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Introduction

This release by Information Services Division reports on hospital stays in relation to a drug misuse diagnosis. This report describes the number of drug-related hospital stays, the number and characteristics of patients admitted to hospital, the substances involved and the geographical variations within Scotland. This includes information on inequalities and some of the health impacts of drug misuse.

Definition change

During October and November 2018, ISD conducted a customer consultation about a proposed change in the definition of a drug-related hospital stay to include admissions due to drug poisoning/overdose. This proposed change would widen the range of stays captured in these statistics in order to measure drug-related hospital activity more comprehensively.

Responses to the consultation (summarised here) indicated that users agreed with the proposed change. Therefore, hospital admissions resulting from drug poisoning/overdose are included within the definition of a drug-related hospital stay reported in these statistics. In this report and the dashboard, drug poisonings/overdoses and mental & behavioural stays are reported as separate Clinical Types. Appendix 2 provides further information about these clinical types, along with further information about the definition change and a description of its impact on the figures reported in these statistics.

Data used in this report

This report includes information on inpatients and day cases discharged from general acute and psychiatric specialties in Scotland, where drug misuse was mentioned in the records at some point during the patient’s hospital stay. The information reported in this publication has been collated using data obtained from the following sources:

- General acute inpatient and day case records (SMR01), years 1996/97 to 2017/18; and,
- Psychiatric inpatient and day case records (SMR04), years 1996/97 to 2017/18.

Due to more timely reporting of psychiatric hospital data, it is now possible to report information up to the most recent available financial year (2017/18) from both the SMR01 and SMR04 datasets, along with trends from 1996/97. A section on combined general acute and psychiatric stays is also included in order to provide a more comprehensive description of hospital stays relating to drug misuse. Further background information is available in Appendix 1.

Dashboard

In order to promote accessibility and user engagement with these statistics, data from this report are visualised in a new Drug-Related Hospital Statistics dashboard. This is available via the ISD website from the dashboard page.

Terminology

Within this report, sometimes the use of technical/statistical terms (e.g. opioids, stays, ‘New patients’) is unavoidable. For further explanation of these terms, please refer to the Glossary.
Main Points

- Over the past 20 years, there was a fourfold increase in the rate of drug-related general acute hospital stays (from 51 to 199 stays per 100,000 population), with a sharper increase observed in recent years.

- After a lengthy period of stability, the rate of drug-related psychiatric stays increased from 29 to 40 stays per 100,000 population between 2014/15 and 2016/17, before decreasing slightly in 2017/18 (38).

- Stays among individuals aged 35 and over increased over the past 20 years. Individuals aged 35-44 years were most common among drug-related patients in general acute and/or psychiatric hospitals. Drug-related general acute patient rates for this group increased more than tenfold from 37 to 399 patients per 100,000 population between 1996/97 and 2017/18.

- In 2017/18, 58% of drug-related general acute hospital stays were due to opioids (drugs similar to heroin) while 51% of drug-related psychiatric hospital stays were associated with ‘multiple/other’ drugs (including hallucinogens, volatile solvents, multiple drug use and use of other psychoactive substances (e.g. ecstasy)).

- In 2017/18, approximately half of the patients with a drug-related general acute or psychiatric hospital stay lived in the most deprived areas in Scotland.

- Since peaking in 1999/00 (276 patients per 100,000 population), drug-related general acute/psychiatric patient rates for 15-24 year olds decreased to 126 in 2012/13, but have since increased to 190 in 2017/18. The 2017/18 patient rate for this age group was the highest recorded since 2004/05 (204 patients per 100,000 population).
Results and Commentary

Following a public consultation on a proposed change in the definition of a drug-related hospital stay, hospital admissions resulting from drug poisoning/overdose are reported in this publication for the first time. Therefore the figures reported in these statistics will not be comparable with the figures reported in previous publications.

This report mainly focuses on the new definition of a drug-related hospital stay (combined drug poisonings/overdoses and mental & behavioural stays). However, in the accompanying dashboards, it is possible to analyse drug poisonings/overdoses and mental & behavioural stays as separate Clinical Types. Appendix 2 provides further information about these clinical types, along with further information about the definition change and a description of its impact on the figures reported in these statistics.

Statistical disclosure control has been applied to protect patient confidentiality. Therefore, the figures presented in these statistics may not be additive and may differ to those reported in previous publications.

Throughout this section, we make reference to ‘stays’, ‘patients’ and ‘new patients’. A ‘stay’ refers to a continuous period of time spent in a hospital setting. A ‘patient’ is an individual admitted to hospital. Each patient may have more than one stay within a financial year. A ‘new patient’ is an individual who has not had a similar drug-related stay in hospital within the previous ten years.

Patient deprivation quintiles are referred to throughout the report. Quintiles divide the population into five equal groups so that 20% of the population of Scotland falls into each quintile (deprivation quintile 1 is the most deprived, deprivation quintile 5 is the least deprived). Small geographical areas are assigned to quintiles based upon the Scottish Index of Multiple Deprivation (SIMD) which calculates deprivation rates with reference to a range of social and economic indicators.

Further background information and a comprehensive list of revisions to this publication is available in Appendix 1.

For further explanations of technical terms, please refer to the Glossary.
1. **General acute**

In 2017/18, there were 10,509 drug-related general acute hospital stays. These stays related to 7,986 patients and of these, 4,323 (54%) were ‘new’ patients.

**Stays**

In 2017/18, the European Age-Sex Standardised Rate (EASR, hereafter referred to as ‘rate’) of drug-related general acute hospital stays was 199 stays per 100,000 population, the highest rate yet recorded. This rate was approximately four times higher than the rate in 1996/97 (51 stays per 100,000 population). Apart from a period of stability from 2003/04 to 2006/07, there has been a general upward trend over time, with a sharper increase observed in recent years (Figure 1.1).

*Figure 1.1: Drug-related general acute hospital rates‡ (Scotland; 1996/97 to 2017/18)*

Drug-related general acute hospital stay rates varied by NHS Board (Figure 1.2). In 2017/18, the highest rates were seen in Ayrshire & Arran (352 stays per 100,000 population), Greater Glasgow & Clyde (268) and Fife (248). Among mainland NHS Boards, the lowest rate was observed in Grampian (118).
Figure 1.2: Drug-related general acute stay† rates‡, by NHS Board of Residence (Scotland; 2017/18p)

Clinical type
In 2017/18, of the 10,509 drug-related general acute hospital stays in Scotland, 9,450 (90%) included a drug-related mental & behavioural diagnosis and 1,791 (17%) stays contained a drug poisoning/overdose diagnosis (Figure 1.3a). These are not mutually exclusive groupings and a total of 732 (7%) drug-related general acute hospital stays included a diagnosis of both clinical types (i.e. a mental & behavioural diagnosis and a drug poisoning/overdose diagnosis).
The 2017/18 rate of drug-related general acute hospital mental & behavioural stays (179 stays per 100,000 population) was approximately four and a half times higher than the rate in 1996/97 (40). Apart from a period of stability from 2001/02 to 2005/06 and a decrease in 2012/13 (108 stays per 100,000 population) the trend was generally upward over time (Figure 1.3b).

In 2017/18, the rate of general acute drug poisoning/overdose stays (34 stays per 100,000 population) was slightly more than twice the rate in 1996/97 (15). Unlike for drug-related mental & behavioural stays, the overdose stay rate fluctuated over time, varying largely within the range of 20 to 25 stays per 100,000 population between 1999/2000 and 2015/16, before increasing considerably in each subsequent year (Figure 1.3b).
Figure 1.3b: Drug-related general acute stay† rates‡, by clinical type (Scotland; 1996/97 to 2017/18)

† See Glossary for definitions of stays, patients and new patients.
p Provisional.
Source: General acute inpatient/day case records (SMR01).

**Drug type**

In 2017/18, opioid-related general acute hospital stay rates (118 per 100,000 population) were over five and half times the rate in 1996/97 (21) (Figure 1.4). Apart from a notable decrease in 2012/13 (possibly as a consequence of the 'heroin drought' of 2010/11), the increasing trend in opioid-related stay rates has been fairly consistent. Explanations for this increase include:

- In the period from 1996/97 to 2006/07, the increase in opioid stays was accompanied by a decrease in hospital stays involving ‘multiple/other drugs’§. The percentage of stays involving ‘multiple/other drugs’ decreased from 42% (1,239) in 1996/97, to 18% (975) in 2006/07 and has remained fairly stable since then (1,842 (18%) in 2017/18). In contrast, the percentage of stays due to opioids increased from 41% (1,212) in 1996/97 to 64% (3,543) in 2006/07 (later peaking at 70% (4,893) in 2010/11). Efforts to improve the accuracy of diagnosis coding are thought to be partially responsible for increasing opioid-related general acute hospital stays during this period.

- A long-term rise in opioid-related mental & behavioural general acute hospital stays (from 13 per 100,000 population in 1996/97 to 107 in 2017/18) has occurred as individuals who have used opioids since the 1980s and 1990s experience greater ill-health from a range of conditions.

The ‘multiple/other’ general acute stay rate decreased markedly from 2000/01 (35 stays per 100,000 population) to 2005/06 (18). The rate then remained fairly stable until 2011/12 (20), since when it has increased to the same rate observed in 2000/01 (2017/18: 35).
Although numbers and rates of opioid-related general acute hospital stays have continued to increase (sharply since 2012/13), the percentage of drug-related stays due to opioids decreased from 2010/11 (4,893, 70%) to 2017/18 (6,114, 58%). This change was associated with increases in stays due to illicit substances other than opioids or ‘multiple/other drugs’ since the early 2010s.

- Sedative/hypnotic-related general acute stay rates increased more than threefold from 8 to 28 per 100,000 population between 2010/11 and 2017/18. The percentage of stays involving sedatives/hypnotics doubled from 7% (456) to 14% (1,461) over the same period. Compared to other drug types, sedatives/hypnotics stays included the largest percentage classified as overdoses (51% (234) in 2010/11 and 35% (417) in 2017/18).

- Cannabinoid-related general acute stay rates more than doubled from 11 to 25 per 100,000 population between 2010/11 and 2017/18. The percentage of stays involving cannabinoids increased from 9% (600) to 13% (1,365) over the same period.

- Cocaine-related general acute stay rates more than doubled from 8 to 21 per 100,000 population between 2010/11 and 2017/18. The percentage of stays involving cocaine increased from 6% (432) to 11% (1,140) over the same period.

- The rate of general acute stays involving ‘other stimulants’ increased from 5 to 12 stays per 100,000 population between 2010/11 and 2014/15, before decreasing to 8 per 100,000 population in 2016/17 and 2017/18. In percentage terms, 4% (273) of general acute stays were related to ‘other stimulants’ in 2010/11, compared to 8% (666) of stays in 2014/15 and 4% (435) of stays in 2017/18.
The changing pattern of stays associated with ‘other stimulants’ is highly likely to have been associated with increases in the availability and use of ‘New’ or ‘Novel’ Psychoactive Substances (NPS) and the subsequent introduction of legislation to control their sale and supply (Psychoactive Substances Act 2016). However, it is noted that the number and rate of hospital stays associated with sedative/hypnotics, which includes new or unlicensed benzodiazepines (for example, etizolam) similarly controlled by the Psychoactive Substances Act 2016, has not reduced.

**Type & length of stay**

In 2017/18, 95% (9,987) of drug-related general acute stays were as a result of an emergency admission rather than a planned (i.e. elective) admission to hospital. Individuals aged under 15 years and 15-24 years (both 97%) had the highest percentages of general acute stays following emergency admission, while individuals aged 55-64 years and 65 years or over had the lowest percentages (both 91%).

General acute stays associated with sedatives/hypnotics (98%), cocaine (97%) and ‘other stimulants’ (97%) most often involved emergency admission. Though still very high, stays associated with cannabinoids (92%) included the lowest percentage admitted as an emergency.

Ninety-eight per cent of general acute stays associated with overdose involved emergency admission, compared with 95% of drug-related mental & behavioural stays. All heroin, cocaine and cannabinoid overdoses (both 100%) were admitted as emergencies.

In 2017/18, the majority of drug-related general acute hospital stays (8,943, 85%) were for less than one week. Older patients were more likely to have longer stays. Fifty-two per cent of patients aged 65 or over stayed more than one week compared with no patients aged under 15.

Fifteen per cent of mental & behavioural general acute hospital stays were for more than one week compared with 11% of overdose stays. Six per cent of opioid overdose stays were for more than one week.
Patients

In 2017/18, the drug-related general acute hospital patient rate was 151 patients per 100,000 population. This was the highest rate yet recorded – just over three and a half times the patient rate in 1996/97 (42 patients per 100,000 population). There was a close correspondence between changes in the stay and patient rates over time. Generally, locations with the highest/lowest stay rates also had similarly high or low patient rates.

In 2017/18, the number of general acute stays per patient was 1.3. Individuals aged 45-54 years had the highest number of stays per patient (1.4).

Sex

In 2017/18, 71% of patients who had a drug-related general acute hospital stay were males (5,592, rate: 213 patients per 100,000 population) (females: 2,394, rate: 88 patients per 100,000 population). Between 1996/97 and 2017/18, the number and patient rate for males was consistently more than double the value for females. Male and female patient rates both followed similar trends, each increasing more than threefold over the time series.

Deprivation

Patients from more deprived areas were more likely to experience a drug-related general acute hospital stay. In each year in the time series, approximately half of patients with a drug-related general acute stay have lived in the 20% most deprived areas in Scotland (Deprivation quintile 1). In 2017/18, 52% of patients (4,185: 394 per 100,000 population) lived in Deprivation quintile 1.

Drug-related general acute patient rates increased for all deprivation quintiles from 1996/97 to 2017/18. The majority of patients lived in the most deprived areas (deprivation quintile 1), where drug-related patient rates increased from 111 to 394 patients per 100,000 population.

For deprivation quintile 1, there has been a sharp increase in rates since 2012/13 (229 patients per 100,000 population). However, the largest percentage increase in rate over the entire time series was observed in quintile 2 (from 44 to 184 patients per 100,000 population between 1996/97 and 2017/18) (Figure 1.5).
Figure 1.5: Drug-related general acute patient† rates‡, by deprivation* quintile (Scotland; 1996/97 to 2017/18p)

† See Glossary for definitions of stays, patients and new patients.
* For an explanation of deprivation measures (Scottish Index of Multiple Deprivation), see Glossary.
p Provisional.
Source: General acute inpatient/day case records (SMR01).

Age group
The highest drug-related general acute hospital patient rate in 2017/18 was observed among individuals aged 35-44 years (399 patients per 100,000 population) (Figure 1.6a).

There have been some fluctuations in the drug-related general acute hospital patient rate over time, with patient rates for individuals aged under 35 years showing a different pattern to rates for those aged 35 and over:

- For 15-24 year olds, rates peaked at around 200 patients per 100,000 population between 1998/99 and 2002/03 (when this was the most common age group), decreasing to 105 in 2012/13 before increasing to 158 in 2017/18.
- For 25-34 year olds, there was a fluctuating increasing trend from 121 to 317 patients per 100,000 population between 1996/97 and 2008/09, before a decrease to 236 in 2012/13 and an increase to 273 in 2017/18. From 1999/00 to 2011/12, individuals aged 25-34 years were most prevalent among drug-related general acute hospital patients.

In contrast, patient rates among most older age groups increased consistently over the time series:

- For 35-44 year olds, rates increased from 37 patients per 100,000 population in 1996/97 to 399 in 2017/18 (more than ten times higher). Since 2013/14, individuals aged 35-44 years have been most prevalent among drug-related hospital patients.
- For 45-54 year olds, rates increased from 12 patients per 100,000 population in 1996/97 to 208 in 2017/18 (more than 17 times higher).
For 55-64 year olds, rate increases were observed slightly later in the time series, increasing from 6 patients per 100,000 population in 2002/03 to 61 in 2017/18 (approximately a tenfold increase in the past 15 years).

**Figure 1.6a: Drug-related general acute patient† rates‡, by age group (Scotland; 1996/97 to 2017/18p)**

The patterns in patient rates observed above clearly demonstrate the ageing profile of drug-related hospital patients. In order to illustrate this more clearly, Figure 1.6b shows drug-related general acute patient rates for two age categories only (individuals aged under 35 years and those aged 35 years and over). Rates for those aged under 35 years increased at the beginning of the time series and (with the exception of the period from 2012/13 to 2014/15) have fluctuated mainly between 120 to 150 patients per 100,000 population since 1998/99 (2017/18: 135 patients per 100,000 population). Rates among individuals aged 35 years and over have increased consistently throughout the time series, from 15 in 1996/97 to 161 in 2017/18 (over a tenfold increase) (Figure 1.6b (data not available in dashboard)).
Figure 1.6b: Drug-related general acute patient† rates‡, by age group (Scotland; 1996/97 to 2017/18p)

† See Glossary for definitions of stays, patients and new patients.

Source: General acute inpatient/day case records (SMR01).

Drug type

In 2017/18, 56% (4,458) of all drug-related general acute hospital patients had a stay in relation to opioids and 21% (1,647) had a stay in relation to ‘multiple/other’ drugs.

Opioid-related stays accounted for the highest percentage of stays (up to 71% (1,863) for patients aged 35-44 years) in all but the oldest and two youngest age groups, where the following patterns were observed:

- Among under 15s, 45% of patients had a stay in relation to ‘other stimulants’, followed by cannabinoids (38%) and ‘multiple/other drugs’ (21%).
- Among 15-24 year olds, 31% of patients had a stay in relation to cocaine, followed by cannabinoids (28%) and ‘multiple/other drugs’ (23%).
- Among those aged 65 and over, 59% of patients had a stay in relation to ‘multiple/other drugs’.

Financial Year

EASR per 100,000 population
New patients

Patients were classed as ‘new’ patients if they had not had a similar drug-related stay in hospital within the previous ten years. In 2017/18, the new patient rate for drug-related general acute hospital stays was 80 new patients per 100,000 population. The drug-related general acute new patient rate has increased since 2006/07 (49 new patients per 100,000 population). However, much of this rate increase has occurred since 2012/13 (52). In 2006/07, 60% of drug-related general acute hospital patients were classed as ‘new’, this percentage had decreased to 54% in 2017/18.

By NHS Board area, drug-related new patient rates were highest in Ayrshire & Arran (108 new patients per 100,000 population), Greater Glasgow & Clyde (107) and Lanarkshire (100), while the lowest rate among the mainland areas was observed in Grampian (45).

Sex

In 2017/18, 71% of new drug-related general acute patients were males (3,081, rate: 116 new patients per 100,000 population) (females: 1,239, rate: 45).

Age group

In 2017/18, the highest drug-related general acute hospital new patient rate was observed among individuals aged 35-44 years (167 new patients per 100,000 population).

As with patient rates, trends in drug-related general acute new patient rates were different among individuals aged under 35 years compared with individuals aged 35 and over:

- For individuals aged 15-24 years and 25-34 years, new patient rates each decreased to their lowest point in 2012/13 (84 and 116 new patients per 100,000 population respectively) and have since increased fairly consistently (to 138 and 145 respectively).
- For individuals aged 35-44, 45-54, or 55-64 years, new patient rates showed consistent increases across the time series from 2006/07 to 2017/18. The largest increase in new patient rates was observed among individuals aged 55-64 years (9 new patients per 100,000 population in 2006/07 to 39 in 2017/18 – more than four times higher).

Drug type

In 2017/18, the highest drug-related new patient rate was for opioids (31 per 100,000 population (37% of new patients)), followed by cannabinoids (17 (21% of new patients)) and ‘multiple/other’ drugs (16 (20% of new patients)). The largest new patient rate increases were observed for sedatives/hypnotics (increasing from 3 per 100,000 population (7% of new patients) in 2006/07 to 11 in 2017/18 (13% of new patients)) and cannabinoids (increasing from 7 per 100,000 population (14% of new patients) in 2006/07 to 17 in 2017/18).

Although ‘opioids’ had the highest drug-related new patient rate in 2017/18, due to the high number of opioid patients (4,458 overall) relative to other drug types, the opioid patient group included the lowest percentage of ‘new’ patients (1,611, 36%) compared to other drugs. The drug types with the highest percentages of ‘new’ patients were:

- Other stimulants (78%: 312 new patients/402 patients);
- Cannabinoids (75%: 918 new patients/1,221 patients); and,
- Cocaine (69%: 720 new patients/1,044 patients).
2. Psychiatric

In 2017/18, there were 1,989 drug-related psychiatric hospital stays. These stays related to 1,731 patients and of these, 1,143 (66%) were ‘new’ patients.

Stays

In 2017/18, the rate of psychiatric hospital stays with a diagnosis of drug misuse was 38 stays per 100,000 population, a small decrease compared to 2016/17 (40). Rates have fluctuated over the time series, with two periods of relative stability from 1998/99 to 2005/06 and from 2006/07 to 2014/15. There was a sharp increase between 2014/15 (29 stays per 100,000 population) and 2016/17 (40), when the highest rate was recorded (Figure 2.1).

Figure 2.1: Drug-related psychiatric hospital rates†‡ (Scotland; 1996/97 to 2017/18p)

† Uses European Standard Population 2013 and National Records of Scotland 2017 mid-year population estimates.
‡ See Glossary for definitions of stays, patients and new patients. For new patient rates, the period from 1996/97 to 2005/06 is excluded due to diagnostic coding changes that affect the ten-year look back of psychiatric (SMR04) hospital records required for calculation. See endnote 2 for further details.

p Provisional.

Source: Mental health inpatient/day case records (SMR04).
Figure 2.2 illustrates the variance of drug-related psychiatric stay rates by NHS Board. In 2017/18, the highest rates were seen in Ayrshire & Arran (57 stays per 100,000 population), Greater Glasgow & Clyde (51) and Forth Valley (49). Among mainland NHS Boards, the lowest rate was observed in Grampian (19).

**Figure 2.2: Drug-related psychiatric stay† rates‡, by NHS Board of Residence (Scotland; 2017/18)**

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<thead>
<tr>
<th>NHS Board of Residence</th>
<th>EASR per 100,000 population</th>
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<td>Ayrshire &amp; Arran</td>
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<tr>
<td>Shetland</td>
<td>14</td>
</tr>
</tbody>
</table>

† See Glossary for definitions of stays, patients and new patients.
p Provisional.
Source: Mental health inpatient/day case records (SMR04).

**Clinical type**

The inclusion of hospital stays with a drug poisoning/overdose diagnosis had little impact on the number of drug-related psychiatric hospital stays reported in these statistics. In 2017/18, all of the 1,989 drug-related psychiatric hospital stays in Scotland included a mental & behavioural diagnosis. Only three stays (0.2%) included a drug poisoning/overdose diagnosis (as the clinical types are not mutually exclusive these were also counted in the mental & behavioural diagnosis figures). This pattern was consistent over time. Fewer than 1% of drug–related psychiatric hospital stays between 1997/98 and 2017/18 included a drug poisoning/overdose diagnosis.

**Drug type**

‘Multiple/other’5 drugs have consistently been associated with the highest rate and percentage of drug-related psychiatric hospital stays (Figure 2.3). In 2017/18, the rate of psychiatric hospital stays associated with ‘multiple/other’ drugs was 19 per 100,000 population, slightly lower than the rate observed in 2016/17 (20). Rate increases observed from 2014/15 to 2016/17 were preceded by a lengthy period of mainly decreasing rates since the previous high in 2002/03 (18). Throughout the time series, ‘multiple/other’ drugs have
been reported in approximately 50% to 60% of drug-related psychiatric stays (2017/18: 1,023; 51%).

In 2017/18, the rate of psychiatric hospital stays associated with opioids was 11 per 100,000 population, a small decrease compared to the rate in 2016/17 (13). The rate of opioid-related psychiatric stays fell from 10 per 100,000 population in 2001/02 to 6 per 100,000 population in 2006/07, before a consistent upward trend to 2016/17 (13 per 100,000 population). In 2017/18, 28% of psychiatric stays (558, 28%) were associated with opioids, a large decrease since 2013/14 (561, 39%), when the highest percentage of opioid-related psychiatric hospital stays was recorded.

**Figure 2.3: Drug-related psychiatric stay† rates‡, by drug type* (Scotland; 1996/97 to 2017/18p)**

![Graph showing drug-related psychiatric stay rates by drug type from 1996/97 to 2017/18](image)

† See Glossary for definitions of stays, patients and new patients.
* For an explanation of the drug types referred to, see endnotes 5 and 7 and Glossary.

The rate of cannabinoid-related psychiatric stays was 6 stays per 100,000 population, a small decrease since 2016/17 (7). The higher cannabinoid stay rates observed since 2015/16 follow a nine-year period of lower rates (around 2 per 100,000 population from 2006/07 to 2014/15). Cannabinoids were associated with 16% (324) of drug-related psychiatric stays in 2017/18 compared to 9% (129) in 2014/15. The large rate and percentage increases observed since 2015/16 may be associated with the use of synthetic cannabinoids.

The rate of sedative/hypnotic-related psychiatric stays decreased from 3 per 100,000 population in 1997/98 to 1 in 2007/08, but has increased in recent years (peaking at 4 in 2016/17). In 2017/18, the rate of sedative/hypnotic-related psychiatric stays was 3 per
100,000 population and these drugs were associated with 9% (177) of drug-related psychiatric stays.

**Type & length of stay**

In 2017/18, two thirds (1,341; 67%) of drug-related psychiatric stays were as a result of an emergency admission rather than a planned (i.e. elective) admission. Individuals aged 15-24 had the highest percentage of psychiatric stays that were an emergency admission (78%), while 55-64 year olds had the lowest percentage of emergency admissions (52%).

The drugs most likely to be involved in emergency psychiatric admissions were cannabinoids (77%), followed by ‘other stimulants’ and ‘multiple/other’ drugs (both 74%).

In contrast to general acute stays, a larger percentage of drug-related psychiatric stays (1,362; 68%) were for one week or more. Older patients were more likely to have longer drug-related psychiatric stays: 83% of patients aged 65 and over stayed for one week or more compared with 63% of patients aged 15-24.

The highest percentage of drug-related psychiatric stays of one week or more were observed in relation to cannabinoids (76%) and ‘multiple/other’ drugs (69%).
Patients

In 2017/18, the drug-related psychiatric patient rate was 33 patients per 100,000 population, slightly lower than in 2016/17 (34) when the highest rate was observed. Fluctuations over time in the drug-related psychiatric patient rate and the sharp increase observed since 2014/15 (25 patients per 100,000 population) corresponded closely with changes in the stay rate. Generally, areas with the highest/lowest stay rates also had similarly high or low patient rates. In 2017/18, the number of psychiatric stays per patient was 1.2.

Sex

In 2017/18, 71% of patients who had a drug-related psychiatric stay were males (1,233; rate: 47 patients per 100,000 population) (females: 498; rate: 19 patients per 100,000 population). The numbers and rates of males were approximately double that of females throughout the time series.

Deprivation

Patients from more deprived areas were more likely to have a drug-related psychiatric stay. In 2017/18, approximately half (855, 49%) of drug-related psychiatric patients lived in the 20% most deprived areas in Scotland (quintile 1). This finding was consistent across the time series, with between 46% and 52% of patients with a drug-related psychiatric stay living in the most deprived communities. In 2017/18, the drug-related psychiatric patient rate for the most deprived quintile (quintile 1) was 79 patients per 100,000 population (Figure 2.4).

**Figure 2.4: Drug-related psychiatric patient† rates‡, by deprivation* quintile (Scotland; 1996/97 to 2017/18³)**

† See Glossary for definitions of stays, patients and new patients.
* For an explanation of deprivation measures (Scottish Index of Multiple Deprivation), see Glossary.
³ Provisional.
Source: Mental health inpatient/day case records (SMR04).
For most deprivation quintiles, drug-related psychiatric patient rates showed a consistent upward trend between 2013/14 and 2016/17, when all rates reached their highest recorded levels. Small decreases in patient rates were observed for all deprivation quintiles in 2017/18 compared to 2016/17.

**Age group**
The highest drug-related psychiatric patient rate in 2017/18 was observed among individuals aged 35-44 years (90 patients per 100,000 population) (Figure 2.5a).

Drug-related psychiatric patient rates for almost all age groups increased from 2014/15 to 2016/17. In 2017/18, a small decrease in patient rates was observed for many age groups compared to 2016/17. Similarly to general acute hospital data, drug-related psychiatric hospital patient rates for individuals aged under 35 years showing a different pattern to rates for those aged 35 years and over:

- For 15-24 year olds, rates peaked at 78 patients per 100,000 population in 1999/2000 and decreased gradually to 22 in 2013/14 before increasing to 38 in 2017/18.
- Between 1998/99 and 2012/13, 25-34 year olds were the age group most commonly admitted to psychiatric hospitals for drug misuse. From their peak in 2002/03 (97 patients per 100,000 population), a fluctuating downward trend in rates was observed for this age group, falling to 55 patients per 100,000 population in 2014/15. This was followed by a sharp increase to 73 patients per 100,000 population in 2016/17 and a decrease to 68 in 2017/18.

Over the time series, consistent increases in drug-related psychiatric patient rates were observed for individuals aged 35 years and over, most notably for the following groups:

- For 35-44 year olds, rates increased from 26 patients per 100,000 population in 1997/98 to 98 in 2016/17 (almost a fourfold increase), before decreasing to 90 in 2017/18. Since 2013/14, individuals aged 35-44 years have been the common age group among drug-related psychiatric hospital patients.
- For 45-54 year olds, rates increased from 9 patients per 100,000 population in 1997/98 to 42 in 2017/18 (more than four times higher).

The patterns in patient rates observed above clearly demonstrate the ageing profile of drug-related hospital patients. In order to illustrate this more clearly, Figure 2.5b (data not available in dashboard) shows drug-related psychiatric patient rates for two age categories only (individuals aged under 35 years and those aged 35 years and over). Drug-related psychiatric patient rates for individuals aged under 35 years decreased by approximately half between 1999/2000 (50 per 100,000 population) and 2014/15 (24) before increasing sharply to 2016/17 (34). Patient rates among individuals aged 35 years and over increased approximately threefold between 1997/98 (10 stays per 100,000 population) and 2016/17 (35). In 2017/18, patient rate decreases compared to 2016/17 were observed for individuals aged under 35 years (32 patients per 100,000 population) and for individuals aged 35 year and over (33).
Figure 2.5a: Drug-related psychiatric patient\(^\dagger\) rates\(^\ddagger\), by age group (Scotland; 1996/97 to 2017/18\(^p\))

Figure 2.5b: Drug-related psychiatric patient\(^\dagger\) rates\(^\ddagger\), by age group (Scotland; 1996/97 to 2017/18\(^p\))

\(\dagger\) See Glossary for definitions of stays, patients and new patients.

\(\ddagger\) Uses European Standard Population 2013 and National Records of Scotland 2017 mid-year population estimates.

\(\p\) Provisional.

Source: Mental health inpatient/day case records (SMR04).
Drug type
In 2017/18, over half (900, 52%) of patients with a drug-related psychiatric stay had it in relation to ‘multiple/other’ drugs and 29% (504) had a stay in relation to opioids. Stays relating to multiple/other drugs were more prevalent than opioid-related stays across all patient age groups, except for patients aged 55-64 years old where a higher percentage of opioid-related stays (21; 37%) was observed compared to multiple/other drug stays (18, 32%).

In 2017/18, 17% (294) of patients with a drug-related psychiatric stay had it in relation to cannabinoids. The highest percentages of patients with cannabinoid-related stays were observed among individuals aged 15-24 years (60, 24%) and 55-64 years (15, 26%).
**New patients**

Patients were classed as ‘new’ patients if they had not had a similar drug-related stay in hospital within the previous ten years. In 2017/18, the new patient rate for drug-related psychiatric stays was 21 new patients per 100,000 population. The drug-related psychiatric new patient rate increased gradually from 2006/07 (12 new patients per 100,000 population) to 2014/15 (16), before relatively large increases in 2015/16 (20) and 2016/17 (23).

The percentage increase in the new patient rate from 2006/07 to 2017/18 was higher than the percentage increase in the patient rate over the same period. Therefore, while in 2006/07, 56% of patients with a psychiatric drug-related stay were classed as ‘new’ patients, this percentage had increased to 66% in 2017/18.

In 2017/18, NHS Ayrshire & Arran had the highest drug-related psychiatric new patient rate (35 new patients per 100,000 population), while the lowest rate among the mainland boards was recorded in Grampian (13).

**Sex**

In 2017/18, 73% of new patients with a drug-related psychiatric hospital stay were males (831, rate: 31 new patients per 100,000 population) (females: 312, rate: 12 new patients per 100,000 population).

**Age group**

In 2017/18, the highest drug-related psychiatric new patient rate was observed among individuals aged 35-44 years (54 new patients per 100,000 population). The rate of new patients aged 15-24 years increased by approximately one half from 2014/15 (18 new patients per 100,000 population) to 2016/17 (31), before a small decrease in 2017/18 (30).

**Drug type**

For drug-related psychiatric hospital stays in 2017/18, ‘multiple/other’ drugs were associated with the highest new patient rate (11 per 100,000 population (50% of new patients), followed by opioids (5 per 100,000 population (24% of new patients)) and cannabinoids (4 per 100,000 population (19% of new patients)).

While they accounted for a relatively small percentage of overall drug-related psychiatric hospital patients in 2017/18, the cocaine (77%: 69 new patients/90 patients) and cannabinoid (74%: 219 new patients/294 patients) patient groups included the highest percentages of ‘new’ patients.
3. **General acute/Psychiatric combined**

Combined analysis for drug-related hospital stays across both types of hospital furthers our understanding of these data by:

- quantifying overall numbers of drug-related stays and patients in each financial year; and,
- providing (in the combined new patient rate) an indication of the overall incidence of problem drug use resulting in hospital admission.

In 2017/18, there were 12,498 drug-related general acute/psychiatric (combined) hospital stays. These stays related to 9,354 patients and, of these, 4,851 (52%) were ‘new’ patients.

Drug-related general acute stays outnumbered comparable psychiatric stays, with 84% (10,509/12,498) of 2017/18 stays in general acute hospitals.

**Stays**

The drug-related general acute/psychiatric combined stay rate increased steadily over the time series, increasing more than two and a half times from 87 to 236 stays per 100,000 population between 1997/98 and 2017/18 (Figure 3.1).

**Figure 3.1: Drug-related general acute/psychiatric combined hospital rates†‡ (Scotland; 1996/97 to 2017/18*)**

![Graph showing drug-related general acute/psychiatric combined hospital rates](image)

† Uses European Standard Population 2013 and National Records of Scotland 2017 mid-year population estimates.

‡ See **Glossary** for definitions of stays, patients and new patients. For new patient rates, the period from 1996/97 to 2005/06 is excluded due to diagnostic coding changes that affect the ten-year look back of general acute (SMR01) and psychiatric (SMR04) hospital records required for calculation. See endnote 2 for further details.

* Provisional.

Source: General acute inpatient/day case records (SMR01) and mental health inpatient/day case records (SMR04) combined.
Clinical type
In 2017/18, of the 12,498 drug-related general acute/psychiatric combined hospital stays, 11,439 (92%) included a drug-related mental & behavioural diagnosis and 1,794 (14%) stays contained a drug poisoning/overdose diagnosis (Figure 3.2a). These are not mutually exclusive groupings and a total of 735 (6%) of these stays included a diagnosis of both clinical types (i.e. a mental & behavioural diagnosis and a drug poisoning/overdose diagnosis).

Figure 3.2a: Drug-related general acute/psychiatric combined stay† numbers, by clinical type (Scotland; 1996/97 to 2017/18p)

† See Glossary for definitions of stays, patients and new patients.

p Provisional.

Source: General acute inpatient/day case records (SMR01) and mental health inpatient/day case records (SMR04) combined.

For general acute/psychiatric hospitals combined, the 2017/18 rate of drug-related mental & behavioural stays (217 stays per 100,000 population) was approaching three times higher than the rate in 1997/98 (76). Apart from a period of stability from 2001/02 to 2006/07 (when the rate ranged between 113 and 119 stays per 100,000 population) and a noticeable decrease in 2012/13 (135) this rate increased fairly consistently over the time series presented (Figure 3.2b).
Figure 3.2b: Drug-related general acute/psychiatric combined stay\(^1\) rates\(^2\), by clinical type (Scotland; 1996/97 to 2017/18\(^p\))

In 2017/18, the general acute/psychiatric (combined) rate of drug poisoning/overdose stays (34 stays per 100,000 population) was twice the rate observed in 1997/98 (17). The drug poisoning/overdose stay rate fluctuated over time, varying largely within the range of 20 to 25 stays per 100,000 population between 1999/2000 and 2015/16, before increasing considerably in each subsequent year.

**Drug type\(^3\)**

In 2017/18, the rate of opioid-related general acute/psychiatric stays was 128 per 100,000 population, over three and a half times the 1997/98 rate (35) (Figure 3.3). The percentage of combined general acute/psychiatric drug-related stays attributed to opioids increased from 40\% (1,986) in 1997/98 to 64\% (5,457) in 2011/12, since when the percentage decreased to 53\% (6,672) in 2017/18.

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\(^1\) See **Glossary** for definitions of stays, patients and new patients.


\(^p\) Provisional.

Source: General acute inpatient/day case records (SMR01) and mental health inpatient/day case records (SMR04) combined.
Figure 3.3: Drug-related general acute/psychiatric combined stay† rates‡, by drug type* (Scotland; 1996/97 to 2017/18p)

Decreases in the rate of general acute stays attributed to ‘multiple/other’⁵ drugs were reflected in the combined general acute/psychiatric stay rate, with a decrease from 51 to 35 stays per 100,000 population between 2002/03 and 2005/06 and an increase from 36 to 54 stays per 100,000 population between 2013/14 and 2017/18. The percentage of stays associated with ‘multiple/other’ drugs almost halved from 1997/98 (2,241, 45%) to 2008/09 (1,851, 23%) and has approximately the same since the (2017/18: 2,865, 23%).

The 2017/18 cannabinoid stay rate (31 stays per 100,000 population) was also the highest yet recorded. From 1997/98 to 2017/18, the rate of cannabinoid-related general acute/psychiatric stays increased almost sixfold from 5 stays per 100,000 population to 31. The percentage of combined general acute/psychiatric drug-related stays attributed to cannabinoids increased from 6% (306) in 1997/98 to 14% (1,689) in 2017/18.

In 2017/18, the sedative/hypnotic stay rate (31 stays per 100,000 population) was the highest recorded across the time series. The rate of sedative/hypnotic-related general acute/psychiatric stays was consistently less than 10 stays per 100,000 population between 1997/98 (9) and 2009/10 (9), but increased more than three times to 31 in 2017/18. The percentage of combined general acute/psychiatric drug-related stays attributed to sedatives/hypnotics decreased from 10% (486) in 1997/98 to between 5% and 6% from 2001/02 to 2010/11, but has since increased to 13% (1,635) in 2017/18.

† See Glossary for definitions of stays, patients and new patients.
* For an explanation of the drug types referred to, see endnotes 5 and 7 and Glossary.
p Provisional.
Source: General acute inpatient/day case records (SMR01) and mental health inpatient/day case records (SMR04) combined.
Patients

In 2017/18, the general acute/psychiatric combined patient rate was 177 patients per 100,000 population. Changes in the patient rate closely corresponded with changes in the stay rate. The combined patient rate increased over two and a half times from 68 to 177 patients per 100,000 population during the period 1997/98 to 2017/18.

In 2017/18, the number of general acute/psychiatric stays per patient was 1.3.

Age group

General acute/psychiatric (combined) drug-related patient rate trends provide clear evidence of an ageing patient profile. There was a clear upward trend in patient rates in the 35-44 and 45-54 year age groups throughout the period 1997/98 to 2017/18. From 2002/03 onwards, a similar increase can also be observed in patient rates among those aged 55-64 years.

Different patterns were observed for younger patients, with decreasing patient rates for 15-24 year olds, followed a series of increases since 2012/13.

These contrasting patterns are examined in further detail below.

Ageing cohort of opioid users

In each year since 2004/05, more than half of general acute/psychiatric combined stays have been associated with opioids. Therefore, changes in the age of patients hospitalised for opioid use have exerted a significant influence on the overall age patterns observed among drug-related hospital patients.

Focusing on general acute/psychiatric combined opioid-related patients, Figure 3.4 demonstrates how, over time, successive age groups have had the highest opioid-related patient rates:

- individuals aged 25-34 years from 1999/00 to 2011/12; and,
- individuals aged 35-44 years from 2012/13 to 2017/18.

Opioid dependency is a chronic, relapsing condition\(^\text{10}\) associated with an increased risk of a range of medical and psychiatric conditions such as liver disease, Chronic Obstructive Pulmonary Disease and depression\(^\text{11}\). As people who use opioids age, their relatively high prevalence of such conditions is likely to result in high rates of hospitalisation\(^6\).

The observed pattern of age-related increases in opioid-related patient rates is consistent with the established body of evidence about an ageing cohort of problem opioid users in Scotland\(^6,\text{12}\).
Hospital stays among young people

Since peaking in 1999/00 (276 patients per 100,000 population), drug-related general acute/psychiatric patient rates for 15-24 year olds decreased consistently to 126 in 2012/13, but have since increased to 190 in 2017/18 (Figure 3.5). The 2017/18 rate was the highest recorded since 2004/05 (204 patients per 100,000 population). Due to their age, most of the patients (1,035, 83%) in the 15-24 year age group were 'new' patients. Therefore, trends in new patient rates were largely similar to trends in patient rates.

Figure 3.4 shows that opioid-related patient rates among 15-24 year olds decreased more than fivefold from 129 patients per 100,000 population in 2002/03 to 24 in 2017/18. If the rate increases for younger people observed since 2012/13 were not associated with opioids, what drug types were young people being hospitalised in relation to?

Throughout the time series from 2012/13 to 2017/18, consistent increases in two drug types were evident for people aged 15-24 years:

- Cannabinoids increased from 30 patients per 100,000 population (2012/13) to 53 (2017/18).
- Cocaine: increased from 24 patients per 100,000 population (2012/13) to 49 (2017/18).

Increases in patient rates for 15-24 year olds for a shorter duration of time were also evident in two other drug types:
• Sedatives/hypnotics: approximately stable from 13 patients per 100,000 population (2012/13) to 13 (2016/17), then increasing to 22 (2017/18).

• Other stimulants: increasing from 14 patients per 100,000 population in 2011/12 to 38 (2015/16), then decreasing to 28 (2017/18).

Figure 3.5: General acute/psychiatric combined patient rates* for individuals aged 15-24 years, by drug type (Scotland; 1996/97 to 2017/18)

These findings indicate an emerging trend of increasing drug-related patient rates among individuals aged 15-24 years. The relative absence of stays associated with opioids (regarded as among the most harmful and addictive substances) may be seen as a positive finding. However, changes in the nature of the substances associated with hospital stays among this age group (e.g. increases in cocaine purity, new types of synthetic cannabinoids, sedatives/hypnotics and other stimulants) may increase the health risks associated with these drugs. The range of substances associated with hospital admission for this age group may also make it difficult to identify appropriate harm reduction and treatment responses.

Drug and Hospital Type

Among all patients with a drug-related stay in 2017/18, 81% were treated in a general acute hospital only, 15% within a psychiatric hospital only and 4% in both general acute and psychiatric hospitals. The majority of patient stays associated with each drug type occurred in general acute hospitals.
New patients

Patients were classed as ‘new’ patients if they had not had a similar drug-related stay in hospital within the previous ten years\(^2\). In 2017/18, 4,851 patients (90 new patients per 100,000 population) had a drug-related general acute/psychiatric hospital stay for the first time. The drug-related general acute/psychiatric combined new patient rate varied little from 2006/07 (55 new patients per 100,000 population) to 2012/13 (58), but has increased markedly since (2017/18 (90)).

Age group

In 2017/18, the highest drug-related general acute/psychiatric new patient rate was observed among individuals aged 35-44 years (187 new patients per 100,000 population).

As with patient rates, trends in drug-related general acute/psychiatric new patient rates were different among individuals aged under 35 years compared with individuals aged 35 and over:

- For individuals aged 15-24 years and 25-34 years, new patient rates decreased to their lowest point in 2012/13 (97 and 132 new patients per 100,000 population respectively) and have since increased (to 159 and 168 respectively).
- For individuals aged 35-44 years, 45-54 years and 55-64 years, new patient rates showed fairly consistent increases across the time series from 2006/07 to 2017/18. The largest percentage increase in new patient rates was observed among individuals aged 55-64 years (9 new patients per 100,000 population in 2006/07 to 42 in 2017/18 – an increase of approaching four and a half times).

Drug type

The opioid patient group was the largest overall, but contained the lowest percentage of ‘new’ patients. A third (33%; 1,596) of all general acute/psychiatric combined opioid patients (4,830) were new patients. In 2017/18, the drug types with the highest percentage of new patients were:

- ‘Other stimulants’\(^2\) (72%: 336 new patients/468 patients);
- Cannabinoids (71%: 1,068 new patients/1,503 patients); and,
- Cocaine (67%: 750 new patients/1,122 patients).

Although opioid patients included the lowest percentage of new patients, they accounted for the highest percentage of ‘new’ drug-related hospital patients (33%), followed by ‘multiple/other’ drugs (25%) and cannabinoids (22%).

Drug and Hospital Type

Among new patients with a drug-related stay in 2017/18, 82% were treated in a general acute hospital only, 15% within a psychiatric hospital only and 3% in both general acute and psychiatric hospitals. The majority of new patient stays associated with each drug type occurred in general acute hospitals.
Endnotes

1. Before 1996/97, diagnosis coding within SMR records was based on International Classification of Diseases 9th Revision (ICD9). ISD introduced International Classification of Diseases 10th Revision (ICD10) coding into SMR records from 1996 onwards. The coding of drug misuse diagnoses changed markedly between these two ICD versions, therefore a considerable increase in the number of drug-related hospital stays was observed between 1995/96 and 1996/97. As this change was likely to be a coding artefact rather than a real increase in drug-related stays, years prior to 1996/97 have been excluded from analyses presented in this report.

2. A new patient is an individual admitted to hospital as an inpatient within a given time period (e.g. financial year) who was found not to have received similar treatment over a specific time period before that admission – ten years in this publication. As the new patients measure incorporates a ten-year look back of SMR records, figures in the period from 1996/97 to 2005/06 would be based partly on ICD9 codes and would be likely to overestimate the number of new patients throughout this period. Therefore, new patient figures are not provided for years prior to 2006/07.

3. Note that, for analysis of numbers of drug stays, patients or ‘new patients’, the sum of the individual drug categories is not equal to the overall total because more than one type of drug can be indicated in a single stay. Similarly with percentages, the sum of the individual drug categories is not equal to 100%.


5. The ‘multiple/other’ drugs category includes hallucinogens, volatile solvents, multiple drug use and use of other psychoactive substances (e.g. ecstasy). This category may also be used to indicate the concurrent use of multiple drugs when individual substances may not be known or cannot be coded using existing diagnosis (ICD10) codes.


7. The ‘other stimulant’ category includes stimulants other than cocaine (e.g. caffeine, amphetamine, methamphetamine, BZP, PMA). See the FRANK website for more information about specific substances (http://www.talktofrank.com/drugs-a-z).

8. Discussion of drug-related psychiatric and combined general acute/psychiatric hospital trends is based on the period from 1997/98 to 2017/18. As psychiatric hospital (SMR04) stays are typically longer than general acute hospital (SMR01) stays, psychiatric episode data are submitted in two parts and compiled and quality assured over a longer time period. Therefore, the change in diagnosis coding from ICD9 to ICD10 at the start of 1996/97 had an impact on the psychiatric figures for the rest of that year. Although 1996/97 data are included in the electronic dashboard, the commentary in sections 2 and 3 is based on the period from 1997/98 onwards, when SMR04 data appear to be more consistent. For further information see Appendix 1.

9. A higher percentage of psychiatric stays (51% compared to 18% of general acute stays in 2017/18) were recorded as involving ‘multiple/other’ drugs. A potential explanation for the ongoing prevalence of ‘multiple/other’ drugs in psychiatric stays is that the limitation on the recording of diagnostic information in SMR records (only six diagnoses may be recorded for any episode) may create difficulties in capturing the details of complex psychiatric clinical presentations or the use of multiple substances prior to admission.


**Glossary**

**ADP**
Alcohol and Drug Partnership. Describes which of the 31 Alcohol and Drug Partnership areas the patient lives in, based on the postcode of their home address.

**Cannabinoids**
Drugs related to cannabis containing chemical compounds which act on cannabinoid receptors in cells that repress neurotransmitter release in the brain. The most notable cannabinoid is tetrahydrocannabinol (THC), the primary psychoactive compound in cannabis. Psychoactive effects may include a state of relaxation, euphoria, introspection, anxiety, paranoia, increase in heart rate and hunger. This group of drugs also includes synthetic cannabinoids: designer recreational drugs such as spice that are chemically different from, but give similar effects to cannabis. Synthetic Cannabinoids have also been associated with states of ‘excited delirium’ among users, which may lead to behavioural problems and, if patients are restrained, death.\(^{15}\)

**Clinical Type**
*Clinical type* is equivalent to an ICD10 diagnostic grouping. *Clinical type* allows results to be broken down on the basis of the following diagnosis groups: Mental & Behavioural (M&B); Overdose (OD); and Combined Mental & Behavioural/Overdose (Combined M&B/OD). Prior to this report, the definition of a drug-related hospital stay was based on the Mental & Behavioural (M&B) clinical type only. See Analytical definitions in Appendix 1 for further details.

**Cocaine**
Cocaine is a strong stimulant mostly used as a recreational drug. It is commonly snorted, inhaled as smoke, or dissolved and injected into a vein. Mental effects may include loss of contact with reality, an intense feeling of happiness, or agitation. Physical symptoms may include a fast heart rate, sweating and large pupils. High doses can result in very high blood pressure or body temperature. After a short period of use, there is a high risk that dependence will occur. Its use also increases the risk of stroke, myocardial infarction, lung problems in those who smoke it, blood infections, and sudden cardiac death.\(^{16}\)

**Day Case**
A day case is a patient who has an elective admission to a specialty for clinical care, and sees a doctor or dentist or nurse (as the consultant’s representative) and requires supervised recovery in the place of treatment. The patient is not expected to, and does not, remain overnight.

**Deprivation**
The *Scottish Index of Multiple Deprivation* (SIMD) is used to calculate deprivation rates. SIMD has 38 indicators in 7 domains
(income, employment, housing, health, education, skills and training, geographical access and crime) at data zone (a small geographical area with up to 1,000 residents) level, which have been combined into an overall index. Rates are reported by quintiles. Quintiles divide the population into five equal groups so that 20% of the population falls into each quintile. SIMD is updated roughly every three years and the version used depends on the year when the patient was discharged from hospital. More information can be found on ISD SIMD webpage.

Discharge
This refers to the end of a given period of health care in a hospital setting known as a continuous inpatient stay (CIS) or Stay (see below). Each stay is initiated by a referral or admission and is ended by a discharge.

EASR
European Age-sex Standardised Rate (EASR) - the rate that would have been found if the population in Scotland had the same age-composition as the hypothetical standard European population. See Analytical definitions in Appendix 1 for further details.

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

Inpatient
This is when a patient occupies an available staffed bed in a hospital and either; remains overnight whatever the original intention or is expected to remain overnight but is discharged earlier.

New patient
An individual admitted to hospital as an inpatient or day case patient within a given time period (e.g. financial year), who has not had a similar drug-related stay in hospital within the previous ten years.

NHS Board
Describes which of the 14 Scottish territorial NHS Boards the patient lives in, based on the postcode of their home address. People who are resident outwith Scotland are included in a separate category labelled 'Outside Scotland'. Those with no fixed abode or unknown are placed in the category “Other/Not Known”.

Opioids
Drugs similar to heroin or morphine. Opioids include opiates (drugs derived from opium, including morphine and heroin (diamorphine)) and semi-synthetic and synthetic drugs such as methadone, hydrocodone, oxycodone and fentanyl. Opioids are most often used medically to relieve pain. The side effects of
opioids may include itchiness, sedation, nausea, respiratory depression, constipation, and euphoria. The euphoria attracts recreational use, and frequent, escalating recreational use of opioids typically results in addiction. Tolerance and dependence will develop with continuous use, requiring increasing doses and leading to a withdrawal syndrome upon abrupt discontinuation. Accidental overdose or concurrent use with other depressant drugs commonly results in death from respiratory depression. Due to their association with addiction and fatal overdose, most opioid drugs are controlled substances.

**Patient**
An individual admitted to hospital as an inpatient or day case patient within a given time period (e.g. financial year).

**Provisional data**
An indication that the data is provisional means that returns from hospitals are not yet complete and the final figure may be different to that recorded when all returns are in.

**Quintile**
Refers to a fifth of the Scottish population, defined by the SIMD (see description for Deprivation above) so that the five groups of data zones range from the most deprived to the least deprived.

**Sedatives/hypnotics**
Drugs which induce sedation by reducing irritability or excitement. This group of drugs includes benzodiazepines (prescribed drugs such as diazepam, alprazolam and Novel Psychoactive Substances (such as etizolam) and z-hypnotics (such as zopiclone). While low doses reduce anxiety and produce a peaceful effect, higher doses may result in slurred speech, staggering gait, poor judgement, and slow, uncertain reflexes. Higher doses may also be used as a hypnotic to induce sleep. In the event of an overdose or if combined with another sedative, many of these drugs can cause unconsciousness and even death.

**Stay**
This refers to a given period of health care in a hospital setting known as a continuous inpatient stay (CIS). A CIS is composed of individual episodes (where the patient is under the care of an individual consultant). An individual (patient) may account for a number of stays during a given reporting period. Each stay is initiated by a referral or admission and is ended by a discharge.
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Further Information

Further Information can be found on the ISD website.

For more information on drug and alcohol misuse see the drug and alcohol section of our website.

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

Further statistics on general acute hospital activity are available at: http://www.isdscotland.org/Health-Topics/Hospital-Care/.

Further statistics on psychiatric hospital activity are available at http://www.isdscotland.org/Health-Topics/Mental-Health/Psychiatric-Hospital-Activity/.

For information about the completeness, timeliness and other data quality issues regarding hospital data submissions contact the Data Management Team at nss.isdDMT@nhs.net.

The next update of this publication will be in winter 2019/20.

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Appendices

Appendix 1 – Background and Methods

Hospital activity data are collected across the NHS in Scotland and are based on nationally available information routinely drawn from hospital administrative systems across the country. The principal data sources are the SMR01 (general acute inpatient and day case) and SMR04 (mental health inpatient and day case) returns.

SMR01 – General acute inpatient and day case return

The statistics presented in the first section of this report are derived from SMR01 and contain information about patients admitted to general acute hospitals, where drug misuse was diagnosed as a factor in the patient's admission or treatment.

SMR01 is an episode based patient record relating to all inpatient and day cases discharged from specialties other than mental health, maternity, neonatal and geriatric long stay in NHS Scotland. The SMR01 basic data set encompasses patient identification and demographic information, episode management information and general clinical information. Items such as length of stay may be derived from the episode management information. A record is generated for each inpatient and day case episode, of which there are about 1,200,000 each year. Attendances at Accident and Emergency Departments that do not result in an admission to hospital are not included. Up to six diagnoses are recorded per SMR01 episode.

SMR04 – Mental health inpatient and day case return

The statistics in the second section of this report are derived from data collected through the mental health inpatient and day case return (SMR04), which records information at admission to, and discharge from psychiatric specialty care.

On the SMR04 form, up to six separate diagnoses can be recorded on both the admission and discharge parts of the record. Diagnosis on discharge may differ from diagnosis on admission. Discharge diagnoses are reported in these statistics as they are regarded as more robust than admission diagnoses. A diagnosis in the first position is regarded as the main diagnosis. A diagnosis in any of the six positions (main and supplementary) is referred to as ‘in any position’.

SMR01 and SMR04 – combined analysis

The statistics presented in this section of the dashboard are derived from combined general acute (SMR01) and psychiatric (SMR04) drug-related hospital records.

Combined analysis of stays includes all general acute and psychiatric activity. However, patients are counted only once per financial year, even though the same patient may have stayed in both general acute and psychiatric hospitals on multiple occasions in that time period.
Analytical definitions

A given period of health care in a hospital setting is known as a continuous inpatient stay (CIS). A CIS is composed of individual episodes (where the patient is under the care of an individual consultant). Each individual patient may have more than one stay in hospital and hence the number of patients in a specific financial year will be less than the total number of stays for that period. Also, patients may have drug-related stays in multiple geographical areas during a financial year, meaning that the sum of stays across all geographical areas will not equal the Scotland total.

For the purposes of this report, a CIS is counted as associated with drug misuse if any of the episodes of which it is comprised include a drug misuse diagnosis in any position. Drug misuse is recorded using the International Classification of Diseases 10th Revision (ICD10) Codes. The following codes were used in this analysis:

i) To define a drug-related hospital stay (referred to as Combined M&B/OD in the dashboard):

Table A1.1: Drug-related hospital stay diagnosis codes

<table>
<thead>
<tr>
<th>ICD 10 Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>F11</td>
<td>Mental and behavioural disorders due to: Opioids</td>
</tr>
<tr>
<td>F12</td>
<td>Mental and behavioural disorders due to: Cannabinoids</td>
</tr>
<tr>
<td>F13</td>
<td>Mental and behavioural disorders due to: Sedatives/Hypnotics</td>
</tr>
<tr>
<td>F14</td>
<td>Mental and behavioural disorders due to: Cocaine</td>
</tr>
<tr>
<td>F15</td>
<td>Mental and behavioural disorders due to: Other Stimulants</td>
</tr>
<tr>
<td>F16</td>
<td>Mental and behavioural disorders due to: Hallucinogens</td>
</tr>
<tr>
<td>F18</td>
<td>Mental and behavioural disorders due to: Volatile Solvents</td>
</tr>
<tr>
<td>F19</td>
<td>Mental and behavioural disorders due to: Multiple/Other Drugs</td>
</tr>
<tr>
<td>T40.0</td>
<td>Poisoning by narcotics: Opium</td>
</tr>
<tr>
<td>T40.1</td>
<td>Poisoning by narcotics: Heroin</td>
</tr>
<tr>
<td>T40.3</td>
<td>Poisoning by narcotics: Methadone</td>
</tr>
<tr>
<td>T40.5</td>
<td>Poisoning by narcotics: Cocaine</td>
</tr>
<tr>
<td>T40.6</td>
<td>Poisoning by narcotics: Unspecified Narcotics</td>
</tr>
<tr>
<td>T40.7</td>
<td>Poisoning by narcotics: Cannabis</td>
</tr>
<tr>
<td>T40.8</td>
<td>Poisoning by narcotics: LSD</td>
</tr>
<tr>
<td>T40.9</td>
<td>Poisoning by narcotics: Unspecified Hallucinogens</td>
</tr>
</tbody>
</table>

For the T-codes listed below, a CIS is counted if there is a presence in the same CIS of at least one of the ICD-10 Mental and Behavioural Disorder codes F11-F16, F18 or F19

| T40.2       | Poisoning by narcotics: Other opioids |
| T40.4       | Poisoning by narcotics: Other synthetic narcotics |
| T42.3       | Poisoning by antiepileptic, sedative-hypnotic and antiparkinsonism drugs: Barbiturates |
| T42.4       | Poisoning by antiepileptic, sedative-hypnotic and antiparkinsonism drugs: Benzodiazepines |
| T43.6       | Poisoning by psychotropic drugs NEC: Psychostimulants with abuse potential |
| T52         | Toxic effect of organic solvents |
ii) To define a drug-related mental and behavioural hospital stay (referred as Mental & Behavioural (M&B) in the dashboard)

Table A1.2: Mental and Behavioural hospital stay diagnosis codes

<table>
<thead>
<tr>
<th>ICD 10 Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>F11</td>
<td>Mental and behavioural disorders due to: Opioids</td>
</tr>
<tr>
<td>F12</td>
<td>Mental and behavioural disorders due to: Cannabinoids</td>
</tr>
<tr>
<td>F13</td>
<td>Mental and behavioural disorders due to: Sedatives/Hypnotics</td>
</tr>
<tr>
<td>F14</td>
<td>Mental and behavioural disorders due to: Cocaine</td>
</tr>
<tr>
<td>F15</td>
<td>Mental and behavioural disorders due to: Other Stimulants</td>
</tr>
<tr>
<td>F16</td>
<td>Mental and behavioural disorders due to: Hallucinogens</td>
</tr>
<tr>
<td>F18</td>
<td>Mental and behavioural disorders due to: Volatile Solvents</td>
</tr>
<tr>
<td>F19</td>
<td>Mental and behavioural disorders due to: Multiple/Other Drugs</td>
</tr>
</tbody>
</table>

iii) To define a drug-related overdose hospital stay (referred as Overdose (OD) in the dashboard)

Table A1.3: ‘Overdose’ hospital stay diagnosis codes

<table>
<thead>
<tr>
<th>ICD 10 Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>T40.0</td>
<td>Poisoning by narcotics: Opium</td>
</tr>
<tr>
<td>T40.1</td>
<td>Poisoning by narcotics: Heroin</td>
</tr>
<tr>
<td>T40.3</td>
<td>Poisoning by narcotics: Methadone</td>
</tr>
<tr>
<td>T40.5</td>
<td>Poisoning by narcotics: Cocaine</td>
</tr>
<tr>
<td>T40.6</td>
<td>Poisoning by narcotics: Unspecified Narcotics</td>
</tr>
<tr>
<td>T40.7</td>
<td>Poisoning by narcotics: Cannabis</td>
</tr>
<tr>
<td>T40.8</td>
<td>Poisoning by narcotics: LSD</td>
</tr>
<tr>
<td>T40.9</td>
<td>Poisoning by narcotics: Unspecified Hallucinogens</td>
</tr>
</tbody>
</table>

For the T-codes listed below, a CIS is counted if there is a presence in the same CIS of at least one of the ICD-10 Mental and Behavioural Disorder codes F11-F16, F18 or F19

<table>
<thead>
<tr>
<th>ICD 10 Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>T40.2</td>
<td>Poisoning by narcotics: Other opioids</td>
</tr>
<tr>
<td>T40.4</td>
<td>Poisoning by narcotics: Other synthetic narcotics</td>
</tr>
<tr>
<td>T42.3</td>
<td>Poisoning by antiepileptic, sedative-hypnotic and antiparkinsonism drugs: Barbiturates</td>
</tr>
<tr>
<td>T42.4</td>
<td>Poisoning by antiepileptic, sedative-hypnotic and antiparkinsonism drugs: Benzodiazepines</td>
</tr>
<tr>
<td>T43.6</td>
<td>Poisoning by psychotropic drugs NEC: Psychostimulants with abuse potential</td>
</tr>
<tr>
<td>T52</td>
<td>Toxic effect of organic solvents</td>
</tr>
</tbody>
</table>

For data presented on drug type, there is an element of double counting as stays, patients and ‘new patients’ may each be associated with multiple drug types (e.g. diagnoses of both opiate and cocaine misuse). If multiple drugs have been noted, the advised coding is to record each substance in a separate diagnosis position where possible. Sometimes the coder may be forced to use the unspecific ICD-10 code F19 (‘multiple/other drugs’), for example, if case notes only state ‘multiple/other drugs’ there is no way of identifying which substances were involved. Sometimes the F19 code may be used if the patient has many other diagnoses recorded, leaving insufficient space to record specific drugs separately.
When gathering information from stays, demographic data (age, gender, deprivation quintile) are extracted from the first episode of the stay (thus corresponding most closely to the circumstances of the patient at the point they entered hospital). However, the allocated year is defined by the date of discharge. Therefore, a stay spanning two financial years (e.g. 2012/13 and 2013/14) will be counted as having occurred in the most recent of those years, or when the patient was discharged (2013/14 in this example).

Some caution is necessary when using these data as (a) drug misuse may only be suspected and may not always be recorded by the hospital, and (b) where drug misuse is recorded, it may not be possible to identify which drug(s) may be involved.

European Age-sex Standardised Rates (EASRs) are calculated because hospital activity rates may vary with the age-sex structure of the populations. The direct standardisation method was used, with the age-sex specific rates of the local population applied to the age-sex structure of a standard population. This gives the overall rate that would have occurred in the local population if it had the same age-sex profile as the standard population. It allows valid comparisons to be made between local areas and other countries with differing population age-sex structures. In the report, EASRs are expressed per 100,000 population per financial year.

The latest available National Records of Scotland mid-year population estimates were used in EASR calculations for NHS Board and Alcohol and Drug Partnership (ADP) analysis and for Scottish Index of Multiple Deprivation analysis. At the time of the analysis, the latest estimates were for the year 2017.

The European Standard Population (ESP) is used to calculate EASRs within this publication. The ESP, which was originally introduced in 1976, was revised in 2013. Before publication of 2012/13 data in February 2014, the Drug Related Hospital Statistics publication used ESP1976 to calculate EASRs. Since 2014, the ESP2013 has been used to calculate EASRs for all years (including those before 2012/13). Therefore, findings from publications since February 2014 are not comparable with earlier publications. See Appendix A1 in the 2013/14 report for further details.

When figures are broken down by geographical area or age the numbers in some categories can be very small. In these cases both differences between categories and trends over time should be interpreted with caution because they may be misleading.

Statistical disclosure control has been applied to protect patient confidentiality. Therefore, the figures presented in these statistics may not be additive and may differ to those reported in previous publications.

**Data quality**

The ISD Data Quality Assurance (DQA) team is responsible for evaluating and ensuring SMR datasets are accurate, consistent and comparable across time and between sources. Details of the quality assurance process are published on the [DQA methodology webpage](#).
Information on SMR data completeness can be found on the SMR completeness webpage, while information on the timeliness of SMR data submissions can be found on the SMR Timeliness webpage.

Note of revisions

The Health & Social Care Team aims to continually improve the interpretation of the data and therefore analysis methods are reviewed and sometimes updated. Analysis programs may be modified occasionally to reflect process changes and improvements.

In addition, the 2017/18 publication incorporated changes in the following areas:

- The definition of a drug-related hospital stay was changed to include stays associated with accidental poisoning/overdose (see Appendix 2 for more details). ‘Clinical Type’ has been introduced to distinguish between Mental & Behavioural and accidental poisoning/overdose stays.

- Age breakdowns were revised from 5-year to 10-year age bands.

- The method for calculating percentages in the analysis of deprivation was changed. In this publication, the percentage distribution of cases by deprivation quintile within a drug type is shown. In previous reports, the number of cases for a specific drug type as a percentage of all cases within a deprivation quintile was shown.

- Deprivation versions applied to the analysis were amended. This publication used SIMD2012 for years 2010/11-2013/14 and SIMD2016 for 2014/15-2017/18. The previous report used SIMD2012 for years 2010/11-2011/12 and SIMD2016 for 2012/13-2016/17.

- Lanarkshire ADP was reported as Lanarkshire North ADP and Lanarkshire South ADP.
Appendix 2 – Definition Change

Background

Information Services Division (ISD) of NHS National Services Scotland publish Drug-Related Hospital Statistics annually. ISD are committed to producing information that meets the needs of stakeholders, customers and the public. In line with this, ISD recently conducted a customer consultation with the purpose of seeking feedback on a proposed change to the International Statistical Classification of Diseases and Related Health Problems, tenth revision (ICD-10) codes used to define a drug-related hospital stay in this publication.

It was proposed to widen the range of drug-related harms captured in the statistics by including stays due to drug poisoning/overdose in order to ensure that relevant hospital activity is measured more comprehensively.

Following positive feedback on the proposed change, hospital admissions resulting from drug poisoning/overdose have been included within the definition of a drug-related hospital stay reported in this publication.

For more information about the consultation, see the Drug-Related Hospital Statistics consultation paper and the Drug-Related Hospital Statistics customer consultation results paper.

Old definition

In the previous publications, a drug-related hospital stay was solely based on the mental and behavioural ICD-10 codes which are shown in Table A1.2 (see Analytical definitions in Appendix 1).

New definition

The definition of a drug-related hospital stay used in this publication was revised to include all ICD-10 codes from the ‘old’ definition plus some accidental poisoning/overdose ICD-10 codes. The full list of the ICD-10 codes is presented in Table A1.1 (see Analytical definitions in Appendix 1).

Comparability

This report is published alongside a revised dashboard which contains new features and data analyses. Due to the definition change, Clinical type has been introduced to make the statistics more useful and to maintain comparability with previously published data. The Clinical type breakdown allows users to view results on the basis of the following diagnosis groups:

- Mental & Behavioural (M&B);
- Overdose (OD);
- Combined Mental & Behavioural/Overdose (Combined M&B/OD).

The first of these categories (M&B) is equivalent to the old definition of a drug-related hospital stay. Hence, selecting this option provides data that are comparable with the data from
previous reports. The second category (OD) was included in order to enable users to examine hospital stays associated with overdose (included for the first time) in greater detail. The ‘Combined M&B/OD’ category represents the new definition of a drug-related hospital stay and is the basis of most of the commentary included in this report.

Impact of new definition

This section briefly describes the impact on numbers of stays/patients/new patients as a result of the definition change.

The change in reported results was mainly influenced by the type of hospital in which the stay occurred. There was a substantial increase (averaging around 14% annually) in the number of general acute hospital stays recorded in the statistics and almost no effect on the number of psychiatric hospital stays (less than a 0.5% annual increase). For general acute/psychiatric combined hospital category, the percentage increases were closer to those observed in general acute hospitals because of the larger proportion of general acute stays compared with psychiatric stays.

There was little variation in terms of percentage increases between numbers of stays, patients and new patients within the same type of hospital. In 2017/18 for example, the addition of general acute hospital overdose stays resulted in a percentage increase for stays, patients and new patients of 11%, 10% and 10% respectively.

For a full breakdown of the impact of the definition change on numbers of stays, patients and new patients by year and hospital type, see Table A2.1 below.
Table A2.1: Percentage increase in the total number of stays/patients/new patients† counted using the new Drug-Related Hospital Statistics definition compared with the old definition, by Financial Year and Hospital Type (Scotland; 1996/97 to 2017/18)  

| Financial year | General Acute | | | Psychiatric | | | Combined Gen acute/Psych | | |
|----------------|---------------|----------|----------|---------------|----------|----------|----------------|----------|
|                | Stays | Patients | New patients | Stays | Patients | New patients | Stays | Patients | New patients |
| 1996/97        | 26    | 26       | x          | 0      | 0        | x          | 17    | 17       | x           |
| 1997/98        | 22    | 23       | x          | 0      | 0        | x          | 14    | 14       | x           |
| 1998/99        | 17    | 18       | x          | 0      | 0        | x          | 12    | 12       | x           |
| 1999/00        | 21    | 22       | x          | 0      | 0        | x          | 14    | 14       | x           |
| 2000/01        | 18    | 19       | x          | 0      | 0        | x          | 13    | 13       | x           |
| 2001/02        | 18    | 19       | x          | 0      | 0        | x          | 13    | 13       | x           |
| 2002/03        | 18    | 19       | x          | 0      | 0        | x          | 13    | 13       | x           |
| 2003/04        | 13    | 14       | x          | 0      | 0        | x          | 9     | 10       | x           |
| 2004/05        | 13    | 14       | x          | 0      | 0        | x          | 10    | 10       | x           |
| 2005/06        | 12    | 13       | x          | 0      | 0        | x          | 9     | 9        | x           |
| 2006/07        | 14    | 15       | 15         | 0      | 0        | 0          | 11    | 11       | 12          |
| 2007/08        | 14    | 15       | 15         | 0      | 0        | 0          | 12    | 12       | 13          |
| 2008/09        | 13    | 14       | 13         | 0      | 0        | 0          | 11    | 11       | 11          |
| 2009/10        | 14    | 14       | 14         | 0      | 0        | 0          | 11    | 11       | 12          |
| 2010/11        | 13    | 14       | 15         | 0      | 0        | 0          | 10    | 11       | 12          |
| 2011/12        | 13    | 13       | 12         | 0      | 0        | 0          | 10    | 10       | 10          |
| 2012/13        | 13    | 14       | 16         | 0      | 0        | 0          | 10    | 11       | 13          |
| 2013/14        | 11    | 12       | 13         | 0      | 0        | 0          | 9     | 10       | 11          |
| 2014/15        | 11    | 11       | 12         | 0      | 0        | 0          | 9     | 9        | 10          |
| 2015/16        | 11    | 11       | 11         | 0      | 0        | 0          | 9     | 9        | 9           |
| 2016/17        | 11    | 11       | 12         | 0      | 0        | 0          | 9     | 9        | 10          |
| 2017/18        | 11    | 10       | 10         | 0      | 0        | 0          | 9     | 8        | 8           |

† See Glossary for definitions of stays, patients and new patients. For new patient rates, the period from 1996/97 to 2005/06 is excluded due to diagnostic coding changes that affect the ten-year look back of SMR01 or SMR04 records required for calculation. See endnote 2 for further details.

p Provisional.

Source: General acute inpatient/day case records (SMR01) and mental health inpatient/day case records (SMR04).
## Appendix 3 – Publication Metadata

<table>
<thead>
<tr>
<th>Metadata Indicator</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Publication title</strong></td>
<td>Drug-Related Hospital Statistics Scotland 2017/18</td>
</tr>
<tr>
<td><strong>Description</strong></td>
<td>Data relating to general acute and psychiatric hospital stays with a diagnosis of drug misuse. These data are presented at a national level and also broken down by demographic characteristics/local geographies.</td>
</tr>
<tr>
<td><strong>Theme</strong></td>
<td>Health and Social Care</td>
</tr>
<tr>
<td><strong>Topic</strong></td>
<td>Substance Misuse</td>
</tr>
<tr>
<td><strong>Format</strong></td>
<td>PDF report with online dashboard</td>
</tr>
<tr>
<td><strong>Data source(s)</strong></td>
<td>General acute inpatient/day case records (SMR01)</td>
</tr>
<tr>
<td></td>
<td>Mental health inpatient/day case records (SMR04)</td>
</tr>
<tr>
<td><strong>Date that data are acquired</strong></td>
<td>SMR01: January 2019; SMR04: September 2018</td>
</tr>
<tr>
<td><strong>Release date</strong></td>
<td>28 May 2019</td>
</tr>
<tr>
<td><strong>Frequency</strong></td>
<td>Annual</td>
</tr>
<tr>
<td><strong>Timeframe of data and timeliness</strong></td>
<td>General acute (SMR01) – information from the period 01/04/1996 to 31/03/2018. Analysis based on the period 1996/97 to 2017/18.</td>
</tr>
<tr>
<td></td>
<td>Psychiatric (SMR04) – information from the period 01/04/1996 to 31/03/2018. Analysis based on the period 1997/98 to 2017/18.</td>
</tr>
<tr>
<td></td>
<td>General acute &amp; psychiatric combined (SMR01 &amp; SMR04) – information from the period 01/04/1996 to 31/03/2018. Analysis based on the period 1997/98 to 2017/18.</td>
</tr>
<tr>
<td><strong>Continuity of data</strong></td>
<td>See background information.</td>
</tr>
<tr>
<td><strong>Revisions statement</strong></td>
<td>All data are revised annually to reflect any changes to analysis and to ensure the most complete information is presented. Data for the most recent financial year are labelled as provisional and may be subject to change in forthcoming publications. Minor revisions of this nature are often due to incomplete data returns at the time of the previous publication.</td>
</tr>
<tr>
<td><strong>Revisions relevant to this publication</strong></td>
<td>See <a href="#">Notes of revision</a> in Appendix 1.</td>
</tr>
<tr>
<td><strong>Concepts and definitions</strong></td>
<td>See <a href="#">Glossary</a>.</td>
</tr>
<tr>
<td></td>
<td>Also, refer to: Hospital Care - Background Information: <a href="http://www.isdscotland.org/Health-Topics/Hospital-Care/">http://www.isdscotland.org/Health-Topics/Hospital-Care/</a></td>
</tr>
</tbody>
</table>
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

Details of data submission issues are available on the SMR Completeness webpage.

Comparability

The NHS Health and Social Care Information Centre (HSCIC) publishes figures on Hospital admissions for drug-related mental health and behavioural disorders in England but should not be directly compared with published data from Scotland. For more information see the Background information on the ISD Hospital Care webpage.

Accessibility

It is the policy of ISD Scotland to make its websites and products accessible according to published guidelines.

Coherence and clarity

The report is available as a PDF file with accompanying statistical dashboards.

Value type and unit of measurement

Numbers, percentages and European Age-sex Standardised Rates per 100,000.

Disclosure

The ISD protocol on Statistical Disclosure Protocol is followed to protect patient confidentiality.

Official Statistics designation

Accredited National Statistic

UK Statistics Authority Assessment


Last published

26 September 2017

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Date of first publication

1998

Help email

nss.isdsubstancemisuse@nhs.net

Date form completed

26 April 2019
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](#).