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Ari Virtanen

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Abstract <p>The report on the drugs situation in 2001 published by the National Drug Monitoring Centre of Finland (in the STAKES) complies with the guidelines for annual national reports given by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). Similar reports are submitted by all the 15 National Focal Points (NFPs) included in the REITOX network co-ordinated by the EMCDDA. The report includes four different approach to drug issues: national drug strategies, epidemiological drug situation, drug demand and supply reduction.</p> <p>Throughout the 1990s, the existing indicators show a constant trend in the drug situation: drug experiments and use as well as related harms increased steadily during the decade. At the turn of the decade, first signs appeared suggesting that the rapid growth in drug experiments and use is possibly slowing down. This is especially apparent among young adults, who are usually the most susceptible to drug experiments. While the methods of different surveys do not allow direct comparison, this "slowing down" -interpretation is supported by school health surveys from 1999 to 2001 and estimates of the prevalence of problem use. It remains to be seen whether this is a random phenomenon or the possible first sign of a new trend.</p> <p>Even if the growth in drug experiments, having started in the early 1990s, were levelling off, harmful effects still clearly follow an up-trend because e.g. in demand for treatment, the adverse effects of problem use seem to surface with a delay of 3–5 years after the experimental and regular use. Looking back five years, drug experiments were rapidly growing in Finland.</p> <p>More attention was paid to national drug questions in the second half of the 1990s. In 1996, multi-sectorial expert co-operation was launched in order to create a national drug strategy. A proposal for a drug policy strategy was presented in spring 1997, resulting in a Government Decision-in-Principle by the end of 1998. Both these endeavours were anchored in a well-balanced approach to drug policy, endorsed by the UN, with equal emphasis on drug demand and supply reduction. The results of the planning are linked to the 2000 Government Decision-in-Principle to enhance drug policy and the supplementary budget related to drugs. In this second Decision the objective was to reduce both the supply and demand of drugs and to arrest the growth of narcotics use and related crime. The intensified measures proposed in the action plan integrate the focal points of anti-drug steps taken by different administrations. An additional EUR 5.5 (FIM 32.5) million was proposed for anti-drug actions in the 2001 budget. A total of about EUR 10 (FIM 60) million was allocated for combating drugs.</p> <p>The Decision calls for action in the domains of five Ministries (Justice; the Interior; Finance; Education; Social Affairs and Health). As far as possible, practical work will be done on a local level. The work is supported by police and prison drug strategies as well as committee reports on drug prevention (youth) and drug treatment by Ministry of Social Affairs and Health.</p>			
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Introduction

The current report on the drugs situation in 2001 published by the National Drug Monitoring Centre of Finland complies with the guidelines for annual national reports given by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) and is also in accordance with the EU Regulation on the EMCDDA. This report is the Finnish contribution to the *Annual Report on the State of the Drugs Problem in the European Union*. Similar reports are submitted by all the 15 National Focal Points (NFPs) included in the REITOX network co-ordinated by the EMCDDA.

The report includes four different approaches to the drug problem. It first describes the political and legal frameworks of drug issues in Finland. The second part of the report includes an overview of the national situation as regards drugs and drug abuse in 2001. The third part concentrates on activities for drug demand reduction and the fourth on measures for drug supply reduction in Finland. In addition, the report discusses three current topics, i.e. polydrug use, effectiveness of treatment and drug users in prison. However no specific research has been carried out on these specific items.

Alcohol has a central role in the Finnish culture of substance abuse. Therefore, when we speak of abuse, it is emphasised that instead of drug abuse we should speak of multi-drug or poly-drug abuse referring to the combined use of narcotics and alcohol or other psychoactive substances. Despite the central role of alcohol, the experimental and habitual use of drugs has increased rapidly in the 1990s – even if there in 2000 appeared first signs of slowing down this trend. The development in 1990's has created a need to outline specific drug policies and to design a drug monitoring system as well as to promote research in the field.

The Finnish terminology on substance abuse is based on an alcohol-oriented culture. The term 'intoxicant abuse' is commonly used in the meaning of abuse of psychoactive substances including alcohol and tobacco. This reflects the comprehensive nature of the problem, which is discussed in the part of the report focussing on drug demand reduction.

The aim of the current report has been to provide objective and reliable information on drugs and drug addiction in Finland. This report could not have been produced without the help of experts in the many drug-related areas. Special thanks are due to them all. Mr Ari Virtanen, Senior Planning Officer of STAKES is responsible for collecting the material for the report and for the final interpretation of the submitted data.

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Summary: Main trends and developments in the drug situation

Throughout the 1990s, the existing indicators show a constant trend in the drug situation: drug experiments and use as well as related harms increased steadily during the decade. At the turn of the decade, first signs appeared suggesting that the rapid growth in drug experiments and use is possibly slowing down. This is especially apparent among young adults, who are usually the most susceptible to drug experiments.

While the methods of different surveys do not allow direct comparison, this “slowing down”-interpretation is supported by school health surveys from 1999 to 2001 and estimates of the prevalence of problem use. It remains to be seen whether this is a random phenomenon or the possible first sign of a new trend.

Even if the growth in drug experiments, having started in the early 1990s, were levelling off, harmful effects will clearly follow an up-trend because e.g. in demand for treatment, the adverse effects of problem use seem to surface with a delay of 3–5 years after the first experiments and regular use. Looking back five years, drug experiments were rapidly growing in Finland. On the other hand, it should be noted that one important reason for the relatively steep growth in harm indicators has to do with their levels in the beginning of 1990s that were exceptionally low in international comparison.

There is one possible positive trend also among drug related harm indicators: the 1998–1999 HIV-epidemic through intravenous drug abuse manifests first signs of decreasing in 2000. Nevertheless, 1,600–1,700 new hepatitis C infections are still reported annually – also in 2000.

Different substances are manifested in the statistics in different ways. For instance, statistics on health care and substance abuse services show the harm of ‘hard drugs,’ amphetamines and opiates, in particular: drug-related morbidity, infections and deaths. In crime statistics, a key role is played by cannabis, although amphetamine is rapidly increasing its proportion of the seizures made. At present, cocaine and ecstasy are reflected only in the Finnish crime statistics.

Polydrug use is typical of Finnish substance abuse. The largest substance abuser group however comprises alcohol addicts, who only occasionally consume other substances. The combinations of substances used in the 1990s have remained unaltered: the most important groups are polydrug users of alcohol and pharmaceuticals; amphetamine and cannabis users who also use alcohol; and opiate users who also use amphetamines and cannabis but not much alcohol. It seems that the role of alcohol is declining, especially among ‘hard-drug’ users.

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

Throughout the late 1990s, ever-increasing attention was paid to drug questions in Finland. In 1996, an inter-administrative expert group was launched to create a national drug strategy. As a result, the proposal for a drug strategy saw the light of day in spring 1997, eventually resulting in

the Government Decision-in-Principle on Drug Policy at the end of 1998. Both these documents fully endorsed a well-balanced approach to drug policy, as recommended by the UN, assigning equivalent weight to both demand and supply reduction measures. Based on the strategy proposal, regional training commenced, leading to planning of local drug strategies in many municipalities.

Nationally, the implementation of the Decision-in-Principle started in 1999, resulting in a proposal for a drug research programme for the Academy of Finland. In addition, the sectorial drug research programme of the State agencies were prepared. Working groups were also launched to chart new drug cultures among young people and to plan the related preventive measures as well as to make proposals for developing drug treatment systems. The relevant Ministries also included drug topics in their medium-term financial and action plans.

In November 1999, a joint consensus meeting between the Academy of Finland and the Finnish Medical Society Duodecim convened in order to develop drug treatment further. The consensus statement of the conference presented developmental needs to promote drug treatment and research in keeping with the 1998 Government Decision-in-Principle. The same line of action was pursued in the report of the working group on young people's drug prevention (2000) and the report of the working group on drug treatment (2001) by the ministry of social affairs and health. The police and the prison authorities have also produced their respective intoxicants and drug strategies in line with the 1998 Government Decision, with demand reduction as an important consideration along with control.

The wide-scale round of planning, described above, indicates that growing drug use and the resulting harms have been recognised as phenomena warranting a broad and multiadministrative national action plan to arrest these developments. The core results of the planning are linked to the 1998 Government Decision and the 2000 Government Decision-in-Principle on Drugs Policy, enhancing the 1998 decision, and related supplementary budget for drug work.

In the 2000 Decision-in-Principle the objective was to reduce both the supply and demand of drugs and to arrest the growth of narcotics use and related crime. The intensified measures proposed in the action plan integrate the focal points of anti-drug steps taken by different administrations. An additional EUR 5.5 (FIM 32.5) million was proposed for anti-drug actions in the 2001 budget. A total of about EUR 10 (FIM 60) million was allocated for combating drugs.

Through the actions of this Decision,

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

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

Concurrently with long-term strategic planning, decisive action has been taken to solve the immediate drug problems on regional and local levels. The focus of prevention has been on young people and improving their life-management skills, especially by means of activation, the use of the new media in combating drugs and early intervention in young people's drug experiments. All central actors involved have invested especially in providing drug training for drug prevention

workers; in addition, a network of municipal co-ordinators in drug prevention has been established. There are also plans to devise a nationwide drug information campaign, incorporating large-scale evaluation.

On a national level, the accent has been on enhancing information flow between actors and the accessibility of the existing data. As a result, services have been launched to disseminate information among drug workers about research results, working methods, municipal drug strategies and antidrug projects run by municipalities or organisations. In addition, telematics services in drug work has been developed: drug information services, discussion forums and anonymous self-testing of personal intoxicant use – e.g. through text messages on mobile phones – have also been developed. Another preventive measure that has been proposed is the introduction of drug tests. However, possible mass screening for drugs has aroused much debate in public. Some amendments to legislation concerning drug tests in working life are now in progress. New bills are under preparation and will be submitted by the end of 2001.

In the treatment system, the development of services for the youth and low-threshold services as well as the related training have been highlighted, the aim being to involve clients in the treatment system as early as possible. At the same time, there has been much debate about harm reduction actions, whose position as a part of treatment has been more widely acknowledged, one example being the development of infection risk counselling as well as the substitution and maintenance treatment system. The three-year experiment in prisons has resulted in well-designed products for drug treatment in prison and for the after-care of released prisoners, in association with organisations in the field.

The debated themes of drug control during the report year included the increasing number of drug offences, the criminal position of user offences and the new ways of combating crime. According to a study published in 1999, prosecutorial and court practices in user offences differed greatly. From the viewpoint of the rights of the individual, the situation is untenable, because the consequences of an offence vary depending on the locality. Therefore, the Office of the Prosecutor-General provided the prosecutors with directions in 2000, concerning the mitigating circumstances under which the prosecutor may refrain from pressing charges, and the Ministry of Justice also prepared a bill, one aim of which is to harmonise punitive practice in drug-user offences. It remains to be seen in the future how the introduction of the new and more lenient punishment (for drug-user offences), taking effect in September 2001, will affect decisions to waive prosecution.

Legislative reforms to enhance the powers and ways of exercising control constitute an integral part of the work done by the control authorities. At the beginning of 2001, the Finnish police were given new, more extensive powers to engage in fictitious purchase and so-called undercover operations. The Customs Administration is preparing for corresponding jurisdiction to be enshrined in the customs law. For prison administration, the amendments to the laws on the enforcement of punishments are under preparation to increase the authority of personnel to confiscate drugs in prison.

Improved co-operation has been characteristic of the activities during the year. In close collaboration with the local authorities, an effort was made to prevent the emergence of public places where drugs are openly sold. On a national level, co-operation between the control authorities has been reinforced and, consequently, the police, customs and the frontier guard approved a joint drug strategy in 2001, with several co-operative sectors for improved antidrug activities. New investigative methods recently made available (telesurveillance and technical surveillance) have

been more widely applied to investigations into organised drug crime. Co-operation with other organisations has been promoted as well, for instance, concerning money laundering (banks and other financial institutions) and precursors (the chemical industry, etc).

Even if the 1990s growth in drug experiments were levelling off, harmful effects will increase because, e.g. in demand for treatment, the negative effects of problem use seem to accumulate with a few years' delay. In the long run, an increase in the prevalence of drug use in the 1990s also reduced regional prevalence differences, a fact that has a direct impact on the spreading of drug-related harm throughout the country. As the users become older, negative effects will affect older age groups both in acute and eventually chronic forms, which are already manifest in terms of the alcohol abuse. Chronic drug-related effects will present a completely new challenge to the treatment system in the coming decades. Some of these impacts, e.g. HIV infections due to intravenous drug use, will also spread to the population that do not use drugs.

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Part I

National drug strategies: Institutional and legal frameworks

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

Regionally, the social welfare and health care departments in the *five State Provincial Offices* and the *Provincial Government of Åland* control and supervise implementation of health care and social welfare services in their region and collaborate with municipalities. Police work is divided into 90 *state administrative districts*, each of which is in charge of drug investigation in its area. In addition, each district has district prosecutors, working independently of the police. There are 66 district courts for exercising juridical power, and the Customs Administration has five customs districts and regional offices.

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

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

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

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

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

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

1 Developments in drug policy and responses

1.1 Political framework in the drug field

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

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

During 1997, the national drug strategy proposal was completed by the National Drug Policy Committee. In 1998, the Government Decision-in-Principle on Drug Policy was published based on the Committee's proposal. In the Decision, the basic approach to drugs policy in Finland is defined as follows:

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

2. The care and treatment of drug abusers is based on the general principle observed in Finnish social welfare and health care to provide all citizens with the services they need. Drug abuse and its consequences increase insecurity in the community and cause harm to other citizens. Positive outcomes of care and treatment impact favourably on the drug and the related crime situations. Continued drug abuse will entail more costs for society than the provision of care services. The effective care and treatment of drug abusers is therefore in the interests of the whole of society. The declaration issued in the special session of the United Nation's General Assembly in 1998 concerning the principles of restricting drug demand draws attention, in addition to care, to reducing the detrimental effects of drug

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

abuse on individuals and the whole of society.⁴ The abusers' families are also in need of special support, guidance and services.

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

The Government has set up a drug policy co-ordination group in order to co-ordinate national drug policy and to intensify collaboration between the authorities in their efforts to implement and monitor the drug programme.⁵ The group has representation from the relevant Ministries and agencies. It has prepared an action plan for intensifying drug policy. The first phase was approved by the Finnish Government on 5 October 2000 (Government Decision-in-Principle on Drugs Policy, 2000).⁶

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

- Finland will promote the goals stated in the Decision-in-Principle in all international collaboration and especially in the bodies of the European Union and the United Nations.
- Finland will take account of the documents adopted at the special session on drugs issues of the UN General Assembly in June 1998.⁷
- Finland aims to continue its as one of the main financiers of the UN Drug Programme, expanding and diversifying the work done to combat drug demand and supply, especially in its neighbouring regions.

The Decision-in-Principle also states that:

- Finland will continue active participation in the EU's collaborative bodies dealing with the drug problem.
- The projects of the EU Phare and Tacis programmes to prevent and combat drug use will be promoted by underlining the importance of support for the civil society and a balanced approach between different measures.
- Finland takes part in developing the joint database within the European Monitoring Centre for Drugs and Drug Abuse (EMCDDA). The expertise of Europol will be utilised in that context.

⁴ <http://www.stakes.fi/neuvoa-antavat/index.html>.

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

⁶ See Chapter 1.2.

⁷ http://www.undcp.org/resolution_1998-06-10_1.html.

- During its EU Presidency, Finland will continue active work to combat drugs.
- Also the report on the Northern Dimension, approved by the European Commission, contains elements that concern Finnish drug policy.

The administration-specific target and action strategies of the Ministries constitute an important avenue of directing policies. In the strategies, the Government, or the Ministry in question, outline the developmental goals, necessary recommendations for action and implementers in their respective administrative fields. The strategy is monitored and evaluated for its duration, which is usually four years. Drug issues are dealt with in the action strategies of four Finnish Ministries.⁸

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

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

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

Also in the domain of the Ministry of Education, special attention is paid to the prevention of risks involving exclusion and to the development of educational services and guidance for excluded children and young people. Young people's workshops will be developed in accordance with the new European Social Fund Objective 3 in the entire country. In the areas covered by Objective 1, the goals of the above-mentioned programme will be applied. During the new programme period, funding will be forthcoming for hiring and training workshop leaders, who support young people's planning for the future. In addition, workshop networking is supported in each region, including the development and distribution of auspicious practices found during the previous programme period. One objective of workshop activities is to establish an interadministrative service system,

⁸ Target and action strategy 2000–2003 of the Ministry of Social Affairs and Health, 1999; Strategic Plan 2001–2005 of the Ministry of the Interior, 2000; Action and Financial Plan 2001–2004 of the Ministry of Education; Action and Financial Plan 2001–2004 of the Ministry of Justice.

in which young people can be join client in all services. The workshop network is also developed as an environment of rehabilitative employment associated with preventive drug work and active social policy.

The Ministry of the Interior will engage in close collaboration with the EU's law enforcement agencies to combat international, professional and organised crime, especially in the spirit of the Tampere Summit. One important result in this field is the fact that the growth of drug-related crime has levelled off. Special attention is paid to tackling international, professional and organised drug crime.

At the beginning of the year 2000, the Police Department of the Ministry of the Interior prepared its own drug strategy for 2000–2003. It described in concrete terms the actions specified in the Government's drug policy resolution and the strategy for combating crime in compliance with the Government platform. The actions aim at creating networks and approaches within and by the police to ensure smooth co-operation between the authorities responsible for drug policy and to keep that policy up-to-date so that implementation and effectiveness of the actions chosen could be monitored in order to prevent the use and proliferation of narcotics.⁹

At the beginning of 2001, the joint drug strategy between the police, customs and the Frontier Guard went into force, aiming at more effective measures to combat drug-related crime by intensified co-operation.¹⁰ The customs authorities, working under the Ministry of Finance, will also present their drug strategy by the end of 2001.

The Ministry of Justice strives for enhancing the effectiveness of criminal policy in the near future, especially to stop an increase in drug offences and repeated crime. This requires guaranteeing adequate resources for the prosecutorial authority, prisons and penal policy as well as broad co-operation between law enforcement agencies, civic organisations and communities. To reinforce criminal policy, some related tasks and the enforcement of punishments in the Ministry's domain will be rearranged.

In order to deter recidivism and drug offences, prison sentences and probation control will be developed further. The aim is to amend the legislation on the enforcement of punishments based on the proposals of a committee in early 2001.

1.2 Policy implementation, legal framework and prosecution

On 5 October 2000, the Finnish Government issued a Decision-in-Principle to expedite the execution of the 1998 Decision-in-Principle to enhance drug policy, the objective being to reduce both the supply and demand of drugs and to arrest the growth of narcotics use and related crime. The intensified measures proposed in the action plan integrate the focal points of anti-drug steps taken by different administrations. An additional EUR 5.5 (FIM 32.5) million was proposed for anti-drug actions in the 2001 budget. A total of about EUR 10 (FIM 60) million was allocated for combating drugs.

⁹ Cf. Chapters 9.5 and 12.2.

¹⁰ Cf. Chapter 12.1.

Through the actions of this Decision,

- anti-drug attitudes in society will be reinforced by targeting preventive drug information at the entire population¹¹
- drug addicts will be given better possibilities for treatment and rehabilitation¹²
- drug offenders' risk of getting caught will be increased; an effort will be made to ensure criminal liability in drug crime; and anti-drug work in prison will be promoted.¹³

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

1.2.1 Narcotics legislation

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

The Narcotics Decree (1603/1993), associated with the Narcotics Act, lays down provisions for the export and import of drugs. The administrative decision of the Ministry of Social Affairs and Health (1709/1993) defines drugs and substances used in their manufacture (precursors), classified as the substances in the 1961 convention (Lists I–IV), the 1971 convention (Lists I–IV) and substances in the 1988 convention (Lists I–II). Drug legislation has subsequently been amended to comply with the EU control regulations on precursors and the changes made in the drugs lists of the United Nations (703–704/1996).

In 1998, the Decree was amended (927/1998) so that the export and import authorisation of a narcotic substance, specified on the Lists I–IV of the Convention on Psychotropic Substances (SopS 60/1976), must follow the pattern of the United Nation's Economic and Social Committee. Substances enumerated on the 1961 Convention List III are exempt from import and export authorisation. During the report period, these lists have been supplemented twice by Decrees of the Ministry of Social Affairs and Health (882/2000, 201/2001). In addition, the Ministry's decision (1708/1993) was technically amended concerning accounting and obligation to notify with regard to drugs and their handling and disposal (983/1998) as well as payment practices, e.g., drug authorisations issued for official duties (1065/2000). The orders of the National Agency for Medicines concerning the importation of personal pharmaceutical substances stipulate the amount of pharmaceuticals defined as narcotics a passenger can legally import to Finland.

Narcotics offences are specified in **the Penal Code (1304/1993)**, whereby drug offences are categorised as *narcotics offences*, *preparation of narcotics offences* and *abetment of narcotics*

¹¹ Cf. Chapter 8.1

¹² Cf. Chapter 8.1.

¹³ Cf. Chapter 12.2.

offences, with sentences ranging from a fine to a maximum of two years' imprisonment; or as *aggravated narcotics offences*, carrying sentences from one to ten years' imprisonment. The criteria for aggravated narcotics offence are as follows:

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

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

Special provisions were added to the law regarding the forfeiture of implements, equipment and materials as well as the assets used for the commission of the offence. The forfeiture of assets concerns the party financing the offence as well as the recipient. The new Penal Code makes it possible to waive prosecution or punishment, if the act, with regard to the circumstances, has not been detrimental to the obedience of the law, or if the guilty parties show having committed themselves to treatment approved by the Ministry of Social Affairs and Health, specified in its administrative decision (1394/1994).

In the summer of 2001, an amendment (654/2001) to the Penal Code concerning narcotics offences was passed, including the new essential elements under the heading of *drug-user offence*.¹⁴ Taking effect on 1 September 2001, the new law concerns persons who illegally use, possesses or try to obtain small quantities of narcotic substances for personal consumption. The penalty is a fine or not more than six months' imprisonment. This enables summary penal proceedings, where the prosecutor can give the punishment outside court. In such cases, the preliminary investigation material is often less extensive than in ordinary preliminary investigation.

This reform clarified the regulations on waiving prosecution in drug crimes. The above-mentioned stipulation was removed from the Penal Code, concerning decision not to enforce prosecution or punishment if the deed, given the circumstances, was not detrimental to the obedience of the law. The Legal Affairs Committee of the Parliament, however, deemed it necessary to clarify the other special provisions in the Penal Code related to this question. These provisions stipulate that prosecution or punishment can be waived, if the offence is to be considered insignificant in view of the amount and quality of narcotics, the situation and circumstances. This is also possible when the suspect has sought to the treatment specified by the Ministry of Social Affairs and Health. The former law required that in the latter case, the persons had to commit themselves to treatment. In addition to this special provision, other regulations on waiving proceedings are also applicable to drug offences.

¹⁴ For a more detailed discussion about the enactment of laws on drug crime in Kainulainen, H. (2000).

1.2.2 Other drug-related legislation

The amendment to the Penal Code regulated *money laundering* (317/1994, 68–79/1998). The purpose of the law is to prevent money laundering, to promote disclosure and investigation and to enhance the recovery of the criminal proceeds. By the **Law Against Money Laundering**, business institutions must require identification of their customers when entering into business relations or conducting transactions exceeding certain threshold amounts. Banks and other financial institutions must report financial transactions of an unusual nature. Failure to identify customers or to obtain relevant documents is punishable by a fine or a maximum of six months' imprisonment. Actual money laundering is processed as a concealment offence under Chapter 32, Paragraph 1 of the Penal Code, the maximum punishment of which is one year and six months' imprisonment (four years for aggravated money laundering and six years for professional money laundering). According to the Penal Code (Paragraph 6, Chapter 32), assets laundered will be confiscated. (Kinnunen, A. 1999.)

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

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

In connection with the Penal Code amendment, legislation on driving under the influence of narcotic substances was revised as well. According to Chapter 23 of the Act (545/1999), a person who operates a motor vehicle after having used a drug other than alcohol, or a drug with alcohol, so that his or her ability to perform faultlessly has been impaired, must be sentenced for *drunken driving* to a fine or imprisonment for at most six months, or, if the circumstances are such that the offence is conducive to endangering others, for *aggravated drunken driving* to at least sixty day-fines or imprisonment for at most two years. The reform also required alterations to the clinical drug examinations conducted by physicians, and therefore the Ministry of Social Affairs and Health issued an order, specifying the drug examination form and how to fill it (1999:25). However, the working group appointed to implement the Government Resolution, issued on 18 January 2001, on improving road safety, proposed in its memorandum in June zero tolerance for drugs in road traffic.¹⁵

In spring 2000, the Finnish Government submitted a proposal to Parliament to amend **the legislation on the forfeiture consequences in the Penal Code** (HE 80/2000). The proposal also concerns the forfeiture consequences specified in the law concerning drug offences. The proposal incorporates the concept of *extended forfeiture of the proceeds*, whereby e.g. persons having committed or abetted a drug offence (or persons accessory to it or persons for whom or in whose

¹⁵ See <http://www.om.fi/11006.htm>.

interests the crime was committed) may be ordered to forfeit their property or a part of it, if the offence may give considerable financial yields. According to the proposal, no forfeiture is however ordered, if the defendant shows probable cause to presume that the property in question was acquired by legal means (the so-called reversed burden of proof).

Amendments to the **Coercive Criminal Investigation Means Act** give the police a right to engage in *wiretapping*, *telecommunications* and *technical surveillance* with regard to drug-related crime (402/95). Moreover, a person found guilty of an aggravated narcotics offence or a punishable attempt to commit such a crime, or of abetment or incitement, may have to undergo a DNA test, whereby the person's DNA is analysed and can be filed in a police register (565/1997). In 1999, the law was supplemented (366/1999) so that technical surveillance may be targeted at places where a crime suspect in all probability will be staying (for example, prison, excluding social welfare and health care facilities). One prerequisite is that the information gathered through viewing can be presumed highly pertinent to solving a crime, which is punishable by a sentence of no less than four years' imprisonment, or is related to a narcotics offence or a punishable attempt thereof.

According to the amendments to the **Act on the Enforcement of Punishments** (364/1999) and amendments to other laws to reinforce the authority of prison personnel in drug control, the prison warden is authorised to order an inmate to undergo a body search. In addition, prisoners must give urine samples or take a breathalyser test as a precondition for unmonitored visits or going on leave. A prisoner may be isolated in order to prevent drug offences. It is also possible to transfer an inmate to another institution, such as a treatment unit for substance abusers. In September 1999, the Finnish Government appointed a committee to prepare a bill for amending legislation on prison sentences and their enforcement. One relevant question to emerge concerns rehabilitation reducing the risk of subsequent criminal activity, including rehabilitation for intoxicant abusers during prison sentence or upon release.¹⁶

The Police Act (493/1995) was amended (21/2001) in order to add provisions for unconventional means of combating and investigating crime. The new methods are *covert operations* (the use of misleading or covert information in investigation or infiltration) and *fictitious purchase* (offer to buy made by a police officer in order to prevent or uncover the possession, sale or production of an illegally held substance or property or in order to recover ill-gotten gains). The ban on incitement, mentioned in the Government bill (HE 34/1999), was nonetheless omitted from the law.

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

¹⁶ See Chapter 9.5.3.

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

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

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

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

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

Under the **Child Welfare Act** (139/1990), children have the right to a safe and inspiring environment as well as well-balanced and many-sided development and precedence concerning special protection. The municipality must take immediate action, if a child's living conditions are threatened or if a young person endangers his or her own health.¹⁷

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

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

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

The **law concerning the protection of privacy in working life** (477/2001) indirectly addresses the question of drug testing at workplaces as well. Based on the Act, the employer may only process personal information about employees that is pertinent to the work at hand, without

¹⁷ See Chapters 9.1.1 or 9.6.

exceptions (including the employee's consent). This requirement concerns also testing for drugs in aptitude tests relating to the job or in assessing an employee's health. The employer must use health care professionals and proper health care services in conducting drug or alcohol tests, as specified in health care legislation. Contrary to the original Government proposal (HE 75/2000), an employee's obligation to undergo a medical examination or tests are stipulated elsewhere. The Ministry of Social Affairs and Health has nominated a working group to look into this matter, and the group will make its necessary proposals by the end of 2001.¹⁸

In 1997, the Ministry of Social Affairs and Health issued an **Order (28/1997) on the detoxification and substitution treatment of opioid addicts with medicines** containing buprenorphine, methadone or lorcetam. A new Order was issued on 2 November 1998 (42/1998), and on 1 July 2000 the Ministry issued a **Decree on the question (607/2000)**. According to the previous orders, the length of the detoxification period possibly preceding substitution treatment was at most 12 months, and the number of units evaluating treatment need was limited to three university hospitals. According to the new Decree, the detoxification treatment period is one month, while substitution treatment as well as maintenance treatment as a new method are meant for longer treatment. Assessment of care need for detoxification, substitution and maintenance treatment is expanded to all Finnish university and other central hospitals as well as Järvenpää Addiction Hospital.

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

The commencement and follow-up of all these treatments are assigned to the above-mentioned hospitals. However, treatment that has started in these units may continue in a public health care or substance abuse service unit, which has an assigned physician and which qualifies for the task according to the unit having initiated treatment. The Decree stresses the importance of providing long-term treatment as close to the patient as possible. Pharmaceutical therapy may be implemented and medicines administered to the patient under controlled circumstances in the care unit. If a patient has shown co-operation, under special circumstances he or she may be provided with more than one, but not more than seven, daily doses at a time. These medicines cannot be administered in a pharmacy.

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

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

¹⁸ See Chapter 9.5.1.

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

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

1.3 Developments in public attitudes and discussion

The increasing weight given to the drug problem as a national concern is reflected in the number of written questions submitted by MPs to the Government. Of all 1,075 written questions submitted in 2000, 41 contained the word 'narcotics'. By the summer of 2001, there had been 50 such questions of a total of 885. Since the Report on the year 2000, the key 'drug themes' in these written questions in Parliament included drug treatment, drug-related crimes and resources of anti-crime activities, spread of infectious diseases, drug tests, prevention of young people's drug use and mothers with drug problems.

These themes were associated with public debate on these issues and with legislative reforms in progress. A Decree was passed concerning substitution and maintenance treatment, and drug treatment issue was tackled by a working group appointed by the Ministry of Social Affairs and Health. Submitted in summer 2001, the memorandum of the working group expressed a desire to amend legislation and especially to augment resources for these activities. In terms of deterring drug crime, a decision to amend the Police Act was made in spring 2001, concerning the so-called unconventional methods of combating and investigating crime. Throughout the year, there was also much debate on the inadequate resources of the police, customs and the frontier guard and on the repercussions this state of affairs has on the prevention of international drug trafficking, which is spreading into Finland. Infectious diseases have been widely discussed, due to intravenous drug abuse and the HIV epidemic in Russia and Estonia. An effort to prepare a law reform concerning drug tests was made in conjunction with the Act on the protection of privacy in working life, but the question was detached from this frame of reference, to be processed in a special working group, which will finish its work by the end of 2001. The Ministry of Social Affairs and Health published a report on young people's drug prevention in autumn 2000. The issue has been discussed as a part of both general substance abuse prevention among the youth and the significance of workshop activities in preventing exclusion.

1.4 Budget and funding arrangements¹⁹

The direct harm-related costs of drugs are calculated in terms of social and health services, crime control, damage to property as well as preventive work and research. The table below shows the harm-related costs of alcohol and drugs (narcotics and abuse of pharmaceuticals) in 1995, 1997 and 1998.

¹⁹ See also Chapter 4.3; Intoxicants Statistical Yearbook 2000; Hein R. et. al., 2000b.

Table 1. Costs of alcohol and drug related harms in Finland 1995, 1997 and 1998

Harm-related costs EUR million (FIM million, 1995 rate)	1995		1997		1998	
	Alcohol	Drugs	Alcohol	Drugs	Alcohol	Drugs
Direct costs	460–590 (2,740–3,495)	100–150 (610–900)	480–615 (2,860–3,650)	100–165 (600–970)	460–585 (2,750–3,480)	115–175 (670–1,020)
Health care and pen- sions	21.9 %	14.0 %	25.8 %	17.7 %	26.8 %	18.0 %
Social services	15.0 %	40.8 %	19.4 %	40.5 %	17.7 %	35.4 %
Criminal justice sys- tem	41.7 %	31.4 %	38.0 %	28.7 %	37.7 %	27.6 %
Damage to property, prevention, supervi- sion and research	21.4 %	13.8 %	16.8 %	13.1 %	17.8 %	19.0 %

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

Table 2. Special financing for alcohol and drug projects in Finland 1998–2001

Project funding system EUR million (FIM million)	1998	1999	2000	2001 (budget)
Financing from the Slot Machine Association for temperance work and services for substance abusers	9.6 (57)	11.3 (67)	12.7 (75.5)	14.3 (85)
Health promotion allocation to drug prevention	1.3 (8.0)	1.9 (11.5)	1.9 (11.5)	1.9 (11.5)
Supplementary budget for drug issues 2001				5.5 (32.5)
Total	10.9 (65)	13.2 (78.5)	14.6 (87)	21.7 (129)

Part II

Epidemiological drug situation

2 Prevalence, patterns and developments in drug use

In the 1990s, an effort was made to chart the experimental use and abuse of drugs in Finland through surveys among the population, targeted at conscripts and schoolchildren in particular. Unfortunately, these studies can only cast partial light on the drug situation: persons using hard drugs have severe problems disqualifying them from the Finnish Defence Forces or ordinary schools and hence also from the surveys. In addition, schoolchildren form an age group too young to include hard-drug users. Therefore, these studies were in the 1990s complemented by surveys directed at adults.

The extent of problem drug use has traditionally been assessed indirectly through drug-related harm recorded by the societal service systems. For example, censuses have been carried out to assess the number of drug abusers in social and health services. By the end of the 1990s, first investigations were completed concerning drug treatment and estimates of problem drug use (amphetamines and opiates) were made in the Greater Helsinki Area and in the rest of the country.²⁰

2.1 Main developments and emerging trends

Studies published during the year indicate that the growth trend in drug experiments, which prevailed throughout the 1990s, seems to be levelling off in the 2000s. This was suggested both by a population survey conducted in 2000 concerning drug use²¹ and preliminary information from the school health survey in 2001²² as well as by estimates of the prevalence of problem drug use.²³ Tentative reviews of these studies do not allow more accurate assessment of the reasons behind these changes or even speculation as to whether it is a question of a random phenomenon, a temporary downswing or something more permanent. This chapter discusses the studies based on which more detailed analyses can be made of the situation and related cultural changes.

In 2001, trends in user cultures and attitudes were examined especially from the viewpoint of young people. According to the international ESPAD survey, Finnish attitudes towards narcotics

²⁰ See Appendix 3: The national drug information system.

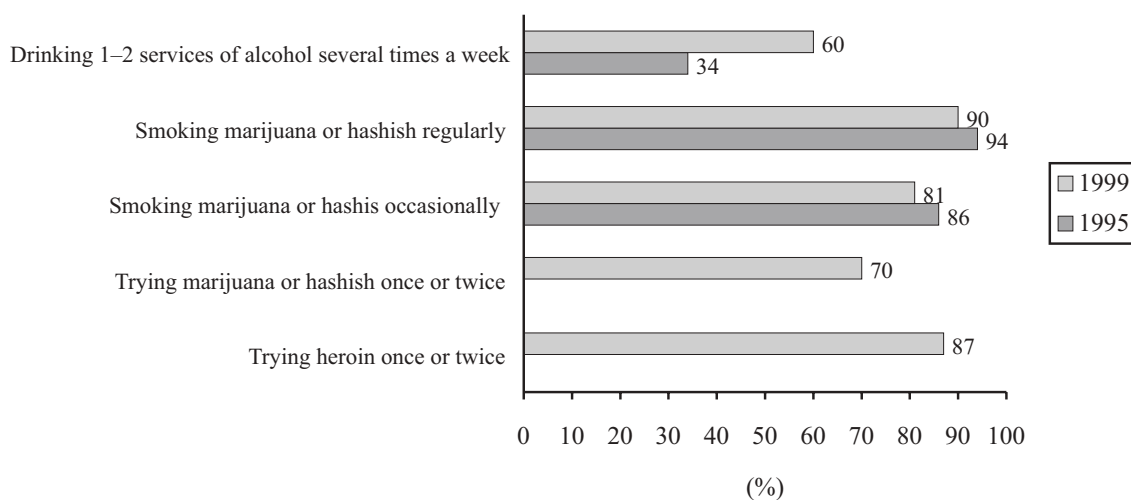
²¹ For more details, see Chapter 2.2.1.

²² For more details, see Chapter 2.2.2.

²³ For more details, see Chapter 2.2.3.

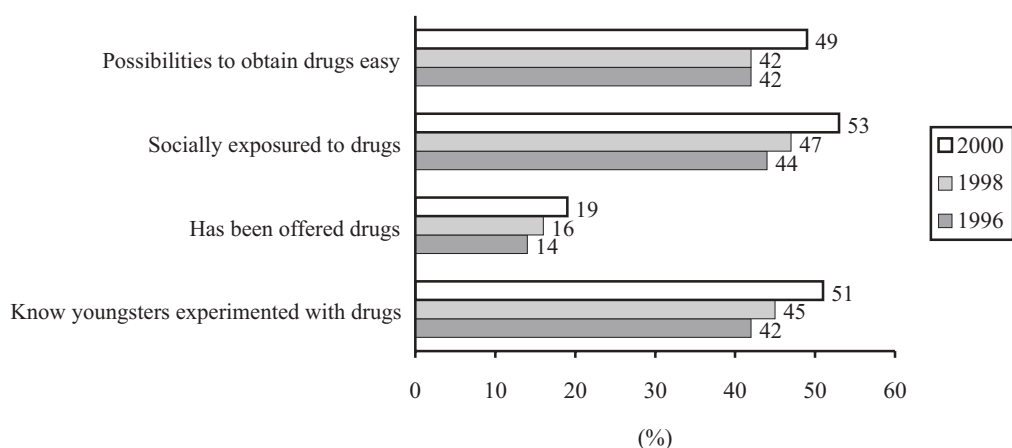
have liberalised somewhat between the years 1995 and 1999. An interesting aspect of attitudinal statements was the fact that attitudes towards narcotics had relaxed somewhat but clearly become stricter towards regular alcohol use (1–2 standard units of alcohol almost every day). An equal proportion of young people to those who had never tried drugs also disapproved of regular smoking of hashish or marijuana. (Ahlström et. al. 2001.)

Figure 1. Proportion of 15–16-year-olds (%) disapproving or strictly disapproving of the following forms of substance use in 1995 and 1999



Young people’s exposure to drugs can be examined on the basis of the situation in their environment and its tendency to expose to drug use. In a review based on the school health survey, the criterion for social exposure to narcotic substances was the questions whether the subject knew a drug user and whether or not the subject him/herself had been offered drugs in Finland. In terms of drug supply, young people were asked to assess their peers’ possibilities to obtain drugs, such as marijuana or hashish, in their locality. Between 1996 and 2000, social exposure to narcotics clearly increased, and it has become easier to acquire drugs. (Luopa et. al. 2000.)

Figure 2. Social exposure to drugs and the ease of obtaining drugs (%) among 15–16-year-olds in 1996–2000



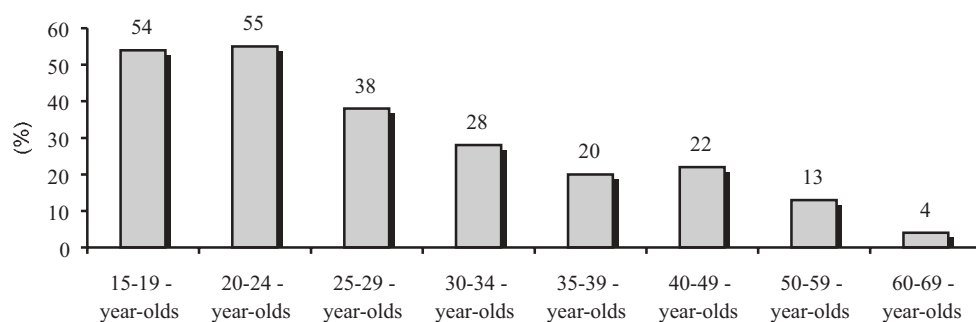
Young people's substance use culture, primarily alcohol use, was studied through group interviews among 13–16-year-olds in 1998 in two secondary schools located in Greater Helsinki (Jaatinen 2000). This study suggested that experience of substance use is generally appreciated among the youth, but their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

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

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

In the 1998 population survey, 64 per cent of men and 65 per cent of women considered smoking hashish a punishable act, whereas in 1996 the percentages were 73 and 76 per cent, respectively (Kontula 1997; Partanen, J. et al. 1999). While opinions among adults have changed somewhat, the legalisation of cannabis was still opposed by 85 per cent of men and 91 per cent of women. The most recent population survey in 2000 did not contain questions about attitudes (Hakkarainen et.al. 2001). Based on this study, it is possible to assess social exposure to drugs in the same way as was done among young people: how drugs affect one's life, i.e. whether the respondent personally knows a drug user. A quarter responded that they knew a user, and this means that the majority of Finns do not have a personal relationship with drugs and that in this respect drugs appear to be relatively distant phenomena in Finnish society. However, the situation changes when examined by age group, and it seems that it is quite common among the Finnish youth to know drug users.

Figure 3. Knowing a drug user personally in Finland by age group (%) in 2000



A small-scale study was conducted in 1999 for the first time to chart the phenomena surrounding ‘recreational drug use.’ The study examined the use of illicit drugs as an aspect of technoculture, which is based on technomusic and dancing, with special clubs or raves as venues.²⁴ According to the author of the study, Finnish technoculture and the use of illegal or otherwise marginal drugs associated with it aim at espousing elitist and refined values in opposition to bourgeois or working-class mass culture. The common denominator was the high number of the so-called new professions among the participants. (Seppälä 1999; Seppälä 2000.)

Finnish rave culture initially involved alcohol use, and ecstasy emerged only gradually (probably in 1990–1994), but not as extensively as e.g. in Great Britain. In Finland, the most obvious differences within technocultures and the related substance use are to be found between the users of so-called stimulants and psychedelic substances.²⁵

2.2 Drug use in the population

2.2.1 General population

Six population surveys were conducted in the 1990s to assess the prevalence of drug use in Finland; the most recent one was carried out in 2000.²⁶ However, population surveys fail to reach all drug users, as some substances are not in widespread use. Therefore, survey results are referred to in terms of the most commonly used substances only, namely cannabis, pharmaceuticals and inhaled solvents. By definition, the latter two do not belong to actual narcotics.²⁷ According to population surveys based on different sample sizes and approaches,²⁸ the proportion of adults having experimented with cannabis has varied in the 1990s as follows:

Table 3. Lifetime prevalence of (experimental) cannabis use according to surveys in 1992–2000

Had used cannabis (%)	Drugs & opinions 1992	Drinking habits 1992	Nordic study 1993	Nordic drinking habits 1996	Drugs & opinions 1996	Drug survey 1998	Drinking habits study 2000
Men	6.0	5.8	9.8	8.3	9.7	12.1	11.7
Women	4.0	2.3	5.2	3.8	4.9	7.6	7.0
Aged 15/16–69/74	4.9	4.1			7.1	9.7	9.3
Aged 18–29	10.6	9.9	12.2	15.7	16.3	19.1	17.1

²⁴ The study was based on observation, interviews and a questionnaire on the Internet (about 100 responses). The study examined the meaning of intoxicants to the members of this culture and its relationship with other current phenomena; the study was not about drug use as a ‘problem’.

²⁵ See Chapter 16.1.

²⁶ In 2000, the target group consisted of 15–69-year-olds, with a sample of 2,500 people participating in the so-called drinking habit survey. The 1,932 people who agreed to take the interview received additional (anonymous) questionnaire about narcotics, and a total of 1,780 responses qualified for analysis; the response percentage was thus 72. (Hakkarainen et. al. 2001).

²⁷ Drugs that are more problematic in terms of addiction potential are discussed in Chapter 2.3.

²⁸ 1992 (postal survey), targeted at 18–74-year-olds, sample 3,457 people (response percentage 71); Drinking habits 1992 (interview), 15–69-year-olds, sample 3,387 people (85%); 1993 (postal survey), 18–69-year-olds, sample 1,275 people (65%); 1996 (postal survey), 16–74-year-olds, sample 3,009 people (68%); Nordic drinking habits 1996 (telephone survey), 18–70-year-olds, sample 1,509 people (76%). (Partanen, J. et. al. 1997). The 1998 study was targeted at 15–69-year-old Finns, with samples of 3,250 people in a postal survey and 550 people in telephone interviews; the response percentages were 65.9% and 77.2%, respectively. (Partanen, J. et.al. 1999.)

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

Table 4. Lifetime prevalence of cannabis use in 1992, 1998 and 2000

	15–19 -year-olds	20–24 -year-olds	25–29 -year-olds	30–34 -year-olds	35–39 -year-olds	40–49 -year-olds	50–69 -year-olds
1992	6.2%	10.1%	10.3%	5.5%	3.6%	2.0%	0.0%
1998	15.7%	20.3%	22.7%	11.3%	11.4%	7.2%	1.4%
2000	12.5%	18.7%	17.1%	17.2%	9.6%	8.2%	2.6%

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

Table 5. Lifetime prevalence of cannabis use by region in 1992 and 1998

	Helsinki	Other cities (pop. over 100,000)	Town (pop. under 100,000)	Semi-urban area	Rural area
1992	12.0%	6.8%	5.2%	2.3%	1.1%
1998	20.2%	13.6%	8.9%	6.1%	2.6%

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

Table 6. Cannabis use during the past year by age group in 1992–2000

	15–24 -year-olds	25–34 -year-olds	35–44 -year-olds	45–54 -year-olds	55–64 -year-olds
1992	4.7% (18–24)	2.0%	0.3%	0.2%	0.0%
1996	8.1% (16–24)	2.4%	0.6%	0.0%	0.0%
1998	9.5%	2.9%	0.6%	0.2%	0.0%
– last month	2.8%	1.5%	0.2%	0.2%	0.0%
2000	6.7%	3.3%	1.4%	0.0%	0.3%
– last month	1.6%	1.2%	0.6%	0.0%	0.3%

It can be concluded from the above Table 6 that at least two out of three of those under 25 having experimented with cannabis do not belong to the ‘regular users of cannabis,’ the minimum criterion being, as stated above, the use of cannabis during the past month. However, in older age groups the proportion of ‘regular users’ is higher.

Table 7. Drug use during the past year by province in 1998

Province	Prevalence of use	Prevalence of use (95% confidence interval)
Entire country	2.8%	2.2%–3.4%
Southern Finland	3.6%	2.4%–4.8%
Western Finland	2.4%	1.4%–3.3%
Eastern Finland	1.8%	0.2%–3.3%
Provinces of Oulu & Lapland	2.4%	0.8%–4.1%

Regionally, drug use and experiments clearly appear to be most prevalent in the Province of Southern Finland. In other provinces, drug experimenting seems to be evenly distributed. However, there is a great deal of ambiguity in the figures, especially as regards Eastern Finland, Oulu and Lapland. (Hakkarainen et. al. 2000, p. 9–12) According to the survey conducted in 2000, of adults having tried or used drugs in the entire country, 2.0 per cent had done so during the past year (1.4–2.7%, with 95% confidence interval).²⁹ Based on lifetime experiments, it would appear that between 1998 and 2000 experiments declined in the Greater Helsinki Area (19.6% > 16.3%), whereas elsewhere in Southern Finland they increased somewhat. Nevertheless, not even this finding is statistically significant. Elsewhere in the country, the changes are relatively small (Hakkarainen et. al. 2001), one possible explanation being that in Greater Helsinki and among the most active experimenters, a saturation point has been reached in Finnish drug culture as regards the prevalence of these experiments.

According to the 2000 (1998) survey, 5.6 (5.0) per cent of men and 3.5 (4.5) per cent of women had used sedatives or tranquillisers for intoxication purposes during lifetime, whereas in 1992 the equivalent percentages were 2.9 for men and 2.3 for women. Based on 2000 (1998) information, 2.6 (2.7) per cent of men and 1.1 (1.3) per cent of women had inhaled solvents for intoxication purposes during lifetime, while the 1992 data showed that 1.0 per cent of men and 0.2 per cent of women had done so.³⁰ The 2000 survey indicated that 1.5 per cent had used sedatives or tranquillizers and 0.3 per cent had used solvents for intoxication purposes during the past year.

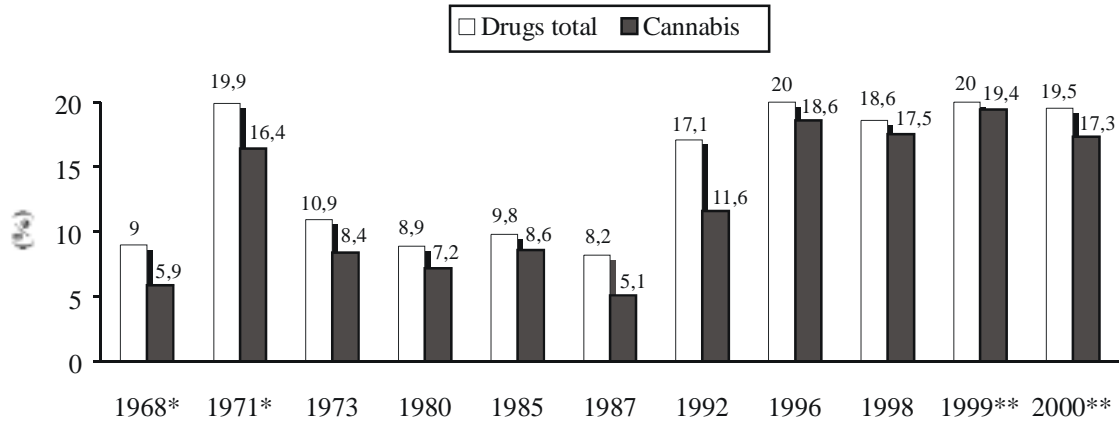
2.2.2 Young people and schoolchildren

In terms of drug use, young people have traditionally been considered a risk group at which the majority of the surveys are directed. The longest time series in the Finnish youth studies consists of the conscript studies, conducted at a few years' interval since 1968. In 2000, an effort was made to enhance the comparability of the time series by only including studies on conscripts who had commenced their service in the Defence Forces (Jormanainen 2000). The comparability is nevertheless hampered by variation in the annual sample sizes (400–2,000 people). According to preliminary information, the percentage showing lifetime drug experiments and use has stabilised at about 20 per cent. This trend is consistent with the results concerning young adults in the 2000 population drug survey.

²⁹ Metso, Leena 2001. Special retrieval of the drug study in 2000 by STAKES.

³⁰ For more detailed information, see http://www.emcdda.org/publications/publications_annrepstat_00.shtml.

Figure 4. Proportion of conscripts having experimented with drugs in lifetime, 1968–2000

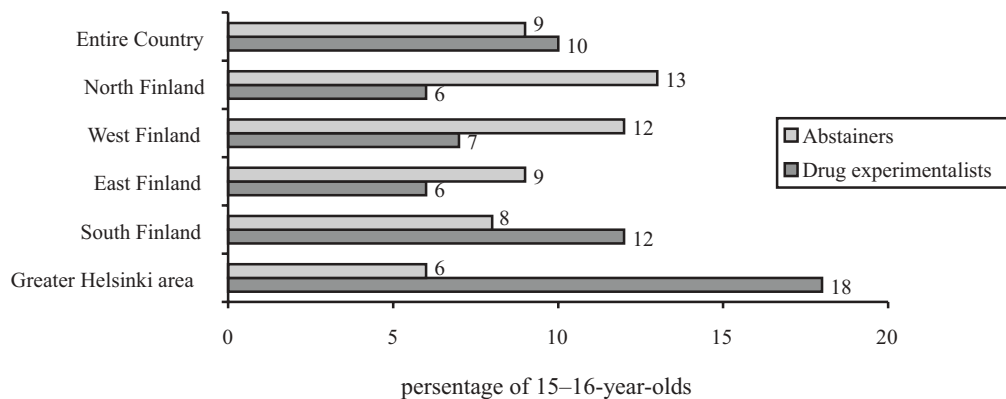


* = Helsinki, Southern and Northern Finland; ** = preliminary information

Nationally, the most representative studies on schoolchildren are the 1995 and 1999 ESPAD surveys. (The ESPAD Reports 1995 and 1999) They showed no great variation between the sexes in drug experimenting among 15-year-olds. The 1995 survey found that five per cent of the respondents had experimented with marijuana or hashish once, while one per cent had done so during the past month. In 1999, the corresponding figures were 10 per cent during lifetime and 2 per cent during the past month. (Ahlström et. al. 1999) About one per cent had experimented with other drugs in 1995, while in 1999 about 2 per cent had done so, with smoked heroin as a new phenomenon emerging, especially among young girls (about 1 per cent of the population). The most recent extensive school health survey conducted in Western and Northern Finland (excluding Lapland) would suggest that the growth in drug experimenting among 14–16-year-olds levelled off between 1999 and 2001 (Lintonen 2001).

When young people’s drug use is examined regionally, it transpires that local differences in alcohol use are relatively small, but more significant on the flip side, i.e. in terms of temperance. Thus drug use seems to reflect general Finnish substance use (mainly alcohol use) behaviour, when drug use is analysed in relation with temperance: in areas where the proportion of temperance is high, substance use is less common, and the same applies to the proportions of drug users and vice versa. On the other hand, drug use is a phenomenon which has thus far been manifest mainly in Southern Finland, urban areas and especially major cities.

Figure 5. Proportion of 15–16-year-olds who have tried drugs during lifetime and who have never used alcohol (abstainers) during 1999 by region (Ahlström et. al. 2000)



2.3 Problem drug use

In 1997, the first Finnish statistical assessment was made concerning the prevalence of hard-drug abuse in Greater Helsinki; the study was later expanded to cover the entire country. The material was collected from the 1995 hospital discharge register, the criminal report register and the database of persons suspected of driving under the influence of drugs (Partanen, P. 1997). In addition, the estimate on Greater Helsinki was extrapolated to the entire country based on the hospital register.³¹ The 1997 data were separately processed for Greater Helsinki and the entire country, and the estimate for the entire country was also based on information from the three registers (Partanen, P. et. al 1999). When the 1998 drug situation was estimated, the information sources were supplemented by one: data from the register of infectious diseases concerning hepatitis C cases due to intravenous drug use during the year. These data were processed in terms of the Greater Helsinki Area, entire Finland and by province (Partanen, P. et. al. 2000). Another assessment was made for 1999.³²

Statistical assessment suggests that drug use increased in the Greater Helsinki area considerably between 1995 and 1997, but it has remained more or less unchanged thereafter. In addition, estimates of amphetamine and opiate users have remained at the same level since 1997. A clear change between 1997 and 1999 is the smaller confidence interval, which means that the accuracy of the estimates has improved year by year. Perhaps the most interesting growth in user figures involves age group over 35-year-olds.

³¹ The method is based on statistical capture-recapture, based on overlapping cases in (mutually independent) samples, enabling the statistical assessment of the size of the entire target population. The samples are defined based on the interventions directed by the service system at the target population (amphetamine and opiate users). The interventions included hospital care for amphetamine or opiate diagnoses, penal action for use or possession of amphetamines or opiates and arrest for driving in road traffic under the influence of amphetamines or opiates.

³² Ibid., to be published in the Finnish medical journal, *Lääkärilehti* 43 / 2001.

Table 8. Prevalence of amphetamine and opiate use (%) in Greater Helsinki and in Finland in 1995, 1997, 1998 and 1999³³

	Greater Helsinki				Entire Finland		
	1995	1997	1998	1999*	1997	1998	1999*
Overall estimate	0.4–0.8	0.7–1.3	0.6–1.0	0.7–0.9	0.3–0.5	0.4–0.5	0.4–0.5
Men	0.6–1.2	1.0–1.9	0.9–1.5	1.1–1.5	0.4–0.7	0.5–0.7	0.5–0.7
Women	0.2–1.0	0.3–1.3	0.3–0.9	0.3–0.5	0.1–0.4	0.2–0.4	0.1–0.2
15–25-year-olds	0.6–1.7	0.8–2.1	1.0–2.0	1.1–1.6	0.5–1.0	0.6–1.0	0.7–1.0
26–55-year-olds	0.3–0.8	0.6–1.4	0.5–0.9	–	0.2–0.4	0.2–0.4	–
– 26–35-year-olds			0.7–1.4	0.8–1.2		0.4–0.8	0.5–0.6
– 36–55-year-olds			0.3–0.9	0.5–1.1		0.1–0.2	0.2–0.5
Amphetamine users	0.3–0.7	0.5–1.3	0.5–1.1	0.4–0.9	0.2–0.4	0.3–0.5	0.3–0.4
Opiate users	0.1–0.3	0.1–0.4	0.2–0.3	0.2–0.3	about 0.1	about 0.1	about 0.1

* = Preliminary information

In 1998, Finland had an estimated 11,500–16,400 users of amphetamines or opiates, of whom 3,300–6,000 lived in Greater Helsinki. Amphetamine users accounted for 70–80 per cent of hard-drug users. It was estimated that in the whole of Finland, some 25–35 per cent of users were women, while in Greater Helsinki their proportion was somewhat higher. Those aged 25 and under were estimated to account for 40 per cent of users in the entire country, but for clearly less, a third, in the Greater Helsinki Area. The year 1998 was the first time when hard-drug use was regionally assessed.

Table 9. Prevalence (%) of amphetamine and opiate use in population aged 15–55 years by region in 1998

	Total	Men	Women	15–25yo	26–35yo	36–55yo	Amphetamines*	Opiates*
Finland	0.4–0.6	0.5–0.7	0.2–0.6	0.7–1.1	0.5–0.7	0.1–0.3	0.3–0.5	0.1
Greater Helsinki	0.7–1.0	1.1–1.5	0.3–0.7	1.0–1.7	0.9–1.5	0.4–1.0	0.5–1.1	0.2–0.3
Southern Finland	0.5–0.9	0.8–1.1	0.2–0.6	0.9–1.5	0.7–1.0	0.3–0.5	0.2–0.9	0.1–0.2
Western Finland	0.2–0.4	0.3–0.5	0.1–0.5	0.5–1.0	0.3–0.6	0.1–0.2	0.2–0.6	0.1
Eastern Finland	0.1–0.4	0.2–0.3	0.0–2.2	0.3–1.6	0.1–0.3 (26–55-y.o.)		0.1	0.0–1.5
Northern Finland	0.1–0.2	0.1–0.3	0.0–1.4	0.2–1.0	0.1 (26–55-y.o.)		0.1	0.0

* = Estimates are based on three registers

³³ The estimated intervals are based on 95-% confidence intervals. Time series are based on results from three registers, otherwise estimates are based on four registers. The sum of estimates differs from the overall estimate because different log-linear models were applied to the combined and separate materials. Partanen, P. et al. 1999.

As indicated by the confidence intervals, the registers on amphetamine and opiate use have so low numbers for Eastern and Northern Finland as to render the estimates unreliable. This is especially the case in terms of women and age group-specific assessments. Estimates can be interpreted in the light of trends in the prevalence of cannabis use and of cannabis experiments during the past year. One possible interpretation is that amphetamines and opiates have spread from Greater Helsinki to the rest of the country after cannabis has done so, which means that it is possible that in the future, the highest growth figures will occur in the provinces where use has earlier been the lowest.

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

The estimates of the number of problem users are especially relevant to treatment need assessment. The Finnish figures are based on estimates of hard-drug users on the one hand, and on the above estimate of regular drug (cannabis) users, which was derived from experiments with cannabis during the previous month. This estimate suggests that Finland has 10,000–15,000 problem users of narcotics; the maximum estimate may even be as high as 25,000–30,000.

Internationally, the most widely used indicator of problem drug use is the prevalence of intravenous use and other related risk behaviour. Having operated in Helsinki for three years, the infection counselling centre *Vinkki* is a place where used hypodermic needles can be exchanged for new ones. At the beginning of 2001, ten municipalities had such a centre. In 2000, the centres were visited by over 4,500 users of intravenous drugs.³⁴ Given this figure, the estimate of the number of problem drug users seems quite accurate because in international comparisons, estimates are usually 2–3 times higher than the observed cases on which they are based.³⁵

³⁴ The estimate is based on the total number of clients at health counselling centres, i.e. possible overlap is not excluded. Estimate is counted on the basis of evaluation reports on basic services by the State Provincial Offices of Southern and Western Finland (Peruspalvelut Suomen lääneissä 2000). It must be noted that many centres did not open until the autumn of 2000, which means that the figures do not reflect actual client numbers accurately. See Chapters 3.3 and 9.2.3 below.

³⁵ See http://www.emcdda.org/multimedia/project_reports/situation/study_local_pdu_report.pdf.

3 Health consequences

3.1 Drug treatment demand

In 1996 and 1998–2000, pilot studies on data collection concerning drug treatment demand were conducted in Finland, based on the European Pompidou model and on the TDI (Treatment Demand Indicator) protocol of the EMCDDA. The studies monitored the problematic use of narcotics and pharmaceuticals (with or without alcohol) among clients in treatment services for substance abusers.³⁶ The studies disregarded persons who primarily abused alcohol but who had no specific problems with drugs or other non-alcoholic substances. According to the 1999 census of intoxicant-related cases in social welfare and health care services, people primarily treated for alcohol problems accounted for about two thirds of outpatient clients in services for substance abusers and little over half of the clients receiving residential treatment services for substance abusers (Virtanen, A. 2000). In addition to specialised drug services, also general and prison health care units participated in the drug treatment study.

As far as demand for drug treatment in 1998–2000 is concerned, the greatest change would appear to be an increase in demand for treatment because of opiates as the primary drug, while the proportion of amphetamines as the primary drug has declined.³⁷

³⁶ In 1996, 43 treatment units participated during 10 weeks, and information concerning some 1,150 Pompidou questionnaires was received. In 1998, 63 treatment units participated for 7.5 months on average (some took part in two months' data compilation only), and information concerning some 2,800 Pompidou questionnaires was received. In 1999, 84 treatment units participated for three months, and information concerning some 1,770 Pompidou questionnaires and 1,700 clients was received. In 2000, 113 treatment units participated throughout the year, with information on 5,686 Pompidou questionnaires and 4,709 clients received. (Sellergren 1997; Partanen, A. 1999; Partanen, A. 2000a; Partanen A. 2001).

³⁷ However, the great change particularly in abuse of medicines and alcohol does not directly reflect the changes in problem use. The number of units participating in data compilation has varied over the years, and the number of units specialising in drug clients has increased, as these units have been most willing to contribute to data compilation. In addition, the growing supply of services is reflected in service demand.

Table 10. Substances used by clients in treatment for substance abuse in 1996, 1998, 1999 and 2000³⁸

Substance category	1 st substance abused (%)				1 st –3 rd substance abused (%)			
	1996	1998	1999	2000	1996	1998	1999	2000
Alcohol	43	19	17	18	63	47	38	37
Cannabis	11	17	16	17	56	65	59	59
Stimulants	26	35	33	28	51	60	58	56
Medicines	9	5	6	5	50	22	30	27
Opiates	10	21	25	29	21	32	36	38
No information	1	3	3	3	–	–	–	–

Of the primary substances abused by the clients participating in the 2000 compilation, amphetamine accounted for 94 per cent of all stimulants, while ecstasy accounted for three per cent. However, when five substances abused were included, it transpired that ecstasy had been used by 10 per cent of the clients, cocaine by 2 per cent and LSD by 3 per cent. Of the primarily used opiates, heroin accounted for about 69 per cent and buprenorphine for 23 per cent. According to information on the year 2000, 80 per cent of opiate users and 76 per cent of amphetamine users mainly used substances by injection. However, almost half of those demanding for treatment for the use of cannabis, tranquillisers, alcohol or polydrug use had also injected substances at some point in their life.

While opiates had by 2000 become the primary substance in terms of reasons for treatment demands, among treatment demands for the first-time the primary substance were not opiates but cannabis (28%), and stimulants (24%), opiates (22%) and an alcohol problem (18%) related to drugs were also common. Injecting opiates or stimulants was somewhat rarer among those demanding for treatment for the first time: a quarter used opiates by smoking and a third used stimulants orally or by sniffing.

However, polydrug use is typical of Finnish drug use. Over half of the clients reported having used at least three different substances (Partanen A. 2000a, 2001).

³⁸ The EMCDDA compiles drug treatment information based on the Treatment Demand Indicator (TDI) criteria, which differ from the figures given here because the TDI protocol does not collect information about clients who demand for treatment primarily for alcohol use nor about clients who have initiated their treatment prior to the year examined even though the treatment continues. Figures that are compatible with the EMCDDA criteria are presented in Appendix 6. See also http://www.emcdda.org/situation/themes/demand_treatment.shtml.

Table 11. Polydrug use of clients in treatment for substance abuse in 1999 and 2000

1st substance	Concurrent use of 2nd and 3rd substance with primary substance (%)									
	Opiate		Stimulant		Cannabis		Medicines		Alcohol	
	1999	2000	1999	2000	1999	2000	1999	2000	1999	2000
Opiate	24	25	45	39	49	42	27	25	7	6
Stimulant	23	22	10	13	60	59	21	21	30	29
Cannabis	10	10	52	49	8	4	16	13	43	39
Medicines	13	17	15	23	34	23	18	14	47	43
Alcohol	6	5	36	40	55	59	52	36	–	–

Three different user profiles among persons seeking drug treatment emerge from this material throughout the 1990s: i) Opiate users, who also indulge in other narcotics, but mostly abstain from alcohol and medicines; ii) Stimulant and cannabis users, who also consume a lot of alcohol; iii) Polydrug users of alcohol and medicines, who also use cannabis but seldom hard drugs. The slight changes in user profiles at the turn of decade show that people who drink alcohol are increasingly using stimulants too and that opiate addicts use tranquillisers.

Almost half of the clients in 1998, 1999 and 2000 were 20–29-year-olds, and a fifth were under 20.³⁹ The clients' average age varied depending on the primary drug used.

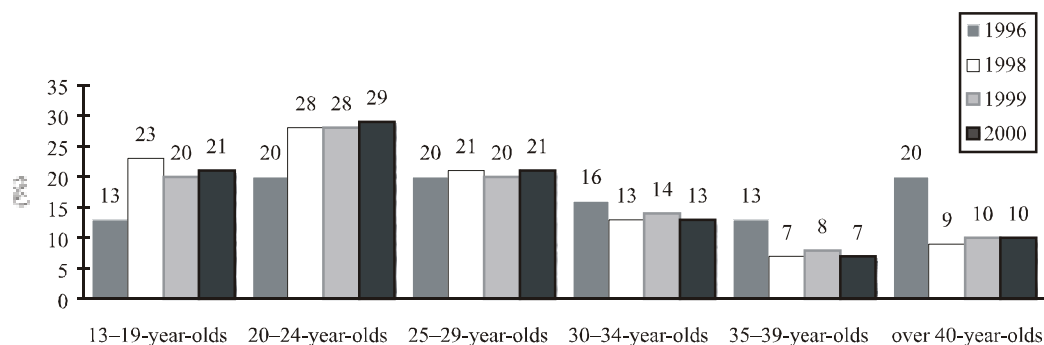
Table 12. Mean age (years) of persons in treatment for substance abuse in 1996, 1998, 1999 and 2000

	Pilot in 1996	Pilot 1998		Pilot 1999		2000	
	– all	– all	– first treatment	– all	– first treatment	– all	– first treatment
Opiates	27.0	26.6	25.1	26.1	24.6	25.9	24.1
Amphetamines	27.3	26.7	25.2	26.4	24.9	27.0	24.8
Cannabis	23.0	21.7	19.9	22.5	19.9	22.1	20.0
Alcohol	33–34	30.2	25.5	31.4	28.9	29.9	25.0

The changes in the client age distributions from 1996 to 1998 seem to be attributable to an increase in narcotic drug abuse. The small differences between the past three years probably result from the changes in the treatment unit samples studied: there was a relative decline in the number of clients in specialised drug treatment units, because a growing number of traditional substance abuse outpatient clinics were included in data collection.

³⁹ In 2000, the mean age of clients in specialised drug treatment units was 24.9 years (outpatients) and 24.7 years (inpatients). The mean age of drug clients in other outpatient services for substance abusers was 25.9 years and 29.0 years in institutional care. The drug clients in prison were on average 32.3 years old.

Figure 6. Abusers of narcotics and medicines by age groups (%) in treatment for substance abuse in 1996–2000



It was also possible to examine the chain of substance use among first-time treatment clients, starting from initial experiments through regular use to a situation where the person finds it necessary to demand for treatment. As regards cannabis, use normally starts at the age of 15, followed by regular use a couple of years later, and another two or three years has elapsed when treatment is demanded, on average at the age of 20. Stimulant users typically start at the age of 19, followed by regular use for three years or so and demanding for treatment after another year, on average at the age of 25. In terms of opiates, use starts on average at 20, followed by regular use for a couple of years and treatment demand after less than a year, on average at the age of 24.

According to the 2000 data, women accounted for a quarter of the clients. Three out of four of the clients were unmarried, while one out of six cohabited or were married. Of the latter group, half were living in the same household with another substance abuser – most commonly a drug user. Only a quarter of problem users had children aged under 18, and one fourth of such children lived in the same household. A tenth of clients worked, almost a sixth were students and 4 per cent were retired. A sixth of clients were homeless. Two-thirds had primary education, one fifth had intermediate education and less than one per cent had an academic degree. One tenth had not finished secondary school. The one-day census of substance abuse clients in all social welfare and health care units also showed (Hakkarainen et. al. 2000) that problem drug users were even more excluded than other substance abusers: half of them were unemployed (other substance abusers: a third) and a fifth of them were homeless (other substance abusers: less than 10 per cent).

The 1999 census of intoxicant-related cases in social and health services, reflecting the prevalence of problem drug use, showed that almost 20 per cent of all clients in outpatient services for substance abusers (A-Clinics and youth clinics) and 30 per cent of clients in institutional treatment (detoxification and rehabilitation) engaged in problem drug use as well (Metso et. al. 2000).⁴⁰ Based on information from 1998, this means that outpatient services for substance abusers annually serve some 8,000 drug clients, and institutional services have about 3,000 drug clients per year (Intoxicant Statistical Yearbook 1999). In the same year, health care (hospital) wards catered for some 1,100 drug patients and for about 900 so-called polydrug users, whose primary intoxicant was not possible or deemed necessary to specify. An estimated 10,500–13,500 people visit social welfare and health care units annually on account of narcotics use.

⁴⁰ The percentages are associated with the use of cannabis, amphetamines opiates or other illegal drugs. The figures do not tell whether the substance constitute the clients main drug use problem, i.e. is the primary drug used.

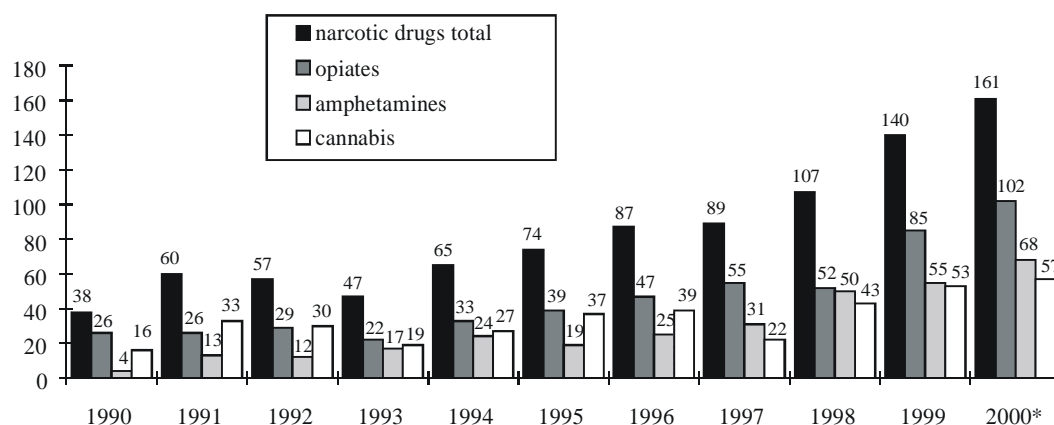
Two-thirds of outpatient clients and over half of residential treatment clients used services for substance abusers for alcohol use only. The proportion of clients in specialised services for abuse of medicines was a couple of percentage points higher than that of narcotics clients. On the other hand, the number of alcohol and pharmaceutical-related patients in hospital inpatient care is relatively much higher: these services cared for over 20,000 alcohol-related and about 3,100 pharmaceutical-related patients in 1998 (Virtanen 2000).⁴¹ Based on the census of intoxicant-related cases, it was estimated that in social and health services, polydrug users numbered annually 23,000–30,000 and abusers of medicines 15,000–20,000 (Hakkarainen et. al. 2000).⁴²

3.2 Drug-related mortality

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

By law, a coroner's forensic examination must be carried out if death has been unexpected or sudden (e.g. homicide, misadventure, suicide, poisoning, occupational disease, medical procedure, etc). In 1998, about 10,000 forensic autopsies were performed in Finland, of which 4,800 led to further chemical forensic analyses. The verdict of death by poisoning was given in about 1,100 cases. Of these, 500 involved pharmaceuticals, with neuroleptics and antidepressants as the dominant substances in terms of primary findings in 1998. However, in 1999 opioids became more prevalent than antidepressants and the second most common drug finding was morphine, which in most cases stemmed from heroin. Some 450 people died of alcohol poisoning in 1999. (Vuori Erkki, personal communication; Vuori et. al. 1999, 2001; Vuori 2000b.)

Figure 7. Forensic findings of narcotic drugs in autopsies in 1990-2000⁴³



* = preliminary information

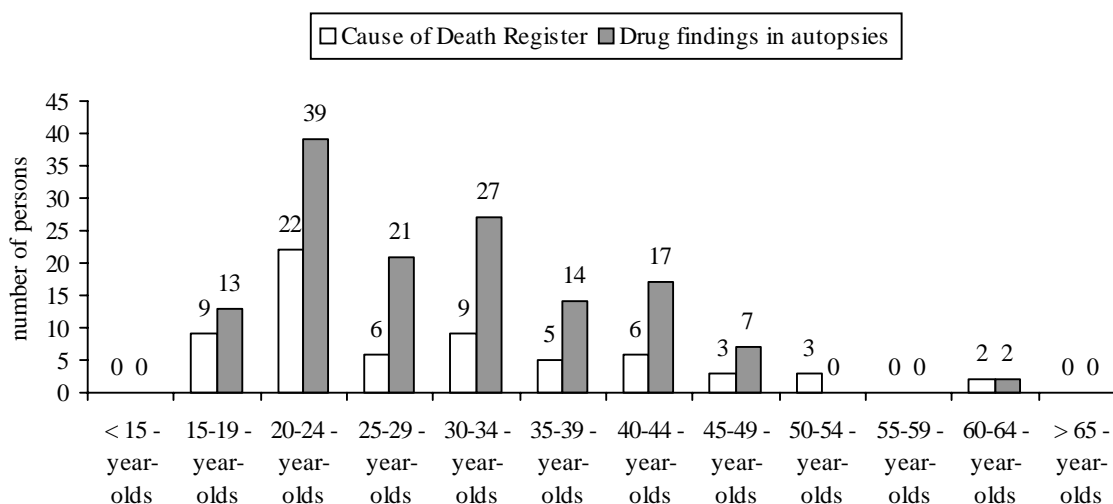
⁴¹ It should be noted that a client may be included in both specialised treatment services for substance abusers and basic health care service statistics due to a different substances used annually.

⁴² It should be noted that the estimates do not eliminate possible overlap.

⁴³ Department of Forensic Medicine at the University of Helsinki (In 1994, 1996, 1999 and 2000 also one cocaine finding).

There is however some ambiguity as to the definition of drug-related deaths based on chemical findings. The figures based on forensic chemical findings give maximum estimate for the number at drug related deaths. When defined in terms of the primary cause of death, these substances were evident in deaths by poisoning, but in terms of findings associated with deaths, some cases were due to other reasons, such as accidents, suicides not involving poisoning or violent deaths, where the substance did not directly cause the death. Previously, poisoning has been the primary cause of death in half of substance findings. As heroin deaths are becoming more common, the situation has changed, so that in 1999 almost two thirds of the cases classified as drug-related deaths based on forensic chemical analyses were categorised as deaths by poisoning in terms of the cause of death as well, i.e. as drug-related deaths in the general mortality register as well.

Figure 8. Drug deaths by age group based on causes of death⁴⁴ or on forensic chemical findings in 1999



Since 1996, there has been an increase in sudden deaths, especially linked to heroin use (due to overdose). In 1995, only one such case was found in Finland, but the situation started to change in 1996, with 9 cases detected, followed by 15 cases in 1997 and 27 cases in 1998. In 1999, 50 heroin deaths and two buprenorphine deaths were detected. Especially the proportion of young people has increased, as over half of the heroin deaths in 1999 involved persons under 25 years of age. According to the preliminary information 62 heroin deaths was detected in 2000.

During 2001, a study on the drug deaths in 1990–1996 was published (Vuori et. al. 2001b), indicating that at the beginning of the 1990s, almost 90 per cent of drug findings involved men. Half of the deceased were under 30 years of age, and 57 per cent had used opioids, 47 per cent cannabis and 27 per cent amphetamines. Alcohol was present in 42 per cent of the deceased. Over a third died of suicide and almost half by accident. About 45 per cent involved deaths by poisoning, and almost 10 per cent involved homicide. Violent deaths were often associated with alcohol along with a narcotics finding. The scene of death was usually home (44%) or outdoors (22%). Almost half died when alone (48%), while a third died in the presence of friends or acquaintances.

⁴⁴ Deaths given to the EMCDDA for the EU comparison are according to the protocols resulting from the EMCDDA's harmonisation work on cause of death registers and including diseases, accidental poisoning and poisoning with indetermined intent as a cause at death and limited to narcotics (excluding polysubstance diagnosis). See http://www.emcdda.org/situation/themes/death_mortality.shtml.

The drug cases involved an above-average number of young retirees, clerical personnel and skilled labourers, while the jobless accounted for as little as eight per cent. Some 20 per cent did not have a fixed address.

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

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

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

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

3.3 Drug-related infectious diseases

It is possible to assess the prevalence of intravenous drug use based on registers of infectious diseases and drug tests.⁴⁵ By the end of 1997, 864 HIV cases had been found in Finland, 28 of which (3%) had been contracted through intravenous drug use (only two of them in Finland).

In 1998, 20 new HIV cases resulting from intravenous drug use were found, mostly in Greater Helsinki – a fifth of all 81 new HIV infections during that year. In 1999, the number increased by 85 cases of all 143 HIV infections recorded in 1999, and in 2000, the total number of new HIV infections due to intravenous drug use was 56 of all 145 HIV infections.⁴⁶ Similar infections, albeit isolated cases, have been detected in 10 other municipalities as well. A seroepidemiologic study conducted in autumn 1998 indicated that three per cent of intravenous drug abusers were

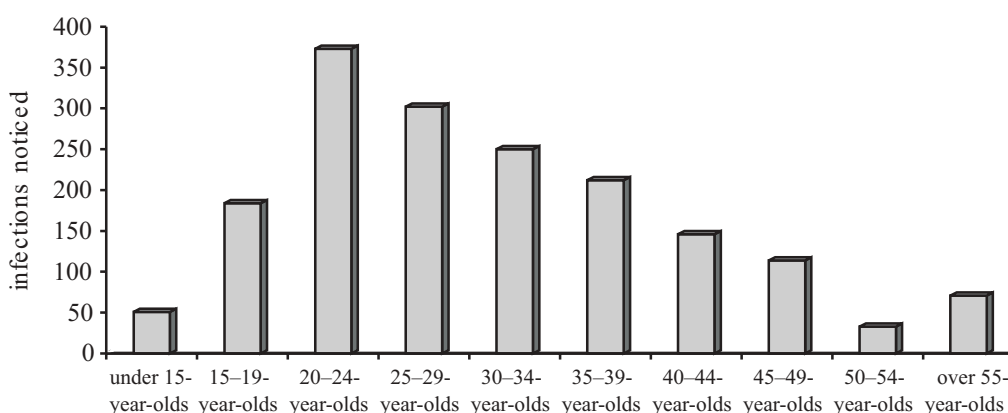
⁴⁵ The National Public Health Institute (Department of Infectious Disease Epidemiology) is responsible for the registration of communicable diseases and for official drug tests in Finland.

⁴⁶ The HIV register of the National Public Health Institute. See http://www.ktl.fi/ttr/hiv_aids.html.

infected with HIV (Partanen, A. 2000b). Voluntary HIV tests performed in prisons and at needle exchange centres in 2000 showed that less than 2.5 per cent of subjects tested positive for HIV.⁴⁷

Recent investigations have shown that some 60 per cent of intravenous drug users have hepatitis C. (Leinikki 1999; Turpeinen et. al. 1999) Of those tested at health counselling centres, 30–60 per cent had hepatitis C. On the other hand, it is estimated that 90 per cent of all hepatitis C infections are attributable to intravenous drug use.⁴⁸ The clear correlation between hepatitis C and intravenous drug use suggests that hepatitis C could be used as an indicator of trends in drug use. In 2000, there were 1,739 new hepatitis C cases, and in recent years this number has remained around 1,500–1,700 per year. Of the viral infections in 2000, over half involved persons under 30 years of age, and most infections had occurred in age group 20–24-year-olds.

Figure 9. Age distribution of new hepatitis C infections in 2000



The first follow-up on the service users at the Vinkki, first health counselling centre for IV-drug users in Helsinki was compiled in 1997, and the second during 1 September 1998–9 June 1999 (Harju 2000). During the 1997, a quarter of the clients having exchanged contaminated needles in Vinkki were voluntarily and anonymously interviewed (Ovaska et. al. 1998). Half of the respondents had hepatitis C and a third had hepatitis B, but nobody had HIV. It was not until 1998 that the first HIV infections were discovered among the clients. The situation among interviewees in 1998–1999 was different only concerning hepatitis B. Of the 1998–1999 interviewees, 56 per cent had reportedly received at least one vaccination against hepatitis B, whereas in 1997 the corresponding proportion was 16 per cent. In 1998–1999 a quarter of the respondents reported having been infected with hepatitis B.⁴⁹

The change in the risk indicator values at Vinkki is noteworthy. However, also the sample profiles of the interviewees have changed somewhat. Nevertheless, information about the infection

⁴⁷ Department of Infectious Disease Epidemiology, National Public Health Institute.

⁴⁸ This percentage is calculated from the cases where the means of transmission has been reported. However, in almost half of the cases it is not known or reported. To investigate the risk of communicable diseases, hepatitis C infections have since 1998 been included in the list of diseases a physician must notify. (Infectious diseases in Finland 2000).

⁴⁹ According to the Department of Infectious Disease Epidemiology of the National Public Health Institute, 556 hepatitis B infections were found in 1999 in the entire country.

risks of sharing drug paraphernalia has been distributed to problem users, and it seems that this information has at least partly reached the users.

Table 13. Indicators of risk behaviour at infection counselling centre Vinkki in Helsinki

	1997	1 Sep. 1998– 9 Jun. 1999
Has not borrowed syringes during the month	55%	67%
Has lent syringes to others	75%	44%
Reportedly cleaned syringes after use	46%	89%
Proportion of multi-risk users ⁵⁰	21%	3%

3.4 Other drug-related morbidity

Drug-induced morbidity is monitored through the hospital patient discharge register. According to the register, the number of drug-related hospital periods has increased rapidly in 1990–2000. Drug-related illnesses have partly become more prevalent because of the increased publicity given to drugs and changes in diagnostic practices. For instance, in 1992 the largest drug treatment unit in Finland, Helsinki University Central Hospital, transferred from unspecified pharmaceutical or drug diagnoses to substance-specific diagnoses, a fact alone accounting for an increase of 100 treatment periods. In 1996, the changeover to the ICD-10 classification caused an increase of 450 drug-related treatment periods, almost half of which were attributable to the changeover.⁵¹

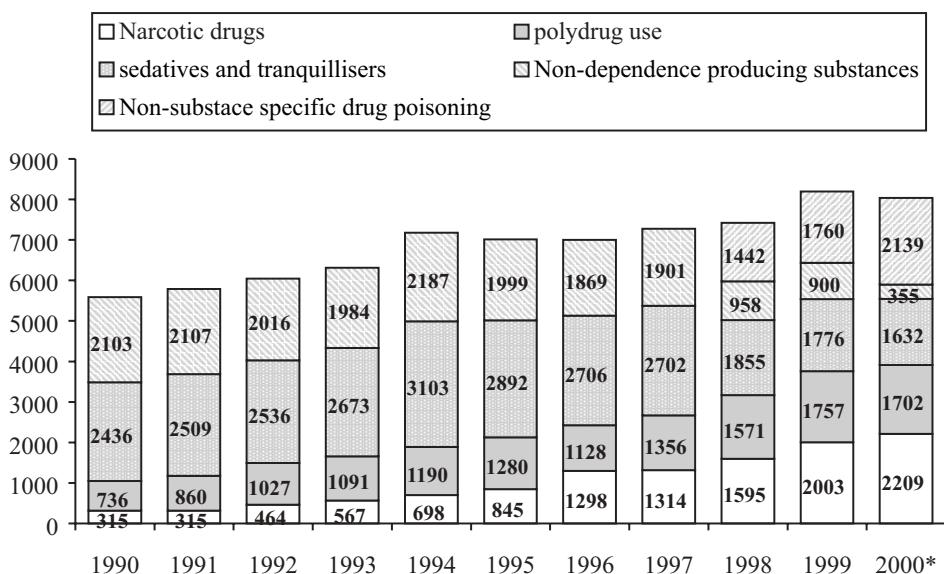
Especially the 1998 hospital statistics suggested that the number of treatment periods recorded due to pharmaceutical or narcotic drug diagnoses have decreased by 17 per cent in a year. This change is mainly due to the alterations in 1998 to applying the Finnish ICD-10 system, which integrated poisoning diagnoses in terms of medicinal poisonings into one diagnosis category (T36), where substances are differentiated by the specific ATC code associated with pharmaceuticals. In 1997, over 3,000 pharmaceutical poisoning diagnoses were made. However, in 1998 almost 1,500 poisoning diagnoses were recorded by the ICD code, without the ATC extension, a fact that makes

⁵⁰ As a multi-risk user is defined a person who had during the previous month engaged in the following acts: lent or borrowed contaminated syringes or other IV paraphernalia (cups, filters, spoons) and shared drugs from one syringe to another by front loading or back loading.

⁵¹ In 1996, the number of drug treatment periods increased by half from the year 1995 (criterion, see footnote 16). Of this addition, more than 500 treatment periods consisted of substance-induced brain syndromes (ICD-10/F1x.3–9). Of these, about 125 treatment periods were estimated to result from a statistical changeover from unspecified drug-induced brain syndromes (ICD-9/292, not previously counted as drug diseases but as polydrug use) to substance-specific brain syndromes; meanwhile, the number of treatment periods due to drug dependence decreased accordingly (in terms of primary diagnosis, the transfer does not show). In the changeover, the number of drug-induced brain syndromes, previously unspecified, decreased by about 200 periods. Moreover, some 100 new treatment periods were introduced into opiate-induced brain syndromes from a group of people aged over 50 (mostly 70 years of age). In hypnotics, sedatives and tranquillisers, the increase in hospital periods caused by brain syndromes was about 150, which almost matches the decline in dependence diagnoses attributable to hypnotics, sedatives and tranquillisers.

it impossible to carry out comparisons over time series on poisonings caused by sedatives, tranquillisers or non-dependence-inducing medicines.

Figure 10. Hospital treatment periods related to narcotics and pharmaceuticals in 1990–2000⁵²

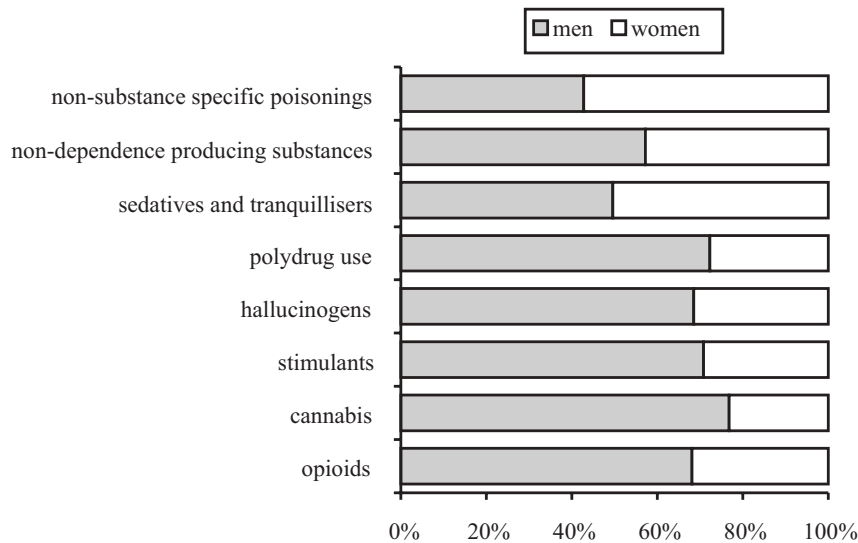


* = preliminary information

The number of treatment periods recorded due to drug diagnoses continued to rise in 2000, as has happened throughout the 1990s. The number of treatment periods related to polydrug use (multiple drug use) declined somewhat, whereas the periods related to soporifics, tranquillisers or non-dependence-inducing substances decreased clearly from the year before. Part of this decline can be explained by an increase in medicine-induced poisonings coded without specifying the substance. Clients treated for narcotics or polydrug use are predominantly men, but there is no major difference in the use of pharmaceuticals leading to health problems between the sexes.

⁵² The cases for substance-specific diagnoses were selected based on the principal drug mentioned in pharmaceutical diagnosis (primary diagnosis and two secondary diagnoses). In 1990–1995, the drug diagnoses are according to the Finnish ICD-9 codes (see appendix 7). In 1996, the classification changed in Finland, and since 1996 ICD-10 has been in use (see appendix 8). The appendix aims at statistical compatibility of drug-related diseases, despite the differences between the classifications.

Figure 11. Hospital treatment periods related to narcotics and pharmaceuticals in 2000* by sex

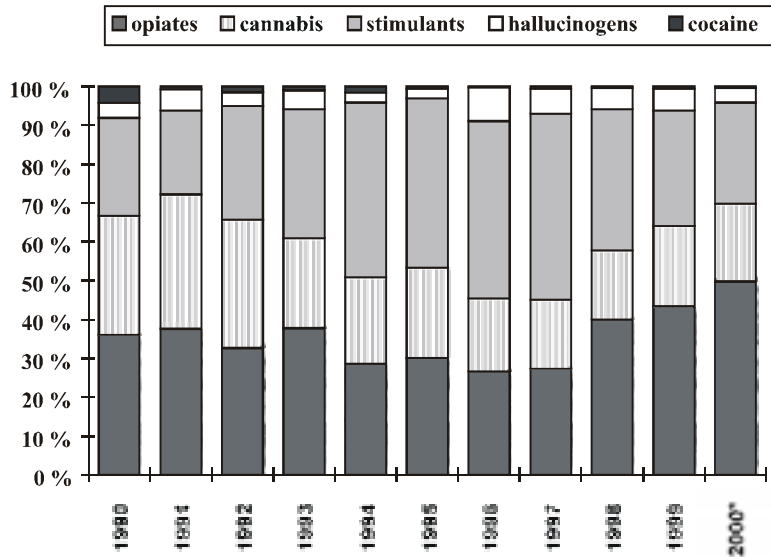


* = Preliminary information on 2000

Most common drug involved in narcotics-related hospital treatment periods in the mid-1990s was amphetamine. In 1998, there was a change of order, as opiate-related treatment periods became more numerous in age group 15–54-year-olds, and this trend continued in 1999 and 2000. This may partly be due to the new Regulation issued by the Ministry of Social Affairs and Health concerning detoxification and substitution treatment for opiate addicts with medicines and stipulating that the assessment of substitution treatment, along with most of the treatment provision, must be done in certain specified hospitals.⁵³ Also the number of cannabis-related treatments has somewhat grown during the past two years. In 2000, an increase in the number of treatment periods was typical of age group 15–24-year-olds, whose proportion of the narcotics treatment periods grew and is now about half of all treatment periods.

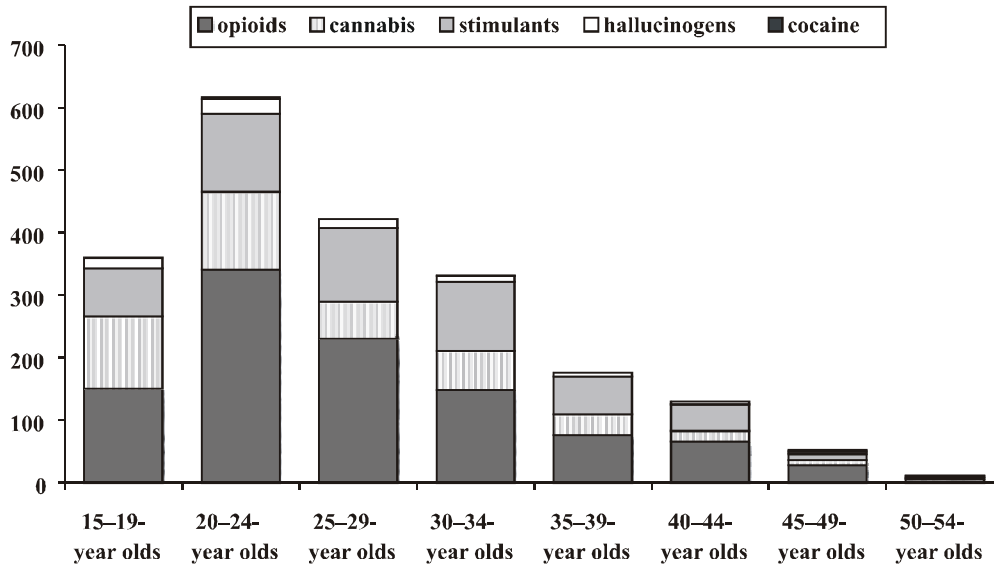
⁵³ In 1998–1999, University Central Hospitals in particular had a key role here. See Chapter 1.2.2.

Figure 12. Drug-related hospital treatment periods (%) for 15–54-year-olds in 1990-2000⁵⁴



* = Preliminary information on 2000

Figure 13. Drug-related hospital treatment periods by age group for 15–54-year-olds in 2000



* = Preliminary information on 2000

⁵⁴ According to highest-level drug diagnosis, see Appendices 7 and 8.

4 Social and legal correlates and consequences

4.1 Social problems

The 1995 Alcohol Act dismantled Finland's monopolistic alcohol system, with the exception of a retail monopoly. At the same time, attitudes became more liberal towards alcohol use, and alcohol was more openly consumed in public places. Also young people were affected by this change of attitudes, probably resulting also in slightly more liberal attitudes towards narcotics and an increase in drug experiments.

During past years, debate has become more heated, as young people's drinking in public places has met with much criticism. Some cities imposed stricter municipal ordinances by banning intoxicant use (i.e. drinking) in public places (e.g. Helsinki) or by pursuing an active zero-tolerance policy (Tampere).

There are also nationwide plans to amend legislation on city ordinances and regulations. A working group on the issue submitted its report to the Ministry of the Interior in January 2000, proposing a bill that e.g. bans intoxicant use in public places, such as stations and ports, children's playgrounds, shopping centres and public transport. It was also proposed that a ban be placed on buying and soliciting sex services causing public nuisance. The bill has not yet been given to Parliament.

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

A small-scale survey was conducted in 1998 among drug users, asking them to assess their needs, expectations and the experiences concerning the social welfare and health care services at their disposal (Nuorvala 1999). The interview of some twenty people in treatment for drug use demonstrated that their drug-related social problems were mostly associated with housing, work and prison experiences. Many people had lost contact with their relatives, and if they had children, the child welfare measures taken by the authorities aroused strong emotions. Another problem was that their circle of friends was narrow, but some people also considered their drug-user subculture in positive yet contradictory terms.

Many social problems had to do with health and treatment: three out of five interviewees also received mental health services, and three out of four had used other health services because of substance abuse (viral infections, overdose or withdrawal symptoms). Psychiatric services were

criticised for giving drug users the runaround or for administering supposedly inappropriate medication, whereas the attitudes towards general health services were more neutral. Specialised services for substance abusers were seldom criticised, but the treatment was considered to lack content: it was perceived as a passive, lonesome, void, uninspiring and eventless state of being. In addition, some clients had problems with gaining access to treatment and with the related criteria.

A study on drug offenders' criminal careers and socio-economic position was published in 2001 (Kinnunen 2001).⁵⁵ The study used cross-sectional data to investigate people who had been convicted of drug offences in 1977–1996 and their situation in 1995. The mean age of the study group then was 30 years. Only a fifth of those convicted in 1977–1996 were in the employed labour force in 1995. Of the subjects, 43 per cent were reportedly unemployed. The distributions are clearly different among those who had been convicted of some other crimes during the same period: of them, 43 per cent were in the employed labour force, while 22 per cent were jobless. The most common professions among drug offenders were unskilled labourer, machinist, mechanic, driver or construction worker. Also service-sector professions, such as salesperson and work in the social sector, were quite common. Drug offenders had little education and were less educated than other people convicted of crimes. Over half of drug offenders (58%) did not have any record of training other than basic education.

The researcher concludes that the study supports the notion that drug control is targeted at persons whose socio-economic position is the lowest. People with drug problems encounter control officials more often than they do drug treatment professionals, and in practice it is still seldom that social and health-related support be incorporated in police work, which follows its own logic.

4.2 Drug offences and drug-related crime

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

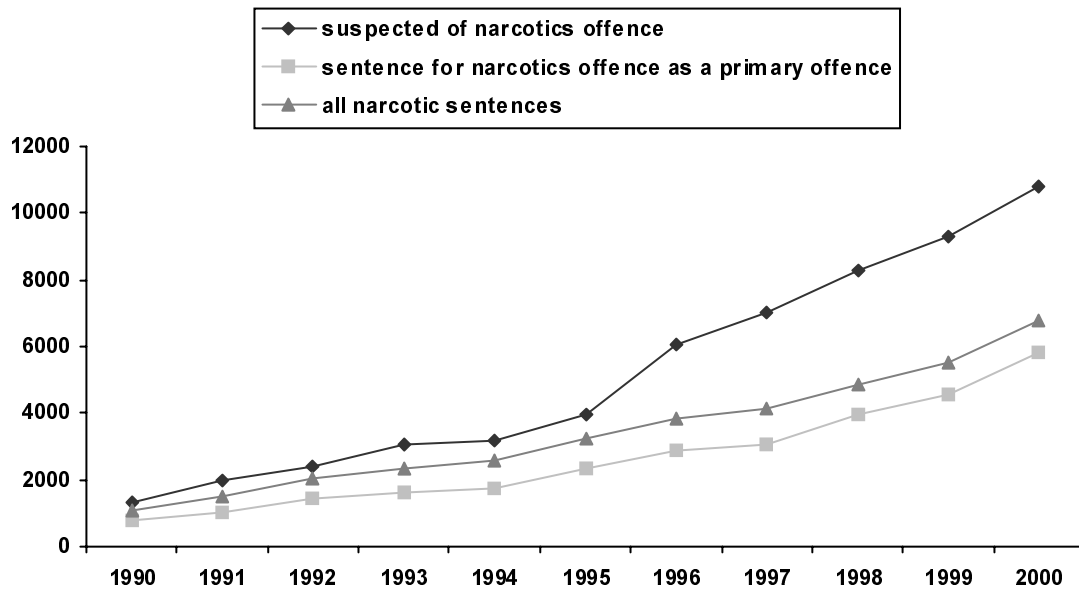
4.2.1 Drug offences

The number of persons suspected of drug offences has rapidly increased in the 1990s. However, this not only reflects the extent of actual crime but also efforts made by the law enforcement agencies.⁵⁶ For instance, the intensified police training in drug questions has contributed to a statistical increase in drug offences.

⁵⁵ See Chapter 4.2.2.

⁵⁶ The official term is narcotics offences according to the Narcotics Act, but this report uses the concept "drug" parallel to "narcotics," and the latter term is used only when it is important to see the connection to the Narcotics Act.

Figure 14. Number of people suspected and convicted of drug offences in 1990–2000*

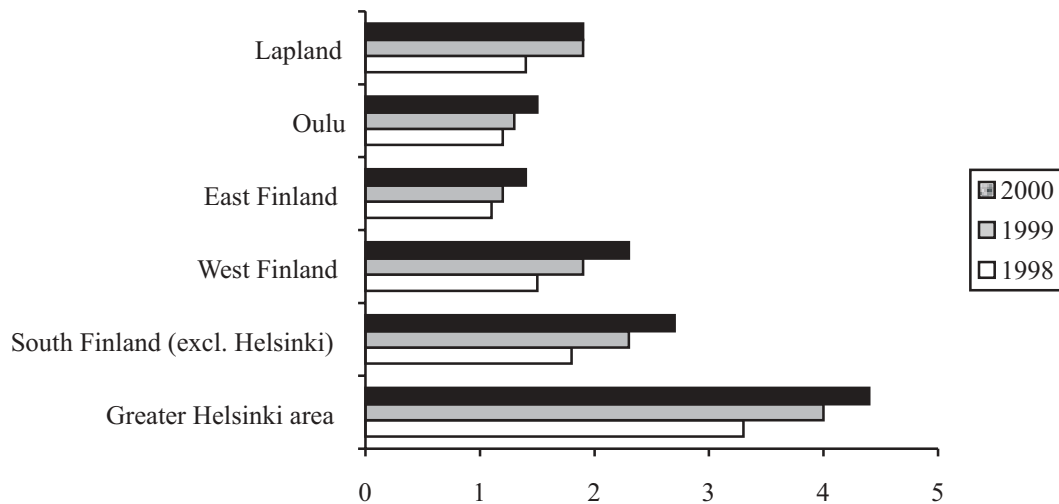


* = preliminary information on 2000

The largest aggregate of reported offences consists of the so-called user offences (use, possession and purchase, specified in the statistics but not in legislation). According to the statistics of the National Bureau of Investigation, they accounted for 60 per cent of all drug offences reported in the 1980s, and for almost 80 per cent in 1990–1998. However, in 1999–2000, user offences only accounted for two out of three of drug offence reports. The 1990s statistics showed a reduction in ‘user offences’ and an increase in ‘possession offences’ as compared to the 1980s. The period 1999–2000 also saw a change in this trend: possession offences accounted for 32 per cent in 1999 and 34 per cent in 2000, while the proportion was 48 per cent in 1998 of all reports of drug offences and drug user offences accounted for 30 per cent in 1999 and 27 per cent in 2000 while the proportion was 22 per cent in 1998 (NBI Newsletter 3th of May 2001; Kinnunen 2000).

In 2000, almost 60 per cent of suspects were aged under 25, and 15 per cent were women. Five per cent of cases allegedly involved aggravated drug offences. About 40 per cent of the drug offences reported were committed in Greater Helsinki. (Poliisin tietoon tullut rikollisuus 1998, 1999, 2000.)

Figure 15. Drug offences per 1,000 inhabitants in 1998–2000 by region



According to the first semi-annual review in 2001 of the National Bureau of Investigation, the number of drug suspects increased by almost 15 per cent from the year before. Especially the number of people suspected of aggravated narcotics offences was growing (NBI Newsletter 24 September 2001).

Drug offences are often uncovered during preliminary investigation of other offences or afterwards by some other means. Amendments to the laws governing preliminary investigation and coercive measures (1989 and 1995) have shifted the focus of criminal investigation towards surveillance and control, with an effort to provide the law enforcement authorities with new telesurveillance equipment. In 2000 (1999), the police and customs were given permission for telesurveillance in 1092 (817) cases and for monitoring telephone conversations in 814 (321) cases. About 44 per cent of the telesurveillance cases were related to narcotics offences. In 80 per cent of cases, permissions for monitoring telephone conversations were applied to aggravated drug offences.

Telesurveillance and monitoring are coercive measures that are taken covertly, without an opportunity for the suspect to be heard beforehand. He or she must however be notified afterwards, in compliance with the Coercive Means Act. Usually, this happens during preliminary investigation, but in some cases the court has given permission to refrain from notifying or to notify at a later date. In 2000 (1999) this has been done in 136 (113) cases.⁵⁷

⁵⁷ Reports of the Police Department of the Ministry of the Interior to the Parliamentary Ombudsman in 1999, 2000 and 2001. See also <http://www.poliisi.fi/julkaisut/telekuuntelu.pdf>.

4.2.2 Drug convictions

In 2000 (1999), the courts of first instance passed 6,789 (5,524) sentences involving drug offences.⁵⁸ Of them, 5,812 (4,551) had a drug offence as the primary count (Syytetyt ja tuomitut 2000).⁵⁹ Of the persons convicted, 73 per cent were fined, 18 per cent received prison sentences and 9 per cent were given suspended sentences. The average length of a prison sentence for a narcotics offence in 2000 was 3.9 months (4.0 months in 1999) while in aggravated narcotics offences, the average length was 36.0 months (35.9 months in 1999).⁶⁰ In 2000 (1999), prosecution was waived in case of 126 (94) suspects.

Court statistics reveal no great changes in judicial practice, but the growing number of drug offenders in prison reflects a change in apparent crime (Aho 1998). Under certain circumstances, the prosecutor or court may waive prosecution in drug offences.⁶¹ In 1999, prosecution was waived in case of about 10 per cent of all persons suspected of drug offences by the police. The key reasons for dismissing a case included insufficient evidence or the fact that the offence was deemed negligible.

Persons suspected of drug offences seem to undergo a harsher treatment than other criminals in the Finnish legal system. A study established that incarceration as a coercive measure in the criminal process appears to concern persons suspected of drug offences in particular (Kainulainen 1998; also Sarvanti 1997). According to the study, incarceration was typically associated with three offender groups: a) homicide suspects, b) suspects (repeatedly) involved in crimes against property and c) suspects in narcotics offences. Persons suspected of drug offences accounted for 25 per cent of these cases. Nevertheless, there must be sufficient grounds for recommending incarceration. The police (or customs) may have followed the suspects for a long time and used informers and other sources, the suspects' telephones may have been tapped and so on. Because drug crime often involves several perpetrators, incarceration is used to ensure a successful investigation by isolating the suspects. The statistics do not say how often incarceration has led to an indictment or sentence. The interviewees reported that the incarcerated suspects (including drug suspects) have usually been charged and convicted.

A study on the judicial grounds for waiving prosecution in narcotics cases suggests that the so-called drug users are not usually incarcerated, but some arrests have been made. Incarceration apparently concerns persons who have allegedly committed aggravated narcotics offences. It seems that the prosecutor decides to refrain from pressing charges if the amount used (or possessed) is small. The most common drug is hashish in small quantities (e.g. a 'joint' shared by several persons). According to the interviewees, when larger quantities or hard drugs have been used (or if used in prison), prosecution will usually ensue. However, the judicial practice is far from uniform, and some prosecutors tend to be less inclined to press charges. Committal to treatment, now possible

⁵⁸ The sentences included a total of 8,338 drug offences alleged in 2000.

⁵⁹ For example, a person is convicted of an aggravated drug offence in the Helsinki District Court if he or she has handled a kilo of hashish, 100 grams of amphetamines or 10–15 grams of heroin. Also other aspects of the offence have a bearing on the severity of the crime, such as criminal proceeds and the organised nature of activities (Kinnunen 1999).

⁶⁰ When the mean length of a prison sentence is calculated, one should note that even though a drug offence is the principal crime and the primary reason for the conviction, the case may also involve other (narcotics) offences. Thus the figures reflect the length of sentences given to drug offenders rather than the length of sentences resulting from drug offences. Nevertheless, the results are not dramatically different from sentences carrying only one count of drug offence. The proportion of such offences is a third of all drug crime. (Syytetyt ja tuomitut 2000.)

⁶¹ Sections 3:5 and 50:7 of the Penal Code and Section 1:7–8 of the Criminal Procedure Act.

under the new law, has seldom been used. It is not common to waive sentences, either. (Kainulainen 1999.)

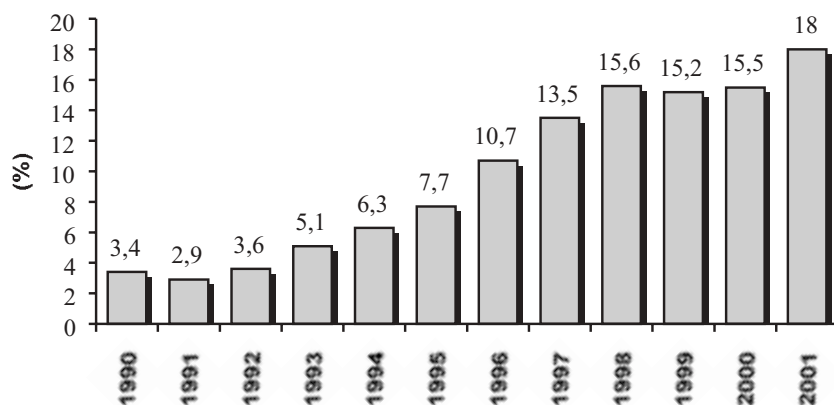
In the report year, a study on all persons having been convicted of narcotics offences in 1977–1996 was completed on the basis of information provided by Statistics Finland. Nationwide census data were utilised in interpreting information from the courts register. Special attention was paid to the criminal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

Persons convicted of narcotics offences were also guilty of many other crimes, especially theft, concealment and unlawful appropriation of vehicles. Drug offenders' criminal careers started when relatively young: the majority received their first criminal conviction as young as 15–16 years of age, i.e. immediately after they had become legally accountable. For a quarter of drug offenders, the narcotics offence was the first convicted crime. Most drug offences were committed at a later age, over 20, at which stage the amount of thefts was generally declining.

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

In 1998–2000, about 15 per cent of all Finnish prisoners served sentences primarily for drug offences, whereas a decade ago their proportion was about 2 per cent. In 2001, the proportion of drug convicts in the prison population started to rise again. Drug-related sentences tend to be longer as well: when in the entire prison population about half were serving sentences lasting for over two years, among drug offenders the proportion was two-thirds.⁶²

Figure 16. Proportion (%) of prisoners primarily convicted of drug offences according to the annual prison census in 1990–2001

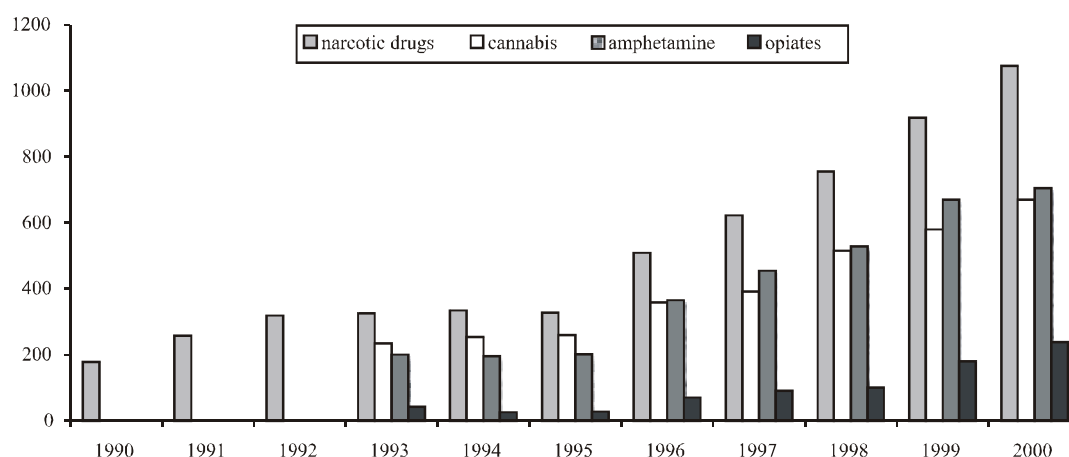


⁶² Situation on 1 October in all prisons, when the prison census was conducted. Since 1998, the census has been carried out on 1 May. According to the 2001 census, the Finnish prisons had 3,170 inmates (2,903 in 2000). The number of persons primarily convicted of drug offences was 449 in 2001 (360 in 2000). In addition, in 2001 there were 123 (84 in 2000) prisoners awaiting trial primarily for drug offences.

4.2.3 Drugs in road traffic

Drugs are present in road traffic as well, and their prevalence can be deduced from law enforcement statistics. In 2000 (1999), the number of intoxicant cases in road traffic was 22,553 (21,940), most of which were alcohol related, carrying convictions of drunken driving. The number of drivers tested for medicines and narcotics impairing the driver's performance was 1,880 (1,683). Of all cases, 1,589 (1,323) involved drugs (medicines or narcotics); the number of cases involving narcotics was 1,074 (918).⁶³ Amphetamines were found in 705 (670) cases, cannabis in 670 (580) and opiates in 237 (180) cases.⁶⁴ In the early 1990s, the number of narcotic drug findings was about 200.

Figure 17. Narcotics findings among suspects for driving under the influence of drugs (in road traffic) in the 1990–2000



Despite the considerable increase in narcotics findings, the number of sentences for driving under the influence of drugs (medicines or narcotics) as the primary offence has not increased correspondingly in the 1990s: in 1991, 277 sentences were passed, whereas in 1998 the number was 356 and 358 in 1999. The difference between the number of suspects (drug findings) and persons convicted is partly due to the fact that many cases involve some other primary offence (such as drunken driving). Legislation on driving under the influence of drugs was altered in 2000, and thus far no information about persons convicted of drunken driving on account of narcotics has been made available.

⁶³ The annual report of the Finnish police 2000. See also <http://www.poliisi.fi>.

⁶⁴ Drug Laboratory of the National Public Health Institute, 2001. (See also Niemi 1999.)

4.3 Social and economic costs of drug consumption

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

Preliminary information on the situation in 1998 suggested that abuse of medicines and narcotics resulted in direct societal costs ranging from EUR 115 (FIM 686) million to EUR 175 (FIM 1,043) million (Hein 2000).⁶⁵ The greatest increase was noticed in the estimated costs of damage to property.

Table 14. Cost of narcotics and medicines -related harm in Finland in 1998

	Minimum EUR (FIM) million	Maximum EUR (FIM) million
Criminal justice system	35 (209)	46 (271)
– Police and rescue services	11 (64)	20 (120)
– Judicial system and prisons	24 (145)	26 (151)
Damage to property	13 (79)	33 (196)
Social services	44 (264)	59 (351)
– Welfare for substance abusers	24 (146)	33 (195)
– Living allowances, child welfare	20 (118)	26 (156)
Health care and pensions	18 (109)	33 (197)
– Inpatient care of drug and medicine abuse	8 (51)	16 (98)
– Outpatient and home care	7 (39)	9 (52)
– Sickness pay	1 (6)	2 (11)
– Disability pensions	2 (12)	6 (36)
Research and prevention	5 (28)	5 (28)
TOTAL	115 (689)	175 (1,043)

In addition to direct costs, narcotics and medicine abuse causes considerable indirect expenses, e.g. in the form of production losses. For example, substance abuse may lead to inefficiency in studies and work and social problems may occur, such as marital break-ups. What is more, there is even a calculable figure for untimely deaths. Rough estimates of indirect costs per year vary between EUR 280–600 (FIM 1,700–3,600) million.

⁶⁵ Cf. also Chapter 1.3, comparing the costs of alcohol and drug abuse in 1995 and 1997.

5 The drug market

5.1 Availability and supply

The supply of narcotics has increased during the year, and the price of hard drugs has come down somewhat. The purity of amphetamine on the market has clearly dropped, but the purity of heroin varies considerably. Heroin mainly comes to Finland directly across the eastern border from St Petersburg area, Russia, or through Narva, Estonia, mainly from Afghanistan. From the Finnish viewpoint, Estonia, like the Netherlands, constitutes an important synthetic-drug production and transit country. Hashish is usually imported to Finland from Spain through Western Europe or Estonia. The supply of ecstasy has increased greatly from the year before, and most of it comes through Estonia. Cocaine has not yet gained much foothold on the Finnish drug market (Hietaniemi 2001; NBI Newsletters 5 March and 23 September 2001).

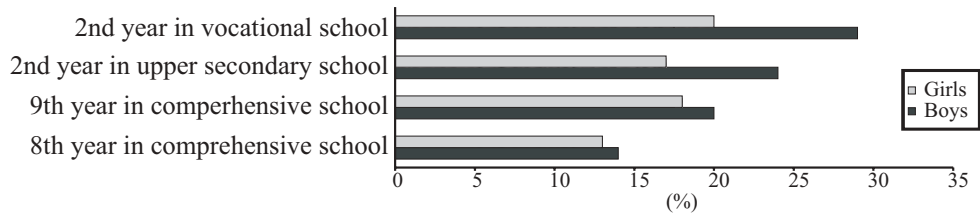
There was a clear change in the presence of Estonian-Russian drug criminals in late 1990s Finland. At the beginning of 2001, foreigners however accounted for less than five per cent of Finnish narcotics suspects, but for over ten per cent of suspects in aggravated narcotics offences. Organised crime operating on Estonian soil is in close collusion with crime organisations run by Russians and other ethnic groups in the Russian Federation and with their Finnish partners in crime. Drugs in Finland are to a lesser degree distributed by Finns and increasingly by Estonians.

The volume of passenger and goods transport between Estonia, Finland and Russia is high, but the possibilities to monitor it are limited. There has been a shift from individual couriers – a technique deemed risky and amateurish – to utilising vehicles for smuggling, and the modes of operation are becoming more varied. The internationality of these operations is further escalated by the fact that the criminal elements in Finland and in its neighbouring areas are active in, for example, Costa del Sol in Spain.

The so-called FINESTO working group has been established to act as a forum for antidrug co-operation between Finland and Estonia. The group concentrates on exposing drug crime and on exchange of antidrug information. The group has three representatives from the Finnish National Bureau of Investigation, one from the Helsinki District Police and three Estonian police officers.

The supply and availability of drugs can be viewed from the perspective of individual citizens' perceived drug supply. Many drug surveys have asked the interviewees whether they have been offered narcotic drugs. According to the 1998–1999 school health surveys, drugs had on average been offered to 16 per cent of 15–16-year-olds and to 23 per cent of 17–18-year-olds during last 12 months. (Rimpelä, M. et. al. 2000.)

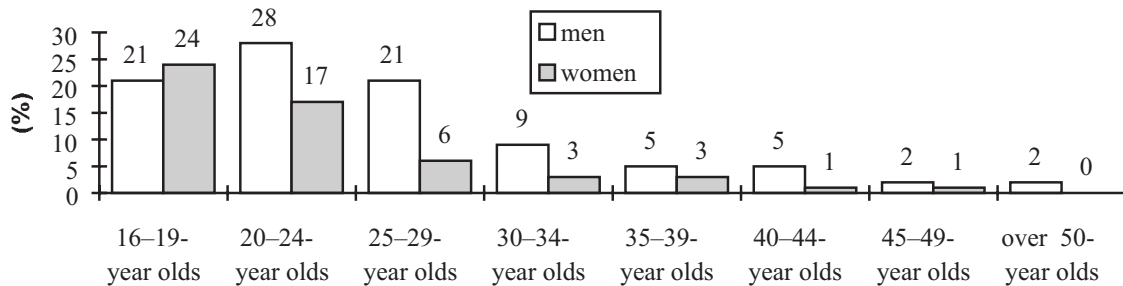
Figure 18. Drug offers to young people (%) during the past 12 months in Finland according to school health surveys in 1998–1999



According to a survey of juvenile delinquency among 15–16-year-olds, about 7.0 per cent of youngsters had used drugs during 1998 (sample of 4,500, response rate 88%). Of the young respondents, almost two-thirds had received their last drug dose free of charge. The responses indicated that the more regularly a person had used drugs during the year, the more likely it was that he or she had to pay for it. Payment was also more likely if the drug use had started at an early age. Irrespective of how regular the use was, girls received drugs for free more often than boys did. Entering the drug scene leads to a situation where a person must pay for drugs, but the price is liable to go down as the drug user gets to know the market better. Only four per cent of drug users had reportedly acquired money by illegal means during the year in order to purchase hashish or marijuana (Kivivuori 1999).

The 1998 population surveys found that 28 per cent of men (9 per cent during the year) and 16 per cent of women (5 per cent) had been offered drugs at least once during lifetime. Drugs had been at least once been offered for free to more than three persons out of four (Metso 2000).

Figure 19. Drug offers to adults (%) during the past 12 months by age group in 1998



5.2 Seizures

During the past 10 years, hashish seizures have clearly increased, and the number of amphetamine and heroin seizures has grown proportionally even more. However, the amounts in kilograms of seized substances may vary a lot. During the year, the amounts of methamphetamine seizures declined considerably, after the Estonian police exposed a methamphetamine laboratory and put it out of business.

The large consignment of heroin seized in 1995 was mainly destined for other countries, and the same applied to some major seizures of cocaine in the 1990s. For instance, almost all cocaine confiscated in 2000 was found on board a luxury liner visiting Finland. The first time ecstasy was seized in larger quantities was as late as in 1995, but especially at the turn of the decade, relatively the largest increases in seizures involved ecstasy. Another indicator of ecstasy's growing prevalence is the fact that seizures were made in 64 localities, as opposed to 40 in the year before.

Gamma (GHB) was introduced into the Finnish market in 1998. However, GHB is not classified as a narcotic in Finland, and thus its supervision is based on pharmaceutical, rather than narcotics, legislation. New synthetic drugs were rarely confiscated in 2000: MBDB (one occasion), 4-MTA (one occasion), GHB (15 occasions) and ketamine (11 occasions).

According to preliminary information, in 2000 a total of 0.6 kilograms of narcotics were seized in prisons (1.8 kg in 1999 and 4.2 kg in 1998) (Annual Report of the Prison Administration 2000).

Table 15. Drugs seized in 1990–2000 (kg)⁶⁶

	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000
Hashish	71.20	101.29	43.86	117.05	64.32	147.51	99.44	197.66	160.97	492.32	196.54
Marijuana	0.60	6.03	3.73	1.19	4.37	4.27	3.51	12.15	8.01	18.17	13.82
Amphetamines	1.38	5.32	11.58	18.70	9.07	20.12	22.14	22.20	24.78	71.26	79.56
Cocaine	0.03	38.14	0.06	0.01	0.04	0.07	0.07	0.12	1.99	1.70	38.58
Heroin	0.03	0.66	1.87	0.68	1.59	16.12	6.45	2.40	1.97	2.88	6.03
Khat	–	39.38	12.60	23.87	88.23	68.11	264.50	249.01	103.94	374.10	348.41
LSD (units)	39	27	337	29	2,541	500	41	323	301	50	2355
Ecstasy (units)	–	–	–	18	–	3,750	1,011	3,062	3,320	17,665	87,393

⁶⁶ Rikollisuustilanne 1999; Annual Statistics of the National Bureau of Investigation, 1999 and 2000.

Table 16. Number of drug seizures in 1993–2000

	1993	1994	1995	1996	1997	1998	1999	2000
Hashish	897	774	1,235	1,312	1,686	1,997	2,259	2,482
Amphetamines	381	415	696	972	1,352	1,641	1,956	2,369
Heroin	39	39	82	145	153	210	342	437
Cocaine				15	16	24	49	40
Ecstasy				52	74	57	159	393
LSD				14	14	...	15	34

The semi-annual statistics on 2001 of the National Bureau of Investigation would seem to indicate that the number of drug seizures will increase by a quarter compared to the previous year. Especially hashish, amphetamine and ecstasy seizures were increasing, whereas heroin seizures seem to have stabilised at the same level as the year before (NBI Newsletter 24 September 2001).

5.3 Price and purity

The price of drugs is relatively high in Finland, many times higher than e.g. in the Netherlands, which is the primary source of narcotics imported to Finland. According to the statistics of National Bureau of Investigation in 2000, the street value of cannabis was EUR 8.4–13.4 (FIM 50–80) per gram, amphetamine sold at EUR 16.8–33.6 (FIM 100–200) per gram, ecstasy at EUR 10–16.8 (FIM 60–100) per tablet, brown heroin at EUR 135–302 (FIM 800–1,800) and white heroin at EUR 168–336 (FIM 1,000–2,000) per gram. Interviews conducted in Helsinki suggest that the price of hard drugs has dropped in the 1990s, whereas cannabis has more or less remained at the same level. The nightmare scenario of wide-scale import of cheap heroin from St Petersburg is still a risk factor; nevertheless, relatively few drug seizures were made at Finland's eastern border at the beginning of 2001.

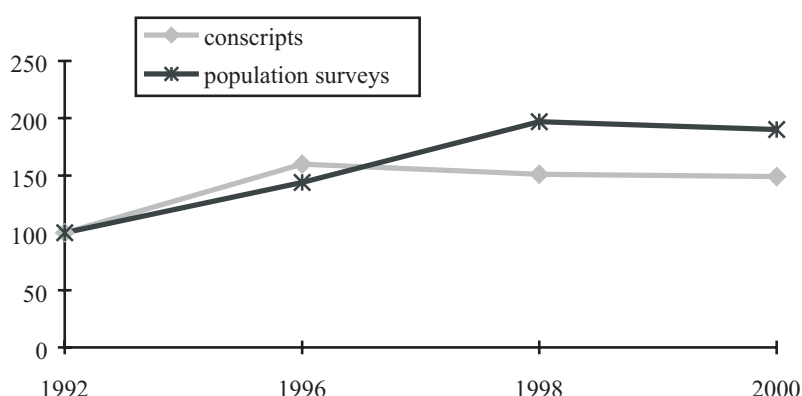
The purity of amphetamine and heroin is regularly tested in Finland by forensic or customs laboratories. Small quantities of cannabis need not to be tested if the suspect has confessed and there is no ambiguity over the substance. The quality of drugs in the street varies much. In 2000 (1997), the average purity of the amphetamine seized was 46 per cent (55 per cent) and 38–73 per cent (50 per cent) for heroin. Over a longer period, the average purity has been about 35 per cent. (CND – Finnish answer.)

6 Trends per drug

6.1 Cannabis

According to the 2000 data, 9.3 per cent of 16–69-year-olds had experimented with cannabis at least once during lifetime (11.7 per cent of men; 7.0 per cent of women). The proportion of those having experimented with cannabis during the past year was 2.0 per cent, which in the corresponding population means approximately 60,000–110,000 people who have used cannabis in one year. The proportion of those having experimented with cannabis during last month was 1.0 per cent. Cannabis experiments have developed during 1992–2000 as shown in the figure below.⁶⁷

Figure 20. Trends in the lifetime prevalence of (experimental) cannabis use in 1992–2000 (1992 = 100)

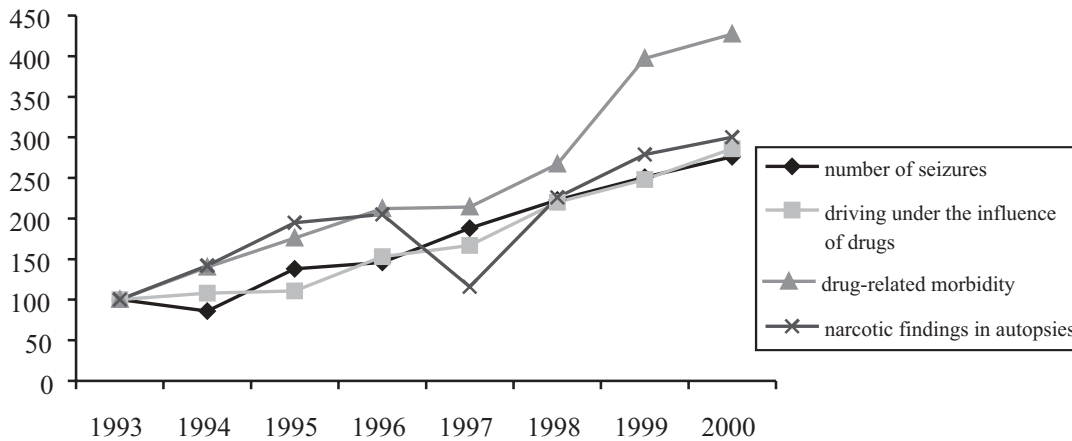


Correspondingly, cannabis-related harm (cannabis seizures made, driving under the influence of cannabis, cannabis-related morbidity and cannabis findings in autopsies)⁶⁸ have developed as follows (1993 = 100):

⁶⁷ Numerical values for this Figure are in Table 3 in Chapter 2.2.1 (population surveys) and in Figure 4 in Chapter 2.2.2 (conscript surveys).

⁶⁸ Indicators of the negative effects of substances are derived separately from drug-specific information in this report: narcotic findings in autopsies (Chapter 3.2, Figure 7), morbidity (Chapter 3.4, Figure 10), driving under the influence of drugs in road traffic (Chapter 4.2.3, Figure 17) and number of seizures (Chapter 5.2, Table 16).

Figure 21. Trends in cannabis-related harms in 1993–2000* (1993 = 100)

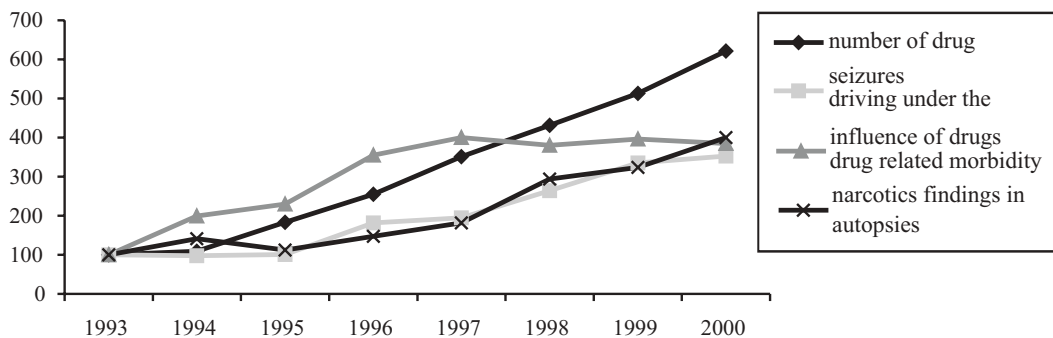


* = Preliminary information on 2000

6.2 Synthetic drugs (amphetamine, ecstasy, LSD)

A study on the prevalence of hard drugs was conducted in 2000, suggesting that Finland had an estimated 7,630–13,050 amphetamine users in age group 15–55-year-olds in 1998. Estimates indicated that women accounted for some 20–30 per cent of amphetamine users. The estimates made on the basis of 1999 preliminary information are in line with these figures.⁶⁹ Correspondingly, the harmful effects associated with amphetamine have developed in 1993–2000 as shown below (1993 = 100). There are no equivalent and comparable time series for ecstasy or LSD – except concerning drug seizures.

Figure 22. Trends in amphetamine-related harms in 1993–2000* (1993 = 100)



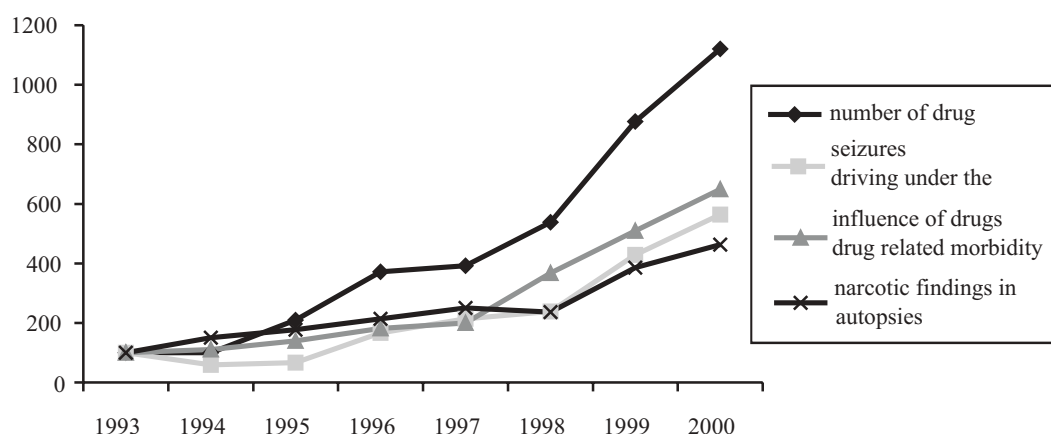
* = Preliminary information on 2000

⁶⁹ See Chapter 2.3.

6.3 Opiates/Heroin

According to the 2000 study on the prevalence of hard drugs, Finland had an estimated 1,800–2,660 opiate users in age group 15–55-year-olds in 1998. Based on the estimate, women accounted for about 25–50 per cent of opiate users. There seems to be some increase in the estimates made on the basis of 1999 preliminary information.⁷⁰ The harmful effects of opiates have developed in 1993–2000 as follows (1993 = 100):

Figure 23. Trends in opiate-related harms 1993–2000* (1993 = 100)



* = Preliminary information on 2000

6.4 Cocaine

Cocaine is often associated with ‘recreational use’, which may partly explain why this substance cannot be made visible by indicators measuring (severe) adverse effects of drug use. On the other hand, the use of drugs (other than cannabis) is so rare in Finland that population surveys cannot accurately reflect it. Therefore, no reliable time series on cocaine are available. Based on the latest police statistics, the number of seizures has decreased in a year, although the amounts in kilos are tenfold because of one major seizure.

6.5 Polydrug use

Finnish substance abuse is characterised by polydrug use. The 1999 and 2000 drug treatment pilots collected information about clients in treatment for substance abuse, who were problem users of narcotics or medicines - with or without alcohol. The result was that when the primary substance and possibly two additional substances were examined, it transpired that almost 60 per cent of the drug clients in the pilot had at least three substances on record and almost 85 per cent

⁷⁰ See Chapter 2.3.

abused at least two substances. In terms of diseases linked to narcotics and medicines, polydrug use has increased steadily.⁷¹ More than one substance finding was also involved in over 50 per cent of all drug-related deaths (based on forensic findings) and in cases of driving under the influence of drugs.

As regards abuse of medicines for intoxication purposes, information about the use of sedatives and tranquillisers has been collected as well. Based on the 2000 survey data, 4.5 per cent of 16–69-year-old men and women had used medicines for non-medicinal purposes at least once during lifetime and 1.5 per cent during the past year. Some 1.8 per cent of the Finnish population had experimented with inhaling solvents or glues during lifetime, but only 0.3 per cent had done so during the previous year.

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

Traditionally, abuse of medicines coincides with alcohol use. A recent development (noticed e.g. in deaths by an overdose) is mixing sedatives, possibly prescribed for medicinal purposes, with heroin.

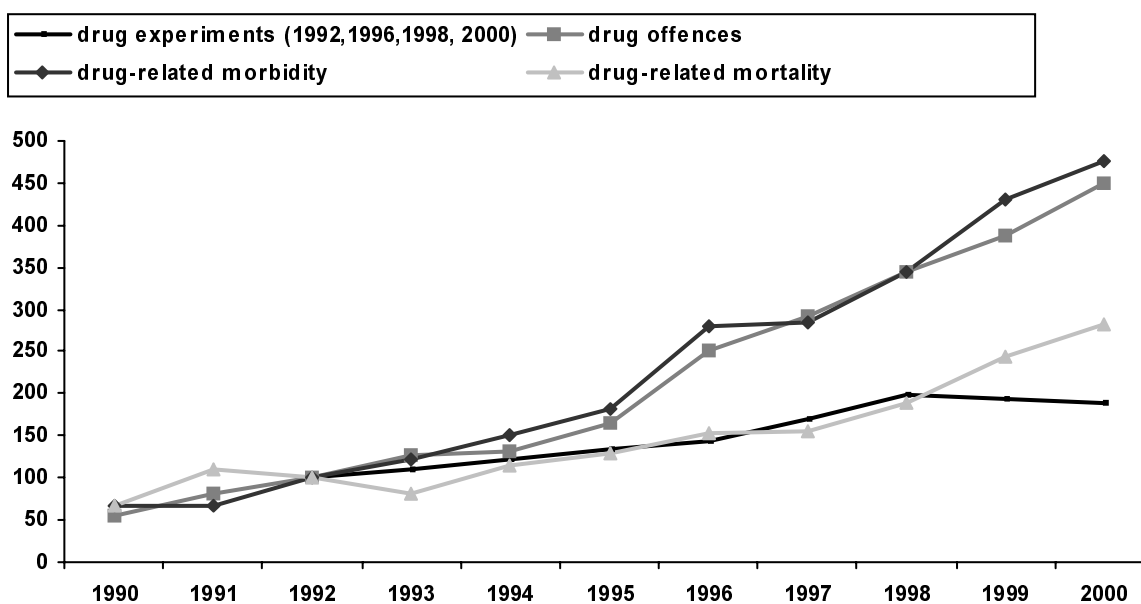
⁷¹ See Chapter 4.2.

7 Discussion

7.1 Consistency between indicators

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

Figure 24. Trends in drug experiments and related harms in 1990–2000* (1992 = 100)



* = Preliminary information on 2000

Drug offence = Persons suspected of a narcotics offence in the statistics of the National Bureau of Investigation (Figure 14); **Drug-related morbidity** = Drug-related diseases according to primary and secondary diagnosis in the health care registers of STAKES (Figure 10); **Drug-related mortality** = Drug findings in autopsies, according to the Department of Forensic Medicine, University of Helsinki (Figure 7); **Experiments and use** = Persons having experimented with cannabis at least once, according to population surveys (Table 3).

While the methods do not allow direct comparison, this “slowing down” -interpretation is supported by school health surveys from 1999 to 2001 and estimates of problem users, which have not changed much since the mid-1990s. It remains to be seen whether this is a random phenomenon or the possible first sign of a new trend.⁷²

Even if the growth in drug experiments, having started in the early 1990s, were levelling off, harmful effects will clearly follow an up-trend because e.g. in demand for treatment, the adverse effects of problem use seem to surface with a delay of 3–5 years after the first experiments and regular use. Looking back five years, drug experiments were rapidly growing in Finland. On the other hand, it should be noted that one important reason for the relatively steep growth in harm indicators has to do with their levels in the 1990s that were exceptionally low in international comparison.

There is one positive aspect of harm indicators, too: the number of new HIV infections through intravenous drug abuse seems to be slightly decreasing. Nevertheless, 1,600–1,700 new hepatitis C infections are still reported annually.

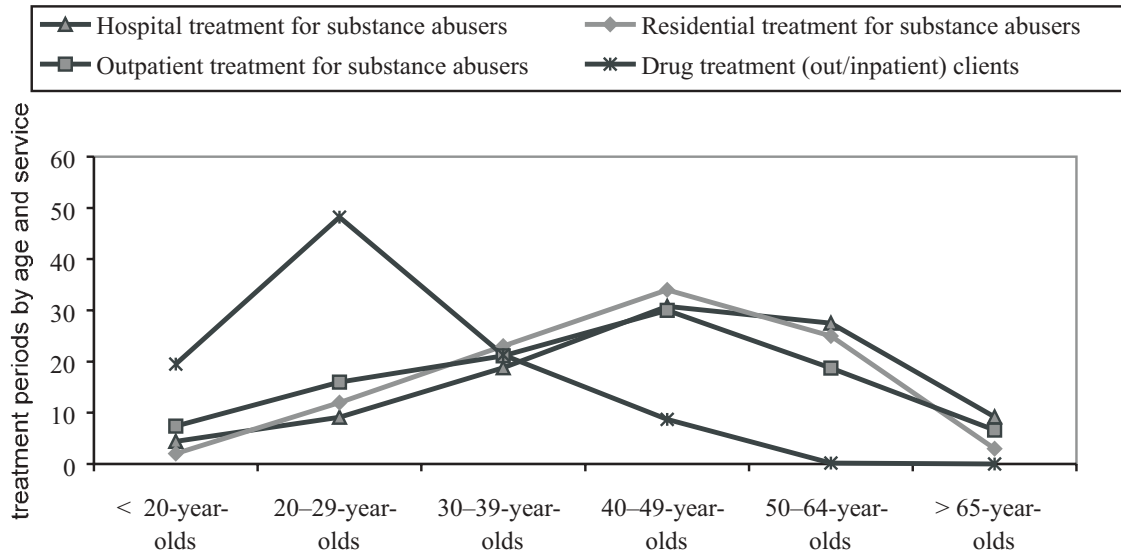
Different substances are manifested in the statistics in different ways. For instance, statistics on health care and substance abuse services show the harm of ‘hard drugs’, amphetamines and opiates, in particular: drug-related morbidity, infections and deaths. In crime statistics, a key role is played by cannabis, although amphetamine is rapidly increasing its proportion of the number of seizures made. At present, cocaine and ecstasy are reflected only in the Finnish crime statistics.

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

While all indicators show that the Finnish substance abuse problem revolves around alcohol, there are three factors that are alarming about the problematic use of narcotics: the above-mentioned rapid growth of drug-related harm, increasing exclusion of problem drug users – which is seen in their position which is even more marginalised than that of other substance abusers or criminals – and the fact that these problems typically concern young people. The latter phenomenon is reflected in the Figure on hospital and drug treatment statistics, shown below:

⁷² This Chapter is based on two articles: Virtanen, Ari 2001(a) and 2001(b).

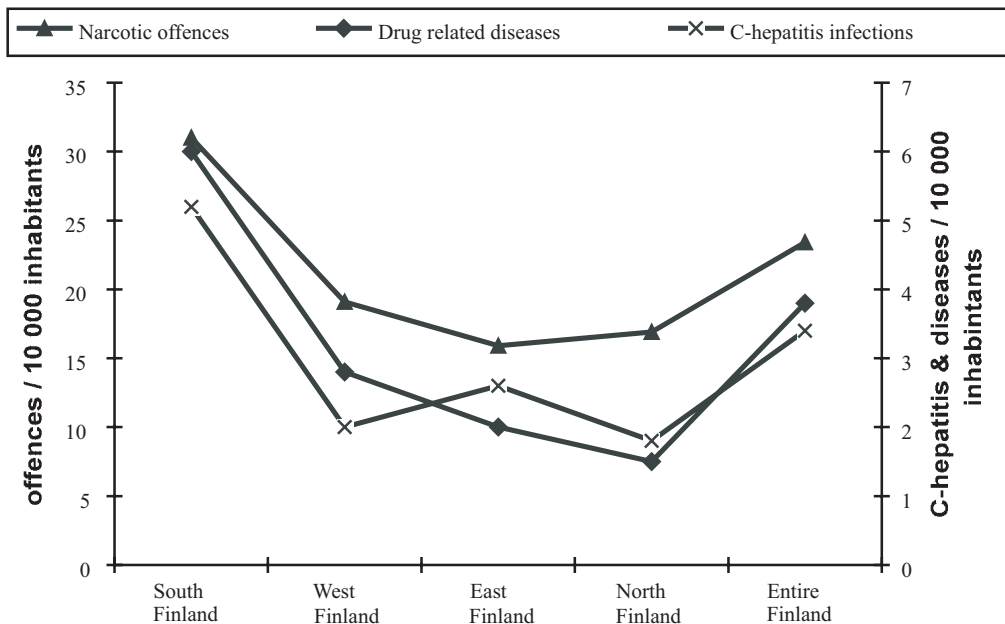
Figure 25. Age structure of substance abuse clients in health care institutions and services for substance abusers in 1999⁷³



The age distributions also show that in 1999, half of the suspects in drug offences were aged 15–25 (National Bureau of Investigation 2000). In addition, half of those having died of heroin poisoning were under 25 years of age (Vuori 2000a), and over half of hepatitis C infections were diagnosed in people under 30 years of age (Kansanterveys 4/2000, Partanen, A. 2000b).

Geographically, drug-related harm is spread all over Finland in the same way as drug experiments and use: Southern Finland and major cities predominate in drug use and drug-related harm as well.⁷⁴

Figure 26. Drug related harms by region in 1999



⁷³ Outpatient services calculated on the basis of clients (up to age group over 60-year-olds) (Hein et. al. 2001c).

⁷⁴ Cf. Chapter 2.2.

Even if the 1990s growth in drug experiments were levelling off, harmful effects will increase because, e.g. in demand for treatment, the negative effects of problem use seem to accumulate with a few years' delay. In the long run, an increase in the prevalence of drug use in the 1990s also reduced regional prevalence differences, a fact that has a direct impact on the spreading of drug-related harm throughout the country.

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

7.2 Implications for policy and interventions

The rapid growth of drug use and the related effects have hastened the development of local and national drug strategies. In 1998, the Government Decision-in-Principle on drug policy was outlined to serve as a frame of reference in national strategic planning, including a draft for a national research programme – but no specific research programme was implemented in 2000. An inter-administrative working group was established to implement and monitor the Decision. In 2000, the Finnish Government upgraded the priority of drug issues and decided to enhance the Decision-in-Principle.

Many local drug strategies have been drawn up since 1998 to prevent and address drug problems. There are at least ten regional drug strategies,⁷⁵ including the four largest Finnish cities (Helsinki, Espoo, Tampere and Turku).

The strategies usually aim at a well-balanced approach, where both drug demand prevention (Part III) and supply reduction (Part IV) are taken into account. In addition, the State Provincial Offices have included the drug question in their regional assessment of basic services provided by municipalities.

Drug research has endorsed public drug debate and decision-making, especially through research reports and statistics on drug use prevalence among the youth and adults, drug offences and seizures, drug treatment demand, heroin deaths and the HIV epidemic caused by intravenous drug use.

In support of the decision-making process, a committee appointed by the Ministry of Social Affairs and Health in autumn 2000 submitted its report on preventing young people's drug use. In the spring of 2001, possibilities to prevent expanding drug crime were improved by introducing new ways of combating it (fictitious purchase and covert operations) and by intensifying the methods already in use (technical surveillance and supervision, collaboration to forestall money laundering).

Drug-related health risks have been prevented by promoting infection risk counselling and exchange of hypodermic needles. Since 1997, a nationwide substitution treatment system has been developed for opiate-dependent clients. In summer 2001, a working group appointed by the Ministry of Social Affairs and Health produced its report to develop the national drug treatment system further.

⁷⁵ Cf. <http://www.stakes.fi/neuvoa-antavat>.

7.3 Methodological limitations and data quality

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

In the 1990s, Finland had regular surveys targeted at schoolchildren, young people, conscripts and the general population. The data on drug use among conscripts span almost three decades.

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

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

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

Part III

Drug demand reduction interventions

8 National strategies in demand reduction

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

Drug demand reduction – especially prevention, drug legislation and the relevant social and health services – belongs to the domain of the Ministry of Social Affairs and Health, while educational, youth, cultural and sports issues are administered by the Ministry of Education. The Ministry of the Interior is in charge of the strategic planning concerning the police.⁷⁶

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

The Finnish municipalities have a relatively extensive autonomy. By law, the municipalities are responsible for providing intoxicant abuser services and temperance work to meet local needs.⁷⁷ The municipalities plan and pursue local intoxicant policies based on inhabitants' needs and rights stipulated by law. They are also responsible for the use of State subsidies, municipal taxes and other revenues.

Civic activities in Finland have a long tradition in complementing the public system. Preventive drug work is done by many non-profit-making general organisations and organisations specialising in public health or substance abuser services.⁷⁸

8.1 Major strategies and activities

At the end of 1998, a Government Decision-in-Principle on Drug Policy (1998) was issued, containing a draft proposal for a drug research programme. The decision was based on the proposal for a national drug strategy drafted in 1997 by officials and experts in the Drug Policy Committee (Drug Strategy 1997). The decision concluded that, in order to combat drug use and distribution of

⁷⁶ See Appendix 1: Organisation chart of drug administration in Finland.

⁷⁷ See the Act on Welfare for Substance Abusers (41/1986), Section 3 and the Temperance Act (828/1982), Section 4.

⁷⁸ See Appendix 4, Actors in demand reduction.

drugs, general socio-political measures are needed along with drug-specific demand and supply reduction activities.⁷⁹ Demand reduction actions are divided into preventive work as well as treatment and support provided for substance abusers and their close persons.

In order to clarify implementation of the 1998 Decision-in-Principle, the Government on 5 October 2000 made second Government Decision-in-Principle to enhance drug policy (2000).⁸⁰ The social welfare and health care target and action plan for 2000–2003, approved by the Government on 28 October 1999, is still in force, outlining developmental objectives, the necessary recommendations and implementers in social and health services.⁸¹

Preventive work and early intervention

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

1. New approaches will be developed to drug education so that:
 - The use of existing programmes on alcohol and drug education in school will be evaluated.
 - Telematics services to prevent drug use will be developed.
 - The role of the school in local network co-operation for young people's drug prevention will be developed through education.
 - Drug and other intoxicants issues will be integrated into the curricula, subjects and the daily activities in comprehensive school, upper secondary school and vocational institutes.
2. In order to promote early intervention in drug problems and to encourage staff to intervene through experience and adequate knowledge of useful working methods:
 - Courses dealing with drugs and educational material will be provided for the vocational and further training of staff working with drug issues.
 - Preventive work will be intensified by increasing the professional skills of personnel working with young people and by promoting multiprofessional co-operation.
3. A committee will be set up to make proposals for preventing drug use among young people and reducing the detrimental effects of abuse, taking account of, in particular, new synthetic drugs, the special needs of immigrants and the most vulnerable groups.
4. Local projects will be launched to support early intervention in young people's problems. Methods to identify and prevent substance abuse among children will be introduced through the student welfare services, based on parents' support.

One aim of the target and action strategy for social and health services, approved by the Government in 1999, is the prevention of substance abuse problems. Prevention will be done, e.g. through regional workers appointed by municipalities to promote preventive drug work in the locality

⁷⁹ For the supply reduction strategy, see Part IV.

⁸⁰ See Chapter 1.2.

⁸¹ See Chapter 1.1.

through multiprofessional collaboration, to co-ordinate local or regional intoxicants strategy and to act as conduits for information between the municipality and various organisations.

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

- In liaison with the Ministry of Social Affairs and Health, organisations will launch a nationwide information campaign to encourage debate about young people's drug use and to emphasise parents' and local actors' responsibility for prevention.
- The nationwide campaign will be complemented by local campaigns.
- Support will be given to the regional co-ordinators in charge of municipal substance abuse work
- Drug prevention will be developed through young people's workshops and together with local youth departments. Risk groups will be given activation and rehabilitation courses together with youth centres.
- The police will give preventive counselling, especially to young people, through basic police work and community policing and in concert with other drug enforcement authorities.
- Supported by the Ministry of Social Affairs and Health, municipalities and drug work organisations in the Greater Helsinki Area will develop local methods of early intervention.
- School staffs will be trained in prevention and to detect students' possible drug use at an early stage.
- Preventive material will be produced for schools.
- Further education for social welfare and health care professionals will be launched to enhance awareness of drugs.

Care of abusers and support for their families

The care and treatment of drug abusers is based on the general principle observed in Finnish social and health services to provide all citizens with the services they need. The aim of welfare for substance abusers is, on the one hand, to prevent and reduce substance abuse and, on the other hand, to minimise related social and health harms, as well as to promote the functional capacity and security of abusers and their families. The abuser is entitled to good medical care and a confidential specialist-client relationship. However, the treatment of drug abusers is made difficult by their changeable motivation and short attention span. Abusers should therefore be offered flexible access to care. The Government Decision-in-Principle on drug policy from the year 1998 incorporates the following approaches to reach this goal:

1. Referral to treatment and care services for drug abusers outside consulting hours is provided by emergency units of health centres and hospitals, joint emergency services of social welfare and the police, in larger population centres by detoxification centres and by special out-patient clinics operating on a 24-hour basis. These services will be expanded.
2. The quality of care required by the Act on Welfare for Substance Abusers has to be ensured equitably throughout the country. The possibility of introducing a system of equalising costs between municipalities in drug treatment will be studied within social services, similar to that already applied in specialised hospital care.

3. Detoxification and substitution therapy will be provided to meet the present needs, observing the Ministry of Social Affairs and Health regulation on the treatment of opiate addicts.
4. The Ministry of Social Affairs and Health will examine the provision of care for pregnant women using drugs and give proposals for its development. In addition, the core idea of the Child Welfare Act and its possibilities to help young substance abusers will be put into practice more widely. The supply of child welfare services based on voluntary procedures will be promoted.
5. Drug prevention in prisons will be developed so that new drug users are not recruited, and drug use does not continue during imprisonment. The amendment to the law on criminal sanctions aims at intensifying drug control in prison. The prison administration directives will be altered to define guidelines for combating drug crime, to prevent harms resulting from drug use and to support inmates in their pursuit of lifestyles free from crime and drugs. The continuity of this support upon release will be ensured together with parties outside prison.
6. Models of action will be developed further and introduced that prevent the spread of communicable diseases and promote the integration of abusers into the service system. The services will be expanded so that they are accessible to the extent needed.
7. A system will be created, whereby those subject to measures by the police are offered expert help in order to assess their situation and to refer them to treatment.
8. The special needs of drug abusers will be taken into consideration in the development of existing services by intensifying personnel training. Low-threshold services, day activities and housing services for the excluded will be launched and expanded, and support persons and supportive services will also be provided.

In terms of the development and accessibility of care, the Government Decision to intensify drug policy in 2000 suggests the following:

- The Ministry of Social Affairs and Health has nominated a working group to make proposals for developing substance abusers' treatment and access to care.
- Emergency health care personnel will be given further training.
- In order to implement detoxification, maintenance and substitution treatment of drug users, further training will be provided for personnel in units engaging in this type of care.
- The system of monitoring treatment services for abusers of narcotics and medicines will be developed.
- Drug rehabilitation in prison will be increased to reintegrate prisoners into society and to reduce recidivism.
- Co-operation with local authorities will be enhanced in order to ensure the continuity of rehabilitation and support for a drug-free lifestyle after prison.

8.2 Approaches and new developments

Demand reduction policy during the year has been a continuation and result of the 1998 Government Decision-in-Principle on drug policy and its implementation. The new approaches are linked to the ideas put forward in the Decision.

The main issues on demand reduction emerging during the year included the prevention of young people's alcohol and drug use, measures to strengthen a low-threshold approach to treatment, assessment of the need for treatment and developing ways of responding to it as well as a harm reduction approach to treatment.

As for the first issue, the multisectorial committee for preventing young people's drug use, appointed by the Ministry of Social Affairs and Health, submitted its report on 9 October 2000. The committee made nine principal statements (Report of the Committee for Preventing Young peoples' drug use), including 49 recommendations for action. According to these statements:

- (1) The multifaceted nature of drug prevention strategies must be stressed, and because the drug situation varies across the country, municipalities must develop approaches integrated into local conditions.
- (2) From the viewpoint of drug prevention, support for the structures of the welfare state is of paramount importance, and this means that the development of societal equality must be actively embraced and youth unemployment must be reduced. In addition, treatment services and their development constitute excellent drug prevention.
- (3) Along with control and supervision, more attention should be paid to reducing harms related to drug demand and use.
- (4) Professional skills and other expertise of prevention done by authorities and non-governmental organisations should be greatly increased, with support for young people's independence, self-determination and activity as key objectives.
- (5) Collaborative structures must be further strengthened to develop local official and unofficial co-operation and networking, to listen to young people's viewpoints and to make efficient use of resources.
- (6) It is important to increase resources to enable collaboration between administrative branches and to make sure that project activities are translated into everyday practices.
- (7) Because there are many types of narcotic substances, an effort should be made to provide adequate factual, realistic and believable information not only about drugs and risks of different drugs but also about their links to (international) crime and inequality.
- (8) The general public and members of the media should be encouraged to assume responsibility, to grasp the complex nature of the drug situation and to avoid stereotyping. There should also be room for opinions critical of drug policy.
- (9) The co-ordinating role of the Ministry of Social Affairs and Health in drug prevention should be fortified by reinforcing the position of the drug policy co-ordination group. Also the role of the Ministry of Education should be solidified in drug prevention both nationally and internationally. In the domain of the Ministry of the Interior, drug prevention should be developed as part of legal education.

Drug treatment and the prevention of drug-related harms were discussed at the consensus meeting on treating drug dependence in Finland, organised by the Academy of Finland and the Finnish Medical Society Duodecim in 1999.⁸² Based on the questions raised at the meeting, the Ministry of Social Affairs and Health appointed a working group in spring 2000 to explore the question of developing treatment for drug abusers. The working group submitted its findings on 1 June 2001

⁸² See <http://www.duodecim.fi/koulutus/konsensuskokoukset>.

(Report of the Committee for developing treatment system for drug abusers), proposing, for example, the following actions:

- (1) In terms of drug treatment systems,
 - municipalities should draw up a treatment strategy concerning problem drug use in their area and integrate the strategy into their general intoxicants and welfare programmes;
 - basic social and health services are mainly responsible for providing treatment and other services for substance abusers;
 - personal service counsellors should be assigned for severely drug dependent clients to ensure adequate care and its monitoring;
 - in addition to basic tasks, mental health care units should, as agreed, provide pharmaceutical care and detoxification treatment for psychiatric patients and to give psychiatric work guidance and consultation;
 - the Ministry of Social Affairs and Health should establish a collaborative body to follow domestic and international developments in treatment for substance abusers and to co-ordinate training in the treatment of drug dependence;
 - the availability of pharmaceutical therapy for opioid-dependent patients should be increased and queues to treatment assessment should be shortened, which requires that treatment is made available to a larger number of clients and that treatment periods already commenced should be transferred to local units of primary health care and specialised drug treatment services;
 - the availability of drug-free therapy for drug problems should be improved through training in treatment models for specialised substance-abuse service, social welfare and health care units;
 - co-operation between the police, prosecutors and social work should be upgraded already at the preliminary investigation stage, especially as regards drug offences involving under-age suspects;
 - the time spent in prison should be utilised by organising action programmes advancing lifestyles free from drugs and crime and by preventing drug-related infectious diseases.

- (2) In terms of training in drug treatment,
 - training in drug treatment should be provided both locally and centrally, and it should be made available not only to professionals working with substance abusers but to others as well;
 - annual seminars or consensus meetings should be held on current issues, such as the medicinal treatment of opioid-dependent clients;
 - to intensify and organise training in the treatment of problem users, an expert network should be established, co-ordinated by the above-mentioned Ministerial body.

- (3) In terms of drug treatment financing,
 - for organising treatment of problem drug users, an annual EUR 8.4 (FIM 50) million of additional State funding should be allocated for the next 5–10 years; this arrangement also requires an additional municipal investment of EUR 25 (FIM 150) million per year;

- the system of equalising substantial costs in specialised health care between hospital districts is suggested to be applied to drug clients, so that municipalities would agree, when necessary, to apply this system to psychiatric specialised health care and mental health work;
- professional assessment of treatment need among drug abusers, carried out in social services, and decision to implement treatment should be delegated to the same parties;
- legislation on sick insurance rehabilitation allowance should be amended so that also unemployed problem users could receive rehabilitation allowance for the duration of treatment, as specified by the Act on Welfare for Substance Abusers.

(4) In terms of legislation on drug treatment,

- stipulations of the Act on Welfare for Substance Abusers, obliging the municipalities, should be amended to specify the joint responsibility of social and health services for organising substance-abuse services;
- preconditions for involuntary treatment based on health hazards in the Act on Welfare for Substance Abusers should be clarified;
- the Act on Welfare for Substance Abusers should stipulate further regulations concerning the medicinal treatment of opioid-dependent clients;
- the provision for authorisation in the Act on Welfare for Substance Abusers should be rephrased so that regulations on the content and organisation of treatment could be issued by a Decree or Order of the Ministry of Social Affairs and Health;
- it is necessary to stipulate an obligation for health centre physicians to instigate involuntary treatment based on health hazards, as prescribed by the Mental Health Act;
- serious drug dependence should be interpreted as a severe mental health disturbance, as defined in the Mental Health Act, which, if other requirements of the law are met, justifies the involuntary treatment of those under 18 years of age.

The newest Intoxicant Barometer (Päihdebarometri 2001) was published in the national seminar on substance abuse in September 2001. This review conveys the visions and experiences of municipal health centre directors and NGOs concerning the substance abuse situation and responses to it in the domains of local authorities and organisations. The Barometer describes events taking place in everyday activities at the moment.

As in previous years, alcohol was considered overwhelmingly the most serious cause of substance abuse problems, but also narcotics are gaining more ground. It was estimated that drug problems are predominantly localised in urban areas. A fifth of health centre directors working in urban municipalities were of the opinion that drugs cause more problems than alcohol, whereas the corresponding proportion in sparsely populated and rural areas was as low as three per cent.

Most health care directors regarded increasing insecurity as a major problem in their locality, and the number of NGO leaders agreeing with them had grown. Insecurity was reported a problem in urban areas, in particular. Wide coverage of drug crime in the media may have in part been conducive to feelings of insecurity.

Intoxicants education in school, enhancement of general living conditions and control by the police were considered the most important avenues of substance abuse prevention; the importance attached to police control and living conditions had increased from the year before. While strict drug laws were not perceived crucial to prevention, NGO leaders' opinions of the significance of

strict drug laws had become clearly more prevalent, while medical directors took a more liberal stance than before.

The majority of medical directors assessed that substance abuse services will remain at the present level rather than increase. On the other hand, local authorities, who had expanded their services, were of the opinion that this increase will continue, especially as regards services directed at drug users, i.e. treatment and health counselling. This was particularly the case in urban municipalities.

Concern about increasing costs due to drug-related illnesses and about insufficient economic resources has grown since last year. The increase in child protection and family clinic activities related to substance abuse worried both NGO leaders and medical directors in 2001. Medical directors' concern about law enforcement and drug control costs had increased considerably (14%) from the year before.

Despite the new services for drug users, it is important that a broad spectrum of services for substance abusers are developed, since people with alcohol problems still constitute the largest group of substance abusers in Finland.

9 Intervention areas⁸³

During the past year, action models in drug work were discussed from a variety of viewpoints in three nationwide seminars (the Finnish Medical Convention, the Social Welfare and Health Care Trade Fair, TERVE-SOS, and the National Seminar on Intoxicants) and one international seminar held in Finland (the INCR seminar discussing opiates and related dependence).

In January was held the nationwide Finnish Medical Convention (2001), an annual forum for further education and specialisation for physicians, organised by the Finnish Medical Association. The medical seminar was staged in Helsinki, but drugs have been widely debated in regional medical seminars as well. The topic 'Drug use expands – any answers?' was discussed as a part of specialisation in addiction medicine and general-hospital psychiatry, and 'Intoxicating substances and pregnancy' was a part of further training for maternity and child welfare clinicians, obstetricians, paediatricians and doctors specialising in substance abuse. The aim was to convey various views on the drug problem comprehensively and to present an up-to-date overview of the treatment methods studied on the one hand, to help recognise mothers with drug problems and to increase information about their care and follow-up and about the effects of substance abuse during pregnancy on the health of the newborn. The symposia that were open to all physicians discussed narcotics under the rubric of 'Pharmaceutical treatment of opiate-dependent patients'. This symposium presented the new Decree on the detoxification, substitution and maintenance treatment of opioid-dependent clients and the first experiences of implementing it and of constructing treatment programmes. The symposium also presented a new study project on buprenorphine-naloxine treatment.

Organised annually in May by STAKES and a collaborating city, the venue for the training and trade fair event for social welfare and health care professionals (TERVE-SOS 2001) was Kuopio in 2001, with 'new welfare responsibility' as its theme. As regards drugs, the seminar discussed the topic 'Alcohol and drugs as a local and national problem'. On a local level, special attention was paid to the drug deaths in Turku, Western Finland, and in Kuopio and elsewhere in Eastern Finland and to the ways of intervention regionally: in Turku, drug poisonings have increased considerably since 1998,⁸⁴ but the two heroin deaths occurring at short intervals in Kuopio in 1999 have not been repeated since. Both studies emphasised the risk of combining opioids (especially heroin) and anxiolytics or tranquillizers (benzodiazepine) as a cause of death by poisoning.

⁸³ In the present report, the theme-specific discussion of action models differs from the previous years. In the former reports, separate undertakings were presented as examples of existing practices, whereas in this report isolated projects are mentioned for special reasons only, i.e. if the project is nationally important due to its scope or theme (as indicated in each case).

⁸⁴ For more detail, see Chapter 3.2.

The *National Seminar on Intoxicants* in September is an annual event on prevention and treatment, organised by the Ministry of Social Affairs and Health, the Finnish Centre for Health Promotion and the Co-operation Forum of Treatment Units for Substance Abusers (PÄIVYT).

The agenda of the seminar encompassed the entire Finnish substance abuse field: abuse of alcohol, medicines, narcotics, surrogates, solvents and other compulsive behaviour (dependence on gambling, the Internet, sex, etc). The approach is not substance-specific but involves a comprehensive focus on the dependence phenomena in general.

The 2001 Seminar on Intoxicants had ten sections, and drugs were specifically discussed under the heading 'New trends in treatment of drug dependence'. In addition, the seminar provided a forum for presenting the broad-scale information campaign on drugs of the Finnish Centre for Health Promotion including national and local activities in 2001–2003⁸⁵ and for the publication of a STAKES guidebook on substance abusers' care facilities and the treatment methods employed by them (Pienimäki ed. 2001).⁸⁶

As an example of new trends in treating drug dependence, the contribution of a Swedish working group (SBU) was presented.⁸⁷ The group had drawn up a summary report on evidence based treatment methods for drug and alcohol addicts (Salaspuro 2001). The study results play an important role in the development of Finnish drug treatment system⁸⁸ as well and, for example, the STAKES guidebook on substance abusers' care facilities and their treatment methods is based on the classifications of this study.

The treatment section of the seminar also discussed the recommendations made by the drug treatment working group, reduction of drug-related harms, cognitive therapies, treatment with medicines and drug treatment in prison.⁸⁹ In addition, the seminar conveyed up-to-date information about the drug situation, drug use, problem use, the drug treatment clientele and young people's drug-related diseases and deaths.⁹⁰

In 2001, Finland hosted the five-day International Drug Research Conference (INRC) on 15–19 July. The theme of the Helsinki conference was "opioids and related dependence"⁹¹. In addition to general lectures, special sessions discussed the following topics: Opioids from clinic to chemistry, G-protein receptors and pain, Opioid modulatory peptides, Synthetic ligands, Progress in receptor biology, Opioid addiction and behaviour, Opioids and pleasures of life, and Opioids and immune function

⁸⁵ Cf. Chapter 9.1.6.

⁸⁶ Cf. Chapter 10.2.

⁸⁷ A study in Swedish, see <http://www.sbu.se>.

⁸⁸ The procedures to develop opioid-dependent clients' treatment with medicines (Chapter 9.3.2) are in part based on the evidence base results presented in this study.

⁸⁹ For prisons in more detail, see Chapters 9.5.3 and 18.

⁹⁰ Corresponding information supplied in subsections in Part II.

⁹¹ Cf. <http://www.biocenter.helsinki.fi/inrc/inrc2001/>.

9.1 Prevention

9.1.1 Infancy and family⁹²

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

The Federation of Mother and Child Homes and Shelters⁹³ is a child welfare organisation, whose goal is to ensure children's right to a favourable and safe development, to support parenthood and families and to prevent violence in the family. The 26 member organisations have 12 homes for pregnant women or mothers with a newborn and 13 shelters for persons facing violence in the family. By the end of 2000, there were two special homes for pregnant women or mothers with substance abuse problems.

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

A central principle of substance abuse work directed at young people is to involve families in all multiprofessional substance abuse work at the earliest stage possible, whether it takes place in school, in a wider context of youth work or in terms of community programmes. To support these activities, the A-Clinic Foundation published a popular drug guidebook for parents. The purpose of the publication is to dissolve the mystical aura surrounding drugs and to encourage parents to discuss substance abuse with their children (Huolesta puheiksi, puheista teoiksi).⁹⁴

9.1.2 School programmes

Drug education in school traditionally involves disseminating information, often as a part of health education on intoxicant-free lifestyles or as a part of legal education. As awareness of drugs is rapidly increasing in society, more resources are directed at media education. There is a shift from a traditional preventive approach towards health promotion through experiencing and participation.

Schools work against drugs by improving the curriculum, student welfare services and networking as a part of prevention at a local level, with pupils and parents as major contributors. Thus, many schools try to devise comprehensive methods of intervening in substance abuse

⁹² See also Chapter 9.6 (paragraph Support for children of drug users).

⁹³ See <http://www.ensijaturvakotienliitto.fi/2toiminta/6hoito.html>.

⁹⁴ See also <http://www.a-klinikka.fi/>.

problems. Because the school cannot act alone, the assistance of official and expert bodies is needed.

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

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

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

To support the school syllabus reform as well as multiprofessional co-operation in school, the 'Information package on drugs' and 'Procedures for upper secondary and vocational schools in antidrug work' were produced in 1997.⁹⁵ The updated and enlarged edition of the information package on drugs was published in 2001, including a constantly updated Internet service (Suomi ja huumeet).⁹⁶ Also serving as a textbook, the information package was made in extensive co-operation with interest groups and it is a tool and background material intended for everybody who needs basic information about drugs. In addition, a report was published in 1998 under the heading *Use of programmes supporting the prevention of substance abuse in school* (Huopanen et. al. 1998). At the beginning of 2001, the project continued in the form of a handbook on co-operation between schools and other actors in drug prevention (Huopanen et. al. 2001). A drug-related web-page for teachers, pupils and parents has also been created.⁹⁷

⁹⁵ *Menettelytapoja lukioille ja ammatillisille oppilaitoksille huumeiden vastaiseen työhön.*

⁹⁶ See 3. update at <http://www.irtihuumeista.fi/huometietopaketti>.

⁹⁷ See URL:<http://www.antidrugnet.org> in Swedish: <URL:<http://www.interdrug.net>>.

9.1.3 Youth programmes outside school

The projects to prevent substance abuse among young people are varied in terms of scope. Workers implementing drug prevention have continued traditional education in schools, PTA meetings and other functions. Sports and youth organisations have also been involved when alternatives to alcohol and drugs experiments or use have been sought. Especially schoolchildren's afternoon activities have been developed in order to promote sports and other activities among juveniles, with a view to enhancing anti-drug work as well. In addition, brief anti-drug projects have been implemented, such as plays and musicals. Such projects are clearly on the increase among young people.

Along with traditional information and education, active preventive and remedial activities have been developed, ranging from clubs to life-management courses spanning several months, with an aim of developing young people's ability to manage their lives. The methods applied include adventure and experience education.⁹⁸ This has made it possible to reach young people who are not susceptible to traditional drug education. Workshops organised for young people have been an important resource, with a possibility of enhancing young people's life-management skills.

For children and young people facing unprotected living conditions, different meeting places (cafés, clubs, shelters) have been established, where it is possible to discuss and alleviate the problems of loneliness, parents' substance abuse and other severe difficulties. A support person may be designated for a young client, or small-group sessions may be arranged for meeting people in a similar situation. New kinds of youth work have also been set up in connection with residents' activities. For example, parents' training groups have been formed in order to distribute information and to discuss approaches to preventing substance abuse. Teams consisting of adults, young people and children have been established for children's and young people's interests and hobbies.

An example of such meeting places, the Walkers youth cafés⁹⁹ provide early intervention, currently operating in 24 localities. An important role in these activities is played by adults, trained volunteers supported by youth work professionals. An effort has been made to develop the youth cafés into safe meeting places, where young people are welcome and can interact individually within the group and with adults. The Walkers activities have set an example for expanding participatory youth work now having started in many localities.

9.1.4 Community (municipal) programmes

Municipal strategies usually cover all substances abused or concentrate on either alcohol or narcotics (Kekki 1998). Especially in small localities, the focus is on alcohol, and only major cities or federations of municipalities have specific drug strategies. A local alcohol and drug programme may also be included in a more extensive municipal programme for the promotion of health and welfare in general. In most cases, the entire population is included, while some strategies only embrace young people and children. An effort is made to set goals that are consistent with the national drug strategy proposal of the 1997 Committee nominated by the Ministry of Social Affairs and Health.

⁹⁸ The activities launched by the Ministry of Education under the International Award Programme (Avartti) as one example (see <http://www.valtakunnallinentyopajayhdistys.fi/avartti.htm>).

⁹⁹ Address and other information about the Walkers cafés at <http://www.asemanlapset.fi/Walkers/Walkers.html>.

The purpose of the municipal strategies or programmes is to chart the local drug situation and the projects underway, as well as to define the targets, actors in charge, timetables and resources of the programmes. There are also inter-municipal, or regional, alcohol and drug programmes. Based on this preliminary work, the development of inter-administrative co-operation as well as new services and treatment alternatives is underway.¹⁰⁰

In May 2000, the National Research and Development Centre for Welfare and Health (STAKES) established an information service package on the Internet for municipalities, presenting municipal drug strategies, drug prevention projects, methods and practices for preventive work as well as links to the virtual library of alcohol and drug publications and to alcohol and drug legislation. The information service package includes also a news calendar, a database of treatment units and statistical tables on alcohol and drugs.¹⁰¹

9.1.5 Telephone help lines

Since 1995, the *drug helplines* of the Free From Drugs association have provided a means of disseminating drug information for early intervention. The helplines operate in the evenings on weekdays throughout the country (22 regional branches, 500 trained volunteers). In addition, nationwide guidance and referral to care are offered by the Drug Dependency Treatment Unit at Helsinki University Central Hospital and, since 1997, at the drug clinic of the Deaconess Institute in Helsinki.¹⁰² The first two of the above-mentioned units belong to the European FESAT drug telephone helpline network, which has 30 units in the EU Member States.¹⁰³

It is increasingly often that the helplines of many other organisations encounter people seeking ways to break free from drug problems involving themselves or a close person.¹⁰⁴ An example of a nationwide service is the helpline of the Poison Information Centre, targeted at professionals and laypersons alike.

For example, the drug helpline of Free From Drugs received some 2,800 (2,600) crisis calls in 2000 (1999), many of which led to further action, such as meetings with close persons. Of the callers, 64 (72) per cent were close persons, while 10 (19) per cent were substance abusers. The phone calls concerned the following substances (2000/1999): cannabis (37/33 per cent), amphetamines (30/25 per cent), heroin (15/9 per cent) and ecstasy (7/7 per cent). (Annual Report 2000) In 1999, the Poison Information Centre received almost 37,000 phone calls, of which less than one per cent concerned narcotics, mostly the amphetamines or GHB. (Annual Report 1999.)

In 1999, a new telephone service was introduced by the A-Clinic Foundation. A mobile phone text message (GSM/WWW) service was incorporated among its telephone service arsenal for assessing blood alcohol level.

¹⁰⁰ The most extensive and comprehensive local drug strategy is that of the City of Helsinki, drawn up in 1997 and updated in 2000, available at <URL:<http://www.hel.fi/sosv/jotu/huumest.htm>>.

¹⁰¹ <http://www.stakes.fi/neuvoa-antavat/>.

¹⁰² In addition to service by telephone, the units of Helsinki University Central Hospital and the Deaconess Institute engage in assessment of care need, referral, short-term follow-up and drug screening.

¹⁰³ At the end of February, the new FESAT guide was published in Finnish, entitled FESAT – perheet ja auttava huumeapuhelin. [FESAT – families and the drug helpline]. International FESAT webpages at <http://www.fesat.org.uk>.

¹⁰⁴ Finnish helplines are at <http://www.asemanlapset.fi/apua>.

9.1.6 Mass media campaigns

A few nationwide drug campaigns have been ongoing during the year. One such campaign was launched during the drug prevention week, including nationwide TV commercials.¹⁰⁵ The autumn of 2001 saw the launch of a broad 'Drug information and local activity campaign 2001–2003' to intensify drug prevention, co-ordinated by the Finnish Centre for Health Promotion in line with the Government Decision of the year 2000. The campaign aims at arousing many-sided and solution-oriented debate about the drug situation and problems, to activate local prevention and co-operation and to stress parents' and local actors' responsibility for the prevention of young people's drug use.

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

The national communications segment started at the end of August in the form of a seminar targeted at members of the media. During the autumn, information will be disseminated in national and provincial newspapers, as TV and radio spots, outdoor advertisements and on the Internet. Advertising will also direct people to visit the campaign homepage, containing information and discussion groups on drug themes.¹⁰⁶

The local campaigns comprise two entities. The larger one contains 13 projects funded by the Ministry of Social Affairs and Health, implementing the above-mentioned objectives. These projects are carried out by organisations, municipalities, research centres and educational institutions. The second entity consists of local activities of the Finnish Health Association NGO and the Finnish Association for Healthy Lifestyles. The former association provides experiences for young people, their parents and youth workers, while the latter organises seminars, discussing the global dimension of drug trade. This entity is financed by the Finnish Slot Machine Association.

Linked to these activities are the six local projects administered by the Finnish Centre for Health Promotion and funded through donations of a private TV company (Oy Ruutunelonen Ab) for anti-drug work. These six projects are implemented by NGOs and municipalities.

In addition to national campaigns, there have been local information campaigns, e.g. launched by organisations in connection with new drug treatment services or local strategies. In addition, educational videos and websites have been created on substance abuse. An effort is made to influence drug information in the media by organising an annual meeting between journalists and bodies doing preventive work, discussing also the possibility to include preventive messages in the programming.

¹⁰⁵ See <http://www.health.fi/paihde/viikko/2000/index2.html>.

¹⁰⁶ See <http://www.puolitotuus.com/etusivu.html>.

9.1.7 Internet services

The Prevnet programme of the A-Clinic Foundation developed modern substance abuse prevention methods based on new technology in 1998–1999. The programme was a result of co-operation between Finnish actors (collaborative network of psychological wellbeing, child welfare and substance abuse work, *Avec*¹⁰⁷) and European partners (the Prevnet Network¹⁰⁸). Co-ordinated by the A-Clinic Foundation, the Prevnet Network project has partners in all EU Member States, several international organisations and countries outside the EU. A project evaluation on the Prevnet-Euro projects (McGourty 2001) and a guidebook for developing telematics services in the field (Tammi et. al. 2000) have been published.

Almost all Finnish organisations in the substance abuse field have modern Internet services.¹⁰⁹ For example, the co-ordinator of the Prevnet project, the A-Clinic Foundation has its own Internet service called the Addiction Link, where people can test their own situation and anonymously ask experts for advice. During the year, the Addiction Link has been supplemented by a test measuring the client's general situation in life and by a Frequently Asked Questions section. Material targeted at educators has been especially added, including a ready-made framework for parent-teacher association meetings and the material of guidebook for parents. One facet of these activities is the Foundation's discussion forum on the web.¹¹⁰

9.2 Reduction of drug related harms

9.2.1 Outreach work

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

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

A new Helsinki-based experiment was the *Viita* field project launched by the A-Clinic Foundation in autumn 2000 among intravenous drug users (Hietalahti et. al. 2001). In the project, four fieldworkers tried to make contact with clients at first through the health counselling centre for IV-drug users, Vinkki, and later, when the users had grown accustomed to the services through peer groups, directly in the field. The method used was mainly counselling, guidance and concrete referral to treatment. During three months in 2000, 71 clients were encountered, a third of whom

¹⁰⁷ See <http://www.avecforum.fi>.

¹⁰⁸ See <http://www.prevnet.net>.

¹⁰⁹ More links at <http://www.makupalat.fi/sospoli5.htm>.

¹¹⁰ More information about the projects at <http://www.paihdelinkki.fi/>. In practice, all major organisations in the field have their own webpages to present their activities. Addresses are to be found on the A-Clinic Foundation's link pages.

were women and a little over a third were aged 25 and over. A third had a regular apartment at their disposal. At the beginning of 2001, the field team started contact café activities in Friday afternoons. There are also plans to arrange peer group training in giving first aid in heroin overdoses, together with the health counselling centre Vinkki. Based on this pilot, further training and peer activities will be planned.

9.2.2 Low-threshold services

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

Traditionally, the hospital and health centre clinics also operate on a low-threshold principle. According to the 1999 one-day census, some 1,200 substance abusers used these services during one day in Finland. (Nuorvala et. al. 2000.)¹¹¹ At drug clinics belonging to the special treatment services for substance abusers, the client either walks in the clinic without referral or is referred by social or health services. The client's physical, psychological and social condition is assessed at the clinic, including a previous history of abuse and dependence. The assessment is usually made by a multi-professional care team together with the client.

Low-threshold services are also provided by crisis centres in different fields and areas. To complement the traditional service organisations, the Finnish Association for Mental Health has developed a versatile model called *Mobile* to give around-the-clock assistance to municipal residents.¹¹² The units established through the project help residents, their relatives or municipal officials in emergencies. The units are on standby around the clock, complementing municipal services. Clients are directed to municipal services, and assistance is given in sudden crises. By the end of 2000, Mobile units operated in seven municipalities.

The most modern low-threshold service is provided within the telematic services of the A-Clinic Foundation (with anonymous consultancy, self-assessment tests and virtual discussion forums as the latest developments).¹¹³ In 2000, the A-Clinic Foundation initiated a broad development project (Virtual clinic), combining traditional and new telematic services into a low-threshold service. The development of treatment, information, training and R&D services is underway,

¹¹¹ If other outpatient services, mental health clinics and home care are counted, the number of clients is higher by half.

¹¹² Today, assistance provided by the Finnish Association for Mental Health consists of ten first aid and crisis centres, an immigrants' crisis centre, SOS service and its mobile unit (the SOS vehicle), seven Mobile support units and their mobile units as well as the nationwide crisis helpline. Other important links in the chain of assistance are family work as well as experimental and developmental rehabilitation. See <http://www.mielenterveysseura.fi/frameset.htm>.

¹¹³ <http://www.paihdelinkki.fi>.

financed by the Finnish Slot Machine Association. In addition, the A-Clinic Foundation has other telematic projects either ongoing or in planning.

9.2.3 Prevention of infectious diseases

The HIV epidemic, which started in 1998 among Finnish drug users, has underlined in public the importance of preventing infectious diseases spreading through intravenous drug abuse. Also in treatment services, attention was paid to reducing the health hazards associated with drug use. For instance, only a few treatment units for substance abusers engage in needle exchange activities. Formerly, pharmacies sold syringes quite freely, but for security reasons, almost a fourth of them have restricted the sale of syringes. Most pharmacies reported that they refrain from selling syringes to minors. (Harju et. al. 2000a.) In spring 1999, The Ministry of Social Affairs and Health, the National Agency for Medicines, the National Public Health Institute, the Association of Finnish Pharmacies and the University Pharmacy dispatched a recommendation to all pharmacies to sell syringes to drug users as well.

Health (infection risk) counselling services for IV-drug users (including a syringe exchange programme) are underway in 13 municipalities.¹¹⁴ The aim is to provide drug abusers with counselling to reduce behaviour involving infection risk. The visitors, who have an opportunity to exchange their hypodermic needles, are also informed about the risks of using contaminated needles, syringes and other drug paraphernalia as well as about sexually transmitted diseases.¹¹⁵ Also condoms are made available. One important aim is to motivate addicts to seek help and abandon the drug habit.¹¹⁶

Table 17. *Clientele of the Finnish health counselling centres for IV-drug users in 2000*

City/town	Opened	Clients (estim.)
Helsinki	Apr/1997	3,250
Espoo	May/2001	-
Vantaa	Oct/2000	200
Tampere	May/1998	475
Turku	Feb/2000	650
Oulu	Oct/2001	-
Lahti	Nov/1999	under 50
Kuopio	Sep/2000	under 50
Jyväskylä	May/2000	under 100
Kotka	Jan/2001	-
Hämeenlinna	Sep/2000	under 50
Rauma	Jul/2000	under 50
Salo	Jan/2001	-
Total		4,750

¹¹⁴ See <http://www.a-klinikka.fi/yhteystiedot/terveysneuvontapisteeet.html>.

¹¹⁵ In August 1998, the National Public Health Institute drew up an “exclamation mark” leaflet for drug users, with basic information and directions how to avoid infections (20,000 copies). In addition, the Finnish Red Cross produced a guide for professionals in primary health care concerning hepatitis C.

¹¹⁶ It has been estimated that visits to the counselling centre for IV-drug users cost EUR 100–135 (FIM 600–800) per client annually. This means that, from the viewpoint of targeting care, it is economical to serve 150 clients at the counselling centre, if this leads to preventing one opioid addiction needing substitution or maintenance treatment (cf. Chapter 9.3.2).

The oldest health counselling centre in Finland, Vinkki, has operated since 1997 in Helsinki. The clients at this centre were clearly older than drug treatment clients elsewhere: almost half were aged over 30, while the corresponding percentage elsewhere was about 30 per cent. Women accounted for a quarter of the clientele. On average, the clients had visited the needle exchange six times during the year. In 2000, Vinkki in Helsinki took 393 voluntary HIV tests, of which 11 turned out to be positive. Hepatitis tests were also conducted among volunteers, who had not previously had this infection. Of 187 hepatitis C tests, 66 came back positive. During the year, 406 people received some type of hepatitis B vaccination. (Harju et. al. 2001.)

According to a study conducted in 1998–1999, 38 per cent (31 per cent in 1997) of the clients visiting the Vinkki in Helsinki were opiate users, 44 per cent (58 per cent in 1997) used amphetamines and 7 per cent used cannabis (Harju et. al. 2000b). Over 80 per cent of the opiate users were under the age of 30, while only half of the amphetamine users were aged under 30. In practice, all used drugs intravenously, but three-quarters of the opiate users and half of the amphetamine users had engaged in intravenous use for less than ten years. The majority of the opiate users also used buprenorphine intravenously.

During the year of 1999, the National Public Health Institute launched a special project to lower the technical threshold for HIV testing. It included theoretical and hands-on training in the use of near-patient HIV tests and aspects of associated counselling. The programme was aimed at prisons and the needle exchange programme action sites. The Ministry of Social Affairs and Health also sponsored a project that included counselling and support for HIV-infected drug abusers. The activities started in the latter part of the year 1999 in the Greater Helsinki Area.

In co-operation with the infection risk counselling centres, a broad study to follow up risk behaviour among intravenous drug users was launched at the beginning of 2000, planned to last for three years. The project is co-ordinated by the A-Clinic Foundation, in collaboration with the National Public Health Institute and the National Research and Development Centre for Welfare and Health (STAKES), and funded by the Ministry of Social Affairs and Health.

In autumn 2000, the Deaconess Institute in Helsinki opened the Kluuvi service centre in central Helsinki to provide specialised services for drug users with HIV infection in Greater Helsinki. The project involves the cities of Helsinki, Espoo and Vantaa and the hospital district of Helsinki and Uusimaa. The centre provides both daytime activities (meals, hygiene, health counselling and treatment with medicines as well as social rehabilitation) and short-term accommodation, and in the future also long-term support housing services. At the end of 2000, the centre had 50 visitors per day. (Niskanen 2000.)

9.3 Treatments

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

The working group concluded that treatment provision is made especially difficult by an incoherent service system and by shortcomings associated with know-how, attitudes and resources.

In treating severe drug addiction, the primary objective is not freedom from drugs, but a reduction in substance abuse and the prevention, elimination and treatment of related health, social and other harms. Successful treatment requires individual, sustained, many-sided and systematic service chains, to which both the client and the system commit themselves. According to the working group, this calls for considerable changes in methods, skills, attitudes, resources and legislation.¹¹⁷

9.3.1 Treatments and health care on a national level

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

The service system consists of outpatient clinics (A-clinics), short-term institutional care (detoxification centres), rehabilitation units and support services (day centres and supported housing) and self-help groups (NA, Narcotics Addicts Anonymous).¹¹⁸ Along with these specialised services, many primary health care and social service units encounter drug problems (social work, child welfare, clinics and wards at health centres, hospitals and especially mental hospitals). The number of specialised service units for drug addicts is limited, and the units are mainly located in Greater Helsinki and other major cities. Since 1996, Finland has had an *ombudsman institution for intoxicant abusers*, based on nongovernmental organisations. Working in the entire country, it is an interest organisation for treatment clients. (Tervo 1998.)

In addition to information and referral to care, primary health care provides specific services for substance abusers. The health centres are mainly responsible for treating poisonings, illnesses and injuries associated with drugs. They can also provide short-term detoxification. Within specialised health care, the general and psychiatric hospitals treat severe withdrawal symptoms and cases needing special hospitalisation. The mental health clinics care for outpatients in psychiatric illnesses, which may involve substance abuse problems. The regulation issued by the Ministry of Social Affairs and Health assigned in Summer 2000 gave a special role to university and central hospitals in assessing the medical detoxification, substitution and maintenance treatment need of opiate addicts.¹¹⁹

According to the 1999 one-day census of intoxicant-related cases in social and health care services, drug clients accounted for a fifth of intoxicant-related clients in psychiatric services and for a fifteenth in other health services. People abusing medicines accounted for over a quarter of psychiatric intoxicant-related clients and for a sixth of intoxicant-related clients in other forms of health care.¹²⁰

Finland has specialised local outpatient offices (e.g. clinics) in over 100 municipalities. In addition, many municipalities have agreed to purchase services for their inhabitants from a public or private service provider.¹²¹ In 2000, about 46,200 people visited the outpatient clinics for substance

¹¹⁷ The recommendations made by the working group are discussed in more detail in Chapter 8.2.

¹¹⁸ Addresses of special service units are available e.g. at <http://www.aseanlapset.fi/Hoito/hoito.html>, <http://www.stakes.fi/neuvoa-antavat>, <http://www.a-klinikka.fi/osoite.htm>, <http://www.health.fi/paihide/palvelut/selviskalenteri.html>.

¹¹⁹ See Chapter 1.2.2.

¹²⁰ It should be noted that drug or medicine-related cases are not mutually exclusive (Nuorvala et al. 2000).

¹²¹ The A-Clinic Foundation has made such agreements with about 130 municipalities, and many municipal A-Clinics have agreements with neighbouring municipalities, sometimes including 20–30 municipalities.

abusers (75 A-Clinics and 12 youth centres). During the year, 11,200 people used residential treatment services (47 institutions) for substance abusers. Of the outpatients, about 30 per cent were women (45 per cent in youth centres), and clients aged under 30 accounted for about 20 per cent. The proportion of women in residential treatment services (detoxification and rehabilitation centres) was about a fifth, and people aged under 30 accounted for 16 per cent. The treatment periods usually lasted for a week or less, but one fifth of the periods lasted longer than two weeks and the proportion of treatment periods over 3 months was 1.4 per cent (Intoxicants Statistical Yearbook 2001; Social Welfare and Health care Statistical Yearbook 2001).¹²²

According to the one-day census in 1999, drug clients accounted for 20 per cent in specialised outpatient services for substance abusers and for 30 per cent in residential treatment. The proportion of cases related to pharmaceuticals was three percentage points higher in both these services (Nuorvala et. al. 2000).

Finland has an estimated 30 units specialising in problem drug users; these units have a special drug treatment programme. Of them, 13 provide residential detoxification services for problem users, 18 provide withdrawal treatment, and 18 give rehabilitation. Drug treatment periods in detoxification and withdrawal are usually 2–3 weeks, while in rehabilitation the duration is 2–3 months or longer. The units are predominantly located in Southern (13) and Western (9) Finland. The province of Oulu, Northern Finland, has five units. Eastern Finland has three units, but, by contrast to the rest of the country, these units mainly concentrate on rehabilitation. There are an estimated 360–440 beds in institutions for drug treatment. There are six institutions specialising in young substance abusers, with a total of 40 beds. In addition, community homes for youngsters have three units specialising in drug treatment, with a total of 23 beds. Given that an average stay in treatment is three months, this means that 1,440–1,760 problem drug users receive residential drug treatment annually. This is a tenth of the estimated number of problem users, given in chapter 2.3 above. (Hakkarainen et. al. 2000.)

The working group for developing treatment system for drug abusers concluded that seeking treatment is in some cases made difficult by the fact that different bodies make treatment need assessment and provide related social services. There are cases where the latter has altered the professionally made assessment, or treatment has been denied because of a shortage of municipal funds. The situation is different in health care because no separate decision to implement treatment is required once the need for care has been established. The working group submitted its proposal for rectifying this drawback. The group also suggested that personal service counsellors be appointed in municipalities to assist people with severe drug problems and to ensure appropriate implementation and co-ordination of measures taken by various actors. (Report of the committee 2001).

9.3.2 Substitution and maintenance programmes

The Ministry of Social Affairs and Health gave regulations in 1997 concerning the treatment of opiate addicts with medicines. This treatment aims at curing the dependence based on a multiprofessional treatment plan, which also defines other medical and psychosocial care and follow-up. The regulation was updated and supplemented in 1998 and 2000.¹²³

¹²² For auxiliary services, see Chapters 9.2.2 and 9.4.3.

¹²³ Cf. Chapter 1.2.2.

According to the Orders of the Ministry (28/1997; 42/1998) and a Decree passed in 2000 (607/2000), substitution treatment by medicines containing buprenorphine, methadone or levacetylmethadol can only be given to patients whose treatment by generally accepted means of detoxification has failed. The new Decree also enabled maintenance treatment. The Decree stipulates that treatment may only start when it is imperative to reduce the negative effects of drug abuse on patients: persons who are not likely to stop using drugs, but who may benefit from maintenance treatment and avoid contracting communicable diseases and other negative health effects and whose quality of life can be improved and who can be trained for more demanding rehabilitative substitution treatment.¹²⁴ Levacetylmethadol has not been used in treatment specified by the Decree because its sales authorisation was cancelled in 2001.

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

The explanatory memorandum on the new Decree estimated the costs of substitution and maintenance treatment. The buprenorphine treatment of one patient costs a total of about EUR 20,000 (FIM 120,000) per year, of which the pharmaceuticals only cost EUR 2,400 (FIM 14,400). Treatment with a pharmaceutical containing methadone, on the other hand, costs about EUR 13,500 (FIM 80,000), of which the pharmaceuticals cost EUR 300 (FIM 1,800).

At the beginning of 2001, some 200 people were in detoxification or substitution treatment by buprenorphine or in methadone substitution treatment, associated with the Ministry's decisions; about half of them were in methadone substitution. In most cases, treatment need assessment was made in Helsinki. (Report of the Working Group on developing medicinal treatment for opioid-dependent clients 2001.)

The working group for developing treatment system for drug abusers proposes that the criterion for additional resources needed is providing treatment for 1,000 opioid-dependent clients per year, which will cost approximately EUR 16.8 (FIM 100) million per year. An equal investment in proper treatment of other drug users is needed. Based on the present system of dividing costs between the State and municipalities, the result was the proposal for augmenting resources, as stated in Chapter 8.2 above. (Report of the working group 2001.)

Another working group was appointed on a tight schedule to propose actions to increase availability of medicinal treatment of opioid-dependent clients. The group submitted its report on 2 October 2001, including proposals for increasing treatment based on the existing regulations and for new regulations to meet present requirements. (Report of the working group 2001.)

According to the working group, the present system makes it possible to expand (medical) treatment services so that all central hospitals provide treatment or at least be prepared to do so; treatment starts on a low-threshold principle, whereupon the patient is transferred as soon as possible

¹²⁴ See Chapter 1.2 and orders on treating opioid-dependent patients with certain medicines.

to follow-up care in another unit. In Greater Helsinki, new units will be authorised to administer this treatment and their staffs will be given further training.

The working group also suggests that under the Act on Welfare for Substance Abusers, the Ministry of Social Affairs and Health could issue a Decree on organising and implementing drug addicts' treatment with medicines. This would enable more flexible implementation of treatment for opioid-dependent clients than the provisions of the existing Government Decree. The Decree should authorise hospitals, health centres, A-Clinics and other substance abuse outpatient or inpatient units as well as health care units in prisons, all of which have received necessary training, to start detoxification treatment with buprenorphine. During detoxification, assessment of possible need for further substitution or maintenance treatment is made in Central Hospitals or in Järvenpää Addiction Hospital.

All substitution and maintenance treatment periods would be reported, without the patients' personal identification information, to a board to be established. When necessary, the board will propose consultation by a special unit, and it also supervises treatment in the country. Authorisation to administer methadone would not be expanded, but because treatment with buprenorphine is transferred to primary health care, there will be better possibilities to implement methadone treatment. A development study is also needed to experiment with treatment given by private physicians, with pharmacies selling the medicines to the clients.

The proposals of the working group will improve the availability of treatment without compromising its quality. Relaxing regulations on buprenorphine treatment is consistent with new information about this substance. These regulations also reflect practice in some other countries, such as the USA, Australia and France, but control in Finland will remain stricter. Despite broader authorisation to implement treatment, control prevails because treatment requires special training and reports to the control board concerning substitution or maintenance treatment periods commenced. The spread of medicines in the street will be prevented by administering pharmaceuticals in the treatment units.

So far some opiate addicts outside the official programme of the Ministry travel regularly abroad, especially to Paris, to get buprenorphine doses needed in the treatment.¹²⁵ Some clients try to treat themselves, but buprenorphine is mainly used intravenously. In Finland, the National Agency for Medicines issues regulations on the personal import of pharmaceuticals, with Order 3/2000 concerning buprenorphine. The purpose of the Order was to curb the wide-scale import of buprenorphine. According to the Order, a passenger may bring an amount equal to 14 days' use of pharmaceutical substances, which are to be considered narcotics, for personal use. In calculating the daily dose, the maximum dose is the one approved for the preparation licensed in Finland. When the same or equivalent substance is reimported, the amount of time elapsed from the previous instance of importation must be longer than that estimated for the personal consumption of the previous consignment.

¹²⁵ Since February 1996, health centre physicians in France have been entitled to prescribe buprenorphine for four weeks (e.g. Subutex used as an analgesic) for substitution (Karvonen 1998).

9.4 After-care and re-integration

To get permanently free from drugs, it is imperative that the person will abandon drug culture and the related lifestyle. The greatest risk of a relapse coincides with discharge from a protected institutional (treatment) environment to everyday settings. Some treatment schemes incorporate a follow-up stage lasting for a year or so. A treatment programme may also include general socio-political measures, arranging housing for the client and reintegration into working life or studies. Participation in e.g. the activities of Narcotics Addicts Anonymous or other support groups for ex-addicts will help the client in creating a drug-free social environment.¹²⁶

9.4.1 Education and Training

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

The EU's Social Fund (the Integra programme) has participated in certain Finnish projects on young substance abusers. Implemented in Greater Helsinki in 1998–1999, the broad-scale project for young drug addicts, *Back to the Future*, reinforced the notion that people facing unemployment and income problems after recovering from drug abuse are in an extremely difficult situation.¹²⁷ These problems include inadequate housing, reduced working capacity, lack of vocational training and problems associated with work and maintaining a drug-free lifestyle.

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

¹²⁶ E.g. Opiatitirippuvaisten tuki ry, Association of support persons for opiate addicts, established in 1998.

¹²⁷ ESF final report on the young drug addicts' Back to the Future project. <http://www.mol.fi/esrprojekti/loppurap/lr970719.html>.

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

9.4.2 Employment measures

During 1999, an after-care stage was incorporated in many rehabilitation projects, including housing services, training and labour policy measures, e.g. for people released from prison (the Kalliola Clinic's so-called VP services) or for young people (the Back to the Future project of the Deaconess Institute).¹²⁸

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

Young people's workshops constitute one example of employment activities: apprenticeships for people under the age of 25. Depending on the municipality and workshop, they engage in different work tasks. A person is hired to a workshop for 5–6 months, and ordinary wages are paid for the work. Workshop activities also enable support for young people's life-management skills and tailor-made educational or career paths. Personal guidance is provided to support a young person's efforts to abandon the drug habit, so that he or she can embark on the above-mentioned path. In the near future, the focus in training workshop instructors is on preventive work and on an ability to recognise problems in young people's lives in order to guide them. In co-operation with the participants, the instructor reaches an agreement on the objectives achievable during the workshop period. This also makes it possible to assign responsibility to young people themselves.¹²⁹

9.4.3 Housing services

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

The housing service units for substance abusers constitute one part of the service system. They are targeted at substance abusers, who need daily support in their housing. Some housing service units also provide rehabilitation, some act as therapeutic communities, offering possibilities for excluded people to regain control over their lives. Finland also has some housing service units

¹²⁸ See Chapters 9.4.1 ja 9.5.2.

¹²⁹ For more detailed information, see <http://www.alli.fi/allison/tyoelama/tyopajat.html#paja>.

specialising in drug users. In 1999 (2000), the number of residents in substance abusers' housing services was 4,300 (4,900). (Kauppinen 2000.)

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

9.5 Interventions in the criminal justice system

9.5.1 Drug testing

As a form of control and prevention, drug testing has aroused much debate in Finland during the report period.¹³⁰ A seminar was organised by Parliament on the issue at the beginning of the legislation process concerning drug tests.¹³¹ Also the Parliamentary Deputy Ombudsman issued a statement on a complaint concerning the legality of drug tests conducted in two schools.¹³² In general it was stated that screening drug use of certain target groups by drug tests is judicially impossible until a law on them is passed. Nevertheless, there may be some instances where drug tests may be legitimate in a democratic society.¹³³

On 18 October 2000, the National Board of Education issued a memorandum on drug testing in schools and other educational institutions.¹³⁴ According to the memorandum, the National Board of Education does not recommend drug testing as mass screening. The recommendation stresses that a law on testing should be passed and that the Ministry of Social Affairs and Health is in the process of appointing a working group to explore the legal aspects of drug testing. With reference to the working group's mandate, decisions on alcohol and drug tests were made on a general level only in connection with legislation on the protection of privacy in working life, and it was agreed that the employee's obligation to undergo a test was to be discussed by this working group.¹³⁵

The working group on drug testing submitted its intermediate report in July 2001 (Intermediate report of the working group 2001), proposing drug testing guidelines, which it will specify in its final report. In the intermediate report, drug testing is seen as one way of early intervention, and therefore certain circumstances may necessitate testing. However, drug testing infringes on fundamental rights of the individual, and thus tests should mainly be voluntary. Tests should always entail support for the subject and possible referral to care.

In the working group's opinion, schools and other educational institutions may carry out voluntary drug tests in some isolated problem situations. The group suggests that the Ministry of

¹³⁰ See Chapter 1.3.

¹³¹ The texts mentioned in this Chapter refer to a paper in a seminar in Parliament on 20 March 2000, held by the Advisory Committee on Intoxicant and Temperance Affairs.

¹³² See *eduskunnan oikeusasiamiehen lehdistötiedote* [Press Release of Parliamentary Deputy Ombudsman] 22.6.2000. at <http://www.eduskunta.fi/>.

¹³³ The Act on the Status and Rights of Patients (782/1992) lays down the preconditions for determining, restoring or maintaining the patient's health by means of health care procedures. While drug tests are not specifically mentioned in legislation, these preconditions are valid in the care situation as well: the patient must be treated in mutual understanding. If the patient refuses a certain treatment or procedure, he or she must be treated by common consent in some other medically acceptable way. For example, testing for HIV is not a minor procedure that can be carried out without the patient's consent. (See also Liljeström 2000.)

¹³⁴ <http://www.oph.fi/info/huumeet/>.

¹³⁵ See Chapter 1.2.2.

Education, together with the Ministry of Social Affairs and Health, prepare directions for schools how to deal with potential drug problems.

According to the working group, drug testing in the workplace must primarily be voluntary. However, employees who may endanger their own or somebody else's life and health may be obligated to take a test. The working group continues to make legislative proposals for drug tests in the workplace.

The group will also prepare regulations to implement drug tests in practice, with an aim of ensuring that the methods used in testing are of a high standard and that the tests do not violate the subjects' rights. The group will finish its work by the end of 2001.

9.5.2 Police work

According to the Police, drug legislation has an important impact on demand reduction. In Finland, the law forbids the use, possession and sale of narcotics; these are punishable acts. The police consider that this ban has a generally preventive effect on citizens.

During the past years, the police have produced preventive material for adults, young people and children alike. The police have also participated in the projects of other stakeholders. Collaboration with schools, social and health authorities and various organisations has traditionally been intensive. According to the police, preventive work plays a major role in combating drugs, and these activities are performed by officers working as youth police and crime investigators. Also the customs authorities stress the viewpoint of prevention, investing resources in material provision and co-operation between the authorities.

In recent years, the police have launched experimental community policing projects in many localities. This approach was selected to be a central working model for the police in the near future, along with combating serious crime. In compliance with the Government Decision issued in 2000 to enhance drug policy, 60 person-years of drug enforcement resources will be targeted at investigating drug crime in 2001, with street control as a focal point.

Street-level supervision makes it possible to stop the potential drug use or crime careers of young people experimenting with drugs. The community police tackles local crime in a problem-oriented approach by relying on police information and inter-administrative collaboration. Networking between authorities and organisations aims at joint measures to intervene in drug abuse at the earliest stage possible.

Local collaborative projects have been implemented, based on the so-called zero tolerance model in some cities (Tampere 1999) or focusing on a group, such as juveniles and their referral to care instead of punishment (Järvenpää 1997–2000); as a follow-up to the latter project, an evaluation study of actions to combat drug crime and to intensify multiprofessional co-operation is underway. In the Järvenpää experiment, the local Board of Substance Abuse Affairs collaborates with the police and other actors to develop solutions for referral to care and waiving prosecution in case of young drug suspects as an alternative to enforcing the relevant penal consequences.¹³⁶ If the young offender opts for this alternative, the prosecutor will postpone legal action (for 2–4 months) until the body referring to care makes a treatment agreement and plan together with the offender, parents and an outpatient clinic or institution for substance abusers. When this period has elapsed, the

¹³⁶ Cf. Chapter 1.2.1.

prosecutor inquires about the implementation of the treatment, and, if the answer is positive, waives prosecution. If the treatment has failed, the prosecutor will submit the case to a court of law.¹³⁷

Special attention was also paid in 1999 to drug use in road traffic. In compliance with the new legislation,¹³⁸ clinical intoxicant-related check-ups (Ministry order 52/1999)¹³⁹ will become more important. Thus a clinical intoxicants check-up must always be carried out by a physician at the request of the police or based on driving under the influence of drugs. There are no threshold levels for substances other than alcohol in terms of drunken driving. The verified use of an intoxicating substance in road traffic as such is not automatically defined as drunken driving, but a person's ability to operate a vehicle must also be impaired. When the presence of a substance other than alcohol is suspected, both blood and urine samples are taken, and a clinical intoxicants check-up is conducted and the related form is filled in. The court ruling is based on the reports and statements of the police, the physician and the National Public Health Institute (alcohol and drug laboratories).

Drug detection equipment to be used at the roadside was put to the test in the Helsinki, Turku and Tampere regions. The experiment is a part of the EU's ROSITA undertaking. The purpose is to list narcotics and medicines harmful in traffic and to examine what kind of equipment is available to roadside testing for drugs, what is the feasibility of this equipment and the judicial aspects of testing in Finland. The Ministry of Transport and Communications commissioned the project, the police is in charge of roadside testing and the National Public Health Institute co-ordinates and administers the project.

In January 2000, the police approved a drug strategy for the years 2000–2003. In terms of demand reduction, the strategy highlights deterrence, early intervention and control actions:

In terms of deterrence¹⁴⁰ and early intervention, the following is proposed:

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

¹³⁷ The final report on the project on referring young drug offenders to care [available in Finnish], Järvenpää Board of Substance Abuse Affairs. The project is also available in the project database <URL:<http://www.stakes.fi/neuvoo-antavat/index.html>>.

¹³⁸ See Chapter 1.2.2.

¹³⁹ <URL:<http://www.vn.fi/stm/suomi/pao/julkaisut/nolo52/kptutk.htm>>.

¹⁴⁰ During 1999, the police arranged in Tampere an EU symposium on preventive work done by law enforcement authorities.

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

- The emergence of local venues for distributing or using drugs will be prevented.
- In agreement with the prosecutorial authority, an effort is made to establish consistent practices (risk for suspect) in prosecuting drug crimes.
- The introduction of an accelerated criminal procedure for young offenders will be supported. The police will check all drug-related information, especially that coming from parents and schools, and take necessary steps.
- The risk of apprehension will be increased with regard to persons operating a motor vehicle under the influence of drugs.
- An effort will be made to ensure expert help in police interventions to assess care need and possibilities and to support municipal projects on referral, in accordance with the Government Decision-in-Principle on drug policy.

9.5.3 Prison work

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

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

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

In compliance with the 1999 administrative targets, each institution will draw up a concrete drug strategy in 1999 and a related action plan for the year 2000. In the near future, the aim is to create a rehabilitative continuum, consisting of the following elements:

- Assessment of the state, motivation and placement of a prisoner.
- Actual rehabilitation.
- Training for release.

February 2001 saw the publication of the follow-up to the prison administration's intoxicants strategy, a handbook on drug control, which is a set of guidelines targeted at prison personnel for practical drug control and inspection. The handbook mainly discusses supervision and inspection, body searches of inmates, drug dependence and the effects and uses of intoxicating substances. In addition, the handbook tells how to recognise a person who is under the influence of drugs and how to carry out supervision when there is a doubt on the issue. The book also instructs personnel to give first aid and provides basic information about referring a prisoner with substance abuse problems to rehabilitation.¹⁴¹

At the beginning of 2001, the Ministry of Justice appointed a committee to prepare the issue of the so-called contract treatment as an alternative to a prison sentence in the same way as community service,¹⁴² intended for offenders facing short prison sentences whose offence has been greatly influenced by a substance abuse problem and who in all likelihood are able to go through the treatment programme decided for them. The committee must clarify the rights and responsibilities of care personnel, the type of care as well as where and how it is implemented.

The committee must also examine the possible need to incorporate contract treatment into suspended sentences. Sentencing to contract treatment requires the defendants' consent and they must commit themselves to the treatment plan and other terms. Contract treatment also involves control. Failure to adhere to the treatment plan or other preconditions specified in court results in a prison sentence or, under mitigating circumstances, in some other penalty. Treatment may include both residential and outpatient care. Because contract treatment is an alternative to a prison sentence, it always involves treatment in an institution.

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

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

¹⁴¹ See also Chapters 12.2 and <http://www.vankeinhoito.fi/8727.htm>.

¹⁴² Cf. <http://www.om.fi/9104.htm>.

In addition, the committee for the prison sentence reform submitted its report in the summer of 2001 in order to revise e.g. the objectives of imprisonment. The goal of enforcing a prison sentence is to enhance the prisoner's possibilities to lead a crime-free life. This is done by promoting his or her life management skills and integration into society.

Prisons have engaged in substance abuse rehabilitation for about ten years. To develop rehabilitation in prison, the substance abuse rehabilitation project (VP) was launched in 1996 by the Ministry of Social Affairs and Health, the prison administration and four major organisations in the substance abuse field. The project ended in spring 1999 (Mutalahti 1999),¹⁴³ resulting in ten service products (e.g. six rehabilitation programmes and training packages) for prison use.¹⁴⁴ Today, substance abuse rehabilitation is based on structured handbook programmes produced in co-operation between the prison administration and organisations in the field and on prison administration strategies.¹⁴⁵

With the rapid onset of an HIV epidemic, more attention has been paid to preventing infectious diseases by giving prisoners preventive education and a possibility to receive disinfectants and vaccination against hepatitis B and get tested for HIV anonymously. Some 1,600 prisoners were tested in 2000.

9.6 Specific targets and settings

Self-help groups for drug users

In Greater Helsinki, there are Narcotics Addicts Anonymous¹⁴⁶ groups for people who want to stop drug use. These include a closed group for drug-dependent persons, a women's group and an open group for all those interested. Also some other major cities have such groups, working often in connection with the local treatment programmes.

Gender-specific services

Outpatient services are usually intended for both men and women facing intoxicant problems, provided in the form of personal, family or group therapy and support. In some units, special women's groups have been set up. There are two facilities for pregnant women or mothers with a newborn, one in Greater Helsinki (five beds; the number of drug and polydrug abusers has constantly increased) and one in Turku (six beds). The proportion of drug or polydrug abusers in the clientele is increasing. Because women usually have overrepresentation in parents' support groups, there are special support groups for the fathers of drug addicts as well.

¹⁴³ See also <http://www.om.fi/11024.htm>.

¹⁴⁴ See <http://www.a-klinikka.fi/vp/vp-projekti.html>.

¹⁴⁵ See Chapter 18.4 and 18.5.

¹⁴⁶ See e.g. <URL:<http://gamma.nic.fi/~netna/alku.htm>>.

Support for children of drug users

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

In the most serious cases, children may be taken into custody, which means that the child is provided for and educated by society. Such action must be taken if childcare is neglected or if some other circumstances at home jeopardise the child's health or development, or if the child endangers his/her own health by using intoxicants, by committing a serious criminal offence or by other such behaviour. An additional requirement is that outpatient services have not been appropriate, possible or adequate and that care outside home is deemed to be in the child's best interests.¹⁴⁷

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

The report of the working group on coercive action in substitute care was completed in 1998, assessing the field of coercive measures and restrictions based on the Child Welfare Act and possible reform needs, with suggestions for amendment (Report of the working group 1998). As a new recommendation, the working group proposed that body searches may be performed in a child welfare institution to obtain samples of blood, hair or urine or some other sample outside the body, if there is cause to believe that the child has used intoxicants.

A budgetary proposal was made in 1999 to improve child welfare measures and to provide care for drug users' children.¹⁴⁸ The system to equalise the extensive costs of child welfare services directs municipal resources so that child welfare clients in every municipality will receive appropriate services, irrespective of the costs incurred. The financial burden is equalised so that the municipality receives compensation if the child welfare costs of a family exceed EUR 25,000 (FIM 150,000). This compensation covers both custodial and non-institutional services for the family and child.

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

¹⁴⁷ Child Welfare Act 683/1983, Sections 16, 17 and 34.

¹⁴⁸ See also Chapter 1.2.

Support for parents of drug users

Many treatment facilities emphasise the role of the families and close support persons in the drug treatment process. Both in residential treatment but also in outpatient services, family-centred therapy is gaining more ground, as seen in the increasing supply of education in the field. Self-help groups have been established for drug abusers' close persons as well. Anybody whose relative or friend is a drug addict may join in. Sometimes the group is a closed one, with the same participants meeting regularly. The Free from Drugs Association has 22 groups in different localities, with some 1,700 group visits annually. In some cases, specific intimate groups have been provided for young people, spouses and fathers.

The Free from Drugs has organised a three-year networking project, *Pilvi vai pouta*, to prevent intoxicant use among the youth, by supporting the parents and by creating regional networks for parents, authorities and volunteers. The project is implemented in three municipalities (Vantaa, Oulu and Porvoo).¹⁴⁹

Drug services in the workplace

Intoxicant-related services targeted at workplaces have focused on the early detection and prevention of substance abuse problems. Drug questions have been incorporated into prevention of substance abuse in general, which aim at maintaining working capacity both through publications and training, but in practice the focus has been on abuse of alcohol and/or medicines and the related dependence. However, according to the statement issued by the Intoxicants in Working Life expert group of the Centre for Occupational Safety, representing the labour market organisations, drug issues can only partly be dealt with in the same manner as other intoxicant questions; in many respects, they call for special measures, e.g. because of the illegality of narcotics. In general, referral to care may be based on an agreement between the client and employer. This must take place by the client's consent. The actual treatment plan is made in the treatment facility by the client and treatment worker. Legislation on workplace drug testing was currently prepared in the Ministry of Labour, but a decision was later made to delegate the task to the working group on drug tests under the Ministry of Social Affairs and Health.¹⁵⁰

In 2000, the Centre for Occupational Safety prepared a net service associated with the drug-free workplace programme. This service is a collection of materials and links to chart substance abuse risks, training as well as the establishment of drug programmes and care referral and rehabilitation procedures in the workplace. The net service will open in 2001. In early 2000, The Finnish Institute of Occupational Health produced a guide on encountering drug users at work (Lusa ed. 2000). The guide is intended for security and health care professionals, but it is suitable for everybody who may meet drug users at work.

Financed by the EU Social Fund, the Finnish Association for the Minnesota Model (Myllyhoitoyhdistys ry.) has trained experts on intoxicants issues for the use of small and medium-sized businesses. Another goal is to establish regional expert networks and model enterprises

¹⁴⁹ Two intermediary reports and final report have been published on the project: *Pilvi vai pouta – aitoa yhteistyötä etsimässä* [Pilvi vai pouta: in search of genuine co-operation] Free From Drugs, Mikkeli 2000. See also <URL:<http://www.reitox.emcdda.org/eddra/explorer/>>.

¹⁵⁰ See Chapters 1.2.2. and 9.5.

dealing with substance abuse problems, assessing the effectiveness and usefulness of the training product. This project resulted in three training process models for small and medium-sized firms.¹⁵¹

Drug services for ethnic minorities

In Finland, health care services are in principle available to all, but especially linguistic and cultural reasons pose some practical problems. Special services for Romanies already exist. Especially in Greater Helsinki, where more than 40 per cent of the immigrants live, the intoxicant service units are only seldom visited by non-native people. In 1998, these units had 190 non-native clients, the majority of whom were Russians. In many units, the number was based on an estimate, and the survey did not eliminate possible overlap.¹⁵²

Järvenpää Addiction Hospital has prepared a special treatment programme for Russian-speaking drug users (especially abusers of heroin), involving ethnic Finns from Ingria, but so far the visits have been occasional. The Helsinki-based health counselling unit for IV-drug users, Vinkki, has one nurse hired especially to treat Ingrian returnees (Kullat 2001). At the beginning of 2001, the Deaconess Institute in Helsinki launched its *Venpro-Pyncnpo* project to assess the need for drug treatment for Russian-speaking immigrants and to plan a treatment system for them. Some immigrants have received help from A-Clinics, and co-operation between the clinics and the Association of Somalis will be further developed (Jouhki 1998). In practice, immigrants can be provided with acute detoxification, but there is lack of other treatment alternatives (Hakkarainen et. al. 2000).

In 1999, services were developed in order to prevent and treat substance abuse problems among ethnic minorities. For instance, the Free from Drugs Association and the Centre for Ingrians train people, who have adequate linguistic skills, to work as helpline operators and support persons both for drug users and their immediate circle. Other actors included municipal social and health services and organisations, such as the Finnish Free Romany Association.

¹⁵¹ ESF final report on the project, see <URL:<http://www.mol.fi/esprojekti/loppurap/lr970353.html>>.

¹⁵² The survey conducted by Director Roger Nordman of the Hangonkatu Rehabilitation Centre in spring 1998 was responded by 14 substance abuse units in Greater Helsinki.

10 Quality assurance

10.1 Quality assurance procedures

The methods used in the quality control of substance abuse work have been haphazard until the late 1990s. The procedure often used was final reporting, which was not totally systematic in form. In recent years, the situation has changed, though. The final reports on projects are more systematically made, partly due to reasons of data processing. Another contributory factor is the publication of foreign and domestic guidebooks on project evaluation. Books published in Finnish include guidelines for evaluating prevention (Kröger et. al. 1998), a manual of preventive substance abuse work (van der Steel ed. 1999) and a guide on substance abuse prevention for co-operation between schools and their interest groups (Huopanen 2001). At the moment, the Finnish Centre for Health Promotion has made the best progress in systematising and published a guidebook on the quality criteria for health promotion projects.¹⁵³

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

The segments are described by the following separate indicators:

Framework criteria:

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

Structural criteria:

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

¹⁵³ *Hanketuki – kansalaisjärjestöjen terveyden edistämisen ohjelmatyö.* [Project support – health promotion programme work done by NGOs]. Finnish Centre for Health Promotion, publications 3/2000. See also: <URL:<http://www.health.fi/paihde/hanketyokalut/index.html>>.

Process criteria:

10. The operational processes consistent with the objective(s) have been defined (TP)
11. The division of labour between the project participants has been specified (TP)
12. Communication between participants at different stages is planned to be active (C)
13. The participants can influence the development of activities (C)
14. Progress at all stages is monitored and periodically evaluated (F)

Outcome criteria:

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

Application criterion (C)

20. The applications of the project can be partly or entirely utilised in the operating environment.

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

10.2 Treatment and prevention evaluation

Because of inadequate resources, evaluation as such has not been given a central position in the objectives of drug projects, and consequently the outcomes of evaluation tend to be process-oriented, retrospective or descriptive rather than systematic or theoretical in nature.

In 1998, the Ministry of the Interior appointed a service assessment group, whose task was to standardise and develop monitoring (evaluation) of basic municipal services in the state provincial offices. One object of special assessment was drugs, including related control and services. The reports of the State Provincial Offices have been published concerning the years 1999 and 2000. (Peruspalvelut Suomen lääneissä 1999, 2000.)

According to the State Provincial Offices, schools are in a key role when it comes to prevention, but they do not have the necessary time and expertise to encounter drug users in the schools – despite the fact that almost all regions have reported major investments in training. In municipalities, multiprofessional drug co-operation groups operate with varying degrees of success, and great expectations are placed on the new municipal co-ordinators of drug work and drug training. As far as treatment is concerned, one common feature seems to be the availability of detoxification services for adults, but the greatest shortcoming is insufficient possibilities for rehabilitation for young people and adults – especially as regards opioid-dependent clients. There are problems in the provision of regional services as well. Clear links were observed between growing property crime and drug use. Narcotics are more prevalent in road traffic as well. All provinces were agreed though that the most effective way of combating drugs is to prevent young people's exclusion

from society. The provincial authorities were also concerned about the sustainability of the changes and results achieved in antidrug work when isolated projects end and their resources have been spent.

The year 2001 saw the publication of the follow-up report on the regional drug action strategy in Kainuu, a region in Eastern Finland (Mustalampi 2001). The report monitors implementation of the strategy a year after its launch and asks how and by whom the programme is carried out in municipalities. The follow-up has shown that the programme has been actively implemented especially in municipalities that have a solid foundation for multiprofessional work and an active alcohol and drug team. Separate resources for implementing the programme have not been forthcoming. After a year, the activities are isolated, having become a myriad of actions and initiatives, while the role of the decision-makers has become more distant. It remains to be assessed later whether the strategic activities have led to permanent work practices locally and regionally.

As regards care, a development project on preparing quality criteria for substance abusers' treatment services has been launched. This project relies on a review of alcohol and drug treatment methods used in Finland. (Pienimäki 2001a.)¹⁵⁴ Based on a survey conducted in all outpatient and inpatient units, the most important operative treatment methods include – in broad terms – supportive therapy, prevention of lapses and learning social skills. The more specific treatment forms were health counselling for drug users, cognitive therapy, motivational interviews and solution-centred therapy. The pharmaceuticals most often used in medicinal treatment were, for opioid-dependent clients, clonidine, benzodiazepines, lofexidine and buprenorphine, and for other drug users, benzodiazepines, mood drugs, antiepileptics and neuroleptics.

Within the treatment systems, especially the infection risk counselling given to intravenous drug users has been evaluated, including the centres Vinkki in Helsinki (Harju et. al. 2000)¹⁵⁵ and Nervi in Tampere (Julin 1999). Two project evaluations were conducted concerning the Prevnnet programme of the A-Clinic Foundation: Prevnnet subprojects (McGourty 1999) and Prevnnet-Euro (Tammi et. al. 2000; McGourty 2001).¹⁵⁶

The so-called VP Project, developing welfare for prisoners with substance abuse problems, was evaluated in 1999. The key operations in the project were turned into ten services, tailor-made for prisoners but applicable elsewhere, too (Mutalahti 1999).¹⁵⁷

The National Audit Office has also drawn attention to the evaluation of antidrug work. In its report, the Office points out as a drawback that by the end of 2000, the drug policy committee, working under the Ministry of Social Affairs and Health, had been unable to produce more specific follow-up reports on implementation of the action programme associated with the 1998 Government Decision-in-Principle. (National Audit Office Report 12/2000.)

¹⁵⁴ See more details in chapters 17.1 and 17.2.

¹⁵⁵ See Chapter 9.2.3.

¹⁵⁶ See also Chapter 9.1.7.

¹⁵⁷ See also chapter 18.5.

10.3 Research

The Government Decision-in-Principle from the year 1998 concerning drug monitoring and research states as follows:

- The possibilities of STAKES to create and maintain up-to-date information systems on the prevalence of drug use, the treatment system, drug research and trends in drug-related crime will be enhanced and collaboration between the authorities monitoring the trends in drug-related crime will be intensified.
- The research projects proposed in the 1997 report of the drug policy committee and other topical and important research projects will be launched, and a cross-sectorial drug research programme will be drawn up for the Academy of Finland.

Appointed on the grounds of the Government Decision-in-Principle on Drug Policy in 1998, the drug strategy co-ordination group has prepared a sector research plan on drugs for the State administration and the related research agencies in order to implement the Government Decision. The group has also proposed that the Academy of Finland launch a fixed-term research programme to find solutions to the growing drug problem in Finland. However, the Academy of Finland did not consider it necessary to create a specific programme on drugs; instead, financing will be channelled through the existing research programmes (e.g. the one on health promotion).

In the sector drug research plan, the quota of drug research in the agencies working under the Ministries was estimated to be 6–7 working years at present. It was suggested that additional five working years were required. The most important national actors are the National Research and Development Centre for Welfare and Health (STAKES), the National Public Health Institute, the Finnish Foundation for Alcohol Studies, the National Research Institute of Legal Policy, the Police College of Finland as well as other units engaging in drug work (Järvenpää Addiction Hospital, the Helsinki – Uusimaa Health Care District, etc). A major aim is to have a distinguished expert on drugs appointed both at STAKES and in the National Public Health Institute, respectively, who, along with their personal research interests, co-ordinate drug research in the agency. A co-ordinating expert is also needed in the National Research Institute of Legal Policy and in co-ordinating nationwide work done in treatment and rehabilitation units.¹⁵⁸

The Academy of Finland and the Finnish Medical Society Duodecim arranged a broad consensus conference on drug dependence treatment in Finland in early November 1999. In its consensus declaration, the meeting emphasised epidemiological research and independent treatment studies, promoting the wider introduction of good treatment practices and methods.¹⁵⁹ The committee on preventing young people's drug use and the working group developing treatment systems for problem users brought up several research themes, but both groups stressed the role of the Academy of Finland in launching multidisciplinary research.¹⁶⁰

¹⁵⁸ Proposal for reinforcing drug research in Government agencies and units engaging in drug work (6 December 1999).

¹⁵⁹ Basic material and propositions of the meeting are published in *Huumeriippuvuuden hoito Suomessa - Konsensuskokous 1.–3.11.1999*. [Treatment for drug dependency in Finland: Consensus meeting 1–3 November 1999]. Finnish Medical Society Duodecim & Academy of Finland. Vammalan kirjapaino, 1999. Available in Finnish only. See also <URL:<http://www.duodecim.fi/koulutus/konsensuskokoukset/>>.

¹⁶⁰ Chapter 8.2.

The latest drug research publications have been issued on the prevalence of drug use among adults and young people,¹⁶¹ young people's descriptions of their drug culture,¹⁶² the prevalence of problem use,¹⁶³ intoxicant-related cases in social and health services,¹⁶⁴ the treatment of drug users,¹⁶⁵ low-threshold clients,¹⁶⁶ backgrounds of drug offences and repeated crime,¹⁶⁷ backgrounds of drug-related deaths¹⁶⁸ and the drug treatment system in prison.¹⁶⁹

A persistent shortcoming is the narrowness of qualitative analysis of the phenomena and a shortage of studies on the effectiveness of the measures taken. However, during the year studies on drugs and technoculture¹⁷⁰ and on intoxicants and the media (Piispa 1999) were completed.

Furthermore, the Nordic Council for Alcohol and Drug Research (NAD), located in Helsinki, has co-ordinated the EMCDDA project on qualitative studies related to drugs. In the near future, NAD will be involved in conducting comparative studies on the costs and other negative effects of drug use as well as on control policy and treatment of drug addicts.

10.4 Training for professionals

Drug training in Finland has been incorporated into the curricula of social welfare and health care education: students have e.g. the possibility to specialise in services for intoxicant abusers and drug prevention. At a university level, drug education has been provided in sociology, public health studies and medicine. The Drug Laboratory of the National Public Health Institute has supervised further education in biomedicine.

The most important training institution in substance abuse work is the annual, nationwide intoxicant seminar, organised by the Finnish Centre for Health Promotion in association with the Ministry of Social Affairs and Health and the national collaborative group on services for substance abusers.¹⁷¹ In addition, hospital districts and State Provincial Offices are increasingly co-ordinating regional co-operation in drug training together with relevant expert organisations.

With units in 22 localities, the Free From Drugs association is an important actor in drug prevention training. The association provides training for its voluntary workers as well.

Concerning post-graduate education in the social and health care sector, the A-Clinic Foundation has provided advanced treatment service training for different professional groups. Järvenpää Addiction Hospital, maintained by the foundation, has provided courses for physicians. In addition, the A-Clinic Foundation is preparing regional models for drug training in a specific project (*Monikko*). The project has commenced in four municipalities, with the aim of improving readiness

¹⁶¹ Chapter 2.2.

¹⁶² Chapter 2.2.

¹⁶³ Chapter 2.3.

¹⁶⁴ Chapters 3.1, 9.3.1 and 9.4. A doctoral dissertation was also published on the development of the treatment system (Kaukonen 2000).

¹⁶⁵ Chapter 3.1.

¹⁶⁶ Chapters 2.3 and 9.2.2.

¹⁶⁷ Chapter 4.2.2.

¹⁶⁸ Chapter 3.2.

¹⁶⁹ Chapters 2.3 and 3.1.

¹⁷⁰ Chapter 2.1.

¹⁷¹ Chapters 8.2 and 9.

among local units providing specialised treatment for substance abusers, in order to act as regional expert centres in preventing drug and polydrug abuse and in developing diversified treatment services for addicts.

The Ministry of Social Affairs and Health has initiative and provides financing in many training systems. In the spring of 2000, the Ministry funded training events, organised by the A-Clinic Foundation and the National Public Health Institute, for health counselling centres for IV-drug users and two-day training sessions in autumn 2000, organised by the A-Clinic Foundation on the medicinal treatment of opiate addicts. A project spanning several years is planned on the Ministry's R&D funds, in order to instruct regional drug training groups, which in turn will organise further education on drug dependence for health care professionals. Consequently, the Ministry's drug treatment working group proposed that a nationwide collaborative body be established to coordinate the network of drug treatment consults and experts.

During the past two years, several textbooks have been published on drug-related training: on basic drug information (Dahl et al 1998), preventive substance abuse work¹⁷² and the treatment of substance abusers in addiction medicine in general (Salaspuro et. al. 1998) and for nurses in particular (Inkinen et. al 2000). Guidebooks have been targeted at smaller groups as well: on temperance education in school,¹⁷³ preventive telematics work,¹⁷⁴ evaluation of substance abuse prevention,¹⁷⁵ encountering heavy drinkers or drug addicts at maternity clinic,¹⁷⁶ early intervention in substance abuse problems (Partanen A. et. al. 1999), encountering drug users in the workplace,¹⁷⁷ in the treatment system (Ahokas et. al 1998), in prison¹⁷⁸ or in primary health care on clients with hepatitis C.¹⁷⁹

¹⁷² Chapter 10.1.

¹⁷³ Chapter 9.1.2.

¹⁷⁴ Chapter 9.1.7.

¹⁷⁵ Chapter 10.1.

¹⁷⁶ Chapter 9.1.1.

¹⁷⁷ Chapter 9.6.

¹⁷⁸ Chapter 9.5.3.

¹⁷⁹ Chapter 9.2.3.

11 Discussion

11.1 Principal intervention strategies and their evolution

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

Nationally, the implementation of the Decision-in-Principle started in 1999, resulting in a proposal for a drug research programme for the Academy of Finland. The Academy however decided to integrate drug research segments into its existing programmes. In addition, the sectorial drug research programme of the State agencies and the action plan for implementing the Government Decision were prepared. Working groups were also launched to chart new drug cultures among young people and to plan the related preventive measures as well as to make proposals for developing drug treatment systems. The relevant Ministries also included drug topics in their medium-term financial and action plans.

In November 1999, a joint consensus meeting between the Academy of Finland and the Finnish Medical Society Duodecim convened in order to develop drug treatment further. The consensus statement of the conference presented developmental needs to promote drug treatment and research on a broad scale and in keeping with the 1998 Government Decision-in-Principle. The same line of action was pursued in the report of the working group on young people's drug prevention (2000) and the report of the working group on drug treatment (2001), both of which further clarified and solidified the 1998 Decision-in-Principle.

The police and the prison authorities have also produced their respective intoxicants and drug strategies in line with the Government 1998 Decision-in-Principle, with demand reduction as an important consideration along with control.

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

Concurrently with long-term strategic planning, decisive action has been taken to solve the immediate drug problems on regional and local levels. The focus of prevention has been on young people and improving their life-management skills, especially by means of activation, supporting parenthood and early intervention in young people's drug experiments. In prevention, the emphasis was on young people's own participation in project planning. All central actors involved have invested especially in providing drug training for drug prevention workers; in addition, a network

of municipal co-ordinators in drug prevention has been established. There are also plans to devise a nationwide drug information campaign, incorporating large-scale evaluation.

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

In the treatment system, the development of low-threshold services and the related training have been highlighted, the aim being to involve clients in the treatment system as early as possible. At the same time, there has been much debate about harm reduction actions, whose position as a part of treatment has been more widely acknowledged, one example being the development of infection risk counselling as well as the substitution and maintenance treatment system.

The control authorities have stressed collaboration in preventive work with other authorities in the field. Another preventive measure that has been proposed is the introduction of drug tests. However, possible mass screening for drugs has aroused much debate in public. Some amendments to legislation concerning drug tests in working life are now in progress. New bills are under preparation and will be submitted by the end of 2001. The three-year experiment in prisons has resulted in well-designed products for drug treatment in prison and for the after-care of released prisoners, in association with organisations in the field.

11.2 Main future trends and strategies

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

To assist the group, a report of the committee planning drug prevention among young people was published in autumn 2000, followed by the report of the drug treatment working group in early spring 2001. The organisation of drug research is still in progress, as regards Government agencies and the Academy of Finland. The introduction of evaluation protocols now in planning will probably impact on funding for drug projects as well.

The 1998 Government Decision-in-Principle has provided national and local drug work with a framework for all activities for the next couple of years. However, it has been unclear as to how activities within this framework are prioritised, a fact that will be reflected in financing. In autumn 2000, a new Government Decision-in-Principle was issued on the subject, with attendant budgetary proposals. At the same time, the drug policy co-ordination group was assigned to draw up an action plan to intensify drug policy. The group will submit its report on the implementation of the Government Decisions and action plan to the Government by the end of 2001.

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

Part IV

Drug supply reduction interventions¹⁸⁰

12 National strategies in supply reduction

The field of supply reduction consists of control directed at the illegal traffic, use or distribution of drugs or at their legal trade or use, e.g., for medical or research purposes.¹⁸¹

Two sectors are highlighted in police operations. Locally, an effort is made to prevent the criminal recruitment of first offenders and juvenile delinquents in particular. Tackling broad-scale aggravated offences perpetrated by professional criminals calls for enhanced surveillance and focusing on individual perpetrators.

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

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

12.1 Major strategies and activities

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

The supply reduction strategy of the police includes actions to prevent the manufacture and import of drugs, to detect drugs and persons distributing them on the market, to expose organisations engaging in manufacture, import and distribution and to maintain a high risk of apprehension. In

¹⁸⁰ The structure of this chapter is based on the Drug Strategy 1997 and related background material (Huumausainestrategia 1997).

¹⁸¹ See Appendix 5: Actors in drug supply reduction.

combating aggravated drug crime, it is important to prevent money laundering and to ensure that criminal proceeds will be seized. The tasks of the customs authorities mainly involve supply reduction at the international borders and exposing organised drug criminals. The police, customs and the Frontier Guard have close collaboration in antidrug actions through a permanent body, the narcotics working group. The National Agency for Medicines focuses on controlling the legal use, import and export of drugs, psychotropic substances and precursors.

In terms of supply reduction, the Government Decision-in-Principle on Drug Policy (1998) suggested that:

- The confiscation of the proceeds obtained through drug offences will be intensified.
- It will be studied whether it is possible to introduce reversed burden of proof in cases of aggravated narcotics offences, so that a person sentenced for such an offence must, in order to avoid confiscation, give preponderant evidence that the property was obtained legally.
- Questions of fictitious purchasing and infiltration will be addressed in connection with the amendment to the Police Act.
- It will be studied what kind of legislative and other measures should be taken to protect witnesses and persons co-operating with the judicial authorities in combating international organised drug crime.
- The drug crime prevention of the police will be intensified by developing the methods used and new forms of international co-operation by the police.
- Resources will be allocated in particular to control at the street level, for preventing the emergence of public places, where drugs are sold and used.
- The personnel resources of the customs administration will be developed, and directed in particular at drug control along the national borders and in goods terminals, as well as at intelligence activities, as required by national and international commitments.
- Customs activities will be intensified also by obtaining more technical control and surveillance equipment.

12.2 Approaches and new developments

In 2000, the most significant change in professional and organised drug crime was the increasing role played by Estonian and ethnic Russian crime bosses on the Finnish drug market, previously dominated by Finns. With the exception of some isolated instances, Estonian-Russian drug crime constitutes the first extensive breakthrough in Finland on the part of criminal elements from Eastern Europe. Finland's neighbouring areas have a vast and extremely cheap supply of hard drugs, especially white injected heroin. Disparities in the standard of living between Finland, Russia and the Baltic countries make it possible to export a wide range of illegal products and services to Finland at a very competitive price. Thus it is not surprising that according to the latest Security Barometer survey, Finns regard anti-drug work, along with tackling violent crime, as one of the foremost duties of the police. (Hietaniemi 2001.)

On 5 October 2000, the Government gave second Decision-in-Principle to intensify drug policy (2000). In terms of intensified control, the Decision suggests that

- police and customs activities focus on preventing drug supply, i.e. illegal import and distribution.
- readiness to investigate ever-increasing drug crime will be improved by training and technical equipment.
- personnel resources of the Customs Administration will be directed at frontier crossing points and loading and unloading terminals: the number of drug dogs and handlers will be increased. More investigators specialising in drug issues will be recruited.
- the number of full-time drug-enforcement officers will be increased from the present 100 man-years by a minimum of 70 man-years, and additional resources will be directed at the street level control in particular, i.e. to prevent drug sale and distribution in public places.
- regulations on drug use will be clarified: in autumn, the Government issued a bill to Parliament, whereby the prosecutors can impose a fine for drug use or possession for personal use (summary penal judgment).
- the prosecutorial authority's possibilities to try drug cases will be enhanced: experienced prosecutors will be appointed to the Office of the Prosecutor-General and major cities. These prosecutors will concentrate on processing drug cases and make their expertise available to prosecutors in other localities.
- in order to improve anti-drug work in prison, inmates' drug testing and other types of drug control will be intensified.
- in November, the Government will make a proposal to the Parliament, whereby a saliva sample can be taken from potential substance abusers in prison.

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

As for supply reduction, the drug strategy for 2000–2003 of the police¹⁸² emphasises:

- Combating professional or otherwise aggravated drug crime. In this respect, the accent is on:
 - * The role of the National Bureau of Investigation as a co-ordinator of international and national anti-crime activities.
 - * The introduction of new surveillance and anti-crime methods.
 - * Co-operation with the prison authorities in order to prevent drug trade taking place or led in prison.
- Intensified street control, which will be implemented by:
 - * Developing local police activities.
 - * Introducing new test methods in road traffic control.
 - * Training peace officers.
- Better readiness to conduct preliminary investigation into drug offences, implemented by:
 - * Enhancing telesurveillance and technical surveillance.
 - * Accelerating chemical sample analyses.
- Intensified confiscation of the criminal proceeds by improving co-operation:
 - * With investigating authorities, debt recovery and tax authorities, prosecutors and prison administration.
 - * Between the Money Laundering Clearing House and other police units.

¹⁸² Police drug strategy 2000–2003. Approved on 24 January 2000.

- Preparation of legislative initiatives concerning reversed burden of proof, witness protection, tax-free compensation for tip-offs as well as legislation on money laundering and amendments to the laws on preliminary investigation and coercive measures.
- International co-operation to implement the Schengen Agreement and bilateral anti-crime and customs agreements.
- Development of police education by applying the training model used in investigating financial crime.
- Development of a system to monitor antidrug activities.
- Scientific research on drug crime.
- Intensified international networking, which will be implemented so that
 - * Co-operation with other authorities will be developed further in order to intensify drug-related training in the neighbouring countries.
 - * The EU's Phare and Tacis programmes on preventing and combating drug use will be promoted.

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

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

At the beginning of 2001, the second part of the prison administration intoxicants strategy was approved, focusing on supply prevention, with efficient control as its core activity. The strategy was published in the form of a handbook on drug control and concentrates mainly on supervision and inspection. The book is intended for prison guards to improve and facilitate their work, with an effort to harmonise working practices in different prisons. Thus, it is a kind of quality manual, incorporating good control practice.¹⁸³

At the same time, the joint drug strategy (PTR) of the police, customs and the Frontier Guard was approved, aiming at more effective antidrug operations by intensified collaboration. The drug strategy of the customs authorities will be completed during 2001.

¹⁸³ See also chapter 9.5.3 and <http://www.vankeinhoito.fi/8727.htm>.

13 Intervention areas

13.1 Operations of the judicial system

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

According to the changes in the Penal Code in 1994, prosecution and sentencing may be waived in case of drug use or other related crime, if the deed does not undermine common obedience to the law or if the perpetrators commit themselves to treatment approved by the Ministry of Social Affairs and Health.¹⁸⁴ These special provisions concern the personal use, import, possession or manufacture of drugs. In some cases, however, prosecutors may have waived prosecution without a proper reason, since court proceedings are considered too cumbersome for imposing a fine. In January 2000, the Office of the Prosecutor-General issued guidelines for waiving prosecution in certain types of drug crime, with the aim of harmonising the practice of waiving prosecution in the country.

According to the guidelines of the Office of the Prosecutor-General (5/2000), when decision not to prosecute an adult is considered, one must take account of the amount and quality of narcotics in question, the duration of use and other circumstances. The point of reference in making the decision is an abstract concept of undermining common obedience to the law. In terms of problem users, punitive actions become less important, balanced out by curative viewpoints. The Section is applicable to juveniles and adults alike, but the offender's young age may be relevant as well, if the deed (experimental use) may be deemed resulting from thoughtlessness or imprudence.

The Ministry of Justice made a proposal for amendment concerning the ambiguity of enforcing the law in the autumn of 2000. In summer 2001, an amendment was passed on drug-user crime, taking effect on 1 September 2001. The amendment defines 'a user crime', which makes it possible to impose a fine in the form of summary penal judgment for the use, possession or attempt to obtain drugs for personal consumption. This makes the abstract concept of obedience to the law redundant in this context, to be replaced by a more precise expression of the quantity, quality, situation or circumstances. The reform does not make the punishment more lenient, as a fine is already now imposed for these offences in a court of law.¹⁸⁵

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

¹⁸⁴ See Chapter 1.2.1.

¹⁸⁵ See Chapter 1.2.1.

is based on the offender's own story or that of an accomplice. It has been said that the burden of proof is more easily satisfied in drug offences.

Legislation on control and surveillance by technical means, carried out by the police and customs officials, may be utilised in preventing and detecting drug trafficking. The law on international assistance in criminal matters acknowledges the controlled delivery of drugs as one avenue of investigation. The Second Naples Convention on customs activities regulates infiltration across the border, and the Schengen Agreement stipulates infiltration within the EU. Such action can only be taken in aggravated crimes. As of 2001, the use of infiltration and undercover purchase activities are possible in combating crime in Finland.¹⁸⁶

In addition to the risk of apprehension and of punishment, the confiscation of the criminal proceeds is an effective deterrent against calculated criminal activities aiming at profit. The present legislation requires that the prosecutor must show the profit made by the offender in each offence. However, in conjunction with the programme on combating financial crime and the grey market, an effort will be made to revise the regulations on the enforcement of sentences relating to the search and confiscation of criminal profit.¹⁸⁷

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

13.2 Control and technical equipment

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

Surveillance of telecommunications used by suspects is a method employed in recent years in investigating aggravated drug offences. The amendments to the law on Coercive Criminal Investigation Means have enabled the monitoring of telecommunications and other technical surveillance. However, these methods are seldom used.¹⁸⁸

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

¹⁸⁶ See Chapter 1.2.2.

¹⁸⁷ See Chapter 1.2.1.

¹⁸⁸ See Chapters 1.2.2. and 4.2.

In prisons, inmates or premises may be searched, for example, if a prisoner is suspected of possessing unauthorised articles or substances.¹⁸⁹ An inmate may also be isolated in prison for a repeated use of intoxicants, in order to intervene in a drug offence or until the illegal substances have disappeared from the prisoner's body. In 1999, the Government appointed a committee to prepare for the reform of prison sentences and their enforcement. One issue emerging in this connection will be the position of rehabilitative and other actions reducing the risk of recidivism.

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

Banks and other financial institutions must report unusual transactions and intervene whenever necessary. They must also submit the relevant documents for auditing. Money laundering issues in Finland belong to the Money Laundering Clearance House of the National Bureau of Investigation (NBI – annual report 2000).¹⁹⁰

13.3 Intelligence and information systems

The prevention of aggravated crime requires the constant development of intelligence and surveillance operations as well as analysis methods targeted at the offenders. This approach is perhaps the only effective means of investigating and preventing crimes perpetrated by professional criminals. Data collection and information management systems have been established for this purpose. Because the customs can no longer perform random checks at internal borders, also the customs authorities are now engaging in extensive international collaboration and intelligence by utilising, for example, the joint EU and Schengen personal registers.

The National Bureau of Investigation is currently monitoring sixty organised crime syndicates, half of which meet the so-called EU criteria for organised crime. Based on this surveillance, national targets have been selected. As a result of the operations carried out in 2000, many leading crime figures have been given lengthy prison sentences. Targeted actions have had a major impact especially on drug wholesale and financing of large-scale drug smuggling. One key problem in these activities is the high cost of comprehensive and extensive operations, placing a great economic burden on local police units in particular. (Hietaniemi 2001.)

In intelligence activities, special attention is paid to exposing foreign partners in crime, since contacts with the international law enforcement community have opened possibilities to uncover these accomplices. The Finnish police and customs liaison officers stationed abroad have been vital to this co-operation, providing a channel for international efforts to investigate organised crime. During 2000, the reassignment of Finnish PTN (Nordic police and customs authorities) police liaisons has been prepared to meet present-day requirements. In practice, this means that the PTN liaison officer in Cyprus will be reassigned to Costa del Sol, Spain. (Hietaniemi 2001.)

¹⁸⁹ See Chapter 1.2.2.

¹⁹⁰ In 1994–1999, 178 notices on money laundering were filed, leading to preliminary investigation; of them, 70 led to pressing charges. About one out of eight convictions was associated with drug crime.

In 1999, the personal registers of the police were reformed to comply with the Personal Data File Act and the Schengen Agreement.¹⁹¹ As a part of the Schengen Agreement, a database (SIS) will be developed for the EU law enforcement authorities, concerning e.g. persons suspected of drug offences or of money laundering. Also the centralised database (CIS) of Europol and the national customs authorities will be developed further.

The National Bureau of Investigation is obliged to monitor and report on the state of national drug crime (statistics and reviews) and to produce a report on implementation of antidrug-crime activities. Monitoring of the drug crime situation underwent revision in 2000. In the future, the focus will shift towards aggravated narcotics offences (drug supply and trafficking) and towards circumstances that are conducive to drug smuggling and trafficking, with special attention paid to major trends and threats from the law enforcement viewpoint. The reform takes account of the objectives to harmonise EU drug statistics.¹⁹²

One team of investigators with the National Bureau of Investigation will monitor criminal activity especially associated with Estonia and Russia, with drug offences as a central concern. The group is also in charge of the Finnish segment of the project entitled the *Development of Tools to Support Prevention of Organised Crime in Practice*, jointly implemented by Europol, the Netherlands, Finland, Italy and Hungary and financed through Falcone funds.

13.4 Collaboration with the private sector and citizens

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

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

13.5 Co-operation between the control authorities

In supply reduction, control policy should be seen as concerted action on the part of all the authorities involved: this will enable the efficient use of the scarce resources. The police, customs and frontier guard will intensify co-operation as well as exchange and analysis of information to prevent smuggling. The need for such collaboration will be further underlined now that the Schengen Agreement is in force, and control of individuals has ceased at internal borders.

In the field of law enforcement intelligence services, the joint collaborative working groups of the National Bureau of Investigation, provinces and the local police have outlined from 1998 an

¹⁹¹ Finnish Decrees 509/1995, 3–4/1998, 658/1998, 1144/1998 and 1466/1994, 1104/1998 etc. See <http://finlex.edita.fi/>.

¹⁹² National Bureau of Investigation 2001.

overview of the most dangerous bands of organised criminals operating in Finland. Based on this information, nationwide targets have been designated, and regional and local targets have been singled out for investigation. Co-operation with other law enforcement officials (especially the so-called PTR collaboration between the police, customs and the frontier guard) and with the tax and debt recovery authorities has been close. An effort has been made to improve the quality of these activities, e.g., by intensifying co-operation with the prosecutorial authority. Consequently, an agreement has been reached with the Office of the Prosecutor-General to assign liaison officers, whose aim is to reinforce synergy especially in questions of the demarcation and targeting of investigation and in investigating the so-called police crime. The activities are scheduled to commence in March 2001. The Police IT Management Agency and the National Board of Customs have also participated in the development project of co-operation between the Finnish authorities (*VIRKE*), which aims at developing legislation and co-operation practices on integration and exchange of official information. (Hietaniemi 2001.)

The crime prevention strategy of the police, focusing on the offenders, presupposes that the police can prevent perpetrators from committing new crimes while in prison. This calls for close co-operation between the police and prison administration.

The control authorities cannot alone succeed in deterring drug offences. To achieve the best results, these activities should be harmonised with other societal anti-drug measures. Prevention, prohibition and law enforcement must form a balanced and congruent entity.

14 Quality assurance

14.1 Training for professionals

Detectives and also other police officers come increasingly often in contact with drug-related crime, a fact that has caused a great demand for further training. An effort to meet this demand has been made each year. Training is primarily provided by experienced members of the drug squad. Established in 1998, the new Police College of Finland has a major role in this respect.

Also the customs authorities have directed resources at training customs officials, both through in-house courses and training by the police. As a part of co-operation between the customs authorities, a guidebook in Finnish and Russian was published in 1997 to prevent the smuggling of drugs and psychotropic substances (Alaniemi et. al. 1997). In addition, training will be provided for the police, customs and the frontier guard, based on the joint drug strategy of these authorities.

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

Implemented by the police in association with UNDCP, the two-year training programme on anti-crime techniques for the law enforcement authorities in Estonia was completed in 1999. The Finnish police still engage in training, which is associated with measures to combat crime and money laundering in Estonia. Officials in Finland's neighbouring areas are also trained within the framework of international customs co-operation. In recent years, the Finnish police, customs and the frontier guard have also launched co-operation with their corresponding partners in the Baltic States and Russia. The National Agency for Medicines and the European Commission have implemented a project to examine the present situation in the use and supervision of legal narcotics in the 13 Phare countries.

14.2 Research

The offence report and court statistics provide information about the trends in drug crime and actions to reduce the supply of drugs. However, access to these data is heavily protected under the data protection regulations, with strict rules on the research use of this material. During the year, offence report statistics were used to assess the number of hard-drug users.¹⁹³ The court statistics have provided material for a study on recidivism, shedding light on repeated drug offences and their social and cultural backgrounds. This study was published at the beginning of 2001.¹⁹⁴

¹⁹³ A joint study between STAKES, the Ministry of the Interior, the National Public Health Institute and the University of Jyväskylä. See Chapter 2.3.

¹⁹⁴ See Chapters 4.1 and 4.2.

A special study on court practice with regard to drug crime was completed in 1999.¹⁹⁵ Another study to evaluate antidrug measures of the police is currently underway, with the purpose of evaluating a special anti-drug project undertaken by the police in Greater Helsinki in 1999–2001. This study zeroes in on local activities, impact assessment and co-operatative working methods. Another aim is to use police information to form a picture of typical drug dealers and their networks.

¹⁹⁵ See Chapter 4.2.

15 Discussion

15.1 Principal intervention strategies and their evolution

The debated themes during the report year included the increasing number of drug offences, the criminal position of user offences and the new ways of combating crime. According to a study published in 1999, prosecutorial and court practices in user offences differed greatly. From the viewpoint of the rights of the individual, the situation is untenable, because the consequences of an offence vary depending on the locality. Therefore, the Office of the Prosecutor-General provided the prosecutors with directions in 2000, concerning the mitigating circumstances under which the prosecutor may refrain from pressing charges, and the Ministry of Justice also prepared a bill, one aim of which is to harmonise punitive practice in drug-user offences. It remains to be seen in the near future as to what the consequences of these guidelines are and how the introduction of the new and more lenient punishment (for drug-user offences), taking effect in September 2001, will affect decisions to waive prosecution.

In the field of supply reduction, important documents published during the year included the programme to intensify the 1998 Government Decision-in-Principle and the sector-specific strategies of the police and prison authorities, aiming at reducing substance abuse and supply in their respective fields. The Customs Administration is drawing up a corresponding strategy in 2001. Legislative reforms to enhance the powers and ways of exercising control constitute an integral part of the work done by the control authorities. At the beginning of 2001, the Finnish police were given new, more extensive powers to engage in fictitious purchase and so-called undercover operations. The Customs Administration is preparing for corresponding jurisdiction to be enshrined in the customs law. For prison administration, the amendments to the laws on the enforcement of punishments are under preparation to increase the authority of personnel to confiscate drugs in prison.

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

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

15.2 Main future trends and strategies

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

International co-operation and its development is however the most important factor predetermining the future guidelines for supply reduction. In these activities, the same international directives as mentioned above for demand reduction will be followed.¹⁹⁶ Another important fact directing supply reduction activities is the Schengen Agreement, which took effect in Finland on 25 March 2001.

¹⁹⁶ See Chapter 11.

Part V

Key issues in 2001

16 Polydrug use

Studies specifically focusing on polydrug use or mixed use of alcohol and/or drugs have not been conducted in Finland. Therefore, the results presented below approach the topic indirectly through other studies, statistics and interventions relating to substance use and abuse.

In this context, polydrug use as a phenomenon is narrowed down as follows:

- As is customary in Finland, polydrug use is defined by applying regular use of substances as the essential criteria (in terms of harms as a part of problem use).
- The definition of polydrug use does not allow making a distinction between simultaneous or alternate use, or whether the use depends on, e.g. supply.
- The definition of polydrug use does not always enable distinction between substance abuse and possible medicinal use coinciding with the use of narcotics.
- As regards chemical findings, some combinations make it difficult to infer whether the findings result from impurities of some substance or from systematic polydrug use.
- The available data do not show how essential are the drug combinations or is the reason for polydrug use e.g. active effort to alleviate some health symptoms through self-care.

16.1 Patterns of drug use and user groups

Many population surveys have studied the use of various substances and mixing alcohol with pills among young people, but no polydrug user profiles have been analysed based on these surveys. As for experimental use, a small-scale study discussed recreational use as a part of new technoculture, with drug combinations examined in detail. In terms of problem use, traces of polydrug use are mainly inferred from drug-related harm statistics, such as treatment, cause of death and drunken driving statistics. However, no detailed analysis has been made concerning the sociodemographic or cultural backgrounds of polydrug users, whose information has been retrieved from harm statistics.

The ESPAD school survey on 1999 found that about three quarters of 15–16-year-olds who had tried tranquillisers or sedatives or some illegal drug other than cannabis had also mixed alcohol with pills, while about half of those who had experimented with cannabis or inhalants had done so. On the other hand, about a third of those having mixed alcohol with pills or used inhalants,

tranquillisers or sedatives had also tried cannabis. The researchers concluded that heavy experimenting with alcohol (being drunk) is linked to experiments with other substances and that substance use is concentrated in the same clusters of young people (Ahlström et al. 1999).

A small-scale study conducted in 1999 for the first time examined the so-called recreational use of drugs, which especially takes place at clubs or one-off parties or raves (Seppälä 1999 and 2000).¹⁹⁷ According to the researcher, the most obvious differences within technocultures and the related substance use in Finland are to be found between the users of so-called stimulants and psychedelic substances.¹⁹⁸

Stimulants (amphetamines, cocaine and ecstasy) give rise to self-assertion, euphoria, sociability, heightened energy, efficiency as well as feelings of empathy and love. Members of a club culture seek an escape from everyday routines and from the dull and grey mainstream. Partying and intoxication offer an escape to a world where one can be happy without a need to perform. A kind of elitism is associated with this subculture: because we are otherwise successful, we can secretly engage in vicious practices. Cocaine, which, according to this material, is increasingly more prevalent within this subculture, is a yuppie drug symbolising wealth, whereas the more ordinary and cheaper amphetamine is dubbed “a poor man’s cocaine”.

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

Based on treatment statistics, it seems as if polydrug use is typical of Finnish problem drug use. Over half of the clients seeking treatment for drug problems have reportedly used at least three different substances.¹⁹⁹

Three different user profiles among persons seeking drug treatment has emerged throughout the 1990s according to the main substances used:

- i) Opiate users, who also indulge in other narcotics, but mostly abstain from alcohol and medicines;
- ii) Stimulant and cannabis users, who also consume large quantities of alcohol;
- iii) Polydrug users of alcohol and medicines, who also use cannabis but seldom hard drugs.

The slight changes in user profiles in the late 1990s show that people who drink alcohol are increasingly using stimulants too and that opiate addicts use tranquillisers. Among the latter group in particular, self-treatment by using tranquillisers may have a part to play in polydrug use, especially

¹⁹⁷ The study is based on observation, interviews and a questionnaire on the Internet. The latter resulted in about 100 responses. The purpose of the study was to examine the meaning of drugs for members of a given subculture and the relevance of this phenomenon today – not substance abuse as a ‘problem.’

¹⁹⁸ Even if drug use cultures differ and include several substances, it is unclear if these substances are mixed or is it perhaps so that different persons just use different substances inside the culture.

¹⁹⁹ See Chapter 3.1.

because the one-day census carried out in all social welfare and health care units and the broad definition of problem use employed in it suggest the problem use of medicines to be more widespread than problem use of narcotics.

16.2 Health-related and social consequences

It is apparent that the health consequences of polydrug use in its various combinations are universal, and this means that international results are applicable to the Finnish situation as well. No specific studies on the combined effects of drugs have been made in Finland, and the same applies to the social consequences as well.

Drug deaths constitute the most serious consequence of narcotics use. These cases almost invariably lead to an autopsy and forensic examination. According to the studies on 1990–1996, in a quarter of the cases involving narcotics finding in forensic chemical analyses, the results showed the presence of several substances. As many as a third of the positive findings made in 2000 involved more than one substance (Vuori et. al. 2000a and 2000b).²⁰⁰

Table 18. Combinations of narcotic substances found in forensic autopsies in 1990–1996

Findings = 426	1990	1991	1992	1993	1994	1995	1996	Total
Opiate + cannabis + amphetamine	0	3	0	1	4	3	3	14
Opiate + amphetamine	0	1	0	2	4	4	2	13
Opiate + cannabis	6	3	4	0	3	5	8	29
Amphetamine + cannabis	2	3	10	7	4	5	10	41

Not all poisoning cases, where substance findings consisted of pharmaceuticals, involved substance abuse; instead, certain pharmaceuticals were clearly associated with suicide. On the other hand, considerable amounts of alcohol (blood alcohol level exceeding 0.5 per mill) were found, for example, in over half of the deaths by pharmaceutical poisoning in 1999.²⁰¹

16.3 Risk assessment and local markets

Health risks associated with polydrug use are apparently the same in Finland as in other countries. No specific Finnish studies on this topic have been conducted, and the same applies to risks as well. Regional drug markets have not been studied since the mid-1990s.

Based on interviews carried out in the mid-1990s among the police and persons active on the drug market, it was established that persons selling drugs usually have a main article they concentrate on. The interviewees nevertheless reported that the majority of the active sellers could, when necessary, provide other substances as well. This means that by the mid-1990s Finland did not

²⁰⁰ Department of Forensic Medicine, University of Helsinki 2001.

²⁰¹ See also chapter 3.2.

have an actual polydrug market, with the possible exception of the so-called “prescription counterfeiters”, characterised by the role of using substances with alcohol, and “partygoers” mixing ecstasy, LSD, cocaine, hashish and amphetamines and who were open to all kinds of substances but who wanted to avoid addiction (Kinnunen 1996).

As with medical risks, a link between social risks and polydrug use is hard to establish, but one possibility to do so is to examine chemical findings involving persons caught while driving under the influence of narcotics. Interestingly enough, it is exactly polydrug use (defined in broad terms) that is increasingly causing risk to road traffic, because as little as a third of these cases involved just one substance.²⁰²

Table 19. Prevalence of narcotics in cases driving under the influence of drugs in 1993–1999

Narcotics findings	1993	1994	1995	1996	1997	1998	1999
1 drug	194	201	178	248	331	345	381
2 drugs	96	109	119	211	243	265	316
3 drugs	31	21	29	47	44	131	165
4 drugs or more	4	3	1	2	4	14	56
Findings, total	325	334	327	508	622	755	918

16.4 Specific approaches to the interventions

In Finland, polydrug use became a more widely discussed issue in the early 1990s, when problems clearly arising from abuse of medicines among problem users of alcohol started to emerge. At the end of the 1990s, the use of narcotics also grew considerably. The increasing assortment of substances led to a need to retrain personnel to deal with problem use of a variety of substances. In the beginning the training was targeted at how to handle new situation where alcoholics also had problems with (psychotropic) substances – perhaps originally prescribed for treatment of addiction. It was not until the turn of the decade that polydrug use became especially topical in training in order to control polydrug use in services for substance abusers.

Co-ordinated by the A-Clinic Foundation, Finland, the Transdrug Project 2001–2003 (Training need analysis in health and social services—A response to expanding polydrug use) started in 2001 with the support of the European Community Leonardo da Vinci programme.²⁰³ The project involves 18 partner organisations based in Finland, Italy, the Netherlands and the Slovak Republic. The project’s overall aim is to improve the quality, relevance and effectiveness of training offered to professionals involved in the management of substance abuse problems.

Changing patterns of use of psychoactive substances and the parallel changes in treatment services require the strengthening of the skills and competence of a broad range of professionals.

²⁰² National Public Health Institute / Laboratory of Substance Abuse 2001.

²⁰³ See <http://www.a-klinikka.fi/transdrug/index.html> cf. also <http://www.leonardodavinci.fi>.

Providing relevant training calls for an understanding of existing and emerging needs for information and training. The Transdrug Project develops methods for exploring and assessing such needs.

The project's activities consist of:

- Development of methods for identifying and analysing training needs among professionals involved in the management of substance abuse problems;
- Testing and fine-tuning of the methods at a local/regional level;
- Production of a Tool Kit that will include case studies illustrating the potential and limitations of the methods used. The Tool Kit can be used as a handbook in training/service planning and as training material.

Improving the quality, relevance and effectiveness of training requires that the perspectives and interests of key stakeholders are taken into account. The Transdrug project is carried out by a broad-based partnership in which are represented the views of service providers, providers of initial and continuing training and professionals involved in the management of substance abuse problems.

In Finland, this undertaking was preceded by a national project called *Monikko*, financed by the Finnish Slot Machine Association, with the aim of creating a training-oriented work model to support readiness to prevent polydrug use and to treat clients with multiple-drug problems.²⁰⁴ During the project (1999–2001), training activities have focused on four project localities, where training need assessment has been made, for instance, in specialised substance abuse services, social and health services, and, to some extent, concerning other professional groups (supervisors, entrepreneurs). The project has participated in organising several training events for a wide range of groups (e.g. workers providing specialised services for substance abusers, social welfare and health care professionals, students, schoolchildren, parents): method training, polydrug training, development and educational seminars, lectures and discussion forums.

16.5 Methodological issues

Methodological questions concern especially the definitions of such concepts as 'polydrug use' and, in the Finnish context, more common 'mixed use of intoxicants', and how to analyse reasons for multiple drug use as well as its settings and consequences in general.

Owing to the limited number of cases, it may be difficult to categorise reliably various combinations of substances into uniform frames of reference or to choose appropriate controls both in population surveys and statistics on drug related harms. User cultures, too, require qualitative analyses in order to clarify the roles played by different substances and their combinations.

Researchers are faced with similar problems when the social and health-related consequences of substance use are assessed: for example, how to establish that social consequences have a causal or other relationship with polydrug use instead of some other reason associated with the drug problem.

As was previously the case with drug use in general, questions have been asked as to whether substances are crucial to polydrug use or whether it is more worthwhile to examine addiction behaviour and other underlying factors, such as psychological problems.

²⁰⁴ See http://www.a-klinikka.fi/kehittamistoiminta/projektit/hanketietokanta/hankkeet_4_f.php?id=32.

17 Effectiveness of treatment – efficiency of interventions

In autumn 1999, the Finnish Medical Society Duodecim and the Academy of Finland staged a consensus seminar discussing the treatment of drug addiction in Finland, with the effectiveness of drug treatment as one topic. According to an introductory lecture on the subject, treatment decisions are usually based on textbooks, review articles, papers delivered by international researchers or opinions of an esteemed colleague. However, it has happened time and again that generally used treatments have turned out to be inefficient, uneconomical or downright dangerous and instructions given in textbooks are often outdated. (Salaspuro 1999.)

17.1 Approaches to treatments and related concepts of effectiveness

The consensus seminar brought up the concept of evidence-based treatment as a guideline for developing the care system further. The issue was clarified by members of the working group evaluating Swedish health care technologies. The Swedish working group (SBU) had drawn up an evidence-based report on the various types of treatment used in alcohol and drug problems.²⁰⁵

The SBU study results play an important role in the development of Finnish drug treatment as well.²⁰⁶ For example, STAKES introduced a guidebook on substance abusers' treatment facilities and their treatment methods in the National Seminar on Intoxicants, including classification of treatment methods based on the SBU study. (Pienimäki ed. 2001.)²⁰⁷

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

It was noteworthy that the most commonly used methods were relatively general in nature, while the so-called specific approaches drawing on a theoretical framework were in a more marginal position (Pienimäki 2001b).²⁰⁸ The most usual method was *general supportive therapy* or *support*.

²⁰⁵ A study in Swedish, see <http://www.sbu.se>.

²⁰⁶ The procedures to develop opioid-dependent clients' treatment with medicines (Chapter 9.3.2) are in part based on the evidence presented in this study.

²⁰⁷ The information contained in the guide will be later incorporated in the drug treatment unit database of STAKES, see <http://www.stakes.fi/neuvoa-antavat/>.

²⁰⁸ See http://www.health.fi/paihde/paihdepaivat/ohjelma_2001.html.

If the criterion was ten per cent or more, the next most popular method was *the prevention of relapse*, while *utilising social support* and *learning social skills* were joint third, followed by *health counselling for drug users* and *solution-centred therapy/method*. The large proportion of health counselling for drug users was due to separate questions for alcohol, narcotics, medicines and polydrug use.

No significant statistical difference was found in the treatment of alcohol, narcotics, medicine or polydrug use. Thus it was interesting to note that all substance use problems were treated with similar psychosocial methods, but some methodological differences were found between outpatient and inpatient care, mostly in terms of the extent that a given method was applied.

17.2 Evaluation of treatments

The above-mentioned SBU working group found 112 randomised and controlled studies on *the psychosocial treatment forms of drug addiction* by the end of 2000 (Salaspuro 2001). Almost all studies were conducted among patients in methadone substitution. The studies could be divided as follows:

1. Supportive treatments, with an effort to create a viable co-operative network between the patient, treatment provider and relatives. These treatments were not based on written directions and their contents were often inadequately described.
2. Treatments based on learning, with an effort to alter the client's drug-related behaviour. Behaviour therapy, which requires adequate training on the part of the therapist, is one example of such treatment. Some treatment methods were based on a guidebook, in which case this type of care could be provided without special training.
3. Psychotherapy, which includes, for example, family therapy and cognitive treatments. Official training programmes have been established (at least in Sweden) for these methods.

The treatment outcomes were more or less the same both among abusers of opiates and of cocaine. The best results were achieved in treatments based on learning. Certain forms of psychotherapy have also been proved to have positive impacts, but the evidence is not as compelling there. Supportive treatment did not have significant positive effects.

Based on seven randomised studies, psychosocial treatments were ineffective in treating dependence on cannabis. No randomised studies on the psychosocial treatment of amphetamine dependence were found.

According to the working group, 55 randomised and controlled studies on methadone substitution were published by the end of 2000. Five studies compared methadone with placebos. All these studies reached the conclusion that methadone reduced abuse of heroin and enhanced the patients' commitment to treatment. One study also indicated lower mortality in the treatment group compared to the control group. In addition, methadone substitution has been proved to lead to considerably better commitment to treatment than comprehensive psychosocial withdrawal treatment lasting for six months.

A meta-analysis conducted in 1998 found that in different cultures and ethnic groups methadone substitution treatment reduced significantly the illicit use of opiates, property crime and HIV-risk

behaviour. Treatment was also shown to reduce the risk of death by an overdose to a quarter of the level prior to the programme.

In the 1990s, sublingually administered buprenorphine was increasingly compared to established methadone treatment. A study conducted in England found that opiate-dependent clients receiving methadone could be transferred to buprenorphine treatment and that after the changeover the patients felt more normal and experienced only minor withdrawal symptoms. It was also shown that buprenorphine's agonistic effects, e.g. euphoria, did not considerably increase with higher dosages, which in turn prolonged the effect of the medicine.

Positive treatment outcomes among opiate addicts have also resulted from an opiate antagonist, naltrexone, which has no narcotic effect. Two studies out of six were able to prove that antidepressants were effective in treating opiate addicts' depression, but they had no impact on the addiction itself.

Thirty-three randomised studies clarified the effects of different pharmaceutical treatments on opiate withdrawal symptoms. Clonidine proved to be effective, and one study showed that buprenorphine was even more effective than clonidine in this respect.

A total of 40 studies had tried various medicines in treating cocaine addicts, but none of them proved to be effective. No studies on medicinal treatment of amphetamine or cannabis dependence were found.

17.3 Methodological issues

In the work of committees of Ministry of Social Affairs and Health on drug treatment (Reports of working groups on treatment systems and medicinal treatment for opiate addicts 2001) the evaluation of treatment efficiency has raised much debate. The starting point of the working groups have been the results of over mentioned SBU report. However both the emphasis of working group reports and the results of SBU-report have also generated critical discussions on the issue.

In the summer of 2001, a team of experts was appointed in Finland to prepare quality recommendations for substance abuse services. One aspect of this work is to define the concept of effectiveness associated with methods more precisely in the Finnish context; at the moment, no official definitions exist. It seems probable, that the contribution of the treatment working groups on quality recommendations and the SBU summary report on the effectiveness of various treatments, referred to above, will guide methodological choices of this new team in investigating the effectiveness of drug treatment and preparing the quality criteria on the issue.

So far, there exists no Finnish research report on effectiveness of drug treatment, but the first evaluation report on developing buprenorphine substitution treatment is about to be published by the A-Clinic Foundation, discussing two important treatment facilities (Järvenpää Addiction Hospital and the Kettutie A-Clinic) and their 170 patients treated with buprenorphine between 1 January 1998 and 30 June 2000.

18 Drug users in prison

The criminal policy tasks of the Ministry of Justice were reorganised as of 1 August 2001. Based on this reform, the enforcement of criminal and community service sanctions was delegated to a new central body, the Criminal Sanctions Agency. The Ministry's Prison Administration Department was also replaced by the Criminal Policy Department, which focuses on strategic steering in this field. The tasks of the department include, among other things, general criminal policy, crime prevention and the strategic steering of the enforcement of punishments. The Criminal Policy Department has annual performance negotiations with the Criminal Sanctions Agency, the Prison Administration and the Probation Service.

The Criminal Sanctions Agency is in charge of leadership and development in enforcing community service and prison sentences in Finland. The agency is comprised of four units, which are responsible for:

- Administration of Prison Administration operations
- Administration of the Probation Service
- Enforcement of prison and community service sanctions
- General administration of prison and probation services

The Prison Administration enforces the prison sentences passed by courts of law as well as detention and remand in custody associated with legal proceedings. The Prison Administration has over 30 prisons across Finland: 17 closed prisons, 15 open prisons and 2 hospital units.

The Probation Service is responsible for community service sanctions, such as the enforcement of community service and juvenile sanctions as well as supervision of probationers and juvenile delinquents serving suspended sentences. The Probation Service has 21 regional and 11 local offices.

18.1 Epidemiological situation

People circulating in prisons are recruited from a population of about 10,000, the current number of inmates being about 3,000. The average repetition rate is about 4.12, and the average length of time spent in prison is 6–7 months. Legislation, the Government programme and practice in the prison service emphasise reducing recidivism in an attempt to reduce social exclusion.²⁰⁹

²⁰⁹ Ministry of Justice/Criminal Policy Department/Criminal Sanctions Agency (formerly known as the Prison Administration Department).

In 1998–2000, some 15 per cent of convicts were serving sentences primarily for drug offences, while ten years ago the figure was two per cent.²¹⁰ Drug offenders' proportion started to grow again in 2001. It is noteworthy that about 40 per cent of prisoners have at least one drug conviction (driving under the influence of narcotic substances included); no changes have taken place in the latter during the past five years. Drug offences tend to carry longer sentences as well: in the overall prison population, about half were serving sentences lasting a minimum of two years, while the proportion among drug offenders was two thirds.

It has been estimated that about two thirds of prisoners have a substance abuse problem on entering prison, and one out of seven suffer from a severe substance abuse problem. Over the years, the typical prisoner with substance abuse problems has changed from a middle-aged alcoholic, who is willing and able to work, to a young polydrug user with multiple problems and no work experience.

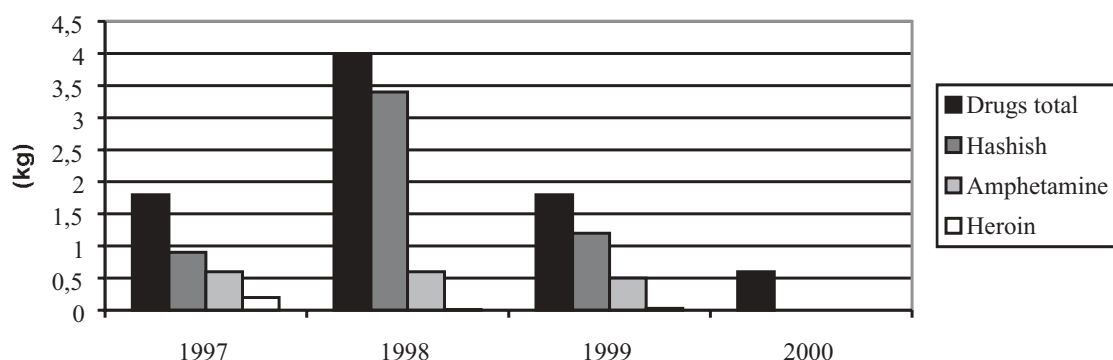
According to an unpublished study made in 1999, almost half of the prisoners had used intravenously drugs at least once during lifetime. Of them, over 50 per cent had injected drugs during the previous month prior to imprisonment. Furthermore, a fifth of the convicts who had used intravenous drugs during lifetime had done so during the past month – probably in prison. This means that over 10 per cent of the inmates continued intravenous drug use during imprisonment. (Arpo 1999.)

Conducted in February 2001, the census of HIV and hepatitis B & C infections in Finnish prisons showed that a third of the 3,108 people who were imprisoned at that time had contracted one or several of the following infections: 884 inmates had hepatitis C, 130 had hepatitis B and 30 had HIV. However, the number of new HIV infections found in prison has dropped more clearly than among injecting drug users outside prisons (Vankiloiden virustartuntatilanne).²¹¹

18.2 Availability and supply of drugs

Preliminary information suggests that in 2000, 0.6 kilos of narcotic substances were confiscated in prisons. The amounts seized have declined during the past two years.

Figure 27. Drug seizures in Finnish prisons in 1997–2000



²¹⁰ See Chapter 4.2.3.

²¹¹ See also <http://www.vankeinhoito.fi/>.

This decline in seizures is attributable to both diminishing demand and supply. One possible explanation for the former is the drug strategy of the Prison Administration and the substance abuse programmes implemented in prisons,²¹² while the latter may have to do with the new and more effective control made possible under the new law.²¹³ The procedures and powers have been in use for a short time only, and it is impossible to say anything definitive about them yet. No studies to follow up the situation are available, either.

18.3 Context Information

Prisoners are obliged to participate in work and other activities in prison, where many types of action programmes are employed in this respect. The purpose of the programmes is to facilitate the prisoner to cope with everyday life after releasing from the prison. The key issues are substance abuse problems and violence, which are, moreover, interconnected.²¹⁴ While alcohol-related problems are the most common variety, drug and multiple substance use predominate the time spent in prison.

In 2001, three prisons commenced a project with the aim of finding a model for integrating substance abuse rehabilitation into work and studies in prison, mainly in preparatory work activities and guided training. The idea behind these activities is to support freedom from alcohol and drugs by talking about drug-free lifestyles during the activities. In the same year, three prisons have launched projects to support the release stage and ex-prisoners' attachment to substance abuse services, work, housing and free-time activities. The partners in this venture are municipalities and organisations (prisons in Kerava, Konnunsuo and Suomenlinna). In addition, the prison hospital is drawing up a handbook for the programme on relapse: it seeks solutions to find a curative approach to relapse into substance abuse. In prison, such a relapse usually leads to disciplinary action.²¹⁵

18.4 Demand reduction policy in prison

Finnish prisons have engaged in substance abuse rehabilitation for about ten years. To develop rehabilitation in prison, the substance abuse rehabilitation project (VP) was launched in 1996 by the Ministry of Social Affairs and Health, the Prison Administration and four major organisations in the substance abuse field. The project ended in spring 1999 (Mutalahti 1999), resulting in ten service products (e.g. six rehabilitation programmes and training packages) for prison use.²¹⁶ Today, substance abuse rehabilitation is based on structured handbook programmes produced in co-operation between the Prison Administration and organisations in the field and on prison administration strategies.

²¹² See Chapter 9.5.3.

²¹³ See Chapters 1.2.2. and 12.2.

²¹⁴ See Chapter 9.5.3.

²¹⁵ Ministry of Justice/Criminal Policy Department/Criminal Sanctions Agency (formerly known as the Prison Administration Department).

²¹⁶ See <http://www.a-klinikka.fi/vp/vp-projekti.html>.

In 2001, a summary of substance abuse rehabilitation programmes in prison was made available to internal use, and ten prisons completed their substance abuse handbook or textbook. There are 19 handbooks in use, four of which are based on the VP project, compiled by NGOs and mainly funded by the Prison Administration. Eighty per cent of substance abuse rehabilitation in prison is based on handbooks. Assessment of the effectiveness and structure of the handbooks will start in 2001, in view of applying the programme in a new prison. Skills among personnel to implement rehabilitation, especially training in methods, have been enhanced.²¹⁷

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

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

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

In addition, 12 closed prisons have one or several drug-free wards. They may involve the inmates' commitment to freedom from drugs and to taking tests, or so-called theme wards, where drug rehabilitation programmes are implemented (alternatively programmes for violence or sexual problems), or general treatment wards, practising community care. The remaining four closed institutions are in the process of establishing such wards or have an outpatient facility on their premises. All open prisons are free from intoxicants. It must be noted that some prisoners participating in the programmes come from ordinary wards, where the inmates have not committed themselves to leading drug-free lifestyles. Drug-free wards account for 10 per cent of the wards in Finnish prisons. The goal is to increase this number fivefold.

Withdrawal symptoms resulting from stopping alcohol or drug use are generally treated in the prison health care system as ordered by the prison physician. If the symptoms are severe, a prisoner may be sent to a prison administration hospital or treatment outside the prison system. An inmate may also seek detoxification or rehabilitation in Hämeenlinna prison hospital. If a prisoner has started medicinal opioid treatment (methadone or buprenorphine) prior to coming to prison, this treatment may continue in co-operation with the unit having initiated care.

²¹⁷ Ministry of Justice, Criminal Policy Department/Criminal Sanctions Agency (formerly known as the Prison Administration Department).

18.5 Evaluation of drug users' treatments in prison

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

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

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

18.6 Methodological issues

Information about substance abuse behaviour is collected during the entrance interview and as a part of normal statistical compilation in the prison health care system; however, the drug section is very limited in these statistics. In addition, it is common that substance abuse information is missing: this is the case with one out of six – one out of three respondents to the entrance interview, where working and functional capacity is assessed. The system as such is not suited for monitoring the treatment of drug-using prisoners. Nevertheless, the health care units of certain prisons have taken part in the general drug treatment data compilation organised by STAKES. Due to their limited scope, these results cannot, however, be generalised to the entire prison service. A comparative in depth survey of the situation of young prisoners in the late 1990s and early 2000s is in planning.

Prisons will increase substance abuse rehabilitation profoundly in 2001–2002. This was made possible by subsidies whereby these resources will double.²¹⁸ Know-how and services in addiction psychiatry will also increase. In 2002, resources will be made available for this purpose, e.g. in co-operation between universities and the prison mental hospital, and in the form of training physicians in specialised psychiatry, among other things.

²¹⁸ See Chapters 8.2 and 12.2.

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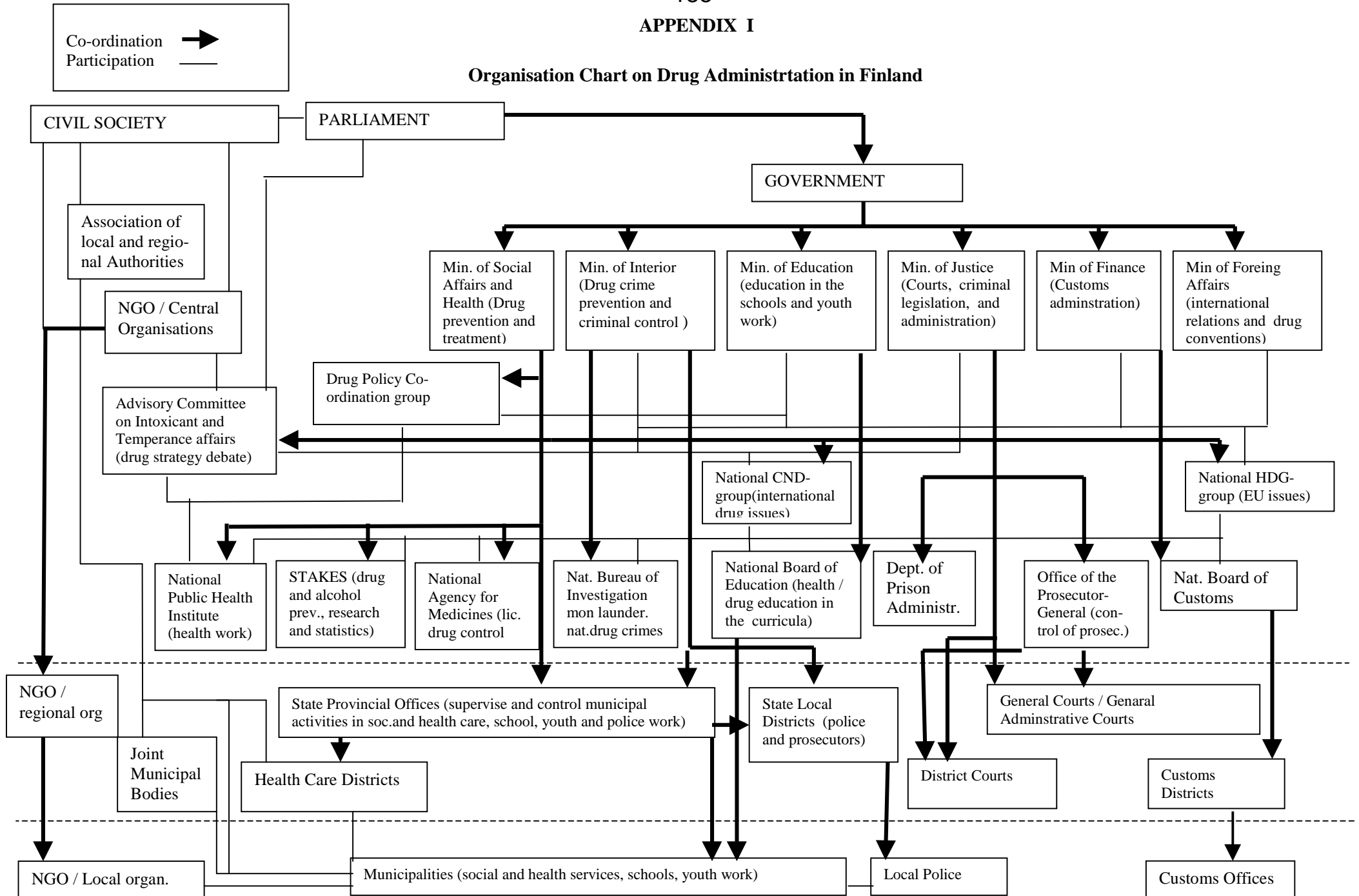
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Organisation Chart on Drug Administration in Finland



APPENDIX 2. Administration of international drug issues in Finland

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

EMCDDA	Ministry, STAKES						Drug Monitoring Centre of the European Union. In charge of drug data compilation and harmonisation. Operates through the REITOX network of national centres
CODRO drug group				Ministry			Body co-ordinating drug issues in external relations of the EU (merged with Horizontal Group in July 2000)
Precursor committee	National Agency for Medicines	Nat. Bureau of Investigation			Customs		Precursor committee of the European Commission
Drug research networks	STAKES, National Public Health Institute		National Research Institute of Legal Policy			A-Clinic Foundation, Centre for Health Promotion, Helsinki University Central Hospital, NAD etc.	Networks in the EU's Fifth research and development programme and e.g. projects operating under the public health programme
Council of Europe							
Pompidou Group	Ministry, STAKES	Ministry, National Bureau of Investigation					Administrative body formed by President Georges Pompidou of France to handle drug issues in Europe. The meeting of Permanent Correspondents a key means of operation
Co-operation with neighbouring areas							
Bilateral relations		Ministry, Nat. Bureau of Investigation			Nat. Board of Customs		Anti-crime activities and customs agreements with Russia and the Baltic countries as main activities
Nordic co-operation							
Nordic Council of Ministers	Ministry	Ministry	Ministry		Nat. Board of Customs	Ministry of Education	Meetings on drug issues between Ministers
Drug committee	Ministry	Ministry	Ministry		Nat. Board of Customs		Multiadministrative forum for exchange of drug information
NAD	Ministry, STAKES						Nordic Council for Alcohol and Drug Research
PTN co-operation		Ministry, Nat. Bureau of Investigation			Nat. Board of Customs		Drug co-operation network of Nordic control authorities, with 18 liaison officers in Europe

APPENDIX 3. National drug information system¹

Epidemiology

Use

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

Treatment

<i>Statistics (Agency responsible)</i>	<i>Criteria</i>	<i>Statistical period</i>
Hospital Patient Discharge register (STAKES)	Personal register ICD-10 diagnoses (since 1996)	Annual statistics
Register of Residential Social Welfare Facilities (STAKES)	Personal register, Residential treatment units for substance abusers. ICD-10 (voluntary)	Annual statistics (since 1996)
Register of infectious diseases (National Public Health Institute)	Personal register HIV (iv-use specified) hepatitis C	Monthly statistics (hepatitis C register since 1998)
Drug treatment information system (STAKES)	No personal identification Voluntary data collection Pompidou model (substance-specific)	Pilot stage (1996, 1998, 1999, 2000, 2001). Covers the entire year since 2000
Census of intoxicant-related cases (STAKES)	No personal identification One-day count in all social and health service units. Problem substances (no primary drug)	Every 4 th year (1995, 1999, ...)

¹ The bulk of drug information in Finland is collected in a centralised manner from information systems as a part of broad data compilation. National and centralised data collection is typical of Finnish up-to-date information compilation. The information in this Table is based on regular and continuous data collection and periodical studies. The information systems are divided into three categories: epidemiological information (on use and harmful effects), project information concerning demand reduction as well as information about libraries and information services.

Substance abuse service statistics (A-Clinic Foundation)	Treatment periods of clients in services for substance abusers No personal identification Not substance-specification	Annual statistics (since 1986)
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Legal control

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

Deaths

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

Demand reduction

Project information

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

Libraries and information services

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

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

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

National Drug Monitoring Centre of Finland²

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

² At a national level, information collection concerning the narcotics situation and drug policy is co-ordinated by the the Ministry of Social Affairs and Health. The National Drug Monitoring Centre co-ordinates the preparation of important national drug reports. For international drug issues and reporting, the Ministry has appointed a working group. All agencies and information providers (such as the Customs, the National Bureau of Investigation, the National Agency for Medicines, the National Public Health Institute, STAKES, etc.) also provide statistical information directly for international bodies, such as the United Nations, the European Union, the Council of Europe, the Nordic Council of Ministers, etc. The same applies to national organisations (the Finnish Centre for Health Promotion, the A-Clinic Foundation, the Free From Drugs Association, etc.)

APPENDIX 4. Actors in drug demand reduction

<i>Actor</i>	<i>Task</i>	<i>Internet address</i>
National Research and Development Centre for Welfare and Health (STAKES)	<ul style="list-style-type: none"> - Preventive drug work, project co-ordination - Support for municipal activities - Drug research - Drug information compilation - Development and communication 	www.stakes.fi/neuvoa-antavat www.stakes.fi/reitox.fin
National Public Health Institute	<ul style="list-style-type: none"> - Public health work, e.g. combating infectious diseases 	www.ktl.fi
Finnish Institute of Occupational Health	<ul style="list-style-type: none"> - Prevention and treatment of drug-related harms in working life 	Http://www.occuphealth.fi
Unit of youth affairs, Dept. Of Cultural Policy, Ministry of Education	<ul style="list-style-type: none"> - Harmonisation of youth policy measures 	Http://www.minedu.fi/opm/nuoriso/index.html
National Board of Education	<ul style="list-style-type: none"> - Plans the national syllabus (including health education and temperance work) 	Http://www.oph.fi
Prison Administration	<ul style="list-style-type: none"> - Provides and develops drug treatment services for prisoners 	Http://www.vankeinhoito.fi
State Provincial Offices	<ul style="list-style-type: none"> - Supervise drug prevention and social and health services (incl. substance abuse services) in municipalities 	Http://www.intermin.fi/suom/laanit/index.html
Health care districts	<ul style="list-style-type: none"> - Regional collaborative bodies in specialised health care, providing health care services for municipalities 	http://www.kuntaliitto.fi/soster/tipa.html
Centre for Occupational Safety, expert group on temperance issues	<ul style="list-style-type: none"> - Implements actions to prevent alcohol and drug harms, in accordance with the treatment referral recommendations of labour market organisations. Develops temperance work to maintain employees' working capacity and a programme on intoxicant-free workplaces 	Http://www.tyoturva.fi/toimes/index.html
Finnish Centre for Health Promotion	<ul style="list-style-type: none"> - Co-ordinates organisational projects through the forum of preventive drug work - Acts as co-ordinator of project funding for drug prevention of the Ministry of Social Affairs and Health 	Http://www.health.fi/paihide/index.html
A-Clinic Foundation	<ul style="list-style-type: none"> - Provides treatment, information, training and R&D services - Acting as director on the Board of national working group on services for substance abusers 	www.a-klinikka.fi
Other organisations in the field	<ul style="list-style-type: none"> - Actors in preventive and curative drug work 	See e.g. http://www.makupalat.fi/so孢子5.htm

APPENDIX 5 Actors in drug supply reduction

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

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

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

APPENDIX 8 ICD-10 Substance	Acute intoxic./ harmful use	Dependence syndrome	Substance induced brain syndrome	Subs- tance abuse total	Poisonings by drugs and medica- ments	Diseases of the liver	Diseases of the pancreas	Cardio- myopathy	Gastritis	Other drug and medicament induced syndromes	Substance use and treatment	Harms total	Others
Alcohol	F10.0-.1	F10.2	F10.3-.9		T51	K70	K86.0	I42.6	K29.2	E24.4, E52, G31.2, G62.1, G72.1	R78.0, Z50.2 Z71.4, Z72.1		O35.4, Q86.0, P04.3
Opiates	F11.0-.1	F11.2 (excl. F11.22-.23)	F11.3-.9		T40.0-4,.6	---	---	---	---	---	R78.1		---
Substance treatment	---	F11.22-.23	---		T50.7	---	---	---	---	---	---		---
Cannabis	F12.0-.1	F12.2	F12.3-.9		T40.7	---	---	---	---	---	---		---
Cocaine	F14.0-.1	F14.2	F14.3-.9		T40.5	---	---	---	---	---	R78.2		---
Stimulants	F15.0-.1	F15.2	F15.3-.9		T43.6	---	---	---	---	---	---		---
Hallucinogens	F16.0-.1	F16.2	F16.3-.9		T40.8-.9	---	---	---	---	---	R78.3		---
Drugs total										X42 - (F11-16, 19 F50.7, 55, T39-40, T42.3-.4,.6, T43.0-.5)			
Sedatives and tranquillizers	F13.0-.1	F13.2	F13.3-.9		T42.3-.4, T42.6-.7		---	---	---	X41 - (see prev.cell)	R78.4		---
Polydrug use	F19.0-.1	F19.2	F19.3-.9										
Non-dependence producing substances	---	---	---	F55	T39, T43.0-2 T43.3-.5 T43.8-.9		---	---	---	X40 - (see prev.cell)	R78.5		---
Medicaments total													
Drugs and medicaments total											R78.1-.5 Z50.3 Z71.5 Z72.2		O35.5, P04.4, P96.1

* = F55, T36, X44 are from 1998 on combined with ATC-drug codes that are referred in the table with A* and N* figures. These new codes in parenthesis (e.g. F55&N02B/N05A/N06) will in future replace old ICD-10 codes written in the cells. During 1998 and 1999 both codes are in practise still used simultaneously or e.g. T36 code is used without ATC-specification, which in the report is defined as "non-substance specific poisoning" (which probably includes several drug/sedative poisoning cases)

APPENDIX 9

Tables

1. Costs of alcohol and Drug related harms in Finland 1995,1997 and 1998
2. Special Financing for Alcohol and Drug Projects in Finland 1998 - 2001
3. Lifetime prevalence of (experimental) cannabis use according to surveys in 1992 -2000
4. Lifetime prevalence of cannabis use in 1992, 1998 and 2000
5. Lifetime prevalence of cannabis use by region in 1992 and 1998
6. Cannabis use during the past year by age group in 1992 - 2000
7. Drug use during the past year by province in 1998
8. Prevalence of amphetamine and opiate use (%) in Greater Helsinki and in Finland in 1995, 1997, 1998 and 1999
9. Prevalence (%) of amphetamine and opiate use in population aged 15-55 years by region in 1998
10. Substances used by clients in treatment for substance abuse in 1996, 1998, 1999 and 2000
11. Polydrug use of clients in treatment for substance abuse in 1999 and 2000
12. Mean age (years) of persons in treatment for substance abuse in 1996, 1998, 1999 and 2000
13. Indicators of risk behaviour at infection counselling centre Vinkki
14. Cost of narcotics and medicines -related harms in Finland in 1998
15. Drugs seized in 1990 - 2000 (kg)
16. Number of drug seizures in 1993 – 2000
17. Clientele of the Finnish health counselling centres for IV-drug users in 2000
18. Combinations of narcotic substances found in forensic autopsies in 1990 – 1996
19. Prevalence of narcotics in cases driving under the influence of drugs in 1993 - 1999

1. Proportion of 15-16 –year olds disapproving or strictly disapproving of the following forms of substance use in 1995 and in 1999
2. Social exposure to drugs and the ease of obtaining drugs among 15-16 –year olds in 1996-2000
3. Knowing a drug use personally in Finland by age group in 2000
4. Proportion of conscripts having experimented with drugs in lifetime, 1968 – 2000
5. Proportion of 15-16 –year old youngsters that have tried drugs during lifetime or have never used alcohol (abstainers) in 1999 by region
6. Abusers of narcotics and medicines by age groups (%) in treatment for substance abuse
7. Forensic findings of narcotic drugs in autopsies in 1990 – 2000
8. Drug deaths by age group based on causes of death or on chemical findings in 1999
9. Age distribution of new hepatitis C infections in 2000
10. Hospital treatment periods related to drugs and pharmaceuticals in 1990 - 2000
11. Hospital treatment periods related to drugs and pharmaceuticals in 2000 by sex
12. Drug-related hospital treatment periods (%) for 15-54-year-olds in 1990-2000
13. Drug-related hospital treatment periods by age groups for 15-54-year-olds in 2000
14. Number of people suspected and convicted of drug offences in 1987 - 2000
15. Drug offences per 1,000 inhabitants in 1998 - 2000 by region
16. Proportion (%) of prisoners primarily convicted of drug offences according to the annual prison census in 1990 - 2001
17. Narcotics findings among suspects for driving under the influence of drugs (in road traffic) in 1990 - 2000
18. Drug offers to young people (%) during last 12 months in Finland according to the school health surveys in 1998 - 1999
19. Drug offers to adults (%) during the past 12 months by age in 1998
20. Trends in the lifetime prevalence of (experimental) cannabis use in 1990 - 2000 (1992=100)
21. Trends of cannabis related harms in 1993 – 2000 (1993 = 100)
22. Trends of amphetamine related harms in 1993 – 2000 (1993 = 100)
23. Trends of opiate-related harms in 1993 – 2000 (1993 = 100)
24. Trends in drug experiments and related harms in 1990 - 2000 (1992 = 100)
25. Age structure of substance abuse clients in health care institutions and services for substance abusers in 1999
26. Drug related harms by region in 1999
27. Drug seizures in Finnish prisons in 1997 – 2000

The current report on the drugs situation in 2001 published by the National Drug Monitoring Centre of Finland complies with the guidelines for annual national drug reports given by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). This report is the Finnish contribution to the EMCDDA publication “Annual Report on the State of the Drugs Problem in the European Union”. Similar reports are submitted by all the 15 National Focal Points (NFPs) of EU Member States included in the REITOX network co-ordinated by the EMCDDA.

The report contains four different approaches to the drug problem. It first describes the political and legal frameworks of drug issues in Finland. The second part of the report includes an overview of the national situation as regards drugs and drug abuse in 2001. The third part concentrates on activities for drug demand reduction and the fourth on measures for drug supply reduction in Finland. In addition, the report includes short introduction to three current topics, i.e. polydrug use, effectiveness of treatment and drug users in prison.