



## **Scottish Drugs Misuse Database**

### **SMR 25a/b Web System: Guidance Notes**

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## **1: How to use this document**

These guidelines should be used as a reference when completing SMR25a and SMR25b datasets **using the SDMD web-system**.

Each section of this document corresponds to a page on the web-system. You will find guidelines, definitions and advice on how to complete both SMR25a and SMR25b forms, in addition to some key information below on general advice about when to submit forms, who should submit, standard conventions for completing the forms and how to use the SDMD web system.

## **2: Which services should complete an SMR25a assessment**

If your service provides a **comprehensive** or **specialist assessment** of clients' care/ treatment needs related to their drug misuse, then SMR25a assessment is relevant to your service.

For the purposes of this document, the term "specialist assessment" is used to describe both comprehensive and specialist assessments.

This assessment aims to identify needs and aspirations of the client, in order to inform decisions about their treatment, care and support.

For clarification on what level of assessment your service carries out, refer to appendix B.

### **3: Which clients are appropriate for inclusion in this dataset**

#### **SMR25a**

SMR25a assessment reports are designed to gather information from the assessment process. The form should only be completed for a client who is starting a new episode of care and who has undergone a specialist assessment of their drug treatment and support needs at your service.

If a client is formally referred to you from another drug service, which has already carried out a specialist assessment for the client's drug treatment needs, then it is not necessary to submit a form. If a client arrives at your service without a formal referral from another agency or service then a form should be submitted.

The following questions should help you to identify which clients to submit SMR25a for:

**Is the client beginning a new episode of care i.e. the client is not in contact with any other drug treatment/support service?**

If Yes, complete SMR25a

**Has the client been informally referred to you by another drug treatment service?**

If Yes, complete an SMR25a

**Is the client re-attending your service for a specialist assessment after being formally discharged previously, and has not been formally referred to you by another service?**

If Yes, complete an SMR25a

**Has the client been formally referred to you by another drug treatment service as part of the client's ongoing episode of care?**

If Yes, **do not** complete an SMR25a. The referring service should have completed one.

**Is the client attending your service for treatment and support for something other than drug use? This includes treatment of alcohol use and non-drug related interventions such as housing and employability.**

If yes, **do not** complete an SMR25a. SMR25a is only appropriate for drug-related treatment.

**SMR25b**

SMR25b follow-up reports are designed to collect data on a client's situation for the duration of their interaction with drug services, once the initial assessment has been carried out (and SMR25a has been submitted). This data will allow for measurement of total time spent in care and for recording of changes that occur throughout care.

Please note that SMR25b cannot be submitted unless there is an existing SMR25a for that client and the episode of care is open.

There are two types of trigger for SMR25b;

- i) Time points, including 12 weeks after initial assessment, 52 weeks after initial assessment and annually thereafter.
- ii) Events; including transfer or referral from your service to another service, and discharge from your service.

**Timepoints**

The timepoints are driven by the date that the Initial Assessment (SMR25a) is completed for a client. This date is used to schedule all future Follow-Up submissions.

To assist with the timepoint submissions, the SDMD online application will notify you as to when a timepoint is approaching for follow-up submission.

**Events**

You are required to submit an SMR25b if your client is referred on from your service to another, even if you maintain contact with the client. This is so the system knows who to notify at the next timepoint in the client's care.

You are required to submit an SMR25b if your client is transferred from your service to another if you end contact with the client. This is so the system knows who to notify at the next timepoint in the client's care.

You are required to submit an SMR25b if you discharge the client from your service. This is so the system knows not to issue any further timepoint notifications.

## **4: Step By Step guides**

### **How to complete an SMR25a**

To submit an SMR25a for a new client:

1. Login to the SDMD web-system using the username/password provided by ISD.
2. Select *SMR25* from the left-hand menu
3. Select *New Assessment* from the expanded left-hand menu

The screen that appears has 4 fields for client data. The system uses these 4 fields to generate a unique Episode of Care Number. When next is clicked on this page, the system will check the details provided against all open Episodes of Care to see if a match is found.

4. Enter The *Forename/Surname/Date of Birth* in full, and select the gender from the drop down list. Then click *Next*
5. If no match has been found on the system, the Personal Details data capture screen will be displayed, with the four fields entered in step 4 already populated. From here you should now proceed through each of the data capture screens in turn, entering the details for your client.

If a match is found the system will return the episode of care that is currently open for the client. You will be asked to review the existing record, and can choose to either proceed with a new submission, or use the existing record to submit an SMR25b.

6. Once all the screens have been completed, you will arrive at the Save/Submit screen. If you are happy that the details on the record are complete, you can click Submit, and the details will be checked and then submitted to the database. If you are not ready to submit the form, you can click Save which will save the data locally and allow you to access it at a later date.

### **How to complete a scheduled SMR25b**

To submit a *scheduled* SMR25b for a client:

1. Login to the SDMD web-system using the username/password provided by ISD.
2. Select *Notifications* from the left-hand menu
3. Select *All*

You will now see a screen with a list of all the Notifications currently outstanding for your service. You can order the list of clients by clicking on any of the fields displayed in the blue header at the top of the page.

4. Locate the client whom you wish to submit a Follow-Up report for.

5. Click on the link to the right of the client's entry in the table. The link will be titled either "12 week follow-up" or "1<sup>st</sup> annual follow-up".

This will take you to the first of the Data Capture screens for the SMR25b. From here you should now move through each of the data capture screens in turn, entering the details for your client.

6. Once all the screens have been completed, you will arrive at the Save/Submit screen. If you are happy that the details on the record are complete, you can click Submit, and the details will be checked and then submitted to the database. If you are not ready to submit the form, you can click Save which will save the data locally and allow you to access it at a later date.

### **How to complete an unscheduled SMR25b**

To submit an *unscheduled* SMR25b for a client:

1. Login to the SDMD web-system using the username/password provided by ISD.
2. Select *SMR25* from the left-hand menu
3. Select *Search*

It is necessary to locate the open Episode of Care for your client before submitting an SMR25b. Using the fields provided, enter the identifiable details of the client and then click search at the bottom of the page. Your client should now appear on the search results screen.

4. Click the radio (circular) button on the left hand side of the clients name.
5. Then click Submit Unscheduled Follow-Up

This will take you to the first page of the Data Capture screens for the SMR25b. From here you should now move through each of the data capture screens in turn, entering the details for your client.

Once all the screens have been completed, you will arrive at the Save/Submit screen. If you are happy that the details on the record are complete, you can click Submit, and the details will be checked and then submitted to the database. If you are not ready to submit the form, you can click Save which will save the data locally and allow you to access it at a later date.

### **How to discharge a client from your service?**

A discharge of a client from your drug service can be completed whenever submitting either a scheduled or unscheduled SMR25b.

1. In the *Current Contact* tab on the data capture screens, answer the question "Is client being actively cared for/treated by this agency?" as *No*.
2. Select a reason for the discharge from the list provided

3. Then enter the date that the discharge should be effective from in the Date of Discharge field.

Once the above steps are completed and the record is submitted successfully, the client will be discharged from your service, and you will no longer receive notifications relating to the clients episode of care. Please note – if you do not discharge a client on the system you will continue to receive notification requests. Only by discharging a client will the requests for follow-up information be halted.

### **How to refer a client to another service?**

A referral to another drug service can be completed whenever submitting either a scheduled or unscheduled SMR25b. Once you have opened the data capture screens for the SMR25b:

1. In the *Current Contact* tab on the data capture screens, answer the question “Has client been referred to another drug treatment/rehabilitation service?” as *Yes*.
2. Select the service you are looking to refer the client to from the drop down list provided
3. Then enter the date of referral in the adjacent field
4. Once the fields are populated, click the Add Row button beneath the fields.

This will enter the referral onto the record. Once the SMR25b is completed and submitted, the referral will be completed on the system.

### **How to transfer a client to another service?**

A transfer to another drug service can be completed whenever submitting either a scheduled or unscheduled SMR25b. A transfer differs from a referral, as it will *also* discharge the client from your care on the system. Once you have opened the data capture screens for the SMR25b:

1. In the *Current Contact* tab on the data capture screens, answer the question “Is client being actively cared for/treated by this agency?” as *No*.
2. Select a reason for the discharge from the list provided
3. Then enter the date that the discharge should be effective from in the Date of Discharge field.
4. Answer the question “Has client been referred to another drug treatment/rehabilitation service?” as *Yes*.
5. Select the service you are looking to refer the client to from the drop down list provided
6. Then enter the date of referral in the adjacent field
7. Once the fields are populated, click the Add Row button beneath the fields.

This will enter the transfer onto the record. Once the SMR25b is completed and submitted, the transfer will be completed. The service listed for the referral will begin receiving notifications for the client, and the client will no longer be listed as

active with the current service. The client will be discharged from your service, and you will no longer receive notifications relating to the clients episode of care.

## **Home Screen**

Once logged in to the web system, the Home screen will be displayed showing your service details. The left hand side menu will display a list of the available options for you to make use of. Logged in as a drug worker, you will have access to the following:

**Home** – This will act as a link back to the home screen displaying your service details.

**Notifications** – Further details below.

- Today
- All
- Referrals
- Unsubmitted

**SMR25** – Further details below.

- New Assessment
- Search

**System Users** – Only accessible by Local System Admin and Central System Administrator

- Manage System Users
- Create System Users
- New Access

**Reports** – Only accessible by Local System Admin and Central System Administrator

- Analysis of Data
- Service Data

**Services** – Only accessible by Local System Admin and Central System Administrator

- Edit Service
- View Service

**Change Password** – Further details below.

**Help** – This screen will allow you to access the online help pages.

**Site Map** - This screen displays the general layout of the site and provides the links to access different sections.

**Logout** – This link will log you out of the system. You will need to log back in to perform any further tasks.

From the home screen a link is provided to allow the blank SMR25a and SMR25b forms to be printed.

## **5: Notifications**

Notifications are designed to assist with the submission of Timepoint follow-ups (see Home Screen help for details). Each notification has an 8-week window within which a corresponding SMR25b can be submitted. The window runs for 4 weeks either side of the scheduled follow-up date.

Each line in the table represents a notification for an open Episode of Care. To action a follow-up request, simply click on the link displayed in the row corresponding to the correct client's episode of care. This will take you to the first of the SMR25b data capture screens. You can then proceed through the follow-up screens and submit the record. Once an SMR25b has been submitted for a notification, the SDMD will update overnight and remove the notification from the list.

Notifications are marked as to their urgency. When the end of a submission window is approaching, notification status changes from current to urgent.

You will only be able to see the notifications for the service you are currently logged into.

The rows on this screen can be both printed, and exported as an Excel file by clicking the corresponding buttons at the foot of the page.

The Notifications panel also displays the Incoming Referral notifications. Each referral notification corresponds to a client who has been referred to your service. You need not action these referrals; they are for information only.

Notifications – **Today** – All the notifications that have been created for your service today.

Notifications – **All** – A list of all the existing notifications that have been created for your service

Notifications – **Referrals** – A list of all the notifications you have received alerting you to client referrals into your service.

Notifications – **Unsubmitted** – A list of all the records that have been created by your service, but have not yet been submitted to the database i.e. saved but not submitted.

## **6: SMR25 – New Assessment**

This link will take you to the first of the data capture screens, this will allow you to complete an SMR25a for a new client. Full details of the contents/definitions in the data capture screens can be found in section 9 onwards.

## **7: SMR25 - Search**

### **Search Client**

You can search for a client by:

- A.) Client Details
- B.) Episode of Care Numbers
- C.) Local Reference
- D.) Community Health Index Number

The search will default to search using the client detail fields. To change to any of the other search options, click the radio button to the left of the required search field.

The search fields will return either an exact or a partial match from the records in the database. A partial match would return all database entries that begin with characters entered for the search e.g. If Jam were entered in the forename field, the system would return all the clients (belonging to the service in question) whose forename begins with Jam i.e. Jamie, James, Jamson etc.

The radio buttons are mutually exclusive i.e. the user can only select one of the above criteria.

The user can restrict the search to include only Open Episodes of Care or Discharged Episodes of Care or both. The default will be Open Episodes of Care.

### **Search Results**

This screen displays all of the Episodes of Care that fit the search criteria entered on the previous page.

If an Episode of Care is listed as *Discharged* in the results screen, then that EOC has been closed by *ALL* services that were involved with the client's care episode. It is important to note that if you have discharged a client from your care, the EOC for the client will only show as discharged once all the involved services have submitted a discharge.

From here you can:

- View previously submitted records for a client by clicking on the corresponding links on the right hand side.

- Submit an unscheduled SMR25b for an open episode of care (e.g. for a referral or discharge)
- Search for any current notifications for an open episode of care.

**Unscheduled Follow-Up** – To submit an unscheduled follow-up for a client click the radio button to the left of the row on the screen. Once selected, clicking the Unscheduled follow-up button will take you to the first page of the SMR25b data capture screens.

**Search Scheduled Follow-Up** – This button searches the Notifications currently on the system for the client. Select the open Episode of Care by clicking the radio button to the left of the rows on the screen. Once selected, clicking the Search Scheduled Follow-Up button will take you to the notifications screen, and any current notifications for the client will be displayed.

If your service has any un-submitted initial assessments (SMR25a) saved on the system, then these will also appear in the search results. However, until the SMR25a has been submitted for a client, it will not be possible to begin an SMR25b nor search for any scheduled follow-ups. The radio buttons alongside these unsubmitted records are not available.

## **8: Change Password**

The purpose of the Change Password screen is to update an existing password with a new one. The SDMD will prompt users to update their password every 28 days. A warning message will appear on login if a password has less than 7 days until it expires.

The system will check that the 'Old Password' entered is correct and that the 'New Password' is the same as the 'Confirm New Password'.

Once the required details have been updated the user can select either 'Submit' to save those changes or 'Cancel' to exit the screen.

### **Best practice for data security**

The information you have access to in the Scottish Drug Misuse Programme contains sensitive personal information on individuals within the Scottish community. Only those individuals who have been authorised to use this system must have access to it; no unauthorised access is permitted.

Authorised user access is controlled through an individual username and password. Only the individual who has been given the username and password can use it; unauthorised access is NOT permitted. It is the authorised individuals' responsibility to ensure their access details are kept securely; failure to do so may result in disciplinary action.

Password length and formation:

Your password must:

- be a minimum of 8 characters containing uppercase and lowercase letters.
- include one numerical digit.
- inclusion of one special characters (\$%^&'!).
- password used should not be found in any dictionary or user's personal information (e.g. date of birth, anniversary, pet's name, favourite football team, mother's maiden name, etc).
- changed on a regular basis (e.g. every 28 days). You will automatically be prompted to change your password 7 days before it will expire.
- not be reused within a 12 month period (i.e. any password that expires in January will not be usable until February of the following year).

Good password practice

- Never share with or tell anyone else what your password is (even hinting).
- Never use the same password for more than one account you are responsible for.
- Where possible, passwords should not be written down. If you do require to write the password down, please keep the note in a secure place and not beside your PC.
- Never leave your PC logged on and unattended. Lock your PC by <ctrl><alt><del><return>. Unlock your PC with the same keystrokes followed by your password.

- Do not give your password to anyone else; only you have been authorised to use your access details.
- Make passwords easy for yourself to remember but difficult for someone else to guess.
- Do not set your passwords to be the same as other passwords used.
- Do not set your password to be the same as the system you are accessing.
- Do not use any password previously used.
- Change your password if you suspect your password has been compromised.

If you can't remember your password or have had 3 login failures, please contact your local system administrator to reset your password. You should reset your password once access has been obtained to something only you know in line with the password standards mentioned above.

### **Breaches of Security**

Breaches of password and other security that has been implemented will result in immediate suspension of your access account and may lead to disciplinary action in line with local procedures.

## **SMR25 – Data Capture Screens**

When you click to start a new assessment or a follow-up submission, you are taken into the data capture screens of the database. The following sections provide guidance and clarification on the fields contained within the data capture screens.

### **Section 9: Client Details**

Each client on the SDMD should only ever have one Episode of Care open at any one time.

Before opening a new Episode of Care, the SDMD needs to check if an open Episode of Care exists for that client.

The information requested on this screen allows the SDMD to carry out this check, and the results returned on the following screen. All four fields must be completed in order to proceed.

<b><u>Item</u></b>	<b><u>Guidance</u></b>
<b>First Name</b>  <b><i>Mandatory</i></b>	Please enter the client's First Name in full.
<b>Surname</b>  <b><i>Mandatory</i></b>	Please enter the Surname in full.  Enter hyphens or apostrophes as separate characters.
<b>Date Of Birth</b>  <b><i>Mandatory</i></b>	Record in the format dd/mm/yyyy.
<b>Gender</b>  <b><i>Mandatory</i></b>	A statement by the individual about the gender they currently identify themselves to be (i.e. self-assigned). Select the appropriate choice from the drop-down list.

If no match is found for the details you have entered, then you will be taken to the SMR25a/b Guidance Notes

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first data capture screen and a new SMR25a can be completed. However, if a match is found, then the SDMD will display a warning message along with a link to the existing Episode of Care (EoC):

- If the existing EoC is not a match for your client, then click the “Back to New Assessment” button and you will be returned to the SMR25a data capture screens and a new EoC number will be created.
- If the existing EoC is a match for your client, you can Submit an SMR25b for the EoC instead of submitting a new SMR25a.

## **SECTION 10: PERSONAL DETAILS**

The top 4 fields are populated with the information entered on the Client Details screen and cannot be edited. If you notice at this stage that the details are incorrect, navigate to the Save/Submit screen, delete the record and begin again.

<b><u>Item</u></b>	<b><u>Guidance</u></b>
<b>Local Ref</b>	If each of your clients is issued with an individual reference number within your service, then please enter it here. This will assist ISD and service staff in identifying the appropriate record, should the need arise.
<b>Ethnic Group</b>	Select the ethnic group of the client (as judged by the client) from the drop-down list.  The stated ethnicity of the client as defined in the Scottish Census 2001 classification.  If other is selected, please specify further.
<b>City / Town</b>	Enter city/ town where client is staying at time of presenting.  There are a number of exceptions: Roofless – record city/town if known and NF1. Temporary/unstable – record address where stayed the night before. Prison, residential rehabilitation, supported accommodation, secure unit – record usual home address. Spending time at more than one address – record address where they spend most time. Young person in long-term foster care/children's home – record where person staying at time of presenting. Students away from home – record where person staying at time of presenting.

**SECTION 11: PRESENTING INFORMATION (OF THIS EPISODE)**

<b><u>Item</u></b>	<b><u>Guidance</u></b>
<b>Main Source of Referral</b>	<p>Only one option should be selected. For definitions of the 'referral' options please see Appendix A: Glossary of terms. (<a href="#">link</a>)</p> <p>If none of the options listed apply, then select "Other" and specify further.</p>
<b>Co-occurring Health Issues</b>	<p>Presenting significant health issues other than drug use either revealed by client or assessed by the worker. Select all that apply. For definitions of the 'co-occurring health' options please see Appendix A: Glossary of terms. (<a href="#">link</a>)</p> <p>If none of the options cover a co-occurring health issue, select "Other" and specify further.</p> <p>There is one exception. Please do not record pregnancy as a co-occurring health issue.</p>

**SECTION 12: Current Contact**

<b><u>Item</u></b>	<b><u>Guidance</u></b>
<b>Contact Name</b>	Enter the name of the worker at your service who should be contacted regarding problems with this submission.
<b>Date contact first made (this episode only)</b>	Enter the date contact was first made with this service by the client, for this episode of drug misuse. Includes face-to-face / letter / phone call.
<b>Date first appointment offered</b>	Enter the date of the first appointment offered to the client to identify their needs, with a view to establishing a clear statement of the type and level of treatment, and support required, regardless of whether the client attended or not.
<b>Date this assessment completed / last seen</b>  <i><b>Mandatory</b></i>	Enter the date that this assessment was completed, OR the date the client was last seen.  Note – This date is a mandatory field, and very important to the record on the database. All follow-up notifications will be scheduled according to this date.
<b>Client being actively treated/cared for by this service</b>	Enter whether the client is currently receiving care from your service.  If No, select all the corresponding reasons from the list provided.  If No is chosen, then this will be viewed on the system as a Discharge from your service. The reason and date MUST be entered to complete the discharge of the client.
<b>Has Client been referred to another drug treatment/rehabilitation</b>	If Yes please provide the date the referral was made as well as the name of the agency in the space provided

<b>treatment/rehabilitation service</b>	
<b>Has Client been referred to a moving on/reintegration service</b>	If Yes please tick the appropriate reason from the options provided.  If Other is selected, please specify further in the space provided.

**SECTION 13: PREVIOUS CONTACT WITH SERVICES**

<b><u>Item</u></b>	<b><u>Guidance</u></b>
<b>Previous contact with any drug treatment services</b>	Indicate whether the client has had a specialist assessment of their drug treatment needs from <b>any</b> drug treatment service in the past. This includes your service or any other the client tells you about.
<b>If yes, year of last contact</b>	Indicate year contact last occurred between the client and any drug treatment service, including your own. The service referred to by the client does not need to still be in operation.
<b>Age when help first sought</b>	Enter the age (in years) of the client, the first time they ever sought professional help for drug misuse. The term "drug misuse" does not include alcohol or tobacco in this instance. Only illicit drug misuse should be considered. This includes over-the counter medicines taken inappropriately, illicit drugs, and volatile substances. It does not include alcohol or tobacco.

**SECTION 14: AGE PROFILE**

<b><u>Item</u></b>	<b><u>Guidance</u></b>
<b>Age when first started using illicit drugs</b>	Enter the age (in years) when the client says they first used illicit drugs. This includes over-the counter medicines taken inappropriately, illicit drugs, and volatile substances. It does not include alcohol or tobacco.
<b>Age at onset of <u>problem</u> illicit drug use</b>	<p>Enter the age (in years) when the client believes problems began as a result of their drug use.</p> <p>Problem drug use refers to illicit drug use, which could be either dependent or recreational. It is not necessarily the frequency of drug use which is the primary 'problem', but the effects that drug taking has on the user's life (i.e. they may experience social, financial, psychological, physical or legal problems as a result of their drug use).</p>

## **SECTION 15: PRESCRIPTION DRUGS PROFILE (CURRENT)**

For each Prescription drug used, complete all of the below fields with the necessary information. Once all the relevant details have been entered, click Add Row at the bottom of the page. This will add the details to the record, and clear the page to allow you to enter the next drug details if necessary.

Once a row has been added, it will appear at the bottom of the page along with the buttons Edit and Delete. If you wish to remove the row from the record, click Delete. If you wish to amend the data in the row, click edit and the information will reappear in the data fields. You can then make the necessary changes and Add the row back to the record.

<b><u>Item</u></b>	<b><u>Guidance</u></b>
<b>Prescription drugs Profile (current)</b>	If the client is in receipt of a prescription related to treatment of addiction, complete the table. If not, indicate either None or Not known, and proceed to section 7.
<b>Details verified</b>	Use this box to indicate if you have verified the prescription drug(s) information provided by the client, either with the prescriber or against the client's formal record of prescription. If you have not verified the prescription, complete the table, and mark "no" to this question.
<b>Drug Name</b>	Record any drug here that has been prescribed (verified or not) to the client <b>for the treatment of their drug misuse or dependence</b> . Do not include drugs that are intended to be prescribed in the near future. If more than 5 drugs are reported by the client, an additional form may be attached to the SMR 25. Ensure that all details are provided, and that both forms are returned to the SDMD.
<b>Main Drug</b>	When more than one drug has been prescribed, the drug worker should decide which drug is the <b>primary prescription for the client's drug problem</b> i.e. to achieve stabilisation/ maintenance, reduction or abstinence. This drug should be recorded in the first line of the table. Note – this drug

	may not necessarily be the drug taken most frequently or in the largest quantities.
<b>Daily dosage (mg)</b>	Enter the daily dose prescribed for each drug listed. <b>Use milligrammes (mg) in all cases.</b> Most drugs are prescribed to be consumed daily. If drugs listed are not, please calculate the daily equivalent dose.

## **SECTION 16: ILLICIT DRUGS PROFILE (PAST MONTH)**

For each Illicit drug used, complete all of the below fields with the necessary information. If you do not have the full information, enter as much as possible. Once all the relevant details have been entered, click Add Row at the bottom of the page. This will add the details to the record, and clear the page to allow you to enter the next drug details if necessary.

Once a row has been added, it will appear at the bottom of the page along with the buttons Edit and Delete. If you wish to remove the row from the record, click Delete. If you wish to amend the data in the row, click edit and the information will reappear in the data fields. You can then make the necessary changes and Add the row back to the record.

<b><u>Item</u></b>	<b><u>Guidance</u></b>
<b>Used in past month</b>	<p>Has the client used illicit drugs in the past month? Select yes or no. If no, proceed to section 10.</p> <p>Include:            Any OTC medicine used inappropriately (e.g. excessive consumption)            Volatile substances used inappropriately (e.g. inhaling gas, sniffing glue)            A drug being used by the person which is prescribed for someone else's use.</p> <p>Exclude:            Any drug related to drug misuse which are prescribed to that person.            A drug prescribed for that person even if not used as directed</p>
<b>Drug name</b>	<p>Select the correct drug name from the drop down menu for every drug reported.</p> <p><b>Do not record alcohol in this section.</b></p>
<b>Main route</b>	<p>The most commonly used method of getting the drug into the body, for each drug listed. Where more than one route is identified, a decision should be made locally about which route is the 'main' route. Where more than two routes are reported, record the two most frequently used routes.</p>

	For definitions of the 'route' options please see Appendix A: Glossary of terms. <a href="#">(link)</a>
<b>How often</b>	Record the frequency of use in the past month for each drug and route listed. Select from the options on the form. For definitions of the 'frequency' options please see Appendix A: Glossary of terms. <a href="#">(link)</a>  Note; the terms 'Experimental', 'Recreational' and 'Occasional' are not suitable options, as they do not specify a 'frequency' of use.
<b>Other route</b>	If applicable, the secondary method of getting the drug into the body. See examples on form.
<b>Quantity</b>	Enter quantity of each drug used in a typical drug-using day. Specify units and amount e.g.  Milligrammes (mg) Millilitres (ml) Ounces (oz), Grammes (g), Binge. This where the total amount is not known as it was taken in a 'binge'. Tablets (tabs) Other
<b>Spend</b>	Enter amount spent in a typical drug-using day for each drug recorded.

**SECTION 17: INJECTING/ SHARING DETAILS**

<b><u>Item</u></b>	<b><u>Guidance</u></b>
<b><u>EVER</u></b>	
<b>Ever Injected</b>	Has the client ever taken a <b>drug of misuse</b> (or had one administered for them by someone else) using a hypodermic needle/ syringe? Do not include legitimate self-injection of prescribed drugs e.g. insulin for diabetes, or drugs injected by trained staff in a professional capacity. Select the appropriate choice. If no, proceed to section 9.
<b>Always used new equipment first</b>	If the client has used new equipment <b>every</b> time they have injected, select yes from the drop-down list provided. Equipment includes needles, syringes, spoons, water, filters etc.
<b>Used a needle or syringe that someone else has used</b>	If the client has ever used a hypodermic needle/ syringe that <b>anyone</b> else has previously used, select yes.
<b>Lent someone else a needle or syringe which client has used</b>	If the client has ever <b>used</b> a hypodermic needle/ syringe and then lent it to <b>anyone</b> , select yes.
<b>Used the same spoon, filter or water as someone else</b>	If the client has ever used the same spoon, filter or water as someone else when preparing drugs for use, select yes.
<b>Age first injected</b>	Enter age, in years, when client first injected.
<b>IN THE PAST MONTH</b>	
<b>ALL ITEMS DEFINED AS ABOVE, BUT APPLY ONLY TO PAST MONTH</b>	

**SECTION 18: BLOOD BORNE VIRUSES**

<b><u>Item</u></b>	<b><u>Guidance</u></b>
<b>Tested for Hepatitis B</b>	Select the appropriate choice from the drop-down box. If yes, provide date of last test, if available. If date of last test is not available, but client is sure they were tested, select yes and omit the date of last test.
<b>Tested for Hepatitis C</b>	Select the appropriate choice from the drop-down box. If yes, provide date of last test, if available. If date of last test is not available, but client is sure they were tested, select yes and leave date blank.
<b>Tested for HIV</b>	Select the appropriate choice from the drop-down box. If yes, provide date of last test, if available. If date of last test is not available, but client is sure they were tested, select yes and leave date blank.
<b>Has the client been at risk since last test?</b>	Since their last test, has the client been involved in any risk behaviours? E.g. injecting drugs, sexual contact, body piercing/ tattoo, needlestick bite, blood transfusion.
<b>Has the client completed a course of vaccinations for Hepatitis B?</b>	Has client completed a full course of vaccinations for Hepatitis B?

**SECTION 19: ALCOHOL PROFILE**

<b><u>Item</u></b>	<b><u>Guidance</u></b>
<b>Consumed alcohol?</b>	Has the client consumed alcohol <b>in the past month</b> ? If yes, complete this section.
<b>How often did the client have an alcoholic drink?</b>	Only answer this question if the answer to the previous question was "Yes". Select the appropriate choice from the drop-down menu.
<b>In a typical day, how many units did the client usually have?</b>	The aim of this section is to establish the drinking habits of the client. Calculate the typical number of units the client has drunk per day in the last month. To calculate the number of units, use whichever method you are comfortable with. If you are unsure how to do this, Appendix E gives a list of standard drinks with their equivalent units. A link to the source website can also be found here.

**Please note** - an SMR25a should NOT be submitted for a client suffering only from Alcohol problems. This page can be used to record alcohol use, but only when in conjunction with Illicit drug misuse.

**SECTION 20: SOCIAL PROFILE**

<b><u>Item</u></b>	<b><u>Guidance</u></b>
<b>Accommodation</b>	Client's current accommodation. Tick one box only. If other, then please specify further. If the client has more than one address, choose the option where they spend the most time. This information should correspond with the address information given in the Personal Details section. For definitions of the 'accommodation' options please see Appendix A: Glossary of terms. <a href="#">(link)</a>
<b>Living situation</b>	Who the client is currently living with. Tick all that apply. If other, then please specify further e.g. with grandparents. If the client has more than one address, choose the place where they spend the most time. If the client is in prison at the time of presenting, strike through this question. For definitions of the 'living situation' options please see Appendix A: Glossary of terms. <a href="#">(link)</a>
<b>Living with other drug users</b>	Is the client living with someone they know to regularly use drugs illicitly? Tick the appropriate box. If the client is in prison, residential rehabilitation or similar, then select "No".
<b>Employment / Education</b>	Client's current employment status. Tick one box only. If other, then please specify further. For definitions of the 'employment/ training' options please see Appendix A: Glossary of terms. <a href="#">(link)</a>
<b>Legal situation</b>	Client's current legal situation. Tick all that apply. If other, then please specify further. For definitions of the 'legal situation' options please see Appendix A: Glossary of terms. <a href="#">(link)</a>

<b>Has client been in prison in previous 12 months?</b>	Tick the appropriate box. If yes, please record length of time since release and name of prison of release. If the client has been in prison more than once in the last 12 months, enter details of most recent release. Include any time spent in prison other than prison visits.
<b>Drug use funded by</b>	How does the client fund their drug habit? Tick all that apply. If other, then please specify further. For definitions of the 'drug use funded by' options please see Appendix A: Glossary of terms. <a href="#">(link)</a>

## **SECTION 21: DEPENDENT CHILDREN**

For each Dependent child, complete all of the below fields with the necessary information. Once all the relevant details have been entered, click Add Row at the bottom of the page. This will add the details to the record, and clear the page to allow you to enter the next child's details if necessary.

Once a row has been added, it will appear at the bottom of the page along with the buttons Edit and Delete. If you wish to remove the row from the record, click Delete. If you wish to amend the data in the row, click edit and the information will reappear in the data fields. You can then make the necessary changes and Add the row back to the record.

<b><u>Item</u></b>	<b><u>Guidance</u></b>
<b>Does client have dependent children</b>	<p>Includes children under 16 years of age (both biological and non-biological) who are dependent on the client. This includes the client's biological children, and any other children who are dependent on the client.</p> <p>Record the age in years of each child. For children under the age of 1, enter an age of 1.</p> <p>For definitions of the 'where the child is living' please see Appendix A: Glossary of terms.<a href="#">(link)</a></p>
<b>Is client or their partner pregnant?</b>	Select the appropriate choice from the drop-down menu.

**SECTION 22: LOCAL USE**

<b><u>Item</u></b>	<b><u>Guidance</u></b>
<b>Local Use Boxes</b>	<p>These boxes are optional. Your service can use them to capture information that may be desirable locally.</p> <p>The entries in the local use boxes will not be entered onto the database unless ISD are requested to do so by the service.</p> <p>If the entries are to be included, ISD will require a list of valid codes per box.</p> <p>ISD will be happy to provide analysis of the local data on request.</p> <p>ISD does not require an explanation of what each code represents.</p> <p><b>Examples of valid local codes notified to ISD:</b></p> <p>Box 1: 1,2,3  Box 2: A,B,C,D,E,F,G,H  Box 3: Y,N</p>

**Section 23: Save/Submit**

<b>Save</b>	<p>The save button will keep the record in its current state and NOT SUBMIT to the database.</p> <p>Saving will cause the record to be partially validated, and any errors encountered will be displayed on screen. Any errors will need to be resolved before the record is saved.</p> <p>Once saved a record will be available to Edit/Delete/Submit at a later date.</p>
<b>Submit</b>	<p>The Submit button will fully validate the record before submitting to the database.</p> <p>If any errors are found they will be displayed on screen, and the record will <i>not</i> be submitted. Once any errors have been resolved, the record can then be submitted to the database.</p> <p>It is not possible to amend/delete a record once it has been submitted to the database. Please ensure all details are correct before attempting to Submit.</p>
<b>Delete</b>	<p>If a record has been saved previously (and NOT submitted) It is still possible to delete the record. If you wish to remove the record from the system, simply click Delete and you will be asked to confirm the action.</p> <p>Once deleted a record cannot be recovered.</p>

**SECTION 24: SMR25b - Interventions**

<b>Known Interventions (Since last report at this or other agencies)</b>	<p>Select interventions the client has received either at your service or at any other service(s) since the last report was submitted. Interventions are split into Interventions for drug misuse and interventions not related to drug misuse.</p> <p>If other interventions have been achieved that are not available in the list, then specify further in the Other text field.</p>
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**SECTION 25: SMR25b - Childcare**

For each child, complete all of the below fields with the necessary information. Once all the relevant details have been entered, click Add Row at the bottom of the page. This will add the details to the record, and clear the page to allow you to enter the next child's details if necessary.

Once a row has been added, it will appear at the bottom of the page along with the buttons Edit and Delete. If you wish to remove the row from the record, click Delete. If you wish to amend the data in the row, click edit and the information will reappear in the data fields. You can then make the necessary changes and Add the row back to the record.

<b>Childcare Interventions</b>	Select childcare interventions that have been received by the client or the client's children.
<b>Has Local authority become involved since last report?</b>	Select Yes if LA has been involved since last report, and complete the corresponding table, entering age of each child as appropriate.

**Appendix A – Glossary of terms**

<b>Section</b>	<b>Options</b>	<b>Definition</b>
<b><u>2- Presenting information– Source of referral</u></b>	Self	Client has referred himself or herself to the organisation.
	Health -GP	A general practitioner (GP) who provides primary care.
	Health- Primary care team	A group of professionals delivering health services in the community at 'primary' or first points of contact with the health service. Includes clinical staff (nurses, physiotherapists, counsellors) and administrative staff (receptionists, practice managers).
	Health- Mental Health	Services specialising in the assessment and treatment of mental ill-health.
	Health- Other	NHS services specialising in the treatment of issues other than drug misuse e.g. occupational health, A&E, needle exchange.
	Social Work- Criminal Justice	Criminal justice based social work service (Victims and Offenders) e.g. Probation Service, Supervision of, and support for released prisoners.
	Social Work- Child and family	Child and family based social work service.
	Social work- Other	Any other social work service not detailed above.
	Criminal Justice- DTTO	Drug Treatment and Testing Order. A

		sentence for drug users who receive treatment for their drug use and have to give regular urine tests to make sure they are not using drugs.
	Criminal Justice- Arrest referral	An intervention seeking to identify problem drug using offenders at the point of entry into the criminal justice system and refer them into treatment.
	Criminal Justice- Drug court	A special court given the responsibility to handle cases involving drug-addicted offenders through an extensive supervision and treatment program.
	Criminal Justice-Prison	Referral from any UK based prison i.e. Prison- based case workers have conducted an assessment of needs to co-ordinate service provision e.g. using Common Addictions Recording Tool (CAART).
	Criminal Justice-Other	Referral from any other Criminal justice based service not detailed above.
	Voluntary service	Referral from any type of voluntary service.
	Education	Referral from an education authority or service.
	Housing	Referral from a housing or homelessness service.
	Other (specify)	Any other referral not specified above.

<p><u>11 - Co-occurring health issues</u></p>	<p>Drug related physical health</p>	<p>Any symptom or diagnosis that is linked to drug use e.g. treatment of abscess, thrombosis, viral illness, dental health problems, malnutrition etc.</p>
	<p>Mental Health</p>	<p>Any symptom or self-diagnosis of a mental health problem whether or not seeking professional support or treatment e.g. depression, anxiety.</p>
	<p>Alcohol</p>	<p>Client's pattern and level of drinking is a concern to either themselves or the worker i.e. they may be experience health, social, financial, or legal problems as a result of their alcohol use.</p>
	<p><u>Other</u></p>	<p><u>Any other significant presenting health issue not detailed above.</u></p>
<p><u>12 - Current contact with service-detail of contact/non contact</u></p>	<p>Received required support</p>	<p>Client's needs met according to assessment i.e. discharged at the end of their treatment, with the agreement of the client and the service</p>
	<p>Disciplinary</p>	<p>Client has been discharged due to misconduct</p>
	<p>Unplanned</p>	<p>Client was referred to the service but did not attend a number of assessment or treatment appointments. The discharge date would be entered as soon as service staff agree that</p>

		the client is no longer on its books or would be viewed as a new client if they re-presented at the service.
	Deceased	Service can confirm that the client is dead
	Referred to other service	Client has been referred on to another drug service with the agreement of the client and the service
<b><u>16 - Illicit profile- Main route</u></b>	Intra-venous	Injected into the vein.
	Swallow	Ingested by eating or drinking.
	Smoke	Vapours produced by substance incineration taken into the lungs, with or without tobacco.
	Snort	Powder taken through the nose e.g. cocaine.
	Inhale	Intake by breathing vapours through mouth and or nose e.g. gas/solvents.
	Sniff	Vapours taken through the nose only e.g. gas/solvents.
	Intra-Muscular	Injected into the muscle.
	Skin Popping	Injected directly under the skin.
	Buccal	Taken against the gums/ mouth cavity (exclude under the tongue)
	Sub-Lingual	Under the tongue.
	Other	Other routes of administration not detailed above.
<b><u>16 - Illicit profile- How often</u></b>	Daily	Habitual use of specified drug every day.
	Most days	Between 4 and 6 days per week.
	Weekends	Friday to Sunday.
	Weekly	Between 1 and 3 days

		per week.
	Fortnightly	Every two weeks.
	Monthly	Every month.
	Less often than monthly	Less than once every month but at least once during the past month..
	Other	Other frequencies not specified above.
<u>20 - Social profile- Accommodation</u>	Owned/ rented	Client currently lives in stable accommodation
	Supported accommodation (drug related)	Client currently lives in supported housing e.g. owned by Registered Social Landlords (RSLs) and either managed by them or specialist agencies.
	Residential rehabilitation	Client is currently engaged in a residential rehabilitation programme aimed to support individuals to attain a drug-free lifestyle and be re-integrated into society. They provide intensive psychosocial support and a structured programme of daily activities which residents are required to attend over a fixed period of time.
	In prison	Client is currently in prison or young offenders institution
	Homeless-temporary/unstable accommodation/ hostel	“Homelessness means not having a home. You don't have to be living on the street to be homeless - even if you have a roof over your head you can still be without a home. This may be because you don't have any rights to stay where

		you live or your home is unsuitable for you." Shelter UK
	Homeless-roofless	Client is currently sleeping on the streets
	Other (specify)	Other accommodation not specified above.
<u>20 - Social profile –Living situation</u>	With spouse/partner	Client is living with spouse/ partner
	With parents	Client is living with parent(s). Includes step/ foster.
	Alone	Client lives alone (includes no children living with client)
	Other (specify)	Other living situation not specified above.
<u>20 - Social profile- Employment/ Education</u>	Employed (paid or unpaid)	Includes self employed and employed part time
	Support into employment	Client is receiving a service and or programme aimed at helping clients to progress towards or get into employment, to stay in employment and to move on in the workplace. Examples New Deal, New Futures, New Opportunities, Beattie Inclusiveness funded projects.
	Unemployed	Client is aged 16 or over and is without a job, is available to start work in the next two weeks and have been seeking a job in the last four weeks, or is waiting to start a job already obtained in the next two weeks.
	Never employed	Client has never been employed (full/part time, paid/ unpaid)
	Long term sick/disabled	Client is claiming Disability Living

		Allowance. This infers client needed help for 3 months because of a severe physical or mental illness or disability, and is likely to need this for at least another 6 months
	School	<u>Client is currently in school.</u>
	Excluded from school	Client is currently excluded from school by the school/ relevant education authority. Includes those in alternative education provision.
	Full time education or training	Client currently undertaking post school education or training programme
	In prison	Client is currently in prison or young offenders institution
	Other (specify)	Other employment/training not specified.
<u>20 - Social profile-Legal situation</u>	None	Client is currently not involved within the criminal justice system.
	Case pending	Client has been arrested and is awaiting the case to be heard or the disposition to be given
	DTTO	Client is currently subject to a Drug Treatment and Testing Order
	Probation or supervision order	Client is currently subject to a probation or supervision order
	In prison	Client is currently in prison or young offenders institution.
	Other	Other legal situation not specified above.

**Appendix B – Levels of Assessment**

<b>Level of assessment</b>	<b>Purpose</b>	<b>Carried out by</b>	<b>Level of information</b>
<b>Simple assessment</b>	Screening- The 'gateway' into care.	Professionally qualified staff in health, housing and social work who are the first contact; vocationally qualified staff; and unqualified staff with training in assessment.	Basic
<b>Comprehensive assessment.</b>	To allow some decisions about treatment, care and support to be made, or whether it is appropriate to refer an individual elsewhere.	Professionally qualified staff in social work or health.	Cover more detailed information on drug use and other factors such as housing, employment, health and benefits
<b>Specialist assessment</b>	When a client has been referred to a specialist service, or has moved on from entry-level assessment.	Professionally qualified staff in social work, health and housing, who may have recognised expertise; vocationally qualified or trained staff in specialist areas where simple specialist assessment is needed; and professionally qualified or trained staff in specialist independent agencies.	Cover in detail the nature and extent of drug use, physical and psychological health, personal and social skills, social and economic circumstances, previous treatment episodes and assets and attributes of the individual.

Definitions and concepts of integrated care and its key elements, including assessment can be found in the Scottish Executive's guidance- 'Integrated Care for Drug Users'. LINK! <http://www.drugmisuse.isdscotland.org/eiu/intcare/intcare.htm>

## **Appendix C – Confidentiality**

The enhanced SDMD collects sensitive personal information on clients as outlined above. In order to obtain permission from the Information Commissioner to do so, ISD has fulfilled all its obligations in line with Data Protection legislation and Client Confidentiality. This appendix describes some of the key processes that are in place to protect the people ISD collects data from.

ISD enters into a Service Level Agreement with each Data Provider, which outlines the responsibilities that are undertaken by users of the enhanced SDMD. To obtain a copy of the Service Level Agreement for your service, speak to your service manager or call ISD on 0131 275 6000.

ISD is obliged to provide an outline of the purpose of this data collection to the clients you submit data for. To this end, a client information leaflet should be given to each client you submit data for, and the client have an understanding of the its content. To obtain leaflets, call 0131 275 6348.

### **Confidentiality of information held by ISD**

ISD is fully committed to the processing of all personal data securely and in accordance with the requirements of Data Protection legislation. The work of ISD is included within the Common Services Agency for Scottish Health Service's registration with the Data Protection Commissioner. ISD is also subject to the Service's Data Protection policy, and abides by the eight Data Protection Principles, which govern the handling of personal data. The Service's Data Protection Officer is Kim Kingan, Gyle Square, 1 South Gyle Crescent Edinburgh, EH12 9EB, Tel: 0131 275 7176

Client confidentiality is regarded as of utmost importance within ISD. Measures to ensure the protection of confidentiality include:

#### **An explicit set of Confidentiality Rules for ISD Scotland Staff**

All new staff are required to read these rules and sign their acceptance of them. Existing staff re-sign every six months. These rules cover the care and release of confidential data, copies are available on request.

#### **The Privacy Advisory Committee**

Any release of person-identifiable data is carefully controlled. The Privacy Advisory Committee, an independent body set up by the Chief Medical Officer to advise ISD, examines requests of a non-routine nature.

#### **Regular Audit of Practice**

Regular internal audits of confidentiality and security practice take place within ISD.

#### **Caldicott Guardian**

In addition to maintaining the measures outlined above, ISD is responding to the recommendations of the Caldicott Committee. The Caldicott Guardian for ISD is Dr

Rod Muir, Trinity Park House, South Trinity Road, Edinburgh, EH5 3SQ, Tel: 0131 551 8639.

The Scottish Drug Misuse Database is managed by ISD. Because of the sensitivity of the information collected, there are additional measures in place to ensure that confidentiality and anonymity are maintained. These are explained on the next page.

## **Confidentiality procedures**

The Database has a system of security levels, which guarantees that access in ISD is restricted to those working within the drugs misuse team.

Paper forms are kept in lockable cabinets and shredded once all the quality issues for a particular period have been resolved.

The 'data processed by ISD relating to drugs misuse' is registered for the purpose of 'health research and statistics' as part of the Common Services Service registration under the Data Protection Act 1984.

## **Client Consent**

In practice, some services do ask for consent while other services see the data collection as a normal part of the administration of the service offered to any clients. However, where client consent is sought it is important that the person is given reassurance that his/her interests are a paramount consideration with everyone involved in SDMD work.

To avoid any misunderstanding, call staff at the SDMD for further clarification.

If there is a problem regarding client consent which may affect the completion of an SMR25 form, please contact us at the SDMD

**Appendix D – SIGN Guideline 74, Appendix 1: The management of harmful drinking and alcohol dependence in primary care**

<http://www.sign.ac.uk/guidelines/fulltext/74/annex1.html>

Beverage type		Alcohol by volume (%)	Measure	Alcohol content (units)
<b>Beers/lagers</b>	Barbican	0.02	440ml	<0.01
	Kaliber	0.05	Pint	0.03
	Tennents LA	1.2	440ml	0.5
	Mild/light beers (various brands)	3.1	Pint	1.8
		3.5	Pint	2.0
	Best bitter (various brands)	3.6	Pint	2.0
	Skol	4.0	Pint	2.3
	McEwans/Labatt	4.1	Pint	2.3
	Guinness draft stout	5.0	440ml	2.2
	Grolsch	5.0	Pint	2.8
	Premium beer/lager (various brands)	5.2	330ml	1.7
		6.0	440ml	2.6
	Stella Artois	9.0	440ml	4.0
	Lowenbrau Pils	9.5	440ml	4.2
	Hofmeister Special			
	Kestral Super			
<b>Ciders/Perries</b>	Strongbow LA	0.9	330ml	0.3
	Woodpecker	3.5	Pint	2.0
	Strongbow	4.5	1000ml	4.5
	Old English	5.5	Pint	3.1
	Strongbow Super	8.0	Pint	4.5
	Diamond White	8.2	275ml	2.3
	Strong White Cider	8.4	1000ml	8.4
<b>Spirit based drinks with mixers (alcopops)</b>	Hooch	4.7	330ml	1.6
	WKD Original Vodka Blue or Iron Brew	5.5	330ml	1.8
		5.5	275ml	1.5
	Smirnoff Ice	5.4	275ml	1.5
	Bacardi Breezer	5.4	275ml	1.5
	Metz Snapps (Black, Still or Original)	5.5	275ml	1.5
		40.0	700ml	28.0
	Vodka Red Square (Barrs Inn Bru)			
Aftershock				
<b>Vodka Hooch</b>	Lemon/Apple/Orange/Hoopers Hooch	4.7-5.1	330ml	1.6-1.7
<b>Shooters (addition to main drink)</b>	Jelly Pots	15.0	47ml	0.7
	Sidekick	20.0	30ml	0.6
	Aftershock	40.0	30ml	1.2
	Frostbite	50.0	30ml	1.5

	Absinthe	75.0	30ml	2.3
<b>Wines</b>	Various brands	9-14	750ml	6.8-10.5
A purchased glass of wine can vary from 125 to 250 ml and can contain 1.1-3.5 units per glass depending on % alcohol. A small (125ml) glass of average strength (12%) wine contains 1.5 units.				
<b>Fortified Wines and other</b>	Cinzano bianco/Buckfast	14.7	750ml	11.0
	Croft Original Sherry	17.5	750ml	13.1
	Cockburn's Port	20.0	750ml	15.0
<b>Spirits</b>	Gordons Dry Gin/Smirnoff	37.5	700ml	26.3
	Vodka	37.5	700ml	26.3
	Bacardi White Rum	40.0	700ml	28.0
	Bells Whisky/Martell cognac brandy	40.0	700ml	28.0
	Captain Morgan's dark rum			
A purchased measure of spirit is 25 or 35 ml. A 25ml measure of 40% spirit contains 1 unit of alcohol.				
<b>Liqueurs</b>	Bailey's Irish Cream	17.0	350ml	6.0
	Archers Peach Schnapps	23.0	700ml	16.0
	Apricot Brandy/Crème de	24.0	700ml	16.8
	Menthe/Malibu	40.0	700ml	28.0
	Pernod/Cointreau/Drambuie			