European Monitoring Centre for Drugs and Drug Addiction

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2008 NATIONAL REPORT (2007 data) TO THE EMCDDA
by the Finnish National Focal Point, STAKES

# FINLAND

# DRUG SITUATION 2008

## New Developments, Trends and in-depth information on selected issues

**REITOX**


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# FOREWORD

*Finland – Drug Situation 2008* is one of the national annual reports compiled by the National Focal Points in the European Information Network on Drugs and Drug Addiction (REITOX) which is co-ordinated by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). The national reports form the basis for the EMCDDA's annual report *The state of the drugs problem in Europe*. The national reports are compiled in accordance with the guidelines provided by the EMCDDA.

The present report consists of two parts. Part A discusses recent developments and research data from 2007 and early 2008. The sections that describe the drug situation during the past year (drug experimentation, problem drug use, health and social correlates and consequences, availability and supply of drugs) are linked with discussion on related societal interventions (prevention, treatment, harm reduction, social rehabilitation and control). Each section begins with background information on the subject and the latest data is discussed in the subsections. Part A is based on last year's report. Part B discusses selected issues relating to drugs, this year's theme being statistics on penal sanctions (Section 11). The length of the sections in the report depends on the amount of data available on each subject area.

Planning Officer Marke Jääskeläinen (STAKES) wrote Subsections 1.3 and 8.4, and Researcher Heini Kainulainen (Finnish Foundation for Alcohol Studies) wrote Section 11 'Statistics on Sanctions'. In addition, Researcher Tuija Hietaniemi (National Bureau of investigation) wrote a significant portion of Section 10. Useful linguistic support was provided particularly by Senior Planning Officer Elina Kotovirta (STAKES). We thank them warmly.

The report was compiled and the remaining sections written by Senior Planning Officers Sanna Rönkä and Ari Virtanen at the Finnish National Focal Point, which operates at STAKES.

Research data and comments from experts on different areas of the drug issue were used in drafting the report. We thank all the experts for their comments.

The report has been approved by the editorial board of STAKES Statistical Products as well as the working group on international co-operation on drug issues.

Helsinki, October 2008

Sanna Rönkä
Senior Planning Officer

Ari Virtanen
Senior Planning Officer

Research and Development Centre for Welfare and Health (STAKES)
PO Box 220,
FI-00531 Helsinki Finland
Tel. +358 9 3967 2369
Fax. +358 9 3967 2497
E-mail: firstname.lastname@stakes.fi
http://www.stakes.fi

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**Authors**
Sanna Rönkä & Ari Virtanen (eds.),

Marke Jääskeläinen, Tuija Hietaniemi & Heini Kainulainen



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**Summary**
Since the mid-1990s, the drug situation in Finland has deteriorated according to nearly all indicators (experimentation, problem use, health detriments, morbidity, mortality, criminality and seizures). Since 2000, drug use and the growth of drug-related harm have levelled off; although problem use only stabilised some years after the other indicators. In recent years, the situation has remained stable with the exception of drug-related mortality which has shown an increase.

According to the 2006 population survey, 13% of 15–69-year-olds had experimented with cannabis sometime in their life. The level was nearly the same as in the 2002 survey and three percentage points higher than in 1998. Among women the percentage was 12% and among men 16%. The proportion of 15–34-year-olds (22%) remained the same in 2002 and 2004. However, changes have taken place within the latter age group: between 2002 and 2006, the proportion of 15–24-year-olds decreased by 6 percentage points, whereas the proportion of 25–34-year-olds grew by the same amount.

Among young people, the use of drugs levelled off, then decreased during the decade. According to the ESPAD survey of school pupils in 2007, 8% of 15–16-year-olds had experimented with cannabis sometime in their life. In 2003 and 1999, the corresponding figures were 11% and 10%.

The number of problem drug users is estimated in Finland based on the number of problem users of amphetamines and opiates, which came to 14,500–19,100 in 2005; this accounts for 0.5–0.7% of 15-54-year-olds among the entire population. Nearly four fifths of problem drug users used amphetamines. The proportion of men was 80%. The majority of problem drug users belonged to the 25–34-year age group.

Studies indicate that the prominent role of alcohol as an additional substance, intravenous use of buprenorphine and co-occurring mental health disorders are typical of Finnish problem drug use. A census of intoxicant-related cases, conducted during one day in 2007 among those attending the services of social and health care units, revealed that approximately a quarter of problem users of intoxicating substances and individuals who had sought help while intoxicated or due to a single use occurrence also used drugs. Based on a study on waiting times for drug treatment, the condition of clients waiting to access inpatient detoxification at substance abuse rehabilitation and withdrawal treatment units has deteriorated somewhat, and the number of those waiting to access replacement treatment has increased to some extent. According to studies, the number of individuals at replacement treatment is estimated at 1,200. The new Decree on replacement treatment has not yet improved access to treatment. Bottlenecks include the transfer from treatment need assessment to regular outpatient replacement treatment – and, in particular, limited outpatient quotas. Substitution and maintenance treatment for opiate addicts is increasingly being transferred to health centres and, in part, also to pharmacies.

The number of drug-related deaths has increased slightly over past years, while the situation has remained stable for other drug-related harm. The number of new HIV and hepatitis infections among intravenous drug users has decreased since 2000. In particular, low-threshold services and their development have been essential in preventing and reducing infectious drug-related diseases. Indeed, health counselling and exchange of clean needles and syringes have prevented thousands of HIV and hepatitis infections.

Problem drug users are usually socially marginalised and feel that they have no prospects in life. In 2007, 65% of drug treatment clients were unemployed and 11% were homeless. The number of drug offences in police records increased by 12% over the previous year. The drugs on the Finnish market are mostly cannabis products, synthetic drugs such as amphetamines and ecstasy, buprenorphine and, above all, benzodiazepines. Heroin is still fairly rare in Finland. Growing cannabis plants at home has continued to become more common in Finland.



**Keywords**
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# INDEX

# A. NEW DEVELOPMENTS AND TRENDS

## 1 National policies and context

Anti-drug activities are largely based on long-term choices in policy and the societal structures that steer those choices. The structures for drug prevention are shaped through drug legislation, the strategies that steer drug policy and action plans. Anti-drug activities (prevention, treatment, reduction of drug-related harm, drug control) become concrete in the implementation of legislation, strategies and action plans.

Many of the national approaches and activities are related to international systems and agreements regarding drug policy. The resources allocated for the activities also play an important role in their implementation.

Based on Government proposal HE 22/2008, the new Narcotics Act (373/2008) entered into force as of the beginning of September 2008. This reform aligns the Finnish drugs legislation with the corresponding EC regulations. The new legislation enhances drug control by increasing co-operation between authorities, but national drug policy guidelines remain the same in other respects. The objective of this reform was to help prevent illegal drug traffic and reduce the use of drugs.

Narcotics offences are specified in the Penal Code (1303/1993), whereby they are categorised as narcotics offence, preparation or abetment of a narcotics offence (maximum sentence 2 years' imprisonment) or as aggravated narcotics offence (1–10 years' imprisonment). In 2001, an amendment was made to the Penal Code (654/2001) which introduced the unlawful use of narcotics (maximum sentence ½ years' imprisonment).

Provisions concerning preventive substance abuse work are laid down in the Temperance Work Act (828/1982). The Act defines the purpose of temperance work as habituating citizens to healthy lifestyles by guiding them to avoid the use of substances and tobacco. According to the Act, the establishment of general prerequisites for substance abuse prevention is primarily the task of the State and municipalities.

The central principles for pupil and student welfare services and the educational objectives are defined in the national curricula for the various educational levels. The legislation related to education required educational institutions to apply them together with social welfare and health care authorities to the local curricula to prevent and treat substance abuse. (477,478,479/2003.)

The Occupational Health Care Act (1383/2001) enables drug testing in the workplace. Before requiring any individual to take a test, the employer must have a written substance abuse programme, which contains the general goals of the workplace and practices to be followed to prevent substance abuse and to help substance abusers in seeking treatment.

Treatment for drug users is regulated under the Act on Welfare for Substance Abusers (41/1986) requiring municipalities to ensure that the provision of substance abuse services meet local needs as regards content and scope. These services must be delivered through the development of general social and health care services and the provision of services that are intended specifically for substance abusers. Such services must be provided primarily through outpatient care and should be easily available, flexible and diversified. Decree 993/2006 issued by the Ministry of Social Affairs and Health lays down the provisions for statements rendered by a referring physician, as stated in the Act on Welfare for Substance Abusers, in the event an individual is required to undergo treatment because their life is at risk.

According to the Act (566/2005, 902/2005) and Decree (646/2005) on rehabilitation benefits and rehabilitation allowances granted by the Social Insurance Institution of Finland, a patient in substance abuse rehabilitation or the rehabilitation service provider will be reimbursed the necessary and reasonable costs resulting from the rehabilitation if: such rehabilitation takes place in a substance abuse rehabilitation unit approved by the Social Insurance Institution of Finland and licensed by the State Provincial Office, responsible for the supervision of such units to provide health and welfare services, and if such rehabilitation is based on a treatment or rehabilitation plan.

The Decree governing the detoxification, substitution and maintenance treatment of opioid addicts (289/2002) was replaced by a new Decree (33/2008), aimed at meeting the increasing need for substitution treatment.[1]

The amendment to the Communicable Disease Act (1383/2003) states that health centres must increasingly provide health counselling for intravenous drug users as well as needle and syringe exchange.

Drug issues are also dealt with in the overall reform of the Penal Code regarding money laundering (68–79/1998) and driving while intoxicated (1198/2002), the amendment to the Coercive Measures Act (646/2003), which lays down the conditions for telecommunications interception, telecommunications monitoring and technical surveillance. Furthermore, provisions concerning drug issues are laid down in the amendments to the Police Act (21/2001, 525/2005), regulating undercover operations and fictitious purchases and principal information gathering methods relating to the prevention, detection and enhanced investigation of serious and organised crime or to the prevention of any preparations to commit a terrorist offence.

The Act on Imprisonment (686/2005) regulates both drug control and drug prevention and treatment work in prisons. The Act stipulates that, in a closed institution, the prison inmate must be provided with the opportunity to stay in a contractual ward where the inmates are committed to supervised intoxicant-free life and to the activities arranged in the ward. An inmate with a substance abuse problem can also be placed for a fixed term in an institution outside prison, where he/she can participate in rehabilitation or other target-oriented activities that reinforce his/her operational abilities – and where he/she does not use intoxicating substances and observes the terms and conditions stipulated for free movement.

1 See further information under Section 1.1.2.

The first Finnish drug strategy was published in 1997, with the aim of arresting the growth of drug use and related crime. Based on this strategy, the Government has issued resolutions in 1998, 2000 and during 2004–2007.

According to the latest resolution, pertaining to 2008–2011, Finnish drug policy is based on general social policy measures, national legislation and international treaties, together aimed at contributing to a reduction in the supply and demand of drugs, and in drug-related harm, so enabling early treatment for those suffering from drug problems and imposing penal liability on those guilty of illegal action. In its drug policy, Finland observes the United Nations international drug control conventions and the EU Drugs Strategy for the period 2005–2012. (Finnish Government 2007a.)[2]

With respect to the drug strategy of 1997, the report of the committee for preventing drug use among young people was prepared in 2000, and the report of the working group on drug treatment in 2001. In addition, the police have produced an anti-drug strategy (2002) for 2003–2006 and the Prison Service (2002) drew up its substance abuse strategy (Sections I–III), which has subsequently been supplemented by a new strategy for 2005–2006. The Customs have also produced a drug strategy for 2002–2005 and a joint drug strategy (PTR) has been drawn up by the police, the Customs and the Border Guard.

Drug control, the prevention of drug use and treatment for drug users are addressed in a variety of key documents relating to the current Government's action programme. In the Government Programme (2007) of Matti Vanhanen's second cabinet, the approach to substances (including drugs) form an important element in the development of primary social and health care services. The Programme emphasises the importance of early intervention as an established part of primary health care as well as securing treatment for substance-abusing pregnant women and providing support services for the children of those with substance problems.

These objectives are shared by the Framework Act governing the restructuring of municipalities and services (169/2007), the Policy Programme for Health Promotion (2007), the Policy Programme for the Well-being of Children, Youth and Families (2007), the Development Programme for Child and Youth Policy (Ministry of Education 2007b), the Government's Decision on the Internal Security Programme (Finnish Government 2008), the National Development Plan for Social and Health Care Services 2008–2011 (Ministry of Social Affairs and Health 2008a) and the Health 2015 public health programme (Ministry of Social Affairs and Health 2001).[3]

## 1.1 Legal framework

### 1.1.1 The new Narcotics Act

According to the new Narcotics Act (373/2008), the production, manufacture, import, export, transit, distribution, processing, possession and use of and trafficking in drugs is prohibited, although exemptions are possible for medical, scientific, investigative and control purposes.

2 See further information under Section 1.2.
3 See further information under Section 1.2.

Under the new Act, the definition of a drug continues to be based principally on international conventions, although a Governmental decree may extend the definition of drugs to include substances which are decided to be placed under control pursuant to Council Decision 2005/387/JHA on the information exchange, risk-assessment and control of new psychoactive substances.

The new Act introduces a total prohibition on the cultivation of coca shrub, khat plant or psilocybin mushrooms and a prohibition on the cultivation of opium poppy, hemp or cactus plants containing mescaline for use as drugs or raw material for drugs.

The National Agency for Medicines will continue to act as the licensing and controlling authority. The new Act contains more specific provisions concerning the competence of the licensing authority; the processing, storage and transport of drugs; the obligation to keep books; seizure and destruction. In addition to the current licenses required for manufacture, import and export, a license will also be required for the import into and export from Finland of any substances, preparations or testing systems used for detecting a drug or containing drugs, and for the processing of drugs.

The Act will also include more detailed provisions on labelling, the obligation to keep books and to give information, seizure and destruction and the monitoring of pharmaceuticals classified as drugs.

In order to reinforce control, the provisions of the new Narcotics Act allow the National Agency for Medicines to obtain information as specified under the Criminal Records Act but also to obtain such information from the register of fines as is necessary for the grant of a license referred to in the Narcotics Act or in European Communities' legislation concerning drug precursors.

The National Agency for Medicines is allowed to disclose information to an authority which has, based on the functions granted to it, the right to obtain confidential information. Correspondingly, the National Agency for Medicines has the right to obtain information required by its licensing and controlling functions.

The National Agency for Medicines will also be allowed to disclose information to an authority which has, based on the functions granted to it, the right to obtain confidential information. Correspondingly, the National Agency for Medicines will have the right to obtain information required by its licensing and controlling functions.

The obligation and mandate of STAKES to act as Finland's representative in the European Information Network on Drugs and Drug Addiction (REITOX) is also specified in legislation.

Since the European Communities' intra- and extra-Community trade regulations on precursors are directly applied to drug precursors, provisions concerning the raw material of drugs or their control are not required under the new Narcotics Act. The new Act does, however govern the competence of the Finnish authorities with regard to the control and monitoring duties specified in regulations.

Following the amendment to the Narcotics Act, the liability to punishment for an illegal act arises where it constitutes either a breach of the Narcotics Act or a narcotics offence, based on the act's severity.

The provision concerning a breach of the Narcotics Act extends the scope of criminal liability according to which acts giving rise to penal liability mainly include the negligence of obligations. Since the obligations concern drugs and precursors, a higher than normal standard of care is required, and negligence, even when caused by carelessness, will

give rise to liability. Unless a more severe punishment for the act is enacted elsewhere in legislation, the person committing a breach of the Narcotics Act can be sentenced to a fine.

Provisions concerning narcotics offences are laid down in Section 50 of the Penal Code as amended by further drug definitions issued from time to time (374/2008).

References to the new Narcotics Act have been incorporated in existing legislation pertaining to drug testing, namely the Occupational Health Care Act (376/2008) and the Act on Protection of Privacy in Working Life (375/2008).

### 1.1.2 Legislation related to demand reduction

*Prevention*

The amendment (56/2007) to the Occupational Health Care Act (1383/2001) specified that before approval, the employer and employees together should discuss the duties in the workplace for which drug tests are applied to in the order of co-operative procedure. Additionally, a positive test result should be confirmed in quality controlled laboratories. (334/2007)

The new Conscription Act (1438/2007) lays down additional regulations according to which a conscript can be referred for examination by a physician or other health care professional concerning their fitness for service or ability to fulfil their duties. The Act includes the conditions under which drugs tests may be carried out.

An examination of a conscript to detect drugs use can be carried out, with their consent, where the conscript has been selected for duties (1443/2007) which require special precision, reliability, independent judgment or quick reactions, and in which the performance of duties while under the influence of drugs or while addicted to drugs might: (1) endanger the life, health or service safety of the conscript or other persons; (2) endanger traffic safety; or (3) endanger the protection of information received while conducting service duties and thus cause harm or damage to public interests protected by confidentiality provisions.

Conscripts on service can be required to undergo an examination if there is justifiable cause to suspect that they are under the influence of drugs while serving or that they have a drug addiction. Based on the individual examination, a conscript may be removed from duties, or discharged from service completely or for a specified period of time.

According to the Non-Military Service Act (1446/2007), a Centre for Non-Military Service or non-military service location can, during the period of service, require an individual undergoing non-military service to undergo an examination or check-up by a nominated physician or other health care professional in order to obtain a certificate of health, in cases where this is necessary for assessing the individual's abilities to fulfil their service duties or fitness for service. In such a case, the Centre for Non-Military Service or non-military service location can require an individual undergoing non-military service to obtain a drug test certificate under the Act on Protection of Privacy in Working Life (759/2004), on grounds similar to those required for tests under the Conscription Act. A certificate may also be required if the individual might endanger business or professional secrecy or cause a significant financial loss to the employer or its customer or if the

person carries out duties which include education, teaching, keeping or otherwise caring for, or other work involving private interaction with, a person underage and which take place without others present.

The drug test and related certificate are subject to provisions of the Occupational Health Care Act (1383/2001). If a person undergoing non-military service refuses to obtain a drug test certificate and the non-military service location has a justifiable reason to suspect that the person has a drug addiction or is carrying out their service under the influence of drugs, that person's fitness for service must immediately be assessed with other methods available in a health examination. If the person is deemed unfit for service, the Non-Military Service Centre may issue a total exemption from peacetime service or an exemption for a specified period.

*Drug-related treatment*

Government Decree 719/2007 granted a total of €3,500,000 of state subsidies to Social and Welfare Centres of Expertise and to municipalities and federations of municipalities for the development of services for substance abusers to cover costs for treatment and for improving treatment. Regional need for subsidies in treating substance abuse and the development of co-operation among authorities as part of the national structural reformation of municipalities and services determine how the subsidies are distributed. Funding programmes pay special attention to female substance abusers and those with mental health problems.

The Child Welfare Act (583/2007) which came into effect at the beginning of 2008 emphasises the ability of adults, who receive services for substance abuse and mental health problems, in taking care of and supporting children under their care. A child should be taken into care by social welfare authorities, and substitute care should be organised for him/her if the child is deprived of care to the extent that it seriously endangers his/her health or development, or if the child seriously endangers his/her own health or development by abusing substances, committing an offence considered to be more than a minor offence, or behaving in other similar ways. If taking into care can be considered beneficial to the child, a specific care plan is made, which states the goals of substitute care and especially how support and assistance will be arranged for the child, his/her parents and guardians and which may contain guidelines for special care in breaking the vicious circle of substance abuse or crime.

The new Decree governing the detoxification and substitution treatment for opioid addicts (33/2008) stresses that only demanding substitution treatment cases should be dealt with by specialist health care; other cases should be treated at the primary health care level. In contrast to the old decree, primary health care service units no longer need to issue an advance notice of the start of treatment to the State Provincial Office and, as far as the evaluation and start of treatment is concerned, the emphasis is on out-patient rather than inpatient care.

In common with the old decree, pharmaceuticals containing buprenorphine or methadone can only be prescribed for the detoxification or substitution treatment of opioid addicts by a physician employed by a health care unit and responsible for its operation or by the physician who assigned this task to him/her. Medical treatment may be conducted and the medication administered to the patient only under the supervision of the health care unit. If the patient's commitment to treatment is high, the health care unit can give him/her pharmaceuticals equivalent to a maximum of eight daily doses (15 in exceptional cases under the new Decree).

However, as an exception to the above and to the old decree, the new Decree allows the combined preparation of buprenorphine and naloxone to be issued from a pharmacy under a pharmacy contract signed by the patient, during the validity of the contract. A *pharmacy contract* refers to a contract by which the patient commits to collect the pharmaceuticals specified in the contract only from one pharmacy and agrees that the pharmacy may transmit treatment-related information to the physician treating the patient and notify other pharmacies of the existence of the pharmacy contract.

*Responses to health and social correlates and consequences*

Amendments 265–266/2007 to the Act on Imprisonment and Detention Act increased the competence of the prison authorities to monitor communication by prisoners with the outside world such that their criminal background, behaviour during imprisonment, suspicious postal delivery or the sender of such post are sufficient grounds for opening and checking a letter or other postal delivery and the contents therein without reading it, appealing to the possibility that the letter or postal delivery may contain forbidden substances or objects. Similar grounds may be used to read a letter if there is reason to believe it will help in preventing or solving a crime, preventing a threat to the order of the prison, or protecting the safety of an inmate or other person.

### 1.1.3 Legislation related to supply reduction

As of the beginning of 2007, an amendment to Section 50 of the Penal Code (928/2006) regarding drugs defined the cultivation and transportation of drugs, as well as consigning someone to transport drugs and attempting to abet a narcotics offence as being narcotics offences. In addition, this amendment and the related Decree 1014/2006 defined an act abetting an aggravated narcotics offence by a member of organised crime when the drug in question is considered an extremely dangerous drug, the drug consignment is large, or the act is committed to in the pursuit of significant financial gain. If the act abetting a narcotics offence can be considered aggravated when assessing the overall situation, the perpetrator should be sentenced to a minimum of four (4) months and a maximum of six (6) years in prison.

## 1.2 Institutional framework, strategies and policies

*Background*

The Drug Policy Action Programme 2004–2007, which was approved during Prime Minister Matti Vanhanen's first term of office (2004–2007), presents three different visions regarding the development of the drug situation by the year 2007: a rising, stable or decreasing trend in development (Ministry of Social Affairs and Health 2004).

The programme's 14 objectives relate to the co-ordination of drug policy, co-operation among authorities in different parts of administration, the availability of drug treatment services in various situations, the increase of expertise, the development of methods to use in substance abuse work, diversifying penal procedures, the development of local co-operation with non-governmental organisations, the development of drug legislation, the increase of international activities and co-operation with neighbouring areas, and investment in drug research. The programme's final report was presented in the spring of 2007 (Ministry of Social Affairs and Health 2007).

The final report concluded that the drug situation showed clear signs of stabilising during the Government's term of office. According to this so-called moderate scenario, a slight increase in those who occasionally experiment with drugs could still be included in the model if the situation remains the same or improves in relation to use on a more regular basis and problem drug use and its adverse effects. It is essential that no changes occur in those who recruit as regular drug abusers. As regards problem drug use and the harm associated with it, society's trends in well-being, especially the employment situation and opportunities in education, should promote positive expectations for the future. The moderate scenario suggests the stabilisation of the judicial and societal conditions in the areas around Tallinn and St Petersburg as a prerequisite in impeding the availability of drugs. According to the estimate, Estonia's EU membership favours this view on development. (Ministry of Social Affairs and Health 2007).

However, the scenario's estimates concerning the link between a decrease in drug use and the development of negative attitudes toward the use of alcohol and binge drinking do not seem to be materialising, and even if the scenario of moderate development did materialise, it is difficult to say whether or not stability would be permanent because the drug markets and culture can change quickly. (Ministry of Social Affairs and Health 2007)

*Drug policy guidelines for 2008–2011*

The resolution of Matti Vanhanen's second Government, which took office in March 2007, concerning co-operation on drug policy for 2008–2011 was completed in the late 2007, based on the above-mentioned moderate scenario (Finnish Government 2007a).

Pursuant to this resolution, the Government will continue to strengthen co-ordination of drug policy and co-operation among administrative sectors during the 2008–2011 administrative period. According to the resolution, the basic requirements of counter-narcotics action in Finland are well ensured: the drug situation can be reliably monitored and effective interventions can be made where required. The programme includes the following seven action points:

1. Preventive work and early intervention

Preventive substance abuse work will be enhanced in social and health care, youth work, schools and educational establishments and its role in the promotion of health and well-being will be consolidated in the restructuring of municipalities and services. Early intervention will be established as part of all health and welfare services. Substance education will be reinforced throughout the educational system. Support will be provided for high-quality information and education activities. Where necessary, the provision of information will be targeted at special risk groups.

2. Combatting drug-related crime

The likelihood of getting caught will be increased for aggravated narcotics offences and those involving distribution carried out in Finland. Criminal liability will be implemented through seamless international co-operation with the offender's home country or country of residence. The import of drugs for the Finnish market will be tackled primarily through seizures at national borders. Control of the distribution of drugs and pharmaceuticals classified as drugs will be integrated into the basic operations of the police. Detection of crime accompanying narcotics offences, particularly concealment, procuration,

blackmailing and money laundering, will be increased. Tracking the benefits arising from an offence and their comprehensive obliteration shall be reinforced.

3. Treatment of drug addiction and reduction of harm from drug use

The development and increased provision of treatment services will continue, with the aim of ensuring equal access to services for all citizens. A range of treatment options, appropriate for the type of addiction, will be offered to drug users. Treatment, health counselling and support directed at reducing drug-related harm (such as diseases, mental health problems and accompanying crime), will be increased. Access to treatment will be facilitated for opioid addicts, and treatment volumes increased to meet demand more fully. Referral to treatment issued by the police will be further reinforced.

4. Intensifying the treatment of drug misuse in connection with criminal sanctions

The effectiveness of imprisonment will be improved through improved planning of prisoners' sentences and release on an individual basis, as required by the new Act on Imprisonment. The operation of allocation units determining the prisoners' placement will be developed and substance abuse rehabilitation and contact work in prisons increased. Support measures for supervised probationary freedom and post-care for released inmates will be improved. Substance abuse rehabilitation included in community sanctions will be strengthened and rehabilitation opportunities for those sentenced to juvenile punishments improved.

5. EU drug policy and international co-operation

Finland will take an active role in planning and implementing the EU-wide drug policy. Finland will participate in international anti-drug collaboration through drug policy forums established by the United Nations, the Council of Europe and the Nordic Council of Ministers. International anti-drug and drug-related harm reduction projects conducted bilaterally or multilaterally and supporting Finland's objectives will be supported through funding within the framework of neighbouring area and development co-operation.

6. Information collection and research regarding drug problems

Long-term follow-up research on the drug situation will be continued and the availability of up-to-date information on the drug situation to those responsible for drug policy will be ensured. National information required for reports on the drug situation by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) and for the data collection systems of the UN will be produced. Research into drug use, drug markets, the treatment of drug users and methods of combating drug-related problems will be furthered and international co-operation by Finnish researchers promoted. Citizens' opinions on drugs, drug use and related harm will be monitored regularly.

7. Co-ordination of drug policies

The Ministry of Social Affairs and Health is responsible for co-ordinating national measures related to drug policy. In support of this, the operations of the Drug Policy Co-ordination Group will continue during the Government's 2008–2011 term of office. Developments in the drug situation will be followed and findings regularly reported to the Government. Co-ordination will encompass the preparation and implementation of legislation and action by the authorities pursuant to overall drug policy. Furthermore, national drug policy will be co-ordinated with alcohol and tobacco policies.

The effectiveness of drug policy implementation will be monitored using indicators including the extent of drug use by age group; the number of problem drug users; hospitalisation periods; drug-related deaths; infectious disease cases related to drug use; narcotics offences; drug seizures; and treatment referrals by the police.

Anti-drug work will also take account of measures contained in other Government action plans and those in, for instance, the Internal Security Programme.

*Measures contained in other Government action plans*

Legislation on the restructuring of municipalities and services entered into force on 23 February 2007. The Framework Act (169/2007) requires municipalities to ensure equal provision of central social and health care services to all Finns. This goal is to be met by reinforcing the municipal structure and capital base, strengthening co-operation between municipalities and ensuring the coverage of the service network.

The *National Development Plan for Social and Health Care Services* (Ministry of Social Affairs and Health 2008a) highlights improvements required in primary health care, social work, care provided by paramedics as well as mental health and substance abuse work.

According to the *Policy Programme for Health Promotion* (Finnish Government 2007b), the Ministry of Social Affairs and Health will prepare a proposal for comprehensive care for pregnant women with intoxicant problems. Furthermore, the Ministry of Social Affairs and Health is currently drawing up a national mental health and intoxicant plan creating policy outlines and operating models for mental health and intoxicant abuse services and for the provision of related on-call services. Both proposals are due to be finalised by the end of 2008.

The *Policy Programme for the Well-being of Children, Youth and Families* (Finnish Government 2007c) aims to create a service system supporting families with children that will form a seamless network to promote the well-being of children and young people and which is able to eliminate threats to well-being in advance and enable effective intervention in problems. A key priority is support services for children and young people, especially in the case of violence, mental health problems or intoxicant problems in families.

The *Child and Youth Policy Development Programme* (Ministry of Education 2007b) affirms that the passing of mental health and substance abuse problem from one generation to the next is one of the most common paths to social marginalisation. The programme underlines that co-operation between child welfare services, substance abuser services and mental health services must be strengthened to meet the welfare and rehabilitation needs of children whose parents require adult services. The programme also addresses penal action for juvenile offences, proposing that juvenile punishments should also involve mental health or substance abuse services.

Furthermore, the *Internal Security Programme* (Finnish Government 2008) emphasises that social marginalisation is often related to long-term problems of subsistence, but also to substance abuse and mental health problems. Breaking the cycle often requires simultaneous measures by various actors and early intervention. Since substances (particularly alcohol) and violence are often interlinked in Finland, the programme aims to reinforce existing support services in order to reduce violence towards children and young people. In addition, the programme focuses on national and international

co-operation among the competent authorities in combatting organised crime and on sector-specific collaboration with business.

The Working Group considering how to enhance the fight against organised crime (Ministry of the Interior 2007) has emphasised that the most urgent measure to be implemented is the collection of information on serious organised crime and integration into the national information systems of the police. Another urgent need is to ensure that organised crime is tackled primarily using methods targeted at serious crime. An essential requirement is therefore that the fight against organised crime should be planned and implemented in a co-ordinated manner.

STAKES has assembled a comprehensive support package for substance abuse work which offers material both for implementing the project to restructure municipalities and services and for improving substance abuse work. The guide emphasises that substance abuse work is an essential part of the broad-based welfare work of municipalities. Since substance abuse work is conducted in co-operation between many actors, setting and achieving objectives requires the commitment of several administrative sectors. Preventive substance abuse work is part of the wider concept of promotion of well-being and health. Corrective substance abuse work is conducted together with mental health services, since many substance abusers also have mental health problems. Primary health care and social services play a central role as a partner for specialised services for substance abusers and as an actor in preventive substance abuse work. Substance abuse work is not conducted only through municipal social and health care, but also in educational establishments, cultural and leisure activities, community planning, the police service and even in business life. Furthermore, organisations and other third-sector actors have their own roles in substance abuse work. (STAKES 2007.)

*Evaluation of drug policy*

The first national drug strategy was prepared by the Drug Policy Committee in 1997. According to the dissertation of Tuukka Tammi (2007), two different views on the drug issue collided within the Committee: the police authorities advocated a drug-free society and advocated strict control policies while the social welfare, health and criminal policy alliance was in favour of harm reduction. The general objective of harm reduction was not solely based on public health concerns. The ideological roots of the concept can be traced back to the tradition of a rational and humane criminal policy that was first adopted in the 1960s and 1970s according to which criminal and social policy primarily aims at minimising social harm.

According to the study, minimising harm has not threatened drug prohibition policy; rather, it has become a part of it. Minimising harm through the establishment of syringe and needle exchange points (health counselling centres) and extended substitution treatment has meant new, specialised services founded upon medicine and the added effort of medical professionals in the treatment of drug-related problems. Penal control of drug use has at the same time become more effective. Therefore, minimising harm has not meant a step toward more liberal drug policy, nor has it debilitated the traditional policy based on complete drug prohibition. Instead, minimising harm combined with punitive prohibition policy forms a new type of two-track paradigm for drug policy. (Tammi 2007)

At regional level, drug and alcohol policy has been evaluated as part of substance abuse work in cities. In the Helsinki area, models for substance abuse work have been evaluated systematically by assessing residents' opinions about the nature of the drug

and alcohol problem and models for solving the problem in which the activities of day centres for drug users (Törmä & Huotari 2005b; Forssèn 2005), health counselling centres (Törmä & Huotari 2005a; Perälä 2007a, 2007b) and models for social housing management (Haapanen 2004) were analysed.

According to estimates, models involving institutionalised drug treatment no longer satisfy the demands of the present, increasingly multifaceted alcohol and drug culture; rather, services must be offered close to the client. Evaluative research suggests that services be developed to allow clients in the weakest position to receive basic services at low-threshold units. Satisfying basic needs by offering enough safe, protective places to rest during the day as well is one way to reduce disorder. Finding a place for substance abusers, who do not have a permanent place of residence, to stay is one of the basic requirements in reducing intoxicant-related disorder. Staggering support according to the client's resources and history of residency is important with regard to living on his/her own. Considering geographical location is also important in planning substance abuse services, for example in the immediate vicinity of areas where the risk of contracting HIV is high. People with the most serious substance abuse and mental health problems do not seek out even low-threshold services. Outreach work should be further developed for these people, for instance, with the support of peer groups.

### 1.3 Budget and public expenditure

The expenditure incurred by the state from drug-related harm has been calculated based on a calculation framework established in Finland (Salomaa 1996; Hein & Salomaa 1998). Such harm-related expenditure thus calculated has been reported in the Yearbook of Alcohol and Drug Statistics published by STAKES since 1998. The calculated public expenditure as presented in this report corresponds to the costs presented in the Yearbook in those respects where they are included in both calculation frameworks.

In 2006, public expenditure[4] caused by drug use totalled approximately 115.6 million euros. Of this amount, a total of 14.3 million euros had been earmarked for anti-drug activities. One of the largest funders of substance abuse work, Finland's Slot Machine Association RAY, allocated 11.6 million euros for drug-related work and prevention. For conducting drug-related research at the Research and Development Centre for Welfare and Health (STAKES), the Ministry of Social Affairs and Health allocated 0.7 million euros. The Ministry also allocated 2 million euros for drug prevention work.

The largest portion of expenditure was incurred by enforcement of law and order, accounting for an estimated 61.5 million euros. The costs attributable to the prison service (33.3 million euros) represented the largest single expenditure item.

Expenditure attributable to prevention accounted for some 18.8 million euros, mostly funds allocated for research and substance abuse work.

Harm reduction activities accounted for a total of 9.8 million euros of earmarked funds. Of this amount, 8.8 million euros were assigned to drug-related disability pension expenditure and 0.9 million euros to drug-related sickness allowances. Compensation paid by the state, for instance to victims of crime, totalled 0.1 million euros.

4 The data used is obtained from budget reports and final accounts reports of ministries, public agencies and other public bodies.

*Table 1. Harm-related costs from drug use incurred by the state in 2006 (EUR million).*

| COFOG | Authority | Reuter's | Budget expend-itures total | Harm-related costs associated with drug use | Labelled |
|---|---|---|---|---|---|
| 03. PUBLIC | 03.1 POLICING | | | | |
| ORDER AND | Policing | Enforcement | 576.7 | 16.1 | |
| SAFETY | Customs control | Enforcement | 141.5 | 5.2 | |
| | 03.2 FIRE AND RESCUE SERVICES | | | | |
| | Fire and rescue services | Enforcement | 62.3 | 2.2 | |
| | 03.3 JURIDICIAL SYSTEM | | | | |
| | District Court | Enforcement | 125.9 | 1.7 | |
| | Court of Appeal | Enforcement | 34.4 | 0.9 | |
| | Supreme Court | Enforcement | 7.0 | 0.1 | |
| | Legal aid | Enforcement | 21.2 | 0.2 | |
| | Enforcement Office | Enforcement | 79.2 | 0.8 | |
| | System of prosecution | Enforcement | 31.3 | 1 | |
| | 03.4 PRISON SYSTEM | | | | |
| | Prison Service | Enforcement | 193.7 | 32.4 | |
| | Open institution work | Enforcement | 5.4 | 0.9 | |
| | 03.5 RESEARCH AND DEVELOPMENT RELATED TO PUBLIC ORDER AND SAFETY | | | | |
| | National Research Institute of Legal Policy | Prevention | 1.1 | 0.04 | |
| | The European Institute for Crime Prevention and Control | Prevention | 0.5 | 0.02 | |
| | 03.6 PUBLIC ORDER NOT ELSEWHERE CLASSIFIED | | | | |
| | Ministry of Justice | Prevention | 82.8 | 0.6 | |
| | Certain paid compensations | Harm reduction | 13.1* | 0.1 | |
| 07. HEALTH | 07.5.0 RESEARCH AND DEVELOPMENT IN THE HEALTH CARE SECTION | | | | |
| CARE | National Research and Development Centre for Welfare and Health (STAKES) | Prevention | 22.7 | 0.7 | Yes |
| | National Public Health Institute | Prevention | 35.3 | 1.2 | |
| | Finnish Foundation for Alcohol Studies | Prevention | 0.5 | 0.2 | |
| | 07.6 HEALTH CARE NOT ELSEWHERE CLASSIFIED | | | | |
| | Ministry of Social Affairs and Health | Prevention | 68.5 | 2 | Yes |
| | Finland's Slot Machine Association | Prevention | 292 | 11.6 | Yes |
| | Finland's Slot Machine Association | Prevention | 292 | 2.4 | |
| 10. SOCIAL | 10.1.1 ILLNESS (IS) | | | | |
| SECURITY | Sickness allowance | Harm reduction | | 0.9 | |
| | 10.1.2 DISABILITY | | | | |
| | Disability pension | Harm reduction | | 8.8 | |
| REVENUE TRANSFERS TO MUNICIPALITIES | | | | 25.5 | |
| COSTS, TOTAL | | | | 115.6 | |

*) Certain paid compensations, with the exception of aid in maintaining Sámi culture and self-administration.

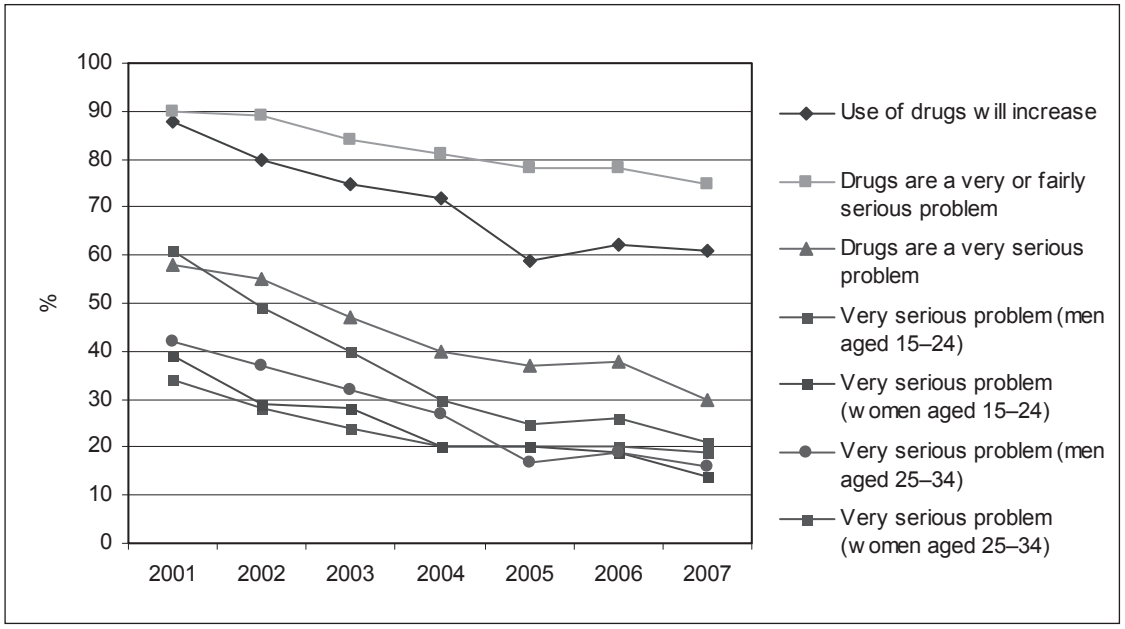
## 1.4 Social and cultural context

*Attitudes to drugs and drug use*

Public attitudes toward drug problems in Finland are gauged in annual Health Behaviour Surveys among the Finnish Adult Population. Respondents have been asked how serious a problem they consider drug use to be in Finland currently and how they believe drug use will develop in Finland in the near future.[5]

A great majority of respondents have continuously considered drug use in Finland a fairly serious problem, with only a few percent believing drug use will diminish in the future. While opinions have moderated somewhat in very recent years, there is still significant concern about drugs, including in younger age groups. (Piispa et al. 2008, 14–16.)

*Figure 1. Opinions of the adult population on drug use 2001–2007.*




Source: Piispa et al. 2008

According to researchers, the more moderate trend in opinions suggest that the people have, to some extent, become accustomed to the presence of drugs and that drug problems have become a normal issue within the gamut of substance abuse problems. This habituation process is most marked among urban youth – in areas with the longest history and the most frequent presence of drugs. Similar results have been obtained in drug surveys conducted by STAKES (Hakkarainen & Metso 2007), in which very few respondents considered the risks of drug use to be small, while the fear of becoming a target of violence due to other people's use of drugs was common. (Piispa et al. 2008, 24–26.)

5 Data for the health behaviour surveys have been collected by a postal survey sent to a representative random sample of 5,000 persons among those aged 15 to 64 years and permanently living in Finland; people living in institutions were excluded from the study. Questionnaires were mailed out during spring (in April) and those who did not respond to the questionnaire were sent, during the two following months, two (in 1996) or three (in 1997–2007) new questionnaires). The number of those who have returned the questionnaire has varied annually between 3250 and 3600. (Piispa et al. 2008)

The Health Behaviour Survey among the Finnish Adult Population has also canvassed respondents' opinions on which drugs should be categorised as mild or hard. Cannabis occupies a special status in the drug use, and opinions, of Finns. In the Health Behaviour Surveys, only cannabis has been categorised as mild. STAKES' drug surveys also indicate that while attitudes to the risk of experimenting with cannabis have become more moderate, attitudes toward other drugs have remained very negative (Hakkarainen & Metso 2007, 548–550). (Piispa et al. 2008, 24–26.)

*Attitudes to cannabis users*

The Finnish use of drugs and the place of cannabis within it, have also been examined from the perspective of cannabis campaigners. In her dissertation, Taru Kekoni asked campaigners how their use of cannabis began, what meanings they attached to their personal use, how they perceived attitudes to cannabis use in society and how those attitudes affected their own social status.[6] (Kekoni 2007, 78)

Interviewees saw social attitudes towards cannabis use as negative, stigmatising and based on ignorance about cannabis and influenced by the strong dominance of alcohol in Finnish substance use culture. In the interviews, reference was made to general 'drug hysteria' and a contrast was drawn with prevailing social attitudes to alcohol, the 'good substance'. (Kekoni 2007, 169–92.)

The researcher concluded that, by including cannabis users in the problematic group of 'drug users', the use of cannabis was socially marginalised, since it created problem identities stigmatised by cannabis use as well as model narratives of social marginalisation. Social bodies embracing this type of social approach were in fact pushing cannabis users outside the sphere of social activity – which could, in turn, cause significantly more problems to cannabis users. If a user's family, for instance, becomes aware of cannabis use, this may entail attempts to refer the user for treatment, house searches or body searches (the latter being considered extremely abusive and strongly stigmatising of the user's identity). According to the interviewees, most treatment referrals were initiated by the parents of young users. In the treatment system, use is reportedly viewed as a problem, with efforts being made to overcome it through outpatient discussions and drug screenings. Treatment discussions were perceived as one-sided and useless since the points of view of users and providers of treatment did not converge (e.g. the gateway theory). (Kekoni 2007, 169-171.)

The interviewees consider coverage by the media of cannabis as sensationalist and the way the effects of cannabis use are reported in the news is, in their opinion, based on ignorance or the prevailing, erroneous information. Identification as a cannabis user in public may result in significant penal sanctions. However, channels such as discussion forums on the Internet, which offer an alternative to the dominance of the mainstream media, enable another kind of exposure and a different perspective from mainstream culture. Based on societal reactions, remaining silent seems to be the means chosen by individuals to protect their social status – a solution which at the same time preserves

6 The researcher contacted the interviewees through the Finnish Cannabis Association and by distributing contact questionnaires at a hemp march held in Tampere in 2003. A total of 36 campaigners were interviewed. Common to all of them was a more or less ideological approach to cannabis, while their ways of using cannabis varied greatly (one subject did not use cannabis at all). One third of the interviewees used cannabis daily and nearly one third either a few times a week or a few times a year. Employed people accounted for 44% of the interviewees, students for 36% and unemployed for 17%. Two thirds were male. Slightly more than a third was aged either 15–24 or 25–34, and slightly more than 10% was aged 35–44 or 45–54. The interviews were conducted using a qualitative and activating method. (Kekoni 2007, 78–92.)

the imbalance between information disseminated in the mainstream media and the perspective of users. (Kekoni 2007, 170-171.)

*Attitudes to problem drug users*

A survey was carried out in January 2007 concerning the attitudes of Finns toward problem drug users[7]. Results indicated that the majority of Finns would be willing to help a close relative or friend who was a drug addict. A total of 81% of the respondents answered 'agree' or 'somewhat agree'. More than half of the respondents also felt that employers should take part in organising treatment for an employee with a drug problem. In addition to the desire to help, most of the respondents (87%) felt that drug addiction can be cured. A total of 73% thought that society should allocate more resources for treating people with drug problems. Drug abuse is seen as a societal problem as only a third (32%) of the respondents felt that drug addiction is completely the fault of the drug user. However, reasons for using drugs were usually seen as deriving from the individual himself/herself. Despite the desire to help and positive attitudes toward treatment, Finns react rather dubiously to drug users. Respondents felt that drug users spread infectious diseases (80%), and, in addition, drug users are also seen as frightening (66%) and unreliable (78%). (Sormunen 2007)

7 Schering-Plough Oy carried out a survey, which examined the attitudes of Finns toward drug abusers. Data was gathered through phone interviews in January 2007. There were 500 respondents to the questionnaire, which represented the typical Finn in terms of age, sex, and place of domicile.

# 2 Drug use in the population

In Finland drug trends have followed international currents but fluctuations in drug use have been particularly strong. Much like other countries, Finland has experienced two major drug waves: one in the 1960s and the other in the 1990s.

Studies show that the trend in drug experimentation of the 1990s was set in motion by men, followed by women in the second half of the decade. The proportion of those having tried drugs during the past year grew until the end of the 1990s, after which the trend clearly levelled off. The same phenomenon can be observed among young people.

The new rise in experimentation and use of drugs that took place in the 1990s was also a youth and generation phenomenon, much like in the 60s. The techno culture landed in Finland at the end of the 1980s, beginning as a small underground movement. The phenomenon started to gain popularity in the mid-1990s, especially among young adults. By the end of 1990s, the phenomenon had diversified and it was no longer only a marginal way of partying among urban youth. Nowadays, the recreational use of drugs connected with partying is no longer solely a part of the techno and rave culture but rather a wider youth culture trend. (Salasuo 2005.)

## 2.1 Drug use in the general population

According to the 2006 population survey, 13% of 15–69-year-olds had experimented with cannabis sometime in their life.[8] The level was nearly the same as in the 2002 survey and three percentage points higher than in 1998. The percentage was 12% among women and 16% among men. The proportion of 15–34-year-olds (22%) remained the same in 2002 and 2006. However, changes have taken place within the latter age group: between 2002 and 2006, the proportion of 15–24-year-olds decreased by 6 percentage points whereas the proportion of 25–34-year-olds grew by the same amount. Thus, it seems as if cannabis has lost some of its significance as part of youth culture whereas the generation that experimented with drugs at the turn of the millennium seems to continue using drugs at an increasing rate. (Hakkarainen & Metso 2007.)

A total of 3% had tried cannabis during the past year, which corresponded to the 1998 and 2002 survey results. The largest increase was seen among 25–34-year-old men: the proportion of experimenters doubled between 2002 and 2006. A total of 1% of adults had used cannabis during the past month: 4% of the 15–24 age group and 3% of the 25–34 age group. The percentages for men were somewhat higher than they were for women. (Hakkarainen & Metso 2007.)

8 The target group of the study comprised 15–69-year-old Finns, among whom a random sample of 5,500 people was chosen using the Finnish Population Information System. The inhabitants of Åland, people living in institutions and those without a permanent home were excluded from the study. Half of the sample consisted of 15–34-year-olds. The aim of the oversampling was to focus the study on the most active population group in terms of drug use. In the analysis, the oversampling of young people was balanced by weighting. 3,029 people answered the postal questionnaire.

*Table 2. Lifetime and 12-month prevalence of cannabis use by age group (%)*

| | 1992 | 1996 | 1998 | 2002 | 2004 | 2006 |
|---|---|---|---|---|---|---|
| Lifetime prevalence | | | | | | |
| All | 5 | 8 | 10 | 12 | 12 | 13 |
| 15–24 | 12** | 14* | 19 | 25 | 18 | 19 |
| 25–34 | 10 | 16 | 19 | 19 | 22 | 25 |
| 35–44 | 4 | 8 | 8 | 11 | 13 | 16 |
| 45–69 | 1 | 2 | 3 | 4 | 5 | 6 |
| 12-month prevalence | | | | | | |
| All | 1 | 2 | 3 | 3 | 3 | 3 |
| 15–24 | 6** | 9* | 10 | 11 | 8 | 9 |
| 25–34 | 2 | 3 | 3 | 4 | 5 | 7 |
| 35–44 | 0 | 1 | 0 | 1 | 2 | 2 |
| 45–69 | 0 | 0 | 0 | 0 | 0 | 1 |

**18–24 yrs *16–24 yrs

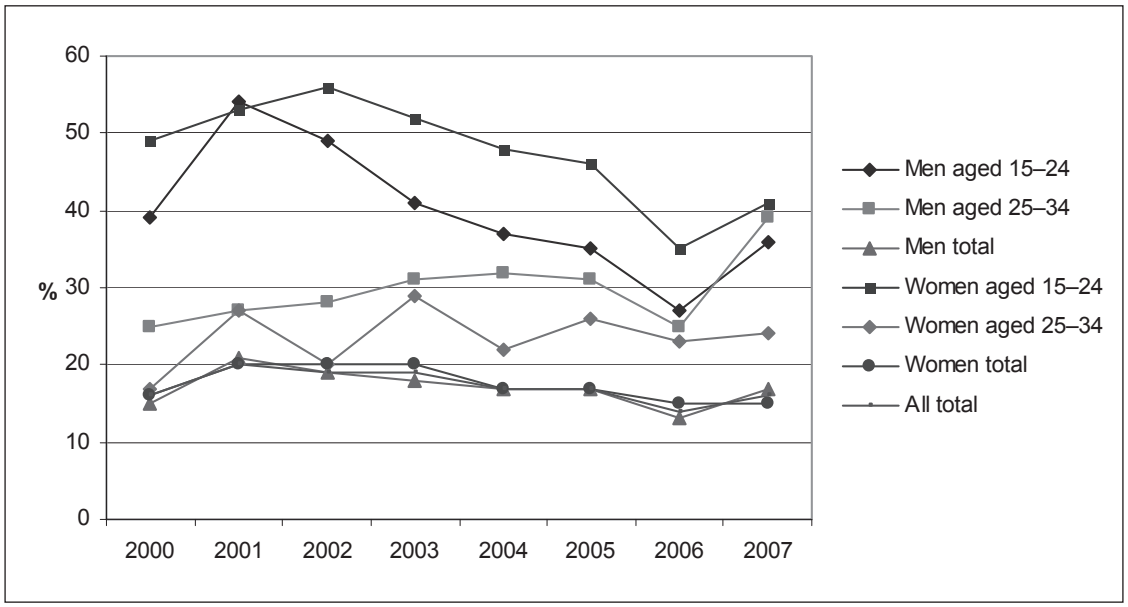
Source: Kontula & Koskela 1992; Kontula 1997; Drug and alcohol surveys 1998, 2002, 2004, 2006, STAKES.

For drugs other than cannabis, the percentages of those having experimented with drugs during their lifetime varied from 2% for those having tried amphetamines to 0.6% for opiates. A total of 1.5% had experimented with ecstasy and 1.0% with cocaine. The group that had experimented the most with amphetamines (9%), ecstasy (5%) and cocaine (3%) were 25–34-year-old men. For all substances and among all age groups, fewer than 2% reported having tried a substance during the past year, and only a few individuals reported having tried a substance during the past month. (Hakkarainen & Metso 2007.)

Hypnotics, sedatives and analgesics had been used for non-medicinal purposes by 7% of the respondents during their lifetime, by 3% during the past year and by 2% during the past month. Age and gender differences were not significant in the case of pharmaceuticals. (Hakkarainen & Metso 2007.)

In the Health Behaviour Surveys among the Finnish Adult Population, the most important annual indicator depicting the development of the drug situation is the proportion of people in various age groups who know someone among their acquaintances who has experimented with drugs. These proportions were growing until the early 2000s, but have been declining ever since. The most significant changes have occurred among 15–24-year-olds. However, the overall trend is not quite unequivocal, given that contact with those who have experimented with drugs has increased among 25–34-year-old males. In addition, 2007 seemed to mark a slight deviation from the previous declining trend, including among the younger age group. (Piispa et al. 2008, 30.)

*Figure 2. Percentage of people, by age group, who know someone among their acquaintances who has experimented with drugs during the past year*




Source: Piispa et al. 2008

Summarising recent research findings, the researchers conducting the Health Behaviour Surveys (Piispa et al. 2008) suggest that although there may be fewer new users experimenting with or starting to use drugs compared to a decade ago, following years of growing use, drugs play a significantly stronger role in Finland in the partying habits of urban youth, recreational use (Salasuo 2005) and problem use of substances (Partanen et al. 2007).

In her study on cannabis activism[9], Taru Kekoni analysed the ways in which cannabis users have become accustomed to the use of cannabis and the personal meanings which users attached to their cannabis use. The researcher concluded that users had a wide range of motives for beginning their use, ranging from happenstance to consideration over several years. Experimentation occurred for the sake of trying out something new but also following a longer history of substance abuse. However, the researcher found a particular perspective on cannabis in the ideological meanings given to its use. She classifies these meanings into four types: use which broadens one's consciousness (stimulating the functioning of senses); medical use for treating diseases (pain or mental diseases); lifestyle use; and ritual use related to enjoyable, quasi-religious experiences. In the mainstream media, use is often simplified into either occasional recreational use or addiction-based (problem) use. For these two uses, the identified ideological dimension is, however, very weak. The research revealed that the stronger the ideological meaning of their cannabis use, the more the users will feel the need to distance themselves from these two methods of use and, moreover, the more conflict the illegality of use and consequent social attitudes may cause to the user's everyday life – even if the use itself remains occasional in nature. (Kekoni 2007, 142–145.)

9 See also Section 1.4. and Kekoni 2008a/b.

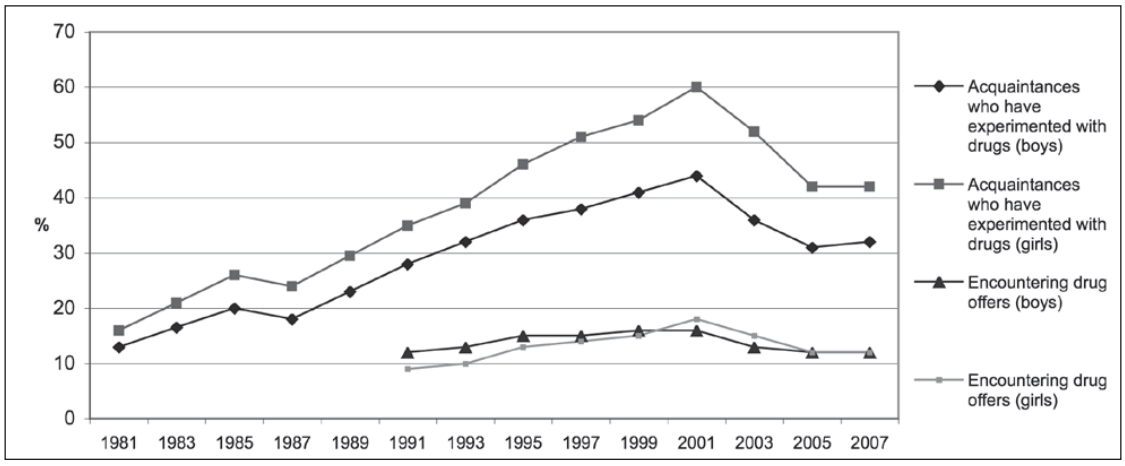
## 2.2 Drug use in the school and youth population

According to the ESPAD survey of school pupils[10], 8% of 15–16-year-olds had experimented with cannabis sometime in their life whereas the corresponding figure was 10% in 1999 and 11% in 2003. For substance use, levelling or reducing trends have been observed throughout the 2000s with respect to binge drinking, the combined use of alcohol and pills, tobacco and cannabis. A downward trend is particularly apparent in the Greater Helsinki area with regard to cities and cannabis. Indeed, in 2007, experimentation with cannabis was nearly as common among young people living in the countryside as among those living in cities. Regionally, however, cannabis experimentation by young people is highest in the Greater Helsinki area, at 12%. (Ahlström et al. 2004, 2008.)

Exceptions to this trend were, however, reflected in a growing use of glues and solvents and, among girls, an increasing use of sedatives and hypnotics. According to the 2007 study, more than 10% of young people had used glues or solvents in their lifetime. Nearly 10% of girls had also used sedatives or hypnotics to become intoxicated. The use of glues and solvents, in particular, is markedly more frequent in the countryside (15% of young people) than in cities (9%). (Ahlström et al. 2008.)

The questions in the national Adolescent Health and Lifestyle Survey[11] aimed at 12–18-year-olds, enable young people's 'social exposure to drugs' to be analysed. Respondents are asked whether they know someone among their acquaintances who has experimented with intoxicants or whether they themselves have been offered such substances. The 2007 survey indicates that the proportion of 14–18-year-olds with at least one acquaintance who has experimented with drugs increased from 1987 until 2001, then started to fall before levelling off in 2007. (Rimpelä A. et al. 2007, 42–44.)

*Figure 3. Social exposure to drugs among 14–18-year-olds (percentage, age-adjusted)*




Source: Rimpelä A. et al. 2007

10 The latest of these surveys was the 2007 ESPAD survey, which involved 299 schools and 5,043 pupils in the 9th grade of secondary school. Data was collected using the same compilation method as in the 1995, 1999 and 2003 surveys. The response percentage was 91% in 2003. (Ahlström et al. 2008.)

11 The survey takes the form of a postal survey repeated every other year. The first survey was conducted in 1977. The survey sample is selected among those aged 12, 14, 16 and 18. The survey includes, for those who had not responded, two new questionnaires of which the latter was available in electronic format. The 2007 survey covered a total of 5,480 youth respondents (response rate 61%). (Rimpelä A. et al. 2007.)

The researchers conclude that both this survey and other surveys of young people (Hakkarainen & Metso 2007) suggest that the reduction in drug use is stopping. The majority of drug offers are made by friends and acquaintances, which indicates that drugs have become part of young people's everyday lives and that availability does not depend solely on supply from external sources. (Rimpelä A. 2007, 51.)

### 2.3 Drug use among specific groups

In terms of substance abuse, young men form a particularly challenging group. Surveys among conscripts have proved an important method of gauging the health-related habits of this group.

The situation among conscripts has been monitored systematically by conducting surveys since 1968. In the 2005 survey, 20% of respondents reported having tried some drug, most often cannabis. In 2002–2004, a random sample of 5% of the salaried personnel of the detachments was tested. According to the results, drugs (amphetamine) were detected in only one test out of 2000. The results may have been partly affected by the fact that information concerning the test was released in advance, which to some degree may have led to the internal selection by the target group. However, drug use appears to be extremely rare among Defence Force personnel or people who pursue a military career, at least compared to the results from many other countries. (Meririnne et al. 2007.)

However, these surveys do not reach men who are not serving as conscripts. Approximately one fifth of males born in a given year do not serve as conscripts. In order to fill this information gap, STAKES, the Finnish Defence Forces, the Ministry of Labour and the cities of Helsinki and Vantaa conducted a survey in 2004–2005 to gather information on the health-related habits of those remaining outside the conscript service and those whose service as conscripts had been interrupted. (Stengård et al. 2008.)[12]

The research findings indicate that the AB men entering the conscript service were younger (18 years on average) than the CDE men exempted from service (20 years in average). Upper secondary school students or graduates accounted for 61% of the AB men and 44% of the CDE men. Compared with the AB men, the CDE men had more often moved away from home, were in a couple relationship and financed their life out of their own salaries. At the same time, unemployment and subsistence-problems were more frequent among CDE men than AB men – particularly among those diagnosed with mental health or substance abuse problems. (Stengård et al. 2008, 74.)

12 The participants of the survey in 2004–2005 included a total of 356 young men outside the conscript service or non-military service and a total of 440 young men assigned to do service in Helsinki and Vantaa. The data was collected through questionnaires and using register data. Health requirements for those entering conscript or non-military service are identified in a medical examination conducted during the recruitment procedure. Persons whose health does not restrict activities in field conditions are placed in military class A, while class B includes those who are considered to have difficulties in surviving in combat forces due to health reasons but who can be trained in various support tasks. Persons in these classes were defined as 'AB men' in the study. If a health-related obstacle to conscript service is identified in a young person, he will be exempted from the service during peacetime (class C), temporarily (class E) or permanently (class D). One in ten conscripts is identified as having a health-related obstacle to service and, in the 2007 recruitment, 80% of them were placed in class C and 11% in class D. Approximately half of the conscripts remained outside the service due to mental health reasons. One in ten conscripts interrupts the service after he has started, approximately half of them for mental health reasons. Those who participated in the survey but had interrupted their service were included in 'CDE men'. (Stengård et al. 2008, 5, 26–27.)

With respect to drugs, the survey examined social exposure to drugs and personal experiments with drugs. According to the survey, more than half (59%) of the AB men and three quarters (75%) of the CDE men reported that they knew someone who had used drugs sometime in their life. A total of 55% of the AB men and 70% of the CDE men had been offered drugs. Drugs had been tried by 16% of the AB men but nearly by half of the CDE men (43%). The proportion of those who had experimented with drugs was high particularly among those men who had interrupted their service (55%) compared to those who had remained outside the service (32%). Of the CDE men, 4% had experimented with intravenous drugs, while none of the AB men had done so. A third of the CDE men were defined as problem alcohol users against a fifth of the AB men. Experimentation with drugs by CDE men was linked to a diagnosis of disease experiments: nearly a quarter of respondents with a somatic diagnosis, half of those with diagnosed mental health problems and almost all respondents with diagnosed substance abuse problems had experimented with drugs. (Stengård et al. 2008, 62–63.)

According to the survey, the childhoods of CDE men had been more problematic in many ways than those of the AB men. Particularly those with diagnosed substance abuse or mental health problems and, to even greater extent, those who had interrupted their service had suffered multiple childhood disadvantages (subsistence-problems, parental alcohol problems etc.) had been accumulated for those with diagnosed substance abuse and mental health problems and, to even greater extent, to those who had interrupted their service. Furthermore, the CDE men had fewer social relationships and hobbies, and less support than the AB men – excluding the 'hobby' of going to bars and clubs. A total of 43% of the CDE men and 23% of the AB men were smokers. More than half of the CDE men, and roughly a third of the AB men, exercised less than once a week. Those with diagnosed substance abuse problems led the least healthy lifestyles. Nearly half of the CDE men were psychologically burdened (sleep disorders, depression etc.), while the corresponding figure for the AB men was less than 10%. The researchers concluded that CDE men suffered more adverse life events and psycho-social problems than AB men – with adverse life events being particularly frequent for those diagnosed with substance abuse problems – and that these problems were even more common among those who had interrupted their conscript service than those who had remained outside the service. (Stengård et al. 2008, 74–80.)

# 3 Prevention

Preventive substance abuse work is part of the wider concept of promotion of well-being and health. In order to improve substance abuse work, a network of municipal contact persons for preventive substance abuse work was established in 2000. By the spring of 2006, 90% of Finnish municipalities had appointed a contact person. Generally, the duties of a contact person include the promotion of preventive substance abuse work through multi-professional co-operation within the municipality, information dissemination among the actors involved in preventive work and co-ordination of the municipal or regional substance abuse strategy.

In municipal substance abuse strategies, preventive substance abuse work is usually seen as part of a continuum including prevention, early intervention and treatment. According to a new concept definition, substance abuse work is divided into preventive and corrective substance abuse work. Municipal substance abuse strategies usually address intoxicating substances as a whole, without making a distinction between drugs and alcohol. Preventive substance abuse work also includes prevention of smoking and functional dependencies.

Quality criteria have been determined for substance abuse prevention (STAKES 2006). The criteria[13] are content related and suited to the prevention and reduction of harm related to substance abuse. The practical implementation of the quality criteria is considered a central tool in improving the quality of substance abuse prevention. The quality criteria do not separate drug prevention from other substance abuse prevention.

School curricula defined by the National Board of Education specify health education as a separate subject. Substance abuse questions are key aspects of this subject. School curricula and pupil and student welfare services should also include drug prevention. For example, strategies for the prevention and treatment of substance abuse should be included in the local curriculum.

Furthermore, substance abuse prevention targeted at young people is carried out in workshops that have been created to activate young unemployed people. Youth workshops are a form of early intervention, and they aim at preventing the exclusion of young people from education.

In working life, drug tests are conducted to prevent drug-related harm and to refer individuals with drug problems for treatment as early as possible. In order to implement this, employers and employees have to co-operate in drafting a written substance abuse programme for the workplace.

Substance abuse prevention involves not only municipalities: organisations and other third-sector actors play a central role in substance abuse work both as individual actors and as service providers for municipalities. The organisations aim to promote discussion and provide information on drugs, drug use and causes and consequences. In addition, the organisations attempt to influence people's attitudes, organise peer support activities and provide post-care for substance abuse patients.

13 Criteria: focus of the work, target group, degree of effectiveness, knowledge base, values, realistic objectives, compatibility of the objectives with other strategies, operational models, resources, monitoring and evaluation, balance in the different subsections and relationship to the original situation.

Drug prevention measures include electronic drug information services, virtual discussion forums and self-testing services for evaluating one's own substance abuse. The dissemination of information and training of professionals has been developed by creating web-based expert forums to support training.

### 3.1 Universal prevention

In Finland, municipalities and joint municipal boards are principally responsible for arranging and providing social and health care services. Promotion of well-being and health is highlighted through inclusion in legislation (Primary Health Care Act), in ongoing policy programmes (the Health 2015 public health programme) and the service quality recommendations which guide policies (for instance, recommendations concerning the quality of services for substance abusers, and quality criteria for substance abuse prevention). In 2007, STAKES conducted a survey among all municipal managers concerning the strategies, methods and follow-up used in the promotion of well-being and health. While a total of 177 out of Finland's 416 municipalities responded (a 43% response rate), they covered nearly two thirds of the Finnish population. (Wilskman et al. 2008, 5.)

The survey found that 41% of those municipalities which responded had explicitly adopted the target specified in the Health 2015 public health programme (Ministry of Social Affairs and Health 2001) that "health problems associated with alcohol and drug use among the young will be dealt with appropriately and will not exceed the level of the early '90s",. The larger the municipality, the more important targets related to substance abuse by young people become: they are included in the action and financial plans of two thirds of municipalities with more than 30,000 inhabitants. Similarly, the quality criteria for substance abuse prevention (STAKES 2006) and recommendations concerning the quality of services for substance abusers (STAKES 2002) are applied in approximately two thirds of those municipalities which responded to the survey, including nearly all municipalities with more than 30,000 inhabitants. Respondents identified future challenges for improving municipal services as including the prevention of lifestyle diseases (substance abuse), and also highlighted the pressures prevailing in treatment and prevention of youth mental health and substance abuse problems and in school health care. (Wilskman et al. 2007, 15–16, 19–20, 32.)

Since 1992, the Finnish Centre for Health Promotion has conducted a Health Barometer survey of municipal and organisation managers on the effort to promote health and expectations for the future. In the 2007 survey[14], in the opinion of the municipal health managers the most important active content in the promotion of health was to promote non-smoking and healthy nutrition as well as substance abuse prevention. Municipal managers emphasised the promotion of traffic safety and working ability as well as raising the level of exercise. According to those responding from organisations, the most important active content at the moment is to support social networks, prevent marginalisation and to reinforce the factors that support mental health. (Parviainen et al. 2007.)

In 2008, STAKES investigated how systematically municipal substance abuse strategy work was carried out by interviewing substance abuse prevention contact persons

14 The survey interviewed 100 municipal health managers, 100 municipal managers, 60 local branch managers of the Finnish Centre for Health Promotion and 60 managers of local branches of YTY, The Cooperative Association of the Social and Health Sectors.

(n=16) and by analysing municipal substance abuse strategies (n=24). The investigation revealed that many municipalities had prepared their substance abuse strategies in line with national guidelines and recommendations, the main output being a document in which municipal actors had committed themselves to work according to a common vision. However, substance abuse strategies often merely consist of descriptions of the current situation and activities. In such cases, the strategies do not direct practical work, and such descriptive strategies offer little support to the development of substance abuse work and networking between the various sectors. Sometimes the strategy has been prepared by a relatively small group of persons working in the municipality's area, and other actors excluded from the process do not see themselves as responsible for implementation of the strategy. The interviews suggest that, to some extent, it is the substance abuse working group which prepared the strategy that is seen as the most important influence on substance policy. Indeed, the substance abuse strategy itself may be forgotten once it has been released from the municipal council, while the substance abuse working group represents continuity and, at best, participation in decision-making. (Kekki & Kajander 2008, 35–36.)

In the strategy data and interviews, the tradition of co-operation emerged as an important factor regardless of the size of municipality. In small municipalities it translated as emphasising individuality, while larger municipalities attempted to compensate for a weak community spirit by underlining professionalism. In addition to strategies, municipalities have various official and unofficial guidelines which may determine, for instance, which authority (the police / health centres) is responsible for intoxicated clients or the operating methods governing how the various authorities should operate regarding their own clientele (youth workers, physicians). Moreover, such practical operational guidelines often have a greater influence on substance abuse work than strategies do. While co-operation and innovation do not necessarily require a formal substance abuse strategy, the interviewees stressed that such a strategy is useful in the implementation of innovations. A strategy facilitates the development of substance abuse work and the commitment by responsible parties to it, and this development work will benefit both clients and employees. (Kekki & Kajander 2008, 36–37.)

Organisations play a key role in substance abuse prevention. The activities of organisations receiving public funding for health promotion were evaluated in 2007 using the European Quality Award model.[15] The model is divided into six parts: (1) Operational Principles and Strategy (according to quality criteria for substance abuse prevention: the focus of work generally and more specifically at various levels of implementation and for predetermined groups); (2) Implementation and Organisation of Activities (ensuring the knowledge base of the work, determining values and selection of the method of implementation); (3) Fruitfulness (the objective in relation to the focus of substance abuse prevention, monitoring and evaluation, balance in the factors underlying quality and results in relation to the initial situation); (4) Expertise (evaluating and utilising the expertise of personnel); (5) Partnerships and Resources (objective-driven co-operation and determination of the required resources); (6) Leadership (the fruitfulness of the planning implementation and organisation of activities). (Wennberg et al. 2007.)

15 The materials used in the evaluation included interviews with representatives of organisations as well as with officials from the Ministry of Social Affairs and Health, analyses of annual reports from organisations and documents relating to the working methods employed in substance abuse prevention, an electronic questionnaire and intensive case studies of those materials as well as other supplementary documentation. The evaluation involved a questionnaire that combined self-assessment and data collection; the questionnaire was forwarded to the contact persons of the organisations. A request was made to forward the questionnaire to those people who were responsible for or who implemented substance abuse prevention in the organisation in question. A total of 53 people responded to the questionnaire. An interactive course on the results was arranged at the end of the evaluation process.

Overall, the role of substance abuse prevention in relation to the other activities of organisations is considered very clear. Among the organisations that have carried out corrective work in substance abuse, a few of those replying found their role somewhat unclear. The provision of information as well as training and consulting are indisputably the leading forms of the work being undertaken. Other methods that were employed were peer support activities, counselling centres, telephone and email counselling, interactive network services, intervention, games, network co-operation, courses and contacting risk groups and substance abusers (early intervention). (Wennberg et al. 2007.)

Publicly funded substance abuse prevention requires that it is effective. The methods employed in substance abuse prevention are generally divided into the more known and established means (often internationally used) and those developed by organisations themselves. In practice, it is only possible to find research and evaluation data on the effectiveness of the original model when evaluating the more known and established methods. While approximately 70% of the respondents considered that the organisations paid sufficient attention to evaluating the effectiveness of substance abuse prevention, it is worth noting that only 42% of the respondents used systematic methodology in their evaluations. (Wennberg et al. 2007.)

The final report of a working group established to develop training in substance abuse prevention and treatment stated that the amount of training in substance abuse and the content of that training varied from one educational establishment to another and at different levels of education. This depended on whether schools, colleges and universities had a teacher interested in the subject, whether there was a teacher responsible for substance abuse prevention and whether the establishment conducted its own research into substance abuse. The results of the working group led to a proposal for a minimum content of training in substance abuse. (Ministry of Education 2007a.)

The proposal by the working group states that the obligation for training in substance abuse prevention should apply to all educational fields in which employees in the social and health sector graduate. It is also important that everyone qualifying in youth work, education and teaching or becoming a deacon or police officer receive the necessary basic preparedness for substance abuse prevention as part of his or her training. In order to ensure the quality and comprehensive and systematic nature of training in substance abuse prevention, it is necessary to specify clearly defined learning objectives for qualifications and professions. Courses should take an equal approach to substance abuse prevention and mental health work, and make this approach apparent in the curriculum and teaching. Those working in the above-mentioned fields should be offered a sufficient amount of good quality further and continuing education to supplement, maintain and strengthen their expertise in substance abuse prevention. Educational programmes in the hotel, restaurant and grocery trades as well as in the security and traffic sectors must also offer substance abuse training that responds to the needs of each profession. An educational establishment should also have an up-to-date drug and alcohol strategy to ensure that the institution’s substance abuse culture develops alongside teaching substance abuse prevention. (Ministry of Education 2007a.)

### 3.2 Selective/indicated prevention

Over the past few years, focused or selective substance abuse projects have produced a wide range of materials that can be applied in substance abuse prevention. These materials have been brought together on the Finnish Centre for Health Promotion's website. Based on the project descriptions on the website, a researcher, Jaana Lähteenmaa,[16] (2005) carried out a study of preventative projects targeted at young people.

The projects were divided based on two key dimensions: The first was the method of influence employed by the programmes, ranging from manipulation as one end of the scale to simple dialogue at the other. The second dimension was the perception of youth culture contained in the projects, in which the interpretations extended from the unidimensional, according to which drugs always constitute a constant threat to young people, to multidimensional, where the relationship to drugs did not form a singular but a more multiformatted picture of drugs. Traditional educational campaigns were generally based on the communication and monologue of one indisputable statement of truth whereas projects based on independent development and learning were often grounded in genuine interaction between all the parties involved. The means of impact generation were the same for all forms of preventative work that see youth culture as a single entity. By contrast, projects that had embraced the concept of multidimensional youth culture had taken selective and focused means to generate effectiveness in line with different target communities. (Lähteenmaa 2005.)

According to Lähteenmaa, it was extremely difficult to evaluate the effectiveness of, or even to compare, the above-mentioned methods. Many projects revealed that, for their implementers, drugs were a good enemy, one that was very distant from the normal lives of people and one that had to be stopped at any cost. She states that the projects often appeared to have a negative understanding of young people. She resorts to the positive value world of the temperance society in Finland at the beginning of the 1900s in order to give a new perspective on substance abuse prevention that would emphasise for young people the opportunity to set the world on a better course and not take the attitude that young people are a problem. (Lähteenmaa 2005.)

Local substance abuse prevention projects have focused on many different groups, including families, Romanies, immigrants, non-heterosexuals and the disabled, but evaluations are generally local, specific to the project, limited and lacking comparative or generalisable research questions.

16 A total of 36 projects by various actors were taken from the Finnish Centre for Health Promotion's 2003–2004 catalogue of substance abuse prevention materials.

# 4 Problem drug use

The number of problem drug users is estimated in Finland based on the number of problem users of amphetamines and opiates, which came to 14,500–19,100 in 2005; this accounts for 0.6–0.7% of 15–55-year-olds among the entire population. Nearly four fifths of problem drug users used amphetamines. The proportion of men was 80%. The majority of problem drug users belonged to the 25–34-year age group.

According to the 2007 data of the drug treatment information system, opiates were the primary problem substance of clients entering drug treatment (representing 46% of all drug treatment clients of the substance abuse services), followed by stimulants (19%), alcohol (17%), cannabis (10%) and pharmaceuticals (7%). Buprenorphine was the primary problem substance for 33% of the clientele.

According to all studies, alcohol is the primary problem substance in Finland, and there is a fairly short history of problem drug use. The central factors of problem drug use in Finland are the relatively young age of users, and consequently a relatively short history of drug use, as well as the central role of buprenorphine in intravenous use. Many drug users are socially marginalised and they mix various drugs, alcohol and pharmaceuticals. In addition to substance abuse problems, many users have mental disorders.

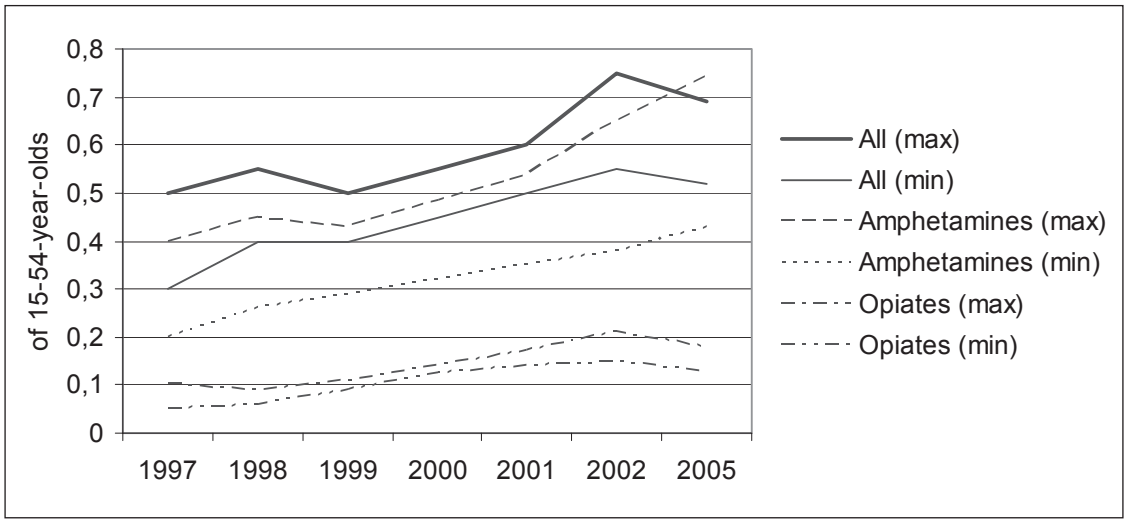
## 4.1 Problem drug use according to statistical estimates

The number of problem users of amphetamines and opiates increased noticeably between 1999 and 2002. Since then, the proportion of problem users of amphetamines and opiates seems to have stabilised. According to statistical estimates, problem users of amphetamines and opiates[17] accounted for 0.6–0.7% of 15–55-year-olds in Finland in 2002. Amphetamine users accounted for 0.4–0.6% and opiate users 0.1–0.2% of the population (Table 4). In 2005, the corresponding figure was 0.5–0.7% of 15–54-year-olds. Amphetamine users accounted for 0.4–0.7% and opiate users for 0.1–0.2% of the population. (Partanen et al. 2007.)

The accumulation of detriment leading to problem drug use seems to occur after a lag of 3 to 5 years from the commencement of use (Virtanen 2005). Thus, the sharp increase in drug experimentation at the end of the 1990s seems to have lead to the growth in the number of problem users at the beginning of the 2000s and correspondingly, the stabilisation of experimentation at the beginning of the 2000s seems to have affected the latest estimates on the number of problem users (Figure 2).

17 According to the national definition used in the study, problem use refers to the use of amphetamines and opiates to such an extent that it causes social or health problems to the user. Furthermore, the authorities have had to intervene in one way or another and this has been recorded in administrative registers.

*Figure 4. Percentage of problem drug users among 15–54-year-olds 1997–2005*




Source: Partanen et al. 2004, 2007.

Statistical estimates on the prevalence of problem drug use[18] based on administrative statistics have been made since 1997. According to these estimates, out of the 15–54-year-old population, there were some 14,500–19,100 amphetamine and opiate problem users in the entire country in 2005 (Table 3).

*Table 3. Development of the number of amphetamine and opiate users in Finland in 1997–2005*

| | **1997*** | **1998** | **1999** | **2001** | **2002** | **2005** |
|---|---|---|---|---|---|---|
| **Overall estimate** | 9,400–14,700 | 11,500–16,400 | 11,100–14,000 | 13,700–17,500 | 16,100–21,100 | 14,500–19,100 |
| **Opiate users *** | 1,500–3,300 | 18,00–2,700 | 2,500–3,300 | 3,900–4,900 | 4,200–5,900 | 3,700–4,900 |
| **Amphetamine users *** | 6,800–11,600 | 7,600–13,000 | 8,300–12,400 | 10,100–15,400 | 10,900–18,500 | 12,000–22,000 |

* = *Estimates are based on information from three registers.*
Source: Partanen et al. 2004, 2007.

18 The estimates of problem drug users are based on the statistical capture-recapture method in which the samples from the same group are used to assess statistically the size of the entire target population. The samples were defined based on the interventions directed by society at the target population (amphetamine and opiate users). The interventions employed by the system included amphetamine or opiate diagnoses recorded in hospitals, penal action for drug offences involving the use or possession of amphetamines or opiates, arrest for driving under the influence of amphetamines or opiates and hepatitis C cases recorded in the infectious diseases register due to intravenous drug use. The estimate intervals are based on 95% confidence intervals of the estimates. Different log-linear models were applied to different subgroups so the sum of the subgroups differs from the overall estimate. (Partanen et al. 2004, 2007.)

Since the estimates of problem users are based on administrative registers in Finland, a user may have been included in a register due to the activity of the authorities. When making international comparisons, it should also be kept in mind that the estimated number of problem users in Finland is based on a fairly wide definition of problem use, especially concerning amphetamine, and the estimate may also include occasional users. However, temporal comparisons of problem users involve a degree of methodological uncertainty because changes have taken place during a short period of time and at the same time, the service system of society has undergone great change. (Virtanen 2004). For example, the substance abuse service system has been strongly developed in the 2000s, which may have reduced the number of people entering hospital care; the increased number of health counselling centres has reduced the occurrence of infectious diseases; the registration procedure for cases of driving while intoxicated has become stricter, which has increased the proportion of drug use in the register of cases of driving while intoxicated; and the introduction of the offence of unlawful use of narcotics has indirectly affected the way the police record different substances in their register. (Partanen et al. 2007.)

The majority of problem users, 75–80%, consisted of amphetamine users, and they accounted for 0.4–0.7% of 15–54-year-olds in Finland in 2005. The estimated proportion of problem users of opiates was 0.13–0.18% of the population. The proportion of women was 20–30% in both substance groups. The proportion of 15–24-year-olds came to 25–35%. Some 50–60% of all problem users were from Southern Finland and more than half of them from the Greater Helsinki area. The proportion of women among problem users seems to be on the constant decline everywhere in Finland, possibly excluding the Greater Helsinki area. The aging trend among users is most evident in the Greater Helsinki area. (Partanen et al. 2007.)

*Table 4. Development of the population share (%) of amphetamine and opiate problem users in Finland in 1998–2005.*

| | 1998 | 1999 | 2001 | 2002 | 2005 |
|---|---|---|---|---|---|
| **Overall estimate** | 0.4–0.55 | 0.4–0.5 | 0.5–0.6 | 0.55–0.75 | 0.52–0.69 |
| **Amphetamine users** | 0.26–0.45 | 0.29–0.43 | 0.35–0.54 | 0.38–0.65 | 0.43–0.74 |
| **Opiate users** | 0.06–0.09 | 0.09–0.11 | 0.14–0.17 | 0.15–0.21 | 0.13–0.18 |
| **Men** | 0.54–0.70 | 0.54–0.66 | 0.58–0.71 | 0.77–1.03 | 0.74–0.98 |
| **Women** | 0.20–0.58 | 0.14–0.24 | 0.20–0.31 | 0.29–0.57 | 0.20–0.31 |
| **15–25-year-olds** | 0.67–1.12 | 0.73–1.02 | 0.81–1.04 | 0.93–1.30 | 0.63–0.95 |
| **26-35-year-olds** | 0.51–0.71 | 0.46–0.59 | 0.64–0.82 | 0.74–1.13 | 0.68–0.94 |
| **36-55-year-olds** | 0.14–0.25 | 0.19–0.46 | 0.22–0.36 | 0.25–0.50 | 0.30–0.54 |

Source: Partanen et al. 2004, 2007.

According to the data from 2005, the upward trend in the number of problem users in Southern Finland has stopped, and the number of problem users has even dropped outside the Greater Helsinki area in Southern Finland. Problem use was clearly on the increase at the turn of the millennium, but now it seems that problem use has spread less in the satellite municipalities of the Greater Helsinki area than was assumed based on data from 2002. If the problem use phenomenon follows the trend evident in Southern Finland, the regional estimates on the extent of problem use (excluding

the Greater Helsinki area) will probably decrease rather than increase in a few years' time. Thus, the drug problem as well as specialised treatment services (substitution treatment, health counselling) would centre in the Greater Helsinki area and possibly some other large cities. (Partanen et al. 2007.)

### 4.2 Profile of clients in treatment

According to the 2007 data of the drug treatment information system[19], the mean age of drug treatment clients was 28.7 years (compared with 28.0, 27.6 and 27.3 in previous years). Men were on average 2.8 years older than women (2.5 years in 2006). The clients of substance abuse outpatient units were the youngest, with a mean age of 27 years. In outpatient drug treatment units and substance abuse inpatient care, the mean age was approximately 30 and in prison health care 33. (Kuussaari & Ruuth 2008.)

Among all drug treatment clients of the substance abuse services, opiates were the primary problem substance of clients entering drug treatment (46%), followed by stimulants (19%), alcohol (17%), cannabis (10%) and pharmaceuticals (7%). Buprenorphine was the primary problem substance of 33% of the clientele (Table 5). The proportion of buprenorphine as the primary substance of those entering treatment has increased the most. Buprenorphine is already the primary substance for a third of drug treatment clients. (Kuussaari & Ruuth 2008.)

*Table 5. Substances used by clients entering treatment for the use of narcotics and pharmaceuticals (% of clientele) in 2000–2007*

| **Substance category** | **Primary problem substance** | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | **2000** | **2001** | **2002** | **2003** | **2004** | **2005** | **2006** | **2007** |
| **Opiates** | 29 | 28 | 28 | 31 | 37 | 37 | 41 | 46 |
| *-heroin* | *20* | *13* | *6* | *3* | *2* | *2* | *2* | *2* |
| *-buprenorphine* | *7* | *12* | *20* | *24* | *29* | *29* | *31* | *33* |
| **Stimulants** | 28 | 26 | 28 | 28 | 22 | 22 | 21 | 19 |
| **Cannabis** | 17 | 20 | 18 | 16 | 14 | 14 | 13 | 10 |
| **Alcohol** | 18 | 19 | 20 | 19 | 19 | 19 | 17 | 17 |
| **Pharmaceuticals** | 5 | 6 | 5 | 6 | 7 | 7 | 7 | 7 |

Source: Drug treatment information system, STAKES.

Table 6 shows a cross tabulation of the drug treatment clients' primary substance alongside the secondary and tertiary substances they used. Using a parallel review of the primary, secondary and tertiary problem substances enables the definition of typical polydrug use profiles. Additional use of stimulants, cannabis and pharmaceuticals was most common in opiate users. The most frequent additional drug for those having entered drug treatment due to stimulants was cannabis, and vice versa: for those having

19 The results are based on data gathered from 110 units (161 in 2007) and 4,141 (4,865) drug treatment clients. Data collection is voluntary for the participating units. A coverage survey conducted in 2004 (Vismanen 2004) estimated that in 2003 the drug treatment information system covered about half of all drug treatment clients in the units providing specialised services for substance abusers.

sought treatment due to cannabis, it was stimulants. For both of these groups, alcohol was the next most common problem substance.

*Table 6. Secondary and tertiary drugs used with the primary drug in 2007, %.*

| Primary drug | | | Use of a second and a third drug in addition to the primary drug (%) | | | | |
|---|---|---|---|---|---|---|---|
| | No. of users | % | Opiates | Stimulants | Cannabis | Pharma-ceuticals | Alcohol |
| Opiates | 1,896 | 46 | 11 | 39 | 36 | 51 | 13 |
| *-heroin* | 69 | 2 | 32 | 44 | 33 | 26 | 4 |
| *-buprenorphine* | 1,368 | 33 | 10 | 41 | 36 | 26 | 14 |
| Stimulants | 801 | 19 | 33 | 10 | 47 | 35 | 30 |
| Cannabis | 425 | 10 | 17 | 41 | 2 | 20 | 46 |
| Pharmaceuticals | 290 | 7 | 23 | 26 | 22 | 15 | 50 |
| Alcohol | 693 | 17 | 13 | 41 | 60 | 43 | <1 |

Source: Drug treatment information system, STAKES

The majority (83%) of drug clients in services for substance abusers had injected drugs some time in their life; 57% of them had injected drugs during the past month and one in six (19%) had shared needles and syringes. Opiates were most commonly used intravenously (82%). Stimulants were also injected by 81% of their users. (Kuussaari & Ruuth 2008.)

The most common single substance of those clients entering drug treatment for the first time (n=655) was cannabis (30%). Other common primary problem substances were stimulants (19%), opiates (19%) and the combined use of alcohol and drugs (25%). The proportion of clients entering treatment for the first time due to buprenorphine use (15%) was at the same level as in the previous year. (Kuussaari & Ruuth 2007.)

There were no great changes in the treatment information of drug users when compared with the previous year. The most significant change was probably the decreased number of units involved in voluntary data collection and the decreased number of clients. In particular, the reported number of new drug users dropped from 884 clients in the previous year to 655 clients. Although the results may not be as generalisable as the results of the previous year, the change in the number of new clients did reflect another change in the data – the fact that clients were slightly older. There was also a change in the estimates on the numbers of problem users. The third notable change was the increased role of cannabis as the primary substance of new clients.

### 4.3 Main characteristics and patterns of use from non-treatment sources

Several separate studies in recent years have examined problem drug use. The studies have focused on the position of alcohol, the intravenous use of buprenorphine and mental disorders.

The evaluation study (Harju-Koskelin 2007) of the OHJAT project at the Järvenpää Addiction Hospital investigated changes in the social situation and quality of life of clients

in substitution or maintenance treatment during their follow-up period (see Section 5.X for further information on the follow-up and changes). Initial interviews[20] revealed that the patients had begun using drugs when they were approximately 15 years old. Most of the interviewees (65%) were under 30 years of age at the time of the interview, the youngest being 19 and the oldest 50. Their initial substance used had been cannabis or benzodiazepines, after which users had rapidly moved on to amphetamines or heroin. Polydrug use had also begun at an early stage in the interviewees' substance use histories. Half of the patients had begun opiate use under the age of 18, and continued their use for 7 years, on average, before beginning treatment. One interviewee reported having never used heroin, but that the use had begun with buprenorphine.

All interviewees had used substances intravenously, with the average duration of intravenous use being 10 years. The youngest age at which intravenous drug use had started was 10; the oldest was 30. On average, users had started injecting drugs at the age of 18. All but one interviewee reported having had treatment previously. Most of the patients had been in treatment several times before, and 28% more than ten times, before they had been able to access substitution treatment. The majority (92%) reported that their longest substance-free period had lasted less than one year. (Harju-Koskelin 2007.)

A survey of all conscripts born in 1981 examined binge drinking and the related psycho-pathological phenomena. The study also provided data on drug use. A total of 85% of the respondents reported that they had consumed alcohol to become drunk during the past 6 months. Of these, 6% said that they had used some drugs, and almost half of this group were drunk every week. Risk behaviour, juvenile delinquency and self-destruction seemed to be connected with young people's regular and weekly binge drinking; this also concerns those who had experimented with drugs. Those who consumed alcohol and smoked cigarettes regularly also had a clearly more positive attitude towards drugs. (Niemelä et al. 2006.)[21]

The addiction psychiatry outpatient clinic at Tampere University Central Hospital carried out a study on 34 clients who came to the assessment for substitution treatment between 1 July 2000 and 30 April 2002 and were transferred to opioid substitution or maintenance treatment after the assessment. This study also revealed the chain of substance use that led to problem drug use. The clients had started to use alcohol at the age of 12 on average, and younger clients had started to use other substances at an earlier age than older clients did: the younger clients had started to use cannabis and sedatives at the age of 14 (older clients at the age of 15) and amphetamines and opiates at the age of 16 (older clients at the age of 22). Nineteen of the clients had hepatitis C and 22 had at least two mental or substance abuse disorders. (Veide et al. 2007.)[22] (See Section 5.3.)

Health counselling centres in Helsinki collected information on their clients' drug use with a voluntary anonymous questionnaire during two weeks in 2005. About 30% of the clients responded. According to the results, their mean age was 27.8 years. One fourth were women and they were on average 1.5 years younger than the men were.

20 In the study conducted in 2003–2005, the data used comprised interviews with 60 individuals in substitution or maintenance treatment in the Helsinki area. The interviews were based on structured questionnaires (EuropASI, SCL-90 and CEST). The initial interviews were conducted 1–1.5 years from the beginning of treatment.

21 The sample consisted of 2,306 18-year-old boys who entered the military service in 1999.

22 The study was conducted at the time when the first Decree on substitution and maintenance treatment was issued in Finland. All clients who passed the assessment were admitted to the Tampere substitution treatment clinic until the places were filled.

The clients had used opiates intravenously for an average of 7.3 years; the most common period of use was 4 years. The intravenous use of buprenorphine had lasted a considerably shorter period of time, 4.2 years. Only 3% of the respondents were in maintenance treatment. (Alho et al. 2007.) [23]

Nearly three out of four respondents said that buprenorphine was the most common drug that they used intravenously and one in four mentioned amphetamine or methamphetamine. However, only 28% used buprenorphine alone; the others could be classified as polydrug users. In 55% of the cases, polydrug use included amphetamine or methamphetamine. About a fourth of the respondents mentioned the use of benzodiazepines together with buprenorphine. Two out of three had used buprenorphine and naloxone intravenously. Only 20% of them considered the use of buprenorphine and naloxone similar to the use of buprenorphine alone, but two out of three still continued their use. (Alho et al. 2007.)

The survey sample was estimated to cover 5–10% of all intravenous drug users in the Greater Helsinki area. Therefore, the results are only indicative. The survey also examined the prices of individual doses; the street price of buprenorphine-naloxone combination tablets was half of the street price of buprenorphine tablets, which partly explains the continuous intravenous use of buprenorphine and naloxone. The result does not necessarily provide evidence for the assumed agonistic effects of combination tablets although the price difference of the substances and the selected users in the survey sample who were used to intravenous use may be factors that have greater impact on the results. (Alho et al. 2007.)

23 During the survey, 589 questionnaires were distributed; 176 of them were returned. However, the response percentage is probably higher as the clients visit the units anonymously and therefore the same client may have visited the unit several times during the survey period.

# 5 Drug-related treatment

According to the Act on Welfare for Substance Abusers, municipalities must provide substance abuse services that are in accordance with the needs of the municipalities both in their content and in coverage. All substances that are used for intoxication are considered intoxicants: alcohol, substitutes, pharmaceuticals and drugs. The social and health care sector must develop primary services to meet the needs of substance abuse services and provide services that are intended specifically for substance abusers, when needed. The units providing specialised services for substance abusers include outpatient care (A-Clinics, youth centres), short-term inpatient care (detoxification units), rehabilitation units and support services (day centres and supported housing) and peer support activities.

In addition to the units providing specialised services for substance abusers, increasing numbers of substance abusers are treated within primary social and health care services, including social welfare offices and child welfare services, mental health clinics, health centre clinics and wards, hospitals and psychiatric hospitals. The Finnish system emphasises that drug treatment as such is often insufficient and the substance abuser should be assisted in solving problems related to income, living and employment.

A quality framework for substance abuse services and Current Care guidelines for the treatment of substance abusers have been created in order to develop substance abuse work. The development policy for drug treatment services emphasises developing low-threshold services and related training. The first health counselling centre intended for the exchange of needles and syringes was set up in Finland in 1997, and substitution and maintenance treatment was introduced as an official part of substance abuse services in 2000. As far as possible, the most difficult-to-treat substance abuse patients (dual or triple diagnosis patients) are treated centrally in units providing specialised services.

In Finland, municipalities are in charge of organising social and health services, but local government lacks monitoring systems that would help identify client group specific welfare deficits and service needs. In particular, the most socially marginalised substance abuse patients face a high risk of being excluded from the service network.

It is alleged that due to the fact that more and more drug users receive medical treatment, substance abuse problems, which previously were considered social problems, are now seen as medical problems and are increasingly handled by the health care services. Since 2000, the drug treatment situation has stabilised; for example, health counselling and the role of medical treatment have become firmly established. Substitution and maintenance treatment for opiate addicts is increasingly being transferred to health centres and, in part, also to pharmacies. This phenomenon reflects the differences in focus between psychosocially and medically oriented substance abuse treatment services.

In addition, the substance abuse service system is facing another kind of challenge: the need to reallocate resources between the treatment of harm caused by increased alcohol consumption, traditional alcohol abuse services and drug treatment.

## 5.1 Treatment systems

*Priorities in treatment services*

In Finland, substance abuse problems have been traditionally seen as social problems to be dealt with by the social welfare services. However, the increase in drug problems at the end of 1990s resulted in the creation of a specialised drug treatment system in which medicine and particularly medical treatment of opiate users have had a key role. Antti Weckroth has analysed professional discussion within substance abuse services and concluded that actors in substance abuse services view their clients simultaneously as biological, psychological and social beings.[24] The analysis suggests that the traditional holistic approach, which has been called a psychosocial approach, has lost some of its importance to evidence-based medical treatments. (Weckroth 2007.)

Weckroth states that the Current Care guidelines on the treatment of alcohol abusers and drug abusers, drawn up by the Finnish Medical Society Duodecim and Finnish Society of Addiction Medicine, mention 11 different psychosocial therapies: dynamic psychotherapy, twelve-step facilitation therapy, cognitive behavioural therapy, motivational interviewing, service guidance, solution focused brief therapy, relapse prevention, systemic family and network therapy, therapeutic community treatment, community reinforcement approach and supportive interaction. While the guidelines define these therapies as forming the cornerstone of the treatment and improving the patients' quality of life, they also acknowledge that evidence on the methods' effectiveness remains scarce. Discussion, therapeutic activity, peer activities and co-operation with the patient's close network are emphasised as basic working methods. A repeated conclusion in the guidelines is that medication can significantly improve the outcomes of psychosocial therapies. While with substances other than opiates the importance of psychosocial therapies is highlighted, drug-free psychosocial therapy, even if intensive, is not described as improving the therapeutic outcome for opioid addiction. (Weckroth 2007, 430–431.)

For Weckroth, the 'psychosocial' approach in substance abuse services is medically focused, since substance abuse services must address difficult phenomena related to humans but the investigation of such problems is either not feasible with the available tools or they are not seen as interesting, for some reason. Attempts to explain the nature of the patients' problems only rarely rely on the 'psychosocial' perspective. Weckroth finds it concerning that in certain professional journals, the number of articles depicting the substance abuse problem as a social problem has been declining in recent years, whereas the 'psychosocial approach' has become an established concept in substance abuse services, mainly due to the substitution treatment debate and the increasing role of medicine. This means that the method is often used while ignoring its definition and, thus used, the approach will not help to improve treatment. Simultaneously, substance abuse work is increasingly being defined and interpreted based on the objectives of health care. (Weckroth 2007, 431-433.)

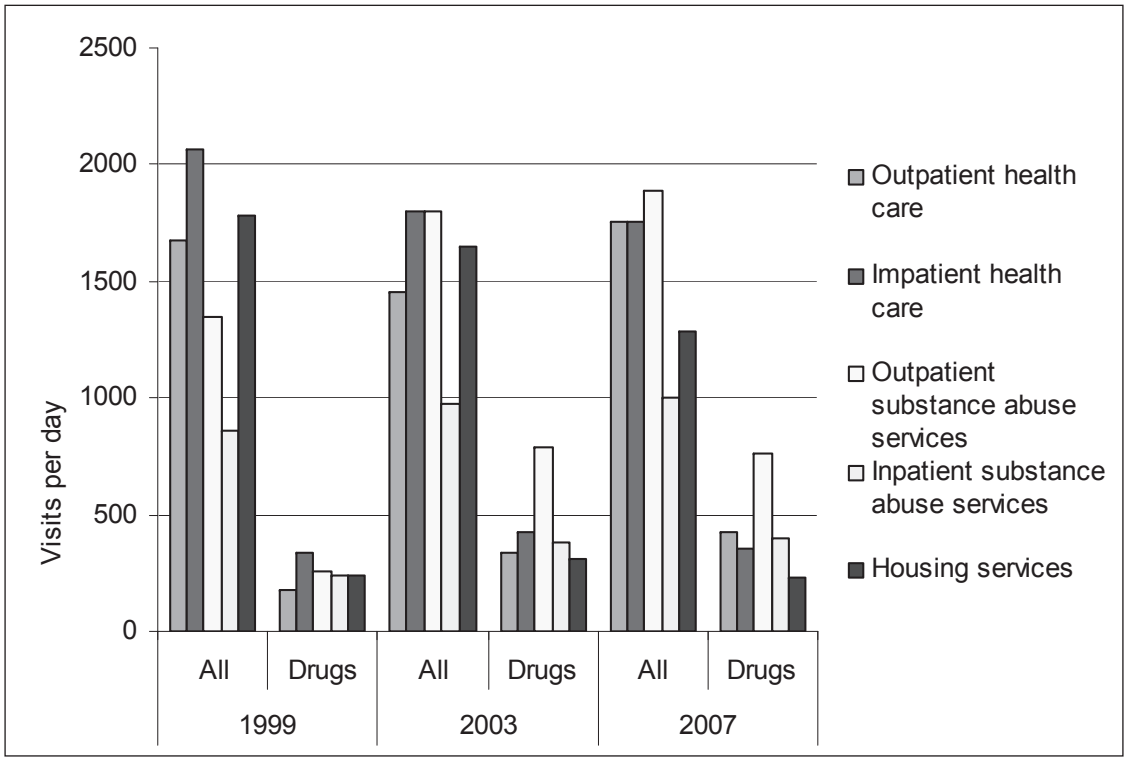
24 Weckroth retrieved the research data by searching the collections of the University of Helsinki and four major professional journals related to substance abuse (*Tiimi, Suomen Lääkärilehti, Duodecim, Sosiaaliturva*), using keywords beginning with 'psychosocial' (Weckroth 2007b, 426).

*Availability of treatment services*

A census of intoxicant-related cases was conducted during one day in 2007 in order to collect information related to substance use. Information was recorded on that day for each client using the services of social or health care units who was believed by the personnel to be a problem user of intoxicating substances, and for each client seeking help while intoxicated or due to a problem related to a single use occurrence, such as an accident. A corresponding census is conducted every four years and, since 1995, in a format allowing comparison. The proportion of drug users among all clients included in the census of intoxicant-related cases was 11% in 1995, 16% in 1999, 27% in 2003 and 24% in 2007. (Nuorvala et al. 2008.)[25]

The causes behind the rapid growth trends in 1999 and 2003 include not only increased demand for treatment services but also the creation of the first health counselling centres for intravenous drug users, showing most in the increased use of outpatient substance abuse services. In Finland, substitution treatment was initiated on a wider scale only in 2002. On the other hand, a cut in alcohol tax in 2004 increased the consumption of alcohol, affecting the relative proportion of alcohol abusers in the 2007 census of intoxicant-related cases. Particularly the proportion of those over 50 grew intensely. (Huhtanen 2008.)

*Figure 5. Intoxicant-related cases in social and health care 1999–2007.*



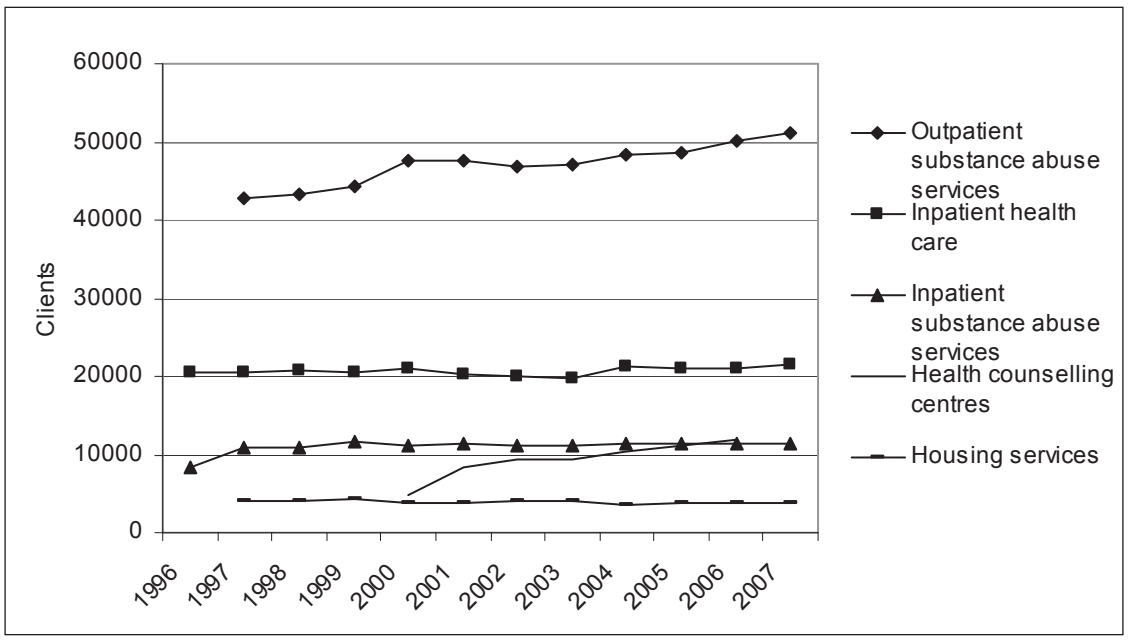

Source: Huhtanen 2008

25 Intoxicant-related visits refer to visits which involve intoxicants either directly or indirectly. The data were based on reports made by service unit personnel. The most recent census was carried out on 9 October 2007, when intoxicant-related cases reached a record high of 12,045.

Based on the findings, drug-related problem use manifests in approximately 40% of the users of outpatient or inpatient substance abuse services, 25% of the users of outpatient health care and 20% of the users of using inpatient health care. Drug-related clients were relatively young in comparison to problem users of other substances. Among patients in substance abuse treatment, two-thirds of those aged under 35 abused drugs in addition to other substances, while among 35–44-year-old or older clients, drugs were abused by only one-third and by significantly less than 10%, respectively. Among the clients included in the census, female drug users accounted for some 30% of those in outpatient care and 20% of those in inpatient care. (Huhtanen 2008.)

The trends suggested by client monitoring in substance abuse service systems accord with the census findings. The greatest changes include the increased number of health counselling centres and their higher number of clients since 2000; more frequent use of outpatient substance abuse services throughout the 2000s; and the higher number of inpatients within health care, particularly in 2004. (Statistical Yearbook on Social Welfare and Health Care 2008.) The increase in the number of clients in outpatient substance abuse services since 2000 was, to a significant extent, attributable to drug-related clients. The range of substances abused also included drugs in the case of 20% of the outpatients in substance abuse services in 1999, 35% in 2003 and 40% in 2007.

*Figure 6. Intoxicant-related clients in social and health care services 1996–2007.*




Source: Statistical Yearbook on Social Welfare and Health Care 2008

The Finnish Ministry of Social Affairs and Health has produced reports on the availability of inpatient detoxification, withdrawal and substitution treatments in 2007 and in 2008.[26] Based on these reports, a patient was able to access inpatient alcohol detoxification

26 The report was based on telephone interviews with unit directors, physicians, head nurses and nurses working in some 20 units providing inpatient detoxification and/or withdrawal treatment and substitution treatment, in ten cities with more than 75,000 inhabitants (Korhonen 2007)

treatment on the same day or within a few days. Alcohol detoxification treatment periods ranged from one day to a few weeks, with the average period being 5–7 days. When the respondents where asked about any changes in demand for services, nearly everyone considered that their clients' condition had worsened after 2004 or 2005. Furthermore, the proportion of older people in the clientele has increased. (Korhonen 2007; Heiskanen & Korko 2008).

For drug-related inpatient detoxification treatment, waiting times were much longer, averaging 1–3 weeks. However, waiting times varied considerably by locality. The duration of treatment ranged from a few days to four weeks, while the average was two weeks. Among drug-related clients, the number of dual or triple diagnosis patients was estimated to have somewhat increased, which was interpreted as reflecting the deteriorating condition of the clientele. (Korhonen 2007; Heiskanen & Korko 2008).

The situation in substance treatment for opioid addicts varied considerably by city. In all major cities but one, an individual had to wait for months to access substitution treatment. According to all units, the problem lies primarily in overly-restrictive quotas for outpatients. Even if the substitution treatment could be initiated in a university hospital, the quotas for outpatients in local units providing substance abuse services do not allow substitution treatment to be carried out over several years. In fact, some localities have attempted to transfer the provision of substitution treatment to primary health care units, but this has not yet become standard practice. The respondents considered that more difficult access to Subutex medication since Estonian accession to the Schengen area had resulted in more clients seeking substitution treatment and longer waiting times for treatment. (Korhonen 2007; Heiskanen & Korko 2008).

In order to improve the availability of treatment, a new Decree on substitution treatment was adopted at the beginning of 2008, enabling pharmacies to distribute substitution treatment medication containing buprenorphine and naloxone. At the beginning of 2008, the number of substitution treatment clients using buprenorphine averaged 650, of whom some 500 used a combined preparation. According to assessments in the summer of 2008, the availability of substitution treatment had not improved significantly and the total number of opiate addicts in substitution treatment was some 1,200 (Ora 2008; Ministry of Social Affairs and Health 2008b).

One possible explanation for the unchanged situation relates to the cost of substitution treatment: a decision on whether the combined preparation of buprenorphine and naloxone should be included in the list of medicinal products carrying an entitlement to higher-rate reimbursement is still pending. Since the average treatment dose of the combined preparation is 19 mg per day, the annual price of the product as delivered from a pharmacy would be approximately 8,000 euros. Due to its high price, very few patients could pay for the preparation themselves and, in this case, the municipality providing the substitution treatment would largely remain responsible for paying the cost of the medication. If the combined preparation is granted the status of a medicinal product carrying an entitlement to higher-rate reimbursement, the medication costs arising from its use would not create such a large burden on municipalities and their spending limits. This would allow municipalities to increase their patient quotas in accordance with the Government's drug policy guidelines, as stated in the background memorandum to the new Decree on substitution treatment. More generous reimbursement would, moreover, create significant overall savings for the Finnish economy. According to an evaluation conducted by a working group tasked with improving treatment for problem drug users, every 20 cents invested in treatment generates approximately a 1 euro saving in the form of reduced harm-related costs. (Ministry of Social Affairs and Health 2008b)

*Treatment services for specific groups*

The essential aim of substance abuse treatment is for the clients' problems and the availability of services to meet. Some of the largest obstacles to receiving treatment were waiting times, the lack of knowledge and skills and negative attitudes towards substance abusers within the primary services and the physical distance of the treatment units within specialised services. (Ministry of the Interior 2005; Mäkelä et al. 2005.)

According to a study by Sanna Väyrynen (2007), the use of drugs causes women in particular to feel disconnected from themselves, their own gender and the dominant culture.[27] The drug scene is fairly male-dominated, as only about a fifth of users are women. The proportion of women in outpatient and inpatient rehabilitation is also smaller than that of men: approximately a third of new clients are women. A woman who uses drugs often lives among drug-using men, and sometimes on their terms. The physical violence or abuse taking place within the drug scene makes the women feel ashamed and becomes part of their sexual identity. This poses a challenge for society to develop rehabilitation methods and units that cater for the special needs of women.

The special problems of pregnant substance-abusing women have been studied at the Department of Obstetrics and Gynaecology of the Helsinki University Central Hospital (HUCH) since 1983. In August 2002, an enhanced care model was introduced, in which the hospital's maternity clinic has a drugs, alcohol and pharmaceuticals clinic and a special care team, which handles the treatment of the substance abuse patients.[28]

The patients come to the clinic every 1 to 4 weeks to visit their personal nurse and physician who monitor their pregnancy and give them psychosocial support for quitting drugs and reorganising the fundamentals of their life. (Halmesmäki et al. 2007)

A study dealing with the treatment at the clinic stated that the shame the pregnant women or mothers feel over their substance abuse problems and fear of the child welfare authorities may prevent them from seeking proper help. For this reason, the treatment should be made easily accessible. Many patients have also felt that being treated in a somatic treatment unit is less stigmatising than having to seek help from a substance abuse or psychiatric unit. (Halmesmäki et al. 2007.)

The best treatment results were achieved by combining pregnancy monitoring and substance abuse treatment, which allowed early contact with child welfare authorities and facilitated the referral for follow-up treatment. The post-natal check-up and birth control were already planned at the hospital. The patient group is very mobile: they move around frequently and their maternity clinic may change a couple of times during the pregnancy. They may spend time in prison or seek substance abuse treatment at another locality, so it is important to co-ordinate the pregnancy monitoring in one place. Thus, it is also easier to monitor the patients' medication. (Halmesmäki et al. 2007.)

According to Törmä and Huotari (2005b), the most socially marginalised substance abusers are not suitable for treatment in rehabilitation units aimed at alcoholics, drug addicts or mental health patients. Some of the clients do not use other services at all; others are major users of services who fluctuate between substance abuse rehabilitation,

27 The study is based on interviews with fifteen 17–27-year-old young women who had used drugs. All the women in the study had been in outpatient or inpatient rehabilitation (or both) for drug use.

28 By the end of November 2005, 312 pregnant drug abusers had been treated under the model. The primary substance of abuse was opiates or amphetamine for 43% of the patients, and 105 (33%) patients only used opiates. Twenty-nine of them (28%) had been in buprenorphine or methadone substitution treatment or buprenorphine detoxification in another treatment unit before becoming pregnant. Twenty-two (21%) women started buprenorphine substitution or detoxification treatment at the clinic.

prison, health care clinics and the street. The most problematic are the so-called dual-diagnosis patients who are clearly in need of psychiatric services but do not have access to them because of their substance use. Thus, the patients' mental health problems are left untreated and they continue self-medicating with drugs and sedatives.

Because the clients with multiple problems are unable to commit to normal treatment or its requirements, they would benefit from less goal-oriented treatment plans and supported housing services. This approach would also require bringing low-threshold services to the clients. Linking the entire treatment chain so that a patient could advance in the treatment system according to his or her own abilities and needs would be of great use to clients with multiple problems. (Törmä & Huotari 2005b.)

### 5.2 Drug-free treatment

During the past decade, the community rehabilitation model has been widely applied in Finnish substance abuse rehabilitation units. The idea behind the model is to consciously utilise the community as support for recovery. The model is implemented in therapeutic communities, with relatively long rehabilitation periods. The objective of community rehabilitation is to integrate the individual first in the community and then back to society.

Arja Ruisniemi (2006) has examined substance addicts' recovery in community treatment using the 12-step facilitation therapy as its central recovery model, in which the individuals committed themselves to attending regular AA and NA group meetings.[29] Based on interviews conducted during the rehabilitation period, the individuals perceived community and feedback from others as an important part of their own change process. On the other hand, drawbacks included the exercise of power within the community and the pressure to be similar to the others. The members of the community had formed relationships with each other, which contributed to safety and trust for the change process. Discipline within the community was seen positively, as an expression of caring. Overall, the interviewees' attitude to the community was a balance between their own needs and actions in the community. (Ruisniemi 2006, 244, 247–248.)

In post-rehabilitation interviews, key themes included either the acceptance of an addict's identity or breaking away from it. The responses represented three different ways of understanding and assessing the change in one's own life: survival, balance and growth. The experience of those who told a survival narrative could be summarised as "Adversity often leads to prosperity". Those who spoke of balance had experienced many kinds of external and internal pressures, but it was just such life challenges which gave some meaning to their lives. One individual told a growth narrative and, by contrast, saw the past as important since it had made them the person they were today. Ruisniemi recognises that the target population in the study was limited and probably included a self-selection bias in the sense that, originally, applications to enter this type of rehabilitation were made by persons who had perceived the rehabilitation model as useful for themselves. Indeed, only 30% of those who had been interviewed at the beginning failed to complete the one-year rehabilitation. However, the study confirms

29 The material consisted of interviews with ten patients that were conducted at the beginning and end of a one-year community rehabilitation period as well as 1–2 years after the rehabilitation. The primary drug was amphetamines for 5 of the interviewees, heroin for 3 and alcohol for 2 of them. Six of them had hepatitis C. Before entering the community, all clients had spent at least two months within the treatment system and had actively sought a long treatment period themselves. (Ruisniemi 2006, 5, 88.)

that the process of breaking away from addiction is seen as a change in which, on an individual basis, emphasis is on close persons, finding one's own lifestyle and reinforcing one's own resources. It could be characterised as social rehabilitation encouraging the individual to begin to interact with the social environment. (Ruisniemi 2006, 244, 247–248, 253–254.)

Ulla Knuuti (2007) studied the lifestyles and recovery processes of people who had stopped using drugs.[30] Drug use that had continued for years had usually caused multiple health problems and problems with work, education, income, living and relationships. The effect of the past on the present was evident in all aspects of life. There were various competing explanations for the changes taking place in an individual recovering from drug addiction. Those who currently had a contact to care for them felt that the contact supported them. Family and significant others had an important role in the maintenance of sobriety. Peer groups also had a large impact on the life of the interviewees. A former drug user encountered disrespect and distrust. The path to becoming an equal citizen was long, due to the attitudes of others, since various actors in society do not always favour the culture of recovery. (Knuuti 2007.)

The study showed that a drug addict needed a sufficient distance from acute drug use for recovery to begin, but living without drugs in itself does not mean that the person has truly recovered. The basis for truly content sobriety is for the person to be freed from the internalised feelings of being different. An optimistic view of the future and a recovery culture that maintains and supports the new way of life are thus emphasised as the central factors that prepare the person for normal everyday life. (Knuuti 2007.)

### 5.3 Medically assisted treatment

In units participating in the drug treatment information system, medical outpatient or inpatient treatment designed for opiate addicts was received by 28% of the clients (n=4141) who had sought treatment primarily for opiate addiction. Buprenorphine (56%) was more common in medical opiate addiction treatment than methadone (40%). Of the buprenorphine used in treatment, 65% contained naloxone in addition to buprenorphine. (Kuussaari & Ruuth 2008)

The OHJAT project conducted in 2003–2007 assessed the rehabilitation and treatment continuum in replacement and maintenance treatment for opiate addicts in the Greater Helsinki area. The project's results have been analysed from the viewpoint of the clients' psychosocial rehabilitation process (Harju-Koskelin 2007) and by evaluating the rehabilitation practises (Koivisto 2007).

The psychosocial rehabilitation in the OHJAT project was analysed based on client interviews at the start, when seeking treatment, and half-yearly during follow-up treatment. Attained development has been reported by comparing the initial interviews with follow-up interviews using the same methodology and taking place one and two years after the initial interviews.[31] The results did not indicate any significant changes in the interviewees' employment and study situation during the two-year follow-up

30 A total of 32 people with a serious drug past were interviewed for the study. At the time of the study, they had been free from illegal drugs for at least a year.

31 The initial interviews were conducted during 24 June 2003–1 July 2005 (see Section 4.3) and the latest follow-up interviews in June 2006. While the initial interviewees numbered 60, three-quarters of them accepted a follow-up interview after one year and, after two years, two-thirds of those for whom a two-year follow-up was possible agreed to an interview. In all, 8 persons dropped out of the follow-up group. (Harju-Koskelin 2007, 27.)

period. A total of two-thirds of the interviewees took part in some form of psychosocial rehabilitation activity during the two-year follow-up period, but the participation periods were often brief and fragmented. Many of the interviewees seemed to lack a longer-term plan for what they wanted to achieve through the rehabilitation activity. (Harju-Koskelin 2007, 47–55.)

Additional abuse of other substances and intravenous drug use reduced markedly during the two-year follow-up period. While the initial interviews indicated that more than half of the clients had abused additional substances during the preceding month, the corresponding share in the two-year follow-up had decreased to one-third. Similarly, a third of the clients reported in the initial interviews that they had shared needles and syringes during the preceding half year but, after the two-year follow-up, this had dropped to zero. The clients' substance-free periods had also become more frequent and longer. According to this study, it seems that among those in substitution treatment, both risk use and additional use will reduce slowly over time. (Harju-Koskelin 2007, 60-67.)

The study's conclusions clearly showed that changes in many psychosocial areas are very slow and small. It is, therefore, evident that at some point substitution treatment clients will have to weigh their own expectations against improvement achieved. This constitutes a potential crisis point in their lives, which may result in substance problem use, increased criminal behaviour or weakening psychological health and deteriorating human relationships. This phenomenon emerged particularly during the one-year follow-up interviews, but the two-year follow-up indicated clearly more positive developments. Factors which may explain the slowness of change include the frequency of additional substance abuse by the clients and the assumption that only one-third of the clients regarded a substance-free life as the aim of their treatment, judged on the basis of their abuse of additional substances. (Harju-Koskelin 2007, 78-82.)

Many small treatment units include psychosocial treatment in their plans, but it is questionable whether they can reach the treatment targets, given existing human resources. The fact that the majority – more than 90% – of the care personnel providing substitution treatment have a professional education background only in health care reduces the possibilities of treatment to also address clients' social problems. The researcher wonders whether treatment could be implemented from another starting point, one where the first objective of treatment would be harm reduction, achieving commitment to care and providing a gradual preparation for rehabilitative substitution treatment. Particularly at the beginning, key targets would include basic social work, ensuring a livelihood and housing as well as seeking social support to foster recovery. Through this approach, it would be important to progress according to the client's situation and personal treatment goals. (Harju-Koskelin 2007, 94-96.)

The rehabilitation practices in the OHJAT project were evaluated in feedback discussions with the personnel in the participating units as well as using questionnaires aimed at patients.[32] Feedback from personnel revealed that confusing terminology and the objectives of medically assisted detoxification, replacement and maintenance treatment had at first hindered co-operation between the parties involved: the patient, the person

32 Personnel views were collected using questionnaires and requesting feedback during 5 development and training days common to the units as well as in 7 themed meetings of the OHJAT project's contact persons (themes included e.g. treatment of intravenous use problems, treatments during waiting time etc.). Patients' views were examined using questionnaires given to the clients of different treatment units immediately after the distribution of medication. A total of 70 responses were obtained, and 20 of them were collected during separate follow-up interviews within the OHJAT project. (Koskelin 2007, 29–33, 51–53.)

who had made the referral for treatment, the payer and the treatment units. For instance, “improving the quality of life” of the client as mentioned in the previous Decree on substitution treatment (2002) was seen in some treatment units as merely requiring daily medication to be given, while other units understood it more widely as including active treatment measures, such as appointments with a personal nurse. According to the different disciplinary perspectives adopted, the impact of collecting a restricted dose of medication every day was seen in a very different light. Some considered it as restoring the patient’s rhythm of life and thereby improving his or her quality of life. Others saw it as controlling the patient’s behaviour and, thus, even reducing the motivation for treatment and resulting in a poorer quality of life. (Koivisto 2007, 33–36.)

The evaluation showed that practically all treatment units conclude a treatment agreement with the patient. The previous Decree on substitution treatment (2002) specified a condition for giving a maximum of eight treatment days’ doses of replacement medication to the client at any one time: the patient must “show good compliance with treatment”. However, the interpretation of this condition varied from one treatment unit to another, and even internally, as well as according to the stage the patient’s treatment had reached. These various interpretations concerned, for instance, the individual’s progress in treatment or his or her adaptation to the treatment system. Similarly, control practices used in treatment (screenings etc.) varied according to the treatment unit and were also based on what impacts they were considered to have, according to the theoretical basis followed. Problems also arose due to the patients’ own withdrawal targets, since the personnel often regarded them as only leading to disappointment and hindering the continuity of treatment (Koivisto 2007, 36–40.)

Those responding to the survey questionnaire were aged 21–53, with half under 30 and more than two-thirds being male. One in four still used drugs intravenously and half also abused other substances, in addition to the substitution treatment. Of the respondents, 71% had problems in their relationships and as many as 85% reported having financial difficulties. Despite the extensive use of additional substances and intravenous drugs, nearly 90% of the respondents reported that rehabilitation had resulted in a change for the better. Two-thirds felt that their relationships with others had improved and more than half believed that their self-esteem had increased alongside the substitution treatment. As an explanation for the latter phenomenon, the respondents stated that they now belonged in a group which has a right to receive treatment. Regarding work or study, one-third reported that their situation had improved. (Koivisto 2007, 54–58, 62–64.)

The patients’ own view of their opiate addiction was disease-oriented and one-third described their addiction solely as a physical disease. Generally, their treatment targets were related to overall rehabilitation and improvement of their life situation. The patients hoped that the treatment would aid their psychological and physical health, relationships and financial situation, but also their aim of stopping additional substance abuse. A total of 59% reported that withdrawal from replacement medication was their target, but only a quarter had been prepared a practical plan for withdrawal from replacement medication and only half of them had some sort of timetable for achieving withdrawal. Nearly 90% of the respondents considered replacement medication as the most important factor supporting rehabilitation in the treatment, but only approximately a quarter considered that medication alone would be sufficient support for them at the moment. A functioning and interactive relationship with the treatment unit’s personnel, in particular, was considered as the second most important factor supporting rehabilitation. (Koivisto 2007, 58-61, 67-69.)

Negative feedback from the patients often included the inconsistencies in activities, situation-specific definition of treatments, unexpected changes to rules and inconsistent practices. These factors weakened interaction and trust-building between patients and personnel. In the light of this, the researcher emphasises that in order for the targets of the treatment unit and those of the patient to meet, it is crucial that the targets and the rehabilitation plan be defined together with the patient and that attainment of agreed targets be monitored regularly. Realistic targets enable positive experiences from the treatment while supporting commitment to treatment. (Koivisto 2007, 70-71.)

In the Hospital District of Southwest Finland, substitution treatment has been organised on a shared basis so that the Addiction Clinic of Turku University Hospital chiefly conducts substitution treatment assessments and initiates treatments, while further treatment for patients is provided in their home municipalities' treatment units.[33] The Addiction Clinic always organises a transfer meeting in the transfer phase. In addition, a steering group for units providing further treatment convenes at the clinic every month. There are 15 units providing further treatment in the district. Cessation of treatment has been rare and the annual rate of remaining in treatment has been 95%. For pregnant women, attempts are made to provide them immediate access to treatment (without waiting times) and, for dual-diagnosis patients, an integrated treatment model will be used, meaning that both substance abuse treatment and psychiatric treatment for the patient are always centralised in one unit. (Mikkonen et al. 2008.)

In the treatment model applied internally in the City of Turku, part of the Hospital District of Southwest Finland, patients are referred, depending on the stage which their individual rehabilitation has reached, to rehabilitative or harm-reducing substitution treatment in psychiatric specialised health care or to basic-level treatment in a health centre. Buprenorphine-naloxone treatments are initiated in an outpatient clinic if the patient does not have a major polysubstance addiction, while methadone substitution treatment is always commenced with a two-week inpatient period. The initiation period in a university hospital ranges from 3 to 6 months, depending on availability under the City's quota for further substitution treatment. In 2008, however, attempts are made to begin new patients' treatment directly in the City's quota for further treatment. (Mikkonen et al. 2008.)

A criterion for rehabilitation treatment is that the patient would benefit from psychosocial rehabilitation and commits to it. The long-term objective is for the patient to attain a substance-free lifestyle and to improve control of his or her life. Every two months, an assessment is made of the patient's current need and progress with regard to his or her targets. The achievement of these targets is supported through weekly meetings with the patient's personal nurse. The target schedule for rehabilitative substitution treatment is two years. Criteria for beginning harm-reducing substitution treatment include poor commitment to treatment, chaotic additional substance use or the fact that rehabilitation is currently not the patient's own target. Medical treatment is conducted in a separate unit distributing medication. A key target is to achieve commitment to treatment and, thus, enable future transfer to rehabilitative substitution treatment. In this approach, the proportion of psychosocial treatment is minimised, treatment meetings are arranged every 3 to 4 months and a personal nurse is not assigned to the patient. Once a patient feels ready to take up rehabilitative treatment, he or she needs to draw up an application in which he or she defines his or her own rehabilitation targets. It

33 The population base of the hospital district is approximately half a million people. The number of opioid addicts at the beginning of 2008 was estimated at 380, of whom 242 were in substitution treatment, meaning that the coverage of treatment was 64% (Mikkonen et al. 2008.)

should be acknowledged that for some patients, however, harm-reducing treatment is a permanent and sufficient form of treatment. In health centres, the treatment is mainly medical: a personal physician takes responsibility for treatment and, during a weekly visit to a nurse, the patient is handed a weekly dose of replacement medication to take with him or her. (Mikkonen et al. 2008.)

A challenge in the treatment system in Southwest Finland is posed by those opioid addicts who remain excluded from treatment. Some of them are only beginning to consider a change process and are not actively interested in substitution treatment, others visit a private physician to obtain codeine treatment or seek treatment abroad, mostly in the Baltic countries. Under the new Decree on substitution treatment, patients with a stable treatment situation can be provided more flexible treatment. This increases the overall availability of substitution treatment since those who only need pharmacies to distribute their medication will free up places under the quota for rehabilitative treatment. One alternative to improve the availability of substitution treatment is to provide medical treatment for the patients who are still on the waiting list, instead of having them wait without medication. In this 'medical approach to waiting lists', the harm-reducing substitution treatment process can be initiated immediately for those eligible for treatment, who would then move on in the shared treatment system once vacancy in a treatment unit arises. The medical approach to waiting lists could also be applied in a case where withdrawal treatment has failed. (Mikkonen et al. 2008.)

According to other Finnish studies, too, commitment to rehabilitative substitution treatment and related treatment results have been fairly good in spite of the fact that the patients seeking treatment have multiple problems.

The clients admitted for opioid substitution and maintenance treatment in 2000–2002 at the addiction psychiatry outpatient clinic at Tampere University Central Hospital typically had multiple problems. (Veide et al. 2007.)[34] During the period of evaluation, opioid replacement or withdrawal treatment was attended by 34 clients, half of them being under the age of 25. All the clients received social assistance and were in debt, 15 were awaiting trial. Their level of education was poor, and their lives involved unemployment, debt and criminal activity. Besides mental health problems, they frequently experienced somatic symptoms, and many had attempted suicide and had hepatitis C. The most common opioid they had used was buprenorphine, and polydrug use was common. However, 70% of the patients remained in substitution and maintenance treatment during the one year follow-up period. The factors predicting that a patient would remain in treatment were a higher age, female gender, a higher level of education and good treatment motivation.

The various models of implementing substitution treatment emphasise different aspects of the relationship between psychosocial and medical treatment. Particularly in university hospitals, medicine and rehabilitation are highlighted. The staggered treatment focuses on the idea that psychosocial treatment is prioritised when the patient feels ready for rehabilitative treatment and is able to define realistically his or her own rehabilitation targets. An alternative to the above-mentioned model is a holistic approach of commitment to treatment and preparation for rehabilitative substitution treatment which includes, particularly at the beginning, basic social work, ensuring livelihood and housing as well as seeking social support to foster recovery. Both of these models find support in various follow-up studies. Common to the models is, however, that both of

34 Cp. Section 4.2.

them highlight how important it is to progress according to the particular circumstances of the client and his or her own treatment targets.

Substitution treatment is usually linked with the treatment of opiate users. There is no special detoxification or substitution treatment for amphetamine addicts. In 2004, a clinical study on the treatment of amphetamine addiction "*Aripiprazole and methylphenidate in the treatment of amphetamine addiction:* a randomised, placebo-controlled double-blind study". (Tiihonen et al. 2006.)[35] The study is the first study on amphetamine in the world that was conducted with a placebo as a so-called randomised study. The target group was individuals living in the Greater Helsinki area who had used amphetamines intravenously for more than 10 years. According to the 2005 intermediary analysis of the study results on 50 patients, methylphenidate seemed to work well in reducing amphetamine use. The comparison of methylphenidate and a placebo in the treatment of amphetamine addiction is on-going.

35 The study was a collaborative effort of the Deaconess Institute, the Department of Psychiatry of the Hospital District of Helsinki and Uusimaa, the Department of Forensic Psychiatry at the University of Kuopio, the Department of Forensic Medicine at the University of Helsinki and the National Public Health Institute. The Department of Psychiatry of the Turku University Hospital will also participate in the follow-up study.

# 6 Health correlates and consequences

The number of drug-related deaths grew along with other detriments at the turn of the millennium (Figure 3), which was a consequence of the increased drug use in the 1990s. Since 2000, the number of drug-related deaths has remained at this higher level. Although no clear declining or increasing trend can be discerned, during very recent years, the number of deaths has slightly increased. Drug-related deaths follow fairly consistently the trends in drug use, especially the trends in the use of injected drugs. Quick changes in the methods of use (intravenous use gains popularity, heroin disappears from the market) or new substances that enter the market can affect the number of deaths by poisoning fairly quickly. Buprenorphine is becoming the most common substance detected in drug-related deaths.

The number of HIV infections caused by intravenous drug use and hepatitis C, B and A cases recorded in the infectious diseases register has clearly declined over the past decade. Health counselling centres and hepatitis A and B vaccinations have played an important role in reducing the spread of drug-related infectious diseases.

Drug-related mental health disorders have increased fourfold since the beginning of the 1990s. Currently, an integrated treatment model is under development for treating 'dual diagnosis' patients, aimed at the simultaneous provision of treatment for the individual's substance problems and psychiatric disorders.

## 6.1 Drug-related deaths and mortality of drug users

Drug-related death cases in Finland can be analysed using three different types of statistics: chemical findings, causes of death and poisoning. Since the number of chemical findings is based on positive drug findings in forensic autopsies, the drug itself is not necessarily always the direct cause or a major indirect cause of death. In Finland, all cases involving an unclear or doubtful cause of death are examined for drugs. Statistics by cause of death are kept based on the EMCDDA protocol[36], under which drug-related deaths include poisoning cases caused by drugs, brain-chemical disorders and dependencies in accordance with ICD 10 codes. The number of poisonings or fatal drug overdoses indicates the number of deaths directly caused by drugs.

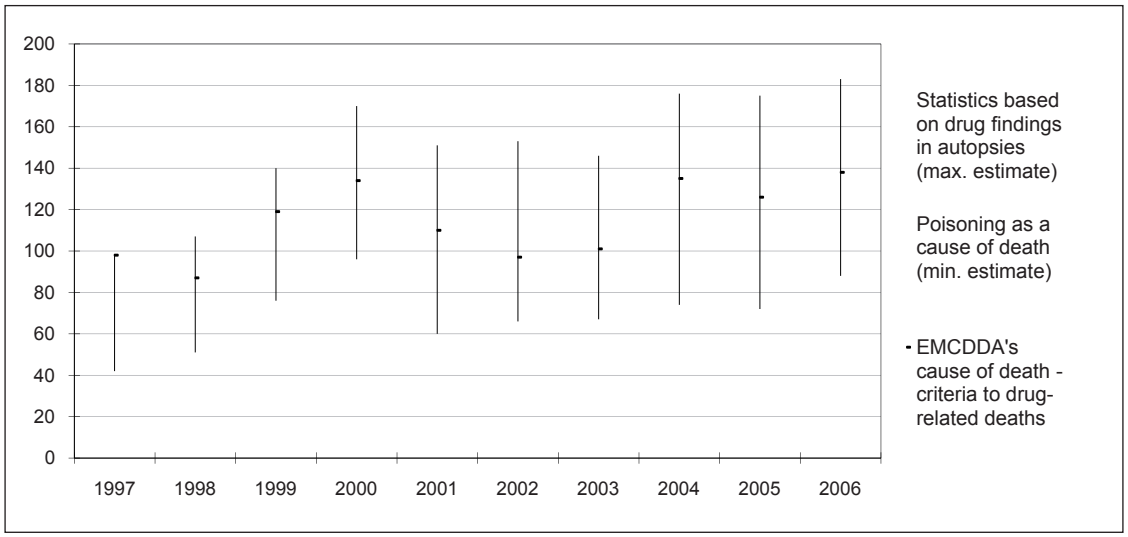
Figure 7 illustrates the development of drug-related deaths in 1995–2006, using the above-mentioned statistical sources[37]. In these three drug-related death statistics, changes occurring since 2000 are highly consistent.

According to information on forensic chemical findings, there were 229 drug-related deaths in Finland in 2007, which is 46 cases more than the previous year. Amphetamine was found in 92 (64) cases and cannabis in 92 (99) cases. The number of deaths caused by either heroin or cocaine have remained at a few cases every year. In 2007, heroin was detected in 1 (2) cases and cocaine in 3 (1) cases. Buprenorphine abuse was detected in 97 (88) deaths. The number of buprenorphine findings has risen from 7 in 2000 to nearly 100 currently. Other opioids – tramadol, oxycodone or fentanyl – were detected in 21 (29) cases. (Department of Forensic Medicine 2008.)

36 The protocol is available as a pdf document at: http://www.emcdda.europa.eu/?nnodeid=1419.

37 All the three statistics are prepared annually concerning the previous year. Unfortunately, at the time this report was prepared, only the chemical finding data was available for 2007.

*Figure 7. Drug-related deaths according to different criteria 1995–2006.*




Source: Statistics Finland; Department of Forensic Medicine, University of Helsinki

There was one finding of gamma-hydroxybutyrate (GHB) both in 2003 and 2004; in both cases, the poisoning caused by the substance was also the cause of death. In the 2003 case, the victim had synthesised the GHB himself and in the latter case, the cause of death was gamma-butyrolactone (GBL), which is a prodrug of GHB. (Vuori 2006 et al.) In 2006, GHB was found in five cases; four of these were deaths by poisoning. No detailed information is available on the circumstances of the cases. (Vuori 2007)

### 6.2 Drug-related infectious diseases

*HIV*

According to the HIV infection statistics maintained by the National Public Health Institute, 191 new HIV infections were reported in 2007 (193 cases in 2006). Since 2000, the number of HIV infections has increased, due to the rise in sexually transmitted HIV infections. By contrast, the number of infections transmitted due to intravenous drug use has remained low: they accounted for 6% of the cases where the means of transmission was reported (5% in 2005).

In addition to this passive monitoring required for the infectious diseases register, the National Public Health Institute has been co-ordinating prevalence surveys[38] conducted approximately once a year. These surveys have aimed to assess the prevalence of infections among those intravenous drug users who do not seek diagnostic testing.

38 The survey has been conducted seven times during 1998–2007. Generally, the survey has been arranged in several health counselling centres during 2–4 weeks. The respondents were clients of the health counselling centres, numbering 150–700. Each participant completes a form anonymously and gives a gingival fluid sample which is examined for antibodies to hepatitis C and HIV. Both the form and the sample will bear the same anonymous participant number, enabling the comparison of individual risk factors against the antibody result. The test is not a diagnosis and, due to the anonymity observed, the results cannot be returned to participants. This fact is emphasised to the participants and it is also essential in terms of the survey's representativeness, since it enables participation by those who do not necessarily wish to learn of their infection. Those who know that they are HIV or hepatitis C positive are encouraged to participate in the survey.

According to the survey results, the prevalence of HIV among intravenous drug users has remained, in spite of the epidemic of the early 2000s, at some 1–2%, which by international standards is a very low proportion. (Arponen et al. 2008.)

According to the 2007 data in the drug treatment information system, fewer than 1% of those who had used drugs intravenously and had taken an HIV test and received their test results (n=2,585) had reported themselves to be HIV positive, while the confirmed data indicated a total of 1.5% to be HIV positive (Kuussaari & Ruuth 2007).

According to a recent study[39], HIV positive intravenous drug users who live in the Greater Helsinki area (Helsinki, Espoo and Vantaa) are marginalised both socially and regionally. There was an HIV epidemic among intravenous drug users in the Greater Helsinki area in 1998, but the epidemic took a downward turn in 2000. All the areas outside the centre of Helsinki, where users said that they had spent time or used drugs at the time of the HIV diagnosis, were areas in which men had the lowest rate of employment (less than 70%). The HIV infections of the intravenous drug users were concentrated in areas described as poverty areas. The conclusion drawn from the study was that when HIV prevalence is low, preventative measures should be targeted especially at socially marginalised drug users who practice risk behaviour and spend their time outside the city centre. (Kivelä et al. 2007)

*Hepatitis C*

In 2007, a total of 1,157 hepatitis C cases were diagnosed (1,181 in 2006). In approximately 40% of these cases the means of transmission was reported. The overall number of new hepatitis C cases has declined slowly but surely since 2000 and, at the same time, the number of infections caused by intravenous drug use has decreased. Nevertheless, the prevalence of hepatitis C among intravenous drug users is at such a high level that any changes will occur slowly, even if the risks are controlled. (National Public Health Institute 2008.)

Based on the prevalence surveys[40] of the National Public Health Institute, the prevalence of hepatitis C is 50–70% among intravenous drug users.

Of the hepatitis infections, the majority are contracted through intravenous drug use: in 2007, it was the cause of 87% of cases where the means of transmission was reported. According to the 2007 results of the drug treatment information system, 63% of those who had used drugs intravenously and had received tests (n=2,727) had hepatitis C. Self-reported information suggested the proportion of positive cases to be slightly lower, a total of 60% (Kuussaari & Ruuth 2008.)

A review by age group indicates that, regarding the hepatitis C infections, the share accounted for by 15–19-year-olds has lowered and that of 20–24-year-olds is showing some indications of decline. The National Public Health Institute (2008) concludes that health counselling and harm reduction work has most probably been effective for the younger age groups and that, nowadays, infections are contracted at an older age if drug use is continued. Among the individuals who had continued intravenous drug use

39 The material for the study consisted of HIV positive drug addicts who visited the clinic of infectious diseases at Helsinki University Central Hospital at least once between 1998 and 2003. Of the 213 clients, interview data on 176 (82.6%) clients was available for the study. The data related to drug use, sources of income, living conditions, education, employment, substance abuse treatment and imprisonment. The clients were also asked to name a maximum of four areas where they had spent time or used drugs at the time their HIV infection was diagnosed.

40 For more details on the surveys, see Subsection ‘HIV’ above.

for ten years and who were registered in the drug treatment information system, nearly 80% have hepatitis C (Kuussaari & Ruuth 2008).

Regionally, the number of infections has declined in Southern, Western and Eastern Finland while in the northern provinces of Oulu and Lapland, the prevalence of hepatitis C doubled from 2006 to 2007. In order to reduce the number of infections in Northern Finland, provision of health counselling for intravenous drug users should be increased. (National Public Health Institute 2008.) Indeed, health counselling is available only in a few localities in Northern Finland.

*Hepatitis B*

The number of acute hepatitis B cases recorded in the infectious diseases register has shown a significant decline over the past decade, and infections contracted through intravenous drug use have decreased the most. In other words, hepatitis B vaccinations for risk groups and the work conducted at health counselling centres aimed at drug users have produced results. In 2007, a total of 23 cases were reported, which is less than one tenth of the number of cases in the peak year of 1997. The means of transmission was identified in 8 cases, and in only one had the infection been contracted through intravenous drug use. (National Public Health Institute 2008).

*Hepatitis A*

In 2007, the number of cases of hepatitis A reported in the infectious diseases registered totalled 17, a record low. Of the reported infections, 7 were contracted abroad, 6 in Finland and 4 cases lacked information on the means of transmission. Of the Finnish infections, 2 had been contracted from a close friend or relative who had been infected while travelling abroad.

In 2002–2003, a hepatitis A epidemic emerged among intravenous drug users in the Greater Helsinki area, causing the number of new cases to soar (393 cases reported in 2002 and 243 in 2003). This growth levelled off in 2004, after which the prevalence has remained low owing to the vaccination of risk groups. As of 2005, intravenous drug users are entitled to hepatitis A vaccine under the national vaccination programme. Seeking a hepatitis A vaccination is also common among those who are planning to travel abroad.

### 6.3 Psychiatric co-morbidity (dual diagnosis)

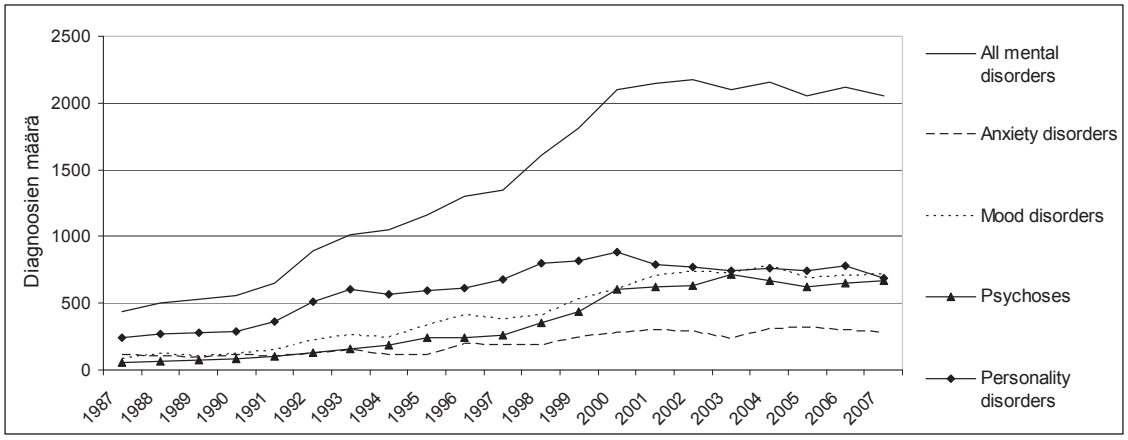
A survey[41] conducted among patients receiving substitution treatment in the Hospital District of Helsinki and Uusimaa (HUS) in 2000–2002 suggested that more than 90% of the patients on substitution treatment displayed psychiatric disorders, in addition to their substance problem. For the majority of the patients, polydrug use was common: in addition to opiate addiction, nearly everyone was diagnosed as being addicted to, or abusing, benzodiazepine (94%). More than half were also diagnosed as being addicted to, or abusing, amphetamines (59%) and approximately half as being addicted to, or abusing, cannabis (51%). Alcohol addiction or abuse was diagnosed in a tenth of these patients (10%). Nearly all substance diagnoses were related to addiction and only some

41 The study included all the patients (70) who started opioid substitution treatment in 2000–2002 at the HUCH Outpatient Department for Opioid Addiction. The retroactive study was based on case histories. All the patients in the study received methadone treatment. (Vorma et al. 2005.)

referred to abuse. The most common psychiatric disorders co-occurring with substance abuse were various personality disorders (86%) and affective disorders (23%). The most typical personality disorders included antisocial or unstable personality disorders. For one in ten patients, the disorder had reached the level of psychosis. The proportion of dual diagnosis patients in the data was significant, and the frequency of psychiatric disorders among patients on substance treatment clearly exceeded the levels observed in the general population. More research on dual diagnosis patients is required, and this group should also be considered in the planning of treatment. (Pirkola et al. 2007a; Vorma et al. 2005.)

Figure 8 shows the number of mental disorder diagnoses co-occurring with drug diagnoses, according to the hospital patient discharge register. The number of diagnoses grew throughout the 1990s, but the trend has levelled off since 2000.

*Figure 8. Mental disorder diagnoses co-occurring with drug diagnoses in 1987–2007 according to the hospital patient discharge register.*




Source: Hospital patient discharge register, STAKES

## 6.4 Other drug-related health correlates and consequences

In her recent dissertation[42], Solja Niemelä (2008) has examined how psychological symptoms in childhood and psycho-social factors in early adulthood correlate with substance abuse and related crimes. According to the study, childhood hyperactivity, conduct problems and co-morbid conduct-emotional problems were predictors of heavy substance use and substance-related offences in early adulthood.

42 The study population included 10% of all Finnish-speaking boys born in Finland in 1981 (n=2,946 or 97% of the target population). In 1989, these boys were 8 years old and any psychiatric symptoms were assessed by using validated questionnaires (the Rutter questionnaire, Children Depression Inventory) completed by teachers, parents and the boys themselves. A follow-up was conducted in the military recruitment examinations in 1999 when the boys were 18 years old (n=2,348 or 80% of those who had participated in the study in 1989). Questionnaires were used in order to assess the subjects' substance abuse, psychological condition, functional ability (Young Adult Self-Report) and use of mental health services. Data on psychiatric diagnoses were collected from the Military Register (in the age of 18–23) and data on offences were retrieved from the National Police Register (in the age of 16–20). These data were available for a total of 92% of those who participated in the study in 1989.

While childhood psychiatric symptoms were predictors of a future narcotics offence record, they did not correlate with self-reported drug use at the age of 18. Psychiatric disorders in early adulthood were common among those using drugs. Teacher reports on the boys' psychiatric symptoms predicted later substance use more accurately than parents' reports. (Niemelä 2008.)

According to the findings of the thesis, substance-use-related outcomes accumulate in boys with psychiatric problems both in childhood and in early adulthood. The researcher suggests that targeted early interventions should be developed in school health care systems, particularly for boys with childhood hyperactivity, conduct problems or co-morbid conduct-emotional problems. (Niemelä 2008.)

In his dissertation (2006)[43], Peter Andersson studied the connection between heroin use and psychological vulnerability that stems from childhood. According to the study, domestic violence has detrimental effects on the care environment of the family. Insensitivity related to feelings of rejection in childhood enhances the child's feelings of insecurity, lowers his or her self-esteem and makes it more difficult for the child to deal with his or her problems. This turned out to be a risk factor behind the onset of heroin use. Correspondingly, a warm atmosphere in the childhood home has the opposite effect. According to the results of the study, people with high self-esteem had a 17 times (odds ratio) lower risk of starting to use heroin than did people in the test group consisting of heroin users. Correspondingly, a pathological and compulsive breakdown in self-confidence in relation to oneself and to others turned out to be 40 times more common among heroin users than among the control group. The risk factors for drug use also include experiences of failure at school. According to the researcher, these results support the statement that the atmosphere at home has a crucial influence on children's mental health and on the accumulation of such protective factors that improve a child's ability to resist drug use.

43 The dissertation was based on a case-control study with a test group of 81 people (aged 38+ 5 years) who had been diagnosed with a drug-related behavioural disorder (heroin use) and a control group of 81 people with no such diagnosis. The groups were also homogenised on the basis of gender and age.

# 7 Responses to health correlates and consequences

Prevention of drug-related deaths is also carried out as part of health counselling related to infectious diseases and in problem user peer group activities. To prevent overdosing, awareness has been raised on the importance of correct dosage and calling for help in time. The issue is also dealt with in drug treatment units with the users, when necessary. Some training concerning the prevention of drug-related deaths is provided as part of the basic training in social welfare and health care.

The treatment and prevention of infectious diseases related to drug use is carried out within primary health care services, specialised services within health care and substance abuse services, health counselling centres and pharmacies that sell syringes and needles. HIV infected patients are treated in university hospitals and the central, regional and psychiatric hospitals in the area.

Low-threshold services in particular have been essential in preventing and reducing infectious diseases spread by intravenous drug use. Drug users can exchange used syringes and needles for clean ones at health counselling centres. An essential part of the operation is health counselling on drug-related infectious diseases and other serious risks related to drug use, such as overdoses and sexually transmitted infections. Health counselling centre services are free of charge for clients and the clients can visit the centres anonymously.

Under the Communicable Disease Act of 2003, municipalities must conduct, in their health centres' operating areas, prevention work against infectious diseases, including dissemination of information on infectious diseases and health counselling. The scope of the Act encompasses health counselling for intravenous drug users and exchanging syringes and needles where necessary. Free hepatitis A and B vaccinations have been included in the vaccination programme for intravenous drug users. Pharmacies have an important role in exchanging syringes and needles in areas where there are no health counselling centres.

## 7.1 Prevention of drug-related deaths

In February 2008, the Ministry of Social Affairs and Health hosted a seminar on the prevention of drug-related deaths. One of the issues to emerge was that users' possible fear of the authorities may have negative impacts, such as not calling the emergency number in an overdose case. The seminar also included a presentation of peer group activities which can reach drug users who are not currently using or not entitled to use the services offered. As an example of this kind of work, the Vinkki Health Advice Centre in Helsinki organises so-called snowball training[44] for former and current users. The task of participants who have received training is to tell other drug users how to prevent drug-related poisoning and to instruct them on how to provide first aid in case of an overdose. In 2008, a research project was launched to investigate the causes and conditions underlying drug-related deaths in Finland. Based on its findings, measures will be planned for preventing drug-related deaths.

44 Information on snowball training has been reported in Finland's previous drug situation reports, in 2006 and 2007. Correlation Network (2008) has published a report on the snowball training in English: "Peer training in a multicultural environment. Snowball and individual training at the Vinkki Health Advice Centre in Helsinki during 2005-2006." See http://www.correlation-net.org/products/snowball.pdf.

## 7.2 Prevention and treatment of drug-related infectious diseases

*Guidelines on outreach work*

Correlation Network (2007) has also issued the publication[45] "Outreach work among marginalised populations in Europe. Guidelines on providing integrated outreach services." These guidelines cover both the principles of outreach work and practical implementation. Training for employees working in outreach services and their well-being at work is considered a key issue. In order to succeed, outreach work also requires co-operation with the other actors in the social welfare and health care sector.

*Vaccination coverage of users in drug abuse treatment*

Based on the data available in the drug treatment information system, of those drug treatment clients who had used drugs intravenously at some point of their lives, approximately two-thirds (71%) had received at least one of the vaccine doses for hepatitis B. A total of 51% had received all three vaccine doses, and 4% had received a booster dose. (Kuussaari & Ruuth 2008.)

*Services in health counselling centres*

Health counselling centres provide counselling on health issues, small-scale health care, testing and vaccination services and case management. These services are provided in all municipalities with more than 100,000 inhabitants and also in municipalities with 50,000–100,000 inhabitants, excluding Lappeenranta and Vaasa. In addition, many smaller municipalities also have their own health counselling centres. Overall, health counselling centre services are offered in more than 30 localities.

In 2005, a total of 44% of the Finnish population lived in municipalities providing health counselling services. By correlating the recorded total number of clients visiting health counselling centres in 2005 (11,800 clients) with the estimated number of problem users in the same year (14,500–19,100 users of amphetamines or opiates), it is estimated that health counselling reaches 60–80% of problem users. However, in the Greater Helsinki area, the reported number of clients was 9,315 while the estimated number of problem users was 5,100-8,200 in 2005. This disparity in comparison with the rest of the country is due to the fact that in the densely populated Greater Helsinki area, up to 20% of the clients attend several centres. These overlaps cannot be eliminated in the data analysis, since the clients can obtain services anonymously, by providing a pseudonym. According to an estimate, the services of health counselling centres reach 80% of problem users in the Greater Helsinki area. (Arponen et al. 2008.)

The operations of health counselling centres have been monitored since 2001. Throughout the period of operation of the centres, the number of clients, visits and exchanged syringes or needles have increased, although in recent years, the number of clients and visits have been levelling off[46]. (Anturiverkosto 2008.)

45 These guidelines have been created based on discussions within a working group assembled by Correlation Network.

46 The health counselling centre statistics for 2007 are not fully complete at the time this report is being prepared.

*Table 7. Activities of health care counselling centres, 2000–2007*

| | 2000 | 2001 | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 |
|---|---|---|---|---|---|---|---|---|
| Health counselling centres | 12 | 18 | 22 | 24 | 24 | 34 | 38 | 38 |
| Clients | 4,800 | 8,400 | 9,300 | 9,300 | 10,400 | 11,800 | 11,900 | n.a. |
| Visits | 32,900 | 44,500 | 55,300 | 70,600 | 83,400 | 80,500 | 73,900 | n.a. |
| Exchanged syringes or needles | 564,500 | 950,500 | 1.1 million | 1.4 million | 1.8 million | 1.9 million | 2.3 million | n.a. |

Source: Anturiverkosto 2008

According to the operating statistics from 2006, health counselling centres carried out a total of 1,409 HIV tests and 582 hepatitis C tests. These tests were available in four out of every five centres. A total of 1,091 of the HIV tests were quick tests. Several centres also provided tests for detecting hepatitis A or B, chlamydia, gonorrhoea or pregnancy. The number of vaccine doses administered totalled 1,950, representing a 3% increase over the previous year. The centres also distributed 58,991 condoms, up 50% from the year before. (Anturiverkosto 2008; Arponen et al. 2008.)

The National Public Health Institute has conducted an evaluation study[47] examining the effectiveness of the health counselling centres' operations. According to the study, the services of health counselling centres have played a central role in the prevention of HIV infection, hepatitis A and B and, to some extent, hepatitis C, as well as in combating epidemics among intravenous drug users and, indirectly, among the entire population. The ambitious objectives set for the HIV infection situation have been attained, namely stopping the epidemic and reducing the annual number of new cases below 30. This is evidenced not only by the data in the infectious diseases register of the National Public Health Institute, but also by targeted prevalence surveys. (Arponen et al. 2008.)

The model of health counselling centres has proven to be a very cost-effective health intervention, and safeguarding its continuation and further development is very important. These services represent a significant social innovation combining low-threshold health services with drug-related harm reduction – a model which has been successfully implemented in parallel with Finland's restrictive drug policy. (Arponen et al. 2008.)

*Health counselling in health centres*

As of 2003, health centres were also rendered legally responsible for conducting work against infectious diseases and exchanging syringes and needles. However, a survey[48] indicates that drug-related health counselling and exchange of syringes and needles is actually carried out rarely: only 9% of responding health centres reported they exchanged clean syringes and needles for drug users. More than half of the health centres are providing health counselling for instance on infectious diseases or reduction of risks

47 The data used in the study was obtained from the National Public Health Institute's infectious diseases register; test results obtained and sampling studies conducted in the health counselling centres; the centres' operating reports and statistics as well as in-depth interviews with 11 employees working in the health counselling centres.

48 The A-Clinic Foundation and STAKES conducted a survey to assess the health centres' practices in exchanging syringes and needles for drug users. The survey also investigated how well health counselling related to drug use is implemented in health centres. The survey was carried out in December 2006 and sent to all the 596 health centres in Finland (including main and sub health centres). A total of 202 replies were obtained, from 188 different municipalities spread evenly around the country.

related to intravenous drug use. More than third of the responding centres (38%) stated that intravenous drug users visit the health centre weekly. Particularly in small localities, the role of health centres in the prevention of drug-related infectious diseases and drug-related harm reduction is crucial, since establishing separate health counselling centres in very small localities is not necessarily feasible. (Malin-Kaartinen & Rönkä 2008.)

In the survey, health centres also evaluated their personnel's skills and knowledge of drug-related issues. Based on the responses, the majority of health centres are very well or fairly well prepared for providing information on infectious diseases. Moreover, knowledge about treatment options within the locality is good. By contrast, health centres' weaknesses include their inability to deal with individuals who use drugs intravenously, to recognise drug-related health problems and their knowledge of the various narcotic substances. Only 33% of the health centres stated that some of their personnel had participated in intravenous drugs-related training during the preceding two years. Increasing the skills and knowledge of employees is key in shaping attitudes to the importance of work with drug users within primary health care. (Malin-Kaartinen & Rönkä 2008.)

Some 56% of the health centres reported that they provide health counselling related to drug use. More specifically, the health centres provide information on infectious diseases (51%), drug treatment locations (41%), reducing the risks related to injection (36%), health counselling centres (37%) and sexual health (36%). In those health centres providing health counselling, two-thirds provide counselling orally and one-third both orally and in written format. Hepatitis tests are available in 86% of the responding health centres, free of charge in most of them (99%). Drug users may obtain a free hepatitis A and B vaccination in nearly half of the health centres. A HIV test is available at 88% of the health centres, but only two health centres reported offering HIV quick tests. (Malin-Kaartinen & Rönkä 2008.)

The survey also assessed health centres' views on who should be responsible for distributing clean syringes and needles. Most of the respondents considered that health counselling centres should be in charge. Other suggested exchange locations included the network of pharmacies, health centres and mobile exchange units. A total of 44%, however, considered that exchange should be carried out in co-operation between all parties concerned. (Malin-Kaartinen & Rönkä 2008.)

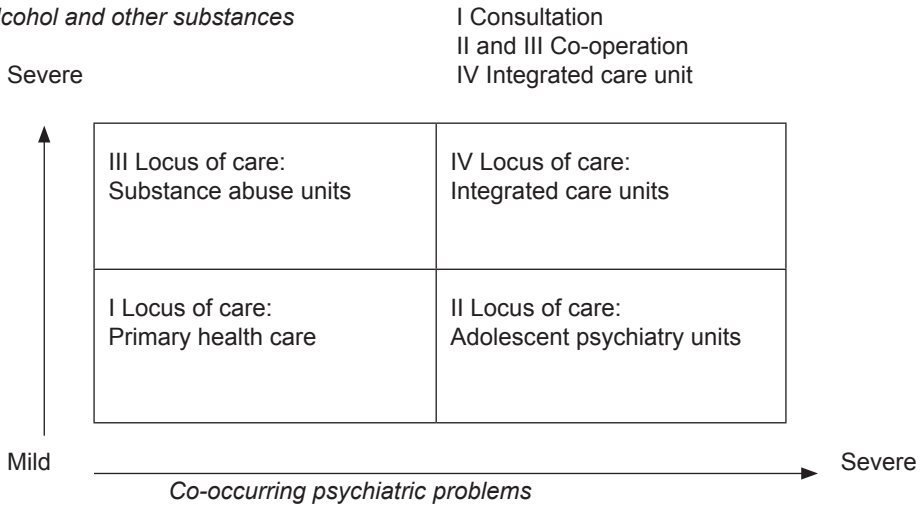
### 7.3 Prevention and treatment of psychiatric co-morbidity

Based on a review of the literature, Mauri Aalto (2007) suggests that the treatment of a dual-diagnosis patient should be integrated, meaning that the individual's disorders should be assessed holistically and the treatment measures addressing the disorders should be initiated simultaneously. In the integrated treatment model, the persons providing treatment must have the necessary treatment skills and research knowledge concerning both substance abuse problems and mental disorders. Integrated treatment is not, in itself, a specific treatment but a model for organising treatment services for dual-diagnosis patients. Integrated treatment involves a multi-professional team and a wide array of treatments ranging from medical addiction treatments to psycho-social therapies. Any treatment should involve a long-term approach and allow some tolerance of substance abuse relapses. In some cases, use-related harm reduction can be regarded as a sufficient objective as such, since the benefits from a treatment also include improving the patient's functional capacities and quality of life.

The publication series “Tietoa nuorten kanssa työskenteleville aikuisille” (*Knowledge for adults working with young people*) by the National Public Health Institute includes a guidebook on the assessment and treatment of young people’s substance abuse disorders and co-occurring mental health disorders. The starting point is that “after a comprehensive assessment, treatment measures are targeted at both disorders and the young person’s development phase and the special characteristics of the substance abuse problem and the co-occurring psychiatric problem are taken into consideration in the treatment”. Within psychosocial treatment, good results have been achieved by combining motivational techniques and/or cognitive-behavioural treatment with family-centred or community-oriented care. When prescribing medication for co-occurring mental health problems, physicians must consider the combined toxic effects of the medication and the patient’s substance of abuse and assess the risk of abuse of the medication. Medical treatment must always be combined with psychosocial treatment. (Pirkola et al. 2007b.)

The treatment of young dual diagnosis patients requires intensive co-operation between the social and health services as well as the clear division of their responsibilities in order to give the young person adequate treatment.

*Figure 9. Care responsibility and co-operation between care providers in relation to the severity of disorders*




*Source: Pirkola et al. 2007b*

The first care contact is usually established within primary health care (section I) such as school or student health care or health centres. In sections II and III the main responsibility lies with units of substance abuse services or the A-Clinic Foundation (youth centres, A-Clinics, inpatient units) which fall under the administration of social services or units of specialised health care services (adolescent psychiatry clinics, adolescent psychiatry wards), which should co-operate seamlessly. For severely symptomatic patients, there should be new types of units (section IV) combining expertise in substance abuse treatment and adolescent psychiatry, so that the units could provide young dual diagnosis patients with integrated treatment interventions. Combining knowledge on adolescent development and disorders with expertise in substance abuse treatment would be efficient and cost-effective and it would meet the needs of the young person. (Pirkola et al. 2007b.)

### 7.4 Interventions related to other health correlates and consequences

The Department of Obstetrics and Gynaecology of the Helsinki University Central Hospital (HUCH) has introduced an enhanced care model in which a special care team handles the treatment of substance abuse patients. Between August 2002 and the end of November 2005, 312 pregnant drug abusers were treated. A total of 32% of the patients also used drugs intravenously during pregnancy. The pregnancies and the births mainly went well. For the most part, the newborn were healthy and the number of anomalies did not exceed the normal average. None of the newborn needed intensive care. The biggest problems were the newborn's withdrawal symptoms, which extended their stay in the hospital. Half of the babies were discharged with the help of support interventions in community care, 21% went on to a substance abuse treatment unit with their mothers, 11% were discharged without support measures, 11% were placed outside the home, 4% were taken into care and one child was given up for adoption. The newborn who had been exposed to drugs in the womb were referred for growth and development monitoring. The mother was also referred for follow-up care. (Halmesmäki et al. 2007.) (See also Section 5.1)

The care model has yielded good results. The treatment of substance-abusing women carried out as teamwork is focused and systematic and at its best, it generates a good degree of trust with the patient. Combining pregnancy monitoring and substance abuse treatment facilitates the referral of mother and child for follow-up treatment. (Halmesmäki et al. 2007.)

# 8 Social correlates and consequences

The results of the drug treatment information system revealed the same facts as many other studies on the risk behaviours, substitution treatment and HIV infections of problem drug users: they have more social problems than the general population. More than three out of five drug treatment clients are unemployed and approximately 10% are homeless, and the clients have a low level of education. As drug use is punishable under criminal law, many clients are also in a vicious cycle of crime and prison.

There was no big change in the number of narcotics offences. In 2007, there were 15,488 narcotics offences known to the police, 67% (10,333) of which were cases of unlawful use of narcotics, 6% aggravated narcotics offences and 27% other narcotics offences. The number of narcotics offences increased by 16 % compared with the previous year. (Statistics Finland 2008.)

*Table 8. Narcotics offences reported by the police and Customs in 1999–2007.*

| | 2000 | 2001 | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 |
|---|---|---|---|---|---|---|---|---|
| Narcotics offences in total | 13,445 | 14,869 | 13,857 | 15,058 | 14,486 | 14,425 | 13,317 | 15,448 |
| Narcotics offence | 12,687 | 12,092 | 5,821 | 5,202 | 4,672 | 4,589 | 4,168 | 4,206 |
| Unlawful use of narcotics | - | 1,899 | 7,240 | 9,084 | 9,217 | 9,248 | 8,480 | 10,333 |
| Aggravated narcotics offence | 741 | 859 | 760 | 742 | 582 | 561 | 657 | 883 |
| Preparation or abetment of narcotics offences | 17 | 19 | 36 | 30 | 15 | 27 | 12 | 26 |

Source: Statistics Finland

## 8.1 Social exclusion

Riikka Perälä (2007) has studied[49] intravenous drug users' interpretations of their problems and the social and health care interventions designed to address those problems. Perälä defined four dimensions determining the nature of the drug problem in a user's everyday life. First, the drug problem does not necessarily have clear boundaries or represent the only problem but, rather, the situation may comprise a variety of problems whose causes and consequences are difficult to discern. In addition to drug use, the users may have family, relationship, subsistence, housing or education problems. Secondly, drug use is not necessarily the most important problem amongst many others: users may need help in other areas first to bring their lives under control. To an outsider, stopping the use of drugs may seem an obvious step, but the user may be most concerned with, for instance, housing. A user confronting multiple problems will bear an emotional burden which may become apparent in everyday life through anxiety,

49 The study is based on ethnographic observation and interview material collected at health counselling centres for intravenous drug users between 2003 and 2006. This summarised article is based on the observation material (1,200 pages of field notes) and client interviews (n=20). A constructionist research approach is applied and the analysis builds upon interpretative frameworks and repertoires identified in the material.

complaining, crying or energy-draining psychological fatigue. The emotional burden of users with multiple problems should be considered in planning the treatment system. Faced with a difficult life stage, a user may not regard stopping drug use as a possible option, since drugs may seem the only way of alleviating anxiety.

Thirdly, drug use is a commonplace experience in the life of a drug user. Unlike in movies or people's imagination, users do not lead their everyday lives in an exciting or shadowy sub-culture or surrounded by professional violent crime. Rather, drug users' lives are filled with routines such as getting and financing their drugs or controlling use-related harm by, for instance, trying to avoid the authorities. Fourthly, the data suggests that drug users are a diversified group. In addition to 'typical' socially excluded young men, users also include people of various age and *habitus* who, except for their drug use, are not socially marginalised. (Perälä 2007b.)

In the light of the material, intravenous drug users appear to be a heterogeneous group which divides into subgroups based on whether the users see themselves as part of the so-called normal or abnormal population. From the point of view of treatment and services, it is worth noting that users speak of their drug use as only one part of their daily programme, which consists of handling multiple simultaneous problems and is characterised by a fast "work rhythm". This usually leads to an oppressive rat race type of existence, and many users would need help to break away from it. Another essential aspect is the users' sense of having no prospects in life. Many feel that they have failed completely in life, and their experiences with strict control measures seem unfair to them, as if they are being kicked when they are already down. Hence, they easily feel resentment towards society and its institutions, which should be taken into consideration in the development of treatment and services. (Perälä 2007a.)

Socio-demographic information concerning drug treatment clients, obtained from the drug treatment information system, has remained quite similar and unchanged over the years. According to the 2007 data (n=4141), 65% of drug treatment clients were unemployed and the clients' level of education was low. For two thirds, the highest level of education achieved was comprehensive school and four per cent had dropped out of comprehensive school. Eleven per cent of the clients were homeless. About a quarter were married or cohabiting, approximately half of these with a partner who also had substance abuse problems. One in three had children under the age of 18. Two thirds of the children did not live with their parents. (Kuussaari & Ruuth 2008.)

No studies have been conducted in Finland on the extent of drug use among socially marginalised people but it is estimated that the majority of homeless people have substance abuse problems.

### 8.2 Drug-related crime

In 2007, the number of narcotics offences recorded by the police (15,448) increased by 16 per cent compared with the previous year. Of all narcotics offences, both the number of cases of unlawful use of narcotics (10,333) and the number of aggravated narcotics offences (883) increased from the previous year. The proportion of cases of unlawful use of narcotics is 67%, the proportion of aggravated narcotics offences is 6% and the proportion of other narcotics offences is 27%. In 2006, 8,500 people were suspected of unlawful use of narcotics, 4,200 were suspected of narcotics offences and 560 were suspected of aggravated narcotics offences. (Statistics Finland 2008.)

Overall, the police suspected 15,231 people of different narcotics offences. Women accounted for 15% (2,338) of all suspects. One sixth of the suspects were less than 21 years old. Underage people were usually suspected of unlawful use of narcotics. Four per cent of all those suspected of narcotics offences were foreigners (664 persons). Usually they were suspected of unlawful use of narcotics; 86 foreigners were suspected of aggravated narcotics offences. (Statistics Finland 2008.)

In 2007, the number of robberies (77) of pharmacies and other locations where intoxicating pharmaceuticals are stored remained at the level of the previous years. However, already 48 robberies occurred in the first half of 2008, and stealing pharmaceutical waste has been involved in more cases than previously. The apparent increase in robberies may reflect the reduction of buprenorphine supply in the market. (National Bureau of Investigation 2008.)

In 2007, a total of 0.3% of all assaults (assault, petty assault and aggravated assault) were committed under the influence of drugs and 63% under the influence of alcohol. A total of 2% of detected robberies and 4% of aggravated robberies in 2007 were committed under the influence of drugs. The presence of alcohol in robbery offences (44%) or aggravated robberies (28%) is still much more common than that of drugs. In 2007, a total of 25% of those suspected of stealing a motor vehicle for temporary use were under the influence of alcohol, 9% were under the influence of drugs and 4% were under the influence of alcohol and another intoxicant. (Statistics Finland 2008).

In 2007, drugs were found in 12% and polydrug use in 3% of all cases of driving while intoxicated. The proportion of drug use in cases of driving while intoxicated grew by one percentage point over the previous year. The cases of driving while intoxicated are divided into cases of driving while intoxicated and cases of driving while seriously intoxicated. In the case of driving while intoxicated, the proportion of drug and polydrug use was 27%, while in the case of driving while seriously intoxicated the proportion was only 5%. (Statistics Finland 2008.) According to data provided by the alcohol and drug laboratory at the National Public Health Institute, the most common actual drugs found in cases of driving while intoxicated were amphetamine (65%) and cannabis (22%) in 2007. A total of 4,854 suspected cases of driving under the influence of drugs or pharmaceuticals were analysed and drugs were found in approximately 66% of the cases. (National Public Health Institute 2008.)

Kekki and Noponen (2008) have studied the criminal history of habitual offenders using drugs[50]. Their analysis confirms the results already suggested by other studies: the first suspected narcotics offence occurs 3–4 years after an individual is suspected of a first crime of any sort. During the year of their first criminal entry in police records on suspicion of having committed a crime, 66% (n=33) of these persons had been suspected of property offences at least once, commonly more than once. During this year, over half were aged 15 or under. Generally, these offences were committed with an accomplice of similar age or in a group of 4 or 5 people. The second most common (n=6) first entry was an offence involving violence.

50 For the study, the information system (PATJA) of the police was used in order to identify all those suspected of unlawful use of narcotics or narcotics offences in Helsinki during 2002 and who had, in addition to drug entries, at least 15 criminal entries in their record. The search was limited to persons aged 25 or under at the time of the first entry. A total of 162 persons fulfilled the criteria in 2002. Using random sampling, 50 of them were chosen and their criminal data were saved as data for the study. These 50 persons had been suspected of a total of 7,627 crimes. The persons in the sample included 42 men and 8 women, born in 1969–1986. Although the criminal entries made by the police do not correspond to the actual criminal history of criminals, the data enables an indicative analysis of the early stages and the intensity of habitual offenders' criminal careers.

Generally, the number of the young people's suspected offences did not rise during the first year but, rather, the accumulation began only later. The most common crimes in these persons' criminal careers included property offences and fraud (n=20), narcotics offences (n=12), offences of violence (n=9) and traffic offences (n=9). Of all other offences, theft was the only offence type of which each person had been suspected at least once. The data indicated that certain individuals had continued to commit similar types of offence from the beginning of their criminal history, with no criminal career 'development' towards increasing the benefit from their crimes or getting caught less often. (Kekki & Noponen 2008.)

All those included in the research data had been suspected of possession of drugs. Drug use entries concerned 82% of the persons, while 68% had an entry referring to trading, supplying or handing over drugs. The most frequent substance-specific entry referred to pharmaceuticals classified as drugs. As many as 80% of the persons had been suspected of illegal possession, use, trading or attempts to obtain pharmaceuticals other than buprenorphine. The second most frequent substance entry concerned hashish (78%), followed by illegal buprenorphine (70%) and amphetamines (68%). The fact that all had been caught for use or possession of more than one substance suggests polydrug use. (Kekki & Noponen 2008.)

Crime planning became less frequent for some persons as their drug use increased. They committed crimes under the influence of drugs or whenever the opportunity arose, although to an outsider, such acts would seem hopeless and the risk of getting caught very high. In all phases in the persons' criminal histories, crimes were committed together with friends, mostly even with the same circle of friends. Those committing crimes had often been targeted by the authorities, who had offered support as well as punishment. However, on the basis of the data, it was impossible to evaluate whether these support measures had been sufficiently intensive or long-lasting. (Kekki & Noponen 2008.)

### 8.3 Drug use in prison

In 2007[51], 14.6% of prison inmates had been imprisoned for narcotics offences. This proportion has been decreasing since 2004, when narcotics offences was the principal offence for 17.9% of inmates.

According to preliminary results of the study on the health, working capacity and treatment needs of the clients of the criminal sanctions system[52], 90% of male inmates and 60% of those performing community service suffer from substance addiction. Some 70% of inmates serving a life sentence and 55% of other groups suffer from alcoholism. A total of 65% of female inmates suffer from drug addiction (the most common substances of abuse are amphetamine and opioids) as do 20% of community service clients. On average, 70% of the clients have a personality disorder (80% of inmates serving a life sentence, 40% of community service clients) and 50% have an antisocial personality disorder (60% of male inmates, 40% of community service clients). In all groups, 50% have hepatitis C and various somatic illnesses. According to an expert estimate, 90% of the clients in the study need some form of medical treatment. (Criminal Sanctions Agency 2007.)

51 The census is conducted on 1 May.

52 The study sample consisted of 700 persons (male and female inmates, prisoners serving a sentence imposed for unpaid fines, inmates serving a life sentence, inmates held in preventive detention and offenders performing community service). The actual research report with a description of the applied methodology, for instance, has not yet been released.

## 8.4 Social costs

In 2006, the costs related to the abuse of drugs and pharmaceuticals amounted to 200–300 million euros in direct costs and 400–850 million euros in indirect costs[53] (Table 9). Social costs and the costs of crime control accounted for the largest portion of the direct costs. The largest portion of indirect costs came from the value of life lost due to premature death.

Direct costs include drug-related costs in health care, social welfare, crime control, property damage caused by crimes, research as well as substance abuse prevention. Health care costs cover drug-induced inpatient care and drug-related outpatient visits to physicians. Social costs comprise drug-related costs in substance abuse services, income support and child welfare services. Crime control encompasses costs from the legal system and those from policing, rescue services and customs. Property damage refers to the monetary value of damage arising from property crimes as well as insurance costs.

Indirect costs include production losses arising from drug use and the value of life lost due to premature, drug-related death. Production losses are calculated based on the number of days of inpatient care provided to those hospitalised due to drug use. Statistics on inpatient days are kept in accordance with the International Classification of Diseases (ICD-10), allowing differentiation between drug-related diagnoses. The value of a life lost due to premature death is calculated so that it equals the alternative costs that would accumulate if the person became completely disabled and would have to be institutionalised for the rest of his/her life.

Of direct drug-related costs, social costs increased the most (by approximately 8%) compared with 2005. Health care costs, by contrast, showed a slight decrease. Both indirect cost items, production losses and value of a life lost grew approximately 7% compared with 2005.

53 Harm-related expenditure has been calculated based on the calculation framework established in Finland (Salomaa 1996; Hein & Salomaa 1998). Harm-related expenditure is published annually in the Yearbook of Alcohol and Drug Statistics published by STAKES.

*Table 9. Costs of the harm caused by drugs by main group in 2005 and 2006, EUR million*

| | 2005 | | 2006 | |
|---|---|---|---|---|
| | Min | Max | Min | Max |
| **Direct costs** | **190** | **274** | **197** | **281** |
| *Health care costs* | 24 | 54 | 21 | 54 |
| *Social costs* | 66 | 71 | 72 | 77 |
| *Crime control* | 53 | 69 | 54 | 70 |
| *Property damage, research, substance abuse prevention* | 47 | 80 | 50 | 81 |
| **Indirect costs** | **363** | **796** | **388** | **851** |
| *Production losses* | 58 | 97 | 62 | 103 |
| *Value of life lost due to premature death* | 305 | 699 | 326 | 748 |
| **Total** | **533** | **1,070** | **586** | **1,132** |

Sources: Yearbook of Alcohol and Drug Statistics 2007 and 2008, STAKES.

# 9 Responses to social correlates and consequences

Multi-professional co-operation between authorities has been emphasised in after-care adjustment activities. This includes social rehabilitation, employment and supported housing services. Education authorities are also involved, particularly in the work for helping young problem users.

The planning of education and vocational guidance are automatically included in the treatment of young people. However, the educational system does not include much training leading to a normal working career that would be adapted to the problem user's abilities. In addition, not enough employers employ these young people. One example of employment activities is youth workshops which are designed for all young people, from non-users to problem users.

In Finland, financially supported housing for substance abusers can be arranged within municipal social services. Housing service units for substance abusers are part of the Finnish substance abuse services. They are meant for substance abusers that need daily support for independent living.

According to the Act on rehabilitative employment activities (189/2001), rehabilitative employment activities are meant for the long-term unemployed to improve their possibilities to find employment. The Act obliges municipalities and employment offices to arrange co-operatively client-specific service packages. However, it is not expedient to start rehabilitative employment activities if the client has an acute substance abuse problem; instead, the client should be directed primarily to substance abuse services.

According to Act 878/1995, prison health care must be organised so that inmates have equal opportunities with the rest of the population to improve their health and prevent illness. They must also have access to sufficient health care services. Substance abuse work in prisons is based on the intoxicant strategy for the prison administration for 2005–2006 drawn up in 2004.

Prison health care provides inmates with information on the effects of intoxicants, health risks related to substance abuse and treatment programmes available in prison as well as outside prison after release. Withdrawal symptoms that accompany quitting substance use are usually treated in prison in line with the instructions given by the prison physician. If an inmate suffers from severe withdrawal symptoms, he/she can be placed in a prison hospital or hospital care outside prison. It is also possible to provide detoxification, substitution and maintenance treatment with opioid medication in prisons.

In co-operation with the relevant organisations, the Prison Service has prepared various alcohol and drug programmes for inmates in prisons and for drug users released from prisons. Nowadays, there are rehabilitation programmes as well as contractual wards supporting an intoxicant-free lifestyle in almost all prison institutions. Rehabilitation programmes are also available in open institutions. Alcohol and drug programmes are usually based on the cognitive-behavioural theory. Community treatment programmes are also implemented in prisons. Prisons aim at close co-operation with substance abuse services outside prison, and in some prisons substance abuse services are outsourced. Inmates have the possibility to participate in AA and NA groups. (Probation Service & Prison Service 2006.)

Those sentenced to over two years' imprisonment are first placed in the assessment and placement unit within their own municipality, where a personal risk and service need assessment is made. The risk and service need assessment considers the factors related to the inmate's life situation and personality that sustain criminal behaviour. Special attention is paid to inmates' substance abuse. Based on the assessment, a preliminary plan for the term of sentence is drawn up in the assessment and placement unit, and the plan is specified and updated in placement institutions. The aim is to enable systematic use of the sentence term to improve the inmate's capability to cope after release without committing crimes. (Probation Service & Prison Service 2006.)

The new Act on Imprisonment requires that a plan based on risk and needs assessment be made for the duration of an inmate's sentence, not only for those who are serving a sentence of over two years, but also for all those inmates who will be released on supervised probation. Additionally, a plan for the duration of an inmate's sentence, which fulfils minimum requirements and which is based on written material, shall be made for admitted inmates sentenced to unconditional imprisonment. The plan also includes a release plan compiled well in advance before an inmate is released and a surveillance plan compiled by the Probation Service for inmates who will be released on supervised probation (Criminal Sanctions Agency 2007).

A work group formed by the Ministry of Justice investigated how drug treatment could be made more effective for those serving community sanctions. The group completed its report, Päihdekuntoutus ja yhdyskuntaseuraamukset (2006: 19) (*Drug Rehabilitation and Community Sanctions)*, in October 2006. The group proposed that drug rehabilitation be incorporated into the enforcement of all community sanctions if necessary. This requires closer, systematic, and client-specific collaboration with the Probation Service and municipal social welfare and health care.

The amendment to the Penal Code concerning unlawful use of narcotics (654–657/2001) introduced the possibility of alternative penal sanctions. The focus was on two special groups: underage offenders should be referred to a multi-professional hearing instead of imposing a fine on them, and problem drug users should be referred to treatment. A multi-professional hearing is considered a more efficient sanction for young offenders than a fine. Treatment referral reduces the social exclusion of problem users as well as drug-related crime.

### 9.1 Social reintegration

The basis for evaluative research on the City of Helsinki's substance abuse work[54] conducted by Törmä, Huotari and Pitkänen (2007) was to find practices that would improve the status of problem drug users and their quality of life and with which it would be possible to reduce the harm experienced by the environment around them. Three case studies were investigated[55]: a model for day centres for substance abusers, a service model for health counselling of drug users, and a service model for social housing management. The researchers compared various models in Helsinki and the immediate vicinity.

54 Data for the study comprises interviews with staff in organisations offering the services (14 interviews in total), and visits to the places in question (8 places).

55 This report concentrates on housing services. Activities in day centres and health counselling centres have been discussed in earlier reports (see http://www.stakes.fi/FI/tilastot/aiheittain/arkisto/paihteet.htm).

The social welfare office for the homeless in Helsinki offers a form of housing support referred to as *Asso's* social housing management. The model offers residents support by helping them with outstanding rent payments, preventing them from losing their home, and reducing harm caused by substance abuse and mental health problems. It resembles the A-Clinic Foundation's supported housing model, for example, in that the superintendent lives in the same building and is therefore constantly available, although he/she may not always be doing superintendent duties. Working alone, however, can become too much of a burden. With supported housing, leases are bound to agreements concerning treatment and support. However, with *Asso* residency is permanent and drug rehabilitation a separate function. The *Asso* model utilises a network of co-operation and chiefly strives to direct clients to the services of other bodies. Supported housing chiefly involves work with clients with its own staff. The success of the social housing management model depends on how well the city's system of services works. From the point of view of offering opportunities to take residence somewhere and reducing harm caused by substance abuse, the model is a promising one, and for some residents it is the only opportunity they have to live independently. (Törmä et al. 2007.)

The study indicates that low-threshold units and work out in the field are crucial in urban substance abuse work. Day shelters that are able to satisfy basic needs, such as rest and nutrition, should be available, and substance abusers who lack a permanent place to live should be offered a place of residence. There have been positive experiences in outreach work in the form of peer work for those living in subcultures and those with serious problems. Due to the diversity typical of the urban environment, services should be tailored to suit various needs. Client-oriented co-operation among various bodies, e.g. a pair work model where an employee of basic services and an employee of specialised services work together with the client, helps people with multiple problems. Because of Helsinki's geographical location, new drugs and new ways of using drugs quickly find their way into the city. Contributions to preventive action against the adverse effects of drug abuse should be made, even if the situation seems to be good, because of the serious HIV situation in the neighbouring areas. (Törmä et al. 2007.)

Finland's first association for drug abusers, *Lumme*, was established in October 2005 and it was registered in the Associations Registry in April 2006. There are approximately 70–80 members, half of which are drug users and half close friends/relatives of users and professionals in the field of substance abuse. The association's activities concentrate on supporting and providing consultation to drug addicts. Support involves, for example, helping out with issues in various offices and at the physician's office. The association distributes syringes and condoms and offers health counselling about infectious diseases, as well as advises on the importance of taking tests for infectious diseases and practising safe sex. *Lumme* is also a voice for those who, for one reason or another, do not take advantage of the services offered by health counselling centres. The members of the association have also cleaned up a couple of places where drug abusers inject themselves. (Soimula 2007).

## 9.2 Prevention of drug-related crime

*Assistance to drug users in prison*

In 2007, a total of 705 inmates (881 in 2006) with substance abuse problems participated in rehabilitation programmes. A total of 315 inmates took part in programmes to minimise recidivism, and 1,152 inmates undertook other types of social rehabilitation. Moreover,

50 inmates were admitted to external institutions for substance abuse treatment or other institutions for rehabilitation. (Criminal Sanctions Agency 2008.)

In 2007, the majority (94%) of convicted prisoners were prepared a plan for the duration of their sentence by an assessment and placement unit. In total, the number of plans made was 4,412. For one in three inmates serving a sentence of over six months, a plan for the duration of the sentence was made based on a risk and needs assessment. For the rest, the plan was based on written material. The most frequent objectives stated in plans included education or training, improving the person's employment prospects, intervention in a substance abuse problem and development of cognitive skills. (Criminal Sanctions Agency 2008.)

A release plan was prepared for slightly more than a third of convict prisoners released. Such a plan was prepared in network co-operation for young people, for those in substance abuse rehabilitation and for those placed in probationary freedom.

In 2007, the reported number of drug confiscations in prisons had decreased from the previous year. The number of confiscations has continued to fall for the second consecutive year. (Criminal Sanctions Agency 2008.)

Riitta Granfelt (2007) has investigated an alcohol and drug programme that prepares female inmates in Vanaja prison for life outside the prison[56]. The loosely structured drug rehabilitation model works well although it is still being developed. Basic conditions for quality rehabilitation include the counsellor's social skills and the knowledge of the influence of the cognitive framework. Female inmates suffer from numerous mental health problems and fear associated with social interaction. Group rehabilitation is not suitable for everyone and therefore work with the individual must also be available. A multi-professional approach is also important to be able to treat the intertwining problems associated with drugs and mental health.

Work with clients in preparing them for life outside prison, the creation of co-operating networks, and the development of systematic rehabilitation continua are not the responsibility of anyone at the moment. Since female inmates with a history of substance abuse have numerous socio-economic problems and problems with family relationships associated with being released from prison, the outcome of alcohol and drug programmes should be included as part of the release plan. Furthermore, it is important that the sick and most marginalised also receive rehabilitation. (Granfelt 2007).

The Probation Foundation Finland has an on-going project called *TERVE* 2005–2008 involving health education and peer support for inmates who are drug users. The purpose of the project is to reduce the amount of infectious diseases as well as other health and social risks and harm arising from the use of drugs and to increase security. Peer activity is being introduced as a new method of working. The goal is to create operations models for prison staff, health counselling and treatment guidance based on peer support, as well as to generate a training programme and guidebook for realising the models. (Probation Foundation Finland 2008).

56 The study was conducted using an ethnographic approach, i.e. participant observation (during 5 months in two courses of the alcohol and drug programme that prepares female inmates for life outside prison) as well as interviews with female inmates and prison staff (15 inmates and about 20 representatives of staff).

Throughout the project, individual days of training and courses in health education and peer support have been organised. In April 2008, the first training was completed, enabling the participants to lead *TERVE* prisoner courses and to use health counselling in working with the individual. A total of 17 nurses or substance abuse counsellors graduated from the course. (Probation Foundation Finland 2008)

During a two-month period in the spring of 2007, the YLE Teksti-TV teletext service presented, as part of the *TERVE* project, preventive material about the adverse effects of using drugs for inmates and prison staff. Topics in the series of articles included viral hepatitis, HIV, alternatives to using needles, drugs and mental health, overdose and first-aid, advice on health issues, and peer activities. According to the survey[57] conducted on the project, two out of five prisoners had visited the project's teletext pages at least once, as had one in six guards. Both the inmates and guards considered drug-related education as useful and desirable. The best remembered items were the information packages concerning viral hepatitis and HIV. Based on the results, the teletext service can reach inmates, who are usually a challenging section of the population to reach. In total, three out of four inmates have the possibility to browse teletext pages. Obstacles to using the service include the absence of a television set and non-functioning remote controls. (Probation Foundation Finland 2007).

*Alternative sanctions*

Based on the amendment to the Penal Code concerning unlawful use of narcotics, the Prosecutor General's instructions for prosecutors in autumn 2002 (Prosecutor General 2002), which were updated in autumn 2006 (Prosecutor General 2006), recommend that prosecutors arrange a hearing for 15–17-year-olds who have been arrested for unlawful use of narcotics for the first time. The young offender, his/her guardian, a representative of the social welfare authorities and the police participate in the hearing where the young offender is informed of the criminal and reprehensible nature of drug use as comprehensively as possible, the offender's life situation is examined and appropriate further measures are decided. After the hearing, the prosecutor can decide to waive charges.

In the same instructions (Prosecutor General 2002; updated in Prosecutor General 2006), the Prosecutor General encourages prosecutors to agree on appropriate treatment referral procedures in their own localities. Especially problem drug users should not be fined for unlawful use of narcotics until the offender's willingness to seek treatment has been examined. In October 2006, the Prosecutor General updated the guidelines and issued instructions whereby in minor cases the police should confiscate the substance, give an oral warning and waive most charges. (Prosecutor General 2006).

Nonetheless, surveys and research indicate that the numbers of hearings and treatment referrals have remained relatively low. Based on a study by Kainulainen (2006), waiving prosecution against drug users has declined since the amendment concerning unlawful use of narcotics in the Penal Code. The sanctions system has thus been made more stringent although it was not the intention of the user offence reform (654–657/2001).

57 Responding to the survey was optional. The questionnaire was distributed in six different prisons to 260 inmates, of whom 102 responded. In addition, the questionnaire was sent by e-mail, through the Criminal Sanctions Agency, to nearly 2,800 guards, of whom 442 responded.

*A drug control project carried out by the police in the Greater Helsinki area*

A drug control project targeted at districts known for drug problems was implemented in the Greater Helsinki area in 1999–2001. The aim of the project was to reduce drug sales and drug-related crime in the dwellings in the area. The project also aimed at reducing the insecurity and disturbance caused by trading in drugs as well as at creating new co-operation practices between the police and other authorities. The project was carried out through extensive drug raids and intensified control in restaurants and on the streets in busy areas. In addition, intensified road traffic control focusing on drugs was carried out in some areas. (Kinnunen et al. 2005.)

An evaluation study[58] (Kinnunen et al. 2005) examined the realisation of the project's objectives: the project did not succeed well in increasing the residents' sense of security in that they failed to notice the raids, and the police paid no attention to those residents who showed interest and would have liked to provide further information about the disturbance in the area. When the news of the police raids spread among the traders, the drug market went deeper underground. The raids reduced drug sales because the traders thought the police operations had intensified for a longer period of time than they actually were, which curbed the activity of some drug users and traders on the market.

The effect of the raids on the amount of crime reported to the police is difficult to evaluate based on statistics, but one possible interpretation is that the results were poor during the initial stage of the project but in time, the operation became more efficient and crime decreased in the districts. There was no significant intensification of co-operation with other authorities. Drug users were not directed to social and health care services; the police took a pessimistic view on drug treatment because they considered the users "lost causes". In terms of improving co-operation, the police also considered it a problem that social workers were only available during office hours. (Kinnunen et al. 2005.)

58 The material was collected in 2000–2001 and it consisted of ethnographic observation of police operations in 5 localities, observation of hearings (20), interviews with police officers, arrested persons, social workers, building managers and residents (a total of 0 interviews), survey forms on the drug raids (22), a sample of reports of an offence (138) and statistics on offences reported to the police in 16 areas before and after the drug raids in 1999–2000. The methodical basis of the study was qualitative evaluation research.

# 10 Drug markets

The drugs on the Finnish market are mostly cannabis products, synthetic drugs such as amphetamines and ecstasy, the buprenorphine preparation Subutex® and especially benzodiazepines. Heroin is still fairly rare in Finland. Among cannabis products, the number of marijuana and cannabis plant seizures has grown in the 2000s, which indicates that the fairly small-scale cultivation of drugs that are partly intended for sale has become more common. The number of seizures of synthetic drugs has remained fairly constant, except for the changes that are due to the phasing of the investigation of large complex crimes. New substances on the market include GHB (gamma-hydroxybutyric acid) and its precursor GBL (gamma-butyrolactone), which are becoming increasingly common. The amount of seized heroin plummeted after 2001 and at the same time, seizures of Subutex® tablets started to increase. The number of Subutex® seizures has also dropped since 2005. (National Bureau of Investigation 2008.)

In drug supply in Finland, organised crime groups led from Estonia have had an important role – at the beginning of the 21st century especially in smuggling and importing drugs and later on also as collaborators of Finnish crime groups, supplying drug consignments for distribution. Recently, Finnish crime groups have taken a more active role in acquiring drugs from abroad and in distributing them in Finland. Nevertheless, co-operation, particularly with Estonian criminals with good contacts to other, e.g. Lithuanian crime groups, remains very important for the Finnish groups. (National Bureau of Investigation 2008.)

## 10.1 Availability and supply of drugs

The import of drugs is an international crime and in recent years, 15–30% of those suspected of aggravated narcotics offences in Finland have been foreigners. In 2007, their proportion rose from 14% in the previous year to 17%. Among foreigners suspected of aggravated narcotics offences, the largest groups in 2007 consisted of Estonians (28%) and Russians (12%). (National Bureau of Investigation 2008.) Organised Estonian crime groups play an important role in acquiring drugs from abroad and smuggling almost all drugs to Finland.

At the same time, the role of Finnish criminals in smuggling and trafficking drugs has strengthened. Finnish criminals also participate in the acquisition of drugs from abroad and distribute them in Finland. This has closed the ranks of Finnish professional crime, which is typically loosely structured, and made it more disciplined. The prominent role played by organised crime groups in Finnish drug crime can be seen, for instance, in the more frequent presence of weapons, particularly gas sprays, as well as in the considerably larger amounts of cash seized in the context of narcotics offences. Organised drug crime groups have also expanded their activities to economic crime and fraud, which is used as a means of financing drug crime (National Bureau of Investigation 2008.)

The majority of drugs are smuggled onto the Finnish market through various routes, particularly from the south and west. About 90% of the amphetamines on the Finnish market come from Estonia or via Estonia, mainly from Lithuania, whereas hashish comes originally from Morocco, passing first through Spain, the Netherlands or Germany and then either through Scandinavia or the Baltic countries. Russia is a significant route

especially for smuggling heroin, but heroin also reaches Finland via other routes. The lack of treatment services and the decreased supply of Subutex on illegal markets may increase the demand for heroin. In addition, Finland is a potential route for the international smuggling of heroin from Russia to elsewhere in Europe. The popularity and supply of cocaine seem to have risen slightly since 2006, but cocaine is still quite rare on the Finnish drug market. (National Bureau of Investigation 2008.)

Before Estonia joined the Schengen area, it was possible to import limited amounts of Subutex, in particular, for personal use on prescription. Larger batches of Subutex have been smuggled into Finland mainly from France. Finnish users also acquire other intoxicating pharmaceuticals from Estonia. Seeds for growing cannabis plants as well as GBL are often ordered from abroad using the Internet.

Since 1997, the annual Health Behaviour Survey among the Finnish Adult Population has asked people if they have been offered drugs during the past year. The number of drug offers increased in the youngest age groups until 2000; the figure decreased from 23% to 15% among 15–24-year-old men between 2001 and 2007. The upward trend in the 1990s and the downward trend in the 2000s are also evident among young women. The number of drug offers encountered by 15–24-year-old women rose to 20% by 2000, but in recent years, it has returned to 12%, the level observed in the first surveys. Among 25–34-year-olds, the proportion of those who had been offered drugs is larger than before. This indicates that those who belonged to the younger age group during the upward trend have reached this upper age group. (Piispa et al. 2008.)

### 10.2 Drug seizures

According to data on drug seizures, the situation prevailing in the Finnish drug market seems fairly stable. In 2007, the overall volume of hashish seizures increased particularly due to a single seizure of 155 kg by the Helsinki police. Marijuana and cannabis plants have been seized more often and, in particular, the number of cannabis plants seized by the police has increased. Nowadays, growing cannabis plants at home, not only for personal use but also for wider distribution, is becoming more frequent in Finland. (National Bureau of Investigation 2008.)

*Table 10. Drugs recorded as seized by the police and Customs in 2000–2007 (kg)*

| | 2000 | 2001 | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 |
|---|---|---|---|---|---|---|---|---|
| Hashish | 196.5 | 566.6 | 482.0 | 423.1 | 467.4 | 430.6 | 282.7 | 360.0 |
| Marijuana | 13.8 | 13.7 | 32.0 | 45.3 | 25.8 | 43.4 | 32.9 | 36.0 |
| Cannabis plants | - | 16.0 | 15.5 | 20.4 | 41.7 | 43.3 | 36.2 | 87.0 |
| Amphetamines/ Methamphetamines | 78.3 | 149.7 | 129.2 | 114.6 | 108.6 | 116.6 | 129.0 | 152.0 |
| Cocaine | 38.6 | 7.3 | 0.4 | 1.1 | 1.1 | 1.2 | 6.5 | 4.0 |
| Khat | 348 | 624 | 1,039 | 1,879 | 2,118 | 2,562 | 3,283 | 3,300 |
| Heroin | 6.0 | 7.9 | 3.0 | 1.6 | 0.2 | 52.4 | 0.2 | 0.4 |
| Subutex (tablets) | 12,951 | 38,200 | 18,700 | 37,284 | 32,970 | 24,478 | 22,979 | 20,600 |
| Ecstasy (tablets) | 87,393 | 82,900 | 45,100 | 35,216 | 23,243 | 52,210 | 39,185 | 83,000 |
| LSD (doses) | 2,355 | 95 | 4,629 | 1,461 | 195 | 452 | 171 | 2,138 |
| GHB/GBL (litres) | | | | | | | 24 | 91 |

Source: National Bureau of Investigation

*Table 11. Number of drug seizures recorded by the police and Customs in 1998–2007**

| | 1998 | 1999 | 2000 | 2001 | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 |
|---|---|---|---|---|---|---|---|---|---|---|
| Hashish | 1,997 | 2,259 | 2,482 | 4,011 | 3,012 | 2,796 | 2,626 | 2,408 | 2,599 | 1,900 |
| Marijuana | 382 | 463 | 663 | 1,223 | 1,275 | 1,712 | 2,067 | 2,305 | 2,269 | 2,400 |
| Cannabis plants | - | - | - | 612 | 923 | 1,170 | 1,406 | 1,633 | 1,378 | 1,900 |
| Amphetamines/ Methamph. | 1,641 | 1,956 | 2,369 | 3,792 | 3,399 | 3,687 | 3,392 | 3,732 | 3,101 | 2,990 |
| Cocaine | 24 | 49 | 40 | 55 | 45 | 49 | 65 | 79 | 82 | 92 |
| Heroin | 210 | 342 | 437 | 557 | 145 | 90 | 45 | 58 | 25 | 20 |
| Subutex | - | - | - | 727 | 741 | 1,008 | 844 | 777 | 840 | 800 |
| Ecstasy | 57 | 159 | 393 | 465 | 329 | 316 | 328 | 363 | 297 | 340 |
| LSD | - | 15 | 34 | 14 | 10 | 20 | 21 | 17 | 15 | 50 |
| GHB/GBL | | | | | | | | | 54 | 184 |

*) In 2003–2005, an adjustment was applied to the statistics in order to take account of seizures related to those unlawful use cases which remained unregistered.

Source: National Bureau of Investigation

Amphetamine seizures increased significantly by weight (152 kg), but the number of seizures (2,990) dropped slightly. In 2007, the largest amphetamine seizures involved 10–12 kg of amphetamine, and temporary supply shortages lead to the replacement of amphetamine with methamphetamine. Ecstasy seizures increased markedly (83,000 tablets, 340 seizures) over the previous year. Cocaine seizures peaked in 2005, but growth did not continue. In 2007, the amounts of cocaine detected (4.0 kg, 92 seizures) remained at the 2006 level. An emerging problem in the Finnish market for synthetic drugs is GHB and its precursor GBL. Indeed, the total volume of GHB and GBL seized in 2008 was significantly higher than in 2007. Khat seizures have grown throughout the 2000s. A total of 3,300 kg of khat was seized in 2007. (National Bureau of Investigation 2008.)

The amount of seized heroin plummeted at the beginning of the 21st century (2004: 0.2 kg). In 2005, a single seizure on the Russian border essentially increased the total amount of seized heroin. In 2006, the amount of heroin seized (0.24 kg) returned to the previous low level, and remained there in 2007 (0.4 kg). (National Bureau of Investigation 2008.)

The amount of buprenorphine preparation Subutex® seized continued to decline (20,600 tablets, 800 seizures). (National Bureau of Investigation 2008.) Large Subutex® consignments are smuggled into Finland from France, and smaller amounts have been brought in, mainly on prescription primarily from Estonia. It has been noted in Estonia that besides Subutex, some physicians have been prescribing Finnish drug users sedatives that are classified as narcotic drugs in Finland and favoured by polydrug users. (Finnish Customs 2006). Estonian accession to the Schengen area in 2008 will reduce the opportunities for 'legal drug tourism', but it will probably also lead to increased smuggling of narcotic pharmaceuticals from the Baltics into Finland. The quantity of other pharmaceuticals classified as narcotic drugs (mainly benzodiazepines and some opiates) seized was somewhat less than in the previous year, but the number of seizures increased slightly (64,000 tablets, 3,300 seizures) (National Bureau of Investigation 2008).

### 10.3 Price and purity of drugs

The laboratory identification of drugs and the testing of the purity of drug consignments take place at the Crime Laboratory of the National Bureau of Investigation or at the Customs Laboratory.

There were no significant changes in the prices of drugs in 2007. In 2007, the average street price per gram was 10–12 euros for hashish, 100–120 euros for white heroin, 15–25 euros for amphetamine, 60–100 euros for cocaine and 12–20 euros for ecstasy tablets. (National Bureau of Investigation 2008.)

# B. SELECTED ISSUES

## 11 Sentencing statistics

In Finland, penal provisions concerning narcotics offences were reformed in 2001, allowing the police to impose fines on drug users. Following the amendment regarding unlawful use of narcotics in the Penal Code, sanctioning practice for narcotics offences has become more stringent: fines are imposed more frequently on drug users, while the use of sanctions other than punishment has fallen.

Traditionally, a deliberate distinction has been drawn in Finland between treatment and punishment: indeed, treatment is not acknowledged as a type of sanction. However, if an offender seeks treatment, this may have an effect on the nature of the sanction imposed. For a minor offence, the prosecutor may waive the prosecution or the court may waive the punishment. In practice, treatment may be an influencing factor in deciding between conditional and unconditional imprisonment. Alternative sanctions to imprisonment include community service and juvenile punishment both of which may include substance abuse rehabilitation. Recent years have seen a debate on the adoption of a completely new sanction, 'contract treatment', whereby the person will be placed, subject to his/her consent, in a treatment institution instead of prison.

### 11.1 Unlawful use of narcotics

The use of drugs and the possession of a minor amount for private use will be considered and punished as unlawful use of narcotics, carrying a fine or a maximum of six months' imprisonment. In reality, the sanction is nearly always a fine (Table 12). The offence of unlawful use of narcotics may be dealt with in a district court, but the sanction is usually determined through an extra-judicial procedure. In this case, the police will issue a fine to the drug user and the prosecutor's duty is to decide upon its confirmation. The average fine in these circumstances was approximately 14 to 15 day-fines. A fine imposed in summary penal proceedings in 2006 averaged 15 day-fines, while the average fine imposed by district courts was 20 day-fines.

Courts have rarely issued waivers of punishment. In the few cases where they did, the reason was usually the offender's young age or request for treatment. It is very unusual that the use of drugs, as a sole offence, will lead to imprisonment. However, if the drug user is unable to pay the fine imposed, the unpaid fine can be converted to imprisonment in a separate trial. In a few percent of the cases involving unlawful use of narcotics, a waiver of prosecution has been issued.

*Table 12. Sanctions imposed for unlawful use of narcotics (Penal Code 50(2a)) as the principal offence, 2002–2006*

| | 2002 | 2003 | 2004 | 2005 | 2006 |
|---|---|---|---|---|---|
| Waivers of prosecution | 371 | 245 | 169 | 143 | 142 |
| Fine (imposed by the police in summary penal proceedings) | 3,103 | 4,151 | 4,420 | 4,561 | 4,269 |
| Waivers of punishment | 46 | 28 | 21 | 14 | 21 |
| Fine (in a district court) | 1,172 | 618 | 565 | 478 | 370 |
| Other punishment | 0 | 1 | 0 | 1 | 0 |
| Conditional imprisonment | 4 | 1 | 2 | 0 | 0 |
| Unconditional imprisonment | 12 | 7 | 7 | 6 | 8 |
| Total | 4,708 | 5,051 | 5,184 | 5,203 | 4,814 |

Source: Derived from figures published by Statistics Finland

*Hearings for underage offenders*

The majority of waivers of prosecution relate to underage offenders. In such cases, the prosecutor may arrange a special hearing to which the young person, his/her parents, a social worker and the police are summoned. The purpose of the hearing is to associate the reprimand with measures by social authorities and local control, such as parental control.

Such hearings are more informal in nature than proceedings in a district court. They provide an opportunity for a discussion with the young offender concerning the offence committed, the reasons leading to it, the consequences of its detection as well as the young person's attitudes to drugs, his/her future plans and the risks inherent in the use of drugs. (See Kainulainen 2006, 49–52; Rönkä 2006, 11.) According to prosecutors, such a hearing underlines the significance of a waiver of prosecution, because the young offender will understand more clearly that he/she has committed a reprehensible act. The offender will also be clearly informed that if he/she repeats the offence, the sanction will be a fine.

Separate statistics on hearings are not published, although the Office of the Prosecutor General monitors the conduct of hearings. In terms of early intervention, a variety of other special measures are used across Finland to deal with underage youths experimenting with drugs. Young people are often considered to need particular help and support and, in these cases, the social welfare authorities are deemed better placed to deal with them than the judicial authorities.

*Treatment rarely a reason for waiving prosecution*

A prosecutor may waive a prosecution if the drug user seeks treatment. A conditional waiver of prosecution, whereby the prosecutor would control the offender's remaining in treatment, is not permitted in Finland. Prosecution is waived very rarely, however, for drug users who have sought treatment.

*Cautions infrequently issued by the police*

For minor offences, the police may, instead of issuing a fine, waive pre-trial investigation and issue a caution to the offender. It is only in the past few years that public debate has started on whether the police should use this approach in self-evidently minor offences of unlawful use of narcotics. Although the legislation has allowed this procedure for a long time, the police have been quite reluctant to use it (Kinnunen & Kainulainen 2002, 312–313). Cautions were issued by the police in only a few percent of all narcotic offences in 2007.

## 11.2 Narcotics offence

A narcotics offence refers to the illegal production, import, export, transport, distribution or possession of a narcotic substance, and can range from small-scale activity related to personal drug use to large-scale distribution of drugs. The severity of sentences imposed for narcotics offences reflect the severity of the underlying acts.

The most common sentence for a narcotics offence is a fine (Table 13) which, in 2006, averaged 36 day-fines. The second most common sanction is imprisonment, split roughly evenly between conditional and unconditional imprisonment. The average length of both conditional and unconditional imprisonment in 2006 was some four months. During the period illustrated in the following table, approximately one in five sentences of unconditional imprisonment were converted into community service, while a waiver of punishment occurred in a few dozen cases.

*Table 13. Sanctions imposed for a narcotics offence (Penal Code 50(1)) as the principal offence, 2002–2006*

| | 2002 | 2003 | 2004 | 2005 | 2006 |
|---|---|---|---|---|---|
| Waivers of prosecution | 512 | 277 | 237 | 266 | 200 |
| Waivers of punishment | 30 | 22 | 19 | 26 | 24 |
| Fine (in a district court) | 1693 | 1435 | 1603 | 1649 | 1559 |
| Other punishment | 4 | 3 | 0 | 1 | 1 |
| Conditional imprisonment | 452 | 410 | 378 | 408 | 406 |
| Unconditional imprisonment | 460 | 398 | 302 | 420 | 397 |
| - of which community service | 97 | 87 | 86 | 77 | 93 |
| Total | 3151 | 2545 | 5184 | 2770 | 2587 |

Source: Derived from figures published by Statistics Finland

*Waivers of prosecution*

Since the reform concerning the unlawful use of narcotics, using a waiver of prosecution as a sanction measure has decreased. Various reasons may underlie a waiver of prosecution. For instance, if a foreign offender has imported a small amount of marijuana, the offender may already have returned to his/her home country by the time the prosecutor receives the case. In this case, the prosecutor can waive the prosecution because of the disproportionate expense involved in pursuing it. Another example might be Finnish offenders who have committed several offences, for which they have already

been sentenced to a considerable period of imprisonment. In such cases, prosecution may not always be appropriate since, under the joint sentence system, any further sanction would not increase the existing total punishment. Accumulated sanctions may have been a factor in favour of waiving prosecution where the offender had already been subject to disciplinary measures in prison. Aspects of reasonableness may have supported the waiving decision if the offender was seriously ill or had sought treatment for the drug problem.

### 11.3 Aggravated narcotics offences

In assessing the gravity of a narcotics offence, attention is paid to the quantity and quality of the narcotic substance, whether financial profit was sought, whether the offenders formed an organised group, whether danger was caused to health and how the narcotics were distributed. Judicial practise is that an individual is sentenced for an aggravated narcotics offence if the quantity involved was at least one kilogramme of hashish, 100 grams of amphetamines, 300 tablets of either ecstasy or LSD or 15 grams of heroin. The penal scale ranges from a minimum of one year to a maximum of ten years' imprisonment and, in the case of multiple offences, up to 13 years' imprisonment.

An aggravated narcotics offence usually results in unconditional imprisonment, the average length of which was three years and two months in 2006. Conditional imprisonment, imposed in roughly one case in five (Table 14), averaged one year and three months in 2006. District courts delivered a total of 307 judgments in 2006 involving an aggravated narcotics offence as the principal offence. A high penal scale is applied for aggravated narcotics offences and, therefore, community service is a rare option. For some aggravated narcotics offences, waiver of prosecution is used as a sanction measure. Such cases involve concurrence reasons, meaning that the offender has already been sentenced to a considerable term of imprisonment and, under the joint sentence system, pursuing the prosecution would not result in any addition to the total existing punishment.

*Table 14. Sanctions imposed for aggravated narcotics offence (Penal Code 50(2)) as the principal offence, 2002–2006*

| | 2002 | 2003 | 2004 | 2005 | 2006 |
|---|---|---|---|---|---|
| Waivers of prosecution | 48 | 24 | 34 | 16 | 29 |
| Waivers of punishment | 0 | 1 | 0 | 1 | 0 |
| Conditional imprisonment | 112 | 81 | 85 | 58 | 77 |
| Unconditional imprisonment | 289 | 289 | 253 | 276 | 230 |
| - of which community service | 1 | 0 | 0 | 0 | 1 |
| Total | 449 | 395 | 372 | 351 | 336 |

Source: Derived from figures published by Statistics Finland

In determining the punishment for an aggravated narcotics offence, the key factor is the quantity of the narcotics substance involved. Other factors include the extent, duration and methodicalness of activities, the seeking of financial profit and the role of the offender in distributing the drug. (See Kainulainen 2007.)

Prison terms for aggravated narcotics offences have been quite long by Finnish standards, as the entire penal scale has been in use. By European standards, sentencing by the Finnish courts might be considered severe, given the modest quantities of narcotics involved compared to those dealt with in many other countries.

### 11.4 Driving under the influence of drugs or pharmaceuticals

It is not possible to distinguish between drugs and alcohol in the Finnish data on sanctions imposed for driving while intoxicated. In 2006, a total of 21,173 persons were sentenced by a district court, with driving while intoxicated or driving while seriously intoxicated as the principal offence. In most cases, the driver had been under the influence of alcohol. In the cases of driving while intoxicated known to the police in 2003–2007, a total of 88% involved the use of alcohol, 9% involved drugs or pharmaceuticals and 3% involved both alcohol and drugs or pharmaceuticals. The penalty for driving while intoxicated is a driving ban for a fixed term.

## Appendix 1. Applicable criminal offence types and sanctions

*Essential elements of offences*

Provisions concerning narcotics offences are laid down in the Penal Code. Three different categories of narcotics offence are defined based on the degree of gravity, from the mildest to the most severe as follows: unlawful use of narcotics, narcotics offence and aggravated narcotics offence.

*Unlawful use of narcotics* include acts where a person uses, or possesses or attempts to obtain a small amount of a narcotic substance for personal use. The sentence applied is a fine or imprisonment for a maximum of six months. The punishment for using drugs is always that for unlawful use of narcotics. If a person possesses a narcotic substance for personal use, the quantity must be small if the offence is to qualify as unlawful use of narcotics. The Prosecutor General has defined the limits for small quantities, which vary according to the narcotic substance involved – for example,. less than 15 grams for marijuana, less than 10 grams for hashish, less than 3 grams for amphetamines and less than 1 gram for heroin. Since the essential elements required for unlawful use of narcotics are fairly restricted, many acts related to personal use will constitute a narcotics offence and be punished accordingly.

Acts entailing punishment for a *narcotics offence* include the illegal production, import, export, transport, distribution or possession of a narcotic substance. The sentence applied is a fine or imprisonment for a maximum of two years. A narcotics offence does not always involve the distribution of drugs. For instance, a narcotics offence is committed by a person if he/she imports some grams of marijuana for personal use or grows some cannabis plants for personal use.

In an *aggravated narcotics offence*, the object of the offence must be a very dangerous narcotic substance or a large quantity of narcotic substance, a substantial profit should be sought, the offender should act as a member of an organised group, serious danger should be caused to the life or health of several people or the narcotic substance should be distributed to minors or in an otherwise unscrupulous manner. The sentence ranges from a minimum of one year to a maximum of ten years' imprisonment. In the case of multiple aggravated narcotics offences, the maximum sentence will rise to 13 years' imprisonment.

*Driving under the influence of drugs or pharmaceuticals* is included in the essential elements of driving while intoxicated. In traffic, zero tolerance is observed, meaning that if the presence of narcotic substances is detected in the blood of a car driver, he/she will always be guilty of drinking while intoxicated. Prior to the amendment which entered into force on 1 March 2003, the offence required a deterioration in the driver's driving ability. Under the current Penal Code, a person who operates a motor-driven vehicle or a tram after having consumed narcotics so that during or after the operation he/she has the active substance of the narcotic used or its metabolic product in his/her blood, shall be sentenced for driving while intoxicated. However, the act is not considered to be driving while intoxicated if the substance or metabolic product is derived from a medical product that the operator has the right to use. The sentence applied is a fine or imprisonment for up to six months. For driving while seriously intoxicated, the sentence is at least 60 day-fines and imprisonment or imprisonment for a maximum of two years.

Under the law, any person driving while intoxicated will be directly issued a driving ban for a fixed term. The length of the ban will be influenced by the gravity of the act, but also by the person's need to use a car, for instance, in his/her job. In practice, the decision on a driving ban for a fixed period is taken either by the police or the court. In recent rulings, the Supreme Court has indicated that the car of a person who repeatedly drives while intoxicated can be confiscated.

*Sanctions system*

Central actors in the Finnish criminal sanctions system are the prosecutor and the judge, although the police do not have significant independent powers to decide on sanctions. The sanctions system itself is fairly simple. The most widely used applicable sanction is a fine.[59] The majority of fines are imposed in extra-judicial summary penal proceedings which can be applied to minor offences. Imprisonment can be either conditional or unconditional, as decided by the judge. Alternative sanctions to prison include community service and juvenile punishment, both requiring proceedings in court. The mildest applicable sanction can be considered to be waiver of measures which can be decided, under certain conditions, by the police, prosecutor or judge.

*The police:* The police can issue a fine for minor offences, subject to confirmation by the prosecutor. This approach is referred to as extra-judicial summary penal proceedings. Of the three types of narcotics offence, this approach is available only for unlawful use of narcotics. For very minor offences, the police may waive the pre-trial investigation and issue an oral caution to the offender. In practice, this is very rare for narcotics offences, as well as for many other types of crimes.

*Prosecutor:* The prosecutor has been granted independent discretionary powers with regard to sanction issues. First, in summary penal proceedings, the prosecutor decides whether or not to confirm the fine issued by the police.[60] Secondly, the prosecutor can decide to waive prosecution, whereby the offender will avoid punishment. Reasons for waiver may refer to the minor nature of the offence, the young age of the offender, the offender's seeking of treatment for his/her substance abuse problem, disproportionate expenses for the process or deeming that the sanctions would be unreasonable. Conditional waiver of prosecution, under which a prosecutor could for instance monitor the treatment of an offender, is not permitted in Finland. The prosecutor may also summon the offender against whom the prosecution was waived and issue an oral caution. This is frequently used where the offender is underage.[61]

*Judge:* The judge may sentence the offender to a fine, conditional or unconditional imprisonment or, under certain conditions, community service or juvenile punishment instead of imprisonment. The judge can also waive punishment, for similar reasons for which the prosecutor may waive prosecution. Waiver of punishment is generally applied only to minor offences. The sanctions system does not recognise treatment as a separate sanction. Whether or not a drug user has sought treatment may influence the choice between conditional and unconditional imprisonment. For minor offences, it can also be a reason for waiving punishment.

59 A fine can range from 1 to 120 day-fines. In the Finnish system, the severity of the act will determine the number of day-fines. The monetary amount payable will be determined based on the offender's financial means. The minimum amount of a day-fine is six euros. If a low-income person is issued with a 10 day-fine sanction for using drugs, he/she will thus be obliged to pay 60 euros.

60 Prior to the reform entering into force on 1 January 1994, this confirmation was the court's task.

61 In criminal law, persons aged 15 to 17 are considered underage. In Finland, the minimum age for criminal liability is 15 years, which means that penal sanctions cannot be imposed on persons under 15.

*Problematic issues in data collection*

1. The statistics do not distinguish between the essential elements of each offence. This is particularly problematic concerning driving under the influence of drugs or pharmaceuticals, since it cannot be distinguished from other cases of driving while intoxicated. In practice, most cases of driving while intoxicated involve the use of alcohol. Moreover, establishing a reliable distinction between unlawful use of narcotics and a narcotics offence is not feasible. Unlawful use of narcotics refers to very minor drug-related offences, but small offences related to personal use may also constitute a narcotics offence. For instance, if a person imports one gram of hashish or grows a few cannabis plants, the essential elements of a narcotics offence are met. Similarly, if a person possesses 20 grams of marijuana for personal use, the case will be processed as a narcotics offence and not as unlawful use of narcotics.

2. It is not possible to identify the types of narcotic substances involved in the offences from the available data.

## Appendix 2. Data collection systems

*The police*

The role of the police in the sanctions system is extremely limited. While the police have the option to issue a caution for minor offences, they do so very rarely. No statistics on cautions are published. In other respects, however, police statistics are detailed and comprehensive. Statistical units include the offence, occurrence and the person suspected of the offence. These statistics are published several times a year (monthly or quarterly). Data are presented also by the age, gender and nationality of suspected offenders.

*Prosecutor*

Statistics concerning prosecutors are not very advanced. The statistical unit is a case, which can also be a group of several offences committed by several persons. While some data broken down by defendant are published, the combination of the statistics of the police and those of the prosecutor is not feasible. A significant piece of information regarding the sanctions system is provided by the figures indicating the frequency of waivers of prosecution. The statistics also enable identification of the reasons underlying a decision to waive prosecution. Separate statistics on treatment cases are not kept. Prosecutor statistics are published annually.

*Court*

The Finnish courts publish good-quality statistics. The statistical unit is the person convicted. The statistics are based on the principal offence, but some statistics involve multiple offence cases. The statistics distinguish between the types of sanction applied: fine, conditional imprisonment, unconditional imprisonment, community service, juvenile punishment or waiver of punishment. Data on average punishments are also provided. The statistics include the factors influencing the measurement of the punishment, such as recidivism. This is not, however, sufficient for describing the exact role of recidivism in the consideration of sanctions, since the judges generally do not provide reasons for their judgments in a manner which would result in the actual entry of recidivism in the related statistics. Court statistics are published annually.

*Combination of data*

A variety of statistics provide information on different issues. Police statistics enable assessment of how many narcotics offences are known to the police and how many individuals the police have suspected of committing narcotics offences. As such, this information is not of very high relevance in the assessment of the sanctions system. Prosecutor statistics enable reliable review of how often the prosecutor has decided to waive prosecution against an offender, and on what grounds. Court statistics enable analysis of the kind of sanctions imposed by the courts and on the average sanctions applied.

Police statistics present significantly higher figures than those which end up in court statistics. A criminal procedure may be interrupted for several reasons: the police cannot solve all suspected offences, the prosecutor may deem the evidence insufficient for prosecution, courts may dismiss some prosecutions, etc. In police statistics, the same person may be suspected of having committed several offences, but the data on such offences may be grouped together as the criminal procedure progresses. For instance,

the courts may deal simultaneously with several offences regarding one person – another reason for the reduction of figures between police statistics and statistics on sanctions.

*Problematic issues in data collection*

1. In Finland, treatment is not an independent sanction although, in practice, it may influence sanctioning. Information is not, however, available from official statistics since none are kept on treatment cases and monitoring of treatment is not the responsibility of the judicial authorities.

2. Statistics do not include information on driving bans. Under the law, a driving ban is an obligatory sanction, but its length varies.

3. Recidivism has its importance as a factor in the measurement of the punishment, and statistics do exist. However, the current statistics do not convey a reliable image on the importance of recidivism, since the judges generally do not provide reasons for their judgments in a manner which would result in the actual entry of recidivism in the related statistics.

4. A conceptual difference must be made between facts referring to the progress of criminal procedures (such as offences remaining unsolved, missing evidence and dismissal of prosecution) and the description of the sanctions system. A review of the criminal sanctions system only takes account of cases in which the issue of guilt is determined for the individual concerned.

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# 13. Tables and figures