Drug Misuse Statistics Scotland 2011
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A National Statistics Publication for Scotland
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About ISD
Scotland has some of the best health service data in the world combining high quality, consistency, national coverage and the ability to link data to allow patient based analysis and follow up.

Information Services Division (ISD) is a business operating unit of NHS National Services Scotland and has been in existence for over 40 years. We are an essential support service to NHSScotland and the Scottish Government and others, responsive to the needs of NHSScotland as the delivery of health and social care evolves.

Purpose: To deliver effective national and specialist intelligence services to improve the health and wellbeing of people in Scotland.
Mission: Better Information, Better Decisions, Better Health
Vision: To be a valued partner in improving health and wellbeing in Scotland by providing a world class intelligence service.

Official Statistics
Information Services Division (ISD) is the principal and authoritative source of statistics on health and care services in Scotland. ISD is designated by legislation as a producer of ‘Official Statistics’. Our official statistics publications are produced to a high professional standard and comply with the Code of Practice for Official Statistics. The Code of Practice is produced and monitored by the UK Statistics Authority which is independent of Government. Under the Code of Practice, the format, content and timing of statistics publications are the responsibility of professional staff working within ISD.

ISD’s statistical publications are currently classified as one of the following:

- National Statistics (ie assessed by the UK Statistics Authority as complying with the Code of Practice)
- National Statistics (ie legacy, still to be assessed by the UK Statistics Authority)
- Official Statistics (ie still to be assessed by the UK Statistics Authority)
- other (not Official Statistics)

Further information on ISD’s statistics, including compliance with the Code of Practice for Official Statistics, and on the UK Statistics Authority, is available on the ISD website.

The United Kingdom Statistics Authority has designated these statistics as National Statistics, in accordance with the Statistics and Registration Service Act 2007 and signifying compliance with the Code of Practice for Official Statistics. Designation can be broadly interpreted to mean that the statistics:

- meet identified user needs;
- are well explained and readily accessible;
- are produced according to sound methods, and
- are managed impartially and objectively in the public interest.

Once statistics have been designated as National Statistics it is a statutory requirement that the Code of Practice shall continue to be observed.
Introduction

This annual publication collates the available information on drug use from a range of national data sources. This report, and previous editions of it, are available on the national drugs misuse information website at www.drugmisuse.isdscotland.org/dmss.

The format of a number of the tables presented in this publication has been revised from previous editions. In addition certain figures (commonly small numbers, for small areas or populations) are not shown. These changes are a result of ‘statistical disclosure control’ (SDC) which aims to prevent the release of information that can lead to the identification of individuals. Further information on the SDC methods applied is available on request.

This publication does not include hospital discharge data, this is due to a backlog in data submissions as health boards move over from Patient Administration Systems to new Patient Management Systems. It is anticipated that this data will be available in April 2012.

This year there are four main sections:

A  Services and treatment for drug users
This section includes information on individuals presenting to drug treatment services and prescription statistics.

B  Health impact of drug use
This section includes information on general practice consultations, maternity and neonatal information, blood-borne viruses and drug-related deaths in Scotland.

C  Criminal justice and social harm
This section includes information on drug-related offences and court proceedings, criminal justice social work, drug misuse and treatment in Scottish prisons and social harm in neighbourhoods.

D  Prevalence of drug misuse
This section includes information from national surveys on reported drug use and research studies on prevalence.

Thanks are given to the organisations who supplied the information presented in this publication. Contact details for these organisations can be found in Appendix A.

Substance Misuse Programme

The Substance Misuse Programme, part of the Information Services Division (ISD Scotland), NHS Scotland, has produced this report. The team:

- provides information to support Alcohol and Drug Partnerships, Local Authorities, NHS boards, specialist drug services, the Scottish Government and others.
- manages the Scottish Drug Misuse Database (SDMD), and ensures the effective and appropriate exploitation of other relevant data collected by ISD e.g. hospital inpatient data.
- develops expertise in the use of available data to produce robust performance and activity indicators to monitor the impact of national and local policies.
• supports the research and analytical work of other organisations, subject to general strategic priorities and ethical and legal considerations.

The team also provides an information service to organisations and individuals who wish to use the data relating to drug misuse collected by ISD Scotland. For further information please phone 0131 275 7051 or email nss.isdsubstancemisuse@nhs.net.
Results and Commentary

A Services and Treatment for Drug Use

A1 Scottish Drug Misuse Database

The Scottish Drug Misuse Database (SDMD) is an important information source on the use of drugs in Scotland. The SDMD provides a wealth of information on drug treatment that Alcohol and Drug Partnerships (ADPs), their individual members and a range of different organisations can use to influence policy, strategies or research to improve the services available to help people with drug problems recover.

Information is collated by drug treatment services in the NHS, local authority, voluntary sector and prisons throughout Scotland at specific points during an individual’s recovery journey, i.e. at:

- Initial Assessment (SMR25a)
- 12 week Follow-up (SMR25b)
- Annual Follow-up (SMR25b)
- Discharge from service (SMR25a or SMR25b)
- Transfer or referral from service (SMR25b)

The database provides us with an opportunity to understand more about the needs of people who present for specialist drug treatment. We anticipate that the follow-up information recorded by the SDMD will be able to tell us about people’s journey through treatment as well as providing evidence of the outcomes they achieve as a result of their engagement with specialist services.

The information in this chapter relates to new clients entering treatment that have given their consent for their information to be recorded in the SDMD. Therefore, it does not cover those already receiving treatment to help them recover from their drug problem.

Key Points

Overview 2010/11

- In 2010/11 10,813 ‘new’ individuals received a specialist assessment of their drug use and care needs, which equates to a rate of 219 per 100,000 of the Scottish population (Table A1.1). This compares with a rate of 240 (11,819) reported in 2009/10. The background information section provides more details relating to data collection.
- Of those reporting illicit drug use, 62% reported using heroin (4,988 individuals) (Table A1.7 and Table A1.8). In 2009/10, this figure was reported to be 67%. This figure has fluctuated since 2006/07. There was a similar decrease between 2007/08 and 2008/09 (69% to 64%) but this was followed by an increase in 2009/10 (67%).
- Forty-four per cent of those under the age of 25 years old, reporting illicit drug use, reported using heroin (Table A1.10). This is a drop from the 51% reported in 2009/10. There has been an overall downward trend in this figure since 2006/07.
- Twenty-four per cent of all individuals (for whom information is available) reported that they had injected in the month prior to seeking treatment. Forty-five per cent reported that they had never injected in 2010/11 (Table A1.20).
In 2010/11 7% of clients reported that they had shared needles/syringes in the previous month. There has been a steady decrease from 12% in 2006/07. The number of clients who had never shared equipment increased over the time period from 56% in 2006/07 to 61% in 2010/11 (Table A1.29).

Of those individuals currently injecting drugs: 76% reported that they had been tested for Hepatitis B; 77% for Hepatitis C and 73% for HIV prior to seeking treatment (Table A1.33). The percentage of individuals being tested for BBVs has increased steadily since 2006/07. (Table A1.34)

Sixty-two per cent of individuals reported that a year or more had elapsed between the onset of problem drug use and treatment first being sought (Table A1.19). This is consistent with previous years.

Five Year trend – 2006/07 – 2010/11

The age profile of ‘new’ individuals being assessed for their drug use care needs has changed over the last five years. In 2006/07, 51% of clients were aged 30 and over. In 2010/11 this figure was 60%. Amongst the 40 and over age group, the number of new clients receiving a specialist assessment for their drug use care needs increased from 15% in 2006/07 to 19% in 2010/11. (Table A1.3 and Figure A1.1)

Figure A1.1 New clients by age group, 2006/07 - 2010/11

Over the last five years, the ways in which new clients report that they use drugs has become safer in terms of injecting, sharing needles and spoons and testing for blood-borne viruses:

- The percentage of clients reporting injecting in the previous month fell from 28% in 2006/07 to 24% in 2010/11. This fall occurred in all age groups apart from those aged 40 years and over, where the figure remained stable at 20% over the five year time period. (Table A1.22)
- In 2010/11, 7% of clients reported that they currently shared needles/ syringes. This is a decrease from 12% reported in 2006/07. The number of clients who had never
shared equipment has also risen over the last five years, from 56% in 2006/07 to 61% in 2010/11 (Table A1.29).

- The number of clients reporting sharing spoons/ water/ filters/ solutions has also fallen: from 20% in 2006/07 to 12% in 2010/11 (Table A1.32).
- An increasing proportion of clients who have injected in the past have been tested for blood borne viruses: in 2010/11 76% were tested for Hepatitis B, 77% for Hepatitis C and 73% for HIV compared to 64%, 66% and 61% respectively in 2006/07 (Table A1.34).

Additional points

Demographic profile of new clients being assessed

This section describes the demographic profile of ‘new’ individuals attending specialist treatment services in Scotland for an assessment of their drug use care needs.

- The male: female attendance ratio in 2010/11 was more than 2:1 (71% male to 29% female). This gender breakdown is consistent with that reported over the past 5 years. There was little variation in the gender breakdown between the age groups. (Table A1.3).
- The median age of new clients was 32 years old (Table A1.2).
- Sixty per cent of new clients in 2010/11 were aged 30 years old or over (Table A1.3). There has been an overall increase in this figure since 2006/07, when the percentage was 51%.
- Almost all (96%) of these new clients in 2010/11 described their ethnicity as ‘white Scottish’ (Table A1.4). This is consistent with the ethnic profile reported in previous years.

Social profile of new clients being assessed

The personal circumstances of the individual seeking treatment or advice from drug services can influence that person’s motivation for seeking help and the extent to which the service can contribute to a change in drug-related behaviour. Information on employment status, current living arrangements and accommodation, source of funding and average amount spent on their drug use, and the individual’s current legal status are potentially relevant factors in the client’s pathway through drug use.

- Just over two-thirds (67%) of individuals in 2010/11 were unemployed, a drop from the 73% of individuals who were unemployed in 2009/10. Twelve percent of individuals were in paid or unpaid employment (including full time education and training) in 2010/11 (Table A1.36).
- Seventy per cent of individuals said that their drug use was funded by benefits, 22% reported that they funded their drug use with crime, and 15% reported that their drug use was funded by debt (Table A1.37).
- The average daily spend, in a ‘typical’ drug using day, for individuals who reported using heroin, was £33 and this is consistent with previous years’ reporting (Table A1.38).
- For individuals using cocaine, the average daily spend, in a ‘typical’ drug using day, was reported to be £114, which has increased from the £87 reported in 2006/07 (Table A1.38).
- Almost three quarters (72%) of individuals (who provided information) reported that they lived in owned or rented accommodation at the time of presentation, a drop from 80% in
Twenty percent reported that they were homeless (includes those reporting living in temporary or unstable accommodation, or a hostel) and 1% reported that they lived in supported accommodation (includes residential rehabilitation) in 2010/11 (Table A1.41).

- Nineteen per cent of individuals had previously been in prison (Table A1.43).
- Forty-one per cent of individuals reported that they had dependent children under the age of 16 years old. This figure has remained largely stable since 2006/07 (Table A1.40).

Clients’ sources of referral and co-occurring health issues

- More than a third (37%) of individuals in 2010/11 referred themselves to specialist drug services. Almost a further third (31%) were referred by a general practitioner, primary care, mental health professional or other health professional, which is an increase from 25% in the previous year. (Table A1.5).
- Almost half (49%) of individuals did not report a co-occurring health issue in addition to their drug use. One quarter (25%) of individuals reported drug-related physical health issues in addition to their drug use, and a further quarter (26%) reported mental health problems as a co-occurring health issue. Sixteen per cent reported alcohol problems as a co-occurring health issue (Table A1.6).

Types of drugs that new clients report using in the last month

- In 2010/11 the drugs most commonly reported by new patients/clients were:
  - heroin (62% or 4,988 individuals)
  - diazepam (34% or 2,707 individuals)
  - cannabis (30% or 2,413 individuals)
  - cocaine (8% or 647 individuals)
  - methadone (8% or 630 individuals)
  - crack cocaine (3% or 245 individuals) (Table A1.7 and Table A1.8).

- Of those who reported illicit drug use, 62% reported using heroin. This has decreased by 5% since 2009/10. However, this figure has fluctuated since 2006/07. There was a similar decrease between 2007/08 and 2008/09 (69% to 64%) but this was followed by an increase in 2009/10 (67%). The percentage of clients reporting use of diazepam, cannabis, cocaine and methadone is similar to that reported over the past 5 years. Those reporting use of crack cocaine has decreased from 7% in 2007/08 to 3% in 2009/10 and 2010/11 (Table A1.7 and Table A1.8).
- Of the 4,988 individuals who reported heroin use, 94% (4,685 individuals) reported it as their main drug of use (Table A1.7 and Table A1.9). This is consistent with the previous year.
- Of those who reported heroin as their main drug of use, 33% reported additional illicit diazepam use, 15% reported using cannabis, 9% reported illicit methadone use and 5% reported using dihydrocodeine (Table A1.11).
- Heroin was less commonly reported in the drugs profile of younger people. Sixty-five per cent or more of all age groups over 25 reported using heroin compared to less than a quarter (23%) of 15 to 19 year olds and 54% of 20 to 24 year olds (Table A1.8). The 15 to 19 year old age group has shown a decrease from the 33% reported in 2009/10.
- Reports of ecstasy use were most common amongst those aged under 20 years old with 10% of under 15 year olds and 9% of 15 to 19 years olds reporting the use of ecstasy in 2010/11. Cannabis use was most common in the under 15 year old age
group; 73% of this age group reported cannabis use. Caution is advised when interpreting these figures because the number of individuals in the 15 years old and under age group is relatively small. (Table A1.8 and Figure A1.1).

- Mephedrone is a new drug which has only been captured by the SDMD in the last 3 years. In 2010/11 133 ‘new’ individuals reported using it with 69 of these reporting it as their main drug (Tables A1.7 and A1.9).

Geographical profile of new clients being assessed

- In 2010/11, of those reporting use of heroin, 19% (947 individuals) were resident in NHS Greater Glasgow & Clyde; 18% (890 individuals) were resident in NHS Lothian; 12% (577 individuals) were resident in NHS Grampian and 9% (466 individuals) were resident in NHS Ayrshire & Arran (Table A1.7).
- Of those reporting cocaine use, 33% (214 individuals) were resident in NHS Greater Glasgow & Clyde; 18% (118 individuals) were resident in NHS Lanarkshire; and 15% (98 individuals) were resident in NHS Lothian (Table A1.7).
- 245 individuals reported crack cocaine use in 2010/11. Of these individuals 48% (118 individuals) were resident in NHS Grampian; 22% (53 individuals) were resident in NHS Greater Glasgow & Clyde; and 18% (44 individuals) were resident in NHS Lothian (Table A1.7).

Age at first use, problem recognition and seeking help

The time between the age when an individual first used an illicit drug, age at onset of problem, and age when (professional) help was sought provide some indication of an individual's journey through drug use.

- In 201011, the majority of individuals were in their teens when they first started using illicit drugs (including volatile substances and over the counter medicines), in their teens/early twenties when their drug use became a problem and in their twenties when they sought help (Table A1.14, Table A1.15 and Table A1.16).
- The length of time between the first use of illicit drugs and the onset of a problem varies from person to person. Over two-fifths (43%) reported that they did not perceive their
drug use to be a problem until five years or more had passed since they reported that they had started using drugs. Seventeen per cent of individuals perceived their use of illicit drugs to be a problem after less than one year (Table A1.17), which is consistent with the information reported in 2009/10.

- The time from the onset of the problem drug use until help was first sought also varied amongst individuals. Over a third (38%) of individuals reported that they first sought help less than a year after they perceived there to be a problem, 22% sought help after one to two years, 13% sought help after three to four years, whilst the remaining 27% waited five years or more before seeking help (Table A1.19). Again this is consistent with the previous year.

Ways in which people take drugs

‘New’ patients/clients, who receive a specialist assessment for their drug use, are asked whether they have ever injected drugs and if they have, whether they have done so in the past month prior to attending the service. Similar questions are also asked about sharing needles/syringes and sharing spoons/water/filters/solutions. These questions provide useful public health information as they offer an insight into the numbers of individuals who have either used equipment previously used by someone else or lent to someone else equipment that they have already used.

- The highest proportions of individuals reporting drug injecting in the previous month were found in the 25 to 29 years old age range; 28% reported injecting in the month prior to attending a service. 26% of 30 to 34 year olds also reported injecting in the previous month (Table A1.22). The age group most likely to inject drugs in 2010/11 was the 25 to 34 age group.
- Only 8% of individuals aged under 20 years old reported injecting in the previous month (Table A1.22). This is a drop from the 12% reported in 2009/10.
- Almost a third (31%) of individuals who had injected drugs reported that they were under 20 years old when they first injected. The median age for first injecting was 22 years old (Table A1.23).
- Half (50%) of individuals reporting heroin use also reported that they injected the drug (Table A1.25).
- Thirty-seven per cent of individuals reporting heroin use reported taking it through injection only. Twelve per cent reported administering the drug both by injection and by another method (e.g. smoking) (Table A1.24).

Alcohol profile

Patients/clients who present at a specialist service for their drug use are also asked to give details of their alcohol consumption, although it should be noted that this section is only completed for clients who have presented to a service for their drug use, rather than their alcohol use.

- Thirty-seven per cent of individuals reported that they had consumed alcohol in the past month (4,054 individuals) (Table A1.35).
- Twenty-nine per cent of those who reported drinking alcohol in the last month and who provided further information on their frequency of alcohol consumption reported drinking alcohol every day. A further 44% reported drinking alcohol at least 1 to 2 days a week (Table A1.35).
Background Information

Data Collection

The analysis presented in this section is based on data collected through SMR25a initial assessments. In April 2006, ISD introduced the SMR25a assessment form to replace the SMR24 form which had been in use since 2001. The revised form reflected the need for more in-depth and focussed information on clients who present for treatment. The new dataset incorporates most of the information that was collected using SMR24 but also included new information, including blood borne virus testing information, information on dependent children and alcohol profile. The SMR25a form is completed at the beginning of an individual’s episode of care.

There have been a number of changes in data collection methods between SMR24 and SMR25a. This means that information from the SDMD for the financial year 2006/07 onwards are not directly comparable with previously published analysis of data collected using SMR24 forms.

Since April 2009, all services which supply data to the SDMD have transferred from completing paper based forms to using the new web-based data collection system, with the exception of General Practitioners, who continue to complete paper forms. General Practitioner data are not included in the analysis within this publication. This system allows follow-up data (SMR25b) to be collected for each new client. It has also reduced the number of duplicate forms being completed for the same treatment episode for clients as all services involved in the delivery of treatment have access to the client’s online form. Full client names are now requested as part of the new web system (where clients give their consent). As submission of data to SDMD relies wholly on the permission of the client, this may lead to a reduction in forms being completed due to clients’ refusal to participate.

Data Developments

SDMD data is collected at the following points throughout a client’s course of treatment:

- Initial Assessment (SMR25a)
- 12 week Follow-up (SMR25b)
- Annual Follow-up (SMR25b)
- Discharge from service (SMR25a or SMR25b)
- Transfer or referral from service (SMR25b)

This will mean that clients’ course of treatment can be followed over time and, if they are transferred or receive shared care, across drug services. These developments aim to provide a greater depth of information on clients’ pathways through treatment.

Understanding the data

The Scottish Drugs Misuse Database is a dynamic source of data. It should be noted that the 2010/11 data presented in this chapter is provisional and may change in future publications as revised data will be used. Caution should therefore be applied when comparing 2010/11 data with previous years.
‘New’ patients/clients

The information presented relates to new patients/clients. The statistics do not reflect the total number of individuals seen by services during any period, although it is anticipated that analysis of follow-up data will allow this to be produced in the future.

New patients/clients
Any person who, at the time of presenting, is not currently in contact with a service that provides a specialist assessment of an individual’s drug use and care needs.

The database neither collects information on the non-client work in which most specialist projects are involved nor measures the number of contacts or the amount of time spent with clients. The data are usually recorded at or around the time of the initial assessment and so no measure of outcome is included in the SMR25a but we would expect to see this in the SMR25b assessments.

Alcohol use may be reported to the database but it should not be reported for clients presenting solely with an alcohol problem.

Local area analysis and trends

Individuals have been included only once within each NHS Board and council area of residence. However, they may appear in more than one area and as a result the sums of the NHS Board and council area data will not equal the Scotland figure. Where data are presented at a national level individuals are counted only once in any year.

Within Ayrshire & Arran NHS Board some agencies continued to collect data using the Ayrshire Common Database based on the SMR24 form after the introduction of the SMR25a form in April 2006. As a result information is unavailable from some agencies for certain questions that are specific to SMR25a.

Background notes on client confidentiality and small numbers

Maintaining patient confidentiality is a fundamental principle in ISD’s work. We take particular care when providing tabular information which results in small numbers appearing in table cells. The tables presented here have been adjusted to conform to ISD’s Statistical Disclosure Control Protocol. This protocol follows Office for National Statistics (ONS) guidance on dissemination of health statistics and has been overseen by an ISD working group, chaired by the ISD Head of Statistics (see http://www.isdscotland.org/Products-and-Services/Data-Protection-and-Confidentiality/ for more information). In line with this and to protect client confidentiality when publishing sensitive data we have revised our protocol on the treatment of small numbers for this year’s publication. The main points are as follows:

a) Client confidentiality.
   • Data tables are classified as sensitive either if the information within them is in itself sensitive, eg. Data on substance misuse, or if it can be combined with data from other sensitive tables to obtain information that might be used to disclose the identity of individuals, eg. age, sex.

b) Small numbers:
   • This protocol applies to all sensitive data.
• For larger geographies (e.g. NHS Board geographies) individual entries <5 are suppressed.
• For smaller geographies entries <10 are suppressed.
• If a suppressed entry can be calculated using another entry, that entry is also suppressed.

Acknowledgements

The co-operation and assistance of the staff at all services contributing to the database and individuals who consent to their data being reported are gratefully acknowledged.

Further information

Information on the Scottish Drug Misuse Database is available at [http://www.drugmisuse.isdscotland.org/sdmd/sdmd.htm](http://www.drugmisuse.isdscotland.org/sdmd/sdmd.htm).
Supplementary information for specific SDMD tables and a copy of the dataset is available at [http://www.drugmisuse.isdscotland.org/publications/10dmss/10dmss.pdf#page=52](http://www.drugmisuse.isdscotland.org/publications/10dmss/10dmss.pdf#page=52)

If you would like further information please contact the Substance Misuse Programme at [mailto:nss.isdsubstancemisuse@nhs.net](mailto:nss.isdsubstancemisuse@nhs.net)
A2 Prescription Statistics

Methadone hydrochloride (methadone oral solution 1mg/ml) is the most commonly used pharmacological treatment for opioid dependency in Scotland. It is used primarily for the treatment of drug addiction, although it is important to note that from the currently available data, it is not possible to identify the number of people receiving methadone specifically for drug treatment purposes. For further information, please refer to the ePharmacy Project discussion within the background information section.

In Tables A2.1 and A2.2, other drugs which are sometimes used in the treatment of opioid dependence are listed. It is important to note that some of these other drugs are also commonly prescribed for other conditions and, as above, from the currently available data it is not possible to identify the number of prescriptions which were specifically for the purpose of treating drug dependence.

Since the publication of Drugs Misuse Statistics Scotland 2010, there have been changes to the methodology used in presenting the data in this chapter.

- The data in these tables for methadone oral solution include only prescriptions for 1mg/ml methadone oral solution instead of all prescriptions of methadone oral solution as previously. This is in line with other publications and reflects the fact that 1mg/ml oral solution is the standard prescription for those on a methadone programme. Methadone oral solution which is greater than 1mg/ml is now included in 'Methadone Other'.
- This publication uses National Records of Scotland (NRS) population estimates aged 15 and over to calculate rates rather than the whole population. This is in line with other prescribing populations and is felt to give a more realistic rate.
- Table A2.4 now presents information on the total costs of methadone prescribing, including ingredient costs, costs of supervision and controlled drug fees. While this presents a fuller picture on the costs of methadone prescribing in Scotland, caution must be used when interpreting the data. Supervision costs and controlled drug fees are locally negotiated, and data is not available centrally for all Health Boards. Therefore comparison across Health Boards is not appropriate.

Due to these changes data in this publication is not comparable to that in previous publications, however comparable data are provided below.

Key points 2010/11

Overview

- In Scotland, in 2010/11, there were 533,733 prescriptions for methadone oral solution (compared to 508,950 in 2009/10), around 122 prescriptions per 1,000 population aged 15 and over (compared to 117 in 2009/10). This is equivalent to 5,834 defined daily doses per 1,000 population aged 15 and over (Table A2.1 and Table A2.3). See background information for details about defined daily doses.
- The total cost of dispensing methadone oral solution (dispensing fees, supervision fees and ingredients) for Scotland in 2010/11 was £28,031,231, around £6,414 per 1,000 population 15 and over (Table A2.4).
- In 2010/11, diazepam, dihydrocodeine and temazepam were prescribed at rates of 200, 99 and 77 prescriptions per 1,000 population aged 15 and over, respectively.
Information Services Division

Buprenorphine was prescribed at a rate of 16 prescriptions per 1,000 population aged 15 and over (Table A2.1).

- Overall in 2010/11 over 637 million milligrams of methadone oral solution 1mg/ml was dispensed in Scotland. This was dispensed in 533,733 prescriptions, an average of 1,194 milligrams per prescription (Table A2.5).

Five year trends - 2006/07 to 2010/11

- Methadone oral solution prescribing rates have risen over the last five years, from 115 prescriptions per 1,000 population aged 15 and over in 2006/07 to 122 prescriptions per 1,000 population in 2010/11. This figure remained stable between 2006/07 and 2009/10, before rising in 2010/11 (Table A2.2).

Figure A2.1 Prescriptions per 1,000 population 15+ by drug type, 2006/07 – 2010/11

- The total cost of methadone oral solution prescriptions has seen an overall increase of 36% from £20,554,554 in 2006/07 to £28,031,231 in 2010/11. This is a larger increase than the increase in the number of prescriptions over the same period (a 9% rise from 488,504 prescriptions in 2006/07 to 533,733 in 2010/11). This rise in costs is largely due to an increase in reported supervision fees which have risen steadily across the 5-year period from £7,893,206 in 2006/07 to £13,683,877 in 2010/11. The gross ingredient cost of methadone oral solution increased from £7,206,365 in 2006/07 to £10,949,705 in 2008/09 before falling year on year to £8,685,660 in 2010/11, while the costs for methadone fees remained stable over the period (Table A2.3 and Table A2.4).

- The prescribing rate of diazepam rose slightly between 2006/07 and 2010/11 from 196 to 200 prescriptions per 1,000 population aged 15 and over. The rate of prescribing of buprenorphine increased from 10 to 16 prescriptions per 1,000 population aged 15 and over between 2006/07 and 2010/11. (Table A2.2).

- The prescribing rate of temazepam decreased between 2006/07 and 2010/11 from 86 to 77 prescriptions per 1,000 population aged 15 and over. The rate of prescribing of
dihydrocodeine fell slightly from 102 to 99 prescriptions per 1,000 population aged 15 and over (Table A2.2).

Geographical profile

- Methadone prescription rates vary across Scotland from 211 prescriptions per 1,000 population aged 15 and over in NHS Greater Glasgow and Clyde to 30 prescriptions per 1,000 population aged 15 and over in NHS Borders (Table A2.1). This is consistent with previous years.
- Ten out of the twelve areas, where information was available for the whole 5 year period 2006/07 to 2010/11, showed an overall increase in the rate of methadone oral solution prescribing. NHS Grampian has seen an increase in the rate of methadone oral solution prescribing between 2006/07 and 2010/11, rising from 93 to 129 prescriptions per 1,000 population aged 15 and over. NHS Tayside also saw an increase in the last 5 years from 45 to 76 prescriptions per 1,000 population aged 15 and over (Table A2.3).
- The cost of methadone oral solution fees and ingredients per 1,000 population varies across Scotland. However, as supervision fees are negotiated locally and data is not held centrally for all Health Boards it is not appropriate to compare across Health boards.
- The prescribing rate of buprenorphine is noticeably higher in Western Isles (38 prescriptions per 1,000 population aged 15 and over) and Lanarkshire (32 prescriptions per 1,000 population aged 15 and over) than the overall Scotland rate (16 prescriptions per 1,000 population aged 15 and over) (Table A2.1).
- The prescribing rate of buprenorphine in Scotland has increased from 10 prescriptions per 1,000 population aged 15 and over in 2006/07 to 16 prescriptions per 1,000 population aged 15 and over in 2010/11. (Table A2.2).

Background information

Prescribed medication can be used for the treatment of drug addiction. Methadone hydrochloride (methadone oral solution) is a commonly used pharmacological treatment for opioid dependence. Methadone oral solution for the treatment of opioid dependence comprises the majority of methadone prescribing. Other formulations of methadone are used in the treatment of severe pain and palliative care. Methadone oral solution 1mg/ml is the standard product prescribed for drug treatment.

There is no national routine information which reports the number of people in Scotland who are receiving methadone hydrochloride oral solution, nor information on the cost per person to the NHS. The Prescribing Information System (PIS) at ISD Scotland holds information derived from prescriptions dispensed in the community in Scotland. The system and information held constitute a key part of the pharmacy payment process. However, the PIS does not currently store patient identifiable information (e.g. name, date of birth, address) that can be used to count the number of people receiving particular medications.

Temazepam and Diazepam are prescribed to sedate, induce sleep, and relieve severe anxiety as well as a substitute medication for problem drug use. Dihydrocodeine and Buprenorphine are used for the relief of moderate to severe pain and also for the management of opiate dependence. Some of these drugs are commonly prescribed for non-drug use related needs and so is not possible to assess precisely what proportion of these prescriptions are for the treatment of drug dependence.
Defined Daily Doses

Defined Daily Doses (DDDs) cited in the following tables are considered to be a more accurate index of prescribing volume than the number of items prescribed alone. It is used to overcome the problem that different medication can have different strengths and different potencies by relating all drug use to a standardized unit, a Defined Daily Dose. A DDD is defined by the World Health Organisation (WHO) as the typical adult daily maintenance dose of a drug.

Although DDDs are considered to be superior to number of items as a unit of comparative analysis, difficulties may arise when they are used in estimating disease prevalence, because they correspond to a drug’s principal reason for use.

Defined Daily Doses used in the production of the following tables are based on the WHO definitions:

- Methadone oral solution 25mg (insofar as methadone oral solution is concerned, it is useful to bear in mind that Department of Health Guidelines (1999) suggest that while 25-40 mg of methadone oral solution is an appropriate initial daily dosage (during assessment), the stabilization dosage offered on a longer term basis should be 60-100 mg/day)
- Dihydrocodeine 150mg
- Buprenorphine 1.2mg
- Diazepam 10mg
- Temazepam 20mg

Instalment dispensing

Single dispensing occurs where the whole of an item is dispensed on one occasion (e.g. multiple doses are dispensed and taken home by patient). Instalment dispensing occurs where a proportion of the prescription item is dispensed on multiple occasions (e.g. a single daily dose is dispensed each day for seven days).

Where items are dispensed in instalments, the number of dispensings exceeds the number of items, but where items are dispensed singly, the number of dispensings will equal the number of items. For many instalment prescriptions the quantity per dispensing is equivalent to the daily dose of methadone requested. However, it should be noted that for a significant proportion of prescription items, there will be a discrepancy between the prescribed daily dose and the amount dispensed by instalment. This is because pharmacies often dispense a double dose of methadone oral solution on Saturdays, to cover Sunday’s instalment; additional doses will also be added to an instalment to cover public holidays.

ePharmacy Project

Data on all prescriptions dispensed in the community is routinely collated by ISD from administrative data collected by Practitioner Services Division as part of a payment process for reimbursing pharmacy contractors.

In recent years more patient identifiers have been collected as part of this process due to the National e-Pharmacy programme, which is being implemented by the Scottish Government to support the new contractual arrangements for Pharmaceutical Services.
However, patient identifying information is not a mandatory requirement for the payment of contractors from which this data is sourced and the completeness of this information depends on a number of factors. These include the type of prescription, the location and type of prescriber, the drug being prescribed and the electronic systems being used.

As part of the National ePharmacy programme, patient identifying information on methadone prescribing is available for patients who receive their printed methadone prescriptions from their GP Practice and information captured by the GP information system. The quality of this information will continue to improve throughout 2011.

ISD has recently assessed the robustness of methadone prescribing information it receives and has concluded that a significant proportion of methadone prescribing takes place in non-General Practice settings such as Harm Reduction Clinics where the information on the prescription is either hand written or does not contain CHI information. Therefore, the overall completeness of patient identifiers for methadone prescribing information is only 50% at this current time. The scope of the National ePharmacy programme, which is now clear, will result in only improvements in the quality of data captured electronically in General Practice systems and will have no impact on the incomplete methadone prescribing data that are captured in non-GP Practice settings.

References


Further information

Although there is currently no routine information on the number of people receiving a methadone prescription, ISD Scotland has published a paper providing estimates of the number of people receiving a methadone prescription. This paper was published in 2005 and is available at http://www.drugmisuse.isdscotland.org/publications/abstracts/isd_methadone.htm.

The Prescribing Information System (PIS) holds information on a variety of different medications prescribed in Scotland. Information on the data and statistics are available at www.isdscotland.org/prescribing.

If you would like further information on methadone prescriptions or on prescriptions of other medications related to drug misuse please contact the Prescribing Team at nss.isdprescribing@nhs.net.
B Health Impact of Drug Use

B1 Hospital Discharges (Data will be published April 2012)

B2 Psychiatric Discharges (Data will be published April 2012)

This publication does not include hospital discharge data, this is due to a backlog in data submissions as Health Boards move over from Patient Administration Systems to new Patient Management Systems. It is planned to make this data available in April 2012. When available data will be published at http://www.drugmisuse.isdscotland.org/
B3 Information from General Practice

Practice Team Information is a system that collects consultation data from general medical practices in Scotland. Data are collected from a sample of practices covering 6% of the Scottish population and include every face-to-face contact between a patient registered with the practice and a member of the practice team. This sample is broadly representative of the Scottish population in terms of age, sex, deprivation and urban/rural mix and allows consultation estimates to be produced for Scotland.

The tables present figures with 95% confidence intervals (CI). This section reports on estimated values, which are derived from a sample of GP practices. The confidence intervals provide a range of values, for which it can be said with a 95% probability that the true value lies within. The confidence intervals are included to indicate the accuracy of these estimates.

Key Points 20010/11

Overview

- In 2010/11, it was estimated that around 0.8% (95% CI 0.6% - 1.1%) of consultations (face-to-face contacts) between patients and General Practitioners (GPs) related to drug use, which equates to approximately 136,270 consultations for drug use (95% CI 92,430-180,120) (Table B3.1). This is consistent with the previous reported years.
- The average estimated number of GP consultations per year for all patients attending a GP consultation was 3.9 (95% CI 3.7 - 4.0). For those with a diagnosis of drug use, the average estimated number of drug use GP consultations per year was 5.2 (95% CI 3.2 - 7.1) (Table B3.1).

Demographic profile

- In 2010/11, it was estimated that 17,440 males and 8,990 females consulted their GP for drug related problems. This equates to a ratio of nearly 2:1 more males than females consulting their GP. This differs from the pattern within the larger population of all consultations to GPs. (http://www.isdscotland.org/PTI/) A higher proportion of females consult their GP compared to males, with a ratio of over 3:2 females to males. (Table B3.2).
- Consultation rates for patients with drug use were highest in the 25 to 44 year old age group with a rate of 121.8 consultations per 1,000 registered patients (95% CI 97.7 – 145.8). For those without a diagnosis of drug use (i.e. all other consultations), higher consultation rates were recorded amongst those aged 65 years and over (Table B3.2).
- For males aged 25 to 44 years old, consultations for drug use made up 8.4% of all consultations compared to 1.5% overall (Table B3.2).
Co-morbidities

- It was estimated that for both men and women aged 15 to 44 years old with a drug use diagnosis, psychological signs and symptoms was the top most common co-morbidity in 2010/11. For male patients with a diagnosis of drug use, 20.3% (95% CI 13.3% – 27.3%) also had a diagnosis of psychological signs and symptoms compared with 8.8% (95% CI of 7.9% – 9.7%) of all patients having this as a diagnosis (Table B3.3).

- It is estimated that among females patients who had a diagnosis of drug use, 23.5% (95% CI 16.3% – 30.7%) also had a diagnosis of psychological signs and symptoms compared with 13.5% (95% CI 12.3 – 14.8%) of all patients having this as a diagnosis (Table B3.3).

- Among males, it was estimated that patients who had a diagnosis of drug use were nearly four times more likely to have a diagnosis of alcohol misuse than all patients with 7.3% (95% CI 4.6% – 9.9 %) of patients who had a diagnosis of drug use having this diagnosis compared to 1.9% (95% CI 1.6% – 2.2%) of all patients. Alcohol misuse was the ninth most common co-morbidity for males but did not feature in the top ten most common co-morbidities for females (Table B3.3).

Deprivation

- It is estimated that the rate of GP consultations for drug use increases as deprivation increases. The estimated GP consultation rate per 1,000 practice population for individuals living in the most deprived areas (deprivation category 1) was over seven times greater than the rate for individuals living in the most affluent areas (deprivation category 5), 87.8 (95% CI 71.7 – 103.9) estimated GP consultations per 1,000 practice population compared to 12.2 (95% CI 6.8 – 17.6) per 1,000 practice population. It should be noted that the estimated consultation rate remains largely the same across deprivation categories for non-drug use consultations (Table B3.4).

- Of the estimated number of patients consulting a GP for drug use nearly half (46%) were patients in the most deprived area (deprivation category 1)(Table B3.4).
Five year trends – 2006/07 to 2010/11

- The estimated percentage of patients attending a GP with a diagnosis of drug use has remained steady between 2006/07 and 2010/11 (0.7% of patients in 2006/07 and 0.6% of patients between 2007/08 and 2010/11 (Table B3.1).

- Similarly, the estimated average number of GP consultations per year relating to drug use has remained relatively stable over the five year period ranging between 5.0 to 5.5 GP consultations per year (Table B3.1).

Background information

Practice Team Information (PTI) is a system for the collection of primary care data from the general practice team, including General Practitioners, practice nurses, phlebotomists and healthcare assistants.

Data are collected from every face-to-face contact between a patient and a member of the practice team including out-of-hours and house calls, but excluding telephone consultations. Currently there are around 60 PTI practices collecting data in Scotland which contribute to the PTI sample. The selected practices involved are broadly representative of the Scottish population in terms of age, gender, deprivation and urban/rural mix. This allows the data collected to be extrapolated to the Scottish population as a whole.

PTI aims to continually improve the interpretation of the data and therefore analysis methods are regularly reviewed and sometimes updated. The method for dealing with small numbers of people in subcategories within practices has been updated in November 2011 and applied to all new and historic data. This has resulted in lower estimates across the board. Therefore figures shown here are not strictly comparable to those published previously. Full details of revisions to PTI data are available at http://www.isdscotland.org/Health-Topics/General-Practice/PTI-Statistics/Note-Of-Revisions.asp

Analysis & Definitions

The analysis is based on data from the sample of practices in each individual year for which complete data were available: 49, 48, 58, 60 and 59 PTI practices collected and submitted complete GP data for the years ending 31 March 2007, 2008, 2009, 2010 and 2011, respectively.

It is important to note that the information presented in this section of the publication does not give a measure of how prevalent drugs misuse is in the community. It does, however, give an insight into some of the characteristics of those who misuse drugs and present to a GP.

For PTI, the diagnosis of drug misuse has been identified using the following set of Read codes:

<table>
<thead>
<tr>
<th>Read code</th>
<th>Read code description</th>
</tr>
</thead>
<tbody>
<tr>
<td>13c..</td>
<td>Drug user</td>
</tr>
<tr>
<td>1P30.</td>
<td>Compulsive uncontrollable drug taking</td>
</tr>
</tbody>
</table>
Information Services Division

1P31. Compulsive drug taking
1P6.. Craving for drugs
63C6. Maternal drug abuse
68U.. Drugs of abuse screening
8B23. Drug addiction therapy
8B2N. Drug addiction detoxification therapy - methadone
8B2P. Drug addiction maintenance therapy - methadone
8B2Q. Drug addiction maintenance therapy - buprenorphine
8B2R. Drug addiction detoxification therapy - buprenorphine
8BA9. Detoxification dependence drug
8BAO. Opiate dependence detoxification
8FB.. Drug rehabilitation
8FB0. Drug detoxification programme completed
9HC.. Substance misuse monitoring
E02.. Drug psychoses
E24.. Drug dependence
E25.. Nondependent abuse of drugs
Eu1.. [X]Mental and behavioural disorders due to psychoactive substance use
SL501 Heroin poisoning
SL502 Methadone poisoning
SL50z Opiate/narcotic poisoning NOS
SL850 Cocaine poisoning
SL96. Hallucinogen poisoning
SL97. Psychostimulant poisoning
SL99y. Other psychotropic poisoning
SL9z. Psychotropic agent poisoning NOS

Interpretation of trend data

Caution must be exercised when interpreting data on trends. Although PTI is generally representative in terms of age, sex, deprivation and urban/rural mix, it may not be as representative in terms of numbers of patients with drug misuse. This is because there can be wide variation in numbers of drug misusing patients in different practices.

Further information

Information about Practice Team Information data collection and statistics is available at http://www.isdscotland.org/isd/1044.html.

If you would like further information on PTI and drug misuse please contact the Substance Misuse Programme at mailto:nss.isdsubstancemisuse@nhs.net.
B4 Maternity and Neonatal Discharges

This section is based on maternity data (SMR02) and neonatal discharges (SMR11, Scottish Birth Record) collected by ISD. More information about SMR02 data can be found at http://www.isdscotland.org/births and data about SMR11 and the Scottish Birth Record can be found here http://www.isdscotland.org/Products-and-Services/Scottish-Birth-Record/.

Care should be taken when comparing numbers over time as some hospitals have improved recording of the currently optional drug misuse data items over the last 5 years. These items were made mandatory as of April 2011, so there was improved recording of these items in anticipation of that change. This will mean that more will be known about drug use in pregnancy in comparison to previous years. While the number of maternities recording drug misuse (from the SMR02 dataset) has increased in recent years, the number of neonatal discharges recording drug misuse (SMR11 & SBR) has remained relatively steady.

Note that a greater number of births than maternities can be recorded as multiple births are recorded as only one maternity. To minimise the potential risk of disclosure where data is shown by NHS board and council area, data have been grouped up into 3 year rolling aggregates in Tables B4.1 and B4.5.

Key Points 2009/10

Overview

- Sixty nine per cent of maternities recording drug misuse in the three year period 2007/08 to 2009/10 were for mothers aged under 30 years old. For all maternities in this three year period just over half (53%) were mothers aged under 30 years old (Table B4.1).
- In 2009/10 there were 925 maternities in Scotland for which drug misuse was recorded, a rate of 16.1 per 1,000 maternities (Table B4.2). Although this is a large increase on the previous year, this is likely to be as a result of better recording of data, rather than an actual increase in drug use during pregnancy, as noted above and in the background information section.
- Of the 930 births in 2009/10 recording drug misuse, 76% were reported as having a full-term normal birthweight (705). However, this figure is much higher for all births, with 90% recorded as having a full-term normal birthweight. Fifteen per cent of the births recording drug misuse were preterm compared to 7% of all births (Table B4.3).
- In 2009/10, around half of the births recording drug misuse, 47% (440 out of 930), were recorded from mothers who lived in the most deprived areas (category 1). For all births in the same year 26% (15,028 out of 58,356) were recorded from mothers who lived in the most deprived areas. The rate of births recording drug misuse per 1,000 births increased from 6.7 per 1,000 births in the least deprived category (category 5) through to 29.3 per 1,000 births in the most deprived category (category 1) (Table B4.4).
- 1,025 neonatal discharges recorded drug misuse in the three year period 2007/08 to 2009/10, which represents a rate of 5.9 per 1,000 live births. This is a slight decrease from 1,060 neonatal discharges recording drug misuse in the three year period 2006/07 to 2008/09, which represented a rate of 6.2 per 1,000 live births. (Table B4.5).
Five year trends – 2005/06 to 2009/10

• The number of maternities recording drug misuse increased from 489 in 2005/06 to 559 in 2006/07 before dropping to 516 in 2007/08 and then increasing to 603 in 2008/09 and peaking at 925 in 2009/10 (Table B4.2). As noted above and in the background information section, this peak is likely to be the result of better recording of data rather than a real increase in the number of maternities recording drug misuse.

• The rate of maternities recording drug misuse per 1,000 maternities followed a similar pattern, rising from 9.4 in 2005/06 to 10.3 per 1,000 maternities in 2006/07, then falling to 9.0 in 2007/08 and subsequently increasing year on year to 16.1 per 1,000 maternities in 2009/10 (Table B4.2).

• The rate of maternities recording drug misuse per 1,000 maternities by the age of the mother increased overall between 2003/04 to 2005/06 and 2007/08 to 2008/09 for all age groups, except for those mothers aged between 20 and 24 years old, where it remained steady at 16.7 maternities recording drug misuse per 1,000 maternities (although it fluctuated in the intervening years) (Table B4.1).

Drugs recorded

• Opioids were recorded in 55% (506) of the maternities for which drug misuse was recorded in 2009/10. Other drugs recorded were cannabinoids in 39% (363) and sedatives in 14% (132) (Table B4.2).

Background information

Data on individual patients are collected by ISD Scotland as a series of Scottish Morbidity Records (SMR). The SMR datasets are a significant local and national information resource, and are used for epidemiological monitoring, health needs assessment, national and local planning and a range of other applications.

Pregnancy

Since 1976 data has been collected on pregnancies relating to antenatal, delivery, postnatal care and abortions managed in Scottish hospitals on the SMR02 (Scottish Morbidity Record - Maternity Discharges). Deliveries account for more than half of SMR02 discharges each year (antenatal, postnatal and abortion episodes make up the remaining discharges) and a national coverage of up to 98% of all births has been achieved (home births are not included).

The SMR02 discharge summary is completed at the end of the episode from patient's case notes and hospital discharge letters. Information collected includes: demographics of the mother, details of the delivery (mode, induction, presentation etc) and on the baby (gestation, birth-weight, etc). Details of up to and including three babies are recorded. In addition up to six diagnoses, a main diagnosis and five secondary diagnoses (using the ICD10 coding classification) can also be recorded. Specific questions are asked about the mother smoking prior to and during pregnancy. Drugs misuse is recorded on the SMR02 using the following ICD10 codes:

<table>
<thead>
<tr>
<th>ICD10</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>F11</td>
<td>Opioids</td>
</tr>
</tbody>
</table>
Additionally drug misuse can be recorded as a hard-coded data item, which was introduced in April 2003. However, not all hospitals are able to submit using the hard-coded data item, as their patient administration system (PAS) has not been modified to allow this.

It should be noted that the NHS Tayside data issues in 2006/07 have been addressed and the data have been revised. There were a number of duplicate records (approx. 500) deleted from the file, and a shortfall in data from NHS Tayside for financial year 2006/07 which cannot be resolved. There was also a small impact on surrounding NHS Board area figures for these years related to this issue.

**SMR02 Quality Assurance Assessment**

An assessment of SMR02 data quality was carried out by the Data Quality Assurance Team at ISD. Results were published in April 2010 and are available at [www.isdscotland.org/data_quality_assurance](http://www.isdscotland.org/data_quality_assurance).

This audit assessed 34 data items from the maternity dataset (SMR02) against information found in the medical record or Scottish Woman-Held Maternity Record (SWHMR). While 18 of the data items did match in 90% or more of the records, the remaining 16 data items matched with less than 90% of the records, five of these were very poorly recorded with fewer than 40% matching. One of the recommendations from this report was that 4 of the 5 data items that were very poorly recorded should become mandatory, rather than remain optional, to improve the quality of this data. These included the following 3 drug misuse related items:

1. Drug Misuse During this Pregnancy
2. Ever Injected Illicit Drugs
3. Drugs Used

As a result of the report recommendation, the ‘Drug Misuse During this Pregnancy’ data item changed from optional to mandatory in April 2011.

**Neonatal discharges**

Neonatal discharges were originally recorded using SMR11 records (including from neonatal units and postnatal cots), with records being generated for sick babies who fall into one of the following categories:

1. Babies who require medical care (other than resuscitation immediately after birth or routine screening)
2. Babies who have a congenital anomaly (whether or not medical treatment is
The SMR11, which was completed only for sick babies admitted to neonatal units, was replaced by the Scottish Birth Record (SBR) from April 2003. The SBR has been incrementally implemented across Scotland from 2003, with all areas (except Inverclyde) now using SBR to record information for sick babies, and the majority of areas now recording information on all births.

Drugs misuse is recorded on the SMR11 and the SBR returns using the following ICD10 codes in addition to those listed for SMR02.

<table>
<thead>
<tr>
<th>ICD10</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>P04.4</td>
<td>Foetus and newborn affected by maternal use of drugs of addiction</td>
</tr>
<tr>
<td>P96.1</td>
<td>Neonatal withdrawal symptoms from maternal use of drug addiction</td>
</tr>
</tbody>
</table>

The figures presented here cover four 3 year aggregates, 2003/04-2005/06 to 2007/08-2009/10. Data for all years shown are revised, so may be different from previously published figures. Care should be taken when comparing numbers over time, as there has been an improvement in drug misuse recording over the last five years. However, it is also worth noting that recording practice of drug misuse diagnoses may vary between hospitals, which may explain some of the variation between NHS health boards or council areas. The replacement of SMR11 with the SBR, which occurred incrementally across Scotland, may also have had an impact on these figures.

We are also aware that some outstanding clinical coding has been entered on the SBR and figures for recent years have increased and differ from those previously published.

**Further information**

Information on the background of the Scottish Birth Record and current development is available at [http://www.isdscotland.org/Products-and-Services/Scottish-Birth-Record/](http://www.isdscotland.org/Products-and-Services/Scottish-Birth-Record/).


B5 Blood-borne Viruses

Key Points 2010

Hepatitis B Virus

Five Year Trends – 2006 to 2010

- The overall number of new diagnoses of hepatitis B virus (HBV) increased, year on year, between 2006 and 2010 from 375 to 835. This rise was not reflected in figures for new hepatitis B infected injecting drug users (IDUs) which declined from 13 in 2006 to 7 in 2010. It should be noted, however, that risk information on HBV cases is collected anecdotally, therefore it is difficult to draw accurate conclusions from the presented data (Table B5.1).

Hepatitis C Virus

Overview

- In 2010, the number of IDUs that were newly diagnosed with hepatitis C virus (HCV) was 1,034. This represents 49% of all new HCV diagnoses (2,125) and 92% of those with a probable/possible route of transmission recorded (1,119) in that year (Table B5.2).
- By the end of 2010, the total number of IDUs diagnosed with HCV was 16,786, representing 57% of all HCV diagnoses (29,310) and 89% of those with a probable/possible route of transmission recorded (18,781) (Table B5.2).
- Among all IDUs diagnosed with HCV, 70% were male (Table B5.3).
- Among all IDUs diagnosed with HCV, 46% were aged under 30 years old at the time of diagnosis, which compares with 31% of those reported to have an ‘other’ probable/possible route of transmission, such as sexual contact, body piercing/tattoo, needlestick, bite, perinatal transmission, and receipt of blood factor/blood transfusion (Table B5.3).

Five Year Trends – 2006 to 2010

- The total number of persons newly diagnosed with HCV increased from a range of 1,533 - 1,634 reports during 2006 and 2008, to 2,032 in 2009 and 2,125 in 2010. The number of IDUs newly diagnosed with HCV decreased from 810 to 736 in 2007 and 2008. They then increased from 910 to 1,034 in 2009 and 2010 (Table B5.2).
- In addition, there was an increase in the number of persons with no information recorded on their probable/possible route of transmission (from 640 to 783 in 2007 and 2008 to 1,006 in 2010), but it is expected that these cases will in the main include IDUs (Table B5.2).
Human Immunodeficiency Virus and AIDS

Overview

- In 2010 there were 20 new cases of HIV infection among IDUs, 15 of which were presumed infected in Scotland. (Table B5.4).
- The median age of new cases of HIV infection among injecting drug users in 2010 was 32 years old (Table B5.6).
- The cumulative total (to 31 December 2010) of HIV infected reports in IDUs is 1,440. IDUs accounted for 22% of the cumulative total of 6,603 HIV infection reports for Scotland (Table B5.4). However, a recent publication ¹ by Health Protection Scotland showed that IDUs accounted for 5% (154 out of 3,009) of all cases reported from 2003 to 2010, and of these 154 cases 62 (40%) were presumed infected outside of Scotland (Table B5.8).
- The cumulative total of AIDS cases registered up to the 31st December 2010 was 477 for IDUs (Table B5.4).

Five Year Trends – 2006 to 2010

- Numbers of HIV reports in IDUs fluctuated between 2006 and 2010, falling for the first year from 25 in 2006 to 11 in 2007, rising to 20 in 2008 it has remained fairly steady until 2010 (Table B5.4).
- The number of HIV infected IDUs in clinical care has declined slightly, year on year, from 388 in 2006 to 368 in 2009. The figures for 2010 show an increase to 392, which is the highest it has been for the last 5 years. During the same time period the number of HIV infected individuals attending for care (for all risk categories) rose, year on year, from 2,409 in 2006 to 3,339 in 2010 (Table B5.7).

Geographical Profile

- Of the cumulative total of infections 50% of HIV infected IDUs were in NHS Lothian (713 of 1,440 reports). A further 22% were in NHS Tayside (314 cases) and 16% in NHS Greater Glasgow and Clyde (224 cases) (Table B5.5).

Background information

Hepatitis B Virus

Health Protection Scotland (HPS) receives notification of positive hepatitis B virus (HBV) tests from all laboratories located in the 14 NHS Board areas. At present no standard exists for the reporting of HBV infection and the amount of information provided by the different laboratories varies significantly. Information on risk factors, clinical history and status of HBV markers is frequently missing, thus it is difficult to determine whether cases are acute or chronic and to estimate the true incidence and prevalence of the virus. HPS are currently working towards developing an enhanced surveillance system for HBV in order to improve the quality of data that they receive.

Hepatitis C Virus

HPS, in association with Scotland’s principal HCV testing laboratories (the West of Scotland Specialist Virus Centre at Gartnavel General Hospital, Glasgow, the East of Scotland Specialist Virus Centre at the Edinburgh Royal Infirmary, the Department of Microbiology at Ninewells Hospital, Dundee, and the Department of Microbiology at Aberdeen Royal Infirmary) collates information on all cases of HCV diagnosed in Scotland. There is no dedicated HCV request form and information is limited to what is available on standard virological test request forms that accompany blood specimens.

Human Immunodeficiency Virus

Voluntary case reporting of HIV and AIDS forms the basis for surveillance in Scotland; this provides information only on diagnosed infections. Data collected by HPS includes limited patient identifiers (initials, soundex code of surname, date of birth, gender and first part of postcode), exposure category (risk group) and geographical location of exposure. Follow-up information such as all AIDS indicator diseases present at the time of the AIDS diagnosis, immunological (CD4 count which is testing to assess the immunological status and thus the stage of HIV disease has reached) monitoring, viral load monitoring and antiretroviral treatment are linked to cases where relevant. The number of individuals undergoing CD4 count/viral load monitoring is a good indicator of the number receiving clinical care.

Due to some recording problems at laboratories that report HIV testing figures, HPS were unable to provide 2009 and 2010 data for HIV-prevalence amongst injecting drug users. HPS are currently working with the laboratories to resolve this problem and intend to publish HIV-prevalence data in due course.

Further information

Information about HPS data collection and research and statistics on blood-borne viruses is available at [www.hps.scot.nhs.uk/bbvsti/index.aspx](http://www.hps.scot.nhs.uk/bbvsti/index.aspx).

B6 Drug-related Deaths

Drug Related Deaths in Scotland 2010 was published by National Records of Scotland on 9th August 2011. This is a National Statistics publication showing statistics of drug-related deaths in 2010 and earlier years, broken down by cause of death, selected drugs reported, age and sex. It includes three tables of figures for NHS Board areas and 3 for Council areas.

Key Points

- On the basis of the definition used for these statistics, there were 485 drug-related deaths registered in Scotland in 2010, 60 (11 per cent) fewer than in 2009. However, this was the third-highest number ever recorded, 30 (7 per cent) more than in 2007 and 193 (66 per cent) more than in 2000. The number of drug-related deaths has risen in six of the past ten years.
- Males accounted for 75 per cent of the drug-related deaths in 2010.
- In 2010, there were 161 drug-related deaths of people aged 25-34 (representing 33 per cent of all drug-related deaths) and 158 drug-related deaths of 35-44 year olds (also 33 per cent). In addition, 65 people aged under 25 died (13 per cent), as did 76 45-54 year olds (16 per cent) and 25 people aged 55 and over (5 per cent).
- The NHS Board areas which accounted for most of the 485 drug-related deaths in 2010 were:
  - Greater Glasgow & Clyde - 167 (34 per cent);
  - Lothian - 73 (15 per cent); and
  - Lanarkshire - 53 (11 per cent).
- Using the annual average for 2006-2010, to reduce the effect on the figures of year-to-year fluctuations.
  - For Scotland as a whole, the average of 496 drug-related deaths per year represented a death rate of 0.10 per 1,000 population.
  - Only one NHS Board area had a higher rate: Greater Glasgow & Clyde (0.15).
  - The next highest rate was for Tayside (0.10).
  - Two areas had rates of 0.09, and three had rates of 0.08.
- Comparing the annual average for 2006-2010 with that for 1996-2000:
  - the percentage increases in the number of drug-related deaths were about the same for males (90 per cent) and females (94 per cent);
  - the percentage increases for 35-44 year olds and people aged 45-54 were larger than for 25-34 year olds and people aged 55 and over, and there was a fall in the number of drug-related deaths of people aged under 25; and
  - the NHS Board areas with the largest increases in the numbers of drug-related deaths were Greater Glasgow & Clyde (up by 64), Lanarkshire (up by 27), Lothian (up by 26) and Ayrshire & Arran (up by 24).
- The standard basis for the figures for individual drugs for 2008 and subsequent years is ‘drugs which were implicated in, or which potentially contributed to, the cause of death’.
  - Of the 485 drug-related deaths in 2010:
    - heroin and/or morphine were implicated in, or potentially contributed to, the cause of 254 deaths (52 per cent of the total);
    - methadone was implicated in, or potentially contributed to, 174 deaths (36 per cent);
    - benzodiazepines (e.g. diazepam) were implicated in, or potentially contributed to, 122 deaths (25 per cent);
    - cocaine, ecstasy and amphetamines were implicated in, or potentially contributed to, 33, 0 and 3 deaths respectively; and
alcohol was implicated in, or potentially contributed to, 127 deaths.

- In 2010, heroin/morphine, benzodiazepines and alcohol were implicated in, or potentially contributed to, markedly fewer deaths than in 2008 and 2009. However, for methadone and cocaine there were only slight differences in the numbers for those three years. Because of a change in the method used to collect information about the substances which were found in the body (section 2), 'individual drugs' figures for 2008 onwards cannot be produced on the same basis as those for earlier years.

- Most drug-related deaths were of people who took more than one drug. There were relatively few deaths for which only one drug (and, perhaps, alcohol) was found present in the body, including 30 for which only heroin/morphine (and, perhaps, alcohol) was reported, and 20 for which only methadone (and, perhaps, alcohol) was mentioned. There were more deaths for which only one drug (and, perhaps, alcohol) was implicated in, or potentially contributed to, the cause (whether or not anything else was present), including 123 cases where that drug was heroin/morphine and 69 where it was methadone.


A list of Tables and Figures is also available at http://www.gro-scotland.gov.uk/statistics/theme/vital-events/deaths/drug-related/2010/tables-figures.html

Further Information

The second annual report from Scotland's National Drug Related Deaths Database, which will include wide ranging information about people who have died from a drug-related death in calendar year 2010, including sociodemographic and substitute prescribing information, was published 28th February and is available at http://www.drugmisuse.isdscotland.org/. The first annual report can also be found at that location.
C Criminal Justice and Social Harm

C1 Offences and court proceedings

Drug related offences 2010/11

Overview

• In the financial year 2010/11 there were 34,347 drug-related offences recorded by Scottish police forces, which is a rate of 658 per 100,000 population (Table C1.1).
• Seventy-eight per cent (26,960) of drug-related offences were for possession. A further 18% (6,144) were for possession with intent to supply (Table C1.2).

Five year trends – 2006/07 to 2010/11

• The rate of drug-related offences recorded per 100,000 population has fluctuated over the five-year period. The rate of drug-related offences recorded per 100,000 population fell between 2006/07 and 2007/08 from 829 to 792 per 100,000 population. Following a rise in 2008/09 to 822 drug-related offences per 100,000 population the rate subsequently fell yearly between 2008/09 and 2010/11 from 822 to 658 per 100,000 population (Table C1.1).

Geographical profile

• In 2010/11, the rate of drug-related offences recorded per 100,000 population was highest in Glasgow City (1,260 per 100,000), West Dunbartonshire (1,230 per 100,000) and Inverclyde (992 per 100,000). Throughout the five-year period, Glasgow City has consistently had the highest rate of drug-related offences recorded per 100,000 population (Table C1.1).
• Most areas saw their rate of drug-related offences fluctuate between 2006/07 and 2010/11. Twenty-eight council areas recorded an overall decrease in the rate of drug-related offences recorded per 100,000 population, over the five year period, compared to 4 council areas that showed an increase (Table C1.1).
• The largest increase in the rate of drug-related offences was in East Lothian from 305 per 100,000 population in 2006/07 to 824 per 100,000 population in 2010/11. The largest decrease in the rate of drug-related offences was in Inverclyde from 1,353 per 100,000 population in 2006/07 to 992 per 100,000 population in 2010/11 (Table C1.1).

Drug Related Court Proceedings 2009/10

Overview

Figures given in Table C1.3 are for all drug offences where the charge was proved in court (including where the drugs offence was a main offence or a secondary offence) and in Tables C1.4 to C1.8 for convictions where a drug offence was the main offence (see background information).

• In 2009/10 there were a total of 9,667 drug offences where the charge was proved. Of these offences 45% (4,351) related to Class A substances, 20% (1,894) related to Class
B substances and 15% (1,445) related to Class C substances. There were a further 1,977 offences with a charge proved where the drug type is not recorded in the court proceedings database (Table C1.3).

- Of the drug offences with a charge proved 2,233 related to heroin, 2,355 to cannabis, 1,707 to cocaine and 241 to ecstasy (Table C1.3).
- In 2009/10 there were 7,662 convictions for drug offences where it was the main offence. Of these convictions 50% (3,845) related to Class A substances, 18% (1,361) related to Class B substances and 13% (968) related to Class C substances. There were a further 1,488 convictions where the drug type is not recorded in the court proceedings database (Table C1.4).

- In 2009/10, men accounted for 85% of convictions for drug offences, where it was the main offence (Table C1.5).
- Fifty-three per cent of the convictions for drug offences, where it was the main offence, were for people aged 30 years old or under (Table C1.6).
- Seventy per cent of convictions for drug offences, where it was the main offence, were for possession (5,379) and 25% for possession with intent to supply (1,934) (Table C1.6).

- For convictions of possession, where it was the main offence, 71% received a fine, while for convictions of possession with intent to supply, 57% were given a custodial sentence and 9% received a fine (Table C1.5).

Five year trends 2005/06 – 2009/10

- From 2005/06 to 2009/10 the number of persons convicted of drug offences, where it was the main offence, increased by less than 1% from 7,606 to 7,662. The proportion of males convicted of these offences slightly decreased (86% in 2005/06 to 85% in 2009/10) and correspondingly the proportion of convictions against females slightly rose (14% in 2005/06 to 15% in 2009/10) (Table C1.5).

- In the five year period from 2005/06 to 2009/10, the number of convictions of possession, where it was the main offence, fell by 6 per cent from 5,739 to 5,379. It fluctuated in the intervening years however, increasing from 5,739 in 2005/06 to 7,007 in 2006/07, before falling yearly to 5,379 in 2009/10 (Table C1.5).

- The number of convictions for possession with intent to supply increased by 13% from 1,705 in 2005/06 to 1,934 in 2009/10 (Table C1.5).
Between 2005/06 and 2009/10, there has been a decrease in the percentage of convictions for drug offences which involve people aged 30 years old and younger (from 64% to 53%) and a corresponding increase in the percentage of convictions which involve people over 30 years old (from 37% to 46%) (Table C1.6).

Background Information

The statistics dealing with recorded crime and court proceedings are not directly comparable as a person may be proceeded against for more than one crime involving more than one victim and there is the possibility that the crime recorded by the police may be altered in the course of judicial proceedings. Also, a crime may be recorded by the police in one year and court proceedings concluded in a subsequent year.

Recorded crime

Statistics on drug-related offences recorded by the police are available from quarterly statistical returns made by the eight Scottish police forces to the Scottish Government Justice Analytical Services Division.

Offences such as possession of drugs are generally discovered and recorded as a result of police activity rather than by being reported to the police by the public. Hence the strength and deployment of the police forces mainly determine the numbers of such offences recorded. It should also be noted that one hit can lead to many seizures and offences, therefore figures across local authorities may fluctuate significantly year on year.

Criminal proceedings in Scottish Courts

Statistics on persons convicted for drug-related offences are available from the Scottish Government's court proceedings database. The data is derived from information held on the police operational computer at the Scottish Police Services Authority (SPSA).
Offences are recorded in the year in which the offender was sentenced, which may not necessarily be the year in which the offence was committed. A person with a charge proved refers to one who has had a plea of “guilty” accepted, or who was proved guilty of at least one offence at trial (Scottish Government Criminal Proceedings bulletins use “person with a charge proved” and “persons convicted” interchangeably). Persons convicted refers to the number of convictions at separate proceedings, therefore an individual who has been proceeded against and convicted more than once in a year will be included more than once in the figures. Where a person is proceeded against for more than one crime or offence, the main offence is identified (i.e. the one with the severest penalty). Where a table refers only to the main offence there may be other offences which were included in the same proceedings but are not reported on. Figures referring to drug offences with a charge proved include all drug offences. Of the drug offences with a charge proved some will be the main offence and others will be a secondary offence to either another more serious drug offence, or to another more serious type of offence (e.g. serious assault). Where a person has more than one offence with a charge proved in the same proceedings this will count as one conviction, therefore the number of offences with a charge proved may not be equal to the number of convictions.

It should be noted that cannabis, cannabis resin, cannabinol and cannabinol derivatives (previously Class C drugs) were reclassified as Class B drugs with effect from 26 January 2009. Offences involving these drug types are included in the table under Other Class A, Class B and Class C depending on the date the offence was committed.

Further information

Information on recorded crime and criminal proceedings is available from the Scottish Government website: www.scotland.gov.uk/Topics/Justice.


C2 Criminal Justice Social Work Interventions

Diversion from Prosecution is the referral of an accused individual to social work departments or other agencies where it is believed that formal criminal justice proceedings are not necessary.

A Probation Order is a form of community sentence. The main purpose of probation is to work with offenders to prevent or reduce their re-offending.

The Drug Treatment and Testing Order (DTTO) is a high tariff disposal for drug-misusing offenders who might otherwise receive a custodial sentence. However, since June 2008 they have been piloted for lower tariff offenders in Lothian (except West Lothian). The intention of a DTTO is to tackle those people whose offending is a direct result of their drug misuse.

For further information on these Criminal Justice Social Work interventions please see the background information.

Key Points 2010/11

Overview

- 31 diversion from prosecution cases were referred to drug treatment / education in 2010/11 (Table C2.1).
- 498 probation orders with a condition of drug treatment / education were made (Table C2.1).
- 661 DTTOs were commenced (Table C2.1).
- Of the DTTOs which were terminated in 2010/11, 45% were terminated on successful completion of the order, 29% were revoked due to a breach and 17% were revoked due to review (Table C2.2).

Five year trend 2006/07 – 2010/11

- Between 2006/07 and 2010/11 the number of cases diverted from prosecution which were referred to drug treatment or education fell from 63 to 31, a decrease of 51% over the five year period (Table C2.1).
- The number of probation orders commenced with a condition of drug treatment / education has fluctuated over the time period falling from 477 in 2006/07 to 404 in 2007/08 and then rose to 506 in 2009/10 before decreasing to 498 in 2010/11 (Table C2.1).
- The number of DTTOs commenced fell from 673 in 2006/07 to 601 in 2007/08, then rose in 2008/09 to 752 before dropping again in 2010/11 to 661 (Table C2.1).
- The proportion of DTTOs terminated upon successful completion of the order has fluctuated across the time period, with an overall increase from 39% in 2006/07 to 45% in 2010/11. The number revoked due to a breach has fluctuated, with an overall decrease from 37% in 2006/07 to 29% in 2010/11. The number revoked due to review has also fluctuated, although this time with an overall increase from 14% in 2006/07 to 17% in 2010/11 (Table C2.2).
Geographical Profile

- The areas that issued the highest numbers of DTTOs were Edinburgh City (168 orders), Glasgow City (83 orders) and South Lanarkshire (67 orders) (Table C2.1).
- The majority of areas did not record any diversions from prosecution referred to drug treatment / education. Forty-five per cent of the cases which were diverted from prosecution in 2010/11 were in North Lanarkshire council area (14 out of 31 cases) (Table C2.1).
- The areas with the highest number of probation orders with a condition of drug treatment / education in 2010/11 were Glasgow City (69 orders), Falkirk (48 orders), Fife (42 orders) and Dundee City (40 orders) council areas (Table C2.1).

Background information

This section provides information on the number of individuals entering treatment through criminal justice interventions. Criminal Justice Social Work (CJSW) services in Scotland are provided by local authorities throughout the country. An aggregate return is submitted annually to the Scottish Government by each local authority, covering data on: Criminal Justice Social Work Reports, Community Service Orders, Probation Orders, Supervised Attendance Orders, Drug Treatment and Testing Orders, Diversion from Prosecution and Throughcare. Information is provided here on the CJSW interventions which direct drug misusers to treatment and includes data on diversion from prosecution schemes, probation orders with a condition of treatment and Drug Treatment and Testing Orders (DTTO). The format and content of the aggregate return continues to evolve, to reflect new demands for information and to clarify points of definition in relation to particular data items. Some caution should therefore be exercised when making comparisons over time. The statistics presented reflect the information as known to the Scottish Government Justice Analytical Services Division at December 2011 and may be subject to revision in future publications. Information presented here is based on data from the aggregate return made by local authorities to the Scottish Government and therefore may differ from information previously published relating to criminal justice interventions.

Diversion from Prosecution is the referral of an accused to social work or other agencies where it is believed that formal criminal justice proceedings are not necessary. The accused is then dealt with through 'diversion schemes' which aim to address underlying causes of offending. Diversion is designed to prevent individuals being prematurely "up-taiffed" into a custodial sentence and to stop the cycle of offending/punishment before it starts. The decision as to whether or not an accused should be diverted is taken by the Procurator Fiscal. Social Work diversion from prosecution schemes aim to provide persons accused of minor offences with support and advice in relation to problems associated with their offending. In such cases prosecution is deferred, subject to successful completion of the scheme.

Probation Orders provide one of the opportunities for Criminal Justice Social Work to focus on offending behaviour. The main purpose of probation is to work with offenders to prevent or reduce their reoffending. This is done by combining oversight and control with help to learn new behaviours and to deal with problems associated with offending. The Probation Order will have an Action Plan in which the offender agrees to address their offending behaviour and its underlying causes. Probation Orders can be used very flexibly by the courts and additional conditions can be attached regarding the offender undertaking unpaid work, their place of residence, curfew (including electronic monitoring), financial recompense to the victim or attendance at a specialist programme such as alcohol or drug
treatment. Probation Orders (as well as Community Service Orders and Supervised Attendance Orders) have been replaced by the Community Payback Order (CPO) for offences committed on or after 1st February 2011. The CPO is a new community penalty which will provide those who issue sentences with a range of options from which they can choose the most appropriate requirement(s), including a drug treatment requirement. Figures from the Scottish Court Service show that in the first two months after CPOs were introduced (February and March 2011), a total of 333 CPOs were imposed, with 15 of these having a drug treatment requirement.

The Drug Treatment and Testing Order (DTTO) is a high tariff disposal for offenders who might otherwise receive a custodial sentence. The Order contains features unique to a community disposal, including a requirement for regular reviews by the court and a requirement that the offender consent to frequent random drug tests throughout the lifetime of the Order. Drug Treatment and Testing Orders (DTTO) are a relatively new community sentence in Scotland, introduced for the first time in 1999. Due to the complex and resource intensive nature of the DTTO, the Order was rolled out across Scotland in phases. Between 1999 and 2002 the Order was rolled out to Glasgow, Fife and Aberdeen. In 2002/03 the Order became available in Edinburgh, Renfrewshire/Inverclyde and Tayside. Data on DTTOs began to be collected through the aggregate return in 2003/04. By 2004/05 the DTTO Drug Treatment and Testing Order (DTTO) was available to the High Court and to Sheriff Courts for offenders resident in most local authority areas (with the exception of Argyll & Bute, Clackmannanshire, Dumfries & Galloway, East Lothian, East Dunbartonshire, Eilean Siar, Falkirk, Highland, Moray, Orkney Islands, Scottish Borders, Shetland Islands, Stirling, West Lothian and West Dunbartonshire). DTTOs have been available to all sheriff courts, the High Court and the Stipendiary Magistrates Court in Glasgow from September 2006. DTTOs are not an option for district courts other than the new justice of the peace courts in Lothian and Borders (with the exception of West Lothian) as part of a pilot exercise, which has been running since June 2008, testing this order with lower tariff offenders. In July 2010 Scottish Ministers published an interim ‘Process Evaluation’ of the pilot. At the same time they announced that funding would continue until end March 2012 to provide an opportunity for collection of longer-term monitoring data for a larger sample of clients.

Further information


Further information on Drug Treatment and Testing Orders (DTTO) is available at: http://www.scotland.gov.uk/Topics/Justice/public-safety/offender-management/offender/community/16906/6826

C3 Drug Misuse and Treatment in Scottish Prisons

Addiction Prevalence Testing (APT) was introduced in 2007 to evidence progress and distance travelled towards the Offender Outcome of ‘reduced or stabilised substance misuse’.

A 5% sample of prisoners entering into custody is tested twice a year for the prevalence of illegal drugs. Similarly, 5% of those leaving custody are randomly tested for drugs to assess the positive impact of prison addictions interventions.

In 2010/11 the average daily population of Scotland’s prisons was 7,853 prisoners\(^2\). There were 17,687 recorded entries into public sector prison in 2010/11\(^3\) (Table C3.2).

Key Points 2010/11

Overview

- Of the 1,343 addiction prevalence tests carried out at prisoner arrival 73% were positive for illegal drug use, including illegal use of prescribed drugs (Table C3.1).
- Of the 735 addiction prevalence tests carried out at prisoner release, 17% were positive for illegal drug use (Table C3.1).
- 4,521 prisoners, 26% of the total 17,687 entries into prisons, were offered an Integrated Case Management (ICM) Substance Misuse Assessment. It should be noted that the assessment is only offered to prisoners in custody for 31 days or longer (Table C3.2).
- The number of prisoners that accepted and undertook an ICM Substance Misuse Assessment in 2010/11 was 4,222 (93% of those offered an assessment) (Table C3.2).
- 13,373 one-to-one motivational support sessions were delivered (Table C3.2).
- Twenty-one per cent of respondents to the 2011 Prison Survey reported use of illegal drugs in prison in the previous month (Table C3.4).
- Of respondents to the 2011 Prison Survey who provided information on injecting, 2% reported injecting drugs in prison in the previous month (Table C3.4).
- Of those who had provided information on sharing injecting equipment (60 prisoners), 87% reported sharing injecting equipment in prison in the previous month (Table C3.4).

Five year trend 2006 – 2010

- The percentage of prisoners being prescribed methadone has increased between 2006 and 2010 according to a census taken on one day in December of each year. On 8\(^{th}\) December 2006 17% (or 1228 prisoners) of the prison population on that day were being prescribed methadone. However, on 17\(^{th}\) December 2010 this had increased to 22% of the prison population (or 1,639 prisoners) being prescribed methadone on that day (Table C3.3).

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\(^2\) Scottish Prison Service Annual Report and Accounts 2010-11.

\(^3\) Source: Scottish Prison Service. Data are extracted from a live management information system and updated on an on-going basis. The information presented here may therefore differ slightly from information shown previously.
**Drugs Recorded**

- Illegal use of benzodiazepines were detected in 53% of the 1,343 prisoners tested on reception and 8% of the 735 prisoners tested on release. Opiates were detected in 36% of prisoners tested on reception and 4% of prisoners tested on liberation. Cannabis was detected in 40% of prisoners at arrival and 4% at release (Table C3.1).
- Of the prisoners reporting use of illegal drugs in prison in the 2011 Prison Survey 68% reported use of heroin in the previous month, 54% reported use of cannabis and 38% use of benzodiazepines. Thirty-five percent reported using Subutex while 22% reported using other opiates (other than heroin and methadone) and a smaller proportion reported methadone (without prescription) 18% (Table C3.4).

**Background information**

**Addiction Prevalence Testing 2009/10**

Addiction Prevalence Testing (APT) was introduced in 2007 to evidence progress and distance travelled towards the Offender Outcome of 'reduced or stabilised substance misuse'.

The Scottish Prison Service (SPS) aims to ensure that prisoners make positive progress towards the Offender Outcomes during their time in custody. This can be referred to as the “prisoner journey”. A 5% sample of all prisoners arriving in custody are tested twice a year for the prevalence of illegal drugs. Similarly, 5% of those leaving custody are randomly tested for drugs to assess the positive impact of addictions interventions. These tests are designed to support measurement of SPS’s progress in achieving a reduction in the number of prisoners testing positive for drug use on entry compared with exit. Prisoners are tested at other times during their sentence to support their participation in addictions programmes and prescribing, or to inform other operational decisions.

Addiction Prevalence Testing was carried out across all prisons during November 2010 and February 2011.

**Addiction Service Outputs**

The Enhanced Addictions Casework Service (EACS) offers a range of treatment interventions and activities to all prisoners in custody for 31 days or more. The aims of the EACS are to:

- Encourage current and former substance misusing prisoners to access addictions treatment within the prison.
- Provide addictions assessment relevant to the needs of the prisoners and the substance of misuse.
- Include prisoners and other relevant support providers in devising and agreeing individualised care plans.
- Give prisoners access to a relevant range of interventions (treatment and care activities relevant to their sentence length).
- Emphasise the importance of consistency and continuity of care, both in the prison setting and in the period immediately around release.
- To minimise the dangers of reduced tolerance levels on release from prison.

An Integrated Case Management (ICM) Substance Misuse Assessment is offered to prisoners in custody for 31 days or longer. Prisoners who are in custody for less than 31
days are not offered the assessment due to the short length of their stay, however can access support through an Addictions Nurse and be referred to either voluntary throughcare or national throughcare addictions services, depending on criteria. The ICM Substance Misuse Assessment includes drugs, alcohol, volatile substances and smoking.

Table C3.2 outlines key outputs delivered by the EACS. This is not comparable with drug strategy outputs published prior to 2006.

Methadone prescribing in prison
This data is a count of the number of prisoners recorded as receiving a methadone prescription on a single day. The data has now been collected on seven occasions: 17th December 2004, 30th December 2005, 8th December 2006, 14th December 2007, 12th December 2008, 11th December 2009, and 17th December 2010.

Kilmarnock prison submitted information for the census for the first time in 2006, while HMP Addiewell submitted for the first time in 2008.

Scottish Prison Survey 2011 – 13th Survey
The Survey, which is undertaken in each of the 16 Scottish prisons, involves all Scottish prisoners. The Survey is designed to achieve a number of objectives:

- To make use of prisoners’ perceptions of service-delivery and service-quality in its business planning.
- To provides prisoners with an opportunity to comment on a range of issues that impact on their experience in prison.
- To allow staff to get a better understanding of how the halls or areas they manage compare to equivalent areas and halls and in so doing to provide a tangible way to help share items of ‘best practice’.
- To allow the SPS, through annual repeats of the same questions, to track progress (or the lack of it) across the various dimensions that are included in the Survey.

The prison survey 2011 took place between May and October 2011, the prisoner survey is now carried out every second year, it will be conducted next in 2013. It is a self-completion, anonymous questionnaire (tick box response) which is hand delivered to each prisoner on site in the establishment on the day the survey takes place. It therefore provides a one-day snapshot of prisoner views in each establishment.

Further information

Details of SPS Prisoner Surveys that have been conducted can be found here: www.sps.gov.uk/Default.aspx?DocumentID=21190703-e7b4-4abc-bc83-44b5d0f06f69.

Research reports with further information on drug misuse and treatment in prison and methadone maintenance in prisons are available from the SPS website at http://www.sps.gov.uk/default.asp.
C4 Social Harm in Neighbourhoods

This chapter is based upon the Scottish Household Survey (SHS), results of which are published annually by the Scottish Government. The survey collects information continuously on a range of topics and is used to give information on the attitudes, behaviours and characteristics of households and individuals in Scotland. The most recent report presents results from 2010 and also results from the two year sampling period 2009/2010, and was published by the Scottish Government in August 2011. Specific analysis from the SHS, at a national level, for 2010, and at a local council area level for 2009/2010 combined is presented in this chapter.

This chapter focuses on the neighbourhoods and community safety section of the survey, looking at adults perceptions of drug-related activities in the local neighbourhood and whether they have any personal experience of drug misuse or dealing in the neighbourhood. The SHS is a sample survey and therefore all figures quoted are estimates rather than precise percentages. Survey reports and further information can be found at [www.scotland.gov.uk/shs](http://www.scotland.gov.uk/shs).

Key Points 2010

**Overview**

- In Scotland in 2010, 11% of adults perceived that drug misuse or dealing was ‘very or fairly common’ in their neighbourhood ([Table C4.1](#)).
- Five per cent of respondents reported that they had personally experienced instances of drug misuse or dealing in their neighbourhood ([Table C4.1](#)).

**Trends**

- The percentage of respondents stating that drug misuse or dealing was ‘very or fairly common’ in their neighbourhood has remained relatively stable (at 11%-13%) between 2006 and 2010. Similarly the percentage of respondents reporting that they had personal experience of drug misuse or dealing also remained stable (at 5%-6%) between 2006 and 2010 ([Table C4.1](#)).

**Gender and age**

Perceptions and experience of drug misuse and dealing varied little by gender. There were some slight variations amongst by age groups

- 25-34 year olds were most likely to perceive drug misuse/dealing as common (at 14%). Thirteen per cent of 16-24 year olds stated that drug misuse was ‘very or fairly common’ in their neighbourhood compared to 6% of over 75 year olds ([Table C4.2](#)).
- Similarly, 8% of 25-34 year olds had personal experience of drug misuse/dealing compared with 2% of those aged 75 or over ([Table C4.2](#)).
Deprivation - 2009/2010

- Perceptions and experience of drug misuse varied by deprivation, as defined by the Scottish Index of Multiple Deprivation 2009\(^4\). In the most deprived category, 27% felt that drug misuse or dealing was ‘very or fairly common’ in their neighbourhood, compared with 2% in the least deprived category (Figure C4.1 and Table C4.3).

- Similarly, 12% of those in the most deprived category said they had personally experienced instances of drug misuse or dealing in their neighbourhood, compared with 1% in the least deprived category (Figure C4.1 and Table C4.3).

**Figure C4.1: Perception and experience of drug misuse or dealing in their local neighbourhood by deprivation, 2009/2010**

Geographical Profile

As mentioned above analysis at council level is possible by combining the results of the 2009 and 2010 surveys. Therefore, the points below refer to two years of data.

For 2009 and 2010 combined, responses on drug misuse and dealing in respondent's neighbourhoods varied among council areas:

- The areas with the highest level of respondents perceiving that drug misuse or dealing was ‘very’ or ‘fairly’ common were East Ayrshire (21%) and Dundee City (18%). These are higher than the national figure of 12% (Table C4.4).

- Orkney Islands (1%), Eilean Siar (2%) and East Dunbartonshire (4%) had the lowest percentage of respondents perceiving that drug misuse or dealing was ‘very or fairly common’ in their neighbourhood (Table C4.4).

- East Ayrshire (10%) and Aberdeen City (8%) had the highest level of respondents stating that they had personally seen instances of drug misuse or dealing in their neighbourhood (Table C4.4).

\(^4\) Detailed information about SIMD 2009 can be found at www.scotland.gov.uk/SIMD.
- Eilean Siar (0%), Orkney Islands (<0.5%), Argyll and Bute and Scottish Borders (2% each) had the lowest percentage of respondents stating that they had personally seen instances of drug misuse or dealing in their neighbourhood (Table C4.4).

**Background Information**

The Scottish Household Survey (SHS) started in 1999, collecting data of households and individuals in private households in Scotland continuously. It produces nationally representative data on an annual basis, and data representative for all local authorities over a two-year period. The survey covers a wide range of topics to allow links to be made between different policy areas. The results are published in a series of annual reports and a number of other Scottish Government publications.

The SHS is designed to provide reliable and up-to-date information on a wide range of aspects of Scottish households and individuals, at both national and local levels and also to allow trends to be detected. The topics covered by the survey include: composition of households, economic activity, housing, neighbourhoods, education, transport, health, local services, culture and sport.

The sample is selected from the Postcode Address File (PAF) for Scotland, using a systematic sample selection criterion. Typically, unclustered sampling is used in local authorities defined as being ‘urban’ whilst a clustered sampling technique is used in local authorities defined as being ‘rural’. This requires a sample of approximately 30,000 households over two years. Computer Assisted Personal Interviewing (CAPI) is used to interview the Highest Income Householder or their partner or spouse about themselves and household members. Additionally, a randomly selected member of the household aged over 16 (this may be the same person) is interviewed on other topics. This allows the survey to be representative at both household and individual level.

**Further information**


Further information on the Scottish Household Survey, previous reports and its methodology can be found at [www.scotland.gov.uk/shs](http://www.scotland.gov.uk/shs).
D Prevalence of Drug Use in Scotland

D1 Estimating National and Local Prevalence of Drug Use

Estimating National and Local Prevalence of Drug Use 2009/10 was published by ISD Scotland on 29th November 2011. Further information can be found in the Full Publication Report. Below is a brief background to the study and a summary of the key findings.

About the Report

The report contains estimates of the prevalence of problem drug use (opiates and benzodiazepines) in 2009/10 for council, Alcohol and Drug Partnership (ADP), health board (HB), and police force areas in Scotland.

In the context of these estimates, problem drug use is defined as the problematic use of opiates (including illicit and prescribed methadone use) and/or the illicit use of benzodiazepines and implies routine and prolonged use as opposed to recreational and occasional drug use. Breakdowns are also given by age group (for males) and gender.

Key Points

- Although the estimated prevalence of problem drug use amongst the 15-64 age group was higher in 2009/10 compared to 2006 (1.71% compared to 1.62%), it cannot be said conclusively that actual prevalence has increased. However, we can be reasonably sure that actual problem drug use prevalence has not declined since 2006.
- The estimated prevalence of problem drug use is higher in men (2.5%) than women (1.0%).

Estimated prevalence rate of problem drug use by Alcohol and Drug Partnership area, ages 15 to 64 years old; 2009/10

Notes:

Error bars are shown to indicate the range of the 95% confidence intervals.
- Amongst men the age group 25 to 34 years old had the highest estimated rate of prevalence (5.0%).
- The highest levels of prevalence were estimated to be in the Glasgow City Council area and Dundee City Council area.
- The estimated population of individuals with problem drug use seems to be getting older. The proportion aged 35 to 64 years old in 2006 was 34% but this estimate had increased to 43% in 2009/10.

**Background**

The report gives estimates of the prevalence of problem drug use for 2009/10. The estimates were derived using similar methods to those used by the University of Glasgow Centre for Drug Misuse Research to calculate estimates for previous years – i.e. 2000, 2003 and 2006. Whilst the estimate of prevalence of problem drug use has increased it cannot be said conclusively that actual prevalence has increased.
D2 Scottish Crime and Justice Survey

The drug use module from the 2009/10 Scottish Crime and Justice Survey (SCJS) was published in January 2011. Further information can be found in the full report. While headline data from the SCJS 2010/11 has already been published, the drugs module from the 2010/11 survey is not due to be published until March 2012 and will be available from the Scottish Crime and Justice Survey website.

Below is a brief background to the study and a summary of the findings.

About the Report

Since 1993, crime surveys in Scotland have included a short self-completion component, part of which asks respondents about their experiences regarding illicit drugs. In 2009/10 13,418 of the 16,036 respondents to the main questionnaire completed this section of the survey.

The illicit drug use questions ask whether adults aged 16 and over have used any of 16 specific drugs at some point in their lives, in the last year and in the last month. Data is also collected regarding how often drugs are used, when they were first used and if respondents have been offered drugs.

Key Points

- A quarter of adults (25.2%) reported having taken illicit drugs at least once during their lives. 7.2% of adults had used one or more illicit drug in the last year. 4.2% of adults had used one or more illicit drug in the last month.

- 31.4% of men reported taking an illicit drug at some point in their lives, compared with 19.5% of women.

Figure D2.1 Reported drug use 2009/10, by age

- ever'
- in last year'
- in last month'

<table>
<thead>
<tr>
<th>age group</th>
<th>% reporting ever</th>
<th>% reporting in last year</th>
<th>% reporting in last month</th>
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<tr>
<td>16-24 years</td>
<td>45</td>
<td>35</td>
<td>10</td>
</tr>
<tr>
<td>25-44 years</td>
<td>40</td>
<td>30</td>
<td>15</td>
</tr>
<tr>
<td>45-59 years</td>
<td>40</td>
<td>30</td>
<td>15</td>
</tr>
<tr>
<td>60 or over</td>
<td>5</td>
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</table>
• 10.1% of men reported having used one or more illicit drug in the last year, compared with 4.5% of women.
• 6.0% of men reported having used one or more illicit drug in the last month, compared with 2.6% of women.
• Drug use at some point in life was more common amongst younger age groups: 38.2% of those aged 16-24 and 41.9% of those aged 25-44 compared to 20.1% of those aged 45-59 and 3.6% of those aged 60 years and older.
• 12.9% of adults reported that someone had offered to give or sell them at least one type of illicit drug in the last year. 46.7% of those offered an illicit drug in the last year had used an illicit drug in the last year.

Background
The Scottish Crime and Justice Survey is a national survey that gathers information about public perceptions and experiences of crime. Since 1993 the surveys have included a short, voluntary, self-completion component, which asks respondents about their experiences regarding illicit drug use, partner abuse and sexual victimisation.
D3 Scottish School Adolescent Lifestyle and Substance Use Survey

Scottish Schools Adolescent Lifestyle and Substance Use Survey 2010 was published by ISD Scotland on 20th December 2011. Further information can be found in the Full Publication Report. Below is a brief background to the survey and a summary of the findings.

About the survey
The research was undertaken by Ipsos MORI Scotland and was commissioned on behalf of the Scottish Government by Information Services Division (ISD Scotland), National Services Scotland.

Key Points
Drug Use
- Twenty-one per cent of 15 year olds and 5% of 13 year olds reported that they had ever used drugs. 19% per cent of 15 year olds and 4% of 13 year olds reported they had used drugs in the last year and 11% of 15 year olds and 3% of 13 year olds reported that they had used drugs in the last month.
- While between 2004 and 2006 there was a substantial decrease in the prevalence of drug use in the last month, between 2006 and 2008 prevalence decreased only among 13 year old boys. Since 2008, prevalence has decreased further only among girls: among 15 year old girls, the decline has been from 11% in 2008 to 9% in 2010 and among 13 year old girls the decrease has been from 3% in 2008 to 2% in 2010.

Smoking
- Among 13 year olds, 3% of both boys and girls were regular smokers. Among 15 year olds, 13% were regular smokers: 11% of boys and 14% of girls.
- Since peaks in 1996 and 1998, the prevalence of regular smoking has substantially reduced over recent years. Among both 13 year olds and 15 year olds, levels are now the lowest they have been since the survey began in 1982.

Drinking
- Forty-four per cent of 13 year olds and 77% of 15 year olds have ever had an alcoholic drink. Fourteen per cent of 13 year olds and 34% of 15 year olds reported consuming alcohol in the last week.
- There was a decrease in the proportion of 13 year olds who had ever had an alcoholic drink: from 52% in 2008 to 44% in 2010. This was also the case, although to a lesser degree, for 15 year olds (82% in 2008 compared with 77% in 2010).
- There was an increase in the proportion of pupils who had drunk in the last week: from 11% in 2008 to 14% in 2010 among 13 year olds and from 31% in 2008 to 34% in 2010 among 15 year olds.

Background
The fieldwork for the survey was conducted between September 2010 and February 2011. Since 2002, only S2 and S4 pupils (these pupils were mainly 13 and 15 years old respectively, at the time of the survey) have been selected to take part in the survey and this was continued in 2010. Overall 37,307 pupils completed the questionnaire. The overall response rate was 62% and was calculated as the product of the class and pupil response rate.

5 Regular smokers – defined as usually smoking at least one cigarette a week
The 2010 survey also produced local reports at NHS Board, local authority and Alcohol and Drug Partnership level. These can be found at the [here](#).
Glossary

Confidence interval  Provides an estimate range of values within which the true value is likely to lie. The width of the confidence interval gives an indication of the reliability of the value (ie. The smaller the range the more reliable the value)

Deprivation  The Scottish Index of Multiple Deprivation (SIMD) is used to calculate deprivation rates. SIMD has 38 indicators in 7 domains (income, employment, housing, health, education, skills and training, geographical access and crime) at datazone level, which have been combined into an overall index. Rates are reported by quintiles. Quintiles divide the population into five equal proportions so that 20% of the population falls into each quintile.

Hospital episode of care  This refers to a given period of health care in a hospital setting. An individual (patient) may account for a number of episodes during a given reporting period. Each episode is initiated by a referral (including re-referral) or admission and is ended by a discharge.

International Classification of Diseases and Related Health Problems (ICD)  The International Statistical Classification of Diseases and Related Health Problems (ICD) revision is used to classify hospital admissions and deaths. The 10th revision is used in analysis.
## List of Tables

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<td>Addiction Prevalence Testing (APT) for Performance Measurement Purposes 2010-11 (November 2010 and February 2011)</td>
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<td>C3.2</td>
<td>Scottish Prison Service: Addiction Service Outputs 2010/11</td>
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<td>Number of prisoners being prescribed methadone on a given day: 2006 - 2010</td>
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<td>C3.4</td>
<td>Drug use in prison: results from the 13th prison survey: May - July 2011</td>
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<td>C4.1</td>
<td>Perception and experience of drug misuse / dealing in the neighbourhood, 2006 – 2010</td>
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<td>C4.4</td>
<td>Perception and experience of drug misuse / dealing in the neighbourhood by local authority, 2009/2010</td>
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</table>
**Contact**

**Michael Sibley**  
Substance Misuse Programme Principal  
[michael.sibley@nhs.net](mailto:michael.sibley@nhs.net)  
0131 275 7066

**Andrea Beard**  
Communications Lead Substance Misuse  
[Andrea.Beard@nhs.net](mailto:Andrea.Beard@nhs.net)  
0131 275 6050

**Further Information**

Further information can be found on the [ISD website](#)

**Rate this publication**

[Click here](#) to provide feedback and rate this publication.
### Appendix

#### A1 – Data source contacts

<table>
<thead>
<tr>
<th>A1 Scottish Drug Misuse Database</th>
<th>C1 Drug-related offences and court proceedings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Substance Misuse Information Strategy Team</td>
<td>Justice Analytical Services (Statistics) Scottish Government Justice Department</td>
</tr>
<tr>
<td>Gyle Square, 1 South Gyle Crescent, Edinburgh, EH12 9EB</td>
<td>St Andrews House Regent Road Edinburgh, EH1 3DG</td>
</tr>
<tr>
<td>Telephone: 0131 275 7051</td>
<td>Telephone: 0131 244 2228</td>
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<tr>
<td><a href="http://www.drugmisuse.isdscotland.org">www.drugmisuse.isdscotland.org</a></td>
<td><a href="http://www.scotland.gov.uk">www.scotland.gov.uk</a></td>
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<th>A2 Prescription statistics</th>
<th>C2 Criminal Justice Social Work interventions</th>
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<tr>
<td>Information Services</td>
<td>Justice Analytical Services (Statistics) Scottish Government Justice Department</td>
</tr>
<tr>
<td>Gyle Square, 1 South Gyle Crescent, Edinburgh, EH12 9EB</td>
<td>St Andrews House Regent Road Edinburgh, EH1 3DG</td>
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<th>C3 Drug misuse and treatment in Scottish prisons</th>
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<tr>
<td>Information Services</td>
<td>Scottish Prison Services Calton House 5 Redheughs Rigg Edinburgh, EH12 9HW</td>
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<tr>
<td>Gyle Square, 1 South Gyle Crescent, Edinburgh, EH12 9EB</td>
<td>Telephone: 0131 244 8745</td>
</tr>
<tr>
<td>Telephone: 0131 275 7099</td>
<td><a href="http://www.sps.gov.uk">www.sps.gov.uk</a></td>
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<td><a href="http://www.isdscotland.org/pti">http://www.isdscotland.org/pti</a></td>
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<th>B4 Maternity and neonatal</th>
<th>C4 Social harm in neighbourhoods</th>
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<tr>
<td>Information Services</td>
<td>Area 1-F (Dockside) Scottish Government Victoria Quay</td>
</tr>
<tr>
<td>Gyle Square, 1 South Gyle Crescent Edinburgh EH12 9EB</td>
<td>Edinburgh EH6 6QQ</td>
</tr>
<tr>
<td>Telephone: 0131 275 6761</td>
<td>Telephone: 0131 244 8420</td>
</tr>
<tr>
<td><a href="http://www.isdscotland.org">www.isdscotland.org</a></td>
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<th>B5 Blood-borne viruses</th>
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58
| Information Services Division | Health Protection Scotland  
Clifton House, Clifton Place  
Glasgow, G3 7LN  
Telephone: 0141 300 1100  
http://www.hps.scot.nhs.uk | Substance Misuse Information Strategy Team  
Gyle Square, 1 South Gyle Crescent,  
Edinburgh, EH12 9EB  
Telephone: 0131 275 7051  
www.drugmisuse.isdscotland.org |
|-----------------------------|-------------------------------------------------|-------------------------------------------------|
| B6 Drug-related deaths  
National Records of Scotland  
Ladywell House  
Ladywell Road  
Edinburgh, EH12 9HW  
Telephone: 0131 334 0380  
www.gro-scotland.gov.uk | D2 Scottish Crime and Justice Survey  
Scottish Crime and Justice Survey  
Scottish Government  
2R St Andrew's House  
Regent Road  
Edinburgh, EH1 3DG  
Telephone: 0131 244 2053  
http://www.scotland.gov.uk |
| D3 Scottish Schools Adolescent Lifestyle and Substance Use Survey  
Drug Misuse Information Strategy Team  
Gyle Square, 1 South Gyle Crescent,  
Edinburgh, EH12 9EB  
Telephone: 0131 275 6482  
www.drugmisuse.isdscotland.org |
# A2 – Publication Metadata (including revisions details)

<table>
<thead>
<tr>
<th>Metadata Indicator</th>
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<tr>
<td>Publication title</td>
<td>Drug Misuse Statistics Scotland 2011</td>
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<tr>
<td>Description</td>
<td>This annual publication presents the latest available information from a range of national data sources relevant to drug misuse.</td>
</tr>
<tr>
<td>Theme</td>
<td>Health and Social Care</td>
</tr>
<tr>
<td>Topic</td>
<td>Substance Misuse</td>
</tr>
<tr>
<td>Format</td>
<td>PDF report with Excel tables</td>
</tr>
<tr>
<td>Data source(s)</td>
<td>Data sources include the Scottish Crime and Victimisation Survey, Scottish Drug Misuse Database, Maternity and Neonatal discharges, Blood-Borne Viruses, drug-related deaths, drug seizures, offences and prison statistics.</td>
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<tr>
<td>Date that data are acquired</td>
<td>Data was requested in October 2011</td>
</tr>
<tr>
<td>Release date</td>
<td>Tuesday 28th February 2011</td>
</tr>
<tr>
<td>Frequency</td>
<td>Annual</td>
</tr>
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<td>Timeframe of data and timeliness</td>
<td>Data published up to 31st March 2011.</td>
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<tr>
<td>Continuity of data</td>
<td>See background information in chapter A1 SDMD</td>
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<tr>
<td>Revisions statement</td>
<td>Data sources will include revised data in future publications.</td>
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<tr>
<td>Revisions relevant to this publication</td>
<td>This publication does not include hospital discharge data, this is due to a backlog in data submissions as health boards move over from Patient Administration Systems to new Patient Management Systems. It is planned to make this data available in April 2012</td>
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<tr>
<td>Concepts and definitions</td>
<td>Guidance on definitions for SDMD is available at <a href="http://www.drugmisuse.isdscotland.org/sdmd/advice.htm">http://www.drugmisuse.isdscotland.org/sdmd/advice.htm</a></td>
</tr>
<tr>
<td>Relevance and key uses of the statistics</td>
<td>Relevant to understanding problem drug use in Scotland. Statistics will be used for policy making and service planning.</td>
</tr>
<tr>
<td>Accuracy</td>
<td>Quality checks are conducted by ISD. Figures are compared to previously published data and expected trends.</td>
</tr>
<tr>
<td>Completeness</td>
<td>It is not mandatory for clients to provide their information in the collection of data through SDMD. See section A1 for further information.</td>
</tr>
<tr>
<td>Comparability</td>
<td>Since April 2009 all services supplying data to SDMD have been moving from paper-based completion onto the new web-based collection system which allows follow-up data to be collected for each client (see A1 background information for further details about follow-up). This has resulted in a reduction in the number of duplicate forms being completed for the same client episode. There have also been some issues with the completeness of the data in recent years. Therefore caution should be used when interpreting trends regarding the number of people accessing drug services in Scotland.</td>
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| Accessibility              | It is the policy of ISD Scotland to make its web sites and
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A3 – Early Access details (including Pre-Release Access)

Pre-Release Access

Under terms of the "Pre-Release Access to Official Statistics (Scotland) Order 2008", ISD are obliged to publish information on those receiving Pre-Release Access ("Pre-Release Access" refers to statistics in their final form prior to publication). The standard maximum Pre-Release Access is five working days. Shown below are details of those receiving standard Pre-Release Access and, separately, those receiving extended Pre-Release Access.

Standard Pre-Release Access:

Scottish Government Health Department
NHS Board Chief Executives
NHS Board Communication leads

Extended Pre-Release Access

Extended Pre-Release Access of 8 working days is given to a small number of named individuals in the Scottish Government Health Department (Analytical Services Division). This Pre-Release Access is for the sole purpose of enabling that department to gain an understanding of the statistics prior to briefing others in Scottish Government (during the period of standard Pre-Release Access).

Scottish Government Health Department (Analytical Services Division)