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SUMMARY

Drug situation

The prevalence of cannabis experiments and use during lifetime is 7.9 - 10.7 per cent among 15 - 69-year-olds and during past year 1.4 - 2.7 per cent. The prevalence rates for other narcotics substances are under 1 per cent during lifetime and under 0.5 per cent during past year. Prevalence rates are 2 - 3 times higher for 15 - 24-year-olds. The prevalence of hard drug abuse among 15 - 64-year-olds is 0.3 - 0.4 per cent. Different substances are manifested in different ways in the statistics of drug use as well as drug related harms.

Statistics on health care and substance abuse services show the harms of ‘hard drugs,’ amphetamines and opiates, in particular. The same drugs are apparent also in infectious diseases and mortality statistics. In crime statistics, a key role is played by cannabis, although amphetamine is rapidly increasing its percentage of seizures made. At present, cocaine and ecstasy are in practice reflected in the Finnish crime statistics only. Some indications of their use can also be found in treatment statistics.

Since the year 1990, the existing indicators show a constant trend in the drug situation: drug experiments and use as well as related harms have increased steadily during the decade. At the turn of the decade, first signs appeared suggesting that the rapid growth in drug experiments and use is possibly slowing down. This is especially apparent among young adults, who are usually the most susceptible to drug experiments, but not so indisputable among the youngest age group. It remains to be seen whether this is a random phenomenon or the possible first sign of a new trend.

While the growth in drug experiments, having started in the early 1990s, may be levelling off, the same does not apply directly to drug-related harms, because e.g. in demand for treatment, the adverse effects of problem use seem to surface with a delay of 3–5 years after the first experiments and regular use. However, there were signs in 2001 suggesting that the growth in drug-related deaths, morbidity and infectious diseases has slowed. The rapidly growing number of new HIV infections due to injecting drug use now seems to be slightly declining, and the same applies to new hepatitis C infections.

The largest substance abuser group in Finland clearly comprises abusers of alcohol, who only occasionally consume other substances. But also polydrug use is typical of Finnish substance abuse. The combinations of substances used in the 1990s have remained unaltered: the most important groups are polydrug users of alcohol and pharmaceuticals; amphetamine and cannabis users who also drink alcohol; and opiate users who also use amphetamines and cannabis but not much alcohol. It seems that the role of alcohol is declining, especially among ‘hard-drug’ users. In the 2000s, alcohol in particular plays a
smaller role among problem drug users and the connection between alcohol and medicines is also growing weaker.

While all indicators show that the Finnish substance abuse problem revolves around alcohol, there are three factors that are alarming about the problem use of narcotics: the growth of drug-related harms, increasing exclusion of problem drug users – which is seen in their position which is even more marginalised than that of other substance abusers or criminals – and the fact that these problems typically concern young people.

**Drug politics**

Throughout the late 1990s, ever-increasing attention was paid to drug questions in Finland. In 1996, an inter-administrative expert group was launched to create a national drug strategy. As a result, the proposal for a drug strategy saw the light of day in spring 1997, eventually resulting in the Government Decision-in-Principle on Drug Policy at the end of 1998. These documents started planning process of local drug strategies in many municipalities. Nationally, implementation of the Decision-in-Principle started in 1999. The core results of the national implementation process are linked to the 2000 Government Decision-in-Principle on Drug Policy, intensifying the 1998 decision, and related supplementary budget for drug work (2001), further specified by the action programme for intensifying drug policy in 2001–2003 issued to the Government by the drug policy co-ordination group in 2002.

The wide-scale round of planning indicates that growing drug use and the resulting harms have been recognised as phenomena warranting a broad and multiadministrative national action plan to arrest these developments. The relevant Ministries also included drug topics in their medium-term financial and action plans. The same line of action was pursued in the report of the working group on young people’s drug prevention (2000) and the report of the working group on drug treatment (2001). The police, the Customs and the prison authorities have also produced their respective intoxicants and drug strategies in line with the Government 1998 Decision-in-Principle.

The objective of these strategies and decisions was to reduce both the supply and demand of drugs and to arrest the growth of narcotics use and related crime. The intensified measures proposed in the action plan integrate the focal points of anti-drug steps taken by different administrations. Government set up a interadministrative drug policy co-ordination group in order to co-ordinate national drug policy and to intensify collaboration between the authorities.

Mostly the anti-drug operations are performed as a part of everyday activities of different administrative sectors. In addition to this the Government decided to allocate supplementary budget funds worth EUR
5.5 million to anti-drug work in the Government Decision on drug policy 2000. Financing continued in 2002, with EUR 7.5 million as supplementary appropriations granted by the Ministry of Social Affairs and Health for drug treatment, EUR 3.3 million additional funding from the Ministry of the Interior for combating serious drug crime, EUR 1.8 million additional funding for drug prevention as part of youth work, for developing antidrug work in prison and for developing drug work in the Customs Administration

The Decision calls for action in the domains of five Ministries (Justice; Interior; Finance; Education; Social Affairs and Health). As far as possible, practical work will be done on a local level.

**The activities against drugs**

Concurrently with long-term strategic planning, decisive action has been taken to solve immediate drug problems at regional and local levels. The focus of prevention has been on young people. All central actors involved have invested especially in providing drug training for prevention workers; in addition, a network of municipal co-ordinators in drug prevention has been established. Training for a vocational examination in substance abuse work has started. A nationwide campaign on drug information is also ongoing, including a broad-scale evaluation.

In the treatment system, the development of low-threshold services and the related training have been highlighted, the aim being to involve clients in the treatment system as early as possible. At the same time, there has been much debate about harm reduction actions, whose position as part of treatment has been more widely acknowledged, one example being the development of infection risk counselling for injecting drug users as well as the substitution and maintenance treatment system. A special training programme has been developed for the scientific basis and treatment practices of substitution treatment. In the past year, major investments have been made to develop the treatment system regionally, as suggested by the relevant working group. Moreover, the general quality framework for substance abuse services was established in national co-operation.

The control authorities have stressed collaboration in preventive work with other authorities in the field. A new narcotics offence type, 'user offence', and, as a related means of reducing demand, a personal hearing and possibilities of care referral for the offenders were introduced. Another preventive measure that has been proposed is the introduction of drug tests. However, possible mass screening for drugs has aroused much debate in public. Some amendments to legislation concerning drug tests in working life are now in progress; a proposal for new legislation in the matter was made in a working group at the beginning of 2002. The three-year experiment in prisons has resulted in well-designed products for drug treatment in prison and for the after-care of released prisoners, in association with organisations in the
field. Furthermore, a working group proposal was made concerning the so-called contractual treatment for substance abusers as an alternative to imprisonment.

Legislative reforms increasing control authority and methods are important for the control activities undertaken by the authorities. In 2001, the police were given new, more extensive powers to engage in undercover purchase and other such operations. The Customs Administration has partly been issued similar powers under the Customs Act. Changes are also underway to give the prison authorities more power to intercept illegal substances in prison. During the year, law enforcement personnel resources for anti-drug work have been greatly increased in the police, customs, prosecutorial and prison administrations. The police, customs and the Border Guard approved a joint drug strategy in 2001, with several co-operative sectors for improved anti-drug activities.

**Demand reduction expenditures on drugs in 1999**

The bulk of drug demand reduction expenses in Finland are covered by public funds, either directly or indirectly as services purchased from organisations or private service providers. This means that the direct contribution to costs made by organisations, especially voluntary NGOs, private service providers and households, has remained relatively minor, and there is no accurate information about these expenses outside public funding.

In 1999, the State and municipalities covered over 80 per cent of the direct costs of demand reduction involving narcotics and intoxicating pharmaceuticals. The direct subsidies granted by the State are estimated at a minimum of 12 per cent and a maximum of 14 per cent, while the share of the municipalities ranged between 70 and 76 per cent; the pension and insurance companies covered 6–11 per cent, businesses and organisations 1–3 per cent and households 3–4 per cent.

The social and health services costs of abuse of narcotic and pharmaceutical substances as well as costs incurred in drug education and research totalled an estimated 64.5–87.9 million euros in 1999, of which EUR 26.0–27.0 million went to specialised substance abuse services, EUR 16.5–29.5 million to health care, EUR 13.6–17.9 million to living allowances and child welfare, EUR 3.2–8.3 million to compensations and disability pensions and EUR 5.2 million to drug research and education. The direct harm-related costs (including law enforcement activities) of drug abuse totalled 127.4–195.9 million euros in 1999.
Drug (and alcohol) use among young people aged 12 - 18

According to a study targeted at 15–16-year-olds in 2001, there is no statistically significant increase in the use of marijuana and hashish during the past year compared to the year 1998. According to the results, 7.7 - 9.3 per cent of the young respondents had experimented with or used hashish or marijuana in last 12 months and the percentage of those having experimented with other drugs was 1.2 - 2.0 per cent. There were no major differences between the sexes.

Young people aged 15–19 accounted for a fifth of the drug clients seeking specialised services for substance abusers, with 43 per cent of the young clients the main drug was cannabis, alcohol in 21 per cent of the cases, stimulants in 19 per cent and opiates in 15 per cent. However, 37 per cent had injected drugs at least once and 23 per cent had also shared needles and syringes with other users.

Drug experiments and being caught at an early age foreshadowed a bleak future. Especially property crimes at an early age and injecting drug use seemed to be correlated with future prison sentences, psychiatric institutionalisation or untimely death.

All recent drug strategies have emphasised the relevance of young people with reference to the drug problem. This is reflected in the fact that school staffs are given advance training for drug prevention, workshops and youth work are suggested as ways to develop drug prevention, and the role of the police in prevention should be enhanced. The Child Welfare Act is applied in treating young problem users as with young people who have some other problems. Youth interventions usually address a more complex problem than just substance abuse, and drug-related interventions are not the only ones to be applied.

An example of law enforcement activity is the obligation to early intervention, specified in connection with the new ‘user crime’ and the fact that first-time young drug offenders should invariably be given a hearing to waive sanctions and to give a reprimand, with the prosecutor, police and social services authorities present.

Social exclusion and reintegration

It evident that those who engage in risk use, those in drug treatment and drug offenders all face a similar risk of exclusion from education, work and housing. Many social exclusion risks are further exacerbated by addiction problems. It is possible that the drug problem has become a permanent part of accumulating social risks of exclusion. However, the phenomenon is too new to yield more than rudimentary information about its present role.
The action plan to combat poverty and social exclusion (2001) contends that the social security and welfare of vulnerable citizens and other inhabitants are protected by the Finnish Constitution. The plan also emphasis that substance abuse, especially drug abuse increase the risk of social exclusion as well as leads often to general life management problems.

As part of societal support and rehabilitation for certain groups facing a risk of exclusion (e.g. reformatory school children, immigrants, prisoners), special treatment and reintegration services have been made available to people with drug problems. However post-rehabilitation care and reintegration takes place primarily by general socio-political, housing, education and employment measures, adapted to drug users’ situation as far as possible.

Conclusion

Even if the 1990s growth in drug experiments were levelling off by the beginning of 2000s, changes in the level of drug related harms do not directly follow that trend because e.g. in demand for treatment, the negative effects of problem use seem to accumulate with a few years’ delay. In the long run, an increase in the prevalence of drug use in the 1990s also reduced regional prevalence differences, a fact that has a direct impact on the spreading of drug-related harms throughout the country.

As the users become older, the negative effects will affect older age groups both in acute and eventually chronic forms (liver cirrhoses due to hepatitis C, etc.), which are already manifest in terms of the substance most commonly abused in Finland, namely alcohol. Chronic drug-related effects will present a completely new challenge to the treatment system in the coming decades. Some of these impacts, e.g. HIV infections due to injecting drug use, will also spread to the population that do not use drugs.

The 1997 drug strategy proposal and the 1998 Government Decision-in-Principle has provided national and local drug work with a framework for all activities for the next couple of years. The drug policy co-ordination group has an important position when deciding how activities within this framework are prioritised and how this will be reflected in finance.
PART I
NATIONAL DRUG STRATEGIES: INSTITUTIONAL AND LEGAL FRAMEWORKS

In Finland, primary responsibility for co-ordinating national drug policy is delegated to the Ministry of Social Affairs and Health, which also prepares narcotics legislation and regulations on the legal manufacture, sale and use of narcotic substances, while the Ministry of Justice prepares laws regulating narcotics offences and the related issues. Other key Ministries participate in the implementation of drug legislation, preparing the relevant regulations within their administrative spheres.¹

Regionally, the social welfare and health care departments in the five State Provincial Offices and the Provincial Government of Åland control and supervise implementation of social and health services in their region and collaborate with municipalities. Police work is divided into 90 state administrative districts, each of which is in charge of drug investigation in its area. In addition, each district has district prosecutors, working independently of the police. There are 65 district courts for exercising juridical power, and the Customs Administration has five customs districts and regional offices.

All 448 Finnish municipalities are responsible for practical implementation of statutory services, which are either provided by the local authorities themselves or purchased from the private sector. The services are mainly financed by municipal tax revenues, state subsidies and partly by user fees.

Organisations and voluntary work have a long tradition in complementing the public sector. Many local, regional and national NGOs engaging in intoxicant prevention and treatment are also active in anti-drug work. Organisations have a great responsibility for the work against substance abuse in collaboration with the authorities. Complementing the official system, organisations largely operate on public funds.

The key Ministries co-ordinating international drug issues are the Ministries of Foreign Affairs, Social Affairs and Health, Justice and the Interior. Their actions are co-ordinated by the national working group on international drug issues, appointed by the Ministry of Social Affairs and Health.²

Finland’s EU Presidency in the second half of 1999 greatly expanded the drug-related domains handled by the Finnish administration. Especially for Finland’s Presidency, a national narcotics subcommittee was established, acting under the National Committee on EU Affairs and parallel with the working group dealing with international drug issues. The subcommittee is led by the Ministry of Social Affairs and Health, and in terms of representation, it is an extended version of the national working group on international drug issues.

¹ See Appendix 1: Organisation chart of drug administration in Finland.
1 DEVELOPMENTS IN DRUG POLICY AND RESPONSES

1.1 Political framework in the drug field

Based on the proposal\(^3\) outlined in the 1997 memorandum of the Drug Policy Committee (Drug Strategy 1997, 56 - 60), the Finnish Government issued a resolution on drug policy (Government decision-in-principle on Drug Policy 1998). It defines the basic approach to drug policy as follows:

Finland’s drug policy is based on general socio-political measures, national legislation and international conventions. The aim is to intensify drug control based on a total prohibition on distribution and use of drugs, to prevent experimenting with drugs and their use, as well as to provide, and facilitate access to, adequate care and treatment for drug abusers. The goal of drug policy is to prevent drug use and the proliferation of drugs while making the individual, social and economic harms entailed by drug abuse, and related prevention, care and control measures, as small as possible. In its drug policy, Finland takes account of the European Union’s lines of action relating to drug policy and foreign and security policies.

In the 1998 Government Decision-in-Principle on Drug Policy, central activities proposed concentrate on drug prevention, treatment and control. In the Decision, the basic approach to drug policy in Finland is defined as follows:

1. The proliferation and use of drugs is prevented primarily by influencing the population’s living conditions on the basis of equality and fundamental rights, by implementing Nordic welfare policy. In this way, we can reduce the factors that expose people to drug use and intoxicant problems. Education and information are the means to influence attitudes and to encourage especially young people to lead a drug-free way of life. Drug use and its related problems and damages can be prevented successfully by an early and efficient intervention in young persons’ drug problems and in symptoms preceding drug use. The educational system and social and health services can intervene at an early stage, if the problems and symptoms can be identified and if they can be tackled in the right way.

\(^2\) See Appendix 2: Administration of international drug issues in Finland.

\(^3\) The proposals concerned both narcotics and medicines abused for intoxication purposes.
2. The care and treatment of drug abusers is based on the general principle observed in Finnish social welfare and health care to provide all citizens with the services they need. Drug abuse and its consequences increase insecurity in the community and cause harm to other citizens. Positive outcomes of care and treatment impact favourably on the drug and the related crime situations. Continued drug abuse will entail more costs for society than the provision of care services. The effective care and treatment of drug abusers is therefore in the interests of the whole of society. The declaration issued in the special session of the United Nation’s General Assembly in 1998 concerning the principles of restricting drug demand draws attention, in addition to care, to reducing the detrimental effects of drug abuse on individuals and the whole of society.\(^4\) The abusers’ families are also in need of special support, guidance and services.

3. The UN drug conventions form the basis for drug control. Finland has ratified the 1988 Convention against the Illicit Trade in Narcotic Drugs and Psychotropic substances (SopS 44/1994), the 1971 Convention on Psychotropic Substances (SopS 60/1976) and the 1961 Single Convention on Narcotic Drugs (SopS 60/1965), with the amendment made in 1972 (SopS 42/1975). The penal provisions concerning narcotics offences were transferred from the Narcotics Act to the Penal Code since the beginning of 1994. The aim of this reform was to intensify the measures to combat international illicit trafficking of drugs, as required by the 1988 UN Vienna Convention. In connection with amending the provisions on narcotics offences, also money laundering was made a punishable act. Thus, actions to promote the manufacture or distribution of drugs by e.g. financing are punishable according to the Penal Code.

In 1999, the Government set up a drug policy co-ordination group in order to co-ordinate national drug policy and to intensify collaboration between the authorities in their efforts to implement and monitor the drug programme.\(^5\) The group has representation from the relevant Ministries and agencies. It prepared an action plan proposition for intensifying drug policy.

Based on the proposition, the Finnish Government issued on 5 October 2000 a Decision-in-Principle to enhance drug policy (2000) and to expedite the execution of the 1998 Decision-in-Principle, the objective being to reduce both the supply and demand of drugs and to arrest the growth of narcotics use and related crime. The intensified measures proposed in the action plan integrate the focal points of anti-drug steps taken by different administrations. An additional EUR 5.5 (FIM 32.5) million was proposed for anti-drug actions in the 2001 budget.\(^6\)

\(^4\) [http://www.stakes.fi/neuvoa-antavat/index.html]

\(^5\) See Appendix 1 (Organisation chart of actors in drug administration)

\(^6\) For a more detailed discussion of the Decision-in-Principle and its implementation, see chapters on the strategies of demand and supply reduction.
Through the actions of this Decision,

- anti-drug attitudes in society will be reinforced by targeting preventive drug information at the entire population\(^7\)
- drug addicts will be given better possibilities for treatment and rehabilitation\(^8\)
- drug offenders’ risk of getting caught will be increased; an effort will be made to ensure criminal liability in drug crime; and anti-drug work in prison will be promoted.\(^9\)

The Decision calls for action in the domains of five Ministries (Justice; Interior; Finance; Education; Social Affairs and Health). As far as possible, practical work will be done at a local level.

According to the Decision, the co-ordination group must also prepare a long-term action programme for intensifying drug policy. The Government was informed about the action programme on 5 February 2002. The action programme for intensified drug policy in 2001 – 2003 (2002) retained the goal of arresting the growth in narcotics use and drug crime. The programme will pursue the policies laid down in the Decision-in-Principle in 2000 and implement drug policy in 2002 mainly on the resource level of the 2001 budget.\(^10\)

As regards international co-operation, the 1998 Government Decision-in-Principle on Drug Policy stressed that:

- Finland will promote the goals stated in the Decision-in-Principle in all international collaboration and especially in the bodies of the European Union and the United Nations.
- Finland will take account of the documents adopted at the special session on drugs issues of the UN General Assembly in June 1998.\(^11\)
- Finland aims to continue its role as one of the major contributors to the UN Drug Programme, expanding and diversifying the work done to combat drug demand and supply, especially in its neighbouring regions.

The new action programme to intensify drug policy (2002) follows the same principles by emphasising that

- Finland will continue as a major contributor to the UN Drug Programme;
- National data systems will be developed in collaboration with the EMCDDA;

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\(^7\) Cf. Chapter 8.1
\(^8\) Cf. Chapter 8.1.
\(^9\) Cf. Chapter 15.1.
\(^10\) Cf. Footnotes 6-9.
- Possibilities for exchange of information within Europol, the Schengen Agreement and bilateral anticrime agreements will be developed further; and
- Finland will ratify the EU Convention approved in 2000 on mutual legal assistance in criminal matters.

The administration-specific target and action strategies of the Ministries constitute an important avenue of directing policies. In the strategies, the Government, or the Ministry in question, outline the developmental goals, necessary recommendations for action and implementers in their respective administrative fields. The strategy is monitored and evaluated for its duration, which is usually four years. Drug issues are dealt with in the action strategies of four Finnish Ministries.12

The action strategy of the Ministry of Social Affairs and Health emphasises combating exclusion and enhancing the position of vulnerable groups. The aim is to promote wellbeing among children and young people, to prevent exclusion and drug problems and to reinforce social work and mental health services. Co-operation with municipalities, administrative bodies, authorities, organisations and the business sector will be intensified in drug prevention, and work organisation and responsibilities will be clarified.

In implementing municipal preventive substance abuse work, the broad starting point expressed in the Government’s previous decisions-in-principle on drug and alcohol policy will be adhered to, concerning the interconnection between supply and demand reduction activities as well as reduction of harms related to substance abuse. The local authorities will redouble their efforts to prevent the use of tobacco, alcohol and narcotics among 12 – 14-year-olds in particular. In addition to young people, actions will be directed at parents, schools, free-time activities and businesses. The police and social welfare authorities will immediately respond to alcohol use in public places, especially when it involves minors. Moreover, the municipalities will appoint regional co-ordinators in charge of substance abuse work and provide adequate training for them.

To support quality control activities for substance abuse work in municipalities, quality recommendations are specified for the strategic period, incorporating recommendations, when necessary, for staffing. In compliance with the Government platform, in substance abuse work, “feasible criteria and quality measures must be established in order to monitor the equitable implementation of social and health services, with client-centredness as a guiding principle.” During the period, the Ministry of Social Affairs and Health will reserve appropriations for further education in social welfare and health care in certain fields, including the treatment of drug addicts.

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Also in the domain of the Ministry of Education, special attention is paid to the prevention of risks involving exclusion and to the development of educational services and guidance for excluded children and young people. Young people’s workshops, where unemployed people aged 25 or younger spend six months getting to know a job that interests them, will be developed in accordance with the new European Social Fund Objective 3 in the entire country. In the areas covered by Objective 1, the goals of the above-mentioned programme will be applied. During the new programme period, funding will be forthcoming for hiring and training workshop leaders, who support young people’s improved life management and planning for the future. In addition, workshop networking is supported in each region, including the development and distribution of auspicious practices found during the previous programme period. One objective of workshop activities is to establish an interadministrative service system, in which young people can be joint clients in all services. The workshop network is also developed as an environment of rehabilitative employment associated with preventive drug work and active social policy.

The Ministry of the Interior will engage in close collaboration with the EU’s law enforcement agencies to combat international, professional and organised crime. At the beginning of the year 2000, the Police Department of the Ministry of the Interior prepared its own drug strategy for 2000–2003. It described in concrete terms the actions specified in the Government’s drug policy resolution and the strategy for combating crime in compliance with the Government platform. The activities aim at creating networks and approaches within and by the police to ensure smooth co-operation between the authorities responsible for drug policy and to keep that policy up-to-date so that implementation and effectiveness of the actions chosen could be monitored in order to prevent the use and proliferation of narcotics. Approved by the supreme police leadership, the antidrug strategy for 2003–2006 of the police further augments the strategy for combating drugs (news release of the Ministry of the Interior, 2 September 2002).13

One key goal mentioned in the target plan of this domain is slowing down the escalation of drug crime. This target is pursued by effective implementation of the police antidrug strategy and by carrying out the intensified measures of the Decision-in-Principle of the year 2000. The strategy aims at preventing drug trade and other distribution of drugs.

At the beginning of 2001, the joint drug strategy between the police, customs and the Frontier Guard went into force, aiming at more effective measures to combat drug-related crime by intensified co-operation.14

The Ministry of Justice strives for enhancing the effectiveness of criminal policy in the near future, especially to stop an increase in drug offences and repeated crime. This requires guaranteeing adequate resources for the prosecutorial authority, prisons and for probation and after-care services as well as broad

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13 Cf. Chapters 12 and 15.2.
co-operation between law enforcement agencies, civic organisations and communities. To reinforce criminal policy, some related tasks and the enforcement of punishments in the Ministry’s domain have been rearranged. In order to deter recidivism and drug offences, prison sentences and probation control will be developed further.

1.2 Legal framework

1.2.1 Narcotics legislation

The Narcotics Act (1289/1993) prescribes the main principles of drug control based on international conventions. With the exception of certain plants specified in a Decree, the definition of a narcotic substance refers to the substances and preparations mentioned in the 1961 UN Single Convention on Narcotic Drugs and the 1971 UN Convention on Psychotropic Substances. The law also acknowledges an obligation to monitor certain precursors, i.e. non-narcotic substances used in making drugs, as specified in the 1988 UN Vienna Convention against the Illicit Trafficking in Narcotic Drugs and Psychotropic Substances. The Act entered into force on 1 January 1994.


The orders of the National Agency for Medicines concerning the importation of personal pharmaceutical substances (6/2001) stipulate the amount of pharmaceuticals defined as narcotics a passenger can legally import to Finland.

Narcotics offences are specified in the Penal Code (1304/1993), whereby drug offences are categorised as narcotics offences, preparation of narcotics offences and abetment of narcotics offences, with sentences ranging from a fine to a maximum of two years’ imprisonment; or as aggravated narcotics

\[\text{Cf. Chapter 15.2.}\]
offences, carrying sentences from one to ten years’ imprisonment. The criteria for aggravated narcotics
offence are as follows:
- The offence involves a highly dangerous substance or large quantities thereof.
- Considerable financial profit is sought.
- The offender acts as a member of a group organised for the extensive commission of such an offence.
- Serious danger is caused for the life or health of several people.
- Narcotics are distributed to minors or in an otherwise unscrupulous manner.
- The narcotics offence, when assessed as a whole, is to be deemed aggravated.

By law, a highly dangerous drug refers to a narcotic substance that can cause death by an overdose,
serious damage to health even after short-term use or severe withdrawal symptoms.

Special provisions were added to the law regarding the forfeiture of implements, equipment and materials
as well as the assets used for the commission of the offence. In addition, the new Penal Code has legal
provisions for waiving prosecution or punishment in drug offences.

In the summer of 2001, an amendment (654/2001) to the Penal Code concerning narcotics offences was
passed, including the new essential elements under the heading of drug-user offence. In effect since 1
September 2001, the new law concerns persons who illegally use, possesses or try to obtain small
quantities of narcotic substances for personal consumption. The penalty is a fine or not more than six
months’ imprisonment. This enables summary penal proceedings, where the prosecutor can give the
punishment outside court. In such cases, the preliminary investigation material is often less extensive than
in ordinary preliminary investigation.

This reform clarified the regulations on waiving prosecution or punishment in drug offences. According
to the new legislation, prosecution or punishment can be waived, if the narcotics offence is to be
considered insignificant in view of the amount and quality of narcotics, the situation and circumstances.
In September 2002, the Office of the Prosecutor-General provided the prosecutors with special directions
as to how sanctions should be meted out in drug-user crimes (VKS:2002:3). Prosecution or punishment
can also be waived when the suspect has sought treatment specified by a Decree (290/2002) of the
Ministry of Social Affairs and Health. The former law required that in the latter case, the persons had to
commit themselves to treatment. In addition to this special provision, other regulations on waiving
proceedings are also applicable to drug offences.

\[15\] For a more detailed discussion about the enactment of laws on drug crime in Kainulainen, H. (2000). See also Chapter 1.3.
1.2.2 Other drug-related legislation

The amendment to the Penal Code regulated money laundering (317/1994, 68-79/1998). The purpose of the law is to prevent money laundering, to promote disclosure and investigation and to enhance the recovery of the criminal proceeds. By the Law Against Money Laundering, business institutions must require identification of their customers when entering into business relations or conducting transactions exceeding certain threshold amounts. Banks and other financial institutions must report financial transactions of an unusual nature. Failure to identify customers or to obtain relevant documents is punishable by a fine or a maximum of six months’ imprisonment. Actual money laundering is processed as a concealment offence under Chapter 32, Paragraph 1 of the Penal Code, the maximum punishment of which is one year and six months’ imprisonment (four years for aggravated money laundering and six years for professional money laundering). According to the Penal Code (Paragraph 6, Chapter 32), assets laundered will be confiscated. (Kinnunen, A. 1999). The Government proposition (HE 52/2002) recommends that separate criteria be specified for money laundering offences and that also brokerage and abetment in concealing or dissipating assets are defined as criteria of engagement in crime. At the same time, the maximum penalties for money laundering would be increased.

To meet the requirements of the new amendments, the National Bureau of Investigation has established a Money Laundering Clearance House. The task of the Clearance House is to promote collaboration between domestic and foreign authorities in combating money laundering. The National Bureau of Investigation reports annually to the Ministry of the Interior on the operations of the Clearance House and its success in counteracting this type of crime.

The Penal Code reform has also addressed the general duty to notification of offences (563/1998) so that persons who are aware of the fact that an aggravated drug offence is afoot but neglect to notify either the authorities or the party at risk in time to prevent such an offence, will be subject to a fine or imprisonment for no more than six months, if indeed such a crime has been committed, for neglect to report an aggravated offence. However, the implications of neglect are not as severe, if the case involves the suspect’s relatives or a person cohabiting with the suspect.

In connection with the Penal Code amendment, legislation on driving under the influence of narcotic substances was revised as well. An important aspect of the reform was that acts previously punishable as ‘driving under the influence of drugs’ became punishable as ‘drunken driving’. According to Chapter 23 of the Act (545/1999), a person who operates a motor vehicle after having used a drug other than alcohol, or a drug with alcohol, so that his or her ability to perform faultlessly has been impaired, must be sentenced for drunken driving to a fine or imprisonment for at most six months, or, if the circumstances are such that the offence is conducive to endangering others, for aggravated drunken driving to at least
sixty day-fines or imprisonment for at most two years. The reform also required alterations to the clinical
drug examinations conducted by physicians, and therefore the Ministry of Social Affairs and Health
issued an order, specifying the drug examination form and how to fill it (1999:25).

On 18 January 2001, the Government issued a resolution to improve road safety. The decision
incorporated a 30-point action programme, which called for, among other things, an investigation into the
introduction of zero tolerance for narcotics in road traffic. Appointed by the Ministry of Justice, the
working group discussing the question suggested in its report on 14 June 2001 that zero tolerance be
introduced.\textsuperscript{16} The Government made its proposal to Parliament in June 2002 (HE 90/2002). According to
it, persons operating a motor vehicle after having used narcotic substances so that they have active
narcotic agents or their metabolites in their blood while driving or immediately thereafter will be
convicted of drunken driving. The provision would not apply to agents and metabolites of pharmaceutical
drugs that the driver is authorised to use. The proposal means that the so-called zero tolerance will be
introduced in road traffic.

In 2001, an amendment to legislation on the forfeiture consequences in the Penal Code (875/2001)
was passed. The amendment concerns the forfeiture consequences specified in the law concerning drug
offences. The amendment adopts the concept of extended forfeiture of the proceeds, whereby e.g. persons
having committed or abetted a drug offence (or persons accessory to it or persons for whom or in whose
interests the crime was committed) may be ordered to forfeit their property or a part of it, if the offence
may give considerable financial yields and if there is reason to believe that the property is partly or fully
derived from criminal activity that cannot be considered negligible. According to the proposal, no
forfeiture is however ordered, if the defendant shows probable cause to presume that the property in
question was acquired by legal means (the so-called reversed burden of proof).

Amendments to the Coercive Criminal Investigation Means Act give the police a right to engage in
wiretapping, telecommunications and technical surveillance with regard to drug-related crime (402/95).
Moreover, a person found guilty of an aggravated narcotics offence or a punishable attempt to commit
such a crime, or of abetment or incitement, may have to undergo a personal examination for obtaining a
DNA identifier, whereby the person’s DNA is analysed and can be filed in a police register (565/1997).
In 1999, the law was supplemented (366/1999) so that technical surveillance may be targeted at places
where a crime suspect in all probability will be staying (for example, prison, excluding social welfare and
health care facilities), if the information gathered by surveillance can be presumed to have a major impact
on solving a drug offence or its punishable attempt. The prerequisites for telesurveillance were altered in
2001 to include crimes against automatic data processing systems. (22/2001). In the same year, personal

\textsuperscript{16} See http://www.om.fi/11006.htm
examination was extended to drug-user offences as well (655/2001). During the report period, the Government has proposed (HE 52/2002) the coercive means Act to be specified so that telecommunications monitoring and telesurveillance could be specifically targeted at an email address, other such telecommunication address or terminal.

According to the amendments to the Act on the Enforcement of Punishments (364/1999) and amendments to other laws to reinforce the authority of prison personnel in drug control, the prison warden is authorised to order an inmate to undergo a body search. In addition, prisoners must give urine samples or take a breathalyser test as a precondition for unmonitored visits or going on leave. A prisoner may be isolated in order to prevent drug offences. It is also possible to transfer an inmate to another institution, such as a treatment unit for substance abusers. In 2001, the prerequisites for personal examination were extended to drug-user offences (656/2001). In its report (2002:3), the so-called contractual treatment committee proposed a law on testing contractual treatment as an alternative to prison sentence for convicts whose offences were significantly influenced by a substance abuse problem and who can be assumed to follow the treatment plan devised for them.\footnote{See Chapter 12.2.}

The Police Act (493/1995) was amended (21/2001) in order to add provisions for unconventional means of combating and investigating crime. The new methods are covert operations (the use of misleading or covert information in investigation or infiltration) and fictitious purchase (offer to buy made by a police officer in order to prevent or uncover the possession, sale or production of an illegally held substance or property or in order to recover ill-gotten gains).

According to the law, a police officer has the right to engage in covert operations, for example, to prevent or uncover an aggravated narcotics offence or professional concealment offence, or if there are other sufficient grounds for suspecting that the subject will commit such a crime. Correspondingly, a police officer is entitled to make a fictitious purchase when necessary to prevent or uncover concealment or a crime carrying a maximum penalty of two years’ imprisonment (narcotics offence and aggravated narcotics offence). The Ministry of the Interior has given more specific regulations and orders concerning the organisation and supervision of both covert operations and fictitious purchase (499/2001). The decision on covert operations is made by a police unit chief authorised by the Ministry of the Interior, while fictitious purchase is decided by a senior police officer.

The amendment to the Police Act (21/2001) also includes security checks to protect legal proceedings and other sessions requiring strict security. These provisions extend the rights of the police to acquire telecommunications information (e.g., in case of suspicion of drug-related crime) and to engage in
technical surveillance (e.g., residential premises in prison). In terms of telecommunications and technical surveillance, the decision is made in accordance with the law on coercive measures in a court of law, or, in urgent cases, by notifying the court within 24 hours after the procedure began. Issues relating to international jurisdiction, associated with the Schengen Agreement, are decided on the basis of a Decree (315/2001).

In addition, the proposal (HE 95/2002) to amend the Customs Act suggests more extensive rights for telesurveillance and other technical surveillance to investigate drug crime.

The prevention of drug use and the treatment of drug abusers are discussed in the Temperance Work Act and the Act on Welfare for Substance Abusers. The Public Health Act, the Social Welfare Act, Occupational Health Act, Act on the Status and Rights of Social Welfare Clients, Act Concerning Health Care Professionals, the Child Welfare Act and the Mental Health Act also regulate services for drug abusers. In addition, the Police Act underlines the importance of crime prevention.

The Temperance Work Act (828/1982) aims at promoting healthy lifestyles among citizens by counselling them to avoid intoxicants and tobacco. The state and municipalities are primarily responsible for establishing proper conditions for temperance work, while the municipalities and organisations are in charge of practical work.

According to the Social Welfare Act (910/1982), the local authorities are obliged to provide social welfare services for inhabitants, to promote welfare and to eliminate social injustice.

Under the Act on Welfare for Substance Abusers (41/1986), services for substance abusers aim to prevent and reduce drug abuse and related social and health harms, to promote the security and functional capacity of intoxicant abusers and their close persons. The Act emphasises municipal responsibility for the implementation of the Act, based on local needs. Municipal health care and social welfare units as well as various NGOs are responsible for providing these services. An amendment made in 2002 specified the organisation and implementation of pharmaceutical treatment of drug addicts (280/2002).

Under the Child Welfare Act (139/1990), children have the right to a safe and inspiring environment as well as well-balanced and many-sided development and precedence concerning special protection. The municipality must take immediate action, if a child’s living conditions are threatened or if a young person endangers his or her own health.\[18\]

\[18\] See Chapters 9.3.
The Act on the Status and Rights of Social Welfare Clients (812/2000) concerns the Social Welfare Act, the Act on Welfare for Substance Abusers and the law on childcare. Among other things, the Act prescribes the grounds on which a social-service provider or implementer is obliged to give, or can use discretion in giving, information about classified documents without the client’s consent. According to the Act, the duty to report includes, for example, the police, prosecutorial authority or a court of law, if information about classified documents is necessary to solve a crime that carries a minimum sentence of four years’ imprisonment (e.g., aggravated drug offence).

The Public Health Act (66/1972) stipulates that the municipalities must provide health counselling, public health services as well as occupational and school health services.

The Occupational Health Act (743/1978) and other legislation related to it, emphasises maintenance of working capacity as one of the major goals for occupational health; the goal includes activities aiming at substance abusers’ referral to care at the workplace.

The law concerning the protection of privacy in working life (477/2001) indirectly addresses the question of drug testing at workplaces as well. Based on the Act, the employer may process personal information about employees that is pertinent to the work at hand, without exceptions (including the employee’s consent). This requirement concerns also testing for drugs in aptitude tests relating to the job or in assessing an employee’s health. The employer must use health care professionals and proper health care services in conducting drug or alcohol tests, as specified in health care legislation. Contrary to the original Government proposal (HE 75/2000), an employee’s obligation to undergo a medical examination or tests is stipulated elsewhere. An employee’s obligation to participate in medical examinations and tests will be stipulated based on a proposal made in the report (2002:2) of the Ministry of Social Affairs and Health working group on drug testing in working life.19 However, there have been some dissenting opinions concerning the proposal and the matter will be further discussed in a Ministry of Labour working group.

In 1997, the Ministry of Social Affairs and Health issued an Order on the detoxification and substitution treatment of opioid addicts with medicines containing buprenorphine, methadone or lavacetylmethadol (28/1997). A new Order was issued on 2 November 1998 (42/1998), and on 1 July 2000 the Ministry issued a Decree on the same topic (607/2000), to be replaced by yet another Decree (289/2002) on 15 April 2002. In the chain of orders and decrees, levacetylmethadol was omitted from substitution treatment, rehabilitative substitution treatment was complemented by maintenance treatment mainly aiming at harm reduction. At the same time, an effort was made to diversify service provision and

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19 See Chapter 9.4.
to facilitate access to care by increasing the number of units assessing the need for treatment and giving pharmaceutical treatment.

In the Decree, opioid addiction is defined by the ICD-10 criteria (F11.2x). All types of treatment require an individual treatment plan, specifying other medical and psychosocial care and follow-up for the patient along with pharmaceutical therapy with buprenorphine or methadone. The Decree defines both detoxification and substitution treatment aiming at drug-free life and detoxification also as rehabilitative care. Meanwhile, new therapy is introduced in the form of maintenance treatment, with harm reduction and enhancement of the patient’s quality of life as focal points. However, also a maintenance treatment programme makes it possible to prepare the patient for rehabilitative substitution treatment. The detoxification period is limited to one month, whereas substitution and maintenance are intended for longer treatment.

In all treatment forms, assessment of the need for treatment and commencement of treatment are defined to take place in a central hospital or other corresponding hospital designated by a federation of municipalities in the health care district, Järvenpää Addiction Hospital or other municipal unit in the health care district, health centres, substance abuse clinics or prison health care units that have a specially appointed physician in charge of treatment and other necessary and proficient personnel, adequate facilities and other requirements needed in treatment. The Provincial Government must be notified when treatment starts and given the name of the responsible physician.

The Decree stresses the importance of providing long-term treatment as close to the patient as possible. Pharmaceutical therapy may be implemented and medicines administered to the patient under controlled circumstances in the care unit. If a patient has shown co-operation, under special circumstances he or she may be provided with more than one, but not more than eight, daily doses at a time. These medicines cannot be administered in a pharmacy.

The Act Concerning Health Care Professionals (559/1994) stipulates, among other things, the ethical principles of health care, whereby health care personnel aim at maintaining and promoting health, preventing disease and treating the patients as well as relieving their suffering by using generally approved and proper procedures.

Based on the Act on the Status and Rights of Patients (559/1994), the patient is entitled to good medical care and related treatment, access to information, self-determination and confidence in the specialist-client relationship.
Under the Mental Health Act (1116/1990), the authorities are empowered to refer an under-age child to psychiatric hospital treatment regardless of the child’s or parents’ will, if failure to organise such treatment essentially endangers the child’s health and safety.

In addition to the Mental Health Act, both the Child Welfare Act and the Act on Welfare for Substance Abusers enable the involuntary treatment of drug abusers. For instance, the criteria for involuntary treatment referred to in the latter include health hazards and violence, but this option is only seldom taken.

1.3 Laws implementation

Persons suspected of drug offences seem to undergo a harsher treatment than other criminals do in the Finnish legal system. A study on 1996-1997 data established that incarceration as a coercive measure in the criminal process appears to concern persons suspected of drug offences in particular (Kainulainen 1998; also Sarvanti 1997). According to the study, incarceration was typically associated with three offender groups: a) homicide suspects, b) suspects (repeatedly) involved in crimes against property and c) suspects in narcotics offences. Persons suspected of drug offences accounted for 25 per cent of these cases.

Nevertheless, there must be sufficient grounds for recommending incarceration. The police (or customs) may have followed the suspects for a long time and used informers and other sources, the suspects’ telephones may have been tapped and so on. Because drug crime often involves several perpetrators, incarceration is used to ensure a successful investigation by isolating the suspects. The statistics do not say how often incarceration has led to an indictment or sentence. The interviewees reported that the incarcerated suspects (including drug suspects) have usually been charged and convicted (Kainulainen 1998).

A study on the judicial grounds for waiving prosecution in narcotics cases suggests that the so-called drug users are not usually incarcerated, but some arrests have been made. Incarceration apparently concerns persons who have allegedly committed aggravated narcotics offences. It seems that the prosecutor decides to refrain from pressing charges if the amount used (or possessed) is small. According to the interviewees, when larger quantities or hard drugs have been used (or if used in prison), prosecution will usually ensue.

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20 The study was based on decisions (677) made in 1997 to waive prosecution for drug offences, sampling of drug cases having started in 1996 in five district courts and their decisions in 1996–1997 (totalling 510 convictions) as well as theme interviews conducted in 1998–1999 among prosecutors and judges in three largest cities in Finland (8 judges and 7 prosecutors).
In some cases, however, prosecutors may have waived prosecution without a proper reason, since court proceedings are considered too cumbersome for imposing a fine. (Kainulainen, H. 1999)

However, the judicial practice has been far from uniform, and some prosecutors tend to be less inclined to press charges. Committal to treatment, now possible under the new law, has seldom been used. It is not common to waive sentences, either. (Kainulainen 1999) In January 2000, the Office of the Prosecutor-General issued guidelines for waiving prosecution in drug offences (VKS:2000:5), with the aim of harmonising the practice of waiving prosecution in the country.

According to the guidelines, when decision not to prosecute an adult is considered, one must take account of the amount and quality of narcotics in question, the duration of use and other circumstances. In terms of problem users, punitive actions become less important, balanced out by curative viewpoints. The Section is applicable to juveniles and adults alike, but the offender’s young age may be relevant as well, if the deed (experimental use) may be attributed to thoughtlessness or imprudence.

After the decision, the Office of the Prosecutor-General made a performance target survey concerning prosecutorial practice in drug offences (news release of the Office of the Prosecutor-General, 16 October 2001). The survey spanned from 1 January to 30 June 2001, during which the prosecutorial units responding to the survey pressed charges for 3,726 drug offences. During the same period, there were 949 non-procedural decisions to waive prosecution, which is 25.5 per cent of the indictments.

Non-procedural decisions to waive prosecution seemed to have a larger proportion in drug offences than in other crimes (16% in recent years). Inconsistencies between the prosecutorial units remained to be a problem in drug-related prosecutorial practice. Comparison of above-mentioned national average (25.5%) to the numbers in the largest prosecutorial units (over 100 indictments for drug crimes during the period studied) showed major differences, ranging from 0.7% to 50.6%.

The Ministry of Justice made a proposal for amendment concerning the ambiguity of enforcing the law in the autumn of 2000. In summer 2001, an amendment was passed on drug-user crime, in effect since 1 September 2001. The amendment defines ‘a user crime’, which makes it possible to impose a fine in the form of summary penal judgement for the use, possession or attempt to obtain drugs for personal consumption. This makes the abstract concept of obedience to the law redundant in this context, to be replaced by a more precise expression of the quantity, quality, situation or circumstances. The reform does not make the punishment more lenient, as a fine is already now imposed for these offences in a court of law.21

21 See Chapter 1.2.1.
On 27 July 2001, the Prosecutor-General and the Ministry of the Interior appointed a working group on drug-user crime to prepare implementation of new legislation on drug use (news release of the Office of the Prosecutor-General, 3 August 2001). The preliminary guidelines for implementation have stressed that: 1) As a rule, a person under 18 years of age, who was arrested for a drug-user crime for the first time, and his/her guardian must attend a hearing that aims at refraining from sanctions and cautioning; the meeting has representation from the police and social services as well. 2) The police should advise all drug-use suspects on seeking treatment, especially in case of problem users. 3) When the case involves adults who do not need treatment, sanctions should be waived in minor user offences at the first time – in other cases, a punishment can be imposed. It was also agreed that the reform should start cautiously, i.e. sanctions are always decided by the prosecutor, if the suspect is under 18 years of age, possibly in need of treatment or if a very dangerous substance is involved. (Jääskeläinen, P. 2002).

The working group’s intermediate report discusses the cases processed under the law since the end of 2001: 271 cases where prosecution was waived and 303 where sanctions were imposed. Preliminary observations suggest that the hearing and cautioning sessions among young people have been successfully launched. In addition, referral to care and waiving prosecution on the grounds of seeking treatment have increased considerably; however, only 20 such decisions were made during the period studied. The police and prosecutors did not have attitudinal problems with referral to care or waiving sanctions because of seeking treatment. The responses nevertheless pointed out the lack of treatment possibilities as an obstacle to these positive attitudes. (Jääskeläinen, P. 2002).

An inherent problem in the new legislation and its implementation is the fact that in police-initiated summary penal proceeding the suspect in effect loses the opportunity of the prosecutor’s waiving sanctions because in these issues the police investigation is too narrow for the prosecutor to weigh the criteria for refraining from sanctions and the decision to waive prosecution is in practice much harder to make than it is to impose sanctions. However, there are preliminary orders to exclude situations, where the legislators have intended that refraining from sanctions be considered, from police-initiated proceedings. The borderline between waiving sanctions and imposing a fine seems vague and therefore the Prosecutor-General should issue formal criteria for the concept of ‘negligible amounts’ of narcotic substances, although according to the principles of jurisdiction the question should be decided in a court of law. Nevertheless, variation in decisions made by different judges and district courts has been so wide that no uniform judicial practice can be perceived. Since the prosecutor must follow the practice of imposing sanctions adopted by the district court, it seems to be hard to achieve uniform prosecutorial practice in the absence of uniform court practice. (Jääskeläinen, P. 2002).
Based on the 1,300 decisions to waive prosecution or to impose sanctions compiled until the middle of the year 2002, 25 prosecutorial units (of 90 State Administrative Districts) had organised hearings for young offenders; in 13 units referrals to care were the reason for waiving prosecution and 41 units reported having met with the police as well as social and health service authorities in order to agree on practical referral to care. In addition, the material had 219 convictions for drug-user crime. Consequently, the judicial system is starting to have enough precedents to decide when to waive sanctions and how the amount and quality of narcotic substances affect the punishment. (Helminen, M. 2002)

The prosecutors were issued by the Office of the Prosecutor-General official directions for implementing legal sanctions for drug-user crime (VKS:2002:3) in September 2002. Compared to preliminary instructions, a novelty was the definition of ‘a negligible amount of drug’. In the guidelines, narcotic substances are divided into three categories depending on the sanctions (a sliding scale of day-fines in case of ordinary use and habitual use) when the user crime criteria are met. The punishable amounts also depend on the substance in question. The first category includes hashish (<10 g), marijuana (<15 g) and Khat (< 1 kg), with sanctions ranging from 5 to 15 day-fines in ordinary cases and 15–20 day-fines in habitual use. The second category comprises amphetamine (< 3 g), its derivatives, such as ecstasy (< 10 tablets) and LSD (< 10 tablets), with sanctions ranging 10–20 day-fines in ordinary cases and 20–25 day-fines in habitual use. The most severe category includes heroin (< 1 g) and cocaine (< 1.5 g), with sanctions ranging 10–25 day-fines in ordinary cases and 20–30 day-fines in habitual use. Pharmaceutical substances classified as narcotics are divided into three categories correspondingly. The amounts reflect the maximum limit under which the cases, if other legal criteria are met, can be processed in terms of summary penal proceedings.

1.4 Developments in public attitudes and debate

During the report period, public attitudes towards drugs were surveyed by the National Public Health Institute. The survey examined health behaviour in the adult population, including six questions on drugs. Three questions concerned opinions about drugs: problems related to narcotics, making a distinction between mild and hard drugs and the necessity of antidrug measures. (Jallinoja, P. et al. 2002)

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The survey material comprised a random sample of 5,000 people selected from 15-64-year-old Finns. A questionnaire was mailed to them in April, and subsequently three reminders for non-respondents. The response percentage was 70; 62% for men and 77% for women.
In spring 2001, 58 per cent of Finns reported drug use to be a very serious problem, while 32 per cent considered it a rather serious problem. The youngest age group differed clearly from the other respondents: 77 per cent of 15–24-year-olds considered drug use a rather serious or very serious problem, whereas in other age groups the percentage ranged between 89 and 97. Of the respondents, 88 per cent reportedly believed drug use to increase in the near future: in the youngest age group, 78 per cent considered that drug use will increase, while in other age groups the percentage was 90–92. In all, 37 per cent were of the opinion that a distinction should not be made between mild and hard drugs; here also the percentage rose with age. Another major factor was the respondent’s sex.
Differences between the sexes become apparent especially in opinions concerning the severity of the drug problem, with 64 per cent of women and 52 per cent of men regarding the drug problem as very serious. The difference between the sexes was most striking among the middle-aged (here, 25–44-year-olds). Differences emerged also in making a distinction between mild and hard drugs: 42 per cent of women and 32 per cent of men considered that such a distinction should not be made. Compared to the rest of the country, both the drug problem and increases in drug use were considered less severe in the Greater Helsinki Area. Thus, it seems that those who have the most contact with both drugs and drug users considered the drug problem along less severe lines. They were also more inclined to believe that drug use does not increase and to make a distinction between mild and hard drugs.

The survey also asked opinions about various societal actions to combat drug abuse. All suggested societal measures were clearly supported by the respondents. As many as 99 per cent were of the opinion that prevention among children and young people is a very or rather important aspect of antidrug work. The least supported item was severe punishments, but also they were considered by 86 per cent to be very or rather important in antidrug work. Again, the younger age group had more respondents who did not consider such activities important in antidrug work. Nevertheless, even in that age group, the clear majority regarded each action as very or rather important.

**Figure 3.**

**Percentages of respondents considering antidrug actions very important in 2001**

In terms of the actions, there were some differences between men and women as well. Women considered all actions more important than men did, especially drug treatment: 54 per cent of men and 69 per cent of women regarded treatment as highly important.
The weight given to the drug problem as a national concern is reflected in the number of written questions submitted by MPs to the Government. Of all 1,075 written questions submitted in 2000, 41 contained the word ‘narcotics’. In 2001, 76 of all 1,429 written questions discussed narcotic drugs. By the summer of 2002, there had been 24 such questions of a total of 668. After the report period of 2001, the proportions of these questions declined somewhat, with 47 questions of about 1,400 asked between the autumns of 2001 and 2002. Main ‘drug themes’ addressed in this context were drug treatment, prevention of the spread of infectious diseases, drug testing, prevention of drug use among young people, police resources, drugs in prison and other control measures.

These themes were associated with public debate on these issues, with budget process and with legislative reforms in progress. The drug treatment issue was tackled by a working group appointed by the Ministry of Social Affairs and Health. Submitted in summer 2001, the working group’s report proposed notable additional budget resources for developing drug treatment, as later implemented in the 2002 budget. In connection with this report, a new Decree on substitution and maintenance treatment was passed in 2002. Infectious diseases have been a much-debated question, especially because of the alarming HIV situation in St Petersburg, Russia, and Tallinn, Estonia. Drug tests in working life and schools were discussed especially in conjunction with the proposals made in the intermediate report of the related working group, issued in early autumn of 2001, and with the publication of its final report in spring 2002. Drug prevention was discussed from the viewpoint of substance abuse work done in school. The resources of the police and prosecutors were discussed in connection with the drug crime situation (e.g. the security barometer of the police 2001) and the 2001 supplementary budget and its follow-up. Drug situation in prison, treatment possibilities and after-care following release were discussed relatively often, and the Ministry of Justice published a working group report on the so-called contractual treatment. In terms of other control measures, themes related to driving under the influence of drugs, staffing at border stations, occupational safety at hospitals etc. were discussed. A Government proposal on driving under the influence of drugs was made public recently.

1.5 Budget and funding arrangements

The direct harm-related costs of drugs are calculated in terms of social and health services, crime control, damage to property as well as preventive work and research. The table below shows the harm-related costs of alcohol and drugs (narcotics and abuse of pharmaceuticals) in 1997, 1998 and 1999.

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23 See also Chapters 4.3 and 19; Yearbook of Alcohol and Drug Statistics 2001, 2002; Hein R. et. al., 2000b.
Table 1.
Costs of alcohol and drug related harm in Finland 1997, 1998 and 1999

<table>
<thead>
<tr>
<th>Harm-related costs</th>
<th>1997</th>
<th>1998</th>
<th>1999</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td>EUR million (FIM million, 1995 rate)</td>
<td>EUR million (FIM million, 1995 rate)</td>
<td>EUR million (FIM million, 1995 rate)</td>
</tr>
<tr>
<td>Direct costs</td>
<td>480-615 (2,860-3,650)</td>
<td>460-585 (2,750-3,480)</td>
<td>500 - 640 (2,965-3,811)</td>
</tr>
<tr>
<td>Health care and pensions</td>
<td>25.8%</td>
<td>17.7%</td>
<td>26.8%</td>
</tr>
<tr>
<td>Social services</td>
<td>19.4%</td>
<td>40.5%</td>
<td>17.7%</td>
</tr>
<tr>
<td>Criminal justice system</td>
<td>38.0%</td>
<td>28.7%</td>
<td>37.7%</td>
</tr>
<tr>
<td>Damage to property, prevention, supervision and research</td>
<td>16.8%</td>
<td>13.1%</td>
<td>17.8%</td>
</tr>
</tbody>
</table>

The public system of basic services is complemented by the project funding system for demand reduction. The Finnish Slot Machine Association grants financial support for the operating costs, investments, R&D and training expenses of social welfare and health care organisations, but not for service provision. The Government decides on the allocation of the appropriations based on proposals made by the Ministry of Social Affairs and Health. The Ministry also provides project funding for health promotion and reduction of intoxicant and tobacco use. For municipal projects, the financial proposals are prepared and projects are assessed by the National Research and Development Centre for Welfare and Health (STAKES) and for the projects of organisations, by the Finnish Centre for Health Promotion. In the Government Decision on drug policy 2000, the Government also decided to allocate supplementary budget funds worth EUR 5.5 (FIM 32.5) million to anti-drug work.

Financing continued in 2002, with EUR 7.5 million as supplementary appropriations granted by the Ministry of Social Affairs and Health for drug treatment, EUR 3.3 million additional funding from the Ministry of the Interior for combating serious drug crime, EUR 0.8 million additional funding from the Ministry of Education for drug prevention as part of youth work, EUR 0.7 million additional funding from the Ministry of Justice for developing antidrug work in prison and enforcement of punishments as well as an additional EUR 0.3 million for developing drug work in the Customs Administration.  

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24 See the action programme for intensifying drug policy for 2001–2003. Monitoring of programme implementation will be discussed in Chapters 8.1 (demand reduction) and 15.1 (supply reduction).
### Table 2.
**Special financing for alcohol and drug projects in Finland 1998 - 2001**

<table>
<thead>
<tr>
<th>Project funding system</th>
<th>1998</th>
<th>1999</th>
<th>2000</th>
<th>2001 (budget)</th>
<th>2002 (budget)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financing from the Slot Machine Association for temperance work and services for substance abusers (alcohol &amp; drugs)</td>
<td>9.6</td>
<td>11.3</td>
<td>12.7</td>
<td>14.3</td>
<td>15.2</td>
</tr>
<tr>
<td>Health promotion allocation to alcohol and drug prevention</td>
<td>1.3</td>
<td>1.9</td>
<td>1.9</td>
<td>1.9</td>
<td>2.5</td>
</tr>
<tr>
<td>Supplementary appropriation for implementing the Government Decision-in-Principle and action programme on drugs</td>
<td></td>
<td></td>
<td></td>
<td>5.5</td>
<td>18.4</td>
</tr>
<tr>
<td>Total</td>
<td>10.9</td>
<td>13.2</td>
<td>14.6</td>
<td>21.7</td>
<td>36.1</td>
</tr>
</tbody>
</table>
PART II  EPIDEMIOLOGICAL DRUG SITUATION

2  PREVALENCE, PATTERNS AND DEVELOPMENT OF DRUG USE

Since the early 1990s, an effort has been made to chart the experimental use and abuse of drugs in Finland through surveys among the population, targeted at conscripts and schoolchildren in particular. Unfortunately, these studies can cast only partial light on the drug situation: persons using hard drugs have severe problems disqualifying them from the Finnish Defence Forces or ordinary schools and hence also from the surveys. In addition, hard-drug users with severe addiction problems may not have a permanent address, a fact excluding them from general population surveys as well.

The prevalence of problem drug use in Finland has not been assessed earlier than in the late 1990s through statistical estimates of the number of problem users, i.e. users of amphetamine and opiates in Greater Helsinki and the entire country.\textsuperscript{25} The extent of problem drug use has traditionally been assessed indirectly through drug-related negative effects recorded by the societal service systems. For example, censuses have been carried out to assess the number of drug abusers in social and health services. By the end of the 1990s, first statistical investigations were completed concerning the treatment of problem drug users.

2.1 Main developments and emerging trends

Studies published during the year indicate that the growth trend in drug experiments, which prevailed throughout the 1990s, seems to be levelling off in the 2000s. This was suggested both by a population survey conducted in 2000 concerning drug use\textsuperscript{26} and preliminary information from the school health survey in 2001\textsuperscript{27} as well as by estimates of the prevalence of problem drug use\textsuperscript{28} Tentative reviews of these studies do not allow more accurate assessment of the reasons behind these changes or even speculation as to whether it is a question of a random phenomenon, a temporary downswing or something more permanent. This chapter discusses the studies based on which more detailed analyses can be made of the situation and related cultural changes.

Nevertheless, future trends in drug experiments and use can be estimated indirectly by examining how the environment socially exposes to drug use. In a review based on the school health survey, the criterion for social exposure to narcotic substances (hashish, thinner or other sniffed substances, intoxicating

\textsuperscript{25} See Appendix 3: The national drug information system.
\textsuperscript{26} For more information, see Chapter 2.2.1.
\textsuperscript{27} For more information, see Chapter 2.2.2.
\textsuperscript{28} For more information, see Chapter 2.2.3.
medicines or other such substances) was whether the subject knew a drug user and whether or not the subject him/herself had been offered drugs in Finland. In terms of drug supply, young people were asked to assess their peers’ possibilities to obtain drugs, such as marijuana or hashish, in their locality. Between 1996 and 2000, social exposure to narcotics clearly increased, and it has become easier to acquire drugs.29 (Luopa et. al. 2000)

Figure 4.
Social exposure to drugs and the ease of obtaining drugs (%) among 15–16-year-olds in 1996–2000

Contact with drug users among the adult population has been charted by the health behaviour surveys of the National Public Health Institute in 1996–2001 (Jallinoja, P. et al. 2002)20

Figure 5.
15–64-year-olds (%) who know a friend who has used drugs in last 12 months by age group and sex in 1996–2001

29 School health survey (15–16-year-olds) data in 1996 (26,287 8th and 9th-year students in secondary school), 1998 (26,747) and 2000 (26,375). The sample is based on voluntary participation of municipalities and municipal school units; the material includes all municipalities and municipal school units responding to all of the three surveys.
30 More information about the survey in Chapter 1.4.
The most recent population survey in 2000 did not contain questions about attitudes (Hakkarainen et al. 2001). Based on this study, it is also possible to assess social exposure to drugs in the same way as was done in the health behaviour survey above, i.e. whether the respondent knows a drug user personally. The percentage of those who knew a drug user was somewhat higher in the drug survey than in the health behaviour survey. This is partly attributable to the question asked: in the latter survey, the question concerned the past year. Nevertheless, the surveys were consistent in showing that as few as 20–25 per cent of the respondents reportedly knew a person who had used drugs. This means that the majority of Finns do not have a personal relationship with drugs and that in this respect drugs appear to be a relatively distant phenomenon in Finnish society, a discouraging factor that may slow the spread of drug experimenting. The situation is however different among those under 25 years of age, since according to both surveys, over half of them knew a drug user. The drug survey in 2000 suggested a decline in drug experimenting among those aged under 30, but this age group also seems to be the most susceptible to shifts in the opposite direction as well.

2.2 Drug use in the population

2.2.1 General population

Six population surveys were conducted in the 1990s to assess the prevalence of drug use in Finland; the most recent one was carried out in 2000. However, population surveys fail to reach all drug users, as some substances are not in widespread use. Therefore, survey results are referred to in terms of the most commonly used substances only, namely cannabis, pharmaceuticals and inhaled solvents. By definition, the latter two do not belong to actual narcotics. According to population surveys based on different sample sizes and approaches, the percentage of adults having experimented with cannabis has varied in the 1990s as follows:

---

31 More information about the survey in Chapter 2.2.
32 In 2000, the target group consisted of 15–69-year-olds, with a simplified random sampling of 2,500 people participating in the so-called drinking habit survey. The 1,932 people who agreed to take the interview received an additional (anonymous) questionnaire about narcotics, and a total of 1,789 responses qualified for analysis; the response percentage was thus 72. (Hakkarainen et al. 2001).
33 Drugs more problematic in terms of addiction potential are discussed in Chapter 2.3.
34 1992 (postal survey), targeted at 18-74-year-olds, sample 3,457 people (response percentage 71); Drinking habits 1992 (interview), 15-69-year-olds, sample 3,387 people (85%); 1993 (postal survey), 18-69-year-olds, sample 1,275 people (65%); 1996 (postal survey), 16-74-year-olds, sample 3,009 people (68%); Nordic drinking habits 1996 (telephone survey), 18-70-year-olds, sample 1,509 people (76%). (Partanen, J. et. al. 1997). The 1998 study was targeted at 15–69-year-old Finns, with samples of 3,250 people in a postal survey and 550 people in telephone interviews; the response percentages were 65.9 % and 77.2% respectively. (Partanen, J. et al. 1999)
Table 3.
Lifetime prevalence of (experimental) cannabis use according to surveys in 1992–2000

<table>
<thead>
<tr>
<th></th>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Men</td>
<td>6.0</td>
<td>5.8</td>
<td>9.8</td>
<td>8.3</td>
<td>9.7</td>
<td>12.1</td>
<td>11.7</td>
</tr>
<tr>
<td>Women</td>
<td>4.0</td>
<td>2.3</td>
<td>5.2</td>
<td>3.8</td>
<td>4.9</td>
<td>7.6</td>
<td>7.0</td>
</tr>
<tr>
<td>Aged 15/16 – 69/74</td>
<td>4.9</td>
<td>4.1</td>
<td></td>
<td></td>
<td>7.1</td>
<td>9.7</td>
<td>9.3</td>
</tr>
<tr>
<td>Aged 18-29</td>
<td>10.6</td>
<td>9.9</td>
<td>12.2</td>
<td>15.7</td>
<td>16.3</td>
<td>22.2</td>
<td>17.1</td>
</tr>
</tbody>
</table>

The 1998 population survey indicated that the supply and use of illegal drugs have clearly increased since 1992 (Partanen, J. et. al. 1999). However, in 2000 this increase seems – at least temporarily – to have stopped (Hakkarainen et. al 2001). Drug use and experiments mainly involved cannabis: 4.9 per cent of adults had tried or used cannabis in 1992, while in 1998 the proportion was 9.7 per cent, but in 2000 the percentage was 9.3. The change from 1998 to 2000 is not statistically significant, though, as it is partly attributable to differences in sampling, which also emerged when comparing the results of the two surveys carried out in 1992. Also on that occasion, a separate questionnaire (drinking habit study) in the interview resulted in lower figures than the postal survey, although responding was possible anonymously by post. Even given the different sampling methods, it is fair to assume that the growing trend in the 1990s has levelled off. The fact that experimenting with cannabis appears to be decreasing among the age groups that are most active in trying drugs suggests that these experiments have become less vigorous.

Table 4.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1992</td>
<td>6.2%</td>
<td>10.1%</td>
<td>10.3%</td>
<td>5.5%</td>
<td>3.6%</td>
<td>2.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>1998</td>
<td>15.7%</td>
<td>20.3%</td>
<td>22.7%</td>
<td>11.3%</td>
<td>11.4%</td>
<td>7.2%</td>
<td>1.4%</td>
</tr>
<tr>
<td>2000</td>
<td>12.5%</td>
<td>18.7%</td>
<td>17.1%</td>
<td>17.2%</td>
<td>9.6%</td>
<td>8.2%</td>
<td>2.6%</td>
</tr>
</tbody>
</table>

Studies in the population surveys of the 1990s have shown that experiments with cannabis are clearly more prevalent in the Greater Helsinki Area among young, unmarried/single and educated people. However the 1998 results indicated that experimenting with cannabis has spread more evenly across the social strata and that the relative differences between the groups have diminished somewhat (Partanen, J. et. al. 1999).
Results from the year 2000 seem to support this trend further. All studies make it clear that cannabis experiments are closely associated with an urban way of life, characterised by heavy alcohol use (Hakkarainen et al 2001).

Compared to lifetime prevalence, a more accurate indicator is drug use in last 12 months. Based on the 1998 study, 3.0 per cent of men and 2.3 per cent of women had used or experimented with cannabis during the past year, and 1.2 per cent of men and 0.7 per cent of women had done so during the past month. When the number of regular drug users has been estimated in Finland, the maximum threshold value is considered to be the number of people who have used cannabis during the past month, i.e. one per cent of the adult population. In the 2000 survey, the corresponding figures of past year cannabis experiments were 2.8 and 1.3 per cent for men and women respectively, and during the past month 1.0 and 0.4 per cent for men and women respectively.

Table 5.
Cannabis use in last 12 months by age group in 1992–2000

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1992</td>
<td>4.7% (18-24)</td>
<td>2.0%</td>
<td>0.3%</td>
<td>0.2%</td>
<td>0.0%</td>
</tr>
<tr>
<td>1996</td>
<td>8.1% (16-24)</td>
<td>2.4%</td>
<td>0.6%</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>1998</td>
<td>9.5%</td>
<td>2.9%</td>
<td>0.6%</td>
<td>0.2%</td>
<td>0.0%</td>
</tr>
<tr>
<td>- in last month</td>
<td>2.8%</td>
<td>1.5%</td>
<td>0.2%</td>
<td>0.2%</td>
<td>0.0%</td>
</tr>
<tr>
<td>2000</td>
<td>6.7%</td>
<td>3.3%</td>
<td>1.4%</td>
<td>0.0%</td>
<td>0.3%</td>
</tr>
<tr>
<td>- in last month</td>
<td>1.6%</td>
<td>1.2%</td>
<td>0.6%</td>
<td>0.0%</td>
<td>0.3%</td>
</tr>
</tbody>
</table>

It can be concluded from Table 5 above that at least two out of three of those under 25 having experimented with cannabis do not belong to the ‘regular users of cannabis,’ the minimum criterion being, as stated above, the use of cannabis during the past month. However, in older age groups the proportion of ‘regular users’ is higher.
### Table 6.
Cannabis experiments and use, prevalence during lifetime and in last 12 months by province (percentage of 15–69-year-olds) in 2000

<table>
<thead>
<tr>
<th>Province</th>
<th>Lifetime use</th>
<th>Prevalence of use, 95-% confidence interval</th>
<th>Use in last 12 months</th>
<th>Prevalence of use, 95-% confidence interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>Entire country</td>
<td>9.3</td>
<td>7.9–10.7</td>
<td>2.0</td>
<td>1.4–2.7</td>
</tr>
<tr>
<td>Southern Finland</td>
<td>13.0</td>
<td>10.3–15.6</td>
<td>2.5</td>
<td>1.3–3.7</td>
</tr>
<tr>
<td>Western Finland</td>
<td>9.2</td>
<td>6.9–11.5</td>
<td>2.3</td>
<td>1.1–3.5</td>
</tr>
<tr>
<td>Eastern Finland</td>
<td>2.9</td>
<td>0.8–5.1</td>
<td>0.3</td>
<td>0.0–0.9</td>
</tr>
<tr>
<td>Province of Oulu</td>
<td>4.4</td>
<td>1.2–7.7</td>
<td>2.0</td>
<td>0.0–4.2</td>
</tr>
<tr>
<td>Province of Lapland</td>
<td>5.6</td>
<td>2.2–10.9</td>
<td>0.0</td>
<td>–</td>
</tr>
</tbody>
</table>

Regionally, drug use and experiments clearly appear to be most prevalent in the Provinces of Southern and Western Finland. Elsewhere, drug experimenting seems to be evenly distributed. However, there is a great deal of ambiguity in the figures, especially as regards the Provinces of Eastern Finland, Oulu and Lapland. Based on lifetime experiments, it would appear that between 1998 and 2000 experiments declined in the Greater Helsinki Area, whereas elsewhere in Southern Finland they increased somewhat. Nevertheless, not even this finding is statistically significant. Elsewhere in the country, the changes are relatively small (Hakkarainen et. al. 2001), one possible explanation being that in Greater Helsinki and among the most active experimenters, a saturation point has been reached in Finnish drug culture as regards the prevalence of these experiments.

According to the 2000 (1998) survey, 5.6 (5.0) per cent of men and 3.5 (4.5) per cent of women had used sedatives or tranquillisers for intoxication purposes during lifetime, whereas in 1992 the equivalent percentages were 2.9 for men and 2.3 for women. Based on 2000 (1998) information, 2.6 (2.7) per cent of men and 1.1 (1.3) per cent of women had inhaled solvents for intoxication purposes during lifetime, while the 1992 data showed that 1.0 per cent of men and 0.2 per cent of women had done so. The 2000 survey indicated that 1.5 per cent had used sedatives or tranquillisers and 0.3 per cent had used solvents for intoxication purposes during the past year.

#### 2.2.2 Young people and schoolchildren

In terms of drug use, young people have traditionally been considered a risk group at which most of the surveys are directed. The longest time series in the Finnish youth studies consists of the conscript studies,

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36 For more detailed information, see http://www.emcdda.org/publications/publications_annrepstat_00.shtml.
conducted at a few years’ interval since 1968. In 2000, an effort was made to enhance the comparability of the time series by only including studies on conscripts who had commenced their service in the Defence Forces (Jormanainen 2000). The comparability is nevertheless hampered by variation in the annual sample sizes (400–2,000 people). According to preliminary information, the percentage showing lifetime drug experiments and use has stabilised at about 20 per cent. This trend is consistent with the results concerning young adults in the 2000 population drug survey.

Figure 6. Conscripts (%) having experimented with drugs in lifetime, 1968–2000

A small-scale study conducted in 1999 for the first time examined the so-called recreational use of drugs, which especially takes place at clubs or one-off parties or raves (Seppälä 1999 and 2000). According to the researcher, the most obvious differences within recreational drug cultures and the related substance use in Finland are to be found between the users of so-called stimulants and psychedelic substances.

Members of a club culture seek an escape from everyday routines and from the dull and grey mainstream. The main drugs used are stimulants (amphetamines, cocaine and ecstasy) which give rise to self-assertion, euphoria, sociability, heightened energy, efficiency as well as feelings of empathy and love. Cocaine, which, according to this material, is increasingly more prevalent within this subculture of post-modern groups, is a yuppie drug symbolising wealth, whereas the more ordinary and cheaper amphetamine is dubbed “a poor man’s cocaine.”

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37 The study is based on observation, interviews and a questionnaire on the Internet. The latter resulted in about 100 responses. The purpose of the study was to examine the meaning of drugs for members of a given subculture and the relevance of this phenomenon today – not substance abuse as a ‘problem.’

38 Even if drug use cultures differ and include several substances, it is unclear if these substances are mixed or is it perhaps so that different persons just use different substances inside the culture.
Participants in psychedelic and technocultures try to penetrate the post-modern surface of the stimulant-related subculture in order to transcend to a ‘level of consciousness’ free from concepts other than instinct and intuition. Preferred substances include LSD, mescaline, psilocybin fungi and, to some degree, also cannabis. Technoculture provides just one way of using psychedelic substances for this group of people, which can be divided roughly into two: people who are mainly interested in psychedelic experiences and persons interested in partying. The former include e.g. ‘computer nerds,’ who also share an interest in technology and curiosity about the functioning of their own brain. The latter psychedelic group comprises people who organise forest parties; the link between man and nature is important to them.

Nationally, the most representative studies on schoolchildren are the 1995 and 1999 ESPAD surveys. (The ESPAD Reports 1995 and 1999) They showed no great variation between the sexes in drug experimenting among 15-year-olds. The 1995 survey found that five per cent of the respondents had experimented with marijuana or hashish once, while one per cent had done so during the past month. In 1999, the corresponding figures were 10 per cent during lifetime and 2 per cent during the past month. (Ahlström et al. 1999) About one per cent had experimented with other drugs in 1995, while in 1999 about 2 per cent had done so, with smoked heroin as a new substance emerging, especially among young girls (about 1 per cent of the population).

Figure 7.
8th and 9th-year secondary school students (%) having tried illicit drugs by number of experiments in 1996–2000

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39 The ESPAD survey concerned 15–16-year-olds, the random sample was specific to school class, 121 classes with 2,161 students participating in 1995 and 177 classes with 3,109 students in 1999. The researchers estimated that only about 5 per cent of the cohort remained outside the sample and that the response percentages were high, 94% (1995) and 90% (1999).

40 Results in detail at http://annualreport.emcdda.org/en/sources/index.html
The estimates in the school health surveys in 1996–2000 support the findings of the ESPAD survey (Luopa P. et al. 2000) above. In the school health survey, differences between the sexes concerning illegal drugs were not significant, except in those having tried substances over five times: in this group, boys had clearly higher percentages. The most recent extensive school health survey conducted in Western and Northern Finland (excluding Lapland) would suggest that the growth in drug experimenting among 14–16-year-olds levelled off between 1999 and 2001 (Lintonen 2001), a finding that supports the results from surveys among the general population and conscripts.

From a statistical viewpoint, there were no significant chronological differences in intoxicants use (other than narcotics) among young people. According to the ESPAD survey, 5 per cent had occasionally used sleeping pills or sedatives without prescription in 1995 (6% in 1999); four per cent had sniffed substances (glue, etc.) in 1995 (5% in 1999). On the other hand, the percentage of those mixing pills with alcohol had dropped from 18 per cent (1995) to 13 per cent (1999).

Figure 8.
8th and 9th-year secondary school students (%) having tried intoxicants by number of experiments in 1996–200042

---

41 Information about sampling in the school health survey in Footnote 29. Table is age and school class adjusted.
42 Information about sampling in the school health survey in Footnote 29. Table is age and school class adjusted.
The school health surveys also showed relatively small changes between 1996 and 2000 in terms of sniffing and abuse of medicines, and also mixing alcohol with pills was almost on the same level in 2000 as in 1996.

### 2.3 Problem drug use

In 1997, the first Finnish statistical assessment was made concerning the prevalence of hard-drug abuse in Greater Helsinki; the study was made by capture-recapture method and later expanded to cover the entire country. The material was collected from the 1995 hospital discharge register, the criminal report register and the database of persons suspected of driving under the influence of drugs (Partanen, P. 1997). The 1997 data were separately processed for Greater Helsinki and the entire country, and the estimate for the entire country was also based on information from the three registers (Partanen, P. et al 1999). When the 1998 drug situation was estimated, the information sources were supplemented by one: data from the register of infectious diseases concerning hepatitis C cases due to intravenous drug use during the year. These data were processed in terms of Greater Helsinki, entire Finland and by province (Partanen, P. et al. 2000). A corresponding assessment was made concerning the year 1999 (Partanen, P. et al. 2001).

Statistical assessment suggests that drug use increased in the Greater Helsinki area considerably between 1995 and 1997, but it has remained more or less unchanged thereafter. In addition, estimates of amphetamine and opiate users have remained on the same level since 1997. A clear change between 1997 and 1999 is the smaller confidence interval, which means that the accuracy of the estimates has improved year by year.

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43 The method is based on statistical capture-recapture, based on overlapping cases in (mutually independent) samples, enabling the statistical assessment of the size of the entire target population. The samples are defined based on the interventions directed by the community at the target population (amphetamine and opiate users). The interventions included hospital treatment for amphetamine or opiate diagnoses, penal action for use or possession of amphetamines or opiates and arrest for driving in road traffic under the influence of amphetamines or opiates.
Table 7.
Prevalence of amphetamine and opiate use (%) in Greater Helsinki and in Finland in 1998 and 1999

<table>
<thead>
<tr>
<th></th>
<th>Greater Helsinki</th>
<th>Whole of Finland</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall estimate</td>
<td>0.7-1.0</td>
<td>0.7-0.9</td>
</tr>
<tr>
<td>Men</td>
<td>1.1-1.5</td>
<td>1.1-1.5</td>
</tr>
<tr>
<td>Women</td>
<td>0.3-0.7</td>
<td>0.3-0.5</td>
</tr>
<tr>
<td>15–25-year-olds</td>
<td>1.0-1.7</td>
<td>1.1-1.6</td>
</tr>
<tr>
<td>26–35-year-olds</td>
<td>0.9-1.5</td>
<td>0.8-1.2</td>
</tr>
<tr>
<td>36–55-year-olds</td>
<td>0.4-1.0</td>
<td>0.5-1.1</td>
</tr>
<tr>
<td>Amphetamine users*</td>
<td>0.5-1.1</td>
<td>0.4-0.9</td>
</tr>
<tr>
<td>Opiate users*</td>
<td>0.2-0.3</td>
<td>0.2-0.3</td>
</tr>
</tbody>
</table>

* = Estimates are based on data from three registers

In 1999, Finland had an estimated 11,000–14,000 users of amphetamines or opiates, of whom 4,100–5,400 lived in Greater Helsinki. Amphetamine users accounted for 70–80 per cent of hard-drug users. It was estimated that some 20–25 per cent of them were women. Those aged 25 and under were estimated to account for 40–50 per cent of the users in the entire country, but for clearly less, closer to 40 per cent, in Greater Helsinki. The year 1999 was the second time when hard-drug use was regionally assessed.

Table 8.
Prevalence of amphetamine and opiate use (%) in population aged 15–55 years by region in 1999

<table>
<thead>
<tr>
<th></th>
<th>Total</th>
<th>Men</th>
<th>Women</th>
<th>15-25- yo</th>
<th>26-35- yo</th>
<th>36-55- yo</th>
<th>Amphetamines*</th>
<th>Opiates*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Finland</td>
<td>0.4-0.5</td>
<td>0.5-0.7</td>
<td>0.1-0.2</td>
<td>0.7-1.0</td>
<td>0.5-0.6</td>
<td>0.2-0.5</td>
<td>0.3-0.4</td>
<td>About 0.1</td>
</tr>
<tr>
<td>Greater Helsinki</td>
<td>0.7-0.9</td>
<td>1.1-1.5</td>
<td>0.3-0.5</td>
<td>1.1-1.6</td>
<td>0.8-1.2</td>
<td>0.5-1.1</td>
<td>0.4-0.9</td>
<td>0.2-0.3</td>
</tr>
<tr>
<td>Southern Finland</td>
<td>0.6-0.7</td>
<td>0.9-1.1</td>
<td>0.2-0.3</td>
<td>1.0-1.4</td>
<td>0.7-0.9</td>
<td>0.3-0.5</td>
<td>0.4-0.7</td>
<td>0.1-0.2</td>
</tr>
<tr>
<td>Western Finland</td>
<td>0.2-0.3</td>
<td>0.4-0.5</td>
<td>About 0.1</td>
<td>0.4-0.6</td>
<td>0.3-0.6</td>
<td>0.1-0.2</td>
<td>0.2-0.5</td>
<td>About 0.1</td>
</tr>
<tr>
<td>Eastern and Northern Finland</td>
<td>0.3-0.5</td>
<td>0.4-0.7</td>
<td>0.1-0.3</td>
<td>0.5-0.8</td>
<td>0.4-1.0</td>
<td>0.1-0.5</td>
<td>0.1-0.4</td>
<td>0.1-0.4</td>
</tr>
</tbody>
</table>

The estimated intervals are based on 95-% confidence intervals. Time series are based on the results of three registers, otherwise results are based on four-register information. The sum of estimates differs from the overall estimate because different log-linear models were applied to the combined and separate materials. Partanen, P. et al. 1999.

The estimate is based on combined data from four registers. Combination of three registers gives an estimated 10,500–13,400 users in the entire country and 3,900–5,700 in Greater Helsinki.
In regional data, Eastern and Northern Finland were combined to minimise the inaccuracy of confidence intervals of user estimates and especially in terms of certain variables (sex, substance, age group).

Estimates can be interpreted in the light of trends in the prevalence of cannabis use and of cannabis experiments in last 12 months. One possible interpretation is that amphetamines and opiates have spread from Greater Helsinki to the rest of the country after cannabis has done so, which means that in the future, the highest growth figures possibly occur in the provinces where use has earlier been the lowest.

Comparisons between major European cities usually concentrate on the number of opiate (heroin) or injecting drug users, and the user figures tend to be around one per cent. In this comparison, the Greater Helsinki Area figures (0.2 – 0.3 per cent) are very low indeed. However, the situation in Helsinki is not as good as suggested by this comparison. Unlike the rest of the European Union (Sweden excluded), it is amphetamine rather than heroin that is the main problem drug in Finland. Because amphetamine is often injected in Finland, amphetamine users too could be included in the European comparison of problem drug users. In this case, the number of problem users in Greater Helsinki has already reached the level of the major European cities.

The estimates of problem-user numbers are especially relevant to treatment need assessment. The Finnish figures are based on estimates of hard-drug users on the one hand, and on the above estimate of regular drug (cannabis) users, which was derived from the prevalence of experimenting with cannabis during the previous month. This estimate suggests that Finland has 11,000–14,000 problem users of narcotics; the maximum estimate could even be as high as 25,000–30,000 based on the figures for regular cannabis use.

Internationally, the most widely used indicator of problem drug use is the prevalence of injecting drug use and other related risk behaviour. Having operated in Helsinki for four years, the infection counselling centre Vinkki is a place where used hypodermic needles can be exchanged for new ones. By the end of 2001, almost twenty municipalities had such a centre. In 2000, the centres in ten municipalities were visited by over 4,500 injecting drug users.\textsuperscript{46} Given this figure, the estimate of the number of problem drug users seems quite accurate because in international comparisons, estimates are usually 2–3 times higher than the observed cases on which they are based.\textsuperscript{47}

\textsuperscript{46} The estimate is based on the total number of clients at health counselling centres, i.e. possible overlap is not excluded. Estimate is counted on the basis of evaluation reports on basic services by the State Provincial Offices of Southern and Western Finland (Peruspalvelut Suomen läänissä 2000). It must be noted that many centres did not open until the autumn of 2000, which means that the figures do not reflect actual client numbers accurately. See also Chapters 3.3 and 10.1 below.

\textsuperscript{47} See http://www.emcdda.org/multimedia/project_reports/situation/study_local_pdu_report.pdf
3 HEALTH CONSEQUENCES

3.1 Drug treatment demand

In 1996 and 1998–2001, pilot studies on data collection concerning drug treatment demand were conducted in Finland, based on the European Pompidou model and on the TDI (Treatment Demand Indicator) protocol of the EMCDDA. The studies monitored the problem use of narcotics and pharmaceuticals (with or without alcohol) among clients in treatment services for substance abusers.\(^{48}\) In addition to specialised services for substance abusers (A-Clinics, youth centres, detoxification and rehabilitation clinics, outpatient and inpatient units specialising in drug treatment), the drug treatment surveys included psychiatric units and prison health care units.\(^{49}\) The number of units and amount of data received have varied over the years. The bulk of the material comes from outpatient units (62% in 2001) and from the Province of Southern Finland (70% in 2001).

The studies disregarded persons who primarily abused alcohol but who had no specific problems with drugs or other non-alcoholic substances. According to the 1999 census of intoxicant-related cases in social and health services, people primarily treated for alcohol problems accounted for about two thirds of outpatient clients in services for substance abusers and little over half of the clients receiving residential treatment for substance abusers (Virtanen 2000). Of the clients (n=5,189) in the drug treatment data compilation in 2001, 18 per cent were first-time clients, 47 per cent were ‘old’ clients receiving a new treatment period, while 13 per cent were ‘old’ clients continuing a treatment period started the year before; for the remaining clients, no information about the possible previous treatment or its commencement was available.

Table 9
Coverage of drug treatment data compilation in 1996–2001

<table>
<thead>
<tr>
<th></th>
<th>Treatment units</th>
<th>Period of data compilation (months)</th>
<th>Questionnaires returned</th>
<th>Data on individual clients</th>
</tr>
</thead>
<tbody>
<tr>
<td>1996</td>
<td>43</td>
<td>2.5</td>
<td>1,332</td>
<td>no information</td>
</tr>
<tr>
<td>1998</td>
<td>63</td>
<td>2.5–7.5</td>
<td>2,862</td>
<td>no information</td>
</tr>
<tr>
<td>1999</td>
<td>84</td>
<td>3.0</td>
<td>1,774</td>
<td>no information</td>
</tr>
<tr>
<td>2000</td>
<td>113</td>
<td>12</td>
<td>5,685</td>
<td>4,709</td>
</tr>
</tbody>
</table>


\(^{49}\) In 2001, 140 units participated in the data compilation: of them, 67 were outpatient units (62% of the clients), of which 44 were A-Clinics (24.2% of the clients), 12 youth centres (13.7% of the clients), 7 units specialising in drug treatment (21.6% of the clients) and 2 addiction psychiatry units in hospital (1.4% of the clients); while 73 provided inpatient care (38% of the clients), of them 11 were detoxification clinics (9.5% of the clients), 28 institutional rehabilitation units (14.3% of the clients), 28 addiction psychiatry units in hospital (7.1% of the clients), 7 inpatient units specialising in drug treatment (5.6% of the clients) and 2 prison health care units (0.8% of the clients).
As far as demand for drug treatment in 1998–2001 is concerned, the greatest change would appear to be an increase in demand for treatment because of opiates as the primary drug, while the proportion of amphetamines as the primary drug has declined.

Table 10.
Substances used by clients in treatment for substance abuse in 1998–2001

<table>
<thead>
<tr>
<th>Substance category</th>
<th>1st substance abused</th>
<th>1st – 3rd substance abused</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol (with drug)</td>
<td>19</td>
<td>17</td>
</tr>
<tr>
<td>Cannabis</td>
<td>17</td>
<td>16</td>
</tr>
<tr>
<td>Stimulants</td>
<td>35</td>
<td>33</td>
</tr>
<tr>
<td>Medicines</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>Opiates</td>
<td>21</td>
<td>25</td>
</tr>
<tr>
<td>No information</td>
<td>3</td>
<td>3</td>
</tr>
</tbody>
</table>

Of the primary substances abused by the clients participating in the 2001 compilation, amphetamine accounted for 92 per cent of all stimulants, while ecstasy accounted for four per cent. However, when five substances abused were included, it transpired that ecstasy had been used by 11 per cent of the clients, cocaine by 2 per cent and LSD by 2 per cent. Of the primarily used opiates, the proportion of heroin had strongly decreased and accounted for about 46 per cent where as the proportion of buprenorphine had strongly increased and already accounted for 43 per cent. Daily use was most common among users of medicines (68%) and opiates (52%), while occasional use (2–6 times a week) was the most common among polydrug users of alcohol and drugs (44%) as well as users of cannabis (37%) and stimulants (37%). According to information on the year 2001, 84 per cent of the opiate users and 76 per cent of the amphetamine users mainly used substances by injection. However, 40–50 per cent of those seeking treatment for the use of cannabis, tranquillisers, alcohol or polydrug use had also injected substances at some point in their life - half of them during the past month.

While opiates had by 2001 become the primary substance in terms of reasons for seeking treatment, among first-time treatment demands the primary substance was not an opiate but cannabis (33%), and stimulants (23%), opiates (17%) or an alcohol problem (22%) related to drugs were also common. Injecting opiates or stimulants was somewhat rarer among those

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50 The EMCDDA compiles drug treatment information based on the Treatment Demand Indicator (TDI) criteria, which differ from the figures given here because the TDI protocol does not collect information about clients who seek treatment primarily for alcohol use nor about clients who have initiated their treatment prior to the year examined even though the treatment continues. Figures that are compatible with the EMCDDA criteria are presented in Appendix 6. See also http://www.emcdda.org/situation/themes/demandTreatment.shtml
seeking treatment for the first time: a quarter used opiates by smoking and a third used stimulants orally or by sniffing. However, polydrug use is typical of Finnish drug use. Over half of the clients reported having used at least three different substances (Partanen A. 2000a, 2001, 2002).

Table 11.
Polydrug use among clients in treatment for substance abuse in 2000 and 2001

<table>
<thead>
<tr>
<th>1st substance</th>
<th>Concurrent use of 2nd and 3rd substance with primary substance (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Opiate</td>
</tr>
<tr>
<td>----------------</td>
<td>-------</td>
</tr>
<tr>
<td>Opiate</td>
<td>25</td>
</tr>
<tr>
<td>Stimulant</td>
<td>22</td>
</tr>
<tr>
<td>Cannabis</td>
<td>10</td>
</tr>
<tr>
<td>Medicines</td>
<td>17</td>
</tr>
<tr>
<td>Alcohol</td>
<td>5</td>
</tr>
</tbody>
</table>

Three different user profiles among persons seeking drug treatment emerge from this material throughout the 1990s: i) Opiate users, who also indulge in other narcotics, but mostly abstain from alcohol and medicines; ii) Stimulant and cannabis users, who also consume much alcohol; iii) Polydrug users of alcohol and medicines, who also use cannabis. The shift in drug user profiles in the early 2000s suggests that the profiles are about to intermix and that the role of cannabis and alcohol is becoming less important among persons seeking treatment. Furthermore, abusers of medicines tend to use less alcohol as an additional substance, and medicines are increasingly often used with opiates (especially buprenorphine).

Figure 9.
Abusers of narcotics and medicines by age group (%) in treatment for substance abuse in 1998–2001
About half of the clients in 1998–2001 were aged 20–29 years, while a fifth were under 20. The youngest clientele was to be found in inpatient units specialising in drug treatment (mean age 23.3 years); clients in outpatient units specialising in drug treatment were almost as young, two years older in outpatient services for substance abusers and four years older in inpatient services for substance abusers. The oldest clients were in prison health care units (mean age 28.9 years). The clients’ mean age varies also depending on the primary substance used.

Table 12.
Mean age (years) of clients in treatment for substance abuse in 1998–2001

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>all</td>
<td>26.6</td>
<td>26.1</td>
<td>25.9</td>
<td>26.0</td>
</tr>
<tr>
<td></td>
<td>first treatment</td>
<td>first treatment</td>
<td>first treatment</td>
<td>first treatment</td>
</tr>
<tr>
<td>Opiates</td>
<td>26.6</td>
<td>25.1</td>
<td>24.6</td>
<td>24.1</td>
</tr>
<tr>
<td>Amphetamines</td>
<td>26.7</td>
<td>25.2</td>
<td>24.9</td>
<td>24.8</td>
</tr>
<tr>
<td>Cannabis</td>
<td>21.7</td>
<td>19.9</td>
<td>22.5</td>
<td>20.0</td>
</tr>
<tr>
<td>Alcohol</td>
<td>30.2</td>
<td>25.5</td>
<td>28.9</td>
<td>25.0</td>
</tr>
</tbody>
</table>

The slight differences in the client age distributions between the past four years probably result from the changes in the treatment unit samples studied: there was a relative decline in the number of clients in specialised drug treatment units, because a growing number of traditional substance abuse outpatient clinics were included in the data collection.

It was also possible to examine the chain of substance use among first-time treatment clients, starting from initial experiments through regular use to a situation where the person finds it necessary to seek treatment. As regards cannabis, use on average starts at the age of 15.7 years, followed by regular use
about two years later, and another two years has elapsed when treatment is sought, on average at the age of 20.7 years. Stimulant users typically start at the age of 19.4 years, followed by regular use for two years and needing treatment after 2.5 years, on average at the age of 23.8 years. In terms of opiates, use starts on average at the age of 20.3 years, followed by regular use after about 1.5 years and treatment demand after 2.5 years, on average at the age of 24.5. In terms of polydrug use of alcohol and drugs, the ages were 13.6 years for starting the use, changing over to regular use at 18.2 years and entering treatment for the first time at the age of 25.5 years.

According to the 2001 data, women accounted for 27 per cent of the clients. Three out of four of the clients were unmarried, while one out of six cohabited or were married. Of the latter group, half were living in the same household with another substance abuser – most commonly a drug user. Only a quarter of problem users had children aged under 18, and a quarter of such children lived in the same household. Almost 60 per cent of the clients were unemployed. A tenth of the clients worked, almost a fifth were students and 5 per cent were retired. Two-thirds had primary education, one fourth had intermediate education and two per cent had an academic degree. One tenth had not finished secondary school. Almost a tenth of the clients were homeless.

Compared to the situation a year ago, homelessness among drug clients receiving services for substance abusers has declined somewhat and their educational level has risen. The one-day census of substance abuse clients in all social welfare and health care units also showed (Hakkarainen et. al. 2000) that problem drug users were even more excluded than other substance abusers: half of them were unemployed (other substance abusers: a third) and a fifth of them were homeless (other substance abusers: less than 10 per cent). Compared with the drug treatment data compilation, the difference is sizeable in terms of homelessness but partly attributable to differences in sampling: the one-day census involved proportionally more drug clients at inpatient clinics (services for substance abusers and psychiatric units), where the homeless accounted for over 20 per cent of the clients, whereas most of the clientele in the drug data compilation came from outpatient care.

The 1999 census above also showed that almost 20 per cent of all clients in outpatient treatment services for substance abusers (A-Clinics and youth clinics) and 30 per cent of the clients in institutional treatment services (detoxification and rehabilitation) engaged in problem drug use as well (Metso et. al. 2000).51 It was then estimated that 10,500–13,500 people visit social welfare and health care units annually on account of narcotics use. The proportion of clients in specialised services for abuse of medicines was a couple of percentage points higher than that of narcotics clients. Based on the census above, it was estimated that in social and health services, polydrug users numbered annually 23,000–30,000 and

51 The percentages are associated with the use of cannabis, amphetamines, opiates or other illegal drugs. The figures do not tell whether the substance constitutes the client’s main drug use problem, i.e. whether it is the primary drug used.
abusers of medicines 15,000–20,000. On the other hand, Two-thirds of outpatient treatment clients and over half of residential treatment clients used services for substance abusers for alcohol use only. (Hakkarainen et al. 2000).

3.2 Drug-related mortality

Definitions of drug-related deaths vary in different countries. In Finland, deaths can be viewed from two perspectives: by investigating the cause-of-death statistics or by assessing sudden and unexpected deaths based on forensic chemical analyses. The latter approach has given a more substance-specific picture of drug-induced deaths in Finland.

By law, a coroner’s forensic examination must be carried out if death has been unexpected or sudden (e.g. homicide, misadventure, suicide, poisoning, occupational disease, medical procedure, etc). In 2000, about 10,000 forensic autopsies were performed, of which every second case led to further chemical forensic analyses. The verdict of death by poisoning was given in over 1,100 cases. Of these, 550 involved pharmaceuticals, with neuroleptics and antidepressants as the dominant substances in terms of primary findings, followed by opioids as the third main substance. In 2000, for the first time morphine, which in most cases stemmed from heroin, became the most common single drug finding. Some 450 people died of alcohol poisoning in 2000, and in 46 cases due to methanol poisoning (Vuori et. al. 1999, 2001; Vuori 2000b, 2002)

Figure 10.
Forensic findings of narcotic drugs in autopsies in 1990-2001

* = Preliminary information

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52 It should be noted that the estimates do not eliminate possible overlap.
53 Department of Forensic Medicine at the University of Helsinki (In 1994, 1996, 1999 and 2000 also one cocaine finding).
There is however some ambiguity as to the definition of drug-related deaths based on forensic chemical findings. Figures based on chemical findings give maximum estimate for the number of drug-related deaths. When defined in terms of the primary cause of death, these substances were evident in deaths by poisoning, but in terms of findings associated with deaths, the findings can be included only in the information of significant conditions which unfavourably influenced the morbid process and thus contributed to the fatal outcome. Examples of such cases include various accidents, suicides due to reasons other than poisoning and homicide, where the substance did not directly cause the death. Previously, poisoning has been the primary cause of death in half of the substance findings. As heroin deaths are becoming more common, the situation has changed, so that in 2000 two thirds of the cases classified as drug-related deaths based on forensic chemical analyses were categorised as deaths by poisoning in terms of the cause of death as well – including both self-inflicted and accidental poisonings.

Figure 11.
Drug deaths by age group based on causes of death\(^{54}\) or on forensic chemical findings in 2000

Between 1996 and 2000 there was an increase in sudden deaths linked to heroin use (due to overdose). In 1995, only one such case was found in Finland, but the situation started to change in 1996, with 9 cases detected, followed by 15 cases in 1997, 27 cases in 1998, 50 in 1999, and in 2000 there were 60 heroin

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\(^{54}\) Death figures given to the EMCDDA for international comparison are according to the protocols resulting from the EMCDDA’s harmonisation work on cause of death registers. Minimum figures include diagnoses for diseases, accidental poisoning and poisoning with indetermined intent limited to narcotics (excluding polysubstance diagnoses). EMCDDA has defined drug deaths by using B-filter of the harmonisation. See [http://www.emcdda.org/situation/themes/death_mortality.shtml](http://www.emcdda.org/situation/themes/death_mortality.shtml)
deaths. However, in 2001 the number of heroin deaths declined sharply, with 30 cases reported according to preliminary information. This positive trend has continued in 2002, with no deaths due to heroin poisoning reported during the first half of the year. The number of buprenorphine findings, on the other hand, has mounted: in 2001, five people died of poisoning with buprenorphine as the primary finding, whereas previously there were only 1–2 such cases per year. In 2000 and 2001, a total of four young people died as a result of the combined effects of ecstasy and an antidepressant called moclobemide. Deaths involve increasingly often young people: of the heroin deaths in 2000, 40 per cent concerned people under the age of 25, and 69 per cent were under 30.

In 2001, a study was published on the drug-related deaths defined by findings in autopsies in 1990–1996 (Vuori et al. 2001b), indicating that at the beginning of the 1990s, almost 90 per cent of the drug findings involved men. Half of the deceased were under 30 years of age, and 57 per cent had used opioids, 47 per cent cannabis and 27 per cent amphetamines. Alcohol was present in 42 per cent of the deceased. Over a third died of suicide and almost half by accident. About 45 per cent involved deaths by poisoning, and almost 10 per cent involved homicide. Violent deaths were often associated with alcohol along with a narcotics finding. The scene of death was usually home (44%) or outdoors (22%). Almost half died when alone (48%), while a third died in the presence of friends or acquaintances. The drug cases involved an above-average number of young retirees, clerical personnel and skilled labourers, while the jobless accounted for as little as eight per cent. Some 20 per cent did not have a fixed address.

Of the deceased, 42 per cent had previous drug convictions, and 34 per cent had been hospitalised because of problems associated with narcotics or medicines. However, a third did not have previous drug convictions or drug-related hospital periods. It is also interesting to note that in most cases, the police or medical examiner were not aware of previous drug-related treatment or crimes – this was known of only a tenth of the deceased.

As for drug deaths in the late 1990s, a study on Turku, the fourth largest city in Finland, was completed in 2001. Due to the sharply increasing deaths by narcotics poisoning in 1998, an investigation into the situation in 1999 was launched. That year, a total of 11 deaths resulted from such poisoning in Turku. Of the deceased, only one was a woman, and nine were under the age of 25. In nine cases, death by heroin poisoning was among the primary causes of death (the only diagnosis in four cases), amphetamine in two cases and medicines in five cases. Polydrug use of narcotics and tranquillisers was present in all the cases where the previous history of substance abuse was possible to trace back. Thus, the most important finding emerging from the study was the presence of large quantities of psychopharmaceutical drugs in the victims. This outcome is in line with international research showing that combined with heroin, benzodiazepines (psychopharmaceutical drugs) pose a major risk of death by an overdose. (Hakkarainen 2001b)

In Turku, the deaths mainly occurred in private residences, and in three cases also other people present were
under the influence of drugs or alcohol. In terms of underlying factors, many deaths were characterised by the victims’ and their peers’ confused and uncontrolled situation in life. Income insecurity and active criminal involvement were commonplace. Nine of the deceased had a criminal background of some sort.

Compared to the situation in the early 1990s, the study on Turku seems to indicate that the people who died of drugs were younger, more excluded and more often involved in criminal activity than was the case before. In addition, the number of deaths by poisoning seems to have grown considerably since the early 1990s.

3.3 Drug-related infectious diseases

It is possible to assess the prevalence of intravenous drug use based on registers of infectious diseases and drug tests.\textsuperscript{55} By the end of 1997, 864 HIV cases were found in Finland, 28 of which (3\%) had been contracted through injecting (intravenous) drug use (only two of them in Finland).

In 1998, 20 new HIV cases resulting from injecting drug use were found, mostly in Greater Helsinki – a fifth of all 81 new HIV infections during that year. In 1999, the infections became an epidemic as the number increased by 85 cases of all 143 HIV infections recorded in 1999. In the following two years, the epidemic levelled off and in 2000, the number of new HIV infections due to intravenous drug use was 56 out of 145 HIV infections reported, and 48 out of 128 in 2001.\textsuperscript{56} The infections started in Helsinki, but similar cases, albeit isolated, have been found in 10 other localities as well.

Voluntary HIV tests performed in prisons and at needle exchange centres in 2001 showed that less than three per cent of the subjects tested positive for HIV.\textsuperscript{57} According to the drug treatment data compilation carried out the same year, 2.5 per cent of those having lifetime experience of injecting drugs (n=2,871) reported having tested positive for HIV. In the interviews conducted in the risk study among injecting drug users (clients at the above-mentioned health counselling centre, n=279) in 2001, 4.5 per cent of the interviewees were reportedly HIV positive (Perälä et al. 2002; Partanen, A. 2002)

Recent investigations have shown that some 60 per cent of the injecting drug users have hepatitis C. (Leinikki, P. 1999; Turpeinen, P. et al. 1999). Of those tested at health counselling centres, 30–60 per cent had hepatitis C. Commenced in 2001, the study on risk behaviour among intravenous drug users

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\textsuperscript{55} The National Public Health Institute (Department of Infectious Disease Epidemiology) is responsible for the registration of communicable diseases and for official drug tests in Finland.

\textsuperscript{56} HIV register of the National Public Health Institute. See http://www.ktl.fi/trr/hiv_aids.html

\textsuperscript{57} Department of Infectious Disease Epidemiology, National Public Health Institute. See also http://annualreport.emcdda.org/en/sources/index.html
showed that about half of the interviewees had been hepatitis-C-positive in the last test (n=279). The drug treatment study conducted the same year indicated that 49 per cent of those having injected drugs during the previous month reported a positive test result (n=1,598).

On the other hand, it is estimated that 90 per cent of all hepatitis C infections are attributable to injecting drug use. The clear correlation between hepatitis C and injecting drug use suggests that hepatitis C could be used as an indicator of trends in injecting drug use. In 2000, there were 1,739 new hepatitis C cases, but in 2001 the number declined by almost 300–400 cases, totalling 1,490. Of the infections in 2001, over half involved persons under 30 years of age, and most infections had occurred in age group 20–24-year-olds. The reduction involved people over 25 years of age.

*Figure 12.*

**Age distribution of new hepatitis C infections in 2001**

![Bar chart showing age distribution of new hepatitis C infections in 2001](image)

According to the drug treatment study, 12 per cent of those seeking drug treatment were hepatitis B positive. However, a little over half of those who have injected drugs at some point in time have received at least one vaccination against hepatitis B and less than a third have been administered all three shots (Partanen, A. 2002).

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58 This percentage is calculated from the cases where the means of transmission has been reported. However, in almost half of the cases it is not known or reported. To investigate the risk of communicable diseases, hepatitis C infections have since 1998 been included on the list of diseases a physician must notify. (Infectious diseases in Finland 2000, 2001).
3.4 Other drug-related morbidity

Drug-induced morbidity is monitored through the hospital patient discharge register. According to the register, the number of drug-related hospital periods has grown rapidly in 1990–2000. Drug-related illnesses have partly become more prevalent because of the increased publicity given to drugs and changes in diagnostic practices. For instance, in 1996, the changeover to the ICD-10 classification caused an increase of 450 drug-related treatment periods, almost half of which were attributable to the changeover.59

Especially the 1998 hospital statistics suggested that the number of treatment periods recorded due to pharmaceutical or narcotic drug diagnoses have decreased by 17 per cent in a year. This change is mainly due to the alterations in 1998 to applying the Finnish ICD-10 system, which integrated poisoning diagnoses in terms of pharmaceutical poisonings into one diagnosis category (T36), where substances are differentiated by the specific ATC code associated with pharmaceuticals. However, poisoning diagnoses are recorded by the ICD code, without a proper ATC extension.60

Figure 13.
Hospital treatment periods related to narcotics and pharmaceuticals in 1990–200161

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59 In 1996, about 125 treatment periods were estimated to result from a statistical changeover from unspecified drug-induced brain syndromes (ICD-9/292) to substance-specific brain syndromes. Moreover, some 100 new treatment periods were introduced into opiate-induced brain syndromes from a group of people aged over 50. See the definitions in Appendices 7 and 8. See also Virtanen 2001.

60 In 1997, over 3,000 pharmaceutical poisoning diagnoses were made. However, in 1998 almost 1,500 poisoning diagnoses were recorded by the ICD code, without the ATC extension, a fact that makes it impossible to carry out comparisons over time series on poisonings caused by sedatives, tranquillisers or non-dependence-inducing medicines. Later, this practice has continued, hence the category ‘non-substance specific poisoning’.

61 The cases for substance-specific diagnoses were selected based on the principal drug mentioned in pharmaceutical diagnosis (primary diagnosis and two secondary diagnoses). In 1990 – 1995, the drug diagnoses are according to the Finnish ICD-9 codes (see Appendix 7). In 1996, the classification changed in Finland, and since 1996 ICD-10 has been in use (see Appendix 8). The appendix aims at statistical compatibility of drug-related diseases, despite the differences between the classifications.
The number of treatment periods based on drug diagnoses remained the same in 2001. The number of treatment periods resulting from polydrug use declined somewhat. Diseases associated with sedatives and tranquillisers have also declined in the past four years. The reason for the latter two developments may in part be an increase in pharmaceutical poisoning diagnoses made without specifying the substance in question. As regards Code F55 (Abuse of non-dependence producing substances), the processing criteria were altered, and the treatment periods based on external causes of disease (X40–X44; Accidental poisoning by exposure to certain pharmaceutical and other drugs) were omitted. This alteration has resulted in considerable statistical changes since 1998. Clients treated for narcotics or polydrug use are predominantly men, but there is no major difference between the sexes in the use of pharmaceuticals leading to health problems.

* = Preliminary information

Figure 14.
Hospital treatment periods related to narcotics and pharmaceuticals in 2001* by sex
Most common drug involved in narcotics-related hospital treatment periods in the mid-1990s was amphetamine. In 1998, there was a change of order, as opiate-related treatment periods became more numerous in age group 15–54-year-olds, and this trend continued in 1999–2001. This change may partly result from reorganisation of the treatment system, whereby the health care sector was assigned more responsibility for opiate users’ pharmaceutical treatment, as required by the Regulations and Decrees issued by the Ministry of Social Affairs and Health, requiring that the detoxification and substitution treatment of opiate addicts with medicines as well as the assessment of substitution treatment, along with most of the treatment provision, must be done in certain specified hospitals. The percentage of cannabis-related treatment periods declined somewhat, having remained relatively stable in recent years, and there was a slight increase in stimulant-related treatments. In 2001, the treatment periods mainly involved 15–34-year-olds; age group 15–19-year-olds declined while the others remained at the same level. In the youngest age group, the reduction concerned opiate-related diagnoses. Stimulant-related diagnoses increased in age group 15–29-year-olds.

* = Preliminary information on 2001

Figure 15.
Drugs-related hospital treatment periods (%) for 15–54-year-olds in 1990–2001

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62 University Central Hospitals in particular had a key role here. See Chapter 1.2.2.
63 According to highest-level drug diagnosis, see Appendices 7 and 8.
4 SOCIAL AND LEGAL CORRELATES AND CONSEQUENCES

4.1 Social problems

Despite the many surveys of drug use carried out around the turn of the decade, precious little research information is available about the possible social problems of people who experiment with and use...
narcotics. There is, however, research information on people considered problem users, injecting drug users or drug offenders, and this information clearly shows a link between the drug problem and social exclusion.

Based on preliminary information about the follow-up study on risk behaviour among injecting drug users in 2001, the subjects formed a homogenous group as regards their substance abuse and general situation.\(^{64}\) Their mean age was 30 years for men and 26 years for women. The group included people engaging in heavy use of a variety of substances and facing many other problems as well. Social exclusion or its risk was reflected in their work, educational and housing situation: three out of four interviewees were jobless. For the majority, the main source of income was living allowance (32%). Less than 40 per cent had post-secondary school education, as opposed to 80 per cent in the corresponding segment of the general population. A tenth were homeless and 27 per cent were in temporary housing, residing, for example, in halfway houses, institutions or with friends. (Perälä et al. 2002). The results are consistent with the reported backgrounds of clients seeking treatment for drug use.\(^{65}\)

A study on drug offenders’ criminal careers and socio-economic position was published in 2001 (Kinnunen 2001).\(^{66}\) The study used cross-sectional data to investigate people who had been convicted of drug offences in 1977–1996 and their situation in 1995. The mean age of the study group was 30 years. Only a fifth of those convicted in 1977–1996 were in the employed labour force in 1995. Of the subjects, 43 per cent were reportedly unemployed. The distributions are clearly different among those who had been convicted of some other crimes during the same period: of them, 43 per cent were in the employed labour force, while 22 per cent were jobless. The most common professions among drug offenders were unskilled labourer, machinist, mechanic, driver or construction worker. Also service-sector professions, such as salesperson and work in the social sector, were quite common. Drug offenders had little training and were less educated than other convicts. Over half of drug offenders (58%) did not have any record of training other than basic education.

Thus it seems that risk users, those seeking drug treatment and convicted drug offenders all are excluded from education, work and housing. There is no research information about the situation of various ethnic minorities, but their problems are exacerbated by cultural differences and the language barrier, which in practice mean more limited treatment opportunities than is the case with other drug users.

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\(^{64}\) Cf. Chapter 3.3.

\(^{65}\) See Chapter 3.1.

\(^{66}\) See Chapter 4.2.2.
4.2 Drug offences and drug-related crime

The Finnish Penal Code forbids e.g. the illicit use, possession, purchase, sale, manufacture, distribution and import of (narcotic) drugs. The control authorities often manage to arrest drug offenders because of their social situation: problem drug users, the excluded and habitual criminals. On the other hand, the police are usually unaware of the more random or experimental use of drugs.

4.2.1 Drug offences

The number drug offences has rapidly increased in the 1990s. However, this not only reflects the extent of actual crime but also efforts made by the law enforcement agencies. Resource allocation to drug surveillance – as was required by the drug strategy of the police – and intensified antidrug training have contributed to the amount of drug offences reported.

The largest aggregate of reported drug offences consists of the so-called user offences (use, possession and purchase, specified in the statistics but not in legislation before the year 2001). According to the statistics of the National Bureau of Investigation, they accounted for 60 per cent of all drug offences reported in the 1980s, and for almost 80 per cent in 1990–1998. However, in 1999–2000, user offences only accounted for two out of three of drug offence reports. (Kinnunen 2001). Owing to the law reform in 2001 (‘user offence’ was specified in legislation) and changes in statistical practice, user offences cannot be estimated in a statistically comparable way. As a result of the amendment of the law on user offence, in effect since September 2001, almost one out of eight drug offences was reported as a user offence.

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Figure 17.
Narcotics offences and sentences for narcotics offences in 1987–2001

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67 The official term is narcotics offences according to the Narcotics Act, but this report uses the concept "drug" parallel to "narcotics," and the latter term is used only when it is important to see the connection to the Narcotics Act.
In 2001 (2000), 15,570 (14,188) narcotics offences were recorded, of which 942 (845) were aggravated offences. The group of people suspected of drug offences on one or several occasions in 2001 comprised 6,468 (7,962) people, of whom 17 per cent were women. Of the suspects, 57 per cent were aged under 25 years. Of all alleged drug offences, 70 per cent involved people aged over 20, while 18–20-year-olds accounted for 24 per cent and younger people 6 per cent; the latter group declined by 1.6 percentage points from the previous year. A total of 561 people were suspected of an aggravated narcotics offence. (Hietaniemi, T. 2002).

The late 1990s saw a clear change in the presence of Estonian-Russian drug criminals in Finland. In 2001, foreigners however accounted for less than five per cent of Finnish narcotics suspects, but for over twenty per cent of the suspects in aggravated narcotics offences. Of those suspected of aggravated narcotics offences, 13 per cent were Estonians or Russians. Organised crime operating on Estonian soil is in close collusion with crime organisations run by Russians and other ethnic groups in the Russian Federation and with their Finnish partners in crime.

At the turn of the decade, almost 40 per cent of the drug offences were committed in the Greater Helsinki Area, while in 2001 the percentage was down to 30. Percentages increased especially in the Provinces of Western and Eastern Finland, mostly in towns and built-up areas (Crime recorded by the police 2001; Hietaniemi 2002).

*Figure 18.*
Drug offences per 1,000 inhabitants in 1998–2001 by region

* = Preliminary information
According to the first semi-annual report of the police in 2002, drug crime appears to be on the same level as the previous year. The most obvious change is the ‘user offence’, a concept not used before and accounting for 45 per cent of all drug offences. Aggravated drug offences have declined by 10 per cent compared to the previous six-month period (Crime recorded by the police, 2nd quarter, 2001, 2002).

Amendments to the laws governing preliminary investigation and coercive measures (1989 and 1995) have shifted the focus of criminal investigation towards prevention of drug offences but also towards intensification of surveillance and control, with an effort to provide the law enforcement authorities with new telesurveillance capabilities.

In 2001 (2000), the police and customs engaged in interception of telecommunications almost as often as the year before, on 473 (498) occasions. The courts gave the police and customs 787 (813) authorisations for interception of telecommunications. In most cases (77%), the interception was motivated by aggravated drug crime. Identification of call-associated data was used clearly more often than the year before. In 2001, the courts granted the police and customs 1,469 (904) authorisations for identification of call-associated data, involving 2,091 (1,202) subscriber lines. Of these authorisations, 38 per cent were issued on the grounds of investigating an aggravated narcotics offence in 2001. Providing information about identifiers and localities, identification of call-associated data has become more important in criminal investigation, while interception of telecommunications now tends to have a lesser role.68

Amendment to the Police Act, enabling covert operations and fictitious purchase in criminal investigation, took effect on 1 March 2001. Based on the law, the Ministry of the Interior issued a Decree on organising and monitoring these activities. No covert operations were undertaken in 2001. The police engaged in one fictitious purchase in order to investigate an aggravated drug offence in 2001, and the operation played a major role in the preliminary investigation. Covert operations must be implemented in a centralised manner (National Bureau of Investigation, Security Police) and also fictitious purchases are centrally supervised (National Bureau of Investigation). The Ministry of the Interior appointed a steering group for monitoring the activities in November 2001. (Hietaniemi 2002).

In addition to drug offences proper, some 2,800 (1,100) reports on suspicious business transactions, most often in connection with currency exchange, were filed under the money laundering law in 2001 (2000).

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The reports involved 330 legal persons. A total of 133 cases entered preliminary investigation, a third of which involved drug crime.69

4.2.2 Drug convictions

In 2001 (2000), the courts of first instance passed 7,657 (6,791) sentences involving drug offences.70 Of them, 6,415 (5,813) had a drug offence as the primary count (Syytetty ja tuomitut 2000; Niskanen, T. 2002).71 Of the persons convicted, 72 per cent were fined, 17 per cent received prison sentences and 9 per cent were given suspended sentences. The average length of a prison sentence for a narcotics offence in 2001 (2000) was 4.0 months (3.9 months) while in aggravated narcotics offences, the average length was 37.0 months (36.0).72 In 2001 (2000), prosecution was waived in case of 155 (126) suspects (2.5 % of all cases). On the other hand, the prosecutors have been more consistent in applying the regulations on refraining from sanctions than the courts have been.73 In 2000, decisions to waive prosecution totalled 1,578, i.e. 11 per cent of all reports of drug offences. The main reasons for waiving prosecution were lack of proof, the insignificant nature of the offence or the principle of concurrence. (Yearbook of Justice Statistics 2001).

During 2001, a study on all persons having been convicted of narcotics offences in 1977–1996 was completed based on information provided by Statistics Finland. Nationwide census data were utilised in interpreting information from the courts register. Special attention was paid to the criminal careers of those born in 1962, with people convicted of other offences as a control group (Kinnunen 2001). The study found that of that cohort, a fifth had received a criminal conviction by the end of 1996 – a third of men and less than a tenth of women. People having received a narcotics conviction accounted for less than one per cent of the cohort.

Persons convicted of narcotics offences were also guilty of many other crimes, especially theft, concealment and unlawful appropriation of vehicles. Drug offenders’ criminal careers started when relatively young: the majority received their first criminal conviction as young as 15–16 years of age, i.e. immediately after they had become legally accountable. For a quarter of drug offenders, the narcotics

69 See http://194.89.205.4/kpr/
70 The sentences included a total of 9,669 (8,338) drug offences alleged in 2001 (2000).
71 For example, a person is convicted of an aggravated drug offence in the Helsinki District Court if he or she has handled a kilo of hashish, 100 grams of amphetamines or 10–15 grams of heroin. Also other aspects of the offence have a bearing on the severity of the crime, such as criminal proceeds and the organised nature of activities. (Kinnunen 1999).
72 When the mean length of a prison sentence is calculated, one should note that even though a drug offence is the principal crime and the primary reason for the conviction, the case may also involve other (narcotics) offences. Thus the figures reflect the length of sentences given to drug offenders rather than the length of sentences resulting from drug offences. Nevertheless, the results are not dramatically different from sentences carrying only one count of drug offence. The proportion of such offences is a third of all drug crime. (Syytetty ja tuomitut 2000).
73 These are stipulated in Sections 3:5 and 50:7 of the Penal Code and in Section 1:7-8 of the Criminal Procedure Act.
offence was the first convicted crime. Most drug offences were committed at a later age, over 20, at which stage the amount of thefts was generally declining.

When drug offenders’ criminal careers were compared to those convicted of other crimes, it turned out that the former group remained criminally active for a longer time. This suggests that drug use has a tendency to maintain involvement in criminal activity. On the other hand, drug users’ high level of criminal activity may also be attributable to detachment from society. The subculture of persons engaging in wide-scale criminal activities involves heavy drug use, which, in turn, is subject to strict societal control.

In 1998–2000, about 15 per cent of all Finnish prisoners served sentences primarily for drug offences, whereas a decade ago their proportion was about 2 per cent. In 2001, the proportion of drug convicts in the prison population started to rise again. Drug-related sentences tend to be longer as well: when in the entire prison population about half were serving sentences lasting for over two years, among drug offenders the proportion was two-thirds. It is noteworthy that about 40 per cent of the prisoners have at least one drug conviction, when drunken driving is included. In addition, most female prisoners have received their sentences for involvement in drug crime. Drug sentences are especially common in the prisons of Southern Finland.74

Figure 19.
Prisoners (%) primarily convicted of drug offences according to the annual prison census in 1990–2002

74 Situation on 1 October in all prisons, when the prison census was conducted until 1997. Since 1998, the census has been carried out on 1 May. According to the 2002 (2001/2000) census, the Finnish prisons had 3,441 (3,170 / 2,903) inmates, of whom women numbered 213 (160 in 2001). The number of persons primarily convicted of drug offences was 498 (449 / 360). In addition, in 2002 (2001 / 2000) there were 111 (123 / 84) prisoners awaiting trial primarily for drug offences. The rest were prisoners serving sentences for enforcement of a fine.
The census of prisoners having contracted HIV or hepatitis B and C infections was carried out, showing the situation on 1 February 2001. The study included virus infections known to prison health care personnel. On that day, there were a total of 3,108 prisoners, of whom 884 had contracted hepatitis C infection, 130 had hepatitis B infection, of whom 32 were carriers. Thirty inmates had HIV. (Vankiloiden virustartuntatilanne 2001).

4.2.3 Drugs in road traffic

Drugs are present in road traffic as well, and their prevalence can be deduced from law enforcement statistics. In 2001 (2000 / 1999), the number of intoxicant cases in road traffic was 22,783 (22,553 / 21,940), most of which were alcohol related, carrying convictions of drunken driving. The number of drivers tested for medicines and narcotics impairing the driver’s performance was 1,844 (1,880 / 1,683). Of all cases, 1,562 (1,589 / 1,323) involved drugs (medicines or narcotics); the number of cases involving narcotics was 1,044 (1,074 / 918). (Annual Report of the Police 2001). Amphetamines were found in 706 (705 / 670) cases, cannabis in 737 (670 / 580) and opiates in 173 (237 / 180) cases. In the early 1990s, the number of narcotic drug findings was about 200.

Figure 20.
Narcotics findings among suspects for driving under the influence of drugs (in road traffic) in 1990–2001.

* = Preliminary information

<table>
<thead>
<tr>
<th>Year</th>
<th>Narcotic Drugs</th>
<th>Cannabis</th>
<th>Amphetamine</th>
<th>Opiates</th>
</tr>
</thead>
<tbody>
<tr>
<td>1990</td>
<td>100</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<tr>
<td>1991</td>
<td>100</td>
<td>0</td>
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<td>0</td>
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<tr>
<td>1992</td>
<td>100</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>1993</td>
<td>100</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<tr>
<td>1994</td>
<td>100</td>
<td>0</td>
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<tr>
<td>1995</td>
<td>100</td>
<td>0</td>
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<tr>
<td>1996</td>
<td>100</td>
<td>0</td>
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<td>1997</td>
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<td>2000</td>
<td>100</td>
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<td>0</td>
</tr>
<tr>
<td>2001</td>
<td>100</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

75 News release of prison administration, 22 February 2001, see http://www.vankeinhoito.fi
76 See also http://www.poliisi.fi
77 Drug Laboratory of the National Public Health Institute, 2002. (See also Niemi 1999)
Despite the considerable increase in narcotics findings, the number of sentences for driving under the influence of drugs (medicines or narcotics) as the primary offence did not increase correspondingly in the 1990s: in 1991, 277 sentences were passed, whereas in 1998 the number was 356 and 358 in 1999. The difference between the number of suspects (drug findings) and persons convicted was partly due to the fact that many cases involved some other primary offence (such as drunken driving). Legislation on driving under the influence of drugs was altered in 2000, incorporating it in ‘drunken driving’. Subsequently, no information about persons convicted of drunken driving on account of narcotics is available in the court statistics.

4.3 Social and economic costs of drug consumption

Drug abuse has detrimental effects at both individual and societal levels. It increases morbidity, social exclusion and causes interpersonal problems and suffering. Moreover, drug abusers face a great risk of untimely death. Substance abuse inflicts damage and expenses on society at all levels. Along with health care expenses, considerable costs are incurred in drug-related control and crime.

Preliminary information on the situation in 2000 suggested that abuse of medicines and narcotics resulted in direct societal costs ranging from EUR 124 million to EUR 189 million (Hein 2002). The greatest increase was noticed in the estimated costs of damage to property.

Table 13. Cost of harms related to narcotics and medicines in Finland in 2000

<table>
<thead>
<tr>
<th>Category</th>
<th>Minimum EUR million</th>
<th>Maximum EUR million</th>
</tr>
</thead>
<tbody>
<tr>
<td>Criminal justice system</td>
<td>38</td>
<td>50</td>
</tr>
<tr>
<td>- Police and rescue services</td>
<td>12</td>
<td>23</td>
</tr>
<tr>
<td>- Judicial system and prisons</td>
<td>26</td>
<td>27</td>
</tr>
<tr>
<td>Damage to property</td>
<td>21</td>
<td>44</td>
</tr>
<tr>
<td>Social services</td>
<td>39</td>
<td>50</td>
</tr>
<tr>
<td>- Welfare for substance abusers</td>
<td>23</td>
<td>30</td>
</tr>
<tr>
<td>- Living allowances, child welfare</td>
<td>16</td>
<td>20</td>
</tr>
<tr>
<td>Health care and pensions</td>
<td>20</td>
<td>39</td>
</tr>
<tr>
<td>- Inpatient care of drug and medicine abuse</td>
<td>10</td>
<td>21</td>
</tr>
<tr>
<td>- Outpatient and home care</td>
<td>7</td>
<td>9</td>
</tr>
</tbody>
</table>

Cf. also Chapters 1.5 and 19, comparing the costs of alcohol and drug abuse in 1997–1999.
In addition to direct costs, narcotics and medicine abuse causes considerable indirect expenses, e.g. in the form of production losses. For example, substance abuse may lead to inefficiency in studies and work and social problems may occur, such as marital break-ups. What is more, there is even a calculable figure for untimely deaths. Rough estimates of indirect costs per year vary between EUR 290–630 million.

5 DRUG MARKET

5.1 Availability and supply

The supply of most drugs increased in Finland in 2001.\textsuperscript{79} Seizures of the country’s most commonly used drugs, hashish and amphetamine, increased by over 60 per cent. Amphetamine and ecstasy are produced on a major scale in Estonia especially for the Finnish and other Nordic markets. Organised crime groups led from Estonia and Russia have a strong and geographically extensive position in trafficking hashish from Morocco via Spain and the Nordic and Baltic countries to Finland.

Heroin supply in Finland subsided in the summer of 2001, with monthly seizures dropping from the average of 60 in spring 2001 to 15 by the end of 2001 and spring 2002. The heroin on the market has a very low purity, under 10 per cent also in major seizures. The bulk of the Finnish heroin comes from Afghanistan and has reached the country via Estonia, but, to some degree, also directly from Russia. As a result of the crisis in the country of origin, heroin supply seems to have dried up after the produce from the previous season has sold out.

The decline in the heroin supply was clearly reflected in the spread of Subutex (buprenorphine), a medicine used for substitution treatment of heroin addicts, to illicit markets and intravenous use. While heroin seizures made by the police were restricted to a small area in the southern parts of the country, Subutex was found as far north as in the Province of Oulu. Subutex is probably imported to the country through the users’ own networks.

\textsuperscript{79} The first part of the Chapter is based on two articles: Hietaniemi 2002; and NBI News release of the 5 March 2001.
The disappearance of heroin is liable to have impacted on burglaries into pharmacies and pharmaceutical warehouses, as the number of break-ins tripled from the year before, totalling 118 in 2001.

Cocaine is still rare on the Finnish market. An increase in cocaine supply and its cheaper price in Europe due to the stricter security measures in the United States have been observed in Finland as well. Cocaine in Finland is mostly seized in connection with other drugs from perpetrators engaging in import and wholesale.

The supply and availability of drugs can be viewed from the perspective of individual citizens’ perceived drug supply. Many drug surveys have asked the interviewees whether they have been offered narcotic drugs. Conducted in 1997–2001, the follow-up studies on health-related behaviour among the adult population asked the interviewees if they had been sold or given drugs in last 12 months. The results showed that drug offers to men have remained stable in all age groups, but there was a slight increase in young women’s group. (Jallinoja et al. 2002)80

80 Survey sampling is discussed in Chapter 1.4.
In the 2001 survey, 93 per cent of the respondents had not been offered drugs in last 12 months. Of those who had been made offers, 80 per cent would have received drugs free of charge at that time. Offers were more numerous in the Uusimaa region (10%) and the Greater Helsinki area (11%), compared to the rest of the country (4–7%) or other cities (6–8%). Of 15–24-year-old men and women living in Greater Helsinki, 36–37 per cent had received drug offers in last 12 months. The corresponding figures were 31–32 per cent in Uusimaa, 24–27 per cent in major cities elsewhere and 20–25 per cent in the entire country. (Jallinoja et al. 2002).

The school health survey asked 15–16-year-olds about the supply of certain substances (hashish, thinner or other sniffed substances, intoxicating medicines and the like) in last 12 months. The survey also asked who had made the offer. The results indicate that the supply of drugs for young people mounted clearly in the late 1990s. (Luopa et al. 2000)
Figure 22.
Drug offers to 15–16-year-old schoolchildren (%) in last 12 months in Finland according to school health surveys in 1996–2000

A survey of criminal behaviour of 15–16-year-olds showed that about 8.5 (7) per cent had used drugs in 2001 (1998). Of those who had used marijuana or hashish in last 12 months, 8.5 (4) per cent had financed their habit by criminal means. The heavy use of cannabis appears to be often associated with illicit ways of acquiring drugs.

According to the survey of juvenile delinquency in 1998, almost two-thirds of the young respondents had received their last drug dose free of charge. The responses indicated that the more regularly a person had used drugs during the year, the more likely it was that he or she had to pay for it. Payment was also more likely if the drug use had started at an early age. Irrespective of how regular the use was, girls received drugs for free more often than boys did. Entering the drug scene leads to a situation where a person must pay for drugs, but the price is liable to go down as the drug user gets to know the market better. (Kivivuori 1999, 2002).

5.2 Seizures

During the past 10 years, the number of hashish seizures has clearly increased, and the number of amphetamine and heroin seizures has grown proportionally even more. However, the amounts in kilograms of seized substances may vary a lot. E.g. the large consignment of heroin seized in 1995 was mainly destined for other countries, and the same applied to some major seizures of cocaine in the 1990s. For instance, almost all cocaine confiscated in 2000 was found on board a luxury liner visiting Finland.

The seizures of cannabis and amphetamine, the most commonly used narcotics in Finland, increased in 2001 by 60 per cent from the year before: the amount of hashish seized tripled and amphetamine almost doubled. Demand for ecstasy on the Finnish drug market has stabilised. The supply of heroin plummeted by the summer, probably as a result of the declining heroin production in Afghanistan.

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81 The survey comprised 4,500 9th-year students in secondary school; response percentage was 88. See also Chapter 20.1.
Small-scale home production of cannabis occurs in Finland: the police confiscated some 5,000 cannabis plants in connection with the 612 seizures carried out in 2001. The police have also seized small amounts of buprenorphine (Subutex pills) from users, and also the seizures made by the customs authorities continued to grow substantially (from about 10,000 pills in 2000 to over 30,000 pills).

The growth in drug seizures is attributable to the more professionally organised import and distribution networks, but also in part to the more effective and better resourced and targeted measures taken by the law enforcement authorities to intervene in the large-scale import and distribution of illegal drugs and to intensify control over these activities. (Hietaniemi 2002)

The volume of passenger and goods transport between Estonia, Finland and Russia is high, but the possibilities to monitor it are limited. There has been a shift from individual couriers – a technique deemed risky and amateurish – to highly professional smuggling; consequently, the consignments intercepted have clearly become larger. The largest consignment of amphetamine in 2001, about 22 kg, was seized in December in Helsinki. The largest hashish seizure came to about 150 kg. Organised crime led from Estonia has a strong position on the Finnish drug market, not only in import and production but also in wholesale and distribution. In addition, about 620 kg of Khat, a drug mostly preferred by immigrants from Somalia, was confiscated in 44 seizures.

New synthetic drugs are still very rare on the Finnish drug scene. While popular in Russia, fentanyls have not come up in large quantities. However, a consignment of 3-methylfentanyl was seized in 2001 on the south-eastern border; this is an extremely potent superdrug known as the ‘Krokodil’ in Russia.

Table 14.
Drugs seized in 1990–2001 (kg)82

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Hashish</td>
<td>71.20</td>
<td>101.29</td>
<td>43.86</td>
<td>117.05</td>
<td>64.32</td>
<td>147.51</td>
<td>99.44</td>
<td>197.66</td>
<td>160.97</td>
<td>492.32</td>
<td>196.54</td>
<td>589.6</td>
</tr>
<tr>
<td>Marijuana</td>
<td>0.60</td>
<td>6.03</td>
<td>3.73</td>
<td>1.19</td>
<td>4.37</td>
<td>4.27</td>
<td>3.51</td>
<td>12.15</td>
<td>8.01</td>
<td>18.17</td>
<td>13.82</td>
<td>16.10</td>
</tr>
<tr>
<td>Amphetam.</td>
<td>1.38</td>
<td>5.32</td>
<td>11.58</td>
<td>18.70</td>
<td>9.07</td>
<td>20.12</td>
<td>22.14</td>
<td>22.20</td>
<td>24.78</td>
<td>71.26</td>
<td>79.56</td>
<td>137.3</td>
</tr>
<tr>
<td>Cocaine</td>
<td>0.03</td>
<td>38.14</td>
<td>0.06</td>
<td>0.01</td>
<td>0.07</td>
<td>0.07</td>
<td>0.12</td>
<td>1.99</td>
<td>1.70</td>
<td>38.58</td>
<td>6.5</td>
<td></td>
</tr>
<tr>
<td>Heroin</td>
<td>0.03</td>
<td>0.66</td>
<td>1.87</td>
<td>0.68</td>
<td>1.59</td>
<td>16.12</td>
<td>6.45</td>
<td>2.40</td>
<td>1.97</td>
<td>2.88</td>
<td>6.03</td>
<td>7.5</td>
</tr>
<tr>
<td>Khat</td>
<td>-</td>
<td>39.38</td>
<td>12.60</td>
<td>23.87</td>
<td>88.23</td>
<td>68.11</td>
<td>264.5</td>
<td>249.01</td>
<td>103.94</td>
<td>374.10</td>
<td>348.41</td>
<td>664.5</td>
</tr>
<tr>
<td>LSD (units)</td>
<td>39</td>
<td>27</td>
<td>337</td>
<td>29</td>
<td>2,541</td>
<td>500</td>
<td>41</td>
<td>323</td>
<td>301</td>
<td>50</td>
<td>2.55</td>
<td>1.026</td>
</tr>
<tr>
<td>Ecstasy (units)</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>18</td>
<td>-</td>
<td>3,750</td>
<td>1,011</td>
<td>3,062</td>
<td>3,320</td>
<td>17,665</td>
<td>87,393</td>
<td>81,228</td>
</tr>
</tbody>
</table>

Table 15.
Number of drug seizures in 1993–2001

<table>
<thead>
<tr>
<th></th>
<th></th>
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<th></th>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Hashish</td>
<td>897</td>
<td>774</td>
<td>1,235</td>
<td>1,312</td>
<td>1,686</td>
<td>1,997</td>
<td>2,259</td>
<td>2,482</td>
<td>4,011</td>
</tr>
<tr>
<td>Amphetamines</td>
<td>381</td>
<td>415</td>
<td>696</td>
<td>972</td>
<td>1,352</td>
<td>1,641</td>
<td>1,956</td>
<td>2,369</td>
<td>3,778</td>
</tr>
<tr>
<td>Heroin</td>
<td>39</td>
<td>39</td>
<td>82</td>
<td>145</td>
<td>153</td>
<td>210</td>
<td>342</td>
<td>437</td>
<td>557</td>
</tr>
<tr>
<td>Cocaine</td>
<td>...</td>
<td>...</td>
<td>...</td>
<td>15</td>
<td>16</td>
<td>24</td>
<td>49</td>
<td>40</td>
<td>55</td>
</tr>
<tr>
<td>Ecstasy</td>
<td>...</td>
<td>...</td>
<td>...</td>
<td>52</td>
<td>74</td>
<td>57</td>
<td>159</td>
<td>393</td>
<td>465</td>
</tr>
<tr>
<td>LSD</td>
<td>...</td>
<td>...</td>
<td>...</td>
<td>14</td>
<td>14</td>
<td>...</td>
<td>15</td>
<td>34</td>
<td>14</td>
</tr>
</tbody>
</table>

5.3 Price and purity

The price of drugs is relatively high in Finland, many times higher than e.g. in the Netherlands. According to the statistics of the National Bureau of Investigation in 2001, the street value of cannabis was EUR 8.0–13.0 per gram, amphetamine sold at about EUR 15.0 per gram, ecstasy at EUR 8–17 per tablet and both white heroin and cocaine at EUR 100–170 per gram. Interviews conducted in Helsinki suggest that the price of hard drugs has dropped in the 1990s, whereas cannabis has more or less remained at the same level. (CND – Finnish answer to 2001 ARQ - Part III)

The purity of amphetamine and heroin is regularly tested in Finland by forensic or customs laboratories. Small quantities of cannabis need not to be tested if the suspect has confessed and there is no ambiguity over the substance. The quality of drugs in the street varies much. The average purity of the amphetamine seized has been around 50 per cent and 33–50 per cent for heroin. In 2001, the average purity of amphetamine seized in the street (less than 50 g at a time) was 42 per cent, and 20 per cent for heroin. (Kinnunen et al. 2002; CND – Finnish answer to 2001 ARQ – Part III)
6 TRENDS PER DRUG

6.1 Cannabis

According to the 2000 data, 9.3 per cent of 15–69-year-olds had experimented with cannabis at least once during lifetime (11.7 per cent of men; 7.0 per cent of women). The percentage of those having experimented with cannabis in last 12 months was 2.0 per cent, which in the corresponding population means approximately 60,000–110,000 people who have used cannabis during the year. A third of them were women and almost half were 25 years of age or younger. The proportion of those having experimented with cannabis in last month was 0.7 per cent. Defined by last month experiments the number of ‘regular cannabis users' might reach 25,000 - 30,000. Cannabis experiments have developed during 1992–2000 as shown in Figure below.83

Figure 23.

Correspondingly, cannabis-related harms (cannabis seizures made, driving under the influence of cannabis, cannabis-related morbidity and cannabis findings in autopsies)84 have developed as follows (1993=100):

---

83 Numerical values for this Figure are in Table 3 in Chapter 2.2.1 (population surveys) and in Figure 6 in Chapter 2.2.2 (conscript surveys).
84 Indicators of the negative effects of substances are derived separately from drug-specific information in this report: narcotic findings in autopsies (Chapter 3.2, Figure 10), morbidity (Chapter 3.4, Figure 13), driving under the influence of drugs in road traffic (Chapter 4.2.3, Figure 20) and number of seizures (Chapter 5.2, Table 15). At the beginning of the time series (1993), the indicators have the following values: cannabis-related deaths 19, morbidity 99, drunken driving 234 and seizures (hashish) 897.
6.2 Synthetic drugs (amphetamine, ecstasy, LSD)

A study on the prevalence of hard drugs was conducted in 2001, suggesting that Finland had an estimated 8,300–12,400 amphetamine (problem) users in age group 15–55-year-olds in 1999. Estimates indicated that women accounted for some 15–25 per cent of the amphetamine users, and about half of the amphetamine users were aged 25 years or younger. Correspondingly, the harmful effects associated with amphetamine have developed in 1993–2001 as shown below (1993=100). There are no equivalent and comparable time series for ecstasy or LSD – except concerning drug seizures, but the use of these substances is indicated in statistics on drug treatment and telephone helplines.

85 See Chapter 2.3.
86 Cf. Footnote 84. At the beginning of the time series (1993), the indicators have the following values: amphetamine-related deaths 17, morbidity (stimulant-related) 142, drunken driving 200 and seizures 381.
6.3 Opiates / Heroin

According to the 2001 study on the prevalence of hard drugs, Finland had an estimated 2,500–3,300 opiate (problem) users in age group 15–55-year-olds in 1999. Based on the estimate, women accounted for about 20–30 per cent of the opiate users and little less than half of the opiate users were 25-year-olds or younger.\footnote{See Chapter 2.3.} The harmful effects of opiates have developed in 1993–2001 as follows (1993=100):\footnote{Cf. Footnote 84. At the beginning of the time series (1993), the indicators have the following values: opiate-related deaths 22, morbidity 161, drunken driving 42 and (heroin) seizures 39.}

\textit{Figure 26.}

\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{trends.png}
\caption{Graph showing trends in opiate-related harms from 1993 to 2001.}
\end{figure}

\begin{itemize}
\item number of drug seizures
\item driving under the influence of drugs
\item drug related morbidity
\item narcotics findings in autopsies
\end{itemize}

* = Preliminary information

6.4 Cocaine

Cocaine is often associated with ‘recreational use’, which may partly explain why this substance cannot be made visible by indicators measuring (severe) adverse effects of drug use. On the other hand, the use of drugs (other than cannabis) is so rare in Finland that population surveys cannot accurately reflect it. Therefore, no reliable time series on cocaine are available. The police statistics suggest no great changes in the number of seizures during the past three years, but there are some signs of an increasing cocaine supply, as is the case elsewhere in Europe, especially as indicated by Internet discussion forums and investigations into youth culture.
### 6.5 Polydrug use

Finnish substance abuse is characterised by polydrug use. The 2001 drug treatment demand study collected information about clients in treatment for substance abuse, who were problem users of narcotics or medicines – with or without alcohol. The result was that when the primary substance and possibly two additional substances were examined, it transpired that almost 60 per cent of the drug clients in the pilot had at least three substances on record and almost 85 per cent abused at least two substances. In terms of diseases linked to narcotics and medicines, polydrug use has increased steadily.\(^9\) More than one substance finding was also involved in a third of all drug-related deaths (based on forensic findings) and in more than every second case of driving under the influence of drugs.

#### Table 16
Prevalence of narcotics in cases of driving under the influence of drugs in 1993–2001

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1 drug</td>
<td>194</td>
<td>201</td>
<td>178</td>
<td>248</td>
<td>331</td>
<td>345</td>
<td>381</td>
<td>522</td>
<td>483</td>
</tr>
<tr>
<td>2 drugs</td>
<td>96</td>
<td>109</td>
<td>119</td>
<td>211</td>
<td>243</td>
<td>265</td>
<td>316</td>
<td>379</td>
<td>410</td>
</tr>
<tr>
<td>3 drugs</td>
<td>31</td>
<td>21</td>
<td>29</td>
<td>47</td>
<td>44</td>
<td>131</td>
<td>165</td>
<td>133</td>
<td>102</td>
</tr>
<tr>
<td>4 drugs or more</td>
<td>4</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>4</td>
<td>14</td>
<td>56</td>
<td>40</td>
<td>49</td>
</tr>
<tr>
<td>Findings, total</td>
<td>325</td>
<td>334</td>
<td>327</td>
<td>508</td>
<td>622</td>
<td>755</td>
<td>918</td>
<td>1,074</td>
<td>1,044</td>
</tr>
</tbody>
</table>

Like medical risks, social risks are hard to delimit to polydrug use in particular, but one possibility to do so is offered by the findings made in connection with persons driving under the influence of drugs. It is interesting to note that especially polydrug use (broadly defined) seems to be an increasing hazard in road traffic, since less than half of the cases anymore involve just one substance.\(^9\)

Already the results of youth surveys point out that abuse of different substances or drugs is concentrated in the same clusters of young people. The ESPAD school survey on 1999 found that about three quarters of 15-16-year-olds who had tried tranquillisers or sedatives or some illegal drug other than cannabis had also mixed alcohol with pills, while about half of those who had experimented with cannabis or inhalants had done so. On the other hand, about a third of those having mixed alcohol with pills or used inhalants, tranquillisers or sedatives had also tried cannabis. (Ahlström et al. 1999).

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\(^9\) See Chapters 3.1 and 3.4.
As regards abuse of medicines for intoxication purposes, information about the use of sedatives and tranquillisers has been collected as well. Based on the 2000 survey data, 4.5 per cent of 15–69-year-old men and women had used medicines for non-medicinal purposes at least once during lifetime. In last 12 months, 1.5 per cent had done so; women accounted for 30 per cent and those aged under 25 accounted for 15 per cent. Some 1.8 per cent of the Finnish population had experimented with sniffing solvents or glue during lifetime, but only 0.3 per cent had done so in last 12 months.

The number of patients in hospital and specialised services for substance abusers, treated for abusing sedatives or tranquillisers, is somewhat higher than that of all narcotics clients. However, the former group consists of older people. Deaths related to pharmaceuticals are four times more common than narcotics deaths. Many deaths related to pharmaceuticals are classified as suicides. After 1993, deaths related to medicines have remained relatively stable.

Traditionally, abuse of medicines has coincided with alcohol use, but recent analyses of drug treatment and drug-related deaths have shown emerging polydrug use of medically prescribed sedatives and heroin. This also indicates the use of pharmaceuticals as ‘self-medication’ for drug problems.

7 DISCUSSION

7.1 Consistency between the indicators

Since the year 1990, the existing indicators show a constant trend in the drug situation: drug experiments and use (time series available on cannabis only) as well as related harms (crime, morbidity and mortality) have increased steadily during the decade. At the turn of the decade, first signs appeared suggesting that the rapid growth in drug experiments and use is possibly slowing down. This is especially apparent among young adults, who are usually the most susceptible to drug experiments.

While the methods do not allow direct comparison, this "slowing down" -interpretation is supported by school health surveys from 1999 to 2001 and estimates of problem users, which have not changed much since the mid-1990s. It remains to be seen whether this is a random phenomenon or the possible first sign of a new trend.91

90 Drug laboratory of the National Public Health Institute, 2001.
91 See also Virtanen 2001(a) and 2001(b).
While the growth in drug experiments, having started in the early 1990s, may be levelling off, the same does not apply directly to drug-related harms, because e.g. in demand for treatment, the adverse effects of problem use seem to surface with a delay of 3–5 years after the first experiments and regular use. Looking back five years, drug experiments were rapidly growing in Finland. On the other hand, it should be noted that one important reason for the relatively steep growth in harm indicators has to do with their levels in the 1990s, which were exceptionally low in international comparison.

However, there were signs in 2001 suggesting that the growth in drug-related deaths, morbidity and infectious diseases has slowed. The rapidly growing number of new HIV infections due to intravenous drug use now seems to be slightly declining, and the same applies to new hepatitis C infections, which in 2001 seem to be at 1,500 new cases, 300–400 fewer than the average in recent years.
Different substances are manifested in the statistics in different ways. For instance, statistics on health care and substance abuse services show the harms of ‘hard drugs,’ amphetamines and opiates, in particular. The same drugs are apparent also in infectious diseases and mortality statistics. In crime statistics, a key role is played by cannabis, although amphetamine is rapidly increasing its percentage of seizures made. At present, cocaine and ecstasy are in practice reflected in the Finnish crime statistics only. Some indications of their use can also be found in treatment statistics, drug helplines and discussion forums.

Polydrug use is typical of Finnish substance abuse. The largest user group however comprises abusers of alcohol, who only occasionally consume other substances. The combinations of substances used in the 1990s have remained unaltered: the most important groups are polydrug users of alcohol and pharmaceuticals; amphetamine and cannabis users who also drink alcohol; and opiate users who also use amphetamines and cannabis but not much alcohol. It seems that the role of alcohol is declining, especially among ‘hard-drug’ users. In the 2000s, alcohol in particular plays a smaller role among problem drug users and the connection between alcohol and medicines is also growing weaker. (Partanen, A. 2000a, 2001 and 2002).

While all indicators show that the Finnish substance abuse problem revolves around alcohol, there are three factors that are alarming about the problem use of narcotics: the above-mentioned rapid growth of drug-related harms, increasing exclusion of problem drug users – which is seen in their position which is even more marginalised than that of other substance abusers or criminals – and the fact that these problems typically concern young people. The latter phenomenon is reflected in the Figure on hospital and drug treatment statistics, shown below:
The age distributions also show that half of the suspects in drug offences were aged 15–25 years. In addition, half of those having died of a heroin poisoning and over 40 per cent of those infected with hepatitis C were under 25 years of age.

Geographically, drug-related harms are spread all over Finland in the same way as drug experiments and use, with Southern Finland and the major cities predominating in drug use and drug-related harms as well.

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92 Outpatient services calculated on the basis of clients (up to age group over 60-year-olds). Statistical Yearbook on Social Welfare and Health Care 2001; Partanen, A. 2002.
Even if the 1990s growth in drug experiments were levelling off, changes in the level of negative effects do not directly follow that trend because e.g. in demand for treatment, the negative effects of problem use seem to accumulate with a few years’ delay. In the long run, an increase in the prevalence of drug use in the 1990s also reduced regional prevalence differences, a fact that has a direct impact on the spreading of drug-related harms throughout the country.

As the users become older, the negative effects will affect older age groups both in acute and eventually chronic forms (liver cirrhoses due to hepatitis C, etc.), which are already manifest in terms of the substance most commonly abused in Finland, namely alcohol. Chronic drug-related effects will present a completely new challenge to the treatment system in the coming decades. Some of these impacts, e.g. HIV infections due to injecting drug use, will also spread to the population that do not use drugs.

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93 Drug-related diseases defined according to primary diagnosis; regions defined by province, North Finland includes the Provinces of Oulu and Lapland. See also Chapter 2.2.
7.2 Methodological limitations and data quality

The amount of Finnish drug information expanded considerably in the 1990s, and an effort was made to improve its quality. Also the technical development of statistical systems has advanced.

Since the beginning of 1990, Finland had regular surveys targeted at schoolchildren, young people, conscripts and the general population. The data on drug use among conscripts span almost three decades. Nevertheless, these methods do not yield information about the most dangerous drugs, which are used by a limited and relatively unreachable group of people.

The bulk of the indicators of drug-related harm is however collected as a part of a larger information system, which may restrict their usefulness as drug-specific information. The Finnish development of drug information systems focuses on a more precise interpretation and utilisation of available data. Examples of this include research reports on the backgrounds of drug offences and deaths, and estimates of the prevalence of amphetamine and opiate (problem) use, retrieved through combined data from different registers. Progress has also been made in the compilation of specific drug treatment data by using the TDI drug treatment demand information protocol compatible at the European level.

Along with information about the drug situation, some research in Finland has been carried out on drug policy and the control and service system. The data on the systems and the improved methods of evaluating projects on drug prevention and drug treatment make it possible to devise more feasible interventions in the future.

Quantitative methods have been widely developed, but the lack of qualitative field studies is a drawback in Finnish drug research, narrowing possibilities to interpret quantitative data and to gain more profound insights into the drug phenomenon. While qualitative drug research issues are already discussed in some theses and dissertations, this lack of information still restricts the possibilities to target public interventions at different drug user groups and cultures.
PART III  DEMAND REDUCTION INTERVENTIONS

8. STRATEGIES IN DEMAND REDUCTION AT NATIONAL LEVEL

Drug demand reduction involves broad activities encompassing authorities, organisations, citizens and several areas in the private sector. This work is done at local, regional and national levels and as a part of international co-operation.

Drug demand reduction – especially prevention, drug legislation and the relevant social and health services – belongs to the domain of the Ministry of Social Affairs and Health, while educational, youth, cultural, physical education and sports issues are administered by the Ministry of Education. The Ministry of the Interior is in charge of the strategic planning concerning the police.  

Subsidies paid from the state budget constitute a central resource basis and a means of exercising control over the planning of substance abuse services. In its annual plans, the Government approves the guidelines and grounds for the distribution of state subsidies for social and health services as well as education and culture. The State provides the municipalities with appropriations for health, social, educational and cultural services, the amounts of which depend on the population, age structure, morbidity, service structure and the unemployment rate in each municipality.

The Finnish municipalities have a relatively extensive autonomy. By law, the municipalities are responsible for temperance work and providing substance abuse services to meet local needs. The municipalities plan and pursue local intoxicant policies based on inhabitants’ needs and rights stipulated by law. They are also responsible for the use of State subsidies, municipal taxes and other revenues.

Civic activities in Finland have a long tradition in complementing the public system. Preventive drug work is done by many non-profit-making general organisations and organisations specialising in public health or substance abuse services.

8.1 Major strategies and activities

At the end of 1998, a Government Decision-in-Principle on Drug Policy (1998) was issued. The decision was based on the proposal for a national drug strategy drafted in 1997 by officials and experts in the Drug

93 See Appendix 1: Organisation chart of drug administration in Finland.
94 See the Act on Welfare for Substance Abusers (41/1986), Section 3 and the Temperance Act (828/1982), Section 4.
95 See Appendix 4, Actors in demand reduction.
Policy Committee (Drug Strategy 1997). The decision concluded that, in order to combat drug use and distribution of drugs, general socio-political measures are needed along with drug-specific demand and supply reduction activities. Demand reduction actions are divided into preventive work as well as treatment and support provided for substance abusers and their close persons.


**Preventive work and early intervention**

According to the 1998 Government Decision-in-Principle, demand reduction is promoted by influencing the population’s living conditions by pursuing Nordic welfare policy and by early and effective intervention in emerging intoxicant problems and in symptoms preceding drug use. The following methods are used to achieve this goal:

- New approaches will be developed to drug prevention and drug education.
- Resources are invested in vocational and further training of personnel working with drug issues.
- A committee will be set up to make proposals for preventing drug use among young people and reducing the detrimental effects of substance abuse.
- Local projects will be launched to support early intervention in young people’s problems.

One aim of the target and action strategy for social and health services for 2000–2003, approved by the Government in 1999, is the prevention of substance abuse problems. Prevention will be done, e.g. through regional workers in charge of co-ordinating municipal substance abuse work, appointed by municipalities.

In terms of prevention, the 2000 Government Decision to intensify drug policy suggests the following:

- In liaison with the Ministry of Social Affairs and Health, organisations will launch a nationwide information campaign.
- The nationwide campaign will be complemented by local campaigns.
- Support will be given to the regional co-ordinators in charge of municipal substance abuse work.

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96 Chapter 1.1 presents the documents discussed in this chapter.
97 For the supply reduction strategy, see Part IV.
- Drug prevention will be developed through young people’s workshops and together with local youth departments.
- The police will give preventive counselling, especially to young people, through basic police work and community policing.
- Supported by the Ministry of Social Affairs and Health, municipalities and drug work organisations in the Greater Helsinki Area will develop local methods of early intervention.
- School staffs will be trained in drug prevention.
- Preventive material will be produced for schools.
- Further education for social welfare and health care professionals will be launched to enhance awareness of drugs.

Care of abusers and support for their families

The care and treatment of drug abusers is based on the general principle observed in Finnish social and health services to provide all citizens with the services they need. The aim of welfare for substance abusers is, on the one hand, to prevent and reduce substance abuse and, on the other hand, to minimise related social and health harms, as well as to promote the functional capacity and security of abusers and their families. Because of the nature of the addiction problem, abusers should be offered a flexible access to care.

The Government Decision-in-Principle on drug policy from the year 1998 incorporates the following approaches to reach this goal:
- Referral to treatment and treatment services for drug abusers outside consulting hours will be expanded.
- The quality of care required by the Act on Welfare for Substance Abusers has to be ensured equitably throughout the country.
- Detoxification and substitution therapy will be provided to meet the present needs.
- The Ministry of Social Affairs and Health will examine the provision of care for pregnant women using drugs.
- The possibilities of the Child Welfare Act to help young substance abusers will be put into practice more widely.
- Drug prevention in prisons will be developed so that new drug users are not recruited, and drug use does not continue during imprisonment.
- Models of action will be developed further and introduced that prevent the spread of communicable diseases and promote the integration of abusers into the service system.
- A system will be created, whereby those subject to measures by the police are offered expert help in order to assess their addiction situation and to refer them to treatment.
- The special needs of drug abusers will be taken into consideration in the development of existing services by intensifying personnel training and expanding low-threshold services for the excluded.

In terms of the development and accessibility of care, the Government Decision to intensify drug policy in 2000 suggests the following:
- The Ministry of Social Affairs and Health has nominated a working group to make proposals for developing substance abusers’ treatment.
- Emergency health care personnel will be given further training.
- In order to implement detoxification, maintenance and substitution treatment of drug users, further training will be provided for personnel.
- The system of monitoring treatment services for abusers of narcotics and medicines will be developed.
- Drug rehabilitation in prison will be increased to reintegrate prisoners into society and to reduce recidivism.
- Co-operation with local authorities and the prison administration will be enhanced in order to ensure the continuity of rehabilitation after release from the prison.

8.2 Approaches and new developments

Demand reduction policy during the year has been a continuation and result of the 1998 Government Decision-in-Principle on drug policy and the 2000 Decision to intensify drug policy. The new approaches are linked to the ideas put forward in the Decisions and to the statements made in the final reports of demand reduction development projects. Working groups on developing prevention and treatment have submitted their reports.

The report of the committee for preventing young people’s drug use (2000)\(^{98}\) was published on 9 October 2000. The committee was appointed by the Ministry of Social Affairs and Health. The committee made nine principal statements. According to these statements:
1. The multifaceted nature of drug prevention strategies and approaches linked to local conditions must be stressed.
2. From the viewpoint of drug prevention, support for the basic structures of the welfare state is of paramount importance.

\(^{98}\) The report is available at [http://www.stm.fi/suomi/julkaisu/julk01fr.htm](http://www.stm.fi/suomi/julkaisu/julk01fr.htm)
(3) More attention should be paid to reducing harms related to drug demand and use.
(4) Professional skills and other expertise of prevention done by authorities and non-governmental organisations should be increased.
(5) Collaborative structures must be further strengthened in co-operation with young people themselves.
(6) It is important to increase resources to enable collaboration between administrative sectors and to make sure that project activities are translated into everyday practices.
(7) An effort should be made to provide adequate factual, realistic and believable information about drugs and risks of different drugs whenever drug prevention is considered.
(8) The public and members of the media should be encouraged to assume responsibility, to grasp the complex nature of the drug situation and to avoid stereotyping.
(9) The co-ordinating role of the Ministry of Social Affairs and Health in drug prevention should be fortified by reinforcing the position of the drug policy co-ordination group. Also the role of the Ministry of Education should be solidified in drug prevention and in the domain of the Ministry of the Interior, drug prevention should be developed as part of legal education.

The Report of the committee for developing the treatment system for drug abusers (2001) was published on 1 June 2001, also this committee was appointed by the Ministry of Social Affairs and Health. The committee proposed, for example, the following actions:

(1) In terms of the drug treatment systems,
- Municipalities should draw up a treatment strategy concerning problem drug use in their area.
- Basic social and health services are mainly responsible for providing treatment for substance abusers.
- Personal service counsellors should be assigned for severely drug-dependent clients.
- Mental health care units should provide pharmaceutical and other detoxification treatment for psychiatric patients.
- A collaborative national body should be established to follow domestic and international developments in treatment for substance abusers and to co-ordinate training in the treatment of drug dependence.
- The availability of pharmaceutical therapy for opioid-dependent patients should be increased and queues to treatment assessment should be shortened.
- The variety and availability of drug-free therapy models for drug problems should be improved.
- Co-operation between the police, prosecutors and social work should be upgraded already at the preliminary investigation stage of drug offences.
- The time spent in prison should be utilised by organising rehabilitation programmes for prisoners.

99 The report is available at http://www.stm.fi/suomi/julkaisu/julk01fr.htm. The issue was previously discussed in 1999 at the consensus meeting organised jointly by the Academy of Finland and the Finnish Medical Society Duodecim on the treatment of drug addiction in Finland. See http://www.duodecim.fi/koulutus/konsensuskokoukset
(2) In terms of training in drug treatment,
- Training in drug treatment should be provided both locally and centrally, and it should be made available not only to professionals working with substance abusers but to others as well.
- Annual seminars or consensus meetings should be held on current drug issues.
- To intensify and organise training in the treatment of problem users, an expert network should be established, co-ordinated by the above-mentioned collaborative national body.

(3) In terms of drug treatment finance,
- For organising treatment of problem drug users, an annual EUR 8.4 million of additional State funding should be allocated for the next 5–10 years; this arrangement also requires an additional municipal investment of EUR 25 million per year.
- The system of equalising substantial costs in specialised health care between hospital districts is suggested to be applied to drug clients.
- Professional assessment of treatment need among drug abusers, carried out in social services, and administrative and financial decision to implement treatment should be delegated to the same parties.
- Legislation on sick insurance rehabilitation allowance should be amended so that also unemployed problem users could receive rehabilitation allowance for the duration of drug treatment.

(4) In terms of legislation on drug treatment,
- As for the Act on Welfare for Substance Abusers, a) stipulations obliging municipalities should indicate that social and health services share responsibility for providing services for substance abusers; b) the criteria for involuntary treatment provision based on health hazards should be clarified; c) based on the Act, it should be possible to issue both regulations on the medicinal treatment of opioid addicts and the Ministry’s Decrees and guidelines for the content and organisation of this treatment.
- It is necessary to stipulate an obligation for health centre physicians to instigate involuntary treatment based on health hazards, as prescribed by the Mental Health Act.
- Serious drug dependence should be interpreted as a severe mental health disturbance, as defined in the Mental Health Act, which, if other requirements of the law are met, justifies the involuntary treatment of those under 18 years of age.

During the year, these statements in principle have been implemented in, for instance, major training seminars in the field (national training events on medicinal treatment and health counselling, trade fair events, TerveSos 2002, and addiction seminars, Nationwide Intoxicant Days).

The annual further and special training forum of the Finnish Medical Association (Finnish Medical Convention) did not discuss addiction medicine as a special theme in 2002. However, on the strength of the previous year’s experiences, the special training of addiction physicians and other specialised health
care personnel was concentrated in Finland’s only addiction hospital, located in Järvenpää; the training concerns health counselling centres for injecting drug users and the medicinal detoxification, substitution and maintenance treatment of opioid-dependent clients.\(^\text{100}\)

Each May, a social welfare and health care training event and trade fair (TerveSos) is arranged by STAKES and some Finnish city, which in 2002 was Jyväskylä, under changing them, this year ‘Social capital accumulates with using it.’ In the field of substance abuse, the focus was on local work and support for it through research and development. The seminar gave the floor to three reports completed by STAKES: an evaluation of local activities to prevent substance abuse harms in Greater Helsinki region; language usage and ways of influencing in drug education; and the impact of monitoring information on the development of drug treatment.\(^\text{101}\)

Another annual event discussing substance abuse work is the nationwide Intoxicant Days, which is held in September, organised by the co-operation forum (Päivyt) of treatment services for substance abusers and the Finnish Centre for Health Promotion. In 2002, the seminar provided a forum for almost all new action models and development work in Finland. One of the framework themes was quality in substance abuse work, and seminars were held on implementation of drug policy programmes, the contact person network in developing substance abuse prevention, changes in drug use and control, national and local views on the drug debate and polydrug use reflected in the statistics, fieldwork and treatment.\(^\text{102}\) The seminar also presented the new national quality framework for substance abuse services,\(^\text{103}\) the drug policy programme of the co-operative board of treatment services for substance abusers,\(^\text{104}\) the present developing state of the contact person network of substance abuse prevention, a comparison of everyday lives of recreational and hard-drug users, first experiences from the nationwide drug campaign launched under the Government’s drug policy programme and the new manifestations and treatment methods of polydrug use in Finland.\(^\text{105}\)

9 PREVENTION

In addition to the immediate actions specified in the 2000 decision to intensify drug policy, the Government gave the national drug policy co-ordination group a task to prepare a long-term action programme for enhancing drug policy. The goal is to arrest the growth in drug use


\(^{101}\) See Chapters 9.4 and 11.1.


\(^{103}\) See Chapter 11.

\(^{104}\) See [http://www.kalliola.fi/huupo.pdf](http://www.kalliola.fi/huupo.pdf)

and crime. In the action programme on intensifying drug policy in 2001-2003 (5 February 2002), the co-ordination group makes the following proposals for prevention and early intervention:

1. Based on the Government’s decision to enhance drug policy in 2000, health promotion appropriations were increased, especially for improving the professional skills and understanding of harm reduction among those engaged in drug prevention.

2. As of 2001, the co-ordination of multiprofessional substance abuse work and professional skills in the municipalities will be consolidated by developing municipal contact person network correspondingly.

3. In 2002-2003, a group of municipalities will be selected from this network for a more specific development project to enhance wider interadministrative leeway.

4. Methods of outreach work will be developed to intervene locally in new drug phenomena as early as possible.

5. Activities to enhance drug information and education, started in 2001, will continue in the form of a nationwide information campaign.

6. As of 2001, the education sector will enhance personnel training emphasising preventive work, as decided by the Government in 2000.

7. In 2002-2003, supplementary training for school personnel will continue in an effort to view drug prevention from a wider and social perspective.

8. Youth workshops and organisations working with them will be allocated a total of 330,000 euros to be used in 2001 for preventing drug use and exclusion. The budget proposal for 2002 has an allocation of EUR 841,000 for drug prevention among young people.

9. In 2002-2003, funds will be forthcoming for training personnel in municipal youth work, non-governmental organisations or for volunteers.

9.1 School programmes

Schools work against drugs by improving the curriculum, student welfare services and networking as a part of prevention at a local level, with pupils and parents as major contributors. Thus, many schools try to devise comprehensive methods of intervening in substance abuse problems. Because the school cannot act alone, the assistance of official and expert bodies is needed.

The school syllabus reform currently underway in Finland supports the qualitative development of health and legal education in school and the establishment of co-operative models between homes and school and with other central actors in the field. The Parliament passed a law (453/2001), whereby basic education will include a new subject, ‘health education.’ Correspondingly, another amendment will make health education, which was formerly taught in conjunction with physical education, a separate subject in
upper secondary (454/2001) and vocational (455/2001) schools. Substance abuse questions are key aspects of this new subject.

The aim is that pupils and students learn about healthy lifestyles, attitudes promoting health and have better readiness to appreciate values associated with health. Education should also support personal growth and enhance physical, psychological and social health and wellbeing. Furthermore, other important segments include social and life-management skills, family and consumer education and achievement of safety skills.

As far as drugs are concerned, a large-scale national post-graduate training programme for teachers was launched in 2001, to be continued in the following years. Locally, the programme is implemented in close collaboration with drug prevention authorities and organisations. It contains a study period of 38 hours, during which the aim is to draw up an action programme on substance abuse prevention in school. This goal is supported by the ongoing process of the national syllabus reform. The attendant goals for student welfare require that schools, when drawing up their curricula, must make a plan for student welfare as well. The plan should define preventive actions to promote health and safety in the school community, a plan for implementing multiprofessional co-operation and a plan for action with regard to various crises, accidents or problem situations (including substance abuse).

The Ministry of Education was allocated an additional EUR 670,000 in 2001 for training teachers to recognise, encounter and discuss drug use in school. The actual measures to be taken, such as preventive education and antidrug activities as well as student-specific actions, are decided locally depending on the case. (Action programme, 5 February 2002). The Ministry has channelled the appropriation to be used through the National Board of Education, which has agreed to train 3,800 people at its training centre (Opeko). Mainly targeted at secondary school principals and teachers throughout the country, the training commenced in September 2001. According to plan, 2,000 people will receive training in 2001 and a further 1,800 in 2002.

Financed by the Ministry of Education, the provision of supplementary training in health education for teaching staffs has started. Health education is included as a new subject in basic teacher training, teacher instructors’ education and extension studies for teachers. This nationwide education is made available by the universities of Jyväskylä and Turku.

To support the school syllabus reform as well as multiprofessional co-operation in school, the ‘Information package on drugs (1997)’ and ‘Procedures for upper secondary and vocational schools in antidrug work (1997)’ were produced in 1997. The updated and enlarged edition of the information
package on drugs was published in 2001, including a constantly updated Internet service.\footnote{See the 3rd update at \url{http://www.irituumeista.fi/huumetietopaketti}} Also serving as a textbook, the information package was made in extensive co-operation with interest groups and it is a tool and background material intended for everybody who needs basic information about drugs. In addition, a report was published in 1998 under the heading ‘Use of programmes supporting the prevention of substance abuse in school’\footnote{See \url{URL:Http://www.antidrugnet.org} in Swedish: <URL:Http://www.interdrug.net>} (Huopanen et al. 1998). At the beginning of 2001, the project continued in the form of a handbook on co-operation between schools and other actors in drug prevention (Huopanen et al. 2001). A drug-related webpage for teachers, pupils and parents has also been created.\footnote{ Cf. Chapter 1.1 of the action and financial plan 2002 - 2005 of the Ministry of Education. Evaluation of the effectiveness of the workshops (in Finnish) at: \url{http://www.minedu.fi/julkaisut/pdf/tvopajaselvitys.pdf}}

9.2 Youth programmes outside school

The projects to prevent substance abuse among young people are varied in terms of scope. Workers implementing drug prevention have delivered information on drugs in schools, PTA meetings and other functions. Sports and youth organisations have also been involved when alternatives to alcohol and drug experiments or use have been sought. Especially schoolchildren’s afternoon activities have been developed in order to promote sports and other activities among juveniles, with a view to enhancing antidrug work as well. In addition, brief antidrug projects have been implemented, such as plays and musicals. Such projects are clearly on the increase among young people. So-called traditional youth work as an everyday activity is increasingly regarded and developed as a form of prevention. Continuity and sustained efforts are the cornerstones of these activities.

Active preventive and remedial activities have been carried out by using different approaches, ranging from clubs to life-management courses spanning several months, with an aim of developing young people’s ability to manage their lives. The methods applied include adventure and experience education.\footnote{The activities launched by the Ministry of Education under the International Award Programme (Avarti) as one example (see \url{http://www.valtakunnallinenyopajayhdistys.fi/avarti.htm})} This has made it possible to reach young people who are not susceptible to traditional drug education. Workshops organised for young people have been an important resource, with a possibility of enhancing young people’s life-management skills.\footnote{In 2001, the Ministry of Education allocated a total of EUR 390,000 for the prevention of drugs and exclusion at youth workshops. This sum will support 18 projects implemented all over Finland, for example, in co-operation with national youth centres. Some projects work directly with young people, for instance, by organising life-management courses applying youth education methods for those who have...}
an addiction problem or face exclusion risk, while other projects train youth workers, such as employees of youth organisations and voluntary leaders, to work on drug issues. Support will also be given to the general operating requirements of municipal youth work. (the Action programme 2002).

Administered jointly by the Ministries of Education and Social Affairs and Health, a project was launched in 2002 to develop drug prevention at youth workshops, especially to enhance readiness to deal with drug issues and to make proposals and recommendations for reducing drug use and related harms among young people. The concrete aims include providing workshops with guidelines for drug work, assessing workshop leaders’ drug training and making suggestions for improvement as well as compiling practices found fruitful in drug prevention.

The 2002 State budget had EUR 841,000 for drug prevention in youth work. The Ministry of Education granted support to 70 projects. This assistance concerned projects enhancing youth workers’ skills to recognise, face and deal with drug problems and to support young people in the best possible way. The target group comprised all employees working with young people in municipalities and other communities in need of information and knowhow concerning drug prevention and youth guidance. Support was also given to improve readiness for prevention in municipalities and communities. However, these funds were not intended for so-called traditional youth work.

For children and young people facing precarious living conditions, different meeting places (cafés, clubs, shelters) have been established, where it is possible to discuss and alleviate the problems of loneliness, parents’ substance abuse and other severe difficulties. A support person may be designated for a young client, or small-group sessions may be arranged for meeting people in a similar situation. An example of such meeting places, the Walkers youth cafés\(^{10}\) provide early intervention, currently operating in 24 localities. An important role in these activities is played by adults, trained volunteers supported by youth work professionals. An effort has been made to develop the youth cafés into safe meeting places, where young people are welcome and can interact individually within the group and with adults. The Walkers activities have set an example for expanding participatory youth work now having started in many localities.

New kinds of youth work have also been set up in connection with local inhabitants’ activities. For example, parents’ training groups have been formed in order to distribute information and to discuss approaches to preventing substance abuse. Teams consisting of adults, young people and children have been established for children’s and young people’s interests and hobbies.

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\(^{10}\) Address and other information about the Walkers cafés at [http://www.asemanlapset.fi/walkers-nuorisokahvilat/walkers-kahvilat_suomessa/](http://www.asemanlapset.fi/walkers-nuorisokahvilat/walkers-kahvilat_suomessa/)
9.3 Family and Childhood

Infancy and family

The information provided by Finnish maternity clinics for families expecting a baby deals with alcohol, tobacco and, to some degree, medicines, excluding narcotics. However, a new guidebook was published in 1999 for health care professionals and educational institutions in the field (Halmesmäki 1999). Most research in the field is alcohol related. There is only one study for training purposes, monitoring the feasibility of different rehabilitation programmes on treating mothers with drug problems at the Oulunkylä Mother and Child Home, Helsinki (Holopainen 1998).

The Federation of Mother and Child Homes and Shelters\footnote{1} is a child welfare organisation, whose goal is to ensure children’s right to a favourable and safe development, to support parenthood and families and to prevent violence in the family. The 26 member organisations have 12 homes for pregnant women or mothers with a newborn and 13 shelters for persons facing violence in the family. By the end of 2000, there were two special homes (Turku; Oulunkylä in Helsinki) for pregnant women or mothers with substance abuse problems. In 2002, three new shelters specialising in addiction problems will be opened.

According to the report of the working group on drug treatment (2001), planning of care for pregnant women must take account of the entire care chain from contraception to the situation after childbirth and beyond. The threshold for seeking treatment should be low, and substitution and detoxification treatment with medicines for opioid-dependent mothers should be made available. Care should be concentrated in specialised maternity units to ensure the best possible treatment and to lower the threshold among drug-addicted mothers attending the clinics. The Ministry of Social Affairs and Health has prepared a three-year Mama project (2002–2004) on substance abuse prevention and early detection among pregnant women as well as the development of support and care services. (the Action programme 2002).

Support for children of drug users

Compared to alcohol problems, abuse of narcotics in Finland has been relatively rare. In addition, drug use usually involves young people, who as adults often abandon drugs but not alcohol. For instance, family violence is primarily associated with alcohol abuse.

\footnote{1} See http://www.ensijaturvakotienliitto.fi/2toiminta/6hoito.html
In the most serious cases, children may be taken into custody, which means that the child is provided for and educated by society. Such action must be taken if childcare is neglected, if some other circumstances at home jeopardise the child’s health or development, or if the child endangers his/her own health by using intoxicants, by committing a serious criminal offence or by other such behaviour. An additional requirement is that outpatient services have not been appropriate, possible or adequate and that care outside home is deemed to be in the child’s best interests. (Child Welfare Act 683/1983, Sections 16, 17 and 34).

A budgetary proposal was made in 1999 to improve child welfare measures and to provide care for drug users’ children. The system to equalise the extensive costs of child welfare services directs municipal resources so that child welfare clients in every municipality will receive appropriate services, irrespective of the costs incurred. The financial burden is equalised so that the municipality receives compensation if the child welfare costs of a family exceed EUR 25,000. This compensation covers both custodial and non-institutional services for the family and child.

The equalisation system is partly financed by intermunicipal fees, partly through state subsidies, which account for half of the estimated total value of equalisation. The equalisation fees of a given municipality depend on the number of inhabitants under the age of 21 years.

In the 1999 statistics on Helsinki, 31 per cent of the placements and custodial cases, enforced on the basis of the Child Welfare Act, resulted from substance abuse in the child’s home environment: a parent’s or guardian’s drug use or dependence on medicines accounted for four per cent of the cases, and the proportion of polydrug use was the same. Only two per cent of the cases were due to the child’s own substance abuse. If this information concerning Helsinki is generalised to the rest of Finland, a total of 1,250 children or young people were placed outside their homes owing to drug use on the part of the child or parents. In a decade, the number of children and adolescents who are especially in child welfare outpatient care has increased considerably. It has also been suggested that the problems of children and young people today are more profound, complex, severe and longer-lasting than before, that there is an increasing need for care outside home and that it is harder to face and treat the problems. (Hakkarainen et al. 2000).

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112 See also Chapter 1.2.
Support for parents of drug users

A central principle of substance abuse work directed at young people is to involve families in all multiprofessional substance abuse work at the earliest stage possible, whether it takes place in school, in a wider context of youth work or in terms of community programmes. To support these activities, the A-Clinic Foundation published a popular drug guidebook for parents. The purpose of the publication is to dissolve the mystical aura surrounding drugs and to encourage parents to discuss substance abuse with their children (Huolestä puheiksi, puheista teoiksi, 2000).113

Many treatment facilities emphasise the role of the family and close support persons in the drug treatment process. Both in residential treatment but also in outpatient services, family-centred therapy is gaining more ground, as seen in the increasing supply of education in the field. Self-help groups have been established for drug abusers’ close persons as well. Anybody whose relative or friend is a drug addict may join in. Sometimes the group is a closed one, with the same participants meeting regularly.

The Non-governmental 'Free from Drugs' organisation has organised a three-year networking project, Pilvi vai pouta, to prevent intoxicant use among the youth, by supporting the parents and by creating regional networks for parents, authorities and volunteers. The project is implemented in three municipalities (Vantaa, Oulu and Porvoo).114 The results will be utilised in the new action model, ‘network of caring,’ which develops co-operation between the organisation’s regional branches and the so-called sponsor schools.

9.4 Other programmes

Self-help groups for drug users

In Greater Helsinki, there are Narcotics Addicts Anonymous115 groups based on mutual support for people who want to stop using drugs. These include a closed group for drug-dependent persons, a women’s group and an open group for all those interested. Also some other major cities have such groups, working often in connection with the local treatment programmes.

113 See also http://www.a-klinikka.fi/
114 Two intermediate reports and final report have been published on the project: Pilvi vai pouta - aitoa yhteistyötä etsimässä, 2000. See also <URL:http://www.reitox.emcdda.org/eddra/explorer/>
115 See e.g. <URL:http://gamma.nic.fi/~netna/alku.htm>
Telephone helplines

Since 1995, the drug helplines of the Free from Drugs association have provided a means of disseminating drug information for early intervention. The helplines operate in the evenings on weekdays throughout the country (22 regional branches, almost 500 trained volunteers). In addition, nationwide guidance and referral to care are offered by the Drug Dependency Treatment Unit at Helsinki University Central Hospital and by the drug clinic of the Deaconess Institute in Helsinki. The first two of the above-mentioned units belong to the European FESAT drug telephone helpline network, which has 30 units in the EU Member States.

It is increasingly often that the helplines of many other organisations encounter people seeking ways to break free from drug problems involving themselves or a close person. An example of a nationwide service is the helpline of the Poison Information Centre, targeted at professionals and laypersons alike.

For example, the drug helpline of Free From Drugs received some 3,150 (2,800) crisis calls in 2001 (2000), many of which led to further action, such as meetings with close persons. Of the callers, 63 (64) per cent were close persons, while 12 (10) per cent were substance abusers. The phone calls concerned the following substances (2001 / 2000): cannabis (38 / 37 per cent), amphetamines (30 / 30 per cent), heroin (15 / 15 per cent) and ecstasy (7 / 7 per cent). (Annual Report 2000; 2001)

Community (municipal) programmes

Municipal strategies usually cover all substances abused or concentrate on either alcohol or narcotics. Especially in small localities, the focus is on alcohol, and only major cities or federations of municipalities have specific drug strategies. A local alcohol and drug programme may also be included in a more extensive municipal programme for the promotion of health and welfare in general. In most cases, the entire population is included, while some strategies only embrace young people and children. An effort is made to set goals that are consistent with the national drug strategy proposal of the 1997 Committee nominated by the Ministry of Social Affairs and Health. The purpose of the municipal strategies or programmes is to chart the local drug situation and projects underway, as well as to define the targets, actors in charge, timetables and resources of the programmes. There are also intermunicipal,
or regional, alcohol and drug programmes. Based on this preliminary work, the development of inter-
administrative co-operation as well as new services and treatment alternatives is ongoing.\textsuperscript{119}

In May 2000, the National Research and Development Centre for Welfare and Health (STAKES) established an information service package on the Internet for municipalities, presenting municipal drug strategies, a database of treatment units, drug prevention projects, methods and practices for preventive work as well as links to the virtual library of alcohol and drug publications and to alcohol and drug legislation.\textsuperscript{120} By the summer of 2002, the database had presentations of 26 municipal or regional drug strategies and references or links to access them.\textsuperscript{121}

Evaluation of drug prevention campaigns in two districts of the city of Vantaa in Greater Helsinki in 1999 showed that the presence of municipal personnel is crucial to this work. There were major differences in how the activities turned out locally. Furthermore, the local inhabitants were of the opinion that responsibility for addiction harms should remain close to the individuals, family and community, but the role of welfare services was also emphasised. The debate and activities launched by the project helped the inhabitants take communal responsibility for addiction problems. Public opinion in the community also had a role, which could be influenced by local network activities. Nevertheless, similar action models resulted in different action profiles in these two localities: the so-called NGO model and municipal model; the former refers to the importance of unofficial and semiofficial in NGO activities, while the latter indicates that the actors were mostly municipal professionals. (Holmila, M., ed. 2002).

For the third time in a row, the provincial governments compiled information about the drug situation and implementation of the Government Decision-in-Principle (1998) as part of the basic municipal service evaluation. In 2001, the provincial governments dispatched questionnaires to municipalities, surveying 1) possible changes in drug use and related harms in recent years; 2) the number of municipalities which had an intersectorial drug/intoxicant strategy; 3) the co-ordination and responsibilities of drug prevention; 4) the degree to which the strategies and practical co-operation were implemented locally; and 5) the organisation of low-threshold services and the medicinal treatment of opioid addicts. A national summary of the results has not been made, but in their basic service evaluation in 2001 the provincial governments reported on the survey based on the responses received by the end of year.\textsuperscript{122}

\textsuperscript{119} The most extensive and comprehensive local drug strategy is that of the City of Helsinki, drawn up in 1997 and updated in 2000, available at <URL:http://www.hel.fi/sosv/jotu/huumest.html>.
\textsuperscript{120} http://www.stakes.fi/neuvoa-antavat/
\textsuperscript{121} The report on the implementation of the regional substance abuse action strategy (\textit{Rajat ovat rakkautta}) in the municipalities of Kainuu, Eastern Finland, was published in 2001 (Mustalampi, S. 2001).
\textsuperscript{122} See basic service evaluation reports on the webpages of the Provincial Governments [in Finnish] (Peruspalvelut Suomen läänissä 2000, 2001) accessible at http://194.89.205.3/suom/laanit/
The survey results show that the network of addiction contact persons in the municipalities has a good coverage, ranging from 73 to 100 per cent, but there is a much greater variation in the coverage of intersectorial drug/intoxicant strategies, 15–50 per cent. On the other hand, there is also much variation depending on the size and resources of the municipality and the severity of the local drug problem and attendant service need. It is even harder to assess the implementation of the strategies. It seems however that the local authorities, which have been motivated to draw up a strategy, have also been motivated to implement it and to establish intersectorial structures locally. A persistent problem appears to be the project-like quality of the strategies and lack of continuity. Not even the large regional supply of services did automatically encourage municipalities to draw up local strategies.

**Mass media campaigns**

The autumn of 2001 saw the launch of a broad ‘Drug information and local activity campaign 2001–2003’ to intensify drug prevention, co-ordinated by the Finnish Centre for Health Promotion in line with the Government Decision of the year 2000. The campaign aims at a many-sided and solution-oriented debate about the drug situation and problems, to activate local prevention and co-operation and to stress parents’ and local actors’ responsibility for the prevention of young people’s drug use.

The overall campaign consists of two mutually complementary entities, co-ordinated by the Finnish Centre for Health Promotion: 1) a national information campaign and 2) local campaigns. The campaign includes broad-scale evaluation, implemented by the National Public Health Institute and STAKES. To support national information, local authorities and drug prevention organisations will arrange regional activities, press conferences and events; also information material will be produced.

The national communications segment started at the end of August in the form of a seminar targeted at members of the media. During the autumn, information will be disseminated in national and provincial newspapers, as TV and radio spots, outdoor advertisements and on the Internet. Advertising will also direct people to visit the campaign homepage, containing information and discussion groups on drug themes.123

In the campaign’s first phase in autumn 2001, information was directed at the general population and a special group, 18–25-year-old young adults. The advertisements targeted at the population were somewhat provocative, encouraging people to debate and to rethink their standpoints. The young adults received more ‘traditional’ information about the negative effects of different narcotic substances. The

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The approach was concrete, focusing on the risks involved. The second phase commenced in April 2002 with two target groups, young people aged under 18 and professionals whose work concerned drug issues. Cannabis and the related risks were the primary topic of the information directed at young people. (Salasuo et al. 2002).

According to the intermediate report of the project evaluation group, the project webpage received 1,406 responses, i.e. an average of 33 responses per day and 234 per week. The activity rate was high, albeit lower than that of the A-Clinic Foundation’s virtual discussion forum, the Sauna, which had an average of 100 messages per day in 2001. Active debaters consisted of a rather small group of people: the most active tenth provided 54 per cent of the comments and the most active participant alone 6 per cent of all comments. During the first weeks, the traditional Finnish approach to the drug problem gave way to more liberal views in the forum. This liberal activity partly entailed making a drug policy statement. Secondly, the liberals gave information and guidance concerning the properties, use and effects of drugs. The third observation concerned the dialogic and argumentative method of debating and exerting influence used by the ‘liberal champions.’ (Piispa 2002).

Many studies have pointed out that especially for the young, the Internet is a major source of drug information and an arena where drug questions are defined. The audience is receptive to the information and advice given by the ‘liberal champions.’ Information generated in discussions is also arguably more interesting than ‘readymade’ facts. The researcher contends that it is not enough if professional drug experts compile information packages about drug harms on their websites. One must also be open to new ways of communication and tactics: you must go to the opposition’s playing field, onto the websites to compete who can make the strongest case.

The local campaigns of the overall project comprised two entities. The larger one contained 13 projects funded by the Ministry of Social Affairs and Health, implementing the above-mentioned objectives. These projects are carried out by organisations, municipalities, research centres and educational institutions. The second entity consisted of local activities of the Finnish Health Association NGO and the Finnish Association for Healthy Lifestyles. The former association provided experiences for young people, their parents and youth workers, while the latter organised seminars, discussing the global dimension of drug trade. This entity was financed by the Finnish Slot Machine Association. Linked to these activities were the six local projects administered by the Finnish Centre for Health Promotion and funded through donations of a private TV company (Oy Ruutunelonen Ab) for antidrug work. These six projects were implemented by NGOs and municipalities. However, the local projects have not been even tentatively evaluated yet.

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124 See http://www.paihdelinkki.fi
In addition to the ‘Drug information and local activity campaign 2001–2003’, there have been local information campaigns, e.g. launched by organisations in connection with new drug treatment services or local strategies. An effort is made to influence drug information in the media by organising an annual meeting between journalists and bodies doing preventive work, discussing also the possibility to include preventive messages in the programming. Because of lacking or confusing information, discussing drugs is often perceived as hard and getting one’s message across seems difficult. While preventive drug work nowadays has other avenues as well, public education is constantly needed. It is important for the educator to know and choose the right role and outlook on the matter. STAKES gave out a publication called 'How to discuss drugs' in a trade fair (TerveSos 2002); it is an overview of drug education practices, research and related problems. It also contains descriptions of good educational practices and suggestions for informative messages and methods. (Soikkeli 2002).

**Drug services in the workplace**

Intoxicant-related services targeted at workplaces have focused on the early detection and prevention of substance abuse problems. Drug questions have been incorporated into prevention of substance abuse in general, with the aim of maintaining working capacity both through publications and training. In practice, however, the focus has been on abuse of alcohol and/or medicines and the related dependence. However, according to the statement issued by the Intoxicants in Working Life expert group of the Centre for Occupational Safety, representing the labour market organisations, narcotics issues can only partly be dealt with in the same manner as other intoxicant questions; in many respects, they call for special measures, e.g. because of the illegality of narcotics. In general, referral to care may be based on an agreement between the client and employer. This must take place by the client’s consent. The actual treatment plan is made in the treatment facility by the client and treatment worker.

In 2000, the Centre for Occupational Safety prepared a net service associated with the drug-free workplace programme. This service is a collection of materials and links to chart substance abuse risks, training as well as the establishment of drug programmes and care referral and rehabilitation procedures in the workplace. The net service was further developed during 2001. In early 2000, The Finnish Institute of Occupational Health produced a guide on encountering drug users at work (Lusa ed. 2000). The guide is intended for security and health care professionals, but it is suitable for everybody who may meet drug users at work.
As a form of control and prevention, drug testing has aroused much debate in Finland during 2000 and 2001. A seminar was organised by Parliament on the issue at the beginning of the legislation process concerning drug tests.\textsuperscript{125} Also the Parliamentary Deputy Ombudsman issued a statement on a complaint concerning the legality of drug tests conducted in two schools.\textsuperscript{126} In general, it was stated that screening drug use of certain target groups by drug tests is judicially impossible until a law on them is passed. Nevertheless, there may be some instances where drug tests may be legitimate in a democratic society.\textsuperscript{127} A survey was conducted in eight major Finnish companies concerning the reasons for new employees’ drug testing. The companies studied had not opted for testing because of an existing drug problem but mainly due to possible future risks. Even more paramount than security was the threat of concomitant crime. According to the researcher, it was less a question of finding substances or measuring working capacity and more of testing work morale. The tests were also considered positive for the company’s public image (Bothas 2002).

On 18 October 2000, the National Board of Education issued a memorandum on drug testing in schools and other educational institutions.\textsuperscript{128} According to the memorandum, the National Board of Education does not recommend drug testing as mass screening. The recommendation stresses that a law on testing should be passed and that the Ministry of Social Affairs and Health is in the process of appointing a working group to explore the legal aspects of drug testing. With reference to the working group’s mandate, decisions on alcohol and drug tests were made on a general level only in connection with legislation on the protection of privacy in working life, and it was agreed that the employee’s obligation to undergo a test was to be discussed by that working group.

The report of the Ministry of Social Affairs and Health working group on drug testing (2002:2) concludes that tests are technically feasible and indicate substances reliably, but they are only relevant at the time of testing. Special attention should be paid to proper testing and analysis methods. Appended to the report is a guide for practical test implementation.

The working group proposed that drug tests should be specifically targeted rather than done as general screening. When appropriately targeted and timed, the tests can help intervene in substance abuse at an

\textsuperscript{125} The texts mentioned in this Chapter refer to a paper in a seminar in Parliament on 20 March 2000, held by the Advisory Committee on Intoxicant and Temperance Affairs.
\textsuperscript{126} See News Release of Parliamentary Ombudsman 22 June 2000.
\textsuperscript{127} The Act on the Status and Rights of Patients (782/1992) lays down the preconditions for determining, restoring or maintaining the patient’s health by means of health care procedures. While drug tests are not specifically mentioned in legislation, these preconditions are valid in the care situation as well: the patient must be treated in mutual understanding. If the patient refuses a certain treatment or procedure, he or she must be treated by common consent in some other medically acceptable way. For example, testing for HIV is not a minor procedure that can be carried out without the patient’s consent. (See also Liljeström 2000).
\textsuperscript{128} See http://www.oph.fi/info/huumet/
early stage, start treatment and possibly slow down the proliferation of drugs. Drug-free work communities also enhance safety and work satisfaction.

As was its mandate, the working group drew up a law proposal concerning drug tests in working life. The law will regulate, among other things, the rights and responsibilities of employees, employers and health care professionals in performing tests and processing the results. The working group has stressed health care objectives also in the law proposal. The tests should be based on work requirements and occupational safety or needs related to a drug-free working environment. The reason for obligatory tests should be assessment of potential risks to life or health. This way the tests would complement the principles of the laws on occupational safety and health. The working group does not take a stand on possible drug tests in the field of education and training not related to work, but it suggests that this be further investigated elsewhere.

Internet services

The Prevnet programme of the A-Clinic Foundation developed modern substance abuse prevention methods based on new technology in 1998–1999. The programme was a result of co-operation between Finnish actors (collaborative network of psychological wellbeing, child welfare and substance abuse work, Avec129) and European partners (the Prevnet Network130). Co-ordinated by the A-Clinic Foundation, the Prevnet Network project has partners in all EU Member States, several international organisations and countries outside the EU. A project evaluation on the Prevnet-Euro projects (McGourty 2001) and a guidebook for developing telematics services in the field (Tammi et al. 2000) have been published.

Almost all Finnish organisations in the substance abuse field have modern Internet services.131 For example, the co-ordinator of the Prevnet project, the A-Clinic Foundation has its own Internet service called the Addiction Link,132 where people can test their own situation and anonymously ask experts for advice. Material targeted at educators has been especially added, including a ready-made framework for parent-teacher association meetings and the material of guidebook for parents. One facet of these activities is the Foundation’s discussion forum (Sauna) on the web. The newest addition to the Addiction Link is a service for parents and the Foreign Info for immigrants, a service developed from the

129 See http://www.avecforum.fi
130 See http://www.prevnet.net
131 More links at http://www.makupalat.fi/sospoli5.htm
132 See http://www.paihdelinkki.fi
immigrants’ viewpoint especially for those of us who have problems with the Finnish language: it has sections in English and Russian.

10 REDUCTION OF DRUG-RELATED HARMS

In the action programme for intensifying drug policy in 2001–2003 (2002), the drug policy co-ordination group proposed in terms of drug harm reduction that:

1. Special training will be provided for emergency care personnel to prevent deaths by poisoning.
2. The spread of infectious diseases is checked by involving drug users in a broad treatment system that pays attention to drug users’ special needs.
3. Accordingly a project on outreach fieldwork will be carried out in the municipalities in Greater Helsinki.
4. Local projects will be implemented to ensure the availability of clean syringes and needles and to assess the effectiveness of the activities.
5. To increase health information and antidrug education, material on drug use and infection risks will be provided for injecting drug users.

10.1 Description of interventions

Outreach work

Methods of intervention have been devised in a few municipal working models. Outreach work is a way of introducing drug work into young people’s ordinary environment, with an attempt to tackle drug problems and other related harms wherever encountered. The work is done among drug abusers in their own setting.

Outreach work targeted at the youth is done only in a few major cities, but also in some minor towns as a part of youth and special youth work. Outreach work in Finland mainly involves street patrols. In the street, the workers on duty can assist people who need help, give first aid, listen to their troubles, offer a possibility to rest or sober up, or just look on how people spend their Friday night. The aim is to mediate between young people and the official care system. The key is to make confidential contact on a mutually voluntary basis and to maintain that contact.

A new Helsinki-based experiment was the Viita field project launched by the A-Clinic Foundation in autumn 2000 among injecting drug users (Hietalahti et al. 2001). In the project, four fieldworkers tried to
make contact with clients at first through the health counselling centre for injecting drug users, Vinkki, and later, when the users had grown accustomed to the services through peer groups, directly in the field. The method used was mainly counselling, guidance and concrete referral to treatment. At the beginning of 2001, the field team started contact café activities in Friday afternoons. The Viita activities depend on the season: in the summer, outreach work is done in the field, where drug users are found in the street and parks, while the winters are spent indoors. It is then that Viita launches its Operation Snowball, a type of peer group activity, with the aim of disseminating information about virus infections and ways of reducing the adverse effects of drug use. (Heinonen 2002).

The peer group activities started in autumn 2001, when 11 drug users aged 20–45 initially recruited from the health counselling centres took the first peer group course. Upon completing the course, the participants were supposed to contact 15 drug users among their friends or acquaintances, interviewing them and recruiting at least one new participant to a similar Snowball operation. The course a) gave information about virus infections, overdose and its first aid; b) practised interviewing through role-play; and eventually c) went to the field to engage in health counselling with the peer worker, to interview other drug users about risks and to give them new information. The first Snowball resulted in 115 questionnaires returned, which means that the field group made contact with 115 drug users, who probably would not have been reached otherwise. The questionnaires had not been analysed yet when the new Snowball group started in February 2002 based on the contacts made by the previous group. The new group was targeted at Russian-speaking drug users in Helsinki and the course took place in January–March 2002.

Low-threshold services

In recent years, the number of the so-called low-threshold day centres has increased in Finland. These services cater for problem users of all intoxicants. In addition to guided and free activities, the day centres offer meals and an opportunity to take a shower. In some cases, also health services are made available. The first-stage homes give temporary accommodation to substance abusers. The immediate needs of the client are addressed, and more permanent solutions are sought within social and health services. However, the first-stage homes primarily serve middle-aged alcohol abusers. According to the one-day census of intoxicant-related cases in social and health services in 1999, the number of clients receiving day centre services on account of substance abuse on a weekday in Finland was about 1,000, and 150 people visited overnight shelters. Less than a quarter of these clients were under 40 years of age. (Nuorvala et al. 2000).

133 The A-Clinic Foundation has published a brochure on preventing drug overdose and helping the victims: Ei syytä panikkiin – huumeiden yliannostuksen ehkäisy ja yliannostuksen saaneen auttaminen [No reason to panic – prevention of drug overdose and helping overdose victims].
Traditionally, the hospital and health centre clinics also operate on a low-threshold principle. According to the 1999 one-day census, some 1,200 substance abusers used these services during one day in Finland (Nuorvala et al. 2000). At drug clinics belonging to the special treatment services for substance abusers, the client either walks in the clinic without referral or is referred by social or health services. The client’s physical, psychological and social condition is assessed at the clinic, including a previous history of abuse and addiction. The assessment is usually made by a multi-professional care team together with the client. Low-threshold services are also provided by crisis centres in different fields and areas and in related telematics or virtual services for substance abusers.

A regionally comprehensive low-threshold treatment centre is planned in Finland’s third-largest city, Tampere. Operating around the clock without appointment, the centre refers clients to treatment, with care need assessment, care motivation and finding suitable treatment for the client as priorities, but it gives health counselling and other health services as well. Treatment is also planned for clients who consider it impossible to stop substance abuse. The low-threshold centre does not have day centre activities.

In the Tampere model, the client may be monitored at the low-threshold treatment centre for two to three days, during which time the care need is assessed. The existing needle exchange and health counselling schemes will be incorporated in the service, respecting the client work principles of the currently operating unit. Because the treatment centre refers clients to existing facilities, it is hoped to clarify the division of labour in the regional service system (youth centre dealing with general problems, children’s and young people’s Drug Stop, outpatient A-Clinic, rehabilitation centre and social emergency services). The project implementation will be monitored by a study.

**Prevention of infectious diseases**

The HIV epidemic, which started in 1998 among Finnish drug users, has underlined in public the importance of preventing infectious diseases spreading through intravenous drug abuse. Also in treatment services, attention was paid to reducing the health hazards associated with drug use. For instance, only a few treatment units for substance abusers have a needle exchange scheme. Formerly, pharmacies sold syringes, but for security reasons, almost a fourth of them have restricted the sale of syringes. Most pharmacies reported that they refrain from selling syringes to minors. (Harju et al. 2000a) In spring 1999,

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134 If other outpatient services, mental health clinics and home care are counted, the number of clients is higher by half.
135 See also Chapter 9.4 and [http://www.apua.info/](http://www.apua.info/)
136 See [http://www.a-klinikka.fi/hoitopalvelut/virtualiset.html](http://www.a-klinikka.fi/hoitopalvelut/virtualiset.html)
The Ministry of Social Affairs and Health, the National Agency for Medicines, the National Public Health Institute, the Association of Finnish Pharmacies and the University Pharmacy dispatched a recommendation to all pharmacies to sell syringes to drug users as well.

Health (infection risk) counselling services for injecting drug users (including a needle exchange scheme) are underway in 19 municipalities. The aim is to provide drug abusers with counselling to reduce behaviour involving infection risk. The visitors, who have an opportunity to exchange their hypodermic needles, are also informed about the risks of using contaminated needles, syringes and other drug paraphernalia as well as about sexually transmitted diseases. Also condoms are made available. One important aim is to motivate addicts to seek help and abandon the drug habit.

Table 17.
CLIENTELE OF THE FINNISH HEALTH COUNSELLING CENTRES FOR INJECTING DRUG USERS IN 2000-2001

<table>
<thead>
<tr>
<th>City/town</th>
<th>Opened</th>
<th>Clients 2000 (estim.)</th>
<th>Clients 2001 (estim.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Helsinki</td>
<td>Apr/1997</td>
<td>3,250</td>
<td>4,500</td>
</tr>
<tr>
<td>Espoo</td>
<td>May/2001</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vantaa</td>
<td>Oct/2000</td>
<td>200</td>
<td>730</td>
</tr>
<tr>
<td>Tampere</td>
<td>May/1998</td>
<td>475</td>
<td>740</td>
</tr>
<tr>
<td>Turku</td>
<td>Feb/2000</td>
<td>650</td>
<td>970</td>
</tr>
<tr>
<td>Oulu</td>
<td>Oct/2001</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lahti</td>
<td>Nov/1999</td>
<td>under 50</td>
<td>under 10</td>
</tr>
<tr>
<td>Kuopio</td>
<td>Sep/2000</td>
<td>under 50</td>
<td>under 100</td>
</tr>
<tr>
<td>Jyväskylä</td>
<td>May/2000</td>
<td>under 100</td>
<td>under 100</td>
</tr>
<tr>
<td>Kotka</td>
<td>Jan/2001</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hämeenlinna</td>
<td>Sep/2000</td>
<td>under 50</td>
<td>100</td>
</tr>
<tr>
<td>Rauma</td>
<td>Jul/2000</td>
<td>under 50</td>
<td></td>
</tr>
<tr>
<td>Salo</td>
<td>Jan/2001</td>
<td></td>
<td>under 50</td>
</tr>
<tr>
<td>Hyvinkää</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Imatra</td>
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<td></td>
<td></td>
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<tr>
<td>Joensuu</td>
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<tr>
<td>Kemi</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Kouvola</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Lohja</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pori</td>
<td></td>
<td></td>
<td>under 10</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>4,750</td>
<td>7,300</td>
</tr>
</tbody>
</table>

139 In August 1998, the National Public Health Institute drew up an ‘exclamation mark’ leaflet for drug users, with basic information and directions how to avoid infections (20,000 copies). In addition, the Finnish Red Cross produced a guide for professionals in primary health care concerning hepatitis C.
140 It has been estimated that visits to the counselling centre for IV-drug users cost EUR 100 – 135 per client annually. This means that, from the viewpoint of targeting care, it is economical to serve 150 clients at the counselling centre, if this leads to preventing one opioid addiction needing substitution or maintenance treatment (cf. Chapter 11.2).
141 Information compiled from the Provincial Governments’ evaluation reports on basic services (Peruspalvelut Suomen läänissä 2000, 2001) and health counselling centres’ reports on activities.
The oldest health counselling centre in Finland, Vinkki, has operated since 1997 in Helsinki. There have been no major changes among the clientele of Vinkki during past two years. More than half of the clientele were aged over 30. Women accounted for almost a quarter of the clientele. On average, the clients had visited the needle exchange five times during the year. In 2001 (2000), Vinkki in Helsinki took 604 (393) voluntary HIV tests, of which 9 (11) turned out to be positive. Hepatitis tests were also conducted among volunteers, who had not previously had this infection. Of 274 (187) hepatitis C tests, 91 (66) came back positive. During the year, 647 (406) people received some type of hepatitis B vaccination. (Harju et al. 2001, Kullat et al. 2002).

In co-operation with the infection risk counselling centres of three largest cities in Finland, Helsinki, Tampere and Turku, and the drug clinic of Deaconess Institute in Helsinki, a broad study to follow up risk behaviour among intravenous drug users was launched at the beginning of 2000, planned to last for three years. The project is co-ordinated by the A-Clinic Foundation, in collaboration with the National Public Health Institute and STAKES, and funded by the Ministry of Social Affairs and Health.¹⁴²

Based on the material accumulated during the project’s first nine months (n=279), the most typical health problems associated with injecting drug use were various infections: 86 per cent of the interviewees had been tested for infections, and half reported having contracted hepatitis C, while 4.3 per cent reportedly had HIV. Over 40 per cent suffered from mental health problems, and a third had had a severe psychosis or other disorder. Almost a quarter had received treatment for overdosing on opiates. From the clients’ viewpoint, the health counselling centres were important as places where they could have at least a modicum of contact with the care system and other people. The centres were also frequently used, as almost half of the respondents had visited them within a week and another quarter within a month. The most commonly used service was needle exchange (93%), laboratory tests (43%) and hepatitis B vaccination (43%). The study showed that the clients were inclined to stop injecting drug use: on a scale of 1 (unlikely) – 10 (very likely), over half of the respondents assessed their likelihood of stopping to be between 7 and 10. (Perälä et al. 2002).

In autumn 2000, the Deaconess Institute in Helsinki opened the Kluuvi service centre in central Helsinki to provide specialised services for drug users with HIV infection in Greater Helsinki. The project involves the cities of Helsinki, Espoo and Vantaa and the hospital district of Helsinki and Uusimaa. The centre provides both daytime activities (meals, hygiene, health counselling and treatment with medicines as well as social rehabilitation) and short-term accommodation, and in the future also long-term support housing

¹⁴² See Chapters 3.3 and 4.1.
services. Day activities are available to HIV-positive drug users every day without referral. Services can also be accessed anonymously.\textsuperscript{143}

At the end of 2001, the centre was visited by 133 HIV-positive drug addicts, of whom 70 per cent were men, and the clients’ mean age was 35 years (18–59 years). Almost all injected drugs daily: 70 per cent used amphetamines while the others used opiates. Everybody consumed alcohol and 80 per cent were benzodiazepine-dependent. The clients’ social standing was exceedingly poor: nobody went to work. A third were in support housing or had a rented municipal apartment, another third lived in a boarding house paid for by the municipality, and the rest were in halfway houses, prisons, treatment homes, with friends and relatives or in a service centre housing unit. The physical condition of the clients was poor as well. Almost all had hepatitis C, and many also had hepatitis B. In some patients, the HIV infection was for some reason progressing rapidly. During the centre’s first operating year, three clients had died.

The service centre also exchanges needles and syringes and performs HIV tests for those who want to it. Of the 242 HIV tests done in 2001, about ten per cent came back positive. According to the project leader, this high percentage seems to indicate that the group of injecting drug users, who face a great risk of an HIV infection, has been reached. Patients are actively referred to drug treatment, but the drug habit is often too deeply ingrained to reject in favour of a brand new way of life. An effort is made to include opiate-dependent clients in methadone maintenance. At present, 24 opiate users are in methadone treatment. The results are very positive: three clients have managed to rent an apartment and everybody has a positive opinion of the treatment. Many HIV-positive addicts prefer not to visit ordinary services because they feel that they are not treated as ‘normal human beings.’ It is important that also this group of people is guaranteed a worthwhile life. (Tuomola 2002).

\textbf{10.2 Standards and evaluations}

At the beginning of 2002, the Ministry of Social Affairs and Health presented the proposal of an HIV expert team for Finland’s national HIV/AIDS strategy (2002:1), concluding that health counselling for drug users is one of the most important tools for preventing HIV. Health counselling should be made available in all major urban areas in three years, and the activities should include needle exchanges. Furthermore, various types of health counselling should be developed. The effectiveness and implementation of health counselling will be evaluated nationally by the year 2004.\textsuperscript{144} Health education should also be increased among prisoners, for example, by lowering the threshold for HIV tests and

\textsuperscript{143} See http://www.hdl.fi/hivjaaids/luelisaa.htm

\textsuperscript{144} The National Public Health Institute will make a proposal for a monitoring and statistical system for health counselling centres by the end of 2002.
In association with representatives of the Department of Social Policy at Helsinki University and the unit of infectious disease of the Helsinki – Uusimaa health care district, Sosiaalikehitys Oy Häme launched in September 2001 a broad-scale evaluation of the special services for HIV-positive drug users (daytime activities, accommodation and housing at the Kluuvi service centre, Helsinki) provided by the Deaconess Institute in Helsinki.

The core material in the study consisted of interviews of HIV-positive and other risk-group clients, the aim being to interview 100 people. The interviews explored the clients’ drug and sexual behaviour, various issues associated with being HIV-positive and health status. The use of specialised HIV services and other social and health services was also investigated, the focus being on their impact on the client’s psychological, physical and social situation and possible changes in it.

Another source of material comprised personnel interviews. In addition, medical, social welfare and health care experts’ views on the effectiveness of specialised HIV services were analysed. The final evaluation report including recommendations is scheduled to be ready in 2002.

11 TREATMENT

In the summer of 2000, the Ministry of Social Affairs and Health appointed a working group on the treatment of drug abusers, to investigate the prerequisites of the existing service system to meet the treatment needs of problem users, to make proposals for developing the service and financial system and to assess the need for amending social welfare and health care legislation. The working group submitted its proposal in June 2001.

The working group concluded that treatment provision is made especially difficult by an incoherent service system and by shortcomings associated with knowhow, attitudes and resources. In treating severe drug addiction, the primary objective is not freedom from drugs, but a reduction in substance abuse and the prevention, elimination and treatment of related health, social and other harms. Successful treatment requires individual, sustained, many-sided and systematic service chains, to which both the client and the

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145 See http://www.stm.fi/suomi/julkaisu/julk01fr.htm
system commit themselves. According to the working group, this calls for considerable changes in methods, skills, attitudes, resources and legislation.\textsuperscript{146}

Following the recommendations made by the working group, the drug policy co-ordination group proposes in the action plan for enhancing drug policy in 2001–2003 (2002) in terms of drug treatment that:

1. In order to enhance drug policy in 2002 and 2003, special State funding will be allocated for increasing treatment referral and rehabilitation services to meet the needs of people with drug problems.

2. Measures will be taken to implement and expand treatment and rehabilitation outside office hours. The detoxification, substitution and maintenance treatment of opioid addicts by methadone and buprenorphine will be expanded to units that meet the necessary requirements. Action models to prevent the spread of infectious diseases will be developed and introduced.

3. An effort is made to improve especially the possibilities of young people, who have committed themselves to treatment, to access a sustained and intensive psychosocial rehabilitation continuum, with necessary inpatient rehabilitation ensured.

4. To intensify referral to treatment, treatment and rehabilitation of pregnant women, who use narcotics or intoxicants, and of their children, a project on maternity clinic activities and other social and health services will be launched.

5. Supplementary education for professionals treating drug addicts will be improved.

6. Supplementary education will be organised especially for health care personnel in order to expand the detoxification, substitution and maintenance treatment of opioid addicts.

11.1 Drug-free treatment and health care at national level

According to the Act on Welfare for Substance Abusers (41/1986), municipalities are responsible for organising services for intoxicant abusers in a way that meets the need; ‘intoxicants’ here refer to all substances used for inducing intoxication: alcohol, surrogates, medicines and narcotics.

The service system consists of outpatient clinics (A-clinics), short-term institutional care (detoxification centres), rehabilitation units and support services (day centres and supported housing) and self-help groups (NA, Narcotics Addicts Anonymous).\textsuperscript{147} Along with these specialised services, many primary health care and social service units encounter drug problems (social work, child welfare, clinics and

\textsuperscript{146} Recommendations made by the working group are discussed in more detail in Chapter 8.2.

\textsuperscript{147} Addresses of special service units are available e.g. at: \url{http://www.health.fi/paihde/palvelut/selviskalenteri.html}, \url{Http://www.stakes.fi/neuvoa-antavat}, \url{http://www.a-klinikka.fi/osoite.htm}
wards at health centres, hospitals and especially mental hospitals). The number of specialised service units for drug addicts is limited, and the units are mainly located in Greater Helsinki and other major cities. Since 1996, Finland has had an ombudsman institution for intoxicant abusers, based on nongovernmental organisations. Working in the entire country, it is an interest organisation for treatment clients. (Tervo 1998).\textsuperscript{148}

In addition to information and referral to care, primary health care provides specific services for substance abusers. The health centres are mainly responsible for treating poisonings, illnesses and injuries associated with drugs. They can also provide short-term detoxification. Within specialised health care, the general and psychiatric hospitals treat severe withdrawal symptoms and cases needing special hospitalisation.\textsuperscript{149} The mental health clinics care for outpatients in psychiatric illnesses, which may involve substance abuse problems. The regulation issued by the Ministry of Social Affairs and Health in summer 2000 gave a special role to university and central hospitals in assessing the medical detoxification, substitution and maintenance treatment need of opiate addicts. As of spring 2002, the health centres have had the same role.\textsuperscript{150}

Finland has specialised local outpatient centres (e.g. clinics) in over 100 municipalities. In addition, many municipalities have agreed to purchase services for their inhabitants from a public or private service provider.\textsuperscript{151} In 2001, about 46,900 people visited the outpatient clinics for substance abusers (76 A-Clinics and 14 youth centres). During the year, 11,400 people used residential treatment services (52 institutions) for substance abusers.\textsuperscript{152} Of the outpatients, 30 per cent were women (45 per cent in youth centres), and clients aged under 30 accounted for about 25 per cent. The proportion of women in residential treatment services (detoxification and rehabilitation centres) was about 23 per cent, and people aged under 30 accounted for 17 per cent. The treatment periods usually lasted for a week or less, but 22.5 per cent of the periods lasted longer than two weeks while the proportion of treatment periods over 3 months was 1.8 per cent (Yearbook of Alcohol and Drug Statistics 2001, 2002; Statistical Yearbook on Social Welfare and Health Care 2001).\textsuperscript{153}

\textsuperscript{148} See also \url{http://www.a-kiltojenliitto.fi/pam_2.html}

\textsuperscript{149} According to the one-day census in 1999, drug clients accounted for a fifth of the substance abuse clients in psychiatric care and one out of fifteen in other health care (Nuorvala et al. 2000).

\textsuperscript{150} See Chapter 1.2.2.

\textsuperscript{151} The A-Clinic Foundation has made such agreements with about 130 municipalities, and many municipal A-Clinics have agreements with neighbouring municipalities, sometimes including 20–30 municipalities.

\textsuperscript{152} According to the one-day census in 1999, drug clients accounted for 20 per cent in specialised outpatient services for substance abusers and for 30 per cent in residential treatment (Nuorvala et al. 2000).

\textsuperscript{153} For auxiliary services, see Chapters 9.3 and 10.1.
By the end of 2000 Finland had an estimated 30 units specialising in problem drug users; these units have a special drug treatment programme.\(^{154}\) Of them, 13 provided residential detoxification services for problem users, 18 provided withdrawal treatment, and 18 gave rehabilitation. Drug treatment periods in detoxification and withdrawal were usually 2–3 weeks, while in rehabilitation the duration was 2–3 months or longer.\(^{155}\) The units were predominantly located in Southern (13) and Western (9) Finland. The province of Oulu, Northern Finland, has five units. Eastern Finland had three units, but, by contrast to the rest of the country, these units mainly concentrated on rehabilitation.\(^{156}\) There were an estimated 360–440 beds in institutions for drug treatment.\(^{157}\) There were six institutions specialising in young substance abusers, with a total of 40 beds. In addition, reformatory schools for young clients had three units specialising in drug treatment, with a total of 23 beds. (Hakkarainen et al. 2000).

The Swedish SBU study results play an important role in the development of Finnish drug treatment.\(^{158}\) For example, STAKES introduced a guidebook on substance abusers’ treatment facilities and their treatment methods in the National Seminar on Intoxicants, including classification of treatment methods based on the SBU study. (Pienimäki ed. 2001).\(^{159}\)

The guidebook is based on a survey using a questionnaire, enumerating 29 different psychosocial methods based on the SBU report. The units responding could also report other methods they were using. The units were asked to identify the methods employed by them and to assess the extent to which they were in use. The scale was from 1 to 4, i.e. the units had to report whether a given method was used with 50 per cent of their clients, with 10–50 per cent, with fewer than 10 per cent or not at all.

It was noteworthy that the most commonly used methods were relatively general in nature, while the so-called specific approaches drawing on a theoretical framework had a more marginal position (Pienimäki 2001b).\(^{160}\) The most usual method was general supportive therapy or support. If the criterion was ten per cent or more, the next most popular method was the prevention of relapse, while utilising social support and learning social skills were joint third, followed by health counselling for drug users and

\(^{154}\) By summer 2002, 54 outpatient and 43 inpatient units specialising in drug treatment had reported to the treatment unit database maintained by STAKES (http://www.stakes.fi/neuvoa-antavat/). The total figure is not accurate as some units may have reported as an inpatient and outpatient unit because they serve both functions and may have reported their different inpatient units (non-medicinal treatment, substitution) as separate units in the database.

\(^{155}\) According to the treatment unit database, the average duration of institutional detoxification is 1–2 weeks, while other rehabilitation lasts for 1 month and community rehabilitation for 6 months or longer.

\(^{156}\) According to the treatment unit database, by summer 2002 Northern Finland had 6 outpatient and 4 inpatient drug treatment units, while Eastern Finland had 6 outpatient and 2 inpatient units. This means that most drug treatment units are still located in the southern parts of the country.

\(^{157}\) According to the treatment unit database, the number of beds had increased to about 620 by the summer of 2002.

\(^{158}\) The procedures to develop opioid-dependent clients’ treatment with medicines (Chapter 11.2) are in part based on the evidence presented in this study.

\(^{159}\) The information contained in the guide has been incorporated in the drug treatment unit database of STAKES, see http://www.stakes.fi/neuvoa-antavat/
solution-centred therapy/method. The large proportion of health counselling for drug users was due to separate questions for alcohol, narcotics, medicines and polydrug use. For opioid-dependent patients, the most commonly used treatment pharmaceuticals were clonidine, benzodiazepines, lofexidine and buprenorphine, for other clients with narcotics problems benzodiazepines, mood drugs, antileptics and neuroleptics.

When the adequacy of treatment services was assessed in 2000, the following conclusion was reached: given that an average treatment period is three months, 360–440 calculatory beds enable the treatment of 1,440–1,760 problem drug users per year. This is a tenth of the estimated number of problem drug users quoted in Chapter 2.3 above (Hakkarainen et al. 2000). Based on this estimate, the working group planning the treatment of problem drug users made its proposal for expanding treatment. On the basis of these recommendations, a special State allocation of EUR 7,570,000 per year will be forthcoming for the expenses of drug treatment in the municipalities in 2002 and 2003. The State subsidy is meant for organising comprehensive service guidance for drug users in treatment, for enhancing treatment and rehabilitation and for increasing detoxification, substitution and maintenance treatment for opioid addicts on the grounds of the relevant Decree (98/2002).

Drug services for minorities

In Finland, health care services are in principle available to all, but especially linguistic and cultural reasons as well as physical, hearing and visual disabilities pose some practical problems.

In Greater Helsinki, where more than 40 per cent of the immigrants live, the intoxicant service units are only seldom visited by non-native people. Some immigrants have received help from A-Clinics. Some specialised substance abuse services have been available to Romanies. Certain immigrants’ associations have had an active role in developing services, and co-operation between the clinics and the Association of Somalis will be further developed. In practice, immigrants can be provided with acute detoxification, but other treatment alternatives are in short supply (Hakkarainen et al. 2000).

Järvenpää Addiction Hospital has prepared a special treatment programme for Russian-speaking drug users (especially abusers of heroin), involving ethnic Finns from Ingria, but so

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161 In 1998, treatment units in Helsinki had 190 non-native clients, the majority of whom were Russians. The survey conducted by Director Roger Nordman of the Hangonkatu Rehabilitation Centre in spring 1998 was responded by 14 substance abuse units in Greater Helsinki. In many units, the number was based on an estimate, and the survey did not eliminate possible overlap. Estimates made in 2001 suggest that there are some 200–500 drug users of Russian origin in the Helsinki area. (Puro 2001).
far the visits have been occasional. The Helsinki-based health counselling unit for injecting drug users, Vinkki, has one nurse hired especially to treat Ingrian returnees (Kullat 2001). At the beginning of 2001, the Deaconess Institute in Helsinki launched its Venpro-Pyncnpo project to assess the need for drug treatment for Russian-speaking immigrants, to plan a treatment system for them and to produce written material needed in treatment. In addition, the A-Clinic Foundation has established webpages for immigrants. The site has information about the Finnish service system for substance abusers and treatment possibilities available in English and Russian. The Free from Drugs Association and the Ingrian centre train volunteers who have the necessary linguistic skills to work on helplines and as support persons for drug users and their relatives. To enhance these activities, an effort has been made to influence the immigrant parents’ attitudes so that help could be provided for the young who have drug problems.

Co-ordinated by the Finnish Blue Ribbon, the national project on developing addiction services for people with disability will be carried out in 2001–2004. The project has participation from the subprojects of the A-Clinic Foundation, the Deaconess Institute in Helsinki, the Kalliola Foundation and the Finnish Blue Ribbon. It will develop substance abuse services that suit the various needs of people with disability. The co-ordination project collects experiences and knowledge from the subprojects and steers the developing of services to meet the needs by co-operation and training among professionals working with people with disability or in the substance abuse field.

11.2 Substitution and maintenance programmes

The Ministry of Social Affairs and Health gave regulations in 1997 concerning the treatment of opiate addicts with medicines. This treatment aims at curing the dependence based on a multiprofessional treatment plan, which also defines other medical and psychosocial care and follow-up. The regulations were upgraded in 1998, and Decrees were passed in 2000 and 2002.

According to the Orders of the Ministry (28/1997; 42/1998) and a Decree passed in 2000 (607/2000, 289/2002), substitution treatment by medicines containing buprenorphine, methadone or levacetylmethadol can only be given to patients whose treatment by generally accepted means of detoxification has failed. The new Decree also enabled maintenance treatment. The Decree stipulates that

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162 The Romano Missio Association has produced a guidebook *Enisen holtomallin suositus* [Recommendation for an ethnic treatment model]. See also [http://www.romanomissio.fi](http://www.romanomissio.fi)
163 See [http://www.hdl.fi/diakoniaprojektit/venpro.htm](http://www.hdl.fi/diakoniaprojektit/venpro.htm)
164 See [http://www.paihdelinkki.fi/](http://www.paihdelinkki.fi/)
165 See [http://www.vapa.info/](http://www.vapa.info/)
treatment may only start when it is imperative to reduce the negative effects of drug abuse on patients: persons who are not likely to stop using drugs, but who may benefit from maintenance treatment and avoid contracting communicable diseases and other negative health effects and whose quality of life can be improved and who can be trained for more demanding rehabilitative substitution treatment.

In the Drug Detoxification Unit of Helsinki University Central Hospital, the criteria for medical detoxification treatment in 1999 included the patient’s age (18 and over), diagnosed opiate dependence (ICD-10 or DSM-IV) and drug screening to detect recent use (in uncertain cases, naloxone test). Criteria for disqualification include uncontrolled polydrug use, acute alcoholism, psychological or somatic illnesses precluding treatment and pregnancy. Accordingly, the criteria for methadone substitution treatment in the Greater Helsinki Area have been age (20 years and over), compulsive use of opiates (for a minimum of four years) and a history of institutional or long-term care. Uncontrolled polydrug use, severe psychological or somatic illnesses precluding treatment and acute alcoholism constitute factors disqualifying a client from substitution treatment. The criteria have remained the same since the beginning of the system.

At the beginning of 2001, some 200 people were in detoxification or substitution treatment by buprenorphine or in methadone substitution treatment, associated with the Ministry’s decisions; about half of them were in methadone substitution. In most cases, treatment need assessment was made in Helsinki. (Report of the Working Group on developing medicinal treatment for opioid-dependent clients 2001). According to an inquiry made in connection with drug treatment information collection it was estimated that about 400 people were in substitution treatment in the middle of the year 2002.

In the report of the committee for developing the treatment system for drug abusers (2001) it is proposed that the criterion for additional resources needed is providing treatment for 1,000 opioid-dependent clients annually, which will cost approximately EUR 16.8 million per year. An equal investment in the proper treatment of other drug users is needed. Based on the present system of dividing costs between the State and municipalities, the result was the proposal for augmenting resources, as stated in Chapter 8.2 above. (Report of the working group 2001). Of the State allocation of EUR 8.4 million proposed in the budget, 7.5 million euros will be granted in 2002 and 2003.

Another working group was appointed on a tight schedule to propose actions to increase the availability of medicinal treatment for opioid-dependent clients. The group submitted its report on 2 October 2001.

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166 Cf. Chapter 1.2.2.
167 See also http://www.stm.fi/suomi/uuutta/uusii05fr.htm
168 It has been estimated that the buprenorphine treatment of one patient costs a total of about EUR 20,000 per year, of which the pharmaceuticals only cost EUR 2,400. Treatment with a pharmaceutical containing methadone, on the other hand, costs about EUR 13,500, of which the pharmaceuticals cost EUR 300.
including proposals for increasing treatment based on the existing regulations and for new regulations to meet the present requirements. (Report of the working group 2001). The working group’s proposals were enforced by a Decree (289/2002) of the Ministry of Social Affairs and Health; in terms of the number of treatment implementers, the flexibility of services and their possibility to shorten queues were improved even more than recommended by the working group. On the other hand, the proposed amount of two weeks’ medication given to the patient at a time under certain circumstances (e.g. successful treatment) was reduced to eight days in the Decree. In addition, the tasks of the expert board monitoring and supervising treatment, suggested by the working group, were assumed by the provincial governments and the supervision duties were also administratively simplified.169

So far, some opiate addicts outside the Ministry’s official programme travel regularly abroad, especially to Paris, to acquire buprenorphine doses needed in the treatment.170 Some clients try to treat themselves, but buprenorphine is also injected. In Finland, the National Agency for Medicines issues regulations on the personal import of pharmaceuticals, with Order 3/2000 concerning buprenorphine. The purpose of the Order was to curb the wide-scale import of buprenorphine. According to the Order, a passenger may bring an amount equal to 14 days’ use of pharmaceutical substances, which are to be considered narcotics, for personal use. In calculating the daily dose, the maximum dose is the one approved for the preparation licensed in Finland. When the same or equivalent substance is reimported, the amount of time elapsed from the previous instance of importation must be longer than that estimated for the personal consumption of the previous consignment.

The first Finnish evaluation of medicinal treatment for drug addicts was completed in early 2002 (Baas et al. 2002). The study concerned detoxification by buprenorphine that started in October 1997 by an outpatient programme at the Kettutie A-Clinic in Helsinki and by an inpatient programme in Järvenpää Addiction Hospital. The goal was to involve opioid-dependent clients in official treatment programmes, to stop the vicious circle of substance abuse, crimes and exclusion, to provide rehabilitative psychosocial treatment and referral to post-detoxification care. The Decree in force at that time enabled buprenorphine treatment to continue for a maximum of 12 months.

During the development project, 171 clients sought treatment; 95 of them started in an inpatient programme, while 76 entered the outpatient programme. The majority of the patients were under the age of 30 (71%), and the largest age group comprised those under 25 years. Seventy per cent were men. Their most pressing problem was long-term polydrug use. Injecting buprenorphine was more frequent than

169 Cf. Chapter 1.2.2.
170 Since February 1996, health centre physicians in France have been entitled to prescribe buprenorphine for four weeks (e.g. Subutex used as an analgesic) for substitution (Karvonen 1998). In Finland, the substance abuse ombudsman and an association providing support for opiate-dependent people (Opiaattiriippuisten tuki ry) conducted interviews during two weeks in 2002 to
heroin use. Dependence on sedatives was commonplace (80%), and so was cannabis use (70%). At the stage of entry, 40 per cent of the patients had also used amphetamines. Risk behaviour was typical and about 80 per cent had hepatitis C. The third major problem was chronic social marginalisation compounded by multiple problems. Many patients did not have vocational training, they were excluded from the labour market and had no network supporting their recovery. They also had housing problems and manifested criminal behaviour.

The results of the follow-up study suggest that as a medicine, buprenorphine is an effective tool for involving the patients in treatment. The average duration of outpatient treatment was six months, and 76 per cent of the patients transferred from inpatient treatment to follow-up care in their locality as agreed. Supported by medicinal treatment, remedial and rehabilitative psychosocial care could also start with most patients. Buprenorphine turned out to be a potent medicine in detoxification and relapse prevention. According to the data, less than 10 per cent relapsed to heroin use during the 12 months follow-up period. The use of other illicit substances also declined considerably during the treatment. Thirty-one patients (18%) withdrew also from buprenorphine. During the inpatient period (1–3 months) detoxification was successful in case of 24 patients. In outpatient care, during 12 months follow-up period, only seven patients successfully withdrew from buprenorphine. Buprenorphine is often abused during the treatment programme. Teaching the right way of administering the medicine proved to be a challenge in both programmes.

The evaluation concluded that the threshold for accessing detoxification by buprenorphine should be lowered and attention should be paid to treatment need assessment, i.e. directing the patients to a form of treatment – be it medicinal or nonmedicinal – that best suits them. Psychosocial treatment merits special consideration along with medicinal treatment. Substitution treatment particularly aims at involving patients, who have multiple problems, in programmes supporting changes in behaviour and social setting. Medication should also be stopped when the patient is ready for it. In the Greater Helsinki Area, another problem is slow patient turnover and long queues: treatment commences in special units, but not enough patients are transferred to primary services once treatment procedure is stabilised. Success in the latter would increase the number of beds available to new patients.

11.3 After-care and reintegration

To get permanently free from drugs, it is imperative that the person will abandon drug culture and the related lifestyle. The greatest risk of a relapse coincides with discharge from a protected institutional
(treatment) environment to everyday settings. Some treatment schemes incorporate a follow-up stage lasting for a year or so. A treatment programme may also include general socio-political measures, arranging housing for the client and reintegration into working life or studies. Participation in e.g. the activities of Narcotics Addicts Anonymous or other support groups for ex-addicts will help the client to adapt to a drug-free social environment.  

To support recovery in medicinal substitution and maintenance treatment in particular, Järvenpää Addiction Hospital has translated a manual of recovery in buprenorphine treatment into Finnish (2002).

**Housing services**

In Finland, it is possible to provide financially supported housing as part of general social services also for substance abusers who do not need specialised housing services.

The housing service units for substance abusers constitute one part of the service system. They are targeted at substance abusers, who need daily support in their housing. Some housing service units also provide rehabilitation, some act as therapeutic communities, offering possibilities for excluded people to regain control over their lives. Finland also has some housing service units specialising in drug users. In 1999, the number of residents in substance abusers’ housing services was 4,300 (Hein et al. 2001).

Based on the one-day census of intoxicant-related cases in social and health services in 1999, one out of eight clients in housing services used narcotics, and almost one out of four abused medicines (Nuorvala et al. 2000).

**Education and Training**

An effort is made to help drug abusers by multiprofessional co-operation. The treatment of juvenile problem users also involves the school authorities. Therefore, planning of education and vocational guidance are an integral part of the treatment process. At the final stages of treatment for older problem users, the presence of educational or employment authorities is not always guaranteed. Another problem with providing education is that persons with long drug careers are not ready for long-term studies. The educational system (e.g. training for the unemployed) can provide only little training for ordinary work, based on the problem users’ abilities, and often the only alternative is a menial job. Because a former drug addict cannot compete on the labour market, his or her motivation to study may be weak.

171 E.g. Opiaattiriippuvaisten tuki ry, Association of support persons for opiate addicts, established in 1998.
The EU’s Social Fund (the Integra programme) has participated in certain Finnish projects on young substance abusers. Implemented in Greater Helsinki in 1998–1999, the broad-scale project for young drug addicts, Back to the Future, reinforced the notion that people facing unemployment and income problems after recovering from drug abuse are in an extremely difficult situation. These problems include inadequate housing, reduced working capacity, lack of vocational training and problems associated with work and maintaining a drug-free lifestyle.

Many-sided education was available to the project participants, but the clients found it hard to perceive educational systems and work options. The alternatives to vocational training are apprenticeship contracts, isolated training possibilities offered by the employment authorities and the rehabilitation allowance of the Social Insurance Institution. Nevertheless, several structural problems emerged during the project, affecting the training choices in the target group. It was not easy to find employers who were willing to enter into apprenticeship contracts. A student in Finland relies on market-based study loans, study grants and housing benefits. Although the State automatically guarantees the study loan, the banks refuse to give loans because almost 90 per cent of the drug clients are not creditworthy due to previous money problems. Neither is it possible to receive the rehabilitation allowance of the Social Insurance Institution solely based on a drug addiction diagnosis, as a secondary diagnosis is also required, e.g. an impairment, disability or disease.

**Employment measures**

In the Back to the Future project, it was also noticed that people who had used drugs had difficulties in finding jobs and were faced with prejudice and other obstacles. The methods used in client work turned out to be inadequate in a situation where jobs are not available. On the other hand, jobs are useless if the threshold of employment is too high. Employment was also hindered by an ongoing drug treatment process. Thus, better possibilities and readiness to gain employment should be ensured in the target group by creating a feasible co-operative network supporting employment, irrespective of sectorial and administrative boundaries. The project outcomes show that a tailor-made approach is successful in employing drug users as well.

Young people’s workshops constitute one example of employment activities: apprenticeships for people under the age of 25. Depending on the municipality and workshop, they engage in different work tasks. A person is hired to a workshop for 5–6 months, and ordinary wages are paid for the work. Workshop

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activities also enable support for young people’s life-management skills and tailor-made educational or career paths. Personal guidance is provided to support the young person’s efforts to abandon the drug habit, so that he or she can embark on the above-mentioned path. In the near future, the focus in training workshop instructors is on preventive work and on an ability to recognise problems in young people’s lives in order to guide them. In co-operation with the participants, the instructor reaches an agreement on the objectives achievable during the workshop period. This also makes it possible to assign responsibility to young people themselves.\footnote{173}

The conclusion drawn by many projects has been that the actions available to social and health services for rehabilitation are inadequate to resolve multiple welfare problems. On the other hand, the situation cannot be rectified by training possibilities, living allowance system or general employment policy alone. Active measures are required of the rehabilitation system – an individual and tailor-made approach transcending administrative boundaries.

### 12 Interventions in the criminal justice system

In the action programme for intensifying drug policy in 2001–2003 (2002), the drug policy co-ordination group proposed to law enforcement authorities in terms of demand reduction that:

1. The police take part in disseminating antidrug information and education locally and nationally as well as in providing material and training for those working with young people.
2. When implementing the national anticrime programme, special attention is paid to the interconnection between drug offences and other types of crime and to the special position that drug crime prevention has in anticrime activities in general.
3. In co-operation between the police and local social welfare and health care authorities, 24-hour emergency services are organised to provide the police with professional help for assessing drug use and care referral.
4. In the prison administration, drug abuse services and their promotion belong to the joint tasks of all personnel, as instructed by the handbook on supervision written for this purpose.
5. In all areas of the prison administration, drug treatment and rehabilitation aim at forming a seamless continuum from detoxification to rehabilitation and reintegration after release.
6. The prison administration is about to appoint a working group exploring, e.g. the organisation of opioid-dependent inmates’ detoxification, substitution and maintenance treatment in prison.
7. For the regional offices of the Probation and Aftercare service in Greater Helsinki, a joint working group has been set up to take care of the supervision of drug-addicted prisoners released on probation.

\footnote{173 For more detailed information, see http://www.alli.fi/allison/tvoelama/tvopajat.html#paja}
8. Curative measures will be increasingly attached to penal sanctions, for example, in March 2002 the Ministry of Justice received the report of the working group on so-called contractual treatment.

**Police Work**

The Finnish law forbids as punishable acts the unauthorised production, cultivation, import, transport, sale, distribution, possession and use of narcotic substances. Legislation thus empowers the police to intervene in the processes where drugs are handled. In January 2000, the police published its drug strategy for 2000–2003. In addition to intervening in drug offences afterwards, the strategy emphasises police role in preventing drug demand as well (Hietaniemi 2002). In terms of demand reduction, the strategy highlights prevention and early intervention as well as control:

In terms of deterrence and early intervention, the following is proposed:

- At a local level, the police will establish co-operative networks together with authorities working with young people and other parties and reach agreement on the practical procedures required by the successful further implementation of early intervention.
- In co-operation with other authorities and civic organisations, the police will do the following: produce educational material, drawing attention to legislation as well as supportive and care services; implement a nationwide information campaign; investigate the extent and nature of drug use in school; and seek ways for breaking free from drugs together with school health services and parents.
- In disseminating information, attention is paid to the link between narcotics and crime and to the serious consequences they have for individuals and society.
- In collaboration with other authorities and civic organisations, the police will provide a nationwide telephone helpline free of charge, to distribute information about the effects, regulations and care possibilities associated with drugs.
- The police and customs authorities will inform about drugs and actions taken to combat related crime, with the aim of reducing drug demand and supply.

In terms of the role of control in demand reduction, the following is proposed:

- The emergence of local venues for distributing or using drugs will be prevented.
- In agreement with the prosecutorial authority, an effort is made to establish consistent practices (risk for suspects) in prosecuting drug crimes.174

174 See also Chapter 1.3.
The introduction of an accelerated criminal procedure for young offenders will be supported. The police will check all drug-related information, especially that coming from parents and schools, and take necessary steps.
- The risk of apprehension will be increased with regard to persons operating a motor vehicle under the influence of drugs.
- An effort will be made to ensure expert help in police interventions to assess care need and possibilities and to support municipal projects on referral, in accordance with the Government Decision-in-Principle on drug policy.

The police approved the agency’s antidrug strategy for 2003–2006 in September 2002. In demand reduction, the new strategy pays more attention to drug users’ referral to treatment. Municipal security plans will incorporate action schemes for drug addicts’ care referral. First-time juvenile drug offenders (under 18 years of age) will be given a hearing with representation from the police, prosecutor, social welfare authorities and parents or guardians. The police will increase drug information for parents and educators.

The police have been active in producing material in support of drug prevention for children, young people and adults working with them. The Finnish police also have a long history of co-operation with schools, social services and organisations. Central to this work has traditionally been law obedience education given by police officers specialising in youth work. Another important aspect of prevention is referral to support and treatment services in collaboration with the social welfare authorities. The police contribute to solving problem situations arising in school together with school and social services personnel and parents. The customs authorities also stress the viewpoint of prevention and, within the limits of their resources, have taken part in material provision and interagency co-operation.

Local police activities are based on community policing and a problem-centred approach, which was adopted in 1996 as the guiding principle for the development of police work. The idea behind community policing is linking law enforcement with the local community, targeting problem-centred activities especially at counteracting ‘everyday mass crime’ and at disturbing behaviour. Another goal is to take heed of the citizens’ expectations placed on law enforcement work. Along with community policing, recent policy-statements have stressed combating serious crime and a perpetrator-centred approach to crime solving. Most Finnish municipalities have drawn up local multisectorial security plans within the framework of the national anticrime programme, but the plans can offer only a limited number of concrete action models for drug prevention carried out by the local police.

Local co-operation has been implemented on a broad scale in certain cities (Tampere in 1999) or focusing on a group of people, such as the youth and their referral to treatment as an alternative to punishment.
(Järvenpää in 1997–2000). As a follow-on to the former, an evaluation of intensified antidrug work and multiprofessional co-operation is underway. Based on the preliminary results, new co-operative models should be developed between the police and social work for encountering drug offenders, for co-operation between treatment units and mental health clinics as well as between school health care and other actors. A system should also be developed to monitor changes in the drug situation based on mutually comparable information from different databases. In the Järvenpää experiment, the local Board of Substance Abuse Affairs collaborates with the police and other actors to develop solutions for referral to treatment and waiving prosecution in case of young drug suspects as an alternative to enforcing the relevant penal consequences. If the young offender opts for this alternative, the prosecutor will postpone legal action (for 2–4 months) until the body referring to care makes a treatment agreement and plan together with the client, parents and an outpatient clinic or institution for substance abusers. When this period has elapsed, the prosecutor inquires about the implementation of the treatment, and, if the answer is positive, waives prosecution. If the treatment has failed, the prosecutor will submit the case to a court of law.

The Finnish law enforcement authorities have made initiatives within the EU to make drug prevention more versatile and to reinforce related multisectorial co-operation (Balance and Partnership, Ministry of the Interior, 14/1999).

12.1 Assistance to drug users in prison

In 1998, the prison administration launched work on a drug strategy to prevent problems arising from drug use in prisons. The strategy resulted in guidelines, introduced in January 1999. (Intoxicants strategy for the prison administration. Part I. 1999) According to the strategy, antidrug work in prison is based on good knowledge of the prisoners and on a community approach, so that no drugs are allowed to enter prison or are produced there. Other aims include creating an environment that is safe and free from intoxicants and enhancing prison inmates’ readiness for lifestyles free from crime and drugs as well as preventing drug-related harms.

In terms of demand reduction, this goal is pursued by:

175 See Kekki, T. 2002 and http://194.89.205.4/pakk/kekki.pdf
176 Cf. Chapter 1.2.1.
177 The final report on the project on referring young drug offenders to care [available in Finnish], Järvenpää Board of Substance Abuse Affairs. The project is also available in the project database <URL:http://www.stakes.fi/neuvoantavat/index.html>
- Developing prison activities so that they support and encourage drug-free lifestyles, by providing special rehabilitation programmes and meaningful work, education and free-time activities, which incorporate elements supporting temperance.
- Supporting a community free from drugs and the prisoners’ responsibility through active presence, knowledge, positive interaction and coherent procedures on the part of personnel.
- Developing conditions to create drug-free settings by spatial arrangements and the appropriate placement of prisoners.
- Providing prisoners with a possibility to participate in planned rehabilitation for the duration of their sentence.
- Supporting voluntary work and the prisoners’ independent activities in prison.
- Utilising health care procedures effectively in prison to prevent communicable diseases transmitted by drug use.
- Using the existing methods of prevention to counteract drug-related subcultures and their negative effects.

February 2001 saw the publication of the follow-up to the prison administration’s intoxicant strategy, a handbook on drug supervision, a set of guidelines targeted at prison personnel for practical drug control and inspection (intoxicant strategy, part II). The handbook mainly discusses supervision and inspection, body searches of inmates, drug dependence and the effects and uses of intoxicating substances. In addition, the handbook tells how to recognise a person who is under the influence of drugs and how to carry out supervision when in doubt. The book also instructs personnel to give first aid and provides basic information about referring a prisoner with substance abuse problems to rehabilitation.178

The intoxicant strategy of prison administration, part III, (Päihdeinfo) was published in February 2002. It is a compendium of the drug programmes and rehabilitation models employed in over 30 prison units.179 It follows the idea embraced in the drug field and strategy that rehabilitation must be a continuum involving the entire service chain: at first, the need for rehabilitation is assessed and acute withdrawal symptoms are addressed, then a multiprofessional rehabilitation plan is drawn up for those interested. The prisoner will be placed in an appropriate unit depending on his or her addiction status, the actual programme starts for those committed to it and at the final stage, the focus is on the inmate’s reintegration into freedom. (Mäki 2002).

The next phase in developing prison administration drug strategies will be the quality assurance of the above-mentioned programmes. The Criminal Sanctions Agency has approved the evaluation criteria for the programmes to ensure that they will be conducive to breaking the inmates’ circle of exclusion and to

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178 See also Chapters 12.2 and http://www.vankeinhoito.fi/8727.htm
179 See http://www.vankeinhoito.fi/4829.htm
reducing recidivism. A study on the development of certain programmes was launched in 2002. An effort is also made to devise a monitoring system for substance abuse work and drug rehabilitation done in prison. (Mäki 2002).

In April 2001, the Ministry of Justice also published the report of the committee, which discussed integrating the penal system with societal support systems in order to implement the goal of reducing habitual crime in accordance with the Government platform (Into crime-free life management 2001). The report suggests, among other things, the following:

- Structural solutions are needed to provide prisoners, who have committed themselves to rehabilitation, with better possibilities enabling a smooth changeover to a life after prison and to safe housing, work or training.
- In enforcing control over ex-convicts on probation, it is a legal requirement that a plan be drawn up together with the client and the local support network, incorporating the requirements associated with the penal sanctions and a plan to use support services.
- Control of persons on probation will be intensified and developed so that it promotes seeking treatment and controlled continuation of care and rehabilitation, which started in prison.
- The provisions of the law on rehabilitative employment activities (189/2001) take account of the fact that, at the request of a person released from prison, fixed-term rehabilitative employment can be provided, if the local authorities or the employment office deem such action conducive to the person’s life-management skills and possibilities of finding a job.
- Prisoners’ possibilities to study or work outside the institution on study or work passes will be supported as part of the gradual release.

**Rehabilitation and treatment models**

Prisons have engaged in substance abuse rehabilitation for about ten years. To develop rehabilitation in prison, the substance abuse rehabilitation project (VP) was launched in 1996 by the Ministry of Social Affairs and Health, the prison administration and four major organisations in the substance abuse field. The project ended in spring 1999 (Mutalahti 1999), resulting in ten service products (e.g. six rehabilitation programmes and training packages) for prison use. Today, substance abuse rehabilitation is based on structured handbook programmes produced in co-operation between the prison administration and organisations in the field and on prison administration strategies.

In 2001, a summary of substance abuse rehabilitation programmes in prison was made available to internal use, and ten prisons completed their substance abuse handbooks or textbooks. There are 19
handbooks in use, four of which are based on the VP project, compiled by NGOs and mainly funded by the Prison Administration. Eighty per cent of substance abuse rehabilitation in prison is based on handbooks. Assessment of the effectiveness and structure of the handbooks will start in 2001, in view of applying the programme in a new prison. Skills among personnel to implement rehabilitation, especially training in methods, have been enhanced. \footnote{See \url{http://www.a-klinikka.fi/vp/vp-projekti.html}}

Drug rehabilitation is divided into information and motivation programmes; group action programmes on drug rehabilitation (less than four months); intensive group action programmes on drug rehabilitation (over four months); and community care programmes. Only one closed institution does not provide such activities. In all institutions, health care, and to some extent also social welfare services, engage in providing valuable rehabilitation for individuals.

Information and motivation are provided for almost 40 per cent of the incoming prisoners (nowadays some 4,000 people), and 20 per cent of the incoming prisoners are given a possibility to participate in rehabilitation in 2002. Because the number of inmates is increasing, it is not possible to reach these percentages in full. It is estimated that 60–80 per cent of the incoming inmates have substance abuse problems, but not all prisoners are willing to deal with their problems, extra incentives notwithstanding. Prison personnel have talked more openly about substance abuse problems, and consequently also prisoners are becoming more motivated to use the services offered.

The theoretical basis of the programmes varies. Most of them are based on cognitive behaviour therapy, while some rely on a solution-oriented approach, community treatment or the 12 steps. Some programmes are complemented by psychotherapy, NLP or logotherapy, but the majority apply several theoretical frameworks. As a rule, the programme includes a rehabilitative period two or three times a week, learning life-management skills, work and/or training, learning hobbies supporting a drug-free lifestyle and prevention of relapse. The programmes require teamwork, and prison – being a multiprofessional working environment – has good possibilities for this.

In addition, 12 closed prisons have one or several drug-free wards. They may involve the inmates’ commitment to freedom from drugs and to taking tests, or so-called theme wards, where drug rehabilitation programmes are implemented (alternatively programmes for violence or sexual problems), or general treatment wards, practising community care. The remaining four closed institutions are in the process of establishing such wards or have an outpatient facility on their premises. All open prisons are free from intoxicants. It must be noted that some prisoners participating in the programmes come from

\footnote{Ministry of Justice, Criminal Policy Department / Criminal Sanctions Agency (formerly known as the Prison Administration Department).}
ordinary wards, where the inmates have not committed themselves to leading drug-free lifestyles. Drug-free wards account for 10 per cent of the wards in Finnish prisons. The goal is to increase this number fivefold.

Withdrawal symptoms resulting from stopping alcohol or drug use are generally treated in the prison health care system as ordered by the prison physician. If the symptoms are severe, a prisoner may be sent to a prison administration hospital or treatment outside the prison system. An inmate may also seek detoxification or rehabilitation in Hämeenlinna prison hospital. If a prisoner has started medicinal opioid treatment (methadone or buprenorphine) prior to coming to prison, this treatment may continue in cooperation with the unit having initiated care. (Annual report of prison and probation service 2001). In early 2002 there were an estimated 25 people in medicinal substitution treatment for opiate-dependent prisoners.

12.2 Alternative forms of punishment

Appointed by the Ministry of Justice, the committee preparing the law on contractual treatment suggested in its report (2002) that a new punishment known as contractual treatment be experimentally introduced as a punishment for offenders with addiction problems. The reform is important because under the current law, treatment cannot be imposed as a punishment for an offence. The contractual treatment punishment is intended for persons whose criminal offence was essentially affected by a substance abuse problem. Contractual treatment could be imposed in lieu of a maximum of eight months’ imprisonment. A prerequisite is that the offenders are willing to commit themselves to treatment. Contractual treatment aims at reducing the risk of further criminal involvement and at enhancing social adaptation. The goal is that the convicts abandon the drug habit and are able to manage their lives without resorting to crime better than they would after a prison term.

In recent decades, an alternative to imprisonment has been sought in order to support the offenders’ crime-free lifestyles. An alternative punishment now in use is community service. However, people with substance abuse problems usually cannot be sentenced to community service, since they are often unable to perform it successfully. The introduction of contractual treatment would improve equality among people convicted of crimes.

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182 See [http://www.om.fi/13620.htm](http://www.om.fi/13620.htm)
One prerequisite for contractual treatment is a clear link between the offence and the substance abuse problem. In practice, it would be imposed for recurrent drunken driving, property crimes and lesser acts of violence. The treatment involved can be inpatient or outpatient care or rehabilitation. It could start, for instance, at a detoxification clinic, to be continued at an A-Clinic on an outpatient basis. It could also include supported housing or support person activities. The client must commit him/herself to a lifestyle free from substance abuse and undergo regular tests to ensure this.

The Probation Service is responsible for the enforcement of contractual treatment. At the prosecutor’s or court’s request or on its own initiative, the agency would assess the possibilities for contractual treatment. The agency would also draw up a treatment plan together with the treatment unit and the suspect. The assessments and plans should be made as early as possible so that the court can have them at its disposal. The duration of this treatment would be a minimum of six months and a maximum of two years, depending on the treatment need.

The court can either impose contractual treatment as planned or it can deny it, if it does not adequately measure up to imprisonment. It should not be imposed if the person is fit for community service, but when the criteria are met, the court should always opt for contractual treatment instead of imprisonment.

The committee proposes that contractual treatment be tested between the beginning of 2004 and the end of 2006 in the areas of eight district courts, which, in the committee’s estimation, would return a total of 100 contractual treatment verdicts per year. During the experiment, the effects of the new system on the participants’ recidivism and their adaptation to society will be assessed. The experiment costs an estimated 1.2 million euros, with an equal amount saved from enforcing the prison sentences. The costs will be covered by the State.

The committee considers that the experiment should only apply to contractual treatment as an alternative to unconditional imprisonment.

12.3 Evaluation and training

The so-called VP Project, developing welfare for prisoners with substance abuse problems, was evaluated in 1999 (Mutalahti 1999). The key operations in the project were turned into ten services, tailor-made for prisoners but applicable elsewhere, too. The projects that were implemented both inside and outside
prison found new approaches to preventing substance abuse problems and treating them during and after imprisonment. The project showed that the prisons have the capability, willingness and many-sided knowhow to engage in substance abuse rehabilitation, to be developed and implemented together with outside actors. Good results can be achieved in method development, implementation and evaluation, if the existing resources are retargeted, if networks are created with substance abuse services outside prison and if this responsibility is assumed by the institution as a whole. The municipality of residence and other actors must commit themselves to the prisoner’s rehabilitation continuum. However, to be systematic, such rehabilitation requires a law to stipulate the organisational and financial responsibilities involved.

In 2000, a study was published on implementing alcohol and drug rehabilitation in prison according to the therapeutic community treatment programme (Tourunen 2000). The study focused on launching a prison ward specialising in substance abuse rehabilitation. It describes ethnographically what happens when a special ward for problem users is established in a prison. Through participatory observation, 28 work team meetings in the ward were followed in three periods during a good year. The material was supplemented by interviews of prison personnel (37) and inmates (37), observation of treatment groups (9) in the ward as well as other observational and documentary material. The study aimed at analysing the tensions brought on by the treatment ward in a prison. These tensions were studied as social conflicts, in which the various parties expressed their attitudes towards the new ward.

According to the study, it is difficult to introduce just any rehabilitation programme into prison, and the participants may find it hard to assume a role in this context. The treatment ward was often perceived as an activity threatening the ‘basic work’ done in prison, and the team working in the ward was considered an ‘elite group,’ undermining the position of other employees. In order for the treatment to be successful, the prisoners must also view the activities in the ward more as self-care coming from outside the prison than as part of traditional prison activities. The fact that the treatment ward is perceived as disciplined, controlled and targeted rehabilitation adapting to the circumstances in prison helps both liaison personnel and participating prisoners accept their respective position in interactive and mutually dependent roles. However, this approach is in many ways in conflict with the principles of humane prison administration, professional assistance and individual rehabilitation. Consequently, both approaches to rehabilitation have to fight for survival inside prison. Despite the tensions, the study showed that alcohol and drug rehabilitation is a worthwhile and necessary aspect of prison administration. Thus, the focus of rehabilitation in prison is shifting from the introduction of activities to their content-related development.

13 QUALITY ASSURANCE

Quality assurance procedures
The methods used in the quality control of substance abuse work have been haphazard until the late 1990s. The procedure often used was final reporting, which was not totally systematic in form. In recent years, the situation has changed, though. The final reports on projects are more systematically made, partly due to reasons of data processing. Another contributory factor is the publication of foreign and domestic guidebooks on project evaluation. Books published in Finnish include guidelines for evaluating prevention (Kröger et al. 1998), a manual of preventive substance abuse work (van der Steel, ed. 1999) and a guide on substance abuse prevention for co-operation between schools and their interest groups (Huopanen et al. 2001). At the moment, the Finnish Centre for Health Promotion has made the best progress in systematising and published a guidebook on the quality criteria for health promotion projects (Project support – health promotion programme work done by NGOs, 2000).183

The quality criteria for health promotion projects are divided into five segments: framework criteria, structural criteria, process criteria, outcome criteria and application criteria. The quality criteria are classified according to focal areas into three groups: client-centred and customer satisfaction (C); target- and plan-centred (TP); and framework-related approach (F).

The segments are described by the following separate indicators:

Framework criteria:
1. The project aims at utilising the participants’ own resources (C)
2. The need for the project is justifiable (TP)
3. The most up-to-date information is used in planning the project (TP)
4. The risks involved in the project have been realistically anticipated (TP)
5. It is possible to evaluate the objective(s) of the project (F)

Structural criteria:
6. The parties benefiting from the project have been identified (C)
7. Participants’ expectations have been taken into account (C)
8. The project has a realistic timetable (TP)
9. The project has a justified budget (TP)

Process criteria:
10. The operational processes consistent with the objective(s) have been defined (TP)
11. The division of labour between the project participants has been specified (TP)

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183 See also: <URL:http://www.health.fi/paihde/hanketyokalut/index.html>
12. Communication between participants at different stages is planned to be active (C)
13. The participants can influence the development of activities (C)
14. Progress at all stages is monitored and periodically evaluated (F)

Outcome criteria:
15. The expected outputs of the processes have been recorded (C)
16. The expected outcomes of the project have been recorded (GM)
17. The unexpected impacts of the processes have been anticipated (F)
18. The cost-effectiveness of the project has been anticipated (F)
19. The health and welfare impacts of the project have been anticipated (TP)

Application criterion (C)
20. The applications of the project can be partly or entirely utilised in the operating environment.

An expert will evaluate the implementation of the criteria on a scale ‘implemented entirely/mainly/partly/not at all’. The criteria are weighted according to the focal area in the expert evaluation: C (10, 5, 1, 0); TP (5, 2.5, 0.5, 0); and F (3, 1.5, 0.3, 0). The value sum of the criteria enables numeric assessment of a project.

An increase in the consumption of alcohol and drugs is rapidly reflected in the need for substance abuse services in the population. Moreover, substance abuse constitutes the most important single public health hazard in Finland. At the behest of the Ministry of Social Affairs and Health, STAKES appointed a working group to draw up a quality framework for substance abuse services (2002), published jointly by the Ministry and the Association of Finnish Local and Regional Authorities in the Nationwide Intoxicant Days in autumn 2002. Through this framework, the public sector – the State and local authorities – strives to find the best possible action models in the field. Both these parties have a central role in the functioning of the service system, because social and health services are steered by the Ministry of Social Affairs and Health and service policy is part of the municipal decision-making process.

The framework recommendations aim to be specific and concrete so as to benefit service planners, organisers, providers and clients. The guidebook also has background information about the service system, the characteristics of substance abuse work and the evaluation criteria for the recommendations. The key principles of the quality recommendations for substance abuse services are as follows (Ministry’s news release, 10 September 2002):
- Drug and alcohol harms must be combated on a wide front in the municipalities. Harm reduction requires conscious local planning and a strategy. The scope and operating principles of services must take account of changes in substance abuse.
- Basic social and health services are an integral part of substance abuse services in all municipalities.
- Viable services for substance abusers are an important aspect of preventing exclusion and enhancing wellbeing and health-related equality.
- A client-centred work approach is ethically justified and socially advantageous. Access to services should be unimpeded. The clients participate in planning, implementation and assessment of their rehabilitation.
- The services will safeguard the fundamental rights of the client.
- Special attention should be paid to the client’s ability to use services. The client’s age, sex, language and other cultural factors must be taken into account when feasible service packages are planned.
- When carefully designed, a population-based and regional system of cost distribution is client-friendly, more cost-effective and easier to control compared to charging fees per visit.
- Fees compensation arrangements must not interfere with flexible and effective service referral.
- In service housing and temporary accommodation, attention must be paid to the quality of the premises and autonomy of the client.
- The leadership of substance abuse services must be solidified. Staffing, skills and personnel’s ability to withstand stress warrant special attention.

**Evaluation**

The drug and alcohol prevention project database of the Finnish Centre for Health Promotion gives a picture of the ongoing and completed projects in the field of drug prevention. At present, the register has projects implemented by NGOs on preventing and reducing substance abuse and related harms. The projects in the register have received funding from three parties: the Ministry of Social Affairs and Health, the Finnish Zonta clubs and TV Nelonen. The register has projects implemented and evaluated since 1997.

At the beginning of 2002, external evaluations made of the project proposals were included in the register. The evaluations concern undertakings started in 2000 or later. The evaluation criteria for the most part conform to the quality criteria for NGOs’ health promotion projects, with information on the criteria given for each project.184 The external evaluations include numerical assessments and graphs made by two evaluators.

Training for professionals

One important factor affecting the quality development of drug work is narcotics training provided for professionals. Drug training in Finland has been incorporated into the curricula of social welfare and health care education: students have e.g. an opportunity to specialise in services for intoxicant abusers and drug prevention. At a university level, drug education has been provided in sociology, public health studies and medicine. The Drug Laboratory of the National Public Health Institute has supervised further education in biomedicine.

The most important training institution in substance abuse work is the annual, nationwide intoxicant seminar, organised by the Finnish Centre for Health Promotion in association with the Ministry of Social Affairs and Health and the national collaborative group on services for substance abusers. In addition, central NGOs are increasingly co-ordinating regional co-operation in drug training together with relevant actors in the field expert organisations.

A national committee was appointed in 2000 to develop and supervise vocational examinations in substance abuse work. The curriculum for training that leads to a vocational degree in substance abuse work must comply with the order issued by the national Board of Education on 20 June 2000 (55/011/2000) concerning the basis of vocational examinations in substance abuse work (Heikkinen-Peltonen et al. 2002). This vocational examination is done as competence-based qualification. Qualification is part of preparatory education. Competence-based qualification does not involve isolated work assignments but a demonstration of professional skills consistent with the objectives crucial to proficiency (core skills, management of information forming a basis for the work, work methods, management of tools and material, management of the work process). The duration of training which leads to a vocational degree in substance abuse work depends on previous studies and work experience. Competence-based qualification makes the student eligible for further education in social and health studies in a polytechnic.

In the adult education syllabus of the Tampere Vocational Institute in Social and Health Care and the Tampere Health Care Institute, training for competence-based qualification in substance abuse work consist of 40 credits. The achievement of the proficiency criteria for the vocational examination in substance abuse work requires supplementary and further training and three years’ work experience. Each participant in the study programme has an individual programme and examination plan.

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185 Chapters 8.2 and 9.
In Tampere, preparatory training consists of three compulsory sections (18 credits + qualification 2 credits): the legal and service systems (4 credits), humane professional approach (6 credits) and the basics and methods of substance abuse work (8 credits). The compulsory section includes learning at work (6 credits) and qualification in the three compulsory sections (2 credits).

Of the two optional sections (18 credits + qualification 2 credits) – psychosocial approach to substance abuse work (9 credits), Christian substance abuse work (9 credits), Myllyhoito® treatment (9 credits), voluntary and NGO substance abuse work (9 credits), prevention (9 credits), independent professional practice (9 credits) – the student must choose at least one of the first three sections. Optional studies include learning at work (10 credits) and qualification in the two optional sections (2 credits).

The statutory responsibilities of the national committee on substance abuse work examinations is responsible for the supervision of competence-based qualification, adequacy of examinations, drawing up contracts for organising competence-based qualification and clarification of evaluation targets, criteria and methods of organising qualification. During its first period (1 December 2000 – 30 November 2003), the committee has made agreements with 16 educational institutions for organising competence-based qualification and granted about 90 diplomas by August 2002.

The further training project on the treatment of drug addiction started in 2000 financed by the Ministry of Social Affairs and Health and co-ordinated by the A-Clinic Foundation. It has participation from key operators in the field, such as the Association of Finnish Local and Regional Authorities, STAKES, the A-Clinic Foundation, the Deaconess Institute in Helsinki, the Free from Drugs Association, Myllyhoitoyhdistys, the Finnish Blue Ribbon and the Tyynelä development centre. The project improves the attitudinal, cognitive and professional aptitude of personnel working in basic or specialised social and health services to recognise and treat with various methods drug addiction and its consequences. Another task is to develop the national networks of drug treatment experts (drug treatment trainers, implementers of substitution treatment and health counselling) and to develop regional and local co-operation between actors engaging in the treatment of drug users. Improved professional skills will promote the availability of treatment services and the establishment of treatment chains based on client needs. By the summer of 2002, the expert and trainer networks of the regional groups (20) had 250 members. The project webpage opened in April 2002,\(^\text{187}\) providing constantly updated information about drug treatment, training and network activities.

\(^{187}\) See [http://www.a-klinikka.fi/husko](http://www.a-klinikka.fi/husko)
In addition, the research unit in addiction medicine at Helsinki University has prepared a study programme, launched on the initiative of the Ministry of Social Affairs and Health, and in co-operation with the A-Clinic Foundation, the National Public Health Institute, the addiction medicine association and the Ministry, for physicians and other treatment providers. The purpose of the programme is to teach the scientific basics and procedures of evidence-based methods to treat opioid addiction. The course includes a self-study section (1 credit) on prearranged material, an intensive course (1 credit) and, when necessary, work practice (1 credit).\textsuperscript{188}

During the past two years, several textbooks have been published on drug-related training: on basic drug information,\textsuperscript{189} preventive substance abuse work\textsuperscript{190} and the treatment of substance abusers in addiction medicine in general (Salaspuro et al. 1998) and for nurses in particular (Inkinen et al. 2000). Guidebooks have been targeted at smaller groups as well: on temperance education in school,\textsuperscript{191} preventive telematics work,\textsuperscript{192} evaluation of substance abuse prevention,\textsuperscript{193} encountering heavy drinkers or drug addicts at maternity clinic,\textsuperscript{194} early intervention in substance abuse problems (Partanen A. et al. 1999), encountering drug users in the workplace,\textsuperscript{195} in the treatment system (Ahokas et al. 1998), in prison\textsuperscript{196} or in primary health care for clients with hepatitis C.\textsuperscript{197} In addition, a guidebook on cognitive family therapy in substitution treatment has been published (Holmberg 2002).

14 DISCUSSION

Principal intervention strategies and their evolution

Throughout the late 1990s, ever-increasing attention was paid to drug questions in Finland. In 1996, an inter-administrative expert group was launched to create a national drug strategy. As a result, the proposal for a drug strategy saw the light of day in spring 1997, eventually resulting in the Government Decision-in-Principle on Drug Policy at the end of 1998. Both these documents fully endorsed a well-balanced approach to drug policy, as recommended by the UN, assigning equivalent weight to both demand and

\textsuperscript{188} See \url{http://www.a-klinikka.fi/jss/kouluutus/tilaisukset}
\textsuperscript{189} Chapter 9.1.
\textsuperscript{190} Chapter 13.
\textsuperscript{191} Chapter 9.1.
\textsuperscript{192} Chapter 9.4.
\textsuperscript{193} Chapter 13.
\textsuperscript{194} Chapter 9.3.
\textsuperscript{195} Chapter 9.4.
\textsuperscript{196} Chapter 12.1.
\textsuperscript{197} Chapter 10.1.
supply reduction measures. Based on the strategy proposal, regional training commenced, leading to planning of local drug strategies in many municipalities.

Nationally, implementation of the Decision-in-Principle started in 1999, resulting in a proposal for a drug research programme for the Academy of Finland. The relevant Ministries also included drug topics in their medium-term financial and action plans. In November 1999, a joint consensus meeting between the Academy of Finland and the Finnish Medical Society Duodecim convened in order to develop drug treatment further. The consensus statement of the conference presented developmental needs to promote drug treatment and research on a broad scale and in keeping with the 1998 Government Decision-in-Principle. The same line of action was pursued in the report of the committee on young people’s drug prevention (2000) and the report of the committee on drug treatment (2001).

The police and the prison authorities have also produced their respective intoxicants and drug strategies in line with the Government 1998 Decision-in-Principle, with demand reduction as an important consideration along with control. Drug demand reduction and care referral are also given more attention in the newest drug strategy for 2003–2006 of the police.

The wide-scale round of planning, described above, indicates that growing drug use and the resulting harms have been recognised as phenomena warranting a broad and multiadministrative national action plan to arrest these developments. The core results of the planning are linked to the 1998 Government Decision, intensifying this decision by the 2000 Government Decision-in-Principle on Drug Policy and related supplementary budget for drug work, further specified by the action programme for intensifying drug policy in 2001–2003 issued to the Government by the drug policy co-ordination group in 2002.

Concurrently with long-term strategic planning, decisive action has been taken to solve immediate drug problems at regional and local levels. The focus of prevention has been on young people and improving their life-management skills, especially by means of activation, supporting parenthood and early intervention in young people’s drug experiments. In prevention, the emphasis was on young people’s own participation in project planning. All central actors involved have invested especially in providing drug training for prevention workers; in addition, a network of municipal co-ordinators in drug prevention has been established. Training for a vocational examination in substance abuse work has started. A nationwide campaign on drug information is also ongoing, including a broad-scale evaluation.

At a national level, the accent has been on enhancing information flow between actors and the accessibility of the existing data. One especially notable approach has been the use of the new media in combating narcotics. As a result, services have been launched to disseminate information among drug workers about research results, working methods, municipal drug strategies and antidrug projects run by
municipalities or organisations. In addition, telematics services have been developed: drug information services, discussion forums and anonymous self-testing of personal intoxicant use.

In the treatment system, the development of low-threshold services and the related training have been highlighted, the aim being to involve clients in the treatment system as early as possible. At the same time, there has been much debate about harm reduction actions, whose position as part of treatment has been more widely acknowledged, one example being the development of infection risk counselling for injecting drug users as well as the substitution and maintenance treatment system. A special training programme has been developed for the scientific basis and methods of substitution treatment. In the past year, major investments have been made to develop the treatment system regionally, as suggested by the relevant working group. Moreover, the general quality framework for substance abuse services was established in national co-operation.

The control authorities have stressed collaboration in preventive work with other authorities in the field. A new narcotics offence type, ‘user offence’, and, as a related means of reducing demand, a personal hearing and possibilities of care referral for the offenders were introduced. Another preventive measure that has been proposed is the introduction of drug tests. However, possible mass screening for drugs has aroused much debate in public. Some amendments to legislation concerning drug tests in working life are now in progress; a proposal for new legislation in the matter was made at the beginning of 2002. The three-year experiment in prisons has resulted in well-designed products for drug treatment in prison and for the after-care of released prisoners, in association with organisations in the field. Furthermore, a proposal was made concerning the so-called contractual treatment for substance abusers as an alternative to imprisonment.

**Main future trends and strategies**

Appointed by the Government, the drug policy co-ordination group is a central actor in future drug work. Its mission is to co-ordinate national drug policy activities, to intensify official co-operation as well as to implement and monitor the national drug policy strategy, specified in the Government Decision-in-Principle.

To assist the group, the report of the committee planning drug prevention among young people was published in autumn 2000, followed by the report of the drug treatment working group in early spring 2001. The recommendations of especially the latter have mostly been implemented in legislation and finance. Moreover, the quality of many isolated drug projects will be financially affected by the introduction of various evaluation protocols now in planning.
The 1998 Government Decision-in-Principle has provided national and local drug work with a framework for all activities for the next couple of years. The drug policy co-ordination group has an important position when deciding how activities within this framework are prioritised, a fact that will be reflected in finance. In autumn 2000, a new Government Decision-in-Principle was issued on the subject, with attendant budgetary proposals. At the same time, the drug policy co-ordination group was assigned to draw up an action plan to intensify drug policy. The programme was submitted to the Government in February 2002.

In addition to the national guidelines, drug policy implementation will take account of the drug conventions of the United Nations as well as the goals set in the UN special drug session on 8–10 June 1998, to be implemented by 2003 and 2008. The new drug strategy for 2000–2004 of the European Union and the related action plan as well as the monitoring demands within the action plan will also have an impact on implementation of the national strategy.
PART IV DRUG SUPPLY REDUCTION INTERVENTIONS

15 NATIONAL STRATEGIES IN SUPPLY REDUCTION

The field of supply reduction consists of control directed at the illegal traffic, use or distribution of drugs or at their legal import, export, trade or use, e.g., for medical or research purposes.\(^{199}\)

Two sectors are highlighted in police activities. Locally, an effort is made to prevent the criminal recruitment of first offenders and juvenile delinquents in particular, at a national level an effort is made to tackle large-scale aggravated offences perpetrated by professional criminals. Combating large-scale illicit drug trafficking run by professional and organised criminals calls for efficient and many-sided intelligence services and analyses, criminal investigation focusing on the perpetrators and smooth international law enforcement co-operation. In the Finnish context, this means co-operation especially with the Baltic states, Russia, the Nordic countries and between the EU Member States. (Hietaniemi 2002).

It is the task of the customs authorities to prevent illegal import and to oversee the legal import of narcotics. At international frontier crossing points, systematic drug control is enforced based on criminal analysis methods. In addition, the District Customs Offices have teams specialising in customs offences. Through targeted actions based on intelligence information, these teams strive to prevent organised and professional drug crime.

The Ministry of Social Affairs and Health is responsible for controlling the legal import, export, sale and use of drugs. The control tools of the National Agency for Medicines include supervision of licences, record-keeping obligations and inspections. The Agency also keeps a register of medicines categorised as narcotics. Through its computerised supervision of narcotics prescriptions, the National Board of Medicolegal Affairs oversees and imposes restrictions on the prescriptions and prescription rights associated with narcotic substances.

\(^{198}\) The structure of this chapter is based on the Drug Strategy 1997 and related background material (Huumausainestrategia 1997).

\(^{199}\) See Appendix 5: Actors in drug supply reduction.
15.1 Major strategies and activities

The fundamental objective of drug supply reduction is to safeguard order and security in society. One important strategic goal is to keep Finland an insignificant and risky marketplace for the international drug business. The maintenance of a high risk in drug trafficking requires that the authorities be properly empowered. The control measures taken must also comply with the rule of law and human rights.

The supply reduction strategy of the police includes actions to prevent the illicit manufacture and import of drugs, to detect illicit drugs and persons distributing them on the market, to expose organisations engaging in manufacture, import and distribution and to maintain a high risk of apprehension. In combating aggravated drug crime, it is important to prevent money laundering and to ensure that criminal proceeds will be seized. The tasks of the customs authorities mainly involve supply reduction on international borders and exposing organised drug criminals. The police, customs and the Border Guard have close collaboration in antidrug actions through a permanent body, the narcotics working group. The National Agency for Medicines focuses on controlling the legal use, production, trade, import and export of drugs, psychotropic substances and precursors.

In terms of supply reduction, the Government Decision-in-Principle on Drug Policy (1998) suggested that:
- The confiscation of the proceeds obtained through drug offences will be intensified.
- It will be studied whether it is possible to introduce reversed burden of proof in cases of aggravated narcotics offences.
- Questions of fictitious purchasing and infiltration will be addressed in connection with the amendment to the Police Act.
- It will be studied what kind of legislative and other measures should be taken to protect witnesses and persons co-operating with the judicial authorities in combating international organised drug crime.
- The drug crime prevention of the police will be intensified by developing the methods used and new forms of international co-operation by the police.
- Resources will be allocated in particular to control at the street level, for preventing the emergence of public places, where drugs are sold and used.
- The personnel resources of the customs administration will be developed, and directed at drug control in particular.
- Customs activities will be intensified also by obtaining more technical control and surveillance equipment.
15.2 Approaches and new developments

Organised crime groups led from Estonia and Russia have clearly established a firm foothold on the Finnish drug market in the 2000s. Moreover, these crime syndicates often have a hand in the distribution of drugs, an activity that was previously almost completely undertaken by Finns. These highly organised groups have viable international networks and connections enabling them to handle the entire import chain, starting from countries and areas where drugs are produced. They are also efficient in organising synthetic production, especially in Estonia. The large drug consignments seized indicate that the import of amphetamine and hashish to Finland aims at making quick profit on an extensive scale. The same wholesalers provide different substances, mostly based on advance orders placed by the dealers. (Hietaniemi 2002).

On 5 October 2000, the Government gave its second Decision-in-Principle to intensify drug policy (2000). In terms of intensified control, the Decision suggests that
- Police and customs activities focus on preventing drug supply, i.e. illegal import and distribution.
- Readiness to investigate ever-increasing drug crime will be improved by training and technical equipment.
- Personnel resources of the Customs Administration will be directed at drug control activities: the number of drug dogs and handlers will be increased. More investigators specialising in drug issues will be recruited.
- The number of full-time drug-enforcement officers will be increased from the present 100 person-years by a minimum of 70 person-years, and additional resources will be directed at street level control in particular.
- Regulations on drug use will be clarified: in autumn, the Government issued a bill to Parliament, whereby the prosecutors can impose a fine for drug use or possession for personal use (summary penal judgment).
- The prosecutorial authority’s possibilities to try drug cases will be enhanced: experienced prosecutors will be appointed to the Office of the Prosecutor-General and major cities. These prosecutors will concentrate on processing drug cases.
- In order to improve antidrug work in prison, inmates’ drug testing and other types of drug control will be intensified.
- The Government will make a proposal to Parliament, whereby saliva specimens can be taken from potential substance abusers in prison.

Sector-specific programmes will describe the strategic focal points in more concrete terms.

As for supply reduction, the drug strategy of the police for 2000–2003 (2000) emphasises:
- Combating professional or otherwise aggravated drug crime. In this respect, the accent is on:
  (i) The role of the National Bureau of Investigation as a co-ordinator of international and national anticrime activities.
  (ii) The introduction of new surveillance and anticrime methods.
  (iii) Co-operation with the prison authorities
    - Intensified street control, which will be implemented by:
      (i) Developing local police activities.
      (ii) Introducing new test methods in road traffic control.
      (iii) Training peace officers.
  - Better readiness to conduct preliminary investigation into drug offences, implemented by:
    (i) Enhancing telesurveillance and technical surveillance.
    (ii) Accelerating chemical sample analyses.
  - Intensified confiscation of the criminal proceeds by improving co-operation:
    (i) With debt recovery and tax authorities, prosecutors and prison administration.
    (ii) Between the Money Laundering Clearing House and other police units.
  - Preparation of legislative initiatives concerning reversed burden of proof, witness protection, tax-free compensation for tip-offs as well as legislation on money laundering and amendments to the laws on preliminary investigation and coercive measures.
  - International co-operation to implement the Schengen Agreement and bilateral anticrime and customs agreements.
  - Development of police education by applying the training model used in investigating financial crime.
  - Development of a system to monitor antidrug activities.
  - Scientific research on drug crime.
  - Intensified international networking, which will be implemented so that
    (i) Co-operation with other authorities will be developed further in order to intensify drug-related training in the neighbouring countries.
    (ii) The EU’s Phare and Tacis programmes on preventing and combating drug use will be promoted.

The new anti-drug strategy of the police for 2003–2006 (2002) stresses the offenders’ high risk of apprehension for committing aggravated drug crimes, the seizure of drugs destined for the Finnish market already before they enter the country, street-level control of narcotics and pharmaceuticals classified as narcotics as well as exposing concomitant crime and tracing criminal proceeds from money laundering and prostitution. In the strategy, the police also suggest that the maximum penalty for an aggravated narcotics offence be increased from 10 to 12 years and that the leaders of organised crime syndicates systematically face more severe punishments.\(^{200}\)

\(^{200}\) See http://www.intermin.fi/intermin/images.nsf/files/5BD72FD1DCA3695AC2256C28003CFB59/$file/huumestrategia.pdf
In terms of supply reduction, the intoxicants strategy for the prison administration (1999) against substance abuse for 1999–2001 stresses that:

- Community work may prevent and deter prisoners from substance abuse and drug-related crime.
- Spatial and activity arrangements enable supervision of drugs entering prison.
- Systematic control and supervision prevents the occurrence of intoxicants in prison.
- Control and supervision activities are subject to constant monitoring and evaluation.
- The prisoners have a right to serve their sentences in an intoxicant-free environment.
- If necessary, drug offenders will be isolated from other inmates in order to prevent disturbances.

At the beginning of 2001, the second part of the prison administration intoxicants strategy was approved, focusing on supply prevention, with efficient control as its core activity. Concentrating mainly on supervision and inspection, the strategy was published in the form of a handbook on drug control. The book is intended for prison guards to improve and facilitate their work, with an effort to harmonise working practices in different prisons. Thus, it is a kind of quality manual on good control practice. The third part of the strategy incorporates all major intoxicant and drug strategies implemented in the prison service.201

At the same time, the joint drug strategy (PTR) of the police, customs and the Border Guard was approved, aiming at more effective antidrug operations by intensified collaboration. The drug strategy of the customs authorities for 2002–2005 was completed at the beginning of 2002. In compliance with the strategy, the customs authorities try to intercept drugs on the border before their distribution. Another aim is to uncover professional drug organisations and put them out of business. To prevent drugs from entering the country, Customs co-operate with national and international authorities. Customs will also ensure that the agency has adequate drug control resources, develop internal training and improve information services on the results achieved in combating drug crime. The strategy is complemented by an action plan (Customs Newsletter 1/2002).202

The Ministry of Defence has also drawn up a drug strategy (2001) for the Defence Forces. The strategy aims to endorse a negative attitude towards drugs in the Defence Forces, making it known both inside the organisation and in society at large, to promote healthy lifestyles, to support antidrug work in society and to create opportunities for co-operation and networking at different levels.203

201 See Chapter 12.1.
The Finnish law enforcement authorities work in close collaboration with their colleagues in the neighbouring areas to fight large-scale drug crime. This co-operation is based on bilateral anticrime agreements between Finland on the one hand and Russia, the Baltic states and Poland on the other. Other Nordic countries, especially Sweden, participate in anticrime work in this region. In addition to operational crime investigation, Finland has been responsible for the project on developing Estonia’s forensic laboratory activities implemented on Phare/Twinning finance.

16 INTERVENTION AREAS

In terms of supply reduction, the action programme for intensifying drug policy in 2001–2003 (2002) set the following objectives:

1. As of 2002, the police seek to expose 5–10 organised crime groups per year.
2. The police, customs and the Border Guard develop their co-operation based on their joint drug strategy (PTR), in force since 2001.
3. In their respective domains, the National Bureau of Investigation and the National Board of Customs will co-ordinate activities to combat professional, organised and international drug crime by pooling information on offences and serial crime in an up-to-date and perpetrator-specific manner and these agencies will, when necessary, lead covert operations and controlled deliveries.
4. Exchange of information between the police and prison authorities will be improved in accordance with the co-operative agreement signed in 2000.
5. The seizure of criminal proceeds will be intensified in co-operation between the police, debt recovery and tax authorities as well as prosecutorial and customs authorities.
6. Readiness to undertake coercive telecommunications measures and technical surveillance will be improved through new technology and by obtaining necessary equipment.
7. The police and prosecutorial authorities will agree on the best policy on drug user crimes.
8. The basic and further police training in combating and investigating drug crime will be renewed: the police, customs and border guard authorities will introduce a joint training programme on combating drug crime and make training opportunities available to officers from these agencies.
9. The effectiveness of antidrug work done by Customs will be enhanced in 2002–2003 by acquiring new technical equipment and by developing investigative techniques.
10. The introduction of unconventional methods employed by the customs authorities in preliminary investigation will be prepared.
11. A key prosecutor system has been established in the major cities: the task of these new prosecutors is to ensure proper liability especially for drug offences and to take part in preliminary investigation, prosecutorial deliberation and in legal proceedings.
12. In 2001, systematic drug tests started in prisons by taking urine specimens and as an experiment on testing saliva specimens on drug-free and open wards.

13. Special examinations in prison will be increased and drug dogs will be introduced in prison.

14. Drug control will be intensified though legislative amendments: better protection will be provided for witnesses and those assisting the authorities in solving crimes; the criteria for crimes perpetrated by offenders using, or threatening to use, violence will be further clarified and upgraded if necessary; the courts will give the police more extensive authority for technical surveillance, including suspects in a private residence.

16.1 Activities in the judicial system

When the 1994 Narcotics Act was prepared, the guiding principle was to tackle professional and organised drug crime. The aim was to make drug use punishable in order to emphasise that drugs are not tolerated and to achieve an effective deterrent, the ultimate goal being to prevent the emergence of an illicit public drug market in Finland.

According to the changes in the Penal Code in 1994, prosecution and sentencing may be waived in case of drug use or other related crime, if the deed does not undermine common obedience to the law or if the perpetrators commit themselves to treatment approved by the Ministry of Social Affairs and Health. These special provisions concern the personal use, import, possession or manufacture of drugs. In some cases, however, prosecutors may have waived prosecution without proper cause, since court proceedings are considered too cumbersome for imposing a fine. In January 2000, the Office of the Prosecutor-General issued guidelines (2000:5) for waiving prosecution in certain types of drug offences.

An amendment of law clarifying judicial practice on user crime took effect in September 2001. The amendment defines ‘a user offence’, which makes it possible to impose a fine in the form of summary penal judgment for the use, possession or attempt to obtain drugs for personal consumption. This makes the abstract concept of obedience to the law redundant in this context, to be replaced by a more precise expression of the quantity, quality, situation or circumstances. The reform does not make the punishment more lenient, as a fine is already now imposed for these offences in a court of law.

Court hearings relating to drug offences differ somewhat from other trials, e.g. as regards the burden of proof. In drug offences, it is more complicated to establish proof because the evidence is based on the

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204 See Chapter 1.2.1.
205 See Chapter 1.2.1 and 1.3.
offender’s own story or that of an accomplice. It has been said that the burden of proof is more easily satisfied in drug offences.

Legislation on control and surveillance by technical means, carried out by the police and customs officials, may be utilised in preventing and detecting drug trafficking. The law on international assistance in criminal matters acknowledges the controlled delivery of drugs as one avenue of investigation. The Second Naples Convention on customs activities regulates infiltration across the border, and the Schengen Agreement stipulates infiltration within the EU. Such action can only be taken in aggravated crimes. As of 2001, the use of infiltration and undercover purchase activities are possible in combating crime in Finland.206

In addition to the risk of apprehension and of punishment, the confiscation of the criminal proceeds is an effective deterrent against calculated criminal activities aiming at profit. The present law recognises the concept of forfeiture of extended profit, whereby a person guilty of, for example, a narcotics offence or aiding and abetting a crime (or who has participated in an offence or on whose behalf the crime was perpetrated), may forfeit their property either partly or in full, if the offence is liable to bring considerable financial benefits.207

As aggravated narcotics offences have become more professional, persons giving evidence have been threatened. Two resolutions have recently been passed in the European Union, exhorting the Member States to enhance resources to counteract international crime. One programme concerns the protection of witnesses in a criminal case, while another one deals with the protection of persons assisting in criminal investigation. The Government Decision-in-Principle 1998 requires that this question be solved in Finland as well. The National Bureau of Investigation has preliminarily surveyed the present situation.

Based on the Government decision-in-principle (2000) on intensified measures to fight drug crime, the Prosecutor-General has appointed one State Prosecutor and seven State Local Office Prosecutors at the local prosecutors’ offices for a term of two years as of 1 February 2001; they will mainly concentrate on drug cases. Of the State Local Office Prosecutors, three are based in Helsinki and one each in the cities of Espoo, Vantaa, Turku and Tampere. These prosecutors are part of the so-called key prosecutor system.

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206 See Chapter 1.2.2. and 4.2.1.
207 See Chapter 1.2.2.
### 16.2 Control and technical equipment

The customs authorities focus on the first links in the chain of drug offences, while the police often deal with crimes occurring later in the chain, after drugs have already been sold or used on the Finnish market.

Surveillance of telecommunications used by the suspects is a method employed in recent years in investigating aggravated drug offences. The amendments to the law on Coercive Criminal Investigation Means have enabled the monitoring of telecommunications and other technical surveillance. However, these methods are seldom used.\(^{208}\)

The National Bureau of Investigation performs duties that involve demanding technical surveillance and intelligence services for the entire police administration. Tasks are on the increase in all domains of technical surveillance. Technical surveillance was mostly used in investigating drug-related, financial and property crime.

In compliance with the customs strategy, the focal point of customs activities has shifted towards the EU’s outer borders. The customs authorities are still monitoring Finland’s borders, including the internal borders of the EU. However, the latter supervision has become more discreet and it increasingly relies on intelligence information. The National Board of Customs has supplied all the major Finnish frontier transit points with adequate equipment and inspection facilities. The importance of special equipment, mobile surveillance and drug dogs is likely to grow in preventing professional drug crime.

In prisons, inmates or premises may be searched, for example, if a prisoner is suspected of possessing unauthorised articles or substances.\(^{209}\) An inmate may also be isolated in prison for a repeated use of intoxicants, in order to intervene in a drug offence or until the illegal substances have disappeared from the prisoner’s body. In 1999, the Government appointed a committee to prepare for the reform of prison sentences and their enforcement. One issue emerging in this connection will be the position of rehabilitative and other actions reducing the risk of habitual crime.

The National Agency for Medicines is authorised to inspect premises, where narcotics or precursors are legally produced, stored, kept or otherwise handled, and to take samples during these inspections. Businesses must notify the Agency of unusual orders or transactions involving precursors. It has authority to prevent the delivery of illicit substances, both domestically and across the border.

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\(^{208}\) See Chapters 1.2.2. and 4.2.1
\(^{209}\) See Chapter 1.2.2.
Banks and other financial institutions must report unusual transactions and intervene whenever necessary. They must also submit the relevant documents for auditing. Money laundering issues in Finland belong to the Money Laundering Clearance House of the National Bureau of Investigation.

Based on a Government decision (2000), the police were given an additional EUR 1.67 million for redoubling their efforts to fight drugs at the street level, with the aim of intervening in the trade and other distribution of drugs, activities that have become more open and disturbing. The police invested this allocation as 35 person-years as follows: the Province of Southern Finland and Greater Helsinki (20), the Province of Western Finland (10) and the Province of Oulu (5). Resources at the street level were also reinforced by 26 person-years. Units in the Provinces of Eastern Finland and Lapland as well as the Mobile Police were required to intensify control by a total of 14 person-years without additional funding allocated. More resources are directed at units that already have officers capable of handling serious drug cases and criminal intelligence. The budget draft of 2002 states that ‘in order to decelerate the growth in drug crime, the drug strategy of the police (2000) and the Government decision to intensify drug policy (2000) will be implemented.’ Associated with this programme, an additional appropriation of EUR 3.2 million is given for appointing 60 police officers to combat serious drug crime.

The Customs Administration decided how to invest the EUR 500,000 granted in the supplementary budget of 2001: the National Board of Customs and the customs districts agreed to hire 11 employees for combating drug crime. Of them, one was stationed in the control and inspection unit of the National Board of Customs to act as a trainer in the agency’s drug dog training centre, while the rest act in the regional administration as chief investigative officers (3), drug detectives (3) and drug dog handlers (4).

In 2002, the prevention, detection and investigation of professional and international drug crime will be strengthened by recruiting new personnel for special control, drug investigation and handling drug dogs in Customs. The agency’s drug liaison system will be enhanced by rearranging the liaison officers’ postings and by appointing a liaison officer to Vyborg, Russia. The focus of these activities will shift to the production areas of illicit drugs destined for Finland and other EU countries.

16.3 Intelligence and information systems

Combating serious and organised crime calls for efficient and up-to-date intelligence services, with related analysis and monitoring of the data, appropriately targeted investigation and smooth, timely and consistent international co-operation between law enforcement authorities. The Finnish police and Customs are in close collaboration both in their respective domains and jointly on international forums.
and in numerous international projects. Nordic co-operation between the police and customs authorities, utilising comprehensive liaison networks that serve all Nordic countries, exemplifies a feasible and effective international model. (Hietaniemi 2002).

Full implementation of the Schengen Agreement commenced in Finland on 25 March 2001. At the same time, the Schengen Information System (SIS) became operational in that country as well. The system has data on persons and property wanted by the police in the Schengen area. Finland is an active participant in information exchange concerning the analysis databases of Europol. The country has a national intelligence data system (register of suspects, EPR1), an important tool for investigating serious drug crime as well. Offences are recorded in the national offence report system, which is used by the police and Customs. The centralised Customs Information System (CIS) of Europol and national customs authorities is also developed further.

The National Bureau of Investigation is in charge of the national operational and strategic monitoring of organised crime and its analysis and investigation. The Bureau also follows the situation especially in national drug crime and produces reports and statistics on it. In 2001, statistical practice was simplified so that the Bureau will only provide statistics on drug seizures and compile situation reports utilising a wide range of material. The data on narcotics offences are extracted from the police performance register, which means that no separate NBI drug statistics are compiled anymore. The situation reports concentrate on outlining the national situation and the related threat scenarios, especially information supporting activities to counteract large-scale drug crime. The Bureau’s Criminal Intelligence Division and its investigative team keep close watch especially on crime organisations led from Estonia and Russia, which play a major role on the Finnish drug market. (Hietaniemi 2002).

16.4 Collaboration with the private sector and citizens

Drug offences are increasingly often detected in connection with everyday police work, such as ordinary investigation or the work done by uniformed police officers. Antidrug activities are heavily dependent on information from the public and other actors, whose contribution is channelled into tip-off lines of the police and customs, with an opportunity to inform on drug offences that are being planned or ongoing. Today, it is possible to report offences via the Internet as well.

To upgrade its activities, the Customs Administration has also signed contracts for collaboration with major transport companies and international suppliers (the so-called MOU contracts). The goal is to
establish active co-operation between customs and business life to prevent drug trafficking through the partners’ ordinary business activities.

16.5 Collaboration between the control authorities

The control authorities have reinforced their co-operation in supply reduction, a fact that also enables better use of the limited resources. The need for increasing international co-operation requires closer collaboration between the national authorities as well. (Hietaniemi 2002).

In Finland, the police, Customs and Border Guard work in close collaboration, as specified by a Decree in 1978. These activities gained momentum after the borders were opened in the Baltic countries and Russia in the 1990s. At present, co-operation in drug issues between these agencies is co-ordinated by the so-called PTR steering group and a special drug steering group of the co-operative forum. Regionally, this work is co-ordinated by the regional PTR steering groups.

A co-operative working group led by the National Bureau of Investigation decides major operations against organised crime syndicates. Based on the information compiled at the agency, the working group selects the targets for nationwide operations.

Criminal investigation co-operates with the tax and debt recovery authorities in the forfeiture of illegal profits in particular. In Finland, criminal investigation is led by the chief investigative officer, not the prosecutor. Collaboration with the prosecutorial authority has been consolidated by reorganising policies, through exchange of officials and by appointing prosecutors specialising in narcotics cases. As representatives of the law enforcement authorities, the Police IT Management Agency and the National Board of Customs have participated in a joint venture to develop co-operation between the Finnish authorities (VIRKE) in an effort to enhance legislation and policies on the integration and handover of official data.

17 QUALITY ASSURANCE

Quality procedures

The narcotic substances seized, with the exception of small quantities of cannabis, are analysed by the Crime Laboratory of the National Bureau of Investigation or by the Customs Laboratory. The analysis methods employed by these laboratories are FINAS accredited.
Training for professionals

Detectives and other police officers come increasingly often in contact with drug-related crime, a fact that has caused a great demand for further training. Training is primarily provided by experienced members of the drug squad. The new Police College of Finland has a major role in this respect.

Also the customs authorities have directed resources at training customs officials, both through in-house courses and training by the police.\textsuperscript{210} In addition, training will be provided for the police, customs and the Border Guard, based on the joint drug strategy of these authorities.

The National Agency for Medicines has arranged seminars on precursors for various control officials in association with the National Board of Customs and the National Bureau of Investigation.

The Finnish police engage in training associated with measures to combat crime and money laundering in Estonia. Officials in Finland’s neighbouring areas are also trained within the framework of international customs co-operation. In recent years, the Finnish police, customs and the Border Guard have also launched co-operation with their corresponding partners in the Baltic States and Russia. The National Agency for Medicines and the European Commission have implemented a project to examine the present situation in the legal use and supervision of narcotics in the 13 Phare countries.

18 DISCUSSION

Principal intervention strategies and their evolution

In 2000, the Office of the Prosecutor-General issued orders to the prosecutors on waiving prosecution in drug offences, and in 2001 a more lenient punishment for ‘drug user crime’ was introduced. The near future will show how these two factors affect decisions to drop charges.

Many new documents relevant to supply reduction have emerged, such as the drug strategies of the police, Customs and prison authorities. Legislative reforms increasing control authority and methods are important for the control activities undertaken by the authorities. In 2001, the police were given new, more extensive powers to engage in undercover purchase and other such operations. The Customs

\textsuperscript{210} As part of co-operation between the customs authorities, a guidebook in Finnish and Russian was published in 1997 to prevent the smuggling of drugs and psychotropic substances (Alaniemi et. al. 1997).
Administration has partly been issued similar powers under the Customs Act. Changes are also underway to give the prison authorities more power to intercept illegal substances in prison. During the year, law enforcement personnel resources for antidrug work have been greatly increased in the police, customs, prosecutorial and prison administrations.

Improved co-operation has been characteristic of the activities during the year. In close collaboration with the local authorities, an effort was made to prevent the emergence of public places where drugs are openly sold. At the national level, co-operation between the control authorities has been reinforced and, consequently, the police, customs and the Border Guard approved a joint drug strategy in 2001, with several co-operative sectors for improved antidrug activities. New investigative methods recently made available (telesurveillance and technical surveillance) have been more widely applied to investigations into organised drug crime. Co-operation with other organisations has been promoted as well, for instance, concerning money laundering (banks and other financial institutions) and precursors (the chemical industry, etc).

Ever-expanding international collaboration, e.g. to control drug crime and money laundering, has provided new contacts and information, which are necessary for combating internationally organised drug crime.

**Main future trends and strategies**

The joint drug strategy of the police, the Customs Administration and the Border Guard, the drug strategy of the Finnish police and the intoxicants strategy of the Prison Administration can be seen as concrete examples of implementing the Government Decision-in-Principle (1998) on drug policy. The actions taken in the near future to reduce drug supply will be congruent with the national crime prevention programme, as specified in the Government platform. On the other hand, the eventual outcome of the legislative reforms now in progress will provide the future framework for methods to prevent crime.

International co-operation and its development are however the most important factors predetermining the future guidelines for supply reduction. In these activities, the international directives mentioned above for demand reduction will be followed.\(^1\) Another important fact directing supply reduction activities is the Schengen Agreement, which took effect in Finland on 25 March 2001.

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\(^{1}\) See Chapter 14.
PART V

19 DEMAND REDUCTION EXPENDITURES ON DRUGS IN 1999

In this report, drug-related costs mean the societal costs resulting from the use and abuse of narcotics and narcotic medicines per year. They are divided into direct and indirect costs.

The direct harm-related costs of abuse of narcotics and pharmaceuticals were approximately 127.4–195.9 million euros in 1999, and the indirect costs are estimated at 286–622 million euros. Of the direct costs, demand reduction expenses came to an estimated 64.5–87.9 million euros in 1999. (Hein 2002)

The direct costs resulting from drug use and abuse include expenses for households, businesses and society at large that would not have otherwise been incurred if drug use or problem use had not taken place. These include the following: hospital expenditure due to drug use, sickness benefits and disability pensions, benefits paid out based on statutory or voluntary accident insurance and life insurance, living allowances due to economic hardship, child welfare costs as well as costs of drug research, prevention and education.

Direct costs also contain supply reduction (control) items left out in this connection: judicial and prison costs as well as police, fire and rescue services costs resulting from drug-related crime, compensation and fines paid by drug users and the value of property lost or destroyed in drug-related accidents and crimes. These items are included in the direct harm costs presented in Chapters 1.5 and 4.3.

Indirect harm-related costs involve estimates of work contributions and tax revenues lost by society and the value of prematurely lost life. The indirect costs correspond to the difference between revenues lost and expenses saved by society. The overwhelmingly largest indirect cost item was the estimated value of lost life due to untimely deaths, EUR 235–538 million.

19.1 Concepts and definitions

The available data on costs partly involve drug cases (narcotics and pharmaceuticals) directly, while others concern intoxicant-related cases (alcohol and drugs) or total expenditure in some social sector (such as child welfare).

When the data involve intoxicant-related cases in general, drug cases are distinguished by using the results of the one-day census of intoxicant-related cases in social and health services in 1999 (Nuorvala
et.al. 2000). During one day, these services encountered over 11,500 such clients. Of them, 23 per cent used services on account of a problem involving pharmaceuticals and 15 per cent due to narcotic substances. A third of the clients were polydrug users. In specialised outpatient services for substance abusers, narcotics clients accounted for almost 20 per cent and in inpatient care for nearly 30 per cent. The figures for clients seeking treatment in these services due to a pharmaceutical-related problem are almost the same.

If cost information is available only in terms of total expenditure of certain societal sector, intoxicant-related cases are estimated based on assumptions made on special reviews or other sources; narcotics cases, in turn, are estimated on the grounds of the census of intoxicant-related cases, as explained above.

The material used in calculation mainly consists of information from official statistics and State final accounts. Additional cost and price information comes from separate studies. Estimates of the proportions of drug cases often vary from one study to another. Consequently, an upper and lower limit must be estimated for harm-related costs, i.e. an estimated cost range.

Table 18
Registers, statistics and data retrieval criteria used in calculating direct costs in 1999

<table>
<thead>
<tr>
<th>Cost item</th>
<th>Register</th>
<th>Agency</th>
<th>Retrieval criteria for drug cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health care (inpatient)</td>
<td>Hospital Patient Discharge Register</td>
<td>STAKES</td>
<td>Drug diagnosis as 1st or 2nd diagnosis</td>
</tr>
<tr>
<td>Health care (outpatient)</td>
<td>Statistics on outpatient care</td>
<td>STAKES</td>
<td>Census of intoxicant-related cases</td>
</tr>
<tr>
<td>Disability pensions</td>
<td>Payments register</td>
<td>Social Insurance Institution, Central Pension Security Institute</td>
<td>Drug diagnosis as 1st or 2nd diagnosis</td>
</tr>
<tr>
<td>Sickness benefits</td>
<td>Payments register</td>
<td>Social Insurance Institution, Central Pension Security Institute</td>
<td>Drug diagnosis as 1st or 2nd diagnosis</td>
</tr>
<tr>
<td>Compensation</td>
<td>Payments register</td>
<td>Insurance companies</td>
<td>Census of intoxicant-related cases</td>
</tr>
<tr>
<td>Substance abuse services (inpatient)</td>
<td>Register of Residential Social Welfare Facilities</td>
<td>STAKES</td>
<td>Census of intoxicant-related cases</td>
</tr>
<tr>
<td>Substance abuse services (outpatient)</td>
<td>Sotka and A-Clinic Foundation</td>
<td>STAKES, A-Clinic Foundation</td>
<td>Census of intoxicant-related cases</td>
</tr>
<tr>
<td>Substance abuse costs in social services</td>
<td>Municipal performance and financial statistics</td>
<td>Municipalities, Sotka</td>
<td>Divided into drugs/others based on the census of intoxicant-related cases</td>
</tr>
<tr>
<td>Living allowance</td>
<td>Living allowance register</td>
<td>STAKES</td>
<td>Addiction-based reasons as 1st-3rd reason for granting benefits; Divided into drugs/others based on the census of intoxicant-related cases</td>
</tr>
<tr>
<td>Child welfare</td>
<td>Child welfare register</td>
<td>STAKES</td>
<td>Helsinki City special report 1999 on the grounds for child welfare measures + Divided into drugs/others based on the census of intoxicant-related cases</td>
</tr>
<tr>
<td>Research</td>
<td>Budgets on appropriations for State agencies and organisations</td>
<td>Final accounts, assistance budgets, reports on activities</td>
<td>Some information drug-related, intoxicant-related costs divided based on the census of intoxicant-related cases</td>
</tr>
<tr>
<td>Prevention</td>
<td>Budgets on appropriations for State agencies and organisations</td>
<td>Final accounts, assistance budgets, reports on activities</td>
<td>Some information drug-related, intoxicant-related costs divided based on the census of intoxicant-related cases</td>
</tr>
<tr>
<td>Control costs</td>
<td>Budgets on appropriations for Ministries and State agencies</td>
<td>State final accounts</td>
<td>Some information drug-related, intoxicant-related costs divided based on the census of intoxicant-related cases</td>
</tr>
<tr>
<td>Indirect costs</td>
<td>Calculations on death risk, toll on employed labour force, GNP prognoses, sales revenues from Prison Administration</td>
<td>Statistics Finland, Ministry of Labour, Ministry of Justice</td>
<td>Some information drug-related, intoxicant-related costs divided based on the census of intoxicant-related cases</td>
</tr>
</tbody>
</table>

19.2 Financial mechanism, responsibilities and accountability

In Finland, the State mainly employs steering by information in the local implementation of social and health services. Regionally, these services are steered and supervised by the Provincial Governments. The local authorities are relatively independent in their preventive and curative substance abuse work. At a local level, all 448 Finnish municipalities are responsible for the practical implementation of statutory services. The local authorities may provide services on their own or together with other municipalities (federations of municipalities) or purchase them from the private or NGO sector. Services are for the most part produced on municipal revenues and calculatory State subsidies and partly by user fees. NGO and voluntary work has a long tradition in complementing the public sector. Organisations have much responsibility for work involving intoxicants (and also drugs) in established co-operation with the authorities. As part of the official system, organisations operate mainly on public funds.²¹²

The data used to compute harm-related costs primarily come from cases known to the social and health service system, the police, insurance companies, organisations etc. The bulk of these expenses are covered by public funds, either directly or indirectly as services purchased from organisations or private service providers. This means that the direct contribution to costs made by organisations, especially voluntary NGOs, private service providers and households, has remained relatively minor.

²¹² See Part I, Chapter 1.1.
In 1999, the State and municipalities covered over 80 per cent of the direct costs of demand reduction involving narcotics and intoxicating pharmaceuticals. The direct subsidies granted by the State are estimated at a minimum of 12 per cent and a maximum of 14 per cent, while the share of the municipalities ranged between 70 and 76 per cent; the pension and insurance companies covered 6–11 per cent, businesses and organisations 1–3 per cent and households 3–4 per cent. (Hein 2002)

19.3 Expenditures at national level

The social and health services costs of abuse of narcotic and pharmaceutical substances as well as costs incurred in drug education and research totalled an estimated 64.5–87.9 million euros in 1999, of which EUR 26.0–27.0 million went to specialised substance abuse services, EUR 16.5–29.5 million to health care, EUR 13.6–17.9 million to living allowances and child welfare, EUR 3.2–8.3 million to compensations and disability pensions and EUR 5.2 million to drug research and education.

Table 19.
Demand reduction costs in Finland 1999

<table>
<thead>
<tr>
<th>Cost item</th>
<th>Minimum (EUR million)</th>
<th>Maximum (EUR million)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health care (inpatient)</td>
<td>9.7</td>
<td>20.5</td>
</tr>
<tr>
<td>Health care (outpatient)</td>
<td>6.8</td>
<td>9.0</td>
</tr>
<tr>
<td>Drug-related pensions</td>
<td>2.2</td>
<td>6.5</td>
</tr>
<tr>
<td>Drug-related sickness benefits</td>
<td>0.5</td>
<td>0.5</td>
</tr>
<tr>
<td>Compensation (insurance companies)</td>
<td>0.5</td>
<td>1.3</td>
</tr>
<tr>
<td>Health care, total</td>
<td>19.7</td>
<td>37.8</td>
</tr>
<tr>
<td>Substance abuse services (in/outpatient)</td>
<td>26.0</td>
<td>27.0</td>
</tr>
<tr>
<td>Living allowances</td>
<td>2.7</td>
<td>7.0</td>
</tr>
<tr>
<td>Child welfare</td>
<td>10.9</td>
<td>10.9</td>
</tr>
<tr>
<td>Social services, total</td>
<td>39.6</td>
<td>44.9</td>
</tr>
<tr>
<td>Research and prevention</td>
<td>5.2</td>
<td>5.2</td>
</tr>
<tr>
<td>Grand total</td>
<td>64.5</td>
<td>87.9</td>
</tr>
</tbody>
</table>

19.4 Expenditures of drug treatment services

The Hospital Patient Discharge Register maintained by STAKES contains information about the numbers of patients and treatment days due to drug-related diagnoses. These data are compiled based on primary and two secondary diagnoses. A minimum (primary diagnosis) and maximum (primary or secondary diagnosis) cost is calculated.

\[213\] Information of the chapters 19.3 - 4. is based on: Hein et. al. 1998; 1999.
Since 1994, the Finnish hospitals have been categorised as follows: primary health care, somatic specialised health care and psychiatric care. In order to assess the inpatient costs resulting from intoxicant-related diseases, the total costs per day were calculated by the type of institution. However and the costs may vary also depending on hospital but this information is excluded from this report. The cost per day was the average cost of one treatment day in each hospital type, i.e. the running costs were divided by the number of treatment days. The basic data are from the year 1995.

The average cost of a treatment day in specialised inpatient care in 1995 was 303 euros. In psychiatric hospitals, the cost of a treatment day was 158 euros. In primary health care and health centres led by a specialist a treatment day cost 171 euros, and 96 euros in other primary health care institutions. Such accurate information was not available on the year 1999, and an average cost increase was added to the 1995 cost.214

The one-day census of intoxicant-related cases gives information about outpatient visits to clinics. The 1999 census recorded 1,231 intoxicant-related cases at health centre and hospital outpatient clinics; this means 449,315 visits per year. There were 140 home health care visits according to the census, corresponding to an annual 51,000 visits. Of these cases, 30 per cent were abusers of narcotics and medicines. Cost information on outpatient visits is the average cost in (outpatient) primary health care. This information concerns the year 1993 when the cost was an average of 30 euros per visit. For 1999, cost increase was added. The cost of a home health care per visit is the same as that of outpatient care.

The overall costs of treatment services for substance abusers in municipalities are derived from municipal action and financial statistics. However, these statistics do not distinguish between inpatient and outpatient costs. In 1994, the costs totalled 71 million euros and 74 million euros in 1995. There is no accurate information about support for NGOs outside public funding. According to a study made in 1996, the substance abuse service costs of organisations came to 6 million euros in both 1994 and 1995. (Kaukonen et al. 1996). Based on the one-day census in 1995, 40 per cent involved users of narcotics and pharmaceuticals. The 1999 costs were calculated by using the cost increase in the public sector.

Living allowance is a temporary form of support, whose purpose is to help indigent people weather economic hardships. The 1990s recession and mass unemployment have meant that living allowance has become a continuous and important means of livelihood for many Finns. In 1999, a total of EUR 438 million was paid out as living allowance. Of it, 2.1 per cent went to households whose primary reason for support was a substance abuse problem, and 5.4 per cent to households where substance abuse was either

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primary, secondary or tertiary reason for support. Based on the one-day census information, it is estimated that one third of the cases involved narcotics.

Child welfare costs are available in terms of institutional care only. No data are collected on family care costs. In 1999, the costs of institutional care amounted to 148 million euros. A quarter of the children came to care because of a substance abuse (alcohol or drugs) problem in the family. Again, a third was attributable to narcotics use.

19.5 Conclusions

When Finnish drug and alcohol harms are examined, one should bear in mind that, for example, in 1999 alcohol use caused society a direct cost of EUR 0.5–0.65 billion and an indirect cost of EUR 2.2–4.3 billion. A quarter of the costs involved health care, less than a fifth social services and almost 40 per cent of law enforcement. This means that alcohol-related harm costs were 3–4 times higher than those of drug abuse. On the other hand, alcohol brought considerable tax revenues, some 1.88 billion euros in 1999. However, the division into alcohol and drug-related costs is often purely a calculatory exercise because, in case of a prevention project, it is difficult to tell exactly which action involves alcohol or drugs. This is why drug-related harm costs should be examined with reserve.

Another problem of calculating and interpreting harm-related costs and especially trends is their partial dependence on official actions, i.e. service provision. The tendency to prefer outpatient care to hospitalisation in the 1990s reduced residential as well as total treatment costs. Social and health service expenditure is contingent on annual appropriations and prioritisation of social services in municipalities. The costs of prevention, education and research also depend on the amounts of subsidies granted. The impacts of these political and structural factors have not been considered in this report.

19.6 Methodological information

The costs related to alcohol and drugs are divided into direct and indirect ones. The direct costs entail expenditure paid for by a societal actor and they have a calculable market price. The indirect costs, on the other hand, do not have a market price as they mainly entail intangible costs.

215 See Chapter 1.5.
The direct costs of substance abuse have been estimated by defining the factors incurring costs and by counting their monetary value. These data come from official registers and statistics, partly from specific studies and surveys. These costs are also assessed by the same methods as in morbidity-related cost assessment in general.

The best chronological and objective indicators are those that can be found directly from registers and which are annually updated: the number of people taken ill, injured or dead as a result of substance use as well as the number of drug-related traffic accidents and crimes. There too specific studies are needed (e.g. the one-day census of intoxicant-related cases) in order to separate drugs from other intoxicant related cases. One problem with specific studies is their time lag. Furthermore, instead of the accurate number of, for instance, drug clients, they only give possible minimum and maximum values based on some more or less general assumptions.

There are also costs that remain outside the calculated figures and are hard to estimate. International victim studies yield information about unreported violence, but efforts to estimate the role of substance abuse in these cases remain haphazard at best. In addition, unreported property crime can be estimated from retail statistics, but the role of alcohol and drugs in this type of crime remains unclear.

In order to estimate indirect costs, theoretically motivated methods were used to assess, for example, production losses or the value of human life. These costs resulted from the loss of work contribution due to prison sentence, temporary injury, sickness or untimely death due to drug use. In addition, the value of prematurely lost life was assessed. However, there are always uncertainties and risks involved in future costs and savings. Therefore, the indirect costs of drug use are given at their present-day value.

Moreover, problem drug use causes other types of loss as well whose monetary value is impossible to determine unequivocally. When drug-related harms are considered, one should also bear in mind the agony, sorrow and nuisance caused by drug abusers to their close persons and to possible crime and accident victims and their relatives.
20. DRUG AND ALCOHOL USE AMONG YOUNG PEOPLE AGED 12–18

The material concerning drug use among young people in this summary is based on existing research information. However, the target groups of different studies may vary. Drug use among young people in Finland has primarily been investigated by surveys among 15–16-year-olds. The studies conducted among wider population segments tend to be less reliable in age group 18-year-olds and younger when it comes to sample size and the number of positive cases. Moreover, in these research reports young people are often categorised as 15–19-year-olds. The categorisation of many social and health consequences also relies on five-year cohorts, the corresponding age group thus being 15–19-year-olds.

Actions targeted at young people are usually part of societal interventions used to help young people in general who may have varying degrees of problems. Intoxicants abuse in general, and narcotics abuse in particular, are regarded as a complex cluster of problems having to do with young people’s life management, and consequently the interventions concern a set of problems going beyond the drug problem itself. In terms of the structure of general interventions in society, this theme chapter refers to the general chapters in this report and mainly brings up certain special cases involving young people with drug problems.

20.1 Prevalence, trends and patterns of use

In 2001, a study was conducted on self-reported criminal behaviour among 15–16-year-olds (Kivivuori 2002). Because narcotics use is a crime in Finland, it was included in the survey as well. The results show no statistically significant increase in the use of marijuana and hashish during the past year compared to the year 1998, when the previous study was made, but there is a significant difference compared to the years 1995 and 1996.\textsuperscript{217} According to the results, 8.5 per cent of the young respondents had tried hashish or marijuana in last 12 months (95%-confidence interval: ±0.8%) and the percentage of those having experimented with other drugs was 1.6 per cent (±0.4%). There were no major differences between the sexes. The percentage of those who had repeated their experiments at least five times had increased since 1998 (1.6%) to 2.2 per cent in 2001.\textsuperscript{218}

\textsuperscript{217} The study asked 15–16-year-olds to report their own criminal behaviour. The sampling depended on the schools. The responses were collected during a special lesson. Samples and response percentages varied as follows: 1,195 / 88.8% (1995); 4,204 / 90.5% (1996); 4,503 / 88.3% (1998); 4,347 / 88.7% (2001). (Kivivuori 2002).

\textsuperscript{218} Cf. Chapter 2.2.2.
The use of cannabis among 15-16-year-olds seems to be positively correlated with going to work and the amount of weekly working hours: the prevalence of cannabis use among those who did not go to work was 8 per cent, while it was 18 per cent among those who worked over 10 hours per week. This observation is consistent with other types of criminal behaviour as well: weekly working hours among 9th-year students were correlated with problematic, or criminal, behaviour. Based on the material, possible reasons included deviation by origin from the group who didn't work, work-related stress, loss of parental control due to working, role models set by co-workers and the larger amount of money at their disposal. The researchers concluded, though, that work is not bad for schoolchildren as long as it is controlled and the number of working hours during school week is relatively low. (Kouvonen 2002).

Of those who had used hashish or marijuana at least once, three per cent were caught in the act. No great changes had occurred since 1996 in this respect. Those who had used marijuana or hashish in last 12 months were also asked whether they had financed their habit by illegal means: 8.5 per cent of the users had engaged in criminal activity in order to obtain drugs, half by selling drugs and a quarter by stealing. Of those who had used cannabis at least five times in last 12 months, a fifth had financed their use by illegal means.

There is only indirect information about exposure to drugs by age group. This can be measured by asking if the respondent knows a person who uses intoxicating substances (here: hashish, thinner or other sniffed substances, intoxicating medicines or other such substances) (Rimpelä, A. et al. 2002).
The most recent comprehensive report on young people’s attitudes towards drugs is the 1999 ESPAD study, which found that 90 per cent of 15–16-year-olds disapproved or greatly disapproved of smoking hashish regularly. In terms of occasional smoking, the percentage was 81 per cent and in terms of smoking once or twice 70 per cent; 87 per cent disapproved or greatly disapproved of experimenting with heroin once or twice. (Ahlström et al. 2000).

In 1998, young people’s lifestyles and substance use culture, primarily alcohol use, were studied more deeply through group interviews among 13–16-year-olds in two secondary schools located in Greater Helsinki (Jaatinen 2000). This study suggested that experience of substance (alcohol) use is generally appreciated among the youth, but their embarking on substance use is characterised by a rhetoric of innocence or helplessness. The former observation refers to young people’s descriptions of their experiences in a manner that exonerates them from responsibility. Young people reportedly experimented with and consumed alcohol as objects of other people’s actions or as victims of circumstance. They used formulations conveying an image of their being not to blame in the eyes of a potential adult listener. This type of rhetoric refers to young people’s community, where the temptation to use intoxicants is too compelling to refuse. Everybody else drinks, especially one’s seniors, and therefore the person making the choice must also drink.

According to the study, substance (alcohol) use is also a vehicle for achieving many pleasurable things. It is perceived as a way of being an adult and of belonging to the crowd of one’s seniors. Partying is an important aspect of young people’s lives. For a 7th-year schoolchild, partying means the fulfilment of wild fantasies and expectations, whereas for 9th-year pupils, parties have become almost trivialities of
Life. The foremost objective of partying is to have a good time. Intoxicants are thus perceived as providing a gateway to togetherness, smooth sociability and freedom from everyday constraints.

Young people are socialised into Finnish intoxicant (alcohol) culture at an early age. They reported that socialisation takes place separately from adults, who nonetheless set the example. Thus young people do not receive the support and information required by a more profound understanding of substance use issues. To some extent, the youth also seem to be aware of this contradiction.

20.2 Health and social consequences

The statistical data on social and health consequences of drug use concern drug-related diseases, reports on hepatitis C and drug-related crime. The Table below is a short summary of the consequences of problem drug use among young people.220

Figure 33

According to the statistics, all indicators show that drug-related harms have clearly increased between 1995 and 2000. According to the primary drug diagnoses of hospital patients in 2001, opiates, cannabis and stimulants had roughly equal percentages. Age group 15–17-year-olds accounted for a minimal percentage of aggravated drug offences.

Young people aged 15–19 accounted for a fifth of the drug clients seeking specialised services for substance abusers.221 Treatment was usually sought on the initiative of the family or friends (28%), but
almost as often on the client’s own initiative (22%) or that of child welfare authorities (18%). Two-thirds had completed secondary school, four per cent had vocational training, while almost 30 per cent had not yet completed secondary school. Two out of three lived with their parents, 18 per cent in an own or rented apartment, 9 per cent were institutionalised, 2.5 per cent were in supported housing, 3.5 per cent were homeless and 2 per cent lived with friends. In terms of substances used, the young clients differed from other drug clients: with 43 per cent of the young clients the main drug was cannabis, alcohol in 21 per cent of the cases, stimulants in 19 per cent and opiates in 15 per cent. However, 37 per cent had injected drugs at least once and 23 per cent had also shared needles and syringes with other users.

There were about 4.5 juvenile drug suspects per 1,000 among 15–16-year-olds in 2001. Drug experiments and being caught at an early age foreshadowed a bleak future. A study followed 119 schoolchildren arrested by the police in Helsinki between 1971 and 1972 (mean age 17 years for girls and 17.5 years for boys) and their progress 20 years later. The conclusion was that 70 per cent of them could be termed unsuccessful: they had pursued a criminal career or ended in prison (40), ended in psychiatric treatment (31) or died (19). In the group, women’s risk of death was 4.5 times higher compared to women of the same age and 4.3 times higher for men. Especially property crimes at an early age and injecting drugs seemed to be correlated with future prison sentences, psychiatric institutionalisation or untimely death. (Turpeinen 2001).

When drug deaths were studied, it transpired that there were 36 deaths in age group 15–19-year-olds based on drug findings in 1990–1996, the total death toll being 426 (Vuori 2001). Towards the end of the decade, drug deaths increased rapidly, including 15–19-year-olds, and this age group still accounted for about 10 per cent of the cases. Especially the percentage of heroin deaths increased, also in this age group, until 2001.222

20.3 Demand and harm reduction responses

All recent drug strategies have emphasised the relevance of young people with reference to the drug problem. This is reflected in the fact that school staffs are given advance training and material is provided for drug prevention. Workshops and youth work are suggested as ways to develop drug prevention, and the role of the police in prevention should be enhanced. The strategies further suggest that the

220 Cf. also Chapters 3.3, 3.4 and 4.2.1.
221 Cf. Chapter 3.1.
222 Cf. Chapter 3.2.
potentials of the Child Welfare Act to help young substance abusers should be better utilised and people subject to police intervention should be offered professional help to treat the drug problem.\textsuperscript{223}

Implementation of youth interventions stresses co-operation between the authorities and with young people themselves in planning the interventions. Special emphasis is given to utilising general services in the welfare state, especially by training public-service personnel to detect and intervene in problems. The governance of Finland is based on a decentralised model, and this means that the local viewpoint is also prominent. More attention should be paid to the present laws (Child Welfare Act, Mental Health Act) in addressing drug problems among those under 18 years of age in particular.\textsuperscript{224}

As part of the most recent Government Decision-in-Principle on drug policy (2000), a large-scale media campaign on drugs was launched in 2001. Since the spring of 2002, one target group has been those aged under 18.\textsuperscript{225} School has a key role in special prevention measures and action policies. Thus, a national broad-scale supplementary drug training programme for teachers has been launched in connection with the syllabus reform and new teaching material has been produced based on new technology.\textsuperscript{226} Youth work outside schools involves also other young people than just 18-year-olds and younger. The same methods can be used in all these groups.\textsuperscript{227}

The Child Welfare Act is applied in treating young problem users as with young people who have some other problems. Youth interventions usually address a more complex problem than just substance abuse, and drug-related interventions are not the only ones to be applied.\textsuperscript{228} Special emphasis is on the possibility of young clients, who have committed themselves to rehabilitation, to enter a sustained and intensive psychosocial treatment continuum, with necessary institutional treatment. Based on 1999 information, there were six treatment units for young substance abusers, with a total of 40 beds. In addition, reformatory schools had three units specialising in drug treatment, with a total of 23 beds.\textsuperscript{229}

The strategies of the police have emphasised the agency’s role in prevention together with other authorities. An examples of law enforcement activity is the obligation to early intervention, specified in connection with the new ‘user crime’ and the fact that first-time young drug offenders should invariably

\textsuperscript{223} Cf. Chapter 8.1.
\textsuperscript{224} Cf. Chapter 8.2.
\textsuperscript{225} For more detail, see Chapter 9.4.
\textsuperscript{226} For more detail, see Chapter 9.1.
\textsuperscript{227} Cf. Chapter 9.2.
\textsuperscript{228} See Chapter 9.3.
\textsuperscript{229} See Chapter 11.1. Young people’s treatment facilities cannot be updated from the STAKES drug treatment database because in it, young people are defined as under 25-year-olds. This means that many facilities only treating adults are defined as units for ‘young people’.
be given a hearing to waive sanctions and to give a reprimand, with the prosecutor, police and social services authorities present.230

20.4 Methodological information

As seen above, it is problematic to make an overview of age group 12–18-year-olds because the most commonly studied age groups in surveys comprises 15–16-year-olds or 15–19-year-olds. It was also unclear whether or not 18-year-olds belong to the target group by definition. In Finland, only police statistics provide systematic information about 15–17-year-olds, a period between the minimum age of criminal accountability and reaching one's majority. In other respects, overviews have had to revert to background studies or register data and special retrieval. No such resources were available in the present report. Besides, the subgroup of drug users would have often been too narrow to yield reliable results even by special data retrieval. There are also very few register studies on drugs and drug use in Finland. Qualitative drug studies are still in their early stages, mainly owing to the short history of the phenomenon and its definition as a problem.

Age group 12–18-year-olds turned out to be problematic also in terms of societal measures as only some segments of legislation (Penal Code, Child Welfare) clearly encompass this group. On the other hand, a comprehensive outlook is often highlighted in youth actions, which means that a substance-specific approach (interventions) may even conflict with the present prevention and treatment ideologies and existing practice. In order to gain an accurate overview of youth interventions, a description of the general system is needed. Excessive emphasis on isolated youth drug projects can give a distorted picture of what is essential in societal measures targeted at young people.

230 See Chapters 1.3. and 12.
21 SOCIAL EXCLUSION AND REINTEGRATION

The material concerning social exclusion and reintegration in this report is based on existing research results. Societal interventions are outlined in the general chapters, while this theme chapter only discusses special cases involving the excluded who use drugs (or excluded drug users).

21.1 Definitions and concepts

Social exclusion is here defined in the narrow sense of the term as a ‘simultaneous accumulation of deficient social resources in an individual.’ The risk of social exclusion may manifest itself, for instance, as indigence, long-term unemployment, homelessness, lack of education, narrowed options to choose freely due to an addiction or other mental health problem or lack of trustworthy social relationships. Social exclusion may also mean ‘exclusion or discrimination so that basic civil liberties are not equitably implemented in everyday life.’ Exclusion may then manifest itself, for example, in difficulty to access services, in infringement of personal freedom (prison, involuntary treatment) or as prejudice associated with minority status.

Reintegration is defined as an activity to help clients readjust to society after rehabilitation. Most of these activities take place as ordinary services available to all, such as social and health services or housing, education and employment services.

21.2 Drug use patterns and consequences observed among socially excluded population

No studies have been conducted in Finland on groups facing exclusion risk and especially their drug habits, but there are some research on alcohol use, and especially so-called hard drinking, as part of special studies on socially excluded risk groups, such as excluded young men or homeless women.

Some studies on special groups facing exclusion risk have nonetheless also discussed drug use and its consequences. Such groups include children in reformatory school, prisoners and certain ethnic minorities. In the latter group, only indirect information can be collected from treatment need assessments, and this means that there is no overall picture of drug user cultures among ethnic minorities, with the exception of some groups: it has been estimated that 1–2 per cent of the Ingrian immigrants in Finland use drugs (especially heroin) and that the drug used by Somalis is Khat.
A psychiatric study on three reformatory schools followed 87 young people (mean age 15.5 years) for almost a year in 1997–1998. The controls consisted of young people (48) in three secondary schools in a nearby town in 1998. The study found that 40 per cent of the reformatory school students had at some time had an addiction problem. This was not a passing phase but had lasted for at least 12 months and had caused major problems. Of these addiction problems, 11.5 per cent involved drug dependence and 4.6 per cent involved harmful use of drugs. Drug problems were more common among girls (23%; boys 10%). In the control group, no addiction problems were detected. Parents’ mental health and addiction problems, criminal offences and domestic violence were important background factors differentiating the reformatory school children from their controls, and also divorce and the break-up of the nuclear family were commonplace. Two out of three considered that they were in reformatory school because of difficulties in ordinary school; half had been in special class. The study showed that 70 per cent had been subject to several child welfare actions. The most distinct factor was the presence of three mental health disorders, having to do with behaviour, mood and addiction; 60 per cent of the reformatory school girls manifested such symptoms. The most central finding in the study was that psychosocial ability to function deteriorated in both groups as a consequence of mental health problems. (Lehto-Salo et al. 2002).

In terms of prisoners facing exclusion risk, it is noteworthy that about 40 per cent of the prisoners have at least one drug conviction, when driving under the influence of drugs is included. It has been estimated that when entering prison, two out of three convicts have a substance abuse problem of some sort and one out of seven suffer from a serious problem. According to an unpublished study conducted in 1999, almost half of the prisoners had some experience of injecting drugs. Of them, over half had used drugs intravenously during the year prior to prison sentence and over a fifth in last month (usually in prison). This means that injecting drug use alone concerns over 10 per cent of the prison population. (Ministry of Justice, Prison Administration).

### 21.3 Relationship between social exclusion and drug use

Especially the so-called hard drugs, amphetamines and opiates, have been shown to be linked with social exclusion. Injecting drug use in particular and other related risk behaviour are regarded as special risks for social exclusion. Indicators that are used for the risk of social exclusion include low levels of education and income, unemployment, homelessness, criminal activity, morbidity, mental health problems and mortality.

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231 The diagnostic assessment of the structured psychiatric interview was made by an SCID interview and research diagnoses.
Studies on the backgrounds of those seeking drug treatment have indicated that almost 60 per cent of the clients were unemployed. A tenth of the clients worked, almost a fifth were students and 5 per cent were retired. Two-thirds had passed comprehensive school, one fourth had post-secondary education and two per cent had an academic degree. One tenth had not finished comprehensive school. Almost a tenth of the clients were homeless. In age group 15–39-year-olds (90% of those seeking drug treatment belonged to this age group) in the general population, 11 per cent were unemployed and 73 per cent were working. In the same age group, 70 per cent of Finns had completed post-secondary education. Chronic social exclusion and accumulated multiple problems were also observed in the first Finnish follow-up study on the medicinal treatment of opiate addicts.

Based on preliminary information about a study on risk behaviour among over 18-year-old injecting drug users interviewed at health counselling centres for IV-drug users, three out of four interviewees were jobless. For the majority, the main source of income was living allowance (32%). However, over half (51%) had resorted to living allowance during last 12 months. Of all Finns aged 20–39 (over 80% of the interviewees belonged to this age group), about 12.5 per cent had resorted to living allowance in last 12 months. Less than 40 per cent of the interviewees had post-secondary education, as opposed to 80 per cent in the corresponding segment of the general population. A tenth of the interviewees were completely homeless and a quarter regarded their homelessness as a permanent state.

Based on the preliminary material of the project, the most typical health problems associated with injecting drug use were various infections: 86 per cent of the interviewees had been tested for infections, and half reported having contracted hepatitis C, while 4.3 per cent reportedly had HIV. Over 40 per cent suffered from mental health problems, and a third had had a severe psychosis or other mental disorder.

It was noticed at the service centre for drug users with HIV infection in Greater Helsinki that the clients’ social standing was exceedingly poor: nobody went to work. A third were in support housing or had a rented municipal apartment, another third lived in a boarding house paid for by the municipality, and the rest were in halfway houses, prisons, treatment homes, with friends and relatives or in a service centre housing unit. The physical condition of the clients was poor as well. Almost all had hepatitis C, and many also had hepatitis B. In some patients, the HIV infection was for some reason progressing rapidly.
Concerning drug-related deaths (11 cases) in Turku, the fourth largest city in Finland, a study was completed in 2001. According to the study, the deaths mainly occurred in private residences, and in three cases also other people present were under the influence of drugs or alcohol. In terms of underlying factors, many deaths were characterised by the victims’ and their peers’ confused and uncontrolled situation in life. Income insecurity and active criminal involvement were commonplace. Nine of the deceased had a criminal background of some sort.237

The risk of social exclusion among prisoners convicted of drug offences has been shown to be higher than among other inmates because of the poor employment status and educational level further complicating their readjustment to society after having served the sentence. According to a study on recidivism, drug convicts’ criminal activity also remained at a higher level for long, which the researcher attributed to the fact that drug use is conducive to criminal behaviour. On the other hand, criminal subcultures embrace drug use, which in turn is subject to strict societal control.238

There is no research information about the risks of social exclusion among various ethnic minorities, but their problems are exacerbated by cultural differences and the language barrier, which in practice mean more limited treatment opportunities than is the case with other drug users.

21.4 Political issues and reintegration programmes

The action plan to combat poverty and social exclusion (2001) contends that the social security and welfare of vulnerable citizens and other inhabitants are protected by the Finnish Constitution. Section 19 of the Constitution stipulates that everyone who is incapable of acquiring the means necessary for a life of dignity has the right to basic subsistence and care. Everybody also has the right to basic income security and adequate social and health services. The plan also emphasises that substance abuse, especially drug abuse, increase the risk of social exclusion as well as leads often to general life management problems.

A key goal mentioned in all drug strategies is the prevention of exclusion, e.g. by stressing the development of low-threshold services for the excluded, increased detoxification services in mental health units and the development of treatment for prisoners. Special emphasis is on the provision of sustained psychosocial care for young people who have committed themselves to treatment. In addition, the law enforcement authorities stress co-operation with State and local authorities, with the aim of intervening in

237 See Chapter 3.2.
238 See Chapters 4.1 and 4.2.2.
the possible exclusion risk of drug suspects and implementing treatment need assessment and referral to treatment, if needs be. An effort is also made to ensure a rehabilitation continuum for prisoners and their possibility to a seamless transfer to freedom and safe housing, work or training by enhancing co-operation between societal actors.\footnote{See Chapters 8.1, 8.2, 11 and 12.}

By law, the municipalities are responsible for organising basic services for substance abusers, and the quality and coverage of services must meet local needs. An annual sum of EUR 7,570,000 will be granted in 2002 and 2003 for special treatment costs of drug users in municipalities. This subsidy is meant for organising referral to treatment, enhancing treatment and rehabilitation and expanding medicinal treatment for opiate addicts.\footnote{See Chapters 11.1 and 11.2.} Helping clients to pursue a drug-free life after rehabilitation is an important aspect of drug harm reduction and getting free from drugs. Post-rehabilitation care and reintegration takes place by general socio-political, housing, education and employment measures, adapted to drug users’ situation as far as possible.

Problem drug users also have an opportunity to live in financially supported housing as part of ordinary social services. Housing service units for substance abusers are one example of this system, and they also provide other service, such as special treatment and catering. Career planning and vocational guidance belong to the multiprofessional treatment process as well. The educational system, however, offers only little vocational training adapted to problem users’ often poor readiness to benefit from ordinary training. There are also many structural finance and provision obstacles to training. Employment measures, on the other hand, are useless if the threshold of job acquisition is too high or if no jobs are available in the first place. One new experiment is to provide workshops for those under 25 years of age, where they can practice work for wages and receive support in getting rid of the personal addiction problem.\footnote{For more detail, see Chapter 11.3 and subsections on housing services, training, supplementary education and employment activities.}

As part of societal support and rehabilitation for certain groups facing a risk of exclusion, special treatment and reintegration services have been made available to people with drug problems as well. Usually all services are implemented multisectorially so that after-care is incorporated in rehabilitation. Some reformatory schools (3 in 1999) have specialised in the treatment of young drug users who have multiple problems.\footnote{See Chapter 11.1.} Preventive, outreach and curative service packages have been directed at immigrants, especially Ingrians (the Internet and telephone services, health counselling and treatment), but the projects are few and in their initial stages.\footnote{National HIV/AIDS strategy of Finland (2002)}
considers health counselling for drug users one of the most important tools of prevention. The first service centre for drug users diagnosed as HIV positive was opened in autumn 2000 in Helsinki. A peer group project was launched in 2001 to recruit clients to give advice on infection risks to fellow drug users remaining outside the care system.

Prisoners perhaps constitute the exclusion risk group that has recently been most often targeted for treatment and after-care services. The prison administration has produced three addiction strategies, all of which have paid attention to demand reduction along with control measures. Various rehabilitative models have been devised and the development of the so-called contractual treatment as an alternative to imprisonment has started. Many rehabilitative models have already been evaluated. The evaluation emphasises commitment on the part of the municipality of residence and other actors to the inmates’ rehabilitation continuum and after-care following release from prison.

21.5 Methodological information

As a term, exclusion is complex and partly also a contentious issue. This brief overview can only touch on some details of it and a more in-depth definition of the concept might have resulted in different considerations but probably not in different conclusions because the drug problem, its role and related specialised services are still relatively new issues in the debate and research on exclusion. It will take a few years before research information will be available. Alcohol has somewhat longer tradition in the exclusion debate.

Drug issues have not been widely discussed in the Finnish political debate until the 1990s, especially during last five years. Drug treatment, including its monitoring and research, is a novelty in Finland, and there is some information about it only from last few years and even less information about drug-related rehabilitation and after-care.

Nonetheless, even this brief overview has made it evident that those who engage in risk use, those in treatment and drug offenders all face a similar risk of exclusion from education, work and housing. Many social exclusion risks are further exacerbated by addiction problems. It is possible that the drug problem has become a permanent part of accumulating social risks of exclusion. However, the phenomenon is too new to yield more than rudimentary information about its present role.

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244 See Chapters 10.1 and 10.2.
245 See Chapter 10.1.
246 See Chapters 12.1–3.
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TERVE-SOS 2002 lecture abstracts. See also http://www.stakes.fi/tervesos


### APPENDIX 2. Administration of international drug issues in Finland

<table>
<thead>
<tr>
<th>United Nations</th>
<th>CND</th>
<th>INCB</th>
<th>Dublin Group</th>
<th>Major donor countries</th>
<th>WHO</th>
<th>HONLEA</th>
<th>Other international organisations</th>
<th>activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ministry of the Interior</td>
<td>Ministry of Justice</td>
<td>Ministry of Foreign Affairs</td>
<td>Ministry of Finance</td>
<td>Other Actors</td>
<td>Activities</td>
<td></td>
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</tr>
<tr>
<td>National Agency for Medicines</td>
<td>Ministry</td>
<td>Ministry</td>
<td>Ministry</td>
<td>Ministry</td>
<td>UN's Commission on Narcotic Drugs (makes decisions on a global level on international drug questions: selection of substances, control actions, money laundering etc.)</td>
<td>UN's International Narcotics Control Board (supervises compliance with the UN Narcotics Conventions)</td>
<td></td>
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</tr>
<tr>
<td>Dublin Group</td>
<td>Ministry</td>
<td>Ministry</td>
<td>A UN body for preparing drug issues, based on an OECD composition</td>
<td>Major contributors to the United Nations International Drug Control Programme (UNDCP) (recommendation: USD 500,000 per year)</td>
<td>Proposes new narcotic substances to the lists incorporated in drug conventions</td>
<td>Unofficial collaborative body of law enforcement agencies</td>
<td></td>
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</tr>
<tr>
<td>Major donor countries</td>
<td>Ministry</td>
<td>Ministry</td>
<td>Major donors to the United Nations International Drug Control Programme (UNDCP) (recommendation: USD 500,000 per year)</td>
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<tr>
<td>WHO</td>
<td>Ministry, Nat. Agency for Medicines, Nat. Public Health I.</td>
<td>Ministry</td>
<td>Ministry</td>
<td>Ministry</td>
<td>UN's Commission on Narcotic Drugs (makes decisions on a global level on international drug questions: selection of substances, control actions, money laundering etc.)</td>
<td>UN's International Narcotics Control Board (supervises compliance with the UN Narcotics Conventions)</td>
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</tr>
<tr>
<td>HONLEA</td>
<td>Nat. Bureau of Investigation</td>
<td>Nat. Board of Customs</td>
<td>Unofficial collaborative body of law enforcement agencies</td>
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<tr>
<td>Other international organisations</td>
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<tr>
<td>Interpol</td>
<td>Ministry, Nat. Agency for Medicines</td>
<td>Nat. Bureau of Investigation</td>
<td>Customs</td>
<td></td>
<td>Collaborative body in police work. Co-operation takes place with national authorities as well (the Drug Enforcement Agency, DEA, of the USA)</td>
<td></td>
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</tr>
<tr>
<td>WCO</td>
<td>National Agency for Medicines</td>
<td>Nat. Bureau of Investigation</td>
<td>Customs</td>
<td>Nat. Board of Customs</td>
<td>World Customs Organisation</td>
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<tr>
<td>FATF</td>
<td>National Agency for Medicines</td>
<td>Nat. Bureau of Investigation</td>
<td>Customs</td>
<td>Nat. Board of Customs</td>
<td>Precursor control</td>
<td></td>
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<tr>
<td>European Union</td>
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</tr>
<tr>
<td>Horizontal Group on Drugs</td>
<td>Ministry</td>
<td>Ministry</td>
<td>Ministry</td>
<td></td>
<td>EU’s intersectorial body preparing and co-ordinating drug questions</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>EUROPOL</td>
<td>Ministry, Nat. Bureau of Investigation</td>
<td>Nat. Bureau of Investigation</td>
<td>Nat. Board of Customs</td>
<td></td>
<td>European Police Office</td>
<td></td>
<td></td>
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</tr>
<tr>
<td><strong>EMCDDA</strong></td>
<td><strong>Ministry, STAKES</strong></td>
<td><strong>Drug Monitoring Centre of the European Union. In charge of drug data compilation and harmonisation. Operates through the REITOX network of national centres</strong></td>
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<tr>
<td><strong>Precursor committee</strong></td>
<td><strong>National Agency for Medicines</strong></td>
<td><strong>Nat. Bureau of Investigation</strong></td>
<td><strong>Customs</strong></td>
<td><strong>Precursor committee of the European Commission</strong></td>
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</tr>
<tr>
<td><strong>Drug research networks</strong></td>
<td><strong>STAKES, National Public Health Institute</strong></td>
<td><strong>National Research Institute of Legal Policy</strong></td>
<td><strong>A-Clinic Foundation, Centre for Health Promotion, Helsinki University Central Hospital, NAD, Youth research etc.</strong></td>
<td><strong>Networks in the EU's Fifth research and development programme and e.g. projects operating under the public health programme</strong></td>
<td></td>
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</tr>
<tr>
<td><strong>Council of Europe</strong></td>
<td><strong>Ministry, STAKES</strong></td>
<td><strong>Ministry, National Bureau of Investigation</strong></td>
<td><strong>Ministry of Education</strong></td>
<td><strong>Administrative body formed by President Georges Pompidou of France to handle drug issues in Europe. The meeting of Permanent Correspondents a key means of operation</strong></td>
<td></td>
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</tr>
<tr>
<td><strong>Co-operation with neighbouring areas</strong></td>
<td><strong>Ministry, Nat. Bureau of Investigation</strong></td>
<td><strong>Nat. Board of Customs</strong></td>
<td><strong>Anti-crime activities and customs agreements with Russia and the Baltic countries as main activities</strong></td>
<td></td>
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</tr>
<tr>
<td><strong>Nordic co-operation</strong></td>
<td><strong>Ministry</strong></td>
<td><strong>Ministry</strong></td>
<td><strong>Ministry</strong></td>
<td><strong>Ministry</strong></td>
<td><strong>Meetings on drug issues between Ministers</strong></td>
<td></td>
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</tr>
<tr>
<td><strong>Drug committee</strong></td>
<td><strong>Ministry</strong></td>
<td><strong>Ministry</strong></td>
<td><strong>Ministry</strong></td>
<td><strong>Nat. Board of Customs</strong></td>
<td><strong>Multiadministrative forum for exchange of drug information</strong></td>
<td></td>
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</tr>
<tr>
<td><strong>NAD</strong></td>
<td><strong>Ministry, STAKES</strong></td>
<td><strong>Ministry, Nat. Bureau of Investigation,</strong> <strong>Boarder Guard</strong></td>
<td><strong>Nat. Board of Customs</strong></td>
<td><strong>Nordic Council for Alcohol and Drug Research</strong></td>
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</tr>
<tr>
<td><strong>PTN co-operation</strong></td>
<td><strong>Ministry, Nat. Bureau of Investigation, Boarder Guard</strong></td>
<td><strong>Nat. Board of Customs</strong></td>
<td><strong>Drug co-operation network of Nordic control authorities, with 18 liaison officers in Europe</strong></td>
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<td></td>
</tr>
</tbody>
</table>
APPENDIX 3. National drug information system

**Epidemiology**

**Use**

<table>
<thead>
<tr>
<th>Schoolchildren</th>
<th>Survey (implementer)</th>
<th>Criteria</th>
<th>Statistical period</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>School health study (STAKES, Tampere university et al.)</td>
<td>Municipality-specific (voluntary) 8th &amp; 9th year comprehensive school and 2nd year upper secondary school and 2nd year vocational institutes</td>
<td>Annual surveys (drug questions since 1996)</td>
</tr>
<tr>
<td></td>
<td>ESPAD (STAKES)</td>
<td>Sample survey 8th &amp; 9th year comprehensive school</td>
<td>Every 4th year (1995, 1999,..)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Young people</th>
<th>Survey (implementer)</th>
<th>Criteria</th>
<th>Statistical period</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Young people's health habit study (Tampere School of Public Health, STAKES)</td>
<td>Sample survey (postal) 12-18 –year-olds</td>
<td>Every 2nd year (question about drug use in immediate circle since 1992)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Population surveys</th>
<th>Survey (implementer)</th>
<th>Criteria</th>
<th>Statistical period</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Drug survey (STAKES)</td>
<td>Sample study (postal)</td>
<td>1998 (every 4th year, next in 2002)</td>
</tr>
<tr>
<td></td>
<td>Drugs in Finland (Ministry of Social Affairs and Health, Helsinki University Department of Public Health Science)</td>
<td>Sample study (postal)</td>
<td>1992, 1996</td>
</tr>
<tr>
<td></td>
<td>Drinking habit study (STAKES)</td>
<td>Sample study (postal and interview)</td>
<td>Every 8th year (drug survey first in 1992, 2000, …)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Survey (Agency responsible)</th>
<th>Criteria</th>
<th>Statistical period</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Hospital Patient Discharge register (STAKES)</td>
<td>Personal register ICD-10 diagnoses (since 1996)</td>
<td>Annual statistics</td>
</tr>
<tr>
<td></td>
<td>Register of infectious diseases (National Public Health Institute )</td>
<td>Personal register HIV (iv-use specified) hepatitis C</td>
<td>Monthly statistics (hepatitis C register since 1998)</td>
</tr>
<tr>
<td></td>
<td>Census of intoxicant-related cases</td>
<td>No personal identification</td>
<td>Every 4th year</td>
</tr>
</tbody>
</table>

The bulk of drug information in Finland is collected in a centralised manner from information systems as a part of broad data compilation. National and centralised data collection is typical of Finnish up-to-date information compilation. The information in this Table is based on regular and continuous data collection and periodical studies. The information systems are divided into three categories: epidemiological information (on use and harmful effects), project information concerning demand reduction as well as information about libraries and information services.
<table>
<thead>
<tr>
<th>(STAKES)</th>
<th>One-day count in all social and health service units. Problem substances (no primary drug)</th>
<th>(1995, 1999, …)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Substance abuse service statistics (A-Clinic Foundation)</td>
<td>Treatment periods of clients in (mainly outpatient) services for substance abusers No personal identification Not substance-specification</td>
<td>Annual statistics (since 1986)</td>
</tr>
</tbody>
</table>

**Legal control**

**Legally used and produced drugs**

<table>
<thead>
<tr>
<th>Statistical basis (Agency responsible)</th>
<th>Criteria</th>
<th>Statistical period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supervision of trade, export and import of drugs (National Agency for Medicines)</td>
<td>Licences, audits</td>
<td>Annual statistics</td>
</tr>
<tr>
<td>Drug prescription control (Nat. Board of Medicolegal Affairs &amp; Nat. Agency for Medicines)</td>
<td>Prescription monitoring at pharmacies (personal register)</td>
<td>Annual statistics</td>
</tr>
<tr>
<td>Use, sale, storage and other handling of precursors as well as import and export (Customs, National Agency for Medicines)</td>
<td>Authorisation, duty to report</td>
<td>Annual statistics</td>
</tr>
</tbody>
</table>

**Illegally used and produced drugs**

| Persons suspected of (narcotic) offences (National Bureau of Investigation and the Customs) | Offence reports (personal register) | Annual (perhaps also semi-annual) statistics. |
| Drug seizures (National Bureau of Investigation & Customs) | Offence reports | Annual statistics |
| Drug offences (Statistics Finland) | Offence reports | Annual and quarterly statistics |
| Drug convictions (Statistics Finland) | Persons accused and convicted in courts of first instance (personal register) | Annual statistics |
| Recidivism register (Statistics Finland) | Persons accused and convicted in courts of first instance | Annual statistics |
| Driving under the influence of drugs (National Public Health Institute & Ministry of the Interior) | Personal register Chemical drug findings Investigation request by the police | Annual statistics |

**Deaths**

**Drug deaths**

<table>
<thead>
<tr>
<th>Statistics (Agency responsible)</th>
<th>Criteria</th>
<th>Statistical period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cause of death statistics (Statistics Finland)</td>
<td>Primary cause of death according to ICD-10 classification (personal register)</td>
<td>Annual statistics</td>
</tr>
</tbody>
</table>

**Drug-related Deaths**

| Forensic examination of cause of death (Department of Forensic Medicine, Helsinki University) | Chemical findings in autopsies (personal register) | Annual statistics |
**Demand reduction**

**Project information**

<table>
<thead>
<tr>
<th>Compiler</th>
<th>Criteria</th>
<th>Outcome</th>
<th>Source/address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Finnish Slot Machine Association</td>
<td>Project allocations granted (theme: temperance work and promotion of substance abuse services)</td>
<td>Small-scale Internet Database</td>
<td><a href="http://www.ray.fi/avustustoiminta/avustuskohteet/avustuskohteet.jsp">http://www.ray.fi/avustustoiminta/avustuskohteet/avustuskohteet.jsp</a></td>
</tr>
<tr>
<td>A-Clinic Foundation</td>
<td>Foundation's project register</td>
<td>Internal Access database</td>
<td>Foundation's central office, questions: <a href="http://www.a-klinikka.fi">www.a-klinikka.fi</a></td>
</tr>
<tr>
<td>Ministry of Labour</td>
<td>Projects of the EU's Social Fund</td>
<td>Internet database</td>
<td><a href="http://www.teho.net/esr/index.html">http://www.teho.net/esr/index.html</a></td>
</tr>
<tr>
<td>Ministry of the Interior ESF</td>
<td>EU's Regional and Structural Fund projects</td>
<td>Internet database</td>
<td><a href="https://fimos2k.atbusiness.com/">https://fimos2k.atbusiness.com/</a></td>
</tr>
<tr>
<td>Other organisational databases</td>
<td>Drug database index</td>
<td>Reference database</td>
<td>See e.g. <a href="http://www.makupalat.fi/sospoli5.htm">http://www.makupalat.fi/sospoli5.htm</a></td>
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<tr>
<td>Etc.</td>
<td></td>
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</tbody>
</table>

**Libraries and information services**

<table>
<thead>
<tr>
<th>Information service and libraries</th>
<th>Material</th>
<th>Contact information</th>
</tr>
</thead>
<tbody>
<tr>
<td>STAKES Information Service</td>
<td>Literature, periodicals, databases and information services in the field</td>
<td><a href="http://www.stakes.fi/stakestieto/tipakoelmat.htm">http://www.stakes.fi/stakestieto/tipakoelmat.htm</a></td>
</tr>
<tr>
<td>Reference databases</td>
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<td>---------------------------------------------------------</td>
<td>-----------------------------------------------------------------</td>
<td>----------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>LINDA</strong></td>
<td>Joint and multisectorial database of universities and special</td>
<td><a href="http://www.lib.helsinki.fi/kirjastola/linnea/tietokannat.htm">http://www.lib.helsinki.fi/kirjastola/linnea/tietokannat.htm</a></td>
</tr>
<tr>
<td></td>
<td>libraries with references to literature and periodicals</td>
<td>Available free of charge at university libraries; Elsewhere, subject to charge (ID and password required)</td>
</tr>
<tr>
<td><strong>ARTO</strong></td>
<td>Joint and multisectorial database of universities and special</td>
<td></td>
</tr>
<tr>
<td></td>
<td>libraries with references to articles</td>
<td></td>
</tr>
<tr>
<td><strong>MEDIC</strong></td>
<td>Finnish medical database produced by the National Library of</td>
<td><a href="http://vertex.helsinki.fi">http://vertex.helsinki.fi</a></td>
</tr>
<tr>
<td></td>
<td>Health Sciences</td>
<td>Available free of charge at Helsinki University libraries; Elsewhere, subject to charge (ID and password required)</td>
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<tr>
<td></td>
<td>services. Also newspaper articles included</td>
<td>Subject to charge (ID and password required)</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Electronic services on the Internet</th>
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</thead>
<tbody>
<tr>
<td>**Alcohol, narcotics and other intoxicants, virtual</td>
<td>Virtual library produced by the STAKES Information Service,</td>
<td><a href="http://www.jyu.fi/library/virtualikirjasto/roads/paihteet.htm">http://www.jyu.fi/library/virtualikirjasto/roads/paihteet.htm</a></td>
</tr>
<tr>
<td>library**</td>
<td>with links to webpages of national organisations and research</td>
<td></td>
</tr>
<tr>
<td></td>
<td>institutions in the field as well as international links</td>
<td></td>
</tr>
<tr>
<td><strong>STAKES: preventive drug work webpages</strong></td>
<td>A website maintained by the Drug Prevention Group at STAKES,</td>
<td><a href="http://www.stakes.fi/neuvoa%2Dantavat/index.html">http://www.stakes.fi/neuvoa%2Dantavat/index.html</a></td>
</tr>
<tr>
<td></td>
<td>disseminating topical information and articles in the field</td>
<td></td>
</tr>
<tr>
<td><strong>Drug link</strong></td>
<td>Webpages maintained by the A-Clinic Foundation on intoxicants,</td>
<td><a href="http://www.paihdelinkki.fi">http://www.paihdelinkki.fi</a></td>
</tr>
<tr>
<td></td>
<td>drug use and services. Includes interactive discussion forums</td>
<td></td>
</tr>
<tr>
<td><strong>Antidrugnet</strong></td>
<td>Drug data base for schools and homes maintained by the Board of</td>
<td><a href="http://www.antidrugnet.org">http://www.antidrugnet.org</a></td>
</tr>
<tr>
<td></td>
<td>Education and the Blue Ribbon Society.</td>
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</tr>
<tr>
<td><strong>Kokototuus/Puolitotuus</strong></td>
<td>Database on drugs (kokototuus) and related interactive discussion</td>
<td><a href="http://www.kokototuus.com/faktat/index.html">http://www.kokototuus.com/faktat/index.html</a></td>
</tr>
<tr>
<td></td>
<td>forum (puolitotuus) maintained by the Finnish Centre for Health</td>
<td><a href="http://www.puolitotuus.com/etusivu.html">http://www.puolitotuus.com/etusivu.html</a></td>
</tr>
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<td></td>
<td>Promotion</td>
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</tbody>
</table>
### Tasks

<table>
<thead>
<tr>
<th>Tasks</th>
<th>Method of operation</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>UN/Annual Report Questionnaire</td>
<td>Co-ordination responsibility, other actors: National Bureau of Investigation, National Agency for Medicines, Ministries, Helsinki Univ.</td>
<td>Annual Report Questionnaire (June)</td>
</tr>
<tr>
<td>UN/Biannual UNGASS follow-up</td>
<td>Co-ordination responsibility, other actors: National Bureau of Investigation, National Agency for Medicines, Ministries, STAKES</td>
<td>Biannual UNGASS follow-up questionnaire (every other year, June)</td>
</tr>
<tr>
<td>EMCDDA/National Report</td>
<td>Produces the Report based on information supplied by actors in the field</td>
<td>National Report on the Drugs Situation in Finland (Finnish-language version in October), Statistical Tables (September)</td>
</tr>
<tr>
<td>EMCDDA/EWS</td>
<td>Data compilation system on new synthetic drugs in collaboration with Europol (National Bureau of Investigation )</td>
<td>Substance-specific reports on new substances when necessary</td>
</tr>
<tr>
<td>EMCDDA/EDDRA</td>
<td>Database on European demand reduction projects</td>
<td>10 national projects per year to the international database</td>
</tr>
<tr>
<td>EMCDDA/Info Maps</td>
<td>Reports on legal control and national information services</td>
<td>Annual updates of information sources and of the data yielded by them (September)</td>
</tr>
<tr>
<td>EMCDDA/Indicator harmonisation</td>
<td>Attempt to provide compatible drug use indicators in co-operation with other Member States</td>
<td>National Report, feedback report and Statistical Tables for EMCDDA (November)</td>
</tr>
<tr>
<td>- Drug treatment</td>
<td>Pilot information compilation in drug units throughout the year, implemented by the Centre</td>
<td>Statistical Tables for EMCDDA (November)</td>
</tr>
<tr>
<td>- Drug deaths</td>
<td>Primary cause-of-death information (Statistics Finland) and special register (Dept. of Forensic Medicine, HU). Co-ordinated by the Centre</td>
<td>Statistical Tables for EMCDDA (November)</td>
</tr>
<tr>
<td>- Prevalence of problem drug use</td>
<td>Annual (for the time being) statistical estimate (Ministry of the Interior, National Public Health Institute, STAKES). Co-ordinated by the Centre</td>
<td>Statistical Tables for EMCDDA (November)</td>
</tr>
<tr>
<td>- Prevalence of drug use</td>
<td>Population surveys of drug use, carried out every 2 – 4 years (STAKES)</td>
<td>Statistical Tables for EMCDDA (November)</td>
</tr>
<tr>
<td>- Drug-related infections</td>
<td>Monitoring of drug-related communicable diseases (National Public Health Institute, A-Clinic Foundation, STAKES). Co-ordinated by the National Public Health Institute</td>
<td>Statistical Tables for EMCDDA (November)</td>
</tr>
<tr>
<td>Alcohol and drug reports</td>
<td>Key information channels on drug statistics within STAKES in co-operation with all national information providers</td>
<td>Alcohol and drugs by region (January) Yearbook of Alcohol and Drug Statistics (November)</td>
</tr>
</tbody>
</table>

248 At a national level, information collection concerning the narcotics situation and drug policy is co-ordinated by the the Ministry of Social Affairs and Health. The National Drug Monitoring Centre co-ordinates the preaparation of important national drug reports. For international drug issues and reporting, the Ministry has appointed a working group. All agencies and information providers (such as the Customs, the National Bureau of Investigation, the National Agency for Medicines, the National Public Health Institute, STAKES, etc.) also provide statistical information directly for international bodies, such as the United Nations, the European Union, the Council of Europe, the Nordic Council of Ministers, etc. Also non-governmental (national) organisations (the Finnish Centre for Health Promotion, the A-Clinic Foundation, the Free From Drugs Association, etc.) produce regular information for over mentioned and research project purposes.
# APPENDIX 4. Actors in drug demand reduction

<table>
<thead>
<tr>
<th><strong>Actor</strong></th>
<th><strong>Task</strong></th>
<th><strong>Internet address</strong></th>
</tr>
</thead>
</table>
| National Research and Development Centre for Welfare and Health (STAKES) | - Preventive drug work, project co-ordination  
- Treatment unit data base  
- Support for municipal activities  
- Drug research  
- Drug information compilation  
[www.stakes.fi/reitox.fin](http://www.stakes.fi/reitox.fin) |
| National Public Health Institute                                         | - Public health work / health promotion e.g. combating infectious diseases                                                             | [http://www.ktl.fi/index.en.html](http://www.ktl.fi/index.en.html)                    |
| Unit of youth affairs, Dept. Of Cultural Policy, Ministry of Education   | - Harmonisation of youth policy measures  
| National Board of Education                                              | - Plans the national syllabus (including health education and temperance work)                                                           | [http://www.oph.fi](http://www.oph.fi)                                                  |
| Prison Administration                                                    | - Provides and develops drug treatment services for prisoners                                                                            | [http://www.vankeinhoito.fi](http://www.vankeinhoito.fi)                              |
| State Provincial Offices                                                 | - Supervise drug prevention and social and health services (incl. substance abuse services) in municipalities                           | [http://www.laaninhallitus.fi](http://www.laaninhallitus.fi)                           |
| Health care districts                                                    | - Regional collaborative bodies in specialised health care, providing health care services for municipalities                             | [http://www.kuntaliitto.fi/so ster/tipa.html](http://www.kuntaliitto.fi/so ster/tipa.html) |
| Centre for Occupational Safety, expert group on temperance issues       | - Develops temperance work to maintain employees’ working capacity and implements actions to prevent alcohol and drug harms, in accordance with the recommendations of labour market organisations. | [http://www.tyoturva.fi/toimes/index.html](http://www.tyoturva.fi/toimes/index.html)   |
| Finnish Centre for Health Promotion                                      | - Co-ordinates organisational projects through the forum of preventive drug work  
| A-Clinic Foundation                                                      | - Provides treatment, information, training and R&D services                                                                          | [www.a-klinikka.fi](http://www.a-klinikka.fi)                                          |
| Municipal network of addiction contact authorities                      | - Municipal co-operation network run by the STAKES                                                                                      | [http://www.stakes.fi/neuvoa-antavat/Pia/index.html](http://www.stakes.fi/neuvoa-antavat/Pia/index.html) |
| Co-operation forum of treatment services for substance abusers          | - Forum of NGOs (PAIVYT)                                                                                                                | [http://www.kalifiola.fi/](http://www.kalifiola.fi/)                                 |
| Other organisations in the field                                         | - Actors in preventive and curative drug work                                                                                           | See e.g. [http://www.makupalat.fi/so spoli5.htm](http://www.makupalat.fi/so spoli5.htm) |
### Appendix 5: Actors in Drug Supply Reduction

<table>
<thead>
<tr>
<th>Actor</th>
<th>Task</th>
<th>Internet address</th>
</tr>
</thead>
</table>
| National Agency for Medicines                    | - Authorises production, import and export of substances classified as narcotics  
  - Prescription practices for medicines classified as narcotics  
  - Supervision of use and sale of legal drugs  
  - Controls legality of the import and export of precursors used in producing drugs | [Http://www.nam.fi/index.html](http://www.nam.fi/index.html) |
| National Board of Medicolegal Affairs           | - Supervises drug prescriptions  
  - Controls medical practice and prescription of medicines classified as narcotics | [http://www.teo.fi/](http://www.teo.fi/) |
| National Bureau of Investigation                | - Co-ordinates national cases of drug offences  
  - Operates the Money Laundering Clearing House  
  - Maintains the Crime Laboratory | For more information, [Http://www.poliisi.fi](http://www.poliisi.fi) |
| National Board of Customs                       | - Co-ordinates national and international contacts  
  - Five customs districts are in charge of regional customs administration  
  - Maintains the Customs Laboratory | [Http://www.tulli.fi](http://www.tulli.fi) |
| Office of the Prosecutor-General                | - Supervises the prosecutorial authority under the Ministry of Justice | [Http://www.om.fi/vksv](http://www.om.fi/vksv) |
| District courts                                 | - Responsible for local jurisdiction | [Http://www.om.fi](http://www.om.fi)  
  [Http://www.om.fi/115.htm](http://www.om.fi/115.htm) |
| State Local Districts                           | - In charge of local police work  
  - Prosecutors working independently of the police | [Http://www.intermin.fi](http://www.intermin.fi)  
  [Http://www.intermin.fi/intsecurity.htm](http://www.intermin.fi/intsecurity.htm) |
| State Provincial Offices                         | - Police division supervises local police administration | [Http://www.intermin.fi](http://www.intermin.fi)  
  [Http://www.laaninhallitus.fi](http://www.laaninhallitus.fi) |
| Police College of Finland                       | - In charge of police education  
  - Monitors projects  
  - Conducts research | For more information, [http://www.poliisi.fi](http://www.poliisi.fi) |
| National Research Institute of Legal Policy     | - Conducts criminological research under the Ministry of Justice | [http://www.om.fi/optula](http://www.om.fi/optula) |
| Prison Administration                           | - Administers prisons under the Ministry of Justice | [http://www.vankeinhoito.fi](http://www.vankeinhoito.fi) |
### APPENDIX 6

#### STANDARD TABLE 03: CHARACTERISTICS OF PERSONS STARTING TREATMENT FOR DRUGS

<table>
<thead>
<tr>
<th>COUNTRY</th>
<th>FINLAND</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year:</td>
<td>2001</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>All treatments</th>
<th>First treatments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>F</td>
</tr>
<tr>
<td>Treatment cases/demands (Number)</td>
<td>2290</td>
<td>866</td>
</tr>
<tr>
<td>Sex distr. (%) Male / (%) Female</td>
<td>72,5</td>
<td>27,4</td>
</tr>
<tr>
<td>Mean age (Years)</td>
<td>28</td>
<td>24,3</td>
</tr>
<tr>
<td>Age distribution &lt;15</td>
<td>0,4</td>
<td>1</td>
</tr>
<tr>
<td>(%)</td>
<td>15-19</td>
<td>18,3</td>
</tr>
<tr>
<td></td>
<td>20-24</td>
<td>35,5</td>
</tr>
<tr>
<td></td>
<td>25-29</td>
<td>19,8</td>
</tr>
<tr>
<td></td>
<td>30-34</td>
<td>12,1</td>
</tr>
<tr>
<td></td>
<td>35-39</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>40-44</td>
<td>4,3</td>
</tr>
<tr>
<td></td>
<td>45-49</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>50-54</td>
<td>0,5</td>
</tr>
<tr>
<td></td>
<td>55-59</td>
<td>0,2</td>
</tr>
<tr>
<td></td>
<td>60-64</td>
<td>0</td>
</tr>
<tr>
<td>&gt;= 65</td>
<td>4</td>
<td>2</td>
</tr>
</tbody>
</table>

| Number of cases with missing inform. on age | 4 | 2 | 6 | 3 | 3 |

| Injection behaviour | - ---- - | - ---- - | - ---- - | - ---- - | - ---- - | - ---- - |
| Currently injecting any drug (%) | 52,8 | 49,8 | 52 | 40,3 | 38 | 14 | 39,7 |
| Ever injected any drug but not currently (%) | 22,8 | 22,2 | 22,6 | 15,2 | - | - | 14,8 |
| Ever injected any drug (%) | 75,4 | 71,1 | 74,2 | 57 | 52,7 | 55,9 |
| IV route of ad. main drug (%) | 52,7 | 54,6 | 53,2 | 34,6 | 40,5 | 36,2 |

<table>
<thead>
<tr>
<th>Main drug (%) - (% IV use)</th>
<th>dr. %</th>
<th>IV %</th>
<th>dr. %</th>
<th>IV %</th>
<th>dr. %</th>
<th>IV %</th>
<th>dr. %</th>
<th>IV %</th>
<th>dr. %</th>
<th>IV %</th>
<th>dr. %</th>
<th>IV %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opiates (total)</td>
<td>33,8</td>
<td>84,9</td>
<td>30,6</td>
<td>84,3</td>
<td>32,9</td>
<td>84,8</td>
<td>23,2</td>
<td>77,4</td>
<td>20,6</td>
<td>82,5</td>
<td>22,5</td>
<td>78,7</td>
</tr>
<tr>
<td>Heroin</td>
<td>16,3</td>
<td>89,3</td>
<td>13,8</td>
<td>84,8</td>
<td>15,5</td>
<td>88,3</td>
<td>10,7</td>
<td>80,4</td>
<td>11,1</td>
<td>76,2</td>
<td>10,8</td>
<td>79,2</td>
</tr>
<tr>
<td>Methadone (any)</td>
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<td>na</td>
<td>0,1</td>
<td>na</td>
<td>0,1</td>
<td>0</td>
<td>0,1</td>
<td>na</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>other opiates</td>
<td>17,3</td>
<td>80,9</td>
<td>17,3</td>
<td>83,8</td>
<td>17,3</td>
<td>81,7</td>
<td>12,5</td>
<td>75</td>
<td>9,5</td>
<td>89,5</td>
<td>11,7</td>
<td>78,2</td>
</tr>
<tr>
<td>Cocaine (total)</td>
<td>0,2</td>
<td>0,2</td>
<td>na</td>
<td>0,2</td>
<td>na</td>
<td>0,2</td>
<td>0,5</td>
<td>na</td>
<td>0,1</td>
<td>na</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cocaine CIH</td>
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<td>na</td>
<td>0,2</td>
<td>na</td>
<td>0,2</td>
<td>0,5</td>
<td>na</td>
<td>0,1</td>
<td>na</td>
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<td>Crack</td>
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<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Stimulants (total)</td>
<td>30,7</td>
<td>78,1</td>
<td>40</td>
<td>71,6</td>
<td>33,2</td>
<td>75,9</td>
<td>25,3</td>
<td>65,4</td>
<td>42,7</td>
<td>54,2</td>
<td>30</td>
<td>61</td>
</tr>
<tr>
<td>Amphetamines</td>
<td>29,1</td>
<td>80,3</td>
<td>36,6</td>
<td>75,6</td>
<td>31,1</td>
<td>78,8</td>
<td>22,5</td>
<td>70,4</td>
<td>36,2</td>
<td>58,6</td>
<td>26,2</td>
<td>65,9</td>
</tr>
<tr>
<td>MDMA and derivates</td>
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<td>1,8</td>
<td>0,9</td>
<td>4</td>
<td>1,3</td>
<td>4</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>other stimulants</td>
<td>1,1</td>
<td>na</td>
<td>1,5</td>
<td>na</td>
<td>1,2</td>
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<td>1,5</td>
<td>na</td>
<td>2,5</td>
<td>1,8</td>
<td>1,8</td>
<td>1,8</td>
</tr>
<tr>
<td>Hypnot. and sedat. (total)</td>
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<td>1,4</td>
<td>9,4</td>
<td>1,3</td>
<td>7,3</td>
<td>1,3</td>
<td>4,8</td>
<td>na</td>
<td>7,5</td>
<td>5,5</td>
<td>5,5</td>
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</tr>
<tr>
<td>Barbiturates</td>
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<td>0,2</td>
<td>0,2</td>
<td>0,2</td>
<td>0</td>
<td>0,5</td>
<td>0</td>
<td>0,3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Benzo diacepines</td>
<td>6,2</td>
<td>1,4</td>
<td>8,9</td>
<td>7</td>
<td>1,4</td>
<td>4,6</td>
<td>na</td>
<td>6,5</td>
<td>na</td>
<td>5,1</td>
<td>na</td>
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<td>others</td>
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<td>0,2</td>
<td>0,2</td>
<td></td>
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<td>0,5</td>
<td>0,5</td>
<td></td>
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<tr>
<td>Hallucinogens (total)</td>
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<td>na</td>
<td>0,1</td>
<td>na</td>
<td>0,2</td>
<td>na</td>
<td>0,1</td>
<td>na</td>
<td>0,1</td>
<td>na</td>
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<tr>
<td>others</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0,1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Volatile inhalants (total)</td>
<td>0,3</td>
<td>0,1</td>
<td>0,3</td>
<td>0,7</td>
<td></td>
<td></td>
<td>0,5</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cannabis (total)</td>
<td>28</td>
<td>19,2</td>
<td>25,6</td>
<td>45,9</td>
<td>28,1</td>
<td>41,2</td>
<td>73,1</td>
<td>80,2</td>
<td>26,7</td>
<td>68,7</td>
<td>22</td>
<td></td>
</tr>
<tr>
<td>Others substance (total)</td>
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<td>0,5</td>
<td>0,3</td>
<td>na</td>
<td>0,5</td>
<td>0,1</td>
<td>0,1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Substance</td>
<td>Acute intoxic./ harmful use</td>
<td>Dependence syndrome</td>
<td>Substance induced brain syndrome</td>
<td>Substance abuse total</td>
<td>Poisonings by drugs and medicaments</td>
<td>Diseases of the liver</td>
<td>Diseases of the pancreas</td>
<td>Cardio-myo-pathy</td>
<td>Gastro-tis</td>
<td>Other drug and medicament related syndromes</td>
<td>Substan-ce use and treatment</td>
<td>Harms Total</td>
</tr>
<tr>
<td>----------------------------</td>
<td>---------------------------</td>
<td>---------------------</td>
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<td>----------------</td>
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<td>-----------------------------------------------</td>
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<td>-------------</td>
</tr>
<tr>
<td>Alcohol</td>
<td>3050A</td>
<td>303</td>
<td>291</td>
<td>980</td>
<td>5710A-5713X</td>
<td>5770D-F, 5771C-D</td>
<td>4255A</td>
<td>5353A</td>
<td>2650A</td>
<td>3575A, 5307A</td>
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<td></td>
</tr>
<tr>
<td>Substitute treatment</td>
<td>---</td>
<td>---</td>
<td>292&amp; E940B</td>
<td>9701A</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td></td>
<td>(same)&amp; E938F</td>
</tr>
<tr>
<td>Cannabis</td>
<td>3052A</td>
<td>3043A</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td></td>
<td>---</td>
</tr>
<tr>
<td>Cocaine</td>
<td>3056A</td>
<td>3042A</td>
<td>292&amp; E938F</td>
<td>9685A</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td></td>
<td>(same)&amp; E939H,L</td>
</tr>
<tr>
<td>Stimulants</td>
<td>3057A</td>
<td>3044A</td>
<td>292&amp; E939H.L</td>
<td>9697A,B,X</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td></td>
<td>(same)&amp; E939H,L</td>
</tr>
<tr>
<td>Hallucinogens</td>
<td>3053A</td>
<td>3045A</td>
<td>292&amp; E939G</td>
<td>9696A</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td></td>
<td>(same)&amp; E939G</td>
</tr>
<tr>
<td>Drugs total</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>E935A-F, E935W</td>
<td>E938F</td>
<td>E939G-U, E939X, E939A-D</td>
<td></td>
<td>(same)&amp; E937, E939E-F</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sedatives and tranquillizers</td>
<td>3054A, 3041A, 3042A</td>
<td>292&amp; E937, E939E-F</td>
<td>967, 9694A-5X</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>E937</td>
<td>E939F - (see prev. cell)</td>
<td></td>
<td>(same)&amp; E937, E939E-F</td>
</tr>
<tr>
<td>Non-dependence producing substances</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>(see previous cell)</td>
<td></td>
<td>---</td>
</tr>
<tr>
<td>Medicaments total</td>
<td></td>
<td></td>
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In the Finnish ICD-9 system there does not exist codes 304.7-.8, 305.8 and letters can be used to differentiate codes (e.g. 9650A = codeine, 9650B = Methadone etc.). Also the codes may have different interpretation e.g. 965.8 and E935W (incl. also dekstroprokxifen and pubrenorfin), E935A-F = E935.0 (Who), E939E = E939.4 (Who [and F=5, G=6, H-L=7]), E940B = E940.1 (Who).
### APPENDIX 8
#### ICD-10

<table>
<thead>
<tr>
<th>Substance</th>
<th>Acute intoxic./harmful use</th>
<th>Dependence syndrome</th>
<th>Substance induced brain syndrome</th>
<th>Sub-tance abuse total</th>
<th>Poisonings by drugs and medicaments</th>
<th>Disease of the liver</th>
<th>Diseases of the pancreas</th>
<th>Cardio-myopathy</th>
<th>Gastritis</th>
<th>Other drug and medicament induced syndromes</th>
<th>Substance use and treatment</th>
<th>Harms total</th>
<th>Others</th>
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<tbody>
<tr>
<td>Alcohol</td>
<td>F10.0-.1</td>
<td>F10.2</td>
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<td>T51</td>
<td>K70</td>
<td>K86.0</td>
<td>I42.6</td>
<td>K29.2</td>
<td>E24.4, E52, G31.2, G62.1, G72.1</td>
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<td>O35.4, Q86.0, P04.3</td>
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<td>Opiates</td>
<td>F11.0-.1</td>
<td>F11.2</td>
<td>F11.3-.9</td>
<td>T40.0-4,.6 (T36&amp;N01AH/N02A)</td>
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<td>F15.3-.9</td>
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<td>Hallucinogens</td>
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<td>Sedatives and tranquillizers</td>
<td>F13.0-.1</td>
<td>F13.2</td>
<td>F13.3-.9</td>
<td>T42.3-.4, T42.6-.7 (T36&amp;N01AF/N03AE/N05BA-BB/N05C)</td>
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<tr>
<td>Non-dependence producing substances</td>
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<td>F55 (&amp; N02B/N05A/N06)</td>
<td>T39, T43.0-.2, T43.3-.5, T43.8-.9 (T36&amp;N02B/N05A/N06)</td>
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* = F55 and T36 are from 1998 on combined with ATC-drug codes that are referred in the table with A* and N* figures. These new codes in parenthesis (e.g. F55&N02B/N05A/N06) will in future replace old ICD-10 codes written in the cells. During 1998 and 1999 both codes were in practise still used simultaneously or e.g. T36 code is used without ATC-specification, which in the report is defined as "non-substance specific poisoning" (which probably includes several drug/sedative poisoning cases)
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<tbody>
<tr>
<td>29</td>
<td>Drug-related harms by region in 2000</td>
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<td>30</td>
<td>Percentage of 15–16-year-olds having committed a criminal offence at least once in 2001</td>
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<td>31</td>
<td>Boys who know over 5 people having used drugs</td>
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<tr>
<td>32</td>
<td>Girls who know over 5 people having used drugs</td>
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