



**REPORT TO THE EMCDDA
by the Finnish National Focal Point**

**FINLAND
DRUG SITUATION 2003**

REITOX

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INTRODUCTION

The current report on the drugs situation in 2003 published by the National Drug Monitoring Centre of Finland complies with the guidelines for annual national reports given by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) and is also in accordance with the EU Regulation on the EMCDDA. This report is the Finnish contribution to the *Annual Report on the State of the Drugs Problem in the European Union*. Similar reports are submitted by all the 15 National Focal Points (NFPs) included in the REITOX network co-ordinated by the EMCDDA.

The report includes four different approaches to the drug problem. It first describes the political and legal frameworks of drug issues in Finland. The second part of the report includes an overview of the national situation as regards drugs and drug abuse mainly in 2002. The third part concentrates on activities for drug demand reduction and the fourth on measures for drug supply reduction in Finland. In addition, the report discusses three current topics, i.e. evaluation of national drug strategies, cannabis related treatment demand and drug related co-morbidity. As an exception to previous year practices, this year every article was ordered from an expert of selected topic.

We remind in the beginning of every report that alcohol has a central role in the Finnish substance abuse or addiction culture. Therefore in Finland it is emphasised that instead of drug abuse we should speak of mixuse of substances or poly-drug abuse referring to the combined use of narcotics and alcohol or other psychoactive substances. However this report concentrates on drug abuse and related harms as well as poly-drug use - and from this point of view alcohol has more marginal role. This is well justified because in Europe (and in REITOX-system) illicit drugs are separated from licit drugs and because of the rapid increase in the prevalence of drug use and related harms in the 1990s – even if there in the beginning of 2000s appeared first signs of slowing down this trend. The development in 1990's has created a need to outline specific drug policies and to design a drug monitoring system as well as to promote research in the field.

The aim of the current report has been to provide objective and reliable information on drugs and drug addiction in Finland. This report could not have been produced without the help of experts in the many drug-related areas. Thanks are due to them all. Special thanks must be given to the experts of STAKES that are responsible of the three special topics of the report: researcher Mr. Tuukka Tammi (Alcohol and drug research group), special planning officer Ms. Airi Partanen (Statistics group), special researcher Mr. Sami Pirkola (Mental health group) and research professor Mr. Kristian Wahlbeck (Mental health group). Mr Ari Virtanen, senior planning officer of STAKES is responsible for collecting the material for the report and for the final interpretation of the submitted data. The translation is produced by Mr. Nils Dahlgren.

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SUMMARY

Drug Situation

In the survey conducted in 2002, 12 per cent of adult respondents reported having tried or used some narcotic substance during lifetime. Drug use during last year was reported by three per cent, while one per cent had used drugs during last 30 days. The study suggests that the 1990s drug trend was set in motion by men, followed by women in the second half of the decade. In terms of recent use, the growth trend was different. The proportion of those having used drugs during last year increased both among men and women between 1992 and 1998, after which the growth trend clearly levelled off.

As regards drugs use and experiments, age group 15–34-year-olds stands out. Regionally, Finnish drug use is prevalent in areas with a high degree of urbanisation and population density. The most frequently used drug is cannabis: a quarter of men and fifth of women in this age group reported having tried cannabis during lifetime. After cannabis come so called party drugs, amphetamines and ecstasy: about five per cent of men and 2.5 per cent of women in the age group 15-34-year olds have used or experimented with them. The abuse of pharmaceuticals in the same age group is slight more prevalent than the use of party drugs. However the abuse of pharmaceuticals differs from the use and experiments with drugs in the sense that it is as prevalent in every age group. The use and experiments with other drugs is much less prevalent as the use of drugs above.

Based on the existing indicators, trends in the drug situation since the mid-1990s seem quite uniform. Both drug experiments and use and negative effects (morbidity, crime and mortality) have gone up at least by half, while morbidity has more than doubled. This decade, however, has seen the first signs of a possibly slowing growth trend in drug experiments and use. This is apparent in regular use, use during last year, as well as among young age groups.

In entering treatment, cumulative harms resulting from problem use seem to occur with a lag of 3–5 years after the first experiments or commencement of use. The stabilisation of harm indicator values in 2001 and 2002 seems to be relatively consistent with the above-mentioned estimate of the delayed effects of drug-use trends on drug-related harms. In addition to the above harm indicators, new HIV infections due to injecting drug use appear to be declining slightly, as is the case with new hepatitis C infections as well. On the other hand, the prevalence of harms is attributable not only to the prevalence of use but also to changes in settings and the ways of using drugs - especially the establishment of health counselling networks for injecting drug users may be one reason for this declining trend of new HIV-infections.

Various drugs occur differently in the harm-related statistics. Statistics on services for substance abusers and health care are prone to display the harms of injected drugs, amphetamines and opiates in particular. These substances play a central role in the register of infectious diseases and cause of death statistics. Cannabis, in turn, is important in crime statistics, even though amphetamine has already become more

prevalent in the number of seizures. In the Finnish context, cocaine and ecstasy are in practice visible in crime statistics only, although their use is occasionally indicated by treatment statistics.

Finnish substance abuse is characterised by polydrug use. However the largest group of substance abusers consists of problem users of alcohol who only occasionally take other substances. The key polydrug user groups are as follows: (i) users of alcohol and medicines (psychopharmaceuticals); (ii) users of amphetamines and cannabis, who also imbibe alcohol; and (iii) opiate users who also take amphetamines and cannabis but not large quantities of alcohol. In the 2000s, alcohol seems to have a more minor role, especially among users with an opiate problem. New phenomena include mixing psychopharmaceuticals with opiates and abusing buprenorphine used in substitution treatment (Subutex) by injecting it. There are also some indications suggestive of a new user culture, where polydrug use is linked with recreational or occasional experiments with various drug combinations.

The crux of the Finnish substance abuse problem is alcohol abuse, but there are three factors that have made problem drug use a special concern since the mid-1990s: the constant, albeit today stabilised, increase in drug-related harms; the more common societal exclusion of problem users, reflected in a position even more disadvantaged than that of other substance abusers or criminals; and the accumulation of problems in young age groups.

It would appear that the growing trend in drug experiments and drug-related harms, having continued throughout the 1990s, is now in the process of stabilising. In terms of experimental drug use, the first indications of this change were recorded at the turn of the millennium, but in harms, the first consistent signs did not appear until 2001 and 2002. Today, the nature and permanence of this trend is unclear. Furthermore, it remains to be seen how the figures are affected by the new substances and practices adopted in evolving youth cultures, which are only tentatively indicated in population surveys, with the possible exception of ecstasy, or by increasing abuse of psychopharmaceuticals, especially meant for substitution treatment. Developments in Finland's neighbouring areas and in the supply of drugs may rapidly change the Finnish situation as well.

Drug politics

The Finnish Government issued on 5 October 2000 a Decision-in-Principle to enhance drug policy, the objective being to reduce both the supply and demand of drugs and to arrest the growth of narcotics use and related crime. The intensified measures proposed in the action plan integrate the focal points of anti-drug steps taken by different administrations. In addition the Government had set up a drug policy co-ordination group in order to co-ordinate national drug policy and to intensify collaboration between the authorities in their efforts to implement and monitor the drug programme. The group has representation from the relevant Ministries and agencies. According to the Decision, the co-ordination group must also

prepare a long-term action plan for more efficient drug policies. The Government was informed about the action plan on 5 February 2002. The Action Plan for More Efficient Drugs Policies in 2001–2003 retained the goals of the Government Decision.

The Government programme of the New Prime Minister Matti Vanhanen's Government, appointed in summer 2003, had the following statements about narcotics: (1) the Government will prepare a drug policy action plan for 2004–2007, (2) preventive substance abuse and drug work will be reinforced, (3) drug policy based on a total ban on drugs will be intensified - the aim is to prevent drug use and the proliferation of drugs as well as to reduce drug offences and other drug-related crime, and (4) in order to enhance public safety and to reduce drug-related, violent and repeated crime in particular a comprehensive and multisectorial programme on internal security will be drawn up.

The anti-drug activities

The report of the multi-administrative Drug Policy Committee (1997) and Government decision-in-principles on Drug Policy 1998, 2000) define the basic approaches to Finnish drug policy. On the basis of these documents, several more targeted and strategic action plans have occurred: the report of the committee for preventing drug use among young people was published in 2000 and of the working group on drug treatment in 2001. In addition, the police (2000, 2002) and the Prison Service (2002) have drawn up substance abuse or drug strategies. Following action approaches have been emphasised in these guiding documents.

The focus of prevention has been on young people: The school syllabus reform currently underway in Finland supports the qualitative development of health and legal education, and a new subject, health education, has been introduced into schools including the anti-drug aspect. In addition so-called workshop activities have been provided to support the vocational skills and social development of young people facing exclusion risk, for example, due to substance abuse. All central actors involved have invested especially in drug training: a supplementary training programme on drugs has been developed for teachers and a competence-based qualification training for a vocational examination in substance abuse work has started. A nationwide campaign on drug information is also ongoing, including a broad-scale evaluation. A network of municipal co-ordinators in drug prevention has also been established and for the first time the general quality frameworks and implementation of municipal drug work have been evaluated. Special development target has been on enhancing information flow between actors and the accessibility of the existing data. As a result, services have been launched to elaborate regional networks of drug work instructors and to disseminate information among drug workers about research results, working methods, municipal drug strategies and anti-drug projects run by municipalities or organisations. In addition, telematic discussion forums and anonymous self-testing services of personal intoxicant use have been developed

In the treatment system, the development of low-threshold services and the related training have been highlighted, the aim being to involve clients in the treatment system as early as possible. At the same time, there has been much debate about harm reduction actions, whose position as part of treatment has been more widely acknowledged, one example being the development of infection risk counselling services for injecting drug users as well as the development of substitution and maintenance treatment system. At the same time, the first evaluations of the feasibility/efficiency of low-threshold services and medicinal treatment have been published. Special training programmes on care practices in both these systems have been worked out. In the past two years, major investments have been made to develop the treatment system regionally, as suggested by the relevant working group. Moreover, the general quality framework for substance abuse services was established in national co-operation.

The control authorities have stressed collaboration in anti-drug work with other authorities in the field. A new narcotics offence type, 'user offence', and, as a related means of a personal hearing and possibilities of care referral for the offenders were introduced. At the beginning of 2002, the Office of the Prosecutor-General issued directions how to apply the law. Furthermore, the agency has provided local prosecutors with training in connection with this reform. The prison administration has produced well-designed products for drug treatment in prison and for the after-care of released prisoners, in association with organisations in the field. Furthermore, proposals have been made concerning juvenile punishment as a care referral tool for young people and the so-called contractual treatment for substance abusers as an alternative to imprisonment. The working groups preparing the issue have made proposals for amending legislation on introducing drug tests into working life.

Especially important for the enforcement authorities are the legislative reforms enhancing supervision authority and techniques. At the beginning of 2001, the police were given a new and more extensive authority to undertake fictitious purchase and undercover operations. Authority to engage in interception and monitoring of telecommunications will be upgraded as of 2004. The Customs Administration has been given part of these authorities under the Customs Act. In addition, more extensive authority to operate has been given to the prison authorities. The new investigative methods (monitoring of telecommunications and technical surveillance) have been primarily targeted at organised crime. Ever-expanding international co-operation and the new Schengen and customs information systems have provided the authorities with a wide range of contacts and data that are needed in order to supervise drug crime and money laundering and to keep internationally organised, professional drug crime under control. A major future challenge is the change occurring in Finland's international operating environment in particular, when the Baltic countries will join the EU in 2004.

A key aspect of activities during the year was the increasing co-operation between the enforcement authorities, other officials and citizens in preventing drug crime. The National Crime Prevention

Programme has brought the police and municipal authorities, the church and other actors closer together in these endeavours, but it has also been pointed out that the action plans in various sectors (e.g. municipal intoxicant and drug strategies) should be interfaced with the anticrime programmes. An effort has also been made to intensify co-operation with business life in terms of money laundering (banks and financial institutions) and control of precursors (chemicals companies, etc.).

The international nature of especially drug supply raises ever more concern also in Finland. The joint Finnish-Estonian drug prevention project (Finesto) between law enforcement authorities will continue and a separate project was established in spring 2003 to prevent drug trafficking from Russia to Finland. The liaison network of the National Board of Customs underwent reorganisation in 2002 and in 2003, the need for the network's further development and the stationing of a new liaison to an area pertinent to drug crime will be explored. In the field of the Ministry of Foreign Affairs, Finland will continue as one of the major donors to the United Nations Office on Drugs and Crime (UNODC). As a major donor the Ministry has set aside in its action and financial plan for 2003–2006 an appropriation to the UN's narcotics programme. The majority of drugs enter the Finnish market through countries in Central Asia and, consequently, the Ministry of Foreign Affairs supports the improvement of the border crossing point at Hayreton in Uzbekistan. The Ministry also aims to finance Phase II in the project on the drug control agency in Tadzhikistan.

Evaluation of Drugs National Strategies

The 1997 drug strategy stated that drug policy must be based on research information about the drug situation and research projects were proposed to be launched, the last one of which was the evaluation of the national drug programme's implementation. Such a research project has not been started yet. The Government Decision-in-Principle on Drugs Policy (1998) and an action plan for more efficient drug policies for 2001–2003 also include propositions to evaluate drugs policy and outline national system for monitoring and self-evaluation of drugs policy.

In addition to general strategies, the committee on preventing drug use among young people (2000) paid attention to the importance of critical youth policy assessment, while in its anti-drug strategy (2003 – 2006), the police set the objective of developing parameters for measuring the effectiveness of drug prevention. The working group on the treatment of problem drug users (2001), for its part, stressed the guiding impact of national frameworks on treatment services and suggested additional appropriations for treatment development. The State Provincial Offices are required to report on the feasibility and effectiveness of the development projects set up on this additional drug treatment funding (2002–2003).

The action plan for more efficient drug policies contains 24 separate actions, each of which has been assigned a body responsible for its implementation (authority or organisation). The drug policy co-ordination group's activities are comprised of monitoring and self-evaluation of administration, not evaluation research as such. The report on programme implementation was published in spring 2003. In it, the responsible parties reported on their activities in 2001 - 2003. Now, the co-ordination group is preparing an action plan for 2004–2007.

In terms of scientific evaluation, the co-ordination group has made some suggestions, such as the evaluation of nationwide drug information campaign, which will be published in late 2003. The multimethod campaign evaluation utilises, among other things, population surveys (campaign visibility), analyses of discussion forums on the Internet and in other media (content analysis; public debate and popular opinion), small-group interviews and interviews of substance abuse workers (reception study) and general analysis of the campaign's socio-political points of departure. The co-ordination group has also suggested that the Academy of Finland launch a separate drug research programme, containing an evaluation component as well, but so far, the undertaking has not made progress in the science policy administration.

No centrally administered general evaluation of Finnish drug policy is in progress, but many specific research projects on some segment of this policy (regional drug strategies/services) or on certain interventions (low threshold services, substitution treatment, services for HIV-positive drug addicts) are ongoing. Studies on quantitative trends in drug use, drug offences and other drug related harms as well as studies on drug users and the systems to help and control them are also employed as monitoring and developmental tools.

In sum, despite the fact that the drug administration has its own system of monitoring drug policy, national drug policy is not evaluated in order to study the overall targets set in the strategies and programmes. On the other hand, isolated interventions are studied from an evaluative viewpoint as well. Why is it, then, that drug policy on the whole is not evaluated more extensively?

From the standpoint of administration and decision-makers, one possible reason is the fact that Finnish drug policy still tries to find its course, and an intersectorially agreed drug policy is a relatively new phenomenon. In the strategies, the drug question is considered part of general social policy and this means that the objectives of drug policy are not unambiguous enough to lend themselves to evaluation through clear-cut research designs. Furthermore, the programmes do not comprise quantitative targets, whose achievement is easy to measure. Many drug policy actions in Finland are assigned to autonomous municipal governments (448 municipalities), a fact that makes data compilation more complex. For the Finnish research sector, the drug issue has traditionally been regarded as a marginal topic - the substance abuse field has mainly been preoccupied with the alcohol issue partly for the sake of the institutional

arrangements of alcohol policy. Interest in evaluation research has also been quite modest and possibly it has been deemed a tool for administrative planning rather than serious research.

To date, evaluation of Finnish drug policy consists of the following parts: (1) the basic system of monitoring and reporting the drug situation mostly to the international organisations, (2) the role of the drug policy co-ordination group in steering national drug policy and its self-evaluation, (3) implementation of separate scientific evaluations which were decided by the co-ordination group, and (4) evaluations of isolated interventions mainly supported by public funds and whose outcomes will be utilised in drug policy steering and finance through the proposals of the co-ordination group.

Cannabis problems in context: understanding increased treatment demand

Cannabis has been significant drug as the primary drug leading to treatment demand (18 % of the cases), despite the fact that the drug treatment data collection indicated the most common primary drugs for entering treatment in 2000–2002 to be stimulants (27 %) and opiates (28 %). The percentage of those entering treatment due to cannabis was the highest at youth centres, offering treatment for under 25-year-olds, with 26 per cent entering treatment primarily for this reason.

Those entering treatment for cannabis predominate in the client group entering treatment for the first-time ever, where the percentage of cannabis clients were 30 % in 2002. The prevalence of cannabis use is also reflected in polydrug use among the drug clients in services for substance abusers, where it was mentioned among the 1st–3rd substance in 60 per cent of the clients. On average, substance abuse treatment was sought first time due to cannabis at the age of 20 years, about five years after the use had started and after about three years of regular use of cannabis. Women accounted for a fifth of those entering treatment. In 2002, the situation of first-time treatment seekers seemed to be somewhat more stable than in previous two years: the percentage of those who had finished primary level of education was higher (85 %), the percentage of the homeless was lower (2 %), and the percentage of those employed or studying was higher (66 %) than before.

The situation of those aged under 20 years, entering treatment mainly for cannabis was more stable compared to those aged 20 or older, e.g. in the first group the share of students or employed were totally 76 per cent while in the second group the share was only 33 per cent. Those aged under 20 also seemed to have more social support, as indicated by treatment referrals made by parents or close persons. Only few (13%) of those aged under 20 entering treatment mainly for cannabis used it on a daily basis, and as few as a quarter of those aged 20 or over did so. Polydrug use of several substances was, however, common in both groups. In the younger age group, alcohol was the most usual secondary substance (40%), while in the older group it was stimulants (41%). Due to polydrug use a quarter of those under 20 years of age

and over half of the older group entering treatment due to cannabis had injected drugs at least once during lifetime.

Finland has no specific drug treatment units targeted at people with cannabis problems and therefore the clients demand treatment from general addiction treatment services. A Helsinki-based youth centre treating many young people entering treatment for cannabis use has indicated that the clients can be divided into three groups based on the reason for treatment need: (1) Some clients enter treatment because of concerned parents who may be confused about their children's striving for self-determination and experimental or long-term cannabis use, (2) the second group comprises young people in whom cannabis causes depression interfering with concentration, schoolwork or studies, and (3) the third and smallest, yet the most demanding, group consists of young people entering treatment due to cannabis-induced psychosis. The link between cannabis and mental disorders is visible in hospital statistics. In terms of hospital in-patient treatment statistics, especially cannabis-related psychoses as well as mood and anxiety disorders increased between 1996 and 2000. For young patients entering treatment for cannabis-related psychosis, the accent is on mental health assessment and agreeing on the suitable treatment unit. The patient's psychological condition permitting, treatment will be also implemented in a substance abuse unit.

A punishment for drug user crime was instituted in 2001, whereby those under 18 years of age must automatically undergo a hearing accompanied by the parents, prosecutor, social worker and a representative of the police. Moreover, the police have been instructed to give all drug suspects guidance in seeking treatment. According to the drug treatment demand information system, those entering treatment for cannabis because of police initiative in 2000 accounted for 4 per cent, followed by 7 per cent in 2001 and 2002. The drug treatment data system does however not give information as to whether treatment referral by the police was associated with the above-mentioned user crime. However increase trend in experimenting and using of cannabis as well as the number of cannabis related harms (seizures, drivers under the influence of drugs, drug findings in autopsies) to the beginning of 2000's supports the interpretation, that the meaning of cannabis in treatment demand is increasing.

Co-Morbidity

Since the 1990s, observations made by professionals working with psychiatric patients in Finland indicate that the patients' use of illicit drugs has increased, especially as regards patients who have the severest psychiatric symptoms and are in need of hospitalisation. No research evidence of this phenomenon has been published, but reports on substance abuse in the population suggest an increase in drug experiments and other indicators of drug use. However it is also known that the health-related and social consequences of drug use typically surface several years after the use has started, some significant exceptions notwithstanding.

Maintained by STAKES, the Hospital Discharge Register (HILMO) is a repository for all Finnish hospital treatment periods including discharge diagnoses. To elucidate trends in psychiatric co-morbidity over time in Finnish in-patient treatment, we have retrieved a time series spanning from 1987 to 2002 from the HILMO register data on discharges with diagnoses related to both problem use of narcotics or pharmaceuticals (excluding alcohol) and at least one other mental health disorder (excluding mental disability).

During the period examined, 1987–2002, a slight increase occurred in the overall number of in-patient treatment periods provided in the Finnish health care system. At the same time, according to HILMO, the co-occurring drug-related and other psychiatric diagnoses increased about fivefold (from 441 treatment periods to 2130 periods). Especially noteworthy was the increase in the dual diagnoses associated with psychotic disorders and mood disorders. Within the psychosis group, a significant increase also occurred in schizophrenic patients who had dual diagnoses.

The treatment periods due to diagnoses of illicit opiate use and other psychiatric disorders have tripled since 1996. An increase is also apparent in the treatment periods based on diagnoses of problem cannabis use and psychiatric disorders. On the other hand, no major changes have occurred in the dual diagnosis periods related to abuse of pharmaceuticals, stimulants (mainly amphetamines) and hallucinogens since 1996.

Because only a modest increase occurred in the overall number of hospital treatment periods provided by the health system during the period studied, observations of the increases in dual diagnosis periods indicate a real change in both absolute and relative proportion of these hospitalisations provided. It should furthermore be noted that, during the period monitored, the number of psychiatric beds constantly declined a fact probably still increasing the relative proportion of dual diagnosis periods. With the downsizing of psychiatric hospitals, the treatment of substance abuse problems became an attractive option for the hospitals. The psychiatric hospitals did not, however, assume a major role in substance abuse treatment because the local authorities declined to pay for ‘expensive’ hospital treatment. More responsibility was given to primary health care and social services, while in specialised services, ‘low-threshold’ treatment units and services were set up for deprived clients.

The treatment of patients suffering from co-occurring drug dependence and other mental disorders is exceptionally demanding and often unrewarding. For example, people with severe mental health disorders typically require a wide range of support measures having to do with housing and everyday life. These patients not infrequently end up in various nursing or rehabilitation homes, peopled by similarly afflicted clients. However, these services are not very suitable for clients who at the same time consume illicit drugs, who do not adapt to the everyday routine, who are prone to have problems with other residents and

personnel and who gravitate towards antisocial networks. International experiences support the observation that the treatment of dual diagnosis patients solely in substance abuse services or mental health services is often fruitless, whereas integrated treatment programmes have turned out more effective.

In terms of the service provision, the report of the working group on the treatment of problem drug users (2001) stated that the use of psychiatric services in treating drug addicts must be solely based on the need for psychiatric expertise. Specialised psychiatric services should enhance their readiness to support primary health care and the social services through consultancy and supervision. Dual diagnosis units specialising in the identification and care of co-occurring addictive and other mental disorders should be established in university hospitals and possibly in other central hospitals as well. On the other hand, addiction to psychopharmaceutical drugs should be primarily treated in specialised psychiatric services. Since the late 1990s, the Finnish Slot Machine Association and the Ministry of Social Affairs and Health have supported strongly the development of new drug addiction treatment services. As yet there is no information whether these funds have been used to develop treatment for co-occurring drug problems and psychiatric disorders.

On the whole, actions to treat drug addiction are faced with a wide range of challenges. Preventive actions taking account of social support, low-threshold units enabling early and later-stage treatment initiation, provision of pharmacological and psychosocial treatments for drug addiction and the treatment of the most demanding patients, i.e. those suffering from co-morbid disorders – all these are important aspects of the treatment and service system for people with drug problems or addiction. As the service system is confronted with new challenges, expertise in addiction psychiatry should be endorsed through education and by setting up units specialising in addiction psychiatry.

PART I

NATIONAL DRUG STRATEGIES: INSTITUTIONAL AND LEGAL FRAMEWORKS

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

Regionally, the social welfare and health care departments in the *five State Provincial Offices* and the *Provincial Government of Åland* control and supervise implementation of social and health services in their region and collaborate with municipalities. Police work is divided into 90 *state administrative districts*, each of which is in charge of drug investigation in its area. In addition, each district has district prosecutors, working independently of the police. There are 63 district courts for exercising juridical power, and the Customs Administration has five customs districts and regional offices.

All 446 Finnish *municipalities* are responsible for practical implementation of statutory services, which are either provided by the local authorities themselves or purchased from the private sector. The services are mainly financed by municipal tax revenues, state subsidies and partly by user fees.

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

The key Ministries co-ordinating international drug issues are the Ministries of Foreign Affairs, Social Affairs and Health, Education, Justice and the Interior. Their actions are co-ordinated by the national working group on international drug issues, appointed by the Ministry of Social Affairs and Health.² Especially a national narcotics subcommittee was established in 1999, acting under the National Committee on EU Affairs and parallel with the working group dealing with international drug issues. The subcommittee is led by the Ministry of Social Affairs and Health, and in terms of representation, it is an extended version of the national working group on international drug issues.

¹ See Appendix 1: Organisation chart of drug administration in Finland.

² See Appendix 2: Administration of international drug issues in Finland.

1 DEVELOPMENTS IN DRUG POLICY AND RESPONSES

1.1 Political framework in the drug field

Based on the proposal³ outlined in the 1997 report of the Drug Policy Committee (Drug Strategy 1997, 56–60), the Finnish Government issued a resolution on drug policy (Government decision-in-principle on Drug Policy 1998). It defines the basic approach to drug policy as follows:

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

In 1999, the Government set up a drug policy co-ordination group in order to co-ordinate national drug policy and to intensify collaboration between the authorities in their efforts to implement and monitor the drug programme.⁴ The group has representation from the relevant Ministries and agencies.

Based on the proposition of the Drug Policy Committee, the Finnish Government issued on 5 October 2000 a Decision-in-Principle to enhance drug policy (Press release of the Government 238/2000), the objective being to reduce both the supply and demand of drugs and to arrest the growth of narcotics use and related crime. The intensified measures proposed in the action plan integrate the focal points of anti-drug steps taken by different administrations.

According to the Decision, the co-ordination group must also prepare a long-term action plan for more efficient drug policies. The Government was informed about the action plan on 5 February 2002. The Action Plan for More Efficient Drugs Policies in 2001–2003 (2003) retained the goal of arresting the growth in narcotics use and drug crime. The programme will pursue the policies laid down in the Decision-in-Principle in 2000 and implement drug policy in 2001 - 2003. The proposals made by the co-ordination group concerned (A) prevention and early intervention; (B) actions to reduce drug-related

³ The proposals concerned both narcotics and medicines abused for intoxication purposes.

⁴ See Appendix 1 (Organisation chart of actors in drug administration)

harms; (C) drug treatment and law enforcement as part of the prevention and reduction of (D) demand and (E) supply. In addition, proposals for (F) international drug co-operation were made.

A. The following proposals were made for prevention and early intervention:

1. Based on the Government's decision to enhance drug policy in 2000, health promotion appropriations were increased, especially for improving the professional skills and understanding of harm reduction among those engaged in drug prevention.
2. As of 2001, the co-ordination of multiprofessional substance abuse work and professional skills in the municipalities will be consolidated by developing municipal contact person network correspondingly.
3. In 2002–2003, a group of municipalities will be selected from this network for a more specific development project to enhance wider interadministrative leeway.
4. Methods of outreach work will be developed to intervene locally in emerging drug phenomena as early as possible.
5. Activities to enhance drug information and education, started in 2001, will continue in the form of a nationwide information campaign.
6. As of 2001, the education sector will enhance personnel training emphasising preventive work, as decided by the Government in 2000.
7. In 2002–2003, supplementary training for school personnel will continue in an effort to view drug prevention from a wider and social perspective.
8. Youth workshops and organisations working with them will be allocated special resources be used for preventing drug use and exclusion among young people.
9. In 2002–2003, funds will be forthcoming for training personnel in municipal youth work, non-governmental organisations and for volunteers.

B. The following proposals were made in terms of drug harm reduction:

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

C. The following the proposals were made in terms of drug treatment:

1. In order to enhance drug policy in 2002 and 2003, special State funding will be allocated for increasing treatment referral and rehabilitation services to meet the needs of people with drug problems.
 2. Measures will be taken to implement and expand treatment and rehabilitation outside office hours. The detoxification, substitution and maintenance treatment of opioid addicts by methadone and buprenorphine will be expanded to units that meet the necessary requirements. Action models to prevent the spread of infectious diseases will be developed and introduced.
 3. An effort is made to improve especially the possibilities of young people, who have committed themselves to treatment, to access a sustained and intensive psychosocial rehabilitation continuum, with necessary inpatient rehabilitation ensured.
 4. To intensify referral to treatment, treatment and rehabilitation of pregnant women, who use narcotics or intoxicants, and of their children, a project on maternity clinic activities and other social and health services will be launched.
 5. Supplementary education for professionals treating drug addicts will be improved.
 6. Supplementary education will be organised especially for health care personnel in order to expand the detoxification, substitution and maintenance treatment of opioid addicts.
- D. The following propositions are made for law enforcement authorities in terms of demand reduction:
1. The police take part in disseminating anti-drug information and education locally and nationally as well as in providing material and training for those working with young people.
 2. When implementing the national anticrime programme, special attention is paid to the interconnection between drug offences and other types of crime and to the special position that drug crime prevention has in anticrime activities in general.
 3. In co-operation between the police and local social welfare and health care authorities, 24-hour emergency services are organised to provide the police with professional help for assessing drug use and care referral.
 4. In the prison administration, drug abuse services and their promotion belong to the joint tasks of all personnel, as instructed by the handbook on supervision written for this purpose.
 5. In all areas of the prison administration, drug treatment and rehabilitation aim at forming a seamless continuum from detoxification to rehabilitation and reintegration after release.
 6. The prison administration is about to appoint a working group exploring, e.g. the organisation of opioid-dependent inmates' detoxification, substitution and maintenance treatment in prison.
 7. For the regional offices of the Probation and Aftercare service in Greater Helsinki, a joint working group has been set up to take care of the supervision of drug-addicted prisoners released on probation.
 8. Curative measures will be increasingly attached to penal sanctions, for example, in March 2002 the Ministry of Justice received the report of the working group on so-called contractual treatment.

E. The following proposals were made for law enforcement authorities in terms of supply reduction:

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

F. In international co-operation, the emphasis is on the UN Conventions and decisions on drugs, especially the objectives set at the General Assembly on 8–10 June 1998 to be implemented by 2003 and 2008. Furthermore, it is stressed that:

1. Finland will continue as a major contributor to the UN Drug Programme;

2. National data systems will be developed in collaboration with the EMCDDA;
3. Possibilities for exchange of information within Europol, the Schengen Agreement and bilateral anticrime agreements will be developed further; and
4. Finland will ratify the EU Convention approved in 2000 on mutual legal assistance in criminal matters.

A report on the implementation of the Action Plan for More Efficient Drugs Policies was completed in early 2003.⁵ In its report, the co-ordination group presents a plan to intensify drug policy for the year 2003. The plan lays out the focal points for various administrations:

The Ministry of Social Affairs and Health is responsible for drug policy co-ordination. The further development of co-ordination in drug prevention is funded through an appropriation for health promotion (45,000 euros). The plan on appropriations for health promotion in 2003 allocated a total of 833,000 euros to 13 projects on drug prevention and the development of treatment for drug users. This appropriation supports prevention among children and young people in particular as well as projects aiming at early intervention in exclusion. In addition to actual narcotics projects, the health promotion appropriation finances several projects on preventing intoxicants use, with the prevention of narcotics use in a pivotal role. In 2003, about 3 million euros will be spent on substance abuse projects. As in 2002, a special State subsidy of 7,570,000 euros was granted in 2003 to costs resulting from the treatment of problem users. Applications for and subsidies from the Finnish Slot Machine Association for the benefit of preventive and corrective drug work are constantly increasing. In 2003, 9 million euros of proceeds from the gaming community will be channelled through various projects on drug prevention and treatment. In line with the action plan, the National Public Health Institute, the Finnish Centre for Health Promotion and STAKES each have their own projects on drug prevention and treatment.

Preventive drug work will continue within the youth services of the Ministry of Education. An appropriation of 840,000 euros, specified in the 2003 budget for the development of youth workshops and drug prevention, will mainly promote the prevention of drug use among young people and the training of personnel in municipal youth services, organisations and volunteer activities as well as support for long-term projects and programmes. The Ministry's youth unit is in charge of its allocation and co-ordination of activities. Drug prevention is included in other youth activities as well, such as youth workshops and afternoon clubs. The curriculum reform of the National Board of Education in 2002 redefined the grounds for the new school curriculum in terms of educational objectives at national level. The goals of health promotion as well as the prevention of and early intervention in intoxicants use are clearly outlined in the curriculum. The new subject, health education, will also reinforce the prevention of substance abuse at schools and vocational institutes. The new curriculum will be introduced into primary education between 2003 and 2006 and into upper secondary school in 2005.

⁵ See <http://www.stm.fi/suomi/julkaisu/julk01fr.htm>

In the administrative sphere of the Ministry of the Interior, the police have not received the appropriations for combating serious drug crime, suggested in the Action Plan for More Efficient Drugs Policies. This has resulted in the increase of the number of organised crime gangs meeting the EU criteria. In 2003, the situation is liable to exacerbate. An additional appropriation of 3,195,570 euros, suggested in the enhancement action plan, would enable the police to hire 60 new officers to fight serious drug crime. This addition aims at detecting 5–10 organised crime groups distributing drugs. The additional appropriation also makes it possible to retain drug control in the street on the level it was in 2001. Co-operation between the police, the Customs Administration and the Border Guard will be further intensified, for example, by improving exchange of register information. The joint Finnish-Estonian drug prevention project (Finesto) will continue on the same level in 2003. A separate project was established in spring 2003 to prevent drug trafficking from Russia to Finland.

Important general objectives in the field of the Ministry of Justice include problem users' referral to treatment and support at all stages of their involvement in the criminal justice system. In terms of sanctions, treatment plays an increasingly important role, especially as regards the contractual treatment sanction. Based on the report of the committee appointed on 28 February 2001, the Ministry will prepare a Government proposal for legislation on contractual treatment as a new criminal sanction so that the proposal can be submitted to Parliament after the elections in spring 2003 – this will probably happen in spring 2004. The reintegration into society of those already convicted will be promoted and recidivism will be reduced through a project called 'Co-operation for crime-free life' in 2002–2005. Drug control in prison will be maintained through drug-free wards and extensive drug testing. In addition, legislative reforms aim at better investigation and seizure of criminal proceeds.

The 2003 action plan of the National Council for Crime Prevention identified drug offences as a focal point. According to the 2003 budget draft, the administrative sector of the Ministry of Justice will receive a 500,000-euro supplement to the 2001 appropriations for intensified actions against drugs for operating costs in enforcing punishments. The allocation of this additional sum will be decided in the performance target negotiations between the Ministry and the Criminal Sanctions Agency. According to a preliminary plan, one third will be directed at surveillance and two thirds at increased rehabilitation. The goal of the special drug prosecutors in 2003 is to collaborate with the key drug prosecutors and, co-ordinated by the Office of the Prosecutor-General, to devise action models to unify and professionalise consideration of charges, prosecution and decision to waive sanctions in drug offences throughout the country. Internal arrangements within the Ministry's sphere will continue to fund a research project on drug crime and the feasibility of the related legislative and criminal processes at the National Research Institute of Legal Policy.

The administrative sector under the Ministry of Finance had no specifically targeted appropriation in 2002 to implement the Government Decision-in-Principle. The financial framework of the Customs Administration for 2003 was supplemented by 504,563 euros in order to implement the Decision-in-Principle. According to the action plan, the number of customs drug enforcement officers will increase and actions will be targeted to tackle international drug crime. In 2003 and 2004, the prevention of professional and organised drug crime will be intensified by making better use of crime prevention technologies and by improving anti-crime information systems. According to the strategic guidelines set forth in the agency's 2003 budget and action and financial plan for 2004–2007, the Customs Administration will in 2003 invest additional resources in developing the crime prevention data infrastructure and technical surveillance equipment as well as in augmenting the automatic system for vehicle identification. The projects now underway are expected to relieve manpower to anti-crime activities at the end of 2004. During the plan period, these resources will be channelled into drug crime investigation, special surveillance and drug dog activities, based on a special plan. The liaison network of the National Board of Customs underwent reorganisation in 2002. In 2003, the need for the network's further development and the stationing of a new liaison to an area pertinent to drug crime will be explored. In addition, the Customs Administration will solidify co-operation with the police in order to achieve desired societal impacts on preventing drug crime.

In the field of the Ministry of Foreign Affairs, Finland will continue as one the major donors to the United Nations Office on Drugs and Crime (UNODC). A major donor is required to grant the UNODC an annual sum of some 500,000 US dollars. In its 2002 budget draft and the action and financial plan for 2003–2006, the Ministry has set aside an appropriation of 100,000 euros as a voluntary general contribution to the UN's narcotics programme; the Ministry also intends to continue this subsidy in the future. The majority of drugs enter the Finnish market through countries in Central Asia and, consequently, the Ministry of Foreign Affairs supports the improvement of the border crossing point at Hayreton in Uzbekistan by 200,000 euros (a total of 400,000 euros in 2002 and 2003). The Ministry also aims to finance Phase II in the project on the drug control agency in Tadzhikistan by 400,000 euros. The Ministry has reserved 700,000 euros for these undertakings in Central Asia in 2004 and 2005. The Ministry is preparing police and border guard co-operation in Northwestern Russia, a project to which Finland has earlier pledged 100,000 euros. The project includes the development of information compilation systems on drug trade in the St Petersburg area. The project will also involve Finnish experts, who assist in charting the narcotics situation, training and organising short study trips to Finland. The UNODC's new proposal has the written consent of the Russian foreign ministry. Finland has not yet made the final decision to finance the project.

The Government Programme of the New Prime Minister Mr. Matti Vanhanen (Government, appointed in summer 2003),⁶ makes the following statements about narcotics:

1. The Government will prepare a drug policy action plan for 2004–2007.
2. Preventive substance abuse and drug work will be reinforced.
3. Drug policy based on a total ban on drugs will be intensified. The aim is to prevent drug use and the proliferation of drugs as well as to reduce drug offences and other drug-related crime.
4. In order to enhance public safety and to reduce drug-related, violent and repeated crime in particular a comprehensive and multisectorial programme on internal security will be drawn up.

1.2 Legal framework

1.2.1 Narcotics legislation

The Narcotics Act (1289/1993) prescribes the main principles of drug control based on international conventions. **The Narcotics Decree (1603/1993)**, associated with the Narcotics Act, lays down provisions for the export and import of drugs. The administrative decision of the Ministry of Social Affairs and Health (1709/1993) defines drugs and substances used in their manufacture (precursors). Drug legislation has subsequently been amended to comply with the EU control regulations on precursors and the changes made in the drug lists of the United Nations (703-704/1996, 201/2001, 983/2001). Responsibilities of the National Agency for Medicines concerning, e.g. import and export authorisations and bookkeeping have been specified by subsequent Decree amendments (927/1998, 983/1998, 1065/2000, 954/2001, 1331/2001). The orders of the National Agency for Medicines concerning the importation of personal pharmaceuticals (6/2001, 1088/2002) stipulate the amount of pharmaceuticals defined as narcotics a passenger can legally import to Finland.

Narcotics offences are specified in **the Penal Code (1304/1993)**, whereby drug offences are categorised as *narcotics offences*, *preparation of narcotics offences* and *abetment of narcotics offences*, with sentences ranging from a fine to a maximum of two years' imprisonment; or as *aggravated narcotics offences*, carrying sentences from one to ten years' imprisonment. The criteria for an aggravated narcotics offence are as follows:

- The offence involves a highly dangerous substance or large quantities thereof.
- Considerable financial profit is sought.
- The offender acts as a member of a group organised for the extensive commission of such an offence.
- Serious danger is caused for the life or health of several people.
- Narcotics are distributed to minors or in an otherwise unscrupulous manner.
- The narcotics offence, when assessed as a whole, is to be deemed aggravated.

⁶ <http://www.valtioneuvoisto.fi/vn/liston/base.lsp?r=696&k=fi>

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

In the summer of 2001, an amendment (654/2001) to the Penal Code concerning narcotics offences was passed, including the new essential elements under the heading of *drug-user offence*.⁷ In effect since 1 September 2001, the new law concerns persons who illegally use, possesses or try to obtain small quantities of narcotic substances for personal consumption. The penalty is a fine or not more than six months' imprisonment. This enables summary penal proceedings, where the prosecutor can give the punishment outside court. In such cases, the pre-trial investigation material is often less extensive than in ordinary preliminary investigation.

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

1.2.2 Other drug-related legislation

The amendment to the Penal Code regulated *money laundering* (317/1994, 68-79/1998). The purpose of the law is to prevent money laundering, to promote disclosure and investigation and to enhance the recovery of the criminal proceeds. To meet the requirements of the new amendments, the National Bureau of Investigation has established a Money Laundering Clearance House. The Government proposal (HE 52/2002) recommends that separate criteria be specified for money laundering offences and that also brokerage and abetment in concealing or dissipating assets are defined as criteria for engagement in crime. At the same time, the maximum penalties for money laundering would be increased.

Chapter 23 of the Penal Code, concerning drunkenness in road traffic (1198/2002), underwent amendment. The new Act stipulates that a person operating a motor vehicle after having consumed narcotics so that his or her blood contains an active narcotic substance or its metabolic derivative during or after the drive shall be sentenced for *drunken driving* in road traffic to a fine or imprisonment for a maximum of six months. The law is not applied if the said substance or its metabolic derivative stems

⁷ For a more detailed discussion about the enactment of laws on drug crime in Kainulainen (2000). See also Chapter 1.3.

from a pharmaceutical drug the driver is entitled to use. However, a person operating a vehicle after having used an intoxicating substance other than alcohol, or such substance with alcohol, so that his or her ability to perform faultlessly has impaired will be sentenced for drunken driving. If the ability to perform is greatly reduced and the circumstances are conducive to endangering the safety of others, the offender shall be sentenced for *aggravated drunken driving* to a minimum fine of 60 day-fine units or imprisonment for a maximum of two years.

In 2001, **an amendment to legislation on the forfeiture consequences in the Penal Code (875/2001)** was passed. The amendment concerns the forfeiture consequences specified in the law concerning drug offences. The amendment adopts the concept of *extended forfeiture of the proceeds*, whereby e.g. persons having committed or abetted a drug offence may be ordered to forfeit their property or a part of it, if the offence may give considerable financial yields and if there is reason to believe that the property is partly or fully derived from criminal activity. According to the proposal, no forfeiture is however ordered, if the defendant shows probable cause to presume that the property in question was acquired by legal means (the so-called *reversed burden of proof*).

Amendments to the **Coercive Measures Act (646/2003)** laid down new provisions under which the authorities may *search a place or person* (house search, body search, etc.), or engage in *interception of telecommunications, monitoring of telecommunications* and *technical observation*. The amendment expands interception of telecommunications and monitoring to email addresses and telecommunications terminals, including the messages and client identification information stored in them, and, in terms of monitoring, also location information of mobile telecommunications. Especially when suspected aggravated drug offences are in question, all these actions can be taken by law – one example being technical interception concerning the domicile where the suspect is likely to reside. The Act will take effect on 1 January 2004.

According to the amendments to the **Act on the Enforcement of Punishments (364/1999)** and amendments to other laws to reinforce the authority of prison personnel in drug control, the prison warden is authorised to order an inmate to undergo a body search. In addition, prisoners must give urine specimens or take a breathalyser test as a precondition for unmonitored visits or before going on leave. A prisoner may be isolated in order to prevent drug offences. It is also possible to transfer an inmate to another institution, such as a treatment unit for substance abusers. In its report (2002:3), the so-called contractual treatment committee proposed a law on testing contractual treatment as an alternative to prison sentence for convicts whose offences were significantly influenced by a substance abuse problem and who can be assumed to follow the treatment plan devised for them.⁸

⁸ See Chapter 12.2.

The Police Act (493/1995) was amended (21/2001) in order to add provisions for unconventional means of preventing and investigating crime. The new methods are *covert operations* (the use of misleading or covert information in investigation or infiltration) and *fictional purchase* (offer to buy made by a police officer to prevent or uncover the possession, sale or production of an illegally held substance or property or to recover ill-gotten gains). The reform of the Police Act also included regulations on *security checks* in order to protect court sessions and other activities in need of special protection (See also Decree 315/2001).

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

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

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

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

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

Under the **Child Welfare Act** (139/1990), children have the right to a safe and inspiring environment as well as well-balanced and many-sided development and precedence concerning special protection. The municipality must take immediate action, if a child's living conditions are threatened or if a young person endangers his or her own health.⁹

⁹ See Chapters 9.3.

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

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

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

The law concerning **the protection of privacy in working life** (477/2001) indirectly addresses the question of drug testing in the workplace as well. Based on the Act, the employer may process personal information about employees that is pertinent to the work at hand, without exceptions (including the employee's consent). This requirement concerns also testing for drugs in aptitude tests relating to the job or in assessing the employee's health. The employer must use health care professionals and proper health care services in conducting drug or alcohol tests, as specified in health care legislation. An employee's obligation to participate in medical examinations and tests was meant to be stipulated based on a proposal made in the report (2002:2) of the Ministry of Social Affairs and Health working group on drug testing in working life. The proposal will however be further processed in the Ministry of Labour working group on 'data protection and surveillance of employees', making its own proposal for the law in its report on 26 June 2003.¹⁰

In 1997, the Ministry of Social Affairs and Health issued an **Order on the detoxification and substitution treatment of opioid addicts with medicines** containing buprenorphine, methadone or levacetylmethadol (28/1997). A new Order was issued on 2 November 1998 (42/1998), and on 1 July 2000 the Ministry issued a Decree on the same topic (607/2000), to be replaced by yet another Decree (289/2002) on 15 April 2002. The present Decree no longer mentions levacetylmethadol, and maintenance is added to the treatment options. The availability of treatment has also been improved by easing up restrictions on treatment units. In the Decree, opioid addiction is defined by the ICD-10 criteria (F11.2x). All types of treatment require an individual treatment plan, specifying other medical and psychosocial care and follow-up for the patient along with pharmaceutical therapy with buprenorphine or methadone. The Decree defines both *detoxification* and *substitution treatment* aiming at drug-free life

¹⁰ See Chapter 9.4.

and detoxification also as rehabilitative care. Meanwhile, a new therapy is introduced in the form of *maintenance treatment*, with harm reduction and enhancement of the patient's quality of life as focal points. The detoxification period is limited to one month, whereas substitution and maintenance are intended for longer treatment.

In all treatment forms, care need assessment and commencement of treatment are defined to take place in a central hospital or other corresponding hospital designated by a federation of municipalities in the health care district, Järvenpää Addiction Hospital or other municipal unit in the health care district, health centres, substance abuse clinics or prison health care units that have a specially appointed physician in charge of treatment and other necessary and proficient personnel, adequate facilities and other requirements needed in treatment. Pharmaceutical therapy may be implemented and medicines administered to the patient under controlled circumstances in the treatment unit. If a patient has shown co-operation, under special circumstances he or she may be provided with more than one, but not more than eight, daily doses at a time. These medicines cannot be administered in a pharmacy.

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

Based on the **Act on the Status and Rights of Patients** (559/1994), the patient is entitled to good medical care and related treatment, access to information, self-determination and confidence in the specialist-client relationship.

Under the **Mental Health Act** (1116/1990), the authorities are empowered to refer an under-age child to psychiatric hospital treatment regardless of the child's or parents' will, if failure to organise such treatment essentially endangers the child's health and safety.

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

1.3 Laws implementation

Persons suspected of drug offences seem to undergo a harsher treatment than other criminals do in the Finnish legal system. A study on 1996–1997 data established that incarceration as a coercive measure in the criminal process appears to concern persons suspected of drug offences in particular (Kainulainen

1998). However, the judicial practice was far from uniform, and some prosecutors tend to be less inclined to press charges (Kainulainen 1999). Because the law was open to interpretation, a proposal for amendment was passed in summer 2001 to unify the practice of waiving charges in drug user offences, taking effect on 1 September 2001.¹¹

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

Based on the 1,300 decisions to waive charges or to impose sanctions compiled until the middle of the year 2002, 25 prosecutorial units (of 90 State Administrative Districts) had organised hearings for young offenders, in 13 units referrals to care were the reason for waiving charges and 41 units reported having met with the police as well as social and health service authorities in order to agree on practical referral to care. In addition, the material had 219 convictions for drug-user crime. Consequently, the judicial system is starting to have enough precedents to decide when to waive sanctions and how the amount and quality of narcotic substances affect the punishment. (Helminen 2002)

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

¹¹ For more detail, see Kainulainen (2002) on the process of passing the new law.

amounts reflect the maximum limit under which the cases, if other legal criteria are met, can be processed in terms of summary penal proceedings.

1.4 Developments in public attitudes and debates

The year 2002 saw completion of two comparative studies on drug debate in major newspaper editorials in 1966–1971, 1972–1985 and 1993–2000 (Törrönen 2002; Hakkarainen et al. 2002).¹² The results showed that throughout these periods recurring themes included an emphasis on collective responsibility in the welfare society and a notion that young people are the main target for drug-related risks and in need of national protection. Changes in focal points, on the other hand, crystallised in three observations: A changeover has occurred in Finland from a closed society facing external threats towards a more globalised world view. In addition, there has been a transition from protecting deviant individuals and groups to safeguarding the entire population, stressing a change in the welfare state from paternalistic protection to clientism underlining the rights and client status of the individual. Expert opinions about the drug problem have also undergone a change from the first drug wave (1966–1972), and the ensuing control-oriented action plan with the police in a key role, to the notion voiced during the second drug wave (1993–2000) that control and police actions are inadequate to solve the narcotics problem and that also preventive work, treatment and harm reduction were required to complement penal control. The latter transition resulted in a more prominent position for the service system in the division of labour between the welfare-state authorities. (Hakkarainen et al 2002).

During the second drug wave (1993–2000), newspapers still regarded international drug trafficking and the related criminal activity as the foremost challenge for Finnish drug policy. However, in a globalised world the operating environment of a restrictive drug policy seemed increasingly difficult to handle. The press adopted two opposing views on the demands made by the police for more resources and authority: on the one hand, criticism gave way to a more sympathetic outlook as the drug problem aggravated, on the other hand, some positive sentiments reversed as the press became aware that the police were using drug crime as a political tool to gain more resources. However, none of the newspapers during the period considered restrictive drug policy an adequate way to prevent and manage the narcotics problem. The newspapers argued that while police control and surveillance were necessary, other avenues had to be pursued as well to regulate and manage this national concern. The editorials concluded that grappling with the national problem required the following: 1) the development of a comprehensive welfare-state drug treatment system by creating special services for problem users as opposed to previous treatment

¹² The criteria for selecting the studied newspapers were as follows: high circulation, nationally and regionally (at least three regions) comprehensive viewpoints, both fact-oriented and less serious newspapers attracting a wide range of readerships. The basic material consisted of 92 editorials in 1966–1971, 66 in 1972–1985 and 133 in 1993–2000. Based on the amount and themes of the editorials, the more indepth time comparison involved 33 articles from the first period, 25 from the second and 42 from the third. (Hakkarainen et al. 2002).

policies and by understanding harm reduction as a complement to restrictive treatment policies; 2) the development of action programmes emphasising a community approach especially to young people; and 3) caution in introducing drug tests so as not to infringe civil liberties by exaggerating drug-related threats. In the 1990s, newspapers argued for a new drug policy in Finland similar to the one proposed in the 1997 drug strategy. Polemic discussions about additional police resources and authority aside, the newspapers did not question official drug policies or the position of the authorities as a source of information; instead, they urged decision-makers and authorities to redouble their efforts in implementing the plans. (Törrönen 2002).

The weight of the narcotics question as a national concern is also reflected in the number of written questions submitted to the Government in Parliament. In 2001, 76 of a total of 1,429 written questions were asked concerning drugs. In 2002, the corresponding figure was 43 out of 1,245. By the summer of 2003, there had been five such questions out of 209. Since the report year of 2002, the proportion of drug-related questions has declined. The major 'drug themes' discussed in Parliament included drug treatment, police resources, control and prison work as well as prevention. In addition to written questions, an equal number of bills concerning drugs were submitted, usually in connection with the budgetary process.

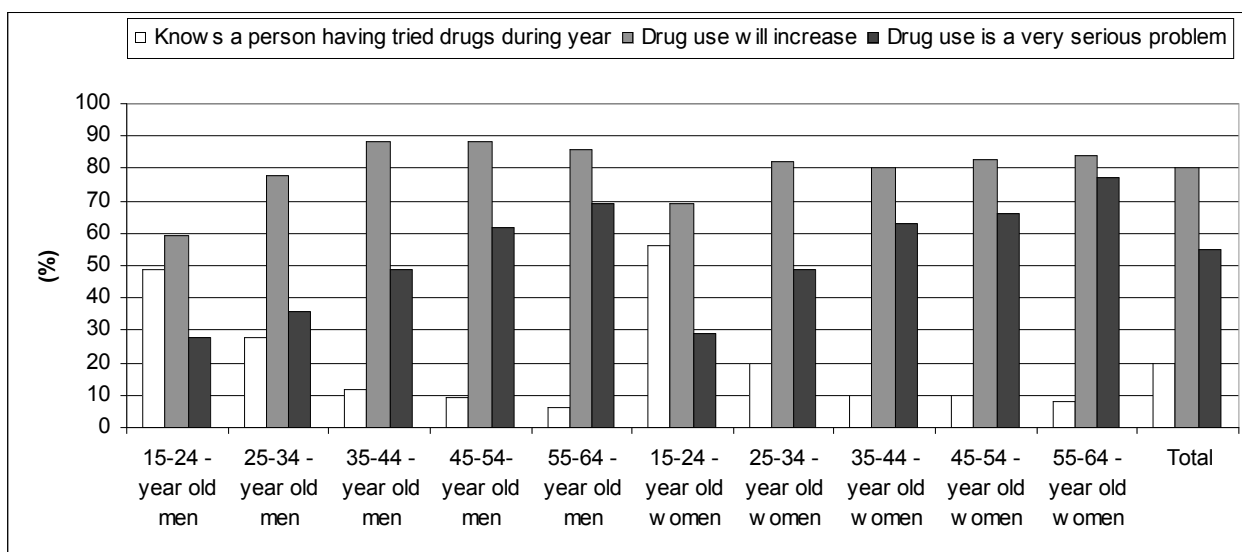
The themes were associated with public debate and the budgetary process as well as law reforms stemming from these themes. In summer 2001, the Ministry of Social Affairs and Health working group on drug treatment suggested major additional funds for developing the treatment of drug addicts and this was later also implemented in the budgets of 2002 and 2003. In connection with the report, a new Decree on substitution and maintenance treatment was passed in 2002. The operational possibilities of the police were addressed when the laws on general security, pre-trial investigation and coercive measures as well as the budget were processed. The drug situation in prison, treatment possibilities and after-care upon release were discussed relatively often; the report of the Ministry of Justice working group on the so-called contractual treatment was also published. Other types of control were discussed in connection with bills and reports on drunken driving and juvenile sanctions. Preventive work was addressed in terms of youth workshops and preventing exclusion among children and young people.

During the report period, attitudes towards drugs were measured in a survey concerning general health behaviour in the adult population, incorporating nine questions about drugs as well.¹³ One of them was about drug use in the respondents' circle of acquaintances, the second was about drug offers made to the respondent and the rest dealt with opinions about drugs (Figure 1) as well as the visibility of the nationwide drug campaign. (Jallinoja et al. 2002 & 2003).

¹³ The survey material comprised a random sample of 5,000 Finns aged 15–64. A questionnaire was mailed in April to the respondents, followed by three reminders to non-responsive recipients. The response percentage was 65 (70% in 2001); 58 (62% for men and 72 (77%) for women.

Figure 1

Opinions in the adult population (% of the age group) about drugs and drug use in 2002



In spring 2002, 55 per cent of the respondents (58% in 2001) reported drug use to be a very serious problem, and 34 per cent (32%) considered it a relatively serious problem. The youngest age group clearly differed from the other respondents: in age group 15–24-year-olds, 68 per cent of men and 74 per cent of women considered drug use a relatively or very serious problem, while in other age groups the percentages were 79–94 for men and 89–98 for women. Of the respondents, 80 per cent (88% in 2001) believed that drug use will increase in the near future; in the youngest age group, 59 per cent of men and 69 per cent of women thought that drug use will increase, while in the other age groups the percentages were 79–88 for men and 80–84 for women. Apparently, the more drug users to the respondent knew, the less severe the problem. On the other hand, the more severe the problem in the respondent’s opinion, the more likely it seemed that drug use will increase. (Jallinoja et al. 2003).

In the adult population, contacts with people having tried drugs during the previous year have clearly become more numerous since 1996, but this increase seems to have stopped after 2001. The majority of the population nevertheless adopted a negative and concerned attitude towards drugs. Drug users were more often known in the Greater Helsinki Area and other major cities, but this fact had a limited bearing on the attitudes towards drugs. Only students and single people, who often also belonged to younger age groups and thus knew more drug users, were less likely to think that drug use will increase or that drugs constitute a serious problem, in contrast to people with other marital status or occupations. However, it is difficult to determine why people who knew drug users were less concerned about drug use. It is possible that they had more experience of experimental and non-problematic drug use. (Jallinoja et al. 2003).

1.5 Budget and funding arrangements ¹⁴

The direct harm-related costs of drugs are calculated in terms of social and health services, crime control, damage to property as well as preventive work and research. Because alcohol is the main substance abused in Finland, the table below shows harm-related costs of both alcohol and drugs (here, narcotics and abuse of pharmaceuticals).

Table 1.

Costs of alcohol and drug related harms in Finland 2000 -2001

	Alcohol (EUR million)				Drugs (EUR million)			
	2000		2001		2000		2001	
	min.	max	min	max	min	max	min	max
Direct Costs	507	666	550	705	124	188	138	204
1. Health care and pensions	107	195	111	206	20	39	22	44
2. Social services	92	120	106	118	39	50	45	50
3. Criminal Justice system	203	235	219	253	38	50	41	54
4. Damage to property, prevention, supervision and research	105	116	114	127	27	49	30	56
Indirect Costs	2370	4400	2443	4563	290	630	300	650
1. Estimated value of production losses	440	510	426	494	53	88	56	94
2. Estimated value of untimely deaths	1930	3890	2017	4069	237	542	243	556

The system of public-sector basic services is complemented by a special funding system for projects on demand reduction. The Finnish Slot Machine Association may grant subsidies to the operating costs, investments, R&D and training activities of social welfare and health care organisations, but not for supporting services. One such target is temperance work and welfare for substance abusers. Allocation is decided in the Government based on proposals of the Ministry of Social Affairs and Health. In 2003 (2002), project subsidies totalled 9.0 million euros (8.8 million) to preventive and corrective drug work. The Ministry also grants subsidies to health promotion as well as experimental and development projects on substance abuse prevention. In the latter model, the proposals for funding are prepared and the proposed projects are assessed at STAKES (municipal projects) or the Finnish Centre for Health Promotion (organisational projects). In 2002 and 2003, an annual grant of 1.0 million euros was given to the prevention of drug use and the intensified treatment of drug users.

As part of the Plan for More Efficient Drugs Policies (2001–2003), a decision was also made in 2003 (2002) to grant 7.5 (7.5) million euros of additional funding to drug treatment in the Ministry of Social Affairs and Health sector; 1.7 (1.7) million to street-level drug control in the Ministry of the Interior sector; 1.5 (1.5) million euros to preventive drug work (as part of youth work) and teaching staff training in the Ministry of Education sector; 1.9 (1.9) million euros for developing anti-drug work in prison,

¹⁴ See also Chapter 4.3; Yearbook of Alcohol and Drug Statistics 2002, 2003.

enforcement of punishments and prosecutors' training in the Ministry of Justice sector; 0.5 (-) million euros for developing drug work in the Customs Administration under the Ministry of Finance; and 0.6 (0.9) million to the UNDCP and its projects in the Ministry of Foreign Affairs sector.¹⁵

¹⁵ See Chapter 1.1 in *Toimenpideohjelma huumausainepolitiikan tehostamiseksi vuosille 2001–2003*. [Action Plan for More Efficient Drugs Policies in 2001–2003] (2003).

2. PREVALENCE, PATTERNS AND DEVELOPMENTS IN DRUG USE

In Finland, an effort has been made to map out drug experimenting and use since the early 1990s through a variety of population surveys, especially among schoolchildren, young people and the general population. An inherent problem with these surveys is, however, that they only shed partial light on the drug problem, while often excluding hard-drug users who do not have ordinary education or a permanent address.

The scale of problem drug use has not been assessed until the late 1990s through statistical estimates of the number of problem users, i.e. amphetamine or opiate users in Greater Helsinki and the entire country.¹⁶ Traditionally, assessments have been made indirectly through drug-related harms recorded by the societal service systems. Censuses have also been conducted to estimate the proportion of drug users in the entire social and health services clientele. In addition, the treatment of problem drug users has been separately monitored since 1996.

2.1 Main developments and emerging trends

According to studies published during the year, the overall growth trend in drug experimenting, prevalent throughout the 1990s, seems to be stabilising in the 2000s. This is indicated by the 2002 population study on drug use,¹⁷ the school health surveys of 2001 and 2002¹⁸ and estimates of the prevalence of problem drug use.¹⁹ The tentative reports on these studies do not allow in-depth analysis of the reasons behind these changes or provide answers to the question whether this is a random occurrence, a temporary lapse or a more permanent outcome.

Another way to analyse trends in drug use and experiments indirectly is to examine how the environment exposes young people socially to drug use. The health behaviour studies on young people (14–18-year-olds) and adults (15–64-year-olds) measured this, for example, by a question whether the respondent knew (in his or her circle of acquaintances) somebody who had used narcotic substances during the past

¹⁶ See Appendix 3: The national drug information system.

¹⁷ For more detail, see Chapter 2.2.1

¹⁸ For more detail, see Chapter 2.2.2.

¹⁹ For more detail, see Chapter 2.2.3.

year (Figures 2a–2d).²⁰ Also these indicators suggest that the trend has stabilised in the 2000s, a finding corroborating the results from direct indicators as well.

Figure 2a. Acquaintances having tried drugs (%) / 12–18-year-old boys

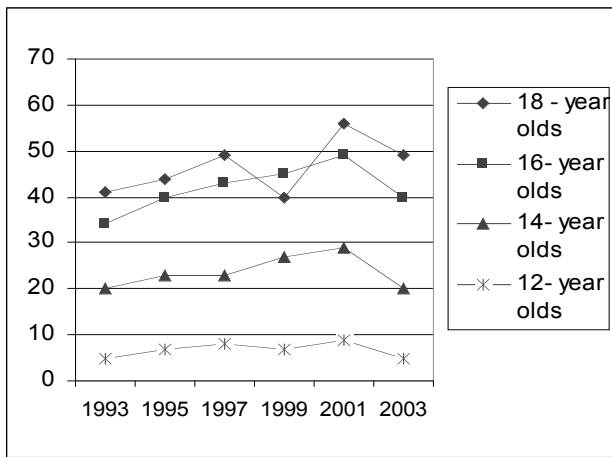


Figure 2b. Acquaintances having tried drugs (%) / 12–18-year-old girls

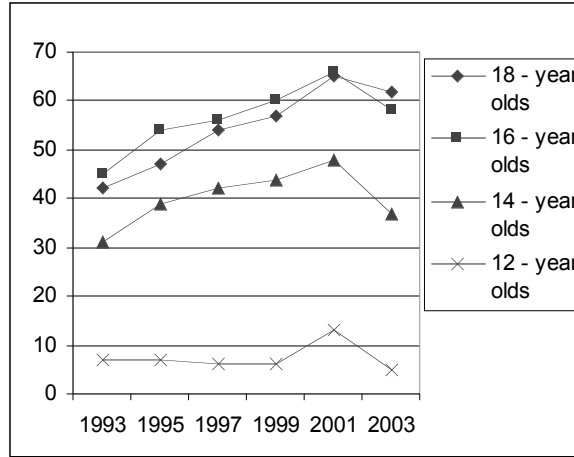


Figure 2c. Acquaintances having tried drugs (%) / 15–64-year-old men

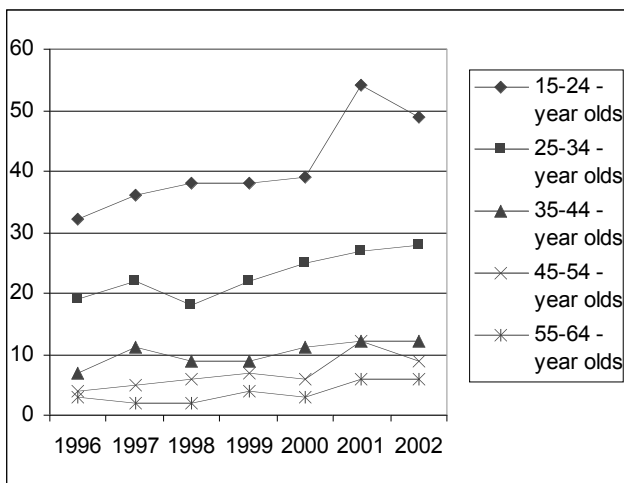
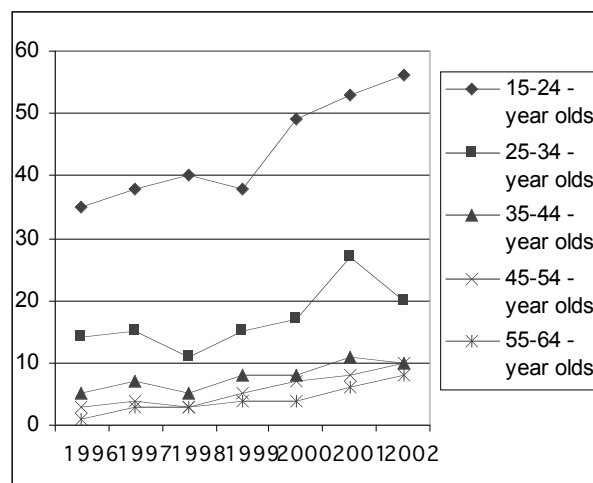


Figure 2d. Acquaintances having tried drugs (%) / 15–64-year-old women



The recent surveys have reached consistent results: only 20 per cent of respondents reportedly knew somebody who had used drugs, and this means that the majority of Finns do not have a personal relationship with drugs. In this respect, drugs appear to be a relatively distant phenomenon in Finnish society, a fact that may slow the further spread of drug experimenting. However, the situation is different

²⁰ The surveys nevertheless define narcotic substances somewhat differently. In young people's health survey (a postal questionnaire, annual sample 10 000, weighted by age groups, and response percentage decreased year by year 78% - 70%, smallest 69 % in 2003), these substances include "hashish, thinner or other sniffed substances, intoxicating pharmaceuticals and other such substances" (Rimpelä A. et al. 2003), whereas in the adult health survey (methodology, see chapter 1.4.), narcotic substances are "e.g. hashish, heroin, cocaine, ecstasy or LSD". (Helakorpi et al. 2002; Jallinoja et al. 2003).

among 15–24-year-olds, half of whom knew a drug user. This age group is the most susceptible to changes possibly reversing the trend as well.

2.2 Drug use in the population

2.2.1 General population studies

After the early 1990s, the prevalence of drug use in Finland has been measured by seven population surveys, the most recent of which was conducted in 2002. Comparable data have been compiled on four surveys.²¹ However, population surveys constitute an inadequate tool for reaching people having tried various drugs because of the low prevalence of certain narcotics. Therefore, the results from different population surveys are compared on a general level for all drugs (Figures 3a and 3b) or specifically in terms of cannabis, which has been used by almost all drug users at some point.

Figure 3a²²

Percentage of men having tried drugs during lifetime or last year

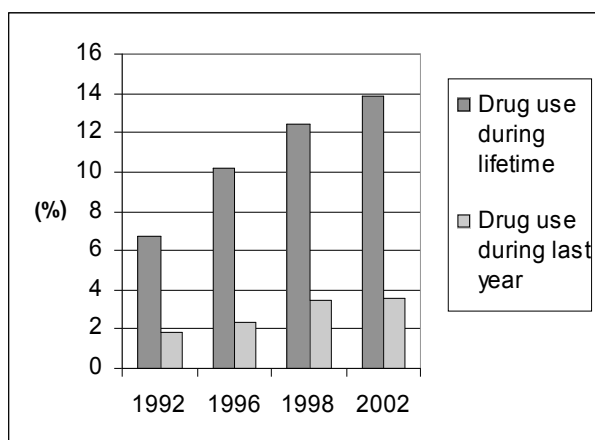
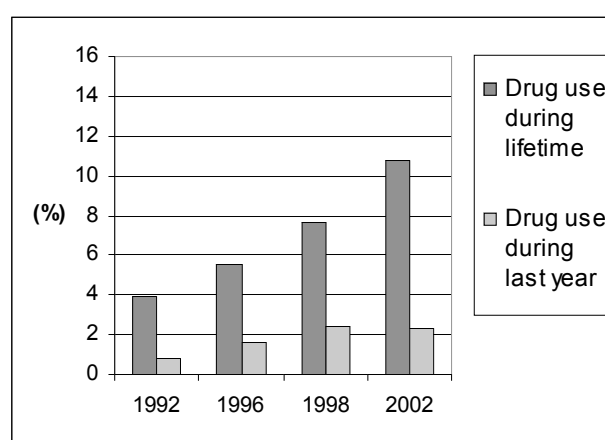


Figure 3b

Percentage of women having tried drugs during lifetime or last year



In the survey conducted in 2002, 12 per cent of adult respondents reported having tried or used some narcotic substance during lifetime. Drug use during last year was reported by three per cent, while one per cent had used drugs during last 30 days. Based on the 2002 results, there were an estimated 450,000 people in Finland who had used drugs during lifetime, about 100,000 had used drugs during last year and

²¹ Four comparable population surveys were conducted in 1992 (Kontula et al. 1992), 1996 (Kontula 1997), 1998 (Partanen J. et al. 1999) and 2002 (Hakkarainen et al. 2003). In all surveys, the material was collected through a postal questionnaire. The surveys were targeted at 18–74-year-olds in 1992; 16–74-year-olds in 1996; and 15–69-year-olds in 1998 and 2002. The response percentages were as follows: 71% (3,457 respondents) in 1992; 68% (3,009) in 1996; 66% (2,143) in 1998; and 63% (2,541) in 2002. To improve comparability, weighting coefficients were used to adjust the sample's sex, age and regional distributions to correspond to those in the entire country. This may have resulted in slight differences in the results from the ones presented previously. (Hakkarainen et al. 2003).

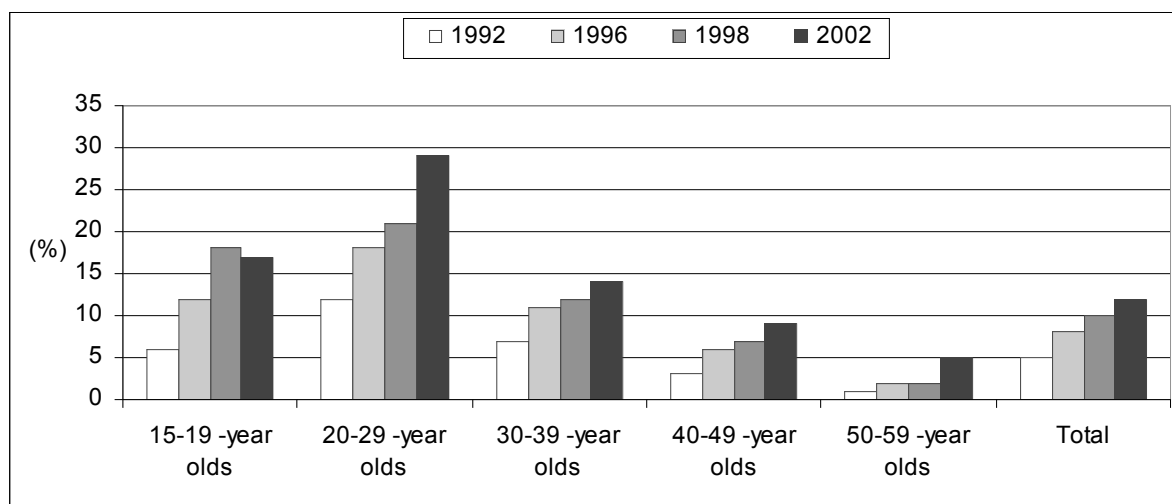
²² In terms of life-time experiments, the corresponding time series for the entire population is as follows : 5.5% (1992), 7.9% (1996), 10.0% (1998) and 12.4% (2002); and in terms of experiments during last year: 1.3% (1992), 2.0% (1996), 2.9% (1998) and 2.9% (2002). (Metso 2003).

some 40,000 had done so during last month. The study suggests that the 1990s drug trend was set in motion by men, followed by women in the second half of the decade. In terms of recent use, the growth trend was different. The proportion of those having used drugs during last year increased both among men and women between 1992 and 1998, after which the growth trend clearly levelled off.

In terms of age group, drug use is unevenly distributed (Figure 4). Because drugs entered Finnish culture as late as in the 1960s, drug use among older age groups (especially 60–69-year-olds) is virtually non-existent. This is why the prevalence of use is liable to increase in the population almost automatically, even though the number of people experimenting with drugs annually does not grow at all, as the elderly age groups having not tried drugs are replaced in the sample (15–69-year-olds) by subsequent generations. According to the researchers, the fact that the figures on recent use indicate no increase suggest that experimenting with drugs has not occurred evenly during the past four years but predominantly before the autumn of 2001 (the material was collected in autumn 2002; Hakkarainen et al. 2003).

Figure 4.

Percentage of those having tried or used cannabis during lifetime by age group in 1992–2002



As regards cannabis use and experiments, age group 20–29-year-olds stands out. In this group, the user figures increased from 12 per cent to 29 per cent during the 10-year period studied. A third of men and a quarter of women reported having tried cannabis during lifetime. During last year, 10 per cent of men and 6 per cent of women had done so; the corresponding figures for last 30 days were 5 per cent for men and 2 per cent for women. On the other hand, among young people under the age of 20, experimenting with drugs grew clearly from 1992 to 1998, but in 2002 it more or less remained on the same level. However, the key role played by young people in drug culture is emphasised by the fact that in age group under 20-year-olds, the numbers concerning use during last year and last month were the highest, on an annual level of approximately 10 per cent and about 4 per cent on a monthly level. In terms of socio-economic standing and

marital status, cannabis use is the most common among students and those unmarried or cohabiting, a further example of the role played by age. (Hakkarainen et al. 2003).

Regionally, Finnish drug use is prevalent in areas with a high degree of urbanisation and population density (Table 2). Especially Greater Helsinki experienced a statistically significant increase in the number of those having tried cannabis between 1992 and 1998, whereupon the growth rate has subsided. In other cities with populations exceeding 100,000, the growth trend started later, but it was statistically significant between 1996 and 2002. In smaller towns and other population centres, these developments have been more moderate and in rural areas, the situation has remained almost unchanged. Cannabis use is regionally concentrated in the Greater Helsinki Area and other localities in Southern Finland. (Hakkarainen et al. 2003).

Table 2.
Percentages of those having tried or used cannabis during lifetime (%) by place of residence

	1992	1996	1998	2002
Greater Helsinki	12	16	21	23
Cities with over 100,000 population elsewhere	5	7	13	15
Other town	5	7	9	11
Population centre or built-up area	2	4	6	7
Other rural area	1	3	2	3

New drug-use features emerging in the 2002 survey included the statistically significant increases in abuse of pharmaceuticals (hypnotics, sedatives, analgesics) and the use of so-called party drugs (amphetamines and ecstasy) since 1998. The growth in abuse of pharmaceuticals may in part be attributable to the inclusion of analgesics in 2002 (omitted from the 1998 data). Of the respondents, seven per cent had abused medicines during lifetime, and three per cent had done so during last year. Narcotics use varies considerably by age, whereas there is no great age variation in the use of pharmaceuticals (Table 3). Among those aged over 35, experiences of abuse of pharmaceuticals during last year were more common than cannabis. Party drugs were mostly used by 20–29-year-olds: 8 per cent of men and 4 per cent of women had used amphetamines, while 8 per cent of men and 3 per cent of women had used ecstasy. Cocaine use was also reported more often than before, mainly in age group 20–29-year-olds (2%). The latter results suggest that the use of stimulants in new party and club cultures associated with techno music is becoming more widespread in Finland as well. (Hakkarainen et al. 2003).

Table 3

Percentages of those having abused various substances during lifetime by age group in 2002

Men				Women			
15-24yo	25-34yo	35-44yo	45-54yo	15-24yo	25-34yo	35-44yo	45-54yo
27.4	22.8	11.4	7.9	23	16.1	11	6.6
7.4	6.1	6.5	6.1	9.8	6.9	8.5	8
5.9	5	2	0.6	2.6	2.6	2.5	0.5
5.5	3.9	0.8	0	2.3	1.7	0.6	0
3.2	2.2	0.8	0	0.3	0.9	0.5	0
1.4	2.1	0.9	0	1.7	0.9	0	0
1.8	1.8	0	0	0.3	0.6	1	0

When analysing the first-time experiments with drugs, the researchers concluded that only in terms of cannabis has recruitment of new users taken place on an extensive scale since the 1960s. On the other hand, the so-called second drug wave in the 1990s attracted new users almost exclusively from the two youngest cohorts, those born in 1980–1987 and 1970–1979, whether in case of cannabis, amphetamine or ecstasy. Thus, the increase in drug use in the 1990s was first and foremost a youth phenomenon. Drawing on youth researchers’ findings on young people’s value systems, the researchers argued that present-day young people and schoolchildren essentially live in a consumer culture, gravitating towards experiences, pleasure and satisfaction. Previously, value systems were built on the ideas and legends of the previous generations, whereas present-day young people belong to a generation whose worldview revolves around new technology and multicultural relations in a post-modern, globalised world. In this setting, drug experiments assume new social meanings and fascinating novelty. The generation gap is furthermore visible in the changes occurring within drug culture. While the 1960s hippie culture was in pursuit of genuine experiences and opening doors into new, internal worlds, the postmodern drug user is a partygoer, taking calculated risks and seeking pleasure from drug experiments as a recreational pastime and a counterbalance to everyday life. (Hakkarainen et al. 2003).

In conclusion, the researchers point out that according to studies, drug use among Finnish young people mainly involves random experiments once or a few times and that there is no evidence of new recruitment of users from older age groups.

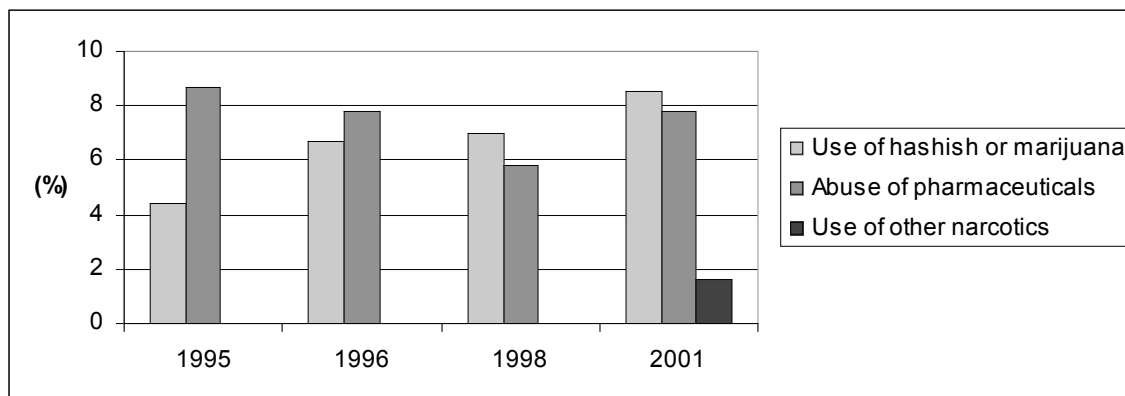
2.2.2 Youth and school surveys

A nationwide investigation into self-reported criminal behaviour of 15–16-year-olds was conducted in 2001 (Kivivuori 2001). Because drug use is a criminal offence in Finland, it was included in the survey. The results showed no statistically significant increase in the use of marijuana or hashish during last year since 1998, when the study was carried out last time. There is, however, a statistically significant

difference compared to the years 1995 and 1996 (Figure 5).²³ According to the results, 8.5 per cent of young respondents had tried hashish or marijuana during last year and 1.6 per cent had tried other drugs. There were no significant differences between the sexes. There was however a statistically significant increase in the group having done this at least five times: from 1.6 per cent in 1998 to 2.2 per cent in 2001.

Figure 5

Percentage of 15–16-year-olds having committed a criminal act at least once during the year (2001)



There seems to be a positive correlation between the use of cannabis products and young people’s working as well as weekly working hours. This observation is in line with other criminal behaviour: among ninth-year students, weekly working hours were linked to problematic behaviour in general, i.e. criminal behaviour. Based on the material, the researchers suggested the following possible reasons: the group essentially differed from those who did not work, the stress caused by work, less parental control because of going to work, role models set by co-workers and the larger amount of spending money available. (Kouvonen 2002).

The results of the 1999 ESPAD survey were utilised to estimate the risk of using drugs – especially cannabis – among 15–16-year-olds. Based on the results, young people face a smaller risk of trying cannabis if they lived with both parents, if the parents knew where their offspring spent their evenings and if the youth were satisfied with their health. The researchers attributed this to single-parent families’ fewer resources to cope with everyday life, and to the fact that children in these families seem to be more prone to make decisions without consulting their parent. According to the researchers, the family provides a safety net especially for boys. Parents, whose educational level is high, seem likely to monitor their sons less than their daughters, which in turn is reflected in increased cannabis experiments among boys. (Ahlström et al. 2002).

²³ In the study, 15–16-year-old respondents were asked about self-reported criminal activity. The samples were determined on the basis of each school. Information was collected in class during a research session. The samples / response percentages varied as follows: 1,195 / 88.8% (1995); 4,204 / 90.5% (1996); 4,503 / 88.3% (1998); 4,347 / 88.7% (2001). (Kivivuori J. 2002).

In Finland, school health surveys are conducted regionally so that half of the country's provinces are studied in alternate years. The 2002 survey encompassed Southern Finland, Eastern Finland and the Province of Lapland. According to it, the percentage of 15–16-year-olds having tried illegal drugs at least once was 10.9 per cent. Compared to the results in 2000, this proportion declined by 0.3 percentage points (Luopa et al. 2003).²⁴ The 2001 school health survey involved the Province of Western Finland and Northern Ostrobothnia; also this survey showed that the use of illicit drugs is levelling off (Lintonen T. 2001). In age group 15–16-year-olds, 8.3 per cent had tried illegal drugs in the Province of Western Finland, while 5.8 per cent had done so in Northern Ostrobothnia; both these figures are about 0.5 percentage points higher than in 1999 (Luopa et al. 2002a, 2002). Both these survey results suggest that the increase in drug use in age group 15–16-year-olds was stabilising at the beginning of the 2000s. This conclusion is consistent with general population surveys and their results and interpretations concerning under 20-year-olds.

A new phenomenon in recent years is the increasing popularity of recreational drug use, closely linked to new international youth culture reaching the country in the late 1980s, i.e. techno and rave culture. This entails a more regular drug use than was the case with drug experiments and an assumption that the use is controlled and has positive impacts. Recreational use can be divided into two categories, partying and expansion of consciousness. Recreational use, which is associated with partying, occurs mainly in the cities as part of weekend and other free-time activities. The new ways of partying have become an important cultural capital for young people, complete with symbols, codes, messages and images. It is typical of this culture that the party situation has no specific goal, it is asexual, comprehensive and interactive. The most commonly used substances are ecstasy, amphetamine and cannabis. The type of use aiming at expansion of consciousness resembles the 1960s hippie movement, but it is adapted to present-day society. For many, this culture is part of a lifestyle, not just a weekend or free-time activity. The preferred substances are LSD, fungi and cannabis, but also ecstasy has a strong position. Drug experiments can be seen as a kind of capital of the psyche in an effort to learn how to control the mind. The substances are often tested a few times, followed by yet other substances. (Salasuo et al. 2002; Seppälä 2000).

Today's youth live in a reality rich in impulses and messages, and young people pursue a wide range of experiences. When drug use spreads to 'ordinary young people', it brings the mainstream of intoxicants use and drug culture closer together. Compared to the traditional drunkenness-oriented intoxicants culture, the change is noteworthy. (Salasuo et al. 2002; Seppälä 2000).

²⁴ School health survey was filled in the 8th and 9th secondary school classes, among the municipalities (and their schools) that attended the survey voluntarily. Data compared included answers from the municipalities that attended both school surveys. The data consisted of 45 950 answers from 2002 and 46 303 answers from 2000. School response percentage was 70 % in 2002.

2.3 Problem drug use

In 1997, the first Finnish statistical estimate of the number of problem users was calculated locally in Greater Helsinki based on data from 1995. Problem use was defined based on the prevalence of various substances and their negative effects (crime, disease and other health risks), i.e. it was mainly defined as injecting drug use. Amphetamines constitute the most commonly injected drug in the country, whereas elsewhere in Europe problem use is assessed by heroin use and/or heroin use by injecting. In Finnish drug culture, problem users were defined as those who used amphetamines or opiates.

The estimate was made based on the capture-recapture method. Later, more material was compiled in 1997–1999 and compilation was expanded to the entire country and to province-specific data. Information is collected from the hospital discharge registers, the criminal reports system, the register of driving while under the influence of narcotic substances and the register of infectious diseases (Partanen P. 1997; Partanen P. et al. 1999, 2000, 2001).²⁵

According to a statistical estimate, drug use expanded considerably in Greater Helsinki between 1995 and 1997, but thereafter the situation has remained more or less stable. Nor have the estimates of the number of amphetamine and opiate users in the entire country altered since 1997. The most significant differences between the 1998 and 1999 estimates were smaller confidence intervals, which means that the estimates have become more accurate each year. (Table 4).

Table 4.

Prevalence of problem use of amphetamines and opiates (%) among 15 – 55 -year-olds in Greater Helsinki and Finland in 1998 and 1999²⁶

	Greater Helsinki		Entire Finland	
	1998	1999	1998	1999
Overall estimate	0.7 - 1.0	0.7 – 0.9	0.4 - 0.6	0.4 - 0.5
Men	1.1 - 1.5	1.1 – 1.5	0.5 - 0.7	0.5 - 0.7
Women	0.3 - 0.7	0.3 – 0.5	0.2 - 0.6	0.1 - 0.2
15–25yo	1.0 - 1.7	1.1 – 1.6	0.7 - 1.1	0.7 - 1.0
26–35yo	0.9 - 1.5	0.8 – 1.2	0.5 - 0.7	0.5 - 0.6
36–55yo	0.4 - 1.0	0.5 – 1.1	0.1 - 0.3	0.2 - 0.5
Amphetamine users*	0.5 - 1.1	0.4 – 0.9	0.3 - 0.5	0.3 - 0.4
Opiate users*	0.2 - 0.3	0.2 – 0.3	appr. 0.1	appr. 0.1

* = Estimates are based on information from three registers

²⁵ The procedure is based on the statistical capture-recapture method, where the overlapping cases in (in principle: mutually independent) samples from the same target 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.

²⁶ The estimate intervals given are based on 95-per cent confidence intervals of the estimates. The time series are based on data from four registers, like most estimates presented in this chapter (with the exception of substance-specific information, excluding C-hepatitis register where such data is not available). The sum of different subgroups differs from the overall estimate because different log-linear models were applied to the combined material and separate materials on the subgroups. (Partanen P. et al. 1999).

Finland had an estimated 11,000 – 14,000 problem users of amphetamines or opiates in 1999, of whom 4,100–5,400 resided in the Greater Helsinki Area.²⁷ Amphetamine users accounted for 70–80 per cent of them and about 20–25 per cent were women. Age group 25-year-olds or younger were estimated to involve some 40–50 per cent of the group in the entire country, while in Greater Helsinki the proportion was closer to 40 per cent. The use of amphetamines and opiates was assessed regionally for the second time in 1999 (Table 5 below). In regional information, the data from Eastern and Northern Finland have had to be combined to minimise the inaccuracy of confidence intervals in user numbers, especially as regards certain variables (sex, substance, age group).

Table 5.

Prevalence of problem use of amphetamines and opiates (%) among 15–55-year-olds by region in 1999

	Total	Men	Women	15-25yo	26-35yo	36-55yo	Amphetam.*	Opiates*
Finland	0.4 - 0.5	0.5 - 0.7	0.1 - 0.2	0.7 - 1.0	0.5 - 0.6	0.2 - 0.5	0.3 - 0.4	appr. 0.1
Greater Helsinki	0.7 - 0.9	1.1 - 1.5	0.3 - 0.5	1.1 - 1.6	0.8 - 1.2	0.5 - 1.1	0.4 - 0.9	0.2 - 0.3
South Finland	0.6 - 0.7	0.9 - 1.1	0.2 - 0.3	1.0 - 1.4	0.7 - 0.9	0.3 - 0.5	0.4 - 0.7	0.1 - 0.2
West Finland	0.2 - 0.3	0.4 - 0.5	appr. 0.1	0.4 - 0.6	0.3 - 0.6	0.1 - 0.2	0.2 - 0.5	appr. 0.1
East and North Finland	0.3 - 0.5	0.4 - 0.7	0.1 - 0.3	0.5 - 0.8	0.4 - 1.0	0.1 - 0.5	0.1 - 0.4	0.1 - 0.4

** = Estimates are based on information from three registers*

These estimates may be appraised in the light of the prevalence of cannabis use, one possible interpretation being that the spread of amphetamines and opiates from Greater Helsinki to the rest of the country took place following cannabis use, which seems to suggest that in the future the highest growth figures are to be found in the provinces where the user figures have previously been the lowest.

In comparisons of European major cities, the percentages of opiate (heroin) users and injecting users are around one per cent. Because in Finland, amphetamines are often injected, it is justifiable to include amphetamine users in European problem-user comparisons as well. When this is the case, the percentage of problem users in Greater Helsinki is on the same level as in other major cities elsewhere in Europe.

Estimates of problem drug users are crucial to care need assessment in particular. Based on the estimated number of amphetamine and opiate problem users, Finland would appear to have some 11,000–14,000 problem users. On the other hand, population surveys concerning the prevalence of regular drug use defined as drug experimenting during last month, indicate that Finland may have as many as 40,000 problem users of drugs.

²⁷ The estimate is based on a combination of information from four registers. The combination of three registers gives an estimated 10,500–13,400 for the entire country and 3,900–5,700 for the Greater Helsinki Area.

3 HEALTH CONSEQUENCES

3.1 Drug treatment demand

Finnish pilot surveys on drug treatment demand were conducted in 1996 and 1998–2002, compatible with the Council of Europe's Pompidou model and the Treatment Demand Indicator (TDI) model of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). Since 2000, the information compilation period has been a calendar year. The system of drug treatment information compilation has yielded data on clients entering substance abuse treatment for the use of narcotics or pharmaceuticals (with or without alcohol).²⁸ The information system excludes completely such problem users of alcohol who did not have a specific narcotics problem. In the census of intoxicant-related cases in 1999, the latter clients were estimated to account for two-thirds of all outpatients and a little over half of inpatients.²⁹ (Virtanen 2001).

In addition to units providing specialised services for substance abusers (A-Clinics, youth centres, detoxification and rehabilitation units, outpatient and inpatient units specialising in drug treatment), psychiatric units and prison health care units took part in compiling information about drug treatment. The number of units and amount of information received have varied each year. The nationwide results from 2002 are based on material collected from 163 units and comprising 5,793 clients.³⁰

The majority of clients (64%) were in outpatient units;³¹ 61 per cent of the material came from the Province of Southern Finland, 23 per cent from the Province of Western Finland, 9 per cent from the Province of Eastern Finland and 7 per cent from the Provinces of Oulu and Lapland. (Partanen A. 2003). Of the clients, 29 per cent did not have previous treatment contacts on account of a drug problem.

While there were no great changes among clients entering drug treatment in 2000–2002 in terms of the main categories of the primary substances causing treatment need (Table 6), there was a clear change between heroin and buprenorphine. Within the category of opiates, heroin as the primary problem drug dropped to 6 per cent in 2002, while the share of buprenorphine rose to 20 per cent; the situation with these substances was reverse in 2000. The percentage of stimulants has remained on the same level,

²⁸ Partanen A. 2001, 2002, 2003.

²⁹ According to the census, almost 20 per cent of all clients in outpatient services for substance abusers (A-Clinics and youth centres) and almost 30 per cent of inpatients (detoxification and rehabilitation centres) had a narcotics problem along with the intoxicants problem. For medicines, the numbers were a few percentage points higher. However, the figures do not indicate whether the said substances constituted the client's principal substance abuse problem. (Virtanen 2003)

³⁰ In 2000, 113 treatment units participated in the compilation (4,709 individual clients); in 2001, a total of 140 treatment units (5,189 clients).

³¹ Of the units participating in the 2002 compilation, 80 were *outpatient clinics* (64% of clients): 52 were A-Clinics (24% of clients), 13 youth centres (15% of clients), 7 units specialising in drug treatment (20% of clients) and 8 were other outpatient units (5% of clients); 81 were *inpatient units* (36% of clients): 13 detoxification units (8% of clients), 30 rehabilitation units (12% of clients), 27 addiction psychiatric units at hospital (8% of clients), 8 units specialising in drug treatment (6% of clients) and 3 other units (1% of clients). There were also 2 prison health care units (1% of clients).

totalling 28 per cent in 2002. Benzodiazepines as the primary substance have remained at 5 per cent and ecstasy at 1 per cent. The popularly debated so-called party drugs – such as ecstasy, cocaine and LSD – were seldom reported as the primary problem drug. The compilation however also included information about the possible 2nd–5th problem drugs used along with the primary substance causing treatment need. When all problem drugs reported by the client were taken into account, 11 per cent had used ecstasy, 2 per cent cocaine and 2 per cent LSD.

Table 6.

Substances used by clients entering treatment for the use of narcotics and pharmaceuticals (% of clientele) in 2000–2002³²

Substance category	1st problem substance			1st-3rd problem substance		
	2000	2001	2002	2000	2001	2002
Opiates	29	28	28	38	40	39
- heroin	20	13	6			
- buprenorphine	7	12	20			
Stimulants	28	26	28	56	55	58
Cannabis	17	20	18	59	62	60
Alcohol (+ narcotic)	18	19	20	37	41	42
Sedatives	5	6	5	27	30	32
No information	3	1	-	-	-	-

In terms of primary substances and their use, opiates and stimulants were mainly injected: 88 per cent of opiate users (89% of buprenorphine users and 94% of heroin users) used drugs by injecting. For stimulants, the percentage was 78. During last month, 74 per cent of opiate users and 54 per cent of stimulant users had injected drugs. Because of combined use of substances, almost half of those entering treatment due to another substance had injected a drug during lifetime.

Since 1990, roughly three different drug user profiles have emerged among clients seeking drug treatment (Table 7 below): Opiate users who also use other narcotics but rarely alcohol or pharmaceuticals; stimulant and cannabis users who also consume large quantities of alcohol; and polydrug users of pharmaceuticals and alcohol who also use narcotics, mostly cannabis. The study results since the beginning of the 2000s suggest no great changes in the drug user profiles: the increase in cannabis together with stimulants and alcohol merely means a return to the situation in 2000, as does the increase in alcohol use as part of polydrug use with pharmaceuticals. The only clear change in the 2000s is the growth in pharmaceuticals as an additional substance used by opiate users. (Partanen A. 2002; Virtanen A. 2003).

³² The EMCDDA compiles information based on the Treatment Demand Indicator (TDI) criteria, which differ from the figures set forth in this report in that the TDI protocol does not collect data on clients seeking treatment primarily for alcohol use or on clients who have sought treatment prior to the year studied although their treatment was still ongoing. Figures consistent with the EMCDDA criteria are given in Appendix 6 See also http://www.emcdda.org/situation/themes/demand_treatment.shtml

Table 7.

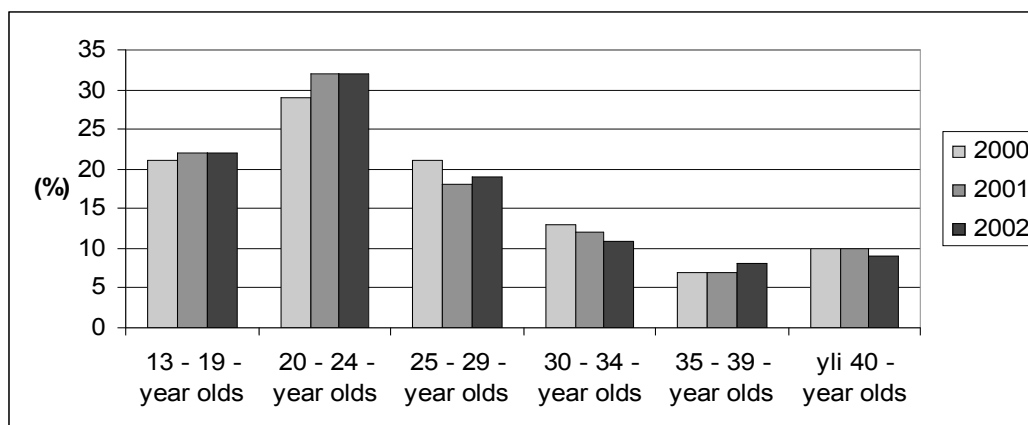
Polydrug use among drug treatment clients in 2001– 2002

1st substance	Concurrent use of 2nd and 3rd substance with 1st substance (%)									
	Opiates		Stimulants		Cannabis		Pharmaceuticals		Alcohol	
	2001	2002	2001	2002	2001	2002	2001	2002	2001	2002
Opiates	24	28	37	43	39	41	29	37	7	8
Stimulants	23	25	12	13	48	61	19	25	24	31
Cannabis	11	11	36	45	3	2	13	17	25	44
Pharmaceuticals	15	19	22	22	24	32	12	13	22	45
Alcohol	7	6	35	39	41	59	25	31	0	0

In the 2000s, about half of drug treatment clients have been aged 20–29, a fifth under 20 years of age (Figure 6 below). Analysis of the age of commencing drug use showed that the two youngest cohorts, those born in the 1970s and 1980s, clearly belonged to the age groups having started the drug use, which now had led to treatment need, during the second drug wave in the 1990s.

Figure 6.

Age distribution (%) of problem users of narcotics and pharmaceuticals in drug treatment in 2000–2002



The youngest clients were to be found in residential (inpatient) treatment units specialising in drug treatment (mean age 24.0 years). Both in specialised drug units and general substance abuser outpatient units the mean age of clients was 25.5 years. The oldest clients were in general substance-abuse inpatient services and in prison health care (28.5 years). The clients' mean age varied depending on the primary drug (Table 8 below).

Table 8.

Mean age (years) of drug treatment clients by primary substance in 2000–2002

	2000		2001		2002	
	All	1st treatment	All	1st treatment	All	1st treatment
Opiates	25.9	24.1	26	24.5	26.7	25.1
Amphetamine	27	24.8	26.5	23.8	26.5	23.9
Cannabis	22.1	20	22.1	20.7	22.1	20.2
Alcohol	29.9	25	28.6	25.5	27.5	21.4

According to the data on 2002, women accounted for 29 per cent of clients. Almost three-quarters were single, while a sixth were married or cohabiting. Over half of those living with somebody shared their household with another problem user, mostly a drug user. A quarter of problem users had children under the age of 18, but only about a quarter of them lived in the same household with their children. Almost 60 per cent were unemployed, a tenth were employed, a fifth were students and 6 per cent were retired. About two out of three clients had primary level of education only, a quarter had secondary level of education and one percent had higher education. Eight per cent had not (yet) finished primary level of education. One in eight drug clients was homeless.

When clients entering treatment first time in the 1998 and 2000 compilations were compared, it transpired that those entering treatment in 2000 were younger by over a year (mean age 22.6 years). The age distribution also accounted for some other changes in the comparison: the increase in the number of single clients and students as well as the growth in cannabis and alcohol as the primary reason for seeking treatment. However, nothing suggested that drug use would start at an earlier age; on the contrary, it seemed that especially parents in the Helsinki area and Southern Finland as well as the authorities elsewhere had intervened in young people's drug use at an increasingly early stage. The growing use of opiates between 1998–2000 followed the general trend among drug treatment clients, even though the increase in those entering treatment first-time for buprenorphine was somewhat smaller than among all clients. Although the materials were not mutually comparable every year (participation in data compilation was voluntary for the treatment units),³³ it was considered that following up first treatment data gave more accurate information about the changes in drug culture and treatment system than overall materials did (Partanen A. et al. 2002).

As regards their social backgrounds, those entering substance abuse treatment for the first time in 2002 were similar to their counterparts in 2000. Among those entering treatment first-time in 2002 the predominant drug was cannabis (30%). It was also common entering treatment for the use of stimulants (26%), mixed use of drugs and alcohol (25%) and opiates (16%) (Table 9 below). Compared to the situation in 2000, a growing number entered treatment first-time for alcohol use associated with drug use, while the share of those entering treatment for opiates was lower. The percentage of those entering

³³ A total of 42 units took part in the compilation in both years, but in terms of the material they stood for the bulk of it, 80% in 1998 and 70% in 2000.

treatment first time for buprenorphine, which belongs to the category of opiates, was also increasing as it did in the overall material on drug clients in services for substance abusers.

Table 9.

Primary problem substance of those entering treatment for the first time in 2000–2002

Substance category	As 1st problem substance (%)		
	2000	2001	2002
Opiate	22	17	16
- heroin	17	8	2
- buprenorphine	4	6	13
Stimulant	24	23	26
Cannabis	28	33	30
Alcohol (+ drug)	18	22	25
Sedatives	2	4	3

Injecting opiates and stimulants was somewhat rarer among those entering treatment for the first time than among all substance abuse clients in 2002: 83 per cent injected opiates and 63 injected stimulants. Opiates and stimulants were also used orally (7% and 17% respectively) or by sniffing (9% and 19% respectively) (Partanen A. 2003).

It is also possible to assess the substance users' "career" leading to treatment for the first time – starting from the first experiments through regular use to a situation where treatment is required. Among those entering drug treatments for the first-time in 2002, cannabis use had on average started at the age of 15.4 years, followed by regular use after about two years and another three years had elapsed before entering treatment, at an average age of 20.2 years. Stimulant users had on average started at the age of 18.5 years, followed by regular use within two years and entering treatment in another 2.5 years, at the age of 23.9 years. In terms of opiates, the use had started at 21.1 years of age, regular use in 1.5 years and entering treatment in another 2.5 years, aged 25.2. In terms of polydrug use of alcohol and drugs, alcohol use had started at the age of 13.1 years, regular use in 3.5 years and entering treatment in less than five years, at the age of 21.4. In 2002, the polydrug users who sought treatment first time primarily for alcohol were clearly younger than a couple of years previously, but there were no major changes in other groups.

3.2 Drug-related mortality

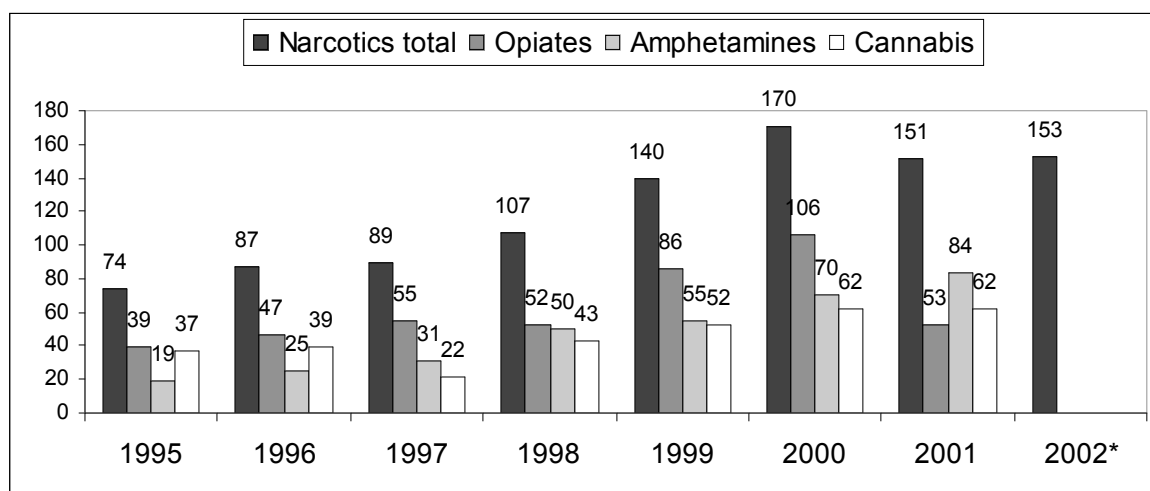
Many countries apply different definitions to drug-related deaths. In Finland, deaths are studied from two different vantagepoints: cause of death statistics and the specific register of unexpected and sudden deaths based on forensic chemistry. In the Finnish context, the latter approach has thus far given more up-to-date and substance-specific information about deaths related to narcotics use.

By law, a forensic coroner's inquest must be conducted in case of an unexpected or sudden death (for example, homicide, accident, suicide, poisoning, industrial disease, health care procedure, etc.). In 2001,

10,058 forensic post-mortems were carried out, with one out of two leading to forensic chemical analyses. Cases involving death by poisoning numbered 1,059, a hundred less than the previous year. Of them, 550 involved poisoning by pharmaceutical substances, with neuroleptics and antidepressants as the most common primary finding, followed by opioids. The greatest increase from previous years took place in opioids and hypnotics (drug findings in Figure 7). The most common pharmaceutical finding in 2000 was morphine/heroin (69 cases), but their share declined clearly in 2001 (28 findings). On 2001, about 403 people died of alcohol poisoning, of which 30 involved poisoning by methanol (Vuori 2003, 2000).

Figure 7.

Forensic chemical findings associated with classic drugs in deaths 1995–2002³⁴



* = Preliminary information

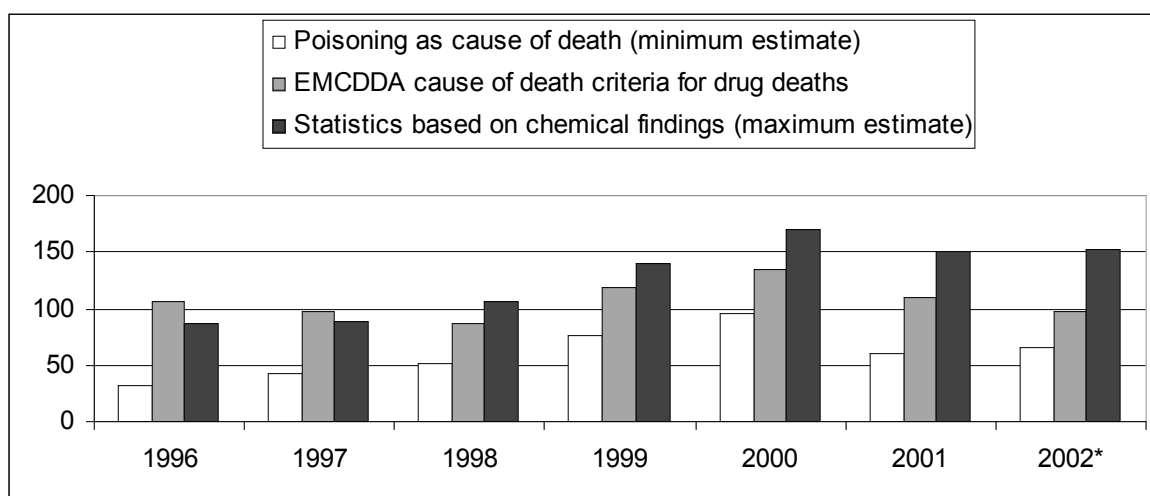
However, the process of defining drug deaths based on chemical findings is not unambiguous; instead, these findings give a sort of maximum estimate of drug-related deaths. Defined by the primary cause of death, the substances are clearly visible in deaths by poisoning, while in other types of death causes chemical findings may only be mentioned in the evidence file (Figure 8). Such cases include, for instance, various accidents, suicides committed by means other than poisoning and homicides, where the substance apparently had no direct bearing on the cause of death. Previously, poisoning has been the cause of death involving only half the chemical findings. When sudden deaths associated with heroin use (so-called deaths by overdose) started to increase, the situation changed though: in 1996 there were 9 heroin deaths, followed by 15 in 1997, 27 in 1998, 50 in 1999 and 60 in 2000. Then, two-thirds of the cases classified as drug deaths in terms of chemical findings could be classified as deaths by poisoning in terms of the primary cause of death as well. In 2001, the number of heroin deaths started to decline rapidly, with 27 cases in the first half of the year, as in the year before, but in the summer the cases became fewer and ceased altogether in autumn 2001. At the same time, the number of cases defined as deaths by poisoning in terms of the primary cause of death declined by about a third and is now about half of all drug deaths

³⁴ Department of Forensic Medicine at the University of Helsinki 2003 (In 1996, 1999, 2000 and 2001 also one cocaine finding).

based on findings. This positive trend continued in 2002. (Vuori 2003; Vuori et al. 2003; 2001).

Figure 8.

Drug deaths by cause of death³⁵ and chemical findings in 1995–2002

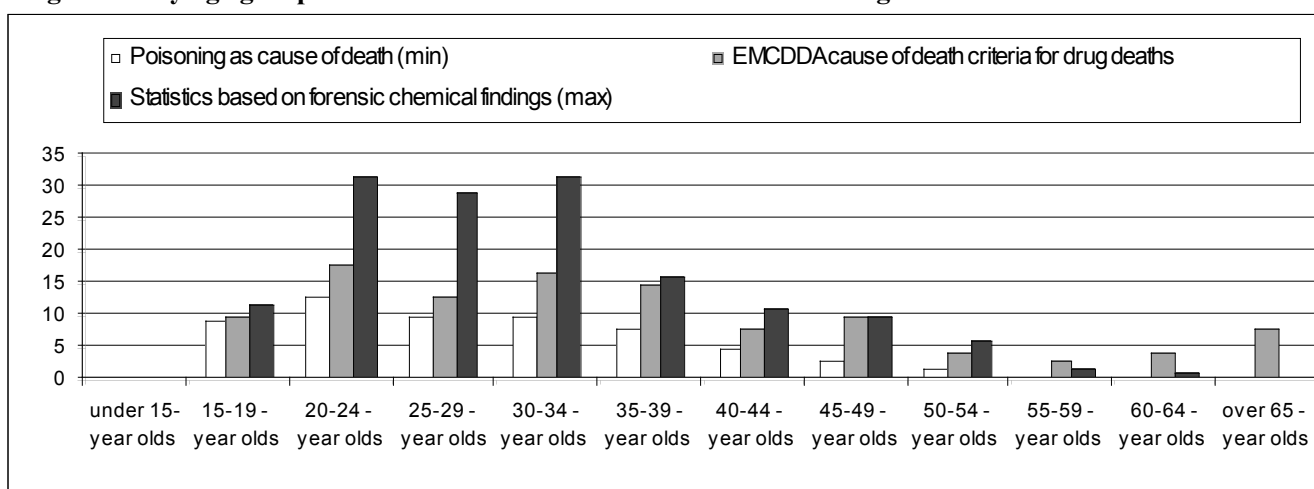


* = Preliminary information

As the number of heroin deaths mounted in the late 1990s, especially the percentages of young people among deaths increased so that according to the EMCDDA cause of death criteria, 40 per cent of drug deaths in 2000 involved people aged under 25 years and 61 per cent were aged under 30. The age distribution levelled off as heroin deaths declined, so that in 2001, under 25-year-olds accounted for 25 per cent and under 30-year-olds 37 per cent (Figure 9). In terms of poisonings, the change is smaller.

Figure 9

Drug deaths by age group in terms of cause of death and chemical findings in 2001



³⁵ Deaths defined based on the primary cause of death according to the cause of death register protocol and Filter B, resulting from the EMCDDA's harmonisation endeavours: in terms of substances, classic narcotics and polydrug use and in terms of diagnoses, poisonings (acute intoxication), harmful use, dependence and other mental and behavioural syndromes are included. The minimum value for drug-related deaths is calculated on the basis of Selection D from the primary cause of death criteria defined for special registers by the EMCDDA: of causes of death, only accidental poisonings and of substances, only classic narcotics are included. (To clarify the definitions, see: http://www.emcdda.org/situation/themes/death_mortality.shtml). The estimate based on substance findings is national and derived from findings of classic narcotics observed in forensic cause of death inquests (cf. the early part of this chapter).

On the other hand, as heroin deaths have declined, the amount of buprenorphine findings has gone up: in 2001, five verdicts of death by poisoning were recorded involving a buprenorphine finding, compared to an annual 1–2 findings previously. In these cases, buprenorphine had been injected and used together with other pharmaceuticals. In 2000 and 2001, a total of four deaths by poisoning were recorded involving cases where a user of ecstasy had simultaneously taken moclobemide, an antidepressant. Three people died of a methadone poisoning in 2001, while the use of gamma claimed one life in 2000 and another one in 2001. (Vuori 2003).

3.3 Drug-related infectious diseases

HIV

In 1998, an HIV epidemic resulting from injecting drug use was detected in Finland. By the end of 1997, as little as three per cent of HIV infections diagnosed in the country were attributed to drug injection, and almost exclusively contracted abroad. In 1998, the proportion went up to 24 per cent of 81 infections reported, followed by about 60 per cent of 143 cases in 1999. In 2000–2001, the percentage of infections contracted by injecting drugs remained at approximately 38 per cent (of all 145/128 cases).³⁶ The domestic epidemic started in Helsinki, with isolated infections flaring up in a dozen localities elsewhere. In 2002, the number of new HIV cases due to injecting drug use continued to decline, being 20 per cent of all 131 cases recorded.

According to the seroepidemiological analyses conducted among clients in Helsinki-based health counselling units in the year of the epidemic, 1998, HIV-positive clients accounted for 3 per cent of all clients. In 2002, the percentage of HIV-positive clients had dropped below 2 per cent. Based on the self-reported test results in the 2002 drug treatment demand data collection, HIV-positive clients accounted for 3 per cent of problem users who had injected drugs during lifetime. (Partanen A. 2003).

The HIV-positive clients interviewed for the follow-up concerning the Kluuvi service centre for HIV-positive clients were clearly older (mean age 35 years) than the clients using needle exchange services (mean age 24 years).³⁷ Of HIV-positive clients, a third were women, whose mean age was three years younger than the men's. Of the centre's clientele, 90 per cent also tested positive for hepatitis C, and half had been hospitalised during last six months. Almost half were unmarried (37% were divorced), a fact partly attributable to their difficult situation. (Törmä et al. 2002).

³⁶ The HIV register of the National Public Health Institute. See http://www.ktl.fi/ttr/hiv_aids.html

³⁷ The number of HIV-positive drug users (148) reached by the Kluuvi service centre by April 2002 was almost 60 per cent of all those HIV-positive people registered by the National Public Health Institute who had contracted the infection due to injecting drug use. For the study, 65 HIV-positive clients at the Kluuvi centre were interviewed. See also chapter 10.1. (prevention of infectious diseases).

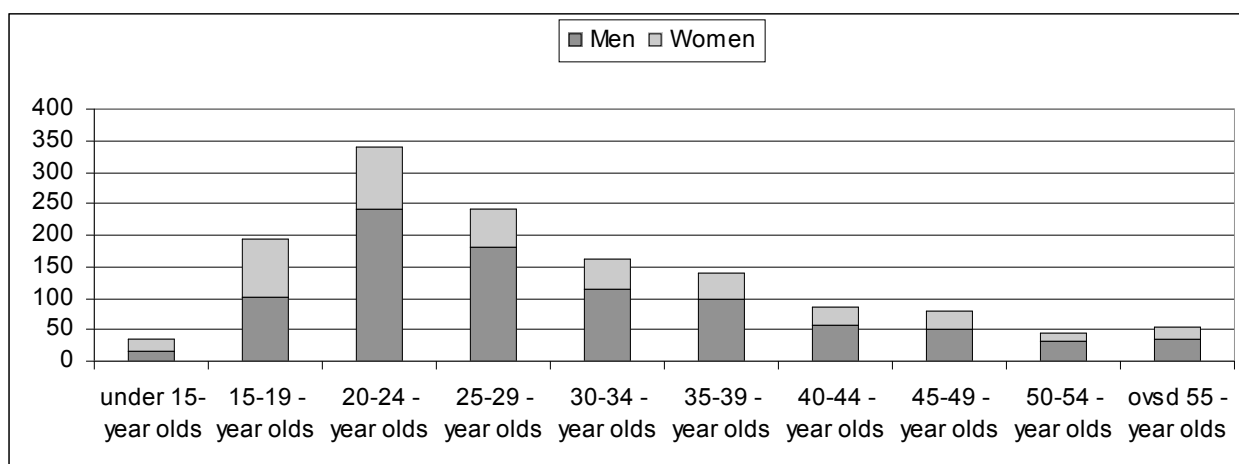
Hepatitis C

According to the surveys conducted at health counselling centres in 2002, 38–60 per cent of injecting drug users had contracted hepatitis C, with the highest percentages to be found at centres in Greater Helsinki and the lowest at centres elsewhere.

Of hepatitis C infections notified in Finland, 90 per cent are estimated to result from injecting drug use.³⁸ In 2000, previously unreported cases of hepatitis C amounted to 1,739, but in 2001 the number declined by almost 300–400 cases from the previous years' average and totalled 1,490. In 2002, the number declined again, with 1,373 new cases reported. Of the infections recorded in 2002, over half involved people aged under 30 - most in age group 20–24-year-olds. Women accounted for almost a third of new hepatitis infections (Figure 10).

Figure 10.

Age and sex distribution of new notified hepatitis C cases in 2002

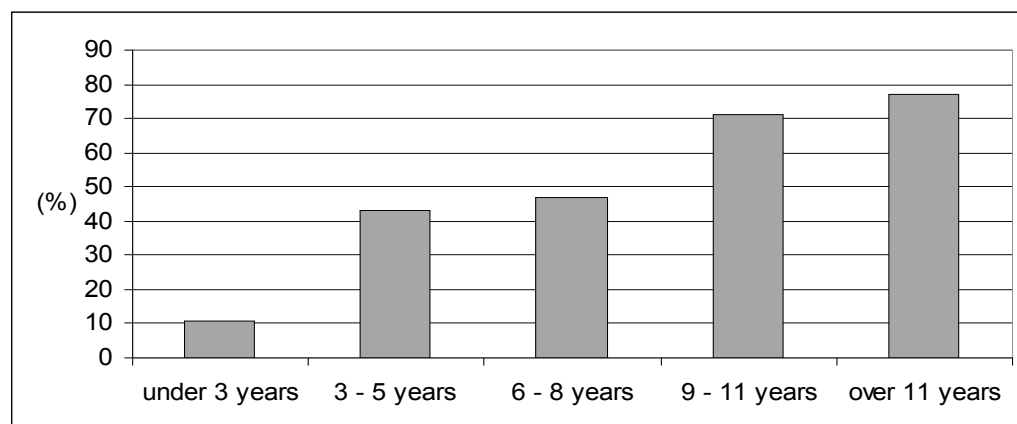


Studies on health counselling clients established a close linkage between hepatitis C infections and the duration of injecting drug use. As little as 10 per cent of those having injected drugs for no more than two years had contracted an HCV infection, while the same applied to almost 80 per cent of those having injected for at least 12 years. (Figure 11 below).

³⁸ The percentage was calculated for cases where the means of transmission was reported. However, in almost half of cases this is not known or remains unreported. In order to examine the risk of communicable diseases, hepatitis C infections were included in 1998 on the list of diseases a physician must report to the authorities. See *Infectious Diseases in Finland 2000, 2001, 2002*.

Figure 11.

Prevalence of hepatitis C infection (%) and duration of injecting drug use at health counselling centres³⁹



Hepatitis B

According to the drug treatment demand study, 11 per cent of clients entering drug treatment in 2002 were hepatitis B positive. This low percentage is explained by the gradually expanding coverage of hepatitis B vaccinations among those who have injected drugs at least once during lifetime. Almost two out of three had received at least one shot against hepatitis B and over a third had received all three shots (Partanen A. 2003.).

Hepatitis A

In 2002, a widespread hepatitis A infection was diagnosed among injecting drug users in the Greater Helsinki Area. The previous such epidemic in Finland occurred in 1994–1995. Hepatitis A spreads among injecting drug users directly from one person to another and through unsanitary injection paraphernalia. Under some circumstances, the virus may spread through contaminated drugs as well.

In spring 2002, mass vaccinations were launched at the health counselling centres in Greater Helsinki to curb the epidemic in the area. Nevertheless, the epidemic spread to other parts of the country in autumn 2002 and in 2003.

3.4 Other drug-related morbidity

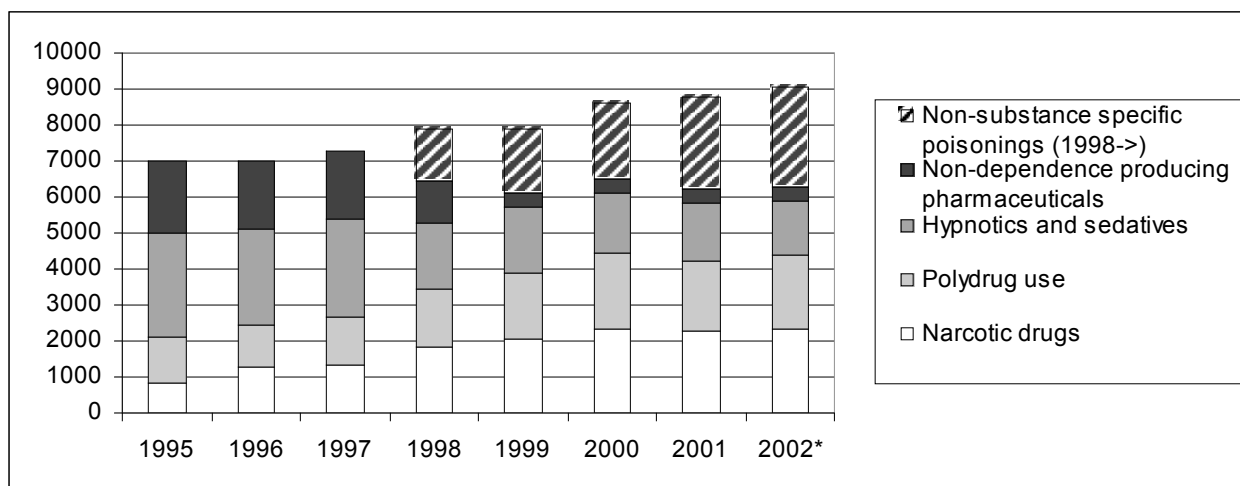
Morbidity caused by drug use is monitored through the Hospital Patient Discharge Register. According to hospital statistics, the number of drug-related treatment periods in hospital wards increased between 1995 and 2002 (Figure 12). Along with more prevalent use, other reasons for the increase in registered drug-

³⁹ Exit poll at health counselling centres in 2002, National Public Health Institute.

related diseases include growing public awareness of drug issues and changes in diagnostic practice. For example, the changeover to the ICD-10 classification in 1996 resulted in a growth of some 450 drug treatment periods.⁴⁰ On the other hand, the Finnish change in diagnostic application to pharmaceutical-induced poisonings, effected in 1998, reduced the number of treatment periods designated with medicine-specific codes by 1,500.⁴¹

Figure 12.

Hospital treatment periods related to narcotics and pharmaceuticals in 1995–2002⁴²



* = Preliminary information

The number of treatment periods with a narcotics diagnosis remained the same in 2001 and 2002, and the same goes for polydrug use as well. In addition, the amount of diseases related to the use of soporifics and sedatives has also declined slightly during the past four years, which is partially attributable to the persistent tendency to record diagnoses for pharmaceutical poisoning without specifying the substance. The patients treated for drugs and polydrug use are predominantly men (Figure 13 below), compared to those treated for abuse of medicines; their distribution by sex is relatively even.

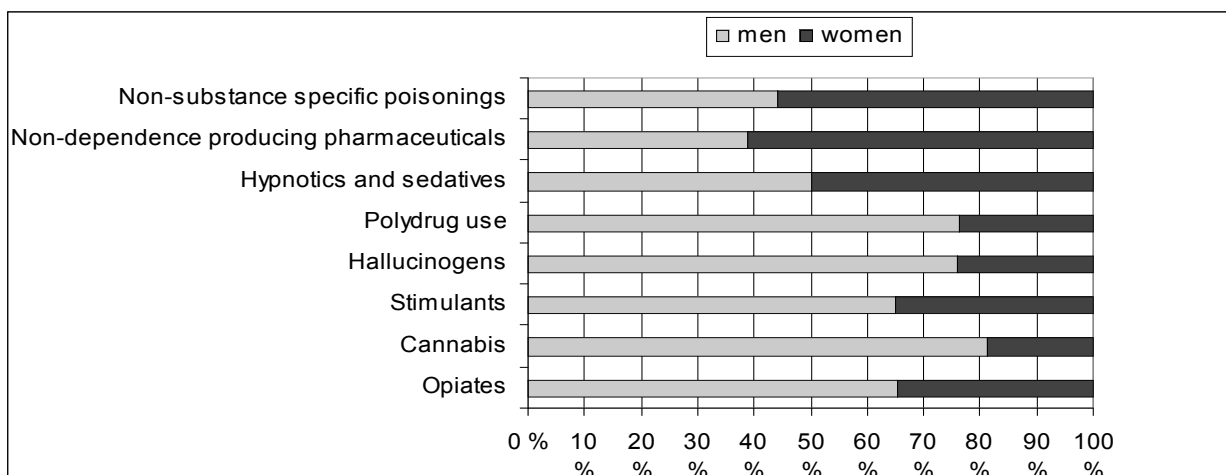
⁴⁰ It is estimated that almost half of this addition was caused by changes in the system. See definitions in Appendix 7 and 8 and Virtanen A. 2002.

⁴¹ According to this changeover, pharmaceutical-related poisoning diagnoses are combined into one diagnosis category (T36), where substance-specific distinctions are made by a separate ATC code for pharmaceutical substances. In 1997, there were over 3,000 such pharmaceutical poisoning diagnoses. However, in 1998 almost 1,500 poisoning diagnoses were recorded by using the ICD code only, without the ATC extension, a fact that makes direct comparisons impossible over time series on poisonings caused by hypnotics and sedatives, or non-dependence-inducing medicines. In practice, substance codes are still inadequately entered (without the extension) into statistical forms; hence the new category, ‘non-substance specific poisoning’.

⁴² The cases for substance-specific diagnosis entities were selected based on the principal narcotics or pharmaceutical diagnosis (primary diagnosis and two subordinate diagnoses). The 1995 drug diagnoses are according to the Finnish ICD-9 codes (see Appendix 6). In 1996, the classification changed in Finland, and since 1996 ICD-10 has been in use (see Appendix 7). The Appendix aims at statistical compatibility of drug-related diseases, despite the differences between the ICD-9 and ICD-10 classifications.

Figure 13

Hospital treatment periods related to narcotics and pharmaceuticals by sex in 2002*

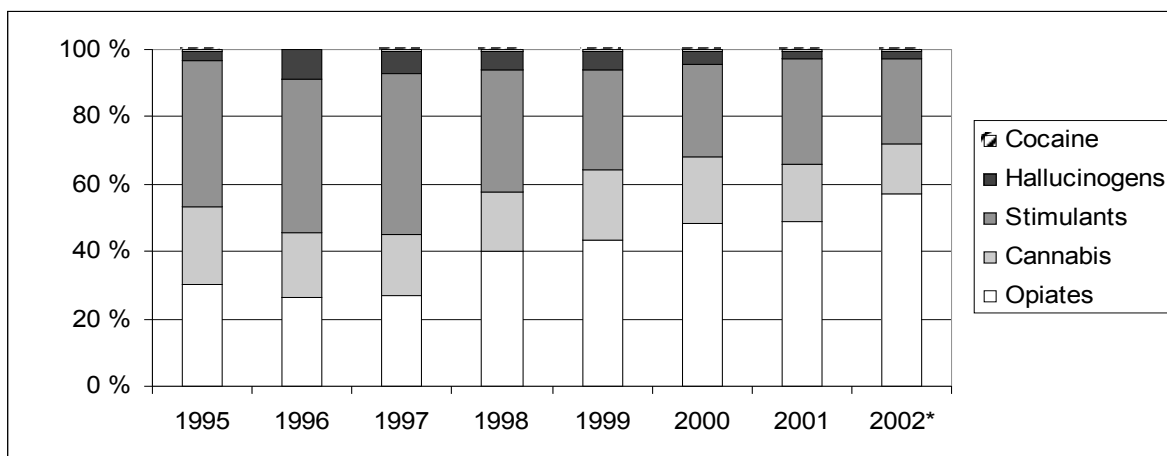


*= Preliminary information

In terms of hospital treatment periods related to narcotics, amphetamine-related treatment periods constituted the largest substance-specific group in the mid-1990s (Figure 14 below). In 1998, there was a change in order, as opiate-related treatment periods took the leading position. This trend continued in 1999–2002 and it may be partly due to changes in the treatment service system, where health care assumed more responsibility for the medicinal treatment of opiate users.⁴³ Correspondingly, the percentages of treatment periods related to cannabis and stimulants (e.g. amphetamines) have decreased in recent years. In terms of cannabis, this is partly due to the increased role of specified drug treatment services, where the percentage of cannabis clients has gone up during this period. For stimulants, on the other hand, client percentages seem to have declined within all treatment services for substance abusers.

Figure 14.

Drug-related hospital treatment periods (%) among 15–54-year-olds by drug in 1995–2002⁴⁴



* = Preliminary information

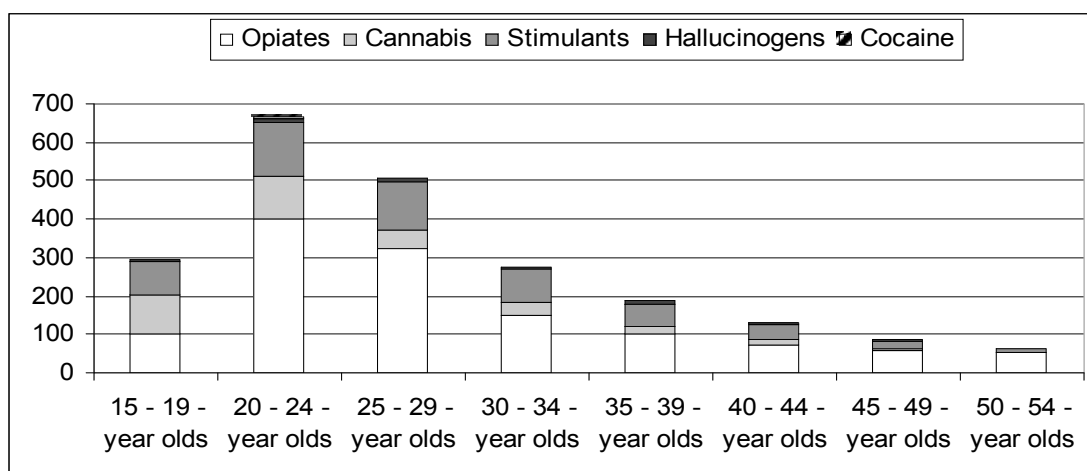
⁴³ Cf. Chapter 1.2.2.

⁴⁴ According to the highest drug diagnosis category. See Appendices 7 and 8.

Narcotics-related treatment periods have for long concentrated on age group 15–34-year-olds, especially among 20–29-year-olds in 2002 (Figure 15 below). This increase involved opiate-related diagnoses in particular. The reduction in stimulant-related diagnoses took place in age group over 20-year-olds, while the reduction in cannabis diagnoses involved over 25-year-olds.

Figure 15.

Drug-related hospital treatment periods by age group in 2002*



* = Preliminary information

4 SOCIAL AND LEGAL CORRELATES AND CONSEQUENCES

4.1 Social problems

Numerous drug use surveys notwithstanding, research information about the possible social problems of people experimenting with or using drugs is in short supply. Nonetheless, it seems that people classified as problem drug users, risk users, clients entering treatment for drugs and people convicted of drug offences all seem to be similarly excluded as far as education, work and housing conditions are concerned. There is no Finnish research information on the situation of the various ethnic minorities either, but their problems are compounded by cultural and language barriers and, in effect, more limited treatment options.

The preliminary findings of the 2001 follow-up study on risk behaviour among over 18-year-old injecting drug users suggest that the health counselling centres are frequented by a clientele using a wide range of substances and whose situation is difficult in many other respects as well.⁴⁵ Social exclusion, or its risk, is apparent in relation to work, education and housing: three out of four interviewees were unemployed at

⁴⁵ See Chapter 10.1 (prevention of infectious diseases)

that moment. Over half (51%) had resorted to living allowance, whereas of all 20–39-year-old Finns (over 80% of interviewees belonged to this age group), as little as about 12.5 per cent had done so during last year. Less than 40 per cent had taken a degree after secondary school, whereas in the general population 80 per cent of this age group had a post-secondary school degree. One out of ten interviewees was completely homeless and 27 per cent were in temporary housing. (Perälä et al. 2002). The results are very much the same when the backgrounds of clients entering drug treatment or drug offenders are examined. (Partanen A. 2003; Kinnunen 2001).

The evaluation conducted on the Kluuvi service centre for HIV-positive drug users indicated that 85 per cent of clients had not worked during last year and two thirds had not done so for last five years.⁴⁶ Of the centre's clients, 59 per cent received living allowance, 18 per cent unemployment benefits and 15 per cent were on pension. Furthermore, 15 per cent had not finished their basic education, while 40 per cent had some record of a post-secondary school degree; 65 per cent of HIV-positive clients went without permanent housing. (Törmä 2002).

Based on a psychiatric study on three reform schools, 40 per cent of pupils had a history of some substance abuse problem.⁴⁷ This was not an occasional disturbance but had lasted for at least a year and caused major disadvantages in the pupil's life. Of these disorders, 11.5 per cent involved drug dependence and 4.6 per cent drug abuse. All drug disturbances were more common among girls (23%; boys 10%). In the corresponding control group, nobody manifested substance abuse problems. The parents' mental health or substance abuse problems, criminal offences and domestic violence were important factors differentiating the backgrounds of reform school pupils from their controls. Divorce and the breakdown of the nuclear family were also common ingredients in reform school children's histories. (Lehto-Salo et al. 2002).

Juvenile drug experiments and getting caught in the act seem to give an ominous prediction about future life. In the study following 119 students in Helsinki (mean age: girls 17, boys 17.5), arrested by the police in 1971–1972, and their success in life twenty years later, it transpired that of this group, 70 could be classified as unsuccessful. This was defined as follows: they had resumed criminal involvement or ended in prison (40), in psychiatric care (31) or died (19). In this group, the risk of death was 4.5 times higher than that of women the same age and 4.3 times higher than that of men. Especially property crimes in early youth and injecting drug use seem to predict future prison sentences, psychiatric hospitalisation or untimely death. (Turpeinen 2001).

⁴⁶ See Chapter 10.1. (prevention of infectious diseases).

⁴⁷ The material comprised 87 young people (mean age 15.5 years) studied for less than a year in 1997–1998. Students (48) in three upper secondary schools in a nearby town were studied as controls in 1998. The diagnostic analysis of the psychiatric interview was carried out through SCID interviews and research diagnoses were made according to the DSM-IV classification

4.2 Drug (narcotics) offences and drug crime

The Finnish Penal Code prohibits, among other things, the illegal use, possession, purchase, sale, manufacture, distribution and import of narcotics. The control network captures drug offenders most often based on their social situation: especially problem drug users, the excluded and habitual criminals are susceptible to control measures, while occasional and experimental drug use only seldom comes to the attention of the police.

4.2.1 Drug (narcotics) offences

There has been a steady increase in drug crime since 1996 to 2001 (Table 10). Resource allocation based on the drug strategy of the police to drug detection and intensified antidrug training have been conducive to the number of drug offences detected.

Table 10.

Drug offences registered by the police in 1995–2002

	1995	1996	1997	1998	1999	2000	2001	2002*
Drug (narcotics) offences total	9052	7868	8323	9461	11647	13445	14869	13857
Drug offence	8654	7132	7781	8910	10701	12687	12092	5821
Drug user offence							1899	7240
Aggravated drug offence	390	728	529	539	958	741	859	760
Preparing and abetting a drug offence	8	8	13	12	15	17	19	36

* = Preliminary information on 2002

In drug offence reports, the largest group consist of the so-called user crimes (use, possession and purchase), which were specified in statistics but not in legislation prior to the year 2001. According to the statistics of the National Bureau of Investigation, they accounted for almost 80 per cent of reports in 1990–1998, while in 1999–2000 as little as two out of three offence reports were associated with user offences (Press release of National Bureau of Investigation, 3 May 2001; Kinnunen 2001). Owing to the legislative reform in 2001 – when user crime was introduced – and some statistical changes, it is impossible to make comparisons of statistically defined user crimes over a longer period of time.⁴⁸

The number of drug offences recorded by the law enforcement authorities in 2002 declined by 7 per cent from the corresponding figures in 2001, but this information should be treated with caution because of differences in recording larger crime entities in particular. Part of this reduction stems from the fact that

⁴⁸ The scope of application in user offences, see Chapter 1.3. One criteria for the seriousness of the offence is the quality and amount of drugs. However, there was some regional variation in court practice: for example, the District Court of Helsinki passed a sentence for aggravated narcotics offence if the person had at one point handled a kilo of hashish, 100 grams of amphetamine or 15 grams of heroin (Kainulainen et al. 2003).

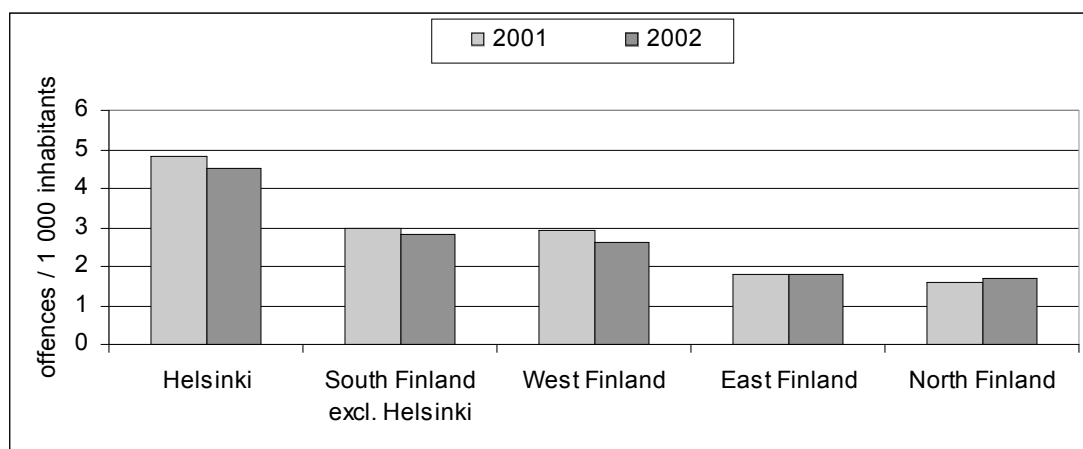
the police spent 12 per cent fewer working hours in combating drug crime than in the year before. In 2002, aggravated drug offences accounted for 5.4 per cent of all drug offences known to the authorities, compared to 6.1 per cent in 2001. For a few years, this decline has been affected by the virtual absence of heroin on the drug market. Especially in Southern Finland, the number of aggravated drug offences have dropped following investigation of major and complicated crime entities, which have international links and which tie resources for a long time. Thus the annually recorded number of aggravated offences depends on the investigative situation as well. (Hietaniemi 2003, Kainulainen et. al 2003).

In 2002, women accounted for about 15 per cent of drug offence suspects and about 14 per cent of aggravated cases. Some 70 per cent of drug offence suspects, and 89 per cent in aggravated cases, were aged over 20 years. (Annual Reports Questionnaire 2003). Of all suspects, 42 per cent were suspected of a drug user offence only (Hietaniemi 2003).

In Southern Finland, the growth in drug crime has already levelled off, but is still ongoing in the country's eastern and northern parts (Figure 16). Drug offences increased somewhat (3%) in the Province of Eastern Finland and as much as by 14 per cent in the Province of Oulu.

Figure 16.

Drug offences per 1,000 population by region in 2001–2002*



* = Preliminary information on 2002

In the late 1990s, a clear change in the role of Estonian and Russian perpetrators took place in Finnish drug crime. In 2002, foreign nationals accounted for only 5 per cent of drug offence suspects, but the percentage was 25 in aggravated drug offences. Of these suspects, 17 per cent were Estonians and 5 per cent Russians. Organised criminal elements operating on Estonian soil work in close collusion with crime organisations run by both Russians and some ethnic minorities in Russia as well as with their partners in Finland. (Hietaniemi 2003).

According to preliminary information of Statistics Finland, the number of drug offences known to the police and customs in the early part of 2003 seems to have grown by 5 per cent from the year before. The greatest change has occurred in the relationship between narcotics offences and a drug user offences: user offences accounted for 57 per cent of all drug crime, and their number increased by 28 per cent from the previous year, while the amount of narcotics offences declined by 17 per cent. An increase of about 5 per cent occurred in aggravated narcotics offences from the year before (Crime recorded by the police, 2nd quarter – preliminary information 2003).

In 2002, the police engaged in interception of telecommunications more extensively than before. A total of 1,557 subscriber lines were intercepted in 2002 (621 in 2001). The courts granted the police and customs 1,253 (787) authorisations for interception. The increase in interception of telecommunications does not result from changes in the crime situation, though. Aggravated drug offences or other crimes where interception may be enforced have not increased essentially compared to the previous year, but the suspects change their subscriber lines often, which means that the police have to reapply for interception and monitoring authorisations. Interception of telecommunications is mainly used in investigating aggravated narcotics offences. The courts granted the police 1,676 (1,469) authorisations for monitoring of telecommunications; the latter means the acquisition of confidential identification information about telecommunications messages. (Press Release of Ministry of the Interior, 24 April 2003).

An amendment to the Police Act, empowering covert operations and fictitious purchase as investigative techniques, took effect on 1 March 2001. Based on this reform, the Ministry of the Interior issued a Decree on the organisation of covert activities and fictitious purchase as well as the related supervision. In 2001, covert activities were not carried out and the police made one fictitious purchase. In 2002, covert operations were applied in detecting and investigating aggravated narcotics offences to a very limited number of suspects. A dozen or so decisions to engage in fictitious purchase were made, only part of which led to actual operations. In some cases, activities were aborted due to changes in pre-trial investigation. (Press Release of Ministry of the Interior, 10 April 2003).

The Money Laundering Clearing House of the National Bureau of Investigation received a little over 2,700 reports on suspicious business transactions in 2002. The number was on the previous year's level. Most reports concerning money laundering came from currency exchange agencies, 65 per cent in 2002. The Clearing House decided to refer 114 cases to pre-trial investigation (133 in 2001), of which 13 per cent (30% in 2001) were associated with drug crime. (Press Release of National Bureau of Investigation, 27 February 2003)

4.2.2 Drug sentences

In 2002 (2001), the courts of first instance passed 8,581 (9,372) sentences for narcotics offences (Table 11). Of them, 7,388 (6,415) involved a drug offence as the primary offence. However, the Narcotics Act underwent revision in 2001 so that a fine through summary penal proceedings can also be imposed as a punishment for drug use. In 2002 (2001), a total of 3,103 (297) such punishments were meted out. (Yearbook of Justice Statistics 2002).

Table 11.

Drug (narcotics) offences and sentences in 1995–2002

	1995	1996	1997	1998	1999	2000	2001	2002*
Drug offences recorded by the police	9052	7868	8323	9461	11647	13445	14869	13857
All drug sentences in courts of 1 st instance	4540	5158	5606	5912	6827	8340	9372	8581
Sentence for drug offence as a primary offence	2354	2877	3082	3985	4551	5812	6415	7388

* = Preliminary information on 2002

Of the sentences in 2001, 72 per cent involved fines, 17 per cent imprisonment and 9 per cent were suspended sentences. The mean duration of a prison sentence for narcotics offences was 4.0 months in 2001 and 37.0 months for aggravated narcotics offences.⁴⁹ In 2001, punishments were waived in case of 155 (2.5%) people guilty of a narcotics offence. The prosecutors, in turn, waived charges clearly more often.⁵⁰ In 2001, 2,013 decisions to waive charges were made, the main reasons being the lack of evidence, the negligible nature of the offence and the principle of concurrence. (Yearbook of Justice Statistics 2002).

A study was completed in 2001, using Statistics Finland register information to examine all those convicted of narcotics offences in 1977–1996 (Kinnunen 2001). It found that people convicted of drug offences had embarked on their criminal careers at a relatively early age. They were often guilty of other offences as well, especially theft, concealment and unauthorised appropriation of vehicles. Drug offences did not become frequent until the perpetrator was aged over 20, when the number of thefts was already in decline. When their criminal careers were compared to non-drug offenders, it turned out that drug offenders' criminal activity seemed to stay on a high level for a longer period of time, suggesting that drug use tends to maintain criminal involvement. The frequent criminal activity of people with drug convictions may also be attributed to their detachment from society. The subculture of those committing multiple crimes embraces drug use, which in turn is subject to heavy societal control.

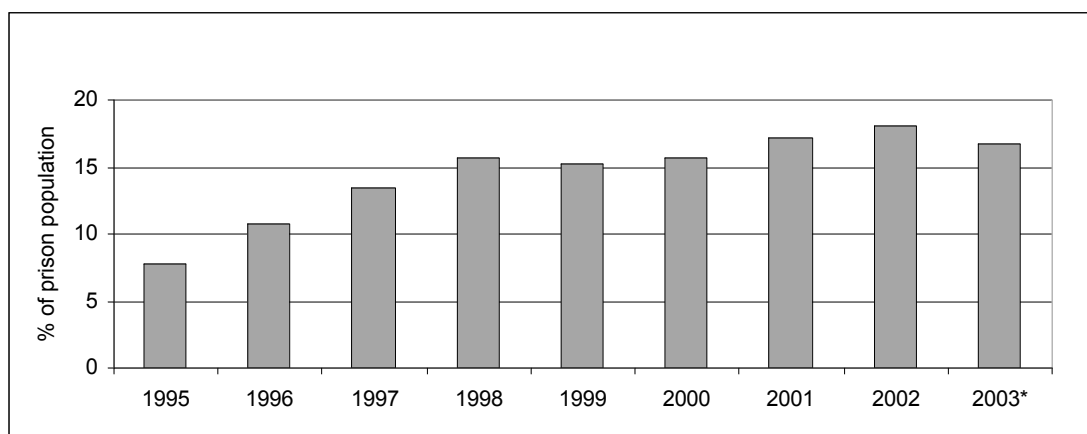
⁴⁹ When calculating the mean duration of a prison sentence, one should note that although the narcotics offence is the main crime on which the sentence was based, there may be other (drug) offences included as well. This is why the figures reflect the length of sentences served by drug offenders rather than the actual sentences. The results thus calculated do not, however, differ much from sentences based on just one offence. On the other hand, such cases account for less than a third of all drug offences. The accused and convicted in 2000.

⁵⁰ These are stipulated in Sections 3:5 and 50:7 of the Penal Code and in Section 1:7-8 of the Criminal Procedure Act.

In 2003, almost a fifth of inmates in Finnish prisons were incarcerated for narcotics offences (Figure 17). The sentences for drug offences are on average harsher as well: in the entire prison population, about half were serving sentences exceeding two years, whereas among drug convicts as many as two-thirds served over two-year sentences. It is noteworthy that about 40 per cent of prisoners had at least one drug conviction, if driving under the influence of narcotics is included. About a quarter of female prisoners had been sentenced for involvement in narcotics offences. Drug offences were particularly often the reason for serving sentences in prisons in Southern Finland.⁵¹

Figure 17.

Percentage of prisoners with drug offence as main offence in annual prison census 1995–2003



* = Preliminary information on 2003

The Criminal Sanctions Agency appointed a working group in 2002 to explore the need to develop prison health care further. According to the group, 46 per cent of prisoners suffered from morbid drug use or drug addiction. At least a quarter of inmates had a medical record of hepatitis C infection and one per cent had such a record of HIV infection. (Annual Report of the Prison and Probation Service 2002).

4.2.3 Drugs in road traffic

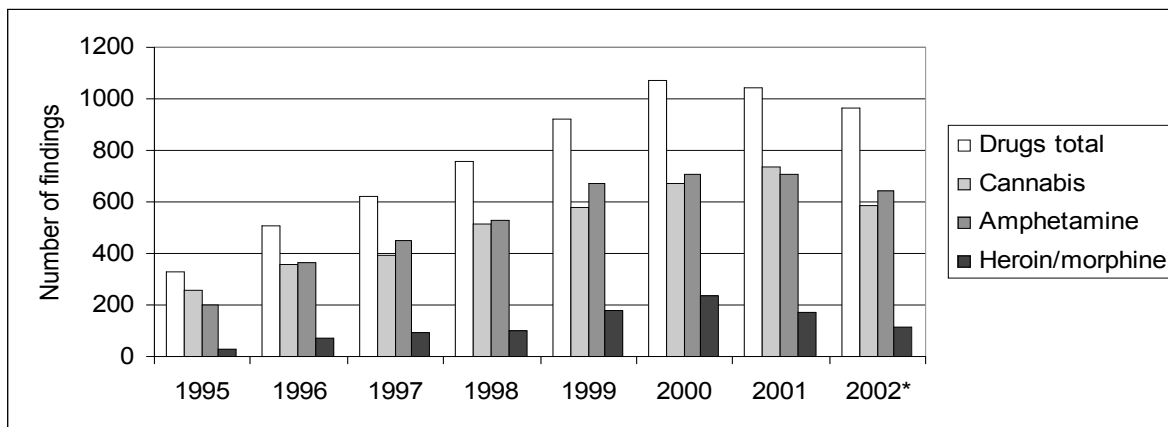
The prevalence of drugs in road traffic is assessed through law enforcement statistics. In 2002, the number of drunken drivers caught in traffic increased so that 18 out of 10,000 drivers were guilty of drunken driving, while in 2001 the number was 14. In 2002, 1,850 (1,844 in 2001) drivers underwent testing for pharmaceutical and narcotic substances impairing performance in road traffic (Figure 18). Such substances were discovered in 1,663 (1,562) cases, of which 967 (1,044) involved narcotics.

⁵¹ Until 1997, the results refer to the situation on 1 October in all prisons, when the census was conducted. Since 1998, the census has taken place on 1 May. According to the 2002 census, there were a total of 3,441 prisoners, of whom 213 were women. The number of persons primarily convicted of drug offences was 498 and there were 111 prisoners awaiting trial primarily for drug offences. The rest were prisoners serving sentences for enforcement of a fine.

(Annual Report of the Police 2002).⁵² The latter findings in 2002 (2001) were distributed as follows: amphetamines in 644 (706) cases, cannabis in 584 (737) and opiates in 116 (173) cases.⁵³

Figure 18.

Narcotics findings from people suspected of driving under the influence of drugs in road traffic



* = Preliminary information on 2002

4.3 Social and economic costs of drug consumption

Problem drug use is detrimental to the individual concerned and society at large. Problem drug use increases morbidity and social exclusion and in the worst case, a person with a drug problem may face an untimely death. Problematic substance abuse causes damage and costs to both the individual and society. In addition to treatment expenses, other major societal costs result from law enforcement and drug-related crime.

Based on preliminary 2001 information (2000 data), the problem use of narcotics and pharmaceuticals resulted in direct societal costs ranging between 138 (124) million and 204 (189) million euros (Hein 2003).⁵⁴ The largest increase from the year before took place in research and prevention costs (Table 12)

⁵² See also <http://www.poliisi.fi>

⁵³ Drug laboratory at the National Public Health Institute 2002.

⁵⁴ Cf. also Chapter 1.5.

Table 12.

Harm-related costs (million Euros) of narcotic and pharmaceutical substances in Finland 2001

	Minimum	Maximum
Enforcement and crime control	41	54
- police and emergency services	13	25
- justice and prison system	28	29
Damage to property	19	42
Social services costs	45	50
- welfare for substance abusers	27	27
- living allowance, child welfare	18	23
Health care and pension costs	22	44
- inpatient care for drug diseases	11	23
- outpatient services and home care	7	10
- sickness payments	2	3
- disability pensions	2	8
Research and prevention	11	14
Total	138	204

Besides direct costs, the problem use of narcotics and pharmaceuticals causes many indirect costs, for example, as production losses etc. Problem use is conducive to inefficiency in schoolwork, studies and salaried work. Problem use also brings social harms, such as marital breakdown. Moreover, a calculatory figure has been created for premature deaths. Estimates of all indirect costs range between 300–650 million euros in Finland.

5 DRUG MARKETS

5.1 Availability and supply

The supply and availability of drugs is discussed here based on the illegal import of drugs and drug offers received by individuals.

Large quantities of amphetamine and ecstasy are produced in Estonia expressly for the Finnish market and elsewhere in the Nordic countries. Crime organisations led from Estonia and Russia also have a geographically strong position in the large-scale smuggling of hashish from Morocco routed via Spain and Nordic or Baltic countries to Finland. Cocaine has been seized in small quantities from importers and wholesalers in Finland, usually in conjunction with other drugs. (Hietaniemi 2003).

The majority of the heroin on the Finnish market originates in Afghanistan, and has entered Finland either through Estonia or directly across the Russian border. In summer 2001, heroin supply to Finland dried out almost completely during the crisis in Afghanistan, so that by the end of 2002 it was detected only a few times per month in Southern Finland. The purity of the heroin on the market was exceptionally low, less than 10 per cent even in major seizures.

The depleting heroin supply in 2001 was clearly reflected in the spread of Subutex (buprenorphine), a medicine used for heroin addicts' substitution treatment, into illegal street trade and intravenous use. Subutex has mainly been imported from France, but its smuggling has an Estonian connection as well. It seems that Subutex is mostly imported through the users' own networks, nowadays also through Estonia. In Finland's neighbouring areas, the decline in heroin supply has led to a growth in the supply of synthetic opiates (3-methylfentanyl), but these substances have been virtually absent from the Finnish market.

The disappearance of heroin from the market seems to have a link to burglaries into pharmacies and medical warehouses; their number tripled from 2000 to 2001. In 2001, there were 118 such burglaries, and a little fewer in 2002, 109.

Another way to look at drug supply and availability is the viewpoint of personal drug offers received by citizens. In 1993–2003, 12–18-year-olds were asked about drug supply as part of young people's health behaviour survey (Figure 19a and 19b); the same question was put to members of the adult population in the adults' health behaviour survey in 1997–2002 (Figures 19c and 19d). Questions were also made as to who had been offered drugs for free or on sale during last year. The results indicate that the increase in drug offers to men has stopped or declined in 2002–2003, with the exception of 25–34-year old men, who had been made slightly more offers than before. (Rimpelä A. et al. 2003; Jallinoja et al. 2002).⁵⁵

Figure 19a.
Drug offers to boys (%) during last year

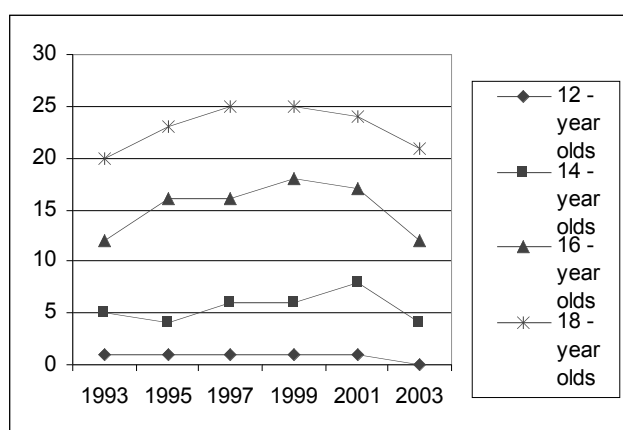
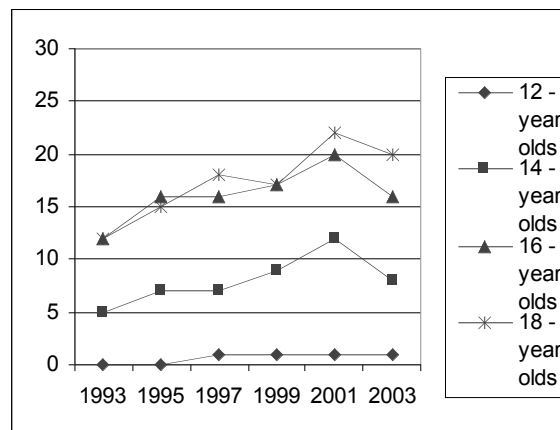


Figure 19b.
Drug offers to girls (%) during last year



⁵⁵ For more information on the sample, see Chapter 1.4. and 2.2.

Figure 19c.
Drug offers to men (%) during last year

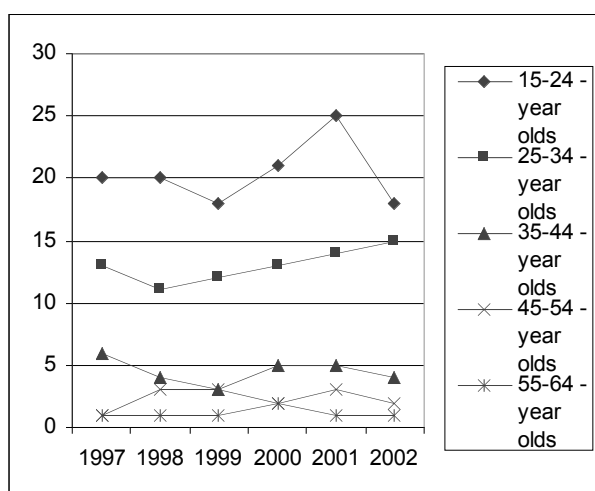
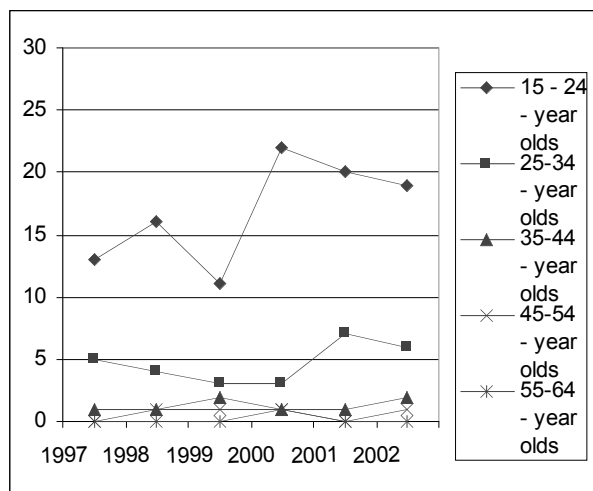


Figure 19d.
Drug offers to women (%) during last year



In the 2002 survey, 94 per cent of 15–64-year-old Finns reported not having been offered drugs during last year. Of those who had been made offers, 80 per cent could have obtained drugs for free at some point. Drug offers were on average more common, for example, in Greater Helsinki and other major cities for 15–24-year-old males and females, a quarter of whom had received drug offers during last year. On closer examination, drug supply to those under 20 years of age was the highest. (Jallinoja et al. 2003). For 14–18-year-olds, the clearest change in the 2000s has been that most drug offers were made by friends and acquaintances by contrast to the 1990s, when offers mostly came from strangers. (Rimpelä A. 2003).

According to a survey of criminal behaviour among 15–16-year-olds, about 8.5 per cent of young people had used drugs in 2001 (7% in 1998).⁵⁶ Of all those who had used marijuana or hashish during last year, 8.5 (4) per cent had financed their habit by illegal means. Consumption of large quantities of cannabis drugs seems to be relatively often associated with illicit ways to acquire drugs. The responses also showed that the more frequent the drug use during the year, the more likely it was that the person had to pay for it. Starting drug use at an early age also reduced free drug supply. On entering the drug scene, the users had to pay more often for drugs, but the price went down once they got to know the market better. (Kivivuori 1999; 2002).

5.2 Seizures

Following the sharp increase in drug seizures in 2001, the amounts in kilos (Table 13) and the number of seizures (Table 14) of most drugs decreased in 2002. The amounts in kilos of the most popular Finnish drugs – hashish and amphetamine – declined by 15 per cent. The number of ecstasy pills seized dropped by almost half and the amount of heroin by over half. In addition, the amount of buprenorphine seized,

⁵⁶ The sample comprised 4,500 9th-year pupils and the response percentage was 88.

i.e. Subutex pills, went down by over half, even though there was no considerable change in the number of seizures.

Table 13.

Drugs recorded as seized by the police and customs in 1995–2002(kg or pills)⁵⁷

	1995	1996	1997	1998	1999	2000	2001	2002
Hashish	147.51	99.44	197.66	160.97	492.32	196.54	589.6	482.3
Marijuana	4.27	3.51	12.15	8.01	18.17	13.82	16.1	32
Amphetamines	20.12	22.14	22.2	24.78	71.26	79.56	137.3	129.2
Cocaine	0.07	0.07	0.12	1.99	1.7	38.58	6.5	0.4
Khat*	68.11	264.5	249.01	103.94	374.1	348.41	664.5	1039.4
Heroin	16.12	6.45	2.4	1.97	2.88	6.03	7.5	3.1
Subutex (pills)	-	-	225	1175	2900	12950	38200	18 700
Ecstasy (pills)	3750	1011	3062	3320	17665	87393	81228	45 065
LSD (pills)	500	41	323	301	50	2355	1026	4679

* = Khat differs from other drugs because its use is not a criminal offence in all EU countries.

Table 14.

Number of seizures recorded by the police and customs in 1995–2002

	1995	1996	1997	1998	1999	2000	2001	2002
Hashish	1235	1312	1686	1997	2259	2482	4011	3012
Marijuana			385	382	463	663	1223	1275
Amphetamines	696	972	1352	1641	1956	2369	3778	3399
Cocaine	...	15	16	24	49	40	55	45
Heroin	82	145	153	210	342	437	558	145
Subutex							727	741
Ecstasy	...	52	74	57	159	393	465	329
LSD	...	14	14	...	15	34	14	10

Despite the high volume of passenger and goods traffic between Russia, Estonia and Finland, the authorities have only limited possibilities to carry out inspections. There has been a changeover from individual couriers, a practice considered risky and amateurish, to well-organised smuggling. Consequently, the consignments seized have become clearly larger than before. The largest consignment of hashish seized in 2002 was 80 kg (150 kg in 2001). During the year, 14 seizures comprising a minimum of 10 kg of hashish were made. Organised criminal elements led from Estonia have a strong foothold in Finland, not only in drug marketing and manufacture but also in wholesale and distribution. (Hietaniemi 2002; 2003).

New synthetic drugs were still rare in Finland. While popular in Russia, fentanyl have rarely come up in Finnish seizures. In 2002, however, a major wholesale consignment of 3-methylfentanyl, a highly potent superdrug known as ‘Krokodil’ in Russia, was seized. (Hietaniemi 2002).

⁵⁷ Occasionally, there is a great deal of variation in the amounts seized in kilos: for instance, in 2000 almost all cocaine seized was found on board a luxury ocean liner. Annual statistics of the drug information services of the National Bureau of Investigation.

5.3 Price and purity

The price of drugs is relatively high in Finland, often many times higher than in, for example, the Netherlands. According to National Bureau of Investigation statistics, the street price of hashish in 2002 was estimated at 8–12 euros per gram; for amphetamine 15–35 euros per gram; for ecstasy 12–20 euros per tablet; for white heroin 150–250 euros per gram; for buprenorphine 50–70 euros per tablet; and for cocaine 70–170 euros per gram. (CND – Finnish answer to 2002 ARQ – Part III).

The purity of drugs is tested regularly for amphetamine and heroin consignments. Small quantities of cannabis need not to be analysed, if the suspect has confessed and there is no doubt as to the substance. In the street, the quality of drugs varies greatly. The average purity of amphetamines have annually varied around 50 per cent, and 33–50 per cent for heroin. In consignments seized in street trade (less than 50 grams) in 2002, the average purity of amphetamine was 40 per cent and 8 per cent for heroin. Especially the purity of heroin has gone down after the year 2000 (Kainulainen et al. 2003).

6 TRENDS PER DRUG

6.1 Cannabis

According to the data on 2002, 12.8 per cent of 15–64-year-old Finns had tried cannabis during lifetime (14.2% of men and 11.4 % of women). During last year, 2.9 per cent had done so (3.4% of men; 2.3% of women). Of them, almost three-quarters were in age group under 25-year-olds. 1.1 per cent had of adult population used cannabis during last month. The latter figure makes it possible to estimate the maximum number of ‘regular cannabis users’ at 40,000 people. Cannabis use and experiments have become more prevalent since the mid-1990s by about 50 per cent (children and adults). On the other hand, it is estimated that the growth in regular use has stabilised in the early 2000s.⁵⁸

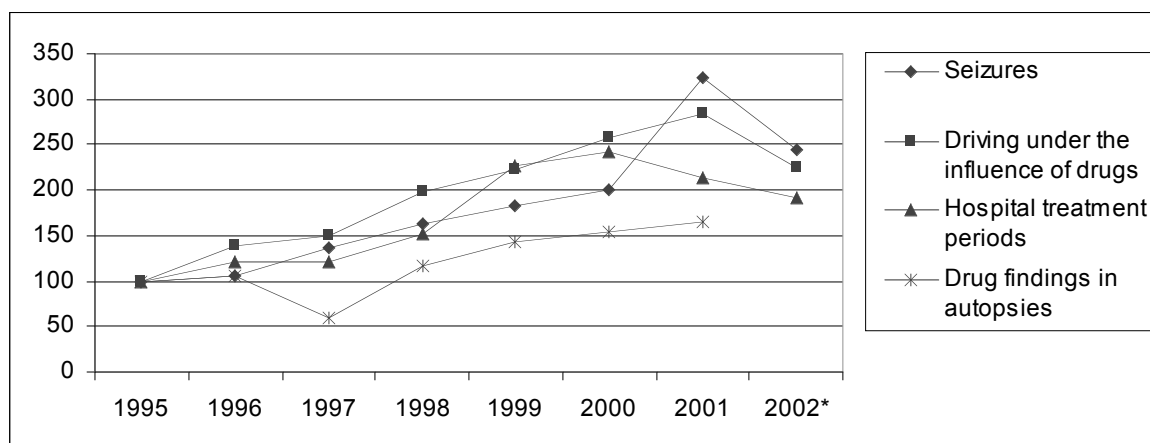
Correspondingly, cannabis-related harms (number of cannabis seizures, driving under the influence of cannabis, cannabis-related disease and cannabis findings in deaths)⁵⁹ have progressed since the mid-1990s as shown in Figure 20 (1995=100).

⁵⁸ Cf. Chapters 2.2.1 and 2.2.2.

⁵⁹ The harm indicators were specified for each substance based on the substance-specific data in this report: deaths (Chapter 3.2, Figure 10), morbidity (Chapter 3.4, Figure 15), driving under the influence of drugs (Chapter 4.2.3, Figure 20) and seizures (Chapter 5.2, Table15). At the beginning of this time series, in 1995, the indicators have the following values: 37 cannabis-related deaths; 174 cannabis-related treatment periods at hospitals; 259 cases of driving under the influence of cannabis; and 1,235 (hashish) seizures.

Figure 20.

Trends in cannabis-related harms in 1995–2002 (1995=100)



* = Preliminary information

6.2 Synthetic drugs (amphetamine, ecstasy, LSD)

According to the 2002 population survey, about 2.2 per cent of 15–64-year-olds had used amphetamine during lifetime (2.6% of men; 1.7% of women). During last year, 0.5 per cent had done so. The data on 1999 suggest that an estimated 0.24–0.36 per cent of 15–64-year-old Finns, i.e. 8,300–12,400 people, were problem users of amphetamine in 1999. It was further estimated that women accounted for about 15–25 per cent of problem users of amphetamine and that a little over half were aged 25 or younger.⁶⁰ In terms of ecstasy, 1.4 per cent of 15–64-year-olds had used ecstasy during lifetime (2% of men; 0.7% of women), and 0.8 per cent had used LSD (1.2% of men; 0.4% of women). For the latter substances, no estimate exists as to the number of problem users.

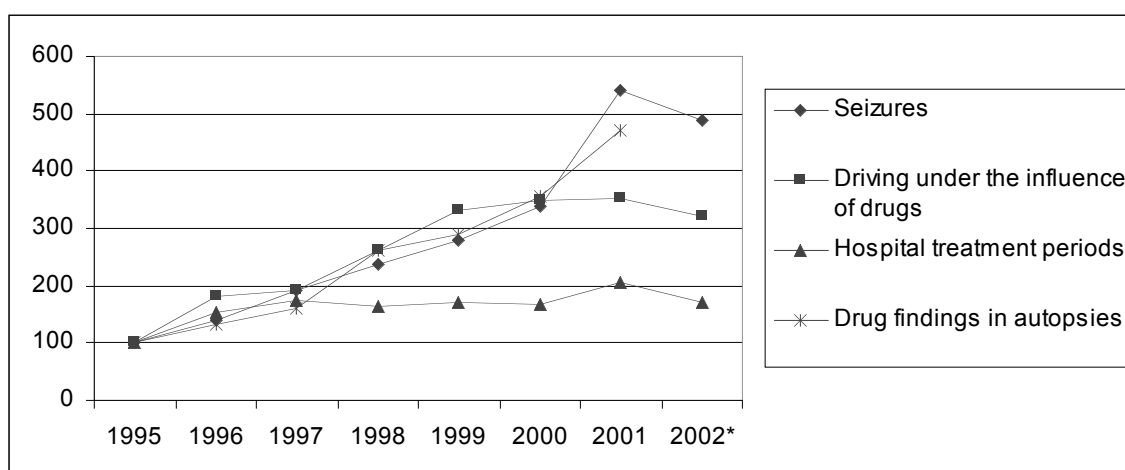
Amphetamine-related harms progressed in 1995–2002 as shown in Figure 21 below (1995=100).⁶¹ No comparable time series are available for ecstasy and LSD (except seizures), but the use of them is indicated e.g. in treatment statistics.

⁶⁰ Cf. Chapter 2.3.

⁶¹ Cf. Footnote 83. At the beginning of this time series, in 1995, the indicators have the following values: 19 amphetamine-related deaths; 327 (stimulant-related) treatment periods at hospitals; 201 cases of driving under the influence of amphetamine; and 696 amphetamine seizures.

Figure 21.

Trends in harms related to the use of amphetamines in 1995–2002 (1995=100)



* = Preliminary information

6.3 Opiates / heroin and buprenorphine

According to the 2002 population survey, about 0.5 per cent of 15–64-year-olds had used opiates during lifetime (0.7% of men; 0.4% of women). During last year, 0.1 per cent had done so. Based on the 1999 data, 0.07–0.1 per cent of this age group were problem users of opiates in 1999, i.e. 2,500–3,300 people. The estimate suggested that women accounted for about 20–30 per cent of opiate users and a little under half were aged 25 or younger.⁶² In the category of opiates, problem use mainly involved heroin until the end of the 1990s, followed by the emergence of buprenorphine in the early 2000s, partly as a substitute for heroin.

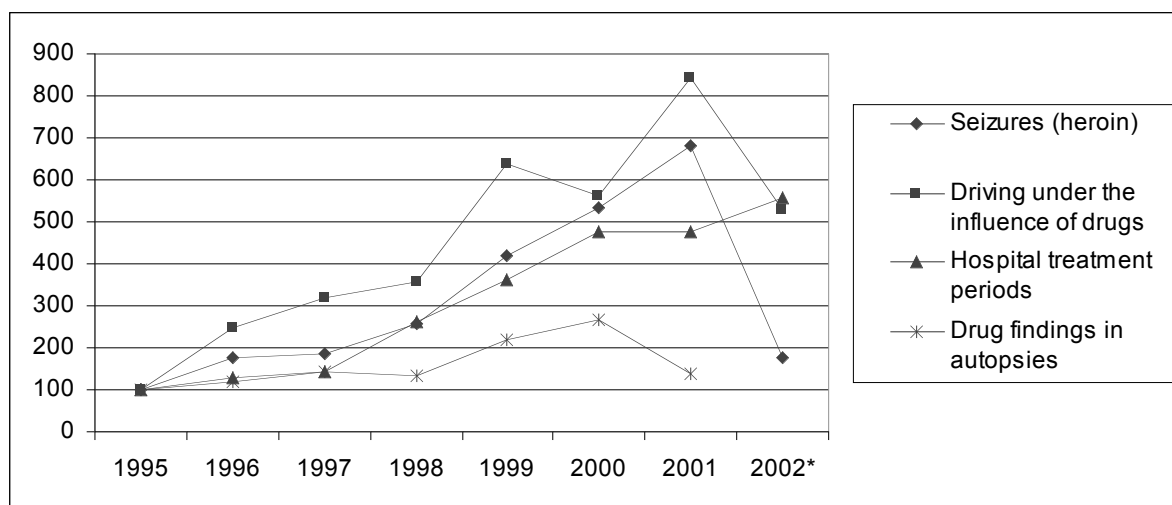
As in the problem use of opiates, it seems that also in opiate-related harms the distribution of substances has changed in the 2000s: more buprenorphine than heroin seizures were made and buprenorphine has clearly become more common than heroin as the primary reason for entering treatment in this category. The number of heroin-related deaths has gone down considerably, while a few buprenorphine-related deaths occurred during last year. Figure 22 illustrates trends in opiate-related (mainly heroin-related) harms in 1995–2002, but due to statistical changes it does not show the impacts of increased buprenorphine use – especially as regards seizures (1995=100).⁶³

⁶² Cf. Chapter 2.3.

⁶³ Cf. Footnote 83. At the beginning of this time series, in 1993, the indicators have the following values: 39 opiate-related deaths; 226 opiate-related treatment periods at hospitals; 28 cases of driving under the influence of opiates; and 82 (heroin) seizures.

Figure 22.

Trends in harms related to the use of opiates in 1995–2002 (1995=100)



* = Preliminary information

6.4 Cocaine

The data on 2002 suggest that 0.7 per cent of 15–64-year-olds had tried cocaine during lifetime (0.9% of men; 0.5% of women). Attached to cocaine are often such labels as ‘recreational use’ or ‘party use’. This in part may explain why this substance is not made visible by indicators measuring (serious) harms. Only in the drug treatment demand statistics does cocaine use come up, but even there it is not the primary reason for treatment need. Police statistics show no major changes in the number of seizures during the past five years, but there are some signs of a growing supply of cocaine in Finland, as observed elsewhere in Europe and reflected in Internet chat rooms and some investigations into youth culture.

6.5 Polydrug use and abuse of pharmaceuticals

Finnish substance abuse and the resulting negative effects are characterised by polydrug use. Studies have shown that already at an early age the use of various substances concentrates on the same individuals. (Ahlström et al. 1999). The 1999 ESPAD school survey indicated that three-quarters of 15–16-year-olds, who had abused hypnotics or sedatives as well as some illegal drug other than cannabis, had also tried mixing alcohol with pills; half of those having tried cannabis or glue had also mixed alcohol with pills. On the other hand, a third of those who had mixed alcohol with pills or abused glue, hypnotics or sedatives had also experimented with cannabis.

Launched in 2002, the new study mapping out drug phenomena examined drug worker interviews, Internet chat rooms and discussions with partygoers who use drugs. Preliminary results suggest that different substances were intentionally mixed and that various medicines (both prescription and non-prescription) were

abused for intoxication. This use aimed at intoxication or heightening or prolonging the effects of a certain substance. Another reason may be an effort to alleviate the tail-end effects of the experience. One typical example is the intensification of the effects of ecstasy, which at least partly led to the hazardous combined use of ecstasy and antidepressants. Mixing alcohol with cocaine, or heroin with stimulants, such as amphetamine or cocaine, or smoking cannabis while under the influence of other substances also emerged in this study. In addition, muscle relaxants, anti-motion sickness medication, neuroleptics, cough mixtures and antidiarrhoeals were used or tried for intoxication purposes. However, it is hard to assess how common these combinations actually are. It may be more accurate to speak about a new polydrug culture, combining a wide range of substances. (Seppälä 2003).

The study showed that medicines and other substances were used in a variety of cultural settings: alone or together with others, at home or outdoors, at restaurants and dance parties. An interesting phenomenon is the usage of the term 'recreation' among this group of people, mainly in reference to the abuse potential of various pharmaceuticals. In this group, recreational use is intertwined with problem use and partly also with the treatment of mental health problems and self-medication. Antidepressants prescribed by a physician are discussed in the same manner as ecstasy and intoxicants. Moreover, pharmaceuticals are consumed in order to medicate different types of anxiety and depression. (Seppälä 2003).

In terms of drug-related harms, polydrug use has a central position in Finland. In the compilation of drug treatment information, almost two out of three clients in services for substance abusers reportedly used at least three substances and about 88 per cent reported the use of at least two substances. In terms of diseases related to narcotics and pharmaceuticals, the number of treatment periods recorded by polydrug use diagnoses has grown correspondingly to the increase in narcotics diagnoses.⁶⁴ Multiple substance findings, i.e. indications of polydrug use, are also present in drug deaths (about a third of cases).

Besides health hazards, also social risks are hard to trace back to polydrug use in particular, but one such possibility is offered by the chemical findings related to persons caught driving under the influence of drugs. Interestingly enough, it is exactly polydrug use (in broad terms) that seems to be increasingly detrimental to road safety, because today only half of suspects tested positive for one substance alone.⁶⁵

Population surveys have compiled information about one key element of polydrug use, 'non-medicinal' (ab)use of pharmaceuticals, especially about hypnotics and sedatives as well as analgesics. According to the 2002 data, 7.1 per cent of 15–64-year-olds had tried hypnotics or sedatives for non-medicinal purposes during lifetime (6.0% of men, 8.1% of women). During last year, 2.9 per cent had done so (2.7% of men; 3.1% of women), i.e. as many as had tried cannabis during last year. While actual narcotics experiments involve the young, under 35-year-olds, the non-medicinal use of pharmaceuticals concerns other age groups

⁶⁴ See Chapters 3.1 and 3.4.

⁶⁵ Drug laboratory at the National Public Health Institute, 2001.

as well. Of 15–64-year-olds, 1.9 per cent had tried inhaling (sniffing) solvents or glue at some point (2.5% of men and 1.3% of women), but only 0.2 per cent had done so during last year.⁶⁶

A working group on the prescription and non-medicinal use of pharmaceuticals mainly affecting the central nervous system completed its report in 2002⁶⁷ Based on information about prescribing and administering these medicines, the working group concluded the criteria for the relevant risk group to be as follows: during the period studied (6 weeks) the patients had received such pharmaceuticals five or more times, enabling access to a minimum of 300 units (tablets); the patient had received at least 500 units of medicine; or the patient had received cough mixture containing at least 1,500 ml of codeine. The size and composition of the risk group was estimated on these criteria, although the group was also liable to comprise patients who were not problem users of any type of drugs, such as patients suffering from cancer or severe pain or substance abuse patients in detoxification, who received higher than average dosages due to their high tolerance to medicines affecting the central nervous system. The risk group was estimated to include 2.7 per cent of the users of CNS-affecting medicines, i.e. some 6,600 patients, receiving 9.7 per cent of all prescriptions for CNS-affecting medicines and 12.9 per cent in terms of dosage. In this risk group, 15–24 and 25–39-year-old men and 40–55-year-old women stood out.

Based on the 1999 data, slightly more clients were hospitalised or in other services for substance users because of (ab)use of medicines than for narcotics use. However, the age structure of those seeking treatment for abuse of pharmaceuticals predominantly involved people who were older than narcotics clients. The number of deaths related to pharmaceuticals in 2002 was almost quadruple the number of narcotics-related deaths, however many of them belonged to the category of suicide. Traditionally, abuse of pharmaceuticals means mixing them with alcohol, but the recent drug treatment follow-up and analyses of drug deaths have indicated that medicinally prescribed sedatives are also mixed with heroin. Another emerging phenomenon is abuse of medicines used for opiate addicts' substitution treatment, especially by injecting buprenorphine (Subutex). This also reflects the use of pharmaceuticals in an effort to 'self-medicate' the drug problem. The users visit different physicians for prescriptions, and substances are imported in an organised manner from abroad. In addition, forged prescriptions, burglaries into pharmacies and medical warehouses as well as the smuggling of medicines from abroad have become more prevalent.

7 DISCUSSION

7.1 Consistency between indicators

Based on the existing indicators, trends in the drug situation since the mid-1990s seem quite uniform (Figure 23). Both drug experiments and use (time series available for cannabis only) and negative effects

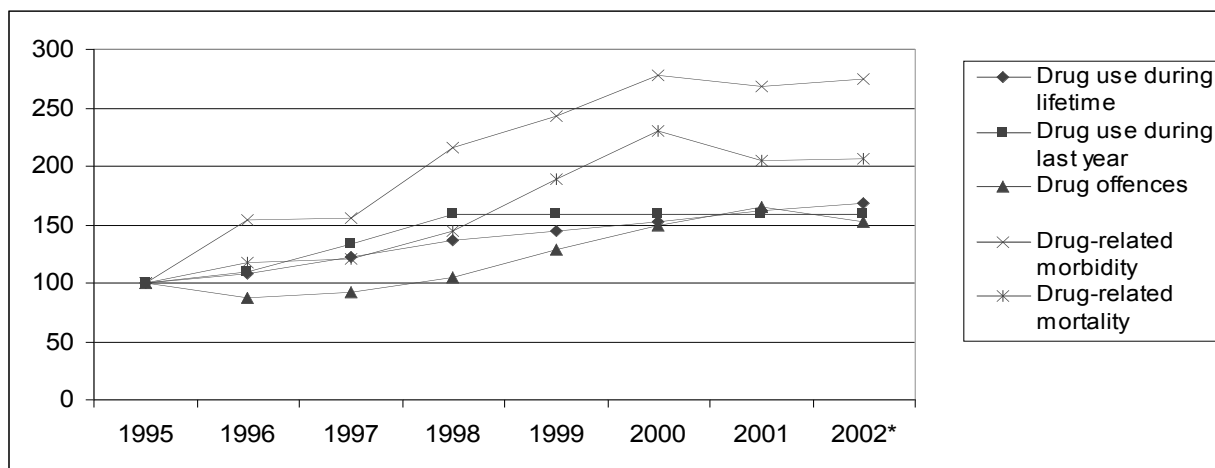
⁶⁶ See Chapter 2.2.1.

⁶⁷ These medicines include pharmaceuticals containing opioids as well as hypnotics, sedatives and other licensed medicines.

(morbidity, crime and mortality) have gone up at least by half, while morbidity has more than doubled. This decade, however, has seen the first signs of a possibly slowing growth trend in drug experiments and use. This is apparent in regular use, use during last year as well as among schoolchildren and under 20-year-olds. All harm indicators seem to be progressing accordingly. It remains to be seen whether this is a temporary trend or the first signs of a new one.⁶⁸

Figure 23.

Trends in drug experiments and drug-related harms in 1995–2002⁶⁹ (1995=100)



* = Preliminary information

Based on the 2002 drug survey results, drug use during last year has apparently stabilised in the past four years. In entering treatment, cumulative harms resulting from problem use occur with a lag of 3–5 years after the first experiments or commencement of use. The stabilisation of harm indicator values in 2001 and 2002 seems to be relatively consistent with the above-mentioned estimate of the delayed effects of drug-use trends on drug-related harms. In addition to the above harm indicators, new HIV infections due to injecting drug use appear to be declining slightly, as is the case with new hepatitis C infections as well. On the other hand, many negative effects are attributable not only to the prevalence of use but also to changes in settings and the ways of using drugs. A specific factor explaining the indicated decline in infectious diseases may be the establishment of health counselling networks for injecting drug users.

Various drugs manifest themselves differently in the harm-related statistics. Statistics on services for substance abusers and health care are prone to display the negative effects of ‘hard’ or injected drugs, amphetamines and opiates in particular. These substances play a central role in the register of infectious diseases and cause of death statistics. Cannabis, in turn, is important in crime statistics, even though

⁶⁸ See also Virtanen A. 2001.

⁶⁹ Drug offences = narcotics offences recorded by the police (Table 11). Drug-related morbidity = drug-related diseases according to primary or subordinate diagnosis in the health care register statistics of STAKES (Figure 12). Drug-related mortality = narcotics findings in deaths according to the Helsinki University Department of Forensic Medicine (Figure 7). Experiments and use = those having tried drugs during lifetime / during last year in population surveys (Figure 3a).

amphetamine has already become more prevalent in the number of seizures. In the Finnish context, cocaine and ecstasy are in practice visible in crime statistics only, although their use is occasionally indicated by treatment statistics and discussion forums as well.

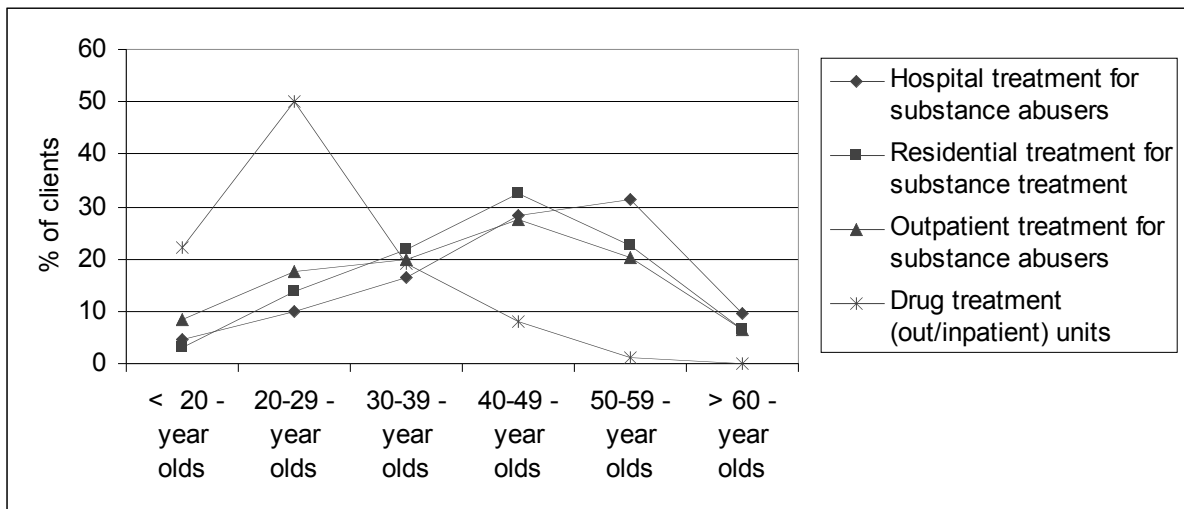
Finnish substance abuse is characterised by polydrug use. The largest group consists of problem users of alcohol who only occasionally take other substances. Throughout the 1990s, the combinations of substances used have remained unaltered. The key polydrug user groups are as follows: (i) users of alcohol and medicines; (ii) users of amphetamines and cannabis, who also imbibe alcohol; and (iii) opiate users who also take amphetamines and cannabis but not large quantities of alcohol. In the 2000s, alcohol seems to have a more minor role, especially among users with an opiate problem. New phenomena include mixing medicines with opiates and abusing opiates used in medicinal substitution (Subutex) by injecting them. (Partanen A. 2001; 2002; 2003). There are also some indications suggestive of a new user culture, where polydrug use is linked with recreation or occasional experiments with various drug combinations.

The crux of the Finnish substance abuse problem is alcohol abuse, but there are also three factors that have made problem drug use a special concern since the mid-1990s: the constant, albeit today stabilised, increase in drug-related harms; the more common societal exclusion of problem users, reflected in a position even more disadvantaged than that of other substance abusers or criminals; and the accumulation of problems in young age groups. About 40 per cent of problem drug users, those died because of drug poisoning or hospitalised for drugs are aged under 25. Young people's involvement in problem drug use is further indicated in Figure 24.

Figure 24.

Age profile of substance abuse clients in health care institutions and treatment services for substance abusers in 2001⁷⁰

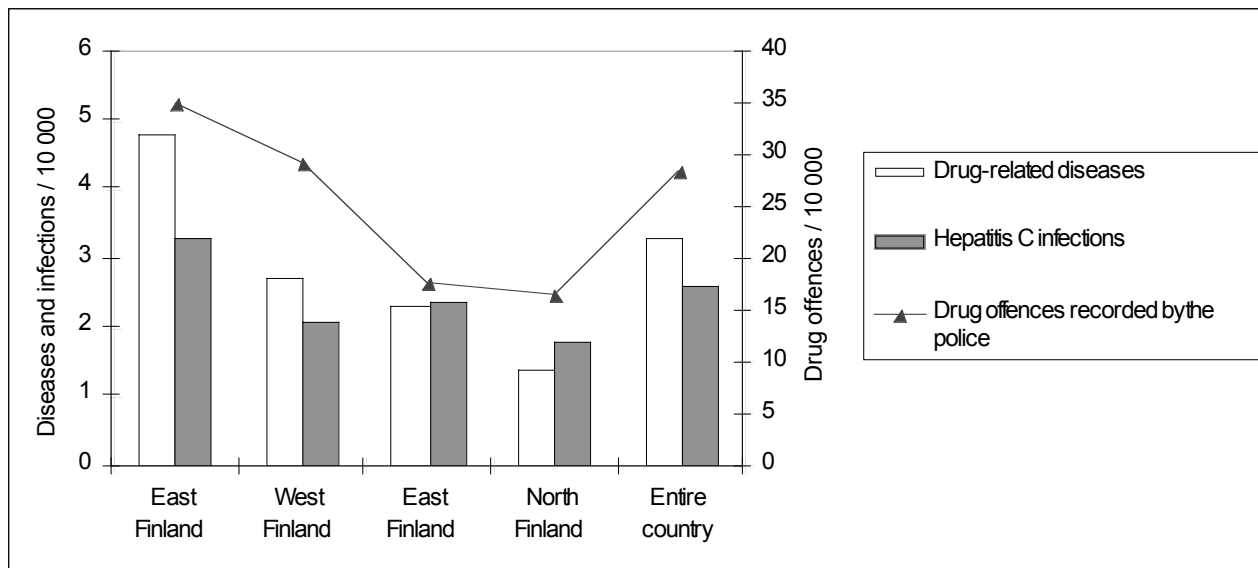
⁷⁰ Outpatient services calculated by clients (last age group over 60-year-olds). *Statistical Yearbook on Social Welfare and Health Care 2002*; Partanen A. 2002.



Geographically, the main drug-related harms are distributed in the same manner as drug use in general: Southern Finland and major cities predominate in both categories (Figure 25).

Figure 25.

Drug-related harms (per 10,000 population) by region in 2001⁷¹



It would appear that the growing trend in drug experiments and drug-related harms, having continued throughout the 1990s, is now in the process of stabilising. In terms of experimental drug use, the first indications of this change were recorded at the turn of the millennium, but in harms, the first consistent signs did not appear until 2001 and 2002. This time lag is highly indicative of the development that starts with drug experiments and use, followed by problem use, as seen in various harm-related registers. Today, it is unclear whether this is just a passing development or the beginning of a new trend. Furthermore, it remains to be seen how the figures are affected by the new substances and practices adopted in evolving youth cultures, which are only tentatively indicated in school statistics but almost not at all in harm statistics, with the possible exception of ecstasy seizures. Developments in Finland's neighbouring areas and in the supply of drugs may rapidly change the Finnish situation as well.

Another emerging trend is abuse of hypnotics, sedatives and substitution medicines (especially buprenorphine). As the users' mean age rises, the harms will expand more widely all over the country and to older age groups in acute and, eventually, chronic forms (e.g. cirrhoses caused by hepatitis C), as has already happened with the long-term harms caused by the principal substance abused in Finland, namely alcohol. The new substances and responding to them on the one hand, and the old substances with the related chronic drug harms on the other, will pose a new challenge to the treatment system in the decades

⁷¹ Drug-related diseases defined by primary diagnosis and regions defined by province so that North Finland covers the Provinces of Oulu and Lapland. See regional information about drug use and problem use in Chapter 2.2.

to come. Some harms, such as HIV infections originally contracted while injecting illegal drugs, will spread outside the drug user circle as well.

7.2 Methodological limitations and data quality

The past few years have witnessed a tremendous influx of new information about drugs and the quality of this information has undergone extensive development. The technical improvement of statistical compilation systems has also accelerated the development.

In Finland, regular population surveys have been carried out since the early 1990s concerning drug experiments and use among schoolchildren, the youth and the entire population. Nevertheless, these methods fail to give information about the most hazardous drugs, used by a small group of people who are not easily approachable.

The majority of drug harm indicators are compiled as part of some larger datasystem, restricting their usefulness somewhat from the viewpoint of drug information. The development of the Finnish drug information systems is directed at more precise interpretation and better utilisation of the information extracted from the indicators. Such examples include investigations into the backgrounds of drug-related crime and deaths as well as estimates of the number of (problem) users of amphetamines and opiates by combining register information. In addition, information about drug clients in services for substance abusers has been produced in Finland by using a compilation method that is compatible with the European system.

In addition to the drug situation, studies have been conducted in recent years on drug policy, drug control and drug service systems, and various prevention or treatment projects have been evaluated. System information, coupled with the development of methods to evaluate preventive and curative drug work, open new prospects for more feasible interventions in the future.

Despite the development of quantitative methods and system information, the absence of qualitative studies on the ways of using drugs and related user cultures is still a noticeable shortcoming in Finnish drug research, although also these topics have been touched upon in some projects and theses. Nonetheless, the scarce volume of scientifically analysed qualitative information limits the possibilities to interpret quantitative and numerical information and to gain more insight into the drug phenomenon. It also undermines efforts to target interventions at the existing drug cultures.

PART III DEMAND REDUCTION INTERVENTIONS

8 STRATEGIES IN DEMAND REDUCTION AT NATIONAL LEVEL

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

Drug demand reduction – especially prevention, drug legislation and the relevant social and health services – belongs to the domain of the Ministry of Social Affairs and Health, while educational, youth, cultural, physical education and sports issues are administered by the Ministry of Education. The Ministry of the Interior is in charge of the strategic planning concerning the police, while the Ministry of Justice is responsible for substance abuse work in done prison.⁷²

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

The Finnish municipalities have a relatively extensive autonomy. By law, the municipalities are responsible for temperance work and providing substance abuse services to meet local needs.⁷³ The municipalities plan and pursue local intoxicant policies based on inhabitants' needs and rights stipulated by law. They are also responsible for the use of State subsidies, municipal taxes and other revenues.

Civic activities in Finland have a long tradition in complementing the public system. Preventive drug work is done by many non-profit-making general organisations and organisations specialising in public health or substance abuse services.⁷⁴

⁷² See Appendix 1: Organisation chart of drug administration in Finland.

⁷³ See the Act on Welfare for Substance Abusers (41/1986), Section 3 and the Temperance Act (828/1982), Section 4.

⁷⁴ See Appendix 4, Actors in demand reduction.

8.1 Major strategies and activities

At the end of 1998, the Government Decision-in-Principle on Drug Policy (1998) was issued. The decision was based on the proposal for a national drug strategy drafted in 1997 by officials and experts in the Drug Policy Committee (Drug Strategy 1997). The decision concluded that, in order to combat drug use and distribution of drugs, general socio-political measures are needed along with drug-specific demand and supply reduction activities.⁷⁵ Demand reduction actions are divided into preventive work as well as treatment and support provided for substance abusers and their close persons.

In order to clarify implementation of the 1998 Decision-in-Principle, the Government on 5 October 2000 gave the second Government Decision-in-Principle to enhance drug policy (2000), with the related Action Plan for More Efficient Drugs Policies in 2001–2003 issued on 5 February 2002. When monitoring the action plan implementation, the drug policy co-ordination group updated the action plan for 2003, and the programme of the new Government, appointed in 2003 under Prime Minister Matti Vanhanen, proposed a new drug policy action plan for 2004–2007 to be drawn up.⁷⁶

Preventive work and early intervention

Substance abuse prevention is promoted by devising new models for drug education and information, by affecting the citizens' living conditions through Nordic welfare policy and by making timely and efficient interventions in emerging drug problems and their first signs.

The report of the committee for preventing drug use among young people (2000)⁷⁷ was published on 9 October 2000. The committee was nominated by the Ministry of Social Affairs and Health. It made nine principal statements, as follows:

- (1) The multifaceted nature of drug prevention strategies and approaches linked to local conditions must be stressed.
- (2) From the viewpoint of drug prevention, support for the basic structures of the welfare state is of paramount importance.
- (3) More attention should be paid to reducing harms related to drug demand and use.
- (4) Professional skills and other expertise of prevention done by authorities and non-governmental organisations should be increased.
- (5) Collaborative structures must be further strengthened in co-operation with young people themselves.
- (6) It is important to increase resources to enable collaboration between administrative sectors and to make sure that project activities are translated into everyday practices.

⁷⁵ For the supply reduction strategy, see Part IV.

⁷⁶ The drug policy action plan for 2001–2003 and its monitoring are discussed in Chapter 1.1. Government programme, see <http://www.valtioneuvosto.fi/tiedostot/pdf/fi/39357.pdf>

⁷⁷ The report is available at <http://www.stm.fi/suomi/julkaisu/julk01fr.htm>

- (7) An effort should be made to provide adequate factual, realistic and believable information about drugs and risks of different drugs whenever drug prevention is considered.
- (8) The public and members of the media should be encouraged to assume responsibility, to grasp the complex nature of the drug situation and to avoid stereotyping.
- (9) The co-ordinating role of the Ministry of Social Affairs and Health in drug prevention should be fortified by reinforcing the position of the drug policy co-ordination group. Also the role of the Ministry of Education should be solidified in drug prevention and in the domain of the Ministry of the Interior, drug prevention should be developed as part of legal education.

Care of abusers and support for their families

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

The Report of the committee for developing the treatment system for drug abusers (2001) was published on 1 June 2001;⁷⁸ also this committee was appointed by the Ministry of Social Affairs and Health. The committee proposed, for example, the following actions:

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

⁷⁸ The report is available at <http://www.stm.fi/suomi/julkaisu/julk01fr.htm>. The issue was previously discussed in 1999 at the consensus meeting organised jointly by the Academy of Finland and the Finnish Medical Society Duodecim on the treatment of drug addiction in Finland. See <http://www.duodecim.fi/koulutus/konsensuskokoukset>

- (2) In terms of training in drug treatment,
- Training in drug treatment should be provided both locally and centrally, and it should be made available not only to professionals working with substance abusers but to others as well.
 - Annual seminars or consensus meetings should be held on current drug issues.
 - To intensify and organise training in the treatment of problem users, an expert network should be established, co-ordinated by the above-mentioned collaborative national body.
- (3) In terms of drug treatment finance,
- For organising treatment of problem drug users, an annual EUR 8.4 million of additional State funding should be allocated for the next 5–10 years; this arrangement also requires an additional municipal investment of EUR 25 million per year.
 - The system of equalising substantial costs in specialised health care between hospital districts is suggested to be applied to drug clients.
 - Professional assessment of treatment need among drug abusers, carried out in social services, and administrative and financial decision to implement treatment should be delegated to the same parties.
 - Legislation on sick insurance rehabilitation allowance should be amended so that also unemployed problem users could receive rehabilitation allowance for the duration of drug treatment.
- (4) In terms of legislation on drug treatment,
- As for the Act on Welfare for Substance Abusers, a) stipulations obliging municipalities should indicate that social and health services share responsibility for providing services for substance abusers; b) the criteria for involuntary treatment provision based on health hazards should be clarified; c) based on the Act, it should be possible to issue both regulations on the medicinal treatment of opioid addicts and the Ministry's Decrees and guidelines for the content and organisation of this treatment.
 - It is necessary to stipulate an obligation for health centre physicians to instigate involuntary treatment based on health hazards, as prescribed by the Mental Health Act.
 - Serious drug dependence should be interpreted as a severe mental health disorder, as defined in the Mental Health Act, which, if other requirements of the law are met, justifies the involuntary treatment of those under 18 years of age.

8.2 Approaches and new developments

During last year, Finnish demand reduction policies mainly followed the guidelines set forth in the 1998 Government drug policy Decision-in-Principle and its more efficient implementation in accordance with the decisions made in 2000 and 2002. The new approaches are grounded in these decisions and the standpoints presented in the final reports of development projects on demand reduction.

During the year, the national focal points of prevention were the nationwide drug campaign and its evaluation (*kokototuus/puolitotuus*), funded by the Ministry of Social Affairs and Health; in the field of education, the proposals made by the Ministry of Education working group on preventing young people's exclusion; and the co-operative project between both Ministries on youth workshops in drug prevention. In addition, the development of the nationwide network of municipal drug prevention contact persons (*liaisons*) has been an important form of regional prevention.

In terms of drug treatment, the national framework for substance abuse services, published by the Ministry of Social Affairs and Health in autumn 2002, and its local implementation in 2003 have been pivotal. A special decision on drug treatment allocated an additional 7.5 million euros to treatment development in 2002 and 2003. About half of this appropriation is directed at expanding the medicinal treatment of opioid-dependent patients. Another focal point has been to consolidate the network of health counselling centres for injecting drug users. In law enforcement, the focus has been on enhancing substance abuse work in prison and the proposals made by the Ministry of Justice working group on contractual treatment.

The above-mentioned policies will be discussed in the annual nationwide Intoxicant Days, a training event organised in September 2003 by the Ministry of Social Affairs and Health, the Finnish Centre for Health Promotion and the co-operative board for substance abuse services (PÄIVYT). The national event provides a forum for representing new interventions and their development in training seminars. In 2003, the framework themes included drug treatment for minors, substance abuse work and media coverage, substance abuse training as an object and tool of development, promotion of school health care, health-promoting drug work, the puzzling buprenorphine, the drug treatment system on the fringe as well as drugs and communicable diseases. The latest Intoxicant Barometer, sounding out social services and NGO leaders, also saw publication on this occasion.

The 2003 Intoxicant Barometer⁷⁹ indicated that alcohol is still regarded as the most problematic substance in the Finnish context. Over a third of social services and NGO leaders considered it a major problem; this was the case more often in urban than rural settings. The second-most important substance abuse problem reported was polydrug use (about 15%) and the third was drug use. Compared to the previous barometer (2001), the situation was perceived as unchanged. When asked about the priority of the methods used in substance abuse prevention, the highest priority was given to intoxicant education in school, followed by the general development of living conditions and control measures (police, strict narcotics laws, supervision of alcohol sale).

The supply of treatment and health counselling services for drug users were still more often regarded as inadequate than adequate. Treatment was especially considered insufficient in urban municipalities, but the

⁷⁹ See also http://www.health.fi/barometrit/paihde/pdf/Paihdebarometri_2003.pdf

latter seemed to have enough health counselling for drug users. The percentage of those who deemed the level of drug treatment and health counselling inadequate declined from the 2001 barometer. This is probably due to the supplementary appropriations granted by the Ministry of Social Affairs and Health in 2002 and 2003 for drug treatment. The number of health counselling centres in major cities has also increased in recent years. Of the respondents, fewer than a third expected drug treatment to expand the next year and a fifth anticipated the same to happen in counselling services. It remains to be seen how the situation in substance abuse service provision in municipalities will change, when the Ministry's supplementary funding ends in 2004. (Intoxicant Barometer 2003).

9 PREVENTION

9.1 School programmes

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

The school syllabus reform currently underway in Finland supports the qualitative development of health and legal education in school and the establishment of co-operative models between home and school and with other important actors in the field. The Parliament passed a law (453/2001), whereby basic education will include a new subject, health education. Correspondingly, another amendment will make health education, which was formerly taught in conjunction with physical education, a separate subject in upper secondary (454/2001, 955/2002) and vocational (455/2001) schools. Substance abuse questions are key aspects of this new subject.

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

The Ministry of Education report (2003:4) on preventing exclusion from education among children and young people enumerates actions to prevent substance abuse in school. It proposes, for example, developing action models for early intervention, addressing schoolchildren's mental health problems, appointing a teacher as substance abuse co-ordinator in each school as well as monitoring enrolment in

education or working life after school in order to reach those at risk of missing education and to avert possible exclusion.

The school health survey for 8th and 9th-year students in 1998 examined the linkage between absenteeism, health and psychosocial problems (fear, anxiety, depression).⁸⁰ It showed that non-attendance because of illness and truancy coincided significantly, especially in terms of absences lasting longer than three days during last month. Absenteeism due to truancy was the most common among children coming from families with below-average education and the same was true when comparing nuclear families with single-parent or remarried families, especially when the children were separated from their parents. Both in girls and boys, the increase in all health-related or psychosocial symptoms was more closely linked to increases in truancy than to increases in non-attendance due to illness. It was especially noteworthy that substance abuse became more prevalent as truancy increased. Among those who did not cut school, 1.2 per cent of girls and 2.7 per cent of boys have been drunk frequently, whereas among those who cut school for over three days per month, the percentages were 15.6 for girls and 26.2 for boys. Correspondingly, in the former group 2.8 per cent of girls and 2.6 per cent of boys used some other substances, while in the latter group 25.9 per cent of girls and 22.8 per cent of boys had done so. (Kaltiala-Heino et al. 2003).

Thus the researchers concluded that frequent absenteeism is a warning signal, suggesting that the student's psychosocial situation should be clarified. On the other hand, absenteeism for over three days per month undermines learning, whereas early intervention in absenteeism and possible treatment need assessment may support the student's psychosocial development, especially if the family lacks normal coping strategies (Kaltiala-Heino et al. 2003). A regional experiment is underway in Pirkanmaa to create a model through networking between school, student welfare, school health care, home, primary health care, child welfare and, if need be, specialised health care, for early intervention in absenteeism based on the existing resources.

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

⁸⁰ The survey is based on voluntary participation among municipalities and municipal schools. The data was collected among 8th and 9th class secondary school students during lesson in 1998. The data consisted of 38 517 answers to the questionnaire.

To support the school syllabus reform as well as multiprofessional co-operation in school, 'Finland and drugs - Information package on drugs (2001)' was published in 2001, including a constantly updated Internet service.⁸¹ Also serving as a textbook, the information package was made in extensive co-operation with interest groups and it is a tool and background material intended for everybody who needs basic information about drugs. During the same year, a handbook on co-operation between schools and other actors in drug prevention was also published (Huopanen et al. 2001). A drug-related webpage for teachers, pupils and parents has also been created.⁸²

9.2 Youth programmes outside school

The projects to prevent substance abuse among young people are varied in terms of their scope. Workers implementing drug prevention have delivered information on drugs in schools, PTA (parents-teachers association) meetings and other functions. Sports and youth organisations have also been involved when alternatives to alcohol and drug experiments or use have been sought. Especially schoolchildren's afternoon activities have been developed in order to promote sports and other activities among young people, with a view to enhancing antidrug work as well. In addition, brief antidrug projects have been implemented, such as plays and musicals. Such projects are clearly on the increase among young people. So-called traditional youth work as an everyday activity is increasingly regarded and developed as a form of prevention. Continuity and sustained efforts are the cornerstones of these activities. For children and young people facing precarious living conditions, different meeting places (cafés, clubs, shelters) have been established, where it is possible to discuss and alleviate the problems of loneliness, parents' substance abuse and other severe difficulties.

Active preventive and remedial activities have been carried out by using different approaches, ranging from clubs to life-management courses spanning several months, with the aim of developing young people's ability to manage their lives. The methods applied include adventure and experience education. This has made it possible to reach young people who are not susceptible to traditional drug education. Workshops organised for young people have been an important resource, with a possibility of enhancing young people's life-management skills. The workshop is a tool for vocational planning and it creates a social, 'therapeutic environment' for individual growth. Learning social skills and self-determination belongs to the goals of these workshops, along with concrete production targets. The workshops are also considered part of youth work and society, intended for those who have, for example, dropped out from vocational training.

⁸¹ See the 3rd update at <http://www.irtihuumeista.fi/huumetietopaketti>

⁸² See [URL:Http://www.antidrugnet.org](http://www.antidrugnet.org) in Swedish: <URL:Http://www.interdrug.net>

Administered jointly by the Ministries of Education and Social Affairs and Health, a project was launched in 2002 to develop drug prevention at youth workshops, especially to enhance readiness to deal with drug issues and to make proposals and recommendations for reducing drug use and related harms among young people. The report of the steering group of the development project on drug prevention at youth workshops (2003:5)⁸³ stressed that such development is based on (1) the principle of normality, i.e. the workshops are considered open learning environments and not labelled as services preventing exclusion; (2) communal and inclusive pedagogics, i.e. the young participants are involved in planning, implementation and assessment; and (3) an ability to tackle the diverse forms of drug user cultures by adjusting workshop activities accordingly. The final report suggests that each workshop should create its own rules approved for drug work. A nationwide development project will be set up for this purpose in 2003, with national steering and provincial experts on workshops and substance abuse work. The latter experts will launch and guide drug work pilots in their respective provinces in autumn 2003. In conjunction with workshops, so-called start-up or preworkshops and low-threshold solution-oriented service entities have been established to enhance young people's functional abilities to take part in labour policy actions, training or rehabilitative work activities. These activities are proposed to cover all workshops.

Project planning for a collaborative project on making contact with recreational drug users is about to commence in 2003 between the A-Clinic Foundation, STAKES, the Finnish Centre for Health Promotion and the Finnish Association for a Humane Drug Policy. The purpose of the undertaking is to create interaction with those who use drugs for recreational purposes, mainly so-called party users, to glean information about such use and to implement projects on reducing related risks, for example, through information, peer group instruction and care referral. A report entitled "*Observations about drugs: research as an early indicator of new drug phenomena*" was completed as background material for the project. (Seppälä 2003).

9.3 Family and childhood

Infancy and family

The information services provided by Finnish maternity clinics for families expecting a baby deal with alcohol, tobacco and, to some degree, medicines, excluding narcotics. However, a guidebook was published in 1999 for health care professionals and educational institutions in the field (Halmesmäki 1999). The Ministry of Social Affairs and Health working group on child welfare clinics prepared a national guidebook for developing the clinics, suggesting that services for families be concentrated in a

⁸³ See <http://www.stm.fi/suomi/pao/ehkhuumetvo/ehkhuumetvo.pdf>

family service centre or network for improved co-operation between home, clinics, daycare, social work, health care and other organisations (Press release of Ministry of Social Affairs and Health, 3rd of March, 2003). The aim is to support interaction between children and parents and to retain steady client contacts. To help families in need of special support, multiprofessional co-operation should be developed and systematic support should be provided through home visits by family counsellors. In addition, it takes courage to intervene in problem situations, such as parents' alcohol or drug abuse. Skill development, work guidance and appointment of persons in charge are required as well.

The joint treatment of mothers and infants has been developed in Finland for over ten years in mother and child shelters for substance abusers. The Oulunkylä shelter in Helsinki and the Pinja-koti in Turku have done groundbreaking work in the field. New mother and child shelters for substance abusers are currently being set up elsewhere in Finland, for example in Espoo, Jyväskylä and Kuopio. The change in substance abuse profiles over last ten years has been reflected in shelter activities as well, so that nowadays most women mainly seek help for drug problems. The relationship of a drug-dependent mother and her child needs an active and secure care environment from the beginning. The first six-month period after birth seems especially crucial. The mothers who have entered interaction and care during pregnancy have the best prognosis for both a drug-free life and adequate parenthood. There is no exact information about factors affecting treatment prognosis, but such a study has commenced in co-operation between the Federation of Mother and Child Homes and Shelters⁸⁴ and the University of Tampere. (Pajulo 2003).

According to the report of the working group on drug treatment (2001), planning of care for pregnant women must take account of the entire care chain, starting from contraception to the situation after childbirth and beyond. The threshold for seeking treatment should be low and substitution and detoxification treatment with medicines for opioid-dependent mothers should be made available. Care should be concentrated in specialised maternity units to ensure the best possible treatment and to lower the threshold among drug-addicted mothers attending the clinics.

Support for children of drug users

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

In the most serious cases, children may be taken into care, which means that the child is provided for and educated by society. Such action must be taken if childcare is neglected, if some other circumstances at

⁸⁴ See <http://www.ensijaturvakotienliitto.fi/2toiminta/6hoito.html>

home jeopardise the child's health or development, or if the child endangers his/her own health by using intoxicants, by committing a serious criminal offence or other misdemeanour. An additional requirement is that non-residential services have not been appropriate, possible or adequate and that care outside home is deemed to be in the child's best interests. (Child Welfare Act 683/1983, Sections 16, 17 and 34).

According to information on the year 2002, Finland had 54,458 children and young people in non-residential child welfare services, while 14,187 were placed in a foster family or institution and 7,829 were officially taken into care. From the year before, the number of children and young people in non-residential care increased by 10 per cent, and the number of those placed or taken into care had increased by about 5 per cent. (Child Welfare Statistics 2002).

Statistics concerning Helsinki in 2002 include also factors that had led to child welfare actions for children in non-residential care (7,544), placements (2,533) and those officially taken into care (1,784). In terms of non-residential care, parents or other family members' substance abuse caused this need in 18 per cent of the cases (13% alcohol abuse / 3% drug use / 2% polydrug use), in placements the percentage was 25 (17% / 5% / 4%) and 32 per cent for those taken officially into care (21% / 6% / 5%). The child's own substance abuse was the reason in only 2–3 per cent of the cases (Child Welfare statistics from Helsinki Social Services Department, client information 2002).

Support for parents of drug users

A central principle of substance abuse work directed at young people is to involve families in all multiprofessional substance abuse work at the earliest stage possible, whether it takes place in school, in a wider context of youth work or in community programmes. To support these activities, the A-Clinic Foundation published a popular drug guidebook for parents. The purpose of the publication is to dissolve the mystical aura surrounding drugs and to encourage parents to discuss substance abuse with their children (*Huolesta puheiksi, puheista teoiksi*, 2000).⁸⁵ A new family-centred drug work guidebook (2003) was published in 2003 by the Free From Drugs Association.

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

⁸⁵ See also <http://www.a-klinikka.fi/>

9.4 Other programmes

Self-help groups for drug users

The Greater Helsinki Area has Narcotics Addicts Anonymous⁸⁶ groups based on mutual support for people who want to stop using drugs. These include a closed group for drug-dependent persons, a women's group and an open group for all those interested. Also some other major cities have such groups, working often in connection with the local treatment programmes. Established in Sweden, the peer group *Kris* for released prisoners has started in Finland as well. Its purpose is to support released prisoners who have substance abuse problems to lead a life free from crime and drugs.

Telephone helplines

Since 1995, the *drug helplines* of the Free from Drugs Association have provided a means of disseminating drug information for early intervention. The helplines operate in weekday evenings throughout the country (22 regional branches, almost 450 trained volunteers). Many important drug-sector organisations have helplines. Some of them belong to the European FESAT drug helpline network, which has 30 units in the EU Member States.⁸⁷

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

For example, the drug helpline of Free From Drugs received some 4,700 (3,150) crisis calls in 2002 (2001), many of which led to further action, such as meetings with close persons. Of the callers, 55 (63) per cent were close persons, while 18 (12) per cent were substance abusers. The phone calls concerned the following substances (2002 / 2001): cannabis (35 / 38 %), amphetamines (25 / 30 %), heroin (7 / 15 %) and ecstasy (8 / 7 %). (Annual Report of Free From Drugs. 2001; 200)

Community (municipal) programmes

Municipal strategies usually cover all substances abused or concentrate on either alcohol or narcotics. Especially in small localities, the focus is on alcohol, and only major cities or federations of municipalities have specific drug strategies. A local alcohol and drug programme may also be included in

⁸⁶ See e.g. <http://www.nasuomi.org/>

⁸⁷ At the end of February 2002, the new FESAT guide was published in Finnish, entitled *FESAT - perheet ja auttava huumepuhelin*. [FESAT – families and the drug helpline]. International FESAT webpages at <http://www.fesat.org>.

a more extensive municipal programme for the promotion of health and welfare in general. In most cases, the entire population is included, while some strategies only involve young people and children.

STAKES maintains an open information service including municipalities' local drug strategies, treatment units regionally, prevention projects as well as tools and practices for preventive work.⁸⁸ By the summer of 2003, the database had presentations of, and references or links to, 74 municipal or regional substance abuse strategies, 27 drug strategies and 23 strategies for young people's substance abuse.⁸⁹ An investigation completed in spring 2002 examined the 105 strategies submitted by municipalities to the database in 1994–2002. Half of them involved towns with populations over 25,000, a third were located in the Province of Southern Finland, a quarter in the Provinces of Eastern and Western Finland, 10 per cent in the Province of Oulu and 5 per cent in the Province of Lapland. One out of ten strategies was regional, encompassing more than one municipality. About 85 per cent resulted from intersectorial co-operation. Municipal responsibilities and substance abuse work were primarily defined from a legislative viewpoint. The majority of the strategies discussed all substances and three-quarters were directed at the general population. In most strategies, substance abuse work was perceived in a comprehensive, sustained and multiprofessional way. Before 1998, the working groups behind local strategies comprised municipal workers only, but since 2000 strategic planning has also included members of the church, police and NGOs. During last few years, the strategies have also been better organised, and their monitoring and evaluation has been anchored in the goals pursued. Especially the most recent strategies have typically adopted a community outlook. (Romppainen 2002).

The provincial governments compiled information about the drug situation and municipal drug strategies as part of the basic municipal service evaluation in 2001.⁹⁰ The survey results show that there is a great regional variation in the coverage of intersectorial drug/intoxicant strategies, 15–50 per cent. On the other hand, there is also much variation depending on the size and resources of the municipality and the severity of the local drug problem and attendant service need. It is even harder to assess the implementation of the strategies. It seems however that the local authorities, which have seen it necessary to draw up a strategy, have also been motivated to implement it and to establish intersectorial structures locally. A persistent problem appears to be the project-like quality of the strategies and lack of continuity. Not even the large regional supply of services did automatically encourage municipalities to draw up local strategies.

Approved by the Government, the target and action plan for social and health services in 2000–2003 proposed, among other things, the setting up of a municipal contact person (liaison) network in substance

⁸⁸ Information delivery to the data bases is based on the municipal's, treatment unit's or project organisation's own initiative and organised by using official data form available in the Internet pages. See <http://www.stakes.fi/neuvoa-antavat>

⁸⁹ The follow-up report on the implementation of the regional substance abuse action strategy in Kainuu (*Rajat ovat rakkautta*) was completed in 2001 (Mustalampi 2001).

⁹⁰ See basic services in Finnish provinces, evaluation reports on basic services on the webpages of the provinces [in Finnish] at <http://194.89.205.3/suom/laanit/>

abuse work. The liaison is tasked with the co-ordination of local substance abuse prevention together with the social and health services, schools and organisations. Another duty is to co-ordinate the municipal or regional substance abuse strategy and to create a two-way channel for exchanging information and experiences between national, regional and local actors in the field of prevention. STAKES co-ordinates the liaison network, and maintains the national database on liaisons through a portal (*neuvoa-antavat*). According to an evaluation of the network's launch, its weakness was the inclusion of municipal liaisons who had been appointed *ex officio* and without a mandate, who were coming from a wide range of backgrounds and whose turnover at the beginning was high. Many liaisons were caught between the delegation of duties from a central authority and a municipal authority that did not allocate resources. In addition, the job description was not clear at the outset, and involved much 'role-searching'. (Warpenius 2002).⁹¹ In April 2003, the national database had contact information on substance abuse liaisons submitted by 407 municipalities. In addition, the State Provincial Offices had 20 liaisons in preventive work.

Mass media campaigns

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

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

The national communications segment will be carried out in national and provincial newspapers, TV and radio spots, outdoor advertisements and on the Internet. Advertising will also direct people to visit the campaign homepage, containing information and discussion groups on drug themes.⁹²

In the campaign's first phase in autumn 2001, information was directed at the general population and a special group, 18–25-year-old young adults. The advertisements targeted at the population were

⁹¹ The result is based on questionnaires on municipal contact persons (195 liaisons, response rate 60%) and regional contact persons (14 liaisons, response rate 71 %) in the substance abuse work as well as feed back forms (171) from training seminars for liaisons.

⁹² See <http://www.puolilotuus.com/etusivu.html> and <http://www.kokototuus.com/faktat/index.html>

somewhat provocative, encouraging people to debate and to rethink their standpoints. The young adults received more 'traditional' information about the negative effects of different narcotic substances. The approach was concrete, focusing on the risks involved. The second phase commenced in April 2002 with two target groups, young people aged under 18 and professionals whose work concerned drug issues. Cannabis and the related risks were the primary topic of the information directed at young people. (Salasuo et al. 2002).

According to the intermediate report of the project evaluation group, the project webpage received 1,406 responses, i.e. an average of 33 responses per day and 234 per week. The activity rate was high, albeit lower than that of the A-Clinic Foundation's virtual discussion forum, the Sauna, which had an average of 100 messages per day in 2001.⁹³ Active debaters consisted of a rather small group of people: the most active tenth provided 54 per cent of the comments and the most active participant alone 6 per cent of all comments. During the first weeks, the traditional Finnish approach to the drug problem gave way to more liberal views in the forum. This liberal activity partly entailed *making a drug policy statement*. Secondly, the liberals gave *information and guidance* concerning the properties, use and effects of drugs. The third observation concerned the *dialogic and argumentative* method of debating and exerting influence used by the 'liberal champions.' (Piispa 2002a; 2002b).

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

The evaluation of the entire project will be ready by the end of 2003. It will explore the visibility of the campaign, its utilisation, the debate aroused by it and its mobilisation potential. These processes will be analysed through various materials (population survey, survey for substance abuse workers, Internet debate, media material, interviews of upper secondary school students, observation of experiencing routes, etc.). Part of this evaluation is critical but, on the whole, the project is regarded as a successful experiment and the continuation of its strengths is recommended. (Jallinoja et al. 2003b).

⁹³ See <http://www.paihdelinkki.fi>

Drug services in the workplace

Intoxicant-related services targeted at workplaces have focused on the early detection and prevention of substance abuse problems. Drug questions have been incorporated into prevention of substance abuse in general, with the aim of maintaining working capacity both through publications and training. In practice, however, the focus has been on abuse of alcohol and/or medicines and the related dependence. However, according to the statement issued by the Intoxicants in Working Life expert group of the Centre for Occupational Safety, representing the labour market organisations, narcotics issues can only partly be dealt with in the same manner as other substance abuse questions; in many respects, they call for special measures, e.g. because of the illegality of narcotics. In general, referral to care may be based on an agreement between the client and employer. This must take place by the client's consent. The actual treatment plan is made in the treatment facility by the client and treatment worker. The Finnish Institute of Occupational Health has published guidebooks on encountering drug users at work, including the risks involved and how to prepare for such situations. (Lusa ed. 2000, 2002).

As a form of control and prevention, drug testing in Finland aroused much debate in 2000 and 2001. A survey was conducted in eight major Finnish companies concerning the reasons for new employees' drug testing.⁹⁴ The companies studied had not opted for testing because of an existing drug problem but mainly due to possible future risks. Even more paramount than security was the threat of concomitant crime. According to the researcher, it was less a question of finding substances or measuring working capacity and more of testing the work morale. The tests were also considered positive for the company's public image (Bothas 2002).

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

As was its mandate, the working group drew up a law proposal concerning drug tests in working life. The law will regulate, among other things, the rights and responsibilities of employees, employers and health care professionals in performing tests and processing the results. The working group has stressed health care objectives also in the law proposal. The tests should be based on work requirements and occupational

⁹⁴ Survey was based on interviews for staff managers in 6 companies and for occupational health personnel in 2 companies. The companies under survey made in early 2000 about 40 % of all drug tests (10 000) in work places. Companies came from 5 business lines.

safety or needs related to a drug-free working environment. The reason for obligatory tests should be assessment of potential risks to life or health. This way the tests would complement the principles of the laws on occupational safety and health.

In its report (2003), the Ministry of Labour working group on data protection and supervision of employees proposed some changes in drug testing to the law on the protection of privacy in working life. The working group suggested new statutes on a drug test certificate, how such a certificate would be presented upon recruitment and the obligation to provide one during employment. It is presupposed that the employees themselves will provide the certificate. The employer's right to require a certificate is linked to certain jobs that call for precision, reliability, independent consideration and alertness. In addition, the employees concerned work on jobs where performance while under the influence of, or dependent on, narcotic substances could endanger life or health or could result in considerable damage. The interests to be protected, then, are life, health, occupational or traffic safety, State security, the environment, trade and professional secrets and the employer's property. The obligation to produce a drug test certificate is mainly associated with the commencement of employment. An employee could also be obliged to provide a certificate, if there is just cause to suspect that he or she is working under the influence of drugs. The law on occupational health services would also oblige the employer, together with the staff, to draw up an antidrug strategy, a prerequisite for drug testing. The law on employer-employee co-operation would stipulate that the tasks, where drug tests are applicable, should be negotiated in co-operation between the employer and representatives of the employees.

Internet services

The Prevnet programme of the A-Clinic Foundation developed modern substance abuse prevention methods based on new technology in 1998–1999. The programme was a result of co-operation between Finnish actors (collaborative network of psychological wellbeing, child welfare and substance abuse work, *Avec*⁹⁵) and European partners (the Prevnet Network).⁹⁶ Launched by the A-Clinic Foundation, the Prevnet Network will continue its operation co-ordinated from Belgium. Specialising in methods of telematics in preventive drug work and exchange of information, the network has actors from twenty European countries. A project evaluation on the original Prevnet-Euro projects (McGourty 2001) and a guidebook for developing telematics services in the field (Tammi et al. 2000) have been published.

Almost all Finnish organisations in the substance abuse field have modern Internet services.⁹⁷ For example, the co-ordinator of the Prevnet project, the A-Clinic Foundation has its own Internet service

⁹⁵ See <http://www.avecforum.fi>

⁹⁶ See <http://www.prevnet.net>

⁹⁷ More links at <http://www.makupalat.fi/sospoli5.htm>

called the Addiction Link,⁹⁸ where people can test their own situation and anonymously ask experts for advice. Material targeted at educators has been added, including a ready-made framework for parent-teacher association meetings and the material of guidebook for parents. One facet of these activities is the Foundation's discussion forum (Sauna) on the web. The newest addition to the Addiction Link is a service for parents and the Foreign Info for immigrants, a service developed from the immigrants' viewpoint especially for those of us who have problems with the Finnish language: it has sections in English and Russian.

10 REDUCTION OF DRUG-RELATED HARMS

10.1 Description of interventions

Outreach work

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

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

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

⁹⁸ See <http://www.paihdelinkki.fi>

The peer group activities started in autumn 2001, when 11 drug users aged 20–45 initially recruited from the health counselling centres took the first peer group course. Upon completing the course, the participants were supposed to contact 15 drug users among their friends or acquaintances, interviewing them and recruiting at least one new participant to a similar Snowball operation. The new Snowball group started in February 2002 based on the contacts made by the previous group. The new group was targeted at Russian-speaking drug users in Helsinki and the course took place in January–March 2002.

Low-threshold services

In recent years, the number of the so-called low-threshold day centres has increased in Finland. These services cater for problem users of all intoxicants. In addition to guided and free activities, the day centres offer meals and an opportunity to take a shower. In some cases, also health services are made available. The first-stage homes give temporary accommodation to substance abusers. The immediate needs of the client are addressed, and efforts are made to create more permanent treatment options for clients in co-operation with other social and health services. However, the first-stage homes primarily serve middle-aged alcohol abusers. The hospital and health centre clinics as well as some drug clinics also operate on a low-threshold principle, in the sense that no referral to treatment or appointment is needed for entering the treatment.

In 2003, an evaluation was completed on the Helsinki-based Kurvi drug clinic, which is the only national centre serving drug users around the clock and was established in 1997.⁹⁹ During five years, almost 10,000 drug users visited the centre. The Kurvi centre has been successful as a major service unit in Greater Helsinki in treatment need assessment and care referral. At the clinic, a decision is made whether the client enters inpatient treatment at Kurvi (for in-depth assessment), outpatient treatment or directly some other unit. While the threshold to Kurvi is low, it fails to reach the most severely excluded users. Thus, to some extent, Kurvi has evolved into a unit catering for clients who are relatively young and whose prognosis is auspicious. The treatment of minors is also deemed a problem both at Kurvi and elsewhere because there are not enough suitable follow-up treatment units. Concern was also expressed about the fact that drug users manifesting psychological symptoms are dropping out of all treatment systems. The incoherence and lack of co-ordination in the Helsinki drug service system as well as the better utilisation of service providers' expertise and other existing structures were seen as challenges for Kurvi and the entire system. (Törmä 2003). It seems fair to extrapolate from these challenges to the services system that the same applies to some degree to the rest of the country as well.

⁹⁹ The evaluation consisted of 15 personnel's, 18 co-operation partners' and 3 principals' interviews (1,5 h / interview) and the data was complemented with questionnaires to the head social workers and outpatient unit directors in Helsinki city (58 questionnaires, response rate 36%). Information from treatment unit's clients were collected with anonymous feed back forms (139) during 3 months from clients in polyclinic (36), inpatient department (64), long term follow-up treatment (10) and from accompanying persons (20). The data was substituted with one hour long theme interviews (30) to the clients in inpatient department (17) and polyclinic (13). Information was also available from telephone service follow-up and from other official documents in the Kurvi Clinic.

Another regionally comprehensive low-threshold treatment centre is located in Finland's third largest city, Tampere.¹⁰⁰ The centre operates 12 hours on weekdays without appointment and it is open on weekends also. The centre refers clients to regional care services. Its primary tasks are treatment need assessment, encouraging treatment motivation and finding units that meet the client's needs, but it also provides its visitors with a setting for anonymous encounters and health services. Needle exchange and health counselling are an integral part of the unit's activities, albeit located elsewhere. The project lasts for three years in an effort to develop low-threshold work practices. Its implementation will be evaluated in a follow-up study to be published in early 2004.

Prevention of infectious diseases

The HIV epidemic, which started among Finnish drug users in 1998, drew public attention to the importance of preventing diseases transmitted by injecting drug use. Starting first as a Helsinki-based trial in 1997, the model of health counselling centres for drug users was a good basis for expanding the activities to other parts of the country as well. One objective of these endeavours is to minimise the spread of infectious diseases resulting from drug use. The services are provided free of charge and anonymously.

At the centre, drug users can exchange their syringes and hypodermic needles for clean ones. Another important aspect of operations is health counselling about drug-related diseases and other serious risks, such as overdose and sexually transmitted diseases. This counselling is provided in an oral and written form. Other frequently used services include HIV and hepatitis tests, hepatitis B and other necessary vaccinations and health care procedures, such as attending to minor wounds. The clients are also encouraged and helped to seek treatment and to stop drug use. Some centres offer medical services provided by a physician. A few centres are in the process of developing peer support activities and field work.

In September 2003, there were health counselling centres in 20 municipalities.¹⁰¹ The centres in Helsinki, Espoo and Lappeenranta (established in 2003) had several units. A mobile unit was operational in Kouvola in 2002 and Kotka in 2002 and 2003. In Greater Helsinki, a mobile unit will be tested as of October 2003. Health counselling centres operate in all major cities (population over 100,000) and in other cities (50,000–100,000 inhabitants) except Vaasa. In addition, such centres exist in 7 towns (20,000–50,000). The centres' opening hours vary much, from 2–3 hours per week to over 30 hours at larger centres.

100 <http://www.a-klinikka.fi/tampere/paaperiaatteet.html>

101 See <http://www.a-klinikka.fi/yhteystiedot/terveysneuvontapisteeet.html>

Client numbers in 2002 ranged from an annual 10 to some 4,300. It was estimated that about 4,800 clients visited the centres in 2000, about 8,600 in 2001 and 9,300 in 2002 (Table 15). There is some overlap in the Greater Helsinki Area (Helsinki, Espoo, Vantaa) as some clients may have used several units. The total number of visits was 32,800 in 2000, followed by 62,300 in 2001 and 72,200 in 2002. The annually growing client and visit numbers make it possible to engage in effective prevention of blood-transmitted diseases because, at least in major cities, the centres have reached most of their target group. The network also facilitates information flow and, when necessary, enable rapid interventions (e.g. mass vaccinations against hepatitis A).

Table 15.

Clientele of the Finnish health counselling centres for injecting drug users in 2000-2001¹⁰²

Population	City / Health Counselling Centre	Started	Number of Clients		
			2000	2001	2002
Over 100 000	Helsinki / Vinkki	April 1997	3 270	4500	4220
	Helsinki / Viitta	Sept. 2000	na	na	na
	Helsinki / Munkkisaari	Dec. 2000	-	1410	1370
	Espoo / Vinkki	May 2001	-	170	450
	Vantaa / Vinkki	Oct. 2000	200	730	990
	Tampere / Nervi	May 1998	480	460	740
	Turku / Milli	Feb. 2000	650	970	1010
	Oulu / Vinkki	Oct. 2000	-	-	30
	Total			4 600	8 240
50 000 - 100 000	Lahti / Jelppi	Nov. 1999	20	under 20	40
	Kuopio / Portti	Sept. 2000	20	40	80
	Jyväskylä / Visiitti	May 2000	80	100	90
	Pori / livee	April 2001	-	under 20	20
	Kotka / Vinkki	Jan. 2001	-	na	under 20
	Total			120	160
under 50 000	Hämeenlinna / LivingRoom	Sept. 2000	50	100	110
	Hyvinkää / Health C C	Jan. 2001	-	-	under 20
	Rauma / Vinkki	July 2000	under 20	20	under 20
	Lohja / Helppi	April .2001		30	70
	Kouvola / Bus	Febr. 2002	-	-	20
	Imatra / Drug Clinc	April 2000	-	-	under 20
	Salo / Uukkari	Jan. 2001	-	40	30
	Valkeakoski / Step	Sept. 2002	-	-	under 20
	Total			60	190
Total (approximately)			4 800	8 600	9 300

The health counselling centres exchanged some 564,000 injection devices in 2000, followed by about 1,000,000 in 2001 and approximately 1,127,000 in 2002. The number of HIV and hepatitis tests conducted and hepatitis B vaccinations administered has also increased each year. Some centres carried out a campaign for hepatitis A vaccinations in 2003 to hold back the new epidemic.

¹⁰² Information compiled from the Provincial Governments' evaluation reports on basic services (*Peruspalvelut Suomen lääneissä 2000, 2001*) and health counselling centres' reports on activities from 2000–2002.

The geographically comprehensive network of pharmacies is also crucial to the prevention of blood-transmitted diseases by safeguarding the supply of clean syringes and needles. In 2001, the majority of pharmacies (88%) reportedly sold injection devices to drug users. Nevertheless, almost 60 per cent reported that they restricted the sale of needles and syringes to drug users in some way, for example, by selling single units or by restricting the number of devices sold at one time. The number of drug user clients and of restrictions on sale were higher in large cities. The pharmacies declining to sell injection devices were concentrated in Helsinki, where almost one out of two of pharmacies reportedly did not sell syringes or needles to drug users. (Partanen A. et al. 2003).

In 2002, pharmacies sold an estimated 470,000 syringe-needle combinations. In 2001, the figure was estimated at 420,000, while in 2000 it was as high as 500,000–600,000. While the number of injection devices distributed by the health counselling centres has increased, pharmacies still have an important role in providing clean needles and syringes. Health counselling centres operate in major cities and towns only and their opening hours are shorter. The sale of injection devices from pharmacies thus complements the system in major localities, while in smaller ones they may provide the only means of acquiring uncontaminated injection devices.

In co-operation with the infection risk counselling centres of the three largest cities in Finland, Helsinki, Tampere and Turku, and the drug clinic of Deaconess Institute in Helsinki, a broad study to follow up risk behaviour among intravenous drug users was launched at the beginning of 2000, planned to last for three years. The project is co-ordinated by the A-Clinic Foundation, in collaboration with the National Public Health Institute and STAKES, and funded by the Ministry of Social Affairs and Health.¹⁰³

Based on the material accumulated during the project's first nine months (n=279), the most typical health problems associated with injecting drug use were various infections: 86 per cent of the interviewees had been tested for infections, and half reported having contracted hepatitis C, while 4.3 per cent reportedly had HIV. Over 40 per cent suffered from mental health problems, and a third had had a severe psychosis or other disorder. Almost a quarter had received treatment for overdosing opiates. From the clients' viewpoint, the health counselling centres were important as places where they could have at least a modicum of contact with the care system and other people. The centres were also frequently used, as almost half of the respondents had visited them within a week and another quarter within a month. The most commonly used service was needle exchange (93%), laboratory tests (43%) and hepatitis B vaccination (43%). The study showed that the clients were inclined to stop injecting drug use: on a scale of 1 (unlikely) – 10 (very likely), over half assessed their likelihood of stopping to be between 7 and 10. (Perälä et al. 2002). By the beginning of June 2002, the follow-up group comprised 355 people of the initially interviewed (n=494). Of them, 52 per cent were hepatitis C positive and three per cent were HIV positive.

103 See Chapters 3.3 and 4.1.

In autumn 2000, the Deaconess Institute in Helsinki opened the Kluuvi (later: Munkkisaari) service centre in central Helsinki to provide specialised services for drug users with HIV infection in Greater Helsinki. The project involves the cities of Helsinki, Espoo and Vantaa and the Hospital District of Helsinki and Uusimaa. The centre provides both daytime activities (meals, hygiene, health counselling and treatment with medicines as well as social rehabilitation) and short-term accommodation, and in the future also long-term support housing services. Day activities are available to HIV-positive drug users every day without referral. Services can also be accessed anonymously.¹⁰⁴ In the client interviews (65) carried out among the HIV positive clients visiting the Centre, 89 per cent reported having hepatitis C and 40 per cent had hepatitis B.¹⁰⁵ A total of 57 per cent had been prescribed psychoactive drugs. Of all clients, 70 per cent visited a day centre regularly. The most frequently used services were meals and social worker's appointment. Other widely used services were the needle exchange and infection physician's appointment. An often mentioned reason was also 'possibility to spend time and rest'. (Törmä et al. 2002; Tuomola 2002).

10.2 Standards and evaluations

At the beginning of 2002, the Ministry of Social Affairs and Health presented the proposal of an HIV expert work group for National HIV/AIDS strategy of Finland (2002:1), concluding that health counselling for drug users is one of the most important tools for preventing the HIV. Health counselling should be made available in all major urban areas in three years, and the activities should include needle exchanges. Furthermore, various types of health counselling should be developed. The effectiveness and implementation of health counselling will be evaluated nationally by the year 2004.¹⁰⁶ Health education should also be increased among prisoners, for example, by lowering the threshold for HIV tests and entering counselling services.¹⁰⁷ The situation should be monitored by an annual overview and support or reintegration measures following release from prison should be developed further.¹⁰⁸

Based on the evaluation of the Kluuvi (later: Munkkisaari) service centre for HIV-positive drug users in Helsinki¹⁰⁹, the centre had by April 2002 managed to reach 148 HIV-positive drug users, i.e. 60 per

104 See <http://www.hdl.fi/hivjaids/luelisaa.htm>

105 The information is based on project evaluation, which was made by April 2002 (see also chapter 10.2). Evaluation was based on anonymous, semistructural interviews for 99 clients in the Centre, 65 that had positive HIV test result and 34 that belong to the HIV risk group. Half of the personnel (16) of the unit as well as 13 experts or co-operation partners was interviewed by 1.5 h long theme interviews. The data was complemented with questionnaires in the near neighbourhood of the Centre (123 answers) and by telephone interviews for 3 local police officers that had different roles in the neighbourhood.

106 The National Public Health Institute has made a proposal for a monitoring and statistical system for health counselling centres by the end of 2002.

107 See Chapter 12.1.

108 See <http://www.stm.fi/suomi/julkaisu/julk01fr.htm>

109 The methodology is referred in the chapter 10.1. (prevention of infectious diseases)

cent of all those HIV positive which had been by then recorded by the National Public Health Institute to have contracted the virus by intravenous drug use. During the centre's operation, the number of HIV positive found in tests was 58 per cent of those new HIV cases related to injecting drug use reported by the National Public Health Institute during the same time. Thus the service centre was very successful in reaching clients from its target group. According to the report, the low threshold and providing services under one roof were the main reasons for the high compliance. According to the survey, almost a third considered their health to be better because of the visits. An equal proportion reported that their housing conditions had improved. A third also mentioned that their drug use had become less frequent. The service centre is the only facility in Finland providing methadone maintenance, and this treatment has proved to be an effective way to avoid risk behaviour and to reduce HIV infections. The project also uncovered a surprisingly large group of drug users who did not have the HIV but who were nonetheless excluded and without proper treatment. The inclusion of this group in services and treatment is important for preventing the HIV epidemic from spreading. (Törmä et al. 2002).

11 TREATMENT

11.1 'Drug-free' treatment and health care at national level

According to the Act on Welfare for Substance Abusers (41/1986), municipalities are responsible for organising services for intoxicant abusers in a way that meets the need; 'intoxicants' here refer to all substances used for inducing intoxication: alcohol, surrogates, medicines and narcotics. Social welfare and health care must develop general services to meet the needs of substance abusers and, whenever necessary, specialised services as well.¹¹⁰

The service system consists of outpatient clinics (A-clinics), short-term institutional care (detoxification centres), rehabilitation units and support services (day centres and supported housing) and self-help groups (NA, Narcotics Addicts Anonymous).¹¹¹ Along with these specialised services, many primary health care and social service units encounter drug problems (social work, child welfare, mental health clinics, clinics and wards at health centres, hospitals and especially mental hospitals). Since 1996, Finland has had an *ombudsman institution for intoxicant abusers*, based on nongovernmental organisations. Working in the entire country, it is an interest organisation for treatment clients.¹¹²

110 See Chapter 1.2.2.

111 Addresses of special service units are available, e.g. in the *Selvis* calendar (2002) or the guidebook on treatment units (Pienimäki A. ed. 2001) or at <http://www.health.fi/paihde/kuvat/Acrobat/Selvis2003.pdf>, [Http://www.stakes.fi/neuvoa-antavat](http://www.stakes.fi/neuvoa-antavat), <http://www.a-klinikka.fi/hoitopalvelut/index.html>

112 See also <http://www.paihdeasiamies.com/>

Finland has specialised local outpatient centres (e.g. clinics) in over 100 municipalities. In addition, many municipalities have agreed to purchase services for their inhabitants from a public or private service provider.¹¹³ In 2002, about 47,400 people visited the outpatient clinics for substance abusers (75 A-Clinics and 15 youth centres). During the year, 11,200 people used residential treatment services (60 institutions) for substance abusers. Of the outpatients, 31 per cent were women (45 per cent in youth centres), and clients aged under 30 accounted for about 27 per cent. The proportion of women in residential treatment services (detoxification and rehabilitation centres) was about 25 per cent, and people aged under 30 accounted for 18 per cent. The treatment periods usually lasted for a week or less, but 22.4 per cent of the periods lasted longer than two weeks while the proportion of treatment periods over 3 months was 1.8 per cent (Yearbook of Alcohol and Drug Statistics 2003; Statistical Yearbook on Social Welfare and Health Care 2003).¹¹⁴ In practice, at least three out of four substance abuse treatment units defined themselves as units specialising in drug treatment in the STAKES treatment unit database.¹¹⁵

According to the Act on Welfare for Substance Abusers, the treatment system first and foremost aims at treating dependence and breaking the vicious circle of abuse as well as achieving more humane living conditions and alleviating suffering. Mere treatment measures may often prove inadequate, as the client also needs help in problems of livelihood, housing and work. As outlined by the legislature, comprehensive treatment emphasises welfare for substance abusers based on social work. The core of the Finnish substance abuse service system – specialised services – mainly continues to work under the social welfare authorities. The strict regulations for medicinal treatment of drug addiction, introduced at the turn of the millennium, assigned special duties to medical professions and the specialised service units, despite that there has been short of physicians in the service units. The proponents of community treatment and non-medicinal options as well as those focusing on the social dimensions of problems have been given much less public attention than the advocates of treatment with medicines. The struggle between the medicinal and non-medicinal models has largely ignored the possibility to use both approaches in parallel. Thus Finnish substance abuse work must in the future be able to demonstrate adequately that treatment is good, when it multiprofessionally combines therapy, social work and medicine in a flexible manner. (Murto 2002).

During the year, a follow-up study was published on a non-medicinal drug rehabilitation project based on community ideas. Implemented at the Kankaanpää A-Clinic since 1997, the rehabilitation period for each client is a year, divided into three stages. The first two stages last three months each in a close-knit community where people learn how to assume responsibility for one's own and the community's wellbeing. The third period lasts six months, comprising individual training periods and three months at work in some private enterprises in Kankaanpää. The employees receive an income equivalent to living

¹¹³ The A-Clinic Foundation has made such agreements with about 130 municipalities, and many municipal A-Clinics have agreements with neighbouring municipalities, including at the most 25 municipalities.

¹¹⁴ For auxiliary services, see Chapter 11.3..

¹¹⁵ <http://www.stakes.fi/neuvoa-antavat/>

allowance, from which they pay for their food, housing and other personal expenses. This also teaches skills in how to spend money and time as a member of society in the workplace or educational institution. Since 1998, the former participants have been debriefed in a follow-up group meeting twice a year. Between 1998 and 2000, the community had 63 adult participants, and 37 (59%) students were debriefed in interviews. A period from two months to five years had elapsed between leaving rehabilitation and the interview. Most interviewees had been drug users. According to the interviews, of the entire student body 45 per cent had remained sober or almost sober. In addition, 18 per cent were employed, 16 per cent studied and 11 per cent had apprenticeships. The interviews pointed out friends, interpersonal relationships and self-help groups as factors that had alleviated the drug problem. Of the interviewees, 94 per cent were satisfied with their lives, the main contributory factor being the comprehensive change in their living situation: family, housing, job, new network of relationships and a drug-free lifestyle. (Ruisniemi 2003).

Drug services for minorities

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

In Greater Helsinki, where more than 40 per cent of the country's immigrants live, the intoxicant service units are only seldom visited by non-native people. Some immigrants have received help from A-Clinics, while some specialised substance abuse services have been available to Romanians.¹¹⁶ Järvenpää Addiction Hospital has prepared a special treatment programme for Russian-speaking drug users (especially abusers of heroin), involving ethnic Finns from Ingria.¹¹⁷ The Helsinki-based health counselling unit for injecting drug users, Vinkki, has one nurse hired especially to treat Ingrian returnees (Kullat 2001). At the beginning of 2001, the Deaconess Institute in Helsinki launched its *Venpro-Pyncnpo* project to assess the need for drug treatment for Russian-speaking immigrants, to plan a treatment system for them and to produce written material needed in treatment.¹¹⁸ During two years, the latter project has made contact with over 40 Russian-speaking clients or their family members.¹¹⁹ In addition, the A-Clinic Foundation has established webpages for immigrants. The site has information about the Finnish service system for substance abusers and treatment possibilities available in English and Russian.¹²⁰ The Free from Drugs Association and the Ingrian centre train volunteers who have the necessary linguistic skills to work on helplines and as support persons for drug users and their relatives.

116 The Romano Missio Association has produced a guidebook *Etisen hoitomallin suositus* [Recommendation for an ethnic treatment model]. See also <http://www.romanomissio.fi>

117 Estimates made in 2001 suggest that there are some 200–500 drug users of Russian origin in the Helsinki area. (Puro 2001).

118 See <http://www.hdl.fi/diakoniaprojektit/venpro.htm>

119 See <http://www.stakes.fi/dialogi/03/dia62003/6.htm>

120 See <http://www.paihdelinkki.fi/>

Co-ordinated by the Finnish Blue Ribbon, the national project on developing addiction services for people with disability will be carried out in 2001–2004. The project has participation from the subprojects of the A-Clinic Foundation, the Deaconess Institute in Helsinki, the Kalliola Foundation and the Finnish Blue Ribbon. It will develop substance abuse services that suit the various needs of people with disability (the visually impaired, the deaf, mentally and physically handicapped, people with cerebral or spinal disorders). The co-ordination project collects experiences and knowledge from the subprojects and steers the developing of services to meet the needs by co-operation and training among professionals working with people with disability or in the substance abuse field.¹²¹

11.2 Substitution and maintenance programmes

The Ministry of Social Affairs and Health gave regulations in 1997 concerning the treatment of opiate addicts with medicines. This treatment aims at curing the dependence based on a multiprofessional treatment plan, which also defines other medical and psychosocial care and follow-up. The regulation was changed in 1998, and Decrees on the issue were passed in 2000 and 2002.¹²²

The substitution treatment by medicines containing buprenorphine or methadone can only be given to patients whose treatment by generally accepted means of detoxification has failed. The maintenance treatment may only start when it is imperative to reduce the negative effects of drug abuse on patients: persons who are not likely to stop using drugs, but who may benefit from maintenance treatment and avoid contracting communicable diseases and other negative health effects and whose quality of life can be improved and who can be trained for more demanding rehabilitative substitution treatment.

According to assessments, Finland, Sweden and Norway execute highly strict and restrictive substitution treatment regimens, where access is limited and expulsion (as punishment) has been common. In Finland, the medicinal substitution for opiate-dependent patients starts at a very late stage. Almost invariably, the patients have been addicted to opiates for years and their treatment in the official system has repeatedly failed. Therefore, most clients entering treatment are seriously excluded. Practice has varied in different parts of the country, so that especially Greater Helsinki has pursued a restrictive treatment policy. (Salaspuro 2002). While the Ministry has lowered the threshold for substitution, and emphasised the flexibility of the Decree, the widespread use of buprenorphine in the street has hampered its introduction into treatment. Understandably, health care personnel find it hard to accept a substance used in the street for official treatment. Another reason is to prefer the time-honoured tradition in Finnish substance abuse services – the importance of a multiprofessional care team, treatment plan and intervention in

¹²¹ See <http://www.vapa.info/>

¹²² Cf. Chapter 1.2.2.

psychological, somatic and social problems – to a medicalised and biomedicalised treatment model (Knuuttila et al. 2003).

At the end of 2002, some opiate addicts outside the Ministry's official programme used to travel regularly abroad, especially to Paris, to acquire buprenorphine doses needed in the treatment. Some clients tried to treat themselves, but buprenorphine was also injected. In Finland, the National Agency for Medicines issued regulations on the personal import of pharmaceuticals, with Order 3/2000 concerning buprenorphine. The purpose of the Order was to curb the wide-scale import of buprenorphine. According to the Order, a passenger may bring an amount equal to 14 days' use of pharmaceutical substances, which are to be considered narcotics, for personal use. When the same or equivalent substance is reimported, the amount of time elapsed from the previous instance of importation must be longer than that estimated for the personal consumption of the previous consignment.

However, the Decree (1088/2002) on personal import of pharmaceuticals to Finland, in force since the beginning of 2003 and consistent with the Schengen Agreement, stopped import from the Schengen countries, for example, France, because the necessary authorisation for legally obtained medicines can only be issued in the person's home country. (Hermanson et al. 2003). Preliminary information suggests the smuggling of buprenorphine from France to have increased in the new situation and that trips have been organised to Estonia, not a signatory to the Schengen Agreement, where the allowed two-week prescription of Subutex is obtained from a pharmacy and imported to Finland.

At the beginning of 2001, some 200 people in 35 treatment units were in detoxification or substitution treatment by buprenorphine or in methadone substitution treatment, associated with the Ministry's decisions; about half of them were in methadone substitution. (Report of the Working Group on developing medicinal treatment for opioid-dependent clients 2001).¹²³ According to an inquiry made in connection with drug treatment information compilation, approximately 400 people in about 100 treatment units were in substitution treatment in the middle of the year 2002. It is estimated, that the number of persons in substitution or maintenance treatment in the middle of 2003 is about 500–600.

Health care personnel were of the opinion that substitution treatment is becoming a 'standard' way of treating people with drug problems. The treatment implementers are relatively happy with the existing procedures and principles, although more information and training are needed for the treatment of this demanding client group. The survey for treatment personnel also indicated that the older the employees, the more likely they were to set the goal of eventually weaning the clients from the substitute medicine and to limit the treatment to one year. On the other hand, the more clients encountered, the harder it was to abide by these restrictions. (Jokinen et al. 2003).

¹²³ See also <http://www.stm.fi/suomi/uutta/uusi05fr.htm>

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

During the development project (1.1.1998 - 30.6.2000), 171 clients sought treatment; 95 of them started in an inpatient programme, while 76 entered an outpatient programme. The majority of the patients were under the age of 30 (71%), and the largest age group comprised those under 25 years. Seventy per cent were men. Their most pressing problem was long-term polydrug use. Injecting buprenorphine was more frequent than heroin use. Dependence on sedatives was commonplace (80%), and so was cannabis use (70%). At the stage of entry, 40 per cent of the patients had also used amphetamines. Risk behaviour was typical and about 80 per cent had hepatitis C. The third major problem was chronic social marginalisation compounded by multiple problems. Many patients did not have vocational training, they were excluded from the labour market and had no network supporting their recovery. They also had housing problems and manifested criminal behaviour.

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

The evaluation concluded that the threshold for accessing detoxification by buprenorphine should be lowered and attention should be paid to treatment need assessment, i.e. directing the patients to the type of treatment – be it medicinal or non-medicinal – that best suits them. Psychosocial therapy merits special consideration along with medicinal treatment. Substitution treatment particularly aims at involving patients, who have multiple problems, in programmes supporting changes in behaviour and social setting. Medication should also be stopped when the patient is ready for this. In the Greater

Helsinki Area, another problem is the slow patient turnover and long queues: treatment commences in special units, but not enough patients are transferred to primary services once treatment procedure is stabilised. Success in the latter would increase the number of beds available to new patients.

11.3 After-care and reintegration

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

Housing services

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

The housing service units for substance abusers constitute one part of the service system. They are targeted at substance abusers needing daily support in their housing. Some housing service units also provide rehabilitation, while some act as therapeutic communities, offering possibilities for excluded people to regain control over their lives. Finland also has some housing service units specialising in drug users. In 2002, the number of residents in substance abusers' housing services was 5,100 (Statistical Yearbook on Social Welfare and Health Care 2003).

Education and Training

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

Employment measures

People who had used drugs had difficulties in finding jobs and were faced with prejudice and other obstacles. The methods used in client work turn out to be inadequate in a situation where jobs are not available. On the other hand, jobs are useless if the threshold of employment is too high. Employment can also be hindered by an ongoing drug treatment process. Thus, better possibilities and readiness to gain employment should be ensured in the target group by creating a feasible co-operative network supporting employment, irrespective of sectorial and administrative boundaries.

Young people's workshops constitute one example of employment activities: apprenticeships for people under the age of 25. Depending on the municipality and workshop, they engage in different work tasks. A person is hired to a workshop for 5–6 months, and ordinary wages are paid for the work. Workshop activities also enable support for young people's life-management skills and tailor-made educational or career paths. Personal guidance is provided to support the young person's efforts to abandon the drug habit, so that he or she can embark on the above-mentioned path. In the near future, the focus in training workshop instructors is on preventive work and on an ability to recognise problems in young people's lives in order to guide them. In co-operation with the participants, the instructor reaches an agreement on the objectives achievable during the workshop period. This also makes it possible to assign responsibility to young people themselves.¹²⁴

12 INTERVENTIONS IN THE CRIMINAL JUSTICE SYSTEM

The Finnish law forbids as punishable acts the unauthorised production, cultivation, import, transport, sale, distribution, possession and use of narcotic substances. Legislation thus empowers the police to intervene in the processes where drugs are handled. In January 2000, the police published its drug strategy for 2000–2003. In addition to intervening in drug offences after the crime has been committed, the strategy emphasises police role in pre-empting drug demand as well (Hietaniemi, T. 2002). In terms of demand reduction, the strategy highlights prevention and early intervention as well as certain control measures. The police approved the anti-drug strategy for 2003–2006 (2002) in September 2002.¹²⁵

In terms of demand reduction, the new anti-drug strategy of the police (2002) emphasises that a drug user intercepted in control activities or investigation will always be given treatment referral and, whenever necessary, directed to social and health services pursuant to the agreed procedures of each police district. It is further required that proper treatment should be a real alternative to punitive measures in all types of punishment for narcotics offences. A local action plan for treatment referral of problem drug users will be

¹²⁴ For more detailed information, see <http://www.alli.fi/allison/tyoelama/tyopajat.html#paja>

¹²⁵ [http://www.intermin.fi/intermin/images.nsf/files/8D6FA0AA1B69B281C2256C2A004642A8/\\$file/huumausainestrategia.pdf](http://www.intermin.fi/intermin/images.nsf/files/8D6FA0AA1B69B281C2256C2A004642A8/$file/huumausainestrategia.pdf)

incorporated in the local security plans, accompanied by an action plan on interagency co-operation for early intervention in young people's related problems and for prevention. To intensify preventive actions, an intervention is made in offences perpetrated by first-time juvenile offenders (under 18 years) in efficient co-operation between the authorities by organising hearings with the offender and the police, prosecutor, social services and parents or guardians. More drug information will also be disseminated to key players, such as teachers, other educators, school nurses, youth workers, team coaches and other people working with children.

12.1 Assistance to drug users in prison

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

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

- Developing prison activities so that they support and encourage drug-free lifestyles, by providing special rehabilitation programmes and meaningful work, education and free-time activities, which incorporate elements supporting temperance.
- Supporting a community free from drugs life style and the prisoners' responsibility through active presence, knowledge, positive interaction and coherent procedures on the part of personnel.
- Developing conditions to create drug-free settings by spatial arrangements and the appropriate placement of prisoners.
- Providing prisoners with a possibility to participate in planned rehabilitation for the duration of their sentence.
- Supporting voluntary work and the prisoners' independent activities in prison.
- Utilising health care procedures effectively in prison to prevent communicable diseases transmitted by drug use.
- Using the existing methods of prevention to counteract drug-related subcultures and their negative effects.

February 2001 saw the publication of the follow-up to the prison administration's intoxicant strategy, a handbook on drug supervision, a set of guidelines targeted at prison personnel for practical drug control and inspection (intoxicant strategy, part II). The handbook mainly discusses supervision and inspection,

body searches of inmates, drug dependence and the effects and uses of intoxicating substances. In addition, the handbook tells how to recognise a person who is under the influence of drugs and how to carry out supervision when in doubt. The book also instructs personnel to give first aid and provides basic information about referring a prisoner with substance abuse problems to rehabilitation.¹²⁶

The intoxicant strategy of prison administration, part III, (*Päihdeinfo*) was published in February 2002. It is an Internet service for prison authorities consisting of the drug programmes and rehabilitation models employed in over 30 prison units. The webpages are updated regularly.¹²⁷ It follows the idea embraced in the drug field and strategy that rehabilitation must be a continuum involving the entire service chain: at first, the need for rehabilitation is assessed and acute withdrawal symptoms are addressed, then a multiprofessional rehabilitation plan is drawn up for those interested. The prisoner will be placed in an appropriate unit depending on his or her addiction status, the actual programme starts for those committed to it and at the final stage, the focus is on the inmate's reintegration into freedom. (Mäki 2002).

Conducted in 2002, a study on case histories in prison health care demonstrated that 46 per cent of prisoners suffered from harmful use of drugs or drug dependence and 39 per cent were dependent on alcohol (Developing prison health care, 2003).¹²⁸ In 2002, 24 prison institutions had substance abuse rehabilitation programmes in place, 21 of which had drawn up a rehabilitation handbook. All open institutions were so-called intoxicant-free units, where the inmates' commitment to a lifestyle free from substance abuse is compulsory and supervised. There are a total of 36 drug-free contractual wards in almost all closed institutions (totalling 15% of all wards). Drug rehabilitation programmes are available in open institutions as well. There are four types of rehabilitation programmes: cognitive substance abuse rehabilitation, comprising short informative sections, motivation, relapse programmes and long-term intensive programmes; *Kisko* programmes based on drug-free community programmes; the Christian action programme (*Krito*); and other programmes combining substance abuse work, prison social work and other functions. If the person has entered opioid (methadone or buprenorphine) substitution or maintenance treatment prior to imprisonment, the treatment may continue in prison in co-operation with the unit having starting it. In 2002 (2001), the opioid medicinal treatment of 45 (22) opioid dependent inmates entering prison was continued. (Annual Report of Prison and Probation services 2002, 2001). Developing prison health care report (2003) proposed instructions (5/442/2002) for prison health care units concerning the treatment of opioid-dependent patients with certain medicines.

The quality of substance abuse rehabilitation in prison service is developed by performance negotiations as well as through qualitative and quantitative targets. Action research is ongoing to develop the so-called cognitive care continuum in rehabilitation to complement other programmes (*Kisko* and *Krito*).

¹²⁶ See also Chapters 15.2 and <http://www.vankeinhoito.fi/8727.htm>

¹²⁷ See <http://www.vankeinhoito.fi/4829.htm>

¹²⁸ The data was collected by health forms for prisoners, that was filled for every 3. male prisoner, for every female or foreign prisoner as well as for every prisoner visited prison health care units.

Procedures to endorse programmes reducing exclusion and recidivism have started as well. The Prison Service has also started compiling follow-up information consistent with the drug treatment indicator system in some prisons, with the aim of expanding it to all prisoners in substance abuse rehabilitation. Information about the inmates' substance abuse problems is collected in health care as well. Placement unit activities enhance quality by promoting the launch of rehabilitative processes. The structural plan of the Prison Service now in preparation will support attempts to utilise the time spent in prison as a process of rehabilitation and overall recovery. In 2003, the treatment continuums will be explored in collaboration with substance abuse organisations as an option to expand co-operation in substance abuse rehabilitation outside prison. (Jungner M. 2003).

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

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

12.2 Alternatives to prison for drug dependent offenders

In the report of the Committee reforming criminal sanctions for juvenile offenders (2003)¹²⁹ it was recommended early and effective intervention in crimes perpetrated by young people. Juvenile punishment, which is currently used in certain parts of the country, may be imposed on a juvenile delinquent (15–17-year-olds), if a fine is deemed insufficient and imprisonment excessive. Juvenile punishment consists of youth service (work programmes, unsalaried work) and supervision. The committee proposed that juvenile punishment be expanded to crimes committed by 18–20-year-olds as well. Based on the proposal, the punishment comprises two forms: the basic form and intensified juvenile punishment with labour service. Basic juvenile punishment consists of supervised meetings, supervised tasks and programmes enhancing social skills, including support and guidance. An offender failing to attend may be ordered to be brought to the following meeting.

Juvenile punishment, intensified with labour service, may be imposed for crimes committed by 18–20-year-olds, if juvenile punishment as such is considered insufficient. Labour service lasting a minimum of 10 hours and a maximum of 100 hours consists of practical training, followed by unsalaried work. If the offender fails to serve the punishment, imprisonment may ensue under special circumstances. A major departure from the existing system is that juvenile punishment can be imposed in part or totally as mental health or substance abuse treatment, in most cases accompanied by basic juvenile punishment. Another novelty in the proposal, the prosecutor may waive charges, if the young offender takes part in a project promoting social coping or has sought treatment in social and health services, for instance, in the form of rehabilitation for substance abusers.

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

In the report of the Committee preparing the law on contractual treatment (2002), appointed by the Ministry of Justice, it was proposed that a new punishment, known as contractual treatment be experimentally introduced as a punishment for offenders with addiction problems.¹³⁰ The reform is important because under the current law, treatment cannot be imposed as a punishment for an offence. The contractual treatment punishment is intended for persons whose criminal offence was essentially affected by a substance abuse problem. In practice, it would be imposed for recurrent drunken driving, property crimes and lesser acts of violence. Contractual treatment could be imposed in lieu of a maximum

¹²⁹ Press Release of Ministry of Justice, 6th of March, 2003. See also <http://www.om.fi/18410.htm>

¹³⁰ Press Release of Ministry of Justice, 22nd of March, 2002. See also <http://www.om.fi/13620.htm>

of eight months' imprisonment. A prerequisite is that the offenders are willing to commit themselves to treatment. The treatment involved can be inpatient or outpatient care or rehabilitation. It could also include supported housing or support person activities. The client must also commit him/herself to a lifestyle free from substance abuse and undergo regular tests to prove this. Contractual treatment aims at reducing the risk of further criminal involvement and at enhancing social adaptation. The goal is that the convicts abandon the drug habit and are able to manage their lives without resorting to crime more successfully than after a prison term.

The report proposes that the Probation Service is responsible for the enforcement of contractual treatment. At the prosecutor or court's request or on its own initiative, the agency would assess the possibilities for contractual treatment. The agency would also draw up a treatment plan together with the treatment unit and the suspect. The assessments and plans should be made as early as possible so that the court can have them at its disposal. The duration of this treatment would be a minimum of six months and a maximum of two years, depending on the treatment need. The court can either impose contractual treatment as planned or it can deny it, if it does not adequately measure up to imprisonment. It should not be imposed if the person is fit for community service, but when the criteria are met, the court should always opt for contractual treatment instead of imprisonment.

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

12.3 Evaluation and training

In the Prison Service, especially substance abuse services underwent strenuous development at the turn of the millennium, followed by various reports evaluating the projects. The so-called VP Project, developing welfare for prisoners with substance abuse problems, was evaluated in 1999 (Mutalahti 1999). The project showed that good results can be achieved in treatment method development, implementation and evaluation, if the existing resources are retargeted, if networks are created with substance abuse services outside prison and if this responsibility is assumed by the institution as a whole. The municipality of residence and other actors must commit themselves to the prisoner's rehabilitation continuum. However, to be systematic, such rehabilitation requires a law to stipulate the related organisational and financial responsibilities involved.

In 2000, a study was published on implementing alcohol and drug rehabilitation in prison according to the therapeutic community treatment programme (Tourunen 2000).¹³¹ The study focused on launching a prison ward specialising in substance abuse rehabilitation. It describes ethnographically what happens when a special ward for problem users is opened in a prison. According to the study, it was difficult to introduce just any rehabilitation programme into prison, and the participants found it hard to assume a role in this context. The treatment ward was often perceived as an activity threatening the ‘basic work’ done in prison, and the team working in the ward was considered an ‘elite group,’ undermining the position of other employees. In order for the treatment to be successful, the prisoners must also view the activities in the ward more as self-care coming from outside the prison than as part of traditional prison activities. The fact that the treatment ward was perceived as disciplined, controlled and targeted rehabilitation adapting to the circumstances in prison helped both liaison personnel and participating prisoners accept their respective position in interactive and mutually dependent roles. However, this approach is in many ways in conflict with the principles of humane prison administration, professional assistance and individual rehabilitation. Consequently, both approaches to rehabilitation have to fight for survival inside prison. Despite the tensions, the study showed that alcohol and drug rehabilitation is a worthwhile and necessary aspect of prison administration.

Some intermediate reports were completed during the year on the ongoing development projects. The project on rehabilitative prison work is intended for prisoners with substance abuse problems in Helsinki, who are ready to commit themselves to a life free from substance abuse and crime. It incorporates rehabilitation, rehabilitative labour, housing services and other kinds of support. The purpose is that the participants already at the labour colony get used to regular employment and that employment and rehabilitation will continue upon release in the same working environment. (Stenberg et al 2003). The Probation Service development project on welfare for substance abusers, in turn, aims to secure continued substance abuse rehabilitation for conditionally released prisoners in Greater Helsinki and to devise models for work with substance abusers in community service and with conditionally released prisoners. The purpose is also to lay the groundwork for a substance abuse strategy for the Probation Service.¹³²

13 QUALITY ASSURANCE

Quality assurance procedures

The methods used in the quality assurance of substance abuse work were haphazard until the late 1990s. In recent years, the situation has changed, though. The final reports on projects are more systematically

¹³¹ Through participatory observation, 28 work team meetings in the ward were followed during a year. The material was supplemented by interviews of prison personnel (37) and inmates (37), as well as observation of treatment groups (9) in the ward.

¹³² See <http://www.rikosseuraamus.fi/17223.htm>

made, partly due to reasons of data processing. Another contributory factor is the publication of foreign and domestic guidebooks on project evaluation. Books published in Finnish include guidelines for evaluating prevention (Kröger et al. 1998), a manual of preventive substance abuse work (van der Steel ed. 1999), a guide on substance abuse prevention for co-operation between schools and their interest groups (Huopanen et al. 2001), and a tool pack for instructors in substance abuse affairs (Montonen et al. 2003).

At the moment, the Finnish Centre for Health Promotion has made the best progress in systematising and published a guidebook on the quality criteria for health promotion projects (Project support – health promotion programme work done by NGOs, 2002).¹³³ The drug and alcohol prevention project database of the Finnish Centre for Health Promotion gives a picture of the ongoing and completed projects in the field of drug prevention. At the beginning of 2002, external evaluations of the project proposals made by two evaluators were included in the register. The external evaluations were made according to the criteria in the guidebook and included numerical assessments and graphs made by the two evaluators.¹³⁴

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

The framework recommendations aim to be specific and concrete so as to benefit service planners, organisers, providers and clients. The guidebook also has background information about the service system, the characteristics of substance abuse work and the evaluation criteria for the recommendations. The key principles of the quality recommendations for substance abuse services are as follows (Press release of Ministry of Social Affairs and Health, 10th of September 2002):

- Drug and alcohol harms must be combated on a wide front in the municipalities. Harm reduction requires conscious local planning and a strategy. The scope and operating principles of services must take account of changes in substance abuse.
- Basic social and health services are an integral part of substance abuse services in all municipalities.

133 See <http://www.health.fi/maarahat/Hanketuki.pdf>

134 See <http://www.health.fi/paihde/hankerekisteri/>

- Viable services for substance abusers are an important aspect of preventing exclusion and enhancing wellbeing and health-related equality.
- A client-centred work approach is ethically justified and socially advantageous. Access to services should be unimpeded. The clients shall participate in planning, implementation and assessment of their rehabilitation.
- The services will safeguard the fundamental rights of the client.
- Special attention should be paid to the client's ability to use services. The client's age, sex, language and other cultural factors must be taken into account when feasible service packages are planned.
- When carefully designed, a population-based and regional system of cost distribution is client-friendlier, more cost-effective and easier to control compared to charging fees per visit.
- Fees compensation arrangements must not interfere with flexible and effective service referral.
- In service housing and temporary accommodation, attention must be paid to the quality of the premises and autonomy of the client.
- The leadership of substance abuse services must be solidified. Staffing, skills and personnel's ability to withstand stress warrant special attention.

In 2003, STAKES has collaborated with NGOs making substance abuse work to develop indicators for evaluation and monitoring of the quality of services in the residential treatment units for substance abusers.

The Finnish Slot Machine Association (RAY) is a key financier of NGO anti-drug development projects in Finland.¹³⁵ In 2003, an evaluation was completed concerning the impacts of the Association's programmes on the development of drug strategies in the selected target cities (Helsinki, Oulu and Kuopio) and on the prospects of low-threshold units in particular (Kaakkinen et al. 2003).¹³⁶ The report indicated major differences in the service organisation between the cities: in Helsinki, social and health services are separate administrations, whereas Kuopio and Oulu have combined the departments. In Helsinki, welfare for substance abusers is provided by the Social Services Department, whereas in Kuopio and Oulu also health care has an important role, especially in organising services for clients with drug problems. The cities also have much in common: in all these cities, drug treatment is centralised into special units and NGOs have a major role. Nevertheless, co-operation over sectorial boundaries seems to need improvement in all types of organisation. What is also apparent in all these cities is the key role of a system originally devised for assisting alcoholics and the homeless; services for drug users have been superimposed on the old system – this is especially the case in Helsinki. The result is a set of service units treating clients with alcohol and drug problems. Nonetheless, many evaluations have established that for

¹³⁵ See Chapter 1.5.

¹³⁶ The evaluation is based on material available concerning the anti-drug projects financed by the RAY, municipal documents and statistics on drugs and drug abuse, as well as 29 actor or expert theme interviews in the treatment field for substance abusers done in Autumn 2002 and Spring 2003. The interviewees were chosen so that in every municipality attending the evaluation some RAY-project participants as well as municipal alcohol or drug treatment experts were interviewed but also other actors providing drug treatment services for some special groups.

some drug user groups, combined services do not function properly and fail to reach many client groups. Thus, the report points out a clear demand for NGO services for problem drug users.

According to the evaluation, the official truth about the need for substance abuse services in many municipalities is the one reflected in the services used. Because the services are targeted in an organisation-centred way, without paying attention to different user groups' subcultures and behaviour, the system only meets 'suitable' users, who manifest a treatment response and who are motivated. Especially young injecting drug users, whose treatment motivation is still low, are easily eliminated from the municipal system. They would require a more active involvement of the treatment system and low-threshold services in order to prevent their subsequent exclusion to a degree that leaves them totally out in the cold. For these groups, municipalities often purchase health counselling, day activities and other harm reduction activities. The evaluation indicates that the projects funded by the Finnish Slot Machine Association have acted as a catalyst for service system development and drawn attention to client groups previously unknown or invisible to the municipal system, which has then had to respond to their needs. The most decisive criterion for developing services for problem drug users is client need, but the Association also considers it important that the projects have municipal backing and the resulting sustainability in the municipal service system. Acting between municipalities and organisations, the Association is expected to continue its sponsorship and risk-taking for the unconventional development of new interventions and services for clients, including those seriously excluded. (Kaakinen et al. 2003).

Training for professionals

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

The most important training institution in substance abuse work is the annual, nationwide Intoxicant Days -seminar organised by the Finnish Centre for Health Promotion in association with the Ministry of Social Affairs and Health and the national collaborative group on services for substance abusers.¹³⁷

A national board of examiners on the substance abuse work was appointed in 2000 to develop and supervise vocational examinations in substance abuse work. The statutory responsibilities of the national

¹³⁷ Chapter 8.2.

board include the supervision of competence-based qualification, adequacy of examinations, drawing up contracts for organising competence-based qualification and clarification of evaluation targets, criteria and methods of organising qualification. The curriculum for training that leads to a vocational degree in substance abuse work must comply with the order (55/011/2000) issued by the national Board of Education concerning the basis of vocational examinations in substance abuse work. This vocational examination is done as competence-based qualification.¹³⁸ Competence-based qualification makes the student eligible for further education in social and health studies in a polytechnic.

Qualification is part of preparatory education. Competence-based qualification does not involve isolated work assignments but a demonstration of professional skills consistent with the objectives crucial to proficiency (core skills, management of information forming a basis for the work, work methods, management of tools and material, management of the work process). The duration of training, which leads to a vocational degree in substance abuse work, depends on previous studies and work experience. (Heikkinen-Peltonen et al. 2002).¹³⁹

The degree is in three compulsory parts: legislation and the service system; humane professionalism; and the basis and methods of substance abuse work. There are two optional sections, one of which must be a psychosocial approach to substance abuse work, Christian substance abuse work or the Minnesota Model. Other options include voluntary and NGO work in services for substance abusers, prevention and independent professional practice. The board on degrees in the substance abuse field has made agreements with 18 institutions for competence-based qualification and issued almost 200 diplomas. (Märkjärvi 2003)

The further training project on the treatment of drug addiction started in 2000, financed by the Ministry of Social Affairs and Health and co-ordinated by the A-Clinic Foundation. It has participation from key operators in the field, such as the Association of Finnish Local and Regional Authorities, STAKES, the A-Clinic Foundation, the Deaconess Institute in Helsinki, the Free from Drugs Association, the Finnish Association for the Minnesota Model, the Finnish Blue Ribbon and the Tyynelä development centre. The project improves the attitudinal, cognitive and professional aptitude of personnel working in basic or specialised social and health services to recognise and treat with various methods drug addiction and its consequences. Another task is to develop the national networks of drug treatment experts (drug treatment trainers, implementers of substitution treatment and health counselling) and to develop regional and local co-operation between actors engaging in the treatment of drug users. By the summer of 2002, the expert and instructor networks of the regional groups (20) had 250 members. The project webpage opened in April 2002,¹⁴⁰ providing constantly updated information about drug treatment, training and network

138 See <http://www.oph.fi/nayttotutkinnot/>

139 See <http://www.health.fi/paihde/paihdepaivat/2002/tiivistelmat/Kanava9.pdf>

140 See <http://www.a-klinikka.fi/huuko>

activities. One subproject in this undertaking involves nationwide training for health counselling centres engaging in needle exchange, co-ordinated by the A-Clinic Foundation in liaison with STAKES and the National Public Health Institute.

In addition, the research unit in addiction medicine at Helsinki University has prepared a study programme, launched on the initiative of the Ministry of Social Affairs and Health, and in co-operation with the A-Clinic Foundation, the National Public Health Institute, the addiction medicine association and the Ministry, for physicians and other treatment providers. The purpose of the programme is to teach the scientific basics and procedures of evidence-based methods to treat opioid addiction. The course includes a self-study section (1 credit) on prearranged material, an intensive course (1 credit) and, when necessary, work practice (1 credit).¹⁴¹

14 DISCUSSION

14.1 Main intervention strategies and trends

The drug policy strategy, prepared in intersectorial co-operation in 1997, and the related Government Decision-in-Principle in 1998 as well as the decision for a more efficient drug policy constitute the central strategic policy statements for demand reduction. Related to them, specific policy guidelines for demand reduction have been prepared: the report of the committee for preventing drug use among young people was published in 2000 and of the working group on drug treatment in 2001. In addition, the police (2000, 2002) and the Prison Service (2002) have drawn up substance abuse or drug strategies, with demand reduction as one focal point. For example, many of the proposals of the drug treatment working group have already been enforced in legislation and financial decisions. These policies are further specified in a concrete action plan for more efficient drug policies in 2001–2003 by the drug policy co-ordination group.

Concurrently with long-term strategic planning, decisive action has been taken to solve immediate drug problems at local and national levels. The focus of prevention has been on young people and improving their life-management skills, especially by means of activation, supporting parenthood and early intervention in young people's drug experiments. In prevention, the emphasis was on young people's own participation in project planning. All central actors involved have invested especially in providing drug training for prevention workers. In addition, a new subject, health education, has been introduced into schools and a supplementary training programme on drugs has been developed for teachers; a network of municipal co-ordinators in drug prevention has also been established. Training for a vocational

¹⁴¹ See <http://www.a-klinikka.fi/jss/koulutus/tilaisuudet>

examination in substance abuse work has started. A nationwide campaign on drug information is also ongoing, including a broad-scale evaluation. So-called workshop activities have been provided to support the vocational skills and social development of young people facing exclusion risk, for example, due to substance abuse. For the first time on a broad scale, the general quality frameworks and implementation of municipal drug work have been evaluated.

Special development target has been on enhancing information flow between actors and the accessibility of the existing data, especially using the new media in combating narcotics. As a result, services have been launched to elaborate regional networks of drug work instructors and to disseminate information among drug workers about research results, working methods, municipal drug strategies and antidrug projects run by municipalities or organisations. In addition, telematics services have been developed: drug information services, discussion forums and anonymous self-testing of personal intoxicant use.

In the treatment system, the development of low-threshold services and the related training have been highlighted, the aim being to involve clients in the treatment system as early as possible. At the same time, there has been much debate about harm reduction actions, whose position as part of treatment has been more widely acknowledged, one example being the development of infection risk counselling for injecting drug users as well as the substitution and maintenance treatment system. At the same time, the first evaluations of the feasibility of low-threshold services and medicinal treatment have been published. Special training programmes on care practices in both these systems have been worked out. In the past two years, major investments have been made to develop the treatment system regionally, as suggested by the relevant working group. Moreover, the general quality framework for substance abuse services was established in national co-operation.

The control authorities have stressed collaboration in preventive work with other authorities in the field. A new narcotics offence type, 'user offence', and, as a related means of reducing demand, a personal hearing and possibilities of care referral for the offenders were introduced. Another preventive measure that has been proposed is the introduction of drug tests. The working groups preparing the issue have made proposals for amending legislation on introducing drug tests into working life. The three-year experiment in prisons has resulted in well-designed products for drug treatment in prison and for the after-care of released prisoners, in association with organisations in the field. Furthermore, proposals have been made concerning juvenile punishment as a care referral tool for young people and the so-called contractual treatment for substance abusers as an alternative to imprisonment.

14.2 Future trends and strategies

The programme for 2004–2007 of the new Finnish Government, appointed in 2003 under Prime Minister Matti Vanhanen, underlines the policies laid down already in the 1997 drug strategy, i.e. drug policy based on a prohibition on drugs. A future key player in drug work is the drug policy co-ordination group, nominated by the Government and tasked with the integration of national drug policy, intensified co-operation between the authorities as well as the implementation and monitoring of the nationally approved drug policy programme. The co-ordination group has a crucial role in defining priorities for action within the framework and their financial consequences. As a new duty, the group will update the drug policy action plan for 2004–2007.

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

PART IV SUPPLY REDUCTION INTERVENTIONS

15 STRATEGIES IN SUPPLY REDUCTION AT NATIONAL LEVEL

The field of supply reduction consists of control directed at the illegal use, distribution or trafficking of drugs or at their legal import, export, trade or use, e.g., for medical or research purposes.¹⁴²

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

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

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

15.1 Major strategies and activities

The police will upgrade its antidrug strategy for 2003–2006 by putting the accent on intercepting drugs before they reach the country. In terms of supply reduction, the police antidrug strategy has the following objectives:

¹⁴² See Appendix 5: Actors in drug supply reduction.

1. To increase the risk of apprehension in aggravated narcotics offences by intensifying the flow of operative information and the use of new supervision and crime prevention methods.
2. To prevent the import of drugs targeted at the Finnish market by reinforcing international co-operation and information exchange in Finland's neighbouring areas, especially with the Baltic states and Russia, and by improving collaboration between the customs and border guard authorities.
3. To expand street-level supervision by making it part of everyday control activities, by training field officers and by intensifying co-operation between the local police and the Mobile Police.
4. To uncover drug-related concomitant crime and criminal proceeds more effectively by targeting crimes associated with professional concealment of property and prostitution and through closer co-operation with the Money Laundering Clearing House and teams tracking criminal proceeds.
5. To effect legislative reforms for severer maximum punishments resulting from narcotics offences and from leading an organised crime group as well as for better witness protection, for more lenient sentences if the suspect co-operates in solving an offence and for granting tax-exempt status to tip-off rewards.¹⁴³

In terms of supply reduction, the intoxicant strategy for the prison administration (1999) against substance abuse for 1999–2001 stresses that:

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

At the beginning of 2001, the second part of the prison administration intoxicant strategy was approved, focusing on supply prevention, with efficient control as its core activity. Concentrating mainly on supervision and inspection, the strategy was published in the form of a handbook on drug control. The book is intended for prison guards to improve and facilitate their work, with an effort to harmonise working practices in different prisons. Thus, it is a kind of quality manual on good control practice. The third part of the strategy incorporates all major intoxicant and drug demand reduction strategies implemented in the prison service.¹⁴⁴

At the same time, the joint drug strategy (PTR) of the police, customs and the Border Guard was approved, aiming at more effective anti-drug operations by intensified collaboration. The drug strategy of the customs authorities for 2002–2005 was completed at the beginning of 2002. In compliance with the

¹⁴³ See

[http://www.intermin.fi/intermin/images.nsf/files/5BD72FD1DCA3695AC2256C28003CFB59/\\$file/huumestrategia.pdf](http://www.intermin.fi/intermin/images.nsf/files/5BD72FD1DCA3695AC2256C28003CFB59/$file/huumestrategia.pdf)

¹⁴⁴ See Chapter 12.1.

strategy, the customs authorities try to intercept drugs on the border before their distribution. Another aim is to uncover professional drug organisations and put them out of business. To prevent drugs from entering the country, Customs co-operate with national and international authorities. Customs will also ensure that the agency has adequate drug control resources, develop internal training and improve information services on the results achieved in combating drug crime. The strategy is complemented by an action plan (*Customs Newsletter* 1/2002).¹⁴⁵

The Ministry of Defence has also drawn up a drug strategy (2001) for the Defence Forces. The strategy aims to endorse a negative attitude towards drugs in the Defence Forces, making it known both inside the organisation and in society at large, to promote healthy lifestyles, to support anti-drug work in society and to create opportunities for co-operation and networking at different levels.¹⁴⁶

15.2 Approaches and new developments

The serious organised criminal elements operating in Finland are mainly led from the neighbouring areas, mainly Estonia and Russia. Organised crime groups led from Estonia have a very strong position in Finnish professional drug crime and prostitution. The delegation of managerial duties is reflected in the crime organisations known to the Finnish law enforcement authorities and in the organisations' direct links to leader figures in Estonian crime, under whose leadership and supervision drugs and prostitutes are imported to the country. In concrete terms, the globalisation of Finnish crime is seen in the rapid increase of foreign prisoners. The leading position of Estonians and Russians is also seen in changes in the nationalities of those suspected of aggravated narcotics offences (The status of crime investigation, final project report 2003).¹⁴⁷ Tripartite co-operation between the Finnish and Estonian police and the militia leadership of the City of St Petersburg and the Leningrad area started in 2002 in order to combat drug crime.

The developments in the neighbouring areas are of the utmost importance for the Finnish drug situation. The growing drug market in Russia and the Baltic countries increases drug trafficking through Finland and builds up pressure for the market to expand towards Finland. This has already happened in case of counterfeit goods and pirated materials. The crime groups, operating from Estonia and relevant to Finland, are already transnationally organised and in 2004 they will be located and operating on EU soil. Actions taken in Estonia and other Baltic countries to tackle the local drug situation and to fight organised crime in their area are crucial to the drug supply targeted at Finland as well. Thus the support given by the Finnish police, customs and border guard to the authorities in these countries will prove vital to Finland

¹⁴⁵ See http://www.tulli.fi/tulli_tiedottaa/uutisia_tullista/2002/ut_01_2002.pdf

¹⁴⁶ See http://www.mil.fi/cgi-bin/printable.pl/tiedotus/ajankohtaista/huumestrategia/index_3.html?

¹⁴⁷ See [http://www.intermin.fi/intermin/biblio.nsf/226B9362C33C4096C2256CD2002C9438/\\$file/4-2003.pdf](http://www.intermin.fi/intermin/biblio.nsf/226B9362C33C4096C2256CD2002C9438/$file/4-2003.pdf)

as well. Consequently, the above-mentioned authorities have agreed to launch a broad-scale training programme together with other EU countries to develop co-operation with the Baltic authorities and border control in particular before the countries' accession to the EU (Press release of the Customs Administration, 14 February 2003).¹⁴⁸

With the enlargement of the EU, also the Baltic countries will adopt the EU's strategy for drugs, joint police, customs and border guard co-operation and become signatories to the related agreements. This will facilitate information exchange and operative collaboration. Therefore, the EU enlargement is not merely a risk but an opportunity as well to respond to organised crime more efficiently and to curb the illegal drug trade as well.

16 INTERVENTION AREAS

16.1 Judicial system

When the 1994 Narcotics Act was prepared, the guiding principle was to tackle professional and organised drug crime. The aim was to make drug use punishable in order to emphasise that drugs are not tolerated and to achieve an effective deterrent, the ultimate goal being to prevent the emergence of an illicit public drug market in Finland. Because of the ambiguities in applying the law on user crimes, an amendment took effect in September 2001 concerning these offences. The amendment defines 'a drug user offence', which enables the imposition of fines for the use, possession for own consumption or attempted purchase of drugs through summary penal proceedings. The grounds for waiving charges were also clarified by specifying the impact of the amounts and quality of narcotic substances, the situation in which they are to be consumed and other circumstances on the nature of the offence.¹⁴⁹ A follow-up study on the effects of the new law on prosecutorial practice is under preparation.

Based on the Government Decision-in-Principle to enhance drug crime prevention, the Prosecutor-General appointed one State prosecutor and seven State local prosecutors for two years as of 1 February 2001 to concentrate on narcotics offences. These appointments have been extended to the end of 2003. The job description of these eight special prosecutors involves prosecutorial deliberation and prosecution concerning extensive and aggravated drug offences. In addition, their work has entailed training other prosecutors (e.g. training in the amendment to the law on drug user crime) and counselling, the development of co-operation in pre-trial investigation as well as many-sided further education to maintain professional skill. The Office of the Prosecutor-General has monitored processing of drug cases

¹⁴⁸ See http://www.tulli.fi/tulli_tiedottaa/lehdistotiedotteet/2003/001_2003.html

¹⁴⁹ For more detail, see Chapters 1.2.1 and 1.3.

implemented through funds for drug crime prevention in line with the Government Decision. (Annual report of The Office of the Prosecutor-General 2002)¹⁵⁰

Legislation on searching locations or persons, monitoring of telecommunications, control and surveillance by technical means, carried out by the police and customs officials, may be utilised in preventing and detecting drug trafficking. The law on international assistance in criminal matters acknowledges the controlled delivery of drugs as one avenue of investigation. The Second Naples Convention on customs activities regulates infiltration across the border, and the Schengen Agreement stipulates infiltration within the EU. Such action can only be taken in aggravated crimes. As of 2001, the use of infiltration and undercover purchase activities are possible in combating crime in Finland.¹⁵¹

Along with the risk of apprehension and punishment, the seizure of the benefits from crime is an especially effective way to thwart calculated criminal involvement for financial gain.¹⁵² The Government proposes (HE 32/2003) that Parliament pass the UN Convention in response to transnational organised crime (the so-called Palermo Convention). The Palermo Convention has regulations on preventing money laundering, extradition for crimes committed, mutual legal assistance in criminal matters, police co-operation and measures to counteract organised crime. The Government issued a proposal in 2002 for more effective witness protection (HE 190/2002).

16.2 Supervision and technical equipment

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

In drug enforcement, the police has stressed the significance of pre-emptive action, for example, community policing and street supervision, as a means of preventing the emergence of places where drugs are sold openly. It is characteristic of the Finnish drug market that drugs are relatively seldom sold in the street; instead, they are traded within the confines of private apartments. Implemented in Greater Helsinki 1999–2002, the special antidrug project of the police aimed to forestall those selling drugs in apartments and to eliminate the resulting disturbance and insecurity.¹⁵³ During the project, the researchers followed the interrogations and interviewed suspects. Preliminary information on the project

¹⁵⁰ See also <http://www.oikeus.fi/vksv/uploads/5t695i6pc6g.pdf>

¹⁵¹ See Chapter 1.2.2. and 4.2.1.

¹⁵² See Chapter 1.2.2.

¹⁵³ The data collection process of the project consisted of six different stages: the planning officers (5) of control attacks were interviewed, participatory observation was implemented during attacks in six different places of residence, police interrogations were followed and 15 suspects as well as 15 police officers attending the control attacks were interviewed, and finally 27 resident and 5 house manager interviews were made and analysis was made on the basis of criminal register data, control attack follow-up forms and pre-trial investigation records (137).

suggests that intensified drug control restrained the market. According to the interviews, in areas raided the sellers and users avoided making personal contact and assumed new ways of communicating with each other, and the market became even more clandestine. One emerging problem was the fact that the raids were occasionally too massive, which meant that those subjected to them grew increasingly more hostile towards society. The project was mainly targeted at users and small-time sellers who already lacked life-management skills. Their need for treatment was not, however, generally assessed and they were not given assistance in accessing social support or health care. The police considered it a problem that the social welfare authorities did not work outside office hours, i.e. when the raids were usually executed. In their final conclusions, the researchers pointed out that breaking the drug abuse cycles would restrain the drug market as well. For this reason, they suggest that police work and the criminal justice system could be used as a method of 'outreach work', so that this effective network could be exploited in offering social welfare and health care support services for people with drug problems. (Kinnunen 2002).

In recent years, telecommunications used by drug suspects have been increasingly often utilised in investigating aggravated drug offences. The amendments to the Coercive Measures Act added interception and monitoring of telecommunications and technical surveillance to the arsenal of investigative techniques. These authorities will be further augmented as of the beginning of 2004.¹⁵⁴ The National Bureau of Investigation provides demanding crime intelligence services for the entire police administration. In all areas of technical surveillance, the assignments are on the increase. The police engaged in technical intelligence activities especially in drug-related, financial and property crimes.

In compliance with the customs strategy, the focal point of customs activities has shifted towards the EU's outer borders. The customs authorities are still monitoring Finland's borders, including the internal borders of the EU. However, the latter supervision has become more discreet and it increasingly relies on intelligence information. The National Board of Customs has supplied all the major Finnish frontier transit points with adequate equipment and inspection facilities. The focus of the liaison system of the Board has been shifted to areas where the illicit drug trade to Finland and elsewhere in the EU originates.

In prisons, inmates or premises may be searched, for example, if a prisoner is suspected of possessing unauthorised articles or substances.¹⁵⁵ An inmate may also be isolated in prison for a repeated use of intoxicants, in order to intervene in a drug offence or until the illegal substances have disappeared from the prisoner's body.

The National Agency for Medicines is authorised to inspect premises, where narcotics or precursors are legally produced, stored, kept or otherwise handled, and to take samples during these inspections.

¹⁵⁴ See Chapter 1.2.2.

¹⁵⁵ See Chapter 1.2.2.

Businesses must notify the Agency of unusual orders or transactions involving precursors. It has authority to prevent the delivery of illicit substances, both domestically and across the border.

Banks and other financial institutions must report unusual transactions and intervene whenever necessary. They must also submit the relevant documents for auditing. Money laundering issues in Finland belong to the Money Laundering Clearance House of the National Bureau of Investigation.

16.3 Intelligence and information systems

Combating serious and organised crime calls for efficient and up-to-date intelligence services, with related analysis and monitoring of the data, appropriately targeted investigation and smooth, timely and consistent international co-operation between law enforcement authorities. The Finnish police and Customs are in close collaboration both in their respective domains and jointly on international forums and in numerous international projects. (Hietaniemi 2002).

Full implementation of the Schengen Agreement commenced in Finland on 25 March 2001. At the same time, the Schengen Information System (SIS) became operational in that country as well. The system has data on persons and property wanted by the police in the Schengen area. Finland is an active participant in information exchange concerning the analysis of databases of Europol. The country has a national intelligence data system (register of suspects, EPRI), an important tool for investigating serious drug crime as well. Offences are recorded in the national offence report register (RIKI), which is used by the police and Customs. In March 2003, the Centralized Information System (CIS) of the EU's Antifraud Office (OLAF) and the customs administrations of the Member States was introduced.¹⁵⁶ Nordic co-operation between the police and customs authorities, utilising comprehensive liaison networks that serve all Nordic countries, exemplifies a feasible and effective international model.

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

¹⁵⁶ See http://www.tulli.fi/tulli_tiedottaa/lehdistotiedotteet/2003/009_2003.html

16.4 National co-operation

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

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

Criminal investigation co-operates with the tax and debt recovery authorities in the forfeiture of illegal profits in particular. In Finland, criminal investigation is led by the chief investigative officer, not the prosecutor. Collaboration with the prosecutorial authority has been consolidated by reorganising policies, through exchange of officials and by appointing prosecutors specialising in narcotics cases.

Implemented since 1999, the National Crime Prevention Programme has spawned local co-operative networks and security plans in most Finnish municipalities. It has brought the police, municipal authorities, business sector, church and other organisations closer together in the fight against crime. Factors causing insecurity in municipalities include substance abuse and disturbances resulting from it. The follow-up report on the project recommends that the programme continue, but it also needs improvement, such as stabilising co-operation, solving regional questions, increasing anticrime knowhow and integrating the crime prevention programme into other undertakings, especially on drugs, drug-related crime and the grey economy. (How did the security plans materialized, 2003)¹⁵⁷

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

Anti-drug activities are heavily dependent on information from the public and other actors, whose contribution is channelled into tip-off lines of the police and customs, with an opportunity to inform on drug offences that are being planned or ongoing. Today, it is possible to report offences via the Internet as well.

¹⁵⁷ See <http://www.om.fi/17254.htm>

17 QUALITY ASSURANCE

The quality of law enforcement activities may be developed by increasing expertise in the field through training and by committing to internationally recognised quality standards.

Detectives and other police officers come increasingly often in contact with drug-related crime, a fact that has caused a great demand for further training. Training is primarily provided by experienced members of the drug squad. The new Police College of Finland has a major role in this respect. The crime prevention and investigation segments of basic and supplementary police training will be increased as well, so that the students are required to know the basics of combating organised crime in particular and to be better prepared for technical investigation.

Also the customs authorities have directed resources at training customs officials, both through in-house courses and training by the police.¹⁵⁸ In addition, training will be provided for the police, customs and the Border Guard, based on the joint drug strategy of these authorities.

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

The Office of the Prosecutor-General has organised a one-week course on drug crime, along with a three-day supplementary course. These courses discussed, among other things, narcotics and their effects, coercive measures with regard to telecommunications as well as their characteristics and problems of producing evidence, questions of forfeiture, criminal proceeds and money laundering, co-operation between the investigator and prosecutor, international legal assistance and extradition of offenders, non-prosecution as well as issues dealing with pharmaceuticals classified as narcotic substances.

The Finnish police engage in training associated with measures to combat crime and money laundering in Estonia. Officials in Finland's neighbouring areas are also trained within the framework of international customs co-operation. In recent years, the Finnish police, customs and the Border Guard have also launched co-operation with their partners in the Baltic States and Russia.

With the exception of small quantities of cannabis, the drugs seized are analysed at the Crime Laboratory of the National Bureau of Investigation or at the Customs Laboratory. Both laboratories employ FINAS accredited analysis methods.

¹⁵⁸ As part of co-operation between the customs authorities, a guidebook in Finnish and Russian was published in 1997 to prevent the smuggling of drugs and psychotropic substances.

18 DISCUSSION

18.1 Main intervention strategies and trends

The narcotics laws were amended in 2001 and a new form of punishment for ‘drug user offences’, more lenient than that applied to narcotics offences, was instituted. At the beginning of 2002, the Office of the Prosecutor-General issued directions how to apply the law. Furthermore, the agency has provided local prosecutors with training in connection with this reform. The near future will show how the amendment affects, for instance, decisions to waive charges.

From the viewpoint of drug supply reduction, key strategies and action plans include the antidrug strategy for 2003–2006 of the police, Parts 1 and 2 of the Prison Service intoxicant strategy, the drug strategy for 2002–2005 of the customs as well as the joint drug strategy of the police, customs and Border Guard (PTR). Especially important for the enforcement authorities are the legislative reforms enhancing supervision authority and techniques. At the beginning of 2001, the police were given a new and more extensive authority to undertake fictitious purchase and undercover operations. Authority to engage in interception and monitoring of telecommunications will be upgraded as of 2004. The Customs Administration has been given part of these authorities under the Customs Act. In addition, more extensive authority to operate has been given to the prison authorities.

A key aspect of activities during the year was the increasing co-operation between the enforcement authorities, other officials and citizens in preventing drug crime. The National Crime Prevention Programme has brought the police and municipal authorities, the church and other actors closer together in these endeavours, but it has also been pointed out that the action plans in various sectors (e.g. municipal intoxicant and drug strategies) should be interfaced with the anticrime programmes. An effort has also been made to intensify co-operation with business life in terms of money laundering (banks and financial institutions) and control of precursors (chemicals companies, etc.).

The new investigative methods (monitoring of telecommunications and technical surveillance) have been primarily targeted at organised crime. Ever-expanding international co-operation and the new Schengen and customs information systems have provided the authorities with a wide range of contacts and data that are needed in order to supervise drug crime and money laundering and to keep internationally organised, professional drug crime under control.

18.2 Future strategies and trends

Appointed in 2003, the new Finnish Government has pledged to prepare a drug policy action plan for 2004–2007. The Government’s programme emphasises the need to draw up a comprehensive and

intersectorial programme on internal security to enhance national safety and especially to reduce drug-related, violent and repeated crime. Thus, the Government has committed itself to continuing the National Crime Prevention Programme. The national drug policy co-ordination group has a central role when the new action plan and its priorities are being shaped in co-operation between various administrations.

In supply reduction, a major future challenge is the change occurring in Finland's international operating environment in particular, when the Baltic countries will join the EU in 2004. At national level, the joint drug strategy of the police, customs and Border Guard, the drug strategy of the police and the intoxicant strategy of the Prison Service are signposts for the future. Moreover, the outcomes of the legislative processes now underway will eventually provide the guidelines for the policies and practices used in crime prevention.

Co-operation with Finland's neighbouring areas, international collaboration and their further development are important factors determining future policies on preventing transboundary drug crime. Supply reduction will follow the same international norms and programmes that were already mentioned in connection with future policies on demand reduction.¹⁵⁹ Activities to reduce supply are also governed by the Schengen regulations, which Finland started to apply on 25 March 2001.

¹⁵⁹ See Chapter 14.

PART 5 SELECTED ISSUES

19 EVALUATION OF DRUGS NATIONAL STRATEGIES

19.1 Existence of evaluation

19.1.1 The role of drug policy evaluation in drug strategies

Along with legislation, other important documents guiding Finnish drug policy include the national drug strategy, drawn up by the drug policy committee in 1997 and, based on it, the Government Decision-in-Principle on drug policy 1998 and the action plan for more efficient drug policies for 2001–2003, approved in 2000. These documents proposed projects to be launched in order to evaluate drug policy and laid down the benchmarks by which the drug administration will monitor and evaluate its activities.

The 1997 drug strategy stated that drug policy must be based on research information about the drug situation and that there were serious shortcomings in the coverage of this information. Thus it was suggested that more resources should be allocated for monitoring drug policy actions and research projects were proposed to be launched, the last one of which was the evaluation of the national drug programme's implementation. Such a research project has not been started yet.

In addition to general strategies, the committee on preventing drug use among young people (2000) paid attention to the importance of critical youth policy assessment, while in its antidrug strategy (2003 – 2006), the police set the objective of developing parameters for measuring the effectiveness of drug prevention. The working group on the treatment of problem drug users (2001), for its part, stressed the guiding impact of national frameworks on treatment services and suggested additional appropriations for treatment development. The State Provincial Offices are required to report on the feasibility and effectiveness of the development projects set up on this additional drug treatment funding (2002–2003).

19.1.2 Evaluation and monitoring system in the administration

As proposed in the drug strategy, the group monitoring the drug action plan (drug policy co-ordination group) was appointed in 1998 in the wake of the Government drug policy resolution. The co-ordination group consists of representatives nominated by various Ministries (Social Affairs and Health; the Interior; Education; Justice; Foreign Affairs) and other expert bodies (National Public Health Institute, STAKES, National Board of Customs). The group is, on average, six times in session each year, discussing interventions planned and carried out within different administrations. The group itself, and drug policy in general, is co-ordinated (Chairperson, Secretary) by the Ministry of Social Affairs and Health.

The co-ordination group produced a follow-up to the Government Decision-in-Principle: an action plan for more efficient drug policies for 2001–2003. The action plan contains 24 separate actions, each of which has been assigned a body responsible for its implementation (authority or organisation). The drug policy co-ordination group's activities are comprised of monitoring and self-evaluation of administration, not evaluation research as such. The report on programme implementation was published in spring 2003. In it, the responsible parties reported on their activities in 2001 - 2003. Now, the co-ordination group is preparing an action plan for 2004–2007, to be approved in late 2003 – early 2004. The plan spans the present Government's term of office.

In terms of scientific evaluation, the co-ordination group has made some suggestions, such as the evaluation of nationwide drug information campaign; the 2001–2003 Action plan for more efficient drug policies proposed a drug media campaign to be implemented, with relatively comprehensive evaluation. Conducted by the National Public Health Institute and STAKES, this evaluation is now ready and will be published in late 2003. (Jallinoja et al., forthcoming) The multimethod campaign evaluation utilises, among other things, population surveys (campaign visibility), analyses of discussion forums on the Internet and in other media (content analysis; public debate and popular opinion), small-group interviews and interviews of substance abuse workers (reception study) and general analysis of the campaign's socio-political points of departure.

Another example of a research approach in the drug policy co-ordination group's work is a report, a rough scenario of drug situation trends, commissioned twice (2000 and 2003) by an expert group from STAKES and the National Research Institute of Legal Policy. The scenario sums up shortly different possible development trends of the drug situation, the contributory factors and State actions to influence these developments. This document, which explores three possible scenarios (the drug situation exacerbates; remains the same; or improves), does not, however, constitute an evaluation of drug policy as such; instead, it is report to form a basis for action planning and containing indicators for evaluation as well.

Other tools to develop monitoring information and evaluation proposed in the action plan are as follows:

1. Better coverage of drug treatment information compilation based on the EMCDDA's treatment demand indicator system (TDI) in order to develop regional monitoring and to improve system compatibility in treatment quality assessment (STAKES).
2. The development of evaluation methods concerning the impacts of drug harm reduction interventions on infection risks (National Public Health Institute).
3. A population survey of drug use in 2002 to monitor the drug-related scenario (STAKES).
4. Monitoring of the functionality of penal legislation and the criminal process and effectiveness of crime prevention strategies (National Research Institute of Legal Policy).

5. The development of general monitoring of the national drug situation within the framework of the EMCDDA's annual report system (STAKES).

The co-ordination group has also suggested that the Academy of Finland launch a separate drug research programme, containing an evaluation component as well, but so far, the undertaking has not made progress in the science policy administration.

The drug policy co-ordination group, its action plans and monitoring reports thus constitute the central tools for Finnish drug policy monitoring and evaluation: in the group, actors and interventions from various sectors come under the same umbrella in order to draw up an action plan as well as to monitor and report on its implementation.

19.1.3 Examples of specific studies evaluating drug policy

No centrally administered general evaluation of Finnish drug policy is in progress, but many specific research projects on some segment of this policy or on certain interventions are ongoing. Studies on quantitative trends in drug use, drug offences and other drug related harms as well as studies on drug users and the systems to help and control them are also employed as monitoring and developmental tools.

More drug-related studies are ongoing today in Finland than ever before: several theses and dissertations, reports, commissioned studies and projects are currently underway. There is no exact information about all studies in progress, but from the present viewpoint, that of drug policy evaluation, it is pertinent to describe the field of drug research in general terms: what interventions are currently studied and how is research positioned institutionally? The following is a list of the main research institutions and examples of their recent or ongoing research projects in terms of the drug policy sector or intervention they discuss.

Research on the prevention and treatment systems

In terms of the administrative sectors in drug policy, the majority of the research work force operates in the social welfare and health care sectors, at the National Public Health Institute and STAKES. The Ministry of Social Affairs and Health and the Finnish Slot Machine Association are active financiers in launching and evaluating various treatment development projects run by municipalities and non-governmental organisations. This is especially reflected in the relatively large number of treatment development projects and treatment studies. The Finnish Slot Machine Association made evaluations (2003)¹⁶⁰ of the impacts of the antidrug projects funded by it on municipal drug strategies and of the significance of low-threshold services. The State Provincial Offices were also obliged to monitor the trends in the local drug situation and services in 1999–2001.

¹⁶⁰ See Chapter 13. Kaakinen et al. (2003).

The Finnish Slot Machine Association has also financed, for example, evaluations of the development projects on substance abuse services in prison (1999, 2000),¹⁶¹ evaluation of the activities of two units giving medicine treatment to opioid-dependent clients (2002),¹⁶² evaluation of a drug clinic providing 24-hour service in the Greater Helsinki Area (2002)¹⁶³ and evaluation of a unit providing treatment for drug users with HIV infection (2003).¹⁶⁴

STAKES has in recent years undertaken several evaluations and investigations concerning treatment services, including their supply and quality. Prevention and its structures also undergo evaluation, but there, unlike in treatment questions, the focus has thus far been on substance abuse work in general or on studies on the prevention of alcohol-related negative effects.¹⁶⁵

Local substance abuse prevention has been evaluated, for instance, in the Department of Sociology at the University of Helsinki, whose research team evaluated the *Klaari* project in the Helsinki area; while the immediate object of evaluation was a new model for local substance abuse work, the researchers extended their critical examination to the general policies of Finnish substance abuse prevention and to the emphasis given to the role of communities in them (Rantala et al, forthcoming).

Research on the law enforcement systems

The activities of the prosecutors and courts in Finland have been evaluated by the National Research Institute of Legal Policy. A follow-up study¹⁶⁶ on the 2001 reform of drug user offences is ongoing. The study is also mentioned in the action plan for more efficient drug policies for 2001–2003. Prior to this, the National Research Institute of Legal Policy had examined, among other things, prosecutorial practice in drug user and possession crimes throughout the country.¹⁶⁷

The drug enforcement activities of the police have been evaluated relatively seldom. An ethnographic evaluation was carried out in the research unit of the Police College of Finland¹⁶⁸ concerning the intensified police supervision of drug users in 1999–2002. In connection with the police drug strategy, an evaluation of co-operation between the police and other authorities in the Tampere area is also in

161 See Chapter 12.3. Mutalahti (1999); Tourunen (2000).

162 See Chapter 11.2. Baas et al. (2002).

163 See Chapter 10.1. (Low threshold services). Törmä et al. (2002).

164 See Chapter 10.1 & 10.2. Törmä et al. (2003).

165 See Chapter 9.4 (community programmes). Warpenius (2002).

166 Researcher Heini Kainulainen.

167 See Chapter 1.3. Kainulainen (1999).

168 See Chapter 16.2. Kinnunen (2002).

progress. Evaluations of police interventions are becoming more numerous as the research activities of the Police College of Finland expand.

Other drug policy research and monitoring

In addition to the above-mentioned research institutions, other actors engage in research that can be loosely termed as drug policy evaluations. For example, the Finnish Foundation for Alcohol Studies has funded studies on the practical implementation of needle exchange activities¹⁶⁹ and alternative drug policy movements.¹⁷⁰ The Academy of Finland has financed a project on harm reduction approaches in Finnish drug policy.¹⁷¹ In addition, STAKES, which belongs to the above-mentioned sectorial research institutions, conducts studies on drug policy approaches and processes. (Tigerstedt et. al. 2002)

19.2 Methodology of evaluation

In sum, despite the fact that the drug administration has its own system of monitoring drug policy, national drug policy is not evaluated in order to study the overall targets set in the strategies and programmes. On the other hand, isolated interventions are studied from an evaluative viewpoint as well. Why is it, then, that drug policy on the whole is not evaluated more extensively?

From the standpoint of administration and decision-makers, one possible reason is the fact that Finnish drug policy still tries to find its course. An intersectorially agreed drug policy is a relatively new phenomenon because the first Finnish strategy was drawn up as late as in 1997, followed by the relevant action plans. In the strategies, the drug question is considered part of general social policy and other social problems and this means that the objectives of drug policy are not unambiguous enough to lend themselves to evaluation through clear-cut research designs. Furthermore, the programmes do not comprise quantitative targets, whose achievement is easy to measure. Many drug policy actions in Finland are assigned to autonomous municipal government (448 municipalities), a fact that makes data compilation more complex.

For the Finnish research sector, the drug issue has traditionally been regarded as a marginal topic; the substance abuse field has mainly been preoccupied with the alcohol issue partly for the sake of the institutional arrangements of alcohol policy. Interest in evaluation research has been quite modest and possibly it has been deemed a tool for administrative planning rather than serious research.

169 Researcher Riikka Perälä

170 Researcher Taru Kekoni

171 Researcher Tuukka Tammi

Ideally, two types of strategy are possible to demonstrate evidence in support of drug policy: the isolated and integrated types. According to the isolated model, the scientific community acts separately and independent of policy and finally, through open and critical scientific discussion, ends up to recommend a certain model of policy. In the integrated or policy-driven model, the research community operates as an assistant to administration, evaluating the practical feasibility of various politically selected ideas.

In practice, neither of these ideal types is implemented in Finland: the drug administration or the research sector have not pursued a strategy of total isolation or integration. Research information has had a role in the shaping of Finnish drug policy and, by the same token, policy and administration have actively influenced the selection of research topics and approaches. The interrelationship between policy and research is not straightforward, but interfaced by various networks (Berridge et al. 1999). Thus, in addition to finding out whether a certain policy leads to the desired results, evaluation research should, for its own sake, explore the information basis and values on which certain drug policy conventions are based. This requires analysis of, e.g., the professional, administrative and scientific groupings through which drug policy actors co-produce the boundaries and meanings of policy and research.

To date, evaluation of Finnish drug policy consists of the following:

1. The basic system of monitoring the drug situation, largely relying on internationally defined (EMCDDA) drug indicators and the production of various international annual drug reports.
2. The role of the drug policy co-ordination group in steering national drug policy and its self-evaluation in co-operation with the sector research units of the related administrations.
3. Implementation of separate scientific evaluations which were decided by the co-ordination group and which in the future will increasingly often be put out to tender.
4. Evaluations of isolated interventions mainly supported by public funds and whose outcomes will be utilised in drug policy steering and finance through the proposals of the co-ordination group.

20 CANNABIS BROBLEMS IN CONTEXT: UNDERSTANDING INCREASED TREATMENT DEMAND

20.1 Demand for treatment for cannabis use

Entering social and health services in relation to cannabis and other narcotics increased in the late 1990s. According to the census of intoxicant-related cases in 1999, most cases related to substance abuse in Finnish social and health services were still associated with alcohol: nine out of ten clients were users of alcohol (Nuorvala et al. 2000). Visits due to abuse of medicines accounted for 22 per cent, cannabis accounted for 11 per cent, amphetamine 9 per cent, while 5 per cent involved opiates in terms of all intoxicant-related visits to social and health services in 1999. A total of 15 per cent of these visits were

associated with the use of some illicit drug. The previous census in 1995 indicated that cannabis-related visits accounted for 9 per cent, and 11 per cent involved the use of some illegal drug.

Cannabis has also been significant as the primary drug leading to treatment demand, despite the fact that the drug treatment data collection for substance abusers¹⁷² indicated the most common primary drugs for entering treatment in 2000–2002 to be stimulants (27%) and opiates (28%). Less than a fifth (19%) entered treatment primarily due to alcohol and secondarily due to related polydrug use, while over a sixth (18%) entered treatment primarily because of cannabis. No significant changes occurred in the percentages of primary substances over the period of 2000–2002. The percentage of those entering treatment due to cannabis was the highest at youth centres, with 26 per cent entering treatment primarily for this reason. The youth centres offer treatment for under 25-year-olds having intoxicant-related or other problems.

Those entering treatment for cannabis predominate in the client group entering treatment for the first-time ever. Cannabis was the most common substance leading to treatment demand among those entering first treatment: 28 per cent in 2000, followed by 33 per cent in 2001 and 30 per cent in 2002. The prevalence of cannabis use is also reflected in polydrug use among the drug clients in services for substance abusers. Cannabis was the most commonly used problem substance among those entering treatment for drug use as the 1st–3rd substance (60%) in 2000–2002.

The social backgrounds, substance use and reasons for entering treatment of those in treatment for the first time due to cannabis appear to have remained relatively stable (Table 16). On average, substance abuse treatment was sought at the age of 20 years, about five years after the use had started and after about three years of regular use. Women accounted for a fifth of those seeking treatment. In 2002, the situation of first-time treatment seekers seemed to be somewhat more stable than in previous years: the percentage of those who had finished first or lower secondary school was higher, the percentage of the homeless was lower, and the percentage of those employed or studying was higher than before. Treatment referral by the authorities seemed to have increased. Mixing alcohol with cannabis appeared to have become more common among those entering treatment primarily for cannabis, but the percentage of those using cannabis daily declined.

¹⁷² See Chapter 3.1.

Table 16.

Those entering treatment for the first time primarily due to cannabis in 2000 - 2002

	Year		
	2000 (N=384)	2001 (N=374)	2002 (N=391)
Women (%)	24	18	21
Mean age (yrs)	20.0	20.7	20.2
Education (%)			
Primary school unfinished/uncompleted	23	16	15
Primary level of education	59	63	70
Secondary level of education	16	20	14
Higher education	-	0	1
Other	3	1	1
Work situation (%)			
Employed	11	12	14
Student	49	47	52
Unemployed	33	36	29
Other	7	5	5
Housing situation (%)			
Own or rented apartment	29	36	36
With parents	57	46	53
Homeless	6	4	2
Other	8	14	7
Mean age of starting alcohol use (yrs)	12.8	13.4	13.1
Mean age of starting use of any narcotic substance (yrs)	15.1	15.6	15.2
Mean age of starting cannabis use (yrs)	15.3	15.7	15.4
Duration of regular use of the substance causing treatment need (yrs)	3.3	3.1	3.1
Frequency of cannabis use (%)			
Not used during last month	14	19	21
Once a week or less	27	25	29
2-6 days per week	38	37	35
Daily	21	19	16
Those having injected drugs (%)	22	28	21
Mean age of starting injecting (yrs)	18.7	18.6	18.9
2nd problem substance (%)			
Opiates	5	3	3
Stimulants	26	29	22
Hypnotics and sedatives	3	5	9
Alcohol	29	32	42
Other	5	5	5
2 nd substance not mentioned	31	26	21
Referral to treatment (%)			
Self referred	22	20	19
Parents or friends	38	27	26
School health care	5	4	6
Child welfare	10	13	15
Other health care	10	8	10
Other social services	6	7	6
Police	4	14	9
Other	6	7	9
In outpatient care (%)	88	81	81

Two-thirds of those aged under 20 years who started a new treatment period mainly because of cannabis in 2002 were in treatment for the first time (Table 17). Those aged over 20 had usually been in substance abuse treatment before.

Table 17.

Social background and reason for entering treatment among persons aged under and over 20 in treatment primarily due to cannabis in 2002

	Under 20-year-olds (N=394)	20-year-olds and older (N=405)
Previous treatment contacts (%)		
No previous treatment contact	63	38
Previous treatment contact	37	62
Mean age	17.3	25.8
Sex (%)		
Male	75	84
Female	25	16
Housing situation (%)		
Steady housing (own or rented apartment, parents, support housing)	87	86
Unstable (friends, shelter, homeless)	2	13
Institution	11	1
Education (highest completed) (%)		
Primary school unfinished/uncompleted	23	5
Primary level of education	73	66
Secondary level of education	4	29
Higher education	-	1
Work situation (%)		
Employed	4	17
Unemployed	20	54
Student	72	16
Full-time mother / father	0	1
Retired	0	6
Other	3	6
Referral to treatment (%)		
Self referred	12	36
family or friends	25	9
Other substance abuse unit	2	8
Health centre	3	10
Hospital or other health care unit	4	11
Social services	35	6
Police	4	10
Other	16	10
Age when cannabis used for the first time (yrs)	14.5	16.5
Frequency of cannabis use		
Not used during last month	16	24
once a week or less	31	22
2-6 days a week	40	31
Daily	13	24
2 nd substance used together with cannabis (%)		
Opiates	2	6
Stimulants	21	41
Hypnotics and sedatives	11	6
Hallucinogens	1	-
Solvents	1	0
Alcohol	40	29
Other narcotic	3	3
2nd substance not mentioned	23	15
Has injected drugs (%)	23	53

The situation of those aged under 20 years was more stable compared to those aged 20 or older. The percentages of the homeless or those in temporary housing and the unemployed were clearly higher in the older age group. Those aged under 20 also seemed to have more social support, as indicated by treatment referrals made by parents or close persons. Another reason for these treatment referrals was the fact that the majority (72%) lived with their parents, whereas only a sixth (18%) of those aged 20 or over did so.

Only few (13%) of those aged under 20 entering treatment mainly for cannabis used it on a daily basis, and as few as a quarter (24%) of those aged 20 or over did so. Those aged under 20, who had been referred to treatment by their parents, mainly used cannabis once a week or less (51%) or on 2–6 days a week (43%) and very seldom on a daily basis (7%). Among those aged under 20 seeking treatment on their own initiative, the use was more regular: almost one out of two (43%) used cannabis on 2–6 days a week, a quarter (26%) did so daily and a third (31%) did so once a week only. Those aged under 20 referred to treatment by child welfare authorities used cannabis quite regularly, 41 per cent on 2–6 days a week, 17 per cent daily and 41 once a week. Those aged 20 or over entering treatment on their own initiative used cannabis as regularly as those under 20, but among those referred to treatment by their parents cannabis use was clearly more regular than with younger clients.

Polydrug use of several substances was, however, common in both groups. Of the younger clients, only a quarter (23%), and of the older ones, one out of seven (15%) did not report any secondary substance. In the younger age group, alcohol was the most usual secondary substance (40%), while in the older group it was stimulants (41%). A quarter (23%) of those under 20 years of age entering treatment due to cannabis had injected drugs at least once during lifetime. In the older age group, the percentage was 53.

No comprehensive statistics are available concerning the underlying reasons for entering treatment for cannabis use. Neither does the drug treatment data collection give direct information about the reasons for entering treatment. However, it allows for making an estimate that some cannabis users entering first-time in treatment have entered treatment because of the concern expressed by their parents even though the use was not extensive. Nevertheless, in some clients cannabis use was quite regular and the associated problems had led to the clients' entering treatment on their own initiative. In the latter group, cannabis use was more regular than among those referred to treatment by their parents.

A Helsinki-based youth centre treating many young people entering treatment for cannabis use has indicated that the clients can be divided into three groups based on the reason for treatment need (Fagerström 2003). Some clients enter treatment because of concerned parents who may be confused about their children's striving for self-determination and experimental or long-term cannabis use. The second group comprises young people in whom cannabis causes depression interfering with concentration, schoolwork or studies. The third and smallest, yet the most demanding, group consists of young people entering treatment due to cannabis-induced psychosis.

A punishment for drug user crime was instituted in 2001, whereby those under 18 years of age must automatically undergo a hearing accompanied by the parents, prosecutor, social worker and a representative of the police.¹⁷³ Moreover, the police have been instructed to give all drug suspects guidance in seeking treatment. No accurate statistics on this referral to care are available. According to the drug treatment compilation among substance abuse clients, those entering treatment for cannabis because of police initiative in 2000 accounted for 4 per cent, followed by 7 per cent in 2001 and 2002. The drug treatment compilation does not give information as to whether treatment referral by the police was associated with the above-mentioned user crime.

20.2 Prevalence of problematic cannabis use and patterns of problems

The problem use of cannabis is not defined unambiguously in Finland. The criterion for active cannabis use is the one employed in population surveys, i.e. use during last 30 days. This figure includes those engaging in random experiments as well as long-term and regular users. On the other hand, excluded long-term users were underrepresented in the population surveys. The estimates based on cannabis use during last 30 days have been considered to yield a rough maximum number of regular cannabis users. In the 2002 population survey, the percentage of those having used cannabis during last 30 days was one, which means 40,000 people (Hakkarainen et al. 2003). The surveys have questions about the frequency of use during last 30 days, but the figures do not translate reliably into the number of regular cannabis users because of the small number of responses.

Finnish medical journals have in recent years debated about the link between cannabis use and mental health disorders pointed out in the international literature. Cannabis is thought to increase the incidence of schizophrenia, although not as much as genetic factors do (Pirkola 2003). Cannabis has also been suggested to make the users liable to depression (Jääskeläinen 2003; Poikolainen 2002). The five-year follow-up on the reasons for starting cannabis use indicated that mental health problems result from cannabis use rather than constitute the reason for it (Poikolainen et al. 2001).

Schizophrenia, mood disorders and anxiety are also reflected in the hospital statistics on those entering treatment for cannabis. The link between cannabis and mental health disorders is visible in hospital statistics. In terms of hospitalisation, especially cannabis-related psychoses as well as mood and anxiety disorders increased between 1996 and 2000. Subsequently, the number has stabilised and started to decline.¹⁷⁴ The total number of hospital periods due to cannabis has followed the same trend.

¹⁷³ See Chapters 1.2. and 1.3.

¹⁷⁴ See Chapter 21.1.

Cannabis is believed to have the same negative effects on pregnancy as tobacco has. A Finnish study found that pregnancies made otherwise normal progress except that 18 per cent of the infants were underweight (Halmesmäki 2000).

In terms of other harms related to cannabis, it should be noted that the number of cannabis findings associated with deaths increased from 16 in 1990 to 61 in 2001. During the past three years the trend has slowed, though.¹⁷⁵ On the other hand, drug findings in road traffic analysed from those suspected of driving under the influence of narcotics has increased steadily since 1995.¹⁷⁶

20.3 Specific interventions for problematic cannabis use

Finland has no specific drug treatment units targeted at people with cannabis problems and therefore the clients demand treatment from general addiction treatment services at local level.¹⁷⁷ In major municipalities, young cannabis users are treated especially at youth centres, which are outpatient facilities intended for under 25-year-olds.

The Helsinki youth centre gives treatment, for example, as family therapy, in which the young person participates when the treatment starts on the parents' initiative (Fagerström 2003). The youth centre also has good experiences of parents' groups, giving support in parenthood. The clients who suffer from depression due to cannabis are treated with acupuncture in order to help stopping cannabis use; also individual therapy is given. For young patients entering treatment for cannabis-related psychosis, the accent is on mental health assessment and agreeing on the suitable treatment unit. The patient's psychological condition permitting, treatment will be implemented in a substance abuse unit. For dual diagnosis patients, assigning treatment responsibilities may take some time due to the related network meetings and official co-operation.

21 CO-MORBIDITY

When illicit drug use and problem use are examined, the biological, psychological and social perspectives are all relevant. Problem use is often caused by drug addiction, which can be reduced to a biological phenomenon, which is believed to emerge from exposure of the reward system of the brain to psychoactive substances. This starts a process, which progressively leads to changes in behaviour that are irrational and harmful to the individual (Schuckit 2000). The results of this process affect not only

¹⁷⁵ See Chapter 3.2.

¹⁷⁶ See Chapter 4.2.

¹⁷⁷ For the treatment systems in general, See Chapter 11.1.

individuals but also their immediate circle and, in broader terms, the very culture they live in. By the same token, it is possible to perceive that environmental factors have a wide range of impacts on the development of an individual susceptible to substance dependence and on the manifestation of possible addiction at any given time. Drug addictions are nowadays considered mental health disorders, whose diagnostic criteria are incorporated in the existing classifications of mental disorders (ICD-10, DSM-IV).

Compared to persons who are not dependent on drugs, drug addicts are also known to have a higher incidence of other mental disorders, the most common being co-morbid mood disorders, anxiety disorders, psychotic disorders and personality disorders. Conversely, problematic drug use and drug dependence are more prevalent in those suffering from other mental health problems (Kessler et al. 1994; Brady et al. 1999). As yet there is no consensus on the underlying reason for this comorbidity and these disorders are thought to be interconnected by many and partially overlapping mechanisms. The key hypotheses are the causal ones (drug addiction is conducive to other mental health and behavioural disorders, or vice versa: other mental health problems lead to drug addiction through self-medication) and hypotheses concerning common – either hereditary (common susceptibility genes) or environmental – background or risk factors for addiction (Murray et al. 2003).

21.1 Main psychiatric diagnoses and prevalence

Since the 1990s, observations made by professionals working with psychiatric patients in Finland indicate that the patients' use of illicit drugs has increased, especially as regards patients who have the severest psychiatric symptoms and are in need of hospitalisation. No research evidence of this phenomenon has been published, but reports on substance abuse in the population suggest an increase in drug experiments and other indicators of drug use. It is also known that the health-related and social consequences of drug use typically surface several years after the use has started, some significant exceptions notwithstanding (Schuckit 2000, Virtanen 2003).

Maintained by STAKES, the Hospital Discharge Register (HILMO) is a repository for all Finnish hospital treatment periods including discharge diagnoses. During the past decades, the diagnosis classification was altered twice, in 1987 and 1996.

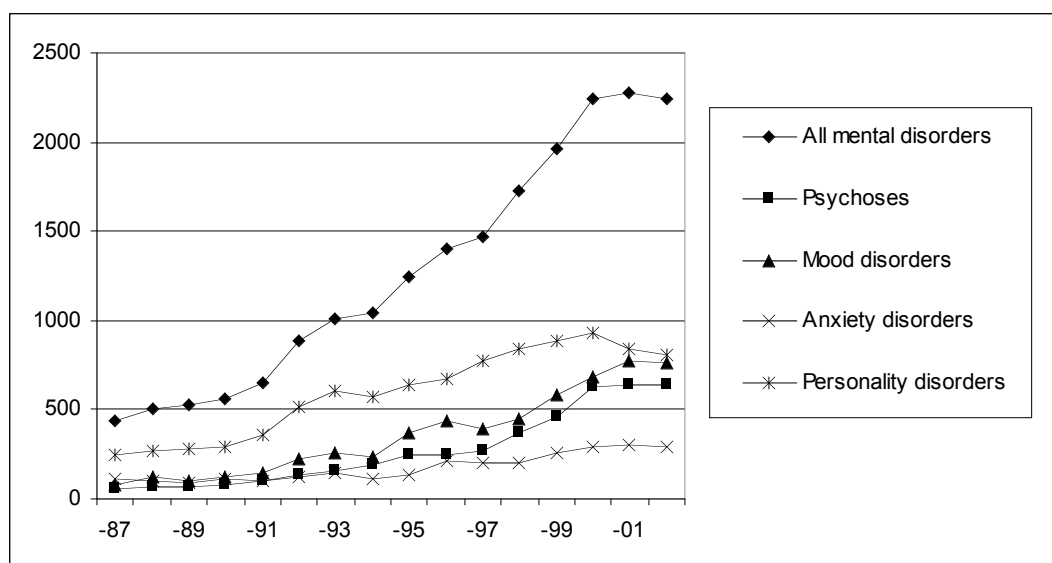
To elucidate trends in psychiatric co-morbidity over time in Finnish in-patient treatment, we have retrieved a time series spanning from 1987 to 2002 from the HILMO register data on discharges with diagnoses related to both problem use of narcotics or pharmaceuticals and at least one other mental health

disorder. Problem use of alcohol and treatment periods for mental disability were excluded from the retrieval.¹⁷⁸

During the period examined, 1987–2002, a slight increase occurred in the overall number of in-patient treatment periods provided in the Finnish health care system. At the same time, according to HILMO, the co-occurring drug-related and other psychiatric diagnoses increased about fivefold (Figure 26). The number of treatment periods associated with simultaneous drug-related and other mental health problems grew from 441 to 2,130 during the period studied. Especially noteworthy was the increase in the dual diagnoses associated with psychotic disorders (54 treatment periods in 1987 vs. 643 in 2002) and mood disorders (83 in 1987 vs. 763 in 2002). Within the psychosis group, a significant increase also occurred in schizophrenic patients who had dual diagnoses: from 33 treatment periods in 1987 to 304 in 2002. The increases in numbers of double diagnosis and other treatment periods were compared and the difference was found statistically significant.

Figure 26.

In-patient treatment periods for mental disorders co-occurring with drug diagnoses in 1987–2002 according to the HILMO register



The substance-specific analysis is restricted to the years 1996–2002, when the International Classification of Diseases (ICD-10) has been in use. The growth trend seems to level off in all substance categories except opiates during the last year observed, 2002, at which point some substance-specific hospitalisations appeared to decline from the year before (Table 18).

¹⁷⁸ Following drug related diagnoses were chosen in the ICD-9 classification 292, 304, 3052- 3057, 3059 and in the ICD-10 classification F11 - F16, F18 - F19 (see also annexes 6 and 7). Mental and behavioural disorder -codes were chosen according to the following criteria: psychotic disorders: 259, 297, 298 or 3012C (ICD-9) and F2* (ICD-10), mood disorders 296, 3004A or 3011D (ICD-9) and F3* (ICD-10), anxiety disorders 3000 - 3009 (ICD-) and F4* (ICD-10) and personality disorders 3010, 3012A, 3014, 3015A, 3016 - 3018 (ICD-9) and F60 - F61 (ICD-10). From the year 1996 (when the implementation of ICD-10 classification started in Finland), drug related treatment periods are also identified according to the primary drug. In this study following drugs are treated separately: opiates (F11), cannabis (F12), hypnotics and sedatives (F13), stimulants, other than cocaine, i.e. mostly amphetamines (F15) and hallucinogens (F16).

Table 18

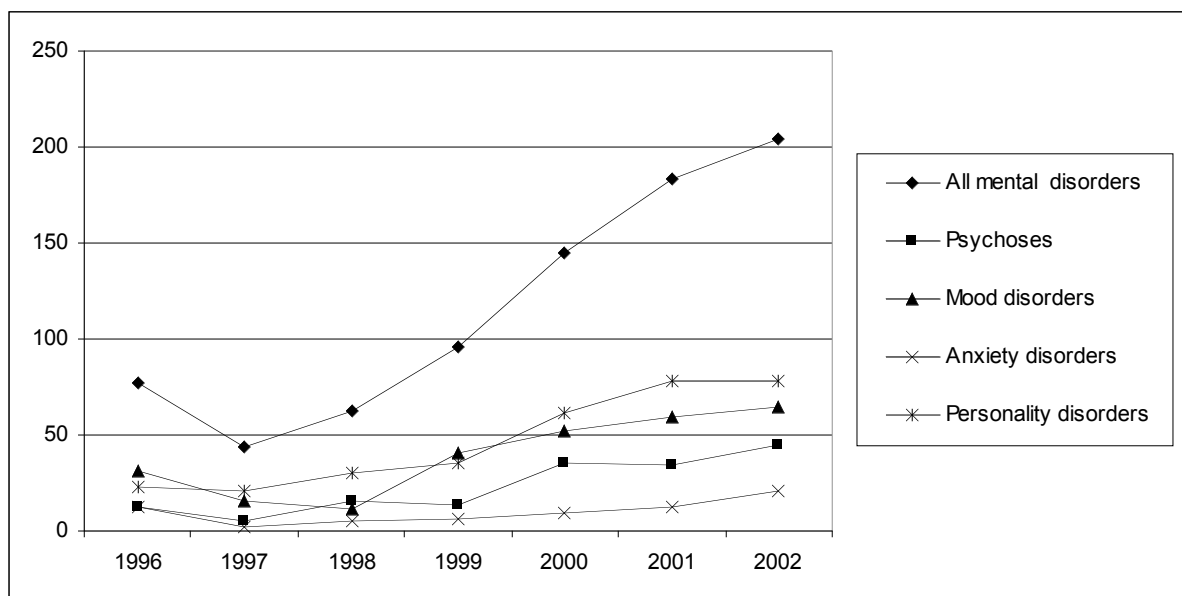
Treatment periods for co-occurrence of some drug-specific diagnoses with mental disorders¹⁷⁹

	1996	1997	1998	1999	2000	2001	2002
Opiates	77	44	62	96	145	183	204
Cannabis	104	125	140	188	250	246	196
Hypnotics and sedatives	578	494	617	638	627	679	622
Stimulants other than cocaine	188	187	175	207	225	255	212
Hallucinogens	17	11	10	25	14	17	21

The treatment periods due to diagnoses of illicit opiate use and other psychiatric disorders have tripled since 1996 (Figure 27). An increase is also apparent in the treatment periods based on diagnoses of problem cannabis use and psychiatric disorders (Figure 28). On the other hand, no major changes have occurred in the dual diagnosis periods related to abuse of pharmaceuticals, stimulants (mainly amphetamines) and hallucinogens since 1996 (Figure 29).

Figure 27

Treatment periods for opioid illicit use and mental disorders



¹⁷⁹ The total number of drug specific diagnoses in the table 18 is much less than the comparable overall number of mental health diagnoses in the figure 26, because the table 18 excludes polydrug use diagnoses and diagnoses related to volatile solvents or cocaine. Especially the number of treatment periods for polydrug use is notable (see e.g. chapter 3.4.).

Figure 28

Treatment periods for cannabis and mental disorders

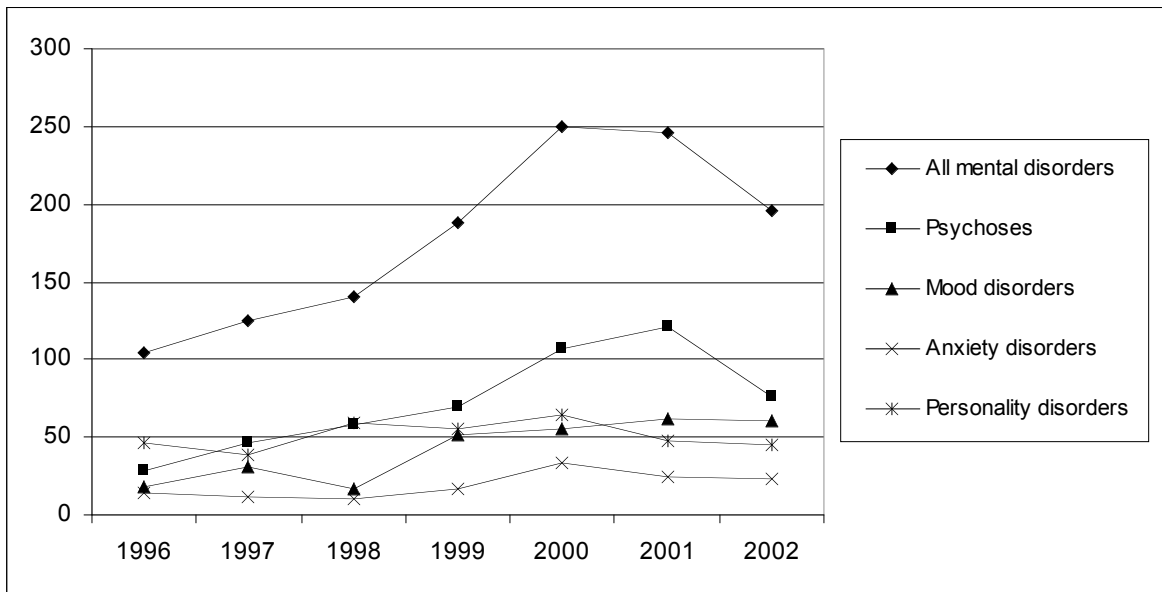
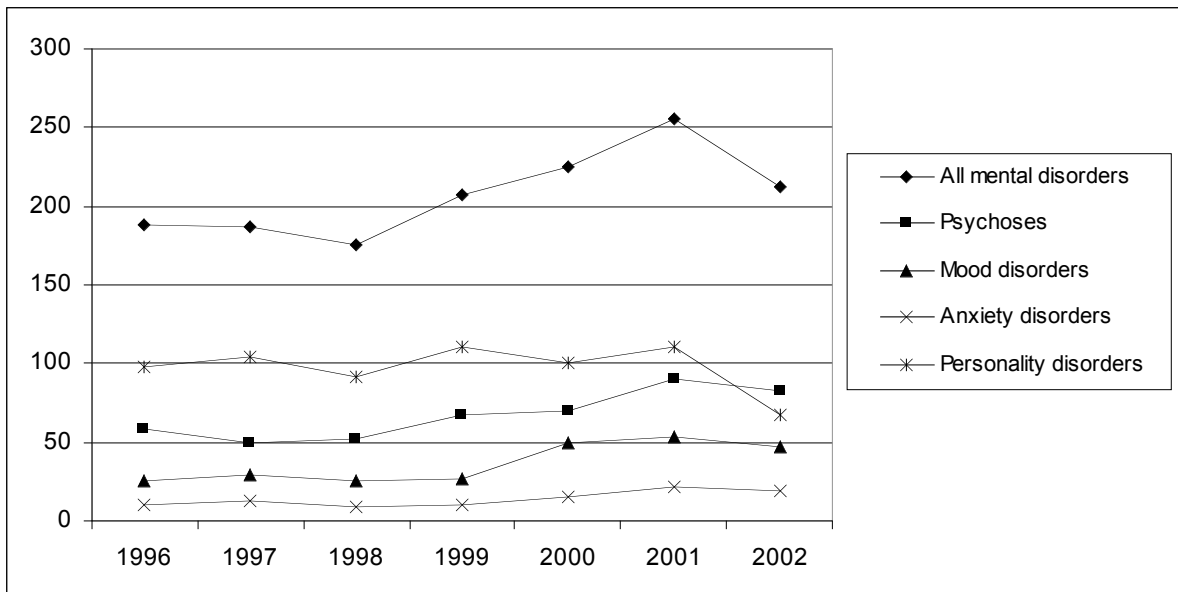


Figure 29

Treatment periods for stimulant (amphetamines) and mental disorders



Because only a modest increase occurred in the overall number of hospital treatment periods provided by the health system during the period studied, our observations of the increases in dual diagnosis periods indicate a real change in both absolute and relative proportion of these hospitalisations provided. While this observation based on register information may also have been affected by some interfering factors – most notably changes in the classification system or possible trends in diagnostic practices – the finding is compelling in suggesting a significant increase in the treatments given to dual diagnosis patients. It

should furthermore be noted that, during the period monitored, the number of psychiatric beds constantly declined (Tuori et al. 2000).

The growth in the number of drug-related dual diagnoses, established here, is consistent with observations of increases in illicit drug experimenting and use, which have evidenced identical trends over time, including the levelling off that occurred in recent years. However, these observations were derived from the study on youth intoxicant habits, conscript surveys and other such investigations, whose target populations presumably differ from those retrieved from the discharge register (Seppälä 2003). To date, no Finnish studies on drug-related dual or multiple disorders in the population or treatment materials have been conducted.

21.2 Impact of psychiatric co-morbidity on treatment services and staff

The treatment of patients suffering from co-occurring drug dependence and other mental disorders is exceptionally demanding and often unrewarding. Comorbidity manifests itself as disproportionate and varied symptoms, impaired functioning, treatment resistance, and special needs that the care system geared towards more limited symptoms has difficulty to meet (Kessler et al. 1996). For example, people with severe mental health disorders typically require a wide range of support measures having to do with housing and everyday life. These patients not infrequently end up in various nursing or rehabilitation homes, peopled by similarly afflicted clients (Willberg 2002). However, these services are not very suitable for clients who at the same time consume illicit drugs, who do not adapt to the everyday routine, who are prone to have problems with other residents and personnel and who gravitate towards antisocial networks.

Responsibility for treating drug problems has been offered to many agencies and organisations, including the third sector, despite the fact that what is needed is medical expertise in particular as well as integration and seamless co-operation within the public service system in a situation where the options of prevention and early intervention in case of one demanding patient group already seem to have run out. International experiences support the observation that the treatment of dual diagnosis patients solely in substance abuse services or mental health services is often fruitless, whereas integrated treatment programmes have turned out more effective (Drake et al. 1998).

21.3 Treatment service provision

The increase in dual diagnosis in-patient periods, on the scale established already today, draws attention to the need for service system development. Given the decline in psychiatric hospital care since the 1980s

and the growth in treatments for dual diagnoses, it is fair to ask whether the cutbacks imposed on the service system were justified. Be that as it may, this trend is certainly problematic for patients with multiple disorders (Tuori et al. 2000). As a result of the recession in the 1990s, specialised substance abuse services underwent downsizing as well, while no corresponding and significant structural reforms were carried out in community substance abuse services.

With the downsizing of psychiatric hospitals, the treatment of substance abuse problems became an attractive option for the hospitals. The psychiatric hospitals did not, however, assume a major role in substance abuse treatment because the local authorities declined to pay for 'expensive' hospital treatment. More responsibility was given to primary health care and social services, while in specialised services, 'low-threshold' treatment units and services were set up for deprived clients. This entailed more responsibility to be transferred to health care. Finding a payer for need-based treatment for clients with substance abuse problems was hard, as seen in the fact that in the late 1990s, clients started to stand up for their rights, supported by the Substance Abuse Ombudsman. When processing complaints, the State Provincial Offices reached the conclusion that clients with substance abuse problems had a subjective right to treatment but not necessarily to the treatment they have sought or that was recommended for them by experts. (Murto 2002).

Many reports and statements concerning drug policy and treatment system development were issued especially in the late 1990s, but they have mainly concentrated on the prevention of drug problems or the pharmacological treatment of drug addiction, while largely ignoring the more demanding patient group with multiple problems due to co-morbid mental disorders. In terms of the service provision, the report of the committee group on developing treatment for drug abusers (2001) stated that the use of psychiatric services in treating drug addicts must be solely based on the need for psychiatric expertise. Specialised psychiatric services should enhance their readiness to support primary health care and the social services through consultancy and supervision. Illicit drug users manifesting psychotic disorders should be referred to specialised psychiatric services for assessment. Dual diagnosis units specialising in the identification and care of co-occurring addictive and other mental disorders should be established in university hospitals and possibly in other central hospitals as well. On the other hand, addiction to psychopharmaceutical drugs should be primarily treated in specialised psychiatric services.

Since the late 1990s, the Finnish Slot Machine Association has supported the development of new drug addiction treatment services. In 2002 and 2003, the Ministry of Social Affairs and Health granted 7.5 million euros respectively for the same purpose. The allocation criteria underline service referral for those suffering from serious drug problems, more efficient treatment and rehabilitation, intensified detoxification, substitution and maintenance treatment for opioid addicts as well as the overall development of the service system, curative action and work practices. As yet there is no information whether these funds have been used to develop treatment for co-occurring drug problems and psychiatric

disorders. It is apparent that the growth in this client segment calls for service system development by enhancing not only resources but also knowledge and care organisation. The question to be addressed at this juncture is the one dealing with the level of organisation in services for substance abusers and addiction psychiatry, i.e., whether the treatment of those suffering from drug addiction and other mental disorders requires special expertise that should be concentrated in specific units (APA 1995; Drake et al. 1998).

21.4 Examples of best practices and recommendations for future policy

Various sources estimate that it typically takes about 3–5 years after the first drug experiments for psychosocial problems to mount and lead to treatment need (Virtanen 2003). The results of the drug surveys conducted are consistent with the increase in the number of hospital treatment periods due to dual diagnoses. It is likely that the survey information about increased use is not directly related to the growth in dual diagnoses now established, since patients with severe and multiple problems probably belong to a group that is hard to reach by studies and surveys and – also from a treatment viewpoint – is identified several years too late. It is a fair assumption that materials based on discharge reports included the homeless and excluded as well as people with multiple problems, often not covered by population surveys. Nevertheless, it seems that the established surveys concerning methods of drug use and experiments yield information consistent with the register study now carried out and serve as a kind of problem indicator. Thus, the surveys may provide useful information about drug use and severe problems, but they do not actually give information about changes in treatment need. Moreover, research should be further developed especially on demanding drug clients with severe symptoms and multiple disorders.

On the whole, actions to treat drug addiction are faced with a wide range of challenges. Preventive actions taking account of social support, low-threshold units enabling early and later-stage treatment initiation, provision of pharmacological and psychosocial treatments for drug addiction and the treatment of the most demanding patients, i.e. those suffering from co-morbid disorders – all these are important aspects of the treatment and service system for people with drug problems or addiction. As the service system is confronted with new challenges, expertise in addiction psychiatry should be endorsed through education and by setting up units specialising in addiction psychiatry.

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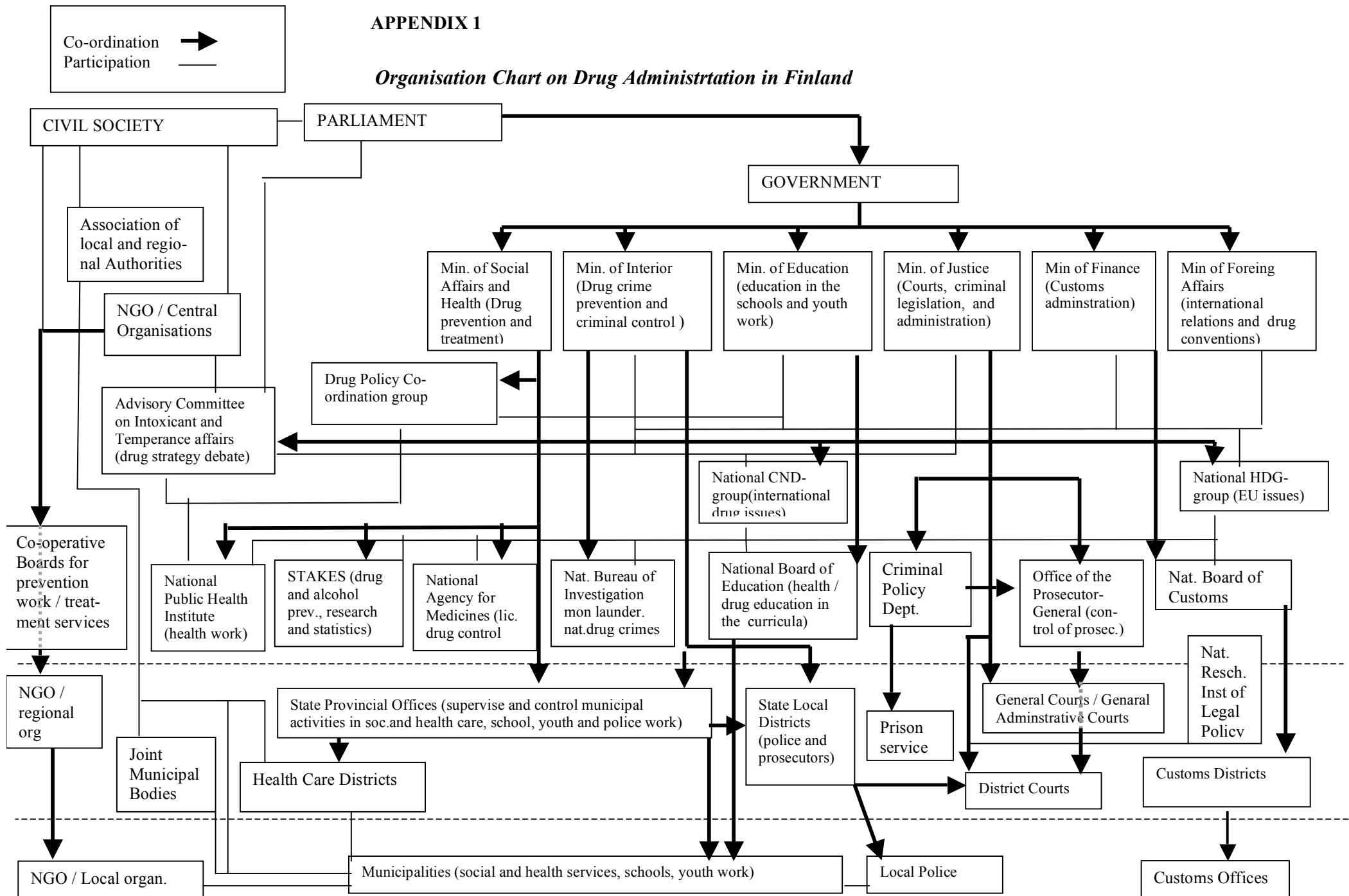
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APPENDIX 1

Organisation Chart on Drug Administration in Finland



APPENDIX 2. Administration of international drug issues in Finland

	Ministry of Social Affairs and Health	Ministry of the Interior	Ministry of Justice	Ministry of Foreign Affairs	Ministry of Finance	Other Actors	Activities
United Nations							
CND	Ministry, National Agency for Medicines	Ministry, Nat. Bureau of Investigation	Ministry	Ministry			UN's Commission on Narcotic Drugs (makes decisions on a global level on international drug questions: selection of substances, control actions, money laundering etc.)
INCB	National Agency for Medicines	Nat. Bureau of Investigation			Nat. Board of Customs		UN's International Narcotics Control Board (supervises compliance with the UN Narcotics Conventions)
Dublin Group				Ministry			A UN body for preparing drug issues, based on an OECD composition
Major donor countries				Ministry			Major contributors to the United Nations International Drug Control Programme (UNDCP) (recommendation: USD 500,000 per year)
WHO	Ministry, Nat. Agency for Medicines, Nat. Public Health I.						Proposes new narcotic substances to the lists incorporated in drug conventions
HONLEA		Nat. Bureau of Investigation			Nat. Board of Customs		Unofficial collaborative body of law enforcement agencies
Other international organisations							
Interpol		Ministry, Nat. Bureau of Investigation					Collaborative body in police work. Co-operation takes place with national authorities as well (the Drug Enforcement Agency, DEA, of the USA)
WCO					Nat. Board of Customs		World Customs Organisation
FATF	National Agency for Medicines	Nat. Bureau of Investigation			Customs		Precursor control
European Union							
Horizontal Group on Drugs	Ministry	Ministry		Ministry			EU's intersectorial body preparing and co-ordinating drug questions
EUROPOL		Ministry, Nat. Bureau of Investigation			Nat. Board of Customs		European Police Office
EMCDDA	Ministry, STAKES						Drug Monitoring Centre of the European Union. In charge of drug data compilation and harmonisation. Operates

							through the REITOX network of national centres
Precursor committee	National Agency for Medicines	Nat. Bureau of Investigation			Customs		Precursor committee of the European Commission
Drug research networks	STAKES, National Public Health Institute		National Research Institute of Legal Policy			A-Clinic Foundation, Centre for Health Promotion, Helsinki University Central Hospital, NAD, Youth research etc.	Networks in the EU's Fifth research and development programme and e.g. projects operating under the public health programme
Council of Europe							
Pompidou Group	Ministry, STAKES	Ministry, National Bureau of Investigation				Ministry of Education	Administrative body formed by President Georges Pompidou of France to handle drug issues in Europe. The meeting of Permanent Correspondents a key means of operation
Co-operation with neighbouring areas							
Bilateral relations		Ministry, Nat. Bureau of Investigation			Nat. Board of Customs		Anti-crime activities and customs agreements with Russia and the Baltic countries as main activities
Nordic co-operation							
Nordic Council of Ministers	Ministry	Ministry	Ministry		Nat. Board of Customs	Ministry of Education	Meetings on drug issues between Ministers
Drug committee	Ministry	Ministry	Ministry		Nat. Board of Customs		Multiadministrative forum for exchange of drug information
NAD	Ministry, STAKES						Nordic Council for Alcohol and Drug Research
PTN co-operation		Ministry, Nat. Bureau of Investigation, Boarder Guard			Nat. Board of Customs		Drug co-operation network of Nordic control authorities, with 18 liaison officers in Europe

APPENDIX 3. National drug information system¹⁸⁰

Epidemiology

Use

Schoolchildren		
<i>Survey (implementer)</i>	<i>Criteria</i>	<i>Statistical period</i>
School health study (STAKES, Tampere university et al.)	Municipality-specific (voluntary) 8 th & 9 th year comprehensive school 2 nd year upper secondary school and 2 nd year vocational institutes	Annual surveys (drug questions since 1996)
ESPAD (STAKES)	Sample survey; 8th & 9th year comprehensive school	Every 4th year (1995, 1999, 2003, ...)
Young people		
Young people's health habit study (Tampere School of Public Health, STAKES)	Sample survey (postal) 12-18 –year-olds	Every 2nd year (question about drug use in immediate circle since 1991, 1993, ...,2003, ..)
Conscript survey (Defence Staff)	Sample survey (interview) Conscripts	First in 1968, at a few years' interval, now annually (1998, 1999, 2000)
Population surveys		
Drug survey (STAKES)	Sample study (postal)	1998, 2002 (every 4th year)
Drugs in Finland (Ministry of Social Affairs and Health, Helsinki University Department of Public Health Science)	Sample study (postal)	1992, 1996
Drinking habit study (STAKES)	Sample study (postal and interview), in future only postal version	Every 8 th year (related drug survey in 1992 and 2000), separate alcohol survey 2004.

Treatment

<i>Statistics (Agency responsible)</i>	<i>Criteria</i>	<i>Statistical period</i>
Hospital Patient Discharge register (STAKES)	Personal register ICD-10 diagnoses (since 1996)	Annual statistics
Register of Residential Social Welfare Facilities (STAKES)	Personal register, Residential treatment units for substance abusers. (ICD-10-code voluntary)	Annual statistics (since 1996)
Register of infectious diseases (National Public Health Institute)	Personal register HIV (iv-use specified) hepatitis C	Monthly statistics (hepatitis C register since 1998)
Drug treatment information system (STAKES)	No personal identification Voluntary data collection Pompidou/TDI model (substance-specific)	Pilot stage (1996, 1998, 1999, 2000, 2001, 2002). Covers the entire year since 2000
Census of intoxicant-related cases	No personal identification	Every 4 th year

¹⁸⁰ The bulk of drug information in Finland is collected in a centralised manner from information systems as a part of broad data compilation. National and centralised data collection is typical of Finnish up-to-date information compilation. The information in this Table is based on regular and continuous data collection and periodical studies. The information systems are divided into three categories: epidemiological information (on use and harmful effects), project information concerning demand reduction as well as information about libraries and information services.

(STAKES)	One-day count in all social and health service units. Problem substances (no primary drug)	(1995, 1999, 2003, ...)
Substance abuse service statistics (A-Clinic Foundation)	Treatment periods of clients in (mainly outpatient) services for substance abusers No personal identification Not substance-specification	Annual statistics (since 1986)

Legal control

Legally used and produced drugs		
<i>Statistical basis (Agency responsible)</i>	<i>Criteria</i>	<i>Statistical period</i>
Supervision of trade, export and import of drugs (National Agency for Medicines)	Licences, audits	Annual statistics
Drug prescription control (Nat. Board of Medicolegal Affairs & Nat. Agency for Medicines)	Prescription monitoring at pharmacies (personal register)	Annual statistics
Use, sale, storage and other handling of precursors as well as import and export (Customs, National Agency for Medicines)	Authorisation, duty to report	Annual statistics
Illegally used and produced drugs		
Persons suspected of (narcotic) offences (Police IT Management Agency, the Customs, Statistics Finland)	Offence reports (personal register)	Annual (perhaps also semi-annual) statistics.
Drug seizures (Police IT Management Agency, The Customs, Statistics Finland)	Offence reports	Annual statistics
Drug offences (Statistics Finland)	Offence reports	Annual and quarterly statistics
Drug sentences (Statistics Finland)	Persons accused and convicted in courts of first instance (personal register)	Annual statistics
Recidivism register (Statistics Finland)	Persons accused and convicted in courts of first instance	Annual statistics
Driving under the influence of drugs (National Public Health Institute & Ministry of the Interior)	Personal register Chemical drug findings Investigation request by the police	Annual statistics

Deaths

Drug deaths		
<i>Statistics (Agency responsible)</i>	<i>Criteria</i>	<i>Statistical period</i>
Cause of death statistics (Statistics Finland)	Primary cause of death according to ICD-10 classification (personal register)	Annual statistics
Drug-related Deaths		
Forensic examination of cause of death (Department of Forensic Medicine, Helsinki University)	Chemical findings in autopsies (personal register)	Annual statistics

Demand reduction

Project information

<i>Compiler</i>	<i>Criteria</i>	<i>Outcome</i>	<i>Source/address</i>
Finnish Slot Machine Association	Project allocations granted (theme: temperance work and promotion of substance abuse services)	Small-scale Internet Database	http://www2.ray.fi/avustustoimavustuskohteet/avustuspaatos2004.php?l1=5
A-Clinic Foundation	Foundation's project register	Internal Project database	Foundation's central office, questions: www.a-klinikka.fi)
STAKES	Project database on drug prevention projects, municipal drug strategies and treatment centres	Internet database	http://www.stakes.fi/neuvoa-antavat/
STAKES	International demand reduction database	European Internet drug database at EMCDDA	http://www.emcdda.org/responses/methods.shtml
Ministry of Labour	Projects of the EU's Social Fund	Internet database	http://www.teho.net/esr/index.html
Finnish Centre for Health Promotion	Projects on preventive drug work	Internet database	http://www.health.fi/paihde/hankerekisteri/
Ministry of the Interior ESF	EU's Regional and Structural Fund projects	Internet database	https://fimos2k.atbusiness.com/
Other organisational databases	Drug database index	Reference database	See e.g. http://www.makupalat.fi/sospoli5.htm
Etc.			

Libraries and information services

Libraries and information services	Material	Contact information
STAKES Information Service	Literature, periodicals, databases and information services in the field	http://www.stakes.fi/stakestieto/tiipa/
STAKES - Reitox – National Drug Monitoring Centre of Finland	Organisation of drug issues, drug policy, narcotics situation, international drug questions	Annual drug report is located in: http://www.stakes.fi/verkkojulk/
University libraries, esp. National Library of Health Sciences, libraries at Kuopio, Jyväskylä, Turku and Tampere Universities	Literature and periodicals in the field	http://www.lib.helsinki.fi/english/libraries/linna/databases.htm (HELKA) http://kuopus.csc.fi/ (Kuopus) http://jykdok.csc.fi/ (Jykdok) http://volter.csc.fi/ (Volter) http://www.uta.fi/laitokset/kirjasto/e-kirjasto (Tamcat)

Reference databases		
LINDA	Joint and multisectorial database of universities and special libraries with references to literature and periodicals	http://www.lib.helsinki.fi/english/libraries/linnea/databases.htm
ARTO	Joint and multisectorial database of universities and special libraries with references to Finnish articles	Available free of charge at university libraries; Elsewhere, subject to charge (ID and password required)
MEDIC	Finnish medical database produced by the National Library of Health Sciences	Http://vertex.helsinki.fi Available free of charge at Helsinki University libraries; Elsewhere, subject to charge (ID and password required)
ALEKSI	Finnish multisectorial article reference database of BTJ/library services. Also newspaper articles included	Http://www.btj.fi Subject to charge (ID and password required)

Electronic services on the Internet		
Alcohol, narcotics and other intoxicants, virtual library	Virtual library produced by the STAKES Information Service, with links to webpages of national organisations and research institutions in the field as well as international links	http://www.jyu.fi/library/virtuaalikirjasto/roads/paiheng.htm
STAKES: preventive drug work webpages	A website maintained by the Drug Prevention Group at STAKES, disseminating topical information and articles in the field	http://www.stakes.fi/neuvoa-antavat
Drug link	Webpages maintained by the A-Clinic Foundation on intoxicants, drug use and services. Includes interactive discussion forums	Http://www.paihdelinkki.fi
Antidrugnet	Drug data base for schools and homes maintained by the Board of Education and the Blue Ribbon Society.	http://www.antidrugnet.org

Kokototuus/Puolitotuus	Database on drugs (kokototuus) and related interactive discussion forum (puolitotuus) maintained by the Finnish Centre for Health Promotion	http://www.kokototuus.com/faktat/index.html http://www.puolitotuus.com/etusivu.html
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National Drug Monitoring Centre of Finland¹⁸¹

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

¹⁸¹ At a national level, information collection concerning the narcotics situation and drug policy is co-ordinated by the the Ministry of Social Affairs and Health. The National Drug Monitoring Centre co-ordinates the preparation of important national drug reports. For international drug issues and reporting, the Ministry has appointed a working group. All agencies and information providers (such as the Customs, the National Bureau of Investigation, the National Agency for Medicines, the National Public Health Institute, STAKES, etc.) also provide statistical information directly for international bodies, such as the United Nations, the European Union, the Council of Europe, the Nordic Council of Ministers, etc. Also non-governmental (national) organisations (the Finnish Centre for Health Promotion, the A-Clinic Foundation, the Free From Drugs Association, etc.) produce regular information for over mentioned and research project purposes.

	by the National Public Health Institute	
EMCDDA/ELDD	European Legal Data base on Drugs	Updating data base, examples of laws implementation
Alcohol and drug reports	Key information channels on drug statistics within STAKES in co-operation with all national information providers	Alcohol and drugs by region (January) Yearbook of Alcohol and Drug Statistics (November)

APPENDIX 4. Actors in drug demand reduction

<i>Actor</i>	<i>Task</i>	<i>Internet address</i>
National Research and Development Centre for Welfare and Health (STAKES)	<ul style="list-style-type: none"> - Preventive drug work, project co-ordination - Treatment unit data base - Support for municipal activities - Drug research - Drug information compilation - Development and communication 	http://www.stakes.fi/neuvo-a-antavat/
National Public Health Institute	<ul style="list-style-type: none"> - Public health work / health promotion e.g. combating infectious diseases 	http://www.ktl.fi/index.en.html
Finnish Institute of Occupational Health	<ul style="list-style-type: none"> - Prevention and treatment of drug-related harms in working life 	http://www.occuphealth.fi/e/
Unit of youth affairs, Dept. Of Cultural Policy, Ministry of Education	<ul style="list-style-type: none"> - Harmonisation of youth policy measures - Living conditions of youth 	Http://www.minedu.fi/opm/nuoriso/index.html http://www.nuoret.org/
National Board of Education	<ul style="list-style-type: none"> - Plans the national syllabus (including health education and temperance work) 	http://www.oph.fi/english/SubPage.asp?path=447;490
Prison Administration	<ul style="list-style-type: none"> - Provides and develops drug treatment services for prisoners 	http://www.vankeinhoito.fi/14994.htm
State Provincial Offices	<ul style="list-style-type: none"> - Supervise drug prevention and social and health services (incl. substance abuse services) in municipalities 	http://www.laaninhallitus.fi/
Health care districts	<ul style="list-style-type: none"> - Regional collaborative bodies in specialised health care, providing health care services for municipalities 	http://www.fimnet.fi/linkit/Laaketiede/Sairaanhoitopiirit/
Centre for Occupational Safety, expert group on temperance issues	<ul style="list-style-type: none"> - Develops temperance work to maintain employees' working capacity and implements actions to prevent alcohol and drug harms, in accordance with the recommendations of labour market organisations. 	http://www.tyoturva.fi/
Finnish Centre for Health Promotion	<ul style="list-style-type: none"> - Co-ordinates organisational projects through the forum of preventive drug work - Acts as co-ordinator of project funding for drug prevention of the Ministry of Social Affairs and Health 	Http://www.health.fi/paihd/index.html
A-Clinic Foundation	<ul style="list-style-type: none"> - Provides treatment, information, training and R&D services 	www.a-klinikka.fi
Municipal network of addiction contact authorities	<ul style="list-style-type: none"> - Municipal co-operation network run by the STAKES 	http://www.stakes.fi/neuvo-a-antavat/Pia/index.html
Co-operation forum of preventive substance abuse work	<ul style="list-style-type: none"> - Forum of NGOs run by Finnish Centre of Health Promotion 	http://www.health.fi/paihd/foorum/index.html

Co-operation forum of treatment services for substance abusers	- Forum of NGOs (PÄIVYT)	http://www.kalliola.fi/fi/sisalto/paihde-tyo/paivyt
Other organisations in the field	- Actors in preventive and curative drug work	See e.g. http://www.makupalat.fi/so/spolis.htm

APPENDIX 5 Actors in drug supply reduction

<i>Actor</i>	<i>Task</i>	<i>Internet address</i>
National Agency for Medicines	<ul style="list-style-type: none"> - Authorises production, import and export of substances classified as narcotics - Prescription practices for medicines classified as narcotics - Supervision of use and sale of legal drugs - Controls legality of the import and export of precursors used in producing drugs 	Http://www.nam.fi/index.html
National Board of Medicolegal Affairs	<ul style="list-style-type: none"> - Supervises drug prescriptions - Controls medical practice and prescription of medicines classified as narcotics 	http://www.teo.fi/
National Bureau of Investigation	<ul style="list-style-type: none"> - Co-ordinates national cases of drug offences - Operates the Money Laundering Clearing House - Maintains the Crime Laboratory 	For more information, http://www.poliisi.fi/poliisi/home.nsf/pages/index_eng
National Board of Customs	<ul style="list-style-type: none"> - Co-ordinates national and international contacts - Five customs districts are in charge of regional customs administration - Maintains the Customs Laboratory 	http://www.tulli.fi/english/index.html
Office of the Prosecutor-General	<ul style="list-style-type: none"> - Supervises the prosecutorial authority under the Ministry of Justice 	http://www.oikeus.fi/vksv/2442.htm
District courts	<ul style="list-style-type: none"> - Responsible for local jurisdiction 	http://www.om.fi/333.htm Http://www.om.fi/115.htm
State Local Districts	<ul style="list-style-type: none"> - In charge of local police work - Prosecutors working independently of the police 	http://www.intermin.fi/en Http://www.intermin.fi/intsecurity.html
State Provincial Offices	<ul style="list-style-type: none"> - Police division supervises local police administration 	http://www.laaninhallitus.fi/lh/home.nsf/pages/index_eng
Police College of Finland	<ul style="list-style-type: none"> - In charge of police education - Monitors projects - Conducts research 	For more information, http://www.poliisi.fi/pakk
National Research Institute of Legal Policy	<ul style="list-style-type: none"> - Conducts criminological research under the Ministry of Justice 	http://www.om.fi/optula/2664.htm
Prison Administration	<ul style="list-style-type: none"> - Administers prisons under the Ministry of Justice 	http://www.vankeinhoito.fi/14994.htm

APPENDIX 6

COUNTRY		Finland													
Year:	2002	All treatments						First treatments							
		M		F		T	M		F		T				
Treatment cases/demands (Number)		2480		1015		3497		706		279		986			
Sex distr. (%) Male / (%) Female		71		29		100		71,7		28,3		100			
Mean age (Years)		25,8		24,8		25,5		23,1		22,1		24,8			
Age distribution		<15		0,3		0,6		0,4		0,6		1,1		0,7	
		15-19		19,1		27,6		21,6		34,5		43,7		37,2	
(%)		20-24		34,4		36,7		35,1		36,4		33,3		35,5	
		25-29		20,5		14,2		18,6		14,2		11,5		13,4	
		30-34		12,3		7,9		11		7,1		3,9		6,2	
		35-39		6,8		5,2		6,3		4		1,8		3,4	
		40-44		3,2		3,6		3,3		1,4		1,8		1,5	
		45-49		2,5		2,6		2,5		1,1		2,2		1,4	
		50-54		0,7		0,8		0,7		0,4		0,4		0,4	
		55-59		0,2		0,3		0,2							
		60-64		0,1		0,5		0,2		0,1		0,4		0,2	
		>= 65		0		0,1		0,1		0,1				0,1	
Number of cases with missing inform. on age		3		0		3		2						2	
Injection behaviour		-----													
Currently injecting any drug (%)		52,4		50,2		51,7		40,1		37,1		39,2			
Ever injected any drug but not currently (%)		24,6		24		24,4		14,2		15,6		14,7			
Ever injected any drug (%)		76,9		74,2		76,1		54,3		52,7		53,8			
IV route of ad. main drug (%)		56,5		59,2		57,3		38,4		39,7		38,7			
Main drug (%) - (% IV use)		dr.	IV	dr.	IV	dr.	IV	dr.	IV	dr.	IV	dr.	IV		
		%	%	%	%	%	%	%	%	%	%	%	%		
Opiates (total)		34,6	87,7	33,2	86,9	34,1	87,5	22,9	81,9	16,1	86,4	21	82,8		
Heroin		6,5	93,6	5,6	90,9	6,2	92,9	2,8	90	2,2	na	2,6	88		
Methadone (any)		0	na	0,1		0,1	na								
other opiates		28,1	86,3	27,5	86,4	27,9	86,3	20,1	80,7	14	87,2	18,4	82,1		
Cocaine (total)		0,2	na			0,2	na	0,4				0,3			
Cocaine CIH		0,2	na			0,2	na	0,4				0,3			
Crack															
Stimulants (total)		32,6	80,1	41,9	72,1	35,3	77,4	28,5	69,2	47,7	54,3	33,9	63,3		
Amphetamines		31,6	81,1	39,9	73,8	34	78,7	26,8	71,7	44,4	56,7	31,7	65,8		
MDMA and derivates		0,5		0,9		0,6		1,3		1,8		1,4			
other stimulants		0,5	na	1,1	na	0,7	na	0,4	na	1,4	na	0,7	na		
Hypnot. and sedat. (total)		6	2,7	8,5	2,4	6,7	2,6	3,3	4,3	5,7		4	2,7		
Barbiturates															
Benzodiazepines		6	2	8,1	2,5	6,6	2,5	3,3	4,3	5		3,8	2,9		
others		0,1	na	0,4		0,2	na			0,7		0,2			
Hallucinogens (total)		0,1	na			0,1	na								
LSD		0,1	na			0,1	na								
others															
Volatile inhalants (total)		0,3		0,4		0,3		0,6		1,1		0,7			
Cannabis (total)		25,8		15,8		22,9		43,8		28,7		39,6			
Others substance (total)		0,4	na	0,3	na	0,3	na	0,6	na	0,7	na	0,6	na		

APPENDIX 7 ICD-9 Substance	Acute intoxic./ harmful use	Depen- dence syndro- me	Substance induced brain syndrome	Substance abuse total	Poisonings by drugs and medicaments	Diseases of the liver	Diseases of the pancreas	Cardio- myo- pathy	Gastri- tis	Other drug and medicament related syndromes	Substan- ce use and treatment	Harms Total	Others
Alcohol	3050A	303	291		980	5710A- 5713X	5770D-F, 5771C-D	4255A	5353A	2650A, 3575A,5307A	---		7607A, 6484A
Opiates	3055A	3040A	292& E935A-F, E935W		9650A-X, 9658X	---	---	---	---	---	---		(7607X, 6283A)& E935A-F, E935W
Substitute treatment	---	---	292& E940B		9701A	---	---	---	---	---	---		(same)& E940B
Cannabis	3052A	3043A	---		---	---	---	---	---	---	---		---
Cocaine	3056A	3042A	292& E938F		9685A	---	---	---	---	---	---		(same)& E938F
Stimulants	3057A	3044A	292& E939H,L		9697A,B,X	---	---	---	---	---	---		(same)& E939H,L
Hallucinogens	3053A	3045A	292& E939G		9696A	---	---	---	---	---	---		(same)& E939G
Drugs total										E935A-F, E935W E938F, E939G,H,L, E940B - (292, 3040A-5A, 3052A-7A, 965, 967, 9690A-7X, 9701A)			
Sedatives and tranquillizers	3054A,	3041A,	292& E937, E939E-F		967, 9694A-5X	---	---	---	---	E937, E939E-F - (see prev. cell)	---		(same)& E937, E939E-F
Polydrug use	3059X	3049X	292 - (292/ (E-codes above)										
Non-dependence producing substances	---	---	---		9651A-7A,9X 9690A, 9691A-3X, 9698X-9X	---	---	---	---	E935G-U, E935X, E939A-D - (see previous cell)	---		(same)& E935G-U E935X, E939A-D
Medicaments total													
Medicaments and drugs total													7607X, 6483A

In the Finnish ICD-9 system there does not exist codes 304.7-.8, 305.8 and letters can be used to differentiate codes (e.g. 9650A = codeine, 9650B = Methadone etc.). Also the codes may have different interpretation e.g. 965.8 and E935W (incl. also dekspropoxifen and pubrenorfin), E935A-F = E935.0 (Who), E939E = E939.4 (Who [and F=5, G=6, H-L=7]), E940B = E940.1 (Who).

APPENDIX 8 ICD-10	Acute intoxic./ harmful use	Dependenc e syndrome	Substance induced brain syndrome	Subs-tance abuse total	Poisonings by drugs and medica-ments	Diseas es of the liver	Diseases of the pancreas	Cardio- myopath y	Gastritis	Other drug and medicament induced syndromes	Substance use and treatment	Harms total	Others
Substance													
Alcohol	F10.0-.1	F10.2	F10.3-.9		T51	K70	K86.0	I42.6	K29.2	E24.4, E52, G31.2, G62.1, G72.1	R78.0, Z50.2 Z71.4, Z72.1		O35.4, Q86.0, P04.3
Opiates	F11.0-.1	F11.2 (excl. F11.22-.23)	F11.3-.9		T40.0-4, 6 (T36& N01AH/N02A)	---	---	---	---	---	R78.1		---
Substance treatment	---	F11.22-.23	---		T50.7 (no 1999 ->)	---	---	---	---	---	---		---
Cannabis	F12.0-.1	F12.2	F12.3-.9		T40.7	---	---	---	---	---	---		---
Cocaine	F14.0-.1	F14.2	F14.3-.9		T40.5	---	---	---	---	---	R78.2		---
Stimulants	F15.0-.1	F15.2	F15.3-.9		T43.6 (T36&A08)	---	---	---	---	---	---		---
Hallucinogens	F16.0-.1	F16.2	F16.3-.9		T40.8-.9	---	---	---	---	---	R78.3		---
Drugs total													
Sedatives and tranquillizers	F13.0-.1	F13.2	F13.3-.9		T42.3-.4, T42.6-.7 (T36& N01AF/N03AE/ N05BA-BB/N05C)		---	---	---	---	R78.4		---
Polydrug use	F19.0-.1	F19.2	F19.3-.9										
Non-dependence producing substances	---	---	---	F55 (& N02B/ N05A/ N06)	T39, T43.0-.2, T43.3-.5, T43.8 -.9 (T36& N02B/N05A/N06)		---	---	---	---	R78.5		---
Medicaments total													
Drugs and medicamens total											R78.1-.5 Z50.3 Z71.5 Z72.2		O35.5, P04.4, P96.1

* = F55 and T36 are from 1998 on combined with ATC-drug codes that are referred in the table with A* and N* figures. These new codes in parenthesis (e.g. F55&N02B/N05A/N06) will in future replace old ICD-10 codes written in the cells. During 1998 and 1999 both codes were in practise still used simultaneously or e.g. T36 code is used without ATC-specification, which in the report is defined as "non-substance specific poisoning" (which probably includes several drug/sedative poisoning cases)

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