

An aerial photograph showing a large, clear, triangular piece of plastic debris floating in the ocean. The debris is surrounded by smaller pieces of trash and is set against a backdrop of dark blue water with white-capped waves. The image is positioned in the top left corner of the page.

Anne Arponen • Henrikki Brummer-Korvenkontio  
Kirsi Liitsola • Mika Salminen

## **Trust and Free Will as the Keys to Success for the Low Threshold Health Service Centers (LTHSC)**

An Interdisciplinary Evaluation Study of the Effectiveness of Health Promotion Services for Infectious Disease Prevention and Control Among Injecting Drug Users

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Anne Arponen, Henriikki Brummer-Korvenkontio, Kirsi Liitsola and Mika Salminen

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(LTHSC)**

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infectious disease prevention and control among injecting drug users*

KTL - National Public Health Institute, Finland  
Department of Infectious Disease Epidemiology and Control  
HIV- Unit

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## **ABSTRACT**

### **Key observations and conclusions**

The report describes an evaluation study undertaken at the National Public Health Institute on the effectiveness of the operations of low threshold health promotion and service centres for injecting drug users (LTHSCs) for the prevention and control of infectious diseases, mainly blood-borne infections. The evaluation study has been undertaken as an interdisciplinary study, utilising both a qualitative and quantitative methodology and materials.

The evaluation clearly shows that the LTHSC intervention has been a significant factor in the prevention of HIV infections, hepatitis A and B infections, and also partly in the prevention of hepatitis C infections, as well as in the control of epidemics among injecting drug users and also, indirectly, as regards the population as a whole. The operation has achieved the targets set for it originally, and along with the operations growing in the areas of introducing additional services, is reaching the target group and reducing infection risks.

It is particularly worth noting that the very ambitious targets set as regards the HIV situation - suppressing the epidemic and limiting case numbers to under 30 new cases annually - have actually been met. This is not only supported by the data produced by the passive incidence surveillance system (National Public Health Institute's Infectious Diseases Register), but also by targeted, sampling-based incidence studies. Compared with the highly realistic threat scenarios, thousands of HIV infections and at least as many different hepatitis infections have been prevented.

As a principal conclusion, it can be acknowledged that the low threshold health promotion and service centres for injecting drug users have been a successful and, even on the basis of a rough financial estimate, a very cost-effective health intervention, and therefore securing the further development and constancy of the operations would be important from the point of view of public health.

The evaluation also shows that the injecting drug user health-counselling model forms a working social innovation, which differs from the prevention models previously used elsewhere by successfully combining low threshold health services and health promotion for harm reduction, without having to simultaneously abandon restrictive drug policies. Therefore, the model is also very-well suited for use in places other than Finland.

In the conclusion section of the report, recommendations were also given for the development of the operation and the strengthening of its framework.

## **Development of the operations of the LTHSCs 1996-2008**

There is a variety of adverse social and health effects related to injecting drug use. Among them, the threat of spreading and increasing infectious diseases is a significant one.

In Finland, the infection risks related to drug use only really became a concern at the end of the 1990s, when hepatitis C virus was identified and the test showing the infection, which was taken into use widely, revealed a significant burden of disease among injecting drug users. At the same time, there were clearer hepatitis B epidemics among the same group as before. When, in addition, the first objective estimates of the number of problem drug users were received in 1997 and they proved to be considerably higher than the previous estimates, the rather large significance to public health became apparent.

Therefore it was decided in Finland to start up a new kind of preventive operation in order to prevent infection problems among injecting drug users. The starting point of the operation was the promotion of health-promoting behaviour models through health counselling centres directed specifically at problem users. The guiding principle is the provision of a health counselling service that is low threshold and practical for clients. The immediate purpose of the operation is to prevent drug use-related health hazards, particularly the spread of blood-borne infectious diseases, whereas the longer-term objective is to increase drug users' health-related knowledge and desire to look after their own health. From the start, one part of the operation was the exchange of used injecting equipment for clean equipment. Although the long-term goal of the operation is also to reduce drug use, it is not its immediate aim.

The operating model does not, however, contradict the absolute prohibition of the use, sale or distribution of drugs contained in the health and regulatory policies, in the implementation of which there have been no changes in Finland. Instead, the model strives to improve the cooperation between the controlling authorities and social welfare and health authorities, so that more of those suffering from drug dependency will seek treatment. This has happened in many parts of the country.

In the original definition, the operating model was described as follows: "A health counselling centre is a place where a[n injecting drug] user can get clean syringes and needles and where the user can return the used syringes and needles, as well as a place where the user and/or those close to him or her have an opportunity for supportive discussions, referral to services, social and health counselling, as well as having small treatment procedures done, such as vaccinations and tests". In addition, important parts of the framework of the health counselling centres' operational criteria are, e.g., *Anonymity* – visiting without a name or any kind of identification, *Reachability* of the location and the services, *User-friendly* atmosphere, *Dialogue* with the users, *Practical* approach to the operation, ideological and moral *Non-judgementality*, as well as *Realistic* hierarchy of goals.

Since the original pilot project, the LTHSC model has been distributed across Finland in such a way that in 2008, there are some 30 centres in operation, covering most of the country. In 2004, an obligation was added in the Communicable Disease Decree for the municipalities to provide health counselling services for injecting drug users, including the exchange of injecting equipment.

The model - or different applications derived from it - has also been transferred to Finland's neighbouring regions. For example, in Estonia, Latvia and Lithuania, as well as in the Russian region of Murmansk, there are prevention projects in operation that are based on the LTHSC model.

Keywords: Health promotion, Low threshold health service center (LTHSC), injecting drugs, blood borne disease, prevention, HIV, Aids, HCV, HBV, HAV, harm reduction

*An interdisciplinary evaluation study of the effectiveness of health promotion services for infectious disease prevention and control among injecting drug users*

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# 1. INTRODUCTION

## 1.1. Problem drug use

The European Monitoring Centre for Drugs and Drug Addiction, EMCDDA, defines problem drug use as injecting drug use or long duration or regular use of opiates, cocaine and/or amphetamines (Huumeongelma Euroopassa 2005). Drug and alcohol addiction is characterised by continuous, frequent or compulsive acquisition and use of the substance, regardless of the adverse social effects and health hazards resulting from the use (Duodecim, terveyskirjasto. Päihde- ja huumeriippuvuus, Huttunen).

Finland has been assessing and surveying the number of problem drug users since 1997. According to estimates, in 2002 there were about 16,000–21,000 problem drug users in Finland. The latest estimate is from 2005; Finland had about 14,000–19,000 problem users of amphetamines or opiates then<sup>1</sup>. Since 2002, no signs have been detected of an increase in the number of problem users.

**Table 1.**

**Amphetamine and Opiate Problem Users in Finland 1997 - 2005.**

	1997	1998	1999	2001	2002	2005
<b>Whole country</b>	9400-14700	11500-16400	11100-14000	13700-17500	16100-21100	14500-19100
Opiate users	1500-3300	1800-2700	2500-3300	3900-4900	4200-5900	3700-4900
Amphetamine users	6800-11600	7600-13000	8300-12400	10100-15400	10900-18500	12000-22000
<b>Capital area</b>	4000-7400	4200-6000	4100-5400	4900-6600	5300-7800	5100-8200
Opiate users	900-2000	1000-1600	1200-1900	1800-2700	2000-3200	1300-2400
Amphetamine users	2800-7400	2600-6000	2500-5000	3200-6900	3300-6000	4000-6000
<b>Southern Finland</b>	nd	6200-10300	6500-8700	10100-20100	9900-14900	7000-12000
<b>Western Finland</b>	nd	2400-3900	2600-4200	3800-5700	4000-5800	3500-5200
<b>East- and North Finland</b>	nd	700-1800	2000-3000	1500-2000	2100-3800	2000-3800

vuoden 2002 jälkeen. According to a statistical estimate based on four registers<sup>2</sup>, in 2005 about 0.5–0.7 per cent of Finland's 15–55-year-old population were problem users of amphetamines and opiates (Partanen et al., 2007).

In 2005, women accounted for 20–25 per cent of problem users in both substance categories. The gender distribution of users has remained approximately the same since 1999. In 2005, a clear majority of the users, 75–85 per cent, were problem users of amphetamine. Their number was estimated at 12,000–22,000. According to the estimate, there were 3,700–4,900 problem users of opiates. The range of the estimate is considerably wider for problem users of amphetamine compared with opiate users, which reflects the heterogeneity of problem users of amphetamine. (Partanen et al., 2007.) According to the study conducted by Alho et al. (2007) on clients of health counselling centres, opiates were the most frequently used injecting drugs in the Greater

<sup>1</sup> Use of amphetamines or opiates that has caused the user adverse social or health effects. In addition, the adverse effects have resulted in an intervention by authorities, which is specified in the authorities' registers. (Partanen, P. 2007.)

Helsinki Area (73%) with buprenorphine the most common among them, while use of amphetamine (24%) was much less common

<sup>2</sup> The notification register of hospitals, the police information system, the register of intoxicated drivers and hepatitis C cases in the National Infectious Diseases Register.

(Alho et al., 2007). According to estimates, there were 5,100–8,200 problem users of amphetamines and opiates in the Greater Helsinki Area in 2005, accounting for about 30–40 per cent (as in 2002) of all problem users in Finland. It is estimated that the number of problem users in the Greater Helsinki Area is closer to the upper rather than the lower end of the estimated range. (Partanen et al., 2007.)

The operational statistics of the health counselling centres in the Greater Helsinki Area show that the centres were visited by about 9,300 problem users in 2005. Partanen et al. (2007) state that the effects of anonymous collection of data are visible particularly in the Greater Helsinki Area, where the clients of health counselling centres use multiple services in the same area and clients come from outside the area as well. With these effects eliminated, the number of clients of the health counselling centres probably falls within the range of the abovementioned statistical estimate. (Ibid.) In the Greater Helsinki Area, the ability of the health counselling centres to reach problem users is generally very good. When comparing the estimated number of problem users in the Greater Helsinki Area with the number of clients in the health counselling centres, Partanen et al. (2007) find that health counselling centres reach a considerable number of problem users within their own areas. They also remark that the health counselling centre network is not geographically complete, which is why some IDUs (injecting drug users) have no access to the service. (Ibid.)

In 2005, about 50–60 per cent of all problem users lived in Southern Finland (60–70% in 2002). It is estimated that there were 7,600–12,900 problem users of amphetamines and opiates in the province of Southern Finland in 2005. (Partanen et al. 2007.) According to the operational statistics of health counselling centres, the centres in the province of Southern Finland reached about 10,000 people in 2005. The health counselling centres in

Western Finland reached about 1,600 of the estimated 3,500–5,200 problem users in the province in 2005. The total number of problem users in the provinces of Eastern Finland, Oulu and Lapland in 2005 was estimated at 2,000–3,800. The availability of health counselling services was poorest in these three provinces. According to the operational statistics, the health counselling centres in these three provinces had a total of 175 clients in 2005 (about 200 in 2006).

The number of clients in the health counselling centres and the estimated numbers of problem users do not directly reflect reachability, as the health counselling centres are mainly visited by IDUs only and the registers used for estimating the number of problem user may contain people who do not inject drugs or can be classified as occasional users. On the other hand, when observations are obtained from several registers, the possible proportion of occasional users in the final estimate is lower. (Partanen et al. 2007).

The estimated numbers of users should be seen as guiding figures when assessing the coverage of health counselling centres. They help to focus the operation and to emphasise the importance of the work in certain areas. It should be noted that the estimated number of problem users has not risen since 2002, while the total number of clients in the health counselling centres increases every year. This means that the ability of the health counselling centres to reach clients improves all the time. Despite the relatively high estimated number of problem users, the frequency of HIV infections acquired through injecting drugs has remained extremely low.

## **1.2. Drug treatment clients**

The profile of drug treatment clients is studied every year by customer surveys to monitor the drugs used, the frequency of injecting drug use and the prevalence of infectious diseases. According to the collection of drug treatment

data<sup>3</sup>, in 2006 opiates were the most common (41%) primary problem substance that caused the user to seek intoxicant treatment. Among those seeking treatment, the proportion of problem users of buprenorphine, an opiate, was considerably higher (31%) than the proportion of problem users of heroin (2%), also an opiate. Other primary problem intoxicants leading to treatment were stimulants (21%), simultaneous use of alcohol and drugs (17%) and cannabis (14%). Tranquillisers (7%) or other drugs were seldom mentioned as the primary problem intoxicant. Polysubstance use was common: nearly two out of three (62%) were using at least three problem intoxicants. (Päihdehuollon huumeasiakkaat 2006, 3. Stakes 2007.)

Of all the drug users seeking intoxicant treatment, 78 per cent had sometimes used injecting drugs. More than half of them (59%) had used injecting drugs within a month. Injection was the most common mode of opiate use among the clients seeking drug treatment (83%). Buprenorphine was injected slightly more often than heroin (88% vs. 82%, respectively). Eighty-one per cent of stimulant users were injecting them. Of those who had injected drugs at least once in their life, 81 per cent had sometimes shared injection equipment with others, and one fifth (19%) had shared injection equipment during the past month. (Ibid.)

The majority of clients seeking drug treatment had previous treatment contacts (86%). Forty-four per cent of the clients had more than one treatment contacts at the same time. The most common simultaneous treatment contacts were contacts with intoxicant outpatient care (52%), outpatient care provided by the general services of social welfare and health care (27%) and health counselling centres (18%). Clients had sought treatment on their own initiative (37%), through the general services of social welfare and health care (30%) or

through intoxicant treatment services (20%). In addition, treatment was sometimes recommended by the user's family (6%) or users were referred for treatment by the police (4%) or the health counselling centre (1%). (Ibid.) There are some possible explanations for the low proportion of health counselling centres. First, clients may generally feel that they made the decision of seeking treatment independently. Second, they may see the health counselling centre primarily as an instance providing guidance and support, not as an actor that actually decides on treatment.

Of clients who had sometimes used injecting drugs, two out of three (69%) had received at least one hepatitis B vaccination, and 49 per cent had received all the three doses. Of all the drug users in intoxicant treatment, nearly 65 per cent had been tested for HIV, hepatitis B and hepatitis C. About 70 per cent had taken an HIV test, 67 per cent a hepatitis B test and 73 per cent a hepatitis C test. Less than two per cent of those who had sometimes used injecting drugs were HIV positive based on their own reports on test results, and according to confirmed test results slightly less than three per cent were HIV positive. According to the users' own reports on test results, 60 per cent were hepatitis C positive and 67 per cent according to confirmed test results. (Päihdehuollon huumeasiakkaat 2006, 5-6. Stakes 2007.)

A questionnaire survey to drug treatment clients revealed that injecting drug use was very common among them and polysubstance use was very typical. The majority of those answering the survey had shared injection equipment with others. The proportion of clients who had received a hepatitis B vaccination was high: about half of all IDUs had received all three doses of vaccine. Many had been tested for HIV and hepatitis. The proportions of positive test results were in line with the figures notified to the National Infectious Disease Register.

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3 LTHSC = low threshold health promotion and service centres for injecting drug users.

### **1.3. Drug treatment**

In Finland, treatment for problem users of drugs is provided by public health care, intoxicant treatment special service units and social welfare services. Whenever possible, long-term outpatient care is provided close to the patient's home (Käypä hoito. Huumeongelmaisen hoito). Stimulants, primarily amphetamine, are the most common drugs among problem users. According to the latest estimates, about 75–88 per cent of all Finnish problem users take amphetamine. Evaluation studies show that the use of amphetamine has been more common than the use of opiates at least since 1997. (Partanen et al. 2007.) There is no efficient specific medication available for amphetamine withdrawal, but the symptoms can be treated (Käypä hoito. Huumeongelmaisen hoito). Tiihonen (2004) discusses the treatment options for stimulant dependence and remarks that the efficiency of psychosocial treatments as the only therapy has generally turned out to be quite low in the treatment of injecting drug addiction. Opiate and amphetamine injecting is very problematic because of the consequences, such as HIV, hepatitis, crime, excess mortality and permanent unemployment. Opiate dependence is treated with substitution treatment using methadone and buprenorphine. A corresponding efficient treatment is not currently available for stimulant dependence, despite continuous research (Tiihonen 2004, 1191). Tiihonen (2004) discusses the possibility of oral substitution treatment for amphetamine addiction with amphetamine or methylphenidate, for example. This would involve replacing injecting drug use with controlled oral use to suppress crime and limit the spreading of infections. (Tiihonen 2004, 1192). According to a recent Finnish study, methylphenidate treatment has proven efficient in decreasing injecting drug use in patients with a severe amphetamine addiction (Tiihonen et al., 2007, 162). Even though pharmacological treatment of amphetamine dependence is still at development stage, users

of amphetamine seek treatment nearly as often as opiate addicts.

Today there is reliable evidence available on the value of substitution treatment with medications like methadone or buprenorphine. Studies have shown that substitution treatment decreases illegal drug use and injecting drug use and reduces behaviour that increases the risk of HIV and other infections, such as sharing of equipment. Substitution treatment has also been shown to improve the patients' social capacity and overall health status. Furthermore, study results suggest possible reduction of criminal activity and a decrease in drug deaths as the outcome of adequate substitution treatment. To be efficient, the therapy must start early and continue without breaks, the duration must be adequate and the dosage of medication correct. (EMCDDA 2006, 72.)

In practice, drug treatment may involve medication-free withdrawal treatment or therapy assisted by medication. The duration and goals vary depending on the patient. Withdrawal treatment is less efficient, because it is difficult to commit oneself to treatment without pharmacological substitution treatment (Hermanson 2001). When we are speaking of treatments for opioid dependence, we usually refer to the following types of treatments with regard to medication and goals. Section 2 in the Decree of the Ministry of Social Affairs and Health (289/2002) concerning withdrawal, substitution and maintenance treatment of opioid addicts with certain medications defines opioid dependence and pharmacological treatment as follows:

1) *opioid dependence* means that the diagnostic criteria of the ICD-10 disease classification code F11.2x are met;

2) *withdrawal treatment* means treatment with buprenorphine- or methadone-containing pharmaceuticals lasting up to one month and aiming to achieve intoxicant-free life for an opioid addict ;

3) *substitution treatment* means rehabilitative treatment of an opioid-dependent person with buprenorphine- or methadone-containing pharmaceuticals, aiming for intoxicant-free life and lasting longer than one month; and

4) *maintenance treatment* means rehabilitative treatment of an opioid-dependent person with buprenorphine- or methadone-containing pharmaceuticals, lasting longer than a month and focusing on harm reduction and improvement of the patient's quality of life.

In substitution treatment, addictive drugs are replaced with medication, but unlike maintenance treatment, substitution treatment aims for future withdrawal from the medication as well. Over the years it has been attempted to lower the threshold for drug treatments, but actual low-threshold substitution treatment is still at planning stage. According to the recommended standard treatment guidelines, withdrawal symptoms in an opioid user can be efficiently suppressed by administering buprenorphine or methadone within 12–24 hours of the last drug dose. Furthermore, it is stated that substitution

treatment is a much more efficient method for treating opioid dependence than long withdrawal treatment of three weeks to four months supplemented by psychosocial therapy. Equal doses of methadone and buprenorphine produce similar results. Even intensive non-pharmacological psychosocial treatment does not improve the results of treatment of opioid abuse and opioid dependency. (Käypä hoito. Huumeongelmaisen hoito.) It is estimated that in 2004 about 700–750 opiate addicts received substitution treatment, the majority of them with buprenorphine. (Virtanen 2006.) At the end of 2005, the estimated number of patients receiving substitution and maintenance treatment had risen to 800–900 (Huumeausainepolitiikan kertomus 2005. STM 2006).

Polysubstance use poses a challenge to health care services and drug surveillance systems,

which are usually based on behavioural indicators concerning the use of a single drug (EMCDDA 2006, 14). Special effort and expertise are required to find the correct treatment for polysubstance users and to affect their risk behaviour. In 2005 and 2006, two out of three drug treatment patients had at least three problem intoxicants (Päihdehuollon huumeasiakkaat 2005, 3; Päihdehuollon...2006, 3.). According to the study conducted by Partanen et al. (2006), polysubstance use is very common among IDUs. The most common injecting drugs are buprenorphine, amphetamine and heroin. According to the study, four out of five primary users of buprenorphine or heroin occasionally take amphetamine. Simultaneous dependence on several intoxicants is common among polysubstance users. For example, an opiate user may also be dependent on tranquillisers. (Seppälä 2003; Partanen ym. 2006, 22–27.)

Polysubstance use considerably increases the risk of overdose. Deaths have been reported in connection with buprenorphine use, but all the cases were associated with abuse, such as administration by injection or simultaneous use with other medicines, drugs or alcohol. (Suominen & Saarijärvi 2003, 4149.) In the initial interview for the Riski (“Risk”) study, 75 per cent of the participants said they had taken alcohol during the past six months, and after the 18-month surveillance period 81 per cent said they had used alcohol. The respective figures for benzodiazepines were 73 and 45 per cent (Partanen et al. 2007, 38).

#### **1.4. Adverse health effects of injecting drug use**

Injecting is the most dangerous method of drug use, because it considerably increases the risk of bacterial and viral infections and exposes the user to vascular and tissue traumas. Other risks associated with injecting drug use include overdose, severe local and systemic infections, such as chronic blood-borne viral diseases, septicaemia and vascular occlusion (EMCDDA 2006, 12). Drug abuse

as such causes serious social and health problems for many people, it is often associated with mental health problems and poses a serious health risk in itself.

Injecting drug use causes a remarkably elevated risk of vascular and tissue trauma. For example, intravenous use of substitution treatment medicines or any other medicines intended to be taken orally is dangerous, because the binders contained in these medicines accumulate in the veins. It is generally recommended that injecting drug users should crush the substance thoroughly and use a filter. Filtering of the substance to be injected eliminates most of the impurities and the binders included in tablets. Additional health risks are caused by quality and purity problems. The quality and strength of heroin, for example, may vary greatly, which exposes the user to a risk of overdose. New drugs, such as the recently popular GHB and GBL, may cause a poisoning in small doses and in combination with other intoxicants. A batch of drugs may become contaminated during transportation, etc. Hiding drugs in body cavities during transport may lead to microbial contamination of the batch in many ways.

Poor injection hygiene and blood contacts expose drug users to bacterial and viral infections. The most typical risk situation is sharing injection equipment and other paraphernalia needed to prepare a drug dose; that is, using instruments that have already been used by someone or passing on one's own used equipment to others. Dirty or used equipment, poor hygiene, such as unclean skin, and impure drugs are factors that increase infection risks in injecting drug use.

Ristola (2003) lists factors that affect the occurrence of infections in drug users. These include behaviour that exposes the user to blood-borne infections, injecting drug use, sharing injection equipment with other users, methods of preparation and use of injecting drugs, destruction of tissue by injections, sexual risk behaviour, prostitution to be able to acquire drugs, effects of intoxication on

sexual behaviour, social situation, crowded living conditions and homelessness (Ristola 2003, 570).

The methods used to prepare drug doses for injection are often non-sterile, and the solutions to be injected contain bacteria. Non-sterile preparation of drugs involves a risk of bacteria entering the user's blood circulation, which may lead to sepsis. After several years of injecting drug use, the veins in the user's limbs are often scarred, which increases the risk of infection at injection sites. Bacterial infections may develop locally or they may spread with blood to other parts of the system. Endocarditis is the most typical of these infections. (Ristola 2003, 570-1; Ristola 2004, 56.)

Injecting drug use always involves a health risk. Shared use of equipment exposes to a possible blood contact and an infection risk that can be reduced by always using one's own, clean needles, syringes and other paraphernalia and by applying the best possible injecting hygiene. According to Ristola (2004), discontinuation of injecting eliminates some infection problems, such as exposure to bacterial infections at injection sites. However, the chronic viral infections HIV and hepatitis B are also transmitted sexually, and protection against them must be kept in mind even when injecting of drugs is discontinued. Cessation of drug use is often an unrealistic goal, but users may nevertheless be willing to protect themselves and others against infections (Ristola 2004, 57).

### **1.5. Blood-borne infections**

The most serious adverse health effects of injecting drug use include preading of and increasing prevalence of HIV and other blood-borne infections in the population, particularly hepatitis B and hepatitis C. Injecting drug users are at risk of contracting infections through injections and sexual contacts. Moreover, hepatitis A has been found to be increasingly associated with injecting drug use.

As regards the risk behaviour associated with blood-borne infections spreading among IDUs, the interest is usually targeted at the injecting situation, sharing of injecting paraphernalia (equipment) and use of condom in sexual contacts. (Partanen et al. 2006, 10). Compared with other modes of transmission, blood-borne infections may spread very rapidly among IDUs, as the method of drug use exposes them to direct blood contacts. Infectiousness of HIV is at its highest during the first two months after transmission of the virus. This is due to the high quantity of virus at the initial stage of infection. A few incidents of shared use may trigger a rapid snowball effect among IDUs.

If equipment is shared with people who have an HIV or hepatitis C infection, for example, one person may infect several others at one time, and they in turn may infect many others. This also increases the risk of sexually transmitted infections. Without a rapid response with an extensive campaign to prevent infection risks, an HIV epidemic among IDUs may spread in a few years to cover even as many as half of the risk group, as happened in Estonia (Salminen 2007).

According to EMCDDA, the primary goal of public health measures in this area today is to reduce injecting drug use and distribute clean injection equipment. Studies have shown a connection between drug use and sexual risk behaviour. Therefore, it is increasingly important to combine measures aiming to affect drug use and public health strategies on sexual health. (EMCDDA 2006, 75.) Moreover, Finland's national HIV/Aids strategy for the period 2008–2012 emphasises the importance of ensuring good availability of clean injection equipment and of paying more attention to sexual health issues (Kansallinen HIV/Aids-strategia 2008–2012).

### **1.5.1. HIV**

The prevalence of HIV and infection risk in certain groups, such as men having sex with

men (MSM<sup>4</sup>) and IDUs, is higher than in the population on average. However, unlike in the nearby regions, the prevalence of HIV has remained low in Finland. In Estonia, for example, the prevalence of HIV among IDUs is estimated to be as high as 54.3–90 per cent depending on the area. The HIV epidemic in Estonia peaked in 2001, with 1,500 diagnosed HIV infections at population level. (EMCDDA 2006.) In Russia and the Baltic countries, the majority of HIV infections are acquired through injecting drug use, and the patients are mainly under 30 years of age. The high HIV figures in the nearby regions naturally cause a risk of infections spreading into Finland. However, there have not been many signs of injecting drug use related infections spreading from nearby regions into Finland.

In Finland, HIV infections were very rare in IDUs until 1998, when an epidemic broke out among users in the Greater Helsinki Area. The epidemic caused a need to reinforce the preventive services targeted at drug users in Finland. This was when the health counselling model began to develop.

### **1.5.2. Hepatitis B**

Hepatitis B is the only disease transmitted through blood and sexual contact that can be efficiently prevented by vaccine (Duodecim, terveyskirjasto). It is also possible to protect oneself against the disease by using a condom and reducing risk behaviour. The hepatitis B virus (HBV) causes an infection of the liver that often leads to a chronic condition, which in turn greatly increases the risk of liver cancer later in life. HBV is most frequently transmitted through blood. Other routes of transmission include sexual contact and transmission from mother to child during labour. (Leinikki 2003a.)

The data in the Infectious Diseases Register show that the number of notified acute hepatitis B cases associated with injecting drug use has fallen in recent years from about

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4 Men who have sex with men.

a hundred to some twenty cases per year. The B hepatitis vaccination is an efficient means of preventing spreading of the infection. The easiest way is to administer vaccinations in connection with the special services targeted at IDUs. (Ristola 2003). In 1998, vaccination recommendations were updated so that efficient vaccinating of IDUs could begin. The health counselling centres have proved excellent in reaching members of the risk group. It is estimated that about a half of long-time drug users have received a hepatitis B vaccination. The achieved coverage of vaccination among IDUs is outstanding. (Leino 2006.)

Based on notifications to the Infectious Diseases Register, 200–400 new hepatitis B cases have been diagnosed in Finland each year for the past ten years. In local outbreaks, young drug users and their sexual partners have often constituted the majority of the infected. Some 20–30 per cent of long-time drug abusers have an HBV infection. (Leinikki 2003a 186; Ristola 2003, 572). Today, injecting drug use is the most significant epidemiological risk factor for contracting hepatitis B, even though the proportion of sexually transmitted infections seems to be on the rise. More than half of Finnish IDUs have acquired a hepatitis B infection at some point of their life. (Leinikki 2003a, 186–187.) The hepatitis B virus often causes a distinct acute hepatitis infection, which is why hepatitis B outbreaks among drug users are easily identifiable (Ristola 2003, 572). The acute form of the disease is not routinely treated with antivirals. The chronic form of the disease is a significant risk factor for the development of chronic liver damage, but many patients with a chronic infection do not experience any symptoms. (Leinikki 2003a, 187–188.)

### **1.5.3. Hepatitis C**

Hepatitis C virus (HCV) infection usually causes a shortlived liver infection with few symptoms. It is easily transmitted through blood – from bloody injection needles and syringes, for example – and evidently a very

small quantity of the virus is enough to cause an infection. (Leinikki 2003a, 191.) Thus, shared containers for dissolving drugs carry a significant infection risk. Such sharing is quite common (WHO 2004; Ristola 2003, 572). In Finland, hepatitis C infections are mainly acquired through injecting drug use. Shared use of needles and syringes involves a high infection risk, while sexually transmitted infections are relatively rare. (Leinikki 2003a, 191, 194.)

Since reporting started in 1995, 1300 to 1900 cases of hepatitis C infection have annually been reported to the National Infectious Disease Register. A part of these are infections that were acquired in the past and are only now diagnosed. The hepatitis C virus was only discovered in the early 1990s and therefore surveillance of HCV infections only starts in 1995. Little is known about the prevalence of the infection in earlier years in Finland (Cf. Leinikki 2003a, 191).

In Finland, about 50 per cent of all IDUs have HCV antibodies, and 70–80 per cent of long-time users carry the virus. In 75 per cent of the patients the disease causes only mild symptoms, and it is typically detected by chance in laboratory tests or routine examinations (Leinikki 2003a, 191–192.). Despite the mild symptoms, even as many as 80 per cent of the patients with hepatitis C remain carriers of the virus, spreading the disease further (Ristola 2003). In the prospective Riski (“Risk”) cohort study the prevalence of hepatitis C-infection was 52% at the initiation the study. Of those who were uninfected on enrolment, 47% of participants got the infection during a 1.5 year follow-up. (Partanen et al. 2006, 31, 50)

In chronic HCV infection the risk of liver damage increases with time. During recent years, increasingly effective treatments using interferon and various antivirals have been developed. Liver damage and the development of disease can be reduced and delayed by treatment. Disease progression can even be completely stopped for a significantly high

proportion of individuals. For a quite high proportion of treated individuals (30-50%), the hepatitis C virus seems to be disappear from the body by the treatment, although the possibility of low level, undetectable infection cannot be completely excluded. This means that the complete loss of infectiousness cannot be completely verified. Only long term prospective followup studies will tell how large a proportion of those who have been treated will stay permanently virus free, i.e. have been completely cured.

Some of the patients who have received current effective treatments, however, do experience a relapse when the treatment is discontinued. These patients receive symptomatic treatment that may involve a liver transplantation at some point. (Leinikki 2003a, 191–192, 194.) Although effective, pharmacological treatment of hepatitis C is expensive and complicated and may cause side effects, and therefore the patient must be highly motivated (Ristola 1999, 227).

In addition, a treated hepatitis C infection does not prevent from future hepatitis C re-infections. A person with a history of hepatitis C may become infected with hepatitis C again, because the hepatitis C virus has numerous subtypes, each of them capable of causing a new infection (Partanen et al.2006, 62). Drug use as such is not a contraindication for treatment, but continuing drug use often involves continuous exposure to new infections, which is why the Finnish pharmacological models have required an intoxicant-free lifestyle (Ristola 1999, 227).

Before starting the treatment, evidence of at least twelve months of complete abstinence from drugs and alcohol is required of all former abusers of intoxicants. (Karvonen 2003.)

The most important goal of HCV primary prevention is to prevent new infections. The means include information and counselling, securing the availability of clean injecting equipment and reducing risk behaviour in

general. With regard to secondary prevention, it is important to find the carriers and prevent the spreading of their infections. Combining HCV testing with the existing supportive measures for drug users can promote secondary prevention of the disease, i.e., infections will be detected and other people can be protected. (Leinikki 2003a, 191, 194.)

Prevention of late complications has an essential role in the secondary prevention of HCV disease. One means for pursuing this is to provide information on the hazards of alcohol use. (Leinikki 2003a 193.) The hepatitis C virus is fairly common among drug users, and the majority of Finnish drug users are also heavy users of alcohol. Therefore, health counselling must emphasise the importance of abstinence from alcohol. (Ristola 2003, 572.) Use of alcohol considerably increases the risk of liver cirrhosis. HIV is another factor that increases the risk of liver diseases<sup>5</sup> (Leinikki 2003a, 194.). Health counselling focuses on reducing the infection risk, detecting infections and referring the infected for treatment.

Health counselling centres for IDUs conduct HCV antibody testing or write referrals for tests. (Leinikki 2003a, 191, 194.) In Finland, the majority of HCV carriers are under 30 years of age. Within twenty years at the latest, HCV is expected to become a considerable burden for health care services. It is estimated that around the year 2020, several hundred people will be treated with medication in Finland each year, severe liver diseases will be diagnosed in 100–300 people and HCV will cause 30–50 extra deaths per year. (Leinikki 2003a, 192.)

As early as in the final report on Finland's first health counselling experiment in 1998, Ovaska et al. state that the health counselling focused on preventing the spreading of hepatitis C and that hepatitis C was the most

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5 For more details, see, for example, Leinikki, P. (2003) Virushepatiitit. In Koskenvuo, K. (edit.) Sairauksien ehkäisy (Prevention of illnesses). Kustannus Oy Duodecim.

common infectious disease diagnosed in IDUs at that time (Ovaska 1998, 32). Even though the number of infections has fallen from the peak years, hepatitis C is still the most common infection among IDUs, and preventing it from spreading is one of the most important goals of health counselling.

#### **1.5.4. Hepatitis A**

Previously the hepatitis risk in IDUs was considered to cover hepatitis B and hepatitis C, as their aetiology is clearly associated with the risk of blood-borne transmission. During the last 10 years, however, it has been found that the same target group has an elevated risk of hepatitis A, and several hepatitis A outbreaks have been described. Earlier it was assumed that hepatitis A is mainly transmitted through the faecal-oral route, primarily through contaminated food or water or in contact between people with poor hand or toilet hygiene.

Outbreak investigations on IDUs have suggested the above mentioned modes of transmission, particularly hygiene-related problems, but in some cases there is also evidence suggesting that an outbreak was caused through faecal contamination of a drug batch. In addition, a more detailed investigation of the natural history of the disease revealed that patients can be viraemic in the blood, particularly at the acute stage. In IDUs this may lead to an atypical mode of transmission through blood.

The extensive hepatitis A outbreak among amphetamine users in the Helsinki region in 1994–1995 suggested that drugs had been contaminated by the virus through faecal contact during transport (Leino et al. 1997). Later, in the 2000s, hepatitis A outbreaks occurred among users in the Greater Helsinki Area. After this, further outbreaks have been prevented by vaccinations. In Finland, hepatitis A vaccination was included in the general vaccination programme for IDUs in 2004.

## **1.6. Harm reduction and the low threshold principle**

### **1.6.1. From harm reduction .....**

The concept of reduction or minimising of harm is essential in health counselling and can be seen as the ideological basis for the work. Harm reduction involves a multitude of measures aiming to reduce the adverse health, social and economic effects of an individual's activities and certain kind of behaviour. Harm reduction is targeted at risk behaviour that is hazardous for health. Such behaviour may be related to the use of drugs, alcohol or tobacco, for example. Furthermore, this category includes risks associated with sexual behaviour, i.e., unsafe sex. When harm reduction associated with drugs is being discussed, the focus is usually on the most hazardous mode of drug use, injections.

According to WHO (2005), health care professionals understand harm reduction as an objective to prevent and reduce the adverse health effects resulting from certain kind of behaviour. As regards injecting drug use, harm reduction measures aim to prevent HIV and other infectious diseases that are transmitted through contaminated injecting and preparation equipment. (WHO 2005.) Practical harm reduction measures related to drugs are a more controversial issue than, for example, the widely accepted and applied interventions associated with the risks of alcohol and tobacco (Cf. Mäkelä 1999, 194). Harm reduction refers to measures taken to reduce adverse effects of drug use when abstinence from drugs is not possible. At an early stage this may involve counselling to prevent an occasional user from becoming a problem user, or providing information on modes of use that reduce adverse effects. At a late stage, the measures may include pharmacological substitution treatment or exchange of used injecting equipment for clean ones. (Mäkelä 1999, 194.)

Interventions that differ from conventional models cause strong reactions, because drug

use is a social taboo and it is illegal and classified as criminal activity. Traditionally, drug use is seen as socially abnormal behaviour, which may partly have resulted in seeing drug users as outsiders existing in the margin of society. This may have promoted social exclusion and social problems. (Cf. Tammi & Hurme 2006.) For example, drug users may not have the courage to talk about their problems when they are using basic health care services. On the other hand, basic health care services may not have the resources and skills to help a drug-dependent client.

Harm reduction policy has been adopted in many Western countries since the 1980s. It can increasingly be seen as an alternative for the conventional drug policy that sees drug use primarily as an illegal activity (Tammi & Hurme 2006, 113). Harm reduction has gained importance in the field of drug policy, but it does not need to be seen as totally opposite to restrictive drug policy, even though the contents contradict each other to some extent (Cf. Mäkelä 1999, 193). In most cases, the instruments of practical drug policy are a combination of harm reduction and control-based approach (Sarvanti 1997, 201). In Finland today, practically opposite approaches are applied side by side in drug policy, but this has not caused any major conflicts so far.

The ideal of a drug-free society does not necessarily see any difference between problem use and occasional or recreational use of drugs, and the same degree of control applies to all. Those in favour of harm reduction policy believe that drug policy based on criminal control has turned out a failure, because it has not reduced the use of drugs. Furthermore, a policy based on penalty may in itself be a force of social exclusion that makes it more difficult to help and treat drug users. (Tammi & Hurme 2006, 113.) Tammi and Hurme (2006) summarise the main theses of harm reduction on drugs and drug use by stating that drug use is a normal, unavoidable activity in society today, which is why the users should be treated with justice as legally

competent citizens, and any attempts to solve their possible problems should be based on a practical approach and scientific facts. Even though harm reduction policy emphasises individual freedom and users' rights, public health problems stand in the background and, thus, the main objective is to improve public health. (Tammi & Hurme 2006, 113, 118–119.)

Harm reduction policy is based on the opinion that the drug problem cannot be eliminated but the associated harmful effects can be controlled by various means. The best known practical applications of harm reduction include giving up punishability of drug use, arranging syringe and needle exchange services for IDUs and a safe place for use, as well as offering pharmacological substitution treatment for opiate users. (Ibid.)

The practical applications of harm reduction vary depending on the general policies of the country or region. The measures may vary from needle and syringe exchange programmes and often debated low-threshold substitution treatments to lawful rooms for using drugs, legalisation of certain drugs or making heroin available on prescription. In principle, in addition to health counselling and equipment exchange, harm reduction includes field work, peer work, pharmacological substitution treatments and flexible availability of other services. The basic idea is to reduce the harmful effects, not to take a stand on the lawfulness or acceptability of drug use. According to this philosophy, nobody should be denied services or treatment, even if their behaviour questions the norms of society or is even illegal.

Among the measures aiming for harm reduction, the most common, best known and, perhaps therefore, most debated one is the system of syringe and needle exchange programmes. The basic idea of these programmes is to guarantee the best possible availability of clean injecting equipment to prevent IDUs from sharing their paraphernalia. Availability of clean equipment

and encouragement to use them are essential elements of HIV prevention and should be seen as a measure that may contribute to a reduction in the demand for drugs. Availability of clean equipment reduces the risk of an HIV infection, and no negative effects have been detected. In addition to providing clean equipment, measures to control HIV should always be combined with other, parallel measures. (WHO 2004.)

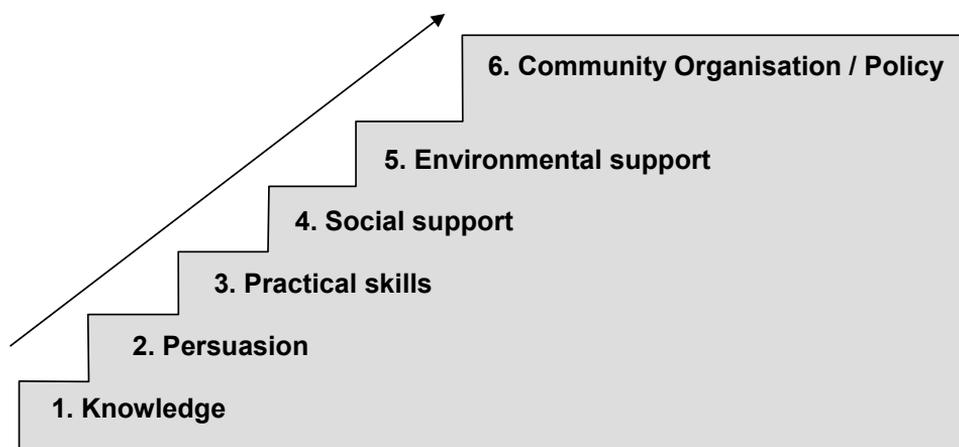
WHO's view on concrete harm reduction requires joint working methods and objectives of those engaged in the work. Efficient co-operation requires everyone involved to accept the policy based on harm reduction and on helping injecting drug users and others suffering from a drug problem. The objective is protection against and avoidance of the health risks associated with drug use, shared use of contaminated equipment and, in particular, serious infections. This thinking and working model improves the health and social status of users and their communities. The resulting beneficial effects on public health are important for the entire population. (WHO 2005.)

treatments are included in the field of harm reduction, because they aim to reduce infection risks through clean drugs by prescribing clean, clinically tested injecting drugs and by offering the opportunity to other modes of use instead of injecting. (E.g. Käll 1996, 207.)

### **1.6.2. .... to low threshold health promotion**

When the possibility of applying the harm reduction model to prevent infectious diseases among IDUs was considered in Finland in the 1990s, a conscious choice of strategy was to emphasise health counselling and low threshold services for drug users. The low threshold refers to availability and approachability of services. In health counselling, what a low threshold means in practice is that the services are free of charge to the clients, non-judgmental, confidential and anonymous, no booking of appointment is required and services are available even to intoxicated clients. Low threshold health counselling centres aim not to turn away people who have been banned from other services. No permanent bans are applied.

**Figure 1. The steps of change for health promotion**



It can be said that the low threshold health counselling services apply the health

The harm reduction model favours distribution of clean, free-of-charge injecting equipment and, ideally, a well-functioning exchange programme. Maintenance and substitution

intervention staircase model introduced by McAlister & Puska as early as 1982. The model is based on proceeding step by step from one health management level to another

with the individual, and finally the desired communal effect is achieved.

The model shows how information (or the lack of it) initially determines the prerequisites for success but is not sufficient on its own to guarantee achievement of the goal. The necessary interim stages represented by the stairs are easy to recognise in the Finnish model of health counselling for IDUs. However, it would be important to ensure that the first threshold or stair remains as low as possible towards the clients, so that users can be reached.

The health counselling centres expect the clients to adhere to certain rules to keep the atmosphere safe and pleasant. Furthermore, certain rules, such as violence ban and strict opening hours, represent order and clarity for drug users and reinforce certain kind of behaviour. A low threshold does not mean that rules can be ignored. The health counselling centres aim to keep the premises peaceful and clean. For instance, the centres avoid administering vaccinations to heavily intoxicated clients. The objective is to keep the threshold for seeking treatment as low as possible and to prevent deaths from overdosage and, perhaps the most important of all, to prevent spreading of serious infections. (E.g., Mönkkönen 2001, 19.) A low threshold is not a synonym of easy work. Quite the contrary, the low threshold approach requires extra commitment and special expertise (Törmä et al. 2003, 105).

## **2. HEALTH COUNSELLING FOR INJECTING DRUG USERS**

The first health counselling centre for IDUs was opened in Helsinki in April 1997. Development of the project began in 1996, but because of strong opposition, the six-month experimental project was not launched until the following year. In addition to being criticised in the media, the project faced opposition from both social welfare services and the police. Moreover, even health care services adopted a negative attitude to the project activities, especially as it was suggested that health counselling for IDUs could be provided in connection with normal health care services. However, the attitudes became more positive when the various actors began to work together and became familiar with the goals and practices. (Mäkelä 1999.)

When HIV infections began to increase among IDUs in 1998, the health counselling centres began to inform drug users through their clients, which brought in many new clients who came for HIV tests and began using the services. The original objectives of starting the first health counselling centre were

- 1) to get in contact with IDUs on a larger scale and to lower the threshold for seeking treatment.
- 2) to reduce the clients' risk behaviour to prevent infections from spreading among themselves and in the rest of the population.
- 3) to obtain information on the situation of IDUs and their risk behaviour in the Greater Helsinki Area. (Ovaska et al. 1998, 14; Partanen et al. 2006, 8.)

Health counselling was first and foremost based on preventive work and, subsequently, on achieving savings in health care costs. Clients were reached outstandingly well.

During the first year of operation (4 April 1997 – 31 December 1997), the health counselling experiment reached 508 clients, 2,157 visits were reported and more than 30,000 syringes were returned on these visits (Ovaska et al. 1997, 17). The health counselling experiment succeeded in reducing the clients' risk behaviour so that shared and multiple use of injecting equipment decreased, even though no big changes could be seen in sexual behaviour (Partanen, 1998). At the beginning, the first health counselling centre, Vinkki, received funds from the Ministry of Social Affairs and Health, and later the operations were financed by the City of Helsinki. (Cf. Mäkelä 1999, 195.)

The original purpose of health counselling centres was to acquire information on epidemics spreading among IDUs and to prevent adverse health effects by providing clean injecting equipment and other supportive services. Preventing new infections and aiming for the earliest possible intervention have been a permanent objective through the years. The goals have expanded and internationally implemented activities and services are increasingly being included in the work.

In 2001, the health counselling centres, the National Public Health Institute and Stakes (the National Research and Development Centre for Welfare and Health) established a sentinel surveillance system for the health counselling centres to streamline and improve documentation and collection of information. Nowadays all the health counselling centres compile annual reports for Stakes and the National Public Health Institute that include figures on customers, customer visits, exchanged syringes and needles, return rates, administered vaccinations, referrals and tests. Lately, the collection of data has been further facilitated and streamlined by developing an internet form to be completed by all the centres.

The health counselling centres aim to influence the turnover and frequency of use of

needles and syringes and to change the clients' risk behaviour. In 2005, the Finnish health counselling centres reached 11,800 clients and the number of visits totalled about 80,000 (operative statistics of health counselling centres in 2005). As clients use pseudonyms to remain anonymous, one client may visit several centres and thus contribute to a higher number of clients in the statistics. However, anonymity and overlapping do not distort the figures concerning the numbers of visits, which tell directly how many times the services were used. In 2005 it was estimated that there were about 14,000 – 19,000 problem drug users in Finland (Partanen et al. 2007). The health counselling centres reached roughly 70 per cent of them.

Amundsen (2006b) states that the implemented syringe and needle exchange programme is not a similar and uniform intervention everywhere and should not be treated as such in literature. First, the services vary: the programme may only involve distribution and exchange of clean equipment, or it may include training and information services, referral for treatment and health care and social welfare services. Second, the services are arranged differently: they may be provided on special premises, at a teller, in a shop, pharmacy or mobile unit, through an automatic vending machine or based on peer exchange. In addition, there may be differences in connections with drug treatment, opening hours, legal status, return procedures or prices. (Amundsen 2006b, 5.)

The Finnish health counselling services are free of charge and anonymous. In 2007, Finland had approximately 30 health counselling centres in 26 towns. Most of them are permanent centres, i.e., services are provided on permanent premises at certain service hours. In some towns, health counselling centres engage in outreach work by visiting the nearby areas, other districts of town or neighbouring towns. In the Greater Helsinki Area, health counselling services are

provided at 13<sup>6</sup> permanent centres and through one mobile unit that has a route with seven stops<sup>7</sup>. Service provision at a permanent centre is the most common arrangement, even though the proportion of mobile units will probably increase. Now there are only two mobile units in Finland. In some towns, peer activities have proved an efficient way to reach users and exchange syringes and needles.

In Finland, syringes and needles can be obtained from health counselling centres or purchased from a pharmacy. The role of pharmacies in promoting the availability of clean syringes and needles is essential with regard to their geographical coverage. Based on a survey conducted by the A-Clinic Foundation in 1997, 1999, 2001 and 2003, pharmacies have about 100,000 identified customer contacts with drug users each year. (Harju et al. 2000a; Perälä et al. 2003; Malin et al. 2004.)

Based on the Government decision-in-principle on drug policy, in 1999 the Ministry of Social Affairs and Health, the National Agency for Medicines, the National Public Health Institute, the Association of Finnish Pharmacies and the Yliopiston apteekki pharmacy chain issued a recommendation for pharmacies to sell injecting equipment to IDUs. According to the latest data, 85 per cent of Finnish pharmacies sell clean syringes and needles to drug users. In most cases this does not involve health counselling or the opportunity to return used equipment. According to the pharmacies participating in pharmacy surveys, the principal form of health counselling provided by pharmacies was informing about health counselling centres. In 2005, pharmacies sold more than 300,000 syringes and needles to drug users, plus more than 55,000 syringe-needle packages (a package contains 3 syringes and needles, disinfectant wipes and information on

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6 LTHSCs maintained by the A-Clinic Foundation: Espoo 5 centres, Helsinki 4 centres, Vantaa 2 centres. Deaconess Institute in Helsinki 2 centres.

7 Deaconess Institute's mobile unit: Helsinki 5 stops, Vantaa 2 stops.

prevention of infections). (The opinion of the Board of the Association of Finnish Pharmacies on pharmacies' role in drug prevention in 2006.)

In 2003, eighty-six per cent of the pharmacies answering the pharmacy survey (651 out of 801 pharmacies answered) said they sell syringes and needles, and about half of them accepted used equipment. The pharmacies basically share the opinion that the distribution of syringes and needles should primarily be arranged through health counselling centres (84%), in co-operation between several actors (47%), through mobile units (41%), through health centres (40%), through pharmacies (22%) and through vending machines (65%). Health counselling centres (82%) and vending machines (65%) were mentioned as the best routes for returning equipment. (Malin et al. 2004, 15.)

Kaukonen (2002) states that the end of the 1990s and beginning of the 2000s can be seen as a period of expansion in specialised drug treatment. The number of special units for drug treatment increased at least tenfold, the number of beds in treatment units rose and a larger selection of special services were targeted at drug users. (Kaukonen, 2002, 156.) Health counselling centres are defined as specialised intoxicant services<sup>8</sup>, included in the so-called restorative intoxicant work. This period of expansion was the time when the number of centres increased. At the same time, other low-threshold drug treatment alternatives were included in the services and pharmacological treatment for the opiate-dependent was expanded (Kaukonen 2002, 156). The idea of harm reduction as the basis of health counselling is, however, partly based on preventive intoxicant treatment aiming at reduction of adverse effects caused by intoxicants. According to Kaukonen (2002),

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8 Specialised intoxicant services: A-Clinics, youth clinics and similar outpatient treatment units, detoxification units and rehabilitation units and day centres for problem users of intoxicants, overnight shelters and housing services and LTHSCs. (Päihdehuollon huumeasiakkaat 2006.)

new services were arranged at the end of 1990s as a response to a distinct rise in drug use, appearance of new drugs in the market and a rapid increase in injecting drug use. Other startling phenomena were the rapid spreading of HIV infection and hepatitides among IUDs and the simultaneous increase of drug deaths from opiate use. (Kaukonen, 2002.)

Martti Lindqvist (1989) writes on the importance of Aids prevention and lists concrete preventive measures and treatments to suppress the epidemic. Lindqvist's list includes, for example, free-of-charge, confidential and, when necessary, fully anonymous tests, professional counselling and support in connection with the tests and comprehensible, concrete and objective information. Lindqvist says: "It is particularly difficult to prevent infections in groups that are socially very negatively branded and have the least ability to control their life. These include injecting drug users and prostitutes – especially as we are often talking about activities that are defined as criminal or are closely associated with crime. Even with these people, gaining their trust and being able to improve their overall life situation is the best – albeit difficult – road to the future." (Lindqvist 1989.26.)

Until 1998, HIV infections transmitted through injecting drug use were individual occurrences and acquired abroad. Active prevention of infectious diseases in IDUs became relevant in connection with a hepatitis A epidemic in 1994–1995, a subsequent hepatitis B epidemic and, finally, an HIV epidemic in 1998. The HIV epidemic peaked in 1999 with 143 diagnosed cases, 84 of these (57%) acquired through injecting drug use. In the Greater Helsinki Area, the epidemic among IDUs detected in 1998 continued to spread until 2000. Since 2000, the number of annually diagnosed new HIV cases acquired through injecting drug use has continued to fall. Less than 10 cases are now diagnosed each year. In the more than 7,000 HIV rapid tests conducted at health counselling centres

and prisons from 1998 to 2003, the proportion of HIV seropositive results fell from 6.7 per cent to 0.4 per cent at health counselling centres and from 2.4 per cent to 0.3 per cent in prisons (Kivelä et al. 2006). The results of anonymous exit polls and tests conducted at health counselling centres each year also indicate that the prevalence of HIV infections has remained low.

Good availability of clean syringes and needles and early intervention were the means to respond to the growing number of infections. Health counselling services were first expanded in the Greater Helsinki Area and then in other parts of Finland. Opening hours were extended and services were improved. At the same time, pharmacies were encouraged to continue selling syringes and needles.

Since 2000, the Helsinki Deaconess Institute has maintained a service centre for HIV positive IDUs in Helsinki. In addition to syringe and needle exchange and other health counselling, the services include meals and various health and social care services. During its years of operation, the service centre has reached 218 HIV positive drug users. Of these, 41 had died by the end of 2006, most of them in accidents and four of Aids. On an average day in 2006 the service centre was visited by 130 individual clients. (HDL annual report 2006, 25.) The services provided by the day centre are intended for HIV positive IDUs only, but the health counselling services provided in the same building are available to all IDUs. Kivelä et al. (2006) state that providing separate services for HIV positive IDUs may have limited this group's contacts with other IDUs, thus restricting formation of networks and spreading of infections (Kivelä et al. 2006). Also, the service centre is responsible for the clients' HIV medication, which further reinforces commitment to the use of the services. According to Kivelä et al., HIV medication may decrease the number of HIV infections, because the infectiousness of the virus is impaired by medication (ibid.). At the service centre, HIV positive drug abusers

enrol as clients under their own names and give the personnel permission to use their information, after which all the daily services of the centre are at their disposal.

The expansion of health counselling has led to emergence of new phenomena in the drug culture. The most significant of these are probably the development of peer activities and the founding of user associations by drug users. The user associations are based on recognising the equality of drug users as users of services. Strong peer support and assistance for drug users in the use of services are other important aspects of the activities.

Internationally, health counselling centres are often known as needle exchange centres or needle exchange programmes<sup>9</sup>. In Finland, the exchange service has always been called health counselling centre<sup>10</sup>, as this reflects better the multiple tasks and the goals of the work. Another purpose of the name is to emphasise the fact that even though syringe and needle exchange is the most important service provided, other services are available as well and all the activities are based on personal contact and a comprehensive approach. Health counselling in itself is defined to involve handling of questions relating to health promotion, disease prevention or treatment, looking for solutions to problems and providing counselling in connection with client/patient contacts in health care in an interactive situation where one of the participants is a health care professional and the other is a client or a patient (Vertio 2003, 1009).

In Finland, health counselling is based on a structure of its own. It was not even tried to adapt the work to the ordinary health care system, as its capacity and expertise would not necessarily have been sufficient for maintaining the operations at the current level.

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9 Needle exchange programs (NEP), Needle and syringe exchange programs, Syringe exchange programs (SEP), Needle exchanges (NX)

10 Low threshold health promotion and service centres (LTHSC).

In recent years, however, the trend has been to take the health counselling closer to basic health care. The Communicable Diseases Act (583/86) and the Communicable Diseases Decree (786/86) specify that health centres are responsible for prevention of infectious diseases in drug users as a health-promoting measure. The decree (1383/2003) appended to the Communicable Diseases Act in 2004 obligates municipalities to provide health counselling for injecting drug users in their area, including exchange of injecting equipment. The Decree states that in addition to what is stipulated by law, the tasks of the municipal body responsible for prevention of infectious diseases and the doctor responsible for infectious diseases at the health centre include prevention of infectious diseases in the area of the health centre, which includes providing information on infectious diseases, health education and health counselling, including health counselling for injecting drug users and, according to the need for prevention of infectious diseases, exchange of injecting equipment. (Infectious disease decree 1383/2003.)

In practice, providing services according to the need means that the municipality should survey the number of IDUs in its area and provide health counselling services for them as efficiently as possible. Organising of extensive services is naturally a matter of discretion if no signs of IDUs in the area are detected in surveys. In Finland, the municipalities are responsible for arranging intoxicant treatment services, but they decide themselves how the services are arranged. The availability of services varies greatly between municipalities. According to a municipality survey conducted in 2004, only about 30 per cent of the municipalities provided syringe and needle exchange services for drug users. Only about 10 per cent of the municipalities answering the survey provided these services in their own area. The health counselling centres were mainly located in large municipalities, with their neighbours using the services to some extent. According to the 2004 municipality survey, 37 per cent of

municipalities did not provide substitution and maintenance treatment for opioid addicts. (Ministry of the Interior 2005, 122.)

Many municipalities purchase health counselling services from third sector actors, even though the aim is to integrate health counselling more closely to the basic services provided by the municipalities. Purchased services may involve certain problems. Health counselling expertise remains with the service provider, and the activities may form a special service isolated from everything else unless active communication and co-operation is established with the health centres. Another problem with purchased services is that they are provided for a fixed term and there may be a tendering procedure involved. Tendering procedures in connection with this kind of health and social welfare services create a somewhat absurd setting for work that can with good reason be said to require long-term effort and commitment. Towns may arrange a tendering procedure for health counselling services as often as every year, which is naturally reflected on the motivation of staff and the quality of work.

It is worth noting, however, that shifting health counselling closer to the basic municipal health care services may create an impression of drug use and the related problems as an everyday issue, which in turn may lead to an illusion of acceptability. On the other hand, a phenomenon handled in specialised services fosters the impression of drug users being just a marginal group. Many service providers, such as the A-Clinic Foundation, the A-Clinics, Christian organisations and the Helsinki Deaconess Institute have solid expertise in providing health care and social welfare services for problem drug users, but their specialised services are not available everywhere in Finland. As an outcome of the Decree to the Communicable Diseases Act, hospital districts launched a training programme on harm reduction and health counselling in 2005. The goal was to enhance health centres' capacity to provide health counselling.

From the very beginning, the basic idea of health counselling has been preventive work, i.e., it aims to prevent diseases and deterioration of health. The objective was to develop a health counselling model that concretely combines disease prevention, health protection and health promotion. The primary goal of health promotion is not to turn people's behaviour into a certain direction but to improve their ability to participate in decision-making concerning their health (Vertio 2003). Health counselling is based on primary prevention<sup>11</sup>, i.e., the goal is to ensure that no one will contract an infection because of lack of information or because of unavailability of preventive equipment (Leinikki 2003).

Marita Poskiparta (2002) approaches the change in health behaviour with the means of resource-oriented health counselling. The stages-of-change model that has been applied to suppress behaviour that causes adverse health effects sees the change of behaviour as a cycle consisting of six different stages. In this process of moving from one cycle to another, clients are seen as equal companions who should assume an active role in the decision-making concerning their own health and who are supported throughout the process. Poskiparta emphasises the fact that changing one's living habits is not an individual event but a long-term process that will take its time. The process advances step by step, with regressions and setbacks. These are common incidences on the way to change, not signs of failure. Change is not a straightforward process from preliminary planning to completion. Instead, individuals shift between the stages until they finally reach permanent change of behaviour. (Poskiparta 2002.)

Finland's national HIV/Aids strategy for 2002–2006 states that preventive measures are based on prevention of new HIV infections, and with regard to injecting drug users, the

challenge is to reduce the number of new HIV infections. Based on the statistics on infectious diseases, the number of HIV infections transmitted through injecting drug use has fallen from 2002 to 2006, while at the same time the goal has been to maintain a high testing rate among the risk group. As regards IDUs, the strategy sees health counselling as one of the most essential means of preventing HIV infections, and a well-functioning further care system and efficient connections with other forms of drug work are needed to complement the counselling services. Furthermore, it is important to ensure that implementation of the decree on the treatment of the opioid-dependent is realised for HIV positive users as well. (Strategy 2002, 18–19.) Referral for services has become more and more important in health counselling over the years, and this has reinforced the contacts between the health counselling staff and other professionals engaged in drug work. The service centre of the Helsinki Deaconess Institute is largely responsible for substitution and maintenance treatment of HIV positive IDUs. Secondly, according to the strategy for 2002–2006, health counselling should be available in all larger towns within three years, and the service should include exchange of injecting equipment.

The number of health counselling centres has grown from 2002 to 2006, but services are not established in all towns and municipalities. The decree appended to the Communicable Diseases Act has been of great importance for achieving the goal, as municipalities are now increasingly making efforts to arrange health counselling services in their area. One of the biggest challenges in the strategy is achievability, according to which health counselling must reach the majority of problem drug users. In 2005, health counselling reached about 11,800 of the estimated 14,000–19,000 problem users (The operative statistics of health counselling centres; Partanen et al. 2007).

The third goal concerns the health counselling work itself. Different health counselling

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11 Prevention of diseases, targeted at healthy individuals as prevention.

methods should be developed, aiming to integrate health counselling as efficiently as possible into municipal health care and social welfare services. (Strategy 2002, 19.) In practice, this goal means that the well-functioning Finnish health counselling system that is currently being run by associations and organisations should increasingly be implemented as part of basic health care services. The purpose is to shift responsibility for the services to municipalities and, consequently, to establish the status of the work and allocate permanent resources for maintenance and development of the services.

The main strengths of the health centre network are geographical coverage, good accessibility and multiple services, such as multi-professional staff and laboratory services. The weaknesses include limited special expertise and possible attitude problems relating to health counselling and the target group. The objective is that health centres take IDUs and prevention of infectious diseases into account in the implementation of population responsibility principle in the area. Municipalities may have decided to arrange counselling at health centres, with assigned personnel responsible for providing the services. Also, the services may be purchased from A-Clinics, etc. Small municipalities often purchase their health counselling services from a bigger neighbour, because providing services for a few potential clients does not serve its purpose and clients might not use the services anyway in a small municipality where everybody knows everybody else.

Depending on the region, even more than ten municipalities may purchase their health counselling services from one bigger neighbour. The integration objective is associated with the goal to provide training in health counselling and the basic idea of harm reduction to reinforce the professional skills and clarify the duties of those engaged in health counselling work. In addition to health counselling, substitution and maintenance treatments are increasingly being transferred

to health centres to lower the threshold for treatment (Rönkä & Salonen 2006).

The Government's drug policy action programme for 2004–2007 emphasises reduction of blood-borne infection risks and of the demand and supply of drugs. Securing the availability of appropriate drug treatment services is specified as an objective. To achieve this goal, efforts will be made to develop and maintain diverse drug treatment services, improve the achievability of treatments and remove obstacles of access to treatment. The availability of drug treatment services will be improved in specialised intoxicant services and basic health care, focusing on low-threshold services for problem users, and in substitution and maintenance therapies that are the most efficient means of preventing infectious diseases, for example. Development of the intoxicant treatment service system emphasises evaluations provided by municipalities and organisations on the sufficiency and functionality of services. Organisation of services according to need, as mentioned in the Decree to the Communicable Diseases Act (1383/2003), is discussed as well (Government decision-in-principle... 2004–2007, 19. Ministry of Social Affairs and Health).

Well-organised health counselling provides information on drug use culture and its changes and the behaviour of the marginal group as a whole. In addition, as a result of efficient testing and reaching of drug users, health counselling centres can rapidly detect any epidemiological changes in the risk group.

### **2.1. Services provided by LTHSCs**

The services provided by LTHSCs vary depending on the weekly opening hours, the premises, the number of personnel and clients and the resources available for the work. The purpose is to establish health counselling services as part of injecting drug culture so that equipment exchange and use of clean

paraphernalia as well as use of the services become common practice. It is a huge challenge for health counselling services to be able to respond to the ever-changing drug use habits, the events and occurrences in the world of drugs and the continuously changing user base.

The health counselling services are free of charge, confidential and anonymous, and they are available without an appointment. Clients are asked to give a pseudonym and their year of birth. In addition to concrete equipment exchange service, the LTHSCs inform clients about treatment facilities and services, refer drug users for treatment and engage in field work, peer training and production of health education material. Even though the Finnish LTHSCs provide diverse services and maintain a low threshold, all IDUs (injecting drug users) are not using the services, and some may never start using them. The reasons for avoiding LTHSCs may include problems with the police, the low threshold being still too high, the problematic role of social networks or fear of being branded. Other ways of obtaining clean equipment, such as pharmacies, outreach work and peer work, are of essential importance for drug users who do not use health counselling services.

All the LTHSCs provide basically the same services, but there are some differences. Syringe and needle exchange forms the basis of the service. This is the most popular service at all the centres and the most important means of attracting clients. The number of exchanged syringes and needles varies by centre: in some centres, clients get as many clean syringes and needles as they turn in, but most centres apply a limit of 40–80 at a time. Clients usually return their used equipment packed in empty bottles or other containers they considered safe. Some centres provide the clients with infection risk containers for collection of used equipment. The personnel of the centre do not handle returned exchange equipment. Instead, clients put the instruments in a risk waste container or, for example, on a tray to facilitate counting, after which they are

dumped in the risk waste container. Returned instruments are not usually counted one by one. Instead, the number of instruments is estimated visually or based on the size of the container. The LTHSC is responsible for waste management of the returned equipment.

The centres conduct HIV and hepatitis testing, either on premises or by referring clients to tests, usually conducted at the health centre, for example. Some centres use a rapid HIV test that gives the answer in 15 minutes, but every positive test result must be confirmed by an analysis of a venous blood sample. If a centre does not provide in-house testing or a referral cannot be written for anonymity reasons, for example, clients are advised to have themselves tested for HIV anonymously at the Finnish Red Cross or the Finnish Aids Council. All LTHSCs provide oral and written information on infectious diseases, health care and treatment facilities, and they treat minor wounds, vasculitides, infections and injuries. Personal contact and discussion are used as a means for building confidential relationships with clients and for providing them with information on health protection.

All LTHSCs offer the opportunity for supportive discussions with the personnel and help in various crises and other acute problems. The most typical vaccinations administered are free-of-charge hepatitis A and B vaccinations, available at nearly all of the LTHSCs by now. Also, all centres distribute free condoms and lubricants and skin cleaning equipment. In addition to syringes and needles, clients are offered other injecting instruments, such as mixing containers and filters. Other services provided by some LTHSCs include, for example, doctor's consultation, meals, acupuncture and use of the internet. Furthermore, some centres have arranged a room where clients can rest. At some centres, visitors can wash clothes and take a shower. There may even be some fresh clothes available. Where doctor's consultation is available, the doctor usually comes for a few hours per week or once in two weeks. The need for doctor's services is usually associated

with severe vasculitides, birth control and referral for treatment. Doctors write prescriptions mainly for birth control pills and antibiotics, and they insert implantable contraceptives free of charge. Some centres have included pregnancy and STD testing in their services, and they are increasingly offering follow-up of liver values for clients with hepatitis C.

All centres provide oral and written information on infectious diseases, health and infection risks and how to avoid them, health risks related to drugs, safe injecting and alternatives for injections. Referral for services has become an important part of the health counselling work. It involves working together with the client to find the best possible services, such as drug treatment or housing, and to support the client in the use of the services. The centres aim to help clients in questions relating to livelihood, housing and criminal justice and to advise the customers in the use of specialised services. All LTHSCs refer clients for services, but opening hours and number of staff, for example, affect the efficiency of this work. Many LTHSCs have formed networks with other centres or actors and initiated international co-operation with other providers of services for drug and intoxicant users.

Mobile units were developed with the aim of making their services as extensive as possible, so that basically the same services would be available at the LTHSCs and mobile units. Mobile units are typically ambulances or vans with two employees. The primary services include syringe and needle exchange, HIV testing, referral for treatment, health care services, referral for services, hepatitis vaccinations and, when necessary, accompaniment service (Törmä & Huotari 2005, 21). A special feature of mobile units is the different structure of client base compared with the ordinary LTHSCs in the Greater Helsinki Area. It seems that a mobile unit can efficiently reach users who do not want to meet other users and are therefore avoiding the other centres. Clients of the mobile unit also

included those who did not use other services, particularly young people, users who had only recently started using drugs and recreational drug users. (Huotari & Törmä 2005, 113–114.) Different risk groups prefer different health counselling services, and the mobile unit has shown that to reach drug users it is a good idea to have parallel services that are provided in different ways (Ibid., 131).

Geographically, the majority of health counselling services are located in Southern Finland, while Northern Finland is almost blank in this respect. Many LTHSCs have signed a purchase agreement with neighbouring municipalities or cities on sharing the costs of services, based on the number of clients from each municipality. Estimated average annual costs per client are about 160 euros.

## **2.2. Basis of the evaluation study**

Extensive studies have been conducted on ways to reduce infection risks among IDUs, and a good mutual understanding has been achieved at international level. Syringe and needle exchange programmes have established their position worldwide as an efficient way of minimising infection risks. Such programmes, implemented with various methods, have been established in prisons as well. Furthermore, HIV and other blood-borne infections are prevented by drug treatments focusing on treating opioid dependency, high-quality treatment of HIV positive drug users and various forms of outreach work. Syringe and needle exchange programmes and opioid substitution treatment have become the most common and, according to experience and studies, the most efficient ways of reducing infection risks among IDUs. (WHO 2004; WHO 2005; EMCDDA 2006.)

Health counselling is a challenging area of research, as intervention is based on social interaction aiming for long-term change. Health counselling uses educational and communicative means to help clients to cope in life and society. Other objectives include providing information, encouraging clients to

pursue health-enhancing improvements and supporting clients in their effort to change. Building health counselling services and reaching customers are a continuous process. Both the provider and user of services are learning to interact and communicate, paying attention to each other's preferences and goals.

A shared learning process and interaction create effects that are difficult to predict in advance. Evaluation of the effects discloses elements that can be expected to be essential for the effectiveness of the work. Effectiveness was sought, for example, in the Riski ("Risk") study. It describes changes of risk behaviour in clients of some LTHSCs during a certain period of time (Partanen et al. 2006). Effectiveness may also refer to increased awareness and knowledge among the clients of a centre and their improved ability to take responsibility for their own health and life. But what kind of downward or upward changes reflect effectiveness, and how can it be measured? How is it possible to confirm whether an intervention has changed the nature of a social phenomenon – the concept of risk – and which factors affected it?

Evaluation of effectiveness is a justified requirement to define the benefits, efficiency, profitability and effects of a new activity. With regard to the requirement of effectiveness, the questions are: what can be evaluated, what can be measured, with what means and how? Is it possible to measure the goals and the efforts to achieve them? The LTHSCs have had multiple goals from the very beginning, some of them difficult to measure. Furthermore, health counselling forms an extensive network that is not fully consistent functionally, and the centres may have different interim goals. The objectives of health counselling change as the operations develop, and working methods are modified according to the clients' needs. Therefore, it is not possible to specify a single, fixed goal and say that the work is successful if this particular goal is achieved.

Despite the abovementioned limitations with regard to the evaluation of effectiveness, assessment of the results of health counselling and harm reduction, like any evaluation of interventive health care measures, should be based on comparing outcomes with the original objectives set for the intervention. This study focused on one important interim objective, i.e., prevention of infectious diseases.

Preventive effects can be measured with various health indicators that may be functional, i.e., descriptive, or based on the final results if they are measurable. The simplest indicator for measuring prevention of infectious diseases is the number of prevented cases of illness in the period following the intervention. If the achieved savings in resources should be evaluated, the evaluation can be based on savings achieved in the direct and indirect costs and the burden of disease. If these are difficult to measure directly, relevant indirect indicators could include reduction of risk behaviour, the number of target group members reached, coverage and the percentage of reached individuals of the entire group. The quantity of resources used can also be used as an indicator. Other possible indicators include various changes in attitudes, false presumptions or values in the target group and/or interest groups during an intervention.

The Government decision-in-principle<sup>12</sup> on 5 February 2004 used three scenarios to describe the possible future development of the drug problem in Finland. In this context, the drug problem referred to all the adverse effects resulting from the use and supply of illegal drugs. According to the scenarios, the situation may A) deteriorate B) remain the same or C) improve. In the scenarios, the year 2007 is defined as the year of evaluating the effectiveness of the programme.

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12 The Government's drug policy action programme for 2004–2007 (Only available in the Finnish language).

The scenario models include descriptions of factors promoting the realisation of the scenario and of public measures that could be used to influence the realisation. The action programme applies various health indicators to separate the scenario models from each other and to monitor their realisation. In this study, the most relevant of these indicators is the number of HIV infections in drug users<sup>13</sup>. The ranges specified for this indicator in the different alternatives are relatively narrow: 50–100 cases per year meant deterioration and fewer than 30 cases improvement of the situation. This is a very ambitious goal in international comparison.

The Government decision-in-principle made in 2001 on the Terveys 2015 (“Health 2015”) public health programme<sup>14</sup> specified goals for the development of citizens’ health and quality of life during the programme period. Prevention of adverse health effects caused by addictive substances is mentioned in connection with the health of young people. Various health indicators were later developed for monitoring of the realisation of the programme. The most relevant of these indicators in this context is the frequency of injecting drug related infections (HIV, hepatitis A, B and C) in 15–24-year-olds.

So-called hard indicators, such as changes in the number of cases, are relatively easy to measure in Finland and can be used as indicators of the effectiveness of an intervention. Compared with many other countries, our advanced health care and infectious diseases monitoring systems enable measurement of changes in the incidences of infectious diseases with high reliability. Therefore, for example, changes in the annual number of diagnosed cases could be used as an indicator. A change in the number of new diagnosed cases basically describes the *incidence* of a disease (the occurrence of new cases during a certain period of time or during

measurement in a certain limited group, usually proportioned to a standard number of population, such as 10,000 or 1,000,000). The figure is never exactly the same as the actual incidence. For example, the accuracy and sensitivity of diagnostic methods used to detect the disease, various delays related to diagnosis and the probability of being diagnosed at all are factors that contribute to differences between the two figures. However, it is estimated that because of the extensive testing conducted in Finland, the number of new HIV and hepatitis B cases reflects very well the true incidence of new infections. With regard to hepatitis C infection, the clinical picture of the disease may cause a longer delay, but in the younger age groups the number of diagnosed new cases is close to the actual incidence. In an efficient intervention, the incidence can be expected to fall rapidly as the result of preventive measures.

Another frequency indicator for a disease can be measurement of its *frequency of occurrence* or *prevalence*. Frequency of occurrence is the percentage of carriers of a disease during a certain period or during measurement in a specific, limited group. Prevalence is the frequency of occurrence proportioned to a larger group, usually 10,000 or 1,000,000 people. Frequency of occurrence is a good indicator for describing the frequency of a disease and basic risk in the population if the disease is permanent and chronically infectious, such as the HIV infection, the majority of hepatitis C infections and some hepatitis B infections. As regards chronic infectious diseases, frequency of occurrence is an indicator that responds more slowly to an efficient intervention, because depending on the clinical picture, the decrease rate of the number of infected in the group under review may be very slow and even equal to the group’s regeneration rate.

Furthermore, frequency of occurrence can be used as an indicator in an opposite way: if reliably measured frequency of occurrence (prevalence) does not increase but remains the same over a short or medium-length period,

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14 Sosiaali- ja terveystieteiden ministeriön julkaisu (Publications of the Ministry of Social Affairs and Health) 2001:4

this suggests effectiveness of the intervention as an element protecting against risk. This, however, requires that the group under review is not saturated. Saturation means that all or the majority of those exposed to risk are already infected. In a saturated epidemic, the frequency of occurrence falls very slowly even if the intervention is efficient.

Using general indicators, a health care intervention can be considered effective if it improves clients' health or prevents deterioration of health. When the effectiveness of LTHSCs is being measured, the use of functional indicators only, such as surveillance of the number of clients or visits, should be avoided, because maintaining or increasing the numbers may easily become a goal in itself. Likewise, hasty conclusions should be avoided when interpreting surveillance statistics. For example, a low number of new HIV infections should not lead to less active testing. Figures reflect activities, but sometimes it is necessary to find out what is going on behind the figures and how they were achieved. For these reasons, the services should be viewed from multiple angles: how customers become attached to health counselling service, how the attachment process proceeds, which risks can and cannot be influenced, etc. What should be done and how to achieve a situation where the clients' knowledge and skills to avoid risks are as good as possible, the client base covers problem users as extensively as possible and the number of new infections remains low even with active testing?

The position of LTHSCs in the field of intoxicant services is unrewarding in the sense that success is difficult to verify. For example, the success of institutional care for drug users can be studied using a before/after setting that describes the drug user's situation before and after treatment. After the treatment it is possible to determine where a change can be seen and what the probable cause was. The goals and achievements of health counselling targeted at IDUs are much more difficult to detect, as clients are not required to commit themselves or to achieve a certain change in

their behaviour. The service is anonymous, free of charge, customer-driven and does not in itself aim for an intoxicant-free life or treatment of the problem. Whenever a client stops using injecting drugs, the positive result cannot be seen, as the client no longer needs the services of the LTHSC and moves on to use other services. A situation where clients are aware of risks and know how to avoid them, care about their own health and possess the knowledge and equipment to protect themselves can be considered an achievement.

Harm reduction applications depend on the conditions defined by the political, epidemiological and cultural environment of the country or region in question. Moreover, the extent and coverage of harm reduction activities and, most importantly, the infectious disease situation greatly influence studying of the public health effects.

In an international comparison, the number of HIV positive IDUs has remained relatively low in Finland, which defines the outlines for the type of information that can be provided on intervention services and their effects. By the beginning of 2008, there were slightly more than 300 reported cases of HIV infections acquired through injecting drug use in Finland, most of which have occurred in the capital area. By comparison, the network of LTHSCs covers most parts of the country, particularly the largest municipalities.

For the purpose of evaluating effectiveness of interventions aiming at infectious disease prevention and/or control, several intervention sub-objectives can be identified. On one hand, the aim may be to completely prevent undesirable outcomes, such as new infection/disease cases and outbreaks or epidemics. This is especially relevant for most vaccination programmes. On the other hand, the objective may be to prevent an increase in existing prevalence in a subpopulation or facilitate the decrease of prevalence to a low, but not necessary zero level. In this case the idea is to lower the risk of a widespread

community epidemic to a level which is as low as is realistically possible.

For some infections and circumstances it has been possible to estimate prevalence thresholds for which there exists a relationship between the likelihood of risk realisation and intervention coverage. If the coverage of the intervention activity is high enough, the likelihood of rapid increases in prevalence becomes low.

Such a situation is highly analogous to the notion of herd immunity which occurs when a large proportion of vaccinated individuals also provide protection for those few who are unvaccinated. The effect is mediated by the easy availability and high coverage use of clean injection equipment as well as avoidance of shared using. This stops the development of infection chains and prevents the formation of wide transmission networks.

Evaluating an intervention prospectively as a comparative study in cities or regions differing in coverage of access to clean injection equipment is possible, but ethically difficult to defend. In addition, such a comparative study design contains several issues that challenge the validity of the experimental setup. In Finland the low prevalence of HIV-infection (which is beneficial from a public health perspective) also makes location based comparative intervention efficacy studies using incidence-outcome measures difficult to perform. For hepatitis C-infection, the difficulties lie with inability to reliably distinguish acute cases from long-term infections.

Instead, the effectiveness of an intervention can be evaluated retrospectively at the same location, i.e. by comparison of emergence of transmission clusters, the preservation of low prevalence or a lowering of prevalence pre- and post-intervention.

The low frequency of HIV infection has enabled accurate monitoring of the epidemic, prevention of other infections typical for IDUs

and building of appropriate structures to prevent future epidemics. In addition to monitoring of the infectious disease situation, sampling surveys and statistics on the operations of the LTHSCs, infections and infection risks in IDUs can be understood through description of the health counselling work, whom it reaches and in what ways.

According to Amundsen (2006b), certain goals can be set for syringe and needle exchange, and the best possible operating models and methods must be found to be able to achieve these goals. Amundsen suggests the following goals for activities targeted at IDUs: prevention of HIV and HCV infections, reduction of risk behaviour and shared use of equipment, reduction of injecting frequency and access to treatment services. (Amundsen 2006b.) While questioning syringe and needle exchange programmes as a superior instrument for prevention of HIV and other infections typical for IDUs, Amundsen (2006a) states that studies should pay more attention to finding out which elements in the exchange programmes are the most efficient with regard to preventing infections. (Amundsen 2006a).

Bastos and Strathdee (2000) emphasise the same issue. They point out that studies on syringe and needle exchange and its effects should focus more on investigating which structural elements of an exchange programme are the most and least efficient in reducing infection risk (Bastos & Strathdee 2000). In the light of international effectiveness studies, Amundsen (2006b) is right in noting that syringe and needle exchange programmes do not apply the same principles everywhere and there may be considerable differences between the contents of the programmes. Therefore, an established syringe and needle exchange programme cannot be automatically expected to be efficient without knowing what it contains, how the services are implemented and how individual elements in the service content contribute to reduction of infection risks. (Amundsen 2006b.) In addition to provision of clean injecting equipment, other

elements of health counselling may have been equally important for positive results.

A syringe and needle exchange programme does not run automatically once it is established. The location of the centre, for example, may affect its ability to reach clients and reduce infection risks. In Finland it has been noticed that if the LTHSC is too far away, too visible, located in connection with another service or cannot be visited anonymously, the goals may not be achieved.

### 3. METHODS AND DATA SOURCES

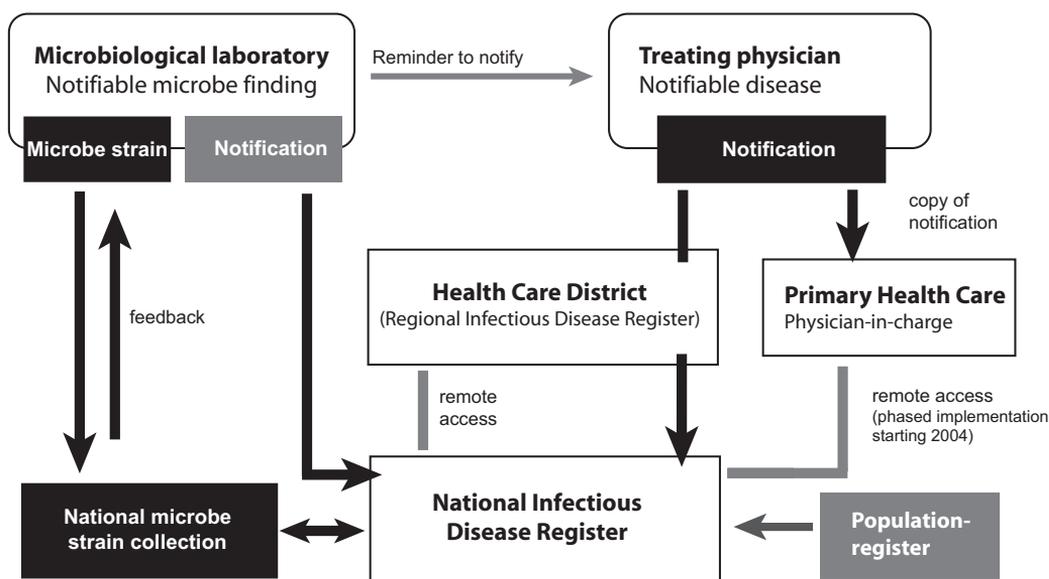
The evaluation of the effectiveness of LTHSCs in prevention and control of infections among IDUs was based on literature, infectious diseases surveillance data and operational statistics compiled from counselling centre reports, as well as register studies used for assessing changes in the numbers of drug users. The most extensive independent empirical part of the study was conducted in the form of qualitative and semi-structured interviews with the actors.

hospital districts have regional responsibility for surveillance of infectious diseases, and the National Public Health Institute is responsible for surveillance at national level. The Ministry of Social Affairs and Health is responsible for the management of national health policy..

#### 3.1.1. Passive surveillance (the National Infectious Diseases Register)

Cases notified to the National Infectious Diseases Register were used as the indicator for surveillance of the epidemic. The National Infectious Diseases Register<sup>15</sup> is maintained by the National Public Health Institute, and notifications to the register come from clinical microbiology laboratories and treating doctors.

**Figure 2. The Electronic Notification System for Infectious Diseases**



#### 3.1. Surveillance of infectious diseases

Surveillance of infectious diseases aims to provide up-to-date information on the frequency of occurrence / prevalence and incidence of infectious diseases. Analysis of the surveillance data provides information on the economic significance of various infectious diseases, which can be used as a basis for allocating resources to prevention and treatment. In Finland, health centres and

Notification is based on an obligation, specified in the Communicable Diseases Act and the Communicable Diseases Decree<sup>16</sup>. The diseases (and their causative organisms) and related additional information to be notified are specified in the abovementioned regulations and the appended instructions based on standardised definitions. The register is the most important national tool for

<sup>15</sup> [www.ktl.fi/tr](http://www.ktl.fi/tr)

<sup>16</sup> The Communicable Diseases Act and the Communicable Diseases Decree

surveillance of infectious diseases and epidemiological changes. It provides up-to-date information on the incidences of infectious diseases and, in some cases, also on the frequency of occurrence (prevalence).

The test laboratories notify all positive findings directly to the National Infectious Diseases Register. Confidential notification is based on social security number. Therefore, notifications can be combined into cases with a high degree of reliability.

Treating doctors send specific doctor's notifications of many infectious diseases, again using the same social security number. This provides additional information on the mode and place of transmission, for example. HIV and hepatitides are infections notified by doctors.

The cases notified to the Infectious Diseases Register reflect the burden of disease in population groups that are efficiently reached by health care services. This is not always the case with infections transmitted through injecting drugs or shared equipment. In addition, these infections may remain symptom-free for a long time, which is why some of the infected may not be tested until years later. In the worst case, this may lead to a situation where an epidemic is not detected until a long time after the onset. With chronic infections, this may rapidly lead to a high latent frequency of occurrence, which means that it is a very challenging task to suppress the epidemic with prevention and control.

Therefore, in addition to passive testing in basic health care, it is reasonable to develop a surveillance system based on anonymous sampling surveys, as this is a more efficient way of detecting changes in the frequency of occurrence in difficult-to-reach groups. Even then, these groups have to be reached somehow. IDUs can be reached through the LTHSCs

### **3.1.2. Low-threshold testing supported by the National Public Health Institute**

The threshold to use public health care services to have oneself tested for infectious diseases is often high for IDUs, due to experienced and feared discrimination. Fear of having to admit drug use and facing the possible negative attitudes of the personnel and ending up in "registers", combined with fear for a positive test result (HIV, for example) may turn into an insurmountable mental and practical obstacle for having oneself tested. These elements are not so dominant at LTHSCs, where drug use concerns everyone and everyone is facing the same risks. This is why testing at LTHSCs is an important means of ensuring that IDUs are reached efficiently for diagnostic testing in order to be able to identify epidemics without delay.

Another threshold associated with the tests is the relatively long waiting period between the actual test and the results. HIV is tested from a blood sample that is sent to a clinical microbiology laboratory for analysis, often in another town. The centre may not receive the result until 1–2 weeks later, which feels like a very long period of uncertainty for the client. That is why some clients tested for HIV never come back to hear the result. The risk is particularly high with IDUs, who are often difficult to reach.

A third testing threshold for IDUs is associated with the type of sample: a conventional HIV test requires a venous blood sample. The veins of IDUs are often in a bad shape because of multiple injections, which is why they do not like to give venous blood samples.

Rapid tests or point-of-care (poc) tests offer a partial solution to the problems related with delayed results and extensive collecting of venous blood samples. These tests can be used at the LTHSC, they only require a blood sample collected from the tip of a finger, and a reliable negative and preliminary positive result is obtained rapidly (in about 15–20

minutes). The tests used in Finland are based on the tested lateral-flow technology. The test in use has proved very reliable in international and Finnish evaluations. Even though a positive rapid test result has to be confirmed by analysing a venous blood sample in a laboratory, experience has shown that these tests are much better approved of by IDUs than conventional HIV tests taken in a laboratory. As early as the end of the 1990s, the National Public Health Institute began to recommend rapid or poc tests for testing IDUs to improve reachability and to be able to inform them about the test result without delay.

In Finland, the Communicable Diseases Act stipulates that the National Public Health Institute and authorised research laboratories have the right to conduct clinical microbiology tests. The purpose of these restrictions is to ensure high quality of testing. In practice, this means that HIV tests, for example, can be analysed by a limited number of central laboratories. However, the law allows the use of poc tests at health care outlets, provided that an authorised test laboratory guarantees the quality of tests and is responsible for training the testers and for quality assurance and monitoring.

The National Public Health Institute provides reference and support laboratory-, quality assurance- and verification services for HIV rapid testing at LTHSCs. All LTHSCs that offer rapid testing have received required training at the HIV unit of the Institute. In addition, the unit co-ordinates quality assurance rounds and monitors testing volume and results at the centres. Furthermore, the HIV unit is responsible for the verification testing of positive results.

### **3.1.3. Sentinel surveillance network and sampling surveys**

Information on the frequency of occurrence of infectious diseases is also received through the exit polls and frequency studies conducted by the IDU sentinel surveillance network every 1–2 years. The sentinel surveillance network

refers to those LTHSCs that participate in studies, supported and supervised by the National Public Health Institute. Usually, the sampling and frequency studies are conducted at several LTHSCs during a period of about 2–4 weeks. The number of participants varies from 150 to 700, approximately. The participants are clients of the LTHSCs.

The participants complete an anonymous form that contains about 10 questions and give a saliva specimen to be analysed for hepatitis C and HIV antibodies. Both specimens are labelled with the same anonymous participant ID, which enables comparison of risk factors with the antibody test result. Since both infections are chronic (HIV becomes chronic in 100% of cases, hepatitis C in about 30–50% of cases), the antibody results reflect the frequency of occurrence at the moment of testing. The oral specimen is actually not saliva but so-called oral mucosal transudate (OMT), collected using a special collection pad (OraSure<sup>®</sup>). The collection pad is coated with an osmotically active substance that draws antibody-rich OMT into the pad through the lining of the mouth. OMT has a much higher antibody content than saliva. The collection pad is kept in a specimen container that is labelled with the participant's ID and contains preservative fluid. This enables storage of the specimens at room temperature for 2–3 weeks. Even after this, they can be analysed for HIV and hepatitis C antibodies at the National Public Health Institute. The test is not diagnostic, and anonymity makes it impossible to inform the participants about the results, which is made clear to them. This is essential for the representativeness of the study, as people who may not be ready to hear about a positive result can participate. Participation is encouraged even if the person knows that he or she is HIV or hepatitis C positive.

Studies based on sampling provide an estimate of the frequency of occurrence of HIV and hepatitis C infections in a target group similar to the participants of the study. It is estimated to represent all IDUs quite reliably. The short

questionnaire included in the frequency studies is used to collect up-to-date information on risks and basic demographic information on the participants..

### **3.2. Operational reports and statistics of LTHSCs**

In 2001, the sentinel surveillance network of LTHSCs and the National Public Health Institute developed a reporting model to be used by the centres for annual collection of relevant indicators for surveillance and evaluation of the work and its effects.

Until 2005, these operational statistics were collected manually and the key indicators were reported to the members of the network and EMCDDA, for example.

Since 2006, the data are collected through an electronic report form developed by the National Public Health Institute<sup>17</sup>. This improves the commensurability of the data content and enables more rapid collection of data.

The indicators representing the operation include, for example, number of customers, number of visits, distributed and returned injecting equipment, principles of exchange, opening hours, conducted HIV and HCV tests, administered HBV and HAV vaccinations and, since 2007, resources.

### **3.3. Estimates of the number of problem drug users**

In 1997, Stakes (the National Research and Development Centre for Welfare and Health), the National Public Health Institute and the Ministry of Interior launched a joint project on statistical evaluation of the extent of problem drug use with the capture-recapture method, using register data describing adverse effects of drug use (Partanen 1997). The method uses the National Public Health Institute's Infectious Diseases Register (TTR), the

notification register of hospitals (HILMO), the police information system (PATJA) and the register of intoxicated drivers (HULAVA).

In the evaluation, problem use is defined as such use of amphetamines or opiates that has caused the user adverse social or health effects resulting in an intervention by authorities, specified in the authorities' registers. The first evaluation concerned the year 1995 and the Greater Helsinki Area only (Partanen 1997). Since 1997, data are collected from all of Finland and since 1998, regional data are recorded as well (Seppälä & al. 1999; Partanen & al. 2000; Partanen & al. 2001). The latest evaluations are from 2005.

Based on observed and overlapping cases in the various registers, a mathematical model was developed to achieve a statistical estimate on the number of drug users not included in any of these registers (Cormack 1989). The estimated total number of problem users is the sum of this estimate and the number of cases in the registers. Overall estimates are expressed as confidence intervals, within which the total number of problem users falls with a 95 per cent probability (Partanen 1999).

### **3.4. Qualitative interview study**

The qualitative section of the study described within this report is included in the surveillance and study co-ordinated by the National Public Health Institute focusing on the role of health counselling services in the reduction of infections and infection risks among IDUs. The interview study surveyed the health counselling staff's opinions on their work, its effects and its significance for management of infection risks among IDUs. The interviews consisted of employees' descriptions of their own roles in the planning and implementation of risk management and of the clients' responsiveness and concretisation of the messages in drug users' lives.

The qualitative material comprises the interviews with the staff of eleven LTHSCs. The goal was to include centres with different

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17 Short URL to this site: <http://www.ktl.fi/portal/9827>  
Updated: 24 February 2008

client bases and opening hours around Finland. The complexity of the interview study made it impossible to visit all the LTHSCs in Finland, but it was decided to include centres at different stages of operation that had opened no later than 2006. The goal was to include centres from municipalities with a population of more than 100,000, 50,000–100,000 and less than 50,000. Eleven interviews altogether were conducted in May, June and July 2007. In 2007, health counselling services were provided in about 35 municipalities, so about one third of the centres participated in the interviews. Most of the interviewees were people responsible for the operation of the LTHSC.

The interview material was collected by qualitative in-depth interviews based on the health counselling staff's accounts on their experiences and opinions concerning their work and its effects. The goal was to describe the health counselling service through an extensive set of questions and topics focusing on basic functions. The interviews lasted from two to nearly four hours, and a total of 25 hours of interview material was collected. Information that would otherwise be difficult or impossible to collect and measure could be obtained by interviews. Basically, the questions were half-structured. Some of them could be answered by merely yes or no, while others required more consideration and analysis of one's own experiences. The purpose of all the questions was to encourage the interviewees to thorough consideration and discussion concerning the development of health counselling services, the changes seen in the clients, the future of the work, etc. The interviewees were given the opportunity to talk about matters they considered important. Often the interview was more like a discussion, with events and phenomena getting entangled with each other. The interviews were mainly narrative, with topics and phenomena being approached with the help of examples and stories that had a clearly distinguishable course of development.

The analysis of the data was data-based and inductive, proceeding from individual observations to an understanding of a universal phenomenon. Data-based analysis is useful particularly when basic information is needed on the characteristics of a specific phenomenon. In this case, the phenomenon was Finnish health counselling work. (Eskola & Suoranta 1998) Transcription of the taped interviews began before the interview round was completed, to be able to adjust the focus of the upcoming interviews. All the interviews were transcribed word for word, and the content was organised according to the topics discussed during the interviews. The material was roughly arranged in categories based on the main topics. These included health counselling as a job, relations with services closely connected with the work, development of Finnish health counselling, the services provided by LTHSCs and their use, clients, drugs, risks and infections. The discussed topics were clearly divided into two main categories: internal and external factors affecting the work.

External factors included the relations of health counselling work and opinions on its role as part of health care services and intoxicant services. The work was affected by the opinions of financiers and administration and, through them, the resources allocated to the work. Information flow to higher levels of the organisation and understanding and appreciation of the work were affected by the media. Its opinions could influence the availability of funding if the higher levels of organisation had no firsthand knowledge of the work in practice. Work with clients was affected by the importance given to the work and funding. The framework set by higher organisational levels influenced the premises, location and opening hours of the centre. These in turn affected the ability to reach clients and the level of interaction.

Internal factors defining the operation, i.e., elements arising from the actual practical work, were related to the clients. Their needs, hopes, drug use and life situation, way of

being and interaction with them defined most of the practical work. The frames of operation were determined by the various services provided for the clients, as well as the demand for services, their necessity and the resources allocated to them. With the help of some distinct for/against questions, the aim was to include quotations representing both opinions, while the sharpest or most comprehensive quotations were selected to represent questions or topics where the interviewees discussed an issue from a broader perspective. The extracts in the text are direct quotations from the interviewees' speech. Because of the rather small number of Finnish LTHSCs and their personnel, no age, gender or location is mentioned in connection with the quotations to ensure anonymity. Background information on the interviewees is provided only as considered necessary.

The group of interviewees (n=13) consisted of eleven women and two men. Their age ranged from 27 to 56 years; the average age was 42. Their experience of health counselling work ranged from one to eleven years; on average they had five and a half years of experience. As regards their education, most of them were health care or social welfare professionals. The most frequently mentioned education was Registered Nurse or Public Health Nurse. Some were Bachelors of Social Services, and some had both health care and social welfare education. All the interviewees had an educational background in health care, social welfare, adolescent work, church social work or intoxicant services. Nearly all the centres had both health care and social welfare professionals among their personnel, most frequently Registered Nurses or Public Health Nurses and Bachelors of Social Services or social workers. Furthermore, some centres employed former or current drug users. The staff of a centre often consisted of employees representing the fields of social welfare and health care services. Their working together seems to be more and more common.

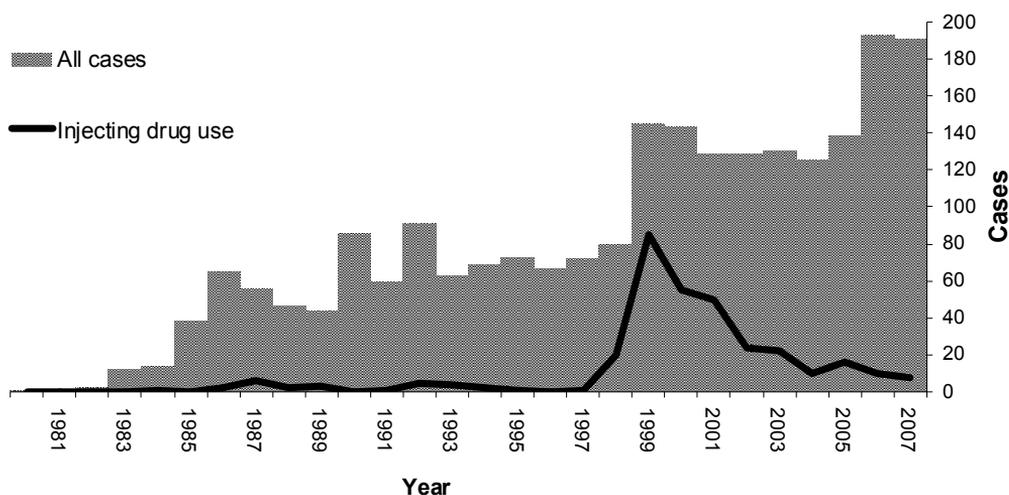
## 4. RESULTS

### 4.1. Development of infection risks

This section of the evaluation study discusses the standardised information produced by the various parts of the infectious diseases surveillance system maintained by the National Public Health Institute on the development of the epidemiology of the most important infectious diseases associated with injecting drug use.

In summary, the number of new diagnosed HIV infections and hepatitis B and hepatitis C cases in IDUs has fallen or remained at a low level since the beginning of the 2000s. The hepatitis A virus caused epidemics among IDUs at the beginning of the 2000s until vaccinations for IDUs were included in the general vaccination programme. After the change in the programme, hepatitis A infection has again become rare.

Figure 3. Annually reported new HIV cases and cases among injecting drug users (NIDR, KTL)



were not related to each other (Liitsola et al. 2000). They belonged to an HIV subtype B strain which is common in IDUs in other parts

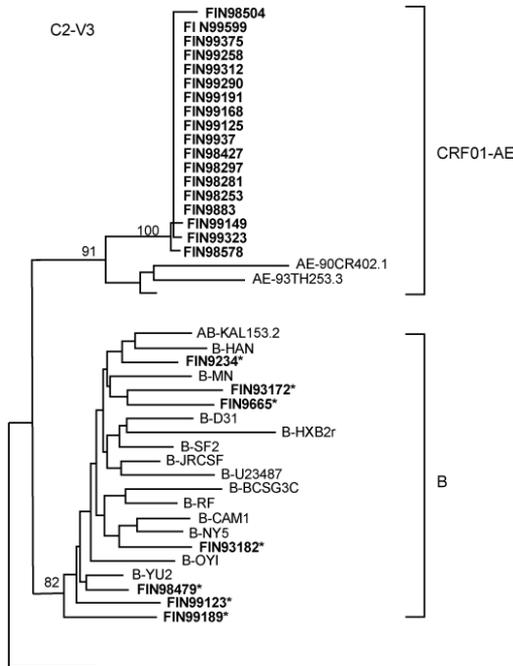
### 4.1.1. Development of the HIV epidemic after 1998

By autumn 2007, there were 324 diagnosed cases of HIV infections in Finland that were acquired through injecting drugs. The majority of these, more than 95%, were associated with one epidemic that broke out in 1998 in the Greater Helsinki Area with a few cases diagnosed in other parts of Finland as well.

The epidemic associated with injecting drug use broke out before health counselling and injecting equipment exchange services for IDUs were widely available in Finland. The HIV epidemic was preceded by several hepatitis B and A outbreaks in the same target group, where hepatitis C infections are common as well.

Closer examination of the HIV epidemic with accurate gene typing techniques, etc., revealed at an early stage that the epidemic was both fresh and caused by a type of virus that had been rare in Finland in this group until then. Before the epidemic that broke out in 1998, about 20 cases had been diagnosed in Finland, and based on the background information they

of Europe (Figure 3: the cases marked with an asterisk). In many cases, this supported the obtained information suggesting an infection acquired abroad. In the first cases, genetic differences were also remarkable, which suggests several transmission chains.



**Figure 4. Virus types in cases associated with injecting drugs (Phylogenetic analysis)**

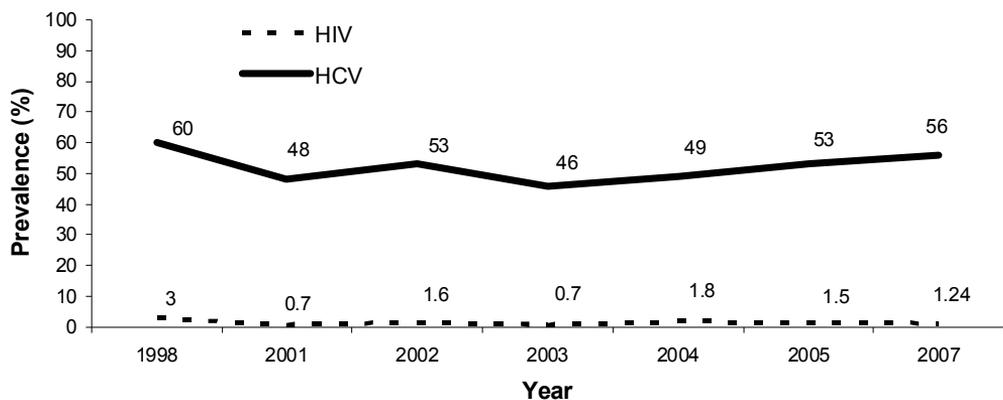
The situation was different in the epidemic that broke out in 1998: the cases were related to each other with regard to both time and place, and typing of the viruses showed that the virus represented the CRF01-AE subtype strain which was relatively rare in Finland. The virus type is common in Southeast Asia but rare in IDUs in other parts of Europe.

The very small genetic difference between the cases indicated rapid development of a transmission chain, which strongly suggested that the epidemic had broken out as the result of shared use of equipment. In the family tree shown in the figure, the epidemic associated with injecting drug use forms a tight cluster. The Finnish cases are marked with the “FIN” prefix. The first two digits in the number refer to the year of diagnosis.

The frequency of occurrence of HIV and HCV infections in IDUs is evaluated in anonymous prevalence studies co-ordinated by the National Public Health Institute approximately once a year. These studies aim to reach even those users who avoid diagnostic testing.

Prevalence studies show that regardless of the epidemic of 1999, HIV prevalence among IDUs in Finland has remained at 1–2 per cent, which is very low in international comparison (EMCDDA 2006). According to the 2005 estimate, the prevalence of HIV in IDUs in Finland was approximately 1.4 per cent (0.5–3.2%, CI 95%), and preliminary data from 2007 shows little change.

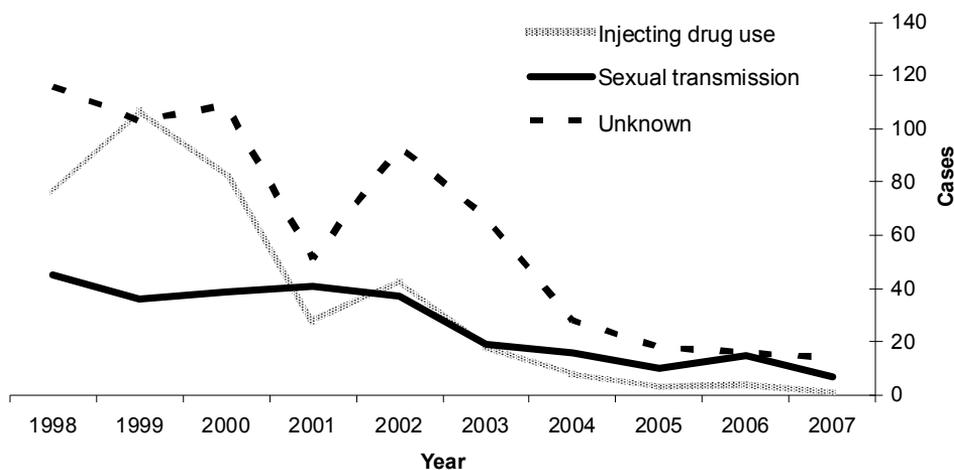
**Figure 5. Frequency of occurrence of hepatitis C and HIV infections in exit polls**



As many as about 84 per cent of the HIV cases associated with injecting drug use notified to the Infectious Diseases Register from 1998 to 2003 were reported in the Greater Helsinki Area (Kivelä et al. 2006; National Infectious Diseases Register).

A study on the background of HIV-infected IDUs (Kivelä et al. 2006) showed that the majority of cases related to the epidemic concentrated in certain geographical areas and the infected were badly off and socially very excluded. The epidemic remained almost completely within the Greater Helsinki area, particularly in Helsinki.

**Figure 6. Acute hepatitis B cases diagnosed in Finland per year**



The HIV-infected IDUs had been using injecting drugs for more than ten years, and the principal drug was amphetamine (more than 70%). The average age of the infected was 32 years, they were male (72%), homeless (66%), had a history of imprisonment (75%) and had been in psychiatric hospital care (41%). (Kivelä et al. 2006.)

The epidemic abated soon after the initiation and expansion of preventive measures. The number of new HIV infections has remained

low, and the number of new infections varies from a few cases to a few dozen per year.

The increasing number of LTHSCs and the equipment exchange, testing and counselling services they provide have contributed to better detection and prevention of new infections.

#### **4.1.2. Hepatitis B (HBV)**

Infections caused by the hepatitis B virus (HBV) in IDUs have decreased considerably in recent years, probably as a result of the implemented extensive vaccination programme.

Also, it can be assumed that the equipment exchange service has limited the spreading of infections. The decrease in the number of new

hepatitis C cases is in line with the decrease of hepatitis B infections. This reduction is particularly distinctive in the young, i.e., 15–19-year-olds. Aiming for the highest possible coverage of hepatitis A and B vaccinations in risk groups is the best means of maintaining the good situation. (Recommendations of the National Public Health Institute).

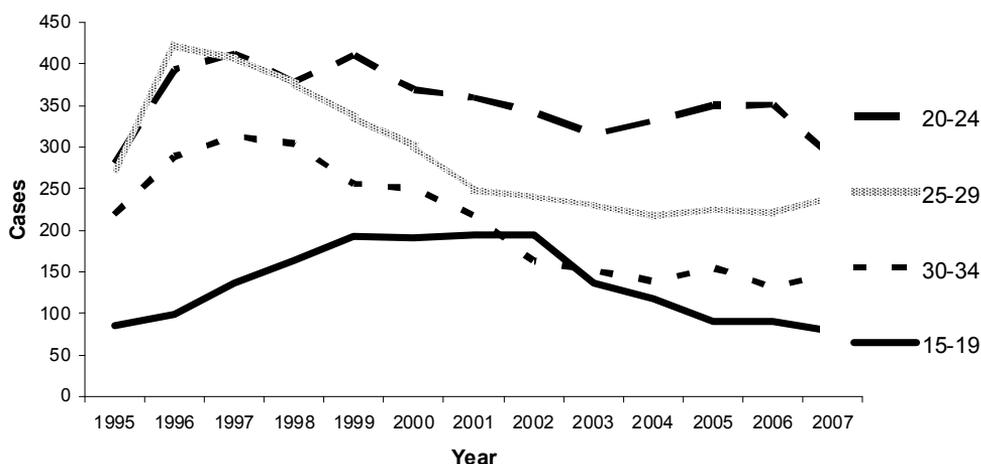
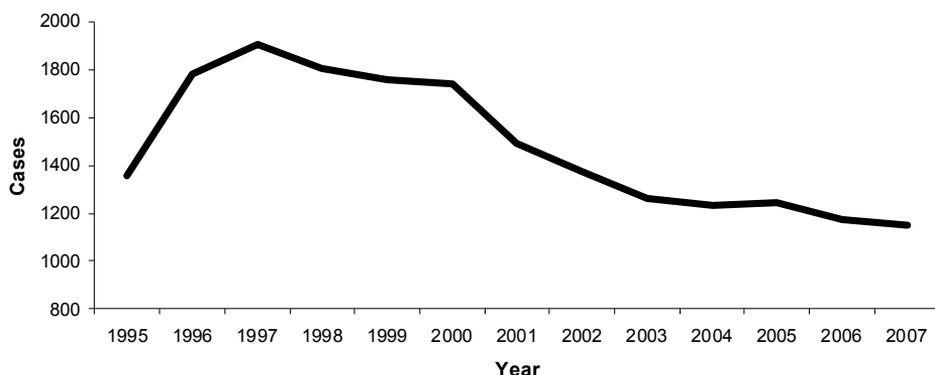
#### **4.1.3. Hepatitis C (HCV)**

Blood contact is by far the most important transmission route for hepatitis C. Levels of

anti-HCV antibodies, used for diagnosing the infection, are high in IDUs in general.

Therefore, a significant but unknown proportion of infections is reflecting the situation years ago, instead of the current epidemic or infection risk.

**Figure 7. All hepatitis C cases diagnosed in Finland per year**



**Figure 8. New hepatitis C cases by age group**

In Finland, the prevalence rate of hepatitis C in IDUs is estimated to be lower than 40 per cent (EMCDDA 2006, 78), even though annual exit polls suggest a higher prevalence rate of about 50–70 per cent.

The diagnostics of HCV infections are challenging, as there are no reliable laboratory tests available for distinguishing fresh infections from those acquired years ago.

For this reason, the actual incidence rate and the reasons for changes in incidences of hepatitis C infections are very difficult to monitor in age groups with a long history of drug use. It is known that use of drugs often begins at an early age, so infections in the youngest age groups probably reflect the development of the epidemic and infection risks better than the total figures.

Even though the annually diagnosed hepatitis C infections are a combination of recent infections and those acquired years ago, the

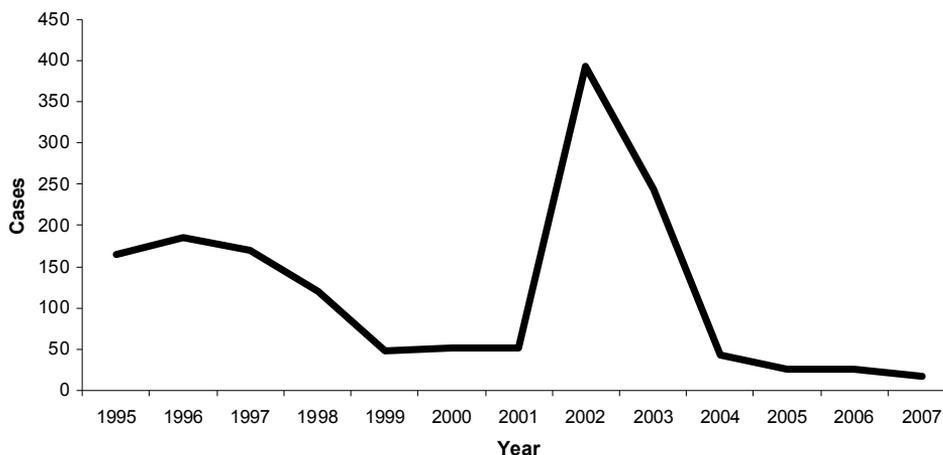
total number of annually diagnosed cases has gradually fallen to almost half from the peak year 1997.

Among different age groups, the most significant decrease in recent years can be seen in the youngest group, 15–19-year-olds.

#### **4.1.4. Hepatitis A (HAV)**

For a long time, it was believed that hepatitis A is only transmitted through water and food after faecal contamination. At the end of the 1990s and the beginning of the 2000s, however, hepatitis A infections were found to be relatively common in IDUs, even in countries where hepatitis A infections are relatively rare or nonexistent in the rest of the population.

**Figure 9. Hepatitis A cases notified to the Infectious Diseases Register per year**



This gave cause to suspect that in addition to the faecal-oral route, blood-borne transmission or even transmission through contaminated drug batches could be possible. Poor hygienic standards and new modes of transmission probably contribute to the increase in hepatitis A infection risk, at least for some IDUs. Even though the exact transmission route has not been confirmed, the association with injecting drug use is very strong.

These kind of epidemics have been described in Finland as well, the first of them in the Greater Helsinki Area in 1994–1995 (Leino et al. 1997). New epidemics and higher than normal frequencies of new cases occurred until the early 2000s. The largest epidemics were seen between the years 2001 and 2003.

To suppress the epidemics, administration of hepatitis A vaccinations was increased regionally at LTHSCs in 2002, and in 2004 hepatitis A vaccinations for the risk group were included in the general vaccination programme. Hepatitis B vaccinations have been administered at LTHSCs since 1997, and they were included in the general vaccination programme in 1998.

The National Public Health Institute recommends (2005) that free of charge hepatitis A and B vaccinations be

administered as part of the general vaccination programme to IDUs, their sex partners and anyone living under the same roof with them. It is particularly important to vaccinate newborn babies of IDU parents. (Hepatitis vaccinations as part of the general vaccination programme.) Prisons have also improved the availability of the vaccine to prevent infections in current and former inmates. (Leinikki 2003a, 188–189).

#### 4.1.5. Development of LTHSCs and their operational indicators

The development of the operations of LTHSCs has been monitored since 2001 through annual reporting. The reporting was co-ordinated by the A-Clinic Foundation, STAKES and National Public Health Institute together, but in 2006 a new electronic reporting model was implemented with better standardised indicators.

seen in the numbers of customers and visits. The strongest relative growth can be seen in the quantity of exchanged injecting equipment. At the same time, the percentage of returned equipment has remained high, clearly above 95% every year.

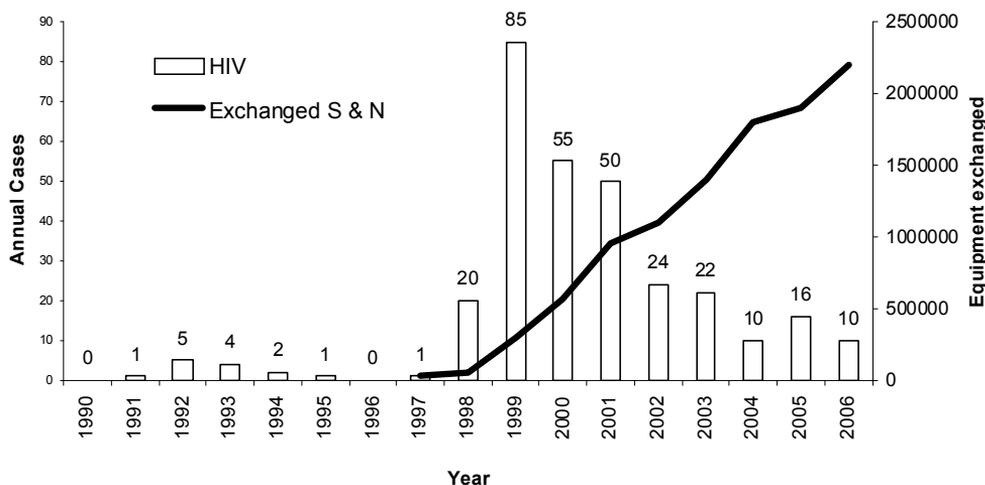
The increase of equipment exchange (like the other indicators) shows a strong negative correlation with the abating of the HIV epidemic after 1999.

**Table 2. Development of the number of clients and visits at LTHSCs**

	2000	2001	2002	2003	2004	2005	2006*
Number of LTHSC	12	18	22	24	24	30+	30+
Clients	4 800	8400	9 300	9 300	10400	11 800	~ 12 000
Visits	32 900	44 500	55 300	70 600	83 400	80 500	~ 90 000
Equipment exchanged	564 500	950 500	1,1 mil.	1,4 mil.	1,8 mil.	1,9 mil.	~ 2.2 mil.

\*preliminary data

**Figure 10. Syringes and needles exchanged at LTHSCs and HIV cases associated with injecting drug use**



At the end of the year 2006, health promotion

Before 2006, the reported figures with the best comparability were the number of customers, the number of visits to the LTHSC and the quantity of exchanged injection equipment (syringes, needles).

All the operative indicators have increased during the years of health counselling, even though some degree of stabilisation can be

and advisory services for injecting drug users were available at close to thirty municipalities. In several municipalities multiple service sites were available.

**Figure 11. Regional distribution of the IDU low threshold health service centers**



Municipally funded (completely or partially) health promotion and infectious disease prevention services are available in all municipalities with a population over 100.000 inhabitants. This means the largest cities of Helsinki, Espoo, Vantaa, Turku, Tampere and Oulu. Services are also available in most municipalities with a population base between 50.000 and 100.000, except in the cities of Vaasa and Lappeenranta. Many smaller municipalities also have an IDU-LTHSC.

Regions where there is clear lack of access to services include Lapland, the autonomous region of Åland and mid-Ostrobothnia. There are no LTHSC services available in the region of Kainuu, either.

Using the municipal population census data from 2005, LTHSC services reach approximately 2.3 million persons, which accounts for 44% of the population. Based on individual client number reporting (11.800) and the estimated problem user population in 2005 (14.500-19.000), health promotion and harm prevention services reach approximately 60 – 80 % of the problem drug users. A

similar, or even better, proportion can be seen if reported LTHSC client numbers and problem drug user estimates from the capital area are used (9315 clients in 2005 and between 5100 – 8200 problem drug users). Up to 20 % of the users are clients at several LTHSC sites; therefore, by a conservative estimate, approximately 80 % of the users can be reached.

For diagnostic testing of infectious diseases, reported data are comparable only beginning in 2006. That year, 1409 HIV-tests and 582 HCV tests were performed. Out of the hiv-tests 1091 were rapid point-of-care tests and 318 were regular laboratory tests. No testing was available in 7 LTHSC sites.

Other tests commonly offered at the sites in 2006 were pregnancy tests, tests for HAV, HBV, Chlamydia trachomatis, Gonorrheal and T.pallidum –infection. One site also offered testing of liver function markers.

According to the reporting by the LTHSC in 2006, the following vaccinations were performed at the sites:

**Table 3. Vaccine doses given at LTHSC in 2006**

dose/vaccine*	HAV-V	HBV-V	HAB-V
I	445	269	421
II	234	95	234
III	n.a.	116	136
yhteensä:	679	480	791

HAV-V: Hepatite-A vaccine, HBV-V: Hepatite-B vaccine, HAB-V: Combined Hepatite A and B vaccine.

Altogether 1950 doses of hepatitis vaccines were administered in 2006, representing a growth of 3 % compared to 2005. Use of combination vaccines increased significantly with similar reduction of individual HAV and HBV-vaccines.

In 2006 the LTHSC distributed 58.991 free condoms. This is a 50 % increase compared to the year before.

## **4.2. Operation of the LTHSCs**

This section discusses the results of the qualitative interview study conducted at LTHSCs (the interview instrument is described in Appendix 8.1).

### **4.2.1. Opinions on health counselling**

In the following, employees tell about their experiences in health counselling and describe everyday life at the centres and the characteristics and importance of the work. The initial framework for the operation and the client base include elements that have affected the construction and establishment of services. The construction and character of the operations are visible in daily encounters with the clients. It can be said that health counselling work is based on the same principles and goals that are applied in outreach work and in approaching difficult-to-reach groups. These include continuity, reliability, flexibility, approachability/reachability, comprehensibility and voluntariness (Svensson 2003).

#### **4.2.1.1. Elements contributing to success of the work**

Finnish health counselling is considered as a successful model for preventing infections in IDUs (injecting drug users). The interviewed LTHSC employees were asked to consider which elements they believed to have contributed to the success of the work and what kind of indicators could be used to describe success. Trust was mentioned as the factor with the greatest impact on success. First, decision-makers had expressed their trust by having the courage to design and introduce the health counselling system. Also, the personnel have shown trust by having the courage to become engaged in health counselling work. Clients were mentioned as the third and most important element of trust. They increasingly had the courage to use the services provided by LTHSCs and to show trust in the personnel and the service system. Trust always involves a risk, uncertainty of

how the situation or interactive relationship will proceed and evolve. One interviewee describes how clients develop trust in health counselling:

*You see, at first we had problems with the schizophrenic attitude of our clients. These old-generation users, they were like "What the hell is that? You go there and the cops will get you in less than a second." Like they had this fear, what's this place? But now when we think what has happened during these ten years. We have a new user generation here. These people are not afraid of LTHSCs at all, because the centres have existed as long as they've been using drugs. It's everyday life for them, it's normal, and it will be normal for all users in future. It's part of their user culture even today, among these new users.*

*Interviewer: Was there a lot of resistance at first, or was it easy to start the work?*

*Interviewee: Well, there were some problems, especially the fear of the police. That was the main obstacle, being afraid of the authorities. We had to keep repeating, over and over, "Hey they know where you hang around anyway; they don't need to come here to get you. I can assure you they know where you're usually hanging around." It's a great achievement that they have realised that "I don't have to go to the pharmacy, I don't need to be stared at while I'm there, and these are nasty situations. I can go there and actually I can get other services there as well." Learning to understand that has been very important.*

Many respondents said that the change of attitude and reduction of risks is already visible in infectious diseases statistics and as reduction of other adverse health effects. The decreased number of HIV infections acquired through injecting drug use was seen as the best indicator of successful health counselling. However, putting excessive emphasis on the infectious disease figures as an indicator of success was considered a problem, particularly with regard to hepatitis C, as more efficient

testing would probably reveal more infections. Furthermore, employees said that syringe and needle exchange programmes have not prevented hepatitis C as efficiently anywhere in the world as they have prevented HIV. The number of administered hepatitis vaccinations and the subsequent reduction of hepatitis A and B infections was also seen as a good indicator of the efficiency and responsiveness of health counselling at its best. In addition to the decreased number of infections, the annual increase of exchanged equipment with a permanent return rate of nearly a hundred per cent was regarded as a good indicator. The number of clients was considered to be a better indicator of the necessity of the work and the ability to reach users than the number of visits. However, the number of visits indicates how actively the service is used. Prevented pregnancies, abortions and uncertain futures of unborn babies were mentioned as abstract, difficult-to-measure indicators of success. Also, the fact that clients spend the whole day at the LTHSC instead of being engaged in criminal activities, for example, was seen as some kind of an indicator of success and harm reduction. Expansion of the work towards comprehensive care of clients was said to indicate that there has been a need for this kind of service and it has been able to respond to the demand.

*What is needed for a change in behaviour? Instruments, concrete instruments, including knowledge, skills and attitude. It's going on all the time, in snowball training and conversations. We aim for a change in the client's behaviour sooner or later. This attitude is part of the success story.*

Many centres made efforts to inform their clients more efficiently of the importance of safe and hygienic injecting, and an increasing number of clients had correct information on vein rotation. The decrease in blood poisonings and severe inflammations was emphasised as an important success indicator. It was stated that even if the role of these conditions is not economically very significant, their prevention is. Nearly all

respondents believed that improved injecting hygiene had reduced inflammations, enhanced the health status of individuals and decreased hospital visits and various injuries. Many believed that the success was the combined result of an early start, pure luck and responding to the possibility of an epidemic with a clear, high-quality operating model from the very beginning. It was said that health counselling had offered a diverse collection of services from the beginning and developed to respond efficiently to new challenges. In addition to HIV prevention, an early focus was placed on hepatitides and promoting the availability of other equipment in addition to the injecting equipment exchange service. The activities and service range were expected to expand in the years to come, aiming for a more comprehensive, long-term approach to the clients' health care and social welfare.

*Unfortunately, I guess that's how it goes in this world, that it takes committed people who believe in what they are doing and are not so much afraid of what others will say. I suppose it was perfect timing, but you can never know for sure. Then I guess one thing is that from the very beginning we have wanted to use and develop all the means that are required for successful health counselling and harm minimisation in general. Substitution treatments, outreach work, peer work, social and health counselling. All these together, we have implemented them all here, or at least we have tried.*

The increasing number of people seeking drug treatment was considered to indicate success, although it was said that there would be even more drug users seeking treatment if treatment facilities had more beds. Successful training of peers and their work among drug users were also mentioned as positive results. Many respondents pointed out that a good location and strict anonymity of clients were important elements for getting the work started. It was said that it would not have been a good idea to set up the services at health centres: it was the system specifically developed for the work,

with services and employees, that guaranteed the development of trust.

*Clients started coming right at the beginning and trust in the field developed immediately. Trust in the health care system and if the authorities say that this is anonymous, then people believe it. In Finland, there's a lot of trust in the system, and no matter how nice you are, clients only come out of their own will. Drug users are really welcome, and this is backed by law. The staff consists of people who really think that 'Welcome, this service is meant just for you, I'm glad you're here.' Interaction with the field is one thing: we are open-minded and ready to listen to drug users. This has proved a good model in Central Europe, so we'll try it in Finland. Listening to drug users and interacting with them has reinforced trust, especially in the Greater Helsinki Area. Clients have been given access to services; we've gone where the people really are. They've been very impressed that we actually go somewhere just for them. We keep our antennae up so that we know what's going on in the field, we go where we are needed.*

Many respondents said that during the years of operation they have seen changes in clients' risk behaviour and in their attitude to their own health. Achieving a change in the way people think was also regarded as one of the most important indicators of success, even though measuring it as such was considered difficult. Risk-taking had become clearly less common, and clients' concern about their own health increased year by year. They had started behaving more politely, LTHSC employees were able to increase their contacts with clients each year, and trust was reinforced. As one employee put it, *"These people are actually behaving themselves now,"* and continued by saying, *"It's a huge leap forward if a person right out of the bush, looking like a forest robber, says 'good morning', carries on a conversation, says 'thank you' and apologises if he happens to lose his temper. The change in this person is*

*so unbelievable that this work must have had some effect.*

Generally, life management was seen as the opposite of social exclusion and being tired of one's own life – these two elements were regarded as important reasons for taking health risks. Improvement of life management was described, for example, by saying:

*Day centre type activities promote management of one's life and the situation in general. The importance of place is emphasised. For example, one client had been in Helsinki messing around for a few days, then came here with a bag of clothes, travelling without a ticket. He took a shower, changed his clothes, washed them and went back to Helsinki. This was a haven for him. It certainly has had an effect on risks, reduced them considerably.*

All centres received new clients every year and clients' lives were often described with the word "chaos", but the majority of them became less prone to risk-taking and their life management improved. Also, it was mentioned that there was still a long way to go to achieve real success and proper coverage of the service, as there were still many IDUs in Finland who did not even have the opportunity to get health counselling and clean equipment. Some of them were geographically out of reach, while others did not use the services for various reasons. Suggested solutions to the problem included better coverage of the LTHSC network, enhanced availability of clean injecting equipment at pharmacies and new work methods, such as outreach work and vending machines for injecting equipment.

#### **4.2.1.2. Legal basis of the operation**

The personnel of the LTHSCs were asked about their opinions on the amendment to the Communicable Diseases Decree in 2004 that obligates municipalities to arrange health counselling for injecting drug users. The purpose of this question was to find out whether the decree has generally changed the nature of health counselling work, whether it

has had any effect on practical work and which direction the work is now taking. All the interviewees were familiar with the amendment and believed that its main effect was improvement of the general acceptability of the work.

*I think that the law is very good, that's how it should be. In a way it creates a legal framework for us. It justifies our work, why we work and what for. It reinforces the credibility of our work and work methods. I believe that one day, as we go on, this will be part of normal basic health care services.*

Most importantly, the decree backs up the work, while earlier many felt that health counselling was almost an outlawed activity. Even though the existence of the decree has promoted the acceptability of the employees' work, nearly all respondents were wondering whether all municipalities actually had arranged services according to the content of the decree. When clients use health counselling services, they are asked to specify their place of residence. Based on this information, the personnel knew which municipalities had not arranged health counselling service despite the need. Respondents did not consider clients from other municipalities a problem; instead, the problem was the fact that these municipalities had not officially admitted the existence of IDUs in their area or seen any need for health counselling services.

*I have experience of this from our neighbouring municipalities. If there's an obligation, is there any sanction then? I can tell you, there's need for this right next door [in a neighbouring municipality]. But they just say they have no need. Then they [clients] come here. They certainly have a need, but some decision-makers don't want it. Health counselling should be obligatory. [In another neighbouring municipality] I think it will never work out. In these municipalities [lists three] there are no services, yet they have many users.*

Because of the Act and Decree, the situation in neighbouring municipalities also had a positive effect:

*I guess many small municipalities just ignore this. For us, the Communicable Diseases Act had a great significance, quite concretely. Because we've had visitors from other municipalities all the time, mostly from our neighbours. They have received the same services, there hasn't been any discrimination. But now, after this Communicable Diseases Act, we had the opportunity to try to charge these municipalities for the services. [A neighbouring municipality] can send them here instead of arranging services of its own. So, now we have an agreement with some of our neighbours. Of course we don't report any names or social security numbers. They just have to believe us when we say that "we had so and so many visits or clients from your area this year." Of course it can be a bad thing if a neighbouring municipality doesn't establish a centre of its own.*

It could be expected that travelling to another municipality for services would for a high threshold and the user would have to be highly motivated to get services. On the other hand, respondents said that users are not necessarily aware of their right to get health counselling in their municipality of residence, and it is not easy to start demanding services.

*I bet there are municipalities that don't even inform people about the existence of this decree. Clients must be well aware of their rights, like "Hey, it's possible for me to get these services." But they certainly aren't shouting about them out there.*

One interviewee said that some municipalities do not necessarily investigate the need for services and can just say that they have no IDUs. On the other hand, some municipalities were actively examining their possible need for services and asked the LTHSC in a neighbouring municipality for help in arranging the services.

*There's no sanction if you don't provide services. How do you specify the need? For example, [a neighbouring municipality] is investigating the need for an LTHSC by trying to find out how many users they have. They go to the pharmacies, the police, the school authorities and ask for their estimates on the number of users. The results are introduced, training is arranged for municipal employees, it is adapted to suit their need. We provide training and a practising opportunity for them. Our doctor thinks that this should be established as the model for small municipalities. Services should be concentrated in some place. Either a car, a mobile unit or some other form of activity that would be connected with the health centres. [The neighbouring municipalities] have realised that they need services, hepatitis C in particular is very common. This project is now at an early stage, services will be established in these municipalities as soon as possible. Recently, the decision-makers in neighbouring municipalities said that they wish that this project could influence the attitudes of professionals, as there are still many prejudiced attitudes and misunderstandings. There is a mini-intervention training on alcohol available – how to take up the question whether someone is drinking too much or not. Similar training is needed for drugs. How to ask if someone is taking drugs, without accusing them. For many users this is their first contact with the treatment system, they are still in contact with society, they are a long way from the emergency clinic and the threshold is high. The LTHSC acts as an important interface. Also, it is important to obtain information on this group – how many they are, how they're doing, their infections, living conditions, physical condition. They are kept visible. This lowers the threshold for other treatment as well. The LTHSC is the initial contact, but it is also important for those who have already fallen off the health care system once.*

Many respondents said that the number of IDUs in some municipalities is not necessarily so high that the municipality should establish

an LTHSC of its own. In such cases, the service could be purchased from a neighbouring municipality, a joint – or rotating – service could be arranged in co-operation with several municipalities, or health counselling could be provided at the health centre. The most annoying situation was when decision-makers just ignored the phenomenon of injecting drug use and did not admit its existence. It was known that attitudes toward the service could have an effect on whether services were arranged or not.

*It of course depends on how municipalities arrange it. Some purchase services, others arrange it themselves. What is worrying is that a few people may be responsible for all the work, for example. In some municipalities, health centre personnel provide health counselling for drug users once a week. If that employee has not thought about it at all and does not feel comfortable about it, it will not lead to anything because that will show in the work. Nobody can be ordered to do this work. Even though I've worked in intoxicant services for more than ten years, when I started this I had to think it thoroughly over in my head, what I was about to get involved in. It's not just that you are told "start doing this." The work may never start at all then. Despite all the different elements, everything is based on interaction. If an employee doesn't believe in what he or she is doing or feels reluctant, it is bound to show. You must be willing to do this work and understand what this is based on. What I find quite sad is that it is the doctor responsible for infectious diseases. In the municipalities where the work has not started, I think it's strange somehow that it can be due to an individual's personal opinion. If the doctor responsible for infectious diseases thinks that this is a job that can't be done, or that this encourages people to do drugs or anything, then they'll not have an LTHSC. Then a new person comes in, for example, and then the municipality may have an LTHSC again, because that person thinks it's a good idea. In my opinion, regulations can't contain stuff that actually means "what my personal opinion is and I'll do this or I won't do that."*

*I'm optimistic enough to think that the decree has been useful at least for those who have been willing to give a thought to this and have considered it thoroughly. Unfortunately, there are municipalities that will not even consider the matter.*

It was stated that doctors of infectious diseases mainly had a very positive attitude to the work, and in some municipalities their active role had an essential importance for getting the work started and carrying it out successfully. The level of knowledge was also assumed to have an effect on arranging health counselling, as it was assumed that knowledge of HIV and hepatitis was concentrated in big cities, which in turn influenced the understanding of the idea and goals of the work. The Decree that supplemented the Communicable Diseases Act was said to have had an effect on the rapid increase and establishment of training. It seemed that health counselling was becoming a profession of its own with high-quality training available. Along with establishing the legal basis for the work, legislation would enable even more diverse and extensive services: health counselling could be included in health centre services, training could be geographically more extensive and the drug treatment threshold could be lower. Many respondents said that there would be potential for much more than what is actually done today and that practical work is dragging behind.

#### **4.2.1.3. LTHSCs as part of the service system**

A group of professionals engaged in active work with IDUs is a relatively new phenomenon in the intoxicant service system. The interviewees were asked about their opinion on health counselling as part of the health care system and what kind of attitudes to the service and employees they have met. In addition to being a new activity, health counselling is sequestered because of the location of the centres. Only one third of the LTHSCs were established at health centres, and co-existence was not always problem-free. One interviewee related how difficult and

exhausting it can be to work next to basic health care services:

*Sometimes the most shocking thing is that even your own colleagues think that "it's not real work."*

*Interviewer: Is that so?*

*Interviewee: Yes. No matter which health care sector you are engaged in, you are bound to meet intoxicant abusers sooner or later. One good example I think is when we were setting up the LTHSC and I came here with a colleague but we didn't have keys yet. Then we went to the health centre to ask if they could open the doors for us so that we could see the place. They said, "where?" and we said, "the LTHSC, you know" and they said "LTHSC, what's that?" We said that it's the LTHSC, and this person said "oh, you mean that shit, that shit?" Then this colleague of mine wondered if she heard right? I said yes, you heard quite right. It's small things like that, somehow. When we started working at the health centre, it was like our staff couldn't use the same lavatory as their staff. Things like that, quite unbelievable. It gets personal, too, like "those are the drug ladies, they're just as awful as their clients." Then again, after five years you have established some good relationships, and things like that. But this was it, to be sure. I have to admit that when clients say they are sometimes mistreated, I certainly can't, well, I quite believe it. Somehow I can accept that ordinary people in the street are ignorant and fear these people, but I just can't take it from my own colleagues. That's where my sense of humour ends these days.*

*I: One would think that you'd face the biggest difficulties and hardest moments when you are seeing your clients?*

*A: No. Then again, if you think of assault or threats – that's what people always ask about first – I haven't encountered any. I have no problems with clients.*

Many felt that LTHSCs had become an essential part of the intoxicant service system, but they were still sequestered from basic health care. Getting closer to intoxicant services was regarded as a natural course of events that still needed development.

*The LTHSC should be located close to intoxicant services and an essential part of them. Short distances geographically. More extensive laboratory services and availability of gynaecological services. Taking care of everything, from beginning to end.*

Closeness to intoxicant services was, however, considered contradictory because LTHSCs as such do not aim for treatment or cessation of drug use. Harm reduction and treatment were seen as opposite to each other particularly when employees from intoxicant services came to work in health counselling on a part-time basis. Even though clients were sometimes referred for treatment, it was not the main purpose of the work, and many part-time employees found it difficult to focus on the client's current health status instead of cessation of use.

It was known that many employees in basic health care had extremely negative attitudes towards drug use and users, and many thought that health counselling is comparable to criminal activity and illegal. Substitution treatment was commonly disapproved of as well, and many employees in basic health care could not understand why drug users should be "given drugs." Also, when an employee transferred from the traditional health care sector to specialised services, colleagues and friends could feel shocked:

*I: And what do people in the health care sector think about you?*

*A: There's one comment that came from the lady next door. She heard that I'm engaged in this work now, and she said "stay away from us then, we don't want to catch anything." All I could say was, Oh.*

*I: Could it be a joke?*

*A: No, this person was not joking. She asked, "aren't you afraid?" What should I be afraid of, I don't know, I'm just not afraid of them. My former colleagues were shocked, "you'll do anything to get yourself into trouble, won't you?"*

Most of the centres located in connection with a health centre were mainly very content with the co-operation and communication. Some of them, however, felt that LTHSCs will never become part of basic health care or be established as a natural part of health centre services, for example. One interviewee wondered why health counselling was physically separate from other community health care and social welfare services. This respondent said that nationwide integration is impossible while some health counselling services are purchased and some are provided by the city itself.

*Everything should be under one organisation. This should not be so diversified. Then again, how would LTHSCs maintained by the Foundation fit in? In a way it's an obstacle for integration that all centres are not under the A-Clinic Foundation. Municipalities do not understand the A-Clinic Foundation at all. They think it's a private foundation that receives as much money as it wants from the Slot Machine Association, while municipalities get nothing.*

Integration of health counselling services into the basic health care system or keeping the two completely separate were not the only possible models. Low-threshold intoxicant services could be combined into efficient systems, keeping doors open to all problem users of intoxicants. Respondents felt that the model was efficient and pointed out that in smaller municipalities it was not even sensible to separate intoxicant services according to the intoxicant, because the professional health counselling staff has resources to help all problem users.

*It's quite diverse and extensive work that we do under one roof, not just syringe and needle exchange and health counselling. We arrange training and participate in the peer support group for children from families with intoxicant problems and in the group for parents of children with intoxicant problems, there's co-operation with the social services. We've also visited suburb centres and tried walk-in services there: clients could come and have a chat, grannies could have their blood pressure measured, and we informed people about the intoxicant service system. We take clients swimming in the summer, and so on.*

*I: Do you think that the extensive work you do has made you more acceptable in the eyes of other people?*

*A: Yes, but syringe and needle exchange is, after all, the basis of the work, and everything else is built around it. In a small town it would not make sense to categorise problem users of intoxicants. Everyone is welcome here. It's a good thing. Clients have adapted to the situation quite well, even though they sometimes call each other "junkies" or "drunkards". On Tuesdays and Thursdays they all dine together in perfect harmony. There's no sense in building artificial fences.*

Only a couple of interviewees felt that health counselling had shifted closer to basic health care and felt that basic health care had knowledge and understanding of health counselling work. Usually, the LTHSC personnel had a good and uncomplicated relationship with a doctor or nurse specialising in infectious diseases, but basically they only had a few contacts outside the LTHSC. Local intoxicant services, such as the intoxicant clinic, were also mentioned as examples of good partners in the work. Communication with local health care services was considered important, particularly with regard to keeping up to date with the infectious disease situation. For example, if the steering group of an LTHSC included a doctor, he or she was a valuable source of information on the infectious disease situation. This information

could be used, for example, to adjust testing services according to need. In one city, a doctor in the steering group had told that hepatitis C infections were being diagnosed in certain districts of the city, and interventions were initiated based on this information. Respondents wished that social welfare and health care professionals would study the principles of health counselling and harm reduction to enhance understanding of the work in basic health care. Some LTHSCs invited health centre personnel to visit them and learn about the work, but hardly anybody ever showed up. Many felt that if basic health care had more knowledge of health counselling, doctors and nurses could more efficiently advise drug users and those unaware of the service to visit an LTHSC. Interviewees assumed and sometimes knew from experience that all nurses, for example, were not prepared to actively meet IDUs, and they could find handling of syringes and needles and encounters with drug users repulsive. One interviewee commented health counselling work saying "This is not basic nurse's work, not basic health care work and not even acceptable at all times." Health counselling was seen as a profession of its own, not necessarily understood by everyone, and the employee's attitude and understanding of the basic principles of the work were of essential importance. Respondents also said that clients very easily noticed if the health counselling employee had a superior attitude, felt awkward or showed repulsion towards the client. Many said that to be able to work in health counselling you must have a certain attitude to the work and you must respect the clients, but merely having a desire to help is not enough.

Part-time employees are one good way of taking health counselling based on purchased services and basic health care closer to each other. Permanent employees of health centres who came from city health care services to work part-time at LTHSCs promoted awareness and acceptability of the work at health centres and were an outstanding channel for exchange of information. At

LTHSCs maintained by cities the personnel often had their main job at the health centre, so the flow of information was smooth. Some felt that the service should be kept sequestered from other health care services, because separate LTHSCs, familiar personnel and the personnel's attitudes were seen as extremely important elements in reaching drug users and maintaining trust. At health centres the services might not reach as many drug users, the content of the work could change and trust might suffer. Many pointed out that compared with other intoxicant or drug services, LTHSC employees maintained a continuous contact with clients and were able to give more time to them than the personnel in other services. Establishing a personal contact and giving time to clients were considered essential for achievement of goals.

*Time is a concept that is somehow vague these days. Everything should happen very fast, and everything is measured in quarters. Here, it may take years for a client to become a human being. Then that someone is no longer a pseudonym but a real person. Many examples spring to mind. The pseudonym "Bad Ben" was hiding under a baseball cap for three years, nobody really saw his face and he never said a word. Then one fine day, something just happened, he takes off his cap and starts talking. These are fantastic situations. That people themselves start acting and opening up. I guess noticing the change of attitudes, I've been here for seven years, I have to say that attitudes have become more positive, I mean society's attitudes to this work. I guess that this, too, is some kind of a reward for hard work.*

Health-related risks and informing about them were seen as strengths of health counselling, as basic health care professionals did not necessarily have appropriate knowledge of the hepatitis C infection, for example, or how to protect oneself against it. The messages from the so-called ordinary health care services were not necessarily sufficient or not quite targeted at this group of clients. In addition, clients needed information on matters related

to social welfare: housing, imprisonment and other topics not related to health.

Representatives of the city management or health care service management had visited most of the LTHSCs, and their visits were greeted with very positive feelings. The visitors included, for example, the director of basic health care services, the city manager, the doctor responsible for intoxicant services and the deputy city manager. Half of the LTHSCs felt that they had a good relationship with health care services and the city management and that these had a very positive opinion of health counselling, its activities, goals and significance. Exchange of information was easy in both directions, and trust in health counselling was high. The other half felt that they had a relatively good relationship with the management of health care and intoxicant services, but the city management kept a distance to health counselling and did not have a correct image of the work, its goals and character.

*I think they don't necessarily know everything about the work. I mean, in a way when the regulation says "prevention of infectious diseases", it is seen as a very narrow field. That you exchange those syringes and needles. These steering group meetings aren't so popular, even though everyone knows well in advance when meetings are held.*

*I: But there's a forum where they can find out?*

*A: Yes. The doctor responsible for intoxicant services was here in the spring. We have a new director of health services since January and I've invited him to visit us, but we haven't seen him yet.*

Whether the services were purchased or provided by municipalities themselves did not affect information flow or attitudes to the work. Distance could be observed in both models. Many respondents felt that their city had "bought a clean conscience" by purchasing health counselling services at too

low a price without any hope of further development of the work. Often the services were not even initially in line with the need, and successful work, such as a growing client base or increase in exchanged equipment, did not result in reassessment of the resources allocated to the work. Some thought that the rather cool relationships between cities and LTHSCs were partly political statements, and one interviewee pointed out, *“of course it's not politically very sexy to help junkies.”* Information flow to decision-makers and their interest in developing the work were considered poor in many municipalities.

*Sometimes you just feel that since the decree says so, we have arranged the services. And that's it. It's not like that in real life, that information would flow smoothly upward in the organisation. It depends on your own contacts, you can contact someone yourself and get your message heard.*

Generally, respondents felt that meetings and being able to tell about your concrete work and to show the achievements were essentially important elements for the success of the work and that communication with upper organisational levels should be reinforced. They said that many of those responsible for financing and development of operations had the opportunity to learn about the work and read the LTHSCs' annual reports, but they also wondered how well the information in the reports is understood and whether anyone actually read them.

*They would receive concrete information, because it can be that “distribution of syringes and needles,” some are content with that image. “I know what an LTHSC is, they distribute syringes and needles and prevent HIV in that way.” Many people have an awfully thin understanding of the work. If they do not know much about the work and then they hear someone say that distribution of syringes and needles isn't a good idea, or that it's not so very necessary because there's no HIV epidemic, then that thin knowledge may get a different content. “And now they're*

*throwing away money, distributing syringes and needles, and they give them some other stuff there, too.” It's really too bad if they don't see the element of effectiveness.*

Principally, all respondents believed that the effects of health counselling show in infectious disease statistics and size of the client base, for example, but in order to achieve good results, to maintain them and to respond to the changing drug use culture as efficiently as possible, a deeper understanding of the work is required. One interviewee pointed out how those responsible for financing of the work are only interested in better and more efficient figures:

*“The emperor wants the things that are the emperor's,” that is, they want those figures. The figures tell nothing, or of course they tell something, but they can't tell anything about what is going on here.*

#### **4.2.1.4. Media**

At the beginning, health counselling received a lot of attention in various media, and public debate on its good and bad effects was rather heated at times. Occasionally, LTHSCs still get public attention, but it seems that their power to attract attention is no longer what it used to be. The interviewees were asked what the public image of health counselling is in their opinion, whether this image is in line with the content of the operation and whether it affects the actual work. A small proportion of the interviewees said they were afraid of publicity in the media and were consciously avoiding it. Some of them were very cautious about giving interviews and comments. They said this was mainly because they feared people's responses that in turn could have an effect on decision-makers and funding and complicate the work.

*The media have become more objective in this matter. LTHSC is now some kind of an established concept. There's more content in the stories, and there have been good articles in the Helsingin Sanomat newspaper, for example. The clients' voice is being heard, the*

*voice of the drug user association is being heard. One could say that this is much more polyphonic these days. But anything can happen anytime, someone wants to write a negative article and it may be published. Would the leading Finnish newspapers do it? More likely it would be the yellow press.*

Representatives of the media were not the only ones with a limited knowledge and understanding of the work. Some respondents said that financiers and decision-makers should polish their knowledge as well. Many interviewees wanted publicity for the work in the media and were content with the tone of the articles. Respondents pointed out that if reporters do not actively produce truthful and up-to-date information on health counselling, the image created by the media was not necessarily correct. At worst, it could be based on beliefs and presumptions and be very distorted and one-sided. In places where LTHSCs received a lot of attention from the local media, active monitoring of reports and articles, such as checking the facts in an article prior to publishing or giving interviews, was seen as a means of survival and a good system of informing the public about health counselling work. Syringe and needle exchange was seen as the absolutely most visible element of the work, and the image created by the media seemed to depend on whether the centre produced information about the work actively itself, although sometimes it was difficult to get the message through.

*I think the image is so one-sided. You get exactly the picture that this is a syringe and needle – and usually they write “distribution”, even though you’ve told them a thousand times that it is exchange, not distribution, that this is a syringe and needle distribution centre. In short.*

*I: Does this affect the funding, like you mentioned that perhaps it is too often thought that health counselling can be provided anywhere?*

*A: Yes, it can support that opinion. Because they may think “it doesn’t matter where you exchange syringes and needles, they don’t need any special place for that, do they?”*

Principally, employees shared the opinion that the image created of the work by the media and the general quality of reports and articles have improved over the years and now the emphasis is more on the idea of harm reduction. At first, newspaper articles were sometimes negative and sensation-hungry. The image created by the media on the nature and principles of the work was not seen as completely false, but sometimes it was considered biased and thin. Whenever health counselling received attention in the media, it often focused on syringe and needle exchange, instead of describing health counselling as a diverse activity. Syringe and needle exchange was said to be “the heart of the work” and a means of attracting clients, but placing the focus on exchange services unfortunately left other important activities and their significance in the background.

*Our image in the media has become much more positive over the years. This is largely due to the decrease in infectious diseases. I would still hope that our work was more appreciated. Not just that we exchange syringes and needles, because there are so many other elements in this work, the exchange service is only a small part of it. Working with clients, developing our work takes time. Then there are campaigns that are very important so that we can give correct information to our clients, and all the related material, things like that. Syringes and needles are the carrot we dangle before drug users to reach them. That’s why they come to the centre. This is not much discussed in public. In our own teams we always say that we should open concepts and services, explain what they really are, what they contain. It is known, but not very widely. Syringes and needles are just one element of harm reduction.*

One problem mentioned by respondents was the image of drug users created by the media.

It was not directly related to the attention LTHSCs received in the media and it was not a new phenomenon, but its influence on attitudes towards health counselling was discussed in many interviews. Respondents said that no matter how truthfully LTHSCs were handled in the media, a certain image of drug users has been printed in people's minds, and this often negative image is attached to health counselling as well. Many wished that public attention and the media's attention would focus more on infection risks in general, the fact that the risks are not limited to a marginal group and that there is interaction between drug users and the rest of the population. Respondents said that people have a rather low tolerance to syringes and needles and drug users, and the image of drug users was sometimes quite biased.

*I can't understand that Finns still have the picture of skinny, filthy and long-haired IDUs living somewhere in a reservation. They think that's how you recognise them. People don't want to think that anyone can be an IDU, right there at the railway station or bus stop. It's not something that concerns a marginal group only, it can be anyone and it may concern anyone. One would hope that there'd be more discussion about this, and about infectious diseases as well.*

*Some people who come to exchange syringes and needles look like they're from the church youth group. You think, this can't be true. You'd never guess what kind of people are using drugs, and a lot.*

Many respondents found that the media paid more attention to drug users and injecting equipment than health counselling itself or its basic idea, prevention of infectious diseases. At least the fear and repulsion that was sometimes reflected back on the LTHSC as a result of the image created by the media was targeted at drug use and users, not prevention of infections. One interviewee relates how the message about health counselling and its clients can be interpreted negatively.

*Well, the message is given correctly, but it changes in the receiver's head, in my opinion because they have this format for the words we use, like drug addict, criminal, and they interpret it through the image created by the media. They see a world where people kill and beat each other and do terrible things. And yet, if we think about the entire field of intoxicant use, the Finnish intoxicant culture, the truth is that in Finland people commit homicide when they're drunk, they beat their wives when they're drunk, their children when they're drunk, or other men when they're drunk. That's the reality, after all. But the media and entertainment industry have created a certain image of a drug addict's world, and that's the vision people have in their minds.*

Many LTHSCs had advertised their services in local newspapers and radio. This was a completely new channel of providing information about health counselling in media targeted at the population at large. These were seen as positive channels of information, and the fact that the advertisements were accepted in the media tells about a change of attitudes.

#### **4.2.1.5. The police**

The police and health counselling represent practically opposite sides with regard to their drug policy. This is bound to show in everyday work sometimes. Relationships between the police and health counselling were mainly regarded as good, and both appreciated each other's work. The large and expanding client base implied that fear of the police did not prevent the majority of clients from attaching themselves to health counselling services. It was said that the police's approval of the work was primarily based on reduced infection risk. Even though the police did not like to handle injecting equipment, the availability of syringes and needles and the return system had the effect that loose injecting equipment was less frequently found on users, as many of them packed their used equipment in a bottle, a safe container or an infection risk container, for example. In addition, a low frequency of HIV

and hepatitis infections was considered to improve the occupational safety of the police.

*We don't have any meetings, it's just consultation when necessary.*

*I: But you have a good relationship, basically?*

*A: Yes. In fact, the city drug police has been involved in the work from the beginning, they supported us when we started the work, they send drug users here and we have agreed that they let us work in peace. At the beginning, patrolmen were sometimes overdoing it a bit, but then we sat down and talked it through.*

Respondents said that most of the clients of LTHSCs were afraid of the police, but this did not stop most of them from coming to the centre. Continuous hiding from the police was part of normal everyday life for clients, and it was often very stressful. Fear of the police and authorities was mentioned as one of the main reasons for not using health counselling services at all. Several interviewees said that especially in the early days of health counselling, many clients believed that policemen were patrolling in front of the LTHSC, or that the personnel gave information to the police. Even though respondents believed that some drug users still stayed away because they were afraid of the police, they also said that the police was helpful in the planning of field work, for example. The police knew where IDUs could be found, which enabled targeting the work at certain areas and certain groups. Also, the police gave valuable information on the estimated number of drug users in certain districts of the city or certain groups of people, for example. Even though the police and health counselling professionals sometimes work side by side quite concretely, none of the LTHSCs had been involved in any major conflicts. The request not to patrol in front of a centre during its opening hours was understood everywhere, even though encounters could not always be avoided.

*A representative of the community police is our contact person. He usually comes here once a year, but we haven't actually had much co-operation with the police. Except that once we almost pulled one of them in here. There was somebody standing behind the door, and then one part-time employee opened the door and said, "Hey! Come on in." He said, "No, no, I won't come now," and we said, "Oh come on in, there's nobody here right now." Then he had to confess that he was from the drug police. He had just come to check if it was quiet here, too. Ha ha. No wonder it's quiet when the drug police is standing behind the door. I have called this contact person of ours once. We had an unpleasant situation when policemen rushed in here after a boy. When I went to ask them, what's going on, they said "Shut up! Are you trying to interfere with our work?" I was standing there with my mouth open. When they left I asked them to give their names. I called the contact person, but the boys [policemen] had already told him that "The personnel at the LTHSC are so rude." But I think it was important to talk about it. That they cannot behave just as they please.*

All interviewees had a positive opinion on their co-operation with the police, even though it was not very active everywhere. When a new LTHSC was being planned, the local police was almost always contacted and informed about health counselling work. Principally, the police had a very positive attitude to health counselling and its employees and vice versa, even though both were aware of the different basis of their work. According to respondents, the attitudes of individual policemen towards LTHSCs and their clients varied greatly. One interviewee pointed out what many others mentioned as well, by saying: *"The higher you are in the organisation of the police, the more positive the attitude."* At individual level, the attitude of policemen towards drug users varied, even though principally the attitude was neutral and professional. Many clients were afraid of the police because they feared raids and being caught with injecting equipment. It was said

that if dirty equipment is found on a drug user in a raid, the consequences could vary greatly depending on the individual policeman. The user may be sent to the nearest LTHSC, or the police may continue the process and arrange a house search, for example.

Contacts with the police were maintained by annual meetings and regular mutual phone calls. The steering group of an LTHSC could include a policeman, or a representative of the police could participate in meetings at the centre. In some cities, the police had asked the LTHSC for brochures they could give to people suspected of using injecting drugs. The police also could send IDUs they met in the field to the LTHSC, for example, by asking them to go and exchange their injecting equipment there. Sometimes the police was given literature on infectious diseases and infection risks, for them to read or to give to drug users to read in the lockup. Principally, respondents felt that the police supported health counselling, and there were no big problems in mutual relationships. The only thing the police was criticised about was their active tendency to fine clients for drug use.

#### **4.2.1.6. Pharmacies**

Respondents said that co-operation with pharmacies was good but not very active. Contacts between pharmacies and LTHSCs were practically always initiated by the LTHSC, and the communication was said to be annoyingly one-sided. Pharmacies had expressed a wish for personnel training and support for encounters with drug users, particularly young ones. In many towns, health counselling personnel had checked which pharmacies sold syringes and needles by telephoning or visiting them, and efforts were made to provide all the pharmacies in the area with LTHSC brochures to be given to customers who bought syringes and needles. Brochures were also delivered to pharmacies that did not sell syringes and needles, and they were encouraged to inform drug users about LTHSCs.

Pharmacies were very interested in prevention of infections, and LTHSCs informed them on health counselling work and infectious diseases on various occasions. Some interviewees said that they had a particularly good relationship with a certain pharmacy, usually one that sold a lot of syringes and needles. Often the pharmacy's attitude towards selling injecting equipment and their contacts with the LTHSC depended on the pharmacist. Many pharmacies were known to be in favour of expanding the health counselling services and enhancing their coverage, and even though many pharmacies sold injecting equipment they wished that LTHSCs would be the primary channel for syringe and needle exchange, as clients could receive other services at the same time. To reach users in the neighbouring areas, an LTHSC and a local pharmacy sometimes reinforced their co-operation so that personnel from the LTHSC went to the pharmacy to take care of syringe and needle exchange. This enabled giving out large quantities of equipment once a week, and equipment could be returned as well, which is typically not possible at a pharmacy.

Pharmacies principally seemed to sell less equipment in big cities than in smaller towns where all pharmacies were known to be selling syringes and needles. LTHSCs aim to keep themselves up to date on pharmacies that sell injecting equipment in their area, and they often have a list on the wall on pharmacies that sell syringes and needles, including their opening hours and prices.

*Quite a few of our clients buy syringes and needles at the pharmacy, too. I'm sure there are other users there as well. Sometimes a client comes who has been using drugs for a long time and has always bought the equipment at a pharmacy. So, many people go to the pharmacy who don't visit LTHSCs.*

It was known that many pharmacies that sold syringes and needles regulated the selling depending on the time of the day. Usually they stopped selling injecting equipment at 9 p.m. In some places, pharmacies had stopped or

restricted the selling of injecting equipment after an LTHSC was established in the area. Selling of syringes and needles had caused or was feared to cause trouble, and other customers could be afraid of drug users. It is also possible that pharmacies felt that the LTHSC replaced pharmacy sales, and selling of equipment was no longer relevant. Syringes and needles were sometimes said to be very expensive, and pharmacies could raise the prices in the evening or weekend. One interviewee had heard a rumour from the clients that a package of two syringes and needles could cost as much as 14 euros. Some interviewees mentioned that the price of injecting equipment could be higher for drug users than, for example, cosmetologists. The selling and prices of syringes and needles were known to vary greatly depending on the area, city or city district. A large district in a city sometimes had only one pharmacy that sold syringes and needles to IDUs, and so it could have a monopoly among users from several districts. Interviewees joked that clean injecting equipment had become a profitable sales article for some pharmacies. The pharmacy's role in enhancing the availability of clean injecting equipment was essential in municipalities that did not have an LTHSC or had one with very limited opening hours. Interviewees said that the selling at pharmacies was often insufficient and the services provided by LTHSCs and pharmacies should be parallel and support each other. Even though LTHSCs often had good relationships with the Association of Finnish Pharmacies and the pharmacies in the area, interviewees said that pharmacies had the right to refuse selling equipment, but naturally it was hoped that all pharmacies would sell syringes and needles.

*We don't co-operate very much. We take our leaflets and brochures there and they call us when they run out. When we came here, the pharmacy across the street stopped selling syringes and needles when the LTHSC opened.*

*I: Did you think that was ok?*

*A: I think that pharmacies should sell. After all, the centre is open only twice a week. That doesn't help very much. If someone asks about the LTHSC on a Friday evening, all you can say is "sorry, come back on Wednesday."*

Selling of equipment at pharmacies was seen as an important extra service for clients of LTHSCs but the primary service for drug users who do not visit LTHSCs. Principally, clients of all LTHSCs sometimes bought their injecting equipment at a pharmacy, even though respondents assumed that pharmacies also reached users who did not visit LTHSCs. One interviewee believed that the users who were in the worst condition and socially most excluded had attached themselves to health counselling services and obtained their clean equipment from the LTHSC. They avoid going to pharmacies, because many like receiving their injecting equipment for free without the feeling of being branded. One interviewee was wondering whether only the wealthiest drug users purchased their injecting equipment at the pharmacy, because it is quite expensive to frequently buy syringes and needles. (In the initial interview of the Riski ("Risk") study, 95 per cent of the participants said they had bought syringes and needles at the pharmacy, and after the 18-month surveillance period 98 per cent said they had bought injecting equipment at the pharmacy. (Partanen et al. 2006, 46). Even though visits to pharmacies became less frequent during the surveillance period, the study shows that practically all clients of LTHSCs sometimes purchase syringes and needles at the pharmacy.

Even though many clients said they bought injecting equipment at the pharmacy, it was mostly because the LTHSC was closed or too far away, and the pharmacy was not their primary source of obtaining injecting paraphernalia. In spite of this, respondents felt that drug users who mainly purchased their equipment at the pharmacy were a marginal group and were not very likely to start using the services of LTHSCs. It could even be considered unnecessary. When one

interviewee was asked, "do your clients buy syringes and needles at the pharmacy?, the answer was, "It's very rarely that I hear that phrase." At some centres, employees believed that people who inject hormones, for example, buy their syringes and needles mainly at the pharmacy. All respondents shared the opinion that pharmacies should sell syringes and needles unless it is unreasonably inconvenient with regard to the pharmacy's other operations.

#### **4.2.1.7. Opening hours**

Typically, there were two or three employees present at the LTHSC during its opening hours, depending on the total number of personnel and the client base. Small centres sometimes had only one employee present. At big centres, the presence of even as many as three employees was sometimes considered insufficient, like in a situation where one employee was with the doctor and one was engaged in a conversation with a client in a quiet corner, which left only one employee standing at the counter and a queue began to form. The number of employees present varied by centre, but typically there were at least two of them. Most LTHSCs open at noon or later. Many interviewees said that principally clients will not arrive before noon, which is why the centres are open mainly in the afternoon or evening. Before opening the doors, employees had the opportunity to meet partners and take care of other duties than those related to customer service. Being open during office hours was considered important, because the services needed by many clients, referrals for them, phone calls and visits had to be taken care of during daytime. Most typically, phone calls were made to the social security office, they were related to treatment alternatives, housing, booking of doctor's appointments and detoxification. Many centres tried to arrange opening hours both during the day and in the evening. Evening hours were kept particularly in the purpose to give working and studying clients the opportunity to get service after office hours. Referral of clients for services was less active at centres that were open mainly or only in the evening. Day

centres or centres that also provided services for others than IDUs usually had longer opening hours, opened earlier and/or closed relatively late. Centres with limited opening hours concentrate their activities almost solely to the evening. If the personnel were engaged in health counselling work on a half-time basis or in addition to their other work, activities and opening hours focused on the evening and were short, usually about two hours at a time. Centres that were open only a few hours per week criticised their short opening hours themselves, saying, for example:

*Drug users often have difficulty knowing what day of the week it is, what time it is, at what time and when some place is open. Then you have to collect your used equipment and go somewhere. That actually requires a lot of planning and time management. Twice a week is good, so that you don't have to wait such a long time until the centre is open again. If you want a truly low threshold centre, it should be open round the clock. Four hours per week is not enough.*

Regular and relatively frequent access to equipment exchange service was considered important, particularly for the homeless and parents of small children. These people could not necessarily collect and store large quantities of used equipment. During holidays, opening hours of LTHSCs often had to be reduced, and according to annual reports, some small centres could be closed for a full month during holidays. Attempts were made to compensate the shorter opening hours by temporarily raising the maximum number of syringes and needles given to clients who did not return equipment and by referring drug users for other services that were available. In practice, only the Greater Helsinki Area provided enough services to enable individual centres to keep their doors closed for longer periods of time without considerably impairing the overall availability of services. During holiday seasons, the maximum limit for exchanged equipment could be raised or even removed. Also, some centres exchanged higher quantities than usual before weekends.

During shorter opening hours, clients did not necessarily visit other LTHSCs, even if they were available. The low interest in using alternative health counselling services was supposed to be associated with distances and, above all, loyalty to place. Favouring a certain centre was believed to be associated with the familiarity and trust developed between the personnel, place and client. Even though clients were assumed to be using the services of more than one centre to some extent, they were known to have one favourite place and one service that they mainly used.

#### **4.2.1.8. Premises**

With regard to the functionality of premises, respondents said that the most important criterion to have a room where you could have a private conversation with a client. The role of private conversations and the opportunity to have them was seen as an element of major importance in health counselling, and the lack of a room for such conversations was considered a big problem.

*It's the employee's responsibility that if you only have a little room and the client starts talking about some private matter at the info counter, then you could say, "wait a second, let's go to the other room to continue." But what can you say when you don't have that other room?*

Respondents said that conversations constituted an important part of health counselling, reinforced trust and had a major role in risk intervention. When one LTHSC moved to smaller premises, the frequency of conversations fell considerably and they became superficial. Respondents feared that the decrease in conversations, due to the smaller premises, could also mean that important discussions on health were often skipped.

*At the old centre it was possible to have a private conversation. Now people are really asking for them. These days there are always two employees present, plus several clients, so conversations are much more superficial than*

*before. We used to have more space. Then again, at that time, you always felt exhausted after these conversations. Rape trials and topics like that really drain your strength. Day centre would be the place for these conversations. These things and phenomena haven't disappeared, you just don't talk about them. Everything depends on space and contact. It's quite annoying.*

The equipment exchange situation was often mentioned as a good opportunity for health counselling, but a high number of clients and forming of queues were seen as irritable and even harmful with regard to counselling. At many centres, employees felt that the lack of separate rooms and lack of an appropriate waiting area were a problem. At some centres, syringe and needle exchange were organised as peer activity, so that the personnel had more time for contacts with clients. If there were several drug users visiting the centre at the same time, rush and lowering one's voice could spoil a good health counselling situation. Separate rooms were considered essential if the services provided at the centre included testing, administration of vaccinations, doctor's consultation and gynaecological services. Limited space affected testing and informing about test results, and employees were asking whether active testing should be conducted at all in a place like this and whether it would be a better idea to send drug users to some other place for tests.

*A referral for HIV and hepatitis tests, and the answer is sent here. We do not conduct in-house testing, for practical reasons. Their veins are in a bad shape and our skills of collecting blood are rusty, plus it would be difficult to transport the blood to analysis. The centre is open in the evening and the blood could not be transported until the following morning. We have not had a single positive HIV test result. If we received a positive result, we should have time for the client. There isn't a good private space here. In that situation I suppose we should contact the crisis services.*

The ideal seemed to be a centre with sufficient space for clients and a reception counter, one room for private conversations, one room for interventions and enough storage space. Not many of the centres in the study met these requirements.

#### **4.2.1.9. Location**

Many LTHSCs had wanted to move or had been forced to move during their history of existence. Finding new premises was often difficult, mainly because of the nature of the activities. Prejudice and suspicion towards the phenomena associated with an LTHSC and its clients almost always complicated the search for new premises. Merchants' associations had the most negative attitudes, even more negative than private individuals. When a centre moved, employees feared that clients would not find the new place, and these fears were realised. Moving of an LTHSC in a small town or from one city district to another caused a surprisingly high decrease in the number of clients. An LTHSC that moved to new premises could get many new clients in a short time, but the majority of its old clients did not come to the centre any more. This led to a conclusion that some clients or client groups do not leave their own district, and particularly in big cities users are loyal to the place.

*That's one phenomenon associated with these small regional units, that all this moving around has shown us that small regional units are awfully important.*

*I: You have acquired knowledge that way?*

*A: Oh yes, definitely. When we move [from a city district to another], the distance is 300–400 metres if you walk through the football fields. It's really a short distance, longer if you take the road, but it's just a stone's throw away. Only the football fields between them. We got dozens of new clients who just hadn't made it across the football field. The same thing when we had to go [to a third place], the*

*clients stayed behind. They didn't come any more [to the new place].*

Also, many drug users were known to travel hundreds of kilometres to their "own LTHSC", even though they did not have to travel so far to obtain their injecting equipment. In connection with one or more moving of the centre it was observed that there were more users than the centre could reach at that moment and that new working models were needed to reach them. Small regional centres, peer workers and outreach work were seen as solutions in order to reach these people.

Most of the interviewees were content with their current location. The location, i.e., whether services were provided in a residential house, was also affected by the number of clients. Discontent with the location was highest at centres that were located clearly outside the very centre of the town. A quiet place with poor connections was assumed to raise the threshold to visit the centre. Of permanent LTHSCs, one in three was located in connection with a health centre, one in three in a residential house and one in three in a building or business premises of its own. Some centres located at a health centre were specifically set up in one room on one evening of the week, for example. In buildings where there were premises of associations or companies, for example, the existence of an LTHSC often caused annoyance in the beginning. The biggest problem and concern was said to be the fear of possible infections. However, discussions with the neighbours and discussions on infection risks have reduced prejudiced attitudes and fears in all directions. Small centres with a small number of clients were assumed to cause fewer problems, and therefore small centres usually met less opposition.

All the interviewees emphasised the importance of location. A centre should be centrally located with good connections. On the other hand, it must not be located too centrally so that clients can come and go unnoticed. Some employees of LTHSCs

operating in connection with a health centre stressed the advantages of the arrangement, while others emphasised the disadvantages. The health centre staff's attitudes towards health counselling were seen as problematic and annoying, even though being located at the health centre enhanced health counselling's connections with basic health care, as well as co-operation and mutual understanding. The biggest advantage of working at a health centre is being close to good laboratory services, which enables in-house testing. The majority of clients felt that they could visit the health centre anonymously and naturally, but for some clients, such as amphetamine users, it was said to be a possible threshold and an obstacle for visiting the centre. Paranoid attitude towards entering the health centre area could leave potential client outside the services.

Many found that arranging health counselling at a health centre was a good step towards establishing the work as part of basic health care, which is emphasised in the HIV-Aids strategy for 2002–2006. The attitude of the health centre personnel towards an LTHSC as their neighbour varied by municipality. In some places they thought that health counselling as a specialised service does not belong at the health centre, while others believed that separation creates more barriers between health counselling and other services. Employees of centres located in a residential or business building found many reasons for not establishing LTHSCs at health centres. Without exception, employees felt that the existence of an LTHSC caused very little reactions in the neighbours, and surprisingly, centres located in residential buildings experienced less pressure from neighbours than others. However, respondents felt that whenever an LTHSC is located in a residential building, it is important to maintain a low profile, and some employees assumed that all residents were not even aware of the existence and operation of an LTHSC in the building. There were individual mentions of situations where clients had parked their cars wrong and someone had complained, or someone living

across the street had criticised the centre. Sometimes, albeit rarely, people could come inside to express their opinion on the centre:

*Some individuals may have come here sometimes to yell at us.*

*I: Do they come inside?*

*A: Some of them, yes, they make it their aim in life. They abuse us and drug addicts in general. Fortunately, these are just individual cases.*

Clients were reminded not to stay loitering outside the LTHSC to smoke a cigarette, for example, and every effort was made to keep the area around the centre clean. If there was resistance against the existence of an LTHSC, it usually came from shopkeepers, etc., instead of private individuals. The centres tried to keep their profile as low as possible in the neighbourhood, and they advised their clients to do the same. The premises were kept as unnoticeable as possible and the area around the centre clean. To avoid misunderstandings, it usually did not say anything about health counselling on the door, so that the elderly, for example, would not mistake the centre for a place where they could have their blood pressure measured.

#### **4.2.2. Key services**

##### **4.2.2.1. Testing**

HIV and hepatitis testing constitute an essential element of health counselling, and testing is one of the most important services provided. Most LTHSCs include HIV and hepatitis B and C testing in their basic services provided on premises, and the rest write referrals for tests. Nearly all respondents said that drug users practically never have themselves tested unless there is risk behaviour in the background. Voluntary testing as such was seen as a very positive phenomenon, but if drug users have themselves tested only when they have exposed themselves to risks, it could be

assumed that the number of risk situations was at least equal to the number of tests taken. Interviewees said that the reason for having oneself tested, i.e., a risk, was associated with shared use of equipment as often as with unprotected sex. Many drug users did not think that having sex exposed them to any significant risks, although the personnel tried to remind them of the possibility of sexually transmitted HIV and hepatitis B, for example.

*There's always risk behaviour in the background. They always know when they should suspect an infection. There's always something that gives them a reason to think that they might have it.*

*I: So they do not come without a reason?*

*A: No. They don't come without a reason. I've never heard any of them say, "I came just for fun." Everyone has [a reason] and everyone is shaking.*

Some clients had themselves tested regularly about every three or four months. This applied mainly to HIV tests. Respondents said that the number of hepatitis C tests was lower, because many of them had been tested already, most of them already had hepatitis C and there is no need for retesting. At many centres, hepatitis C testing was just in the process of being included in regular services, and more efficient testing was initially expected to lead to a higher number of hepatitis C diagnoses. In daily health counselling work, employees tried to emphasise the importance of regular testing, but in a way this was also a problem because having oneself tested regularly could create an illusion of taking good care of oneself. Many pointed out that drug users who tested themselves regularly were known for repeated risk behaviour, and some of them could be under the false impression that infections could be kept away by taking tests. At all the centres, the personnel assumed that all clients had not been tested for HIV and hepatitis. Most answers included comments like *"maybe half of them have taken a test at one time or other,"* or *"it is a very small minority of them*

*who have had themselves tested at least once."* Some centres estimated that the majority of their clients had been tested for HIV and hepatitis at least once, yet they said that clients were still too passive with regard to testing. At many centres, the majority of clients had never been tested, and many drug users were too scared to have themselves tested after risk behaviour. Respondents said that some users were convinced that the people who had shared equipment or had unprotected sex with them did not have an infection, and so they had no risk of an infection and no need for taking a test. Trust associated with social relationships and superficial norms of the group could create an illusion of safe shared use of equipment and risk-free unprotected sex.

Depending on the LTHSC, testing was arranged either on premises or on referral. In-house testing requires the presence of a nurse, rather extensive opening hours and an agreement on laboratory services so that confirmation samples can be sent forward. At many centres, testing was available on a certain day at certain hours. Most centres used a rapid HIV test that gives the result in 15 minutes. Hepatitis tests always require a venous blood sample, which is why transport of blood samples to the laboratory must be guaranteed to be able to collect samples. Rapid HCV tests are becoming more common, which may lower the threshold of testing and facilitate testing procedures in the future. Many centres had chosen the referral system because in-house testing was too complicated to arrange. The centres that wrote referrals felt that this raised the threshold for having oneself tested. The reasons for not testing on premises were related to practical questions, such as limited space, opening hours and personnel. The centres that used the referral system had found that getting a drug user to go to the laboratory was difficult. When laboratories sent test results to the LTHSC, the number of received results was but a fraction of the number of referrals written. Thus, the number of referrals written did not automatically indicate the number of tested clients. Low

threshold in-house testing was considered very important for the clients. Roughly, the lower the threshold for testing, the higher percentage of clients had been tested at least once. The principle was to always ask clients when they were last tested and to remind them of the days when testing was available. Even though risk situations motivated people to have themselves tested, many drug users did exactly the opposite, i.e., they did not want to or dare have themselves tested after being exposed to a risk. Many clients who would not have themselves tested despite encouragement said that their refusal was due to fear of infection. Other reasons included the referral system and, with a few clients, indifference. The fear of infection and testing was intensified by risks taken with occasional partners outside permanent relationships and by the fear of having transmitted an infection to others. One interviewee said that the other clients of the LTHSC were an element that raised the threshold for testing, and the popularity of different tests varied greatly.

*Only a fraction of them have had themselves tested at least once. There's simply no way of getting them here for tests. They just don't have the courage, that's one reason. Another reason is that you want to have yourself tested and you decide to come, and then there are other people here. This place is so small that you cannot just anonymously disappear in the crowd. Whenever you go in there, everyone knows that it's the treatment room. I've told clients that they can say "Hey, there's something I need to tell you, could we talk in private?" Somehow they still feel that's a threshold, I assume that it is a threshold anyway. In Helsinki, for example, there are so many clients that nobody will pay any attention if you go into the treatment room.*

*I: What about hepatitis C tests? They [hepatitis C tests] are much easier for clients. You can talk about them aloud: "Yes, I want that hep C test! Can I take it now?" That's not a problem, but an HIV test is. One fear associated with an HIV test is that since it's a rapid test, you get the answer immediately.*

*Quite recently, one drug user took a rapid HIV test and said he'd been going back and forth about it for a year. Then he came, and he was sweating and shaking because he was so terribly scared to hear the answer. It was negative.*

When the personnel estimated the proportion of clients who had taken HIV and hepatitis tests, their opinions were quite consistent. All believed that there were many clients who had never had themselves tested despite a history of risk behaviour. Based on the number of clients and conducted tests, the personnel of one centre estimated that less than half of the clients had been tested during the past twelve months. The personnel of another centre estimated that about 15 per cent of all clients had been tested during the past twelve months. In both cases, there was a group of drug users who took tests as often as four times per year. Every LTHSC had clients who took tests regularly, at least once in six months. Their proportion of all clients was estimated to be relatively low: the average estimate was about ten per cent.

Almost without exception, clients felt that taking a hepatitis C test was less stressful than an HIV test, even though many had a strong fear for hepatitis C.

*Some of them are very careful and keep their syringes and needles strictly out of the reach of others to avoid transmission. If they test positive for hepatitis C, many of them worry about whom they may have infected already. Sometimes the whole gang comes to have themselves tested in one day. Most of them have a sensible attitude, and they do not want to infect others. Yesterday one client tested positive for hep C but wasn't upset at all, "You can fix it with interferon."*

One interviewee told about a client who had the courage to have herself tested for HIV after being exposed to risk:

*There was this one girl who said that...Fortunately, she had a female friend*

*with her. I mean, at some point she just totally freaked out, she was so terribly scared. She said, "Oh God, I'll become a believer if I don't have HIV now." We said that she shouldn't make too hasty promises, because she didn't necessarily have HIV. She'd had unprotected intercourse a long time ago, and now the guy had showed up and said he was HIV positive. He had found out only recently himself. Just think about it! It's terrible when you have to start figuring out, "I was with him then." Then when they come [for the test] their whole world is upside down.*

Respondents said that a positive test result was an eye-opener for many clients and usually reduced conscious risk-taking.

*Hearing the test result is truly a crisis for that person. It's not quite the same today, I've noticed that. They used to say, "I have hepatitis C, after all." These younger ones don't think that way. I've noticed that it's an eye-opener, but they won't stop using drugs. Their way of thinking changes to some extent, that's for sure. You can see it in them and their way of acting after that.*

According to the interviewees' experiences, drug users who tested positive for hepatitis C or, particularly, HIV, could either cut down their drug use or start using even more drugs with an even more irresponsible attitude. After getting an HIV diagnosis, clients could choose total celibacy and isolate themselves from others in some way. Also, there were examples of clients who became completely drug-free after testing positive for HIV. Clients were very rarely indifferent about an HIV infection, and many respondents said that, sadly, only after receiving a positive test result clients actually began to understand the infection risks associated with drug use.

*I know there are some clients who have changed in some way if the situation has become serious enough. One of my own clients stopped using intoxicants after testing positive for HIV. That was the last drop somehow. Diagnoses may have positive effects, if you*

*think about it that way. Positive test results trigger positive changes.*

Respondents felt that clients showed little interest in protection against STDs, and during conversations on sexual health, clients practically never spontaneously discussed conditions like chlamydia or condyloma. Unprotected sex was found to be common, and information on safe sex habits did not lead to changes in behaviour as efficiently as promotion of safe injecting. All the LTHSCs said that their clients paid little attention to STDs and protection against them, and sometimes the attitude was totally indifferent. An STD, such as chlamydia, did not change their risk behaviour, and some respondents said that a client could receive as many as three or four courses of antibiotics for chlamydia in one year.

*Not really about STDs. HIV is certainly the most dreaded sex disease. They talk very little of syphilis, for example, "Could I have syphilis, I'm so afraid that I have syphilis," you never hear them say anything like that. We haven't talked much about them either, because they haven't been so common. There was some kind of a gonorrhoea cluster, and it was discussed in connection with the testing. They are not so much afraid of chlamydia, except that they have these fears that are often related to their permanent relationships. You could see it during testing, because they could have caught the chlamydia during an escapade, and they were wondering how they could handle the process. Then they could say that they were going to beat up someone in the field as there was someone out there with chlamydia. Then again, many have it. They're not so much afraid of the disease, because they know it can be treated with antibiotics, and they are not very concerned about infertility.*

Reactions to an HIV or hepatitis C diagnosis varied depending on the individual, but in general, a positive result was said to reduce risk taking and increase responsibility. On the other hand, one interviewee knew an HIV

positive client who intentionally offered his used syringes and needles to others, but they were rarely accepted. The matter had been discussed seriously with the client, and he was not known to have infected his acquaintances. After a diagnosis, many clients were very concerned that they might already have infected other people. They experienced fear and guilt and wanted to know how to protect others. There were very few mentions of drug users intentionally infecting others, even though it sometimes happened.

*I think it depends on the person, some of them are very responsible, but of course there are always those who don't give a damn about it [HIV]. I've never met anyone who would say that it doesn't matter whom you infect. They would never say it aloud.*

Many respondents said that drug users have a rather neutral attitude to each other's infections and had not observed discrimination or branding among the users. However, a polite distance was often kept to HIV positive drug users. Even in the Greater Helsinki Area, the number of HIV positive IDUs was estimated to be so low and the user circles so small that most users knew who had the HIV and avoided shared use of equipment and other risks with them. It was assumed that a hepatitis infection could even have some significance as an element of being included in the group, and it could reinforce an individual's "user identity", at least in the eyes of other users.

#### **4.2.2.2. Vaccines and vaccination**

Administration of hepatitis A and B vaccinations is an essential part of health counselling work and an important element of preventive health care. The majority of LTHSCs administer vaccinations on premises, and the rest write referrals to the health centre, for example. Vaccinations are free of charge to IDUs, and in connection with administration the clients are asked to give their name and social security number to be able to register the vaccinations in the health centre's information system. According to the

interviewees, clients were very receptive with regard to vaccines, and most of them were willing to give their personal information to be able to receive vaccinations and have them registered. The aim was to vaccinate and test new clients as soon as possible. Even though giving their personal information was not a key issue for most clients, administering vaccinations to minors was thus not officially possible, even though they should have been vaccinated as early as possible. Only a few users who were known or assumed to be minors had the courage to visit an LTHSC, and they were often very frightened and did not want to disclose their identity. All the interviewees assumed that the coverage of hepatitis A and B vaccinations was good at least among their regular clients and that health counselling had succeeded outstandingly in vaccinating IDUs. Many respondents estimated that at least about 60 per cent of their clients had received all three doses of hepatitis B vaccine. Efforts were made to prevent dropping out of vaccination programmes by always asking clients about their vaccinations and, when necessary, calling prisons or treatment facilities, etc., to inquire about vaccinations administered there. Some centres had noticed that the number of administered vaccinations had fallen slightly, because the coverage was already so good.

*Years ago, when hepatitis A vaccinations were administered in a steady stream, at some point our nurse complained that her hands were going numb. Our vaccination services are very good indeed. And there's demand for them.*

Many believed that the level of protection achieved against hepatitis A and B was excellent, because in addition to LTHSCs, these vaccinations are administered at health clinics and prisons, and they are offered to the family members of IDUs. One interviewee said that sometimes, however, you get the feeling that clients take vaccinations because they have the opportunity, without actually thinking which vaccines they receive and what they protect against. This was not seen as a problem; rather, respondents were glad that

clients were receptive to the services offered to them.

When interviewees were asked about IDUs' family members visiting the centre, many said that clients' spouses and other family members hardly ever come to the LTHSC, but if they do, it is to get a hepatitis vaccination. On the other hand, some said that every now and then people who are not IDUs and do not even know any IDUs show up at the centre and want vaccinations. They are advised to go to their own health centre. Administration of vaccinations was regarded as a good opportunity for health counselling, as you could talk in private and the situation was not loaded with similar tension as an HIV test, for example. Some respondents said that some IDUs are afraid of vaccinations and needles despite their injecting drug use, because they could experience great pain due to local inflammations, for example. Administration of vaccinations was seen as a technical element of health counselling, like syringe and needle exchange.

#### **4.2.2.3. Principles on exchanged quantities**

Depending on the centre, clients who did not bring used equipment with them were given one to ten syringes and needles at a time. HIV positive clients received only one syringe and needle from the centre if they did not return any equipment at all. A typical maximum number of syringes and needles exchanged at a time was 80, but the limit ranged from 40 to 100. Some centres did not apply a strict one-to-one exchange principle, and they had not set any maximum limits for equipment exchange. The maximum limits have been raised over the years: in the early days of health counselling, a maximum of 15 syringes and needles could be exchanged at a time (Ovaska et al. 1998, 14). The centres did not apply any maximum limits for returned equipment, but the majority of LTHSCs had a one-to-one exchange principle. During holiday seasons or in special cases, often when someone said he or she came from a long distance, the maximum limits could be temporarily ignored. At many centres, the

limit for exchanged needles was fifty per cent higher than for syringes, or clients could get a slightly higher number of needles than syringes upon request. Needle consumption was higher, because it was sometimes difficult to find an injection site if the veins were in a bad shape or the user did not have much experience of injecting. Clients had criticised poor availability of syringes and needles at centres that applied exchange limits and had limited opening hours. Exchange limits were particularly problematic for those who came from a long distance and exchanged equipment for other users. Many clients wanted to exchange about twice the quantity allowed. Good availability of syringes and needles and alternative ways of obtaining them were considered important with regard to efficient prevention of infectious diseases. If a centre is open once a week and users are allowed to have three syringes and needles each, it is not nearly enough to cover the need for clean equipment for a whole week. One interviewee was contemplating on removal of the limits:

*We must have small regional units, and there must be as many syringes and needles available as are needed in the field. We don't quite follow these principles ourselves, we limit the quantity of exchanged equipment, and so on.*

*I: Would there be need for higher quantities?*

*A: My personal opinion is yes. It should be so that you get as many new syringes and needles as you bring with you. At first it was quite justified to have limits, so that we got these indicators, visitors, that we're not doing this for nothing.*

The purposes of exchange limits included efficient control of syringe and needle rotation and regular encounters with clients. One of the interviewees considered the reasons for unlimited and limited equipment exchange:

*If someone brings a hundred syringes and needles, and then there's a limit of 40, that*

*seems strange. That client may not be able to come here every week. If someone collects equipment in the province and comes to the centre where we really hope that “they would come, and often,” the reality may be quite different for the clients. The user’s own life is elsewhere, the visit to the LTHSC is only a small fraction of it after all. At some point, the LTHSC may have a very important role in someone’s life, if you walk with them for a while through some episode in life. It can be associated with infectious diseases or services. In other respects, the LTHSC is quite a limited element in that person’s life. We are trying to trigger change, to influence the clients’ knowledge and attitudes so much that they can carry it on, so this can be seen as an important thing, the snowball effect. Of course we’re not really so important in that person’s life, we must understand that as well.*

The LTHSCs could clearly be divided into two categories: those who wanted to keep maximum limits for exchanged equipment and those who did not see any reason for limits. Both alternatives were contemplated, as sufficient availability of equipment and reaching clients were both seen as essential goals of health counselling. One interviewee pondered whether unlimited exchange affected the attachment of clients:

*Basically, the principle [of unlimited exchange] is good, there are no justified reasons for maximum limits. Clients come here anyway. If someone comes once in two months or once in a month to pick up a pile of syringes and needles, then you can have a chat with that person once a month, check that their vaccinations are up to date. How much more could you give that person if you met once a week? If you just remember to talk to that person, they often stay to chat if they haven’t been here for a while, they ask how we’re doing. Of course there are those who come every week or many times a week, they come to pick up a few syringes and needles and to see if any of their friends are here. Those who come often hang around in the centre of the city, but then there are those who*

*expressly come here. There’s no justified reason to limit the quantity of syringes and needles. There’s also the element of independence, that they can pick up a high quantity, take care of it, but if they need help or anything they can always come here. There’s no need to patronise people or make them come here all the time. And of course, one thing is that they can pick up equipment for other users.*

Thus, rare but regular visits could be seen as a positive phenomenon if the person was given enough clean equipment and there was some time reserved for discussion. Infrequent visits were assumed to be associated with improved life management and health, and low use of health counselling services was not necessarily a sign of social exclusion or increased risk behaviour.

#### **4.2.2.4. Importance of returned equipment**

LTHSCs wished that a high proportion of used injecting equipment would end up at the LTHSC for disposal, but they understood that it was not always possible. Even though most clients replaced the clean equipment they received with an equal quantity of used instruments, it was difficult or even impossible for many drug users in a strenuous situation to return equipment. The homeless were known to hide used instruments in the woods or to carry them in their bags. Therefore, many homeless IDUs disposed of their syringes and needles one at a time and were therefore allowed to have only the minimum amount of clean equipment. Also, IDUs who used housing services or lived with children were said to have problems with storing used equipment. Some respondents asked whether the strict requirement of returning equipment could be relieved if a client disposed of the instruments appropriately, or whether the primary focus should be on ensuring the availability of clean equipment. Even though equipment exchange is legal, drug users were afraid of carrying used equipment around because of the police. While the equipment in itself is not illegal, many were said to have been fined for drug use after being caught with

injecting equipment in a state of intoxication. This was mentioned in nearly all the interviews.

*On the other hand, the police itself was against this fining practice, but then again, they sure know how to do it. For example, they fine people for drug use quite unreasonably if they are caught with used equipment. It's got nothing to do with common sense. That's one reason why the homeless throw their used instruments around. If the police fines them for their used equipment, they'll certainly stop carrying it around.*

Respondents wished that the police would not harass people who just had injecting equipment with them and would let them have their syringes and needles exchanged for clean ones. Many interviewees said that there are clients with a careless or indifferent attitude who just come to get a few syringes and needles that you can get without returning any used ones. These clients sometimes had to be reminded and even reproached to make them understand that the service is based on returning of equipment, not just distribution. Many of them got the message and even the most stubborn ones started returning their syringes and needles. Returning of used equipment was seen as an element that promoted responsibility for one's drug use, and this seemed to be important for the users themselves. It was said that returning of equipment justified the service, because it was considered highly undesirable to find used syringes and needles lying around in public places or poorly disposed of. Homeless IDUs or those with children at home did not always have the opportunity to store high quantities of used equipment, and they disposed of syringes and needles one at a time with unsorted waste. Clients were said to be relatively skilled in packing syringes and needles and disposing of them safely, and they did not want to leave injecting equipment lying around in public places or anywhere where someone might be exposed to a needle sting injury. One interviewee said that clients were concerned about the criticism from society so that they

wanted to clean up after other users and "tourists" and make sure that injecting equipment left in public places is collected and disposed of appropriately. This way, many of them want to show that drug users can take responsibility for their habit and not harm others. It was often mentioned that clients were looking after each other to ensure correct disposal of equipment and use of clean injecting paraphernalia. Many respondents had noticed that using clean equipment had become a norm and matter of course for the majority of drug users, and more and more users seemed to be adopting this thinking. It was stated that clients often carried and exchanged equipment for others. They were reminded of the importance of careful packing of the instruments as they could be stung by each other's needles. Clients were given positive feedback for good and safe packing, and they were quite skilled in packing equipment safely in closed bottles or containers, for example. Especially in hot weather, clients were reminded to pick up all used instruments in their homes and places where they used drugs and to return them to the centre, because equipment that contained potentially infectious blood and was loaded with bacteria was at risk of being reused. The importance of cleaning up places where drugs are used and returning used equipment, for example, was always emphasised with the focus on the users' own safety and health.

Many respondents said that returning of equipment is a good practice in general, as it justifies the service and reduces exposure to reuse of injecting equipment among drug users. In spite of this, nearly all respondents were willing to distribute clean equipment without exchange, as good availability of clean injecting paraphernalia was seen as the most important issue. On the other hand, many respondents pondered what the appropriate quantity would be and whether health risks could really be eliminated altogether by giving more equipment to users. Also, returning of syringes and needles had a political importance with regard to general acceptability of the service. Many respondents

said that it would have been impossible to establish health counselling services at all if the work was based on distribution instead of exchange. For the majority of users, equipment exchange had become a regular routine and they considered their weekly visits to the LTHSC as normal as going to the grocery store. Despite regular returning of equipment and good return rates, many respondents criticised the one to one principle of the exchange service. They said that the majority of equipment would probably be returned even if the one to one rule was discontinued, as well as the maximum limits that were often applied to the quantity of exchanged instruments. It was pointed out that clients had to make several visits if the quantity of equipment received for returned instruments was small or limited. This in turn could reduce the motivation to return used equipment or acquire clean instruments.

#### **4.2.2.5. Written material in health counselling**

All LTHSCs provided written material on infectious diseases and protection against them, etc., for their clients. The material was often in the form of brochures and leaflets, and the texts were brief but included all the essentials. There were handouts on HIV, hepatitis, STDs, safe injecting, birth control, drug treatment facilities and drugs.

*They often take brochures with them when they leave. When, at some level, they come up with the idea that they should seek treatment, they pick up a brochure of the treatment facility. We always give one, even if it didn't lead to anything in six months, a year or two years. In any case, there's the idea that you could seek treatment at some point, and that's great of course. It will lead to something sooner or later. When we give test results, hepatitis C is quite a shock for many. They are not in the condition to receive all the information. Then we concretely put a leaflet in their hand and ask them to come back for conversation when they're ready for it.*

Handouts on HIV and hepatitis C seemed to have the most important role. They were the most read and most used in work with clients. Brochures on safe sex that contained information on condom use and STDs, etc., were the least popular. Other topics discussed in the provided written material included over- and underuse of medicines, dental hygiene, first aid, overdose, violence, self-detoxification, the important phone numbers in the area and nutrition. Brochures on infectious diseases and other topics were not sorted according to whether the purpose was to provide preventive or restorative information. Based on the interviews, at least the material on hepatitis C infection was most frequently used after the diagnosis, while information on drugs and safe injecting was mostly used for preventive purposes. In general, the preventive effect of written material was considered limited, even though clients usually had familiarised themselves with the topics discussed in the material.

Many respondents said that the amount and quality of text could have a critical significance for whether the handout was read at all. Depending on the topic, the handouts were sometimes said to be too general and sometimes too detailed. There were ten brochures and leaflets available on hepatitis C, different with regard to the extent of the content and the approach to the topic – the virus, infection risks and living with the infection. On the other hand, it was mentioned that due to its high frequency, clients have many questions about hepatitis C, which is why there should be plenty of information available, both detailed and general. One factor affecting the popularity of handouts was their visibility at the centre. At one centre, a pile of leaflets with information on abscesses was left on the exchange counter by accident. Clients picked them up when they came to exchange equipment and began to discuss the topic. If all handouts were always kept on the shelf, clients did not pick them up as easily and did not start talking about the topics discussed in them. The place of leaflets and brochures was changed regularly, and various

posters were sometimes put on the walls. Many centres had introduced theme months, during which the purpose was to exchange thoughts on the topic, such as safe sex, with all the customers.

One disadvantage of written material was that there sometimes was too much of it and its quality varied too much. At some centres, employees were frustrated because they did not know what kind of handouts were available, and nearly all centres had a different brochure on hepatitis C. It was pointed out that clients “drowned in material”, and respondents feared that the original purpose would be watered down by replacing quality with quantity. Many respondents said that the centre had independently produced information packages on topics where the available written material was very incoherent, and they had bundled the best and most essential information packages together. All interviewees shared the opinion that the text in a handout should not be too loaded with information, abundant or heavy to read. However, even a plentiful amount of text on HIV or hepatitis C, for example, did not have any negative effects in a situation where a client had received a positive test result. After the diagnosis, clients wanted information on their infection, and the LTHSC staff tried to provide them with as much written information as possible. In particular, the amount of text was said to have a critical effect on whether the client even considered reading the handout:

*I had a client who wanted information on STDs, and I gave him this. When he saw it he said he's not going to read it now, there's too much text.*

Interviewees said that “reading is not necessarily in” among clients, and in addition to a reluctance to read, they could have real problems with handling written text, especially if it contained plenty of information in a compact form or the topic was somehow difficult or abstract. Almost all the interviewees said that dyslexia and

concentration problems were very common among their clients.

*We have so many clients with dyslexia, for instance, that you start thinking that you could just as well blow your nose with these. A concrete, hands-on approach would be much more efficient.*

*I: That would require a lot of your time, wouldn't it?*

*A: Absolutely. Time and resources.*

In addition to traditional factual brochures, some LTHSCs offered handouts in the form of comic strips, produced by Järvenpää Addiction Hospital. The clients were very willing and able to read them. Some clients picked up quite difficult-to-read brochures and read them, as there always were clients who could and would read texts with an intense information content. Some respondents said that women take more brochures than men and read them, and women in general are more aware of adverse health effects and willing to do something to reduce them. One purpose of self-made handouts was to pay attention to nutrition and maintenance of health, for example.

*When you've been using drugs for a long time, you start having food-related problems. They need information on how to put some fat on their bones to survive the winter.*

Information packages compiled by the centres themselves on injecting, infectious diseases and other health counselling topics were sometimes distributed to policemen and guards, for example, so that they could read them and then deliver them to drug users in the lockup. Respondents said that policemen were interested in information on infectious diseases as well as other information available at the LTHSCs. When drug users ended up in the lockup, they could use the intoxicant-free time by reading “Lockup leaflets”, compact packages of health counselling information. Although the handouts were not always very

popular, respondents felt that there should always be written material available on the most important health counselling topics. Written material was seen as a supplement to oral counselling, even if its role as such was limited. Respondents felt that the clients did not really understand the information in a handout unless it was also discussed orally. If there was plenty of time for clients, personal encounters and discussions on health-related topics largely replaced written information.

All the LTHSCs had plenty of written material available, but some respondents felt that clients needed more information on the use of the filter, for example. Abundant intravenous use of buprenorphine and medicines made it even more essential to remind clients of the importance of using a filter. Clients did not always realise that the fillers contained in tablets block their blood vessels, which causes swelling of hands, for example. All centres were concerned about the low rate of filter use. Despite being aware of the risks, many clients refused to use filters, because they believed that part of the active agent in the tablet is caught in the filter. The same phenomenon was reported by Malin et al. (2006): they interviewed intravenous users of buprenorphine, and very few interviewees were willing to use a filter, despite being aware of the risks (Malin et al. 2006).

One interviewee suggested that a national health counselling newspaper should be introduced that would come out every month and discuss important health counselling topics. It could be targeted at all IDUs and it would be distributed through the LTHSCs and health centres. The purpose of the publication would be to discuss important topics chosen by health counselling professionals. Although the newspaper would be put together by professional editors, it could include drug users' experiences and opinions on infectious diseases and endocarditis, for example. In the current situation, the problem was that all the centres were publishing, cutting, gluing and copying material. One idea that came up in the interviews was to establish an electronic

health counselling material bank. All written material should be provided in electronic form as well, and health counselling employees could use the information bank to print out just the information they needed on different topics. An information bank was expected to benefit small centres in particular, and those employees who are not engaged in full-time health counselling work. An extensive information bank is now at the planning stage, and the purpose is to introduce it as soon as possible.

#### **4.2.2.6. Peer work improves reachability**

The results of arranged peer activities were very satisfactory everywhere. The importance of peer work was expected to increase in the future, and it was expected to be established as an important part of health counselling work. Peer training was considered important for the participants and because it improved the chances of reaching drug users who were not attached to services and were difficult to find. Important up-to-date information on the drug situation and drug culture was obtained from peers. The centres that had trained peer workers said that they sometimes exchanged up to 800 syringes and needles at a time. Usually, peer workers were allowed to exchange as many syringes and needles as they returned, in some places more than the ordinary maximum quantity, such as 200 instruments at a time. Peer work secured the availability of clean equipment when the LTHSC was closed. Peer workers were assumed to reach users who would hardly ever enter an LTHSC, as well as users who felt that the threshold for visiting the centre was still too high. Peers apparently reached plenty of people, as they could exchange thousands of syringes and needles in a short period of time.

*I: I suppose you hear about clients' wishes from peer workers?*

*A: Yes.*

*I: Does this current model meet their expectations?*

*A: Well, syringes and needles are the reason why people come here. That's the most important thing. Else we could just as well close the place. That's the reason why people come. We try to add services that we expect to be important for them, based on their messages and our own experiences. Personally, I think that using peer workers and hearing the clients is very important. I guess it's quite hard for decision-makers to accept that junkies come to tell us what we should give them, like they'd be happy with anything, but even so. At least they can tell what kind of services they need. I mean, what direction these services should take, what kind of problems they face in the networks, and so on. It makes complete sense to let clients themselves consider what is important for them. It's about their life, this isn't about my life at all.*

At centres that had not yet launched peer activities, many respondents talked about clients who actually were already engaged in peer work, as they exchanged equipment for others and tried to improve injecting safety. Drug dealers were also sometimes known to give clean equipment to their customers when they bought drugs. Through peer training, clients improved their knowledge on infectious diseases, for example, and false beliefs and impressions going around in the field could be broken. The information distributed by peers was considered much more reliable, because they had first-hand experience of drug use. Clients were said to be enthusiastic about the opportunity to become engaged in peer work, both at centres where courses had already been successfully arranged and where they were still at the planning stage.

*When we had that first group, they were extremely committed, everyone completed the course, they were always on time and would have liked to continue the training. Doing something together with people is already an*

*impulse for change. Today, all but one – an amphetamine user – of the members of that group are in substitution treatment. Even though that is by no means a goal or anything, but when you're thinking of these matters, it triggers a change.*

Typically, training was arranged on five evenings and included information on risks related to drug use culture and means of reducing them. Experts were invited to training sessions to tell about HIV, hepatitises, overdose, sexuality, living with an infection, etc. Even though the purpose was to train individuals, the trainees were supported by each other through group counselling, and together they developed safer drug use culture. Peer activities were by no means easy to organise, and success was not guaranteed. Sometimes only a few people showed up for the training course. All of those who completed the so called Snowball training did not become active peer workers who could engage in responsible health counselling work. On the other hand, during the training users could show a new side of themselves and achieve their goal outstandingly.

*You can't get peer workers just like that. There's one or two of them from here and there. The Snowball training is shorter, there's no difficulty to get people to participate, but actual peer work is another thing. Drug users know that they can't necessarily commit themselves to meetings, keeping agreed hours, and so on.*

*When we arranged the first Snowball training, the course had already begun, and one of our most chaotic, perhaps the most chaotic, speed [amphetamine] user showed up at the door and said, you're starting this training here, and he'd definitely like to participate. We're standing there at the door thinking, this can't be true. We told him what it was all about and asked, "Do you think you could commit yourself to this and take your place in the course? Do you think you want to join?" He said, "Absolutely." Then we decided to say, "Welcome." It turned out to be a brilliant*

*decision. It was the exact opposite to what one could think of him, all the trouble and everything, all the chaotic fuss. He was totally correct, made sharp, correct questions, took care of his job in the field, finished what he started. For myself, it was such a first eye-opener, they're often just in your own head, these attitudes and impressions on what these people are capable of.*

*I: Is he still engaged in the work?*

*A: Yes. He is. He exchanges large quantities of equipment and is just like he was then.*

Peer workers could be employed at LTHSCs and take care of the syringe and needle exchange service. Respondents felt that this improved the health counselling staff's opportunities to have relaxed conversations with clients and helped to manage the busy opening hours. The employees had grown accustomed to the presence of peers as co-workers, even though it felt peculiar at first. In their own networks, the helpers, i.e., drug users engaged in active peer work, meet young and old users, daily and recreational users, users with families and users who study or work (Malin, 2006a). The interviews with LTHSC employees revealed that these users or user groups are exactly the ones that were assumed to be out of the reach of LTHSC services.

One advantage of peer work was a rapid flow of up-to-date information. Through peer workers, information could be distributed in the field on the current infectious disease situation and existing risks, and peer workers brought back information on the situation in the field. The peers were mainly active drug users, but peer training motivated many of them to seek drug treatment. Peer workers were not necessarily less active after cessation of drug use, but the character of their work could change to some extent. Some interviewees talked about their experiences on how a person who has stopped using drugs has to keep a distance to his or her old friends and even the LTHSC. It was pointed out that

many were at a great risk of starting again, and the risk was still there years later.

*When we talk about the peers' drug use, we're talking about people who are using drugs. But if you haven't touched drugs. One employee had not used drugs for five years, and after the first work shift I asked, how does this work feel? He said that he wouldn't have believed that it comes so close again, he'd had a dream about using drugs the following night, and he hadn't used drugs for five years and was supported by the AA. This is where the world of drug use comes in. When you have stopped using intoxicants, you must have enough time, because there's always the risk of starting again. You have to be really careful and think whether an LTHSC is the best choice for your first job after that? In intoxicant service facilities, treatment facilities, you're sober, you talk about quitting and you set goals, but here you have to face the cruel world again.*

The role of peer work as part of health counselling was expected to increase. At some LTHSCs, peers were in charge of certain tasks, such as the syringe and needle exchange. They were increasingly providing support for other drug users, offering information and attending meetings with them. Also, trained peers recruit new ones. Interviewees said that peers are very cautious about whom they recruit. They can be even stricter than the LTHSC personnel.

#### **4.2.2.7. Field work and outreach work**

Some LTHSCs that participated in the interviews were engaged in outreach work, and experiences on its potential to reach new customers were positive. Field work was conducted in parks, residential homes and the users' own homes. In one town, in a short period of time field work reached about a hundred drug users, half of whom did not know about the existence of the LTHSC located nearby or its services. Some of them had heard about the LTHSC, but they had not had the courage to visit it. The first contact with a field worker encouraged many of them to come and visit the centre. New clients were

often found through regular clients. Usually, field workers took the first step by introducing themselves and telling where they came from. Then they asked if the people knew about the LTHSC and if they needed its services. Field workers carried small quantities of clean injecting equipment and handouts about the LTHSC with them.

The challenging nature of outreach work was not considered a problem, but the insufficient resources to arrange it were a problem. Almost without exception, outreach work was irregular and usually based on project funding or carried out in co-operation with a partner. Reinforcement of the role of outreach work was seen as an alternative for extended or increased opening hours. At some centres, the field work carried out by peers was considered essentially important, because they had many contacts with users that would have been impossible for the other employees. On the other hand, field work carried out by the LTHSC personnel also focused on users who did not have any previous contacts with services or drug users due to their age, for example. Increasing, maintaining or initiating outreach work was mentioned as a very important goal by almost all the LTHSCs.

*They should have the courage to come, because our long-time users have started at a very young age themselves, even at 11, 12, 13, 14 or 15. What if they had met this person then, what would they be today? Outreach work is terribly difficult when there are minors involved. How do the parents react, or the authorities, child welfare workers, everyone? It's not so simple. You rather let them come and tell their age. If you give an LTHSC brochure and the mother or father finds it in the child's pocket, they call us and yell, "what do you mean by advertising drugs to our child?" Your hands are really tied. At that point it would be really important to have a contact, even if it was just visiting the LTHSC. After all, there's a grown-up person there who treats you like a human being and kind of gives you the space to think things over, to produce what you want. Then trust*

*develops and you may be able to influence them. They must not be scared away.*

Reaching minors and adolescents through outreach work was seen as an efficient procedure, but from a moral aspect it was considered a very difficult and sensitive issue. Many respondents reflected on efficient methods and good practices to facilitate outreach work and encounters with minors.

#### **4.2.2.8. Opportunities for personal encounters**

Clients did not necessarily have any other contacts with community services, and for many users visiting an LTHSC could be the first step into the social service system. LTHSCs often acted as an interface and an interpreter between IDUs and the social service system. The role of the centres and their employees in the clients' lives could be associated with establishing a certain kind of normal social contact. Many interviewees stated that despite the low threshold, LTHSCs are sometimes seen as representatives of the "bad society" and a symbol of the norms that drug users basically object to, as many of them have bad experiences of these norms or are prejudiced against them.

*Just the other day we were properly scolded. This person has been behaving very badly, he has threatened us and he's been banned from coming here several times. His behaviour has been really a problem. We were talking to him again, but the only result was yelling and scolding. He said the reason was "I've spent my whole life in institutions, and that's why I can't stand rules and restrictions." We tell him that we've lived in institutions as well, and rules and restrictions are annoying at times, but you must adapt to society, society doesn't have to adapt itself to your behaviour. And you don't have to come here, you can stay out if the people here are so awful. Nobody's forced to come here. Then again, others feel that this is really good service, they discuss their personal life and so on. Trust is important. Our former nurse had been here for a year, and then one day, one trouble-*

*maker who was just leaving blurted out, "Actually, you're one helluva great person."*

On the other hand, client relationships that lasted for years reinforced trust in health counselling and society in general.

*For example, there was this one client, when he first came here he was very - maybe it has to do with trust and discovering it - furtive, he would never look directly at you, you could never quite figure out what he was saying either. When he sat down on that chair, the sweating began immediately. Little by little, when you started talking to him, he actually became a peer worker for us in the neighbouring town. Now he's in prison and he's written to us from there and visited us when he's on leave. Somehow the relationship has changed completely, he's found something he can trust.*

For many clients, health counselling was said to be an educational element that provided clients with knowledge and skills to survive in society and promoted responsibility, honesty and polite communication. The health counselling personnel consciously based their conduct on friendliness and matter-of-factness, but also on a certain degree of firmness. Respondents said that clients often had multiple problems, many had been using drugs for a very long time and many were firmly against the official and unofficial norms of society. When they went to meet authorities, they often behaved in the same manner as they did in their own reference group.

*We will not accept bad habits, because then others in the treatment system have to face their bad behaviour because it was accepted at the LTHSC. They have achieved something by threats. In the housing office they will not get anywhere by threatening someone.*

Conversations with clients were the best opportunities to discuss matters related to health and wellbeing in general. These conversations were largely based on listening and endless repeating of matters – such as

ways of avoiding risks. The high importance of equipment exchange was recognised and seen as the basis of the work, but the importance of conversations was emphasised in the actual health counselling. One purpose of the conversations was to make clients understand why they should use clean equipment and why they should take care of their health. In addition to drug use, many other matters were discussed with the clients as well. Clients could lack supportive conversation in their own living environment, and they felt that it was therapeutic to talk to an outsider. Intoxicant-free life is required to be able to attend AA meetings, and there were not many places available for active drug users where someone would listen to them without demands for abstinence from intoxicants, seeking treatment or putting matters in a positive light. One problem was that the same manners that applied among drug users were present in communication with others. Many drug users were in a situation where all their friends and acquaintances were drug users as well, and the ways of social communication applied in the user community were repeated in their everyday activities. In addition to their way of speaking and general being, drug users often talked about nothing but drugs. Interviewees were pondering the role of the LTHSC and its personnel in the clients' lives. The clients' social network often consisted almost exclusively of other drug users, and their way of life and their identity were very intoxicant-oriented. Many spent the most part of their days engaged in drug use.

*Often [the best thing is] when a client sits down and we discuss some everyday matter. They often say that it's great to be able to talk about something else than getting drugs, preparing doses and taking drugs. All their friends are drug users, so the topics they discuss are rather limited. We represent normal everyday life for them somehow. Humanity for human beings.*

Personal service relationships were based primarily on trust and the fact that clients always met a professional and reliable person

at the LTHSC. Clients felt that it was important to be able to frankly tell that they were hiding from the police and to talk about their life honestly, without having to tell lies. However, there were certain topics, such as serious criminal offences, that were normally not touched in conversations. The support provided by the personnel was particularly important, for example, when clients were waiting to be admitted for treatment, to go to prison or to receive a test result, or felt that they had received poor service somewhere because they were drug users. Although clients liked to spend several hours at the LTHSC, respondents believed that all of them came to the centre primarily to get clean syringes and needles, and spending time in a comfortable atmosphere and socialising were added value to them.

Jokinen (2005) studied what topics of discussion were the most popular at LTHSCs. Fifteen LTHSCs kept a record of conversations with clients on one day. The average duration of a conversation was 5–10 minutes and the topics included drug treatment (33%), injecting (21%), infectious diseases (18%), sexual health (11%) and other topics (17%). (Jokinen 2005). A similar impression was formed from the interviews, although it seemed that the so called other topics, such as joyful and sad everyday events, played a very important role in conversations, and discussions on treatment and health were often based on them. The importance of personal contact was visible in the repetition of primary health messages, as respondents told that they kept repeating the same things, even to regular clients, including infection risks, safe sex and the importance of clean injecting equipment. Taking in information and concretely applying it was a slow process, and clients were known to often forget what had been discussed.

*The most important thing is to trigger a change in their thinking. It must be produced for the clients to ponder, so that they understand it and accept it as their own way of thinking. The clients understand that “this is what I want to do, this is what I have to do.”*

*A client may have a hundred syringes and needles, and yet he routinely shares equipment with his girlfriend. It's really important that something happens in a person's way of thinking, that this is not seen as too instrumental. Of course, the technical part with vaccinations and tests at the LTHSC is important, but the internationally discussed behavioural change is important, no matter how small it is. If people care about themselves enough to use a smaller needle for injecting, that can be a big change in those people's systems. We aim to continue educational counselling, that's what makes this work meaningful. If you just exchanged syringes and needles, that would be like working in a factory, if there wasn't anything else.*

The majority of respondents felt that anonymity was the basis of low threshold services, and they said that health counselling definitely had to be based on anonymity. Anonymity was particularly important at the beginning of the relationship with a client, as this stage often involved suspicions and fears targeted at the service. When the relationship evolved and trust developed, the importance of anonymity decreased and clients no longer protected their identity so strictly. Although all the centres knew many of their clients by name, the principle was to always use pseudonyms. Clients were willing to disclose their name when they came to get a vaccination, and respondents said that many of them quite openly asked for assistance in filling out various applications and forms where their personal information was visible.

Most clients had a criminal background in the sense that they had been in prison or were going to prison, the police was looking for them or they had told about crimes they had committed. Without exception, the personnel did not want to get involved in these matters, and clients were always notified if they were “telling too much” in a conversation. Some said that anonymity and avoiding discussing criminal offences protected both the personnel

and the client. One interviewee said that if the clients had to use their own names, or if they told about crimes they had committed, the personnel might have to give evidence as a witness in court about what they had heard, and after that they would no longer be able to continue health counselling work. Because of the anonymity principle, the personnel do not have to tell about themselves more than what is considered necessary. If a client was intoxicated and began to talk about criminal offences, for example, the standard procedure often was to stop the situation and start talking about something else. Interviewees said that clients were sometimes ashamed afterwards when they realised that they had revealed too much of their life to the personnel, and then they stayed away for a while.

While crime was mentioned to be everyday life for the clients of LTHSCs, as their mere existence was criminalised in a way, respondents did not feel that the level of criminality was very high. Most clients were said to be “basic users”, “minor criminals” or “petty thieves”, and more professional sellers or drug dealers were not regular visitors to the LTHSCs. Respondents assumed that high-level drug criminals do not necessarily use drugs themselves. The personnel had not faced much violence in their work, particularly in the smaller centres, but threats and forcing were sometimes experienced, for example, when the number of syringes and needles a client wanted to exchange exceeded the maximum limit. The personnel of the largest LTHSCs had sometimes been threatened, hit and assaulted in their free time, but these cases were relatively rare and associated with the most restless centres with the highest number of clients. In many interviews, oral insults and loud swearing were said to be even more stressful than occasional physical incidents, and sometimes the continuous stress on the personnel resulted in recurring sick leaves. One interviewee gives an extreme example on how demanding clients sometimes lose their temper because the service is too slow, and what may ensue:

*One of the worst insults is that we are “f\*\*\*ing old cows” because we are so darn slow. This is always the response if they don’t get service at once. Then they threaten to kill us, to beat us up, sometimes they’ve threatened our families, and “I know where you live” and “I know that you have this and this child.” I mean that’s really tough, you know it’s so tough that sometimes you think, well, I may not be able to take this any more.*

*I: Do you think they’d actually do something, that the threshold isn’t very high?*

*A: Oh yes. The threshold isn’t high. They say, “It doesn’t matter. I don’t care. You get five years for homicide. It doesn’t matter, I’ve been inside so many times already, or I’ve killed once or five times already, or how many was it.” They say, “I won’t lose anything if I do it.” And that’s the truth, they won’t lose anything. It is tough, certainly, and not everyone can take it. Many employees have been on long sick leaves after something like this.*

*I: So we’re talking about mental violence?*

*A: Mental violence, yes, I think that’s the most brutal form. Of course, it’s not nice to be beaten up either. You see, for a drug user, “I’m gonna kill you” is the same as “Oh, hi.” They don’t realise that a so called ordinary person cannot necessarily bear to hear it everyday, and hissed between the teeth. “You cannot stop me when I’m out there, I cannot be stopped there.” That’s not very nice to hear.*

Sometimes the clients’ way of handling matters was oppressive, but if they were notified about bad behaviour, they usually were very sorry and apologised. A large crowd made the centre restless and difficult to manage, which in turn was believed to increase the risk of violence. It was also felt that a large crowd of users at the centre increased selling of drugs on premises and interfered with the actual health counselling work. Large crowds and spending a long time

at the centre were known to keep some clients away, and sometimes the atmosphere could become very trying and restless. Some centres managed to get the situation under control and reduce the crowd by limiting the availability of coffee or food and by raising the maximum limit of syringes and needles exchanged at a time. Splitting large centres into smaller and regionally more scattered units was seen as the best way to control restlessness and improve safety at work. However, the majority of clients were considered harmless, and the threat of violence was not present every day at all. Amphetamine users could sometimes be restless and hallucinatory, and clients who used hormones in addition to drugs could be scary, but nevertheless, violence was considered rare. Some said that every now and then they noticed that clients carried guns and knives, for example, but they never used them to threaten the personnel. Many respondents said that nearly all clients carried a cutting weapon or a gun, but they had not caused problems. The personnel do not normally handle used injecting equipment, so there were practically no accidents with needles, and the risk of blood-borne transmission at work was not considered very high. Clients were known to even protect the personnel from possible transmission, and they did not want the personnel to touch used equipment.

*When we shake it so that we could fit more instruments in [the waste container] when they are poured in a pile through that narrow opening, they say "Hey, don't touch it, I have hep C," and then they shake it themselves. Ha ha. They are protecting us. They say, "These are filthy," and I say "Yes, I know."*

Health counselling work was mainly considered safe, and all the interviewees liked their work. Safety aspects were taken into account, for example, by having an extra exit and by ensuring that employees were never working alone in a shift. Great care was taken to ensure the safety of personnel, especially at centres that were not located in connection with a health centre or other facility or were open only in the evening. Some centres have

an emergency button for the personnel. Pressing the button triggers an alarm that starts sounding around the centre, and the security firm is alarmed. The button was efficient if the alarm was sounding everywhere in the centre, as the majority of clients would leave immediately and the hazardous situation could be resolved. Some employees said that alarming a security guard by pushing a button is a good precaution, but it often took about five minutes for the security guard to arrive, and this was an annoyingly long time. The centres rarely alarmed the police; usually they called the security guard first if a hazardous situation arose. The police was acclaimed for very rapid arrival when necessary, and there were always many of them. As regards occupational safety, one interviewee said that the personnel's threshold to notify about dangerous and threatening situations is very high.

With regard to personal contact, respondents were asked to consider what situation was the best for health counselling. Most respondents said that administering a vaccination was the best possible opportunity for health counselling. The criteria usually included privacy and a peaceful atmosphere. Also, the situation had to be neutral enough. On the other hand, good discussions on safe sex, for example, could develop with couples or clients who were good friends with each other and in groups. Testing was not considered the best possible situation for health counselling, even though it inevitably involved providing health information, as the client had to be prepared for a possibly positive test result.

*Vaccination is a good opportunity. It must absolutely be private. Never in a crowd. The client is always alone in a treatment situation. Wound treatment provides a good opportunity as well, also if clients want to show their veins. Testing, too, if you're testing for hepatitis it's ok. But if it's an HIV test, then it's difficult to exchange thoughts at a general level. During those fifteen minutes you have to prepare the client for possibly receiving a positive result. You can never know. You can*

*inquire about risk behaviour, when was the last time, have you ever thought that you could test positive. If the result is positive the client won't be falling from so high.*

*I: Have you ever had a client who tested positive.*

*A: There was one positive result in a rapid test. We sent it to the laboratory for confirmation, and fortunately it came back as negative. Those two weeks with the client were tough, for both of us. The client was waiting for the confirmation. You can never know what the result will be, so you have to keep the situation under control. Although we've never had a positive result, you cannot expect that you'll never have any.*

*The first visit is a good opportunity. At first, tests and vaccinations provided good opportunities. Now the clients are familiar, you get in contact with them when they come to exchange syringes and needles. The contact does not have to be private every time, often there's one client and many staff members, or a group of friends or a couple. Conversations are often good. You cannot force information on them, you must be patient. You have to wait until the clients are ready to receive information, but you have to accept the fact that some of them just want to exchange their equipment.*

Many respondents said that some degree of counselling was included in the majority of contacts with clients. Usually, employees tried to exchange at least a few words with all clients and ask how they were doing. If the centre had relatively limited opening hours or a large client base, lack of time became the main obstacle for counselling and conversations.

*It can be in private or in a group. A peaceful atmosphere. You should be able to be there as long as necessary. You should make questions, be very interactive: "What do you do in situations like this, how do you mix the stuff, how do you inject, do you know your dealer*

*well, where do you get it, do you know what's in it, is it clean." You must be sensitive, sense how the client is feeling. The situation should be reviving and encouraging, not discouraging. Something like in teaching pedagogy or life itself, you shouldn't get the feeling "I'm no good for anything," when you should be saying "I can and I will, and I'm going to work on that."*

For me, what happens outside is more important than this concrete exchanging of syringes and needles. That equipment takes people's thoughts to some incident that could happen with them or something like that. But being able to sit down and concentrate on a topic outside the exchange service. Of course it may be that the exchange service can be developed so that you can discuss a topic, but here, for example, it is simply impossible. We have so many clients that there is a queue behind your back, you cannot concentrate on what is important. Then, this may change it so that it is not important. For example, at our centre, trained peers are largely responsible for running the syringe and needle exchange service. The others focus on establishing contacts with people and deepening them, discussing topics that are important for us. What I would like to emphasise is that these are centres for social welfare and health counselling. Health counselling is an extensive and incredibly important element, and then there is the other part with referrals for treatment and everything else that is not actually associated with health care. Yes, we have a lot of that.

#### **4.2.3. The customers**

An HIV-positive addict who has stopped taking drugs told health counselling personnel about his personal experiences of the time when special services for drug users were starting to become more widespread in Finland:

*He was a person who told me about this operation, that when – and this has been told by many of the old ones who are still alive,*

*also the ones who are still using – ...that when it opened in Kluuvi, it started from being very small. So it was wonderful when the word came out in the streets that there is a place you can go when you are under the influence. That was a miracle in itself, and he did not believe it. He went to see where this kind of a place could be. The doors were locked, he rang the doorbell, and the door was opened for him. The first question he was asked, the first thing, was: “Well, hello. Welcome. Have you eaten today?” And then he is offered bread, coffee, and food. He can be in peace; he gets to rest. He said that it was something that he had never experienced before, not in his whole life: he was welcome somewhere just as he is. I was listening to him. I still get shivers when I think about it, that someone really... Of course, I have known that there are people who have absolutely no place in this world, other than some bushes by the beach. And nobody wants them. It was the first Christmas in that person’s life when he had... It was Christmas, the meal was prepared together, they got a meal, they could be in peace, and they were given chocolate boxes. It was something so magical. And not being turfed out. Think about it. I just thought: “How terrible that we still have people in our society who’ve never got anything good from this life.”*

#### **4.2.3.1. Changes in the numbers of customers and visits**

In the majority of the health counselling centres, the numbers of customers grew significantly in the first years of operation and gradually levelled out. In the locations where the operation was relatively new and it was clearly being diversified, the number of customers might double each year. Mainly, a small increase in the numbers of customers and visits was seen. In locations where the numbers of syringes and needles handed out increased, the number of customer visits decreased some. In busy centres, the decrease of customer visits was a good thing in view of the overburdened service, but it was felt to be basically wrong and that raising the ceiling for

the amount of equipment handed out was sometimes a solution dictated by necessity. The number of customers visiting in the course of a day varied greatly, depending on the area. In the more quiet centres, there could be about 10 customers in opening time of a few hours, whereas the busy centres might see some 200 people visit within a few hours. Numbers of customers and their visits tell much about the extent and circumstances of the discussions that could be had with them.

Many reported having experienced a drop in customers, for example, at the time of moving to a new address, when some of the old customers had dropped out and new ones were coming slowly to replace them. At one centre, the number of customers had dropped significantly in connection with the move, but the reason was thought to also be the simultaneous large increase in substitution therapy locations. Marked changes in customer numbers were seen to be sometimes sudden and possibly due to, for example, irregular opening hours during holiday periods, the centre moving, temporary worsening of the availability of drugs, or an increase in therapy locations. If the number of customers was relatively small, several people being in prison at the same time could cause a clear drop in visit numbers. Some had been contemplating how often a customer has to visit a health counselling centre before he or she can be considered a regular customer. The general conclusion was that those visiting once a month or more often could be called regular customers. Many estimated the proportion of regular customers to be at least a third of the total number of customers.

Several mentioned that, after years of operation and along with the stabilisation of the customer base, the average age of the customers had been rising year by year and that there were no longer so many new people, particularly new drug users, coming in. Many believed that drug use among young people had decreased, and that the trend will in the long term become evident as a customer base that keeps getting older. On the other hand,

staff in a couple of centres were surprised that, although the customer numbers had remained nearly at the same level for the past couple of years, in one centre nearly half and in another a third of the customers in the last few years were new customers who had never before used the services of a health counselling centre. This raised questions about where a large proportion of the old customers had gone. Often, the reason for dropping out of the services was death, imprisonment, or a move to another area. It was, however, emphasised that many managed to stop using drugs and that the dropping out of customers could also be a positive thing. A few of those interviewed mentioned that the proportion of women's visits had increased over the years. Although women generally accounted for only about a quarter of the customers, their frequency of visits and attachment to the service was in many places noticeably better than men's. In some areas, the proportion of the customers who were women could be as great as half, and this was thought in one interview to be due to women also looking after men's equipment needs. Despite the differences in gender distribution or variance in the average age, the customers of all health counselling centres mainly consisted of the 'middle class' of drug users. No major special characteristics or obvious special groups were mentioned among the customers, except that in the health counselling centres in Southern Finland there were some visits from Finns living in Sweden, some even visiting fairly regularly. Most often, they were on holiday in Finland and took with them sometimes fairly large amounts of clean equipment. For the most part, the customers of the health counselling centres were found to be in fairly good physical condition, and there was not a lot of absolute squalor seen among the customers.

*The message has reached those who are in the worst situation. Perhaps they do not have an internal sense of direction; they cannot do anything about their behaviour. The drug users in Finland are a little better off than in many countries. If you live in the street, your basic needs are not satisfied and you cannot*

*use your resources for injecting and other things to do with it. According to Maslow's hierarchy of needs, you are only able to take in information after your basic needs are satisfied. The Finns are able to take in information about health behaviour. For example, in Eastern European countries, there are users of injecting drugs who are in such a wretched state, who have nothing. On the other hand, accessibility becomes lower the more marginalised the group is. There is, of course, this group that has completely dropped out, mainly in the capital region. They were the first to become infected with HIV. There are a lot of mental health problems, cases of homelessness, people in really difficult situations. When you are in that kind of a situation, you cannot even be responsible for yourself or others, or you just don't care.*

#### **4.2.3.2. Reaching customers**

Syringe and needle exchange was considered to be the best and, in the end, the only way to get customers to come into a health counselling centre. The personnel were asked whether testing and counselling of customers might be as effective as the current exchange of equipment and whether risk management and the prevention of adverse effects would be achievable also by other means. The majority said "no". Everyone was of the opinion that there would be no chance of reaching drug users with testing only. One of the people interviewed stated that the low-threshold HIV testing should be expanded outside the risk group to the level of the entire population, but to reach injecting drug users and get them to be tested requires other means also. Another interviewee said that using testing alone would only reach people who wanted the test result, not drug users. He said that it is quite possible to test and achieve good discussions along with an exchange programme, but testing alone is by no means enough to attract the target group. The subject was given a lot of thought.

*I would see the syringe and needle exchange as the prevention method in this bad thing. It*

*is then a supporting function, the testing and advising. They cannot be separated from each other. If you only hand out equipment, it helps to some extent. But if you don't give any advice and do not even attempt to have a discussion, then it is... In that sense, the person in the exchange situation is always a better alternative than a dispensing machine, but if you have to choose and in any case have to get [the equipment], then it is also necessary to have dispensing machines. Because this person does understand enough to know that he must use a clean one so he wouldn't become infected. He has received that information somewhere already. Testing, on the other hand, is catching the HIV cases so that they don't spread it further. Testing and counselling is better than nothing, but if you don't get clean equipment anywhere and you are going to use substances anyway, the situation is quite hopeless. It is a little similar to how it is with sex education. If you think that pregnancy prevention should suffice, so that you won't get pregnant, then you would only think about that and not the diseases in that situation. If you only give information, information, information but don't give any equipment – no condoms, no guidance on using the coil or the pill – then it is inevitable that people will be having intercourse. There will inevitably be pregnancies, also unwanted ones. In my opinion, this is exactly the same game. There must be some equipment available.*

It was also contemplated whether the risk of infections could be reduced by focusing more on drug treatments. It was seen as a problem for drug treatment that not everyone was motivated to undergo treatment. Getting into treatment was sometimes difficult, the treatment itself could be difficult for many, and treatment was not a guarantee of ceasing to use injecting drugs. The application that was considered best in reducing adverse effects was the Finnish health counselling model, in which exchange, testing, support, and treatment work side by side and support each other.

#### **4.2.3.3. Guidance to the services**

In guiding customers to the services, an attempt was made, jointly with the customer, to find the services matching the person's objective and to help and support the person in the use of the services. Guidance to the services was said to be the 'other side of the work', as distinct from services directly relating to health matters.

*There are a lot who simply don't know what they should do, which channels to go through to apply for something. Quite a lot of guidance is given on where to go or on sorting things out, for instance, with the social services, what should be submitted and where. Even we don't have to know everything. We can phone and ask for advice.*

Almost all of those interviewed mentioned in particular that seeking drug treatment is difficult at times. Keeping agreed appointments was difficult for many; the customers had bad experiences of the service system and were afraid of being badly treated.

*What I would think is that, when our customers visit, for example- Now I am saying bad things on the tape again. But when they go, for example, to the emergency clinic, when they are taken, I know that the attitude of the staff is something so horrible that these people say they won't go to that place. "No way am I going there", they say if they are told that now we are going to the emergency clinic, we must go now. I think it's been horrible, from the stories they tell. One customer had to go there. This one customer had some problem with his feet, probably had injected in them, and wondered whether there had been an infection or something. He went there and, after he had queued for some time, the doctor came to the door and told him to strip off there in the waiting room where there were other people present. Said: "Drop your trousers; I'll look from here." This was the worst I have heard. It is really humiliating, but this is how they are treated. Or they are not seen at all or they are just turfed out. Then they are crying there.*

*When they feel bad, they really do feel very bad. I just think it is so wrong.*

The personnel of health counselling centres act between the customer and the service system as contact people, interpreters, assistants, and providers of support. Often, despite having the will, the customers did not have the means or information about where they could seek help for problems, whom to contact and how. Informing the customers about the services was a challenge for the personnel because, for example, in the capital region, the services of health counselling centres were continuously used across town boundaries, and, also elsewhere in Finland, customers arrived from other areas. Therefore, the personnel had to be up to date with the service practices and treatment possibilities in several towns or municipalities. Some of the personnel practised concrete guidance to services, for example, by accompanying current and prior customers to agreed appointments such as treatment assessments, by taking HIV medication to the customers, and by implementing substitution therapies.

*I don't think the health counselling service is some kind of an independent unit, a lonely island. It does in my mind belong to the intoxicant abuse treatment system, or to the health care system in general. There are lots of co-operation partners; it is not even the intention that at the centre would be done that we would have to be experts in every field. It's more that this is a place that guides to the services. I think that in the health counselling work it also means walking beside the customer in a very concrete sense. Whether it is going to the intoxicant polyclinic or to the social services, a health centre, an A clinic, or an intoxicant psychiatry polyclinic. ...That the employee is still quite aware of the service places available but not that every area would need to be taken care of here. But that we know where to guide customers to and start sorting these things out together with the customer. Some municipalities have these service advisers provided by the municipality, but we do not.*

#### **4.2.3.4. Customers' knowledge of infectious diseases**

Although it was felt that the customers of health counselling centres had a lot of correct information about infectious diseases, drug use, and the related risks, there was also false information and ignorance. There was the most false information or ignorance amongst the customers concerning hepatitis C. The biggest single belief among the customers was in the encapsulation of hepatitis C. In the majority of the centres, customers had talked about the encapsulation of hepatitis C and that once encapsulated it was no longer contagious. Encapsulation comments continued to be heard even though people had been told that this was the most common false belief already for some time. False information, particularly on encapsulation, was considered unfortunate, as customers were also passing the incorrect information on.

*It is really difficult for the customers to understand what is meant by 'carrier', that one can pass the infection on and what it means if you have been ill but do not remain a carrier and do not infect others. Health care personnel, who are not often involved in these things, do not necessarily have precise information, so incorrect information can also come from that direction.*

There was also some lack of information about successive infection and vaccination relating to hepatitis C. It emerged during the interviews that very few customers know about the possibility of catching hepatitis C again, and that so-called successive infection / reinfection was not common knowledge. Often, it was thought that if two or more people have hepatitis C or HIV, they can use the same equipment safely. Another unclarity or supposition was related to vaccinations – for example, if a person had been vaccinated against hepatitis A and B, it was understood that immunity against hepatitis C had also been received.

No false beliefs as such were said to have been heard about HIV, although information on the

subject may have been lacking. Generally speaking, the customers had much correct information about HIV, and not one of the customers was unaware of its risks in relation to drug use. One of the few false beliefs about HIV that was heard is that it can kill instantly. HIV was generally seen as a very frightening threat that was unavoidably related to injecting drug use. There was some lack of clarity about HIV medication, mainly concerning how it should be committed to and how the practical implementation might work. Some of the wildest individual myths or false beliefs regarding HIV were known to be caused by customers' mental problems – i.e., they did not believe they had an HIV infection or thought there is a secret vaccine for HIV. These cases were, however, extremely rare. The customers did not always fully understand or know that it was possible for several infections to exist one upon the other or in parallel, and what the health consequences could be. It was stressed particularly to those with HIV or hepatitis infections that it is especially important to protect oneself and others from new infections and that multiple infections and continuous exposure to new infections should be avoided. Multiple infections or continuous exposure makes starting any treatments more difficult and hampers the effectiveness of treatments. They also worsen the infected person's health significantly. For this reason, for example, shared-use situations, where an HIV-positive person is allowed to use the shared equipment last are to be avoided.

About STDs, it was stated that there was sometimes an impression that they cannot be acquired via the mouth. Other impressions related to drug use and risks of infection were said to be related to, for example, licking needles or thinning the blood with aspirin. Drug use affected many in such a way that menstrual periods stopped, and the customers were sometimes said to believe that if you do not have periods, you cannot get pregnant. Also, an irregular menstrual cycle was said all too often to create an illusion of contraception. Pregnant drug users were said to sometimes

believe that drug use does not affect the foetus. There had been an impression among one local user group that injection was the safest way to use drugs. There was also said to be uncertainty about cleaning the equipment, particularly about boiling to sterilise it.

Some of the respondents were of the opinion that particularly the young and, nowadays, injecting drug users generally had correct information about infectious diseases, their mechanism of infection, and protection from them. Attempts were made to counter beliefs and false impressions in the day-to-day health counselling work, where repetition of things was said to be a slow, but the best, way of getting information across. The value of peer training in spreading correct information was also seen as great. Peers were able to pass the message on within their own networks and, one hopes, to reach those drug users who did not visit health counselling centres.

Although there were false impressions and beliefs among customers of all health counselling centres regarding infectious diseases and risks related to drug use, the customers generally had a good idea of the dangers connected to injecting drug use.

#### **4.2.3.5. Mental disorders**

Psychiatric diagnoses and treatment of intoxicant dependency were commented on in statements that, amongst other things, customers' day-to-day life is often controlled far more by intoxicant dependency than, for example, by a diagnosed mental disorder, and the customers hoped primarily for help for their intoxicant dependency problems. It was known that there were many mental health problems among all customer groups, as both reasons for and consequences of intoxicant use. Many of those interviewed wondered whether the intoxicant abuse could have been prevented by addressing a customer's budding mental health problems or general bad feelings.

*Yes, there are. Double diagnoses. Self-medication with some of them. In some, the*

*use of intoxicants has triggered mental health problems. There is madness living in every one of us, and if you use enough intoxicants, the madness creeps out.*

Many customers said they use drugs as medication, and the drug was not necessarily seen as a drug but primarily as medicine. Amphetamines were known to be used for concentration problems and buprenorphine as substitution therapy for heroin addiction. Buprenorphine specifically was often mentioned as keeping many customers feeling functional; they did not get a euphoric feeling from it but a normal feeling. Euphoria was mainly experienced when the addiction had not yet developed. Everyone said that some customers have mental health problems. Some estimated that even the majority of them had a mental health problem as well as the intoxicant abuse problem, in addition to which some had a significant somatic disease, such as HIV. Drug users were said to often have learning difficulties, ADHD, problems with concentration, Asperger's syndrome, schizophrenia, depression, anxiety disorders, instability, affective syndromes, paranoia, and personality disorders. Many were known to have a double diagnosis, but nevertheless the majority of the customers' mental health problems were estimated to remain undiagnosed. The background of the customers was often said to be traumatic and thought to have caused even serious mental health problems. In addition to problems with concentration, anxiety was mentioned, which was treated with tranquillisers. Nearly all stated that the customers included both those for whom drug and alcohol use, mainly the use of amphetamines, had the role of self-medication and those for whom the use of drugs and alcohol had triggered mental health problems or changed the personality. It was thought that, for example, panic attacks could be a reason for or consequence of drug use, and some of the depression and anxiety can be connected to diagnosed HIV or hepatitis. For many, amphetamines served as self-medication for depression and ADHD. Many customers were reported to have said that drug

use helps with a general bad feeling, bringing pleasure though turning against pleasant feelings in the end.

*I would see it in the way that, for many, it has been it, the really good experience. That is why they have been such good experiences: there has been so much feeling bad. When I am with these people, this is what I seem to see and hear. On the one hand, there is the good feeling from the substance, but then there is also the good feeling about the group. To belong to a group, to be in a tight group, a part of something – an important part of something: a group. That brings a good feeling and also the substance itself. These people describe it as amphetamine hitting so hard the first time, the first time of something they had never experienced before. When you think about some young person who has a lot of good things in life and so on, it may be that it isn't so important; the experience doesn't gain such importance, not to mention that if you really have some kind of problem with concentration and ADHD, the amphetamine brings ability to concentrate and peace from the rest of the world.*

*It may be dyslexia or some event at some stage of life that has started to create this impression that "I am not really worth anything" or then some other event in life that has provided some kind of ease from an intoxicant, a means of medicating yourself to something better than the situation otherwise would have been at that moment.*

Mental health disorders were thought to be connected to greater risk-taking, in relation to both drugs and sex. Mental health disorders were thought to cause social exclusion and thus inability to take care of hygiene in the injecting situation, even though some were known, on the other hand, to be neurotically hygienic. The majority mentioned that particularly depression, which is common in customers, was clearly connected to greater risk-taking. Depression was often thought to be caused by both drug use and one's general situation in life. On the other hand, it was

contemplated whether indifference to a person's own health was dependent on depression or mental health problems or was generally typical of many customers.

*Their lives are very stressful, and, in practice, they live in the middle of a crisis. Their experiences are certainly what they are, maybe such traumatic experiences that cause this feeling of a crisis, or the family that they come from, or the personal relationships they are in, and then the police are always breathing down their neck. This living within a crisis often has the effect that there is no future. There is no vision of what to do when grown up, when there is no vision of being grown up. When the life that you can imagine spans perhaps only a few days or a few weeks into the future, then it makes no difference whether you are healthy or not or whether you have hepatitis, which some 20 years on will do something. Your own health doesn't matter, it doesn't matter what reputation you have around town, and sexual behaviour doesn't matter – whether you are at the level of a whore or see yourself as a whore. Does it matter when you are going to die soon anyway? The stress and living within such a crisis... Many people's lives just are in such a mess.*

The crises in life were often connected to general despair, violence, deaths of people who were close to the user, living at the margins of society, and constant fear.

*A person living within such a mess certainly sometimes also looks for some way to ease the feeling, without considering risks. To make it through it all. There is no strength at that point to think about the risks.*

Many of those interviewed said that customers often had self-destructive tendencies and exhibited much risk-taking. Self-destruction was thought to be connected, for example, to a crisis caused by age or simply awareness of using drugs. To identify oneself as a user or an addict was seen to cause self-hate, and the

drug use and risk-taking could act as a conscious punishment of the self:

*Some have a negative attitude to their own bodies, that there is nothing worth saving. It can, of course, always be thought that some people have a background of sexual abuse or something. Some have, and this kind of self-destructive in a way- ...as a punishment for him- or herself. It is said about drug use that, for some, it is self-destructive behaviour.*

It was thought that the mental health problems of some customers, along with a chaotic life situation, expose them to greater than usual risks of infection. It was seen as a particular challenge for health counselling to influence risk-prone customers, and this requires personal contact, time, and patience. For moving toward safer drug use and sexual behaviour, clean injection equipment alone was not enough. Also many tools and taking into account the customer's life as a whole were required.

#### **4.2.3.6. Risky behaviour**

Workers attempted to bring safe sex into the conversation whenever possible. Some of those interviewed thought that in other health counselling centres, probably a lot more sexual counselling was given, although the interviews indicated that nearly all of the centres felt that the amount of sexual counselling they had given was fairly low and inadequate, and the subject difficult. The customers' sexual habits were not necessarily straightforward or simple, so offering a neutral product such as a condom was considered the easiest way to open the conversation. Despite their attempts to keep the subject of safe sex in conversation, the personnel felt their opportunities to open conversations and to address the risks were limited. It was stated that health counselling has educational, informative, and instrumental significance in promoting safer injecting practices but its abilities to influence safe sex are very limited. It was seen as more problematic to intervene with sex than with injecting, because there seemed to be a higher number of risky

situations and their social significance was greater. For example, sex could be offered in exchange for money or drugs, there could be force involved, and sex was often engaged in under intoxicant influence. Intoxication was stated to be definitely the most common reason for engaging in unprotected sex. In the sexual health study carried out by the Tampere health counselling centre Nervi in 2006, 50 per cent of the respondents (about 97) were always/often or every other time intoxicated when engaging in sex, and 72 per cent stated that they had been intoxicated during their last intercourse (Ovaska et al. 2006).

Shared use of injection equipment often takes place when no clean equipment is available, during withdrawal symptoms, when another person's equipment is used by mistake, when one is intoxicated, or if the use situation takes place with people who are close (EMCDDA 2001). Also, the group's norms and rituals have an effect on the situation and can cause shared use to occur even if clean equipment is available (WHO 2004). In the interviews, customers were said to succumb to shared use of equipment particularly when they had withdrawal symptoms, had a compulsive need for the drug, were intoxicated, or found clean equipment scarce (such as in prison). For many, sharing equipment was a sign of strengthening a friendship or relationship and trust, although intentional shared-use situations were considered rare.

*It is still regrettably common to use others' equipment. It just will not get through.*

*I: In what kinds of situations?*

*A: They are probably the situations where you are somewhere in the middle of the night and there is only the one set of equipment. No matter how much you try to stress that there is never such a hurry that there isn't time to get new equipment. Night-time is bad. It would be possible to get it from the machine. On the other hand, nobody would go even 500 metres to get it if there is already one set there in front of you. Clean or not.*

*The craving for the substance can be so great at that point and that clean equipment is not there. There are some customers who say that, no matter how bad the craving is, they will not use dirty equipment. There are differences in that also. If you ask: "Well, do you clean it in any way?" they reply: "I did clean it with that Sterets pad." Sometimes I think that we don't really talk about the cleaning so much. We talk more about "always your own clean equipment", but should we still also consider that the person's own set isn't always there? We haven't wanted to bring it up a lot; it is only the second best alternative if that comes up. But the situation may be that it isn't there, and then the only thing in the head is "your own clean equipment". If you don't have it, then the next alternative doesn't enter your head.*

*I: How about this unprotected sex. What is often behind it?*

*A: Some may think: "That doesn't concern me" or that moment. It may also be that you look after contraception but the other person doesn't. These things you hear also. In steady relationships, you trust the other person in the extreme even if you have been together for a week and in general terms nearly moved in together.*

*I: Are there some norms that would maybe affect risky behaviour?*

*A: There is probably that if you inject with shared equipment with your partner, it is some kind of a sign of trust.*

*I: You can't really say "no" in that situation, maybe.*

*A: Exactly. It is the sort of thing that, by doing this, we belong together.*

Unfortunately, personnel saw and heard about situations in which a person considered to be very 'disease-free' had hepatitis C or HIV and, because of this, other infected people were found in the group of friends. In the interviews

it emerged that trust in an acquaintance being 'disease-free' was not very often based on actual information so much as on the will to trust. Although a person may tell acquaintances that tests were done, any such test may have been several years earlier. For many, clean equipment took second place at the stage when they were offered drugs, and many were known to be unable to decline a risky situation in these cases.

*No matter what we do, still the customers in some situations forget that they should have their own equipment. When they are gathered somewhere in an utterly intoxicated state, the needles and syringes have got mixed up, or they have brought no clean ones with them, a person has drifted into some group maybe in the middle of a trip to the shop and then someone else's equipment is used to inject. Then there are these beliefs in using only a certain mate's equipment because that person doesn't have anything. Then it comes out that the other person has something. There are coincidences but also calculated risks. Calculated because they have received information about the risks and the fact that they should have their own equipment at the health counselling centre and they are also taking this information to the field to those who are not customers. But if the situation is such that a person's own clean equipment is not there and still the substance has to be had, then a calculated risk is probably taken.*

There was a constant effort to remind customers that equipment is always personal and should be used only once. The message of always using clean equipment was felt to be problematic also because experience showed that it was not always possible for the customers to get clean equipment and that there was not necessarily enough information available about cleaning the equipment. Staff attempted to tell the customers also about boiling and cleaning the equipment, although it was stressed that cleaning should be used only as a secondary solution if clean equipment was not available. On the other hand, it was known that needles become blunt

from being boiled several times or from strong disinfection.

#### **4.2.3.7. Difficulty of influencing sexual behaviour**

All of those interviewed were of the opinion that the operation had had more effect on minimisation of the risks related to drug use than managing the risks related to sexual behaviour. Discussing sex and sexual health was considered challenging, and means for development in this area had clearly been contemplated. In some centres, theme weeks or months had been introduced, during which it was attempted to exchange thoughts with the customers, for example, about pregnancy prevention and sexually transmitted diseases.

*No new infections have arrived in the area through injecting drugs. However, there have been new infections through sex. And through our customers, a couple of cases of infection have come about. So there is still work in this area of health counselling, particularly on the "remember to use the condom" message. Although the customers are rather well aware of HIV being difficult to catch through sex – so this is what they use as an excuse. So if they are thinking "one out of a thousand – that is not likely"... but you never know when you are the one thousandth.*

The reduction of sex-related risks was seen as problematic, in addition to its intimate nature also because the customers had different ideas and habits related to sex, and looking at some of them would definitely require an unhurried and peaceful situation.

*It is somehow more challenging to intervene in sex. It is somehow so much more sort of normal; sex is a part of a person's life. It isn't only connected to this group of customers. It is quite a similar situation also otherwise. You do try, and now again should try more, to raise this subject. During the one project there was a lot of discussion about what sex means, and it demanded a more peaceful kind of situation. It seems that things to do with injecting can be talked about more freely even*

*here, what happens in the injecting situation. But then, if you think about "What is sex?" then it is somehow... Is it anal sex, vaginal sex, or what is it? Goodness, last year or some time ago, a guy came in who did not use himself but said that he had had a hepatitis-C-positive girlfriend for a time. That guy wanted to take the tests. He was told that it is very difficult to catch during sex but, absolutely, let's take the test anyhow. We tried to calm him down. The guy said that they had had sex that was sort of wilder. We told him that it's true that in anal sex the risk is greater because there can be a blood infection. The guy said that they had been slashing, that they really had that kind of a thing. In his world, it was connected to sex. It was what he had always done with girlfriends. Really, the conversation demanded a different kind of space, a conversation like that. You can to some extent also talk about sex just like this, but if it becomes personal in the way that "What is your sex life like?" ...*

For HIV, the route of infection was expected to be increasingly through heterosexual contact, also among users of injecting drugs. Risky situations related to shared equipment were considered to have been decreased, but customers continued to have a lot of unprotected sex. The personnel throughout seemed to be of the opinion that influencing safe sex was harder than influencing injecting behaviour. Risky behaviour related to injecting drug use seems to have reduced also elsewhere, whereas sexual behaviour has not moved in a safer direction. Many mused that if risky sexual behaviour remains as common as it is now, sexually transmitted HIV infections may become a primary route of infection also among injecting drug users, of which there have been indications also elsewhere (Kral et al. 2001 and Lindenburg et al. 2006).

Customers were said to be having a lot of unprotected sex, and the risks related to sexual behaviour were not always understood or seen as significant. On condom use, it was commented that it was not at all a matter of course that everyone was able to use condoms,

and they were said, for example, to be used "like a sock". There was unprotected sex particularly in steady relationships or with a regular partner, which may have increased trust, especially at the start of the relationship. Many stated that, in extreme cases, a steady relationship for some could, in practice, mean that the customer had known the partner for only a week, and that a person may have several regular partners. Staff also attempted to remind the customers that also regular partners could have one-off relationships and that this is why testing and, especially, the use of a condom were particularly important means of protection.

*I: What are the key sayings in your work?*

*A: Always use your own equipment and use a condom. Always have the condom with you. The average age of the customers is 25, and it is not always possible to tell from the outside who is using drugs. Summer will come, festivals... people are moving around. There are bar crawls and one-night stands. It is hypocritical to say: "I am in a good relationship." When there is some booze in the head, then they do anything. It isn't even necessary to be drunk. Casual relationships just happen; it is a simple fact. No matter how much they are in a steady relationship, even a good one. A 25-year old girl, the guy is 30, and he has HIV or hepatitis C – then unfortunately the thousandth time happens there and the other thousandth at home, then the partner also has some casual fling. This is why it is necessary to keep banging on about using condoms all the time. It is so important! I have been at schools' parent evenings to talk about these things and received some disapproving looks when using these exact words, but this is just how it is.*

Through the customers, attempts were made to get steady and casual sexual partners to come in to be tested and vaccinated. Many respondents stated that more attention should be given to the prevention of sexually transmitted diseases, not just in relation to the risk groups but also at the level of the entire

population. Influencing certain risk groups alone was not seen as sufficient. A great deal more public prevention and openness is needed to influence sexual behaviour.

*You can see from the customers whether they want to talk about things related to sex. Offering condoms is a good situation to talk about sex. Many start blushing but take them. It is a good way to start, and further discussions can come from it. Then you can ask about STDs and explain how they are transmitted and what the symptoms are. To offer condoms is a low-threshold approach, because nobody is forced to take them. Condoms are an easy way for everyone, because you can say “no” and the matter is left there. If you started to talk to a stranger just like that, you cannot know how that person is going to feel about it if you don't know the person. You cannot know whether the person has suffered abuse, how the person feels about his or her sexuality, what the sexual behaviour is like if the person is a prostitute, so you cannot start offending anyone. If you present it in a natural way, that this is one thing among the products available, in that case it is not necessary to make a big deal out of it.*

In the interviews it was mentioned that asking about the need for condoms and lubricant creams and supplying them may arouse surprising reactions in customers, such as “I am no homo” or “I don't do smuggling.” Comments like this were said to describe well how talking about sex is clearly more difficult than talking about drug use. Attempts were made at addressing sexual health matters by giving the customers condoms, reminding them about testing, giving hepatitis C vaccinations, and giving information about the pregnancy prevention options. In centres where a doctor was present, his or her role was very important, particularly in relation to women's sexual health. Pregnancy prevention counselling was also considered an important part of the health counselling work, and attempts were made at many centres to increase its role.

*There has been some discussion in the working group about pregnancy prevention – meaning that it wouldn't be only “a condom protects from infectious diseases” but more pregnancy prevention counselling and that it would be possible to get the pill. This is something that has been discussed in the working group from time to time. In steady relationships, these people do not care about condoms and lubricants; it is not the service they need.*

Customers were known to understand that there is a risk of infection in unprotected sex and, for women, the possibility of getting pregnant. Nobody had unprotected sex because of not knowing the risks, but many other reasons were said to be found for it. Risky sex was often due to circumstances where protection was very difficult or even impossible. Intoxication and the exchange of sex for various favours were said to be the most typical reasons for taking risks in sexual behaviour, in addition to pure indifference. The position of women in the protection was said in many interviews to be weaker than men's. Female customers gave some accounts of rape and other kinds of violence that had made protection impossible. In a steady relationship, unprotected sex was thought to be connected to trust and closeness, and the interviews revealed that, in steady relationships, more attention was given to the prevention of pregnancy than to infectious diseases.

*Many do not see it as prostitution if it is connected with the circle of acquaintances. If there is a man who gets the drugs and they then have a sexual relationship, this is not classed as prostitution as such, more as a relationship. It can start as a relationship or on the basis of substance supply. It is not seen as...*

*I: But this is not an uncommon phenomenon?*

*A: No. It is a blurred line. Many women have a guy who supplies, but the girls do also get money, but to what extent is it prostitution? At*

*least it is not there a lot in conversation. But it is true that, for example, violence is partly connected to these relationship issues. There are masses of them, rapes, compared to in the general population.*

#### **4.2.3.8. Risk of infection in prisons**

Finnish prisons have not implemented needle and syringe exchange programmes. Instead, prisoners have access to a disinfectant meant for the cleaning of use equipment, Virkon. Many mentioned that the risk of infections related to drug use in prisons is still high but has probably become lower with the Virkon solution, which can be used to disinfect equipment; to the Probation and After-Care Association's Terve project, which was recently brought to a conclusion; and to peer training organised in prisons. Those who knew well the situation in prisons said that the availability of the Virkon solution and health counselling was not systematic or certain in all prisons. Mainly, the view was that injecting drug use will not end in prisons, and that exchange of use equipment should be arranged in prisons. The positive effects of exchange might become evident, in addition to reduction in risk of infection, as increased general security. One of the interviewees contemplated the organisation of equipment exchange:

*On the other hand, I am thinking of the staff there, the prison guards. They are doing their work understaffed. Would it bring security? I think it would bring security there. Those who are addicted would be able to medicate their own addiction as they see fit. This also becomes its own communal game there, the choice of substances. Some customers of the old union have been saying that, some time in the '70s and '80s, those who used could use in peace. It brought peace to the house; everyone knew his place. It was not made into a big deal. Maybe things have changed; nowadays there are these gangs and others who are trying to dominate certain things. Maybe it has changed. That is a difficult question. But definitely health counselling messages in every*

*possible way, in-house health counselling, and Virkon definitely.*

*I: That these would be the sorts of things that could be done?*

*A: Absolutely. Personally, I would always at the end of the day turn to the opinion that those who use there should be able to use safely. These questions are always so multidimensional.*

Personnel were of the opinion that drug use in prison has greater risks than that in freedom, and using is more difficult in every way. Firstly, equipment is not officially available but has been smuggled into the prison. Secondly, prisoners who use drugs are often forced to share their meagre equipment with other prisoners. Thirdly, injecting must happen really quickly, because unsupervised time is relatively limited. Fourthly, it has been heard from customers who have been in prison that disinfecting of syringes and needles corrodes the equipment and that cleaning is too slow a procedure. Disinfecting equipment by boiling takes approximately 15 minutes and with Virkon solution at least 10 minutes. If several people wanted a dose of drugs and there was only one set of equipment, cleaning it after every injection was very often not done.

*There is that Virkon there, and you get it in the basic hygiene package, but some people say that it is difficult to go and ask for more of it. It is the same whether you tell about [your use], because everyone gets the basic hygiene package. After that, the asking is personal. It isn't easy. Often, I ask the question of the prison guards: "What difference does it make if there is Virkon to clean the equipment with or if there is clean equipment?" The role of the prison guard is, of course, terribly difficult. It is difficult to think about if there were syringes and needles. The prison guards sometimes hoped for just one place, some tube, to return the equipment to when it is broken, so that it wouldn't be stuck in the guard's own fingers.*

*I: But apparently they do exist there?*

*A: Yes. Unfortunately, there are so few of them that we keep using the same ones.*

*I: So this isn't working in prisons in the desired way?*

*A: No. Unfortunately. It is already good that this Virkon is now there, and it should at least be available in public washing areas.*

The respondents said that, for the most part, the customers know about the risks related to injecting drug use in prison and, naturally, would like to use clean equipment also in prison. Many of the respondents mentioned that they try to discuss alternative use methods with the customers before a known term of imprisonment. Many said that it is not at all uncommon for a customer to stop using or at least reduce use during imprisonment. Mostly, the reasons cited for temporary cessation of use were stated as the high cost of drugs in prison, possible indebtedness, and fear of violence. Imprisonment was not, however, thought to work as permanent detoxification or cure, because many customers were stated to have returned to injecting drug use after the imprisonment.

*One woman did not use for the entire time she was in prison. She was released on leave, but the health counselling centre was closed. She would have liked to come in for a chat and to get some support. She had not used for a couple of weeks but started to use again. This person had nowhere to live, so she was bunking with mates who were using. How can you be in that situation without using? There have been a lot of these kinds of cases. It has been vexing when the people who have been in prison return to civilian life and have no place to go. Except to other users. Many do, however, stop using during their time in prison.*

On the other hand, it was stressed that, thanks to effective testing, a good HIV situation, and increases in the amount of information year by

year, the customers were healthier when entering prison, which can reduce risks of infection somewhat. Although it was mentioned in the interviews that many stop or reduce injecting drug use during time in prison, there were also many mentions of those who do not change their habits of use and try to continue using drugs in the same way as in freedom. Those who do not stop during imprisonment were the most reckless in their use habits. They were long-term users and more risk-prone, and many of them had hepatitis C or HIV and often a compulsive need to acquire – and use – drugs. Personnel presented a picture of HIV-positive injecting drug users who had continuous prison sentences, many of whom were known to use drugs also during imprisonment. Stopping and the extent of risk of infection were considered also in connection with awareness that a large proportion of prisoners are drug users and in prison precisely because of drugs. Despite the decreased frequency of injecting and the opportunities for disinfecting, the risks of even a single injection taken in prison were seen as enormous. It was stressed, on the other hand, that there is no clear information available on the real risk of infection in prisons, because there is no definite information available on how many become infected during imprisonment.

When interviewees were asked for an estimate of how many customers had had prison sentences, the responses varied between “at least a third” and “certainly 80 per cent”. The majority of the estimates were somewhere in the middle, and, on average, about half of the customers had probably been in prison at least once. The situation was different regarding HIV-positive active drug users, because a definite majority of them had been in prison. One of those interviewed described how common prison sentences and drug use in prison are among HIV-positive addicts:

*Ha-ha, everyone, several times. All of them, several times. They are always on the lookout. More than one. I mean, it is more of an exception if someone hasn't been [in prison]. I*

*know someone who has not been in prison yet, a woman. But everyone else has, some several times and also long sentences. I mean, these are HIV-positive addicts, every one of them an injecting drug user. They inject every possible substance that you can ever imagine to be injected in a vein, even those that should not be injected.*

*I: Is the injecting 'it', then?*

*A: Yes. That is the thing. Especially for these people, Tenox and everything goes in the vein.*

*I: Do you think there should be exchange in prisons?*

*A: Yes, I do. It is done here also, and when they know for certain that these people are using.*

Most often, customers had been in prison because of unpaid fines, and prison sentences were said to be a part of everyday life among the customers. Drug use, crime, fines, prison, and risk of infection in prison were seen as forming a very common circle in the lives of many customers. The proportion of customers who had been in prison had no connection to the number of customers or the size of the town or health counselling centre. More than half of the respondents were of the opinion that the current measures aimed at preventing infections were inadequate and that exchange of equipment should be arranged in prisons. Organising this activity was, on the other hand, seen as problematic from the prison guards' point of view, and their difficult position was lamented. Clean syringes and needles were considered to bring safety not only to prisoners but also to prison guards. Availability of equipment was thought to work also as a calming element in everyday life in prisons, because people would be able to 'self-medicate' in peace and safety.

The knowledge and skills of health counselling centre personnel had been utilised through organising peer education courses for drug users in prison. Successful events had

also been held for prison guards, in which health counselling centre personnel came in to talk about injecting drug use, the related risks of infection, and how to avoid them. The role of prisons in the prevention of infectious diseases was considered important, particularly because of the implementation of vaccination programmes and testing. Every person coming into a prison was offered vaccinations as well as HIV and hepatitis C tests, and you could also have them at any time on request. Many mentioned that the health counselling centre and prison co-operated in the implementation of vaccinations for injecting drug users. There had been phone calls from prisons to health counselling centres, asking about vaccinations given to a customer so that any missing doses could be continued in prison, and the vaccination programme had also been checked by calling the prison about courses of vaccination started there. It was considered another good thing about prisons that many customers had been tested for hepatitis and HIV during their imprisonment.

The co-operation between prisons and health counselling centres, which has been increasing over the years, seemed natural, because to a large extent their customers were the same, many of them drifting between the two services. A prisoner who had been using drugs was given information about the nearest health counselling centre at the time of release, and it was mentioned in the interviews that prisoners who had just been released often came directly to the health counselling centre, and the motive was not nearly always getting clean equipment. Many just-released prisoners were noted to be in very good condition, and they had received comprehensive health services during their time of imprisonment. Attempts were made to ask them about drug use during their imprisonment and to remind them about the lower tolerance caused by drug-free time and the resultant increased risk of overdose. Released prisoners often have more need of the social expertise of the health counselling centre, and the centres tried to provide them with information, for example, about

accommodation services. Many prisoners have a longstanding relationship with a health counselling centre, so it was said to be a natural point of reference for them and the first contact to society after release.

#### **4.2.3.9. Those remaining outside health counselling services**

All of those interviewed thought that their own health counselling service did not reach all of the injecting drug users in the area. Personnel were asked to consider who, on the basis of their experience, was left outside and why. Everyone was able to cite several user groups not reached by the service. The biggest reasons for exclusion were lack of trust, fear, geographical distance, and ignorance of the service's existence. Information about those remaining outside had been built up from several sources of information, such as the police, other authorities, and customers. All of the centres were visited by people or groups who came in to exchange equipment even from very long distances. For example, there were customers from Rovaniemi visiting a centre in Helsinki.

*I: Does it feel that the health counselling activities have been organised in a comprehensive way in Finland?*

*A: No, it hasn't been organised in a comprehensive way. I don't think that it is in every town, at least available from health centres. At least not in the north – are there any in the north?*

*I: They are organising one in Kemi.*

*A: Well, Kemi is where you would imagine it to be, but then there should also be Rovaniemi, Kemijärvi, Sodankylä, and it wouldn't do any harm to have it available in smaller towns, no harm. I don't think everyone gets it here in the south. I don't think so. I don't think exchanging is done in every health centre, in every town.*

One of the interviewees stated that the centre's number of customers was exceptionally high

because approximately 10 of the nearby municipalities did not have any health centre services at all and all of the users in the nearby areas were dependent on the one centre. Nearly every centre had made outsourcing service agreements with nearby municipalities, although, depending on the area, some municipalities refused both to make an outsourcing service agreement and to organise a centre of their own, despite these municipalities having injecting drug users.

*There are a lot of users in the Swedish-speaking areas but no services. Under no circumstances do they want this kind of thing in their duck pond. This has been admitted out loud.*

There was also contemplation about whether there were sufficient health counselling services in Eastern Finland, because people with Russian origin travelled regularly to use the services in Southern Finland. From customers coming a long distance, information was received about users who were not within the reach of any health counselling service, and information about those remaining outside the services was also received from the local customers. The role of the police as a provider of information was seen as very important with regard to knowing about the coverage of the services. The police told health counselling centres of areas from which they had encountered users and where they were moving. Attempts were made to send the health counselling message to these places, for example, through exploratory field work, via a mobile unit, through peers, and through customers.

In many interviews, the thought was expressed that the users who remained outside the services were in the lowest or the highest socio-economic class or from ethnic minority groups, which strengthened the impression that most customers of health counselling centres are the 'middle class' of drug users. The users who are physically in the poorest health or excluded, for whom moving around was known to cause problems, did not often

use the services of health counselling centres but received clean equipment through a friend or a relative. There were also several mentions of long-term addicts, at least 40–50-year-old ‘old Mohicans’, who were often stated to have made the decision that they did not need the services of the society. Old users were known to have an attitude of great suspicion toward the health counselling service. Although the services are generally praised, visiting health counselling services can still be experienced to be humiliating, as can the entire care system, as some of the drug users interviewed by Perälä stated (2002, 84).

*Crossing the threshold can be difficult. If you started to use by snorting and have used for some time already, those injecting are looked down on. When you one day find yourself injecting, it is a demotion of the ego. If you, on top of that, went to exchange syringes and needles, that would make you into an addict. Nobody wants to consider him- or herself an addict. It is shameful, an identity crisis.*

Several mentioned that injecting drug users who were working or studying or who had families did not end up using the health counselling services, mainly because they are afraid of being recognised.

*Certainly, if, for example, you are in a profession that leaves you afraid of being recognised. I wonder where all the immigrants are. Now the Roma have started appearing. The Roma have also now found the health counselling centre. Some of them, though, are so lost. They just think there are cameras, recordings, and so on. There will always be some who are never going to use this.*

*I: Can you guess at why that is?*

*A: The trust is not necessarily there. They don't dare to come, care to come, or they are not terribly interested in their health.*

The status of an injecting drug user or an addict was stated to impose a high threshold for many, and many did not want to be

branded as an addict in the eyes of others – and, in the beginning, least of all in their own eyes. It was observed that coming to a health counselling centre was a ‘demotion’ for many and the final sign of them being addicts.

*Of course, many do not want to face that they are addicts. It demands a great deal from a person that he or she place a hand on the door of the social services or some health counselling centre. It is a threshold. Although we are talking about a low threshold, it is not low at all. It is enormous. For young, intoxicated people, it probably is no big deal, but for some it is – perhaps also to the young ones. Their attitudes are different – particularly for older people. It takes a lot for them to open that door.*

Those remaining outside health counselling services were known to include minors, immigrants, Roma, and youth from ‘normal’ families. In some areas, there were also mentions of Swedish-speaking Finns, Ghanaians, handicapped and disabled injecting drug users, and young social users. The Roma culture was stated to be strictly against drug use, with use very much hidden, and Roma were seen among customers only in the capital region, overall. The centres outside the capital region were visited by only a few Roma customers, although by their own accounts and through the police it was known that there were more users in this population group. From the accessibility standpoint, it was seen as a good thing that, often, after a few Roma started using the services of a health counselling service, new customers gradually started to appear through them. With the increase in Roma customers, their peer education training was being planned, through which the health counselling message could be brought to those who did not yet have the courage to come to the health counselling centre.

*It is terribly difficult for the Roma to come. The culture in itself is a culture where use is not accepted. If there is use, then in a way the user is excluded from his or her own culture*

*and tribe. Then, in a way, if they reveal that they are users or if it comes out, then they no longer belong in their own tribe and culture. It is difficult. There are a few of them among the customers, but they say: "I am getting these for a mate. I don't use myself." We do know that they are users, but we do not question it.*

The number of Roma customers in the capital region has clearly increased in the last few years. There was a particular need for counselling for young Roma people, but it had to be done in a rather secret way and so that the rest of the community would not find out – for example, in some centres after opening hours. The youngsters wanted clean equipment, condoms, and advice on contraception matters, although officially the Roma culture and its rules do not approve of the use of intoxicants – or condoms. It was clear that there was injecting drug use among Roma across Finland, but their attachment to health counselling services was thought to demand particular efforts and understanding of the culture. Immigrants or those with refugee background were not evident among the customers of any of the health counselling centres, although in several centres it had been heard from the local police that there was injecting drug use among them. In many areas, the injecting drug users of Russian background were seen to be left outside the services, although in some towns they were even said to be particularly “forthcoming in using the services”, at least when compared to other minorities. There are very few intoxicant-related services directed at minorities. Many of the respondents contemplated whether, for example, Roma, immigrants, or Russians need bespoke health counselling services. As a rule, it was not seen as necessary to arrange even smaller-scale special services. It was felt that it would be more meaningful to try to bring these groups within the scope of the current health counselling model. Although there were similarities in responses concerning certain groups remaining outside the services, the customer relationships of, for example, Roma,

Russian, and pregnant people, and people with families, could vary by area.

There were known to be neighbourhoods or areas in every town where there were injecting drug users who hardly moved from these areas. Respondents expressed fear that the regional user groups and their unreachability would be a problem if there was, for example, HIV among them and they could not be reached for inclusion in the scope of health counselling services. Just before the interview, it had been heard from a doctor of infectious diseases in one city that many hepatitis C infections had been found in a neighbourhood about 10 kilometres from the health counselling centre. This was known to be too far for many users to travel to seek health counselling services. In some locations, it was mentioned that the health counselling centre’s location next to the health centre may pose a very great hurdle for many. Also outside the services’ reach were those whose home towns did not offer an opportunity to get clean equipment anonymously, and who could not or did not want to travel to another town. Visiting pharmacies was said to be very stigmatising, particularly in smaller places, and pharmacies were apparently cross-used; i.e., the nearest pharmacy was not the one visited. Everyone thought there are users who remain outside health counselling services but that reaching them would be possible, at least to some extent. Many stated, however, that there are also some users for whom outreach and identification is not worth insistence on resources, because health counselling services are not for everyone.

*Then, on the other hand, there are also the copers. How great is our need to reach those people who go and get tested somewhere, get the syringes and needles somewhere, go to work somewhere, manage their lives? What is the interest? Do they have any need of us, for our type of service? The international estimate is that if 60 per cent are reached through health counselling services, that is already really good.*

It was estimated that there were 14,000–19,000 problem users in 2005. According to statistics, the health counselling centres reached about 11,800 customers and had a total of 80,000 visits in 2005. A rough estimate of the proportion of problem users reached by health counselling services in 2005 is 63–85 per cent. There is some inevitable overlapping in the customer relationships, particularly in areas where plenty of services are available and the health counselling network is dense. On the other hand, health counselling centres are centralised in certain areas, so there are large regional differences in coverage. The fear of being recognised and labelled, which is shared by many customers, is immediately reduced if the customer has the opportunity to visit centres other than those in his or her own area. The reason for travelling a greater distance or from a nearby town was often precisely anonymity, because there might be an employee in the centre in the person's home town who knows the customer from somewhere else, or the environment is so small and familiar that knowledge of one's drug use could spread.

*In a small town, not everyone will come, even though it is possible to visit anonymously. Nobody walks in through the door anonymous; there is always a chance of coming across someone you know. Particularly if you have children, that cannot happen. There are no mothers or fathers as customers, although they do exist. Working students do not visit.*

Often, customers wanted to visit a health counselling centre farther away, even if clean equipment was available at a more nearby centre. Despite the low threshold for coming to a health counselling centre, that threshold can be surprisingly high for some users, and, in particular, visits in smaller towns did not always remain anonymous or unnoticed. The threshold for health counselling was increased by turnover in personnel, which meant that creating trust and regularity was slower, although not impossible. On the other hand, in some centres where staff had over the years

changed even significantly, the customers were said to be used to the fact that there may be a different person behind the desk nearly every time. Building trust could, in fact, be connected with the service itself and the place, not always tied to certain people. From the beginning, in Finland, the idea of health counselling has been that customers can use any health counselling services, irrespective of their home town. Therefore, visits do not have to take place near the home or even in the home town. In the capital region, the variety of services available makes it possible in practice to choose the health counselling service or pharmacy one wants to visit. One of the interviewees stated that a customer should be able to select his or her services, because not all customers get on equally well with all of the employees and not everyone creates a relationship with one trusted employee that he or she wants to deal with.

#### **4.2.3.10. Groups demanding special attention**

Customers demanding special attention were not always those who were left outside the services of health counselling centres. They also included those whose life situation and risk-taking level were such that it was felt that there were insufficient resources to address them in addition to the everyday health counselling work. Individuals and groups requiring special attention were considered to need deeper focus, from both the health counselling centres and health care services. Mostly, the contemplation about special focus concerned women, the young, and the homeless.

#### **4.2.3.11. Women**

The proportion of women among customers at health counselling centres was 28 per cent in 2005. In 2006, 31 per cent of the customers treated for intoxicant abuse were women (30% in 2005). Many of those interviewed brought up women as a group needing special attention and services, particularly in relation to prostitution and rape. The opportunities for women to avoid health risks and their position in social circles were often seen as worse than men's. It was also observed that many women

who had been using drugs for a long time and spending their time within the drug culture had as the years went by “lost their femininity” and had to be “as hard as men”.

#### **4.2.3.11.1. Prostitution**

It was known that some women were forced to sell themselves to finance their use of drugs. Prostitution was not always voluntary, but there could be a procurer behind it, who also acted as the woman’s ‘minder’ and supplier of drugs. Women could be dependent on the men financially, socially, and mentally. It did not seem possible for these women to release themselves from the circle of selling themselves, acquiring drugs, and using drugs. For many, fear or violence prevented seeking the services provided by Pro-tukipiste or other service providers. It was thought that the women needed focused services, for example, related to pregnancy prevention matters and having children, as well as health counselling services open to only women. In these services, it would be possible to concentrate, for example, on why it was felt that women’s possibilities to control risks were generally seen as weaker than men’s.

When asked about customers’ prostitution, those interviewed found it hard to define what prostitution means in practice. Comments on the subject included “if drug use is a taboo, prostitution is even more so”. Many women were known to exchange sex for drugs or money, although they did not necessarily feel themselves that they were engaging in prostitution. It was known that sex was often unprotected, and the reason for this could be choice but often also force. Women were also generally seen to have more limited possibilities to decline sex or to use condoms. All of those interviewed knew that there were those among the customers who engaged in systematic prostitution, paid sex being their main source of income, but the numbers were relatively small. In these cases, it was a profession and, accordingly, sex was most often protected. The majority were known to be within the scope of the services of Pro-tukipiste. Replies concerning the number

engaging in prostitution ranged from “a few” to “there are not hundreds of them”. Those selling sex or exchanging sex for favours were found among ‘ordinary-looking’ young people, people of Russian origin, striptease dancers, HIV-positive people, and many others, also men. There was no special way of recognising them, nor is one necessarily needed, but, if the situation was known, the women were encouraged to be in contact with Pro-tukipiste and were given plenty of condoms. Those exchanging sex for services were seen to be mostly young women, although the phenomenon was evident in all age groups. Young women’s prostitution was considered to be connected to many different risks and also clear abuse.

In the health counselling centre of Tampere, Nervi, a sexual health survey was conducted in 2006, and replies were received from about 100 customers. Although there were no direct questions about sexual violence, some gave accounts of rape and sexual violence, which they encountered both in their steady relationships and outside them. To a question about selling sex in exchange for money or drugs, 19 of the 96 respondents answered “yes”, and 12 of these were men (Ovaska et al. 2004). Exchanging sex for money or drugs is not unusual among the customers of any health counselling centre, and the phenomenon is not limited to women. Many said that they had been thinking about the infections spread through unprotected heterosexual contact and risky sexual behaviour and that they believed that, for example, in the spread of HIV, heterosexual contact could gradually become the main route of infection also for injecting drug users. Financing drug use with sex is an effective route for the spread of HIV and other sexually transmitted diseases, and, through prostitution, infections can spread from drug users to the general population. On the other hand, many reminded that infections can also spread from the general population to drug users, because drug users do not live separately from the rest of the society, and many people in the general population are unaware of their infection. As

many of the respondents observed, prostitution is a difficult and blurred concept, and the relevant customers themselves do not necessarily see their activities as prostitution.

#### **4.2.3.11.2. Pregnancies**

Facing pregnant drug users was often experienced as difficult, and it was considered to be one of the most challenging subjects of health counselling work. Because of anonymity, the situation could not be intervened in without the customer's consent or her own wish. A particular problem was seen in frightening away a pregnant mother if the situation were to be addressed, for example, by contacting child welfare authorities or by suggesting treatment alternatives. Particular carefulness and focus on the situation were required with pregnant customers. Generally, staff attempted to discuss the pregnancy with the customer by telling her about different treatment alternatives and by encouraging her to look into, for example, a HAL polyclinic<sup>1</sup> or outpatient care elsewhere. Often in these cases, the personnel offered to accompany the customer at least to the first visit. Many interviewees knew of the operations of the Päiväperho family support centre in Tampere and hoped to have similar services elsewhere in Finland. Päiväperho offers a low-threshold service to pregnant women with intoxicant abuse problems and to families with a small child, and it operates as a middleman between child welfare, intoxicant abuse care, and maternity and family planning clinics. If a customer did not agree to seek care, her visits, drug use, and situation were monitored and she was given as much support as possible. Many customers were reported to stop visiting the health counselling centre when becoming pregnant, which made it even more difficult to intervene in the situation. Many also hid their pregnancies, for example, in fear of compulsory treatment or authorities' intervention, which could lead to both the mother and the child being left beyond the

reach of treatment. Sometimes, accounts of pregnancies and continuous drug use of a pregnant mother were heard through other customers when clean equipment was being collected for the pregnant woman:

*It is terrible when you know that the person who comes in to collect- when you know whom the things are being taken to and you know there is a baby or a child. And you have no idea what it is like there. Then there are those who don't dare who are pregnant. They don't dare to come here, and then they do not tell at the maternity clinic that they are using before it comes out at some stage. Then they are already in the final stages of the pregnancy when it comes out that they are using. They don't dare to come here when they are expecting the baby, in case I or someone else calls [a social worker] and then they are taken somewhere or they are made to have an abortion or compulsory sterilisation. There was just that kind of a woman here, really nice, had been using substances for a long time. Then all of a sudden she stopped coming here. Then one guy let slip that she is expecting a baby. She stopped coming here as soon as she became pregnant. Kept using throughout, nearly to the end.*

On the other hand, it was mentioned that many bring up their pregnancy for the first time at the health counselling centre, and, in interviewees' experiences, the majority of pregnant drug users ultimately agree to seek appropriate treatment. For many women, the health counselling centre could in the initial stages of the pregnancy be the only place where both the pregnancy and the drug use were known. In some health counselling centres, pregnancy tests are done at the centre, and in some places where doctor's services are available, also gynaecological examinations are carried out. In this way, attempts were made to make the threshold for telling about the pregnancy and subjects related to sexual health as low as possible. Also, some centres have made agreements for low-threshold referral of women to gynaecological services, which has proved a very good practice from

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18 Drug, alcohol, and prescription medication polyclinic.

the women's point of view. Pregnant women – but also those who had just given birth or parents of young children – often did not dare to tell or seek help for their intoxicant abuse problem, for fear of the children being taken away. Many users were known to have children at home, and sometimes customers had prams with them during visits to health counselling centres. From time to time, reports to child welfare services had to be made, but, without knowledge of the person's name, the process was often left somewhat in limbo, and the mother could disappear, with her children, from services' reach. A few of those interviewed were of the opinion that a stricter approach should be adopted to the treatment of intoxicant abusers during pregnancy and that there should be more opportunities to intervene. It was mentioned that, in the case of some customers, compulsory treatment during pregnancy would seem radical but be the only way to protect the child. Particularly when considering the position of the child and the child's future, many of those interviewed adopted a clearly sombre tone and spoke of their frustration with the limits of their possibilities to influence the situation. It was seen as problematic that injecting drug users who became pregnant did not necessarily mention their use during their visits to the maternity clinic, and many customers were known to use injecting drugs throughout their pregnancies. Therefore, possible exposure to infections, as regards both shared equipment and sex, was considered a phenomenon requiring particular attention.

It was seen as problematic that many, particularly young, injecting drug users, wanted to get pregnant. Getting pregnant was also observed to be a relatively easy way to get into substitution therapy. In addition to the pregnant mother, the mother's partner or partners at the time could use the pregnancy as a route to substitution therapy. The importance of issues related to family planning and pregnancy prevention were both emphasised as an important part of the health counselling work. As stated above, many women continued their risky behaviour while pregnant

and were continuously exposed to different health risks and infectious diseases, in relation to both injection and unprotected sex. In the areas where there were no special services available for mothers or families with substance abuse problems, more co-operation with the local maternity clinic was hoped for. It was known from experience that the mothers hardly ever dared to speak about their use at the maternity clinic and that, on the other side of things, there were hardly ever any questions asked at the maternity clinics about use.

#### **4.2.3.12. Minors and young people**

Minors are surprisingly rare as visitors to health counselling centres. The number of users who are minors was not thought to be high, though it was thought to be higher than the statistics would lead one to believe. Many minors did not dare to visit health counselling centres, and none of the centres officially provides services for minors, but all personnel had experience of customers known or thought to be minors. Dealing with these drug users was considered to be another of the most difficult issues in health counselling work. All employees were aware that there was injecting drug use among minors and that many start to use when young. Nearly half of the users participating in the Riski study had started injecting under the age of 18, and every fifth person under the age of 16 (Partanen et al. 2006). Responses given under a pseudonym and with the wrong year of birth had the effect that nobody could be turned away from the services, even if there was an idea that a customer was a minor.

*There are those, probably more than what our statistics say. The very minimum statistics-wise. I think that there are more of them, because people give a year of birth that makes them 18. Then when they are really 18, they say: "Now you can change the year of birth." On the other hand, it is really difficult to estimate the exact age, for example, with young girls. If they want to exchange the equipment, we take it from there; that is the most important thing.*

*We have tried to draw the line at not exchanging the equipment of minors. But then there is the other side, which is what I am then thinking: then they are going to use used equipment. If nobody gives new equipment to them, then they use the used things. On the other hand, if we start giving things to them, then there is child welfare to consider. We run into the Finnish law there. They are young and don't get intoxicants, just as they don't get booze. That is one of the trickiest things.*

Attaching these young users to health services was very difficult, and they did not necessarily receive the kind of health guidance that they may have needed. If a customer was proved to be a minor – for example, by giving his or her real year of birth by mistake – further measures were discussed with the customer. One of the interviewees emphasised that, if the authorities had to be contacted, the minor must be told this honestly. The employee should not, for example, call the social services duty number without informing the customer. When the young person hears this, he or she will probably leave, perhaps never to return.

Scaring a customer away was considered very harmful, because, in the worst case, the young person could drop out of the reach of all services even at the initial stage of drug use. If young people were frightened or indifferent, it was very difficult to talk to them about the risks. It was mentioned that the young and minors were often still in the stage of 'falling in love' with the drug and do not think they could ever become addicts. Some young people were said to see drugs as 'nice' and a good alternative for alcohol. It was observed that young people exhibited much risky behaviour and many did not comprehend the risks that could be connected to drug use.

*Maybe the risks happen at the stage when you are learning and you are in the position of an apprentice. When you learn from friends or mates how these drugs are used. You are there, somehow at the mercy of the other person, taking what you are given.*

Many thought or knew that there were people among the customers who took clean equipment to minors. In the interviews, also the sexual behaviour of the young, which was known to be risky, was raised as an issue, as well as the fact that the young had many sexually transmitted diseases. In some areas, accounts of hepatitis C infection in the young had been heard from doctors who were acquaintances. Worry over minors being left without any counselling on safe sex and clean equipment was great, and the biggest dilemma was whether to exchange clean equipment for them and whether to give them the services of health counselling centres. The majority of the interviewees were of the opinion that supply of clean equipment had to be guaranteed to users, as well as all other health counselling services, irrespective of the age of the user. Some said that, because of anonymity, a customer being a minor cannot be influenced, although one could try to create an objective, caring atmosphere where they receive all information and support that the other users get.

The most common argument for the exchange of equipment for minors was that they, if any, were the ones to whom clean equipment should be offered, because they do not yet have infections. Many are minors when they start using and often take a lot of risks, out of ignorance or through not understanding. Many thought it incredible that precisely the young would have to inject with equipment used by other people and be exposed to health risks. It was known that the young often contracted at least hepatitis C before finding their way to becoming customers of health counselling centres. Hepatitis C infection indicates, nearly without fail, injecting drug use, and it was known in the health counselling centres that minors had some hepatitis C infections. The youngest carrier of hepatitis C encountered was 15 years of age. Vaccinating young people was seen as very important, although vaccination requires the customer's real year of birth and name. A message had been received from child welfare authorities that

they knew of many drug users who are minors and that it is good if they are offered clean equipment. One of the interviewees said that not all minors are within the scope of child welfare services, and hepatitis C is not the first thing that child welfare workers warn them about. All of the interviewees backed the idea of exchanging equipment also for minors, although a couple of those interviewed wondered about its legality. Many said that under no circumstances would they like to exchange equipment for children, but those a little under 18 years of age should be guaranteed the availability of clean equipment. The majority of the minors reached, for example, through field work and who already used injecting drugs were around 16–17 years old, not necessarily younger than that.

*We are particularly trying to reach the underage. The problem is more that we don't reach the young people than that we would have some other problem with them. We want to highlight the customer relationships of the underage and the horror of their use awakens feelings, but we should first reach them, make contact. Let's think about that when we are swarming with underage customers. But when there are none of them in any health counselling centre... That is, by the way, where the attitude to health counselling centres shows, that it is just awful if an underage person comes into a health counselling centre. Even if the person was there moving around in that group, but then when he or she comes into the centre, well, goodness me... "Do you take minors?!" Then the thought comes into one's head that do people have the impression about a health counselling centre that it is some black hole of darkness? If a customer comes him- or herself, then there is at least some contact with that person.*

All of those interviewed mentioned that there was more injecting drug use among minors than the statistics of health counselling centres lead one to believe and that centres with fixed locations did not reach this group well enough. There were attempts to develop new means to

reach this user group, mainly via exploratory work and co-operation with youth services. Although it was thought that the majority of users who were minors were already within the scope of child welfare services, it was also pointed out that child welfare contact was not enough to remove the risks of infection.

#### **4.2.3.13. Homeless**

In 2006, 11 per cent of drug users receiving intoxicant abuse services were homeless (12 per cent in 2005). Of the customers participating in the Riski study, 12 per cent stated in the initial interview that they were homeless (Partanen et al. 2006). The interviews indicated that there were homeless people among the customers of nearly all of the health counselling centres, and this did not seem to be connected to the size of the town or location. It was estimated in some centres that approximately 30 per cent of the customers were homeless, and in others the estimate was just over 10 per cent or a few isolated cases. Many stated that not all of the homeless are, in fact, completely without a place to live. Many had friends or acquaintances that they could stay with, or if an acquaintance was in prison, they could stay at that person's home. Homelessness and social exclusion were thought to be connected with greater risk-taking and ending up in risky situations. In particular, taking care of injection hygiene was seen as a big problem.

*They [the homeless] are often also those who will use anything they get their hands on at the time. In a way, they live dependent on other people, because they cannot really steal anymore, because it is obvious a mile away that that person cannot be allowed in, or a security guard must follow the person all the time. And they can't sell sex either; they don't have the capacity to play in that field. They are in the way a little; they live on charity. Although I am sure they also do pay with some money, they definitely use what happens to be there and it may be that, when you get that bit of something, it doesn't matter so much what you inject it with. It is so muddled. If there were food, a place to live, all the other*

*wellbeing there, and you wouldn't be in such a bad state, then, even if you had some mental health problems, even bad ones, wouldn't you be in a better position to look after the injecting situation?*

According to Ristola (2003), staying in, for example, night shelters or flats that are being used as places to use drugs exposes the user to tuberculosis contagion. Because of the immune deficiency related to HIV infection, tuberculosis can spread rapidly if significant numbers of people with HIV are among the drug users (Ristola 2003). To reduce the risk of contagion among the homeless, several interviewees suggested drug use rooms where it would be possible to use the drugs in a clean and controlled environment. It was stated in the interviews that, despite being excluded and multi-problem, Finnish homeless drug users were in relatively good condition when compared with their international counterparts. They have the opportunity to receive health services and financial assistance. In Finland, drug use is relatively invisible, and it isn't evident in the cityscape as open injecting. It was thought that only a few live in absolute squalor and that those people are mainly concentrated in Helsinki. On the other hand, homelessness was seen as an ambiguous concept, because, for many, places to live changed constantly and the customer's life was said to be "also otherwise so chaotic". Those completely without a place to live were said to visit health counselling centres a little more often than other customers, because they did not have a place to store needles and syringes and were said to move around more. The homeless did not really have any other place to sort out their affairs than in the health counselling centres. Being without a place to live, real homelessness, becomes particularly apparent in the wintertime, when those in the very worst condition said that they were living in stairways. Many of the long-term homeless were said to have been barred from nearly all possible accommodation and other services. In the centres that had as many as hundreds of homeless customers, these people were often observed to commit crimes in hopes of getting

into a prison for the winter. The same is reported by Hypén (2004) in his study of the imprisonment circle, according to which, particularly in winter, homeless people resort to crime in order to get food and lodging, to get into prison (Hypén 2004, 56). It was mentioned that it felt really bad to hear people wonder whether they should commit a crime or acquire an HIV infection so that they would get the services to satisfy their basic needs.

#### **4.2.4. Drugs**

##### **4.2.4.1. Drugs used**

Everyone mentioned amphetamine and buprenorphine as the most commonly used injected drugs, and their use seemed to be divided more or less equally among the clients. Many also mentioned heavy use of cannabis and benzodiazepines. Of the respondents in the Risk study, 95 per cent had at some time used cannabis, and 80 per cent had used benzodiazepines. It was remarked that that benzodiazepines<sup>19</sup> strengthen the effect of opiates and ease withdrawal symptoms, and they were very often used in parallel (Partanen et al. 2006). Use of different medicines was very common among the clients of the LTHSCs. In particular, the use of benzodiazepines was considered heavy, and these substances were used both for withdrawal symptoms and, for example, as a substitute for drugs. Many were also observed to inject medicines. All interviewees felt that all of the clients were more or less polysubstance users, although many clients said that they mainly keep to one substance, often either opiates or stimulants.

*But at least looking at our clients, everything goes – even though they claim: "At least I don't use such and such, just very little of this." Somehow, it seems to me that it's "whatever – just stick it in."*

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<sup>19</sup> Anxiety-reducing, tranquillising medicines that reduce tension in striated muscles and prevent cramps.

Many felt that reckless polysubstance use often leads to greater health risks and makes any treatments much more difficult.

*There are very few who only use buprenorphine. The Finns use benzos. The risk-taking of polysubstance users is greater. How can you know what the client has been using? There is buprenorphine or amphetamine and then a huge armoury of drugs, so it is impossible to decipher what the effect is.*

The primary intoxicants varied according to the area in the sense that everyone had experiences of periodic availability of amphetamine and buprenorphine, and their role as the primary intoxicant varied over time. Often, if one was not available, the other might be used.

*I: Are there many polysubstance users among the clients?*

*A: All of them. If the upper [amphetamine] runs out in a town, then they drink or take the substitute [buprenorphine]. A pure alcoholic or a pure drug addict does not exist; one of those instead could be put up in a showcase. Nowadays, they have learned to go into detox to get some Diapams. They have realised that it gets rid of the hangover. To some extent, it is always polysubstance use, a game.*

In the same week, in one area, low availability of buprenorphine might be mentioned, whereas elsewhere there are reports of sudden improvement in availability. Apparently, the availability of amphetamine and buprenorphine varies with the region of Finland, and also changes in other substances can be very sudden and area-specific.

*Mainly, they mix the substances they use, at least medicines. Some only take amphetamine and medicines, some only Subutex and medicines. There are also those who use amphetamine and Subutex as a cocktail. There is a minority who would not use benzos and who clearly would use Subutex or*

*amphetamine. There are really few heroin users. Heroin changed into Subutex seven years ago. Why would the situation change again? Now, there is cocaine on the market, and someone mentioned crack as well. Cocaine has come up in conversations: It is still expensive. There is no reason heroin would not come if the market just changed. There would be plenty of users.*

Buprenorphine, mainly Subutex, was considered safe by the clients because of its uniform quality, and many did not miss heroin, which they might have used previously. Uniform quality was useful in the sale and purchase situation: the dose size can be increased only to a certain point, and an overdose cannot easily be taken if the substance is used on its own. The interview study of Malin et al. (2006) revealed that many have replaced the use of heroin with buprenorphine and that some have succeeded in reducing or stopping their use of amphetamine via buprenorphine. Buprenorphine was often considered medicine, not a drug, and its use was not necessarily considered drug abuse so much as medication. The users of buprenorphine were not as intoxicated as the users of heroin, and it was considerably easier to communicate with them. For many, buprenorphine served as self-medication, and the ultimate purpose of its use was not reckless intoxication but maintaining functional capacity and awareness. Many, however, were left wondering what would be the role of substitution treatment and buprenorphine given during it for those who had no prior heroin addiction but who had been using buprenorphine itself from the beginning. Of the injecting users of buprenorphine who responded to the study of Alho et al. (2007), over 75 per cent replied that they use it as self-medication for their addiction or to prevent withdrawal symptoms, and only 10 per cent replied that the reason was to attain euphoria and enjoyment. Self-medication for addiction may also keep the users knowingly away from heroin, which keeps the demand for heroin low (ibid., 76). The uniform quality appreciated by many was

connected to purity, reduced risk of overdose, and clear pricing. Buprenorphine is, however, life-threatening if used in conjunction with alcohol and particularly benzodiazepines, and the risk is also increased by injecting use (Kintz 2001). This combination was regrettably common among the clients.

It was remarked that heroin was still the primary intoxicant at the beginning of the 2000s but then disappeared almost completely as the years went by. However, in 2007, clients reported significant improvement in the availability of heroin, and the poor state of the clients also suggested that availability had improved.

It was remarked that GHB and GBL, which have a paralysing effect on the central nervous system, are a fairly recent phenomena among the clients, and there were fears of their use becoming increasingly commonplace. It was remarked in the interviews that it is important to know which drugs the clients are using and how, so that the risks brought by their use can be recognised in time and the clients can be warned about them. In other words, the personnel aim to remain always one step ahead of the clients before a new drug or method of use becomes common. For example, injecting use of GHB and GBL was a fairly new phenomenon, and the content and focus of the related warning message had to be carefully considered. The frequency of polysubstance use was surprising, and all of those interviewed mentioned that their clients were, nearly without exception, polysubstance users. The drugs used most were buprenorphine, amphetamine, alcohol, cannabis, and medicines. There were mentions of individual persons or groups who used only one intoxicant, had a long history of use, and were still able to manage their lives fairly well. Mainly, these were heroin users. The life management of polysubstance users and users of stimulants seemed weaker, even though totally reckless intoxicant abuse was not a defining factor for the entire client base. For many, the primary intoxicant varied with

availability, feeling, or motive, and one of those interviewed recounted the following:

*Those who want to go into substitution treatment speak openly about using Subutex even if they are in fact using amphetamine.*

When injected, anabolic substances – mainly hormones – cause an equal health risk if there is shared or multiple use of equipment. In 1995 interviews of prisoners, 9.6 per cent stated that they had used anabolic steroids, and 3.7 per cent had also been using them during their imprisonment (Korte et al. 1998). Interviewees in the present study were asked whether there were those among their clients who injected anabolic substances. The majority responded in the affirmative but that there were relatively few of them. Most injecting users of anabolic substances were men and used other drugs also, particularly amphetamine. On the other hand, there were also those who only used hormones and who collected syringes and needles from an LTHSC. Injecting users of anabolic substances preferred to inject with muscle syringes, with a longer needle than usual. Some LTHSCs had muscle needles in their selection. Some of the respondents thought that the change in muscle needle stocks indicates that there are, in fact, more injecting users of anabolic substances than they knew about and that, for many, the use of, e.g., amphetamine or buprenorphine was primary. One of the interviewees describes the clients using hormones:

*You can see it clearly from their appearance and they are quite direct in saying that they are injecting hormones.*

*I: Are they using other substances?*

*A: Well, they use everything possible: heroin, Subutex, methadone, everything mixed, a little of everything at some stage. Then I know of one person who is injecting quite regularly and completely recklessly. You can see clearly from his appearance that he has been injecting hormones for a long time. I would not want to get in his way when he goes berserk.*

Another interviewee said, of the clients' motives for using hormones: "One is a fairly active user of substances but also an active user of anabolics. He explains his use with going to the gym to stay in better shape because he has HIV."

The biggest threat with regard to drug use was seen as the worsening of buprenorphine's availability and heroin replacing it. Also, the HIV situation in Estonia was seen as problematic, along with heroin being brought to Finland from there and the mixing of user populations.

*At the moment, our clients are going to Tallinn. I have sometimes interviewed them. If you think that, in Tallinn, 50 per cent of the IDUs are HIV-positive, then they are not in contact with each other very much anyhow... They are using quite a lot of heroin over there and come here to pick up buprenorphine and downers.*

*I: Somehow you would think that they would want the heroin, so the buprenorphine is not a substitute, but it is the primary intoxicant?*

*A: Yeah, it is the primary intoxicant. Many say that they are quite happy that they have managed to change it [heroin] to buprenorphine.*

No HIV infections have been reported as a result of injecting drug use in Estonia, and only a few HIV infections from injecting drugs in Russia have been reported. Although all of those interviewed mentioned that there are many among the clients for whom buprenorphine worked as a method of withdrawal from heroin and as self-controlled substitution treatment, there were also many clients who had no previous heroin addiction. Low availability of buprenorphine was seen as a threat and, with it, the increased abuse of other substances and their replacing buprenorphine.

*You don't see heroin except very little, but there is talk about it. It comes up in*

*conversations. I don't mean that it is good that Subutex is injected, but as an alternative the clients are saying that they are using GHB and GBL for withdrawal symptoms. So, there is GHB, GBL, alcohol, medicines, benzos. It is not at all a good combination. There are these risk factors, and more are coming all the time. If there is no Subutex available, it really does not mean that nothing would be used. There isn't as much [Subutex] available in Estonia as there used to be.*

#### **4.2.4.2. Starting drug use**

There were no actual questions about starting drug use, but many recounted reasons heard from clients, and situations that led them to start using injecting drugs. For many clients, use had started as a way to ease a bad feeling, or out of interest or curiosity about new experiences, but also sometimes it was dictated by circumstances.

*Of course, it is always the person's own choice. Nobody else causes you to use drugs, I mean, at the end of the day. But it is not always your own choice anyhow. I know people from here whose previous generations and generations before that have been users. If, for example, you are already an FAS child, what choice is there for you?*

Many clients said that originally they had no intention to ever move on to injecting drug use, because it was seen as a repulsive method of use. For some of the clients, moving on to injecting drug use took years, whereas with others it started almost immediately, at the beginning of their experimenting with drugs. Injecting often had been learned from the person from whom the drug had been acquired, and not many performed the injection for themselves the first time.

*It is most common with these young beginners that they find themselves at some party at someone's place. There is inevitably a dealer there who wants to get new clients, because his or her own supply depends on it. Then there are those who will help with the injecting. And it may be the one time you try*

*and that is it. They say that now that the heroin has come back again.*

*I: Has it?*

*A: Oh yes, it has. They say that these young people don't know what they are messing about with. It is around, and it is now apparently something completely pure.*

*I: How has the drifting into injecting happened then?*

*A: Maybe it is that other intoxicant culture also: When they get drunk, that is risk behaviour if anything is. In the state of total drunkenness, they don't comprehend what they are doing, with whom they are going, if it is cold outside, if they fall on some sharp edge. Injecting is maybe a similar thing; you just have to go to the edge straight away. They just don't care. Many start their use of drugs with injecting. A needle is quite close to cannabis. In some publications, there had been articles about how the clients should be spoken with, so that they would not teach the young users. If there are younger users there, don't teach them: "Refuse to teach and pay attention not to inject in front of others; it is your own thing and your own problem and your own habit – do not tempt others." Ex-users started in their time by using cannabis and swore never to inject, moved on to stronger substances orally, and were already members of the gang. It was one fine day when a mate guided you and taught how handy and quick it is to inject into a vein. The guy had his arm stretched out immediately. At that stage, caring about the self was already pretty weak. There is curiosity and interest in experiencing things.*

Often, the use of drugs or intoxicants had already continued for several generations and the model for drug abuse had been received in childhood. For many, the use was said to have started with a matter related to school, such as various learning difficulties or bullying. Often, the reason for starting was the feeling of affinity in the group using drugs, the feeling of being special and accepted. On the other hand,

not everyone had a problematic background. There were many among the clients for whom experimenting with drugs had been one experience among many to be bought with money. Some clients had originally had a lot of surplus money to spend. Often, a person continuing with drug use was felt to have been affected by the inability of society to help with his or her original problems, and, finally, the possibilities of the society's service system to help with problems related to drug abuse were questioned. Society's role was seen as twofold, because many were prepared to accept help from society, although they felt a certain bitterness toward it and its manifestations.

*If you somehow get past this middle class impression that the media creates of these clients of ours, probably I represent the same middle class, if you get past the idea that an addict is this and an addict is that. Then this is interesting; the stories of these people are absolutely incredible. They keep inside them a foreign world, which is sometimes also frightening. These people are not- maybe they also sometimes- the stories are such that they give me goosebumps here. A low threshold... we don't really have anywhere to escape from this with those stories. They are sometimes hard, but everyone has to find his or her own means of getting over them.*

*I: Which of the stories are the hardest?*

*A: Well, generally, personally what I always try to find from these stories is where this person comes from, the reason. Always searching for the answer to the question of why: Why do they come here or why do they use these services? Sometimes the stories open up and there is always some kind of a history there in the person's background. No matter the client, there is always some kind of a history there.*

*I: What do you mean by history?*

*A: There is dyslexia, a child welfare background, everything possible. Some kind of*

cause and effect can always be found. I don't dig them up, and they don't interest me such that I would go searching. I'm just thinking through these stories about why that person is here. What is interesting is how they are coping with their own set of circumstances. If the story starts unfolding in some way, then we may have reached the stage where at some point you can say something straight to the person: "Why are you still prattling on about doing this?" There comes a point when you get close somehow and perhaps can ask: "Do you think you should stop injecting?" or "Do you think you should go into treatment?" Or if there are raised voices, you can say: "Shut your gob, why don't you?" Some kind of a contact like this is created. That is the thing for me, working here.

*I: You start to create some trust?*

*A: Exactly.*

*I: Are you happy in your work?*

*A: Sometimes I am; sometimes I am not.*

*I: Does this seem significant and important?*

*A: Yes, absolutely. There are so many levels in this work. There is the angle of public health, then there is the angle of human rights. For these people, this is some kind of – this may sound how it does, but still it is my opinion – a refuge. If time passes and a kind of from-me-to-you contact is formed with any of the employees, then they can be the only places in their lives where... With the daily chaos that many of these people live in. Stories are happening out there that we don't even want to hear.*

*I: Is it so chaotic?*

*A: It is for many. And where are the places where they can share them, to look for some kind of an ease to it, the events that they have to face out there? In that way, it is important. That leads me to think that if there are places like this where this margin can somehow get*

*from the grey area to this normality – or whatever it may be – close to that level, then it must be safe also for society, mustn't it? If a subculture lives its own life completely and nobody knows anything about it, then it creates its own laws completely, meanings and morals and everything possible. I believe it is like this: There are still level-headed people working here. There are also many peers who are somehow on the same level with them. Through that they see that perhaps there is also something sensible going on here. Maybe it is possible to talk about certain things here, which will also bring some safety to the surroundings. It is obvious. It is a really important point. Then I referred to these peer actors; that brings a lot of good to society, the kind that we can never see.*

#### **4.2.4.3. Safe injecting techniques**

In LTHSCs, clients are taught how to find veins and avoid injecting in an artery. Teaching safe injecting techniques was seen as very useful, and it was even thought that, through it, infections and vascular occlusion could be avoided. One of the interviewees mentioned that even long-term drug users who have been injecting for a long time are really interested in improving injecting technique and hygiene. Several mentioned that clients are often very worried about the condition of their veins and welcome information about protecting them. Also part of teaching safe injecting was continuous reminding to use filters and of the correct way of dissolving and crushing tablets.

Everyone mentioned that a large proportion of the clients are worried about their health and tried to avoid damaging themselves or taking intentional risks. The more long-term the client relationships were, the more people paid attention to their health.

*Some are [worried]; some are not. Some fling out comments like: "Legends die at 27; nothing matters." Some are really worried about all the infections, scratches, everything. Some are not interested at all; they hide their*

*infections. Some are genuinely worried, cannot find veins, inject in their necks. We have attempted to talk about other methods of use. The need to inject becomes apparent here; the addiction is hard.*

*They are worried. In a way, it is funny when you think that they inject any kind of stuff in that vein and don't have a clue what it has been mixed in or made from. There they still are, utterly concerned about their veins, their hearts, and this and that.*

For the majority, the greatest worry regarding health was related to the condition of their veins. Veins that were in as good a condition as possible were said to be for many vitally important, although safe injecting was not significant to some clients; even amputated fingers did not necessarily change a person's injecting technique to a safer one. The situation seemed to be the same with vein infections, bad injection technique, and the wrong kind of injecting. Gangrene, amputations, and endocarditis were easily overlooked in consideration of one's injecting behaviour. Serious health hazards resulting from certain kinds of drug use were seen to be useable as a kind of education by scaring, which – ironically enough – was said to often work. Pictures of amputated fingers and limbs and heavy stories about problems caused by hepatitis C awoke in the clients a clear desire to avoid risks and to get information about safer use. On the other hand, scare tactics were said to be very damaging in attempts to prevent drug use. One of the interviewees describes how messages that are unnecessarily extreme may even drive a young person to try drugs:

*The normal education is education by scaring, and when they feel that it isn't true, they consider all advice invalid. "Cannabis doesn't give you a lousy feeling; it is really nice." It doesn't correspond to the impression of the main media. They already know people who inject, but they are by no means those dirty, homeless, psychotic people lying in some ditch. Education by scaring does not work; a*

*kind of lighter approach based on caring about yourself would be better.*

Education by scaring may have had its place when the drug use had been continuing for some time and the person had an indifferent attitude to the hazards caused by it.

#### **4.2.4.4. Injecting and the needle hook**

In the interviews, the personnel were asked for their views on the clients' desire to stop using drugs or injecting drug use. Many gave their opinions as to why, for example, opioid substitute treatment drugs (mainly Subutex) and amphetamine are injected. The main reason for injection was said to be the price. When injected, a considerably smaller dose of the drug is enough, which makes the use less expensive, particularly if the availability of the drug is low. Also, the effect can be felt almost immediately. According to Suominen & Saarijärvi, when used as a medicine and taken as a tablet under the tongue, the proportion of the buprenorphine transferred to the blood is about 30–35 per cent of that of injecting. When used like this, the medicine takes effect sooner, lasts longer, and achieves the same effect as dosage under the tongue but with a smaller dose (Suominen & Saarijärvi 2003, 4149–4150).

Another reason for injecting was thought to be the so-called needle hook, a separate addiction to injections and injecting use. Many were said to have moved very quickly to injecting drug use after experimenting with other intoxicants. Injecting was said to be an integral part of the Finnish drug use culture, and it was mentioned in many interviews that many clients inject “whatever happens to be there” and that “some inject everything”. The ‘needle hook’ was thought to develop fairly quickly after injecting drug use starts. One of the interviewees said that the addiction to injections can be so great that, for meeting with clients in substitution treatment, vein posters used as teaching material had to be covered up. It had been heard from the clients that, although injecting in itself did not feel

bad, injecting with used equipment seemed wrong. Also, in a vaccination situation, the clients could be very nervous and the injection given during the vaccination was not at all enjoyable. Injecting and injections were, therefore, observed to have differences, with self-injection as a ‘completely different thing’. With regard to stopping the use of drugs, it was remarked that, for many clients, stopping injecting was as hard as ceasing to use the drug itself. Again, injecting drug use was said to be a part of Finnish use culture, with various medicines also being injected. Many said injecting was **the** thing for clients.

*The needle hook is a very big hook. It is a big part of the drug use culture: the Finns inject medicines and everything. We are a nation of injectors. Is the response that, in Finland, substances have cost a lot when compared with those in Central Europe? In Holland, for example, there are people who come from Suriname for whom the body is sacred and injecting is not done. They are in good condition, because they use heroin by smoking, and this has affected the local drug use culture. It can be seen in the drug consumption facilities in Holland that there is not a lot of injecting. They do, of course, have their own problems, crack smoking and lung problems.*

Addiction to injections became apparent with those clients who were said to inject even in their necks if veins cannot be found. The clients were said to sometimes be ‘scared to death’ about infections caused by injecting and to worry about their health, although this did not necessarily prevent them from injecting or reduce it. Attempts were made to actively inform the clients about alternative methods of use, such as snorting and absorption through mucous membranes, and how addiction to injections can still be satisfied.

*It is the injecting that is the thing. We do talk about alternative methods of use, but they do in principle know them already. Moving to injecting has happened because the substances*

*are so expensive and there is so little of them available. Better efficiency, in their view, and they do not see the other side, which is what their bodies can withstand.*

A change in attitudes could be seen and beliefs such as that injecting is the safest method of use had diminished. Clients were said to be increasingly aware of the risks associated with injecting drug use. Despite this, many said, injecting drug use is never going to disappear.

#### **4.2.4.5. Stopping drug abuse**

The personnel were asked about the clients’ desire and attempts to stop injecting drug use. Of those participating in the Risk study, more than half considered stopping injecting drug use to be either likely or very likely. The majority of the respondents, however, considered completely stopping their use of injecting drugs to be very unlikely (Partanen et al. 2006). In some centres, the majority of the clients were known to have been in detoxification and to want to stop injecting drug use. One of the most central roles of the LTHSCs is to guide and motivate the clients into drug treatment. In the opinion of many, the difficulty of getting into treatment also made the personnel’s role as recommenders of treatments more difficult. It was known that the majority primarily wanted pharmacological treatment and talked about stopping injecting drug use as a general topic of conversation. The desire to stop was apparent at least in the clients’ conversations, in which they contemplated stopping injecting if they were to get into substitution treatment. It was remarked that talk about stopping was particularly common among those who were waiting to get into treatment. At that stage, the clients had mentioned that their drug use was self-medication of withdrawal symptoms, and it was not seen as voluntary.

*The talk is more on the level of saying that one should get into substitution treatment. The fear of being completely without intoxicants is a really big fear for many.*

*It is really common, meaning that people get tired of their way of life and lifestyle. It [stopping] is in the mind of everyone at some stage and is seen in conversations and as attempts.*

Lapses were seen as acceptable in the healing process, because already a small change in behaviour or a person's genuine desire to help him- or herself created hope for a change. A few respondents stated that lapses and unsuccessful treatments were a part of the process of reducing the amount of drugs, and that, for many, the first treatment is not the last. Recovery was seen as a long road. Pharmacological treatments were for many the only feasible solution for trying to stop injecting drug use. However, many lacked the control to regulate the medication they received in substitution treatment, and a two-week dose could be used in two days. In particular, it was the inability of many to control and especially to reduce their drug use that was seen as a problem. Many tried to stop the use of all drugs at once but always kept returning to the same starting point. One interviewee compared the sudden attempts to stop to weight loss, which easily becomes a similar yo-yo phenomenon. On the other hand, it was also mentioned that some clients ceased using drugs easily, or at least managed to reduce the amount they used, without medication and independently. In one centre, a self-withdrawal guide had been prepared, which contained much information about the kinds of issues that should be considered in reducing drug use or stopping it. In the guide, the importance of social support and good preparation was emphasised especially. The addition of the self-withdrawal guide to the electronic material bank being prepared could be worthwhile, because the difficulty of reducing drug use was emphasised in many of the interviews. For many, the difficulty of stopping was primarily related to social matters, and they did not have the ability to be apart from other users.

*It is such a farfetched idea. Sobriety is for other people. Many are in the queue for*

*substitution treatment; many have detoxification attempts behind them. The queue for substitution treatment is at least a year long. The places are not there. If someone gets pregnant, she goes to the front of the queue. Places become available if someone drops out or dies. I have heard that people get pregnant to get into substitution treatment. The clients are impatient people and should get in straight away. If they have to wait for two weeks, then let's forget that whole idea.*

The length of the queues for substitution treatment was sometimes considered even ridiculous, and this phenomenon was mentioned all over Finland. Many wondered whether the queues for drug treatment are a sign of real insufficiency of resources or whether there is another reason behind it. For many clients, knowledge of the length of the queues alone may have had an effect on whether they wanted to get involved in the process or try to medicate their addiction themselves. For example, according to Alho et al. (2007), there is a 12–18-month queue for opioid substitution treatment in Helsinki. About half of the clients of the LTHSCs in the capital region would want to go into substitution treatment, but only some 13 per cent receive treatment at the moment (ibid., 75). It was remarked that very few people left the queues and that usually those who did leave had died.

#### **4.2.4.6. Getting into substitution treatment and its organisation**

It was hoped that the structures of the drug abuse treatment system will be simplified and that low-threshold substitution treatments will become more commonplace. Many respondents mentioned reduction of the drawbacks created by the complexity of the current treatment chain, and treatment services as a whole, as the primary bottleneck. Problems were considered to exist mainly in the mechanisms of getting into treatment. In practice, it was fairly easy for a client wanting to get into treatment to get a referral for assessment of the need for treatment, but, after

this, the process slowed down. It was stated in the interviews that, in a big town, one single person might be handling the payment commitments issued for the treatments, although it was, at the same time, understood that there was an attempt to centralise treatment decisions in one place so that assessment of the treatment and its quality can remain constant. Several mentioned that the difficult process of getting into substitution treatment was as big a problem in the field of reducing drug-related harm as the meagreness of the LTHSCs' financing.

Often, the difficulty was affected by the interim stages of getting into substitution treatment, which were considered to be slow and unreasonably hard on the clients. The length of the queue for treatment, the scarcity of treatment places, and the difficulty of assessment were also lamented by the clients of LTHSCs interviewed by Malin et al. (2006). Some were of the opinion that clients had to sink even lower in their drug abuse to meet the criteria for substitution treatment while the clients who were in the worst condition or who were the most frustrated were not able to go through even the current substitution treatment assessment. Easing substitution treatment assessment and lowering the threshold for the provision of substitution treatment were presented as requests for further development of operations. In a low-threshold replacement treatment, a desire at a particular time to break free of the injecting drug use and the related lifestyle would be enough to get into treatment.

*Substitution treatment is good. It is just that, in Finland, this thing is so damned controlled and getting in is so difficult; the threshold is really high. If a client comes in through the door, a familiar client, who has 'had it up to here', treatment should be started immediately. Do the assessment and so on, but start the medication immediately. Do the screening and monitor the side use. Reward the clients for stopping the side use; nowadays it is punished. Often, nowadays, that causes*

*the game to start, the lying and dishonesty caused by fear that people will drop out of the treatment if they have happened to use something on the side. On the other hand, sometimes people come into substitution treatment without any real desire to fix themselves up or to stop using.*

Getting into substitution treatment did not stop the use of drugs for all clients. Many continued to collect syringes and needles during their substitution treatment. The general consensus was that there were too few substitution treatment places in relation to the need, and staying in them was considered to be hard under current practice. It was hoped that the threshold for entering substitution treatment would become as low overall as it currently is for only the seriously ill; the HIV-positive; or, for example, pregnant IDUs. Many shared the view that an individual's desire to stop using drugs should be a sufficient criterion for immediate entry into substitution treatment. In all of the centres, a large proportion of clients or even the majority were estimated to want to get into treatment and stop, or at least reduce, their injecting drug use. The lives of some clients can become running around from one treatment to another, and the clear aim can become blurred. The significance of short-term detoxification in stopping or reducing the use of intoxicants or ceasing to inject was seen as almost nil. Non-pharmacological treatment programmes, all of which were easier to get into, were considered to be good; however, they were not thought to be treatments that meet everyone's needs. For many clients, long-term rehabilitation was seen as in a key position on the road toward a more controlled and, possibly, more intoxicant-free life. On the other hand, it was known that substitution treatment patients are not always as upstanding as might be hoped, because many continued active abuse at the same time. Compulsory detoxification attempts before the start of substitution treatment were almost inevitably seen as unnecessary and even as picking on the clients.

*Substitution treatment assessment and the practices of entering substitution treatment are completely irrational. One example springs to mind. There was one guy, over 50 years of age, who had been using opiates since he was nine years old. He had first been in methadone treatment and interrupted that himself. After that, into this polyclinic model that we had here as a trial with [the local] network, implemented with four people. He got into that, in principle straight from the street into treatment. He interrupted that after he received an inheritance. Now he is again seeking substitution treatment, and he has to go through the assessment procedure from the beginning. He has been assessed twice, and now he has to go through the six-month assessment procedure once again.*

*I: Six months?*

*A: It often takes that long with these people because they don't have the strength to go into the assessment place to pee in a pot, to tell the same stories again, once again, which they have already told twice in their lives. Once again, it is determined whether he is to be a client in substitution treatment or not. An average citizen can see a mile off that he should be accepted for substitution treatment straight away. Then there are also these practices where there are people who have been using substances their entire life and never been anywhere within the service network, or have had some contact with it but not had their intoxicant-related problems confirmed there. They have not been in detox or anywhere else. They are being marched – I mean it is absolutely laughable – to detox because the regulation speaks of the psychiatric unit for intoxicant abusers, that this is how it must go. So, a person goes into detox and knows that this visit is a joke. They say it out loud: "Do they think I am a complete prat? I have to go with the kids, the juniors" – in their eyes, children – "into detox and come out of there so that the criteria of a regulation are fulfilled?" All of us can say that the person needs the substitution treatment, just judging by his appearance.*

*I: Is it so that, for many, totally intoxicant-free detoxification is not the right alternative?*

*A: Absolutely, absolutely. I mean, there are those people, I am sure a lot of them. Then on the other hand I am thinking about something – these are again personal opinions – that methadone v. buprenorphine... methadone is poison when compared to buprenorphine. It is obvious, clear as day. Because buprenorphine medication is considerably more difficult to monitor and also more expensive, methadone is recommended for people. My opinion is that buprenorphine could well be the kind of thing through which many people could be connected to the network, with a considerably lower threshold and start to bring it down gradually.*

*I: Should something be done for this situation?*

*A: Well, absolutely something should be done; it is completely clear. People are picking up huge amounts of medication from Estonia and also bring all sorts of other things along with them, benzo-based medicines, alcohol. Then we have this mixed-use dilemma on our hands. As I said before, no such thing exists anymore as pure one-substance users. They inject pharmacological substances and destroy their veins and their health, leading to amputations and so on. Then when you ask individual police officers, for example: "Give your personal opinion of which is better on the street, heroin or buprenorphine," they say straight away that of course Subutex is easier for them, and of course it is easier for us as well if people are using that and not heroin.*

*I: I have understood that this injecting of Subutex is quite an economical method. If it were available, then people would be prepared to stop injecting it? Does it seem a little like a supply/demand sort of thing?*

*A: Yes. It is precisely like that; it is ridiculously expensive. The market will always fill a gap with something. Whether it is bupre or heroin or something, it finds something.*

*Personally, I think anyhow that the use of intoxicants is a constant in some way. From the standpoint of health counselling, the situation that people are injecting all kinds of benzos in themselves and every possible medication is just awful.*

It was hoped that substitution treatment would expand and become an increasing part of basic health care, as well as that the threshold for entry into treatment would become lower and that treatment would become more individualised for client needs. Some said that substitution treatment could be implemented through LTHSCs, or that the opportunity for treatment could be brought closer to the clients in another way.

*If we stick to how many unsuccessful treatment attempts there had to be, I think it is senseless that clients are going in to go through unsuccessful treatments in order to get into substitution treatment. Financially alone, what it costs, really... Then there are still many who have gone into Wismar to have treatment; their functional capacity is quite good and possibly they go to work. They just don't have enough unsuccessful attempts to be able to get into substitution treatment. I think that there could be substitution treatment at the LTHSCs, but it would need to be at a different time from normal opening hours. But at the LTHSCs, why could there not be substitution treatment there? It could work, but at a different time.*

As an alternative to official substitution treatment, many clients collected opioid substitution medicine in Estonia and medicated themselves in this way. The main reason for procuring this medicine was considered to be intent not to get intoxicated but to maintain functional capacity. The clients who sought replacement treatment medication from Estonia were said to be those who could not manage the current substitution treatment process, who waited for years in the queues, or who did not have enough unsuccessful treatment attempts behind them. It was estimated that getting into

pharmacological substitution treatment could in some areas take as long as two years.

In the experience of LTHSC personnel, the majority of IDUs wanted to get into substitution treatment. Increasing the number of places in substitution treatment and lowering the threshold were considered important, particularly with Estonia's entry to the Schengen area. In many centres, it was known that clients were already going to Estonia every week, and it was thought that travel between the countries will increase as moving across the borders becomes easier. As a consequence of the Schengen Convention, the importation of prescription buprenorphine from Estonia will end completely, or at the very least will become much more difficult. Thus, heroin, which is easily available on the street in Estonia, may also find a Finnish user base. Those interviewed thought that, although many Finnish users would rather choose buprenorphine than heroin, if the availability of buprenorphine is bad, many will probably move on to using heroin. The main worry was that users of buprenorphine were forced to move back to heroin, and that also those – most often young buprenorphine users – with no previous heroin addiction will start using that drug. The future travel between Estonia and Finland without passports was seen as a big concern, and many thought that it will change the demand for and supply of the drugs sold on the street and have an inevitable effect on the infectious disease situation among Finnish IDUs. It was thought that, so far, there had been almost no contact between Estonian and Finnish IDUs, because Estonians use a lot of heroin whereas its use is fairly rare in Finland. It was considered possible for the contact between the populations to become closer if the availability of buprenorphine worsens.

*I am still expecting problems with this in Finland as soon as Estonia joins the Schengen Convention. Really, it will really bring more problems. When moving becomes easier, without a doubt it will bring problems. It will bring substances, it will bring people both*

*here and there, it will bring the diseases. When Finns go there, they don't need passports anymore. At the moment, when you have to have a passport, our user doesn't go there. Then when no passports are needed, two hours on a boat there, cheaper stuff. But you don't go there with your paraphernalia in your pocket, and you don't come back with it. There is a hell of a lot of HIV over there, and I don't think it will stay there. It will probably explode.*

In the Finnish government's drug policy action programme for 2004–2007, the expansion of the European Union and the Schengen zone entering into force, particularly in the Baltic countries, are considered to be a challenge to the operating environment of the drug policy. The abolishing of border checks, particularly between Finland and Estonia, as mentioned in the interviews, will create a challenge with regard to the spread of drug-related and infectious diseases, according to the government decision in principle from the Ministry of Social Affairs and Health.

#### **4.2.4.7. Attitudes to health hazards**

Injecting drug use is connected to other risks in addition to the possibility of an HIV or hepatitis infection. These include, for example, infections caused by poor injecting hygiene, vein damage, and risks related to certain injecting areas (such as the groin) (EMCDDA 2001). In the interviews, a question was asked about which health hazards were the worst and the most feared by the clients and what they were primarily trying to prevent with the use of clean equipment.

*HIV is the definite number one. Some still don't dare to come for an HIV test, because they think that it might be positive. Infectious diseases are the number one. HIV, hepatitis C, then the others and the STDs.*

*I: What are the clients' attitudes towards each other's hepatitis and HIV infections?*

*A: Quite often, when a client comes in to be tested, a question gets asked: "Do you know*

*anyone who has it?" They say, yeah, they do, there is such and such. Someone may have someone quite close. Maybe they don't know about other people's infections; there is just that fear about your own infection. It doesn't matter that the other person has it. Hepatitis C is not as significant as maybe HIV is. But when you know, for example, that one group who have been using together and, for example, this particular girl who was tested and who was HIV-positive and somehow the others are saying that "she is the last person you'd imagine to have it. We always thought that her equipment at least could be used, because she is always so careful"... But although it [HIV] was known, there was still risk behaviour in that group. When they did not have [the equipment], they kept using the same stuff although they knew about it. It makes you wonder what goes on in a person's head at that point and whether they really always... a person explains that "they were accidents; I accidentally took the equipment". It is something I have been thinking about: Does the craving for the substance really surpass, for example, knowing that someone has HIV, that you'd even use that person's equipment just to be able to inject?*

Almost everyone mentioned that HIV is the most feared hazard caused by drug abuse, although some mentioned hepatitis C as that feared most, because HIV is relatively rare in Finland. As far as infectious diseases were concerned, HIV was definitely the most feared infection, followed by hepatitis C, other hepatitises, and sexually transmitted diseases. The clients could feel that talking about sexually transmitted diseases and having treatment for them fit the health counselling model badly, and they were not very willing to bring them up.

*HCV is the current number one. HIV is rare in this group; on the heterosexual side, the numbers are huge. HCV is certainly the number one. There have been campaigns about it. Not a lot of people come in to be tested for STDs. It is known that there is unprotected sex, but still clients are asking*

*where they could go regarding this. They do not want to have treatment in the LTHSC. I suppose there is some kind of threshold for coming into that treatment room.*

Although HIV seemed to be the most important reason for using clean equipment, also vein and other infections were very feared health hazards. Poor condition of the veins makes injecting more difficult, and serious infections can lead to hospitalisation, where the seriousness of the situation is very concrete. On the other hand, some did not change their behaviour even after having limb amputations and long hospital stays behind them. The consequences of infections were often seen as remote, and one interviewee stated that it is very unlikely that a client would have time to die of HIV or AIDS. The health of many will collapse before the real hazards of HIV show up, for example, due to complications caused by hepatitis C if the condition of the liver weakens, or the client dies of an overdose, in an accident, or from foul play. Many were said to be indifferent to infections, because it was known that good treatments exist for many of them. In all of the client groups, sexually transmitted diseases were the health hazards played down the most, and they were considered easily curable.

*HIV is the most feared, terrible. Hepatitides are a laughing matter. There are differences in the attitudes to hepatitis C; some take it seriously. It will change in the next few years with the first symptomatic cases. When people see users with hepatitis C infections becoming yellow and itchy and their stomachs bloating, then it will get scary. Many are quite casual about it, listing the illnesses they have. It is sadly commonplace. It is connected to the identity, a serious hard user, because he has all the hepatitides. Sexually transmitted diseases are not significant. Sex is a difficult subject to talk about, because some are having no sex at all; for some it is a tool, a way of pleasing; and some don't remember having had sex when under the influence. Clients' sexual behaviour does not necessarily correspond to the impression that people have*

*of sex otherwise. It is not necessarily satisfying. How could I describe it?*

There were differences in the clients' avoidance of risks. The long-term clients – not necessarily those with the greatest duration of abuse – were said to care the most for their health.

*Many have taken in the idea of avoiding certain things. It depends on the duration of the client relationship. Long-term clients have a clear thought pattern about the reasons for clean equipment and what good it causes and brings them. Those who have not visited so often are still practising the thought pattern in their heads of "Why am I doing this, why clean equipment?" It can be seen that people learn.*

Avoiding health hazards and the fear of them was to a large extent connected to whether the person had existing infections. People with no diagnosed infections were mainly afraid of HIV and hepatitis C, whereas people with HIV or hepatitis C infections were primarily frightened of vein infections and overdoses.

#### ***4.2.4.8. How the numbers of infections will develop***

Many contemplated how, in view of the risk behaviour observed through their work, the occurrence of infections might develop in the future. Almost everybody was of the opinion that HIV infections through heterosexual contact are going to increase in the general population and also among IDUs, but that the number of infections through injecting equipment would remain low. It was stated that, in particular, the incidence of HIV is totally dependent on the extent to which people are tested. Many said that testing should be as effective and commonplace as possible in all of the LTHSCs but also among the general population. Many saw Estonia's high HIV numbers as a threat also to the Finns, although the clients of the centres were said to be well aware of Estonia's risks of

infection and to avoid them to the best of their ability.

*HIV will stay low. There may be an epidemic in the user circles, because someone can spread and infect unknowingly. I don't believe that, among our clients, it will ever develop into a complete disaster. That Estonian traffic is it. That is the thing. But we will just try to focus on the testing so that the client knows what the name of the game is. Of course the fear is always there, but, if we respond to it quickly, then I don't believe we will ever reach Estonia's numbers. The risk is there, though, because shared use exists in any case. No matter what we do, still the clients in some situations forget that they should have their own injection equipment. When they are gathered somewhere in an utterly intoxicated state, the needles and syringes have become mixed up or they have taken no clean ones with them, a person has drifted into some group – maybe in the middle of a trip to the shop – then someone else's equipment is used. Then there are these beliefs that they should use only a certain mate's equipment, because that person doesn't have anything. Then it comes out that the other person has something. There are coincidences but also calculated risks. Calculated because, at the centre, they have received information about the risks and about the fact that they should have their own equipment, and they are also taking this information to the field to those who are not clients. But if the situation is such that a person's own clean equipment is not there and still they have to have the substance, then they probably do take a calculated risk.*

*The fear of HIV is permanent. HIV is under control and the risk of infection is small. The education does not reach as far as safe sex, and sexually transmitted [HIV] infections will increase. Safe sex is a big challenge. It may transfer from the ordinary population to the drug users. HCV will remain high; hepatitis A and B will decrease.*

Hepatitis C was seen as more problematic because of its high prevalence. Some clients

were shocked when they received a positive hepatitis C test result, because, in their opinion, they had been careful to use clean syringes and needles. It was contemplated what could be behind these infection incidences, and whether HCV is spreading in some way that has not been understood or known enough to be spoken of. It was thought that many have not understood that a risk of infection, in addition to syringes and needles, is also connected to other equipment, or that there is a habit maintained in the use culture that involves a risk of infection that has not been recognised. Hepatitis A and B were thought to be dramatically reduced, and signs of this were already showing.

*I would hope so for the injecting drug user, or in principle I hope that for everyone's sake. You have to be an optimist and believe in this work. If the LTHSCs can carry on with their work without the funds being continuously cut, the number of infections will stay low. But sexually transmitted HIV infections will certainly increase.*

*I: What about HCV?*

*A: It is so huge, the number of positive people, but I don't think that it will rise, at least. Of course it will rise now that I've said that. What will really happen now when the first cases of cirrhosis patients result from this hepatitis C? Regarding that, I am thinking about these interferon treatments, of how strictly they are keeping to total sobriety. If you are in substitution treatment at the moment, it is possible to get into interferon treatment, at least in some places.*

*We have not been able to reduce the number of hepatitis C infections with this operation as much as we should. That also is a global trend. Hepatitis C is like the number one priority that we should be able to concentrate on. It is terribly difficult. It would really need to be about taking people by the hand. There should be a lot more resources for it, to show how it can be that you cannot get hepatitis C into your body. It is in many cases too late by*

*then already. Resources – a lot of it is to do with that.*

Although HIV was seen as the biggest threat among the infectious diseases, hepatitis C was seen as particularly problematic because of its frequency and the attitudes toward it. Attempts were made to focus on prevention by telling clients of its worst consequences; speaking of the control of alcohol consumption; and, above all, emphasising that it is a serious disease. Despite the changes in attitudes that could be observed among the clients and the increased awareness, the seriousness of hepatitis C was generally downplayed. Many believed that the seriousness of the infection will be understood only when its concrete symptoms are beginning to show among the clients. It was suggested that follow-up of liver values for clients with hepatitis C could be started in LTHSCs, because a large number of the clients have the infection. At the same time, the seriousness of the situation would become concrete when it is possible to follow the progress of the disease. Thus, another downplayed matter, the high consumption of alcohol among those with a hepatitis C infection, would be seen in a concrete way.

*I hope that the situation will stay as it is, that HIV does not suddenly flare up from somewhere again. But as long as we manage to carry on exchanging these, that's how long this will work. There will always be users. I don't think that they will stop. We have not managed to get rid of the booze or the cigarettes in this country, so I don't think we'll get rid of the drugs either. If this operation carries on, then it is worth its price when you think how many HIV-positive people there could be if this operation did not exist. There would be an appalling number of them.*

The likely increase of sexually transmitted HIV infections both in the general population and among IDUs was seen as a risk related to infectious diseases. Many thought that if HIV spreads again in this population, it will probably do so through sexual contact. Although it was stated that risk behaviour still

exists in connection with both drug abuse and sex, the risks taken were considered to be bigger and more common when it comes to sexual behaviour. There is evidence that situations where an IDU has a risk of being exposed to an HIV infection are also connected to sexual behaviour, not so much to injecting. Sexual contact between men, women engaging in sex for commercial purposes, and being under 40 years of age are the primary risk factors for IDUs with regard to acquiring an HIV infection (Kral et al. 2001).

*Not everyone will come in to be tested. I am thinking that it [HIV] is a thing that will still explode, specifically through heterosexual contact. And, when it explodes, it will probably be some terrible bomb.*

#### **4.2.4.9. Development of health counselling**

In many centres, the typically fixed-term funding was seen as evident in the personnel's work input and general atmosphere. Many said that, particularly towards the end of a year, the operation had to be proved to be efficient and worthy of new funding, which was felt to be frustrating and hard. Also, the fear of tendering procedures for the services made the personnel nervous, in relation to both purchased services and services of centres operating under the city authorities.

*General attitudes have changed a great deal; that is a fact.*

*I: Have they?*

*A: Oh yes. I mean, I am not complaining, but I am complaining about the city's attitude towards it. The resources that have been granted for this operation over the years are ridiculous; they really are quite laughable, versus the work that has been done here.*

*I: So, there is a lack of money?*

*A: It is always acute. Oh, well, I cannot be bothered to complain about it, because nothing can be done about it.*

*Luckily, there is no competition anywhere apart from the capital region. It can arrive elsewhere as well. It is possible that someone will start to offer exchange of syringes and needles on the cheap, and if there are those decision-makers there who see that it can be done from a car, through plexiglass. This is quite possible in the future. That is why it is important that the decision-makers understand what this is really about. If it starts going in the direction of "let's just exchange them or hand out methadone through a hatch", one person can quite easily be there surrounded by alarm buttons; it can easily be taken care of like that. This is a bad thing.*

*It [the operation] is probably growing, but personally I have quite mixed feelings at the moment somehow. When you have been visualising what this operation could be and how this could develop and then it feels as though it is started to be pulled down, the funds are cut so much... It must also be remembered what this health counselling work is. Some see it as very narrow, that it is about preventing infectious diseases and of course it is that, and minimisation of harm, but then when you get to the minimisation of harm, that is a very wide concept and includes the social side and generally the entire person. Where it would grow – or, well, it is at least our area of development – would be this peer activity and guidance to services, but, with these resources, it feels that not a lot of developing will be done there.*

The possible narrowing down of LTHSCs' operations and cutting of their funding was seen as a key challenge for the health counselling services.

*It has been proved that if one HIV infection is prevented, the salary has been earned and the funding has been earned. The Law on Intoxicant Abusers is a pretty good safeguard. In large cities, on the other hand, tendering*

*procedures can cause problems. Who will do it the cheapest? Competition and fighting for survival always lead away from the clients and good service. The problems will come – if they come – from the side of the administration.*

By no means did all of the respondents feel that additional services were needed in the selection of their LTHSC. Many emphasised that the threshold for treatment has to be lowered and that the social welfare services for IDUs could be improved in every way but that, with the current resources, this should primarily happen outside the LTHSCs. Although attempts were made to carry out treatment procedures for clients in the LTHSCs and they were seen as important, one of those interviewed said that the centre should not be turned into a 'small health centre' but that the threshold for seeking services should be lowered throughout the health care and social welfare systems. Providing all-round treatment was ultimately seen as the responsibility of health centres, whereas a health counselling service ought to recognise its limits with regard to how far the resources will stretch and how many services can be housed under one roof. Guidance to services attempted to ensure that the client received the right kind of attention and treatment for his or her problems. One of the interviewees mentioned that, although the conversations in LTHSCs are confidential, this is not a long-term therapy relationship, and this impression should not be given to the clients. Those who co-operated greatly with other LTHSCs wanted to emphasise that, regardless of the many similarities and the room for development in the operations, all of the LTHSCs are different from each other in their history, clients, number of visits, and physical setting. Therefore, LTHSCs should not all be led forcibly in the same direction. Instead, the most appropriate services and methods of operation for that particular centre should be identified. It has been seen through practice that not all services automatically work in all centres.

*They [another location] have already experienced things that are new to us; the stages we are at are so different. There, they are much further along with these additional services, while here they are still deliberating and considering what will follow from this, what then, what it will affect, impressions among the clients, etc. If a work method works elsewhere, it does not necessarily work here. These people are so different. For example, drug consumption facilities as a service is not a thing that is worth even considering; on the other hand, it may be considered somewhere else. In this way, we are just at such different stages; although we are doing the same things, still the development stages are at different levels. We cannot all be on the same trajectory. Of course, it is possible to incorporate parts of it into your operation, developing your work; that goes without saying. Common policies for basic services are good, but special services are a different thing. Develop them within your resources.*

#### **4.2.4.10. Suggestions of new services and development of the content of existing services**

In the interviews, suggestions came up for extending and improving the health counselling model in use, as well as for entirely new kinds of services. Clearly the most typical direction of development was organising peer education training. One key service that respondents hoped would be incorporated in the LTHSCs was comprehensive doctor's services. In the centres where a doctor was available once a week or twice a week, the desire was for doctor's services to be available at least once a week. In the centres with no doctor's services available, it was hoped that *in situ* doctor's services could be made available even once a month. It was stated that many clients had a very high threshold for visiting a health centre to see a doctor or to seek medical services in general. The clients saw a doctor only when they absolutely had to, usually when the problem was already very serious. The biggest need for a doctor was connected to bad vein

infections and gynaecological matters. In addition to doctor's services, many expressed a need for social workers and their knowledge of the service structure. In centres with no personnel in the area of social welfare, the focus and competence mainly centred on health-related matters. It was stated that the best personnel structure involves equal competence in the areas of health care and social welfare. For practical reasons, testing for HIV and hepatitides was not available in some centres, but a clear need for testing was expressed, as the clients were said to be fairly lazy about making use of test referrals. The referral itself increased the threshold for getting tested, but also going into a laboratory and anonymity being endangered were seen as issues that raised the threshold for testing. In some centres, one could guide the clients to be tested at low-threshold drug service units, but it was not necessarily possible to visit these anonymously. Many were charting the possibilities of organising HIV and hepatitis testing in their own LTHSCs.

A need also emerged for a co-ordinator, who would be competent in harm reduction and health counselling, to organise and monitor the success of the operations and training nationally. Opinion was expressed that training is needed around Finland so that it always also responds to the needs and issues specific to each centre. The ideology of harm reduction was said to be a significant and permanent part of work with intoxicant abusers, but practical guidance in its implementation was lacking.

*There are negotiations with the city at the moment about what can be done in these centres outside opening hours. One thing could be the assessment of treatment needs and something else. I don't know if it would be done by our personnel or the city's employees and what co-operation there might be. It is expanding in that direction, though. There is something going on here all the time.*

The majority of the interviewees had been thinking about the possible arrival of drug

consumption facilities and syringe dispensers in the Finnish health counselling field. There were no direct questions about drug consumption facilities, but the matter was often mentioned as part of the contemplation of the future of health counselling services and new forms of services. Legal and controlled drug consumption facilities have been established, for example, in Holland and in Canada. Their aim is to offer the users a safe place to use drugs, clean equipment, and an opportunity for health counselling. The need for drug consumption facilities was justified by the growing numbers of the homeless and those very badly off, and by their limited possibilities of looking after injection hygiene. Injecting drug use was said to be a permanent part of the Finnish drug use culture, which is why attempts should be made to make the use situation safer and more controlled. It was hoped that discussion of drug consumption facilities would be opened up, even if their establishment becomes topical only at some point far in the future. If there were legal, safe consumption facilities, the clients would not need to carry as much used equipment with them, because they would get the equipment they need in the room and could also leave the equipment there.

*Because this is quite a crazy situation in the sense that the client comes here, we exchange the syringes and needles for clean ones, the person goes over there [points outside the window], uses it there... What is the sense in that when the person could go in that room, use it there more safely, and leave the syringes and needles there? Why do we have to operate like this, so that the person goes across the road into a doorway or to a park? This situation is totally stupid. By now, we should already dare in Finland to talk about this drug consumption facility. Drugs are a part of our modern society, and they always will be. Injecting use of medicines and drugs is not going to disappear from this country. I also believe that nowadays the police, for example, probably support the establishment of these drug consumption facilities. In Amsterdam, the police are very active in establishing drug*

*consumption facilities. Over there, clients are also registered for the drug consumption facility.*

*I: Perhaps it would be more controlled?*

*A: That is it precisely; it would be more controlled, and the health counselling and harm reduction can be carried out much more effectively.*

Three of those interviewed supported the establishment of drug consumption facilities but brought up the difficulties in their establishment in practice. Support for drug consumption facilities was clearly focused on big cities and those client bases that had a lot of homelessness and many badly off people. The interviewees emphasised that it would not by any means be necessary to establish drug consumption facilities in all locations, only in the locations where there is a real need for them. Drug consumption facilities would not be open to all drug users. Visits would be limited to registered users. However, there was no clear consensus on the suitability of this operation for the Finnish system.

Drug consumption facilities were justified with statements that drug use would become more controlled and harm reduction more effective and comprehensive. Instead of 'injection rooms', the term 'drug consumption facilities' was hoped to convey the message that injecting is not the only method of using drugs. Drug consumption facilities would also provide an opportunity to offer safer methods of use. A realistic time for establishing drug consumption facilities was thought to be in 10 years' time, although earlier action was hoped for. Drug consumption facilities were discussed also in other centres than those supporting them. Many were convinced that, at some stage, a drug consumption facility will be opened in Finland. A couple of those interviewed considered the idea of drug consumption facilities ridiculous in their areas but said that different areas have different problems, and that if drug consumption

facilities provide an answer to these problems, they should be discussed.

Vending machines containing syringes and needles would improve the geographic availability of clean equipment. Many felt that, for some users, visiting an LTHSC or a pharmacy was sometimes difficult or even impossible. Opening times, distances, anonymity, and a fear of being labelled raised the threshold for visiting an LTHSC or a pharmacy. The best thing about vending machines was considered to be that clean equipment would be available around the clock, and that the return could be done at the same time. It was remarked that many drug users are mobile at night, when the availability of clean equipment is in practice non-existent.

*If I only think about infectious diseases, then my opinion is that they should be available. But how about getting into [chuckle]... ? This discussion was last had when these condom vending machines came, that "the underage can get into them". Oh, dear.*

*I: So, is the close proximity and availability of syringes and needles going to get someone to start injecting drugs?*

*A: No, no, really no. You have to want to do it, or then you end up in that situation by accident somewhere completely different, but definitely not because the vending machine is there.*

*I: Do you think that they would be a good addition?*

*A: Yes, I do. They should be in the places these people move around in, so that they would still be easily available. I would not put them in schools. It could be, for example, in health centres, but placed so that not everyone notices who just went there. It would be the sort of thing where you put your dirty equipment there and get clean equipment in exchange.*

Nearly all of the interviewees supported syringe and needle vending machines. Even those who did not directly support them were not opposed to them. Many were of the opinion that vending machines should be installed specifically near places frequented by drug users, such as city centres and suburbs. Vending machines would be a fairly easy and low-cost way of reaching the user populations in the suburbs. By no means all users who live in the suburbs used the services of an LTHSC, which most often is located in the town or city centre. Users who stayed in the suburbs had been mentioned by the clients and the police and had been heard about through field work. It was stated that vending machines serve drug users irrespective of their age and socio-economic class, or their social status. Many said that vending machines would be a very good addition to the services and that they would have a clear function in improving the comprehensive availability of clean equipment. In the same breath, it was stated that vending machines would not in any way be a service that would replace personal health counselling, but rather a good additional service to existing health counselling services and for maximisation of the coverage of clean equipment. Vending machines could not in any way achieve the change in the thought patterns of risk behaviour that the health counselling operations are trying to achieve through personal contact. They were, however, said to be a good addition to the services, particularly in view of the goal of prevention of infectious diseases.

Despite the health counselling network having good coverage on a regional level and despite the extended opening hours, the coverage of health counselling and, particularly, the coverage of clean equipment was not considered to extend to all suburbs, locations, or users. The supporters of vending machines hoped that LTHSCs' contact details would be on them. Vending machines were desired for both small and large towns – in large towns because of the high numbers of users and uneven coverage, in small towns for

anonymity, distance, and equipment availability reasons.

It was thought that vending machines would also serve users who do not visit LTHSCs in any case, such as recreational users and minors. Through their own will or, for example, because of their location, not all drug users will become attached to health counselling services. To reduce the risk of infection for these users, compromises regarding the principle of personal contact in health counselling are necessary.

In many towns, methods of operation had been discussed that would allow health counselling to be extended beyond town centres. There are several LTHSCs in the capital region, because the number of users is high, the distances are great, transport connections are limited, and many hardly move from their own area. For example, in Espoo, which has no official centre, there are five LTHSCs. The solution of establishing several small, regional centres has clearly been a good one. The capital region is not the only area where decentralisation of the services was considered to be a good solution. In many other areas, the same problem of reachability was agonised over. Many towns had suburbs or nearby towns that health counselling services did not reach. For these locations, for example, permanent centres or the services of mobile units, automatic vending machines, or field work were being planned. In larger cities, numbers of LTHSC clients were said to be so high already that the operations would soon need to be decentralised to even more units. Small regional centres would be able to form contacts and offer services as close as possible to the drug users' living environment. The maintenance of large LTHSCs and operating in them was difficult, both for the personnel and for the clients.

Many brought up the idea of a day-centre-type operation, which could be a part of the current health counselling services or operate separately but would be specifically intended for all IDUs. Many of those interviewed hoped

that the day centre would have regular and long opening hours, meals, and meaningful activities. It was hoped that the services of the day centre would be close to those offered to HIV-positive addicts by the service centre of the Helsinki Deaconess Institute.

*The direction that I think health counselling work could also develop in is that there could be this kind of full-service house that would already do social work... These kinds of service centres for drug users, and the ticket for admission cannot be that you are HIV-positive. But I remember a client... I mean, if there is one place you can refer a homeless person to and the person is barred from there also, you feel pretty helpless at that point. Sometimes you just feel that you run out of means or guidance or advice.*

Requests for day-centre-type operations have been received from both clients and personnel. Staff had differing views on what was meant by a day centre, how it would be implemented, and to whom it would be directed. Opinions ranged from a totally intoxicant-free place to a solution wherein drug users are offered a wide range of services in addition to being in the company of others, and where intoxication would be allowed.

*There have been very good experiences abroad of those full-service lodging houses, where accommodation and all other services are under the same roof, starting with substitution treatment. They would be one solution to this problem of homelessness. We don't actually need a lot of intoxicant-free places anymore. There should be some places where there is still the channel onward if the person wants it.*

A day centre was said to be a natural part of health and social counselling, which nowadays focuses in any case on the holistic support of a person and bringing the person within the scope of the services. A possibility of an encounter, creating a contact, and the multidisciplinary approach were considered to be the strengths of day centres. Such an

operation was seen as a help in attending to the clients' affairs on the social side, the sorting out of which was considered time-consuming, and as making long, health-related discussions easier. Day or service centres were also thought to work as a calming element by keeping the people off the streets and by giving them a meaningful environment with meaningful activities that give the days a rhythm. One of the interviewees stated that "inactivity is the drug user's worst enemy" and that inactivity leads to frustration, crime, and disturbances. The same consequences were said to be caused also by the decentralisation of services and bureaucracy.

*As many activities as possible under the same roof. It makes the client's life easier and is also better for the service system. If we are having the clients run around in circles, they get frustrated.*

It was thought that day-centre-type operations would work best in connection with small centres, where client numbers are not high. There was more support for the operation in smaller towns, and it seemed that in large towns there were plenty of other services to which the clients could easily be guided. In smaller towns, the availability of other services was more limited, and thus a model with as many services as possible under one roof was seen as a good solution. Day centres offering many services were thought to serve those in the most excluded position and the homeless best, but also the young users. One of the problems of day centres was seen as the burden placed on the personnel by their long opening hours and the long attendance times of the clients. In locations where LTHSCs had been modified in the direction of a day centre, it was mentioned that clients could stay at the centre all day, which meant that there was time to have conversations with them. The opportunity to spend a whole day in one place instead of, for example, being 'out shoplifting in the city' was seen as a part of harm reduction. The down side of these matters, which in themselves were seen as positive, was the intoxication of the clients and, when

the client base is large, occasional agitation. Day-centre-type operations have been tried in some centres, but experiences showed that being in the same facilities as health counselling services during the same opening hours was a bad solution.

Arranging day-centre-type operations in fairly small facilities was thought to be possible if the numbers of clients are manageable already at the beginning, the opening hours are long, and there are enough personnel to manage both the day centre and health counselling services. One alternative was seen as being organising day centre operations in the facilities of an LTHSC but with different opening hours. The facilities of many LTHSCs could be empty on six days of the week. Many LTHSCs hoped that the existing facilities and competence could be utilised also in similar services, such as day centres. Many of the interviewees said that, although attempts are made to keep the threshold for LTHSCs as low as possible, a low threshold would be needed in other services as well. Many said that the threshold for other services that the clients need is sometimes very high.

#### ***4.2.4.11. The personnel's experience of their work***

Workers have endeavoured to increase multi-profession competence and co-operation in the provision of health counselling services. However, combining the different working methods of the various areas of social welfare and health care, differences in the focus of the work, and the different starting points of the employees sometimes created difficulties in the day-to-day work. One interviewee described how tension can sometimes flare up between staff members and how demanding client work can have an effect in relations becoming frayed also within the work community.

*There are so many difficult areas that it isn't even worth thinking about them. This constant lack of resources and flaws in the treatment chains that are incredibly hard. Of course, the*

*impression and thoughts of the personnel about what a low threshold is or what it could be differ a great deal, what it means. It is difficult in the sense that a low threshold means that intoxicated people are walking in here and they can be in any state whatsoever. Someone can see a gun sometimes in a person's pocket. We all have our limits, and the limits are different. What are the kinds of things and phenomena that we can afford to take on, or how close to the client can we get? That creates a kind of- When those limits and structures are difficult to create, then the sort of hope for a common ground or a wish or a desire that everyone would act in the same way with the clients... That those limits and structures are sought in little things, which for others are irrelevant. That those limits can be found somewhere that happens there in the encounter between people and it is thought that, in that way, security is created within that community. Some may think that it is created from regulations or precise definitions of how we must act. Those are probably sometimes hard.*

*I: Are there conflicts sometimes?*

*A: Of course. Those phenomena are so powerful and unknown to the average citizen, the phenomena that the clients bring with them. Then, of course, social and health care work on the premises – this kind of multi-profession co-operation is an absolute prerequisite, but still there are differing views about what is important and how to act. On the health care side, it is very hierarchical, on the social side not so much – the people there are used to acting mainly as individuals. There are huge amounts of those kinds of tensions that are seen probably nowhere else. This is studied a lot on the basis of figures, risk behaviour, and infectious diseases, but the phenomena that the clients bring with them, the lawlessness, the violence, the complete misery that these people carry around with them ... of course it has an effect on the work community. It demands constant supervision of work, discussion of the issues.*

*Previously it was more true, but still today you have to explain your work, justify its existence. That, on the other hand, shows that it isn't self-evident, the right of existence. More rarely one must justify it to those in basic health care, but there, too. Even to the employees of social welfare and health care sometimes, officials, etc. Always, whenever anything little happens, a needle is found somewhere, there we are in the media, and then comes the justification to the ordinary people, to political decision-makers. There are sometimes also the intoxicant-abuse-side employees you have to explain yourself to. Labelling. In some LTHSCs – or in whatever job these days – funding can be tight and information about it spills onto the shoulders of the personnel. It cannot be kept on the level of administration, because the discussion may be public. A grassroots worker would have enough to contend with to manage his or her own work, but having to worry about whether there is going to be funding next year... The personnel are actively worried about funding, particularly in the capital region. Being established is a kind of bubble, because there have been many projects in the LTHSCs, but the basic funding from the city has always been insufficient. Although it seems established and the numbers of clients are ridiculously large, we are on the edge all the time.*

In the interviews, the employees were asked about the most satisfying moments in their work and about feelings of success. All of those interviewed enjoyed their work despite its sometimes difficult nature, and, for the majority, the most satisfying moments were related to client work, the trust created, and witnessing the positive changes. Many emphasised the slowness of seeing the positive results of their work and that changes took time.

*I: What is most satisfying about this work?*

*A: That people come again. If they have some kind of problem and they get help. Last time we fixed a pair of shoes. ...Although it is clear*

*that they must not be attached to this place with all their problems, make the personnel their carers. They are happy, they dare to come, they dare to come and get a vaccination although it can be painful. It is also a sign of trust that they dare to show a hand that hurts and believe that the personnel want what's best for them. A natural interaction is the aim. The problem with intoxicants is not always the main thing, but it is the encounter in itself.*

*When you have achieved a confidential relationship, little by little, the client has started to talk about treatments and then a year or a year and a half has passed and the person is at the point of wanting to go into treatment. Now when you see that the person is going through the treatment successfully and healing – and when the process has maybe lasted for four years – that is quite satisfying. You come across old ex-clients elsewhere and they do say hello, no problem. There are success stories, but it is a long and rocky road in this work. This work is not fast by any means. The targets must be set very far ahead and progress toward them is in tiny little steps. Even four years can pass. In the client's life it is a very short time if you consider that the person is nearly 30 years old and started using at 13 or 14. It is that person's whole life. That person has to make a total change of life and that means everything. Jump into a life that is completely alien. Nobody can do that in a moment. You have to get used to the other life in small portions before you dare to jump into it. Changing your steady group of friends is difficult, because it may be that there is nothing else. The social environment and social relationships are just there. What then? You are pretty much left with nothing. Nobody wants to be alone anyhow. Social contact is important. But then, if you go and have a little taste of another kind of life and you get new acquaintances and little by little you get into the flow of it, then you may notice that it isn't so terrible after all. It can take time.*

## **5. DISCUSSION AND CONCLUSIONS**

### **5.1. Effectiveness based on infectious-disease-related indicators**

As measured by infectious disease surveillance indicators and evaluated via indirect indicators, health counselling for IDUs seems to have had an impact in the control of the epidemic's negative effects on public health and in the reduction of IDUs' infection risk, particularly with regard to shared used of equipment. Objective and ample information about infectious diseases and other health hazards as well as access to clean injection equipment seems to have reached the majority of IDUs and achieved visible changes.

Health counselling has also had an impact in the sense that the will to use clean equipment has strengthened among IDUs, and improvement in the availability of clean equipment was not found to increase drug abuse. Health counselling work has been efficient also in that the costs of the health counselling operation and its services will in a preventive manner, even according to a rough calculation, amount to less than the treatment of new HIV infections, hepatitises, endocarditis, and other health hazards.

If the case statistics produced by the infectious diseases surveillance system described in Section 4 and the information on the frequency of occurrence contained in Section 2 are studied in the light of health indicators and the effectiveness targets set for them, health counselling can be observed to have achieved its targets: Of the alternative scenarios described in the government's drug policy action programme for 2004–2007, the scenario of the situation improving has materialised as regards infectious diseases. In 2007, only 10 new HIV cases related to injecting drug use were diagnosed in Finland,

and the majority of these were diagnosed in foreigners. Numbers of cases have remained at this low level already for several years. This number is clearly below the rather ambitiously set target of 30 new cases in the improvement scenario and indicates that the transmission chains have been successfully broken and a larger epidemic has, at least for the moment, been prevented.

The majority of the indicators developed for the surveillance of the effectiveness of the Health 2015 programme connected to intoxicants used by young people and related infectious disease problems have developed positively in the health counselling operation's period of effect. Newly reported HIV and hepatitis A, B, and C infections have decreased or remained at their originally low levels in the 15–24 age groups. The most distinct change in the last few years has been with hepatitis C; the number of cases in young people has gone into a clear decline.

Fortunately, there have been few cases of HIV among young people (15–24 years of age) in Finland, and the case numbers have declined clearly in the last few years.

Of particular significance has been the information that the frequency of HIV infections has at no stage exceeded the 5% threshold among IDUs. It is likely that this has been an important factor in that it reduced the risk of a self-feeding epidemic being created.

The almost annually conducted sampling-based prevalence studies performed at the LTHSC have shown no evidence of a hidden epidemic among IDUs since 1998. The studies also show few negative changes in the risk environment.

The prevalence studies and the early LTHSC activities had a clear role in recognising the outbreak and limiting its spread. Expansion of the LTHSC functions after the first outbreak seems to have succeeded to work as an effective transmission stopping and prevalence limiting intervention.

International experiences show that in the regions where the frequency of HIV infections rises above 5–10% at some stage, prevention work becomes considerably more difficult. When the frequency is sufficiently high, risks in users easily accumulate and become so high that preventive measures are no longer enough to stop the transmission chains, and the infection becomes endemic in the group, leading before long to a very high frequency. This has often happened with other epidemics, and the most recent example of this kind of development can be found in Estonia. The prevalence studies conducted by the Estonian Tervise Arengu Institute show that HIV infections have already reached a frequency of over 50% among the IDUs in the Tallinn region, and a frequency of nearly 90% has been reported in Eastern Estonia (Uuskülä et al. 2006). In Estonia, an operation similar to the Finnish health counselling and harm reduction was established only after a delay of several years, and the operation was slow to get off the ground.

Although it is clear that the social situation and the prerequisites for the operation in Estonia and in Finland do not correspond to each other, many issues, such as the primary drugs, the frequency of injection as a use method, and the estimated numbers of users, are similar. In Estonia, incidence has remained very high after the initial peak in the epidemic, at approximately 500–600 cases annually (still about one third of the peak year), and the nearly tenfold decrease seen in Finland has not taken place.

Estonia's epidemic is an unfortunate example of how quickly the situation with blood borne infection epidemics among IDUs can deteriorate very sharply. The example emphasises the necessity of long-term prevention work for keeping the risks under control.

## **5.2. Cost effects**

In initial calculation of the effect of the HIV epidemic among IDUs, an estimate was used

according to which the direct treatment costs caused to society by one infection came to approximately 170,000 EUR (Leinikki 2003a). This estimate has changed little since, and it is still useable as a generalisation for producing a rough cost estimate. However, to estimate indirect cost savings, a much more diverse analytic approach would be required. This was not within the possibilities of this study.

International estimates of the annual costs caused to health care by one HIV infection in Western countries are in the range of 10,000–50,000 EUR. A supposition can be made that, in Finland, annual treatment and examination costs per patient could be in the range of 10,000–15,000 EUR (Salminen 2007). In calculating the costs of an IDU who has acquired an HIV infection, it must also be taken into account that many of those infected also have a hepatitis C infection. In Finland, pharmacological treatment of one case of hepatitis C costs about 10,000–20,000 EUR a year (Ristola 2004, 56–57). For example, in Germany, a 48 week course of treatment for hepatitis C costs approximately 23,500 EUR (EMCDDA 2003). The further the hepatitis C progresses, the more expensive its treatment becomes.

If half of the clients of LTHSCs (that is, about 6,000) or half of the problem users (roughly 8,000) acquired HIV infections and annual treatment costs stayed in the region of 15,000 EUR, the annual costs to the public health service could be 90–120 million euros. Preventing IDUs' infections is also important, because pharmacological treatment of the infections and committing to the treatments is often a big challenge for this group, which increases the costs even further.

The funds for the LTHSCs often come from different sources and are directed both to the maintenance of the operation and to its development. For example, the total costs of the LTHSCs in Helsinki maintained by the A-Clinic Foundation were 814,196 EUR in 2005, which as a sum of money would, as a rough estimate, be enough for the treatment costs of

some 50 HIV infections. Only a fraction of the centres' costs go toward equipment.

### **5.3. Accessibility and reachability**

The World Health Organization (WHO) has estimated that, in order to be effective, health counselling directed to IDUs should reach approximately 60% of the users. The statistics for the operations of LTHSCs indicate that this figure has been reached.

In reaching a significant proportion of IDUs, the LTHSCs have succeeded in their work and attempted to achieve a situation in which not a single client becomes infected through ignorance or poor availability of clean equipment. The decrease in HIV infections among IDUs may have had a part in improving the status of drug users and made a change in the behaviour of marginal groups feasible.

Because of the improvement in the infectious disease situation, it is more difficult than before to label a drug user as an excluded, potentially big spreader of infections, and in this sense the border between the margin and the rest of the population has narrowed. The increase of sexually transmitted HIV infections in the last few years moves the risk group thinking increasingly in the direction of the so-called normal population and to infections through heterosexual contact. The risks naturally also apply to IDUs, who continue to be at risk of contracting infections also through sexual contact. Through health counselling work, IDUs have been given the instruments of knowledge and skills to protect their health and that of others in this process. Nevertheless, changing the mode of thinking and translating it into concrete actions is a slow process, and work in that field will never end.

Although interviews for this study were carried out in only 11 centres, the number of clients reached by them is nearly 90 per cent of all clients of the Finnish LTHSCs. From the interviews, the similarities between the centres became apparent, but so do their differences.

There is no one specific operating model or development path that would be common to all LTHSCs; rather, their operations are affected both by internal regulations emanating from the client work and by the framework created by their external setting.

Vuori (1993) remarks on the adequacy of health services by considering that queues are a typical sign of inadequacy or an ineffective organisation and that it is the task of political decision-making to ensure adequate services. Queues existed in the LTHSCs in large towns, and it was remarked that they kept getting longer. These were due to both increased numbers of clients and the queues in drug treatment, which had an impact on the LTHSCs' day-to-day work.

At least in the largest towns, health counselling is accessible in that the majority of IDUs have an opportunity to use the service. The accessibility is not decreased by high cost of services, because they are free of charge to everyone; however, it may be diminished by geographical issues and the endangerment of anonymity. The health counselling service has been acceptable because its position in the prevention of infectious diseases and in reaching IDUs has been officially recognised. The criteria for acceptability have been fulfilled also from the viewpoint of the client base, which can be seen in the growing numbers of clients and the attachment to the service.

### **5.4. Reachability of testing for and vaccinations against infectious diseases**

In many centres, it was estimated that around 10 per cent of the clients had themselves tested regularly. Being tested regularly is a very good habit, and attempts should be made to increase its popularity among other clients. If, however, there is always risk behaviour behind the clients having themselves tested, at least 10 per cent of the clients are likely to engage in continuous risk behaviour. Despite this worrying background factor, possible

epidemics can be quickly detected through regular testing. In Finland, HIV infections related to injecting drug use have been diagnosed only, on average, at the age of 35, so there is every reason to emphasise the importance of regular testing for young users and new clients. Many remarked that attempts are being made to get young users and new clients to be tested as early as possible and to protect them with the vaccinations on offer.

Of those participating in the Risk study, a great majority had at some point been tested for hepatitis and HIV, and a majority (85–93%) had had themselves tested in the previous or current calendar year. Of the respondents, about 91 per cent had taken an HIV test, 88 per cent a hepatitis C test, 86 per cent a hepatitis B test, and 53 per cent a hepatitis A test. More than half of the respondents had a hepatitis C infection, and four per cent had an HIV infection. (Partanen et al. 2006)

In some centres, it was estimated that only a fraction of the clients had ever been tested for HIV or hepatitis, and there were significant town-specific differences in the proportions who had been tested. The option of being tested through a referral was thought to be the most significant single factor raising the threshold. On the other hand, in those locations where testing had been arranged at the centre, the proportion of clients who came in to be tested could be just as small.

Apparently fear, unwillingness, or other reasons could be just as significant in raising the threshold for testing as flaws connected to the facilities. However, it would be desirable that attempts be made to get all those clients who have not been diagnosed with HIV or hepatitis C infections to come in to be tested at least once a year, as well as after having been exposed to infection or if drugs have been used in many different groups. All of the LTHSCs should try to organise testing that is as low-threshold and comprehensive as possible and to intensify or continue its active offering.

It is hoped that rapid tests for HIV and hepatitis C, which are becoming more common, will lower the threshold for carrying out the tests and having the tests taken. It would, however, be advisable to have up-to-date recommendations prepared on the rules related to testing and the practical implementation.

### **5.5. Co-ordination of health counselling services**

Finnish LTHSCs operate under different funding and under the rules of different towns, with no comprehensive or common policy for the operations. For this reason, it would be important that LTHSCs be able to utilise each other's competence and experiences in the development of their own operations. Common meetings are nearly impossible because of the number of centres and distances. Personnel in the largest centres participate in international seminars in order to receive information about international developments in harm reduction. Passing this information on to the rest of the Finnish health counselling field would be as important as exchange of internal information within Finland.

The differences in the responses of small and large towns were not so significant that they could have been differentiated by this characteristic. Dissatisfaction with the current health counselling was highest with the people who had been involved in the operation for nearly its entire duration. In their comments, the recently increased difficulties relating to the development of the work, the increase of the often demanding clientele, and the fixed-term nature of health counselling as far as funding is concerned were emphasised. Fixed-term and project-type funding created clear dissatisfaction among the personnel and do not motivate or enable a long-term approach to the work. In terms of funding, health counselling operations are too often fixed-term projects, the real success of which, however, depends primarily on constancy and long duration.

## **5.6. Trust in social welfare and health services**

Many clients had at some point in their lives lost trust in social welfare and health services and their ability to help those with intoxicant abuse problems. Many had multiple diagnoses of mental health conditions, but often the diagnoses were not felt to have any significance to the improvement of their day-to-day lives. On the contrary, many had become even more depressed after being given an answer as to the source of their problems and yet being left without any help. Many had experienced their children being taken into care when they were trying to get help for their intoxicant problem. Others had been turned away from treatment because they had been late for appointments or could not stop supplementary use.

Users might shy away from coming into an LTHSC because of worry that the police or someone else would recognise them, and visiting a pharmacy was not always a pleasant service experience either. According to the accounts of the personnel, many clients always had too much or too little of something when dealing with the basic services; that is, they might be too intoxicated, too multi-problem, too unreliable, or too frightening. It could also be that they were not in bad enough condition to get service, were not polite enough to be heard, or had too short a history of use to receive treatment. Despite a serious case of blood poisoning or another situation demanding acute treatment, some refused to the end to seek first aid, because they did not want to face the condemning looks of health care personnel.

Better and more versatile services for those with intoxicant problems were demanded in the majority of the interviews. Personnel often felt that, while it is possible to increase the service selection of health counselling and link it more closely with drug treatments, at the end of the day it is the task and the duty of the basic services to bear their share of the responsibility to help this group of client.

## **5.7. Clients' trust is the key**

Trust seemed the most significant single factor in the success of health counselling. In all of the interviews, the importance of trust was emphasised, as was how that trust was being built and maintained in the day-to-day work. The trust built between health counselling and the so-called marginal group may also be reflected in other parts of the service system that are essential for this group, and the repercussions of this can be very positive indeed.

IDUs and basic health care and social welfare services moving closer to each other may, however, be a slow process, despite IDUs' increased trust in the services. Kuussaari (2006) interviewed people working in social welfare and health care services, seeking their opinions related to drugs and drug users.

The study showed that attitudes of understanding to drugs were developed by those working in special services, whereas more unsympathetic opinions were centralised with those working in basic care. Kuussaari considered the sometimes even hostile attitudes to drug users held by those working in basic services to be particularly damaging, with a view to the significant amount of preventive drug work being undertaken in basic services.

It emerged in the interviews that attitudes to drug users and drug services among those in basic services continue to be negative. The relationship of LTHSCs to the media seemed to be a positive and balanced one. However, a hope was expressed that, when LTHSCs are presented in the media, a more versatile impression of them could be given, describing the content of their work more widely. Co-operation with the police seems to have settled into reserved politeness, although in some areas the relations can be very warm. Fear of the police does not stop the majority of Finnish IDUs from using health counselling services.

## **5.8. Quantities of equipment exchanged**

As stated above, the operations are adequate to the extent that health counselling services have reached a large proportion of the estimated group of problem users. A certain kind of inadequacy could, however, be observed, for example, in the limits set for equipment quantities, because larger quantities were requested more often than they were available.

The interviews indicated that clients would be willing to exchange larger quantities of equipment than some LTHSCs were willing to exchange. In towns where the availability of health counselling services was limited and either large numbers of people visited other regions or pharmacy sales are not comprehensive, removal of quantity limits for exchanged equipment should be considered. It might be possible to test the real level of the exchange quantities needed by removing the limits, for example, for a set term, during which it can be assessed whether the limits are at all in line with the quantities exchanged in that time. The need for raising the exchange quantities could also be tested by giving regular and long-term clients, who are tested regularly and who receive their vaccinations, the same amount of equipment as they return. Removal of the limits could also be considered with certain individuals or groups, such as the homeless and those with families.

According to the operations' statistics, there seems to be no direct correlation between the quantity of exchanged equipment and the size of the town. The statistics show that in towns of fewer than 50,000 inhabitants, the quantity of exchanged equipment can be four times that of a town with over 100,000 inhabitants. Large towns and large centres stand out mainly because of their large exchange quantities, but with small and mid-size towns, the trend is not as clear. Both in towns with 50,000–100,000 inhabitants and those with under 50,000, the exchange quantities vary a great deal. In small towns, the variation is between a few hundred

sets of equipment exchanged annually to approximately 30,000, and in midsize towns it is a couple of thousand to over 40,000. The size of the town is not in itself an indication of the quantity of equipment exchanged; it would seem that this is affected somewhat by, for example, the number of clients, the opening hours, and the limits set for exchange quantities. Even with small numbers of clients, the quantities exchanged can be relatively high if the centre is open more frequently than once a week and there are no limits to the quantity of equipment exchanged.

Differences in quantities of equipment given and exchanged may produce contradictory messages about what the policy, expectation, and aim of health counselling are with regard to the exchange. The biggest problem with the principle of exchange quantities is the possible insufficiency of equipment.

Quantity limits for exchanged equipment can easily be applied in the locations where the centre is frequently open, or if the clients are able to get their equipment elsewhere – for example, from pharmacies – without it causing excessive difficulties for them. If these conditions are not met, the availability of equipment may be inadequate. Quantity limits set for exchanged equipment may also have a financial bearing, because, although syringes and needles are not in themselves expensive, their unlimited exchange might increase the costs of the operations in the long run.

The factors supporting the removal of limits are the limited availability of other services, geographic distances, limited opening hours, and the fact that many clients collect injection equipment for other people at the same time. The expectation of yet higher numbers of users being attached to the services with the help of quantitative limits for exchanged equipment is not, however, an aim in itself, although high or growing numbers of clients and client visits do provide a certain kind of confidence for the operation. The benefits of regular reachability can be seen in a decreased risk of exclusion and risk behaviour, in which

low-threshold health counselling is attempting to intervene.

Without the low-threshold health counselling work, reaching clients and creating contacts with IDUs would be limited almost entirely to drug treatments. According to the statistics of the LTHSCs (2005), in the centres where equipment is exchanged and given to the client according to need, without a requirement of one-for-one exchange, the rate of return is often higher than in the centres with limited exchange.

According to the 2004 and 2005 statistics for the LTHSCs' operations, 98 per cent of the syringes and needles were returned. The figure may in reality be slightly higher, because several centres have reported the return percentage as "over 100" instead of reporting the precise percentage. Return quantities exceeding 100 per cent are not return percentages as such. In fact, they demonstrate how much used equipment is handed in to the LTHSCs in relation to what is handed out. According to the operation statistics, the return percentages of several centres keep rising year by year, in many cases already being close to 100 per cent.

### **5.9. Significance of selling injection equipment in pharmacies**

It was hoped that the pharmacies that sell syringes and needles would continue to sell them and in that way provide a parallel service to the LTHSCs'. According to the latest estimates, 85 per cent of the pharmacies in Finland sell clean syringes and needles to drug users (according to the opinion of the Board of the Association of Finnish Pharmacies on pharmacies' role in drug prevention in 2006).

Although, in percentage terms, pharmacy sales have comprehensive coverage, many cities or regions do not have equipment available in pharmacies. For example, in Helsinki in the spring of 2007, approximately 30 per cent of pharmacies sold syringes and needles to drug

users, and the corresponding figure in Espoo was 75 per cent. On the basis of the interviews, in smaller towns, all of the area's pharmacies could sell equipment, which is very good because of distance issues and the very limited opening hours of the LTHSC.

Health counselling is provided in Finland, on average, for four and a half hours at a time, and the length of the opening hours varies from one to 10 hours. In Finland, no centres are open late in the evening or during the night; the centres are usually closed by 8pm, at the latest, and many pharmacies stop selling injecting equipment at 9pm. At weekends, the availability of health counselling services is very limited. On Saturdays, services are available at three and on Sundays at two centres, all of which are located in the capital region. Drug users have a clear need to get injecting equipment also on weekends. Support for automatic vending machines was high among those interviewed, because they would cover the users and regions that are not currently reached by the centres, either geographically or in their hours of operation.

### **5.10. True annual need for injection equipment**

Those who inject drugs, particularly buprenorphine, inject the drug, on average, three times a day and hence need three clean syringes and needles per day (Harju et al. 2000b; Alho et al. 2007; Malin et al. 2006). According to the operation statistics for 2005, a client exchanges, on average, 25 syringes and needles in every visit (21 in 2004), and the quantity of equipment exchanged annually is approximately 150 syringes and needles per client (170 in 2004, 160 in 2006).

Taking the quantity of pharmacy sales (620,000 in 2005) into account, one injecting drug user receives approximately 200 clean syringes and needles a year. The annual quantity of syringes and needles handed out at the LTHSCs varied in 2006 between Mikkeli's approximately 20 sets of equipment and Kouvola's more than 300 sets of equipment

per client. The drug users who responded to the Risk study used approximately 40 needles per month and a slightly lower number of syringes (Partanen et al. 2006). Of those responding to the Risk study, many used their own equipment at least twice, so if they had been using clean equipment for every injection, approximately 80 sets would have been needed.

If a client exchanges or receives an average of 150 syringes and needles annually, this quantity will suffice for approximately two months' hygienic injecting. If the injection frequency remains at an average level of two to three times per day, the user needs some 900 clean syringes and needles in the course of the year. By comparing the quantities of exchanged equipment and client numbers, an average user receives from the LTHSC approximately one fifth of the equipment he or she needs to inject with a clean syringe and needle every time. Therefore, one syringe and needle is used six times, on average, and 80 per cent of injections are performed with used equipment.

According to the statistics for 2005, some 11,800 different individuals visited the LTHSCs and approximately 1.9 million syringes and needles were handed out (13,500 individuals and 2.1 million syringes and needles in 2006). If every client used two to three clean syringes and needles per day, the total quantity of equipment handed out should be approximately 12 million syringes and needles.

In 2005, the total quantity of syringes and needles handed out by LTHSCs and sold by pharmacies was about 2.5 million. In proportion to the number of problem users (14,000–19,000), the annual requirement of injecting equipment might be approximately 12–17 million. Although the numbers do not confirm shared use and not everyone injects two to three times per day, the figures are indicative in that, in all likelihood, not every user can use a clean syringe and needle for every injection. The quantities acquired at

LTHSCs and pharmacies are not necessarily enough to cover the entire equipment needs of the estimated number of LTHSC clients or problem users, although the total quantity of syringes and needles exchanged rises each year. Reuse of own injecting equipment carries health hazards, and the current quantity of clean equipment is not sufficient to remove them.

There are no uniform guidelines or bases for the quantities of equipment exchanged or handed out, or for developing the quantities in proportion to client numbers or growth of operations. Quantities exchanged and the minimum amount of equipment handed out should, therefore, be more in line with the clientele and its needs. Among the factors to be considered are opening hours; numbers of client visits; other services specialised in selling, handing out, or exchanging equipment and their availability; and the geographical location in relation to the areas frequented by the clients. Clients need very different quantities of equipment, and the quantities are not the same for every visit.

Attachment of clients can be slow or fast, and in the initial stage of the operation, limited exchange quantities apparently work well in attachment to the service. At the beginning of the operation, exchange limits may also act as justification for the operation, because they also enable statistics on fairly large visit numbers to be compiled. On the other hand, in the locations where limitless exchange has been the policy from the beginning, visit numbers have gradually grown and levelled out. In the locations where maximum exchange amounts had at some stage been increased or abandoned, the number of clients had remained the same, even though visit numbers had most often gone down and quantities of equipment exchanged had often increased, even by dozens of per cent. Policies concerning exchange equipment should take the client base, the centre's opening hours, and its geographical location, as well as the proximity, opening hours, and reachability of other places offering or selling injecting

equipment, into account. From the standpoint of health hazard reduction, clean equipment should be available in quantities that correspond to the need.

### **5.11. Influencing health risks through health counselling and referral to treatment**

According to Vertio (2003), the factors most often measured in evaluating the effectiveness of health counselling are changes in risk factors and behaviour after the intervention. Even very limited amounts of counselling have been found to have an effect on people's behaviour. He states that, even though the effectiveness of health intervention has been measured, for example, by changes in numbers of illnesses and deaths, the intervention itself and counselling as part of it have been studied considerably less.

The purpose of this interview study was specifically to review the health counselling operation itself and its possibilities to influence the risks. On the whole, health counselling is a social process, the results of which can be reviewed through its methods. The risk reduction power of even a short health counselling encounter that takes place on the client's terms was significant, in the respondents' opinion. It is possible that a client who visits an LTHSC regularly has more specific information about the risks related to the use of drugs, how to avoid them, and different treatment options than, on average, a large-scale alcohol user has on the dangers of alcohol or a smoker about the harm caused by smoking.

#### **5.11.1. Infection risks**

In the personnel's opinion, clients had a lot of correct information about infection risks and ways of avoiding them, and the quantity and quality of information grows year by year. However, there is still a lot of false information being attached to, for example, hepatitis C, and personal counselling was considered the best method of changing this situation. Furthermore, the role of peers in

passing on the information was seen as very important.

#### **5.11.2. Mental health disorders**

Many mental health problems existed in all client bases. Of those participating in the Risk study, 42 per cent stated in the initial interview that they had experienced mental health problems in the last six months. The longer the surveillance progressed, the fewer mental health problems were felt to exist (Partanen et al. 2006). It is stated in the recommended standard treatment guidelines that those with drug problems who have a mental illness or a serious mental health disorder belong within the scope of psychiatric treatment and should be offered simultaneous intoxicant treatment (Käypä hoito. Huumeongelmaisesta hoito). It was, however, the view of the personnel that clients rarely received help for both their intoxicant and mental health problems. Mental health problems were felt to be connected to greater health risks, as well as to general inability and frustration in the field of avoidance of risks.

#### **5.11.3. Risks associated with sex**

In all of the interviews, the difficulty of intervening in risk behaviour associated with sex was raised. Sex may have been discussed, for example, in a situation where the client was offered condoms. The popularity of condoms seemed to vary by area, and it was not felt that there were any differences between the genders in accepting them. According to the operation statistics, the LTHSCs hand out an average of 12 condoms a year to each client.

It was known that there was a lot of unprotected sex, and using contraception was not common. In addition to STDs, unprotected sex resulted in pregnancies, in which intervention attempts involved pregnancy prevention counselling and free contraceptive pills and capsules. Many women who had become pregnant were known to continue their injecting use during the pregnancy. The same phenomenon could be detected from the

treatment experiences of the Women's Clinic's drug, alcohol, and medicine polyclinic in 2002–2005. A third of the patients were using injecting drugs during pregnancy, and nine out of 10 had a partner at the start of the pregnancy who was not necessarily the father of the child. (Halmesmäki et al. 2007)

The possibility of HIV infections through heterosexual contact among the clients was considered to be on the increase. Of the HIV-positive addicts in Boston, 38 per cent used condoms irregularly, and heavy use of alcohol was combined with a higher risk of engaging in unprotected sex (Ehrenstein et al. 2004). It was remarked in the interviews that intoxication was probably the biggest reason for engaging in unprotected sex. Risk situations related to both sex and drug abuse are, however, connected to many social practices and norms. Through studying them, one can attempt to change these situations.

Epidemiological understanding of infection risks related to drug abuse may overshadow the way in which risks are understood in the day-to-day life of a drug user. Taking risks or ending up in risk situations is mainly connected with social interaction and its habits.

Through co-operation with the social sciences, it is possible to get closer to understanding the risks and to charting the situations and environments where risks arise. Risk reduction should increasingly take into consideration the social situations where injecting takes place, rather than simply carrying on with the message of never sharing equipment. Better means for risk reduction can be developed through studying drug use situations and identifying the related risks. (Rhodes 1997; Rhodes et al. 2004; Rhodes & Simic 2005)

It is stated in Finland's HIV and AIDS strategy draft for 2008–2012 that, according to established practice, counselling related to sexual health belongs within the scope of the LTHSCs. Sexual health includes prevention of infectious diseases and pregnancies.

Increasingly strong inclusion of safe sex as part of special services for IDUs has also been noticed elsewhere, because, although injection behaviour has become safer over the years, the same development has not taken place for sexual behaviour (Lindenburg et al. 2006).

## **5.12. Special groups reached poorly by the services**

### **5.12.1. Roma**

In many towns, the most 'noticeable' group not reached by the service was Roma. The day centre maintained by the Helsinki Deaconess Institute, Kaalo, is a day centre aimed at Roma. Its aim is to reduce the exclusion of Roma people from the normal service system, as well as to act as cultural interpreters in the co-operation between authorities. A worker of Kaalo has been regularly available in East Helsinki health counselling centre Vinkki. (Helsinki Deaconess Institute 2006)

It was remarked that Roma are gradually beginning to make contact with the LTHSCs; however, this development was visible in only a few towns. According to Vertio (2003), the behavioural progress within the communities can take place in how there are people in the community who are the first to take in the new idea or operating model, after which they are followed by the early and the late majority. This type of development seemed to be typical, for example, of Roma using injecting drugs.

### **5.12.2. City suburbs**

Suburbs and users within them who were unreachable by the service, mentioned in several interviews, worried members of personnel across Finland. Kivelä et al. (2006) studied the development of an HIV epidemic among the IDUs in the Helsinki area. They observed that drug users lived and used drugs within certain areas and in certain groups, and HIV infections became concentrated in socially excluded groups and in geographic areas with a lot of unemployment and a lower-

than-average standard of living. It is particularly worth noting that 40 per cent of the HIV-positive IDUs had no contact with the city centre of Helsinki, where health counselling services would have been available.

On the basis of the interviews, an understanding was formed that there are several towns and neighbourhoods from which users do not venture and that the current services, in their current form, cannot reach them.

### **5.12.3. Recreational users' fear of being labelled**

Malin (2006) has contemplated the reasons for remaining outside the services of LTHSCs. The reasons given by the peer workers she has interviewed correspond well to those raised by the personnel of the LTHSCs. Recreational users do not want to visit the centre mainly because of the other users there and because of being labelled an addict. Being labelled may mean having that label both in other people's eyes and in their own. Unwillingness to become attached as a client may also be due to the clearly common fear of authorities.

It was mentioned in the interviews that the most common fears of authorities were related to the police and child welfare. Some drug users may have the impression that the LTHSCs are unreliable because they co-operate with different authorities. Also the impression that an LTHSC passes clients' information on is clearly a strong one. (Cf. Malin 2006)

### **5.13. Revision needs concerning LTHSC operational reporting**

The LTHSCs send data on the most important indicators of the operations annually to Stakes and the National Public Health Institute. On the basis of the indicators, the quantities of exchanged equipment, clients, and client relationships can be monitored, as can the quantities of tests and vaccinations carried out. The LTHSCs have also been requested to

compile an annual report on their operations, which is attached to the key statistical data. The annual reports provide important information on how the LTHSCs are doing. However, it seems that, over the years, they may have become too much of a reiteration of established practices.

Furthermore, there are great differences in the annual reports. Whereas a large LTHSC may compile a report with dozens of pages, a small one may describe its operation in only a few lines or fail to write the report at all. Therefore, it may be necessary to revise the reporting model to include some latitude. The aim is not to make the report model longer or to add more information on the operation to the existing framework but to make it correspond better to a particular centre's events in the year being reviewed. Describing key issues rather than producing text for its own sake, even if it were in a slightly more concise format, would produce valuable information on the centre's day-to-day work.

The issues brought up during the interviews, the fears, and the feelings of success or failure, or contemplation on various new projects, cannot be found in the current annual reports. Neither do they include any feelings concerning the development of the operation or the challenges, the starting points of which are within the clients or the operation itself. It would be recommended that the annual reports boldly bring up comments on issues that have been preoccupying the personnel during the year in question and about projects carried out and their successes. There is no need to list reforms or suggestions worth developing simply to form a list, or to leave any out in fear of not getting funding, either.

### **5.14. Development needs concerning peer activities and outreach fieldwork**

Peer activities can be implemented in practice on three levels. The first of these is peer support in which clients exchange thoughts and experiences of drug-related issues. The

second level is peer education in which clients are trained to become health counselling tutors with the aim of incorporating health counselling information into their own networks of acquaintances.

In Finland, peer training courses, the so-called Lumipallo (Snowball) training courses, have been organised since 2001. The participants receive a certificate for successfully completing the training course. The third level of peer activity, helpers or 'jobists' (peer work) are drug users who have taken the Lumipallo course and who are given a bespoke work assignment in an LTHSC or in the field (Malin 2006). Peer activities have become more popular also in Finnish harm reduction, and its role is expected to grow significantly.

In addition to increasing peer work, many mentioned that the need to increase outreach field work is great, particularly in reaching heavily excluded or young users. Svensson (2003) states that continuity and regularity can be considered to be the basis for successful outreach field work. Even if new contacts were not formed for a while, or the target group does not show an interest in the message given or in the service, it is important to be there regularly. The requirement of continuity and regularity is also associated with trust, the building of which can a slow process. In those locations where outreach field work had been undertaken, its main problem was considered to be the limited funding and other resources, irregularity, and fixed-term nature of the operation.

### **5.15. Challenges of prevention of hepatitis C infections**

Health counselling has clearly had an effect on risk reduction connected to injecting behaviour, particularly as regards HIV, but the effect is considerably more difficult to demonstrate clearly in connection with hepatitis C. Case numbers have gone down from those of the peak years, but the

development is fairly slow and case numbers are still rather high. The number of infections in the youngest age group, the 15–19-year-olds, has, however, gone into a clear decline in the last few years, which is a good sign.

The basic reason for the slow decline in the incidence of hepatitis C is epidemiological: hepatitis C had already reached a very high incidence among users at the beginning of the 1990s, possibly even earlier. Because incidence among users is commonly higher than 50%, the total risk of encountering the infection is very high even in occasional shared-use situations. For this reason, any intervention with coverage and protection effects that are not close to 100% can have only a slow effect on the case numbers. Thus, the prevention of a hepatitis C epidemic requires long-term work.

Another reason may be that hepatitis C is easily acquired through other shared equipment, such as dissolving cups and filters, and this message has not been entirely understood. Rhodes et al. (2004) state that harm reduction practices should, as soon as possible, be directed toward prevention, which is more effective from the hepatitis C standpoint. A study of the risk management of IDUs in London showed that hepatitis C infection is considered to be a common and unavoidable consequence of injecting drug use.

Other observations of Rhodes et al. (ibid.) concerning factors furthering the spread of hepatitis C were the uncertainty and ambivalence of the interviewees concerning information related to hepatitis C. Infection risks – i.e., the situations in which an infection can be acquired – were not clear either, and neither was the understanding of the health consequences of hepatitis C. There was also ambivalence as to what the result of an HCV antibody test means. The drug users interviewed felt that a positive hepatitis C test result was played down among the users and considered secondary to HIV in importance. The interviewees felt that the availability of

clean equipment was good, and the majority of them stated that they never use shared syringes and needles. Sharing equipment was, however, connected to many situations where sharing of equipment was not considered sharing but was associated with social, moral, and environmental elements that mitigated or removed the thought of direct sharing of equipment.

The most important observation in Rhodes's study was that hepatitis C is understood in relation to HIV, and communications about the related risks have been brought into a framework originally centred on HIV. The supposition can be made that this relative risk connection weakens the conception of the reduction of risks related to hepatitis C. The majority of those interviewed did not consider hepatitis C the most significant danger related to injecting drug use; of the viral infections, HIV was considered to be the biggest threat (ibid.). Similar results can be observed on the basis of the interviews carried out at the LTHSCs, and it can be stated that hepatitis C is often compared with HIV. HIV remains the most feared infection also among Finnish drug users, and there is still a lot of ambivalence connected to hepatitis C.

The decline in the number of new hepatitis C infections shows that the direction is positive, although nearly a thousand infections are still diagnosed annually. Because of hepatitis C's high frequency and infectiousness, the number of infections among IDUs around the world is higher than the number of HIV infections. Because it is fairly difficult for hepatitis C to be transmitted through sexual contact, the majority of its carriers have probably engaged in some kind of risky behaviour related to injecting drug use or had another kind of blood exposure. Because testing for hepatitis C is by no means carried out in all of the LTHSCs, it is possible that many acquire and spread the infection unknowingly.

Is the spread of hepatitis C infections connected to shared use of the kinds of paraphernalia that are not considered to

involve an infection risk in shared use, such as splitting the drug dose from one syringe into another also by removing the plunger or the needle<sup>20</sup> from the receiver's syringe or by dividing out a ready dose from the same syringe? It is also possible that shared use exists with different paraphernalia in the use of different drugs and that, for example, users of buprenorphine share filters more often than users of amphetamine. Only by establishing the actual drug use situations can an attempt be made to understand why hepatitis C continues to spread even though there are clear indications that risk behaviour has decreased.

In a client survey conducted in 2005 at the Turku LTHSC, Milli, the clients were asked about the habit of using their own equipment several times. About 41 per cent replied that they used their own used equipment daily. With this information known, attempts began to actively emphasise to the clients that syringes and needles are disposable and that clean equipment should be used for every injection. After the emphasis was placed on the equipment being disposable, in the next year's survey, only 27 per cent reported having used their own used equipment, and 53 per cent of the respondents stated that they never used anyone else's equipment. In addition to the infection risk related to shared use of syringes and needles, it is important to consider the bacterial risks related to multiple use, which can be reduced by using clean equipment that is only used once, as well as by using the filter only once. Emphasising the disposable nature of equipment has reduced infections in the clients significantly.

Moving to disposable use was also evident in the Risk study, in which the respondents typically reused their own equipment twice, and in the final interview carried out a year and a half later, only once (Partanen et al. 2006, 47).

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20 Backloading and frontloading.

### **5.16. Regional coverage of health counselling based on actual need**

In view of the coverage of health counselling and reaching drug users, it is particularly important that services be available where the drug users are. In small towns, organising health counselling services may be difficult because of the lack of personnel and implementers. Starting up the operation may also become more difficult if it meets with a lot of opposition from citizens or decision-makers. For this reason, co-operation among many parties is needed in the planning of the operation. In small towns, the health centre may be the most natural place to provide the service, and it must be ensured that the personnel get the training and support to enable a successful operation. When required, personnel of the LTHSCs provide help and advice to each other.

Estimates of the number of problem users indicate that it was thought that there were 2,000–3,800 problem users in the provinces of Eastern Finland, Oulu, and Lapland in 2005. Even if the number in reality was smaller, the LTHSCs in these regions currently reach a maximum of five per cent of the region's problem users.

Even though there have been attempts to organise health counselling operation in Lapland, there was not a single LTHSC there in 2006, and only one was operating in the province of Oulu. In the province of Eastern Finland, attempts have been made to establish LTHSCs in the largest towns, and, out of these three provinces, their reachability is the best.

There are no estimates of the number of problem users in the province of Åland, and there is no health counselling operation there. Also, many other mainly Swedish-speaking areas lack health counselling services. The network of LTHSCs does not cover the whole country, and in some regions there were sometimes large availability gaps in the services, resulting in infection risks.

### **5.17. The need to determine user numbers for each region**

Analysis of risks by region should clearly be under better control. For this purpose, fact-based regional estimates of the numbers of injecting drug users should be prepared, and the development of health counselling operations should be based on this information.

Separate examination of operational and client statistics for drug treatment, health care, or social welfare do not usually produce sufficient information on the actual regional extent of problem use, because drug use is often concealed. Relying on the 'guesstimate' data produced by them can easily lead to a 'head in the sand' type of thinking, which may backfire when the concealed risks materialise at some point in the future. Therefore, other, targeted means should be used for determining the actual risk and drug use situation. Implemented correctly, such methods include, for example, results of anonymous questionnaires and capture–recapture-type regional surveys.

Without fact-based estimates of the need for injecting equipment exchange, the obligation specified for the health care authorities in the Communicable Disease Decree is not going to be fulfilled.

### **5.18. Prisons**

The WHO urges prisons to provide functional disinfecting methods for injecting and tattooing equipment, as well as adequate information and training if the exchange of clean injecting equipment is felt to be unnecessary or impossible. Disinfecting is slow, however, and there is no guarantee of its correct use. Therefore, inadequate cleaning may create a false sense of safety, and disinfecting can be considered to be only the next best alternative when compared with

exchange programmes (WHO 2004; WHO 2005).

A sampling survey conducted by the Criminal Sanctions Agency encompassing 700 prisoners showed that approximately 50% of the prisoners have hepatitis C (Criminal Sanctions Agency 2006). The frequency of HIV in prisons is only a few per cent, so infection frequencies in prisons correlate almost fully to the general figures among IDUs. However, no data can be found on how many become infected during imprisonment.

Interviews undertaken with prisoners in 1995 revealed that 70.1 per cent of the prisoners had at some stage used illegal drugs, 27.7 per cent had used them in their imprisonment, and 21.7 per cent had started using drugs while in prison. Of the respondents, 19.2 per cent said that they had used injecting drugs and 10.7 per cent had injected while in prison. (Korte et al. 1998)

A 1999 report by the National Public Health Institute studying infection risks in prisons showed that, of the prisoners interviewed (approximately 552), some 50 per cent had engaged in injecting drug use. 52 per cent of them had injected during imprisonment, and seven per cent had injected for the first time in prison. About 47 per cent of the respondents had shared injecting equipment in prison and approximately 43 per cent had shared equipment when they last used injecting drugs. The majority of IDUs had at least two sexual partners who were injecting drug users (45%). In 1999, 33 people tested positive for HIV in prisons. (National Public Health Institute studies 1999; Vankeinhoodon vuosikertomus 1999, 48)

The national HIV/AIDS strategy for 2002–2006 sets a decrease in prisoners seeking HIV testing and counselling as a target for the prevention of HIV infections in prisons, as well as the adoption of new methods of operation in order to reduce the significant infection risk related to shared use of syringes and needles (Strategia 2002, 19). In

2005, the work to prevent HIV and hepatitis infections included health education and ensuring opportunities for protection from infections. A hygiene package given to every prisoner contains instructions on the use of condoms, as well as on cleaning and disposing of injection equipment, as well as personal disinfecting equipment. In particular, those who have used injecting drugs are encouraged to get tested for HIV. Of the 1,073 tests carried out in 2005, two new infections were found (Criminal Sanctions Agency 2005, 48). Finland's national HIV/AIDS strategy for 2008–2012 emphasises that, to prevent infections among prisoners, it would be important to prevent infections contracted in prisons, for example, by providing an opportunity for using clean injecting equipment.

According to statistics collected by the National Public Health Institute, of the roughly 11,000 rapid tests carried out in prisons in 1999–2005, 45 were positive. Of the HIV-positive IDUs, of whom 324 had been diagnosed by autumn 2007, 14 per cent had been reached by testing carried out in prisons. Therefore, testing in prisons is clearly an effective channel for detecting infections. On the other hand, some of the infections may already have been tested for and diagnosed elsewhere.

Of the IDUs interviewed during the Risk study, 38 per cent stated in the initial interview that they had at some time been in prison (Partanen et al. 2006). The interviews indicated that prison sentences were very common among the clients of the LTHSCs, and the longer the drug use had lasted, the more likely the person was to have had at least one prison sentence. Infection risk in prisons was mainly considered in all of the interviews to be higher than in freedom. The majority of the personnel hoped that the opportunity of exchanging clean equipment would also be available in prisons.

### **5.19. Need for guiding recommendations on health counselling service contents and settings**

The evaluation study revealed that the health advisory and promotion work performed at the injecting drug users Low Threshold Health Service Centers still is based on the models developed in the late 1990s. The original model has proved its effectiveness by reaching its original objectives and it is applied in most LTHSCs. Naturally the model has developed and become more varied in its content.

Partially this has also led to a development where LTHSCs have developed the content of their services into different directions in different parts of the country. This is often useful, since needs differ geographically and between groups of customers. At the same time, there is a danger that over time service content diverges so much from the original framework, that it will not anymore fulfill the original objectives. In a worst case scenario this may mean that responsibility to provide health promotion services laid out in the infectious disease statute are replaced by something completely different in content. By such action only the form, not the contents of the statute are fulfilled.

Fortunately there are still only few signs of such a development, but isolated examples can be recognized. In some instances pharmacy sales of injection equipment have erroneously been regarded as sufficient and in other cases health promotion without injection equipment exchange likewise. Neither of these activities fulfills the original requirements of health promotion services for injecting drug users.

It would therefore be useful to publish clear guidelines with minimum requirements of what constitutes low threshold health promotion and prevention services for injecting drug users. This would help not only to ensure the quality of content of the services, but also at the set-up and planning stage of a new site in a new location. It is clear that the

recommendations and guidelines would need to be adaptable to varying local conditions and irrespective of the size of the community, as well as the local problem user profile. The guidelines would need to contain all necessary functions and facilities necessary as well as optional components which would be adaptable to local needs.

The development of the guidelines would be best suited to be organized under either a Ministry of Social Affairs or Health, or ministerial sectoral agency coordinated expert group.

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Systematic monitoring and annual reporting of the performance and content of the LTHSC as well as long-term cooperation have been key to the development of the Finnish model of health promotion and harm prevention among IDU.

The deep knowledge and skill of implementation of the LTHSC workers are an irreplaceable resource in the fields of intoxication and infection risk prevention services. Especially those workers who contributed to the report by donating their time for the in-depth interviews deserve acknowledgement. Through the long and fruitful interviews a much clearer picture of the essence of the low threshold health promotion and harm prevention work is now available for a wide audience.

Furthermore, equal gratitude is directed towards the clients of the LTHSCs, the users of injected drugs. They themselves have shown by their actions at the LTHSC, that illicit drug users do care about health matters, not only their own, but also the health of others. This is exemplified by the customers' strong desire to protect both themselves and others from infectious diseases and by the willing participation in various surveys and studies which serve common good and a public health purpose. Hopefully this will reduce the prejudiced and stereotypic attitudes and beliefs commonly held against the users.

It's important to acknowledge those civil servants and professionals in public office and among the NGOs who originally developed the LTHSC pilot project and concept. Such forerunners were found at the A-Clinic Foundation, the Helsinki Deaconess Center, the Ministry of Social Affairs and Health and

its research and expert organizations: the National Public Health Institute - KTL and STAKES.

Without the open attitude of these key persons and frequent fights against commonly held strong negative attitudes, the LTHSC activities would not have gotten off the ground. The pioneers spoke for the absolute necessity of establishing the services and based their arguments on solid scientific evidence, but also on a strong humanitarian way of thinking. Without this effort, the HIV-epidemic and other infectious diseases would have spread widely among the injecting drug users, causing unmeasurable amounts of personal suffering.

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## 8. APPENDICES

### **8.1. Appendix 1: Questions asked in the interviews and the themes discussed**

- Financer of the operation and implementer of the service
- Number and educational background of personnel
- What kind of a working environment is the LTHSC?
- Is there a realistic picture of your operation and work among administration members or among the financiers of the operation?
- What, in your view, is an LTHSC's image in the media?
- What is your relationship like with the police?
- What is your relationship like with pharmacies?
- What views do you or your clients have of risk behaviour in prisons and the infection risks of prisons?
- Which are your most important or most utilised co-operating organisations?
- What kinds of support services do you have?
- What are the attitudes of people in the neighbourhood to the existence of your centre?
- The new Communicable Diseases Act and Communicable Diseases Decree oblige municipalities to take care of prevention of infectious diseases by providing health counselling for injecting drug users. What impact has this had on Finnish health counselling operations, and what impact is it going to have?
- Finnish health counselling operations have been spoken of as a success story. Which factors have, in your view, affected the success of the work?
- In your view, with what kinds of indicators, figures, or observations can health counselling work and its impact be measured and evaluated?
- What is the health counselling centre's role in the service field? What kind of actor is it?
- How is Finnish health counselling work going to change, what will its focus be, and what kinds of activities or services will increase their role?
- What kinds of threats or challenges might health counselling work face in the future? What is the role of brochures and information packages in health counselling and the provision of information on infectious diseases? In which situations are they a good thing? Do you have other forms of service? Tell me about them.
- What are your thoughts on peer work and its role in this operation?
- And what are your thoughts on outreach work / field work? What is its role?
- How significant in this work is the referral to services, support, and knowledge for use of the service system?
- What is the significance of the services being anonymous and free of charge in view of the success of the entire health counselling operation?
- What are your opening hours, and are they good in their time of day and duration?
- Is the size and quality of your premises good?
- What is the significance of the location of the health counselling centre to the work?
- The LTHSCs are also open to the IDU's family members. Are these services used?
- What kinds of injecting equipment exchange quantities and exchange policies are appropriate, in your view?
- Do you give condoms on request, or do you actively offer them, and are the quantities you hand out adequate?
- What is a good health counselling situation, and how is it created?
- Do you believe that exchanging clean equipment only, without any personal contact, would constitute effective prevention of infectious diseases?
- Do you perform tests and vaccinations at the centre? Which ones?

- What is the role of returning used equipment? Is it as significant as handing out clean equipment?
- Has using clean equipment and exchanging equipment become a habit among users? Have there been changes in their ways of thinking?
- Have there been clear changes in the numbers of clients or visits in the course of your operation?
- How many injecting users of anabolic substances are there among your clients?
- How many of your clients engage in prostitution?
- How great a proportion of your clients have been in prison?
- How great a proportion of your clients are homeless (only of the remainder)?
- How great a proportion of your clients have had HAV and HBV vaccinations?
- How great a proportion of your clients have been tested for HIV at least at some point? How about in the last year or otherwise routinely?
- How great a proportion of your clients have been tested for HCV?
- Why are tests being sought? In what kinds of situations are they sought?
- Why do some not get tested?
- How great a proportion of your clients seek or have at some time sought treatment aiming at stopping drug use?
- How great a proportion of your clients would you estimate want to stop their injecting drug use?
- Do your clients have mental health problems?
- Are mental health problems connected to risk behaviour and infection risks?
- Are your clients concerned about their own health?
- Which groups or individuals remain outside health counselling services?
- How many of your clients are minors?
- To whom or to what kinds of issues should health counselling work pay more attention?
- Which drugs do your clients primarily use?
- How great a proportion of your clients are polysubstance users, and does polysubstance use create problems in view of harm reduction or health counselling considerations?
- Is the threshold for getting into substitution treatment too high?
- Has the current health counselling model, in your view, had an impact on reducing the risk behaviour among your client group?
- In your view, is the impact greater in relation to risk use or sexual behaviour?
- How is the seriousness of different health hazards understood; which is the most feared and which the most underplayed?
- Do your clients have factual information about different infectious diseases and mechanisms of infection, or is there also false information or beliefs?
- Does a positive test result change risk behaviour and risk-taking?
- Would the 'mere' testing for HIV and hepatitis and counselling be as effective as the current exchange of equipment carried out in conjunction with health counselling?
- How do you expect the incidence of infectious diseases to develop among IDUs?
- Are such bottlenecks or problem areas created within the intoxicant system as cause the operation not to be as efficient as it could be?
- What is most difficult or challenging in this work?
- Would you tell me about a top moment in the work?
- Do you have other forms of service? Tell me about them.
- What are your thoughts on peer work and its role in this operation?
- And what are your thoughts on outreach work / field work? What is its role?
- How significant in this work is the referral to services, support, and knowledge for use of the service system?
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  - Why are tests being sought? In what kinds of situations are they sought?
  - Why do some not get tested?
  - How great a proportion of your clients seek or have at some time sought treatment aimed at stopping drug use?
  - How great a proportion of your clients would you estimate want to stop their injecting drug use?
  - Do your clients have mental health problems?
  - Are mental health problems connected to risk behaviour and infection risks?
  - Are your clients concerned about their health?
  - Which groups or individuals remain outside health counselling services?
  - How many of your clients are minors?
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  - Has the current health counselling model, in your view, had an impact in reducing the risk behaviour among your client group?
  - In your view, is the impact bigger in relation to risk use or sexual behaviour?
  - How is the seriousness of different health hazards understood; which is the most feared and which the most underplayed?
  - Do your clients have factual information about different infectious diseases and mechanisms of infection, or is there also false information or beliefs?
  - Does a positive test result change risk behaviour and risk-taking?
  - Would 'mere' testing for HIV and hepatitis and counselling be as effective

as the current exchange of equipment carried out in conjunction with health counselling?

- How do you expect the infectious disease incidence to develop among IDUs?
- Are bottlenecks or problem areas created within the intoxicant system that cause the

operation not to be as effective as it could be?

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- Would you tell me about a top moment in the work?