Home Office

Ministry of JUSTICE

NHS
National Treatment Agency for Substance Misuse

DRUG INTERVENTIONS RECORD

Completion Guidelines & Field by Field Guidance for the Drug Interventions Record suite of forms

Applies to the suite of forms in use from 1 April 2009

DH Department of Health

Version 1.0

CONTENTS

1 Introduction

This guidance document is for community and prison DIP teams in England and Wales. It outlines how to complete the Drug Interventions Record suite of forms, providing general completion guidelines and more detailed “field by field” guidance for completing each of the fields on the forms. Each form is described separately.

2 Drug Interventions Record (DIR)

2.1 Overview - DIR

1. The responses to some questions on the DIR are used for both continuity of care and monitoring and research.

- **The left-hand - blue portion - of this form collects information that will be used to support continuity of care for the client**

- **The right-hand - green portion - of the form collects information that will only be used for monitoring and research purposes**

2. Almost all fields will be used by both community and prison teams in England and Wales. Where there is a difference:

- Prisons-only fields are marked with a **P**

- Community-only fields are marked with a **C**

3. The free text boxes, within the continuity of care sections, should be used with thought. Details given should be brief and relevant and designed to assist the continuity of care - not to summarise all the available information / opinion relating to the client.

4. Throughout the whole form, but particularly on the monitoring and research (M&R) side, you should give all the details requested and use the required format, wherever one is specified. Comprehensive, accurate and consistent completion is vital if the data collected is to be meaningful and informative.

Consent

5. Key points to remember are:
- Consent is not required for monitoring and research purposes but, as good practice, clients should be told that information will be used in this way. (See DIR for a form of words);
- Informed consent is required to share client information for continuity of care purposes;

- Consent may be given or withdrawn at any stage of the process e.g. at arrest or when on the caseload. If a client has initially refused, ask again at any appropriate point;
- Consent is not a condition of access to treatment but lack of consent may delay service delivery and involve additional assessments. This needs to be explained in detail to the client;
- Any local arrangements for sharing information need to be covered by local consent documents and local information sharing protocols.

Exit points

6. Exit points are highlighted at the relevant points throughout these guidelines. An Exit Point is a point at which an episode of engagement with a client closes and the M&R section of the form is sent to the data manager or equivalent. It does not necessarily mean the client leaves the Programme.

KEY POINT

In the community, if the DIR is not being used as part of the assessment tool and the contact does not lead to a care plan, only the green section (monitoring and research) needs to be completed.

In prisons, both sections (blue and green) should always be completed; the DIR should always stay with the CARATs file and a photocopy should be sent to CJITs.

The filing and storage of DIR forms should always be undertaken in line with local guidance and the Data Protection Act (DPA).

The full, potential Exit Points are:

EXIT POINT 1 Further intervention is not needed (8.1)

Complete green sections only of DIR up to, and including, 8.1 and send to DIP local or regional Data Manager.

CARATs/Healthcare teams will complete both (blue & green) sections of the DIR, and then detach the green section (M&R) and send it to the Regional Data Manager. Blue section (Continuity of Care) will be kept in a separate file within the CARATs office.

EXIT POINT 2 Further intervention is required but not accepted (8.2) and no Follow up Assessment has been given

8.2 is only an EXIT point where the individual does not accept further intervention and no Follow up Assessment has been imposed (community)[1]. Complete green sections only of DIR up to and including 8.2, recording reason for refusal and send to DIP local or regional Data Manager.

CARATs/Healthcare teams will complete both (blue & green) sections of the DIR up to 8.2; the complete form should be retained for 4 weeks to enable the CARAT worker to return to the individual to establish whether or not they now wish to engage. If the client still does not wish to engage then the worker should detach the green section (M&R) and send it to the Regional Data Manager. The Blue section (Continuity of Care) will be kept in a CARATs casework file as the client may wish to re-engage at a later date. If the client re-engages then the initial DIR could be used as a reference tool. If within 6 months of the SMTA the client changes their mind and wishes to re-engage with CARATs this may be recorded on an Activity Form (5.1 & 5.2); if the client agrees to re-engage outside of this timeframe (6 months) then a new DIR will need to be completed instead.

EXIT POINT 3 Client transferring to DAT of residence prior to care plan – CJIT to DAT/CSP of residence (8.3) **(CJIT ONLY)**

Complete both sections (blue & green) of DIR up to, and including, 8.4 where appropriate.

[1] If, in the community, a Follow up Assessment is given the CJIT worker should continue to complete the DIR (attempting to agree a care plan with the individual at 9.3) as part of the Follow-up Assessment process.

Send DIR green sections completed up to 8.4 to the DIP local or Regional Data Manager of the CJIT who carried out the assessment, and, with client consent, send DIR blue sections, completed up to 8.4, to new CJIT Single Point of Contact.

EXIT POINT 4 Client transferring to prison but prior to care plan - CJIT to Prison (8.5)
(CJIT ONLY)

Complete both sections (blue and green) of DIR up to and including 8.5 where appropriate.

Send DIR green sections, completed up to 8.5, to the DIP local or Regional Data Manager of the CJIT who carried out the assessment and, with client consent, send DIR blue sections, completed up to 8.5, to the prison CARATs team.

EXIT POINT 5 Client transferring to DAT of residence following assessment but prior to care plan – CARATs to DAT/CSP of residence (8.6)
(CARAT ONLY)

Send DIR green sections, completed up to 8.7, to the DIP local or Regional Data Manager of the prison that carried out the assessment, and with client consent send DIR blue sections, completed up to 8.7, to the CJIT Single Point of Contact. A copy of the blue section will be kept in a separate file within the CARATs office.

EXIT POINT 6 Client transferring to another prison following assessment but prior to care plan – CARATs to another prison (8.8)
(CARAT ONLY)

Send DIR green sections, completed up to 8.8, to the Regional Data Manager of the prison that carried out the assessment and, with client consent, send DIR blue sections to the new prison CARATs team. A copy of the blue section will be kept in a separate file within the CARATs office.

EXIT POINT 7 A CSMA is not completed for the client (9.1)
(CARAT ONLY)

CARATs teams will complete both (blue and green) sections of the DIR, recording the date the CSMA was not completed at 9.1 (this could be the date the CSMA appointment was not attended), and then detach the green section (M&R) and send it to the Regional Data Manager. The blue section (Continuity of Care) will be kept in a CARAT casework file as the client may wish to re-engage at a later date. If the client re-engages then the initial DIR could be used as a reference tool; the CARAT Worker will use the Activity Form to re-engage the client if they re-engage within 6 months of the SMTA (as under EXIT point 2), otherwise a new DIR will need to be completed.

EXIT POINT 8 Client does not agree to care plan (9.3) (see note at Key Point)

CJITs - complete green sections only of DIR up to and including 9.3, recording date of refusal. Send to the DIP local or regional Data Manager.

CARATs teams will complete both (blue and green) sections of the DIR and then detach the green section (M&R) and send it to the Regional Data Manager. Blue section (Continuity of Care) will be kept in a CARAT casework file as the client may wish to re-engage at a later date. If the client re-engages then the initial DIR could be used as a reference tool; the CARAT Worker will use the Activity Form to re-engage the client if they re-engage within 6 months of the SMTA (as under EXIT point 2), otherwise a new DIR will need to be completed.

7. When the DIR has been completed, up to and including 9.6 where appropriate, send green sections to the DIP local or regional Data manager and either retain blue sections on file and copy and send to next appropriate worker, for example if CJIT services are located on separate sites, or if appropriate for the Tier 3 specialist service.

8. CARATs/Healthcare teams will complete both (blue & green) sections of the DIR and then detach the green section (M&R) and send it to the Regional Data Manager. The blue section (Continuity of Care) is part of the CARATs casework file and should be filed there.

9. All papers must be dealt with in line with local procedures, which must be in accordance with DPA and FOI requirements.

10. "Taken onto the caseload": for the purposes of the DIR, a client is "taken onto the caseload" when a case manager (CJIT worker or CARATs worker) is allocated and a care plan is agreed with that client, and this is indicated in 9.3 of the DIR.

11. **For CARATs teams:** Clients will be deemed to be on the "Active caseload" once a CSMA and Care Plan has been completed and agreed. This is to reflect the fact that the CSMA and Care Plan are regarded as Tier 3 Interventions and this mirrors what is happening in the community. The SMTA is regarded as a Tier 2 Intervention, and whilst the client would not be deemed to be on the "Active caseload" at this point it will not preclude CARATs teams from working with the client whilst awaiting an appointment to complete the CSMA and Care Plan. These clients are known as "triage" cases and work will be delivered within an Initial Care Plan.

12. **For the Community only:** If an initial care plan is drawn up and agreed at Tier 2 level, even though at that point the CJIT worker is aware that a further, comprehensive care plan assessment is required via a specialist Tier 3 provider, that client may be treated as taken onto the CJIT caseload. This is only if, as above, a case manager is allocated at that point and the initial care plan is agreed with the client.

11. The DIR and Activity Form both require DAT, Prison and Treatment Agency codes. The DAT and Prison codes can be found on the Home Office website www.drugs.gov.uk/drug-interventions-programme/guidance/DIR. The treatment agency codes should be obtained from your regional NTA team.

12. Annex A of this document provides guidance on the terminology associated with homelessness.

2.2 Field by Field - DIR

DRUG INTERVENTIONS RECORD (DIR)				
Section on form	**Field**	**Guidance**		**Completion Guidance**
		Continuity of Care	**Monitoring & Research**	
Section 1 Form Completion				
1.1	Name (Person 1)	Full name	Full name	Name of drug worker completing the DIR rather than agency name
	Phone	Full phone number (including area code)	Full phone number (including area code	Contact phone number of drug worker who completed the form; either landline, mobile or both.
	Sections completed	Tick more than one box where appropriate	Tick more than one box where appropriate	Only tick to indicate a completed section if every question from that section has been completed. If the whole DIR form has been completed, tick “all” rather than each individual section. This allows another worker or the Data Manager to seek clarification if required.
	DAT/Prison name	Full name of DAT/CSP/Prison	Full name of DAT/CSP/Prison	Name of either the DAT/CSP area or Prison in which Person 1 works. NB. Reference to DAT means DAT or CSP (Community Safety Partnership)
	Name (Person 2)	Full name	Full name	Name of drug worker completing the DIR rather than agency name
	Phone	Full phone number (including area code)	Full phone number (including area code	Contact phone number of drug worker who completed the form; either landline, mobile or both.
	Sections completed	Tick more than one box where appropriate	Tick more than one box where appropriate	Only tick to indicate a completed section if every question from that

				section has been completed. If the whole DIR form has been completed, tick “all” rather than each individual section. This allows another worker or the Data Manager to seek clarification if required.
	DAT/Prison name	Full name of DAT/CSP/Prison	Full name of DAT/CSP/Prison	Name of either the DAT/CSP area or Prison in which Person 1 works. NB.Reference to DAT means DAT or CSP (Community Safety Partnership)
1.2	Name	Full name of receiving drug worker to whom form is being sent.	[redacted]	Full name (if known) of receiving drug worker – this is usually someone in a physically separate part of the same CJIT, or in a different CJIT if individual resides out of area, or a CARAT/Healthcare Team member. This section should be completed as fully as possible.
	Organisation	Full team/agency name		Full name of the team/agency which the DIR will be sent to (either internal of the CJIT or external (either other CJIT or CARAT) in which Receiver 1 works.
	Phone	Full phone number (including area code)		Contact phone number of Receiver 1. Even if the worker is based within the original CJIT or CARAT, the full phone number including extension should be included.
	Date sent	DD/MM/YYYY format		Date that the DIR form was sent, not when it was first opened.
	Name	Full name of receiving drug worker receiving the form in addition to the first named		Where the form is sent to more than one person, the first person’s name should be included as the first

		person.	[redacted]	person (Receiver 1) in 1.2; the most prominent other person should be included as the second name (Receiver 2).
	Organisation	Full team/agency name		Full name of the team/agency which the DIR will be sent to (either internal of the CJIT or external (either other CJIT or CARAT) in which Receiver 2 works.
	Phone	Full phone number (including area code)		Contact phone number of Receiver. Even if the worker is based within the original CJIT or CARAT, the full phone number including extension should be included.
	Date sent	DD/MM/YYYY format		Date that the DIR form was sent, not when it was first opened.
Section 2 About the client				
2.1	First Name	Client's first name in full	[redacted]	
	First Initial	[redacted]	One character only – first letter of client's first name.	
	Surname	Client's surname in full	[redacted]	
	Surname initial	[redacted]	One character only – first letter of client's surname	Names such as "O'Connell" should be recorded as "O". For clients with double-barrelled surnames, record the first letter of the first surname only.
	Date of birth	DD/MM/YYYY format	DD/MM/YYYY format	
	Gender	Tick one box only	Tick one box only	
	Number	This field should not be completed until required (guidance will be provided).	This field should not be completed until required (guidance will be provided).	
2.2	Address	Full residential address	[redacted]	Full residential address is needed. If this is not known the worker

			[redacted]	should provide as much information as possible.
	Contact details – Postcode	Full postcode if known	If a postcode is available, enter the first part of the client's postcode excluding the last two letters of the second part of the postcode (e.g. OX11 2BA would be recorded as OX11 2XX).	
	No fixed abode	Tick if applicable	Tick if applicable	
	Phone number	Full landline number (including area code)	[redacted]	The phone number listed should be the number the client is most likely to be contactable on.
	Mobile number	Full mobile number (if appropriate)		
	Prison number	Enter full prison number		Enter the prison number from, for example, the referral, LIDS etc
	Location (wing/cell)	Enter full location		Enter the location at the time the form is completed, eg from the referral, from LIDS etc. This information will need to be kept up to date for continuity of care purposes.
2.3	Please state first language	For all areas to state in the free text box what the individual's first language is; answer must be given by the client.	**Wales only** – Complete the 3 digit box	**Wales only** – provide the code from the substance misuse common data set.
2.4	Does the individual being assessed consider themselves to have a disability?	Tick one box only	Tick one box only	Must be as stated by the client. As a subjective answer is required, there is no standard definition which will be adopted for the purpose of completing this question.
2.5	Disabilities/Special needs	Free text box. Detail as	[redacted]	Information should ideally be based

		provided by individual and/or observed by the worker (eg restricted mobility, literacy, education levels).	[redacted]	on that given by the client. Drug workers should only make comments if a disability/special need is obvious from the assessment, and if the individual has elected not to mention it. Such examples could include literacy problems, restricted/impaired mobility, reduced education levels.
2.6	Is client pregnant?	Tick Yes or No. If Yes, insert due date. If due date is not known, tick 'due date not known'.	Tick Yes or No. If Yes, insert due date. If due date is not known, tick 'due date not known'.	Must be as stated by the client
	Give due date	DD/MM/YYYY format or 'due date not known'	DD/MM/YYYY format or 'due date not known'	If client does not know whether she is pregnant or not, the answer should be recorded as 'no'. The due date is the expected date of the birth.
2.7	Is client a PPO?	Tick one box only	Tick one box only	Has the client been identified as being on a Prolific and other Priority Offender Scheme? **Note for prisons staff only:** This box is for completion by CARATs staff only, not Healthcare staff.
2.8	Nationality at birth	Country of nationality at birth - enter the ISO 3-letter country code	Country of nationality at birth - enter the ISO 3-letter country code	Country of nationality at birth must be as stated by the client. If they do not wish to give an answer, the 'Not stated' code ZZZ should be used. Annex B contains a list of country codes, e.g. GBR = United Kingdom. This list should be made available to workers for reference.
2.9	Ethnic group	Tick one box only	Tick one box only	Must be as stated by the client. If

				they do not wish to give an answer, the 'Not stated' box should be used.
2.10	Religion	Tick one box only	Tick one box only	Must be as stated by the client. If they do not wish to give an answer, the 'Not stated' box should be used.
2.11	Please give details of issues requiring immediate attention/action by CJIT/CARATs workers	Optional free text box - information should be included which needs immediate action by drug worker. This section should NOT be used as a matter of routine, rather it should be the first point of reference for the CJIT/CARAT worker receiving the DIR for continuity of care purposes. It should be used to highlight those issues which need **immediate** action/attention. **If this box is used, please tick the immediate action box on page 1.**	[redacted]	The worker who has carried out the assessment should summarise key points which need **immediate** action by recipient in partner agency. This section may be used to record information from a local risk assessment and might be used to record risk or history of overdose, self-harm, risk to others including workers, urgent accommodation issues, mental or physical health issues and/or specific needs that might affect the client's ability to understand what is happening to them (eg learning impairment). All issues should be written as accurately and precisely as possible to enable the drug worker to be aware of them and take the necessary action. What constitutes immediate issues will be for the worker to decide; based on their previous experience and knowledge of the individual case. This section does not constitute a risk assessment for the worker or the client and does not supersede any arrangements for such assessments.

				If this box is used, please ensure that it is highlighted by ticking the immediate action box on the first page. **For prisons staff only:** It is also important to note that standard procedures for risk of self-harm must still be followed even if reference is made in 2.11, 2.12 and 2.13. Any interventions delivered prior to a CSMA and full care plan must be included in an initial care plan.
2.12	Please give a summary of key client background (non-health issues) to inform continuity of care	Optional free text box - information should make reference to all non health issues which the drugs worker should be aware of in relation to offering appropriate treatment provisions. **If this box is used, please tick the immediate action box on page 1.**		The worker who has carried out the assessment should summarise key points needed by recipient in partner agency in order to facilitate effective continuity of care. It will be for the worker to judge what needs to be included within this section based on experience and the individual case. Such non health issues may include finance, accommodation and family issues for example. The information contained here should accurately summarise information contained later in the form.
2.13	Please give a summary of key health issues (mental or physical)	Optional free text box - information should make reference to all health issues		The worker who has carried out the assessment should summarise key points needed by recipient in

		(mental and physical), previous drug use and drug treatment, or alcohol use if appropriate. **If this box is used, please tick the immediate action box on page 1.**	[redacted]	partner agency in order to facilitate Continuity of Care. Information listed should summarise the individual's health/treatment history detailing drug related issues and any possible mental health issues which need addressing. It is important to also include details of any treatment which is currently underway. It will be for the worker to use their experience and the individual's case history to decide what information is relevant and should be included.
Section 3 **Initial Contact/Required Assessment details**				
3.1	Date of contact	DD/MM/YYYY format	DD/MM/YYYY format	
3.2	Contact made with	Tick one box only	Tick one box only	Indicate whether first contact with the individual was made by CARATs or by Prison Healthcare
3.3	Prison where contact made	Enter Prison code where this contact is being made	Enter Prison code where this contact is being made	Insert the prison code (as per the prison code list).
3.4	DAT/CSP where client is resident	Enter DAT/CSP where the client is resident	Enter DAT/CSP where the client is resident	4 digit code of the DAT/CSP where the client is normally resident (outside prison). If client is NFA use address of benefit office for DAT/CSP of residence.
3.5	Date of initial reception	DD/MM/YYYY format	DD/MM/YYYY format	Date of reception into prison during this custodial period
3.6	Date of reception in this prison	DD/MM/YYYY format	DD/MM/YYYY format	Enter the date that the client first entered **this** prison
3.7	Date of initial contact/RA appointment	DD/MM/YYYY format	DD/MM/YYYY format	Date of client's first contact with drug worker – either date of required assessment, or first appointment session.

3.8	DAT/CSP where contact made	Enter 4 digit DAT/CSP code where this contact is being made	Enter 4 digit DAT/CSP code where this contact is being made	4 digit code of the DAT/CSP in which the client had their initial contact, e.g. where the Required Assessment or voluntary contact with a drug worker took place.
3.9	DAT/CSP where client is resident	Enter 4 digit DAT/CSP code where the client is resident	Enter 4 digit DAT/CSP code where the client is resident	4 digit code of the DAT/CSP in which the client resides; the residence should correspond to 2.2.
3.10	Where was the Required Assessment/Initial contact carried out?	Tick one box only (provide a short description if appropriate)	Tick one box only and provide a short description if 'other' is ticked – up to a maximum of 50 characters	Tick the box relating to the venue where the required assessment/initial contact was undertaken. If 'other', please keep to under 50 characters so it can be easily interpreted for monitoring purposes.
Section 4 Contact outcome/assessment				
4.1	What prompted the SMTA?	Tick one box only	Tick one box only and provide a short description if 'other' is ticked – up to a maximum of 50 characters	This box should be used to indicate the primary method of referral for the SMTA
4.2	Prison where SMTA was undertaken	Enter Prison code for establishment where SMTA was undertaken	Enter Prison code for establishment where SMTA was undertaken	Please enter the 4 digit prison code (from the prison code list)
4.3	Date when the SMTA was undertaken	DD/MM/YYYY format	DD/MM/YYYY format	
4.4	Assessed by	Tick one or both boxes	Tick one or both boxes	Both boxes should be ticked if CARATs and clinical staff have carried out a joint assessment
4.5	What prompted the Initial Screening/Triage Assessment?	Tick one box only and provide a short description if 'other' is ticked – up to a maximum of 50 characters	Tick one box only and provide a short description if 'other' is ticked – up to a maximum of 50 characters	The initial screening/triage assessment is an opportunity for a trained drug worker (including clinical staff) to establish the nature and extent of drug misuse, level of need an individual may have and

				what interventions and action may be required, including dealing with any immediate issues. Tick the one option which outlines how the individual was directed to the drug worker for an initial screening/triage assessment The free text box should be used only if none of the answers provided is accurate.
4.6	DAT/CSP undertaking initial screening/Triage assessment	Enter DAT/CSP code for the CJIT undertaking this initial screening/triage assessment	Enter DAT/CSP code for the CJIT undertaking this initial screening/triage assessment	4 digit code of DAT/CSP area in which the individual received their initial screening/triage assessment
4.7	Date where the initial screening/triage assessment was undertaken	DD/MM/YYYY format	DD/MM/YYYY format	Date on which the screening/assessment was undertaken
Section 5 Legal profile				
5.1	What is your prison status?	Tick one box only	Tick one box only	This information should be sought from the client in the first instance and should be verified on LIDS. If client is on licence recall, note as sentenced.
5.2	What is the length of your prison sentence?	Tick one box only	Tick one box only	The appropriate box should be ticked in respect of individuals who have been sentenced. The box should be left blank in respect of individuals on remand.
5.3	What prompted your current/most recent contact with the criminal justice system?	Tick a maximum of 2 boxes and provide a short description – up to 50 characters – if 'other' is ticked.	Tick a maximum of 2 boxes and provide a short description – up to 50 characters – if 'other' is ticked.	The client's current/most recent contact may be related to more than two offences if, for example, he has been charged with three or more offences at one time. The

				worker must select what are known, or what appear to be, the two most serious offences. Police colleagues will be able to advise on relative seriousness. If in doubt, use your judgement. Where the individual has been drugs tested under inspector's discretion for a non trigger offence, this offence should be written in the free text box. The offences that are ticked are not a confession of guilt, and should be the offence(s) that the individual was arrested for (but not necessarily charged with) in the first instance. If "Other" is selected, give details up to a maximum of 50 characters, which can be easily interpreted for monitoring.
5.4	Other legal details	Free text in which worker should include other useful information to inform Continuity of Care. E.g. any conditions or restrictions on bail, details of next court hearing, earliest release date etc. This should be brief and relevant to Continuity of Care.		Need exists for information to be precise and detailed, explaining key historical details as well as information about outstanding legal issues and progress of custodial/community punishments. If you know EDR or date of next court appearance note the date in the box.
Section 6 Drug and alcohol use				
6.1	Have you ever misused	Tick one box only – Yes or	Tick one box only – Yes or No	The term drug misuse here refers to

	drugs?	No		the illegal or illicit drug taking or alcohol consumption which leads a person to experience social, psychological, physical or legal problems related to intoxication or regular excessive consumption and/or dependence. Drug misuse is therefore drug taking which causes harm to the individual, their significant others or the wider community. By definition, those requiring drug treatment are drug misusers. (See Models of Care 2002)
	If Yes – have you misused in the last month, or in the month before you entered prison?	Tick one box only – Yes or No	Tick one box only – Yes or No	For the community this question is in reference to the client's drug misuse over the past month. For Prisons this question, and the drug profile captured under 6.2, is in reference to drug misuse in the month prior to custody. There may be circumstances where a prisoner is referred (or self-refers) to CARATs in relation to a drug misuse problem that has developed whilst in custody, in which case this question should be recorded as Yes in order to complete 6.2.
6.2a	What drugs have you misused most often in the last month and how often? First tick the top 3 drugs misused most often (Drug	If the client misused drugs in the last month or month prior to entering prison (6.1 = Yes and Yes) complete this question.	If the client misused drugs in the last month or month prior to entering prison (6.1 = Yes and Yes) complete this question.	At least one drug should be recorded if the client misused drugs in the last month or month prior to entering prison as indicated under 6.1

	1 being your main drug). Then tick the frequency of use.	Tick the top 3 drugs misused most problematically by the client, with the most problematic drug misused recorded under the Drug 1 tick box. For each drug recorded (maximum of 3) tick the frequency of use – daily, weekly, or monthly. If the illicit drug is not listed provide details under 'other'.	Tick the top 3 drugs misused most problematically by the client, with the most problematic drug misused recorded under the Drug 1 tick box. For each drug recorded (maximum of 3) tick the frequency of use – daily, weekly, or monthly. If the illicit drug is not listed tick 'other'.	If the client is unable to decide which drug they misuse most problematically (Drug 1), the worker is required to make a decision based on the information provided by the client. If "Other" is selected, give the name of the drug on the Continuity of Care side and record frequency. For monitoring and research, if two different drugs are mixed together and then used as one, record the substances mixed under Drug 1 and Drug 2.
6.2b	How do you administer Drug 1?	Tick <u>one</u> route of administration.	Tick <u>one</u> route of administration.	If the client administers Drug 1 in more than one way record the most often used route.
6.3	Are you taking any of these prescribed drugs?	Tick which drugs are prescribed and record daily dosage if known using mls/mgs. Use converter for benzodiazepines.	Tick which drugs are prescribed and record daily dosage if known using mls/mgs. Use converter for benzodiazepines.	If "other" is selected give name of drug, up to a maximum of 100 characters, and record daily dosage, if known, using mls/mgs.
6.4	What age did you start misusing Drug 1?	Give client's age at first use of Drug 1 (in years)	Give client's age at first use of Drug 1 (in years)	The age (in years) that the client first recalls using Drug 1.
6.5	How much would drugs cost you each week each if you (had to) pay for them?	Amount in £s	Amount in £s	This should be the client's estimate
6.6	What is your injecting status?	Tick one box only If the client has injected within the 28 days leading up to this assessment tick "Currently injecting",	Tick one box only If the client has injected within the 28 days leading up to this assessment tick "Currently injecting", otherwise if they	

		otherwise if they have injected but not within the last 28 days tick “Previously injected (but not currently)”.	have injected but not within the last 28 days tick “Previously injected (but not currently)”.	
6.7	Have you ever shared any equipment?	Tick one box only	Tick one box only	This refers to all aspects of sharing `equipment' involved in taking drugs such as needles, syringes, mixing water, filters, spoons, cups, pipes etc.
6.8	Have you shared any equipment in the last month?	Tick one box only	Tick one box only	
6.9	Summary of last drugs used (what, when and how much)	Free text. Provide brief summary of what, when and how much the client last used, including prescribed drugs.		This box refers to the last time someone used drugs.
6.10	Have you had treatment for your drug use in the last two years?	Tick one box only. If treatment was received during a previous period of custody, tick yes.	Tick one box only. If treatment was received during a previous period of custody, tick yes.	Treatment is used here in its broadest sense and includes interventions such as structured support, substitute prescribing, specialist treatment that may have been provided through previous engagement with e.g. a Drug Treatment Agency, CDT, CJIT, CARAT Team, GP, to address physical, psychological or mental health issues related to drug misuse.
6.11	Are you currently receiving treatment for your drug use?	Tick one box only. If treatment is being provided from a specialist drug treatment provider(s) (Tier 3 or Tier 4), please provide name of agency and agency	Tick one box only. If 'yes', give the agency code and/or name of the agency.	For description of treatment see 6.10. If "yes" and for continuity of care, further details can be provided in the other relevant information section (6.14), or if immediate attention/action needs to be drawn

		code. Further details can be provided in 6.14 of any additional information highlighted in 6.3.		to the attention of the CJIT/CARAT worker complete sections 2.10, 2.11, 2.12. It is important that this box is completed.
6.12	GP Name	If client is registered, enter as much detail as known.	[redacted]	
	Address	Free text		
	Phone Number	Free text		
	Knows about drug use	Tick box if client states that GP knows about his/her drug misuse		
	Is prescribing for drug use	Tick box if client states that GP is prescribing for his/her drug misuse		
	Client has no GP	Tick box if client is not registered with a GP		
6.13	Have you had treatment for your drug use whilst in prison in the past?	Tick one box only. If treatment was received during a previous period of custody tick yes.	Tick one box only. If treatment was received during a previous period of custody tick yes.	Check with prisoner if they have accessed any treatment in prison previously. If it comes to light that they have a current CARAT file in another prison, efforts must be made to obtain this as duplicate SMTAs must not be undertaken and cannot be counted towards the KPT.
6.14	Other relevant information	Free text To include any other relevant information about client's current or previous treatment; options for help and support that may need to be considered for their	[redacted]	

		care plan; and any relevant contact details of agencies/workers not given elsewhere.	[redacted]	
6.15	Has a first night initial clinical intervention been provided by a doctor?	Tick Yes or No. If Yes tick whether the client has been prescribed methadone or another drug.	Tick Yes or No. If Yes tick whether the client has been prescribed methadone or another drug.	Ask client on arrival/check records to determine whether a first night initial clinical intervention has been provided by a doctor and what was prescribed to the client. Do not include prescribing under Patient Group Directions (PGDs). This question is specifically about prescribing by a doctor.
6.16	In the last month, or the month before entering prison, how often have you had a drink?	Tick one box only	Tick one box only	Response should be based on individual's assessment of their alcohol consumption.
6.17	How many units of alcohol do you drink on a typical drinking day?	Tick one box only	Tick one box only	Response to be based on individual's assessment of quantity most usually consumed. This question is trying to ascertain how much alcohol is drunk when the individual usually drinks per day. If the individual drinks 4 days a week, then the answer should reflect how much alcohol is usually consumed on these days. A UK unit is 10ml or 8 grams of pure alcohol. The number of units in a drink depends how strong each particular drink is and the quantity involved. A pint of normal strength (3.5%) lager/cider is 2 units; 175ml of 12% wine is 2 units, 1 single measure (25ml) of

				40% spirit is 1 unit and a 275ml bottle of Alco Pop (5.5%) is 1.5 units.
6.18	How long have you drunk at these levels?	Free text box State time in weeks, months or years, depending on extent of alcohol history.	[redacted]	Response to be based on individual's assessment of consumption over time. Answer should be in weeks, months or years depending on extent of alcohol use. Examples of acceptable answers include: 3 weeks, 7 months or 4 years 3 months. Answers should be rounded up where appropriate into a whole week, month or year.
6.19	What age did you start drinking alcohol?	Age must be classed using two digits	Age must be classed using two digits	Response to be based on client's assessment of the age that they first drank alcohol; consumption at that age did not necessarily have to be to any excess.
6.20	How often do you have the following units of alcohol on one occasion Females: 6 or more units? Males: 8 or more units?	Tick one box only	Tick one box only	Response to be based on individual's assessment of their drinking habits. A breakdown of what a unit of alcohol is can be found at 6.17. Less than monthly should be used when the quantity is drunk less than 11 times a year; monthly when the quantity is drunk once a month; weekly when the quantity is drunk once or twice a week and daily or almost daily when the quantity is drunk 4 times or more a week. The drug worker and individual may need to decide upon which response is appropriate.

6.21	How long have you drunk at these levels?	Free text box. State time in weeks, months or years, depending on extent of alcohol history.		Response to be based on individual's assessment of consumption of 6 or 8 units of alcohol over time. Answer should be in weeks, months or years depending on extent of alcohol use. Correct answers, for example, would be: 3 weeks, 7 months; or 4 years 3 months. Answers should be rounded up where appropriate into a whole week, month or year. The response to this question may be the same as given under 6.18 if the client drinks 6 (females) / 8 (males) units or more on a typical drinking day.
6.22	Have you drunk alcohol in the last week?	Tick one box only If 'yes', record the number of units drunk over the last week.	Tick one box only If 'yes', record the number of units drunk over the last week.	The term last week includes the last 7 days from the date of the assessment. A "yes" answer will be generated by consuming any quantity of alcohol; the exact amount will need to be specified using the guide to alcohol under the guidance to question 6.17. The number of units should be answered using 3 digits, e.g. consuming 27 units during the last 7 days will be expressed as 027.
6.23	Please give details of type of alcohol and quantity drunk within the last week	Free text box. Answers should be kept precise and accurate to enable Continuity of Care.		Free text box should be used to list the individual's drinking habit over the past 7 days. The individual should be encouraged to state the

				different forms of alcohol which they have consumed and a rough guess as to the quantity or units consumed, e.g. lager, 10x500ml cans: 20 units; 1 bottle white wine: 10 units.
Section 7 **Social needs profile**				
7.1	Where are you currently residing?	Tick one box only	Tick one box only	Relates to where client is residing at the time of the assessment. If in the community, workers should go to Q7.2; if in prison/residential facility, workers should go to Q7.5.
7.2	Do you have access to accommodation within the community?	Tick one box only		Gives indication of need for CJIT worker to refer/progress action to further identify accommodation needs and arrangements using locally agreed procedures.
7.3	What are your accommodation arrangements in the community?	Tick one box only. Relates to accommodation arrangements of client at time of assessment.	Tick one box only. Relates to accommodation arrangements of client at time of assessment.	Please consider this section as providing an initial indication of accommodation needs in the community to prompt further referrals/action. Section 7.4 and **Annex A** provides more detail and description.
7.4	Please give further details of the type of accommodation	Tick one box only It is acknowledged that details are not extensive, or exclusive to one section. If details not listed, tick 'other' and use free text to list details e.g. Temporary - (Other) Private rented	Tick one box only. If details not listed, tick 'other'.	The types of accommodation listed have been highlighted to provide a more consistent overview of the client's accommodation status, and seek to highlight issues which could indicate the need for prioritising further referral(s) and action. It is acknowledged that details are not extensive, or exclusive to one

				section, and includes buildings as well as other accommodation such as a caravan or boat. If details are not listed tick 'other' and use the free text to identify detail, i.e. caravan. Those whose accommodation status is NFA means they do not have a permanent base i.e. it is likely to be on a night by night basis and should therefore be considered as a priority for a specialist housing assessment/action and/or intervention. Temporary Accommodation referred to in this section may be of any variety and could refer to types of accommodation secure e.g. for a period greater than 2 weeks but less than 6 months; the client may require ongoing support to sustain existing arrangements, prevent likelihood of homelessness e.g. through access to related skills on sustaining a tenancy, developing lifeskills and access advice to help prepare and facilitate move-on to more settled accommodation as appropriate. (Important for worker to note that occasionally a client will have temporary accommodation secured under a homelessness duty).

				Settled accommodation referred to in this section indicates secure/long term accommodation. The principal characteristic is that the occupier has security of tenure in the medium to long term, or is part of a household whose head holds such security of tenure. It is important to note that clients could still be at risk of losing their accommodation e.g. if there are rent/mortgage arrears, so it's important that assumptions are not made, as they may require support/advice to broker/sustain existing arrangements.
7.5	Who are you living with in the community?	Tick one box only		This information provides an indication of potential social support arrangements that may be available and/or need to be brokered. For those currently in or about to enter custody the information should refer to their most recent or usual situation when in the community. If details not listed, tick 'other' and use free text to record details, e.g. options might be living with others unknown in a House of Multiple Occupancy, Hostel, etc.
7.6	Will you return to the same accommodation in the community?	Tick 'Yes' if arrangements in place to return to the same accommodation; provide details in free text. Tick 'No' if arrangements are not yet in place, and use free	For completion for those clients who will be returning to the community from Prison or Residential facility. Tick yes if arrangements in place to return to the same accommodation.	For completion for those clients who will be returning to the community from Prison or Residential facility. This information should be informed in prison by work progressed in support of the NOMS REDUCING RE-

		text to outline where client intends to live, including if they are awaiting confirmation of an offer of accommodation.		OFFENDING HOUSING AND HOUSING SUPPORT FRAMEWORK (Dec '06), which provides a model of an integrated approach to the management of offender housing and housing support needs. This framework highlights that those in prison should have had an initial Housing Needs Assessment undertaken within four days of reception into prison, where appropriate action is taken to secure/terminate property, change of circumstance reported to relevant provider/authority e.g. tenancy/benefit. Whilst in custody: a full housing risk and options assessment and a review of the housing assessment to identify changes in circumstances; early application to housing providers; intervention to improve chances of housing. As an emergency measure: homelessness applications; identify housing support needs; support actual access to housing/finance; connect to emergency provision. CARAT teams should seek where possible to access this information. Tick Yes, if arrangements are in place to return to the same accommodation, and provide

				details in free text using the details listed in 7.4 where possible, e.g. Temporary - Staying with family as short-term guest in XXXX (town/city), Short term B&B in XXXX (town/city). Tick No, if arrangements for their return to the community are not yet in place, and use free text to outline where client intends to live, including if they are awaiting confirmation of an offer of accommodation. Where possible use details listed in 7.4 to describe accommodation e.g. Temporary - Awaiting confirmation of B&B in XXXX.
7.7	Do you have any housing issues that have not been addressed?	Tick one box only. If Yes, use free text box to record issues identified.	[redacted]	This section can be used to record any relevant information which may prevent an individual from receiving/sustaining a tenancy, including previous antisocial behaviour. If yes, CJIT/CARAT worker should use the free text to record issues which can inform action needed to prevent homelessness, as well as find accommodation, e.g. arrange for access to housing advice /support in line with locally agreed arrangements.
7.8	Please give details of any financial or other concerns relating to staying at/maintaining your current home (eg securing	Use free text to record issues. Please tick NFA box if client's accommodation	[redacted]	This section can be used to record financial issues related to accommodation which may prevent an individual from receiving/sustaining a tenancy.

	possessions)?	status is NFA in the community or was NFA prior to entry into custody and provide details of town where last benefit/cash payment was received		If yes, CJIT/CARAT worker should use the free text to record issues which can inform action needed to prevent homelessness. Suggested action for workers includes referral using locally agreed arrangements for Housing Advice in the community/prison, making a Housing Benefit application, help with dealing with issues such as rent/mortgage arrears.
7.9	Are there any outstanding financial issues that you are concerned about?	Tick Yes or No to indicate whether the client has any outstanding finance issues that they are concerned about. Use the free text box to record what those issues are.		
7.10	Location of dependent children (under 16) for whom you have parental responsibility	Where dependent children have been identified please provide the number of children in each category in the box provided. Tick 'other' if not listed and record in free text to provide details such as if living with a Grandparent or sibling, or if there are non-dependent children residing at the address that the client is returning to. Show the number of children, their	Where dependent children have been identified please provide numbers of children in box identified. Use free text to record 'other' category.	This section should be completed by all workers. Drug Services commissioned through the DAT are expected to take account of NTA Models of Care, Every Child Matters, and related guidance e.g. for working with families and carers, and reflects the recommendations highlighted to address issues raised in the Hidden Harm Report (2003). Recommendations included the need for all drug treatment agencies to record an agreed minimum consistent set of data

		ages, gender and the relationship.		about the children of clients presenting to them. This section seeks to identify information which could contribute to establishing what further information or action is needed. The information does not replace any existing arrangements in place and should take account of any existing local arrangements which operate to ensure protection of children and vulnerable adults.
7.11	What is your current employment status?	Tick one box to indicate the client's current employment status. Use the free text box to record any needs and / or issues relating to employment, training and education for the client.	Tick one box to indicate the client's current employment status.	
7.12	Immediate action following assessment but prior to care plan (only if required)	Tick services provided and give name of agency or service, and name of worker, if known – to be completed by the community only. This section is used to record immediate action taken by the CJIT worker (if required) following assessment and prior to drawing up a care plan with the client. Tick as many boxes as appropriate. Any issue which, if not quickly	Tick services provided and give name of agency or service, and name of worker, if known – to be completed by the community only. Tick any relevant boxes.	This section is used to record Immediate action taken by the CJIT worker (if required) following assessment and prior to drawing up a care plan with the client. Examples of immediate action may include referral for urgent, health, housing needs or where client is a victim of abuse. Details of agency worker with whom contact is made should be highlighted, where possible, to inform further arrangements for continuity of care. Tick as many boxes as appropriate

		addressed, is likely to have a significant adverse impact on the client taking up or maintaining their contact in a drug treatment programme. The name and contact details of agency and/or worker should be provided if known (name and contact details for the drug worker preferable for continuity of care purposes).		to record IMMEDIATE action.
7.13	Tick non-structured treatment interventions delivered to address immediate and urgent needs which cannot wait for the CSMA to be completed – prisons only	Tick any non-structured interventions delivered prior to CSMA. Give details of 'Other' non-structured interventions delivered to address immediate needs, if applicable.	Tick any non-structured interventions delivered prior to CSMA. Give details of 'Other' non-structured interventions delivered to address immediate needs, if applicable.	Any interventions of this kind: (a) low level (non-structured)' (b) to address immediate and urgent needs, and/or (c) where the client is in prison for less than 28 days, that are delivered prior to a CSMA must be agreed with the client in an <u>initial</u> care plan. Within prisons, initial care plans may be appropriate for prisoners in the very early days of custody, or those who are due to be released shortly after an SMTA is undertaken (if shortly to be released, the plan would need to include and address issues for release). The initial care plan sets goals and milestones based on needs identified and will facilitate a focus on a client's engagement in the treatment

				system, to ensure their needs are met, to build a therapeutic alliance, and to ensure appropriate support if they are waiting to undergo a comprehensive assessment. These clients are classes as being on the “triage” caseload. The CARAT team should retain the DIR for up to 4 weeks to enable sections 8 and 9 of the DIR to be completed.
Section 8 Assessment outcome				
8.1	Is further intervention needed?	Tick Yes or No. If no, tick a further box to indicate the reason why no further intervention is needed (use free text box if appropriate). If the no box is ticked, this is an exit point for Continuity of Care purposes. If the yes box is ticked, continue with completing the DIR.	Tick Yes or No. If no, tick a further box to indicate the reason why no further intervention is needed (use free text box if appropriate). If the no box is ticked, this is an exit point for Monitoring and Research purposes. If yes, continue to complete DIR. All of these reasons are EXIT points and further sections of the form cannot be completed.	Further intervention(s) in this context have been identified following an initial screening/triage assessment where an individual's needs have been identified. Further interventions to address those needs may include: a further assessment, to clarify action and appropriate ongoing support; any further meetings with a drug worker or substance misuse worker for a follow up assessment (if not already undertaken); support with referral and access to treatment and related support, delivered as part of Tier 2,3 or 4 treatment provision. If "no" box is ticked, this reflects the decision on the part of the drug

				worker that the client does not require further intervention and therefore exits the DIP process; **this does <u>not</u> relate to the client's view**. If the client feels that no further intervention is needed, but the drug worker believes that further intervention is needed, the "Yes" box should be ticked.
8.2	Is further intervention accepted?	Tick either yes or no; if the answer is no, tick a further box to indicate the reasons why no further intervention has been accepted by the individual. If the no box is ticked, this is an exit point for Continuity of Care purposes. If the yes box is ticked, continue with completing the DIR. If the client is subject to the Required Assessment process, and the drug worker considers that further intervention is needed, then a follow up assessment should be arranged and the first No box selected. If the individual does not wish, or does not attend a follow up assessment appointment,	Tick yes or no. If yes, continue to complete DIR. A no response should reflect the reason given by client. However, in a case where the client did not accept further intervention but a Follow-up Assessment was required, tick the first No and continue to complete the DIR. If client did not agree to further intervention but a Follow-up Assessment was NOT given, tick the second No and provide the reason why the client did not accept. If 'other' is selected, give details up to a maximum of 50 characters, which can be easily interpreted for monitoring.	The monitoring and research section should be sent to the Data Manager. In prisons, if the client refuses to engage CARATs should not immediately complete section 8.2. The DIR should be retained for a maximum of 4 weeks until a follow-up has been undertaken to review the prisoner's wishes. If he/she still refuses to engage the M&R section should be sent to the Data Manager.

		then this is a criminal offence and could lead to prosecution. **Note for prisons staff only**: If client refuses further intervention tick second 'no' box to indicate exit point.	All of these reasons are EXIT points and further sections of the form cannot be completed.	
8.3	Client has been transferred by CJIT to DAT/CSP of residence – give DAT/CSP code	Enter DAT/CSP code where the client is resident	Enter DAT/CSP code where the client is resident	If this section is completed, this is an exit point and no further sections of the form should be completed. The continuity of care section should be sent to the CJIT with the client's consent, and the monitoring and research section should be sent to the Data Manager of the DAT which carried out the assessment.
8.4	Has client been referred to specialist drug treatment in DAT/CSP of residence as part of the referral to CJIT?	Tick one box only. If used, give agency details: name, code and referral date (DD/MM/YYYY).	Tick one box only. If used, give agency details: name, code and referral date (DD/MM/YYYY). Agency code should be the NDTMS code for the agency – this should be 5 or 6 characters long.	This treatment agency should be a Tier 3 or 4 treatment provider and this should only be completed if the CJIT team who carried out the assessment are making the referral as part of the transfer to the DAT of residence.
8.5	Client been transferred by CJIT to prison – give prison code	Enter Prison code where client is being sent	Enter Prison code where client is being sent	If this section is completed, this is an exit point and no further sections of the form should be completed. The continuity of care section should be sent to the Prison CJIT with the client's consent, and the monitoring and research section

				should be sent to the Data Manager of the DAT which carried out the assessment.
8.6	Client is transferred by CARATs to DAT/CSP of residence – give DAT/CSP code	Enter DAT/CSP code where the client is resident	Enter DAT/CSP code where the client is resident	
8.7	Has client been referred to specialist drug treatment in DAT/CSP of residence as part of the referral to CJIT?	Enter name of agency, agency code and date of referral to the agency. Agency code should be the NDTMS code for the agency – this should be 5 or 6 characters long.	Enter name of agency, agency code and date of referral to the agency. Agency code should be the NDTMS code for the agency – this should be 5 or 6 characters long.	This box should be completed in full where CARATs/Healthcare have made a referral to an external drug treatment provider, but this must be as part of the referral to CJIT.
8.8	Client is transferred by CARATs to another prison – give prison code	Enter Prison code where client is being sent	Enter Prison code where client is being sent	4 digit code (as per the prison code list) and ensure that the CARAT file containing the SMTA (DIR) is sent to the next prison, and the M&R section (DIR) is sent to the Regional Data Manager.
Section 9 **Care plan and caseload**				
9.1	Has a CSMA been completed by CARATs worker?	Tick Yes or No. If Yes, record the date the CSMA was completed in DD/MM/YYYY format. If No, record the date in DD/MM/YYYY format and tick the reason why the CSMA has not been undertaken. If 'Client disengaged from services' is	Tick Yes or No. If Yes, record the date the CSMA was completed in DD/MM/YYYY format. If No, record the date in DD/MM/YYYY format and tick the reason why the CSMA has not been undertaken. If 'Client disengaged from services' is ticked, this is an EXIT point -	All efforts should be made to ensure that a client who needs and agrees further intervention has a CSMA. A CSMA should be arranged for these clients once the SMTA has been undertaken. 9.3 must not be completed by prisons unless 9.1 = Yes.

		ticked, this is an EXIT point - do not complete the rest of the form.	do not complete the rest of the form.	
9.2	Was the care plan appointment as a result of an RA Follow up Assessment?	Tick one box only	Tick one box only	If the Follow up Assessment was intended to facilitate a care plan agreement, the yes box should be ticked.
9.3	Has a care plan been agreed with client?	Tick Yes or No If Yes, record the date the care plan was agreed in DD/MM/YYYY format. The client is on the caseload of the CJIT/CARAT which agreed this care plan, from this date. If No, record the date that either the client did not turn up for the care plan appointment, or the date they did not agree the proposed care plan in DD/MM/YYYY format, and tick the reason why the care plan has not been drawn up. If 'other' is ticked, please provide a reason, up to a maximum of 50 characters. This is an EXIT point and further sections of the form cannot be completed.	Tick Yes or No If Yes, record the date the care plan was agreed in DD/MM/YYYY format. The client is on the caseload of the CJIT/CARAT which agreed this care plan, from this date. If No, record the date that either the client did not turn up for the care plan appointment, or the date they did not agree the proposed care plan in DD/MM/YYYY format, and tick the reason why the care plan has not been drawn up. If 'other' is ticked, please provide a reason, up to a maximum of 50 characters. This is an EXIT point and further sections of the form cannot be completed.	Care planning should be undertaken in line with Models of Care Update 2006 and Care Planning Guidance 2006 (NTA). **For community only:** Following triage-level assessment, it is good practice to produce an initial care plan with the client. For clients taken onto the CJIT caseload this will be essential. There may be a number of reasons for a care plan not being agreed. If the worker believes that the client may change their mind, a DIR can remain open for 4 weeks after an initial assessment was conducted. If the care plan has still not been agreed within that time period, 'No' should be ticked and the date recorded. Raise a new DIR if the client makes contact again after 4 weeks or longer. Not all clients on the CJIT caseload will be required to undergo a comprehensive assessment, and will therefore remain on their initial

				care plan which will be regularly reviewed, in line with guidance, until they are eventually discharged from the CJIT caseload. **For Prisons only**: 9.3 represents a full care plan following a CSMA - this question and subsequent questions cannot be completed unless a CSMA has been completed, i.e. 9.1 = Yes. If a client has a CSMA but does not agree a care plan, or has not had a CSMA, this question is to remain blank. The client will not be on the "Active" caseload unless they have a CSMA and full care plan. The client will remain on the "triage" list between 7.13 and 9.1/9.3, i.e. following an Initial Care Plan and prior to CSMA and full care plan (or review of the initial care plan) being completed. If the client continues to disengage for 6 months or more a new DIR must be completed for those who subsequently wish to re-engage; this will not count towards the KPT.
9.4	Give details of **new** referrals to specialist drug treatment agencies	Enter code and/or name of the agency that the client has been referred to.	Enter code and/or name of the agency that the client has been referred to.	

		Agency code should be the NDTMS code for the agency - this should be 5 or 6 characters long. Information on up to 3 agencies can be recorded.	Agency code should be the NDTMS code for the agency - this should be 5 or 6 characters long. Information on up to 3 agencies can be recorded.	
9.5	Treatment	Tick which interventions are to be delivered and indicate who will be delivering them. If the intervention has commenced, record the date in DD/MM/YYYY format, otherwise use the Activity Form to record the commencement date.	Tick which interventions are to be delivered and indicate who will be delivering them. If the intervention has commenced, record the date in DD/MM/YYYY format, otherwise use the Activity Form to record the commencement date.	In the Community the DIR can be kept for a maximum of a week to record any commencement dates before it is sent to the Data Manager. In Prisons the DIR can be kept for up to 20 working days to enable the CSMA and Care Plan to be recorded (under 9.1 and 9.3) and any interventions that have started to be captured here. Any treatment interventions which commence (within the current care plan) after the DIR has been sent to the Data Manager must be recorded on an Activity Form (Section 3.3 for Prisons; section 3.6 for CJITs) Interventions should be delivered in line with MoC (NTA 2006) arrangements, including interventions to minimise the risk of overdose and diversion of prescribed drugs.
9.6	Other types of support (non-treatment)	Tick which types of support are to be delivered and indicate who will be	Tick which types of support are to be delivered and indicate who will be delivering	If the support did not commence before the DIR is sent off to the Data Manager, provide

		delivering them. Record the date that each type of support commenced in DD/MM/YYYY format. Provide a short description of the type of support if 'Other' is ticked, up to a maximum of 50 characters.	them. Record the date that each type of support commenced in DD/MM/YYYY format. Provide a short description of the type of support if 'Other' is ticked, up to a maximum of 50 characters.	commencement information on the Activity Form (Community only).
Client's consent	Continuity of care	Tick which agencies client agrees to share information with. Form should be signed and dated by client and worker.	[redacted]	Further advice about information sharing can be found in the Background Briefing paper.
End of DIR completion		The DIR is now complete for continuity of care for this client for this episode. All papers must be dealt with in line with local procedures which must be in accordance with DPA and FOI requirements.	The M&R is now complete for the client for this episode. Any further significant activity for a client on the caseload should be recorded on the Activity Form. Detach the right-hand (green) side of the DIR and send to the CJIT data manager or regional data manager.	

3 Initial Contact Form (ICF)

3.1 Overview - ICF

INITIAL CONTACT FORM: COMMUNITY

INITIAL CONTACT FORM: CARATS

1. The Initial Contact Form is to be completed when a non-caseload client has a meaningful contact with a CJIT worker, where a required assessment has not been imposed, or with CARATs / Prison Healthcare for a client who is in prison. It is necessary for monitoring and research purposes that accurate data is collected at the initial stage when a client first comes into contact with DIP, other than via a Required Assessment.

2. The Initial Contact Form enables, for example, a picture to be built of entry routes into the programme, other than via a Required Assessment, the role played by partners and the profile (ethnicity, age, gender etc) of those being contacted. This will inform national and local performance management, policy development and allocation of future resources. For those cases where assessment is offered but refused, data collected to this point will assist local and national analysis of attrition rates both between areas and between groups of clients in order to inform corrective action and/ or a wider strategic approach as appropriate. This will capture a fuller picture of all activity in the field, even on cases which do not progress on a particular occasion, reflecting more realistically the work and activity undertaken by CJITs and CARATs.

3. The Initial Contact Form is a stand-alone monitoring and research form. Its purpose is to enable meaningful contacts to be recorded that do not progress onto an assessment, thereby saving wastage of full DIR forms. You should use your judgement as to which is the most appropriate form to use with the aim of reducing paper wastage.

4. It is recognised that more than one contact may be made with a client during their time in custody. However not all initial contacts necessarily lead to the client's engagement (i.e. assessment, care plan etc). If the client does not engage at the initial contact, each subsequent new contact is effectively a new starting point and therefore beginning of the process, i.e. a new initial contact.

5. The definition of an **initial contact** is as follows:

For a potential client, contact is the first stage of engagement with a CJIT or CARATs worker. Contact can be made in a range of settings, mainly police custody suites, court premises, CJITs' places of work, or in prison through referral to CARATs teams.

6. The definition of **contact** is:

when the individual has had face-to-face or telephone contact with the CJIT or CARATs worker who has provided (in full or in part) an explanation of the help and support available and the next stages of the process, including confidentiality and consent.

7. The explanation should cover such issues as:

- A brief overview of the worker's role and that of the team
- The help and support available for the individual
- The need for the worker to ask some questions to help inform decisions about options
- How any information will be used
- How and when information might be shared with others, including issues around confidentiality and informed consent
- Initial harm reduction advice
- Information needed in order for the individual to be assessed
- Responses to any questions the individual may have about the team and help on offer
- Assurances that assessment (if in the police station) is independent of the police

8. The worker should then establish if an assessment is appropriate and if the individual will accept the offer of an assessment. The worker will record the final outcome of the contact and offer the team's contact details for future reference if no further action is appropriate or is refused.

The Initial Contact Form should not be used to record any contact which is less than that set out above.

9. The Initial Contact Form should be sent to the appropriate data manager using the same route/process as used for the main DIR.

3.2 Field by Field - ICF

3.2.1 Community

INITIAL CONTACT FORM – CJITs			
Section on form	**Field**	**Guidance**	**Completion Guidance**
Section 1 - Form completed by			
1.1	Name	Name of worker who completed form	
	Phone	Phone number of worker	
	DAT/CSP	Name of the DAT/CSP in which client is seen	
Section 2 - About the client			
2.1	First initial	One character only – first letter of client's first name	
	Surname initial	One character only – first letter of client's surname	
	Date of birth	DD/MM/YYYY format	
	Gender	Tick one box only	
2.2	Postcode	If a postcode is available, enter the first part of the client's postcode, excluding the last two letters of the second part of the postcode (e.g. OX11 2BA would be recorded as OX11 2XX).	
	No fixed abode	Tick if applicable	
2.3	Nationality at birth	Country of nationality at birth - enter the ISO 3-letter country code	Country of nationality at birth must be as stated by the client. If they do not wish to give an answer, the 'Not stated' code ZZZ should be used. Annex B contains a list of country codes, e.g. GBR = United Kingdom. This list should be made available to

			workers for reference.
2.4	Ethnic group	Tick one box only	Must be as stated by the client
2.5	Religion	Tick one box only	Must be as stated by the client
2.6	Does the individual being assessed consider themselves to have a disability?	Tick one box only	Must be as stated by the client
Section 3 - Initial contact			
3.1	Date of initial contact	DD/MM/YYYY format	
3.2	DAT/CSP where contact made	Enter DAT/CSP code where the contact is being made	
3.3	DAT/CSP where client is resident – give code	Enter DAT/CSP code where the client is resident	
3.4	If the Initial Contact/Required Assessment did not lead to a Screening/Initial Triage assessment, why not?	Tick one box only. If 'other' is selected, provide a description up to a maximum of 50 characters.	

3.2.2 Prisons

INITIAL CONTACT FORM – CARATs			
Section on form	**Field**	**Guidance**	**Completion Guidance**
Section 1 **Form completed by**			
1.1	Name	Name of worker who completed form	
	Phone	Phone number of worker	
Section 2 **About the client**			
2.1	First initial	One character only – first letter of client's first name	
	Surname initial	One character only – first letter of client's surname	
	Date of birth	DD/MM/YYYY format	
	Gender	Tick one box only	
2.2	Postcode	If a postcode is available, enter the first part of the client's postcode, excluding the last two letters of the second part of the postcode (e.g. OX11 2BA would be recorded as OX11 2XX).	
	No fixed abode	Tick if applicable	
2.3	DAT/CSP where client is resident	Enter DAT/CSP code where the client is resident	
2.4	Is the client a PPO?	Tick one box only	
2.5	Nationality at birth	Country of nationality at birth - enter the ISO 3-letter country code	Country of nationality at birth must be as stated by the client. If they do not wish to give an answer, the 'Not

			stated' code ZZZ should be used. Annex B contains a list of country codes, e.g. GBR = United Kingdom. This list should be made available to workers for reference.
2.6	Ethnic group	Tick one box only	Must be as stated by the client
2.7	Religion	Tick one box only	Must be as stated by the client
2.8	Does the individual being assessed consider themselves to have a disability?	Tick one box only	Must be as stated by the client
2.9	Date of initial reception	DD/MM/YYYY format	
2.10	Date of reception in this prison	DD/MM/YYYY format	
2.11	Prison status	Tick one box only	
Section 3 First contact details			
3.1	Date of contact	DD/MM/YYYY format	
3.2	Contact made with	Tick one box only	
3.3	Prison where contact made	Enter Prison code where this contact is being made	
3.4	Referral Method	Tick one box only If 'other' is selected, provide a description up to a maximum of 50 characters.	
3.5	Reason client did not have an SMTA	Tick one box only If 'other' is selected, provide a description up to a maximum of 50 characters.	

4 Activity Forms (AF)

4.1 Overview - AF

ACTIVITY FORM: COMMUNITY

ACTIVITY FORM: CARATs

1. The Activity Form (AF) is for monitoring and research purposes only. The form collects information about clients who are on the caseload, or have been transferred between teams. It has four key purposes:

1. To record outcomes in relation to an initial or follow-up Required Assessment for clients on your team's caseload OR for clients on another team's caseload	**Section 3 CJIT AF** **Section 4 CJIT AF**
2. To record information on commencement of treatment and other support provided, and care plan updates, for clients already on the team's caseload	**Section 3 CJIT AF** **Section 3 CARATs AF**
3. To reflect transfers between teams, whether it be a transfer from one CJIT to another CJIT, or from a CJIT to a CARATs or vice versa, or CARATs in one prison to CARATs in another, and any new treatment and care plan information	**Section 5 or 6 CJIT AF** **Section 4 CARATs AF**
4. To record case suspensions, closures and re-engagements	**Section 7 CJIT AF** **Section 5 CARATs AF**

2. Sections 1 and 2 capture information about the form's completion and the client's details.

3. The Activity Form should be sent to the appropriate data manager using the same route/process as used for the main DIR.

4.2 Field by Field – AF

4.2.1 Community

ACTIVITY FORM – CJITs			
Section on form	**Field**	**Guidance**	**Completion Guidance**
Section 1 Form completed by			
1.1	Name	Name of worker who completed form	
	Phone	Phone number of worker	
	DAT/CSP	Name of the DAT/CSP in which client is seen	
Section 2 About the client			
2.1	First initial	One character only – first letter of client's first name	
	Surname initial	One character only – first letter of client's surname	
	Date of birth	DD/MM/YYYY format	
	Gender	Tick one box only	
	Number	This field should not be completed until required (guidance will be provided).	
2.2	Postcode	If a postcode is available, enter the first part of the client's postcode, excluding the last two letters of the second part of the postcode (e.g. OX11 2BA would be recorded as OX11 2XX).	
	No fixed abode	Tick if applicable	
2.3	DAT/CSP where client is resident	Enter DAT/CSP code where the client is resident	If client is NFA, use address of benefit office for DAT/CSP of residence

2.4	DAT/CSP where activity undertaken	Enter DAT/CSP code where activity undertaken	
2.5	Does the individual being assessed consider themselves to have a disability?	Tick one box only	Must be as stated by the client
2.6	Please state first language	Complete the 3 digit box – Wales only	
2.7	Nationality at birth	Country of nationality at birth - enter the ISO 3-letter country code	Country of nationality at birth must be as stated by the client. If they do not wish to give an answer, the 'Not stated' code ZZZ should be used. Annex B contains a list of country codes, e.g. GBR = United Kingdom. This list should be made available to workers for reference.
2.8	Ethnic group	Tick one box only	Must be as stated by the client
2.9	Religion	Tick one box only	Must be as stated by the client
Section 3 **Client is on or is suspended from your caseload**			
3.1	Did the client attend and remain for the duration of the RA – Initial Assessment?	Tick Yes or No If Yes, provide the date of the RA – Initial Assessment in DD/MM/YYYY format. If No, provide the date in DD/MM/YYYY format, and tick the reason why client did not attend and remain. If 'other' is selected, provide a description, up to a maximum of 50 characters.	
3.2	Was an RA – Follow up Assessment required?	Tick Yes or No	
	Did they attend and remain?	Tick Yes or No	
3.3	If client is on your caseload and has	Tick Yes or No	This should be completed if the client has

	had an RA – Follow up Assessment appointment set by another DAT, did they attend and remain?		had an RA – Initial Assessment carried out by another CJIT who has then required the client to attend a Follow up Assessment in their DAT of residence: did they attend and remain?
3.4	If the client is currently on a DRR, has Probation case manager been sent relevant continuity of care information?	Tick Yes or No	Worker to decide what information is relevant
3.5	Please give details of any new referrals to specialist treatment provider/s (since care plan agreed)	Enter code and/or name of the agency that the client has been referred to. Agency code should be the NDTMS code for the agency - this should be 5 or 6 characters long. Information on up to 2 agencies can be recorded.	
3.6	What structured support has commenced since care plan agreed?	Tick which interventions have commenced since the care plan was agreed. Record the date that each intervention commenced in DD/MM/YYYY format.	
3.7	What other support has commenced since care plan agreed?	Tick which interventions have commenced since the care plan was agreed. Record the date that each intervention commenced in DD/MM/YYYY format.	
3.8	Date care plan reviewed	DD/MM/YYYY format	
Section 4 **Client is on or is suspended from another CJIT's caseload**			
4.1	Did the client attend and remain for the duration of the RA – Initial Assessment?	Tick Yes or No. If Yes, provide the date when reviewed, in DD/MM/YYYY format.	

		If No, provide the date in DD/MM/YYYY format, and tick the reason why not. If 'Other' is selected, provide a description, up to a maximum of 50 characters.	
4.2	Was the RA – Follow up Assessment needed?	Tick Yes or No	
4.3	Has CJIT case manager been sent relevant continuity of care information?	Tick Yes or No	Has the CJIT where the client is on the caseload been notified that their client has tested positive in another area (with the client's consent)?
4.4	If client is currently on a DRR has Probation case manager been sent relevant continuity of care information?	Tick Yes or No	Have Probation been notified of a client who has tested positive and is currently on a DIR (with the client's consent)?
Section 5 **Client transferred from the caseload of another CJIT/CARATs**			
5.1	DAT/CSP or prison from which client transferred	Enter DAT/CSP or Prison code from where client transferred	
5.2	Has care plan been reviewed and agreed with client since transfer to this CJIT?	Tick Yes or No. If Yes, provide the date when reviewed, in DD/MM/YYYY format. If No, provide the date in DD/MM/YYYY format, and tick the reason why not. If 'Other' is selected, provide a description up to a maximum of 50 characters.	
5.3	Please give details of any new referrals made by you to specialist treatment provider/s (since care plan was agreed)	Enter code and/or name of the agency that the client has been referred to. Agency code should be the NDTMS code for the agency - this should be 5	

		or 6 characters long. Information on up to 2 agencies can be recorded.	
5.4	Which structured support (treatment) has been commenced since transfer?	Tick which interventions have commenced since transfer - Record the date that each intervention commenced in DD/MM/YYYY format.	
5.5	Which other types of support (non-treatment) have been commended since transfer?	Tick which interventions have commenced since transfer - Record the date that each intervention commenced in DD/MM/YYYY format.	
Section 6 **Client assessed by another CJIT/CARATs but not yet on a caseload**			
6.1	DAT/CSP or Prison from which client transferred	Enter DAT/CSP or Prison code from where client was transferred	
6.2	Was the appointment as a result of an RA – Follow up Assessment?	Tick Yes or No	
6.3	Has care plan been agreed with client since transfer?	Tick Yes or No If Yes, record the date the care plan was agreed in DD/MM/YYYY format. The client is on the caseload of the CJIT/CARAT which agreed this care plan from this date. If No, record the date that either the client did not turn up for the care plan appointment, or the date they did not agree the proposed care plan in DD/MM/YYYY format, and tick the reason why the care plan has not been drawn up. If 'other' is ticked, provide the reason up to a maximum of 50	

		characters.	
6.4	Please give details of any new referrals to specialist treatment provider/s (since care plan agreed)	Enter code and/or name of the agency that the client has been referred to. Agency code should be the NDTMS code for the agency - this should be 5 or 6 characters long. Information on up to 2 agencies can be recorded.	
6.5	Which structured support (treatment) has commenced since transfer?	Tick which interventions have commenced since transfer - Record the date that each intervention commenced in DD/MM/YYYY format.	
6.6	Which other types of support (non-treatment) have been commenced since transfer?	Tick which interventions have commenced since transfer - Record the date that each intervention commenced in DD/MM/YYYY format.	
Section 7 **Client re-engagement, case suspension or closure**			
7.1	Date client re-engaged	DD/MM/YYYY format	
7.2	Please tick reason client re-engagement after case suspension	Tick one box only	
7.3	Date case suspended	DD/MM/YYYY format	
7.4	Why was the case suspended?	Tick one box only. If 'other' is selected, provide a description, up to a maximum of 50 characters.	

7.5	Date case closed	DD/MM/YYYY format	
7.6	Why was the case closed?	Tick one box only. If ‘other’ is selected, provide a description up to a maximum of 50 characters.	

4.2.2 Prisons

ACTIVITY FORM – CARATs			
Section on form	**Field**	**Guidance**	**Completion Guidance**
Section 1 Form completed by			
1.1	Name	Name of worker who completed form	
	Phone	Phone number of worker	
	Prison name	Name of the prison in which client is seen	
Section 2 About the client			
2.1	First initial	One character only – first letter of client's first name	
	Surname initial	One character only – first letter of client's surname	
	Date of birth	DD/MM/YYYY format	
	Gender	Tick one box only	
	Number	This field should not be completed until required (guidance will be provided).	
2.2	Postcode	If a postcode is available, enter the first part of the client's postcode, excluding the last two letters of the second part of the postcode (e.g. OX11 2BA would be recorded as OX11 2XX).	
	No fixed abode	Tick if applicable	
2.3	DAT/CSP where client is resident	Enter DAT/CSP code where the client is resident	If client is NFA use address of benefit office for DAT/CSP of residence
2.4	Prison where activity undertaken	Enter Prison code where this activity undertaken	
2.5	Date of initial reception	DD/MM/YYYY format	

2.6	Date of reception in this prison	DD/MM/YYYY format	
2.7	Prison status	Tick one box only	
2.8	Is client pregnant?	Tick one box only	Must be as stated by the client
	Give due date	DD/MM/YYYY or tick due date not known	
2.9	Does the individual being assessed consider themselves to have a disability?	Tick one box only	Must be as stated by the client
2.10	Is client a PPO?	Tick one box only	
2.11	Nationality at birth	Country of nationality at birth - enter the ISO 3-letter country code	Country of nationality at birth must be as stated by the client. If they do not wish to give an answer, the 'Not stated' code ZZZ should be used. Annex B contains a list of country codes, e.g. GBR = United Kingdom. This list should be made available to workers for reference.
2.12	Ethnic group	Tick one box only	Must be as stated by the client
2.13	Religion	Tick one box only	Must be as stated by the client
Section 3 **Client is already on the CARAT caseload**			
3.1	Date care plan reviewed	DD/MM/YYYY format	This refers to a formal Care Plan review, as detailed in the CARAT practice manual. This is the review of a care plan that has been completed following a CSMA (i.e. section 9.1 and 9.3 of the DIR has already been completed, or Activity Form section 4.5 following a CSMA if the client was transferred to the prison) This question only needs to record those reviews that are undertaken when a client has completed (or not completed)

			treatment delivered as part of their current care plan, or when a client's treatment requirements change (e.g. a new treatment intervention is to commence). Reviews that are undertaken in response to a significant change in client circumstances, e.g. their legal/custodial status, do not need to be recorded here. For IDTS - a Care Plan review must be held at the completion of the first 28 days.
3.2	Which structured treatment interventions in the current care plan have now ended?	Tick any interventions commenced in the current care plan that have now ended and record the date the intervention ended in DD/MM/YYYY format – the end date will be the date treatment was completed or the date it stopped. For each intervention that ended record whether the intervention ended in a planned way, unplanned or was withdrawn - indicate, by ticking, the exit status relating to the intervention - planned exit, unplanned exit or intervention withdrawn. Only one type of exit status can be ticked. Information on clinical treatments should be provided by clinical teams	Definitions for "Planned exit", "Unplanned exit" and "Intervention withdrawn" are provided for each structured intervention type in Annex C of this document.
3.3	What new treatment interventions have commenced as part of the current care plan?	Tick which interventions have commenced. Record the date that the intervention commenced in DD/MM/YYYY format.	Note any new treatment that has commenced under the current care plan that has not already been recorded (on earlier an Activity Form or the DIR). It is

		Information on clinical treatments should be provided by clinical teams	important that all new interventions commenced are captured.
Section 4 **Client transferred from another CARAT/CJIT**			
4.1	DAT/CSP or Prison from which client transferred	Enter DAT/CSP or Prison code from where client was transferred	
4.2a	Which substances misused by the client brought them into treatment? Tick the top 3 drugs that brought them into treatment (Drug 1 should be the most relevant)	Tick up to 3 drugs that brought the client into this episode of treatment with Drug 1 being the most relevant.	The drug/s recorded will be those for which the client is being treated. Alcohol is included on the list. If two different drugs are mixed together and then used as one, record the substances mixed under Drug 1 and Drug 2.
4.2b	Has any first night initial clinical intervention been provided by a doctor? (for clients transferred from the community)	Where the client has been transferred in from the community Tick No or Yes. If Yes, tick whether the client has been prescribed methadone or another drug.	Ask client on arrival/check records to determine whether a first night initial clinical intervention has been provided by a doctor and what was prescribed to the client. Do not include prescribing under Patient Group Directions (PGDs). This question is specifically about prescribing by a doctor. This question is specifically for clients transferred into prison from the community - no first night initial clinical intervention is ordinarily required for a client who has been received from another prison.
4.3	Does the client have a current CSMA completed?	Tick Yes or No. If No, indicate if a CSMA is going to be completed for the client. If a CSMA is not going to be completed tick a reason	Where 'No' is ticked, this is an EXIT point – if the client does not already have a current CSMA and a CSMA is not going to be completed a care plan cannot be agreed, and therefore the client is not

		why not - If 'Other' is selected, provide a description up to a maximum of 50 characters. This is an EXIT point.	taken onto the CARATs “Active” caseload for the purposes of monitoring and research. Do NOT complete any more of the form - send it to the Data Manager.
4.4	CSMA has been completed by CARAT worker Give date completed	Give date when the CSMA was completed in DD/MM/YYYY format.	If a CSMA is completed by the prison receiving the client indicate here the date it took place.
4.5	Has care plan been agreed with client since transfer?	Tick Yes or No. If Yes, provide the date when the care plan was agreed, in DD/MM/YYYY format. If No, tick the reason why not. If 'Other' is selected, provide a description up to a maximum of 50 characters. This is an EXIT point.	If ‘No’ this is an EXIT point. A client is not taken onto the CARATs “Active” caseload for the purposes of monitoring and research if a care plan is not agreed. Complete 4.5 and send the form to the Data Manager - Do NOT complete any more of the form. A full care plan cannot be agreed without a current CSMA. If the client does not already have a CSMA then one must be completed by the receiving prison and the date recorded under 4.4 in order to record a care plan at 4.5.
4.6	What treatment interventions have commenced as part of the newly agreed care plan?	Tick which interventions have commenced. Record the date that the intervention commenced in DD/MM/YYYY format. Information on clinical treatments should be provided by clinical teams.	This section is to record the start dates of any <u>new</u> treatment interventions that have commenced under the new care plan. Treatment commencement dates cannot be recorded under 4.6 without 4.5 = Yes (care plan agreed and client has a CSMA).
Section 5 **Client re-engagement, case suspension or closure**			
5.1	Date client re-engaged	DD/MM/YYYY format	This section should be completed if a client had been suspended from the “Triage” or “Active” caseload whilst in this

			prison but is now re-engaging with treatment – once a re-engaged date has been recorded the client is now considered to be back on the CARATs caseload for the purposes of monitoring and research. If the client has commenced any new treatment interventions, as a result of this re-engagement, these should be recorded under section 3 of the Activity Form.
5.2	Please tick reason client was re-engaged after case suspension	Tick one box only	
5.3	Date case suspended	DD/MM/YYYY format	This date should be completed if a client is suspended from the CARATs caseload during their stay in the prison, for example if they disengage from the service or are unable to participate in treatment due to incapacity. Those clients with whom you have agreed an initial care plan will not yet be recognised as an open case on DIRWeb (sections 9.1 and 9.3 of the DIR have not been completed); therefore, you do not complete an Activity Form to suspend or close the case.
5.4	Why was case suspended?	Tick one box only. If 'other' is selected, provide a description up to a maximum of 50 characters.	
5.5	Date case closed	DD/MM/YYYY format	
5.6	Why was the case closed?	Tick one box only. If 'other' is selected, provide a description up to a maximum of 50 characters.	A client's case may be closed for any of the reasons listed on the form. If a client is transferred to another prison, or to the CJIT, please record the code of the prison

			/ CJIT to which the client is going – this allows the record to be linked up with the records of the other prison / CJIT to determine whether the client was successfully transferred.
5.7	Which structured treatment interventions in the current care plan have now ended as a result of this suspension or closure?	Tick any interventions commenced in the current care plan that have now ended as a result of the client being suspended or closed (due to release of transfer) and record the date the intervention ended in DD/MM/YYYY format - the end date will be the date treatment was completed or the date it stopped. For each intervention that ended record whether the intervention ended in a planned way, unplanned or was withdrawn - indicate, by ticking, the exit status relating to the intervention - planned exit, unplanned exit or intervention withdrawn. Only one type of exit status can be ticked. Information on clinical treatments should be provided by clinical teams.	Definitions for “Planned exit”, “Unplanned exit” and “Intervention withdrawn” are provided for each structured intervention type in Annex C of this document.

5 Required Assessment (RA) Form – Community Only

5.1 Overview - RA

1. The Required Assessment Form is for Monitoring and Research (M&R) purposes only and is only to be used by CJITs. The form captures information relating to a required assessment where this has been imposed by the police.

2. The form should be completed for any clients who where **not** on the case load at the time who have had an initial and or follow-up required assessment imposed. The outcome of the required initial and or follow-up assessment should be recorded on the form – this will be used to monitor attendance at, and the outcome of, the assessment appointment.

3. For clients on the caseload at the time of the test, similar information about attendance and outcome of a required assessment appointment is to be recorded on the community Activity Form.

4. When a client has both the RA – Initial and Follow up Assessment in the same DAT (i.e. in their DAT of residence) the same form can be used to record the outcomes.

5. The Required Assessment Form should be sent to the appropriate data manager using the same route/process as used for the main DIR.

5.2 Field by Field - RA

REQUIRED ASSESSMENT FORM			
Section on form	**Field**	**Guidance**	**Completion Guidance**
Section 1 Form completed by			
1.1	Name	Name of worker who completed form	
	Phone	Phone number of worker	
Section 2 About the client			
2.1	First initial	One character only – first letter of client's first name	
	Surname initial	One character only – first letter of client's surname	
	Date of birth	DD/MM/YYYY format	
	Gender	Tick one box only	
	Number	This field should not be completed until required (guidance will be provided).	
2.2	Contact details – Postcode	If a postcode is available, enter the first part of the client's postcode, excluding the last two letters of the second part of the postcode (e.g. OX11 2BA would be recorded as OX11 2XX).	
	No fixed abode	Tick if applicable	
2.3	Does the individual being assessed consider themselves to have a disability?	Tick one box only	Must be as stated by the client
2.4	Nationality at birth	Country of nationality at birth - enter	Country of nationality at birth must be as stated by

		the ISO 3-letter country code	the client. If they do not wish to give an answer, the 'Not stated' code ZZZ should be used. Annex B contains a list of country codes, e.g. GBR = United Kingdom. This list should be made available to workers for reference.
2.5	Ethnic group	Tick one box only	Must be as stated by the client
2.6	Religion	Tick one box only	Must be as stated by the client
Section 3 RA Information			
3.1	DAT/CSP where client resident	Enter DAT/CSP code where the client is resident	
3.2	DAT/CSP where Required Assessment was undertaken	Enter DAT/CSP code where Required Assessment was undertaken	The DAT code should reflect where the RA – IA or the RA - FA was undertaken (or where it should have been carried out – for the clients who did not attend).
3.3	Is the Required Assessment an Initial Assessment or a Follow up Assessment?	Tick one box only and insert date in DD/MM/YYYY format	If the RA is an Initial Assessment, go to Section 4. Do not complete Section 5. If the RA is a Follow-up Assessment, go to Section 5. Do not complete Section 4.
Section 4 RA – Initial Assessment			
4.1	Did the client attend and remain for the duration of the Required Assessment?	Tick Yes or No. If Yes, tick where the RA was carried out and go to question 4.3. If 'Other; is ticked, provide a description up to a maximum of 50 characters. If No, tick the reason why the client did not attend the RA. If 'Did not attend - other' is selected, provide a description up to a maximum of 50	

		characters.	
4.2	Have police been informed of failure to attend and remain?	Tick Yes or No.	
4.3	During the RA – Initial Assessment, did the drug worker set the time and date for an RA – Follow up Assessment?	Tick Yes or No. If No, tick the reason the appointment date was not given. If 'other' is selected, provide a description up to a maximum of 50 characters.	
4.4	What did the Required Assessment lead to?	Tick 'Screening/Triage Assessment', 'Care Plan' or 'None of the above'. If 'None of the above' is selected then tick the reason why the RA did not lead to a screening/triage or care plan. If 'Other' is selected, provide a description up to a maximum of 50 characters.	
Section 5 RA – Follow up Assessment			
5.1	Did the client attend and remain for the duration of the Required Assessment?	Tick Yes or No. If Yes, tick where the RA was carried out; if 'Other' is ticked, provide a description up to a maximum of 50 characters. Then answer question 5.3. If No, tick the reason why the client did not attend the RA. If 'Did not attend - other' is selected, provide a description up to a maximum of 50 characters and answer question 5.2.	

5.2	Have police been informed of failure to attend and remain?	Tick Yes or No.	
5.3	What did the RA Assessment lead to?	Tick 'Screening/triage Assessment', 'Care Plan' or 'None of the above'. If 'None of the above' is selected then tick the reason why the RA did not lead to a screening / triage or care plan. If 'Other' is selected, provide a description up to a maximum of 50 characters.	

6 Continuity of Care Update Form

6.1 Overview – CoC Update Form

1. The Continuity of Care Update Form is a **non-mandatory** document, the purpose of which is to update personal client information if it has changed significantly from the information recorded on their DIR. This form has been created following requests received by the Home Office from regional colleagues requesting a standardised form. This form is designed to replace existing regional forms which serve the same purpose if required, but DATs are under no obligation to adopt this form and are welcome to continue using existing local forms if they wish. The Prison Service is similarly content for CARATs to use this form for the same purpose but, as before, it is not mandatory.

2. The form has no Monitoring and Research purposes and should not be sent to the Home Office. Its only purpose is to allow CJITs/CARATs workers to capture new information on the client which is not mentioned, or has altered, from the information on the existing DIR.

3. The form could be completed for any caseload client who has any personal information, circumstances or immediate issues which have changed since the DIR was completed. This form could be used when a client is transferring from one CJIT to another, or from one prison establishment to another, and sent to the receiving CJIT/CARAT via the established communication channels. If any information is recorded which notifies a receiving CJIT/CARAT team of any changes to the individual's immediate issues, information should be recorded as comprehensively as possible, ensuring contact details of the original CJIT/CARAT team is included to allow for future communications to be made if needed.

6.2 Field by Field – CoC Update Form (CoC)

CONTINUITY OF CARE UPDATE			
Section on Form	**Field**	**Guidance**	**Completion Guidance**
Section 1			
Form Completion	Name	Full name and team/agency name	Complete section as fully as possible to allow receiving CJIT worker an opportunity to contact sending CJIT to discuss
	Phone	Direct phone number	
	Date	DD/MM/YYYY format	Date that this form is being completed
Section 2			
About the client	First name	Client's first name	Full name should be given. This form will not be used for monitoring.
	Surname	Client's surname	
	Date of birth	DD/MM/YYYY format	If known
Section 3			
Contact details	Address	Full address, including postcode if known, if client has changed address since DIR.	If address is same as the address disclosed on the DIR there is no need to complete this section.
	No Fixed Abode	Tick if applicable	Permanent accommodation includes owned, rented, supported accommodation. If this is the case the full address needs to be listed and NFA box should not be ticked.
	Phone/Mobile Number	Both numbers are requested	Only fill in whatever contact number is available. If client is unwilling to disclose details, ensure that contact address is complete. It is important that the receiving CJIT is able to contact the client.
Section 4			

Significant events	Describe any significant changes since the DIR was originally completed	All notable changes to the client's personal background should be noted	Details to be listed here range from changes in the client's substance use, criminal involvement and forthcoming court dates. Physical/psychological health and social needs should be included. Any information which is not on the DIR or has changed since the DIR was completed should also be included, and should be described in sufficient detail for a receiving CJIT to be able to understand the issues at stake.
Section 5			
Immediate issues or actions	Identify immediate issues or actions – either proposed or needing to be proposed	Reference must be made to any immediate issues or actions that the drug worker needs to be aware of.	Immediate issues or actions might include increased client vulnerability, raised recent overdose of self-harm likelihood, urgent accommodation issues, health needs etc.

7 Annex A: Housing and Homelessness terminology for completion of the DIR

The following briefing provides guidance on the various circumstances associated with homelessness. There are a number of different categories of people who may be homeless or have experienced homelessness, and their characteristics and circumstances can be very different from each other. Consequently, catch-all terms such as '*the homeless*' or '*the homeless population*' should be avoided.

Communities and Local Government have been working with the Home Office, NTA and a number of key partners and other government departments to establish a common terminology for use when referring to these specific groups, whether verbally or in written form. This glossary is available at http://drugs.homeoffice.gov.uk/publication-search/dip/improving-practice-housing/ACHTerminologyandGlossary?view=Binary and may be subsequently updated. The attached table can be used as background information to particularly help inform CJIT workers in the community and CARAT teams in their recording of the needs/issues/actions relating to their clients' accommodation status using the Drug Interventions Record (DIR).

Housing - Terms and Descriptions for help with completion of the DIR and ongoing Continuity of Care
It is important to note that on occasion a client will also have accommodation secured under a homelessness duty**.**

Term	Description	Notes
Description of Accommodation Status and types of accommodation		
No Fixed Abode (NFA)	Describes someone who does not have a fixed base – and may often sleep in different places on a night by night basis. This may include people who are rough sleepers, i.e. people sleeping, or bedded down, in the open air (such as on the streets, or in doorways, parks or bus shelters); people in buildings or other places not designed for habitation (such as barns, sheds, car parks, cars, derelict boats, stations, or 'bashes')	It is likely to be on a night by night basis and should therefore be considered as a priority for a specialist housing assessment/ action and/or intervention The following should NOT be considered NFA : people in hostels or shelters; people in campsites or other sites used for recreational purposes; squatters, travellers
Insecure or transitory accommodation	This can include a range of accommodation arrangements. The principle characteristic is that the arrangement is precarious, the person has no or very little security of tenure and so may be required to leave at very short notice. Insecure accommodation can range from hostel accommodation provided on a nightly basis to staying with friends / sleeping on friends' floor or sofa. The client may require ongoing support to sustain existing arrangements, prevent homelessness and develop life skills to help them move on to more settled accommodation.	This term <u>is not</u> recorded in the DIR but may be used by Housing colleagues Housing and drug sectors independently distinguish Insecure or transitory accommodation from Temporary accommodation, as explained in the description of the latter below.
Temporary Accommodation which may include types listed below but not exclusively	To avoid confusion, this term should only be used to refer to temporary accommodation that is being secured by a local authority as a discharge of its responsibilities under the homelessness legislation. Most people in temporary accommodation are owed the main homelessness duty (which means that the local authority must ensure that they have suitable accommodation available until a settled home becomes	Whilst in a housing context, temporary accommodation describes temporary accommodation secured by a local authority as a discharge of its homelessness duty, drug workers may use the term to describe accommodation arrangements which are short term. It is important in these

	available). Consequently, it would not be appropriate to characterise their position of people in temporary accommodation as “insecure” (even though they may technically have only a low degree of security of tenure).	circumstances to be able assess needs and to inform what ongoing support may be required to prevent likelihood of homelessness and access advice, lifeskills to help prepare and facilitate move-on to more settled accommodation as appropriate, When liaising with the local authority /Housing Association a drug worker be aware of what this term refers to under arrangements secured by their local authority.
➢ Hostel	Accommodation owned or leased and managed either by a local authority, housing association or non-profit making organisation, where the accommodation is usually not self-contained and bathroom and/or kitchen facilities are shared. However, some hostels comprise self-contained units within a block reserved for families that have experienced homelessness, with a communal room or reception area and possibly an on-site manager but otherwise indistinguishable from normal flats. (P1E Guidance, sections 34-40)	Hostel
➢ Bed and Breakfast accommodation	Typically involves the use of privately managed hotels, or units and annexes associated with such establishments, where households share at least some basic facilities. Meals may or may not be provided. (P1E Guidance, sections 34-40)	Bed and Breakfast accommodation
➢ Refuge	A building or part of a building managed by a voluntary organisation and used wholly or mainly for the temporary accommodation of persons who have left their homes as a result of - (a) physical violence or mental abuse, or (b) threats of such violence or abuse, from persons to whom they are or were married or with whom they are or were co-habiting	Statutory definition of a Refuge in a housing context

Short term tenancy	Private sector leased properties leased by a council or RSL	
Settled Accommodation which may include types listed below but not exclusively	Settled accommodation referred to in this section indicates secure/long term accommodation. The principal characteristic is that the occupier has security of tenure in the medium to long term, or is part of a household whose head holds such security of tenure. Can include a range of scenarios, e.g. an assured or assured shorthold tenancy in the private rented sector, an assured (or starter) tenancy with a registered social landlord (housing association), a secure (or introductory) tenancy with a local authority, owner occupation.	It's important to note that clients in settled accommodation could still be at risk of losing their accommodation e.g. if there are rent/mortgage arrears or risk of relationship breakdown. So, they may require support/advice to help them sustain their existing arrangements.
Further brief description of terms which are used in the context of the Homelessness Act/Homelessness Legislation		
Homeless person	Broadly speaking, someone is defined in law as 'homeless' if they do not have any accommodation which they have a legal right to occupy (e.g. under a licence or a tenancy), which is available for all of their household, which is accessible to them, and which it would be reasonable for them to continue to occupy. Although a rough sleeper who literally had nowhere to live would be homeless, a person living in a hostel would not be statutorily homeless (unless it was not reasonable for them to continue to live there).	
Threatened with homelessness	This means someone is likely to become homeless within 28 days.	Threatened with homelessness
Homelessness Acceptance	A person who has been accepted by a local housing authority as being owed a main homelessness duty (either to prevent their homelessness or to secure suitable alternative accommodation for them). This duty is owed to housing applicants who are eligible for assistance, unintentionally homeless (or threatened with homelessness) and who fall within a priority need group.	Homelessness Acceptance

Intentionally homeless	A person becomes homeless intentionally if they become homeless as a consequence of their own deliberate behaviour (and, but for which, it would have been reasonable for them to continue to occupy the accommodation)	Intentionally homeless
Housing Advice	Housing Authorities have a duty to ensure that advice and information about homelessness and prevention of homelessness are available free of charge to anyone in their district	

Homelessness - Terms and Descriptions for help with completion of the DIR and ongoing Continuity of Care

Suggested terminology	**Group(s) referred to**	**Do not say :**
rough sleepers	rough sleepers	
people living in insecure accommodation	people staying with friends temporarily / sleeping on floors or sofas people moving in and out of hostels and/or staying with friends	The single homeless
people at risk of homelessness	people at risk of homelessness	People vulnerable to homelessness [*avoid this because it could be confused with being vulnerable for the purpose of priority need*.]
people living in hostels	people living in hostels	The single homeless
people living in temporary accommodation	people living in temporary accommodation provided as a discharge of a homelessness function	homeless families
homeless acceptances	people accepted by a local housing authority as owed a main homelessness duty	The statutorily homeless
families/households that have experienced homelessness	families/households owed the main homelessness duty	Homeless families / households
homeless people	people who are actually homeless (i.e. as defined in	

or people who are statutorily homeless	law as 'homeless' for *they do <u>not</u> have any accommodation which they have a legal right to occupy and which is available to them and their household and is reasonable to occupy*) Although a rough sleeper who literally had nowhere to live would be homeless, a person living in a hostel would not be statutorily homeless (unless it was not reasonable for them to continue to live there).	

<u>Different types of tenancies</u>

Secure tenancy (local housing authorities)

Local authority housing, allocated through its housing register, will generally be let on a secure tenancy. This offers long-term security of tenure for as long as the tenant keeps to the terms of the tenancy agreement.

Assured Tenancy (housing associations and private landlords)

Offers similar long-term security of tenure to a secure tenancy provided by a local authority (see above) in that as long as the tenant does not break the terms of the Tenancy Agreement s/he can continue to live in the property. Housing allocated through the local authority's housing register may include nominations to housing association property, usually let on assured tenancies.

Assured Shorthold Tenancy (housing associations and private landlords)

An assured shorthold tenancy may be for a fixed period of time, and, as a minimum offers security of tenure for at least 6 months. It may not provide long-term security of tenure because the landlord can seek repossession by giving 2 months notice after 6 months or the end of the agreed fixed term. Some housing association tenancies may initially be assured shorthold tenancies where they are granted on a probationary basis ("starter tenancies") or on a temporary basis (as supported housing).

Demoted tenancies

Local authorities, housing action trusts and registered social landlords may apply to the court to allow a secure or assured tenancy to be brought to an end by a demotion order. If an order is granted, the tenancy is replaced with a less secure form of tenancy - a demoted tenancy.

Non Secure Tenancy (local housing authorities)

Local housing authority accommodation is let under non-secure tenancies in specified circumstances, including when an authority sub lets accommodation they are leasing from another landlord, e.g. under schemes known as 'Private Sector Leasing'. Under these schemes, the local authority is the immediate landlord of the tenant. Non-secure tenancies cannot offer long-term security of tenure (and are usually used to provide temporary accommodation). The local authority can bring such a non-secure tenancy to an end by giving reasonable notice (usually 4 weeks) and of course, such 'PSL' tenancies must end when the head lease between the authority and the landlord expires.

Licence agreement

Only applies where the conditions for a tenancy do not exist e.g. in a hostel or hotel that offers non-self contained accommodation. Right of use but no tenancy rights. This is the least secure option and provides very little security. Licences can generally be withdrawn with reasonable notice (which may be as little as a few days). However, it is possible to draw up conditions to the Licence but this does not extend as far as the rights provided for in the alternative options.

References

www.drugs.homeoffice.gov.uk – The cross-government drug strategy website for drug professionals and others interested in the strategy. It includes all the information released by the Home Office on DIP.

www.nta.nhs.uk – the website of the National Treatment Agency for England includes details of the NTA's work programme, as well as publications and guidance for those in the drug treatment sector. Includes all the information on Models of Care.

www.communities.gov.uk – The Office of Communities and Local Government is responsible for policy on housing, planning, devolution, regional and local government and the fire service. It also takes responsibility for the Social Exclusion Unit, the Neighbourhood Renewal Unit and the Government Offices for the Regions. The website contains useful information on housing, homelessness, Supporting People etc.

www.housingcorp.gov. website of the Housing Corporation, which is the government agency that currently funds new affordable homes and regulates housing associations in England. The Housing Corporation also has a dedicated **Centre for Research and Market Intelligence** (CRMI). CRMI produces quality research, analysis, innovation and good practice. It aims to make the Housing Corporation world renowned for being the centre of expertise for housing policy and information.

8 Annex B: ISO Country Codes for ‘Nationality at Birth’ field

The following is a complete list of the current officially assigned ISO 3166-1 alpha-3 codes, with country names being English short country names officially used by the ISO 3166 Maintenance Agency (ISO 3166/MA). These codes should be used to complete the ‘Nationality at Birth’ field on the forms.

GBR	United Kingdom	GIB	Gibraltar	NIU	Niue
ABW	Aruba	GIN	Guinea	NLD	Netherlands
AFG	Afghanistan	GLP	Guadeloupe	NOR	Norway
AGO	Angola	GMB	Gambia	NPL	Nepal
AIA	Anguilla	GNB	Guinea-Bissau	NRU	Nauru
ALA	Åland Islands	GNQ	Equatorial Guinea	NZL	New Zealand
ALB	Albania	GRC	Greece	OMN	Oman
AND	Andorra	GRD	Grenada	PAK	Pakistan
ANT	Netherlands Antilles	GRL	Greenland	PAN	Panama
ARE	United Arab Emirates	GTM	Guatemala	PCN	Pitcairn
ARG	Argentina	GUF	French Guiana	PER	Peru
ARM	Armenia	GUM	Guam	PHL	Philippines
ASM	American Samoa	GUY	Guyana	PLW	Palau
ATA	Antarctica	HKG	Hong Kong	PNG	Papua New Guinea
ATF	French Southern Territories	HMD	Heard Island and McDonald Islands	POL	Poland
ATG	Antigua and Barbuda	HND	Honduras	PRI	Puerto Rico
AUS	Australia	HRV	Croatia	PRK	Korea, Democratic People's Republic of
AUT	Austria	HTI	Haiti	PRT	Portugal
AZE	Azerbaijan	HUN	Hungary	PRY	Paraguay
BDI	Burundi	IDN	Indonesia	PSE	Palestinian Territory, Occupied
BEL	Belgium	IMN	Isle of Man	PYF	French Polynesia
BEN	Benin	IND	India	QAT	Qatar
BFA	Burkina Faso	IOT	British Indian Ocean Territory	REU	Réunion
BGD	Bangladesh	IRL	Ireland	ROU	Romania
BGR	Bulgaria	IRN	Iran, Islamic Republic of	RUS	Russian Federation
BHR	Bahrain	IRQ	Iraq	RWA	Rwanda
BHS	Bahamas	ISL	Iceland	SAU	Saudi Arabia

BIH	Bosnia and Herzegovina	ISR	Israel	SDN	Sudan
BLM	Saint Barthélemy	ITA	Italy	SEN	Senegal
BLR	Belarus	JAM	Jamaica	SGP	Singapore
BLZ	Belize	JEY	Jersey	SGS	South Georgia and the South Sandwich Islands
BMU	Bermuda	JOR	Jordan	SHN	Saint Helena
BOL	Bolivia	JPN	Japan	SJM	Svalbard and Jan Mayen
BRA	Brazil	KAZ	Kazakhstan	SLB	Solomon Islands
BRB	Barbados	KEN	Kenya	SLE	Sierra Leone
BRN	Brunei Darussalam	KGZ	Kyrgyzstan	SLV	El Salvador
BTN	Bhutan	KHM	Cambodia	SMR	San Marino
BVT	Bouvet Island	KIR	Kiribati	SOM	Somalia
BWA	Botswana	KNA	Saint Kitts and Nevis	SPM	Saint Pierre and Miquelon
CAF	Central African Republic	KOR	Korea, Republic of	SRB	Serbia
CAN	Canada	KWT	Kuwait	STP	Sao Tome and Principe
CCK	Cocos (Keeling) Islands	LAO	Lao People's Democratic Republic	SUR	Suriname
CHE	Switzerland	LBN	Lebanon	SVK	Slovakia
CHL	Chile	LBR	Liberia	SVN	Slovenia
CHN	China	LBY	Libyan Arab Jamahiriya	SWE	Sweden
CIV	Côte d'Ivoire	LCA	Saint Lucia	SWZ	Swaziland
CMR	Cameroon	LIE	Liechtenstein	SYC	Seychelles
COD	Congo, the Democratic Republic of the	LKA	Sri Lanka	SYR	Syrian Arab Republic
COG	Congo	LSO	Lesotho	TCA	Turks and Caicos Islands
COK	Cook Islands	LTU	Lithuania	TCD	Chad
COL	Colombia	LUX	Luxembourg	TGO	Togo
COM	Comoros	LVA	Latvia	THA	Thailand
CPV	Cape Verde	MAC	Macao	TJK	Tajikistan
CRI	Costa Rica	MAF	Saint Martin (French part)	TKL	Tokelau
CUB	Cuba	MAR	Morocco	TKM	Turkmenistan
CXR	Christmas Island	MCO	Monaco	TLS	Timor-Leste
CYM	Cayman Islands	MDA	Moldova, Republic of	TON	Tonga
CYP	Cyprus	MDG	Madagascar	TTO	Trinidad and Tobago
CZE	Czech Republic	MDV	Maldives	TUN	Tunisia

DEU	Germany	MEX	Mexico	TUR	Turkey
DJI	Djibouti	MHL	Marshall Islands	TUV	Tuvalu
DMA	Dominica	MKD	Macedonia, the former Yugoslav Republic of	TWN	Taiwan, Province of China
DNK	Denmark	MLI	Mali	TZA	Tanzania, United Republic of
DOM	Dominican Republic	MLT	Malta	UGA	Uganda
DZA	Algeria	MMR	Myanmar	UKR	Ukraine
ECU	Ecuador	MNE	Montenegro	UMI	United States Minor Outlying Islands
EGY	Egypt	MNG	Mongolia	URY	Uruguay
ERI	Eritrea	MNP	Northern Mariana Islands	USA	United States
ESH	Western Sahara	MOZ	Mozambique	UZB	Uzbekistan
ESP	Spain	MRT	Mauritania	VAT	Holy See (Vatican City State)
EST	Estonia	MSR	Montserrat	VCT	Saint Vincent and the Grenadines
ETH	Ethiopia	MTQ	Martinique	VEN	Venezuela
FIN	Finland	MUS	Mauritius	VGB	Virgin Islands, British
FJI	Fiji	MWI	Malawi	VIR	Virgin Islands, U.S.
FLK	Falkland Islands (Malvinas)	MYS	Malaysia	VNM	Viet Nam
FRA	France	MYT	Mayotte	VUT	Vanuatu
FRO	Faroe Islands	NAM	Namibia	WLF	Wallis and Futuna
FSM	Micronesia, Federated States of	NCL	New Caledonia	WSM	Samoa
GAB	Gabon	NER	Niger	YEM	Yemen
GEO	Georgia	NFK	Norfolk Island	ZAF	South Africa
GGY	Guernsey	NGA	Nigeria	ZMB	Zambia
GHA	Ghana	NIC	Nicaragua	ZWE	Zimbabwe

9 Annex C: PRISONS ONLY - Definitions for “Planned exit”, “Unplanned exit” and “Intervention withdrawn”

The definitions below are to enable the completion of the exit status information on the Prisons Activity Form for any structured treatment interventions that have ended. For each intervention type “planned exit”, “unplanned exit” and “intervention withdrawn” is defined.

Intervention:	**Planned exit**	**Unplanned exit**	**Intervention withdrawn**
Intensive drug treatment programme	Client completed the programme	Client did not complete the programme or they were released prior to completion of the programme, or client did not complete the programme due to transfer to hospital	A decision was made by the provider to withdraw the intervention due to a serious breach of contract by the client
Five-day opioid stabilisation	Client completed the 5 days	Client elected not to complete the programme or they were released prior to completion of stabilisation, or client did not complete the stabilisation due to transfer to hospital	A decision was made by the provider to withdraw the intervention due to a serious breach of contract by the client
Alcohol detoxification	Client completed detoxification	Client elected not to complete the detoxification or they were released prior to completion of detoxification, or client did not complete the detoxification due to transfer to hospital	A decision was made by the provider to withdraw the intervention due to a serious breach of contract by the client
Benzodiazepine reduction	Client completed the reduction based on clinical assessment, or client was transferred to another establishment and will continue their reduction	Client elected not to complete the reduction or they were released prior to completion of the reduction, or client did not complete the reduction due to transfer to hospital	A decision was made by the provider to withdraw the intervention due to a serious breach of contract by the client
Opioid detoxification 14 days	Client completed detoxification	Client elected not to complete the detoxification or they were released	A decision was made by the provider to withdraw the

		prior to completion of detoxification, or client did not complete the detoxification due to transfer to hospital	intervention due to a serious breach of contract by the client
Opioid detoxification more than 14 days	Client completed detoxification	Client elected not to complete the detoxification or they were released prior to completion of detoxification, or client did not complete the detoxification due to transfer to hospital	A decision was made by the provider to withdraw the intervention due to a serious breach of contract by the client
Opioid maintenance (Buprenorphine)	Client completed maintenance treatment or client was transferred to another establishment and will continue maintenance treatment, or client was released with onward referral to the community to continue their treatment (this includes a two-way communication between the prison and community with sharing of assessment and care planning information to ensure continuity of care)	Client disengaged from the treatment or was unable to continue with the treatment due to transfer to hospital, or was released at short notice	A decision was made by the provider to withdraw the intervention due to a serious breach of contract by the client
Opioid maintenance (Methadone)	Client completed maintenance treatment or client was transferred to another establishment and will continue maintenance treatment, or client was released with onward referral to the community to continue their treatment (this includes a two-way communication between the prison and community with sharing of assessment and care planning information to ensure continuity of	Client disengaged from the treatment or was unable to continue with the treatment due to transfer to hospital, or was released at short notice	A decision was made by the provider to withdraw the intervention due to a serious breach of contract by the client

	care)		
Naltrexone	Client was transferred to another establishment where treatment is to be continued, or client was released with onward referral to the community to continue their treatment (this includes a two-way communication between the prison and community with sharing of assessment and care planning information to ensure continuity of care)	Client disengaged from the treatment or was unable to continue with the treatment due to transfer to hospital, or was released at short notice	A decision was made by the provider to withdraw the intervention due to a serious breach of contract by the client