to custody that client has attended for education eg school, college, university.	Should not change (record as per TOP date).
Physical health status	PHSTAT	Self-reported physical health (extent of physical symptoms and bothered by illness) score in the 28 days prior to custody of 0 to 20, where 0 is poor and 20 is good.	Should not change (record as per TOP date).
Acute housing problem	ACUTHPBM	Has client had an acute housing problem (been homeless) in the 28 days prior to custody?	Should not change (record as per TOP date).
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.	Should not change (record as per TOP date).
Housing risk	HRISK	Has client been at risk of eviction within the 28 days prior to custody?	Should not change (record as per TOP date).

Field description	CSV header	Definition	Field updatability
Quality of life	QUALLIFE	Self-reported quality of life score (such as able to enjoy life, gets on with family and partner) in 28 days prior to custody of 0 to 20, where 0 is poor and 20 is good.	Should not change (record as per TOP date).

Appendix A: definition of structured treatment

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

Structured treatment definition

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

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

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

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

- harm reduction advice and information
- BBV screening and immunisation
- advocacy
- appropriate access and referral to healthcare and health monitoring
- crisis and risk management support

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 needs hearing aids, or needs to lip-read what people say
3	Manual dexterity	Should be used where the client has 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 eg 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

If client has parental responsibility, do any of these children live with the client? (PRNTSTAT)

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

Code	Reference data	Definition
11	All the children live with client	The client has parental responsibility for one or more children under 18 and in the 28 days prior to entering the secure setting all of the client’s children (who are under 18) lived with them the majority of the time
12	Some of the children live with client	The client has parental responsibility for children under 18 and in the 28 days prior to entering the secure estate some of the client’s children (who are under 18) lived with them the majority of the time
13	None of the children live with client	The client has parental responsibility for one or more children under 18 but in the 28 days prior to entering the secure estate none of the client’s children (under 18) lived with them, they all lived in other locations for the majority of the time.
15	Client declined to answer	Only use where client declines to answer

If client has parental responsibility and/or children living with them, what help are the children receiving? (EHCSC1/2/3)

If either parental responsibility is ‘yes’ or there were children under the age of 18 living in the same house as the client in the 28 days prior to custody then this field should be completed. If more than one option applies, then complete EHCSC2/ EHCSC3 as appropriate.

Code	Reference data	Definition
1	Early Help (family support)	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)
2	Child in Need (LA service)	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
3	Has a Child Protection Plan (LA service)	Social worker has led enquiries under Section 47 of the Children Act 1989. A child protection conference has determined that the child remains at continuing risk of 'significant harm' and a multi-agency child protection plan has been formulated to protect the child
4	Looked after Child (LA service)	Arrangements for the child have been determined following statutory intervention and care proceedings under the Children Act 1989. Looked after children may be placed with parents, foster carers (including relatives and friends), in children's homes, in secure accommodation or with prospective adopters
5	None of the children are receiving any help	None of the children are receiving early help nor are they in contact with children's social care
6	Other relevant child or family support service	Any other child or family support service not mentioned
7	Not known	-
99	Client declined to answer	Question was asked but client declined to answer

Appendix D: discharge reason and exit reason definitions

Discharge reasons

Code	Reference data	Definition
80	Treatment completed – drug free	The client no longer requires structured drug (or alcohol) treatment interventions and is judged by the clinician not to be using heroin (or any other opioid, prescribed or otherwise) or crack cocaine or any other illicit drug
81	Treatment completed - alcohol free	The client no longer requires structured alcohol (or drug) treatment interventions and is judged by the clinician to no longer be using alcohol
82	Treatment completed – occasional user (not opiates or 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
83	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 pathway with two-way communication and care-planned structured drug treatment pathways are available
84	Transferred – in custody	The client has received a custodial sentence or is on remand and a continuation of structured treatment has been arranged. This will consist of the appropriate onward referral of care planning information and a two-way communication between the referring and the receiving secure setting treatment providers to ensure that an assessment and care-planned treatment will be provided as appropriate
74	Transferred – recommissioning transfer	Client has been transferred for ongoing structured treatment at another treatment provider as a result of this service being decommissioned
71	Incomplete - onward	The client has finished treatment at this secure setting

Code	Reference data	Definition
	referral offered and refused	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
85	Incomplete – dropped out	The treatment provider has lost contact with the client without a planned discharge and activities to re-engage the client back into treatment have not been successful
86	Incomplete – treatment withdrawn by provider	The treatment provider has withdrawn treatment provision from the client eg 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
88	Incomplete – treatment commencement declined by the client	The treatment provider has received a referral and has had a face-to-face (or equivalent) contact with the client after which the client has chosen not to commence a recommended structured drug treatment intervention
98	Incomplete – client deported	Without completing their episode of structured treatment, the client has been deported to another country
99	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
89	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 re-present for treatment after more than 21 days, then they will be deemed to have started a new treatment journey.

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

Transferring clients to a secure hospital

When a client is transferred to substance misuse treatment within a secure 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

Transferring a client for court appearance/video links

If a client leaves their current secure estate to attend court (either in person or via a video link) and this requires them to be transferred to another prison for a short time, their episode of treatment at the current estate should be closed down, including:

- Intervention exit date
- Discharge date and reason (transferred – in custody)
- Exit date and exit status (transferred)

If, after their court appearance, the client returns to the original estate within a short period of time the episode may be re-opened by removing the discharge date, discharge reason, exit date and exit status. However, it is important that the old interventions remain closed and new interventions are opened to signal that the client has reengaged in treatment.

Note: This is only permitted in the specific scenarios described above. If the client is released to the community, even if only for a short time, and then re-presents to the secure estate, a new episode of treatment should be opened. It is not permissible to re-open the old episode in this scenario.

Exit reason

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

Code	Reference data	Definition
T	Transferred	The client has been transferred to another secure setting.
R	Released	The client is no longer in a secure setting and has been released.
A	Absconded	The client has escaped from the secure setting without permission.
D	Died	During their time in the secure setting the client has died.

Appendix E: definitions of interventions

Adult secure settings, immigration removal centres (IRCs) and young offender institutions (YOIs) with over 18 populations should use the following interventions.

Clinical interventions

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 (eg 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.

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.

Naltrexone

Naltrexone provided during custodial stay or prior to release 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.

See Drug misuse and dependence: UK guidelines on clinical management for further information.

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

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. See Drug misuse and dependence: UK guidelines on clinical management for further information.

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

Opioid reduction – methadone or buprenorphine

The intervention recorded should reflect the medication prescribed – the 3 options are:

- opioid reduction – methadone
- opioid reduction – buprenorphine
- opioid reduction – buprenorphine depot injection (eg Buvidal)

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. See Drug misuse and dependence: UK guidelines on clinical management, Department of Health. For a planned detoxification the reduction is normally completed within 12 weeks or less, but this time period can be extended depending on response. If there is use of opioid drugs in addition to the prescribed medication, or other significant loss of stability, the reduction must be

reviewed with consideration of the need for dose increase, treatment review and optimisation

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. See Drug misuse and dependence: UK guidelines on clinical management, Department of Health.

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.

Opioid maintenance – methadone or buprenorphine

The intervention recorded should reflect the medication prescribed – the 3 options are:

- opioid maintenance – methadone
- opioid maintenance – buprenorphine
- opioid maintenance – buprenorphine depot injection (eg Buvidal)

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.

It should also be considered where 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. See updated guidance for prison based opioid maintenance prescribing for further information.

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.

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 standalone 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.

Psychosocial interventions

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 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.

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.

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.

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 a 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.

Alcohol – brief intervention

This intervention should be used for recording brief interventions for alcohol. 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 or who would benefit from a brief intervention prior to release (including release on temporary license).

- 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, including prior to release. See 2011 NICE alcohol commissioning guidance.

Further definitions are provided in the 2011 NICE alcohol commissioning guidance.

Brief interventions for alcohol that are delivered in isolation (without other structured treatment) do not need to be reported to NDTMS.

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 (or equivalent) contact where a simple or extended brief intervention has been provided.

Appendix F: 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 (eg 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. However, 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 and aimed at meeting mental health needs. Examples of this kind of intervention include 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 G: recording TOP in secure settings

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

There are 3 different areas covered by the TOP – substance use, substance risk behaviours and health and social functioning. The latter includes information on psychological health, physical health, work/education, housing and overall quality of life.

The TOP should be completed for all adult clients within 2 weeks of their initial reception, ideally when the client is being assessed for their treatment need. This may be on the date of initial reception into custody or shortly thereafter.

The TOP should reflect the 28 days prior to custody and 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 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. 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 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 should be used for all structured substance misuse clients except those being treated in Immigration Removal Centre's (IRC's). All questions on the form should be answered; zero should be recorded where the client does not use that particular substance and NA used when the question has not been answered.

In the community, adult treatment providers record TOP with clients at treatment start and at regular review points as part of a review of the service user's recovery care plan. Community treatment providers also complete the TOP at treatment exit.

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

Appendix H: continuity of care for clients transferred to a community provider

This document outlines the correct data process for transferring clients from a secure setting to a community provider. This data process should be followed to ensure that the number of clients being transferred is not overinflated in the data.

Transferring clients from a secure setting to a community provider

If a client is engaged in structured treatment in the secure setting and is coming to the end of their sentence to be released into the community you will need to consider their discharge reason. You may encounter the following scenarios:

The client requires ongoing structured treatment in the community (see Appendix A for the definition of structured treatment):

- Their discharge reason should be recorded as ‘transferred – not in custody’ (see Appendix D for the discharge reason definitions)
- The referral on release status should be ‘referred to structured treatment provider’ or ‘referred to structured treatment provider and recovery support’ as appropriate
- The appropriate discharge date must be completed
- The client should have a prison exit reason of ‘released’ and the prison exit date should be the date that they left the prison
- The exit destination should be populated with the Local Authority that the client is being transferred to
- Two way communication should take place between the prison provider and the community provider to ensure the opportunities for continuity of care are maximised

The client requires ongoing structured treatment but does not want to engage with a community service:

- Their discharge reason should be recorded as ‘onward referral offered and refused’.

- The ‘referral on release status’ is likely to be ‘no onward referral’.
- The appropriate discharge date must be completed.
- The client should have a prison exit reason of ‘released’ and the prison exit date should be the date that they left the prison.
- The exit destination should be populated with the Local Authority that the client is being released to.

The client requires ongoing non-structured recovery support treatment only:

- Their discharge reason should be recorded as ‘treatment complete – drug free’, ‘treatment complete – alcohol free’ or ‘treatment complete – occasional user (not opiates or crack)’.
- The referral on release status would be ‘referred to recovery support services’.
- The appropriate discharge date must be completed.
- The client should have a prison exit reason of ‘released’ and the prison exit date should be the date that they left the prison.
- The exit destination should be populated with the Local Authority that the client is being released to.

The client DOES NOT require any further/ongoing treatment or recovery support in the community. They have completed all elements of their Care Plan and are drug and/or alcohol free.

- Their discharge reason should be ‘Treatment completed – drug free’ or ‘Treatment completed – alcohol free’.
- The referral on release status would be ‘no onward referral’.
- The appropriate discharge date must be completed.
- The client should have a prison exit reason of ‘released’ and the prison exit date should be the date that they left the prison.
- The exit destination should be populated with the Local Authority that the client is being released to.

The client was unexpectedly released from court and therefore the prison treatment provider has been unable to transfer the client's care to the community provider in a planned way.

- Their discharge reason should be 'Incomplete – client released from court'.
- The referral on release status would be 'no onward referral'.
- The discharge date should be the last face-to-face (or equivalent) contact with the client.
- The client should have a prison exit reason of 'released' and the prison exit date should be the date that they left the prison.
- The exit destination should be populated with the Local Authority that the client was released to.

Note: a client should only be recorded as 'transferred' if there is an ongoing structured treatment need.

If you record 'transferred' for clients that you refer for recovery support only, the discharge reason/referral on release status is incorrect.

Further structured treatment – ensuring linkage of data

NDTMS uses client's initials, DOB and sex to link prison to community treatment episodes. It is important that this information is accurately recorded on NDTMS to ensure linkage is possible. For those continuing in structured treatment the secure setting should provide the receiving community service with relevant information via appropriate secure communication methods.

For community teams it is also helpful for them to know the 'Prison Exit Date' so that they can plan for the client's return to the community.

Two way communication

If a client is being transferred for ongoing structured treatment there should be two way communication between the secure estate and the community treatment provider. The community treatment provider should be expecting the client and ideally the client should be given an appointment with a specific date and time that they need to attend the community treatment provider.

Appendix I: housing situation

Code	Reference data	Definition
1	Owns home	-
2	Rented home only – self-contained – rents from a private landlord	-
3	Rented home only – self-contained - rents from a social landlord (local authority or housing association)	-
4	Rented home only – shares facilities - rents from a private landlord	Shares facilities with others, eg shared kitchen or bathroom
5	Rented home only – shares facilities - rents from a social landlord (local authority or housing association)	Shares facilities with others, eg shared kitchen or bathroom
6	Other – university or college accommodation	-
7	Other – living with friends permanently	-
8	Other – living with family permanently	-
9	Other – supported accommodation	Where housing, support and sometimes care services are provided to enable independent living. Permanent solution, not a homelessness response
10	Other – healthcare setting	eg mental health institution or hospital
11	Other – accommodation tied to job (including Armed Forces)	-
12	Other – approved premises	Approved premises offer an enhanced level of public protection in the community and are used primarily for high and very high risk of serious harm individuals released on licence from custody (have been called bail or probation hostels in the past)
13	Other – authorised Gypsy and Traveller site	-

14	No home of their own – living with friends as a short-term guest	Has own bed space
15	No home of their own – living with family as a short-term guest	Has own bed space
16	No home of their own – sofa surfing (sleeps on different friends' floor or sofa each night)	Does not have a bed space
17	No home of their own – lives on the streets/rough sleeping	-
18	No home of their own – squatting	-
19	No home of their own – night/winter shelter	-
20	No home of their own – bed and breakfast, or other hotel	-
21	No home of their own – hostel	-
22	No home of their own – supported accommodation	Where housing, support and sometimes care services are provided to enable independent living – specifically provided as a temporary solution to alleviate homelessness/enable move to more permanent situation
23	No home of their own – temporary housing	Other forms of temporary housing not already stated
24	No home of their own – unauthorised Gypsy and Traveller encampment	-

Revision history

Version	Author	Change
7.3	J Palmer	PREGNANT - removed "applies to female clients only" Formatting updates
7.2	A Rimell	Updates made since V7.1 Format of the document changed to Department of Health and Social Care (DHSC) standard. Changes to text to reflect the transition of NDTMS from Public Health England (PHE) to the Office of Health Improvement and Disparities (OHID). Minor corrections to the text and updates to hyperlinks. General updates to improve accessibility.
7.1	P Brand	Updates made since V7.0 RECONNECT – text update to definition ‘This field should be populated if the client’s exit status is ‘released’.’ and to field updatability ‘Required when the client is released. Should not change (record as at release from secure setting).’ HOMELESSEXIT – text update to definition ‘This field should be populated if the client’s exit status is ‘released’’ and to field updatability ‘Required when the client is released. Should not change (record as at release from secure setting).’
7.0	P Brand W Richardson	CDS-Q New headers HOUSING – What is the client’s current housing situation? DOMVIC – Has the client ever been the victim of domestic abuse? DOMPER – Has the client ever abused someone close to them? HIVTESTDT – HIV latest test date SEXWORK – Has the client ever received money or goods in exchange for sex? RECONNECT – Has the client been provided with Reconnect support? HOMELESSEXIT – Is the client threatened with homelessness in the 56 days (8 weeks) following exit from secure estate? BINGEDRINK – How often has the client had 6 or more units if female, or 8 or more if male, on a single occasion in the last 28 days VOLNPWORK – Days in volunteering or unpaid structured work placement New reference data items Opioid maintenance – buprenorphine depot injection (eg Buvidal) Opioid reduction – buprenorphine depot injection (eg Buvidal) Dropped headers

Version	Author	Change
		TRSTAGE – Treatment stage DAYSVOLN – Days in volunteering UPDWORK – Days in unpaid structured work placement Amendments SEX – field description changed to ‘client stated sex’ from ‘client stated sex at registration of birth’ PRNTSTAT – field description changed to ‘If client has parental responsibility, do any of these children live with the client?’ from ‘Do any of these children live with the client?’ EHCSC (1)(2)(3) – field description changed to ‘If client has parental responsibility and/or children living with them, what help are the children receiving?’ from ‘What help are the client’s children/children living with the client receiving?’ NPSUSE – field description ‘Use of New Psychoactive Substances (NPS) during treatment’ changed to ‘Use of Psychoactive Substances (PS) during treatment Appendix I added SEX – field definition changed to ‘The sex as stated by the client on their birth certificate or gender recognition certificate.’ CONSENT – field definition changed to ‘Whether the client has agreed for their data to be shared with NDTMS. Informed and evidenced consent must be sought from all clients. For further information on obtaining NDTMS consent, see NDTMS consent and confidentiality guidelines.’ EHCSC (1)(2)(3) - field definition changed to ‘Prior to entering custody, what help are the client's children and/or any other children living with the client receiving? This question only applies to the children aged under 18 for which the client has parental responsibility (regardless of whether this child lives with the client or not) and to children aged under 18 living with the client (regardless of whether the client has parental responsibility or not).’