**Substance Misuse Secondary Uses Data Set**

**Implementation Date: 1st April 2014**

**Guidance / Business Rules**

Version: 1.2

Author: Welsh Government

**REVISION HISTORY**

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| **Version** | **Author** | **Purpose / Reason** | **Date** |
| 1.2 | S Thompson | Agency code and Source of referral – additional guidance has been amended to reflect that the dataset implementation has now occurred. | May 2015 |
| 1.2 | S Thompson | Modality exist status – additional guidance amended to clarify differences between the planned / unplanned definition versus the positive, negative and neutral closure reasons used in the KPI calculations | May 2015 |
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**1. 0 Purpose**

This document provides additional guidance to substance misuse treatment providers and Area Planning Boards (APBs) for the submission of the Substance Misuse Data Set to the National Database.

It does not cover the entry of data onto operational systems (i.e. the web based tool, case management tools etc.) Therefore, what users see on their data entry screens might differ to the data item names and permissible values submitted to the national data base.

This guidance should be read in conjunction with the ‘Business Specification’ document.

**1.1 Data Reporting**

A record must be submitted to the Welsh National Database for Substance Misuse (WNDSM) for all individuals referred for substance misuse treatment in Wales. This is a mandatory requirement and Welsh Government funding is dependent on full compliance. Full population of the WNDSM will also allow substance misuse treatment providers to respond to the data required to comply with the current Substance Misuse Key Performance Indicators.

Additional information on the Key Performance Indicators will be available at [www.wales.gov.uk/substancemisuse](http://www.wales.gov.uk/substancemisuse).

**1.2 (i) Agencies Providing Structured Treatment.**

APBs must ensure that treatment providers agree responsibilities for submission of the Substance Misuse Data Set for those individuals who are receiving structured treatment from more than one agency.

For example: Agency 1 – Provides assessment, key working and case management.

Agency 2 – Provides substitute opiate prescribing and key working.

In the above example it is appropriate for both agencies to submit the activity that they are responsible for to the WNDSM.

However, if they are the case managing agency then they will also be expected to ensure that the Treatment Outcomes Profile (TOP) is also populated.

A list of structured modalities is available at Appendix 1.

**1.2 (ii) Agencies Providing Less Structured Treatment**

General support, guidance and harm reduction advice can have a beneficial effect for individuals either to support structured interventions or to help prepare an individual for treatment. Appendix 1 provides a list of less structured modalities to enable agencies to capture activity appropriately.

Treatment providers who are only submitting a less structured modality record are not mandated to undertake TOP.

**1.3 Submission Dates to the Welsh National Database for Substance Misuse (WNDSM).**

Agencies are required to submit data monthly (by the 7th working day) via the NHS Wales Data Switching Service (NWDSS). The timetable for the submission of data and the subsequent reports are set out on the supporting Substance Misuse Website.

Treatment Providers are asked to contact [substancemisuse-queries@wales.nhs.uk](mailto:substancemisuse-queries@wales.nhs.uk), if there are any difficulties in submitting their data.

**1.4 NWIS Substance Misuse Website.**

Information submitted by treatment providers is available via the NWIS website for management information purposes only. Access to these web based reports, is restricted and a user name and password will be required. Please contact [substancemisuse-queries@wales.nhs.uk](mailto:substancemisuse-queries@wales.nhs.uk) for further advice.

It is the intention to extend the number of reports that is available through the website. However, in the meantime, there is a limited ‘ad-hoc’ reporting facility for APBs or provider agencies to request specific data. Ad hoc queries should be made to the help desk at NWIS at the following email address: [substancemisuse-queries@wales.nhs.uk](mailto:substancemisuse-queries@wales.nhs.uk).

**1.5 Data Quality.**

The Substance Misuse Data Set will be subject to a number of data quality checks as it is important to ensure the reliability of the information supplied. For further information on the data quality checks that are in place please see the companion document entitled ‘Data Quality / Verification Rules’.

Once fully operational, agencies and commissioners will receive data compliance reports on a monthly basis so any potential errors in data can be rectified.

**1.6 Principles of confidentiality.**

The establishment of the WNDSM and the data definitions guidance brings with it the necessity to adhere to controls imposed by statutory Acts of Parliament and NHS information protocols. Guidance on the key legislation and protocols affecting data collection systems is laid out in Appendix 2.

All drug and alcohol treatment services must have a clear confidentiality / data handling policy, which is understood by all members of staff. An interpretation of that policy should be presented and clearly explained to the client / patient, both verbally and in written form, before assessment for treatment begins. It should be explained on the client’s first visit and as a minimum must describe:

* What information will be collected by the treatment service.
* When and what information will be shared with any other services and organisations involved in their care.
* Who the information will go to and why.
* How the individual can report concerns on the use of their information

***Sharing Substance Misuse Data with WNDSM***

Many agencies will have their own confidentiality policies to cover their own specific needs. However, in the case of information collected and shared with the WNDSM, there is a requirement that consent is obtained from the patient as a client’s initials, date of birth, gender, NHS number and partial postcode is populated.

This consent can be made either orally or in writing but should be given when the client is appropriately informed on how this information is used. Ideally this will form part of the process for obtaining consent when explaining local data collection policies. Most individuals are reassured when they understand the reasons for collecting and reporting on the information requested.

For individuals who do not consent, their information should not be submitted to the WNDSM.

**1.7 Substance Misuse – Tiers of Service**

Substance Misuse treatment is provided at four tiers of service aimed at remedying an identified problem or condition. Full definitions of these tiers for treatment are included at Appendix 3.

Services that are delivering tiers 2 to 4 should be submitted to the WNDSM. Tier 2 is essentially covered by the submission of less structured modalities and Tiers 3 and 4 are covered by the structured modalities. Full definitions of the treatment modalities are included at Appendix 1.

**2.0 Additional Guidance in respect to the Specific Data Fields**

The following section provides additional guidance in populating the Substance Misuse Dataset.

This should be read in conjunction with the Business Definition document as the following is **not the complete list,** but only lists those data items where additional guidance has been given.

Appendix 4 also provides information to when we would expect data items to be populated and what is likely to change over the period of a client’s treatment journey.

|  |  |
| --- | --- |
| **Data field & Business Definition** | **Additional Guidance.** |
| **Date of Birth**  The date of birth of the client. | In exceptional cases, where the date of birth is unknown, the default date of ‘18111111’ should be submitted. |
| **Gender**  The gender of a client (as stated by the client). | Gender identity is a person's sense of identification with either the male or female sex, as manifested in appearance, behaviour, and other aspects of a person's life. |
| **Reduced Postcode**  This is the reduced postcode of the client.  This is the usual address nominated by the client. If clients that usually reside elsewhere are staying in hotels, hostels or other residential establishments for a short term, say a week, they should be recorded as staying at their usual place of residence. However if long term, such as at boarding school, the school address must be recorded. University students may nominate either their home address or the address of their university accommodation.  If a client has no fixed abode, this should be recorded with the appropriate code (ZZ99 3) | The ‘reduced’ postcode consists of the first 4 characters of the postcode plus one space plus the first character of the second part of the post code. This could also be the first 3 characters where the first part of the postcode is 3 characters long as shown in the example below.  Example  If the full UK postcode is CF24 0AL, the submitted ‘reduced’ postcode entered would be ‘CF24 0’, as shown in the layout above. |
| **NHS Number**  The NHS Number of the client.  The NHS Number is allocated to an individual, to enable unique identification for NHS Healthcare purposes. | Guidance in populating the NHS number will be sent separately available from NWIS.  NWIS will contact all agencies to ensure they have the necessary processes in place to collect this data item |
| **Agency Codes**  This is a unique identifier for the Treatment Provider (Agency) and is the nationally recognised code assigned to the agency or practice by the NHS Wales Informatics Service (NWIS). | The unique identifier of the agency will be assigned by NWIS.  Please contact [substance.misuse-queries@wales.nhs.uk](mailto:substance.misuse-queries@wales.nhs.uk) for further information in obtaining codes.  Current codes are as listed in Appendix 6. |
| **Date of Referral**  The date that the referral was received by the agency.  For referrals by telephone, letter, email, online or fax, the date of referral should be recorded as the date the telephone call was made or the date the letter, email etc. was received by the agency.  Prison Referrals:   1. If a referral is received for a client whilst in prison, the referral date will be the date the client is released from prison. 2. If the agency begins working with a client before they are released the original referral date should be used as the date of referral. | Submission of data to the Substance Misuse National Data Base will be triggered by the receipt of a referral to a Substance Misuse Agency.  Please see Appendix 5 for further information in how this data is used when calculating waiting times. |
| **Source of Referral**  The source of referral of each client referral into a substance misuse agency. | Since April 2014 the source of referral codes commence from 30, to ensure that these are distinct from the codes previously utilised by the dataset.  This data item is utilised to provide baseline information to examine emerging patterns and trends in referral pathways and to enable us to link this information to drop out rates. |
| **Assessment Date**  The date that the initial assessment was completed.  The full scope and depth of the assessment will vary according to the presenting needs of a client, but should include an initial assessment of the client’s physical health and mental health needs. | *This field must be completed if there is an entry for treatment date. If a treatment date is entered without an assessment date this will be reported as a data quality issue.*  **Common scenarios in reporting assessment dates:**  If an individual fails to attend for their assessment without advising the agency, the referral record and the ‘reason contact ended’ should be ‘did not attend’. A record should be closed in this way if the treatment provider has lost contact with client for 8 weeks or more without a planned discharge and all attempts to re-engage the client have not been successful.  If they subsequently take up the offer of assessment, and have not been closed on the system as per scenario above, a new referral should be submitted with the referral date being the date the client contacts the agency to state they would like an assessment. The date of the assessment would then be the ‘new’ assessment date. |
| **Local Authority**  The Local Authority of the client, based on the postcode of their usual place of residence at assessment. | In the event that the client presents with no fixed abode, the code should be that of the local authority in which the agency is located.  Where tier 4 treatment is being provided, the code for the local authority responsible for the referral should be used.  Code 999 (Other – Outside Wales) **must not** be used for instances where the client lives outside the agency area but does live in Wales. |
| **Ex Services Personnel**  To establish whether the client has advised that they have previously served in the armed forces. | ‘Previously served’ is defined as anyone who has served for at least **one day** in HM Armed Forces (Regular or Reserve), or Merchant Seafarers and Fisherman who have served in a vessel at a time when it was operated to facilitate military operations by HM Armed Forces. |
| **Parental responsibility**  The parental responsibility of the client – i.e. whether or not dependents reside with them. | Young people between 16 and 18 should also be asked whether they have parental responsibility.  Parental responsibility includes biological parents, step parents, foster parents, adoptive parents and guardians. It should also include de facto parents where an adult cohabits with the parent of a child or the child alone and have taken on full or partial parental responsibilities. |
| **Children Living in Household**  The number of children under 18 that live in the same household as the client at least one night a week. The client does not necessarily need to have parental responsibility for the children. | This question is designed to indicate the number of young people in a household at risk due to parental or sibling drug use. Therefore, this question for children in care should be recorded as 0, unless the young person is living with other siblings. In this case the number of siblings should be recorded. |
| **Problem Substance 1**  The main problem substance that has led the client to present (or be referred) to the substance misuse agency.  The specific substance causing the problem should still be recorded even if an individual advises that they are currently substance free. | A problematic substance can include alcohol, any illegal drug, over the counter / prescription medicine used inappropriately (either not prescribed to the client or used contrary to prescribing guidelines).  If a client presents with more than one problem substance the agency is responsible for clinically deciding which one is primary.  ***Note:*** *If a client has been prescribed substitute opioid medication (i.e. Methadone or Buprenorphine) these should not be listed as the main problem substance and instead Opiates should be recorded. If the client is using Methadone / Buprenorphine not prescribed to them it is then appropriate to list them as the problem substance.* |
| **Problem Substance 2 and 3** | These should only be populated where appropriate. Please populate **9996** if there is no second drug and **9997** for no third drug |
| **Injecting status**  The injecting status of the client. | This does not include injecting for a bona fide medical purpose – only injecting illicit substances. |
| **Accommodation need**  The current accommodation need of the client. | The following provides guidance as to the sub-categories that can be considered within the relevant codings on the system.  01 No Fixed Abode – urgent housing problem  o Live on streets  o Use night hostels (night-by-night basis)  o Sleep on different friend’s floor each night  02 Housing problem  o Staying with friends/family as a short term guest  o Night winter shelter  o Direct Access short stay hostel  o Short term B&B or other hotel  03 No housing problem  o Local Authority (LA)/Registered Social Landlord (RSL) rented  o Private rented  o Approved premises  o Supported housing/hostel  o Traveller  o Own Property  o Settled with friends/family |
| **Treatment Modality**  The treatment modality / intervention a client is receiving as part of their treatment journey | A client may have more than one treatment modality running sequentially or concurrently within a journey and may have more than one of the same type running concurrently as long as the setting (provider) in each are different.  All Treatment Modalities must have a start date and an end date when the modality is concluded.  Full definitions of the modalities are listed in Appendix 1 |
| **Modality Referral Date**  The date when it was mutually agreed that the client required the specified modality / intervention of treatment. | For the first modality / intervention in a journey, this should be the date that the client was referred to the treatment requiring a structured modality / intervention.  For subsequent modalities, it should be the date that both the client and the key worker agreed that the client is ready for the modality / intervention. |
| **Date of First Appointment Offered for Modality**  The date of the first appointment offered to commence the specified treatment modality. | This should be mutually agreed as appropriate for the client. |
| **Modality End Date**  The date when the treatment modality ended. | Where a client cuts short a treatment modality (i.e. an unplanned exit), the date of the last face-to-face contact should be used. |
| **Modality Exit Status**  The exit status from a treatment modality. | A planned exit is where treatment has completed, this includes:   * Treatment Complete * Treatment Complete – Problematic Substance Free * Referred to another service * Moved to GP Led Prescribing   Unplanned exit is where treatment is withdrawn by the provider, this includes clients who:   * Did not attend or respond to follow up contact * Moved from area (if client moved from geographical area but was also referred to another service, the latter should be captured.) * Retained in custody / prison * Deceased * Declined treatment   NB these classifications are different to the positive / negative and neutral closure reasons used to calculate KPIs\*.  \*Please see KPIs for specific definitions. |
| **Other Problem Substance Used**  This should be completed if the client has used any other substance within the last 28 days (4 weeks) prior to the TOP interview date other than alcohol, opiates, crack, cocaine, amphetamines and cannabis | If the client has used more than one ‘other problem substance’ in the last 28 days (4 weeks) the most predominant substance should be recorded. |
| **Psychological Health Status**  A score, as stated by the client, with regards to their perceived psychological health status (anxiety, depression and problem emotions and feelings etc.). | A scale of 0 (poor) to 20 (good) is used. |
| **Physical Health Status**  A score, as stated by the client, with regards to their physical health status (extent of physical symptoms and bothered by illness etc.). | A scale of 0 (poor) to 20 (good) is used. |
| **Urgent Housing Problem Status**  To establish if the client has had an acute housing problem in the last 28 days (4 weeks) prior to the TOP interview. | Acute housing problem is defined as:   * The client is of no fixed abode and has been sleeping a night by night basis on the streets. * The client has been sleeping in a night shelter on a night by night basis. * The client has been sleeping on different friends’ floors each night. |
| **Risk of Eviction Status**  To establish whether the client has been at risk of eviction over the last 28 days (4 weeks) prior to the TOP interview. | Risk of eviction is defined as:  A verbal warning from their landlord concerning their tenancy that concerns some infringement of the agreement such as rent or mortgage arrears.  OR  A formal written warning, notice seeking possession or court order which may result in their eviction from their property |
| **Quality of Life Status**  A score, as stated by the client, with regards to their overall quality of life (e.g. able to enjoy life, gets on well with family and partners). | A scale of 0 (poor) to 20 (good) is used. |

**3.0 Frequently Asked Questions**

***Opening a record (referral) on the WNDSM.***

**Q: How do you submit records to the WNDSM when it involves a Single Point of Engagement?**

**A:** As Single Points of Engagement (SPoE) within an area have become increasingly common there have been a number of queries on how this data should be captured on the WNDSM. If agencies in an area are operating the same collection system your query should be first referred to your local manager. If the services involved are not utilising the same data collection systems then the following provides the most common scenarios:

***Scenario 1: Where a service user comes into a SPoE and is considered to need a treatment which is undertaken by SPoE staff (usually this will be for a less structured intervention i.e. brief intervention).***

In this case the client referral, assessment and treatment and closure dates following delivery of the intervention, are all recorded and submitted to the WNDSM by the SPoE.

***Scenario 2: Where a service user comes into a SPoE and is assessed and deemed not to require treatment or who subsequently DNAs.***

In this case the service user’s referral, assessment and closure date/reason is recorded and submitted to the WNDSM by the SPoE.

***Scenario 3: Where a service user comes into SPoE and is assessed as requiring treatment, and is therefore referred from SPoE to a treatment agency.***

In this case the service user’s referral and assessment dates are captured by SPoE. SPoE also records the closure date and the closure reason as being “*referred to another agency*”. The referral and assessment dates will be included in the information sent to the agency as part of the onward referral process.

The receiving agency records the referral date, and assessment date onto their own record for the service user using the referral and assessment dates that are supplied with the service user’s information from the SPoE. The source of referrals should be coded as Single Point of Engagement (code 56). If the service user does not subsequently present to the onward referred agency, the record should be updated with a closure date i.e. the intended appointment date, with DNA as the reason for closure.

***NB.*** This guidance discusses ‘DNAs’ in line with how they should be dealt with from a data perspective. Agencies / commissioners should ensure that they have adequate policies in place to minimise DNAs and to follow up on clients appropriately.

**Q. Who is responsible for submitting tier 4 activities to the WNDSM?**

**A.** This would ordinarily be the tier 4 agency themselves. However, if a community based treatment service is continuing to undertake reviews with the client whilst they are in residential treatment then they may submit TOP data. These roles need to be agreed between residential and community provider on a case by case basis. *To note the Welsh National Database for Substance Misuse only captures information in welsh services.*

**Q. I have submitted a number of referrals with their primary substance but these do not seem to be on the system?**

**A.** The dataset has been built to expect that this data is not available until the assessment. The web reports have been amended to include a drop down option of capturing how many referral records have not yet reached assessment this will allow you to see how many of your records could be affected at any given time.

***Information collected at assessment/ treatment stage.***

**Q. In relation to the changes you have categorised a number of items as collected at assessment items. Is the assumption that a client receives just one assessment, as from an operational perspective this can occur over a period of time?**

**A.** In relation to populating the assessment data it is expected that this information is collected and built over a period of time. However, for the purposes of the data collection we have split the dataset into sections so that agencies can receive feedback on what data items have been populated or which is ‘missing’. This will allow agencies to ensure whether it is reasonable that specific data is not available for any particular record at a given time. Appendix 4 of this document provides agencies with additional clarity on whether specific data fields are expected to be updated through the lifetime of the treatment journey or if they should remain ‘fixed’.

**Q. If it is not clinically appropriate to offer hepatitis b vaccination or offer blood borne virus testing then which option should we record?**

**A.** For these incidences option 1 should be recorded (vaccination not required). However, it is expected that agencies have robust operating procedures to enable them to ascertain clinical appropriateness.

**Q. I notice that the question in relation to first language has been omitted from this dataset, is there a reason behind this?**

**A.** This is still considered vital information in relation to managing the needs of an individual client and therefore should be collected locally. It is likely that this will feature in future iterations of the dataset once the requirements for national recording is finalised.

**Q. I have a client who is prescribed acamprosate as a relapse prevention medication, which is highlighted within the detoxification modality; do I always have to ‘tick’ this one?**

**A.** No you would only ‘tick’ the detoxification modality if they were in receipt of detoxification. It is recognised that psychosocial interventions can also be undertaken alongside pharmacological interventions such as the prescribing of relapse prevention medication i.e. acamprosate and disulfiram

**Q. CBT appears as part of the psychosocial intervention in both substitute prescribing and in the psychosocial intervention treatment modality, how do they know which one this should be reported against?**

**A.** It is recognised that CBT (and other psychosocial interventions) maybe delivered by an agency alongside substitute prescribing and if this is the case then the substitute prescribing modality can be used. If substitute prescribing is not delivered but the CBT is then the psychosocial intervention element should be ‘ticked’.

**Q. Structured day programmes are included as interventions in both psychosocial interventions and structured prescribing but are also considered to be a treatment modality in their own right. How should a service report a structured day programme they are delivering?**

**A.** If a client must attend 3 – 5 days per week (minimum 16 hours a week) then the structured day programme modality should be used. If a client is receiving less input than this then you would use either psychosocial intervention or substitute prescribing depending on whether the latter is in place or not?

**Q. What happens if a client has children under 18 but they do not know where they live – what do you record on the database?**

**A.** Under the parental responsibility data item you would capture it as a code 03 (the client is a parent of children under 18 but they all live full time in other locations). For the ‘children living in household’ field you would use ‘00’ – no children live in the same household as the client. Code 99 should be used if a client does not wish to answer.

***Information collected in relation to the Treatment Outcomes Profile***

**Q. What is TOP?**

**A.** The TOP (Treatment Outcomes Profile) was developed as a clinical outcome monitoring tool to measure change and progress in key areas of the lives of people being treated in drug and alcohol services. It contains 20 questions referring to clients substance use, injecting behaviour, crime, health and quality of life to be collected at start, review, exit and post treatment exit.

**Q. When should TOP be completed?**

**A.** TOP should be completed for all primary drug clients receiving structured treatment who are aged 16 and over and is collected at 3 stages:

*- At start of new treatment journey* (to capture pre-treatment snapshot of client behaviour and situation)

- *And then every three months*(usually as part of a care plan review), and:

- *At Treatment Exit (t*o capture post-treatment snapshot of client behaviour and situation).

**Q. When completing the TOP form it asks to record substance misuse over the past 28 days. If a client is on a methadone prescription and not using illicits on top, should we record the clients’ use of methadone in ‘other’?**

**A.** No. If a client is on prescribed methadone then there would not be a requirement to include this on the TOP form. Anything else that is not prescribed to them and they have deemed to be a problematic substance should be recorded on the TOP form. If there is more than 1 substance that could be included on the ‘other’ section of the form then the most problematic one should be recorded.

***Information collected at discharge stage.***

**Q. How will ‘treatment completions’ be reported from the discharge codes?**

**A.** The discharge codes ‘treatment completed – problematic substance free’ and ‘treatment completed (treatment goal(s) reached)’ will be utilised to measure treatment completions.

Additional information is available within the Key Performance Indicator guidance on how this data is utilised to populate the outcome performance indicators.

**Q. Planned and unplanned exits are discussed within the guidance, how are these terms defined?**

**A.** Planned exits are defined as treatment complete (problematic substance free), treatment completed (treatment goal reached), referred to another service and moved to GP Led Prescribing.

Unplanned exits would be defined as treatment withdrawn by the provider, did not attend or respond to follow up contact, moved from area, prison / retained in custody, deceased and treatment commencement declined by client.

**Q. If a client presents injecting a drug and nothing else, and on treatment exit they are no longer injecting, but still using the substance can they be recorded as treatment complete?**

**A.** In some circumstances it would be possible to use the treatment completed (reached client goals) code, however only if their continued use of the drug was judged not to be problematic (i.e. not using frequently) or requiring further treatment.

**Q. If a client is at two providers concurrently, and exits one agency (mutually agreed) but remains with the other agency for specialist prescribing what would the discharge reason be?**

**A.** Client should be closed as referred to another agency as there is still a defined treatment need for the client.

**Q. What is a reasonable period of abstinence before you can state ‘treatment completed – problematic substance free’?**

**A.** It is expected that there is a period of sustained abstinence (e.g. 28 days) before this discharge code is applied. However, in every case, the decision to discharge the client rests with the substance misuse worker and their professional judgement when taking into account all relevant circumstances.

**Q. A client is currently receiving treatment within an agency but is then transferred within the agency to another site which has a different agency code.**

**A.** Providers are asked to consider their own agency codes and keep them to a minimum to reduce the need to do this. If providers feel that they need to amend their current agency codes they are advised to contact their local commissioner in the first instance and thereafter liaise with the respective Substance Misuse Advisory Regional Team within the Welsh Government.

However, if this scenario occurs then the client’s case should be closed at the original agency code with reason as ‘referred to another agency’.

**Q. What discharge code should be used when you contact the client following referral and they state that they are not ready to engage in treatment or when assessed there is not a treatment need for the client?**

These records should be closed with the code ‘inappropriate referral’ or ‘treatment commencement declined by client’ if a client expressed the wish that they did not wish to continue into treatment. This code should **not** be used when a client does not engage – in these cases the discharge code ‘did not attend or respond to follow up contact’ should be used.

**Q. What do you mean by “discharge to GP led services”?**

This should only be used when a client is closed to substance misuse services but will continue to receive specific substance misuse treatment (i.e. substitute prescribing) from their GP.

**Appendix 1: Modality Definitions**

**STRUCTURED TREATMENT MODALITIES**

1. ***Inpatient Treatment***

An Inpatient Unit (IPU) provides care to service users with substance-related problems (medical, psychological or social) that are so severe that they require medical, physical and psychological care. The key feature of the IPU is the provision of these services with 24 hour cover 7 days per week, from a multi-disciplinary clinical team who have had specialist training in managing addictive behaviours

Treatment in an inpatient (admitted) setting may involve one or more of the following interventions

1. Assessment
2. Stabilisation
3. Assisted withdrawal (detoxification).

A combination of all three may be provided or one followed by the other.

IPU treatment is based on a plan of care, developed prior to admission, and should encompass relevant preparatory work and a seamless transition to on-going treatment after discharge.

The three main settings for inpatient treatment are:

* General hospital psychiatric units
* Specialist drug misuse inpatient units in hospitals
* Residential rehabilitation units (usually as a precursor to the rehabilitation programme)

The modality / intervention start date is the date of admission to the inpatient facility.

***i) Inpatient Treatment Assessment Only (Definition of Intervention)***

Individuals with drug and alcohol dependence present with a wide range of psychiatric, physical and social problems.

Substance misuse services provide a comprehensive assessment of these needs and formulate a treatment care plan to tackle them.

A hospital setting permits a higher level of medical observation, supervision and safety for service users needing more intensive forms of care. Specific tasks of the IPU may include assessment of substance misuse / mental health / physical health / social problems.

***ii) Inpatient Treatment Stabilisation (Definition of Intervention)***

IPU should have care pathways, clinical protocols and sufficient human and physical resources to offer the following range of stabilisation procedures:

1. *Dose titration.*

Admission to an IPU with staff skilled in monitoring the effects of methadone and the opioid withdrawal syndrome may prevent the individual dropping out of treatment, or else continuing to supplement their prescribed methadone or buprenorphine dose with illicit opioids.

1. *Dose titration on injectable opioid medication*

IPU admission allows interventions to optimise the service users’ injection technique, and 24 hour monitoring allows safer and more efficient calculations of dosage.

1. *Stabilisation on maintenance therapy*

Use of heroin on top of prescription of methadone can be problematic and attempts to tackle it within the community may lead to increasing doses of methadone and rising opioid tolerance without the desired break from the illicit drug market. A short (one or two week) admission to an IPU may be an effective way of breaking this cycle, particularly when followed up by day care or intensive community support.

1. *Combination assisted withdrawal / stabilisation*

A period of IPU treatment may allow assessment and treatment of the withdrawal symptoms from stimulant drugs, alcohol or benzodiazepines, and in doing so facilitate stabilisation on opioid maintenance treatment. Such individuals can then continue to receive tier 3 interventions in a community setting.

***iii) Inpatient Treatment Detoxification / Assisted Withdrawal (Definition of Intervention)***

Assisted withdrawal should only be encouraged as the first step in a longer treatment process, and needs to be integrated with relapse prevention or rehabilitation treatment programmes.

Withdrawal in an IPU setting offers better opportunities for clinicians to ensure compliance with medication and to manage complications. IPU admission also offers a major opportunity to recruit service users into longer term treatment to reduce the risk of relapse back into regular drug or alcohol use.

The IPU should have care pathways, clinical protocols and sufficient human and physical resources to offer assisted withdrawal for a wide range of single and poly drug and alcohol misuse problems.

This **may** also include pharmacological interventions (excluding maintenance substitute opiate prescribing) such as acamprosate, disulfiram, methadone, buprenorphine, lofexidine, naltrexone, and other prescribing for symptomatic treatment such as nausea.

***2. Residential Rehabilitation***

Residential rehabilitation consists of a range of treatment delivery models or programmes to address drug and alcohol misuse, including abstinence drug interventions within the context of residential rehabilitation. There are three broad types of rehabilitation provision:

* Rehabilitation programmes based on Social Learning Theory
* 12-step programmes based on the Minnesota Model of addiction recovery treatment
* Faith-based therapeutic communities.

Residential rehabilitation providers may also manage (‘second stage’), or have access to, substance free supported accommodation where a client moves after completing an episode of care in a residential rehabilitation unit and where they continue to have a care plan, receive key work and a range of substance and non substance related support.

Residential rehabilitation programmes normally combine a mixture of group work, psychosocial interventions and practical and vocational activities.

The modality / intervention start is the date of admission to a residential establishment or the date on which the detoxification element is started (if detox and rehab are being provided as one package).

***3. Community Detoxification***

***Community based prescribing for withdrawal from alcohol***

This can include pharmacological interventions (excluding maintenance substitute opiate prescribing) such as acamprosate, disulfiram, methadone, buprenorphine, lofexidine, naltrexone, and other prescribing for symptomatic treatment such as nausea. This may include, relapse prevention, respite, stabilisation and/or preparation for abstinence based treatment.

The modality / intervention start is the date of dispensing the first dose of medication.

All prescribing interventions must be carried out in line with the Drug Misuse and Dependence – UK Guidelines on Clinical Management 2007. NICE Guideline on Psychosocial Interventions in Drug Misuse 2007.

***4. Substitute Opioid Prescribing (Methadone) and related Psychosocial Interventions***

Substitute Opioid Prescribing (methadone) - maintenance treatment & structured evidence based psychosocial interventions. The care plan for prescribing should include key working to deliver:

* Care plan reviews
* Provision of advice and information
* Harm reduction advice and interventions
* Interventions to increase motivation
* Relapse prevention.

The plan may also include more formal psychosocial interventions including Motivational Interviewing (MI), Community Reinforcement Approach, Cognitive Behavioural Therapy, Family Therapy, and Behavioural Couples Therapy, structured day programmes, structured 1-1 counselling and structured group work.

The modality / intervention start is the date of dispensing the first dose of medication.

All prescribing interventions must be carried out in line with the Drug Misuse and Dependence – UK Guidelines on Clinical Management 2007. NICE Guideline on Psychosocial Interventions in Drug Misuse 2007.

***5. Substitute Opioid Prescribing (Buprenorphine) and related Psychosocial Interventions***

Substitute Opioid Prescribing (Buprenorphine) maintenance treatment & structured evidence based psychosocial interventions. The care plan for prescribing should include key working to deliver:

* Care plan reviews
* Provision of advice and information
* Harm reduction advice and interventions
* Interventions to increase motivation
* Relapse prevention.

The plan may also include more formal psychosocial interventions including Motivational Interviewing (MI), Community Reinforcement Approach, Cognitive Behavioural Therapy, Family Therapy, and Behavioural Couples Therapy, structured day programmes, structured 1-1 counselling and structured group work.

The modality / intervention start is the date of dispensing the first dose of medication.

All prescribing interventions must be carried out in line with the Drug Misuse and Dependence – UK Guidelines on Clinical Management 2007. NICE Guideline on Psychosocial Interventions in Drug Misuse 2007.

***6. Psychosocial Interventions***

Psychosocial interventions are structured treatment interventions that encompass a wide range of actions. Key working is the basic delivery mechanism for a range of key components including the review or care or treatment plans and goals, provision of drug related advice and information, harm reduction interventions and interventions to increase motivation and prevent relapse. Help to address social problems, for example housing and employment, is also important.

The plan may also include more formal psychosocial interventions including Motivational Interviewing (MI), Community Reinforcement Approach, Cognitive Behavioural Therapy, Family Therapy, Behavioural Couples Therapy, Structured day programmes, structured 1-1 counselling and structured group work.

Formal psychosocial interventions may be provided alone or in combination with other interventions and should be targeted at addressing assessed need. They may be provided:

* To treat substance misuse or co-occurring mental disorders
* Alone or in addition to pharmacological interventions, (this can include relapse prevention medication i.e. acamprosate and disulfiram)

Formal psychosocial interventions should be provided in accordance in line with the Drug Misuse and Dependence – UK Guidelines on Clinical Management 2007. NICE Guideline on Psychosocial Interventions in Drug Misuse 2007. The type of psychosocial intervention should be selected on the basis of the problem and treatment need of a specific client, guided by the available evidence base of effectiveness.

The modality / intervention start is the date of the first formal and time limited appointment.

***7. Structured Day Programmes***

Structured Day Programme (SDPs) provides a range of interventions where a client must attend 3 – 5 days per week (minimum 16 hours a week). Interventions tend to be either a fixed rolling programme or an individual timetable, according to client need. In either case, the SDP includes the development of a care plan and regular key working sessions. The care plan should address drug and alcohol misuse, health needs, offending behaviour and social functioning.

SDPs usually offer a programme of defined activities for a fixed period of time. Clients will usually attend the programme according to specified attendance criteria, and follow a set timetable that will include group work, psychosocial interventions, educational and life skill activities. Some clients may be attending a SDP as a follow-on or a pre-cursor to other treatment types, or may be attending as part of a criminal justice programme supervised by the probation service (e.g. DRR) or community rehabilitation.

This modality should only be used by agencies who are delivering structured day programmes as part of a commissioned service.

The modality / intervention start is the date that the client starts the programme.

**LESS STRUCTURED MODALITIES**

***8. Health & Recovery Support Intervention***

During structured treatment, Recovery Orientated Systems of Care (ROSC) should be recorded for interventions delivered alongside and / or integrated with a psychosocial or pharmacological intervention. Therefore, at least one other modality (listed above) needs to be populated. ***Recovery support interventions can also be delivered and recorded outside of treatment however would not be captured on this database.***

The following options are available for recording this activity

**ROSC – Peer support / mentoring**

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| --- |
| **Definition** – A supportive relationship where an individual has direct or indirect experience of drug and alcohol problems maybe specifically recruited on a paid or voluntary basis to provide support and guidance to peers. Peer support can also include less formal arrangements where shared experience is the basis of the support (e.g. as part of a social group).  Where peer support programmes are available, staff should provide information on access to service users, and support access where service users express an interest in using this type of support. |

**ROSC – Facilitated access to self help group**

|  |
| --- |
| **Definition** – Staff provide service user with information about self help groups. If a service user has expressed an interest in attending a group then the staff member should facilitate initial contact with the group, e.g. arranging transportation to group, attending initial session with service user |

**ROSC – Social, financial and relationship support**

|  |
| --- |
| **Definition** – Staff have assessed that there is a need for on-going support as part of the comprehensive assessment process or as part of their on-going review. Under each heading further information is provided to what type of support can be recorded here.   * Family support (i.e. arranging family support for the family in their own right or family support that includes the individual in treatment) * Parenting support (i.e. referral to a parental support worker) * Financial support (i.e. referral to benefit / debt advisor) * Housing support (i.e. referral to a housing agency for specialist housing support (this can include a range of activities which are designed to allow an individual to maintain their accommodation or deal with an urgent housing need). * Employment support (i.e. include specific specialised employment support actions by the treatment service, and /or active referral to an agency for specialist employment support). * Education & training support (i.e. include specific specialised education / training support actions by the treatment service, and /or active referral to an agency for specialist education / training support). * Supported work projects (referral to a service providing paid employment positions where the employee receives significant on-going support to attend and perform duties). |

**ROSC – Aftercare support**

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| **Definition** - Following completion of treatment there is an agreement for periodic contact between a service provider and the former participant in the structured treatment phase of support. The support is initiated by the service provider |

**ROSC – Relapse prevention support**

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| --- |
| Support which is provided to clients who have completed their substance misuse treatment in order to prevent relapse. This can be defined as:   * Evidence based psychosocial interventions to support substance misuse relapse prevention (these are delivered following completion of structured substance misuse treatment. These interventions have a specific substance misuse focus and are delivered within substance misuse services) * Evidence based mental health focused psychosocial interventions to support continued recovery. (Evidence based psychosocial interventions for common mental health problems that support continued recovery by focusing on improving psychosocial well-being that might otherwise increase the likelihood of relapse to substance use. These are delivered following completion of structured substance misuse treatment and maybe delivered outside substance misuse services but referred from substance misuse services). |

**ROSC –Diversionary activities**

|  |
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| This indicates whether the client is involved in an activity that is designed to divert the client away from substance use.  This activity should be sustained and part of a wider programme of recovery rather than a one off session. |

***9. Brief Interventions***

These are brief opportunistic interventions focused on motivation. They normally consist of one or two brief sessions between 10 and 60 minutes, which often focus on exploring ambivalence about changing behaviour and are offered in a non-judgemental way. They should be offered to people with no or limited contact with services if they have identified concerns about their drug misuse (for example, attendees at a needle exchange or in primary care). For people not in contact with drug treatment services, such interventions are likely to produce real benefits. However, they would not routinely be offered as the main intervention by a key worker once a care plan for structured treatment was in place (Clinical Management Guidelines). It is noted that this can also include relapse prevention within this context.

This includes a client that receives information only either verbally or in writing but no further treatment.

***10. Harm Reduction***

This is where a client is given specific advice and techniques for reducing the harm from drug misuse, such as advice on safer injecting techniques and minimising the risk of overdose.

**Appendix 2: Principles of Confidentiality**

The statutes and protocols listed below are designed to be patient centered. However, the same level of security and protection of data offered by these statutes and protocols will be applied to any person regardless of the name given to that entity. For example, where the entity mentioned is ‘patient’ this may be interpreted as applying to ‘client’.

All the items listed below are extracted from documentation available on the Health of Wales Information Service (HOWIS) website. If you do not have access to HOWIS, copies of the relevant documentation will be sent to you by contacting the Substance Misuse Helpline at NHS Wales Informatics Service on telephone number 029 2050 2375 (WHTN 1790 2375) or email address [*substancemisuse-queries@wales.nhs.uk*](mailto:substancemisuse-queries@wales.nhs.uk)*.*

The Substance Misuse activity data that is collected by and stored on information systems at NHS Wales Informatics Service does NOT contain any person identifiable data.

**STATUTES**  
The Data Protection Act (DPA) received royal assent in July 1998. It embraces eight principles designed to safeguard personal data in terms of accuracy, security, storage, transmission and purpose to which the data is used. Personal data (as defined in the Freedom of Information Act 2000 – see below) is data which relates to a living individual who can be identified from those data.

The eight principles are:

1. Personal data shall be processed fairly and lawfully and, in particular, shall not be processed unless at least one of the conditions listed in Schedules 2 and/or 3 of the Act is met. *(These schedules provide a comprehensive list of the circumstances that determine whether the data being processed falls within the protection of the Act.)*.
2. Personal data shall be obtained only for one or more specified and lawful purposes, and shall not be further processed in any manner incompatible with that purpose or those purposes.
3. Personal data shall be adequate, relevant and not excessive in relation to the purpose or purposes for which they are processed.
4. Personal data shall be adequate and, where necessary, kept up to date.
5. Personal data processed for any purpose or purposes shall not be kept for longer than is necessary for that purpose or those purposes.
6. Personal data shall be processed in accordance with the rights of data subjects under this Act.
7. Appropriate technical and organizational measures shall be taken against unauthorized or unlawful processing of personal data and against accidental loss or destruction or, or damage to, personal data.
8. Personal data shall not be transferred to a country or territory outside the European Economic Area unless that country ensures an adequate level of protection for the rights and freedoms of data subjects in relation to the processing of personal data.

**The Freedom of Information Act 2000**

The Freedom of Information Act (FoIA) received royal assent in November 2000 and came into effect on the 1st January 2005. Under this Act, all public bodies have a legal duty to ensure that requestors are able to access information about how they operate, make decisions about their performance and spend monies from the public purse etc. The Act promotes the transparency and accountability for all that fall within it.

**The Environmental Information Regulations 1992**

The regulations provide the public with a right to request access to environmental information held by public bodies. This includes certain right to access health-related information and works in conjunction with the Freedom of Information Act.

**Health and Social Care Act 2008**

The Act formally established the National Information Governance Board for Health and Social Care (NIGB) which has replaced the Patient Information Advisory Group (PIAG) as the statutory body with responsibility for section 251 of the NHS Act 2006. The powers under Section 251 of the NHS Act 2006 (originally section 60 of the Health and Social Care Act 2001) remain unchanged and will continue to apply to patient data generated in England and Wales. Applications for Section 251 approval, to set aside the common law duty of confidentiality will be considered.

**PROTOCOLS**

**Caldicott**

In its report published in December 1997, the Caldicott Committee recommended improvements in the way the NHS handles and protects patient information particularly in the establishment of a network of ‘Caldicott Guardians’. The report underpinned the NHS Wales Strategy ‘Better Information – Better Health’.  
Under the concept of ‘Caldicott Guardianship’, there are 6 principles governing the protection of patient identifiable data. These principles are:-

1. Justification of the use or transfer of patient identifiable information.
2. Patient identifiable information is not to be used unless there is no alternative.
3. Where the use of patient identifiable information is considered essential, each individual item of information should be justified with the aim of reducing identifiability.
4. Access to patient identifiable information should be restricted to those who need to see it and they should have access only to those items that they need to see.
5. All those individuals who access patient identifiable information should be aware of their responsibilities towards maintaining patient confidentiality.
6. Every use of patient identifiable information must be lawful. Each organization must appoint someone responsible for ensuring the organization complies with legal requirements.

While the role of the Guardian has moved on side by side with the reorganisation of the Health Service in Wales, the principles established by the Caldicott Committee remain relevant. The Wales approach now differs from that of the original manuals published in 1999 and 2003. The new Wales approach has recognised the responsibilities of the Guardians within the wider context of Information Governance and all the elements that fall under that responsibility. To this end a new all Wales foundation manual for Caldicott Guardians has been launched called Caldicott: Principles into Practice. <http://www.wales.nhs.uk/sites3/home.cfm?orgid=783>.

**IT Security**

NHS Wales Informatics Service, like all NHS organizations is responsible for ensuring that the technology supporting its information systems is robust and protected from both intentional and non-intentional interference. Management of IT Security follows a set of rules and procedures to the level stipulated by the Institute of British Standards (BS7799) and IS027000. Security for all data under this protocol is ensured through establishing effective management of area that includes:

* Minimum specifications for PCs and portable computers.
* Password control – password formats, frequency of compulsory password changes, control of password breaches.
* Control of the ‘human interface’ particularly in areas such as the level of permitted access to information systems and the security safeguards that must be performed when people leave the organization.
* Control of malicious software.
* Control of procurement, installation, repair and disposal of computer systems.
* The control of the impact of identified risks through the application of Risk Management.
* The Statement of System Secure Policy (SSP) and Secure Operating Procedures (SOP); respectively what a system will contain and how it will be operated.
* Secure Systems Management, Data Network Security and Data Security.  
  Essentially, statements covering the approach to maintaining security of information systems and the data contained therein.

**Appendix 3: Definitions of the four tiers of treatment available for substance misuse**

**Substance Misuse Services**

*Tier 1 – Non Substance Misuse Treatment Specific Services*

Services offered by a wide range of professionals (e.g. primary care medical services, generic social workers, teachers, community pharmacists, probation officers, housing officers and homeless persons units). Tier 1 services work with a wide range of clients including substance misusers, but their sole purpose is not simply substance misuse.

*Tier 2 – Open Access Service*

Services providing accessible services for a wide range of substance misusers referred from a variety of sources, including self-referrals. The aim of the treatment in this tier is to help substance misusers to engage in treatment without necessarily requiring a high level of commitment to more structured programmes or a complex or lengthy assessment process. Services in this tier include needle exchange programmes and other harm reduction measures, substance misuse advice and information services and ad hoc support not delivered in a structured programme of care.

*Tier 3 – Structured Community Based Services*

Provides services solely for substance misusers in a structured programme of care. Services within this tier include structured cognitive behaviour therapy programmes, structured substitute medication maintenance programmes, community detoxification, or structured day care (either provided as a drug-free programme or as an adjunct to methadone treatment). Structured community-based aftercare programmes for individuals leaving prisons are also included in tier 3.

*Tier 4 – Residential and Inpatient Services*

Services aimed at those individuals with a high level of presenting need. Services in this tier include inpatient drug/alcohol treatment, including detoxification and residential rehabilitation. Tier 4 services usually require a higher level of motivation and commitment from the substance misusers than for services in lower tiers.

**Appendix 4- Updating data items.**

The following table provides advice to treatment agencies in respect to:

* What data items are needed to open a record.
* When data items would be expected to be populated.
* What data items may change over the course of a clients’ journey.

***It is recognised that sometimes items will change i.e. a name change and this section should only serve as guidance in what is expected.***

|  |  |  |  |
| --- | --- | --- | --- |
| **Item** | | **Collection Stage** | **Description** |
| **REFERRAL DETAILS** | | | |
| First Letter of Surname | | To be completed when record is loaded. | Should not change.  √ MUST be completed. If not, record rejected. |
| First Letter of Forename | | To be completed when record is loaded. | Should not change.  √ MUST be completed. If not, record rejected. |
| Date of birth | | To be completed when record is loaded. | Should not change.  √ MUST be completed. If not, record rejected. |
| Gender | | To be completed when record is loaded. | Should not change.  √ MUST be completed. If not, record rejected. |
| Ethnic Category | | Completed at assessment stage. | Should not change.  √ MUST be completed. |
| Agency Code | | To be completed when record is loaded. | Should not change.  √ MUST be completed. If not, record rejected. |
| NHS Number | | Completed at assessment stage. | Should not change.  If amended NWIS need to be formally advised. |
| Agency Client Number | | To be completed when record is loaded. | Should not change.  This should be consistent across all events at the Agency. |
| Referral Date | | To be completed when record is loaded. | Should not change.  √ MUST be completed. If not, record rejected. |
| Source of Referral | | Completed at referral stage. | Not expected to change (i.e. at start of an event). |
| **ASSESSMENT DETAILS** | | | |
| Reduced Postcode | | Completed at assessment stage. | May change (i.e. current situation). |
| Local (Unitary) Authority | | Completed at assessment stage. | May change (i.e. current situation). |
| Assessment Date | | Completed at assessment stage. | Not expected to change (i.e. at start of an event). |
| Previously Treated | | Completed at assessment stage. | Not expected to change (i.e. at start of an event). |
| Ex services personnel | | Completed at assessment stage. | Not expected to change (i.e. at start of an event). |
| Parental Responsibility | | Completed at assessment stage. | Not expected to change (i.e. at start of an event). |
| Children Living in Household | | Completed at assessment stage. | Not expected to change (i.e. at start of an event). |
| Problem Substance Number 1. | | Completed at assessment stage. | √ MUST be completed.  Should not change (i.e. at start of an event). |
| Problem Substance Number 2. | | Completed at assessment stage. | Should not change (i.e. at start of an event). |
| Problem Substance Number 3. | | Completed at assessment stage. | Should not change (i.e. at start of an event). |
| Injecting status | | Completed at assessment stage. | Not expected to change (i.e. at start of an event). |
| Hepatitis B Vaccination Status | | Completed after assessment stage. | May change (i.e. current situation). |
| Blood Borne Virus Test Status | | Completed after assessment stage. | May change (i.e. current situation). |
| Co-occurring Mental Health Issues | | Completed at assessment stage. | Not expected to change (i.e. at start of an event). |
| Accommodation need | | Completed at assessment stage. | Not expected to change (i.e. at start of an event). |
| Employment Status | | Completed at assessment stage. | Not expected to change (i.e. at start of an event). |
| **TREATMENT MODALITY DETAILS** | | | |
| Treatment Modality | | Completed at treatment stage. | May change (i.e. current situation). |
| Against each modality that is appropriate at the time those marked \* will then be completed where appropriate. | | | |
| Modality Referral Date \* | | Completed after assessment stage | Not expected to change (i.e. at start of an event). |
| Date of First Appointment Offered for Modality \* | | Completed after assessment stage | Not expected to change (i.e. at start of an event). |
| Modality Start Date. \* | | Completed at treatment stage. | Not expected to change (i.e. at start of an event). |
| Modality End Date \* | | Completed after treatment stage. | Not expected to change (i.e. at end of an event). |
| Modality Exit Status \* | | Completed after treatment stage. | Not expected to change (i.e. at end of an event). |
| **TREATMENT OUTCOMES PROFILE DETAILS** | | |  |
| TOP Number | Completed at TOP interview. | | Not expected to change (i.e. as at TOP date). |
| TOP Interview Date | Completed at TOP interview. | | Not expected to change (i.e. as at TOP date). |
| Treatment Stage | Completed at TOP interview. | | Not expected to change (i.e. as at TOP date). |
| Number of days alcohol used | Completed at TOP interview. | | Not expected to change (i.e. as at TOP date). |
| Number of days opiate used | Completed at TOP interview. | | Not expected to change (i.e. as at TOP date). |
| Number of days crack used | Completed at TOP interview. | | Not expected to change (i.e. as at TOP date). |
| Number of days Cocaine used | Completed at TOP interview. | | Not expected to change (i.e. as at TOP date). |
| Number of days Amphetamines used | Completed at TOP interview. | | Not expected to change (i.e. as at TOP date). |
| Number of days Cannabis used | Completed at TOP interview. | | Not expected to change (i.e. as at TOP date). |
| Other Problem Substance Used | Completed at TOP interview. | | Not expected to change (i.e. as at TOP date). |
| Number of days Other Problem Substance used | Completed at TOP interview. | | Not expected to change (i.e. as at TOP date). |
| Injected Total | Completed at TOP interview. | | Not expected to change (i.e. as at TOP date). |
| Inject with Needle or Syringe used by someone else? Inject using a spoon, water or filter used by someone else? | Completed at TOP interview. | | Not expected to change (i.e. as at TOP date). |
| Shoplifting | Completed at TOP interview. | | Not expected to change (i.e. as at TOP date). |
| Drug Selling | Completed at TOP interview. | | Not expected to change (i.e. as at TOP date). |
| Theft from or of a vehicle, Other Property Theft or Burglary, Fraud, Forgery and Handling Stolen Goods | Completed at TOP interview. | | Not expected to change (i.e. as at TOP date). |
| Committing assault or violence | Completed at TOP interview. | | Not expected to change (i.e. as at TOP date). |
| Psychological Health | Completed at TOP interview. | | Not expected to change (i.e. as at TOP date). |
| Days paid work | Completed at TOP interview. | | Not expected to change (i.e. as at TOP date). |
| Days attended College or school | Completed at TOP interview. | | Not expected to change (i.e. as at TOP date). |
| Physical Health | Completed at TOP interview. | | Not expected to change (i.e. as at TOP date). |
| Acute Housing Problem | Completed at TOP interview. | | Not expected to change (i.e. as at TOP date). |
| Risk of Eviction | Completed at TOP interview. | | Not expected to change (i.e. as at TOP date). |
| Quality of Life | Completed at TOP interview. | | Not expected to change (i.e. as at TOP date). |
| **DISCHARGE DETAILS** | | | |
| Date Contact Ended | | Completed at discharge stage. | Not expected to change (i.e. at end of an event). |
| Reason Contact Ended | | Completed at discharge stage. | Not expected to change (i.e. at end of an event). |

**Appendix 5: Common Scenarios in respect to waiting time management**

When considering how to calculate waiting times, the following should be noted:

* All waiting times are measured in working days.
* The waiting time target is 20 working days. First day is day ‘0’ and then is counted up to day ‘19’.
* The national data collection system includes bank holidays as working days.
* Date of first appointment offered for a modality maybe a future date, but waiting times will only be calculated when a client actually commences a modality (i.e. the treatment start date).
* In cases where a treatment waiting time is narrowly missed, the date of first appointment offered for a modality will allow areas to demonstrate whether there has been difficulty in a client attending previous appointments.
* The waiting time ‘start date’ for clients who have been assessed as requiring residential rehabilitation should be calculated from the date when the client and keyworker have agreed that the client is ready for residential rehabilitation and that they will be referred for a funding decision (as appropriate).
* The waiting time ‘start date’ for clients who are accessing treatment following release from prison should be calculated from the day a client is released from prison and is available for treatment. The revised dataset also allows areas to show subsequent waits for treatment modalities. Treatment waits in these scenarios should begin when the client and keyworker agree that the client is ready.

**Appendix 6. List of Agency Codes**

|  |  |
| --- | --- |
| **Org Code** | **Agency Name** |
| LB060 | ARCH Anglesey |
| LB070 | ARCH Conwy |
| LB080 | ARCH Denbighshire |
| LB090 | ARCH Flintshire |
| LB100 | ARCH Gwynedd |
| LB110 | ARCH Wrexham |
| WEC010 | Cwm Taf Primary Care Drug & Alcohol Service (PCDAS) |
| WLA010 | TEDS General Support |
| WLB010 | Drugaid Caerphilly |
| WLB020 | Drugaid Blaenau Gwent |
| WLB030 | Drugaid Merthyr |
| WLB050 | Drugaid Newport |
| WLB060 | Drugaid RCT |
| WLB070 | Drugaid Torfaen |
| WLB080 | Drugaid Monmouthshire |
| WLB130 | Drugaid CYP Torfaen |
| WLB140 | Drugaid CYP Monmouthshire |
| WLB150 | Drugaid Goals NPS Caerphilly |
| WLB160 | Drugaid YPSD |
| WLB170 | Drugaid Pembrokeshire Choices |
| WLB180 | Drugaid Ceredigion Choices |
| WLB190 | Drugaid Carmarthenshire Choices |
| WLB220 | DDAS |
| WLB310 | DDAS OA Ceredigion |
| WLB320 | DDAS OA Carmarthenshire |
| WLB330 | DDAS OA Pembrokeshire |
| WLB410 | DDAS CJ Orders |
| WLB420 | DDAS Without Orders |
| WLC010 | RCT CDAT Llwyn-yr-eos |
| WLC040 | RCT CDAT Mountain Ash |
| WLC050 | RCT CDAT-Merthyr |
| WLE330 | PSALT |
| WLE340 | NEWID CYMRU |
| WLF010 | DASH (Previously Ogwr DASH) |
| WLG010 | YPDAS (RCT) |
| WLK010 | Carmarthen CDAT (previously WWSMS) |
| WLK020 | Ceredigion CDAT (previously WWSMS) |
| WLK030 | Pembrokeshire CDAT (previously WWSMS) |
| WLN020 | BCU - Ynys Mon |
| WLN030 | BCU - Gwynedd |
| WLP010 | BCU - Flintshire |
| WLP020 | BCU - Conwy |
| WLP030 | BCU - Wrexham |
| WLP050 | BCU - Denbighshire |
| WLQ010 | Inroads - Cardiff |
| WLQ020 | Inroads - Barry |
| WLR020 | Kaleidoscope DRR |
| WLR050 | Kaleidoscope Prescribing - DRR - Carmarthen |
| WLR060 | Kaleidoscope Prescribing - DIP - Carmarthen |
| WLR070 | Kaleidoscope -RPS- DIP Bridgewater/ Neath / Port Talbot |
| WLR080 | Kaleidoscope -RPS- DIP RCT / Merthyr Tydfil |
| WLR090 | Kaleidoscope -RPS- DIP Cardiff & Vale of Glamorgan |
| WLR100 | Kaleidoscope -RPS- DIP Swansea |
| WLR120 | Y.O.S Monmouthshire (Kaleidoscope) |
| WLR130 | Y.O.S Torfaen (Kaleidoscope) |
| WLR160 | Blaenau Gwent DAYS |
| WLR170 | Caerphilly DAYS |
| WLS020 | CAU Vale |
| WLS030 | CAU Adfer Unit |
| WLS040 | CAU Therapeutic Day Care |
| WLS050 | CAU East Cardiff |
| WLS060 | CAU West Cardiff |
| WLS100 | Salvation Army - Bridge Project |
| WLS110 | Salvation Army - CAU |
| WLS200 | EDAS Cardiff |
| WLS210 | EDAS Barry |
| WLT020 | Cardiff CADT - Social Work |
| WLT030 | Cardiff CADT - Counselling |
| WLT040 | Cardiff CADT- STIR |
| WLT050 | Vale CADT - Social Work |
| WLT060 | Vale CADT – Counselling |
| WLU030 | Safe Haven |
| WLW010 | GSSMS |
| WLW040 | YPSMS (Gwent) |
| WLW050 | Caerphilly CDAT |
| WLW060 | B@1 Barnardos |
| WKS010 | SOLAS (TARS) Cardiff |
| WKS020 | SOLAS (TARS) Vale |
| WKT010 | GDAS CMDS Blaenau Gwent |
| WKT011 | GDAS CMDS Caerphilly |
| WKT012 | GDAS CMDS Monmouthshire |
| WKT013 | GDAS CMDS Newport |
| WKT014 | GDAS CMDS Torfaen |
| WKT020 | GDAS OA Blaenau Gwent |
| WKT021 | GDAS OA Caerphilly |
| WKT022 | GDAS OA Monmouthshire |
| WKT023 | GDAS OA Newport |
| WKT024 | GDAS OA Torfaen |
| WKT030 | GDAS CRC ATR Blaenau Gwent |
| WKT031 | GDAS CRC ATR Caerphilly |
| WKT032 | GDAS CRC ATR Monmouthshire |
| WKT033 | GDAS CRC ATR Newport |
| WKT034 | GDAS CRC ATR Torfaen |
| WKT040 | GDAS CRC DRR Blaenau Gwent |
| WKT041 | GDAS CRC DRR Caerphilly |
| WKT042 | GDAS CRC DRR Monmouthshire |
| WKT043 | GDAS CRC DRR Newport |
| WKT044 | GDAS CRC DRR Torfaen |
| WKT050 | GDAS CRC RAR Blaenau Gwent |
| WKT051 | GDAS CRC RAR Caerphilly |
| WKT052 | GDAS CRC RAR Monmouthshire |
| WKT053 | GDAS CRC RAR Newport |
| WKT054 | GDAS CRC RAR Torfaen |
| WKT060 | GDAS NPS ATR Blaenau Gwent |
| WKT061 | GDAS NPS ATR Caerphilly |
| WKT062 | GDAS NPS ATR Monmouthshire |
| WKT063 | GDAS NPS ATR Newport |
| WKT064 | GDAS NPS ATR Torfaen |
| WKT070 | GDAS NPS DRR Blaenau Gwent |
| WKT071 | GDAS NPS DRR Caerphilly |
| WKT072 | GDAS NPS DRR Monmouthshire |
| WKT073 | GDAS NPS DRR Newport |
| WKT074 | GDAS NPS DRR Torfaen |
| WKT080 | GDAS NPS RAR Blaenau Gwent |
| WKT081 | GDAS NPS RAR Caerphilly |
| WKT082 | GDAS NPS RAR Monmouthshire |
| WKT083 | GDAS NPS RAR Newport |
| WKT084 | GDAS NPS RAR Torfaen |
| WAH010 | Open Minds |
| WJC010 | Broadway Lodge |
| WJC030 | Ashcroft House |
| WJC020 | Wrington Lodge |
| WPC010 | Carmarthen Social Care SM Team |
| WPD010 | Kaleidoscope Powys - Newtown |
| WPD020 | Kaleidoscope Powys - Llandrindod Wells |
| WPD030 | Kaleidoscope Powys - Ystradgynlais |
| WPD040 | Kaleidoscope Powys - Brecon |
| WPD050 | Kaleidoscope Powys - Welshpool |
| WPD060 | Signpost |
| WPD070 | Kaleidoscope Powys - DIP Newtown |
| WPD080 | Kaleidoscope Powys - DIP Welshpool |
| WPD090 | Kaleidoscope Powys - DIP Llandrindod Wells |
| WPD100 | Kaleidoscope Powys - DIP Brecon |
| WPD110 | Kaleidoscope Powys - DIP Ystradgynlais |
| WPE020 | CAIS Ynys Mon |
| WPE030 | CAIS Gwynedd |
| WPE040 | CAIS Conwy |
| WPE050 | CAIS Denbighshire |
| WPE060 | CAIS Flintshire |
| WPE070 | CAIS Wrexham |
| WPE080 | CAIS Powys |
| WPE090 | CAIS Hafan Wen |
| WPE100 | CAIS Tyn Rodyn |
| WPE120 | CAIS Conwy Day Programme |
| WPF010 | Include |
| WPJ010 | Brynawel House |
| WPK010 | RISMS |
| WPL010 | South Wales CAMHS |
| WPQ030 | Gwent GP Consortium |
| WPQ050 | South Wales DIP Swansea |
| WPQ060 | South Wales DIP RCT & MT |
| WPQ070 | South Wales DIP C&V |
| WPQ080 | South Wales DIP B&NPT |
| WPR010 | Barnardos Gwent |
| WPR020 | Barnardos North Wales |
| WPS010 | Caerphilly Drug & Alcohol |
| WPU010 | Flintshire YPDAT |
| WPV010 | Cwm Taf Alcohol Liaison Service |
| WXX999 | English Bucket Code |