

1. INTRODUCTION

1.1 The Report of the Ministerial Drugs Task Force, *Drugs in Scotland: Meeting The Challenge*, was published in 1994. One of the primary recommendations of the report was that:

“...in each health board area, a small group of senior people should be established to draw up a local action plan for tackling drug misuse locally and thereafter driving and monitoring its delivery.”

The report went on to further recommend that the group be known as the ‘Drug Action Team’ and “...consist of senior local figures from the statutory and non-statutory agencies, including the health board, the social work department, the education department, the police and the voluntary sector.”

The Drugs Task Force envisaged that the new Drug Action Teams would be supported by a Drugs Development Officer whose principal duty would be to ensure that all of the component parts of the strategic plan were being carried out. In addition, other duties such as needs assessment work could be undertaken.

1.2 The inaugural meeting of the Shetland Drug Action Team [DAT] was held on 3 November 1995. Colin Cox was appointed as a temporary ‘Drug Strategy Co-ordinator’ and the first full-time Drug Development Officer, Sandra Matheson, took up post on 1 April 1996. At this time there was also an Alcohol Misuse Co-ordinating Committee – AMCC - in Shetland serviced by an Alcohol Development Officer, Stephanie Primrose. Ms. Matheson left in February 1998 and the position remained vacant until the appointment of Nina Goodlad in October of that year.

1.3 In August 1999, Shetland DAT agreed to combine the functions of both the DAT and the local AMCC and in February 2000 formally became the Shetland Alcohol and Drug Action Team [SADAT]. Ms. Goodlad and Ms. Primrose both left their posts in September 1999 and were replaced by Morag Hedges who undertook the duties of both posts on a secondment basis. The writer took over as Alcohol and Drug Development Officer [ADDO] from Ms. Hedges in December 2000. In January 2001, an Alcohol and Drug Development Assistant, Clare Hicks, was appointed. She left a year later in January 2002 and was replaced by Margaret Birnie in March 2002.

1.4 The life of the Shetland Alcohol and Drug Action Team has been characterised by instability and change. It would appear from Minutes and associated papers that its original Strategic Plan was based on little more than the convictions of Team Members, anecdotal evidence from a variety of sources, general statistics from Northern Constabulary and the results of two surveys of the secondary school population in 1992 and 1995. The advent of the Scottish Executive’s structured Corporate Action Plan template two years ago has sharpened the strategic focus of the SADAT but there has remained recognition that existing reports and information should form the basis of a more comprehensive needs assessment exercise.

1.5 This report is an attempt to collate and analyse relevant information contained within national and local studies in order to help to ascertain the scale of problems in Shetland arising from drug and alcohol misuse and hence establish strategic priorities for the SADAT.

2 NATIONAL STUDIES

2.1 NHS Scotland Information & Statistics Division [ISD] – Statistical Reports To Shetland Drug Action Team April 2001 and 2002.

Statistical information contained in these reports covers the six years from 95/96 to 00/01 and refers specifically to new problem drug users reported to the Scottish Drug Misuse Database either by the client's GP or the Shetland Community Drugs Team. The definition of 'new' is:

- (a) the person is attending the service for the first time ever, or
- (b) the person has attended before but not within the previous six months.

The data is recorded at or around the time of the initial face-to-face contact and includes no measure of outcome.

Misuse of alcohol may be reported to the database in circumstances only when it is secondary to some other drug of misuse.

DAT Trends: 1995/6 – 2000/01

The table below illustrates the total numbers of new individual clients recorded for each of the indicated years.

	95/96	96/97	97/98	98/99	99/00	00/01
Male	25	22	33	20	13	12
Female	1	5	10	4	4	4
TOTAL	26	27	43	24	17	16

The same figures are analysed below according to Postal District of Residence.

	95/96	96/97	97/98	98/99	99/00	00/01
ZE1	5	3	11	11	14	13
ZE2	0	2	2	3	1	3
Unspecified	21	22	30	10	2	0
TOTAL	26	27	43	24	17	16

Some initial observations based on the above data are:

- A significantly higher number of males than females are reported to the database as problem drug users.
- The total number of new clients was similar in three out of the six years. There was a sharp increase in 1997/98 and a significant decrease in 1999/00.
- Between 1997/98 and 1998/99 the number of new presentations almost halved.
- Despite the large number of unspecified post codes recorded, the figures for 1999/00 and 2000/01 appear to bear out the speculation that few new clients present from outwith the ZE1 area.

Main drug reported by new individual clients:

	95/96	%	96/97	%	97/98	%	98/99	%	99/00	%	00/01	%
Heroin	2	7.7	2	7.4	2	4.7	2	8.3	3	17.6	6	37.5
Morphine	1		0		0		0		0		0	
Methadone prescribed	-	1	2		2		2		1		1	
Methadone Other	-	2	0		1		3		1		1	
DF118 prescribed	-	0	2		0		2		0		0	
DF118 – other	0		0		1		0		0		0	
Buprenorphine	1		1		1		0		1		0	
Other opiates	0		1		2		0		0		4	25
Diazepam prescribed	-	0	0		1		0		0		0	
Diazepam – other	2		1		2		0		0		0	
Temazepam other	-	1	0		0		0		1		0	
Other Benzodiazepines	1	3.8	2	7.4	4	9.3	4	16.7	2	11.8	1	6.3
Amphetamines	4	15.4	5	18.5	18	41.9	5	20.8	6	35.3	0	
Cocaine	0		0		1		0		1		1	
Ecstasy	0		2		3		0		0		0	
Cannabis	10	38.5	9	33.3	5	11.6	6	25.0	1	5.9	2	12.5
Solvents	1		0		0		0		0		0	
TOTAL	26		27		43		24		17		16	

Number of clients reporting alcohol used as a secondary drug:

	95/96	%	96/97	%	97/98	%	98/99	%	99/00	%	00/01	%
Alcohol	18	69.2	13	48.1	29	67.4	9	37.5	5	29.4	3	18.8

- The figures for Shetland are small but reflect the emergence of a discernable trend. In the four years between 1995 and 1999, most new problem drug users reported their main drug as amphetamine followed by cannabis, other benzodiazepines and heroin with alcohol playing a major role as a secondary drug.
- This is in marked contrast to the rest of Scotland where heroin is consistently reported as the main drug – in around 50% of cases - followed by prescribed methadone. Amphetamines and cannabis are reported in 4 – 5% of cases and alcohol as a secondary drug in approximately 10% of cases.
- In 1999/00 however, the picture in Shetland appears to change and begins to reflect the Scottish situation. The latest figures show heroin and other opiates now the main drug reported by new clients and amphetamine figures falling to zero.

Injecting Behaviour:

	95/96	96/97	97/98	98/99	99/00	00/01
Injected in previous month	7	8	18	5	7	6
Injected in past/not previous month	4	6	6	5	3	2
Has never injected	12	11	19	14	7	6
Information unavailable	3	2				2
TOTAL	26	27	43	24	17	16

Sharing of injecting equipment (for those who injected in previous month):

	95/96	96/97	97/98	98/99	99/00	00/01
Shared in previous month	1	3	6		1	
Shared in past/not previous month	1	1			1	
Has never shared	4	3	4	1	4	4
Information unavailable	1	1	8	4	1	2
TOTAL	7	8	18	5	7	6

- With the exception of the most recent year, more new individual clients report injecting drugs in the previous month than report heroin as the main drug and this clearly indicates that other drugs are being injected. ISD's statistics show that in addition to heroin, new problem drug users in Shetland reported injecting:
 - Morphine
 - Methadone
 - DF118
 - Dipipanone
 - Buprenorphine
 - Other opiates
 - Diazepam
 - Temazepam
 - Other Benzodiazepines
 - Amphetamines
 - Cocaine
 - Ecstasy
 - Alcohol
 - Other Drugs

Although these figures relate to small numbers of individuals over six years, they nevertheless indicate a propensity to risk-taking – that may or may not be informed – amongst the drug using population of Shetland.

Hospital inpatient statistics

This information is derived from SMR01 forms and collected by ISD. It relates to patients admitted to general hospitals – mainly for emergency treatment – where drug misuse is diagnosed as a factor in the patient's need for treatment.

Non-psychiatric admissions for drug misuse in Shetland; drug type: 1996/97 to 2000/01

	TOTAL	Opioids	Cannabinoids	Sedatives/ Hypnotic	Cocaine	Other Stimulants	Hallucinogens	Volatile Solvents	Other Psychoactive Substances
1996/97	10	1	0	1	0	0	1	0	7
1997/98	8	1	0	0	2	1	1	0	3
1998/99	10	0	2	0	0	3	0	1	4
1999/00	10	1	4	0	0	3	0	0	2
2000/01	1								

HIV

Information on HIV infection and AIDS is collected by the Scottish Centre for Infection and Environmental Health [SCIEH] and records whether or not the case is an intravenous drug misuser.

Records show that between 1990 and 2000 there were no HIV infected reports among injecting drug users in Shetland.

Seizures of Controlled Drugs

The statistics presented by ISD are of limited use as figures are provided for the Northern Constabulary area as a whole. The general trend is an increase in the overall number of seizures with those of Class B drugs [including amphetamines and cannabis] far outnumbering those of Class A drugs [including heroin, cocaine, methadone and ecstasy]. In 1999 there were twenty-two recorded seizures of heroin in contrast to one in 1995 although it is important to note that changes in drug seizures do not necessarily imply similar changes in the prevalence of the misuse of controlled drugs. In fact those twenty-two seizures amounted to only 100g of heroin whereas the same amount of cocaine was obtained from only six seizures in the Northern Constabulary area.

Drug-related Deaths

Information about drug-related deaths from 1994 to 1999 was compiled by the Registrar General for Scotland via an improved system for collecting information in Scotland introduced in 1994. Figures **exclude** known suicides, road traffic and other accidents which occurred under the influence of drugs and deaths from AIDS where the risk factor is believed to be the sharing of needles. Figures **include** deaths from occasional or experimental misuse of drugs and accidental overdoses of prescribed medicine as well as some unrecognised suicides.

In 2000, a new definition of 'drug related death' was introduced and is reflected in the Scotland and Shetland figures for the year 2000 in the table below. These figures **include** deaths caused by mental and behavioural disorder due to psychoactive substance use: opioids; cannabinoids; sedatives or hypnotics; cocaine; other stimulants including caffeine; hallucinogens and multiple drug use and use of other psychoactive substances. Also **included** are accidental poisoning; intentional self-poisoning by drugs, medication and biological substances and 'event of undetermined intent, poisoning', **and where a drug listed under the Misuse of Drugs Act (1971) was known to be present in the body at the time of death**. Deaths due to mental and behavioural disorders due to use of alcohol, tobacco and volatile substances are **excluded** as are deaths resulting from the injection of contaminated heroin. Deaths from AIDS where the risk factor was believed to be sharing needles and road traffic accidents and other accidents that occurred under the influence of drugs are also **excluded**.

Drug-related Deaths, Scotland and Shetland 1994 – 2000

	1994	1995	1996	1997	1998	1999	2000
Scotland	247	251	270	263	276	340	292
Shetland	1	0	1	1	1	0	1

On the face of it, the number of drug-related deaths in Shetland is too low to cause concern. However, when the numbers are viewed as a rate per 100,000 population, and compared to other Health Board areas in Scotland, the picture changes and Shetland emerges as having a much more significant problem as the following table illustrates.

Drug-related deaths, by health board area, 1995-99 [number and rate per 100,000 population]

Health board area	1995		1996		1997		1998		1999	
	No.	Rate	No.	Rate	No.	Rate	No.	Rate	No.	Rate
Scotland	251	4.9	267	5.2	263	5.1	276	5.4	340	6.6
Argyll & Clyde	24	5.5	19	4.4	20	4.7	26	6.1	29	6.8
Ayrshire & Arran	17	4.5	12	3.2	9	2.4	7	1.9	29	7.7
Borders	1	0.9	2	1.9	-	-	1	0.9	-	-
Dumfries & Galloway	5	3.4	3	2.0	11	7.5	6	4.1	9	6.1
Fife	5	1.4	10	2.9	20	5.7	15	4.3	11	3.2
Forth Valley	9	3.3	6	2.2	11	4.0	9	3.3	19	6.8
Grampian	15	2.8	31	5.8	27	5.1	31	5.9	42	8.0
Greater Glasgow	98	10.7	96	10.6	69	7.6	94	10.3	112	12.4
Highland	3	1.4	4	1.9	3	1.4	3	1.4	8	3.8
Lanarkshire	16	2.9	13	2.3	22	3.9	28	5.0	27	4.8
Lothian	40	5.2	53	6.9	46	6.0	37	4.8	38	4.9
Orkney	-	-	1	5.1	1	5.0	-	-	1	5.1
Shetland	-	-	1	4.3	1	4.3	1	4.4	-	-
Tayside	18	4.6	16	4.1	23	5.9	18	4.6	14	3.6
Western Isles	-	-	-	-	-	-	-	-	1	3.6

Drug-related Convictions

Sheriff Court	Year	Possession with intent to supply			Possession			Other*
		Number	% Custodial Sentence	% aged under 21	Number	% Custodial Sentence	% aged under 21	
Lerwick	1996	3	67	33	17	-	35	1
Lerwick	1997	-	-	-	17	-	6	2
Lerwick	1998	1	0	0				
Lerwick	1999	2			12			

* Includes illegal importation of drugs, production and manufacture of drugs, money laundering related offences and other drug related offences.

2.2 Estimating the National and Local Prevalence of Problem Drug Misuse in Scotland – Report to the Shetland Drug Action Team October 2001.

This report summarises research undertaken by the Centre for Drug Misuse Research at the University of Glasgow and the Scottish Centre for Infection and Environmental Health to estimate the prevalence of problem drug misuse [defined as use of opiates and benzodiazepines, including methadone] in the Shetland Drug Action Team Area.

Data for Shetland was extracted from the Scottish Drug Misuse Database and augmented with data contributed directly by Shetland Community Drugs Team [SCDT]. Data was also supplied by Northern Constabulary and Shetland Islands Council Social Care Service on problem drug users identified from criminal justice sources.

From these sources, 54 individuals were identified as using opiates or benzodiazepines in 1999 or 2000 in Shetland. These data were used to arrive at the estimate of 109 problem drug users in the area in 2000. This prevalence estimate represents 0.9% of the population aged 15 to 54. The Scotland-wide problem drug use prevalence rate is 2.0%.

These results are shown below in tabular form:

Estimates of the number of problem drug users and prevalence:

	Known	Total Estimate		Population (15 – 54)	Prevalence	
		n	95% CI*		%	95% CI
Shetland	54	109	66 - 237	12,359	0.9	0.5 – 1.9
Scotland	22,795	55,800	43,664 – 78,443	2,853,682	2.0	1.5 – 2.7

* CI – Confidence Interval. By quoting a single figure for the prevalence of drug misuse it is possible to present a spurious degree of precision in the estimation of an activity that by its very nature is hard to estimate. It is more helpful to provide an estimate of the prevalence of problematic drug misuse, which also includes the range within which the true estimate is likely to be found.

The highest prevalence rates amongst the non-rural Council areas are found in the major urban centres. The highest prevalence rate is Glasgow City at 3.8% of the population aged 15 – 54 [95% CI 3.3 - 4.3%]. The next highest is Dundee City at 3.5% [95% CI 2.4 – 5.9%]. The third highest is Aberdeen City at 3.0% [95% CI 2.2 – 4.8%].

Although many people would associate Scotland’s drug problem with the two cities of Glasgow and Edinburgh, it is striking that Aberdeen City has the third highest prevalence in Scotland behind Dundee.

The prevalence of problematic drug misuse overall is lower in the rural Council areas and in only two cases does it exceed 1.5% [Dumfries and Galloway and East Ayrshire]. Apart from Eilean Siar and Orkney, the remaining rural Council areas have prevalence rates around 1% of the population aged 15 – 54.

The survey concludes that whilst problematic drug misuse is occurring in all parts of Scotland, it is probably a mistake to think of Scotland as having a single drug problem. What appears to be happening is that Scotland is faced by a series of more local drug problems. The

drug problems in Glasgow, Edinburgh and Dundee, for example, are all long standing and relatively well studied. There are indications in all of these areas that there are significant numbers of older drug users [those aged over 35]. In the case of Aberdeen by comparison, we are now seeing a rapid onset of a relatively new problem and, as a result, many of the drug users tend to be somewhat younger. Similarly, whilst there are clear indications that problematic drug use is linked to social exclusion, this does not mean that all of the local epidemics of problematic drug use will be equally associated with deprivation. In Aberdeen, for example, problematic drug use appears to be much less closely tied to indicators of deprivation than in many other areas.

In addition, we are now seeing the development of problematic drug misuse in many of the rural areas of Scotland – areas that up till now have not been associated with problematic drug misuse. At the present time however, it remains the case that problematic drug misuse is less widespread within the rural parts of Scotland than within the major urban areas.

Finally, the authors note that at the moment the use of cocaine is not on a par with that of heroin amongst problematic drug users in Scotland, but we need to ensure that if this situation were to change we would have rapid and detailed knowledge of that fact.

2.3 Crack, Cocaine and Amphetamine Use Seminar – Stirling, 1 November 2001

Three of the speakers at the above seminar presented papers imparting information that is useful when attempting to build a picture of problematic drug misuse in the Shetland Islands.

Detective Superintendent Matt Hamilton, the National Drugs Co-ordinator at the Scottish Drug Enforcement Agency, referred to the World Drug Report 2000 and made the following points:

- Poly-drug use is now the norm.
- Cocaine is shipped in large consignments – 10 x that of opiates.
- Abuse of cocaine fell in the United States by 70% over the 1985 – 1999 period.
- Reduction of cocaine usage in the United States has seen a corresponding rise in the use of ecstasy. As a result cocaine traffickers are increasingly targeting Europe.
- Aberdeen is now a feature of the trafficking picture.
- Increasing seizures and falling prices would indicate that more cocaine is being shipped.
- Crack cocaine has been recovered in Glasgow, Edinburgh and Aberdeen.
- Popularity and recoveries of amphetamine have decreased across Scotland although the drug has remained prevalent in fishing and rural communities in the North.
- In the Northern Constabulary police area, ecstasy is second in popularity to cannabis.

Alex Meikle of the Scottish Drugs Forum, referring to data from the ISD, confirmed that reported problematic amphetamine use in Scotland has almost halved between 1996 and 2001. Ecstasy use has remained virtually stable but the use of cocaine and crack cocaine has increased significantly although the numbers are small when compared to the figures for heroin.

Reported problematic use of cocaine and crack cocaine to drug agencies by new individual clients in 1996 and 2001:

	Aberdeen		Dundee		Glasgow	
	Cocaine	Crack	Cocaine	Crack	Cocaine	Crack
1996	29	1	1	0	30	5
2001	42	61	10	1	151	15

One rural area that has shown a significant increase in reported problematic use of cocaine and crack cocaine to drug agencies by new individual clients since 1996, is Aberdeenshire – illustrated below:

	Aberdeenshire	
	Cocaine	Crack
1996	8	2
2001	12	38

Given the close economic and transport links between Shetland and Aberdeen and the similar societal circumstances of low unemployment and relative affluence, it is likely that cocaine and crack cocaine will become increasingly available in Shetland.

Malcolm Bruce from the Community Drug Problem Service in Edinburgh spoke about amphetamine use, suggesting that there is a ‘hidden epidemic’. Since many more people use amphetamines than use heroin, increasing numbers of users will require treatment. However, he acknowledged that most stimulant users don’t see themselves as ill and probably wouldn’t come forward for treatment – indeed for most users, amphetamines are a ‘lifestyle choice’.

2.4 Smoking, drinking & drug use among young people in Scotland in 2000

The main purpose of this survey was to continue to monitor smoking, drinking and drug use among secondary school children aged 12 – 15. Information was obtained from more than 4,700 pupils in 150 schools in Scotland during the autumn term of 2000.

Drug Use

Pupils had high levels of awareness of illegal drugs. In 2000, the proportions who had heard of cannabis [92%], heroin [89%] and cocaine [88%] were around nine in ten. Crack was the next most commonly heard of drug [81%]. This represents an increase in awareness of this drug since 1998 when 78% of pupils reported having heard of crack.

Nearly half of pupils [47%] had at some point been offered at least one drug, mainly cannabis. There was a sharp increase with age in the numbers of young people exposed to drugs in this way. By the age of 14 [61%] or 15 [70%] the majority of young people had been offered drugs.

Among 15 year olds, one third of pupils had ever used drugs and 22% had done so in the last month. Boys were more likely than girls to have ever used drugs [19% compared with 14%] and were also more likely to report using drugs in the last month and the last year.

Cannabis was by far the most widely used drug – 13% reported use of this drug in the last year. By age 15, 30% of pupils had used at least one drug in the last twelve months, mainly cannabis.

Alcohol Use

21% of pupils had had an alcoholic drink in the previous week. In 1990, this figure was 14%. In most previous surveys boys had been more likely than girls to have drunk in the last week. In 2000, there was no overall difference in the proportions of boys and girls who drank.

There was a clear increase in the amount of alcohol consumed by those who drank – from an estimated average of 8.2 units in 1992 to 11.1 units in 2000. The increase in consumption was concentrated on spirits. Beer, lager, cider and shandy accounted for 44% of the amount drunk by boys. Among girls, spirits accounted for a third of the alcohol drunk in the last week, with alcopops accounting for a further 30%.

39% of pupils had never had an alcoholic drink, although this figure was much higher among 12 year olds [67%] than 15 year olds [13%].

2.5 Annual Scottish Drug Trends Seminar, Stirling 30 October 2001

Speaking at the above seminar, Sally Haw of the Health Education Board for Scotland said that 50,000 young people and 300,000 young adults use drugs but only a small proportion of them will go on to develop a problem. There are, however, particular groups of young people who are more vulnerable to drug misuse. These are:

- School truants/excludes
- Looked after children
- Young offenders
- Young homeless
- Children of drug misusing parents.

3 LOCAL STUDIES

3.1 Shetland Health Board Health and Lifestyle Survey 1999

This was a comprehensive survey and 2660 people - approximately 11.5% of Shetland's population - returned completed questionnaires.

Alcohol

Although 21% of respondents claimed that they never drank or had given up drinking, 38% drank every week – 5% of them on a daily basis. The tables below indicate how frequently respondents reported drinking and how this differs between the sexes.

Frequency	Number	%
Never drink	461	17.3
Given up	126	4.7
Drink less than once a month	503	18.9
Drink monthly but not weekly	559	21.0
Drink 1 – 2 days a week	565	21.2
Drink 3 – 5 days a week	313	11.8
Drink daily	133	5.0
TOTAL	2660	100

Frequency	Number			% of totals for each gender	
	Total	Males	Females	Males	Females
Never drink/given up	587	228	359	19	24.6
Drink less than once a month or monthly but not weekly	1062	432	630	36.5	43.2
Drink from one day to up to five days a week	868	438	430	37.3	29.5
Drink daily	133	91	42	7.6	2.9

Respondents were asked if they had drunk alcohol in the seven days prior to completing the survey questionnaire, and, if they had, to estimate how many units of alcohol they had consumed.

Slightly more females than males reported that they had had a drink: 65.4% compared to 60.1%. The questionnaire gave some examples of the number of units in different drinks to help respondents work out the number of units in order to answer this question.

The table below shows the percentage of respondents who were drinking safe, hazardous and dangerous levels of alcohol in the week prior to the survey – categories that are defined as illustrated. [These figures are based only on those who had reported consuming alcohol in these previous seven days.]

Category	Males	Females
Safe	Up to 21 units per week	Up to 14 units per week
Hazardous	Between 22 and 50 units per week	Between 15 and 34 units per week
Dangerous	More than 50 units per week	More than 35 units per week

Drinking Levels by Gender:

Category	Males %	Females %
Safe	42	45
Hazardous	28	35
Dangerous	10	5
No reply	20	15
TOTAL	100	100

It is important to note that since this survey was conducted, the UK Government's preferred way of advising about sensible drinking levels has been to give the following daily benchmarks:

MEN

Most men can drink up to three to four units of alcohol a day without significant risks to their health.

WOMEN

Most women can drink up to two to three units of alcohol a day without significant risk to their health.

Drugs

17% of respondents indicated that they had taken drugs at some point in the past with cannabis being the most commonly mentioned drug. Heroin and cocaine were the drugs least reported, however – 0.8% or 22 individuals – said that they had injected drugs. [This is remarkably similar to the figure of 0.9% arrived at in the prevalence study quoted above.]

3.2 Shetland Youth Information Service [SYIS] - Snapshot Survey – November 2000

In 2000, a sub group of the Shetland Drugs Forum called the 'Under 16s Services Working Group' was established. The main remit of the group was to look at existing services for the under 16s relating to drug use and identify areas for development. As part of this exercise, the group decided to conduct a survey of young people to determine their knowledge of drug awareness and the services available to them.

The survey took place in late October/early November 2000 and was conducted by staff of Shetland Youth Information Service. A total of 135 young people were surveyed and a profile is given below:

Age [Years]	Number	Percentage
12	20	15
13	17	13
14	22	16
15	46	34
16	10	7
17	7	5
18	9	9
19	4	4

Male: 48%

Female: 52%

Area of residence	Percentage
Lerwick	43
North Isles	31
North Mainland	6
West Mainland	6
South Mainland	11

Respondents were asked about their use of alcohol and drugs. The following figures are taken from the survey report, which does not indicate why the responses from the 17 – 19 year olds were not included in the tables. There are also other serious unexplained discrepancies in the figures - reproduced below - that are presented in the report and the findings should therefore be treated with caution.

ALCOHOL	12	13	14	15	16
Only once	18%	22%	16%	6%	-
Monthly	36%	9%	20%	20%	34%
Weekly	25%	52%	48%	71%	41%
2-3 x Weekly	-	8%	4%	3%	17%
Daily	-	-	-	-	8%
Never	21%	9%	4%	-	-

CANNABIS	12	13	14	15	16
Only once	12%	26%	32%	8%	25%
Monthly	-	9%	-	-	-
Weekly	-	9%	-	3%	17%
2-3 x Weekly	-	-	-	3%	-
Daily	-	-	-	3%	-
Never	88%	56%	68%	83%	58%

Alcohol and cannabis were the two substances used most widely by the young people surveyed. In addition, a very small number reported having used solvents/ecstasy. Use of 'Acid' [LSD] was reported by around five, 15 year olds and 'Speed' [Amphetamine] by a couple of 16 year olds [the percentage figures given in the report do not equate to whole

numbers of respondents]. Young people surveyed had to mention by name the drugs they had used and no one referred to heroin.

Age of First Use:

Age [Years]	Alcohol %	Cannabis %
8	4	
9	2	
10	7	
11	14	
12	46	31
13	16	27
14	4	14
15	4	18
16	3	5
17		5
18		

It is apparent from the above table that all the respondents who had used alcohol had done so before they could legally do so – one or two at a very young age.

Those who took part in the survey were asked ‘Where is it most likely that drugs/alcohol are used?’ The responses are shown below:

Location	Number who reported using here
Home	52
Friends	90
Outside	93
School	15
Youth Club	40
Nights out/discos	35

Given a number of options, respondents indicated where they would go for help:

Service	Yes	No	Don't Know
Alcohol Advice Centre	56	70	23
Citizen's Advice Bureau	13	100	25
Doctors	80	50	20
Drugs Project	73	45	25
Family	88	53	23
Friends	143	21	5
Health Promotion Department	24	70	23
Hospital	70	68	23
Shetland Youth Information Service	108	38	18
Social Work	43	105	24
Teachers	34	77	21
Youth Workers	46	47	43

The report notes that most of the information was collected by SYIS staff and this is likely to have affected the outcome.

Other suggestions that would make getting information or help easier were:

Service	Number of people making suggestion
Telephone Helpline	11
Internet Information	3
Young Person's Drug Project	1
Nearby Information Place	5
A Specific Centre	2

Finally, 42 young people expressed concern about friends or families' alcohol or drug use.

3.3 Brae High School Lifestyle Survey - 2001

Years 1 – 6 at Brae High School were surveyed in 2001 about their smoking, drinking and drug use. 251 questionnaires were completed.

Drinking

From year 3 onwards, all respondents say they have tried alcohol. The table below shows the numbers in years 1 and 2 who say they have tried alcohol, and gives the percentages [in brackets] of the sex/year groups.

	Male	Female	Not Known	Total
Year 1 has tried alcohol	17 [77]	19 [66]	1	36
Year 1 has not tried	5 [23]	10 [34]		15
Year 2 has tried alcohol	24 [77]	19 [90]	1	43
Year 2 has not tried	7 [23]	2 [10]		9

The figures in the above table equate to 37/52 [71%] of children in year 1 and 44/53 [83%] of children in year 2 saying that they have tried alcohol. Overall, 227/251 [90%] of respondents have tried alcohol.

The ages at which boys started drinking ranged from 3 to 14 with an average of 10.1. For the girls, the range was 4 to 15 with an average of 10.8. Those who said they were with their parents the first time they drank had an average starting age of 9.4 [107 children] while those who were not with their parents [101 children] had an average starting age of 11.6.

The majority of years 1 and 2 say they drink 'hardly ever' [70%], but by years 5 and 6, 22% say they drink 'most days'.

The percentage of those drinking in pubs is small for all ages except the eldest, and less than 20% of any age group drinks out of doors. The percentage of those drinking at discos rises from 24% to 41% in years 1 and 2 to over 70% in later years. The number drinking at friends' houses also increases through the year groups. In all year groups at least a third of those who drink, drink at home, but the youngest group has the highest proportion: 70% of year 1 drinkers drink at home.

In summary, the report concludes that nearly all pupils have some sort of experience of alcohol, although it is unclear from the report whether or not those who report drinking at

home do so with the consent of their parents. By the later years in school some pupils are spending considerable sums on alcohol and drinking at discos and with friends as well as at home.

Drug Taking

Few respondents say they have tried drugs – only 19, less than 8% of the 251 who completed the survey. Of these 19, seventeen say they have tried cannabis, hash or dope. In addition, three mention speed, two ecstasy and one ‘poppers’. Two didn’t provide a list of drugs they had tried. The ages at which the respondents first tried drugs are listed below [one did not give an age].

Age drugs first tried	Frequency
12	1
13	8
14	6
15	3

Seven said they mix drugs with alcohol [two did not answer this]. Only six of these listed the drugs mixed with alcohol: all said cannabis or hash and in addition two said speed and ecstasy. Two of the seven were in year 4, four in year 5 and one in year 6.

Twelve people indicated where they got drugs – one wrote ‘not telling’ and six omitted the question. Of the twelve, seven said ‘friends’, two said ‘somewhere on the street’ and one each said ‘pedlar’ [sic], ‘other people’ and ‘people I know’.

In summary, it appears that drug taking is very much a minority activity amongst these respondents. Those who do indulge are understandably unwilling to disclose their sources.

3.4 An Exploratory in depth investigation of the impact of cultural and social factors on heroin use patterns in Shetland, Anke Stallwitz, 2001

For this dissertation project, part of the final year of her BSc in Psychology, Stallwitz conducted in depth interviews with twelve heroin users aged 24 – 41 years in Shetland over a two-month period during summer 2000. Her study was set in Lerwick, which she describes as “affluent, small, remote and isolated”, and specifically concentrated on heroin use involving both ‘drugs agency’ and ‘recreational’ heroin users.

On the basis of her interviews, Stallwitz charts the development of heroin use in Shetland over the last thirty years.

She postulates that the heroin scene began as a consequence of the arrival in Shetland of huge numbers of construction workers who were recruited to build the Sullom Voe oil terminal in the 70s and 80s. Inevitably, a number of these workers used heroin however, the scene they established and their style of use was, and – for those that remain - still is, quiet and controlled and well integrated into their lives.

From the late 80s to the late 90s, Shetland’s drug culture was profoundly influenced by the rise of the rave scene. Drugs – particularly ‘dance drugs’ such as amphetamine, ecstasy, LSD and cannabis - became far more available, widespread and accepted in Shetland.

Although the rave scene has declined, its legacy has been a significant increase in the availability and consumption of drugs in general, including heroin, the growing involvement of youngsters in the heroin scene and an increase in intravenous and polydrug use.

The results of Stallwitz' investigation clearly demonstrate the widespread prevalence and availability of drugs such as cannabis, amphetamines, ecstasy and, to a lesser extent, cocaine in Shetland in general and Lerwick in particular. Purchased and consumed in the same social setting as, and together with, alcohol, recreational drugs have become a widely accepted aspect of Lerwick's nightlife and pub scene and Shetland's general social/party scene. Similar to alcohol, the use of recreational drugs is not restricted to particular populations but involves a wide age range, males and females and people from all different social backgrounds with varying drugs preferences. Again similar to alcohol, the style of consumption often tends to be excessive.

Although available in Shetland, even if to a lesser extent than recreational drugs, heroin has hitherto been explicitly excluded from the general alcohol and drugs scene. The scene surrounding the purchase and consumption of heroin has traditionally existed in an extremely secretive, controlled, comparatively small, underground form, carefully hidden from day-to-day public life. Consequently, in Shetland, the general public's attitude towards heroin is that it represents a socially unacceptable drug. To the same degree to which the consumption of alcohol is socially desirable the use of heroin is socially stigmatised. Furthermore, the risk of being discovered to be involved in this highly stigmatised substance is intensified in a small and close-knit place such as Shetland.

Recent developments, however, not only suggest a greater and easier availability and increasing notability of heroin on the islands and a growing number of more diverse users, but also the beginning of a reduction in the severe stigma by which the drug has been previously characterised. Part of these developments is also an increasing number of young people in a scene previously dominated by older users. More chaotic and reckless, the former group seem to exhibit far less of an effort to maintain the traditional standards of secretiveness and control and, Stallwitz suggests, are also more likely to share injecting equipment.

Stallwitz puts forward a range of 'potential future outcomes' with regard to Shetland's heroin scene. These include:

- The spread of undifferentiated polydrug use amongst young heroin users.
- A diminishing stigma and rising numbers of heroin users resulting in a growing demand for, and the spreading of less secretive use of, heroin in Shetland. This trend might even lead to the transition of heroin to a 'pub drug'.

Alternatively:

- Curtailment of the spread of heroin use because the social stigma attached to heroin may be too deeply ingrained in Shetland society for the social costs associated with its consumption to lose their deterrent effect.
- The possibility that the majority of young heroin users might adjust their currently uninhibited and reckless appearing drug use related behaviour after their first encounters with the adverse effects of the stigma in the form of labelling and social exclusion.

Stallwitz concedes, however, that the development of an urban-like, problematic heroin scene with possible criminal tendencies is a further option. However, the small size of the Shetland community, its relative affluence and low unemployment rate might function as constraining factors powerful enough to prevent a seriously problematic trend, which has so far been the case as exemplified by the older users.

3.5 Shetland Drugs Forum – Community Council Consultations 2001/2002

Since Autumn 2001, a continued effort by the Shetland Drugs Forum to engage with the wider community has resulted in a number of Shetland's eighteen Community Councils inviting Drugs Forum members to attend meetings.

So far, representatives of the Drugs Forum have met with the following councils:

- Lerwick
- Bressay
- Gulberwick, Quarff and Cunningsburgh
- Aithsting and Sandsting
- Nesting and Lunnasting
- Yell.

Contact has been made with a number of other councils and meetings arranged over the next few months. These are:

- Burra and Trondra
- Delting
- Fetlar
- Northmaven
- Skerries
- Unst
- Whalsay

This means that contact has been made with almost two-thirds of Community Councils. To date one council has refused to invite representatives to a meeting.

Some of the issues that have been raised so far are:

- Drugs are not a visible problem in Shetland and, therefore, people feel removed from the issue, particularly in comparison with the visibility of alcohol.
- Lots of people in communities don't come across drugs and there is a perception that the problem is centred in Lerwick.
- Stigma and finger-pointing makes it very difficult to seek help. The Shetland Community Drugs Team [SCDT] can offer confidentiality but not anonymity.
- People seek help with a problem at a late stage because of this stigma.
- Employers are wary of employing anyone with a drug/alcohol problem – although there may be a greater tolerance of alcohol problems than drug problems.
- There is a desire for parental education.
- There should be more awareness raising.
- Concern about a 'harm reduction' approach.
- Referral information should be more accessible.

- Where should people go to for help?
- How should their children be educated about drugs?
- There is a need to publicise SCDT.
- Drug dealers are punished too leniently.
- Lack of Customs and Excise staff and Police presence is a concern.
- Are drugs being landed in out-of-the-way places and will the use of the drug dogs simply exacerbate this?
- The community as a whole needs to create a back-up for the drug dogs.

3.6 Gaps in Drug and Alcohol Rehabilitation Services in Shetland – Consultation March 2002

This was a very small exercise conducted by the writer in March this year and involved seeking the opinions of key NHS Shetland staff and others about gaps in drug and alcohol rehabilitation services in Shetland. Potentially, upwards of 50 people could have contributed but only nine did.

The following gaps in services had been highlighted already by a working group set up to discuss how best to use current Scottish Executive Drug Rehabilitation funding:

- Formal assessment and aftercare for people with drug/alcohol problems.
- Aftercare in respect of the availability of employment opportunities.
- A lack of buddying/self-help groups i.e. a lack of positive examples for people who may be considering recovery/AA, which can be a prime motivating factor.
- No specialised dedicated nurse to carry out supervised community alcohol detoxification [as is the case in Orkney].
- Chronic alcohol users yo-yo between hospital and unhealthy living conditions. Help is needed to break this cycle.

Staff were asked if they agreed/disagreed with the gaps in services identified above and to point out any others.

All the respondents bar one agreed with the gaps identified. The one expressed doubts that the ‘dedicated nurse model’ is right for Shetland. Two of the other respondents liked the idea of a specialised community nurse but had reservations, namely –

- How would s/he spread her/himself throughout the Isles?
- S/he would soon become known as the ‘alcohol nurse’ and that may make some people unwilling to see her/him.

Four respondents – all GPs - highlighted the problem of detoxifying patients with serious alcohol problems. One favoured a residential option, believing that there are times when the person with alcohol problems is best removed from home surroundings for a time, pointing out that sometimes the rest of the family need this. Another drew attention to the problem of arranging and supervising a home detoxification regime, particularly if the patient lives alone, and said that the hospital is reluctant to admit such patients. Two GPs who reported regularly detoxifying patients at home thought it would be good to have more support for people after they have detoxified in order to help break the cycle of drinking/detox/drinking.

Two GPs observed that most of their heavy drinking patients seemed to have little difficulty obtaining employment when they're 'dry', citing "an incredible level of tolerance" about alcohol problems.

Finally, one GP felt that there was no co-ordination between services and a lack of support for drug users 'out of hours'.

4. CONCLUSIONS

In the mid 1990s, drug use in the Shetland Islands was fairly small-scale and did not mirror the situation in mainland Scotland. The main drug of choice would appear to have been amphetamine and there is some anecdotal evidence to suggest that amphetamine use was linked to alcohol consumption i.e. users taking the drug to stay awake longer and so consume more alcohol.

The numbers of new individual clients recorded peaked in 1997/98 with just over 40% reporting amphetamine as their main drug. In that same year, just under 70% reported alcohol as a secondary drug. Heroin was reported by fewer than 5% - two individuals, and anecdotal evidence would indicate only intermittent supplies of this drug reaching the Shetland Islands. Since 1998 however, the situation in Shetland has increasingly reflected the national picture. Latest figures show that over 60% of new clients now report heroin or other opiates as their main drug and reports of amphetamine as a main drug have fallen to zero.

Importation of cocaine and crack cocaine is an obvious potential problem for Shetland. Use of these drugs is recognized in Aberdeen and the surrounding rural area where, like Shetland, problematic drug use appears to be much less closely tied to indicators of deprivation than in many other areas. Since the Shetland Islands' main transport and economic links are to Aberdeen, it is not unreasonable to suggest that a market for cocaine and crack cocaine may develop in Shetland.

Against a global backdrop of falling opium and cocaine production there has been a corresponding rise in the manufacture and spread of amphetamine-type stimulants [ATS] throughout the 1990s. With fewer areas available for growing coca and poppies – the war in Afghanistan has had a huge impact on global heroin production – drugs are increasingly being synthesised in laboratories in Asia. Ever new and more inventive ways are also being found to misuse prescription drugs. Anyone familiar with the drugs scene in Glasgow in the late 80s/early 90s will be aware of the abuse of Temazepam before the introduction of gelthix capsules. Use of the opiate drug Oxycodone, brand name OxyContin [and dubbed 'hillbilly heroin' by the media] has seen a huge rise in parts of the US and in March this year, a student in Hull died after taking a cocktail of drugs that included alcohol and OxyContin. Elizabeth Wurtzel's latest book describes in detail her abuse of the prescription drug Ritalin.

Predictions of a significant increase in polydrug use [described by Stallwitz as "...the spread of undifferentiated polydrug use – including heroin"], an increase in heroin use [by younger people and in injecting as the route of administration] and a corresponding decrease in the stigma attached to heroin in Shetland should be treated with caution since constraining factors may be powerful enough to prevent a seriously problematic trend.

This needs assessment has tended to concentrate more on drugs than alcohol, simply because the national and local information is more coherent. It is clear, however, that proportionately, the number of problem drug users in the Shetland Islands is small and levels of alcohol consumption constitute a more significant problem. The contrast between the findings of the

national survey of young people and the local Brae high school survey are particularly marked. Nationally, 67% of 12 year olds had never had an alcoholic drink whereas in Brae, 71% of those surveyed in year 1 said they had tried alcohol. The Brae findings are consistent with the SYIS Snapshot Survey where the majority of respondents reported trying alcohol by the age of 16 years – more than half by age 12.

It is important to remember, as Regis Wieland of ERIT [Federation of European Professionals Working in the Field of Drug Abuse] said at the Crack, Cocaine and Amphetamine Use Seminar in November 2001, that alcohol, tobacco and cannabis are the ‘gateway’ drugs – young people who use these are more likely to go on to try other drugs. Yet as Professor Peter Brunt pointed out at the Plan for Action on alcohol problems conference in March this year, we must beware of targeting young people – it is often better to target their role models. Indeed, the fact that 107 respondents in the local Brae survey said they were with their parents the first time they drank and had an average starting age of 9.4 years, would seem to indicate the intelligence of this approach.

A theme common to many of the studies quoted is the tolerance of Shetland society to alcohol and alcohol problems. Tackling alcohol problems requires a long-term approach and making the cultural shift to more sensible and responsible drinking will be a very slow process.