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# Drug Situation in Finland 2011

REPORT





European Monitoring Centre  
for Drugs and Drug Addiction



NATIONAL INSTITUTE  
FOR HEALTH AND WELFARE

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by the Reitox National Focal Point, THL

**FINLAND**  
**DRUG SITUATION 2011**  
New developments, trends and in-depth  
information on selected issues

**REITOX**

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## Foreword

*Finland – Drug Situation 2011* is an annual drug report by the Finnish National Focal Point. The report consists of two parts. Part A discusses the latest developments and research data from recent years, mainly focusing on 2010 and early 2011. The drug situation is described from the perspectives of legislation, policies, use, harm, treatment and other interventions, and the drug issue is approached from the health, social and criminal points of view. Part B discusses selected issues related to drugs; this year, the issues discussed are *Health correlates and consequences in prison* and *Problem drug use by parents of underage children and by pregnant women*.

Senior Specialist Ulla Knuuti from the Criminal Sanctions Agency wrote chapter 11 about drug use and health care services in prison. Research scientist Anna Leppo from the University of Helsinki and Senior Planning Officer Elina Kotovirta from the National Institute for Health and Welfare wrote chapter 12 about problem drug use by parents of underage children and by pregnant women. The report was compiled and the remaining sections written by Senior Planning Officers Hannele Tanhua and Ari Virtanen at the Finnish National Focal Point, which operates at the National Institute for Health and Welfare. Also, researchers Sarianna Wilppula from the National Bureau of Investigation and Heini Kainulainen from the National Research Institute of Legal Policy contributed substantially to the editing of chapters 9 and 10.

Several experts contributed to and provided helpful comments on the preparation of the report (Appendix 1). We extend our warmest thanks to everyone involved in the preparation of the report. The report has been approved by the editorial board of Printed Products, Information, THL, as well as the working group on international co-operation on drug issues. The report is available in Finnish in print and online, and in English online. We would like to extend special thanks to Semantix language services for the translation of this report.

*Finland – Drug Situation 2011* is one of the national annual reports compiled by the National Focal Points in the European Information Network on Drugs and Drug Addiction (REITOX) which is coordinated by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). The national reports form the basis for the EMCDDA's annual report *The state of the drugs problem in Europe*.

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## Abstract

Hannele Tanhua, Ari Virtanen, Ulla Knuuti, Anna Leppo, Elina Kotovirta. Finland – Drug Situation 2011. National Institute for Health and Welfare (THL). Report 63/2011. 133 pages. Helsinki 2011. ISSN 1798-0070 (pdf)

Drug use and drug-related problems have remained fairly stable in Finland over the past years. According to the most recent estimates, 0.6% to 0.7% of the population aged 15 to 55 are problem drug users. Nearly four fifths of problem drug users used amphetamines. The percentage of men was almost 80%. A new challenge is the increased popularity of new psychoactive substances, which pose a health hazard. However, with the revision of the Narcotics Act it is now much easier and quicker to ban any emerging substances.

The most recent data from 2010 show that cannabis experimentation and home growing of cannabis have increased. User percentages were highest in the age group 15 to 34. About 17% of Finns aged 15 to 69 reported that they had tried cannabis at some point in their lives, 4% within the past year. The percentage was slightly higher for men than for women.

The prominent role of alcohol as an additional substance, intravenous use of buprenorphine and co-occurring mental health disorders are typical of Finnish problem drug use. Drug users seeking treatment increasingly name pharmaceutical opioids as their principal substance. Based on data from the 2009 drug use treatment coverage survey, drug use treatment was given to about 13,000 clients. The number of individuals attending substitution treatment in 2010 was estimated at 1,800. According to the 2010 data of the drug treatment information system, the mean age of drug treatment clients was 30 years. Opiates were the primary problem substance of more than half of the drug treatment clients of substance abuse services, followed by stimulants, cannabis and alcohol at about 10% each. Pharmaceuticals were the primary problem substance for 6% of the clients entering treatment. The percentage of buprenorphine as the primary substance of those entering treatment has increased the most in the 2000s, being now about one third. Experts have noted that the funding base for the voluntary treatment system aimed at pregnant women and families with substance abuse problems has deteriorated in recent years, to the point of treatment places being lost; it is therefore harder than ever to gain access to treatment.

The reduction of drug-related harm has been particularly successful in the area of communicable diseases. The number of cases of HIV and hepatitis C infections through intravenous drug use has decreased markedly. The health counselling centres, which among other things provide a needle and syringe exchange service, play a key role in this. Major measures in social welfare and health care services to combat drug use and to reduce drug-related harm will continue to include enhancement of prevention and early intervention together with development of drug addiction treatment services, increased offering of treatment and better coverage of health counselling services.

In the past few years, documented drug-related crime has again been on the increase. In 2010, nearly 20,000 drug-related offences were recorded, an increase of 7% on the previous year. One of the factors explaining the increase in narcotics offences is that home growing of cannabis is becoming more popular. More cases of aggravated narcotics offences were uncovered than in any year in the past decade. The internationalisation of drug-related crime has brought added challenges particularly to the uncovering and pre-trial investigation of aggravated narcotics offences. However, despite these international trends Finland is not a prime target in the worldwide drug trade due to its remote location and relatively small population. Also, there is a very low level of corruption in the police, and society at large is geared towards rooting out organised crime.

There are 28 prisons in Finland, all very different in their size, operating culture, structures and traditions. The exact number of drug users in prisons is not known, but the drug market in prisons is small compared to the drug market on the outside.

**Key words:**

intoxicant analgesics, narcotics offences, drugs, drug-related harm, drug users, drug policy, drug research, substance abuse prevention, public expenditure, consequences, harmful effects of substance abuse, substance abuse treatment, substance abuse culture, substance abuse rehabilitation, substance abuse problems, substance abuse services, substance abuse work, substance abuse services



## Tiivistelmä

Hannele Tanhua, Ari Virtanen, Ulla Knuuti, Anna Leppo, Elina Kotovirta. HuuMETILANNE Suomessa 2011. Terveyden ja hyvinvoinnin laitos (THL). Raportti 63/2011. 133 sivua. Helsinki 2011. ISSN 1798-0070 (pdf)

Huumausaineiden käyttö ja niihin liittyvät ongelmat ovat pysyneet Suomessa viime vuodet melko vakaalla tasolla. Viimeisimmän arvion mukaan vuodelta 2005 huumausaineiden ongelmakäyttäjää arvioitiin olevan 0,6–0,7 % maan 15–55-vuotiaasta väestöstä. Lähes neljä viidestä ongelmakäyttäjistä oli amfetamiinin käyttäjiä. Miesten osuus huumeidenkäyttäjistä oli lähes 80 %. Uutena haasteena on terveydelle vaarallisten aineiden eli niin sanottujen muuntohuumeiden yleistyminen. Uudistetun huumausainelain myötä niiden kieltäminen on kuitenkin huomattavasti helpompaa ja nopeampaa kuin aikaisemmin.

Uusimmat tiedot vuodelta 2010 osoittavat kannabiskokeilujen ja kannabiksen kotikasvatuksen lisääntyneen. Eniten käyttöä esiintyi 15–34-vuotiaiden keskuudessa. Noin 17 prosenttia 15–69-vuotiaista suomalaisista ilmoitti kokeilleensa joskus kannabista, viimeisen vuoden aikana noin 4 prosenttia. Miehet kokeilevat hieman useammin kuin naiset.

Suomalaiselle huumausaineiden ongelmankäytölle tyypillistä on alkoholin vahva asema oheispäihteenä, ruiskuhuumeidenkäyttäjien buprenorfiinin käyttö ja samanaikaiset mielenterveyden häiriöt. Huumehoitoon hakeutuessa ilmoitetaan lääkeaineopioidit yhä useammin eniten ongelmia aiheuttavaksi päihteiksi. Korvaushoidossa arvioitiin vuonna 2010 olevan 1 800 henkilöä. Ilmoitettujen tietojen perusteella huumehoitoa annetaan noin 13 000 henkilölle. Huumehoidon tietojärjestelmän vuoden 2010 tulosten mukaan päihdehuollon huumeasiakkaiden keski-ikä oli 30 vuotta. Ensisijaisina hoitoon hakeutumiseen johtaneina päihteinä yli puolella olivat opiaatit. Noin kymmenesosa hakeutui hoitoon stimulanttien, kannabiksen tai alkoholin takia. Kuusi prosenttia hakeutui hoitoon lääkkeitä takia. Buprenorfiinin osuus hoitoon hakeutuneiden päähuumeena on lisääntynyt 2000-luvulla kaikkein voimakkaimmin ja buprenorfiini onkin päähuumeena jo kolmanneksella huumeasiakkaista. Asiantuntijat ovat kiinnittäneet huomiota siihen, että päihdeongelmallisille perheille ja raskaana oleville naisille suunnatun vapaaehtoisuuteen nojaavan hoitojärjestelmän taloudelliset toimintaedellytykset ovat viime vuosina huonontuneet ja hoitopaikkoja on jopa jouduttu lakkauttamaan, minkä seurauksena hoitoon pääsy on entistä hankalampaa.

Huumeiden käytön aiheuttamien haittojen vähentämisessä on erityisesti onnistuttu tartuntatautiin ehkäisyssä. Ruiskuhuumevälitteisten hiv-tartuntojen ja C-hepatiittitapausten määrät ovat selvästi vähentyneet. Tartuntatautiin ehkäisemiseksi olennaista on ollut terveysneuvontapisteiden toiminta, johon kuuluu esimerkiksi käytettyjen neulojen ja ruiskujen vaihto. Keskeisimpiä sosiaali- ja terveydenhuollon toimenpiteitä huumausaineiden käytön ja siihen liittyvien haittojen vähentämisessä ovat jatkossakin ehkäisevän työn ja varhaisen puuttumisen tehostaminen sekä huumausaineriippuvuuden hoitopalvelujen kehittäminen, hoidon tarjonnan lisääminen ja terveysneuvontatyön kattavuuden varmistaminen.

Muutamien viimeisten vuosien aikana tilastoitu huumausainerikollisuus on ollut jälleen nousussa. Vuonna 2010 kirjattiin lähes 20 000 huumausainerikosta, mikä on seitsemän prosenttia edellisvuotta enemmän. Yksi huumausainerikoksen määrän kasvua selittävä tekijä on kannabiksen kotikasvatuksen yleistyminen. Törkeitä huumausainerikoksia paljastettiin enemmän kuin aiemmin viimeisen kymmenen vuoden aikana kertaakaan. Huumausainerikollisuuden kansainvälistyminen on tuonut lisähaastetta etenkin törkeiden huumausainerikosten paljastamiseen ja esitutkintaan. Kansainvälisestä kehityksestä huolimatta Suomi ei kuitenkaan ole maailman huumekaupan tärkeimpiä kohteita syrjäisen sijaintinsa ja vähälukuisen väestöpohjansa takia. Huumausainetilanteeseen vaikuttaa myös poliisin korruptoitumattomuus ja yhteiskuntajärjestelmä, joka pyrkii järjestäytyneen rikollisuuden kitkemiseen.

Suomessa on 28 vankilaa, jotka ovat kooltaan, toimintakulttuuriltaan, rakenteiltaan ja perinteiltään varsin erilaisia. Huumausaineiden käyttäjien määrää vankiloissa ei tiedetä tarkasti, mutta vankiloiden huumemarkkinat ovat siviilin puolella toimiviin huumemarkkinoihin verrattuna pienet.



**Asiasanat:** huumaavat kipulääkkeet, huumausainerikokset, huumeet, huumehaitat, huumeiden käyttäjät, huume politiikka, huume tutkimus, ehkäisevä päihdetyö, julkiset menot, seuraamukset, päihdehaitat, päihdehoito, päihdekulttuuri, päihdekuntoutus, päihdeongelmat, päihdepalvelut, päihdetyö, päihdehuolto

## Sammanfattning

Hannele Tanhua, Ari Virtanen, Ulla Knuuti, Anna Leppo, Elina Kotovirta. Huumausainetilanne Suomessa 2011. Kansallinen huumevuosiraportti EMCDDA:lle. [Narkotikasituationen i Finland 2011. Nationell årsrapport om narkotikaläget till EMCDDA:]. Institutet för hälsa och välfärd (THL). Rapport 63/2011. 133 sidor. Helsingfors, Finland 2011. ISSN 1798-0070 (pdf)

I Finland har droganvändningen och de därmed förknippade problemen hållits på en tämligen stabil nivå under de senaste åren. Enligt den senaste uppskattningen från 2005 var 0,6–0,7 procent av landets befolkning i åldern 15–55 år narkotikamissbrukare. Nästan fyra av fem missbrukare använde amfetamin. Andelen män av droganvändarna uppgick till nästan 80 procent. Att de hälsofarliga substanserna, de så kallade modifierade drogerna, har blivit vanligare utgör en ny utmaning. I och med den reformerade narkotikalagen går det dock betydligt lättare och snabbare än tidigare att förbjuda sådana.

De nyaste uppgifterna från 2010 visar att provandet på och hemmaodlingen av cannabis har ökat. Användningen var vanligast bland personer på 15–34 år. Av finländarna på 15–69 år uppgav cirka 17 procent att de hade provat på cannabis någon gång och 4 procent att de gjort det under det senaste året. Provandet är något vanligare hos män än kvinnor.

Det finländska narkotikamissbruket kännetecknas av alkoholens starka ställning som kompletterande rusmedel, konsumtion av buprenorfin bland dem som använder intravenösa droger och samtidiga psykiska störningar. De som uppsöker narkomanvård uppger allt oftare opioider för medicinskt bruk som de rusmedel som orsakar mest problem. Sammanlagt 1 800 personer uppskattades genomgå substitutionsbehandling år 2010. På basis av de uppgifter som anmälts ges cirka 13 000 personer narkomanvård. Enligt 2010 års resultat med stöd av informationssystemet för narkomanvården är genomsnittsåldern för de narkotikaberoende klienterna 30 år. Över hälften uppsökte vård på grund av opiater som primärt rusmedel. Cirka en tiondedel uppsökte vård på grund av stimulanter, cannabis eller alkohol. Sex procent uppsökte vård på grund av läkemedel. Bland dem som uppsökt vård har buprenorfinet som huvuddrog ökat allra mest på 2000-talet, och de facto är buprenorfin redan huvuddrog hos en tredjedel av de narkotikaberoende klienterna. Experterna har fäst uppmärksamhet vid att de ekonomiska verksamhetsförutsättningarna för det på frivillighet baserade vårdssystemet för familjer och gravida kvinnor med missbruksproblem har försämrats under de senaste åren och att man har varit tvungen att till och med dra in vårdplatser, vilket har lett till att det är allt svårare att få vård.

I fråga om reduceringen av skadorna till följd av droganvändning har i synnerhet förebyggandet av smittsamma sjukdomar utfallit väl. Hiv som överförs via användningen av intravenösa droger har liksom antalet C-hepatitfall minskat tydligt. Hälsorådgivningarnas verksamhet, som omfattar till exempel utbyte av begagnade nålar och sprutor, har varit av väsentlig betydelse i förebyggandet av smittsamma sjukdomar. De viktigaste vård- och omsorgsåtgärderna för att minska droganvändningen och de därmed förknippade problemen kommer också framöver att vara en effektivisering av det förebyggande arbetet och det tidiga ingripandet samt utveckling av vårdtjänsterna vid narkotikaberoende, ökning av vårdutbudet och trygghet av hälsorådgivningsarbetets omfattning.

Under de senaste åren har den statistikförda narkotikabrottsligheten igen ökat. År 2010 registrerades nästan 20 000 narkotikabrott, vilket är sju procent mer än året innan. En faktor som förklarar det ökade antalet narkotikabrott är att hemmaodlingen av cannabis har blivit vanligare. Antalet avslöjade grova narkotikabrott var större än någonsin tidigare under de senaste tio åren. Narkotikabrottsligheten blir allt mer internationell, vilket har medfört ytterligare utmaningar framför allt i samband med avslöjandet av narkotikabrott och förundersökningen av sådana. Trots den internationella utvecklingen hör Finland på grund av sitt perifera läge och det fåtaliga befolkningsunderlaget inte till världens viktigaste objekt för narkotikahandeln. Narkotikasituationen påverkas också av korrupsionsfriheten hos polisen och samhällssystemet, som arbetar för att utrota den organiserade brottsligheten.

I Finland finns 28 fängelser av mycket olika storlek och med mycket olika verksamhetskultur, strukturer och traditioner. Man känner inte exakt till antalet droganvändare i fängelserna, men narkotikamarknaden i fängelserna är liten jämfört med narkotikamarknaden i det civila.

**Ämnesord:** smärtstillande droger, narkotikabrott, narkotika, narkotikaskador, droganvändare, narkotikapolitik, narkotikaforskning, förebyggande missbruksarbete, offentliga utgifter, konsekvenser, rusmedelsskador, missbrukarvård, rusmedelskultur, missbrukarrehabilitering, missbruksproblem, missbrukartjänster, missbruksarbete

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# A. NEW DEVELOPMENTS AND TRENDS

# 1. National policies and context

Anti-drug activities are largely based on long-term policy choices and the societal structures that steer those choices. Structures for drug prevention consist of drug legislation and strategies on whose basis drug policy and action plans are steered. Anti-drug activities (prevention, treatment, reduction of drug-related harm, curbing of supply) become concrete in the implementation of legislation, strategies and action plans.

Many national approaches and activities are related to international systems and agreements regarding drug policy. The resources allocated have a significant impact on the implementation of drug policy.

## 1.1. Legal framework

### New legislation concerning drugs

In 2010–2011, **two new drug legislation amendments** were prepared. The purpose of these is to outpace EU legislation in the national monitoring of new psychoactive substances. First, MDPV – a drug that has caused a great deal of trouble – was banned by an amendment (595/2010) to the Narcotics Act (373/2008). The amended Narcotics Act entered into force in June 2011. The Act as amended stipulates that in the future the Finnish government may classify new intoxicating substances, i.e. new psychoactive substances, as narcotic drugs at its own initiative. Under the new Act, any new substance entered in the EU early warning system may be nationally classified as a narcotic drug after its health hazards have been evaluated. The manufacture, sale, possession, use and import of such substances can now be prohibited much more quickly by Government Decree. Under the Act as amended, the Finnish government may nationally classify not only new psychoactive substances but also pharmaceuticals as narcotic drugs if their pharmacological properties are equivalent to those of narcotic drugs.

Amendments pertaining to the prevention of drug use were enacted to the **Youth Act** (72/2006) in 2010. Sections on multi-sectoral co-operation in guidance and service networks for adolescents and on outreach youth work were added to the Act. Multi-sectoral co-operation involves both local and central government authorities. The purpose of outreach youth work is for instance to contact young people who need help because of a substance abuse problem and to introduce them to services and other means of support conducive to their growth and independence and to their access to education and the labour market. The Act entered into force on 1 January 2011 (693/2010).

The **Act on Vocational Education** (630/1998), the Act on Vocational Adult Education (631/1998), the Polytechnics Act (351/2003), the University Act (558/2009) and the Criminal Records Act (770/1993) were amended to revise the criteria for not accepting students and to enable institutions to revoke study rights if security concerns so require. Among the amendments were provisions concerning student drug tests. The amendments will enter into force on 1 January 2012 (HE 164/2010).

The **Health Care Act** (1326/2010), which entered into force at the beginning of May 2011, requires preventive substance abuse work in the health care system to be planned and implemented so as to integrate with other local preventive substance abuse and mental health care efforts. The purpose of coordinating services is to improve the potential for substance abusers to receive effective treatment, as substance abuse problems often co-occur with mental health disorders and other health problems. The purpose of mental health services for children and adolescents is to provide help at an early stage in emotional and behavioural disturbances and other mental health problems in childhood and adolescence, which will reduce the probability of them later developing a substance abuse problem.

The **Act on investigating the circumstances of a young person suspected of an offence** (633/2010) entered into force at the beginning of 2011. The purpose of this Act is to effect a survey of the social conditions of the young person in question and the reasons leading to his/her committing an offence, and also the potential for supporting that person in leading a crime-free life.



The **Act on electronic monitoring sentences** (330/2011) will enter into force on 1 November 2011. A person with an electronic monitoring sentence must comply with the daily programme and movement restrictions imposed on him/her. The sentence may involve work, training, rehabilitation or other activities designed to improve functional capacity. The convict is obliged to stay at home at all times when there is no predetermined reason for him/her to go outside. Absolute abstinence from intoxicating substances is also required, and this is monitored through tests.

The **Community Service Act** (1055/1996) was amended (641/2010) to include a requirement not to use drugs while performing community service; this amendment entered into force at the beginning of 2011. In cases of suspected drug use, the convict is required to submit a urine or saliva sample; a positive sample will lead, depending on the situation, to a reprimand, a notification to the prosecutor, or even the discontinuation or denial of community service. Moreover, as of the beginning of 2011 the Community Service Act tripled the availability of activities other than work in community service. A convict may now participate more extensively in rehabilitation and programmes supporting life management skills.

### Definition of drugs

Under the Narcotics Act, the definition of a drug is based principally on international conventions, although a Government Decree may extend the definition of drugs to include substances which it has been decided should be placed under controls pursuant to EU Council Decision 2005/387/JHA on the information exchange, risk-assessment and control of new psychoactive substances. The amendment (373/2008) to the Narcotics Act that entered into force in June 2011 stipulates that in the future the Finnish government may classify new intoxicating substances, i.e. new psychoactive substances, as narcotic drugs at its own initiative.

The Decree on substances, preparations and plants considered as narcotics (543/2008) lists the substances and preparations defined as narcotics in the UN Single Convention on Narcotic Drugs (SopS 44/1994) and the UN Convention on Psychotropic Substances (SopS 23/1967). The names of the substances in the Decree have been updated to correspond to those used in international lists. In addition, the Decree lists substances placed under narcotics control at the community level, including 4-MTA, PMMA, 2C-I, 2C-T-2, 2C-T-7, TMA-2, 1-benzylpiperazine and most recently mephedrone, and also the substances nationally classified as narcotic drugs.

### Narcotics Act

According to the Narcotics Act (373/2008), which entered into force in September 2008,<sup>1</sup> the production, manufacture, import, export, transit, distribution, processing, possession and use of and trafficking in drugs is prohibited, although exemptions are possible for medical, scientific, investigative and control purposes.

Sanctions prescribed in the Narcotics Act are divided according to the severity of the offence into administrative coercive measures and sanctions for offences against the Narcotics Act and for narcotics offences. Administrative coercive measures apply for instance to promote compliance with the requirements of the Act and include prohibition of further action and/or a default fine to enforce such a prohibition. Offences against the Narcotics Act include for instance intentional neglecting of the obligations of the Act. Unless a more severe punishment for the act is provided for elsewhere in the legislation in force, a person committing an offence against the Narcotics Act can be sentenced to a fine. Provisions concerning the more serious narcotics offences are laid down in Chapter 50 of the Penal Code (38/1889).

Under the Narcotics Act, the Finnish Medicines Agency (Fimea) is the licensing and controlling authority for narcotic drugs and drug precursors. A licence is required for the manufacture, import, export and handling of drugs unless this is specifically exempt by law, as for instance for many of the actors in the

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<sup>1</sup> See the amendments to the Act in section 1.1.

health care sector. The Decree on Narcotics Control (548/2008) lays down more specific provisions on the licence administration, operations subject to authorisation and their supervision under the Narcotics Act. The trade in and handling of drug precursors is provided for in more detail by EC Regulations.<sup>2</sup>

### Legislation on substance abuse prevention

There are many other legislative provisions intended to prevent, treat and monitor drug use and problem use of drugs. Provisions concerning preventive substance abuse work are laid down in the **Temperance Work Act** (828/1982). This Act defines the purpose of temperance work as habituating citizens to healthy lifestyles by guiding them in avoidance of the use of substances and tobacco. According to the Act, the establishment of general prerequisites for substance abuse prevention is primarily the task of central and local government. Pursuant to the Act, each local authority must have a designated body responsible for temperance work. This body must cooperate with the local health care, social welfare and education services in particular. The **Temperance Work Decree** (233/1983) further specifies that this body must cooperate with organisations engaging in temperance work and substance abuse prevention and promoting healthy lifestyles.

The **Child Welfare Act** (417/2007) provides for essential care and support for children in cases where the person responsible for the care and education of the child is a client of a substance abuse service, for instance, and for the eventual foster care, taking into care or providing of substance abuse services for the child if the child himself/herself seriously jeopardises his/her health or physical development through substance abuse. An amendment to the Child Welfare Act entered into force in March 2010 containing a provision on submitting an anticipatory child welfare notification. An anticipatory child welfare notification must be submitted when there is reasonable cause to suspect that a forthcoming child will need child welfare support measures immediately after the birth. In other words, an anticipatory child welfare notification must be submitted by someone who has certain knowledge that a mother-to-be or father-to-be has a substance abuse problem or a severe mental health disturbance or is subject to a custodial sentence. A suspicion of substance abuse is not in itself enough for submitting an anticipatory child welfare report.

The key principles for pupil and student welfare services and the educational objectives are defined in the national curricula for the various educational levels. **Legislation related to education** (477–479/2003) has required educational institutions to apply these principles, together with social welfare and health care authorities, in local curricula in order to further the prevention and treatment of substance abuse.

The **Government Decree on welfare clinic services, school and student health services and preventive oral health services for children and youth** (380/2009) lays down provisions concerning health examinations in welfare clinics and carried out by school and student health services. According to the Decree, sufficient and regular health examinations and health counselling are aimed at enhancing early support and preventing social marginalisation. In health counselling, individuals are supported and their psychosocial welfare promoted; this includes preventing the use of alcohol, tobacco and other intoxicants. The Decree specifies that welfare clinics must adopt extensive health examinations – as in school health care – involving the entire family. Health examinations in eighth grade in comprehensive school highlight the importance of early detection, intervention and further treatment in any substance abuse problems.

The **Occupational Health Care Act** (1383/2001) enables drug testing in the workplace. Before requiring any individual to take a test, the employer must have a written substance abuse programme, which contains the general goals of the workplace and practices to be followed to prevent substance abuse and help substance abusers in seeking treatment. The Act on the Protection of Privacy in Working Life (759/2004) regulates employers' rights and their limitations concerning drug tests required from employees. However, there are special regulations in several sectors regarding drug use monitoring, required because of the nature of the work done in those sectors. Such provisions may be found in the Conscription Act

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<sup>2</sup> (EC) Regulations Nos. 273/2004 and 111/2005 and Regulations amending them, and the implementing Regulation (EC) No. 1277/2005.

(1438/2007), the Aviation Act (1194/2009) and the Act on traffic safety duties in the railway system (1664/2009). The Ministry of Social Affairs and Health has issued instructions on drug tests in working life. (Ministry of Social Affairs and Health 2006).

### Legislation on services and harm reduction

Treatment for drug users is regulated by the **Act on Welfare for Substance Abusers** (41/1986), requiring municipalities to ensure that the provision of substance abuse services meets local needs as regards content and scope. These services must be delivered through the development of general social and health care services and the provision of services that are intended specifically for substance abusers. Such services must be provided primarily through outpatient care and should be easily available, flexible and diversified.

At the moment, both the **Act on Welfare for Substance Abusers** (41/1986) and the **Mental Health Act** (1116/1990) allow for commitment to involuntary treatment, but in practice involuntary treatment is never applied to substance abusers.

The **Decree governing detoxification and substitution treatment for opioid addicts** (33/2008) stresses that unlike under previous legislation only demanding substitution treatment cases should be dealt with by specialist health care; other cases should be treated at primary health care level. With respect to the evaluation and beginning of treatment, the focus is on outpatient rather than inpatient care. Pharmaceuticals containing buprenorphine or methadone can only be prescribed for the detoxification or substitution treatment of opioid addicts by a physician employed by a health care unit and responsible for its operation, or by the physician who assigned this task to him/her.<sup>3</sup> However, the Decree also allows a combined preparation of buprenorphine and naloxone to be issued from a pharmacy under a pharmacy contract signed by the patient. A pharmacy contract refers to a contract by which the patient commits to collecting the pharmaceuticals specified under the contract from only one pharmacy, and agrees that this pharmacy may transmit treatment-related information to the physician treating the patient and notify other pharmacies of the existence of the pharmacy contract.

The amendment of the **Decree on Prescription of Medicines** (490/2008) specifies the conditions for prescribing a narcotic substance for medicinal use and, if special therapeutic reasons exist, for prescribing special preparations outside the special authorisation procedure under the Medicines Act for medicinal use. A condition for prescribing a preparation requiring special authorisation is that no other therapies are available for treating the patient or that the desired outcome cannot be achieved using other therapies. Special authorisation can be granted on a patient-specific basis and, at most, for one year at a time. Based on the amendment, a cannabis-based analgesic can also be prescribed in certain cases. However, cannabis-based medicines do not have wider marketing authorisation.

The **Communicable Disease Decree** (786/1986) requires that the municipal body responsible combating infectious diseases ensure that work is undertaken for the prevention of infectious diseases, including the provision of health counselling for intravenous drug users as well as needle and syringe exchange. In addition, as part of the general vaccination programme, Decree 421/2004 recommends free hepatitis A and B vaccines for intravenous drug users, their sexual partners and individuals living in the same household.

### Penal Code

Narcotics offences are provided for in chapter 50 of the **Penal Code** (39/1889), in an amendment to which (1304/1993) they were categorised as narcotics offences, or the preparation or abetting of narcotics offences (maximum sentence 2 years' imprisonment), or aggravated narcotics offences (1 to 10 years'

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<sup>3</sup> Medical treatment may be conducted and the medication administered to the patient only under the supervision of the health care unit. If the patient's commitment to treatment is high, the health care unit can give him/her pharmaceuticals equivalent to a maximum of eight daily doses (15 in exceptional cases).

imprisonment). Another amendment was enacted to the Penal Code in 2001 (654/2001), defining unlawful use of narcotics (maximum sentence six months' imprisonment). In 2006, a further amendment (928/2006) rendered attempts at preparation of and abetting a narcotics offence as punishable acts.

Dealing with the unlawful use of narcotics is possible in summary penal proceedings (692/1993). This may be done in cases where the penal provision applicable does not include a punishment more severe than a fine or a maximum of six months' imprisonment. A summary penal order is issued by the police, a customs official or another public official performing controls stipulated by law, on their own initiative or on behalf of the prosecutor. Through amendment 578/2008 to the Penal Code, it was determined that a fine imposed in summary penal proceedings may not be converted into imprisonment. In practice, this means that offenders issued a fine in summary penal proceedings by the police or the prosecutor for the unlawful use of narcotics may no longer be sent to prison instead. Charges may be waived for unlawful use of narcotics if the offender agrees to seek treatment or if, in the case of an offender under the age of 18, a reprimand is given. (Kainulainen 2009.)<sup>4</sup>

Chapter 23 of the Penal Code (39/1889) concerns driving while intoxicated, including provisions on drugs. Since 2002, a zero-tolerance policy has been in effect concerning the use of drugs or pharmaceuticals classified as narcotics while driving, unless the driver has a valid prescription for them.

The control of illegal drugs is also provided for in the Coercive Measures Act (450/1987), which sets forth terms and conditions for wiretapping, telecommunications monitoring and technical monitoring, and in the Police Act (493/1995), which provides in more detail for undercover action, pseudo purchases and other significant intelligence methods in the prevention, uncovering and solving of serious and organised crime (including drug crime).

### Legislation on sanctions

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

### Administrative reorganisation and related legislation reform 2009–2010

The Narcotics Act was amended to designate the **Finnish Medicines Agency (Fimea)** as the licensing and controlling authority as of 1 November 2009 (593/2009), assuming the former duties of the simultaneously abolished National Agency for Medicines (775/2009).

With the merger of the National Research and Development Centre for Welfare and Health (STAKES) and the National Public Health Institute (KTL) into the **National Institute for Health and Welfare (THL)** as of 1 January 2009 (668/2008), the new agency acquired the STAKES mandate specified in the Narcotics Act of acting as the representative of Finland in the European information network on drugs and drug addiction (REITOX) (775/2009).

The **National Police Board** is a new central government agency that began operations on 1 January 2010. Under this reorganisation, the National Bureau of Investigation, the Finnish Security Intelligence Service, the National Traffic Police, the Police College, the Police Technical Centre and the local police departments were all brought under the new National Police Board. Further in the central government reorganisation, the State Provincial Offices were abolished and their police functions divided among the new **Regional State Administrative Agencies** (896/2009). A reorganisation was also effected in the prison

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<sup>4</sup> See also 9.3 Alternatives to prison.

service, as the former Criminal Sanctions Agency, Probation Service and Prison Service merged into the new **Criminal Sanctions Agency** as of 1 January 2010 (953/2009).

As the State Provincial Offices were abolished, their duties concerning quality, monitoring and customers' legal safeguards in education, social welfare and health care basic services were transferred to the new Regional State Administrative Agencies as of the beginning of 2010 (896/2009). One year earlier, the former National Authority for Medicolegal Affairs and National Product Control Agency for Welfare and Health merged into the new **National Supervisory Authority for Welfare and Health (Valvira)** (669/2008), whose duties include the nationwide administration of the aforementioned duties of the Regional State Administrative Agencies, which Valvira also assists in their regional duties.

## 1.2. Institutional framework, strategies and policies

Finnish drug policy is based on general social policy measures, national legislation and international treaties, together aimed at contributing to a reduction in the supply of and demand for drugs, and in drug-related harm, enabling early treatment for those suffering from drug problems and imposing penal liability on those engaged in illegal activities. This policy has not fundamentally changed in recent years. However, monitoring has been tightened through enactment of legislation on new psychoactive substances. In its drug policy, Finland observes the United Nations international drug control conventions and the EU Drugs Strategy for the period 2005–2012. (Finnish Government 2007a.) Anti-drug work will also take account of measures contained in other Government action plans (including those adopted by previous Governments and still valid) and those under the Internal Security Programme, for instance.

### Background

The first Finnish drug strategy was published in 1997, with the aim of arresting the growth of drug use and the related crime. Based on this strategy, the Government has issued resolutions in 1998, 2000, 2004 (for 2004–2007) and 2007 (for 2008–2011).

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

According to the study, minimising harm has not presented a threat to the drug prohibition policy; rather, it has become part of it. Minimising harm through the establishment of syringe and needle exchange points (health counselling centres) and extended substitution treatment has meant new, specialised services founded upon medicine and increased efforts by medical professionals to treat drug-related problems. At the same time, penal control of drug use has become more effective. Therefore, minimising harm has not meant a step towards a more liberal drug policy, nor has it vitiated the traditional policy based on complete drug prohibition. Instead, minimising harm combined with punitive prohibition policy forms a two-pronged paradigm for Finland's drug policy. (Tammi 2007.)

Aarne Kinnunen noted in his doctoral dissertation, completed in 2008,<sup>5</sup> that despite its social welfare and health care elements the Finnish drug policy continues to rely principally on the criminal justice

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<sup>5</sup>The study discusses the development of the drug market and drug-related crime since the mid-1990s, the criminal careers and socio-economic status of narcotics offenders, and efforts to solve the problem of drug-related crime through official enforcement. The study is based on statistics, observations of police work, interviews with the authorities and people in the drug market, and official documents. It shows that since the mid-1990s drug use has become more common, drug problems have become more serious, and drug control has become stricter. Prevention of drug problems became a key issue for the authorities, and more resources were allocated to anti-drug measures. Control through the criminal justice system was reinforced, and drug prevention took top priority in the strategies of the Police and the

system. It was estimated that offenders convicted of narcotics offences in Finland were subject to more severe sanctions than those convicted of other offences. The criminalisation of drug use and the tightening of the practice of issuing fines demonstrate that a stricter moralist view of drug use and other high-risk behaviour is now prevalent. Moreover, criminal control tends to focus on persons of low socio-economic status. (Kinnunen 2008.)

Heini Kainulainen came to a similar conclusion in her dissertation. According to her, the criminal justice sanction system<sup>6</sup> has in recent years focused increasingly on the offender, particularly in the case of offenders who are substance abusers. For example, waiving charges remains an extremely rare outcome, even though it would be especially needed in narcotics offences. The police have traditionally been reluctant to apply this procedure, since intervention in users' actions has been considered crucial. For a long time, prosecutors concurred. (Kainulainen 2009.)

Traditionally, it has been considered important in Finnish criminal policy to prefer values of humanity and social justice and to focus on preventive action. Sanctions have been considered a secondary resort. However, in drug policy criminal justice has retained a central role despite the fact that harm-reduction policy has made inroads and the welfare society has been able to provide a growing range of care services for problem users. (Kinnunen 2008.)

### Co-ordination of drug policies

The Ministry of Social Affairs and Health is responsible for coordinating national measures related to drug policy. The principal coordinating body for drug policy is the national Drug Policy Coordination Group led by the Ministry of Social Affairs and Health; each administrative sector brings matters under preparation with relevance for general drug policy to the group for discussion. The bodies represented in this group are the Ministry of the Interior, the National Police Board, the Ministry of Justice, the Office of the Prosecutor General, the Ministry of Finance, the Customs authorities, the Ministry of Education and Culture, the National Board of Education, the Ministry for Foreign Affairs, the National Institute for Health and Welfare and Fimea. The Drug Policy Coordination Group discusses legislative amendments and recent research findings and submits initiatives for action. The group regularly reports to the Government about the drug situation and new measures.

Pursuant to the Government Programme, the Drug Policy Coordination Group is preparing an action plan for 2011–2015 for reducing drug use and its adverse effects. The Government Programme states that low-threshold services, medical counselling and outreach work for drug users will be increased; the efficiency of treatment referrals carried out by the police will be enhanced; and opportunities for the treatment of drug problems during imprisonment will be increased. (Finnish Government 2011a.)

The Drug Policy Coordination Group submitted its final report on the achievement of drug policy co-operation in spring 2011. The final report addressed the attainment of the goals outlined in the Government Resolution for 2008–2011 regarding the following areas of action: 1) Preventive work and early intervention; 2) Combating drug-related crime; 3) Treatment of drug addiction and reduction of harm from drug use; 4) Intensifying the treatment of drug misuse in connection with criminal sanctions; 5) The EU's drug policy and international co-operation; and 6) Information collection and research regarding drug problems. (Ministry of Social Affairs and Health 2011a.)

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Customs. The prevention and uncovering of drug-related crime was introduced as an objective in police surveillance nationwide. This manifested itself as a marked increase in crime statistics. (Kinnunen 2008.)

<sup>6</sup> In the drug use offence reform that entered into force in 2001, the police were given the authority to issue summary fines to drug users; at the same time, alternative sanctions were heavily recommended. Underage offenders should be given a reprimand instead of imposing a fine, and problem drug users should be referred to treatment. However, in practice this reform led in the early 2000s to a substantial increase in summary fines issued to drug users. Because there is less scope for waiving charges in this case, the practice also led to a decline in the use of waiving of charges, and thereby decreased the use of alternative sanctions and indirectly led to stricter sanctions overall. The effect of guiding problem users to treatment that was sought in the 'unlawful use of narcotics' reform has not been achieved in practice: it is still extremely rare for charges to be waived for drug use offenders who have sought treatment. (Kainulainen 2009a.) See also 9.3 Alternatives to prison.

### *1. Preventive work and early intervention*

The goal was

- to enhance preventive substance abuse work in social and health care, youth work, schools and educational establishments,
- to consolidate its role in the promotion of health and well-being in the restructuring of municipalities and services,
- to establish early intervention as part of all health and welfare services, and
- to reinforce substance education throughout the educational system, and
- to support high-quality information and education concerning drugs and to target information provision to high-risk groups as necessary.

The final report notes that the effectiveness and quality of preventive work have been supported by improving methods, by training, by enhancing the knowledge base for preventive work and by supporting substance abuse prevention projects. Supporting local authorities and NGOs has been crucial in improving expertise. Also, expertise in substance abuse services was supported in the substance abuse training development project until 2009 and thereafter through support for the network of substance abuse work teachers. Outreach youth work has been a particular subject for improvement. At the moment, there are 230 two-person teams in outreach youth work around Finland. (Ministry of Social Affairs and Health 2011a.)

Early intervention in offences committed by young offenders has been effected in co-operation with various authorities. The purpose of the police engaging in early intervention is to prevent the development of a vicious circle of crime and substance abuse. Co-operation between the police and the health care and social welfare authorities is particularly important in improving the conditions of children and adolescents in problem families where the parents have a history of substance abuse. (Ministry of Social Affairs and Health 2011a.)

The National Core Curriculum was revised to take the goals of the Policy Programme for Health Promotion into account. The National Core Curricula for Pre-School Education and Basic Education have been revised with respect to student welfare services and promotion of safety. The National Vocational Education Qualification Requirements and the National Core Curriculum for Vocational Education were revised to introduce topics for maintaining health and working capacity into common modules and vocational studies while taking the requirements of each particular field into account. (Ministry of Social Affairs and Health 2011a.)

The police have cooperated closely with schools in anti-drug efforts and have appointed a liaison officer for each school. School resource officers and community policing have enabled the police to establish a close co-operation. The police have published information locally and nationwide on drug-related crime, new psychoactive substances, drug offences under investigation and their backgrounds. (Ministry of Social Affairs and Health 2011a.)

According to the prosecutor guidelines on unlawful use of drugs, a first offender under the age of 18 must by default be given a reprimand; instead of being fined, their charges should be waived and a verbal warning given instead. The reprimand session is attended by the young offender himself/herself and his/her parent or guardian, and also representatives of the police, the prosecutor and the social welfare authorities. In 2008, five of Finland's prosecution units gave no reprimands at all, whereas in 2010 all but one prosecution unit gave reprimands. (Ministry of Social Affairs and Health 2011a.)

### *2. Combating drug-related crime*

The goal was

- to increase the likelihood of being caught with respect to aggravated narcotics offences and those involving distribution carried out in Finland,
- to implement criminal liability through seamless international co-operation with the offender's home country or country of residence,

- to tackle the import of drugs into the Finnish market primarily through seizures at national borders, but also outside the country on a case-by-case basis,
- to integrate control of the distribution of drugs and pharmaceuticals classified as drugs into the basic operations of the police,
- to enhance the detection of crimes accompanying narcotics offences, particularly concealment, procurement, extortion and money laundering, and
- to reinforce the tracking of criminal gains and their comprehensive recovery.

The police and the other PTR authorities<sup>7</sup> have stepped up their combating of serious crime, which partly explains the increase in the number of aggravated narcotics offences recorded. The police have not otherwise assigned increased resources to combating drug-related crime. The focus in investigating drug-related crime is on the recovery of criminal gains, which has resulted in a weakening of the operating potential of drug-related crime. (Ministry of Social Affairs and Health 2011a.)

According to the seizure statistics of the police and Customs, the number of cannabis plants seized has increased. This is probably in part due to the increasing popularity of home-growing and the easy availability of cannabis seeds over the Internet, but also to the fact that authorities now uncover home-growing more efficiently. In 2010, the combined volume of marijuana seizures was almost 45% more than in 2008. (Ministry of Social Affairs and Health 2011a.)

Finland has participated actively in international Joint Investigation Teams (JIT), and more teams are being set up. The police have had a total of 27 JITs between 2004 and 2010 (3 in 2008 and 9 in 2010). The highest number of teams have been set up for investigating aggravated narcotics offences, which is a reflection of the internationalisation of drug-related crime. Most frequently these JITs have involved the Swedish and Estonian authorities. (Ministry of Social Affairs and Health 2011a.)

In the group of synthetic drugs, amphetamines have retained their leading status in comparison with the volume of seizures in 2008. The percentage of methamphetamine on the amphetamine market and in the seizure statistics of the authorities has clearly increased. A remarkable change from the situation in 2008 is that the range of new synthetic drugs, known as new psychoactive substances, has broadened substantially. The availability of ecstasy, for instance, has declined as it has been replaced by new psychoactive substances such as MDPV, mCPP and Bromo-Dragonfly. The volumes of seizures of narcotic pharmaceuticals have also been on the increase in recent years. Since 2008, the popularity of ‘gamma’ (GHB) and ‘lakka’ (GBL) has clearly declined. (Ministry of Social Affairs and Health 2011a.)

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

The goal was

- to continue the development and increased provision of treatment services, with the aim of ensuring equal access to services for all citizens,
- to offer drug users a range of treatment options, appropriate to the type of addiction in question,
- to increase treatment, health counselling and support directed at reducing drug-related harm (such as diseases, mental health problems and accompanying crime),
- to facilitate access to treatment for opioid addicts, and to increase treatment volumes to meet demand on a more comprehensive basis, and
- to make referral to treatment by the police more efficient.

Latest estimates suggest that there were between 14,500 and 19,100 problem drug users in 2005, representing 0.5% to 0.7% of the Finnish population aged 15 to 54. The number of individuals attending substitution treatment in 2010 was estimated at 1,800. Unofficial expert estimates indicate that treatment for drug abuse is given to about 15,000 Finns every year. (Ministry of Social Affairs and Health 2011a.)

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<sup>7</sup> PTR is the Finnish acronym for police, Customs and the Border Guard.



The prevention of drug-related deaths has not been as successful as the combating of other drug-related harm such as communicable diseases. The number of HIV infections caused by intravenous drug use and hepatitis C, B and A cases recorded in the National Infectious Diseases Register has clearly declined over the past decade. Fewer than a dozen cases of HIV infections among intravenous drug users are registered annually: there were eight such cases in 2010. Health counselling centres and hepatitis A and B vaccinations have played an important role in reducing the spread of drug-related infectious diseases.

In 2008, a cross-sectoral and multi-discipline evaluation study on the effectiveness of low-threshold health guidance efforts in Finland was published, entitled *Luottamus ja vapaaehtoisuus terveysterveystapistoiminnan onnistumisen edellytyksinä* (Trust and voluntary participation as criteria for the success of health counselling centres) (Arponen et al. 2008). The study shows that the intervention of health counselling centres among intravenous drug users has constituted a significant factor in the prevention of HIV infection, hepatitis A or B infections and, to some extent, hepatitis C infections, as well as in combating epidemics. The evaluation further shows that the model based on health counselling centres for intravenous drug users is a functioning social innovation which differs from preventive models previously employed elsewhere, as it successfully combines low-threshold health care services and health promotion with reduction of drug-related harm without abandoning our restrictive drug policy. The model would therefore be quite well applicable in other countries too. (Ministry of Social Affairs and Health 2011a.)

The challenge for the future is to maintain the health counselling centre system at its present extent. The network of health counselling centres is currently good though not quite comprehensive, as coverage could be better in northern Finland and on Åland. (Ministry of Social Affairs and Health 2011a.)

As of the beginning of February 2008, a new Decree of the Ministry of Social Affairs and Health on the detoxification and substitution treatment of opioid addicts with certain medicinal products (33/2008) entered into force, aimed at lowering the threshold for treatment and emphasising its role in outpatient settings instead of institutions, providing care at the level of basic health care and increasing opportunities for unsupervised medication dosing, which would decrease the number of visits to the treatment unit. The Ministry of Social Affairs and Health has evaluated how this Decree has been put into practice. According to the 2008 assessment, in most parts of the country there is no demand for withdrawal and substitution treatment for opioid addicts. Opioid addicts are centralised in major cities, particularly in the Greater Helsinki area and the city itself. In most parts of the country, no queues for treatment exist; the time limits imposed by the treatment guarantee are only exceeded in certain major cities. In these cities, plans exist for the fulfilment of the treatment guarantee. The primary medication for substitution treatment is a combination of buprenorphine and naloxone, followed by methadone; pure buprenorphine is used only rarely. (Ministry of Social Affairs and Health 2011a.)

Bringing opioid substitution treatment under the treatment guarantee increased the availability of substitution treatment and shortened its treatment queues. Today, opioids are the most commonly used group of drugs among persons entering treatment for substance abuse. At the same time, substance abuse services in municipalities have found it difficult to cope with the increasing treatment demands for alcohol-related problems. The problem in providing substance abuse services is to ensure that a sufficiently diverse range of detoxification, sobering-up stations, housing services and psychosocial services is available for the management of different types of substance abuse problems. (Ministry of Social Affairs and Health 2011a.)

The problem with substitution treatment is that patients still need to queue for the actual treatment after assessment of their need for treatment and a treatment decision. In the future, substitution treatment will increasingly be provided at health centres. (Ministry of Social Affairs and Health 2011a.)

A working group on securing treatment for substance-abusing pregnant women was appointed by the Ministry of Social Affairs and Health in 2008. Underlying this working group was the entry in the Government Programme specifying special attention to treatment and services offered to pregnant women. The working group returned its final report in February 2009, and the legislative amendments proposed there in are being prepared during 2011 as part of the work of the working group evaluating incentives in social welfare and health care services. (Ministry of Social Affairs and Health 2011a.) In 2010, the Ministry

of Social Affairs and health appointed a working group to discuss support services for children of parents with substance abuse problems; this working group returned its report at the beginning of 2011. (Ministry of Social Affairs and Health 2011b).

The police have guided and supported substance abusers in seeking treatment, cooperating closely with the social welfare and health care authorities. The training provided by the police in the combating of drug-related crime takes referral to care into account. In 2006, the police issued a procedural guideline on the unlawful use of narcotics to govern police actions in the field. Despite this guidance, ultimately the decision to seek treatment is made by the substance abuser himself/herself. The number of treatment places is very limited in several communities, which restricts effective referral to treatment. Each year, prosecutors waive charges in 30 to 40 cases due to referral to treatment. (Ministry of Social Affairs and Health 2011a.)

#### *4. Intensifying the treatment of drug abuse in connection with criminal sanctions*

The goal was

- to improve the effectiveness of imprisonment through the better planning of prisoners' sentences and release on an individual basis, as required by the new Act on Imprisonment,
- to develop the procedures of allocation units determining prisoner placement and to increase substance abuse rehabilitation and contact work in prisons,
- to improve support measures for supervised probationary freedom and post-care for released inmates,
- to bolster substance abuse rehabilitation included in community sanctions, and
- to enhance rehabilitation opportunities for those sentenced to juvenile punishments.

Between 2008 and 2011, participation by prison inmates in actions reducing the risk of recidivism has increased. Individual plans for the term of sentence are increasingly drawn up for inmates and persons sentenced to community sanctions. This allows individual factors to be taken better into account in the course of serving the sentence. The return of released inmates to society has been eased by increasing the number of open prison placements. Finland's first release unit was set up in 2010 to ensure supported and controlled release of prison inmates. Two further release units are in the pipeline. The use of supervised probationary freedom has been increased, but the goal for its use has not been attained because of a reduction in the number of supervisory officials. (Ministry of Social Affairs and Health 2011a.)

#### *5. EU drug policy and international co-operation*

The goal was

- to participate actively in the planning of the common EU drug policy and in international anti-drug collaboration through drug policy forums established by the United Nations, the Council of Europe and the Nordic Council of Ministers, and
- to support international anti-drug and drug-related harm reduction projects conducted bilaterally or multilaterally and supporting Finland's objectives, within the framework of neighbouring area and development co-operation funding.

On 2 December 2010, the Government adopted a Resolution on Finland's policy in international anti-drug efforts. This document was prepared in a multi-discipline international anti-drug co-operation working group appointed by the Ministry of Social Affairs and Health. (Ministry of Social Affairs and Health 2010a.)

Finland was the only Nordic member of the Commission on Narcotic Drugs (CND) under the UN Economic and Social Council (ECOSOC) from 2008 to 2011. Finland contributed actively to the shaping of resolutions at the annual sessions of the CND. Finland also participated in the work of the Pompidou Group of the Council of Europe. In 2008, the Pompidou Group published a Russian version of publication B15/2008 of the Finnish National Public Health Institute, which demonstrates that the harm reduction services implemented in Finland are highly cost-effective. Finland has participated in the work of the Nordiskt Narkotikaforum adjacent to the Nordic Council of Ministers and chaired the forum in 2011. (Ministry of Social Affairs and Health 2011a.)

## 6. Information collection and research regarding drug problems

The goal was

- to continue long-term follow-up research on the drug situation and to secure the availability of up-to-date information on this situation for those responsible for drug policy,
- to produce the national information required by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) for reports on the drug situation, and for the UN data collection systems,
- to promote research into drug use, drug markets, the treatment of drug users and methods of combating drug-related problems and to promote international co-operation by Finnish researchers, and
- to monitor regularly citizens' opinions on drugs, drug use and related harm.

Information is collected on drugs nationwide annually, and drug-related research is undertaken by the National Institute for Health and Welfare, the Youth Research Network, NGOs and universities, among others. The Finnish Foundation for Alcohol Studies is an important funding provider for drug-related research. Between 2007 and 2010, the Academy of Finland funded the Research Programme on Substance Use and Addictions, which generated plenty of information on factors predicting substance abuse and addictions, epidemiological and biological knowledge, and information on perceptions and treatments; its findings may be leveraged in the future both in the rehabilitation of problem users and in the development of pharmaceuticals. (Ministry of Social Affairs and Health 2011a.)

In addition to research institutions and universities, bodies such as the A Clinic Foundation engage actively in research. The A Clinic Foundation has run projects focusing on the life patterns of patients in outpatient and inpatient care in substance abuse services, drug users in Helsinki, families using substance abuse services, substitution treatment, substance abuse rehabilitation in prisons, and the work of organisations founded by drug users and patients themselves. (Ministry of Social Affairs and Health 2011a.)

During the 2007–2011 term of government, numerous doctoral dissertations on drug-related topics were completed in Finland; topics included the drug market in Helsinki, the criminal careers of drug users, services for disadvantaged drug users, treatment services for substance-abusing pregnant women and mothers of small children, cannabis activism, control of drug users by the criminal justice system, young women and drugs, drug user recovery and peer support, substance abuse and driving, low-threshold health care guidance services, the spreading of HIV infections among intravenous drug users, and the combined effect of anabolic steroids and stimulatory drugs on the central nervous system. (Ministry of Social Affairs and Health 2011a.)

### 1.3. Government programmes and working groups affecting drug policy

Broad-based development of general welfare policy and of social welfare and health care services continues. Substance abuse and mental health services constitute an important service package in the **PARAS project governing the local government and basic services reform**. The **National Development Plan for Social and Health Care Services (the Kaste programme)** (Ministry of Social Affairs and Health 2008) and its implementation plan (Ministry of Social Affairs and Health 2009a) highlight improvements required in primary health care, social work, care provided by paramedics as well as mental health and substance abuse work. Two interim reports were completed in the Kaste programme in 2010 (Ministry of Social Affairs and Health 2010b, 2010c). The Kaste and Paras programmes will continue during the 2012–2015 term of government. The Government Programme is also planned to incorporate a broad-based action plan to reduce poverty, social inequality and social exclusion.

The **Policy Programme for Health Promotion 2007–2011** (Finnish Government 2007b) set as a goal that the Ministry of Social Affairs and Health would prepare a proposal for the comprehensive care of pregnant women with intoxicant problems. In 2010, the Ministry of Social Affairs and Health appointed a working group to discuss support services for children of parents with substance abuse problems; this working group returned its report at the beginning of 2011. According to its recommendations, efforts to

support the children of parents with substance abuse problems must be coordinated, developed and supported at the national level. The working group proposes a legislative amendment to guarantee pregnant women the subjective right to gain immediate access to treatment need assessment and to the substance abuse treatment deemed necessary in that assessment. The working group also noted that legislation should be enacted to ensure a sufficient number of school social workers and school psychologists. (Ministry of Social Affairs and Health 2011b.) The legislative amendments proposed for ensuring treatment for pregnant women with substance abuse problems are being prepared during 2011 as part of the work of the working group evaluating incentives in social welfare and health care services.

The report (Ministry of Social Affairs and Health 2009b) by the **Mieli 2009 Working Group, concentrating on the development of mental health and substance abuse work**, underlined prevention and early intervention as well as shifting the service focus to primary and outpatient services. According to the Working Group, people with both mental health and substance abuse problems must be able to access services flexibly through a one-stop shop and on an equal basis in comparison to other people. However, this would require the modification of the service structure, and it would be reasonable to make such changes within the framework of the ongoing, broad-based PARAS restructuring project. To enable eventual operating reforms, the National Institute for Health and Welfare also published a guide to strategic planning in mental health and substance abuse services at the local or regional level. (Laitila et al. 2009.) The Working Group also proposes that the contents of the Mental Health Act, the Act on Welfare for Substance Abusers and the Temperance Work Act be updated and the possibility of grouping them be assessed.

The Ministry of Social Affairs and Health and the National Institute for Health and Welfare are responsible for implementing the national plan for mental health and substance abuse work. The National Institute for Health and Welfare published a report on the national plan for mental health and substance abuse work, its reception<sup>8</sup> and its implementation plan in 2010. (Partanen et al. 2010.)

The Health Care Act reform, social services legislation reform and development of legislation regarding compulsory care are key legislative projects that will have an impact on mental health and substance abuse action extending far beyond public services to the third sector. This involves not only the social welfare and health care sector but also education, culture and other leisure functions, businesses and bodies responsible for housing and living environments.

The **National Action Plan to Reduce Health Inequalities 2008–2011** (Ministry of Social Affairs and Health 2008b) laid down practical guidelines for reducing socio-economic health inequalities. The action plan also sought to address certain special needs groups, such as families suffering from substance abuse and mental health problems. In the context of this action plan, the National Institute for Health and Welfare has set up an online service named Kaventaja,<sup>9</sup> providing information on welfare and health differentials, factors affecting them and means for narrowing them. The National Institute for Health and Welfare and the Finnish Institute of Occupational Health are also engaging in a joint project (Teroka)<sup>10</sup> for developing practices and collating information for attaining the goal in narrowing health differentials.

The **Policy Programme for the Well-being of Children, Youth and Families 2007–2011** (Finnish Government 2007c) aimed to create a service system supporting families with children, forming a seamless network to promote the well-being of children and young people. This system was to be capable of eliminating threats to well-being in advance and enable effective intervention in the case of problems. A

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<sup>8</sup> In an open Internet survey conducted with municipal social welfare and health care services, NGOs, educational institutions, etc., development of outpatient and basic services was considered important, and also the strengthening of the status of the patient. Criticism was voiced particularly regarding the weak presence of social services in the plan. Responses also showed concern about the threshold of access to treatment for substance abuse patients rising from its present level. The greatest uncertainty was prompted by the transfer of psychiatric hospital care to general hospitals.

<sup>9</sup> The Kaventaja service of the National Institute for Health and Welfare is at [http://kaventaja.thl.fi/fi\\_FI/web/kaventaja-fi](http://kaventaja.thl.fi/fi_FI/web/kaventaja-fi).

<sup>10</sup> The Teroka project is at <http://www.teroka.fi/teroka/>.

key priority was support services for children and young people, especially in the case of violence, mental health problems or intoxicant problems in families. The final report of this Policy Programme has now been published. It noted that legislation had been developed, successful efforts had been undertaken to prevent the social exclusion of young people, and low-threshold services for families had been increased. (Finnish Government 2011b.)

Under the Youth Act (72/2006), a youth policy development programme shall be prepared every fourth year. The first **Child and Youth Policy Development Programme 2007-2011** (Ministry of Education 2007) affirmed that the passing of mental health and substance abuse problems from one generation to the next is one of the most common paths to social exclusion. The programme underlined that co-operation between child welfare services, substance abuse services and mental health services must be strengthened to meet the welfare and rehabilitation needs of children whose parents require adult services. Regarding criminal law, mental health or substance abuse services could also be included in juvenile punishments. The evaluation report of the Policy Development Programme has been published. The report explores the legislative, information and resource steering that took place in the area of child and youth policy during the programme. (Advisory Council for Youth Affairs 2011.) Preliminary work for the statutory programme for 2012–2015 was done in 2010; the programme itself will be drawn up in autumn 2011 and will include goals for preventing substance abuse among young people. (Ministry of Education and Culture.)

The **Internal Security Programme** is an extensive, cross-sectoral programme running over two periods, from 2008 to 2011 and from 2012 to 2015, comprising 74 measures to maintain and improve security. Since intoxicants (particularly alcohol) and violence are often interlinked in Finland, the programme aims to reinforce existing victim support services in order to reduce violence towards children and young people. The programme also outlines goals for national and international co-operation between authorities to combat organised crime and for border security and customs surveillance to prevent the illegal importing of drugs. (Finnish Government 2008.) Interim reports have been published annually on the implementation of the Internal Security Programme (Ministry of the Interior 2009; 2010; 2011). The interim report for 2011 discusses how the goals set in the programme have been attained. The report notes that most of the goals outlined, such as preventing social exclusion, combating organised crime and improving border security and customs surveillance, have been implemented fairly well and that the indicators defined in the programme have improved. The report also describes measures implemented as part of programme implementation. (Ministry of the Interior 2011.)

## 1.4. Economic analysis

### Public expenditure from drug-related harm

The expenditure incurred from drug-related harm by the Finnish government is calculated based on a long-established calculation framework. (Salomaa 1996; Hein & Salomaa 1998.) The harm-related expenditure thus calculated has been reported since 1998 in the Yearbook of Alcohol and Drug Statistics published by the National Institute for Health and Welfare.<sup>11</sup> The calculated public expenditure as presented in this report corresponds to the costs presented in the Yearbook in those respects where they are included in both calculation frameworks.

In 2009, public expenditure<sup>12</sup> caused by drug use totalled approximately EUR 128 million. Of this amount, a total of EUR 11.7 million had been earmarked for anti-drug activities. One of the largest funding providers for substance abuse work, Finland's Slot Machine Association (RAY), allocated EUR 8.5 million

<sup>11</sup> On 1 January 2009, the National Research and Development Centre for Welfare and Health (STAKES) and the National Public Health Institute were merged, forming the National Institute for Health and Welfare (THL).

<sup>12</sup> The data used were obtained from budget reports and final accounts reports for the year published by ministries, public agencies and other public bodies.

to drug-related work and prevention. To drug-related research conducted at the National Institute for Health and Welfare the Ministry of Social Affairs and Health allocated EUR 1.0 million. The Ministry also allocated EUR 2.2 million to drug prevention work. In 2010, the Ministry of Education and Culture allocated about EUR 1 million to various projects for preventing substance abuse among young people.

The largest portion of public expenditure due to drug-related harm is incurred by the enforcement of public order and safety, accounting for an estimated EUR 69.2 million in 2009. As in previous years, the costs attributable to the prison service (EUR 36.7 million) represented the largest single item of expenditure.

Expenditure attributable to the prevention of drug-related harm accounted for some EUR 15.1 million, mostly funds allocated to drug research and substance abuse work. Harm reduction activities accounted for a total of EUR 10.7 million. Of this amount, EUR 9.5 million went to drug-related disability pension expenditure and EUR 1.1 million to drug-related sickness allowances. Compensation paid by the state, for instance to victims of crime, totalled EUR 0.1 million.

Table 1. Costs of drug-related harm incurred by the government in 2009 (EUR million)

COFOG	Authority	Reuter's	Budget expenditure total	Harm-related costs associated with drug use	Earmarked
03. PUBLIC ORDER AND SAFETY	03.1 POLICING				
	Policing	Enforcement	664.5	18.6	
	Customs control	Enforcement	160.8	5.9	
	03.2 FIRE AND RESCUE SERVICES				
	Fire and rescue services	Enforcement	73.7	2.6	
	03.3 JUDICIAL SYSTEM				
	District Court	Enforcement	138.1	1.8	
	Court of Appeal	Enforcement	38.3	1.0	
	Supreme Court	Enforcement	8.1	0.1	
	Legal aid	Enforcement	40.8	0.3	
	Enforcement Office	Enforcement	94.1	0.9	
	System of prosecution	Enforcement	40.0	1.3	
	03.4 PRISON SYSTEM				
	Prison Service	Enforcement	213.6	35.7	
	Open institution work	Enforcement	6.0	1.0	
	03.5 RESEARCH AND DEVELOPMENT RELATED TO PUBLIC ORDER AND SAFETY				
	National Research Institute of Legal Policy	Prevention	1.9	0.06	
	The European Institute for Crime Prevention and Control	Prevention	0.5	0.02	
	03.6 PUBLIC ORDER NOT ELSEWHERE CLASSIFIED				
	Ministry of Justice	Prevention	81.4	0.6	
	Certain paid compensations	Harm reduction	11.5*	0.1	
07. HEALTH CARE	07.5.0 RESEARCH AND DEVELOPMENT IN THE HEALTH CARE SECTOR				
	National Institute for Health and Welfare	Prevention	61.2	1.0	Yes
	Foundation for Alcohol Studies	Prevention	1.1	0.1	
	07.6 HEALTH CARE NOT ELSEWHERE CLASSIFIED				
	Ministry of Social Affairs and Health	Prevention	74.7	2.2	Yes
	Finland's Slot Machine Association	Prevention	278.0	8.5	Yes
	Finland's Slot Machine Association	Prevention	278.0	2.6	
10. SOCIAL SECURITY	10.1.1 ILLNESS (IS)				
	Sickness allowance	Harm reduction	779.3	1.1	
	10.1.2 DISABILITY				
	Disability pension	Harm reduction	3159.0	9.5	
REVENUE TRANSFERS TO MUNICIPALITIES				33.4	
<b>COSTS TOTAL</b>				<b>128.4</b>	

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

Classification according to the Classification of the Functions of Government (COFOG) and Peter Reuter (2006).

**Table 2. Estimate of central government transfers to municipalities related to costs of drug-related harm incurred by the government (\***

	Authority	Reuter's	Harm-related costs associated with drug use	Costs incurred by central government (*
07. HEALTH CARE	07.2 OUTPATIENT CARE SERVICES	Harm reduction	9.8	2.5
	07.3 HOSPITAL SERVICES, IN PATIENT CARE	Harm reduction	20.2	5.0
10. SOCIAL SECURITY	10.4.0 FAMILY AND CHILDREN (IS)			
	Child welfare services	Harm reduction	44.0	11.0
	10.7.0 SOCIAL EXCLUSION NOT CLASSIFIED ELSEWHERE (IS)			
	Substance abuse services	Treatment	51.4	12.9
	Income support	Harm reduction	8.1	2.0
<b>REVENUE TRANSFERS TO MUNICIPALITIES TOTAL</b>				<b>33.4</b>

\*) In Finland, local government is responsible for providing social welfare and health care services. The central government contributes to their funding by paying central government transfers to municipalities. The estimate of central government transfers related to costs of drug-related harm is based on a study conducted by Mellin et al. (2006). According to the study, the central government pays for about one fourth of the local authorities' social welfare and health care costs.

### Social costs related to drugs

In 2009, costs related to the abuse of drugs and pharmaceuticals amounted to about EUR 230 to 320 million in direct costs and EUR 550 to 1,210 million in indirect costs<sup>13</sup> (Table 3). Social welfare costs accounted for the largest percentage, nearly one third, of all direct costs. Next came costs incurred through the enforcement of public order and safety, accounting for approximately one fourth. The largest percentage of indirect costs came from the value of life lost due to premature death.

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

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

In 2009, social costs again increased the most of all direct drug-related costs, by nearly 8% on the previous year. Other indirect costs increased at a more moderate rate: costs related to the enforcement of public order and safety rose by about 0.3%, and health care costs by about 3%. The costs of research and preventive substance abuse work, by contrast, decreased by more than 5%. In indirect costs, the value of lives lost due to drug-related deaths increased markedly, by some 4,1%, and production losses by 4.5%, due to the increase in the number of drug-induced deaths and days in drug-induced inpatient care.

<sup>13</sup> The expenditure incurred from drug-related harm is calculated based on a framework long established in Finland. (Salomaa 1996; Hein & Salomaa 1998.) Harm-related expenditure is published annually in the Yearbook of Alcohol and Drug Statistics published by THL.



**Table 3. Costs of drug-related harm by main group in 2008 and 2009, EUR million**

	<b>min</b>	<b>2008 max</b>	<b>min</b>	<b>2009 max</b>
<b>Direct costs</b>	<b>223</b>	<b>312</b>	<b>229</b>	<b>321</b>
Health care costs	23	56	23	58
Social costs	93	99	100	107
Public order and safety	60	78	60	78
Property damage, research, substance abuse prevention	48	79	47	77
<b>Indirect costs</b>	<b>526</b>	<b>1,164</b>	<b>548</b>	<b>1,213</b>
Production losses	65	108	68	113
Value of life lost due to premature death	461	1,057	480	1,100

Sources: Yearbook of Alcohol and Drug Statistics 2010 and 2011, THL.

## 2. Drug use in the population

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

Much like in the 1960s, the new rise in experimentation with and the use of drugs in the 1990s was a youth and generational phenomenon. The techno culture landed in Finland at the end of the 1980s, beginning as a small underground movement. This phenomenon began to gain in popularity in the mid-1990s, especially among young adults (aged 15–34). By the end of the 1990s, the phenomenon had diversified and was no longer only a marginal way of partying among urban youth. Studies show that the trend in drug experimentation of the 1990s was subject to gender-specific variation and was set in motion by men, followed by women only in the second half of the decade. The percentage of those having tried drugs grew until the end of the 1990s, after which the trend clearly levelled off. Today, drug use is much more a part of everyday life for young people and is much more firmly established as a party pastime and as a component of substance abuse.

Nonetheless, drug experimentation and use are still significantly more prevalent now than at the beginning of the 1990s. This increase is partly explained by the increasing percentage in the domain of population surveys of the generation that began its drug experiments in and after the 1990s, while older generations with no drug experiences at all are dropping out. The most recent data show that experimentation is on the increase again, now particularly in the 25 to 34 age group. According to data for 2010, about 17% of Finns aged 15 to 69 reported that they had tried cannabis at some point in their lives, 4% within the past year. Men accounted for slightly more of those who had tried cannabis than women. The highest incidence of use was in the age group of 15 to 34.

### 2.1. Drug experimentations in Finland

According to the population study results from 2010, the percentage of the population aged 15 to 69 who had at some point in their lives tried cannabis was 17%.<sup>14</sup> The percentage was 13% among women and 20% among men. There was a heightened incidence of experimentation, 36%, in the young adult age group (aged 25–34). The percentage of those who had at some point in their lives tried other drugs was 2.1% for amphetamines, 1.7% for ecstasy, 1.5% for cocaine and 1.0% for opiates. In the age group of young adults aged 25 to 34, the percentage of those who had at some point in their lives tried other drugs was 6.4% for amphetamines, 5.9% for ecstasy, 4.3% for cocaine and just under 3% for opiates. Based on the survey, a total of 4% had tried cannabis during the past year, and far less than 1% had experimented with other substances. The percentage of those who had tried cannabis during the past month was 1%. Hypnotics, sedatives or painkillers had been misused by 6.5% of the general population at some point in their lives, misuse being defined as using them for non-medicinal purposes, without a physician's prescription or in larger doses than prescribed, the most common motive for such usage being the ability to sleep soundly. The percentage of misuse of pharmaceuticals was 9.9% in the age group of young adults aged 25 to 34. (Hakkarainen et al. 2011a; Hakkarainen et al. 2011b.)

The percentage of those who had tried cannabis within the past year seems to have increased slightly throughout the 2000s. This is not a statistically significant increase, however. However, significant changes

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<sup>14</sup> The sample space of the study comprised Finns aged 15 to 69, from whom a random sample of 4,250 people was chosen in autumn 2010. The basic sample consisted of 3,000 randomly chosen members of the target group, while the additional sample consisted of 1,250 members of the age group 15 to 39. The aim of the oversampling was to focus the study on the most active population group in terms of drug use. The participants were given the options of responding online or returning a questionnaire by mail. Online responses were protected by personal IDs and passwords. To increase the response rate, the participants were sent a reminder form twice. A total of 2,023 responses were received (48%), the lowest response rate ever in this series of studies that had begun in 1992. (Hakkarainen et al. 2011b.)

have occurred particularly within the age group of 15–34: from 2002 to 2010, the percentage of those who had tried cannabis remained almost stable in the 15–24 age group, while increasing almost to the level of the younger group in the 25–34 group. In other words, cannabis use almost tripled in the 25–34 group during this period. It would thus seem that cannabis is no longer the exclusive province of youth culture; also, the cannabis use of the generation that was experimenting around the turn of the 2000s seems to have acquired permanence. There are also notable differences in drug use between the genders: in the youngest age group men and women are almost on a par, but later the figures for men diverge. Unlike with men, the recent use percentage among women decreases sharply in the 25–34 age group. (Hakkarainen et al. 2011a.)

The percentage of those who had tried cannabis during the past month remained at 3% in the 15–34 age group but was only 1% in the 35–44 age group, demonstrating that long-term, regular use of cannabis has not become a widespread phenomenon, at least not yet. An exception to this rule is formed by men who began their drug use around the turn of the 2000s; no fewer than 15% of them reported that they had used cannabis during the past year, and 5% during the past month. (Hakkarainen et al. 2011a.)

**Table 4. Lifetime and 12-month prevalence of cannabis use by age group, 1992–2010, %.**

		199	199	199	200	200	201
Lifetime							
	al	5	8	1	1	1	1
	15–	12	14*	1	2	1	2
	25–	1	1	1	1	2	3
	35–	4	8	8	1	1	2
	45–	1	2	3	4	6	6
12-mth prevalence							
	al	1	2	3	3	3	4
	15–	6	9*	1	1	9	1
	25–	2	3	3	4	7	1
	35–	0	1	0	1	2	1
	45–	0	0	0	0	1	0
		* = ages 18–24; ** = ages 16–					

Source: Hakkarainen et al. 2011b.

In Finland, alcohol use and related problems have traditionally been far more common than drug use and related problems. However, drug use has increased substantially over the past 15 years. But how are alcohol use and drug use linked in Finland? This question was approached by combining data from the questionnaires from 1998, 2002 and 2004 referred to above. The material was divided into five categories: (1) persons who had never encountered drugs, (2) persons with occasional drug encounters, (3) persons who had tried drugs, (4) cannabis users and (5) multi-substance users.<sup>15</sup> (Hakkarainen & Metso 2009.)

<sup>15</sup> The categories were more specifically defined as follows: (1) persons who had never been offered drugs and had never tried them; (2) persons who had been offered drugs but had never tried them; (3) persons who had at some time tried drugs but had not used or tried them within the past 12 months; (4) persons who had used cannabis within the past 12 months and before that and who had tried (no more than two) other drugs; and (5) persons who had been using more than two different drugs, also within the past 12 months. In all, the study included data on 7,227 persons. Logistical regression analysis was used.

Binge drinking (at least 6 units of alcohol at one time) and restaurant visits were the most common by far among cannabis users and polydrug users, and the least common among persons who had never encountered drugs. This difference remained significant even when the data were controlled for gender and age. The intoxicant use of pharmaceuticals was particularly heightened among polydrug users. The study suggests a clear correlation between alcohol consumption, particularly binge drinking, and drug use. The often-quoted hypothesis that cannabis use tends to replace alcohol use does not seem to hold true, at least not in Finland; on the contrary, cannabis use tends to occur alongside heavy drinking. (Hakkarainen & Metso 2009.)

A more recent phenomenon in Finnish drug use, emerging in the late 2000s, is the rapid increase in the home growing of cannabis. This phenomenon manifests itself in crime statistics and has also been probed by survey.<sup>16</sup> Seizure statistics show that while the number of cannabis plants seized annually was only a few hundred in the 1990s, this figure had ballooned to several thousand by the 2000s, and in 2010 the number of plants seized was 15,000. A similar rapid growth may be seen by comparing the data from the 2008 and 2010 population studies. In 2008, the lifetime prevalence of hashish was greater than that of marijuana (10% vs. 9%), but by 2010 their positions had switched (12% vs. 13%). In terms of 12-month prevalence, cannabis overtook hashish in 2008, and according to the 2010 population study, 2% of the adult population had used hashish but 4% had used marijuana. Moreover, 10% of the respondents declared that they personally knew someone who was growing cannabis, even though only 1% had themselves engaged in home growing. Nevertheless, the obvious shift in the relative status of hashish and marijuana experiments is probably largely due to increased domestic home growing of cannabis. By comparing the responses to questions concerning home growing during the past month, the researchers estimated that there must be almost 10,000 active home growers of cannabis in Finland. (Hakkarainen et al. 2011a.)

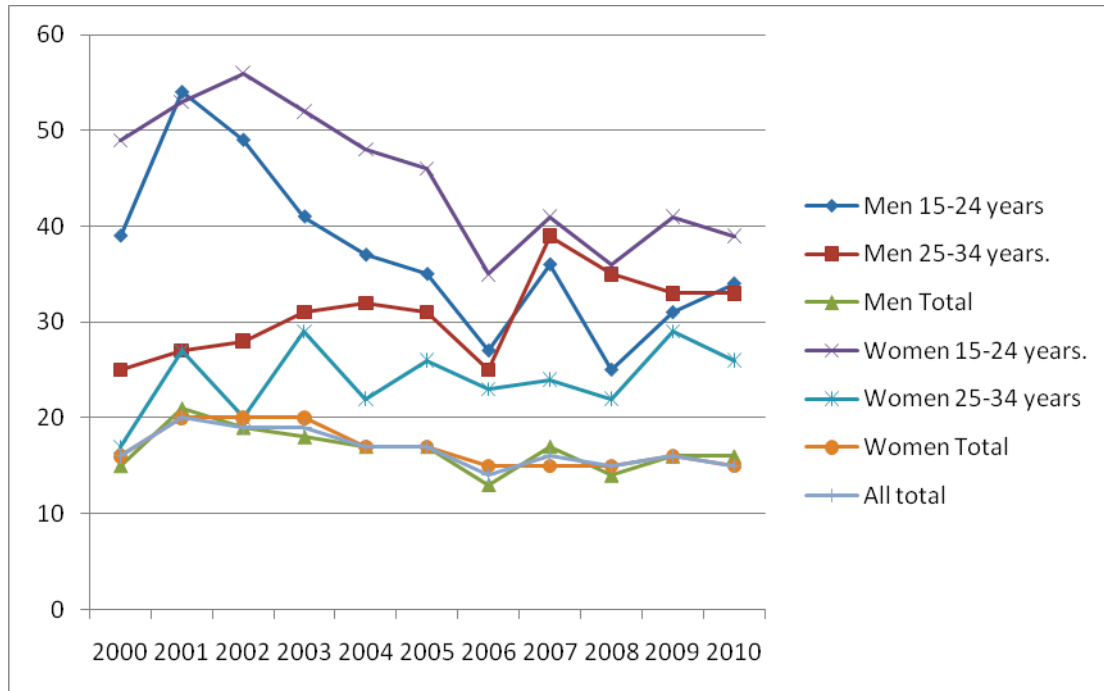
The survey shows that the majority (72%) of those practicing home growing of cannabis fall into the category of having 1 to 5 cannabis plants. Only slightly over 2% of the respondents noted that they grow more than 20 plants at a time. The online survey was weighted towards small-scale home growers, as the seizure statistics of the police show that 13% of seizures involved plantings of more than 20 plants. In all, about one in five respondents had had dealings with the police because of home growing of cannabis. The survey also revealed that the principal sources for information and for acquisition of seeds or seedlings were the Internet and other home growers – the percentage of cannabis sellers as sources was almost nil. More than two thirds of the respondents reported that they had invested no more than EUR 100 in their most recent harvest. (Hakkarainen et al. 2011a.)

Cannabis is typically grown by male adolescents and young adults who are more likely than other members of their age group to live alone and who are less settled in terms of family or children. About half of those practicing home growing are daily users of cannabis, whereas the percentage of daily users in general population studies is about 6%. Among the home growers 22% were heavy users (more than 1 g per day). Principal reasons given for home growing were: for the grower's own needs; the enjoyment of growing the crop; avoiding the illegal drug market; and the better quality of home-grown cannabis. Only 10% of respondents mentioned selling cannabis as a motive, although one in three did consider that they might offer their produce to their friends. The relationship between alcohol and cannabis among home growers was dualist: combined use was routine for one in ten, one in three reported that they used both together no more than 1 to 3 times per month, and one in three reported that they almost never use both together. (Hakkarainen et al. 2011a.)

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<sup>16</sup> Finnish home growers of cannabis were recruited for the study via a website dedicated to the subject. The interviews (38) were conducted in 2008. There were 36 men and 2 women, most of them (55%) in the 25 to 34 age group. Also, an anonymous online questionnaire was targeted at Finnish home growers of cannabis in 2009. There were 1,298 respondents, 80% of whom had grown cannabis during the past year. The research material was compared to the results of the 2008 population survey and the preliminary results of the 2010 population survey. (Hakkarainen et al. 2011b.)

In the Health Behaviour Surveys among the Finnish Adult Population (aged 15 to 64),<sup>17</sup> the most important annual indicator depicting the development of the drug situation is the percentage of people in various age groups who know someone who has experimented with drugs. These percentages increased until the early 2000s but then went into a decline until the middle of the decade. The change has been clearest among the age group of 15 to 24. For the population as a whole, however, the decrease halted at the 15% level towards the end of the 2000s due to sharp annual shifts in the trend since 2006, especially in younger age groups. (Piispa et al. 2008; Helakorpi et al. 2011.)



**Figure 1. People who know at least one person who has experimented with drugs during the past year, %.**

Source: Helakorpi et al. 2011.

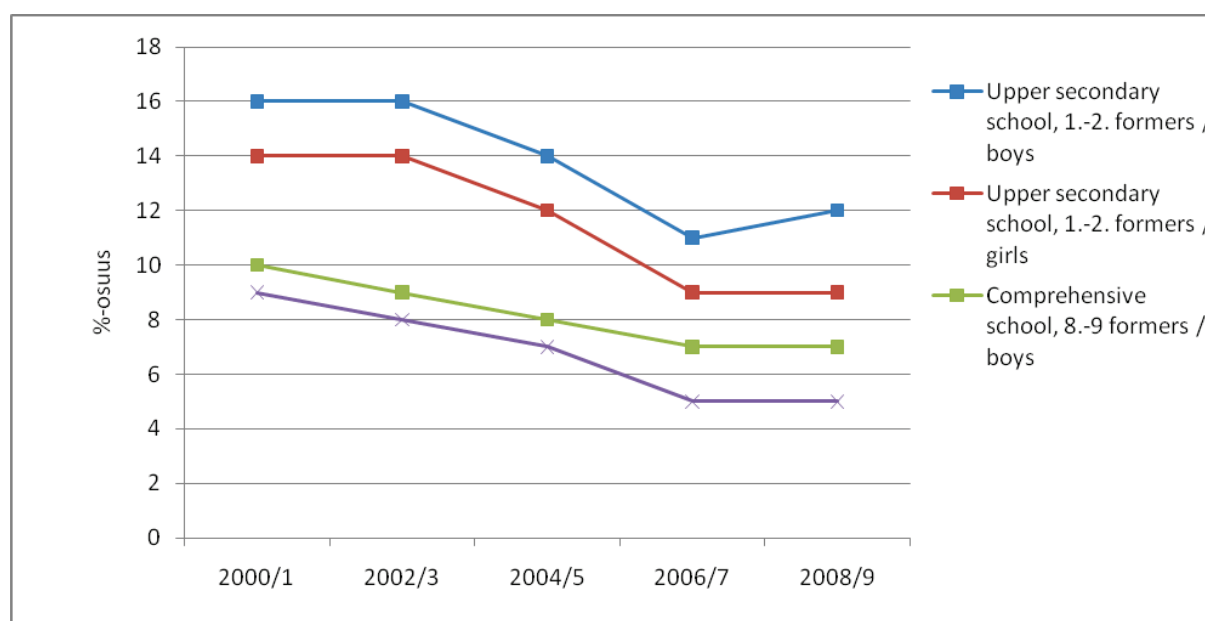
After a plateau period, drug use in Finland began to increase again by the turn of the 2010s. This increase owes a great deal to cannabis use among men aged 25 to 34. It also correlates clearly with the increased home growing of cannabis. User trends for other substances have been relatively stable, with the possible exception that in the group of stimulants ecstasy and cocaine have caught up with amphetamine. In the group of opiates, it is noteworthy that the use of buprenorphine and other pharmaceutical opioids (tramadol, fentanyl, oxycodone) Misuse of hypnotics and sedatives ranks between the use of cannabis and the use of other illegal drugs; these pharmaceuticals are usually used for sleep problems but also for intoxication purposes and to alleviate or enhance the effects of other intoxicants. The combined use of alcohol and drugs is a characteristic feature of substance abuse in Finland, as witness the fact that of those who have used drugs during the past year about half are also high-risk users of alcohol. Despite the plateau of the early 2000s, by 2010 drugs seem to have strengthened their position in the partying habits of young urban adults (men) and recreational use and as a cause of social exclusion related to substance abuse. (Hakkarainen et al. 2011a.)

<sup>17</sup> Data for the health behaviour surveys have been collected by a postal survey sent to a representative random sample of 5,000 persons among those aged 15 to 64 years of age and permanently living in Finland; people living in institutions were excluded from the study. Questionnaires were mailed out during the spring (in April) and those who did not respond were sent two (in 1996) or three (in 1997–2009) new questionnaires during the following two months. The number of those returning the questionnaire has varied annually between 3,000 and 3,600. In 2010, there were 2,826 respondents (57%). (Piispa et al. 2008; Helakorpi et al. 2011.)

## 2.2. Drug use in the school and youth population

According to the 2007 ESPAD survey of school pupils,<sup>18</sup> 8% of children aged 15 to 16 had experimented with cannabis at some time in their lives, whereas the corresponding figure was 10% in 1999 and 11% in 2003. Differences between girls and boys were not significant. The percentage of respondents who reported having tried illegal ‘hard’ drugs was 0% to 2%. (Ahlström et al. 2008.)

Similar results may be found in the national school health survey, which on a biennial cycle covers half of Finland’s municipalities each year and is aimed at 8th and 9th grades in comprehensive school and the 1st and 2nd years of upper secondary school.<sup>19</sup> The distribution data are fairly even regionally except for southern Finland, where levels were on average one third higher than in the rest of the country. However, there are differences according to educational attainment. In 2008–2009, an estimated 11% of students in the 1st and 2nd years of upper secondary school had tried illegal drugs at some time in their lives, while the figure for students in the 1st and 2nd years of vocational education was 17%. (Luopa et al. 2010.)



**Figure 2: School health survey: Students who had tried illegal drugs at least once, %**

Source: Luopa et al. 2010.

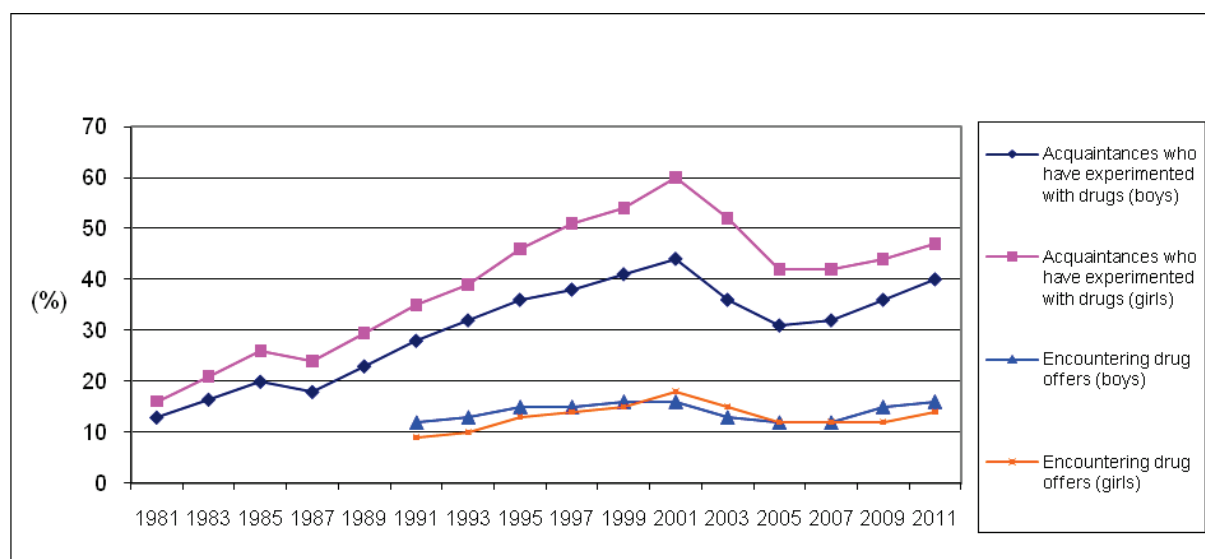
According to the ESPAD survey, pupils doing well in school use substances of any kind less frequently than those performing poorly. Throughout the history of the ESPAD survey, drug experimentation has been low (4% to 5%) among pupils doing well in school, and in 2007, for instance, the difference in cannabis use was considerable between high-performing and low-performing pupils (3% vs. 17%). A similar phenomenon emerges based on questions gauging truancy. According to the 2007 results, 4% of pupils who had not skipped a class during the last month had experimented with cannabis at some point, while among

<sup>18</sup> The latest of these surveys was the 2007 ESPAD survey, which involved 299 schools and 5,043 pupils in the 9th grade of comprehensive school. Data were collected using the same compilation method as in the 1995, 1999 and 2003 surveys. The response rate was 91% in 2003. (Ahlström et al. 2008.)

<sup>19</sup> The national school health survey is conducted under a teacher’s guidance during one class period. The respondents return their anonymous forms to the teacher, who seals all the forms for that class in an envelope in the presence of the pupils. The class envelopes are then put together in a package by the school and sent to the research group. Finland has been divided into two geographical areas, each surveyed in alternate years. In examining trends and changes, comparable material is used from those schools that have participated in the survey every time, whether in odd-numbered or even-numbered years. A total of 535 comprehensive schools and 321 upper secondary schools were included. The combined data from odd-numbered and even-numbered years included 81,057 to 83,915 respondents per year in comprehensive school and 39,084 to 43,242 in upper secondary school. The change data covered, depending on the years considered, between 61% and 65% of all pupils in the 8th and 9th grades of comprehensive school in Finland and between 51% and 58% of all pupils in the 1st and 2nd years of upper secondary school. (Luopa et al. 2010.)

pupils who had skipped classes at least three times, one third had experimented with cannabis at some point. By contrast, the educational background of the pupil's family does not significantly influence experimentation, notwithstanding the fact that experimenting with drug use originally (in the mid-1990s) first emerged in families with a higher education background. (Metso et al. 2009, 79–81, 84–86.)

The questions in the national Adolescent Health and Lifestyle Survey, aimed at young people aged 12 to 18,<sup>20</sup> enable the analysis of their 'social exposure to drugs'. Respondents are asked whether any of their acquaintances has experimented with intoxicants or whether they themselves have been offered such substances. The survey indicates that the percentage of young people aged 14 to 18 with at least one acquaintance who has experimented with drugs increased between 1987 and 2001 and then started to fall before levelling off in 2007. The 2011 survey shows that the majority of drug offers are made by friends and acquaintances, which indicates that drugs have become part of young people's everyday lives and that availability is not particularly scarce nor dependent solely on supply from external sources. In 2011, one in six boys and girls under the age of 18 had been offered drugs. (Raisamo et al. 2011, 38–40, 65–66.)



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

Source: Raisamo et al. 2011.

Links between adolescents' experiences of bullying at school and using drugs were explored in a nationwide study where the relevant responses from a survey of 8-year-old schoolchildren (boys) and interviews with their parents and teachers were compared with interview responses over a 10-year follow-up period.<sup>21</sup> The results indicate that a boy being a bully at school at the age of 8 is a fairly reliable predictor of experimentation in drug use later, at the age of 18. Regular bullying also seemed to predict later drug use fairly well independently of the other variables taken into account in the study. Being bullied, by contrast, actually seemed to decrease the likelihood of drug use at a later age. As regards regular

<sup>20</sup> The survey takes the form of a postal survey repeated every other year, the first being conducted in 1977. The survey sample is selected from among those aged 12, 14, 16 and 18. For those who have not responded, the survey includes two new questionnaires, the final one being available in electronic format. The 2011 survey covered a total of 4,566 youth respondents (response rate 47%). (Raisamo S et al. 2011.)

<sup>21</sup> The research material was collected in 1988 and 1998. The 1989 material consists of a 10% random sample of the entire age group of 8-year-olds in that year. There were 2,946 boys. For these children, interviews with their parents and teachers were included in the study. Concerning school bullying, the children were asked both about being a victim and being a bully, whereas parents and teachers were only asked about being a victim. The follow-up study was conducted in 1999; about 78% of the original research target group responded to questions about tobacco, alcohol and drug use. The results are slightly skewed by the fact that there were more respondents with experiences of school bullying among the respondents lost from the original group than there were among those who responded to the follow-up. Logistical regression analysis was used. (Niemi et al. 2011.)

smoking, the correlation was completely reversed. The researchers explain the link between bullying and later drug use by referring to the antisocial personality characteristics of bullies. It should be noted, though, that the study only concerned boys. (Niemelä et al. 2011.)

In Finland, data on twins born between 1983 and 1987 have been gathered in the *FinnTwin 12–17* studies. These data have been used to analyse the role of drug use determinants in drug experimentation: the role of individual, peer group and family variants in young people's experiments with cannabis (Korhonen et al. 2008) and the effect of early-age depression on later drug experiments (Sihvola et al. 2008). The purpose was to conduct a two-phase assessment of these interrelationships. First, the twins in the study sample were analysed as individuals. Subsequently, controls were introduced to account for any family-specific (genetic) sources of error by targeting the analysis at those twins for whom a determinant in drug experimentation (and early-age depression) actually distinguished one twin from the other in the same family.

The study examining the effects of individual, peer group and family variants on drug use<sup>22</sup> therefore found that 13.5% of the twins included in the study had experimented with cannabis by the age of 17.5 years. These experiments had been significantly influenced by early initiation into smoking, frequent binge drinking, the number of smoking friends, the number of friends who had experimented with drugs, weekly binge drinking by the family's father and, for boys, aggressive behaviour in early youth. When the model was specified by targeting the analysis at twin pairs of whom only one twin had experimented with drugs, the results changed. Ultimately, determinants significantly influencing experimentation with drugs included the following: a teacher's report of hyperactivity or aggressiveness at the age of 12, initiation into smoking and binge drinking at 14 or earlier, a high number of smoking friends (more than 5 persons) and, at 14, at least one friend who has experimented with drugs. However, the researchers point out that many determinants of drug experimentation discovered in other research literature (family attitudes, discipline, general environmental factors, availability of drugs) had to be excluded from the study's original list of variants. (Korhonen et al. 2008.)

In the most recently published twin study, the analysis of a possible connection between smoking and drug use was explored on the basis of surveys among subjects aged 17.5 years.<sup>23</sup> The study compared structural equation models, the first assuming that smoking had a cause-and-effect impact on starting drug use and the second assuming that shared genetic and/or environmental factors underlie both. In both models, genetics had a lot to do with both starting smoking and starting drug use. The model where early smoking was assumed to influence drug use fit the data somewhat better, but shared genes could not be completely ruled out. By contrast, starting smoking had no direct impact on continued drug use (using drugs more than four times during their lifetime); the impact of smoking was indirect, through starting drug use. As a factor in continuing drug use, individual environmental factors emerged as more significant than they were for continuing smoking (smoking more than 50 times during their lifetime). (Huizink et al. 2010.)

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<sup>22</sup> Research data consisted of five full birth cohorts of twins from 1983 to 1987 (n=5,600 twins), baseline surveys targeted at the twins and their parents when the twins were aged 11 to 12 (coverage 87%), a follow-up survey when they were aged 14 (coverage 88%) and a second follow-up survey when they were aged 17.5 (coverage 92%). The data also included teacher assessments of twins aged 11 to 12 years. The cluster of determinants was selected based on a literature review and assessed using the baseline survey and the first follow-up survey, while drug use was gauged through the survey addressed at 17.5-year-olds. After cleaning and inspection, the final data comprised information on 3,118 persons (twins). These data were analysed using logistic and conditional logistic regression analyses by using the odds ratio as a measure of association. (Korhonen et al. 2008.) A comprehensive description of the twin study can be found here: <http://wiki.helsinki.fi/display/twineng/Finntwin12>.

<sup>23</sup> The material was obtained from the twin study referred to in the previous footnote. This time, tobacco and drug use was studied among 17.5-year-olds, and finally the material consisting of data on 3,744 twins was analysed. The material was analysed using a model with two alternative multiple variable methods and standard statistical tests. (Huizink et al. 2010.)



### 2.3. Drug use among students

In 2008, a survey was conducted among students at universities and universities of applied sciences to explore their health, health behaviour, related factors and use of health care services.<sup>24</sup> The average age of respondents was 24 at universities of applied sciences and one year more at universities. Women accounted for 63% of the respondents. With regard to intoxicant use, it was found that more than 90% of students use alcohol and that one in four men and almost one in ten women have more than 6 units at a time each week. 22% of students reported that they had tried cannabis at some time in their lives; about one in three of these had tried it during the past year. The figure for other drugs was about 3%, of which likewise about one in three during the past year. The percentage of cannabis users was higher among men, but there were no significant differences relative to educational attainment. (Kunttu & Huttunen 2009.)

According to Kunttu & Huttunen, the lowest level of alcohol use by faculty was found among students of medicine. A voluntary survey on intoxicant use among students was conducted at a general examination session at the Faculty of Medicine at the University of Tampere in 2007.<sup>25</sup> The average age of respondents was 24, and 62% of them were women. The survey indicated that while more than 90% of students used alcohol, the percentage of those who drank more than 6 units at one time at least once a week was more than 25% among men but only about 2% among women. 23% of the students had tried cannabis, but fewer than 2% had tried other drugs. The incidence of cannabis experimentation was the same among men and women. (Meriläinen et al. 2010.)

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<sup>24</sup> The sample space of the study consisted of Finnish students aged under 35 studying for a bachelor's degree at a university of applied sciences (sample 4,984, 46% men) or a university (sample 4,983, 45% men). The total response rate, after three reminders, was 51%; the rate was higher among university students (55%). A similar study was conducted among university students only in 2000 and 2004. (Kunttu & Huttunen 2009.)

<sup>25</sup> The sample space of the study consisted of 1st to 5th year students at the Faculty of Medicine at the University of Tampere. The questionnaire was distributed at a compulsory examination session. There were 497 students at the examination, and 468 acceptable forms were returned (response rate 94%).

## 3. Prevention

### 3.1. General remarks on substance abuse prevention in Finland

Substance abuse prevention affects awareness of, attitudes to and rights pertaining to intoxicants; factors protecting from harm from substance abuse and risk factors; and the usages, availability, offering and harmful effects of intoxicants.

Substance abuse prevention is provided for by law and forms part of the wider concept of promotion of well-being and health. In Finland, municipalities and joint municipal boards are principally responsible for arranging and providing social and health care services. Substance abuse prevention is highlighted through inclusion in legislation (Primary Health Care Act, Temperance Work Act, Child Welfare Act, Youth Act), in ongoing policy programmes (the Health 2015 public health programme, Kaste) and the service quality recommendations which guide policies (for instance, recommendations concerning the quality of services for substance abusers, and quality criteria for substance abuse prevention).

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

Local authorities are recommended to have a mental health and substance abuse service strategy in place, defining the responsibilities of substance abuse services at health centres. (Ministry of Social Affairs and Health 2009b.) However, a study<sup>26</sup> shows that only 69% of health centres have an approved strategy for substance abuse services. Moreover, only 65% of health centres have a plan approved by management for reducing harm caused by substance abuse. In the study, 73% of health centres stated that they undertake mini-interventions aimed at reducing alcohol use. Health counselling for drug users was only provided by one in three health centres (35%), and 40% had agreed on shared practices for identifying drug users. (Rimpelä et al. 2009a.)

In order to improve substance abuse work, a network of municipal contact persons for substance abuse prevention was established in 2000. The duties of a contact person include the promotion of substance abuse prevention through multi-professional co-operation in the municipality, information dissemination between the actors involved in prevention and co-ordination of the municipal or regional substance abuse strategy.

Development of the municipal and regional networks for substance abuse prevention is carried out within the framework of the National Alcohol Programme. The National Institute for Health and Welfare (THL) is the programme's main co-ordinator, steering the implementation of the municipal programme. In addition, THL is developing the regional developer network for substance abuse. It also collects and disseminates best practices in the field. Regional State Administrative Agencies are hiring regional coordinators to ensure that the programme's policy lines are implemented in both regional and municipal substance abuse strategies.

Substance abuse prevention involves not only municipalities: NGOs and other third-sector actors play a central role in the practical work of substance abuse prevention both as individual actors and as service providers for municipalities. The NGOs aim to promote discussion and provide information on drugs, drug

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<sup>26</sup> Directors of health centres (n=231) were sent an online survey in October 2008, requesting a joint response from the management group. In addition to aspects of actively promoting health among the population, the questionnaire included questions on how the management viewed health promotion and key public health programmes. Responses were received from 190 health centres (82%), including all of the largest ones (50,000+ residents) and 89% of the medium-size ones (20,000 to 49,999 residents).

use and the related causes and consequences. In addition, NGOs attempt to influence public attitudes, organise peer support activities and provide post-care for substance abuse patients.

The Finnish Centre for Health Promotion (Tekry) is a substance abuse policy opinion leader. It supports self-control of substance abuse and prompts public debate by publishing information on intoxicants and *vox populi* opinions. The organisation supports and develops networks and conveys information between NGOs and other actors both nationally and internationally. Tekry coordinates a substance abuse prevention theme week, the purpose of which is to raise the profile of substance abuse prevention and to increase co-operation among actors that would survive the theme week. Themed events are held at various locations during the theme week. In 2011, the theme for the week was *Päihdeilmastomme kaipaa muutosta* (We need a change in our intoxicant climate). The Finnish Centre for Health Promotion also organises *Päihde- ja mielenterveyspäivät* (National substance abuse and mental health seminar), the most extensive annual training event for substance abuse service professionals, aiming to develop and showcase current trends in prevention, treatment and rehabilitation. Drug issues are also discussed at the seminar. (Tekry 2011a.) The organisation also maintains a material databank on substance abuse prevention, with relevant materials gained from NGOs, local authorities and other actors. (Tekry 2011b.)

Quality criteria have been determined for substance abuse prevention. The criteria are qualitative and suited to the prevention and reduction of harm related to substance abuse.<sup>27</sup> The practical implementation of the quality criteria is considered a central tool in improving the quality of substance abuse prevention. These quality criteria do not separate drug prevention from other substance abuse prevention. (STAKES 2006.)

The Ministry of Education and Culture supports preventive drug and substance abuse work by providing funding for improving the potential for prevention, for training employees and volunteers, and for running long-term projects. Drug use prevention also forms a component of other youth activities such as youth workshops and afternoon clubs. Education and information projects concerning young people's lifestyle choices are also supported as and when possible.

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

The *Neuvoa-antavat* themed service (<http://neuvoa-antavat.stakes.fi>) is the national substance abuse online service maintained by the National Institute for Health and Welfare. The website includes a database of substance abuse treatment facilities and of strategies.

### 3.2. General substance abuse prevention

#### Youth work and policy

Substance abuse prevention components of the Youth Policy Development Programme 2007–2011, implemented pursuant to the Youth Act, have been run under the coordination of the Ministry of Education and Culture, in co-operation with the Ministry of Social Affairs and Health and the Ministry of the Interior, and youth work methods have been developed from the substance abuse prevention perspective.

Preventiimi, a national knowledge centre for youth substance abuse prevention, has published support materials for high-quality substance abuse education. In its guide, preventive substance abuse work with young people is considered to include social empowering, general prevention and risk prevention. The purpose of general prevention is to provide young people with current information on various intoxicants and the risks caused by their use. In addition to health risks, these include problems that substance abuse

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<sup>27</sup> Criteria: focus of the work, target group, degree of effectiveness, knowledge base, values, realistic objectives, compatibility of the objectives with other strategies, operational models, resources, monitoring and evaluation, balance in the different subsections and relationship to the original situation.

may cause in relationships with friends, in school work and in families. How these matters are discussed and from what perspectives, and which examples are used, should be as closely related to the young people's own experiences as possible. Simply dishing out information is not necessarily enough. Efforts should also be made to ensure that the young people can process the information given to them and that the understanding they gain is relevant for their world. (Pylkkänen et al. 2009.)

Whereas prevention aimed at adults usually focuses on adverse health effects and risk factors, substance abuse prevention aimed at young people may avoid mentioning intoxicants at all and instead focus on building up life management skills overall. The general prevention aspect of youth work is based on giving young people guidance, help and support in growing up and in becoming a member of society, assisting them in coping with issues that they cannot necessarily handle on their own. What is essential is that the young people concerned feel that they are themselves participating in making decisions that affect their lives. (Pylkkänen et al. 2009.)

Preventiimi, which is administered by HUMAK University of Applied Sciences, also provides professionals with continuing education in substance abuse prevention for young people. Preventiimi is one of the national youth service and development centres designated by the Ministry of Education and Culture in a resolution adopted in 2011. Preventiimi provides training in substance abuse prevention for youth work professionals and others involved with young people, networking with local authorities and NGOs. Substance abuse prevention training for young people is being given and developed at the Preventiimi centre, one of the national youth service and development centres. Its projects also support prevention at schools, and it has produced a variety of materials. Support for projects aimed at young immigrants has been increased. Several hundred young people have participated in the international youth education programme Avartti, which is intended for all young people. The website of Preventiimi, a knowledge centre for youth substance abuse prevention, is at [www.preventiimi.fi](http://www.preventiimi.fi).

### **General substance abuse prevention at school**

Finland applies what is known as an environmental strategy in substance abuse prevention in schools, the aim being to make schools into a safe and risk-reducing environment for pupils. Schools also constitute part of local substance abuse prevention networks.

Substance abuse prevention at schools consists of:

- intoxicant education in normal classroom teaching, e.g. integrated into the compulsory health education subject,
- support for healthy growth and development,
- promotion of a safe and healthy learning environment,
- school health care support and extensive health examinations,
- availability of guidance and assistance in confidence,
- support for learning, helping pupils stay at school and cope,
- leisure activities,
- a school curriculum to prevent substance abuse and ground rules outlining what to do in a case of substance abuse at the school,
- planned and learned correct and timely intervention in substance abuse,
- co-operation with homes,
- co-operation with substance abuse services, and
- co-operation with other professionals and active citizens in the local substance abuse prevention network.

According to a recent evaluation study, both teachers and pupils in Finland are highly motivated to engage in the health education subject: teachers and pupils alike feel that there is much discussion in health education classes, and a notable percentage of pupils discuss the topics with their friends and parents after

the classes. A qualification in health education will be required from teachers after a transition period, as of the beginning of 2012. (Aira 2010.)

Because substance abuse education is integrated into the school curriculum, school-based drug prevention programmes play a secondary role in Finland's drug strategy. Schools may decide for themselves whether to implement such programmes, and they are not systematically monitored. In 2008, two thirds of all upper-level comprehensive schools held health theme days, and more than one in ten held health theme weeks. (Aira 2010.)

The police have cooperated closely with schools in anti-drug efforts and have appointed a liaison officer for each school. School resource officers and community policing have enabled the police to establish a close co-operation. The police have published information locally and nationwide on drug-related crime, new psychoactive substances, drug offences under investigation and their backgrounds. The information published is preventive in nature and specifically targeted at adolescents who are susceptible to experimenting with drugs.

### 3.3. Selective substance abuse prevention

Grants awarded from appropriations for youth work in 2010 have been used to support prevention projects aimed at risk groups among young people. Such projects have been organised by local authorities, NGOs, young people's workshops and national youth centres. Outreach youth work in particular has been improved, and at the moment there are 230 two-person teams in outreach youth work around Finland. The youth research network, working for instance with the National Institute for Health and Welfare, has been conducting research on substance abuse prevention.

Related to this issue, a guidebook for parents and people working with young people has been produced on how to approach anxiety and substance abuse and identify problems. (Fröjd et al. 2009).

In surveys for the promotion of health and wellbeing at upper secondary schools and vocational education institutions,<sup>28</sup> respondents were asked what the procedure was when drug use was suspected. In all, the number of cases of drug use reported was very low, though notably higher at vocational education institutions (n=29) than at upper secondary schools (n=13). Generally, the procedure was for a teacher, group leader or headmaster to talk to the student in question. Vocational education institutions are markedly more active in referring students to student health care in these cases and also in contacting the parents in the case of a student aged under 18 and/or child welfare services and/or the police. (Rimpelä et al. 2009b; Väyrynen et al. 2009.)

*Päihdelinkki (AddictionLink, www.paihdelinkki.fi)* Over ten years ago a key organisation in the field of substance abuse treatment and prevention, the A-Clinic Foundation, created a national drug information service (AddictionLink at www.paihdelinkki.fi) to support anti-drug work. AddictionLink is a low-threshold web service providing information on addictions as well as self-help tools. The aim of the *Kuivaushuone (Drying room)* discussion forum is to stop using drugs. The most popular discussion forum is *Sauna*, where the aim is to mitigate the harmful effects of substance abuse. (AddictionLink 2011.)

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

### 3.4. Targeted substance abuse prevention

Targeted substance abuse prevention aimed at young people often takes place in sheltered youth homes, rehabilitation units for young people and workshops. Substance abuse treatment and rehabilitation for

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<sup>28</sup> A largely coherent survey was conducted in 2008 among all upper secondary schools (n=416) and institutions with vocational upper secondary qualification programmes (n=192). The response rate was 90% for upper secondary schools and 84% for the other institutions.

young people is also a form of risk prevention, being aimed at discouraging them from returning to an intoxicant-favouring lifestyle. (Pylkkänen et al. 2009.)

In 2009, the National Institute for Health and Welfare published a guide on early identification of mental health and substance abuse problems. This guide is intended for social welfare and health care professionals involved with clients to help them identify and screen for mental health problems and substance abuse problems among young people and adults. It provides indicators for risk assessment and practical advice for prevention. Regarding drugs, the guide stresses the importance of a confidential client relationship and of having sufficient basic information on drugs. The guide does not recommend routine drug testing as a screening procedure. Drug testing is feasible as a component of a treatment relationship encouraging a lifestyle change. (THL 2009a.)

Early intervention in offences committed by young offenders has been effected in co-operation with various authorities. The purpose of the police engaging in early intervention is to prevent the development of a vicious circle of crime and substance abuse. Co-operation between the police and the health care and social welfare authorities is particularly important in improving the conditions of children and adolescents in problem families where the parents have a history of substance abuse.

According to the prosecutor guidelines on unlawful use of drugs, a first offender under the age of 18 must by default be given a reprimand; instead of being fined, their charges should be waived and a verbal warning given instead. The reprimand session is attended by the young offender himself/herself and his/her parent or guardian, and also representatives of the police, the prosecutor and the social welfare authorities. Reprimands were issued and charges waived thereafter in 40 cases in 2008, in 66 cases in 2009 and in 161 cases in 2010. The increase in the number of reprimands can be considered a positive trend, as it means that the procedure is being increasingly applied and that prosecutors are increasingly willing to do so. In 2008, five of Finland's prosecution units gave no reprimands at all, whereas in 2010 all but one prosecution unit gave reprimands.

Health counselling centres<sup>29</sup> engage in risk group prevention. Local authorities and NGOs also perform outreach work to find individuals not covered by services, such as school dropouts or drug users who do not use the services of the health counselling centres. Targeted information about the risks of drug use is also provided by NGOs in various relevant environments such as rock festivals or techno music events. (See e.g. Finnish Red Cross 2010; YAD 2011.)

### 3.5. National and local media campaigns

A report by Mikko Piispa (Piispa 2010b) published in the year under review focused in its first part on evaluating the pilot version of the Street Team campaign launched in 2007 by the Youth Against Drugs (YAD) NGO and in its second part on evaluating the first three months of the new version of the campaign launched in 2010. The project was run online, with participants signing up at the YAD Street Team website, which contained a number of tasks that gave points when correctly performed. The tasks were either online tasks or real-world tasks. The purpose of the YAD Street Team was to publicise YAD and the values and attitudes it represents. The YAD Street Team sought to influence young people's attitudes to drugs at the grass-roots level. The young people who join Street Team are basically critical of drugs to begin with, and membership of the campaign means that they are willing to declare their opinions in their respective peer networks. Indeed, the word of such participants often carries more weight in substance abuse discussions among young people than education provided by official sources.

Traffic and waterway safety campaigns are organised annually, focusing on all substance abuse. A general intoxicant education campaign is also conducted during the annual substance abuse prevention week (week 45). Each year during the week, two regional radio stations (Radio Auran Aallot and Radio

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<sup>29</sup> See chapter 7. Responses to health correlates and consequences.

Melodia) conduct an anti-drug campaign in co-operation with the education authorities, the Turku Customs, the Irti Huumeista NGO and corporate sponsors.

## 4. Problem drug use

The number of problem drug users in Finland is estimated based on the number of problem users of amphetamines and opiates, which was 14,500 to 19,100 in 2005; this accounts for 0.6% to 0.7% of the population aged 15 to 55. Nearly four fifths of problem drug users used amphetamines. The percentage of men was almost 80%, the majority of problem drug users being in the age group 25 to 34.

According to the 2010 data from the National Drug Treatment Information System, opiates were the major primary problem substance of clients entering drug treatment (representing 55% of all drug treatment clients of the substance abuse services), followed by stimulants (14%), cannabis (13%), alcohol (11%), and pharmaceuticals (6%). These results reflect the provision of treatment, since substitution treatment is so far available only to opiate users. Buprenorphine was the primary problem substance for as much as one third of the clientele. Although among the drug users with the most severe problems there are persons who use both amphetamines and opioids, the hard core of Finnish drug use consists of combined use featuring both polydrug use of opioid-based painkillers and sedatives (benzodiazepines) on the one hand and alcohol and cannabis on the other.

According to studies, alcohol is the primary problem substance in Finland. In fact, problem drug use is a very recent social problem in Finland. Typical factors underlying problem drug use in Finland are the relatively young age of users and, consequently, a relatively short history of drug use, albeit the average age of drug users has risen substantially over the past ten years. A particular feature is the central role of buprenorphine in intravenous use. Many drug users are socially marginalised in many ways and, in addition to substance abuse problems, have several other social and health-related problems.

### 4.1. Prevalence and incidence estimates of problem drug use

Estimates on the prevalence of problem drug use<sup>30</sup> based on administrative statistics have been made since 1997. According to these estimates, out of the population aged 15 to 54, there were some 14,500 to 19,100 amphetamine and opiate problem users in the entire country in 2005. (Partanen et al. 2007.)

The number of problem users of amphetamines and opiates<sup>31</sup> increased noticeably between 1999 and 2002. Since then, the proportion of problem users of amphetamines and opiates seems to have stabilised. The majority of problem users, 75% to 80%, consisted of amphetamine users, and they accounted for 0.4% to 0.7% of the population aged 15 to 54 in Finland in 2005. The estimated proportion of problem users of opiates was 0.13% to 0.18% of the population. The percentage of women was 20% to 30% in both substance groups. While the proportion of young people aged 15 to 24 was about 25% to 35%, they were no longer the largest user group, the age group 25 to 34 having already exceeded the younger age group's percentage. (Partanen et al. 2007.)

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<sup>30</sup> The estimates of problem drug users are based on the statistical capture-recapture method in which the samples from the same group are used to assess statistically the size of the entire target population. The samples were defined based on the interventions directed by society at the target population (amphetamine and opiate users). The interventions employed by the system included amphetamine or opiate diagnoses recorded in hospitals, penal action for drug offences involving the use or possession of amphetamines or opiates, arrest for driving under the influence of amphetamines or opiates and hepatitis C cases recorded in the infectious diseases register due to intravenous drug use. The estimate intervals are based on 95% confidence intervals of the estimates. Different log-linear models were applied to different subgroups, so the sum of the subgroups differs from the overall estimate. (Partanen et al. 2004; 2007.)

<sup>31</sup> According to the national definition used in the study, 'problem use' refers to the use of amphetamines and opiates which is so extensive that it causes social or health problems for the user. Furthermore, the authorities have had to intervene in one way or another, and this has been recorded in administrative registers. The intention was to produce a new estimate in 2010 using the 2008 data, but in analysing the register data it was found that because of a change in the register systems, the results were no longer compatible with earlier studies. New estimates of the number of problem users were therefore postponed by two years while the basis for retrieving data is re-evaluated.



**Table 5. Development of the percentage in the population (%) of amphetamine and opiate problem users in Finland in 1998–2005.**

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

Source: Partanen et al. 2004; 2007.

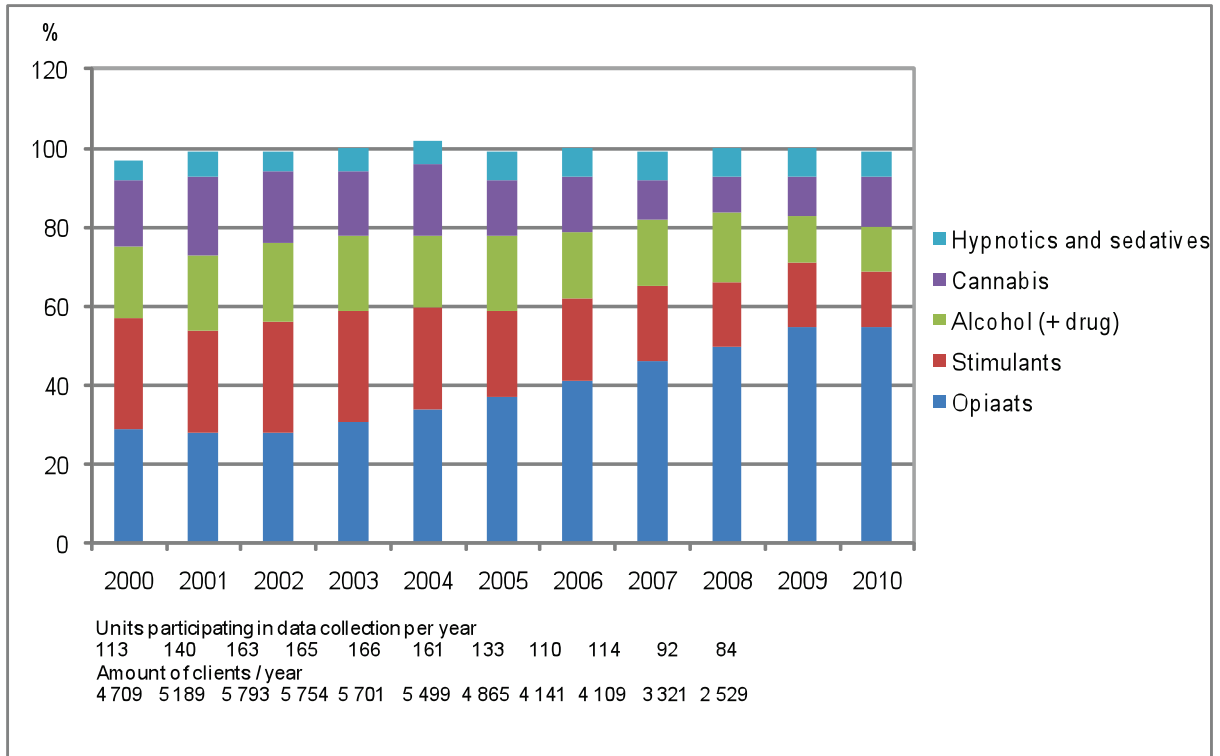
Some 50% to 60% of all problem users were from Southern Finland and more than half of them from the Greater Helsinki area. The proportion of women among problem users seems to be on the constant decline everywhere in Finland, possibly excluding the Greater Helsinki area. The aging trend among users is most evident in the Greater Helsinki area. In the light of data from 2005, it seems possible that the drug problem as well as specialised treatment services (substitution treatment, health counselling) will be concentrated in the Greater Helsinki area and possibly some other large cities. (Partanen et al. 2007.)

#### 4.2. Problem drug use in a wider context

According to the 2010 data of the national drug treatment information system,<sup>32</sup> the mean age of drug treatment clients was 30 years. Among all drug treatment clients of the substance abuse services, opiates were the major primary problem substance of clients entering drug treatment (55%), followed by stimulants (14%), cannabis (13%), alcohol (11%) and pharmaceuticals (6%). Buprenorphine, an opiate, was the primary problem substance for as much as 32% of the clientele (Figure 4). The percentage of buprenorphine as the primary substance of those entering treatment has increased the most in the 2000s, being now about one third. (Väänänen 2011.)<sup>33</sup>

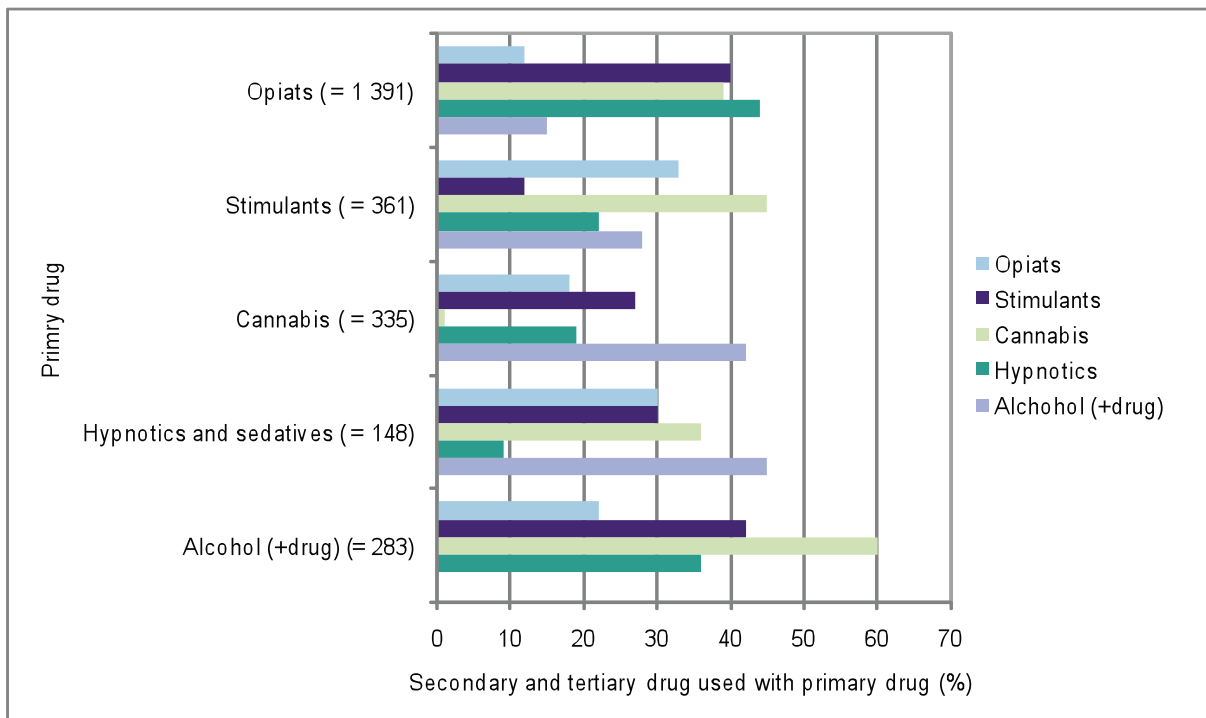
<sup>32</sup> These data are based on anonymous data collection through the voluntary participation of treatment units. The participation of treatment units in data collection has declined considerably since 2006, which can be seen in client numbers too (cf. diagram). Correspondingly, the number of new patients seeking care has dropped to 355. This makes the data less comprehensible and weakens year-on-year compatibility. Because of this, a coverage survey was circulated among 525 treatment units in 2008; the response rate was 61%. The survey indicated that the number of drug user clients was 12,807, meaning that the coverage of the drug treatment survey is about 32% of the clientele. A similar survey was conducted in 2004, when the number of clients was 17,825 but the coverage percentage the same, even though there were at that time only 165 treatment units in the Drug Treatment Information System. It would thus seem that the Drug Treatment Information System covers as large a percentage of the client domain as it did in 2004. The principal data collection problems mentioned in the surveys were a lack of resources, a small number of drug user clients, and overlapping information systems. The technical problem of data collection is being addressed with a new, online application that will probably be introduced as of 2012. See also Section 5.2. (Väänänen 2011.)

<sup>33</sup> The percentage of opiates was higher than in reality in the substance-specific calculations up to 2009, because for technical reasons the patients in substitution treatment were counted twice in some cases. In 2009, this overlap accounted for no more than 6% of the cases, and in the figures for 2010 the overlap was eliminated. (Väänänen 2011.)



**Figure 4. Primary substances used by clients entering treatment for the use of narcotics and pharmaceuticals (% of clientele) in 2000–2009.**

Source: Drug Treatment Information System, THL.



**Figure 5. Secondary and tertiary drugs used with the primary drug in 2009, %.**

Source: Drug Treatment Information System, THL.

Figure 5 summarises the secondary and tertiary drugs used by clients together with their primary drugs. Using a parallel review of the primary, secondary and tertiary problem substances enables the definition of typical polydrug use profiles. These profiles have remained relatively unchanged throughout the 2000s.

Additional use of stimulants, cannabis and pharmaceuticals was most common among opiate users. Those entering drug treatment due to stimulants use cannabis, pharmaceuticals, opiates and alcohol in parallel and on an even basis, whereas the most frequent additional drugs for those who sought treatment due to cannabis no longer included pharmaceuticals or opiates. Those entering treatment due to alcohol use also use cannabis, and to a lesser extent opiates. (Väänänen 2011.)

The majority (77%) of drug clients in substance abuse services had injected drugs some time in their life; half of them had injected drugs during the past month, and one in seven had shared needles and syringes. Injection was the most common mode of use with opiates (74% of users) and stimulants (76%). (Väänänen 2011.)<sup>34</sup>

In drug-related death statistics, which indirectly reflect problem use, the most striking phenomenon is the increase of buprenorphine findings associated with deaths year on year in the 2000s. From fewer than 10 cases in 2000, the number of such findings reached more than 110 in 2009. In 2009, deaths from accidental poisoning caused by buprenorphine accounted for about half of all drug-related deaths from poisoning. Meanwhile, the number of cannabis findings has increased by half to more than 100 cases, while the number of amphetamine findings has risen by one fourth to about 90 cases.

By contrast, the number of deaths caused by either heroin or cocaine were restricted to a few cases every year during the same period. Thus, the death statistics also indicate that the proportion of buprenorphine in problem use has increased in relation to other key drugs throughout the 2000s. Drug-related death statistics also reveal the ageing of problem drug users, as according to the Cause of Death Register the proportion of under 25-year-olds has decreased from more than one third in 2000 to about 15% in 2009. At the same time, the largest age group by far in terms of the percentage of drug-related deaths (38%) is the 25–34 age group. The extent of polydrug use noted in drug treatment is also well illustrated in the statistics on drug-related deaths, almost in the same way as in drug treatment statistics (cf. Salasuo et al. 2009).<sup>35</sup>

## Data on problem drug use from non-treatment sources

In late 2009, a study was conducted on the substances used by drug users in Helsinki, how they used them and where they obtained them.<sup>36</sup> The criterion for inclusion in the study was that the interviewees had to be active users; however, persons who had not been actively using drugs for up to a month were also accepted. Out of the 100 people interviewed, 71 were men and 29 women; 23 of the interviewees were in substitution treatment, 20 of them men. The average age of the interviewees was about 29 years. However, more than two thirds of the women were under 28 years of age, as compared with less than a third of the men. The substitution treatment patients included in the study were on average older than the other interviewees (average age about 32 years). More than half of the interviewees were not in a steady relationship at the time of the interview. (Tammi et al. 2011.)

The interviewees were seriously disadvantaged. The majority (79%) of them were unemployed at the time of the interview, three fourths of them had only completed comprehensive school, and the highest educational attainment among them was vocational education or upper secondary school. More than half of the interviewees had a place to live, whether own or rented, but one in four lived in a shelter or were completely homeless. Three out of four respondents named social security as their principal source of

<sup>34</sup> For 2010, the percentages were calculated using figures including the missing data, which explains the decrease in the percentage of intravenous use. (Väänänen 2011.)

<sup>35</sup> See chapter 6.3. Drug-related deaths and mortality of drug users

<sup>36</sup> The study was a structured interview study whose participants (100) were recruited at the end of 2009 through anonymous health counselling centres intended for drug users (needle and syringe exchange points) (67), through peer support interviews in user networks (20) and through two outpatient clinics providing harm-reducing substitution treatment (15). The interviewees were instructed to approach women and immigrants in particular to gain a representative sample. The interviews lasted between 30 and 60 minutes. Two of the interviews were eventually discarded because of reliability issues. Only statistically significant differences were analysed; the tests used were the Fisher exact test, Chi test, and t-test in variance analysis. This study forms part of the European Quaf2 project. (Tammi et al. 2011.)

income, and nearly one in six named drug trading or other illegal activities; by comparison, no one's principal source of income was begging or prostitution. Two out of every three interviewees had had trouble with the police more than once in the preceding year. (Tammi et al. 2011.)

For all interviewees, the average period of drug use was 13 years, the shortest being 3 and the longest 35 years. Interviewees in substitution treatment had been drug users for longer than the average, the average among them being 17 years. Most of the users had begun using drugs during the 'second wave' of drug use increase in Finland after the mid-1990s. The most commonly used substances during the previous month were opioids (88 respondents), followed by benzodiazepines (81), alcohol and cannabis (73) and amphetamines (66). The most frequently used opioid was buprenorphine as Subutex (60), followed by buprenorphine-naloxone combination (Suboxone) (39) and methadone (14). More than 90% of the interviewees used Subutex intravenously, and a similar percentage may be obtained for Suboxone and methadone when the interviewees in substitution treatment are excluded. Injecting Suboxone was particularly popular with users under the age of 28. Amphetamine was also used intravenously by more than 90% of users, whether amphetamine, metamphetamine or MDPV; 26 respondents said they had used MDPV during the previous month. (Tammi et al. 2011.)

Nearly half of those who had used benzodiazepines during the previous month (39 out of 81) had used them on a daily basis. Half of them had obtained the benzodiazepine from a physician, and about one fourth of them had used the illegal market. Four out of five of those who had used opioids during the previous month (74 out of 88) had used them on a daily basis; 23 of these were in substitution treatment. Nearly half of those who had used Subutex during the previous month (29 out of 60) had used it on a daily basis, and more than 80% had used it at least every other day. Four out of five Subutex users had obtained the substance on the illegal market. More than half of Suboxone users had obtained the substance on the illegal market. Amphetamine use is more occasional: out of the 56 respondents who said they had used amphetamine during the previous month, only 8 had used it on a daily basis, and 17 at least every other day. (Tammi et al. 2011.)

Certain statistically significant differences were observed in substance profiles with regard to user age: benzodiazepines were more common among those under 30 than in older age groups, whereas in the older group there were more amphetamine users who had not used the substance at all in the previous month. Gender analysis showed that men more frequently than women had used drugs in the previous month in all substance groups except for amphetamine. The substitution treatment patients interviewed used alcohol, benzodiazepines and cannabis just as commonly as the rest of the respondents, but amphetamines more rarely. All except one of the substitution treatment patients had used self-procured opiates during their treatment. (Tammi et al. 2011.)

Assessing forms of polydrug use was one of the key findings of the study. Although the study does not allow for broad generalisation, it may be concluded that among the drug users with the most severe problems there are persons who use both amphetamines and opioids; the most common pattern, however, is combined use featuring both polydrug use of opioid-based painkillers and sedatives (benzodiazepines) on the one hand and alcohol and cannabis on the other. (Tammi et al. 2011.)

The most common substances found in the blood and urine samples of intoxicated drivers<sup>37</sup> were benzodiazepines and amphetamines. The study also showed that polydrug use was common in cases of suspected driving while intoxicated. It was considered important for intoxicated drivers to be referred to treatment and rehabilitation as an alternative to being convicted and sentenced, because being caught for driving while intoxicated would be a good opportunity for reaching out to substance abusers and referring them to treatment. (Karjalainen et al. 2010.)

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<sup>37</sup> The study concerned cases between 1977 and 2007 of drivers apprehended by the police and suspected of driving while intoxicated (total number of suspects during the period: 31,963).

How the problem use of drugs is addressed is influenced by conceptions of problem use in society at large. Shifts in the discussion and scope of substance abuse and of addiction in general in the press between 1968 and 2006 has been analysed on the basis of articles published in Finland's leading daily newspaper.<sup>38</sup> The findings show that four trends may be identified over the 40-year period: an increasing number of articles on the topic, the expansion of discussion of the phenomenon from alcohol use to various other kinds of divergent behaviour, the mainstreaming of a previously marginal phenomenon, and a shift from social models explaining the phenomenon to personal histories. Over the period examined, the number of articles in this area per year would seem to have doubled. As recently as in the 1970s and 1980s, the phenomenon was identified with a specific group of people who had problems with a specific behavioural pattern, usually related to a specific substance (alcohol or drugs). The problems were seen as functions of the social status of these groups and not discussed as wider phenomena. From the 1990s onwards, however, addiction has been identified in highly diverse areas (work, gaming, TV, Internet use, eating disorders, etc.), and today a large percentage of the population could be described as being addicted to something. As the problem is seen to affect an increasing percentage of the population, it is becoming less of an anomaly and more of a mainstream phenomenon. At the same time, the identification of problems with a specific social status has decreased, and addiction is now seen largely as a personal problem; this is also reflected in the treatment of addiction, particularly in the medicalisation of treatment. (Hellman 2009; 2010.)

In a joint Nordic study, the harm caused by illegal drug use to family members and friends was studied in the Nordic countries by asking respondents about personal experiences of drug users among their family and friends, the harm caused by them and the willingness of the respondents to help drug users close to them.<sup>39</sup> The study showed that respondents in Helsinki differed from those in the other Nordic capitals in that they had fewer personal experiences of drug users in their proximity than the other respondents. In Helsinki, 45% of respondents had had concerns about the drug use of someone personally known to them (12% within the previous year), whereas the figure in the other Nordic capitals was 56% to 67% (22% to 28%). The researchers explained this difference by referring to Finland's relatively brief history of drug use (compared to Denmark in particular), lower number of users of hard drugs (compared to Denmark and Norway) and shorter history of hard drug use (compared to all other Nordic countries). Similarly, fewer respondents in Helsinki had been personally acquainted with someone receiving treatment for substance abuse, but the difference between Helsinki and the other Nordic capitals was no longer significant in responses concerning personal acquaintance with someone receiving treatment within the previous year. (Melberg et al. 2011.)

There were also clear differences between Helsinki and the other Nordic capitals as to how serious the drug problem overall was considered by people who knew problem drug users personally. In Helsinki, 30% of respondents had experienced a fear of violence because of drug use by a person close to them in their lifetime (9% during the previous year), whereas the figures in the other Nordic countries were 20% to 23% (5% to 7%). Correspondingly, in Helsinki 11% of respondents had had to call in the police because of drug use (3% during the previous year), whereas the figures in the other Nordic countries were 4% to 6% (1% during the previous year). The researchers explain this difference too by the fact that this problem set is unfamiliar in Helsinki and that, on the other hand, Finland's drug policy is traditionally control-oriented,

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<sup>38</sup> The study examines articles published in the Helsingin Sanomat newspaper, the concept of 'addiction' referring to any discussion of a problematic or repeated behaviour over which the individual has little or no control, or to specific concepts such as 'alcoholism', 'problem use', 'bulimia', etc., and the treatment of same. The articles were selected from the same period of three weeks in even-numbered years. In all, 200 articles were found between the years 1968 and 2006. Analysed by decade, the number of articles varied as follows: 49 articles in 1968–1978, 26 in 1980–1988, 63 in 1990–1998, and 62 in 2000–2006. The material was analysed using the content analysis method. The daily circulation of Helsingin Sanomat has been between 400,000 and 500,000 since the 1990s. (Hellman 2009.)

<sup>39</sup> The study was conducted using a representative sample of 3,092 persons in the capital cities of the Nordic countries. The persons selected were over the age of 18 and were contacted by e-mail and asked to respond anonymously to an online questionnaire with 34 questions. The response rate was slightly over 50%. The group of participants did not significantly differ from the general population in terms of gender, age or educational attainment, at least not in the case of Helsinki. Cross-referencing and logistical regression analysis were used. (Melberg et al. 2011.)

which is reflected in how citizens act. However, there were no great differences between the countries as regards how large a percentage of those personally acquainted with problem users had attempted to get those problem users to seek treatment. (Melberg et al. 2011.)

With regard to drug-related harm, the views of respondents personally acquainted with drug users differed from one another in that the perceived harm sometimes proved to be greatest in the countries with the longest history of drug-related problems. By contrast, there were only minor differences between countries in conceptions of drug-related harm in the previous year among respondents personally acquainted with drug users. In all the cities, the most experiences of drug-related harm were cited by women and by respondents who had experience of a drug problem in a person close to them, for instance in their own family. When comparing the drug problem with a variety of common diseases (e.g. diabetes, asthma, cancer), the seriousness of the drug problem was assessed in much the same way in all the countries. In all, the incidence of personal experiences of drug-related harm proved to be slightly lower in Helsinki than in the other Nordic countries. (Melberg et al. 2011.)

## 5. Drug-related treatment services

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

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

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

A quality framework for substance abuse services (Ministry of Social Affairs and Health 2002) and Current Care guidelines (Duodecim 2006) for the treatment of drug abusers have been created in order to develop substance abuse work. The development policy for drug treatment services emphasises developing low-threshold services and related training. The first health counselling centre intended for the exchange of needles and syringes was set up in Finland in 1997, and substitution and maintenance treatment was introduced as an official part of substance abuse services in 2000. As far as possible, the most difficult-to-treat substance abuse patients (multiple-diagnosis patients) are treated centrally in units providing specialised services.

It is alleged that, due to the fact that more and more drug users are receiving medical treatment, substance abuse problems, which were previously considered social problems, are now regarded as medical problems and are increasingly being handled by the health care services. Substitution treatment for opiate addicts is increasingly being transferred to health centres and, in part, also to pharmacies. This phenomenon reflects the differences in focus between psychosocially and medically oriented substance abuse treatment services. Another reason would be that municipalities are attempting to transfer these services from the specialist level to the primary level in order to generate savings.

It is also a challenge for the substance abuse service system to see substance abuse problems as a part of broader problem spectra that include mental health problems, needs for new treatment and a vicious circle of social exclusion.

### 5.1. Strategy and treatment systems

According to the Government Resolution concerning the drug policy for 2008–2011, treatment services will be developed and their provision increased, in order to ensure equal access to services for all citizens. Drug users will be offered a range of treatment options, appropriate for the type of addiction in question and, for instance, access to treatment will be facilitated for opioid addicts. In addition, the objective is to increase the types of treatment, health counselling and support directed at reducing drug-related harm such as diseases, mental health problems and crime. (Finnish Government 2007a.)

## Treatment system

In Finland, services for substance abusers are provided within both social welfare and health care. Specialised services for substance abusers are mainly provided under social welfare. Outpatient treatment within these specialised services is free of charge for the client, whereas inpatient treatment and housing services for substance abusers generally requires a payment commitment by the social welfare office of the client's home municipality. The provision of services for substance abusers currently takes multiple forms: it can form part of a municipality's own operations or co-operation with a private provider of services for substance abusers (often with the largest such provider, the A-Clinic Foundation). Moreover, it can also be arranged within a municipal federation or foundation for treating substance abusers or through purchase agreements with other organisations or private companies. For instance, according to 2008 data among A-Clinics (n=75) providing outpatient substance abuser services for adults, 61 were municipal and 14 were maintained by the A-Clinic Foundation. In all, the A-Clinic Foundation has concluded agreements with approximately a hundred municipalities for the provision of substance abuser services. Federations of municipalities providing substance abuser services total three, each involving from 24 to 71 member municipalities. Providers of institutional, detoxification and rehabilitation units most often include foundations, NGOs or private service providers. (Kekki & Partanen 2008.)

The restructuring of municipalities and services (the Paras project) aims to broaden the population base<sup>40</sup> for social welfare and health care services. When services are organised based on larger population bases, it is expected that service quality and availability will improve and that substance abuse clients can be served more consistently throughout the country. The fact that the numbers of clients among municipalities are unevenly distributed is primarily influenced by practices in referring clients for treatment and an emphasis on outpatient treatment. For instance, downscaling inpatient services is not due to a reduced need for treatment, but is in part influenced by municipalities' attempts to restrict social welfare costs. Instead of using specialised health care and specialised services for substance abusers, the current trend involves moving treatment increasingly to primary health care. (Kekki & Partanen 2008.)<sup>41</sup>

Emphasising outpatient care is a characteristic feature of social welfare and health care during the 2000s: the elderly are supported in order to enable them to remain at home and people with mental health problems are offered independent housing, outpatient support and peer support groups rather than institutional rehabilitation. Such changes are also affecting treatment practices. The use of community support, individual therapy and social support has declined as the medical approach has gained ground. A challenge for the future lies in the fact that substance abuser services are not considered core services within the service system. Indeed, substance abuse problems are seen as marginal, and people with such problems are deemed a source of disturbance rather than clients needing treatment. (Kekki & Partanen 2008.)

In 2009, the opinions of local authorities and organisations on substance abuse services were surveyed in the Substance Barometer of the Finnish Centre for Health Promotion.<sup>42</sup> From the local authorities' point

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<sup>40</sup> The 415 municipalities in Finland (2008; 342 in 2010) are required to organise primary health care and closely related social welfare services when their population base is at least 20,000. In such cases, universal services which must be implemented locally for substance abusers comprise assessment of the risk of substance abuse, health counselling aimed at risk reduction, primary-level detoxification in health centres, referring substance abusers to specialised services for treatment, participation in long-term further treatment, and the treatment of acute problems. Furthermore, mandatory regional services requiring a large population base include the following: specialised services for substance abusers, consultation services complementing local services, demanding institutional detoxification and rehabilitation treatment for substance abusers (pregnant women, dual-diagnosis patients, drug users) and inpatient services for certain small special groups (such as language minorities, immigrants or the disabled). (Kekki & Partanen 2008.)

<sup>41</sup> For their study, Kekki and Partanen analysed written material produced by parties organising services for substance abusers as well as information obtained through a total of 21 telephone interviews and 2 e-mail messages during 2008, concerning the methods of organising substance abuse services and topical phenomena of substance abuse work at the local government level. Most interviewees were directors, project managers or co-ordinators in substance abuse work or social welfare. However, these results cannot be generalised for application throughout Finland, since the study analysed municipalities and regions (and their representatives) whose substance abuse services are diverse and organised. (Kekki & Partanen 2008.)

<sup>42</sup> The Substance Barometer is compiled every other year. In 2009, the survey was conducted in the form of phone interviews with 100 local government officials in charge of substance abuse services and 37 managers of NGOs. The local government random sample consisted of



of view, there were particular shortcomings in housing services and detoxification (27% and 25% of respondents, respectively). There was a need for diverse housing services particularly for people with markedly declined functional capacity and for detoxification services available sufficiently near for local residents. From the NGOs' point of view, there were particular shortcomings in acute detoxification services (30% of respondents) because of excessive waiting times and in rehabilitative institutional treatment (22%), leading the treatment chain to malfunction and clients to drop out of the services. More than half of the local authority respondents reported that the weakened economic situation had not yet affected client access to substance abuse treatment, but more than one in five municipalities were considering revising their criteria for access to treatment; in one in five municipalities, the criteria had already been revised and clients referred to local services in their home municipalities. Nearly half of the NGO respondents considered that the economic situation had already made access to treatment more difficult. The Substance Barometer also indicated that the municipal and service structure reform, i.e. the Paras project (cf. section 1.2) had not yet had a significant impact on the availability of substance abuse and mental health services locally. (Tekry 2009b.)

The purpose of the mental health and substance abuse plan (the Mieli project) is to develop substance abuse services together with mental health services in order to lower the threshold to treatment for customers of both, to raise the profile of basic services and to provide more flexible treatment by 2015 (cf. section 1.2). At the same time, the aim is to move the focus from treatment to promotion of wellbeing, prevention and early intervention methods. The progress of the project from the perspective of substance abuse work was evaluated in 2009, for instance through a questionnaire circulated among decision-makers.<sup>43</sup> The questionnaire responses considered the policies in the plan to be steps in the right direction but too general in nature. Many resented the administrative (i.e. non-treatment) approach in developing the treatment system; it was also considered that the advantages and disadvantages of the current system had not been explored sufficiently to claim that the development was evidence-based, and at the same time fears were voiced that the concept of treatment would become too narrow, focusing only on basic health care services. Also, there were no specific instructions or sufficient resources for implementing the project or for conducting a follow-up study, which undermined the credibility of the project – regardless of the fact that an estimated EUR 14 million had been indirectly invested in it between 2008 and 2010. (Kuussaari & Partanen 2010; Wahlbeck 2010.)

Riikka Perälä has studied the ways in which local authorities organise their social welfare and health care services through a case study involving co-operation between local authorities and Christian substance abuse service NGOs.<sup>44</sup> The conclusions of the study indicate that on the side of the NGOs the co-operation is increasingly managerial, with increased control. Co-operation is based on business models rather than partnership. Thus, the ideological nature of the NGOs operations is in danger of being compromised. From the point of view of local authorities, the domain of NGOs with its new service packages is a sort of 'Wild West' which seems difficult to manage, and competitive tendering and strict control are emerging as the policy du jour. Competitive tendering, however, is proving inflexible, and policy outlines set in the course of tendering may cause unexpected results that often place the clients of the services at a disadvantage. In the customer-provider model used in competitive tendering, the actual clients cannot influence the content of the service, and cost consciousness often trumps quality in developing services. The author of the study

130 municipalities, with regional compensation and weighted for population. The NGO sample focused on NGOs committed to the alcohol programme launched in 2004 and the drug programme launched in 2006 (cf. section 1.2 Drug policy). The sample included 50 NGOs. The response rate was 76%. (Tekry 2009b.)

<sup>43</sup> The online questionnaire was in two parts and was sent to all local authorities in Finland in March 2009. The first part concerned the obligations of local government dependent on population base, and the second part concerned how services were organised. Responses were received from 318 local authorities for the first part and from 313 for the second. (Kuussaari & Partanen 2010.)

<sup>44</sup> The material for the study consists of themed interviews with 20 local government officials and representatives of Christian substance abuse service organisations collaborating with the local authorities, conducted in autumn 2008. There were 8 local authorities involved, 5 large (population more than 100,000) and 3 medium-sized; civil servants responsible for liaison with NGOs were interviewed, as were 12 persons responsible for the operations of various service points run by the NGOs involved. (Perälä 2010.)

also notes that local government officials and service providers also consider that they do not have enough influence on the system. The role of NGOs in generating service innovations is rather questionable in situations where NGOs are required to describe their operations on a single A4 form and in such a fashion that they can be assigned point scores for competitive tendering. Although the new service culture is hoped to increase networking, to strengthen the civic society and to shape services to match citizens' needs better, the reality as outlined in the study is very different – albeit there are in fact some examples of successful cooperation. (Perälä 2010.)

In a study on institutional substance abuse treatment and substance abuse control, data on substance abuse clients of the social welfare and health care services, the police and the prison administration from between 1985 and 2006 were compared.<sup>45</sup> Up until the recession of the early 1990s, the volume of rehabilitative social welfare and the number of treatment days in institutional care increased year on year as the welfare state and the social sector were built up. The focus was on softer values in treatment, not so much on coercive measures. However, following the recession the number of beds in institutional substance abuse treatment was drastically cut, the number of treatment days reduced and control increased; this was also partly due to the general increase in the use of drugs. By the mid-2000s, the number of related prison sentences issued has grown particularly because of extended sentences for drug-related crimes, drunk driving and violent crime. In 1985, prison inmates with a substance abuse background accounted for 45% of the prison population, but this figure had risen to 84% by 2006. It would thus appear that institutional control of drug-related harm has increased the most in prisons, where control and rehabilitation are strictest and days stayed are the most expensive. This would seem to dovetail with Finland's two-track interpretation of drug policy, whereby drug users are subjected to increasingly strict control while a low-threshold service network (excluded from the study referred to here) is being set up for drug users. (Obstbaum et al. 2011.)

### Quality of treatment

A quality framework for substance abuse services (Ministry of Social Affairs and Health 2002) and Current Care guidelines (Duodecim 2006) for the treatment of drug abusers have been created in order to develop substance abuse work. The first health counselling centre intended for the exchange of needles and syringes was set up in Finland in 1997, and substitution and maintenance treatment was introduced as an official part of substance abuse services in 2002; the relevant Decree also specified the criteria for the treatment. Since then, the development policy for drug treatment services has emphasised developing low-threshold services and related training. As far as possible, the most difficult-to-treat substance abuse patients (multiple-diagnosis patients) are treated centrally in units providing specialised services.

Over the past two years, the aforementioned recommendations (Ministry of Social Affairs and Health 2002; Duodecim 2006) have been augmented with compilation articles of updated treatment studies published in professional journals, involving treatment of patients suspected of using new psychoactive substances (Lapatto-Reiniluoto et al. 2011), encountering substance abuse patients at an emergency clinic (Salaspuro 2009), encountering cannabis users in basic health care (Tacke et al. 2011), improving treatment for pregnant substance-abusing women (Pajula 2011), opioid substitution treatment for young people (Mikkonen et al. 2010) and ADHD and intoxicants (Niemelä et al. 2010). The Guide for Nurses was revised for teaching purposes in 2010 with updated articles on how to identify substance abusers, how to treat drug poisonings and withdrawal, how to refer intravenous drug users to treatment, and the co-occurrence of substance abuse and mental health problems (Mustajoki et al. eds. 2010).

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<sup>45</sup> The study was based on inpatient treatment days for drug-related illnesses in the case of health care; on detoxification, rehabilitation and housing services treatment days in substance abuse special services in the case of social services; on statistics on taking into custody in the case of the police; and on health studies and interviews conducted in prisons in 1985 (n=1,099), 1992 (n=325) and 2006 (n=711). (Obstbaum et al. 2011; Joukamaa et al. 2010; see also sections 5.3 and 9.4.)

## Access to treatment

The practical difficulty in substance abuse treatment is that the clients' problems and the availability of services do not necessarily meet. Some of the largest obstacles to receiving treatment are waiting times, the lack of knowledge and skills and negative attitudes towards substance abusers within the primary services and the physical distance of the treatment units within specialised services. One possible solution particularly for drug users is service guidance, a more personal counselling service for drug problem users (see also section 8.3 Social rehabilitation).

Non-medical treatment and short-term detoxification are available for amphetamine problem users, but access to continued treatment is much more difficult to obtain. Treatment options for the use of cocaine, a stimulant, are even more limited because it is not very widespread. Some amphetamine problem users do undergo occasional treatment periods for amphetamine psychoses at hospital psychiatric wards, but there is no dedicated longer-term psychiatric care available for them. It has been alleged that amphetamine problem users must actually use other substances as well in order to qualify for treatment, so much so that a user may begin to take opiates merely for the purpose of passing the treatment screening. However, in many cases the onset of opiate use does not see the discontinuation of amphetamine use. As a consequence of seeking care, an amphetamine user may become addicted to opiates in addition. Medical treatments for amphetamine use are also under development, but in Finland at least it is extremely rare to be given medical treatment for amphetamine use. (Rönkä et al. 2010.)

The opiate addiction treatment with the best proven track record is medical substitution treatment. (Duodecim 2006.) Opioid addicts are centralised in major cities, particularly in the Greater Helsinki area and the city itself. In most parts of the country, no queues for treatment exist. The time limits imposed by the treatment guarantee (for non-urgent cases, assessment of treatment needs within 3 days and access to treatment within 3 months and, for specialist health care, assessment of treatment needs within 3 weeks and access to treatment within 6 months) are only exceeded in certain major cities. In order to improve the availability of medical treatment, a new Decree on substitution treatment was issued at the beginning of 2008, enabling pharmacies to distribute substitution treatment medication containing buprenorphine and naloxone. However, pharmacy contracts proved to be problematic from the viewpoint of the customer's personal data protection, as the contracts were deemed to constitute a sensitive personal data file, the use of which was not approved by the Data Protection Board until autumn 2010, and even then only in conjunction with a patient's individual treatment and detoxification plans (Laine 2010). The aim in amending the Decree was the appropriate scaling of treatment (demanding patients being allocated to specialist health care, others to primary level; long-term care at a level which enables a normal life for the patient and is cost-efficient for the system). (Ministry of Social Affairs and Health 2009e.)

Cross-section surveys conducted by an importer of substitution treatment pharmaceuticals among treatment units indicate that the number of substitution treatment clients was about 1,500 in November 2008, of whom about 300 were treated at health centres. Similar surveys conducted in November 2009 seem to indicate that the number of substitution treatment clients had increased to 1,800. The surveys show that Subuxone, a combination preparation containing buprenorphine and naloxone, accounts for about 60% of substitution treatment and methadone for the remaining 40%. The use of buprenorphine only, i.e. Subutex, in substitution treatment is limited to a number of isolated cases according to the surveys. (MSD 2010.) A coverage survey for the Drug Treatment Information System in 2008 indicated that about 1,000 people had attended a medical treatment needs assessment for opiate addicts and that 2,300 clients had received medical treatment during the same time. (Väänänen 2011.)

## Treatment services

In a study evaluating the treatment of drug addiction in Finland and its backgrounds, it was noted that five fundamental changes have taken place in forms of treatment and their underlying assumptions over the past 50 years.<sup>46</sup> The study shows that drug addiction treatment can be divided into five phases: the psychiatric phase in the late 1960s; the social therapy phase in the early 1970s; the decline of drug treatment between 1975 and 1986; the drug treatment derived from the social therapy outpatient care tradition after 1986; and the expansion of specialist drug treatment since the late 1990s. The shifts in treatment methods were above all about changes in therapeutic reasoning: as drug addiction came to be regarded not as a personality aberration but as a problem manifesting itself in interaction, thinking and actions, the focus shifted from searching for the causes of drug addiction to seeking successful solutions. The technologies geared towards discipline and the patient's acknowledgement of his/her (alcohol) addiction were replaced by communal technologies and self-control techniques. Obedience and social conformity were joined by an emphasis on active client participation as the scope of drug addiction broadened from considering only the personality of the individual to an understanding of the client's family and its internal interaction and from there to considering entire population groups (e.g. youth rebellion). The author of the study notes that a solution-oriented approach gradually took centre stage in family therapy and therapeutic communities. In all, treatment in the 1970s, 1980s and 1990s was characterised by a trend towards voluntary and active participation by clients. Nevertheless, the problems of dropping out of treatment persisted; entering the 1990s, drug users could not identify with the forms of treatment available. (Selin 2010; 2011a; 2011b.)

Psychodynamics was joined in the 1990s by two new disciplines, behavioural and cognitive psychology, according to the former of which addiction is more of a learned behaviour than an identity trait. The latter focuses on an individual's capacity for influencing the factors exposing him/her to addictive behaviour. The breakthrough of substitution treatment, supported by brain research, had the medical impact of shifting the focus from curing drug addiction to managing the risks of drug use. The earlier psychodynamic theory of addiction combined with an epidemiological viewpoint did not allow for interventions of any specific kind. However, as more knowledge was gained about the neurochemistry of the brain and the communicable diseases caused by drugs, the door was opened for specific risk-reducing measures. This change enabled the monitoring of the social effectiveness of treatment, which boosted the position of evidence-based medicine. (Selin 2010; 2011a; 2011b.)

By 2002, as substitution treatment and maintenance treatment became generally accepted, medical treatment of opioid addicts had completely changed in its approaches, highlighting the medical side. The causes of addiction were eventually sidelined, and the emphasis was now on promoting a self-image conducive to self-control techniques and abstinence. Instead of eliminating the client's own thoughts and mental problems, cognitive and behavioural therapy seeks to replace harmful habits and skills with new, better skills that prevent the client from relapsing. The purpose of such a change is to highlight the match between drug treatments and the hopes and desires of potential clients with drug problems. At the same time, opiate addiction as a specifically defined somatic illness has become easier to control, and clients are more likely to stick with the treatment. However, substitution treatment does not in and of itself forfeit the control inherent in treatment or a transition towards an ethically sustainable way of providing treatment: substitution treatment too makes use of social control techniques to control and normalise the body. At the same time, the treatment system requires clients to conform to its logic and to behave more predictably and to be more patient – which may require a drug addict to display precisely the kind of active initiative the lack of which led him/her to need treatment in the first place. (Selin 2010; 2011a; 2011b.)

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<sup>46</sup> The study was based on articles collected from five periodicals (*Tiimi*, *Suomen lääkärelehti*, *Aikakauskirja Duodecim*, *Alkoholipolitiikka/Yhteiskuntapolitiikka*, *Sosiaalilääketieteellinen aikakauskirja*), all of which except *Tiimi* also publish refereed articles. The articles span five decades, from 1965 to 2005. Detailed analysis involved articles on treatment methods, treatment problems and proposed measures. The texts were analysed in the light of the research framework of the analytics of power developed by Michel Foucault. (Selin 2010; 2011a; 2011b.)

### Low-threshold services

In the social welfare and health care system, ‘low-threshold services’ generally mean services designed to emphasise that users can seek them easily and without fear of consequences. The concept is, however, a problematic one; in Finland, as originally coined it referred to syringe and needle exchange points or health counselling centres for drug users. Later, the concept expanded to include a wide range of services for the marginalised, such as overnight shelters, day centres and night cafés – and, increasingly, substitution treatment. The latter highlights the downside of the concept: even in low-threshold services there is a threshold, especially where the most marginalised people are concerned, and the criteria for staying in treatment cannot be satisfied. Interviews with the most marginalised drug users have highlighted the question of whether the concept of low-threshold services should be shifted from the technical service model perspective to a broader perspective of integration into society. With such a perspective shift, the concept would present mixed messages: on the one hand, its aim would be to guarantee drug problem users the basics of a feasible life, but on the other hand, it casts the persons who need help the most as a special needs group, which at the same time marginalises them. The low threshold would thus simultaneously be pulling them into and pushing them out of society at large. The author of the study expresses the wish that ‘low-threshold services’ would turn out to be a transitional concept principally reflecting the inability of the social welfare and health care system to adapt to new treatment needs and that the need for this concept will eventually disappear. The increasing incidence of clients with multiple problems and polydrug users requires a different, reality-based approach from the system. (Törmä 2009.)

Two kinds of low-threshold service points – a health counselling centre and a maternity clinic for substance abusers – were evaluated in a study to explore differences in defining low-threshold services in the meeting of clients’ new needs and the service systems in day-to-day operations.<sup>47</sup> Although both service points offered services to a particularly problematic client group while emphasising a pragmatic and soft approach, i.e. keeping the threshold low for clients to use the services, there were great differences between the units. The health counselling centre was a small unit run by an NGO and focusing on the psychosocial approach, whereas the maternity clinic was part of a large, public hospital with a primarily biomedical approach to problem drug use. The former could be approached anonymously and informally, while the latter in practice required a referral from a physician. The latent threshold in these two services was thus very different. Also, the health counselling centre depended on the client taking the initiative or on the interaction of the client and the care personnel, while the maternity clinic focused on pregnancy monitoring, and treatment was pursued on the terms of the medical personnel. Both services emphasised the client’s freedom of choice, although at the health counselling centre control measures were mainly only in place to safeguard the internal and external safety of the unit, whereas at the maternity clinic pressure and control was exerted on the client if she persisted in her substance abuse; the principal focus of the personnel was in such a case the safety of the child. At the health counselling centre, lifestyle changes in individuals were motivated indirectly, with respect for their autonomy, while at the maternity clinic pregnant women were directly encouraged to change their lifestyle. There was thus a clear difference in the treatment approach of the two low-threshold service units: reduction of harm at the health counselling centre and professional treatment at the maternity clinic. (Leppo & Perälä 2009.)

### Substitution treatment

The HUS addiction psychiatry unit conducts the majority of needs assessments for substitution treatment in the Greater Helsinki area. A study<sup>48</sup> compared the results for patients whose substitution treatment begun in

<sup>47</sup> The data were collected over a period of 12 months through participatory observation and interviews at a health counselling centre and a major maternity clinic in the Greater Helsinki area. (Leppo & Perälä 2009.)

<sup>48</sup> Treatment outcomes were examined retroactively based on patient documentation from HUS and further treatment units (municipal health care and social welfare services, the A-Clinic Foundation, the Deaconess Institute in Helsinki and health care services in the prison system). Intoxicant use was assessed on the basis of the drug testing of urine samples. The study involved 114 patients from 2003–2005 and 70 patients from 2000–2002.

2003–2005 to the results of those whose treatment began in 2000–2002. In 2003, the treatment was extended to patients aged 18 to 19 and to patients whose addiction had lasted for one to three years.<sup>49</sup> At the same time, needs assessments for substitution treatment were transferred to outpatient consultations, and buprenorphine was introduced alongside methadone. (Vorma et al. 2009.)

In the 2003–2005 material, the average age of patients (30 years) was, as expected, lower than in the 2000–2002 material (34 years). Also, the patients had on average been using opioids for two years less (8 years vs. 10 years). Almost all (90%) of the patients had another substance abuse problem in addition to opioid addiction. The most common substances involved in problem use or addiction were benzodiazepines for 85% of the patients (94% in 2000–2002), amphetamines for 56% (59%), and cannabis for 51% (51%). Problem use or addiction to alcohol was found in 18% of the patients, as opposed to 10% in the earlier material. Two thirds of the patients presented with a simultaneous psychiatric disturbance. Both mood swings and anxiety were found in about one in five patients. Schizophrenia, a schizoid personality disorder or a delusional disorder was found in 5% of the patients. A personality disorder was diagnosed in 51% of the patients, as opposed to 86% in the 2000–2002 material. This decrease in diagnoses was explained by the lower average age of the patients and the transfer of interviews to outpatient consultations. (Vorma et al. 2009.)

Waiting times for treatment have varied widely in the Greater Helsinki area (3 to 12 months). Normally, substitution treatment includes medical treatment and monitoring but also treatment of any simultaneous mental health disorders, any other substance abuse services required, including detoxification if necessary, and psychosocial and occupational rehabilitation. One third of the patients who began their treatment at HUS went on to further treatment elsewhere. (Vorma et al. 2009.)

In 2003–2005, 80 patients were started on methadone and 34 on buprenorphine. With 10 patients, buprenorphine was replaced with methadone in the course of the treatment. During the monitoring period, the average daily dose of methadone was 102 mg (varying from 20 to 190 mg). In buprenorphine substitution treatment, the average daily dose was 16 mg (varying from 2 to 28 mg). For the majority of patients with personality disorders, methadone was used for the substitution treatment. Of those who began treatment in 2003–2005, 63% were on benzodiazepine, as opposed to 87% of those who began treatment in 2000–2002.<sup>50</sup> (Vorma et al. 2009.)

The percentage of patients who stayed the entire 18-month course of treatment was 77% (89% in 2000–2002). For two patients treatment was discontinued because of drug-related crime, and for five others because of violence or threat of violence. In the remaining cases, either the patient dropped out or the treatment was discontinued as ineffective. Four patients withdrew from the treatment. During the 18-month monitoring period one of the patients died, and certain others found employment or were granted rehabilitation support or a pension. (Vorma et al. 2009.)

The findings<sup>51</sup> for simultaneous use of other intoxicants were less encouraging than before. Only in one case out of ten (12%, as opposed to 30% in 2000–2002) all the drug screens came back negative. Only 44% of the patients tested negative for opiates other than the substitution treatment drug (75% in 2000–2002), 29% tested negative for amphetamine (43%), and 32% tested negative for cannabis (48%). These findings were attributed to the assumption that since the threshold of substitution treatment used to be higher, polydrug use was probably taken more seriously, too. (Vorma et al. 2009.)

The various models of implementing substitution treatment emphasise different aspects of the relationship between psychosocial and medical treatment. Particularly at university hospitals, medicine and rehabilitation are highlighted. The staggered treatment focuses on the idea that psychosocial treatment is

<sup>49</sup> Before 2003, opioid addicts over the age of 20 whose compulsive use of opioids had lasted for at least four years were admitted to treatment.

<sup>50</sup> The downward trend has continued, and when the article was written in 2009, only 35% of patients at the opioid addiction outpatient clinic at HUCH were on benzodiazepine.

<sup>51</sup> Out of the 2003–2005 material, data on drug screening of urine samples were collected for 87 patients over the last 12 months of the 18-month monitoring period, and for 56 of the patients who began treatment in 2000–2002. Data were also collected from further treatment units if samples had been taken continuously at least twice a month.

prioritised when the patient feels ready for rehabilitative treatment and is able to define realistically his or her own rehabilitation targets. An alternative to the above-mentioned model is a holistic approach of commitment to treatment and preparation for rehabilitative substitution treatment which includes, particularly at the beginning, basic social work, ensuring livelihood and housing as well as seeking social support to foster recovery. Both of these models find support in various follow-up studies. Common to the models is, however, that both of them highlight how important it is to progress according to the particular circumstances of the client and his or her own treatment targets – in other words, the client's motivation for treatment.

### Community-based rehabilitation

In community-based drug rehabilitation, various frames of reference and models are used for specifying the client's position and forms of interaction within the community. Instrumental and hierarchical communities primarily promote lifestyle changes with the help of the community, whereby the main effort lies in making the client adapt to the unit's social order and operational structure. Thus, the client does not have many opportunities to influence the community's everyday activities but, rather, behavioural changes are believed to occur, in part, involuntarily and through compulsion. In such hierarchical models, the difference between staff and clients is clear and client control is strict. This approach is countered by a client-oriented perspective, the 'confrontation with reality' model, whose purpose is to contribute to two-way communication. This means reduced control, a more even distribution of power and responsibility among all community members as well as the clients' participation in decision-making.<sup>52</sup>

The post-rehabilitation life of participants in community-based drug rehabilitation was studied in a follow-up study which explored integration into society, considering abstinence from intoxicants, avoidance of crime, getting a home, a job and a place to study, and establishing social networks.<sup>53</sup> The study showed that about 60% of participants were still sober more than a year after the rehabilitation. Most of the relapses had occurred within one year of the rehabilitation, but even following a relapse participants made an effort to prevent further relapses, and the interval between relapses had increased. However, the fear of repeated relapses was seen as a problematic shadow on everyday life. None of the participants had committed new crimes after rehabilitation; two out of three had found a job or a place to study. Most of the respondents in the study had also found accommodation. Many were worried about the future and about being stigmatised for being rehabilitees in both places of study and in the workplace: honesty, it seems, was not always the best policy. Many participants had only acquired a very thin social network, and peer support was not always available to them. Self-help groups offered an important channel for connecting with other people for many of the participants and accordingly represented the most popular form of further treatment. The author of the follow-up study concluded that community-based rehabilitation can attain good results but that results are always subjective; also, not everyone can be helped if their motivation is not good enough to achieve recovery. We should note that one third of the participants dropped out of the rehabilitation. Even in community-based rehabilitation, participants should be sufficiently considered as individuals; dropouts from rehabilitation take a heavy toll on the persons themselves and on society. (Prättö et al. 2009.)

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<sup>52</sup> Cf. Forsell et al. 2010, section 5.2 Characteristics of treated clients.

<sup>53</sup> The material consisted of freeform interviews by 52 drug rehabilitees with persons who had been community participants between 1998 and 2007. Two out of three of them had completed the entire 15-month rehabilitation programme. Participants in the study responded to the questionnaire while participating in further treatment weekends at the community, having already completed their original rehabilitation programme. The material was collected in two stages, partly in the early 2000s and the final interviews between 2003 and 2007. (Prättö et al. 2009.)

## Peer support

In her doctoral dissertation, Elina Kotovirta studied the non-profit, peer-support- based fellowship of Narcotics Anonymous (NA), its recovery programme, and the former drug users who regard themselves as members of the fellowship.<sup>54</sup> According to Kotovirta, at its simplest NA's recovery theory can be described in two sentences: (1) there are drug dependent addicts who have an addiction disease, and (2) through an NA way of life recovery is possible. According to Kotovirta, NA may appear as strictly normative viewed from the outside, but in practice each member can adapt the programme in the way that best suits him/her. However, in the absence of more extensive knowledge of the fellowship, the norms reflected in NA texts or the fanaticism of individual NA members may drive some people away. (Kotovirta 2009.)

A recurring observation of the study was that a fellowship can help fill the void left by the absence of drug use and contributes strongly to the building of social capital. Fellowships offer uninterrupted support but cannot replace acute treatment. NA has been shown to be a significant factor supporting abstinence in parallel with, and as an extension of, an official treatment system, but seldom independently. NA can never fully replace professional support, nor should it be left with sole responsibility for treatment. The interaction between NA and the official treatment system is clearly demonstrated in the study. NA receives new members through treatment units and recommendations by individual professionals, while participation in NA improves the results of the official treatment system by supporting abstinence and community involvement. Simultaneously, fellowships significantly reduce the expenditure of the official treatment system. In the opinion of the interviewees, the NA programme is suitable for everyone and can be applied to anyone's life. They also regarded NA as being best capable of fulfilling its fellowship function as a single-issue movement focusing solely on drug addiction, and not on mental problems, for example. None of the interviewees mentioned the spirituality of the 12 steps recovery programme as an obstacle to joining NA, although for some this had contributed to a negative first impression of NA. (Kotovirta 2009.)

## New and broader perspective on rehabilitation

A dissertation published in 2009 discussed rehabilitation from the perspective of the participation of the rehabilitee.<sup>55</sup> The study highlighted three kinds of participation. At the early stage, rehabilitation is mainly based on managing a new, intoxicant-free lifestyle (life management participation), where the rehabilitee adapts to the discipline required in inpatient rehabilitation. As the rehabilitee begins to trust himself/herself to abstain from intoxicants, he/she begins to make independent decisions concerning rehabilitation and to seek experiences of meaningful participation beyond the rehabilitation itself (life politics participation) and can thus gain independence from the institutional mindset. Further, the rehabilitee must discover a path to establishing social relationships in order to develop his/her self-esteem and ground rules (life orientation participation). The rehabilitation process thus transcends official administrative boundaries and extends to the realm of social interaction which is difficult for the counsellors to even analyse. (Mattila-Aalto 2009.)

As the rehabilitee is in continuous interaction with the environment, analysis performed within the rehabilitation institution is inadequate for explaining the rehabilitation process, and the system in itself does

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<sup>54</sup> The study data consists of NA fellowship's programme texts, episodic interviews (n = 24) and questionnaires (n = 212). The interview material was collected during summer and autumn 2003. 11 women and 13 men were interviewed. At the time of the interview, the interviewees were between 20 and 49 years old and had all been members of NA for at least a year. To discover the recovery status of the interviewees, they were contacted again one year after the initial interview. 23 of the original group could be reached. One of them no longer participated in the NA programme. Questionnaire data were collected at the NA's annual jubilee conventions in 2003 and 2004. The author participated in the NA events, reporting on the research and distributing questionnaires to be completed on site. Interested participants also took forms away to give to those who could not participate in the event. The purpose of the form was to collect views of people considering themselves NA members concerning their recovery and the NA programme. The form was divided into five sections: participation in the NA programme, treatment history, personal history of substance abuse, assessment of situation in life, and social relationships. Collected data were analysed using explorative factor analysis. (Kotovirta 2009, 24–30.)

<sup>55</sup> This phenomenon was studied by interviewing 13 former problem drug users who had been using drugs for an average of 15 years and had been clean for about 7 years. Five of the interviewees had a physical disability. Also, 34 professionals and lay people named by them as their helpers were interviewed. (Mattila-Aalto 2009.)



not guarantee rehabilitation. Rehabilitation rules do not necessarily help the rehabilitee to attain the goals set for the rehabilitation, such as gaining employment and establishing himself/herself in areas of life where interaction follows different principles. As rehabilitation as a participatory and energising action is a process more complex than just individual participation, we should perhaps turn our notion of rehabilitation on its head and consider what kind of participation generates rehabilitation, and what rehabilitation programmes should offer in order to enable this. Parties commissioning and providing rehabilitation services are encouraged to engage in partnerships to export rehabilitation outcomes beyond the boundaries of the rehabilitation service itself. In substance abuse services, there is now a trend towards seeking outcomes in therapeutic interaction relationships in addition to developing treatment methods; this means the counsellor and the client forming an ‘alliance’ to help the client. Developing the quality of the interaction relationship may even prove to be a potential solution for one of the major problems of substance abuse services, dropouts. (Mattila-Aalto 2009.)

### Role of substance abuse counsellors in treatment

According to the Current Care recommendations for drug-related treatment, psychosocial methods form the basis for the treatment, even though the evidence for their effectiveness in the treatment of certain drug problems is thin. Medication often only alleviates symptoms, although substitution treatment has proved effective for opioid addiction in particular. An open and confidential treatment relationship between the client and the substance abuse counsellor is an important tool in the identification and treatment of a drug problem. (Duodecim 2006.)

This perspective was highlighted in a study on the personalities and interaction skills of substance abuse counsellors.<sup>56</sup> The study indicates that counsellors may be divided into three groups according to their personalities: firstly, those who scored high in social activity, friendliness and openness but low in diligence; secondly, those whose scores were almost completely the opposite, except that their low points were not in openness but in balance; and thirdly, those whose personality traits were close to average in all areas. The findings were surprising in the sense that the first two groups were practically equal in their interaction skills, whereas the third group ranked considerably lower. A similar level of achievement in interaction may thus be achieved by almost diametrically opposed personalities, which according to the author of the study demonstrates that it is possible to learn a wide range of interaction skills through training and professional experience. Analysed by gender, the results were embarrassing for men, as women proved to be better in interaction skills in all dimensions of the evaluation survey. Another interesting finding was that counsellors with substance abuse recovery experiences of their own (about 10% of them) were on a par with the rest in their interaction skills, even though they were less diligent and balanced personalities. Many of the counsellors with recovery experiences of their own had begun their drug use in their early teens and experienced a lot of problems because of this. Thus, in terms of mental status, the majority of counsellors with recovery experiences of their own are better suited in view of their history of drug use to treating anti-social and borderline patients rather than patients with paranoid tendencies. (Saarnio 2009; 2010; 2011.)

In the aforementioned study, Saarnio also evaluated counsellors’ personality traits (cf. the previous paragraph) in relation to their general therapeutic orientation, measured by their degree of specialisation (in a particular form of therapy), the length of their training, their enthusiasm about their chosen field and their

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<sup>56</sup> The data for the study were collected at inpatient substance abuse service units (n=17), through interviews with 162 therapists. In the interviews, the participants filled in a background information form and took a personality test. They were also given for evaluation a form with five personal and treatment histories related by five clients of substance abuse services and their family members. Three out of five respondents returned the evaluation questionnaire. The questions in the personality tests were allocated to PK5 factors estimating the social activity, friendliness, diligence, balance and openness of the respondent. The purpose of the evaluation questionnaire was to explore the interaction skills of the respondents, and the responses were analysed by an external group of experts who ranked the responses according to four dimensions: empathy, sincerity, respect for clients and concrete action. The results were analysed using one-way analysis of variance and the t test. (Saarnio 2009; 2010.)

religious orientation. The findings show that counsellors using several different methods were less conscientious than highly specialised counsellors. Counsellors with a long training were less conscientious but also more socially active than others. Friendliness, openness and emotional balance were personality traits that correlated with being enthusiastic about one's job. Being religious correlated particularly well with respect for the client. (Saarnio 2011.)

Substance abuse service professionals were surveyed concerning substance addictions.<sup>57</sup> They were asked to evaluate factors leading to substance abuse problems and to estimate who has the responsibility for the development of an addiction and for recovery from it. Differences in conceptions between professional groups were compared. Asked to name 1 to 3 features that they felt best described substance addiction, four out of five substance abuse service professionals considered substance addiction to be a learned survival trait, two out of three considered it to be an emotional disorder, and two out of five considered it to be a lifestyle prompted by social conditions. Analysed by professional group, the respondents agreed on substance addiction being an emotional disorder, but statistically significant differences were found in their opinions on substance addiction being a brain disorder or personality disturbance on the one hand or a lifestyle prompted by social conditions on the other. Differences in favouring either of these two models were the greatest between physicians and social welfare professionals, but were not as sharp between other health care professionals and social welfare professionals. (Pennonen et al. 2010.)

When professionals are asked who or what an addiction is caused by, the majority will opt for an addiction being due to the individual rather than circumstances. On the other hand, they also tend to consider that responsibility for treating the problem lies more with the individual than with society. In the study, attitudes of professionals were gauged using a fourfold matrix tabulating the individual's responsibility for the emergence of the problem (high vs. low) against the individual's responsibility for taking care of the problem (high vs. low). This yielded four models: the moral model (high/high), the education model (high/low), the compensatory model (low/high) and the medical model (low/low). The findings show that about three out of five respondents considers drug addicts (other than cannabis addicts) through the moral model, which emphasises personal responsibility, while one in six consider them through the education or compensatory model, and only one in ten through the medical model. Cannabis is the intoxicant most closely related to alcohol, hence the increased support for the moral model at the expense of the education and medical models. For cannabis users, health care professionals tend to go with the moral model most frequently (75%), while social welfare professionals favour it least (under 60%). The same tendency is true of other drugs too to some extent, but the difference is not statistically significant. However, somewhat surprisingly health care professionals (excluding physicians) are significantly less in favour of the medical model in the case of other illegal drugs than any other groups. The authors of the study feel that for a multi-professional treatment team responsible for treating problem drug users to be able to pool forces effectively to help clients, they should acknowledge these differences between professional groups and address them transparently in the course of the treatment process, taking different points of view into account. (Pennonen et al. 2010.)

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<sup>57</sup> The material for the study was collected at the turn of 2007–2008. Because the substance abuse services system in Finland is very complex and fragmented (Kekki et al. 2008), simple cluster sampling was employed: first, key service providers were contacted to obtain research permits, following which an invitation to the study was sent to substance abuse service outpatient units in three major cities and similar units run by NGOs, the purpose being to obtain regionally comparable data. The Criminal Sanctions Agency sent the survey to its own units. The survey form was returned by 520 employees (response rate 51%), of which 41% had a social services qualification, 3% were doctors, 32% were other health care professionals, and 25% were other persons involved in substance abuse services. The mean age of respondents was 41.8 years; 76% were women; and 55% had a university-level degree. The views of the various groups were analysed by cross-referencing and the use of standard statistical tests. (Pennonen et al. 2010.)

## 5.2. Characteristics of treated clients

The Drug Treatment Information System involves the anonymous collection of information concerning problem substance users who have sought treatment due to drugs. Treatment units supply information for the system on a voluntary basis. The Information System is estimated to contain information on about one third of the drug-related treatment provided in 2009.

In 2010, 31% of the clients participating in drug treatment information collecting were women (37% of under 30-year-olds). The average age of the interviewees was about 30 years. The men were on average more than two years older than the women. The clients' educational attainment was low, and most of them were unemployed (60%). Also, a majority lived alone (59%), and nearly one in ten (9%) was homeless. 24% were married or cohabiting, women more commonly than men. Of those who were married or cohabiting, more than half (61%) had another problem substance user in the same household, women more commonly (79%) than men (46%). More than one third of the clients (35%) had children under the age of 18, but the children were living at home in only 32% of the cases. Of the youngest clients, most (60%) were still living with their parents. (Väänänen 2011.)

In 2010, the most common reason for the interviewees being in treatment was voluntarily seeking treatment (34%); 30% had been referred to treatment through general social welfare and health care services, and 23% through substance abuse services. Some of the clients had been persuaded to enter treatment by their family (5%) or the police (2%). The youngest age group differed from the rest: of those under 18 years of age, 18% sought treatment with the support of their parents and 47% through child welfare services. Of the clients seeking drug treatment, 63% had begun their treatment period in 2010. For 13% of clients, treatment had begun the year before, while 23% were pursuing longer treatment periods. Only 14% had absolutely no previous treatment contacts due to drug use. (Väänänen 2011.)

In 2010, the majority of drug treatment clients were treated in substance abuse services in outpatient care (50%) or inpatient care (27%), the remaining clients being treated at outpatient units specialising in drug treatment (15%), institutional drug treatment (8%) and prison drug treatment (1%). The majority of the clients whose principal drugs were opiates were placed in substance abuse outpatient care (44%) or drug treatment (24%), but many also in substance abuse inpatient care (22%). More than half of the clients whose principal drugs were hypnotics, sedatives or cannabis were placed in substance abuse outpatient care. Of the clients whose principal drugs were stimulants, 48% entered substance abuse outpatient care and 37% entered substance abuse inpatient care. Combined use of alcohol and drugs usually resulted in entering substance abuse outpatient or inpatient care. In specialised outpatient drug treatment, no fewer than 86% of the clients had opiates as their principal drug. The largest groups of clients in inpatient drug treatment used opiates (68%) or stimulants (18%) as their principal drugs. (Väänänen 2011.)

The most common forms of outpatient care in 2010 were rehabilitative treatment and a period of assessment of treatment needs. The most common forms of inpatient care rehabilitative treatment and detoxification. A total of 44% of clients who had sought treatment primarily for opiate addiction received medical outpatient or inpatient treatment designed for opiate addicts. Methadone and buprenorphine were almost equally used in the medical treatment of opiate addicts (45% and 44%, respectively). Of the buprenorphine used in medical treatment, 14% was in the form of Subutex or Temgesic and 86% in the form of Suboxone, which also contains naloxone. (Väänänen 2011.)

In 2010, the youngest clientele was in substance abuse outpatient care, the mean age being about 29 years. In substance abuse inpatient units the mean age was about 30 years, in inpatient drug treatment units about 31 years, in outpatient drug treatment about 33 years, and in prison health care units about 34 years. Other simultaneous treatment contacts were reported for 42% of clients. The most common types of these were substance abuse outpatient care (21% of all clients), health counselling centres (11%), general social welfare or health care outpatient care (11%) and self-help groups (5%). (Väänänen 2011.)

### 5.3. Client trends in substance and drug treatment

As discussed above, the Finnish substance abuse service system is heterogeneous; both social welfare and health care services must be taken into account. The numbers of cases of drug-related treatment have been estimated using general care statistics (cf. section 6.2 Drug-related treatment periods in hospitals and Figure 5) and three separate studies conducted by the National Institute for Health and Welfare. The *substance abuse census* is conducted during one day and collects information concerning clients who used the services of social welfare or health care units due to an injury caused by substance abuse or while intoxicated. This census, implemented at four-year intervals, enables an estimate to be made as to how large a percentage of all clients of social welfare and health care services are substance abusers. *Collecting of information on drug-related treatment* is a voluntary, continuous system of information collecting at treatment units for compiling anonymous, individual information on clients undergoing drug-related treatment (see section 4.3 for problem drug use and section 5.2 for clientele). A *coverage survey* was used to estimate the overall volume of drug-related treatment by treatment unit and by region for 2003 and 2008.

#### Substance abuse census

A census of intoxicant-related cases took place in 2007. The census is conducted during one day and collects information concerning clients who used the services of social welfare or health care units due to an injury caused by substance abuse or while intoxicated. This census is carried out every four years and, since 1995, in a format allowing comparison. The percentage of drug users among all clients included in the census of intoxicant-related cases was 11% in 1995, 16% in 1999, 27% in 2003 and 24% in 2007. (Nuorvala et al. 2008a.)<sup>58</sup>

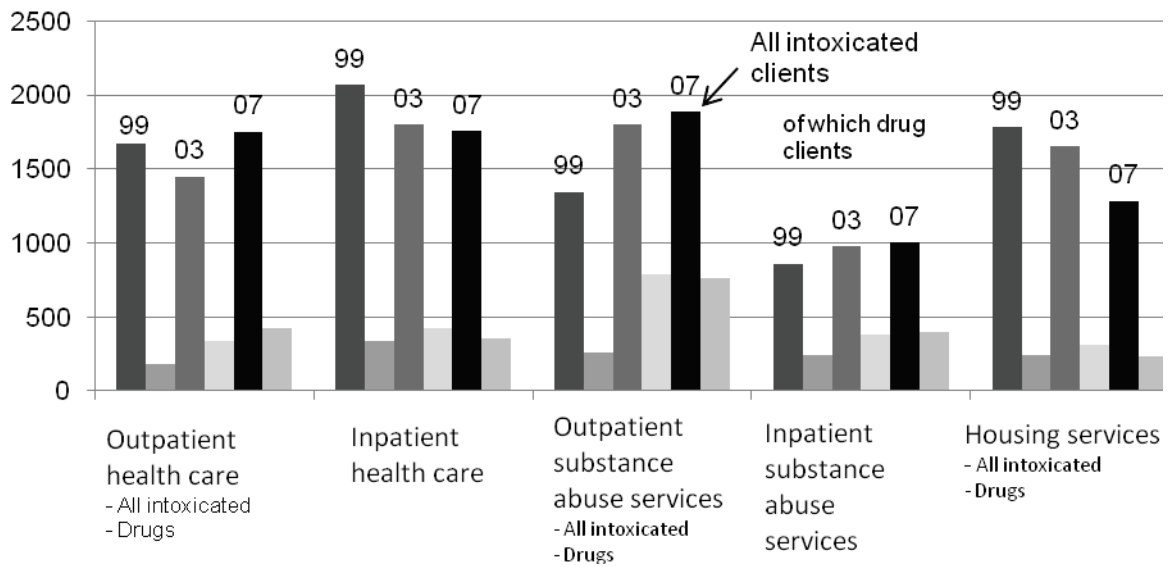
The causes behind the rapid growth in 1999 and 2003 include not only increased demand for treatment services but also changes in the service structure. The first health counselling centres for intravenous drug users were established in the late 1990s, and this manifested itself as an increase in the use of outpatient substance abuse services. Substitution treatment was not initiated on a wider scale until 2002, which is reflected in the number of drug treatment clients using substance abuser services or outpatient health care in 2003 and 2007.

While the range of substances abused included drugs with 20% of the outpatients in substance abuse services in 1999, this figure had risen to 35% in 2003 and 40% in 2007. On the other hand, a cut in alcohol tax in Finland in 2004 increased the consumption of alcohol, and its delayed impact may be seen in the increased relative proportion of alcohol abusers in the 2007 census of intoxicant-related cases. This impact is particularly visible in the group of those over 50 years old. In the 2007 census of intoxicant-related cases, relatively little information was obtained from health counselling centres for intravenous drug users and, consequently, the proportion of drug users may have been underestimated in the 2007 census. (Huhtanen 2009; Nuorvala et al. 2008b.)

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<sup>58</sup> Intoxicant-related visits refer to visits which either directly or indirectly involve intoxicants. The data were based on reports made by service unit personnel. The most recent census was carried out on 9 October 2007, when intoxicant-related cases reached a record high of 12,045.

## Clients per day

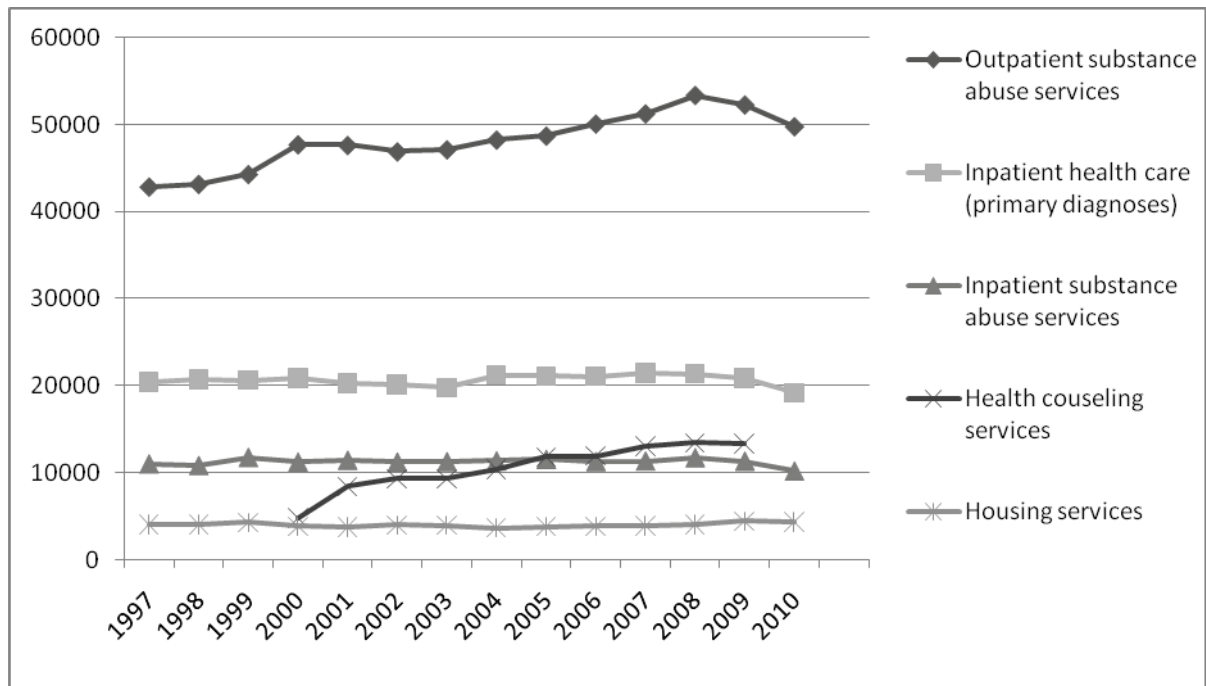


**Figure 6. Intoxicant-related cases in social welfare and health care 1999–2007.**

Source: Huhtanen 2009.

Based on the findings, drug-related problem use manifests itself in approximately 40% of the users of outpatient or inpatient substance abuse services, 25% of the users of outpatient health care and 20% of the users of inpatient health care. Among the clients included in the census, female drug users accounted for some 30% of those in outpatient care and 20% of those in inpatient care. In comparison to problem users of other substances, drug-using clients were relatively young. Among patients in substance abuse treatment, two thirds of those aged under 35 used drugs in addition to other substances, while among clients aged 35 to 44 drugs were used by only one third, and the figure for clients older than that was less than 10%. (Huhtanen 2009.) In addition to their age structure, drug-using clients differed from other users of substance abuse services in terms of marginalisation and mental health problems. Homelessness was significantly more common among drug users than other client groups, and over half of clients with a history of drug abuse suffered from depression or other mental disorders. (Nuorvala et al. 2008b.)

The overall trend suggested by long-term client monitoring in substance abuse service systems is in accordance with the census findings. The greatest changes include the increased number of low-threshold health counselling centres and their higher number of clients since 2000 and the more frequent use of outpatient substance abuse services (including substitution treatment). Towards the end of the decade, client numbers in both outpatient and inpatient care decreased while increasing in housing services. (Yearbook of Alcohol and Drug Statistics 2011.)



**Figure 7. Intoxicant-related clients in social welfare and health care services 1996–2010.**

Source: Yearbook of Alcohol and Drug Statistics 2011.

### Coverage survey

In 2009, about 60% of the substance abuse service units that received the drug treatment coverage survey responded.<sup>59</sup> The reported number of clients in drug-related treatment was 12,807, or 18% of all substance abuse service clients. In considering this figure, we should note that the survey was not targeted accurately, nor were responses comprehensive. On the other hand, there was no provision for eliminating overlapping client relationships in the survey. A similar survey was conducted regarding clientele for 2004. At that time, 324 units responded, reporting 75,018 substance abuse service clients and 17,825 (24%) drug user clients. The coverage of the Drug Treatment Information System compared to the domain of clients in drug-related treatment was the same in both surveys (32%). This would seem to indicate that the decrease in client numbers observed is an actual trend and not due to the decreased number of units returning information. (Väänänen 2011.)

The majority of the units that responded (78%) reported that they provided substance abuse services for drug user clients. The percentage of drug users out of all substance abuse service clients was the highest at outpatient and inpatient units specialising in drug-related treatment (58% and 89%, respectively), at the inpatient unit conducting medical treatment needs assessments for opiate addicts (78%) and in addiction psychiatry outpatient treatment at hospitals (75%). Drug users also accounted for a high percentage of substance abuse service clients in prisons (52%). By contrast, the percentages were considerably lower in outpatient substance abuse services at A-Clinics (10%), health centres (17%), detoxification stations (11%) and rehabilitation units (23%).

The data in the Drug Treatment Information System cover the different types of treatment unit fairly representatively, although the clientele in prisons and in outpatient treatment at health centres is under-represented. Specialised drug-related treatment was widely provided. The most common criteria for specialised drug-related treatment were the unit's right to provide medical treatment for opiate addicts

<sup>59</sup> The survey was relatively comprehensive with regard to specialised substance abuse services, but not so much with regard to health care outpatient services, for instance at municipal health centres. There was no provision for eliminating overlapping client relationships in the survey. Nevertheless, nearly two out of three treatment units responded, and the overall number of clients corresponds quite well to the annual number of substance abuse service clients obtained by combining data from other separate registers (cf. Figure 5).

(43%) and a treatment programme dedicated to drug users (38%). Just under 20% of the units had a specialised ward for drug-related treatment. (Väänänen 2011.)

Based on the survey data for 2008, drug user clients were concentrated in the Province of Southern Finland (43%) and the Province of Western Finland (36%), with 16% of them in Helsinki alone. The coverage survey for 2004, on the other hand, showed that no fewer than 70% of clients were located in the Province of Southern Finland and 17% in the Province of Western Finland, the figure for Helsinki being 43%. This indicates that, compared with the data for 2003, the drug user clientele had spread out more widely in southern and western Finland. Also, the coverage of the Drug Treatment Information System would seem to have improved for southern Finland but weakened for the rest of the country. (Väänänen 2011.)

## 6. Health correlates and consequences

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

The number of drug-related deaths grew along with other detriments at the turn of the millennium as a consequence of increased drug use in the 1990s. In the early 2000s, the number of deaths remained at this higher level. Over the past few years, the number of drug-related deaths has shown signs of rising again. This increase may be explained by the prevalence of polydrug use, risk behaviour and inexperience associated with drug use, the use of pharmaceuticals for intoxication, and mental health problems. It would be particularly important for users to be aware of the dangers of combined use, particularly with opioids, benzodiazepines and alcohol.

### 6.1. Drug-related infectious diseases

More than 64% of the drug user clients of substance abuse services had at some time in their lives taken all three tests: HIV, hepatitis B and hepatitis C. 70% had taken an HIV test, 66% a hepatitis B test and 74% a hepatitis C test. A hepatitis A test had been taken by 56% of clients.<sup>60</sup> (Väänänen 2011.)

#### HIV

According to the HIV infection statistics maintained by the National Institute for Welfare and Health, 188 new HIV infections were reported in 2010 (178 in 2009). Since 2000, the number of HIV infections has increased, due to the rise in sexually transmitted HIV infections. The number of intravenous infections, by contrast, has remained low: in 2010, only 8 infections caused by intravenous drug use were reported, which is only 4% of the reported total (7% in 2009). (THL 2011.)

In addition to the passive monitoring enabled by the National Infectious Diseases Register, the National Institute for Health and Welfare has been co-ordinating prevalence surveys conducted approximately once a year.<sup>61</sup> These surveys have aimed to assess the prevalence of infections also among those intravenous drug users who do not seek diagnostic testing. According to the survey results, the prevalence of HIV among intravenous drug users has remained, in spite of the epidemic of the early 2000s, at some 1% to 2%, which by international standards is very low. (Arponen et al. 2008.)

#### Hepatitis C

In 2010, the number of new hepatitis C infections reported was 1,132. This was 88 more than in 2009. However, because it is difficult to distinguish acute HCV infections from those contracted years ago, trends in case numbers must be viewed with caution. The majority of cases in 2010 (596) were reported in intravenous drug users. The incidence of HCV among intravenous drug users is so high (55%) that bringing it down is a slow process that will take a decade at least even in the best case where risks are brought under immediate

<sup>60</sup> These percentages are lower than in the previous year's report, because they have been calculated from figures that include the missing data (18%–30%).

<sup>61</sup> Generally, the survey has been arranged at several health counselling centres during two weeks on a total of eight occasions between 1998 and 2009. The respondents were clients of health counselling centres, numbering between 150 and 700. The respondents fill in an anonymous risk questionnaire and give a saliva sample, which is analysed for hepatitis C and HIV antibodies. Both the form and the sample bear the same anonymous participant number, enabling the comparison of individual risk factors against the antibody result. The test is not a diagnosis and, due to the anonymity observed, the results cannot be returned to participants. This fact is emphasised to the participants and it is also essential in terms of the survey's representativeness, since it enables participation by those who do not necessarily wish to learn of their infection. All clients of the health counselling centres are encouraged to participate in the study regardless of their HIV or HCV status.



control. The number of unclear cases has decreased slightly but remains high (406 cases in 2010). (Hulkko et al. 2011.)

The number of annual cases in the age groups 15 to 19 and 20 to 24 have remained stable or decreased. This may be a sign that health counselling for intravenous drug users and the related preventive work has decreased the risk of infection most effectively in younger age groups and that hepatitis C is now more typically contracted at a later age, after prolonged intravenous drug use. Indeed, the number of annual cases in age groups over 25 is increasing. Regionally, the incidence of hepatitis C has remained fairly stable in recent years, being the highest in the [now former] Provinces of Southern Finland and Oulu. Health counselling for intravenous drug users should be further enhanced in high-incidence areas to reduce the number of infections. (Hulkko et al. 2011.)

**Table 6. Hepatitis C according to physicians' reports, arranged by means of transmission, 1999–2010.**

	1999	2001	2003	2005	2007	2008	2009	2010
<b>Injecting drugs</b>	1,001	822	627	621	416	508	433	596
<b>Sex</b>	35	42	46	61	63	68	65	73
<b>Perinatal</b>	10	3	1	5	4	9	9	10
<b>Blood products*</b>	23	19	22	24	17	15	1	9
<b>Other</b>	40	31	34	35	23	31	26	38
<b>Unknown</b>	643	574	533	497	634	513	527	406
<b>Total</b>	<b>1,753</b>	<b>1,492</b>	<b>1,264</b>	<b>1,244</b>	<b>1,157</b>	<b>1,144</b>	<b>1,061</b>	<b>1,132</b>

Source: Hulkko et al. 2011.

\*) In the period from 1995 to 2003, four known cases of HBV infections transmitted via the transfusion of Finnish blood. Since 2000, no HCV infections transmitted via the transfusion of Finnish blood components have been reported. Monitoring the means of HCV transmission was initiated in 1998.

## Hepatitis B

The number of acute hepatitis B cases recorded in the National Infectious Diseases Register has shown a significant decline over the past decade, and infections contracted through intravenous drug use have decreased the most, meaning that hepatitis B vaccinations for risk groups and the work conducted at health counselling centres aimed at drug users have produced results. One case of hepatitis B contracted through intravenous drug use was reported in 2010 (none in 2009). Altogether there were 46 new infections, and the means of transmission was identified in 16. During the peak in 1998, the number of new infections was 256. (Hulkko et al. 2011.)

## Hepatitis A

In 2010, the number of new hepatitis A cases reported totalled 14. At least 10 of these had been contracted abroad. During the past few years, the number of infections has remained low. In 2002–2003, a hepatitis A epidemic emerged among intravenous drug users in the Greater Helsinki area, causing the number of new cases to soar. This growth levelled off in 2004, after which the prevalence has remained low owing to the vaccination of risk groups. Intravenous drug users, their sexual partners and persons living in the same household have had access to hepatitis A vaccination free of charge under the national vaccination programme since 2005. Seeking a hepatitis A vaccination is also common among those who are planning to travel abroad. (THL 2011.)

## Follow-up study of HIV strains among intravenous drug users

Skar et al. conducted a detailed study<sup>62</sup> of HIV epidemics among intravenous drug users in Stockholm and Helsinki, using both molecular epidemiology and epidemiology data. In summer 2006, the number of HIV infections among intravenous drug users in Stockholm began to spike, and the epidemic persisted until the end of 2007 with a total of more than 70 new cases. Prior to this, some 20 cases of HIV infection through intravenous drug use had been recorded in the Stockholm area annually since the early 1990s. In western Europe, HIV epidemics among intravenous drug users are principally caused by the HIV-1 B subtype. Of the infections among intravenous drug users in Sweden in 2001–2002, 85% were of the B subtype, and the majority of these had been contracted in Sweden; however, a handful of cases were reported as having been contracted in Finland. Finland experienced an HIV epidemic among intravenous drug users beginning in 1998. This epidemic was caused by the HIV-1 recombinant subtype CRF01-AE, which is common in Southeast Asia. (Skar et al. 2011.)

It was shown using phylogenetic analysis that the strain which caused the epidemic in Stockholm was CRF01-AE and came from Helsinki. Although several transmissions of CRF01-AE from Finland to Sweden were detected, the epidemic had a single source. While the CRF01-AE variant spread rapidly in Stockholm, the spread of the B subtype continued at a moderate pace. No biological factor could be isolated that would have explained the rapid spread of CRF01-AE: no difference in virus levels in the blood could be observed between patients infected by the B subtype and patients infected by the CRF01-AE subtype. However, a number of socio-demographic differences were noted; for instance, nearly all heroin users contracting the disease had CRF01-AE, whereas both B and CRF01-AE were common among amphetamine users. The CRF01-AE epidemics in both Stockholm and Helsinki are probably best explained by the appearance of HIV in networks of previously HIV-negative intravenous drug users, with risk behaviour related to drug injection and/or sex. (Skar et al. 2011.)

Studying local epidemics among intravenous drug users in Stockholm and Helsinki produced data on key factors in the spreading of HIV (number of virus strains, temporal and spatial distribution patterns, time from infection to diagnosis). These data may be used to enhance monitoring and to prevent infections. Combining phylogenetic and epidemiology data results in an effective tool for studying epidemics caused not only by HIV but by other infectious diseases too. (Skar et al. 2011.)

## 6.2. Drug-related treatment periods in hospitals

In 2010, inpatient wards registered 6,467 drug-related treatment periods in which a drug-related disease i.e. a disease related to narcotics or medicines, was the primary diagnosis, and 9,599 treatment periods in which a drug-related disease was the primary or secondary diagnosis. Half of the treatment periods involved various kinds of pharmaceutical poisoning. The number of all drug-related treatment periods and of cases of pharmaceutical poisoning has increased since 2005. The number of all drug-related treatment periods has increased by about 10% in the past five years. Over the same period, the number of individual clients has only increased by 2%, while the number of treatment days has decreased by 8%.

As in earlier years, about half of the drug-related inpatient care treatment days at hospitals were used for treatment of drug addiction, i.e. detoxification (17,077 treatment days). The number of inpatient treatment periods for drug addiction has increased by one fifth since 2005 while the average length of treatment periods has decreased.<sup>63</sup> The number of inpatient treatment periods for pharmaceutical addiction has decreased since 2005, while the number of inpatient treatment periods for drug poisoning has almost

<sup>62</sup> Materials and methods: The material for the study consisted of 74 cases of HIV infection associated with intravenous drug use, diagnosed in the Stockholm area between 2004 and 2007. The following data were obtained from patient records: year of diagnosis, age, gender, principal drug, housing conditions, CD cell count and virus burden. A blood sample was also taken from patients for a HIV-1 V3 loop sequence. The V3 sequences were analysed using phylogenetic and phylodynamic methods. Also, 83 V3 sequences obtained from HIV-positive intravenous drug users in Helsinki between 1998 and 2007 were added to the analysis. Statistical analyses were used to compare virus counts and CD4 counts among the infected patients. (Skar et al. 2011.)

<sup>63</sup> Taking medication into account, 14.5 days > 13.1 days.

doubled. However, drug poisonings only represent a small percentage of all the cases where pharmaceutical poisoning was the primary diagnosis (3,901 in 2010). The number of inpatient treatment periods for drug and pharmaceutical poisoning decreased by about 10% on 2009 but remains 4% higher than in 2005.

The number of inpatient health care treatment periods for drug-induced behaviour and mental health disturbances is now permanently lower than in the 1990s, which probably reflects changes that have occurred in the service system, such as an increased reliance on outpatient care and improved drug-related treatment. In 2009, however, the number of inpatient care treatment periods spiked by one fifth. In 2010, the number of inpatient treatment periods again decreased slightly on the previous year (2%) but remains higher than in the mid-2000s. It is possible that the economic recession has increased the need for caring for acute cases within the health care system rather than in inpatient care in substance abuse services, which are outsourced.

A client may be admitted to inpatient care because of intoxication. The number of treatment periods for drug intoxication has also been slightly increasing in recent years. However, treatment days in inpatient care for alcohol intoxication outnumber those for drug intoxication by a factor of more than 10.

**Table 7. Treatment periods for drug-related diseases 2006–2010, with a drug-related disease as the primary or secondary diagnosis.**

	2005	2006	2007	2008	2009	2010
<b>State of intoxication</b>	635	667	659	689	776	857
<b>Behavioural and mental health disorders caused by drugs</b>	714	705	707	676	818	842
<b>Drug and pharmaceutical addiction</b>	2,614	2,716	2,562	2,868	2,911	2,792
of which drug addiction	823	948	936	1,040	1,136	1,129
of which as primary diagnosis	577	664	625	726	773	690
<b>Drug and pharmaceutical poisoning</b>	4,238	4,433	4,481	4,653	4,948	4,511
of which drug poisoning	116	141	140	172	211	199
of which as primary diagnosis	103	126	122	145	197	170
<b>Other</b>	554	507	591	625	593	597
<b>TOTAL</b>	<b>8,755</b>	<b>9,028</b>	<b>9,000</b>	<b>9,511</b>	<b>10,046</b>	<b>9,599</b>

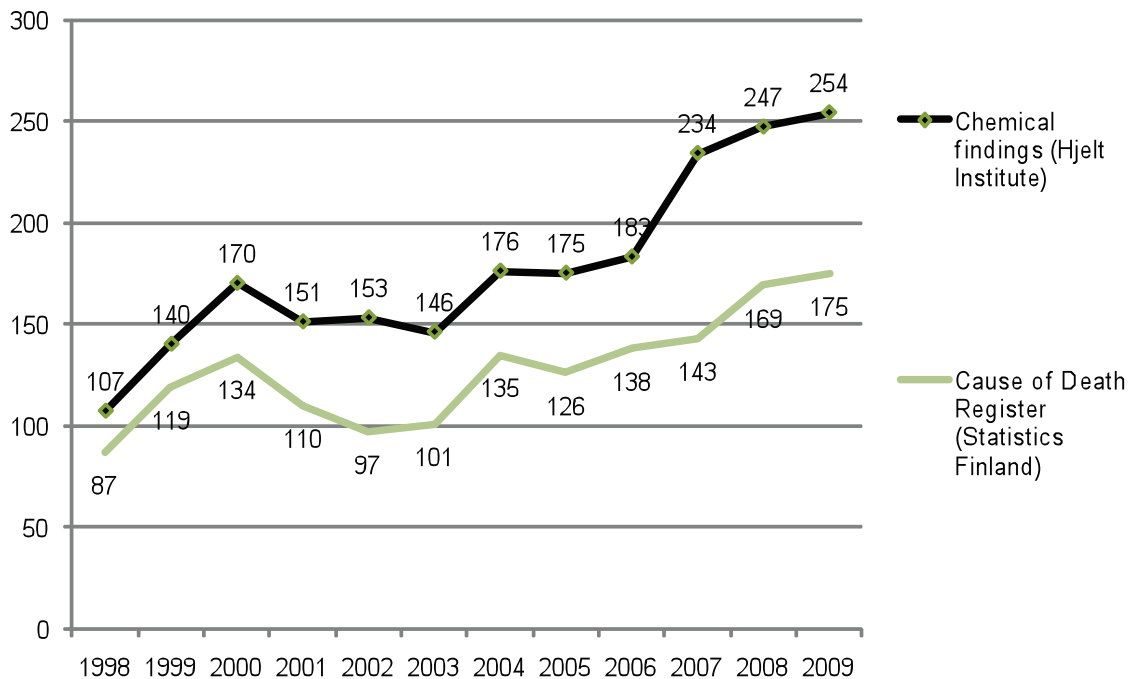
Source: Institutional health care. SVT, THL.

### 6.3. Drug-related deaths and mortality of drug users

Drug-related death cases in Finland can be analysed using three different types of statistics: chemical findings, causes of death and poisoning. Since the number of chemical findings is based on positive drug findings in forensic autopsies, the drug itself is not necessarily always the direct cause or a major indirect cause of death. In Finland, all cases involving an unclear or doubtful cause of death are examined for drugs. Statistics by cause of death are kept based on the EMCDDA protocol,<sup>64</sup> under which drug-related deaths include cases of intentional and unintentional poisoning (i.e. overdosing) and mental health disturbances due to drug use. In Finland, the causes of death statistics are produced by Statistics Finland. A separate report was compiled for cases of accidental poisoning in 2007. Table 9 shows a summary of the three different ways of analysing drug-related deaths for 2007. The table shows that analysing the deaths by cause of death produces a bias towards the older age groups.

<sup>64</sup> Data are extracted from the national cause of death statistics on the basis of WHO ICD-10 codes. The protocol is available as a PDF document at: <http://www.emcdda.europa.eu/?nnodeid=1419>.

In Figure 6, the trend in drug-related deaths is illustrated on the basis of causes of death and drug findings. In these drug-related death statistics, changes occurring since 2000 are highly consistent. An exception to this rule arises in the sharp increase in the number of findings in 2007 and in the number of entries in the National Cause of Death Register in the following year.



**Figure 8. The number of drug-related deaths based on causes of death and drug findings in 1998–2009.**

Source: Hjelt Institute and Statistics Finland 2010.

The number of chemical findings increased by 46 on the previous year in 2007 and by 13 in 2008, and remained stable at this high level in 2009. The Department of Forensic Medicine at the Hjelt Institute expects the growth trend to continue in 2010. Findings of cannabis and gamma-hydroxybutyric acid increased substantially in 2009 (Table 8). The number of deaths caused by either heroin or cocaine has remained at a few cases every year. The intoxicant use of buprenorphine, on the other hand, continues to grow. (Hjelt Institute Department of Forensic Medicine 2011; Vuori et al. 2009.)

The chemical findings referred to here are findings made in forensic toxicology investigations. A forensic toxicology investigation is always conducted when there is reason to suspect drug use. However, even if a positive result is found for a blood sample in such an investigation, this is only entered on the death certificate and officially registered if the forensic physician considered the finding a substantial one. For cannabis, only 53% of positive blood samples were entered on the death certificate, whereas the figures for findings of amphetamine and opiates were 81% and 91%, respectively. (Lahti et al. 2009.)

**Table 8. Drug findings in forensic toxicology investigations of cause of death 2003–2009.**

	2003	2004	2005	2006	2007	2008	2009
Heroin	4	0	3	2	1	3	3
Buprenorphine	73	72	83	88	97	104	111
Cannabinoids	82	80	71	99	94	93	119
Amphetamines	51	52	66	64	94	73	94
Methadone	3	11	14	21	26	33	34
Cocaine	1	3	2	1	3	3	4
Gamma	1	1	2	6	2	1	9
Total	147	176	179	191	234	247	254

\*Data for 2010 are not yet available. Intoxication use cannot be distinguished from pharmaceutical use until the death certificate data are available.

Source: Hjelt Institute Department of Forensic Medicine 2011.

### Accidental deaths of adult Finns 1971–2008

The purpose of this study was to explore the causes of accidental deaths in Finland and their long-term trends. Cause of death statistics for fatal accidents to persons over 15 years old between 1971 and 2008 were explored for the study. The findings show that the number of fatal traffic accidents had decreased dramatically. At the same time, the number of cases of alcohol poisoning had increased, particularly from 2003. The number of deaths by poisoning had also increased. Between 1998 and 2008, the majority of fatal poisonings among both men and women not due to alcohol were caused by the use of psychotropic pharmaceuticals, drugs and opioids. Accident prevention efforts should be focused according to the trends uncovered. (Korhonen et al. 2010.)

### Nordic study on drug-related deaths in 2007, Finnish component

A Nordic research team reviewed all of the positive drug findings for 2007 in attempting to describe what Nordic drug-related deaths are like and what the substances are that cause them.<sup>65</sup> In the case of Finland, the findings showed that the number of drug-related deaths per 100,000 inhabitants in 2007 was 4.02. In the Nordic countries in general, the place of death was in the capital city area in 29% to 35% of the cases in 2007, while the corresponding figure in 1991 had been between 53% and 75%. In Finland, about 15% of those who died from drugs in 2007 were women. The largest number of fatalities was found in the 25 to 29 age group. The average age of persons dying from drugs in Finland increased from 2002 to 2007. The number of fatalities in the 20 to 29 and the 25 to 34 age groups also increased. (Simonsen et al. 2011.)

Considered by drug classification, class I substances such as cocaine, fentanyl, heroin/morphine, ketobemidone, methadone, oxycodone, etc. caused 40% of all drug-related deaths. Of class II substances (amphetamine, methamphetamine, MDMA, etc.), amphetamine in particular caused a number of deaths (7%). The number of fatalities from heroin and morphine had dropped to almost nil by 2007. On the other hand, Finland had higher percentages than any other Nordic country of fatalities caused by class III substances (benzodiazepine, buprenorphine, meprobamate, zolpidem, etc.) (35%) and by class IV substances (other drugs and poisons, including ethanol and carbon monoxide) (17). The drug most

<sup>65</sup>This was the fifth study of this kind conducted in the Nordic countries over the past 23 years. The material for the study was obtained from forensic autopsies and toxicology analyses in the five Nordic countries (Finland, Sweden, Norway, Denmark, Iceland). These data were compared to similar data from 1991, 1997 and 2002. For the purposes of the study, a 'drug user' was someone who, according to police records or an autopsy report, had been using substances listed in Schedule I or Schedule II of the UN Single Convention on Narcotic Drugs (1961) or in Schedule III or Schedule IV of the UN Convention on Psychotropic Substances (1971). The causes of death determined the principal toxic agent and, in cases involving polydrug use, the substance with the highest levels, being most probably the substance that caused death.

commonly found was buprenorphine, and drug-related deaths ascribed to buprenorphine increased from 16 cases in 2002 to 32 cases in 2007, accounting at that point for 25% of all drug-related deaths. Methadone fatalities were not previously analysed in the statistics, but in 2007 methadone was listed as the cause of death in 16 cases. This indicates that the methadone used in opioid substitution treatment is finding its way onto the illegal market. Tramadol fatalities increased from 9 cases in 2002 to 14 cases in 2007. Combined use was common in all the Nordic countries; in Finland, a typical scenario was using ethanol and several (5 on average) other substances simultaneously. (Simonsen et al. 2011.)

Mikko Piispa categorised the causes of drug-related death as drug addiction, going crazy and self-medication. Piispa considers that in about half of the cases of drug-related death the deceased can be considered to have been actual drug addicts, characterised by compulsive use and diagnosed with intoxicant addiction, for instance. The subjects in these cases were over 20 years of age. In the ‘going crazy’ category are subjects aged 15 to 30 whose drug use had not (yet) become compulsive. Self-medication involves people who use drugs to alleviate their mental health problems (subjects over the age of 20) or somatic illnesses (subjects over the age of 30). Several of these actually have prescribed medication but use other drugs too. (Piispa 2010a.)

**Table 9. Drug-related deaths by age group in 2007, according to various categorisations.**

	15–19	20–24	25–29	30–34	35–39	40–44	45–49	50–54	55-	TOTAL
<b>Chemical findings / drug-related deaths (Hjelt Institute)</b>	16	58	54	31	29	23	12	8	3	234
<b>Deaths by accidental poisoning (Salasuo et al. 2009)</b>	10	35	35	20	22	11	4	3	2	142
<b>Deaths by cause of death and EMCDDA categorisation (Statistics Finland)</b>	6	22	28	19	18	15	12	11	12	143

Sources: Piispa 2010a; Statistics Finland 2008.

In 2007, one in six (17%) of all deaths of young adults (aged 15 to 34) were drug-related. Accidental poisoning from drug use or polydrug use accounted for about one in ten (8% to 11%)<sup>66</sup> of all deaths of persons aged 15 to 34. The major causes of death in this age group in 2007 were: disease 29%, suicide 27%, road traffic accident 17%. By contrast, alcohol poisoning accounted for only 3% of deaths in this age group. In examining the larger age group of 15 to 44, we find that drugs are involved in 11% of all deaths, accidental drug poisoning being the cause of death in 5% to 7% of cases.<sup>67</sup>

A study by Piispa<sup>68</sup> on drug-related deaths in 2007 explored the backgrounds of and events leading to these deaths, the contributing substances and how they were used. The study clearly shows how common polydrug use is, how risk-prone and inexperienced young drug users are, how pharmaceuticals are used for intoxication and how mental health problems are relevant in this context. Ignorance of the dangers of combined use was particularly apparent in cases of opioid, benzodiazepine and alcohol use among young people. (Piispa 2011.)

<sup>66</sup> The figure is 8% according to the National Cause of Death Register maintained by Statistics Finland (2008) and 11% according to Salasuo et al. (2009).

<sup>67</sup> The figure is 5% according to the National Cause of Death Register maintained by Statistics Finland (2008) and 7% according to Salasuo et al. (2009).

<sup>68</sup> The study material consisted of the cause of death documents for 2007 where traces of drugs were found in the deceased in a forensic autopsy. The research approach was material-oriented qualitative research as per Glaser & Strauss 1967 and Charmaz 2006.

Most of the deceased (88%) were men. The mean age of those who died was 31 years, and the median was 28 years. The largest number of fatalities was in the 20 to 24 age group. Of the 234 drug-related deaths in the year studied, 142 were due to an accidental overdose; of these, 83 involved drugs and 59 involved both drugs and alcohol. In the cases involving only drugs, the drug use had been going on for a longer time and often involved a drug addiction and intravenous drug use. The cases involving both drugs and alcohol, by contrast, were usually cases of ‘going crazy’ and of being inexperienced in using drugs. In 14 cases it appeared that the drugs had been used for self-medication. The histories to these cases mentioned serious mental health problems and somatic illnesses. (Piispa 2011.)

In the majority of the deaths caused by drugs, several drugs were discovered in the forensic autopsy. Opioids were the most frequently found drug type, and more than half of the deaths caused by opioids were ascribed to two drugs used in substitution treatment, buprenorphine and methadone. All the opioid fatalities were caused by pharmaceutical opioids, and all of the cases also involved benzodiazepines and/or alcohol. The combined use of buprenorphine and alcohol or benzodiazepines and alcohol seemed to increase the risk of overdosing. The amphetamine fatalities were different from the opioid fatalities. These cases never involved alcohol, and the deceased were older on average than those who died of opioids. (Piispa 2011.)

Of the other drug-related deaths, 45 were suicides. In most of these cases there was a history of mental health problems. Women accounted for 12 of the suicides, a clearly higher percentage than in the other categories of drug-related deaths. The mean age and median age of the deceased were lower than in the other categories. There were 21 deaths which were drug-related but where the cause of death was another type of accident; 20 were caused by illness and 6 by homicide. (Piispa 2011.)

### Driving while intoxicated in Finland 1977–2007

According to a register study,<sup>69</sup> driving while intoxicated seems to have become more common, as over the past three decades the number of cases of driving while intoxicated reported to the police has multiplied by a factor of 18. The most common substances found in the blood and urine samples of intoxicated drivers were benzodiazepines and amphetamines. Polydrug use was also very common. (Karjalainen et al. 2010.)

An exploration of the social background of intoxicated drivers showed that being socially disadvantaged correlated with driving while intoxicated.<sup>70</sup> Because being socially disadvantaged correlates with substance abuse more generally, narrowing the gaps between socio-economic groups would be beneficial both in reducing and preventing drug use in general and in curbing driving while intoxicated in particular. Intoxicant use is often begun at an early age, and the majority of intoxicated drivers are young; therefore substance abuse prevention and early intervention with young people are crucially important. (Karjalainen et al. 2010.)

A study<sup>71</sup> shows that over a five-year monitoring period mortality among persons suspected of driving while intoxicated was almost ten times higher than among sober drivers. A particularly high risk – 15 to 25 times that of the general population – was noted among those suspected of driving while intoxicated who were found to have been using two or more intoxicants simultaneously on the occasion of their first offence (drugs / pharmaceuticals impairing driving ability / alcohol). The most common causes of death among those suspected of driving while intoxicated were suicide, accidental overdose of drugs or pharmaceuticals and alcohol-related diseases or accidental alcohol poisoning. Two thirds of those who drove while intoxicated were intoxicated at the time of their death, as opposed to one fifth of the control population.

<sup>69</sup> The study concerned cases between 1977 and 2007 of drivers apprehended by the police and suspected of driving while intoxicated (total number of suspects during the period: 31,963).

<sup>70</sup> The social backgrounds of persons suspected by the police of drinking while intoxicated, between 1993 and 2006 (n=5,859), were compared to those of a control group representing a balanced sample of the population (n=74,809). The relevance of social background factors as predictors of driving while intoxicated was evaluated using logistical regression.

<sup>71</sup> The study included drivers apprehended by the police and suspected of driving while intoxicated, between 1993 and 2006 (n=5,832); their mortality was compared against the mortality of the Finnish population in general. The mortality was assessed using the Kaplan-Meier method and Cox regression.

The significance of intoxication as a contributing cause of death was elevated in cases where the primary cause of death was a traffic accident or homicide. (Karjalainen et al. 2010.)

The widespread use of benzodiazepines among those suspected of driving while intoxicated was one of the key findings of the study. The study showed that benzodiazepine users had a higher risk of premature death than amphetamine users and that combined use of benzodiazepines and other drugs or alcohol was very common. Although it was not recorded why the drivers had taken benzodiazepines, it seems likely that most cases involved substance abuse; therefore more attention should be paid to the intoxicant use of legal pharmaceuticals. (Karjalainen et al. 2010.)

The study also showed that polydrug use was common in cases of suspected driving while intoxicated. It was considered important for intoxicated drivers to be referred to treatment and rehabilitation as an alternative to being convicted and sentenced, because being caught for driving while intoxicated would be a good opportunity for reaching out to substance abusers and referring them to treatment. (Karjalainen et al. 2010.)



## 7. Responses to health correlates and consequences

The prevention of drug-related deaths is carried out as part of health counselling related to infectious diseases and in problem user peer group activities. The best-known ways of reducing drug-related harm are health counselling, medical substitution treatment programmes and needle and syringe exchange programmes for intravenous drug users. Distributing information about safe use and providing peer support are also at the core of substance abuse work for harm reduction. Users are informed about correct dosages to avoid overdoses, and the importance of calling the rescue services immediately in an emergency is highlighted. The issue is also dealt with in drug treatment units with users, when necessary. Some training concerning the prevention of drug-related deaths is provided as part of basic training in social welfare and health care.

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

Low-threshold services in particular have been essential in preventing and reducing infectious diseases spread by intravenous drug use. There are separate health and social security counselling centres for drug users at about 35 locations in Finland. Drug users can exchange used syringes and needles for clean ones at health counselling centres. An essential part of this operation is health counselling on drug-related infectious diseases and other serious risks related to drug use, such as overdoses and sexually transmitted infections. Health counselling centre services are free of charge for clients, who can visit the centres anonymously.

The websites of the health and social security counselling centres<sup>72</sup> provide information on their location, on harm reduction, on field work and on peer support activities. The websites also give access to a materials databank with information for instance on infectious diseases, various drugs, health counselling, sexual health and first aid in an overdose emergency. (A Clinic Foundation 2011.)

In 2009, 3.1 million syringes were exchanged at the counselling centres.<sup>73</sup> The most recent survey on needles and syringes sold at pharmacies was conducted in 2003. At that time, pharmacies sold 600,000 needles/syringes per year.

Information collected anonymously indicates that the health counselling centres had some 13,000 clients in 2009. The most visits were to the health counselling centres in Helsinki (about 8,350), Vantaa (about 900), Turku (about 890), Espoo (about 825) and Tampere (about 568).

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

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<sup>72</sup> Website (in Finnish): <http://toimipaikka.a-klinikka.fi/vinkki/>.

<sup>73</sup> Requested data needles.

## 7.1. Prevention of drug-related emergencies and reduction of drug-related deaths

Information for drug users on what to do in an emergency situation and how to prevent death from overdoses is provided in connection with all health counselling. However, the increase of drug-related deaths has also been taken into account by the authorities,<sup>74</sup> and there is concern about the combined use of opioids, benzodiazepines and alcohol, which was evident in the findings of a study<sup>75</sup> published in spring 2011. Combined use seemed to be a central part of the drug culture of the disadvantaged in Helsinki. Combined use of opioids, benzodiazepines and/or alcohol is the cause of a significant percentage of drug-related deaths in Finland. The study concluded that users should be informed of the risks of combined use to prevent drug-related deaths. Also, attention should be paid to intoxicant use of pharmaceuticals and the development of prescription practices to curb such use should be explored. (Tammi et al. 2011.)

Information on drugs is available on a 24/7 basis from third-sector helplines, for instance. Helplines are anonymous and free of charge for the caller. There are also rapid drug communications rings maintained by NGOs whose purpose is to distribute up-to-date information on drugs and the risks involved in using them. (A Clinic Foundation 2011; Finnish Red Cross 2008.)

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

More than two out of three (64%) of the drug user clients of substance abuse services had at some time in their lives taken all three tests: HIV, hepatitis B and hepatitis C. About 2% of the drug user clients of substance abuse services<sup>76</sup> who had at some time used drugs intravenously were HIV positive, while 71% tested positive for hepatitis C and about 5% for hepatitis A and B. Based on the data available in the drug treatment information system, of those drug treatment clients who had used drugs intravenously at some point in their lives, more than half (55%) had received at least one of the vaccine doses for hepatitis B. A total of 39% had received all three vaccine doses.<sup>77</sup> (Väänänen 2011.)

Health counselling centres offer exchange of syringes and needles and also provide counselling on health issues, small-scale health care, testing and vaccination services and case management. Health counselling centre services are provided in all municipalities with more than 100,000 inhabitants and, overall, at more than 35 locations. Many counselling centres offer anonymous instant HIV tests free of charge. The user's family members and acquaintances may visit the counselling centre too if they wish. Some health counselling centres undertake field work. The purpose of field work is to reach substance abusers not normally reached by the service system and to make services available to them.

According to an evaluation study, the services of health counselling centres have played a central role in the prevention of HIV, hepatitis A and B and, to some extent, hepatitis C, as well as in combating epidemics among intravenous drug users and therefore indirectly in the population at large. The ambitious objectives set for the HIV infection situation have been attained, namely stopping the epidemic and bringing the annual number of new cases below 30. The health counselling centre model has proven to be a very cost-effective health intervention, and safeguarding its continuation and further development is very important. (Arponen et al. 2008.)

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<sup>74</sup> Measures include publications on drug-related deaths; a seminar on drug deaths organised by the Ministry of Social Affairs and Health in 2008; and a seminar on work to reduce drug-related harm, organised by the Deaconess Institute of Helsinki in May 2011.

<sup>75</sup> In this study, 100 drug users in Helsinki were interviewed concerning which drugs they use, how they use them and how they obtain them; a European structured interview was used, translated into Finnish. This study formed part of the Second Multi-City Study on Quantities and Financing of Illicit Drug Consumption, or Quaf2. (Tammi et al. 2011.)

<sup>76</sup> Self-notified testing and result (n=1,583).

<sup>77</sup> These percentages are lower than in the previous year's report, because they have been calculated from figures that include the missing data (18%–30%).

**Table 10. Activities of health care counselling centres 2002–2009.**

	2002	2003	2004	2005	2006	2007	2008	2009
<b>Health counselling centres</b>	22	24	24	34	38	38	38	38
<b>Clients</b>	9,300	9,300	10,400	11,800	11,900	13,000	13,427	13,291
<b>Visits</b>	55,300	70,600	83,400	80,500	73,900	92,000	77,921	79,735
<b>Exchanged syringes or needles</b>	1.1 mil.	1.4 mil.	1.8 mil.	1.9 mil.	2.3 mil.	2.6 mil.	2.7 mil.	3.1 mil.

Source: Anturiverkosto 2010.

Under the Communicable Diseases Act and Decree, health centres / local authorities must provide health counselling for users of intravenous drugs and, as necessary, syringe and needle exchange and free vaccination against hepatitis A and B. According to a study on health promotion undertaken by health centres,<sup>78</sup> only half of Finland's health centres (51%) reported that they offer hepatitis vaccinations to users of intravenous drugs and their sex partners, and only about one in four (27%) reported that they offer syringe and needle exchange. The study poses the question of whether these low figures are due to low demand or whether health centres are simply not bothering to provide the service, statutory requirements notwithstanding. It is also possible that in responding to the survey, health centres did not mention services that were outsourced (for instance from the A-Clinic Foundation). (Rimpelä et al. 2009a.)

### 7.3 Drug-related harm reduction through peer group activities

Merging the expertise and experiences of peer groups and professionals has resulted in several new approaches in recent years, and peer support is increasingly used alongside professional work. The service system is increasingly taking the opinions of peer groups and experiential experts into account in the planning, implementation and evaluation of services to better meet the needs of the clients.

The Vinkki Health Advice Centre has almost from the first trained drug users to become peer educators or peer assistants who describe what they have learned to other drug users and collect information on the views, actions and networks of drug users. Peer training is based on an international substance abuse risk prevention programme where active participation by substance abusers themselves is of crucial importance.

The Vinkki outreach street clinic is also based on peer efforts. The purpose of the street clinic is to find the most excluded and most concealed client groups, to provide them access to services with a low threshold and to guide them to existing services. The street clinic employs a physician, a nurse and a peer support worker. The peer support worker is of huge importance in finding clients, in gaining their trust and in supporting the professionals for instance on house calls.

There is also a drug user association in Finland named Lumme ry, dedicated to supporting and counselling drug users, to reducing the negative stigma of drug use and to promoting equitable treatment of drug users. Lumme aims to promote a lifestyle free from substance abuse problems, to promote and maintain activities among members and their families based on their own initiative, to encourage interaction between people with similar life situations and the conveying of life improvement experiences from one person to another, and to find new ways of preventing and reducing substance abuse problems. Lumme engages in education and publicity on drug issues; organises leisure activities and group meetings; publishes a newsletter; cooperates with NGOs in the same field in Finland and abroad, with substance

<sup>78</sup> See 3.1 Universal prevention.

abuse services and the social welfare and health care sectors; and cleans up needles and syringes in public parks and other similar areas.

NGOs have launched a project named Osis, a centre of excellence in peer support for drug users in the Greater Helsinki area. The project brings together the work of various NGOs under one roof. Osis runs projects such as Napero, created by Omaisiet huumetyön tukena ry. for peer support for women and families, its purpose being to use peer efforts to reach pregnant women who are substance abusers, to offer them support and counselling and to direct them to services. Stop huumeille ry. has a project with three types of action: *Sosiaalivasara* (Social hammer), *Fattaluuta* (Social security sweep) and *Yhteisellä asialla – samalla viivalla* (Common cause – on the same line). *Sosiaalivasara* is a feedback channel primarily for substance abuse clients; anyone can phone or e-mail in or visit the office for a personal talk. The purpose of this is to collect positive and negative experiences of the service and treatment system. *Fattaluuta* aims to bring together a peer support group that can be trained to act as interpreters and counsellors for people who need help with services and how to find them. *Yhteisellä asialla – samalla viivalla* meetings are co-operative sessions where clients, peer support workers, experiential experts, professionals, workers and decision-makers meet to improve the service system and its operating procedures. (A Clinic Foundation 2011.)

#### **7.4 Prevention and treatment of other drug-related health correlates and consequences**

According to the quality recommendations for substance abuse services, substance abusers with serious mental health problems tend to fall through the cracks between substance abuse services and mental health services in the present service system. The quality recommendations stipulate that a client should primarily be provided with help at that social welfare or health care unit at which he/she seeks help. Municipalities must also have a clearly agreed division of duties in substance abuse services. In particular, the principal responsibility for treatment of substance abusers with mental health problems must be defined. A method suitable for evaluating dual-diagnosis patients at emergency clinics in basic health care and somatic specialist medical care or by social services has been developed in the Pohjanmaa project. (O. Kampman & A. Lassila 2007.)

## 8. Social correlates and social reintegration

The results of the drug treatment information system revealed the same facts as many other studies on the risk behaviours, substitution treatment and HIV infections of problem drug users: they have more social problems than the general population. More than three out of five drug treatment clients are unemployed and approximately one tenth are homeless, and clients have a low level of education.

Multi-professional co-operation between authorities has been emphasised in after-care adjustment activities. Drug problem users are often socially excluded and disadvantaged and have drug culture related social network. Treatment and rehabilitation are required to take a comprehensive, long-term approach with concrete help. This includes social rehabilitation, employment and supported housing services. The education authorities are also involved; the planning of education and vocational guidance are automatically included in the treatment of young people.

### 8.1. Social exclusion and drug use

The drug information system provides information annually on the socio-demographic situation of drug treatment clients and reveals that the situation has remained surprisingly unchanged for years. According to the 2010 data (n=2,529), 60% of drug treatment clients were unemployed and the clients' level of education was low. For two thirds (60%), the highest level of education achieved was comprehensive school, and 4% had dropped out of comprehensive school. Moreover, 9% of them were homeless. About a quarter were married or cohabiting, more than half of these (61%) with a partner who also had substance abuse problems. One in three (35%) had children under the age of 18. Two thirds of these children did not live with their parents. (Väänänen 2011.) As drug use is punishable under criminal law, many clients are also in a vicious cycle of crime and prison.

Being socially disadvantaged and being likely to turn to crime show a positive correlation: the weaker a family's financial standing is, the more likely it is that an adolescent in that family has committed criminal offences and been subject to violence. A survey among Finnish-speaking pupils in the 9th grade of comprehensive school (aged 15–16)<sup>79</sup> showed that the probability of experimenting with cannabis is the higher the worse off the family is. Of the young people who described the financial situation of their family as very good, only 5% reported that they had used cannabis during the current year. Similarly, of the young people who described the financial situation of their family as extremely poor, 14% reported that they had used cannabis during the current year. Cannabis use was also the more probable the less support and control the young person's parents provided (4% of young people under strong control, 9% of those under weak control). (Kivivuori et al. 2009.)

Finnish studies have shown that the majority of young people who commit homicide have similar family backgrounds (instability, lack of care, intoxicant abuse, domestic violence), an early history of disruptive behaviour (learning problems and behavioural problems at school, petty crimes) and problem use of intoxicants begun at a young age. Half of all young offenders who have committed a homicide have been diagnosed as drug users in the psychological evaluation following the offence. For a significant percentage of them, the parents or at least one of them had a history of problem use of alcohol. (Kivivuori et al. 2009.)

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<sup>79</sup> In 2008, 5,826 young people responded to a questionnaire about self-declared crime. The sample space consisted of all pupils in the ninth grade (aged 15 to 16) in Finnish-language schools in Finland. The National Research Institute of Legal Policy conducts a survey on youth crime at regular intervals. The questionnaire contains questions regarding 21 forbidden or criminal acts. For each, the respondents are asked whether they have ever committed such an act in their lives, and if so, whether they have committed that act less than one year prior to the survey.

Young people who receive a suspended sentence for a narcotics offence have a high risk of recidivism. The study showed that the social ties, use of time and cognition of young probationers influenced the risk of recidivism the more the poorer their education, housing situation and work or study situation was. Obvious or worrying drug use was found in 11% of probationers, and slight or occasional use in 14%. Problem users of drugs were subjected to somewhat more effective surveillance during their suspended sentence than other probationers. The more severe the probationer's drug problem was considered, the more the probation focused on that particular problem. (Harrikari 2010.)

In a study of short-term prisoners, the most unfortunate were those young prisoners who had begun their criminal careers in their childhood or youth. They were the most active as criminals in adulthood too, and they used more alcohol and drugs and began earlier than others. They were also the least confident of finding legal paid employment after their release. (Kivivuori & Linderborg 2009.)

## 8.2. Social reintegration

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

### Homelessness and the programme to reduce long-term homelessness

In 2011, there were about 7,400 homeless people in Finland, about 7,000 of them single. Some 4,000 of them live in the Greater Helsinki area. There are some 350 homeless families, more than half of them in Helsinki. Substance problem users are a risk group for homelessness.

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

The goal of the Ministry of the Environment's programme to reduce long-term homelessness 2008–2011 is to halve the number of the long-term homeless by 2011. The programme combines housing procurement with the securing of sufficient housing support services. The ultimate goal is to eliminate long-term homelessness completely by 2015. Homelessness has in fact decreased in all growth centres, particularly in the Greater Helsinki area, where local authorities engage in long-term and multi-sectoral cooperation to combat homelessness.

### Young people's social charter

Under the Government Programme 2012–2015, the aim is to provide everyone under the age of 25 and all new graduates under the age of 30 with a job or traineeship or a placement in studies, workshops or rehabilitation within three months of becoming unemployed. To this end, a working group was appointed in autumn 2011 to prepare a proposal for what is known as the young people's social charter. Implementation will begin in 2012, and the policy will be fully in place at the beginning of 2013. Exclusion of young people from working life will be prevented through a variety of measures by the employment and economic development authorities. Despite previous such measures, youth unemployment remains high. According to employment exchange statistics, there were 54,600 unemployed jobseekers under the age of 29 in August 2011, of whom 30,300 were under the age of 25. About one third of them have only completed comprehensive school. Nearly half of these unemployed persons have a vocational qualification or a bachelor's degree yet cannot find a job.

The training guarantee will form part of the young people's social charter. Everyone completing comprehensive school will be guaranteed a further placement at an upper secondary school, in vocational education, in apprenticeship training, at a workshop, in rehabilitation or elsewhere. Comprehensive education lays the groundwork for the employment of young people. However, just completing

comprehensive school is not enough; a secondary-level qualification is in practice a necessity for finding employment or for entering further studies. Some young people drop out at every stage of the education and training system. Some do not study further at all after comprehensive school, and some of those who do never complete a qualification. The result is that there are some 100,000 young adults (aged 25 to 34) in Finland who have no post-comprehensive qualification or degree of any kind.

Outreach youth work is intended for helping young adults under the age of 29 who are beyond the reach of training or the labour market. They need support in order to make use of the public-sector services available to them. In 2011, 223 local authorities are receiving a government grant for hiring 270 outreach youth workers. This covers 70% of Finland's municipalities. In 2010, outreach youth work contacted nearly 11,000 young people; 22% of them said they were unemployed even though they had not registered as jobseekers.

Implementing the young people's social charter requires broad-based cooperation between public actors. The Ministry of Social Affairs and Health stresses the importance of proactive prevention of social exclusion, early detection of problems and support for solving them. When a child's growth process is secured, he/she can grow up into a young person with a firm hold on training and on working life. During the current term of government, the Ministry of Social Affairs and Health is coordinating a programme to reduce poverty and social exclusion; this is also closely connected with the implementation of the young people's social charter.

#### **Cultural added value to preventing drug use**

In August 2011, Finland organised a Nordic drug forum in Helsinki with topics including the prevention of drug use and social exclusion through cultural efforts. It was proposed at the meeting that cross-sectoral efforts between the cultural, health care and wellbeing services must be supported and that culture must be incorporated into the routines of the social welfare and health care services.

In 2008, the Finnish Cultural Foundation launched the *Myrsky* (Storm) project to strengthen the wellbeing and the social and mental growth of young people by bringing art and culture into their lives. Another aim was to introduce young people to new forms of arts activities. *Myrsky* was principally aimed at adolescents aged 13 to 17, who are difficult to reach with traditional means. In the project, adolescents engaged in a variety of arts events under the guidance of professional artists. All adolescents were eligible, but particular attention was paid to those threatened by social exclusion. Some of the arts events were aimed at immigrants, mental health rehabilitees and institutionalised young people. Over a period of three years, more than 14,000 young people have had the opportunity to create art on their own terms. The *Myrsky* evaluation study shows that such activities strengthen the wellbeing of young people: arts activities make young people more content and happier with their lives while improving their social skills and capabilities. Art also boosts social participation among young people.

## 9. Drug-related crime, its prevention and drug use in prisons

### 9.1. Drug-related crime

Documented drug-related crime surged in the 1990s. Crime accompanying drug use, such as crime against property and driving under the influence of drugs, also increased in the 1990s. This growth levelled off after 2000. The statistical increase in cases of driving while intoxicated was boosted by the zero tolerance approach with regard to drugs and driving, adopted in 2003. In the past few years, documented drug-related crime has again been on the increase. In 2010, nearly 20,000 drug-related offences were recorded, an increase of 7% on the previous year. In 2008, the statistics only showed the offences reported to the police, but as of 2009 Statistics Finland changed its information base to include offences investigated by the Customs as well. This change may in fact explain part of the growth in the number of crimes, as it is observed later in the report that no corresponding growth in sanctions for drug-related crimes was found. (Kainulainen 2011a.)

According to the police, Finnish professional crime has typically been loosely structured, but is now closing ranks and becoming more disciplined. Major drug-related crimes investigated in Finland clearly show that the drug trade is professional and largely handled by organised crime groups. Criminal motorcycle gangs in particular hold a strong position in the drug trade in Finland and have close and functioning relations to groups abroad, particularly organised crime in Estonia. The prominent role played by organised crime groups in Finnish drug crime can be seen, for instance, in the more frequent presence of weapons, particularly gas sprays, as well as in the larger amounts of cash seized in the context of narcotics offences. Organised criminal groups have extended their domain from the traditional drug trade and property crime to financial crime and fraud, as organised crime seeks to generate rapid profits and increase its influence in the legal economy and in society at large. (National Bureau of Investigation 2011.)

According to the seizure statistics of the police and Customs, the number of cannabis plants seized doubled between 2007 and 2010. In 2010, 15,000 cannabis plants were seized, more than ever before. This is probably in part due to the increasing popularity of home-growing and the easy availability of cannabis seeds over the Internet, but also to the fact that authorities now uncover home-growing more efficiently. In 2010, the combined volume of marijuana seizures was almost 45% more than in 2008. (National Bureau of Investigation 2011.)

In the group of synthetic drugs, amphetamines have retained their leading status in comparison with the volume of seizures in 2008. The percentage of methamphetamine on the amphetamine market and in the seizure statistics of the authorities has clearly increased. A remarkable change from the situation in 2008 is that the range of new synthetic drugs, known as new psychoactive substances, has broadened substantially. The availability of ecstasy, for instance, has declined as it has been replaced by new psychoactive substances such as MDPV, mCPP and Bromo-Dragonfly. The volumes of seizures of narcotic pharmaceuticals have also been on the increase in recent years. Since 2008, the popularity of 'gamma' (GHB) and 'lakka' (GBL) has clearly declined. (National Bureau of Investigation 2011.)

#### Narcotics offences

In 2010, some 12,100 cases of unlawful use of narcotics were recorded, about 62% of all documented drug-related crime. There were about 6,500 cases of basic narcotics offences (33%). One of the factors explaining the increase in narcotics offences is that home growing of cannabis is becoming more popular. There were nearly 1,100 cases of aggravated narcotics offences, about 5% of all narcotics offences. Preparation or abetting of narcotics offences appears only rarely as a documented offence. (Kainulainen 2011a.)



More cases of aggravated narcotics offences were uncovered than in any year in the past decade. The police and the other PTR authorities<sup>80</sup> have stepped up their combating of serious crime, which partly explains the increase in the number of aggravated narcotics offences recorded; the police have not otherwise added resources to combating drug-related crime. The focus in investigating drug-related crime is on the recovery of criminal gains, which has resulted in a weakening of the operating potential of drug-related crime.

**Table 11. Drug-related crime reported to the police in 2000, 2004 and 2007–2008, and drug-related crime reported to the police, Customs and Border Guard in 2009–2010\***

	2000	2004	2007	2008	2009	2010
<b>Narcotics offences total</b>	13,445	14,486	15,448	15,482	18,524	19,724
<b>Narcotics offence</b>	12,687	4,672	4,206	4,835	6,274	6,444
<b>Unlawful use of narcotics</b>	-	9,217	10,333	9,823	11,257	12,158
<b>Aggravated narcotics offence</b>	741	582	883	789	922	1,083
<b>Preparation or abetment of narcotics offences</b>	17	15	26	35	71	39

\*The compilation of statistics changed as of 2009. The statistics for 2009 and 2010 include crimes reported to the Customs and Border Guard. This accounts for a 5% to 6% increase in the volume of drug-related crime.  
Source: Statistics Finland.

In 2010, there were 20,403 suspects in narcotics offence cases. (Statistics Finland 2011.) Of course, the same persons may commit several narcotics offences in the course of a year. In 2010, the police suspected a total of 5,909 individual persons of narcotics offences. The number of individual persons suspected of aggravated narcotics offences was 759. Compared with 2007, the number of individual persons suspected of narcotics offences overall had increased by 36% by 2010, and the number of individual persons suspected of aggravated narcotics offences by 42%. (National Bureau of Investigation 2011.)

The percentage of suspects of foreign origin in aggravated narcotics offences has increased remarkably in recent years. In 2010, no fewer than 35% of people suspected of committing aggravated narcotic offences were foreigners. This is twice the percentage recorded in 2007. The largest groups of suspects were Estonians and Russians/Russians living in Estonia. The number of Estonian suspects in particular increased notably in 2010. The nationality distribution of suspects has continued to diversify. The people suspected of aggravated narcotics offences in 2010 included Nigerians but also a growing number of Iranians, Iraqis, Dutch, Gambians and Lithuanians. On the Finnish market, Finnish criminals generally manage the reception and distribution of drugs in Finland, while foreigners are engaged in import and smuggling. (National Bureau of Investigation 2011.) The internationalisation of drug-related crime has brought added challenges particularly to the uncovering and pre-trial investigation of aggravated narcotics offences, for instance because of interpreting requirements.

The number of individual persons suspected of ordinary narcotics offences has also increased, being about 18% larger in 2010 than in 2008. The number of individual persons suspected of aggravated narcotics crimes recorded by the police and Customs in 2010 was 31% more than in 2008.

<sup>80</sup> PTR is the Finnish acronym for police, Customs and the Border Guard.

In 2010, the authorities confiscated nearly EUR 1.1 million in cash (about EUR 990,000 in 2009 and about EUR 1.1 million in 2008) in connection with investigating narcotics and doping offences, which illustrates the volume of this area of crime. Other forms of payment such as stolen property are also used in the drug trade. (National Bureau of Investigation 2011.)

### Narcotics convictions

In 2009, nearly 3,300 offenders were fined in summary penal proceedings, as compared with about 3,650 offenders fined in district courts. The total number of offenders fined was almost 7,000. A prison sentence was mandated in about 4,000 cases, more than half them (n=2,548) unconditional imprisonment. Charges were waived by the prosecutor for about 390 persons, and 41 persons were acquitted by a district court. As the number of crimes reported to the law enforcement authorities has grown, so has the number of sentences. We should note, though, that while the narcotics offence statistics of the police and Customs have shown sharp growth, no similar growth can be found in sanctions. (Kainulainen 2011b.)

Analysing sanctions by principal crime, we find that the most common sanction is a fine imposed in summary penal proceedings, followed by a fine imposed in a district court. Adding up the fines imposed in summary penal proceedings and in district courts, we find that 96% of all sanctions imposed for unlawful use of narcotics between 2005 and 2009 were fines. Waiving charges remains a little-used option, but prison sentences are even more rare. (Kainulainen 2011b.)

Summary fines are issued by the police have averaged at 15 day-fines in recent years. In cases where unlawful use of narcotics was the principal offence,<sup>81</sup> the sanction was a summary penal order in 87% of the cases (3,756) and a fine imposed by a court in 9% of the cases (367), while in 4% of the cases (189) the charges were waived.<sup>82</sup> Punishment was waived in 15 cases, and a prison sentence imposed in 11 cases. There has been no significant change in sanctions in recent years. (Kainulainen 2010.)

Between 2000 and 2009, the average number of day-fines in sanctions imposed for basic narcotics offences as defined in chapter 50 section 1 of the Penal Code was between 25 and 37. After the amendment regarding the unlawful use of narcotics, the average fine increased slightly, as in many cases minor narcotics offences are now handled in summary penal proceedings and never brought to court. In 2009, the average fine for a narcotics offence was 37 day-fines. (Kainulainen 2011b.)

Narcotics offences do lead to prison sentences too. If the same person is sentenced for several offences at once, the average sanction is usually more severe. In cases where only one offence is cited in the sentence, the average sanction for both conditional and unconditional imprisonment has been about four months. In 2009, the average sentences for unconditional and conditional imprisonment were 4.4 months and 4.1 months, respectively. (Kainulainen 2011b.)

For aggravated narcotics offences, the choice of punishment is in practice between unconditional and conditional imprisonment. An unconditional prison sentence is generally imposed for an aggravated narcotics offence; conditional imprisonment is considerably more rare. The average length of unconditional prison sentences has varied over the years; in 2009 it was about 3 years and 5 months (41.7 months). The average for conditional prison sentences has remained at about 1 year and 3 months for several years. Sometimes the sentences imposed for aggravated narcotics offences are quite long. (Kainulainen 2007; Kainulainen 2011b.)

Because of the proliferation of home growing of cannabis, there have been inconsistencies in punishment practices in the courts. In order to harmonise prosecution practices, the narcotics prosecution team has drafted a recommendation to estimate the volume of the harvest gained from cannabis plants. The average yield of one plant is estimated at 25 grammes. The recommendation notes that a prosecutor could demand

<sup>81</sup> Unlawful use of narcotics may be included as a secondary offence in decisions issued by district courts for other offences, and these cases are not usually included in the 'principal offence' statistics.

<sup>82</sup> See 9.3 Alternatives to prison.

imprisonment for growing more than 10 plants and a fine if there are fewer plants. (Hakkarainen et al. 2011a; Prosecutor General's Office 10 June 2010.)

### Driving while intoxicated

In 2010, the total number of cases of driving while intoxicated decreased by 10% on the previous year. However, the number of cases involving drugs (3,125) and polydrug use (693) remained steady, and the percentage of cases involving alcohol thus decreased. In 2010, the cause of driving while intoxicated was alcohol use in 82% of the cases, drug use in 15%, and polydrug use in 3%. (Statistics Finland 2011.) In 2010, drugs and pharmaceuticals were tested for in 4,532 cases of driving while intoxicated. Of these, 90% were positive for at least one drug or pharmaceutical. The most frequently detected substances in drug and pharmaceutical tests in 2010 were benzodiazepines (70% of the cases), amphetamines (55%) and cannabis (42%). (National Bureau of Investigation 2011.)

A register study published in 2009<sup>83</sup> assessed the manifestation of, and trends in, driving under the influence of drugs or pharmaceuticals in Finland between 1977 and 2007. During this period, driving under the influence of drugs or pharmaceuticals increased by a factor of 18. Of all suspects during the monitoring period, a total of 89.6% were men, but the annual percentage of women increased slightly. Women accounted for 6.9% of suspects in 1977 and 10.3% in 2007. This trend has statistical significance. The most frequently detected substances were benzodiazepines (75.7%), amphetamines (46%), cannabis (27.7%) and opioids (13.8%). The most frequent narcotic substances, amphetamines and cannabis, began to appear during the late 1980s, and the number of drug use cases began to grow as Finland adopted a zero tolerance approach to drugs and driving in 2003. (Ojaniemi et al. 2009.)

Most (77.1%) of those caught driving while under the influence of drugs tested positive for more than one substance. The most common findings in cases of polydrug use were benzodiazepines with alcohol (20%) and benzodiazepines with amphetamines (18%). Benzodiazepines were present in the five most frequently found combinations. The percentage of polydrug use cases where alcohol was involved have decreased during the monitoring period (one fifth of samples in 2007). (Karjalainen et al 2010.)

### Other drug-related crime

In 2010, there were 87 cases of burglary at pharmacies and care institutions with the intent of obtaining pharmaceuticals classified as drugs, almost the same as in the previous few years and in the early 2000s. Between 2005 and 2007, however, the number of such offences per year was a third lower. The increase in burglaries is probably due to the reduced availability of Subutex. (National Bureau of Investigation 2011.)

In certain categories of crime the perpetrators are intoxicated in a large percentage of cases, but alcohol use is far more common than drug use or polydrug use. Out of all cases of all types of assault (assault, petty assault and aggravated assault), 59% were committed under the influence of alcohol but only 0.4% under the influence of other substances and 1% under the influence of both alcohol and other substances. The comparable figures are 34%, 2% and 7% for all robberies; 13%, 2% and 1% for theft offences (petty theft, theft, aggravated theft); and 25%, 8% and 3% for stealing a motor vehicle for temporary use. (Statistics Finland 2010.)

Money laundering offences in Finland are mainly associated with drug-related or financial crime. In 2010, the most common types of offence in data submitted for pre-trial investigation were organisation of illegal immigration, narcotics offence, tax fraud and fraud. Between 1994 and 2010, of all the cases where data on suspicious business actions were submitted for pre-trial investigation, 46% involved financial crime, 10% involved narcotics offences and 9% involved money laundering. Money laundering based on

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<sup>83</sup> The study was conducted as register-based research, including all cases of driving under the influence of drugs or pharmaceuticals (n=31,963) in Finland between 1977 and 2007. All toxicological analyses were conducted on blood and/or urine in the same laboratory (alcohol and drug laboratory of the National Institute for Health and Welfare, formerly under the National Public Health Institute).

corporate ownership structures, dealing in receipts and the grey economy undertaken by organised crime groups has become more common. In recent years, well above half of all reported cases of money laundering in Finland have involved the transborder movement of funds, usually from Finland to abroad. There are relatively few professional criminals in Finland specialising in money laundering, which is usually undertaken by persons in criminals' immediate circle of acquaintances. (National Bureau of Investigation 2011.)

The Financial Intelligence Unit of the National Bureau of Investigation has compiled a report<sup>84</sup> on Finnish money laundering cases for the period 1994 to 2010. Of the 96 judgments issued, 46 involved a narcotics offence as a predicate offence. In the remaining cases, the predicate offence was a financial offence. With respect to the rest of the cases, other predicate offences included hormones trade, alcohol smuggling, bank robbery, appropriation, means of payment fraud, fraud or usury. The most common sentence included in the study was conditional imprisonment. Of unconditional prison sentences, nearly all were joint sentences involving several offences – chiefly narcotics offences. (National Bureau of Investigation 2011.)

## Reforms

The amendment to the Penal Code concerning unlawful use of narcotics introduced the possibility of alternative penal sanctions. The focus was on two special groups: underage offenders should be reprimanded instead of imposing a fine on them, and problem drug users should be referred to treatment. A multi-professional reprimand is considered a more efficient sanction for young offenders than a fine. Treatment referral reduces the social exclusion of problem users as well as drug-related crime. According to studies and surveys, referral to treatment in particular has seldom been used. (Kainulainen 2011b.)

According to Act 878/1995, prison health care must be organised so that inmates have equal opportunities with the rest of the population to improve their health and prevent illness. They must also have access to sufficient health care services. Prison health care provides inmates with information on the effects of intoxicants, health risks related to substance abuse and treatment programmes available in prison as well as outside prison after release. No new substitution treatment periods are initiated in prisons, but for prisoners whose substitution treatment period began before imprisonment, treatments are continued.

## 9.2. Prevention of drug-related crime

### Study among police on changes in drug-related crime and police operations

A study by Tuula Kekki (2009)<sup>85</sup> examined police officers' views on changes in drug-related crime and police operations. These interviews suggest that police officers are in favour of a zero tolerance approach to drug use, justifying this based on the criminalisation of use currently in force, the clearing up of the user's accompanying crimes and discovery of the users' drug-user acquaintances. Drug use is deemed part of organised crime and, consequently, a factor undermining public order and safety. Police officers considered their most important objective to be increasing safety on the streets. Among various police units, patrolling police encounter drug users most frequently, often in connection with an accompanying crime committed by the user. Individuals with a criminal background are more likely to draw the attention of street patrols.

<sup>84</sup> The study data included judgments issued by District Courts and Courts of Appeal. The collecting of cases began with the year 1994, when money laundering was criminalised in Finland. The dataset covers nearly all cases between 1994 and 2002 and contains some judgments from the years 2003 to 2010. A challenge in data collection lay in the fact that, until 2003, no essential elements required were specifically defined for money laundering crimes; instead, these were punished as receiving offences.

<sup>85</sup> The study data included police interviews (n=23), a police survey (n=165), pre-trial investigation records of unlawful use cases in Tampere from 1 September 2001 to 31 August 2002 and notices of investigation concerning drug-related and accompanying crime in Helsinki in 2002 and 2003. The interviews were conducted between 2003 and 2006, and thematic analysis was applied after they were transcribed. The police survey used a questionnaire issued to police officers serving in Tampere, and a quantitative analysis of the data was made. Pre-trial investigation records and notices of investigation were coded and analysed using SPSS statistical analysis software.

According to the police officers, prioritisation has led to a smaller number of staff participating in the prevention of actual drug crime. Such prioritisation is due to a lack of resources, investigation potential and assessment of the degree of harmfulness. Experienced police officers emphasised that in order to increase job satisfaction, professional skills and effectiveness, the police should resume traditional crime prevention methods: intelligence operations, observation and establishing contacts with the underworld. Now they spend time preparing reports on offences and conducting interviews, leaving no time for investigation. (Kekki 2009.)

International studies highlight the role of the police in curbing the visible drug culture and abolishing drug dealing locations. However, Finnish police officers do not feel that such objectives are appropriate in the Finnish context since drug use and dealing in Finland mainly take place indoors. Police officers did not view that the purpose of their work is to attempt to raise drug prices or wind down dealer organisations, nor did they assess the effectiveness of their work in relation to the structure of the drug market or the availability or price of certain substances. (Kekki 2009.)

### 9.3. Alternatives to prison

#### Referral for treatment, and reprimand

Alternative sanctions to prison have been developed for drug users: a reprimand procedure for young users and referral to treatment for problem users. The Prosecutor General has encouraged prosecutors to waive charges for drug users who have sought treatment. (Prosecutor General 2006:1.) The guidelines also note that breaking a drug addiction may be difficult and may require several treatment periods differing in content. Accordingly, it is possible to waive charges because of seeking treatment multiple times for the same individual. Seeking treatment must be demonstrated by written proof indicating that the drug user has sought treatment at a treatment institution or has booked a place or an appointment there.

According to data collected by the Prosecutor General's office, in 2009 treatment was cited in 30 decisions to waive charges. The figure for 2010 was 38. Analysed against the data from Statistics Finland, this shows that nearly 8% of all cases involving punitive waiving of charges were the result of referral to treatment. According to the data collected by the Prosecutor General's office, the majority of such decisions were made in Turku (57%). Of those seeking treatment, 70% were men and 30% were women. One in five were underaged (n=6). In 43% of the cases, the offence only involved mild drugs. In 33% of the cases, a pharmaceutical classified as a drug was discovered. A further 10% of the cases cited only hard drugs (amphetamines). The remaining 13% involved combinations of various drugs. Subutex or Suboxone was mentioned in nearly one out of every three cases.

An offender who sought treatment and whose charges were waived might be indicted with only a petty narcotics offence such as one-off drug use. In some of the cases, the offender had been using drugs for some months; in some cases, for a few years. In nearly all cases, the type of offence was unlawful use of narcotics. In a handful of cases, the offender had also committed another offence such as forgery, petty firearms offence or unlawful possession of alcohol. The materials also included some cases of a narcotics offence involving the growing of cannabis or the transfer of drugs. (Kainulainen 2011b.)

Based on the amendment to the Penal Code concerning unlawful use of narcotics, the Prosecutor General's instructions for prosecutors issued in 2002 (Prosecutor General 2002) and updated in autumn 2006 (Prosecutor General 2006) recommend that prosecutors arrange a reprimand session for 15-17-year-olds who have been arrested for unlawful use of narcotics for the first time. The young offender, his/her guardian, a representative of the social welfare authorities and the police participate in the session where the young offender is informed of the criminal and reprehensible nature of drug use as comprehensively as possible, the offender's life situation is examined and appropriate further measures are decided. After the session, the prosecutor may decide to waive charges. If the young offender does not attend, or if it is determined in some other way at the session that waiving charges is not a feasible option, this course of action may be abandoned. (Prosecutor General 2006:1.) A fine may then be imposed on the young offender.

In October 2006, the Prosecutor General updated the guidelines and issued instructions whereby in minor cases the police should confiscate the substance, give an oral warning and waive further charges. Nonetheless, surveys and research indicate that the numbers of reprimands and treatment referrals have remained relatively low. A survey conducted in 2009 revealed that offenders under the age of 18 had been reprimanded in 66 cases (40 in 2008) and that problem users of drugs had been referred to treatment in 30 cases (40 in 2008). (Prosecutor General's Office 2010.) According to the figures published by Statistics Finland, charges had been waived in 136 cases involving underage offenders. Analysing these two sources together reveals that nearly half of the underage offenders whose charges were waived were reprimanded; on the other hand, reprimands were issued in 17% of all cases where charges were waived.

In 2010, 161 reprimand sessions were held. In 2008, 2009 and 2010, the most reprimands were issued in Western Finland and Eastern Finland, and the fewest in Länsi-Uusimaa, Lapland and Central Finland. Helsinki, Pirkanmaa, Oulu, Salpausselkä and Itä-Uusimaa had an average or higher than average number of reprimands, while Ostrobothnia and Kanta-Häme were average or lower than average. (Finnish Police 2011.)

In a typical case, the reprimanded young offender was guilty of experimenting with cannabis on a small number of occasions. He/she was offered the substance personally or was reported to be responsible for acquiring it. Only a few cases involved a young offender with a longer history of cannabis use, and even then the longest period of use recorded was two years. Some cases involved not unlawful use of narcotics but a narcotics offence, because the young offender had distributed a small amount of drugs to another person or kept drugs in his possession with intent to distribute.

In 2010, a survey was conducted among prosecution units concerning reprimands issued to young offenders in cases of unlawful use of narcotics followed by a decision to waive charges, and referrals to treatment for problem drug users followed by a decision to waive charges. The numbers of cases are summarised in the following table:

**Table 12. Reprimands and referrals to treatment by prosecution unit.**

	Reprimand	Referral to treatment
Helsinki.	4	2
Länsi-Uusimaa		
Itä-Uusimaa	13	
Kanta-Häme	4	
Salpausselkä	7	1
Western Finland	98	13
Tampere Region	2	3
Ostrobothnia	4	
Central Finland	2	
Eastern Finland	19	
Oulu	7	
Lapland	1	19
<b>Total</b>	<b>161</b>	<b>38</b>

Source: Prosecutor General's Office 2011.

A reprimand session might be attended by the parents, a social worker, a foster home representative or a police officer in addition to the young offender. In some cases it was mentioned that an official had not attended a session despite being invited. The prosecutor's decision sometimes included a description of how the young offender behaved at the reprimand session. Support from the young offender's family or

child welfare services helped convince the prosecutor of the appropriateness of this approach. (For more on reprimands, see Kainulainen 2009.)

### **Dissertation on the criminal control of drug users in Finland**

In her doctoral dissertation, Heini Kainulainen (2009) examined the criminal control of drug users in Finland. The dissertation contains multiple sections, and its empirical section discusses alternative sanctions such as waiving measures and waiving prosecution, as well as referral to treatment and reprimands, which were added to alternative sanctions during the reform concerning the unlawful use of narcotics during the 2000s. The analysis indicates that proper consideration of sanctions has not been possible in the current processes. For instance, drug users have repeatedly been fined in summary penal proceedings.

The data indicate that the waiving of measures has been used very seldom, although there is a particular need for it especially in relation to narcotics offences. For decades, the police have been reluctant to apply this procedure, since they consider it crucial to intervene in drug users' actions. Prosecutors largely agreed with this view from the 1960s to the 1980s. Waiving punishment was common in the early 1970s, but within a few years practices became stricter. In the 1990s the procedure for waiving measures was reformed, after which waiving prosecution became more common. (Kainulainen 2009.)

Alongside the reform concerning the unlawful use of narcotics in the early 2000s, sanctioning practices became stricter, since fining drug users in summary penal proceedings became more frequent and the number of cases where prosecution was waived declined. According to Kainulainen, the reform regarding the unlawful use of narcotics has not been successful, since waiving charges as a result of the offender seeking treatment is extremely rare. (Kainulainen 2009.)

# 10. Drug markets

Internationalisation has had an impact on drug-related crime. Major and aggravated narcotics offences investigated by the police indicate that, in general, the drug trade is professional and strongly dominated by organised crime groups. However, despite these international trends Finland is not a prime target in the worldwide drug trade due to its remote location and relatively small population. Also, there is a very low level of corruption in the police, and society at large is geared towards rooting out organised crime. (Perälä 2011.)

In drug supply in Finland, organised crime groups from Estonia have played an important role – at the beginning of the 21st century in terms of smuggling and importing drugs and later on as collaborators with Finnish crime groups, supplying drug consignments for distribution and delivery. Estonian criminals chiefly function outside Finland. The importance of criminals of other nationalities in the drug trade directed at Finland is also increasing. The group of foreign players importing drugs in Finland has become more diverse and the role of Lithuania in particular in the Finnish drug trade is clearly strengthening. (National Bureau of Investigation 2011.)

On the one hand, the drug market appears organised and professional. On the other hand, the market is made up of several levels, where upper-level importers and wholesalers, mid-level distributors and low-level street dealers operate in different ways. This study demonstrates that drug dealing in Helsinki, whether we consider the very top or the very bottom of the pyramid, is a far from rational pursuit. The undertakings are not very systematic; they are more a reaction to intoxicant addiction(s) and other problems. (Perälä 2011.)<sup>86</sup>

The drugs on the Finnish market are mostly cannabis products, particularly home-grown marijuana or hashish; amphetamines and ecstasy and other synthetic drugs; the substitution treatment preparation, Subutex; and many pharmaceuticals classified as narcotic substances, particularly benzodiazepines. The number of marijuana and cannabis plant seizures has particularly grown in the 2000s, which indicates that the fairly small-scale cultivation of drugs partly intended for sale has become more common. The growing use of GHB and its precursor GBL seems to have peaked. By contrast, there are increasing numbers of new psychoactive substances on the market. Heroin is still fairly rare in Finland. The amount of seized heroin plummeted after 2001, and at the same time seizures of Subutex tablets began to increase. Seizures of Subutex declined from 2008. (National Bureau of Investigation 2011.)

## 10.1. Availability and supply of drugs

No truly open drug market, such as those found in some major cities in Europe, exists in Finland; most of the sale and use of illegal drugs takes place in private homes. (Kinnunen 2008.) Home cultivation of cannabis has become more popular in recent years, as is apparent from the number of seizures. The number of seized cannabis plants doubled from 2007, which was probably due to the increased popularity of home growing and the fact that seeds are easy to buy over the Internet, and also due to the authorities becoming more effective at combating home growing. (National Bureau of Investigation 2011.)

Cases of home-grown cannabis in Finland usually involve cultivation for the grower's own use, with cultures of no more than 20 plants. In the five most severe sentences imposed by a district court for home

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<sup>86</sup> The study material was mostly collected through ethnographical field work, including observations and interviews. Interviews with officials and minutes of pre-trial investigations concerning aggravated drug crimes are also included. The study takes a constructionist viewpoint, according to which language shapes reality. Therefore people evince differing conceptions of reality in their speech.



growing in 2002 and 2003, the average number of plants involved in the offence was 11, the median being 6. The largest culture consisted of 130 plants. (Kainulainen 2006; Kainulainen 2011a.)

A study conducted among home growers of cannabis<sup>87</sup> supported this, noting that the overwhelming majority of respondents were growing 1 to 5 plants at a time. These findings show that domestic production has increased in significance and that marijuana has surpassed hashish as the leading cannabis product. Using marijuana grown by the user himself/herself or obtained from a grower known to the user is now more common than buying marijuana on the market. (Hakkarainen et al. 2011a.)

Most growers order their seeds (chemically treated seeds that produce pistillate plants, which in turn produce more seeds) over the Internet, are given them by people they know, or obtain them from their own cultivation. Detailed growing instructions may also be found online. Also, the sale of equipment (which in itself is legal) required for home growing at certain shops favoured by home growers helps. The majority of home growing cases occur in major cities. The flower of a cannabis plant of a high-quality variant and grown under favourable circumstances can have a THC content of more than 10%. In the street trade, a cannabis flower is more valuable than low-grade hashish. (National Bureau of Investigation 2011.)

By early 2011, no websites selling drug-like substances aimed specifically at the Finnish market had been detected. However, people are increasingly ordering cannabis seeds, new psychoactive substances, intoxicating herbal products and GBL online from abroad for their personal use. GBL or 'lakka'<sup>88</sup> in particular is ordered by mail and express cargo from the Netherlands, the UK and Poland, but also imported from Germany via Estonia. The foreign companies selling these substances clearly state on their websites that the stuff they are selling is 100% GBL, which metabolises into GHB or 'gamma' in the body. The substance is sent to customers in plastic bottles whose labels indicate that they contain cleaning agents, for instance. The development of the product range of online shops selling spice products reflects how flexibly the supply can change to changes in the legal status of various substances: in 2009, sellers began to offer alternative mixtures for smoking instead of those classified as drugs. Synthetic cannabinoids (such as JWH compounds) are available in both powdered and crushed form. (National Bureau of Investigation 2011.)

### Import and the drug market

The import of drugs is an international crime, and in recent years 15% to 35% of those suspected of aggravated narcotics offences in Finland have been foreigners. Organised Estonian crime groups play an important role in the acquiring abroad and smuggling into the country of almost all drugs found in Finland. Finnish criminals are responsible for the distribution and sale of the drugs in Finland. (National Bureau of Investigation 2011.)

Drugs are imported to Finland by land concealed in cars, vans and trucks. Couriers carry drugs concealed in their clothes and luggage and, increasingly, within their bodies. Drugs are also imported by sea in cargo ships, fast ferries and private yachts. Drugs also arrive by air, although large quantities of drugs are no longer brought by passengers. This is due to tightened security on both passengers and luggage. Instead, larger quantities are flown in by air cargo and through courier companies. In most cases, imported drugs are transferred via a cache, the seller hiding the stuff and then drawing a map or making a note of the GPS coordinates of the location. The map or coordinates are then offered to potential buyers. (National Bureau of Investigation 2011; Perälä 2011.)

The majority of drugs are smuggled onto the Finnish market through various routes, particularly from the south and west. According to the police, 90% of the amphetamine imported to Finland in recent years

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<sup>87</sup> For this study, 38 Finnish home growers of cannabis were interviewed in 2008, an anonymous online survey with 65 questions was targeted at Finnish home growers of cannabis (1,298 responses being received, of which 1,054 from growers) in 2009, and population survey materials analysed for hashish and marijuana use were examined.

<sup>88</sup> Gamma-butyrolactone (GBL), known in colloquial Finnish as 'lakka', is a substance governed by the Medicines Act and used as a cleaning agent and industrial chemical.

has come from Estonia, the majority of it originating in central Europe. Currently, amphetamine and metamphetamine are also produced in Lithuania and trafficked to the Finnish markets by Estonian dealers. Today, amphetamine import is highly systematic and on a large scale. The usual scheme sees the Estonian dealers cache the amphetamine, with the Finns buying a map using which they retrieve the product. The drug culture in Russia is becoming more Western, and the use of amphetamine, ecstasy and cocaine in particular is increasing. Amphetamine production in northwestern Russia is also increasing, which may be of relevance for the Finnish drug market too. Hashish, in turn, originates in Morocco, passing first through Spain, the Netherlands or Germany and then by sea, through Scandinavia or the Baltic countries. Seizures of khat have increased by a factor of 10 in the 2000s. Customs officials report that khat seizures occur at least 3 or 4 times per week. (National Bureau of Investigation 2011; Perälä 2011.)

Russia has been a significant route, especially for smuggling heroin, but heroin also reaches Finland via other routes. The lack of treatment services and the decreased supply of Subutex on the illegal market may increase the demand for heroin. In addition, Finland is a potential route for the international smuggling of heroin from Russia to elsewhere in Europe. The threat of drug smuggling via the Nordic countries (including Finland) to Russia is also a point to consider, as drugs are being smuggled through the northeastern corner of the EU to Russia in particular, especially by Lithuanian criminal groups active in international cocaine trafficking. (National Bureau of Investigation 2011.) Hashish smuggling via Finland to Russia has also increased significantly. (Finnish Customs 2011.)

A study on the drug market in Helsinki reveals that the operations are separated into distinct levels. The actors and modus operandi are different on each level, albeit there may be some overlap between them. The actors on the upper level may be described as the Brain, the Left Hand and the Wallet. The Brain has a Contact, who is the source of the supply. Bringing the drugs into the country commonly involves a Go-Between, a Mule and a Tester. The actors on the upper level are better than other operators at avoiding being caught. (Perälä 2011.)

There are considerably more mid-level actors than there are upper-level actors. A mid-level dealer usually operates with a small circle of mates, known as a 'court'. A 'court' consists of a few trusted individuals, principally the Brains, the Help and the Muscle. They do not have as high a status and are not as technically proficient as the actors on the upper level. They use their own product in larger quantities and in a less controlled way than the upper-level actors. Nevertheless, both in Helsinki and abroad the mid-level dealers or Wholesalers are considered the most important people on the drug market, because it is through them that the upper-level actors gain their revenue. (Perälä 2011.)

The lower level is made up of gramme dealers and users. A batch of drugs may be resold one gramme or one pill or one 'fix' at a time. All of the lower-level actors themselves use the drugs they sell, their sales are small in volume, and there are considerably more actors on the lower level than on the other levels. The operations here are often quite brutal. Drug use brings a measure of uncertainty to the running of the system and erodes trust between actors. Everyday life becomes chaos as verbal agreements fail to be honoured. By contrast, the authorities have become very good at controlling this level with tactical means. (Perälä 2011.)

### **Smuggling of pharmaceuticals classified as drugs**

Using intoxicating pharmaceuticals as drugs is very common among Finnish substance abusers. Acquiring intoxicating pharmaceuticals is done particularly by exploiting the lack of centralised monitoring of the dispensing of pharmaceuticals: prescriptions are obtained from several physicians, and the pharmaceuticals thus obtained are both sold on the illegal market and used by the users themselves. Pharmaceutical are also obtained from abroad. There is a lively tourist trade in pharmaceuticals in Estonia; substantial quantities of pharmaceuticals classified as prescription drugs in Finland, e.g. benzodiazepines, are imported from Estonia to Finland by ship passengers. In the first half of 2011, pharmaceuticals classified as drugs (other than Subutex) have been seized mostly in postal deliveries from abroad. Passengers carrying these substances almost invariably arrive in Helsinki, and most of them live in the Greater Helsinki area. Concerning other narcotic pharmaceuticals, opportunities for 'legal drug tourism' were reduced and their

smuggling from the Baltics has increased with the enlargement of the Schengen zone. With the end of 'legal drug tourism', smuggling drugs within the body became more common in the traffic between Finland and Estonia. Pharmaceutical tourism to the Far East has also become more common, as has the purchase of pharmaceuticals online from all over the world. (National Bureau of Investigation 2011; Finnish Customs 2011.)

As a result of the latest enlargement of the Schengen area, drug users living in Finland can no longer import Subutex legally from Estonia under prescriptions signed there. Larger quantities of Subutex have been smuggled into Finland, mainly from France, but as drug tourism to Estonia waned, the role of Sweden as a source of Subutex strengthened. Britain, which lies outside the Schengen area, is becoming an important source alongside France, and Norway is also emerging. Subutex is available on prescription in Lithuania too. The potential offshoring of Subutex production to the Far East will probably increase online sales, in particular. The percentage of Subutex among pharmaceuticals classified as drugs seized by the Customs has increased substantially during the first half of 2011 to about 65%. Subutex is now imported in batches of hundreds of tablets instead of dozens as before, so the dealers are gaining bigger margins. Subutex is often brought from France to Sweden and from there to Finland either by car via the north or by ferry passengers. (Finnish Customs 2011.)

### Drug production facilities

No synthetic drugs production facilities have been discovered in Finland. Overall, during recent years, only a handful of small facilities for the precipitation of amphetamine sulphate have been found. These have been procuring the necessary chemicals by ordering them from players in the chemistry field or by stealing them from research institutes or workplaces in the chemistry sector. Thus, combating illegal activities is also highly dependent on the alertness of the sector's players. Trade in the precursors required for drug production is often associated with legal business operations, but some legally transported chemicals may also end up in the production of drugs in Finland's neighbouring areas. In terms of the trade in precursors, Finland occupies a high-risk position: there are illegal drug production facilities in Russia and in all the Baltic states, and Finland engages in trade in chemicals or through transport of precursors with all these countries. No significant precursor seizures have been conducted in Finland. Precursor seizures are an effective means of preventing drug production and rendering it more difficult. (National Bureau of Investigation 2011.) In 2010, the Customs authorities seized ephedrine in tablet form. The users were fitness activists and had no intent of manufacturing drugs. (Finnish Customs 2011.)

In May 2010, the police made a unique discovery in Helsinki, including nearly 60 kg of mCPP, a substantial number of Bromo-Dragonfly blotters and a tablet-making machine. Often marketed as a substitute for ecstasy, mCPP is a new psychoactive substance classified as a pharmaceutical in Finland. The police estimate that the quantity of mCPP seized would have been sufficient for about 800,000 tablets. The cumulative total of ecstasy tablets seized in Finland since 1993 is 525,000, so it is likely that only a small part of this quantity of mCPP had been intended for the Finnish market. A substantial number of Bromo-Dragonfly blotters was discovered in the same raid. Resembling LSD and considered highly dangerous, Bromo-Dragonfly is banned from pharmaceutical use in Finland. (National Bureau of Investigation 2011.) In the near future, drug manufacturing may spread to Finland from countries that already have illegal drug production facilities.

## 10.2 Narcotics offences

Data on drug seizures indicate that the situation prevailing in the Finnish drug market is fairly stable. Criminal cases concerning cannabis cultivation and narcotic pharmaceuticals have become more common in 2010. An increase in the online ordering of new psychoactive substances and intoxicating herbal products has been noted by the Customs authorities. In 2010, the Customs Laboratory detected new psychoactive substances in 459 samples, totalling 5.2 kg. There were 52 different new psychoactive substances detected, and 13 herbal products (2008: 13). The number of new psychoactive substance

discoveries, types of new psychoactive substance and types of herbal product all increased from 2009. (National Bureau of Investigation 2011; Finnish Customs 2011.)

**Table 13. Drugs recorded as seized by the police and Customs in 2003–2010 (kg).**

	2003	2004	2005	2006	2007	2008	2009	2010
Hashish	423.1	467.4	430.6	282.7	360.0	47.0	440.0	250.0
Marijuana	45.3	25.8	43.4	32.9	36.0	56.0	100.0	80.0
Cannabis plants (pcs)		7,840.0	9,460	7,510.0	7,600.0	14,000	12,500.0	15,000.0
Cannabis plants (kg)*	20.4	41.7	43.3	36.2	87.0	41.0	45.0	31.0
Amphetamines + Methamphetamines**	114.6	108.6	116.6	129.0	152.0	130.0 + 17.0	110.0+5	113+39
MDPV							4.0	9.5
Cocaine	1.1	1.1	1.2	6.5	4.0	3.0	2.8	4.2
Khat	1,879.0	2,118.0	2,562.0	3,283.0	3,300.0	2,250.0	3,300.0	4,700.0
Heroin	1.6	0.2	52.4	0.2	0.4	0.2	2.0	0.4
Subutex (tablets)	37,284	32,970	24,478	22,979	20,600	12,000	17,000	15,000
Ecstasy (tablets)	35,216	23,243	52,210	39,185	83,000	34,000	15,100	27,000
LSD (doses)	1,461	195	452	171	2,138	3,082	620	790
Bromo-Dragonfly (pcs)							1,200	7,600
GBL+GHB** (litres)				24.0	91.0	150 + 9	84+2	37+5

\* = In addition to the number of cannabis plants entered; mainly plant parts.

\*\* = Combined until 2007, separate from 2008.

Source: National Bureau of Investigation 2011.

**Table 14. Number of drug seizures recorded by the police and Customs in 2000–2010.**

	2000	2002	2004	2006	2007	2008	2009	2010
Hashish	2,482	3,012	2,626	2,599	1,900	1,500	1,940	1,933
Marijuana	663	1,275	2,067	2,269	2,400	3,000	3,700	4,018
Cannabis plants	-	923	1,406	1,378	1,900	2,100	2,650	2,716
Amphetamine/metamphetamine	2,369	3,399	3,392	3,101	2,990	2,900 + 120	2,910 +125	3,154+199
Cocaine	40	45	65	82	92	107	102	126
Heroin	437	145	45	25	20	25	26	9
Subutex	-	741	844	840	800	850	940	1,126
Ecstasy	393	329	328	297	340	250	190	229
LSD	34	10	21	15	50	73	52	73
GHB/GBL				54	184	170 + 80	112 +28	69+40
Khat				180	199	130	220	227

\*) In 2003-2005, the statistics were adjusted in order to take account of seizures related to those unlawful use cases which remained unregistered.

Source: National Bureau of Investigation 2011.

In 2010, the number of seizures of **cannabis products** in Finland was higher than ever. The number of **cannabis plants** seized (about 15,000) was also higher than ever: the number of seized cannabis plants had doubled since 2007. The amount of **marijuana** seized was the second highest per year on record, about 80 kg. This figure has nearly tripled since 2007. The growth is explained by factors such as a small number of exceptionally large seizures from smuggling undertaken by foreign parties from the Netherlands to Finland. In 2010, the amount of **hashish** seized was 250 kg. The volumes of seizures of the most popular imported drugs are crucially affected by the results of investigative operations focusing on large-scale smuggling. Thus, seizures of hashish have varied considerably from one year to the next. In the light of recent figures, it would seem that large-scale smuggling of hashish to Finland is continuing with no sign of decline. The largest individual quantities seized in 2010 were a batch of about 90 kg brought from Belgium to Finland concealed in a vehicle and a batch of about 44 kg brought from Germany concealed in a vehicle combination aboard a ship. (National Bureau of Investigation 2011.)

In the group of synthetic drugs, **amphetamines** have retained their leading status in comparison with the volume of seizures in 2007. In 2010, the amount was 113 kg, slightly more than in the previous year. In the largest single operation, Customs officials seized 15.6 kg of amphetamine in the possession and residences of members of a criminal organisation. There were four other seizures of more than 5 kg apiece, three from an outdoor cache and one from a warehouse. Shortages in amphetamine supply are continuing to be filled with **metamphetamine**, the percentage of which on the Finnish drug market and smuggling has continue to grow as is the case elsewhere in the Nordic countries and in the Baltic states. In 2010, the amount of confiscated metamphetamine was 39 kg. The largest single seizure was an exceptionally large outdoor cache of nearly 20 kg of methamphetamine, enough for more than 100,000 doses. (National Bureau of Investigation 2011.)

Alongside and among amphetamine on the market there are increasing amounts of methylenedioxypyrovalerone (**MDPV**), seizures of which in 2010 more than doubled from the previous year to 9.5 kg (the total of more than 300 items seized). MDPV findings have already been made in the forensic autopsies of some drug users in Finland. (National Bureau of Investigation 2011.)

The quantity of **ecstasy** seized in Finland per year increased to about 27,000 tablets in 2010, although even this is considerably lower than the peak annual figures of more than 80,000 tablets in the 2000s. Indeed, new psychoactive substances seem to be edging out substances such as MDMA,<sup>89</sup> and even amphetamines to some extent. Some 5,500 tablets of **mCPP** (chlorophenylpiperazine),<sup>90</sup> marketed as an alternative to ecstasy, were confiscated in Finland in 2010. (National Bureau of Investigation 2011.)

Only small amounts of **LSD** were seized in 2010 (just under 800 blotters), but substantial amounts of **Bromo-Dragonfly**<sup>91</sup> were found (more than 7,600 blotters). (National Bureau of Investigation 2011.)

The Customs authorities seized 239 grammes of **spice products**<sup>92</sup> in 2010. This is considerably less than the total for 2009, which included a few large batches of spice products that were seized. According to the labels, these herbal products contain a combination of plants, but the ingredients do not list the synthetic cannabinoids (such as JWH-018) that give the products their intoxicating properties. (Finnish Customs 2011.)

**Cocaine** has grown slightly in popularity on the Finnish market in the past few years, but it remains rather a marginal drug: only just over 4 kg of cocaine was seized in 2010, in more than 100 items. (National Bureau of Investigation 2011.)

<sup>89</sup> After the emergence of benzylpiperazine (BZP, classified as a drug in Finland, Fimea 1 September 2008) as an alternative to ecstasy, the European market has seen 'party pills' containing substances such as 1-(3-chlorophenyl)piperazine (mCPP), which is legal in most EU Member States.

<sup>90</sup> The National Agency for Medicines (now Fimea) classified mCPP as a pharmaceutical as of 25 August 2005. See also 10.1 Illegal drug production facilities.

<sup>91</sup> Fimea classified Bromo-Dragonfly as a pharmaceutical as of 1 January 2010. See also 10.1 Illegal drug production facilities.

<sup>92</sup> Synthetic cannabinoids have been included in the pharmacopoeia as they have been identified.

The popularity of **GHB** and **GBL** in Finland, which began to rise in 2007, has now clearly declined, and the volume of seizures per year continued to fall, being 42 litres in 2010. The popularity of GHB and GBL seems to have waned elsewhere in Europe too.<sup>93</sup> In February 2011, however, Customs tracked down a large-scale and systematic operation for importing and distributing GBL in southwestern Finland. A Finnish man was suspected of ordering 1,000 litres of GBL from a Chinese pharmaceutical company. A total of 860 litres were seized, making this the largest single seizure of GBL in Finland to date. The substance was intended for the drug market in the Greater Helsinki area, and the batch would have been worth more than EUR 1 million on the street. (National Bureau of Investigation 2011.)

The volume of seizures of **khat**, a drug favoured by Finnish residents of Somali extraction, continued to rise in 2010 to about 4,700 kg, the highest such figure since the arrival of the substance in Finland. (National Bureau of Investigation 2011.)

The amount of seized **heroin** in Finland plummeted at the beginning of the 21st century. The volume of heroin on the market remains low. Seizures in 2010 totalled about 0.5 kg. (National Bureau of Investigation 2011.)

Heroin has largely been replaced by the buprenorphine preparation **Subutex**, seizures of which (about 15,000 tablets) fell again after a rise in the previous year. Seizures conducted in Estonian traffic have been decreasing and acquisition is undergoing a redirection process. The quantity seized of **other pharmaceuticals classified as narcotic drugs** (mainly benzodiazepines and some opiates) remained high at some 90,000 tablets. (National Bureau of Investigation 2011.)

### 10.3. Price and purity of drugs

Street prices of drugs remained fairly stable in 2010. The price of cannabis went up slightly, one gramme of cannabis selling for EUR 15–20. The typical street price for hashish in 2010 was about EUR 9 per gramme, slightly lower than in previous years (EUR 6–12). In Lapland, the price was higher, about EUR 20 per gramme. The average street price per gramme in 2010 was EUR 33 for amphetamines, about EUR 120 for heroin, EUR 60 to 100 for cocaine, EUR 12 to 20 for ecstasy tablets and EUR 10 to 15 for LSD blotters. A Subutex tablet traded for about EUR 25 to 35 on the street on average in 2010, but in northern Finland the price could be anything up to EUR 120 to 160. The price depends on the quantity bought. The street price of MDPV is reported to have been EUR 60 to 80 per gramme, but lower prices of EUR 25 to 40 have also been reported. A 0.5-litre bottle of GBL costs about EUR 60 when ordered online; the street price in Finland is EUR 1 to 20 per millilitre depending on the concentration. The unit price of intoxicating pharmaceuticals on the illegal market is EUR 1 on average nationwide. (National Bureau of Investigation 2011.) A single dose of khat is 150 to 250 grammes and costs about EUR 25 when fresh. (Perälä 2011.)

Finnish street prices for drugs vary greatly depending on the sales location: in Helsinki and the Greater Helsinki area, prices are clearly lower in general than in regional centres. A study conducted in the spring of 2011 suggests that, in regional centres, the price of amphetamines, popular among hard drug users, may be well be double that of Helsinki. Hashish and Subutex are also clearly more expensive outside the Helsinki area. Unlike the prices of smuggled drugs, cannabis prices do not show regional variation. However, under special conditions, such as when drugs are smuggled into a prison, prices may be very high on a case-by-case basis. (National Bureau of Investigation 2011.)

The laboratory identification of drugs and testing the purity of drug consignments are done at the Crime Laboratory of the National Bureau of Investigation or at the Customs Laboratory. In Finland, routine analyses of concentrations of seized drugs are only conducted for amphetamine and methamphetamine if the seized quantity exceeds 10 grammes or, for heroin, 2 grammes. On request, concentrations of cannabis plants and marijuana are analysed for consignments exceeding 150 grammes. In other respects, concentrations are not analysed. (National Bureau of Investigation 2011.)

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<sup>93</sup> According to the Europol OCTA 2011, some Member States have reported an increase in the popularity of GHB and GBL.

No significant changes were found in the average concentrations of drug samples during 2010. What all drugs have in common is that there are huge variations in concentration. Average concentrations are about 20% by weight for amphetamines and about 30% per weight for cocaine and metamphetamine. The average concentrations based on analyses of cannabis plant and marijuana seizures have slightly increased in recent years, being about 5% by weight of THC in 2010. (National Bureau of Investigation 2011.)

## B. SELECTED ISSUES



# 11. Drug-related health policies and services in prison

## 11.1 Prison system and prison population

Measured by the number of prisoners, Finland's criminal policy is moderate. The crime situation has remained relatively stable in recent years, and the overall number of documented offences has slightly decreased in nearly all types of crime since the early 2000s. Some 15,400 judgments were entered in the register of judgments in 2010. As at 1 May 2011, the Finnish prison population consisted of 2,639 convicts (81%), 569 remand prisoners (17%) and 69 default prisoners (2%). The overall number of prisoners has fallen sharply since 2005. The average daily number of prisoners in 2010 was 3,291, which was 15% less than in 2005. The number of foreign prisoners has increased steadily since the 1990s and has continued to do so during the past year. As at 9 September 2011, the Finnish population consisted of 3,254 prisoners (3,315 as at 24 September 2010), of whom 479 were foreigners (416 as at 24 September 2010). Foreigners accounted for 14.7% of all prisoners (12.5%), and this figure has also been increasing in recent years. Of the foreign prisoners, 459 (386 as at 24 September 2010) were men and 20 (30) were women.

The principal offence of the convicts was a narcotics offence in 47% of the cases, a property offence in 16% and a sexual offence in 10%. There were 657 remand prisoners in Finnish prisons as at 9 September 2011, of whom 235 were foreigners; thus, 35.6% of remand prisoners were foreigners. Narcotics offences are the most prevalent principal offence among foreign remand prisoners (38%), followed by property offences (35%). (National Bureau of Investigation 2011.)

Most of the sentences are short, lasting less than one year; each year, slightly under 7,000 periods of imprisonment begin. In 2010, 91.5% of the new arrivals in the prison population were men and 8.5% were women. Offences against the person are the most common principal offence among convicts (44%). As at 1 May 2011, 17% of convicts (15.6% in 2010) and 3% of remand prisoners (4% in 2010) were in prison for a narcotics offence. The percentage of those accused of and sentenced for narcotics offences remained stable between 2005 and 2009.

### Organisation of the Criminal Sanctions Agency and substance abuse policy 2012–2016

The criminal sanctions sector was reorganised as of the beginning of 2010, with the former Criminal Sanctions Agency, Prison Service and Probation Service being merged. The purpose of the Criminal Sanctions Agency is to carry out sentences and to remand prisoners in custody. The Criminal Sanctions Agency comprises the Central Administration, the Health Care Unit and three Criminal Sanctions Regions. Each Criminal Sanctions Region has an Assessment Centre that takes care of preparing statements, assessing convicts and planning prison sentences and assignments. The basic units of the Criminal Sanctions Regions are the community sanctions offices (15), open prisons (12) and closed prisons (16); the total number of prisons at the moment is 28. The Criminal Sanctions Agency employs some 3,200 people.

The Criminal Sanctions Agency is currently working on a substance abuse policy for 2012–2016. The policy will be completed by the end of 2011 and will govern substance abuse work at the Agency nationwide, laying the groundwork for developing substance abuse services in the three Criminal Sanction Regions in the near future. The substance abuse policy will determine the goals for substance abuse services and the level to be reached by the end of 2016, using the current situation as the baseline.

### Prisoner information system and studies on intoxicant use by prisoners

Finland has a comprehensive prisoner information system including data on risk assessments and needs assessments, drug tests conducted while in prison, participation in substance abuse rehabilitation and drug-related disciplinary measures. The data in this chapter are mainly derived from the prisoner information

system, along with recent studies on drug use, including studies on the drug market in prisons (Perälä 2011), prisoner health (Joukamaa 2010), drug tests (Obstbaum et al. 2009), short-term prisoners (Kivimäki & Linderborg 2009) and prison safety (Junninen 2008), and the prison life quality survey (2010).

Relatively few studies have been conducted in Finland focusing only on intoxicant use among prisoners, and even those that do exist do not always distinguish between drug use and alcohol use. The state of health of clients of the Finnish criminal sanctions system was studied in 2006. The sample consisted of some 600 prisoners and some 100 clients of community sanctions offices. The study methods used were questionnaires, interviews conducted by nurses, psychiatric interviews, laboratory tests and a medical examination. Intoxicant addiction was ten times as prevalent among prison inmates as in the general population. The most commonly used intoxicant was alcohol, as is the case in the Finnish population in general.

**Table 15. Incidence (%) of intoxicant abuse diagnoses among prison inmates.**

Addiction	At some time in their lives	At the time of the examination	Most common in sub-sample
Some kind of addiction	84	17	Fine default prisoners 97% / 33%
Alcohol addiction	66	11	Fine default prisoners 87% / 24%
Opioid addiction	22	4	Fine default prisoners 35% / 7%
Cannabis addiction	19	1	Fine default prisoners 26% / 0%, Male prisoners** 23% / 2%
Cocaine addiction	4	0	-
Amphetamine addiction*	40	5	Male prisoners** 48% / 6% Female prisoners 44% / 6%
Addiction to tranquilisers	23	3	Fine default prisoners 32% / 2%, Male prisoners** 27% / 3%
Hallucinogen addiction	4	-	Fine default prisoners 9%
Solvent addiction	3	-	-

\*\* Male prisoners' here refers to prisoners who are male and who are serving a fixed-term unconditional prison sentence but are not life prisoners, fine default prisoners or community service prisoners.  
Source: Criminal Sanctions Agency 2011.

The study indicates that prisoners and other sanctioned offenders are more sick today than 20 years ago when the previous similar survey was conducted. Substance abuse problems among convicted offenders have mushroomed: 84% of all male prisoners and nearly all default prisoners have had an intoxicant addiction at some time in their lives. Two out of three had an alcohol addiction, and two out of five had an amphetamine addiction. Amphetamine addiction was common among all prison inmate groups. Nearly half (40–48%) of the male prisoners, default prisoners and female prisoners had had an amphetamine addiction at some point in their lives; the figure was 29% for life prisoners. At the time of the examination, 6% of the prisoners had an amphetamine addiction. Among male prisoners, 27% had had an opioid addiction at some point in their lives. (Joukamaa 2010.)

The study by Kivimäki & Linderborg on short-term prisoners (2009) shows that prolific substance abuse is common among short-term prisoners. Nine out of ten prisoners said that intoxicant use had influenced their criminal actions. More than half had committed a crime in order to obtain intoxicants. The study also explored the availability of substance abuse treatment in prisons. Prisoners did not consider treatment and rehabilitation to be control measures violating their interests. The findings of the study support the present criminal policy aim to increase the supply of treatment and rehabilitation during periods of imprisonment.

## 11.2. Contribution of the Health Care Unit of the Criminal Sanctions Agency to substance abuse work

The Health Care Unit of the Criminal Sanctions Agency is responsible for the health care of remand prisoners and convicts during their time in prison. The administrative sector of the Ministry of Justice is currently exploring the transfer of prison health care to the general health care system. Nearly 200 health care professionals work at prisons and at the two prison hospitals.

The personnel of the Health Care Unit make an important contribution to substance abuse work in providing substance abuse treatment. This is particularly important when a prisoner is admitted. The need for detoxification and withdrawal treatment is assessed by surveying the prisoner's substance abuse situation prior to being imprisoned. Substance abuse treatment provided by health care services consists of the treatment of substance-related illnesses and substance-related psychiatric treatment, and substitution treatment for opioid addicts. Health care personnel do not participate in the actual substance abuse rehabilitation undertaken during a period of imprisonment; this is managed by specially trained personnel at prisons such as substance abuse treatment instructors, psychologists and social workers.

Under the Communicable Diseases Act, the central government is responsible for preventing the spread of communicable diseases in prisons. It is the duty of health care personnel to ensure that prisoners are instructed on how to protect themselves particularly against diseases transmitted by blood contact or sexual contact and to prevent their spreading. Communicable disease prevention is undertaken in prisons through health education and by ensuring opportunities for protection. The hygiene package issued to each prisoner contains instructions on condom use and on the cleaning and disposal of injection syringes and needles, and also a personal hygiene kit.

Finnish prisons do not distribute or exchange needles for intravenous drug users. Disinfectant suitable for cleaning needles and syringes is available at the prison clinic, as are condoms. Disinfectant should also be anonymously available in the common facilities of a prison. In practice, prisoners do not use disinfectant dispensers in the common facilities to clean their syringes and needles because they believe that prison personnel are monitoring them (see e.g. Perälä 2011). Prisoners are recommended to take tests for hepatitis A, B and C and any vaccinations thought necessary. The communicable disease situation is monitored closely together with outside parties, and if a risk of infection through shared use of syringes and needles is detected, rapid preventive action is taken.

**Table 16. Hepatitis and HIV tests conducted and positive test results in 2010.**

Test	No. of tests conducted	No. of positive test results
S-HBsAg	394	4
S-HCVAb	578	133
A-HIV	1,045	2

Source: Criminal Sanctions Agency 2011.

Nearly half (42%) of all prisoners<sup>94</sup> had hepatitis C; 9% had hepatitis A and 8% had hepatitis B. An HIV infection was found in 1.0% of prisoners. (Joukamaa 2010.) The number of hepatitis and HIV tests conducted, as a percentage of the prisoner population, has remained stable, as has the number of positive results.

According to a Decree of the Ministry of Social Affairs and Health (33/2008), substitution treatment for opioid addicts may be started on an opioid-dependent patient who has not been detoxified. According to the relevant Decree (33/2008), the need for treatment of an opioid addict may be assessed and treatment initiated at the Health Care Unit of the Criminal Sanctions Agency. To date, the Health Care Unit has not conducted assessments or begun treatment, but courses of substitution treatment begun by prisoners prior to prison admission have been continued. In 2010, there was an average of 50 prisoners each day receiving substitution treatment.

### 11.3. Substance abuse rehabilitation and monitoring during imprisonment

At the Assessment Centre, a prison sentence plan is drawn up for the prisoner listing the points that the prisoner should address during his/her imprisonment. In drawing up the plan, the Assessment Centre will take the prisoner's substance abuse rehabilitation needs and the severity of his/her substance abuse problem into account, and this will influence prisoner placement. For about one prisoner in four, principally for those with a prison sentence of more than six months, the prison sentence plan is drawn up using a risk and needs assessment based on a face-to-face interview.

In the risk and needs assessment, the prisoner is asked whether and how he/she used drugs before being sent to prison. In 2010, only 554 risk and needs assessments with point scores were conducted. The decline in the number of risk and needs assessment is due among other things to the fact that the assessment process is being revised.

**Table 17. Risk and needs assessments conducted and substance abuse histories recorded, 2008–2010.**

	2008	2009	2010
No. of risk and needs assessments	902	708	554
History of drug use in risk and needs assessments (%)	73.3	72.6	61.6

Substance abuse rehabilitation in prison consists of a substance abuse rehabilitation needs assessment, substance abuse rehabilitation guidance, motivational instruction, relapse treatment, group-format rehabilitation programmes of varying intensity, personal therapy, the possibility of placement in an external substance abuse treatment facility, release training and networking services after release. Various forms of substance abuse rehabilitation are available in nearly all closed prisons. Some of the open prisons specialise in substance abuse rehabilitation. The rehabilitation is mainly undertaken by rehabilitative prison personnel: psychologists, instructors and social workers. There are some 50 instructors specifically engaged for substance abuse work in prisons. The Health Care Unit participates in substance abuse rehabilitation for prisoners only to a very limited extent due to a lack of human resources.

The motivation and effectiveness programmes used in prisons must be approved through an accreditation procedure. The preference is for international programmes with research findings to back up their effectiveness. In addition to group sessions, one-on-one discussions are held with prisoners for whom group work is not suitable; they can discuss substance abuse issues in confidence by appointment. One-on-one discussions are also often used as an extension of group sessions. Peer groups in prison (NA and AA groups) and KRIS-Finland are important contributors to abstinence from substance abuse.

<sup>94</sup> The prisoners were examined between 2005 and 2007.

According to data from the prisoner information system, 340 prisoners in 2010 entered a substance abuse rehabilitation programme that is accredited or accepted as a good practice. There are no substance abuse rehabilitation programmes in prisons specifically aimed only at drug users.

**Table 18. Participants in rehabilitation programmes in prisons, 2008–2010.**

	2008	2009	2010
Participants in accredited substance abuse rehabilitation programmes	636	444	440
Participants in accredited activities to prevent recidivism	262	288	313
Participants in other social rehabilitation (including non-accredited substance abuse rehabilitation programmes)	937	528	611
<b>Total</b>	<b>1,835</b>	<b>1,260</b>	<b>1,264</b>

After 2008, the overall number of rehabilitation participants decreased due for instance to recording practices: after 2008, substance abuse briefings less than 4 hours long were no more entered under rehabilitation. Also, the accredited substance abuse rehabilitation programmes of the Criminal Sanctions Agency have been cut back because of a lack of resources. We should note that prisoners with substance abuse problems often benefit from other programmes and forms of work aiming at preventing recidivism, since these include elements supporting a substance-abstinent lifestyle even though they do not count as substance abuse rehabilitation proper. Indeed, it is difficult to draw a line between substance abuse rehabilitation proper and other forms of rehabilitation, as there may well be content overlap between them.<sup>95</sup>

Rehabilitation in prison is at its most effective when linked to other survival support measures in society. Therefore, the aim is to organise prisoners' participation in prison activities so that their studies, work and leisure activities form an integrated daily schedule or dovetail with substance abuse work. Instead of regarding prison as an isolated bubble, contacts with the outside world must be emphasised, and services outside the prison should be available even while in prison.

In December 2010, a survey on the quality of prison life was conducted at four prisons; the survey included questions on substance abuse by the prisoners during their time in prison.

**Table 19. Survey among prisoners concerning substance abuse while in prison.**

After arriving at this prison, have you...	Open prison / open block	Closed prison	Total
started using intoxicants	1	1	2
stopped using intoxicants	73	67	140
moved to milder drugs	1	0	1
continued using intoxicants as before	3	7	10
Did not use intoxicants before arriving at this prison	80	19	99
Total	158	94	252

Source: Criminal Sanctions Agency 2011.

According to the respondents, intoxicant use during imprisonment was very rare. More than half (55.6%) of the respondents said that even if they had used intoxicants before arriving at the prison, they

<sup>95</sup> Methods used in prisons include the Swedish 'Five discussions about change' programme, based on motivational interviews; for most prisoners, the change aimed at involves substance abuse. However, the programme is of a general nature and is classified as a programme aimed at preventing recidivism. Therefore it does not show up in statistics on substance abuse rehabilitation.

stopped completely while in prison; or else they had not used intoxicants in the first place (39.3%). We should note that the survey was framed so as to ask the prisoners about the prison that they were in at the moment. Not nearly all prisoners arrive at a prison from the outside; they may arrive from remand custody or from another prison where they had not used intoxicants. According to Perälä (2011), some convicts when sent to prison stop dealing in and using drugs, at least for the duration of their prison sentence.

Substance abuse monitoring means monitoring that intoxicants are not used and preventing drug-related crime in prisons; this is primarily the responsibility of the prison monitoring personnel. Drug tests and special inspections are conducted in prisons, and many prisons have a drug detector dog on the premises (23 in all at the end of 2010). The main purpose of having a dog is to keep drugs outside the prison walls and to find any drugs brought in.

Compartmentalisation in closed prisons makes it possible for some prisoners involved in programme activities to stay in a contract block, which involves undertaking to abstain from substance abuse. There are not very many contract blocks, some 20 at the moment. Some prisons have no contract blocks at all, even though monitoring data suggest that the more there are intoxicant-free areas in the prison, the fewer problems and needs for disciplinary action there are. (Junninen 2008.)

A prisoner may not be subjected to a substance test without specific cause. A prisoner may be tested if there is reason to suspect that he/she is under the influence of alcohol or another intoxicating substance or doping substance. In such a case, the prisoner may be required to take a breathalyser test or to provide a urine or saliva sample.

A breathalyser test, urine sample or saliva sample may be set as a condition for an unsupervised meeting, placement in a contract block, permission to leave, study permit, civilian work permit, monitored outside activities, placement in an open prison or placement in an outside facility.

Basically, a positive test result always results in the revoking of certain privileges: the prisoner usually loses his/her open prison placement or has his/her trial freedom revoked. If a prisoner in an ordinary cell block is caught using intoxicants, the sanction is usually a disciplinary measure. If a prisoner gives a positive sample while participating in a rehabilitation programme, he/she is transferred out of the programme and the incident is treated as a relapse, following which the prisoner may re-enter rehabilitation.

The results of intoxicant tests are documented comprehensively in the prisoner information system. Therefore drug tests may be regarded as the primary source for drug use by prisoners while in prison. In 2010, more than 19,500 drug tests were performed on urine. Just under 1,500 of these were sent to a laboratory for confirmation and further tox screening; 727 findings were confirmed. The substances most commonly found were benzodiazepine, buprenorphine and amphetamine.

**Table 20. Urine and saliva tests taken**

Tests	2008	2009	2010
Urine tests taken	20 540	20 446	19 446
Test sent for confirmation	1 207	1 732	1 495
Test positive after confirmation	539	619	727
Saliva tests taken	72	427	1 107
Test sent for confirmation	-	-	1 073
Test positive after confirmation	-	-	7

Source: Criminal Sanctions Agency 2011.

An article by Obstbaum, Tyni & Ryyänen (2009) describes the results of intoxicant tests based on data extracted from the prisoner information system in 2008. In that year, 24,951 intoxicant tests were conducted in prisons. The majority of these tests were conducted in open prisons and in connection with various permits, various rehabilitation programmes and contract blocks, and among prisoners who had given their written consent to being tested. There was only a very low percentage of positive findings among these groups. This demonstrates that if prisoners have committed to abstaining from intoxicants,

they will not use them; or else, for whatever reason, they do not get caught. The highest percentage of positive findings was among prisoners who had been tested because of suspected intoxication.

According to Perälä (2011), benzodiazepine-based pharmaceuticals are a perennial favourite on the prison market. Buprenorphine is also popular, mainly because it can be packed into a small space and it is difficult for a drug detector dog to find if it is well packed. It also has the highest profit margin on the prison market, and it only shows up on a drug test for a short time after use. Amphetamines are the second most popular drug in prisons. Like buprenorphine, it can be packed economically, and it also only shows up on a drug test for a short time after use. However, its profit margin is not as good as that of buprenorphine, and a drug detector dog can find it more easily. (Perälä 2011.)

Occasionally urine test results indicating cannabis use are found in prisons. This is usually the result of cannabis use outside prison, as the substance shows up in drug tests for a long time. Hashish, on the other hand, is used to some extent in prisons, even though its scent is such that it is easy not only for drug detector dogs but for personnel too to notice. It is bulky to smuggle in and does not carry much of a profit margin. (Perälä 2011.)

According to Obstbaum, Tyni & Rynänen (2009), offenders do not greatly differ from one another regarding positive drug test results except for sexual offenders. Most commonly positive test results are found in those guilty of narcotics offences, but on the other hand they tend to get tested more too. Benzodiazepine use is common in all groups, though most in the groups of violent crime and property crime offenders.

Just under 500 disciplinary measures are imposed annually in prisons because of self-intoxication. This number has remained stable in recent years. More serious offences – narcotics offences, prison breaks and violent crime – are reported to the police.

Prisoners discovered to be dealing in intoxicants or otherwise committing narcotics offences while in prison are isolated from the rest of the prison population if necessary to prevent disruptions. For them too, the ultimate aim is to break the cycle of drug-related crime and to foster an intoxicant-free lifestyle. Local cooperation agreements between the prison and the police determine what the consequences of a drug discovery will be: a disciplinary matter within the prison or a referral to a police investigation.

**Table 21. Drugs discovered in prisons, 2008–2010.**

Chemical findings	2008	2009	2010
Amphetamines	191 g	141 g	94 g
Cannabis	85 g	133 g	95 g
Subutex in powder form	-	-	19 g
Subutex tablets	141	77	77
Heroin	0.2 g	2 g	0 g
Cocaine	0.98 g	20 g	1.3 g
Hormones (liquid)	-	-	55 ml
Hormone tablets	2,478	1,294	900
Absorbed substances and powders (stamps, letters)	314	256	190
Pharmaceuticals classified as drugs, in tablet form	1,549	1,766	1,089
Other unidentified pharmaceuticals	3,740 pcs	4,165 pcs	4,046 pcs
Drug syringe		176 pcs	97 pcs
Needle		215 pcs	123 pcs
Pipe		12 pc	21 pcs
Other drug use implements		10 pc	8 pcs

Source: Criminal Sanctions Agency 2011.

In 2010, less drugs were seized in prisons than in previous years. The combined amount of cannabis, amphetamines and heroin seized in 2010 was under 200 grammes, compared with about 600 g per year in 2003–2005. The decreasing trend may be ascribed to tighter security (including the use of drug detector dogs), intoxicant-free blocks and drug testing. These factors add up to an increased risk of being caught. Losing a place in an open prison is an effective deterrent to being caught in a drug-related offence.

There are many unidentified tablets doing the rounds in prisons; imports of hormones may be one reason for this. Persons coming into possession of these substances may not know what it is that they contain. (Perälä 2011.)

#### 11.4. Quality of services

The Central Administration of the Criminal Sanctions Agency is responsible for monitoring attainment of the substance abuse work goals through performance management, inspections and external audits. Internal Inspection is a key actor in substance abuse work quality control, monitoring the implementation of substance abuse work as required by law, for instance concerning the goals entered in the prison sentence plans. In addition to monitoring through inspections, quality management and evaluation, special reports and research findings are used to support the steering of substance abuse work.

Under the Act on Welfare for Substance Abusers (41/1986), local authorities are responsible for providing substance abuse services. The Criminal Sanctions Agency is not a rehabilitation institution as referred to in the rehabilitation legislation, and the primary task of a prison is not to rehabilitate but to execute punishments. Finland's prison legislation emphasises the preventing of recidivism and providing prisoners with the faculties they need to lead a crime-free lifestyle. Because a substance abuse problem is one of the key individual factors perpetuating a criminal lifestyle, a period in prison is a good time to stop and think about intoxicants.

In co-operation with the relevant organisations, the Prison Service has prepared various alcohol and drug programmes for inmates in prisons and for drug users released from prisons. In the future, prisons will aim to focus on activities requiring special expertise in criminal behaviour. Substance abuse rehabilitation that requires no particular familiarity with the criminal sanctions client in question can be outsourced where the expertise is available, i.e. from substance abuse service providers outside the prison. The aim in substance abuse rehabilitation is to employ methods that are effective, of high quality and reasonably comprehensive. In particular, methods in use outside prisons are increasingly being taken into prisons, since in the current economic situation it makes no sense to maintain parallel systems. The quality of outsourced services will also be particularly addressed in the future.

Special attention has been paid to the quality of the Criminal Sanctions Agency's own substance abuse rehabilitation programmes. All motivation and effectiveness programmes to be deployed in the criminal sanctions sector must be approved in an accreditation procedure before widespread introduction. Also, the aim is to provide each programme with an individual quality standard.

The structural decisions taken when the Health Care Unit was set up on 1 October 2006 have in some ways complicated cooperation between the unit and prison personnel. The administrative sector of the Ministry of Justice is currently exploring the transfer of prison health care to the general health care system. The Criminal Sanctions Agency is currently developing client assessment procedures and their tools. Client assessment will become a process lasting the duration of the sanction and including expert statements, initial evaluations by the convicts themselves, interim reports during the sanction and a final report as the sanction concludes.

#### 11.5. Reintegration of drug users after release from prison

The various rehabilitation programmes in prisons involved 1,260 inmates in 2009 (1,835 in 2008). A total of 444 inmates participated in substance abuse rehabilitation programmes, 288 in programmes to minimise recidivism and 528 in other types of social rehabilitation. The purpose of the programme steering group set up in 2009 is to inspect the content of social rehabilitation in prisons. (Criminal Sanctions Agency 2010a.)



A probationary freedom system was adopted at the end of 2006, with the aim of promoting an inmate's reintegration into society after release. The maximum length of probationary freedom is six months; it is a measure between imprisonment and parole. During probationary freedom, the inmate must participate in an activity, such as work, studying, rehabilitation or completing compulsory military service, and commit for instance to an intoxicant-free life and to respecting the obligation to remain in contact. In 2008, the daily number of inmates in probationary freedom averaged 50. Based on the experience gathered, probationary freedom appears to be an effective means of reducing the risk factors associated with release from prison, such as relapsing into substance abuse and subsequently returning to a vicious circle of crime. (Mohell 2009.) The Act on electronic monitoring sentences (330/2011) entered into force on 1 November 2011. A person with an electronic monitoring sentence must comply with the daily programme and movement restrictions imposed on him/her. The convict is obliged to stay at home at all times when there is no predetermined reason for him/her to go outside. Absolute abstinence from intoxicating substances is also required, and this is monitored through tests.

Probation Foundation Finland is currently running a project called Placement into Controlled Housing (2009–2011). Its aim is to reduce homelessness among released prisoners and other clients of the criminal sanctions system both nationwide but particularly in the Greater Helsinki area. It will also help reduce recidivism and the use of expensive social welfare and health care services. *Osaava ohjaus* (Skillful Guidance) 2010–2013 is a project run by the Probation Foundation with the aim of creating a multi-professional cooperation and expertise exchange model to reach out to adults at risk of social exclusion. The project also offers training for professionals. The project has received ESF funding and is being run jointly with other actors. (Probation Foundation Finland 2011.)

Since 1999, the Regional Prison of Southern Finland and City of Helsinki Social Services Department have been engaging in rehabilitation work for prisoners with substance abuse problems (Kuva); prisoners enter the system when they are transferred to open prison and continue with the same contact persons as during their imprisonment. Selected prisoners participate in work rehabilitation provided by the City and therapeutic outpatient rehabilitation provided by A-Clinic substance abuse services. Financial matters and debts can be settled with the execution authorities and debt counselling. Prisoners also have peer support group meetings. The aim is for prisoners to become accustomed to working regularly while still in the open prison and to continue working in the same job immediately after their release. The majority of participants have no permanent place to live and are clients of the municipal social services for the homeless. By the end of 2010, 121 prisoners had entered rehabilitation, of whom seven have participated in work rehabilitation after their release. More than half of them were released under Kuva. (Probation Foundation Finland 2011.)

## 11.6. Discussion, methodological limitations and knowledge gaps

The exact number of drug users in prisons is not known, but as Perälä (2011) observes, the drug market in prisons is small compared to the drug market on the outside. The important thing for monitoring the drug situation is to have a reliable statistical system for indicators relevant for substance abuse work, e.g. the number of substance abuse rehabilitation participants, the incidence of communicable diseases associated with substance abuse, the incidence of substance abuse during a prison sentence, the costs of outsourced services, and the attainment of substance abuse rehabilitation goals entered in the prison sentence plans. These data can be obtained from existing information systems. For a statistical system to support decision-making effectively, the contributing actors must be active and methodical in entering data into it.

There are not enough research data or statistics available on drug detoxifications performed or harm-reducing measures undertaken during prison sentences. We do not know how many drug users overdose immediately after being released from prison. The drug test system is not foolproof, since prisoners may only be tested when intoxicant use is suspected or when certain permits are involved. Also, it is sometimes

very difficult to detect intoxication clinically. The percentage of prisoners participating in group-form substance abuse rehabilitation programmes is quite small.

There are 28 prisons in Finland, all very different in their size, operating culture, structures and traditions. In some prisons there are scarcely any findings of indicators of drug use during prison sentences, while in others the results of surveys, seizures and drug tests indicate that drug use is fairly common. In a closed setting like a prison, drug use involves not only the usual adverse effects but also debt recovery and coercion to commit narcotics offences, which is why many prisoners wish to spend their time in prison completely isolated from other prisoners. Intoxicant monitoring will thus be paid more attention in the future.

# 12. Problem drug use by parents of underage children and by pregnant women

## 12.1 Extent of the problem

This chapter discusses problem drug use by parents of underage children and by pregnant women. The extent and nature of this phenomenon has been studied very little in Finland. There is a fair amount of research on the effects of drug use during pregnancy and their treatment, but almost none on the extent, nature and treatment of problem drug use by parents of underage children.

There are no research findings or reliable estimates of how large a percentage of problem drug users have underage children, although this point has been examined with regard to clients of substance abuse services. In 2010 more than one out of three clients (35%) seeking substance abuse treatment because of drug use in had children under the age of 18 and around one third (32%) out of these had their children living in the same household. (Väänänen 2011.)

Estimates of problem use of alcohol, drugs and pharmaceuticals by pregnant women usually group these together; in other words, there are no data specifically on drug use. In a survey conducted by Pajulo et al. (2001), 6% of the pregnant women in southwestern Finland were classified as at-risk users of intoxicants (alcohol, drugs, pharmaceuticals). The survey employed the Substance Abuse Screening Inventory (SASSI) questionnaire, and responses were anonymous. However, Pajulo's study also gauged at-risk use prior to pregnancy, and it seems reasonable that some of the respondents would have reduced or quit their drug use when they got pregnant. (Mäkelä 2009.) A monitoring study was conducted at special maternity clinics for problem substance users in the Hospital District of Helsinki and Uusimaa between 1992 and 2001, involving a total of 526 women referred to special monitoring from a normal maternity clinic because of intoxicant use (alcohol, drugs, pharmaceuticals). This group referred to special monitoring represented 0.4% of all of the pregnant women in the region. (Sarkola et al. 2007.)

## 12.2. Political and legislative environment

Under the Act on Welfare for Substance Abusers (41/1986), substance abuse services must be offered to substance problem users, their families and other people close to them to the extent determined by the client's need for help, support and treatment. The best interests of the problem user and people close to him/her must be prioritised. Section 11 of the Act on Welfare for Substance Abusers allows for involuntary commitment to treatment in case of a health risk, but this provision is applied only rarely. However, coercive measures are often exercised on substance problem users pursuant to the Mental Health Act (1116/1990).

The Child Welfare Act (417/2007) and the Health Care Act (1326/2010) require that any children are taken into account in all services intended for adults, including substance abuse services. The Health Care Act also notes that the health care authorities must provide for essential services to protect pregnant women and newborn babies. These services must be provided in cooperation with the social services authorities.

An amendment to the Child Welfare Act entered into force in March 2010 containing a provision on submitting an anticipatory child welfare notification (section 25c). An anticipatory child welfare notification must be submitted when there is reasonable cause to suspect that a forthcoming child will need child welfare support measures immediately after the birth. In other words, an anticipatory child welfare notification must be submitted by someone who has certain knowledge that a mother-to-be or father-to-be has a substance abuse problem or a severe mental health disturbance or is subject to a custodial sentence. A

suspicion of substance abuse is not in itself enough for submitting an anticipatory child welfare report. There are as yet no national statistics on how anticipatory child welfare reports have been used.

The Decree on maternity and child welfare clinics, school and student health services and preventive oral health care for children and young people (380/2009) specifies that audit forms must be introduced systematically for all families at maternity and child welfare clinics and that intoxicant use must always be discussed and the audit form used in the extensive health examinations (at 4 months, 18 months and 4 years). The explanatory memorandum to the Decree stresses that parents who use drugs and pharmaceuticals classified as drugs must be better identified and helped at maternity and child welfare clinics. The Decree further stipulates that a wellbeing plan must be drawn up for a family whenever there is concern that there may be substance abuse in the family. The wellbeing plan must determine goals and forms of support, and its implementation must be monitored. A case worker must be assigned to the family to coordinate support.

The quality recommendations for substance abuse services (Ministry of Social Affairs and Health 2002) note that high-quality client work requires that the needs for treatment and support of children of parents who are substance abusers must always be surveyed. Similarly, the Current Care recommendations prepared by Duodecim and the Finnish Society of Addiction Medicine concerning the treatment of alcohol and drug problem users (Treatment of alcohol abuse 2005; Treatment of drug abusers 2006) underline that the wellbeing of children in the family must always be taken into account in treatment scenarios.

Parents' substance abuse problems are one of the three focus areas in preventive mental health and substance abuse work as per the National plan for mental health and substance abuse work (Ministry of Social Affairs and Health 2009b). According to the plan, transgenerational mental health and substance abuse problems should be better improved and prevented than at present. For instance, in a case where a parent has mental health or substance abuse problems, the case worker should always assess the children's eventual need for treatment and support in order to prevent and reduce the risk of children and adolescents developing mental health problems or drifting into substance abuse.

The report by the Working Group examining how to ensure treatment for pregnant women with intoxicant problems (Ministry of Social Affairs and Health 2009f) states that pregnant women need to be granted a subjective right to immediate assessment of their need for substance abuse treatment and access to treatment required by the assessment. Seeking voluntary treatment must be rendered easy, and the appropriate substance abuse services should be offered. While special competences must be centralised at university hospitals and central hospitals, part of the follow-up can be carried out at maternity clinics. According to the working group, Finland should explore the potential for following the lead of Denmark and Norway in enacting legislation on voluntary entry to involuntary treatment, whereby a pregnant woman could commit herself to a treatment place by signing a treatment contract valid for an agreed period, even if she later changes her mind and no longer wishes to continue the treatment.

The working group suggests a legal amendment which would also enable involuntary treatment based on the health risk posed to the unborn child. Currently, the relevant Act (41/1986) allows for a person to be ordered into treatment for five days due to a health risk. According to the Working Group, this involuntary treatment period should be increased to 30 days and enable the continuation of such treatment until the end of the pregnancy. (Ministry of Social Affairs and Health 2009f).

Legislation on involuntary treatment is being prepared in 2011 as part of a broader legislation initiative concerning the right of self-determination of social welfare and health care clients. After being written up as a Government Bill, it will be taken to the Constitutional Law Committee of Parliament. Committing pregnant women who are substance abusers to involuntary treatment is a problematic issue from the basic human rights perspective, as it violates the woman's constitutional right to self-determination. On the other hand, the foetus being protected through the involuntary treatment has no protected rights at all, since basic human rights are acquired at birth.

### 12.3. Treatment

Finland's substance abuse service system is diverse but fragmented. Large municipalities have A Clinics providing substance abuse services or combined units for mental health and substance abuse services, units providing detoxification and substance abuse rehabilitation services, and dedicated substance abuse prevention units. These work with both individuals and families. Many substance abuse treatment facilities maintained by local authorities or NGOs now offer treatment services to entire families, enabling parents to enter treatment with their children.

There are many different kinds of outpatient and inpatient care services available for substance abusers who have underage children or are pregnant women, but there are no systematic data on how many treatment periods families have taken or on what their contents or results have been. The existing studies concern women, principally pregnant women. There is very little research on the treatment of the substance abuse problems of parents of underage children.

#### Finland's system of maternity and child welfare clinics

Maternity and child welfare clinics constitute an important part of the preventive and health-promoting operations of the basic health care services managed by local government, which reaches substance abusers too. These services are voluntary for families and free of charge. At a combined maternity and child welfare clinic, a nurse and a physician work with the family from the mother's pregnancy until the child goes to school. At least one house call shall be paid on families expecting their first baby or who have recently had their first baby. Families expecting their first baby shall be provided with multi-professional family coaching including parents' group activities.

Nearly all families expecting or bringing up a child use the services of maternity and child welfare clinics. An estimated 0.2% to 0.3% do not use maternity clinic services, and an estimated 0.5% do not use child welfare clinic services. These clinics thus play an important role in supporting abstinence from substance abuse and in identifying substance abusers and referring them to treatment. According to instructions issued to the clinics, intoxicant use during pregnancy and its effects on the foetus and the newborn baby must be discussed with all mothers and, if possible, fathers. The impact of parents' substance abuse on the child must also be discussed.

According to information received from A Clinics, the instructions at maternity and child welfare clinics have clearly improved, as the latter now increasingly refer clients to the A Clinics. Maternity clinics also refer clients to maternity outpatient clinics, and child welfare clinics cooperate with maternity outpatient clinics.

#### Examples of services offered by local authorities and NGOs to pregnant women who are substance abusers and to families with small children

##### *HAL services in specialist medical care, maternity hospitals and social paediatrics*

In specialist medical care, there are HAL services (from the Finnish acronym for 'drugs, alcohol and pharmaceuticals') at maternity outpatient clinics to which pregnant women who are substance abusers are referred from maternity clinics for monitoring during their pregnancy. This is a multi-professional treatment model where psychosocial approaches are combined with medical monitoring of the pregnancy. The development of a health care system for pregnant women has been considered an important social policy issue since the mid-1990s, and the maternity clinic network has been extended to cover the entire country after the turn of the millennium. (Leppo 2008a.) Two thirds of the clients of these services are referred from maternity clinics and the rest from substance abuse services or other places such as emergency outpatient clinics. All university hospitals have HAL services, which treat a total of about 400 mothers who are substance abusers each year. Concentrating this treatment at university hospitals is justifiable, because at smaller maternity hospitals and central hospitals the patient numbers are small and the necessary expertise is not available.

In HAL services, an obstetrician monitors the somatic progress of the pregnancy and the health of the foetus. At every hospital, the treatment team includes several professionals such as a psychiatric specialist nurse, a midwife, a social worker, a paediatrician and a psychologist. The focus and content of the work of these professionals vary from one clinic to another, but all teams are multi-professional and networked. The treatment team conducts a survey of the social situation of a pregnant substance abuser, support her maternity in every way and aim to motivate her to abstain from intoxicants during her pregnancy. Abstinence is not nearly always attained, but reduced doses and reducing substance abuse is also a relevant goal.

HAL services are voluntary and are based on establishing a good treatment relationship between the mother and the professionals. Their purpose is to detect pregnancy as early as possible, to identify and minimise intoxicant-related damage to the foetus, to explore the life situation of the pregnant woman as broadly as possible, to inform her of the harmful effects of substance abuse, to motivate her towards abstinence, and to find a location for further substance abuse treatment. Pregnancy monitoring involves repeated alcohol and drug tests and laboratory tests relevant for at-risk groups, such as hepatitis B, hepatitis C and HIV. Those requiring further treatment are generally referred to such treatment during their pregnancy so as to guarantee smooth continuity of that treatment after childbirth.

Pregnant women who are opioid addicts are eligible for opioid substitution treatment because of their pregnancy, pursuant to a Decree of the Ministry of Social Affairs and Health. In Helsinki, this substitution treatment is given at the outpatient clinic of the maternity hospital of Helsinki University Central Hospital. Other hospital districts provide this treatment at substance abuse treatment units. Treatment of pregnant women who are substance abusers is coordinated by the maternity outpatient clinics at Helsinki University Central Hospital, Kuopio University Hospital and Oulu University Hospital, and by the substance abuse psychiatry units at Turku University Central Hospital and Tampere University Hospital.

In Finland, nearly all mothers give birth at a hospital. Maternity hospitals thus have fairly good coverage of pregnant women who are substance abusers. For instance, the three maternity hospitals of Helsinki University Central Hospital record some 500 intoxicant-related appointments with a physician per year, the majority of them with new patients. These hospitals between them manage one fourth of all births in Finland, about 14,500 per year. In 2009, they handled deliveries for 73 HAL services patients; for 48 of them it was their first child.

Children exposed to intoxicants during pregnancy are transferred to the social paediatrics surgery for long-term monitoring immediately after being discharged from the maternity hospital. Mothers with substance addictions are invited to a social paediatrics appointment for the first time towards the end of their pregnancy. The babies have their first appointment at the age of 2 to 6 weeks, whether living at home, at a mother and child home, at a substance abuse treatment facility, at a children's home or with a foster family. There are 3 to 8 control appointments during the children's first year of life, and the monitoring continues until they go to school.

The children in the Greater Helsinki area known to have been exposed to alcohol or drugs during pregnancy are automatically tagged for monitoring by the social paediatrics outpatient clinic at the Children's Hospital. The social paediatrics unit works particularly with families that have conspicuous substance abuse problems. Clients of this unit are in practice also clients of child welfare services. The outpatient clinic also monitors children in other departments of the hospital who are suspected of being abused, and cooperates in many ways with child welfare services. Patient growth and development and their health are monitored comprehensively. Attention is paid for instance to speech development and any signs of hyperactivity. The interaction skills of the child and parent are also important, and the situation of the parents as it pertains to the child is also addressed. Children are monitored for any signs of abuse. Children exposed to substance abuse are monitored until they enter school.

*City of Tampere: Päiväperho*

In Tampere, a pregnant woman with a substance abuse problem and families with small children have a one-stop shop for services named Päiväperho (Butterfly), a link between child welfare services, substance abuse services, maternity clinics and family counselling clinics. Päiväperho may be contacted by phone, or clients can just turn up without an appointment. Clients who make contact are offered the option of seeking the appropriate treatment and support. Those who are pregnant can gain access to treatment almost immediately. The service is free of charge, although a client fee is charged for detoxification. Päiväperho has a family rehabilitation ward, to which a social worker at the regional social welfare centre can refer clients.

Päiväperho offers maternity clinic and child welfare clinic services, a low-threshold meeting place, crisis therapy and detoxification, substance abuse rehabilitation for families, substitution treatment, occupational therapy and physiotherapy. Päiväperho also provides services in the form of child welfare outpatient support services, decided upon by a social worker, meaning house calls to families requiring support as agreed, depending on their situations and needs. Päiväperho has established a smoothly running operating model and a network of treatment services among municipal service providers. Good experiences have been gained for instance in group psychotherapy for mothers and children. (Belt & Punamäki 2007.)

*Pidä kiinni (Hold tight) treatment system of the Federation of Mother and Child Homes and Shelters*

The Federation of Mother and Child Homes and Shelters set up its first treatment facility for substance abusers who were pregnant or who had just given birth, and their children, in Helsinki in 1990. This treatment model was expanded to nationwide coverage during the 1990s and 2000s; from the late 1990s onwards, the percentage of problem drug users among clients has increased substantially. (Leppo 2008a.) Mother and child homes specialising in substance abuse services offer outpatient and inpatient services to mothers and babies, and a limited number of treatment places for fathers too.

The Federation of Mother and Child Homes and Shelters runs a national specialised treatment system known as *Pidä kiinni* (Hold tight), consisting of seven mother and child homes around Finland specialising in substance abuse problems (alcohol, drugs, pharmaceuticals), and their outpatient services units. So far, the *Pidä kiinni* homes and service units have rehabilitated some 1,500 families. The service reaches some 250 families annually, of which about 100 are referred to mother and child shelters and about 150 to outpatient services. The client families mostly consist of mothers and children. In 2010, for example, the seven homes had 81 client families (81 mothers, 19 fathers, 90 children) and the seven outpatient service units had 138 client families (138 mothers, 52 fathers, 140 children). On average, 40% to 50% of these have their first appointment during pregnancy. There is now a tendency to seek treatment earlier in the pregnancy. Mothers are generally well committed to abstinence during their stay at a mother and child home, relapses being rare. The homes also provide help in dealing with various authorities such as child welfare clinics and child welfare services. Clients are most commonly referred to the treatment by child welfare services, but also by maternity clinics, HAL services at central hospitals and substance abuse services. Clients' networks are engaged regularly in the course of the rehabilitation.

*Other forms of work*

Some hospitals and health centres have adopted a model where a substance abuse nurse is on duty, performing triage on patients using an audit form alongside normal surgery duties. Substance abuse nurses may talk to the patient at this point or book an appointment for them. Other employees at the health centre may also refer a patient to the substance abuse nurse. Experiences so far indicate that the mini-interventions, personal appointments, follow-up appointments and outpatient detoxification treatments provided by the substance abuse nurses fit in well with the operating practices of health centres.

Social work at police stations is an important element in responding to problems quickly. Social work at police stations involves intervening in situations requiring social work that emerge in the course of police

work. This generally involves children, young offenders, family and domestic violence, mental health patients, substance abusers and persons undergoing acute crises.

Early intervention by professionals is supported by material available free of charge, published by NGOs, local authorities and central government. There is a method developed to help parents with substance abuse problems, *Lapset puheeksi* (Talk about children), which can support parents in helping their children.

### Treatment as described in research

Riitta Hyytinen conducted a qualitative study on everyday care work (2007), concerning the treatment process of a single family in the family ward of a substance abuse treatment facility and addressing the difficulty of implementing child-oriented treatment in the substance abuse treatment system: coordinating the rehabilitation of a parent with a substance abuse problem and the child welfare aspect is a challenge, and the perspective of the child is in danger of being ignored. Hyytinen (2007) emphasises that children should be actively involved in the rehabilitation process and should have the opportunity for processing the fears, disappointments and uncertainties that living in a drug user family entails. Hyytinen notes that there are not enough treatment places for families, and treatment queues are extensive. Inadequate child welfare resources also make it difficult to get help to families in time. The research material consisted of recorded interaction situations related to the family rehabilitation, and documentation on the rehabilitation and the treatment process.

Child psychiatrist Marjukka Pajulo (2010) has studied the effectiveness of the treatment of mother-child pairs at mother and child homes specialising in substance abuse treatment, investigating the interaction skills of mothers with their children. A passive attitude to the baby and weak interaction after childbirth were worryingly common, but there was individual variation. In two thirds of the mothers whose interaction skills were gauged both during the pregnancy and four months after delivery, these skills improved. The study involved 34 mother-child pairs; the research material consisted of interaction situations recorded on video, interviews with the mothers, and forms filled out by them. Statistical analysis was applied.

Elina Virokannas (2011) conducted a discourse analysis oriented interview study to explore experiences of motherhood among mothers with drug problems. In these interviews, 19 mothers described how their motherhood had been shaped in relation to social workers with child welfare services. The mothers' experiences and interview responses focused on defending their identity as a mother against moral disapproval and the doubts and attempted interventions of the child welfare authorities. The author came to the conclusion that in order to foster good interaction, child welfare workers should be more sensitive in their encounters with mothers with drug problems.

Anna Leppo (2008b) employed qualitative methods to study the everyday progress of treatment and treatment interaction at a maternity outpatient clinic specialising in the treatment of pregnant women with substance abuse problems. Her study describes how professional work with pregnant women with severe drug problems, highlighting the challenges, problems and tensions involved. The work is highly challenging in terms of interaction: the employees have to balance between the needs and autonomy of the mother on the one hand and securing the wellbeing of the foetus on the other. The professionals sought to motivate the mother to abstinence in various ways; the study describes what 'motivating to abstinence' involves in practical terms. The study was based on ethnographic observations of everyday life at a maternity outpatient clinic.

Heli Kukko and Erja Halmesmäki (1999) conducted a retrospective study of the progress of the pregnancy of 111 substance abusers and the state of health of their newborn babies. These pregnant women had been treated at HAL services between 1985 and 1995: 111 women with a total of 120 pregnancies. The purpose of the study was to explore the effectiveness of the treatment model. According to Kukko & Halmesmäki, in 61% of the cases the pregnant woman managed to stop using drugs by the 32nd week of pregnancy or to abstain from hard drugs for the remainder of the pregnancy. The majority of the women



used several drugs, and just under one third of them were regular or daily users (1–7 times per week) of hard drugs when they became pregnant. The women who quit or cut down on their drug use had a better pregnancy and delivery than those who continued their drug use unchanged throughout; the birth weight of their children was higher, for instance. The researchers concluded that HAL monitoring can be considered an effective intervention in drug use during pregnancy.

Hanna Kahila and her colleagues (Kahila et al. 2007) studied the course and outcome of pregnancy in buprenorphine users in a study analysing buprenorphine users treated in HAL services between 2002 and 2005. The study material involved 67 pregnancies. Some of the women were undergoing buprenorphine substitution treatment when they became pregnant (9), some started buprenorphine substitution treatment during pregnancy (24), and some continued their originally illegal use of buprenorphine throughout the pregnancy (34). The progress of pregnancy was normal among buprenorphine users, and the percentage of premature births, for instance, was no higher than normal. However, the babies born to buprenorphine users were often small for their gestational age (SGA). No fewer than 76% of them suffered from neonatal abstinence syndrome (NAS), and 57% of them had to be given morphine because of the severity of their withdrawal symptoms. The incidence of sudden infant death syndrome (SIDS) was considerably higher than normal.

Taisto Sarkola et al. (2007) conducted a register and patient record study of placements and taking into care among the 626 children born to clients of HAL services between 1992 and 2001 up to the year 2003, at which time the children in question were aged 2 to 12. The mothers were under HAL monitoring during their pregnancies because of alcohol or drug problems. Of the children, 50% had been placed outside the home or taken into care as a child welfare measure at some time in their lives, and 38% of them when under the age of two years. The following factors showed a strong correlation with the child being placed outside the home as a child welfare measure: daily alcohol use by the mother before or during pregnancy; a positive drug test result from the mother during pregnancy; regular contact between the mother and substance abuse services during pregnancy; the mother being institutionalised because of a substance abuse problem after childbirth; the mother's partner having a substance abuse problem; daily smoking by the mother during pregnancy; the mother being unemployed or homeless; NAS due to the mother's opiate use; the child being placed in the neonatal monitoring ward immediately after birth.

Three maternity clinics in southern Finland monitored the health of substance-abusing women who were pregnant between 1992 and 2001, up to the end of 2007.<sup>96</sup> Mothers with substance abuse problems have a risk of death more than 20 times higher than normal mothers. The risk of a violent or accidental death was particularly high. Similarly, mothers who were substance abusers logged almost twice as many inpatient visits to health centres, slightly more than twice as many treatment days, and much more than twice the number of outpatient clinic visits than mothers who did not have a substance abuse problem during pregnancy. A particularly high morbidity risk (20 to 60 times higher than normal) was found for mental health conditions related to alcohol and drug use, and also for infectious diseases (10 to 20 times higher than normal). Similarly, the risk of being institutionalised for alcohol and drug abuse during pregnancy was almost 20 times higher for women who were substance abusers than for those who were not, and they also received 10 times as much in sickness insurance compensation for drugs for treating substance abuse problems. Moreover, mothers who were substance abusers were twice as likely to fall onto

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<sup>96</sup> In this study, mothers with an alcohol or drug problem were referred to enhanced support and monitoring treatment at intervals of 2 to 4 weeks during maternity counselling. In all, 526 expectant mothers were referred to treatment because of a substance abuse problem between 1992 and 2001 and gave birth to 626 children; the total number of children born in Finland during this period was 172,600. For the research design, 1,792 mother-child pairs were selected from the Medical Birth Register as a control group (three controls for each case studied) on the basis of the age of the mother at childbirth and the date of birth, among other factors; the excluding factor was if the mother had a substance abuse related Care Register entry at the beginning of the monitoring period. The registers used for monitoring in this study were the Medical Birth Register, the Care Registers for Social Welfare and Health Care, the Social Security Register and the National Cause of Death Register. Of the mothers with substance abuse problems, 25% had used alcohol daily before their pregnancy and 11% during their pregnancy; the figures for opiates were 12% and 6%, respectively. The data were analysed using logistic regression analysis, and the odds ratio was used as an indicator for comparison with a 95% confidence interval. (Sarkola et al. 2007; Kahila et al. 2010.)

basic unemployment allowance because of unemployment and more than 10 times more likely to fall onto disability pension (primarily because of various mental health problems) than mothers who were not substance abusers. All indicators thus point to an accumulation of morbidity and social problems among mothers who are substance abusers, also in the long term. (Kahila et al. 2010.)

#### 12.4. Evaluation of the current situation

Legislation specifies a number of measures to be taken to improve the situation of pregnant women with substance abuse problems and their children. However, these statutory requirements are not always reflected on the ground. Despite the comprehensive network of maternity and child welfare clinics, the services available are insufficient and tend to focus on corrective action. Cases pile up at child welfare services when not enough is done in the area of preventive action.

Substance abuse services seem to be highly susceptible to economic fluctuations, as they are dependent on the resources available to local authorities. Recovering from a substance abuse problem is a long-term process requiring various kinds of treatment and support at various points along the way, and it would thus be important to retain diversity in substance abuse services, including the treatment of parents and families with substance abuse problems.

Another problem is that substance abuse treatment models have largely been developed from the perspective of male users, and treatment practices are geared towards male clients. For children, the problem is that the support system focuses on adults, i.e. the parents, all too often ignoring the special and individual needs of the children.

As of the beginning of 2010, social welfare and health care services were subsumed under the ‘lump sum government grant’ (2010 government grant reform, Government Bill 174/2009 and Acts 1704–1732/2009). Despite the reform, the grounds for the imputed costs of social welfare and health care services have not changed.

The fundamental purpose of the government grant system is to equalise differences in both costs and revenue bases between municipalities. However, no comprehensive description of service contents has been prepared at the legislation level, and thus the provision of services varies from one municipality to the next. The risk in the ‘lump sum government grant’ system is that the providing of services for marginal groups of disadvantaged citizens will be neglected in favour of other service sectors that are more advantageous for local politics or are aimed at the majority of the population. Marginalised local residents do not necessarily have equal opportunities for influencing local government decisions.

Treatment guarantees and service guarantees and their related sanctions aim to improve access to treatment. However, the treatment guarantee in practice only covers substitution treatment for opiate addicts in the area of non-urgent care, and the service guarantee does not directly apply to substance abuse services. One of the narrowest bottlenecks in the treatment of substance abusers, including pregnant women, parents and families with substance abuse problems, is that treatment is dependent on the often very inadequate substance abuse services budget subordinate to social services. Access to treatment is governed in practice not by a client’s actual need for treatment but by the resources allocated by the local authority to substance abuse treatment.

Experts have noted that the funding base for the voluntary treatment system aimed at pregnant women and families with substance abuse problems has deteriorated in recent years, to the point of treatment places being lost; it is therefore harder than ever to gain access to treatment. (Kalland 2008; Leppo et al. 2008; Pajulo 2011.) For instance, the operations of mother and child homes and outpatient care units specialising in substance abuse treatment has been developed on funding from the Slot Machine Association (RAY), and funding was supposed to have been taken over by central and local government as of the beginning of 2011. About EUR 1.5 million was allocated for this purpose to the general government grants paid to municipalities for 2011. However, whether this money is actually used for treating substance abusers who are pregnant or have small children is completely up to the local authorities. Local government budgets

being strained, it is all too easy for the money intended for pregnant women with substance abuse problems to be snapped up by other applications.

# Appendix 1.

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