Drug and Alcohol Treatment Waiting Times

DATWT Web System: Guidance Notes

Version 7
# Table of Contents

<table>
<thead>
<tr>
<th>Section Number</th>
<th>Topic</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>How to use this document</td>
<td>4</td>
</tr>
<tr>
<td>2</td>
<td>Which services should contribute to DATWT data collection?</td>
<td>4</td>
</tr>
<tr>
<td>3</td>
<td>Which clients are appropriate for inclusion in this dataset?</td>
<td>5</td>
</tr>
<tr>
<td>4</td>
<td>When should information be recorded?</td>
<td>5</td>
</tr>
<tr>
<td>5</td>
<td>Managing Waiting</td>
<td>5</td>
</tr>
<tr>
<td>5.1</td>
<td>Non-Attendance</td>
<td>5</td>
</tr>
<tr>
<td>5.2</td>
<td>Periods of Unavailability</td>
<td>9</td>
</tr>
<tr>
<td>6</td>
<td>Step by Step Guides</td>
<td>10</td>
</tr>
<tr>
<td>7</td>
<td>Home Screen</td>
<td>11</td>
</tr>
<tr>
<td>8</td>
<td>DATWT – New Record</td>
<td>12</td>
</tr>
<tr>
<td>9</td>
<td>DATWT – Search</td>
<td>12</td>
</tr>
<tr>
<td>10</td>
<td>Change Password</td>
<td>13</td>
</tr>
<tr>
<td>11</td>
<td>DATWT Data Capture Screens</td>
<td>15</td>
</tr>
<tr>
<td>11.1</td>
<td>Client Details</td>
<td>15</td>
</tr>
<tr>
<td>11.2</td>
<td>Waiting Times Details</td>
<td>17</td>
</tr>
<tr>
<td>11.3</td>
<td>Save</td>
<td>25</td>
</tr>
<tr>
<td>Appendices</td>
<td>Title</td>
<td>Page</td>
</tr>
<tr>
<td>------------------</td>
<td>--------------------------------------------</td>
<td>------</td>
</tr>
<tr>
<td>A</td>
<td>Glossary of terms</td>
<td>26</td>
</tr>
<tr>
<td>B</td>
<td>Treatment Type Definitions</td>
<td>Separate Document</td>
</tr>
<tr>
<td>C</td>
<td>A Note on Assessment</td>
<td>31</td>
</tr>
<tr>
<td>D</td>
<td>Confidentiality</td>
<td>34</td>
</tr>
</tbody>
</table>
1: How to use this document

These guidelines should be used as a reference when completing Drug and Alcohol Treatment Waiting Times datasets using the Drug & Alcohol Treatment Waiting Times (DATWT) web-system.

Each section of this document corresponds to a section on the web-system. You will find guidelines, definitions and advice on how to complete the Drug and Alcohol Treatment Waiting Times dataset. Also included below is some key information on general advice about when to submit, who should submit, standard conventions for entering the data and how to use the DATWT web system.

2: Which services should contribute to DATWT data collection?

All services providing Tier 3 or 4 interventions should be contributing to DATWTs.

This is taken from the NTA Models of Care 4 Tier System.

#### Tier 1: Drug and alcohol-related information and advice, screening and referral by generic services

Tier 1 interventions take place within the setting of universal services, such as general healthcare, social care or criminal justice settings. They include drug and alcohol treatment screening and assessment, referral to specialised drug and alcohol treatment and drug and alcohol advice and information.

#### Tier 2: Open access, non care-planned drug and alcohol specific interventions

Tier 2 includes provision of drug and alcohol related information and advice, referral to structured drug and alcohol treatment, brief psychosocial interventions and harm reduction interventions (e.g. needle exchange). Settings will often be the same as tier 3, but there may in addition be access through pharmacies or criminal justice settings.

#### Tier 3: Structured, care-planned drug and alcohol treatment

This is drug and alcohol treatment in the community with regular sessions to attend, undertaken as part of a care plan. Prescribing, structured day programmes and structured psychosocial interventions (counselling, therapy etc) are always Tier 3. Advice, information and harm reduction can be Tier 3 if they are part of a care plan.

#### Tier 4: Drug and alcohol specialist inpatient treatment and residential rehabilitation

This is residential drug and alcohol treatment – inpatient treatment and residential rehabilitation. Treatment should include arrangements for further treatment or aftercare for clients finishing treatment and returning to the community.
3: Which clients are appropriate for inclusion in this dataset?

Information should be collected on every new problem drug or alcohol user who attends a service for either Tier 3 or 4 interventions either for the first time ever or having been discharged after attending a service previously.

A client can have up to two open waiting time records within a single service, a drug treatment waiting time record and an alcohol waiting time record (but only one of each).

4: When should information be recorded?

Waiting time’s data should be recorded by agencies on an ongoing basis. It is essential that the key data items are recorded routinely and that individual client records are kept up to date. It is of particular importance that the removal date is entered as soon as agreement has been reached that the client is no longer attending the service in order to exclude clients not waiting for assessment or treatment from the waiting times statistics.

Please note ISD will extract data from the web-based system for inclusion in the quarterly national publication two weeks after the end of any given period.

Please ensure that data is always complete by this point.

5: Managing Waiting

It is important that the following are recorded to reflect the true wait of a client:
- Non-Attendance (Section 5.1)
- Periods of Unavailability (Section 5.2)

5.1: Non-Attendance

There are two categories of client non-attendance within the waiting times system:
- Could Not Attend (CNA)
- Did Not Attend (DNA)

Could Not Attend (CNA)

It is recognised that there are circumstances where the client has to cancel and reschedule an appointment. It is at the discretion of each individual service how many times a client can reschedule an offer of an appointment.

Services should however be aware that for the purpose of monitoring waiting times for the HEAT target, each time a clients cancels their appointment in the lead up to assessment their waiting time is reset to zero.
Where the client cancels their appointment for treatment the client’s wait will pause at ‘Date Ready for Treatment 1’ and will start again at the client’s latest date of non-attendance. For CNAs this will be the date they cancelled the appointment, and for DNAs the date of the appointment they failed to attend.

Did Not Attend (DNA)

If the patient/client does not report for their appointment, with no prior notice, a DNA should be recorded.

It is at the discretion of the service to decide whether or not to remove a patient/client from the waiting list after a DNA.
**DNA Case Study 1:**

Referral received 28th June

Client offered an assessment appointment of 5th July

Client does not attend appointment on 5th July

Client offered another assessment appointment on 8th July

Client attends appointment on 8th July

Clock starts (wait begins) 28th June

Clock restarts at 5th July (waiting time reset to zero)

Clock stops (wait ends) 8th July

**Current Wait = 3 days**

**DNA Case Study 2:**

Referral received 28th June

Client offered an assessment appointment of 5th July

Client does not attend appointment on 5th July

Client removed from the waiting list on 5th July

**Total Wait = 0 days**
DNA Case Study 3:

- Referral received 28th June
- Clock starts (wait begins) 28th June
- Client offered an assessment appointment of 5th July
- Client attends assessment appointment on 5th July
- Recovery plan agreed on 5th July
- Date ready for treatment – 5th July
- Date offered for start of Treatment 11th July
- Clock pauses at 5th July – Date Ready for 1st Treatment. Clock starts again at 11th July – Latest DNA for 1st treatment.
- Client does not attend for treatment on 11th July
- Client offered another appointment on 18th July
- Client attends appointment on 18th July
- Clock stops (wait ends) 18th July

Current Wait = 14 days Time between 28th June and 18th July is 20 days. However clock is paused between 5th July and 11th July which equals 6 days. Actual wait = 20 days – 6 days.

Cancelled by the service

Cancellations resulting from operational circumstances should not result in any detriment to the patient/ client.
5.2: Periods of Unavailability

Unavailability is a period of time when the patient/client is considered to be unavailable for treatment. This can be for medical, social or criminal justice reasons.

The unavailability start date should be the first date that the client was unavailable and the unavailability end date should be the last date that the client was unavailable. Please note that appointments cannot be offered during any periods of unavailability.

Clients who become unavailable for treatment while they are waiting for an appointment will have all periods of unavailability subtracted from their waiting time.

The waiting time clock will be restarted from the date the client becomes available to accept an appointment or admission date.

---

**Unavailability Case Study 1:**

- Referral received 28<sup>th</sup> June
- Clock starts (wait begins) 28<sup>th</sup> June
- Client becomes unavailable – 30<sup>th</sup> June
- Clock pauses at 30<sup>th</sup> June
- Client becomes available – 20<sup>th</sup> July
- Client offered an assessment appointment of 25<sup>th</sup> July
- Clock continues at 20<sup>th</sup> July
- Client attends appointment on 25<sup>th</sup> July
- Clock stops (wait ends) 25<sup>th</sup> July
- Current wait = 7 days (2 days from 28<sup>th</sup> to 30<sup>th</sup> June + 5 days from 20<sup>th</sup> July to 25<sup>th</sup> July)
6: Step By Step guide

How to complete a Drug and Alcohol Treatment Waiting Times Record

To submit a record for a new client:

1. Login to the DATWT web-system using the username/password provided by ISD.
2. Select Waiting Times Records from the left-hand menu
3. Select New Record from the expanded left-hand menu

The screen that appears has 10 fields for client data. The system uses these 10 fields to generate a unique Waiting Times Record Number. When next is clicked on this page, the system will check the details provided against all open Waiting Times Records to see if a match is found.

4. Select whether the client has been referred for drug treatment or alcohol treatment from the drop down list.

5. Enter the Forename/Surname/Date of Birth in full. Select the gender and ethnicity from the drop down list. Enter the Postcode of the client, CHI number and local reference number (see guidance in section 11 about use of CHI, local reference and anonymous clients). Then click Next

6. If no match has been found on the system, the Waiting Times Record data capture screen will be displayed, with the fields entered in step 5 already populated. From here you should now proceed through each of the data capture screens in turn, entering the details for your client.

If a partial match is found the system will return the waiting times record that is currently open for the client. You will be asked to review the existing record, and can choose to either proceed with a new submission, or use the existing record to record waiting times information. If an exact match is found you will not be able to continue creating a new record for the client

7. Once you have entered as much information as you have at this time you can click Save, and the details will be checked and then submitted to the database. Once Save has been clicked, you will not be able to edit data that has been entered, however you will still be able to add additional data to the record.
7: Home Screen

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

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

**Waiting Time Records:** Further Details Below
- New Record
- Search
- Flat File Extract

**System Users** — Only accessible by Local System Admin and Central System Administrator
- Manage System Users
- Create System Users
- New Access

**Reports** — Only accessible by Area Reporters and Central System Administrator
- TBC

**Services** — Only accessible by Local System Admin and Central System Administrator
- Edit Service
- View Service

**Change Password** — Further details below.

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

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

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

Please note if you also enter SMR25 forms via the web-based system you will also have access to the SMR25 functions. Please refer to SMR25 Guidance Notes for more information. [http://www.drugmisuse.isdscotland.org/sdmd/SMR25%20GuidanceWeb.pdf](http://www.drugmisuse.isdscotland.org/sdmd/SMR25%20GuidanceWeb.pdf)
8: DATWT – New Record

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

9: DATWT - Search

Search Client

You can search for a client by:
A.) Client Details
B.) Unique Waiting Time Record Number
C.) Unique Reference used in Your Local System
D.) Unique Community Health Index Number

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

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

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

The user can restrict the search to include only Open Waiting Times Records or Closed Waiting Times Records or both. The default will be Open Waiting Times Records.

Search Results

This screen displays all of the Waiting Times Records that fit the search criteria entered on the previous page.

From here you can:

View records for a client by clicking on the corresponding links under the column heading ‘Client Type’.
10: Change Password

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

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

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

Best practice for data security

The information you have access to in the Drug and Alcohol Treatment Waiting Times system contains sensitive personal information on named individuals. Only those individuals who have been authorised to use this system must have access to it; no unauthorised access is permitted.

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

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

Good password practice
- Never share with or tell anyone else what your password is (even hinting).
- Never use the same password for more than one account you are responsible for.
- Where possible, passwords should not be written down. If you do require to write the password down, please keep the note in a secure place and not beside your PC.
- Never leave your PC logged on and unattended. Lock your PC by <ctrl> + <alt> + <del> together, then <return>. Unlock your PC with the same keystrokes followed by your password.
• Do not give your password to anyone else; only you have been authorised to use your access details.
• Make passwords easy for yourself to remember but difficult for someone else to guess.
• Do not set your password to be the same as the system you are accessing.
• Do not use any password previously used.
• Change your password if you suspect your password has been compromised.

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

Breaches of Security
Breaches of passwords and/or other security that has been implemented will result in immediate suspension of your access account and may lead to disciplinary action in line with local procedures.
11: DATWT– Data Capture Screens

When you click to start a new waiting times record, you are taken into the data capture screens of the database. The following sections provide guidance and clarification on the fields contained within the data capture screens.

11.1: Client Details

Each client on the DATWT system should only ever have one Drug Treatment Waiting Time Record and/or one Alcohol Treatment Waiting Time Record open at any one time.

Before opening a new Drug or Alcohol Waiting Time Record, the system needs to check if an open Waiting Time Record exists for that client.

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

<table>
<thead>
<tr>
<th>Item</th>
<th>Guidance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client Type</td>
<td>Select whether this is a waiting time record for drug treatment or alcohol treatment.</td>
</tr>
<tr>
<td>Mandatory</td>
<td></td>
</tr>
<tr>
<td>Forename</td>
<td>Please enter the client’s Forename in full.</td>
</tr>
<tr>
<td>Mandatory</td>
<td></td>
</tr>
<tr>
<td>Surname</td>
<td>Please enter the Surname in full.</td>
</tr>
<tr>
<td>Mandatory</td>
<td>Enter hyphens or apostrophes as separate characters.</td>
</tr>
<tr>
<td>Date of Birth</td>
<td>Record in the format dd/mm/yyyy.</td>
</tr>
<tr>
<td>Mandatory</td>
<td></td>
</tr>
<tr>
<td>Gender</td>
<td>A statement by the individual about the gender they currently identify themselves to be (i.e. self-assigned). Select the appropriate choice from the drop-down list.</td>
</tr>
<tr>
<td>Mandatory</td>
<td></td>
</tr>
<tr>
<td>Ethnicity</td>
<td>Select the ethnic group of the client (as judged by the client) from the drop-down list.</td>
</tr>
<tr>
<td></td>
<td>The stated ethnicity of the client as defined by the 2011 Scottish Census Ethnicity Categories.</td>
</tr>
<tr>
<td></td>
<td>If other is selected, please specify further.</td>
</tr>
<tr>
<td></td>
<td>For the list of the ethnicity options please see Appendix A: Glossary of terms.</td>
</tr>
<tr>
<td>CHI Number</td>
<td>Enter the 10-digit CHI number.</td>
</tr>
<tr>
<td></td>
<td>The Community Health Index (CHI) is a population register, which is used in Scotland for health care purposes. The CHI number uniquely identifies a person on the index.</td>
</tr>
</tbody>
</table>
| Postcode | Enter postcode of where client is staying at the moment.  
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>There are a number of exceptions:</td>
</tr>
<tr>
<td></td>
<td>• Roofless – record NF1.</td>
</tr>
<tr>
<td></td>
<td>• Temporary/unstable – if known record postcode of address where stayed the night before.</td>
</tr>
<tr>
<td></td>
<td>• Prison, residential rehabilitation, supported accommodation, secure unit – record postcode of usual home address.</td>
</tr>
<tr>
<td></td>
<td>• Spending time at more than one address – record postcode of address where they spend most time.</td>
</tr>
<tr>
<td></td>
<td>• Young person in long-term foster care/children’s home – record postcode of where person is staying at time of presenting.</td>
</tr>
<tr>
<td></td>
<td>• Students away from home – record postcode of where person is staying at time of presenting.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Local Reference</th>
<th>If each of your patients/clients are issued with an individual reference number within your service, then please enter it here. This will assist ISD and service staff in identifying the appropriate record, should the need arise.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mandatory if client requests to remain anonymous.</td>
<td></td>
</tr>
<tr>
<td>Has the client requested to remain anonymous?</td>
<td>Select ‘Yes’ if the client has indicated that they do not wish their personal details (eg. name, date of birth) to be recorded on the database.</td>
</tr>
<tr>
<td>Mandatory</td>
<td>If selecting yes, ensure that the local reference has been completed to allow you to identify the client for completion of the waiting times record.</td>
</tr>
</tbody>
</table>
# 11.2: Waiting Times Details

<table>
<thead>
<tr>
<th>Referral</th>
<th></th>
</tr>
</thead>
</table>
| **Date Referral Made** | **Definition:** date referral made is the date on which a referral is made to a service.  
**Recording Rules:**  
1. Where a referral date is offered by letter, the date on the letter should be recorded as the referral date.  
2. Where an electronic referral is made, the date the referral was made should be recorded as the referral date.  
3. Where a referral has been made by telephone and then followed by written confirmation the date of the telephone referral takes precedence and should be recorded as the referral date.  
4. The referral date must be on or before the current date. |
| **Date Referral Received** | **Definition:** The date that:  
a) the referral notification is received by the agency,  
or  
b) the date that the client first made contact with an agency as a result of problem drug use, including written, face-to-face and telephone contact.  
Both the above include the following:  
- Self-referral  
- Referral from third party  
- Referrals from ‘gateway’ systems  
- Intra agency referrals for an agency providing both tier 2 and 3 interventions  
- Intra agency referrals between tier 3 interventions  
- Inter agency referrals between tier 3 interventions  
**Recording Rules:**  
1. The referral received date must be recorded for all patients/ clients.  
2. If a written referral has been made this is the date the referral letter was received/ stamped and not the date it reaches the relevant team or worker.  
3. Where a referral has been made by telephone and then followed by written confirmation the date of the telephone referral takes precedence and should be recorded as the referral received date.  
4. The date referral received can be the same as the date referral made.  
**Points to note:**  
1. The date referral received is used to calculate the waiting time between referral and treatment. |
<table>
<thead>
<tr>
<th>Source of Referral</th>
<th>Only one option should be selected. For definitions of the ‘referral’ options please see <a href="#">Appendix A: Glossary of terms</a>. If none of the options listed apply, then select “Other” and specify further.</th>
</tr>
</thead>
</table>

**Assessment**

| Date Offered for Assessment | **Definition:** Date offered for assessment is the date of the first appointment offered to the client to identify their needs and aspirations with a view to establishing a clear statement of the type and level of treatment, care and support.  

**Recording Rules:**  
1. The date offered for assessment cannot be within any defined periods of unavailability.  

Please see [Appendix C: A Note on Assessment](#) for further information on the definition of ‘Assessment’.

| Non-attendance Category (for assessment) | For definitions of the ‘non-attendance category’ options please see [Appendix A: Glossary of terms](#).  

**Recording Rules:**  
1. One non-attendance category must be recorded for each non-attendance.  
2. All DNAs, CNAs and cancellations must be recorded.  
3. A non-attendance category should only be recorded when a non-attendance date or the code denoting removed/remained on the list has been supplied.  

**Points to Note:**  
1. Further appointment dates can be offered according to local and national guidance.  
2. Appointment arrangements cancelled by the service will not adversely affect the waiting period for the patient. The clock will not be reset. |
| **Non-Attendance Date (for assessment)** | **Definition:** The date the patient/client did not attend, date patient/client cancelled their appointment or admission or the date the service cancelled the appointment arrangements.  

**Recording Rules:**  
1. Non-attendance date must be recorded when a non-attendance category has been recorded.  

**Points to note:**  
1. Appointment arrangements cancelled by the service will not adversely affect the waiting period for the client. The clock will not be reset.  

For definitions of the ‘non-attendance outcome’ options please see [Appendix A: Glossary of terms](#). |
| **Non-attendance Outcome (for assessment)** | **Definition:** To identify whether a client has been removed or has been retained on a waiting list after they cancelled or failed to attend their appointment or after the service cancelled the client’s appointment.  

**Recoding Rules:**  
1. The non-attendance outcome must be recorded when a non-attendance category has been entered.  

**Points to note:**  
1. If a client is removed the removal date and removal reason must be populated before the record can be saved.  
2. If ‘to be confirmed’ is selected, the row will not be locked until either retained or removed is selected once a decision has been made regarding the outcome of the non-attendance.  

For definitions of the ‘non-attendance outcome’ options please see [Appendix A: Glossary of terms](#). |
| **Date Assessment Started** | **Definition:** Actual date client attends for their assessment appointment.  

**Recording Rules:**  
1. The date assessment started cannot be within any defined periods of unavailability.  

Please see [Appendix C: A Note on Assessment](#) for further information on the definition of ‘Assessment’. |
<table>
<thead>
<tr>
<th>Drug and Alcohol Treatment Waiting Times</th>
<th>DATWT Guidance Notes</th>
</tr>
</thead>
</table>

**Date Recovery Plan Agreed**

**Definition:** The date that:

a) a client’s recovery plan is signed off by client and staff
or

b) in the absence of a recovery plan, the date that agency staff and the client agree the type and level of treatment, care and support to be provided.

**Points to Note:**

1. In some cases the date that an assessment is started and the date that a recovery plan is agreed or decision on treatment is made may be the same date.

**Treatment**

<table>
<thead>
<tr>
<th>Date Ready for Treatment</th>
<th>Definition: The date that a client is available and ready for treatment as agreed between client and case worker.</th>
</tr>
</thead>
</table>
|                          | **Points to Note:**
|                          | 1. For the first treatment this will be the same as the ‘Date Recovery Plan Agreed’, and will be automatically populated by the WTs system. |

<table>
<thead>
<tr>
<th>Treatment Type</th>
<th>Definition: The type of structured care initially required by the client as stated in the care plan or agreed with the client.</th>
</tr>
</thead>
</table>
|                | **Recording Rules:**
|                | 1. This must be a valid code from the list provided.
|                | 2. Only one treatment code can be recorded for each treatment.
|                | 3. A treatment code cannot be entered more than once for the one waiting time record.
|                | 4. All clients ready for treatment, i.e. have a date ready for treatment or date recovery plan agreed, must have a treatment type recorded. |
|                | **Points to Note:**
|                | 1. If a number of treatment interventions have been identified as a priority for the patient/client then the one which is required to start first should be recorded under first treatment.
|                | 2. The treatment type is used in conjunction with other waiting times data items to report on waiting times for treatment. |

For the ‘Treatment Types’ options please see Appendix A: Glossary of terms. For full definitions please refer to Appendix B: Treatment Type Definitions.
| **Date Offered for Treatment** | **Definition:** Date offered for beginning of the type of structured care initially required by the client as stated in the recovery plan or agreed with the client.  

**Recording Rules:**  
1. The date offered for treatment cannot be within any defined periods of unavailability. |
|-------------------------------|----------------------------------------------------------------------------------|
| **Non-attendance Category (for Treatment)** | **For definitions of the ‘non-attendance category’ options please see Appendix A: Glossary of terms.**  

**Recording Rules:**  
1. One non-attendance category must be recorded for each non-attendance.  
2. All DNAs, CNAs and cancellations must be recorded.  
3. A non-attendance category should only be recorded when a non-attendance date or the code denoting removed/remained on the list has been supplied.  

**Points to Note:**  
1. Further appointment dates can be offered according to local and national guidance.  
2. Appointment arrangements cancelled by the service will not adversely affect the waiting period for the patient. The clock will not be reset. |
| **Non-Attendance Date (for Treatment)** | **Definition:** The date the patient/ client did not attend, date patient/ client cancelled their appointment or admission or the date the service cancelled the appointment arrangements.  

**Recording Rules:**  
1. Non-attendance date must be recorded when a non-attendance category has been recorded.  

**Points to note:**  
1. Appointment arrangements cancelled by the service will not adversely affect the waiting period for the client. The clock will not be reset.  

For definitions of the ‘non-attendance outcome’ options please see Appendix A: Glossary of terms. |
### Non-Attendance Outcome (for Treatment)

**Definition:** To identify whether a client has been removed or has been retained on a waiting list after they cancelled or failed to attend their appointment or after the service cancelled the client's appointment.

**Recoding Rules:**
1. The non-attendance outcome must be recorded when a non-attendance category has been entered.

**Points to note:**
1. The client patient will be retained on the list after the service cancels the client's appointment arrangements. The client's waiting time clock will not be affected.
2. If a client is removed the removal date and removal reason must be populated before the record can be saved.
3. If 'to be confirmed' is selected, the row will not be locked until either retained or removed is selected once a decision has been made regarding the outcome of the non-attendance.

For definitions of the ‘non-attendance outcome’ options please see [Appendix A: Glossary of terms](#).

### Date Treatment Started

**Definition:** The date the client begins treatment ie. the date the client attends the first treatment appointment for the type of structured care initially required by the client as stated in the recovery plan or agreed with the client.

**Recording Rules:**
1. The date treatment started cannot be within any defined periods of unavailability.

### Removal Date

**Definition:** The date that the client was discharged ending the current structured (Tier 3/Tier 4) treatment episode.

**Recording Rules:**
1. Removal date must be entered when a removal reason has been entered.
2. If a client has had a planned discharge then the date agreed within this plan should be used.
3. If a client's discharge was unplanned then the date of last face to face contact with the treatment provider should be used.
4. If a client has had no contact with the treatment provider for two months then for DATWTs monitoring purposes it is assumed that the client has exited treatment and a discharge date should be returned at this point using the date of the last face to face contact with the client. This should be recorded as an unplanned discharge.

It should be noted that this is not meant to determine clinical practice and it is understood that further work beyond this point to re-engage the client may occur.
Additionally, it is important to note that these definitions are designed to support accurate data reporting of the client’s treatment journey. However, they should not be used to subvert established clinical practice within agencies. For example, an agency may have a policy of keeping cases open for 2-3 months following the last face-to-face contact with the client to attempt to re-engage them in treatment. If this is the case services may keep the record open during this period, however when a decision is made to remove the client the data of removal should be the date of the last face-to-face contact.

**Points to Note:**
1. It is of particular importance that the removal date is entered as soon as agreement has been reached that the client is no longer attending the service. This will ‘stop the clock’ and the client will no longer appear to be ‘still waiting’.

<table>
<thead>
<tr>
<th>Removal Reason</th>
<th>Definition: Indicates why the patient has been removed from the waiting list.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Recording Rules:</strong></td>
</tr>
<tr>
<td></td>
<td>1. A removal reason must be entered when a removal date is supplied.</td>
</tr>
</tbody>
</table>

For definitions of the ‘removal reasons’ options please see Appendix A: Glossary of terms.

<table>
<thead>
<tr>
<th>Unavailability</th>
<th>Definition: Date the period of unavailability commences.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Recording Rules:</strong></td>
</tr>
<tr>
<td></td>
<td>1. An unavailability start date must be recorded when the patient becomes unavailable for social, medical or criminal justice reasons.</td>
</tr>
<tr>
<td></td>
<td>2. Periods of unavailability cannot overlap even if the unavailability is due to different reasons.</td>
</tr>
</tbody>
</table>

**Points to Note:**
1. There may be more than one period of unavailability.
2. Unavailability periods are inclusive of the start and end date.
3. If consecutive periods of unavailability are recorded for the same reason the time recorded for the period of unavailability will be aggregated and one period of unavailability will be recorded when analysing waiting time information.
4. The unavailability start date and unavailability end date will be used in the calculation of waiting times.
5. The system allows up to 5 periods of unavailability to be recorded.
<table>
<thead>
<tr>
<th>Unavailability Type</th>
<th><strong>Definition:</strong> To identify the reason for a period of unavailability, for example whether the unavailability is due to social, medical or criminal justice unavailability.</th>
</tr>
</thead>
</table>
|                     | **Recording Rules:**  
|                     | 1. Unavailability type is recorded when it is known that the patient is unavailable for treatment, for a specified or unspecified period of time.  
|                     | 2. Unavailability type must be entered when unavailability start date is provided.  
|                     | 3. Only one unavailability type code must be recorded for each period of unavailability. |
|                     | **Points to Note:**  
|                     | 1. Periods of unavailability will be deducted in the calculation of waiting. |
|                     | For definitions of the ‘unavailability type’ options please see Appendix A: Glossary of terms. |

<table>
<thead>
<tr>
<th>Unavailability End Date</th>
<th><strong>Definition:</strong> The date on which the period of unavailability ends.</th>
</tr>
</thead>
</table>
|                         | **Recording Rules:**  
|                         | 1. The unavailability end date can be blank if the end of unavailability is not known – it is expected that this would be reviewed periodically.  
|                         | 2. Multiple periods of unavailability can be recorded, but only the final period of unavailability can have no end date recorded. |
|                         | **Points to Note:**  
|                         | 1. The client is not available on the ‘unavailability end date’.  
|                         | 2. The unavailability period is inclusive of the start and end date.  
|                         | 3. Periods of unavailability for medical, social or criminal justice will be deducted in the calculation of waiting times.  
|                         | 4. If consecutive periods of unavailability are recorded for the same reason the time recorded for the period of unavailability will be aggregated and one derived period of unavailability will be used for analytical purposes.  
|                         | 5. Along with the unavailability start date the date will be used in the calculation of waiting times. |
### 11.3: Save

| **Save** | The Save button will fully validate the record before submitting to the database.  
If any errors are found they will be displayed on screen, and the record will *not* be submitted. Once any errors have been resolved, the record can then be submitted to the database.  
It is not possible to amend/delete completed screens once it has been saved to the database. However it is possible to add additional data to the record. Please ensure all details are correct before attempting to save it.  
When a record is successfully saved a green tick will be displayed at the top of the page with the message ‘Success. The waiting times details have now been saved’. If you leave the record without successfully saving it any details which have been entered will be lost. |
| **Delete** | If a record has not yet been saved it is still possible to delete the record. If you wish to remove the record from the system, simply click Delete and you will be asked to confirm the action.  
Once a record is deleted it cannot be recovered. |
## Appendix A – Glossary of terms

<table>
<thead>
<tr>
<th>Section</th>
<th>Options</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Presenting</td>
<td>A - White</td>
<td></td>
</tr>
<tr>
<td>information–Ethnicity</td>
<td>1A Scottish</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1E English</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1F Welsh</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1G Northern Irish</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1H British</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1J Irish</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1K Gypsy/ Traveller</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1L Polish</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1Z Any other white ethnic group</td>
<td></td>
</tr>
<tr>
<td></td>
<td>B - Mixed or multiple ethnic groups</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2A Any mixed or multiple ethnic groups</td>
<td></td>
</tr>
<tr>
<td></td>
<td>C - Asian, Asian Scottish or Asian British</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3F Pakistani, Pakistani Scottish or Pakistani British</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3G Indian, Indian Scottish or Indian British</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3H Bangladeshi, Bangladeshi Scottish or Bangladeshi British</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3J Chinese, Chinese Scottish or Chinese British</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3Z Other</td>
<td></td>
</tr>
<tr>
<td></td>
<td>D - African, Caribbean or Black</td>
<td></td>
</tr>
<tr>
<td></td>
<td>4D African, African Scottish or African British</td>
<td></td>
</tr>
<tr>
<td></td>
<td>4E Caribbean, Caribbean Scottish or Caribbean British</td>
<td></td>
</tr>
<tr>
<td></td>
<td>4F Black, Black Scottish or Black British</td>
<td></td>
</tr>
<tr>
<td></td>
<td>4Z Other</td>
<td></td>
</tr>
<tr>
<td></td>
<td>E - Other ethnic group</td>
<td></td>
</tr>
<tr>
<td></td>
<td>5B Arab</td>
<td></td>
</tr>
<tr>
<td></td>
<td>5Z Other</td>
<td></td>
</tr>
<tr>
<td></td>
<td>F - Refused/Not provided by patient</td>
<td></td>
</tr>
<tr>
<td></td>
<td>98 Refused/Not provided by patient</td>
<td></td>
</tr>
<tr>
<td>Presenting information – Source of referral</td>
<td>G - Not Known 99 Not Known</td>
<td>Client has referred himself or herself to the organisation.</td>
</tr>
<tr>
<td>-------------------------------------------</td>
<td>-----------------------------</td>
<td>-------------------------------------------------------------</td>
</tr>
<tr>
<td>Health - General Practitioner</td>
<td>Self</td>
<td>A general practitioner (GP) who provides primary care.</td>
</tr>
<tr>
<td>Health - Primary care team</td>
<td>Health - Accident &amp; Emergency</td>
<td>A group of professionals delivering health services in the community at ‘primary’ or first points of contact with the health service. Includes clinical staff (nurses, physiotherapists, counsellors) and administrative staff (receptionists, practice managers).</td>
</tr>
<tr>
<td>Health - Mental Health</td>
<td>Health - Other</td>
<td>Services specialising in the assessment and treatment of mental ill-health.</td>
</tr>
<tr>
<td>Social Work - Criminal Justice</td>
<td>Social Work - Child and family</td>
<td>Criminal justice based social work service (Victims and Offenders) e.g. Probation Service, Supervision of, and support for released prisoners.</td>
</tr>
<tr>
<td>Social Work - Other</td>
<td>Social work - Other</td>
<td>Any other social work service not detailed above.</td>
</tr>
<tr>
<td>Criminal Justice - DTTO</td>
<td>Criminal Justice - Arrest referral</td>
<td>Drug Treatment and Testing Order. A sentence for drug users who receive treatment for their drug use and have to give regular urine tests to make sure they are not using drugs.</td>
</tr>
</tbody>
</table>
|                                          |                             | An intervention seeking to identify problem drug using offenders at the point of entry into the criminal
<table>
<thead>
<tr>
<th>Criminal Justice- Drug court</th>
<th>A special court given the responsibility to handle cases involving drug-addicted offenders through an extensive supervision and treatment program.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Criminal Justice-Prison</td>
<td>Referral from any UK based prison i.e. Prison- based case workers have conducted an assessment of needs to co-ordinate service provision e.g. using Common Addictions Recording Tool (CAART).</td>
</tr>
<tr>
<td>Criminal Justice-Other</td>
<td>Referral from any other Criminal justice based service not detailed above.</td>
</tr>
<tr>
<td>Specialist Substance Misuse Service: Statutory</td>
<td>Referral from a statutory specialist substance misuse service</td>
</tr>
<tr>
<td>Specialist Substance Misuse Service: Voluntary</td>
<td>Referral from a voluntary specialist substance misuse service</td>
</tr>
<tr>
<td>Specialist Substance Misuse Service: Other</td>
<td>Referral from a specialist substance misuse service not detailed above.</td>
</tr>
<tr>
<td>Non-Specialist Substance Misuse Service: Voluntary</td>
<td>Referral from a voluntary service that is not a specialist substance misuse service.</td>
</tr>
<tr>
<td>Education</td>
<td>Referral from an education authority or service.</td>
</tr>
<tr>
<td>Housing</td>
<td>Referral from a housing or homelessness service.</td>
</tr>
<tr>
<td>Other (specify)</td>
<td>Any other referral not specified above.</td>
</tr>
<tr>
<td>Non-attendance category</td>
<td></td>
</tr>
<tr>
<td>Did not attend (DNA)</td>
<td>The patient/ client may be categorised as did not attend (DNA) when he/she did not attend an appointment and gave no prior warning of non-attendance.</td>
</tr>
<tr>
<td>Could not attend (CAN)</td>
<td>The patient/ client may be categorised as could not attend (CNA) when the service is notified in advance that he/she will not attend an appointment.</td>
</tr>
<tr>
<td>Cancelled by service</td>
<td>Appointment dates may be cancelled by the service for a variety of reasons. Patients/</td>
</tr>
</tbody>
</table>
clients may receive short notice of the cancellation.

| Non-attendance outcome | Retained | If the client is retained on the list after they cancelled their appointment for treatment (CNA) their waiting time clock will be reset to the date they cancelled the appointment.

If the client is retained on the list after they failed to attend their appointment for treatment (DNA) their waiting time clock will be reset to the date of the appointment.

If the service cancels the client’s appointment arrangements the client will be retained on the list. The clients waiting time clock will not be affected.

| Removed | If the outcome of the client not attending the offered appointment is that the patient is to be removed from the waiting list this option should be selected.

Removal date and reason must also be recorded.

| Unavailability Type | Medical | Unavailable for treatment due to medical reasons
| Social | Unavailable for treatment due to social reasons
| Criminal Justice | Unavailable for treatment due to criminal justice reasons

| Treatment Type | Structured Preparatory Intervention
| Structured Psychosocial Intervention
| Rehabilitation: Residential
| Detoxification/ Inpatient Treatment: Residential
| Detoxification: Community Based
| Prescribing: GP
| Prescribing: Specialist
| Structured Day Programmes
| Other Structured Interventions

Please refer to Appendix B: Treatment Type Definitions for full definitions.
<table>
<thead>
<tr>
<th>Removal Reason</th>
<th>Planned discharge: received required support.</th>
<th>Client’s needs met according to assessment i.e. discharged at the end of their treatment, with the agreement of the client and the service.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Planned discharge: referred to other service</td>
<td>The client has been referred onto another agency with the agreement of the client and the agency.</td>
</tr>
<tr>
<td></td>
<td>Planned discharge: referred to GP</td>
<td>The client has been referred onto GP with the agreement of the client and the agency.</td>
</tr>
<tr>
<td></td>
<td>Unplanned discharge</td>
<td>The client was referred and did not attend a number of assessment or treatment appointments. In this case the discharge date should be entered as soon as agency staff agree that the client is no longer on its books or would be viewed as a new client if they re-presented at the agency.</td>
</tr>
<tr>
<td></td>
<td>Disciplinary</td>
<td>Client has been discharged due to misconduct.</td>
</tr>
</tbody>
</table>
Appendix C – A Note on Assessment

The following definitions from the Models of Care Update 2006 for drugs and alcohol may help to clarify where assessment ends (for the purposes of recording information in the Scottish Waiting Times Framework). When we talk about assessment in this context, we are describing ‘Comprehensive Assessment’, as defined below: assessment that leads to the development of a recovery support plan. We recognize that such an assessment does in itself have therapeutic value, however, it will not constitute in itself, a tier 3 or 4 intervention. Consequently, the treatment type start date will be the first date after a recovery support plan is established – this may be partway through a comprehensive assessment.

Models of Care – Drugs – 2006

Models of Care – Alcohol – 2006

Substance misuse assessment is a process to establish the nature and extent of drug and alcohol misuse, what level of need an individual may have and what interventions are required. Assessment varies in its depth and level of detail, depending on the purpose and anticipated outcome of the assessment process. Models of Care 2006 identified three levels of assessment: screening, triage and comprehensive assessment, and provides a detailed description of each level of assessment.

Screening assessment

Screening assessment is a brief process that aims to establish if an individual has a drug and alcohol problem, related or coexistent problems and whether there is any immediate risk for the service user. The assessment should identify those who require referral to drug/alcohol treatment services and the urgency of the referral. Screening assessment may include an element of brief opportunistic intervention aimed at engaging or preparing the service user for treatment. Screening assessment is likely to be carried out in generic settings.

Triage assessment

Triage assessment usually takes place when an individual with problem drug/alcohol use first contacts specialist drug/alcohol treatment services. The aim of triage assessment is to determine the seriousness and urgency of the individual's problems and the most appropriate type of treatment for them. It involves a fuller assessment of the individual's drug and alcohol problems than is conducted at screening, as well as assessment of a service user's motivation to engage in treatment, current risk factors and the urgency of need to access treatment. As a result of a triage assessment, a service user might be offered services within the assessing agency or onward referral to another service. A further outcome of triage
assessment is that, where appropriate, work is undertaken to further engage and prepare the service user for treatment.

Following triage-level assessment, it may be good practice to produce an initial recovery support plan for service users. For service users taken onto Criminal Justice intervention services this may be essential, but it may also be useful in other treatment services, particularly for service users who are identified as at high risk, who have complex drug/alcohol-related problems or are likely to be hard to engage.

Within prisons, initial recovery support plans may be appropriate for prisoners in the very early days of custody, or those who are due to be released shortly after the triage is undertaken.

The initial recovery support plan is to facilitate a focus on a service user’s engagement in the treatment system, to ensure their immediate needs are met, to build a therapeutic alliance and to ensure appropriate support if they are waiting to undergo comprehensive assessment. Not all service users will be required to undergo a comprehensive assessment, and some may remain on their initial recovery support plan and be reviewed until they are discharged from treatment.

**Strength-based Assessment**
Strength-based assessment is defined as the measurement of those emotional and behavioural skills, competencies and characteristics that create a sense of personal accomplishment, contribute to satisfying relationships with family members, peers, and adults, enhance one’s ability to deal with adversity and stress, and promote one’s personal, social and academic development.

Strength based assessments allow the service user and worker to begin the development of a therapeutic and trusting relationship. A strength-based assessment will encourage the service user to identify their individual strengths and how they will support their recovery journey. The information gained from the assessment will form the service users recovery plan and overall individual service design.

**Comprehensive assessment**
Comprehensive assessment is targeted at drug/alcohol misusers with more complex needs and those who will require structured drug/alcohol treatment interventions. The assessment aims to determine the exact nature of the service user’s drug and alcohol problems, and coexisting problems in the other domains of health (mental and physical), social functioning and offending. A full risk assessment should also be conducted. Comprehensive assessment may be conducted by more than one member of a multidisciplinary team, because different competences may be necessary to assess different areas of service user need (e.g. a doctor needs to assess service users for prescribing interventions involving controlled drugs – a supplementary prescriber may also be involved; or a psychologist may need to carry out psychometric assessment).

Comprehensive assessment can be seen as an ongoing process rather than a single event. Comprehensive assessment will be carried out when a service user may:
• Require structured and/or intensive intervention
• Have significant psychiatric and/or physical co-morbidity
• Have significant level of risk of harm to self or others
• Be in contact with multiple service providers
• Have a history of disengagement from drug treatment services
• Be pregnant or have children “at risk”.

Comprehensive assessment provides information that will contribute to the development of a recovery support plan for a service user.

Appendix D – Confidentiality

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

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

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

Confidentiality of information held by ISD
ISD is fully committed to the processing of all personal data securely and in accordance with the requirements of Data Protection legislation. The work of ISD is included within the Common Services Agency for Scottish Health Service’s registration with the Data Protection Commissioner. ISD is also subject to the Service’s Data Protection policy, and abides by the eight Data Protection Principles, which govern the handling of personal data. The Service’s Data Protection FOI Lead is Trish Ruddy, Gyle Square, 1 South Gyle Crescent Edinburgh, EH12 9EB, Tel: 0131 275 6744

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

An explicit set of Confidentiality Rules for ISD Scotland Staff
All new staff are required to read these rules and sign their acceptance of them. Existing staff re-sign every six months. These rules cover the care and release of confidential data, copies are available on request.

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

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

Caldicott Guardian
In addition to maintaining the measures outlined above, ISD is responding to the recommendations of the Caldicott Committee. The Caldicott Guardian for ISD is Janet Murray, Gyle Square, 1 South Gyle Crescent Edinburgh, EH12 9EB, Tel: 0131 275 6954

The Drug and Alcohol Treatment Waiting Times system is managed by ISD. Because of the sensitivity of the information collected, there are additional
measures in place to ensure that confidentiality and anonymity are maintained. These are explained below.

**Confidentiality procedures**

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

The ‘data processed by ISD relating to substance misuse’ is registered for the purpose of ‘health research and statistics’ as part of the Common Services Service registration under the Data Protection Act 1998.

**Client Consent**

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

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

If there is a problem regarding client consent which may affect the completion of a Waiting Times Record, please contact us at ISD.