



European Monitoring Centre
for Drugs and Drug Addiction



**2005 NATIONAL REPORT TO THE EMCDDA
by the Finnish National Focal Point, STAKES**

FINLAND

DRUG SITUATION 2005
**New Developments, trends and in-depth
information on selected issues**

REITOX

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FOREWORD

The 2005 National Report to the EMCDDA by the Finnish National Focal Point is one of the national annual reports on the drug situation compiled by the National Focal Points in the REITOX network, co-ordinated by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). Based on the national reports, an annual report on the drug problem is drafted in the European Union and Norway. The national reports are compiled in accordance with the guidelines provided by the EMCDDA.

The present report has a clear focus on recent developments in the drug situation. First, long-term developments are analysed briefly, and then the most recent developments and trends are looked more thoroughly (part A). Finally, the report discusses three selected issues on drugs (part B). The long-term analysis is divided into two sections, the first one dealing with the drug situation as a whole and the second with anti-drug activities. Part A discusses the drug situation in another order. The chapters that describe the different aspects of the drug situation during the past year (drug experimentation, problem drug use, health problems, social problems, availability and supply of drugs) are linked with discussion on related societal interventions (preventive work, treatment, harm reduction, social rehabilitation, control). The selected issues discussed in part B are (1) Gender differences, (2) European Drug policies: extended beyond illicit drugs? (3) Developments in drug use within recreational settings.

It should be remembered that alcohol has long played a central role in Finnish substance abuse culture. Therefore it is still underlined in Finland that substance abuse behaviour should be looked at comprehensively in place of focusing on drugs alone. Nevertheless, this report will focus on drug use, drug-related harm and poly-drug use, all of which are approaches where alcohol has a minor role. This focus is justifiable as it is customary in Europe to deal with drugs separately from the abuse of legal substances and the problem use of alcohol. This division also applies to the REITOX data production.

The Finnish National Focal Point, which compiled *the 2005 National Report to the EMCDDA*, operates at the National Research and Development Centre for Welfare and Health (STAKES). On drafting the report, research data and comments from experts on different areas of the drug issue were made use of. We thank all experts for their comments. Special thanks are due to Development manager Airi Partanen (Stakes), senior planning officer Kristiina Kuussaari (Stakes) and researcher Sari Sjöberg (Åbo Academi). Researcher Sjöberg has produced the chapter 14 in the report, "Developments in drug use within recreational settings". Senior Planning Officer Ari Virtanen at the Finnish National Focal Point was in charge of the compilation of the report as a whole.

STAKES

Research and Development Centre for Welfare and Health
Ari Virtanen, Senior Planning Officer
PO Box 220, 00531 Helsinki, Finland
Tel. +358 9 3967 2378
Fax. +358 9 3967 2497
E-mail ari.virtanen@stakes.fi
[Http://www.stakes.fi/verkkojulk/](http://www.stakes.fi/verkkojulk/)

DESCRIPTION

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Abstract <p>In 1995–2001, all indicators (experimentation, problem use, health problems, morbidity, mortality, criminality and seizures) suggested that the drug situation was aggravating. As for 2001–2003, however, nearly all indicators show clear signs of a weakening of the trend. Problem use is the only exception in the time period as it increased slightly in 2001–2002. During 2004 the same trend continues except the figures in the mortality which started again to increase. In the late 1990s, drug experimentation and harm increased particularly in the youngest age group (aged 15–24). On entering the 2000s, the trend seems to be evening out in this age group, but instead there is some increase among 25–34-year-olds. At the core of anti-drug activities have been the establishment of drug prevention and youth workshop networks, addition of drug prevention sections in school curricula, enhancement of low-threshold and substitution treatment, investments in health counselling centres, development of drug treatment in prisons, and introduction of new control methods.</p> <p>According to the most recent data, those who had used drugs during the past year accounted for about 3% and problem users for about 0.5 % of the adult population (aged 15–64). Some 7% of schoolchildren (aged 15–16) had used drugs during the past year. The 15–24 age group had the highest level of both use (12%) and problem use (0.9–1.3%). The same age group also showed the highest figures in drug-related harm (drug-related diseases and deaths, or drug treatment clients). But there are some signs of change in the figures, evening out among those under 25 and increasing among those over 25. As in the year 2004, anti-drug activities have focused on drug prevention at schools, early intervention in young people at risk of exclusion; increasing the regional coverage of substitution treatment and health counselling; networking in street-level control and social work (among drug use offenders) and developing care for those released from prison;</p> <p>The main gender differences in drug use are: girls start experimenting with illicit drugs even at an earlier age than boys do; after the age of 25 women’s drug use decreases much more rapidly than men’s drug use; women in general use drugs much less than men do. On the other hand, among severely excluded substance abusers, the differences that come with age are not so drastic. Gender-specific interventions are mostly related to gender specific facilities and to a specific groups such as prostitutes and mothers.</p> <p>The Drug Policy Action Programme 2004 - 2007 (2004) has only one direct reference to alcohol. Direct references to tobacco are also scarce. Doping substances are not mentioned at all. This is partly due to the legislation and administrative structures related to the co-ordination of different substances. Ministry of Social Affairs and Health administrate the first three substances. In Finland, the abuse of alcohol, pharmaceuticals or drugs is referred to as substance abuse. These so-called intoxicants include tobacco but not doping substances. The connections between programmes, substances and related interventions is grounded on this concept.</p> <p>Recreational drug use is a proportionally new concept in the Finnish drug debate and is related to spread of techno culture. First the new party culture spread to ordinary restaurants that serve alcohol, nightclubs and discos, which started to play techno music. In Finland there are not many clubs or bars that are specialised in one type of music. So the phenomena came part of wider trend in youth culture. In Finland, recreational drug use has primarily been prevented by penal sanctions, monitoring public places and at the music festivals popular among young people, so drugs are mainly used in private premises. Only lately there has been some interest in two-way education that does not aim at a total ban on drugs but at the reduction of the risks of recreational drug use.</p>			
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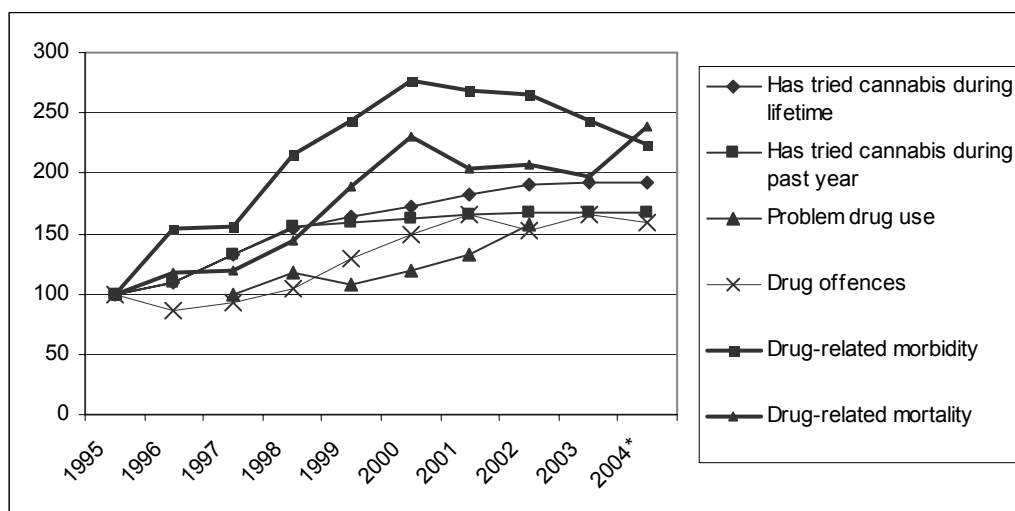
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THE STARTING POINTS FOR DRUG SITUATION AND DRUG PREVENTION

DRUG SITUATION¹

The development of the drug situation is presented in the following time series, which shows that the growth trend in demand, supply and other drug-related detriments that lasted throughout the 1990s showed signs of stabilising at the turn of the 21st century according to various indicators.

Figure 1. Trends in drug use and drug-related harm 1995-2004 (1995 = 100)



* = preliminary information

Drug experimentation and use

Studies show that the trend in drug experimentation of the 1990s was set in motion by men, followed by women in the second half of the decade (Figures 2a, 2b). The proportion of those having used drugs during the past year grew until the end of the 1990s, after which the trend clearly levelled off. The same phenomenon can be observed among young people (Figures 3a and 3b).

¹ See Virtanen 2005. Updated data from Part A. More specific information on the sources of the figures and tables in this section, see Section 16, "Figures and Tables".

Figure 2a. Percentage of men (15-69 years) having tried drugs during their lifetime or in the past year

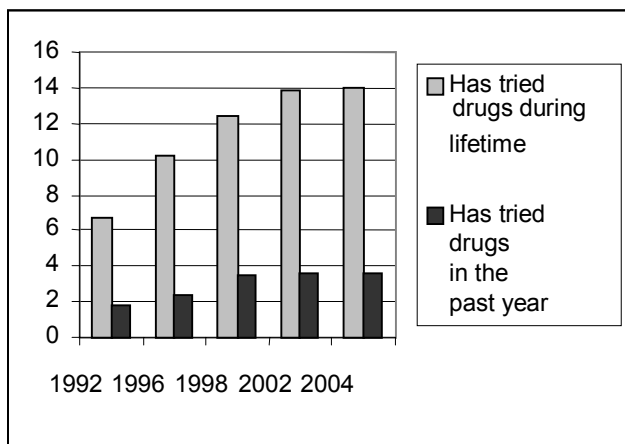


Figure 2b. Percentage of women (15-69 years) having tried drugs during their lifetime or in the past year

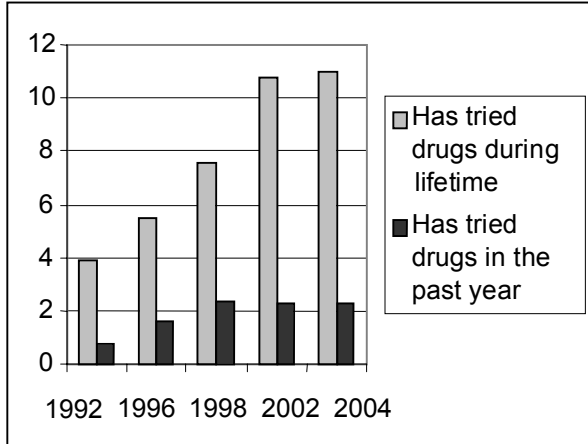


Figure 3a. Percentage of boys (15-16 years) having tried cannabis during their lifetime or in the past year

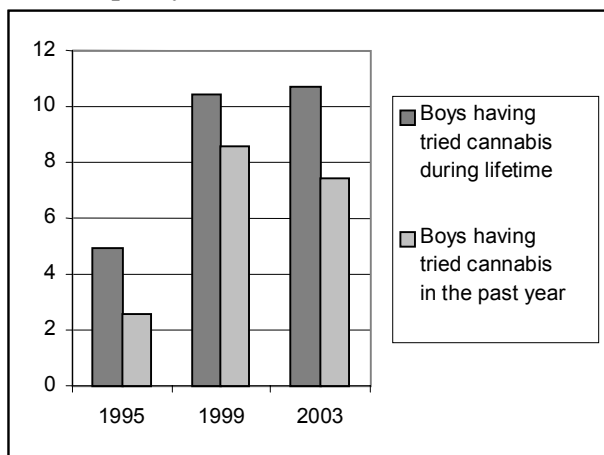
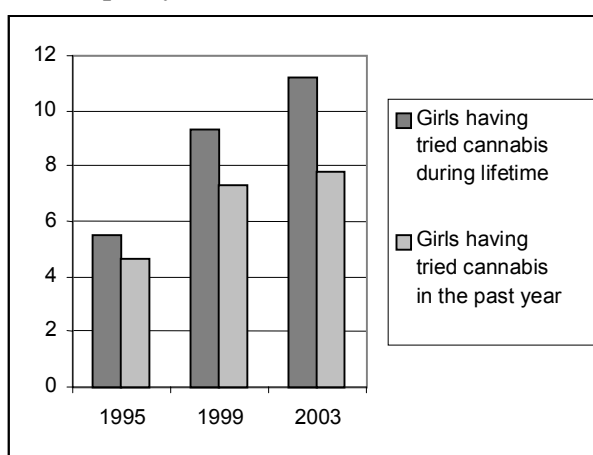


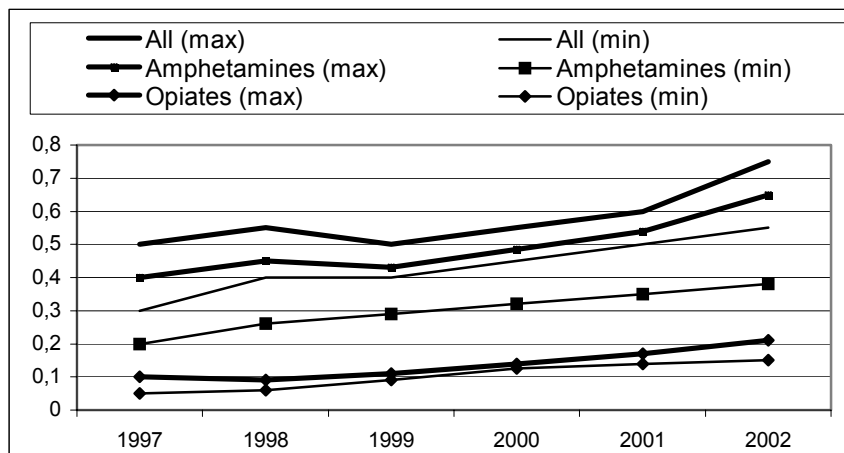
Figure 3b. Percentage of girls (15-16 years) having tried cannabis during their lifetime or in the past year



Problem drug use

The accumulation of detriment leading to problem drug use seems to occur after a lag of 3 to 5 years from the commencement of use. Thus, the sharp increase in drug experimentation at the end of the 1990s seems to have led to the growth of the number of problem users at the beginning of the 21st century (Figure 4).

Figure 4. Percentage of problem drug users (amphetamines and opiates) among 15–55-year-olds 1997–2002



The drug treatment information compiled from units providing specialised services for substance abusers helps in determining the development of a problem user's profile. The most significant change lately has been the sharp increase in the problem use of buprenorphine. During the past few years, buprenorphine has replaced heroin almost completely as the main drug used by drug treatment clients of substance abuse services and is already on the same level as the problem use of stimulants (Table 1).

Table 1. Substances used by clients entering treatment for the use of narcotics and pharmaceuticals (% of clientele) in 2000–2004

Substance category	1st problem substance					1st–3rd problem substance				
	2000	2001	2002	2003	2004	2000	2001	2002	2003	2004
Opiates	29	28	28	31	34	38	40	39	43	46
- heroin	20	13	6	3	3					8
- buprenorphine	7	12	20	24	27					36
Stimulants	28	26	28	28	26	56	55	58	57	55
Cannabis	17	20	18	16	15	59	62	60	58	56
Alcohol	18	19	20	19	18	37	41	42	40	39
(+ drug)										
Sedatives	5	6	5	6	6	27	30	32	36	38

Drug-related health problems

Drug-related deaths (Figure 5) follow fairly consistently the trends in drug use, especially the trends in the use of injected drugs, as the most common cause of drug-related death is death by poisoning, the number of which reacts quickly whenever a new drug consignment enters the market or methods of use change (intravenous use gains popularity, heroin disappears from the market). The delayed increase in problem use should also be seen in hospital statistics, but these show that the number of drug treatment patients in hospital wards has been on the decline (Figure 6). This phenomenon may reflect a decrease in problems related to drug use, but it is more likely a result of changes in the service system and the increase in drug treatment services and outpatient services (substitution treatment, health counselling). Lately the mental health problems suffered by problem drug users have also come to the fore (Figure 7).

Figure 5. Drug-related deaths according to different criteria 1995–2004

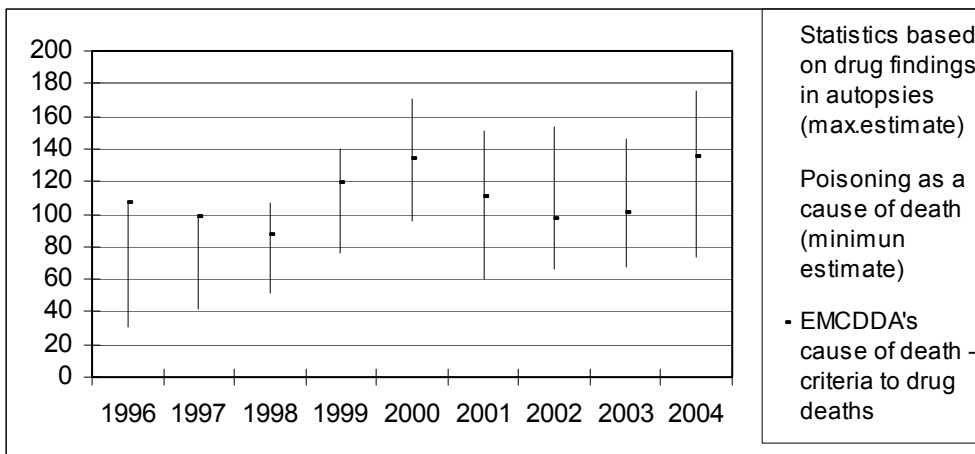


Figure 6. Hospital treatment periods related to narcotics by gender 1995–2004

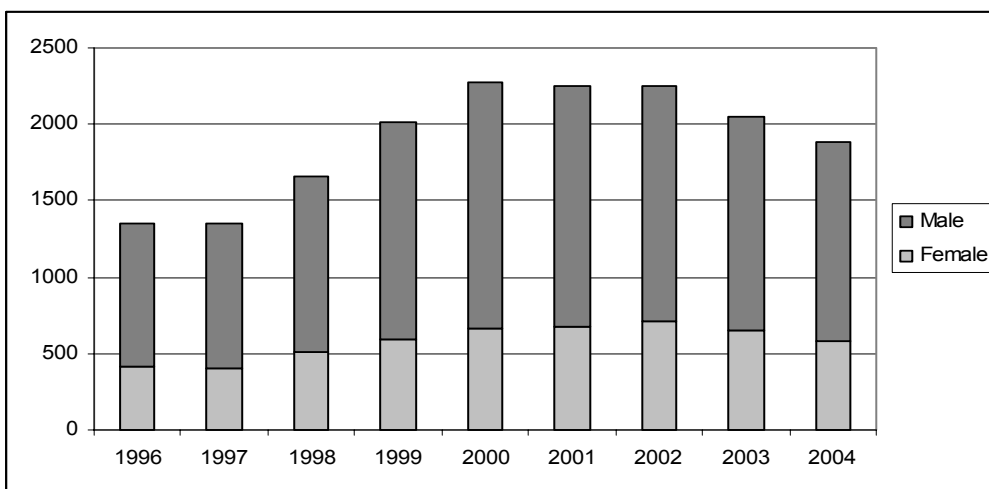
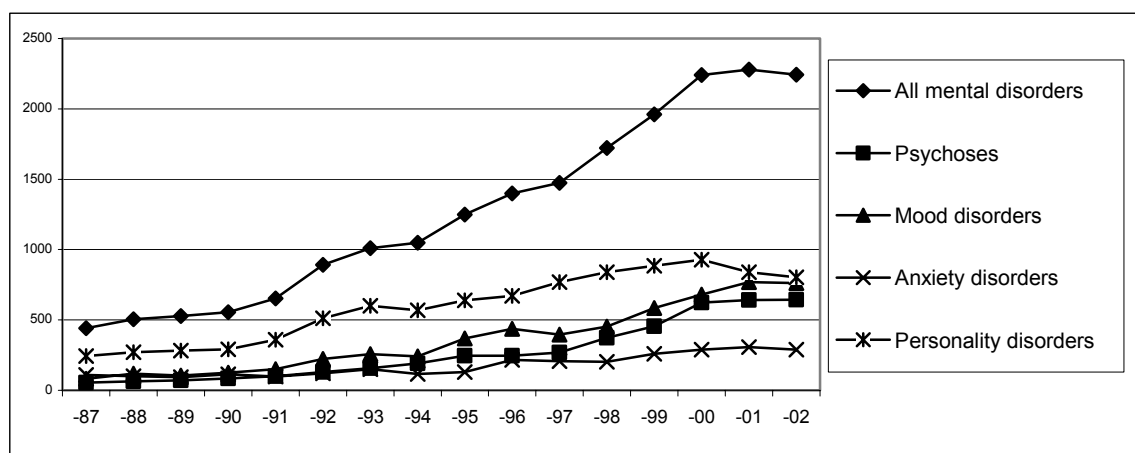


Figure 7. Mental disorder diagnoses co-occurring with drug diagnoses in 1987–2002 according to the hospital patient discharge register



Drug-related social problems

According to all statistics, problem drug users tend to have a lower level of education and are more often unemployed and/or homeless than the population in general. An important variable that reflects social exclusion is drug-related crime, either directly through drug offences (Table 2) or indirectly through other offences (e.g. driving while intoxicated). In Finland, the use of narcotics is a punishable offence; many offences are related to this particular type of offence and thus indirectly reflect the prevalence of drug use. The recently adopted zero tolerance for drug use in traffic explains the rapid growth in these offences in 2003 (Figure 8). The evolution in the number of people sentenced to imprisonment for drug offences clearly reflects the pattern of social exclusion in relation to drugs (Figure 9). The values of all the above-mentioned comparable indicators remained at a fairly even level during the beginning of the 21st century after the rapid increase at the end of the 1990s. However, one example of the aggravation of problem drug use and social exclusion is that an estimated 43% of prison inmates suffer from morbid drug use.

Table 2. Drug offences reported to the police and Customs in 1995–2004

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
Drug offences in total	9,052	7,868	8,323	9,461	11,647	13,445	14,869	13,857	15,058	14,486
Drug offence	8,654	7,132	7,781	8,910	10,701	12,687	12,092	5,821	5,202	4,672
Drug-user offence							1,899	7,240	9,084	9,217
Aggravated drug offence	390	728	529	539	958	741	859	760	742	582
Preparation and abetment of drug offences	8	8	13	12	15	17	19	36	30	15

Figure 8. Narcotics findings from people suspected of driving under the influence of drugs in road traffic, 1995–2004

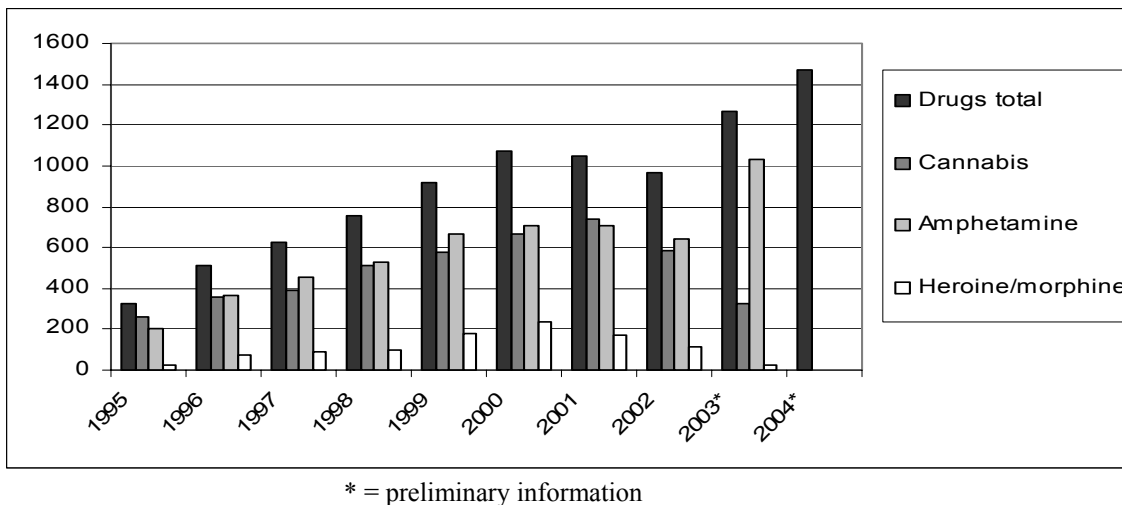
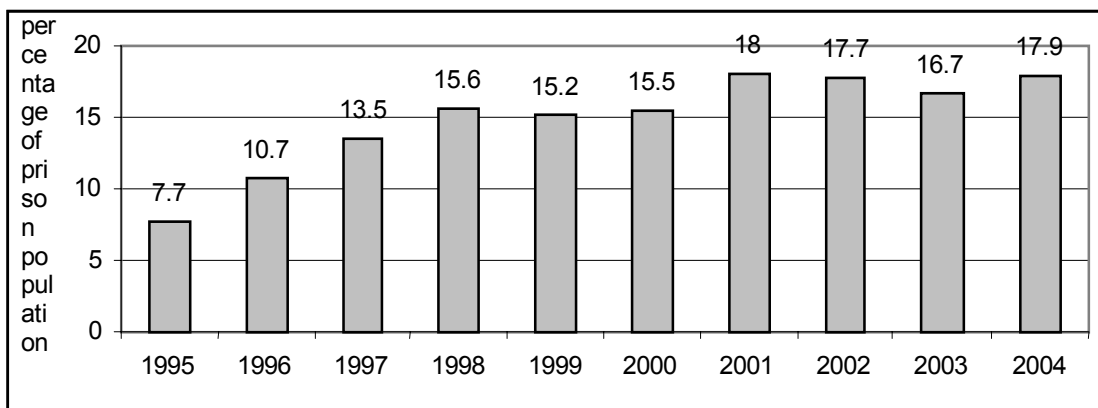


Figure 9. Percentage of prisoners with a drug offence as their principal offence in annual prison census, 1995-2004



Drug markets

One reason for drug experimentation, drug use and problem drug use is the supply of drugs. The prevalence of supply is reflected in citizens’ personal experiences of having been offered drugs (Figures 10a-b; 11a-b) and in the number of drug seizures (Tables 3 and 4). These indicators also showed growth towards the end of the 1990s and a levelling off at the turn of the 21st century.

Figure 10a. Drug offers to boys (%) in the past year

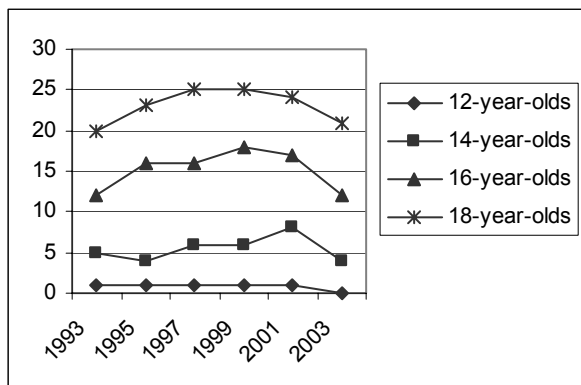


Figure 10b. Drug offers to girls (%) in the past year

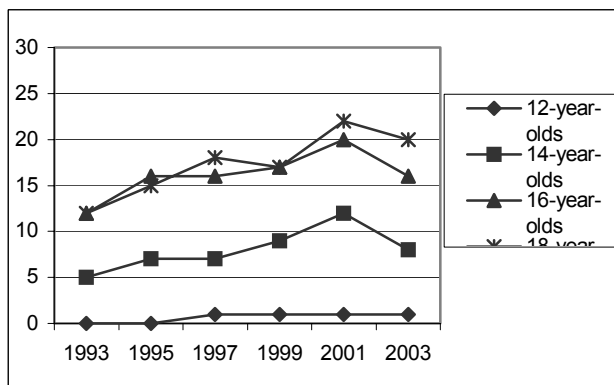


Figure 11a. Drug offers to men (%) in the past year

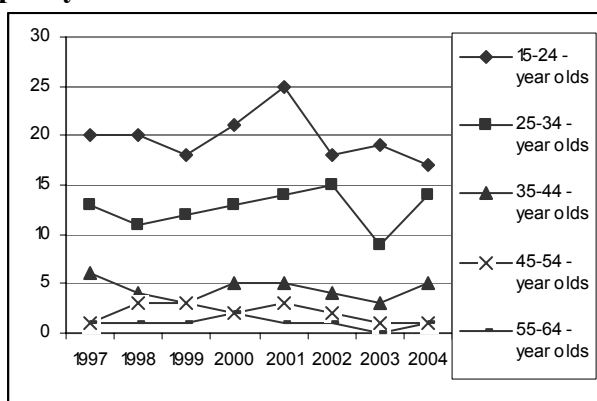


Figure 11b. Drug offers to women (%) in the past year

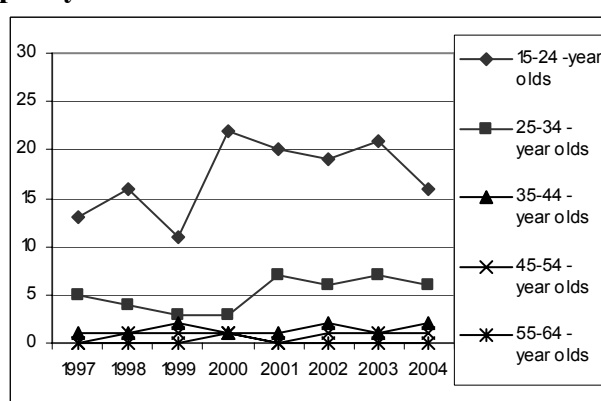


Table 3. Drugs recorded as seized by the police and Customs in 1995–2004

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
Hashish	147.51	99.44	197.66	160.97	492.32	196.54	589.6	482.3	423	467
Marijuana	4.27	3.51	12.15	8.01	18.17	13.82	16.1	32	45	26
Amphetamines	20.12	22.14	22.2	24.78	71.26	79.56	137.3	129.2	114.6	102
Cocaine	0.07	0.07	0.12	1.99	1.7	38.58	6.5	0.4	1.1	1.1
Khat*	68.11	264.5	249.01	103.94	374.1	348.41	664.5	1,039.4	1,879	2,118
Heroin	16.12	6.45	2.4	1.97	2.88	6.03	7.5	3.1	1.6	0.2
Subutex (tablets)	-	-	223	1,175	2,898	12,951	38,200	18,700	37,284	32,970
Ecstasy (tablets)	3,750	1,011	3,062	3,320	17,665	87,393	81,228	45,065	35,216	3,243
LSD (tablets)	500	41	323	301	50	2,355	1,026	4,679	1,460	196

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

Table 4. Number of drug seizures recorded by the police and Customs in 1995–2004

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
Hashish	1,235	1,312	1,686	1,997	2,259	2,482	4,011	3,012	2,796	2,626
Marijuana	-	-	385	382	463	663	1,223	1,275	1,712	2,067
Amphetamines	696	972	1,352	1,641	1,956	2,369	3,778	3,399	3,687	3,392
Cocaine	-	15	16	24	49	40	55	45	49	65
Heroin	82	145	153	210	342	437	558	145	90	45
Subutex	-	-	-	-	-	-	727	741	1,008	844
Ecstasy	-	52	74	57	159	393	465	329	316	328
LSD	-	14	14	-	15	34	14	10	20	21

ANTI-DRUG ACTIVITIES²

Anti-drug activities are largely based on long-term choices in policy and the structures that steer these choices. The central structures of drug prevention are determined in drug legislation, the strategies that steer drug policy and action plans. The focal points of anti-drug activities (prevention, treatment, reduction of drug-related problems, drug control) become concrete in the implementation of tasks related to the above-mentioned structures. Many of the national approaches and activities are related to international systems and agreements regarding drug policy. The resources allocated for the activities also play an important role in their implementation.

Drug legislation³

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

² See Virtanen 2005. Updated data from Part A.

³ See Virtanen 2005, Part A, Section 1.2. Updated data from Part A, Section 1.2.

offence (1–10 years' imprisonment). In 2001, an amendment was made to the Penal Code (654/2001) which introduced the drug-user offence (maximum sentence ½ years' imprisonment).

The amendment to Section 11 of the Basic Education Act (453/2001) introduced a new subject, health education, to primary education, and the amendment to the Basic Education Act (477/2003) regulated curricula and pupil and student welfare services. Strategies for the prevention and treatment of, for example, crises, school bullying and substance use should be recorded in the local curriculum.

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

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

Drug policy⁴

The Finnish Government issued a decision in principle on 5 October 2000 to enhance drug policy based on the first Finnish drug strategy from 1997. The objective was to reduce both the supply and demand of drugs and to arrest the growth of drug use and related crime. The Government set up a drug policy co-ordination group to co-ordinate, implement and monitor the

⁴ See Virtanen 2005, Part A, Section 1.1. Updated data from Part A, Section 1.1.

national drug policy programme. The group had representation from the relevant Ministries and agencies. The co-ordination group prepared an action plan for more efficient drug policies for 2001–2003 (2003). In line with the Programme (2003) of the Finnish Government lead by Matti Vanhanen, the co-ordination group drafted a drug policy action plan for 2004–2007 (2004), which was approved by the Finnish Government by a decision in principle at the beginning of 2004 (see Section 1.1). In addition, as part of the Government programme, a cross-sectoral programme on internal security has been drawn up in order to increase public security.

With respect to the drug strategy of 1997, the report of the committee for preventing drug use among young people was published in 2000, and the report of the working group on drug treatment in 2001. In addition, the police have produced an anti-drug strategy (2002) for 2003–2006 and the Prison Service (2002) drew up its substance abuse strategy (Sections I–III), which has subsequently been supplemented by a new strategy for 2005–2006. Both emphasise drug control as well as reduction of demand. The Customs have also produced a drug strategy for 2002–2005 and a joint drug strategy (PTR) has been drawn up by the police, the Customs and the Border Guard. The Health 2015 public health programme (2001) sets as one of its goals the appropriate treatment of the health problems associated with alcohol and drug use, and the national plan of action to combat poverty and social exclusion 2003–2005 (2003) calls for more effective drug prevention measures, sufficient treatment for drug users and the expansion of measures to alleviate the negative effects of drug use.

Drug prevention⁵

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

The reform of the school curriculum supports the qualitative development of health and legal education in school and the establishment of co-operative models between home and school and

⁵ See Virtanen 2005, Part A, Section 3. Updated data from Part A, Section 3.

other important actors in the field. The new school curriculum now regulates health education as a separate subject in upper secondary and vocational schools. Substance abuse questions are key aspects of this new subject. School curricula and pupil and student welfare services should also include drug prevention. Furthermore, many schools have implemented their own substance abuse prevention programmes in co-operation with organisations, the authorities and parents.

As a form of early intervention, youth workshops have been organised to prevent the exclusion of young people from education. The aim is to support young people's vocational skills by building a bridge between education and working life. Learning social skills and self-determination are the goals of the workshops, which are also considered part of youth work and other social work intended for those who, for example, have dropped out of vocational education.

Drug tests have been introduced in working life in order to prevent drug-related problems and to refer individuals with drug problems for treatment as early as possible. Network-based expert forums have been developed for training and the exchange of information. Other drug prevention measures are drug information services, virtual discussion forums and anonymous self-testing services for assessing one's own substance abuse. The first nationwide drug information campaign was implemented in 2001–2003. The campaign also included an extensive follow-up study.

Drug treatment⁶

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

⁶ See Virtanen 2005, Part A, Section 5. Updated data from Part A, Section 5.

abusers, increasing numbers of substance abusers are treated within primary social and health care services, including social welfare offices and child welfare services, mental health clinics, health centre clinics and wards, hospitals and mental hospitals.

The development policy for drug treatment services emphasises developing low-threshold services and related training. The aim is to get drug abusers to enter the treatment system as early as possible. The Finnish system also emphasises that drug treatment as such is often insufficient and so the substance abuser should be assisted in solving problems related to subsistence, habitation and employment. Both the traditional drug-free treatment and substitution and maintenance treatment, which are new in the Finnish system, have been used in the actual drug treatment. Investments have been made especially in the development of treatment practices for the latter along with the new legislation on the subject. Targeted substance abuse services have also been arranged for specific groups (Russian immigrants, Romanies etc.). Services aimed at immigrants have been facilitated by immigrants' improved proficiency in Finnish. In 2002–2003, the Government invested 15 million euros in the regional development of the drug treatment system on the basis of the proposals made by the working group that dealt with the matter. In addition, a significant amount of resources have been allocated to drug treatment training, and both electronic and manual training packages have been produced for the public (A-Clinic Foundation's *AddictionLink*), for the providers of treatment services (A-Clinic Foundation's *Huuko project*) and physicians (*Päihdelääketiede*, a textbook of addictive disorders).

Reduction of drug-related health problems⁷

A central method in preventing drug-related health problems is outreach work that covers the everyday living environment and combats problem use and related problems where they appear. In Finland, the target group for outreach work has traditionally been small, mainly young people in big cities on Friday nights.

The HIV epidemic that began in 1998 among drug users brought to the public eye the importance of preventing communicable diseases spread by intravenous drug use. The operating model of health counselling centres for drug users, which started as a trial in Helsinki in 1999,

⁷ See Virtanen 2005, Part A, Section 7. Updated data from Part A, Section 7.

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

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

Reduction of drug-related social problems⁸

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

⁸ See Virtanen 2005, Part A, Section 9. Updated data from Part A, Section 9.

abuse services. They are meant for substance abusers that need daily support for independent living. There are also rehabilitation services available in some housing service units.

The anti-drug strategy for the police for 2003-2006 (2002) emphasises that a drug user met in connection with police control activities and investigation shall always be provided treatment referral and that appropriate treatment should be a real alternative to penal sanction for a problem drug user. According to the amendment to the Penal Code (654/2001), multiprofessional hearings can be arranged as an alternative to a fine for minors having committed a drug-user offence.

According to Act 878/1995, prison health care must be organised so that inmates have equal opportunities with the rest of the population to improve their health and prevent illness. They must also have access to sufficient health care services. Nowadays, there are rehabilitation programmes as well as contractual wards supporting an intoxicant-free lifestyle in almost all prison institutions. Rehabilitation programmes are also available in open institutions. If the inmate started opiate treatment (methadone or buprenorphine) before entering prison, the treatment can be continued in prison in co-operation with the treatment unit where it was started.

In co-operation with the relevant organisations, the Prison Service has prepared various alcohol and drug programmes for inmates in prisons and for drug users released from prisons. The alcohol and drug programmes of prisons enable an individual rehabilitation continuum from the evaluation of rehabilitation needs to integrating the person released from prison to society.

Furthermore, proposals have been made on the use of juvenile punishment as an instrument for treatment referral (alternative sanctions: psychiatric or substance abuse treatment or orientation to working life). In the case of adults, the aim is to include substance abuse treatment in a more extensive way in community service, which can be imposed as an alternative to imprisonment, but there are no plans to propose treatment as an alternative to sanctions.

Drug control⁹

The central actors in drug control are the police, the Customs and the National Agency for Medicines. Two areas are emphasised in the activities of the police: the focus at the local level is on preventing first-time offenders and especially young offenders from becoming criminals and at the national level on reducing wider and more serious crime as well as professional criminals and their prerequisites to operate. The latter has been the particular focus in recent years. The task of the Customs is to prevent the illegal import of drugs and to supervise the legal import of drugs. The control method used by the National Agency for Medicines is the license control of legal manufacture, trade, import and export of substances. The National Authority for Medicolegal Affairs controls the drug prescription practice for narcotics used as medicines.

The national crime prevention programme started in 1999 has created local co-operation networks and safety plans for the majority of Finnish municipalities. The programme has intensified the co-operation of the police and municipal authorities as well as business and industry, the church and other actors in crime prevention. In municipalities, the disturbances caused by young people and their substance use have been brought up as factors that increase insecurity, and integrating the crime prevention programme with other (alcohol and drug) programmes of municipalities has been proposed as one solution.

The amendments to legislation that aim at increasing control authority and methods form a central part of preventing organised professional crime. At the beginning of 2001, the police was given new, more extensive authority for fictitious purchases and undercover operations. The authority to intercept and monitor telecommunications was increased at the beginning of 2004. The Customs Administration has been given the corresponding authority in accordance with the Customs Act, and the drug control authority of prison authorities has been increased. Co-operation with business and industry has also been developed concerning money laundering (banks and financial institutions) and drug precursor control (chemical companies etc.). Related to money laundering, banks and financial institutions have to report any unusual money transactions.

⁹ See Virtanen 2005, Part A, Section 11. Updated data from Part A, Section 11.

International co-operation

Drug control in Finland is based on UN drug conventions. Finland has ratified the 1988 UN Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances (SopS 44/1994), the 1971 Convention on Psychotropic Substances (SopS 60/1976) and the 1961 Single Convention on Drugs (SopS 43/1965) with the amendment made in 1972 (SopS 42/1975). Finland has also signed the 1988 UN Vienna Convention, which emphasises methods for preventing both supply and demand in battling international illicit drug trafficking.

Finland strives to be active in all international forums concerned with drug issues and participates in co-operation in the following organisations:

The UN Commission on Narcotic Drugs (CND), which decides on international drug issues at a global level, and the International Narcotic Control Board (INCB), which decides on compliance with international conventions. Other international organisations working in the field of drugs are Interpol, the World Customs Organisation (WCO) and FATF, which is responsible for drug precursor control.

In Europe, drug issues are dealt with in the Council of Europe's Pompidou Group. The co-ordinating body within the EU is the Horizontal Working Party on Drugs (HDG). The EU-wide drug policy is steered by the EU Drugs Strategy 2005–2012 and the Action Plan on Drugs 2005–2008.

In the EU, Eurojust, which co-ordinates the investigation of drug crimes, Europol and the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) also deal with drug questions, the latter focusing on drug situation data.

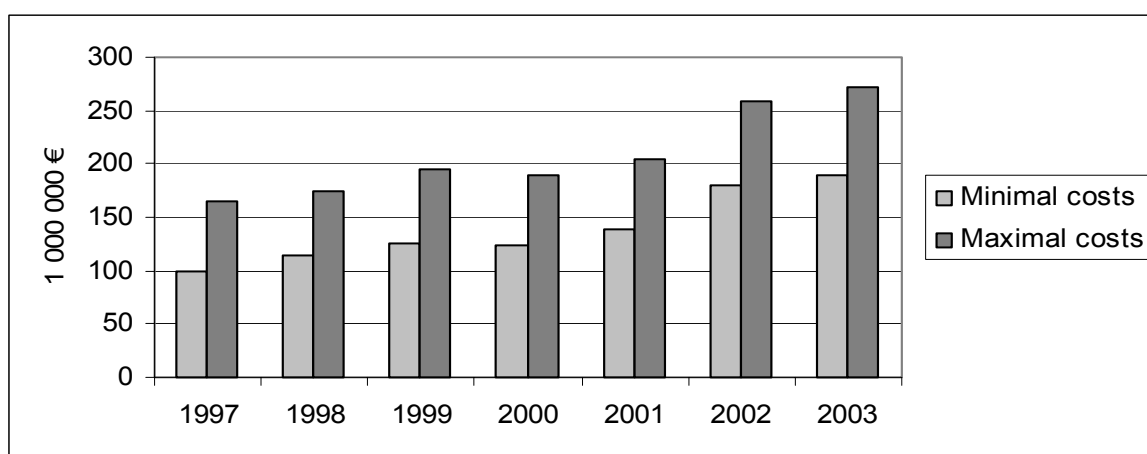
In the battle against internationally organised, professional drug crime, Finland's participation in international co-operation (e.g. in neighbouring areas) and the new European Schengen system and Customs Information System (CIS) have provided the authorities with new connections and information for controlling drug crime and money laundering.

In the Nordic countries, drugs are discussed in the Drug Committee and the drug cooperation network of Nordic control authorities, PTN (police, Customs, Frontier Guard).

Drug-related costs

Drug-related costs consist of the costs related to the abuse of drugs and pharmaceuticals and the detriment caused to health (hospitals etc.), social welfare (substance abuse services etc.) and crime control (the police, prisons etc.) as well as the resources of preventive work and research. The costs have grown considerably since the mid-1990s along with the increase of drug use and problem drug use, but they are still much lower than alcohol-related costs (EUR 615 - 810 million) (Yearbook of Alcohol and Drug Statistics 2005)

Figure 12. Costs of the harm caused by drugs (minimum-maximum) in Finland 1997–2003



A. NEW DEVELOPMENTS AND TRENDS

1. Drug policy and legislation

National strategies and action programmes, drug-related legislation, national resources to intensify drug policy and public opinion concerning such policy provide the guidelines for drug policy. This section discusses strategies and legislation from the points of view of drug policy co-ordination, the measures to reduce demand and supply, international co-operation, and research. The measures to reduce demand may be part of drug prevention work, treatment or the prevention of health and social harm, whereas reduction of supply falls under control measures and their development.

The following goals were set in the Drug Policy Action Programme in Finland 2004–2007 (2004):

1. Strengthening the co-ordination of drug policy at the national level.
2. Intensifying co-operation among the competent authorities with respect to drug precursors.
3. Increasing the local co-operation of the social and health services, education authorities, youth service, the police and the prosecutor in order to prevent social exclusion among young drug users and refer abusers to treatment.
4. Increasing the collaboration of the police, Customs, Frontier Guard, prosecutor and private security branch in order to reduce drug supply.
5. Securing access to appropriate services in order to treat drug abuse.
6. Increasing the use of treatments within the context of penal sanctions.
7. Improving staff skills related to the prevention and treatment of drug problems
8. Strengthening multi-professional co-operation and prevention of substance abuse in pupil and student welfare.
9. Developing new methods for the work of preventing substance abuse and strengthening local co-operation between the authorities in drug prevention.
10. Strengthening the role of non-governmental organisations in drug prevention.
11. Revising Finnish drug legislation, taking into account relevant amendments to Community legislation and the entry onto the market of new synthetic substances thus far not covered by drug control.

12. Promoting international action to prevent the use and spread of drugs. Intensifying national co-ordination of international co-operation on drug issues and taking measures to prepare for the enlargement of the European Union.
13. Continuing Finnish support for the work against drugs in neighbouring areas and within the framework of development co-operation.
14. Developing a knowledge basis and research regarding drugs.

The amendments to drug legislation during the past year comprised:

(1) The Act on the Protection of Privacy in Working Life, including restrictions to drug testing in working life, according to which such testing should be based on an anti-drug strategy that has been drawn up in collaboration at the work place. The Act also regulates that a job applicant or employee should provide the employer with a drug test certificate if the nature of the work is such that the use of drugs could cause bodily harm or damage or if the employee is suspected of being under the influence of drugs.

(2) The amendment to the Criminal Records Act, which regulates when a person can receive an extract of his or her own entries in the criminal records to be submitted to the employer in order to take on employment which involves working with minors on a permanent basis and to a material degree.

(3) The conditions laid down in the Act on rehabilitation benefits and rehabilitation allowances granted by the Social Insurance Institution of Finland concerning the right of a person in rehabilitation as provided in the Act on Welfare for Substance Abusers to receive rehabilitation allowance.

(4) The amendment to the Road Traffic Act, which specifies the grounds for the physician's duty to report that a driver has diminished ability to drive and for imposing a driving ban on the holder of a driving licence due to driving while intoxicated.

(5) The Juvenile Punishment Act, whereby juvenile punishment replaces other sanctions for under 18-year-old offenders. Juvenile punishment includes supervised tasks that promote social adjustment and orientation to working life and work.

(6) The new Imprisonment Act, which regulates the rights of substance-abusing remand prisoners or sentenced prisoners to services and the prerequisites for their reintegration into society.

(7) The amendments to the Coercive Measures Act, which give the authorities greater powers for technical surveillance and telecommunications monitoring.

(8) The amendment to the Police Act, which specifies the regulations concerning information acquisition by the police.

(9) The Act on mutual assistance between EU Member States in freezing property or evidence in criminal matters.

The abuse of drugs and pharmaceuticals causes society harm-related costs of approximately EUR 160–220 billion annually. According to the budget proposal for 2004, the separate costs of the drug policy action programme 2004–2007 for the year 2004 are the same as the costs for the last year of the 2001–2003 programme.

The number of drug-related speeches in Parliament that reflect attitudes towards drugs has not altered during the past three years. The speeches have dealt with amendments to legislation discussed in Parliament or situation reports submitted by the Government to Parliament. Topics have included the Act on the Protection of Privacy in Working Life, the amendment to the Penal Code concerning human trafficking, pandering and prostitution as well as the Government's Report on Finnish Security and Defence Policy. The most common themes were drug testing and international drug trafficking,

Researchers emphasise that people in Finland are still very concerned about drugs. According to a population survey, 81 per cent of respondents consider drug use to be a serious problem in Finland. This figure has however dropped by 9 percentage points during the past three years. Attitudes have thus become more lenient. This is also reflected in the number of those who consider drug use to be a very serious problem (40%), which has dropped by 18 percentage points during the same time period. 28% of the population predicted that drug use in Finland would decrease or remain at the current level, compared with 12% three years ago. It would appear that citizens still disapprove of drugs, but that the scare caused by the rapid increase in drug use in the 1990s and the related serious harm (e.g. sudden deaths) has receded. (Piispa et. al. 2005)

1.1 Drug policy 2004–2007

1.1.1 Co-ordination of drug policy 2004–2007

Goal¹⁰

- Implementing and developing drug policy at the national level in a co-ordinated manner. Continuing effective co-operation among the competent authorities.
- Reforming the Finnish Narcotics Act and Decree to be consistent with Community legislation and speeding up taking substances used as intoxicants under supervision.

Implemented in 2004¹¹

- The co-ordination group was appointed for the current term of 1 January 2004–31 December 2007.
- In 2004, a working group to prepare the development of drug legislation was set up by the administrative decision of the Ministry of Social Affairs and Health. The working group is preparing the Narcotics Act and the related Government Decree and Decree of the Ministry of Social Affairs and Health on the basis of the Government proposal so that the new legislation replaces the current legislation from August 2005 onwards.

Areas of priority in 2005¹²

- New drug legislation is replacing current legislation from August 2005.
- Training related to the amendments to drug legislation is commencing in provinces.
- Guidelines for alcohol and drug programmes for provinces are being prepared.
- Meetings on alcohol and drug programmes are being arranged at State Provincial Offices that are responsible for co-ordinating work on the programme by regional and local authorities and organisations.
- Organisations' drug policy reports are being completed.

¹⁰ Drug Policy Action Programme in Finland 2004–2007

¹¹ Drug policy report of 2004.

¹² Statement of the drug policy co-ordination group 2005.

1.1.2 Demand reduction 2004–2007

1.1.2.1 Prevention

Goal

- Intensifying the prevention of substance abuse by children and young people in co-operation with pupil and student welfare services and other authorities who work to prevent substance abuse.
- Planning and carrying out substance abuse prevention in local co-operation between youth, social and health services and educational and employment authorities.
- Strengthening the position of contact persons specialised in substance abuse work as coordinators of substance abuse prevention.
- Implementing new methods for special groups in preventive work.
- A better approach to reach young people who have drug problems and are facing a risk of exclusion.
- Strengthening systematic drug prevention and its position and reducing substance abuse by young people.
- Preventing substance abuse among young people in co-operation between municipal social and health services, education authorities, youth service, the police and the prosecutor.
- Improving skills related to the prevention and treatment of drug problems among those who come into contact with drug users in the course of their work.

Implemented in 2004

- The grounds for the school curriculum prepared by the National Board of Education were introduced at all levels of education. Based on the standards that guide the grounds for the school curriculum, all schools and educational establishments should determine the measures for the prevention of substance abuse and early recognition of and intervention in problems as part of pupil and student welfare services.
- Material related to substance abuse prevention for schools and educational establishments has been produced for the pupil and student welfare services section of the edu.fi portal

of the National Board of Education in co-operation with the National Research and Development Centre for Welfare and Health (STAKES) and organisations.

- Substance abuse issues have been dealt with during the year in all training events related to pupil and student welfare services and the development of teaching health education.
- Readiness for drug prevention in youth workshops was improved by a separate training project.
- STAKES co-ordinated in co-operation with State Provincial Offices a contact person network in substance abuse work for which five training sessions were arranged during the year.
- A development network consisting of local experts, with which contents and material for substance abuse prevention is developed, was separated from the contact person network.
- Training and information material was produced for STAKES's Neuvoa-antavat portal. The portal also includes a substance abuse treatment unit database, alcohol and drug strategy and project databases as well as an information package for the contact person network.

Areas of priority in 2005

- Plans for pupil and student welfare services are being introduced at all levels of education in the autumn of 2005.
- The new curricula for health education covering substance abuse and prevention are being introduced in upper secondary schools.
- The working group on addiction training appointed by the Ministry of Education is starting operations.
- Drug prevention in youth workshops is being established.
- Evaluation of municipal substance abuse services and prevention is being finalised.
- Quality criteria for substance abuse prevention are being finalised.

1.1.2.2 Drug treatment

Goal

- Intensifying co-operation between municipal social and health services, education authorities, youth service, the police and the prosecutor in referring drug abusers for treatment.

- Getting considerably more drug abusers than before to enter social and health services.
- Providing drug abusers with high quality and extensive substance abuse services.
- Improving the availability of drug-free and substitution treatment and access to treatment.
- Strengthening the role of non-governmental organisations as service providers, experts, and providers of peer support and voluntary work.

Implemented in 2004

- Quality evaluation forms and models for grading services based on the quality framework for substance abuse services were prepared for municipalities to be used as tools for evaluating and inviting tenders for both their own and outsourced services.
- The focus for the development of a treatment service system for problem drug users continued to be low-threshold services and extending substitution treatment for opiate addicts.
- The special problems of young immigrants were addressed in various projects, also in co-operation with Russia and Estonia.

Areas of priority in 2005

- Practical implementation of the quality framework for substance abuse services

1.1.2.3 Reduction of drug-related health problems

Goal

- Getting considerably more drug users than before to enter social and health services.
- Preventing the spread of communicable diseases among drug users.

Implemented in 2004

- As for health problems, the focus for the development of a treatment service system for problem drug users was on health counselling.

Areas of priority in 2005

- A regional development project for mental health and substance abuse services is getting underway.

1.1.2.4 Reduction of drug-related social problems

Goal

- Improving post-treatment support and rehabilitation.
- Connecting treatment measures more closely to penal sanctions.
- More expansive use of sanctions for drug-user offences, thus decreasing drug-related crime.
- More effective use of the time spent during a prison sentence to start substance abuse treatment and to increase treatment motivation.
- Intensifying local, regional and national co-operation with social services and health care authorities in enforcing imprisonment and community service.
- Securing the services for persons released from prison and those serving community sanctions as part of the National Development Project for Social Services in Finland.
- Increasing the number of prisoners serving sentences in substance abuse units outside prison and intensifying the rehabilitation of persons released from prison.

Implemented in 2004

- Prosecutor General's directions for prosecutors (VKS:2002:3) state that a drug-dependent person is not to be fined before he or she has been referred to treatment and his or her willingness to seek treatment has been examined. Almost all prosecutorial units have a procedure for treatment referral.
- A juvenile punishment for under 18-year-old offenders, which includes activities and programmes that promote social adjustment, was established and introduced nationwide at the beginning of 2005.
- The intoxicant strategy for the prison administration for 2005–2006 was finalised. The operating principles of the strategy include giving the prisoner a possibility to systematic

substance abuse treatment and rehabilitation as well as an intoxicant-free environment during the sentence.

Areas of priority in 2005

- Planning the training for treatment referral by the police is underway.
- The final report on the Social Work Undertaken at Police Stations project is being finalised.
- A report on co-operation between the criminal sanction system and substance abuse services is issued.

1.1.2.4 Other action plans for demand reduction

Alcohol programme for 2004–2007 (2004)

The goal of the national alcohol programme is to reduce the adverse effects of alcohol. Two of the three means in the programme to reach that goal also concern drugs. The first is in reducing the problems of children, young people and families. This is targeted by supporting parents in child upbringing, preventing domestic violence, securing the conditions for child protection and providing alcohol and drug education. Another means is in reducing the adverse effects of high-risk alcohol use. This is targeted by preventing disturbances and violence, by increasing traffic, occupational and leisure time safety and with appropriate treatment services. Other means are directly aimed at reducing the total consumption of alcohol. An essential feature of the programme is that it is implemented locally in co-operation with the state, municipalities, business and industry, and organisations (civil society). The programme also has indicators for evaluating its implementation.

Contractual treatment trial (2005)

In February 2002, the Ministry of Justice appointed a working group to prepare a proposition for the Government proposal on testing contractual treatment and related legislation based on a contractual treatment committee report and the statements on the report. The working group issued its report to the Minister of Justice in May 2003. Contractual treatment would be

substance abuse treatment intended for those who cannot be sentenced to community service due to their substance abuse problems. The trial would be regionally restricted. (Memorandum of the Contractual trial Committee, 2002)

Preparations to introduce contractual treatment as a separate type of punishment were given up in January 2005. Instead, linking substance abuse treatment more closely with community service, for instance as a requirement for community service, is under preparation.

Substance abuse treatment as a requirement for community service is intended primarily for those offenders who have a serious substance abuse problem and who can be expected to follow a treatment plan. Substance abuse treatment would not be part of the punishment but commitment to the treatment would be a requirement for sentencing to community service instead of imprisonment. The Probation Service would supervise fulfilling the requirement and support the offender. A community service sentence would require the consent and commitment of the accused to the treatment plan imposed as well as other conditions. (See <http://www.om.fi/tulostus/12032.htm>)

Intoxicant strategy for the prison administration for 2005–2006 (2004)

The Prison Service's substance abuse prevention is based on the operating principles of the Prison Service's substance abuse work, according to which

- substance abuse work in prisons is based on the prison administration values, knowing the prisoner and interaction with the prisoner,
- the prison treats a prisoner with substance abuse problems equally with other prisoners,
- substance abuse work in prisons is based on the professional skills and teamwork of social and health services and control authorities as well as on co-operation with the surrounding society,
- the prison responds to the need for help and, if a prisoner is found to be intoxicated, intervenes immediately with control and treatment measures and/or considers it a breach of order,
- the prison utilises the prison term to bring about change,
- a prisoner has a chance to get systematic substance abuse treatment and rehabilitation as well as an intoxicant-free environment during the sentence,

- the prison monitors, evaluates and develops substance abuse work regularly and evaluates the efficiency of its work.

The operating principles are implemented in prisons as follows:

- Substance abuse work in prison includes appropriate health care and an assessment of the prisoner's rehabilitation need.
- The prisoner is provided with housing that supports an intoxicant-free lifestyle and a contact person specialised in substance abuse work.
- When needed, the prisoner participates in substance abuse counselling and is motivated to enter rehabilitation.
- The prisoner has a chance to get medical, psychosocial and occupational rehabilitation as needed.
- Prisons supervise substance abuse work and maintain a service system for treatment and rehabilitation.
- In addition to the statutes on correctional treatment, the prison observes in substance abuse work the principles and methods of health care and, where applicable, of social services as well as the principles that the police and the Customs observe in control work.
- The prison provides systematic rehabilitation, which includes substance abuse work and networking to secure a care chain for the customer, to promote the prisoner's recovery and to anchor him or her to peer support work.
- Prison personnel carry out substance abuse work in co-operation according to their professional skills and tasks.

1.1.3. Supply reduction 2004–2007

Goal

- Dealing with issues related to drug precursors centrally in a national working group comprised of the responsible authorities.
- Intensifying co-operation between the competent authorities regarding drug precursors.
- Preventing the import of a drug onto the Finnish market in its country of origin and revealing drug smuggling at the Finnish borders.

- Increasing the seizure of the proceeds of crime when detecting and investigating offences in co-operation between the police, the Customs, the debt recovery and tax authorities and the prosecutor.
- Application of the new Penal Code provisions on forfeiture of the proceeds of crime in full.
- Security stewards and guards are able to recognise and appropriately intervene in sale and other spread as well as use of drugs.

Implemented in 2004

- The Ministry of Social Affairs and Health has appointed a working group for controlling drug precursors and intensifying co-operation between the competent authorities. The working group started its operation in 2004.
- According to the order on crime intelligence and crime analysis issued by the Ministry of the Interior (16 January 2004), the crime intelligence development project and the strategies set by the PTR National Executive Team, the National Bureau of Investigation started measures on 1 April 2004 to establish a national Crime Intelligence and Crime Analysis Centre and municipal crime intelligence and crime analysis units.
- Crime intelligence and crime analysis operations were provided with full resources and were started nationwide in October 2004.
- Complex crimes that call for multisectoral co-operation between authorities, and within which criminal activities are organised, were selected as targets for prevention within serious crime. The targets for prevention are mainly crime organisations specialised in the import and distribution of drugs.

Areas of priority in 2005

- The working group on drug precursor control and co-operation between the competent authorities are to handle the Community legislation on drug precursors under preparation and training and information needs arising from the amendments to the Community legislation, as well as the situation of drug precursors in Finland.
- The joint crime intelligence and crime analysis operations of the police, the Customs and border guard authorities are to intensify crime monitoring, the transmission of

information related to crime prevention, finding targets for prevention within serious crime, as well as crime analysis and the linking of crimes.

Other action plans for supply reduction

Internal Security Programme 2005–2015 (2004)

On 23 September 2004, the Finnish Government approved a decision in principle on an internal security programme. The programme deals with security primarily from an individual's point of view and the aim of the programme is to increase everyday security. The most important of the central threats for internal security in the future is the growth of social exclusion. Other challenges include the increase of accidents and vulnerability of the information society, hard crime directed from abroad, weakening of people's everyday security, maintenance of border security and customs control and prevention of terrorism. Seventy-nine different measures are proposed for the implementation of the programme. (A Safer Community - internal security programme 2005 - 2015).

According to the programme, drug crime will be prevented by

1. increasing co-operation in neighbouring areas, especially with the Baltic countries and Russia,
2. efficient international co-operation that prevents professional and organised crime groups from networking by making them liable for offences in their home country or country of residence,
3. improving investigation of drug-related crime, especially crimes related to receiving stolen property and pandering,
4. intensifying drug treatment,
5. intensifying referral for treatment of problem drug users,
6. intensifying the use of treatment measures within the context of penal sanctions,
7. carrying out the following measures concerning legislative reforms:
 - improving witness protection and protection of the parties involved in a criminal process;
 - appropriate treatment should be a real alternative to penal sanctions for a problem drug user in all types of punishment (a fine, a suspended sentence or an unconditional sentence of imprisonment);

- examining the possibility to change the maximum sentence for an aggravated drug offence from 10 years to 12 years;
- examining the possibility to make the reward for a tip-off exempt of taxation.

In addition, it is proposed that young people who are facing a risk of exclusion are supported, early intervention in problems is enhanced, pupil and student welfare services and educational guidance are developed, emergency social services are created nationwide, the opportunities for vulnerable groups to find employment is improved, integration of immigrants into the society is supported, and prevention of communicable diseases is developed in co-operation with the European Union and the World Health Organisation (WHO).

1.1.4. International co-operation on drug issues 2004–2007

Goal

- Promoting the implementation of the objectives of international co-operation in accordance with the Government decision in principle (1998).
- Minimising smuggling of drugs to Finland, drug trafficking, drug-related crime as well as drug use and related social and health problems.
- Intensifying the co-ordination of international issues both in Finland and internationally.
- Preventing smuggling of drugs and drug-related social and health problems from spreading from neighbouring areas to Finland.
- Intensifying anti-drug activities in neighbouring areas of Finland.
- Promoting the prevention of drug cultivation in developing countries.

Implemented in 2004

- Finland participated in all the EU bodies dealing with drug issues.
- Finland participated actively in preparing the EU drugs strategy for 2005–2012
- Finland participated in the meeting of Nordic ministers in charge of drug issues held in Iceland on 10–11 August 2004.
- Finland participated in arranging the Eastern European youth forum in Ekaterinburg on 6–7 October 2004 as part of the Council of Europe's Pompidou Group.

- In the UN Commission on Narcotic Drugs (CND), Finland drafted the first proposal on intensifying international drug data collection, presented as a joint EU motion for a resolution, which the USA also accepted.
- Finland has financed the activities of the United Nations Office on Drugs and Crime (UNODC) and projects in Uzbekistan to establish a regional information and co-ordination centre and to build the border crossing point in Hayreton.
- In Peru, Finland financed the “Alternatives to drug cultivation” programme in the form of technical and institutional support.
- Finland has financed several projects in neighbouring areas in the Republic of Karelia, Vyborg region, Murmansk region and Northwest Russia.
- Based on the Council of Baltic Sea States (CBSS) Task Force programme and the EU’s Northern Dimension Partnership for Health and Social Protection programme, a network was created to help establishing health counselling for intravenous drug users in Latvia in accordance with the Finnish model.

Areas of priority in 2005

- In accordance with the action plan for 2004–2007, Finland is participating actively in planning and implementing drug policy in the UN Commission on Narcotic Drugs (CND) and the Dublin Group, European Union working groups, the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), Europol, the Council of Europe’s Pompidou Group and the Nordic Council of Ministers.
- Finland is continuing and tightening anti-drug co-operation in its international and bilateral activities and is promoting and implementing joint initiatives.

1.1.5. Drug research and monitoring 2004–2007

Goal

- Strengthening the knowledge and skills basis related to drugs.
- Examining drug use and the images of drug use, various consequences of drug use, the service system and treatment of drug users, drug-related crime and the possibilities to intervene in it. Analysing and evaluating the debate related to drug policy.

Implemented in 2004

- The Academy of Finland has started to prepare a substance abuse and addiction research programme for 2007–2010.
- During 2004, the National Research and Development Centre for Welfare and Health (STAKES) reported new study results on substance abuse among school children, problem drug users, people's attitudes towards drugs and drug policy opinions.
- STAKES also reported new study results on the use of substance abuse services, clients in drug treatment and risk behaviour of intravenous drug users.
- In 2004, two dissertations dealing with drug use were published: one examined underage patients in drug treatment and the other examined the development of recreational use of drugs in Finland.
- A report on the experiment on early identification of drug trends was issued.
- Evaluation material for a nationwide drug campaign was collected by the National Public Health Institute in Finland in April–June 2004.
- The National Public Health Institute has developed testing methods for drug use and examined the background of substance addiction as well as treatments and their effects.
- The National Public Health Institute has monitored the occurrence of drug-related communicable diseases and the related use of services, client mobility and travel in neighbouring areas.
- The National Public Health Institute started a research project on the medical treatment of amphetamine addiction in the autumn of 2004.
- Rehabilitation in prisons, treatment referral in police work and drug-related and organised crime has been studied in the Police College of Finland.
- The National Research Institute of Legal Policy monitors the effects of new the drug-user offence.
- Many organisations and public actors have published project follow-up studies.
- In relation to drugs, dissertations have been published, for instance, on the rehabilitation of drug addicts through community education.
- An annual drug report was issued.

Areas of priority in 2005

- Preparation of the substance abuse and addiction research programme is continuing.
- STAKES, the National Public Health Institute in Finland and the National Research Institute of Legal Policy are to report on drug use among school children and adults' opinions on drugs, clients in drug treatment, drug-related risk behaviour, communicable diseases, cases of driving while intoxicated and drug crime.
- Ongoing studies are underway.
- National and local project follow-up studies are being supported.
- An annual drug report is being prepared.

1.2 Drug legislation

1.2.1 Narcotics Act

In 2004, a working group to prepare the development of drug legislation was set up by the administrative decision of the Ministry of Social Affairs and Health. The working group is preparing the Narcotics Act and the related Government Decree and Decree of the Ministry of Social Affairs and Health on the basis of the Government proposal so that the new legislation replaces the current legislation from August 2005 onwards.

1.2.2 Legislation related to demand reduction

1.2.2.1 Prevention

The Act on the Protection of Privacy in Working Life (759/2004) regulates the conditions for drug testing in working life. The starting point for the Act is that a person applying for a job or an employee him or herself provides the employer with a drug test certificate.

At the recruitment stage, an employer can only ask the person who has been selected for the job for a drug test certificate. The employer has the right to use the information on the certificate if the job requires precision, reliability, independent judgement or quick reactions. Furthermore, it

is required that the employee concerned works in a job where performance under the influence of, or addicted to, drugs could endanger (1) the life, health or occupational safety of the employee or other persons, (2) national defence or state security, (3) traffic safety, (4) the protection of information received while working, or (5) business and professional secrets, or could cause more than minor level of financial loss to the employer, or could increase (6) the risk of significant environmental damage. The employer also has the right to ask for a drug test certificate if the employee is to carry out tasks in which special trust is required, which include working with minors, or in which there is access to drugs.

The employee is obliged to submit a drug test certificate during his or her employment relationship if the employer has justifiable cause to suspect that the employee is under the influence of drugs at work or that the employee has a drug addiction. A further requirement is that drug testing is essential to establish the employee's working or functional capacity. In addition, the employer is obliged to draw up in co-operation with personnel an anti-drug programme for the workplace, the provisions on which are laid down in the amendment to the Occupational Health Care Act (740/2004).

Drug testing is also regulated by amendments to the Act on Co-operation within Undertakings (761/2004), the Act on Co-operation in Government Departments and Agencies (762/2004), the State Civil Servants Act (763/2004), the Act on Civil Servants in Local Government (764/2004) and the Act on Parliamentary Civil Servants (193/2005). The Government Decree (218/2005) lays down provisions for drug testing, quality requirements for the test laboratories (accreditation), the issue of examination referrals, the employee's consent to issuing a referral, sampling and analysing samples, and interpretation and informing of test results and the possible contest of the issue.

The amendment to the Criminal Records Act (654/2004) regulates when a private individual may obtain an extract of his or her own entries in the criminal records for purposes of taking a job that on a permanent basis and to a material degree involves working with minors and for which the extract must be submitted to the employer or an authority according to the Act on Checking the Criminal Background of Persons Working with Children (504/2002). The data regarding the decision on a person having been sentenced for any of the following offences are included in the extract: committing an indecent act, sexual offence, manslaughter, murder, homicide, aggravated assault, aggravated robbery or drug offence.

1.2.2.2. Drug treatment

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

1.2.2.3 Reduction of drug-related health problems

The amendment to the Road Traffic Act (113/2004) regulates the physician's duty to report a vehicle driver's medical condition concerning his or her right to drive to a competent police authority. The guidelines for implementation issued by the Ministry of Social Affairs and Health state that the physician's report can only include such information as concerns the person's health requirements for a driving licence and the additional measures suggested by the physician to more precisely evaluate the patient's health or its effects on his or her driving ability. A driving licence may not be granted or renewed to an applicant or to a driver who is addicted to psychopharmaceuticals or who, even if not addicted to such a substance, abuses them regularly.

The amendment to the Road Traffic Act (1103/2004) states the grounds for imposing a driving ban on the holder of a driving licence. According to the Act, a driving ban is imposed for a minimum of one month on a driver found guilty of driving while intoxicated and a driving ban for a minimum of three months is imposed on a driver guilty of causing a serious traffic hazard or driving while seriously intoxicated. In case of recidivism, the length of the driving ban is a minimum of six months if the driver repeats the offence of driving while intoxicated, driving while seriously intoxicated or causing a serious traffic hazard during a period of five years. If the driver commits the offence twice, the court imposes a driving ban for a minimum of one year. The court can impose a driving ban for a maximum of five years. If a person fails to fulfil the

requirements for a driving licence or does not submit a doctor's certificate regarding that licence to the police, a driving ban is imposed until further notice.

According to the Act on safety tasks in the rail system (1167/2004), tasks cannot be carried out under the influence of alcohol or other intoxicating substances, and pharmaceutical substances that may affect carrying out the tasks can only be used if a medical expert in the rail sector or occupational health care approves their use while carrying out safety tasks.

1.2.2.4 Reduction of drug-related social problems

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

According to the Juvenile Punishment Act (1196/2004; 1284/2004), punishment for a minimum of four months and a maximum of one year can be imposed on juvenile offenders less than 18 years of age. Supervision appointments, activities that promote social adjustment carried out under supervision and supervised orientation to working life and work are arranged for the offender during his or her sentence. Meetings that the offender is obliged to attend can be arranged for a maximum of eight hours a week. Before sentencing, the Probation Service must formulate an enforcement plan for the juvenile punishment at the request of the public prosecutor or court. The offender must not use alcohol or other intoxicating substances or be under the influence of intoxicating substances when attending supervision appointments or the other meetings mentioned above.

With respect to a breach of the conditions set in the enforcement plan for the juvenile punishment, the offender must first be given an oral or written reprimand, then a written warning, and finally the juvenile punishment can be discontinued and converted into another sentence that is to correspond to the portion of the juvenile punishment that has not yet been served. Before these measures, the offender has the right to be heard.

According to the Act on imprisonment (767/2005)¹³, the offender can be placed straight from liberty into an open institution instead of a closed institution, if he or she has been given a sentence of conversion of fine or sentenced to imprisonment for a maximum of one year and if he or she commits to an intoxicant-free lifestyle and its supervision. In a closed institution, the prisoner must be provided with the opportunity to stay in a contractual ward where the prisoners are committed to supervised intoxicant-free life and to the activities arranged in the ward. The prisoner can be transferred from a closed institution to an open institution for a fixed term, if the transfer promotes the implementation of the plan for the term of punishment and the prisoner follows the programmes and rules of the ward, commits to not using intoxicating substances and accepts the supervision of intoxicant-free life. A prisoner with a substance abuse problem can also be placed for a fixed term in an institution outside prison, where he or she can participate in rehabilitation or other target-oriented activities that reinforce his or her operational abilities – and where he or she does not use intoxicating substances and observes the terms and conditions stipulated for free movement. The aim of the activities arranged by the prison is to promote the prisoners' adjustment to society by increasing their readiness for a crime-free life, by maintaining and increasing their professional skills and by supporting their intoxicant-free lifestyle.

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

¹³ See also the Detention Act (768/2005).

1.2.3 Legislation related to supply reduction

According to the amendment to the Penal Code (650/2004) concerning offences against the administration of justice, a person who knows that an aggravated drug offence is in preparation and fails to report it to the authorities or the endangered person in time in order to prevent the offence shall be sentenced, if the offence or a punishable attempt is committed, to a fine or to imprisonment for a maximum of six months for failure to report an aggravated offence.

The amendment to the Coercive Measures Act (651/2004) grants the officer conducting the pre-trial investigation the authority to intercept and record telecommunications messages, if there is reason to suspect a person of a drug offence and if the information available can be assumed important for solving a crime. The authority to conduct technical audio surveillance at the domicile where the suspect is likely to reside can also be granted, if solving the crime would be essentially more difficult by using less-invasive coercive measures.

The amendment to the Police Act (525/2005) specifies the provisions concerning information acquisition. According to the provisions, technical audio surveillance and technical visual surveillance in prisons requires that the person, based on his or her behaviour or otherwise, can be reasonably suspected of committing an offence, such as a drug-related offence. On similar grounds and to prevent direct threat to life or health, telecommunications monitoring can be targeted at a telecommunication subscription, telecommunication address, or telecommunication terminal used or presumably used by the person or such subscription or terminal can be temporarily closed and permission can be granted to receive information on those mobile stations from which specific information is entered through a base station close to a specific location to a telecommunication system. The requirement for undercover operations is still an aggravated drug offence and the requirement for fictitious purchasing is that it is necessary to detect an offence for which the maximum penalty is at least 2 years imprisonment (for instance drug offence). The court will decide on telecommunications interception, telecommunications monitoring and acquiring information on the location of mobile stations as well as technical surveillance that requires placing a surveillance device at the domicile where the suspect resides. If the operation cannot be delayed, the commanding officer will decide on its implementation until the court has deliberated on the matter. The head of the police unit prescribed by the Decree of the Ministry of the Interior decides on undercover operations, and the director of the district

police department, the National Bureau of Investigation or the Security Police, or the commanding officer appointed by the director, decides on fictitious purchases.

When necessary, in order to prevent surveillance, technical surveillance, fictitious purchases, undercover operations and informant operations from being revealed, the police can use misleading or covert information. In addition, a member of the police force is not obliged to reveal the identity of any person in his service who provides that said member of the police force with confidential information or to disclose information on any person who has carried out fictitious purchases or undercover operations, if disclosing such information would endanger the safety of this person or his or her family.

1.2.4 Legislation related to international co-operation

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

1.2.5. Legislation related to drug research

Drug research is regulated by norms that concern research in general. An amendment to the Medical Research Act (295/2004) was issued during the year. The amendment states that medical research shall respect the inviolability of human dignity, that before any research is undertaken the ethics committee shall have given a favourable opinion on the research plan, and that medical research on persons may not be conducted without the subject's informed consent in writing.

1.3. Drug-related costs

The abuse of drugs and pharmaceuticals causes society harm-related costs of approximately EUR 190–272 million annually, including the costs of police and emergency services, justice and prison systems, damage to property, social services, health care, pensions and research and prevention. As regards public funds for anti-drug activity, special project appropriations for 2004 can be specified for different administrative sectors and compared with the costs of the previous drug policy action programme 2001–2003.

According to the budget proposal for 2004, the separate costs generated by the Drug Policy Action Programme 2004–2007 correspond to the costs of the last year of the previous drug policy action programme (2003). The biggest changes can be seen in the treatment sector, which will no longer benefit from the temporary appropriation of EUR 7.5 million granted for 2002–2003 and the treatment measures initiated with this funding will in the future have to be funded directly by municipalities. The operating costs of the police and the Customs reflect the overall costs of their anti-drug activities as opposed to the additional appropriations presented in the previous action programme; thus, the figures are not comparable with the previous years' figures.

Table 5. Estimated resources of Drug Action Plans 2001–2003, 2004–2007 (EUR million)¹⁴

	2001	2002	2003	2004
The Ministry of Social Affairs and Health sector				
- health promotion	1.01	1.01	1.01	1.01
- state subsidy for municipal drug treatment		7.57	7.57	
- state subsidy for municipal social services and health care costs		8.55		
- subsidies granted from the proceeds of the Finnish Slot Machine Association		8.8	9.0	10.2
- agencies and institutions under the Ministry of Social Affairs and Health		0.23	0.64	0.58
The Ministry of Education sector				
- personnel training and other operating costs	0.67	0.84	0.84	
- preventive work		0.84	0.84	0.84
The Ministry of the Interior sector				
- operating costs of the police	1.68	1.68	1.68	(9.5)
- proposal for additional appropriations for combating serious drug crime		(3.2)	(3.2)	(25.5)
The Ministry of Justice sector				
- operating costs of a crime prevention project		0.03	0.03	0.03
- enforcement of punishments	0.67	1.35	1.35	1.35
- operating costs for prosecution and debt recovery	0.42	0.42	0.42	0.42
- operating costs of the National Research Institute of Legal Policy		0.07	0.07	0.07
The Ministry of Finance sector				
- proposal for additional appropriations for operating costs of the Customs Administration (2002)	0.5	(1.01)	(1.5)	(5.3)
The Ministry of Foreign Affairs sector				
- voluntary donation for UNDCP	0.33	0.02	0.02	0.1
- donation for UNDCP				0.7
- - for monitoring the situation in Afghanistan		0.05		
- - for a project to combat drug cultivation in Afghanistan		0.5		
- - for the improvement of the border crossing point at Hayreton in Uzbekistan		0.2	0.2	
- - proposal for other projects in Central Asia			(0.3)	
- - for the activities of a Finnish expert in Moscow		0.08		
- project support for anti-drug activities in neighbouring areas				0.4

¹⁴ Government decisions in principle on (1) more efficient drug policies 2001 - 2003 (2) drug policy action plan for 2004 – 2007 (2004). Figures in parenthesis mean that the costs are not exactly targeted to the drugs.

1.4. Opinions on drug issues

During 2004, drugs were mentioned in some 150 of the over 10,000 speeches given in the plenary sessions of the Finnish Parliament. One-fourth of the speeches on drugs dealt with internal security and drug trafficking (for example, as part of development co-operation), one-fourth drug testing, 15% treatment and prevention as well as drug crime and about 10% drug users in prisons. The themes in the speeches given in Parliament reflect the programmes, statements and reports proposed by the government as well as law proposals, such as the budget and the proposed amendments to the Act on the Protection of Privacy in Working Life (drug tests) and the amendment to the Penal Code concerning human trafficking, pandering and prostitution, or the Government's Report on Finnish Security and Defence Policy.

The number of speeches on drugs in Parliament was almost the same in the periods of 1 July 2003 - 1 July 2004 and 1 July 2004 - 1 July 2005. Thus, the extent of the debate has not altered much in the past three years. However, the number of speeches was only half of the number of the speeches given in Parliament during the corresponding periods in 1999–2000, 2000–2001 and 2001–2002. This can be seen to reflect the levelling out of the scare caused by the drug phenomenon in Finnish society as well as the decline in drug-related legislative activity, which was still needed at the turn of the 21st century when anti-drug measures had to be developed rapidly in order to control the phenomenon that was new in Finnish society.

The 2004 Health Behaviour Survey among the Finnish Adult Population measured public opinion on the gravity of the drug situation (Piispa et. al. 2005). Comparing the 2004 results with the results from the three previous years shows that the proportion of those who consider drug use a serious problem (81%) has declined by 9 percentage points in three years. At the end of the scale are 15–24-year-old males; among them, the share of those who consider drug use a serious problem declined from 75 to 56 per cent between 2001 and 2004. A clear indication of more lenient views is also the fact that the share of those who consider drug use a very serious problem (40%) has decreased by 18 percentage points. These trends are evident among both men and women in all age groups. The opinions of those with acquaintances who have tried drugs and those who have been offered drugs (see Section 10) on the gravity of the drug situation are clearly more lenient. Thus, it can be said that among people and in places where drug use is more common, people are less concerned about drugs than those (older age groups and people in the countryside) who have little personal experience with drugs.

Correspondingly, the 2004 Youth Barometer¹⁵ shows that the proportion of those who consider drugs a major risk was over 80% but 7% of respondents did not consider drugs a risk at all. In the youngest age group, 15–19-year-olds, 10% of respondents did not consider drugs a risk. Ninety per cent of young people with vocational qualifications did not find drug use acceptable, whereas among those with a higher education degree the corresponding figure was 84%. In terms of region, drug use was more commonly acceptable in Greater Helsinki, as only 75% of respondents in that region were completely against it. Eighteen per cent of respondents considered drugs to be a part of young people's lives in one way or the other (Hirvola, 2004).

The changing trend was also shown in the health behaviour survey when estimating the future development of the level of drug use. In 2004, some 28% of respondents estimated that drug use would decrease or remain at the current level, whereas the corresponding figure in 2001 was about 12%. In the age group of 15–24 years, where experimental use of drugs is most common according to studies, over 45% of respondents expected drug use to decrease or remain at the current level; the increase compared with the data from three years ago is almost 25 percentage points.

When evaluating different drugs, people clearly separated cannabis from other drugs. The majority (two-thirds) of respondents considered cannabis a mild drug, whereas the corresponding proportion three years ago was clearly less than half of the respondents. All the other drugs were considered hard drugs by the majority of the respondents. Every fifth respondent said that he or she could not make the above-mentioned classification. In addition, one-third thought that such classification should not be made at all.

According to researchers, the results can be seen to show that the concern caused by the rapid increase in drug use and serious drug harm (e.g. sudden deaths) in the 1990s is passing over. However, the changes in Finns' opinions and estimations do not mean that drug use is culturally acceptable. The health behaviour surveys in 2001 and 2004 clearly indicated tough attitudes towards drugs in Finland, since four out of five respondents considered drugs a serious problem and one-third considered all drugs equally dangerous.

¹⁵ For the Youth Barometer, 1,820 persons aged 15–29 were interviewed by phone in December 2003. The samples were drawn from the population register by systematic sampling.

2. Drug experimentation and use¹⁶

According to the 2004 population survey, 12% of 15–69-year-olds had tried cannabis at least once during their lifetime; the percentage had not changed since the 2002 survey. The percentage for 15–34-year-olds (21%) had not changed either between 2002 and 2004. Three per cent of 15–69-year-olds had tried cannabis during the past year, which corresponds to the results of the 1998 and 2002 surveys. The results seem to indicate that fewer and fewer 15–24-year-olds experiment with cannabis. On the other hand, one third of those who experiment with cannabis continue its use. The studies on younger people, 15–18-year-olds, show that experimentation with drugs has ceased to grow and in some parts of the country has started to decline.

2.1. Drug use in the general population¹⁷

The extent of the trend in experimenting with drugs and people's exposure to drugs were evaluated especially in the 2004 population survey on drug use and attitudes towards drugs as well as in the more limited annual Health Behaviour Survey among the Finnish Adult Population, which enquired as to whether the respondents knew somebody who has used narcotic substances instead of enquiring about their own drug use.

According to the 2004 population survey¹⁸, 12% of 15–69-year-olds had tried cannabis at least once during their lifetime; the percentage had not changed since the 2002 survey. Between 2002 and 2004, the share of 15–24-year-olds having tried cannabis during their lifetime (21%) had declined by 4 percentage points and the share of 25–34-year-olds (23%) had grown by 4 percentage points. Three per cent had tried cannabis during the past year, which corresponds to the 1998 and 2002 survey results. The percentages for various age groups had not changed since 2002. Two per cent of adults had used cannabis during the past month compared with 1% in the last two surveys. In the 15–24 age group, use during the past month had grown from 4 per cent to 6 per cent according to the latest survey. The change is, however, so small that it may be due to random variation. The percentages for men were somewhat higher than for women: Fourteen per cent compared with women's 10% for those having tried cannabis during their lifetime and 3.5%

¹⁶ See Virtanen (2004), Sections 2.1 and 2.2.

¹⁷ See "data library" or "statistical bulletin" in <http://annualreport.emecdda.eu.int/fi/home-fi.html>.

¹⁸ The population survey was carried out as a postal questionnaire among 15–69-year-old Finns. The sample consisted of a 1,786 person panel sample + an independent sample of 2,206 persons taken from the population register. The response percentage was 63%: Seventy-six per cent for the panel sample and 53% for the additional sample. (Hakkarainen P. et al. 2005.)

compared with women's 2.5% for those having tried cannabis in the past year. (Hakkarainen et al. 2005.)

Table 6. Percentage of 15–34-year-olds having tried drugs according to the 2004 survey

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

For other drugs, the percentages of those having tried drugs during their lifetime varied from 2% for amphetamines to 0.5 per cent for heroin, the percentages for 15–34-year olds being higher. This age group had also experimented with the recreational use of ecstasy (3% during their lifetime) and cocaine (2%).

The 2004 survey also looked at the patterns of initiation and continuation for drug use, in this case cannabis. The initiation of use is measured by how many (new) users (%) started using cannabis during the past year, i.e. had tried cannabis for the first time during the past year. The continuation of use is measured by how many (%) of those people who had tried cannabis during their lifetime had also tried cannabis during the past year. The results indicate that new users account for 0.5% of the whole population, 0.8% for women and 0.2% for men. The youngest age group, 15–24-year-olds had the most new users (2%). Regarding the continuation of use, 18% of those having tried cannabis during their lifetime had also used it during the past year (21% of men and 14% of women). The percentage is the highest for 15–24-year olds (36%) and declines with age by about half for every 10 years. Thus, it seems that interest in drug use decreases with age.

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

According to the 2004 survey, drug use and binge drinking are closely connected. The results show that those having tried cannabis during their lifetime are four times more likely to binge drink

(criteria: consuming more than six doses of 1.5 cl absolute alcohol) compared with those who have never used drugs and who have never been offered drugs. The same goes for those who use several drugs. The connection is almost ten-fold for cannabis-users. More than half those who have used cannabis or several drugs had been drunk before turning 13, compared with 10% for those who have never used drugs and who have never been offered drugs. According to the results, bar visits per month also correlated with drug experimentation and use.

According to the annual Health Behaviour Survey among the Finnish Adult Population, 17% of both men and women know someone who has tried drugs. Acquaintances having tried drugs were clearly more common in cities and among 15–24-year-olds. In this age group, women had more acquaintances who had experimented with drugs than men did. Regionally, people from Southern Finland (the region of Uusimaa) and big cities knew more drug users than people elsewhere. Three per cent of respondents knew more than five users but in the youngest age group, the percentages were 9% for men and 11% for women. (Piispa et. al. 2005)¹⁹ A noteworthy aspect of this survey is that the percentage of population who knew more than five drug users corresponds to the percentage of those who had tried drugs in the past year according to the previously mentioned population survey.

Figure 13a. Acquaintances having tried drugs (%) 15-64-year-old men 1996–2004

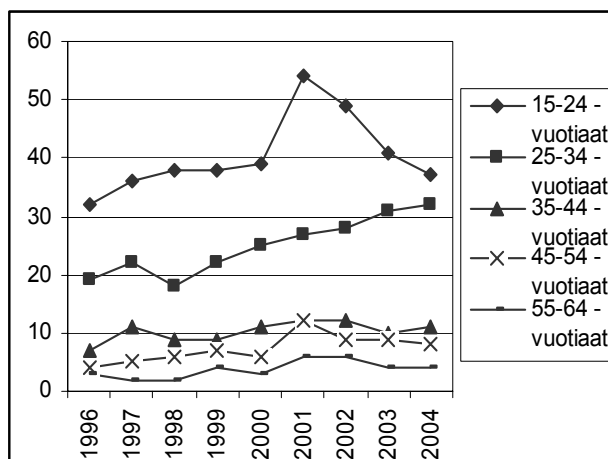
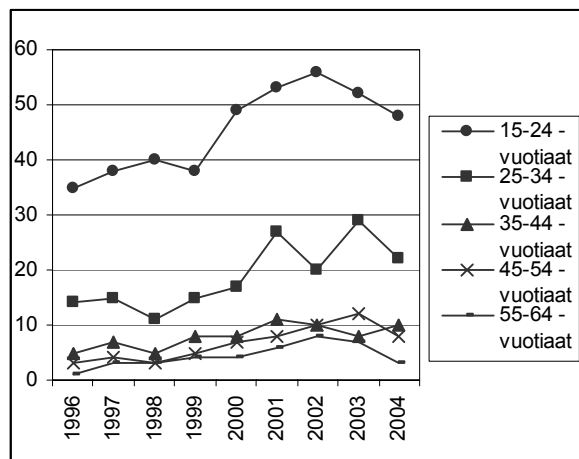


Figure 13b. Acquaintances having tried drugs (%) 15-64-year-old women 1996–2004



In Finland, drug use has been seen as a generation phenomenon.²⁰ Drug trends have followed international currents but in our country, fluctuations in drug use have been particularly strong.

¹⁹ The Health Behaviour Survey among the Finnish Adult Population (AVTK) comprised a random sample of 5,000 Finns aged 15–64. The response percentage was 68% (67% in 2003), 61% (60%) for men and 74% (73%) for women. (Piispa et al. 2005.)

²⁰ See also Part B, chapter 14.

Much like other countries, Finland has experienced two major drug waves: one in the 1960s and the other in the 1990s. The term "wave" is fitting as between the waves, from the mid 1970s to the beginning of the 1990s, drug experimentation and use were very low.

In Finland, the use of cannabis began to spread slowly in the early 1960s. Experimentation and use started with a small core group of people, mostly musicians, artists and bohemians. Gradually, the use of cannabis started to gain popularity with several different groups, in universities and schools. At the beginning of the 1970s the number of people who used or experimented with cannabis was estimated at 30,000–40,000 at its highest. Most of these people lived in the Greater Helsinki area. The prevalence of experimentation and use began to plummet in the early 1970s. The most important reasons for this were the changes taking place in international youth culture, fading of hippie-culture. (Salasuo 2005.)

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

2.2 Drug use among school children²¹

Experiments with drugs and trends in drug use among young people are investigated every four years in national school surveys (ESPAD, HBSC), which are also part of European comparison surveys²², and regional school health surveys conducted every two years.²³

²¹ See "data library" or "statistical bulletin" in <http://annualreport.emcdda.eu.int/fin/home-fi.html>.

²² The latest of these surveys was the 2003 ESPAD survey, which involved 200 schools and 3,321 pupils in 9th grade of secondary school. Data was collected with the same compilation method as in the 1995 and 1999 surveys. The response percentage was 92% in 2003. (Ahlström et al. 2003). See also EMCDDA's Annual Report 2004 web site, Standard Table 2. WHO's health behaviour study (HBSC) was conducted in Finland in 2002. The sample of 15-year-olds consisted of 1,745 pupils (see HBSC 2003).

²³ The school health survey was filled in by the 8th and 9th graders in secondary schools and by the 1st and 2nd graders in upper secondary schools in the municipalities (and their schools) that attended the survey voluntarily. Surveys are conducted every two years in the Provinces of Western Finland and Oulu (the last time was in 2003) and every two years in the other provinces, i.e. Southern Finland, Eastern Finland and Lapland (the last time was in 2004). The data consisted of 47,265 (2003) and 56,328

According to the ESPAD survey (Ahlström, et al. 2003), 11% of 15–16-year-olds had experimented with an illegal drug sometime in their life whereas in 1999 the corresponding figure was 10%. The amount of experimentation nearly doubled between 1995 and 1999, but since then there has been no significant growth. Experimentation with illegal drugs usually involved cannabis. In addition, the results of regional school health surveys conducted every two years in different provinces show that drug experimentation has not increased in the 21st century and in some areas, it has even decreased (Luopa et al. 2005). In the Provinces of Western Finland and Oulu, the percentage of 15–16-year-olds who had tried drugs during their lifetime was 7% in 2003 and according to the same school health survey for 2004, the percentage for the Provinces of Southern Finland, Eastern Finland and Lapland was 9%. According to the surveys, 12% of 17–19-year-olds in the Provinces of Western Finland and Oulu had tried drugs during their lifetime whereas the percentage for Southern Finland, Eastern Finland and Lapland was 16%.

According to ESPAD results, 7.5% of 15–16-year-olds had experimented with some illegal drug during the past year, and 2.5% during the past month. WHO's 2002 school health study (HBSC, 2003) gave almost similar results: 10% of 15-year-olds had experimented with cannabis sometime in their life and 7.5% during the past year. Two and a half per cent of respondents in the latter study were regular users and 0.5% heavy users.

2.3 Drug use among specific groups

According to a study on underage young people in drug treatment, the central factor affecting their self-image is their attitude towards their own drug use.²⁴ These young people may see themselves as drug users, former drug users, willing to quit drugs or incapable of quitting drugs. They see drug-free living as part of normal life. A typical feature in their accounts was separating ordinary life and the drug life outside it. In their stories, the young patients crossed the boundary back and forth without attaching permanently to the other side. One reason for this might be that the treatment of the underage patients had been started regardless of their own will. Those drug users who seek treatment voluntarily have to emphasise more their desire to become

(2004) replies gathered from 8th and 9th grade pupils and 24,308 (2003) and 28,894 (2004) replies from upper secondary school pupils. The response percentages for 8th and 9th grade pupils were 81% (2003) and 78% (2004). (Luopa 2005.)

²⁴ The study deals with the views of 17 underage patients in drug treatment units on their life and substance use. Discourse analysis was used and the study focused on the meanings drug use had for the young people and the kinds of self-image the interviews revealed. (Virokannas 2004.)

clean in order to be admitted to treatment, and therefore they cannot cross the boundary as easily. (Virokannas 2004.)

Fifteen 15–27-year-old girls who had used drugs were interviewed for a dissertation on the reasons behind young girls' drug use. According to the girls, drug use offers a way of differentiating oneself and experiencing adventures. "Normal people" are considered dull, whereas the drug scene symbolises excitement and adventure. The incentive for using drugs is not so much the substances themselves but rather the drug-using friends who seem fascinating. The unknown is both scary and tempting because of the danger and suspense involved. Challenging the unknown also includes testing one's internal boundaries. Drug use offers a channel to differentiate oneself, seek experiences and increase one's social competence. When exposed to drug education, the girls only paid attention to the danger aspects that seemed exciting to them. Another common factor behind a girl's drug experimentation is infatuation with a drug-using boy. Some girls also said that they had sought consolation from drugs for their own depression and anxiety, which were often linked with feelings of loneliness and rejection. Physical appearance was also mentioned as a factor; some girls felt that they had no friends because they "didn't look right". They felt inadequate compared with the images of women promoted by the media. In this context, drug use can be seen as an alternative way to build one's own identity and to be accepted by others. (Väyrynen 2005.)

3. Prevention²⁵

The Basic Education Act, General Upper Education Act, Vocational Education and Training Act and Vocational Adult Education Act and the relevant decrees have been amended to emphasise a pupil's/student's right to pupil/student welfare services and to oblige educational institutions to prepare a curriculum with recorded strategies, for instance, for crises, school bullying and prevention and treatment of substance use. As early intervention as possible is emphasised in case of young people who face exclusion risk because, for example, young people attending comprehensive school are still "under the eye" of the school and, due to being underage, easy to reach. Substance abuse prevention projects have shown that the deeper and more advanced the problem is, the harder it is to intervene. The majority of the people who have dropped out of projects have had co-occurring substance abuse and mental health problems.

²⁵ See Virtanen 2004, Section 9.

Web-based dissemination of information is increasingly used to train professionals and for alcohol and drug education. Among online services for professionals, national services have had an important role in the training of substance abuse workers as well as in their regional work. Online drug education aimed at young drug users should be more open to feedback from users, offer neutral information and guide drug users towards more controlled and safe drug use. The challenge in the future is the restructuring of the information society and the traditional service system in a world where people want to do more things independently.

3.1 General prevention²⁶

The Basic Education Act, General Upper Education Act, Vocational Education and Training Act and Vocational Adult Education Act and the relevant decrees have been amended.²⁷ The central amendments concern teaching, a pupil's/student's right to pupil/student welfare services and the obligation to prepare for the curriculum the objectives for developing pupil/student welfare services and for drafting a safety plan. All comprehensive schools must adopt the new curriculum by 1 August 2006. Strategies for the prevention and treatment of, for example, crises, school bullying and substance use should be recorded in the local curriculum. On a national level, drug prevention aimed at young people is carried out in 230 youth workshops that have been created to activate young unemployed people. Substance abuse prevention is a central part of workshop activities. Every year, at least 7,000 young people participate in these workshops for at least six months. Rules on substance use are established between staff and participants separately in each new group starting the workshop. A nationwide network of community trainers and support persons and a handbook for community training are being created to support the independent operation of workshops. By the end of 2007, a total of 200 workshops will have received further training in substance abuse prevention and especially drug prevention. (Brochure of Ministry of Education 2005)

Two follow-up surveys, a school survey and a health centre survey, were conducted on alcohol and drug education included in school curricula and the use of the school health survey conducted every second year.²⁸

²⁶ See <http://annualreport.emcdda.eu.int/fi/home-fi.html> .

²⁷ See Section 1.2.2.1.

²⁸ **School Health survey**, see Section 2.2. **The school survey** was sent to headmasters in comprehensive schools with upper grade students (N=814). Specialist schools were not included in the study. **The health centre survey** was

According to the report on the school survey, the vast majority (93%) of schools had arranged alcohol and drug education events, mostly individual educational events, in addition to alcohol and drug education related to health education. One in four schools co-operated with an external party in alcohol and drug education and more than half the schools participated in individual events. Out of all the various alcohol and drug education programmes, the Smokefree Class Competition had the most participants (66% of schools). Every other school implemented its or the municipality's own alcohol and drug education programme. One school in four co-operated with the Lions-Quest programme. The drug information bus HuBu had also visited every fourth school. According to the survey, the curriculum for health education was in place for the 7th grade in 73% of schools and for the 9th grade in 25% of schools. Thirty-five per cent of schools reported having a qualified health education teacher. Health education is most often taught by physical education, biology and home economics teachers. (Rimpelä M. et al. 2005.)

The results of the school health survey had been used effectively in one third of the schools in the municipalities that had ordered the results. Schools had used the results as part of their pupil welfare services and school health care and in health education, parents' evenings and internal evaluation. The majority of health centres reported having used the school health survey results to improve school health care and substance abuse prevention, and one fifth had used the results in a broader sense to promote the wellbeing of children and young people.

One form of substance abuse prevention at workplaces is drug testing during recruitment and during the employment relationship. In the latter case, an employee who tests positive for drugs may be referred for treatment. In 2004, the Act on the Protection of Privacy in Working Life was passed, which defines the conditions for testing (see Section 1.2.2 1). The Act or its grounds do not, however address the technical problems of testing: many new drugs are not detected in limited drug screening, different substances are detected in different ways (hypnotics for a month, cannabis for two weeks and heroin only for a couple of days) and it is difficult to distinguish sporadic use from problem use – especially in differentiating the legal use of pharmaceuticals from illegal use. It is also assumed that the actions of an employee in their free time might affect their work, but why should this be the case only for drugs? The reason for testing is not always related to occupational safety; common reasons are fear of crime, questions of image and threat to information security. With drug testing, the responsibility for occupational

sent to the head nurses of health centres (N=265). This report is based on the replies received by 26 May: 516 comprehensive schools (response percentage 63%) and 173 health centres (response percentage 65%).

safety, which traditionally lies with the employer (work is a risk factor), is in a way transferred to the employee (employee is a risk factor). The most problematic aspect of the above-mentioned Act, in terms of substance abuse prevention, is that it does not mention treatment referral or treatment as a consequence of positive test results. (Bothas 2005.)

During the past year, several reports have been published on the use of various communication channels in the training of professionals as well as in alcohol and drug education.

In order to develop communication on alcohol and drug issues, Finland has implemented 19 addiction training/information seminars for journalists during the last 20 years. The seminars have been implemented systematically as events that the participants must apply for. The participants have to explain in writing why they would be suitable candidates for the seminar. The selection of participants emphasises work experience in the field as well as a balance between different professional groups. The seminars have been partly sponsored, but the participants cover their own costs. The aim has been to hold the seminars in different cities, from 1995 onwards in different Baltic countries. The seminars continue to be successful because of their interactive nature and because they have become a kind of institution, a forum for presenting objective information from different points of view. Participants feel privileged to receive all the new information in such a pleasant atmosphere. Central themes have included current issues, contacts with other journalists in the field and visits with the substance abuse services in the seminar city or related facilities. (Peltoniemi 2004.)

An example of web-based alcohol and drug education is the national AddictionLink Internet service introduced in 1996, which focuses on prevention and information on addiction problems. It also serves as a self-help site for people who want to try quitting substance use on their own and it is also of use to treatment services to some extent. AddictionLink includes an information bank consisting of articles on various substances and treatment services, a possibility to test one's own substance use, self-help tools for individuals and families, pages for children, an anonymous counselling service and a discussion forum. The site currently receives on an average of 30,000 hits per month. Linking telematic services with other substance abuse services has proven its usefulness. It has also been noted that the services only work well on a national level. The challenge in the future is the restructuring of the information society and the traditional service system in a world where people want to do more things independently. (Lehmusvaara, ed. 2004.)

A local co-operation project of the Päijät-Häme and Itä-Uusimaa regions dealt with the possibilities for online consultation between professionals.²⁹ The experiment showed that the use of the general online consultation services was low. Instead, users focused more on local issues. The project management team decided to expand the consultation service into a national service and attach it to AddictionLink since a nationwide, previously familiar service would reach more professionals. AddictionLink has nine experts who besides their regular work answer questions sent to the counselling service. The local project also emphasised the need for treatment units' own web pages, as many of those who answered the survey use Internet services on a daily basis. (Bothas 2005.)

A report on the use of new technology in the web-based co-operation of a national development group consisting of substance abuse prevention professionals (22 members + 2 co-ordinators) was issued in 2004. According to the report, an interactive online learning environment motivated participants to produce, edit and disseminate material and to discuss issues together. The results of the development work and examples of best practices are published in the national substance abuse portal (STAKES's Neuvoa-antavat portal) for use by anyone involved in substance abuse prevention and as a basis for education. The network participants will continue the development by networking on a local level (differing thus from the development of AddictionLink). The aim is to maintain expert networks and to exchange information and opinions on new strategies and practices on a local level before they are implemented on a wider scale. (Romppainen et al. 2004.)

A study was conducted on the discussions in the most extensive virtual discussion forum in Finland, Sauna, which is part of the AddictionLink web site.³⁰ (Roine 2004a, 2004b) Five central approaches were found in the forum's messages: (1) drug use is considered either an extremely good or bad experience, (2) controllability of drug use becomes an ideal, (3) drug use is seen as the individual's own choice, (4) acceptability of drug use is justified by comparing it, for example, with the use of alcohol, or (5) people in the forum indicate that they are experts in the field and thus qualified to give advice to others by referring to exact research-based information. People in the forum draw a strict line between themselves and those drug users that

²⁹ The survey was sent to some 340 social welfare and health care professional from the Päijäthäme region. The main target groups were social workers, school nurses, child welfare clinic nurses, youth workers, church social workers, school psychologists, school social workers, family counsellors and family workers. The objective was to reach social welfare professionals from a wide range of fields. The survey was not sent to substance abuse workers because the aim was to discover the needs of those who encounter substance abuse issues more irregularly in their work. (Bothas et al. 2003.)

³⁰ The study dealt with 426 messages sent to Sauna in January–March 2002, which were selected from 27 message chains starting from the latest themes.

they classify as drug addicts and they do not see drug use causing themselves any particular problems. According to the study, people participating in the Sauna discussion could be reached with drug education that would offer neutral information and guide drug users towards more controlled and safe drug use. (Roine 2004a.)

According to an extensive study on drugs on the Internet and in youth culture (Seppälä et al. 2004), drug use is a strong symbol of social resistance and independence, even freedom. Drug users side more with criminals than with the authorities. Drugs make life more exciting and give it new content. They also give users social status in their own circles. Furthermore, the drug culture may seem as a tempting alternative in a situation where a person has poor work and study prospects. The party and youth culture differs in many ways from the traditional alcohol culture. This poses new challenges for substance abuse prevention. Even co-operation partners must be recruited from new places, from the bar world and from among representatives of subcultures. Hearing users themselves in discussions on the risks and detriments related to drug use would also make it easier to initiate dialogue with them. It would also improve the image of the authorities. There is also demand for low-threshold discussion forums in which users could discuss more freely their drug problems.

Substance abuse prevention was also dealt with on a large scale as part of neighbouring area cooperation during a project implemented in 2002–2003 in the Vyborg area (Budusheje) (Heinänen 2004). The project participants from Finland included the Helsinki Social Services Department, the University of Helsinki, the Finnish Association for Healthy Lifestyles and the Youth Organisation NAD. The participants from Vyborg included the Youth Department and an anti-drug organisation, and the participants from Sweden represented MKFC Stockholm Folk High School. The project aimed to present models for substance abuse prevention, promote co-operation between the authorities and non-governmental organisations and to create a network of actors in substance abuse prevention from Vyborg, Finland and other Nordic Countries. The project highlighted the importance of substance abuse prevention, created multiprofessional networks, increased the competence of the participants and developed work practices between public services and NGOs. The central resources of the project were derived from the commitment level of the networks and new partnerships between different actors. The special competence of immigrant workers from the former Soviet Union also facilitated the implementation of the project. Another project that included co-operation with neighbouring areas was the Sillakaar project on developing third sector co-operation within Christian substance abuse work in Estonia.

3.2 Selective prevention³¹

Selective substance abuse prevention has been targeted at young people facing the risk of social exclusion and young immigrants.

Eighteen projects around Finland participated in a national rehabilitation trial for young people in 2001–2003. Young people who had dropped out or were in danger of dropping out of comprehensive school, upper secondary school or vocational training were chosen for the projects.³² In addition to difficulties with school attendance and studies, the young people could have other problems that increase the risk of social exclusion, such as alcohol or drug problems, but the project only dealt with them indirectly. (Suikkanen et al. 2004; Linnakangas et al. 2004.). According to the project results, two out of three young people had had their life situation improved significantly due to intervention in problems. Early intervention was possible because young people attending comprehensive school are still “under the eye” of the school and, due to being underage, easy to reach. In addition to the “partnership” of school and home, cross-sectoral co-operation to support young people facing exclusion risk is also important as is the existence of a person who co-ordinates co-operation between different services. This allows the young people at risk to get the support and help they need as early as possible.

Brief follow-up reports regarding local projects have been published on the following topics: co-operation between a personal counsellor and the authorities (Karjalainen et al. 2004), co-operation between the authorities, voluntary organisations and families (Rokka 2004), operation of a regional collaborative group on substance abuse prevention (Saari et al. 2005) and family work (Raitanen 2005). During the 2.5-year Nuotta project, efficient work with a personal counsellor helped 73% of 160 17–24-year-olds who were neither employed nor studying to find a meaningful direction in life. The young persons’ backgrounds included insolvency, criminal offences, substance abuse and mental problems. The project was most successful with young people who had not accumulated too many problems. The majority of the people who dropped out of the project had both substance abuse and mental health problems. A total of 450 young people and family members participated in treatment in the three-year project on cross-administrative co-operation with families (Nuorten talo, *Young people’s house*). The project

³¹ See <http://annualreport.emcdda.eu.int/fin/home-fi.html>.

³² Projects involved 576 persons in the age group of 15–17 years who had a rehabilitation plan prepared. Some 8% of the participants dropped the project.

came about from the need to address emerging problems of children and young people as early as possible. Even though some of the young people had multiple problems, the project made it possible for them to make concrete plans for the future. Many were also able to improve the quality of their life and increase their social contacts. A 3-year project on substance abuse prevention (Nuorten juttu, *Young people's thing*) aimed to create contacts with students, schoolchildren and co-operation networks and to develop the contents of health education taught in schools. Low-threshold methods for local substance abuse services were created with the schools. The participants of the 3-year family work project (Voitto kotiin, *A victory for home*) consisted of 22 clients with family members who were chosen from family centres and associations of mother and child homes and shelters. Two families did not participate in the project and four dropped out. The project was carried out in the form of family meetings. The clients received support for parenting and they were given the opportunity to take part in vacation activity. Even though the parents felt the camp activities were more leisurely fun rather than serious-minded substance abuse prevention, almost all the mothers and most fathers felt that the family meetings had provided them with clear and practical advice for coping with everyday life. All the projects showed that project-type multiprofessional co-operation close to everyday life and the active participation of the entire family are successful methods in substance abuse prevention.

The "Kotiin Helsinkiin" ("Home in Helsinki") project focusing on immigrants (Heinänen 2004) was carried out as two sub-projects in 1999–2003 and was targeted at people who had moved to Helsinki from the former Soviet Union and especially at young Ingrians involved with criminal offences and drug use. The objective of the project was to influence the target group through substance abuse prevention, providing them better access to services and treatment referral. During the last year of the project, the help line received more than 300 calls, more than 800 client visits were made (by a physician, psychologist, foreign expert consultants) and there were family contacts with approximately 100 clients. Eight clients received treatment in the St. Petersburg area. In addition, the project included network training and Finnish lessons. Based on the experiences gained from the project, a proposal has been submitted whereby substance abuse prevention among immigrants should be consolidated and included in basic services, the core services used in the project should be continued (help line, personal discussions, parent groups, family work, treatment referral, maintenance of the web site) and treatment referral should be developed in the office of substance abuse affairs at St Petersburg's regional addiction hospital. Other aims are to use the experiences of immigrants to build peer support systems, to combine the working practices of both the country of origin and the country of destination, to use other

languages besides Finnish and to utilise the immigrants' own channels to promote the use of low-threshold services.

4. Problem drug use³³

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

In 2004, the main drugs used by drug treatment clients of substance abuse services were opiates (34%), amphetamines and other stimulants (26%), alcohol and drugs (18%), cannabis (15%) and hypnotics and sedatives (6%). The popularity of buprenorphine (Subutex) as a main drug used by drug treatment clients has increased significantly, and it is the main drug of four out of five opiate users. Intravenous use was also common: three out of four drug treatment clients had injected drugs at least once during their lifetime. The majority of the clients of health counselling centres providing needle and syringe exchange use buprenorphine by injection. Polydrug use is also very common among drug users, but the most severe cases are the most excluded and aged addicts who tend to use "anything they can get" from alcohol and substitutes to heroin and Subutex.

4.1 Estimates of the number of problem users³⁴

Statistical estimates on the prevalence of problem drug use³⁵ have been made nationally since 1997. According to these estimates, out of the 15–55-year-old population, there were some 16,000–21,000 amphetamine and opiate problem users in the entire country in 2002.

³³ See Virtanen 2004, Sections 2.3 and 3.1.

³⁴ See "data library" or "statistical bulletin" in <http://annualreport.emcdda.eu.int/fi/home-fi.html> .

³⁵ **The estimates of problem drug users** are based on the statistical capture-recapture method in which the samples from the same group are used to assess statistically the size of the entire target population. The samples were defined based on the interventions directed by society at the target population (amphetamine and opiate users). The interventions employed by the system included amphetamine or opiate diagnoses recorded in hospitals, penal action for drug offences involving the use or possession of amphetamines or opiates, arrest for driving under the influence of amphetamines or opiates and hepatitis C cases

Table 7 Development of the number of amphetamine and opiate users in Finland in 1997–2002

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

* = Estimates are based on information from three registers

The majority of problem users, 70–75%, consisted of amphetamine users. According to the study, about 80–85% of amphetamine users and 75% of opiate users were men. The proportion of the youngest problem users has varied from 40 to 50%.

Table 8. Development of the population share (%) of amphetamine and opiate problem users in Finland in 1998–2002.

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

Some 60–70% of all problem users were from Southern Finland (population share 0.85–1.25%), more than half of them from the Greater Helsinki area (0.9–1.35%). The corresponding population shares were 0.4–0.6% in Western Finland and 0.3–0.5% in Eastern and Northern Finland. In the Greater Helsinki area, the problem users were slightly older than elsewhere in Finland.

recorded in the infectious disease register due to intravenous drug use. The estimate intervals are based on 95-per cent confidence intervals of the estimates. Different log-linear models were applied to different subgroups so the sum of the subgroups differs from the overall estimate. (Partanen P. et al. 2004.)

4.2 Clients in drug treatment³⁶

In 2003, all social and health service units took part in a one-day census of intoxicant-related cases, which examined all the cases related to substance abuse in each unit during the day in question. The results indicate that 44 per cent of the clients in outpatient care and 47 per cent of the clients in inpatient care in the units providing specialised services for substance abusers had used pharmaceuticals or drugs. The figures for drugs were 35% and 40%. The results have changed significantly from 1999 when the share of drug treatment clients was just under 20% in substance abuse outpatient care and about 30% in inpatient care. (Metso 2004.)

The drug treatment information system, which is voluntary and anonymous for substance abuse units, collects information on clients who have entered drug treatment for the abuse of pharmaceuticals or narcotics. The coverage survey of the drug treatment information system³⁷ conducted in spring 2004 estimated the number of people who had entered drug treatment in 2003. Overall, it was assessed that the drug treatment information system reached roughly half of all the drug treatment clients in substance abuse units. According to the drug treatment information system, the share of drug users of all the clients of substance abuse services was about half of the results of the census of intoxicant-related cases: 18% in substance abuse outpatient care and 27% in inpatient care. The latter estimate reflects, however, the problem drug use related to substance abuse better than the census of intoxicant-related cases. (Vismanen 2004.)

According to the census of intoxicant-related cases, the share of drug treatment clients in outpatient health care services (hospitals, mental hospitals, health centres and mental health clinics) and in inpatient health care services (hospitals, mental hospitals, health centre wards) is 23% of all the alcohol and drug treatment clients in health care services.

The profiles of drug treatment clients in the information system and in the census are quite similar regarding all substance abuse units. On the other hand, in the census, the age and gender profiles of all the clients of substance abuse units largely matched the recorded clients of

³⁶ See "data library" or "statistical bulletin" in <http://annualreport.emcdda.eu.int/fi/home-fi.html> .

³⁷ For the coverage survey of the drug treatment information system, all the 551 units of substance abuse services were sent a survey regarding their alcohol and drug treatment clients. 324 of the units responded and 260 units said that they provide treatment especially for drug users. Of all the units in the drug treatment information system (164), 122 responded to the coverage survey. Overall, the units (units of substance abuse services as well as substance abuse units in health care and prisons) reported about 75,000 alcohol and drug treatment clients, of which 17,850, i.e. almost a quarter, were drug clients. (Vismanen 2004.)

corresponding substance abuse units, even though the latter information is based much more on limited basic statistics. (Vismanen 2004.) Thus, the results of the drug treatment information system can be evaluated to reflect quite well the drug treatment clients in substance abuse services. Furthermore, both the drug treatment information system and the census of intoxicant-related cases indicate that clients in drug treatment are badly off: only 10% were employed, 10% are homeless and according to the census, almost 40% suffered from co-occurring mental problems. (Nuorvala et al. 2005.) However, in the drug treatment information system, the drug treatment clients in outpatient and inpatient care are systematically five years younger than the drug treatment clients in the census. The difference can be explained by the fact that youth centre clients are emphasised in the drug treatment information system. It can also be estimated based on the census that abusers of pharmaceuticals that are a little older on the average are underrepresented in the drug treatment information system. (Partanen 2004; Nuorvala et al. 2004.)

Despite small differences, the census of intoxicant-related cases also emphasised the youth of the clients in drug treatment. According to the census, of all the intoxicant-related cases in social and health service units, drugs were involved in 63% of the cases of under 20-year-olds, in 75% of the cases of 20–29-year-olds, and in 40% of the cases of 30–39-year-olds. The mean age of all the clients was 44 years. (Nuorvala et al. 2005.)

The 2004 results of the drug treatment information system are based on data gathered from 166 units and 5,701 drug treatment clients. According to the information, the drug treatment clients were mainly men (72%), young adults and single. Their educational level was low, and unemployment was common (60%). Every ninth client (11%) was homeless. The majority of the drug treatment clients had received drug treatment before, and one-sixth entered drug treatment for the first time. (Partanen A. 2004, 2005.)

Of the clients in the drug treatment information system, 8.7% were from inpatient treatment units specialised in drug treatment and 21.7% of outpatient units specialised in drug treatment. Thirty-nine point five per cent were from general substance abuse outpatient units and 26.1% from inpatient units. The mean age of the clients in the drug treatment information system was 27.3 years (compared with 26.8 the year before). Men were on average 3 years older than women were (compared with 2 years the year before). The clients of inpatient treatment units specialising in drug treatment were the youngest, with the mean age of 25.2 years. In substance abuse outpatient units, the mean age of clients was 25.8 years, in outpatient treatment units

specialised in drug treatment 27.9 years and in substance abuser inpatient care 29.1 years. In prison health care, the mean age was 32.2 years. (Partanen A. et al. 2005.)

Of all the clients in the drug treatment information system, opiates were the primary problem substance of those clients entering drug treatment (34%), followed by stimulants (26%), mixed use of drugs and alcohol (18%), cannabis 15% and pharmaceuticals (6%). Buprenorphine was the primary problem substance of 27% of the clientele. Almost two out of three clients (62%) had used at least three substances.

The most common substance of those clients entering drug treatment for the first time (n = 990) was cannabis (31%), followed by mixed use of drugs and alcohol (26%) and the use of stimulants (23%). The group differed from all treatment clients mostly in the case of opiates (13%) and buprenorphine (11%). For those clients entering drug treatment for the first time, we can also assess the path from experiments to regular use to treatment. The results show that the time lag between initiation of drug use and regular use is 1.5–2.5 years, and the time lag from initiation of use to seeking treatment appears to be roughly 4 years. The shortest lag can be seen among buprenorphine users (2.5 years), but they had often started intravenous drug use more than a year before they started using buprenorphine. Thus, it is uncommon for anyone to start drug use with buprenorphine, even with intravenous use. In other aspects, buprenorphine users do not differ much from the other drug users entering treatment. (Virtanen, ed. 2005.)

Almost three out of four (74%) drug clients in services for substance abusers had injected drugs at least once during lifetime, two thirds of these (59%) during the past month, and approximately a fourth (23%) used shared needles and syringes. The most common way to use opiates was intravenous (86%). Intravenous use of buprenorphine (89%) was almost as common as intravenous use of heroin (92%). Stimulants were also injected by 79 per cent of their users.

4.3 Problem drug use and users according to other studies

The Kuopio Military Province Headquarters arranged a medical re-examination for service personnel who had to suspend their military service or for conscripts who failed to respond to their call-up or fell ill. The situation of those summoned for re-examination was monitored from 1993–2003 according to ICD category. The information was based on required medical certificates. The number of those summoned for re-examination grew from 202 in 1993 to 335 in 2003. Mental and

behavioural disorders were the biggest ICD category in the re-examinations (roughly 55% of the cases). Within this category, the most significant change was the increase of mental and behavioural disorders due to psychoactive substance use (F10-F19): in 1993, these cases accounted for 2.2%, in 1999 for 10.1% and in 2002 for 27.3%. In 2003, the percentage dropped to 20.7%. The percentages related to alcohol have declined continuously, while those related to drugs have increased. Alongside cannabis and amphetamines, it was not uncommon for those summoned for re-examination to use injected drugs, and there was an increasing prevalence of substances used in combination. (Koskinen et al. 2005.)

A practical problem of substitution treatment in Finland has been the patients' concurrent use and injection of buprenorphine.³⁸ Those who inject drugs actively explain their use by the fact that intravenous use is more effective and cheaper than using drugs in other ways. If a patient's medication is adequate, he or she should not have a pharmacological reason for using more drugs. The beliefs regarding the effectiveness of a substance are indeed central in the needle addiction phenomenon. These beliefs among users stem from the times of active use and the immediate feeling of pleasure caused by drug use and especially injecting as well as the social interaction and rituals related to intravenous use. The study emphasised that injection itself is a form of addiction; it can be seen as a functional concurrent addiction. It cannot occur unless the person is or has been addicted to a substance causing physical addiction and injected it. Quitting the intravenous use of drugs seems to require a completely new social network for the patient, which does not include other drug addicts.

The health counselling centres for intravenous drug users exchange needles and syringes and provide some other services (health counselling, discussions, HIV rapid tests, treatment for angitis, hepatitis B vaccination etc.). The mobile health counselling unit (ambulance) operating in the Helsinki area was assessed during its year of operation.³⁹ Some 5% of clients had acute need for follow-up care. Roughly a third of clients were women and the mean age of clients was approximately 31.7 years. The majority of new clients were 20–29 years old. During the month preceding their first visit, a third of new clients had not used any other health counselling

³⁸ The material for the study into drug users' experiences on injection and its compulsiveness (Harju 2004) consisted of interviews of 12 persons. Those interviewed were patients of two outpatient substitution treatment units in Helsinki. The material was analysed using the grounded theory method.

³⁹ The operation started at the end of 2003 and in 2004, it had 700 clients, in total 2,350 client visits. The material of the study consisted of survey forms on 212 new clients, who had not used health counselling services during the month preceding their visit. In addition, theme interviews were conducted on 20 clients. (The clients were chosen anonymously, using pseudonyms) Interviews were also conducted on the personnel of the unit (8), other service providers (7) and pharmacists and police officers (4) operating in the neighbourhood. (Törmä et al. 2005 b.)

services (before a revisit 9%). Of the 20 clients who were interviewed, 14 were men, the majority were 19–23 years old (9), and the oldest client was over 40 years old. Most clients (15) used Subutex intravenously, seven of these as their primary substance. Amphetamines were the primary drug of six users, and others used both Subutex and amphetamines. The majority of clients had started using drugs when they were under 20 years old. The majority (13) of those interviewed had started the intravenous use of drugs within two years of initiating their use. However, approximately three out of four of those monitored (212) had not shared needles and syringes during the month preceding their visit to the unit. (Törmä et al. 2005b.)

The Deaconess Institute in Helsinki conducted a project on drug treatment for people who have been excluded from services (2003). The client criteria consisted of a drug problem and at least one diagnosed mental problem or a psychological symptom that negatively affects the patient's life, or social exclusion. Project participants were chosen from the most socially deprived clients of the Helsinki-based low-threshold drug addiction treatment clinic, Kurvi. Twelve per cent of the clients in the project had an HIV infection, 12% were homeless and nearly half the group had attempted suicide at some point. Forty-three per cent of the clients in the project continued with follow-up treatment, either in outpatient or inpatient care. However, the treatment and rehabilitation process was not long lasting for many of the clients, as most of them returned to the Kurvi clinic from follow-up care after a few weeks or months.

Alcohol and drug abusers who are on the brink of social exclusion or already excluded usually visit the no-threshold day centres, where people can go in daytime even when intoxicated and the services of which include interaction with others, meals, the possibility to wash etc. According to a study on the clients at the Stoori day centre in Helsinki, the clientele, which traditionally consisted of alcoholics, now also includes drug addicts (one fourth of the clients)⁴⁰. The customers are polydrug users for whom there are no special services and who are unable to commit to normal drug treatment and its requirements. Over the years, the clients have increasingly shown a poor physical condition and their problems have deepened. Approximately half the clients were homeless and half of these used drugs. Drug-using clients were typically ten years younger than the rest of the clientele, but also clearly older than clients in actual drug treatment. Furthermore, the group differed from the normal drug treatment clients in that even if a client had injected drugs regularly, they claimed using alcohol as their primary substance. Even though a large part of drug-using clients had psychological and even psychotic symptoms, only

⁴⁰ A semi-structured survey was conducted on 81 clients of the centre, 20 of whom could be considered drug clients. (Törmä et al. 2005.)

15% (three) had resorted to any kind of psychiatric services. Of the entire clientele, approximately two thirds had been in prison – however only a third for drug offences.

A new project, "Kynnykset pois" (No thresholds), was launched as a follow-up to the above-mentioned project. For the duration of the project, the services of Stoori were combined with the Kurvi drug addiction treatment clinic, which operates 24 hours a day. Of the joint clientele, the study focused on clients with multiple problems, the so-called project clients⁴¹. In 2003–2004, there were 320 project clients, 12 of whom were interviewed. One third of the group were under 30-year-old addicts on the brink of exclusion, whereas the older ones could already be deemed marginalised. For all the younger clients, the intravenous use of Subutex was the primary method of drug use. The older clients tended to use "anything they could get" from alcohol and substitutes to heroin and Subutex. The most common psychological symptom among the clients was opiate addiction, but clients also had other substance addictions. Almost all older clients were homeless, had been to prison and had had a much disrupted family background. Even the youngest clients did not live on their own, had a criminal background and a somewhat disrupted family background. However, the basic physical health of the young clients was good, whereas the lifestyle had already affected the health and physical appearance of the older clients.

The problem drug use situation has been studied near the Finnish border, in Northwest Russia. The most common problem substance is alcohol, which is used in the area, on average, more than elsewhere in Russia, and also mortality rates are highest there. It was estimated in 2001 that near the Finnish border, the Murmansk area had 6,000–25,000 drug addicts; the Republic of Karelia had 5,000–7,000 drug addicts, the St Petersburg area 4,000–6,000 addicts and St Petersburg itself had roughly 40,000. The most common problem substance is heroin. Synthetic drugs have also emerged lately, for example tablets that are used recreationally. In St Petersburg, cocaine is a fairly new addition to the drug market, and its price has quickly dropped to a third of what it first was.⁴² (Pakkasvirta 2004.)

⁴¹ The project clients had to meet at least two of the following criteria: a psychological diagnosis, distinct psychological symptoms, psychological symptoms that seriously interfere with the ability to manage everyday life, lack of life management skills, exceptional use of treatment services (outsider, major user) or unstable social situation (no social relationships, devoid of a permanent home). In 2003, approximately 7% of all 1,300 clients of the drug addiction treatment clinic were classified as project clients. By January 2005, the number of project clients had grown to 320 as the entire basic group had grown by 1,700 clients evaluated at the clinic. Twenty-three project clients had been referred from the day centre to the drug addiction treatment clinic and among them 12 agreed to an interview. They were also asked for a permission to use their personal drug treatment information. (Törmä et al. 2005)

⁴² In Russia, drug use was prohibited in practice at the beginning of the 1990s and it was officially prohibited in 1998. Since 2004, people found in possession of small quantities of drugs for personal use are fined.

5. Drug treatment⁴³

According to a survey on basic municipal services, one third of municipalities do not provide outpatient detoxification treatment for drug users and one fourth have no inpatient detoxification systems. Thirty per cent have a system for the distribution of needles and syringes. One third does not provide substitution or maintenance treatment for opiate addicts. Opiate addicts have to wait on average two weeks to be admitted to substitution and maintenance treatment, but this can take up to a year in Southern Finland.

According to a study made in Helsinki, the alcohol and drug treatment service system is fractured and built on the treatment needs of alcohol abusers. New resources are urgently needed in the treatment of substance abusers with mental health problems, in creating comprehensive treatment programmes for children and young people, and in organising treatment for opiate addicts. Other studies support these results. The service system should also be better equipped to offer acute services quickly (detoxification) and more resources should be allocated to post-treatment rehabilitation. Many severely socially excluded clients would benefit from less goal-oriented treatment plans and supported housing services.

Drug-free community treatment emphasises the meaning of the community's clear rules to problem users who have mostly lived without any rules. The rules facilitate integration into the treatment community, which eventually enables integration into society. An estimated 700–750 opiate addicts were in substitution treatment in 2004. According to the drug treatment information system, two thirds of those in substitution treatment were treated with buprenorphine. A study on methadone treatment showed that a majority of clients tend to stay in treatment. As substitution treatment is a long-term project, suggestions have been made to make it part of primary substance abuse services or primary health care services.

⁴³ See Virtanen 2004, Section 11.

5.1 Drug treatment systems⁴⁴

Treatment systems and their evaluation

One part of the survey on basic municipal services submitted by State Provincial Offices to municipalities (446 municipalities) in 2003 dealt with the availability of substance abuse services (Evaluation of Basic Services 2004). According to the municipal survey, 24-hour detoxification for drug addicts was usually arranged in rehabilitation units, detoxification units or specialised health care services. One third of municipalities reported that they do not provide outpatient detoxification treatment for drug users, and one fourth had no inpatient detoxification systems. An opiate addict can be admitted to substance abuse outpatient care in under a week in every municipality, and to inpatient rehabilitation in under a week in two out of three municipalities. Thirty per cent of municipalities have a system for needle and syringe exchange, but only 10 per cent have it within the municipality. The explanation for this is that neighbouring municipalities use the health counselling centres of bigger municipalities. One third does not provide substitution or maintenance treatment for opiate addicts. In most cases, this type of treatment is arranged in another municipality and mainly in substance abuse outpatient care or partly in specialised health care services and health centres. Opiate addicts have to wait on average two weeks to be admitted to substitution and maintenance treatment, but this can take up to a year in some municipalities in Southern Finland. On the other hand, some small municipalities have very little demand for drug treatment.

The use of general social and health care services by substance abusers does not vary much from one municipality to another. Instead, there are significant differences in the use of specialised services for substance abusers: in municipalities with more than 150,000 inhabitants, the number of clients in substance abuse inpatient and outpatient services is 50% higher than the average for the country, and housing services, day centres and so on, which are intended to meet the clients' basic needs, have twice as many clients. Correspondingly, in small municipalities (under 20,000 inhabitants) the utilisation rate of these services is less than half the average for Finland. (Nuorvala et al. 2005.) Since 1990, there has been a clear trend in the development of the services: the number of treatment periods in drug and alcohol rehabilitation units has declined by half, treatment periods in hospital wards are at the same level as in 1990, and client visits in substance abuse outpatient services have increased by a third. Even though periods of inpatient

⁴⁴ See <http://annualreport.emcdda.eu.int/fi/home-fi.html>

care have become shorter, the number of rehabilitation patients has reduced by half. Outpatient services have been increased strongly, but the threshold for treatment seems to have become higher. It appears that the availability of acute services has declined and the most socially excluded and severely addicted substance users face the highest risk of being excluded from services. A change has also taken place in the organisation of the services: services are provided to an increasing extent by organisations, not however, private service providers. With this change, public control of services has become more difficult. A researcher states that acute treatment services for substance abuse should be seen as part of basic services, and some type of treatment guarantee⁴⁵ should be applied to them. Municipalities should also increase their competence as buyers of services in a reorganised service system. (Kaukonen 2005.)

A study on the thresholds for treatment and services of alcohol and drug abusers ⁴⁶ confirmed the assumptions of the previous study: even though services have increased and diversified as the clientele's problems have become more complex, the problem is that not everyone has access to services. The service system should be better equipped to offer acute services quickly (detoxification). More resources should also be allocated for post-treatment rehabilitation because even if treatment places increase, the benefit gained will be limited if there is no after-care available. In addition, the need to improve education and skills is apparent. (Mäkelä et al. 2005.)

The evaluation of the local service systems in Helsinki⁴⁷ revealed that the city's substance abuse service system has been built on the treatment needs of alcohol abusers. The treatment system is fractured and the organisation of the services has weaknesses. The treatment of drug addicts requires especially low-threshold services and long inpatient periods, which diminishes the resources reserved for the care of alcoholics. Furthermore, treatment requires increasingly specialised competence and more and more knowledge on health care. A project was conducted on treatment referral of substance abusers (36) and the coordination of interventions by various service providers. The results showed that personal case management proved to be a good way to

⁴⁵ The maximum time taken for a patient to be admitted to care need assessment, detoxification and actual treatment.

⁴⁶ The material used in the study consists of speeches given at a local service development seminar (17), interviews with social and health care workers in two localities (13) and interviews with clients in outpatient and inpatient treatment units (22) as well as the results of the group work in a peer group seminar (26). (Mäkelä et al. 2005.)

⁴⁷ In the Helsinki project, the client feedback data was collected from various types of service units intended for different client groups and having different work practices. Data was collected between 1 November 2002 and 31 December 2002. The respondents included 107 outpatient clients and 177 inpatient clients. In addition, 25 specialists and co-operation partners of substance abuse services were interviewed in autumn 2002 and spring 2003. Questions on the treatment system were also answered by seven outpatient unit directors and a third of senior social workers. (Törmä et al. 2004.)

commit a drug user to the service system. However, even in this trial the most socially excluded people, whose motivation was low, seemed to drop out of the project (Korteniemi 2004). Resources are also needed for organising adequate treatment for substance abusers with mental health problems and opiate addicts. These problems are also common to substance abuse services in other cities.

According to an assessment made at the low-threshold unit (Matala)⁴⁸, which was established in 2002 in Tampere and is open around the clock, the unit was successful at reaching 18–25-year-old drug addicts and polydrug users who had previously only had contact with health counselling and social services. The most sought-after services were health care and medical services. The Matala unit gathered a large amount of users in need of support and treatment services in one place and proved successful in reaching new clients and motivating them, in concentrating care need assessments in one place and in developing care continuums. However, the project did not succeed in one of its main objectives, to reduce waiting lists for treatment, because the clientele kept expanding and the need for parallel social and health services increased. (Kekki 2004b.)

After two years of operation, Matala has clearly delineated its services. Clients who are unwilling to quit drugs are offered day centre and health counselling services. Once a client has reached a point where he or she wants to quit substance use, the client is transferred to outpatient rehabilitation focused on supporting life management, which includes the option to be referred for detoxification or rehabilitation in another unit. Outpatient rehabilitation includes group activities for those waiting to be admitted to opiate substitution treatment. After the rehabilitation process, Matala is a place where clients can always return after a relapse. The unit does not test the client's motivation, nor do clients have to meet high requirements to earn their place in the unit, but they are not allowed to use or sell substances at the unit and the unit will not tolerate threats or violence. The experiences gained at Matala have shown that the goal-oriented methods typical in substance abuse work are not efficient with drug abusers who are still using drugs. During its two years of operation, the unit has had 900 clients, an average of 170 per month. Matala also has a health counselling centre, Nervi, which has approximately 200 clients per month. The problems of the service system in Tampere are the same as those in other cities: inadequate availability of detoxification treatment and mental health services for drug clients. (Perkiö et al. 2004.)

⁴⁸ The assessment of the Tampere low-threshold unit was made by presenting a questionnaire to the staff (to the entire staff before the commencement of the activities and a year after), to clients (86 out of all 572 clients responded) and interest groups (the questionnaire was sent to 52 representatives of various interest groups; the response percentage was 60%) a year after activities were started.

The Department of Acute Psychiatry at the University Hospital of Tampere conducted a voluntary survey (2 January 2002–31 May 2005) on 84 patients who were starting their drug treatment and who had been admitted to treatment because of severe drug addiction and whose treatment was intended to last at least 3 months.⁴⁹ The mean age of the respondents was 26.4 years and one third of them were women. Of the respondents, more than 90% used opiates, 90% used drugs every day and 90% used drugs intravenously. A quarter of the patients also had other diagnosed mental disorders. According to a follow-up survey conducted on patients who were discharged from the ward to follow-up care after a month, 47 had begun follow-up treatment and 35 remained in treatment. After three months, 31 patients remained in treatment, 19 of whom were in substitution or maintenance treatment (one third in methadone treatment). The reasons for discontinuing treatment were: a breach of the conditions of contractual treatment (13 clients), the patients' own will (12), the patients felt that the treatment did not suit them or they had problems when transferring to follow-up treatment (9) by being put, for example, on a waiting list. The staff reported that the relapses were often surprising to them because more than half the patients that were assessed to be highly motivated dropped out of treatment. (Järvenkylä 2004.)

With respect to treatments, the discontinuance rates varied from 10 per cent for substitution and maintenance treatment to 74 per cent for other treatments. Receiving other medication in addition to substitute medication for opiate addiction helped the patients. Eighteen patients were referred to traditional substance abuse units in which treatment is usually planned in one-month periods. Half of these dropped out of treatment at the very beginning, and only one remained in treatment after three months. Thirteen patients were referred to specialised drug treatment units that planned treatment in at least six-month periods. Eleven patients began treatment in these units and after six months, six patients remained in treatment. The written feedback revealed the differing attitudes of traditional alcoholics and young drug users towards controlled treatment and the patient's independence in treatment. Alcoholics had a more positive attitude towards control, whereas drug users wanted to have a say in their own treatment. The patients most committed to treatment were 25–29-year-olds. Those who were at the initial phase of drug use were most successful at sticking with treatment. Other factors that facilitated this were a stable relationship and children who lived at home. One fourth of the patients diagnosed with a psychiatric disorder remained in treatment after three months. Patients felt that discussions and interaction were the most important part in all phases of treatment. In addition, medical treatment

⁴⁹ The study was conducted in collaboration with 21 other treatment units in Pirkanmaa. Seventy-seven per cent of the survey questionnaires were returned and approved (65 patients).

was deemed an important element of treatment. As the treatment progressed, the importance of peer support grew. (Järvenkylä 2004.)

Many of the clients at the low-threshold day centre intended for the most disadvantaged drug users (Stoori)⁵⁰ have no intention of giving up substance use; they are merely looking for a roof over their heads and the possibility to rest. The most popular services at day centres are coffee and meals, the possibility to take care of personal hygiene and clothing, discussions with personnel and the services of a social worker in handling practical issues. Many have overwhelming difficulties in dealing with normal services in society. (Törmä 2005b.)

Some of the clients do not use other services at all; others are major users of services who fluctuate between substance abuse rehabilitation, prison, health care clinics and the street. The most problematic are the so-called dual-diagnosis patients who are clearly in need of psychiatric services but do not have access to them because of their substance use. Older clients especially have symptoms that cannot be treated by substance abuse services. Thus, the patients' mental health problems are left untreated and they continue self-medicating with drugs and sedatives. There is also a clear demand for substitution and maintenance treatment; even though many of the most excluded clients have been waiting for years to be admitted to substitution treatment, they have repeatedly been suspended from waiting lists.

The most excluded substance users are not suitable clients for treatment in units providing specialised care for alcoholics, drug addicts or mental health patients. They are usually unable to commit to normal treatment or its requirements. According to the study, these clients would benefit from less goal-oriented treatment plans and supported housing services. Linking the entire treatment chain so that a patient could advance in the treatment system according to his or her own abilities and needs would be of great use to clients with multiple problems. There is also a need for services for female clients, as they are often especially troubled clients in male-dominated treatment units and many of them have been forced to prostitute themselves in order to finance their drug habit. Increasing numbers of young people are facing social exclusion as a result of being "recycled" in the service system and not having a real chance to commit to anything. The study shows that it would be especially important to treat young people's psychological problems before they start self-medicating with drugs. (Törmä 2005b.)

⁵⁰The project clients of the "No thresholds" project (see Section 4.3.)

The Finnish Society of Addiction Medicine issued a drug policy statement regarding the development of the drug treatment system, in order to implement the Government Resolution on a Drug Policy Action Programme 2004–2007. According to the statement:

- 1 A special annual appropriation should be reserved for 2005–2007 for the development of low-threshold services and substitution and maintenance treatment.
2. With the help of the special appropriation, municipalities should be obliged to secure drug treatment services in accordance with the legislative amendments related to treatment guarantee that came into force on 1 March 2005.
3. A sales permit for the combined buprenorphine-naloxone preparation, which is efficient and carries a lower risk of abuse, should be approved immediately.
4. The legislation on the medical treatment of opiate addicts should be revised to enable distribution of the combined buprenorphine-naloxone preparation through pharmacies and to entitle the buprenorphine-naloxone preparation to special refund of costs.
5. The State should support research on the medical treatment of chronic opiate addicts.
6. The Finnish Medical Association should address the problem of prescription drug abuse that concerns the entire medical profession. (Finnish Society of Addiction Medicine 22 November 2004.)

A study carried out as part of Finland's neighbouring area co-operation concerning the drug treatment system in Northwest Russia showed that the quality of drug treatment varied significantly in the area. There are not enough treatment places, especially in the countryside: treatment consists mainly of detoxification, and rehabilitation is in its early stages. For example, there are some 1,200 treatment places and some 60 rehabilitation places in St. Petersburg. Treatment is free in public institutions if the client can be recorded in administrative registers. Another problem is that there is no social assistance available after treatment. Drug users' visits to physicians have recently shown a decrease, which probably means that drug users have started to use other substances instead of heroin. A special risk in the drug situation in Northwest Russia is the number of HIV infections. Officially, there are some 35,000 HIV patients in Northwest Russia, but experts say that the actual number is most likely five-fold. HIV infection is common among drug users and approximately half the street prostitutes (most of whom are also drug addicts) are HIV positive, according to a 2004 study. Traditionally, drug questions have been handled either by health care services or by the militia (through treatment or punishment), but there has been no co-operation between these two. (Pakkasvirta 2004.)

Training system for drug treatment

In the spring 2005, assessments were made on a website intended for substance abuse units dealing with drug treatment skills and training (www.a-klinikka.fi/huuko) and other online training systems⁵¹ (e.g. Bothas 2005a; Romppainen et al. 2005.)

Treatment systems for special groups

At the child welfare clinic in Riihimäki, a town with a population of 25,000, drug-using pregnant women are informed of their possibilities for getting help and support to protect the child. They are also encouraged to participate in a treatment programme that would help them stop using drugs. The aim of the treatment programme is that the mother always deals with the same public health nurse, physician, substance abuse worker and social worker. The necessary laboratory and maternity clinic visits are programmed to support more frequent child welfare clinic visits. If the mother refuses contact, a child welfare report is made once the child is born. In the hospital, the child is monitored for a week to detect any withdrawal symptoms and to see how the parents react to the child. After the mother has returned home, a child welfare clinic worker will visit the family home. In the beginning, the family will have frequent appointments at the child welfare clinic and the future will be based on the wellbeing and development of the child and the situation of the family. (Koskivuori et al. 2004.)

The maternity clinic of the University Hospital of Tampere has a special parent-infant unit with psychiatric and addiction medicine expertise that coordinates the comprehensive care of mothers. The unit monitors a family's situation for a year after the birth of a child. Between 1 June 2002 and 28 February 2003, 40 mothers were referred to the unit (1.2% of all women who had given birth) based on the Alcohol Use Disorders Identification Test (AUDIT). Eighty-three per cent of these mothers had used drugs. Twenty-one mothers were in need of active substance abuse treatment. Three of them were in opiate substitution treatment and four in some other substance abuse treatment. Thus, 14 mothers were summoned to assessment of the need for substance abuse treatment. Twelve mothers were diagnosed with substance dependence, half of whom had used either amphetamines or opiates intravenously. All mothers under assessment were diagnosed with mental health problems. (Alaja et al. 2004.)

⁵¹ Cp. Section 3.1.

Since the end of 2002, the University Hospital of Tampere has assessed the situation of 110 families during a parent-infant project, and it has started opiate treatment with 11 pregnant women addicted to opiates. All options were considered when a patient started treatment, including detoxification, and if the patient was not motivated or was incapable of any other kind of treatment, buprenorphine treatment was initiated. Concurrent use was monitored at least twice a month by drug screening and by searching for injection marks. All patients continued to use other medication during pregnancy, such as hypnotics. When the results were reported, two of the patients were still pregnant, six had given birth to a healthy child and three had had a miscarriage due to serious foetal damage. Two mothers had received buprenorphine treatment throughout their pregnancy and in both cases the pregnancy had ended in foetal damage. Both had started treatment before becoming pregnant. However, their drug screening constantly produced negative results. (Strengell et al. 2005.)

The number of women receiving buprenorphine treatment during pregnancy has been higher in the Greater Helsinki area than in Tampere, but organ damage has been detected in only one user of street drugs. In both units, buprenorphine doses have been kept at a minimum level that only just prevents withdrawal symptoms. No damage caused by buprenorphine has been reported to the Finnish Register of Congenital Anomalies. Neither has animal testing revealed any anomalies that could be connected with the use of buprenorphine. Because of the limited amount of research, small samples and the ambiguity of results, no firm conclusions can be drawn on the safety of buprenorphine during pregnancy. Based on patient cases, it would seem that especially in the early stages of pregnancy buprenorphine doses should be kept as low as possible. More information exists on the use of methadone during pregnancy, which might make it a safer option during early pregnancy. It should be noted that most opiate-addicted women who become pregnant use buprenorphine, and changing medication during pregnancy poses its own risks. However, if treatment is started with methadone, it may be prudent to transfer to buprenorphine before childbirth in order to avoid withdrawal symptoms in the newborn baby. (Strengell et al. 2005.)

5.2 Drug-free treatment⁵²

A study was conducted at the Mikkeli-community, a rehabilitation unit for adults over 18 years of age suffering from severe substance addiction. The community operates on the principles of

⁵² See <http://annualreport.emcdda.eu.int/fi/home-fi.html>

community education. The subjects in the study consisted of 43 patients, 15 women and 28 men, who had sought treatment between September 1998 and the end of 1999. Seventeen patients stayed until the end of the rehabilitation programme. The clients in the community are called pupils and it is their task to learn a new way of life while in rehabilitation. The most important aspect of this process is to change habits, attitudes and values – the community does not aim to change the basic personality of the pupils. Integrating into the community helps patients integrate into society. According to the community's principles, drugs have served to numb emotional pain in the patient's life, drugs have come between the individual and his or her social life and the development of the patient's personality has been arrested in many ways, especially if drug use has started at a young age. (Hännikäinen-Uutela 2004.)

Community treatment prohibits violence and the threat of using violence, substance use and sexual relationships. These prohibitions serve to guarantee the patients' physical integrity and safety. The community acts like a family during rehabilitation, the staff act as parents and older clients act as older siblings. In this new family, the individual has a chance to experience positive human relations. However, each patient is responsible for his or her actions. These simple operating models help an individual to understand and control his or her life situation and to make changes in life style and substance use. (Hännikäinen-Uutela 2004.)

In another treatment unit providing community treatment for drug addicts aged over 18, the Kisko unit of Kalliola clinics, patients are encouraged to pursue a substance-free life style and lifelong growth.⁵³ The clinic staff regards community treatment especially suitable for drug addicts who have grown up without limits and who have a long history of substance use. As the patients have not learned basic life skills at an early age, these are introduced to them in the everyday life of the community. The practices and rules within the community create learning experiences for the patients and enable them to assume responsibility. According to the staff, the hierarchical structure of the treatment unit is beneficial in that rules do not have to be constantly discussed. The majority of those who drop out of treatment tend to do so at the beginning, when they have not committed to the programme. The support of the community is very important in this phase. The clients stated that the unit is suitable for drug addicts who have a long and extensive history of substance abuse. Treatment at Kisko requires a strong will from the clients to become sober. Other drug treatment units were criticised for being too much like "rest homes". In their interviews, the patients tended to glorify toughness and they often saw their

⁵³ The entire staff (10) and 15 patients were interviewed for the study. Ten people who had finished the treatment and five who had dropped out were also interviewed.

entire life stories as heroic tales. Thus, seeking treatment at Kisko, which is known to be a demanding place, was seen as another heroic act. Even though the interviewees also talked about the softer sides of the treatment at Kisko, its reputation as a “tough place” seemed to boost the patients’ self-esteem. In the appraisal of Kisko’s operations, the feedback on the treatment was very positive. The study showed that Kisko has a certain status among drug users. One interviewee said that he had enjoyed the treatment at Kisko “which is often likened to a concentration camp”, whereas another patient who had dropped out of treatment said that he was disappointed with himself “for not having graduated from the drug addicts’ university”. (Heikkilä 2005, 2005b.)

5.3 Substitution and maintenance treatment⁵⁴

In 2003, an estimated 700–750 people were undergoing medical substitution and maintenance treatment. (Vorma et al. 2005). According to the drug treatment information system in 2004, 19 per cent of those who had sought treatment for opiate addiction received medical outpatient or inpatient treatment. The proportion was some percentage points higher than the year before (16%). According to the system, in 2004 buprenorphine (63%) was the most common pharmaceutical used in medical treatment for opiate addiction, followed by methadone (32%). Sixty per cent of the buprenorphine used in treatment was Subutex® and 40% was Suboxone®, which contains naloxone. (Partanen A. 2005.)

The Helsinki detoxification clinic has been providing buprenorphine treatment for opiate addicts for over five years. In 2004, forty patients received substitution treatment and a third of these received methadone treatment. The choice of medication is tailored to the individual: some have transferred from buprenorphine to methadone because the buprenorphine dose has been insufficient and they have continued intravenous use even though the dose has been at the maximum level. The success of any treatment requires motivation on the part of the patient. Multiple problems and polydrug use tend to make committing to treatment more difficult. A personalised treatment plan for the following three-month period is drafted for each patient. The patient goes to the clinic daily to receive the allotted dose and in time, if there are no signs of intravenous use and the patient complies with all agreements, he or she may be given doses to take at home – up to a week’s worth of doses for those who are at an advanced stage in their treatment. In addition to medication, treatment includes weekly visits with a personal nurse.

⁵⁴ See "data library" or "statistical bulletin" in: <http://annualreport.emcdda.eu.int/fi/home-fi.html>

According to the study, if substitution treatment is successful the patient's identity as a drug addict gradually fades away. However, if the treatment is unsuccessful, the patient is not signed out automatically; instead, a lighter version of substitution treatment is suggested, which only includes medication. The weaknesses identified in the operation of the unit were the lack of psychiatric knowledge or co-operation with units providing psychiatric treatment. (Saukkonen 2005.)

The addiction psychiatry unit at the Helsinki University Central Hospital (HUCH) is the most important centre for assessing substitution and maintenance treatments for opiate addicts. Since 1997, 178 opiate addicts have received substitution and maintenance treatment at the unit. Psychosocial rehabilitation (visits with physicians and personal nurses, group treatment etc.) is an essential part of overall treatment. In addition, the patients' urine is screened randomly for the presence of drugs at least 4 times a month. A follow-up study was conducted on the results of the new substitution treatment periods started at the unit during 2000–2002, i.e. 70 treatment periods. The retroactive study was based on case histories. The follow-up period lasted from the beginning of the treatment periods until the end of June 2004 or the end of the treatment. (Vorma et. al. 2005.)

All patients received methadone treatment⁵⁵. During the study period, the patients were admitted to treatment based on a more demanding assessment than presently in use (patients had to be opiate addicts more than 20 years of age and had to have used opiates compulsively for at least four years). During the study period, three out of four of the patients were men with a mean age of 33.8 years. At the time they started treatment, their median time of regular opiate use was 10 years and nearly all had chronic hepatitis C. Almost all patients had a dependence diagnosis and a co-occurring psychiatric diagnosis, usually a personality disorder or mood disorder. (Vorma et. al. 2005.)

Patients committed to treatment well; 94% remained in treatment after one year of starting treatment. During the follow-up period, nine patients dropped out of treatment or their treatment was discontinued. Opiate use declined to the extent that out of the patients (56) who had received treatment for at least a year and a half, 75% had not used additional opiates during the past year. Other addictions also decreased. Two patients were detoxified from methadone maintenance as planned. Because nearly all patients were addicted to benzodiazepines, and as benzodiazepine enhances the sedative effects of substitution medication, the study considered it important that

⁵⁵ The dosage used was on average 130 mg per day. Sixty-one patients also received benzodiazepine medication.

dependency on benzodiazepines is treated before opiate substitution treatment is started or at its very beginning. Even though the patients have multiple problems and need a lot of psychosocial support, those who rehabilitate successfully should be transferred to primary health care services to receive follow-up treatment because treatment lasts for a long time. (Vorma et al. 2005.)

A follow-up study was made on 55 patients admitted to the drug addiction clinic at Kuopio University Hospital between 1 February 2001 and 1 February 2002. Fifty-eight per cent of the patients used amphetamine as one of their main substances, 27% used opiates and 58% cannabis. Almost half the patients used three or more substances and 15% used both amphetamines and opiates. The number of patients that dropped out of treatment during the year was quite high (25%). However, after a year, 50% of the patients remained in treatment. Drug use decreased among these patients and the number of intravenous drug users fell by more than half, and some found employment. One third of patients remained in substitution treatment after a year. The substitution treatments took up almost all the treatment capacity at the drug addiction clinic and resulted in long waiting lists for treatment referral and the admission of new patients. Much like the HUCH study, this study supports the scaling of treatment and the transfer of established treatments to primary health care. (Aira et al. 2004.)

The previous studies suggested that established treatments should be transferred to primary health care units. The municipality of Nurmijärvi, which is located in Southern Finland and has a population of 35,000, carried out a study on substitution treatment in primary health care, i.e. in health centres. The Nurmijärvi health centre began administering substitution treatment in 1998, and by spring 2002, the centre had treated thirteen opiate addicts. By spring 2004, thirty patients had received treatment. The appraisal of the operation was based on 27 interviews with key people in the municipality. The material was collected in 2003–2004. The results emphasised that treatment must be based on sufficient expertise and resources: one employee specialised in substance abuse issues – who also participates in the treatment of other substance abusers – has time to administer substitution treatment to approximately five opiate addicts at a time. This way, there is also time for the psychosocial support needed by the patients. A personal nurse is appointed for each patient, and collaboration with other parties and family members is possible. An effective security system must be in place in order to prevent burglaries and robberies, and a separate space must be allocated for the conversations between nurse and patient. According to the study, the opiate addicts treated in the health centre seldom resort to violence or threats. Neither do they cause problems to other patients at the health centre. The drug treatment patients were themselves quite pleased with the treatment they had received. It served their interest to

behave well so that their treatment would not be discontinued. Regularity and support also promote the rehabilitation of patients and their learning of everyday skills. According to the study, the transfer of substitution treatment to a local health care unit is successful if it is prepared for in advance, thus diminishing prejudices against substitution patients and the treatment itself. (Halmeaho et al. 2005.)

A trial was conducted on the transfer of substitution treatment to day centres for homeless people. The trial resulted in similar observations and conclusions as in the above-mentioned health centre study. The report on the trial was based on observations and interviews⁵⁶ carried out in Helsinki over a two-year period. The report stated that at the beginning of the transfer, problems arose from the integration of traditional care-oriented methods and highly professional medical treatment. The working community was divided into day centre workers and methadone workers. Likewise, the clientele was divided. Substitution treatment clients were initially treated in the same way as other clients were, i.e. by applying a highly client-oriented approach. As a result, power was transferred to the clients and they wanted to have control over the content of their treatment, the use of screening tests and the dosage of their medication. After a year and a half from the beginning of the trial, the staff had gained expertise and had started to demand more co-operation and responsibility from the clients. The criteria for starting treatment and remaining in it have been defined more precisely. A decision was also made to provide substitution treatment and rehabilitation as a specialised service separated from the traditional care functions of the day centre. The report stated that the transfer of new treatment methods should be carefully prepared in advance, employees should be provided with continuous education and the contents of treatment should be defined in detail at its very beginning. (Forssén 2004, 2005.)

6. Drug-related health problems⁵⁷

The number of new cases of infectious diseases related to drug use is on the decline. Among registered cases, hepatitis C cases have decreased steadily since their number peaked in 1997. At the same time the number of HIV infections contracted through intravenous drug use has also dropped. According to the drug treatment information system for 2004, almost two thirds of problem drug users have hepatitis C, and approximately 2–3% are HIV positive.

⁵⁶ The study included one year of participatory observation and six theme interviews with the employees who administer methadone treatment. The employees also wrote texts on themes given by the researcher for the purposes of the study.

⁵⁷ See Virtanen 2004, Sections 3.2–3.4 and 21.

Mental health problems are also prevalent among intravenous drug users. Many younger drug treatment clients suffer from depression, whereas older clients are often dual diagnosis patients. However, many problem users who suffer from serious mental health problems have not received psychiatric treatment. Problems associated with intravenous drug use are also common.

According to preliminary information for 2004 on forensic toxicological findings in cause of death analyses, drugs were detected in 176 cases. In 74 cases, the cause of death was drug poisoning. A special aspect of Finland's situation in 2002–2004 was that buprenorphine had become the most common opiate finding in drug death cases, which reflects the strong increase in buprenorphine use also seen in drug treatment information.

6.1. Drug-related deaths and mortality of drug users⁵⁸

In 2004, there were 176 (146 in 2003) drug-related deaths in Finland according to preliminary information on forensic chemical findings. Defined by the primary cause of death (poisonings) according to the EMCDDA criteria for special mortality registers (the register of autopsies in Finland), the number was 74 (67) (Vuori 2005). These different estimates provide the limit values for the number of drug-related deaths in Finland. Estimated by the EMCDDA criteria for general mortality registers, which will be used for international comparisons in the future, the number of drug-related deaths (135) would be between the above-mentioned limit values (Huohvanainen 2005). According to the registers, the share of 15–24-year-olds ranged between 20 % and 30%.

For opiates, the classification of chemical findings is not comparable with previous years because buprenorphine, which has become an increasingly common opiate finding, is not detectable in the opiate screening test. Thus in 2004, only 35 cases comparable to previous statistics were detected in opiate screening, most of which involved codeine. The new opioids, (buprenorphine, tramadol, methadone and oxycodone) have become more common, and, for example, buprenorphine was found in 73 cases. The numbers of amphetamine and cannabis findings are comparable to previous years' statistics: amphetamine was found in 51 cases (51 in 2003) and cannabis in 80 cases (82). The number of heroin deaths continued to remain low during 2003–2004: 4 cases in 2003 and no cases in 2004. This is consistent with the continuous decline in heroin deaths that started in 2001. Instead, the

⁵⁸ See "data library" or "statistical bulletin" in <http://annualreport.emcdda.eu.int/fi/home-fi.html>. For definitions, see <http://www.emcdda.eu.int/?nnodeid=1419>

number of buprenorphine findings in drug-related deaths by poisoning has increased rapidly. Buprenorphine was the most common opiate finding in forensic autopsies – mostly in combination with benzodiazepines, sedatives or alcohol. (Vuori 2005.)

6.2 Drug-related infectious diseases⁵⁹

The number of registered hepatitis C cases decreased between 1995 and 2004, and the decrease was steady after the peak of 1997. At the same time, the number of registered hepatitis B cases and HIV infections has declined. The results confirm that the number of virus infections associated with intravenous drug use has dropped significantly in Finland throughout the 21st century. Quite a few cases are still registered within the youngest age group (15–24-year-olds). This indicates that preventive measures aimed at drug users do not reach the youngest users in a sufficient manner. (Infectious Diseases in Finland 2004.)

HIV

In 2004, 129 cases of HIV infections were reported (132 cases in 2003). In 2004, the development of the number of infections contracted through intravenous drug use continued on a positive path: in cases where the means of transmission was reported, infections contracted through intravenous drug use accounted for 7% (17%) showing a decline for the fifth year in a row (Infectious Diseases in Finland 2004). According to the information provided by the clients for the 2004 drug treatment information system, of those who had used drugs intravenously and had taken an HIV test and received their test results (total=3015) two per cent were HIV positive (3% of those tested).⁶⁰ (Partanen A. 2005.) The Munkkisaari Service Centre for HIV positive drug abusers had some 200 HIV positive clients at the end of 2004. Approximately 40 clients received HIV medication. Approximately one hundred problem drug users visit the centre daily. The centre also exchanges needles and syringes for HIV negative drug users, and it provides methadone treatment. Currently, 60 clients are in methadone treatment at the centre. (Niskanen et al. 2005.)

⁵⁹ See ""data library or "statistical bulletin" in <http://annualreport.emecdda.eu.int/fi/home-fi.html>

⁶⁰ More than three quarters of drug treatment clients have been tested for HIV and hepatitis A, B and C. About one fifth of the data on infectious diseases is lacking, which may distort the result. (Partanen A. 2004.)

Hepatitis C

In 2004, 1,238 (1,265 in 2003) hepatitis C cases were diagnosed in half of which the means of transmission was reported. Over 80% of the cases are estimated to have been contracted through intravenous drug use (Infectious Diseases in Finland 2004). According to the information provided by the clients for the 2004 drug treatment information system, 63% of drug treatment clients who had been tested for hepatitis C and had received test results (total=3,216) had hepatitis C. Among intravenous drug users, 68% were infected with hepatitis C. (Partanen A. 2005.) The study on the mobile health counselling unit reported that none of the under 20-year-old clients of the unit had hepatitis C, as far as they knew, whereas one third of 20–24-year-olds had hepatitis C as did one fourth of 35–39-year-olds. (Törmä et al. 2005b.)

Hepatitis B

The number of acute hepatitis B cases recorded in the infectious diseases register has shown a significant decline in the past 10 years (57 in 2004). Infections contracted through intravenous drug use have decreased the most, the proportion being 14% in 2004 out of all the cases where the means of transmission was reported (the means of transmission is reported in only about one third of cases). At the beginning of the follow-up period, smaller epidemics took place among drug users in various localities, for example in Kuopio and Turku. Probable reasons for the decline are the comprehensive needle and syringe exchange system and the hepatitis B vaccinations provided for intravenous drug users at health counselling centres. Another proof of the success of the needle and syringe exchange system is that new hepatitis B cases related to intravenous drug use have occurred mainly in localities which do not have exchange units, for example in Vaasa. The decrease in hepatitis C cases also reflects the importance of using clean needles and syringes in preventing hepatitis (Infectious Diseases Register 2004). According to the information provided by the clients for the 2004 drug treatment information system, 9% of all tested drug treatment clients had hepatitis B. Among those who had injected drugs sometime in their life, two thirds had received at least one shot against hepatitis B and almost half of them had received all three shots. This explains partly the low prevalence of hepatitis B among drug treatment clients. (Partanen A. 2004.) According to the study on the mobile health counselling unit, out of all age groups, 20–24-year-olds had received the most vaccinations against hepatitis B (85%). On average, half the follow-up clients had been vaccinated. (Törmä et al. 2005b.)

Hepatitis A

In 2004, there were 42 hepatitis A cases in Finland, nine of which were contracted in Finland. Thus the rapid rise in hepatitis A cases that started among intravenous drug users in the Greater Helsinki area in 2002 (393 cases) and 2003 (242 cases) took a downward swing. Since the beginning of 2005, the hepatitis A vaccination has been included in the national vaccination programme for intravenous drug users. According to the information provided by the clients for the 2004 drug treatment information system, 6% of drug treatment clients were infected with hepatitis A.

6.3 Other drug related morbidity⁶¹

According to a 2003 study, the inpatient admissions of patients suffering simultaneously from drug addiction and other mental disorders have grown five-fold between 1987 and 2002. At the same time, the number of psychiatric inpatient beds has been cut sharply. Thus, the share of drug treatment clients' inpatient periods has increased in relation to the total amount of psychiatric treatment periods (Pirkola et al. 2004). The connection between substance abuse problems and other health problems (especially mental health problems) has also been detected in other studies. A study on risk behaviour among drug users⁶² revealed that during the six months prior to the interviews, 41% of the respondents had suffered from mental problems and 29% had experienced a psychosis. Many had had problems associated with injecting: shivers (43%), paresthesia (43%), angiitis (23%) and abscesses (16%). In addition, approximately half the respondents had bad teeth, a third had breathing difficulties and a fourth suffered from chest pain. About one out of ten had had problems related to overdosing. (Partanen, A. et al. 2004b) Co-occurring mental health problems are clearly prevalent among the most disadvantaged problem drug users who frequent the day centre Stoori and who are partly excluded from treatment services. Twenty of these clients were interviewed and these interviews revealed that 30 per cent had had psychotic symptoms related to substance abuse, 15 per cent had had other psychotic symptoms and 10 per cent suffered from chronic depression. All young clients suffered from depression, whereas many older clients were clearly dual diagnosis patients and in addition to drug dependence, they suffered from fear, psychosis, anxiety, panic attacks and

⁶¹ See "data library" or "statistical bulletin" in <http://annualreport.emecdda.eu.int/fi/home-fi.html>.

⁶² The study included 494 initial interviews which were conducted between 12 September 2000–15 May 2002 in three health counselling centres engaging in needle exchange (Helsinki, Tampere, Turku) and the Helsinki-based drug clinic Kurvi which is open around the clock. Of these, 354 participated in the follow-up group. Follow-up interviews continued until the end of 2003, but the report on them has not been finished yet.

one had paranoid schizophrenia – but none had received psychiatric treatment. (Törmä et al. 2005a.)

6.4. Other drug-related health problems and their consequences

In 2004, pharmaceuticals and drugs were found in 3,065 cases of driving while intoxicated (2,577 cases in 2003). This accounts for 11% of all cases of driving while intoxicated. Among these, drugs were found in 1,467 cases (1,266). In February 2003, the regulations regarding driving while intoxicated were amended by the introduction of so-called zero tolerance for drugs. Partly due to this, drug findings in traffic increased by more than 50% between 2002 and 2003.

According to the 2003 data, cannabis accounted for 25.5% of the findings (60% in 2002), amphetamine 81.8% (66.7%) and heroin 2% (12%). The zero tolerance partly explains the changes in substance-specific percentages: according to the new Act, sentencing now only requires evidence of one drug, so in cases of polydrug use, if one drug is found, others are not looked for. For example buprenorphine, which is categorised as a pharmaceutical substance, is only looked for if an actual drug is not found. In addition, substances are now analysed only based on blood tests, which decreased cannabis findings as cannabis can be detected in blood for only a short period, whereas in urine it stays longer.

7. Reduction of drug-related health problems⁶³

Blood-transmitted diseases are a major health problem caused by intravenous drug use. Therefore, prevention and treatment of infectious diseases is an essential part of drug treatment. In 2004, there were health counselling centres that exchange needles and syringes to prevent infectious diseases in 23 localities, mainly in cities with over 50,000 inhabitants.

According to follow-up studies on drug treatment, co-occurring mental health problems are common among drug users. Substance abuse services and mental health services have yet to divide responsibility and establish co-operation regarding these cases. Even though there are separate units for these cases especially in hospitals' psychiatric wards, there is no treatment system specialised in dual diagnosis patients in Finland.

⁶³ Cp. Virtanen 2004, Section 10.

7.1 Prevention of drug-related deaths⁶⁴

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

7.2 Prevention and treatment of drug-related infectious diseases⁶⁵

Prevention and treatment of drug-related infectious diseases is provided by

1. primary health care services according to the new Communicable Diseases Decree⁶⁶
2. specialised services within health care and substance abuse services
3. health counselling centres (by needle and syringe exchange)
4. pharmacists selling syringes and needles

University hospitals with other central, regional and psychiatric hospitals in the area are in charge of the treatment of HIV infected patients. An HIV positive drug user is entitled to good personalised treatment regardless of where he or she lives. Hepatitis C treatment can be given in collaboration with the detoxification unit during detoxification only if it has been found to work well. For hepatitis A and B vaccinations, Finland follows a selective vaccination policy: among others, intravenous drug users and their sexual partners are provided a vaccination free of charge. According to the new Communicable Diseases Decree, health centres have been given a new responsibility of preventing infectious diseases, including health counselling for drug users and, if needed, exchange of syringes and needles.

In 2004, there were health counselling centres that exchange needles and syringes to prevent infectious diseases in 23 localities, mainly in cities with over 50,000 inhabitants. The centres also provide counselling on health issues, small-scale health care, testing and vaccination services and case management. The number of clients in health counselling centres (10,400) increased

⁶⁴ See <http://annualreport.emcdda.eu.int/fi/home-fi.html>.

⁶⁵ See <http://annualreport.emcdda.eu.int/fi/home-fi.html>.

⁶⁶ See Section 1.2.2.

significantly from the two previous years (both years 9,300). The number of visits (83,400) and the number of syringes and needles exchanged (1,760,000) had grown by some 20% over the previous year (70,600 / 1,435,000). (Partanen A. 2005.) The number of syringes and needles sold by pharmacists decreased slightly, amounting to 462,000 (486,000) in 2004. In 2003, 86% of pharmacists reported being ready to sell syringes and needles to drug users. According to the data for 2003, about half the pharmacists selling needles and syringes also take them in. The support of the pharmacist network in the health counselling of intravenous drug users is particularly important for those drug users who have no access to health counselling centres. (Partanen A. 2004b.)

The interaction and discussions between personnel and clients at health counselling centres were examined based on a one-day census. A questionnaire was sent to each health counselling centre, requesting the personnel to analyse discussions they had during client contacts. Fifteen units out of 21 responded to the questionnaire. The most common contacts were quite brief: the personnel exchanged the clients' needles and syringes for new ones. The conversations during these contacts (n = 183) lasted on average 5–10 minutes. Of the main topics discussed, 18% concerned infectious diseases, 11% concerned sexual health, 33% concerned drug treatment (substitution treatment, intoxicant-free wards of prisons, the Probation Service etc.), and 21% concerned intravenous drug use. Other topics were dental diseases, relationships, children, small talk etc. (Jokinen 2005.)

In the evaluation of the mobile health counselling unit, according to the personnel the units' assets are that it brings services close to the customers and minimises disturbances to the surroundings. However, some customers had a difficult time remembering the timetables of the unit. As the unit was only equipped to serve a limited number of clients at a time, queues built up, which the clients felt stigmatised them. As long as the number of customers was moderate at each stopping point, the customers did not have to deal much with each other or the subculture of drug users. Even though the choice in services was sufficient, the premises limit them and the services have to be provided in a hurry. Only one per cent of the clients used the actual treatment or follow-up treatment services of the unit. The use of other services was scant also because a great deal of the visits took place outside office hours. However, the personnel estimated that the majority of the clients already use treatment services and they are not totally excluded, but the clients also included occasional drug users. Thus, it is assumed that the mobile service unit does not reach the most excluded clients. Instead, it reached young clients who were in the early stages of drug use. Many clients were used to handling their affairs at permanent health counselling

centres, and to them the mobile unit was only a supplementary service. Suggestions to improve the services included making the mobile service less noticeable, increasing co-operation with health counselling and other services and targeting the services more accurately to fill service vacuums – possibly even employees going out onto the streets to work with users. (Törmä et al. 2005a.)

It is estimated that a couple of hundred Russian-speaking drug users who are at a high risk of infectious disease live in Finland. Their situation is aggravated by their ignorance of existing services, language problems, the lack of services, their ignorance of Finnish privacy policy and fears of being deported. The majority of these people use heroin and buprenorphine as their primary substance. Drug problems among immigrants are connected to the busiest years of remigration at the turn of the 21st century and the problems and crises that the then teenage (13–15-year-old) immigrants, the so-called second-generation immigrants, have had with immigration and integration into society. Young people's drug use can also be seen as part of the change in Finnish alcohol and drug culture. The services in Helsinki were not prepared for the needs of young Russian immigrants. These needs have been met to an extent through special drug prevention projects that are carried out in Russian, and the number of Russian-speaking clients in substance abuse services has remained unchanged – with the exception of the year 2001. One example of the services is a project launched in autumn 2002 which by using the so-called snowball method and by training 11 Russian-speaking drug users contacted 28 new users, 90% of whom were reached for the first time. A similar project was carried out in Russia, and the results revealed the need for and possibilities of peer work among drug addicts in St. Petersburg. Another aim was to reach out to HIV positive drug addicts in the Tallinn area and prisons in Estonia, and to offer them assistance. Towards the end of the project, activities were extended to Lithuania. The future challenges for this type of neighbouring area projects are to define a common value base for drug treatment and to develop the co-ordination of substance abuse prevention, solutions for securing resources, networking and project work. (Puro 2005.)

7.3 Prevention and treatment of co-morbidity⁶⁷

Drug-related mental problems are common according to all drug treatment studies (Vorma et al. 2005, Törmä et al. 2005a, 2005b). The treatment of drug and mental problems is carried out in

⁶⁷ See <http://annualreport.emcdda.eu.int/fi/home-fi.html>.

practice within substance abuse services or through case managers. Some of the treatments take place at addiction psychiatry units of university central hospitals. However, a clear division of labour between substance abuse services and mental health services has yet to be established. Currently, no treatment system in Finland is specialised in dual diagnosis patients.

7.4 Prevention and treatment of other health problems

Prevention of other health consequences suffered by drug users or caused by them to others is carried out within, among others, traffic safety and accident campaigns. The new amendment to legislation on a physician's duty to issue a report to the police concerning granting and verifying a person's right to drive a vehicle can also be considered a preventive measure against substance-related accidental fatalities.⁶⁸ In the case of drivers of other than heavy goods vehicles, a driving licence may not be granted or renewed if the person in question is addicted to psychopharmaceuticals or who, even if not addicted to such a substance, abuses them regularly to an extent that might affect his or her ability to drive.

A physician gets information on a client's driving capacity by interviewing the client and by conducting a clinical examination. The problems of a clinical examination include the wide array of complications generated by substance use, mental morbidity and the mixed use of pharmaceuticals, drugs and alcohol. A physician's duty to issue a report on a client's driving capacity is not put into effect if the substance abuser is receiving substitution treatment or other treatment for his or her substance abuse problem, nor is the report issued if such treatment has been discontinued because also in this case, the duty to provide notification as specified by legislation is not put into effect. Nor is a report issued in the case of dual diagnosis patients, persons under strong medication or persons suspected of driving while intoxicated, unless other criteria for the duty to report are met. In the latter case, the police decide whether the person is capable of driving. (Seppä 2005a, 2005b.)

⁶⁸ See Section 1.1.7 and for traffic safety: <http://www.health.fi/index.php?page=kampanjat>; http://www.health.fi/index_en.php.

8. Drug-related social problems⁶⁹

Problem drug users are a socially excluded group: according to the 2004 drug treatment information system, 62% of drug treatment clients were unemployed, two thirds had primary level education only and 11% could be classified as homeless. As drug use is punishable under criminal law, many users are also in a vicious cycle of crime and prison.

The number of registered drug offences (15,338) has decreased by 4% from 2004. The number of drug-user offences has grown somewhat, accounting for 60% of all drug offences, whereas the number of aggravated drug offences has shown a clear decline. Forty-six per cent of prison inmates suffered from morbid drug use or drug addiction. In 2004, 16% of prison inmates were incarcerated for a drug offence.

8.1 Social exclusion

The 2004 drug treatment information system revealed the same facts as do many other studies on risk behaviour among problem drug users, substitution treatment and HIV infections: problem drug users are a socially excluded group. Sixty-two per cent of drug treatment clients were unemployed. Two thirds had primary level education only, and one in ten had dropped out of primary education. Approximately 11% of clients could be classified as homeless. About a fifth was married or cohabiting, half of these with a partner who also had substance abuse problems. One in three had children under the age of 18. Three fourths of the children lived elsewhere. (Partanen A. 2005.)

The study on the most disadvantaged drug addicts (at the Stoori day centre) revealed that the most common background variables of social exclusion were the lack of a permanent home (almost half the clients), a low level of education, unemployment, low subsistence level, abuse and a prison background (two out of three clients). Other factors behind exclusion were the thresholds and low availability of treatment services – especially for dual diagnosis patients. (Törmä 2005a.)

According to the study conducted at the Department of Acute Psychiatry at the University Hospital of Tampere, mental health problems are often the cause behind a client discontinuing treatment. Homeless people dropped out of treatment more often than those who had a home. A few clients

⁶⁹ Cp. Virtanen 2004, Section 4.

discontinued their treatment due to a prison sentence. On the other hand, clients who were married or co-habiting were more committed to treatment. Patients were also more committed to treatment if they had children who lived at home or they hoped to get back their children who had been put into care. (Järvenkylä 2005.)

8.2 Drug-related crime⁷⁰

In 2004, 15,338 drug offences were reported to the police (14,486 reports of an offence). Of these, 60% (n = 9,310) were drug-user offences, 4% aggravated drug offences and 36% other drug offences. The number of drug offences dropped by 4% when compared with the previous year. Their number rose slightly only in the Province of Western Finland (source PolStat). The number of persons suspected of drug offences has declined over the past four years. In 2004, 4,411 people were suspected of drug offences and 454 people were suspected of aggravated drug offences. (National Bureau of Investigation 2005)

In 2004, a study was conducted on 15–16-year-old juveniles as offenders, victims and subjects of control.⁷¹ The proportion of boys and girls who have used or tried marijuana or hashish sometime in their life (i.e. have committed a drug-user offence) almost doubled between 1995 and 2001, from five to almost ten per cent. The situation did not change between 2001 and 2004. Eight per cent of both boys and girls had used marijuana or hashish during the past year, and the proportion of those who had used substances at least five times within a year came to 2.1%. Five per cent of drug-user offences involving marijuana or hashish committed by young people have been reported to the Police. Seven point two per cent of those who had used marijuana or hashish during the past year had financed their use illegally. More than half of these young people had acquired money by selling drugs, the rest mainly by stealing. Only 0.6 per cent of young people had tried marijuana or hashish during the past year and financed it by illegal means. Of the girls, 1.9 per cent and of the boys, 1.6 per cent had used another drug, usually LSD or ecstasy. (Kivivuori 2005.)

⁷⁰ See "data library" or "statistical bulletin" in <http://annualreport.emecdda.eu.int/fi/home-fi.html>.

⁷¹ The latest survey was carried out in spring 2004. The respondents were 5,142 ninth graders in secondary school. The young people in this main sample represent Finnish-speaking educational establishments maintained by municipalities. Based on methodology study, this limitation does not prevent the generalisation of results into the target population. (Kivivuori 2005.)

Mass crime by young people has decreased over the past 10 years, mainly through the decline in damage to property and theft. At the same time, the proportion of law-abiding young people, i.e. young persons who have not committed any offences during the past year (53% of girls and 46% of boys), has shown a constant growth. Reasons for this include changes in the ways young people spend their free time. The proliferation of computers into homes has definitely had an impact, but it is also possible that the new information and communication technologies offer new possibilities for criminal activity and information on how to commit offences. Other possible reasons behind the decline in offences committed by young people are the increasing competitiveness in society and the fear of being stigmatised as well as the role of the media in promoting the sensitivity of society to immoral acts and petty crime. (Kivivuori 2005.)

According to information for 2000–2003, 64% of homicides and 71% of assaults were committed under the influence of alcohol. The offender was under the influence of drugs in 6% of homicide cases and in 2% of assault cases. The number of offences committed under the influence of drugs and their proportion of recorded violent offences has increased since the beginning of the 1990s, especially in robbery offences. Despite this, the presence of alcohol in robbery offences is still much more common (43%) than that of drugs (9%). (Lehti et al. 2004.)

The number of persons convicted of drug offences as the principal offence (those who have been convicted in court or ordered to pay fines through summary penal proceedings⁷²) has increased every year since 1991. In 2004, the courts of first instance passed 7,756 sentences for drug offences (7,460 in 2003). There were 3,336 (3,309) sentences passed in cases where the principal offence was a drug offence and 4,420 (4,151) summary penal judgements were issued. Of the sanctions imposed for drug offences in 2004, 85% were fines, 7% were unconditional sentences of imprisonment, 6% were suspended sentences and 1% were community sanctions. Some 5,000 (4,806) of the sanctions were imposed for drug-user offences. In 2004, the average sentence for an aggravated drug offence was 2 years and 10 months in prison. A total of 338 persons were sentenced for an aggravated drug offence. (Niskanen 2005.) According to data for 2003, the prosecutor made the decision to waive charges in 547 cases and charges were dropped or penalties waived in District Courts in about a hundred cases (Yearbook of Justice Statistics 2004).

Sanctions imposed for drug offences as the principal offence were divided in 1993–2002 as follows: a fine was imposed in 70% of the cases, an unconditional sentence of imprisonment in

⁷² If the litigant agrees, sentence to pay fine is left to the prosecutor's discretion and do not go to courts of first instance at all

18% of the cases and a suspended sentence in 10% of the cases. In 2002, the average sentence for an aggravated drug offence was 3 years and 3 months in prison and in case of suspended sentences, 1 year and 4 months. A few suspended sentences were imposed for drug offences, and their average length was 4 months. In total, the proportion of prisoners with drug offence as their principal offence came to 18% of the entire prison population in 2002. (Kainulainen 2004.)

A study on repeated offences examined prison data for 1998–2001 for principal offences based on annual prison population surveys.⁷³ The results showed that 25.5% of those convicted to prison for drug offences (26% for all offences) are back in prison within a year, 38% (42%) within two years and 41.5% (47%) within three years. However, the new offence has not necessarily been a drug offence. The number of drug offence recidivists declines by age: 50% of 18–20-year-olds are back in prison within a year (within three years 75%), 30% of 21–29-year-olds (51%), 23% of 30–39-year-olds (36%), and 13% of 40–49-year-olds (29%). (Hypen 2004.)

8.3 Drug use in prisons⁷⁴

A working group appointed to develop prison health care (2002) reported that 46 per cent of inmates suffered from morbid drug use or drug addiction. In 2005 (2004), 16.1% (17.9%) of prison inmates were incarcerated for a drug offence, and the number among remand prisoners was 20.7% (23.5%) (Muiluvuori 2005). Eight hundred and twenty-five (1,081) drug findings were verified in the 15,360 (17,597) tests for drugs and pharmaceuticals conducted in prisons in 2004. The most common findings were benzodiazepine, buprenorphine and amphetamine. (Annual Report of the Finnish Prison and Probation Services 2004.)

The buprenorphine findings are partly due to opiate substitution treatment, which can be part of the rehabilitation of drug-addicted inmates. During the year, 50 (50) patients entered prison who were in opiate treatment before being sentenced to prison and whose opiate treatment was continued in prison. A total of 1,170 (1,411) HIV tests were conducted, which revealed four new HIV infections, i.e. only 0.3% of those tested. According to medical records, at least one fourth of the inmates had hepatitis C and 4% had had hepatitis B at some point (Honka et al. 2004; Annual Report of the Finnish Prison and Probation Services 2004)

⁷³ The prison population survey is conducted annually on 1 May in all prisons, and the principal offence is the offence for which the sentence is the longest.

⁷⁴ See "data library" or "statistical bulletin" in <http://annualreport.emcdda.eu.int/fi/home-fi.html>.

8.4 Social costs of drug consumption

The estimated direct costs of drug consumption and related harms for 2003 were as follows: enforcement and crime control EUR 49–63 million (EUR 54–67 million in 2002), damage to property, research and prevention EUR 51-85 million (damage and property EUR 28 - 65 million; research and prevention EUR 21 million), social services EUR 58-64 million (53–58 million), health care and pensions EUR 32- 60 million (EUR 24–48 million). The overall costs rose from EUR 181–260 in 2002 to EUR 190 - 272 million in 2002. (Yearbook of Alcohol and Drug Statistics 2004)

9. Reduction of drug-related social problems⁷⁵

According to the law, there is an obligation to multi-professional hearings and referral to treatment for minors related to drug-user offence to prevent exclusion. However, demand for referral to treatment has been limited, because treatment is not a tempting enough alternative to a fine, which is the usual sanction for a drug-user offence. In addition, the police do not see themselves as convincing treatment counsellors.

The most excluded substance abusers do not usually commit well to treatment. They would benefit from less goal-oriented treatment and rehabilitation programmes and supported housing services. An important question in the treatment of excluded substance abusers is how the transfer from treatment and rehabilitation programmes to follow-up care is arranged so that the person suffering from a drug problem will not return to specialised health care or substance abuse services.

The Prison Service has developed intoxicant-free wards and models for substance abuse work. Prisons emphasise especially the connection of substance abuse work done in prisons and other actors in society. Securing the inmates' possibilities to receive follow-up treatment after release is important to reduce recidivism, because after release, the health and suitability for the employment market of those who have been in the vicious cycle of prison life is poor, their housing situation is bad and they face a high risk of exclusion.

⁷⁵ Cp. Virtanen 2004, Section 12.

9.1 Social rehabilitation⁷⁶

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

The Deaconess Institute in Helsinki conducted a project on drug treatment for people who have been excluded from services (2003). For many of the clients in the project – the most disadvantaged clients at the drug addiction treatment clinic, Kurvi – the treatment and rehabilitation process was not long lasting as most of them returned to the Kurvi clinic from follow-up care after a few weeks or months. Many current treatment services are too demanding for some of them, and instead of an intensive and complex treatment system, treatment measures related to the assessment of mental state and medication would be sufficient for them at first. After that, the treatment could continue within housing services that support the clients' physical and psychosocial recovery or in a rehabilitation home type unit that would not be unconditionally intoxicant-free. A follow-up project was conducted, and it reinforced the fact that many severely socially excluded clients would benefit from less goal-oriented treatment plans and supported housing services. (Törmä et al. 2005b.)

Lappeenranta, a city of 60,000 inhabitants, has tried to solve the housing problems faced by substance abusers through a trial housing course. The course is organised by the city's substance abuse services. (Pohjolainen 2004.) The clients need supported housing mainly because they have been evicted from their apartments due to rent arrears and disturbances. The course lasts for three months. At the beginning of the housing course, a housing contract similar to a treatment contract and a three-month lease for accommodation in a supported housing unit are made with the client. The participants must have their substance use under control, and substance use during the course is prohibited. When necessary, the clients must take breath tests or undergo screening at a local substance abuse unit. The course is not discontinued if a participant has a random relapse. The most common difficulties the clients face are finding an apartment and paying off their debts. A

⁷⁶ See <http://annualreport.emcdda.eu.int/fi/home-fi.html>

new apartment is not provided to a client until he or she has rehabilitated enough to feel capable of retaining a permanent home. If a suitable apartment is not found within three months, the client is given a temporary apartment in a housing unit supported by the substance abuse services. For many clients, it has been sufficient to superficially get their financial matters in order or simply to have the time and place to compose themselves. However, some clients have been forced to discontinue the course. Their typical behaviour has been to “just give up” when some part of the plan is not working or they encounter problems. Many of them have lost faith in society and justice.

9.2 Prevention of drug-related crime⁷⁷

One of the ways to prevent social exclusion related to drug offences is to arrange a multiprofessional hearing for young people who have been arrested for committing a drug-user offence for the first time. The prosecutor, the police, social welfare authorities, the offender and his or her family members participate in the hearing. According to information from the Office of the Prosecutor-General for 2003, the hearing procedure has been used some 100 times annually and after the hearing, the prosecutor has almost always decided to waive charges. In the case of problem drug users, a fine, which is the usual sanction for a drug-user offence, is not imposed until the offender’s willingness to seek treatment has been examined. However, only 100 decisions to waive charges based on the person seeking treatment have been made, even though some 7,000 drug-user offences have been reported. Problem drug users who are arrested by the police are referred to treatment by the police or social welfare and health care authorities before the case is presented to the prosecutor. It is possible that the treatment referral of persons who have been caught by the police is inefficient as almost without exception, prosecutors are ready to make the decision to waive charges based on the person seeking treatment.

A study on the collaboration between the Tampere police department and the adjoined social outpatient clinic Paussi examined the referral for treatment of problem drug users as stipulated in the law on drug-user offence as well as the multiprofessional hearings for minors having committed a drug-user offence as an alternative to a fine.⁷⁸ The study showed that the majority of those suspected of drug-user offences were socially excluded to some degree, i.e. homeless,

⁷⁷ See <http://annualreport.emecdda.eu.int/fi/home-fi.html>.

⁷⁸ The material consisted of 255 pre-trial investigation records, the interviews of 12 police officers, 5 social workers and 1 prosecutor as well as interviews of 10 outpatients. In addition, a survey was sent to 260 police officers, 60% of whom responded. (Kekki 2004b.)

unemployed or trapped in a cycle of crime. More than half of them were also suspected of some other offence. Paussi employees were also familiar with many of them already through child welfare services or crimes committed as minors. In practice, treatment referral by the police meant that police officers inform the suspects about Paussi or bring them there. Once the suspect has arrived to Paussi, the social welfare and health care professionals refer him or her for treatment. Treatment referrals have however been infrequent. Reasons for this are: suspects do not consider the police to be an authority to which they should admit drug addiction or the need for treatment, entering treatment is not a sufficiently attractive alternative to being fined, and the police do not see themselves as convincing treatment counsellors. (Kekki 2004b.)

According to a study conducted in Helsinki and Turku⁷⁹, differing attitudes in particular hampered co-operation between the police and social workers. The police saw drugs as illegal and users as criminals who were personally responsible for their own situation, and emphasised the damage that drugs can cause to society and other citizens and stressed the importance on intervening with the prohibited behaviour. On the other hand, social workers considered drug use a result of various social problems and often out of the user's control. Thus, drug users need help and support in order to solve their problems. Even if the authorities agreed on a drug policy based on a total ban on drugs, co-operation was deemed to be hindered by strict boundaries between administrative sectors. (Andérssen 2003.)

In 2004, risk and service need assessments related to criminal behaviour were made for those who were sentenced to two years' imprisonment or more. Based on the compiled information on 1,100 inmates, participation to substance abuse rehabilitation was recommended to 31 per cent of inmates. (Hypén 2004.) It is assumed that among short-term prisoners there is even more need for rehabilitation. According to a study on prison health care, 46% of inmates suffer from morbid drug use or drug addiction. As inmates have to stop using alcohol in prison, some of them may resort to other intoxicants that are easier to use clandestinely. Because of this, physicians working for the Prison Service decided on guidelines in 2004 to minimise the use of addictive pharmaceuticals when treating inmates. (Annual Report of the Finnish Prison and Probation Services 2005.)

In 2004, all prison institutions had alcohol and drug programmes that support an intoxicant-free lifestyle. Eight hundred and forty (873 in 2003) inmates participated in rehabilitation programmes and 1,100 (1,646) in treatment motivation or relapse treatment. Fifty inmates were in opiate

⁷⁹ For the study, police officers and social workers were interviewed in Helsinki and Turku in the spring of 2001. Nine group interviews were held for 35 field workers who were not specialised in drug cases.

substitution treatment. Almost all closed institutions also had intoxicant-free contractual wards. Currently 15% of all closed wards are contractual.⁸⁰ Fifty (39) inmates were placed in institutions outside prison, and 288 (250) inmates participated in programmes to reduce recidivism. Sometimes a fixed-term placement covers the whole term of short imprisonment, but it is more usual that the placement takes place towards the end of the sentence. According to data for 2003, more than half of the institutional placements lasted less than 3 months. However, the total duration of a client's rehabilitation is usually longer because the rehabilitation started in prison is often continued within municipal rehabilitation services. (Karsikas 2004; Karsikas et al. 2004.)

According to new legislation related to correctional treatment, imprisonment is seen as a three-phase process, which consists of risk and need assessment, enforcement of the prison sentence and preparation for being released. The activities and treatment programmes on the intoxicant-free ward in the Helsinki prison were evaluated from November 2002 to April 2003.⁸¹ The intoxicant-free ward has an established position and structure in the prison. Enough inmates with substance abuse problems come to the ward, and the personnel have comprehensive education and competence in the field. According to the evaluation, however, employees find it difficult to concentrate in developing the activities of one ward in addition to their other tasks, and inmates find it hard to break free from the prison and prisoner culture. From the rehabilitation point of view, the nature of the ward and the contents of the treatment programme are not clearly structured nor do the resources of the ward meet with all the quality requirements for substance abuse services. The external framework for treatment does exist, but more training is required as well as a commitment to long-term efforts from the personnel and a commitment to securing conditions of activity from the prison and the Criminal Sanctions Agency. (Tourunen et al. 2004.)

Important hindrances to anchoring persons released from prison into society and implementing personalised rehabilitation are the inmates' poor health, short sentences and their excessive number in relation to places in prison institutions⁸². Released prisoners are easily excluded from primary services due to prejudice and lack of resources: municipalities do not believe in their ability to recover and some services do not even want to acknowledge these people as valid

⁸⁰ See <http://www.vankeinhoito.fi/4829.htm>

⁸¹ The study included a one-month period of participatory observation targeted at the ward's work team and community meetings. In addition, three group interviews were held among inmates, a feedback discussion with researchers and inmates and 11 individual interviews of inmates. The work team's substance abuse counsellors (2) and prison guards (2) were interviewed individually.

⁸² The material consists of public documents from the "Co-operation for crime-free life" project, the results of the network training workshops organised by the Criminal Sanctions Agency in Tampere, interviews with specialists, authorities and the third sector (25) and the accounts of two persons with a criminal background undergoing rehabilitation. (Rantala 2004b.)

clients. Various organisations offer services that enable a released prisoner to get support for different problems under the same roof, but this type of activity is hampered by the short-term nature and insecurity of municipal and State funding. The work capacity and health of those trapped in a cycle of prison is usually poor. Local-level networking as a means to solve serious social problems does more to support problems in social structures than solve them. Serious questions to be addressed on a national level include: who should go to prison, with what type of punishments and what legislative reforms are needed to reduce the number of prisoners. This is a challenge also for social and health services, because the less they invest in socially excluded people the more these people become the responsibility of judicial and law enforcement authorities. Improving the life of people with a criminal background will also increase the sense of security among citizens and overall savings for society. (Rantala 2005.)

A joint substance abuse work development project by the District Offices of Probation Service in Greater Helsinki was carried out between December 2001 and 2004.⁸³ Some aims of the project were to secure a care continuum for released prisoners with substance abuse problems, to develop new working methods for the Probation Service's substance abuse work and to increase related competence. The project had 95 registered clients, half of whom participated in intensive work. Each counsellor had a maximum of eight clients. The clients participated in the project voluntarily, and most of the contacts were made in prison well before the clients were released. The clients valued the rehabilitation provided in prisons. They gave positive feedback on the personnel's strength and capacity to offer support and help in difficult situations. On the other hand, the clients had ambiguous feelings about the meetings between themselves and various treatment sectors. A specific source of fear was relapse, which the clients feared would affect their benefits. They were also worried about how they would find housing after being released from prison. According to the project evaluation, motivating the clients is a central part of the work and it is essential that the clients commit to handling their own affairs. The employees highlighted the importance of a trusting and open atmosphere between themselves and the clients. The clients are not abandoned if they relapse; instead, they are supported in their continued efforts to live an intoxicant-free life. The development project emphasised the importance of employees having suitable training, versatile competence in the fields of substance abuse prevention and correctional treatment and in project work involving the co-ordination of network activities. (Reijonen et al. 2004a:,2004b.)

⁸³ The evaluation of the development project was conducted between 20 November 2003 and 19 April 2004, and the material used in the evaluation included documents produced by the project, theme interviews with all four specialised counsellors working on the project, four interviews with clients suggested by the personnel and group interviews made with inmates in intoxicant-free wards of prisons in Helsinki, Hämeenlinna and Kerava on inmates' opinions of substance abuse rehabilitation in prison and their wishes regarding the continuation of rehabilitation after their release.

10. Drug markets⁸⁴

The drugs on the Finnish market are mostly cannabis products, synthetic drugs such as amphetamines, ecstasy to some extent and the buprenorphine preparation Subutex. Heroin and cocaine are fairly rare in Finland. The number of seizures of cannabis products and buprenorphine (Subutex®) has not varied much in the 21st century; the number of ecstasy and amphetamine seizures has declined somewhat, and the number of heroin seizures has plummeted. Among cannabis products, the number of marijuana and cannabis plant seizures has grown somewhat as has the amount of Subutex seized by the police. Previously, Subutex seizures were made mostly in border traffic.

The number of offers of drugs to individuals has remained constant or dropped somewhat during the 21st century. In drug supply, organised crime groups led from Estonia have had an important role in smuggling almost all drugs to Finland in recent years. Since 2003, the role of Finnish crime groups in the distribution of drugs has increased, but the Estonian organised crime groups are still the main suppliers of drugs to Finland.

10.1 Availability and supply of drugs⁸⁵

The import of drugs is an international crime, and approximately 20% of those suspected of aggravated drug offences are foreigners. Among these, the biggest groups in 2004 consisted of Estonians (45% of foreign suspects) and Russians (10%). (National Bureau of Investigation 2005.)

Organised crime groups led from Estonia have an important role in smuggling almost all drugs to Finland. However, the number of Estonian or Russian citizens suspected of aggravated drug offences has decreased from the previous year, whereas the role of Finnish crime groups in the distribution of drugs in Finland has grown. For example, the proportion of persons suspected of aggravated drug offences who were born in Estonia, Russia or the Soviet Union increased significantly since the end of the 1990s but in 2003–2004, their share decreased by half from the beginning of the decade, to 11 per cent. (National Bureau of Investigation 2005.)

⁸⁴ Cp. Virtanen 2004, Section 5

⁸⁵ See "data library" or "statistical bulletin" in <http://annualreport.emcdda.eu.int/fi/home-fi.html>

At the same time, the role of Finnish crime groups in the trafficking of drugs has increased, which has closed the ranks of Finnish professional crime that is typically loosely structured and unestablished and increased violence related to organised crime. The latter is already evident in the growing amount of military explosives confiscated from crime groups. The significance of economic crime as an important financing means for organised crime also grows. (National Bureau of Investigation 2004.)

In addition to the direct sea connection between Finland and Estonia, smuggling takes place from Estonia via Sweden and the Åland Islands as well as via Haparanda and Tornio to Finland. Amphetamines and buprenorphine are smuggled via Estonia and Russia, and the first signs of the transfer of sorting and packing of synthetic drugs to Finland emerged in 2004 with the discovery of a Rohypnol factory. Smuggling routes from Russia to Finland through the eastern frontier also have an increasingly important role. (National Bureau of Investigation 2004, 2005.)

The adult health behaviour survey in 1993–2004 asked people if they had been offered drugs for free or for sale during the past year (Piispa et al. 2005). According to the survey, the number of drug offers has levelled off and even decreased in the 21st century. In 2004, 5% of the adult population were offered drugs. The percentages were the highest in the 15–24 age group: 17% for males (19% in 2003) and 16% for females (21%). In the older age groups, relatively more offers were made to men than to women. The number of drug offers to men has fluctuated a great deal: in 2004, 14% of all men aged 25–34 were offered drugs (9 per cent in 2003, but 15 per cent in 2002). For women, the figure has remained at a constant 6–7 per cent. Only 20 per cent of those who were offered drugs were offered them for sale. The main group of people who were offered drugs were unmarried students in the Greater Helsinki area or in other big cities.

10.2 Drug seizures ⁸⁶

During the 21st century, the trend for drug seizures has stabilised similarly to the trend for drug supply indicated by population surveys. (National Bureau of Investigation 2004, 2005; Kainulainen 2005)

⁸⁶ See "data library" or "statistical bulletin" in <http://annualreport.emcdda.eu.int/fi/home-fi.html>.

The total amount of seized cannabis remained constant throughout the beginning the 21st century: hashish seizures dropped in kilograms (467 kg in 2004) and in number (2,626), but marijuana seizures grew in kilograms (26 kg) and in number (2,067). The number of cannabis plants seized (7,829 plants + 42 kg) and the number of seizures (1,406) more than doubled.

Amphetamine seizures (102 kg, 3,392 seizures) declined slightly, whereas ecstasy seizures dropped considerably (23,243 tablets, 328 seizures). There have been no big changes in cocaine seizures (1.1 kg, 65 seizures). The same goes for LSD (196 doses).

The amount of seized heroin plummeted at the beginning of the 21st century and it was very low in 2004 (200 grams, 45 seizures). However, it is worth noting that in summer 2005, the Finnish Customs made the largest heroin seizure ever (51.7 kilograms) on the Russian border from a truck that was on its way to Sweden. This supports the assessment that Russia's role as an international smuggling route of heroin is growing. During the same period, seizures of the buprenorphine preparation Subutex® remained at an even level (32,970 tablets, 844 seizures in 2004). The amount of Subutex seized by the police grew considerably, whereas the amount seized by the Customs declined. However, the total amount of Subutex seized in early 2005 shows a decline. The number of robberies from pharmacies and other locations where intoxicating pharmaceuticals are stored (74) has also remained constant.

Khat seizures grew steadily in the beginning of the 21st century. Customs seized a total of 2,119.84 kg of khat in 2004, 1,887.78 kg the year before and only about 1,000 kg in 2002. In Finland, khat is mainly used by ethnic minorities. Despite this, khat keeps the authorities busy, especially the Customs. The majority of khat seizures are made at airports. (Finnish Customs – Annual Report 2005.)

10.3 Price and purity of drugs ⁸⁷

Laboratory identification of drugs and the testing of the purity of drug consignments take place at the Crime Laboratory of the National Bureau of Investigation or at the Customs Laboratory. In 2003, the average purity of amphetamine in street trade was 35% (range between 2.8%–98%) and the corresponding figure was 17% for metamphetamine (2.2%–36%), 6% for white heroin (2.7%–31%) and 70% for cocaine (59%–74%). In wholesale, substances were on average purer. The

⁸⁷ See "data library" or "statistical bulletin" in <http://annualreport.emcdda.eu.int/fi/home-fi.html>

average purity of amphetamine in wholesale was 60%, the corresponding figure being 33% for metamphetamine, 7% for white heroin and 80% for cocaine (National Bureau of Investigation 2004). No data for 2004 is available concerning the purity of different drugs sold on the street because the purity of drugs is tested only in consignments of more than 5 grams (nowadays over 10 grams) (the purity of marijuana is tested only upon request).

The average purity of amphetamine in wholesale and street seizures was more or less 50% throughout the 1990s. In 2004, the average purity of amphetamine dropped to 34 per cent (48% in 2003). The purity of heroin has varied strongly over the years. During recent years, however, heroin consignments have been seldom submitted for testing. In 2004, five heroin consignments were tested, the average purity being 26.5%. (Crime Laboratory of the National Bureau of Investigation 2005)

In 2004 the average price per gram in street trade was EUR 8–12 for hashish, EUR 120–200 for white heroin, EUR 15–35 for amphetamine, EUR 67–168 for cocaine, EUR 12–20 for ecstasy tablets and EUR 50–80 for Subutex tablets. (Drug information service of the National Bureau of Investigation and Customs Laboratory)

11. Drug-related law enforcement activities⁸⁸

In the last few years, drug crime investigation has focused on the prevention, investigation and detection of professional organised drug crime. Intelligence operations related to drug crime have been targeted especially at laundering criminal proceeds through legitimate companies. Drug control in the street has been improved by increasing the number of police officers who are not experts in the demanding drug crime investigation.

To intensify the prevention of organised crime, the police, the Customs and the Border Guard have established joint crime intelligence units that aim to standardise working methods and produce up-to-date analysed information on crimes and criminals for the purposes of operational activities. Lately, more focus has been put on investigating laundering criminal proceeds through legitimate companies. In addition, a working group appointed by the Ministry of Justice has

⁸⁸ Cp. Virtanen 2004, Section 16.

suggested the introduction of punishment by confinement for young people and an increase of authority for police officers engaged in undercover activity (prerequisites for anonymous testimony and complicity in an offence).

11.1 Drug control system

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

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

Based on pre-trial investigation records and interviews with officers in charge of investigations, a study was conducted on 15 complex crimes at the end of the 1990s. At the end of the decade, professional drug crime was typically carried out by small and loosely structured groups, but the impact of Russian and Estonian organised crime groups was clearly getting stronger. The geographically widest areas of distribution and operation were controlled by organisations led by Finnish criminals, but these also used the services of foreign smugglers. Foreign groups recruited young immigrants who had been excluded because of insufficient language skills and who, in many cases, also suffered from substance addiction. Extensive use was also made of new communication devices (mobile phones, anonymous subscriptions, email and the Internet). These channels became more difficult to use after the police were granted more control authority. As many activities leave an easily traceable track, crime groups had to avoid using electronic money

transfers and had to start using cash. Prisons in Finland and elsewhere are crucial places for recruiting new members for crime groups, maintaining contacts and planning activities. Drug crime also took advantage of legitimate means, including transport companies for smuggling, real estate businesses for storing drugs and restaurant and construction businesses for money laundering. (Hietaniemi et al. 2005.)

Even though the Central Chamber of Commerce has supported the idea of preventing economic crime, it is claimed that increased control measures have more negative than positive effects on societal and economic activity. However, to some extent risk awareness has been promoted by legislation that obligates companies to check the intentions of their customers. Preventing crime requires knowledge and action before a crime is committed, which emphasises the importance of standardised procedures on a national level and in different fields, as the lack of countermeasures creates opportunities for illegal activity. (Hietaniemi et al. 2005.)

11.2 Judicial system

The Office of the Prosecutor-General has been closely monitoring the way in which the revised drug-user offence legislation functions. The police supreme command and the Prosecutor-General have agreed that the police do not automatically fine under 18-year-olds who have committed a drug-user offence and are willing to seek treatment. Instead, these cases are submitted to the prosecutor for consideration, which ensures that the possibility to waive sanctions is a real alternative. (Virtanen 2005; Metsäpelto 2003.)

Almost all prosecutorial units have created a procedure for treatment referral in co-operation with the police, representatives of substance abuse services and other social welfare and health care services. If a drug user is caught and shows reluctance to seek treatment, neither the police nor the prosecutor has the possibility to motivate the drug user to treatment or evaluate his or her need for treatment. (Virtanen 2005; Metsäpelto 2003.)

A working group appointed by the Ministry of Justice has suggested the introduction of punishment by confinement for juvenile offenders. Compliance with the punishment by confinement would be controlled by electronic monitoring equipment and in the case of house arrest, also with a monitoring device installed in the offender's home. Punishment by confinement could be enforced as house or regional arrest. The maximum term of house arrest would be 20

days, and the maximum term of regional arrest would be 12 days. Courts would decide on house arrest, and the police would mainly decide on regional arrest. House arrest would also be considered in sentencing and decisions to waive charges. (Ministry of Justice, press release 14 October 2004)

The working group memo on undercover operations (2005) suggests new methods for the police to work in preventing crime. The working group suggests that an undercover police officer could testify anonymously, but only in cases dealing with offences for which the maximum sentence is at least ten years (for example an aggravated drug offence). The matter would be decided by court, and the identity of the witness would not be revealed to the judge in charge. An undercover police officer could be granted, as part of his or her undercover activities, permission to participate in the activities of an organised crime group and to commit crimes. The condition would be that there is reason to believe that the offences would be committed even if the police officer were not involved. The permission would be granted by court decision in cases dealing with offences for which the maximum sentence is at least ten years.

11.3 Monitoring methods and technical equipment

In 2004, interception of telecommunications was targeted at 446 persons (414 in 2003). The courts granted 2,028 (1,840) authorisations for telecommunications interception. This development is due to the fact that some of the suspects have been using several subscriber lines. The average duration of telecommunications interception was 24 days. Telecommunications interception has had an important role especially in solving aggravated drug offences. In 2004, the number of persons whose telecommunications were monitored was 775 (1,025). The courts granted a total of 1,822 (1,948) authorisations for telecommunications monitoring. Slightly more than one fifth of these involved drug crime. Technical audio surveillance is a more seldom used method of investigation, and in 2004 it was used in 33 (52) cases, most of which involved a prison inmate suspected of an aggravated drug offence. Technical audio surveillance was carried out 8 times on premises used for permanent residence. (Kainulainen 2005.).

Undercover operations and fictitious purchasing have been used mainly in investigating aggravated drug offences. In 2002, undercover operations were used only in a few cases involving in total under 10 suspects. In 2003, the numbers went up slightly but still remained low.

In 2002, the police used fictitious purchases in 10 cases involving in total under 20 suspects. The number has continued to drop over the subsequent years. (Kainulainen et. al. 2004.)

The Money Laundering Clearing House of Finland received 4,300 reports of suspicious business transactions during 2004. Gaming companies and currency exchange companies in particular reported more cases than before, accounting for 80% of all reports. The second highest number of reports came from banks. Five hundred and fifty-one reports, mainly related to economic and drug crimes, led to pre-trial investigation. There were 25 cases of interrupted currency transfer, in which the total value of business amounted to EUR 1.4 million. By its very nature, the prevention of money laundering is international; 40% of all cases investigated involved cross-border transfers. Due to its international nature, bilateral agreements have been made with the money laundering authorities of 14 countries. (National Bureau of Investigation, press release 16 February 2005)

In prisons, the prerequisites for monitoring drug supply are created by organising spaces and activities as well as creating suitable ward and cell structures. Intoxicant control is also facilitated by appropriately positioning personnel and through technical means. Local co-operation agreements between a prison and the police define the sanctions imposed when drugs are discovered: whether the issue is dealt with in prison as a breach of discipline or whether it is referred to the police for investigation. Other authorities have participated in special inspections, and co-operation between authorities has increased in all areas of control. In addition, many prisons now have a drug detector dog; the dog is not only used during special inspections for intoxicant control but also during daily prison inspections. (Intoxicant strategy for the prison administration 2004, 24–25.) Drug detector dogs have also been borrowed from the police and the Customs, which has approximately 50 of them. (*Drug detector dogs at Finnish Customs* brochure 2005).

11.4 Intelligence and information systems

To intensify the prevention of organised crime, the police, the Customs and the Border Guard (PTR co-operation) have established joint crime intelligence units that aim to standardise working methods and to produce up-to-date analysed information on crimes and criminals for the purposes of operational activities. Activities started in the middle of 2004, when Regional PTR crime intelligence groups were established in provinces and the national PTR Crime Intelligence Centre

of the National Bureau of Investigation was established. In addition, some border crossing points have local PTR crime intelligence units. Some 30 people work in PTR crime intelligence, two thirds of whom are from the police and one third from Customs and the Border Guard. The National Bureau of Investigation is in charge of practical arrangements and co-ordination. Based on initial experiences, PTR crime intelligence has bolstered the investigation of organised crime and mass crime. (Boarder Guard press release 10.3.2005)

According to the report on the Status of Crime Investigation project (2003), crime intelligence and related operative crime analysis is not sufficiently perceived as basic activity of crime prevention. Intelligence operations are targeted mainly at drug crime, even though they should be targeted at all forms of professional or organised crime. With respect to information systems, the report states that after the introduction of the drug-user offence there have been problems in compiling statistics on the numbers of drug offences, which hampers the planning of control measures. The summary penalties issued for drug-user offences do not contain sufficient information on the quantity and purity of the seized narcotic substance, on whether the suspect is a first-time offender, whether the suspected offence has been detected in street supervision etc. Monitoring crime is also hampered by the fact that an aggravated drug offence committed by several persons is recorded as one offence. Earlier in cases concerning the same drug consignment, the offences of each accomplice were recorded separately if his or her role in the crime was a separate offence.

Part B. SELECTED ISSUES

12. Gender differences

The main gender differences in drug use are: girls start experimenting with illicit drugs even at an earlier age than boys do; after the age of 25 women's drug use decreases much more rapidly than men's drug use; women in general use drugs much less than men do. On the other hand, among severely excluded substance abusers, the differences that come with age are not so drastic. Gender-specific interventions are mostly related to gender specific facilities on to a specific groups, e.g. mothers and prostitutes..

Drug prevention targeted at children and young people is the same for boys and girls and usually carried out in schools. Prevention may be more gender-oriented when it is carried out in connection with activities that are somewhat gender-specific, such as hobbies. Drug treatment methods are the same for men and women – only the treatment facility may be gender-specific. There are gender-specific treatment services for drug-using mothers and prostitutes. The reduction of health problems related to long-term social exclusion and social rehabilitation is carried out using the same methods for both genders, except for gender-specific institutions such as women's prisons. There are also some random gender-specific housing, employment and rehabilitation services.

12.1. Drug statistics - gender differences

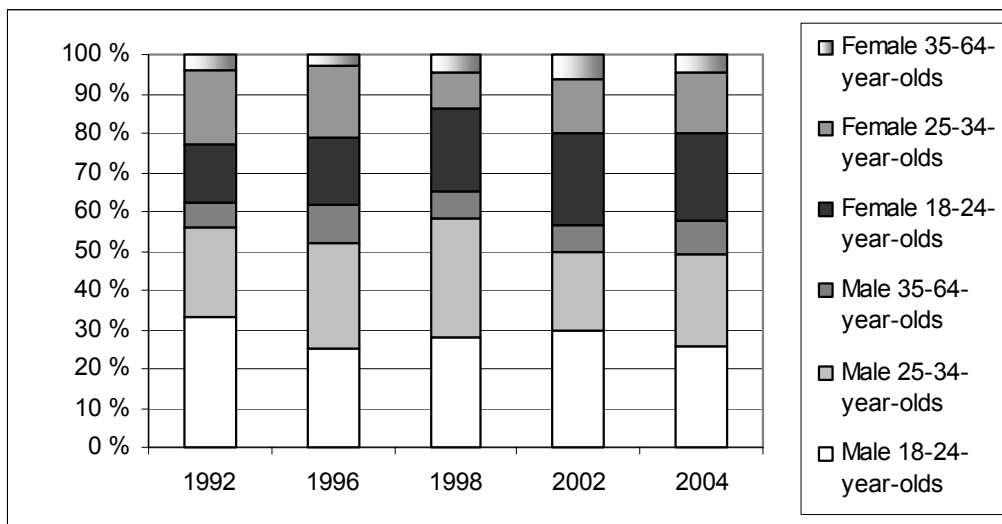
Drug experimentation and use

The proportion of men having tried cannabis sometime in their life is higher (14%) than that of women (11%). The differences are smallest among the youngest age groups, 11% for 15–16-year-old boys and girls⁸⁹ and 22% for 15–24-year-old boys and 20% for girls of the same age. After this, the relative proportion of men increases and from the age of 45 onwards is manifold compared to the proportion of women. There were no gender differences among 15–16-year-olds in the prevalence of drugs use other than cannabis. However, these differences increase with age, especially in the case of amphetamines. Among 15–24-year-olds, 6% of men and 2.2% of

⁸⁹ Girls start experimenting with drugs even earlier than boys: 11 % of 15–16-year-old boys and 12 % of 15–16-year-old girls have experimented with any drug in their life (the Espad Report 2003.)

women had used amphetamines. The same phenomenon, albeit somewhat slower, can also be seen in the case of LSD, ecstasy and cocaine. The older age groups show greater differences between genders. The proportion of opiate-using men is much higher than the proportion of opiate-using women in all age groups. (Huhtanen et. al. 2005.)

Figure 14. Has tried cannabis during lifetime; by age and gender group



The differences are clearer in cannabis use during the past year or regular use. The proportion of boys and girls having tried cannabis during the past year was almost the same among 15–16-year-olds (approximately 8%). On the other hand, there are already differences among 15–24-year-olds: 12% of men and only 8% of women had tried cannabis during the past year. Gender differences in the use of cannabis were emphasised in the older age groups. For example, 6% of 25–34-year-old men had tried cannabis during past year compared with 1.5% of women of the same age. The regular use of drugs is usually estimated on the basis of use during the past month. There were no big differences between genders in the number of times 15–16-year-olds had used cannabis during the past month. However, among 15–24-year-olds, the proportion of men having tried cannabis during the past month (9.7 %) was nearly three-fold compared with women in the same age group (3.9%), and the differences increase in the older age groups. (Hakkarainen et al. 2005.)

Fifteen 15–27-year-old girls in drug treatment were interviewed for a dissertation on the reasons behind young girls’ drug use. According to the girls, drug use offers a way of differentiating oneself and experiencing adventures. “Normal people” are considered dull, whereas the drug scene symbolises excitement and adventure. The incentive for using drugs is not so much the substances themselves but rather the drug-using friends who seem fascinating. A common factor

behind a girl's drug experimentation is infatuation with an older drug-using boy. Some girls also said that they had sought consolation from drugs for their own depression and anxiety, which were often linked with feelings of loneliness and rejection. In this context, drug use can be seen as an alternative way to build one's own identity and to be accepted by others. (Väyrynen, S. 2005)

The population's opinions on drugs also differ somewhat according to gender. The proportion of those who consider drugs a severe problem has decreased significantly in the 21st century. According to latest research data, 81% of the population consider drugs a serious problem in society, compared with 90% at the beginning of the 21st century. Fifty-five point five per cent of 15–24-year-old men and 68 % of 25–34-year-old men consider drugs a serious problem, compared with 65% and 78% of women, respectively. Thus women seem to adopt a more serious attitude towards drugs at a younger age than men do. (Piispa et al. 2005.)

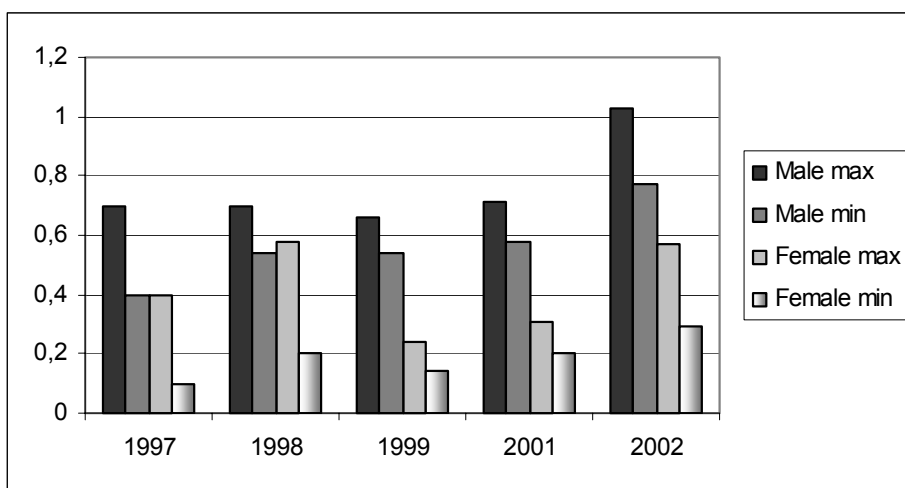
With regards drug experimentation and regular use, there are two clear trends. Firstly, the proportion of women having tried drugs sometime in their life grew considerably between 1992 and 2004. Most of the growth took place among the youngest age group, i.e. women under 25, and the differences between genders in this group have become marginal. The phenomenon is most likely a result of the rapid increase in young people's cannabis experiments in the 1990s. The growth trend in the proportion of women has also been evident in the 24–34 age group since the end of the 1990s. However, there are no big changes between the proportion of genders in drug use during the past year. Secondly, with regards recent and regular drug use, the proportion of men increases drastically with age. One explanation could be the formation of families and women's role in them. This interpretation is supported by the fact that 52% of women under 25 know at least one person who uses drugs, whereas in the age group 25–34-years-old only 21% know someone who uses drugs. Among men, the corresponding figures are 37% for the younger age group and 33% for the older age group.

Problem drug use

The same phenomenon can be seen in the estimates on problem drug use, according to which it seems that it is easier for women to quit experimenting with drugs and they also become problem drug users much more seldom than men do. The number of problem drug users has increased considerably in the 21st century. In 2002, the proportion of problem drug users among men was

0.77–1.03% whereas the proportion among women was 0.29–0.57%. The proportion of women among problem drug users seems to have stayed fairly constant, as opposed to their proportion among those experimenting with drugs. Among problem users of amphetamines, the proportion of women is approximately 15–20 per cent and among opiate users some 25 per cent. We must keep in mind, however, that in the younger age group almost half of those experimenting with drugs are women. It is thus much less common for experimental use to turn into regular use among women than it is among men in this age group. When examined by age group, the proportion of problem users decreases steadily from 0.93–1.3 per cent among 15–24-year-olds to 0.25–0.5 per cent among 35–55-year-olds. (Partanen P. et al. 2004.)

Figure 15. Proportion (%) of amphetamine or opiate problem users among 15 - 54-year-olds



One possible factor behind drug use and experimentation is the use of alcohol. In Finland, the use of drugs and alcohol are closely connected. The risk of cannabis users (drug use during last year and also before it) to binge drink (more than 6 proportion of alcohol on a single occasion) at least once a month is more than three times higher compared with those who have never tried drugs, and the risk of those who have experimented (once in lifetime) with drugs is at least double. Gender differences in the use of drugs and binge drinking are very similar. The risk of men to binge drink at least once a month is three times higher compared with women. The proportion of men who have tried cannabis during the past month is more than double the proportion of women, and among problem drug users, the proportion of men is three-fold compared with women. (Hakkarainen et. al. 2005; Partanen P. et. al. 2004.) However, there are some differences. Women's cannabis use decreases rapidly with age, whereas their use of alcohol and binge drinking decrease much more slowly. The cannabis use starts to decrease rapidly after 25-year-of-age but the decline of binge drinking starts not until after 35-year-of-

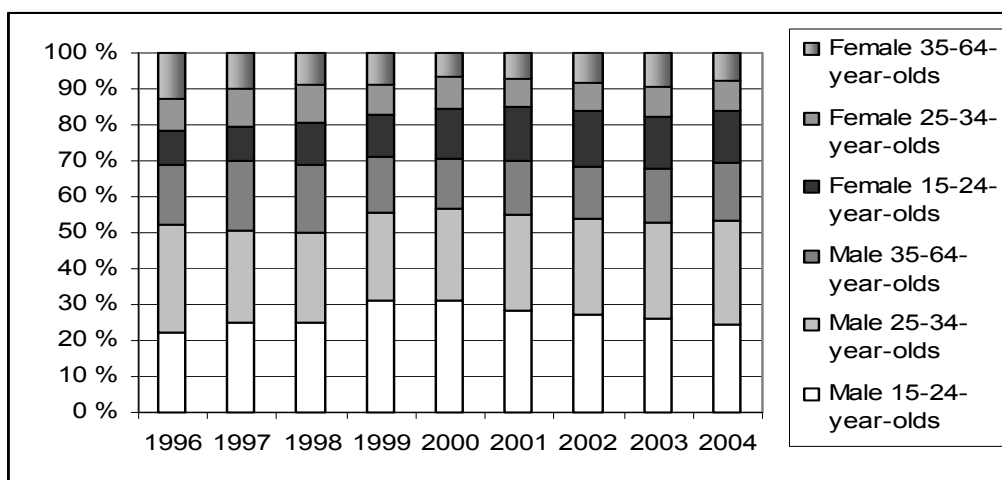
age and still remains at the level of 10 %. (Huhtanen et. al. 2005; Helakorpi et. al. 2005.) It can thus be assumed that women are more worried of the risks that experimenting with and using illegal drugs can pose for them as mothers (role models for their children) and for the unity of their family (the risk of children being taken away from them).

Drug-related harm

Drug treatment clients in hospitals

Women account for some thirty per cent of clients with drug-related problems treated in hospitals. The number of women had increased more than 40 % during last 10 years and in the same time the proportion of women under 25 has more than doubled, being 47%. No such development can be seen among other age groups. In hospital statistics, the proportion of 25–34-year-old women is 27% of the patients and the proportion of women over 35 is 25%. The proportion of women over 35 treated in hospitals is much higher than in drug (inpatient or outpatient) treatment units (13%) whereas among under 25-year-olds the proportion is the other way round. The proportions of women treated in hospitals and in drug treatment units among 25–34-year olds are almost identical. According to the census of intoxicant-related cases, the difference between figures is explained by the fact that (older) patients with longer lasting somatic problems are treated more in hospitals. (Finnish Care Register maintained by STAKES, Nuorvala et. al. 2004; Partanen A. et al. 2005.)

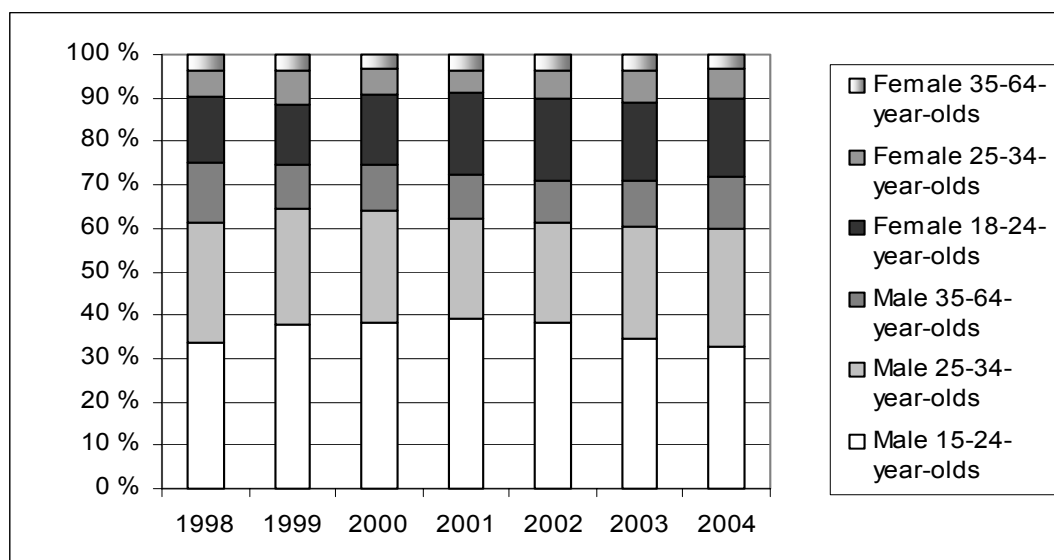
Figure 16. Drug-related morbidity by age and gender group



Drug treatment clients in substance abuse services⁹⁰

In services specialised in drug treatment, women account for 28% of the clients and about a third of the new clients. The proportion of 15–24-year-old women among drug treatment clients has increased in the 21st century, but the biggest change has taken place within this age group, between 15–19-year-olds and 20–24-year-olds. The system does not enable direct temporal comparison because the data collection is voluntary and the units vary. However, it is noteworthy that in 2000, the proportion of 15–19-year-old women clients was 33% and the proportion of 20–24-year-olds was 28% whereas in 2004, the corresponding proportions were reversed. Thus, the proportion of the youngest female clients in drug treatment has clearly declined. No similar trends can be seen in other age groups for either gender. (EMCDDA Statistical Table 3 results from Finland 1998–2004.)

Figure 17. Drug treatment clients by age groups and gender groups

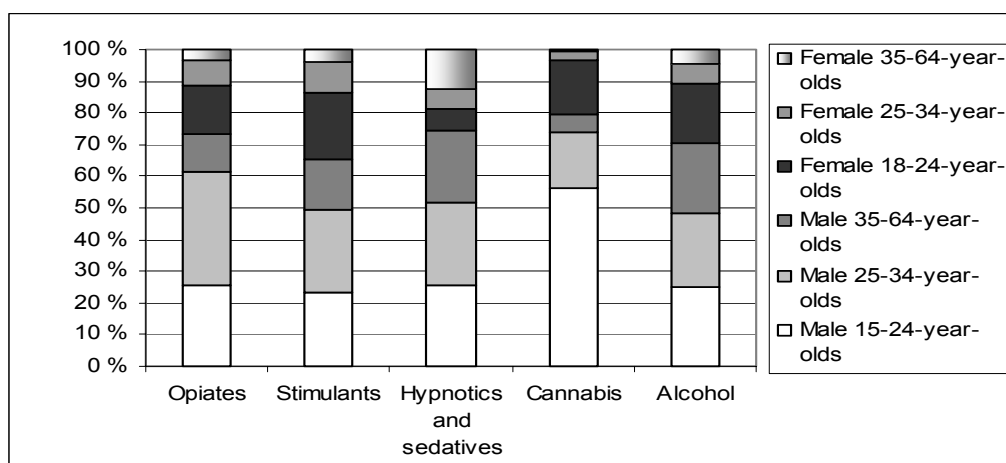


With regards different substances, the situation differs for stimulants and cannabis. The relative proportion of women entering treatment and using stimulants as their primary substance (31%) is significantly higher than that of men (21%). The situation is reversed for cannabis, as it is the primary substance for 11% of women and 17% of men. Women seem to start drug use and intravenous drug use on average a year earlier than men and regular use more than a year earlier than men. The clearest differences can be seen with stimulants and buprenorphine. Women start using stimulants at approximately 18 years of age (men 18.6) and regular use at 20.2 (men 22.2).

⁹⁰ Figures in this chapter are based on drug treatment demand information system from 1998 to 2004

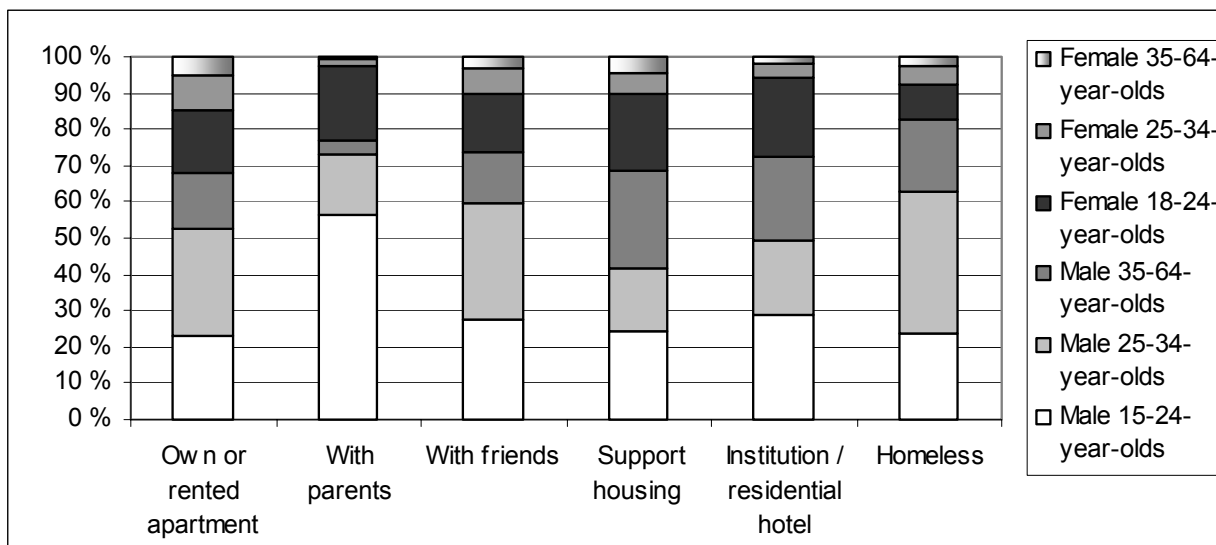
Women start using buprenorphine on average at 20.0 years of age (men 21.5), and its use becomes regular at 21.3 (men 23.3). Intravenous use starts on average at 18.6 years of age among women and at 19.3 among men. Thus, it appears that women’s problem drug use begins at an earlier age than men’s does, which is also seen slightly in the case in drug experimentation. However, the rapid decrease in women’s drug experimentation and use with age can also be seen in the drug treatment clientele, as from 25 onwards the proportion of female clients declines much faster than the proportion of male clients does. (Partanen A. et al. 2005.)

Figure 18 Primary problem substance of drug treatment clients by age and gender group in 2004



There are no significant gender-specific differences in the social background of drug treatment clients. With regards treatment, the proportion of women (girls) that are referred for treatment by child welfare services is higher than that of men (boys). This also accounts for women’s mean age when entering treatment (25.3) compared with men’s mean age (28.1). A slightly higher proportion of women (69%) than men (63%) have been vaccinated against hepatitis B. Women are more often married or co-habiting (29%/19%) and they live in their own or a rented apartment more often than men do (66%/55%). Women also live much more often with another substance abuser (79%) than men do (42%). Family relations seem to have more significance for female problem drug users than they do for male problem drug users. Thirteen per cent of men and 7% of women were homeless.

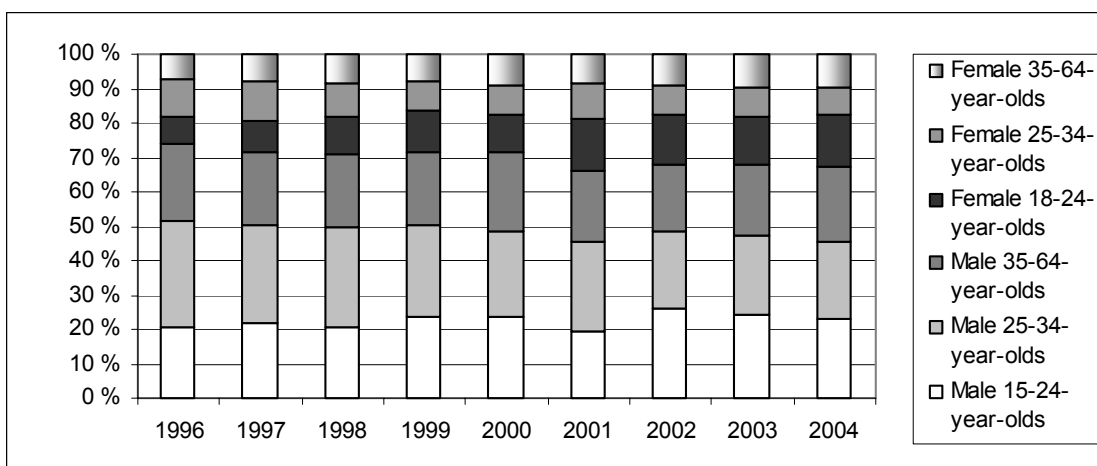
Figure 19. Housing situation of drug treatment clients by age and gender group in 2004



Drug-related infectious diseases

In 2004, approximately a third of new hepatitis C infections, which were mainly contracted through intravenous drug use, were detected in women. Since 1996, the proportion of 15–24-year-olds among those infected has grown from 30 to 40 per cent and the proportion of 25–34-year-olds has declined from 40 to 30 per cent. In addition, in the youngest age group, the proportion of women has risen from 29 per cent to 40 per cent. Thus in total, the proportion of 15–24-year-old women of those infected with hepatitis C has risen from 8.5 per cent to 15.5 per cent, whereas the proportion of 25–34-year-olds has declined. The proportion of 25–34-year-old men has also declined. (Infectious Diseases in Finland 2004.)

Figure 20. Hepatitis C infections by age and gender group



The number of new registered hepatitis C cases has dropped steadily since it peaked in 1997. The number of registered hepatitis B and HIV cases has also decreased. This confirms that virus infections contracted through intravenous drug use have declined considerably in Finland throughout the 21st century. However, there are still quite a few new cases among the youngest age group (15–24-year-olds). The number of hepatitis C cases has increased only among 20–24-year-old women during the 21st century. (Infectious Diseases in Finland 2004.) Even though the growth of the proportion of women in the youngest age group seems to indicate an increase in women's problem drug use, the decline of the proportion of women in the next age group supports the interpretation that as women become adults, their drug use and problem drug use tends to decline significantly. On the other hand, women's proportion of hepatitis cases among 35–64-year-olds remained at an even level throughout the period under review. This reflects the fact that experiments with intravenous drug use have stabilised at the current level among both men and women with a long history of drug and alcohol abuse.

Drugs and crime

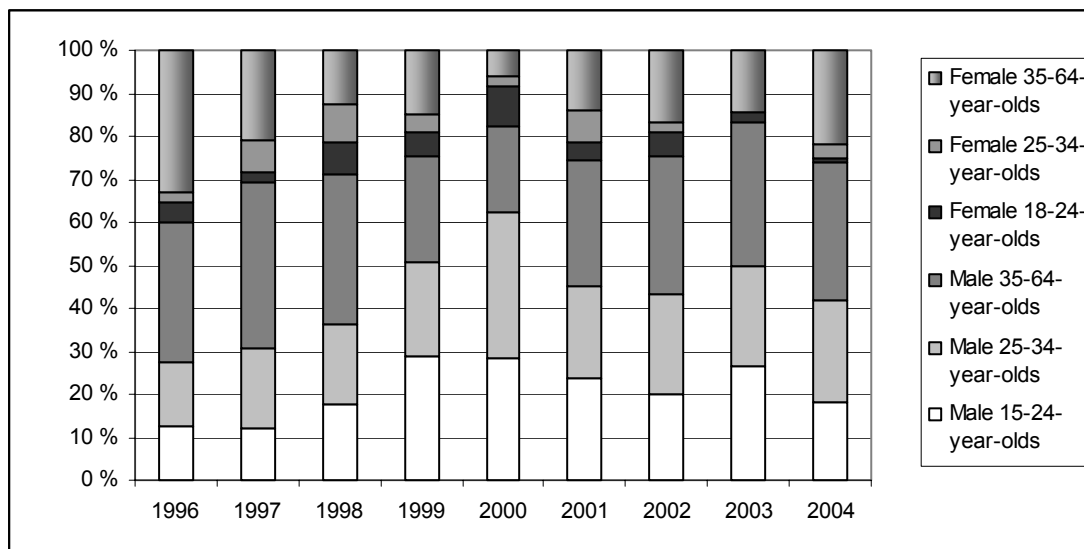
Women's relative proportion of those suspected of drug offences has varied over the years. In the 1990s, women's relative proportion of all those suspected of drug offences dropped somewhat, even though the absolute number of suspects grew. Control measures are essential in the detection of drug offences. The lowered number of female suspects thus either reflects the actual gender distribution or it reflects the fact that control measures were targeted more at men. In 2004, of those suspected of drug offences or aggravated drug offences, 15% were women. Altogether, one fifth of suspects were under 21 years old and 5% were 15–17 years old. Among the latter age group, one in four was a girl. There is no data on the gender distribution among the other age groups, but according to statistics on recidivism, women's recidivism percentage is almost 15 percentage points lower than men's is. Thus women's proportion of drug offenders also seems to decline with age. (Kainulainen 2005; Honkatukia 2005.)

Drug-related deaths

Drug-related deaths decreased significantly from 2000 to 2003. Their number has dropped especially among under 25-year-olds and among 25–34-year-olds. On the other hand the number of drug-related deaths has remained constant in the older age group. In the 21st century, the proportion of 15–24-year-old women among drug-related deaths reached its peak in 2000 (9%) and the proportion of 25–34-year-old women in 2001 (8%). Since then, the proportions of these

two age groups have dropped rapidly. In the same time the proportion of the oldest age group, 35–64-year-olds, has increased to 20 % of all death cases. In 2004 the total number of deaths increased more than 30 % but the overall trend still continued and the proportion of the oldest female group reached 25 %.

Figure 21. Drug-related deaths by age and gender group



Among deaths by poisoning, the largest age group is 25–34-year-olds (30 cases in 2004). The second largest group is the under 25-year-olds (23 cases), followed by the over 35-year-olds (21 cases). Defined by the primary cause of death, women’s proportion of deaths by poisoning is 9%. The proportion is highest (14%) among over 35-year-olds. The figures are low but the difference between women’s proportions of drug-related deaths in general and deaths by poisoning can somehow be explained by the fact that deaths by poisoning are usually accidental whereas drug-related deaths in general also include suicides - and the among the oldest age group the proportion of women is 55 % of all deaths by intentional poisoning. (Vuori 2005.)

Summary

There would appear to be three central factors that differentiate men from women with regard to drug use, problem drug use and drug-related harm.

(1) Young girls experiment with drugs (and alcohol) at least as much if not more than boys do. One explanation for this is that girls often have a slightly older group of friends (older boyfriends), thus more friends who are already experimenting with drugs. However, still at the

beginning of the 1990s, among young adults, men experimented with cannabis twice as often as women did. As drug use in general increased after the mid 1990s, young women's experimentation grew, and this is reflected today in the steadily increased numbers of women who have tried drugs sometime in their lifetime, especially among those aged 20–25 and over.

(2) The proportion of women having tried cannabis sometime in their life grew considerably between 1992 and 2004. Most of the growth took place among the youngest age group, i.e. women under 25, and the differences between genders in this group have become marginal. The growth trend in the proportion of women has also been evident among the 24–34-year-olds. The differences are clearer in cannabis use during the past year. Among women who have used drugs during the past year, the proportion of 25–34-year-olds is approximately a third of the proportion of 15–24-year-olds. Among 25–34-year-old men, the prevalence of last year experimentation and use is four times as high as among women of the same age group while in the age group 15–24-year-olds the difference is only 50 %. The proportion of women among drug treatment clients also declines more rapidly after the age of 25 than the proportion of men. These results may reflect gender differences in commitment to family life. This is supported by the fact that among 25–34-year-old drug treatment clients, women have a more stable housing situation, marital status and family background than men do. It appears that as women reach the age when they start forming families, their drug use and problem drug use declines.

(3) Third possible factor behind drug use and experimentation is alcohol. . The risk of cannabis users to binge drink at least once a month is more than three times higher compared with those who have never tried drugs. The risk of men to binge drink at least once a month is three times higher compared with women. Gender differences in the use of drugs and binge drinking are very similar. The proportion of men who have tried cannabis during the past month is more than double the proportion of women, and among problem drug users, the proportion of men is three-fold compared with women. However, there are some differences. Women's cannabis use decreases rapidly with age, whereas their use of alcohol and binge drinking decrease much more slowly. The cannabis use starts to decrease rapidly after 25-year-of-age but the decline of binge drinking starts not until after 35-year-of-age.

These phenomena apply to under 35-year-olds. On the other hand, there are opposite trends in the proportions of women over 35 years of age among drug treatment clients treated in hospitals, drug users who have contracted infectious diseases and drug-related death cases. One possible explanation is that in these cases women have used alcohol and drugs for a long time and that

somatic problems increase as people age. Of all those seeking treatment for substance abuse (including alcohol) problems, the proportion of women has increased rapidly over the past few years, and is today more than 25%. Two out of three of all women treated for substance abuse are over 35 years of age. (Nuorvala et al. 2004). Especially this older age group is treated in hospitals. This partly explains the large proportion of 35–64-year-old women among drug related death cases. The number of infectious diseases among over 35-year-olds has not declined for either gender. One explanation for this is that people with a long history of alcohol use may have contracted infectious diseases when experimenting with drugs and injection, but these chronic diseases are only detected as they are hospitalised for other reasons as they get older.

12.2. Gender-specific responses for reducing drug use

As mentioned above, the central gender-specific differences are: young girls start experimenting with drugs even at an earlier age than boys do, women's drug experimentation starts to decline after the age of 25 much more rapidly than men's does, and the prevalence of drug use in general is much lower among women than it is among men, the exception being the most excluded drug and alcohol abusers. Thus, gender-specific interventions reflect these differences.

Children and young people

Prevention targeted at children and young people usually takes place in schools. There are no gender-specific prevention programmes because there are no significant differences in the prevalence of experimentation in this age group.

As prevention is also carried out in connection with different hobbies, which can be dominated by one gender or the other, the focus of prevention may differ but, as far as is known, there are no gender-specific programmes. Of those few projects that focus on the recreational use of drugs, there is no information of separate gender-specific programmes.

One gender-specific form of operation is the so-called Girls' Houses, which function as meeting places for 10–28-year-old girls. The main aim of the Girls' Houses is to support the growth and identity of girls and young women. The Houses also organise theme groups, such as groups for girls who have been sexually abused, groups for lonely or depressed girls, groups for girls from substance using families, groups for girls who act out sexually and groups for young mothers. (Presentation of the Girls' House 2005.)

Drug treatment

Only the largest treatment units have gender-specific treatment programmes. There is however a need for services targeted at female clients as they face specific troubles in male-dominated treatment units and many of them have been forced to prostitute themselves in order to finance their drug habit. One form of treatment is peer group activities, which are sometimes carried out on different premises for different genders. Overall, men and women are basically treated with the same methods. There are services that target pregnant women, i.e. the time when women's drug use starts to decline rapidly. These services focus on preventing future health problems of both mothers-to-be and their children.

Child welfare clinics have developed substance abuse prevention, especially after the damage that alcohol can do to a foetus was more widely revealed. Treatment services have been targeted at pregnant alcoholics and heavy users of alcohol, and gradually prevention has been expanded to include other substances, pharmaceuticals and drugs.

One model of drug prevention in child welfare clinics is in place in the town of Riihimäki. At the child welfare clinic in Riihimäki, drug-using pregnant women are informed of their possibilities to get help and support to protect the child. The aim of the treatment programme is that the mother always deals with the same public health nurse, physician, substance abuse worker and social worker. The necessary laboratory and maternity clinic visits are programmed to support more frequent child welfare clinic visits. If the mother refuses contact, a child welfare report is made once the child is born. In the hospital, the child is monitored for a week to detect any withdrawal symptoms. After the mother has returned home, a child welfare clinic worker will visit the family home. In the beginning, the family will have frequent appointments at the child welfare clinic and the future will be based on the wellbeing and development of the child and the situation of the family. (Koskivuori et al. 2004.)

Another model, which focuses more on excluded drug-using women, is the parent-infant project at the University Hospital of Tampere. A patient (i.e. parent) may suffer from FAS or FAE because her own mother has been a substance abuser. The financial situation of the patients is usually poor and they may be homeless and involved in crime and prostitution. At the beginning of treatment, a specialist in psychiatry assesses the patient's need for treatment by conducting a

substance abuse and psychiatric examination. The situation of the patient's spouse is also assessed, if necessary. All alternatives are considered in the assessment, including detoxification, and if the patient is not motivated or is incapable of any other kind of treatment, buprenorphine treatment is initiated. Concurrent use is monitored at least twice a month by drug screening and searching for injection marks. A multiprofessional team participates in the assessment. Network meetings are arranged during pregnancy and during the first year of the child's life. The meetings are attended by employees of the maternity clinic and the paediatric observation and maternity wards as well as family members of the patient. The aim of the meetings is to plan the patient's treatment, support, rehabilitation and monitoring. Follow-up treatment is planned for those mothers and families that need it. Follow-up monitoring may be carried out by social services or a low-threshold substance abuse unit. (Sterngell 2005.)

In addition, there are separate shelters for children and women where they are supported in parenting and life management. Some shelters are meant especially for families and mothers with substance abuse problems, others for women who suffer from domestic abuse. There are also mother and child homes that women can enter during pregnancy or with a small baby. The father can also live there, if necessary. Mother and child homes seek to foster good child-parent bonding and to teach parents step by step how to cope with life and look after their baby.

Reduction of health and social problems

The reduction of health problems is in many cases related to treatment and the treatment process. Specific services that reduce health problems include health counselling services for injecting drug users. Treatment services and health counselling services are mainly the same for both men and women. The differences mainly have to do with individual treatment units, but treatment programmes and methods are basically the same for both genders. However, there are gender-specific programmes for sex workers, primarily for female prostitutes, but the content of these services is not especially drug-specific. In some cases the services include outreach work.

The reduction of social problems is usually also carried out as part of treatment services and it focuses mainly at integrating former drug users into society. The services are the same both for men and women and often also for people with different types of exclusion problems and who are at different stages of exclusion. However, there are some gender-specific services, usually for women. The services focus on social rehabilitation and there are separate workshops for men and

women, housing units and half-way houses for women and a Drop-in Centres for Homeless Women. These services are available, but only incidentally in the fringe area of the service network. For example, the Drop-in Centre for Homeless Women (Salli) in Helsinki develops and tests new models and methods of social work. The aim is to reach out to new groups of homeless people, such as pregnant women and drug users who are receiving substitution or maintenance treatment. Salli offers women comprehensive support and the opportunity to discuss their issues and handle their affairs. At the centre, clients can take care of personal hygiene and clothing and cook and rest. (Presentation of the Drop-in Centre for Homeless Women 2005.)

A sort of last-resort service to reduce exclusion is the criminal justice system and related services. Treatment referral carried out by the police is the same for boys and girls as well as for men and women. However, prison services are gender-specific in that they are carried out at different premises (women's prisons). The methods used are however the same, with the exception of specialised services for drug-using mothers who are in prison.

13. European Drug Policies: Extended beyond illicit drugs?

Drug Policy Action Programme 2004–2007 (2004) has been prepared alongside the Alcohol Programme 2004–2007. However the Drug Policy Action Programme has only one direct reference to alcohol. Direct references to tobacco are also scarce. Doping substances are not mentioned at all. This is partly due to the legislation and administrative structures related to the co-ordination of different substances. Ministry of Social Affairs and Health administrate the first three substances. In Finland, the abuse of alcohol, pharmaceuticals or drugs is referred to as substance abuse. These so-called intoxicants include tobacco but not doping substances. The connections between programmes, substances and related interventions is grounded on this concept.

The Drug Policy Action Programme has also been harmonised with Government's Internal Security Programme, the national development project for social services, the target and action plan for social and health services, drug strategies of the police and Customs, and the combined strategy of the police, Customs and Border Guard for combating serious crime. Substance-specific objectives are stated in the public health programme: "Smoking by young people will decrease, to less than 15% of those aged 16–18; health problems associated with alcohol and

drug use among the young will be dealt with appropriately and will not exceed the level of the early 90s.”

13.1. Different substances in the drug strategies

The Drug Policy Action Programme 2004 - 2007 (2004) only has one direct reference to alcohol: “The aim is to make youth workshop activities permanent during the present Government’s term and to develop them at the regional level. These types of action also aim to support and rehabilitate young people with alcohol and drug problems in collaboration with the local substance abuse services.”

Direct references to tobacco are also scarce: “The National Board of Education defines together with the National Research and Development Centre for Welfare and Health the objectives and central principles for pupil and student welfare to be recorded in the bases of curriculum for all education stages except adult education. These objectives include prevention of tobacco smoking and substance use.”

Doping substances are not mentioned in the Drug Policy Action Programme.

In Finland, the abuse of alcohol, pharmaceuticals or drugs is referred to as substance abuse. These so-called intoxicants include also tobacco, especially in prevention targeted at young people, but they do not include doping substances. One reason for this is the administrative division of labour, according to which the strategies on drugs, alcohol and tobacco are co-ordinated by the Ministry of Social Affairs and Health, whereas doping issues are co-ordinated by the Ministry of Education.

There are state-level programmes for alcohol and drugs; for other substances, programmes are mainly local or carried out by organisations.

13.2 Genesis and Rationale

Rationale of drug and alcohol programmes

Drug and alcohol programmes (2004 - 2007) have very few direct references to specific substances. On the other hand, both programmes refer on a more general level to substance abuse, problem use, related harm and prevention. These are referred to in the objectives of the programmes as well as in the means to achieve these objectives.

The Drug Policy Action Programme and substance abuse

The objectives of the Drug Policy Action Programme 2004 2007 (2004) include the following direct references to substance abuse, covering everything from drug prevention to treatment and using the criminal justice system to treat inmates:

1. Strengthening multi-professional co-operation and prevention of substance abuse in pupil and student welfare.
2. Developing new methods for the work of preventing substance abuse and strengthening local co-operation between the authorities in drug prevention. Adopting a more effective approach to reaching young people who have drug problems and are facing a risk of exclusion, strengthening systematic drug prevention and its position and reducing substance abuse by young people.
3. Providing drug abusers with high quality and extensive substance abuse services.
4. More effective use of the time spent during a prison sentence to start substance abuse treatment and to increase treatment motivation. Increasing the number of prisoners serving sentences in substance abuse treatment units outside prison and intensifying the rehabilitation of persons released from prison.

The Alcohol Programme and substance abuse

The objectives and strategies of the Alcohol Programme do not refer directly to drugs, but the means outlined in the programme have several references to drugs. However, there are indirect

references to drugs through the concept of substance abuse. The following list examines the strategies of the drug and alcohol programmes starting from the main strategies in alcohol policy stated in the Alcohol Programme. These have been compared with the objectives of the Drug Policy Action Programme. It is also noteworthy that services related to drug prevention and treatment are often implicitly considered as part of general welfare services. Concerning these, the programmes have many more similarities but in the following, the objectives of the programmes are compared by focusing on the concept of substance abuse.

Table 9. Comparison of objectives and means between Finnish Alcohol programme and Finish Drug policy action programme;

Alcohol programme 2004 - 2007	The Drug Policy Action Programme 2004-07
National level	
<p>Reducing the harmful impact of drinking on the welfare of children and families.</p> <p>* Supporting people and their social network is most effective through local-level substance abuse prevention, social welfare and health care services and services related to education, sports and culture.</p> <p>* Developing substance abuse strategies in municipalities, sports and other organisations and promoting alternative activities to alcohol use.</p> <p>* Legislation should be supported, for example, through broadly-based substance abuse prevention targeted at young people and through teaching traffic safety.</p> <p>* Broadly-based substance abuse prevention also includes other intoxicants besides alcohol.</p>	<p>* Intensifying the prevention of substance abuse by children and young people in co-operation with pupil and student welfare services and other authorities who work to prevent substance abuse.</p> <p>* Implementing new methods for special groups in preventive work.</p> <p>* Adopting a more effective approach to reaching young people who have drug problems and are facing a risk of exclusion, strengthening systematic drug prevention and its position and reducing substance abuse by young people.</p>
<p>Reducing risk-level drinking and its harmful effects.</p> <p>* Harmful effects of substance abuse can and should be prevented through social policy that promotes wellbeing.</p> <p>* Securing the availability and comprehensiveness of substance abuse services.</p> <p>* Organisations in social welfare and health care have developed their own <i>programme for 2004–2006 to prevent substance abuse</i>. Organisations follow the programme’s objectives and guidelines as they participate in co-operation related to the Alcohol Programme.</p>	<p>* Providing drug abusers with high quality and extensive substance abuse services.</p> <p>* More effective use of the time spent during a prison sentence to start substance abuse treatment and to increase treatment motivation.</p> <p>* Increasing the number of prisoners serving sentences in substance abuse treatment units outside prison and intensifying the rehabilitation of persons released from prison.</p>

Local level	
<p>Strategy and administration</p> <ul style="list-style-type: none"> * Municipalities draw up and update a substance abuse strategy, which also addresses alcohol issues, as part of a municipal welfare programme. * A contact person specialised in substance abuse work, a cross-sectoral working group on substance abuse issues and a local substance abuse strategy form the basic structures of substance abuse prevention co-ordination in a municipality. 	<ul style="list-style-type: none"> * Developing new methods for the work of preventing substance abuse and strengthening local co-operation between the authorities in drug prevention. * Strengthening the position of contact persons specialised in substance abuse work as co-ordinators of substance abuse prevention.
<p>Substance abuse prevention</p> <ul style="list-style-type: none"> *The aim is to develop substance abuse strategies in municipalities, sports and other organisations and to promote alternative activities to alcohol use. * Planning and steering substance abuse prevention is implemented in municipalities as part of welfare and health promotion. * Sufficient resources are allocated to the municipal contact persons specialised in substance abuse work. * Municipalities will help maintain a drug and alcohol free environment on premises and at events intended for children and families. 	<ul style="list-style-type: none"> * Strengthening multi-professional co-operation and prevention of substance abuse in pupil and student welfare.
<p>Substance abuse treatment services</p> <ul style="list-style-type: none"> * Developing treatment for alcoholics in municipalities according to the Act on Welfare for Substance Abusers and the quality framework for substance abuse services with the aim of guaranteeing sufficient and timely treatment. 	<ul style="list-style-type: none"> * Providing drug abusers with high quality and extensive substance abuse services. Improving the availability of drug-free treatment and substitution treatment and access to care.

As in the Drug Policy Action Programme, there are few direct references to tobacco in the Alcohol Programme. The only reference can be found in the section where the objective “to achieve a down-turn in the overall consumption of alcoholic beverages” is connected to “reducing the use of tobacco and alcohol among working age people”. However, tobacco is referred to indirectly in both programmes through the concept of substance abuse – especially within the context of prevention targeted at young people.

Genesis of drug and alcohol programmes

The first Finnish drug strategy was published in 1997. Based on this, the Government made a decision in principle on drug policy in 1998 integrating general social policy, national legislation and international conventions. The objective of the drug policy is to prevent the import, distribution and use of drugs and to reduce drug-related individual, social and economic problems. The means to achieve these objectives include enhancing drug control based on a complete ban, preventing drug experimentation and use and providing sufficient treatment and better access to treatment.

Furthermore, Finland applies to its drug policy the objectives defined at the special session on drugs of the United Nations' General Assembly in 1998, the drug strategy and action plan of the European Union (2000–2004), the guidelines for EU foreign and security policy and the objectives of the action programme of the Council of Europe's Pompidou Group.

As a result of the aggravated drug situation, the Government gave a decision in principle on 5 October 2000 to enhance the national drug policy (2000). The action programme was implemented from 2001 to 2003 by the ministries responsible for drug issues. Its objectives included the prevention of and early intervention in drug use, treating drug users and supporting their family members, reducing drug-related harm, increasing control measures, international co-operation, research and follow-up and harmonising, implementing and developing drug policy.

The first alcohol programme was drawn up before the drug strategy. The first WHO European Alcohol Action Plan was issued for 1992–1999. The second Alcohol Action Plan continued until 2005. Both these Action Plans have affected Finnish alcohol programmes. Since 1995, the Ministry of Social Affairs and Health has been in charge of planning the alcohol policy without the former alcohol company playing a central role in the planning. The Ministry's Advisory Committee on Intoxicant and Temperance Affairs has drawn up two national alcohol programmes (for 1997–2000 and for the 2000s) based on the WHO European Alcohol Action Plans. The first of these was prepared for 1997–2000 and the other for 2001–2003. However, alcohol issues have lost some of their urgency both at the WHO and the European level, and there is no certainty that the European Alcohol Action Plan will continue after 2005.

The different emphases of the programmes are reflected in legislation. The Narcotics Act emphasises a complete ban and defines the ban and possible exceptions to the ban. The Act is

complemented by legislation related to substitution treatment and the exchange of needles and syringes. With regards other measures, the Act refers to legislation that touches on drugs and other intoxicants. On the other hand, the first section of the Alcohol Act states, “the purpose of the Act is to prevent detrimental societal, social and health effects caused by alcoholic substances by controlling the consumption of alcohol.” The Act does not suggest a total ban on use, but it is restricted through special provisions. Correspondingly, the Decree on Measures to Reduce Tobacco Smoking states, “in organising information and education and in producing health education programmes and other material aimed at reducing smoking, the Ministry of Social Affairs and Health shall use specifically the expertise and services of the Ministry of Education, central organisations of local authorities, and the relevant non-governmental organisations.” Smoking is also restricted through special provisions; a total ban has not been suggested. Other relevant legislation includes the Temperance Work Act, the Act on Welfare for Substance Abusers as well as the Penal Code, which are referred to in the Narcotics Act.

Thus, the Drug Policy Action Programme (and related legislation) emphasises control measures more than the Alcohol Programme does, specifies the methods of treatment and harm reduction in more detail and states its goal is to lower the threshold between control and care. Furthermore, the Drug Policy Action Programme is more closely tied to international conventions and programmes than is the Alcohol Programme.

13.3. Administrative Responsibilities and co-ordination of action programmes

The following table examines co-operation between administrative sectors in the current organisational structures or in the ongoing development projects regarding alcohol, drugs, tobacco, and doping substances.

Table 10. Cross-administrative structures: drugs, alcohol, tobacco and doping substances

Programmes	Co-ordination	Participants
Drug Policy Action Programme 2004–2007	Ministry of Social Affairs and Health	

– Co-ordination group		Ministry of Social Affairs and Health Ministry of the Interior Ministry of Education Ministry of Foreign Affairs National Research and Development Centre for Welfare and Health, STAKES National Public Health Institute Office of the Prosecutor-General National Board of Customs
– Working group on drug legislation (2006)		Ministry of Social Affairs and Health Ministry of Justice Ministry of Finance National Public Health Institute National Agency for Medicines National Board of Customs National Bureau of Investigation
Alcohol Programme 2004–2007	Ministry of Social Affairs and Health	
– National steering group		Ministry of Social Affairs and Health Ministry of Transport and Communications Ministry of Justice Ministry of Education Ministry of the Interior Ministry of Finance National Public Health Institute National Research and Development Centre for Welfare and Health, STAKES National Product Control Agency for Welfare and Health Finnish Institute of Occupational Health Nordic Council for Alcohol and Drug Research The Association of Finnish Local and Regional Authorities Service Union United PAM Finnish Hotel and Restaurant Association FHR Finnish Centre for Health Promotion
– Co-ordination group (local projects)		Ministry of Social Affairs and Health National Public Health Institute National Research and Development Centre for Welfare and Health, STAKES Finnish Institute of Occupational Health Alko Inc. Finnish Centre for Health Promotion State Provincial Offices (6) The City of Tampere (over 200,000 inhabitants) The Municipality of Virolahti (less than 5,000 inhabitants)
Tobacco	Ministry of Social Affairs and Health	

– Control of tobacco legislation		Ministry of Social Affairs and Health National Product Control Agency for Welfare and Health State Provincial Offices Municipalities Industrial safety districts Customs Corporate self-control
Doping substances	Ministry of Education (legislation: Ministry of Justice)	
– The Finnish Antidoping Agency FINADA		The Finnish Olympic Committee Ministry of Education Finnish Sports Federation Finnish Society of Sports Medicine

According to the table, the Ministry of Social Affairs and Health co-ordinates drug, alcohol and tobacco policy. However, drug policy is co-ordinated by a national drug policy co-ordination group, which is separate from the structures that co-ordinate alcohol and tobacco policy. Concerning prevention and treatment, the responsible parties are similar (except for doping substances). Concerning control, however, the chains of responsibility are different. Drug-related activities are controlled by the Ministry of Social Affairs and Health and the National Agency for Medicines (import and related licences), and equally strongly by The Ministry of the Interior (the Police and Boarder Guard), Ministry of Justice (Prison Service) and the Ministry of Finance (the Customs). Alcohol issues are controlled by the Ministry of Social Affairs and Health, the National Product Control Agency for Welfare and Health, State Provincial Offices, municipalities and restaurants but also the Ministry of the Interior (the Police), Ministry of Justice (Prison Service) and the Ministry of Finance (the Customs). The chain of control is similar for tobacco and alcohol. Compared with drug control, the control of tobacco and alcohol is appreciably more multi-stepped, focuses on controlling legal use, emphasises self-control and extends more widely to the local level.

Drugs and alcohol – harm-related costs and funding of programmes

No special appropriations were allocated for the Drug Policy Action Programme for the years 2004–2007. The total drug-related costs for all administrative sectors (combatting serious drug

crime, promoting health, operating costs of the Customs Administration etc.) are however estimated to amount to tens of millions of euros. As part of the Drug Policy Action Programme, drug treatment services received a special appropriation of €15 million for 2002–2003. In its supplementary budget for 2003, the Government granted a special appropriation of €1 million for the implementation of the Alcohol Programme in 2003–2005. The money was used to acquire and produce material that supports the activities of the partners in the Alcohol Programme, to organise national and local events and to cover the costs of co-ordination. No grants are to be distributed from this sum. However, compared with drug-related costs, there are manifold alcohol-related costs for all administrative sectors.

14. Developments in drug use within recreational settings

Recreational drug use is a relatively new concept in the Finnish drug debate and is connected to the diffusion of new party and techno culture. The culture spread fairly slowly in Finland. Techno culture was first a small underground movement, but it started to gain increasing popularity among young people and young adults in the mid 1990s. The new party culture spread to ordinary restaurants that serve alcohol, nightclubs and discos, which started to play techno music. At the same time, it began to incorporate features that are typical to Finnish alcohol culture, such as binge drinking. Finnish nightlife, however, is not distinctly divided into clubs or bars that are specialised in one type of music. Recreational drug use can no longer be examined simply as part of techno culture but as a wider trend in youth culture. Because drug use has primarily been prevented by penal sanctions, monitoring public places and at the music festivals popular among young people, drugs are mainly used in private premises.

It has been noted that "conventional" drug education does not correspond to the way recreational users perceive drug use. Instead so called two-way education has been promoted be used for recreational drug use. The approach does not aim at a total ban on drugs but at the reduction of the risks and harm related to drugs. Likewise, the drug policy aimed at treatment or harm reduction has been targeted at problem drug users in particular, while the recreational users do not want to identify themselves as problem drug users. Sometimes adequate treatment for them is the opportunity to talk about drug use with an expert. So the Internet has become an important communication channel and discussion forum for drug users and this has been noted in substance abuse prevention as well as means for treatment and harm reduction.

14.1 Definition of recreational drug use

Recreational drug use is a new concept in the Finnish drug debate. Recreational drug use only started to be included in discussions on drugs along with experimental and problem use at the beginning of the 21st century. The term “recreational drug use” was not accepted in public debate unreservedly. For example, an editorial in the leading Finnish daily newspaper Helsingin Sanomat considered the term “recreational drug use” too light-hearted (Huumeiden viihdekäytöstä... 2003). The term was also criticised in public by the police, some politicians and anti-drug non-governmental organisations (Ehkäisevän päihdetyön ... 2005, 10–11). Speaking of recreational drug use was considered dangerous because it gave too positive and harmless an image of drug use. It was also in contradiction with the goals of the official drug policy and an unacceptable expression from the point of view of drug policy, as the starting point of the Finnish drug policy is that all drug use is drug abuse.

The definition of recreational drug use is based on the cultural context. Besides the substances used, it incorporates users, environments, ideologies and motives of use, the mechanisms that support drug use, frequency of use and consequences of use. Recreational drug users are ordinary, often well-off and successful young people or young adults, and the positive effects of recreational drug use are emphasised. People are aware of the risks of and harm from recreational drug use and they think that drug use will cause no problems for them. Recreational drug use always includes an assumption of the controllability of drug use. The definition also includes the idea that the user is not socially excluded. Drug use occurs in free time and it must not interfere with the user’s work or studies. No other drug crime than offences involving use or possession of drugs is usually related to recreational drug use. Substances are usually supplied in small amounts between friends without the purpose of financial gain (Salasuo et al. 2002; cp. EMCDDA 2002b).

14.2. The trends of recreational drug use

The metaphor “drug wave” has been adopted in Finland to describe the prevalence of drug experimentation and use (Hakkarainen 1992, Partanen et al. 1999)⁹¹ The first drug wave refers to the use of drugs that started to spread in the 1960s with the hippie movement and plummeted by the mid 1970s. After that, drug use was a marginal phenomenon in Finland until it started to

⁹¹ See also chapter 2.1.

increase rapidly at the beginning of the 1990s. This increase was called the second drug wave and was connected to techno culture. With the second drug wave of the 1990s, drug use has become more diversified and the number of substances used is greater than before..

Drugs and drug use were first linked with young people and youth culture in the 1960s, when drugs were also considered a social problem for the first time in Finland (Hakkarainen 1992). The youth phenomenon known as the hippie movement spread from the USA to other western countries. The use of drugs, mainly cannabis and LSD, was an expression of social protest by white, middle-class young Americans and a symbol of a new way of life (Miller 1991). The roots of the first Finnish drug wave were in the ideology of the hippie movement, even though it had less significance here than in other western countries (see Hakkarainen 1992:60–78, Salasuo 2003).

The second Finnish drug wave, which began in the 1990s, also has international roots. A new kind of party culture, better known as techno culture (has also been called rave or club culture), began to take shape at the end of the 1980s in the UK. Ecstasy became the symbol of this new music trend and culture (see the summary of the birth of techno culture Salasuo 2004a).

Compared to other Western European countries, the new form of drug use as part of the new party and techno culture spread fairly slowly in Finland. The first club night was held in Finland in 1988. First, techno culture was a small underground movement and it had an elitist reputation. However, ecstasy was already well known at the beginning of the 1990s, and the use of ecstasy had a special meaning. It symbolised a new form of substance use that people used to distinguish themselves from the traditional alcohol culture (see also Seppälä 1999). Techno culture started to gain increasing popularity among young people and young adults in the mid 1990s.

At the end of the 1990s, the phenomenon started to diversify and its popularity was established. At the same time, it started to lose its original nature and become part of the nightlife of “ordinary” young people and young adults. The new party culture spread to ordinary restaurants that serve alcohol, nightclubs and discos, which started to play techno music. At the same time, it began to incorporate features that are typical to Finnish alcohol culture, such as binge drinking. Recreational drug use can no longer be examined simply as part of techno culture but as a wider trend in youth culture. (Hakkarainen et al. 2003, Salasuo 2004d, Salasuo 2005, Salasuo et al. 2005)

Recreational drug use in Finland today⁹²

In Finland, people use and experiment with drugs to a far lesser extent than in most other Western European countries (e.g. EMCDDA 2004a). This has been explained by Finland's distant location in Europe and thus the smaller supply of drugs as well as by the strong position of alcohol in Finnish culture (Hakkarainen 1992). Many schoolchildren binge drink (Ahlström et al. 2003; see also Lähteenmaa 2004) and it is easy for young people to obtain alcohol (Holmila et al. 2005). Because alcohol is a legal substance, it has usually been clearly differentiated from illegal drugs, and there is a clear distinction between the use of alcohol and drugs. However, according to a new study, Finnish drug and alcohol cultures are closely connected with each other (Hakkarainen et al. 2005).

Some international studies have shown that drug use is more common at night-time venues, such as restaurants, discos and nightclubs, than at other leisure-time venues that are popular with young people and young adults. Connections between certain music styles and recreational drug use have been found (Calafat et al. 1999, 2001 and 2003, EMCDDA 2002b; see also EMCDDA 2005). It is not easy to distinguish specific sub or youth cultures based on different music styles or cultures in Finland. Various music styles and cultures are not clearly differentiated from each other, and Finnish nightlife, for example, is not distinctly divided into clubs or bars that are specialised in one type of music. (See, however, Törrönen & Maunu 2004). Even though the media has in particular linked drugs to techno and other electronic dance music, no music style or other similar "youth culture" can be said to promote drug use.

In Finland, drugs are mostly used in big cities in the south, such as Helsinki and the Greater Helsinki area, Turku and Tampere. Even though the new party culture has become part of mainstream youth culture and increasing numbers of young people spend their leisure time in line with the codes of party culture, only a small number of these people use drugs. Although

⁹² The prevalence of recreational drug use is difficult to estimate with population surveys. Information on experimental drug users has been collected via the Internet and discussion forums (e.g. Roine 2004, Salasuo 2004c, Seppälä 1999, Seppälä 2003, Seppälä et al. 2004, Sjöberg 2005) The target population includes young adults from 18–30 years of age. Pauliina Seppälä's (1999) master's thesis examined drug use within techno culture (N=12). The material for Mikko Salasuo's dissertation (2004c), which included 60 user interviews and 400 survey replies collected via the Internet, was obtained in 1999–2001. Because of the fact that the majority of recreational drug users have never been involved with the authorities (drug treatment, the police), also register data available would probably provide a false image of typical recreational drug use and users.

young people's attitudes towards cannabis in particular, and in the youngest age groups also the attitudes towards ecstasy, have become more lenient, the majority of young people take a very negative stand towards drugs and they have not tried any of the illegal drugs (Hakkarainen et al. 2004, Piispa et al. 2005). This is shown, for example, by the fact that when Finnish material for the 2003 IREFREA study was collected in Turku, it was difficult to find enough people for the target group (Kuussaari 2003, 348–353).

14.3. Different cultures of recreational drug use

The new party culture and the second drug wave have been compared with the first drug wave and its ideology adopted from the hippie movement. Even though some similarities can be found, the second drug wave lacks the political nature of drug use, the collective expression of social protest and radicalism that were typical of the first drug wave. The protest was replaced by relaxation, momentary escape from everyday life, maximising pleasure, seeking new experiences and socialising with friends. Recreational drug use has been seen as part of the consumer, experience and information society. It has been associated with hedonism, aesthetic values and the shaping of identity as well as with interest in spirituality and the desire to “expand consciousness”. And it emphasises the individual's freedom and responsibility to choose his or her own way to spend free time and experience pleasure without the rules being dictated by others. The importance of the Internet in the spread of recreational drug use should not be underestimated; since the Internet enables anonymous communication, it has a significant role in shaping and maintaining various drug cultures. Within the stimulant culture, people working in IT or the new media have particularly been associated with recreational drug use. Recreational drug users are considered as being well-educated, financially and socially well-off people (Salasuo et al. 2002:155–157; see also Partanen 2002).

It is possible to distinguish three different cultures of drug use within recreational drug use: party culture, i.e. stimulant culture; psychedelic culture, i.e. the so-called expansion of consciousness; and habitual drug use, which refers to ”pot smokers”, i.e. habitual users of cannabis⁹³ The categories have been formed based on the content, primary motives and environments of use, and they are meant to be indicative. They are not strictly defined and different subgroups may overlap. The subgroups may also include different, possibly contradictory cultures. Transitions

⁹³ The descriptions of the cultures of drug use are based on the article *Huumeiden viihdekäyttö ajankuvana [Recreational drug use as a reflection of the spirit of time]* [Salasuo et al. 2002] and partly on the *Huumeet Internetissä ja nuorisokulttuureissa [Drugs on the Internet and in youth cultures]* report [Seppälä et al. 2004, 59–102].

between the cultures may also occur. What is common for all the subgroups is that they have influenced each other. Cannabis is the most common drug in all cultures of drug use. The use of cannabis has become an everyday event and cannabis has become a “general drug” that suits many situations. It is no longer necessarily considered a drug. A typical feature of recreational drug use in Finland is that drugs are mainly used at home or on other private premises. Drug use in public places (clubs, restaurants) is avoided due to the risk of being caught. Drugs are often used either before or after going to a club, in which case people do not have to carry drugs with them.

Habitual users of cannabis, i.e. so-called pot smokers. Habitual users of cannabis, i.e. pot smokers, form the largest and most common subgroup within recreational drug use. This is not a homogenous user group or culture of drug use although according to some users, there is a common pot subculture. Pot smokers mostly use cannabis alone or together with friends. The roots of habitual drug use are in the first drug wave at the end of the 1960s and the beginning of the 1970s. Methods of use vary between different groups and cultures of use. An essential feature is the position of cannabis as the primary substance. Cannabis use may be related to everyday relaxation and intensifying sensations as well as to seeking experiences in special situations. It is part of users’ (overall) way of life and for some it may also be an ideological choice (see also Oinonen 2000).

Party, i.e. stimulant, culture. When recreational drug use has been discussed in public, most attention has probably been paid to party culture, i.e. stimulant culture, which has also been called rave or techno culture. Ecstasy and amphetamine are the most popular drugs within party culture; cannabis and to some extent “gamma” (GHB, Gamma Hydroxy Butyrate) are also used. Cocaine is quite rare in Finland and it is very expensive compared with amphetamine. Cocaine has only occasionally been available on the Finnish drug market. People use stimulants for partying, relaxation and hedonism. The use of stimulants is often related to leisure time and weekends and socialising with friends. Party culture is concentrated in restaurants and nightclubs, and dancing plays a significant role. Stimulants are used to intensify the sensations produced by music and dancing. They can also relieve tiredness and give energy for partying and dancing. Private rave parties that were once arranged in warehouses or other such places have been replaced by commercial events (e.g. <http://www.koneisto.com>).

Psychedelic culture, i.e. expansion of consciousness. Psychedelic culture, which has its roots in the ideology of the hippie movement, is the most marginal and invisible subculture within

recreational drug use. Hallucinogens, such as LSD, magic mushrooms and cannabis, play a central role in this culture. Substances circulate mainly among small groups of friends. The availability of LSD has been rather scarce in Finland. Magic mushrooms are grown at home to some extent, although some mushrooms also grow in the wild in Finland. People within the psychedelic culture have contradictory attitudes towards ecstasy. So-called research chemicals are also used to some degree. In psychedelic culture, drug use is related to expanding consciousness, increasing self-knowledge and seeking experiences and also to just having fun. Psychedelic drugs are almost exclusively used on private premises or other quiet places, such as in nature. Even though there may be several very different motives and forms of drug use within psychedelic culture, all users take a common “serious” attitude towards drug use. It can be described as being ideologically important for users; however, considering drug use “religious” is an over-interpretation (see Sjöberg 2005)⁹⁴.

Recreational drug use, risks and social norms

The main risk in using illegal drugs is that the user cannot be sure of the strength, purity or real consistency of a substance. Different substances and methods of use have different risks. A user’s inexperience is also often a risk factor if he or she does not know the right dosage or combined effects of substances or considers some substances harmless. The “official drug information” often differs from experience-based knowledge, i.e. the information provided by other users or found on the Internet (see e.g. Salasuo 2004, Seppälä 1999, Seppälä et al. 2004, Sjöberg 2005). Minimising and anticipating harm and risks are particularly important in recreational drug use, and drug use is controlled by the culture’s own (sometimes publicly unexpressed) norms and social sanctions. The social norms and sanctions within recreational drug use in Finland include not approving intravenous drug use. The use of heroin is publicly disapproved of and heroin users are considered “losers”. (Salasuo et. al. 2002:158–161, Seppälä et al. 2004)

Certain rituals and social norms – “cultural instructions for use” to reduce the risks and harm related to drug use – have been adopted especially by ecstasy users. This has been called the health literacy of the users (Salasuo 2004b; see also Calafat et al. 2001:181–200). Ecstasy-related deaths often attract a lot of attention, even though they are quite rare. In 2000–2004, there were seven deaths caused by ecstasy poisoning in Finland. In these cases, the cause of death was the combined effect of ecstasy and the antidepressant moclobemide. (Vuori 2003, 2005) “Ecstasy

⁹⁴ The use of psychedelic drugs was examined using material (N=38) collected by Sari Sjöberg (2005) in 2002–2004

death” is however a misleading expression and it has been suggested that it should be defined more accurately (EMCDDA 2004a, 37). No official “pill testing” (see e.g. Benschop et al. 2002) of ecstasy tablets is carried out in Finland, but the practise is known among users in Finland.

14.4. Responses to recreational drug use.

Drug policy often aims at a balance between sanctions regulated by drug legislation and treatment measures that improve the life of drug users. Finland is in principle committed to following a strict drug policy. The drug policy currently implemented in Finland can be roughly divided into two different operating models: implementing restrictive drug policy by emphasising penal actions to prevent drug use, and reducing drug-related social and health problems (Tammi 2002; Virtanen 2002; see also Scenario of Finnish Drug Situation 2004 - 2007.).

In Finland, the drug policy aimed at harm reduction has been targeted at problem drug users in particular. Intravenous drug users have been provided with units engaging in needle exchange, hepatitis vaccination and health counselling, and opiate addicts have been offered the opportunity for medical substitution treatment. Harm reduction policy, however, has not included recreational drug use; instead, the traditional restrictive drug policy has been implemented. Decriminalisation of drug use has been discussed from time to time in Finland in connection with the amendment of drug legislation. However there has been a desire to preserve punishment for use as a legal principle measure in the work against drugs.⁹⁵

Drug control

Legislation on drug offences was revised in 1993 with the introduction of the so-called seventh section according to which, sanctions may be waived if the offence is deemed of minor significance in view of the circumstances, not considered as offending general obedience to the law, or if the offender has sought treatment approved by the Ministry of Social Affairs and Health. However, this possibility was used quite rarely and the legislation was not implemented in practice as intended by the legislator (see Kainulainen 1999, Kainulainen 2002).

⁹⁵ See description of the history of Finnish drug legislation in Hakkarainen 1992:131–150, Kainulainen 1999, 2002.

Legislation on drug offences was reformed again in 2001. The possession, acquisition and use of small amounts of drugs became a drug-user offence that did not need to be taken to the District Court. The police can impose a fine immediately at the scene of the crime and the prosecutor later confirms the fine (called the summary penal proceeding practice). It was considered important that a fine should not be imposed automatically. Especially underage (under 18-year-old) first-time offenders should be referred to a multiprofessional (the prosecutor, the police and a representative of social services) hearing and, when needed, to treatment. (see Kainulainen 2005).

The majority of drug offences reported to the police have been cases of use and possession of drugs for personal consumption, which means that there has been the possibility to waive charges. The decision to waive charges has been left to prosecutors. An examination of the general trend for decisions to waive charges from the beginning of 2000 indicates that this practice has rarely been applied. The most common sanction for a drug offence has been a fine. The number of decisions to waive charges has decreased whereas the number of those fined through summary penal proceedings has grown. A study of the decisions to waive charges reveals that the opportunities to arrange hearings for juvenile offenders and the number of treatment referrals have however increased. (Kainulainen 2005; for hearings, see also Scenario of Finnish Drug Situation 2004 - 2007:15–16)

Recreational drug use has been controlled especially by police monitoring and raids. The majority of arrests involved the use of cannabis or the possession of small amounts of drugs. As a sanction, the offenders have mainly been given day-fines based on their income. Their intention has been to give a message that no form of drug use is acceptable in Finland. Supervision has particularly been increased at the music festivals popular among young people. The police have circulated among festival crowds with drug detector dogs, thus aiming at preventing drug use. Raids on events that play techno or other electronic music have been most visible and they have attracted the most publicity. Control measures have also been targeted outside events. However, the highest law enforcement authorities have considered control measures (drug tests, raids with drug detector dogs) targeted e.g. at schools or confirmation camps as illegal or unfounded.

Drug treatment and substance abuse prevention

The increase in recreational drug use has also set new challenges for the drug treatment sector and substance abuse prevention. The harm caused by recreational drug use is somewhat different from the harm related to traditional problem drug use, such as substance addiction, infectious diseases transmitted by dirty needles and syringes (HIV, hepatitis) and committing property offences to finance drug use. The efficiency of “conventional drug education” in the prevention of recreational drug use has also been questioned. At the end of 2001, a 2-year pilot study started in Helsinki. The aim of the study was to find research methods to identify new drug use phenomena quickly (see the study reports of the project: Seppälä 2003, Seppälä et al. 2004).

Drug treatment and social and health services. Only a small number of those who experiment and use drugs face problems. The majority of them only try drugs a few times (Hakkarainen & Metso 2003). No studies have been conducted in Finland on the degree to which recreational drug users use social and health services or the number of acute emergency room visits made due to recreational drug use. Data was gathered through e-mails and interviews from three health care units in Helsinki for the "Huumeet Internetissä ja nuorisokulttuureissa" (Drugs on the Internet and in youth cultures) report. According to the data, cannabis was the most common substance to cause problems. Often, patients did not use their own initiative to seek treatment due to problems caused by cannabis use, but they were coerced into treatment by someone else (school, parents etc.) (Seppälä et al. 2004:103–104; cp. EMCDDA 2004b: 82–92). There were also some mentions of the use of ecstasy and, to lesser extent, other stimulants. Often, the recreational users of these substances only wanted to talk about their drug use with an expert. Sometimes, other problems behind drug use resulted in longer treatment (Seppälä et al. 2004:103–104).

Drug education and substance abuse prevention. Drug education has generally been considered the most important form of anti-drug work (cp. Ehkäisevän päihdetyön ... 2005, p. 16; Scenario of Finnish Drug Situation 2004 - 2007, p. 23–24). Recently, some criticism has been directed at drug education (e.g. Hippi 2001, Soikkeli 2002). When the efficiency of drug education has been evaluated from the perspective of recreational drug use, its main problem has been that the image of drug use provided by drug education does not correspond to the way recreational drug users perceive drug use. It has been suggested that “conventional” drug education should be replaced by so-called two-way education, which besides providing practical information, aims at creating contacts with drug users and the people who deal with the drug phenomenon in their work

(Seppälä et al. 2003). Two-way education does not aim at a total ban on drugs but at the reduction of the risks and harm related to drug use. The Internet has become an important communication channel and discussion forum for drug users, and this has been noted in substance abuse prevention (see Ehkäisevän päihdetyön ... 2005, p.17; see also Piispa 2002a and 2002b).

Anti-drug activities of non-governmental organisations. In Finland, various non-governmental organisations have had a significant role in anti-drug activities, and in addition to the police, some parents' associations, for example, have actively provided drug information (Hakkarainen 1992; see also Ehkäisevän päihdetyön... 2005; Scenario of Finnish Drug Situation 2004 - 2007, p. 24–25).⁹⁶ The Finnish Centre for Health Promotion (<http://www.health.fi>) co-ordinates national organisations that work to prevent substance abuse. The largest and most visible NGOs are the Free from Drugs Association (<http://www.irtihuumeista.fi>), YAD (Youth against Drugs) Finland (<http://www.yad.fi>), Elämä On Parasta Huumetta (Life is the Best Drug) Association (<http://www.elamaonparastahuumetta.fi>) and the Finnish Health Association (<http://www.terveys.fi>). These NGOs primarily focus on substance abuse prevention, drug education, voluntary work and organising various events, and not so much on working to prevent recreational drug use. Many NGOs and anti-drug organisations have dismissed the concept of recreational drug use and considered it morally dubious. The Finnish Association for a Humane Drug Policy (<http://www.hppry.org>), established in 2001, is quite exceptional among the NGOs as it actively promotes the implementation of a drug policy aimed at harm reduction for recreational drug use. Organisations that promote permitting the use of cannabis such as the Finnish Cannabis Association (<http://www.sky.org>) have also participated in the debate on recreational drug use.

Anti-drug campaigns in 2000–2005. Anti-drug campaigns have not been directed at specifically preventing the recreational use of drugs; their intention has been to arouse new kind of drug debate. The Finnish Centre for Health Promotion arranged in 2001–2003 a unique nation-wide campaign against drugs, which included drug information (newspaper, radio and TV advertisements), traditional drug education on the effects of drugs (<http://www.kokototuus.com>) and a discussion forum (<http://www.puolitotuus.com>) on the Internet (see the final report on the campaign by Jallinoja et al. 2003). In addition to alcohol treatment and prevention, the A-Clinic Foundation (<http://www.a-klinikka.fi>) has increasingly focused its activities on general substance

⁹⁶ There are already dozens of anti-drug NGOs and small associations in Finland. Their contribution to the work against drugs is quite varied. Finland's Slot Machine Association (<http://www.ray.fi>) supports the activities of many of these NGOs and associations.

abuse prevention. It maintains AddictionLink (<http://www.paihdelinkki.fi>), which includes the popular discussion forum, Sauna, and provides information on drugs and their effects and the risks related to drug use. Studies have also been published on AddictionLink's discussion forum Sauna and on its users and discussions (Lehmusvaara 2002 and 2004, Piispa 2002a and Piispa 2002b, Roine 2004). YAD started the "Rave Against Drugs" project in 2005 (http://www.yad.fi/esitteet/rad_projekti.htm) aimed especially at recreational drug users, and a decision has been made to make it a permanent part of YAD's activities.

What does the future look like for recreational drug use in Finland?

Both Finnish drug waves have international roots. The new party and techno culture that came along with the second drug wave first spread in Finland quite slowly. The phenomenon expanded and diversified at the end of the 1990s, when it began to incorporate national features and became part of mainstream youth culture. It is likely that international trends will continue to steer the trends for recreational drug use in Finland. If various drug cultures and the Finnish alcohol culture further intertwine in the future, the changes in alcohol culture and policy may also be reflected in the trends for recreational drug use.

In Finland, recreational drug use has primarily been prevented by penal sanctions. Monitoring has been carried out especially in public places and targeted at open drug use. It has been claimed that control measures have in fact been directed most severely at those who are socially excluded (Kinnunen 2002). If this is the case, it will be difficult to intervene in recreational drug use or even significantly reduce it by mere police control. It is very difficult, if not impossible, to prevent recreational drug use when it is part of (youth) culture or other international trends, and as regards treatment measures, they cover only a small number of recreational drug users.

According to the most recent studies, drug experimentation and use have taken a downward swing in the 21st century (Hakkarainen et al. 2001 and 2003; see also Hurme 2005:11–12). However it has been estimated that the second drug wave, which began in the 1990s, will not subside in the same way as the first drug wave did; rather, it will become a more permanent phenomenon. Thus, drug use and recreational drug use in particular will become part of our cultural heritage in much the same way as alcohol culture has (Seppälä et al. 2001, Salasuo 2005, Salasuo et al. 2005). The use of cannabis in particular seems to have become established in certain social groups.

15. Bibliography

- Action plan for more efficient drug policies for 2001–2003. Toimenpideohjelma huumausainepolitiikan tehostamiseksi 2001-2003 ja raportti ohjelman toteutumisesta (2003). Sosiaali- ja terveysministeriö, työryhmämuistioita 2003:8. Ks. <http://www.stm.fi/suomi/julkaisu/julk01fr.htm>
- Ahlström, S., Metso, L. & Tuovinen, E-L. (2003). Nuorten juominen vähentynyt - usein humaltuminen ei. Yhteiskuntapolitiikka 68, (6).
- Aira, M. & Tacke, U. (2004). Kuopion yliopistollisen sairaalan huume- ja lääkeriippuvuuspoliklinikan toiminta. Suomen Lääkärilehti 59, (27-29). Ks. <http://www.laakarilehti.fi/sisallys/index.html?nr=27,yr=2004>
- Alcohol Programme 2004 - 2007 (2004). Alkoholiohjelma 2004 - 2007 - työväline alkoholihaittojen ehkäisyyn (2004). Sosiaali- ja terveysministeriön esitteitä 2005:2. Ks. myös <http://www.stm.fi/Resource.phx/hankk/hankt/alkoholi2004/index.htm>
- Alcohol Programme for 2000s (2000). Alkoholiohjelma 2000-luvulle (2000) - yhteistyötä ja vastuuta. Työryhmämuistioita 29/2000. Ks. myös <http://pre20031103.stm.fi/suomi/eho/julkaisut/alkoholi/alkoholi.pdf>
- Alcohol Programme 1997 - 2000 (1997). Alkoholiohjelma 1997 - 1999 (1997). Sosiaali- ja terveysministeriön monisteita 14/1997.
- Andersen, S. (2003). Finnish police officers and social workers discussing drugs. Article in Pedersen ed. (2003).
- Annual Report of the Finnish Prison and Probation Services 2004. Kriminaalihoitolaitos. Vuosikertomus 2004. Ks. <http://www.rikosseuraamus.fi/31725.htm>
- A Safer Community - internal security programme (2004). Arjen turvaa – sisäisen turvallisuuden ohjelma (2004). Sisäasiainministeriön julkaisu 44/2004. Ks. myös [http://www.intermin.fi/intermin/biblio.nsf/6999D85A980CD058C2256F180034DCC8/\\$file/442004.pdf](http://www.intermin.fi/intermin/biblio.nsf/6999D85A980CD058C2256F180034DCC8/$file/442004.pdf)
- Boarder Guard Press release 10.3.2005. Poliisi, tulli ja rajavartiolaitos tehostavat yhteistyötään rikollisuuden torjunnassa. Ks. <http://www.rvl.fi/rvl/bulletin.nsf/PFBDArch/092BA519A4C807F5C2256FC00025B58D?opendocument>
- Bothas, H. (2005). Päihdelinkin ekonsultaatio. Verkkokonsultaatiota ammattilaiselta toiselle. A-klinikkasäätiön monistesarja nro 46 / 2005. Ks. http://www.a-klinikka.fi/julkaisut/verkkojulkaisut/ekons_loppurap.pdf
- Bothas, H. (2005a). Lannistaako laki työpaikkojen testausinnostuksen. Teoksessa Raitasalo ym. 2005.
- Brochure of Ministry of Education 2005. See in Finnish: <http://www.minedu.fi/opm/nuoriso/tyopajat.html>
- Crime Trends in Finland 2004. Rikollisuustilanne 2004. Oikeuspoliittinen tutkimuslaitos, julkaisuja 215/2005, Hakapaino Oy, Helsinki. Ks. <http://www.om.fi/optula/31877.htm>
- Crime Trends in Finland 2003. Rikollisuustilanne 2003. Oikeuspoliittinen tutkimuslaitos, julkaisuja 209/2004. Hakapaino Oy, Helsinki. Ks. <http://www.om.fi/optula/2662.htm>
- Customs drug strategy for 2002–2005. Tullin huume-strategia 2002 - 2005. Ks. <http://www.tulli.fi/>

Drug detector dogs at Finnish Customs brochure 2005. Tullin huumekoirat –esite. Tullihallitus 2005. Ks. myös http://www.tulli.fi/fi/07_Tulli_tutuksi/07_Tullin_huumekoirat/Tullin_huumekoirat05.pdf

Drug policy action programme 2004 - 2007. See Government decision in principle ..(2004)

Drug Policy Report of 2004. Huumausainepoliitiikan kertomus 2004. Huumausainepoliittinen koordinaatioryhmä, sosiaali- ja terveysministeriön monisteita 2005:5. Ks. myös <http://www.stm.fi/Resource.phx/publishing/store/2005/05/cd1115725946243/passthru.pdf>

Drug strategy 1997. Huumausainestrategia 1997 (1998): Huumausainepoliittisen toimikunnan mietintö. Komiteamietintö 1997:10. Oy Edita Ab, Helsinki Ks. <http://pre20031103.stm.fi/suomi/eho/julkaisut/huumeistr/sisally1.htm>

Ehkäisevän päihdetyön järjestöjen huumausainepoliittinen mietintö 2005. Terveyden edistämisen keskus: Helsinki. http://www.health.fi/timage.php?i=60&f=2&name=huumausainepoliittinen_mietinto.pdf

EMCDDA 2002a. Huumeiden käyttäjät ja lainsäädäntö EU:ssa. Teemana huumeet –Tilannekatsaus no. 2. <http://www.emcdda.eu.int/index.cfm?fuseaction=public.Content&nNodeID=439&sLanguageISO=EN>

EMCDDA 2002b. Huumeiden viihdekäyttö – keskeinen haaste EU:lle. Teemana huumeet – Tilannekatsaus no. 6. <http://www.emcdda.eu.int/index.cfm?fuseaction=public.Content&nNodeID=439&sLanguageISO=EN>

EMCDDA 2004a. Huumeongelma Euroopan Unionissa ja Norjassa. Vuosiraportti 2004. Euroopan huumausainepoliittisen seurantakeskus: Lissabon. <http://annualreport.emcdda.eu.int/download/ar2004-fi.pdf>

EMCDDA 2005. Youth Media. Thematic Papers. European Monitoring Centre for Drugs and Drug Addiction, Lisbon. <http://www.emcdda.eu.int/index.cfm?fuseaction=public.Content&nNodeID=7079&sLanguageISO=EN>

Evaluation of Basic Services (2004). Lääninhallitusten keskeiset arviot peruspalvelujen tilasta 2004. Sisäasiainministeriön julkaisut 19/2005. ks. <http://www.intermin.fi/julkaisu/192005>

Finnish Customs – Annual Report 2005. Suomen Tulli. Vuosikertomus 2004. Ks. http://www.tulli.fi/fi/04_Julkaisut/08_Vuosikertomukset/vuosikertomus_2004_fi.pdf

Finnish Parliament Documents 2004 - 2005. Suomen Eduskunta - valtiopäiväasiat (2005). Ks. <http://www.eduskunta.fi>

Forssén, T. (2005). Kun ylläpitohoito päiväkeskukseen tuli. Tiimi 5 / 2005

Forssén, T. (2005a). Huumehoidon asiantuntijuuden rakentuminen päiväkeskuksessa. Stakes raportteja 1/2005. Ks. myös <http://www.stakes.fi/verkkojulk/pdf/rap05/Ra1-2005.pdf>

Government decision in principle on Drug Policy Action Programme in Finland 2004-2007 (2004). Valtioneuvoston periaatepäätös huumausainepoliittisesta toimenpideohjelmasta vuosille 2004 - 2007 (2004). Sosiaali- ja terveysministeriön julkaisuja 2004:1. Ks. myös <http://www.stm.fi/Resource.phx/publishing/store/2004/02/ad1075981306613/passthru.pdf>

Government decision in principle to enhance drug policy 2001 - 2003 - follow up report (2003). Toimenpideohjelma huumausainepoliitiikan tehostamiseksi 2001 -2003 ja raportti ohjelman toteutumisesta (2003). Sosiaali- ja terveysministeriö, työryhmämuistioita 2003:8. Ks. <http://www.stm.fi/suomi/julkaisu/julk01fr.htm>

- Hakkarainen, P. (1992). Suomalainen huumeekysymys. Huumausaineiden yhteiskunnallinen paikka Suomessa toisen maailmansodan jälkeen. Alkoholitutkimussäätiön julkaisuja no. 42. Alkoholitutkimussäätiö: Helsinki.
- Hakkarainen, P. & Metso, L. (2001). Onko huumeiden käytön yleistymisen taittumassa? – Vuoden 2000 huumeekyselyn tulokset. Yhteiskuntapolitiikka vol. 66 (3), s. 277–283.
- Hakkarainen, P. & Metso, L. (2003). Huumeiden käytön uusi sukupolvi. Yhteiskuntapolitiikka vol. 68 (3), s. 244–256.
- Hakkarainen, P. & Metso, L. (2004). Suomalaisten suhtautuminen huumeisiin ja huumeisiin. Mielenpitoet ja asenteet väestössä 2002. Yhteiskuntapolitiikka 69, (1)
- Hakkarainen, P. & Metso, L. (2005). Märkä pilvi ja vuosi 2004. Yhteiskuntapolitiikka 70 (2005): 3.
- Halmeaho, M. & Nuorvala, Y. (2005). Korvaushoito niveltyneen hyvin Nurmijärven terveyskeskukseen. Tiimi 2 / 2005. Ks. myös <http://www.a-klinikka.fi/tiimi/>
- Harju, O. (2004). Piikkikoukku - mitä ilmiön takana. Tiimi 1/2004. Ks. <http://www.a-klinikka.fi/tiimi/>
- HBSC (2003). Young people's health in context. Health Behaviour in School-aged Children study: international report from the 2001/2002 survey. Ks. Chapter 2, page 88. http://www.euro.who.int/eprise/main/who/InformationSources/Publications/Catalogue/20040601_1
- Heikkilä K. (2005). Rankkaa hoitoa vai hoivaa tukevaa rakennetta? Kiskon klinikan maineen problematiikkaa. Tiimi 1 / 2005.
- Heikkilä, M. & Roos, M. toim. (2004). Sosiaali- ja terveydenhuollon palvelukatsaus 2005. Sosiaali- ja terveysalan tutkimus ja kehittämiskeskus, Gummerus kirjapaino, Saarijärvi 2004
- Heinänen, M. (2005). Tulevaisuus - "Budusheje". Viipurin alueen ehkäisevän päihdetyön projekti 2002 - 2003. Loppuraportti. Helsingin kaupungin sosiaalivirasto, selvityksiä 2004:7. Ks. http://www.hel.fi/sosv/julkaisu/selvitykset/2005/07_tulevaisuus.pdf
- Helakorpi, S., Patja, K., Prättälä, R. & Uutela, A. (2005). Suomalaisten aikuisten terveystietoisuuden ja terveys, Kevät 2005. Kansanterveyslaitoksen julkaisuja B, 18/2005. Ks. http://www.ktl.fi/attachments/suomi/julkaisut/julkaisusarja_b/2005/2005b18.pdf
- Hietaniemi, T. & Korpisaari, H. (2005). Rikosten ehkäisy järjestäytyneen rikollisuuden torjunnassa. Järjestäytyneen huumauserikollisuuden toimintatavat ja ennaltaehkäisyyn mahdollisuudet 1990-luvun lopun Suomessa. Teoksessa Hietaniemi, T. toim. (2005)
- Hietaniemi, T. toim. (2005): Rikostutkimus 2003 - 2004 -vuosikirja. Keskusrikospoliisi. Ks. [http://www.poliisi.fi/poliisi/krp/home.nsf/files/Rikostutkimus_2003-2004/\\$file/Rikostutkimus_2003-2004.pdf](http://www.poliisi.fi/poliisi/krp/home.nsf/files/Rikostutkimus_2003-2004/$file/Rikostutkimus_2003-2004.pdf)
- Hietaniemi, T. (2004a). Tilastotietoja huumauserikoksista 2003. Keskusrikospoliisin rikostietopalvelu.
- Hietaniemi, T. (2004). Huumauserikollisuus 2003 - näkymiä 2004. Keskusrikospoliisin rikostietopalvelu, heinäkuu 2004.
- Hippi, K. (2001). Päihdevalistusprojektisuunnitelmien arviointia. STM:n ja RAY:n vuonna 1998 rahoittamat projektit. Sosiaalipolitiikan lisensiaatin tutkielma. Turun yliopisto: Turku.
- Holmila, M., Karlsson, T. & Raitasalo, K. (2005). Alaikäisten alkoholistot. Yhteiskuntapolitiikka vol. 70 (3): 305–310.

- Honkatukia P. (2005). Naiset rikoksen tekijöinä ja uhreina. Teoksessa Rikollisuustilanne 2004
- Huohvanainen, M. (2005). Peruskuolemansyyrekisteristä huumeepoiminta EMCDDA:n kriteerien GMR(b) mukaan. Tilastokeskus. Ks. poimintaehdot <http://www.emcdda.eu.int/?nnodeid=1419>
- Hirvola, M. (2004). Tutkittua tietoa nuorten suhtautumisesta huumeisiin. Myötaote 4/2004. Ks. http://www.elamantapaliitto.fi/muut/MYOTIS04_4_NETTI.pdf Ks. myös <http://www.minedu.fi/nuora/julkaisut/barometri2004.pdf>
- Huhtanen P. & Metso L. (2005). Erillisajot huumeita koskevista väestökyselyistä 1992 - 2004.
- Hurme, T. toim. (2005). Huumeainepolitiikan kertomus vuodelta 2004. Sosiaali- ja terveysministeriön monisteita 2005:5. Ks. <http://www.stm.fi/Resource.phx/publishing/store/2005/05/cd1115725946243/passthru.pdf>
- Huumeiden viihdekäytöstä puhuminen on kevytmielistä. Pääkirjoitus. Helsingin Sanomat 11.5.2003.
- Hypen, Kimmo (2004a). Vankilasta vuosina 1993 – 2004 vapautuneet ja vankilaan uudestaan palanneet. Rikosseuraamusviraston julkaisuja 1/2004.
- Hypen, K. (2004). Tilastotietoja vankiloiden huumeasiakkaista. Oikeusministeriö, vankeinhoitolaitos, 2004.
- Hännikäinen-Uutela, A-L. (2004). Uudelleen juurtuneet. Yhteisökasvatuksella lupaavia tuloksia narkomaanien kuntoutuksessa. Jyväskylä Studies in Education Psychology and Social Research 252. Ks. <http://selene.lib.jyu.fi:8080/vaitos/studies/studeduc/9513919323.pdf>
- Infectious diseases in Finland 2004. Tartuntataudit Suomessa 2004. KTL B12 / 2005. Ks. myös http://www.ktl.fi/portal/suomi/julkaisut/julkaisusarjat/kansanterveyslaitoksen_julkaisuja_b/
- Infectious diseases in Finland 2003. Tartuntataudit Suomessa 2003. KTL B7 / 2004. Ks. myös http://www.ktl.fi/portal/suomi/julkaisut/julkaisusarjat/kansanterveyslaitoksen_julkaisuja_b/
- Internal Security Programme 2005–2015 (2004). Sisäisen turvallisuuden seurannan järjestäminen. Kansliapäällikköryhmän ehdotus. Sisäasianministeriön julkaisut 12 / 2005. Ks. [http://www.intermin.fi/intermin/biblio.nsf/72738DD9DF91ABBAC2256FE9003970AB/\\$file/122005.pdf](http://www.intermin.fi/intermin/biblio.nsf/72738DD9DF91ABBAC2256FE9003970AB/$file/122005.pdf)
- Intoxicant strategy of Prison Service I (1999). Vankeinhoitolaitoksen päihdestrategia. Osa I. Toimintaohje vuosille 1999-2001. Oikeusministeriön ohje 27.1.1999. Ks. <http://www.vankeinhoito.fi/4890.htm>
- Intoxicant strategy of Prison Service II (2001). Vankeinhoitolaitoksen päihdestrategia Osa II. Päihdevalvonnan käsikirja (2001). Ks. <http://www.vankeinhoito.fi/4890.htm>
- Intoxicant strategy of Prison Service III (2001). Vankeinhoitolaitoksen päihdestrategia Osa III. Päihdeinfo (2001). Ks. <http://www.rikosseuraamus.fi/4890.htm>
- Jallinoja, P., Helakorpi, S. & Uutela, A. (2004). Huumekontaktit, huume mielipiteet ja valtakunnallisen huumeviestintäkampanjan havaittavuus. Tutkimus aikuisista suomalaisista. Kansanterveyslaitoksen julkaisuja B 1 / 2004. Edita, Helsinki. Ks. http://www.ktl.fi/portal/suomi/osastot/epidemiologia_ja_terveyden_edistaminen/julkaisut/

Jallinoja, P., Piispa, M. & Tigerstedt C. (2003). Koko totuus huumeekampanjasta. Valtakunnallisen hankkeen arviointi. Terveyden edistämisen keskuksen julkaisuja 10/2003. Terveyden edistämisen keskus: Helsinki. <http://www.health.fi/timage.php?i=109&f=1&name=Huumeekampanja.pdf>

Jokinen, P. (2005). Terveysneuvontapisteissä keskustellaan monista aiheista. Tiimi 2/2005. Ks. <http://www.a-klinikka.fi/tiimi/205/tervneuv.html>

Järvenkylä, V. (2004). Päihdepsykiatrisen työn kehittäminen Pirkanmaan sairaanhoitopiirin alueella. Seurantatutkimus huumeapotilaiden hoitoon sitoutumisesta. Pirkanmaan sairaanhoitopiirin julkaisuja 6/2004.. Ks. http://www.pshp.fi/tuty/julkaisu/2004/2004_6.pdf

Kainulainen, H. (2005). Päihde- ja dopingrikokset. Teoksessa Rikollisuustilanne 2004

Kainulainen, H. & Kinnunen, A. (2004). Päihderikokset. Kirjassa Rikollisuustilanne 2003. Ks. <http://www.om.fi/optula/2662.htm>

Kainulainen, H. (2004). Seuraamuskäytäntö humausainerikoksissa. Kirjassa Rikollisuustilanne 2003. Ks. <http://www.om.fi/optula/2662.htm>

Karjalainen, P. & Blomgren, S. (2004). Oikorata vai mutkatie? Sosiaalista kuntoutusta ja työelämäpolkuja nuorille. FinSoc, Arviointiraportteja 2/2004. Ks. <http://www.stakes.fi/finsoc/julkaisut/sarjat/ar/Nuotta.pdf>

Karsikas, V. (2004). Ulkopuolisessa kuntoutuksessa olleiden seuranta. Julkaisematon muistio, Rikosseuraamusvirasto 23.8.2004.

Karsikas, V. & Sunimento, K. (2004). Vankien sijoitus ulkopuoliseen laitokseen vuonna 2003. Rikosseuraamusviraston monisteita 9/2004. Ks. <http://www.rikosseuraamus.fi/27372.htm>

Kaukonen, O. (2005). Torjunta vai poisto. Päihdepalvelujen kehitys laman jälkeen. Yhteiskuntapolitiikka 70 (2005):3

Kekki, T. (2004a). Poliisin ja Paussin naapuruussuhde Sorinkadulla. Poliisin ja sosiaalitoimen yhteistyö huumeekysymyksessä. Tampereen huumeepilotin 3. raportti. Tampereen sosiaali- ja terveystoimen tutkimuksia 2/2004. Ks. [http://www.poliisi.fi/intermin/images.nsf/files/31EB6DCB1DCDAE48C2256EA8002F3754/\\$file/sospo.pdf](http://www.poliisi.fi/intermin/images.nsf/files/31EB6DCB1DCDAE48C2256EA8002F3754/$file/sospo.pdf)

Kekki, T. (2004). Ei kauhealla väännöllä vaan kipinän saaneena. Matalan kynnyksen kehittämishanke vaihtoehdoisen tuen ja muumekuntoutuksen tarjoajana. Tampereen huumeepilotin 2. raportti. Tampereen kaupungin sosiaali- ja terveystoimen tutkimuksia 1/2004. Ks. [http://www.poliisi.fi/intermin/images.nsf/files/75DC0B406290FF21C2256EA8002E0AA7/\\$file/matala.pdf](http://www.poliisi.fi/intermin/images.nsf/files/75DC0B406290FF21C2256EA8002E0AA7/$file/matala.pdf)

Kinnunen A., Perälä R. ja Telkkä T. (2004). Poliisin huumevalvontaprojekti pääkaupunkiseudulla. Seurantatutkimus. Luonnos 21.9.2004. Poliisiammattikorkeakoulu.

Kivivuori, J. & Salmi, V. (2005). Nuorten rikoskäyttäytyminen 1995 - 2004. Oikeuspoliittinen tutkimuslaitos, julkaisuja 214 / 2005. <http://www.om.fi/optula/31515.htm>

Korteniemi, P. (2004). Mikä palveluohjauksessa toimi, kenen kohdalla ja missä olosuhteissa? Helsingin kaupungin sosiaalivirasto, Tutkimuksia 2004:1. Ks. myös <http://www.hel2.fi/sosv/julkaisu/tutkimuksia/2004/Palveluohjausloppuraportti.pdf>

Koskinen, T & Puustinen, L. (2005). Miksi varusmiespalvelu keskeytyy? Seuranta Kuopion sotilasläänin alueella 1993 - 2003. Suomen lääkirilehti 2/2005. Ks. myös <http://www.laakarilehti.fi/>

- Koskivuori, S. & Nurmi, H. (2004). Raskaana olevan huumeidenkäyttäjän hoito- ja yhteistyökäytännöt Riihimäellä. Tiimi 3-4/2004.
- Kuussaari, K. (2003). Fieldwork Report. Teoksessa Calafat, A. et al. (eds.) Enjoying the Nightlife in Europe. The Role of Moderation. Sonar Project/IREFREA: Valencia, s. 348–353.
- Lehmusvaara, L. (2002). Sauna on haittojen vähentämistä. Tiimi vol. 38 (2), s. 17–20
- Lehmusvaara, L. toim. (2004). Päihdelinkki III. Vuosien 2000 - 2003 kehittämissuorituksen loppuraportti. A-klinikkasäätiö. Ks. http://www.a-klinikka.fi/julkaisut/verkkojulkaisut/plinkki00_03.pdf
- Lehti, M. & Kivivuori, J. (2004). Väkivaltarikoksista epäiltyjen päihtymys. Kirjassa Rikollisuustilanne 2003. Ks. <http://www.om.fi/optula/2662.htm>
- Lillsunde, P. (2005). Ennakkotiedot vuoden 2004 huumelöydöksistä tieliikenteessä. Kansanterveyslaitoksen huumelaboratorio.
- Linnakangas, R. & Suikkanen, A (2004). Varhainen puuttuminen - mahdollisuus syrjäytymisen ehkäisyyn. Sosiaali- ja terveysministeriön selvityksiä 2004:7. Ks. <http://www.stm.fi/Resource.phx/publishing/store/2004/05/hu1083758936712/passthru.pdf>
- Luopa, P., Räsänen, M, Jokela, J. & Rimpelä, M. (2005). Kouluterveyskyselyn valtakunnalliset tulokset vuosina 1999 - 2004. Stakes, Aiheita 12/2005. Ks. <http://www.stakes.fi/verkkojulk/pdf/aiheita/Aiheita12-2005.pdf>
- Luopa, P., Sinkkonen, A., Jokela, J., Ojajärvi, A & Räsänen, M. (2004). Nuorten hyvinvointi ja terveys 2000, 2002 & 2004 - osaraportit pääkaupunkiseudulta, Etelä-Suomesta, Itä-Suomesta ja Lapin läänistä. Ks. <http://www.stakes.fi/kouluterveys/julkaisu/raportit.htm>
- Lähteenmaa, J. (2004). Nuorisokulttuuri ja alkoholi 2000-luvun alun Suomessa: lievää käännettä humala- ja alkoholikielteisyyteen ja sen tulkintaa. Teoksessa Tommi 2004. Alkoholi- ja huumeetutkimuksen vuosikirja. Alkoholi- ja huumeetutkijain seura ry: Helsinki, s. 27–36.
- Majava, A. (2004). Onko huumeidenvastaiselle valistuksella tulevaisuutta? Tiimi 3/2004. Ks. <http://www.a-klinikka.fi/tiimi/>
- Malin K. & Holopainen A. & Tourunen J (2004). "Mä käytän subua, että mä pysyn terveenä ja pystyn toimimaan". Käyttäjän kokemuksia ja näkemyksiä buprenorfiinin käytöstä. Julkaisematon käsikirjoitus A-klinikkasäätiön haastattelututkimuksesta elokuussa 2004.
- Malin, K., Partanen, A., Holmström, P. & Holopainen, A. (2004). Apteekkien ja terveysneuvontapisteiden yhteistyötä kannattaa kehittää. Tiimi 5/2004. Ks. <http://www.a-klinikka.fi/tiimi/>
- Marttunen, M. & Kivivuori, J. (2005). Nuorisoriikollisuus. Teoksessa Rikollisuustilanne 2004.
- Memorandum of the Contractual trial Committee, 2002. Sopimushoitotoimikunnan mietintö (2002): Laki sopimushoidon kokeilemisesta. Oikeusministeriö, komiteamietintö 2002:3. Edita Publishing Oy, Helsinki. Ks. <http://www.om.fi/17478.htm>.
- Metso, L. (2004a). Erillisajo Stakesin vuoden 2003 päihdetapauskennasta.
- Metso, L. (2004). Erillisajo Stakesin vuoden 2003 ESPAD-koululaiskyselystä.
- Metsäpelto, L. (2003). Syyttäjän näkökulma huumeiden ongelmakäyttäjien hoitoon. Tiimi 6/2003. Ks. myös <http://www.a-klinikka.fi/tiimi/>

- Miller, T. (1991). *The Hippies and American Values*. University of Tennessee Press: Knoxville, TN.
- Mokka, R. (2003). *Konemusiikin ystävät 2003*. Helsingin Sanomien viikkoliite NYT no. 30 (25.-31.7.2003).
- Muiluvuori M. (2004). *Tilastotietoja vankiloista EMCDDA:n tilastotauluun 10*. Oikeusministeriö, Vankeinhoitolaitos, 2004.
- Mäkelä, M., Nieminen, J. & Törmä, S. (2005). *Hoito ja palvelujärjestelmän kynnykset päihdeongelmaisten kannalta*. Pikassos OY & Sosiaalikehitys Oy. Ks. http://www.stakes.fi/neuvoa-antavat/tutkimus/Kynnysraportti_2005.pdf
- National Bureau of Investigation (2004). *Keskusrikospoliisi: Huumausainerikokset ja takavarikot Suomessa 2004*.
[http://www.poliisi.fi/poliisi/krp/home.nsf/files/huumausainerikokset_2004/\\$file/huumausainerikokset_2004.pdf](http://www.poliisi.fi/poliisi/krp/home.nsf/files/huumausainerikokset_2004/$file/huumausainerikokset_2004.pdf)
- National Bureau of Investigation (2005). *KRP 2005: Keskusrikospoliisin huumetietopalvelun tilastoja vuodelta 2004*.
- Niskanen, M. & Nummi, M. (2004). *Erityispalveluja hiv-positiivisille huumeiden käyttäjille*. Viesti 6/2004.
ks. <http://www.hdl.fi/julkaisut/viesti62004.pdf>
- Niskanen, T. (2005). *Tilastotietoja huumetuomioista tuomioistuinrekisteristä*. Tilastokeskus.
- Nuorvala Y. & Metso L. & Kaukonen O. & Haavisto K. (2004). *Muuttuva päihdeasiakkuus. Päihdetapauskennat 1987-2003*. *Yhteiskuntapolitiikka* 69, (6). (Artikkeli painossa)
- Nuorvala, Y. & Metso, L. (2004b): *Päihdepalvelut*. Artikkeliteoksessa Heikkilä ym. (2004).
- Oinonen, T. (2000). *Kannabiksen käyttö nuorten aikuisten päihdekulttuurina*. *Nuorisotutkimus* vol. 20 (1), s. 32–42.
- Pakkasvirta, T. (2004). *Luoteis-Venäjän päihdetilanteesta*. *Myötäote* 4 / 2004.
- Parker, H., Aldridge, J. & Measham, F. (1998). *Illegal Leisure. The Normalization of Adolescent Recreational Drug Use*. Routledge: London.
- Partanen, A. (2005). *Julkaisematon yhteenveto terveysneuvontapalvelujen toiminnasta 2004*: Stakes.
- Partanen, A, Uutela, P. & Virtanen, A. (2004). *Päihdehuollon huumeasiakkaat 2003*. Stakes, Tiedonantajapalaute 12 / 2004. Ks. <http://www.stakes.info/2/6/2,6,4.asp>
- Partanen, A., Holmström, P. Holopainen, A. & Perälä, R. (2004b). *Piikkihuumeiden käyttäjät Riskitutkimuksessa Buprenorfiinin pistäminen yleistynyt huumeiden sekakäytössä*. *Suomen Lääkärilehti* 59, (39).
Ks. http://www.laakarilehti.fi/sisallys/index.html?nr=39_yr=2004
- Partanen, J. (2002). *Huumeet maailmalla ja Suomessa*. Teoksessa Hakkarainen, P. ja Kaukonen, O. (toim.) *Huumeiden käyttäjä hyvinvointivaltiossa*. Gaudeamus: Helsinki, s. 13–37.
- Partanen, J. & Metso L. (1999). *Suomen toinen huumeaalto*. *Yhteiskuntapolitiikka* vol. 64 (2), s. 143–149.

- Partanen, P., Hakkarainen, P., Holmström, P., Kinnunen, A., Leinikki, P., Partanen, A., Seppälä, T., Virtanen, A. & Vätkki, J (2004). Amfetamiinien ja opiaattien ongelmakäyttö Suomessa 2002. Yhteiskuntapolitiikka 69 (3).
- Peltoniemi, T. (2004). Toimittajien päihdekoulutus - Päihdetiedotusseminaarien 20-vuotinen taival. A-klinikkasäätiön monistesarja 38 / 2004. Ks. <http://www.a-klinikka.fi/julkaisut/verkkojulkaisut/pts20v.pdf>
- Perkiö, M. & Simula, H. (2004). Tampereen matalan huumehoitomalli. Tiimi 6 / 2004. Ks. <http://www.a-klinikka.fi/tiimi/>
- Piispa, M. (2002a). Jätetäänkö nettikeskustelut huumeista liberaaleille? Tiimi vol. 38 (2), s. 12–13.
- Piispa, M. (2002b). Nettikeskustelut huumeista liberaalien leirinä. Tiimi vol. 38 (6), s. 15–17.
- Piispa, M., Jallinoja, P., Helakorpi, S. & Uutela, A. (2005). Huumekontaktit, huumemielipiteet, huume kampanja. Tutkimus aikuisista suomalaisista vuonna 2004. Kansanterveyslaitoksen julkaisuja B1/2005. Kansanterveyslaitos: Helsinki. http://www.ktl.fi/attachments/suomi/julkaisut/julkaisusarja_b/2005/2005b1.pdf
- Pirkola, S & Wahlbeck, K. (2004). Huumausaineisiin liittyvien ja samanaikaisten muiden mielenterveyshäiriöiden takia toteutuneet sairaalahoidot. Suomen Lääkärilehti 59, (15-16).
- Pohjolainen, L. (2004). Päihdehuollon asumiskurssi - keino vastata asumisongelmiin. Tiimi 3-4 / 2004. Ks. <http://www.a-klinikka.fi/tiimi/arkisto/3404/asumis.html>
- Policy statement issued by the Finnish Society of Addiction Medicine (2005). Päihdelääketieteellisen yhdistyksen huume poliittinen kannanotto (2005). Ks. http://www.terveysportti.fi/kotisivut/sivut.koti?p_sivusto=65
- Presentation of the Girls' House (2005). Tyttöjen talon esittely (2005). ks. <http://nuoriso.hel.fi/mitaVoitTehdaJaMissa/kohdennettuNuorisotyö/tyttöjenTaloJaTyttötyö.php>
- Presentation of the Drop-in Centre for Homeless Women (2005)..Asunnottomien naisten tukipisteen esittely 2005: Ks. <http://www.hdl.fi/asumispalvelut/tukipistesalli.htm>
- Programme of the Finnish Government lead by Matti Vanhanen. Pääministeri Matti Vanhasen hallituksen ohjelma 24.6.2003. Ks. <http://www.valtioneuvosto.fi/vn/liston/base.lsp?r=696&k=fi>
- Project on drug treatment for people who have been excluded from services (2003).Palvelujen ulkopuolelle jääneiden huumeongelmaisten hoito-projekti - yhteenveto vuodelta 2003. Helsingin diakonissalaitos, 2003.
- Puro, P. (2005). HIV-tartuntatautiriskien vähentäminen painopisteenä lähialueyhteistyössä. Kvartti 1/05. Ks. <http://www.hel2.fi/tietokeskus/kvartti/2005/HIV-tartuntariskien.pdf>
- Raitanen, M. (2005). Voitto kotiin. tutkimus ennalta ehkäisevän päihdetyön voitto kotiin -projektista. Nuorten Puolesta ry. Nuorisotutkimusvertosto/Nuorisotutkimusseura, verkkojulkaisuja 2005. Ks. http://www.nuorisotutkimusseura.fi/tiedoston_katsominen.php?dok_id=107
- Raitasalo, K-M., Alho, H., Lindeman, J., Roine, R. & Tigerstedt, C. toim. (2005). Tommi 2005. Alkoholi- ja huume tutkimuksen vuosikirja. Alkoholi- ja huume tutkimus seura ry. Karisto Oy, Hämeenlinna 2005. Ks. http://www.stakes.fi/neuvoa-antavat/julkaisut/Tommi_2005.pdf
- Rantala, K. (2004a). Onko nykykeinoista vankilakierteen katkaisuun? Haaste 3/2004. Ks. <http://www.om.fi/haaste/27961.htm>

- Rantala, K. (2004). Vankilasta vapautuvat huumeiden käyttäjät: sosiaalinen ongelma? Uusintarikollisuuden vähentäminen yksilökohtaisella työotteella ja verkostoituen. Tampereen huumeepilotin 4. raportti. Tampereen sosiaali- ja terveystoimen tutkimuksia 3/2004. Ks. [http://www.poliisi.fi/intermin/images.nsf/files/ABAE95FC516B3A2FC2256EA8002FA8BD/\\$file/vv-raportti040602.pdf](http://www.poliisi.fi/intermin/images.nsf/files/ABAE95FC516B3A2FC2256EA8002FA8BD/$file/vv-raportti040602.pdf)
- Rantala, K. (forthcoming in 2004a). Drug prevention as coordination: the vicious circle of devolving responsibility in primary prevention. Forthcoming in *Drugs: education, prevention and policy*.
- Report of the committee for preventing drug use among young people (2000). Nuorten huumeiden käytön ehkäisyoimikunnan mietintö (2000). Sosiaali- ja terveysministeriö, Komiteamietintö 2000:3. Oy Edita Ab, Helsinki. Ks. <http://pre20031103.stm.fi/suomi/eho/julkaisut/ehosisallys23.htm>
- Report on the status of crime investigation project (2003). Rikostutkinnan tila -selvityshanke. Sisäasiainministeriön poliisiosasto, julkaisusarja 4 / 2003. Ks. [http://www.intermin.fi/intermin/biblio.nsf/226B9362C33C4096C2256CD2002C9438/\\$file/4-2003.pdf](http://www.intermin.fi/intermin/biblio.nsf/226B9362C33C4096C2256CD2002C9438/$file/4-2003.pdf)
- Rimpelä, A., Lintonen, T., Pere, L., Rainio, S. & Rimpelä, M. (2003). Nuorten terveystapatutkimus 2003. Tupakkatuotteiden ja päihteiden käytön muutokset 1977 - 2003. Stakes, Aiheita 13/2003. Ks. <http://www.stakes.fi/verkkojulk/pdf/Aiheita13-2003.pdf>
- Rimpelä, M., Ojajarvi, A., Luopa, P. & Kivimäki, H. (2005). Kouluterveyskysely, kouluterveydenhuolto ja terveystieto. Perusraportti kyselystä yläkouluille ja terveyskeskuksille. Stakes, työpapereita 1 / 2005. Ks. <http://www.stakes.fi/kouluterveys/raportointi/tyopapereita0105.pdf>
- Roine, M. (2004). Huumeidenkäytön merkitykset internetin keskusteluryhmässä. Diskurssianalyttinen tapaustutkimus A-klinikkasäätiön Päihdelinkin Sauna-foorumista. A-klinikkasäätiön monistesarja nro 39. Ks. www.a-klinikka.fi/julkaisut/verkkojulkaisut/saadiskurssi.pdf
- Rokka, A-M. (2004). Anjalankosken Nuorten juttu -projektin (2000 - 2003) loppuraportti. A-klinikkasäätiön monistesarja 41. Ks. http://www.a-klinikka.fi/julkaisut/verkkojulkaisut/nuorten_juttu.pdf
- Romppainen, P. & Saunio, A-L. (2004). Verkkopohjaisesta oppimisympäristöstä tukea kehittämistyöhön? Kokemuksia ehkäisevän päihdetyön perusteet -verkkokurssista. Stakes, Aiheita 21/2004.
- Salaspuro, M., Kiiänmaa, K. & Seppä, K. (toim.) (2003). Päihdelääketiede. Kustannus Oy Duodecim, Gummerus kirjapaino Oy, Jyväskylä.
- Saari, M. & Vesterbadka, H. (2005). Nuorten talo -projektin (2002 - 2004) loppuraportti A-klinikkasäätiön monistesarja nro 47 / 2005. Ks. http://www.a-klinikka.fi/julkaisut/verkkojulkaisut/nuorten_talo.pdf
- Salasuo, M. (2003). Tajunnan kumous – ensimmäinen huumeaalto. Teoksessa Peltonen, M., Kurkela, V. ja Heinonen, V. (toim.) *Arkinen kumous. Suomalaisen 60-luvun toinen kuva*. SKS: Helsinki, s. 84–109.
- Salasuo, M. (2004a). Ekstaasin jäljillä – MDMA:n eli ekstaasin historia ja leviäminen länsimaiseen nuorisokulttuuriin. *Sosiaalilääketieteellinen aikakauslehti* vol. 41 (1), s. 71–84.
- Salasuo, M. (2004b). Ekstaasin käyttäjien terveyden lukutaito – riskien ja haittojen tunnistaminen, ehkäisy ja vähentäminen. *Nuorisotutkimus* vol. 22 (1), s. 30–42.
- Salasuo, M. (2004c). Huumeet ajankuvana. Huumeiden viihdekäytön kulttuurinen ilmeneminen Suomessa. Stakesin tutkimuksia 149. Stakes: Helsinki.
- Salasuo, M. (2004d). Muuttuvat ekstaasimarkkinat – käytön leviäminen, markkinoiden muotoutuminen ja torjunnan haasteet. Teoksessa *Rikostutkimus 2003–2004*. Julkaisija Keskusrikospoliisi: Vantaa, s. 27–55.

- Salasuo, M. (2005). Huumeaallot sukupolvi-ilmiöinä. Teoksessa Tommi 2005. Alkoholi- ja huume tutkimuksen vuosikirja. Alkoholi- ja huume tutkimus seura ry: Helsinki, s. 75–86.
- Salasuo, M. & Rantala K. (2002). Huumeiden viihdekäyttö ajankuvana. Teoksessa Hakkarainen, P. ja Kaukonen, O. (toim.) Huumeiden käyttäjä hyvinvointivaltiossa. Gaudeamus: Helsinki, s. 38–67.
- Salasuo, M. & Seppälä, P. (2005). The Party Scene of Helsinki. NAT – Nordic Studies on Alcohol and Drugs. English Supplement vol. 22, s. 142–145.
- Saukkonen, A. (2005). Vieroitushoitopoliklinikalla jo viiden vuoden kokemus korvayshoidosta. Tiimi 1 / 2005
- Seppä, K. (2005). Päihteet ja ajokyky. Suomen lääkärilehti 60 /2005), 25-26.
<http://www2.fimnet.fi/pdf/2005/SLL252005-2811.pdf>
- Seppälä, P. (1999). Ravekulttuuri ja laittomat päihteet: yhteisöllisyyttä, etiikkaa ja identiteettiä. Kansainvälistä taustaa ja suomalainen tapaustutkimus. Sosiaalipolitiikan pro gradu –tutkielma. Helsingin yliopisto: Helsinki.
- Seppälä, P. (2003). Havaintoja huumeista. Tutkimus uusien huumeilmiöiden varhaisena tunnistajana. Stakesin raportteja 275. Stakes: Helsinki.
- Seppälä, P. & Mikkola, T. (2003). Voisiko valistus olla kaksisuuntaista? Tiimi vol. 39 (1), s. 11–13.
- Seppälä, P. & Mikkola T. (2004). Huumeet Internetissä ja nuorisokulttuureissa. Havaintoja huumeiden merkityksistä ja riskikäsitteistä käyttäjäpiireissä. Stakesin raportteja 287. Stakes: Helsinki.
- Seppälä, P. & Salasuo M. (2001). Aaltoja vai vedenpinnan pysyvää nousua? Yhteiskuntapolitiikka vol. 66 (1), s. 71–75.
- Sjöberg, S. (2005). Näkymättömät huumeiden käyttäjät. (Julkaisematon käsikirjoitus)
- Scenario of Finnish Drug Situation 2004 - 2007. Skenaario Suomen huumeainetilanteen kehityksestä 2004–2007. Valtioneuvoston periaatepäätös huumeainepoliittisesta toimenpideohjelmasta vuosille 2004–2007. Sosiaali- ja terveysministeriön julkaisuja 2004/1. Sosiaali- ja terveysministeriö: Helsinki, s. 15–20.
- Soikkeli, M. (2002). Miten puhua huumeista. Stakes: Helsinki.
- Statistical Yearbook on Social Welfare and Health Care 2004. Sosiaali- ja terveydenhuollon tilastollinen vuosikirja 2004. Stakes. SVT/Sosiaaliturva (tulossa)
- Strengell, P., Vahtola, M., Tammela, O. & Seppä, K (2005). Raskauden aikainen buprenorfiinihoito - riskit ja hyöty punnittava tarkkaan. Duodecim 2005; 121 (4): 392-9. Ks.
<http://www.duodecim.fi/aikakauskirja/>
- Suikkanen A., Martti, S. & Linnakangas, R. (2004). Homma hanskaan - nuorten kuntoutuskokeilun arviointi. Sosiaali- ja terveysministeriön selvityksiä 2004:5. Ks.
<http://www.stm.fi/Resource.phx/publishing/store/2004/05/hu1083758276684/passthru.pdf>
- Tammi, T. (2002). Onko Suomen huume politiikka muuttunut? Teoksessa Hakkarainen, P. ja Kaukonen, O. (toim.) Huumeiden käyttäjä hyvinvointivaltiossa. Gaudeamus: Helsinki, s. 252–271.
- The anti-drug strategy for the police for 2003-2006 (2002). Poliisin huumeainesten vastainen strategia vuosille 2003 - 2006 (2002). Hyväksytty 30.8.2002. Sisäasiainministeriön poliisiosasto. Ks.

<http://www.intermin.fi/intermin/home.nsf/pages/E932269A4FD88A29C2256B3C0036E4B2?opendocument>

The Espad report 2003. Alcohol and other drugs use among students in 35 European countries. CAN, Modintryckoffset AB, Stocholm November 2004

The Health 2015 public health programme (2001). Terveys 2015 -kansanterveysohjelma (2001). Valtioneuvoston periaatepäätös. Sosiaali- ja terveysministeriön julkaisuja 2001:4. Ks. <http://pre20031103.stm.fi/suomi/eho/julkaisut/ehosisallys15.htm>

The intoxicant strategy for the prison administration for 2005–2006. Vankeinhoidon päihdestrategia vuosiksi 2004 - 2006. Ks. <http://www.rikosseuraamus.fi/29334.htm>

The Money Laundering Clearing House of Finland, Annual Report 2004. Rahanpesun selvittelykeskus, vuosikertomus 2004. Keskusrikospoliisi. Ks. [http://www.poliisi.fi/poliisi/krp/home.nsf/files/RAP_vuosikertomus_2004/\\$file/RAP_vuosikertomus_2004.pdf](http://www.poliisi.fi/poliisi/krp/home.nsf/files/RAP_vuosikertomus_2004/$file/RAP_vuosikertomus_2004.pdf)

Tourunen, J & Perälä, J. (2004). Kohti kognitiivista yhteisöhoitoa? Helsingin vankilan päihdeettömän osaston arviointi- ja kehittämistutkimus. Rikosseuraamusviraston julkaisuja 2/2004. Ks. <http://www.rikosseuraamus.fi/26138.htm>

Törmä, S. & Huotari, K. (2005a). Palvelut liikkeelle. Liikkuvan terveysneuvontayksikön toiminnan ulkoinen arviointi. Sosiaalikehys Oy & Helsingin Diakonissalaitos, Edita Prima OY.

Törmä, S. & Huotari, K. (2005b). Huono-osaisimmat ja moniongelmaisimmat päihteiden käyttäjät avun tarvitsijoina ja asiakkaina. Sosiaalikehys Oy & Helsingin Diakonissalaitos, Edita Prima OY.

Törmä, S., Huotari, K. & Inkeroinen, T. (2004). Koordinointia ja kumppanuuksia! Helsingin päihdehuollon ulkoinen arviointi. Helsingin kaupungin sosiaalivirasto. Tutkimuksia 2003:4. Ks. <http://www.hel.fi/sosv/julkaisu/tutkimuksia/2003/Paihdearvio.pdf>

Törmä, S., Huotari, K. & Inkeroinen, T. (2003). Helsingin Diakonissalaitoksen Kurvin huumeepoliklinikan ulkoinen arviointi. Sosiaalikehys Oy:n julkaisuja 1/2003.

Törmä S., Huotari K., Kinnunen, R. & Nieminen, J. (2002). Erityispalvelut hiv-positiivisille huumeiden käyttäjille. Kluuvien palvelukeskuksen toiminnan arviointi. Sosiaalikehitys Oy:n julkaisuja 1/2002.

Törrönen J. (toim.) (2004). Valvontaa ja vastuuta. Päihteet ja julkisen tilan moraalisaantely. Gaudeamus.

Villikka, H. (2004). Selvitys huumeiden käyttäjien hoitoon suunnatun vuoden 2002 valtionavustuksen käytöstä. Sosiaali- ja terveysministeriön selvityksiä 2004:12. Ks. <http://www.stm.fi/Resource.phx/publishing/store/2004/06/mk1086872982135/passthru.pdf>

Villikka, H. (2003). Kartoitus opioidiriippuvaisten lääkekorvaushoidon hoitojonoista. Sosiaali- ja terveysministeriön Monisteita 2003:16. Ks. <http://www.stm.fi/Resource.phx/publishing/store/2003/10/is1067439877589/dokumentti.pdf>

Virokannas, E. (2004). Normaalin rajan molemmilla puolilla - tutkimus huumehoitoyksikön nuorten identiteettien rakentumisesta. Stakes, Tutkimuksia 144. Gummerus kirjapaino Oy, Saarijärvi.

Virtanen, A. (2005). Drugs in Finland. 2004 national report to the EMCDDA by the Finnish National Focal Point, the STAKES. Statistical Report 2 / 2005. Ks. <http://www.stakes.info/files/pdf/Raportit/Reitox2004eng.pdf>

Virtanen, A. (2004). Drugs in Finland. 2004 national report to the EMCDDA by the Finnish National Focal Point, the STAKES. Statistical Reports 2 / 2004. Ks http://www.stakes.info/files/pdf/Raportit/DRUG_REPORT2003.pdf

Virtanen, M. (2002). Huume politiikan hauras kompromissi. Yhteiskuntapolitiikka vol. 67 (6), s. 511–512.

Vismanen, E. (2004). Huume hoidon alueellisen kattavuuden arviointi (julkaisematon)

Vorma, H., Sokero, P., Turiainen S. & Katila H. (2005). Opioidikorvaushoito tehoaa. Korvaushoito Hyksin päihdepsykiatrian yksikössä 2000 - 2002. Suomen Lääkärilehti 9/2005. Ks. myös <http://www.laakarilehti.fi/>

Vuori, E. (2004). Tilastotietoja oikeuskemiallisista huumausainelöydöksistä kuolemantapauksissa. Helsingin yliopiston oikeuslääketieteen laitos.

Vuori, E., Henry, J.A., Ojanperä, I., Nieminen, R., Savolainen, T., Wahlsten, P. & Jäntti, M. (2003). Death Following Ingestion of MDMA (Ecstasy) and Moclobemide. Addiction 98: 365–368.

Väyrynen, S. (2005). Tytön ja huumeidenkäytön lupaukset. Tiimi 3-4/2005. Ks. http://www.a-klinikka.fi/tiimi/3405/huumeet_tytot.html

Working group to develop prison health care (2002). Vankien terveydenhuollon kehittäminen (2002). Rikosseuraamusviraston monisteita 1/2003. Ks. <http://www.rikosseuraamus.fi/uploads/3rvv4zo6jcx9.pdf>

Working group memo on undercover operations (2005). Anonyymi todistelu ja peitepoliisin oikeus osallistua rikollisryhmän toimintaan. Oikeusministeriön työryhmämietintöjä 2005:5. Ks <http://www.om.fi/31402.htm>

Yearbook of Alcohol and Drug Statistics 2004. Päihdetilastollinen vuosikirja 2004. Stakes. SVT/Sosiaaliturva 2004 (julkaisematon)

Yearbook of Justice Statistics 2004.. Oikeustilastollinen vuosikirja 2004. Tilastokeskus, Oikeus 2004:18. Helsinki 2005.

16. Changes in legislation

Amendment to the Road Traffic Act. Tieliikennelain muutos (113/2004)

Amendment to the Penal Code. Rikoslain muutos (650/2004)

Amendment to the Coercive Measures Act. Pakkokeinolain muutos (651/2004)

Act on the Protection of Privacy in Working life. Yksityisyyden suojaa työelämässä koskevan lain muutos (579/2004)

Following amendments to the following Acts:

1. Amendment to the Occupational Health Care Act (740/2004).
2. Amendment to the Act on Co-operation within Undertakings (761/2004),
3. Amendment to the Act on Co-operation in Government Departments and Agencies (762/2004),
4. Amendment to the State Civil Servants Act (763/2004),
5. Amendment to the Act on Civil Servants in Local Government (764/2004)
6. Amendment to the Act on Parliamentary Civil Servants (193/2005).

The Government Decree (218/2005)

Amendment to the Criminal Records Act (654/2004)

Act on rehabilitation benefits and rehabilitation allowances (566/2005)

Amendment to the Road Traffic Act (113/2004; 1103/2004)

Amendment to the Act on safety tasks in the rail system (1167/2004)

Juvenile Punishment Act (1196/2004; 1284/2004),

Act on imprisonment (767/2005)

Detention Act (768/2005)

Amendment to the Penal Code (650/2004)

Amendment to the Coercive Measures Act (651/2004)

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