Publication Report

Scottish Drugs Misuse Database (SDMD)

NHS Health Board Overview of Initial Assessments for Specialist Drug Treatment 2012/13

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A National Statistics Publication for Scotland

Contents

Introduction

This report on the Scottish Drugs Misuse Database (SDMD) presents the available information on **individuals presenting for initial assessment (for a new drug treatment episode) at specialist drug treatment services in 2012/13.**

The SDMD, which is managed by ISD Scotland, was set up in 1990 to collect information about people with drug problems, based on data obtained when individuals first made contact with services (or reinitiated contact following a gap of at least six months since last attendance). Services contributing to the SDMD include specialist drug services and General Practitioners.

The SDMD is an important and widely used national information source on problem drug use in Scotland. It 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.

Further detail on the SDMD is included within Appendix A1-Background information.

Rather than inputting directly into the national SDMD database, some ADPs capture information from drug treatment assessments using local data collection systems. SDMD provides a validated data upload facility which ADPs can utilise by extracting data from their local system and uploading it to SDMD. Problems with local data collection systems have occurred in two NHS Health Boards:

- Glasgow City ADP: Issues with the data quality and completeness of a range of data items and non-compliance with the SDMD file upload specification meant that a large proportion of 2012/13 data from Glasgow City ADP were unavailable or could not be validated.
- NHS Tayside: Technical issues with file upload from the local IT system of one specialist service operating across Tayside ADPs meant that a large proportion of 2012/13 data from NHS Tayside were unavailable.

As a result of these problems:

- Section 1 of this report (overall numbers, gender and age of individuals assessed) includes 2012/13 data from NHS Greater Glasgow & Clyde and NHS Tayside.
- Section 2 of this report (illicit and prescribed drug use, injecting behaviour, health, socio demographics) does not include 2012/13 data from NHS Greater Glasgow & Clyde and NHS Tayside. As a result, it has not been possible to present Scotland level overall figures and analysis has largely been restricted to comparisons between NHS Health Boards in 2012/13 and over time.

Efforts are ongoing to resolve the issues experienced in these boards and it is hoped that the 2013/14 report will include revised 2012/13 data from NHS Greater Glasgow & Clyde and NHS Tayside alongside complete 2013/14 SDMD data from all NHS Health Boards.

Further detail on data quality and completeness issues is included within Appendix A2-Data Quality.

Key themes of this report

This report focuses on information provided by **individuals presenting for initial assessment (for a new drug treatment episode) at specialist drug treatment services in 2012/13**[1]. This provides us with insights into their substance misuse needs and aspects of their social circumstances and behaviours at the point when they made contact with drug treatment services. It contains:

- Section 1: provisional analysis of the number and rate of initial specialist assessments for drug treatment and the gender and age of individuals assessed in 2012/13 and over time (Scotland and NHS Health Boards); and,
- Section 2: provisional analysis of key measures of illicit and prescribed drug use, injecting behaviour, health, socio demographics in 2012/13 and over time (NHS Health Boards (excluding NHS Greater Glasgow & Clyde and NHS Tayside)).

Methods

The information presented relates to all individuals receiving an initial assessment in 2012/13 and do not reflect the total number of individuals seen by services. Some individuals will have had more than one initial assessment during 2012/13, however, only their first initial assessment during the time period is counted and analysed. For some individuals, this may have been their first contact with specialist drug treatment services, while for others this assessment may be one case within a series of treatment episodes spanning multiple years. Individuals are identified using a simple exact matching technique based on forename initial, surname and date of birth. In future reports, it is hoped that probability matching techniques will be applied in order to improve the methodology of identifying individuals. This should provide a more accurate estimate of the number of individuals participating in an initial assessment for specialist drug treatment.

SDMD is a dynamic source of data. It should be noted that the 2012/13 data presented in this report is provisional and may change in future publications as revised data will be used. The 2013 European Standard Population (ESP2013) has been used to calculate all European Age-Sex Standardised Rates (EASRs) within this publication. The European Standard Population (ESP), which was first used in 1976, was revised in 2013. EASRs can be compared with other EASRs within this publication as the ESP2013 has been applied to all data within this publication. Previous reports used ESP1976 to calculate EASRs. Figures using ESP1976 and ESP2013 are not comparable. Therefore, some findings from this publication are not comparable with previous ISD reports. See Appendix A3 for further details.

Due to small numbers, some data in the associated tables have been suppressed. For this reason, unlike in previous years, figures for council area of residence are also not reported. This approach is consistent with ISD's protocols on 'Statistical Disclosure Control' (SDC) which aim to prevent the release of information that can lead to the identification of individuals. Further information on SDC methods applied by ISD is available here.

While attempts have been made to ensure the terminology used is as clear as possible, the nature of this report means that the use of technical/statistical terms is unavoidable. For further explanation of these words or phrases, please refer to the Glossary.

[1] Individuals are only counted once during each 12 month period. Appendix A1 - Background Information provides more details relating to SDMD data collection.

Key points

Section 1: Scotland and NHS Health Board of Residence

Demographics

- In 2012/13, 11,861 individuals participated in an initial assessment for specialist drug treatment. This equates to a European Age-Sex Standardised Rate (EASR) of 222 per 100,000 population. The overall EASR has fluctuated since 2006/07, with a maximum of 246 in 2007/08, but has been stable at approximately 220 per 100,000 population since 2009/10.
- Since 2006/07, an increasing proportion of individuals from older age groups have been assessed for specialist drug treatment each year. In 2006/07, half (51%) of individuals were aged 30 and over, compared with two-thirds (66%) in 2012/13. Likewise, the percentage of individuals aged 40 and over has increased from 15% in 2006/07 to 26% in 2012/13.

Section 2: NHS Health Board of Residence (excludes NHS Greater Glasgow & Clyde[2] and NHS Tayside[3])

Illicit drug use

- In all NHS Health Boards, heroin, cannabis and diazepam were the illicit drugs most frequently reported to have been used in the past month.
- In the majority of NHS Health Boards, the percentage of individuals reporting heroin as the main illicit drug used in the past month decreased from 2011/12 to 2012/13.
- Between 2011/12 and 2012/13, reported heroin use among individuals aged under 25 years reduced across almost all NHS Health Boards.

Injecting & Sharing

- In most NHS Health Boards, a notable decrease in the percentage of individuals reporting current injecting has occurred since 2006/07.
- Sharing of needles/syringes and paraphernalia (e.g. spoons/water/filters/solutions) reported by those injecting drugs in the past month varied between NHS Health Boards but was generally low (less than 10%).

Prescription drug use

- In almost all NHS Health Boards methadone was currently prescribed in over half of assessments where a prescription drug was reported. Diazepam was the second

[2] Glasgow City ADP: Issues with the data quality and completeness of a range of data items and non-compliance with the SDMD file upload specification meant that a large proportion of 2012/13 data from Glasgow City ADP were unavailable or could not be validated. This resulted in a decision not to publish 2012/13 data from NHS Greater Glasgow & Clyde in Section 2.

[3] NHS Tayside: Technical issues with file upload from the local IT system of one specialist service operating across Tayside ADPs meant that a large proportion of 2012/13 data from NHS Tayside were unavailable. This resulted in a decision not to publish 2012/13 data from NHS Tayside in Section 2.

most commonly prescribed drug reported at assessments for drug treatment in 2012/13.

Health

- In all NHS Health Boards, more than three-quarters of individuals who reported injecting at some point in the past had been tested for Hepatitis B, Hepatitis C or HIV.

Employment/Education

- In almost all of the NHS Health Boards where Employment/Education status was reported, the most common reported status was ‘unemployed’.

Accommodation

- In many NHS Health Boards, approximately 10% of individuals assessed for specialist drug treatment reported they were homeless.

Results and Commentary

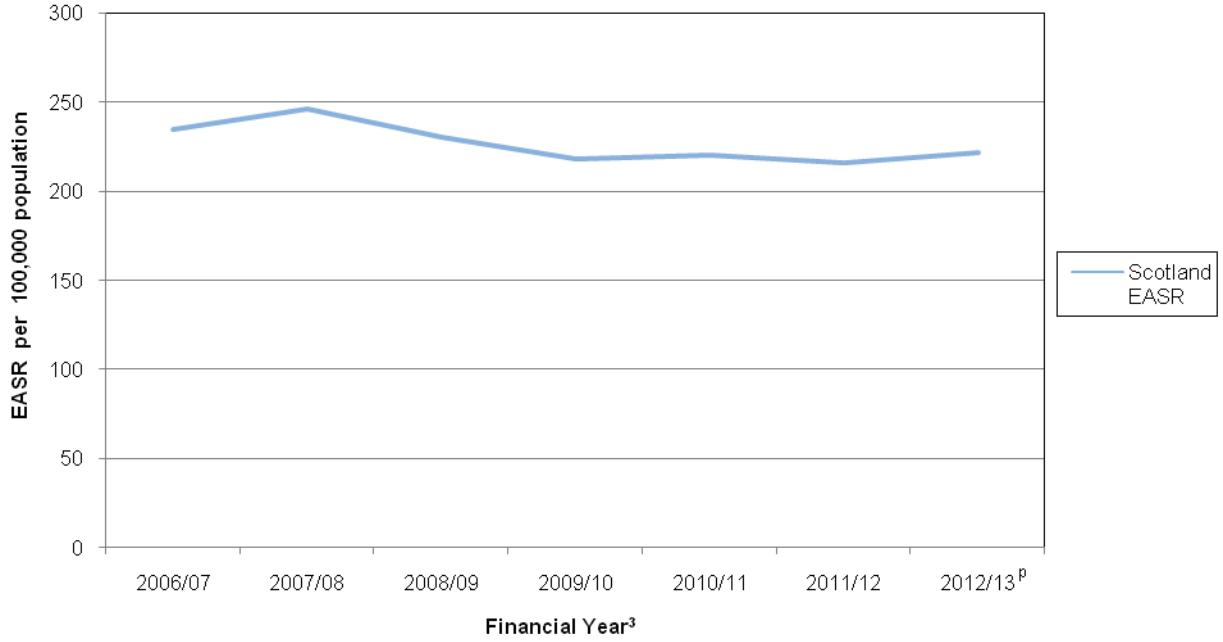
Section 1: Scotland and NHS Health Board of Residence

Demographics

This section describes the demographic profile of individuals presenting for an initial assessment of their drug use care needs at specialist drug treatment services in Scotland. As stated above, for some individuals this may have been their first contact with specialist drug treatment services, while for others this may be one case within a series of treatment episodes spanning multiple years.

In 2012/13, 11,861 individuals participated in an initial assessment for specialist drug treatment. This equates to a European Age-Sex Standardised Rate (EASR) of 222 per 100,000 population (similar to 216 per 100,000 population in 2011/12). The overall EASR has fluctuated since 2006/07, with a maximum of 246 in 2007/08, but has been stable at approximately 220 per 100,000 population since 2009/10 (Table A1.1 and Figure 1).

Figure 1: European Age-Sex Standardised Rate per 100,000 population (using ESP2013[1,2]) of individuals participating in an initial assessment for specialist drug treatment in Scotland (2006/07 - 2012/13)



Notes:

1. The European Standard Population (ESP), which was first used in 1976, was revised in 2013. All European Age-Sex Standardised Rates (EASR) within this report have been calculated using the ESP2013. EASRs from previous reports would have been calculated using ESP1976 and are not comparable with EASRs in this report. The EASR is calculated using ESP2013 and 5-year age groups (0-4, 5-9, up to an upper age group of 90+). See Appendix A3 for further details.
2. The population estimates used in the calculation of rates above are based on the 2011 Census results.
3. Data for all financial years has been revised.

p. Provisional

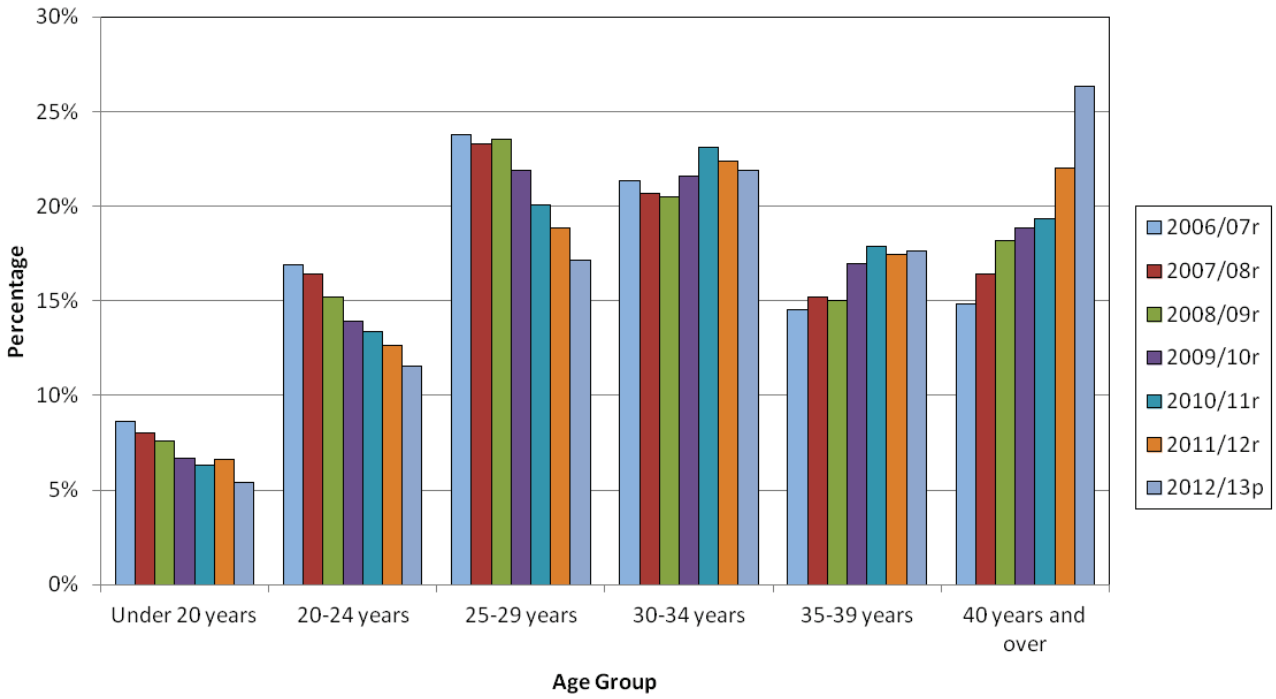
Among NHS Health Boards, the highest EASRs per 100,000 population were 319 and 305 in NHS Ayrshire & Arran and NHS Fife respectively (Table A1.1). The lowest EASRs per

100,000 population were observed in NHS Western Isles and NHS Highland (124 and 120 per 100,000 population respectively)[4].

Table A1.2 shows the gender and age of individuals assessed for specialist drug treatment in 2012/13. The ratio of male to female assessments in 2012/13 was approximately 2:1 (69% male); similar to previous years.

Since 2006/07, an increasing proportion of individuals from older age groups have been assessed for specialist drug treatment each year (Table A1.3 and Figure 2). The median age of individuals assessed for specialist drug treatment in 2006/07 was 30 years, compared to 33 years in 2012/13. In 2006/07, half (51%) of individuals were aged 30 and over, compared with two-thirds (66%) in 2012/13. Likewise, the percentage of individuals aged 40 and over has increased from 15% in 2006/07 to 26% in 2012/13.

Figure 2: Percentage of individuals participating in an initial assessment for specialist drug treatment in Scotland by age group (2006/07 – 2012/13)



Notes:
- r. Revised
- p. Provisional

Of those individuals who specified their ethnic origin, more than 95% described themselves as 'White Scottish'. This was consistent with the ethnic profile reported in previous SDMD reports. However, this differed from the ethnic profile of the Scotland population, which in the 2011 Scottish Census (http://www.scotlandscensus.gov.uk) reported 84% as 'White: Scottish'.

[4] NHS Orkney data were suppressed in Table A1.1 due to the small number of cases and are therefore not described in this commentary.

Section 2: NHS Health Board of Residence (excludes NHS Greater Glasgow & Clyde and NHS Tayside)

This section of the report does not include 2012/13 data from NHS Greater Glasgow & Clyde and NHS Tayside. As a result, it has not been possible to present Scotland level overall figures and analysis has largely been restricted to comparisons between NHS Health Boards in 2012/13 and over time. See Appendix A2 – Data Quality for further information.

Source of referral

Table A1.4 shows the source of referral for assessment for specialist drug treatment. The distribution of referral sources reflects the local network of health, social care and justice agencies within NHS Health Boards. Almost all NHS Health Boards reported that referral source information was available for over 90% of individuals. In all NHS Health Boards, either 'Self' or 'Health' referrals were the most common sources of referral to specialist drug treatment.

Illicit drug use

Examining drugs reported in any of the five possible illicit drug fields within the SMR25a form provides an indication of general patterns of recent drug use among those assessed for specialist drug treatment. In all NHS Health Boards, heroin, cannabis and diazepam were the illicit drugs most frequently reported to have been used in the past month in 2012/13 (Table A1.5 and Table A1.6). Reported heroin use ranged from 30% to 64% of assessments, while reported cannabis and diazepam use both generally ranged from approximately 25% to 33% of assessments.

The main illicit drug used in the past month is recorded in the first illicit drug field of the SMR25a form and is considered to be the substance for which individuals are seeking specialist drug treatment. In the majority of NHS Health Boards, heroin was the most common main illicit drug (reported in the first illicit drug position) used in past month (Table A1.7). Cannabis and diazepam were often the second and third most prevalent main illicit substances, often reported in between 20% and 30% of assessments.

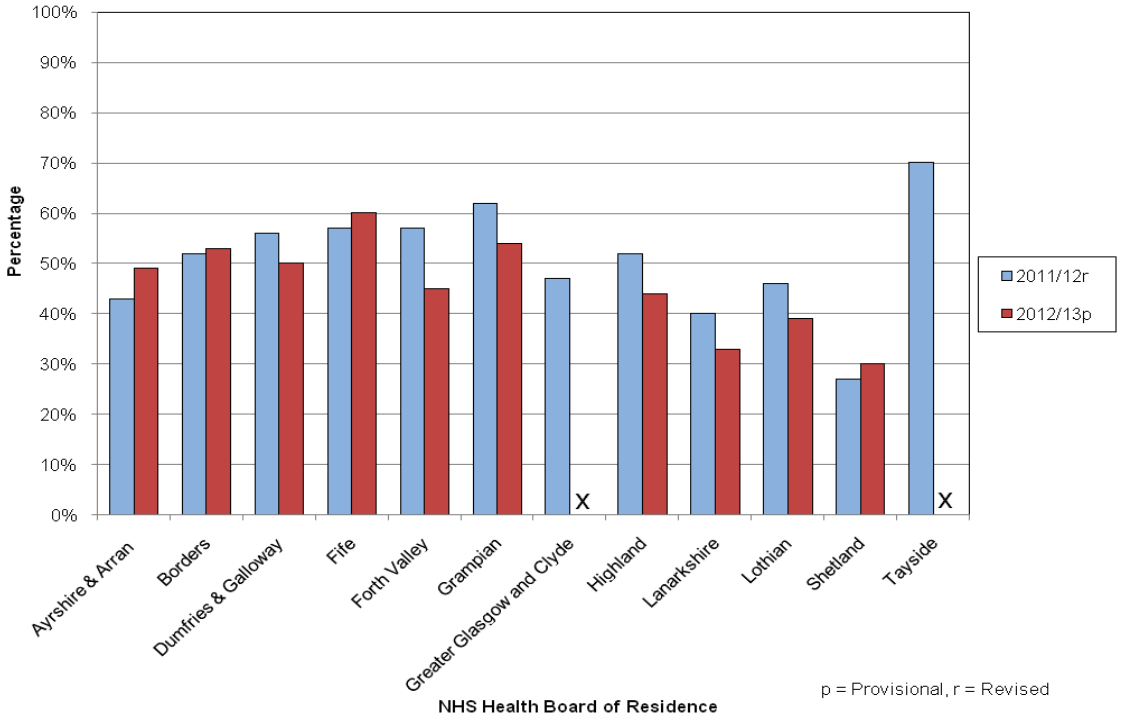
Heroin use

In 2012/13, the percentage of individuals reporting heroin as the main illicit drug used in the past month ranged from 30% to 60% across NHS Health Boards. In many NHS Health Boards, the percentages observed in 2012/13 were consistent with a trend whereby, since 2006/07, decreasing proportions of individuals assessed have reported heroin as their main illicit drug (Table A1.7 and Figure 3). However, four NHS Health Boards reported an increase between 2011/12 and 2012/13.

Between 2011/12 and 2012/13, reported heroin use among individuals aged under 25 years reduced across almost all NHS Health Boards (Table A1.8 and Figure 4).

There was considerable variation between NHS Health Boards (from 46% to 68%) in the percentage of heroin users reporting that they had injected heroin in the past month (Table A1.9, Table A1.10). In many of the NHS Health Boards, the percentage of heroin users reporting recent injecting changed little between 2011/12 and 2012/13.

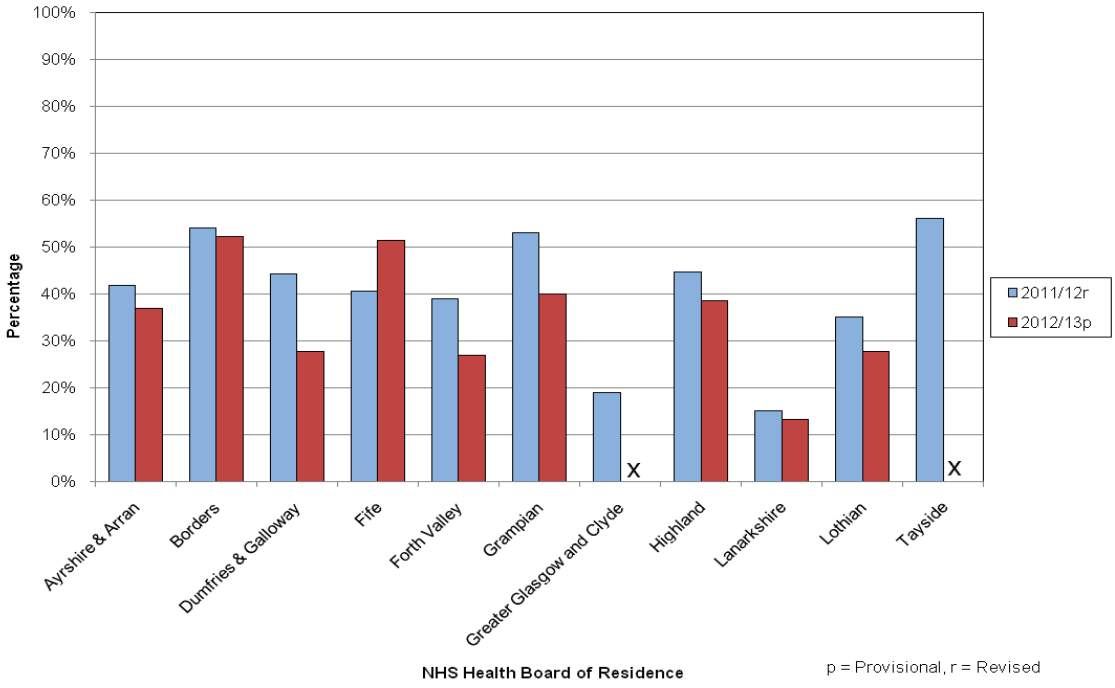
Figure 3: Percentage of individuals reporting heroin as main illicit drug in past month by NHS Health Board of Residence (2011/12 - 2012/13)



Notes:

1. Includes NHS Health Boards of residence where percentage was not suppressed for years 2011/12 and 2012/13.

Figure 4: Percentage of individuals aged under 25 years reporting heroin use in past month by NHS Health Board of Residence (2011/12 - 2012/13)



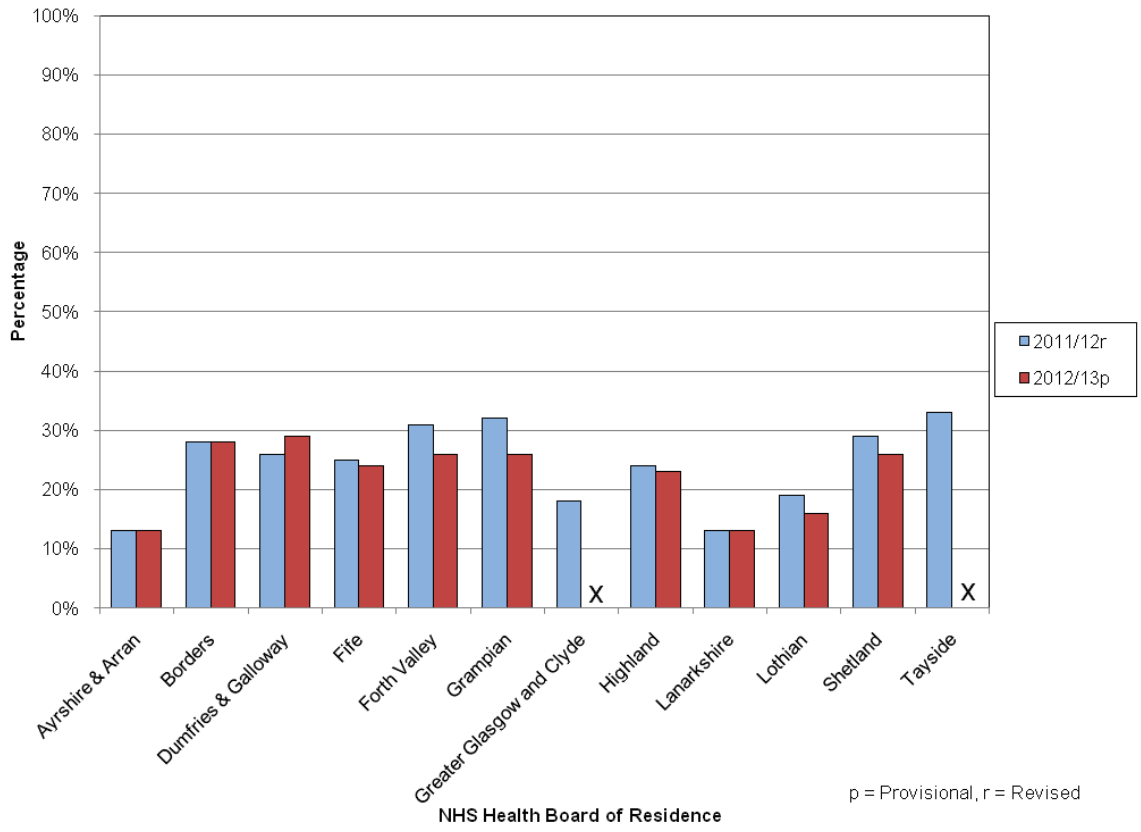
Notes:

1. Only includes NHS Health Boards of residence where percentage was known and not suppressed for both years 2011/12 and 2012/13.

Injecting behaviour

When comparing current injecting behaviour among users of all illicit substances (Table A1.11, Table A1.12 and Figure 5), there was little change observed in the majority of NHS Health Boards between 2011/12 and 2012/13. However, in most NHS Health Boards a notable decrease in the percentage of individuals reporting current injecting has occurred since 2006/7. The percentage of individuals reporting that they 'never injected' varied considerably between NHS Health Boards.

Figure 5: Percentage of individuals reporting injecting in past month by NHS Health Board of Residence (2011/12 - 2012/13)



Notes:

1. Only includes NHS Health Boards of residence where percentage was known and not suppressed for both years 2011/12 and 2012/13.

Reported sharing of needles/syringes among those injecting drugs in the past month (Table A1.13, Table A1.14) varied between NHS Health Boards but was generally low (less than 10%). The percentage of injectors reporting shared needles/syringes in the past was higher (ranging between 18% and 44%). In general, there was no change between 2011/12 and 2012/13 in those reporting sharing in the past month.

While percentages were low, similar variation between NHS Health Boards was observed in respect of the percentage of injectors reporting sharing of injecting paraphernalia (e.g. spoons/water/filters/solutions) in the past month (Table A1.15, Table A1.16). Likewise, in all NHS Health Boards the percentage of injectors reporting recent sharing of paraphernalia had decreased since 2006/07.

Prescription drug use

A substantial number of individuals assessed for specialist drug treatment in 2012/13 were recorded as being currently prescribed a drug for the treatment of addiction. Among NHS Health Boards, the percentage of individuals with current prescriptions ranged from 27% to 61% (Table A1.17, Table A1.18).

Methadone (an Opioid Replacement Therapy or ORT) was the most common drug prescribed for the treatment of addiction. In almost all NHS Health Boards, methadone was currently prescribed in over half of assessments where a prescription drug was reported.

Other ORTs[5] were prescribed to up to 15% of individuals where a current prescription drug was reported. No cases were found in which methadone and an 'Other ORT' were concurrently prescribed. In numerous mainland NHS Health Boards, over three quarters of individuals reporting a current prescription drug were prescribed methadone or an 'Other ORT'.

Diazepam (often prescribed for the treatment of opiate withdrawal symptoms) was the second most commonly prescribed drug reported in 2012/13. Up to 32% of patients in individual NHS Health Boards reported diazepam prescriptions during assessments for specialist drug treatment.

Health

Many individuals who were assessed for specialist drug treatment reported that they had co-occurring health issues (Table A1.19). There was considerable variation between NHS Health Boards in relation to the most common type of co-occurring health issue recorded.

The risk of contracting Blood Borne Viruses (BBVs) is higher amongst people who inject drugs than in other populations [1]. Of those who had reported injecting at some point in the past and where BBV testing information was provided (over 80% for all NHS Health Boards), More than three-quarters of individuals had been tested for Hepatitis B, Hepatitis C or HIV in all NHS Health Boards (Table A1.20).

Table A1.21 shows the percentage of individuals reporting alcohol consumption in the past month and the frequency of use. Although some variation was observed, most NHS Health Boards reported alcohol use in the past month at between 25% and 40% of individuals. Amongst those individuals drinking in the past month, the most common frequency of consumption was 'every day' or '1-2 days per week'.

[5] This category includes buprenorphine (subutex), buprenorphine & naloxone (suboxone), lofexidine and naltrexone.

Other social/lifestyle factors

Across all NHS Health Boards, employment/education status was reported for more than 80% of individuals. At least half of individuals were reported as unemployed in almost all NHS Health Boards (Table A1.22).

The living situation of individuals known to use drugs can have a profound impact on their lives; living with other individuals known to use drugs may influence the likelihood of reducing their problem drug use while living alone may be a risk factor for drug-related death [2]. In all mainland NHS Health Boards, 'living with other drug users' and 'lives alone' were the two most common responses (Table A1.23).

Across all NHS Health Boards where accommodation was known (90% or over in almost all NHS Health Boards), most individuals reported that they lived in 'owned/rented accommodation' (Table A1.24). In many NHS Health Boards, approximately 10% of individuals reported they were homeless.

In relation to their legal situation, approximately one half to two-thirds of individuals assessed in each NHS Health Board reported they were not currently subject to any legal proceedings or sanctions (Table A1.25).

References

[1] WHO (2012) Guidance on Prevention of viral Hepatitis B and C among People who inject Drugs, Available at: http://apps.who.int/iris/bitstream/10665/75357/1/9789241504041_eng.pdf?ua=1

[2] Andrews, J.Y. & Kinner, S.A., 2012. Understanding drug-related mortality in released prisoners: a review of national coronial records. BMC Public Health, 12(1), p.270. Available at: http://www.biomedcentral.com/1471-2458/12/270/abstract

Glossary

ADP	Alcohol and Drug Partnership
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).
CoSLA	Convention of Scottish Local Authorities
DATWT	Drugs and Alcohol Treatment Waiting Times database
EASR	European Age-Sex Standardised Rate; the rate that would have been found if the population in Scotland had the same age-composition as the hypothetical standard European population. The 2013 European Standard Population (ESP2013) has been used to calculate the EASRs within this publication. The European Standard Population (ESP), which was first used in 1976, was revised in 2013. Previous reports used ESP1976 to calculate EASRs. Figures using ESP1976 and ESP2013 are not comparable. Therefore, findings from this publication are not comparable with previous ISD reports.
HEAT	Health Improvement, Efficiency, Access and Treatment
ISD	Information Services Division
ORT	Opioid Replacement Therapy
SDMD	Scottish Drug Misuse Database

List of Tables

Table No.	Name	Time period	File & size
A1	2014-06-24-SDMD-Tables.xlsx		Excel [295kb]
A1.1	New individual patients/clients reported: years ending 31 March 2007 to 2013	1 April - 31 March 2007 - 2013	
A1.2	New individual patients/clients reported by age group and gender: year ending 31 March 2013	1 April - 31 March 2013	
A1.3	New individual patients/clients reported by age group: years ending 31 March 2007 to 2013	1 April - 31 March 2007 - 2013	
A1.4	Source of referral to specialist drug treatment services: year ending 31 March 2013	1 April - 31 March 2013	
A1.5	All illicit drugs used in the past month: year ending 31 March 2013	1 April - 31 March 2013	
A1.6	All illicit drugs used in the past month: years ending 31 March 2007 to 2013	1 April - 31 March 2007 - 2013	
A1.7	Main illicit drug used in the past month: years ending 31 March 2007 to 2013	1 April - 31 March 2007 - 2013	
A1.8	Heroin use in the past month (individuals aged under 25 years): years ending 31 March 2007 to 2013	1 April - 31 March 2007 - 2013	
A1.9	Heroin use in the past month (route of administration): year ending 31 March 2013	1 April - 31 March 2013	
A1.10	Heroin use in the past month (injecting): years ending 31 March 2007 to 2013	1 April - 31 March 2007 - 2013	
A1.11	Injecting behaviour: year ending 31 March 2013	1 April - 31 March 2013	
A1.12	Current injecting: years ending 31 March 2007 to 2013	1 April - 31 March 2007 - 2013	
A1.13	Sharing of needles/syringes: year ending 31 March 2013	1 April - 31 March 2013	
A1.14	Current sharing of needles/syringes: years ending 31 March 2007 to 2013	1 April - 31 March 2007 - 2013	
A1.15	Sharing of spoons/water/filters/solutions:	1 April - 31	

	year ending 31 March 2013	March 2013	
A1.16	Current sharing of spoons/water/filters/solutions: years ending 31 March 2007 to 2013	1 April - 31 March 2007 - 2013	
A1.17	Drugs currently prescribed for the treatment of addiction: year ending 31 March 2013	1 April - 31 March 2013	
A1.18	Drugs currently prescribed for the treatment of addiction: years ending 31 March 2007 to 2013	1 April - 31 March 2007 - 2013	
A1.19	Co-occurring health issue(s): year ending 31 March 2013	1 April - 31 March 2013	
A1.20	Blood Borne Virus (BBV) testing: year ending 31 March 2013	1 April - 31 March 2013	
A1.21	Alcohol consumption: year ending 31 March 2013	1 April - 31 March 2013	
A1.22	Employment status: year ending 31 March 2013	1 April - 31 March 2013	
A1.23	Living situation: year ending 31 March 2013	1 April - 31 March 2013	
A1.24	Accommodation status: year ending 31 March 2013	1 April - 31 March 2013	
A1.25	Legal situation: year ending 31 March 2013	1 April - 31 March 2013	

Contact

Lee Barnsdale
Principal Information Analyst
leebarnsdale@nhs.net
0131 275 6055

Stephen Snedker
Senior Information Analyst
stephen.snedker@nhs.net
0131 275 7054

Further Information

Further information can be found on the ISD website

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Appendices

A1 – Background Information

Policy Context

The SDMD is an important and widely used national information source on the misuse of drugs in Scotland. Amongst the aims of the database are to support services, Alcohol and Drug Partnerships (ADPs), the NHS and the Scottish Government by:

- monitoring problem drug use;
- collecting social and demographic information about individuals presenting to services for assessment of their drug use and treatment/care needs;
- helping to identify, or confirm, trends in drug use at a national and local level;
- informing discussions about service provision and service design; and,
- providing data for ADPs to help them take forward local strategies.
-

The database, established in 1990, holds information on demographic and behavioural characteristics of individuals who have had a specialist assessment of their drug use treatment and care needs by specialist drug services (provided by statutory and non-statutory services across a range of settings) and some medical services (general practice, hospital etc.). Specialist services providing tier 3 and 4 interventions within local authorities, NHS, prisons and the third sector are all expected to submit data to the SDMD.

Scotland's national drugs strategy The Road to Recovery: A New Approach to Tackling Scotland's Drug Problem, launched in May 2008, highlighted the need for 'evidence informed drugs policy and practice' and, as part of this, 'improving data on the drug misusing population'. The strategy's Action Plan included the following 'key action': to 'Work with Information Statistics Division (ISD) to deliver (by April 2008) an enhanced Scottish Drug Misuse Database (SDMD) to improve outcome data on a person's journey through treatment' thus providing better outcome data to inform policy and practice.

To this end, ISD was asked to develop SDMD to allow the collection of information on individuals throughout their treatment pathway (i.e. not only at initial assessment). From April 2008, ISD began to introduce an enhanced, web-based, SDMD Follow-up Reporting System. The expanded database offered the potential to collect information on substance misuse and the wider social circumstances that may underpin recovery throughout the course of treatment, forming a valuable source of information on the outcomes of drug treatment for services, ADPs and the Government in Scotland.

In April 2009 a new joint Framework for Alcohol and Drug Partnerships (ADPs) was signed by the Scottish Government, NHS and the Convention of Scottish Local Authorities (CoSLA). Under the new Framework ADPs began to create outcomes-focused local strategies. Delivering Better Outcomes: An Outcomes Toolkit for Alcohol and Drug Partnerships was published alongside the Framework to assist in the process of improving services through a focus on outcomes. In 2011, the Scottish Government initiated a programme of work to draft a set of core outcomes and indicators for ADPs. This led to the development of a set of 34 indicators, including five 'recovery' related indicators, which would be derived from the SDMD follow-up monitoring data.

Data Collection

The SDMD, managed by ISD Scotland, was set up in 1990 to collect information about people with drug problems, based on data obtained when individuals first made contact with services (or reinitiated contact following a gap of at least six months since last attendance). 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 detailed information on individuals who presented for treatment. The new dataset incorporated 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. Therefore, this report only describes trends from 2006/07 onwards.

Since April 2009, all services which supply data to the SDMD have transferred from paper to electronic proforma, using the web-based data collection system or other local systems (with the exception of General Practitioners (GPs), who continue to complete paper forms[6]). Using this system, data are collected at the following points throughout an individual's course of treatment:

- Initial assessment (SMR25a proforma)**:** http://www.drugmisuse.isdscotland.org/sdmd/smr25A.pdf
- 12 week follow-up (SMR25b proforma): http://www.drugmisuse.isdscotland.org/sdmd/smr25B.pdf
- Annual follow-up (SMR25b)
- Ad-hoc follow-up (SMR25b)
- Discharge from service (SMR25a or SMR25b)
- Transfer or referral from service (SMR25b)

There are two possible methods of submitting data to the SDMD, both of which use a secure internet connection. The first is an online form. Service providers log onto the SDMD application and submit data directly to ISD via a web form. The second is a file upload facility within the application. This allows a local system administrator to log onto the application and submit a batch file of data from their local system directly to ISD, at given points in time.

Local area analysis and trends

Individuals have been included only once within each NHS Board and council area of residence. However, individuals may be counted 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.

[6] GP data are not included in the analysis within this publication.

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.

If you would like further information please contact the Health Improvement Team at nss.isdsubstancemisuse@nhs.net

A2 – Data Quality

General Issues

The introduction of the SDMD web system provided opportunities for services to share information and therefore avoid duplication of SMR25 submissions. This has resulted in a slight reduction of overall numbers.

Information on waiting times for drug and alcohol treatment is provided by the treatment services and collected in the Drug and Alcohol Treatment Waiting Times (DATWT) database which went live across Scotland on 1st April 2011. DATWT collects information about the length of time people wait for specialist drug and/or alcohol treatment after they have been referred to treatment services in Scotland. In 2011, the Scottish Government established HEAT[7] target A11 that by March 2013, 90% of people who need help with their drug or alcohol problem will wait no longer than three weeks for treatment that supports their recovery. Specialist services providing tier 3 and 4 interventions should be submitting information to both the DATWT and the SDMD, however ISD comparisons of SDMD and DATWT completeness have demonstrated a clear difference in compliance. This demonstrates that, in some areas, SDMD completeness appears to have decreased as services prioritise their resource to ensure that the HEAT target is maintained.

A related issue is that the submission of data to SDMD via the web system relies wholly on the informed consent of the individual to the collection and use of their patient identifiable data, increasing the risk that individuals may refuse to participate. However, one of the features of the DATWT is the ability to submit anonymous records (where the record has been stripped of personal identifiers). Recent experience has suggested that locating the DATWT database alongside SDMD may have inadvertently contributed to a decrease in data completeness (detailed below). Some areas, in particular Orkney and Argyll & Bute have reported significant issues with individuals withholding consent and therefore these data are not submitted to the SDMD.

Issues specific to NHS Health Boards

Rather than inputting directly into the national SDMD database, some ADPs capture information from drug treatment assessments using local data collection systems. SDMD provides a validated data upload facility which ADPs can utilise by extracting data from their local system and uploading it to SDMD. Problems with local data collection systems have occurred in two NHS Health Boards:

Glasgow City ADP

Glasgow City ADP has been working towards an electronic solution to extract data from local systems and use for the SDMD data upload facility for some time. During 2011/12 and 2012/13, Glasgow City ADP undertook a project to transfer their Community Addiction Teams (CATs) to a new IT platform. The aim of this project was to ensure that all CATs submit SMR25a records directly to SDMD via electronic file upload from a single system (Carefirst). However, although all CATs were transferred to Carefirst by April 2013, Carefirst is not yet compliant with the file upload specification for SDMD and the monthly data upload process has not been implemented.

[7] This is one of the national Health improvement, Efficiency Access and Treatment (HEAT) targets (number A11). This target was achieved in 2013 and has since been converted to a HEAT standard.

While Glasgow City ADP manually produced a file of 2012/13 Carefirst data by the agreed deadline, this did not conform to the agreed SDMD file upload specification and there were issues with the data quality and completeness of a range of data items. It was therefore not been possible to validate these data or to upload them into the SDMD dataset in a manner consistent with other data submissions.

Therefore, due to poor data quality/completeness for many data items, it has only been possible to use 2012/13 SMR25a returns from Glasgow City ADP in Section 1 of this report (overall numbers, gender and age of individuals assessed).

Data quality and completeness issues affected a wide range of the data items used in Section 2 of the report (illicit and prescribed drug use, injecting behaviour, health, socio demographics). As 52% of individuals from NHS Greater Glasgow & Clyde who were assessed for specialist drug treatment in years 2009/10 to 2011/12 were resident in the Glasgow City ADP area, it was necessary to exclude 2012/13 NHS Greater Glasgow & Clyde data from Section 2 of this report. Furthermore, as NHS Greater Glasgow & Clyde residents accounted for 25% of all individuals assessed for specialist drug treatment in Scotland in years 2009/10 to 2011/12, it has not been possible to include overall Scotland level figures within Section 2.

These problems will also affect information on SDMD follow-up assessments (SMR25b). Although CATs submit both SMR25a and SMR25b data, they frequently transfer individuals to external (purchased) services for treatment. As, purchased services often rely on SDMD for notifications to submit assessment of individuals they are treating, it is anticipated that the lack of regular SMR25a submissions from Glasgow City ADP will also impact on the level of SMR25b (follow-up) submissions across NHS Greater Glasgow & Clyde. This issue will be described in further detail in the forthcoming SDMD follow-up report.

Glasgow City ADP are continuing to work with ISD and the Scottish Government in an attempt to improve data quality and completeness levels. It is hoped that the 2013/14 report will include revised 2012/13 data from NHS Greater Glasgow & Clyde alongside complete 2013/14 SDMD data from all NHS Health Boards.

Tayside ADP

Following routine data quality/completeness analysis, issues with poor quality and completeness levels across a range of data items were identified in NHS Tayside. A wide range of SDMD data items were not extracted nor sent to ISD due to technical issues with the file upload process associated with the local IT system (MIDIS) used by one Tayside specialist service. As this service operates in each of the Tayside ADPs (Angus ADP, Dundee City ADP, Perth & Kinross ADP) it has been necessary to exclude NHS Tayside data from the majority of this report. NHS Tayside residents accounted for 7% of all individuals assessed for specialist drug treatment in Scotland in years 2009/10 to 2011/12.

Section 1 of this report (overall numbers, gender and age of individuals assessed) includes 2012/13 SMR25a returns from NHS Tayside.

Section 2 of the report (illicit and prescribed drug use, injecting behaviour, health, socio demographics) does not include 2012/13 SMR25a data from NHS Tayside due to completeness issues which affect a wide range of the data items used.

NHS Tayside and ISD are working together to improve data quality and completeness, which may enable 2012/13 data to be included in future publications. It is hoped that the 2013/14 report will include revised 2012/13 data from NHS Tayside alongside complete 2013/14 SDMD data from all NHS Health Boards.

A3 – Changes to the European Standard Population

The 2013 European Standard Population (ESP2013) has been used to calculate the European Age-Sex Standardised Rates (EASRs) within this publication. The European Standard Population (ESP), which was first used in 1976, was revised in 2013. Previous reports used ESP1976 to calculate EASRs. EASRs calculated using ESP1976 cannot be compared with EASRs calculated using ESP2013. This section contains a worked example of EASRs using both ESP1976 and ESP2013 to show how the rates differ and why they cannot be compared.

Example: Number of individuals receiving an specialist assessment for their problem drug use care needs in Scotland (2006/07-2012/13)

Based on the number of individuals assessed in each of the financial years, the following rates were calculated:

Crude Rate

The crude rate is the total number of people with an event in a country or region, divided by the total population of that country or region, and is normally expressed 'per 1,000', 'per 10,000' or 'per 100,000'.

Making comparisons on the crude rate can be misleading if the age structures of the populations of the countries or regions are quite different. Areas with larger percentages of younger people are unlikely to have as high levels of death as areas with larger percentages of older people – and therefore if we don't adjust for these differences we may draw the wrong conclusion about the health of an area simply because of the age-structure of the population. EASRs allow us to make comparisons between different geographical areas as they allow the effects of having different age structures in either the same population over time or different geographies to be removed.

European Age-Sex Standardised Rate (EASR) using ESP1976

For each 5 year age group, the crude rate is calculated and then the weighted average of all age groups is taken based on the weightings of the 1976 European Standard Population, to give the overall EASR.

European Age-Sex Standardised Rate (EASR) using ESP2013

For each 5 year age group, the crude rate is calculated and then the weighted average of all age groups is taken based on the weightings of the 2013 European Standard Population, to give the overall EASR.

The table and chart below are for illustrative purposes to show how the rates differ.

Table A3.1: Comparison of European Age-Sex Standardised Rates (EASRs) of individuals receiving an specialist assessment for their problem drug use care needs in Scotland using both 1976 and 2013 European Standard Populations, and crude rates, by financial year (2006/07-2012/13)

	Financial Year						
	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13
Number of individuals	12,464	13,120	12,345	11,665	11,745	11,625	11,861
Crude Rate per 100,000 population	243	254	237	223	223	219	223
EASR per 100,000 population (ESP1976)	259	270	253	238	239	234	238
EASR per 100,000 population (ESP2013)	235	246	231	219	220	216	222

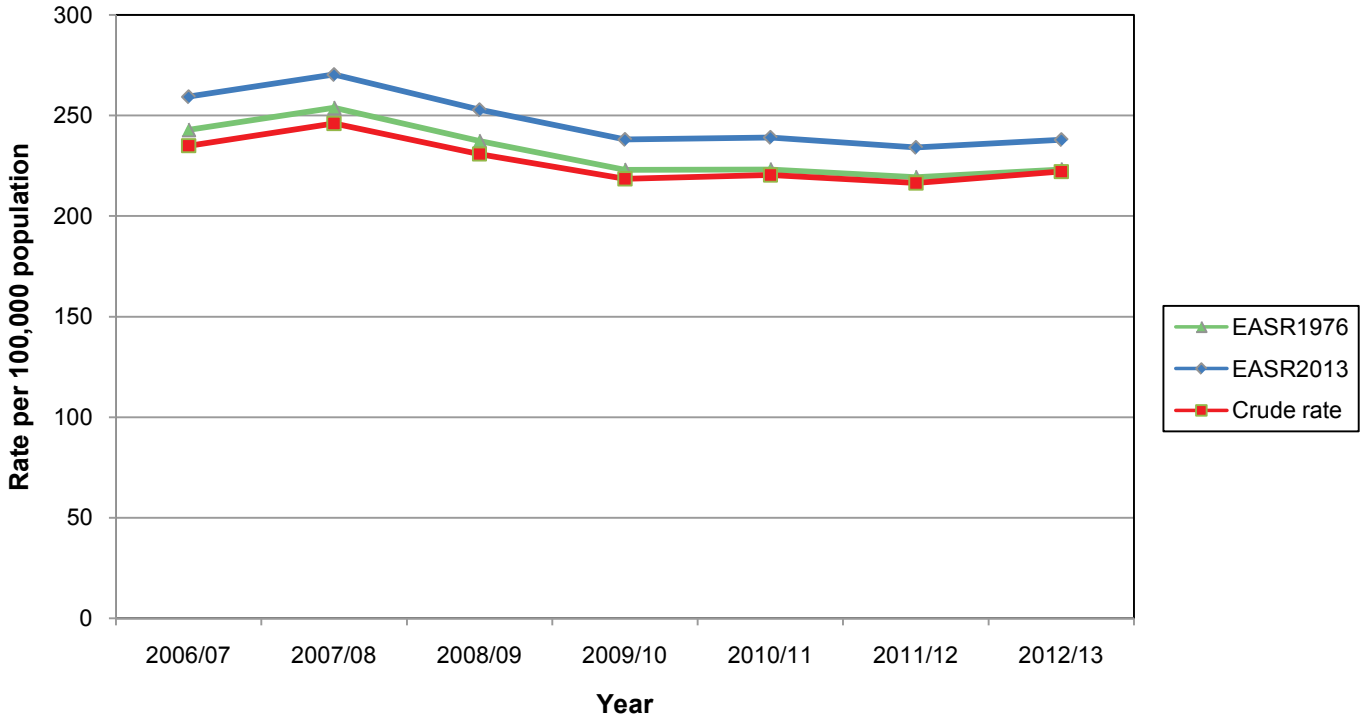
From this example (see Table A2 and Figure A2 below), it can be seen that the EASR (using ESP2013) is the lowest of the three rates. The Crude Rate is slightly higher than this, and the EASR (using ESP1976) is a little higher still. The age profile of individuals receiving a specialist assessment for their problem drug use care needs has been moving towards the older age groups year on year since 2006/07. With the ESP2013 being more skewed towards an older population than ESP1976, it would be expected that the EASR per 100,000 population using ESP2013 would be lower than using ESP1976. The analysis in Table A2 (above) proves that the EASR using ESP2013 is consistently lower than the EASR using ESP1976. The trends shown for each method of calculating rates are similar, giving confidence to trend analysis. EASRs (using ESP1976) are not comparable with EASRs (using ESP2013). For example, comparing the EASR (using ESP1976) for 09/10 in a report issued in 2013, to an EASR (using ESP2013) relating to the same financial year 09/10, in a report issued in 2014, is meaningless. On this basis, findings from this publication are not comparable with previous ISD reports.

Further Information can be obtained from:

ISD Website: http://www.isdscotland.org/Products-and-Services/GPD-Support/

ONS website: http://www.ons.gov.uk/ons/about-ons/get-involved/consultations/consultations/implementation-of-the-2013-european-standard-population/index.html

Figure A3.1: Comparison of European Age-Sex Standardised Rates (EASRs)[1,2] individuals receiving an specialist assessment for their problem drug use care needs in Scotland using both 1976[3] and 2013[4,5] European Standard Populations, and crude rates, by financial year (2006/07-2012/13)



Notes:

(1) The population estimates used in the calculation of rates above are based on the 2011 Census results.
(2) The European Standard Population (ESP), which was first used in 1976, was revised in 2013. European Age-Sex Standardised Rates (EASRs) using ESP1976 and ESP2013 are not comparable.
(3) European Age-Sex Standardised Rate (EASR), calculated using ESP1976 and using 5 year age groups 0-4, 5-9 up to an upper age group of 85+.
(4) European Age-Sex Standardised Rate (EASR), calculated using ESP2013 and using 5 year age groups 0-4, 5-9 up to an upper age group of 90+.
(5) The upper age group for the 2013 European Standard Population structure is 95+. However, due to Scotland population estimates data being unavailable for the 95+ age group for all required geographies, the upper age group used is 90+. This is an amalgamated age group containing both the 90-94 and 95+ age groups.

A4 – Publication Metadata (including revisions details)

Metadata Indicator	Description
Publication title	Scottish Drugs Misuse Database (SDMD) - NHS Health Board Overview of Initial Assessments for Specialist Drug Treatment 2012/13
Description	This annual publication presents the latest available information on initial assessments for specialist drug treatement in the Scottish Drug Misuse Database (SDMD). Information is presented by NHS Board of Residence.
Theme	Health Improvement
Topic	Substance Misuse
Format	PDF report with Excel tables
Data source(s)	Scottish Drug Misuse Database.
Date that data are acquired	Extracted September 2013, additional Glasgow City ADP data added March 2014.
Release date	Tuesday 24th June 2014
Frequency	Annual
Timeframe of data and timeliness	Data published up to 31st March 2013.
Continuity of data	See Appendices A1 and A2.
Revisions statement	Data from the most recent year is considered provisional and subject to revision in future publications. Data are subject to routine quality assurance checks and may be revised periodically to improve accuracy.
Revisions relevant to this publication	The 2013 European Standard Population (ESP2013) has been used to calculate the European Age-Sex Standardised Rates (EASRs) within this publication. The European Standard Population (ESP), which was first used in 1976, was revised in 2013. Previous reports used ESP1976 to calculate EASRs. EASRs calculated using ESP1976 cannot be compared with EASRs calculated using ESP2013. Therefore, findings from this publication are not comparable with previous ISD reports. Further detail regarding this change and a worked example of EASRs using both ESP1976 and ESP2013 is included in Appendix A1.
Concepts and definitions	Guidance on definitions for SDMD is available at http://www.drugmisuse.isdscotland.org/sdmd/advice.htm
Relevance and key uses of the statistics	Relevant to understanding problem drug use in Scotland. Statistics will be used for policy making and service planning.
Accuracy	Quality checks are conducted by ISD. Figures are

	compared to previously published data and expected trends.
Completeness	It is not mandatory for individuals to provide their information in the collection of data through SDMD. Data quality & completeness issues have been observed in relation to NHS Greater Glasgow & Clyde and NHS Tayside. NHS Greater Glasgow & Clyde and NHS Tayside resident information has been excluded from Section 2 of this publication. See Appendix A2 for further information.
Comparability	Since April 2009, all services supplying data to SDMD have been moving from paper-based completion onto the new web-based collection system. This has resulted in a reduction in the number of duplicate forms being completed for the same individual 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.
Accessibility	It is the policy of ISD Scotland to make its web sites and products accessible according to published guidelines.
Coherence and clarity	The report is available as a PDF file with tables clearly linked for ease of use.
Value type and unit of measurement	Numbers, percentages and European Age-Sex Standardised Rates per 100,000 population.
Disclosure	Disclosure has been applied in line with ISD Scotland Disclosure Control.
Official Statistics designation	National Statistic
UK Statistics Authority Assessment	National Statistics
Last published	26th March 2013
Next published	November 2014
Date of first publication	1998
Help email	nss.isdsubstancemisuse@nhs.net
Date form completed	10th June 2014

A5 – 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)

A6 – ISD and Official Statistics

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 NHS Scotland 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.