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for Drugs and Drug Addiction



knowledge for welfare and health

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EMCDDA
by the Finnish National Focal Point, STAKES

FINLAND

DRUG SITUATION 2006
New Developments, Trends and in-depth
information on selected issues

REITOX

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FOREWORD

Finland – Drug Situation 2006 is one of the national annual reports compiled by the National Focal Points in the European Information Network on Drugs and Drug Addiction (REITOX) which is co-ordinated by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). The national reports form the basis for the EMCDDA's annual report *The state of the drugs problem in Europe*. The national reports are compiled in accordance with the guidelines provided by the EMCDDA.

The present report consists of two parts. Part A discusses recent developments and research data from 2005 and early 2006. The sections that describe the drug situation during the past year (drug experimentation, problem drug use, health and social correlates and consequences, availability and supply of drugs) are linked with discussion on related societal interventions (prevention, treatment, harm reduction, social rehabilitation and control). Each section begins with background information on the subject and the latest data is discussed in the subsections. Part B discusses three selected issues relating to drugs. These issues, chosen by the EMCDDA, are (1) Cocaine in Finland, (2) Drug use and problems among very young people, and (3) Drugs and driving. The length of the sections in the report depends on the amount of data available on each subject area.

Research data and comments from experts on different areas of the drug issue were used in drafting the report. We thank all the experts for their comments. Special thanks are due to Senior Researcher Tuija Hietaniemi (National Bureau of Investigation) and Researcher Heini Kainulainen (Finnish Foundation for Alcohol Studies). The report is based on last year's report compiled by Senior Planning Officer Ari Virtanen.

Researcher Mikko Salasuo (Finnish Youth Research Society) wrote Section 12 'Cocaine in Finland' and Section 13 'Drug use and problems among very young people'. Laboratory Director Pirjo Lillsunde (National Public Health Institute) wrote Section 14 'Drugs and driving'. We thank them warmly.

The report as a whole was compiled by Sanna Rönkä and Pirita Salonen at the Finnish National Focal Point, which operates at STAKES.

Helsinki, December 2006

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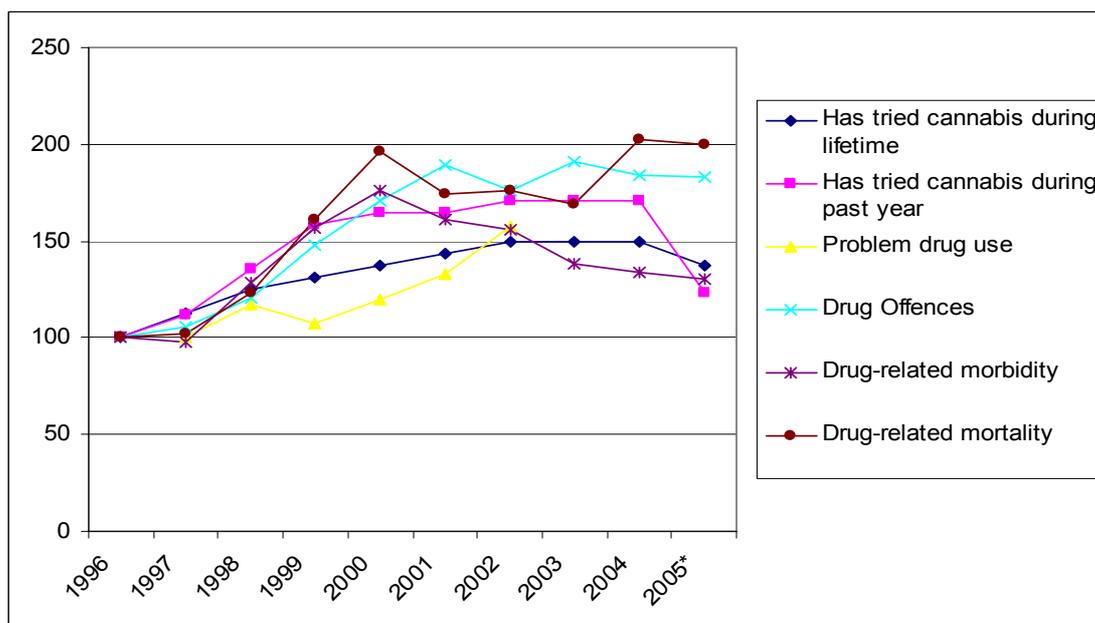
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Abstract <p>In 1995–2001, all indicators (experimentation, problem use, health detriments, morbidity, mortality, criminality and seizures) suggested that the drug situation was aggravating. However, in 2001–2005 this trend showed clear signs of weakening. Population surveys indicate that the number of 15–24-year-olds experimenting with cannabis is decreasing. Among the entire population, the number of people having experimented with cannabis sometime in their life has remained at a constant 12 per cent throughout the 21st century.</p> <p>Drug treatment clients are mainly men, young adults and single people. Opiates, stimulants, cannabis and the combined use of alcohol and drugs were the primary problem substances of the clients entering drug treatment in 2005. The proportion of buprenorphine as the primary substance of those entering treatment has increased the most. Buprenorphine was the most common pharmaceutical used in the medical treatment for opiate addiction. Treatment periods at substance abuse treatment units have become longer as the physical condition of clients has worsened and polydrug use has become more common. The availability of treatment and waiting times vary considerably between different localities. The numbers of hepatitis C, B and A cases and HIV infections among intravenous drug users have either decreased or remained at a low level in the 21st century. Buprenorphine is becoming the most common finding in drug-related deaths by poisoning. The victims of buprenorphine-related deaths have been mainly young people. Problem drug users are a socially marginalised group. In 2005, 62% of drug treatment clients were unemployed and 12% were homeless. The number of drug offences reported by the police dropped by 0.8% when compared with the previous year. There were no significant changes in drug seizures in 2005. A few large consignments constituted an exceptional feature in seizures.</p> <p>At the core of anti-drug activities have been the establishment of drug prevention and youth workshop networks, developing quality criteria for substance abuse prevention, addition of drug prevention sections in school curricula, enhancement of low-threshold services, investments in health counselling centres, development of drug treatment in prisons, and the introduction of new control methods.</p> <p>School health surveys also indicate that drug experimentation among pupils has not increased during the 21st century. According to the drug treatment information system, there are isolated or only a few cases of less than 15-year-olds entering treatment annually. The treatment system does not specifically consider underage drug users. In Finland, hard drugs have not gained a foothold among very young people and this in turn has prevented serious drug problems within the age group.</p> <p>The latest population surveys indicate that there has been a very slight rise in the use of cocaine, but this increase cannot be considered as having any statistical significance. Experimentation and use centre on the 20–29-year-old age bracket; a good 2 per cent of them said that they had experimented with or used it at some time in their lives. Based on qualitative studies, it can be assumed that use is centred almost entirely in large cities and that it is closely tied with the partying and leisure activities of young adults who represent the socio-economic elite of their age bracket. The random nature of use is the cause of relatively few health hazards. Quantities of seized cocaine and the number of cases have remained low, not including a few exceptional years. Changes occurring in the price of the substance may well have a significant impact on the prevalence of its use in Finland.</p> <p>In Finland, a motor vehicle driver is guilty of driving while intoxicated if his or her blood contains a narcotic drug or its metabolic derivative during or after driving. Zero tolerance does not apply to the use of pharmaceuticals that have been prescribed to the driver by a physician. However, the use of these pharmaceuticals is a punishable offence if it impairs the driver's driving ability. In 2005, pharmaceuticals or drugs that are hazardous to traffic safety were detected in 88% of all suspected drug drivers (3,008 cases). The most common substances detected were hypnotics and sedatives (benzodiazepines). These were detected in 59% of the examined cases. Actual illicit drugs were detected in 59% of the examined cases. The increase in the number of people caught driving while under the influence of drugs is due to more efficient police operations.</p>			
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SUMMARY

In 1995–2001, all indicators (experimentation, problem use, health detriments, morbidity, mortality, criminality and seizures) suggested that the drug situation was aggravating. However, in 2001–2005 this trend showed clear signs of weakening (Figure 1).

Figure 1. Trends in drug use and drug-related harm 1996-2005 (1995=100)



*) preliminary data

Sources: Alcohol and Drug Studies, STAKES; Partanen et al. (2004); National Bureau of Investigation; Hospital patient discharge register, STAKES; Department of Forensic Medicine, University of Helsinki.

1. National policies and context

The Drug Policy Action Programme 2004–2005 was implemented within the drug policy. In co-operation with State Provincial Offices, STAKES continued to co-ordinate the contact person network in preventing substance abuse. With regards to drug crime prevention, co-operation between the police, the Customs and the Border Guard as well as co-operation with other countries' law enforcement authorities has been developed further. The Government Decree that regulates the practices for drug testing at workplaces came into force in 2005.

2. Drug use in the population

Population surveys indicate that the number of 15–24-year-olds experimenting with cannabis is decreasing. School health surveys also indicate that drug experimentation among pupils has not increased during the 21st century. Drug experimentation is more common among boys than it is among girls. Among the entire population, the number of people having experimented with cannabis sometime in their life has remained at a constant 12 per cent throughout the 21st century.

3. Prevention

Quality criteria have been determined for substance abuse prevention. Anti-drug organisations operate under a joint drug programme. Special drug prevention programmes have been carried out at the local level in order to reach immigrants.

4. Problem drug use

Drug treatment clients are mainly men, young adults and single people. Opiates, stimulants, cannabis and the combined use of alcohol and drugs were the primary problem substances of the clients entering drug treatment in 2005. The proportion of buprenorphine as the primary substance of those entering treatment has increased the most.

5. Drug-related treatment

Buprenorphine was the most common pharmaceutical used in the medical treatment for opiate addiction. Treatment periods at substance abuse treatment units have become longer as the physical condition of clients has worsened and polydrug use has become more common. The availability of treatment and waiting times vary considerably between different localities.

6. Health correlates and consequences

The numbers of hepatitis C, B and A cases and HIV infections among intravenous drug users have either decreased or remained at a low level. Buprenorphine is becoming the most common finding in drug-related deaths by poisoning. The victims of buprenorphine-related deaths have been mainly young people.

7. Responses to health correlates and consequences

Especially low-threshold treatment services play an important role in preventing and reducing infectious diseases related to drug use. Developing peer group activities, among other things, has reduced the spread of infectious diseases related to intravenous drug use.

8. Social correlates and consequences

Problem drug users are a socially marginalised group. In 2005, 62% of drug treatment clients were unemployed and 12% were homeless. The number of drug offences reported by the police dropped by 0.8% when compared with the previous year. The proportion of violent offences committed under the influence of drugs has grown since the 1990s. The proportion of drug or polydrug use in cases of driving while intoxicated has not risen since the previous year. In 2005, 16% of prison inmates were incarcerated for a drug offence.

9. Responses to social correlates and consequences

Various projects related to social reintegration have been carried out. The “Kynnykset pois” (*No thresholds*) project aimed at creating a service model that enables access from low-threshold services to high-threshold treatment services. A national project to develop substance abuse prevention at youth workshops provided good experience with communal training. In prisons, drug users have been provided with substance abuse rehabilitation and opiate treatment. Of alternative penal sanctions, treatment referral has been rarely used.

10. Drug markets

The drugs on the Finnish market are mostly cannabis products, synthetic drugs such as amphetamines and ecstasy, buprenorphine and benzodiazepines. The import of drugs is an international crime and in recent years, 20–30% of those suspected of aggravated drug offences have been foreigners. There were no significant changes in

drug seizures in 2005. A few large consignments constituted an exceptional feature in seizures. According to a recent study, the average purity of amphetamines in street trade was 24 per cent.

11. Drug-related law enforcement activities

In the last few years, drug crime investigation has focused on the prevention, investigation and detection of professional organised drug crime. Undercover operations and fictitious purchasing have been used mainly to investigate aggravated drug offences. In 2005, undercover operations and fictitious purchasing were used less than the year before.

12. Drug use and related problems among very young people

According to school health surveys, isolated experimentation with drugs among 14–16-year-olds increased during the period 1997–2001. However, the latest trend indicates a reduction in experimentation. The trends in cigarette smoking and the consumption of alcohol are also on the decline. With regards to risk groups, there has been a downswing in the number of pupils neglecting their compulsory education. Adolescent mass crime is also on the decline. According to the drug treatment information system, there are isolated or only a few cases of less than 15-year-olds entering treatment annually. The treatment system does not specifically consider underage drug users. In Finland, hard drugs have not gained a foothold among very young people and this in turn has prevented serious drug problems within the age group.

13. Cocaine in Finland

The latest population surveys indicate that there has been a very slight rise in the use of cocaine, but this increase cannot be considered as having any statistical significance. Experimentation and use centre on the 20–29-year-old age bracket; a good 2 per cent of them said that they had experimented with or used it at some time in their lives. Based on qualitative studies, it can be assumed that use is centred almost entirely in large cities and that it is closely tied with the partying and leisure activities of young adults who represent the socio-economic elite of their age bracket. The random nature of use is the cause of relatively few health hazards and therefore, these have not been listed separately in different statistics. Substance-specific information is available on the Internet sites of various organisations as well as in the brochures distributed by them. Quantities of seized cocaine and the number of cases have remained low, not including a few exceptional years. The average price per gram in street trade is estimated in the realm of EUR 60–100. Changes occurring in the price of the substance may well have a significant impact on the prevalence of its use in Finland.

14. Drugs and driving

In Finland, a motor vehicle driver is guilty of driving while intoxicated if his or her blood contains a narcotic drug or its metabolic derivative during or after driving. Zero tolerance does not apply to the use of pharmaceuticals that have been prescribed to the driver by a physician. However, the use of these pharmaceuticals is a punishable offence if it impairs the driver's driving ability. In 2005, pharmaceuticals or drugs that are hazardous to traffic safety were detected in 88% of all suspected drug drivers (3,008 cases). The most common substances detected were hypnotics and sedatives (benzodiazepines). These were detected in 59% of the examined cases. Actual illicit drugs were detected in 59% of the examined cases. The increase in the number of people caught driving while under the influence of drugs is due to more efficient police operations.

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A. NEW DEVELOPMENTS AND TRENDS

1 National policies and context

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

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

The Narcotics Act (1289/1993) prescribes the main principles of drug control based on international conventions. The related Narcotics Decree (1603/1993) lays down provisions for the export and import of drugs. The administrative decision by the Ministry of Social Affairs and Health (1709/1993) defines narcotics and the substances used in their manufacture. Drug legislation has subsequently been amended to comply with EU control regulations on precursors and the changes made in the Drug Schedules of the United Nations. Drug offences are specified in the Penal Code (1303/1993), whereby they are categorised as drug offence, preparation or abetment of a drug offence (maximum sentence 2 years' imprisonment) or as aggravated drug offence (1–10 years' imprisonment). In 2001, an amendment was made to the Penal Code (654/2001) which introduced the drug-user offence (maximum sentence ½ years' imprisonment).

The amendment to Section 11 of the Basic Education Act (453/2001) introduced a new subject, health education, to primary education. In 2003, the legislation related to education obligated the National Board of Education to define together with the National Research and Development Centre for Welfare and Health (STAKES) the central principles for pupil and student welfare services and the educational objectives to be applied to the national curriculum. Educational institutions were obligated to apply them together with social welfare and health care authorities to the local curricula (477,478,479/2003). Strategies for promoting health and safety, preventing and treating crises, school bullying and substance use as well as organising the necessary co-operation should be recorded in the curricula as part of pupil and student welfare services.

The ideal of a healthy lifestyle is emphasized in the Temperance Work Act (828/1982). The main objectives set out in the Act on Welfare for Substance Abusers (41/1986) are the reduction of substance abuse and the provision of necessary municipal treatment services. The substitution and maintenance treatment of opiate addicts are regulated by a Decree (289/2002). The Government Decree on the amendment to the Communicable Disease Act (1383/2003) states that health centres must increasingly provide health counselling for intravenous drug users as well as needle and syringe exchange. Substance abuse problems are also addressed in the Child Welfare Act, Social Welfare Act, Primary Health Care Act, Mental Health Act and the Act on the Status and Rights of Patients.

Drug issues are also dealt with in the overall reform of the Penal Act regarding money laundering (68-79/1998) and driving while intoxicated (1198/2002), the amendment to the Act on the Enforcement of Penal Sanctions (656/2001), which addresses the authority of prison staff in drug control, the amendment to the Coercive Measures Act (646/2003), which lays down the conditions for telecommunications interception, telecommunications monitoring and technical surveillance, and the amendment to the Police Act (21/2001), which regulates undercover operations and fictitious purchases.

The Finnish Government issued a resolution on 5 October 2000 to enhance drug policy based on the first Finnish drug strategy from 1997. The objective was to reduce both the supply and demand of drugs and to arrest the growth of drug use and related crime. The Government set up a drug policy co-ordination group to co-ordinate, implement and monitor the national drug policy programme. The group had representation from the relevant Ministries and agencies. The co-ordination group prepared an action plan for more efficient drug policies for 2001–2003 (2003). In line with the Programme of the Finnish Government lead by Matti Vanhanen, the co-ordination group drafted a drug policy action plan for 2004–2007 (2004), which was approved by the Finnish Government by a resolution at the beginning of 2004.

In terms of administration, the 2004–2007 programme aims at strengthening the co-ordination of drug policy at the national level and at revising Finnish drug legislation by taking into account relevant amendments to Community legislation and the increasingly rapid entry onto the market of substances thus far not covered by drug control. In order to address drug demand, the aim within drug prevention is to develop new methods, strengthen local co-operation between the authorities and support the reinforcement of the role of non-governmental organisations. In addition, pupil and student welfare services aim at strengthening multi-professional and local co-operation in order to prevent social exclusion among young drug users. In the realm of treatment, the aim is to secure access to appropriate services in order to treat drug abuse, improve skills related to the prevention and treatment of drug problems and to increase the use of treatments within the context of penal sanctions. In order to reduce drug supply, the aim is to increase the collaboration of the police, Customs, Border Guard, prosecutor and private security branch and to intensify co-operation among the competent authorities with respect to drug precursors. Furthermore, the knowledge base and research regarding drugs is being developed. Other objectives are to promote international action to prevent the use and spread of drugs and to continue supporting the work against drugs in neighbouring areas and within the framework of development co-operation. (Ministry of Social Affairs and Health 2004.)

In addition, as part of the Government programme, a cross-sectoral programme on internal security has been drawn up in order to increase public security (Ministry of Interior 2005).

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

The Health 2015 public health programme (2001) sets as one of its goals the appropriate treatment of the health problems associated with alcohol and drug use.

The national plan of action to combat poverty and social exclusion 2003–2005 calls for more effective drug prevention measures, sufficient treatment for drug users and the expansion of measures to alleviate the negative effects of drug use.

1.1 Legal framework

1.1.1 The new Narcotics Act

The Government has submitted to Parliament a proposal for a new Narcotics Act and for some related Acts. In the autumn of 2006, the proposal for the Act was still pending in Parliament.

The objective of the new Narcotics Act is to strengthen drug control, but it does not aim to change national drug policy. The Act aims to prevent the illegal import of drugs into Finland, the illegal export of drugs from Finland as well as the manufacture, distribution and use of drugs. Concerning drug precursors, the Act complies with the European Communities' intra and extra-Community trade regulations on precursors. The Act does not suggest essential changes to existing principles and methods; it only proposes some specifications.

1.1.2 Legislation related to demand reduction

Prevention

Drug testing in accordance with the Occupational Health Care Act (1383/2001) is dealt with in the Government Decree on drug testing (218/2005). The Decree aims at ensuring drug testing is conducted in line with good occupational health care practices and laboratory quality standards, taking into account the integrity and protection of the privacy of the persons tested as well as their other fundamental rights. The Decree lays down provisions for the quality requirements of the test laboratories, the issue of examination referrals, informing and receiving consent from the person to be tested, taking, handling and analysing samples, interpretation and providing information on test results and the possible contest of the test results.

Drug-related treatment

According to the Act on rehabilitation benefits and rehabilitation allowances granted by the Social Insurance Institution of Finland (566/2005), a rehabilitation patient is entitled to rehabilitation allowance if rehabilitation is necessary to remain in, return to or enter working life and if the patient has entered rehabilitation through the treatment referral system of the workplace or through occupational health care. This does not apply to family rehabilitation. In addition, it is required that rehabilitation takes place in a substance abuse rehabilitation unit approved by the Social Insurance Institution of Finland and that rehabilitation is based on a treatment or rehabilitation plan. Discretionary compensation for maintenance and other costs can be paid during rehabilitation, and discretionary rehabilitative assistance can be paid after rehabilitation if it is necessary for the employment of the rehabilitation patient.

In accordance with the Government Decree on medicinal products with reimbursement status granted on special grounds and diseases regarded as severe

on medical grounds (616/2005), naltrexone used in the treatment of opiate addiction is now subject to basic reimbursement.

Responses to health correlates and consequences

The Act on the Emergency Services College (607/2006) stipulates that at the request of the College a student is obliged to submit to a drug test performed by a health care professional and laboratory staff if there is justifiable cause to suspect that the student is intoxicated while in practical training organised by the college or at a place of work. A health care professional can provide the College with a written report of the drug test result.

The Aviation Act (1242/2005) stipulates that in order to evaluate the conditions for granting, renewing and suspending aviation licences, the Finnish Civil Aviation Authority has the right, without being bound by confidentiality regulations, to obtain information on the applicant or holder of the licence regarding endangering flight safety or using a narcotic substance in aviation or while performing a duty related to flight safety in the ground organisation from the criminal records, fine records, data systems of the judicial administration, and from criminal cases submitted to the prosecutor for consideration of charges and pre-trial investigation authorities.

The Finnish Civil Aviation Authority must grant a right of passage for a security restricted area at an airport to a person who works at or regularly visits the area if a security check shows that the applicant has not been sentenced, for example, for a drug offence. (The Aviation Act 1242/2005)

A duty in an aircraft, glider or other equipment used for aviation or a duty related to flight safety in the ground organisation cannot be performed by a person who has used a narcotic substance so that it is detected in his system. If such a person performs a duty in an aircraft or a duty related to flight safety in the ground organisation, even though he has used a narcotic substance so that it is detected in his system, he shall be sentenced to a fine for using a narcotic substance in aviation. (The Aviation Act 1242/2005)

Responses to social correlates and consequences

The amendment to the Public Order Act (582/2005) prohibits the consumption of intoxicating substances in public places in built-up areas, at checkpoints and on public transport. The prohibition does not concern drinking alcohol in parks or similar areas if it does not unreasonably hinder others from using that area for its intended purpose. As drug use is an offence under the Penal Code, the use of drugs is always forbidden in places set out in the Public Order Act.

According to the Act on imprisonment (767/2005), the offender can be placed straight from liberty into an open institution instead of a closed institution, if he or she has been given a sentence of conversion of fine or sentenced to imprisonment for a maximum of one year and if he or she commits to an intoxicant-free lifestyle and its supervision. In a closed institution, the prisoner must be provided with the opportunity to stay in a contractual ward where the prisoners are committed to supervised intoxicant-free life and to the activities arranged in the ward. The prisoner can be transferred from a closed institution to an open institution for a fixed term, if the transfer promotes the implementation of the plan for the term of sentence and the prisoner follows the programmes and rules of the ward, commits to not using intoxicating substances and accepts the supervision of intoxicant-free life. A prisoner with a substance abuse problem can also be placed for a fixed term in an institution

outside prison, where he or she can participate in rehabilitation or other target-oriented activities that reinforce his or her operational abilities – and where he or she does not use intoxicating substances and observes the terms and conditions stipulated for free movement. The aim of the activities arranged by the prison is to promote the prisoners' adjustment to society by increasing their readiness for a crime-free life, by maintaining and increasing their professional skills and by supporting their intoxicant-free lifestyle.

According to the Act, a prisoner can be ordered to give a blood or saliva sample or take a breath test if there is cause to suspect that he or she is under the influence of alcohol or other intoxicating substance. To monitor the health of a prisoner who suffers from withdrawal symptoms, he or she can be put under 24-hour technical supervision. The prisoner can also be placed in solitary confinement to prevent continuous use of intoxicating substances or a drug crime. A frisk or physical examination can be conducted if a prisoner is suspected of possessing prohibited substances (for instance drugs) and if he or she is suspected of a drug-user offence or a crime for which the maximum penalty is more than six months. According to the amendment to the Coercive Measures Act (769/2005), a remand prisoner's communication with another person can be restricted during pre-trial investigation if there is just cause to suspect that the communication may endanger the purpose of the pre-trial detention.

According to the Detention Act (768/2005), a prisoner on remand cannot possess drugs or drug paraphernalia. A remand prisoner's incoming letter, postal item or message can be copied if it is evident, e.g. from reading such mail, that it is likely to contain plans for or information on a drug-user offence. A remand prisoner's phone call can be recorded if it is evident, e.g. from listening to the phone call, that it is likely to contain plans for or information on a drug-user offence. If a person visiting a remand prisoner has smuggled or attempted to smuggle drugs into prison, this person can be prohibited from visiting the prison for a maximum of six months (visiting prohibition). A physical examination can be conducted on a remand prisoner if there is justifiable cause to suspect the remand prisoner of a drug-user offence. A remand prisoner can be placed in solitary confinement if it is deemed necessary in order to prevent continuous use of intoxicating substances or a drug offence.

1.1.3 Legislation related to supply reduction

The amendment to the Police Act (525/2005) specifies the provisions concerning information acquisition. According to the provisions, technical audio surveillance and technical visual surveillance in prisons requires that the person, based on his or her behaviour or otherwise, can be reasonably suspected of committing an offence, such as a drug-related offence. On similar grounds and to prevent direct threat to life or health, telecommunications monitoring can be targeted at a telecommunication subscription, telecommunication address, or telecommunication terminal used or presumably used by the person. Such subscription or terminal can be temporarily closed and permission can be granted to receive information on those mobile stations from which specific information is entered through a base station close to a specific location to a telecommunication system. The requirement for undercover operations is still an aggravated drug offence and the requirement for fictitious purchasing is that it is necessary to detect an offence for which the maximum penalty is at least 2 years' imprisonment (for instance drug offence).

1.1.4 Legislation related to international co-operation

The Act on the execution in the European Union of orders freezing assets or evidence (540/2005) regulates as a requirement to national implementation of an order that the offence is considered a criminal offence when committed under similar circumstances in Finland. Irrespective of whether the act is considered a criminal offence under similar circumstances in Finland, Finland cannot refuse execution if the offence is a criminal offence for which the maximum penalty is at least 3 years' prison sentence according to the law of the Member State that issued the freezing order.

1.1.5. Legislation related to drug research

No new information available.

1.2 Institutional framework, strategies and policies

Co-ordination of drug policy in 2005

The broadly based expert working group appointed by the National Research and Development Centre for Welfare and Health, STAKES, formulated the quality criteria for substance abuse prevention in 2005. The criteria support and guide actors as well as financiers. The criteria can be applied to all substance abuse and the reduction and prevention of related detrimental effects. In co-operation with State Provincial Offices, STAKES continued to co-ordinate the contact person network in preventing substance abuse. The network comprises 407 municipal contact persons and 17 provincial contact persons. The tasks of a contact person include promoting multi-professional co-operation in municipal or regional substance abuse prevention, co-ordinating municipal or regional substance abuse strategies and communicating between the municipality and other organisations. In 2003–2004, the principles for the new school curriculum were finalised, which included measures for the prevention of substance abuse and for the early recognition of and intervention in problems. Upper secondary and vocational schools started to implement the principles for the new school curriculum regarding the new regulations for pupil and student welfare services in 2005. The majority of comprehensive schools have adopted the new curriculum. The objective within youth work was to incorporate drug prevention in all activities. (Ministry of Social Affairs and Health 2006b.)

The scaling of drug treatment should be developed further, and patients should have access to long-term outpatient treatment near their domicile. The intensity of substitution treatment should be reduced and treatment should increasingly be offered by primary services. The Current Care guidelines for the treatment of substance abusers were introduced on 23 January 2006. Waiting lists for substitution treatment have become slightly shorter in the Greater Helsinki area. The effectiveness of imprisonment in preventing recidivism is being improved by making individual plans for each inmate's sentence term in line with the new law on imprisonment that came into force on 1 October 2006. The post-care of released inmates is being developed based on the recommendations of the Ministry of Justice, the Ministry of Social Affairs and Health and the Association of Finnish Local and Regional Authorities. (Ministry of Social Affairs and Health 2006b.)

With regards to drug crime prevention, the police have focused on organised drug syndicates involved in the import and distribution of drugs. Co-operation between the police, the Customs and the Border Guard as well as co-operation with other countries' law enforcement authorities has been developed further and increased by, for example, developing joint technical monitoring equipment. Street-level drug control remains at the same level as it was at the turn of the century. An increasing number of drug-user offences have been detected in connection with other police operations. The penal sanctions imposed for drug use have tightened since the amendment to the Penal Code concerning drug-user offences was introduced in 2001. The number of drug users fined through summary penal proceedings has grown whereas the number of decisions to waive charges has decreased. (Ministry of Social Affairs and Health 2006b.)

In 2005, Finland participated in international anti-drug activities within the EU, the UN, the Council of Europe and the Nordic Council. Finland has supported projects arranged by the United Nations Drug Control Programme as well as many neighbouring area projects within different administrative sectors and organisations. In 2005, the preparation for Finland's EU Presidency also included drug policy. The Academy of Finland launched a substance abuse and addiction research programme for 2007–2010. (Ministry of Social Affairs and Health 2006b.)

Case study on drug policy

According to an analysis by Tuukka Tammi (2006), two different views on the drug issue collided within the 1997 Drug Policy Committee in Finland; the police authorities advocated a drug-free society and insisted on policies of strict control but the social welfare, health and criminal policy alliance was in favour of harm reduction. The committee produced the first national drug strategy in 1997. The general objective of harm reduction was not solely based on public health concerns. The ideological roots of the concept can be traced back to the tradition of a rational and humane criminal policy that was first adopted in the 1960s and 1970s. According to this tradition, criminal and social policy was primarily aimed at minimising overall social harm. The aims and measures of the drug strategy were a compromise between two logics, which has since paved the way in Finland for further elaboration of the policy of harm reduction and stricter criminal controls on drug users.

1.3 Budget and public expenditure

Costs of the harm caused by drugs

In 2004, the costs related to the abuse of drugs and pharmaceuticals amounted to 200–300 million euros in direct costs and 400–800 million euros in indirect costs (Table 1). Social costs and the costs of crime control accounted for the largest portion of the direct costs. The indirect costs grew considerably due to the increase in drug-related deaths. The largest portion of indirect costs came from the value of life lost due to premature death.

Table 1. Costs of the harm caused by drugs by main group in 2003 and 2004, EUR million

	2003		2004	
	Min	Max	Min	Max
Direct costs	190	272	191	272
<i>Health care costs</i>	32	60	33	63
<i>Social costs</i>	58	64	63	69
<i>Crime control</i>	49	63	51	65
<i>Property damage, monitoring, research Substance abuse prevention</i>	51	85	44	75
Indirect costs	313	680	367	803
<i>Production losses</i>	60	100	61	102
<i>Value of life lost due to premature death¹</i>	253	580	306	701
Total	503	952	558	1,075

Sources: Yearbook of Alcohol and Drug Statistics 2005 and 2006, STAKES.

¹ The value of life lost is calculated so that it equals the alternative costs that would accumulate if the person became completely disabled and would have to be institutionalised for the rest of his/her life.

1.4 Social and cultural context

Attitudes to drugs and drug use

According to the Health Behaviour Survey among the Finnish Adult Population (Natunen et al. 2006), 78 per cent of Finns considered in spring 2005 drug use to be a serious or very serious problem, whereas the corresponding figure was 90 per cent four years ago. A clear indication of more lenient views is also the fact that the proportion of those who consider drug use a very serious problem (37%) dropped by 21 percentage units between 2001 and 2005. The changing trend was also shown in the health behaviour survey when assessing the future development of the level of drug use. In 2005, thirty-eight per cent considered that drug use would remain at the current level; in 2001, the corresponding figure was only 11%. This change reflects the stabilisation of the drug situation.

Women have always had stricter views than men have on the gravity of the drug situation. In the spring 2005 survey, the proportion of women who considered drugs a serious problem came to 82 per cent; the corresponding figure for men was 74 per cent. The influence of age on opinions is also evident: the older the respondent, the more serious he or she considered the drug situation. Correspondingly, 80 per cent of pensioners and only 58 per cent of students considered drug use a very serious or serious problem.

However, the changes in Finns' opinions do not mean that drug use is culturally acceptable. According to the health behaviour survey, four out of five respondents still considered drug use a serious problem in Finland; half of them even considered it a very serious problem. When asked about the future development of drug use, almost three out of five respondents believed that drug use would increase. (Natunen et al. 2006.) It seems that citizens still disapprove of drugs, but that the scare caused by the rapid increase in drug use in the 1990s and the related serious harm is passing over.

According to the 2006 Youth Barometer², 23 per cent of men and 14 per cent of women agree or somewhat agree that it is acceptable to use mild drugs, such as cannabis products. Younger men have tougher attitudes towards mild drugs: 18 per cent of 15–19-year-old men found the use of mild drugs acceptable, whereas the corresponding figure for 20–25-year-old men was 27 per cent. There were no differences between different age groups among women (Myllyniemi 2006). The differences between the attitudes of men in different age groups reflect the results of studies on drug use: it would appear that the young generation born at the end of the 1980s is less interested in experimenting with drugs than the older age groups are (see Section 2).

Drugs in the media

Anttila and Kuussaari (2005) studied the normalisation of alcohol and drug use in the Finnish youth media. The material consisted of 12 issues of the *Demi*, *Suosikki* and *City* youth magazines³ from 2003, 36 issues in total. According to their analysis, *Demi*

² For the Youth Barometer, 1,900 persons aged 15–29 were interviewed in March 2006. The samples were randomly chosen from the population register. Quotas were determined for gender, region, language and age so that their proportion of the material corresponded with the proportion of variables in the basic group.

³ The target group of *Demi* consists of 12–18-year-old girls, and its circulation is 209,000. The target group of *Suosikki* consists of 12–18-year-old girls and boys, and its circulation is 284,000. *City* is a free tabloid with a circulation of 225,000, and its target group consists of young adults over 18 years of age.

dealt with drugs in an educational tone, and girls in particular were expected to be responsible and rational in terms of substance use. In *Suosikki*, alcohol and drugs were presented as harmful but on the other hand, they were accepted as part of the wild “rock ’n’ roll lifestyle” of male idols. The *City* magazine, which is directed at young people over 18 years of age, discussed mild drugs with a positive undertone, but celebrities who were addicted to hard drugs were considered losers. According to Anttila and Kuussaari, the life stories and legends of rock and pop stars normalise drug use in youth media, but especially articles directed at young women also contain arguments against substance use.

2 Drug use in the population

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

Studies show that the trend in drug experimentation of the 1990s was set in motion by men, followed by women in the second half of the decade. The proportion of those having tried drugs during the past year grew until the end of the 1990s, after which the trend clearly levelled off. The same phenomenon can be observed among young people. It would appear that the young generation born at the end of the 1980s is less interested in experimenting with drugs than the older age groups. Nonetheless, drug experimentation and use are still more prevalent than at the beginning of the 1990s. (Hakkarainen & Metso 2006.)

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

Experiments with drugs and trends in drug use among young people are investigated every four years in national school surveys (ESPAD, HBSC), which are also part of European comparison surveys⁴, and regional school health surveys conducted every two years.⁵

According to the 2003 ESPAD survey, 11% of 15–16-year-olds had experimented with an illegal drug sometime in their life whereas in 1999 the corresponding figure was 10%. The amount of experimentation nearly doubled between 1995 and 1999, but since then there has been no significant growth. Experimentation with illegal drugs usually involves cannabis. According to ESPAD results, 7.5% of 15–16-year-olds had experimented with some illegal drug during the past year, and 2.5% during the past month. WHO's 2002 school health study (HBSC, 2003) gave almost similar results: 10% of 15-year-olds had experimented with cannabis sometime in their life and 7.5% during the past year. Two and a half per cent of respondents in the latter study were regular users and 0.5% heavy users. (Ahlström et al. 2004.)

⁴ The latest of these surveys was the 2003 ESPAD survey, which involved 200 schools and 3,321 pupils in 9th grade of secondary school. Data was collected with the same compilation method as in the 1995 and 1999 surveys. The response percentage was 92% in 2003. (Ahlström et al. 2003). See also EMCDDA's Annual Report 2004 web site, Standard Table 2. WHO's health behaviour study (HBSC) was conducted in Finland in 2002. The sample of 15-year-olds consisted of 1,745 pupils (see HBSC 2003).

⁵ The school health survey was filled in by 8th and 9th graders in secondary schools and by 1st and 2nd graders in upper secondary schools in the municipalities (and their schools) that attended the survey voluntarily. The survey is conducted every two years in the Provinces of Western Finland and Oulu and every two years in the Provinces of Southern Finland, Eastern Finland and Lapland. The material covers approximately 38–39% of all 8th and 9th graders in secondary schools and 54–57% of all 1st and 2nd graders in upper secondary schools. (Luopa et al. 2006.)

2.1 Drug use in the general population

According to the 2004 population survey⁶, 12% of 15–69-year-olds had tried cannabis at least once during their lifetime; the percentage had not changed since the 2002 survey. Between 2002 and 2004, the share of 15–24-year-olds having tried cannabis during their lifetime (21%) had declined by 4 percentage points and the share of 25–34-year-olds (23%) had grown by 4 percentage points. Three per cent had tried cannabis during the past year, which corresponds to the 1998 and 2002 survey results. The percentages for various age groups had not changed since 2002. Two per cent of adults had used cannabis during the past month compared with 1% in the last two surveys. In the 15–24 age group, use during the past month had grown from 4 per cent to 6 per cent according to the latest survey. The change is, however, so small that it may be due to random variation. The percentages for men were somewhat higher than for women. For drugs other than cannabis, the percentages of those having tried drugs during their lifetime varied from 2% for amphetamines to 0.5 per cent for heroin, the percentages for 15–34-year-olds being higher. This age group had also experimented with the recreational use of ecstasy (3% during their lifetime) and cocaine (2% during their lifetime). (Hakkarainen et al. 2005.)

Table 2. Percentage of 15–34-year-olds having tried drugs according to the 2004 survey

	During lifetime			During the past year			During the past month		
	All	15–24-year-olds	25–34-year-olds	All	15–24-year-olds	25–34-year-olds	All	15–24-year-olds	25–34-year-olds
Cannabis	12	21	23	3	10	4	2	6	2
Amphetamines	2	4	5	0.5	2	0.5	–	1	–
Ecstasy	1	3	3	0.5	2	0.5	–	1	–

Source: Hakkarainen & Metso (2005).

The 2004 population survey also looked at the patterns of initiation and continuation for drug use, in this case cannabis. The initiation of use is measured by how many (new) users (%) started using cannabis during the past year, i.e. had tried cannabis for the first time during the past year. The continuation of use is measured by how many (%) of those people who had tried cannabis during their lifetime had also tried cannabis during the past year. The results indicate that new users account for 0.5% of the whole population, 0.8% for women and 0.2% for men. The youngest age group, 15–24-year-olds had the most new users (2%). Regarding the continuation of use, 18% of those having tried cannabis during their lifetime had also used it during the past year (21% of men and 14% of women). The percentage is the highest for 15–24-year-olds (36%) and declines with age by about half for every ten years. Thus, it seems that interest in drug use decreases with age.

⁶ The population survey was carried out as a postal questionnaire among 15–69-year-old Finns. The sample consisted of a 1,786 person panel sample + an independent sample of 2,206 persons taken from the population register. The response percentage was 63%: Seventy-six per cent for the panel sample and 53% for the additional sample. (Hakkarainen & Metso 2005.)

When the results for 2004 are compared with those for 1998 and 2002, the most interesting finding concerns 15–24-year-old first time users. The results show that fewer and fewer 15–24-year-olds start using cannabis, as the percentage of new users has declined systematically: 3.4% in 1998, 2.5% in 2002 and 2.0% in 2004. It could be assumed that the proportion of those having tried drugs during their lifetime will decline with time in this age group, the first signs of which have appeared in the past two years. However, according to all surveys, one third of those 15–24-year-olds trying cannabis have continued its use.

The alcohol panel study⁷ conducted in 2003, 2004 and 2005 also included a few questions on drug use. The respondents were asked about drug experimentation during their lifetime and their drug use during the past 12 months. The results show that 11–12 per cent had tried cannabis sometime in their life. It is worth noting that in the age group of under 25-year-olds drug experimentation has decreased since 2003. In 2004 and 2005, 18% of under 25-year-olds reported having tried cannabis sometime in their life, compared to 24–25% in previous years. The use of amphetamine has decreased among under 25-year-olds from 4% in 2002 to 1%, and the use of ecstasy has also decreased by half. However, cocaine use seems to have increased slightly among young adults. (Hakkarainen & Metso 2006.)

According to the results of the annual Health Behaviour Survey among the Finnish Adult Population for 2005, 17% of both men and women know someone who has tried drugs. Acquaintances having tried drugs were clearly more common in cities and among 15–24-year-olds. In this age group, women had more acquaintances who had experimented with drugs than men did. Regionally, people from Southern Finland (the region of Uusimaa) and big cities knew more drug users than people elsewhere. Three per cent of respondents knew more than five users but in the youngest age group, the percentages were 9% for men and 11% for women (Natunen et al. 2006).⁸ A noteworthy aspect of this survey is that the percentage of population who knew more than five drug users corresponds to the percentage of those who had tried drugs in the past year according to the previously mentioned population survey from 2004.

The 2005 Health Behaviour Survey gathered for the first time information on where people had been offered drugs and by whom. Being offered drugs was even rarer than knowing someone who had tried drugs. Only six per cent of the respondents had been offered drugs for free or for sale during the past year. Again, the youngest age groups differed from the rest. Eighteen per cent of 15–24-year-old women and 15% of men in the same age group had been offered drugs during the past year. Two thirds of under 45-year-old respondents who had been offered drugs during the past year said that the people who offered them drugs were friends or acquaintances. Seventy-eight per cent of these friends or acquaintances had offered drugs in their own home or someone else's home, and only 22 per cent had offered drugs either in a club or a restaurant and 10 per cent in the street, in a park or at a festival. Unknown young people or adults who had offered drugs had done so mainly outside (street or park 38%) or in restaurants (38%). (Natunen et al. 2006.)

⁷ The alcohol panel study dealt with the effect of the changes in alcohol taxes on people's drinking habits. The study gathered information from the same respondents each year, and every year an additional sample independent of the original sample was also drawn. The report by Hakkarainen & Metso (2006) is based only on the material gathered from the additional samples.

⁸ The Health Behaviour Survey among the Finnish Adult Population comprised a random sample of 5,000 Finns aged 15–64. The response percentage was 66% (68% in 2004), 59% (61%) for men and 73% (74%) for women. (Natunen et al. 2006)

2.2 Drug use in the school and youth population

According to school health surveys, drug experimentations have not increased in the 21st century. In 2004–2005, six per cent of 15–16-year-olds had experimented with drugs sometime in their life, whereas at the turn of the century the corresponding figure was 9%. Experimentation with illegal drugs also decreased among 17–19-year-olds: 13% in the 2004–2005 survey compared with 15% in the 2000–2001 and 2002–2003 surveys. In the older age groups, the prevalence of drug experimentation varied significantly by region. Boys had experimented with illegal drugs more than girls had. (Luopa et al. 2006.)

2.3 Drug use among specific groups

According to a dissertation being written on the reasons behind young girls' drug use, the girls describe drug use as a means of differentiating from others and experiencing adventures⁹. The girls had often started using drugs as a result of several factors; in the beginning, drugs offered the girls a way to increase their social competence, and the drugs themselves were not as important to the girls as were the related symbols and social aspects. The girls were also more likely to experiment with or use drugs if they admired or were in a relationship with a drug-using man. (Väyrynen 2005.)

The study by Obstbaum (2006) compared criminal behaviour between Finnish-speaking and Swedish-speaking young people¹⁰. Young people aged 15–16 years were asked among other things about the use of marijuana and hashish, the use of pharmaceuticals for intoxicating purposes and the use of other drugs. The results revealed that the use of marijuana or hashish was more common among Finnish-speaking young people. Around 7% of those who had used marijuana or hashish had financed it by illegal means. There were no differences in the use of pharmaceuticals or other drugs between the two language groups.

⁹ Fifteen 15–27-year-old girls who had used drugs were interviewed for the study.

¹⁰ In the spring of 2004, the National Research Institute of Legal Policy carried out a questionnaire survey on criminal behaviour to which 5,142 Finnish-speaking and 1,137 Swedish-speaking 9th graders responded.

3 Prevention¹¹

The target and action plan for social and health services for 2002–2003, which was approved by the Government, proposed, among other things, setting up a municipal contact person network for substance abuse work. The contact person is in charge of the co-ordination of municipal substance abuse prevention together with the social and health services, schools and organisations. The contact person also co-ordinates the municipal or regional substance abuse strategy.

In municipal substance abuse strategies, preventive substance abuse work is usually seen as a continuum including prevention, early intervention and treatment (Romppanen 2005). According to a new concept definition, substance abuse work is divided into preventive and corrective substance abuse work. Preventive substance abuse work includes general prevention and risk prevention, and thus substance abuse work should be given a new definition in the substance abuse strategies. Municipal substance abuse strategies usually address intoxicating substances as a whole, without making a distinction between drugs and alcohol.

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

The school curricula regulate health education as a separate subject in upper secondary and vocational schools. Substance abuse questions are key aspects of this subject. School curricula and pupil and student welfare services should also include drug prevention. For example, strategies for the prevention and treatment of substance use should be included in the local curriculum. Many schools have implemented their own substance abuse prevention programmes in co-operation with organisations, the authorities and parents.

On a national level, substance abuse prevention aimed at young people is carried out in youth workshops that have been created to activate young unemployed people. Youth workshops are a form of early intervention, and they aim at preventing the exclusion of young people from education. In working life, drug tests are conducted to prevent drug-related harm and to refer individuals with drug problems for treatment as early as possible.

Anti-drug organisations operate under a joint drug programme¹². The organisations aim to promote discussion and provide information on the causes and consequences of drug use, affect people's attitudes, organise peer support activities and provide post-care for substance abuse patients.

Other drug prevention measures are drug information services, virtual discussion forums and self-testing services for assessing one's own substance abuse. Web-based dissemination of information is used to train professionals and for alcohol and drug education.

¹¹ Substance abuse prevention is also dealt in Section 12.4.

¹² Organisations' drug programme 2006–2008, see Section 1.

3.1 Universal prevention

Two follow-up surveys, a school survey and a health centre survey, were conducted on alcohol and drug education included in school curricula and the use of the school health survey conducted every second year.¹³ According to the report on the school survey, the vast majority (93%) of schools had arranged alcohol and drug education events, mostly individual educational events, in addition to alcohol and drug education related to health education. One school in four co-operated with an external party in alcohol and drug education and more than half the schools participated in individual events. Out of all the various alcohol and drug education programmes, the Smokefree Class Competition had the most participants (66% of schools). Every other school implemented its or the municipality's own alcohol and drug education programme. One school in four co-operated with the Lions-Quest programme. The drug information bus HuBu had also visited every fourth school. According to the survey, the curriculum for health education was in place for the 7th grade in 73% of schools and for the 9th grade in 25% of schools. Thirty-five per cent of schools reported having a qualified health education teacher. Health education is most often taught by physical education, biology and home economics teachers. The results of the school health survey had been used effectively in one third of the schools in the municipalities that had ordered the results. Schools had used the results as part of their pupil welfare services and school health care and in health education, parents' evenings and internal evaluation. The majority of health centres reported having used the school health survey results to improve school health care and substance abuse prevention, and one fifth had used the results in a broader sense to promote the wellbeing of children and young people. (Rimpelä et al. 2005.)

Conducting drug tests at the workplace requires that a written anti-drug programme be drawn up for that workplace. The programme should outline the goals and applicable practices at the workplace for preventing substance use and for referring people with substance abuse problems to treatment (Centre for Occupational Safety 2005). The ethical problems of drug tests stem from the fact that the law gives companies the right to dismiss a person based on his test results, even if he had used drugs in his free time and drug use had no effect on his performance at work (Bothas 2005).

Reports have been published on the use of various communication channels both in the training of professionals as well as in education in the field of substance abuse prevention. A local co-operation project of the Päijät-Häme and Itä-Uusimaa regions dealt with the possibilities for online consultation between professionals.¹⁴ The experiment showed that the use of the general online consultation services was low. Instead, users focused more on local issues. (Bothas 2005.)

¹³ School Health survey, see Section 2.2.

¹⁴ The survey was sent to some 340 social welfare and health care professional from the Päijät-Häme region. The main target groups were social workers, school nurses, child welfare clinic nurses, youth workers, church social workers, school psychologists, school social workers, family counsellors and family workers. (Bothas et al. 2003.)

3.2 Selective/indicated prevention

Brief follow-up reports regarding local substance abuse prevention projects have been published on, for example, the operation of a regional collaborative group on substance abuse prevention and family work. The target group of the Vammala A-Clinic's Nuorten talo (*Young people's house*) project consisted of people less than 29 years of age. The project drew attention to the importance of substance abuse prevention in the region. Methods for implementing prevention measures were developed in co-operation with health education. (Saari & Vesterbacka 2005). The Voitto kotiin (*A victory for home*)¹⁵ family work project developed practices for working with the entire family. The project was based on family meetings and long-term operation that is expected to lead to permanent changes in family interaction and attitudes towards intoxicating substances. (Raitanen 2005.)

In the Greater Helsinki area, special drug prevention projects have been carried out to reach Russian immigrants and their families. In order to overcome language and cultural problems, Russian-speaking people with an immigrant background have been employed in substance abuse services. Project monitoring revealed that family work is an important method especially for prevention, but the service system does not have enough resources to carry out family work. (Puro 2005b.)

Experiential alcohol and drug education methods, including plays and so called experience routes, have been used in Finland for some ten years. Experience routes are like exhibitions that young people walk through watching demonstrations on drugs, for example. According to estimates, the experiential alcohol and drug education methods currently used aim at teaching young people correct behaviour, but they do not often encourage critical and individual thinking. (Rantala, Salasuo & Soikkeli 2005; 2006.)

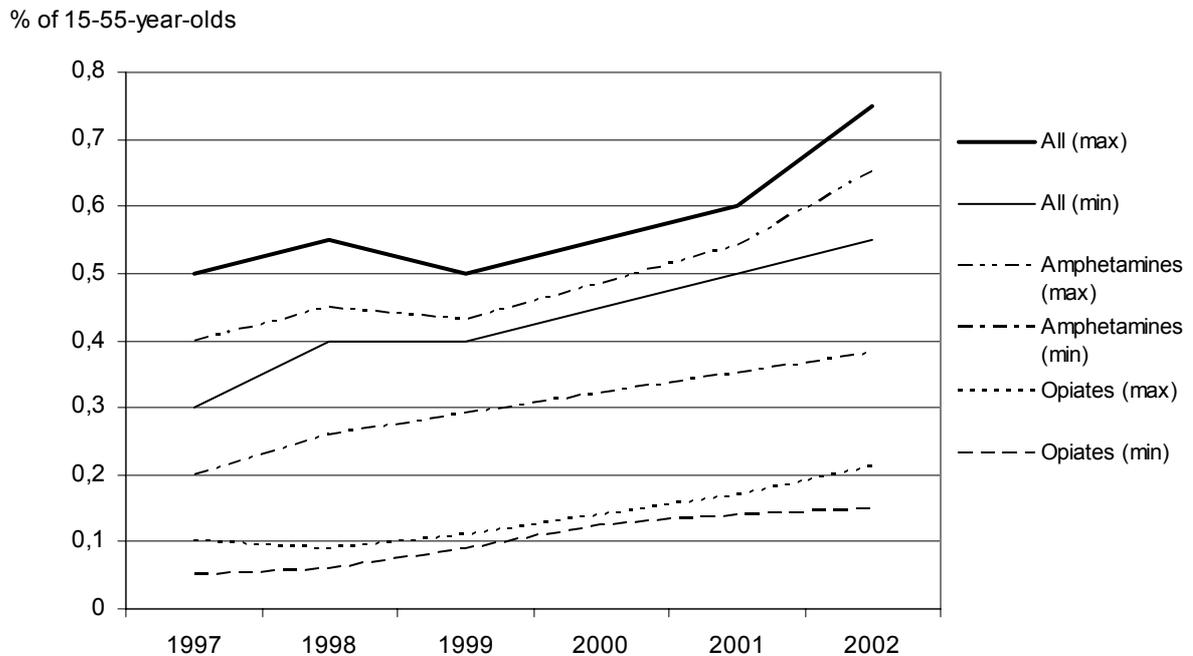
¹⁵ The target group of the 3-year project consisted of clients from associations of mother and child homes and shelters and family centres as well as their family members in the Kymi, North Karelia and Finland Proper regions. A total of 22 families participated in the project.

4 Problem drug use

According to statistical estimates, problem users of amphetamines and opiates¹⁶ accounted for 0.6–0.7% of 15–55-year-olds in Finland in 2002. Amphetamine users accounted for 0.4–0.6% and opiate users 0.1–0.2% of the population (Table 4). Even though population studies show that the prevalence of annual experimental use is stabilising, the number of problem users of amphetamines and opiates has noticeably increased since 1999.

The accumulation of detriment leading to problem drug use seems to occur after a lag of 3 to 5 years from the commencement of use. Thus, the sharp increase in drug experimentation at the end of the 1990s seems to have led to the growth of the number of problem users at the beginning of the 21st century (Figure 2).

Figure 2. Percentage of problem drug users among 15–55-year-olds 1997–2002



Source: Partanen et al. 2004.

¹⁶ According to the national definition used in the study, problem use refers to the use of amphetamines and opiates to such an extent that it causes social or health problems to the user. Furthermore, the authorities have had to intervene in one way or another and this has been recorded in administrative registers.

Statistical estimates on the prevalence of problem drug use¹⁷ have been made nationally since 1997. According to these estimates, out of the 15–55-year-old population, there were some 16,000–21,000 amphetamine and opiate problem users in the entire country in 2002.

Table 3. Development of the number of amphetamine and opiate users in Finland in 1997–2002

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

* = Estimates are based on information from three registers

Source: Partanen et al. 2004.

The majority of problem users, 70–75%, consisted of amphetamine users. According to the study, about 80–85% of amphetamine users and 75% of opiate users were men. Some 60–70% of all problem users were from Southern Finland (population share 0.85–1.25%), more than half of them from the Greater Helsinki area (population share 0.9–1.35%). The corresponding population shares were 0.4–0.6% in Western Finland and 0.3–0.5% in Eastern and Northern Finland. In the Greater Helsinki area, the problem users were slightly older than elsewhere in Finland.

¹⁷ The estimates of problem drug users are based on the statistical capture-recapture method in which the samples from the same group are used to assess statistically the size of the entire target population. The samples were defined based on the interventions directed by society at the target population (amphetamine and opiate users). The interventions employed by the system included amphetamine or opiate diagnoses recorded in hospitals, penal action for drug offences involving the use or possession of amphetamines or opiates, arrest for driving under the influence of amphetamines or opiates and hepatitis C cases recorded in the infectious disease register due to intravenous drug use. The estimate intervals are based on 95-per cent confidence intervals of the estimates. Different log-linear models were applied to different subgroups so the sum of the subgroups differs from the overall estimate. (Partanen P. et al. 2004.)

Table 4. Development of the population share (%) of amphetamine and opiate problem users in Finland in 1998–2002

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

Source: Partanen et al. 2004.

According to the censuses of intoxicant-related cases¹⁸, the proportion of cannabis users doubled and the proportion of amphetamine users trebled between 1995 and 2003. Opiate use increased clearly between 1999 and 2003. Of the intoxicants used, the proportion of opiates was 5% in 1999 and 12% in 2003. In 2003, 27% of all the clients of substance abuse services had used some illicit drug; the corresponding figure in the previous census in 1999 was 16%. In the 2003 census, a fifth of the clients had used drugs intravenously, but there was no data for 22 per cent of the cases. (Nuorvala et al. 2004.)

The drug treatment information compiled from units providing specialised services for substance abusers helps in determining the development of a problem user's profile. The most significant change lately has been the sharp increase in the problem use of buprenorphine. During the past few years, buprenorphine has replaced heroin almost completely as the main drug used by drug treatment clients of substance abuse services and is already on the same level as the problem use of stimulants.

Drug treatment clients are relatively young. According to the census of intoxicant-related cases, of all the intoxicant-related cases in social and health service units, drugs were involved in 63% of the cases of under 20-year-olds, in 75% of the cases of 20–29-year-olds, and in 40% of the cases of 30–39-year-olds. The mean age of all the clients was 44 years (Nuorvala et al. 2004). According to the drug treatment information system, the drug treatment clients in outpatient and inpatient care are systematically five years younger than the drug treatment clients in the census. The difference can be explained by the fact that the drug treatment information system emphasises youth centre clients. Based on the census, it can also be estimated that slightly older abusers of pharmaceuticals are underrepresented in the drug treatment information system. (Vismanen 2004.)

¹⁸ The census of intoxicant-related cases is conducted within one day every four years in all social and health service units. The most recent census was carried out in 2003.

According to the census of intoxicant-related cases 44% of the clients in outpatient care and 47 per cent of the clients in inpatient care in the units providing specialised services for substance abusers had used pharmaceuticals or drugs. The figures for drugs were 35% and 40%. The results have changed significantly from 1999 when the share of drug treatment clients was just under 20% in substance abuse outpatient care and about 30% in inpatient care. (Metso 2004.)

4.1 Prevalence and incidence estimates

No new information available.

4.2 Profile of clients in treatment

According to the 2005 results of the drug treatment information system¹⁹, the drug treatment clients were mainly men (70%), young adults and single. They had a low level of education, and unemployment was common (62%). Every eighth client (12%) was homeless. The majority of the drug treatment clients had received drug treatment before, and one sixth (17%) entered drug treatment for the first time in 2005. (Kuussaari & Salonen 2006.)

The mean age of the clients was 27.6 years (compared with 27.3 the year before). Men were on average 3 years older than women were. The clients of substance abuse outpatient units and inpatient drug treatment units were the youngest, with the mean age of 26 years. In outpatient drug treatment units and substance abuse inpatient care, the mean age was 29 years and in prison health care 31 years. Of all the clients of substance abuse services, 8% were in inpatient units and 23% in outpatient units specialised in drug treatment. Thirty-seven per cent were in general substance abuse outpatient units and 29% in inpatient units. (Kuussaari & Salonen 2006.)

Among all drug treatment clients of substance abuse services, opiates were the primary problem substance of the clients entering drug treatment (37%), followed by stimulants (22%), the combined use of drugs and alcohol (19%), cannabis (14%) and sedatives (7%). Buprenorphine was the primary problem substance of 29% of the clientele. Almost two out of three clients had used at least three substances (Kuussaari & Salonen 2006). The proportion of buprenorphine as the primary substance of those entering treatment has increased the most. Buprenorphine is already the primary substance for more than a fourth of drug treatment clients and opiate users.

¹⁹ The results are based on data gathered from 161 units and 5,499 drug treatment clients. The data collection is voluntary for the participating units. A coverage survey conducted in 2004 (Vismanen 2004) estimated that in 2003 the drug treatment information system covered about half of all drug treatment clients in the units providing specialised services for substance abusers.

Table 5. Substances used by clients entering treatment for the use of narcotics and pharmaceuticals (% of clientele) in 2000–2004

Substance category	1st problem substance					
	2000	2001	2002	2003	2004	2005
Opiates	29	28	28	31	34	37
-heroin	20	13	6	3	3	2
-buprenorphine	7	12	20	24	27	29
Stimulants	28	26	28	28	26	22
Cannabis	17	20	18	16	15	14
Alcohol and drug	18	19	20	19	18	19
Sedatives	5	6	5	6	6	7

Source: Drug treatment information system, STAKES.

The most common single substance of those clients entering drug treatment for the first time (n=884) was cannabis (24%). Other common primary problem substances were stimulants (21%), opiates (18%) and the combined use of alcohol and drugs (28%). The proportion of clients entering treatment for the first time due to buprenorphine use (16%) increased by five percentage units when compared with the previous year. Three out of four (77%) drug clients in services for substance abusers had injected drugs sometime in their life; 58% of them had injected drugs during the past month and one in six (16%) had shared needles and syringes. Opiates were most commonly used intravenously (85%). The intravenous use of buprenorphine (88%) was almost as common as the intravenous use of heroin (92%). Stimulants were also injected by 82 per cent of their users. (Kuussaari & Salonen 2006.)

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

The Kuopio Military Province Headquarters arranges a medical re-examination for service personnel who suspend their military service²⁰. Mental and behavioural disorders are the biggest ICD category in the re-examinations (roughly 55% of the cases). Within this category, the most significant change between 1993 and 2003 was the increase of mental and behavioural disorders due to alcohol and drug use (F10–F19): in 1993, these cases accounted for 2.2%, in 1999 for 10.1% and in 2002 for 27.2%. In 2003, the percentage dropped to 20.7%. The percentages related to alcohol have declined continuously, while those related to drugs have increased. Alongside cannabis and amphetamines, it is not uncommon for those summoned for re-examination to use hard drugs, and there seems to be an increasing prevalence of substances used in combination. (Koskinen & Puustinen 2005.)

²⁰Re-examinations are mainly arranged to determine fitness for service of those who had to suspend their military service, conscripts who failed to respond to their call-up and reservists who fell ill. The situation of those summoned for re-examination was monitored from 1993–2003 according to the ICD category. The information was based on required medical certificates. The number of re-examinations totalled 335 in 2003 (202 in 1993).

According to the assessment on the mobile health counselling unit (ambulance)²¹, some 5 per cent of clients had acute need for follow-up care. Roughly a third of the clients were women and the mean age of the clients was 31.7 years. The majority of new clients were 20–29 years old. During the month preceding their first visit, a third of new clients had not used any other health counselling services (before a revisit 9%). Most clients used buprenorphine intravenously. The majority of those interviewed had started the intravenous use of drugs within two years of initiating their use. However, approximately three out of four of the clients monitored had not shared needles and syringes during the month preceding their visit to the unit. (Törmä & Huotari 2005a.)

In the “Kynnykset pois” (*No thresholds*) project, the services of a day centre were combined with a drug addiction treatment clinic that operates 24 hours a day. Of the joint clientele, the study focused on clients with multiple problems, the so-called project clients²². One third of the group was under 30-year-old addicts on the brink of exclusion, whereas the older ones could already be deemed marginalised. For all the younger clients, the intravenous use of buprenorphine was the primary method of drug use whereas among the older clients, substance use was more varied. The most common psychological symptom among the clients was opiate addiction, but they also had other substance addictions. Almost all older clients were homeless. The basic physical health of the young clients was good, whereas the lifestyle had already affected the health and physical appearance of the older clients. (Törmä & Huotari 2005b.)

The Central Social Services Centre of the Helsinki Social Services Department has used personal case management as a working method with clients who have drug problems. Personal case management aims at improving competence in the co-ordination of services and in counselling the client. The main target group for the case management method has been users of hard drugs, who are motivated to change their life and who need comprehensive support. The effectiveness of case management and the rehabilitation of clients were monitored by employing case-specific realistic evaluation as part of the work with clients. (Peitola 2006.)²³

According to Malin, Holopainen & Tourunen (2006), the experiences of buprenorphine users themselves should be taken into account more when planning buprenorphine substitution treatment.²⁴ By involving users in the planning and by recognising their expertise in issues related to the use of buprenorphine, new doors could be opened in substitution treatment. The users interviewed for the study used buprenorphine mainly as a form of self-medication, and they needed the substance in order to feel healthy despite the fact that its use also caused many problems.

²¹ The operation started at the end of 2003 and in 2004, the unit had 700 clients, in total 2,350 client visits. The material of the study consisted of survey forms on 212 new clients, who had not used health counselling services during the month preceding their visit. In addition, theme interviews were conducted on 20 clients. Interviews were also conducted on the personnel of the unit, other service providers and pharmacists and police officers operating in the neighbourhood. (Törmä & Huotari 2005a)

²² There were a total of 320 project clients in 2003–2004; twelve of them were interviewed. The project clients had to meet at least two of the following criteria: a psychological diagnosis, distinct psychological symptoms, psychological symptoms that seriously interfere with the ability to manage everyday life, lack of life management skills, exceptional use of treatment services (outsider, major user) or unstable social situation (no social relationships, devoid of a permanent home). In 2003, approximately 7% of all clients of the drug addiction treatment clinic were classified as project clients. (Törmä & Huotari 2005b)

²³ The material for the study consisted of theme interviews with the social workers who had used the method and four clients who had received case management. The social workers and clients interviewed were a selected sample and represented those who had enough experience in case-specific realistic evaluation. (Peitola 2006)

²⁴ The study by Malin et al. (2006) was based on interviews with twelve problem users of buprenorphine. The theme interviews were conducted at the Vinkki health counselling centre in Helsinki and at the Järvenpää Addiction Hospital.

5 Drug-related treatment

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

A quality framework for substance abuse services has been created for the development work. In addition to the units providing specialised services for substance abusers, increasing numbers of substance abusers are treated within primary social and health care services, including social welfare offices and child welfare services, mental health clinics, health centre clinics and wards, hospitals and mental hospitals.

The development policy for drug treatment services emphasises developing low-threshold services and related training. The aim is to get drug abusers to enter the treatment system as early as possible. The Finnish system also emphasises that drug treatment as such is often insufficient and so the substance abuser should be assisted in solving problems related to subsistence, habitation and employment.

While the consumption of various intoxicants has grown, the social effectiveness of substance abuse services has been estimated to have weakened (Kaukonen 2005). Local government lacks monitoring systems that would help identify client group specific welfare deficits and service needs. In particular, the most socially marginalised substance abuse patients face a high risk of being excluded from the service network. The number of clients in substance abuse services has not grown consistently, but the treatment periods have become longer, as the physical condition of clients is increasingly poor and polydrug use is becoming increasingly common.

After the turn of the century, the drug treatment situation has stabilised; for example, health counselling and the position of medical treatment have become firmly established. Substitution and maintenance treatment for opiate addicts is increasingly being transferred to health centres. The substance abuse service system faces a new challenge because resources have to be divided between treatment of the harm caused by increased alcohol consumption and drug treatment.

5.1 Treatment systems

Availability of treatment services

According to the report on the evaluation of basic services, 24-hour detoxification for drug addicts was usually arranged in rehabilitation units, detoxification units or specialised health care services. One third of municipalities reported that they do not provide outpatient detoxification treatment for drug users, and one fourth had no

inpatient detoxification systems. A client can be admitted to substance abuse outpatient care in under a week in every municipality and to inpatient rehabilitation in under a week in two out of three municipalities. Thirty per cent of municipalities have a system for needle and syringe exchange, but only 10 per cent provide these services within the municipality. (Ministry of Interior 2005.)

Two thirds of municipalities had agreed to provide substitution and maintenance treatment for opiate addicts. In most cases, this type of treatment was arranged in another municipality and mainly in substance abuse outpatient care or in specialised health care services and health centres. Almost half of the municipalities reported that they have no need for substitution treatment. In municipalities that provide this service, opiate addicts have to wait on average two weeks to be admitted to substitution and maintenance treatment, but this can take up to a year in some municipalities in Southern Finland. Almost half of the municipalities had no data on the need for substitution treatment for opiate addicts or its availability. (Ministry of Interior 2005.)

Kuussaari (2006) writes that there is a lot of uncertainty among drug treatment workers regarding the treatment system. The workers do not always know where and how drug users are treated in their own municipality. The uncertainty may also reflect the change that the drug treatment system is currently going through.

Developing services for the severely problematic substance abusers

Getting the severely problematic substance abusers into treatment usually requires bringing low-threshold services to the clients. Many severely socially excluded clients would benefit from less goal-oriented treatment plans and supported housing services. (Ministry of Interior 2005; Mäkelä et al. 2005.)

According to Törmä and Huotari (2005b), the most socially marginalised substance abusers are not suitable clients for treatment in units providing specialised care for alcoholics, drug addicts or mental health patients. Linking the entire treatment chain so that a patient could advance in the treatment system according to his or her own abilities and needs would be of great use to clients with multiple problems. There is also a need for services for female clients. Increasing numbers of young people are facing social exclusion as a result of being “recycled” in the service system and not having a real chance to commit to treatment. The study shows that it would be especially important to treat young people’s psychological problems before they start self-medicating with drugs. (Törmä & Huotari 2005b.)

5.2 Drug-free treatment

The Kisko unit of Kalliola Clinics provides community treatment for drug addicts who have a long and extensive history of substance abuse.²⁵ Patients are encouraged to pursue a substance-free life style and lifelong growth. The study showed that Kisko has a certain status among drug users. One interviewee said that he had enjoyed the treatment at Kisko “which is often likened to a concentration camp”, whereas another patient who had dropped out of treatment said that he was disappointed with himself “for not having graduated from the drug addicts’ university”. Even though the

²⁵ The Kisko Unit of Kalliola Clinics is a treatment unit providing community treatment for drug addicts over 18. The entire staff (10) and 15 patients were interviewed for the study. Ten people who had finished the treatment and five who had dropped out were also interviewed.

interviewees also talked about the softer sides of the treatment at Kisko, its reputation as a “tough place” seemed to boost the patients’ self-esteem. In the appraisal of Kisko’s operations, the feedback on the treatment was positive. (Heikkilä 2005.)

Ruisniemi (2006) has studied the change in the self-image of a person recovering from substance addiction in community treatment²⁶. The community was consciously used to promote change and the peer group was considered important. The 12-step programme was the central recovery model in the community, and those in rehabilitation committed themselves to attend regular AA and NA group meetings. According to the study, the interviewees’ self-image seemed to have become more flexible and their attitudes towards other people had changed. They felt that community feedback and activities had helped them to change.

The Vinkki health counselling centre in Helsinki has provided peer group activities for drug-using clients since 2001. Peer group activities are implemented on three levels: peer support, snowball training²⁷ (peer education) and so-called Helpers (peer work). The Helpers participate in snowball training and after this, they are assigned individually tailored tasks that they carry out at the health counselling centre or among networks of drug users. Helpers are not required to live a drug and alcohol free lifestyle. Helpers provide health counselling and clean needles and syringes for other drug users, teach them how to dispose of needles and syringes safely, and hand out brochures on risk behaviour. (Malin 2006.)

The drug users encountered by the Helpers usually had two factors in common: they were afraid of the authorities and therefore, they were unwilling to become clients of health counselling centres.²⁸ The Helpers felt that they, as peers, had access to networks of drug users that the health counselling centres were unable to reach. The Helpers acted as communicators between drug users and the authorities, and they provided the authorities with important information on life in the social networks of drug users. The Helpers provided drug user networks with information on how to reduce drug-related problems. The study on Helpers emphasised that peer group activities should be developed to drug users who have a family and are afraid of child welfare authorities. Peer group activities could also offer a way to reach those young drug users who so far have not become clients of health counselling centres. (Malin 2006.)

The Children and Adolescents' Substance Abuse Outpatient Clinic in Turku²⁹ deploys a structured individual brief intervention programme that consists of an evaluation visit as well as 12 actual visits.³⁰ The treatment programme aims at dealing with the young person’s life situation comprehensively, and the young client is encouraged to

²⁶ The material consisted of interviews with ten patients that were conducted at the beginning and end of a one-year community rehabilitation period as well as 1–2 years after the rehabilitation. (Ruisniemi 2006.)

²⁷ In the snowball method, drug users are recruited to help other users at the local level. Clients of Vinkki are trained as tutors who disseminate health counselling information to their networks of friends and acquaintances. (Malin 2006.)

²⁸ The article by Malin (2006) is based on theme interviews with six Helpers.

²⁹ The Children and Adolescents' Substance Abuse Outpatient Clinic was founded in 2003. Its activities became part of the Children and Adolescents' Outpatient Clinic maintained by the City of Turku, so that young people seeking treatment would not be stigmatised because of their substance abuse problem. The project also aimed at separating the treatment of underage substance abusers from other substance abuse treatment, so that when seeking treatment young people would not come into contact with adults who have used drugs for a long time and who deal drugs, as this might expose the young clients to more problems.

³⁰ The evaluation visit and the final visit of the intervention programme are intended for both the young client and his or her parents, and in the middle of the programme the parents visit without their child, but the other visits are for the young person alone. In 2004, 127 young people came to the outpatient clinic and 33 of them underwent the intervention (during the evaluation visit 18 of them admitted to having used or tried cannabis). Boys accounted for two thirds of the clients, and the mean age of all the clients was 15.5 years. During the year, seven young clients were discovered to use drugs intravenously. (Jonsson 2005.)

join a treatment programme and to reduce or stop substance use. The programme provides the client with health counselling on risk behaviour related to substance use. Drug screening tests are conducted randomly or when necessary. The young person is taught to recognise the dangerous and problematic situations related to substance use and he or she is encouraged to find alternative activities. During the intervention, the young person sets personal goals regarding substance use, and the realisation of these goals is discussed analytically with the client in an encouraging atmosphere. After the actual treatment programme is over, the client is scheduled for follow-up visits in 1, 3, 5 and 12 months. (Jonsson 2005.)

Of those young people who came to the outpatient clinic and underwent the intervention in 2004, the majority had reduced their substance use when their situation in the month preceding the final visit was compared with their situation in the month preceding the evaluation visit. The comparison of the data of the final visit and the data of the follow-up visits showed that substance use did not decrease after the intervention was over. The feedback young people and their parents gave on the intervention programme was mainly positive. The staff reported that the support and help provided by the outpatient clinic greatly contributed to the fact that many young people reduced their substance use during the programme. (Jonsson 2005.)

5.3 Medically assisted treatment

According to the drug treatment information system in 2005, 27 per cent of those who had sought treatment for opiate addiction received medical outpatient or inpatient treatment. The proportion was clearly bigger than the year before (19%). According to the information system, buprenorphine (86%) was the most common pharmaceutical used in the medical treatment for opiate addiction, followed by methadone (14%). Thirty-nine per cent of the buprenorphine used in treatment was Subutex® or Temgesic® and 61% was Suboxone®, which contains naloxone. (Kuussaari & Salonen 2006.)

In August 2006, the Ministry of Social Affairs and Health conducted a study on the availability of 24-hour detoxification services.³¹ The study dealt with the situation in the largest cities and urban municipalities and thus cannot be generalised for the whole country. In the units that were studied, a drug user could generally be admitted to detoxification within one to three weeks, although there was much variation between the units. The duration of the detoxification periods varied in the units from 24 hours to four weeks. In addition to the availability of treatment, the study aimed at discovering whether there had been changes in the demand for services lately or compared with previous years. Most respondents had not observed any changes in waiting times or client numbers. However, almost all reported that the physical condition of the clients had deteriorated in the past few years. The composition of the clientele had remained the same in most localities. (Renko & Vuorinen 2006.)

Vorma et al. (2005) studied substitution treatment, how well patients remained in treatment, substance abuse during treatment, social rehabilitation, and psychiatric comorbidity at the addiction psychiatry unit of the Helsinki University Central Hospital (HUCH).³² During the study, opiate abuse declined to the extent that out of the

³¹ The study was based on telephone interviews with 15 inpatient detoxification units in ten largest cities (with over 75,000 inhabitants) in Finland. The results are not based on official statistics, but rather on information received from the appointment books at the time of the study and on the subjective views of the interviewees on the changes in demand.

³² The study included all the patients who started opioid substitution treatment in 2000–2002 at the HUCH Outpatient Department for Opioid Addiction. 70 new treatment periods were started during the study. One person started the treatment

patients who had received treatment for at least a year and a half, 75% had not used additional opiates during the past year. Almost all the patients were polydrug users at the time they started treatment but during the treatment, other substance addictions also decreased clearly. Patients committed to treatment well; 94% remained in treatment after one year of starting the treatment. During the follow-up study, part of the patients returned to active working life, but more patients were granted sick leave or disability pension. During the treatment, the patients were medically assessed and therefore were able to apply for appropriate subsistence support. A notable fact was that no new HIV infections were detected during the treatment. Nearly all the patients were addicted to benzodiazepines.

The municipality of Nurmijärvi, which is located in Southern Finland and has a population of 35,000, carried out a study on substitution treatment in primary health care, i.e. at the local health centre.³³ The central conclusion of the study was that it is possible to treat opiate addicts at health centres with substitute medication and psychosocial support, but the treatment must be based on sufficient expertise and resources. The transfer of substitution treatment to a local health care unit is successful if it is prepared for in advance and the staff is provided with related training. The physical facilities must be adequate, and an effective security system must be in place in order to prevent burglaries and robberies. Opiate addicts seldom caused disturbances to the staff or other patients at the health centre. (Halmeaho & Nuorvala 2005). A trial was also conducted on the transfer of substitution treatment to a day centre for homeless people. The trial resulted in similar observations and conclusions as in the health centre study (Forssén 2005).

Strengell et al. (2005) studied eleven pregnant women who received buprenorphine treatment for opiate addiction.³⁴ All patients also continued to use other medication during pregnancy. When the results were reported, two of the patients were still pregnant, six had given birth to a healthy child and three had had a miscarriage due to serious foetal damage. Two mothers had received buprenorphine treatment throughout their pregnancy and in both cases, the pregnancy ended in foetal damage. Both had started treatment before becoming pregnant, and their drug screening constantly produced negative results. The material of the study consisted of isolated cases, and no one reason can be given to explain the anomalies. The damage cannot be traced to buprenorphine, because the patients had also used other pharmaceuticals during early pregnancy, and the anomalies could be random findings. However, the role of buprenorphine cannot be completely ruled out. (Strengell et al. 2005.)

There is a need to develop the psychosocial rehabilitation system for patients in substitution treatment (Makkonen 2005)³⁵. With the OHJAT project, the A-Clinic Foundation has studied the psychosocial rehabilitation of clients in substitution treatment in the Greater Helsinki area and the factors that prevent or support

twice during the study period. The retroactive study was based on case histories. All the patients in the study received methadone treatment. (Vorma et al. 2005)

³³ The Nurmijärvi health centre began administering substitution treatment in 1998 and by spring 2002, the centre had treated thirteen opiate addicts. By spring 2004, thirty patients had received treatment. The appraisal of the operation was based on 27 interviews with key people in the municipality. The material was collected in 2003–2004. (Halmeaho & Nuorvala 2005)

³⁴ All options were considered when a patient started treatment, including detoxification, and buprenorphine treatment was initiated if the patient was not motivated or was incapable of any other kind of treatment. Concurrent use was monitored at least twice a month by drug screening and by searching for injection marks.

³⁵ The report evaluated the current state and development needs of detoxification treatment in Southern Savonia and North Karelia.

psychosocial rehabilitation³⁶ (Harju-Koskelin 2006). The biggest challenge in the psychosocial rehabilitation of patients in substitution treatment was employment, as 80% of the clients were long-term unemployed. Some of them were also in debt or were involved in criminal activity. Many clients had still not completely left the criminal lifestyle behind them, and 40% of those interviewed had committed offences³⁷ during the treatment period.

Weckroth (2006) has studied the mechanisms of the use of power in a drug treatment unit that provides substitution treatment. According to the researcher, the clients' marginal status in society is emphasised when the typical classification of "drug users' world" and "normal people's world" is linked with the use of power in a treatment institution.

³⁶ The study was conducted through bi-annual interviews with clients who had received substitution treatment in substitution treatment units in the Greater Helsinki area from six months to a year. Data was also gathered through questionnaires. Sixty clients in opiate substitution treatment participated in the study.

³⁷ When subjects were asked about criminal activity, drug-user offences were excluded from the data.

6 Health correlates and consequences

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

Drug-related psychiatric co-morbidity has increased fourfold since the beginning of the 1990s. The treatment of co-occurring drug and mental problems is carried out in practice within substance abuse services. Substance abuse services still have insufficient resources for treating substance abusers who also suffer from severe mental health problems. These so-called dual diagnosis patients are often excluded from psychiatric services due to their substance abuse problem. The prevention of other drug-related health consequences, such as deaths and accidents, has been included for example in traffic safety campaigns.

Buprenorphine abuse has increased substantially in Finland in the 21st century. Buprenorphine is also becoming the most common finding in drug-related deaths by poisoning.

6.1. Drug-related deaths and mortality of drug users

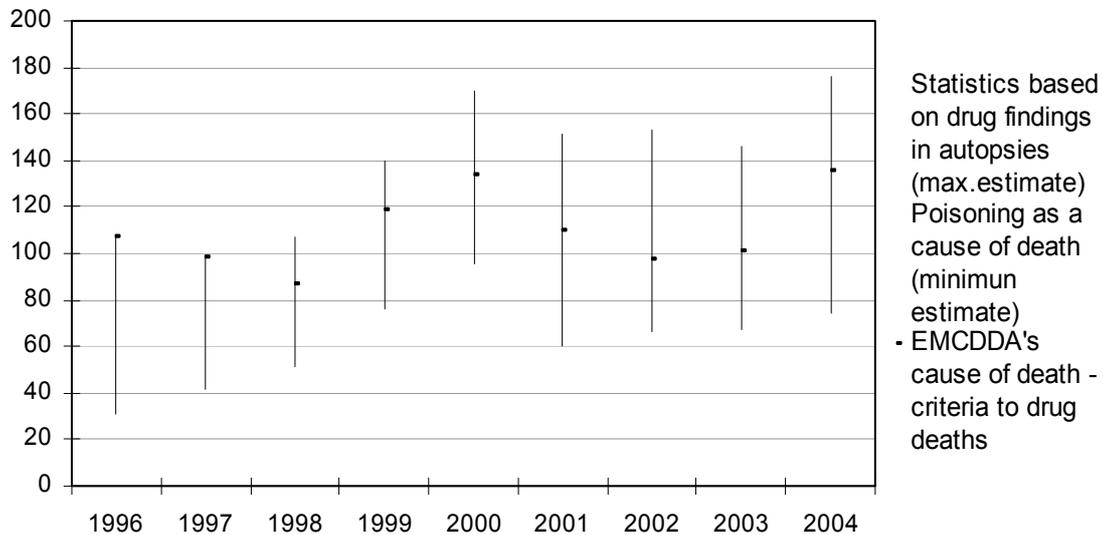
Drug-related deaths can be examined based on cause of death³⁸ and chemical findings. According to information on forensic chemical findings, there were 174 (176 in 2004) drug-related deaths in Finland in 2005. Opiates were found in 36 (35) cases. Buprenorphine, which has become an increasingly common opiate finding, is not detectable in the opiate screening test, but it was found in 83 (73) cases. Amphetamine was found in 65 (51) cases and cannabis in 71 (80) cases. The number of heroin deaths continues to remain low, with 4 cases in 2003 and no cases in 2004–2005. Two people died of cocaine poisoning in 2005. Thirty-nine percent of the victims of drug-related deaths were under 30 years old. (Department of Forensic Medicine 2006.)

The victims of buprenorphine-related deaths have been mainly young people. In 2002, two thirds of the victims were under 25 years old, and in 2003–2004 one third belonged to this age group. Typically, young people who have died of buprenorphine poisoning have first consumed alcohol and/or benzodiazepines and have then injected buprenorphine and gone to sleep or passed out without ever waking up again. (Vuori et al. 2006.)

Drug-related deaths (Figure 3) follow fairly consistently the trends in drug use, especially the trends in the use of injected drugs. Quick changes in the methods of use (intravenous use gains popularity, heroin disappears from the market) or new substances that enter the market can affect the number of deaths by poisoning fairly quickly.

³⁸ The figures for drug-related deaths in 2005 had not been published by the time this report was compiled.

Figure 3. Drug-related deaths according to different criteria 1995–2004



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

6.2 Drug-related infectious diseases

HIV

According to the HIV infection statistics maintained by the National Public Health Institute, there were 138 HIV infections in 2005 (128 cases in 2004). The number of infections contracted through intravenous drug use accounted for 11% of cases where the means of transmission was reported, showing a slight increase over the previous year (7% in 2004). According to the data for the drug treatment information system in 2005, of those who had used drugs intravenously and had taken an HIV test and received their test results (n=3,850) two per cent were HIV positive as reported by the clients themselves. (Kuussaari & Salonen 2006.)³⁹

The number of drug users with chronic HIV viremia in Finland has been estimated at 250–300. HIV infection causes chronic viremia in almost all cases. The number of HIV cases related to the HIV epidemic that began at the end of the 1990s has so far remained below 250 in the Greater Helsinki area, and the prevalence of these cases in the area is also low (under 5%) among drug users. (Ristola 2006.)

Hepatitis C

In 2005, a total of 1,236 hepatitis C cases were diagnosed (1,267 in 2004). In approximately 60% of these cases, the means of transmission was reported and of

³⁹ Some 70% of drug treatment clients had been tested for HIV and hepatitis B and C. More than half of the clients had been tested for hepatitis A. Results on virus tests are somewhat uncertain, as much of the data on the virus test questions was insufficient; for example, for 28% of the clients there was no data on hepatitis C tests. (Kuussaari & Salonen 2006.)

these cases, four fifths were contracted through intravenous drug use (National Public Health Institute 2006). According to the data for the drug treatment information system in 2005, of those who had used drugs intravenously and had been tested for hepatitis C and received their test results (n=4,056) 66 per cent had hepatitis C as reported by the clients themselves (Kuussaari & Salonen 2006). The study on the mobile health counselling unit reported that none of the under 20-year-old clients of the unit had hepatitis C, as far as they knew, whereas one third of 20–24-year-olds had hepatitis C as did three fourths of 35–39-year-olds (Törmä & Huotari 2005a). According the assessment of Ristola (2006), there are more than 15,000 drug users with chronic hepatitis C viremia in Finland.

Hepatitis C has been most prevalent within the Hospital District of Helsinki and Uusimaa (HUS). In 2004, the number of hepatitis C cases within the HUS district had declined by 48% when compared to the number in 1997. It seems that the decline is partly due to the introduction of health counselling because from 1997 to 2004, both the number of clients and the number of syringes and needles exchanged multiplied at health counselling centres. Pharmacies also have an important role in ensuring the availability of clean needles and syringes.

In Finland, hepatitis C started to spread on a larger scale in the 1990s. However, its health consequences and burden to the health care system will not be fully revealed until after 2010, as it takes years for cirrhosis of the liver due to hepatitis C to develop (Ristola 2006). The results of the treatment for hepatitis C have improved over the past few years and in most cases, a lasting treatment result can be achieved (Färkkilä 2005). According to pharmaceutical consumption statistics, a couple of hundred patients receive treatment for hepatitis C each year in Finland and according to Ristola (2006), a health economic analysis should be conducted on whether the treatments should be available for more people with hepatitis C.

Hepatitis B

The number of acute hepatitis B cases recorded in the infectious diseases register has shown a significant decline in the past decade. In 2005, 32 cases were reported (National Public Health Institute 2006). The means of transmission was reported in half of the hepatitis B cases, and infections contracted through intravenous drug use had decreased the most (3 cases in 2005). The number of drug users with chronic hepatitis B viremia in Finland is estimated at 300–500 (Ristola 2006).

The decline in the number of hepatitis B cases is partly due to the vaccinations provided for intravenous drug users at health counselling centres and an effective needle and syringe exchange programme (e.g. Leino 2005). According to the data for the drug treatment information system in 2005, two thirds of those who had injected drugs sometime in their life had received at least one shot against hepatitis B (Kuussaari & Salonen 2006). According to the study on the mobile health counselling unit, out of all age groups, 20–24-year-olds had received the most vaccinations against hepatitis B (85%). On average, half the follow-up clients had been vaccinated. (Törmä & Huotari 2005a).

Hepatitis A

According to the infectious diseases register maintained by the National Public Health Institute there were 26 hepatitis A cases in Finland in 2005. Sixteen of the cases were contracted abroad and 6 in Finland. In four cases, the means of transmission was not reported.

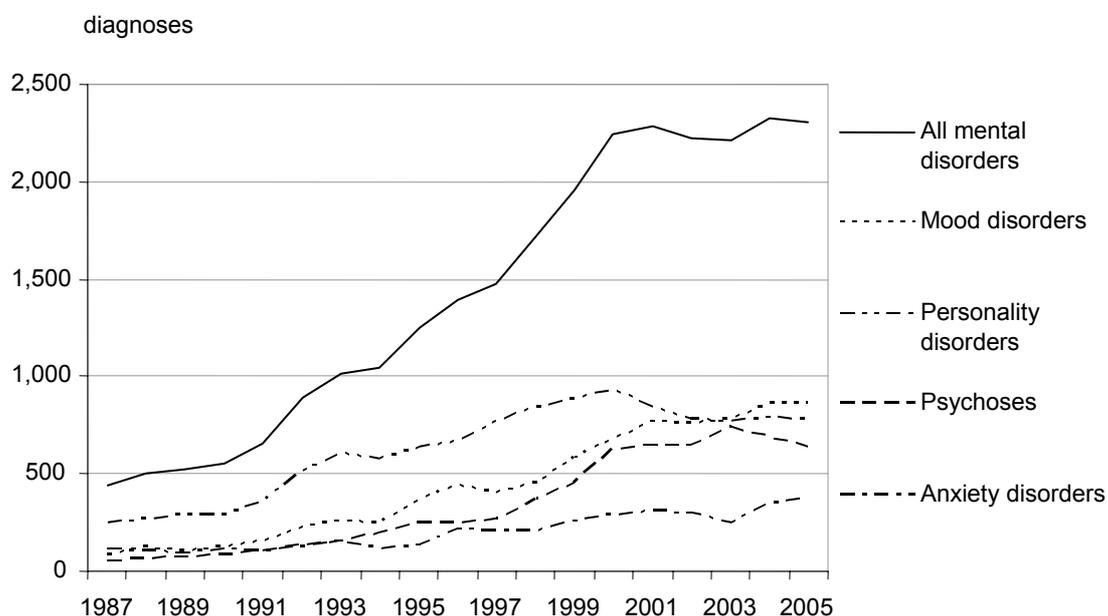
The year 2004 showed a downward turn in the hepatitis A epidemic that had started among intravenous drug users in the Greater Helsinki area and had caused a rapid rise in new infections (393 cases were diagnosed in 2002 and 243 in 2003). Since the beginning of 2005, the hepatitis A vaccination has been included in the national vaccination programme for intravenous drug users.

6.3 Psychiatric co-morbidity (dual diagnosis)

Co-occurring mental health problems are clearly prevalent among the most disadvantaged problem drug users who are partly excluded from treatment services. According to a study on the clients at the Stoori day centre in Helsinki, 30 per cent of drug treatment clients had had psychotic symptoms related to substance abuse, 15 per cent had also had psychotic symptoms at other times and 10 per cent suffered from chronic depression. All young clients suffered from depression, and many older clients were clearly dual diagnosis patients, but none had received psychiatric treatment. (Törmä & Huotari 2005a.)

Figure 4 shows the number of mental disorder diagnoses co-occurring with drug diagnoses. The number of all psychiatric disorder diagnoses grew throughout the 1990s, but the trend has levelled off in the 2000s.

Figure 4. Mental disorder diagnoses co-occurring with drug diagnoses in 1987–2005 according to the hospital patient discharge register.



Source: Hospital patient discharge register, STAKES

6.4 Other drug-related health correlates and consequences⁴⁰

Ellermaa, Turtiainen and Seppälä (2005) studied the occurrence of alcohol and other intoxicants in blood samples analysed by the National Institute of Public Health one year before and one year after the legislation on zero tolerance⁴¹ came into effect. The study also dealt with the prevalence of the combined use of intoxicants as well as the connection of laboratory findings to the reason a driver was caught. In addition, the study evaluated the effect of the law on zero tolerance on the number of analysis requests by the police and on drivers' substance use in traffic. The material for the study consisted of cases where the police had suspected a driver of intoxication, stopped him or her, and after assessing the situation requested that the driver be tested for alcohol and other intoxicants.⁴²

The most common finding in the study was alcohol (in 72% of cases in 2002 and in 66% in 2003). Pharmaceuticals in the benzodiazepine group were found almost as often. The third most common finding was drugs in the amphetamine group, and amphetamine was the most common actual drug. In 2002, 15% of the drivers in the study had used amphetamine alone or combined with other intoxicants compared to 22% in 2003. Two thirds of those tested had used substances from at least two substance groups. The most common combination was alcohol and a pharmaceutical in the benzodiazepine group (44% in 2002 and 37% in 2003). The next most common case was combined use of amphetamines and benzodiazepines (11% of cases in 2002 and 16% in 2003). The material for the study was selected according to specific criteria, so the results cannot be directly generalised to all cases of driving while intoxicated. Of the drivers in the study, 3.6% tested negative for both alcohol and drugs in 2002, and 5.2% tested negative in 2003. Men accounted for 90% of the material. (Ellermaa et al. 2005.)

⁴⁰ See also Section 14 'Drugs and driving'.

⁴¹ In February 2003, the regulations regarding driving while intoxicated were amended in Finland with regards to drugs by the introduction of the so-called law on zero tolerance. The law stipulates that a motor vehicle driver may be sentenced for driving while intoxicated if his or her blood contains a narcotic substance or its metabolic derivative during or after driving, without the prosecutor having to prove otherwise that the condition of the driver was impaired.

⁴² A total of 2,375 cases that met the conditions set for the material arrived to the National Public Health Institute during the two-year follow-up period. The number of samples grew by 32% during the latter follow-up year when compared to the year preceding the law on zero tolerance (1,024 samples in 2002 and 1,351 samples in 2003). The period preceding the law on zero tolerance (1 February 2002–31 January 2003) is indicated here by 2002 and the period following the legislation (1 February 2003–31 January 2004) is indicated by 2003.

7 Responses to health correlates and consequences

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

Low-threshold services in particular have been essential in preventing and reducing infectious diseases spread by intravenous drug use. Drug users can exchange used syringes and needles for clean ones at health counselling centres. An essential part of the operation is health counselling on drug-related communicable diseases and other serious risks related to drug use, such as overdoses and sexually transmitted infections. Health counselling centre services are free of charge for clients and the clients can visit the centres anonymously. Pharmacies have an important role in exchanging syringes and needles in areas where there are no health counselling centres. Since 2004, health centres have had a new responsibility of preventing infectious diseases, including health counselling for drug users and, if needed, the exchange of syringes and needles. Free hepatitis A and B vaccinations have been included in the vaccination programme for intravenous drug users.

Some training concerning drug-related deaths is provided as part of the basic training in social welfare and health care – in emergency care training, for example. Prevention of drug-related deaths is also carried out as part of health counselling related to infectious diseases and in problem user peer group activities. The issue is also dealt with in drug treatment units, when necessary.

7.1 Prevention of drug-related deaths

No special projects to prevent drug-related deaths are currently underway. Some training concerning drug-related deaths is provided as part of the basic training in social welfare and health care – in emergency care training, for example. Prevention of drug-related deaths is also carried out as part of health counselling related to infectious diseases and in problem user peer group activities. The issue is also dealt with in drug treatment units, when necessary.

7.2 Prevention and treatment of drug-related infectious diseases

At the beginning of 2005, the National Public Health Institute in Finland recommended a new vaccination programme. For the first time, the hepatitis A vaccination was included in the general vaccination programme. This decision was made based on the hepatitis A epidemics of the past few years among intravenous drug users and their circle of acquaintances. Isolated cases where the hepatitis A infection had been contracted abroad have not caused epidemics and therefore, the only target groups for the hepatitis A vaccination sited in the general vaccination programme are intravenous drug users and their contacts as well as patients with haemophilia. (National Public Health Institute 2005.)

The vaccination programme also recommends the hepatitis B vaccination for specific risk groups, including intravenous drug users, their sex partners and people living in

the same household. It is deemed especially important that the newborn babies of parents who use drugs intravenously are vaccinated. The means to reduce hepatitis C infections among drug users are to reduce intravenous drug use or to reduce risk behaviour related to intravenous drug use. Infectious diseases related to drug use are usually contracted by problem drug users. Thus, according to Ristola (2005), Finland cannot in the coming years afford to cut down operations that aim to prevent infectious diseases related to drug use.

In 2005 there were health counselling centres that exchange needles and syringes in 32 localities, mainly in cities with over 50,000 inhabitants. The centres also provide counselling on health issues, small-scale health care, testing and vaccination services and case management. The number of clients in health counselling centres (11,700) increased from the previous year (10,400), even though the number of visits (80,300) dropped (83,700 in 2004). The number of syringes and needles exchanged (1,845,000) grew by some 5% over the previous year (1,760,000 in 2004). (Heino 2006.)

The interaction and discussion between personnel and clients at health counselling centres were examined based on a one-day census in November 2004. A questionnaire was sent to each health counselling centre requesting the personnel to analyse the discussions they had during client contacts. The questionnaire was sent to 21 units, and 15 of them responded. The conversations during the contacts lasted on average 5–10 minutes. The examination of the discussion themes did not include the exchange of the clients' needles and syringes for new ones at the centres. Of the main topics discussed, 18% concerned infectious diseases, 11% concerned sexual health, 33% concerned drug treatment (substitution treatment, intoxicant-free wards of prisons, the Probation Service etc.), and 21% concerned intravenous drug use. Other topics were dental diseases, relationships, children, small talk etc. (Jokinen 2005.)

The mobile health counselling unit brings drug treatment services onto the streets and close to drug users. An evaluation made by Törmä and Huotari (2005a) revealed that according to the personnel, the unit's assets are that it brings services close to the customers and minimises disturbances to the surroundings. As the unit was only equipped to serve a limited number of clients at a time, queues built up, which the clients felt stigmatised them. As long as the number of customers was moderate at each stopping point, the customers did not have to deal much with each other or the subculture of drug users. Even though the choice in services was sufficient, the premises limited them and the services had to be provided in a hurry. (Törmä & Huotari 2005a.)

Only one per cent of the clients used the actual treatment or follow-up treatment services of the unit. The use of other services was scant also because a great deal of the visits took place outside office hours. However, the personnel estimated that the majority of the clients already use treatment services, but the clients also included occasional drug users. Thus, it is assumed that the mobile service unit does not reach the most excluded clients. Instead, it reached young clients who were in the early stages of drug use. Many clients were used to handling their affairs at permanent health counselling centres, and to them the mobile unit was only a supplementary service. Suggestions to improve the services included making the mobile service less noticeable, increasing co-operation with health counselling and other services and targeting the services more accurately to fill service vacuums – possibly even employees going out onto the streets to work with users. (Törmä & Huotari 2005a.)

It is estimated that a couple of hundred Russian-speaking drug users who are at a high risk of infectious disease live in Finland. This risk is increased by intravenous drug use, ignorance of existing services, language problems, ignorance of Finnish privacy policy and fears of being deported. The problems are most prevalent in Helsinki, where the majority of Russian-speaking immigrants live. Drug problems among immigrants are connected to the busiest years of remigration at the turn of the 21st century and the problems and crises that the then teenage (13–15-year-old) immigrants, the so-called second-generation immigrants, have had with immigration and integration into society. Drug use by these young Russian-speaking people can also be seen as part of the change in Finnish alcohol and drug culture. A significant factor for the immigrants was that in the 1990s, the service system in the Greater Helsinki area was not prepared to meet the needs of Russian immigrants and it was particularly not prepared to support adolescents. (Puro 2005a.)

A special drug prevention project directed at Russian-speaking immigrants was launched in autumn 2002. Within the project, the so-called snowball operation based on peer work was implemented among drug users in Helsinki. Substance abuse workers trained intravenous drug users to recognise the risks of infectious diseases as a result of intravenous drug use and to tell other drug users how to prevent those risks. The project specifically aimed at taking the immigrants' language and cultural differences into consideration. The Helsinki-based Russian language snowball project trained 11 drug users who helped to reach 28 Russian-speaking and 81 bilingual or Finnish-speaking drug users. The snowball operation was able to contact ninety per cent of them for the first time. A similar project was carried out in Russia, and the results revealed the need for and possibilities of peer work among drug addicts in St. Petersburg. Another aim was to reach out to HIV positive drug addicts in the Tallinn area, Lithuania and prisons in Estonia, and to offer them assistance. The future challenges for this type of neighbouring area projects are to define a common value base for drug treatment and to develop the co-ordination of substance abuse prevention, solutions for securing resources, networking and project work. (Puro 2005; Puro & Tuori 2006.)

7.3 Interventions related to psychiatric co-morbidity

Drug-related mental problems are common according to all drug treatment studies (e.g. Vormaa & Kuoppasalmi 2005, Törmä & Huotari 2005a, 2005b). Polydrug use and especially the use of benzodiazepines with drugs usually indicate the existence of a co-occurring mental disorder. However, dual diagnosis patients rarely respond well to treatment even if they are treated in line with appropriate clinical guidelines (Turtiainen & Kuoppasalmi 2005).

7.4 Interventions related to other health correlates and consequences

The September 2004 amendment to the Road Traffic Act stipulated that a physician has a duty to report to the police authority, without being bound by professional secrecy, if there have been permanent changes in a patient's health that have rendered him or her unfit to drive. The only information the physician is allowed to report to the police is that the health requirements for a driving licence are not met. Any related additional measures may also be reported.

The application guidelines for the duty to report define strict criteria that have to be met before the physician can report a patient unfit to drive due to substance abuse. The

medical certificate may not be sent to the police authority without the patient's consent unless these strict criteria are met. The application guidelines emphasise that the decision usually requires additional tests and that the assessment should be made separately for each individual and taking into consideration the type of their driving license. According to the guidelines, the criteria for the duty to report are met when substance abuse has caused permanent changes in the patient's health, thus affecting his or her abilities to function, perceive, judge and react. The criteria for the duty to report are also met if neuropsychological tests show that substance abuse has clearly weakened the patient's functional ability or if the patient's behaviour has, due to severe addiction or substance abuse, changed permanently, an example of this being that he or she repeatedly drives under the influence. (Seppä 2005.)

A pivotal question in assessing a substance abuse patient's fitness to drive is whether the substance abuse disorder can be diagnosed as a permanent condition. There is no simple test for the assessment of a substance abuse patient's fitness to drive, and the assessment is particularly difficult when the patient has a dual diagnosis. Especially those in opiate substitution treatment often have other co-occurring psychiatric disorders. Another difficult group of patients is those who repeatedly seek treatment within emergency services without committing to long-term treatment: a physician is not entitled to report patients to the police authority based on isolated encounters. Even though the decisions concerning driving fitness have to be made on a case-by-case basis, some guidelines are needed that could be applied to drug-addicted patients in substitution treatment and in other long-term rehabilitation programmes. (Seppä 2005.)

8 Social correlates and consequences

The 2005 drug treatment information system revealed the same facts as do many other studies on problem drug users' risk behaviour, substitution treatment and HIV infections: problem drug users are a socially marginalised group. In 2005, 62 per cent of drug treatment clients were unemployed and 12 per cent were homeless. Sixty-seven per cent of the clients had primary level education only and six per cent had dropped out of primary education (Kuussaari & Salonen 2006). As drug use is punishable under criminal law, many clients are also in a vicious cycle of crime and prison.

There was no big change in the number of drug offences. In 2005, 15,209 drug offences were reported by the police (14,425 reports of an offence, see Table 6). Of these, 61% (9,285) were drug-user offences, 4% aggravated drug offences and 35% other drug offences. The number of drug offences dropped by 0.8% when compared with the previous year. (National Bureau of Investigation 2006.)

Table 6. Drug offences reported by the police and Customs in 1999–2005

	1999	2000	2001	2002	2003	2004	2005
Drug offences in total	11,647	13,445	14,869	13,857	15,058	14,486	14,425
Drug offence	10,701	12,687	12,092	5,821	5,202	4,672	4,589
Drug-user offence			1,899	7,240	9,084	9,217	9,248
Aggravated drug offence	958	741	859	760	742	582	561
Preparation or abetment of drug offences	15	17	19	36	30	15	27

Source: Statistics Finland

In 2005, sixteen per cent of prisoners were sentenced to prison for drug offences (Probation Service & Prison Service 2006).

8.1 Social exclusion

Problem drug users are a socially marginalised group. Sixty-two per cent of drug treatment clients were unemployed, two thirds had primary level education only and six per cent had dropped out of primary education. Twelve per cent of the clients were homeless. About a fifth was married or cohabiting, half of these with a partner who also had substance abuse problems. One in three had children under the age of 18. Three fourths of the children did not live with their parents. (Kuussaari & Salonen 2006.)

According to a study on the clients at the Stoori day centre⁴³, about a third of the clients interviewed had used drugs occasionally, but 25% of the clients interviewed were classified as drug users according to their main substance. The data makes it possible to compare the life situation of the drug treatment clients of the day centre with other client groups classified by type: alcoholics, those who use alcohol and pharmaceuticals⁴⁴ and those who use substitutes. The drug treatment clients at Stoori are characterised by social marginalisation and the need to become intoxicated. They use drugs almost daily, and polydrug use is more common among them compared with other clients and they have mental health problems more often than other groups. Even though drug-using clients are typically ten years younger than other client groups at Stoori, they are still clearly older than clients in other substance abuse units and health counselling centres. The drug-using clients at Stoori can be divided into major users of treatment services and those excluded from treatment services. A large part of drug users use social and health services frequently, but the day centre also reaches drug users who are excluded from treatment services. (Törmä & Huotari 2005b.)

Of the Stoori clients, users of drugs and substitutes are more often homeless than alcoholics are. The drug users' main source of income is unemployment benefit, and they also receive income support more often than other groups. A third of the drug users said that they also make an income by committing crime; in other groups, crime was not reported as a source of income. Drug and substitute users suffer from hunger more often than other groups. Drug users and those who use alcohol and pharmaceuticals considered most often their health to be poor. (Törmä & Huotari 2005b.)

8.2 Drug-related crime

The number of drug offences recorded by the police started to level off at the turn of the century and this trend continues. In 2005, the number of drug offences reported by the police (15,209) dropped by 0.8% when compared with the previous year. Of all drug offences, the number of drug-user offences (9,285) and the number of aggravated drug offences (649) have remained almost stable when compared with the previous year. The proportion of drug-user offences is 61%, the proportion of aggravated drug offences is 4% and the proportion of other drug offences is 35%. In 2005, the number of people suspected of drug offences amounted to 4,515 and the number of people suspected of aggravated drug offences came to 415. (National Bureau of Investigation 2006.)

The number of robberies of pharmacies and other locations where intoxicating pharmaceuticals are stored (81) declined for the first time since the beginning of the 21st century to less than 100 cases. (National Bureau of Investigation 2006.)

According to the studies on juvenile offenders conducted by the National Research Institute of Legal Policy, the proportion of 15–16-year-old boys and girls who have used or tried marijuana or hashish sometime in their life (i.e. have committed a drug-user offence) doubled from five to almost ten per cent between 1995 and 2001. The situation did not change between 2001 and 2004⁴⁵. Eight per cent of both boys and

⁴³ Eighty-one clients at the day centre were interviewed for the study.

⁴⁴ Clients who regularly use pharmaceuticals in addition to daily alcohol use.

⁴⁵ The survey was carried out in spring 2004. The respondents were 5,142 ninth graders in secondary school. The young people in this main sample represent Finnish-speaking educational establishments maintained by municipalities. Based on methodology study, this limitation does not prevent the generalisation of results into the target population. (Kivivuori 2005)

girls had used marijuana or hashish during the past year, and the proportion of those who had used these substances at least five times within a year came to 2.1%. Seven point two per cent of those who had used marijuana or hashish during the past year had financed their use illegally. More than half of these young people had acquired money by selling drugs, the rest mainly by stealing. Only 0.6 per cent of young people had tried marijuana or hashish during the past year and financed it by illegal means. Of the girls, 1.9 per cent and of the boys, 1.6 per cent had used another drug, usually LSD or ecstasy. (Kivivuori 2005.)

The differences between the criminal behaviour of Finnish and Swedish-speaking young people were examined in a separate study by extending the sample to cover Swedish-speaking pupils⁴⁶. The use of marijuana or hashish is 2.8 percentage units more common among Finnish-speaking boys and girls. Between the two language groups, there are no differences in the use of other drugs or in financing drug use by illegal means. There are also no differences in the prevalence of pharmaceutical abuse, but Finnish-speaking pupils explained their pharmaceutical abuse more often by the willingness to try them or have fun whereas among Swedish-speaking pupils, the pharmaceutical abuse was more often related to depression or willingness to forget unpleasant things. The study strengthens the image of Swedish-speaking Finns as a positively deviating minority⁴⁷, and the smaller amount of criminal activity among Swedish-speaking Finns has been explained by the fact that they belong to a minority group. (Obstbaum 2006.)

In 2005, two per cent of assaults were committed under the influence of drugs and 66 per cent under the influence of alcohol. The proportion of violent offences committed under the influence of drugs⁴⁸ has grown since the 1990s, especially robbery offences. A tenth of detected robberies and a sixth of aggravated robberies in 2005 were committed under the influence of drugs. Despite this, the presence of alcohol in robbery offences is still much more common (45%) than that of drugs. (Lehti & Sirén 2006.)

Drugs were found in 8 per cent and polydrug use in 3 per cent of all cases of driving while intoxicated in 2005. Their proportions have not grown since last year. The cases of driving while intoxicated are divided into cases of driving while intoxicated and cases of driving while seriously intoxicated. In the cases of driving while intoxicated, the proportion of drug and polydrug use is 20 per cent and in the cases of driving while seriously intoxicated only 5 per cent (Niemi 2006). The most common drugs found in the cases of driving while intoxicated were amphetamine and cannabis (see also Section 14).

8.3 Drug use in prison

In 2005⁴⁹, 16.1% of prison inmates were incarcerated for a drug offence; the corresponding figure in the previous year was 17.9%. Eight hundred and four (825) drug findings were verified in the 17,632 (15,360) tests for drugs and pharmaceuticals conducted in prisons in 2005. The most common findings were benzodiazepine, cannabis, buprenorphine and amphetamine. Medical use accounted for about a third of the findings. During the year, 40 (49) patients entered prison whose opiate

⁴⁶ 5,142 Finnish-speaking pupils and 1,137 Swedish-speaking pupils.

⁴⁷ According to the population register, 5.5 per cent of Finns spoke Swedish as their first language in 2004.

⁴⁸ Here, persons under the influence of drugs include those under the influence of drugs or pharmaceuticals and those under the influence of both drugs and alcohol.

⁴⁹ The census is conducted on 1 May.

treatment continued in prison. A total of 1,073 (1,170) HIV tests were conducted, which revealed two new HIV infections, i.e. only 0.19% of those tested. (Probation Service & Prison Service 2006.)

Those sentenced to more than two years' imprisonment are first placed in the assessment and placement unit within their own municipality, where a personal risk and service need assessment is made. The Criminal Sanctions Agency recorded the risk and service need assessments of 1,731 prisoners between 2002 and June 2005⁵⁰. According to the interviews conducted for the risk and service need assessments, 60 per cent of the inmates had used drugs sometime in their life, 33.4 per cent had never used drugs and there was no data on drug use for 6.6 per cent of the inmates. About 32 per cent of the inmates said that their drug use was related to criminal activities, but there was no data on this connection for 37 per cent of the inmates. (Criminal Sanctions Agency 2006.)

⁵⁰ As risk and service need assessments are only made for those sentenced to more than two years' imprisonment, the results cannot be generalised for short-term prisoners, who use drugs considerably more than long-term prisoners.

9 Responses to social correlates and consequences

Multi-professional co-operation between authorities has been emphasised in after-care adjustment activities. This includes social rehabilitation, employment and supported housing services. Education authorities are often involved in the care of young problem users. The planning of education and vocational guidance are automatically included in the treatment of young people. However, the educational system does not include much training leading to a normal working career that would be adapted to the problem user's abilities. In addition, not enough employers employ these young people. One example of employment activities is youth workshops. In Finland, financially supported housing for substance abusers can be arranged within municipal social services. Housing service units for substance abusers are part of the Finnish substance abuse services. They are meant for substance abusers that need daily support for independent living.

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

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

Prison health care provides inmates with information on the effects of intoxicants, health risks related to substance abuse and treatment programmes available in prison as well as outside prison after release. Withdrawal symptoms that accompany quitting substance use are usually treated in prison in line with the instructions given by the prison physician. If a prisoner suffers from severe withdrawal symptoms, he or she can be placed in a prison hospital or hospital care outside prison. It is also possible to provide detoxification, substitution and maintenance treatment with opioid medication in prisons. (Probation Service & Prison Service 2006.)

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

Those sentenced to over two years' imprisonment are first placed in the assessment and placement unit within their own municipality, where a personal risk and service need assessment is made. The risk and service need assessment considers the

factors related to the prisoner's life situation and personality that sustain criminal behaviour. Special attention is paid to prisoners' substance use. Based on the assessment, a preliminary plan for the term of sentence is drawn up in the assessment and placement unit, and the plan is specified and updated in placement institutions. The aim is to enable systematic use of the sentence term to improve the prisoner's capability to cope after release without committing crimes. (Probation Service & Prison Service 2006.)

Important hindrances to anchoring persons released from prison into society and implementing personalised rehabilitation are the inmates' poor health, short sentences and their excessive number in relation to places in prison institutions⁵¹. Released prisoners are easily excluded from primary services due to lack of resources as well as prejudice: municipalities do not believe in their ability to recover and some services do not even want to acknowledge these people as valid clients. Various organisations offer services that enable a released prisoner to get support for different problems under the same roof, but this type of activity is hampered by the short-term nature and insecurity of municipal and State funding. (Rantala 2005.)

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

9.1 Social reintegration

The "Kynnykset pois" (*No thresholds*) project (2003–2005) conducted by the Deaconess Institute in Helsinki aims at creating a service model that enables access from low-threshold services to high-threshold treatment services. According to a study⁵², it is difficult for clients to commit to treatment because in order to enter treatment, they should be able to phone for an appointment and arrive on time for that appointment. The project workers have helped the clients by reminding them of their appointments and when needed, by taking them for treatment. Clients who do not arrive on time for their appointment may be dropped from the waiting list, and they have to start all over again. The project workers have tried to influence the treatment units to become more flexible in the case of some clients. In order to be admitted to a treatment unit a client must have high motivation to quit drugs, which can be too demanding for those clients who are in poor physical condition and socially excluded. (Törmä and Huotari 2005.)

In 2003–2005, the Ministry of Social Affairs and Health and the Ministry of Education co-ordinated a national project to develop substance abuse prevention at youth workshops. The method developed by the project for the workshops was communal

⁵¹ The material consists of public documents from the "Co-operation for crime-free life" project, the results of the network training workshops organised by the Criminal Sanctions Agency in Tampere, interviews with specialists, authorities and the third sector (25) and the accounts of two persons with a criminal background undergoing rehabilitation. (Rantala 2004b.)

⁵² The material consisted of client data from 12 drug users with multiple problems and interviews with 81 clients and 4 workers.

training. The aim of communal training is that the workshops develop communal operating models for preventing and dealing with substance abuse problems. Communal training helped with clarifying the workshop rules for substance use, developing activities and committing workshop participants to the activities. Communal training also increased communal responsibility and solidarity and lowered the threshold for intervention. (Ministry of Social Affairs and Health 2006.)

9.2 Prevention of drug-related crime

Assistance to drug users in prison

The most common rehabilitative activity in prisons is substance abuse rehabilitation. A total of 2,303 (1,990) prisoners participated in substance abuse rehabilitation. Brief group meetings that provide information on various substance abuse themes are arranged in prisons; a total of 1,316 prisoners participated in them. A total of 987 (848) prisoners participated in actual rehabilitation programmes, and 258 prisoners participated in a community treatment programme. Thirty-four (50) prisoners were placed in a substance abuse treatment or rehabilitation unit outside prison. Municipalities partly funded the substance abuse treatment outside prison. Some prisoners continued rehabilitation in an institution after release with a guarantee of payment from their own municipality. Of the prisoners, seventeen (14) were placed in the Silta-Valmennusyhdistys association for rehabilitation. (Probation Service & Prison Service 2006.)

A total of 1,316 (708) risk and service need assessments and related plans for the sentence term were made in 2005. The goal was to draw up a plan for all inmates who had been sentenced to more than two years' imprisonment. The plan was made for 95% of them. It is assumed that the need for rehabilitation is even greater among short-term prisoners. (Probation Service & Prison Service 2006.)

Somewhat more drugs were confiscated from prison inmates in 2005 than in the previous year. The amount of cannabis, amphetamine and heroin confiscated during the year amounted to 757 (592) grams. Because of stricter control (e.g. drug detector dogs) and the growing number of intoxicant-free wards and intoxicant tests conducted in them, the amount and use of intoxicants in prisons have remained constant and even declined in the long term. These factors have increased the risk of being caught. (Probation Service & Prison Service 2006.)

During the year, prisons took in 40 (49) inmates whose opiate treatment was continued in prison. Physicians have decided on guidelines that clearly aim at minimising the use of addictive pharmaceuticals (central nervous system pharmaceuticals) in substance abuse treatment. These guidelines have been taken into consideration in the basic selection of Prison Service pharmaceuticals. (Probation Service & Prison Service 2006.)

Alternative sanctions

The Prosecutor General's instructions for prosecutors in autumn 2002 (VKS 2002:3) recommend that prosecutors arrange a hearing for 15–17-year-olds who have been arrested for committing a drug-user offence for the first time. The young offender, his or her guardian, a representative of the social welfare authorities and the police participate in the hearing. In the hearing, the young offender is told about the criminal and reprehensible nature of drug use as comprehensively as possible, the offender's

life situation is examined and appropriate further measures are decided. After the hearing, the prosecutor can decide to waive charges.

A recent study (Kainulainen 2006a) examined the changes in the practices of waiving charges. The data on the decisions to waive charges for 2001–2003 included 243 cases in which a hearing was arranged for the offender whose charges were waived. This accounts for 18 per cent of all decisions. The young person was usually guilty of trying a mild drug or other minor drug use. Eighty per cent of the cases were boys and 20 per cent were girls. (Kainulainen 2006a.)

According to information for 2005 from the Office of the Prosecutor General (two prosecutor surveys between 1 January 2005 and 10 March 2006), the hearing procedure was used some 120 times annually and after the hearing, the prosecutor almost always decided to waive charges (Office of the Prosecutor General 2006).

According to a separate study on hearings⁵³ (Rönkä 2006), the authorities use different discourses when talking to young people about drugs. They talk about the health and social consequences of drug use, its immoral and illegal nature and the way in which drug use hinders young people from integrating into society. The young offenders themselves talk very little in the hearings. They mainly respond briefly to the prosecutor's questions or agree with the authorities' comments. Social workers also did not speak much in the examined hearings, and drug education was mainly provided by the prosecutor and the police. The drug education on health and social consequences given by the authorities was one-dimensional. The study did not deal with the effectiveness of hearings. (Rönkä 2006.)

The Prosecutor General's instructions for prosecutors (VKS 2002:3) encourage prosecutors to agree on appropriate treatment referral procedures in their own localities. Especially problem drug users should not be fined for a drug-user offence until the offender's willingness to seek treatment has been examined. According to a study on sanctions in drug offences (Kainulainen 2006a), some decisions to waive charges based on the person seeking treatment were made right after the introduction of the amendment to the Penal Code concerning drug-user offences. The data on the decisions to waive charges in 2001–2003 included 178 mentions about treatment; this corresponds to 13% of all decisions. Seventy per cent of the cases were men and 30 per cent were women. Treatment focussed on minors; almost half the cases were 15–17-year-olds. Those whose charges were waived were typically guilty of drug use or possession of drugs for personal consumption. Almost half the cases involved mild drugs. According to the most recent surveys conducted by the Office of the Prosecutor General, the number of cases involving treatment has shrunk almost to zero. (Kainulainen 2006a.)

According to the most recent information from the Office of the Prosecutor General (two prosecutor surveys between 1 January 2005 and 10 March 2006), only 34 decisions to waive charges based on the person seeking treatment were made during the survey period. As more than 7,000 drug-user offences were presented to the prosecutor during that period, the number of the decisions to waive charges can be considered small. However, according to the Office of the Prosecutor General, the decision to waive charges is made almost always if the offender seeks treatment, but there have been no suitable cases. Problem drug users arrested by the police are referred to treatment by the police or social welfare and health care authorities. (Office of the Prosecutor General.)

⁵³ The data consists of the observations on 12 hearings between October 2003 and May 2004. The hearings were held in Southern Finland.

10 Drug markets

The drugs on the Finnish market are mostly cannabis products, synthetic drugs such as amphetamines and ecstasy, the buprenorphine preparation Subutex® and benzodiazepines. Heroin and cocaine are still fairly rare in Finland. Among cannabis products, the number of marijuana and cannabis plant seizures has grown in the 21st century, which indicates that the fairly small-scale cultivation of drugs that are partly intended for sale has become more common. The number of seizures of synthetic drugs has remained fairly constant, except for the changes that are due to the phasing of the investigation of large complex crimes. The amount of seized heroin plummeted after 2001 and at the same time, seizures of Subutex® tablets started to increase. In 2005, however, Subutex® seizures both in border traffic and among users dropped considerably. (National Bureau of Investigation 2006.)

Table 7. Drugs recorded as seized by the police and Customs in 2000–2005 (kg)

	2000	2001	2002	2003	2004	2005
Hashish	196.5	566.6	482	423.1	467.4	430.6
Marijuana	13.8	13.7	32	45.3	25.8	43.4
Amphetamines	78.3	149.7	129.2	114.6	101.8	114.5
Cocaine	38.6	7.3	0.4	1.1	1.1	1.2
Khat*	348	624	1,039	1,879	2,118	2,562
Heroin	6.0	7.9	3.1	1.6	0.2	52.4
Subutex (tablets)	12,951	38,200	18,700	37,284	32,970	24,478
Ecstasy (tablets)	87,393	82,900	45,100	35,216	23,243	52,210
LSD (doses)	2,355	95	4,629	1,461	195	452

* = Khat differs from other drugs because its use has not been criminalised in all EU countries.

Source: National Bureau of Investigation

Table 8. Number of drug seizures recorded by the police and Customs in 1998–2004

	1998	1999	2000	2001	2002	2003	2004	2005
Hashish	1,997	2,259	2,482	4,011	3,012	2,796	2,626	2,408
Marijuana	382	463	663	1,223	1,275	1,712	2,067	2,305
Amphetamines	1,641	1,956	2,369	3,778	3,399	3,687	3,392	3,732
Cocaine	24	49	40	55	45	49	65	79
Heroin	210	342	437	558	145	90	45	58
Subutex	-	-	-	727	741	1,008	844	777
Ecstasy	57	159	393	465	329	316	328	363
LSD	-	15	34	14	10	20	21	17

Source: National Bureau of Investigation

The number of offers of drugs to individuals has remained constant or dropped somewhat during the 21st century. In drug supply in Finland, organised crime groups led from Estonia have had an important role – at the beginning of the 21st century especially in smuggling and importing drugs and later on also as collaborators of Finnish crime groups, supplying drug consignments for distribution. In recent years,

the role of Finnish crime groups in the distribution of drugs in Finland as well as in the acquisition of drugs from abroad has increased, but the Estonian collaborators of Finnish crime groups around Europe are still the main suppliers of drugs to Finland. (National Bureau of Investigation 2006)

10.1 Availability and supply of drugs

The import of drugs is an international crime and in recent years, 20–30% of those suspected of aggravated drug offences in Finland have been foreigners (28% in 2005). Among these, the largest groups in 2005 consisted of Estonians (32% of foreign suspects) and Russians (25%). (National Bureau of Investigation 2006.)

Organised crime groups led from Estonia play an important role in acquiring drugs from abroad and smuggling almost all drugs to Finland. The largest groups of foreign citizens suspected of aggravated drug offences were Estonians and Russians, whose proportion increased significantly from the end of the 1990s up to 85% of foreign suspects. However, since 2003, their share has clearly decreased to 57% of foreign suspects and 16% of all persons suspected of aggravated drug offences in 2005. (National Bureau of Investigation 2006.)

At the same time, the role of Finnish criminals in smuggling and trafficking drugs has strengthened. Finnish criminals also participate in the acquisition of drugs from abroad and distribute them in Finland. This has closed the ranks of Finnish professional crime, which is typically loosely structured, and made it more disciplined. Readiness to use violence within organised drug crime is evident in the growing number of guns and ammunition confiscated during drug crime investigation. Organised drug crime groups have also expanded their activities to economic crime, which is used as a means of financing drug crime. (National Bureau of Investigation 2006.)

The majority of drugs are smuggled onto the Finnish market through various routes from south and west. About 90% of the amphetamines on the Finnish market come from or via Estonia, whereas hashish comes from Morocco via Spain and either Scandinavia or the Baltic countries. Russia is a significant route especially for smuggling heroin. The amount of Subutex® seized decreased in 2005 but at the same time, the Customs made an exceptionally large heroin seizure on the Russian border which, together with other observations, indicates that an increase in heroin demand may lead to a growth in the supply and use of drugs in Finland. However, the amount of heroin seized from drug users continued to be small in 2006. (National Bureau of Investigation 2006.)

Since 1996, the annual Health Behaviour Survey among the Finnish Adult Population has asked people if they have been offered drugs during the past year. Among the entire population, the share of those who have been offered drugs has been quite small (5–7%). The results for 2005 showed that six per cent of the respondents were offered drugs for free or for sale during the past year. The number of drug offers increased in the youngest age groups until the turn of the century; since then, the figure has decreased from 25 per cent to 15 per cent among 15–24-year-old men. The number of drug offers made to young women in the Greater Helsinki area has not declined as much. Two thirds of all respondents said that they were offered drugs by friends or acquaintances, four fifths of whom offered drugs in their own or someone else's home. (Natunen et al. 2006.)

10.2 Drug seizures

There were no significant changes in drug seizures in 2005 (National Bureau of Investigation 2006, Kainulainen 2006). Hashish seizures dropped in kilograms (431 kg in 2005) and in number (2,408) from the previous year, but marijuana seizures grew in kilograms (43 kg) and in number (2,305), as did the number of cannabis plants seized (9,460 plants + 43 kg) and the number of seizures (1,633). (National Bureau of Investigation 2006.)

Amphetamine seizures (115 kg, 3,732 seizures) increased slightly. Ecstasy seizures grew considerably (52,210 tablets, 363 seizures) when compared with the previous year, but the total figures for the previous year were exceptionally low. There were no big changes in cocaine seizures (1.2 kg, 79 seizures). Khat seizures have grown throughout the 21st century. A total of 2,562 kg of khat was seized in 2005. (National Bureau of Investigation 2006.)

The amount of seized heroin plummeted at the beginning of the 21st century (2004: 0.2 kg). In summer 2005, the Finnish Customs made its largest heroin seizure ever (51.7 kg) on the Russian border from a camper van that was on its way to Sweden. This seizure essentially contributed to the total amount for the year (52.7 kg), and it supports the assessment that Russia's role as an international smuggling route of heroin is on the rise. (National Bureau of Investigation 2006.)

The amount of seized buprenorphine preparation Subutex® declined by a fourth (24,478 tablets, 777 seizures). The number of Subutex® tablets seized by the Customs declined by half from the previous year, and the number of tablets seized by the police, which grew considerably in the previous years, also took a downward swing. (National Bureau of Investigation 2006.)

An exceptional feature in the seizures by the Customs was large consignments; in addition to 325 kg of hashish and 51.7 kg of heroin, large quantities of other drugs were also found in one lot. According to the Customs' estimates, this indicates that attempts are being made to smuggle drugs in larger consignments than before. (Customs Laboratory 2005.)

10.3 Price and purity of drugs

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

The Crime Laboratory of the National Bureau of Investigation examined amphetamine seized in street trade (0.5–10 g) between September 2005 and March 2006. A total of 304 samples were analysed. The range of the purity of amphetamine was 0–99.1 per cent, the average purity being 24 per cent and the median value 23 per cent. The average purity has dropped significantly compared with the figures in 1993, when the average purity was 30 per cent and the median value 32 per cent. When examined by region, the purity of amphetamine was highest in the Greater Helsinki area and lowest in Eastern Finland. The size of the test sample was not related to its purity. (National Bureau of Investigation 2006.)

In 2005, the average price per gram in street trade was EUR 6–12 for hashish, EUR 60–120 for white heroin, EUR 15–25 for amphetamine, EUR 60–100 for cocaine and EUR 12–20 for ecstasy tablets. (National Bureau of Investigation 2006.)

11 Drug-related law enforcement activities

In the last few years, drug crime investigation has focused on the prevention, investigation and detection of professional organised drug crime. The central aim of drug-related criminal intelligence has been to uncover organised crime groups. Drug control in the street has been improved by increasing the number of police officers who are not experts in the demanding drug crime investigation.

To intensify the prevention of organised crime, the police, the Customs and the Border Guard have established joint crime intelligence units that aim to standardise working methods and produce up-to-date analysed information on crimes and criminals for the purposes of operational activities. Lately, more focus has been put on investigating laundering criminal proceeds through legitimate companies. In addition, a working group appointed by the Ministry of Justice has suggested the introduction of punishment by confinement for young people and an increase of authority for police officers engaged in undercover activity (prerequisites for anonymous testimony and complicity in an offence).

11.1 Drug control system

In the last few years, drug crime investigation has increasingly focused on the prevention, investigation and detection of professional organised drug crime. Combating drug supply has made it possible to constrain the operations of organised drug syndicates, and efforts have been made to prevent criminal activity targeting Finland by seizing drug shipments before they are smuggled to our country. International co-operation in the investigation of drug crime has increased strongly, which ties up many resources. The fluctuations in the number of aggravated drug offences can be explained by a few large-scale investigations that have extended investigation times but also increased the number of drug crimes solved. (Virtanen 2005)

However, the problem with large-scale, complex drug crimes and the related seizure-centred drug crime investigation is that less attention is paid to reducing drug demand. The increase in problem drug users and in the demand for drugs has led to growth in professional drug trafficking. Drug control in the street has been improved by increasing the number of police officers who are not experts in the demanding drug crime investigation. Efficient perpetrator-specific drug crime prevention targeted at drug users and sellers can also reduce other crime in the area and thus increase the sense of safety of the inhabitants. This requires, however, networking and co-operation of the police and other authorities. (Virtanen 2005.)

11.2 Criminal intelligence

To intensify the prevention of organised crime, the police, the Customs and the Border Guard (PTR co-operation) have established joint criminal intelligence units that aim to standardise working methods and to produce up-to-date analysed information on crimes and criminals for the purposes of operational activities. Activities started in 2004 with the establishment of regional PTR criminal intelligence groups in provinces and the national PTR Criminal Intelligence Centre of the National Bureau of Investigation. In addition, some border crossing points have local PTR

criminal intelligence units. Some 30 people work in PTR criminal intelligence, two thirds of whom are from the police and one third from Customs and the Border Guard. The National Bureau of Investigation is in charge of practical arrangements and national co-ordination. Based on initial experiences, PTR criminal intelligence has bolstered the investigation of organised crime and mass crime. (Border Guard 2005.)

11.3 Monitoring methods

In 2005, the interception of telecommunications targeted 562 (535 in 2004) persons suspected of offences. The courts granted 1,506 (2,028) authorisations for telecommunications interception. Telecommunications interception has had an important role especially in solving aggravated drug offences. In 2005, the number of persons whose telecommunications were monitored was 775 (1,025). The courts granted a total of 1,419 (1,822) authorisations for telecommunications monitoring. The number of telecommunications subscriptions that were intercepted or monitored has risen slightly because coercive measures related to telecommunications are increasingly targeted at other telecommunications addresses besides traditional phone numbers. In 2005, 60.5% (77% in 2004) of telecommunications interception targeted aggravated drug crime. The fall is mainly due to the fact that the use of telecommunications interception has expanded to other areas of crime. (Ministry of Interior 2006.)

Undercover operations and fictitious purchasing have been used mainly in investigating aggravated drug offences. In 2002, the decision to use undercover operations was made only in a few cases involving fewer than 10 suspects. In 2003, the number rose to target 30 suspects but in 2005, the use of undercover operations fell again. In 2002, the police decided to use fictitious purchases in 10 cases involving fewer than 20 suspects. In the following years, the number of decisions to use fictitious purchases and the number of suspects involved in fictitious purchases has declined. (Ministry of Interior 2006.)

The Money Laundering Clearing House of Finland received 3,661 reports of suspicious business transactions during 2005 (4,315 in 2004). A total of 385 reports (551) led to pre-trial investigations, and 12.5% (25% in 2004) of the cases related to drug offences. (Money Laundering Clearing House 2006.)

In prisons, the prerequisites for monitoring drug supply are created by organising spaces and activities as well as creating suitable ward and cell structures. Intoxicant control is also facilitated by appropriately positioning personnel and through technical means. Local co-operation agreements between prisons and the police define the sanctions imposed when drugs are discovered; i.e. whether the issue is dealt with in prison as a breach of discipline or whether it is referred to the police for investigation. Other authorities have participated in special inspections, and co-operation between authorities has increased in all areas of control. In addition, many prisons now have a drug detector dog; the dog is not only used during special inspections for intoxicant control but also during daily prison inspections. (Criminal Sanctions Agency 2004.) Drug detector dogs have also been borrowed from the police and the Customs, which has approximately 50 of them. (Finnish Customs 2005).

B. SELECTED ISSUES

12 Drug use and related problems among very young people

There has been a discernible increase in drug use and its resultant problems in some EU countries. An increase has been detected in the under 15-year-old age group, where cannabis use and sniffing have risen. The discovery of heroin, cocaine and pharmaceuticals abuse among very young people, as young as 11–12-year-olds, has also caused concern. Relatively little information is available about drug experimentation and use among very young people, and this article collates Finnish research data under this central theme. The cornerstones of the review include the prevalence of use, methods of use, socio-economic background, the health and treatment services currently on offer, legislation and the prevention of substance abuse. The review continues within the given framework to first examine issues related to the prevalence of abuse, then young substance abusers receiving care and thirdly, young people in the group at risk. The last two sections centre on a review of harm caused by abuse, legislation and the prevention of substance abuse. The extent of the sections varies according to the amount of research data available for each sub area.

12.1 Drug use, attitudes and supply among very young people

The latest comparative indicators of use related to young people and drugs are found in the school health survey 2005. It examines the long-term trends in drug experimentation among 8th and 9th graders in comprehensive schools (14–16-year-olds). During the period 1997–2001, isolated experimentation with drugs within this age group increased from 7 per cent to 10 per cent in boys and from 6 per cent to 9 per cent in girls. However, the latest trend indicates a reduction in experimentation. The figures for boys and girls have returned to the 1997 level (Luopa et al. 2006). Temporally the trend is in line with the wider trend in experimentation with drugs. According to Hakkarainen and Metso (2005), experimentation and use reached their peak at the start of the 2000s following the rise in the 1990s, since when experimentation and use have evened out or even declined slightly.

The information obtained in a survey on health habits in adolescents (Rimpelä et al. 2005) concerning drug-using acquaintances and drug supply corresponded temporally to the trend in experimentation. The number of 14–18-year-olds having drug-using acquaintances had declined from 36 per cent to 31 per cent in boys and from 52 per cent to 42 per cent in girls. Within the 14-year-old age group there was a similar decline from 19 per cent to 16 per cent in boys and from 37 per cent to 29 per cent in girls.

There have been no fundamental changes in the supply of drugs. Within the 14–18-year age group, there was a decline in 2003–2005 by 1 per cent in boys and 3 per cent in girls. In both age groups, 12 per cent of adolescents had been offered drugs at some time. The figures within the 14-year age group were also lower than before.

With respect to boys, the figure had remained at 4 per cent and for girls, it had fallen from 8 per cent to 6 per cent (Rimpelä et al. 2005).

According to the ESPAD survey⁵⁴, in 1995, around 5 per cent of adolescents in Finland had at sometime experimented with cannabis. Four years later, 10 per cent of Finnish adolescents had experimented with cannabis. The spread in the use of cannabis (16% in 1999) was also seen throughout all of the ESPAD materials. In 1995, one per cent of Finnish adolescents had experimented with drugs other than hashish or cannabis whereas the corresponding figure was 4 per cent in all ESPAD countries. In the latest study (2003), 11 per cent of Finnish adolescents had used cannabis. The corresponding figure in all the materials came to 21 per cent. The percentage of 15–16-year-olds who had experimented with an illegal drug during the past year in Finland came to 7.5 per cent, and 2.5 per cent had experimented with an illegal drug during the past month. Cannabis was the most common illegal drug in all the countries participating in the study. In Finland, 3 per cent had tried other drugs, whereas the corresponding figure was 6 per cent on the average in all other countries. In 2003, the other substances experimented with in Finland and worth paying attention to were amphetamines and ecstasy (Ahlström et al. 2004). Indications of adolescents having used heroin do not appear anywhere in the materials.

In 2003, the use of pharmaceuticals among Finnish adolescents in order to become intoxicated was noticeably more common than among other European adolescents. In particular, the combined use of alcohol and pharmaceuticals (17%) clearly differed from adolescents in the other ESPAD countries (9%). The combined use of pharmaceuticals and alcohol in 1999 was also more common in Finland than in the other ESPAD countries (Finland 13%, other countries 8%). (Ahlström et al. 2004.)

The final age-specific indicator to be examined among very young people was the attitude towards cannabis among 15–16-year-olds. According to the youth barometer⁵⁵ published in the autumn 2006 (Wilska 2006), the age group has an extremely negative attitude towards cannabis products. Eighty per cent of 15-year-olds did not approve at all of the use of cannabis, and 20 per cent identified with the claim “somewhat disagree”. None of the 15-year-olds participating in the study considered the use of cannabis acceptable, and the alternatives “somewhat agree” and “strongly agree” remained at 0 per cent in the four-step response scale. The attitude to cannabis also becomes less tempered the older one gets. This was seen in the 16-year-old age group, where 6 per cent of the respondents approved of the use of cannabis and 8 per cent approved with reservations. Furthermore, the number of those absolutely against cannabis dropped to 65 per cent. It is particularly interesting to note that when looking at 15–29-year-olds, the relatively most significant change in attitude takes place specifically between the ages of 15 and 16 years.

Regionally, the figures for experimentation among very young people do not substantially differ from each other. In 2003, the proportion of 15–16-year-olds who had experimented with drugs came to around 7 per cent in western and northern

⁵⁴ The European School Survey Project on Alcohol and Other Drugs (ESPAD) is a survey on the use of intoxicating substances among adolescents that is conducted in European countries once every four years. Thirty-five countries took part in the 2003 survey. The survey involved 15–16-year-olds. In Finland, this age group is ninth-graders, which is the final year of comprehensive school.

⁵⁵ For the Youth Barometer, 1,900 persons aged 15–29 were interviewed in March 2006. The samples were randomly chosen from the population register. Quotas were determined for gender, region, language and age so that their proportion of the material corresponded with the proportion of variables in the basic group.

Finland and in 2004, the figure was 9 per cent in a similar school survey in southern, eastern and northern Finland (Ahlström et al. 2004; Rimpelä et al. 2005).

Based on various studies, it can be stated that the use of drugs among very young people in Finland is relatively minor. The strong position of cannabis does not promote the onset of problem drug use at a young age. The attitude to drugs is highly negative, and the general drug trend is on the decline in all respects. The major particular problem is the combined use of alcohol and pharmaceuticals in order to become intoxicated. Moreover, the sniffing of industrial chemicals has remained at a constant 3–5 per cent since the beginning of the 1990s. On the European scale, drug use among very young people in Finland clearly falls behind the consumption of alcohol.

12.2 Very young people in care statistics and risk groups at the onset of use

According to the drug treatment information system, there are isolated or only a few cases of less than 15-year-olds entering treatment annually. Low levels of use, the experimental nature of use and the strong emphasis on experimentation with cannabis products have not given rise to a serious drug problem among very young people. In these respects, the trend has remained the same throughout the beginning of the 2000s. (Partanen et al. 2004.)

An estimated 9,000 children are annually taken into care in Finland, an estimated 76 per cent due to alcohol abuse and 14 per cent due to drug use by a parent or parents. There has been a slight increase in the number over the past few years. However, the number of children falling within the sphere of non-institutional support has grown significantly; there are now more than 50,000. Overall, 64,000 children can be considered as living in families that use intoxicants and fall within the sphere of social welfare. Most of these are related to alcohol abuse. (STAKES 2006b.)

The EMCDDA defines young people who drop out from school and those who have interrupted their comprehensive schooling as a potential risk group. In Finland, pupils who do not complete their compulsory education do not get a school leaving certificate. They can be divided into three groups: those that completely neglect their compulsory education and those that have gone beyond the age for compulsory education with or without a certificate of resignation. The number of 7–17-year-olds completely neglecting their compulsory education has been relatively small, at around 60–90 children or adolescents annually. About 200 pupils each year go beyond the age for compulsory education with or without a certificate of resignation. However, it can be stated that there has been a slight downswing in the number of pupils neglecting their compulsory education. (Kumpulainen 2005.)

Juvenile delinquency is seen as one spur to marginalisation and consequently to the use of drugs. In 1995, the Criminology Unit of the National Research Institute of Legal Policy launched a self-confessed crime survey that extended to the entire country; the survey was repeated in 1996, 1998, 2001 and 2004. The studies were directed at ninth grade comprehensive school pupils (15–16-year-olds) because the ninth grade is the last stage where the entire age group is in the same institution. The studies were limited to Finnish language upper schools, and the focus was on presenting the main trends. The main trends in criminal behaviour become more evident when the trend in the primary types of crime is made more succinct: theft, vandalism, violence and drug use. Acts of theft include stealing from shops, school and home as well as buying stolen goods. Vandalism to property refers to writing and drawing on walls as well as to vandalism at school or elsewhere. Violence refers to fighting in a public

place or to beating up another person. In addition to the above-mentioned variables, the study included the use of marijuana or hashish as isolated acts.

Theft had declined considerably in the period covered by the study. The most distinguishable period of decline preceded the 2001 evaluation. However, the trend in the 2000s appears to have levelled out. The same trend is also apparent in intentional vandalism. In other words, adolescents at the age 15–16 in 2004 were involved much less in crimes against property than young people of the same age in the mid-1990s.

With respect to violence, no similar consistent trend in an upward or downward swing was observed. However, the level indicated in the latest evaluation is considerably lower than it was in 2001.

The trend in criminality is similar when examined separately for boys and girls. The same trends are apparent in both genders. It can be stated that for boys, the proportion of 15-year-olds involved in theft dropped by almost 20 percentage units over a ten-year period; for girls, it dropped about 10 percentage units.

The decline in adolescent mass crime has also signified the fact that the percentage of adolescents who refrain from all forms of criminal behaviour distinctly increased from 1995–2004. Overall, when examined, the 15–16-year-olds of today are much more law-abiding than were adolescents of the same age 10 years ago. This is true at least for traditional mass crime that often takes place in public places, especially with respect to theft and vandalism. (Marttunen & Salmi 2005.)

12.3 Other intoxicants and the problems caused by drugs among very young people

Alcohol consumption and cigarette smoking are considered to predispose young people to experiment with drugs (cp. Hakkarainen & Metso 2005). Below is a brief report on the latest trends in alcohol consumption and cigarette smoking among very young people. Some detrimental indicators are also examined.

Alcohol

In 2005, nine out of ten 12-year-olds stated that they did not drink alcohol even in small amounts – the percentage of temperate girls was slightly higher than it was for boys. There were considerably more temperate 14 and 16-year-old boys than girls. Temperance became much more commonplace among very young people after 1997–1999. In 2005, 58 per cent of 14-year-old boys and 46 per cent of girls stated that they were temperate whereas in 1999, the corresponding figures were 36 per cent and 30 per cent. (Rimpelä et al. 2005.)

In 2005, the percentages of those drinking at least small amounts of alcohol once a month or more often were: 12-year-olds 2 per cent; 14-year-old girls 22 percent, boys 15 per cent; 16-year-old girls 49 per cent, boys 51 per cent. A rise in the consumption of alcohol once a month or more often stopped among 12–16-year-olds between the years 1997–1999, after which there was a downswing in alcohol consumption, among girls slightly earlier than among boys. Between 2003 and 2005, drinking became even more sporadic among 14-year-olds and among 16-year-old girls.

In 2005, none of the 12-year-old boys and only a few of the girls responding to the survey consumed alcohol frequently, i.e. at least once a week. Only a very few of the

14-year-olds stated that they drank frequently. Six per cent of girls and four per cent of boys consumed alcohol at least once a week. Prevalence increased with age. The rising trend among 14–18-year-old girls to consume alcohol each week continued from the beginning of the 1980s until 2001, since when the situation has remained almost constant. The rise in the weekly consumption of alcohol among boys took a downward swing after 1999, but it once more rose from 2003–2005. From 2003–2005, the weekly consumption of alcohol increased among 16 and 18-year-old boys. There was a slight decline in weekly consumption among 14-year-olds of both genders. (Rimpelä et al. 2005.)

In summary, it can be stated that binge drinking has been rare among 12-year-olds. In 2005, 7 per cent of 14-year-old girls and 4 per cent of boys reported that they consumed alcohol to become very drunk once a month or more often. When studied according to age group, binge drinking became rarer in the 14 and 16-year age groups from 1997–2005. Binge drinking among 14 and 16-year-old girls also became rarer between 2003 and 2005; no change was visible among boys in the same age group. (Rimpelä et al. 2005.)

The opinions of adolescents concerning the commonplace nature of alcohol were also studied from 1979 to 2005. In 2005, the answers to the claim “the moderate use of alcohol is part of everyday life” were noticeably more favourable among 12-year-olds than they had been earlier. Fifty-five per cent of the boys and 49 per cent of the girls strongly or somewhat agreed with the claim. (Rimpelä et al. 2005.)

At the turn of the millennium, the rising trends among very young people in consuming alcohol and binge drinking stopped, and they took a downward swing among 12–14-year-olds and 16-year-old boys. While this positive trend was at its best, a change concerning alcohol taxes was implemented on politico-commercial grounds. Based on existing information, this change could be assumed to increase the consumption of alcohol. In order to control imports, taxes on alcohol were lowered considerably because alcohol import quotas were eliminated in traffic between Finland and Estonia when the latter joined the EU. The decision resulted in the easier availability of alcohol and prices fell at the same time. Now that a year has passed since the changes came into force, two changes are becoming apparent in the trends in alcohol consumption among adolescents: temperance is still prevalent among young people but on the other hand, the downward trends in the repeated consumption of alcohol and binge drinking have stopped. (Rimpelä et al. 2005.)

The greatest reductions in alcohol tax were on spirits. When converted to total alcohol content, young people drink two thirds of their alcohol as beers, ciders and long drinks. This factor may have contributed to the fact that younger age groups have not increased their consumption. (Rimpelä et al. 2005.)

In the opinion of Lähteenmaa (2004), the phenomena of youth culture should be taken into consideration particularly when explaining the rise in temperance. Several, albeit probably quantitatively small adolescent groups that do not to consume alcohol may have influenced the majority of young people in bringing forth this refusal as an alternative worthy of consideration. She gives examples of temperate youth: straight edgers whose ideology includes the denial of hedonism, as well as Muslim immigrants.

At the end of the 1990s, Finnish society became concerned about the mounting malaise of children and adolescents. Growing queues to child psychiatrists, the mounting load for child protection and special education, and the results of the prevalence of binge drinking and drug experimentation sparked off wide discussion

and action for the good of young people at both the local and national levels. The significance of this factor was already considered in 2003. Active discussion about the roles of schools and parents in the electronic media, newspapers and professional journals along with the results of studies probably changed attitudes to the responsibility for education at home and at school. The combined actions on many different fronts could serve to explain why the positive changes were most evident among younger age groups. (Rimpelä et al. 2005.)

Cigarette smoking

According to the survey on health habits among adolescents (2005), 22 per cent of 14–18-year-old boys and 23 per cent of girls smoked cigarettes daily in 2005. The proportion of 14–16-year-olds that smoked cigarettes daily is almost the same as for the 1979 figures, which were the lowest ever recorded. Cigarette smoking among 14–18-year-olds showed a temporary decline at the end of the 1970s, especially after the law reform intended to restrict cigarette smoking among adolescents. However, the effect was brief and smoking among girls in particular started to become more widespread at the end of the 1990s. The differences in the prevalence of cigarette smoking between girls and boys have subsequently evened out. In recent years, cigarette smoking among girls has been more widespread than it has among boys in corresponding age groups. The onset of experimenting with cigarette smoking shifted to a later age during 2003–2005. (Rimpelä et al. 2005.)

Attitudes towards cigarette smoking have become tougher. In 2005, almost everyone approved of the ban on selling cigarettes to people less than 18 years of age, and almost 70% approved of smoke-free cafes, bars and restaurants. Of 12 and 14-year-olds, almost 80% considered smoking is for “losers”. (Rimpelä et al. 2005.)

The proportion of very young people experimenting with cigarette smoking has declined steadily and significantly from the end of the 1970s until spring 2005. At the outset of the new millennium, cigarette smoking among adolescents has achieved the objective set during the 1970s in the health-oriented smoking policy and legislation. Experimentation with cigarette smoking and regular cigarette smoking has taken a downward swing. The favourable trend took place in the 2000s, especially among teenagers. (Rimpelä et al. 2005) The positive trend also includes a downward drop in the number of girls smoking cigarettes. The change had already begun earlier with 14 and 16-year-olds. Overall, the differences between the genders smoking cigarettes are minimal.

The restrictions on smoking as specified in the health-oriented smoking policy have received the approval of adolescents. The purchase of tobacco products was restricted back in the 1970s, when the sales prohibition was applied to adolescents less than 16 years of age. In 1987, the vast majority of 14–18-year-olds approved of the prohibition on selling tobacco products to youth under the age of 16. When the sales age limit was raised to 18 in 1995, only 66% initially approved of the new prohibition. Subsequently, the situation has changed decisively. Now, nine out of ten 14–18-year-olds and almost all 12-year-olds approve of the prohibition. It is noteworthy that there is virtual unanimity in the approval of the ban directed towards one's own age group. (Rimpelä et al. 2005.)

In 1997, the majority of 14–18-year-olds considered that smoke free arrangements should be made in cafes, bars and restaurants for those who do not smoke cigarettes. Measures were indeed taken to limit cigarette smoke in these places as from 2000. In the 2005 survey, adolescents were prepared for tougher limitations, even for a total ban on smoking. Sixty-two per cent of 14–18-year-olds and almost all

12-year-olds agreed with the claim “cafes, bars and restaurants should be smoke free”. (Rimpelä et al. 2005.)

The positive attitude of young people towards non-smoking can also be linked more generally to the ongoing discussion across society on not smoking and on the detriments of smoking. The cigarette smoke produced by one person and that others have to breathe in, so-called passive or forced smoking, is a significant health-related concern. The proportion of young people who spend time on smoke-filled premises has also declined considerably. (Rimpelä et al. 2005.)

In the light of different studies (Rimpelä et al. 1998; Rimpelä et al. 2005), it would appear that the trends in cigarette smoking, the consumption of alcohol and the use of drugs amongst very young people are all similar; they are on the decline.

12.4 National substance abuse prevention and strategies

In the national programmes, the work to prevent harm from substance abuse as well as the entire service system is directed to respond to the needs of the situation in Finland. Based on the programmes, the service system has to be functional both with respect to its basic services and to the specialised services it offers. The programmes especially emphasise and support local activities in preventing the harm caused by intoxicants. The objective of the policies in the current Government programme is to prevent and ward off through action at the local and national levels social and health detriments that result from the use of intoxicants. The programmes drawn up in the 2000s emphasise the fact that the prevention and management of harm requires contributions from state and municipal administration, non-governmental organisations, business and industry, and the citizens themselves. (Romppanen 2005.)

The contact person for substance abuse prevention, the cross-administrative working group that monitors substance abuse prevention overall and the local substance abuse strategy form the basic structure for co-ordinating substance abuse prevention in a municipality in accordance with the programme. The Drug Policy Action Programme for 2004–2007, the latest general outline for drug policy, was drawn up in 2004. The measures taken by the programme relate to such aspects as drug policy co-ordination, reducing the demand and supply of drugs and mitigating the harm caused by drugs. The programme was preceded by the Government’s resolution in 1999 concerning drug policy, the Action plan for more efficient drug policies for 2001–2003 that was published in 2003, the report of the committee for preventing drug use among young people that was published in 2000, and the Drug Strategy that was published in 1997. The programmes included the objectives for preventing and treating the harm caused by drugs. According to the Drug Policy Action Programme for 2004–2007, working methods will be developed and field participation in the strategy and work of the programme will be bolstered through a special developer network.

In addition to the recommendations of the national programmes, the work of municipalities in preventing substance abuse is also governed by legislation. The Act on Welfare for Substance Abusers states that substance abuse services are to aid a person who has problems related to substance use as well as aid his or her family and other close people. The services must be provided to aid, support and treat a person, his or her family and other close people on the basis of their needs. Other legislation that applies to substance abuse prevention in a municipality includes the Alcohol Act, Decree on Welfare for Substance Abusers, Social Welfare Act, Social

Welfare Decree, Child Welfare Act, Child Welfare Decree, Mental Health Act, Mental Health Decree, Penal Code, Act on Measures to Restrict Tobacco Smoking, and the Decree on Measures to Restrict Tobacco Smoking. The municipal drug policy is governed in particular by the Narcotics Act and the Decree on Narcotics as well as by the international agreements that constitute their background. (Romppanen 2005.)

Several different care methods are used in drug treatment. Assessments have been made of the effectiveness of the different treatment methods for alcohol and drug users, for example in the Current Care guidelines by the Finnish Medical Society Duodecim. Further information about successful working practices is also available from the descriptions of good practices. (Romppanen 2005) The treatment methods are directed at all drug abusers, but solutions suitable for underage drug users are developed within their framework. (Kuoppasalmi 1999.)

12.5 Conclusion

It appears as if the intoxicant situation among very young people in Finland has taken a positive turn over the past few years. The trend for all intoxicants has taken a downward swing. Moreover, the attitude towards different intoxicants is highly negative. In this respect, the trend among very young people is positive. In Finland, the combined use of alcohol and pharmaceuticals is still prevalent when compared to elsewhere in Europe. As far as drugs are concerned, the situation has calmed down after the rise in the 1990s. In Finland, hard drugs have not gained a foothold among very young people and this in turn has prevented serious drug problems within the age group. It is believed this trend will continue, and it looks as if alcohol is set to continue as by far the largest problem area among very young people.

Minors constitute one particular target group as the care system is being developed. The difficulty in care is the particularly large variation according to geographic location. Moreover, the structure of the care system for minors is still considered deficient.

13 Cocaine in Finland

The use of cocaine and its resultant problems have been on the rise in Europe since the turn of the millennium. According to the European Monitoring Centre for Drugs and Drug Addiction, cocaine has also become an important factor on European drug markets. The EMCDDA estimates that around 9 million Europeans (3% of all adults) have used cocaine at least once in their lives. Users are predominantly young, 15–34-year-old adults, particularly young men and city dwellers (EMCDDA 2005). The use of cocaine varies considerably in different countries. Finland is listed among those countries where cocaine is still very rarely encountered, a marginal and elite drug. All the available indicators (population surveys, confiscation statistics, care statistics and qualitative studies) allude to the fact that use and subsequent harm are still extremely insignificant in Finland (cp. Hakkarainen & Metso 2003; Rikollisuustilanne 2005).

Crack cocaine has not been encountered at all in Finland. Official statistics and qualitative studies have revealed no indication of experimentation with or use of the substance (inc. Perälä 2002; National Bureau of Investigation 2006b). Crack cocaine has an extremely poor reputation among Finnish substance users and its spread onto the Finnish drug market can be viewed as extremely unlikely. This section focuses particularly on the prevalence of snortable cocaine as a powder, which is by far the most common form of use of the substance in Finland. Intravenous use has also appeared in care statistics for some years but it is extremely rare (cp. Hakkarainen & Metso 2003; 2005).

13.1 Prevalence of use

The latest population surveys (Hakkarainen & Metso 2003; 2005) indicate that there has been a very slight rise in the use of cocaine, but this increase cannot be considered as having any statistical significance. Experimentation and use centre on the 20–29-year-old age bracket. A good 2 per cent of them said that they had experimented with or used it at some time in their lives. There is virtually no indication of use in other age groups.

Based on qualitative studies (Seppälä 2001; Salasuo 2004a), it can be assumed that use is centred almost entirely in large cities and that it is closely tied with young adults partying and enjoying their leisure time. The group using cocaine represents the socio-economic elite of their age bracket and use is very random by nature. Therefore, from the perspective of the population at large, this is an issue of strictly confined drug use.

Situations where cocaine is used commonly also feature indulging in alcohol and the use of other illegal intoxicants, such as cannabis, ecstasy and amphetamines. Typical user situations are private parties and having a good time, where cocaine figures along with drinking alcohol (Salasuo 2004a). In Finland, the use of cocaine is interspersed with the general combined use of intoxicants. According to the latest population survey (Hakkarainen & Metso 2005), 45 per cent of users of different substances had experimented with cocaine.

Based on statistics, it is not possible to determine precisely the age or sex distribution of cocaine use in Finland. In these respects, the prevalence of use can be compared

with that of other stimulants such as amphetamines and ecstasy, the use of which is centred considerably on the 20–29-year age bracket; use by men is around twice as prevalent as use by women. Qualitative observations support the interpretation that cocaine use is centred on the above-mentioned age bracket and its distribution between genders (see Salasuo 2004a).

Owing to its minimal use, the health hazards engendered by cocaine have not been reported separately in treatment unit studies. The problems are mainly associated with toxic symptoms generated by isolated instances of use. Other cases are so isolated that no mention of them is found in any reports. Cocaine has been the primary finding in post mortem forensic toxicology as follows: 1 case in 2005 (preliminary information), 2 cases in 2004, 0 cases in 2003, 2 cases in 2002, 1 case in 2001 and 1 case in 2000. (Department of Forensic Medicine 2006.)

13.2 Harm reduction

There are several different places in Finland that experimenters or users can contact in the event of problematic situations. The Poison Information Centre, which serves the entire country, is the most important channel of information. Individual organisations also operate emergency telephone services for drug abusers. They do not specialise in any particular substance and they are operated by trained volunteers.

The Internet is the major source of information for users. Telematic substance abuse prevention maintained by organisations in Finland is extremely progressive and, for instance, www.paihdelinkki.fi provides explicit information concerning substances and their detriments. The same website also includes information on treatment units. Furthermore, individual organisations such as Youth Against Drugs distribute flyers at parties on the risks of using drugs, including cocaine. It can be said that substance-specific information is generally easily available (Salasuo 2004b). In the event of use leading to problems, users mainly seek hospital treatment. The largest cities also have round-the-clock units specialised in drugs. Cocaine being cited as a reason for seeking treatment at one of these units is extremely rare. For instance, not a single case has been reported in 2006 (Kurvi Drug Clinic 2006).

13.3 Cocaine and law enforcement agencies

The law enforcement agencies have no measures directed especially at cocaine. Monitoring the cocaine trade and smuggling is coupled with other prevention of drug-related crime. Quantities of seized cocaine and the number of cases have remained low since the end of the 1990s. The amount of seized cocaine has remained below 2 kilograms, not including a few exceptional years, and the number of seizures has varied between 50–80.

The quality or purity of cocaine has varied between 59–74%. The street price of the substance is estimated in the realm of EUR 60–100/g (National Bureau of Investigation 2006). Active partygoers have reported that the price per gram in street trade and restaurants fluctuates between EUR 100 and 150. The high price partially determines the profile of use and users (cp. EMCDDA 2005).

13.4 In conclusion

Cocaine use in Finland can be regarded as a relatively minor problem. With respect to stimulants, amphetamines and ecstasy dominate the market. They cost considerably less and they are more readily available. Therefore, the use of cocaine is confined to the exclusive recreational use of a very small number. The random nature of use is the cause of relatively few health hazards and therefore these have not been listed separately in different statistics. Crack cocaine has not been encountered at all in Finland and it is not expected to become established here. Amphetamines and buprenorphine used in substitution treatment constitute the core of problematic use. Cocaine appears almost exclusively within the sphere of recreational users. In these respects, changes occurring in the price of the substance may well have a significant impact on the prevalence of its use in Finland.

14 Drugs and driving

Road safety risks and substance addiction are national health problems. Drugs and driving has been prioritised in the EU Drug Policy Action Programme. Intoxicant control in road traffic is extensive in Finland when compared to many other countries. The police breathalyse about 1.5–2 million drivers at the roadside every year⁵⁶ and they pay more and more attention to recognising external signs of drug use.

The vision of the Finnish National Road Safety Programme (Ministry of Transport and Communications 2005, 2006) is that nobody should die or be seriously injured on Finnish roads. The goal is to continuously decrease the number of road accident casualties. The number of road accident fatalities should be lowered from the current 7.2 fatalities per 100,000 inhabitants to 4.7 fatalities per 100,000 inhabitants by 2010 and to 1.9 fatalities per 100,000 inhabitants by 2025. Safety and health are the main objectives of the traffic policy.

The Drug Policy Action Programme in Finland 2004–2007 (Ministry of Social Affairs and Health) states that “the monitoring of drug use related to traffic safety shall be developed both through international co-operation and e.g. with the police and the Ministry of Transport and Communications”. The Drug Policy Action Programme emphasises the early recognition and treatment of drug problems as well as the importance of training police officers and other control authorities in issues related to drug use.

Samples of suspected intoxicated drivers are analysed in Finland by the National Public Health Institute. The National Public Health Institute is intensifying traffic research related to intoxicants, thus supporting the implementation of the Government’s road safety, alcohol and drug programmes.

14.1 Policy

The regulations regarding driving while intoxicated were amended on 1 February 2003 (Penal Code, Chapter 23, Sections 3, 4, 5, 12). According to the amendment, a motor vehicle driver is guilty of driving while intoxicated if his or her blood contains a narcotic drug or its metabolic derivative during or after driving. The exceptions to this are pharmaceuticals that the driver is entitled to use, provided, that the use of these substances has not impaired his or her performance in road traffic.

The term “narcotic drugs” refers to the substances specified in the Narcotics Act (1289/1993). Narcotic drugs also include technical solvents and narcotic gases. The penal provisions concerning road traffic deal with preventing the use of narcotic substances that are hazardous to traffic safety. Based on research-based information, it has not been possible to set legal limits similar to the blood alcohol limit for drugs that are hazardous to traffic safety. That is why zero tolerance for drugs was introduced in the legislation. Nevertheless, illegal drug use is a drug offence as such. However, if a driver is sentenced for driving under the influence of drugs, he or she will not be sentenced simultaneously for a drug-user offence.

⁵⁶ The population of Finland is 5.2 million.

Pharmaceuticals classified as narcotic drugs can be used as prescribed pharmaceuticals. Non-prescription pharmaceuticals, e.g. cough medicines, can also be used. Pharmaceuticals that contain intoxicating substances can be acquired and used legally and illegally. Zero tolerance does not apply to the use of pharmaceuticals that the driver is entitled to use. However, the use of these pharmaceuticals is a punishable offence if it impairs the driver's driving ability. Zero tolerance does not apply to the use of a pharmaceutical that has been acquired from abroad legally if it does not impair the driver's driving ability.

There are two levels of driving while intoxicated: driving while intoxicated and driving while seriously intoxicated. The minimum limit for driving while intoxicated is a blood alcohol concentration of 0.5 per mille or a breath alcohol concentration of 0.22 mg/l. The corresponding limits for driving while seriously intoxicated are a blood alcohol concentration of 1.2 per mille and a breath alcohol concentration of 0.53 mg/l. Zero tolerance is applied to drugs. If a driver is entitled to use (prescribed by a physician) e.g. psychotropic substances, such as benzodiazepines, that are classified as narcotic drugs, zero tolerance will not be applied. Instead, whether the driver's driving ability was impaired due to the use of benzodiazepines will be assessed. The criteria for road traffic offences and intoxicant tests are presented in Table 9.

A driver shall be sentenced for driving while seriously intoxicated if he or she has used an intoxicant other than alcohol or such intoxicant and alcohol together so that his or her performance is significantly impaired and the circumstances are such that the offence is conducive to endangering the safety of others.

The main principles of the legislation for driving while under the influence of drugs and/or pharmaceuticals are as follows (Penal Code, Chapter 23):

Legislation (Penal Code, Chapter 23, Sections 3–5)

Basis

- The law on zero tolerance for drugs
- The law on the impairment of driving ability concerning pharmaceuticals that the driver is entitled to use

Drugs and pharmaceuticals are included in the legislation related to driving while intoxicated

- Two levels: Driving while intoxicated and driving while seriously intoxicated

Table 9. Criteria for road traffic offences and intoxicant tests.

Offence	Blood alcohol concentration (‰)	Breath alcohol concentration mg/l	Performance	Circumstances are such that	Procedure
Driving while intoxicated					
Alcohol	0.5	0.22			Precision breathalyser/ blood test
Other intoxicant than a legally acquired/used pharmaceutical					Observation form, clinical test for intoxication + blood (and urine) sample
Legally acquired/used pharmaceutical			Impaired		Observation form, clinical test for intoxication + blood (and urine) sample
Alcohol + a pharmaceutical that the driver is entitled to use			Impaired		Observation form, clinical test for intoxication + blood (and urine) sample
Driving while seriously intoxicated					
Alcohol	1.2	0.53		Conducive to endangering the safety of others	Precision breathalyser or blood sample
Alcohol	0.5	0.22	Significantly impaired	Conducive to endangering the safety of others	Observation form, clinical test for intoxication and blood and urine sample
Other intoxicant			Significantly impaired	Conducive to endangering the safety of others	Observation form, clinical test for intoxication and blood and urine sample
Alcohol + other intoxicant			Significantly impaired	Conducive to endangering the safety of others	Observation form, clinical test for intoxication and blood and urine sample

Source: Lillsunde et al. (2003).

Reasons for the amendment

Prior to the amendment, the police had to prove that the driving ability of a driver under the influence of drugs was impaired. After the amendment, drug drivers are treated the same way as drunken drivers. In both cases, when the limit for driving while intoxicated is exceeded, there is no need to prove that the driver's driving ability was impaired due to the said substance.

Before the amendment, the impairment of driving ability was difficult to prove. Many drug drivers were not sentenced in court. The difficulty to provide evidence of impaired driving ability lowered the motivation of the police to intervene in driving while under the influence of drugs. At the same time, the proportion of drug drivers involved in road accidents grew. These reasons led to the amendment of legislation.

14.2 Occurrence of alcohol and drugs in road traffic

The police require drug tests of drivers who they suspect of using drugs. A driver may seem intoxicated but a breath test shows no sign of alcohol. In cases of road traffic offences and causing a traffic hazard, the police investigate the possible presence of intoxicants. Other road users may report a suspected intoxicated driver to the police.

In Finland, research, expertise and information on driving while intoxicated centres on the National Public Health Institute. Since 1977, the National Public Health Institute has conducted laboratory analyses of samples of suspected intoxicated drivers, submitted the related statements, maintained statistics and archived the material. After the introduction of the precision breathalyser system in 1998, the centralised quality control of the system also became the responsibility of the National Public Health Institute.

The proportion of drunken drivers (blood alcohol concentration of more than 0.5 ‰) and those who had consumed small amounts of alcohol (blood alcohol concentration of less than 0.5 ‰) in the traffic flow has been monitored for over 30 years by regular roadside tests. Approximately one in 600 drivers in the traffic flow is a drunken driver. The proportion of drunken drivers in the traffic flow has declined during the above-mentioned period but the share of those who had consumed a small amount of alcohol has risen. Due to the lack of reliable roadside drug testing devices, a similar study on drugs has not been carried out.

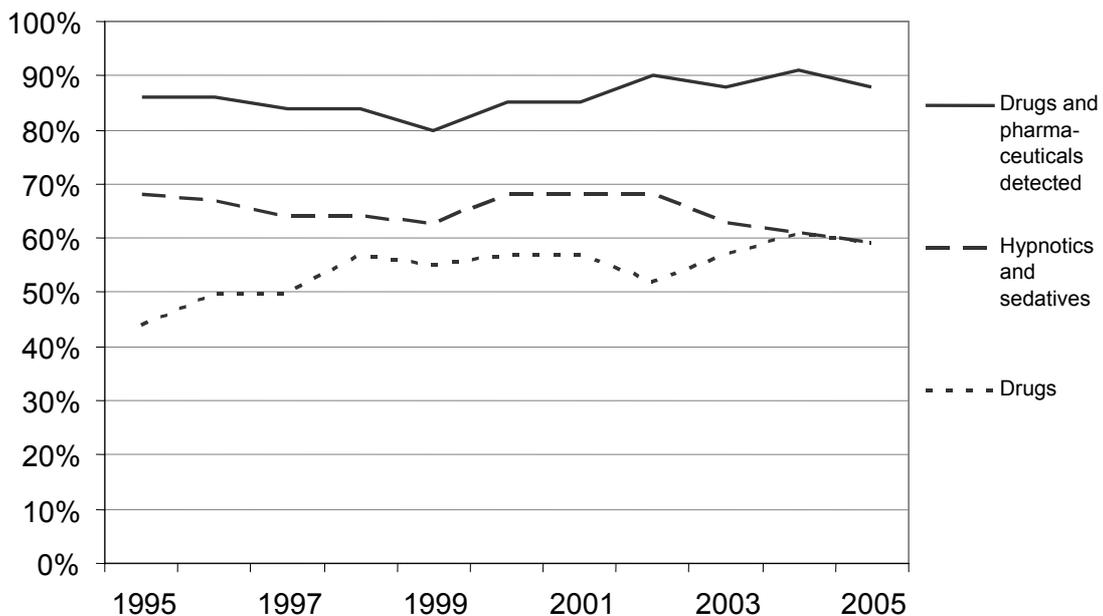
Analysis requests related to driving while intoxicated made by the police in 2005 were divided as follows: A total of 11,546 blood samples for estimating blood alcohol concentration were submitted to the laboratory. The number of breath samples measured with a precision breathalyser came to 14,628. A total of 3,420 suspected cases of drug or pharmaceutical use were examined. The number of suspected intoxicated drivers was annually more than 30,000 at the turn of the 1990s. Their number has now levelled off, amounting to some 25,000. The number of cases of drug or pharmaceutical use has been on the increase since 2003, i.e. since the so-called law on zero tolerance came into force. The number of drug test samples requested by the police of drivers has doubled by 2006.

Statistics on suspected drug drivers

In 2005, pharmaceuticals or drugs that are hazardous to traffic safety were detected in 3,008 cases, i.e. in 88% of all suspected drug drivers (3,420). The most common substances detected were hypnotics and sedatives, i.e. benzodiazepines (Figure 5). These were detected in 2,010 suspected drug drivers, i.e. in 59% of the examined cases. Actual illicit drugs were detected in 59% of the examined cases, i.e. in 2,024 cases.

Even though the number of persons caught while driving under the influence of drugs seems to have increased in recent years, it does not mean that the drug problem has become more severe. The police have become more efficient, especially since the law on zero tolerance came into force in 2003. The ability of the police to identify a drug driver has improved and the police have been given saliva rapid test kits, which have made it easier to identify uncertain cases of amphetamine use.

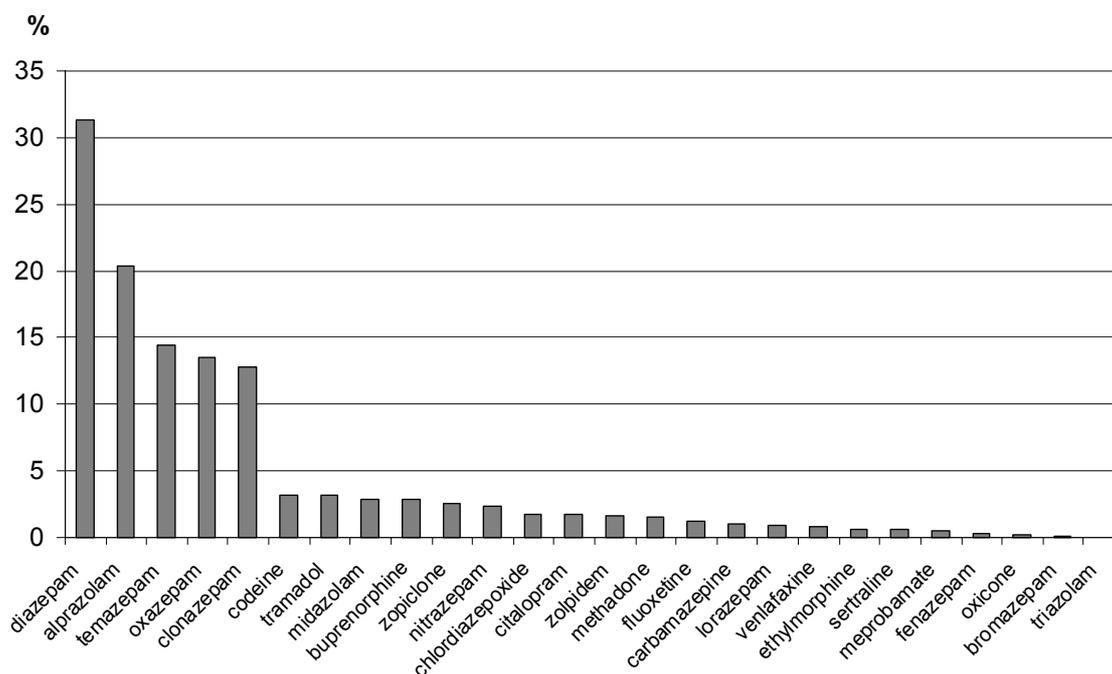
Figure 5. Drugs and pharmaceuticals detected in suspected drug drivers 1995–2005



Source: National Public Health Institute/Drug Analytics Unit

About 90% of the samples of suspected drug drivers submitted by the police have contained substances that are hazardous to traffic safety. The most common findings have been sedatives, but the proportion of actual illicit drugs has increased to the same level in recent years (Figure 6).

Figure 6. The most common findings from drug drivers in 2005, %



Source: National Public Health Institute/Drug Analytics Unit

Zero tolerance drugs

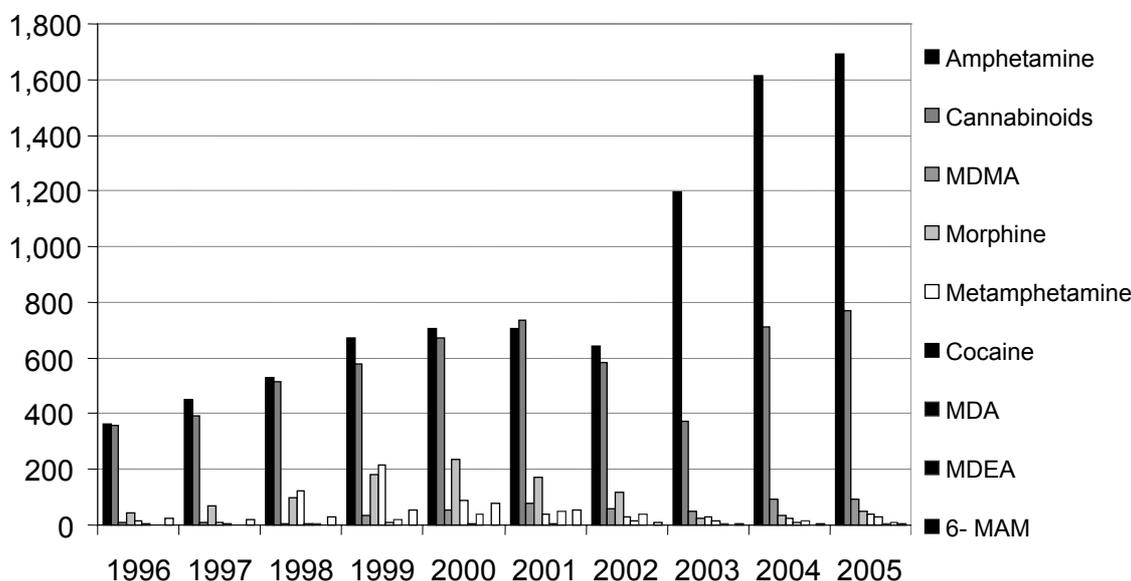
Of the actual zero tolerance drugs that are not used for medicinal purposes, amphetamine is still the most common substance detected in suspected intoxicated drivers (Table 10 and Figure 7). Another commonly detected drug is cannabis. A new finding was methylenedioxyethylamphetamine, MDEA, which is similar to ecstasy. There were also a few findings of gammahydroxybutyrate (GHB) in traffic. The number of cocaine findings seems to be on the increase. The number of morphine and heroin findings is clearly below the level found at the turn of the century. Methamphetamine findings also passed their peak in 1999, when some illegal laboratories were closed in the neighbouring areas of Finland.

Table 10. Occurrence of actual drugs in cases of driving while intoxicated.

Drug	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
Cannabis	358	390	514	580	670	737	584	374	709	768
Amphetamine	364	453	528	670	705	706	644	1,199	1,614	1,690
Metamphetamine	14	12	125	218	90	41	31	28	24	41
MDMA	8	10	7	32	56	78	58	47	95	91
MDA	0	1	5	19	39	51	39	4	13	5
MDEA	1	0	0	0	0	0	0	0	0	9
Morphine/Heroin	44	71	100	180	237	173	116	26	35	47
Heroin	26	19	31	56	77	52	10	4	7	5
Cocaine	3	4	4	11	4	7	16	15	12	27
GHB	..	..	..	..	..	..	..	..	..	3

Source: National Public Health Institute/Drug Analytics Unit

Figure 7. Occurrence of actual drugs in suspected cases of driving while intoxicated.



Source: National Public Health Institute/Drug Analytics Unit

Pharmaceuticals

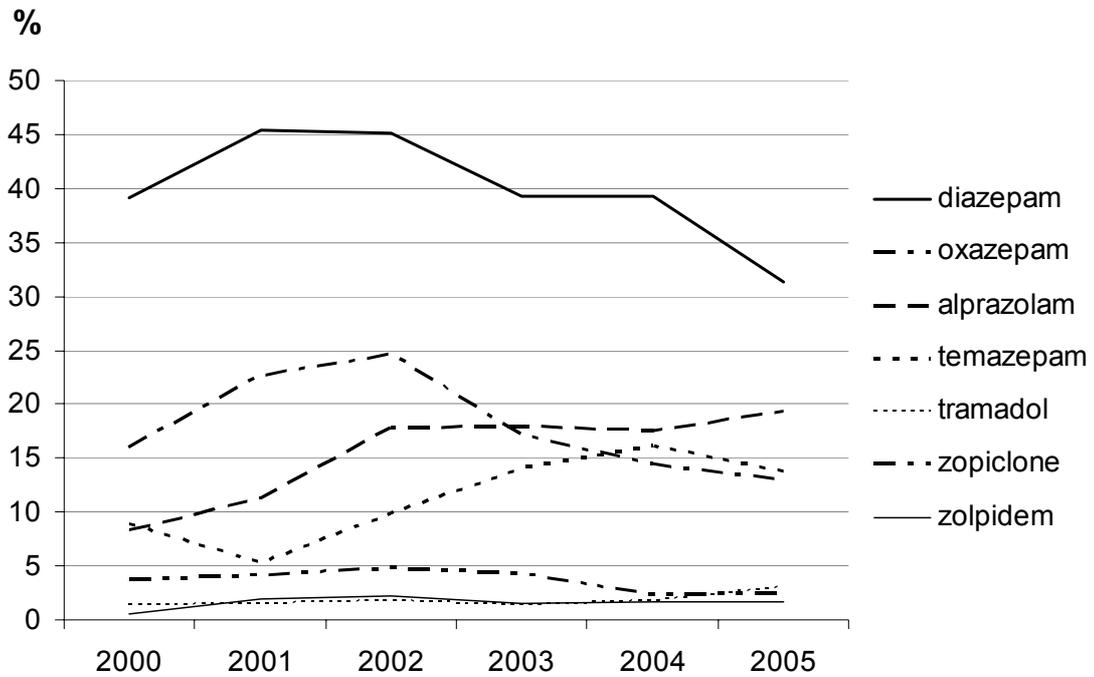
Some pharmaceuticals that are generally used to treat illnesses may impair a driver's performance in road traffic. Pharmaceuticals that are hazardous to traffic safety are listed in the Letter of Instructions 1758/81 by the National Board of Health and in the Pharmaca Fennica medicine guide. The packages of pharmaceuticals that may impair driving ability are labelled with a red triangle. Central nervous system pharmaceuticals labelled with a red triangle include hypnotics and sedatives, many psychopharmaceuticals, strong analgesics and some antihistamines.

In 2005, the total number of samples of suspected cases of driving while intoxicated came to 3,420. Diazepam, alprazolam, temazepam, oxazepam and clonazepam were the most common substances detected in the samples. Clonazepam findings have increased almost fivefold when compared to 2003. Clonazepam is increasingly found used together with actual drugs, e.g. amphetamine. Fenazepam is a benzodiazepine derivative that is not used for medicinal purposes in Finland and it is not included in the list of narcotic drugs. It has spread from Russia to Finnish drug abusers in recent years.

Buprenorphine has found its way to opiate users, as the availability of heroin has been scarce. Buprenorphine was detected in the samples of some 100 drivers in 2005. The number of meprobamate findings was very small earlier but now it is on the increase.

The trend in recent years (Figure 8) shows that the proportion of alprazolam and temazepam has grown and the proportion of diazepam and oxazepam has slightly declined in the examined cases.

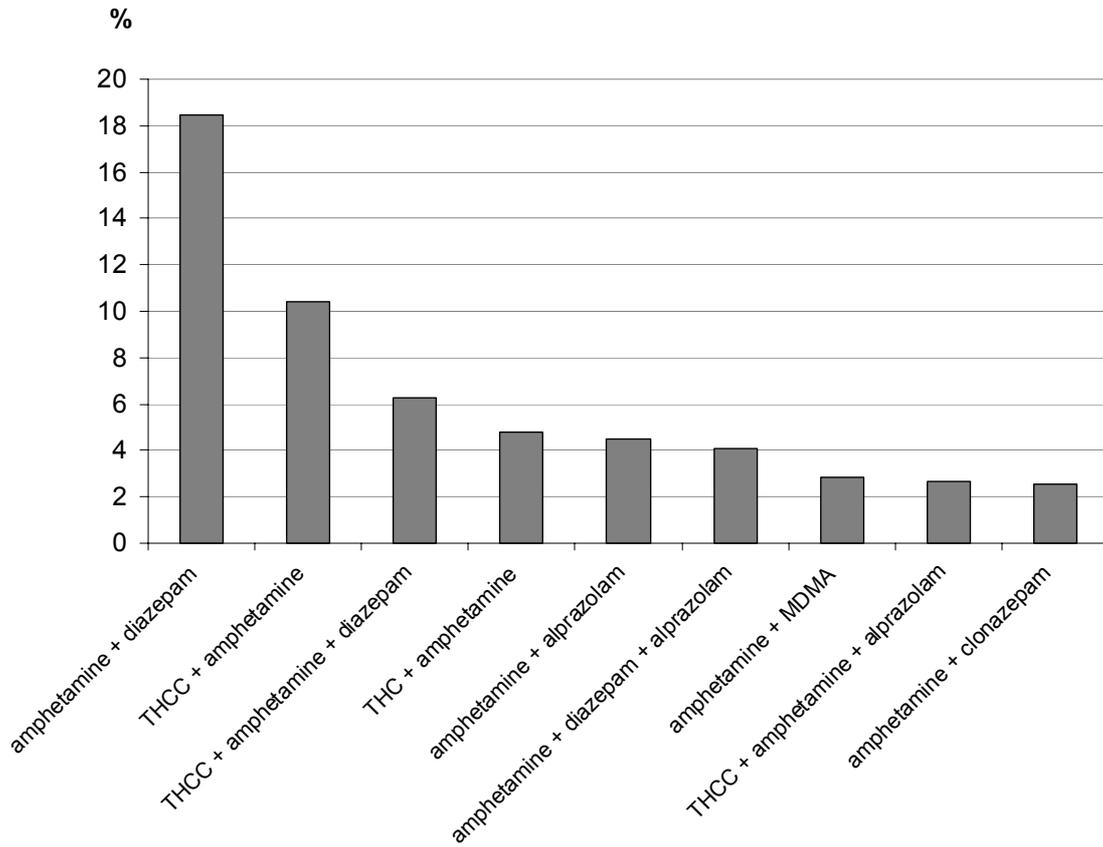
Figure 8. Occurrence of hypnotics and sedatives in suspected cases of driving while intoxicated 1996–2005.



Source: National Public Health Institute/Drug Analytics Unit

Benzodiazepines are usually detected with amphetamine and cannabis. In particular, diazepam, alprazolam and clonazepam are often detected with actual drugs (Figure 9).

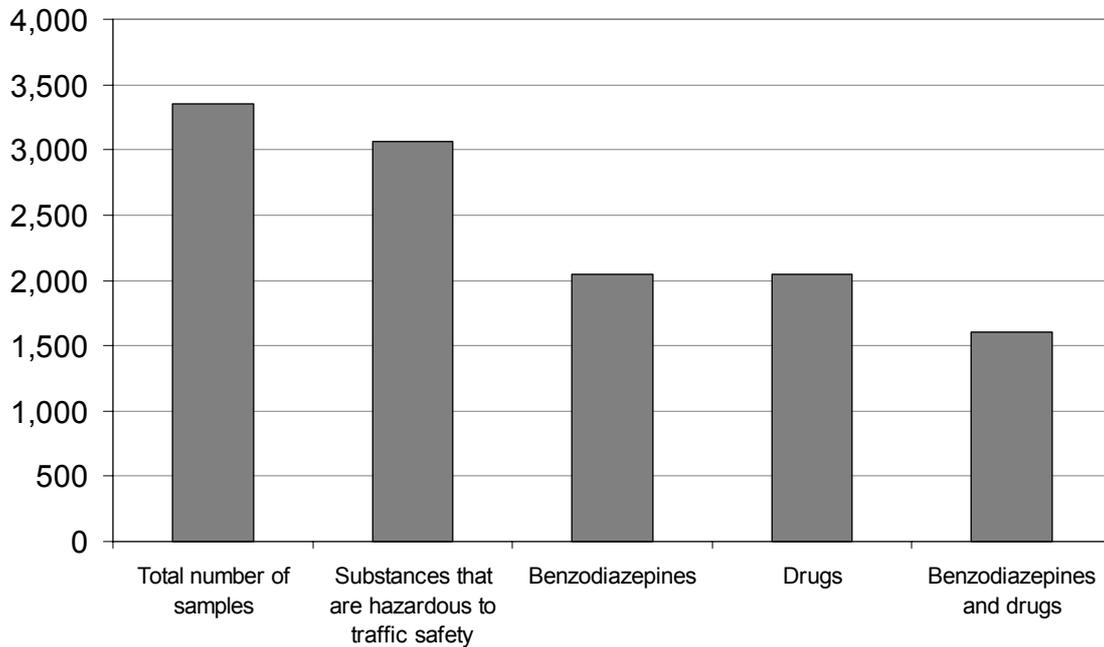
Figure 9. Combined use of amphetamine and cannabis with other substances (number) in 2005.



Source: National Public Health Institute/Drug Analytics Unit

Illicit drugs were detected in 79% of the benzodiazepine cases. The 'positive samples' column in Figure 10 also includes other substances that are hazardous to traffic safety in addition to benzodiazepines and illicit drugs. Some of the detected benzodiazepine concentrations are clearly above the usual therapeutic levels, but mostly the detected concentrations of pharmaceuticals correspond to the usual therapeutic levels.

Figure 10. Occurrence of benzodiazepines and actual drugs in 2004

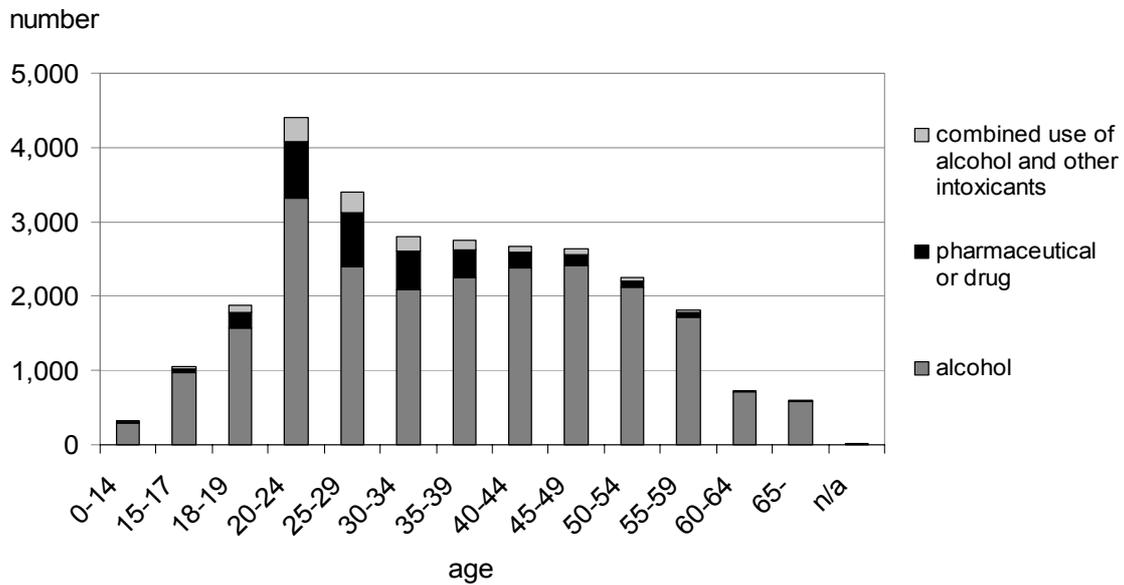


Source: National Public Health Institute/Drug Analytics Unit

Drug drivers by age and gender group

Approximately 90% of all people caught driving while intoxicated are men. In 2005, only 7% of people caught driving under the influence of alcohol were women. The peak in the age columns represents the younger age groups, the under 30-year-olds (Figure 11).

Figure 11. Suspected intoxicated drivers by age group in 2005.



Source: National Public Health Institute/Drug Analytics Unit

Road accidents

In Finland, traffic insurance pays compensation for approximately 85,000 road accidents a year. The role of drugs and pharmaceuticals in these accidents is usually not investigated. According to the data on road accidents compensated by insurance companies, some 14,000 people are injured in road accidents every year. The role of drugs and pharmaceuticals is rarely investigated in these cases either. In recent years, approximately 400 people have been killed in road accidents annually. Of the drivers of vehicles involved in fatal accidents, every fifth is under the influence of alcohol. The role of drugs has been significantly smaller: in 2003, actual drugs were detected in 3% of the cases (n=11), and 6% (n=26) of drivers involved in fatal accidents were under the influence of pharmaceuticals that affect driving ability. However, an increasing number of drivers involved in road accidents have been under the influence of drugs in the past ten years. The role of drugs and pharmaceuticals is always investigated in fatal accidents.

14.3 Procedure in suspected cases of drug driving

Police activities and sampling

When a police officer suspects a driver of being under the influence of drugs, the officer uses an observation form, "huumeet/tieliikenne" (*drugs/road traffic*) (Dnro SM-2003-03116/Vi-3), to document external signs of drug use. The officer then takes the suspect in for a clinical test for intoxication, which is performed by a physician, and for blood and urine testing. The police officer requests a statement from the drug laboratory and, if necessary, acquires other evidence and appends it to the pre-trial investigation records. (Figures 12 and 13)

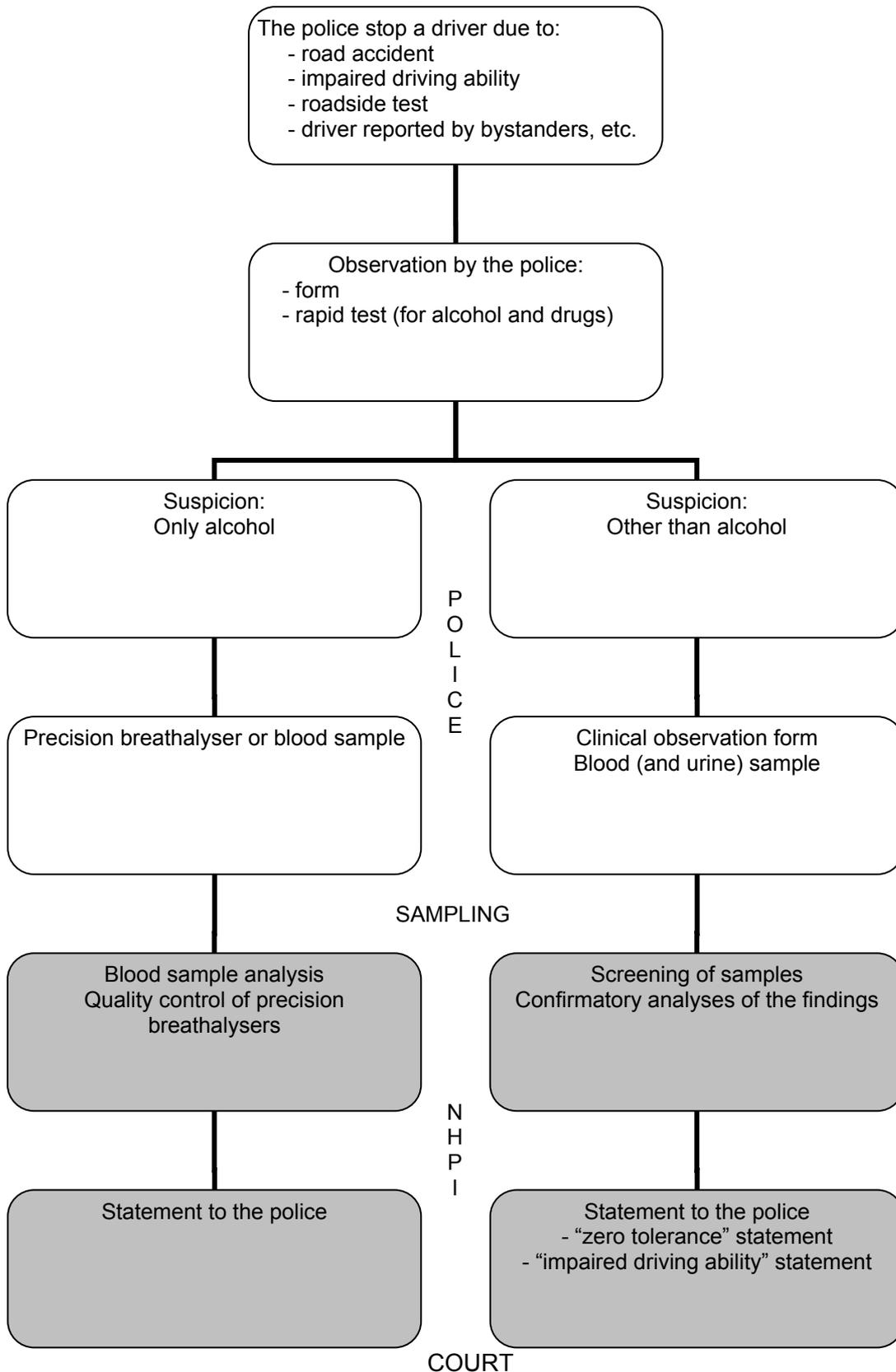
The roadside screening method used for drugs, comparable to the breathalyser test for alcohol, is the saliva test. Drug use in road traffic must always be confirmed from a blood sample in a laboratory. Section 3 of Chapter 6 of the Coercive Measures Act entitles the police to test a driver's driving fitness by screening (breathalyser or saliva test kit) even if the driver is not suspected of driving while intoxicated (Instruction given by the Ministry Of Social Affairs and Health SM-2003-03114/Vi-3). A driver who refuses to be tested must submit to a physical examination. A physical examination can be performed on a suspected intoxicated driver.

If the screening result comes out positive, the actual pre-trial investigation is carried out to determine, based on the precision breathalyser, clinical test for intoxication or blood test, whether the alcohol or drug concentration in the exhaled air or blood of the suspected intoxicated driver exceeds the threshold of punishability. The precision breathalyser test and blood test are considered physical examinations (Coercive Measures Act, Chapter 5) that require suspicion of an offence.

Drug drivers have also often committed other offences, the most common being various property offences and violent offences in addition to drug and road traffic offences. Thus, thorough pre-trial investigation may solve many other offences as well. Drug drivers may be armed and they may flee when the police try to stop them in road traffic.

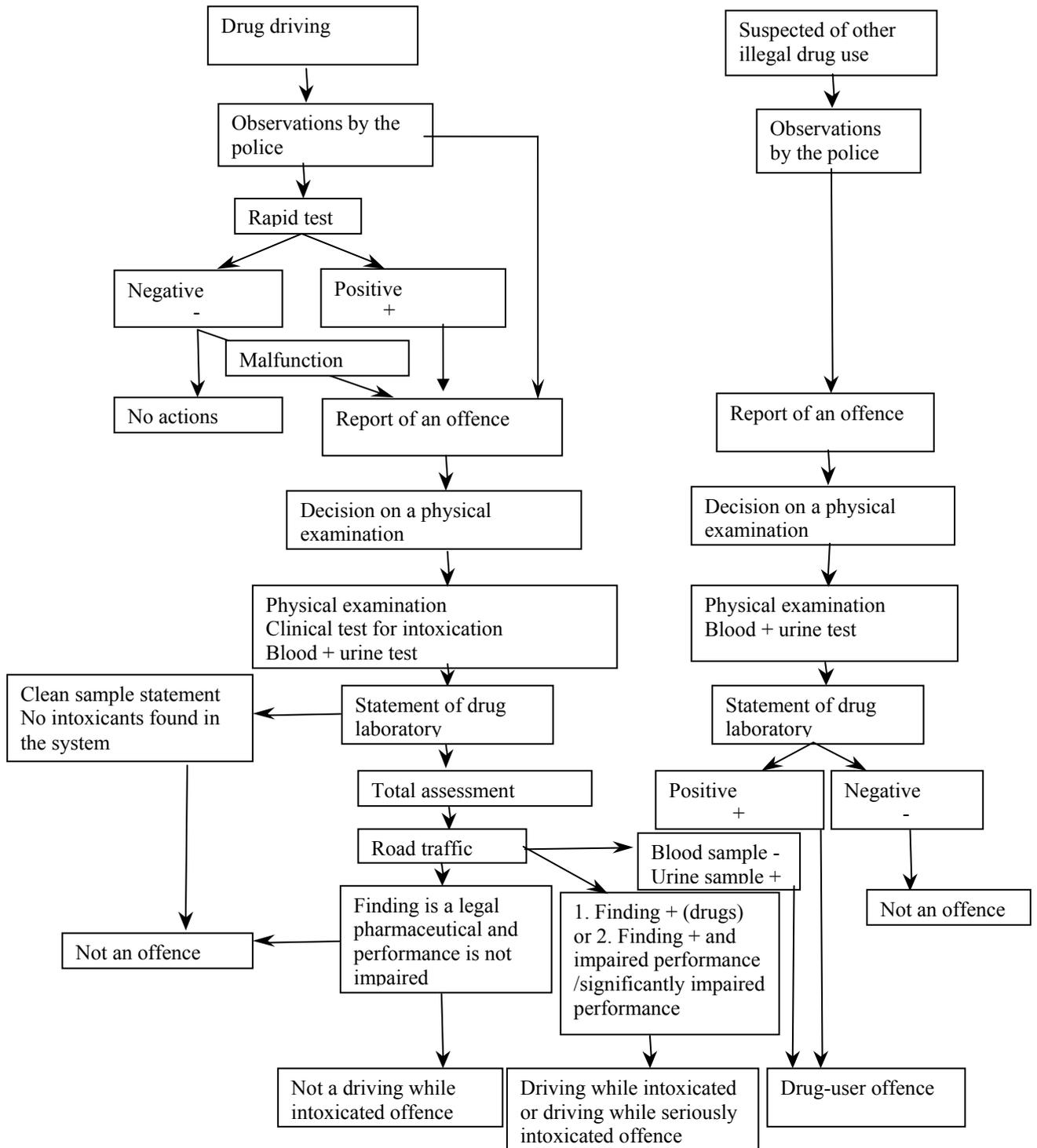
Even if a driver is not found guilty of driving while intoxicated, he or she may be found guilty of a drug-user offence (Penal Code, Chapter 50, Section 2a) in a case where the blood sample has tested negative but the urine sample has tested positive or where the person, while suspected of driving while intoxicated, has been in the possession of a small amount of drugs for personal use (Figure 12). It is customary not to sentence a person simultaneously for a drug-user offence and for drug driving.

Figure 12. Procedure in cases of driving while intoxicated.



Source: Lillsunde et al. (2003)

Figure 13. Procedure in cases of drug use.



Source: Lillsunde et al. (2003)

Laboratory activities

The alcohol and drug laboratory of the National Public Health Institute has been accredited in accordance with quality standard EN ISO/IEC 17025. Forensic chemical analyses are carried out using accredited methods. The methods have been developed in line with legislative requirements and international recommendations regarding the handling and analysing of forensic chemical samples as well as the needs of intoxicant control in road traffic.

Based on the results of laboratory analyses, a case-specific expert statement is issued, signed by a chemist in charge of the appropriateness of laboratory activities. An expert physician also signs the statement when pharmaceuticals or high concentrations of drugs are found. The type of statement depends on the findings.

The system of intoxicant control in road traffic has been developed together with different ministries (e.g. the law on zero tolerance, rapid drug testing). Training material has been produced for the police, and police officers have been trained in recognising the external signs of drug use. Important projects carried out in co-operation with the police include: "Alkoholi liikenteessä – Ratsiatutkimusta Uudellamaalla 25 vuoden ajan" (*Alcohol in road traffic – roadside testing in Uusimaa for 25 years*), "Tarkkuusalkometri autossa -projekti" (*Precision breathalyser in the car project*), the Rosita 2 EU-USA project, the EU research project DRUID and the planned register studies, which aim to study statistically the lifespan of intoxicated drivers and define ways to recognise when people are at risk of driving while intoxicated and to prevent those risks. Some of the projects have received external funding from the EU.

The laboratory test findings of the alcohol and drug laboratory play a key role when cases of driving while intoxicated are tried in Court. The development of analysis methods to meet the needs of the police is the result of systematic work over several decades. The measuring ranges for pharmaceuticals hazardous to traffic safety have been set so that they cover the concentration levels at which each pharmaceutical has been proven to impair driving ability.

Laboratory methods

The concentration of alcohol in a blood sample (ethanol) is measured using gas chromatography. Drug and pharmaceutical testing focuses on actual drugs and pharmaceuticals hazardous to traffic safety, i.e. pharmaceuticals that affect or may affect a person's psychomotor performance. In addition to a more general immunologic screening by compound groups, each sample is submitted for two gas chromatographic/mass spectrometric tests that screen the sample for 75 compounds hazardous to traffic safety. The mass spectrometric detection optimises the reliability of the analyses. The use of different detection techniques increases the scope, sensitivity and indisputable evidential value of the screening.

The drugs screened are amphetamines (amphetamine, methamphetamine and several of their synthetic derivatives such as ecstasy), opiates (heroin, morphine, buprenorphine and their metabolic derivatives), cocaine and its metabolic derivatives, cannabinoids (Δ^9 -THC and its metabolic derivatives), gammahydroxybutyrate (GHB) and LSD, if there are signs of their use.

Pharmaceutical groups that are hazardous to traffic safety are also screened in cases of driving while intoxicated. Each of these groups contains many different compounds. The primary focus is on hypnotics and sedatives (benzodiazepines,

zopiclone, zaleplon and zolpidem), antipsychotics, antidepressants, antiepileptics and pharmaceuticals used for opiate substitution treatment (buprenorphine, methadone).

Zero tolerance statements on drugs

The law on zero tolerance stipulates that a motor vehicle driver be sentenced for driving while intoxicated if his or her blood contains a narcotic drug or its metabolic derivative during or after driving. The term “narcotic drugs” refers to the substances specified in the Narcotics Act (1289/1993). However, illegal drug use must be separated from the use of pharmaceuticals prescribed by a physician, so the zero tolerance statement is issued only in cases where the laboratory findings involve substances classified as actual drugs that have no medicinal use (amphetamine, methamphetamine, MDMA, MDEA, MDA etc.; tetrahydrocannabinol [THC] or its metabolic derivative hydroxytetrahydrocannabinol [THC-OH]; cocaine or its metabolic derivative benzoylecgonine; the metabolic derivative of heroin 6-monoacetylmorphine [MAM]; LSD; GHB). Other substances found in low concentrations (e.g. benzodiazepines) are reported in the statement as secondary findings. If, for example, a high concentration of benzodiazepine is found, a statement is issued on the high concentration and its effect on driving ability is assessed.

Statements on substances used for medicinal purposes

Zero tolerance does not apply to pharmaceuticals classified as narcotic drugs, if the patient is entitled to use them. The laboratory cannot know whether a person has a prescription for the detected pharmaceutical. Therefore, if actual drugs are not found, a statement with an attached conclusion is issued on the other findings. However, the statement will include the following text next to all those findings that are pharmaceuticals classified as narcotic drugs in the list of the National Agency for Medicines: *if the driver is not entitled to use the aforementioned pharmaceuticals, zero tolerance for drugs may be applied (Penal Code, Chapter 23, Section 3)*. The conclusion assesses the effect of the detected pharmaceutical concentrations on the tested person’s driving ability according to the following six-step scale:

To eliminate pharmaceuticals or drugs:

1. It is unlikely that...
2. It is somewhat unlikely that...
3. It cannot be ruled out nor confirmed that...

To implicate the use of pharmaceuticals or drugs:

4. It cannot be ruled out that...
5. It is somewhat likely that...
6. It is likely that....

The conclusion and classification in the statement is based on a case-specific assessment by an expert physician.

Statements on high concentrations of zero tolerance drugs

When a zero tolerance statement is issued and a high concentration of a drug or pharmaceutical has been found, a statement on the high concentration of a pharmaceutical or drug is attached to the zero tolerance statement. The statement includes a conclusion, i.e. an assessment on the effect of the detected drug and pharmaceutical concentrations on the person’s driving ability. The conclusion and classification in the statement are based on a case-specific assessment by an expert physician.

14.4 Prevention

International studies have shown that the most effective ways to prevent driving while intoxicated are control campaigns carried out by the police that include monitoring drivers' driving ability at sobriety checkpoints across the country, random breath testing, lowering concentration limits and the temporary suspension of a driving licence. These methods have been used for drug control in road traffic in Finland. The limit for blood drug concentration was lowered to zero. In addition to breath testing for alcohol, the police have been trained to recognise external signs of drug use, and an observation form for recognising external signs of drug use has been developed for use by police officers. If police officers suspect a driver of being on drugs, they are also permitted to use saliva tests kits in roadside testing. The police have actively informed the public on road traffic control campaigns, the introduction of drugs testing etc.

Pharmaceuticals hazardous to traffic safety are labelled with a red triangle in Finland. The physician prescribing the pharmaceutical as well as the pharmacist selling it should warn the patient if the pharmaceutical is hazardous to traffic safety. Information leaflets on pharmaceuticals and driving have been produced for pharmacies to hand out to patients. Ultimately, however, the driver is responsible. A guideline given to all drivers is that if they feel tired or drowsy, they should not drive.

Right to drive, fitness to drive, substance addiction and treatment referral

Getting caught driving while intoxicated is usually the first clear sign of a substance abuse problem. A large proportion of those sentenced for driving while intoxicated in Finland suffers from addiction, and two thirds of them repeat the offence. Heavy users of intoxicants usually have multiple problems, and they are more prone to accidents and at a higher risk of premature death than the rest of the population. Early intervention into substance abuse problems has countless positive effects on public health, society and the economy. Thorough assessment, treatment and follow-up of substance abusers helps prevent substance addiction and thus road accidents caused by intoxicated drivers.

The EU Directive on driving licences (91/439/EEC) that came into force in Finland on 1 July 1996 stipulates that driving licences shall not be issued to, or renewed for, applicants or drivers who are dependent on alcohol, drugs or pharmaceuticals or who are unable to refrain from driving under the influence of those substances. A driving licence may be renewed after a proven period of abstinence. New medical certificate forms have been introduced that include sections dealing with dependency.

Since the beginning of 1999, detailed instructions and guidelines have been issued to meet the demands of the EU Directive. The Ministry of the Interior has issued the instruction "Päihderiippuvuus ja ajo-oikeus" (*Substance addiction and the right to drive*) (SM-2003-03220/Vi-3) to the police. The Ministry of Social Affairs and Health has produced a guidebook for physicians "Päihderiippuvuuden arviointi ja ajokelpoisuus" (*Assessment of substance addiction and fitness to drive*) (Ministry of Social Affairs and Health 1998).

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