Scottish Drug Misuse Database

Overview of Initial Assessments for Specialist Drug Treatment 2016/17

Publication date 26 June 2018
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Introduction

The Scottish Drug Misuse Database (SDMD) was set up in 1990 to collect information about people in Scotland with problem drug use. Services contributing to the SDMD include specialist drug services and some medical services. Data are collected when individuals make contact with services providing tier 3 and 4 interventions¹ (i.e. structured community and residential treatment) or reinitiate contact following a gap of at least six months since last attendance. This provides insights into drug treatment needs and the social circumstances and behaviours of individuals at the point when they contact services for treatment.

The SDMD is a unique and widely used national data source that provides information which may be used to identify trends in activity over time, make comparisons between areas/groups, conduct research, improve services, and influence policy in relation to service provision for problem drug use.

Further details on the SDMD are included within Appendix 1 - Background information.

This report presents information on individuals presenting for initial assessment for a new drug treatment episode at specialist drug treatment services in 2016/17. It should be read in conjunction with the SDMD electronic dashboard, which is publicly available and provides users with accessible, interactive content based on data from 2006/07 (the year in which the current data collection form (SMR25a) was introduced) to 2016/17.

For further explanation of technical terms please refer to the Glossary.

¹ Detailed information about Tier 1-4 interventions can be found in http://www.isdscotland.org/Health-Topics/Waiting-Times/Drugs-and-Alcohol/Docs/DATWT_TreatmentTypes_rev.pdf.
Main Points

- In 2016/17, initial assessments for specialist drug treatment relating to 11,721 individuals were recorded on the Scottish Drug Misuse Database.

- Drug services are increasingly dealing with an older population; the percentage of individuals assessed for specialist drug treatment who were aged 35 and over increased from 29% in 2006/07 to 51% in 2016/17.

- Heroin was the most common substance people reported needing help with, although reported use of heroin has decreased over time. Among those who indicated recent drug use, the percentage of individuals reporting heroin as their main drug decreased from 64% in 2006/07 to 46% in 2016/17.

- Reported heroin use shows a particularly sharp decline among younger people; the percentage of under 25s reporting recent heroin use decreased from 58% in 2006/07 to 25% in 2016/17.

- There has been a decrease in reports of injecting drug use; the percentage of individuals who reported that they were currently injecting drugs declined from 28% in 2006/07 to 18% in 2016/17.

- Sharing of needles/syringes and other injecting equipment increases the risk of blood borne virus infection. Between 2006/07 and 2016/17 sharing of needles/syringes decreased from 12% to 6% and sharing of other injecting equipment fell from 20% to 9%.
Results and Commentary

This report focuses on information provided by individuals presenting for initial assessment for a new drug treatment episode at specialist drug treatment services in 2016/17 and for whom data were submitted to ISD on a SMR25a form. It contains:

- **Using the Electronic Dashboard** – Description of the structure of an electronic dashboard which includes information used in this report.

- **Section 1: SDMD Data Quality and Completeness (Scotland and Area of Treatment)** – Summary description of the completeness and data quality of SDMD initial assessment submissions in 2016/17 and comparison of the number of individuals recorded in SDMD initial assessment records and drug treatment records from the Drug and Alcohol Waiting Times database (DATWT). Detailed findings are provided in Appendix 2 - Data Quality.

- **Section 2: SDMD Findings (Scotland and Area of Residence)** – Analysis of the number of initial assessments for specialist drug treatment recorded in SDMD, socio-demographic characteristics, measures of ‘illicit’ and prescribed drug use, injecting behaviour and Blood Borne Virus testing. The findings are presented for 2016/17 along with trends since 2006/07. NHS Board/ADP findings are described where those differed from national findings and were sufficiently robust to merit inclusion (see Section 1).

The information presented in this report does not reflect the total number of individuals seen by services. As individuals are identified by matching SDMD records by forename initial, surname initials, gender and date of birth, the reliability of analysis is dependent upon data quality (Section 1). Some individuals will have had more than one initial assessment during 2016/17, however, only their first recorded initial assessment during the time period is counted and analysed. For some, this may have been their first contact with specialist drug treatment services, while for others it may have been part of a series of treatment episodes spanning multiple years. Individuals have been included only once within each NHS Board or ADP area of residence. However, individuals may be counted in more than one area and, as a result, the sums of the NHS Board and ADP area data will not equal the Scotland figure. Where data are presented at a national level, individuals are counted only once in any year.

Due to data quality and completeness issues, limited 2012/13 and 2013/14 data were available for some areas (Appendix 2 - Data Quality). Therefore, Scotland and relevant NHS Board/ADP trend analyses are incomplete or available only for a limited range of indicators in 2012/13. In Section 2, where indicators are affected by missing data, columns have been excluded from charts and dashed lines have been used to connect valid data points in line charts. For these line charts, it is important to note that the ‘true’ indicator value in years where data were missing was unknown and may differ from the value represented by the dashed line.

SDMD is a dynamic source of data. It should be noted that the 2016/17 data presented in this report is provisional and may change in future publications.

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2 The term ‘illicit drugs’ includes (as per the SMR25a and SMR25b proforma and guidance) use of solvents, ‘novel’ or ‘new’ psychoactive substances (NPS)/legal highs or inappropriate use of ‘Over The Counter’ (OTC) medications.
Some figures (commonly small numbers, for small areas or populations) are not shown. This is as a result of ‘Statistical Disclosure Control’ which aims to prevent the release of information that can lead to the identification of individuals. Further information on the statistical disclosure control methods applied by ISD Scotland is available from the ISD website.

Please note that in this report some percentages, which are based on sums of individual categories, may not equal sums of percentages from the dashboard due to rounding of figures in the dashboard.

Using the Electronic Dashboard
Information accompanying this report is published in an electronic dashboard. It is recommended that the dashboard should be referred to while reading this report. Commentary within this report includes references to dashboard content using the following format:

- (Geography>Domain>Indicator)

Where:

<table>
<thead>
<tr>
<th>Options within ‘Geography’:</th>
<th>Options within ‘Domain’:</th>
<th>Options within ‘Indicator’ for ‘Injecting and sharing’ domain:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Board of Residence</td>
<td>Data quality and completeness</td>
<td>Injecting behaviour</td>
</tr>
<tr>
<td>ADP of Residence</td>
<td>Demographics</td>
<td>Sharing needles/syringes</td>
</tr>
<tr>
<td></td>
<td>Drug profile</td>
<td>Sharing other injecting equipment</td>
</tr>
<tr>
<td></td>
<td>Prescribed drug profile</td>
<td>Blood Borne Virus (BBV) testing</td>
</tr>
<tr>
<td></td>
<td>Heroin profile</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Injecting and sharing</td>
<td></td>
</tr>
</tbody>
</table>

For example, (NHS Board of Residence>Demographics>Gender profile) means that the content relevant to the commentary can be found when:

1. the ‘NHS Board of Residence’ Geography is selected;
2. the ‘Demographics’ Domain is selected; and,
3. the ‘Gender profile’ Indicator is selected.

All Indicators in each Domain contain Scotland figures. Therefore, when referring to Scotland data in this report, only the Domain and Indicator selection are specified (e.g. Demographics>Gender profile).

Once the relevant content has been selected, Scotland level information or information on specific areas (e.g. ‘NHS Borders’) or groups (e.g. heroin within the ‘Main drug’ Indicator of
the ‘Drug profile’ domain) can be charted by clicking on the relevant row in the data table in the top left-hand corner of the dashboard.

Nearly all the data referred to in this report can be accessed using the dashboard. However, some statistics may require the associated data table to be exported. This can be done by clicking the ‘Export data’ button when the relevant Geography, Domain and Indicator are selected.

The dashboard contains background and contextual information relevant to the publication. All notes relevant to the data can be found within the specific pages. For further information about the electronic dashboard, please see the User Guide.
Section 1: SDMD Data Quality and Completeness (Scotland and Area of Treatment)

Introduction
In 2012/13 and 2013/14, problems with data collection systems in specific NHS Boards prevented publication of comprehensive national SDMD data. Reflecting these issues and publication of the UK Statistics Authority’s Guidelines on Administrative Data Quality Assurance in 2015, the Annual SDMD Report for 2014/15 included a detailed investigation of data quality and completeness, and established that the publication of a national report was possible. This section summarises 2016/17 data quality and completeness findings (see also Appendix 2 - Data Quality).

Data Completeness
Specialist services providing tier 3 and 4 interventions (i.e. structured community and residential treatment) should be submitting information on assessments for specialist drug treatment to both SDMD and the Drug and Alcohol Treatment Waiting Times database (DATWT). These are separate systems which are managed separately locally and have different processes and procedures. Comparison of the numbers of individuals recorded on these systems suggests that SDMD completeness was lower. In 2016/17, SDMD data on Initial Assessments was estimated to be 66.2% complete (i.e. two in three individuals assessed for specialist drug treatment were recorded on SDMD). This is similar to the figure for 2015/16 (66.5%) and was the lowest SDMD completeness estimate since DATWT was introduced in 2011/12 (Data quality and completeness>SDMD compliance with DATWT and Table 1).

Table 1: SDMD data completeness (compared to DATWT) by financial year (number of individuals, Scotland, 2011/12-2016/17)

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of individuals on SDMD</th>
<th>Number of individuals on DATWT</th>
<th>Percentage SDMD completeness compared to DATWT</th>
<th>Percentage of anonymous records on DATWT</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011/12</td>
<td>10,340</td>
<td>15,227</td>
<td>67.9</td>
<td>25.4</td>
</tr>
<tr>
<td>2012/13</td>
<td>10,784</td>
<td>14,719</td>
<td>73.3</td>
<td>22.6</td>
</tr>
<tr>
<td>2013/14</td>
<td>x</td>
<td>15,330</td>
<td>x</td>
<td>22.3</td>
</tr>
<tr>
<td>2014/15</td>
<td>11,181</td>
<td>15,574</td>
<td>71.8</td>
<td>18.3</td>
</tr>
<tr>
<td>2015/16</td>
<td>10,655</td>
<td>16,034</td>
<td>66.5</td>
<td>16.9</td>
</tr>
<tr>
<td>2016/17</td>
<td>10,322</td>
<td>15,590</td>
<td>66.2</td>
<td>14.5</td>
</tr>
</tbody>
</table>

‘x’ - not reported due to data quality and completeness issues.
1. Records submitted from prisons are excluded from this comparison.
2. Number of individuals on DATWT includes all anonymous drug waits. As each anonymous record in DATWT must be counted as a unique individual (there is no way to identify repeat clients), the number of individuals identified for comparison with SDMD may be slightly inflated.
3. Initial Assessments.

3 Detailed information about Tier 1-4 interventions can be found in http://www.isdscotland.org/Health-Topics/Waiting-Times/Drugs-and-Alcohol/Docs/DATWT_TreatmentTypes_rev.pdf.
While these estimates may be inexact due to contextual and system-related issues (described fully in Appendix 2 - Data Quality), the extent of the differences observed in recording between the DATWT database and the SDMD means that it is not appropriate to consider individuals recorded on SDMD as the complete population of individuals assessed for specialist drug treatment.

Despite issues comparing SDMD with DATWT, there is an increased probability that SDMD cohorts from areas of low completeness may be unrepresentative of all service users. ADP level comparisons of SDMD and DATWT data are problematic due to differences in service delivery and SDMD data recording. However, NHS Board comparisons (Table A2.1) are considered more robust and are used to determine how findings are reported. On this basis, findings from the following areas (with 50% or lower completeness) are not described in Section 2 of this report:

- NHS Highland: 37%
- NHS Orkney: <50% (exact figure suppressed)

Data Representativeness

As DATWT data were more complete than SDMD data, they were also assumed to be more representative of the population assessed for specialist drug treatment. National SDMD-DATWT completeness estimates by age and gender (Table 2) showed higher relative completeness for individuals aged under 25 (particularly females). Data completeness for the age group ‘35+’ was lower than the completeness for all ages combined. Over-representation of individuals from specific age/gender groups increases the likelihood that characteristics or behaviours more common among those groups may be over-reported. Such bias can be partly corrected by data weighting. However, as differences were generally minor, SDMD was deemed sufficiently representative.
Table 2: SDMD data completeness (compared to DATWT) by age group and gender (number of individuals\textsuperscript{1,2}, Scotland, 2016/17)

<table>
<thead>
<tr>
<th>Gender</th>
<th>Age Group</th>
<th>Number of individuals on SDMD\textsuperscript{3}</th>
<th>Number of individuals on DATWT</th>
<th>Percentage SDMD completeness compared to DATWT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Males</td>
<td>Under 25</td>
<td>911</td>
<td>1,132</td>
<td>80.5</td>
</tr>
<tr>
<td></td>
<td>25-34</td>
<td>2,345</td>
<td>2,996</td>
<td>78.3</td>
</tr>
<tr>
<td></td>
<td>35+</td>
<td>4,111</td>
<td>5,382</td>
<td>76.4</td>
</tr>
<tr>
<td></td>
<td>All ages</td>
<td>7,367</td>
<td>9,510</td>
<td>77.5</td>
</tr>
<tr>
<td>Females</td>
<td>Under 25</td>
<td>353</td>
<td>421</td>
<td>83.8</td>
</tr>
<tr>
<td></td>
<td>25-34</td>
<td>1,135</td>
<td>1,409</td>
<td>80.6</td>
</tr>
<tr>
<td></td>
<td>35+</td>
<td>1,466</td>
<td>1,985</td>
<td>73.9</td>
</tr>
<tr>
<td></td>
<td>All ages</td>
<td>2,954</td>
<td>3,815</td>
<td>77.4</td>
</tr>
<tr>
<td>All persons</td>
<td>Under 25</td>
<td>1,264</td>
<td>1,553</td>
<td>81.4</td>
</tr>
<tr>
<td></td>
<td>25-34</td>
<td>3,480</td>
<td>4,405</td>
<td>79.0</td>
</tr>
<tr>
<td></td>
<td>35+</td>
<td>5,577</td>
<td>7,367</td>
<td>75.7</td>
</tr>
<tr>
<td></td>
<td>All ages</td>
<td>10,321</td>
<td>13,325</td>
<td>77.5</td>
</tr>
</tbody>
</table>

1. Records submitted from prisons are excluded from this comparison.
2. This analysis excludes DATWT anonymous clients, focusing on those who provided age and gender information.
3. Initial Assessments.

Indicator Completeness

In 2016/17, improvements in completeness were noted in relation to the majority of indicators (a summary of indicator completeness is available in the dashboard) at a national level. A decrease was observed in two indicators but it was marginal, i.e. from 96.9% to 96.6% and from 89.6% to 89.5%. However, for the indicators described below, data completeness was generally low across Scotland or varied by NHS Board/ADP of treatment. These indicators have been included in the report and electronic dashboard because of: a) their relevance to the issue of problem drug use and b) in order to highlight poor data quality. However, findings may be biased by observed variations in reporting and results should be interpreted carefully in light of the following information. Comprehensive 2016/17 indicator completeness data is provided in the electronic dashboard (Data quality and completeness> Indicator completeness).

- **Co-Occurring Health Issues**: This indicator potentially provides valuable insights into health issues that may be risk factors for relapse or drug-related death (e.g. older people with a drug problem were admitted to hospital more frequently and had a higher prevalence of a range of medical/psychiatric conditions than the rest of the Scottish population (SDF: 2017)\textsuperscript{4}). In 2016/17, data completeness across Scotland was 59%.

(compared to 56% in 2015/16) and varied widely between areas (33% of NHS Shetland records included valid data compared to 91% of records from NHS Ayrshire & Arran)\(^5\).

- **Age First Started Using Drugs**: This variable is a useful indicator in assessing age of onset of drug misuse. In 2016/17, overall completeness for Scotland was 79% (compared to 76% in 2015/16). Data completeness in NHS Western Isles was low (36%).

- **Alcohol Consumption**: It is likely that a high proportion of those assessed for specialist drug treatment also consumed alcohol. Across Scotland, 2016/17 completion was 83% (compared to 80% in 2015/16). However, considerable variations in data recording were observed between NHS Boards and ADPs. Completion was as low as 55% in NHS Shetland and NHS Western Isles. Seventeen ADPs had completeness of 90% or greater, while four ADPs collected these data in less than 70% of records. Of these four ADPs, Glasgow City ADP (57% complete) was the mainland area with the lowest completion rate.

- **Injecting Behaviour**: This measure provides information about injecting status of individuals who were recorded on SDMD. National completeness in 2016/17 was 85% (compared to 83% in 2015/16). Completion varied substantially at NHS Board and ADP levels. In NHS Shetland and NHS Greater Glasgow & Clyde completeness was 55% and 62% respectively. Of the remaining 12 NHS Boards, eight had completeness above 90%.

**Comparisons between Area of Treatment and Area of Residence**

The data quality and completeness analyses presented in this section of the report are based on the individual’s *area of treatment* (i.e. the NHS Board/ADP where an individual was assessed for specialist drug treatment) while the findings presented in Section 2 are based on analysis by *area of residence* (thought to be of most value to users of these statistics). Therefore, in order for the findings from Section 1 to function as measures of the reliability of findings in Section 2, there should be a high degree of correspondence between treatment and resident populations. In 2016/17, in all 14 NHS Boards, 96% or greater of individuals assessed for specialist drug treatment were resident in the same area (Table A2.2).

**Other Data Quality and Completeness Indicators**

The electronic dashboard contains other data quality and completeness indicators which may be of interest to users of these data. The completeness of SDMD 3-month follow-up (SMR25b) recording for the most recent treatment episode for each individual recorded on SDMD in 2016/17 is provided in Data quality and completeness>SDMD follow up completeness. This shows that, nationally, 19% of initial assessments had follow-up data recorded on SDMD after three months (slightly lower than in 2015/16 (20%)).

Numbers of unplanned discharges are monitored by services because such events may be associated with the relapse of individuals to problem drug use. Data quality and completeness> Unplanned discharge before treatment shows that the percentage of discharges before treatment which were unplanned decreased from 31% in 2015/16 to 25% in 2016/17. Unplanned discharges as a percentage of discharges during treatment continued

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\(^5\) The probable reason for low completeness of this variable is that it has no ‘none’ category. While the absence of a response could be assumed to mean there were no co-occurring health issues, there is evident ambiguity associated with responses.
to decrease across the time series (from 50% in 2011/12 to 35% in 2016/17) (Data quality and completeness> Unplanned discharge during treatment).

Conclusions
While SDMD does not provide data on all people seeking help for problem drug use, it provides data on a demographically representative group of individuals assessed for specialist drug treatment and includes a wide range of indicators (e.g. illicit drug use, prescribed drug use, injecting behaviour) that are not available from other comparable national administrative data sources.

The findings from Section 1 emphasise the importance of carefully considering quality and completeness information when interpreting data and are reflected in the following guidelines for the SDMD analysis presented in Section 2:

- Statistics (e.g. standardised rates) which may be unreliable due to potential under/over-representation of specific groups in the population assessed for specialist drug treatment are not reported.

- Areas where completeness in comparison to DATWT was estimated to be 50% or lower are not described as there is a higher probability that SDMD findings may be unrepresentative.

- For indicators with considerable geographical variation in completeness, only Scotland level figures are reported.
Section 2: SDMD Findings (Scotland and Area of Residence)

Demographics
This section describes the demographic profile of individuals presenting for an initial assessment of their needs at specialist drug treatment services in Scotland. 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.

New Individual Patients/Clients
In 2016/17, initial assessments for specialist drug treatment relating to 11,721 individuals were recorded on SDMD (Demographics>New individual patients/clients). The annual number of individuals assessed and recorded since 2006/07 has ranged between 11,335 (2011/12) and 12,932 (2007/08) (Figure 1).

Figure 1: Number of initial assessments by financial year (Scotland; 2006/07-2016/17)

1. 2013/14 is not reported due to data quality and completeness issues.

There was considerable variation over time in the number of initial assessments recorded on SDMD when analysed by specific NHS Board or Alcohol and Drug Partnership (ADP) area. These variations may reflect fluctuations in the demand for specialist drug treatment or may be due to changes in service configuration or the completeness of data submission over time.

Across Scotland, 70% of individuals stated they had previously been in contact with drug treatment services. By NHS Board area, the percentage of individuals previously in contact with drug treatment services ranged from 61% in Shetland and 62% in Forth Valley to 76% in Ayrshire & Arran, Grampian, and Western Isles.
Age Profile
Since 2006/07, an increasing percentage of individuals recorded on SDMD have been from older age groups. In 2006/07, 29% of individuals assessed for specialist drug treatment were aged 35 and over, compared with 51% in 2016/17. Assessments among individuals aged 25-34 (until 2012/13 the group most often assessed for specialist drug treatment) decreased from 45% in 2006/07 to 34% in 2016/17. The percentage of individuals aged under 25 years also decreased from 26% in 2006/07 to 14% in 2016/17. The median age at assessment increased from 30 years in 2006/07 to 35 years in 2016/17 (Demographics>Age profile and Figure 2).

Figure 2: Percentage of individuals by age group and financial year (Scotland; 2006/07-2016/17)

1. 2013/14 is not reported due to data quality and completeness issues.

In 2016/17, the age breakdown in the majority of NHS Board areas was similar to that of Scotland with the 35 and over age group most prominent among those assessed. Differences in age composition were most marked in Fife, where 60% of individuals were aged 35 and over while only 31% were aged 25-34. The median age of individuals assessed for treatment in 2016/17 varied across NHS Board areas, from 29 years (Western Isles) to 36 years (Greater Glasgow & Clyde and Fife) (NHS Board of Residence>Demographics>Age profile and Figure 3).
Figure 3: Percentage of individuals by age group and NHS Board\textsuperscript{1,2} of residence (Scotland; 2016/17)

1. NHS Shetland and NHS Western Isles are not included in this chart due to the suppression of small numbers.
2. NHS Highland and NHS Orkney are not included due to data completeness issues.

**Gender Profile**

In 2016/17, 72\% of individuals assessed for specialist drug treatment were male, similar to previous years ([Demographics\textgreater;Gender profile]). The percentage of males in NHS Board areas ranged from 65\% in Tayside to 76\% in Forth Valley and 79\% in Western Isles, 82\% in Shetland ([NHS Board of Residence\textgreater;Demographics\textgreater; Gender profile]).

**Source of Referral**

The distribution of referral sources reflects local networks of health, social care and justice agencies within NHS Boards. Valid responses were provided in 96\% of cases. The most common referral source was ‘Self’ (46\%), followed by ‘Health’ (22\%). Just under one-sixth (16\%) of initial assessments were referred by ‘Criminal Justice’ ([Demographics\textgreater;Source of referral]).

In nine NHS Board areas, ‘Self’ referral was the most common (67\% of referrals in Fife were by ‘Self’). In Grampian, ‘Health’ referrals were the most common, accounting for 41\% of individuals. The highest percentages of ‘Criminal Justice’ referrals were observed in Ayrshire & Arran and Forth Valley (28\% and 25\% respectively) ([NHS Board of Residence\textgreater;Demographics\textgreater; Source of referral]).

**Employment Status**

Employment/education status was reported at assessment for 87\% of individuals. In 2016/17, 49\% of individuals reported being unemployed at the time they were assessed for specialist
drug treatment, 24% reported an ‘other’ employment status and 14% reported being employed or in full time education/training (Demographics>Employment status).

Among individuals assessed for specialist drug treatment, the highest percentage reported as unemployed was observed in NHS Borders (64%), while the highest percentage employed (19%) was observed in NHS Forth Valley (NHS Board of Residence>Employment status).

Living Situation
The living situation of individuals known to use drugs may influence personal outcomes. Living with other drug users may increase the risk of relapse to problem drug use while living alone may be a risk factor for drug-related death. Among individuals recorded on SDMD, ‘lives alone’ (38%) was the most common living situation, followed by ‘friends/other family’ and ‘spouse/partner’ (both 16%), and ‘living with parents’ (15%). Living with ‘spouse/partner’ decreased compared to 2015/16 (20%). Only 12% reported living with ‘other drug users’ - a decrease since 2011/12 (34%) (Demographics>Living situation).

Accommodation Status
In Scotland, 66% of individuals reported that they lived in owned/rented accommodation, a slight increase from 63% in 2015/16. More than one-tenth (12%) of individuals reported being homeless when they were assessed for specialist drug treatment (similar to 2015/16 (11%)) (Demographics>Accommodation status).

The highest percentage of people who were homeless when assessed for specialist drug treatment was observed in Western Isles (24%), followed by Grampian (22%) (NHS Board of Residence>Demographics>Accommodation status). Among ADP areas, Aberdeen City reported the highest percentage of individuals who were homeless (27%) when assessed for specialist drug treatment (this was an increase from 22% in 2015/16). (ADP of Residence>Demographics>Accommodation status).

Legal Situation
In 2016/17, sixty-two percent of individuals assessed for specialist drug treatment were not currently subject to any legal proceedings or sanctions, while 15% had a case pending and 15% were in prison (Demographics>Legal situation).

Among NHS Board areas, Shetland had the lowest percentage of individuals with no legal proceedings or sanctions against them at the time of assessment (48%). The second lowest percentage was in Grampian (52%). However, the low percentage in Shetland may have

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6 ‘Other’ employment status includes school, excluded from school, long term sick / disabled, in prison and other.
been influenced by the low completeness of responses for this indicator (61% in Shetland compared to 95% in Grampian). In Grampian, 28% of individuals assessed were in prison, compared to only 7% in Lanarkshire (NHS Board of Residence>Demographics>Legal situation).

**Co-Occurring Health Issues**

In 2016/17, 59% of the individuals assessed for specialist drug treatment reported that they had co-occurring health issues. Fifty-seven percent of individuals who reported a co-occurring health condition reported drug-related physical issues, 54% reported mental health issues and 28% reported alcohol issues (Demographics>Co-occurring health issues).
Drug Profile

All Drugs

Examining drugs reported in any of the five illicit\(^9\) drug fields in SDMD provides an indication of patterns of recent problem drug use among those assessed for specialist drug treatment. Of the 11,721 individuals recorded on SDMD in 2016/17, 76% (8,896) reported illicit drug use in the month prior to initial assessment, with approximately half (4,617; 52%) reporting the use of heroin. Cannabis (2,821; 32%), diazepam (2,596; 29%) and cocaine/crack cocaine (1,694; 19%) were the next most frequently reported drugs.

There was a general downward trend in recent heroin use across the time series from 2006/07 (68%) to 2016/17 (52%) (Drug profile> All drugs and Figure 4).

For a number of years (2009/10-2014/15), the percentage of individuals reporting recent cocaine/crack cocaine use ranged from 11% to 13%. However, recent cocaine/crack cocaine use has increased to 19% (2016/17) over the last two years, similar to the percentage reported in the pre-2009/10 period. This change may be related to decreases in price and increases in purity of cocaine (European Drug Report 2017\(^{10}\)).

Figure 4: Type of illicit drug used in the month prior to assessment among individuals reporting recent illicit drug use by financial year (Scotland; 2006/07-2016/17)

1. 2012/13 and 2013/14 are not reported due to data quality and completeness issues.
2. ‘OST’ - Opioid Substitution Therapy.

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\(^9\) The term ‘illicit drugs’ includes (as per the SMR25a and SMR25b proforma and guidance) use of solvents, ‘novel’ or ‘new’ psychoactive substances (NPS)/legal highs or inappropriate use of ‘Over The Counter’ (OTC) medications.

In all NHS Board areas with the exception of Grampian and Lanarkshire, heroin, cannabis and diazepam were the drugs most often reported to have been used in the month prior to assessment. In Grampian and Lanarkshire, cocaine/crack cocaine was the third most commonly used drug. Of individuals reporting recent illicit drug use, heroin was most commonly reported in Fife (67%), compared with only 37% in Lanarkshire. Cannabis was recently used by up to 45% of individuals in Western Isles, followed by Forth Valley (37%), while the highest percentage of recent diazepam usage (41%) was observed in Grampian. 

(NHS Board of Residence>Drug profile>All drugs). ADP areas within NHS Greater Glasgow & Clyde generally reported high levels of recent diazepam use, with the highest percentages observed in West Dunbartonshire and Renfrewshire (both 48%) (ADP of Residence>Drug profile>All drugs).

Main Drug
The main drug used is recorded in the first illicit drug field of the SMR25a form and is considered to be the substance for which individuals were seeking specialist drug treatment. In 2016/17, among the 8,896 individuals providing information on recent illicit drug use, heroin was the most common main drug (4,112; 46%), followed by cannabis (1,763; 20%), cocaine/crack cocaine (856; 10%), and diazepam (837; 9%).

The absence of reported figures for 2012/13 and 2013/14 reduces certainty about trends over the past five years. However, the following changes across the time series were observed (Drug profile>Main drug and Figure 5):

- The percentage of individuals reporting heroin as their main drug decreased from 64% in 2006/07 to a range between 45% and 47% since 2014/15.
- The percentage of individuals reporting cannabis as their main drug increased from 14% in 2006/07 before stabilising at 20% in each reported year from 2011/12.
- Reporting of cocaine/crack cocaine as a main drug decreased from 8% in 2008/09 to 5% in 2009/10, but has since doubled to 10% (856) in 2016/17 (increasing by 3 percentage points compared with 2015/16).
- Reporting of diazepam increased from 6% in 2006/07 to 11% in 2011/12, but had a small decrease in the following years, with 9% observed in 2016/17.
- The percentage reporting ‘other Opioid Substitution Therapy (OST) drugs’ as their main drug increased from less than 1% in 2006/07 to 3% (295) in 2016/17.

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11 OST is also known as ORT (Opioid Replacement Therapy).
12 ‘Other OST drugs’ includes: buprenorphine & naloxone (Suboxone ®), buprenorphine (Subutex ®), lofexidine (Britlofex ®) and naltrexone.
Main Drug by Area
Heroin was the most common main illicit drug reported in all NHS Board areas. Fife and Tayside (63%) had the highest percentage of recent drug users reporting heroin as their main drug, compared to 35% in Lanarkshire (NHS Board of Residence>Drug profile>Main drug by area). Other notable findings include:

- The highest percentage of recent drug users reporting cannabis as their main drug was observed in Forth Valley (28%), with the national average being 20%.
- In Lanarkshire, 17% of individuals reported cocaine/crack cocaine as their main drug, compared to 10% nationally.
- The highest use of diazepam as main drug was observed in Western Isles and Greater Glasgow & Clyde (35% and 14% respectively), compared to 9% across Scotland.
- 7% of individuals assessed for specialist drug treatment in Borders reported dihydrocodeine as their main drug compared to a Scottish average of 2%.
- In Forth Valley, higher than average percentages of individuals reported either amphetamines or mephedrone as their main drug (cumulatively, 5% compared to 2% across Scotland).

Age When First Started Using Drugs
Across the time series, median age at first use of drugs remained stable at 15 years. In 2016/17, 33% of individuals reported being under 15 years old when they started using drugs.
and 30% were between 15 and 19 years (Drug profile>Age when first started using drugs).

**Alcohol Consumption**

Of the 9,742 individuals who provided information on their recent alcohol use, 40% (3,913) had consumed alcohol in the month prior to commencing specialist drug treatment. Of those recently consuming alcohol, over a third (1,369; 35%) reported drinking every day in the past month. A steady increase in the percentage of individuals who consumed alcohol every day in the month prior to assessment was observed in the most recent years, from 29% in 2014/15 to 35% in 2016/17 (Drug profile>Alcohol consumption).
Prescribed Drug Profile
This part of the report presents findings about drugs prescribed at the time individuals had their initial assessment. The medications described will generally have been prescribed prior to assessment for specialist drug treatment and should not be interpreted as reflecting the treatments prescribed during specialist drug treatment episodes.

All Prescribed Drugs
In 2016/17, 4,926 (42%) of individuals recorded on SDMD reported that they were currently prescribed a drug for the treatment of addiction. Methadone (an Opioid Substitution Therapy or OST) was the most commonly prescribed drug (56% (2,741) of assessments where a current prescription was reported). The next most common category was ‘other drugs’\(^\text{13}\) (1,951; 40%), which increased substantially compared with 2015/16 (1,691; 34%). Diazepam (often used to treat opiate withdrawal symptoms) was the third most commonly prescribed drug (610; 12%), followed by ‘other sedatives’ (445; 9%) and ‘other OSTs’\(^\text{14}\) (361; 7%) (Prescribed drug profile>All prescribed drugs).

The main changes over time in prescribed drug use were the decrease in methadone prescribing from 2011/12 (73%) to 2016/17 (56%) and in diazepam prescribing from 2006/07 (28%) to 2016/17 (12%). An increase in ‘other drugs’ prescribing occurred from 2011/12 (22%) to 2016/17 (40%), while a general increase in ‘other OST drugs’ was evident from 2006/07 (2%) onwards (Prescribed drug profile>All prescribed drugs and Figure 6).

\(^{13}\) ‘Other drugs’ included mostly a range of anti-depressants and anti-psychotics. While not specifically for the treatment of addiction, these drugs are used to treat co-morbid conditions which, if left untreated, may result in individuals’ withdrawing from specialist drug treatment.

\(^{14}\) ‘Other OST drugs’ includes: buprenorphine & naloxone (Suboxone ®), buprenorphine (Subutex ®), lofexidine (Britlofex ®) and naltrexone.
Figure 6: Type of drugs currently prescribed among individuals reporting current prescription by financial year (Scotland; 2006/07-2016/17)

1. 2012/13 and 2013/14 are not reported due to data quality and completeness issues.
2. ‘OST’ - Opioid Substitution Therapy.

In most NHS Boards, methadone was the drug most commonly prescribed, accounting for between 39% (Forth Valley) and 77% (Dumfries & Galloway) of assessments where a current prescription was recorded. In Western Isles and Forth Valley ‘other drugs’ were most commonly prescribed. There were wide variations between areas in the percentage of individuals currently prescribed diazepam; ranging from 3% (Tayside) to 26% (Lothian) (NHS Board of Residence> Prescribed drug profile>All prescribed drugs).

Main Prescribed Drug
In 2016/17, among the 4,926 individuals who were currently prescribed a drug for the treatment of addiction, 54% (2,681) reported methadone as their main prescription, followed by ‘other drugs’ (1,282; 26%) and ‘other OST drugs’ (344; 7%). Although figures for 2012/13 and 2013/14 were not available, the percentage of currently prescribed individuals reporting methadone as their main prescribed drug decreased from 71% in 2011/12, while the percentage reporting ‘other drug’ prescribing increased from 11% in the same time period. Decreases over the entire time series (2006/07 to 2016/17) were evident in relation to diazepam (9% to 4%) and dihydrocodeine (8% to 2%). ‘Other OST drugs’ showed largely the opposite trend, increasing from 2% in 2006/07 to 9% in 2014/15 before decreasing slightly in the following years (Prescribed drug profile>Main prescribed drug and Figure 7).
Figure 7: Main currently prescribed drug among individuals reporting current prescription by financial year (Scotland; 2006/07-2016/17)

1. 2012/13 and 2013/14 are not reported due to data quality and completeness issues.
2. ‘OST’ - Opioid Substitution Therapy.

**Main Prescribed Drug by Area**

Methadone was the most common main prescribed drug reported in all NHS Board areas except Forth Valley where it was the second most common after ‘other drugs’. Dumfries & Galloway (77%) had the highest percentage of individuals currently prescribed methadone, compared to 39% in Forth Valley. Prescription of ‘other OST drugs’ varied from 2% of currently prescribed individuals in Tayside to 14% in Lanarkshire (NHS Board of Residence>Prescribed drug profile>Main prescribed drug by area).
Heroin Profile

**Individuals aged under 25**

In Scotland, heroin use among individuals who reported illicit drug use decreased from 58% (1,593/2,729) of those aged under 25 in 2006/07 to 25% (314/1,270) in 2016/17. As this fall in heroin use occurred during a period when the numbers of under 25s assessed for drug treatment also reduced, the marked decrease in the numbers reporting heroin use is noteworthy (Heroin profile>Individuals aged under 25 and Figure 8).

**Figure 8: Percentage of recent drug users who reported heroin use by age group and financial year (Scotland; 2006/07-2016/17)**

1. 2012/13 and 2013/14 are not reported due to data quality and completeness issues.

There was wide variation across NHS Board areas in reported heroin use among under 25s. In Forth Valley and Lanarkshire 17% of individuals under 25 reported using heroin, while in Borders 62% of under 25s assessed were heroin users (NHS Board of Residence>Heroin profile> Individuals aged under 25). Only 3% of under 25s assessed in the Inverclyde ADP area reported using heroin (ADP of Residence>Heroin profile> Individuals aged under 25).

**Individuals aged 35 and over**

There was a moderate decrease in the percentage of older drug users (i.e. those aged 35 and over) reporting recent heroin use from 67% (1,755/2,620) in 2006/07 to 60% (2,711/4,500) in 2016/17. As this downward trend across the time series was accompanied by an increase in the number of older individuals recorded on SDMD, the total number of heroin users aged 35 and over has increased despite the percentage reduction in older drug users reporting heroin use (Heroin profile>Individuals aged 35 and over and Figure 8).
Among NHS Board areas, Lanarkshire had the lowest percentage (48%) of individuals aged 35 and over reporting heroin use, while the highest percentages were observed in Tayside and Fife (70%) (NHS Board of Residence>Heroin profile>Individuals aged 35 and over).

**Route of Use of Heroin**

In 2016/17, 40% (1,837/4,617) of individuals who had used heroin in the month prior to assessment reported injecting the drug. This was notably lower than in years prior to 2015/16 when the percentage of injecting heroin users ranged from 47% (2,060/4,396) in 2014/15 to 53% (2,272/4,291) in 2011/12 (Heroin profile>Route of use of heroin and Figure 9).

**Figure 9: Route of use of heroin among individuals reporting recent heroin use by financial year (Scotland; 2006/07-2016/17)**

1. Heroin users who did not provide injecting information are not included in this chart.
2. 2012/13 and 2013/14 are not reported due to data quality and completeness issues.

By NHS Board area, Lanarkshire reported the lowest percentage (30%) of recent heroin injectors, while Dumfries & Galloway (57%) reported the highest percentage. A notable reduction in injecting among recent heroin users between 2015/16 and 2016/17 was observed in Borders (from 54% to 40%) (NHS Board of Residence>Heroin profile>Route of use of heroin).
Injecting and Sharing
This part of the report presents findings about the injecting and sharing behaviours of individuals assessed for specialist drug treatment. Injecting data are collected in two distinct sections of the SMR25a form:

1. how drugs consumed in the past 30 days were administered; and,
2. previous/current injecting and sharing behaviours.

The data described below relate to the second of these sections. Responses may differ slightly from the information on heroin injecting (Route of Use of Heroin) due to data quality and completion issues.

Injecting Behaviour
Eighty-five per cent (9,957) of individuals recorded on SDMD provided information on injecting behaviour in 2016/17. Of those, 51% (5,047) stated they had never injected drugs, 31% (3,074) reported doing so in the past and 18% (1,836) currently injected drugs. Despite the unavailability of 2012/13 and 2013/14 Scotland figures, there has been a general downward trend in the percentage of individuals reporting current injecting since 2006/07 (28%) (Injecting and sharing-Injecting behaviour and Figure 10).

Figure 10: Injecting behaviours among individuals reporting injecting by financial year (Scotland; 2006/07-2016/17)

1. Due to rounding, sum of percentages may not equal 100%.
2. 2012/13 and 2013/14 are not reported due to data quality and completeness issues.
**Sharing Needles/Syringes**

In 2016/17, past sharing of needles/syringes was reported by 32% (1,509/4,742)\(^{15}\) of individuals who reported past or current injecting. Current sharing was reported by 6% (277/4,742). A general downward trend in the percentage of injectors currently sharing needles/syringes has been observed since 2006/07 (12%) ([Injecting and sharing>Sharing needles/syringes](#)) and Figure 11).

**Figure 11: Reported sharing of needles/syringes among individuals reporting injecting by financial year (Scotland; 2006/07-2016/17)**

![Chart showing reported sharing of needles/syringes by financial year.]

1. Reported Injectors who did not provide sharing information are not included in this chart.
2. 2012/13 and 2013/14 are not reported due to data quality and completeness issues.

**Sharing Other Injecting Equipment**

In 2016/17, past sharing of injection-related equipment other than needles/syringes (hereafter referred to as ‘other injecting equipment’) was reported by 41% (1,780/4,389)\(^{16}\) of individuals who reported past or current injecting. Current sharing of other injecting equipment was reported by 9% (385/4,389). As with needles/syringes, a general downward trend in the percentage of individuals reporting current sharing of other injecting equipment has been observed since 2006/07 (20%) ([Injecting and sharing>Sharing other injecting equipment](#)) and Figure 12).

\(^{15}\) The denominator is lower than the total number of individuals who injected drugs due to missing data for the question on sharing needles/syringes.

\(^{16}\) The denominator is lower than the total number of individuals who injected drugs due to missing data for the question on sharing other injecting equipment.
**Figure 12: Reported sharing of other injecting equipment among individuals reporting injecting by financial year (Scotland; 2006/07-2016/17)**

1. Reported Injectors who did not provide sharing information are not included in this chart.
2. 2012/13 and 2013/14 are not reported due to data quality and completeness issues.

**Blood Borne Virus (BBV) Testing**

The risk of contracting Blood Borne Viruses (BBVs) is higher amongst people who inject drugs than in other populations \(^{17}\). In 2016/17, among the 4,910 individuals who had reported previous injecting, information was available on whether individuals were tested for Hepatitis B, Hepatitis C and HIV in 90%, 90%, and 89% of cases respectively. Previous testing for Hepatitis B, Hepatitis C and HIV was reported by 77%, 79% and 77% of individuals respectively (Injecting and sharing>Blood Borne Virus (BBV) testing).

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**Glossary**

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Definition</th>
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<tbody>
<tr>
<td>ADP</td>
<td>Alcohol and Drug Partnership</td>
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<tr>
<td>BBV</td>
<td>Blood Borne Virus</td>
</tr>
<tr>
<td>CoSLA</td>
<td>Convention of Scottish Local Authorities</td>
</tr>
<tr>
<td>DATWT</td>
<td>Drugs and Alcohol Treatment Waiting Times database</td>
</tr>
<tr>
<td>Denominator</td>
<td>The lower portion of a fraction, used to calculate a rate or ratio.</td>
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<tr>
<td>EASR</td>
<td>European Age-Sex Standardised Rate; the rate that would have been found if the population in Scotland had the same age- and sex- composition as the hypothetical standard European population.</td>
</tr>
<tr>
<td>HEAT</td>
<td>Health Improvement, Efficiency, Access and Treatment</td>
</tr>
<tr>
<td>ISD</td>
<td>Information Services Division</td>
</tr>
<tr>
<td>LDP</td>
<td>Local Delivery Plan</td>
</tr>
<tr>
<td>Numerator</td>
<td>The upper portion of a fraction, used to calculate a rate or ratio.</td>
</tr>
<tr>
<td>OST</td>
<td>Opioid Substitution Therapy (also known as Opioid Replacement Therapy (ORT))</td>
</tr>
<tr>
<td>Other Injecting Equipment</td>
<td>Sterile injecting equipment other than needles/syringes. These items are distributed to improve injecting hygiene and to prevent the spread of Blood Borne Viruses. Citric acid/Vitamin C and sterile water are used to dissolve drugs (particularly heroin) into an injectable solution. Wipes and swabs allow people who inject drugs to sterilise injecting sites. Sharps bins are distributed to facilitate the safe disposal of used needles. Filters help prevent larger particles from entering the syringe after preparation of the drug, and spoons or other forms of cookers such as ‘stericups’ facilitate the sterile cooking of drugs.</td>
</tr>
<tr>
<td>SDMD</td>
<td>Scottish Drug Misuse Database</td>
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## List of Tables

<table>
<thead>
<tr>
<th>Table No.</th>
<th>Name</th>
<th>Time period</th>
<th>File &amp; size</th>
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<tr>
<td></td>
<td>Scottish Drug Misuse Database dashboard</td>
<td>2006/07 to 2016/17</td>
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</tbody>
</table>
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Further Information

Further Information can be found on the ISD website.
For more information on SDMD see the Scottish Drug Misuse Database section of our website. For related topics, please see the Drugs Misuse pages.

The Scottish Public Health Observatory (ScotPHO) provides information on various aspects of drug misuse in Scotland: ScotPHO drug misuse section.

The next release of this publication will be in spring 2019.

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Appendices

Appendix 1 – Background information

Policy Context
The Scottish Drug Misuse Database (SDMD) is a unique 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.

The SDMD was developed by ISD 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.

The Drugs Strategy Delivery Commission (DSDC) was established in 2009 to monitor and assess the delivery of the Road to Recovery. In 2013, the DSDC published the Independent Expert Review Of Opioid Replacement Therapies In Scotland which stated that Scotland requires a new coordinated national approach to develop the relevant evidence base to support a better understanding of the natural history of substance use problems and the delivery of improved treatment and recovery outcomes. Systematic collection and management of routine data from services should be the foundation for this work. Reflecting
these aims, ISD have been commissioned by Scottish Government to develop an integrated
drug and alcohol information system which will amalgamate the existing functions of the
SDMD, Drug & Alcohol Treatment Waiting Times database (DATWT) and gather additional
information on alcohol treatment outcomes (see Drug and Alcohol Information System
(DAISy) below).

A joint decision was taken in November 2014 by the Scottish Government, members of the
DSDC and relevant stakeholders that the original work of the DSDC had been concluded.
Since then, the Scottish Government has worked closely with key stakeholders to develop
the new Partnership for Action on Drugs in Scotland (PADS) group which was launched in
January 2016. The PADS group has been set up to reduce problem drug use and
complement the work of the established Road to Recovery strategy. The group brings
together leaders from the fields of addiction, mental health, inequality, social work and health
and social care and is leading and focusing the sector on three priorities:
• building communities focused on recovery and tackling stigma;
• quality and consistency of service planning and delivery; and,
• harm reduction and reducing drug-related deaths.

SDMD 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 contains both mandatory and non-mandatory data items
and 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\(^{18}\)). Using
this system, data are collected at the following points throughout an individual’s course of
treatment:
• Initial assessment (SMR25a proforma): [http://www.isdscotland.org/Health-
Topics/Drugs-and-Alcohol-Misuse/Docs/smr25A.pdf](http://www.isdscotland.org/Health-
Topics/Drugs-and-Alcohol-Misuse/Docs/smr25A.pdf)

\(^{18}\) GP data are not included in the analysis within this publication.
Information Services Division

- 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.

1. Service providers log into the SDMD application and submit data to ISD via a web form.
2. File upload via the SDMD application. This allows a local system administrator to log into the application and submit a data file from their local system directly to ISD.

**Drug and Alcohol Information System**

The Drug and Alcohol Information System (DAISy) is a national database being developed to collect drug and alcohol, outcomes and waiting times information from staff delivering specialist drug and alcohol interventions. By developing a single system it is hoped that the amount of data entry required by ADPs and Specialist Services will reduce and go some way to ensure data quality and completeness can be managed more effectively.

DAISy will gather key demographic and outcome data on people who engage in drug/alcohol treatment services. It will enable us to improve our understanding of the impact of drug/alcohol treatment services at both a local and national level and consequently enable us to improve the way that we plan and deliver these services.


**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.
Appendix 2 – Data Quality
The reporting of SDMD has changed since 2011/12 as a result of concerns regarding completeness and data quality. In particular, issues associated with specific NHS Boards (described in 2014/15 report) led to the following changes to national reporting.

- In 2012/13, the SDMD Annual Report included Scotland-level data on a limited range of indicators (overall numbers, gender and age of individuals assessed) in Section 1. A comparison between NHS Boards (except NHS Greater Glasgow & Clyde and Tayside) in relation to a wider range of indicators (illicit and prescribed drug use, injecting behaviour, health and socio demographics) was included in Section 2.

- In 2013/14, no SDMD Annual Report was published. An electronic dashboard showing NHS Board and ADP level comparisons across a comprehensive range of indicators (overall numbers, gender, age, illicit and prescribed drug use and injecting behaviour etc.) was produced. However, it was not possible to provide Scotland-level analyses for those indicators or 2013/14 data for NHS Greater Glasgow & Clyde and Tayside.

Following extensive collaborative work between NHS Boards and ISD, the quality and completeness of data improved sufficiently to allow publication of a full national 2014/15 SDMD Annual Report. As in 2014/15, Section 1 of the 2016/17 report provides an account of data quality and completeness, reflecting both the issues encountered in previous years and the UK Statistics Authority’s (UKSA) Guidelines on Administrative Data Quality Assurance (January 2015) which further emphasised the need to critically appraise the representativeness and reliability of administrative data. This Appendix provides further technical detail to accompany Section 1 along with a summary of ongoing data quality management work undertaken by ISD.

Data Completeness
In addition to the summary provided in Section 1, it is useful to provide a more detailed account of the SDMD-Drug and Alcohol Treatment Waiting Times (DATWT) comparison and the potential areas of bias.

Methodology
The comparison of SDMD and DATWT completeness does not involve data linkage and is based on numbers of individuals assessed for specialist drug treatment (not numbers of individuals treated). For each financial year, the following individual counts are compared:

Numerator = Number of individuals with initial assessment (IA) record on SDMD\(^{19}\)

Denominator = Number of individuals with drug-related wait record on DATWT\(^{20}\)

NHS Board/ADP area is assigned based on location of the service attended (may be different to individual’s area of residence). Therefore, records for individuals who live outside Scotland or have an unknown area of residence are included.

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\(^{19}\) With the following exclusions: SDMD records submitted by GPs; records listed in SDMD database as ‘logically deleted’; records with no submission date; SDMD records with no first and last name (or initial), no date of birth, and/or gender; records submitted by prison services.

\(^{20}\) With the following exclusions: SDMD records submitted by prison services, records with no assessment date.
Each individual is counted once within Scotland and NHS Board or ADP on the basis of the person identifiable information provided. Therefore, an individual will only be counted once within each geography/time period in spite of multiple valid drug waits/assessment. However, if an individual attended services in different NHS Board or ADP areas, this individual may be counted in more than one NHS Board or ADP. Only the most recent episode within each geography is counted in each Financial Year (i.e. 1 April to 31 March).

**NHS Board completeness findings**

Table A2.1: SDMD data completeness (compared to DATWT) by NHS Board of treatment (number of individuals\(^1,2\), 2016/17)

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<thead>
<tr>
<th>NHS Board of Treatment</th>
<th>Number of individuals on SDMD(^3)</th>
<th>Number of individuals on DATWT</th>
<th>Percentage SDMD completeness compared to DATWT</th>
<th>Percentage of anonymous records on DATWT</th>
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<tr>
<td>NHS Ayrshire &amp; Arran</td>
<td>816</td>
<td>1,147</td>
<td>71.1</td>
<td>12.0</td>
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<td>NHS Borders</td>
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<td>99.0</td>
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<td>NHS Dumfries &amp; Galloway</td>
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<td>NHS Fife</td>
<td>801</td>
<td>1,429</td>
<td>56.1</td>
<td>57.1</td>
</tr>
<tr>
<td>NHS Forth Valley</td>
<td>521</td>
<td>659</td>
<td>79.1</td>
<td>0.5</td>
</tr>
<tr>
<td>NHS Grampian</td>
<td>967</td>
<td>1,217</td>
<td>79.5</td>
<td>9.1</td>
</tr>
<tr>
<td>NHS Greater Glasgow &amp; Clyde</td>
<td>2,249</td>
<td>4,097</td>
<td>54.9</td>
<td>4.8</td>
</tr>
<tr>
<td>NHS Highland</td>
<td>190</td>
<td>515</td>
<td>36.9</td>
<td>29.3</td>
</tr>
<tr>
<td>NHS Lanarkshire</td>
<td>1,458</td>
<td>2,114</td>
<td>69.0</td>
<td>8.1</td>
</tr>
<tr>
<td>NHS Lothian</td>
<td>2,117</td>
<td>2,719</td>
<td>77.9</td>
<td>16.5</td>
</tr>
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<td>NHS Orkney</td>
<td>*</td>
<td>12</td>
<td>*</td>
<td>16.7</td>
</tr>
<tr>
<td>NHS Shetland</td>
<td>33</td>
<td>24</td>
<td>137.5</td>
<td>8.3</td>
</tr>
<tr>
<td>NHS Tayside</td>
<td>697</td>
<td>1,172</td>
<td>59.5</td>
<td>16.0</td>
</tr>
<tr>
<td>NHS Western Isles</td>
<td>33</td>
<td>32</td>
<td>103.1</td>
<td>9.4</td>
</tr>
<tr>
<td><strong>Scotland</strong></td>
<td><strong>10,322</strong></td>
<td><strong>15,590</strong></td>
<td><strong>66.2</strong></td>
<td><strong>14.5</strong></td>
</tr>
</tbody>
</table>

\(^*\) - suppressed due to small numbers.
1. Records submitted from prisons are excluded from this comparison.
2. Number of individuals on DATWT includes all anonymous drug waits. As each anonymous record in DATWT must be counted as a unique individual (there is no way to identify repeat clients), the number of individuals identified for comparison with SDMD may be slightly inflated.
3. Initial Assessments.
4. Scotland figure does not equal the sum of numbers reported for individual NHS Boards as a person can be counted in more than one board but only once in Scotland.

**Issues with comparison**

There are a number of potential explanations for lower relative completion of SDMD compared to DATWT.
In 2011, the Scottish Government established Health Improvement, Efficiency, Access and Treatment (HEAT) target A1, which stated 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. DATWT was implemented in 2011 to collect information on this target. Since then, SDMD completeness appears to have been comparatively low. It is possible that, in some areas, inputting data to demonstrate compliance with this target/standard may have been prioritised above SDMD data input.

SDMD requires that individuals provide informed consent for the collection and use of their identifiable data. However, DATWT allows anonymous records to be submitted, reducing the risk that individuals may not consent. This difference may have contributed to an increase in individuals withholding consent for their data to be recorded on SDMD.

The SDMD web system (introduced in 2009) helps avoid record duplication by allowing services to check if an SMR25 already exists. In the absence of comprehensive data on specialist drug treatment assessments in Scotland, SDMD completeness is measured against DATWT. Although DATWT provides a useful comparison, neither dataset accurately captures the entire population assessed for specialist drug treatment:

- As anonymous records are permitted in DATWT, it is not possible to identify the ‘true’ number of individuals assessed for specialist drug treatment. Details of the percentage of DATWT individuals with a 2016/17 drug wait who were recorded anonymously are included in Table A2.1. Without personal identifiers, each anonymous record in DATWT must be counted as a unique individual, potentially inflating the number of individuals for comparison with SDMD.

- DATWT and SDMD are separate systems which are managed separately and have different processes and procedures. Comparisons may be inexact due to differences in the service codes used in a small number of areas and differences in patient management processes (for example, a small number of ADPs triage individuals and then refer them to other services for assessment/treatment (in some cases, submitting DATWT data but no SDMD data)).

Comparisons between Area of Treatment and Area of Residence

The data quality and completeness analyses presented in this section of the report are based on the individual’s area of treatment (NHS Board or ADP) (i.e. the area where an individual was assessed for specialist drug treatment). Data quality and completeness is analysed this way because:

1. NHS Board/ADP treatment services submit SDMD data to ISD based on the patients they assess. Therefore, data quality and completeness issues can only be identified by evaluating records on the basis of NHS Board/ADP of treatment. Likewise, data quality and completeness issues are addressed in communication between ISD and the NHS Board/ADP submitting those records.

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21 After March 2013, this became a HEAT standard, and, from 2015/16, a Local Delivery Plan (LDP) Standard for NHS Boards.

22 However, even after excluding all anonymous DATWT records (therefore assuming that all anonymous individuals in DATWT had a further drug wait in the same area in 2016/17 where they consented to their personal details being recorded), national SDMD completeness was still only around 78% compared to DATWT.
2. Specialist drug treatment waiting times from DATWT are reported by area of treatment only. Therefore, analysis of SDMD data quality and completeness by area of treatment facilitates use of DATWT data for comparisons in terms of completeness, representativeness etc.

However, an individual may be assessed for treatment outwith the NHS Board or ADP in which they reside. The key SDMD findings presented in Section 2 are based on analysis by area of residence because this is thought to be of most value to the users of these statistics. In order for data quality and completeness findings from Section 1 to function as measures of the reliability of findings in Section 2, there should be a high degree of correspondence between the SDMD treatment and resident populations. Table A2.2 shows the correspondence between area of treatment and area of residence by NHS Board.

In all except three ADPs, over 90% of individuals assessed were also resident in the same area (data not shown). Two of the three ADPs where the overlap between individuals assessed and resident was lower than 90% (Clackmannanshire and Stirling) together constitute the part of NHS Forth Valley (where 99.6% of individuals assessed were resident). NHS Forth Valley operates a pan-Board service structure resulting in movement of service users between ADP services to receive specialist drug treatment. This local arrangement provides an explanation of the comparatively low percentage of residents treated in each of the relevant ADP areas.

Table A2.2: Percentage of individuals assessed resident in the same NHS Board of treatment (2016/17)

<table>
<thead>
<tr>
<th>NHS Board of Treatment</th>
<th>Number of individuals assessed</th>
<th>% Individuals resident</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS Ayrshire &amp; Arran</td>
<td>816</td>
<td>98.8</td>
</tr>
<tr>
<td>NHS Borders</td>
<td>200</td>
<td>97.5</td>
</tr>
<tr>
<td>NHS Dumfries &amp; Galloway</td>
<td>277</td>
<td>99.3</td>
</tr>
<tr>
<td>NHS Fife</td>
<td>800</td>
<td>99.9</td>
</tr>
<tr>
<td>NHS Forth Valley</td>
<td>521</td>
<td>99.6</td>
</tr>
<tr>
<td>NHS Grampian</td>
<td>967</td>
<td>99.9</td>
</tr>
<tr>
<td>NHS Greater Glasgow &amp; Clyde</td>
<td>2249</td>
<td>98.0</td>
</tr>
<tr>
<td>NHS Highland</td>
<td>190</td>
<td>99.5</td>
</tr>
<tr>
<td>NHS Lanarkshire</td>
<td>1457</td>
<td>99.6</td>
</tr>
<tr>
<td>NHS Lothian</td>
<td>2117</td>
<td>99.6</td>
</tr>
<tr>
<td>NHS Orkney</td>
<td>*</td>
<td>100.0</td>
</tr>
<tr>
<td>NHS Shetland</td>
<td>33</td>
<td>100.0</td>
</tr>
<tr>
<td>NHS Tayside</td>
<td>696</td>
<td>99.7</td>
</tr>
<tr>
<td>NHS Western Isles</td>
<td>33</td>
<td>97.0</td>
</tr>
</tbody>
</table>

"*" - suppressed due to small numbers.

1. Individuals assessed in prison were excluded from this analysis as they are counted within an area of residence based on their home postcode and are therefore not analysed as a distinct group in Section 2 of this report.
SDMD Data Management
Positive relationships with data suppliers and robust data quality assurance are crucial in ensuring the integrity of SDMD data. The ISD Data Management team examines data quality and completeness issues in specific areas and documents these in order to understand data and assess the likelihood and impact of inaccurate reporting.

Ongoing Data Quality Work
In addition to working with specific areas, the ISD Data Management team routinely provide data suppliers with a range of monthly and biannual surveillance reports to assist them in improving the completeness and quality of SDMD data.

During 2016/17 ISD Data Management continued to identify services that remained active on the SDMD system, although they had been physically decommissioned. All services decommissioned in 2016 or 2017 were removed from the system.

Compliance and Initial Assessment-12 Week Follow-up reports have now been issued for two years and have helped to increase compliance with data submission processes and data quality across all SDMD submissions.

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23 The routine surveillance reports to NHS Boards/ADPs provide information on all SMR25 records submitted to ISD. However, this Annual Report presents information on individuals with problem drug use and therefore cannot be compared with those outputs.
Appendix 3 – Publication Metadata

<table>
<thead>
<tr>
<th>Metadata Indicator</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Publication title</td>
<td>Scottish Drug Misuse Database - Overview of Initial Assessments for Specialist Drug Treatment 2016/17</td>
</tr>
<tr>
<td>Description</td>
<td>This publication presents the latest available information on initial assessments for specialist drug treatment recorded in the Scottish Drug Misuse Database (SDMD). Information is presented for Scotland and by NHS Board/Alcohol and Drug Partnership (ADP) of Residence.</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 electronic dashboard</td>
</tr>
<tr>
<td>Data source(s)</td>
<td>Scottish Drug Misuse Database (SDMD), Drug and Alcohol Treatment Waiting Times database (DATWT)</td>
</tr>
<tr>
<td>Date that data are acquired</td>
<td>Extracted September 2017</td>
</tr>
<tr>
<td>Release date</td>
<td>Tuesday 26 June 2018</td>
</tr>
<tr>
<td>Frequency</td>
<td>Annual</td>
</tr>
<tr>
<td>Timeframe of data and timeliness</td>
<td>Data published up to 31 March 2017</td>
</tr>
<tr>
<td>Continuity of data</td>
<td>See Section 1, Appendix 1 and Appendix 2.</td>
</tr>
<tr>
<td>Revisions statement</td>
<td>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.</td>
</tr>
<tr>
<td>Revisions relevant to this publication</td>
<td>A number of revisions have been made from the last publication. The revisions in this publication are also applied to findings which relate to previous years.</td>
</tr>
<tr>
<td></td>
<td>- The drug ‘Gabapentin’ is included in the category ‘other drugs’. In previous reports it was incorrectly included within the ‘Mephedrone’ category. This change impacts all drug-related indicators within the domains Drug profile and Prescribed drug profile. Eight illicit drug records and 26 prescribed drug records in the period 2010/11 to 2015/16 were affected by this change.</td>
</tr>
<tr>
<td></td>
<td>- The drug ‘Morphine’ is included in the category ‘other opiates’. In previous reports it was incorrectly omitted from this category. This change impacts all drug-related indicators within the domain Prescribed drug profile. 16 prescribed drug records in the period 2010/11 to 2015/16 were affected by this change.</td>
</tr>
<tr>
<td>Concepts and definitions</td>
<td>Guidance on definitions for SDMD is available at: <a href="http://www.isdscotland.org/Health-Topics/Drugs-and-Alcohol-">http://www.isdscotland.org/Health-Topics/Drugs-and-Alcohol-</a></td>
</tr>
<tr>
<td><strong>Relevance and key uses of the statistics</strong></td>
<td>Relevant to understanding problem drug use in Scotland. Statistics will be used for policy making and service planning.</td>
</tr>
<tr>
<td><strong>Accuracy</strong></td>
<td>Quality checks are conducted by ISD. Figures are compared to previously published data and expected trends. Data quality &amp; completeness issues are described in Section 1 and Appendix 2.</td>
</tr>
<tr>
<td><strong>Completeness</strong></td>
<td>It is not mandatory for individuals to provide their information in the collection of data through SDMD. Data quality &amp; completeness issues are described in Section 1. See Appendix 2 for further information.</td>
</tr>
<tr>
<td><strong>Comparability</strong></td>
<td>Data quality &amp; completeness issues are described in Section 1. See Appendix 2 for further information.</td>
</tr>
<tr>
<td><strong>Accessibility</strong></td>
<td>It is the policy of ISD Scotland to make its web sites and products accessible according to published guidelines.</td>
</tr>
<tr>
<td><strong>Coherence and clarity</strong></td>
<td>The report is available as a PDF file with relevant dashboard content clearly highlighted for ease of use.</td>
</tr>
<tr>
<td><strong>Value type and unit of measurement</strong></td>
<td>Numbers and percentages.</td>
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<td><strong>Disclosure</strong></td>
<td>The ISD protocol on Statistical Disclosure Protocol is followed.</td>
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<tr>
<td><strong>Official Statistics designation</strong></td>
<td>National Statistics</td>
</tr>
<tr>
<td><strong>Last published</strong></td>
<td>4 April 2017</td>
</tr>
<tr>
<td><strong>Next published</strong></td>
<td>Spring 2019</td>
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<td><strong>Date of first publication</strong></td>
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<td><strong>Help email</strong></td>
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</tr>
<tr>
<td><strong>Date form completed</strong></td>
<td>16 May 2018</td>
</tr>
</tbody>
</table>
Appendix 4 – Early access details

Pre-Release Access

Under terms of the "Pre-Release Access to Official Statistics (Scotland) Order 2008", ISD is 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.

Standard Pre-Release Access:
Scottish Government Health Department
NHS Board Chief Executives
NHS Board Communication leads
Appendix 5 – 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 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.