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Combined Substance Abuse and Mental Health Treatment Episode Data Set (TEDS)

State Instruction Manual

with State TEDS Submissions System (STSS) Guide

Version 4.1

Prepared for:

Center for Behavioral Health Statistics and Quality
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February 2016

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Acknowledgments

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BHSIS Resource Center (**https://bhsisresourcecenter.smdi.com**)
This website provides federal, state, and other agency partners with contact information and other resources necessary for successful implementation of BHSIS program components. This manual is available for download from this site. All succeeding changes to the manual will be posted to the site.

TEDS Project Office
To reach the TEDS Project staff for technical support, technical assistance, questions on this manual and/or to request access to the BHSIS Resource Center, send an email to **technicalsupport_CLD@smdi.com**.

Summary of Updates in Version 4.1

This updated version of the Combined Substance Abuse and Mental Health TEDS Instruction Manual is issued to provide further clarification on the TEDS reporting guidelines and edits. It does not involve any significant changes in TEDS requirements, reporting procedures, or on the STSS functionalities. These updates are intended to give users a more efficient, transparent, and self-reliant experience in their TEDS file reporting.

Version 4.1 contains the following:

- Updates to existing guidelines; most are simply clarifying statements based on questions we received from the states
- Updated examples used to explain certain reporting concepts
- Updated STSS screenshots, including the modified STSS Error Report
- Consolidated discussion on edit checks under a new chapter entitled Validation Edits
- Added **Appendix E. List of Edit Checks**, a listing of all the validation edits for easy reference
- Added few new validation edits, which are identified in Appendix E
- Added **Appendix F. Using TEDS Records for BGAS Tables**, a guide for calculating the substance abuse National Outcome Measures (NOMs)
- Corrections were made on the following:
    - Attendance at SA Self-Help Groups in Past 30 Days
      Code 07 – Some Attendance
      Should read: Code 06 – Some Attendance
    - Detailed Drug Code
      Code 06 Methadone – 0601 Methadone
      Should read: Code 06 Non-prescription Methadone – 0601 Non-prescription Methadone

      Code 20 Other Drugs – 2002 "Spice," Carisoprodol (Soma), and other drugs
      Should read: Code 20 Other Drugs – 2002 Synthetic Cannabinoid "Spice," Carisoprodol (Soma), and other drugs

Summary of the 2014 TEDS Modifications

In August 2014, the *Combined SA and MH TEDS State Instruction Manual* was developed to integrate the instructions for substance abuse and mental health data reporting. The manual provides a single reference manual for the modified TEDS system. The modified TEDS system incorporates mental health (MH) data collection while retaining the substance abuse (SA) data reporting protocol closely intact.

Below is a summary of modifications made on the TEDS structure in May and June 2014. ***No further modifications to the TEDS structure were made after these dates.***

(1) New Data Elements (May 2014):
The new data elements below were appended to the end of the standard TEDS record (i.e., the record typically used for substance abuse TEDS reporting). States reporting substance abuse records may begin submitting these data fields as soon as modifications can be made to their data extraction programs. For the states reporting mental health records, the records must contain these two data elements.

- **Diagnostic Code Set Identifier** – This data field identifies the disease standard classification systems (alternately referred to as diagnostic code sets) used to report diagnostic codes. The addition of this data field provides flexibility by allowing the use of different diagnostic code sets across records.
- **Substance Abuse Diagnosis** – States must use this data field to report the substance abuse diagnosis. It replaces the existing **SuDS 4 Diagnostic Code (DSM or ICD)**. States must transition to this field at the earliest possible time.

(2) Refinements were made to some existing TEDS data elements (May 2014):

- Changes to variable names:
  - Renamed Ethnicity to Hispanic or Latino Origin
  - Renamed Psychiatric Problem in Addition to Alcohol or Drug Problem to Co-occurring Substance Abuse and Mental Health Problems
- Coding changes to **Substance Abuse Problem** and **Detailed Drug Code**:
  - Drug lists were revised to make them consistent in the fields Substance Abuse Problem and Detailed Drug Code.
  - The redundant code *1605 Other Sedatives* was deleted.
  - Changed the name of the STSS function “Commit” to “Upload.”

(3) The integration of mental health data collection in TEDS resulted in two major changes (June 2014):

- Adjustment of categories in certain TEDS data elements; and
- Addition of mental health data elements to the TEDS structure. The specific changes included the following:
  a) Response categories for some TEDS data elements were adjusted to make them applicable for mental health data reporting:
     - **Client Transaction Type**
     - **Education**
     - **Employment Status**
     - **Type of Treatment Service/Setting**
     - **Reason for Discharge, Transfer, or Discontinuance of Treatment**
     - **Living Arrangements**
     - **Detailed Not in Labor Force**

b) Data elements needed for mental health data reporting, and not previously collected in TEDS, were added:
   - **Legal Status at Admission to State Hospital**
   - **SMI/SED Status**
   - **School Attendance Status**
   - **Mental Health Diagnosis: One, Two, and Three**
   - **CGAS/GAF Score**

Chapter 1: Introduction

Summary

This document is the *TEDS State Instruction Manual* for reporting admission and discharge/update data to the Substance Abuse and Mental Health Services Administration's (SAMHSA's) Treatment Episode Data Set (TEDS). The manual describes the TEDS data system and the information needed to produce and submit standard admission and discharge/update data files to the TEDS Project Office.

This updated edition of the *TEDS State Instruction Manual* integrates instructions for substance abuse and mental health data reporting and provides a single reference manual for TEDS. The TEDS framework allows for the reporting of mental health client-level data as an alternative method to the MH-CLD, an approach developed under the SAMHSA-funded Data Infrastructure Grants (DIGs). Note that the substance abuse TEDS data reporting protocol is preserved in the current TEDS framework. This manual is intended for all state substance abuse and mental health (or behavioral health) agency staff, including state consultants and/or contractors, involved in the collection, extraction, and submission of TEDS data files. Assistance in using this manual and with developing and submitting files is provided by the BHSIS contractor, Synectics for Management Decisions, Inc.

TEDS is a compilation of demographic, substance use, mental health, clinical, legal, and socioeconomic characteristics of persons who are receiving publicly-funded substance abuse and/or mental health services. State administrative data systems, claims, and encounter data are the primary data sources. The state role in submitting TEDS to SAMHSA is critical, on one hand, because TEDS is the only national data source for client-level information on persons who use substance abuse treatment services. On the other hand, it also provides a mechanism for states to report treatment admissions and discharges of persons receiving mental health services. This reporting framework supports SAMHSA's initiative to build a national behavioral health data set accessible (with appropriate confidentiality protection) by the public; local, state, and federal policymakers; researchers; and many others for comparisons and trends on the characteristics of persons receiving substance abuse and/or mental health treatment services. TEDS provides outcomes data in support of SAMHSA's program, performance measurement, and management goals.

To submit data to TEDS, states are required to extract data from their systems using a predetermined format and, to the extent possible, convert state data elements to TEDS data definitions (see Chapter 4, State Data Crosswalk, of this manual). The use of consistent reporting formats and data definitions is essential to the production of standard national data.

Data are collected from admission records and discharge/update records. For the purpose of annual reporting to SAMHSA, update records are required only for mental health reporting. It is not unusual for people with mental illness to be engaged in treatment for an extended period of time. In order to conduct intermediate analysis of their outcomes, submission of update records is critical. The update record uses the same data reporting format as a discharge record.

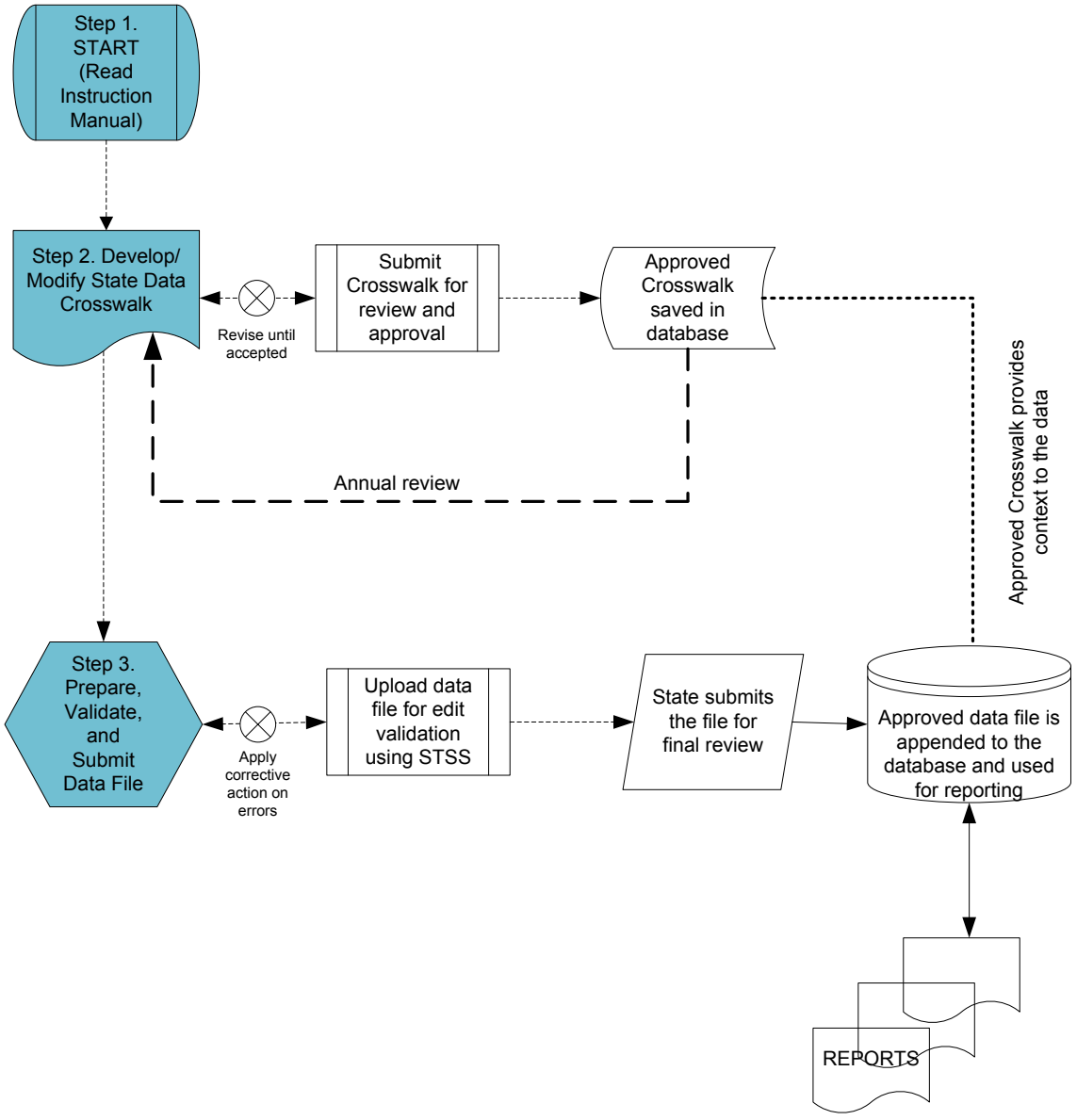
The data are processed and stored as two separate datasets (i.e., admission dataset and discharge/update dataset) and are linkable using a unique client identifier that is a key field in both files. This unique client identifier must not contain any personal identifying information in accordance to the

Health Insurance Portability and Accountability Act (HIPAA). States use the web-based State TEDS Submission System (STSS) to validate and submit records on a monthly, quarterly, or semi-annual schedule.

General Reporting Process

The general reporting process for TEDS is summarized in the following steps and illustrated in the diagram below (Figure 1).

FIGURE 1. TEDS REPORTING PROCESS



Step 1: START (Read Instruction Manual). State staff involved in the extraction of data must read the *TEDS State Instruction Manual*. Please request technical support if needed by emailing **technicalsupport_cld@smdi.com**.

Step 2: Develop/Modify State Data Crosswalk. Prior to initiating any data extraction or file preparation, states must develop and submit a state data crosswalk for review and approval. A state data crosswalk contains a one-to-one mapping of state data fields, codes, and categories to the TEDS data fields, codes, and categories. It also captures state comments or data notes that provide context to the reported data. (See Chapter 4, State Data Crosswalk, of this manual for details.) States are to submit a modified state data crosswalk if changes in the state data collection protocol and/or data system significantly affect the quality (context) and quantity (volume) of data. The state data crosswalk is reviewed on an annual basis.

Step 3: Prepare, Validate, and Submit a Data File. After the state data crosswalk is approved, states can generate their TEDS data files. States are advised to use the online State TEDS Submission System (STSS) to validate the files for system and relational edits. (See Chapter 5, State TEDS Submission System (STSS) Guide, of this manual for details.) Data files that are submitted to the TEDS Project Office through other means (e.g., FTP, secured attachment to an email, disks, etc.) will be processed using a validation process similar to the one in the STSS.

Once the state has validated its files and applied any necessary corrective actions, the state needs to put the corrected file through the validation process again using the STSS. If the file passes all edits, the state clicks the “Submit” button for final processing. The TEDS Project Office logs the file and conducts the final review. During this time, Project Office staff may consult with the state for clarification. When there are no further questions, the state data files are accepted, and the records are added to the TEDS database for national reporting and data analysis.

Federal Data Collection Authority

Section 505 (a) of the Public Health Service Act (42 U.S.C. 290aa-4) directs the SAMHSA Administrator to collect data on the number of public and private behavioral health treatment programs and the number and characteristics of individuals seeking treatment through such programs. **Appendix A** provides additional information on the authority for and history of TEDS.

Chapter 2: State Participation and Quality Control

Both the state and the TEDS Project Office need to undertake a series of measures regarding TEDS data submission and processing to ensure that the TEDS database contains accurate and valid data. States should develop procedures to ensure that the data they submit to TEDS are accurate and in the correct format as specified in this manual.

State Responsibilities

Each state is responsible for:

- Developing and/or modifying the state data crosswalk in accordance with the state's most recent available state data collection protocol.
- Ensuring that each record in the data submission contains the required key fields, all fields in the record contain valid codes, and no duplicate records are submitted.
- Cross-checking data items for consistency on related data fields.
- Responding promptly to TEDS error reports by resubmitting corrected data file.
- Reviewing TEDS Quarterly Feedback Tables for accuracy, comparing TEDS data with comparable state data to ensure the state data have been completely and accurately reported to TEDS, and notifying the TEDS Project Office of any data issues identified. The Quarterly Feedback Tables show the count and percent distribution as of the reporting quarter of all TEDS admission and discharge data items submitted by the state in the past three years.
- Responding to any questions about potential data problems and resolving all data issues identified or providing an explanation for why the data issue cannot be resolved or does not require resolution.
- Submitting data to TEDS according to the agreed-upon reporting schedule.
- Notifying the TEDS Project Office as soon as the state determines it cannot meet a scheduled submission.

TEDS Project Office Responsibilities

The TEDS Project Office is responsible for:

- Reviewing state data crosswalks for completeness and consistency with the reporting standards.
- Processing state data submissions quickly (generally within 2-3 business days).
- Providing states with technical support to ensure their file meets the required format and specifications.
- Ensuring that each record in the TEDS database is unique.
- Assisting states in interpreting the Error Report and providing guidance on the required corrective action.
- Ensuring appropriate security of state submissions with respect to data confidentiality and privacy.
- If so instructed, promptly returning the CD to the state when this submission method is used.
- Providing states with TEDS Quarterly Feedback Reports in a timely manner at the end of each calendar quarter.

Chapter 3: Reporting Framework

The TEDS framework allows each client's unique treatment experience to be reported, whether the client receives only substance abuse treatment, only mental health treatment, or both. While the substance abuse and mental health treatment episodes are tracked separately in TEDS, it provides flexibility in reporting information for clients with co-occurring mental health and substance use problems.

Treatment Episodes

The concept of a treatment episode is an analytic construct and may differ across states. This section gives an example of a complete treatment episode for a client receiving substance abuse treatment and several examples of an operational definition of a treatment episode for a client receiving mental health services.

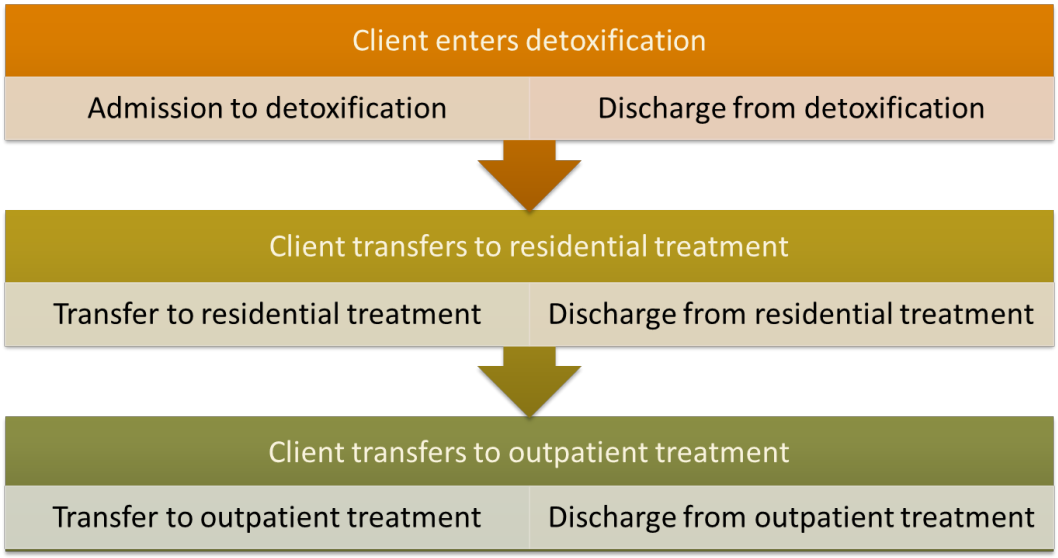
For each movement into a different service type/setting, TEDS is set up to collect data on the two endpoints (admission and discharge). For substance abuse, the different service types refer to items 01-08 listed under the TEDS Type of Treatment Service/Setting data field (e.g., Detoxification, hospital inpatient; Detoxification, free-standing residential; Rehabilitation/Residential – hospital, etc.). For mental health, this refers to the different treatment settings, items 72-76, under the TEDS Type of Treatment Service/Setting data field (e.g., State Psychiatric Hospital, SMHA-Funded/Operated Community-Based Program, etc.). And for clients with co-occurring mental health and substance abuse problems, client movement into a different service type/setting also includes the start of a mental health service, which may or may not involve the end of a substance abuse service, or vice versa.

The TEDS structure was modified in 2014 to allow periodic updates of outcomes for persons receiving mental health services as interim assessment points (updates). Persons with mental illness tend to remain longer in the service system than persons receiving substance abuse services only; therefore, an interim assessment is a critical component of the treatment process.

An example of a complete treatment episode for a client with a substance abuse problem is illustrated in Figure 2:

- The client is admitted to detoxification, generating an admission record.
- The client completes detoxification and is transferred to residential treatment, generating a discharge record from detoxification and a transfer admission record to residential treatment.
- The client completes residential treatment and is transferred to outpatient treatment, generating a discharge record from residential treatment and a transfer admission record to outpatient treatment.
- The client completes outpatient treatment and is discharged, terminating the episode.

FIGURE 2. SAMPLE SEQUENCE OF A SUBSTANCE ABUSE TREATMENT EPISODE



The experience of a person receiving mental health services may differ significantly from the case illustrated above. Depending on the unique needs of a person with mental illness and the state service delivery model, multiple services may be received sequentially or concurrently from different mental health specialty providers such as the state psychiatric hospital, community-based programs, residential treatment centers, and other psychiatric facilities (e.g., psychiatric wards in private or general hospitals). Persons with co-occurring mental health and substance use problems may experience yet a different model of service delivery since they may either (a) receive treatment from an integrated substance abuse and mental health program, (b) receive a referral to enter a substance abuse treatment program after discharge from a mental health program, or (c) receive a referral to enter a mental health program after discharge from a substance abuse program. Note that the foregoing discussion serves only as a general illustration of a treatment process.

The operational definition of a treatment episode hinges largely on how services are provided in the state and how data are collected and stored in the state database(s).

The TEDS reporting structure is based on client-level data reported at the beginning and end (and interim, for mental health) points of treatment in specific service types/settings:

- Each client record has an identifier that is unique (statewide) to that client. The total number of client records reflects the volume of services delivered, while the count of client IDs reflects how many individuals received services.
- Service types/settings vary widely in their rates of utilization and client length-of-stay. It is critical to have information on each of the service types/settings that make up an episode of treatment to understand the service mix.
- Treatment episodes can be constructed by linking the admission and discharge/update records to create episodic trends and patterns in service usage overall or to examine client treatment patterns in particular.

Treatment Admissions and Transfers

Admission Definition

The definition of "admission" is slightly different for reporting substance abuse versus mental health treatment admissions.

- For substance abuse clients, an admission in TEDS is defined as the formal acceptance of a client into substance abuse treatment. *An admission has occurred if, and only if, the client begins SA treatment*. Events such as initial screening, referral, and wait-listing for substance abuse treatment are considered to take place before the admission to treatment and should not be reported to TEDS as admissions.
- For mental health clients, in order to remain consistent with the Block Grant requirements, which are operationally defined in SAMHSA's Uniform Reporting System (URS), *all clients receiving services from a program operated or funded by the State Mental Health Authority (SMHA) during the reporting period should be reported, including clients who received* only mental health evaluation, screening, or assessment.

Some states do not collect information on clients' treatment admissions and discharges as administrative data. These states need to devise a method for identifying a client's admission to treatment. For example, a state might use the service pre-authorization start date or the service start date on claims as a proxy for admission date. Another method would be to use an algorithm that determines a service gap defined as the length of time in-between services. For example, a state might define a service gap of 1-3 days to be still within the same treatment episode. Other factors such as the time elapsed between service authorizations, continuity of the types of services covered, client participation in treatment, and the provider type or location may also be taken into consideration when developing an operational definition of "admission."

Initial Admissions and Transfers

The TEDS Admission System includes information on two events:

- Initial admission to a service type/setting
- Transfer, which may represent different situations, such as: (a) from one service type/setting to another within a single episode of treatment, (b) from one level of care to another within the same provider network, or (c) from one facility to another to receive short-term care (e.g., medical care)

In some state data collection systems, a separate record is generated for every billable service (e.g., group therapy, individual therapy, etc.). If all of these services were delivered within a single service type/setting (e.g., outpatient), report any single one of these records to TEDS as an admission. TEDS does not attempt to collect data on every service delivered, but expects reporting of an admission to a new service type/setting**.**

Please report a change in service type/setting (e.g., from inpatient hospitalization to community-based program) or a change from a substance abuse service to a mental health service, or vice versa, whether or not that change results in a corresponding change in provider. The determination of the appropriate

type of admission (i.e., initial or transfer) will depend on the state data system, which in turn is influenced by the state substance abuse and mental health service delivery systems.

Ideally, a change in service type/setting or provider that occurs within a single treatment episode should be reported to TEDS as a transfer admission. Some states use date- and time-based algorithms to identify continuous episodes of treatment, even when all records are reported to the state as initial admissions. States that do so are requested to report these data to TEDS as initial admissions and transfer admissions thereafter, if possible. However, this may not be feasible at all times. Thus, it is also acceptable for states to label their submissions as initial admissions and not use transfer admissions at all.

The TEDS record specifications for initial admissions and transfers are identical except in the **Client Transaction Type** field:

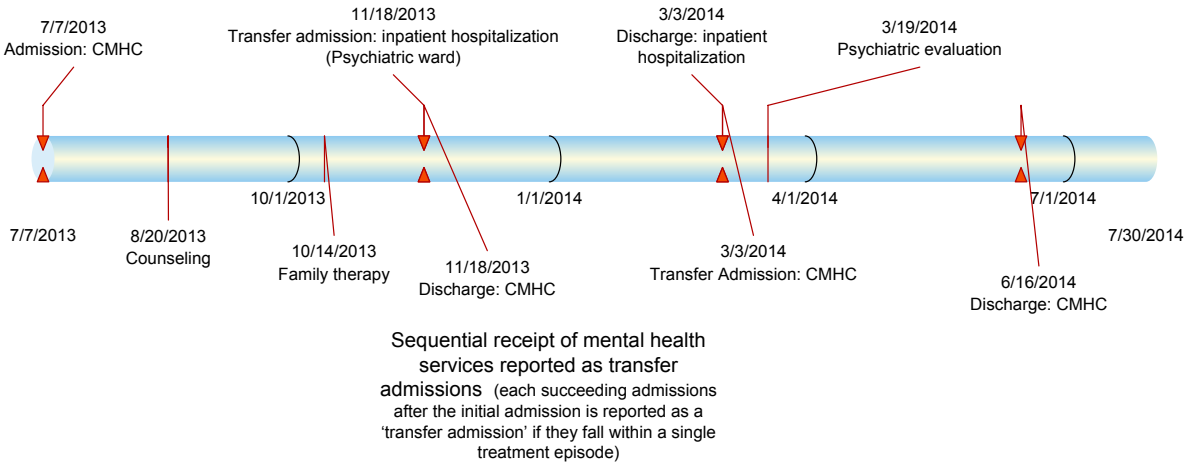
- Initial admission records should be coded *A Admission (SA) or M Admission (MH)*
- Transfer admission records should be coded *T Transfer (SA) or X Transfer (MH)*

Admissions and transfer records may be included in the same admission data file submissions, and the same edit and validation protocols will apply.

The succeeding figures illustrate four possible TEDS reporting scenarios of a mental health client's initial and transfer admissions from one treatment service type/setting to another (Figures 3–6).

Scenario 1: Sequential Receipt of Services

FIGURE 3. GENERAL SCENARIO OF SEQUENTIAL RECEIPT OF SERVICES

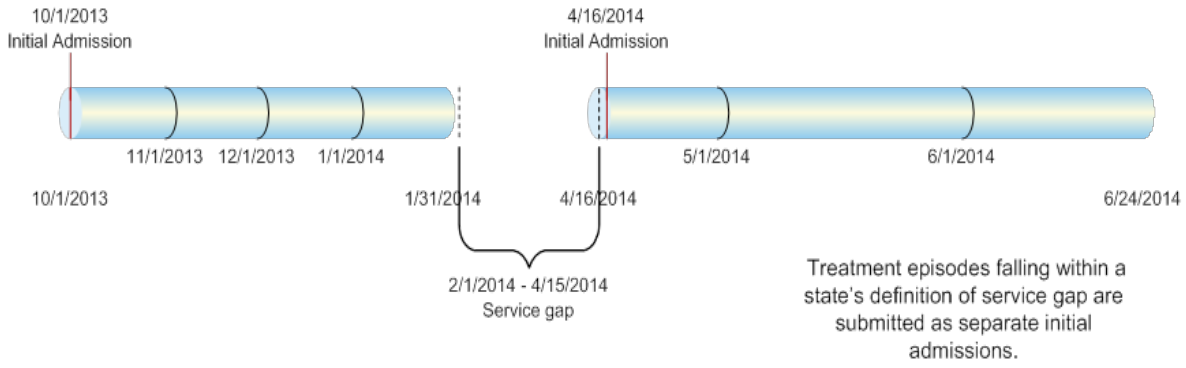


Scenario 1 Description: When services are provided in a sequential manner with no gap in time (representing continuity of services), a complete treatment episode with distinct initial admissions, transfers, and discharges can be identified and reported. States are expected to report the admission/discharge records associated with each change in the person's treatment service type/setting (signified by ▼▲ in the diagram), but not with every individual service provided within those service types/settings. All admission events may be reported as initial admissions if the state does not have an operational definition of a treatment episode. In this case, a "transfer admission" is not used.

Figure 3 shows each admission with a corresponding discharge event. In certain cases, discharges are not reported or do not occur when a person changes service type/setting. Under this circumstance, TEDS will store the admission record submitted until the corresponding discharge record is submitted. The TEDS Project Office will inform states periodically of the number of admission-discharge matches and number of unmatched submitted admission or discharge records.

Scenario 2: Service Gaps in Treatment

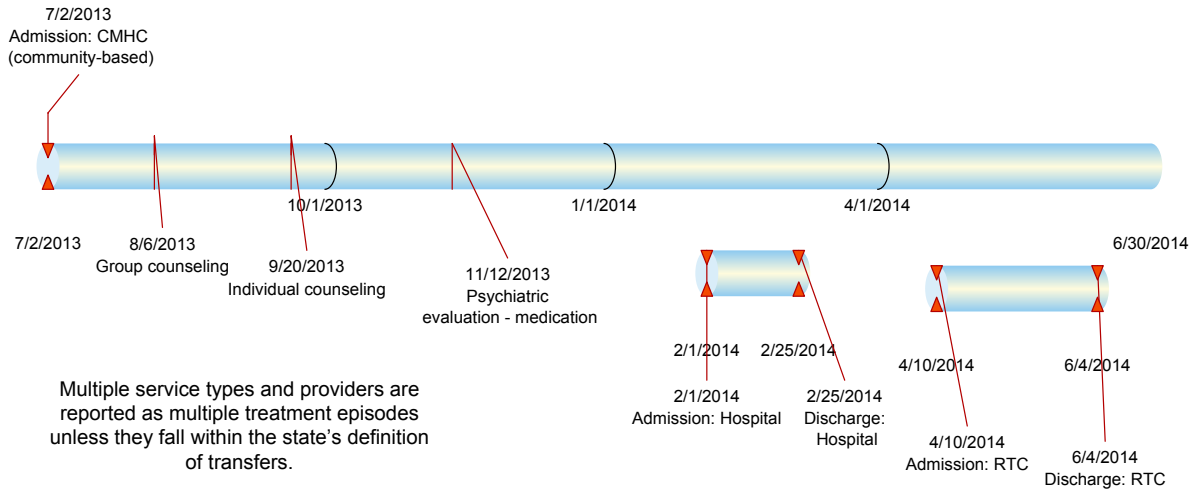
FIGURE 4. GENERAL SCENARIO OF SERVICE GAPS IN TREATMENT



Scenario 2 Description: Individuals receiving mental health and/or substance abuse treatment services may drop out of services for an extended period of time and then present themselves again to resume services. In TEDS, this scenario is considered as two separate treatment episodes, that is, an initial admission record is submitted for 10/1/2013 and similarly for 4/16/2014 and a corresponding discharge record is expected for each admission record. The discharge event that will ultimately be recorded for the 10/1/2013 admission in the scenario above may either be a formal discharge (e.g., from an inpatient setting) or an administrative discharge, according to the state's policy for determining when treatment for the client has administratively ended.

Scenario 3: Overlapping Episodes

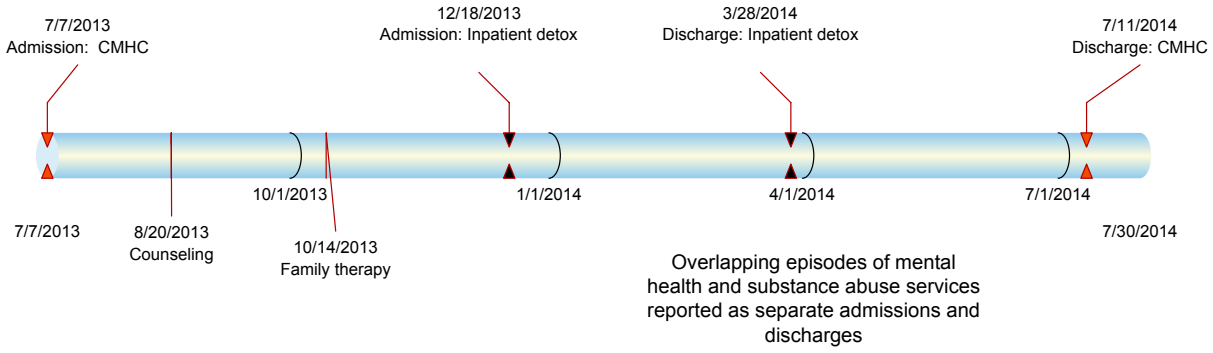
FIGURE 5. GENERAL SCENARIO OF OVERLAPPING EPISODES



Scenario 3 Description: Depending on the structure of the state's service delivery system and data system infrastructure, treatment episodes for persons receiving mental health services may not be on a single track. The state may record service delivery as concurrent services from different providers (e.g., different CMHCs or local governing entities [LGEs]) or as independent treatment episodes). In the diagram for Scenario 3, there are three initial admissions that should be reported: 7/2/2013, 2/1/2014, and 4/10/014. Remember that a corresponding discharge record is expected for each reported admission record.

Scenario 4: Treatment Services for Co-occurring Substance Abuse and Mental Health Problems

FIGURE 6. GENERAL SCENARIO OF RECEIPT OF SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES



Scenario 4 Description: A person with co-occurring substance abuse and mental health problems may receive treatment simultaneously or sequentially. In either case, the admission to/start of a mental health treatment service should be reported as separate initial admission from a substance abuse treatment admission, regardless of whether the admission is to the same or different service provider. Mental health

services should be reported as mental health admissions in the **Client Transaction Type** data field and substance abuse services should be reported as substance abuse admissions. The TEDS Project Office will consult with the state if this reporting method is not feasible (e.g., cases in which a single admission and discharge is reported for a client who received mental health and substance abuse services delivered by a single service provider).

Treatment Discharges and Updates

Discharge Definition

For TEDS, a discharge is defined as the termination of services in a particular service type/setting, or with a particular service provider, whether or not the client's treatment episode will continue in another service type/setting or with a different service provider.

- Services may be terminated for many reasons: treatment program completion, transfer to another service type/setting, client drop-out, facility termination, or the client's inability to continue treatment because of death, incarceration, or other life circumstances.

States that do not collect discharges as administrative data need to devise a method for assigning a client's discharge status from treatment. A state that uses pre-authorization or claims data must define the termination of a service or episode by using the end date of the pre-authorized service or service date on the claims data as proxy variables. States can also use an algorithm for determining service gaps (i.e., the length of time between services), which then defines the end of an episode and the beginning of a new one. When operationalizing these concepts, it is important to also consider other factors that may affect the definition such as the time elapsed between service authorizations, continuity of the types of services covered, client participation in treatment, and the provider type or location. The TEDS Project Office will assist states in developing the operational definition.

Update Definition

At the present time, client update records are required only for mental health reporting. SMHAs are required to submit updates in order to allow intermediate assessment of client outcomes while the client is still in treatment. SMHAs should submit updates at least once a year, preferably close to the end of the reporting period observed in the state's URS reporting.

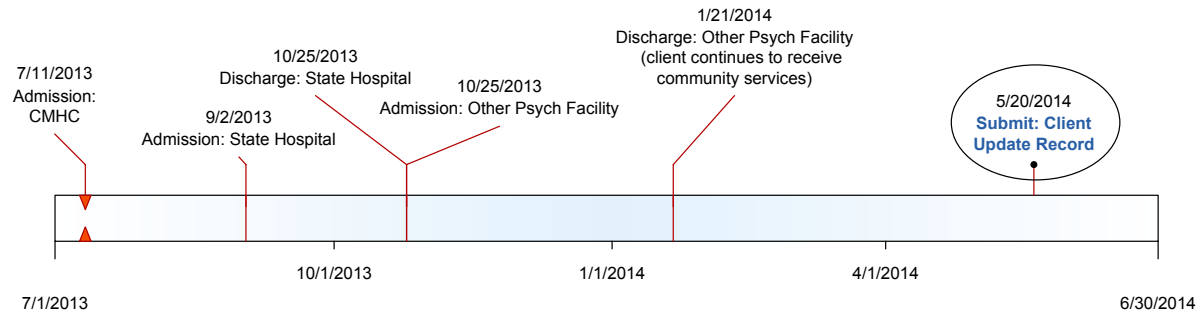
- Updates are required because persons with mental illness or co-occurring mental illness may continue receiving services from the SMHA beyond a 12-month period. It is already a common practice among SMHAs to require providers to conduct periodic assessments or reviews or to submit data (status) updates of clients known to be receiving mental health services. The frequency of updates varies across states from monthly, to quarterly, semi-annually, or annually. States may submit all available update records or the most recent available update record.

An update record is not a discharge record. A discharge record is submitted upon termination of a particular treatment service type/setting or the client's treatment episode. An update record is submitted while the client is still in treatment. However, both record types provide needed data points for reporting client status or for evaluating outcomes.

Discharge and update records may be included in the same discharge data submissions, and they will receive similar edit validation on relevant data fields.

The scenario depicted in Figure 7 shows that the state updated the client's status on 5/20; this data update should be submitted to MH-TEDS as an update record. If the update record is not submitted, information reported in the 1/21 discharge record will be used as the most recent available information on the client's status.

FIGURE 7. SUBMISSION OF UPDATE RECORD



Relevant Dates in Discharge and Update Records

The TEDS record specifications for discharges and updates are identical except for some specific discharge data fields (i.e., **Date of Discharge** and **Reason for Discharge, Transfer, or Discontinuance of Treatment**) which are irrelevant for the update records.

Date of Discharge is the date on which the client was officially discharged from treatment or disenrolled from the public mental health system. The **Date of Discharge** is not relevant when submitting an update record, so use code *01010006 Not Applicable*.

Date of Discharge frequently represents an administrative discharge in cases where clients have dropped out of treatment. Many state systems have a policy whereby a client who has not participated in treatment for a certain number of days is administratively discharged. When assigning a discharge date, use the state policy for determining administrative discharges. Please briefly describe the state's administrative discharge policy in the state data crosswalk.

In the absence of a state policy, TEDS recommends the following operational definition of administrative discharge:

> *A substance abuse treatment episode should be assumed to have ended if the client has not received a treatment service in 3 days in the case of inpatient or residential treatment, or 30 days in the case of outpatient treatment.*
>
> *For mental health clients, the threshold for determining that the treatment episode has ended may be longer (i.e., some states use a threshold ranging from 90, 180, 210, or 365 days).*

Note that a client returning for service after the elapsed time should be reported as an admission to a new treatment episode.

Date of Last Contact or Data Update is a data field in which the meaning of the reported date differs depending on whether a discharge or update record is submitted.

- If submitted in a discharge record, this data field is interpreted as the **Date of Last Contact** (i.e., the most recent date on which the client attended treatment, received a service, or had some other face-to-face encounter with treatment staff). This is not a key field in a discharge record, but this information is critical in calculating a client's length of stay in treatment.
- If submitted in an update record, this data field is interpreted as the **Date of Data Update** (i.e., the most recent date on which the client's status and outcomes were reviewed or re-evaluated, usually at the provider level, in accordance with the SMHA policy on updates or periodic client assessment). This is a key field in an update record.

All update/discharge records must contain field values that were collected at time of update/discharge. The update/discharge field values should not be retained or derived from the admission record, unless specified in the discharge file specifications table; for example, demographics (date of birth, gender, race, and ethnicity) are collected only at time of admission so the same field values are expected in the update/discharge record. Any item that cannot be updated or confirmed as unchanged since admission should be coded as "unknown."

General Guidelines

This section contains TEDS reporting guidelines applicable to both admission and discharge data. Unless specified, the guidelines are for both substance abuse and mental health data submissions.

Eligible Facilities

Substance Abuse TEDS:

Report data collected from all substance abuse treatment facilities and programs operating with public funds. Please submit data from privately funded programs if available to the state. The state data crosswalk should list all applicable facility types included in the state's TEDS reporting; these may include but are not limited to:

- Facilities that receive state/public funding
- Facilities that are licensed/certified by either the state substance abuse agencies (SSAs), Mental Health Departments, Departments of Public Health, or Health Departments
- Medicare-certified facilities
- Medicaid-certified facilities
- Federally-qualified health centers (FQHC)
- Certified opioid treatment programs
- Community-based correctional programs
- Hospitals/VA hospitals/state hospitals
- State-licensed/certified solo practitioners
- State/correctional DUI/DWI providers

- State divisional service centers
- Private facilities

Mental Health TEDS:

All mental health programs and facilities under the auspices of the SMHA are covered in MH-TEDS reporting. These programs and facilities may be either operated or funded by the SMHA.

Eligible Clients

Substance Abuse TEDS:

Admission date: TEDS accepts admission records with an admission date of January 1, 2000, or later.

Clients: Data should be reported for all clients in the reporting facilities, regardless of individual client funding source—federal block grants, Medicaid, private insurance, self-pay, or free care. Indicate in the state data crosswalk which substance abuse treatment clients are included or excluded in TEDS reporting, for example:

- All clients in facility
- State/public-funded clients only
- All clients in facility except DUI
- SSA-funded clients with substance abuse or co-occurring substance abuse and mental health problems
- State/public-funded clients only are required; data on all clients are requested and received from some facilities

Mental Health TEDS:

Admission date: TEDS accepts admission records with an admission date of January 1, 1920, or later.

Clients: The scope of eligible clients should be consistent with URS reporting. Data should be reported for all child and adult clients who received mental health services from programs operated or funded by the SMHA. The following guidelines should be observed:

- Include all identified persons who received mental health and support services regardless of service setting. The reporting should cover all service types, including screening, assessment, and crisis services from programs operated or funded by the SMHA. This includes registered clients receiving only telemedicine services.
- Include all persons with mental illness (or co-occurring mental illness) who receive mental health and support services that are funded by Medicaid under the auspices of the SMHA.
- Include any other persons who are counted as being served by the SMHA or come under the auspices of the SMHA system. This includes persons served under Medicaid waivers if the mental health component of the waiver is considered to be part of the SMHA system.

Frequency of Data Submission

Frequency of data submission varies by state, from monthly, to quarterly, to semi-annually.

SAMHSA prefers client data to be submitted to TEDS as states receive the data from providers and as the data become available from the state data system, typically within 2 months of the client admission date. Monthly or quarterly reporting is strongly recommended. Submitting files more often will help ease the burden of reporting very large data files and will allow for more timely detection and resolution of data problems.

Annual "Freezing" of TEDS Database

Every year, SAMHSA "freezes" the SA TEDS database on or about October 15. This frozen database is used for annual reports, public use files, and BHSIS Short Reports prepared throughout the subsequent year. For example, the file frozen as of October 15, 2015, will be used to produce annual admissions reports for calendar year (CY) 2014 and a discharge report for CY 2013. Data not received by the cut-off date will be accepted into the database and will appear in trend tables in subsequent annual reports and public use files. This practice is being considered for mental health TEDS data.

MH-TEDS Data Submission: Special Notes

Submission of Records in the Initial Year of MH-TEDS Reporting:

To ensure the appropriate reporting of all eligible mental health clients, particularly those who have long been engaged in treatment, a baseline date has to be established for the initial year of a state's MH-TEDS submission. This baseline date is the first day of the 12-month reporting period. The baseline date is used to get a snapshot of all clients engaged in treatment who were admitted on or before the baseline date.

Thus, in a state's first year of MH-TEDS data submission, the state should report all of the following:

- Admission records for—
  - clients who were receiving services on the baseline date; and
  - clients who received services during the reporting period;
- Updates—
  - that occurred within the reporting period; and
  - for clients who were receiving treatment services for at least 12 months prior to the baseline date and continued to receive services during the reporting period, the update record dated closest to the baseline date (this will allow for a more recent change measurement of a client's outcomes); and
- Discharges that occurred within the reporting period.

States in their initial year of MH-TEDS reporting must have an approved state data crosswalk in place before submitting test files or actual MH-TEDS files.

Submission of Records in Succeeding Years of MH-TEDS Reporting:

After the initial year of MH-TEDS data submission, states should submit the succeeding admission, transfer, discharge, and update records on a routine basis, based on the state's preferred frequency of reporting. Routine submission of records is advantageous to the states and facilitates data processing at the TEDS Project Office. It is not necessary to wait until the statutory due date of December 1st each year to submit MH-TEDS files.

If the state is in possession of additional MH-TEDS records pertaining to previous year's reporting, the records may be submitted at any time. The TEDS database will be updated accordingly.

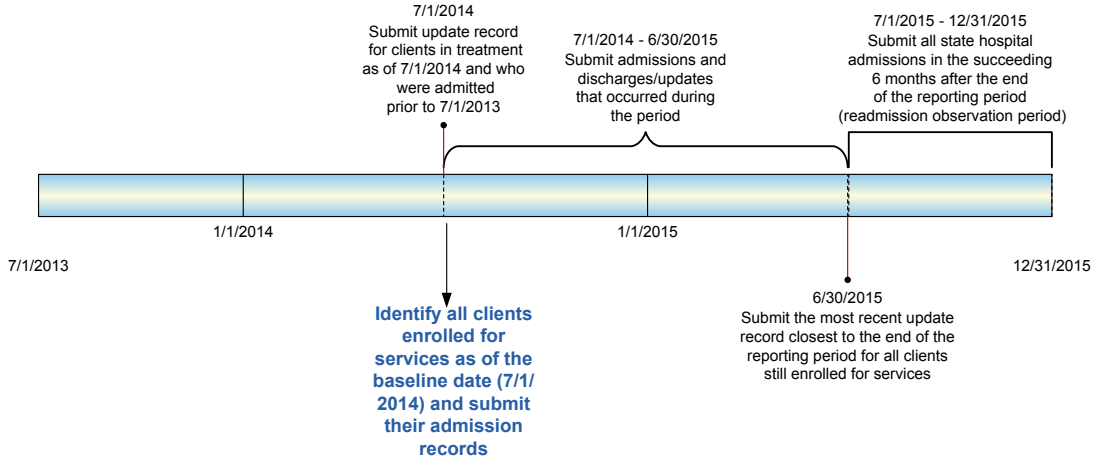
Additional notes:

- Mental health data collected according to the TEDS framework must conform to the state's URS reporting period. States may use either the calendar year or the state fiscal year, with or without a lag time, as long as it is the same as the state's URS reporting period.

  For example, if the state URS data due on December 1, 2015, covers the period of July 1, 2014, through June 30, 2015, then the state MH-TEDS should cover the same period for the December 1, 2015, due date.

- In order to generate the URS tables that are populated using the MH-TEDS, the current expectation is that, by December 1st, reporting states will submit as many relevant admission, update, and discharge records as possible covering the reporting period. Insufficient submission of data by this date will result in a delay in completing the state's URS tables.
- So that the state's State Hospital 30-day and 180-day Readmission Rates NOM (see Figure 8 below) may be calculated, the state must submit records for all admissions and discharges that occurred during the reporting period plus the records for admissions that occurred in the 6 months following the end of the reporting period. In the example shown in Figure 8, this means that records for all state hospital admissions that occurred between July 1, 2014, and December 31, 2015, must be submitted by March 1st of the following year (March 1, 2016).
- If the admission record for clients receiving services on the baseline date is more than 12 months old, submit an update record. If multiple update records are available, select the update record dated closest to the baseline date.
- Submit an update record for all clients who remained in treatment at the end of the reporting period.

FIGURE 8. DETERMINING BASELINE DATE AND RECORDS FOR MH-TEDS REPORTING

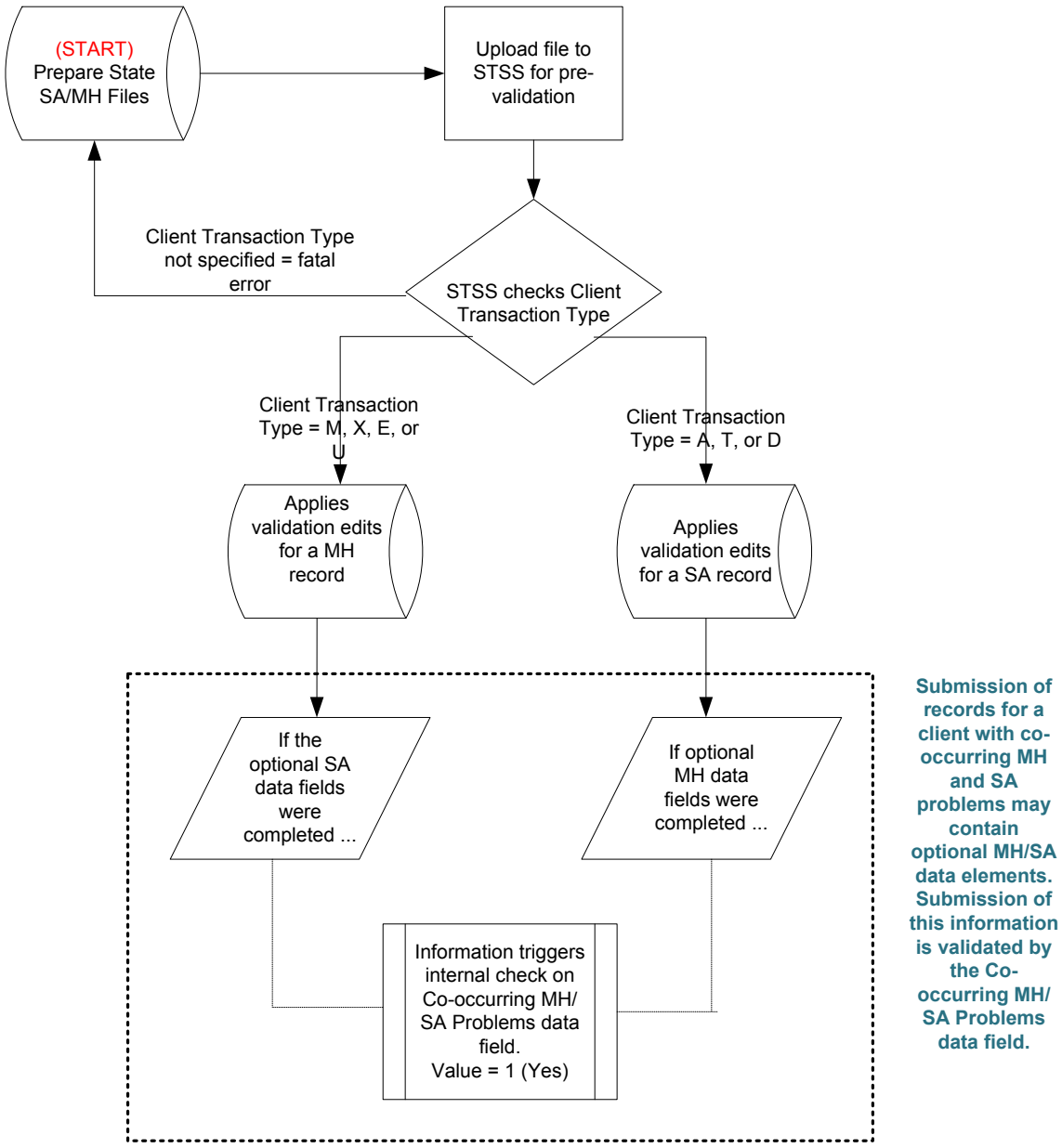


Clients with Co-occurring Substance Abuse and Mental Health Problems

Clients with mental illness who also have a co-occurring substance abuse problem may receive a substance abuse treatment service as part of their treatment continuum.

- When the client is referred for a substance abuse treatment and enters treatment, submit a TEDS substance abuse admission record. STSS will perform all relevant substance abuse validation edits on the record.
- When the client is referred for mental health services and is enrolled with an SMHA-operated or funded program, submit a mental health TEDS admission record. STSS will perform all relevant mental health validation edits on the record.
- Submitting optional data elements:
    - A substance abuse admission record may contain optional mental health data fields such as SMI/SED Status, CGAS/GAF Score, etc. for a client with co-occurring mental health and substance abuse problems. When this happens, the TEDS system will verify that the **Co-occurring Substance Abuse and Mental Health Problems** data field is marked *1 Yes*. This verifies the legitimacy of the submission.
    - States may submit all optional substance abuse data fields such as Substance Abuse Problem, Route of Administration, Frequency of Use, etc. in a mental health record; this will trigger a verification of the **Co-occurring Substance Abuse and Mental Health Problems** data field as shown in Figure 9 below.
    - When admissions to a SA and MH treatment are not reported as separate events (i.e., there is only one admission record although the client receives both services), please contact the TEDS Project Office for guidance to avoid potential reporting issues.

FIGURE 9. SUBMISSION OF ADMISSION RECORDS FOR A CLIENT WITH CO-OCCURRING SA AND MH PROBLEMS



Legend: Client Transaction Types: A = SA Initial Admission, T = SA Transfer Admission, D = SA Discharge, M = MH Initial Admission, X = MH Transfer Admission, E = MH Discharge, U = MH Update

Integrating Substance Abuse and Mental Health Data File Submissions

States can combine their substance abuse and mental health records submission into a single data file. The following file submission options are available:

(1) Separate file submissions for SA and MH admissions and discharges may be appropriate when

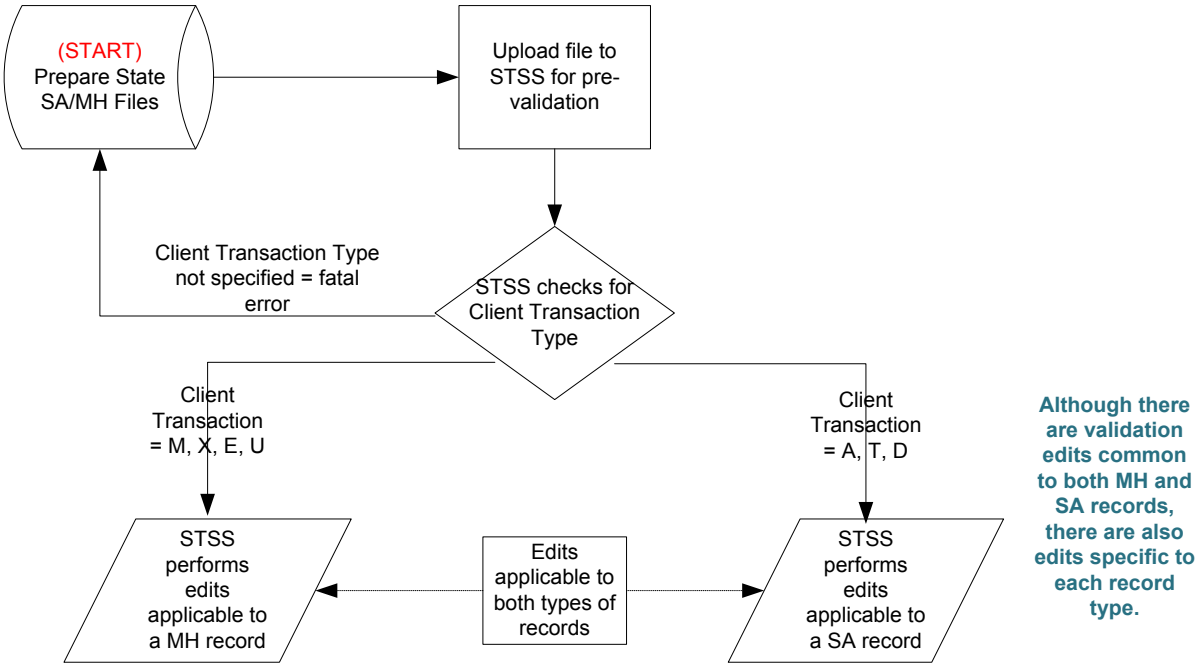
- SSA and SMHA are separate agencies.
- SSA and SMHA are newly integrated and opt to continue with separate file submissions because the SA and MH data systems are not yet integrated.
- SSA and SMHA have integrated SA and MH data systems but opt to keep the reporting for SA and MH TEDS separate.

(2) Combined file submission for SA and MH admissions or SA and MH discharges may be appropriate when

- SSA and SMHA are part of a single agency with an integrated IT system.

Note that a combined file submission for mental health and substance abuse records will still require separate submissions of admission and discharge/update files. When a TEDS file is processed (combined or not), each record is first identified as MH or SA through a **Client Transaction Type** code. Once identified, the appropriate validation edits are used for each type of record. Certain validation edits apply to both MH and SA records but there are also specific validation edits for each (Figure 10).

FIGURE 10. VALIDATION EDITS



Chapter 4: State Data Crosswalk

Purpose

To prepare data for submission to TEDS, states extract data from their systems using a predetermined format and, if necessary, convert state data elements to TEDS data definitions. The use of consistent reporting formats and data definitions is essential to the production of standard national data.

The state data crosswalk contains specific instructions for mapping or translating the data fields and categories in the state system to the appropriate TEDS data fields and categories. It provides basic information necessary to develop a computer program that will extract and convert state data to the TEDS specifications. The TEDS Project Office manages all state data crosswalks through the Crosswalk Management System (CWMS).

Every effort is made to establish a consistent conversion of state data to the TEDS database, thereby maximizing comparability across states. SAMHSA recognizes, however, that some state field definitions and/or categories may not exactly match those in TEDS. Differences, when they exist, should be documented in the state data crosswalk. This information will aid SAMHSA and other researchers in the interpretation of individual state TEDS data.

Preparation

The TEDS Project Office provides the state with a data crosswalk template on an Excel spreadsheet prefilled with the TEDS fields, categories, and codes. See **Appendix B** for a sample crosswalk.

The state completes the template by assigning the state data fields, categories, and codes to the appropriate TEDS data fields, categories, and codes.

- States are encouraged to discuss any data crosswalk questions or difficult mapping issues with the TEDS Project Office staff.
- For every data field, states should map their categories to TEDS categories. If a category is not eligible for TEDS but is collected by the state, include the category on the data crosswalk but note that it is excluded from TEDS.

  For example, when reporting SA-TEDS, the state field analogous to the TEDS **Type of Treatment Service/Setting** *may include a category called "assessment-only." This category should be included on the data crosswalk as a separate item with a notation in the Comment column that the item will be excluded since it is not reportable to SA-TEDS. With this information, the state programmer can ensure that admission records involving assessment-only services are indeed excluded from the state's SA-TEDS submissions.*

The TEDS Project Office reviews the state data crosswalk to ensure compatibility with TEDS data specifications and information requirements. Discrepancies are discussed and resolved with the state.

- After the data crosswalk has received a technical review and approval from the TEDS Project Office and the state has been advised that it may proceed with file testing, the approved data crosswalk is reported to SAMHSA/CBHSQ. TEDS Project Office staff key the field mapping shown on the approved crosswalk into the CWMS and send a copy of the data crosswalk to the state for confirmation.

The state uses the final approved data crosswalk to develop a computer program to extract and convert state data to the TEDS format specifications. The state should establish procedures to ensure that the approved data crosswalk is implemented correctly by the state's data extraction/conversion program.

Twelve months after the date of the last submitted revision to a state's data crosswalk, TEDS Project Office staff reviews the crosswalk on file. During the review process, the state is asked to review its data crosswalk for accuracy and relevance.

Additional Documentation on the Data Crosswalk

The data crosswalk should also describe the overall state system and reporting capabilities. Incorporate this information under the "Comment" column of the spreadsheet or as an attachment. This information will aid SAMHSA and other researchers in the interpretation of individual state TEDS data. The information may include but is not limited to the following:

- The **Client Identifier** reported to TEDS should be unique within the state behavioral health treatment agency or, at a minimum, unique within separate substance abuse and mental health treatment agencies. The ID should be assigned once to a single individual and used across all reporting periods on all records involving that individual. It should not contain in full or partial personally identifying information or protected health information such as Social Security number, birth date, etc. If a state cannot meet these requirements, please discuss the issue with the TEDS Project Office and note the state's capability in the data crosswalk.
- **Client Transaction Type** differentiates *Initial admissions* and *Transfers/changes of service*. This distinction is critical in the analysis of complete treatment episodes (see the Treatment Episodes subsection). Describe the state's capability to differentiate these concepts and to report them to TEDS, statewide or within or between providers, in the data crosswalk.
- Fields not collected in the current state system—if some fields are not currently collected in the state system but the state has concrete plans to collect the data in the future, indicate on the data crosswalk an approximate date that the state plans to begin submission of the field.
- Until the state has added the **Diagnostic Code Set Identifier** and the diagnostic code fields for substance abuse and mental health in the record layout, it is important that the state reports the code set used in the data crosswalk**.**
    - Whenever appropriate, the state should provide contextual information in the Comment section of the state data crosswalk or as an addendum to the state data crosswalk to serve as data notes on their TEDS files submissions.
    - The state's operational definitions on the following concepts should be included in the data crosswalk (Note: please provide a copy of the state's data dictionary, if available, citing the relevant pages for reference):
        - Admissions, discharges, and episodes (if different from TEDS definition)
        - Employed and unemployed
        - SMI, SED, and At risk for SED (if the latter category is used by the state)
        - Administrative discharge policy

- Data update practice/policy (frequency, concerned population, relevant data fields)
- Cite if there are any unreported service types/settings, under-reporting of clients (or excluded providers), and/or over-reporting (duplication issues)

Changes to the Data Crosswalk

Additions, deletions, or changes to the state data crosswalk must be reported to the TEDS Project Office and must be documented in the revised data crosswalk.

- Periodically, a state may upgrade its data system, adding to or changing the data items or categories it collects. Whenever a state adds, deletes, or changes the mapping of a state data field or category to a TEDS data field or category, the TEDS Project Office must be notified.
- The TEDS Project Office will assist the state in revising the data crosswalk to reflect these changes.
- When states are updating an existing data crosswalk, they should provide information only for new or changed data fields. Designate unchanged fields as “current.”
- If the state data system is changed substantially, it may be necessary to establish a completely new data crosswalk.

The approved revised data crosswalk must be used for subsequent file submissions. This means the state must update its data extraction/conversion program to ensure that the state data fields, categories, and codes continue to be accurately mapped to the TEDS data fields, categories, and codes.

Chapter 5: State TEDS Submission System (STSS) Guide

Overview

States can use the State TEDS Submission System (STSS) to verify that appropriate file specifications (see **Appendix C** and **Appendix D**) are followed and their files meet all edit checks (see **Appendix E**). The STSS uses the complete TEDS edit procedures for both mental health and substance abuse data files. At the end of the validation test, the state receives a processing report summarizing the results and is referred to the error report for detailed error listings. The state is advised to select a relatively small number of records (e.g., 500) for an initial test prior to testing the complete file. This will identify errors that may prevent the successful submission of the complete file. States are expected to correct the errors and retest the file as many times as necessary to ensure all errors have been corrected prior to submitting the files. States that are unable to correct all errors after several attempts should contact the TEDS Project Office for assistance. When all errors are corrected, the state submits the file through the STSS for final processing.

The TEDS Project Office performs a final review of the submitted file and may contact the states to discuss additional corrections. Once the file is determined final, the file records are added to the TEDS database. The TEDS Project Office will provide a complete copy of a state's data file to that state upon request.

Steps in TEDS File Submission

The following sections provide step-by-step instructions for successfully submitting a TEDS data file. Screenshots are provided and the function buttons are explained. There are six steps to a successful submission of a TEDS data file:

(1) Access and log on to the STSS using the credentials provided by the TEDS Project Office.
(2) Upload a data file to the STSS.
(3) Run the STSS validation function to validate the data file.
(4) Review processing and error reports.
(5) Correct data errors and revalidate corrected data file.
(6) Submit file to TEDS for final processing.

Step 1: Access and Log on to the STSS

- Obtain the STSS secure URL, user ID, and password from the TEDS Project Office.
- Note: State representatives may use the same login credential to submit substance abuse and mental health data files. Those who are new to STSS but already have login credentials for the BHSIS Resource Center need only request access rights to STSS.
- Data files to be uploaded to the STSS must be accessible through the user's PC, either on a PC drive or on an accessible network drive.
- Use the STSS navigation links. Do not use the browser "Back" button.

Log-in page

Button	Action
Sign on	Opens the Submission Log (Home) page.

Submission Log (Home) Page

Once logged on, you will see the **Submission Log,** which is also the **Home** page (see Figure 11). This page displays information about the state files uploaded to the STSS.

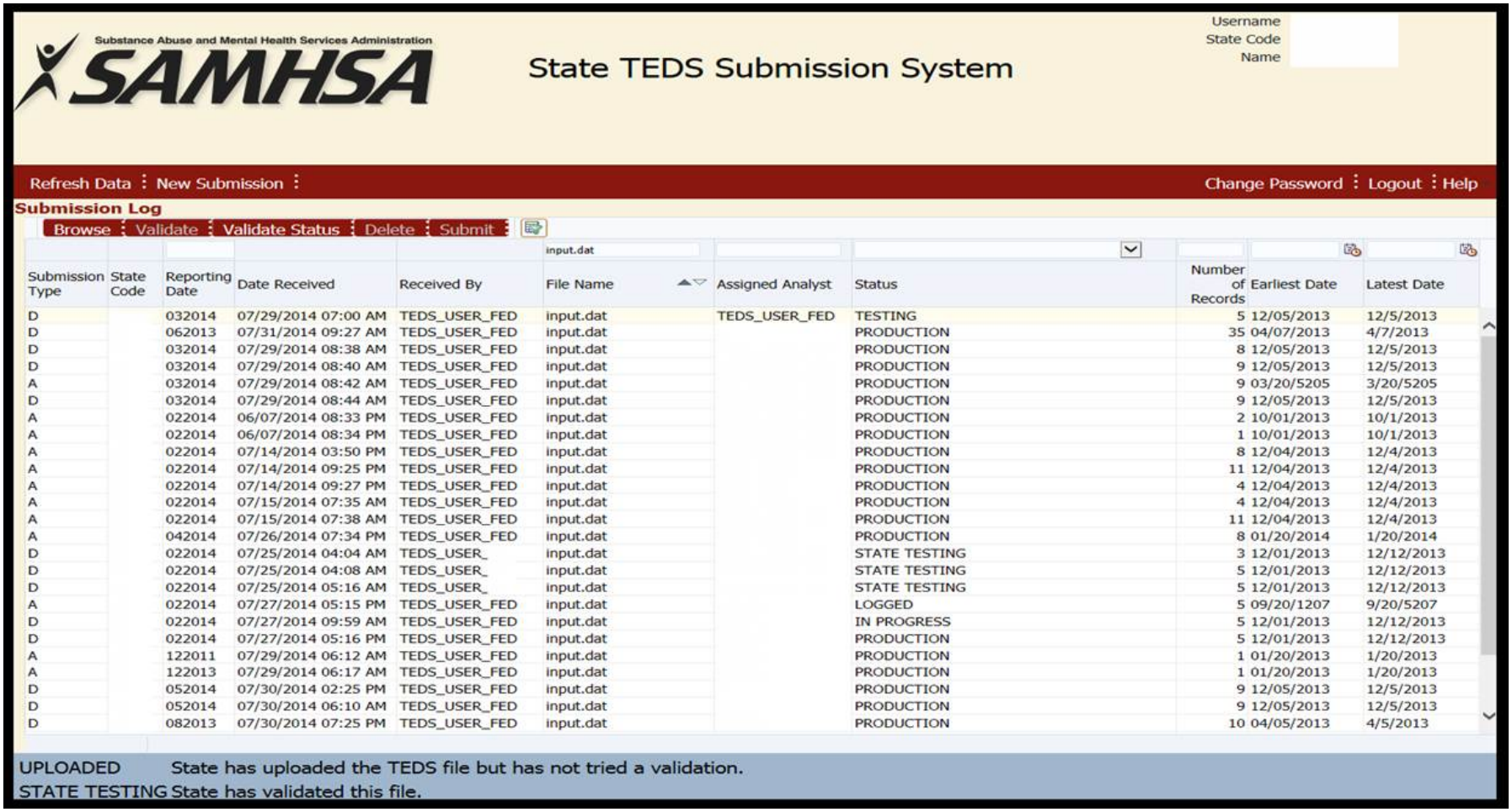
- All files that have been uploaded to the STSS remain in the log until final submission to TEDS or deletion by the user.
- The columns in the log can be sorted or filtered using the search criteria tools at the top of each column.

The "Help" button drops down a menu with two choices: TEDS Resources and About. TEDS Resources will open a window to the *TEDS* page of the BHSIS Resource Center (to reference other TEDS-related information). *About* provides details about the STSS release (i.e., version, environment, etc.) that are useful when reporting problems to **technicalsupport_cld@smdi.com**.

Column	Description
Submission Type	Specifies if file contains Admission or Discharge/Update records
Reporting Date	Date the state created the file
Date Received	Date the file is uploaded
Received by	ID of person uploading the file
File Name	Name of the file
Assigned Analyst	Analyst assigned to the state
Status	*Uploaded*: Data file has been uploaded to STSS but has not yet been validated. *State Testing*: State has run trial validation on the file. *Logged*: File has been formally submitted by the state for final processing by the TEDS Project Office. *In Progress*: File validation is ongoing. *Testing*: TEDS Project Office is reviewing the submitted (logged) file. *Production*: TEDS Project Office has processed the file. *Archived*: Submission has been archived (added to the TEDS database).

Column	Description
	File is only visible if specifically queried.
Number of Records	Number of records in the file
Earliest Date	Earliest Admission/Discharge date in the file
Latest Date	Latest Admission/Discharge date in the file

FIGURE 11. SUBMISSION LOG (HOME) PAGE



To perform an action on a file, select (highlight) the file and select one of the function buttons in the menu located above the log:

Button	Action
Browse	Displays data for individual records, as well as basic information about the file.
Validate	Validates the file by running the TEDS validation edits.
Validate Status	Opens the Validation Status screen. This option is available only for files that have been validated but not finally submitted to TEDS.
Delete	Deletes the file from the submission log. Use this option for a file that fails a large number of edit checks and must be corrected before resubmission.
Submit	Submits the file for final processing by the TEDS Project Office. The intent to submit is verified, and the status in the submission log changes from *State Testing* to *Logged*. The state is notified by email that the submission was successful.
Refresh Data	Reloads and updates information in the submission log.
New Submission	Resets to upload a new file.

Link	Action
Change password	Users can change the assigned password. Password must be 8-12 characters long, and it must contain at least one number, both uppercase and lowercase letters, and at least one special character (! @ # $ % ^ & *).
Logout	Logs out the user and displays the Log-in page.

Step 2: Upload a Data File to the STSS

(1) From the Submission Log (Home) page, click “New Submission” to upload a new file. You will be asked to enter:

- The type of submission (specify if the files contains admission or discharge records)
- Reporting date (MMYYYY)—This date must match the reporting date specified in all records contained in the file. All records must have the same reporting date.
- The file name (with complete path)—Use “Browse” to locate the file on the user’s PC and select the file to be uploaded.

(2) Click “Upload.” The upload process may take a few minutes, depending on connection speed and file size.

- If the upload is successful, the message “File has been successfully uploaded” will be displayed.
- If the **Reporting Date** or **State Code** in the first record does not match the entry to STSS, the upload attempt will fail and the user will receive an error message. In case of an error, users should check three possible causes: (1) the wrong field value was entered on the first record of

the file; (2) an incorrect field value was entered on the STSS; or (3) the wrong file was selected on STSS. To correct the error, re-upload a corrected file for (1) or click “Browse” to either re-enter the correct field value for (2) or re-select the correct file for (3).

- If the type of submission is incorrect (e.g., an admission file is uploaded but was typed in as a discharge file in the Submission Type), the file will upload successfully and will appear normal in the **Submission Log**, but validation processing will result in errors in all records.

Step 3: Validate the Data File

Once the file is uploaded and appears at the top of the **Submission Log**, it is now ready for edit checks (validation) to be performed. Click “Validate” to open the **Validation Specifications** page.

Validation Specifications Page

The **Validation Specifications** page (see Figure 12) contains a summary of the data file selected for validation.

Prior to running the validation function, the user may set a threshold that will stop processing if a certain percentage or number of records is rejected because of fatal errors. This feature is especially useful for large date sets that may have systematic errors.

- The threshold can be set as a percentage (“Failure Threshold”); or
- The threshold can be set as an absolute number of records (“Failure Threshold Total”).

If different threshold levels are set in the percentage and number fields, the higher threshold will apply.

If both threshold values are blank, all records will be processed.

Button	Action
Start Validation	Opens Validation Status page to initiate file validation.
Return to Log	Returns to the Submission Log (Home) page.

Validation Status Page

The **Validation Status** page (Figure 13) provides detailed information about the load status, failure thresholds, and statistics pertaining to the validated data files. During validation processing, the validation status is updated every 5 seconds (or at a user-set interval) until processing is complete.

FIGURE 12. VALIDATION SPECIFICATIONS PAGE

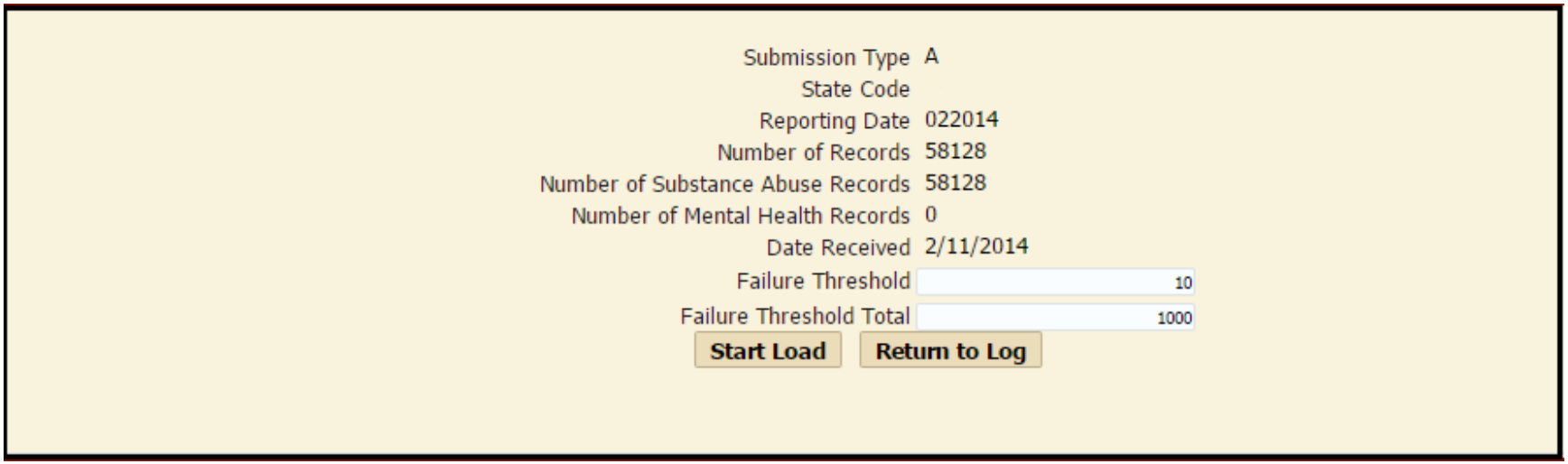
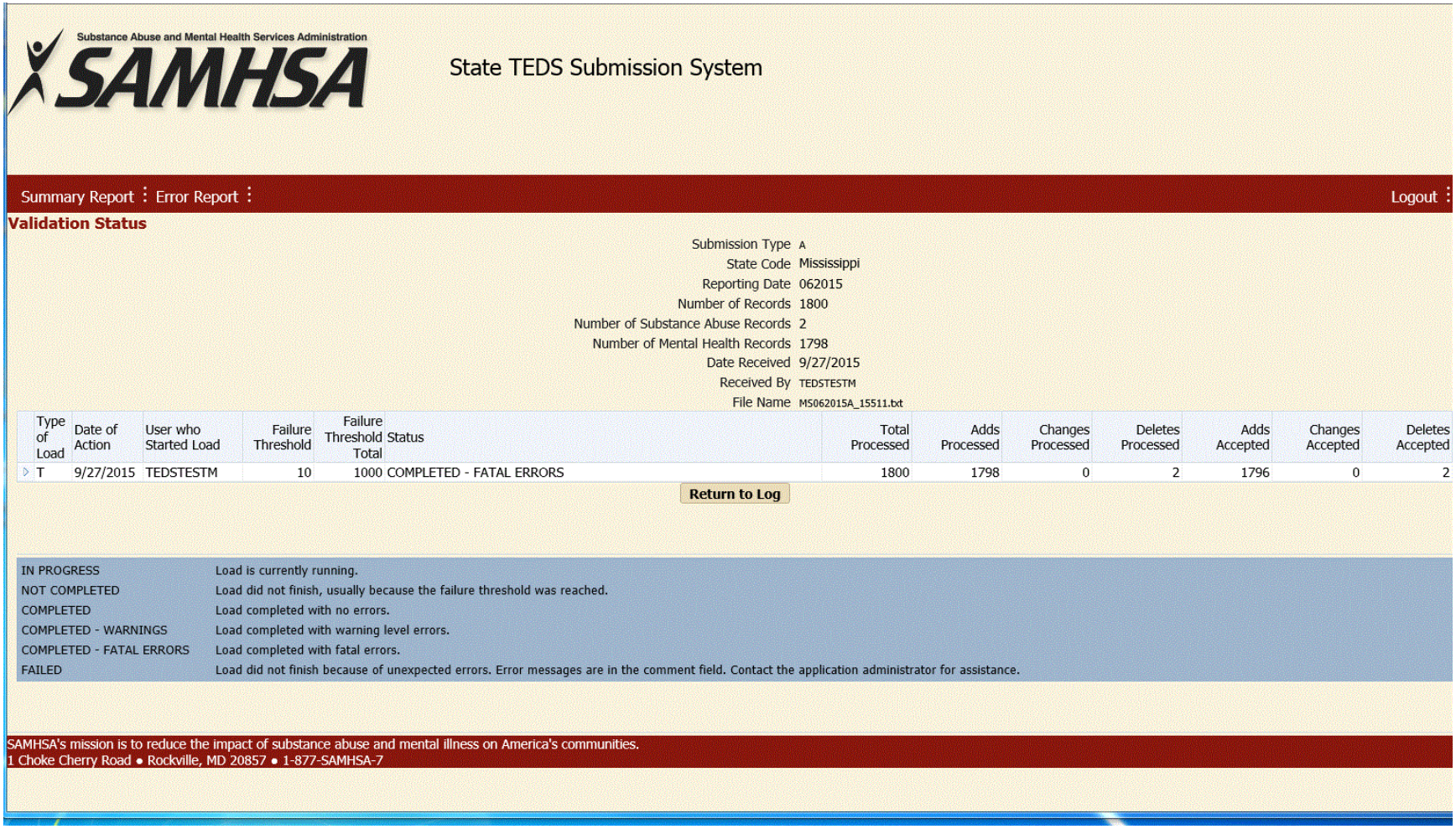


FIGURE 13. VALIDATION STATUS PAGE



Substance Abuse and Mental Health Services Administration
SAMHSA

State TEDS Submission System

Summary Report | Error Report | Logout

Validation Status

Submission Type A
State Code Mississippi
Reporting Date 062015
Number of Records 1800
Number of Substance Abuse Records 2
Number of Mental Health Records 1798
Date Received 9/27/2015
Received By TEDSTESTM
File Name MS062015A_15511.txt

Type of Load	Date of Action	User who Started Load	Failure Threshold	Failure Threshold Total	Status	Total Processed	Adds Processed	Changes Processed	Deletes Processed	Adds Accepted	Changes Accepted	Deletes Accepted
T	9/27/2015	TEDSTESTM	10	1000	COMPLETED - FATAL ERRORS	1800	1798	0	2	1796	0	2

Return to Log

IN PROGRESS	Load is currently running.
NOT COMPLETED	Load did not finish, usually because the failure threshold was reached.
COMPLETED	Load completed with no errors.
COMPLETED - WARNINGS	Load completed with warning level errors.
COMPLETED - FATAL ERRORS	Load completed with fatal errors.
FAILED	Load did not finish because of unexpected errors. Error messages are in the comment field. Contact the application administrator for assistance.

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When validation processing is completed, the final status is displayed. The status may indicate the presence of errors. See **Appendix E** for a list of validation edits, the corresponding error statement generated when an edit is violated, and the recommended corrective action. Below is a summary of the different types of errors (see Chapter 6, Validation Edits, for further discussion on errors):

- A *fatal* error causes a record to be rejected. The record will not be added to the database. The state is expected to review the specified edit violations, take necessary corrective action, and resubmit the corrected record(s) or file(s) for reprocessing. Generally, fatal errors are the result of missing or invalid code(s) in key data fields as well as the presence of duplicates.
- A *warning* error is non-fatal and usually results from invalid code(s) in non-key data fields. The record will be processed and appended to the database, with the value of the data field replaced by the system-defined *Invalid data code* unless specified otherwise. The state is expected to review the specified edit violations, take necessary corrective action, and resubmit the corrected record(s) as replacements. Preferably, these warning errors are corrected by the state during the testing period and prior to submitting the file for final processing.
- An *informational* message, considered a non-fatal error, is generated to inform the state that an edit was not performed due to missing data or that the edit did not produce the expected outcome. A common situation that generates an informational message is when records with **State Provider Identifiers** cannot be found in the SAMHSA Inventory of Behavioral Health Services (I-BHS). The record will be processed and appended to the TEDS database. The state is expected to determine whether the facility is eligible for inclusion in the I-BHS. If the facility is eligible, a corrective action should be undertaken; if the facility is not eligible, the state may ignore the informational message. Please see Chapter 6 for more details.

Load Status	Description
In Progress	File validation is ongoing.
Not Completed	This message generally means that the fatal error threshold value has been exceeded. The user may either have to rerun the validation with a higher threshold setting or log out of the STSS and make corrections to the file. To rerun the validation with a modified threshold, click “Start a New Load” to return to the **Validation Status** page. Modify the threshold level and click “Start Validation.”
Completed	The file was found to be error-free and is ready for submission to the TEDS Project Office for final processing.
Completed - Warnings	This indicates that some records contain invalid data in one or more fields. These records were processed and the field values were replaced by the system-defined code for invalid data.
Completed - Fatal Errors	This indicates the process has completed with fatal errors although the threshold has not been exceeded. Records with fatal errors have been rejected.
Failed	The validation process on the file did not complete because an unexpected error was encountered. This often indicates a fundamental file problem, such as the wrong file format or incorrect record length. Error messages identifying the problem appear in the comment field. For assistance in resolving the

Load Status	Description
	problem, contact the TEDS Project Office.

Step 4: Review Processing and Error Reports

Processing reports are generated from the **Load Status** page.

Button	Action
Summary Report	Opens the *Submission Processing Results Summary*. This report displays, by **System Transaction Type**, (1) the number of records submitted, accepted, and rejected; (2) the number of records rejected with fatal errors, and (3) other summary statistics, as appropriate, such as the number of records with non-fatal errors and number of discharge records with missing admission records. This report provides an overall evaluation of the quality of the file. If a state's data extraction program is working correctly, the number of errors in any file submission should be minimal. If a field has a large number of errors, it usually indicates a systematic error that, once corrected, will resolve the errors for all or many of the records.
Errors Report	Opens the *Errors in TEDS Submission* report. This report details, for each record with errors, the record number, field name and erroneous value, key fields, a brief description of the error, and the required corrective action. The report format was revised to include the corresponding Edit Number that users can use to refer back to Appendix E of this manual. This report aids in the identification of non-systematic errors. Individual records can be examined to identify the cause of the errors and decide how to resolve them. Examination of this report will enable states to resolve most errors. Please refer to the list of edits when reviewing this report.

Reports can be viewed immediately after completion of the validation process or at a later time. To open the reports from the **Submission Log** (Home) page, click "Validate Status" to open the **Load Status** page. Click "Summary" and/or "Errors" to view the reports (see Figures 14 and 15).

It is critical that states review their processing reports to identify both systematic and individual errors found in the submitted records. Early detection of errors permits corrections to be made prior to submitting the data file for final processing.

States are responsible for reviewing these reports, resolving the errors, and resubmitting corrected records.

The TEDS Project Office will assist states in the identification and resolution of both systematic and non-systematic errors.

FIGURE 14. SUBMISSION PROCESSING RESULTS SUMMARY PAGE (ADMISSION FILE)

TEDSLDR1 05/06/2015

SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION
CENTER FOR BEHAVIORAL HEALTH STATISTICS AND QUALITY
TREATMENT EPISODE DATA SET
SUBMISSION PROCESSING RESULTS SUMMARY - ADMISSIONS

		DATE OF ADMISSION	
SUBMISSION NUMBER:			
STATE:		EARLIEST	LATEST
REPORTING DATE:		03/11/1997	04/30/2015
	Total	SA	MH
RECORDS SUBMITTED:	15,196	15,196	0

PROCESSING RESULTS SUMMARY

	PROCESSED	ACCEPTED	REJECTED	PERCENT REJECTED
ADDS	14,661	14,648	13	0.09%
CHANGES	483	382	101	20.91%
DELETES	52	46	6	11.54%
TOTAL	15,196	15,076	120	0.79%

REJECTED RECORDS DUE TO FATAL ERRORS

	STATE CODE	PROVIDER ID	CLIENT ID	CO-DEP CODE	DATE OF ADMISSION
ADDS	0	0	0	0	0
CHANGES	0	0	0	0	0
DELETES	0	0	0	0	0
TOTAL	0	0	0	0	0

SUBMISSION PROCESSING RESULTS SUMMARY PAGE (DISCHARGE FILE)

TEDSLDR1 05/06/2015

SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION
CENTER FOR BEHAVIORAL HEALTH STATISTICS AND QUALITY
TREATMENT EPISODE DATA SET
SUBMISSION PROCESSING RESULTS SUMMARY - DISCHARGES

		DATE OF DISCHARGE	
SUBMISSION NUMBER:			
STATE:		EARLIEST	LATEST
REPORTING DATE:		08/31/2004	04/30/2015
	Total	SA	MH
RECORDS SUBMITTED:	13,880	13,880	0

PROCESSING RESULTS SUMMARY

	PROCESSED	ACCEPTED	REJECTED	PERCENT REJECTED
ADDS	13,607	13,566	41	0.30%
CHANGES	66	38	28	42.42%
DELETES	207	190	17	8.21%
TOTAL	13,880	13,794	86	0.62%

REJECTED RECORDS DUE TO FATAL ERRORS

	STATE CODE	PROVIDER ID	CLIENT ID	CO-DEP CODE	DATE OF DISCHARGE
ADDS	0	0	0	0	0
CHANGES	0	0	0	0	0
DELETES	0	0	0	0	0
TOTAL	0	0	0	0	0

	NO RECORD FOUND	DUPLICATE KEY WITHIN SUBMISSION	DUPLICATE KEY IN DATABASE	DATE OF LAST CONTACT/ UPDATE	OTHER FATAL ERRORS
ADDS	N/A	28	13	0	0
CHANGES	28	0	N/A	0	0
DELETES	17	0	N/A	0	0
TOTAL	45	28	13	0	0

ACCEPTED RECORDS WITH NON-FATAL ERRORS	149
ACCEPTED RECORDS WITH NO ASSOCIATED ADMISSION RECORD	0

FIGURE 15. ERROR REPORT PAGE (REVISED VERSION)

SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION
CENTER FOR BEHAVIORAL HEALTH STATISTICS AND QUALITY
TREATMENT EPISODE DATA SET - MH DISCHARGES/UPDATES
FATAL AND WARNING ERRORS IN TEDS SUBMISSION - GROUPED BY REASON

SUBMISSION NUMBER: XX022015

RECORD NUMBER	SYSTEM TRAN TYPE	PROVIDER ID	CLIENT ID	CO-DEP	CLIENT TRAN TYPE	DATE OF DISCHARGE	SERVICE CODE	FIELD NAME	STATE REPORTED VALUE	TYPE OF ERROR (FATAL/NON FATAL)	EDIT VIOLATION	Edit No.	CORRECTIVE ACTION
21	A	XXXXXX	ZZZZZZZZ	2	D	02/08/1999	07	DATE OF DISCHARGE	N/A	Y	Field is either blank, has an invalid value, or wrong date format; record is rejected and not processed.	D15	Discharge Date must be a valid calendar date in the format MMDDYYYY
13623	A	XXXXXX	ZZZZZZZZ	2	D	08/30/1995	07	Date of Last Contact or Data Update	N/A	Y	Field value is before January 1, 1920; record is rejected and not processed.		Date of Last Contact or Data Update must be January 1, 1920 or later
6332	A	XXXXXX	ZZZZZZZZ	2	D	02/10/2009	07	Date of Last Contact or Data Update	02152010	N	Field value is later than the Discharge date; record is processed but value is replaced with the system code; '01010009' for invalid data.	D23	Date of Last Contact or Data Update must be the same date or earlier than the current date or the Discharge Date
6091	C	XXXXXX	ZZZZZZZZ	2	D	08/16/2011	07	Date of Last Contact or Data Update	02152012	N	Field value is later than the Discharge date; record is processed but value is replaced with the system code; '01010009' for invalid data.	D23	Date of Last Contact or Data Update must be the same date or earlier than the current date or the Discharge Date
12823	C	XXXXXX	ZZZZZZZZ	2	D	12/06/2007	08	Date of Last Contact or Data Update	08302010	N	Field value is later than the Reporting date; record is processed but value is replaced with the system code; '01010009' for invalid data.	D23	Date of Last Contact or Data Update must be the same date or earlier than the current date or the Discharge Date
1207	C	XXXXXX	ZZZZZZZZ	2	U	07/28/2011	07	Detailed Not in Labor Force	93	N	Field is either blank or has an invalid value; record is processed but value is replaced with the system code '99' for invalid data.	D27	Records with invalid data should be reviewed and replaced with valid values specified in the Manual
13586	C	XXXXXX	ZZZZZZZZ	2	U	05/01/2013	07	Detailed Not in Labor Force	10	N	Field is either blank or has an invalid value; record is processed but value is replaced with the system code '99' for invalid data.	D34	Records with invalid data should be reviewed and replaced with valid values specified in the Manual

Step 5: Correct Data Errors and Revalidate Corrected Data File

States are expected to resolve errors in current file submissions and take necessary action to avoid the same errors in future submissions.

- Corrections cannot be made within the STSS: states must correct records using their state systems or programs and revalidate the file.
- Files with errors should be deleted from the STSS before the corrected files are uploaded. To delete files:
    - Click “Return to log” to return to the **Submission Log (Home)** page.
    - Select (highlight) file to be deleted.
    - Click “Delete” to delete the file.
- After corrections have been made to the data file, upload the file to the STSS as a new submission and repeat the validation process.

This sequence (upload, validate, review, correct, revalidate) can be repeated as many times as needed to produce a file that the state deems ready for submission to TEDS.

Step 6: Submit File to TEDS for Final Processing

When the file validation has been completed and reviewed, and the file has been corrected, the file has to be revalidated. When the file has successfully completed the validation process with no further errors, the file is ready to be submitted for final processing by the TEDS Project Office.

To submit the file to TEDS for final processing:

- Click “Return to log” to return to the **Submission Log (Home)** page.
- Select (highlight) the file and click “Submit” for final processing.

In the final processing, the TEDS Project Office thoroughly reviews the file. If necessary, staff contacts the state with questions.

Changing/Correcting Records in the TEDS Database

There are instances when states need to correct a data field value such as wrong birth date on a record that has already been submitted, processed by the TEDS Project Office, and added to the TEDS database. There are two methods to correct a record, depending on the type of data field involved:

- To correct an error in a key field, use Method 1.
- To correct an error in a non-key field, use either Method 1 or 2.

Method 1: Delete and Add Records

To correct an error in a key field, the original record must be deleted and a record containing the correct key fields added.

- Submit a record in which the key fields match the original record, but with a **System Transaction Type** code of *D Delete*. Non-key fields may be left blank or contain the original values. In the data submission, include the corrected record with **System Transaction Type** code *A Add*, showing the values for all data fields.
- The Delete record will be processed first, removing the record from the database. Then the Add record, which contains values for all data fields, will be appended to the database.

Method 2: Change (Replace) Records

Records with errors in non-key fields may also be corrected by changing the existing record.

- Submit a complete record in which the key fields match the original record, but with the **System Transaction Type** code *C Change*. The *Change* record will replace the existing record in the TEDS database; it must contain correct values for all fields in the record.

Special Case: Changes to the Admission Fields on the Discharge Record

If the values of the key fields were changed in the admission record, it is essential that these corrected values are appended to the corresponding discharge record. This is especially important because key fields are used to link the admission and discharge records.

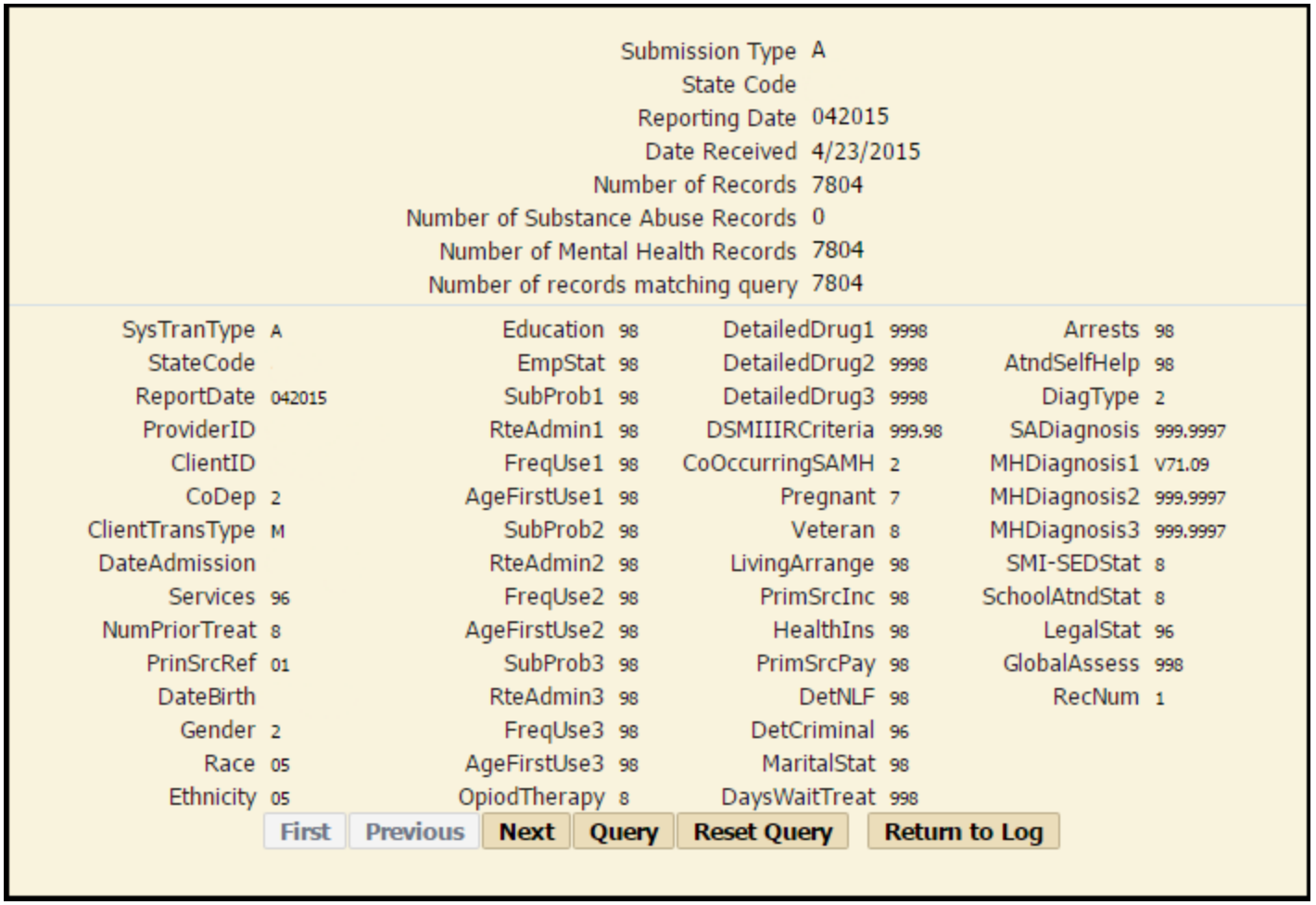
Other STSS Functions: Browsing and Querying Files

The “Browse” and “Query” functions are used to examine records with errors and identify the source of the error.

The “Browse” button on the **Submission Log (Home)** page enables the user to view individual records in a data file and to perform data queries on a file.

- Select (highlight) a file and click “Browse.” The **Browse** page (Figure 16) displays data for the first record in the file, as well as basic information about the file. Standard navigation buttons permit viewing of the first, next, and previous records in the file.
- The “Query” button at lower right enables viewing of a specific record or subset of records. Click “Query” to open the **Query** page (Figure 17). This page has the same format as the Browse page, but all the data cells are empty. To conduct a query:
- Enter value(s) for the desired variable(s).
- For example, to view records for male clients from a specific provider, enter the **State Provider ID** and *1 Male* in the **Gender** field.
- Click “Execute Query” to display the first record that meets the criteria and the total number of records meeting the criteria. Use the standard navigation buttons to view these records.

FIGURE 16. BROWSE PAGE

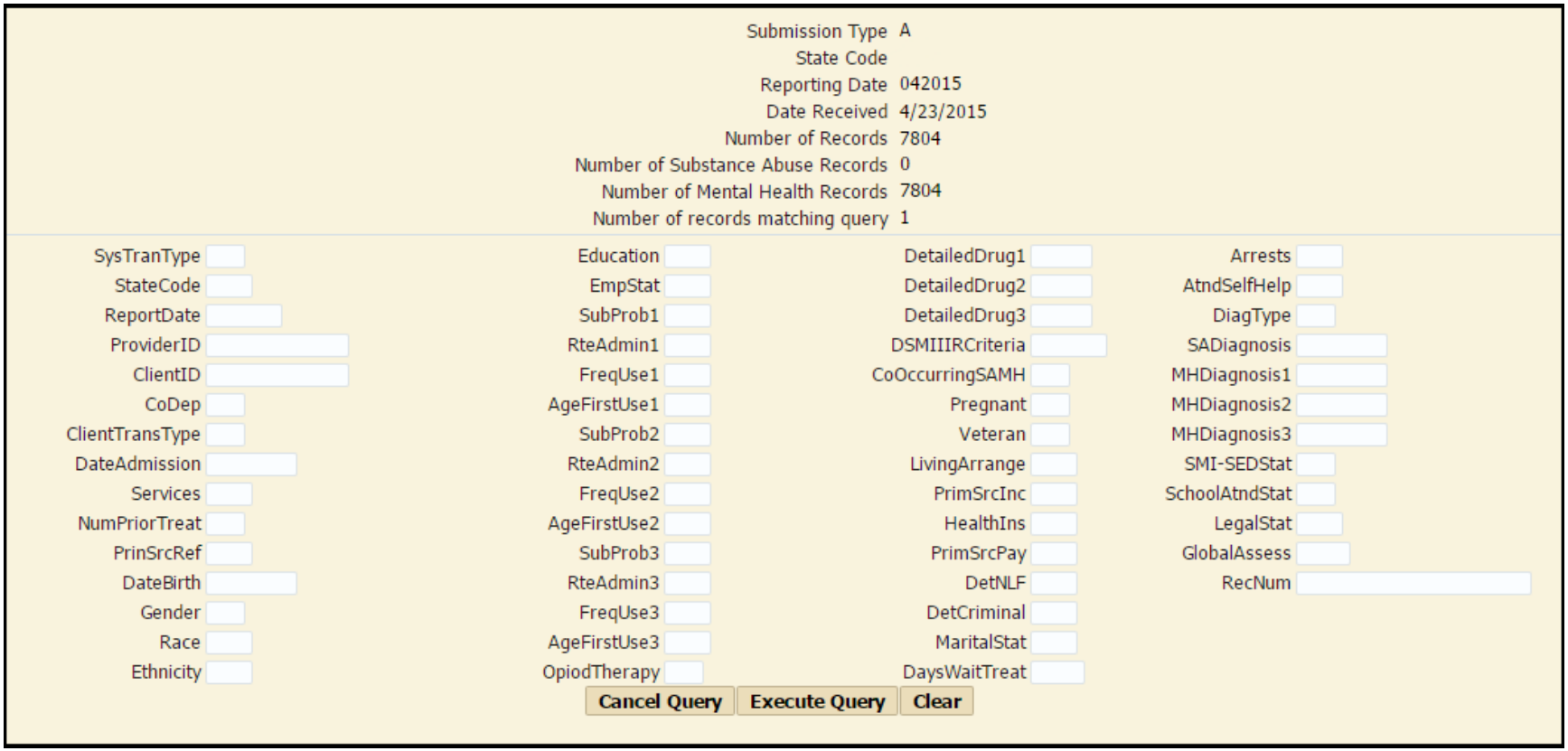


Submission Type	A
State Code	
Reporting Date	042015
Date Received	4/23/2015
Number of Records	7804
Number of Substance Abuse Records	0
Number of Mental Health Records	7804
Number of records matching query	7804

SysTranType	A	Education	98	DetailedDrug1	9998	Arrests	98
StateCode		EmpStat	98	DetailedDrug2	9998	AtndSelfHelp	98
ReportDate	042015	SubProb1	98	DetailedDrug3	9998	DiagType	2
ProviderID		RteAdmin1	98	DSMIIIRCriteria	999.98	SADiagnosis	999.9997
ClientID		FreqUse1	98	CoOccurringSAMH	2	MHDiagnosis1	V71.09
CoDep	2	AgeFirstUse1	98	Pregnant	7	MHDiagnosis2	999.9997
ClientTransType	M	SubProb2	98	Veteran	8	MHDiagnosis3	999.9997
DateAdmission		RteAdmin2	98	LivingArrange	98	SMI-SEDStat	8
Services	96	FreqUse2	98	PrimSrcInc	98	SchoolAtndStat	8
NumPriorTreat	8	AgeFirstUse2	98	HealthIns	98	LegalStat	96
PrinSrcRef	01	SubProb3	98	PrimSrcPay	98	GlobalAssess	998
DateBirth		RteAdmin3	98	DetNLF	98	RecNum	1
Gender	2	FreqUse3	98	DetCriminal	96		
Race	05	AgeFirstUse3	98	MaritalStat	98		
Ethnicity	05	OpiodTherapy	8	DaysWaitTreat	998		

First Previous Next Query Reset Query Return to Log

FIGURE 17. QUERY PAGE



System Transaction Type and Key Fields: Important Notes

Several levels of processing are performed with the key fields and **System Transaction Type**.

(1) Each record must have valid codes for all key fields and for **System Transaction Type**.
(2) Key fields in a new file submission are compared to those of other records in the file, then to records in the TEDS database. Each **System Transaction Type** code is processed separately, in the order below:
    i. Records with a **System Transaction Type** code *D Delete* will delete a record with matching key fields.
    ii. Records with a **System Transaction Type** code *A Add* will be added to the database unless the key fields match a record already in the TEDS database. If the *Add* record matches the key fields of an existing record, the *Add* record will be rejected as a duplicate.
    iii. Records with a **System Transaction Type** code *C Change* will change a record with matching key fields by replacing the record.

(3) Key fields in a discharge file submission are matched to the admission records in the TEDS database. Any discharge record that matches an admission record on all key fields is flagged and reported as a match. If no match is found, the discharge record will be accepted into the database, and reported in the Processing Summary Report. States are encouraged to identify systematic errors responsible for failed matches and to correct and resubmit the data.

The **System Transaction Type** and the key fields are central to the processing of TEDS records.

System Transaction Type identifies whether the record:

- is being *added* to the database;
- *changes* (by replacement) an existing record in the database; or
- *deletes* an existing record from the database.

Key Fields

Key fields are the required fields for each record. If any of these values is missing or invalid, the record will be rejected and a fatal error generated. These fields are:

- **State Code**
- **State Provider Identifier**
- **Client Identifier**
- **Codependent/Collateral**
- **Client Transaction Type**
- **Date of Admission**, **Date of Discharge**, and **Date of Last Contact or Data Update**
- **Type of Treatment Service/Setting**

Non-STSS File Submission and Processing

States are strongly encouraged to use STSS to submit files because it is highly secure and accessible to authorized users only (web-based and available 24/7).

Data Transmission Protocols

As an alternative to STSS, data must be transmitted by one of the following methods: sent electronically by FTP, sent as a secure email attachment, or submitted on a read-only CD. Passwords for password-protected files must be transmitted to the TEDS Project Office separately from the data transmission. Each data file must be accompanied by the following information:

- Two-character state abbreviation
- Reporting date (month and year)
- Whether the submission is a first submission or a resubmission
- Number of records in the submission
- State point of contact (name, phone number, and email address)
- An indication of whether or not the CD should be returned (if applicable)

Electronic Transmission via FTP

Contact the TEDS Project Office to identify a mutually acceptable method for transmission.

Transmission as an Email Attachment

Contact the TEDS Project Office to make appropriate arrangements for transmitting the data in a secure manner.

- File format: ASCII flat file

File must be password protected, encrypted, and compressed. Contact the TEDS Project Office for information on acceptable encryption software.

Transmission on CD

Use appropriate mailing containers to avoid damage and delay in the receipt of the submission.

- CD type: CD-R (read-only; CD-RW not recommended)
- File format: ASCII flat file

Send data to:

TEDS Project Office
Synectics for Management Decisions
1901 North Moore Street, Suite 900

Arlington, VA 22209
Phone: 703-807-2337 (Mayra Walker)

File Processing for Non-STSS Data Files

- The TEDS Project Office will subject non-STSS data files to the same processing procedures that are performed on STSS file submissions. The TEDS Project Office will work closely with the state until the files are acceptable for submission.
- If few non-critical errors are found, the TEDS Project Office adds acceptable records to the database and continues to work with the state on records requiring corrective action.
- The TEDS Project Office emails the *Processing Summary Report* and, if applicable, the *Errors in TEDS Submission* Report to the states so that errors can be corrected.
- States are expected to review these reports for each file submission, make corrections to erroneous data, and resend the corrected files using the agreed upon transmission method.
- If the initial process indicates significant numbers of records with errors or records rejected, or a pattern of errors that indicates a systematic data problem, the TEDS Project Office emails both the *Processing Summary Report* and the *Errors in TEDS Submission* Report to the state and notifies the state by telephone or email that the file will not be accepted for production.
- If the state submission cannot be processed because the entire submission is unreadable, the TEDS Project Office will contact the state to inform them of the problem.
- For situations in which a resubmission is necessary, states may send the file as a separate "special" resubmission, or they may include the resubmission with their next regular submission. States should resubmit corrected files in a timely manner.

The TEDS Project Office will repeat the sequence of upload, validation, review, and correction if necessary until the Project Office and the state feel the data are acceptable for addition to the TEDS databases. The final *Processing Summary Report* and, if applicable, the *Errors in TEDS Submission Report,* will be emailed to the state for its records.

TEDS Data Security

The TEDS Project Office performs the final processing using the TEDS Data Management System (TDMS), a web-based Oracle system that provides management capabilities for the TEDS databases. This dual-level processing is a security measure that protects the TEDS database from direct access by anyone other than the TEDS Project Office.

- The STSS is accessed through a secure web site. Data submitted through STSS have a secure connection for transmission.
- When data are submitted by other means, the security of the data during transmission from the state to the TEDS Project Office is the responsibility of the state, although the TEDS Project Office will make every reasonable effort to accommodate state security needs. At a minimum, it is recommended that submitted data files be password protected and encrypted. The state must coordinate with the TEDS Project Office to ensure that the encryption methodology is available to the Project Office.

The TEDS Project Office manages the data files sent by the states as well as the TEDS database in a secure manner:

- Data files sent by the states are processed promptly.
- CDs are kept in a locked vault within a locked room accessible only by authorized TEDS Project Office personnel.
- Once processing is complete, the files are destroyed or returned to the state, according to the state's instructions.

The TEDS databases are maintained on a secure server with ID and password access limited to SAMHSA and TEDS Project Office staff. The server and back-up files are located in a secure co-location site.

Chapter 6: Validation Edits

Each data field in records is checked to ensure that it contains valid codes before the record is accepted and added to the TEDS database. These checks are called the field edits. If an invalid code is found, the field will be filled with a code indicating *Invalid data* and a warning error generated. States must employ corrective action on these records as specified in the Error Report (see Step 4 of the *Steps in TEDS File Submission* discussed within the **STSS Guide** section of this manual).

Some fields are interdependent, such as **Employment Status** and **Detailed Not in Labor Force**. Edit checks are performed to ensure that values in interdependent fields are consistent with each other. These edits, commonly referred to as relational edits, are fairly numerous, and are detailed in the individual field descriptions (see **Appendix D**). For example, a relational edit exists between **Pregnant at Admission** and **Gender**. The valid code Yes or No for Pregnant at Admission requires that Gender is Female. The Not Applicable code must be used if Gender is Male. Warning errors are issued when relational fields are inconsistent. In employing corrective action, states must review all data fields relevant in the established relationship.

Below is a summary of the common types of errors as presented in Chapter 5:

- A *fatal* error causes a record to be rejected. The record will not be added to the database. The state is expected to review the specified edit violations, take necessary corrective action, and resubmit the corrected record(s) or file(s) for reprocessing. Generally, fatal errors are the result of missing or invalid code(s) in a key data field as well as the presence of duplicates.
- A *warning* error is non-fatal and usually results from invalid code(s) in a non-key data field. The record will be processed and appended to the database, with the value of the data field replaced by the system-defined *Invalid data code* unless specified otherwise. The state is expected to review the specified edit violations, take necessary corrective action, and resubmit the corrected record(s) as replacement. Preferably, these warning errors are corrected by the state during the testing period and prior to submitting the file for final processing.
- An *informational* message, considered a non-fatal error, is generated to inform the state that an edit was not performed due to missing data or that the edit did not produce the expected outcome. A common situation that generates an informational message is when records with **State Provider Identifiers** cannot be found in the SAMHSA Inventory of Behavioral Health Services (I-BHS). The record will be processed and appended to the TEDS database. The state is expected to determine whether the facility is eligible for inclusion in the I-BHS. If the facility is eligible, a corrective action should be undertaken; if the facility is not eligible, the state may ignore the informational message. Please see the Information Message section of this Chapter for additional guidance.
- In addition to the above, errors may also be encountered during the file upload process and/or the final file processing. Please see **Appendix E**.

Common Errors in TEDS Submission

To help prevent potential errors and to assist in interpreting error reports, states are alerted to the following commonly occurring errors. A complete list of edit checks is provided in **Appendix E**.

Fatal Errors: Duplicate Record

This indicates that a record has already been submitted to TEDS.

We recommend that states employ quality assurance checks to ensure that the same records are not submitted more than once. Possible methods a state can use to minimize duplicate records include:

- Add a flag to the state system to indicate records that have been submitted to TEDS.
- Alternatively, if the state has a field indicating the date a record was added or updated in the state system, the TEDS extraction program could be designed to include only records added or changed since the date of the previous submission.

Frequently, however, this error is caused by an attempt to change an existing record that fails because the wrong **System Transaction Type** code was used.

Please see *Changing/Correcting Records in the TEDS Database* as discussed in the STSS Guide section of the manual for detailed instructions on making changes to records.

Non-Fatal (Warning) Errors: Fields with Relational Edit Checks

Warning errors frequently occur for a data field that is interdependent (related) with another data field. Details of field interdependence are discussed in the individual field descriptions in **Appendix D** and presented as edit checks in **Appendix E**. **To submit the highest quality of data to TEDS, states should correct warning errors prior to submitting the file for final processing.**

The most frequent errors include the following:

- The field **Detailed Not in Labor Force** is intended to provide additional information only where **Employment Status** is *04 Not in the labor force*. For all other **Employment Status** codes, **Detailed Not in Labor Force** should be coded as *96 Not applicable* or, if the state does not collect the data, *98 Not collected*.
- The field **Detailed Criminal Justice Referral** is intended to provide additional information only where **Referral Source** is *07 Court or criminal justice referral*. For all other **Referral Source** codes, **Detailed Criminal Justice Referral** should be coded as *96 Not applicable* or, if the state does not collect the data, *98 Not collected*.
- The **Detailed Drug Code** fields are intended to provide more specific information on the drugs reported in the **Substance Abuse Problem** fields. Do not use the **Detailed Drug Code** fields to report additional drugs.
- A warning error will be generated if the drugs reported in the **Detailed Drug Code** fields are not subcategories of drugs reported in the **Substance Abuse Problem** fields. The following is an example of the correct use of the **Detailed Drug Code** fields. A client abuses both alprazolam and clorazepate. These are reported in the **Substance Abuse Problem** (primary) and **Substance Abuse Problem** (secondary) fields with the same code, *13 Benzodiazepines*. **Detailed Drug Code** (primary) should be coded *1301 Alprazolam* and **Detailed Drug Code** (secondary) should be coded as *1303 Clorazepate*.
- Submission of optional substance abuse information in a mental health record or optional mental health information in a substance abuse record will get a warning error if the **Co-occurring**

Substance Abuse and Mental Health Problems is not *1 Yes*. The submission of these data fields in both the mental health and substance abuse is allowed only if the client has co-occurring substance abuse and mental health problems.

- When submitting update records for mental health clients, the **Date of Discharge** must be *01010006 Not Applicable* and the **Reason for Discharge** must be *96 Not Applicable*. If a valid calendar date is reported in the **Date of Discharge**, the record is rejected (fatal error). If the **Reason for Discharge** is not *96 Not Applicable*, *97 Unknown*, or *98 Not Collected*, a warning error will be issued.

Informational Message: When Relational Edits Are Not Performed or No Facility Match Is Found in the I-BHS

An informational message is generated to inform the state that either a relational edit was not performed because one of the data fields did not have a valid value or a match in facility IDs between the TEDS **State Provider ID** and the I-BHS Facility ID did not produce a result. These messages directly impact the quality of data submitted, and therefore states should review them and take appropriate steps to keep the problem at a minimum. Oftentimes, the action to correct the problem might require consulting the primary source of data (i.e., providers), improving the state's data collection protocol, including internal data validity checks in the state's file preparation processes, or contacting the I-BHS Project Office.

The following is a discussion of the match performed between the State Provider ID and the I-BHS.

Every TEDS record must contain a **State Provider ID**. The TEDS validation edit process attempts to match the **State Provider ID** to the state ID field reported in the I-BHS. When a match is found, the following I-BHS information is appended to the record: I-BHS ID, county, Metropolitan Statistical Area, and, if applicable, the name of the federal agency with which the facility is affiliated (e.g., a VA Medical Center is affiliated with the Department of Veterans Affairs). If a match for the TEDS **State Provider ID** is not found in the I-BHS, an informational message is generated. Under this circumstance, the record will be added to the TEDS database but no additional information from the I-BHS, as stated above, will be appended.

We strongly encourage states to ensure that the **State Provider ID** of all facilities providing treatment services is listed on the I-BHS, to the extent possible. Facilities that provide support services only, perform administrative functions only such as referral, intake, screening, claims, etc., or solo practitioners are excluded in the I-BHS. Please refer to the State I-BHS User's Manual available in the BHSIS Resource Center and/or contact the I-BHS Project Office at 1-888-301-1143 for more detail information on the facility inclusion and exclusion criteria of the I-BHS.

- State I-BHS representatives and the I-BHS Project Office are responsible for ensuring that all facilities in a state's behavioral health system that meet the I-BHS eligibility criteria (i.e., facilities providing direct treatment services) are included, and that facility information is correct and up to date.
- The I-BHS Online system permits state representatives to view, change, add, and delete facilities. The state I-BHS representatives must obtain authorization to use the I-BHS online system through the I-BHS Project Office.

The following situations may be responsible for the failure to find TEDS **State Provider ID**s in I-BHS.

- The facilities that states have listed in the I-BHS may not have the same reporting and functional structure as the entities states report to TEDS. For example, for TEDS data reporting a state might use the State Provider ID for the Regional Behavioral Health Authority or Local Management Entity ID instead of ID for facility at the specific location where services are provided.
- The state facility listing in the I-BHS has not been updated. States are encouraged to regularly review and update their facility list.
- The facility may already exist in the I-BHS, but does not have the State Provider ID in the required State ID field.
- The state facility reporting TEDS data do not meet the eligibility criteria for inclusion in the I-BHS.

Undetectable Errors

Undetectable errors refer to field values that remain consistent with the established field and relational edits and cannot be identified through the validation process. These errors, however, can critically impact the integrity of the data. For example:

- A female client's **Gender** is incorrectly reported as *Male*. If a valid code is used, the field value will pass the edit. Hence, the error on the reported field value cannot be detected. The state may identify this issue through data audit of provider records. Once the error is discovered, the state must change the field value that has been on record.
- If the admission/transfer record information becomes outdated during the course of treatment (for example, a client's **Employment Status** is correctly coded as *Unemployed* at the time of admission but the client later becomes employed), do not change the data in the admission/transfer record. Instead, the update/discharge record should reflect the client's new status. Since improper changes to admissions data usually cannot be detected by the TEDS Project Office, it is very important that states avoid this type of error.

Errors in Matching Admission and Discharge Records

Files submitted through the STSS for final processing are usually added to the TEDS database within 2 business days. Because admission records are generally submitted before the related update/discharge records, linking discharge and admission records is performed during TEDS processing of the discharge/update file submission. The result of this record matching is shown in the Submission Processing Results Summary for the discharge/update file.

Files submitted through the STSS are matched to the TEDS database but not to other state files pending submission to TEDS. Therefore, a discharge/update file submission may generate "No matching admission" errors if the matching admission record is in a file that has not yet been submitted for final processing and therefore has not yet been added to the database. These non-matching errors can be ignored until the TEDS Project Office completes final processing of all pending state files. Submitting admission files at least one full day before submitting discharge files can alleviate this problem.

The TEDS Project Office will advise the state if there are problems with the match rate (i.e., the percentage of discharge records without an associated admission record) and will send the final processing report displaying the actual match rate to the state.

Chapter 7: Frequently Asked Questions (FAQs)

Is it important to report the *Codependent/Collateral* field?

Yes. **Codependent/Collateral** identifies whether the record is for a client receiving treatment for substance use disorder, or for someone seeking services because of problems arising from his or her relationship with a substance user. **Codependent/Collateral** is a *Key field*. Use code *2 Client* for mental health reporting.

What if a client has multiple admission records on the same day?

A client may receive a separate admission record for every billable service (e.g., group therapy, individual therapy, etc.). If all of these services were delivered within a single service type/setting (e.g., outpatient), report only one of these records to TEDS. TEDS does not collect data on the individual services delivered, but only on the general service setting.

On the Substance Abuse Prevention and Treatment Block Grant (SABG), what is pre-populated with TEDS data?

TEDS data are used to pre-populate some tables in the federal SABG application. These tables comprise SAMHSA's National Outcome Measures (NOMs) and include:

NOM	TEDS fields used to derive SA NOM
Employment/Education Status	**Employment Status** and **Detailed Not in Labor Force**
Stable Housing Situation	**Living Arrangements**
Criminal Justice Involvement	**Arrests in Past 30 Days**
Alcohol Abstinence	**Substance Abuse Problem** and **Frequency of Use**
Drug Abstinence	**Substance Abuse Problem** and **Frequency of Use**
Social Support	**Attendance at Self-Help Groups in Past 30 Days**
Retention	**Date of Admission** and **Date of Last Contact**

The client population subject to SABG reporting is a subset of the TEDS client population. The pre-populated tables in the SABG application exclude:

- Clients receiving medication-assisted opioid therapy—with the exception of the retention table.
- Clients who received treatment in short-term settings where no change would be expected to occur between admission and discharge (i.e., detoxification)—with the exception of the retention table.
- Clients whose treatment was terminated by death and/or incarceration.
- Records that do not have valid values at both admission and discharge in the applicable TEDS data fields.

States can exclude facilities that receive no SABG funds from these tabulations. Sometime around the end of February, the TEDS Project Office sends to each state a list of the SA treatment facilities that they report to TEDS indicating which facilities the state included in the previous year's SABG application. States are asked to reply by mid-April as to which facilities, if any, the state would like to exclude from their SABG application tables.

This is an optional service provided to the states. It is not mandatory and does not affect TEDS reporting requirements. **States should report to TEDS all facilities' data, whether or not the facilities receive SABG funds.**

Many states have wanted to replicate the coding used to derive the NOMs variables and have found it difficult to do so. The TEDS Project Office has developed a document, "Using TEDS Records for BGAS Tables" (**Appendix F**), to assist states in understanding SAMHSA's coding requirements. The TEDS Project Office can provide other assistance as well, including SAS code and detailed tables of the numbers of records at each stage of the NOMs calculations, which states can compare with their own calculations.

What is the reporting schedule for TEDS data used to pre-populate the SABG tables?

Synectics supplies three iterations of calendar year data to SAMHSA through its WebBGAS contractor: on or about May 15, an update about December 15, and another update about February 15 of the following year. Thus, the cut-off dates for TEDS CY 2013 data inclusion in the SABG application tables are April 30, 2014; November 30, 2014; and January 31, 2015. Data not received by the cut-off date will appear in the next iteration of the application tables.

Which MH URS tables are pre-populated with TEDS data?

Mental health data submitted through TEDS will be used to pre-populate select URS tables as requested by the state. The following URS tables can be pre-populated:

- URS Tables 2a and 2b (MHBG 13A and 13B) – Total Unduplicated Served by Age, Gender, Race, and Ethnicity
- URS Table 3 (MHBG 14) – Total Served by Setting, by Age and Gender
- URS Tables 4 and 4a (MHBG 18) – Employment
- URS Tables 14a and 14b (MHBG 15B and 15C) – Adults with SMI and children with SED served by age, gender, race, and ethnicity
- URS Table 15 (MHBG 19) – Living Situation
- URS Table 15a (MHBG 15a) – Adults with SMI and children with SED by service setting
- URS Tables 20a and 20b (MHBG 25A and 25B) – 30- and 180-day state hospital readmissions

Depending on the completeness of state data submitted to TEDS, the state may also request that URS Tables 5A, 5B, 6, and 21 be pre-populated.

Prior to generating the URS tables, the BHSIS Data Analysis Group will consult with each state regarding the summary statistics derived from the compiled MH-TEDS data files that will be used to pre-populate

the tables. The pre-populated URS tables will then be combined with the rest of the URS tables to comprise a complete state URS data set for the reporting period.

What is the reporting schedule for TEDS data used to pre-populate the MH URS tables?

To meet the statutory due date for the Community Mental Health Services Block Grant (MHBG) data requirements, all admissions and discharges/updates for all populations covered under the URS reporting period should be submitted by **December 1st** of each year.

State hospital admission records for the 6 months following the end of the state URS reporting period should be submitted no later than **March 1** the following year.

State data will be processed accordingly to produce the following mental health National Outcome Measures (NOMs):

- Access to Services/Capacity
- Employment (for adults)/School Attendance (for children)
- Stable Housing Situation
- Involvement in Criminal Justice System
- State Hospital 30-day and 180-day Readmission Rates

NOM	TEDS fields used to derive MH NOM
Access to Services/Capacity	*Total unduplicated count of clients who received a service during the reporting period by demographic characteristics (age, gender, race, ethnicity). The counts are based on the state file submissions for the reporting period.*
Employment Status	**Employment Status** and **Detailed Not in Labor Force**
Education Status	**Education** and **School Attendance Status**
Stable Housing Situation	**Living Arrangements**
Criminal Justice Involvement	**Arrests in Past 30 Days**
State Hospital Readmission Rates	**Date of Admission**, **Date of Discharge**, and **Type of Treatment Service/Setting**

APPENDICES

Appendix A. Background

Section 505 (a) of the Public Health Service Act (42 US 290aa-4) directs the Administrator of the Substance Abuse and Mental Health Services Administration (SAMHSA) to collect data on public and private behavioral health treatment programs and individuals seeking treatment through such programs.

Section 505 (a) of the Public Health Service Act (42 US 290aa-4) is available at **http://www.gpo.gov/fdsys/pkg/USCODE-2010-title42/pdf/USCODE-2010-title42-chap6A-subchapIII-A-partA-sec290aa-4.pdf**. An excerpt of the full text also follows below.

(a) Requirement of annual collection of data on mental illness and substance abuse

The Secretary, acting through the Administrator, shall collect data each year on—

(1) the national incidence and prevalence of the various forms of mental illness and substance abuse; and

(2) the incidence and prevalence of such various forms in major metropolitan areas selected by the Administrator.

(b) Requisite areas of data collection on mental health

With respect to the activities of the Administrator under subsection (a) of this section relating to mental health, the Administrator shall ensure that such activities include, at a minimum, the collection of data on—

(1) the number and variety of public and nonprofit private treatment programs;

(2) the number and demographic characteristics of individuals receiving treatment through such programs;

(3) the type of care received by such individuals; and

(4) such other data as may be appropriate.

(c) Requisite areas of data collection on substance abuse

(1) With respect to the activities of the Administrator under subsection (a) of this section relating to substance abuse, the Administrator shall ensure that such activities include, at a minimum, the collection of data on—

(A) the number of individuals admitted to the emergency rooms of hospitals as a result of the abuse of alcohol or other drugs;

(B) the number of deaths occurring as a result of substance abuse, as indicated in reports by coroners;

(C) the number and variety of public and private nonprofit treatment programs, including the number and type of patient slots available;

(D) the number of individuals seeking treatment through such programs, the number and demographic characteristics of individuals receiving such treatment, the percentage of individuals who complete such programs, and, with respect to individuals receiving such treatment, the length of time between an individual's request for treatment and the commencement of treatment;

(E) the number of such individuals who return for treatment after the completion of a prior treatment in such programs and the method of treatment utilized during the prior treatment;

(F) the number of individuals receiving public assistance for such treatment programs;

(G) the costs of the different types of treatment modalities for drug and alcohol abuse and the aggregate relative costs of each such treatment modality provided within a State in each fiscal year;

(H) to the extent of available information, the number of individuals receiving treatment for alcohol or drug abuse who have private insurance coverage for the costs of such treatment;

(I) the extent of alcohol and drug abuse among high school students and among the general population; and

(J) the number of alcohol and drug abuse counselors and other substance abuse treatment personnel employed in public and private treatment facilities.

This legislation arose from a need for federal-level information to document accomplishments under federal block grant funding for substance abuse treatment and prevention. A previous reporting system, the Client-Oriented Data Acquisition Process (CODAP), had been discontinued in 1981 with the establishment of block grants. These grants were awarded to the states beginning in 1982 without any reporting requirements. Some states maintained their own systems independent of CODAP, while others discontinued their client-level data systems.

To address the requirements of the legislation and to provide substance abuse treatment data for the research community, the National Institute on Drug Abuse (NIDA) and the National Institute on Alcohol Abuse and Alcoholism (NIAAA) established a new CODAP-like client database, the Client Data System (CDS). CDS was intended to provide a minimum data set on treatment of persons with substance abuse problems in the United States, including client characteristics, types of drugs used, and services provided to clients. It included data primarily from publicly funded treatment facilities, although some private facilities were included.

The CDS was developed collaboratively by the federal government, states, and national organizations, including the National Association of State Alcohol and Drug Abuse Directors (NASADAD). Important considerations in the development of the CDS were (1) the need to incorporate and build upon existing state reporting systems and (2) the need to ensure that CDS would produce data useful for state administrative purposes. The impetus for CDS was to achieve standardization and comparability of data

among state systems in such a way that facilities would not be burdened with additional reporting requirements beyond those already imposed by the states. The resulting data set consisted of a core of 19 demographic and substance abuse treatment variables and 15 supplemental items, collected at the time of admission for treatment.

NIDA and NIAAA awarded grants to state alcohol and drug abuse agencies so that states could modify their client systems to accommodate the set of variables. Nationwide implementation of the CDS, including the District of Columbia and Puerto Rico, began in October 1990. With the reorganization of the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA) in 1992, CDS became the responsibility of SAMHSA.

In late 1994, SAMHSA renamed the Client Data System the Treatment Episode Data Set (TEDS), indicating that the scope of the system would be extended to collect information about episodes of treatment for substance abuse, rather than just admissions for treatment. To provide more comprehensive data on the treatment of substance abuse clients, SAMHSA developed the TEDS discharge data system. It was fully implemented in the majority of states by 2000 and provides basic discharge data that can be linked to the corresponding client admission.

In 2006, the TEDS data system was modified to include data fields for National Outcome Measures (NOMs). In the TEDS admission system, 9 of the original 25 data fields were designated as NOMs, and one additional field was added. These variables were added to the discharge system. Another NOMs data field was added in 2010.

In 2014, the TEDS record was modified to accommodate the transition to the use of ICD-10 in all U.S. health care settings. In addition, TEDS was modified to include the collection of mental health data as required by the Community Mental Health Block Grant. Specific mental health data fields not previously collected in TEDS were appended to the TEDS record while modifications in data fields common to both mental health and substance abuse data collection were modified as necessary while maintaining the compatibility with past substance abuse data submission.

Appendix B. TEDS Crosswalk Worksheet

Instructions for TEDS Crosswalk Worksheet

Complete data field definitions and coding guidelines are provided in the Data Dictionary (Appendix D) contained in this manual. Please refer to this Appendix when developing the state data crosswalk for appropriate mapping.

In columns "State Item" and "Code," insert the state data field name/description that corresponds to the TEDS field and, when available, the state code (usually a number), respectively.

A comment column (not shown) is provided where states can add operational definitions and other contextual information that may help in understanding the mapping of the data.

Important notes:

- If more than one state code corresponds to a single TEDS code, insert additional lines (rows) for those codes, as needed (see example below).
- If information for an individual client is not available, use the code for "Unknown."
- "Not collected" should be used only when the item is not reported to TEDS for any clients.

EXAMPLE:

TEDS DATA			State Data		
TEDS #	Code	Data item description	State item #	Code	Corresponding State Data Item Description
17		**Employment Status**		#	**Employment**
	01	Full time		01	Full time
	02	Part time		02	Part time
	03	Unemployed		03	Unemployed, looking for work
	04	Not in labor force		04	Homemaker
	04	Not in labor force		05	student
	04	Not in labor force		06	retired
	04	Not in labor force		08	Incarcerated

Sample: Combined SA and MH State Data Crosswalk

This sample crosswalk is for illustrative purposes only. It shows data fields and item categories for both mental health and substance abuse file submissions. States may create separate SA and MH crosswalks if preferred. If a state plans to submit optional SA and MH items, it is important to review the sample mapping below.

TEDS DATA				State XX Data		
TEDS #	**Code**	**Data item description**		**State item #**	**Code**	**State Data Item Description**
ADMISSION (INITIAL/TRANSFER)						
System Data Set	*All 3 System Data Set fields (System Transaction Type, State Code, and Reporting Date) are required to process the file.*					
SDS 1	**System Transaction Type**					
	A	Add			A	A Add
	C	Change			C	C Change
	D	Delete			D	D Delete
SDS 2 **(key field)**	**State Code**			NA	**FIPS State Code**	
		2 characters				2 characters
SDS 3	**Reporting Date**			NA	**Month and year data file creation**	
		MMYYYY				MMYYYY
Minimum Data Set	*Unless specified as optional, the following MDS fields must be reported.*					
MDS 1 **(key field)**	**State Provider Identifier**			NA	**Provider ID**	
		1-15 characters				7 characters
MDS 2 **(key field)**	**Client Identifier**			NA	**Client ID**	
		1-15 characters				7 Numeric characters
MDS 3 **(key field)**	**Codependent/Collateral**			02	**Collateral**	
	1	Codependent/collateral			Y	Yes
	2	Client			N	No (for all MH clients)

MDS 4 **(key field)**	**Client Transaction Type**					
	A	Initial Admission (SA)			A	New Admission (SA)
	T	Transfer or change in SA service			T	Client is transferred from a different service setting or provider (SA)
	M	Initial Admission (MH)			M	New Admission (MH)
	X	Transfer or change in MH service			X	Client is transferred from/change in service setting or provider (MH)

MDS 5 **(key field)**	**Date of Admission**			NA	**Date of Admission**	
		MMDDYYYY				MMDDYYYY

MDS 6 (optional for MH reporting)	**Previous SA Treatment Episodes**				**Number of SA Prior Treatment Episodes** *State note: if available, data will be reported for clients with co-occurring SA and MH disorders.*	
	0	0 Previous episodes			0	0 Previous episodes
	1	1 Previous episode			1	1 Previous episode
	2	2 Previous episodes			2	2 Previous episodes
	3	3 Previous episodes			3	3 Previous episodes
	4	4 Previous episodes			4	4 Previous episodes
	5	5 or more Previous episodes			5	5 or more Previous episodes
	7	Unknown			7	Unknown
	8	Not collected			98	Not collected (for MH only clients)

MDS 7 (optional for MH reporting)	**Referral Source**			05	**Referral source**	
	01	Individual			IND	Individual/Self
	02	Alcohol/Drug Abuse care provider			ADP	A/D Abuse Program
	03	Other health care provider			HCP	Health Care Provider
	04	School (Educational)			SED	School/Educational
	05	Employer/Employee Assistance Program (EAP)			EAP	Employer/EAP
	06	Other community referral			ASR	Adult Self Reliance
	06	Other community referral			CPS	Child Protection Service
	06	Other community referral			DHC	DHW/FACS-CPS
	06	Other community referral			DHO	DHW/FACS - Other
	06	Other community referral			DHW	DHW/FACS - Mental health
	06	Other community referral			MHA	Mental Health Agency not DHW
	06	Other community referral			NAA	Indian Agency
	06	Other community referral			OCR	Other Community Referral
	06	Other community referral			SHG	Self Help Group
	06	Other community referral			SHH	State Hospital (N&S)
	06	Other community referral			SRP	Adult/Youth Self Reliance
	06	Other community referral			YSR	Youth Self Reliance
	07	Court/criminal justice referral/DUI/DWI			BYR	Byrne Grant Non-Drug Court Probation
	07	Court/criminal justice referral/DUI/DWI			DCR	Drug Court Referral
	07	Court/criminal justice referral/DUI/DWI			DUI	Court/Criminal DUI
	07	Court/criminal justice referral/DUI/DWI			NDU	Court/Criminal Justice Non-DUI
	07	Court/criminal justice referral/DUI/DWI			OCJ	Other Criminal Justice
	07	Court/criminal justice referral/DUI/DWI			PAR	IDOC-Re-entry Program Parole
	07	Court/criminal justice referral/DUI/DWI			PPO	Probation/Parole Office
	97	Unknown			UNK	Unknown
	98	Not collected			998	Not collected

MDS 8	**Date of Birth**			NA	**Date of Birth**	
		MMDDYYYY				mmddyyyy
	01010007	Unknown				
	01010008	Not collected				

MDS 9	**Gender**			NA	**Sex**	
	1	Male			M	Male
	2	Female			F	Female
	7	Unknown			U	Unknown
	8	Not collected			98	Not collected

MDS 10	**Race**			NA	**Race** *State note: clients check all applicable categories*	
	01	Alaska Native (Aleut, Eskimo)			AN	Alaska Native
	02	American Indian/ Alaska Native			AI	American Indian
	13	Asian				
	23	Native Hawaiian or Other Pacific Islander				
	03	Asian or Pacific Islander			AP	Asian/Pacific Islander
	04	Black or African American			BL	Black
	05	White			WH	White
	20	Other single race			OT	Other
	21	Two or more races				
	97	Unknown			UN	Unknown
	98	Not collected			98	Not collected

MDS 11	**Hispanic or Latino Origin (Ethnicity)**			NA	**Ethnicity**	
	01	Puerto Rican			PR	Puerto Rican
	02	Mexican			MX	Mexican
	03	Cuban			CU	Cuban
	04	Other Specific Hispanic or Latino			OH	Other Hispanic
	05	Not of Hispanic or Latino Origin			NH	Non Hispanic
	06	Hispanic or Latino - specific origin not specified				
	97	Unknown			UN	Unknown
	98	Not collected			98	Not collected

MDS 12	**Education (MH-NOM)**			08	**Education**	
	00	Less than one grade completed or no schooling			00	None, never attended school
	01	Grade 1			01	First Grade
	02	Grade 2			02	Second Grade
	03	Grade 3			03	Third Grade
	04	Grade 4			04	Fourth Grade
	05	Grade 5			05	Fifth Grade
	06	Grade 6			06	Sixth Grade
	07	Grade 7			07	Seventh Grade
	08	Grade 8			08	Eighth Grade
	09	Grade 9			09	Ninth Grade
	10	Grade 10			10	Tenth Grade
	11	Grade 11			11	Eleventh Grade
	12	Grade 12 or GED			12	Twelfth grade/high school graduate
	12	Grade 12 or GED			20	GED
	13	1st Year of College/University (Freshman)			13	One year of college
	14	2nd Year of College/University (Sophomore) or Associate Degree			14	Two years of college
	14	2nd Year of College/University (Sophomore) or Associate Degree			35	Associate Degree
	15	3rd Year of College/University (Junior)			15	Three years of college
	16	4th Year of College/University (Senior) or Bachelor's Degree			16	Baccalaureate degree
	17	Some Post-Graduate Study - Degree not completed				
	18	Master's Degree completed				
	19-25	Post-graduate study				
	70	Graduate or Professional School - Includes Master's and Doctoral study or degrees, Medical School, Law School, etc. [This code may be used instead of detailed codes 17-25.]			40	Master's degree
	70	Graduate or Professional School - Includes Master's and Doctoral study or degrees, Medical School, Law School, etc. [This code may be used instead of detailed codes 17-25.]			41	Doctoral degree

MDS 12	**Education (MH-NOM)**			08	**Education**	
	71	Vocational school [Includes business, technical, secretarial, trade, or correspondence courses which provide specialized training for skilled employment.]			80	Technical trade school
	72	Nursery school, pre-school			50	Nursery school
	73	Kindergarten			30	Kindergarten
	74	Self-contained special education class			82	Special education class
	97	Unknown			99	Unknown
	98	Not collected			98	Not collected

MDS 13	**Employment Status (SA/MH NOM)**			11	**Employment**	
	01	Full-time			FT	Full Time
	01	Full-time			AF	In Armed Forces
	02	Part-time			PT	Part Time
	03	Unemployed			UE	Unemployed
	04	Not in labor force			NL	Not in Labor Force
	04	Not in labor force			IN	Inmate of Institution
	05	Employed, Full/Part-time not specified				
	97	Unknown			UN	Unknown
	98	Not collected			98	Not collected

MDS 14 (A, B, C) (optional for MH reporting)	**Substance Abuse Problem, (Primary, Secondary, Tertiary) (SA NOM)**			21	**Substance Abuse Problem, (Primary, Secondary and Tertiary)** *State note: if available, data will be reported for clients with co-occurring SA and MH disorders.*	
	01	None			01	None
	02	Alcohol			02	Alcohol
	03	Cocaine/Crack			03	Cocaine/Crack
	04	Marijuana/Hashish			04	Marijuana/Hashish
	05	Heroin			05	Heroin
	06	Non-Prescription Methadone			06	Non-Prescription Methadone
	07	Other Opiates And Synthetics			07	Other Opiates And Synthetics
	08	PCP-phencyclidine			08	PCP-phencyclidine
	09	Hallucinogens			09	Other Hallucinogens
	10	Methamphetamine/Speed			10	Methamphetamine
	11	Other Amphetamines			11	Other Amphetamines
	12	Other Stimulants			12	Other Stimulants
	13	Benzodiazepines			13	Benzodiazepines
	14	Other Tranquilizers			14	Other non-Benzodiazepine Tranquilizers
	15	Barbiturates			15	Barbiturates
	16	Other Sedatives or Hypnotics			16	Other Non-Barbiturate Sedatives or Hypnotics
	17	Inhalants			17	Inhalants
	18	Over-the-Counter Medications			18	Over-the-Counter
	20	Other Drugs			20	Other
	97	Unknown			97	Unknown
	98	Not collected			98	Not collected (for MH only clients)

MDS 15 (A, B, C) (optional for MH reporting)	**Route of Administration (of Primary, Secondary, Tertiary Substances)**				**Route of administration** *State note: if available, data will be reported for clients with co-occurring SA and MH disorders.*	
	01	Oral			01	Oral
	02	Smoking			02	Smoking
	03	Inhalation			03	Inhalation
	04	Injection (intravenous, intramuscular, intradermal, or subcutaneous)			04	Injection (intravenous, intramuscular, intradermal, or subcutaneous)
	20	Other			20	Other
	96	Not applicable			96	Not applicable
	97	Unknown			97	Unknown
	98	Not collected			98	Not collected (for MH only clients)

MDS 16 (A, B, C) (optional for MH reporting)	**Frequency of Use (of Primary, Secondary, Tertiary Substances) (SA NOM)**			21	**Frequency of Use (Primary, Secondary, and Tertiary)** *State note: if available, data will be reported for clients with co-occurring SA and MH disorders.*	
	01	No Use in the Past Month			01	No Use In The Past Month
	02	1-3 Days in the Past Month			02	1-3 Times In Past Month
	03	1-2 Days in the Past Week			03	1-2 Times In Past Week
	04	3-6 Days in the Past Week			04	3-6 Times In Past Week
	05	Daily			05	Daily
	96	Not applicable			96	Not applicable
	97	Unknown			97	Unknown
	98	Not collected			98	Not collected (for MH only clients)

MDS 17 (A, B, C) (optional for MH reporting)	**Age at First Use (of Primary, Secondary, Tertiary Substances)**				**Age at First Use** *State note: if available, data will be reported for clients with co-occurring SA and MH disorders.*	
	00	Newborn With Substance Dependency Problem			00	Newborn With Substance Dependency Problem
	01-95	Age At First Use (in years)			01-95	Age At First Use (in years)
	96	Not applicable			96	Not applicable
	97	Unknown			97	Unknown
	98	Not collected			98	Not collected (for MH only clients)

MDS 18 **(key field)**	**Type of Treatment Service/Setting**			03	**Type of Treatment Service/ Setting**	
	01	Detoxification, 24-hour service, Hospital Inpatient			DH	Detox - Hosp Inpatient
	02	Detoxification, 24-hour service, Free-Standing Residential			DF	Detox - free-standing residential
	03	Rehabilitation/Residential - Hospital (other than Detoxification)			HP	Hospital Residential
	04	Rehabilitation/Residential - Short term (30 days or fewer)			SR	Short Term Residential
	05	Rehabilitation/Residential - Long term (more than 30 days)			LR	Long Term Residential
	06	Ambulatory - Intensive outpatient			IO	Intensive Outpatient
	07	Ambulatory - Non-intensive outpatient			AS	Ancillary Services
	08	Ambulatory - Detoxification			DO	Detox -Outpatient Ambulatory
	72	State psychiatric hospital			10	State psychiatric hospital
	73	SMHA funded/operated community-based program			30	All other agencies (i.e., PACT, CMHC, Outpatient Clinics)
	74	Residential treatment center			11	Residential Treatment Center for Children
	75	Other psychiatric inpatient			12	Inpatient (Level of Care)
	76	Institutions under the justice system			13	Jail/Correctional Facility
	96	Not applicable (use only for codependents or collateral clients (SA) and for MH clients receiving MH assessments, evaluation, or screening only)			96	Not Applicable (for codependents or collateral clients (SA) and for MH clients receiving MH assessments, evaluation, or screening only)

MDS 19 (optional for MH reporting)	**Medication-Assisted Opioid Therapy**			16	**Methadone** *State note: if available, data will be reported for clients with co-occurring SA and MH disorders.*	
	1	Yes			Y	Yes
	2	No			N	No
	6	Not applicable				
	7	Unknown			U	Unknown
	8	Not collected			8	Not collected (for MH only clients)

Supple-mental Data Set	Unless specified as a NOM, the following SuDS fields are optional for both SA and MH reporting.				

SuDS (1, 2, 3)	**Detailed Drug Code (Primary, Secondary, and Tertiary)**			NA	**Detail Drug** *State note: if available, data will be reported for clients with co-occurring SA and MH disorders.*	
	0201	Alcohol			0201	Alcohol
	0301	Crack			0301	Crack
	0302	Other Cocaine			0302	Other Cocaine
	0401	Marijuana/Hashish, THC, and any other cannabis sativa preparations			0401	Marijuana/Hashish
	0501	Heroin			0501	Heroin
	0601	Non-prescription Methadone			0601	Non-prescription Methadone
	0701	Codeine			0701	Codeine
	0702	Propoxyphene (Darvon)			0702	Propoxyphene (Darvon)
	0703	Oxycodone (Oxycontin)			0703	Oxycodone (Oxycontin)
	0704	Meperidine (Demerol)			0704	Meperidine (Demerol)
	0705	Hydromorphone (Dilaudid)			0705	Hydromorphone (Dilaudid)
	0706	Butorphanol (Stadol), morphine (MS Contin), opium, and other narcotic analgesics, opiates, or synthetics			0706	Other Opiates or Synthetics
	0707	Pentazocine (Talwin)			0707	Pentazocine (Talwin)
	0708	Hydrocodone (Vicodin)			0708	Hydrocodone (Vicodin)
	0709	Tramadol (Ultram)			0709	Tramadol (Ultram)
	0710	Buprenorphine (Subutex, Suboxone)				
	0801	PCP			0801	PCP or PCP Combination
	0901	LSD			0901	LSD
	0902	DMT, mescaline, peyote, psilocybin, STD, and other hallucinogens			0902	Other Hallucinogens
	1001	Methamphetamine/Speed			1001	Methamphetamine/Speed
	1101	Amphetamine			1101	Amphetamine
	1103	MDMA, Ecstasy			1103	MDMA, Ecstasy
	1109	"Bath salts", phenmetrazine, and other amines and related drugs			1109	Other Amphetamines
	1201	Other Stimulants			1201	Other Stimulants
	1202	Methylphenidate (Ritalin)			1202	Methylphenidate (Ritalin)
	1301	Alprazolam (Xanax)			1301	Alprazolam (Xanax)
	1302	Chlordiazepoxide (Librium)			1302	Chlordiazepoxide (Librium)
	1303	Clorazepate (Tranxene)			1303	Clorazepate (Tranzene)
	1304	Diazepam (Valium)			1304	Diazepam (Valium)

SuDS (1, 2, 3)	**Detailed Drug Code (Primary, Secondary, and Tertiary)**			NA	**Detail Drug** *State note: if available, data will be reported for clients with co-occurring SA and MH disorders.*	
	1305	Flurazepam (Dalmane)			1305	Flurazepam (Dalmane)
	1306	Lorazepam (Ativan)			1306	Lorazepam (Ativan)
	1307	Triazolam (Halcion)			1307	Triazolam (Halcion)
	1308	Halazepam, oxazepam (Serax), prazepam, temazepam (Restoril), and other benzodiazepines			1308	Other Benzodiazepine
	1309	Flunitrazepam (Rohypnol)			1309	Flunitrazepam (Rohypnol)
	1310	Clonazepam (Klonopin, Rivotril)			1310	Clonazepam (Klonopin, Rivotril)
	1401	Meprobamate (Miltown)			1401	Meprobamate (Miltown)
	1403	Other non-benzodiazepine tranquilizers			1403	Other Tranquilizer
	1501	Phenobarbital			1501	Phenobarbital
	1502	Secobarbital/Amobarbital (Tuinal)			1502	Secobarbital/Amobarbital (Tuinal)
	1503	Secobarbital (Seconal)			1503	Secobarbital (Seconal)
	1509	Amobarbital, pentobarbital (Nembutal), and other barbiturate sedatives			1509	Other Barbiturate Sedatives
	1601	Ethchlorvynol (Placidyl)			1601	Ethchlorvynol (Placidyl)
	1602	Glutethimide (Doriden)			1602	Glutethimide (Doriden)
	1603	Methaqualone (Quaalude)			1603	Methaqualone
	1604	Chloral hydrate and other non-barbiturate sedatives/hypnotics			1604	Other Non-Barbiturate Sedatives
	1701	Aerosols			1701	Aerosols
	1702	Nitrites			1702	Nitrites
	1703	Gasoline, glue, and other inappropriately inhaled products			1703	Other Inhalants
	1704	Solvents (paint thinner and other solvents)			1704	Solvents
	1705	Anesthetics (chloroform, ether, nitrous oxide, and other anesthetics)			1705	Anesthetics
	1801	Diphenhydramine			1801	Diphenhydramine
	1809	Other antihistamines, aspirin, Dextromethorphan (DXM) and other cough syrups, ephedrine, sleep aids, and any other legally obtained, non-prescription medication			1809	Other Over-the-counter
	2001	Diphenylhydantoin/Phenytoin (Dilantin)			2001	Diphenylhydantoin/Phenytoin (Dilantin)
	2002	Synectic Cannabinoid “Spice,” Carisoprodol (Soma), and other drugs			2002	Other Drugs

SuDS (1, 2, 3)	**Detailed Drug Code (Primary, Secondary, and Tertiary)**			NA	**Detail Drug** *State note: if available, data will be reported for clients with co-occurring SA and MH disorders.*	
	2003	GHB/GBL (gamma-hydroxybutyrate, gamma-butyrolactone)			2003	GHB/GBL
	2004	Ketamine (Special K)			2004	Ketamine (Special K)
	9996	Not applicable - use when the value in "Substance Abuse Problem" is 01 (None)			9996	Not applicable
	9997	Unknown			9997	Unknown
	9998	Not collected			9998	Not collected (for those prior to August 1, 2006 and for MH only clients)

SuDS 4	**Diagnostic Code (DSM or ICD) (If state record layout includes SuDS 18 and SuDS 19, use code 999.98 for this field.)**				**Diagnostic Code** *State note: Refer to SuDS 19 and MHA 1a-c*	
	xxx.xx	Specify if code from DSM or ICD				
	xxx_ _ _	where "-" represents a blank				
	xxx. _ _	where "-" represents a blank				
	xxx.x _	where "-" represents a blank				
	999.97	Unknown				
	999.98	Not collected			999.98	Not collected

SuDS 5	**Co-occurring Substance Abuse and Mental Health Problems (Old SA name: Psychiatric problem in addition to alcohol or drug problem)**			20	**Psychiatric problem in addition to alcohol or drug**	
	1	Yes - Client has co-occurring substance abuse and mental health problems			Y	Yes
	2	No - Client does not have co-occurring substance abuse and mental health problems			N	No
	7	Unknown			U	Unknown
	8	Not collected			8	Not collected

SuDS 6	**Pregnant at Admission**				**Pregnancy status**	
	1	Yes - Female client was pregnant at admission			1	Yes - Female client was pregnant at admission
	2	No - Female client was not pregnant at admission			2	No - Female client was not pregnant at admission
	6	Not applicable - Use this code for male clients			6	Not applicable - Use this code for male clients
	7	Unknown			7	Unknown
	8	Not collected			8	Not collected

SuDS 7	**Veteran Status**			NA	**Veteran Status**	
	1	Veteran			Y	Yes
	2	Not a Veteran			N	No
	7	Unknown			U	Unknown
	8	Not collected			8	Not collected

SuDS 8	**Living Arrangements (SA/MH NOM)**			09	**Residential status**	
	01	Homeless - Clients with no fixed address; includes homeless shelters			HL	Homeless
	01	Homeless - Clients with no fixed address; includes homeless shelters			13	Homeless
	02	Dependent Living - Clients living in a supervised setting such as a residential institution, halfway house, or group home and children (under age 18) living with parents, relatives, or guardians or in foster care			DL	Dependent living
	03	Independent Living - Clients living alone or with others without supervision; includes adult children (age 18 and over) living with parents and adolescents living independently			IL	Independent living
	04	Private residence, living arrangement not specified, adults (temporary code MH only)			15	Private Residence (for adults)
	22	Dependent living: residential care (MH only)			04	Supported Residential
	32	Dependent living: foster home/foster care (MH only)			02	Foster Home or Family Sponsor Home
	42	Dependent living: crisis residence (MH only)			06	Crisis Care
	52	Dependent living: institutional setting (MH only)			08	Nursing Home/Physical Rehabilitation
	62	Dependent living: jail and other institutions under the justice system (MH only)			10	Local Jail or Correctional Facility
	62	Dependent living: jail and other institutions under the justice system (MH only)			11	State Correctional Facility
	72	Dependent living: adults in private residence who need assistance in daily living (MH only)				
	97	Unknown			UN	Unknown
	98	Not collected			98	Not collected

SuDS 9	**Source of Income/Support**			12	**Source of Income**	
	01	Wages/Salary			W	Wages/Salary
	02	Public Assistance			P	Public Assistance
	03	Retirement/Pension			R	Retirement/Pension
	04	Disability			D	Disability
	20	Other			O	Other
	21	None			N	None
	97	Unknown			U	Unknown
	98	Not collected			98	Not collected

SuDS 10	**Health Insurance**			13	**Health insurance**	
	01	Private Insurance			PI	Private Insurance
	02	Blue Cross/Blue Shield			BB	Blue Cross/Blue Shield
	03	Medicare			ME	Medicare
	04	Medicaid			MD	Medicaid
	06	Health Maintenance Organization (HMO)			HM	Health Maintenance Organization (HMO)
	20	Other (e.g., TRICARE)			OT	Other
	21	None			NO	None
	97	Unknown			UN	Unknown
	98	Not collected			98	Not collected

SuDS 11	**Payment Source, Primary (Expected or Actual)**				**Primary Source of Payment**	
	01	Self-Pay				
	02	Blue Cross/Blue Shield				
	03	Medicare				
	04	Medicaid				
	05	Other Government Payments				
	06	Worker's Compensation				
	07	Other Health Insurance Companies				
	08	No Charge (Free, Charity, Special Research, or Teaching)				
	09	Other				
	97	Unknown				
	98	Not collected			98	Not collected

SuDS 12	**Detailed Not in Labor Force (SA/MH NOM)**			NA	**Detailed not in labor force**	
	01	Homemaker			01	Homemaker
	02	Student			02	Student
	03	Retired			03	Retired
	04	Disabled			04	Disabled
	05	Resident of institution or persons receiving services from institutional facilities such as hospitals, jails, prisons, etc.			05	Inmate Of Institution
	06	Other - For example, volunteer, seasonal worker			06	Other
	07	Sheltered/non-competitive employment (MH only)			13	Not in Labor Force: Sheltered employment settings
	96	Not applicable			96	Not applicable
	97	Unknown			97	Unknown
	98	Not collected			98	Not collected

SuDS 13	**Detailed Criminal Justice Referral**			NA	**Detailed criminal justice referral**	
	01	State/Federal Court			01	State/Federal Court
	02	Other Court - Court other than state or federal court			02	Other court
	03	Probation/Parole			03	Probation/Parole
	04	Other Recognized Legal Entity - For example, local law enforcement agency, corrections agency, youth services, review board/agency			04	Other Recognized Legal Entity
	05	Diversionary Program (e.g., TASC)			05	Diversionary Program (E.G., TASC)
	06	Prison			06	Prison
	07	DUI/DWI			07	DUI/DWI
	08	Other			08	Other
	96	Not applicable			96	Not applicable
	97	Unknown			97	Unknown
	98	Not collected			98	Not collected

SuDS 14	**Marital Status**			NA	**Marital status**	
	01	Never Married - Includes clients who are single or whose only marriage was annulled			S	Never Married (Single)
	02	Now Married - Includes married couples, those living together as married, living with partners, or cohabiting			M,L	Now Married
	03	Separated - Includes those legally separated or otherwise absent from spouse because of marital discord			P	Separated
	04	Divorced			D	Divorced
	05	Widowed			W	Widowed
	97	Unknown			U	Unknown
	98	Not collected			98	Not collected

SuDS 15	**Days Waiting to Enter SA Treatment**			NA		
	000-996	Number of days waiting				
	997	Unknown				
	998	Not collected			998	Not Collected

SuDS 16	**Arrests in Past 30 Days (SA/MH NOM)**			NA	**Arrests in 30 days prior to admission**	
	00-96	Number of arrests			00	None
	00-96	Number of arrests			01-96	01-96
	97	Unknown			97	Unknown
	98	Not collected			98	Not collected

SuDS 17	**Attendance at SA Self-Help Groups in Past 30 Days - Admission (SA-NOM)**				**Frequency of attendance at self-help SA programs (AA, NA, etc.) in 30 days prior to admission** *State note: if available, data will be reported for clients with co-occurring SA and MH disorders.*	
	01	No attendance			1	No attendance in the past month
	02	Less than once a week - 1 to 3 times in the past 30 days			2	1-3 times in past month (less than 1 per week)
	03	About once a week - 4 to 7 times in the past 30 days			3	4-7 times in past month (about 1 per week)
	04	2 to 3 times per week - 8-15 times in the past 30 days			4	8-15 times in past month (2-3 times per week)
	05	At least 4 times a week - 16 to 30 times in the past 30 days			5	16-30 times in past month (4+ times per week)
	06	Some attendance - Number of times and frequency is unknown			6	Some attendance but frequency unknown
	97	Unknown			97	Unknown
	98	Not Collected			98	Not Collected (for MH only clients)

SuDS 18	**Diagnostic Code Set Identifier**				**Diagnostic Code Set**	
	1	DSM-IV			1	DSM-IV code
	2	ICD-9				
	3	ICD-10				
	4	DSM-5			4	DSM-5
	5	DSM-IIIR				
	7	Unknown				
	8	Not collected				

SuDS 19	**Substance Abuse Diagnosis - (use this in lieu of SuDS 4)**				**Substance Abuse Diagnosis** *State note: if available, data will be reported for clients with co-occurring SA and MH disorders.*	
	xxx.xxxx				xxx.xxxx	
	xxx- - - - -	where "-" represents a blank			xxx- - - - -	
	xxx. - - - -	where "-" represents a blank			xxx. - - - -	
	xxx.x- - -	where "-" represents a blank			xxx.x- - -	
	xxx.xx- -	where "-" represents a blank			xxx.xx- -	
	xxx.xxx-	where "-" represents a blank			xxx.xxx-	
	999.9997	Unknown			999.97	Unknown (for MH only clients)
	999.9998	Not collected			999.98	Not collected

Mental Health Admission Data Set	The following MHA fields are optional for SA reporting but may be reported for persons with co-occurring MH and SA problems if information is available					
MHA 1a	**MH Diagnosis - One**				**MH Diagnostic Code - one** *State note: if available, data will be reported for clients with co-occurring SA and MH disorders*	
	xxx.xxxx				xxx.xxxx	
	xxx- - - - -				xxx- - - - -	
	xxx. - - - -				xxx. - - - -	
	xxx.x- - -				xxx.x- - -	
	xxx.xx- -				xxx.xx- -	
	xxx.xxx-				xxx.xxx-	
	999.9997	Unknown			999.9997	Unknown (for SA only clients)
	999.9998	Not collected			999.9998	Not collected (for clients receiving MH evaluation/screening only)

MHA 1b	**MH Diagnosis - Two**				**MH Diagnostic Code - two**	
	xxx.xxxx				xxx.xxxx	
	xxx- - - - -				xxx.- - - -	
	xxx. - - - -				xxx. - - - -	
	xxx.x- - -				xxx.x- - -	
	xxx.xx- -				xxx.xx- -	
	xxx.xxx-				xxx.xxx-	
	999.9997	Unknown			999.9997	Unknown (auto-coded for SA only clients)
	999.9998	Not collected			999.9998	Not collected (for clients receiving MH evaluation only)

MHA 1c	**MH Diagnosis - Three**					
	xxx.xxxx					
	xxx- - - - -					
	xxx. - - - -					
	xxx.x- - -					
	xxx.xx- -					
	xxx.xxx-					
	999.9997	Unknown				
	999.9998	Not collected			999.9998	Not collected (for all clients; state collects only 2 MH diagnoses for every client)

MHA 2	**SMI/SED Status**				**SMI/SED Status** *State note: if available, data will be reported for clients with co-occurring SA and MH disorders*	
	1	SMI			1	Yes to SMI
	2	SED			1	Yes to SED
	3	At risk for SED (optional)				
	4	Not SMI/SED			2	No to both
	7	Unknown			--	Blank field for both
	8	Not collected			8	Not collected (for SA only clients)

MHA 3	**School Attendance Status (MH NOM)**				**School Attendance Status**	
	1	Yes, client has attended school at any time in the past 3 months			01	Attending school
	2	No, client has not attended school at any time in the past 3 months			02	Not in school
	6	Not applicable			06	MH client age less than 3 or greater than 17 (except for young adults 18-21 protected by IDEA)
	7	Unknown			UN	Field is blank
	8	Not collected			08	Not collected (for SA only clients)

MHA 4	**Legal Status at Admission to State Hospital**				**State Hospital - Legal Status at Admission**	
	01	Voluntary-self				
	02	Voluntary-others (parents, guardians, etc)				
	03	Involuntary-civil			1	Involuntary - Civil
	04	Involuntary-criminal			2	Involuntary - Criminal
	05	Involuntary-juvenile justice				
	06	Involuntary-civil, sexual			3	Sexual Offender
	96	Not applicable			96	Not applicable (for other admissions records not to state hospital)
	97	Unknown			7	Unknown
	98	Not collected			8	Not collected (for SA only clients)

MHA 5 (Optional for MH reporting)	**CGAS/GAF Score**				**GAF/CGAS Score** *State note: State does not use collect this information.*	
	0-100	Score				
	997	Unknown				
	998	Not Collected			998	Not Collected (for all clients)

UPDATE/DISCHARGE RECORD

Discharge Data Set	Unless specified as optional, these DIS fields are mandatory.					
DIS 1	**System Transaction Type**					
	A	Add			A	A Add
	C	Change			C	C Change
	D	Delete			D	D Delete

DIS 2 **(key field)**	**State Code**			NA	**FIPS State Code**	
		2 characters				2 characters

DIS 3	**Reporting Date (MMYYYY)**			NA	**Month and year data file created**	
		MMYYYY				MMYYYY

DIS 4 **(key field)**	**State Provider Identifier**			NA	**Provider ID**	
		1-15 characters				7 characters

DIS 5 **(key field)**	**Client Identifier**			NA	**Client ID**	
		1-15 characters				7 characters

DIS 6 **(key field)**	**Codependent/collateral**			30	**Collateral**	
	1	Codependent/collateral			Y	Yes
	2	Client			N	No (for all MH clients)

DIS 7 (key field)	Type of Treatment Service/Setting			33	Service at Discharge	
	01	Detoxification, 24-hour service, Hospital Inpatient			DH	Detox - Hosp Inpatient
	02	Detoxification, 24 hour service, Free-Standing Residential			DF	Detox - free-standing residential
	03	Rehabilitation/Residential - Hospital (other than Detoxification)			HP	Hospital Residential
	04	Rehabilitation/Residential - Short term (30 days or fewer)			SR	Short Term Residential
	05	Rehabilitation/Residential - Long term (more than 30 days)			LR	Long Term Residential
	06	Ambulatory - Intensive outpatient			IO	Intensive Outpatient
	07	Ambulatory - Non-intensive outpatient			NO	Non-Intensive Outpatient
	08	Ambulatory - Detoxification			DO	Detox -Outpatient Ambulatory
	72	State psychiatric hospital			10	State psychiatric hospital
	73	SMHA funded/operated community-based program			30	All other agencies (i.e., PACT, CMHC, Outpatient Clinics)
	74	Residential treatment center			11	Residential Treatment Center for Children
	75	Other psychiatric inpatient			12	Inpatient (Level of Care)
	76	Institutions under the justice system			13	Jail/Correctional Facility
	96	Not applicable (use only for codependents or collateral clients)			96	Not Applicable

DIS 8 (key field)	Date of Last Contact or Data Update			37	End date of last service or last data update	
		MMDDYYYY				MMDDYYYY
	01010007	Unknown				
	01010008	Not collected				

DIS 9 (key field)	Date of Discharge			38	End date of last service	
		MMDDYYYY				MMDDYYYY
					01010006	Not applicable (used for MH update records)

DIS 10	**Reason for Discharge, Transfer, or Discontinuance of Treatment**			32	**Reason for Discharge**	
	01	Treatment completed			CTS	Treatment Completed
	02	Dropped out of treatment (lost contact, administrative discharge, left against medical advice, eloped, failed to return from leave, and client choice)			APA	Left Against Professional Advice
	03	Terminated by facility			TDS	Terminated by Facility
	04	Transferred to another treatment program or facility			04	Transferred
	14	Transferred to another treatment program but client is no show			14	Transferred but client did not show up
	05	Incarcerated or released by or to courts			INC	Incarcerated
	06	Death			D	Death
	07	Other (includes aging out of the children's MH system, extended placement (conditional release), and all other reasons)			O	Other
	08	Unknown - This code will continue to be accepted. However, States are encouraged to use the code 97 Unknown instead.			U	Unknown
	24	Transferred to another treatment program or facility that is not in the SSA or SMHA reporting system			30	Transferred to another treatment program funded by Medicaid (not within the purview of SMHA)
	34	Discharged temporarily to an acute medical facility for medical services (MH only)			22	Discharged for acute medical care
	96	Not applicable			96	Not applicable (used for MH update records)
	97	Unknown			97	Unknown
	98	Not collected			98	Not collected

DIS 11 through DIS 20: Values for the following data fields must be taken from the admission record associated with the discharge record			
DIS 11	**Provider Identifier at Admission (MDS 1)**		
DIS 12	**Client Identifier at Admission (MDS 2)**		
DIS 13	**Codependent/Collateral (from admission record MDS 3)**		
DIS 14	**Client Transaction Type (from admission record MDS 4)**		
DIS 15	**Date of Admission (from admission record MDS 5)**		
DIS 16	**Type of Service/Setting at Admission (from admission record MDS 18)**		
DIS 17	**Date of Birth (from admission record MDS 8)**		
DIS 18	**Gender (from admission record MDS 9)**		
DIS 19	**Race (from admission record MDS 10)**		
DIS 20	**Hispanic or Latino Origin (Ethnicity) (from admission record MDS 11)**		

DIS 21 (A, B, C) (optional for MH reporting)	**Substance Abuse Problem (Primary, Secondary, and Tertiary) (SA NOM)**			31	**Substance Problem at discharge, (primary, secondary, and tertiary)** *State note: if available, data will be reported for clients with co-occurring SA and MH disorders*	
	01	None			01	None
	02	Alcohol			02	Alcohol
	03	Cocaine/Crack			03	Cocaine/Crack
	04	Marijuana/Hashish			04	Marijuana/Hashish
	05	Heroin			05	Heroin
	06	Non-Prescription Methadone			06	Non-Prescription Methadone
	07	Other Opiates And Synthetics			07	Other Opiates And Synthetics
	08	PCP-phencyclidine			08	PCP-phencyclidine
	09	Hallucinogens			09	Other Hallucinogens
	10	Methamphetamine/Speed			10	Methamphetamine
	11	Other Amphetamines			11	Other Amphetamines
	12	Other Stimulants			12	Other Stimulants
	13	Benzodiazepine			13	Benzodiazepine
	14	Other Tranquilizers			14	Other Tranquilizers
	15	Barbiturates			15	Barbiturates
	16	Other Sedatives or Hypnotics			16	Other Sedatives or Hypnotics
	17	Inhalants			17	Inhalants
	18	Over-The-Counter Medications			18	Over-The-Counter
	20	Other Drugs			20	Other
	97	Unknown			97	Unknown
	98	Not collected			98	Not collected (for MH only clients)

DIS 22 (A, B, C) (optional for MH only)	**Frequency of Use at Discharge (Primary, secondary and tertiary) (SA NOM)**			34	**Frequency of Use at Discharge (Primary, secondary and tertiary)** *State note: if available, data will be reported for clients with co-occurring SA and MH disorders*	
	01	No Use In The Past Month			01	No Use In The Past Month
	02	1-3 Days In the Past Month			02	1-3 Times In Past Month
	03	1-2 Days In the Past Week			03	1-2 Times In Past Week
	04	3-6 Days In the Past Week			04	3-5 Times In Past Week
	05	Daily			05	Daily
	96	Not applicable			96	Not applicable
	97	Unknown			97	Unknown
	98	Not collected			98	Not collected (for MH only clients)

DIS 23	**Living Arrangements at Discharge (SA/MH NOM)**			35	**Living arrangement at discharge**	
	01	Homeless - Clients with no fixed address; includes homeless shelters			01	Homeless
	02	Dependent Living - Clients living in a supervised setting such as a residential institution, halfway house, or group home, and children (under age 18) living with parents, relatives, or guardians or in foster care			02	Dependent living
	03	Independent Living - Clients living alone or with others without supervision; includes adult children (age 18 and over) living with parents and adolescents living independently			03	Independent living
	04	Private residence, living arrangement not specified, adults (temporary code MH only)			15	Private Residence (for adults)
	22	Dependent living: residential care and other residential status (MH only)			04	Supported Residential
	32	Dependent living: foster home/foster care (MH only)			02	Foster Home or Family Sponsor Home
	42	Dependent living: crisis residence (MH only)			06	Crisis Care
	52	Dependent living: institutional setting (MH only)			08	Nursing Home/Physical Rehabilitation
	62	Dependent living: jail and other institutions under the justice system (MH only)			10	Local Jail or Correctional Facility
	72	Dependent living: adults in private residence who need assistance in daily living (MH only)			11	State Correctional Facility
	97	Unknown			97	Unknown
	98	Not collected			98	Not collected

DIS 24	**Employment Status at Discharge (SA/MH NOM)**			39	**Employment status at discharge**	
	01	Full-time - working 35 hours or more each week, including active duty members of the uniformed services			01	Full Time
	01	Full-time - working 35 hours or more each week, including active duty members of the uniformed services			01	In Armed Force
	02	Part-time - working fewer than 35 hours each week			02	Part Time
	03	Unemployed - looking for work during the past 30 days or on layoff from a job			03	Unemployed
	04	Not in labor force - not looking for work during past 30 days, or a student, homemaker, disabled, retired, or an inmate of an institution. Clients in this category are further defined in Detailed Not in Labor Force (SuDS 12).			04	Not in Labor Force
	04	Not in labor force - not looking for work during past 30 days, or a student, homemaker, disabled, retired, or an inmate of an institution. Clients in this category are further defined in Detailed Not in Labor Force (SuDS 12).			04	Inmate of Institution
	05	Employed, full/part-time not specified (MH only)			--	Not used
	97	Unknown			97	Unknown
	98	Not collected			98	Not collected

DIS 25	**Detailed Not in Labor Force at Discharge (SA/MH NOM)**			36	**Detailed not in labor force at discharge**	
	01	Homemaker			01	Homemaker
	02	Student			02	Student
	03	Retired			03	Retired
	04	Disabled			04	Disabled
	05	Resident of institution or persons receiving services from institutional facilities such as hospitals, jails, prisons, etc			05	Inmate Of Institution
	06	Other			06	Other
	07	Sheltered/non-competitive employment (MH only)			13	Not in Labor Force: Sheltered employment settings
	96	Not applicable			96	Not applicable (all records with Employment Status not “04”)
	97	Unknown			97	Unknown
	98	Not collected			98	Not collected

DIS 26	**Arrests in Past 30 Days - Discharge (SA/MH NOM)**			40	**Arrests in 30 days prior to discharge**	
	00-96	Number of arrests			00	None
	00-96	Number of arrests			01-96	01-96
	97	Unknown			97	Unknown
	98	Not collected			98	Not collected

DIS 27 (optional for MH only)	**Attendance at SA Self-Help Groups in Past 30 Days - Discharge (SA NOM)**			50	**Frequency of attendance at self-help SA programs (AA, NA, etc.) in 30 days prior to discharge** *State note: if available, data will be reported for clients with co-occurring SA and MH disorders.*	
	1	No attendance in the past month			1	No attendance in the past month
	2	Less than once a week - 1 to 3 times in the past 30 days			2	1-3 times in past month (less than 1 per week)
	3	About once a week - 4 to 7 times in the past 30 days			3	4-7 times in past month (about 1 per week)
	4	2 to 3 times per week - 8-15 times in the past 30 days			4	8-15 times in past month (2-3 times per week)
	5	At least 4 times a week - 16 to 30 times in the past 30 days			5	16-30 times in past month (4+ times per week)
	6	Some attendance - Number of times and frequency is unknown			6	Some attendance but frequency unknown
	97	Unknown			97	Unknown

DIS 27 (optional for MH only)	**Attendance at SA Self-Help Groups in Past 30 Days - Discharge (SA NOM)**			50	**Frequency of attendance at self-help SA programs (AA, NA, etc.) in 30 days prior to discharge** *State note: if available, data will be reported for clients with co-occurring SA and MH disorders.*	
	98	Not Collected			98	Not Collected (for MH only clients)

DIS 28 **(key field)**	**Client Transaction Type**				**Client Transaction Status**	
	D	Discharge (SA)			D	Discharge - Program Type: SA
	E	Discharge (MH)			E	Discharge - Program Type: MH
	U	Data Update (MH)			U	MH Update

Mental Health Discharge Data Set	The following MHD fields are optional for SA reporting but may be reported for persons with co-occurring MH and SA problems if information is available					
MHD 1	**Diagnostic Code Set Identifier**				**Diagnostic Code Set**	
	1	DSM-IV			1	DSM-IV code
	2	ICD-9				
	3	ICD-10			3	ICD-10
	4	DSM-V			4	DSM-V
	5	DSM-IIIR				
	7	Unknown				
	8	Not Collected				

MHD 2a	**MH Diagnosis - One**				**MH Diagnostic Code** *State note: if available, data will be reported for clients with co-occurring SA and MH disorders*	
	xxx.xxxx				xxx.xxxx	
	xxx- - - - -				xxx- - - - -	
	xxx. - - - -				xxx. - - - -	
	xxx.x- - -				xxx.x- - -	
	xxx.xx- -				xxx.xx- -	
	xxx.xxx-				xxx.xxx-	
	999.9997	Unknown			999.9997	Unknown (for SA only clients)
	999.9998	Not collected			999.9998	Not collected (for MH clients receiving MH evaluation only)

MHD 2b	**MH Diagnosis - Two**				**MH Diagnostic Code**	
	xxx.xxxx				xxx.xxxx	
	xxx- - - - -				xxx- - - - -	
	xxx. - - - -				xxx. - - - -	
	xxx.x- - -				xxx.x- - -	
	xxx.xx- -				xxx.xx- -	
	xxx.xxx-				xxx.xxx-	
	999.9997	Unknown			999.9997	blank field or for SA only clients
	999.9998	Not collected			999.9998	Not collected (for MH clients receiving MH evaluation only)

MHD 2c	**MH Diagnosis - Three**				**MH Diagnostic Code**	
	xxx.xxxx					
	xxx- - - - -					
	xxx. - - - -					
	xxx.x- - -					
	xxx.xx- -					
	xxx.xxx-					
	999.9997	Unknown				
	999.9998	Not collected			999.9998	Not collected (for all clients; state collects only 2 MH diagnoses for every client)

MHD 3	**SMI/SED Status**				**SMI/SED Status** *State note: if available, data will be reported for clients with co-occurring SA and MH disorders*	
	1	SMI			1	Yes to SMI
	2	SED			1	Yes to SED
	3	At risk for SED (optional)				
	4	Not SMI/SED			2	No to both
	7	Unknown			--	Blank field for both
	8	Not collected			8	Not collected for SA only clients

MHD 4	**School Attendance Status (MH NOM)**				**School Attendance Status**	
	1	Yes, client has attended school at any time in the past 3 months			01	Attending school
	2	No, client has not attended school at any time in the past 3 months			02	Not in school
	6	Not applicable			06	MH client age less than 3 or greater than 17

MHD 4	**School Attendance Status (MH NOM)**				**School Attendance Status**	
	7	Unknown			UN	Field is blank
	8	Not collected			08	Not collected (for SA only clients)

MHD 5	**Education (MH NOM)**				**Education/Grade Level**	
	00	Less than one school grade or no schooling			00	None, never attended school
	01	Grade 1			01	First grade
	02	Grade 2			02	Second grade
	03	Grade 3			03	Third grade
	04	Grade 4			04	Fourth grade
	05	Grade 5			05	Fifth grade
	06	Grade 6			06	Sixth grade
	07	Grade 7			07	Seventh grade
	08	Grade 8			08	Eighth grade
	09	Grade 9			09	Ninth grade
	10	Grade 10			10	Tenth grade
	11	Grade 11			11	Eleventh grade
	12	12th grade or GED			12	Twelfth grade/high school graduate
	12	12th grade or GED			20	GED
	13	1st year of college/university (Freshman)			13	One year of college
	14	2nd year of college/university (Sophomore) or Associate's Degree			14	Two years of college
	15	3rd year of college/university (Junior)			15	Three years of college
	16	4th year of college/university (Senior) or Bachelor's Degree			16	Baccalaureate degree
	70	Graduate or professional school			17	Post graduate school
	71	Vocational school			80	Technical trade school
	72	Nursery school, pre-school			50	Nursery school
	73	Kindergarten			30	Kindergarten
	74	Self-contained special education class			82	Special education
	97	Unknown			97	Unknown
	98	Not collected			98	Not collected

MHD 6 (Optional for MH reporting)	**CGAS/GAF Score**			**CGAS/GAF Score** *State note: State does not use collect this information.*

	0-100	Score				
	997	Unknown				
	998	Not Collected			998	Not Collected (for all clients)

Appendix C. File Specifications

Data File Specifications

(1) Data files must be submitted as fixed-length ASCII flat files. Three fixed record length sizes are currently accepted by the TEDS system.

- Short fixed-length (Admissions-138, Discharges-137): For substance abuse reporting only. This is a backward compatible fixed length (i.e., the old file format continues to be accepted).
- Medium fixed-length (Admissions-147, Discharges-137): For substance abuse reporting only. This becomes the applicable fixed-length for substance abuse admission records when the following data fields have been included: (1) **SuDS 18 Diagnostic Code Set Identifier** and (2) **SuDS 19 Substance Abuse Diagnosis**. A discharge record with record length of 137 is deemed to have a field value of *D Discharge - Substance abuse treatment* for **DIS 28 Client Transaction Type**.
- Long fixed-length files (Admissions-178, Discharges-170): For mental health reporting as well as for substance abuse reporting when any of the optional mental health data fields are reported.

(2) Fields must occupy the column(s) specified in the file structure tables.
(3) All fields must have valid values (see **Appendix D**).
(4) Only printable alphanumeric ASCII characters are valid.
(5) Numeric fields must be right-justified and filled with zeros.
(6) All alphanumeric fields must use valid entries with no blank spaces, except **State Provider Identifier** and **Client Identifier**, which must be left-justified and filled with blank spaces.
(7) A field filled with 9s, indicating *Invalid data,* is reserved for use by the TEDS Project Office.
(8) The end of a record may be indicated with either LF (line feed) or CR-LF (carriage return-line feed).
(9) End-of-file markers are optional, as is line feed (LF) for the last record in the file.

Admission Record Structure

The data fields of the admission record are:

System Data Set (SDS)

Fields 1–3 are processing control fields. They identify the type of submission, the state, and the reporting date. Each state is required to submit data for all SDS fields.

Minimum Data Set (MDS)

Fields 4–30 include demographic, substance abuse, and treatment characteristics. Each state is required to submit data for all MDS fields. However, substance abuse data in the MDS fields are

optional for mental health. However, states are encouraged to submit the information if collected for mental health clients with a co-occurring substance abuse problem.

Supplemental Data Set (SuDS)

Fields 31–47 include psycho-socioeconomic characteristics or additional detail for MDS data fields.

With the exception of those fields designated as National Outcome Measures (NOMs) (see **Appendix D – Data Dictionary**), reporting of SuDS data fields is optional for both mental health and substance abuse. However, states are encouraged to report all SuDS fields available in the state data system.

Fields 48–49 have been appended to the admission record. Field 48 identifies the diagnostic code set used to report the substance abuse and mental health diagnostic codes. SuDS 19 (field 49) will replace SuDS 4 and has been formatted to also accommodate the longer ICD-10 codes.

The addition of these two new fields allow for flexibility in reporting diagnostic codes. States may use different diagnostic code sets to report diagnostic codes across different records but should use a consistent code set for reporting the substance abuse and mental health diagnostic codes within the same record.

The substance abuse field allows for separate reporting of the substance abuse diagnosis and mental health diagnosis.

Mental Health Admission Data Set (MHA)

Fields 50–56 are mental health fields that have been appended to the admission record. These are optional reporting for substance abuse but states are encouraged to submit the information, if available, for substance abuse clients with a co-occurring mental health problem.

Admission File Specifications

Field Position	Field	Field Name	Data Type	Field Length	Begin Column	End Column
System Data Set						
1	SDS 1	System Transaction Type	Alphanumeric	1	1	1
2 KEY	SDS 2	State Code	Alphanumeric	2	2	3
3	SDS 3	Reporting Date	Numeric	6	4	9
Minimum Data Set						
4 KEY	MDS 1	State Provider Identifier	Alphanumeric	15	10	24
5 KEY	MDS 2	Client Identifier	Alphanumeric	15	25	39
6 KEY	MDS 3	Codependent/Collateral	Numeric	1	40	40
7 KEY	MDS 4	Client Transaction Type	Alphanumeric	1	41	41

Field Position	Field	Field Name	Data Type	Field Length	Begin Column	End Column
8 KEY	MDS 5	**Date of Admission**	Numeric	8	42	49
9 KEY	MDS 18	**Type of Treatment Service/Setting**	Numeric	2	50	51
10	MDS 6	**Previous SA Treatment Episodes**	Numeric	1	52	52
11	MDS 7	**Referral Source**	Numeric	2	53	54
12	MDS 8	**Date of Birth**	Numeric	8	55	62
13	MDS 9	**Gender**	Numeric	1	63	63
14	MDS 10	**Race**	Numeric	2	64	65
15	MDS 11	**Hispanic or Latino Origin (Ethnicity)**	Numeric	2	66	67
16 NOM	MDS 12	**Education**	Numeric	2	68	69
17 NOM	MDS 13	**Employment Status**	Numeric	2	70	71
18 NOM	MDS 14a	**Substance Abuse Problem**, Primary	Numeric	2	72	73
19	MDS 15a	**Route of Administration**, Primary	Numeric	2	74	75
20 NOM	MDS 16a	**Frequency of Use**, Primary	Numeric	2	76	77
21	MDS 17a	**Age at First Use**, Primary	Numeric	2	78	79
22 NOM	MDS 14b	**Substance Abuse Problem**, Secondary	Numeric	2	80	81
23	MDS 15b	**Route of Administration**, Secondary	Numeric	2	82	83
24 NOM	MDS 16b	**Frequency of Use**, Secondary	Numeric	2	84	85
25	MDS 17b	**Age at First Use**, Secondary	Numeric	2	86	87
26 NOM	MDS 14c	**Substance Abuse Problem**, Tertiary	Numeric	2	88	89
27	MDS 15c	**Route of Administration**, Tertiary	Numeric	2	90	91
28 NOM	MDS 16c	**Frequency of Use**, Tertiary	Numeric	2	92	93
29	MDS 17c	**Age at First Use**, Tertiary	Numeric	2	94	95
30	MDS 19	**Medication-Assisted Opioid Therapy**	Numeric	1	96	96
Supplemental Data Set						
31	SuDS 1	**Detailed Drug Code**, Primary	Numeric	4	97	100
32	SuDS 2	**Detailed Drug Code**, Secondary	Numeric	4	101	104
33	SuDS 3	**Detailed Drug Code**, Tertiary	Numeric	4	105	108
34	SuDS 4	**Diagnostic Code (DSM or ICD)**	Alphanumeric	6	109	114
35	SuDS 5	**Co-occurring Substance Abuse and Mental Health Problems**	Numeric	1	115	115
36	SuDS 6	**Pregnant at Admission**	Numeric	1	116	116
37	SuDS 7	**Veteran Status**	Numeric	1	117	117
38 NOM	SuDS 8	**Living Arrangements**	Numeric	2	118	119

Field Position	Field	Field Name	Data Type	Field Length	Begin Column	End Column
39	SuDS 9	**Source of Income/Support**	Numeric	2	120	121
40	SuDS 10	**Health Insurance**	Numeric	2	122	123
41	SuDS 11	**Payment Source, Primary (Expected or Actual)**	Numeric	2	124	125
42 NOM	SuDS 12	**Detailed Not In Labor Force**	Numeric	2	126	127
43	SuDS 13	**Detailed Criminal Justice Referral**	Numeric	2	128	129
44	SuDS 14	**Marital Status**	Numeric	2	130	131
45	SuDS 15	**Days Waiting to Enter SA Treatment**	Numeric	3	132	134
46 NOM	SuDS 16	**Arrests in Past 30 Days – Admission**	Numeric	2	135	136
47 NOM	SuDS 17	**Attendance at SA Self-Help Groups in Past 30 Days – Admission**	Numeric	2	137	138
48	SuDS 18	**Diagnostic Code Set Identifier**	Numeric	1	139	139
49	SuDS 19	**Substance Abuse Diagnosis** (use in lieu of SuDS 4)	Alphanumeric	8	140	147
Mental Health Admission Data Set						
50	MHA 1a	**Mental Health Diagnosis – One**	Alphanumeric	8	148	155
51	MHA 1b	**Mental Health Diagnosis – Two**	Alphanumeric	8	156	163
52	MHA 1c	**Mental Health Diagnosis – Three**	Alphanumeric	8	164	171
53	MHA 2	**SMI/SED Status**	Numeric	1	172	172
54 NOM	MHA 3	**School Attendance Status**	Numeric	1	173	173
55	MHA 4	**Legal Status at Admission to State Hospitals**	Numeric	2	174	175
56	MHA 5	**CGAS/GAF Score** (optional for MH)	Numeric	3	176	178

Discharge/Update Record Structure

The data fields of the discharge or update record are described below. Each state is required to submit data for all fields except for CGAS/GAF score which remains optional.

System Data Set (SDS)

Fields 1–3 and 32 are processing control fields. They identify the type of submission, the state, and the reporting date.

Key Discharge Fields

Fields 4–10 are used to uniquely identify each record. Fields 4–9 are Key fields.

Fields from Admission Record

Fields 11–20 contain data from the admission record that is associated with the discharge record. The fields identified as "link" are those that are used to link the admission and discharge/update records, and the remaining fields are used for verification. Link records represent a complete treatment episode or a treatment event.

National Outcome Measures (NOMs)

Fields 21–31 contain the NOMs data fields and are collected at time of discharge from treatment or at time of data update.

Mental Health Discharge/Update Data Set (MHD)

Fields 33–40 are specific to mental health and are collected at time of discharge from treatment or at time of data update.

Discharge/Update File Specifications

Field Position	Field	Field Name	Data Type	Field Length	Begin Column	End Column
System Data Set						
1	DIS 1	System Transaction Type	Alphanumeric	1	1	1
2 KEY	DIS 2	State Code	Alphanumeric	2	2	3
3	DIS 3	Reporting Date	Numeric	6	4	9
Key Discharge Fields						
4 KEY	DIS 4	State Provider Identifier (at discharge)	Alphanumeric	15	10	24
5 KEY	DIS 5	Client Identifier	Alphanumeric	15	25	39
6 KEY	DIS 6	Codependent/Collateral (at discharge)	Numeric	1	40	40
7 KEY	DIS 7	Type of Treatment Service/Setting (at discharge)	Numeric	2	41	42
8 KEY	DIS 8	Date of Last Contact or Data Update	Numeric	8	43	50
9 KEY	DIS 9	Date of Discharge	Numeric	8	51	58
10	DIS 10	Reason for Discharge, Transfer, or Discontinuance of Treatment	Numeric	2	59	60
Data from Admission Record						
11 LINK	DIS 11	State Provider Identifier	Alphanumeric	15	61	75
12 LINK	DIS 12	Client Identifier	Alphanumeric	15	76	90
13 LINK	DIS 13	Codependent/Collateral	Numeric	1	91	91
14 LINK	DIS 14	Client Transaction Type	Alphanumeric	1	92	92
15 LINK	DIS 15	Date of Admission	Numeric	8	93	100
16 LINK	DIS 16	Type of Treatment Service/Setting	Numeric	2	101	102

Field Position	Field	Field Name	Data Type	Field Length	Begin Column	End Column
17	DIS 17	**Date of Birth**	Numeric	8	103	110
18	DIS 18	**Gender**	Numeric	1	111	111
19	DIS 19	**Race**	Numeric	2	112	113
20	DIS 20	**Hispanic or Latino Origin (Ethnicity)**	Numeric	2	114	115
National Outcome Measures (NOMs)						
21 NOM	DIS 21a	**Substance Abuse Problem at Discharge – Primary**	Numeric	2	116	117
22 NOM	DIS 21b	**Substance Abuse Problem at Discharge – Secondary**	Numeric	2	118	119
23 NOM	DIS 21c	**Substance Abuse Problem at Discharge – Tertiary**	Numeric	2	120	121
24 NOM	DIS 22a	**Frequency of Use at Discharge – Primary**	Numeric	2	122	123
25 NOM	DIS 22b	**Frequency of Use at Discharge – Secondary**	Numeric	2	124	125
26 NOM	DIS 22c	**Frequency of Use at Discharge – Tertiary**	Numeric	2	126	127
27 NOM	DIS 23	**Living Arrangements at Discharge**	Numeric	2	128	129
28 NOM	DIS 24	**Employment Status at Discharge**	Numeric	2	130	131
29 NOM	DIS 25	**Detailed Not in Labor Force at Discharge**	Numeric	2	132	133
30 NOM	DIS 26	**Arrests in Past 30 Days – Discharge**	Numeric	2	134	135
31 NOM	DIS 27	**Attendance at SA Self-Help Groups in Past 30 Days – Discharge**	Numeric	2	136	137
Mental Health Discharge/Update Data Set						
32 KEY	DIS 28	**Client Transaction Type at Discharge**	Alphanumeric	1	138	138
33	MHD 1	**Diagnostic Code Set Identifier**	Numeric	1	139	139
34	MHD 2a	**Mental Health Diagnosis – One**	Alphanumeric	8	140	147
35	MHD 2b	**Mental Health Diagnosis – Two**	Alphanumeric	8	148	155
36	MHD 2c	**Mental Health Diagnosis – Three**	Alphanumeric	8	156	163
37	MHD 3	**SMI/SED Status**	Numeric	1	164	164
38 NOM	MHD 4	**School Attendance Status**	Numeric	1	165	165
39 NOM	MHD 5	**Education**	Numeric	2	166	167
40	MHD 6	**CGAS/GAF Score** (optional for MH reporting)	Numeric	3	168	170

Appendix D. Data Dictionary

SA/MH TEDS Data Dictionary

The Data Dictionary provides critical information about the substance abuse (SA) and mental health (MH) data fields in the Treatment Episode Data Set (TEDS). This document may be used as a reference for reporting treatment data either by the Single State Agencies for Substance Abuse Services (SSAs) or the State Mental Health Authorities (SMHAs). Details provided include the field and item (category) definitions, valid entries and coding structure, validation edits performed, and guidelines for collecting and reporting data to TEDS.

Each field has been assigned a reference number that incorporates the data set name and the position of the element in the record layout. Data set names include System Data Set (SDS), Minimum Data Set (MDS), Supplemental Data Set (SuDS), Discharge Data Set (DIS), and Mental Health data sets (i.e., Mental Health Admissions [MHA] and Mental Health Updates/Discharges [MHD]). Data fields identified as "key" are those elements which, taken together, uniquely identify each record.

Coding Missing Data

Because individual state data collection systems have diverse requirements, there are some data fields that may not be available at the state level. These are labeled as optional for mental health and/or substance abuse reporting. SAMHSA encourages states to report as many of these fields as possible.

However, sometimes missing data cannot be avoided. TEDS missing data codes include:

- *Not applicable:* Valid for interdependent data fields only, where the value of one field is dependent on the value of another. For example, *6 Not applicable* is the correct value for *Pregnant at Admission* when the value of *Gender* is *1 Male*.
- *Unknown:* Should be used to indicate that, although the state collects and reports data for a field, the value for an individual client is not known.
- *Not collected:* Should be used when a state's data system does not collect a particular field. This code is typically used for an optional data field not reported by the state (rather than *Unknown*).

In some data fields, states may collect a subset of the valid values and these fields may have specific instructions on the use of *Unknown* and *Not collected*. Please review the detailed instructions for each field in the following pages.

Data Dictionary Definitions

The following information is provided (as appropriate) for each variable:

Description	Valid entries
Validation edits	Guidelines
Related fields	Field length
Data type	Reference number and column(s)

VARIABLE NAME: AGE AT FIRST USE (PRIMARY, SECONDARY, TERTIARY SUBSTANCES)

DESCRIPTION

For substances other than alcohol, this field identifies the age at which the client first used the corresponding substance identified in **Substance Abuse Problem (Primary, Secondary, Tertiary)**.

For alcohol, this field records the age at the first intoxication.

VALID ENTRIES

Code	Description
00	NEWBORN with substance dependency problem
01-95	AGE AT FIRST USE (in years)
96	NOT APPLICABLE – Use when the value in **Substance Abuse Problem** is *01 None*.
97	UNKNOWN – Individual client value is unknown.
98	NOT COLLECTED – State does not collect this field.

VALIDATION EDITS

If this field is blank or contains an invalid value, the value will be changed to *99 Invalid data* and a warning error will be generated.

For SA admission records,the **Age at First Use** field is compared to the *Age at Admission,* which is a calculated value (**Date of Admission** minus **Date of Birth**). If *Age at Admission* is less than **Age at First Use**, a warning error will be generated requiring the state to investigate the validity of both the client's **Date of Birth** and **Age at First Use**. The state is expected to apply a corrective action and submit a corrected record. Meanwhile, the record will be processed and *99 Invalid data* will replace the reported value in the **Age at First Use** until a corrected record is submitted.

When this information is reported on a mental health record, **Co-occurring Substance Abuse and Mental Health Problems** must be *1 Yes*, or a warning error will be generated.

GUIDELINES

If the value in **Substance Abuse Problem** is *01 None*, this field should be coded *96 Not applicable*.

Mental health reporting: This field is optional**.** Reporting of this information on a mental health record is allowed only for clients with co-occurring mental health and substance abuse problems.

RELATED FIELDS: **Substance Abuse Problem**, **Route of Administration**, **Frequency of Use**, **Detailed Drug Code**, *Age at Admission* (Calculated)

Mental health reporting: **Co-occurring Substance Abuse and Mental Health Problems**

FIELD LENGTH: 2

DATA TYPE: Numeric

REFERENCE NO. AND COLUMN(S):

Admission record: MDS17a: 78-79
MDS 17b: 86-87
MDS 17c: 94-95

VARIABLE NAME: ARRESTS IN PAST 30 DAYS (SA/MH NOM)

DESCRIPTION

Indicates the number of arrests in the 30 days prior to the reference date (i.e., date of admission or date of discharge)

VALID ENTRIES

Code	Description
00-96	NUMBER OF ARRESTS
97	UNKNOWN – Individual client value is unknown.
98	NOT COLLECTED – State does not collect this field.

VALIDATION EDITS

If this field is blank or contains an invalid value, the value will be changed to *99 Invalid data* and a warning error will be generated.

GUIDELINES

Arrests in Past 30 Days is defined by SAMHSA as an outcome measure, and it is collected at admission and at discharge to assess change.

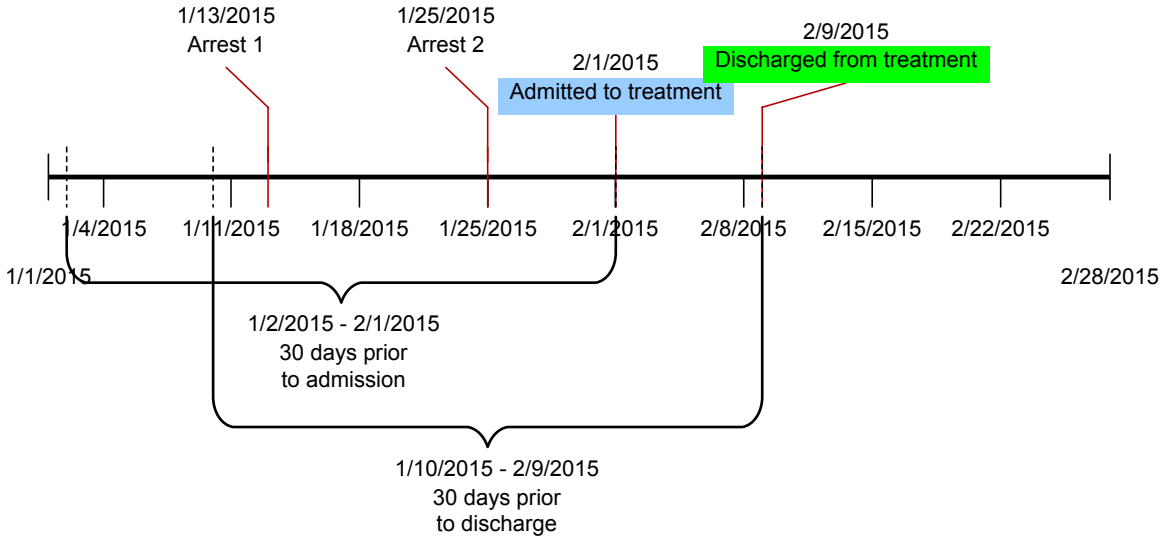
- For admission records, the reference period is the 30 days prior to admission.
- For discharge/update records, the reference period is the 30 days prior to discharge/update.

This item is intended to capture the number of times the client was arrested for any cause during the reference period.

Any formal arrest should be counted, regardless of whether incarceration or conviction resulted and regardless of the status of the arrest proceedings on the reference date.

If the dates of admission and discharge/update are close together, so that the reference periods overlap, arrests falling in the overlap should be counted as occurring in the 30 days prior to admission. They should not be counted again in the 30 days prior to update/discharge. For example: If the date of admission is February 1st and the date of discharge is February 9th, arrests that happened on January 13th and 25th should be reported at time of admission. They should not be reported again at the time of discharge because the 30-day timeframe overlapped between the two data reporting periods. Any arrest incidents that happened during the time gap between admission and discharge should be reported as arrest 30 days prior to discharge.

VARIABLE NAME: ARRESTS IN PAST 30 DAYS—continued



RELATED FIELDS: None
FIELD LENGTH: 2
DATA TYPE: Numeric
REFERENCE NO. AND COLUMN(S):
Admission record: SuDS 16: 135-136
Discharge record: DIS 26: 134-135

VARIABLE NAME: ATTENDANCE AT SA SELF-HELP GROUPS IN PAST 30 DAYS

DESCRIPTION

This field indicates the frequency of attendance at a substance abuse self-help group in the 30 days prior to the reference date (the date of admission or date of discharge). It includes attendance at Alcoholics Anonymous (AA), Narcotics Anonymous (NA), and other self-help/mutual support groups focused on recovery from substance abuse and dependence.

VALID ENTRIES

Code	Description
01	NO ATTENDANCE
02	LESS THAN ONCE A WEEK – 1 to 3 times in the past 30 days
03	ABOUT ONCE A WEEK – 4 to 7 times in the past 30 days
04	2 TO 3 TIMES PER WEEK – 8 to 15 times in the past 30 days
05	AT LEAST 4 TIMES A WEEK – 16 to 30 times or more in the past 30 days
06	SOME ATTENDANCE – Number of times and frequency is unknown
97	UNKNOWN – Individual client value is unknown.
98	NOT COLLECTED – State does not collect this field.

VALIDATION EDITS

If this field is blank or contains an invalid value, the value will be changed to *99 Invalid data* and a warning error will be generated.

When this information is reported on a mental health record, **Co-occurring Substance Abuse and Mental Health Problems** must be *1 Yes*, or a warning error will be generated.

GUIDELINES

For admission records, the reference period is the 30 days prior to admission, and for discharge records, the reference period is the 30 days prior to discharge.

Use *06 Some attendance* only if it is known that the client attended a self-help program during the reference period, but there is insufficient information to assign a specific frequency.

Use *97 Unknown* when it is not known whether the client attended a self-help program during the reference period.

Substance abuse reporting: This variable is defined by SAMHSA as an outcome measure, and is collected at admission and at discharge to assess change.

Mental health reporting: This field is optional and currently measures only the client's attendance at a substance abuse self-help group. Reporting of this information on a mental health record is allowed only for clients with co-occurring mental health and substance abuse problems.

RELATED FIELDS: Mental health reporting: **Co-occurring Substance Abuse and Mental Health Problems**

FIELD LENGTH: 2

DATA TYPE: Numeric

VARIABLE NAME: ATTENDANCE AT SA SELF-HELP GROUPS IN PAST 30 DAYS—continued

REFERENCE NO. AND COLUMN(S):

Admission record:	SuDS 17: 137-138
Discharge record:	DIS 27: 136-137

VARIABLE NAME: CGAS/GAF SCORE

DESCRIPTION

This field specifies the Children Global Assessment Scale (CGAS) score for children and adolescents or the Global Assessment of Functioning (GAF) score for adult clients.

VALID ENTRIES

Code	Description
0-100	CGAS/GAF Score
997	UNKNOWN – Individual client value is unknown.
998	NOT COLLECTED – State does not collect this field.

VALIDATION EDITS

If this field is blank or contains an invalid value, the value will be changed to *999 Invalid data* and a warning error will be generated.

When this information is reported on a substance abuse record, **Co-occurring Substance Abuse and Mental Health Problems** must be *1 Yes*, or a warning error will be generated.

GUIDELINES

Report only if the state is using the **CGAS/GAF**. Report client's score at time of admission, update, and/or discharge.

Use *998 Not collected* if the state does not collect these data for all or a subset of the population. Cite in the crosswalk the functioning instrument/tool that the state uses instead of or in addition to CGAS/GAF.

Reporting of this field is optional for both substance abuse and mental health clients.

Substance abuse reporting: This field is optional. Reporting of this information on a substance abuse record is allowed only for clients with co-occurring mental health and substance abuse problems.

RELATED FIELDS: None
FIELD LENGTH: 3
DATA TYPE: Numeric
REFERENCE NO. AND COLUMN(S)
Admission: MHA 5: 176-178
Discharge: MHD 6: 168-170

VARIABLE NAME: CLIENT IDENTIFIER—KEY FIELD

DESCRIPTION

This field is used to identify the person receiving treatment.

VALID ENTRIES

1 to 15 alphanumeric characters

VALIDATION EDITS

If this field is blank, contains an invalid value, or is all zeros, the record will be rejected and not processed. A fatal error will be displayed in the processing report.

GUIDELINES

The **Client Identifier** must be unique within the state. The **Client Identifier** should be assigned once to a single individual and used for all subsequent transactions involving that individual. It should not contain HIPAA-protected health information (PHI) or personal identifying information, in full or in part, such as Social Security number, birth date, etc.

If the existing client ID is not consistent with the guideline above, please discuss with the TEDS Project Office and/or note on your crosswalk the state's plan to convert the ID into a non-PHI ID.

A *substance abuse treatment client* is a person who meets the following criteria:

- Has a substance abuse problem or is being treated as a codependent of a person with a substance abuse problem (see instructions for **Codependent/Collateral**).
- Has completed the screening and intake process ***and*** has been formally admitted for treatment or recovery service to a substance abuse treatment program. A person who has completed only a screening or intake process or has been placed on a waiting list is ***not*** a client.
- Has a client record.

A *mental health treatment client* is a person who meets the following criteria:

- Has received mental health services, including support services, screening, assessment or crisis services through SMHA-funded or -operated facilities or programs. Telemedicine services are included if they are provided to registered or identified clients. A person who has completed only a screening or intake process ***is*** considered a client and should be reported.
- Has a client record or can be identified in the state database.

RELATED FIELDS: None
FIELD LENGTH: 15
DATA TYPE: Alphanumeric (left-justified and filled with blank spaces)
REFERENCE NO. AND COLUMN(S):

Admission record:	MDS 2: 25-39
Discharge record:	DIS 5: 25-39
	DIS 12: 76-90

VARIABLE NAME: CLIENT TRANSACTION TYPE—KEY FIELD

DESCRIPTION

This field identifies whether a record represents (a) MH/SA initial or transfer admission, (b) MH/SA discharge, or (c) mental health update.

VALID ENTRIES

Code	Description
A	INITIAL ADMISSION – Substance abuse treatment
T	TRANSFER/CHANGE IN SA SERVICE
D	DISCHARGE – Substance abuse treatment
M	INITIAL ADMISSION – Mental health treatment
X	TRANSFER/CHANGE IN MH SERVICE
E	DISCHARGE – Mental health treatment
U	DATA UPDATE – Mental health treatment client

VALIDATION EDITS

If this field is blank or contains an invalid value, the record will be rejected and not processed. A fatal error will be displayed in the processing report.

For backward compatibility in substance abuse reporting, if the record has a length of 137, it will be deemed a value of *D Discharge - Substance abuse treatment*.

GUIDELINES

Each *Initial admission* and *Transfer* record should have an associated discharge record.

If *Initial admissions* and *Transfers* within one treatment episode cannot be identified in a state data system, such changes in service or facility should be reported as *Initial admissions*. This reporting procedure (i.e., the state is submitting all admissions as initial and the concept of transfer is not used) must be noted in the state data crosswalk.

The assignment of the appropriate **Client Transaction Type** is informed by the type of treatment service/setting that is being reported. For example, the record of a person with co-occurring mental illness admitted to a substance abuse treatment must contain any of the codes 01-08 for **Type of Treatment Service/Setting** to assign a value of *A Initial Admission – Substance abuse treatment*.

Data Update applies only to mental health reporting.

RELATED FIELDS: None
FIELD LENGTH: 1
DATA TYPE: Alphanumeric
REFERENCE NO. AND COLUMN(S):
Admission record: MDS 4: 41
Discharge record: DIS 14: 92
DIS 28: 138

VARIABLE NAME: CODEPENDENT/COLLATERAL—KEY FIELD

DESCRIPTION

Indicates whether treatment is for a primary substance abuse problem or arises from the client's relationship with someone with a substance abuse problem. For mental health reporting, use *Client for field value.*

VALID ENTRIES

Code	Description
1	CODEPENDENT/COLLATERAL
2	CLIENT

VALIDATION EDITS

If this field is blank or contains an invalid value, the record will be rejected and not processed. A fatal error will be displayed in the processing report.

GUIDELINES

A **Codependent/Collateral** is a person who has no substance abuse problem but because of his relationship with someone with a substance abuse problem, suffers from emotional and/or behavioral condition that affects his/her ability to maintain a healthy and mutually satisfying relationship. The following conditions apply to an individual reported as codependent/collateral:

- Is seeking a treatment service for problems arising from his or her relationship with someone with a substance abuse problem.
- Has been formally admitted for service to a treatment unit.
- Has his/her own treatment record.

If the state submits records for codependents/collaterals, the fields **State Code**, **State Provider Identifier**, **Client Identifier**, **Client Transaction Type**, and **Date of Admission** must be reported. Reporting of the remaining fields is optional. For all items not reported, the data field should be coded with the appropriate *Not collected* or *Not applicable* code.

If this field is not collected, use *2 Client* as the default value.

If a *Client* with an existing record becomes a *Codependent*, a new admission record for a *Codependent* should be submitted. Conversely, a *Codependent* who becomes a *Client* requires a new admission record as a *Client*.

RELATED FIELDS: None
FIELD LENGTH: 1
DATA TYPE: Numeric
REFERENCE NO. AND COLUMN(S):
Admission record: MDS 3: 40
Discharge record: DIS 6: 40
DIS 13: 91

VARIABLE NAME: CO-OCCURRING SUBSTANCE ABUSE AND MENTAL HEALTH PROBLEMS

DESCRIPTION

This field indicates whether the client has co-occurring substance abuse and mental health problems.

VALID ENTRIES

Code	Description
1	YES – Client has co-occurring substance abuse and mental health problems.
2	NO – Client does not have co-occurring substance abuse and mental health problems.
7	UNKNOWN – Individual client value is unknown.
8	NOT COLLECTED – State does not collect this field.

VALIDATION EDITS

If this field is blank or contains an invalid value or both SA and MH diagnoses are valid (not *Unknown* or *Not Collected*), the value will be changed to *9 Invalid data* and a warning error will be generated.

Substance abuse reporting: If the record includes a valid value for any mental health-related fields identified as optional for substance abuse reporting, then **Co-occurring Substance Abuse and Mental Health Problems** must be *1 Yes* or a warning error will be generated. The reporting of the optional mental health fields in a substance abuse record is allowed only for persons with co-occurring substance abuse and mental health problems.

Mental health reporting: If the record includes a valid value for **Substance Abuse Diagnosis**, a valid value other than *1 None* for **Substance Abuse Problem (Primary, Secondary, or Tertiary)**, or a valid value for any other substance abuse-related fields identified as optional for mental health reporting, then **Co-occurring Substance Abuse and Mental Health Problems** must be *1 Yes,* else a warning error will be generated. The reporting of the optional substance abuse fields in a mental health record is allowed only for persons with co-occurring substance abuse and mental health problems.

GUIDELINES

Reporting of this field is optional for both substance abuse and mental health clients.

The assessment of co-occurring substance abuse and mental health problems may be based on clinical diagnoses, screening results, claims information, or self-report. The crosswalk should note whether the same determination method is used across the state or is determined by individual providers. If the method is statewide, the crosswalk should specify and describe the method.

RELATED FIELDS: Mental health reporting: **Substance Abuse Problem**, **Route of Administration**, **Frequency of Use**, **Age at First Use**, **Detailed Drug Code**, **Substance Abuse Diagnosis**, **Attendance at SA Self-Help Groups in Past 30 Days**

Substance abuse reporting: **CGAS/GAF Score**, **SMI/SED Status**, **Mental Health Diagnosis**

FIELD LENGTH: 1

DATA TYPE: Numeric

REFERENCE NO. AND COLUMN(S):

Admission record: SuDS 5: 115

VARIABLE NAME: DATE OF ADMISSION—KEY FIELD

DESCRIPTION

If the **Client Transaction Type at Admission** is an *Initial Admission*, this field indicates the date when the client receives his or her first direct treatment or service.

If the **Client Transaction Type at Admission** is a *Transfer*, this is the date when the client receives his or her first direct treatment in the new treatment setting/service program or new provider he or she transferred to.

VALID ENTRIES

Code	Description
MMDDYYYY	where MM must be 01 through 12 DD must be 01 through 31 YYYY must be 2000 or later for SA admissions/transfers YYYY must be 1920 or later for MH admissions/transfers

VALIDATION EDITS

If this field is blank, uses the wrong date format, or contains an invalid value, the record will be rejected and not processed. A fatal error will be displayed in the processing report.

Substance abuse records with a **Date of Admission** before January 1, 2000, will be rejected.

Mental health records with a **Date of Admission** before January 1, 1920, will be rejected.

Date of Admission may be the same as **Date of Last Contact/Data Update**, but cannot be later.

Date of Admission may be the same as **Date of Discharge**, but cannot be later.

Date of Admission cannot be later than the current date or the **Reporting Date**.

See **Appendix E** for additional edits.

GUIDELINES

Use valid calendar dates. The system will perform an internal check for valid calendar dates. For example, February 30th is an invalid value.

RELATED FIELDS: **Date of Last Contact/Data Update**, **Date of Discharge**

FIELD LENGTH: 8

DATA TYPE: Numeric (MMDDYYYY)

REFERENCE NO. AND COLUMN(S):

Admission record: MDS 5: 42-49

Discharge record: DIS 15: 93-100

VARIABLE NAME: DATE OF BIRTH

DESCRIPTION

This field identifies the client's date of birth.

VALID ENTRIES

Code	Description
MMDDYYYY	where MM must be 01 through 12 DD must be 01 through 31
01010007	UNKNOWN – Individual client value is unknown.
01010008	NOT COLLECTED – State does not collect this field.

VALIDATION EDITS

If this field is blank, uses the wrong date format, or contains an invalid value, the value record will not be processed. A fatal error will be displayed in the processing report.

If the **Date of Birth** is later than the current date or date of admission, the record will be processed but the field value will be replaced with the system code *01010009* for invalid date.

If the **Date of Birth** is a valid value but gives a calculated age of > 95 years old at time of admission, **Date of Birth** will generate a warning error. The state should verify the correct **Date of Birth**.

Date of Birth is used to calculate *Age at Admission*, which must be equal to or greater than **Age at First Use (Primary, Secondary, and Tertiary)**. If not, a warning error will be generated. The **Date of Birth** will be stored as reported but the state is expected to verify this value together with the **Age at First Use** since it cannot be determined which one is incorrect.

See **Appendix E** for additional edits.

GUIDELINES

Use valid calendar dates. The system will perform an internal check for valid calendar dates. For example, February 30th is an invalid value.

Date of Birth cannot be later than the current date, the **Date of Admission**, or result in a calculated age of greater than 97 years old.

RELATED FIELDS: *Age at Admission (calculated)*, **Age at First Use (Primary, Secondary, and Tertiary)**

FIELD LENGTH: 8

DATA TYPE: Numeric (MMDDYYY)

REFERENCE NO. AND COLUMN(S):

Admission record: MDS 8: 55-62

Discharge record: DIS 17: 103-110

VARIABLE NAME: DATE OF DISCHARGE—KEY FIELD

DESCRIPTION

Indicates the date when the client was formally discharged from the treatment facility, service, or program.

VALID ENTRIES

Code	Description
MMDDYYYY	where MM must be 01 through 12 DD must be 01 through 31 YYYY must be 2000 or later for SA discharges YYYY must be 1920 or later for MH discharges

VALIDATION EDITS

If this field is blank, uses the wrong date format, or contains an invalid value, the record will be rejected and not processed. A fatal error will be displayed in the processing report.

Date of Discharge may be the same as **Date of Admission**, but cannot be earlier.

Date of Discharge may be the same as **Reporting Date**, but cannot be earlier.

Date of Discharge may be the same as **Date of Last Contact/Data Update**, but cannot be earlier.

Substance abuse reporting: Records with a **Date of Discharge** before January 1, 2000, will be rejected.

Mental health reporting: Records with a **Date of Discharge** before January 1, 1920, will be rejected.

This field should be coded *01010006 Not Applicable* if the **Client Transaction Type** is *U Mental health update*. If a valid value is reported, the record will be rejected and not processed.

GUIDELINES

Use valid calendar dates. The system will perform an internal check for valid calendar dates. For example, February 30th is an invalid value.

For clients who discontinued treatment but have no formal discharge date, use the state's administrative policy to determine the **Date of Discharge**.

If the state does not have an administrative discharge policy, the state is encouraged to develop an operational definition for MH-TEDS reporting. This may be accomplished in consultation with the state's program administrators or subject area experts, by consideration of the state's policy on periodic clinical review or assessment of clients (e.g., length of stay on medication management without an office visit or receipt of other service), or a distribution analysis of the average time interval between service dates. Alternatively, the TEDS Project Office recommends the following definition:

> *A treatment episode may be assumed to have ended if the client has not received a treatment service in 3 days in the case of inpatient or residential treatment, or 30 days in the case of outpatient treatment.*

VARIABLE NAME: DATE OF DISCHARGE—continued

For mental health clients, the threshold for determining that treatment episode has ended may be longer (i.e., some states use a threshold ranging from 90, 180, 210, or 365 days).

RELATED FIELDS: **Date of Admission**, **Date of Last Contact/Data Update**
FIELD LENGTH: 8
DATA TYPE: Numeric (MMDDYYYY)
DATA TYPE: Numeric
REFERENCE NO. AND COLUMN(S):
Discharge record: DIS 9: 51-58

VARIABLE NAME: DATE OF LAST CONTACT OR DATA UPDATE—KEY FIELD

DESCRIPTION

Indicates a) the date of a client's last treatment service or b) the most recent date when a client's record was updated, depending on the type of record submitted. If a discharge record, this field is interpreted as Date of Last Contact. If a Mental Health update record, this field is interpreted as Date of Data Update. This is a key field for a Mental Health update record.

VALID ENTRIES

Code	Description
MMDDYYYY	where MM must be 01 through 12 DD must be 01 through 31
01010007	UNKNOWN – Individual client value is unknown.
01010008	NOT COLLECTED – State does not collect this field.

VALIDATION EDITS

The **Date of Last Contact or Data Update** is a KEY field for mental health update records. It must contain a valid value. If this field is blank, uses the wrong format, or contains invalid value, the record will not be processed. A fatal error will be displayed in the processing report.

The **Date of Last Contact or Data Update** is not a KEY field for either substance abuse or mental health discharge records. If it is blank, uses the wrong date format, or contains invalid value, the value for the **Date of Last Contact** will be changed to *01010009 Invalid Data* and a warning error will be generated.

Date of Last Contact or **Date of Data Update** may be the same as **Date of Admission**, but cannot be earlier.

Date of Last Contact or **Date of Data Update** may be the same as **Reporting Date**, but cannot be later.

See **Appendix E** for additional edits.

GUIDELINES

Use valid calendar dates. The system will perform an internal check for valid calendar dates. For example, February 30th is an invalid value.

Date of Last Contact is reported for either a mental health or substance abuse discharge record and **Date of Data Update** is reported for a mental health update record.

See Relevant Dates in Discharge and Update Records section of this Manual for guidance in completing this field.

Date of Last Contact or **Date of Data Update** is used is used by SAMHSA in computing the outcome measure *Retention (length of stay)*. **States are encouraged to submit Date of Last Contact in addition to Date of Discharge** because **Date of Discharge** often reflects an administrative discharge. **Date of Last Contact more accurately reflects the length of time the client is engaged in treatment.**

VARIABLE NAME: DATE OF LAST CONTACT OR DATA UPDATE—continued

RELATED FIELDS: **Date of Admission**, **Date of Discharge**
FIELD LENGTH: 8
DATA TYPE: Numeric (MMDDYYYY)
REFERENCE NO. AND COLUMN(S):
Discharge record: DIS 8: 43-50

VARIABLE NAME: DAYS WAITING TO ENTER SA TREATMENT

DESCRIPTION:

Indicates the number of days from the first contact or request for a substance abuse treatment service until the client was admitted and the first clinical substance abuse service was provided.

VALID ENTRIES

Code	Description
000-996	NUMBER OF DAYS WAITING
997	UNKNOWN – Individual client value is unknown.
998	NOT COLLECTED – State does not collect this field.

VALIDATION EDITS

If this field is blank or contains an invalid value, the value will be changed to *999 Invalid data* and a warning error will be generated.

When this information is reported on a mental health record, **Co-occurring Substance Abuse and Mental Health Problems** must be *1 Yes*, or a warning error will be generated.

GUIDELINES

Reporting of this field is optional for both substance abuse and mental health.

This item is intended to capture the number of days the client must wait to begin substance abuse treatment because of program capacity, treatment availability, admissions requirements, or other program requirements.

It should not include time delays caused by client unavailability or client failure to meet any requirement or obligation.

Data should be entered as, for example, 1 day = 001, 10 days = 010, etc.

Mental health reporting: This field is optional. It measures the number of days a client must wait to enter a substance abuse treatment (not a mental health treatment). Reporting of this information on a mental health record is allowed only for clients with co-occurring mental health and substance abuse problems.

RELATED FIELDS: None
FIELD LENGTH: 3
DATA TYPE: Numeric (right-aligned and filled with zeros)
REFERENCE NO. AND COLUMN(S):
Admission record: SuDS 15: 132-134

VARIABLE NAME: DETAILED CRIMINAL JUSTICE REFERRAL

DESCRIPTION

This field provides more detailed information about those clients who are coded as *07 Criminal justice referral* in **Referral Source**.

VALID ENTRIES

Code	Description
01	STATE/FEDERAL COURT
02	OTHER COURT – Court other than state or federal court
03	PROBATION/PAROLE
04	OTHER RECOGNIZED LEGAL ENTITY – For example, local law enforcement agency, corrections agency, youth services, review board/agency
05	DIVERSIONARY PROGRAM – For example, TASC
06	PRISON
07	DUI/DWI
08	OTHER
96	NOT APPLICABLE – Use this code if **Referral Source** is not *07 Criminal justice referral*
97	UNKNOWN – Individual client value is unknown. This code should also be used when the state collects only a subset of the categories.
98	NOT COLLECTED – State does not collect this field.

VALIDATION EDITS

If this field is blank or contains an invalid value, the value will be changed to *99 Invalid data* and a warning error will be generated.

If **Referral Source** is not *07 Criminal justice referral* this field should be *96 Not applicable*, or a warning error will be generated.

GUIDELINES

Reporting of this field is optional for both substance abuse and mental health.

This field should have a valid value (not *96*) when **Referral Source** is *07 Criminal justice referral*. Code *96 Not applicable* must be used if **Referral Source** is other than *07 Criminal justice referral*.

If the state collects a subset of the categories, clients not fitting the subset should be coded as *97 Unknown*. For example, if the state collects only *07 DUI/DWI*, all other records where **Referral Source** is coded *07 Criminal justice referral* should code this field as *97 Unknown*.

RELATED FIELDS: **Referral Source**
FIELD LENGTH: 2
DATA TYPE: Numeric
REFERENCE NO. AND COLUMN(S):
Admission record: SuDS 13: 128-129

VARIABLE NAME: DETAILED DRUG CODE (PRIMARY, SECONDARY, TERTIARY)

DESCRIPTION

Identifies in greater detail the drug problem recorded in **Substance Abuse Problem (Primary, Secondary, Tertiary)**. Detailed drug codes enable distinction between substances in cases where a client uses two or more drugs that are assigned the same **Substance Abuse Problem** code.

Substance Abuse Problem		Detailed Substance Abuse Code	
Code	Substance	Code	Generic substance (brand name example)
01	None	9996	Not applicable
02	Alcohol	0201	Alcohol
03	Cocaine/crack	0301 0302	Crack Other cocaine
04	Marijuana/hashish	0401	Marijuana/hashish, THC, and any other cannabis sativa preparations
05	Heroin	0501	Heroin
06	Non-prescription Methadone	0601	Non-prescription Methadone
07	Other opiates and synthetics	0701 0702 0703 0704 0705 0706 0707 0708 0709 0710	Codeine Propoxyphene (Darvon) Oxycodone (Oxycontin) Meperidine (Demerol) Hydromorphone (Dilaudid) Butorphanol (Stadol), morphine (MS Contin), opium, and other narcotic analgesics, opiates, or synthetics Pentazocine (Talwin) Hydrocodone (Vicodin) Tramadol (Ultram) Buprenorphine (Subutex, Suboxone)
08	PCP – Phencyclidine	0801	PCP
09	Hallucinogens	0901 0902	LSD DMT, mescaline, peyote, psilocybin, STD, and other hallucinogens
10	Methamphetamine/Speed	1001	Methamphetamine/Speed
11	Other amphetamines	1101 1103 1109	Amphetamine Methylenedioxymethamphetamine (MDMA, Ecstasy) “Bath salts,” phenmetrazine, and other amines and related drugs
12	Other stimulants	1201 1202	Other stimulants Methylphenidate (Ritalin)

VARIABLE NAME: DETAILED DRUG CODE (PRIMARY, SECONDARY, TERTIARY)—continued

Substance Abuse Problem		Detailed Substance Abuse Code	
Code	Substance	Code	Generic substance (brand name example)
13	Benzodiazepines	1301 1302 1303 1304 1305 1306 1307 1308 1309 1310	Alprazolam (Xanax) Chlordiazepoxide (Librium) Clorazepate (Tranxene) Diazepam (Valium) Flurazepam (Dalmane) Lorazepam (Ativan) Triazolam (Halcion) Halazepam, oxazepam (Serax), prazepam, temazepam (Restoril), and other benzodiazepines Flunitrazepam (Rohypnol) Clonazepam (Klonopin, Rivotril)
14	Other tranquilizers	1401 1403	Meprobamate (Miltown) Other non-benzodiazepine tranquilizers
15	Barbiturates	1501 1502 1503 1509	Phenobarbital Secobarbital/Amobarbital (Tuinal) Secobarbital (Seconal) Amobarbital, pentobarbital (Nembutal), and other barbiturate sedatives
16	Other sedatives or hypnotics	1601 1602 1603 1604	Ethchlorvynol (Placidyl) Glutethimide (Doriden) Methaqualone (Quaalude) Chloral hydrate and other non-barbiturate sedatives/hypnotics
17	Inhalants	1701 1702 1703 1704 1705	Aerosols Nitrites Gasoline, glue, and other inappropriately inhaled products Solvents (paint thinner and other solvents) Anesthetics (chloroform, ether, nitrous oxide, and other anesthetics)
18	Over-the-counter medications	1801 1809	Diphenhydramine Other antihistamines, aspirin, Dextromethorphan (DXM) and other cough syrups, ephedrine, sleep aids, and any other legally obtained, non-prescription medication
20	Other drugs	2001 2002 2003 2004	Diphenylhydantoin/Phenytoin (Dilantin) Synthetic Cannabinoid (Spice), Carisoprodol (Soma), and other drugs GHB/GBL (gamma-hydroxybutyrate, gamma-butyrolactone) Ketamine (Special K)
96	Not applicable	9996	Not applicable – Use when the value in **Substance Abuse Problem** is *01 None*.
97	Unknown	9997	Unknown – Individual client value is unknown.
98	Not collected	9998	Not collected – State does not collect this field.

VARIABLE NAME: DETAILED DRUG CODE (PRIMARY, SECONDARY, TERTIARY)—continued

VALIDATION EDITS

If this field is blank or contains an invalid value, the value will be changed to *9999 Invalid data* and a warning error will be generated.

The two-digit **Substance Abuse Problem** codes form the first two digits of the associated **Detailed Drug** code. The table above indicates the **Substance Abuse Problem** and associated **Detailed Drug** codes.

For a substance abuse admission record, if a **Detailed Drug** code is not a valid subset of the corresponding **Substance Abuse Problem**, the **Detailed Drug** code field value will be replaced by *9999 Invalid data*. For example, if **Substance Abuse Problem** contains the value *03 Cocaine, crack*, then the **Detailed Drug** code must contain the value *0301 Crack* or *0302 Other cocaine*.

When this information is reported on a mental health record, **Co-occurring Substance Abuse and Mental Health Problems** must be *1 Yes*, or a warning error will be generated.

GUIDELINES

This field is optional for both substance abuse and mental health.

A record may not have duplicate **Substance Abuse Problem** codes with identical **Routes of Administration** unless the **Detailed Drug** codes are different.

The following example uses **Substance Abuse Problem** code *13 Benzodiazepines* and **Detailed Drug** codes *1301 Alprazolam* and *1304 Diazepam*.

For example:

- The primary and secondary **Substance Abuse Problem** codes are both *13 Benzodiazepines*.
- The primary and secondary **Routes of Administration** are both *01 Oral*.

If the **Detailed Drug** code is not collected, the primary and secondary substances are considered duplicates, and the secondary **Substance Abuse Problem** and **Route of Administration** codes will be set to *99 Invalid data*.

However, if the primary **Detailed Drug** code is *1301 Alprazolam* and the secondary code is *1304 Diazepam*, the primary and secondary substances would be considered as different substances.

Drug code description modifications: Please note that the descriptions for the following drug codes were modified in 2014 to provide clarity by naming specific drugs that may be reported within the category:

Old description (before 2014):	New description:	
0706 Other Opiates or Synthetics	0706	Butorphanol (Stadol), morphine (MS Contin), opium, and other narcotic analgesics, opiates, or synthetics
1109 Other Amphetamines	1109	“Bath Salts,” phenmetrazine, and other amines and related drugs
1809 Other Over-the-counter	1809	Other antihistamines, aspirin, Dextromethorphan (DXM) and other cough syrups, ephedrine, sleep aids, and any other legally obtained, non-prescription medication
2002 Other Drugs	2002	Synethic Cannabinoid “Spice,” Carisoprodol (Soma), and other drugs

VARIABLE NAME: DETAILED DRUG CODE (PRIMARY, SECONDARY, TERTIARY)—continued

Drug code corrections: The following corrections were made in 2014.

Old code (before 2014):	Correct code:
1010 Methamphetamine/Speed (The old code was printed in past versions of the TEDS manual)	1001 Methamphetamine/Speed
1203 Other Stimulants	1201 Other Stimulants
1605 Other Sedatives	Dropped because redundant
For barbiturate sedatives, use:	1509 Amobarbital, pentobarbital (Nembutal), and other barbiturate sedatives
For non-barbiturate sedatives, use:	1604 Chloral hydrate and other non-barbiturate sedatives/hypnotics

Not new (contained in the August 2008 TEDS Manual) but recently added to crosswalk:

0710 Buprenorphine (Subutex, Suboxone)

Mental health reporting: This field is optional. Reporting of this information on a mental health record is allowed only for clients with co-occurring mental health and substance abuse problems.

RELATED FIELDS: **Substance Abuse Problem**, **Route of Administration**

Mental health reporting: **Co-occurring Substance Abuse and Mental Health Problems**

FIELD LENGTH: 4

DATA TYPE: Numeric

REFERENCE NO. AND COLUMN(S):

Admission record: SuDS 1: 97-100
SuDS 2: 101-104
SuDS 3: 105-108

VARIABLE NAME: DETAILED NOT IN LABOR FORCE

DESCRIPTION

Provides more detailed information about those clients who are coded as *04 Not in labor force* in **Employment Status**.

VALID ENTRIES

Code	Description
01	HOMEMAKER
02	STUDENT
03	RETIRED
04	DISABLED
05	RESIDENT OF INSTITUTION – Persons receiving services from institutional facilities such as hospitals, jails, prisons, long-term residential care, etc.
06	OTHER - For example, volunteer, seasonal worker, other categories used by the state not specified
07	SHELTERED/NON-COMPETITIVE EMPLOYMENT (Mental health only)
96	NOT APPLICABLE – Use this code if **Employment Status** is not *04 Not in labor force*.
97	UNKNOWN – Individual client value is unknown. This code should also be used when the state collects only a subset of the categories.
98	NOT COLLECTED – State does not collect this field.

VALIDATION EDITS

If this field is blank or contains an invalid value, the value will be changed to *99 Invalid data* and a warning error will be generated.

This field should be used only when **Employment Status** is *04 Not in labor force*. For all other **Employment Status** codes, this field should be coded *96 Not applicable*.

If this field has a valid value other than *96 Not applicable* when Employment Status is not *04 Not in labor force*, the value will be changed to *99 Invalid data* and a warning will be generated.

GUIDELINES

Detailed Not in Labor Force is defined by SAMHSA as an outcome measure, and is collected at admission and at discharge/update to assess change.

- If the state collects a subset of the categories, clients not fitting the subset should be coded as *97 Unknown*. For example, if the state collects only *04 Disabled*, all other records where **Employment Status** is coded *04 Not in labor force* should use *97 Unknown* for this field.
- If the state does not collect **Detailed Not in Labor Force**, all records should be coded *98 Not collected*.

Mental health reporting: Report this field for clients aged 16 and older whose **Employment Status** is coded *04 Not in labor force*. If the state does not collect **Employment Status** for clients 16 and 17 years old or if the client is under age 16, this field should be coded as *98 Not collected*.

VARIABLE NAME: DETAILED NOT IN LABOR FORCE—continued

RELATED FIELDS: **Employment Status**

FIELD LENGTH: 2

DATA TYPE: Numeric

REFERENCE NO. AND COLUMN(S):

Admission record: SuDS 12: 126-127

Discharge record: DIS 25: 132-133

VARIABLE NAME: DIAGNOSTIC CODE (DSM OR ICD)

DESCRIPTION

States are expected to begin reporting the new fields for substance abuse diagnosis and mental health diagnoses. This field will be retired.

Client diagnosis can be reported in this field by using either the *Diagnostic and Statistical Manual of Mental Disorders (DSM)* from the American Psychiatric Association or the *International Classification of Diseases - 9 (ICD)* from the World Health Organization. To report an ICD-10 diagnostic code, state should use SuDS 19, MHA 1a-c, and MHD 2a-c.

VALID ENTRIES

Code	Description (acceptable diagnostic code formats)
XXX.XX	
XXX_ _ _	where "_" represents a blank
XXX._ _	where "_" represents a blank
XXX.X_	where "_" represents a blank
999.97	UNKNOWN – Individual client value is unknown.
999.98	NOT COLLECTED – State does not collect this field.

VALIDATION EDITS

If this field is blank or contains an invalid value, the value will be changed to *999.99 Invalid data* and a warning error will be generated.

GUIDELINES

For states that have not transitioned to using the substance abuse and mental health diagnostic code fields, reporting of substance abuse diagnosis in this field is preferred, but mental health diagnosis is also acceptable.

Substance abuse reporting: States should endeavor to transition to using **SuDS 19 Substance Abuse Diagnosis** and **MHA 1a-c Mental Health Diagnosis**. These diagnostic code fields can accept any version of the DSM and ICD.

Mental health reporting: Use **SuDS 19 Substance Abuse Diagnosis** to report SA diagnosis and **MHA 1a-c** and **MHD 2a-c Mental Health Diagnosis** to report MH diagnoses. Use *999.98 Not collected* for this field.

While a three-character code with no decimal or following digits will be accepted, more complete diagnoses have at least one digit to the right of the decimal. States should strive to obtain complete coding with sufficient digits to accurately code the diagnosis.

RELATED FIELDS: None
FIELD LENGTH: 6
DATA TYPE: Alphanumeric (left-justified and filled with blank spaces)
REFERENCE NO. AND COLUMN(S):
Admission record: SuDS 4: 109-114

VARIABLE NAME: DIAGNOSTIC CODE SET IDENTIFIER

DESCRIPTION

This field indicates the diagnostic code set(s) used to report the **Substance Abuse Diagnosis** and/or **Mental Health Diagnoses (One, Two, Three)** for a client.

VALID ENTRIES

Code	Description
1	DSM-IV
2	ICD-9
3	ICD-10
4	DSM-5
5	DSM-IIIR
7	UNKNOWN – Individual client value is unknown.
8	NOT COLLECTED – State does not collect this field.

VALIDATION EDITS

If this field is blank or contains an invalid value, the value will be changed to *9 Invalid data* and a warning error will be generated.

If **Substance Abuse Diagnosis** and/or **Mental Health Diagnosis (One, Two, Three)** contains a valid diagnostic code (i.e., other than *999.9997 Unknown* or *999.9998 Not Collected*) then this field should have a valid value (codes 1 through 5 only) or a warning error will be generated.

GUIDELINES

Consistent use of one type of diagnostic code set should be observed when reporting the SA and MH diagnostic codes for each record. TEDS will accept different code sets used across the submitted records, although this practice is not strongly encouraged.

Substance abuse reporting:

- States that are not yet using this data field should continue to report the diagnostic code set information in the state data crosswalk. Under this circumstance, the state cannot report diagnostic codes using different code sets for each record, that is, the state should choose only one diagnostic code set (e.g., ICD-9) to report the client diagnosis across all records.
- The **Diagnostic Code Set Identifier** must be used if the fields **Substance Abuse Diagnosis** and/or **Mental Health Diagnoses (One, Two, and Three)** are used.

Mental health reporting:

- The **Diagnostic Code Set Identifier** and **Mental Health Diagnosis (One, Two, and Three)** are collected at admission and at time of update/discharge to assess change.

RELATED FIELDS: **Substance Abuse Diagnosis**, **Mental Health Diagnosis (One, Two, and Three)**

FIELD LENGTH: 1

DATA TYPE: Numeric

VARIABLE NAME: DIAGNOSTIC CODE SET IDENTIFIER—continued

REFERENCE NO. AND COLUMN(S):

Admission record: SuDS 18: 139

Update/Discharge record: MHD 1: 139

VARIABLE NAME: EDUCATION

DESCRIPTION

This field specifies a) the highest school grade completed for adults or children not attending school or b) current school grade for school-age children (3-17 years old) attending school.

VALID ENTRIES

Code	Description
00	LESS THAN ONE SCHOOL GRADE OR NO SCHOOLING
01-11	GRADES 1-11 (specify current or highest attained grade level per guideline)
12	GRADE 12 OR GED
13	1st YEAR OF COLLEGE/UNIVERSITY (Freshman)
14	2nd YEAR OF COLLEGE/UNIVERSITY (Sophomore) or ASSOCIATE DEGREE
15	3rd YEAR OF COLLEGE/UNIVERSITY (Junior)
16	4th YEAR OF COLLEGE/UNIVERSITY (Senior) or BACHELOR'S DEGREE
17	SOME POST-GRADUATE STUDY – Degree not completed
18	MASTER'S DEGREE COMPLETED
19-25	POST-GRADUATE STUDY
70	GRADUATE OR PROFESSIONAL SCHOOL – Includes Master's and doctoral study or degrees, medical school, law school, etc. ***This code may be used instead of detailed codes 17-25.***
71	VOCATIONAL SCHOOL – Includes business, technical, secretarial, trade, or correspondence courses which provide specialized training for skilled employment
72	NURSERY SCHOOL, PRE-SCHOOL – Includes Head Start
73	KINDERGARTEN
74	SELF-CONTAINED SPECIAL EDUCATION CLASS – No grade level equivalent
97	UNKNOWN – Individual client value is unknown.
98	NOT COLLECTED – State does not collect this field.

VALIDATION EDITS

If this field is blank or contains an invalid value, the value will be changed to *99 Invalid data* and a warning error will be generated.

Substance abuse reporting: Field edit is performed but not age check and relational edit vis-à-vis **School Attendance**.

Mental health reporting: If school age (within 3 through 17, or 18 through 21 for young adults under IDEA), this field must have a valid value when **School Attendance** is either *1 Yes* or *2 no*, or the field value will be replaced with the system code *99 Invalid data*. If the reported value is *98 Not collected*, the state is requested to briefly describe its data collection plan for this mental health NOM. Note: Age will be calculated at midpoint of the state's elected reporting period. Age is not rounded-up.

VARIABLE NAME: EDUCATION—continued

GUIDELINES

Substance abuse reporting: This data element is collected as the highest school grade completed for substance abuse clients. It is reported only at time of admission.

Please use the code corresponding to the appropriate grade level. Instead of reporting 17-25 years in school, you may also use code 70.

Mental health reporting: This data field is related to the field value reported in **School Attendance**. Additional guidelines below should be observed to remain consistent with mental health NOMS reporting.

- Report *current grade level* for school-age children (3-17 years old and 18-21 years of age if the client is in special education) who attended school at any time in the past three months.
- Report *highest grade level* completed for school-age children who have not attended school at any time within the past three months.
- Report *highest grade level* completed for all adults, whether currently in school or not.
- For non-school-age children (age less than 3 years), use code *00 Less than one school grade*.

School includes, but is not limited to, any one or combination of home-schooling, online education, alternative school, vocational school, or regular school (public, private, charter, traditional, military, magnet, independent, parochial, etc.), at which the child is enrolled in any of the following school grade levels: nursery/pre-school (including Head Start), kindergarten, elementary/middle school (Grades 1-8), middle/high school (Grades 9-12, including General Equivalency Degree or GED), vocational school (including business, technical, secretarial, trade, or correspondence courses which are not counted as regular school enrollment and are not for recreation or adult education classes), or college/professional degree.

If the information is collected at the time when the school year just ended, report the recent school grade level completed (not the grade level the child is advancing to in the next school year).

For children who are home-schooled or children in special education but have been mainstreamed in regular school grades, please report the equivalent grade level.

Use code *74 Self-contained special education* for children in a special education class that does not have an equivalent school grade level.

Code *72 Nursery school/pre-school, including Head Start* is used typically for children ages 3-4 years old (but may also apply to older children) who meet the following definition of nursery school/pre-school. Use code *00 Less than one school grade* for children 3-4 years old who do not meet this definition.

A nursery school is defined as a group or class that is organized to provide educational experiences for children during the year or years preceding kindergarten. It includes instruction as an important and integral phase of its program of child care. Private homes in which essentially custodial care is provided are not considered nursery schools. Children attending nursery school are classified as attending during either part of the day or the full day. Part-day attendance refers to those who attend either in the morning or in the afternoon, but not both. Full-day attendance refers to those who attend in both the morning and the afternoon. Children enrolled in Head Start programs or similar programs sponsored by local agencies to provide preschool education to young children are counted under nursery school. (Source: The American Community Survey).

VARIABLE NAME: EDUCATION—continued

RELATED FIELDS: **School Attendance**
FIELD LENGTH: 2
DATA TYPE: Numeric
REFERENCE NO. AND COLUMN(S):
Admission record: MDS 12: 68-69
Discharge record: MHD 5: 166-167

VARIABLE NAME: EMPLOYMENT STATUS

DESCRIPTION

This field identifies the client's employment status.

VALID ENTRIES

Code	Description
01	FULL TIME – Working 35 hours or more each week, including active duty members of the uniformed services
02	PART TIME – Working fewer than 35 hours each week
03	UNEMPLOYED – Looking for work during the past 30 days or on layoff from a job
04	NOT IN LABOR FORCE – Not looking for work during the past 30 days or a student, homemaker, disabled, retired, or an inmate of an institution. ***Clients in this category are further defined in*** **Detailed Not in Labor Force**.
05	EMPLOYED, FULL/PART-TIME NOT SPECIFIED (TEMPORARY CODE, may be used in mental health reporting only)
97	UNKNOWN – Individual client value is unknown.
98	NOT COLLECTED – State does not collect this field.

VALIDATION EDITS

If this field is blank or contains an invalid value, the value will be changed to *99 Invalid data* and a warning error will be generated.

GUIDELINES

Detailed Not in Labor Force provides a detailed breakdown of the category *04 Not in labor force*. All records with this category should have an entry in **Detailed Not in Labor Force**.

Employment Status is defined by SAMHSA as an outcome measure and is collected at admission and at discharge/update to assess change.

Seasonal workers are coded based on employment status at the time of measurement. For a seasonal worker employed full time at the time of measurement, **Employment Status** should be coded *01 Full time*. A seasonal worker who is not in the labor force at the time of measurement should be coded *04 Not in labor force.*

Substance abuse reporting: Use codes 01 through 04, 97, and 98 only.

Mental health reporting: Report **Employment Status** only for clients aged 16 and older. If the state does not collect employment status for clients 16 and 17 years old or the client is under age 16, the field should be coded as *98 Not collected*.

If a state does not collect full-time and part-time employment separately, the code *05 Employed, Full/Part-time not specified* should be used. States are encouraged to develop the capacity to collect and report both full-time and part-time employment.

Additional guidelines for mental health reporting are provided below to remain consistent with the mental health NOMs reporting:

VARIABLE NAME: EMPLOYMENT STATUS—continued

Coding of clients with overlapping employment statuses:
When clients are engaged in two or more activities (have overlapping statuses) during the period when their status is collected by the SMHA, use the Department of Labor's system of priorities to determine the appropriate employment status. The prioritization rule is that labor force activities (such as working or looking for work) take precedence over non-labor force activities (such as student and homemaker), and working or having a job takes precedence over looking for work.

Use code *01 Full time, 02 Part time*, or *05 Employed Full/Part-time not specified* if the client is employed and a student or is employed and retired.

Use code *03 Unemployed* if the client is a student and actively searching for work (includes sending out resumes, visiting unemployment centers, interviewing, etc.)

Refer to **http://www.bls.gov/cps/cps_htgm.htm** for more information on the government measurement of unemployment from the Bureau of Labor Statistics.

Reporting of a person in an internship program:
The Individuals with Disabilities Education Act (IDEA) ceases to apply for young adults (18-21 years old) once they receive their high school diploma. The following rules should be observed in determining whether the adult client in an internship program should be reported as *04 Not in labor force*, *01 Full time*, *02 Part time*, or *05 Employed Full/Part-time not specified*.

1. If the internship is a school requirement, whether paid or not, the person should be considered a "student" (**Employment Status** code *04 Not in labor force* and **Detailed Not in Labor Force** code *02 Student*).
2. If the internship is not a school requirement, is an unpaid position, does not displace regular employees, or does not entitle the person to a job at the end of the internship period, then report the person's status as **Employment Status** code *04 Not in labor force* and **Detailed Not in Labor Force** code *06 Other*.
3. If the internship is not a school requirement, pays minimum wage with an overtime provision, the employer benefits from the internship through the client's engagement in actual operations of the business and performing productive work, then the person is employed (*01 Full time*, *02 Part time*, or *05 Employed Full/Part-time not specified*).

RELATED FIELDS: **Detailed Not in Labor Force**
FIELD LENGTH: 2
DATA TYPE: Numeric
REFERENCE NO. AND COLUMN(S):
Admission record: MDS 13: 70-71
Discharge record: DIS 24: 130-131

VARIABLE NAME: FREQUENCY OF USE (OF PRIMARY, SECONDARY, TERTIARY SUBSTANCES)

DESCRIPTION

Specifies the frequency of use of the corresponding substance identified in **Substance Abuse Problem (Primary, Secondary, Tertiary)**.

VALID ENTRIES

Code	Description
01	NO USE IN THE PAST MONTH
02	1-3 DAYS IN THE PAST MONTH
03	1-2 DAYS IN THE PAST WEEK
04	3-6 DAYS IN THE PAST WEEK
05	DAILY
96	NOT APPLICABLE
97	UNKNOWN – Individual client value is unknown.
98	NOT COLLECTED – State does not collect this field.

VALIDATION EDITS

If this field is blank or contains an invalid value, the value will be changed to *99 Invalid data* and a warning error will be generated.

When this information is reported on a mental health record, **Co-occurring Substance Abuse and Mental Health Problems** must be *1 Yes*, or a warning error will be generated.

GUIDELINES

Substance abuse reporting: **Frequency of Use** is defined by SAMHSA as an outcome measure, and is collected at admission and at discharge, with the related variable **Substance Abuse Problem**, to assess change.

Mental health reporting: This field is optional. Reporting of this information on a mental health record is allowed only for clients with co-occurring mental health and substance abuse problems.

RELATED FIELDS: **Substance Abuse Problem**, **Route of Administration**, **Age at First Use**, **Detailed Drug Code**
Mental health reporting: **Co-occurring Substance Abuse and Mental Health Problems**

FIELD LENGTH: 2

DATA TYPE: Numeric

REFERENCE NO. AND COLUMN(S):

Admission record: MDS 16a: 76-77
MDS 16b: 84-85
MDS 16c: 92-93

Discharge record: DIS 22a: 122-123
DIS 22b: 124-125
DIS 22c: 126-127

VARIABLE NAME: GENDER

DESCRIPTION

This field identifies the client's gender.

VALID ENTRIES

Code	Description
1	MALE
2	FEMALE
7	UNKNOWN – Individual client value is unknown.
8	NOT COLLECTED – State does not collect this field.

VALIDATION EDITS

If this field is blank or contains an invalid value, the value will be changed to *9 Invalid data* and a warning error will be generated.

If **Gender** is *1 Male*, then **Pregnant at Admission** must be *6 Not applicable*.

GUIDELINES

Transgender clients should be coded as the gender with which the client identifies:

- Transgender male (designated female at birth but identifies as male) - code as *1 Male*
- Transgender female (designated male at birth but identifies as female) - code as *2 Female*

RELATED FIELDS: **Pregnant at Admission**
FIELD LENGTH: 1
DATA TYPE: Numeric
REFERENCE NO. AND COLUMN(S):
Admission record: MDS 9: 63
Discharge record: DIS 18: 111

VARIABLE NAME: HEALTH INSURANCE

DESCRIPTION

This field specifies the client's health insurance at admission. The insurance may or may not cover behavioral health treatment.

VALID ENTRIES

Code	Description
01	PRIVATE INSURANCE (other than Blue Cross/Blue Shield or an HMO)
02	BLUE CROSS/BLUE SHIELD
03	MEDICARE
04	MEDICAID
06	HEALTH MAINTENANCE ORGANIZATION (HMO)
20	OTHER (e.g., TRICARE)
21	NONE
97	UNKNOWN – Individual client value is unknown. This code should also be used if the state collects Medicare and Medicaid as a single category.
98	NOT COLLECTED – State does not collect this field. This code should also be used when the state collects only a subset of the categories.

VALIDATION EDITS

If this field is blank or contains an invalid value, the value will be changed to *99 Invalid data* and a warning error will be generated.

GUIDELINES

Reporting of this field is optional for both substance abuse and mental health clients. States are encouraged to report data for all categories in the list of valid entries, but reporting a subset of the categories is acceptable. **Health Insurance** should be reported, if collected, whether or not it covers behavioral health treatment.

- If the state collects a subset of the categories, clients not fitting the subset should be coded as *98 Not collected*. For example, if the state collects only *03 Medicare* and *04 Medicaid*, all other categories of **Health Insurance** should be coded as *98 Not collected*.
- If a state collects Medicare and Medicaid as a single category, **Health Insurance** should be coded as *97 Unknown*.
- If the state does not collect **Health Insurance**, all records should be coded *98 Not collected*.

RELATED FIELDS: None
FIELD LENGTH: 2
DATA TYPE: Numeric
REFERENCE NO. AND COLUMN(S):
Admission record: SuDS 10: 122-123

VARIABLE NAME: HISPANIC OR LATINO ORIGIN (ETHNICITY)

DESCRIPTION

This field identifies client's specific Hispanic or Latino origin, if applicable.

VALID ENTRIES

Code	Description
01	PUERTO RICAN – Of Puerto Rican origin regardless of race
02	MEXICAN – Of Mexican origin regardless of race
03	CUBAN – Of Cuban origin regardless of race
04	OTHER SPECIFIC HISPANIC OR LATINO – Of known Central or South American or any other Spanish culture or origin (including Spain), other than Puerto Rican, Mexican, or Cuban, regardless of race
05	NOT OF HISPANIC OR LATINO ORIGIN
06	HISPANIC OR LATINO—SPECIFIC ORIGIN NOT SPECIFIED – Of Hispanic or Latino origin, but origin not known or not specified
97	UNKNOWN – Individual client value is unknown.
98	NOT COLLECTED – State does not collect this field.

VALIDATION EDITS

If this field is blank or contains an invalid value, the value will be changed to *99 Invalid data* and a warning error will be generated.

GUIDELINES

If a state simply collects Hispanic or Latino origin as "Yes/No," use code *06 Hispanic or Latino, origin not specified* for a "Yes" response.

If a state collects Hispanic or Latino origin as a "Race" category, then **Hispanic or Latino Origin (Ethnicity)** should be coded as *06 Hispanic or Latino, origin not specified* and **Race** should be coded as *97 Unknown*.

RELATED FIELDS: **Race**
FIELD LENGTH: 2
DATA TYPE: Numeric
REFERENCE NO. AND COLUMN(S):
Admission record: MDS 11: 66-67
Discharge record: DIS 20: 114-115

VARIABLE NAME: LEGAL STATUS AT ADMISSION TO STATE HOSPITAL

DESCRIPTION

This field identifies the client's legal status at the time of admission to a state psychiatric hospital.

VALID ENTRIES

Code	Description
01	VOLUNTARY – Self
02	VOLUNTARY – Others (by guardian, parents, etc.)
03	INVOLUNTARY – Civil
04	INVOLUNTARY – Criminal
05	INVOLUNTARY – Juvenile Justice
06	INVOLUNTARY – Civil - Sexual
96	NOT APPLICABLE – Use this code if **Type of Treatment Service/Setting** is not *72 State psychiatric hospital*
97	UNKNOWN – Individual client value is unknown.
98	NOT COLLECTED – State does not collect this field.

VALIDATION EDITS

If this field is blank or contains an invalid value, the value will be changed to *99 Invalid data* and a warning error will be generated.

This field should be used only when **Type of Treatment Service/Setting** is *72 State psychiatric hospital*. For all other **Type of Treatment Service/Setting** codes, this field should be coded *96 Not applicable*.

GUIDELINES

This information is used to report the State Hospital 30-day and 180-day Readmission Rates NOM by forensic and non-forensic status based on the client's legal status at time of admission at the state psychiatric hospital.

Codes *01 Voluntary-Self*, *02 Voluntary - Others*, and *03 Involuntary - Civil* are classified as non-forensic while codes *04 Involuntary - Criminal*, *05 Involuntary - Juvenile Justice*, and *06 Involuntary - Civil-Sexual* are classified as forensic.

Use code *03 Involuntary - Civil* for individuals who are committed for dangerousness due to mental illness.

Use code *04 Involuntary - Criminal* for juvenile clients who are adjudicated as adults.

Use code *06 Involuntary - Civil-Sexual* for clients civilly committed under laws that are referred to as 'sexual predator' laws in some states. This differs from code *03 Involuntary - Civil*.

Use code *97 Unknown* if the state collects these data but for some reason a particular record does not reflect an acceptable value.

Use code *98 Not collected* if the state does not collect these data either for all clients or a particular subset of the population.

VARIABLE NAME: LEGAL STATUS AT ADMISSION TO STATE HOSPITAL—continued

RELATED FIELDS: **Type of Treatment Service/Setting**
FIELD LENGTH: 2
DATA TYPE: Numeric
REFERENCE NO. AND COLUMN(S):
Admission record: MHA 4: 174-175

VARIABLE NAME: LIVING ARRANGEMENTS

DESCRIPTION

Identifies whether the client is homeless, a dependent (living with parents or in a supervised setting), or living independently on his or her own.

VALID ENTRIES

Code	Description
01	HOMELESS – Clients with no fixed address; includes homeless shelters
02	DEPENDENT LIVING – Clients living in a supervised setting such as a residential institution, halfway house, or group home, and children (under age 18) living with parents, relatives, or guardians or (substance abuse clients only) in foster care
22	DEPENDENT LIVING: RESIDENTIAL CARE – Individual resides in a residential care facility. This level of care may include a group home therapeutic group home, board and care, residential treatment, rehabilitation center, or agency-operated residential care facilities.
32	DEPENDENT LIVING: FOSTER HOME/FOSTER CARE – Client resides in a foster home, i.e., a home that is licensed by a county or state department to provide foster care to children, adolescents, and/or adults. This category includes therapeutic foster care facilities, a service that provides treatment for troubled children within private homes of trained families.
42	DEPENDENT LIVING: CRISIS RESIDENCE – A time-limited residential (24 hours/day) stabilization program that delivers services for acute symptom reduction and restores clients to a pre-crisis level of functioning
52	DEPENDENT LIVING: INSTITUTIONAL SETTING – Client resides in an institutional care facility providing care 24 hours/day, 7 days/week. May include skilled nursing/intermediate care facility, nursing homes, institute of mental disease (IMD), inpatient psychiatric hospital, psychiatric health facility, veterans' affairs hospital, state hospital, or Intermediate Care Facility/MR.
62	DEPENDENT LIVING: JAIL/CORRECTIONAL FACILITY/OTHER INSTITUTIONS UNDER THE JUSTICE SYSTEM – Client resides in a jail, correctional facility, detention center, prison, or other institution under the justice system with care provided on 24 hours/day, 7 days/week.
72	DEPENDENT LIVING: PRIVATE RESIDENCE – Adult clients living in a house, apartment, or other similar dwelling who are heavily dependent on others for daily living assistance
03	INDEPENDENT LIVING – Clients living alone or with others in a private residence and capable of self-care. Includes adult children (age 18 and over) living with parents and adolescents living independently. Also includes clients who live independently with case management or supported housing support.
04	PRIVATE RESIDENCE, LIVING ARRANGEMENT NOT SPECIFIED – Living arrangements of adult clients not known (temporary code)
97	UNKNOWN – Individual client value is unknown.
98	NOT COLLECTED – State does not collect this field. This code should also be used when the state collects only a subset of the categories.

VALIDATION EDITS

If this field is blank or contains an invalid value, the value will be changed to *99 Invalid data* and a warning error will be generated.

VARIABLE NAME: LIVING ARRANGEMENTS—continued

GUIDELINES

Living Arrangements is defined by SAMHSA as an outcome measure and is collected at admission and at discharge/update/ to assess change.

States are encouraged to report data for all categories in the list of valid entries, but reporting a subset of the categories is acceptable.

- If the state collects a subset of the categories, clients not fitting the subset should be coded as *98 Not collected*. For example, if the state collects only *01 Homeless*, all other categories of **Living Arrangements** should be coded as *98 Not collected*.

Substance abuse reporting: May continue to use codes 1 through 3, 97, and 98 only.

Mental health reporting: Use all codes, particularly the finer breakdown of the Dependent Living category (codes 02 through 72) in reporting living arrangements.

- **Use *02 Dependent Living* for children under age 18 living with parents, relatives, or guardians but use code *32 Foster Care/Foster Home* if living under a foster care arrangement.**
- **Use *22 Dependent Living Residential Care* if living arrangement is with a residential care facility, including Residential Treatment Centers (RTCs).**
- **Use *72 Dependent Living in Private Residence* only for adults; use *02 Dependent Living* for children.**

RELATED FIELDS: None
FIELD LENGTH: 2
DATA TYPE: Numeric
REFERENCE NO. AND COLUMN(S):
Admission record: SuDS 8: 118-119
Discharge record: DIS 23: 128-129

VARIABLE NAME: MARITAL STATUS

DESCRIPTION

This field describes the client's marital status. The following categories are compatible with categories used in the U.S. Census.

VALID ENTRIES

Code	Description
01	NEVER MARRIED – Includes clients who are single or whose only marriage was annulled
02	NOW MARRIED – Includes married couples, those living together as married, living with partners, or cohabiting
03	SEPARATED – Includes those legally separated or otherwise absent from spouse because of marital discord
04	DIVORCED
05	WIDOWED
97	UNKNOWN – Individual client value is unknown.
98	NOT COLLECTED – State does not collect this field.

VALIDATION EDITS

If this field is blank or contains an invalid value, the value will be changed to *99 Invalid data* and a warning error will be generated.

GUIDELINES

Reporting of this field is optional for both substance abuse and mental health clients.

RELATED FIELDS: None
FIELD LENGTH: 2
DATA TYPE: Numeric
REFERENCE NO. AND COLUMN(S):
Admission record: SuDS 14: 130-131

VARIABLE NAME: MEDICATION-ASSISTED OPIOID THERAPY

DESCRIPTION

This field identifies whether the use of opioid medications such as methadone or buprenorphine is part of the client's treatment plan.

VALID ENTRIES

Code	Description
1	YES
2	NO
6	NOT APPLICABLE
7	UNKNOWN – Individual client value is unknown.
8	NOT COLLECTED – State does not collect this field.

VALIDATION EDITS

If this field is blank or contains an invalid value, the value will be changed to *9 Invalid data* and a warning error will be generated.

When this information is reported on a mental health record, **Co-occurring Substance Abuse and Mental Health Problems** must be *1 Yes*, or a warning error will be generated.

GUIDELINES

Substance abuse reporting: If the client is not in treatment for an opioid problem (codes *05 Heroin*, *06 Non-prescription methadone*, or *07 Other opiates and synthetics*) in one of the **Substance Abuse Problem** fields, this field may be coded *6 Not applicable*. This is not mandatory because it is possible that the client is being treated with opioid therapy for a substance abuse problem not among the maximum of three that can be listed.

Mental health reporting: This field is optional. Reporting of this information on a mental health record is allowed only for clients with co-occurring mental health and substance abuse problems.

RELATED FIELDS: None
FIELD LENGTH: 1
DATA TYPE: Numeric
REFERENCE NO. AND COLUMN(S):
Admission record: MDS 19: 96

VARIABLE NAME: MENTAL HEALTH DIAGNOSIS (ONE, TWO, THREE)

DESCRIPTION

Client's diagnosis is used to identify the mental health problem that provides the reason for client encounter or treatment. This can be reported by using either the *Diagnostic and Statistical Manual of Mental Disorders (DSM)* from the American Psychiatric Association or the *International Classification of Diseases (ICD)* from the World Health Organization.

VALID ENTRIES

Code	Description (acceptable diagnostic code formats)
XXX.XXXX	
XXX_ _ _ _ _	where "_" represents a trailing blank space
XXX._ _ _ _	where "_" represents a trailing blank space
XXX.X_ _ _	where "_" represents a trailing blank space
XXX.XX _ _	where "_" represents a trailing blank space
XXX.XXX _	where "_" represents a trailing blank space
999.9997	UNKNOWN – Individual client value is unknown.
999.9998	NOT COLLECTED – State does not collect this field.

VALIDATION EDITS

If this field is blank or contains an invalid value, the value will be changed to *999.9999 Invalid data* and a warning error will be generated.

Duplicate diagnostic codes across the three **Mental Health Diagnosis** fields are not permitted. If duplicate codes are found, the first occurrence will be processed but succeeding occurrences will be replaced with *999.9999 Invalid data*, and a warning error will be issued.

When this information is reported on a substance abuse record, **Co-occurring Substance Abuse and Mental Health Problems** must be *1 Yes,* or a warning error will be generated.

GUIDELINES

Substance abuse reporting: This field is optional. Reporting of this information on a substance abuse record is allowed only for clients with co-occurring mental health and substance abuse problems.

Mental Health reporting: This field is collected for mental health clients at admission and at discharge/update to assess change.

States can report up to three mental health diagnoses by completing the **Mental Health Diagnosis (One, Two, Three)** data elements in sequential order (i.e., you are not allowed to report a valid code in the **Mental Health Diagnosis – Three** field if **Mental Health Diagnosis – One and Two** fields are coded *999.9997 Unknown* or *999.9998 Not Collected*. Substance abuse diagnosis should be reported in the **SuDS 19 Substance Abuse Diagnosis** field.

While a three-character code with no decimal or following digits will be accepted, more complete diagnoses have at least one digit to the right of the decimal. States should strive to obtain complete coding with sufficient digits to accurately code the diagnosis.

If the client has more than three mental health diagnoses, use the algorithm below.

VARIABLE NAME: MENTAL HEALTH DIAGNOSIS (ONE, TWO, THREE)—continued

If the diagnoses are collected through administrative method (i.e., based on the clinician's evaluation of the person and reported in the client's case record):

1. Report the primary and secondary diagnoses, if available
2. If primary/secondary diagnoses are not identified, **and**
   a. if the state is using DSM-IV or earlier editions, or the state has retained the DSM axial structure, then

      - Conduct your search for diagnostic codes using both Axis I and II. Report all diagnoses in Axis I (clinical disorders) first followed by diagnosis in Axis II (personality disorders and mental retardation) unless a personality disorder in Axis II was labeled as primary diagnosis, then it should be reported first;

   b. if axis classifications are no longer used (such as in DSM-5), then

      - Report in chronological order starting from the diagnosis that appears on top of the list or first cited in the clinician's report.

If the state is using claims/encounter data to collect a client's diagnosis and multiple diagnostic codes are reported, use the following rule:

- Use the three most cited mental health diagnoses in client service claims/encounters data available within the timeframe of the reported treatment event. The state should describe in the data crosswalk the method used.

Mental health and personality disorder codes should be given priority in reporting over no diagnosis (V71.09), deferred diagnosis (799.9), and other V/Z codes unless these are the only diagnoses on record.

If the client has only one reported mental health diagnosis, use code *999.9997 Unknown* for **Mental Diagnoses Two and Three**. However, if it is state policy to collect no more than one mental health diagnosis, use code *999.9998 Not collected* for **Mental Diagnoses Two and Three**.

RELATED FIELDS: **Diagnostic Code Set Identifier**
FIELD LENGTH: 8
DATA TYPE: Alphanumeric (left-aligned and filled with blank spaces)
REFERENCE NO. AND COLUMN(S):

Admission record:	MHA 1a: 148-155
	MHA 1b: 156-163
	MHA 1c: 164-171
Discharge record:	MHD 2a: 140-147
	MHD 2b: 148-155
	MHD 2c: 156-163

VARIABLE NAME: PAYMENT SOURCE, PRIMARY (EXPECTED OR ACTUAL)

DESCRIPTION

This field identifies the primary source of payment for this treatment episode anticipated at the time of admission.

VALID ENTRIES

Code	Description
01	SELF-PAY
02	BLUE CROSS/BLUE SHIELD
03	MEDICARE
04	MEDICAID
05	OTHER GOVERNMENT PAYMENTS
06	WORKER'S COMPENSATION
07	OTHER HEALTH INSURANCE COMPANIES
08	NO CHARGE – For example, free, charity, special research, or teaching
09	OTHER
97	UNKNOWN – Individual client value is unknown. This code should also be used if the state collects Medicare and Medicaid as a single category.
98	NOT COLLECTED – State does not collect this field. This code should also be used when the state collects only a subset of the categories.

VALIDATION EDITS

If this field is blank or contains an invalid value, the value will be changed to *99 Invalid data* and a warning error will be generated.

GUIDELINES

Reporting of this field is optional for both substance abuse and mental health treatment clients. States are encouraged to report data for all categories in the list of valid entries, but reporting a subset of the categories is acceptable.

- If the state collects a subset of the categories, clients not fitting the subset should be coded as *98 Not collected*. For example, if the state collects only *03 Medicare* and *04 Medicaid*, all other categories of **Payment Source** should be coded as *98 Not collected*.
- If a state collects Medicare and Medicaid as a single category, **Payment Source** should be coded as *97 Unknown*.

States operating under a split payment fee arrangement with multiple payment sources should default to the payment source with the largest percentage. When the payment percentages are equal, the state can select any source.

RELATED FIELDS: None
FIELD LENGTH: 2
DATA TYPE: Numeric

VARIABLE NAME: PAYMENT SOURCE, PRIMARY (EXPECTED OR ACTUAL)—continued

REFERENCE NO. AND COLUMN(S):

Admission record: SuDS 11: 124-125

VARIABLE NAME: PREGNANT AT ADMISSION

DESCRIPTION

This field indicates whether a female client was pregnant at time of admission.

VALID ENTRIES

Code	Description
1	YES – Female client was pregnant at admission.
2	NO – Female client was not pregnant at admission.
6	NOT APPLICABLE – Use this code for male clients or pre-pubescent females.
7	UNKNOWN – Individual client value is unknown.
8	NOT COLLECTED – State does not collect this field.

VALIDATION EDITS

If this field is blank or contains an invalid value, the value will be changed to *9 Invalid data* and a warning error will be generated.

If **Pregnant at Admission** is *1 Yes* and the value of **Gender** is *1 Male*, this field is changed to *6 Not Applicable*.

GUIDELINES

Reporting of this field is optional for both substance abuse and mental health treatment clients.

RELATED FIELDS: **Gender**
FIELD LENGTH: 1
DATA TYPE: Numeric
REFERENCE NO. AND COLUMN(S):
Admission record: SuDS 6: 116

VARIABLE NAME: PREVIOUS SA TREATMENT EPISODES

DESCRIPTION

This field indicates the number of previous treatment episodes the client has received in any substance abuse treatment program.

VALID ENTRIES

Code	Description
0	0 PREVIOUS EPISODES
1	1 PREVIOUS EPISODE
2	2 PREVIOUS EPISODES
3	3 PREVIOUS EPISODES
4	4 PREVIOUS EPISODES
5	5 OR MORE PREVIOUS EPISODES
7	UNKNOWN – Individual client value is unknown.
8	NOT COLLECTED – State does not collect this field.

VALIDATION EDITS

If this field is blank or contains an invalid value, the value will be changed to *9 Invalid data* and a warning error will be generated.

When this information is reported on a mental health record, **Co-occurring Substance Abuse and Mental Health Problems** must be *1 Yes*, or a warning error will be generated.

GUIDELINES

Substance abuse reporting: This field may be self-reported by the client at the time of intake, or it may be derived from the state data system.

Mental health reporting: This field measures the substance abuse treatment history of the client only. This does not include or pertain to the client's mental health treatment history. This field is optional. Reporting of this information on a mental health record is allowed only for clients with co-occurring mental health and substance abuse problems.

Changes in service for the same episode (transfers) should not be counted as separate previous episodes.

The number of prior treatments for a codependent/collateral record should include only treatments as a codependent.

RELATED FIELDS: None
FIELD LENGTH: 1
DATA TYPE: Numeric
REFERENCE NO. AND COLUMN(S):
Admission record: MDS 6: 52

VARIABLE NAME: RACE

DESCRIPTION

This field identifies the client's race.

VALID ENTRIES

Code	Description
01	ALASKA NATIVE (Aleut, Eskimo) – A person having origins in any of the original peoples of Alaska. **This category may be reported if available.**
02	AMERICAN INDIAN/ALASKA NATIVE – A person having origins in any of the original peoples of North America and South America (including Central America and the original peoples of Alaska) and who maintains tribal affiliation or community attachment. **States collecting *Alaska Native* should use this category for all other American Indians.**
03	ASIAN OR PACIFIC ISLANDER – A person having origins in any of the original peoples of the Far East, the Indian subcontinent, Southeast Asia, or the Pacific Islands. **This category may be used only if a state does not collect *Asian* and *Native Hawaiian or Other Pacific Islander* separately.**
04	BLACK OR AFRICAN AMERICAN – A person having origins in any of the black racial groups of Africa.
05	WHITE – A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.
13	ASIAN – A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.
20	OTHER SINGLE RACE – Use this category for instances in which the client is not identified in any category above or whose origin group, because of area custom, is regarded as a racial class distinct from the above categories.
21	TWO OR MORE RACES – Use this code when the state data system allows multiple race selection and more than one race is indicated.
23	NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER – A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.
97	UNKNOWN – Individual client value is unknown.
98	NOT COLLECTED – State does not collect this field.

VALIDATION EDITS

If this field is blank or contains an invalid value, the value will be changed to *99 Invalid data* and a warning error will be generated.

GUIDELINES

The Office of Management and Budget (OMB) does not include *Alaska Native* as one of its required categories. However, states that collect this category may report it as *01 Alaska Native* and use code *02 American Indian/Alaska Native* for other American Indians.

OMB requires that *Asian* and *Native Hawaiian or Pacific Islander* be collected as separate categories. However, if a state does not collect those categories, the older category *Asian or Pacific Islander* may be used.

VARIABLE NAME: RACE—continued

If a state collects a single **Race** value (i.e., report only one race), and the choice selection includes *Hispanic or Latino* as a category, **Race** should be coded as *97 Unknown* for all reported *Hispanic or Latino* and the **Hispanic or Latino Origin (Ethnicity)** should correspondingly be coded as *06 Hispanic or Latino, origin not specified*.

If a state collects multiple races for each client:

- If only one race is designated, use the code for that race. If that race is *Hispanic or Latino*, then **Race** should be coded as *97 Unknown* and **Hispanic or Latino Origin (Ethnicity)** should be coded as *06 Hispanic or Latino, origin not specified.*
- If the state system collects a “primary” or “preferred” race among multiple races, use the code for that race.
- If the state uses an algorithm to designate a “primary” race when multiple races have been specified, use the code for the algorithm-identified “primary” race.
- If *Hispanic or Latino* is specified as one of two or more races and the state identifies a "primary" race other than *Hispanic or Latino*, use the code for the state-identified “primary” race.
- If *Hispanic or Latino* is specified as one of two or more races and the state identifies *Hispanic or Latino* as the "primary" race, **Race** should be coded as *97 Unknown* and **Hispanic or Latino Origin (Ethnicity)** should be coded as *06 Hispanic or Latino, origin not specified*.
- If two or more races have been specified and none of the above situations applies, use code *21 Two or more races*.

RELATED FIELDS: **Hispanic or Latino Origin (Ethnicity)**
FIELD LENGTH: 2
DATA TYPE: Numeric
REFERENCE NO. AND COLUMN(S):
Admission record: MDS 10: 64-65
Discharge record DIS 19: 112-113

VARIABLE NAME: REASON FOR DISCHARGE, TRANSFER, OR DISCONTINUANCE OF TREATMENT

DESCRIPTION

This field indicates the outcome of the treatment episode/event or the reason for transfer or discontinuance of treatment.

VALID ENTRIES

Code	Description
01	TREATMENT COMPLETED – All parts of the treatment plan or program were completed.
02	DROPPED OUT OF TREATMENT – Client chose not to complete treatment program, with or without specific advice to continue treatment. Includes clients who drop out of treatment for unknown reasons, clients with whom contact is lost, clients who fail to return from leave ("AWOL"), and clients who have not received treatment for some time and are discharged for administrative purposes.
03	TERMINATED BY FACILITY – Treatment terminated by action of facility, generally because of client non-compliance with treatment or violation of rules, laws, policy, or procedures.
04	TRANSFERRED TO ANOTHER TREATMENT PROGRAM OR FACILITY – Client was transferred to another treatment program, provider, or facility for continuation of treatment.
05	INCARCERATED, OR RELEASED BY OR TO COURTS – Clients whose course of treatment is terminated because the client has been subject to jail, prison, or house confinement, or has been released by or to the courts.
06	DEATH
07	OTHER – Client transferred or discontinued treatment because of change in life circumstances. Examples: change of residence, illness or hospitalization, "aging out" of children's services, completion of MH assessment or evaluation that did not result to referral for a treatment service.
14	TRANSFERRED TO ANOTHER TREATMENT PROGRAM OR FACILITY, BUT CLIENT IS NO SHOW – Client was transferred to another treatment program, provider, or facility, and it is known that client did not report for treatment.
24	TRANSFERRED TO ANOTHER TREATMENT PROGRAM OR FACILITY THAT IS NOT IN THE SSA OR SMHA REPORTING SYSTEM – For example, client is transferred to a Medicaid facility that is not mandated to report client data to the state substance abuse/behavioral health agency. The receiving facility is outside the purview of the SSA or SMHA.
34	DISCHARGED FROM THE STATE HOSPITAL TO AN ACUTE MEDICAL FACILITY FOR MEDICAL SERVICES
96	NOT APPLICABLE – Should be used only when submitting a Mental Health update record (i.e., **Client Transaction Type** = *U Update*).
97	UNKNOWN – Individual client value is unknown.
-	NOT COLLECTED – State does not collect this field.
98	

VALIDATION EDITS

If this field is blank or contains an invalid value, the value will be changed to *99 Invalid data* and a warning error will be generated.

VARIABLE NAME: REASON FOR DISCHARGE, TRANSFER, OR DISCONTINUANCE OF TREATMENT—continued

If the old code *08 Unknown* is used (this code is being discontinued), the value will be replaced by the preferred code *97 Unknown* and an informational message will be generated.

If code *96 Not Applicable* is not used for a Mental Health update record, the value will be changed to *99 Invalid data*.

RELATED FIELDS: None
FIELD LENGTH: 2
DATA TYPE: Numeric
REFERENCE NO. AND COLUMN(S):
Discharge record: DIS 10: 59-60

VARIABLE NAME: REFERRAL SOURCE

DESCRIPTION

This field describes the person or agency referring the client to treatment.

VALID ENTRIES

Code	Description
01	INDIVIDUAL (includes self-referral) – Includes the client, a family member, friend, or any other individual who would not be included in any of the following categories; includes self-referral due to pending DWI/DUI.
02	ALCOHOL/DRUG ABUSE CARE PROVIDER – Any program, clinic, or other health care provider whose principal objective is treating clients with substance abuse problems, or a program whose activities are related to alcohol or other drug abuse prevention, education, or treatment.
03	OTHER HEALTH CARE PROVIDER – A physician, psychiatrist, or other licensed health care professional; or general hospital, psychiatric hospital, mental health program, or nursing home.
04	SCHOOL (Educational) – A school principal, counselor, or teacher; or a student assistance program (SAP), the school system, or an educational agency.
05	EMPLOYER/EMPLOYEE ASSISTANCE PROGRAM (EAP) – A supervisor or an employee counselor.
06	OTHER COMMUNITY REFERRAL – Community or religious organization or any federal, state, or local agency that provides aid in the areas of poverty relief, unemployment, shelter, or social welfare. This category also includes defense attorneys and self-help groups such as Alcoholics Anonymous (AA), Al-Anon, and Narcotics Anonymous (NA).
07	COURT/CRIMINAL JUSTICE REFERRAL/DUI/DWI – Any police official, judge, prosecutor, probation officer or other person affiliated with a federal, state, or county judicial system. Includes referral by a court for DWI/DUI, clients referred in lieu of or for deferred prosecution, or during pretrial release, or before or after official adjudication. Includes clients on pre-parole, pre-release, work or home furlough or TASC. Client need not be officially designated as “on parole.” Includes clients referred through civil commitment. ***Clients in this category are further defined in*** **Detailed Criminal Justice Referral**.
97	UNKNOWN – Individual client value is unknown.
98	NOT COLLECTED – State does not collect this field.

VALIDATION EDITS

If this field is blank or contains an invalid value, the value will be changed to *99 Invalid data* and a warning error will be generated.

GUIDELINES

All records with code *07 Court/criminal justice referral/DUI/DWI* should provide details in **Detailed Criminal Justice Referral**.

Mental health reporting: This field is optional.

RELATED FIELDS: **Detailed Criminal Justice Referral**
FIELD LENGTH: 2
DATA TYPE: Numeric
REFERENCE NO. AND COLUMN(S):
Admission record: MDS 7: 53-54

VARIABLE NAME: REPORTING DATE

DESCRIPTION

This field identifies the month and year of the record as created by the state.

VALID ENTRIES

Code	Description
MMYYYY	MM must be 01 through 12

VALIDATION EDITS

If the **Reporting Date** on the first record of the file does not match the **Reporting Date** entered in STSS, the file will be rejected; therefore, it cannot be uploaded for processing. An error message will be displayed on STSS. Note that the **Reporting Date** must be a valid calendar date in the format MMYYYY. It cannot be blank or contains an invalid value.

If the file is uploaded for processing but the second and succeeding records do not match the **Reporting Date** entered in STSS, these records will be rejected and not processed. A fatal error for the unprocessed records will be displayed in the processing report.

GUIDELINES

Every record in a single submission file must contain the same **Reporting Date**.

RELATED FIELDS: None
FIELD LENGTH: 6
DATA TYPE: Numeric (MMYYYY)
REFERENCE NO. AND COLUMN(S):
Admission record: SDS 3: 4-9
Discharge record: DIS 3: 4-9

VARIABLE NAME: ROUTE OF ADMINISTRATION (OF PRIMARY, SECONDARY, TERTIARY SUBSTANCES)

DESCRIPTION

This field identifies the usual route of administration of the corresponding substance identified in **Substance Abuse Problem (Primary, Secondary, Tertiary)**.

VALID ENTRIES

Code	Description
01	ORAL
02	SMOKING
03	INHALATION
04	INJECTION (intravenous, intramuscular, intradermal, or subcutaneous)
20	OTHER
96	NOT APPLICABLE
97	UNKNOWN – Individual client value is unknown.
98	NOT COLLECTED – State does not collect this field.

VALIDATION EDITS

If this field is blank or contains an invalid value, the value will be changed to *99 Invalid data* and a warning error will be generated.

When this information is reported on a mental health record, **Co-occurring Substance Abuse and Mental Health Problems** must be *1 Yes*, or a warning error will be generated.

GUIDELINES

If the value in **Substance Abuse Problem** is *01 None*, this field should be coded *96 Not applicable*.

Mental health reporting: This field is optional. Reporting of this information on a mental health record is allowed only for clients with co-occurring mental and substance abuse problems.

RELATED FIELDS: **Substance Abuse Problem**, **Frequency of Use**, **Age at First Use**, **Detailed Drug Code**

Mental health reporting: **Co-occurring Substance Abuse and Mental Health Problems**

FIELD LENGTH: 2

DATA TYPE: Numeric

REFERENCE NO. AND COLUMN(S):

Admission record: MDS 15a: 74-75
MDS 15b: 82-83
MDS 15c: 90-91

VARIABLE NAME: SCHOOL ATTENDANCE STATUS

DESCRIPTION

This field specifies the school attendance status of school-age children and adolescents (3-17 years old), including young adults (18-21 years old) who are protected under the Individuals with Disabilities Education Act (IDEA), receiving mental health services.

VALID ENTRIES

Code	Description
1	YES – Client has attended school at any time in the past three months.
2	NO – Client has not attended school at any time in the past three months.
6	NOT APPLICABLE – For non school-age clients (i.e., less than 3 years old and adults, 18 years and older except if protected under the IDEA).
7	UNKNOWN – Individual client value is unknown.
8	NOT COLLECTED – State does not collect this field.

VALIDATION EDITS

If this field is blank or contains an invalid value, the value will be changed to *9 Invalid data* and a warning error will be generated.

Substance abuse reporting: Field edit is performed but not age check and relational edit vis-à-vis **School Attendance**.

Mental health reporting: Age check edit will be performed. If the **Date of Birth** is either *01010007 Unknown*, *01010008 Not collected*, or *01010009 Invalid date*, the age check will not be performed and an informational message will be provided. Age is calculated at midpoint, as specified below, to remain consistent with the URS. Age is not rounded-up.

December 31—if the URS reporting period starts July 1

February 28—if the URS reporting period starts September 1

March 31—if the URS reporting period starts October 1

June 30—if the URS reporting period starts January 1

September 30—if the URS reporting period starts April 1

Code *6 Not Applicable* should be used for children younger than 3 years old, young adults not covered under the IDEA, and all adults, or the value will be changed to *9 Invalid data*.

GUIDELINES

Substance abuse reporting: This field is optional.

Mental health reporting: School Attendance is defined by SAMHSA as a mental health outcome measure for children, and it is collected at admission and at update/discharge to assess change.

This data field applies to all school-age children, 3-17 years old, including young adults 18-21 years old who are protected under the Individuals with Disabilities Education Act (IDEA). These young adults are in Special Education Program and continue to receive mental health services through the state's Children Mental Health system.

VARIABLE NAME: SCHOOL ATTENDANCE STATUS—continued

It is not the intent of this data element to identify children who are in Special Education. The intent is to ensure reporting of persons who are 18-21 years old who meet the IDEA eligibility criteria.

"At any time in the past three months" means at least one day of school attendance in the past three months, counting from the day the information is collected.

"School" includes, but is not limited to, any one or a combination of home-schooling, online education, alternative school, vocational school, or regular school (public, private, charter, traditional, military, etc.), at which the child is enrolled in any of the following school grade levels: nursery/pre-school (including Head Start), kindergarten, elementary/middle school (Grades 1-8), middle/high school (Grades 9-12, including General Equivalency Degree or GED), vocational school (including business, technical, secretarial, trade, or correspondence courses which are not counted as regular school enrollment and are not for recreation or adult education classes), or college/professional degree.

Use code *6 Not Applicable* for clients who are not of school age: children younger than 3 years old (i.e., birth to two years old) and all persons who have reached the age of 18, except the 18-21 year old clients who are in Special Education per the IDEA and continue to receive services from the Children's Mental Health System.

Use code *7 Unknown* if the state collects this information for the applicable population but for some reason a particular record does not reflect an acceptable value.

Use code *8 Not collected* if the state does not collect these data either for all clients or a particular subset of the population.

RELATED FIELDS: None
FIELD LENGTH: 1
DATA TYPE: Numeric
REFERENCE NO. AND COLUMN(S):
Admission record: MHA 3: 173
Discharge record: MHD 4: 165

VARIABLE NAME: SMI/SED STATUS

DESCRIPTION

This field indicates whether the client has serious mental illness (SMI) or serious emotional disturbance (SED) using the state's definition.

VALID ENTRIES

Code	Description
1	SMI
2	SED
3	AT RISK FOR SED (OPTIONAL)
4	NOT SMI/SED
7	UNKNOWN – Individual client value is unknown. Includes clients undergoing evaluation for SMI or SED eligibility pending any decision.
8	NOT COLLECTED – State does not collect this field.

VALIDATION EDITS

If this field is blank or contains an invalid value, the value will be changed to *9 Invalid data* and a warning error will be generated.

When this information is reported on a substance abuse record, **Co-occurring Substance Abuse and Mental Health Problems** must be *1 Yes*, or a warning error will be generated.

An age check will be performed. *01 SMI* should be used for adults 18 years and older. *02 SED or 03 At Risk for SED* should be used for children and adolescents 17 years old and younger. An exception is given to young adults, 18-21 years old, who are protected under the IDEA and continue to receive mental health services from the state's Children Mental Health system. Age is calculated at midpoint, as specified below, to remain consistent with the URS. Age is not rounded-up.

December 31—if the URS reporting period starts July 1

February 28—if the URS reporting period starts September 1

March 31—if the URS reporting period starts October 1

June 30—if the URS reporting period starts January 1

September 30—if the URS reporting period starts April 1

See **Appendix E** for additional edits.

GUIDELINES

Substance abuse reporting: This field is optional. Reporting of this information on a substance abuse record is allowed only for clients with co-occurring mental health and substance abuse problems.

SMI/SED Status is collected at admission and at time of discharge/update to assess change.

State definitions of SMI and SED should be reported in the crosswalk. Specify also if the state provides mental health services to only persons with seriously persistent mental illness (SPMI); serious mental illness (SMI); any mental illness; or any combination of these. Similarly, specify if the state provides mental health services to children with serious emotional disturbance (SED) only, children with emotional disturbance, or both.

VARIABLE NAME: SMI/SED STATUS—continued

Code *3 At risk for SED* is optional reporting. If used, cite the state operational definition of "At risk for SED" in the crosswalk.

Use code *4 Not SMI or SED* if the client has not been found eligible for SMI or SED services.

Use code *7 Unknown* for a client undergoing evaluation for SMI or SED eligibility pending any decision.

Use code *7 Unknown* if the state collects these data but for some reason a particular record does not reflect an acceptable value.

Use code *8 Not collected* if the state does not collect these data either for all clients or a particular subset of the population.

RELATED FIELDS: None
FIELD LENGTH: 1
DATA TYPE: Numeric
REFERENCE NO. AND COLUMN(S):
Admission record: MHA 2: 172
Discharge record: MHD 3: 164

VARIABLE NAME: SOURCE OF INCOME/SUPPORT

DESCRIPTION

This field identifies the client's principal source of financial support.

VALID ENTRIES

Code	Description
01	WAGES/SALARY
02	PUBLIC ASSISTANCE
03	RETIREMENT/PENSION
04	DISABILITY
20	OTHER
21	NONE
97	UNKNOWN – Individual client value is unknown.
98	NOT COLLECTED – State does not collect this field. This code should also be used when the state collects only a subset of the categories.

VALIDATION EDITS

If this field is blank or contains an invalid value, the value will be changed to *99 Invalid data* and a warning error will be generated.

GUIDELINES

Reporting of this field is optional for both substance abuse and mental health clients. States are encouraged to report data for all categories in the list of valid entries, but reporting a subset of the categories is acceptable.

- If the state collects a subset of the categories, clients not fitting the subset should be coded as *98 Not collected*. For example, if the state collects only *02 Public assistance*, all other categories of **Source of Income/Support** should be coded as *98 Not collected*.
- If the state does not collect **Source of Income/Support**, all records should be coded *98 Not collected*.

For children younger than 18 years old, report the primary parental source of income/support.

RELATED FIELDS: None
FIELD LENGTH: 2
DATA TYPE: Numeric
REFERENCE NO. AND COLUMN(S):
Admission record: SuDS 9: 120-121

VARIABLE NAME: STATE CODE—KEY FIELD

DESCRIPTION

This field identifies the state submitting the record.

VALID ENTRIES

Two-character state abbreviation

VALIDATION EDITS

If the **State Code** on the first record of the submitted file does not match the **State Code** shown in STSS, the file will be rejected and not uploaded for processing. An error message will be displayed on STSS.

If the file is uploaded for processing but the **State Code** on the second and succeeding records does not match the **State Code** shown in STSS, these records will be rejected and not processed. A fatal error for the unprocessed records will be displayed in the processing report.

RELATED FIELDS: None

FIELD LENGTH: 2

DATA TYPE: Alphanumeric

REFERENCE NO. AND COLUMN(S):

Admission record: SDS 2: 2-3

Discharge record: DIS 2: 2-3

VARIABLE NAME: STATE PROVIDER IDENTIFIER—KEY FIELD

DESCRIPTION

This field identifies the provider of the mental health or substance abuse treatment service.

VALID ENTRIES

1 to 15 alphanumeric characters

VALIDATION EDITS

If this field is blank, contains an invalid value, or is all zeros, the record will be rejected and not processed. A fatal error will be displayed in the processing report.

The **State Provider ID** is compared to the *ID* fields contained in the Inventory of Behavioral Health Services (I-BHS). If a match is found, the **I-BHS ID**, **County**, **MSA**, and **Agency** from the I-BHS are appended to the TEDS record. If no match is found, the record will be processed, but an informational message that no match was found in the I-BHS will appear on the processing report. The state must add the facility's **State Provider ID** in the I-BHS if it meets the I-BHS inclusion criteria.

GUIDELINES

We strongly encourage states to ensure that the **State Provider IDs** of all facilities that meet the I-BHS inclusion criteria are entered in the I-BHS.

Mental health reporting: **State Provider ID** may be any existing ID assigned to the provider. In the absence of an ID, a constructed 15-alphanumeric descriptor of the provider may be used to establish its unique identity (e.g., Region 1 CMHC). This descriptor has to be used consistently for any reporting of a service record associated with the specified provider.

Reporting by mental health providers may vary by state, depending on the service delivery model. Special reporting circumstances should be noted in the data crosswalk.

RELATED FIELDS: None

FIELD LENGTH: 15

DATA TYPE: Alphanumeric (left-justified and filled with blank spaces)

REFERENCE NO. AND COLUMN(S):

Admission record: MDS 1: 10-24

Discharge record: DIS 4: 10-24
DIS 11: 61-75

VARIABLE NAME: SUBSTANCE ABUSE DIAGNOSIS

DESCRIPTION

Client's diagnosis is used to identify the substance abuse problem that provides the reason for client encounter or treatment. This can be reported by using either the *Diagnostic and Statistical Manual of Mental Disorders (DSM)* from the American Psychiatric Association or the *International Classification of Diseases (ICD)* from the World Health Organization.

This field accepts DSM versions IIIR, IV, and 5, ICD-9, and ICD-10. States are encouraged to use this field instead of **SuDS 4 Diagnostic Code (DSM or ICD)**.

VALID ENTRIES

Code	Description (acceptable diagnostic code formats)
XXX.XXXX	
XXX_ _ _ _ _	where "_" represents a blank
XXX._ _ _ _	where "_" represents a blank
XXX.X_ _ _	where "_" represents a blank
XXX.XX _ _	where "_" represents a blank
XXX.XXX _	where "_" represents a blank
999.9997	UNKNOWN – Individual client value is unknown.
999.9998	NOT COLLECTED – State does not collect this field.

VALIDATION EDITS

If this field is blank or contains an invalid value, the value will be changed to *999.9999 Invalid data* and a warning error will be generated.

If a valid value for **Substance Abuse Diagnosis** is reported on a mental health record, **Co-occurring Substance Abuse and Mental Health Problems** must be *1 Yes*.

GUIDELINES

Reporting of this field is optional for both substance abuse and mental health clients.

Both DSM and ICD codes are accepted. The state must specify the coding system and version (DSM-IIIR, DSM-IV, DSM 5, ICD-9, ICD-10) in the **Diagnostic Code Set Identifier** field. While a three-character code with no decimal or following digits will be accepted, more complete diagnoses have at least one digit to the right of the decimal. States should strive to obtain complete coding with sufficient digits to accurately code the diagnosis.

Substance abuse reporting: It is preferred that states use this field to report SA diagnosis instead of **SuDS 4 Diagnostic Code (DSM or ICD).** However, states not ready to make the transition may continue to report the diagnostic code in **SuDS 4 Diagnostic Code (DSM or ICD)**.

RELATED FIELDS: **Diagnostic Code Set Identifier**
Mental health reporting: **Co-occurring Substance Abuse and Mental Health Problems**

FIELD LENGTH: 8

DATA TYPE: Alphanumeric (left-aligned and filled with blank spaces)

REFERENCE NO. AND COLUMN(S):

Admission record: SuDS 19: 140-147

VARIABLE NAME: SUBSTANCE ABUSE PROBLEM (PRIMARY, SECONDARY, TERTIARY)

DESCRIPTION

This field identifies the client's substance abuse problem(s) ranked in the order of use.

VALID ENTRIES

Code	Description
01	NONE
02	ALCOHOL
03	COCAINE/CRACK
04	MARIJUANA/HASHISH – Includes THC and any other cannabis sativa preparations
05	HEROIN
06	NON-PRESCRIPTION METHADONE
07	OTHER OPIATES AND SYNTHETICS – Includes buprenorphine, butorphanol, codeine, hydrocodone, hydromorphone, meperidine, morphine, opium, oxycodone, pentazocine, propoxyphene, tramadol, and other narcotic analgesics, opiates, or synthetics
08	PCP – PHENCYCLIDINE
09	HALLUCINOGENS – Includes LSD, DMT, mescaline, peyote, psilocybin, STD, and other hallucinogens
10	METHAMPHETAMINE/SPEED
11	OTHER AMPHETAMINES – Includes amphetamines, MDMA, 'bath salts', phenmetrazine, and other amines and related drugs
12	OTHER STIMULANTS – Includes methylphenidate and any other stimulants
13	BENZODIAZEPINES – Includes alprazolam, chlordiazepoxide, clonazepam, clorazepate, diazepam, flunitrazepam, flurazepam, halazepam, lorazepam, oxazepam, prazepam, temazepam, triazolam, and other benzodiazepines
14	OTHER TRANQUILIZERS – Includes meprobamate, and other non-benzodiazepine tranquilizers
15	BARBITURATES – Includes amobarbital, pentobarbital, phenobarbital, secobarbital, etc.
16	OTHER SEDATIVES OR HYPNOTICS – Includes chloral hydrate, ethchlorvynol, glutethimide, methaqualone, and other non-barbiturate sedatives and hypnotics
17	INHALANTS – Includes aerosols; chloroform, ether, nitrous oxide and other anesthetics; gasoline; glue; nitrites; paint thinner and other solvents; and other inappropriately inhaled products
18	OVER-THE-COUNTER MEDICATIONS – Includes aspirin, dextromethorphan and other cough syrups, diphenhydramine and other anti-histamines, ephedrine, sleep aids, and any other legally obtained, non-prescription medication
20	OTHER DRUGS – Includes diphenylhydantoin/phenytoin, GHB/GBL, ketamine, synthetic cannabinoid "Spice", carisoprodol (Soma), and other drugs

VARIABLE NAME: SUBSTANCE ABUSE PROBLEM (PRIMARY, SECONDARY, TERTIARY)—continued

Code	Description
97	UNKNOWN – Individual client value is unknown.
98	NOT COLLECTED – State does not collect this field.

VALIDATION EDITS

If this field is blank or contains an invalid value, the value will be changed to *99 Invalid data* and a warning error will be generated.

When this information is reported on a mental health record, **Co-occurring Substance Abuse and Mental Health Problems** must be *1 Yes*, or a warning error will be generated.

A record may not have duplicate **Substance Abuse Problem** codes with identical **Routes of Administration** unless the **Detailed Drug Codes** are different; otherwise, a warning error will be generated.

For example:

- The primary and secondary **Substance Abuse Problem** codes are both *13 Benzodiazepines*.
- The primary and secondary **Routes of Administration** are both *01 Oral*.

If **Detailed Drug Code** is unknown or not collected, the primary and secondary substances are considered duplicates, and the secondary **Substance Abuse Problem** and **Route of Administration** codes will be set to *99 Invalid data*.

If **Detailed Drug Code** is valid (not unknown or not collected) and has the same value for both primary and secondary substances, the primary and secondary substances are considered duplicates, and the secondary **Substance Abuse Problem** and **Routes of Administration** codes will be set to *99 Invalid data* and the **Detailed Drug Codes** will be set to *9999 Invalid data*.

However, given the example above, if the primary **Detailed Drug Code** is *1301 Alprazolam* and the secondary code is *1304 Diazepam*, the primary and secondary substances would be considered as different substances.

GUIDELINES

Each **Substance Abuse Problem** field (primary, secondary, or tertiary) has associated fields: **Route of Administration**, **Frequency of Use**, **Age at First Use**, and **Detailed Drug Code**. The primary **Substance Abuse Problem** code corresponds to the primary codes in the other fields, the secondary code to the secondary, and the tertiary to the tertiary. The optional field **Detailed Drug Code** is used to provide more detailed descriptions of the substances reported.

Substance abuse reporting: **Substance Abuse Problem** is defined by SAMHSA as an outcome measure, and is collected at admission and at discharge, with the related variable **Frequency of Use**, to assess change.

Mental health reporting: This field is optional. Reporting of this information on a mental health record is allowed only for clients with co-occurring mental health and substance abuse problems.

RELATED FIELDS: **Route of Administration**, **Frequency of Use**, **Age at First Use**, **Detailed Drug Code**
Mental health reporting: **Co-occurring Substance Abuse and Mental Health Problems**

FIELD LENGTH: 2

VARIABLE NAME: SUBSTANCE ABUSE PROBLEM (PRIMARY, SECONDARY, TERTIARY)—continued

DATA TYPE: Numeric

REFERENCE NO. AND COLUMN(S):

Admission record:	MDS 14a: 72-73
	MDS 14b: 80-81
	MDS 14c: 88-89
Discharge record:	DIS 21a: 116-117
	DIS 21b: 118-119
	DIS 21c: 120-121

VARIABLE NAME: SYSTEM TRANSACTION TYPE

DESCRIPTION

This field identifies the appropriate action that needs to be undertaken, that is, whether the record is added to the database, changes (by replacement) an existing record in the database, or deletes an existing record from the database.

VALID ENTRIES

Code	Description
A	ADD – Add a new record to the database.
C	CHANGE – Change values in a record already in the database.
D	DELETE – Delete an existing record from the database.

VALIDATION EDITS

If this field is blank or contains an invalid entry, the file will be rejected and not processed. A fatal error will be displayed in the processing report.

If the key fields of an *A Add* record match the key fields of an existing record, the *A Add* record will be rejected as a duplicate and a warning error will be generated.

The key fields of a *C Change* or *D Delete* record must match the key fields of an existing record, or the record will be rejected and not processed and a warning error will be generated.

GUIDELINES

Actions are performed in the order listed below:

1. Records with a **System Transaction Type** code of *D Delete* will delete a record with matching key fields.
2. Records with a **System Transaction Type** code of *A Add* will be added to the database unless the key fields match a record already in the TEDS database.
3. Records with a **System Transaction Type** code of *C Change* will change a record with matching key fields by replacing the record.

Changes to an existing record in the database can be made by

1. Submitting a *C Change* record, which replaces the existing record, or
2. Submitting a *D Delete* record and then an *A Add* record that replaces the deleted record. (See **Changing/Correcting Existing Records in TEDS Database** under the **STSS Guide** section of the Manual).

RELATED FIELDS: None
FIELD LENGTH: 1
DATA TYPE: Alphanumeric
REFERENCE NO. AND COLUMN(S):
Admission record: SDS 1: 1
Discharge record: DIS 1: 1

VARIABLE NAME: TYPE OF TREATMENT SERVICE/SETTING—KEY FIELD

DESCRIPTION

This field describes the type of treatment service or treatment setting in which the client is placed at the time of admission or transfer.

VALID ENTRIES

Code	Description
01	DETOXIFICATION, 24-HOUR SERVICE, HOSPITAL INPATIENT – 24 hours per day medical acute care services in hospital setting for detoxification of persons with severe medical complications associated with withdrawal
02	DETOXIFICATION, 24-HOUR SERVICE, FREE-STANDING RESIDENTIAL – 24 hours per day services in non-hospital setting providing for safe withdrawal and transition to ongoing treatment
03	REHABILITATION/RESIDENTIAL — HOSPITAL (OTHER THAN DETOXIFICATION) – 24 hours per day medical care in a hospital facility in conjunction with treatment services for alcohol and other drug abuse and dependency
04	REHABILITATION/RESIDENTIAL — SHORT TERM (30 DAYS OR FEWER) – Typically, 30 days or fewer of non-acute care in a setting with treatment services for alcohol and other drug abuse and dependency
05	REHABILITATION/RESIDENTIAL— LONG TERM (MORE THAN 30 DAYS) – Typically, more than 30 days of non-acute care in a setting with treatment services for alcohol and other drug abuse and dependency; may include transitional living arrangements such as halfway houses
06	AMBULATORY— INTENSIVE OUTPATIENT – At a minimum, treatment lasting two or more hours per day for 3 or more days per week (includes partial hospitalization)
07	AMBULATORY — NON-INTENSIVE OUTPATIENT – Ambulatory treatment services including individual, family and/or group services; may include pharmacological therapies
08	AMBULATORY — DETOXIFICATION – Outpatient treatment services providing for safe withdrawal in an ambulatory setting (pharmacological or non-pharmacological).
72	STATE PSYCHIATRIC HOSPITAL – All SMHA-funded and SMHA-operated organizations operated as hospitals that provide primarily inpatient care to persons with mental illnesses from a specific geographical area and/or statewide
73	SMHA-FUNDED/OPERATED COMMUNITY-BASED PROGRAM – Include community mental health centers (CMHCs), outpatient clinics, partial care organizations, partial hospitalization programs, PACT programs, consumer run programs (including Club Houses and drop-in centers), and all community support programs (CSP)
74	RESIDENTIAL TREATMENT CENTER – An organization, not licensed as a psychiatric hospital, whose primary purpose is the provision of individually planned programs of mental health treatment services in conjunction with residential care for children and youth, and in some cases, adult care.
75	OTHER PSYCHIATRIC INPATIENT – A private provider or medical provider licensed and/or contracted through the SMHA.
76	INSTITUTIONS UNDER THE JUSTICE SYSTEM – Mental health services provided in a jail, prison, juvenile detention center, etc.
96	NOT APPLICABLE – Use this code only for 1) substance abuse codependents/collateral clients and 2) mental health clients receiving assessment, evaluation, or screening services only.

VARIABLE NAME: TYPE OF TREATMENT SERVICE/SETTING—continued

VALIDATION EDITS

If this field is blank or contains an invalid value, the record will be rejected and not processed. A fatal error will be displayed in the processing report.

If the **Type of Treatment Service/Setting** does not correspond to the **Client Transaction Type**, the record will be rejected and not processed and a warning error will be generated. This means the **Type of Treatment Service/Setting** must use codes 01 through 08 if **Client Transaction Type** is either *A Initial Admission – substance abuse treatment* or *T Transfer/Change in SA service* and codes 72 through 76 if **Client Transaction Type** is either *M Initial Admission – mental health treatment* or *X Transfer/Change in MH service*.

GUIDELINES

Substance abuse reporting: Use codes 01 through 08.

In some states, a client may be admitted to (enrolled in) more than one substance abuse treatment setting *on the same day*, with the same or different providers. This may generate multiple client admissions *on the same day*. However, TEDS requires that a treatment episode have only one initial admission. Using the following prioritized list of TEDS substance abuse treatment categories, states should select as the TEDS initial admission the one with the highest priority. Admissions to treatment services/settings with lower priorities may be submitted to TEDS as transfer admissions.

1. Detoxification, 24-Hour Service, Hospital Inpatient
2. Detoxification, 24-Hour Service, Free-standing residential
3. Ambulatory—Detoxification
4. Rehabilitation/Residential—Hospital
5. Rehabilitation/Residential—Long Term (more than 30 days)
6. Rehabilitation/Residential—Short Term (30 days or fewer)
7. Ambulatory—Intensive Outpatient
8. Ambulatory—Non-Intensive Outpatient

Mental health reporting: Use codes 72 through 76.

If a client has co-occurring substance abuse and mental health problems **and** the admission or discharge record reported is for a substance abuse treatment, **Client Transaction Type** should have a substance abuse admission/discharge code and **Type of Treatment Service/Setting** should use any codes from 01 through 08. If the admission or discharge record is for a mental health treatment, **Client Transaction Type** should have a mental health admission/discharge code and **Type of Treatment Service/Setting** should use any codes from 72 through 76.

If a client received only mental health assessment, screening, or evaluation and was discharged to receive services outside the purview of the SMHA or discharged but no treatment is necessary, the record should be coded *96 Not Applicable*.

RELATED FIELDS: None
FIELD LENGTH: 2
DATA TYPE: Numeric
REFERENCE NO. AND COLUMN(S):
Admission record: MDS 18: 50-51
Discharge record: DIS 7: 41-42
DIS 16: 101-102

VARIABLE NAME: VETERAN STATUS

DESCRIPTION

This field indicates whether the client has served in the uniformed services (Army, Navy, Air Force, Marine Corps, Coast Guard, Public Health Service Commissioned Corps, Coast and Geodetic Survey, etc.).

VALID ENTRIES

Code	Description
1	VETERAN
2	NOT A VETERAN
7	UNKNOWN – Individual client value is unknown.
8	NOT COLLECTED – State does not collect this field.

VALIDATION EDITS

If this field is blank or contains an invalid value, the value will be changed to *9 Invalid data* and a warning error will be generated.

GUIDELINES

Reporting of this field is optional for both substance abuse and mental health clients.

A veteran is a person 16 years or over who has served (even for a short time), but is not now serving, on active duty in the U.S. Army, Navy, Air Force, Marine Corps, Coast Guard, or Commissioned Corps of the U.S .Public Health Service or the National Oceanic and Atmospheric Administration, or who served as a Merchant Marine seaman during World War II. Persons who served in the National Guard or Military Reserves are classified as veterans only if they have ever been called or ordered to active duty (excluding the 4-6 months of initial training and yearly summer camps).

RELATED FIELDS: None

FIELD LENGTH: 1

DATA TYPE: Numeric

REFERENCE NO. AND COLUMN(S):

Admission record: SuDS 7: 117

Appendix E. List of Edit Checks

The list of edit checks contained in this Appendix is provided for better understanding of the validation process in TEDS. Incorporating and programming these edits in the state's computer programs to prepare TEDS files would be beneficial as it will allow for real-time feedback. States can immediately apply corrective actions on their files. As a result, it will help minimize the number of data errors identified when testing the state TEDS files using STSS.

For nomenclature of errors, please refer to the Validation Edits section of this Manual.

This Appendix is intended to be used with the Error Report generated by STSS after a file submission. Relevant edit violations for each data field cited in the Error Report are discussed fully in the succeeding tables. It provides information on the edit (correct data submission), type of error, explanation of the violation, outcome or result of violating the edit, and the recommended corrective action.

When addressing errors involving relational edits, the state must review all relevant data fields irrespective of whether the reported field value was stored or replaced with an invalid value. The nature of these edits is such that it is not clear which field violated the expected relationship. In some cases, the edit assumes a certain level of hierarchy between variables, which causes some field values to be stored while others are replaced with invalid value or an expected value. This assumption, however, should not be taken to mean that the stored value is correct. The state still has to verify and validate that assumption. Relational edits would not "run" when one of the fields is either an Unknown or Not Collected.

The following cases assumed certain hierarchy among variables:

- Date of Birth trumps the Age of First Use—DOB value is stored
- Gender trumps pregnancy status—if Male, pregnancy value is replaced
- Reporting of both SA and MH diagnoses—will change the Co-occurring MH and SA Problems from "No" to "Yes"

To remain consistent with the URS, edits involving age checks on mental health records will use age calculated at the midpoint of the reporting period. Age is not rounded up and client's age is reported as zero if less than 12 months. The following reference dates for age calculation will be observed:

- December 31—if the reporting period starts July 1
- February 28—if the reporting period starts September 1
- March 31—if the reporting period starts October 1
- June 30—if the reporting period starts January 1
- September 30—if the reporting period starts April 1

Edits involving age check on substance abuse records will use age calculated at time of admission.

Calculated age greater than 95 years old will be capped at 95.

Please note that majority of the edit checks presented are already in place. A few others are in the process of implementation.

EDIT CHECKS WHILE UPLOADING A FILE IN STSS (pop-up error messages in STSS)

Edit No.	Field Name	Error Type	Edit Statement	Violation: Result	Corrective Action	Applicable Records
S1	Reporting Date	Fatal (F)	Reporting Date on the first record of the file and the Reporting Date entered in STSS must match	Reporting Date on first record did not match with STSS: File is rejected and not uploaded	*WARNING: To successfully upload a file, the* **Reporting Date** *written on the first record of the file must match the Reporting Date entered in STSS. It must be a valid calendar date in the format MMYYYY*	All Admissions, Discharges or Updates; SA and MH records
S2	Reporting Date (continued)	Fatal (F)	Reporting Date on second and succeeding records in the file must match the Reporting Date entered in STSS	Reporting Date on some records did not match with STSS: Applicable records are rejected and not processed	*WARNING: To correct rejected records, the* **Reporting Date** *on the records must match the Reporting Date entered in STSS. It must be a valid calendar date in the format MMYYYY*	All Admissions, Discharges or Updates; SA and MH records
S3	State Code	Fatal (F)	State Code on the first record of the file and the State Code entered in STSS must match	State Code on the first record did not match with STSS: File is rejected and not uploaded	*WARNING: To successfully upload a file, the* **State Code** *written on the first record of the file must match the State Code entered in STSS*	All Admissions, Discharges or Updates; SA and MH records
S4	State Code (continued)	Fatal (F)	State code on second and succeeding records in the file must match the State Code entered in STSS	State Code on some records did not match with STSS: Applicable records are rejected and not processed	*WARNING: To correct rejected records, the* **State Code** *on the records must match the State Code entered in STSS*	All Admissions, Discharges or Updates; SA and MH records

EDIT CHECKS FOR ADMISSION RECORD

Edit No.	Field Name	Error Type	Edit Type	Edit Statement	Violation; Result	Corrective Action	Applicable Records
A1	Age at First Use	NF	Field	Age at First Use must have a valid value. Blank is not accepted.	Age at First Use is either blank or has an invalid value; record is processed but field value is replaced with the system code '99' for invalid data.	*Records with invalid data should be reviewed and replaced with valid values specified in the Manual*	All SA Admissions [and MH Admissions, if reported]
A2	Age at First Use (continued)	NF	Relational	A valid value for a SA data field is accepted on a MH record only when a client is reported to have co-occurring MH and SA problems.	Age at First Use has valid value (not '96', '97', '98') but Co-occurring MH and SA Problems field value is a '2 No' in a MH record; record is processed with the reported field value.	*This is a SA data field only;* **Co-occurring MH and SA Problem** *data field must be a 'Yes' to allow reporting on a MH record. Review both fields and take corrective action*	MH Admissions, if reported
A3	Age at First Use (continued)	NF	Relational	Age at First Use must be less than the calculated age at admission.	Age at First Use is greater than the calculated age at admission; record is processed but field value is replaced with the system code '99' for invalid data.	**Age at First Use** *must not be greater than the calculated Age at Admission using the reported* **Date of Birth**. *Review both fields and take corrective action*	All SA Admissions
A4	Arrests in Past 30 Days - Admission	NF	Field	Arrests in Past 30 Days - Admission must have a valid value. Blank is not accepted.	Arrest data field is either blank or has invalid value; record is processed but field value is replaced with the system code '99' for invalid data	*Records with invalid data should be reviewed and replaced with valid values specified in the Manual*	All Admissions
A5	Attendance at SA Self-Help Groups in Past 30 Days - Admission	NF	Field	Attendance at SA Self-Help Group in Past 30 Days must have a valid value. Blank is not accepted.	Attendance at SA Self-Help Groups data field is either blank or has an invalid value; record is processed but field value is replaced with the system code '99' for invalid data.	*Records with invalid data should be reviewed and replaced with valid values specified in the Manual*	All SA Admissions [and MH Admissions, if reported]

Edit No.	Field Name	Error Type	Edit Type	Edit Statement	Violation; Result	Corrective Action	Applicable Records
A6	Attendance at SA Self-Help Groups in Past 30 Days – Admission (continued)	NF	Relational	A valid value for a SA data field is accepted on a MH record only when a client is reported to have co-occurring MH and SA problems.	Attendance at SA Self-Help Groups data field has valid value (not '97' or '98') but Co-occurring SA and MH Problems field value is a '2 No' in a MH record; record is processed with the reported field value.	*This is a SA data field only;* **Co-occurring SA and MH Problems** *data field must be a 'Yes' to allow reporting on a MH record. Review both fields and take corrective action*	MH Admissions, if reported
A7	CGAS/GAF Score	NF	Field	CGAS/GAF Score must have a valid value. Blank is not accepted.	CGAS/GAF Score is either blank or has an invalid value; record is processed but field value is replaced with the system code '999' for invalid data.	*Records with invalid data should be reviewed and replaced with valid values specified in the Manual*	All MH Admissions [and SA Admissions, if reported]
A8	CGAS/GAF Score (continued)	NF	Relational	A valid value for a MH data field is accepted on a SA record only when a client is reported to have co-occurring MH and SA problems.	For a SA record, CGAS/GAF Score has a valid value (not '997' or '998') but Co-occurring SA and MH Problems data field has a value of '2 No'; record is processed with the reported field value.	*This is a MH data field only;* **Co-occurring SA and MH Problems** *data field must be a 'Yes' to allow reporting on a SA record. Review both fields and take corrective action*	SA Admissions, if reported
A9	Client ID	F	Field	Client ID is a KEY field. It must have a valid value. Blank or all zeros is not accepted.	Client ID is blank, an invalid value, or all zeros; record is rejected and not processed.	*See Manual for guidance on acceptable ID format*	All Admissions
A10	Client Transaction Type	F	Field	Client Transaction Type is a KEY field. It must have a valid value. Blank is not accepted.	Client Transaction Type is either blank or has an invalid value; record is rejected and not processed.	*Must report a field value using only the valid codes specified in the Manual*	All Admissions
A11	Codependent/ Collateral	F	Field	Codependent is a KEY field. It must have a valid value. Blank is not accepted.	Codependent/Collateral is either blank or has an invalid value; record is rejected and not processed.	*Must report a field value using only the valid codes specified in the Manual*	All Admissions

Edit No.	Field Name	Error Type	Edit Type	Edit Statement	Violation; Result	Corrective Action	Applicable Records
A12	Co-occurring SA and MH Problems	NF	Field	Co-occurring SA and MH Problems must have a valid value. Blank is not accepted.	Co-occurring SA and MH Problems is either blank or has an invalid value; record is processed but field value is replaced with the system code '9' for invalid data.	*Records with invalid data should be reviewed and replaced with valid values specified in the Manual*	All Admissions
A13 New	Co-occurring SA and MH Problems	NF	Relational	Co-occurring SA and MH Problems must be 1 Yes if valid codes are reported in both SA and MH diagnostic fields.	Co-occurring SA and MH Problems is '2 No' when both SA and MH diagnoses are reported; record is processed but field value is replaced with the system code '9' for invalid data.	*When both SA and MH diagnoses are reported,* **Co-occurring SA and MH Problems** *must be a '1 Yes'*	All Admissions
A14	Date of Admission	F	Field	Date of Admission is a KEY field. It must be a valid calendar date and in a valid format. Blank is not accepted.	Date of Admission is either blank, has an invalid value, or uses the wrong date format; record is rejected and not processed.	*Admission Date must be a valid calendar date in the format MMDDYYYY*	All Admissions
A15	Date of Admission (continued)	F	Field	SA admission record must have an Admission Date of January 1, 2000, or later.	Date of Admission is before January 1, 2000; record is rejected and not processed.	*SA* **Date of Admission** *must be January 1, 2000, or later*	SA Admissions
A16	Date of Admission (continued)	F	Relational	MH admission record must have an Admission Date of January 1, 1920, or later.	Date of Admission is before January 1, 1920; record is rejected and not processed.	*MH* **Date of Admission** *must be January 1, 1920, or later*	MH Admissions
A17	Date of Admission (continued)	F	Relational	Date of Admission must be either the same date or earlier than the current date or the Reporting Date	Date of Admission is later than the current date or the Reporting Date; record is rejected and not processed.	**Date of Admission** *must be the same date or earlier than the current date or the Reporting Date*	All Admissions
A18	Date of Birth	F	Field	Date of Birth must be a valid calendar date and in a valid format. Blank is not accepted.	Date of Birth is either blank, has an invalid value, or uses the wrong date format; record is rejected and not processed.	**Date of Birth** *must be a valid calendar date in the format MMDDYYYY*	All Admissions

Edit No.	Field Name	Error Type	Edit Type	Edit Statement	Violation; Result	Corrective Action	Applicable Records
A19	Date of Birth (continued)	NF	Relational	Date of Birth may be the same or earlier than the current date or Date of Admission. In addition, Date of Birth that gives a calculated age of > 95 years old at time of admission will be flagged for state verification.	Date of Birth (DOB) is later than the current date or the date of admission, or gives a calculated age of > 95 years; record is processed but field value is replaced with the system code '01010009' for invalid date. If DOB gives a calculated age of > 95 at time of admission, the reported field value is temporarily stored until state verification of the DOB.	**Date of Birth** *may be the same or earlier than the current date or Date of Admission and DOB do not give a calculated age of > 95 at time of admission. Review both fields and take corrective action.*	All Admissions
A20	Days Waiting to Enter SA Treatment	NF	Field	Days Waiting to Enter SA Treatment must have a valid value. Blank is not accepted.	Days Waiting to Enter SA Treatment is either blank or has an invalid value; record is processed but field value is replaced with the system code '999' for invalid data.	*Records with invalid data should be reviewed and replaced with valid values specified in the Manual*	All SA Admissions [and MH Admissions, if reported]
A21	Days Waiting to Enter SA Treatment (continued)	NF	Relational	A valid value for a SA data field is accepted on a MH record only when a client is reported to have co-occurring MH and SA problems.	Days Waiting to enter SA Treatment has valid value (not '997' or '998') but Co-occurring MH and SA Problems field value is a '2 No' in a MH record; record is processed with the reported field value.	*This is a SA data field only;* **Co-occurring MH and SA Problems** *data field must be 'Yes' to allow reporting on a MH record. Review both fields and take corrective action*	MH Admissions, if reported
A22	Detailed Criminal Justice Referral	NF	Field	Detailed Criminal Justice Referral must have a valid value. Blank is not accepted.	Detailed Criminal Justice Referral is either blank or has an invalid value; record is processed but field value is replaced with the system code '99' for invalid data.	*Records with invalid data should be reviewed and replaced with valid values specified in the Manual*	All Admissions

Edit No.	Field Name	Error Type	Edit Type	Edit Statement	Violation; Result	Corrective Action	Applicable Records
A23	Detailed Criminal Justice Referral (continued)	NF	Relational	Detailed Criminal Justice Referral must have a valid value (other than '96 Not Applicable') if Referral Source is '07 Criminal Justice'.	Detailed Criminal Justice Referral has valid value other than '96' when Referral Source is not '07 Criminal Justice'; record is processed but field value is replaced with the system code '99' for invalid data.	**Detailed Criminal Justice Referral** *must be a '96 Not Applicable' if* **Referral Source** *is not '07 Criminal Justice'. Review both fields and take corrective action*	All Admissions
A24	Detailed Drug Code	NF	Field	Detailed Drug Code must have a valid value. Blank is not accepted.	Detailed Drug Code is either blank or has an invalid value; record is processed but field value is replaced with the system code '9999' for invalid data.	*Records with invalid data should be reviewed and replaced with valid values specified in the Manual*	All SA Admissions [and MH Admissions, if reported]
A25	Detailed Drug Code (continued)	NF	Relational	Detailed Drug Code must be a valid subset of the reported Substance Abuse Problem.	Invalid subset of the reported Substance Abuse Problem; record is processed but field value is replaced with the system code '9999' for invalid data.	*Records with invalid data should be reviewed and replaced with valid values.* **Detailed Drug Code** *must be a valid subset of the reported* **Substance Abuse Problem**. *Review both fields and take corrective action*	All SA Admissions
A26	Detailed Drug Code (continued)	NF	Relational	A valid value for a SA data field is accepted on a MH record only when a client is reported to have co-occurring MH and SA problems.	Detailed Drug Code has valid value (not '9996', '9997', '9998') but Co-occurring SA and MH Problems field value is a '2 No' in a MH record; record is processed with the reported field value.	*This is a SA data field only;* **Co-occurring SA and MH Problems** *data field must be a 'Yes' to allow reporting on a MH record. Review both fields and take corrective action*	MH Admissions, if reported
A27	Detailed Not in Labor Force	NF	Field	Detailed Not in Labor Force must have a valid value. Blank is not accepted.	Detailed Not in Labor Force is either blank or has an invalid value; record is processed but field value is replaced with the system code '99' for invalid data.	*Records with invalid data should be reviewed and replaced with valid values specified in the Manual*	All Admissions

Edit No.	Field Name	Error Type	Edit Type	Edit Statement	Violation; Result	Corrective Action	Applicable Records
A28	Detailed Not in Labor Force (continued)	NF	Relational	Detailed Not in Labor Force must have a valid value (other than '96 Not Applicable') if Employment Status is '04 Not in labor Force'.	Detailed Not in Labor Force has a valid value other than '96' when Employment Status is not '04 Not in Labor Force'; record is processed but field value is replaced with the system code '99' for invalid data.	**Detailed Not in the Labor Force** *must be a '96 Not Applicable' if* **Employment Status** *is not '04 Not in the Labor Force.' Review both fields and take corrective action*	All Admissions
A29	Diagnostic Code (DSM or ICD)	NF	Field	Diagnostic Code must have a valid value. Blank is not accepted.	Diagnostic Code is either blank or has an invalid value; record is processed but field value is replaced with the system code '999.99' for invalid data.	*Records with invalid data should be reviewed and replaced with valid values specified in the Manual*	All Admissions
A30	Diagnostic Code Set Identifier	NF	Field	Diagnostic Code Set Identifier must have a valid value. Blank is not accepted.	Diagnostic Code Set Identifier is either blank or has an invalid value; record is processed but field value is replaced with the system code '9' for invalid data.	*Records with invalid data should be reviewed and replaced with valid values specified in the Manual*	All Admissions
A31 New	Diagnostic Code Set Identifier (continued)	NF	Relational	Diagnostic Code Set Identifier must have a valid value when SA Diagnosis or MH Diagnosis has a valid value that is not '999.9997 Unknown' or '999.9998 Not Collected'.	Diagnostic Code Set Identifier is either blank or has an invalid value when SA Diagnosis or MH Diagnosis fields has valid value other than '999.9997' or '999.9998'; Record is processed but field value is replaced with the system code '9' for invalid data.	**Diagnostic Code Set Identifier** *must have a valid value (1-5 only) when valid SA Diagnosis or MH Diagnosis value (cannot be '999.9997' or '999.9998') is reported. Review all relevant fields and take corrective action*	All Admissions
A32	Education	NF	Field	Education must have a valid value. Blank is not accepted.	Education is either blank or has an invalid value; record is processed but field value is replaced with the system code '99' for invalid data.	*Records with invalid data should be reviewed and replaced with valid values specified in the Manual*	All Admissions

Edit No.	Field Name	Error Type	Edit Type	Edit Statement	Violation; Result	Corrective Action	Applicable Records
A33 New	Education (continued)	NF	Relational	Education must have a valid value when School Attendance Status is either '1' or '2'.	Education is either blank or has an invalid value when School Attendance Status is either '1' or '2'; record is processed but field value is replaced with the system code '99' for invalid data.	**Education** *field should have valid value for school-age children if* **School Attendance Status** *has a value of '1' or '2'. Review both fields and take corrective action*	MH Admissions for school-age children (3-17 years old)
A34	Employment Status	NF	Field	Employment Status must have a valid value. Blank is not accepted.	Employment Status is either blank or has an invalid value; record is processed but field value is replaced with the system code '99' for invalid data.	*Records with invalid data should be reviewed and replaced with valid values specified in the Manual*	All Admissions
A35	Frequency of Use	NF	Field	Frequency of Use must have a valid value. Blank is not accepted.	Frequency of Use is either blank or has an invalid value; record is processed but field value is replaced with the system code '99' for invalid data.	*Records with invalid data should be reviewed and replaced with valid values specified in the Manual*	All SA Admissions [and MH Admissions, if reported]
A36	Frequency of Use (continued)	NF	Relational	A valid value for a SA data field is accepted on a MH record only when a client is reported to have co-occurring SA and MH problems.	Frequency of Use has a valid value (not '96', '97', '98') but Co-occurring MH and SA Problems field value is a '2 No' in a MH record; record is processed with the reported field value.	*This is a SA data field only;* **Co-occurring SA and MH Problems** *data field must be a 'Yes' to allow reporting on a MH record. Review both fields and take corrective action*	MH Admissions, if reported
A37	Gender	NF	Field	Gender must have a valid value. Blank is not accepted.	Gender is either blank or has an invalid value; record is processed but field value is replaced with the system code '9' for invalid data.	*Records with invalid data should be reviewed and replaced with valid values specified in the Manual*	All Admissions

Edit No.	Field Name	Error Type	Edit Type	Edit Statement	Violation; Result	Corrective Action	Applicable Records
A38	Health Insurance	NF	Field	Health Insurance must have a valid value. Blank is not accepted.	Health Insurance is either blank or has an invalid value; record is processed but field value is replaced with the system code '99' for invalid data.	*Records with invalid data should be reviewed and replaced with valid values specified in the Manual*	All Admissions
A39	Hispanic or Latino Origin (Ethnicity)	NF	Field	Hispanic or Latino Origin must have a valid value. Blank is not accepted.	Hispanic or Latino Origin is either blank or has an invalid value; record is processed but field value is replaced with the system code '99' for invalid data.	*Records with invalid data should be reviewed and replaced with valid values specified in the Manual*	All Admissions
A40	Legal Status at Admission to State Hospital	NF	Field	Legal Status must have a valid value. Blank is not accepted.	Legal Status at Admission to State Hospital is either blank or has an invalid value; record is processed but field value is replaced with the system code '99' for invalid data.	*Records with invalid data should be reviewed and replaced with valid values specified in the Manual*	All MH Admissions [and SA Admissions, if reported]
A41	Legal Status at Admission to State Hospital (continued)	NF	Relational	Legal Status must have a valid value when Type of Treatment Service/Setting is '72 State Psychiatric Hospital'. All other service types or settings must have a value of '96 Not Applicable'.	Legal Status at Admission to State Hospital value is either '01' through '06' but Type of Treatment Service/Setting is not '72'; record is processed but field value is replaced with the system code '99' for invalid data.	**Legal Status** *is for state hospital setting only, '72'. Use '96' for all* **Type of Treatment Service/Setting** *from '73' through '76'. Review both fields and take corrective action.*	All MH Admissions
A42	Living Arrangements	NF	Field	Living Arrangements must have a valid value. Blank is not accepted.	Living Arrangements is either blank or has an invalid value; record is processed but field value is replaced with the system code '99' for invalid data.	*Records with invalid data should be reviewed and replaced with valid values specified in the Manual*	All Admissions

Edit No.	Field Name	Error Type	Edit Type	Edit Statement	Violation; Result	Corrective Action	Applicable Records
A43	Marital Status	NF	Field	Marital Status must have a valid value. Blank is not accepted.	Marital Status is either blank or has an invalid value; record is processed but field value is replaced with the system code '99' for invalid data.	*Records with invalid data should be reviewed and replaced with valid values specified in the Manual*	All Admissions
A44	Medication-Assisted Opioid Therapy	NF	Field	Medication-assisted Opioid Therapy must have a valid value. Blank is not accepted.	Medication-Assisted Opioid Therapy is either blank or has an invalid value; record is processed but field value is replaced with the system code '9' for invalid data.	*Records with invalid data should be reviewed and replaced with valid values specified in the Manual*	All SA Admissions [and MH Admissions, if reported]
A45	Medication-Assisted Opioid Therapy (continued)	NF	Relational	A valid value for a SA data field is accepted on a MH record only when a client is reported to have co-occurring MH and SA problems.	Medication-Assisted Opioid Therapy has a valid value (not '6', '7', '8') but Co-occurring MH and SA Problems field value is a '2 No' in a MH record; record is processed with the reported field value.	*This is a SA data field only;* **Co-occurring SA and MH Problems** *data field must be a 'Yes' to allow reporting on a MH record. Review both fields and take corrective action*	MH Admissions, if reported
A46	Mental Health Diagnosis	NF	Field	Mental Health Diagnosis must have a valid value. Blank is not accepted.	Mental Health Diagnosis is either blank or has an invalid value; record is processed but field value is replaced with the system code '999.9999' for invalid data.	*Records with invalid data should be reviewed and replaced with valid values specified in the Manual*	All MH Admissions [and SA Admissions, if reported]
A47 (a, b, c)	Mental Health Diagnosis (continued)	NF	Relational	Up to three MH diagnoses may be reported but they must not be of the same diagnostic code. Else it is a duplicate.	Duplicate. There are at least two reported diagnostic codes that are the same. The first will be processed, other(s) will be considered duplicate(s) and the field value is replaced with the system code '999.9999' for invalid data.	*Duplicates exist. At least two diagnoses of the same codes are reported in* ***MH Diagnoses (One, Two, Three)****. Please take corrective action.*	All MH Admissions

Edit No.	Field Name	Error Type	Edit Type	Edit Statement	Violation; Result	Corrective Action	Applicable Records
A48	Mental Health Diagnosis (continued)	NF	Relational	A valid value for a MH data field is accepted on a SA record only when a client is reported to have co-occurring SA and MH problems.	For a SA record, Mental Health Diagnosis has a valid value other than 999.9997 or 999.9998 but Co-occurring MH and SA Problems data field has a value of '2 No'; record is processed with the reported field value.	*This is a MH data field only;* **Co-occurring MH and SA Problems** *data field must be a 'Yes' to allow reporting on a SA record. Review both fields and take corrective action*	SA Admissions, if reported
A49	Payment Source	NF	Field	Payment Source must have a valid value. Blank is not accepted.	Payment Source is either blank or has an invalid value; record is processed but field value is replaced with the system code '99' for invalid data.	*Records with invalid data should be reviewed and replaced with valid values specified in the Manual*	All Admissions
A50	Pregnant at Admission	NF	Field	Pregnant at admission must have a valid value. Blank is not accepted.	Pregnant at Admission is either blank or has an invalid value; record is processed but field value is replaced with the system code '9' for invalid data.	*Records with invalid data should be reviewed and replaced with valid values specified in the Manual*	All Admissions
A51	Pregnant at Admission (continued)	NF	Relational	Gender must be '2 Female' when Pregnant at Admission has value of '1 Yes'.	Pregnant at Admission has a value of '1' with gender of '1 Male'; record is processed but field value is replaced with the system code '6' for Not Applicable.	*INFORMATIONAL: Value for* **Pregnant at admission** *has been replaced with '6 Not Applicable' to conform with* **Gender** *'2 Male'*	All Admissions
A52	Previous SA Treatment Episodes	NF	Field	Previous SA Treatment Episodes must have a valid value. Blank is not accepted.	Previous SA Treatment Episodes is either blank or has an invalid value; record is processed but field value is replaced with the system code '9' for invalid data.	*Records with invalid data must be reviewed and replaced with valid values specified in the Manual*	All SA Admissions [and MH Admissions, if reported]

Edit No.	Field Name	Error Type	Edit Type	Edit Statement	Violation; Result	Corrective Action	Applicable Records
A53	Previous SA Treatment Episodes (continued)	NF	Relational	A valid value for a SA data field is accepted on a MH record only when a client is reported to have co-occurring SA and MH problems.	Valid value (other than '7' or '8') is reported for Previous SA Treatment Episodes but Co-Occurring MH and SA Problems field is a '2 No'; record is processed with the reported field value.	*This is a SA data field only;* **Co-occurring SA and MH Problems** *data field must be a 'Yes' to allow reporting on a MH record. Review both fields and take corrective action*	MH Admissions, if reported
A54	Race	NF	Field	Race must have a valid value. Blank is not accepted.	Race is either blank or has an invalid value; record is processed but field value is replaced with the system code '99' for invalid data.	*Records with invalid data should be reviewed and replaced with valid values specified in the Manual*	All Admissions
A55	Referral Source	NF	Field	Referral Source must have a valid value. Blank is not accepted.	Referral Source is either blank or has an invalid value; record is processed but field value is replaced with the system code '99' for invalid data.	*Records with invalid data should be reviewed and replaced with valid values specified in the Manual*	All Admissions
A56	Route of Administration	NF	Field	Route of Administration must have a valid value. Blank is not accepted.	Route of Administration is either blank or has an invalid value; record is processed but field value is replaced with the system code '99' for invalid data.	*Records with invalid data should be reviewed and replaced with valid values specified in the Manual*	All SA Admissions [and MH Admissions, if reported]
A57	Route of Administration (continued)	NF	Relational	A valid value for a SA data field is accepted on a MH record only when a client is reported to have co-occurring SA and MH problems.	Route of Administration has a valid value (not '96', '97', '98') but Co-occurring MH and SA Problems field value is '2 No' in a MH record; record is processed with the reported field value.	*This is a SA data field only;* **Co-occurring SA and MH Problems** *data field must be a 'Yes' to allow reporting on a MH record. Review both fields and take corrective action*	MH Admissions, if reported

Edit No.	Field Name	Error Type	Edit Type	Edit Statement	Violation; Result	Corrective Action	Applicable Records
A58	School Attendance Status	NF	Field	School Attendance Status must have a valid value. Blank is not accepted.	School Attendance Status is either blank or has an invalid value; record is processed but field value is replaced with the system code '9' for invalid data.	*Records with invalid data should be reviewed and replaced with valid values specified in the Manual*	All MH Admissions [and SA Admissions, if reported]
A59	School Attendance Status (continued)	NF	Relational	To perform the age validation check, both School Attendance Status and Date of Birth fields must have valid values.	Age check cannot be performed if reported Date of Birth is either '01010007', '01010008',' 01010009'; informational message is generated.	*INFORMATIONAL: Validation using age criteria is not performed. Please review all relevant fields and take corrective action.*	All MH Admissions
A60	School Attendance Status (continued)	NF	Relational	A value of '1 Yes', '2 No', or '7 Unknown' must be reported only for 3-17 years old with the exception for young adults under the IDEA, 18-21. All other ages (and those not under the IDEA) must have a value of '6 Not Applicable'. If this data field is not collected, use '8 Not Collected'	School Attendance Status value for clients between 3 and 17 years old is '6' or clients > 21 years old have a value of '1' or '2'; record is processed but field value is replaced with the system code '9' for invalid data.	*Records with invalid data should be reviewed and replaced with valid values consistent with the coding guideline in the Manual. Review all relevant fields and take corrective action*	All MH Admissions
A61	SMI/SED Status	NF	Field	SMI/SED Status must have a valid value. Blank is not accepted.	SMI/SED Status is either blank or has an invalid value; record is processed but field value is replaced with the system code '9' for invalid data.	*Records with invalid data should be reviewed and replaced with valid values specified in the Manual*	All MH Admissions [and SA Admissions, if reported]
A62 New	SMI/SED Status (continued)	NF	Relational	Age check is performed. SMI status must be 18 years and older; SED/At Risk of SED status must be 17 years and younger. Young adults, 18-21, may have either SMI or SED/At Risk of SED.	SMI/SED Status value does not conform to the guideline on age criteria; record is processed but field value is replaced with the system code '9' for invalid data.	*Records with invalid data should be reviewed and replaced with valid values consistent with the age criteria specified in the Manual*	All MH Admissions

Edit No.	Field Name	Error Type	Edit Type	Edit Statement	Violation; Result	Corrective Action	Applicable Records
A63	SMI/SED Status (continued)	NF	Relational	A valid value for a MH data field is accepted on a SA record only when a client is reported to have co-occurring SA and MH problems.	For a SA record, SMI/SED Status has a valid value other than '7 Unknown' or '8 Not Collected' but Co-occurring SA and MH Problems data field has a value of '2 No'; record is processed with the reported field value.	*This is a MH data field only;* **Co-occurring SA and MH Problems** *data field must be a 'Yes' to allow reporting on a SA record. Review both fields and take corrective action*	SA Admissions, if reported
A64 New	SMI/SED Status (continued)	NF	Relational	To perform the age validation check, both SMI/SED Status and Date of Birth fields must have valid values.	Age check cannot be performed if reported Date of Birth is either '01010007', '01010008',' 01010009'; informational message is generated.	*INFORMATIONAL: Validation using age criteria is not performed. Please review all relevant fields and take corrective action.*	All MH Admissions
A65	Source of Income/Support	NF	Field	Source of Income/Support must have a valid value. Blank is not accepted.	Source of Income/Support is either blank or has an invalid value; record is processed but field value is replaced with the system code '99' for invalid data.	*Records with invalid data should be reviewed and replaced with valid values specified in the Manual*	All Admissions
A66	State Provider ID	F	Field	State Provider ID is a KEY field. It must have a valid value. Blank or all zeros is not accepted.	State Provider ID is either blank, an invalid value, or all zeros; record is rejected and not processed.	*See Manual for guidance on acceptable ID format*	All Admissions
A67	State Provider ID (continued)	Non Fatal (NF)	Relational	A match of the State Provider ID is conducted with the list of state facilities in the I-BHS.	State Provider ID did not find a match in the I-BHS; informational message is generated.	*INFORMATIONAL: This Provider ID did not find a match in the I-BHS. Please refer to Chapter 6 of the TEDS Manual for guidance.*	All Admissions
A68	Substance Abuse Diagnosis	NF	Field	Substance Abuse Diagnosis must have a valid value. Blank is not accepted.	Substance Abuse Diagnosis is either blank or has an invalid value; record is processed but field value is replaced with the system code '999.9999' for invalid data.	*Records with invalid data should be reviewed and replaced with valid values specified in the Manual*	All Admissions

Edit No.	Field Name	Error Type	Edit Type	Edit Statement	Violation; Result	Corrective Action	Applicable Records
A69	Substance Abuse Diagnosis (continued)	NF	Relational	A valid Substance Abuse Diagnosis reported on a MH record must give a value of '1 Yes' for the Co-occurring MH and SA Problems data field.	Substance Abuse Diagnosis has a valid value (not '999.9997' or '999.9998') but Co-occurring SA and MH Problems field value is a '2 No' in a MH record; record is processed with the reported field value.	*This is a SA data field only;* **Co-occurring SA and MH Problems** *data field must be a 'Yes' to allow reporting on a MH record. Review both fields and take corrective action*	MH Admissions, if reported
A70	Substance Abuse Problem (Primary, Secondary, Tertiary)	NF	Field	Substance Abuse Problem must have a valid value. Blank is not accepted.	Substance Abuse Problem is either blank or has an invalid value; record is processed but field value is replaced with the system code '99' for invalid data.	*Records with invalid data should be reviewed and replaced with valid values specified in the Manual*	All SA Admissions [and MH Admissions, if reported]
A71	Substance Abuse Problem (Primary, Secondary, Tertiary) (continued)	NF	Relational	A valid value for a SA data field is accepted on a MH record only when a client is reported to have co-occurring MH and SA problems.	Substance Abuse Problem has a valid value (not '01', '97', '98') but Co-occurring SA and MH Problems field value is a '2 No' in a MH record; record is processed with the reported field value.	*This is a SA data field only;* **Co-occurring SA and MH Problems** *data field must be a 'Yes' to allow reporting on a MH record. Review both fields and take corrective action*	MH Admissions, if reported

Edit No.	Field Name	Error Type	Edit Type	Edit Statement	Violation; Result	Corrective Action	Applicable Records
A72 (a, b, c)	Substance Abuse Problem (Primary, Secondary, Tertiary) (continued)	NF	Relational	A record with the same Substance Abuse Problem and Route of Administration must have different Detailed Drug Code across the Primary, Secondary, and Tertiary SA Problems. Else it is a duplicate.	Duplicate. Two or more SA Problems are reported with the same Route of Administration and Detailed Drug Code; the first SA Problem with the same Route of Administration and Detailed Drug Code is processed, other(s) will be considered as duplicate(s) and the SA Problem(s) and Route(s) of Administration will be replaced with the system code '99' and the Detailed Drug Code(s) with '9999' for invalid data.	*Duplicate(s) exists. Two or more* **SA Abuse Problem** *with the same* **Route of Administration** *and* **Detailed Drug Code** *are reported. Review these fields and take corrective action.*	All SA Admissions
A73	System Transaction Type	Fatal (F)	Field	System Transaction Type must have a valid value. Blank value is not accepted.	System Transaction Type is either blank or has an invalid value; record is rejected and not processed.	*Must report a field value using only the valid codes specified in the Manual*	All Admissions
A74	Type of Treatment Service/Setting	F	Field	Type of Treatment Service/Setting is a KEY field. It must have a valid value. Blank is not accepted.	Type of Treatment Service/Setting is either blank or has an invalid value; record is rejected and not processed.	*Must report a field value using only the valid codes specified in the Manual*	All Admissions
A75	Type of Treatment Service/Setting (continued)	F	Relational	Type of Treatment Service/Setting setting must conform to the Client Transaction Type.	Type of Treatment Service/Setting value does not conform to the reported Client Transaction Type; record is rejected and not processed.	**Type of Treatment Service/Setting** *must use either codes '01-08' if* **Client Transaction Type** *is either 'A' or 'T', or codes '72-76' if Client Transaction Type is either 'M' or 'X'*	All Admissions

Edit No.	Field Name	Error Type	Edit Type	Edit Statement	Violation; Result	Corrective Action	Applicable Records
A76	Veteran Status	NF	Field	Veteran Status must have a valid value. Blank is not accepted.	Veteran Status is either blank or has an invalid value; record is processed but field value is replaced with the system code '9' for invalid data.	*Records with invalid data should be reviewed and replaced with valid values specified in the Manual*	All Admissions

EDIT CHECKS FOR DISCHARGE/UPDATE RECORD

Edit No.	Field Name	Error Type	Edit Type	Edit Statement	Violation; Result	Corrective Action	Applicable Records
D1	Arrests in Past 30 Days - Discharge	NF	Field	Arrests in Past 30 Days - Discharge must have a valid value. Blank is not accepted.	Arrest value is either blank or invalid; record is processed but field value is replaced with the system code '99' for invalid data.	*Records with invalid data should be reviewed and replaced with valid values specified in the Manual*	All Discharges and MH Updates
D2	Attendance at SA Self-Help Groups in Past 30 Days - Discharge	NF	Field	Attendance at SA Self-Help Groups in Past 30 Days - Discharge must have a valid value. Blank is not accepted.	Attendance at SA Self-Help Groups is either blank or has an invalid value; record is processed but field value is replaced with the system code '99' for invalid data.	*Records with invalid data should be reviewed and replaced with valid values specified in the Manual*	All SA Discharges [and MH Discharges or Updates, if reported]
D3	Attendance at SA Self-Help Groups in Past 30 Days – Discharge (continued)	NF	Relational	A valid value for a SA data field is accepted on a MH record only when a client is reported to have co-occurring MH and SA problems.	Attendance at SA Self-Help Groups has valid value (not '97' or '98') but Co-occurring MH and SA Problems field value is a '2 No' in a MH record; record is processed with the reported field value.	*This is a SA data field only;* **Co-occurring SA and MH Problems** *data field must be a 'Yes' to allow reporting on a MH record. Review both fields and take corrective action*	MH Discharges or Updates, if reported

Edit No.	Field Name	Error Type	Edit Type	Edit Statement	Violation; Result	Corrective Action	Applicable Records
D4	CGAS/GAF Score	NF	Field	CGAS/GAF Score must have a valid value. Blank is not accepted.	CGAS/GAF Score is either blank or has an invalid value; record is processed but field value is replaced with the system code '999' for invalid data.	*Records with invalid data should be reviewed and replaced with valid values specified in the Manual*	All MH Discharges or Updates [and SA Admissions, if reported]
D5	CGAS/GAF Score (continued)	NF	Relational	A valid value for a MH data field is accepted on a SA record only when a client is reported to have co-occurring MH and SA problems.	For a SA record, CGAS/GAF Score has a valid value other than '997 Unknown' or '998 Not Collected' but Co-occurring MH and SA Problems data field has a value of '2 No'; record is processed with the reported field value.	*This is a MH data field only;* **Co-occurring SA and MH Problems** *data field must be a 'Yes' to allow reporting on a SA record. Review both fields and take corrective action*	SA Admissions, if reported
D6	Client ID	F	Field	Client ID Is a KEY field. It must have a valid value. Blank or all zeros is not accepted.	Client ID is either blank, an invalid value, or all zeros; record is rejected and not processed.	*See Manual for guidance on acceptable ID format*	All Discharges and MH Updates
D7	Client ID at Admission	NF	Field	Client ID at Admission must be a valid value.	Client ID at Admission is either blank, has an invalid value, all zeros; record is processed with the reported field value.	*Field value should conform to the Admission Record. Please review and replace with valid values.*	All Discharges and MH Updates
D8 New	Client Transaction Type at Admission	NF	Field	Client Transaction Type at Admission must be a valid value.	Client Transaction Type at Admission is either blank or has an invalid value; record is processed with the reported field value.	*Field value should conform to the Admission Record. Please review and replace with valid values.*	All Discharges and MH Updates
D9	Client Transaction Type at Discharge	F	Field	Client Transaction Type is a KEY field. It must have a valid value. Blank is not accepted.	Client Transaction Type at Discharge is either blank or has an invalid value; record is rejected and not processed.	*Must report a field value using only the valid codes specified in the Manual*	All Discharges and MH Updates

Edit No.	Field Name	Error Type	Edit Type	Edit Statement	Violation; Result	Corrective Action	Applicable Records
D10 New	Codependent/Collateral at Admission	NF	Field	Codependent/Collateral at Admission must be a valid value.	Codependent/Collateral at Admission is either blank or has an invalid value; record is processed with the reported field value.	*Field value should conform to the Admission Record. Please review and replace with valid values.*	All Discharges and MH Updates
D11	Codependent/Collateral	F	Field	Codependent is a KEY field. It must have a valid value. Blank is not accepted.	Codependent/Collateral is either blank or has an invalid value; record is rejected and not processed.	*Must report a field value using only the valid codes specified in the Manual*	All Discharges and MH Updates
D12	Date of Admission	NF	Field	Date of Admission must be a valid value and format.	Date of Admission is either blank, uses the wrong date format, or has an invalid value; record is processed but field value is replaced with the system code '01010009' for invalid data.	*Field value should conform to the Admission Record. Please review and replace with valid values.*	All Discharges and MH Updates
D13	Date of Birth at Admission	NF	Field	Date of Birth must be a valid calendar date and in a valid format.	Date of Birth at Admission is either blank, an invalid value, wrong date format; record is processed but field value is replaced with the system code '01010009' for invalid data.	*Field value should conform to the Admission Record. Please review and replace with valid values.*	All Discharges and MH Updates
D14	Date of Discharge	F	Field	Date of Discharge is a KEY field. It must be a valid calendar date and in a valid format. Blank is not accepted.	Date of Discharge is either blank, has an invalid value, or wrong date format; record is rejected and not processed.	**Date of Discharge** *must be a valid calendar date in the format MMDDYYYY*	All Discharges
D15	Date of Discharge (continued)	F	Field	Date of Discharge is a KEY field for substance abuse and must be on or after January 1, 2000.	Date of Discharge is before January 1, 2000; record is rejected and not processed.	**Date of Discharge** *must be January 1, 2000 or later*	All SA Discharges

Edit No.	Field Name	Error Type	Edit Type	Edit Statement	Violation; Result	Corrective Action	Applicable Records
D16	Date of Discharge (continued)	F	Field	Date of Discharge is a KEY field for mental health and must be on or after January 1, 1920.	Date of Discharge is before January 1, 1920; record is rejected and not processed.	**Date of Discharge** *must be January 1, 1920 or later*	All MH Discharges
D17	Date of Discharge (continued)	F	Relational	Date of Discharge must be either the same or earlier than the Reporting Date.	Date of Discharge is later than the Reporting date; record is rejected and not processed.	**Date of Discharge** *must be the same date or earlier than the current date or the* **Reporting Date**	All Discharges
D18	Date of Discharge (continued)	F	Relational	Date of Discharge must be either the same or later than the Date of Admission.	Date of Discharge is earlier than the Date of Admission; record is rejected and not processed.	**Date of Discharge** *must be the same date or later than the* **Date of Admission**	All Discharges
D19	Date of Discharge (continued)	F	Relational	Update means the client has not been discharged from treatment. Date of Discharge field should be '01010006 Not Applicable.'	Date of Discharge is a valid date; record is rejected and not processed.	**Date of Discharge** *must be '01010006' when* **Client Transaction Type** *is 'U Update'. Records with invalid data should be reviewed and take corrective action.*	MH Updates
D20	Date of Last Contact or Data Update	F	Field	Date of Last Contact or Data Update is a KEY field for MH update records. It must have a valid value and format. Blank is not accepted.	Date of Last Contact or Data Update is either blank, uses the wrong date format, or has an invalid value; record is rejected and not processed.	**Date of Last Contact or Data Update** *must be a valid calendar date in the format MMDDYYYY*	MH Updates
D21	Date of Last Contact or Data Update (continued)	F	Field	Date of Last Contact or Data Update is a KEY field for MH update records. Valid field value must be January 1, 1920, or later.	Date of Last Contact or Data Update is before January 1, 1920; record is rejected and not processed.	**Date of Last Contact or Data Update** *must be January 1, 1920, or later*	MH Updates
D22	Date of Last Contact or Data Update (continued)	F	Relational	Date of Last Contact or Data Update in a MH update record must be either the same or earlier than the Reporting Date.	Date of Last Contact or Data Update is later than the Reporting date; record is rejected and not processed.	**Date of Last Contact or Data Update** *must be the same date or earlier than the current date or the* **Reporting Date**	MH Updates

Edit No.	Field Name	Error Type	Edit Type	Edit Statement	Violation; Result	Corrective Action	Applicable Records
D23	Date of Last Contact or Data Update (continued)	NF	Field	Date of Last Contact or Data Update must have a valid value and format. Blank is not accepted.	Date of Last Contact or Data Update is either blank, uses the wrong date format, or has an invalid value; record is processed but field value is replaced with the system code '01010009' for invalid data.	**Date of Last Contact or Data Update** *must be a valid calendar date in the format MMDDYYYY. Records with invalid data should be reviewed and take corrective action.*	All Discharges
D24	Date of Last Contact or Data Update (continued)	NF	Relational	Date of Last Contact or Data Update must be either the same or earlier than the Reporting Date.	Date of Last Contact or Data Update is later than the Reporting date; record is processed but field value is replaced with the system code '01010009' for invalid data.	**Date of Last Contact or Data Update** *must be the same date or earlier than the current date or the* **Reporting Date**	All Discharges
D25 New	Date of Last Contact or Data Update (continued)	NF	Relational	Date of Last Contact or Data Update must be either the same or later than the Date of Admission.	Date of Last Contact or Data Update is earlier than the Admission date; record is processed but field value is replaced with the system code '01010009' for invalid data.	**Date of Last Contact or Data Update** *must be the same date or later than the* **Date of Admission**	All Discharges
D26	Date of Last Contact or Data Update (continued)	NF	Relational	Date of Last Contact or Data Update must be either the same or earlier than the Discharge Date.	Date of Last Contact or Data Update is later than the Discharge date; record is processed but field value is replaced with the system code '01010009' for invalid data.	**Date of Last Contact or Data Update** *must be the same date or earlier than the current date or the* **Date of Discharge**	All Discharges
D27	Date of Last Contact or Data Update (continued)	NF	Field	Date of Last Contact or Data Update must be January 1, 2000, or later.	Date of Last Contact or Data Update is before January 1, 2000; record is processed but field value is replaced with the system code '01010009' for invalid data.	**Date of Last Contact or Data Update** *must be January 1, 2000, or later. Records with invalid data should be reviewed and take corrective action.*	SA Discharges

Edit No.	Field Name	Error Type	Edit Type	Edit Statement	Violation; Result	Corrective Action	Applicable Records
D28	Date of Last Contact or Data Update (continued)	NF	Field	Date of Last Contact or Data Update must have a valid field value of January 1, 1920, or later.	Field value is before January 1, 1920; record is processed but field value is replaced with the system code '01010009' for invalid data.	**Date of Last Contact or Data Update** *must be January 1, 1920. or later. Records with invalid data should be reviewed and take corrective action.*	MH Discharges
D29	Date of Last Contact or Data Update (continued)	NF	Relational	Either the Date of Last Contact or Data Update or the Date of Discharge must be valid when the System Transaction Type is 'D Delete' or 'C Change.'	The System Transaction Type is 'D' or 'C' but the Date of Last Contact or Data Update is blank, uses the wrong date format, or has an invalid date; if the Date of Discharge is valid, the Date of Last Contact or Data Update field value is replaced with the system code '01010009' for invalid data.	*INFORMATIONAL: The* **Date of Last Contact or Data Update** *field value was replaced with the system code for invalid data.*	All Discharges
D30	Detailed Not in Labor Force	NF	Field	Detailed Not in Labor Force must have a valid value. Blank is not accepted.	Detailed Not in Labor Force is either blank or has an invalid value; record is processed but field value is replaced with the system code '99' for invalid data.	*Records with invalid data should be reviewed and replaced with valid values specified in the Manual*	All Discharges and MH Updates
D31	Detailed Not in Labor Force (continued)	NF	Relational	Detailed Not in Labor Force must be a '96 Not Applicable' if Employment Status is not '04 Not in labor Force', '97', or '98'.	Detailed Not in Labor Force has a valid value that is not '96' , '97', '98' when Employment Status is not '04 Not in Labor Force'; record is processed but field value is replaced with the system code '99' for invalid data.	*Records with invalid data should be reviewed and replaced with valid values consistent with the coding criteria in the Manual. Review both fields and take corrective action*	All Discharges and MH Updates

Edit No.	Field Name	Error Type	Edit Type	Edit Statement	Violation; Result	Corrective Action	Applicable Records
D32	Diagnostic Code Set Identifier	NF	Field	Diagnostic Code Set Identifier must have a valid value. Blank is not accepted.	Diagnostic Code Set Identifier is either blank or has an invalid value; record is processed but field value is replaced with the system code '9' for invalid data.	*Records with invalid data should be reviewed and replaced with valid values specified in the Manual*	All Discharges and MH Updates
D33	Diagnostic Code Set Identifier (continued)	NF	Relational	Diagnostic Code Set Identifier must have a valid value when MH Diagnosis has valid value that is not '999.9997 Unknown' or '999.9998 Not Collected'.	Diagnostic Code Set Identifier is either blank or has an invalid value when MH Diagnosis field(s) has valid value other than '999.9997' or '999.9998'; record is processed but field value is replaced with the system code '9' for invalid data.	*Records with invalid data should be reviewed and replaced with valid values specified in the Manual. Review all relevant fields and take corrective action*	All MH Discharges and MH Updates
D34	Education	NF	Field	Education must have a valid value. Blank is not accepted.	Education is either blank or has an invalid value; record is processed but field value is replaced with the system code '99' for invalid data.	*Records with invalid data should be reviewed and replaced with valid values specified in the Manual*	All Discharges and MH Updates
D35	Education (continued)	NF	Relational	Education must have a valid value when School Attendance is either '1' or '2' for school-age children receiving MH services (3 through 17 years old and young adults 18 through 21 under IDEA).	Education is either blank or has an invalid value when School Attendance is either '1' or '2'; record is processed but field value is replaced with the system code '9' for invalid data.	**Education** *field should have valid value for school-age children if* **School Attendance** *has a value of '1' or '2'. Review both fields and take corrective action*	MH Discharges and Updates
D36	Employment Status	NF	Field	Employment Status must have a valid value. Blank is not accepted.	Employment Status is either blank or has an invalid value; record is processed but field value is replaced with the system code '99' for invalid data.	*Records with invalid data should be reviewed and replaced with valid values specified in the Manual*	All Discharges and MH Updates

Edit No.	Field Name	Error Type	Edit Type	Edit Statement	Violation; Result	Corrective Action	Applicable Records
D37	Frequency of Use	NF	Field	Frequency of Use must have a valid value. Blank is not accepted.	Frequency of Use is either blank or has an invalid value; record is processed but field value is replaced with the system code '99' for invalid data.	*Records with invalid data should be reviewed and replaced with valid values specified in the Manual*	All SA Discharges [and MH Discharges or Updates, if reported]
D38	Frequency of Use (continued)	NF	Relational	A valid value for a SA data field is accepted on a MH record only when a client is reported to have co-occurring SA and MH problems.	Frequency of Use has a valid value (not '96', '97', '98') but Co-occurring SA and MH Problems field value is a '2 No' in a MH record; record is processed with the reported field value.	*This is a SA data field only;* **Co-occurring SA and MH Problems** *data field must be a 'Yes' to allow reporting on a MH record. Review both fields and take corrective action*	MH Discharges and MH Updates, if reported
D39	Gender at Admission	NF	Field	Gender must be a valid value.	Gender is either blank or an invalid value; record is processed but field value is replaced with the system code '9' for invalid data.	*Field value should conform to the Admission Record. Please review and replace with valid values.*	All Discharges and MH Updates
D40	Hispanic or Latino Origin (Ethnicity) at Admission	NF	Field	Hispanic or Latino Origin must be a valid value.	Hispanic or Latino Origin is either blank or an invalid value; record is processed but field value is replaced with the system code '99' for invalid data.	*Field value should conform to the Admission Record. Please review and replace with valid values.*	All Discharges and MH Updates
D41	Living Arrangements	NF	Field	Living Arrangements must have a valid value. Blank is not accepted.	Living Arrangements is either blank or has an invalid value; record is processed but field value is replaced with the system code '99' for invalid data.	*Records with invalid data should be reviewed and replaced with valid values specified in the Manual*	All Discharges and MH Updates
D42	Mental Health Diagnosis	NF	Field	Mental Health Diagnosis must have a valid value. Blank is not accepted.	Mental Health Diagnosis is either blank or has an invalid value; record is processed but field value is replaced with the system code '999.9999' for invalid data.	*Records with invalid data should be reviewed and replaced with valid values specified in the Manual*	All MH Discharges or Updates [and SA Admissions, if reported]

Edit No.	Field Name	Error Type	Edit Type	Edit Statement	Violation; Result	Corrective Action	Applicable Records
D43	Mental Health Diagnosis (continued)	NF	Relational	Up to three mental health diagnoses may be reported but they must not use the same diagnostic code. Else it is a duplicate.	Duplicate. There are at least two reported diagnostic codes that are the same. The first will be processed, other(s) will be considered duplicate(s) and the field value is replaced with the system code '999.9999' for invalid data.	*Duplicates exist. At least two MH Diagnoses of the same codes are reported in* **MH Diagnoses (One, Two, and Three)**. *Please take corrective action.*	All MH Discharges and MH Updates
D44	Mental Health Diagnosis (continued)	NF	Relational	A valid value for a MH data field is accepted on a SA record only when a client is reported to have co-occurring MH and SA problems.	For a SA record, Mental Health Diagnosis has a valid value other than 999.9997 or 999.9998 but Co-occurring MH and SA Problems data field has a value of '2 No'; record is processed with the reported field value.	*This is a MH data field only;* **Co-occurring SA and MH Problems** *data field must be a 'Yes' to allow reporting on a SA record. Review both fields and take corrective action*	SA Discharges, if reported
D45 New	Race at Admission	NF	Field	Race must be a valid value.	Race at Admission is either blank or an invalid value; record is processed but field value is replaced with the system code '99' for invalid data.	*Field value should conform to the Admission Record. Please review and replace with valid values.*	All Discharges and MH Updates
D46	Reason for Discharge, Transfer, or Discontinuance of Treatment	NF	Field	Reason for Discharge, Transfer, or Discontinuance of Treatment must have a valid value. Blank is not accepted.	Reason for Discharge, Transfer, or Discontinuance of Treatment is either blank or has an invalid value; record is processed but field value is replaced with the system code '99' for invalid data.	*Records with invalid data must be reviewed and replaced with valid values specified in the Manual*	All Discharges

Edit No.	Field Name	Error Type	Edit Type	Edit Statement	Violation; Result	Corrective Action	Applicable Records
D47	Reason for Discharge, Transfer, or Discontinuance of Treatment (continued)	NF	Field	Field value must use code '97' for Unknown.	Reason for Discharge, Transfer, or Discontinuance of Treatment is '08 Unknown'; record is processed but field value is replaced with '97' the preferred code for Unknown.	*INFORMATIONAL: Code 08 will be retired soon. Value is replaced with new Unknown code, 97*	All Discharges
D48	Reason for Discharge, Transfer, or Discontinuance of Treatment (continued)	NF	Relational	Reason for Discharge, Transfer, or Discontinuance of Treatment must be '96 Not Applicable' on MH update records.	Reason for Discharge, Transfer, or Discontinuance of Treatment is not '96' on MH update record; record is processed but field value is replaced with the system code '99' for invalid data.	**Reason for Discharge, Transfer, or Discontinuance of Treatment** *must be '96' when* **Client Transaction Type** *is 'U Update'. Records with invalid data should be reviewed and take corrective action.*	MH Updates
D49	School Attendance Status	NF	Field	School Attendance Status must have a valid value. Blank is not accepted.	School Attendance Status is either blank or has an invalid value; record is processed but field value is replaced with the system code '9' for invalid data.	*Records with invalid data should be reviewed and replaced with valid values specified in the Manual*	All MH Discharges or Updates [and SA Admissions, if reported]
D50	School Attendance Status (continued)	NF	Relational	To perform the age validation check, School Attendance Status and Date of Birth fields must both have valid values.	Age check cannot be performed if reported Date of Birth is either '01010007', '01010008',' 01010009'; informational message is generated.	*INFORMATIONAL: Validation using age criteria is not performed. Please review all relevant fields and take corrective action.*	All MH Discharges and MH Updates

Edit No.	Field Name	Error Type	Edit Type	Edit Statement	Violation; Result	Corrective Action	Applicable Records
D51	School Attendance Status (continued)	NF	Relational	A value of '1 Yes', '2 No', or '7 Unknown' must be reported only for clients 3-17 years old with the exception for young adults 18-21 under the IDEA. All other ages (and those not under the IDEA) must have a value of '6 Not Applicable'. If this data field is not collected, use '8 Not Collected'	School Attendance Status value for clients between 3 and 17 years old is '6' or clients > 21 years old have a value of '1' or '2'; record is processed but field value is replaced with the system code '9' for invalid data.	*Records with invalid data should be reviewed and replaced with valid values consistent with the coding guideline in the Manual. Review all relevant fields and take corrective action*	All MH Discharges or Updates
D52	SMI/SED Status	NF	Field	SMI/SED Status must have a valid value. Blank is not accepted.	SMI/SED Status is either blank or has an invalid value; record is processed but field value is replaced with the system code '9' for invalid data.	*Records with invalid data should be reviewed and replaced with valid values specified in the Manual*	All MH Discharges or Updates [and SA Admissions, if reported]
D53	SMI/SED Status (continued)	NF	Relational	Age check is performed. SMI status must be 18 years and older; SED/At Risk of SED status must be 17 years and younger. Exception exists for younger adults 18-21 under IDEA when either SMI or SED/At Risk of SED is accepted.	SMI/SED Status does not conform to the guideline on age criteria; record is processed but field value is replaced with the system code '9' for invalid data.	*Records with invalid data should be reviewed and replaced with valid values consistent with the age criteria specified in the Manual*	All MH Discharges or Updates
D54	SMI/SED Status (continued)	NF	Relational	A valid value for a MH data field is accepted on a SA record only when a client is reported to have co-occurring MH and SA problems.	For a SA record, SMI/SED Status has a valid value other than '7 Unknown' or '8 Not Collected' but Co-occurring MH and SA Problems data field has a value of '2 No'; record is processed with the reported field value.	*This is a MH data field only;* **Co-occurring MH and SA Problems** *data field must be a 'Yes' to allow reporting on a SA record. Review both fields and take corrective action*	SA Admissions, if reported

Edit No.	Field Name	Error Type	Edit Type	Edit Statement	Violation; Result	Corrective Action	Applicable Records
D55	SMI/SED Status (continued)	NF	Relational	To perform the age validation check, SMI/SED Status and Date of Birth fields must both have valid values.	Age check cannot be performed if reported Date of Birth is either '01010007', '01010008',' 01010009'; informational message is generated.	*INFORMATIONAL: Validation using age criteria is not performed. Please review all relevant fields and take corrective action.*	All MH Discharges and MH Updates
D56	State Provider ID at Admission	NF	Field	State Provider ID must be a valid value.	State Provider ID at Admission is either blank, an invalid value, or all zeros; record is processed with the reported field value.	*Field value should conform to the Admission Record. Please review and replace with valid values.*	All Discharges and MH Updates
D57	State Provider ID	F	Field	State Provider ID is a KEY field. It must have a valid value. Blank or all zeros is not accepted.	State Provider ID is either blank, an invalid value, or all zeros; record is rejected and not processed.	*See Manual for guidance on acceptable ID format*	All Discharges and MH Updates
D58	State Provider ID (continued)	Non Fatal (NF)	Relational	A match of the State Provider ID is conducted with the list of state facilities in the I-BHS.	State Provider ID did not find a match in the I-BHS; informational message is generated.	*INFORMATIONAL: This **State Provider ID** did not find a match in the I-BHS. Please refer to Chapter 6 of the TEDS Manual for guidance.*	All Discharges and MH Updates
D59	Substance Abuse Problem (Primary, Secondary, Tertiary)	NF	Field	Substance Abuse Problem must have a valid value. Blank is not accepted.	Substance Abuse Problem is either blank or has an invalid value; record is processed but field value is replaced with the system code '99' for invalid data.	*Records with invalid data should be reviewed and replaced with valid values specified in the Manual*	All Discharges and MH Updates
D60	Substance Abuse Problem (Primary, Secondary, Tertiary) (continued)	NF	Relational	A valid value for a SA data field is accepted on a MH record only when a client is reported to have co-occurring SA and MH problems.	Substance Abuse Problem has a valid value (not '01', '97', '98') but Co-occurring SA and MH Problems field value is a '2 No' in a MH record; record is processed with the reported field value.	*This is a SA data field only; **Co-occurring SA and MH Problems** data field must be a 'Yes' to allow reporting on a MH record. Review both fields and take corrective action*	MH Discharges and MH Updates, if reported

Edit No.	Field Name	Error Type	Edit Type	Edit Statement	Violation; Result	Corrective Action	Applicable Records
D61	System Transaction Type	Fatal (F)	Field	System Transaction Type must have a valid value. Blank value is not accepted.	System Transaction Type is either blank or has an invalid value; record is rejected and not processed.	*Must report a field value using only the valid codes specified in the Manual*	All Discharges and MH Updates
D62	Type of Treatment Service/Setting at Admission	NF	Field	Type of Treatment Service/Setting must be a valid value.	Type of Treatment Service/Setting at Admission is either blank or has an invalid value; record is processed with the reported field value.	*Field value should conform to the Admission Record. Please review and replace with valid values.*	All Discharges and MH Updates
D63	Type of Treatment Service/Setting (continued)	F	Field	Type of Treatment Service/Setting is a KEY field. It must have a valid value. Blank is not accepted.	Type of Treatment Service/Setting is either blank or has an invalid value; record is rejected.	*Must report a field value using only the valid codes specified in the Manual*	All Discharges and MH Updates
D64	Type of Treatment Service/Setting (continued)	F	Relational	Type of Treatment Service/Setting must conform to the Client Transaction Type.	Type of Treatment Service/Setting does not conform to the reported Client Transaction Type; record is rejected and not processed.	**Type of Treatment Service/Setting** *must use either codes '01-08' if* **Client Transaction Type** *is 'D', or codes '72-76' if Client Transaction Type is either 'U' or 'E'*	All Discharges and MH Updates
D65	Date of Last Contact or Data Update (continued)	F	Relational	Date of Last Contact or Data Update must be either the same or later than the Date of Admission.	Date of Last Contact or Data Update is earlier than the Date of Admission; record is rejected and not processed.	**Date of Last Contact or Data Update** *must be the same date or later than the* **Date of Admission**	MH Updates

Other Edit Checks During Record Processing:

Edit No.	Field Name	Error Type	Edit Type	Edit Statement	Violation; Result	Corrective Action	Applicable Records
O1	**System Transaction Type** = *A* (*Add*)	F	Other	An *Add* record that matches all the key fields of an existing record is considered a duplicate.	A duplicate record already exists in the TEDS database; the *Add* record is rejected.	*Review all key fields of rejected record and resubmit for processing*	All Admissions, Discharges or Updates; SA and MH records
O2	**System Transaction Type** = *C* (*Change*) or *D* (*Delete*)	F	Other	A record that matches the key fields in the *Change* or *Delete* record must already exist in the TEDS Admission database.	No record in the TEDS database matches the key fields of the Change or Delete record; the *Change* or *Delete* record is rejected and not processed.	*Review all key fields of rejected record and resubmit for processing*	All Admissions, Discharges or Updates; SA and MH records
O3	All Key fields	F	Other	Each record in the file must be unique.	Duplicate record(s) exists in the file; record is rejected and not processed.	*Review all records in the file and delete duplicates. Use all key fields to find duplicates.*	All Admissions, Discharges or Updates; SA and MH records
O4	All Key fields	NF	Other	Each discharge or update record must have a matching admission record in the TEDS database.	No admission record match; discharge or update record is processed.	*INFORMATIONAL. No matching admission record found for this discharge record. Submit the admission record associated with the discharge record.*	All discharges and MH updates

Appendix F. Using TEDS Records for BGAS Tables

PREPARATION OF TEDS LINKED ADMISSION/DISCHARGE RECORDS
FOR BGAS TABLES
All BGAS Forms

General Procedure

Exclude:

- Records from facilities not eligible for BGAS (according to state list).
- Records for codependents at admission OR at discharge.
- Records where age is less than 12 or age is unknown.

Calculate length of stay (LOS):

- If **Date of Last Contact** is a) missing, b) earlier than **Date of Admission**, OR c) later than **Date of Discharge**, change **Date of Last Contact** to **Date of Discharge**.
- Calculate LOS as **Date of Last Contact** minus **Date of Admission**.
- Exclude if LOS is 0 days or a negative number.
- If the **Type of Treatment Service/Setting at Discharge** is Ambulatory outpatient, Ambulatory intensive outpatient, or Ambulatory detoxification, add 1 day to LOS.

Recode missing, not collected, and invalid NOMs variables:

- NOMs variables are, for both admission and discharge: **Substance Abuse Problem (Primary, Secondary, Tertiary)**, **Frequency of Use (Primary, Secondary, Tertiary)**, **Living Arrangements**, **Employment Status**, **Detailed Not In Labor Force**, and **Arrests in Past 30 Days**; and (discharge only) **Reason for Discharge**.
- Recode missing, not collected, and invalid data to SAS 'missing' code to exclude from calculations.
- Valid values are
  Substance Abuse Problem (Primary, Secondary, Tertiary): 1-20
  Frequency of Use: 1-5; 96 if **Substance Abuse Problem** = 1
  Living Arrangements: 1-3
  Employment Status: 1-4
  Detailed Not In Labor Force: 1-6; 96 if **Employment Status** = 1-3
  Attendance at Self-Help Groups in Past 30 Days: 1-6
  Reason for Discharge: 1-7, 14

- Missing, not collected, and invalid codes are 97, 98, and 99, respectively; also include code 8 for **Reason for Discharge**.

Specific BGAS Tables

Form T-1. Employment/Education Status

Exclude:

- All **Types of Treatment Service/Setting at Discharge** except *Short-term residential, Long-term residential, Outpatient*, and *Intensive outpatient*.
- Records where **Medication-Assisted Opioid Therapy** is planned.
- Records where **Reason for Discharge** is *Death*.
- Records where **Reason for Discharge** is *Incarceration*.

Recode **Employment Status**/**Detailed Not In Labor Force**

- If **Employment Status** is *Not in labor force* and also:
- If **Detailed Not In Labor Force** is *Student*, then change **Employment Status** to *Student* (new code);
- If **Detailed Not in Labor Force** is anything other than *Student*, change **Employment Status** to *Non-student* (new code).

Numerator (Employed/student at admission):

- Include only records where **Employment Status at Admission** is *Employed full-time, Employed part-time*, or *Student* AND **Employment Status at Discharge** is not missing.

Numerator (Employed/student at discharge):

- Include only records where **Employment Status at Discharge** is *Employed full-time, Employed part-time*, or *Student* AND Employment Status at Admission is not missing.

Denominator:

- Exclude records where **Employment Status at Admission** is missing OR **Employment Status at Discharge** is missing.

Form T-2. Stable Housing Situation

Exclude:

- All **Types of Treatment Service/Setting at Discharge** except *Short-term residential*, *Long-term residential*, *Outpatient*, and *Intensive outpatient*.
- Records where **Medication-Assisted Opioid Therapy** is planned.
- Records where **Reason for Discharge** is *Death*.
- Records where **Reason for Discharge** is *Incarceration*.

Numerator (Stable housing at admission):

- Include only records where **Living Arrangements at Admission** is *Independent living* or *Dependent living* AND **Living Arrangements at Discharge** is not missing.

Numerator (Stable housing at discharge):

- Include only records where **Living Arrangements at Discharge** is *Independent living* or *Dependent living* AND **Living Arrangements at Admission** is not missing.

Denominator:

- Exclude records where **Living Arrangements at Admission** is missing OR **Living Arrangements at Discharge** is missing.

Form T-3. Criminal Justice Involvement – No Arrests

Exclude:

- All **Types of Treatment Service/Setting at Discharge** except *Short-term residential*, *Long-term residential*, *Outpatient*, and *Intensive outpatient*.
- Records where **Medication-Assisted Opioid Therapy** is planned.
- Records where **Reason for Discharge** is *Death*.

Numerator (No arrests at admission):

- Include only records where **Arrests in Past 30 Days at Admission** is *Zero* AND **Arrests in Past 30 Days at Discharge** is not missing.

Numerator (No arrests at discharge):

- Include only records where **Arrests in Past 30 Days at Discharge** is *Zero* AND **Arrests in Past 30 Days at Admission** is not missing.

Denominator:

- Exclude records where **Arrests in Past 30 Days at Admission** is missing OR **Arrests in Past 30 Days at Discharge** is missing.

Forms T-4A-C & T-5A-C. Alcohol and Drug Use/Abstinence

Exclude:

- All **Types of Treatment Service/Setting at Discharge** except *Short-term residential*, *Long-term residential*, *Outpatient*, and *Intensive outpatient*.
- Records where **Medication-Assisted Opioid Therapy** is planned.
- Records where **Reason for Discharge** is *Death*.

Definition of the BGAS abstinence variable:

- Identify a subset of records that have a valid **Substance Abuse Problem**/**Frequency of Use** pair at both admission and discharge at one of the levels of **Substance Abuse Problem (Primary, Secondary, and Tertiary)**.
- Alcohol abstinence is defined as all records in the subset that do not meet the criteria for alcohol use.
- Drug abstinence is defined as all records in the subset that do not meet the criteria for drug use.

Coding of the BGAS abstinence variable:

- Reduce each of 6 valid **Substance Abuse Problem**/**Frequency of Use** pairs to a single variable with the values:
- No alcohol use (**Substance Abuse Problem** is *Alcohol*, **Frequency of Use** is *No past month use*)
- No drug use (**Substance Abuse Problem** is a named drug, **Frequency of Use** is *No past month use*)
- Alcohol use (**Substance Abuse Problem** is *Alcohol*, **Frequency of Use** is *1-3 times in past month* through *Daily*)
- Drug use (**Substance Abuse Problem** is a named drug, **Frequency of Use** is *1-3 times in past month* through *Daily*)
- No alcohol or drug use (**Substance Abuse Problem** is *None*, **Frequency of Use** is *Not applicable*).
- Define a subset of records where there is a valid value for at least one of the 3 new admission variables AND at least one of the 3 new discharge variables.

- Valid pairs:
  - Where **Substance Abuse Problem** is any valid value of 2-18 or 20 with a **Frequency of Use** value of 1-5.
  - Where **Substance Abuse Problem** is 1 (*None*) and **Frequency of Use** is 96 (*Not applicable*). This was a valid pair in the 2006 BGAS, was not valid in the 2007 preliminary BGAS, but was restored as valid in the 2007 BGAS final, and remains valid to date.

- Within the subset, create alcohol and drug use/abstinence variables at admission and at discharge.
- Alcohol Use/Abstinence: *Alcohol use* if any of the 3 new admission variables is coded *Alcohol use*, otherwise *Alcohol abstinence*.
- Drub Use/Abstinence: *Drug use* if any of the 3 admission pairs is coded *Drug use*, otherwise *Drug abstinence*.

Form T-4A. Alcohol Abstinence

- Include only subset defined above (valid **Substance Abuse Problem**/**Frequency of Use** pair at admission and at discharge).

Numerator (Alcohol Abstinent at Admission):

- Include only records where Alcohol Use at Admission is *Abstinence*.

Numerator (Alcohol Abstinent at Discharge):

- Include only records where Alcohol Use at Admission is *Abstinence*.

Denominator:

- No additional inclusions/exclusions.

Form T-4B. Alcohol Abstinence at Discharge, Among Alcohol Users at Admission

- Include only subset defined above (valid **Substance Abuse Problem**/**Frequency of Use** pair at admission and at discharge).

Numerator (Alcohol use at admission and abstinence at discharge):

- Include only records where Alcohol Use at Admission is *Use* and Alcohol Use at Discharge is *Abstinence*.

Denominator (Alcohol use at admission):

- Include only records where Alcohol Use at Admission is *Use.*

Form T-4C. Alcohol Abstinence at Discharge, Among Alcohol Abstinent at Admission

- Include only subset defined above (valid **Substance Abuse Problem**/**Frequency of Use** pair at admission and at discharge).

Numerator (Alcohol abstinence at admission and alcohol abstinence at discharge):

- Include only records where Alcohol Use at Admission is *Abstinence* and Alcohol Use at Discharge is *Abstinence*.

Denominator (Alcohol abstinence at admission):

- Include only records where Alcohol Use at Admission is *Abstinence*.

Form T-5A. Drug Abstinence

- Include only subset defined above (valid **Substance Abuse Problem**/**Frequency of Use** pair at admission and at discharge).

Numerator (Drug abstinent at admission):

- Include only records where Drug Use at Admission is *Abstinence*.

Numerator (Drug abstinent at discharge):

- Include only records where Drug Use at Discharge is *Abstinence*.

Denominator:

- No additional inclusions/exclusions.

Form T-5B. Drug Abstinence at Discharge, Among Drug Users at Admission

- Include only subset defined above (valid **Substance Abuse Problem**/**Frequency of Use** pair at admission and at discharge).

Numerator (Drug use at admission and abstinence at discharge):

- Include only records where DRUG USE AT ADMISSION is Use and DRUG USE AT DISCHARGE is Abstinence.

Denominator (Drug use at admission):

- Include only records where DRUG USE AT ADMISSION is Use

Form T-5C. Drug Abstinence at Discharge, Among Drug Abstinent at Admission

- Include only subset defined above (valid **Substance Abuse Problem**/**Frequency of Use** pair at admission and at discharge).

Numerator (Drug Abstinence at Admission and Drug Abstinence at Discharge):

- Include only records where Drug Use at Admission is *Abstinence* and Drug Use at Discharge is *Abstinence*.

Denominator (Drug Abstinence at Admission):

- Include only records where Drug Use at Admission is *Abstinence*.

Form T-6. Social Support – Attendance at Self-Help Programs

Exclude:

- All Types of Treatment Service/Setting at Discharge except Short-term residential, Long-term residential, Outpatient, and Intensive outpatient.
- Records where **Medication-Assisted Opioid Therapy** is planned.
- Records where **Reason for Discharge** is *Death*.

Numerator (Attendance at self-help groups at admission):

- Include only records where **Attendance at SA Self-Help Groups in Past 30 Days at Admission** is *1-3 times* or more OR *Some attendance, frequency unknown* AND **Attendance at SA Self-Help Groups in Past 30 Days at Discharge** is not missing.

Numerator (Attendance at self-help programs at discharge):

- Include only records where **Attendance at SA Self-Help Groups in Past 30 Days at Discharge** is *1-3 times* or more OR *Some attendance, frequency unknown* AND **Attendance at SA Self-Help Groups in Past 30 Days at Admission** is not missing.

Denominator:

- Exclude records where **Attendance at SA Self-Help Groups in Past 30 Days at Admission** is missing OR **Attendance at SA Self-Help Groups in Past 30 Days at Discharge** is missing.

Form T-7. Length of Stay (LOS)

Recode **Type of Treatment Service/Setting at Discharge**:

- If **Type of Treatment Service/Setting at Discharge** is *Hospital detoxification*, *Residential detoxification*, or *Ambulatory detoxification* AND **Medication-Assisted Opioid Therapy** is planned, recode **Type of Treatment Service/Setting at Discharge** to *ORT detoxification* (new code).
- If **Type of Treatment Service/Setting at Discharge** is *Outpatient* AND **Medication-Assisted Opioid Therapy** is planned, recode **Type of Treatment Service/Setting at Discharge** to *ORT outpatient* (new code).
- No additional inclusions/exclusions.

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