



CLIENT REF KEYWORKER ** DOB

SEX M F START REVIEW EXIT POST EXIT DATE

To be completed at treatment start and exit by the keyworker with the client

Use 'N/A' only if the client does not disclose information or does not answer

SUBSTANCE USE	How many days in the past 28 have you used any of these substances? On an average using day, how much did you use/drink? How old were you when you first used these substances?				
	Number of days used in the past 28 days	Amount used on an average using day	GRAMS	UNITS	Age when substance first used*
A. Cannabis	<input type="text"/> 0-28	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
B. Alcohol	<input type="text"/> 0-28	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
C. Tobacco/nicotine	<input type="text"/> 0-28	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
D. Opiates (Illicit)	<input type="text"/> 0-28	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
E. Crack	<input type="text"/> 0-28	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
F. Cocaine	<input type="text"/> 0-28	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
G. Ecstasy	<input type="text"/> 0-28	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
H. Amphetamines	<input type="text"/> 0-28	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
I. Solvents	<input type="text"/> 0-28	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
J. Ketamine	<input type="text"/> 0-28	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
K. GHB	<input type="text"/> 0-28	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
L. Psychoactive Substances	<input type="text"/> 0-28	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
M. Tranquilisers	<input type="text"/> 0-28	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
N. Other substance 1 Specify:	<input type="text"/> 0-28	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
O. Other substance 2 Specify:	<input type="text"/> 0-28	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
P. Other substance 3 Specify:	<input type="text"/> 0-28	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

RISK BEHAVIOUR	Tick YES or NO to the following questions		
	A. Alcohol use	In the past 28 days have you drunk more than 8 units (male) or more than 6 units (female) during a single drinking episode?	Yes <input type="checkbox"/>
B. Ever injected*	Have you ever injected a substance?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
C. Injecting	If yes, have you injected a substance within the past 28 days?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

PATTERNS OF USE	Tick YES or NO to the following questions					
	A. During the past 28 days, have you drunk alcohol:			B. During the past 28 days, have you used any of the other substances listed above (except tobacco):		
On a weekday, during the daytime	Yes <input type="checkbox"/>	No <input type="checkbox"/>	On a weekday, during the daytime	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
On a weekday, during the evening	Yes <input type="checkbox"/>	No <input type="checkbox"/>	On a weekday, during the evening	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
On a weekend, during the daytime	Yes <input type="checkbox"/>	No <input type="checkbox"/>	On a weekend, during the daytime	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
On a weekend, during the evening	Yes <input type="checkbox"/>	No <input type="checkbox"/>	On a weekend, during the evening	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
On your own	Yes <input type="checkbox"/>	No <input type="checkbox"/>	On your own	Yes <input type="checkbox"/>	No <input type="checkbox"/>	

HEALTH AND WELLBEING	How do you feel about your life? Think about how you feel at the moment. On the scale circle the score that is true for you	
	A. Overall, how satisfied are you with your life today?	0 1 2 3 4 5 6 7 8 9 10
B. Overall, how anxious did you feel yesterday?	0 1 2 3 4 5 6 7 8 9 10	not at all anxious extremely anxious
C. Overall, how happy did you feel yesterday?	0 1 2 3 4 5 6 7 8 9 10	not at all happy extremely happy
D. Overall, how well do you get on with your family?	0 1 2 3 4 5 6 7 8 9 10	not at all well extremely well
E. Overall, how well do you get on with your friends?	0 1 2 3 4 5 6 7 8 9 10	not at all well extremely well
F. Unsuitable housing Housing situation that is likely to have a negative impact on health and wellbeing and/or on the likelihood of achieving positive outcomes.	Yes <input type="checkbox"/>	No <input type="checkbox"/>

* Answer at start only ** Not submitted to NDMS. For quantity use whichever measurements you find most useful for that substance.

YP COMBINED REVIEW FORM - CLIENT INFORMATION REVIEW (CIR)

CLIENT REF CIR DATE STAGE: PARTIAL FULL (6 monthly)

Can be completed when any of the answers change (partial), and at least every 6 months (full)

BBV	Hep B intervention status ^	Offered & accepted: Not yet had any vaccinations <input type="checkbox"/>	Immunised already <input type="checkbox"/>		
		Offered & accepted: Started vaccinations <input type="checkbox"/>	Not offered <input type="checkbox"/>		
		Offered & accepted: Completed course <input type="checkbox"/>	Not appropriate to offer <input type="checkbox"/>		
		Offered & refused <input type="checkbox"/>	Deferred-clinical reason <input type="checkbox"/>		
	Hep C intervention status ^	Offered & accepted: Not yet had a test <input type="checkbox"/>	Not offered <input type="checkbox"/>		
		Offered & accepted: Had a hep C test <input type="checkbox"/>	Not approp. to offer <input type="checkbox"/>		
		Offered & refused <input type="checkbox"/>	Deferred-clinical reason <input type="checkbox"/>		
HOME	Is the client threatened with homelessness in the next 56 days (8 weeks)? ^	Yes <input type="checkbox"/>	No <input type="checkbox"/>		
	Has the client ever been the victim of domestic abuse? ^	Yes - currently <input type="checkbox"/>	Yes - previously <input type="checkbox"/>	Yes - curr and prev <input type="checkbox"/>	No <input type="checkbox"/>
ABUSE		Declined to answer <input type="checkbox"/>	Not app. to ask <input type="checkbox"/>		
	Has the client ever abused someone close to them? ^	Yes - currently <input type="checkbox"/>	Yes - previously <input type="checkbox"/>	Yes - curr and prev <input type="checkbox"/>	No <input type="checkbox"/>
		Declined to answer <input type="checkbox"/>	Not app. to ask <input type="checkbox"/>		
HEALTH	Has YP been offered a screen for STIs (including Chlamydia)? ^	Offered and accepted <input type="checkbox"/>	Offered and refused <input type="checkbox"/>	Assessed as not appropriate to offer <input type="checkbox"/>	
	Latest health care assessment date	<input type="text"/>			
SAFEGUARDING	Is YP subject to a Child Protection Plan? ^	Never <input type="checkbox"/>	Previously <input type="checkbox"/>	Currently <input type="checkbox"/>	
	Pregnant?	Yes <input type="checkbox"/>	No <input type="checkbox"/>		
	Parental responsibility for a child aged under 18 years? ^	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Declined to answer <input type="checkbox"/>	
	If client has parental responsibility, do any of these children live with the client?	All <input type="checkbox"/>	Some <input type="checkbox"/>	None <input type="checkbox"/>	Declined to answer <input type="checkbox"/>
	How many children under 18 in total live in the same house as the client? ^	<input type="text" value="0-30"/>		Undisclosed number <input type="checkbox"/>	Declined to answer <input type="checkbox"/>
	If client has parental responsibility and/or children living them, what help are the children receiving?	Early help (family support) <input type="checkbox"/>	None receiving any help <input type="checkbox"/>		
		Child in need (LA service) <input type="checkbox"/>	Declined to answer <input type="checkbox"/>		
	CPP (LA service) <input type="checkbox"/>	Other relevant child or family support service <input type="checkbox"/>			
	(record up to 3 options)	Looked after child (LA service) <input type="checkbox"/>	Not known <input type="checkbox"/>		
MENTAL HEALTH	Does client have a mental health treatment need? ^	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Declined to answer <input type="checkbox"/>	
	Is client receiving treatment for their mental health need?	Community mental health team <input type="checkbox"/>			
		Improved Access to Psychological Therapy (IAPT) <input type="checkbox"/>			
		Receiving mental health treatment from GP <input type="checkbox"/>			
		Receiving NICE recommended intervention <input type="checkbox"/>			
	(If yes, record up to 3 options)	Has space in health based place of safety for crises <input type="checkbox"/>			
		Treatment need identified but no treatment being received <input type="checkbox"/>			
	Client declined treatment <input type="checkbox"/>				

^ indicates that field completion is required if completing a 'full' CIR.

YP COMBINED REVIEW FORM - SUB INTERVENTION REVIEW (SIR)

CLIENT REF

SIR DATE

Proportion of face-to-face appointments with keyworker

All face-to-face/ Mostly face-to-face/Equal mix/ Mostly digital/All digital

To be completed at 6 monthly review and exit by the keyworker (client doesn't need to be present)

PSYCHOSOCIAL	Cognitive and behavioural interventions	<input type="checkbox"/>	Multi-component programmes	<input type="checkbox"/>
	Motivational interventions	<input type="checkbox"/>	Contingency management	<input type="checkbox"/>
	Structured family interventions	<input type="checkbox"/>	Counselling	<input type="checkbox"/>
MULTI-AGENCY WORKING	Education/training	<input type="checkbox"/>	Sexual health/pregnancy	<input type="checkbox"/>
	Employment/volunteering	<input type="checkbox"/>	Meaningful activities	<input type="checkbox"/>
	Housing	<input type="checkbox"/>	Disability services	<input type="checkbox"/>
	Generic family support	<input type="checkbox"/>	Behavioural services	<input type="checkbox"/>
	Generic parenting support	<input type="checkbox"/>	Young carers	<input type="checkbox"/>
	Peer support involvement/mentoring	<input type="checkbox"/>	Smoking cessation	<input type="checkbox"/>
	Mental health	<input type="checkbox"/>	Youth services	<input type="checkbox"/>
	Offending	<input type="checkbox"/>	Children's social care	<input type="checkbox"/>
	Client provided with domestic abuse support for victim/survivor	<input type="checkbox"/>	Client provided with domestic abuse support for perpetrator	<input type="checkbox"/>
	Health	<input type="checkbox"/>		

WHEN AND HOW TO COMPLETE THE YOUNG PEOPLE'S OUTCOMES RECORD (YPOR)

Complete the green section within 2 weeks either side of the first intervention start date at the beginning of a young person's treatment journey.

All sections should be completed within 2 weeks either side of the discharge date of when the young person's treatment journey ends.

The questions in the green section should focus on the 28 days before the date the form is being completed. You can also complete the record at regular points during treatment (for example, at care-plan reviews), though this is not mandatory.

Start by entering the details of the young person and keyworker, and the date and treatment stage at which the form is being completed. The young person and keyworker should then complete this form together.

There are 5 kinds of questions:

- (1) Days – the number of using days in the past 28 days. Use an event-based calendar with the young person to improve recall, but only record the total here.
- (2) Quantity – the amount used on an average using day.
- (3) Age – the age (in years) the young person first used the substance, whether or not this was first problematic use. Round down to get a whole number: for example, if the young person was 14 and a half, record the age as 14.
- (4) Yes and no – a simple tick for yes or no.
- (5) Ratings scale – an 10-point scale from poor to good. Together with the young person mark the scale at an appropriate place.

All information from the YPOR will be collected and reported to the same standards of confidentiality and security as other information collected during treatment. For more details, see the consent and confidentiality toolkit issued as part of the core dataset documentation.

Ounces to grams converter

Ounces	Grams
One ounce	28
Half an ounce (½)	14
Quarter of an ounce (¼)	7
Eighth of an ounce (⅛)	3.5
Sixteenth of an ounce (1/16)	1.8

Alcohol units converter

Drink	%ABV	Units
Pint ordinary strength lager, beer or cider	3.5	2
Pint strong lager, beer or cider	5	3
440ml can ordinary strength lager	3.5	1.5
440ml can strong lager, beer or cider	5	2
440ml can super strength lager or cider	9	4
1 litre bottle ordinary strength cider	5	5
1 litre bottle strong cider	9	9

Drink	%ABV	Units
Glass of wine (175ml)	12	2
Large glass of wine (250ml)	12	3
Bottle of wine (750ml)	12	9
Single measure of spirits (25ml)	40	1
Bottle of spirits (750ml)	40	30
275ml bottle alcopops	5	1.5