

Vili Varjonen
Hannele Tanhua
Martta Forsell
Riikka Perälä

Finland Drug Situation 2012

REPORT





European Monitoring Centre
for Drugs and Drug Addiction



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by the Reitox National Focal Point, THL

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DRUG SITUATION 2012
New developments, trends and in-depth
information on selected issues

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Foreword

Finland – Drug Situation 2012 is an annual drug report by the Finnish National Focal Point. The report consists of two parts. Part A discusses the latest developments and research data from recent years, mainly focusing on 2011 and early 2012.

The drug situation is described from the perspectives of legislation, policies, use, harm, treatment and other interventions, and the drug issue is approached from the health, social and criminal points of view.

Part B discusses drug-related special themes; this year, institutional treatment for drug users and the drug situation in Helsinki.

Chapter 11 on institutional care for drug users was contributed by research scientist Riikka Perälä from the University of Helsinki, and chapter 12 on the drug situation in Helsinki by Senior Planning Officer Vili Varjonen from the National Institute for Health and Welfare.

The report was compiled and the remaining sections written by Senior Planning Officers Vili Varjonen, Hannele Tanhua and Martta Forsell at the Finnish National Focal Point, which operates at the National Institute for Health and Welfare (THL). Also, researchers Sarianna Petrell from the National Bureau of Investigation and Heini Kainulainen from the National Research Institute of Legal Policy contributed substantially to the editing of chapters 9 and 10. The assistance of research scientist Marke Jääskeläinen in the reporting of morbidity statistics is much appreciated.

Several experts contributed to and provided helpful comments on the preparation of the report (Appendix 1). We extend our warmest thanks to everyone involved in the preparation of the report. The report has been approved by the editorial board of Printed Products, Information, THL, as well as the working group on international co-operation on drug issues.

The report is available in Finnish in print and online, and in English online.

Finland – Drug Situation 2012 is one of the national annual reports compiled by the National Focal Points in the European Information Network on Drugs and Drug Addiction (REITOX) which is co-ordinated by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). The national reports form the basis for the EMCDDA's annual report *The state of the drugs problem in Europe*.

Helsinki, November 2012

Vili Varjonen
Senior Planning Officer

Hannele Tanhua
Senior Planning Officer

Abstract

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This report is a compilation of the most recent Finnish research on drugs and key indicators of the drug situation in Finland.

Generally, drug use and drug-related problems have remained fairly stable in Finland over the past years.

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

According to the 2011 ESPAD survey of school pupils, 12% of boys and 10% of girls aged 15 to 16 had experimented with cannabis at some time in their lives. The 2011 ESPAD survey was the first of its kind in Finland to include separate questions on hashish use, marijuana use and home growing of marijuana. Hashish use was reported by 7% of the boys and marijuana use by 10%, while the figures for girls were 4% and 6%, respectively; 12% of the boys and 10% of the girls reported that they knew someone who had grown cannabis at home. Among the pupils themselves, however, home growing was extremely rare: only 1% of the boys and none of the girls reported having grown cannabis at home at some time.

In recent years, drug-related treatment has focused on the treatment of problem use of opiates and polydrug use. Opiates are far more likely to cause serious problems and lead users to seek treatment than cannabis, for instance. Thus, the fact that the percentage of opiate user clients is increasing does not directly translate into an increase in drug use overall in Finland. According to the collecting of information on drug-related treatment conducted by the National Institute for Health and Welfare each year, opiates were the primary problem drug for 59% of clients seeking treatment at drug treatment units in 2011. More than half of the clients reported that they had a problem use history with at least three intoxicants. In recent years, nearly all of the opiate use recorded in Finland has involved synthetic, pharmaceutical opioids. Two of these, buprenorphine and methadone, are used both as intoxicants and as detoxification or substitution treatment medication. Substitution treatment medication is typically taken under a physician's supervision and orally, while drug use is typically intravenous and involves the use of other drugs too.

Among the drug users seeking treatment who were not opiate problem users, cannabis was the most common drug leading the clients to seek treatment. The percentage of cannabis as a primary cause for seeking treatment was considerably elevated in the youngest age groups. In fact, it was the most common problem drug reported as a cause for seeking treatment in the age group of under 20.

The increased use of designer drugs shows in the statistics on seizures by Customs. The amendment to the Narcotics Act that entered into force in June 2011 stipulates that in the future the Finnish government may classify designer drugs as narcotic drugs at its own initiative. Under the new Act, any new substance entered in the EU early warning system may be nationally classified as a narcotic drug after its health hazards have been evaluated. Under the Act as amended, the Finnish government may nationally classify not only designer drugs but also pharmaceuticals as narcotic drugs if their pharmacological properties are equivalent to those of narcotic drugs.

A national action plan to reduce substance abuse and its harmful effects for 2012–2015 was adopted in August 2012. The measures outlined in the Government Resolution concern prevention and early intervention; combating drug-related crime; treatment of drug addiction and reduction of drug-related problems; enhancing substance abuse treatment in connection with penal sanctions; EU drug policy and international cooperation; collecting of information and research on drug-related problems; and drug policy coordination.

Key words:

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

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A. NEW DEVELOPMENTS AND TRENDS

1 National policies and context

The purpose of drug policy is to prevent the use and distribution of drugs so as to minimise the economic, social and individual harm and costs of their use and prevention. Finland's drug policy is based on general social policy measures, national legislation and international treaties, together aimed at contributing to a reduction in the supply of and demand for drugs, and in drug-related harm, enabling early treatment for those suffering from drug problems and imposing penal liability on those engaged in illegal activities.

Drug policy is coordinated by the **Ministry of Social Affairs and Health** and implemented by the various administrative sectors in cooperation. The Drug Policy Coordination Group led by the Ministry has the job of developing and coordinating national drug policy and to monitor the drug situation. Finland's drug policy is based on the Government Resolution on an Action Plan to Reduce Drug Use and Related Harm 2012–2015 and on the Drug Strategy adopted in 1997. In its drug policy, Finland observes the United Nations international drug control conventions and the EU Drugs Strategy for the period 2005–2012.

The resources allocated have a significant impact on the implementation of drug policy.

1.1 Legal framework

Legislation concerning drugs that entered into force in 2011

The amendment (373/2008) to the Narcotics Act that entered into force in June 2011 stipulates that in the future the Finnish government may classify designer drugs as narcotic drugs at its own initiative. Under the new Act, any new substance entered in the EU early warning system may be nationally classified as a narcotic drug after its health hazards have been evaluated.

Under the Act as amended, the Finnish government may nationally classify not only designer drugs but also pharmaceuticals as narcotic drugs if their pharmacological properties are equivalent to those of narcotic drugs.

Following this amendment, the pharmaceutical substance tapentadol was classified as a narcotic drug in Finland. Under the Narcotics Act, the manufacture, import, trading, possession and use of the substance are prohibited. The relevant Decree (1093/2011) entered into force on 1 November 2011.¹

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

The **Act on Vocational Education** (630/1998), the Act on Vocational Adult Education (631/1998), the Polytechnics Act (351/2003), the University Act (558/2009) and the Criminal Records Act (770/1993) were amended to revise the criteria for not accepting students and to enable institutions to revoke study rights if security concerns so require. Among the amendments were provisions concerning student drug tests. The amendments entered into force on 1 January 2012 (HE 164/2010). The University Act was amended (954/2011) to include provisions on potential drug testing for students.

¹ Seven designer drugs were classified as narcotic drugs in Finland by a Decree (117/2012) as of 12 March 2012. The synthetic cannabinoids JWH-018, JWH-073 and JWH-081 were classified as narcotic drugs, as were the MDPV-like mCPP, the MDPV derivative methylon, the central nervous system stimulant 2-DPMP and the LSD-like Bromo-Dragonfly.

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

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

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

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

Definition of drugs

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

Narcotics Act

According to the Narcotics Act (373/2008), which entered into force in September 2008,² the production, manufacture, import, export, transit, distribution, processing, possession and use of and trafficking in drugs is prohibited, although exemptions are possible for medical, scientific, investigative and control purposes.

Sanctions prescribed in the Narcotics Act are divided according to the severity of the offence into administrative coercive measures and sanctions for offences against the Narcotics Act and for narcotics offences. Administrative coercive measures include prohibition of further action and/or a default fine to enforce such a prohibition. Offences against the Narcotics Act include for instance intentional neglecting of the obligations of the Act. Unless a more severe punishment for the act is provided for elsewhere in the legislation in force, a person committing an offence against the Narcotics Act can be sentenced to a fine. Provisions concerning the more serious narcotics offences are laid down in Chapter 50 of the Penal Code (39/1889).

² See the amendments to the Act in section 1.1.

Under the Narcotics Act, the Finnish Medicines Agency (Fimea) is the licensing and controlling authority for narcotic drugs and drug precursors. A licence is required for the manufacture, import, export and handling of drugs unless this is specifically exempt by law, as for instance for many of the actors in the health care sector. The Decree on Narcotics Control (548/2008) lays down more specific provisions on the license administration, operations subject to authorisation and their supervision under the Narcotics Act. The trade in and handling of drug precursors is provided for in more detail by EC Regulations.³

Legislation on substance abuse prevention

There are many other legislative provisions intended to prevent, treat and monitor drug use and problem use of drugs. Provisions concerning preventive substance abuse work are laid down in the **Temperance Work Act** (828/1982). This Act defines the purpose of temperance work as habituating citizens to healthy lifestyles by guiding them in avoidance of the use of substances and tobacco. According to the Act, the establishment of general prerequisites for substance abuse prevention is primarily the task of central and local government. Practical measures in this area are generally undertaken by local authorities and by temperance and public health organisations. Pursuant to the Act, each local authority must have a designated body responsible for temperance work. This body must cooperate with the local health care, social welfare and education services in particular. The Temperance Work Act is scheduled for revision in 2013. The purpose of this revision is to develop local measures for prevention of harmful impacts of substance abuse. Local aspects of measures aimed at preventing harmful impacts of substance abuse will be considered more closely than before in revising the Act. The **Temperance Work Decree** (233/1983) further specifies that this body must cooperate with organisations engaging in temperance work and substance abuse prevention and promoting healthy lifestyles.

Under the **Child Welfare Act** (417/2007), a child is entitled to a safe growing environment, balanced and well-rounded development and special protection. When the parent, guardian or person otherwise responsible for the care and upbringing of a child is a client of substance abuse services, mental health services or other social welfare or health care services and as a result is judged to be impaired in his/her ability to manage the care and upbringing of the child, the child's need for care and support must be investigated, and sufficient care and support must be provided. An amendment to the Child Welfare Act entered into force in March 2010 containing a provision on submitting an anticipatory child welfare notification. An anticipatory child welfare notification must be submitted when there is reasonable cause to suspect that a forthcoming child will need child welfare support measures immediately after the birth. In other words, an anticipatory child welfare notification must be submitted by someone who has certain knowledge that a mother-to-be or father-to-be has a substance abuse problem or a severe mental health disturbance or is subject to a custodial sentence. A suspicion of substance abuse is not in itself enough for submitting an anticipatory child welfare report.

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

The **Government Decree on welfare clinic services, school and student health services and preventive oral health services for children and youth** (380/2009) lays down provisions concerning health examinations in welfare clinics and carried out by school and student health services. According to the Decree, sufficient and regular health examinations and health counselling are aimed at enhancing early support and preventing social marginalisation. Another purpose of health counselling is to prevent substance abuse and thereby promote psychosocial wellbeing. The Decree specifies that welfare clinics must adopt extensive health examinations – as in school health care – involving the entire family. Health

³ (EC) Regulations Nos. 273/2004 and 111/2005 and Regulations amending them, and the implementing Regulation (EC) No. 1277/2005.

examinations in eighth grade in comprehensive school highlight the importance of early detection, intervention and further treatment in any substance abuse problems.

The **Occupational Health Care Act** (1383/2001) enables drug testing in the workplace. Before requiring any individual to take a test, the employer must have a written substance abuse programme, which contains the general goals of the workplace and practices to be followed to prevent substance abuse and help substance abusers in seeking treatment. The Act on the Protection of Privacy in Working Life (759/2004) regulates employers' rights and their limitations concerning drug tests required from employees. Drug control is justified in sectors where special legislative provisions apply. Such provisions may be found in the Conscriptio Act (1438/2007), the Aviation Act (1194/2009) and the Act on traffic safety duties in the railway system (1664/2009). The Ministry of Social Affairs and Health has issued instructions on drug tests in working life. (Ministry of Social Affairs and Health 2006).

Legislation on services and harm reduction

According to the Constitution (731/1999), those who cannot obtain the means necessary for a life of dignity have the right to receive indispensable subsistence and care.

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

The **Social Welfare Act** (710/1982) requires local authorities to provide social welfare services, including substance abuse services.

At the moment, both the **Act on Welfare for Substance Abusers** (41/1986) and the **Mental Health Act** (1116/1990) allow for commitment to involuntary treatment. Section 11 of the Act on Welfare for Substance Abusers allows for involuntary commitment to treatment in case of a health risk, but this provision is applied only rarely. However, coercive measures are often exercised on substance problem users pursuant to the Mental Health Act (1116/1990).

The **Decree governing detoxification and substitution treatment for opioid addicts** (33/2008) stresses that unlike under previous legislation only demanding substitution treatment cases should be dealt with by specialist health care; other cases should be treated at the primary health care level. Pharmaceuticals containing buprenorphine or methadone may only be prescribed for the detoxification or substitution treatment of opioid addicts by a physician employed by a health care unit who is responsible for this function, or by a physician designated by him/her.⁴ However, the Decree also allows a combined preparation of buprenorphine and naloxone to be issued from a pharmacy under a pharmacy contract signed by the patient. A pharmacy contract is an agreement by which the patient commits to collecting the pharmaceuticals specified under the contract from only one pharmacy and agrees that this pharmacy may transmit treatment-related information to the physician treating the patient and notify other pharmacies of the existence of the pharmacy contract.

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

⁴ Medical treatment may be conducted and the medication administered to the patient only under the supervision of the health care unit. If the patient's commitment to treatment is high, the health care unit can give him/her pharmaceuticals equivalent to a maximum of eight daily doses (15 in exceptional cases).

on the amendment, a cannabis-based analgesic can also be prescribed in certain cases. However, cannabis-based medicines do not have an actual marketing authorisation.

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

Penal Code

Narcotics offences are provided for in chapter 50 of the **Penal Code** (39/1889), in an amendment to which (1304/1993) they were further categorised as narcotics offences, or the preparation or abetting of narcotics offences (maximum sentence 2 years' imprisonment), or aggravated narcotics offences (1 to 10 years' imprisonment). An amendment to the Penal Code enacted in 2001 (654/2001) defined the unlawful use of narcotics (maximum sentence six months' imprisonment). In 2006, a further amendment (928/2006) rendered the preparation of and abetting a narcotics offence punishable acts.

Dealing with the unlawful use of narcotics is possible in summary penal proceedings (692/1993). This may be done in cases where the penal provision applicable does not include a punishment more severe than a fine or a maximum of six months' imprisonment. A summary penal order is issued by the police, a customs official or another public official performing controls stipulated by law, on their own initiative or on behalf of the prosecutor. Through amendment 578/2008 to the Penal Code, it was determined that a fine imposed in summary penal proceedings may not be converted into imprisonment. In practice, this means that offenders issued a fine in summary penal proceedings by the police or the prosecutor for the unlawful use of narcotics may no longer be sent to prison instead. Charges may be waived for unlawful use of narcotics if the offender agrees to seek treatment or if, in the case of an offender under the age of 18, a reprimand is given. (Kainulainen 2009.)⁵

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

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

Legislation on sanctions

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

⁵ See also 9.2 Alternatives to prison.

1.2 Drug policy and its coordination

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

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

Background

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

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

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

Aarne Kinnunen noted in his doctoral dissertation, completed in 2008,⁶ that despite its social welfare and health care elements the Finnish drug policy continues to rely principally on the criminal justice

⁶ The study discusses the development of the drug market and drug-related crime since the mid-1990s, the criminal careers and socio-economic status of narcotics offenders, and efforts to solve the problem of drug-related crime through official enforcement. The study is based on statistics, observations of police work, interviews with the authorities and people in the drug market, and official documents. It shows that since the mid-1990s drug use has become more common, drug problems have become more serious, and drug control has become stricter. Prevention of drug problems became a key issue for the authorities, and more resources were allocated to anti-drug measures. Control through the criminal justice system was reinforced, and drug prevention took top priority in the strategies of the Police and the

system. Sanctions for drug-related offences in Finland are more severe than for other offences. The criminalisation of drug use and the tightening of the practice of issuing fines demonstrate that a stricter moralist view of drug use and other high-risk behaviour is now prevalent. Moreover, criminal control tends to focus on persons of low socio-economic status. (Kinnunen 2008.)

Heini Kainulainen came to a similar conclusion in her dissertation. According to her, the criminal justice sanction system has in recent years focused increasingly on the offender,⁷ particularly in the case of offenders who are substance abusers. For example, waiving charges remains an extremely rare outcome, even though it would be especially needed in narcotics offences. The police have traditionally been reluctant to apply this procedure, since intervention in users' actions has been considered crucial. For a long time, prosecutors concurred. (Kainulainen 2009.)

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

Current drug policy

A new Government was appointed in Finland in June 2011. The new Government Programme included the following commitments:

- The efficiency of measures to protect the entire population, but especially children and young people, from the adverse effects caused by alcohol, tobacco, other drugs and gambling problems will be enhanced.
- An action plan will be drafted to reduce drug abuse and its effects.
- Needs for developing drug legislation will be reviewed.
- Low-threshold services, medical counselling and outreach work for drug users will be increased.
- The efficiency of treatment referrals carried out by the police will be enhanced.
- Opportunities for the treatment of drug problems during imprisonment will be increased.

(Finnish Government 2011a.)

The Government Resolution on an Action Plan to Reduce Drug Use and Related Harm was adopted in August 2012. This Action Plan has five component areas: 1) Preventive work and early intervention; 2) Combating drug-related crime; 3) Treatment of drug addiction and reduction of harm from drug use; 4) The EU's drug policy and international co-operation; and 5) Information collection and research regarding drug problems. (Ministry of Social Affairs and Health 2012a.)

1. Preventive work and early intervention

Under the Temperance Work Act (828/1982), preventive substance abuse work is the responsibility of local authorities. Preventive substance abuse work is carried out in social and health care, youth work, schools and educational institutions, parishes and NGOs. Cooperation between administrative sectors and between authorities at the local level is crucial for preventing drug-related harm. The quality and methods of

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

⁷In the drug use offence reform that entered into force in 2001, the police were given the authority to issue summary fines to drug users; at the same time, alternative sanctions were heavily recommended. Underage offenders should be given a reprimand instead of imposing a fine, and problem drug users should be referred to treatment. However, in practice this reform led in the early 2000s to a substantial increase in summary fines issued to drug users. Because there is less scope for waiving charges in this case, the practice also led to a decline in the use of waiving of charges, and thereby decreased the use of alternative sanctions and indirectly led to stricter sanctions overall. The effect of guiding problem users to treatment that was sought in the 'unlawful use of narcotics' reform has not been achieved in practice: it is still extremely rare for charges to be waived for drug use offenders who have sought treatment. (Kainulainen 2009.) See also 9.2 Alternatives to prison.

substance abuse prevention are being developed by the National Institute for Health and Welfare and by NGOs and local authorities. The purpose of the forthcoming revision of the Temperance Work Act is to reinforce the status of substance abuse prevention in municipalities and to ensure that preventive work is taken into account as local government structures change.

The Youth Act (72/2006) also requires improved planning and implementation of multiprofessional cooperation among local authorities. For this purpose, local authorities must have a guidance and service network in place for young people, involving representatives of the education, social welfare, health care and youth authorities and of the employment administration and the police. This network interacts with NGOs that provide services for young people.

Goals for the current electoral period include:

- enhancing the participation of young people in decision-making concerning substance abuse prevention and its implementation,
- clarifying the division of duties and structures in preventive work,
- supporting substance abuse prevention at schools and in pupil and student welfare services,
- engaging the police and other authorities in closer cooperation at the local level,
- intervening in crimes committed by young people with substance abuse problems at an early stage, and
- increasing reprimands issued by prosecutors to underage first-time offenders.

2. Combating drug-related crime

The purpose of crime prevention is to increase the likelihood of being caught with respect to aggravated narcotics offences and those involving distribution carried out in Finland. The aim is to implement criminal liability through seamless international co-operation with the offender's home country or country of residence. Drug imports are being combated through cooperation between the police, Customs and the Border Guard (PTR cooperation), the aim being to seize drugs at the border, except if a more comprehensive investigation of criminal activities calls for controlled delivery or similar measures. Control of the distribution of drugs and pharmaceuticals classified as drugs at the street level is part of the basic operations of the police. It is also important to uncover secondary drug-related crime such as money laundering and to recover criminal proceeds.

Goals for the current electoral period include:

- enhancing intelligence-led law enforcement between the law enforcement authorities,
- combating drug-related crime online,
- exploring how drug legislation can be revised to prevent the harmful effects of designer drugs, and
- increasing cooperation between laboratory authorities to prevent the harmful effects of designer drugs.

3. Prevention and treatment of drug-related harm

Under the Act on Welfare for Substance Abusers (41/1986), substance abuse services must be offered to substance problem users, their families and other people close to them to the extent determined by the client's need for help, support and treatment. The best interests of the problem user and people close to him/her must be prioritised. There is solid evidence that providing treatment for a drug abuser is ultimately less expensive for society than not providing treatment. What may complicate the handling of drug problems in the public service system is that drug use is a criminal offence and clients may not dare report their problems even if asked.

Recovering from a substance abuse problem is a long-term process requiring various kinds of treatment and support at various points along the way, and it would thus be important to retain diversity in substance abuse services. The Government Programme states the aim of increasing low-threshold services, health advisory services and outreach work for substance abusers. The threshold to treatment must be further lowered, and obstacles to seeking treatment removed. It is also important to bring the substance abuse services of local authorities, NGOs and parishes closer together in terms of development and supply.

Goals for the current electoral period include:

- ensuring the coverage and quality of health advisory services for substance abusers,
- exploring the current situation in the drug treatment system to improve the coverage of services,
- enhancing the efficiency of treatment referrals by the police,
- improving information exchange between the authorities, treatment services and peer group activities,
- preventing abuse of prescription drugs, and
- increasing opportunities available for treatment of substance abuse problems while serving a sentence for a criminal offence.

4. EU drug policy and international cooperation

In accordance with the Government Resolution on Finland's Policy in International Drug Control, Finland is participating actively in the planning and implementation of the forthcoming EU Drugs Strategy and Action Plan and in action against drugs in the drug policy contexts of the United Nations, the Council of Europe, Baltic regional cooperation and the Nordic Council of Ministers, and also in other established forums.

Finland aims to help dismantle overlaps in the activities of the EU and the Council of Europe. Finland also uses development cooperation funds for combating drug use.

Finland supports the leadership of the UN Office on Drugs and Crime (UNODC) in the planning and implementation of international drug control. Finland actively supports the efforts of the EU to enhance the drug strategy and actions of the EU in the context of the UN and in other international drug control cooperation.

Goals for the current electoral period include:

- clarifying Finland's actions in various forums, and
- continuing to support the drug control efforts of the UNODC through general funding and theme-based funding.

5. Information collection and research regarding drug problems

Research into drug use, drug markets, the treatment of drug users and methods of combating drug-related problems is being furthered and international co-operation by Finnish researchers promoted. Public opinion regarding drugs, their use and their harmful effect is canvassed regularly. National information is also submitted to the information-collecting systems of the EU and the UN. Drug-related research is being carried out by the National Institute for Health and Welfare, the National Research Institute of Legal Policy and universities, among others.

Goals for the current electoral period include:

- enhancing research in the sector, and
- developing drug policy evaluation as a tool for supporting decision-making.

1.3 Government programmes and working groups affecting drug policy

In 2011–2015, preventing poverty, inequality and social exclusion forms one of the three focus areas in the Government Programme. The Government's **cross-sectoral action plan for reducing social exclusion, poverty and health problems** aims to create a permanent operating model whereby the promoting of health and wellbeing and the reduction of inequality are mainstreamed into all public decision-making. The action plan includes spearhead projects in various administrative sectors aiming to facilitate participation. (Ministry of Social Affairs and Health 2012b).

Broad-based development of general welfare policy and of social welfare and health care services continues. The **National Development Plan for Social and Health Care Services (KASTE)** is in its second four-year period. (Ministry of Social Affairs and Health 2012c.) This plan focuses on primary health care, social welfare, first response care, mental health services and substance abuse services.

The **National Plan for Mental Health and Substance Abuse Work, Mieli 2009–2015** (Ministry of Social Affairs and Health 2009b) underlines prevention and early intervention as well as shifting the

service focus to primary and outpatient services. According to the plan, people with both mental health and substance abuse problems must be able to access services flexibly through a one-stop shop and on an equal basis in comparison to other people. To enable eventual operating reforms, the National Institute for Health and Welfare also published a guide to strategic planning in mental health and substance abuse services at the local or regional level. (Laitila et al. 2009.)

The Ministry of Social Affairs and Health and the National Institute for Health and Welfare are responsible for implementing the national plan for mental health and substance abuse work. The National Institute for Health and Welfare published a report on the national plan for mental health and substance abuse work, its reception⁸ and its implementation plan in 2010. (Partanen et al. 2010.)

Key areas of interest in the development of mental health and substance abuse services include experiential expertise and peer group support, reforming the legislation on compulsory care, new means for reducing coercive measures, and low-threshold basic services, extending far beyond public services to the third sector. This involves not only the social welfare and health care sector but also education, culture and other leisure functions, businesses and bodies responsible for housing and living environments. (Ministry of Social Affairs and Health 2009b).

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

The **Policy Programme for the Well-being of Children, Youth and Families 2007–2011** (Finnish Government 2007c) aimed to create a service system supporting families with children. A key priority was support services for children and young people, especially in the case of violence, mental health problems or intoxicant problems in families. The final report of this Policy Programme was published in 2011. It noted that legislation had been developed, successful efforts had been undertaken to prevent the social exclusion of young people, and low-threshold services for families had been increased. (Finnish Government 2011b.)

Under the Youth Act (72/2006), a youth policy development programme shall be prepared every fourth year. The first **Child and Youth Policy Development Programme 2007-2011** (Ministry of Education 2007) affirmed that the passing of mental health and substance abuse problems from one generation to the next is one of the most common paths to social exclusion. The programme underlined that cooperation between child welfare services, substance abuse services and mental health services must be strengthened to meet the welfare and rehabilitation needs of children whose parents require adult services. Regarding criminal law, mental health or substance abuse services could also be included in juvenile punishments. (Advisory Council for Youth Affairs 2011.) The statutory programme for 2012–2015 was completed in December 2011; it includes goals for preventing substance abuse among young people. (Ministry of Education and Culture 2012.)

⁸ In an open online survey targeted at municipal social welfare and health care services, NGOs, educational institutions and other bodies, the responses indicated that development of outpatient and basic services and strengthening the status of the client are seen as particularly important points. Criticism was voiced particularly regarding the weak presence of social services in the plan. Responses also showed concern about the threshold of access to treatment for substance abuse patients rising from its present level. The greatest uncertainty was prompted by the transfer of psychiatric hospital care to general hospitals.

⁹ Kaventaja service of the National Institute for Health and Welfare: http://kaventaja.thl.fi/fi_FI/web/kaventaja-fi

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

The **Internal Security Programme** is a regularly adopted extensive, cross-sectoral programme comprising measures in various administrative sectors to maintain and improve security. Previous Government Resolutions concerning such a programme were adopted in 2004 and 2008. Interim reports have been published annually on the implementation of the 2008 Internal Security Programme (Ministry of the Interior 2009; 2010; 2011). The programme for 2012–2015 is the third cross-sectoral programme of its kind. Because social exclusion causes security threats, one of the objectives of the programme is to reduce social exclusion. Social exclusion generally involves substance abuse, and the programme aims to target security threats related to alcohol and other substance abuse. (Ministry of the Interior 2012.)

A working group appointed by the Ministry of the Interior and the **Ministry of Social Affairs and Health** prepared a **report on the taking into custody, transport, treatment and care of intoxicated persons**. The working group concluded that the involvement of the police in the apprehension, transport and taking into custody of intoxicated persons should be reduced and the role of social welfare and health care professionals augmented. Sobering-up stations should be located adjacent to a health care emergency clinic, a substance abuse service unit or a police custody unit. Key development points included improving of substance abuse prevention and services for the homeless in order to reduce the need for taking intoxicated persons into custody, clarifying the role of the private security sector with regard to assignments involving intoxicated persons, trying out new operating models, and improving information exchange between actors and statistics compilation. Regional special features and the long distances in sparsely populated areas should be taken into account in the development. (Ministry of the Interior 2011b.)

1.4 Economic analysis

Public expenditure from drug-related harm

The expenditure incurred from drug-related harm by the Finnish government is calculated based on a long-established calculation framework. (Salomaa 1996; Hein & Salomaa 1998.) The calculation framework was updated in 2011 and 2012, and the expenditure figures given in this section were derived using the updated framework. Harm-related expenditure is published annually in the Yearbook of Alcohol and Drug Statistics published by THL. The expenditure incurred by the government given here is consistent with that given in the Yearbook of Alcohol and Drug Statistics for 2010.

In 2010, public expenditure¹¹ caused by drug use totalled approximately EUR 229 million, or about 0.2% of GDP. Public expenditure incurred from drug-related harm has increased by an average of 8% per annum in real terms between 2006 and 2010. The increase in expenditure has been notable in social services (22%). By comparison, public funding for substance abuse prevention has decreased by 23%. Public expenditure from drug-related harm consists mainly of the costs of treating and correcting problems. A large portion of the expenditure goes towards the enforcement of public order and safety. (Jääskeläinen 2012.)

The largest part of the public expenditure from drug-related harm, some EUR 77 million (30%), goes towards the enforcement of public order and safety, followed by EUR 58–60 million (23%) for court and prison costs from drug-related cases. Social services came third at EUR 43–61 million (23%). The majority of this expenditure was incurred through child welfare services (about EUR 31 million). (Jääskeläinen 2012.)

Expenditure from drug-related harm in health care is considered to include outpatient and inpatient care in primary health care and specialist medical care, which amounted to a total of EUR 28–48 million in 2010. Drug-related pensions and sickness allowances added up to EUR 7–21 million. Substance abuse

¹¹ The data used were obtained from budget reports and final accounts reports for the year published by ministries, public agencies and other public bodies.

prevention comprises the appropriations allocated by the Slot Machine Association. Substance abuse prevention may also be undertaken in municipalities on local government budget funds, but there is no way to include these costs in the calculation of expenditure from drug-related harm. Public funding for substance abuse prevention amounted to 4% of all public funding for treating drug-related harm, and has decreased by 23% in real terms between 2006 and 2010; mostly funds allocated to drug research and substance abuse work. (Jääskeläinen 2012.)

Table 1. Expenditure from drug-related harm by primary and secondary category in 2010, EUR million

	Minimum	Maximum	Average	Change on previous year, %
DIRECT COSTS	324.7	380.1	352.4	0.5
Health care costs	27.7	48.2	38.0	-1.1
Specialist medical care	24.0	37.5	30.7	-2.4
<i>*Somatic specialist medical care</i>	10.9	13.7	12.3	-4.8
<i>*Psychiatric specialist medical care</i>	13.1	23.8	18.4	-0.7
Primary health care	3.6	10.7	7.2	5.2
Pensions and sickness allowances	6.8	21.0	13.9	1.4
Disability pensions	3.0	16.9	9.9	4.1
Sickness allowances	0.8	1.3	1.1	-5.5
Family pensions	3.0	3.0	3.0	-2.1
Social services costs	49.4	67.9	58.6	2.0
Substance abuse services	15.8	32.8	24.3	-0.1
Income support	2.0	3.4	2.7	3.6
Child welfare services	31.3	31.3	31.3	3.7
Home services	0.3	0.4	0.3	4.0
Public order and safety	77.0	77.0	77.0	5.7
Police	44.0	44.0	44.0	16.1
Rescue services	22.2	22.2	22.2	-4.8
Customs	10.8	10.8	10.8	-7.0
Border Guard	-	-	-	-
Judicial system and prison service	57.9	59.9	58.9	1.7
Courts, prosecutors, legal aid and execution	12.2	14.2	13.2	14.9
Prison service	45.3	45.3	45.3	-1.8
Other	0.4	0.5	0.4	30.9
Accidents and criminal damage	96.4	96.4	96.4	-2.7
Other expenditure				
General substance abuse prevention	9.6	9.6	9.6	-13.6

*) Classification according to the Classification of the Functions of Government (COFOG).

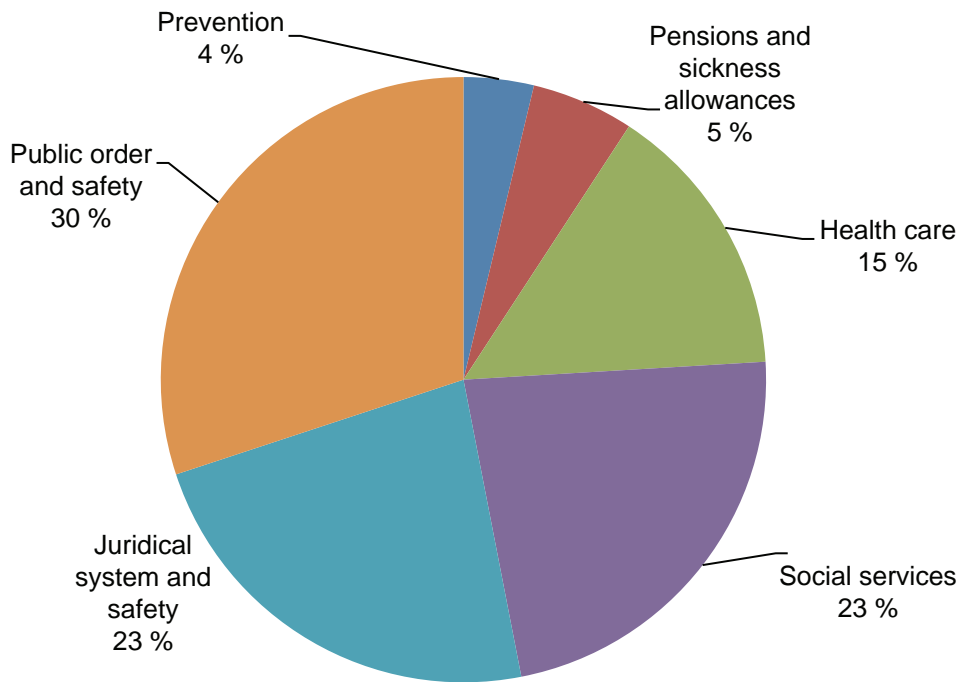


Figure 1. Breakdown of public expenditure from drug-related harm in 2010.

Source: Expenditure from drug-related harm 2010, National Institute for Health and Welfare.

Social costs related to drugs

In 2010, costs related to the abuse of drugs and pharmaceuticals amounted to about EUR 229 to 284 million in social costs (Table 2). Social costs include not only public-sector costs but also costs incurred by enterprises and households. Social costs include insurance compensation paid as a result of drug-related injuries, fires and traffic accidents, and criminal damages. In all, the costs of damage from drug-related accidents and crimes in 2010 amounted to EUR 96 million. Between 2006 and 2010, expenditure from drug-related harm decreased by an average of 9% per annum in real terms. This, however, was mainly due to a decrease in insurance compensation paid on accidents. (Jääskeläinen 2012.)

Expenditure from drug-related harm amounted to about 0.2% of GDP in 2010, or 0.1 percentage points less than in 2009. This decrease was due to the fact that the expenditure itself remained virtually the same but GDP went up. Expenditure from drug-related harm accounted for 2.8% of the costs of maintaining public order and safety paid by central and local government. (Jääskeläinen 2012.)

Table 2. Expenditure from drug-related harm by main group in 2006–2010 (at market prices), EUR million.

	Health care		Pensions and sickness allowances		Social welfare		Maintaining public order and safety		Judicial system and prison service		Other (substance abuse prevention)		Accidents and criminal damage		Expenditure total	
	Min	Max	Min	Max	Min	Max	Min	Max	Min	Max	Min	Max	Min	Max	Min	Max
2006	24	41	6	19	37	52	67	67	51	52	12	12	98	98	295	341
2007	25	43	7	20	41	56	69	69	54	56	13	13	95	95	303	352
2008	28	48	7	19	45	62	73	73	57	59	11	11	96	96	317	368
2009	28	48	7	20	48	67	73	73	57	59	11	11	99	99	324	377
2010	28	48	7	21	49	68	77	77	58	60	10	10	96	96	325	380

Source: Expenditure from drug-related harm 2010, National Institute for Health and Welfare.

2 Drug use in the population

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

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

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

2.1 Drug experimentation in Finland

According to the population study results from 2010, the percentage of the population aged 15 to 69 who had at some point in their lives tried cannabis was 17%.¹² The percentage was 13% among women and 20% among men. There was a heightened incidence of experimentation, 36%, in the young adult age group (aged 25–34). The percentage of those who had at some point in their lives tried other drugs was 2.1% for amphetamines, 1.7% for ecstasy, 1.5% for cocaine and 1.0% for opiates. In the age group of young adults aged 25 to 34, the percentage of those who had at some point in their lives tried other drugs was 6.4% for amphetamines, 5.9% for ecstasy, 4.3% for cocaine and just under 3% for opiates. Based on the survey, a total of 4% had tried cannabis during the past year, and far less than 1% had experimented with other substances. The percentage of those who had tried cannabis during the past month was 1%. Hypnotics, sedatives or painkillers had been misused by 6.5% of the general population at some point in their lives, misuse being defined as using them for non-medicinal purposes, without a physician's prescription or in larger doses than prescribed, the most common motive for such usage being the ability to sleep soundly. The percentage of misuse of pharmaceuticals was 9.9% in the age group of young adults aged 25 to 34. (Hakkarainen et al. 2011a; Hakkarainen et al. 2011b.)

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

¹² The sample space of the study comprised Finns aged 15 to 69, from whom a random sample of 4,250 people was chosen in autumn 2010. The basic sample consisted of 3,000 randomly chosen members of the target group, while the additional sample consisted of 1,250 members of the age group 15 to 39. The aim of the oversampling was to focus the study on the most active population group in terms of drug use. The participants were given the options of responding online or returning a questionnaire by mail. Online responses were protected by personal IDs and passwords. To increase the response rate, the participants were sent a reminder form twice. A total of 2,023 responses were received (48%), the lowest response rate ever in this series of studies that had begun in 1992. (Hakkarainen et al. 2011b.)

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

The percentage of those who had tried cannabis during the past month remained at 3% in the 15–34 group but was only 1% in the 35–44 age group, demonstrating that long-term, regular use of cannabis has not become a widespread phenomenon, at least not yet. An exception to this rule is formed by men who began their drug use around the turn of the 2000s; no fewer than 15% of them reported that they had used cannabis during the past year, and 5% during the past month. (Hakkarainen et al. 2010b.)

Table 3. Lifetime and 12-month prevalence of cannabis use by age group, 1992–2010, %.

		1992	1996	1998	2002	2006	2010
Lifetime	All	5	8	10	12	13	17
	15-24	12*	14**	19	25	19	21
	25-34	10	16	19	19	25	36
	33-44	4	8	19	11	16	22
	45-69	1	2	8	4	6	6
12 month prevalence	All	1	2	3	3	3	4
	15-24	6*	9**	10	11	9	12
	25-34	2	3	3	4	7	11
	33-44	0	1	0	1	2	1
	45-69	0	0	0	0	1	0
* = 18–24-ages; ** = 16–24-ages							

Source: Hakkarainen et al. 2011b.

In Finland, alcohol use and related problems have traditionally been far more common than drug use and related problems. However, drug use has increased substantially over the past 15 years. But how are alcohol use and drug use linked in Finland? This question was approached by combining data from the questionnaires from 1998, 2002 and 2004 referred to above. The material was divided into five categories: (1) persons who had never encountered drugs, (2) persons with occasional drug encounters, (3) persons who had tried drugs, (4) cannabis users and (5) multi-substance users.¹³ (Hakkarainen & Metso 2009.)

¹³ The categories were more specifically defined as follows: (1) persons who had never been offered drugs and had never tried them; (2) persons who had been offered drugs but had never tried them; (3) persons who had at some time tried drugs but had not used or tried them within the past 12 months, or who had tried drugs for the first time within the past 12 months; (4) persons who had used cannabis within the

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

A more recent phenomenon in Finnish drug use, emerging in the late 2000s, is the rapid increase in the home growing of cannabis. This phenomenon manifests itself in crime statistics and has also been probed by survey.¹⁴ Seizure statistics show that while the number of cannabis plants seized annually was only a few hundred in the 1990s, this figure had ballooned to several thousand by the 2000s, and in 2010 the number of plants seized was 15,000. A similar rapid growth may be seen by comparing the data from the 2008 and 2010 population studies. In 2008, the lifetime prevalence of hashish was greater than that of marijuana (10% vs. 9%), but by 2010 their positions had switched (12% vs. 13%). In terms of 12-month prevalence, cannabis overtook hashish in 2008, and according to the 2010 population study, 2% of the adult population had used hashish but 4% had used marijuana. Moreover, 10% of the respondents declared that they personally knew someone who was growing cannabis, even though only 1% had themselves engaged in home growing. Nevertheless, the obvious shift in the relative status of hashish and marijuana experiments is probably largely due to increased domestic home growing of cannabis. By comparing the responses to questions concerning home growing during the past month, the researchers estimated that there must be almost 10,000 active home growers of cannabis in Finland. (Hakkarainen et al. 2011a.)

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

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

past 12 months and before that and who had tried (no more than two) other drugs; and (5) persons who had been using more than two different drugs, also within the past 12 months. In all, the study included data on 7,227 persons. Logistical regression analysis was used.

¹⁴ Finnish home growers of cannabis were recruited for the study via a website dedicated to the subject. The interviews (38) were conducted in 2008. There were 36 men and 2 women, most of them (55%) in the 25 to 34 age group. Also, an anonymous online questionnaire was targeted at Finnish home growers of cannabis in 2009. There were 1,298 respondents, 80% of whom had grown cannabis during the past year. The research material was compared to the results of the 2008 population survey and the preliminary results of the 2010 population survey. (Hakkarainen et al. 2011a; Hakkarainen et al. 2011b.)

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

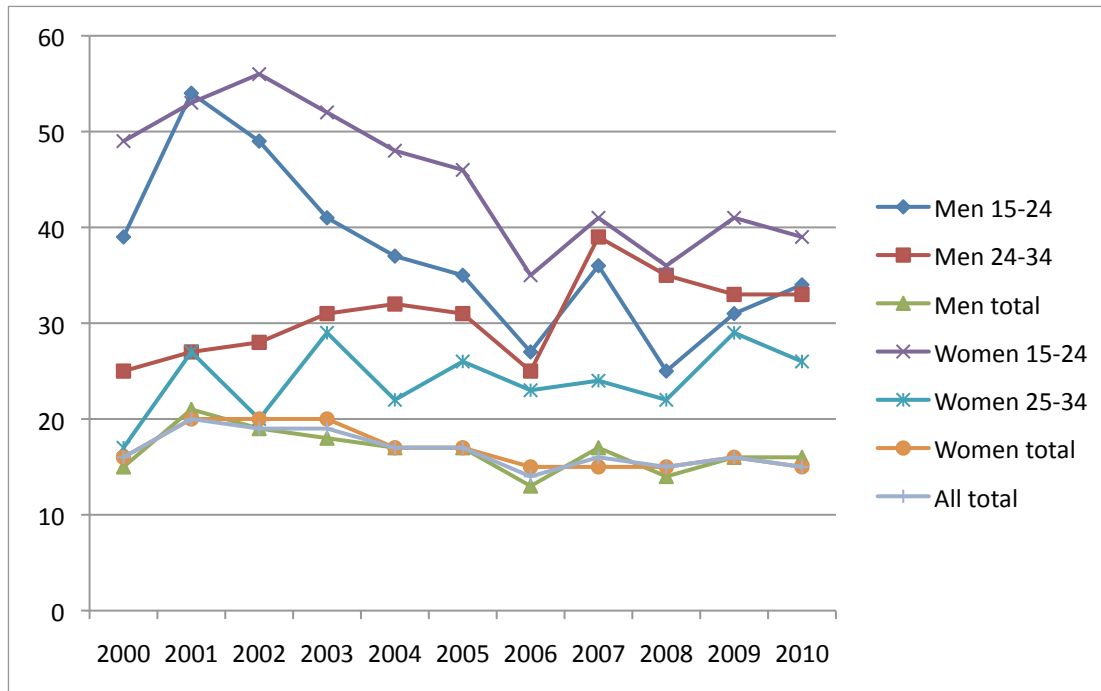


Figure 2. People who know at least one person who has experimented with drugs during the past year, %.

Source: Helakorpi et al. 2011.

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

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

position in the partying habits of young urban adults (men) and recreational use and as a cause of social exclusion related to substance abuse. (Hakkarainen et al. 2010b.)

2.2 Drug use in the school and youth population

According to the 2011 ESPAD survey of school pupils, 12% of boys and 10% of girls aged 15 to 16 had experimented with cannabis at some time in their lives, whereas the corresponding figure was 10% in 1999, 11% in 2003 and 8% in 2007. The 2011 ESPAD survey was the first of its kind in Finland to include separate questions on hashish use, marijuana use and home growing of marijuana. Hashish use was reported by 7% of the boys and marijuana use by 10%, while the figures for girls were 4% and 6%, respectively; 12% of the boys and 10% of the girls reported that they knew someone who had grown cannabis at home. Among the pupils themselves, however, home growing was extremely rare: only 1% of the boys and none of the girls reported having grown cannabis at home at some time. For other drugs, the trend has been rather stable: in 2011, 5% reported that they had tried an illegal drug besides cannabis at some time in their lives. (Raitasalo et al. 2012.)

Drug use among school pupils is also surveyed in the national school health survey, which on a biennial cycle covers half of Finland's municipalities each year and is aimed at 8th and 9th grades in comprehensive school and the 1st and 2nd years of upper secondary school.¹⁶

The distribution data are fairly even regionally except for southern Finland, where levels were on average one third higher than in the rest of the country. However, there are differences according to educational attainment. In 2010–2011, an estimated 14% of students in the 1st and 2nd years of upper secondary school had tried illegal drugs at some time in their lives, while the figure for students in the 1st and 2nd years of vocational education was 21%. (School health survey 2011.)

¹⁶ The national school health survey is conducted under a teacher's guidance during one class period. The respondents return their anonymous forms to the teacher, who seals all the forms for that class in an envelope in the presence of the pupils. The class envelopes are then put together in a package by the school and sent to the research group. Finland has been divided into two geographical areas, each surveyed in alternate years. In examining trends and changes, comparable material is used from those schools that have participated in the survey every time, whether in odd-numbered or even-numbered years. A total of 535 comprehensive schools and 321 upper secondary schools were included. The combined data from odd-numbered and even-numbered years included 81,057 to 83,915 respondents per year in comprehensive school and 39,084 to 43,242 in upper secondary school. The change data covered, depending on the years considered, between 61% and 65% of all pupils in the 8th and 9th grades of comprehensive school in Finland and between 51% and 58% of all pupils in the 1st and 2nd years of upper secondary school. (Luopa et al. 2010.)

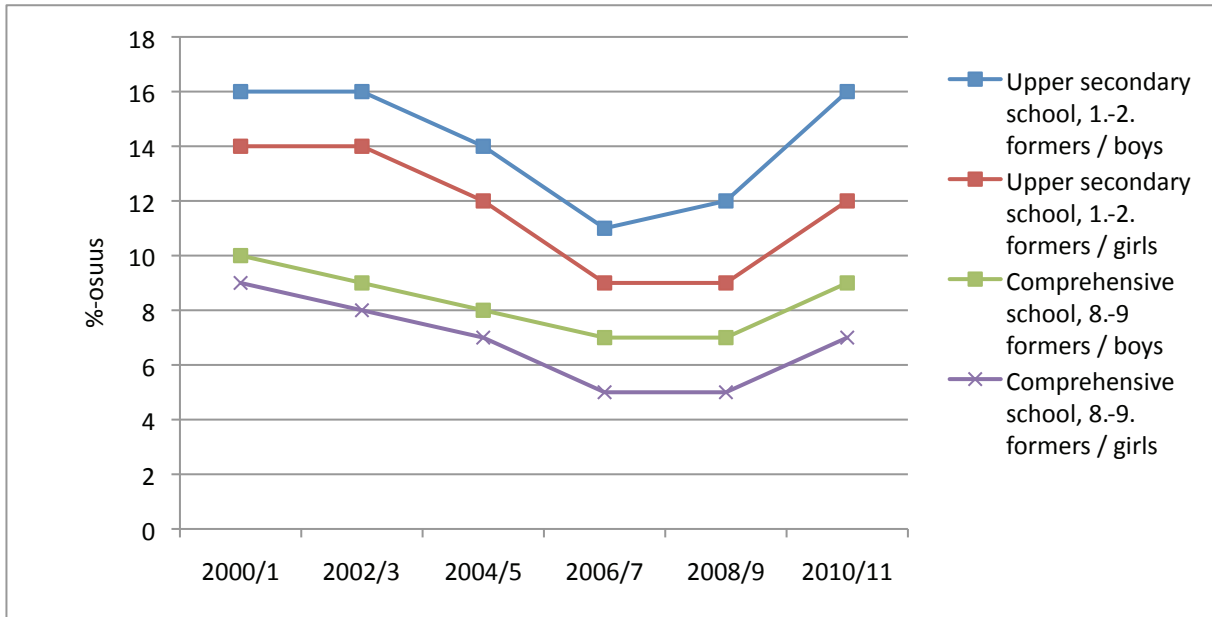


Figure 3. School health survey: Students who had tried illegal drugs at least once, %

Source: School health survey 2011.

The ESPAD study also included questions on the risks of intoxicant use. There was no significant difference between boys and girls in the appreciation of the risks involved in trying cannabis. In 2011, just under 30% of both boys and girls considered that trying cannabis involved high risk. The percentage of those who consider the risks of trying cannabis to be high has decreased steadily except for a slight upward bump between 2003 and 2007. The appreciation of the risks involved in trying ecstasy or amphetamines has also decreased among young people, more among boys than among girls. (Raitasalo et al. 2012.)

The questions in the national Adolescent Health and Lifestyle Survey,¹⁷ aimed at young people aged 12 to 18, enable the analysis of their 'social exposure to drugs'. Respondents are asked whether any of their acquaintances has experimented with intoxicants or whether they themselves have been offered such substances. The survey indicates that the percentage of young people aged 14 to 18 with at least one acquaintance who has experimented with drugs increased between 1987 and 2001 and then started to fall before levelling off in 2007. The 2011 survey shows that the majority of drug offers are made by friends and acquaintances, which indicates that drugs have become part of young people's everyday lives and that availability is not particularly scarce nor dependent solely on supply from external sources. In 2011, one in six boys and girls aged 18 had been offered drugs. (Raisamo et al. 2011.)

¹⁷ The survey takes the form of a postal survey repeated every other year, the first being conducted in 1977. The survey sample is selected from among those aged 12, 14, 16 and 18. For those who have not responded, the survey includes two new questionnaires, the final one being available in electronic format. The 2011 survey covered a total of 4,566 youth respondents (response rate 47%). (Raisamo S et al. 2011.)

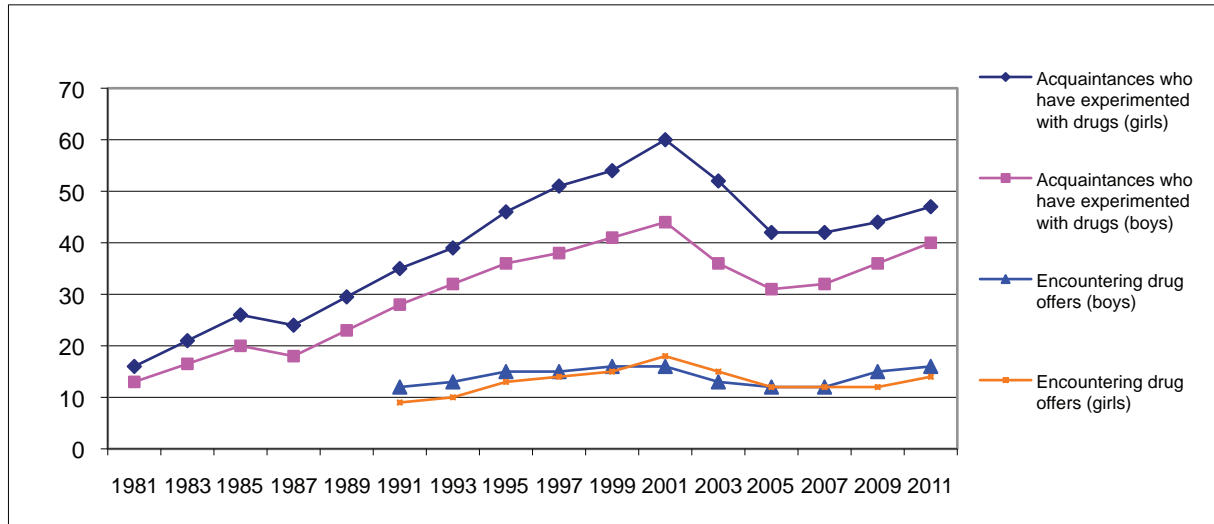


Figure 4. Social exposure to drugs among 14 to 18-year-olds (percentage, age-adjusted and gender-adjusted).

Source: Raisamo et al. 2011.

Links between adolescents' experiences of bullying at school and using drugs were explored in a nationwide study where the relevant responses from a survey of 8-year-old schoolchildren (boys) and interviews with their parents and teachers were compared with interview responses over a 10-year follow-up period.¹⁸ The results indicate that a boy being a bully at school at the age of 8 is a fairly reliable predictor of experimentation in drug use later, at the age of 18. Regular bullying also seemed to predict later drug use fairly well independently of the other variables taken into account in the study. Being bullied, by contrast, actually seemed to decrease the likelihood of drug use at a later age. As regards regular smoking, the correlation was completely reversed. The researchers explain the link between bullying and later drug use by referring to the antisocial personality characteristics of bullies. It should be noted, though, that the study only concerned boys. (Niemelä et al. 2011.)

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

The study examining the effects of individual, peer group and family variants on drug use¹⁹ therefore found that 13.5% of the twins included in the study had experimented with cannabis by the age of 17.5

¹⁸ The research material was collected in 1988 and 1998. The 1989 material consists of a 10% random sample of the entire age group of 8-year-olds in that year. There were 2,946 boys. For these children, interviews with their parents and teachers were included in the study. Concerning school bullying, the children were asked both about being a victim and being a bully, whereas parents and teachers were only asked about being a victim. The follow-up study was conducted in 1999; about 78% of the original research target group responded to questions about tobacco, alcohol and drug use. The results are somewhat skewed by the fact that there were more subjects who had reported being bullied at school in the loss-to-follow-up group than there were among respondents to the follow-up survey. Logistical regression analysis was used. (Niemelä et al. 2011.)

¹⁹ Research data consisted of five full birth cohorts of twins from 1983 to 1987 (n=5,600 twins), baseline surveys targeted at the twins and their parents when the twins were aged 11 to 12 (coverage 87%), a follow-up survey when they were aged 14 (coverage 88%) and a second follow-up survey when they were aged 17.5 (coverage 92%). The data also included teacher assessments of twins aged 11 to 12 years. The

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

In the most recently published twin study, the analysis of a possible connection between smoking and drug use was explored on the basis of surveys among subjects aged 17.5 years.²⁰ The study compared structural equation models, the first assuming that smoking had a cause-and-effect impact on starting drug use and the second assuming that shared genetic and/or environmental factors underlie both. In both models, genetics had a lot to do with both starting smoking and starting drug use. The model where early smoking was assumed to influence drug use fit the data somewhat better, but shared genes could not be completely ruled out. By contrast, starting smoking had no direct impact on continued drug use (using drugs more than four times during their lifetime); the impact of smoking was indirect, through starting drug use. As a factor in continuing drug use, individual environmental factors emerged as more significant than they were for continuing smoking (smoking more than 50 times during their lifetime). (Huizink et al. 2010.)

2.3 Drug use by university students

In 2008, a survey was conducted among students at universities and universities of applied sciences to explore their health, health behaviour, related factors and use of health care services.²¹ The average age of respondents was 24 at universities of applied sciences and one year more at universities. Women accounted for 63% of the respondents. With regard to intoxicant use, it was found that more than 90% of students use alcohol and that one in four men and almost one in ten women have more than 6 units at a time each week. 22% of students reported that they had tried cannabis at some time in their lives; about one in three of these had tried it during the past year. The figure for other drugs was about 3%, of which likewise about one in three during the past year. The percentage of cannabis users was higher among men, but there were no significant differences relative to educational attainment. (Kunttu & Huttunen 2009.)

According to Kunttu & Huttunen, the lowest level of alcohol use by faculty was found among students of medicine. A voluntary survey on intoxicant use among students was conducted at a general examination session at the Faculty of Medicine at the University of Tampere in 2007.²² The average age of respondents was

cluster of determinants was selected based on a literature review and assessed using the baseline survey and the first follow-up survey, while drug use was gauged through the survey addressed at 17.5-year-olds. After cleaning and inspection, the final data comprised information on 3,118 persons (twins). These data were analysed using logistic and conditional logistic regression analyses by using the odds ratio as a measure of association. (Korhonen et al. 2008.) A comprehensive description of the twin study can be found here: <http://wiki.helsinki.fi/display/twineng/Finntwin12>.

²⁰ The material was obtained from the twin study referred to in the previous footnote. This time, tobacco and drug use was studied among 17.5-year-olds, and finally the material consisting of data on 3,744 twins was analysed. The material was analysed using a model with two alternative multiple variable methods and standard statistical tests. (Huizink et al. 2010.)

²¹ The sample space of the study in 2008 consisted of Finnish students aged under 35 studying for a bachelor's degree at a university of applied sciences (sample 4,984, 46% men) or a university (sample 4,983, 45% men). The total response rate, after three reminders, was 51% for students at universities of applied sciences and somewhat higher, 55%, for university students. A similar study was conducted among university students only in 2000 and 2004. (Kunttu & Huttunen 2009.)

²² The sample space of the study consisted of 1st to 5th year students at the Faculty of Medicine at the University of Tampere. The questionnaire was distributed at a compulsory examination session. There were 497 students at the examination, and 468 acceptable forms were returned (response rate 94%).

24, and 62% of them were women. The survey indicated that while more than 90% of students used alcohol, the percentage of those who drank more than 6 units at one time at least once a week was more than 25% among men but only about 2% among women. 23% of the students had tried cannabis, but fewer than 2% had tried other drugs. The incidence of cannabis experimentation was the same among men and women. (Meriläinen et al. 2010.)

3 Prevention

3.1 General remarks on substance abuse prevention in Finland

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

Substance abuse prevention is principally governed by the Temperance Work Act (828/1982), the Temperance Work Decree (822/1976) and the Act on Welfare for Substance Abusers (41/1986). Provisions concerning preventive substance abuse work are laid down in the Temperance Work Act (828/1982). This Act defines the purpose of temperance work as habituating citizens to healthy lifestyles by guiding them in avoidance of the use of substances and tobacco. According to the Act, the establishment of general prerequisites for substance abuse prevention is primarily the task of central and local government. Practical measures in this area are generally undertaken by local authorities and by temperance and public health organisations. Pursuant to the Act, each local authority must have a designated body responsible for temperance work. This body must cooperate with the local health care, social welfare and education services in particular. The Temperance Work Act is scheduled for revision in 2013. The purpose of this revision is to develop local measures for prevention of harmful impacts of substance abuse. The Temperance Work Decree (233/1983) further specifies that this body must cooperate with organisations engaging in temperance work and substance abuse prevention and promoting healthy lifestyles. Section 17 of the Local Government Act states that a 'municipal body' is the municipal council, the municipal board, a committee or another body appointed by the council with decision-making powers. When the Temperance Work Act entered into force in 1984, temperance committees in municipalities were disbanded and the duties specified in the Act were to be assigned to another municipal body, generally the social services committee, the health care committee or the education committee. (Strand 2011.) The purpose of the Act on Welfare for Substance Abusers (41/1986) is to prevent and reduce problem drug use and related harmful social and health impacts, and also to enhance the functional capacity and safety of substance abusers and persons close to them.

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

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

Local authorities are recommended to have a mental health and substance abuse service strategy in place, defining the responsibilities of substance abuse services at health centres. (Ministry of Social Affairs

and Health 2009b.) However, a study²³ shows that only 69% of health centres have an approved strategy for substance abuse services. Moreover, only 65% of health centres have a plan approved by management for reducing harm caused by substance abuse. In the study, 73% of health centres stated that they undertake mini-interventions aimed at reducing alcohol use. Health counselling for drug users was only provided by one in three health centres (35%), and 40% had agreed on shared practices for identifying drug users. (Rimpelä et al. 2009a.)

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

Development of the municipal and regional networks for substance abuse prevention is carried out within the framework of the National Alcohol Programme, whose principal coordinator is the National Institute for Health and Welfare. All six Regional State Administrative Agencies have a regional coordinator for the National Alcohol Programme responsible for implementation of the Programme goals in their respective regions and for coordinating actions to prevent harm from substance abuse. In addition, THL is developing the regional developer network for substance abuse. It also collects and disseminates best practices in the field. Substance abuse prevention involves not only municipalities: NGOs and other third-sector actors play a central role in the practical work of substance abuse prevention both as individual actors and as service providers for municipalities. The NGOs aim to promote discussion and provide information on drugs, drug use and the related causes and consequences. In addition, NGOs attempt to influence public attitudes, organise peer support activities and provide post-care for substance abuse patients.

Quality criteria have been determined for substance abuse prevention. The criteria are qualitative and suited to the prevention and reduction of harm related to substance abuse.²⁴ The practical implementation of the quality criteria is considered a central tool in improving the quality of substance abuse prevention. These quality criteria do not separate drug prevention from other substance abuse prevention. (STAKES 2006.)

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

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

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

²³ Directors of health centres (n=231) were sent an online survey in October 2008, requesting a joint response from the management group. In addition to aspects of actively promoting health among the population, the questionnaire included questions on how the management viewed health promotion and key public health programmes. Responses were received from 190 health centres (82%), including all of the largest ones (50,000+ residents) and 89% of the medium-size ones (20,000 to 49,999 residents).

²⁴ Criteria: focus of the work, target group, degree of effectiveness, knowledge base, values, realistic objectives, compatibility of the objectives with other strategies, operational models, resources, monitoring and evaluation, balance in the different subsections and relationship to the original situation.

3.2 Environmental prevention

Regulation of taxes on alcoholic beverages is one of the principal tools of alcohol policy. The taxation of alcoholic beverages has been amended several times in the 2000s. The tax rates were lowered when Estonia joined the EU in 2004. This was motivated by an increase in passenger imports of alcohol. Since then, taxes have again been raised, four times in all (in 2008, twice in 2009, and in 2012).²⁵

The blood alcohol limit for drunk driving in Finland is 0.05%, and 0.12% for aggravated drunk driving. Offenders who have active substances of narcotics or their metabolic products in their blood may also be sentenced for drunk driving or aggravated drunk driving.

The sale and delivery of mild alcoholic beverages (up to 22%) to persons under 18 years of age is prohibited, and the sale and delivery of strong alcoholic beverages (over 22%) to persons under 20 years of age is prohibited. Possession of alcoholic beverages by persons under 18 years of age is prohibited, and possession of strong alcoholic beverages by persons under 20 years of age is prohibited. Alcoholic beverages with an alcohol content of no more than 4.7% may be sold in food shops; Alko has a monopoly on the retail sale of all products with a higher alcohol content. Retail outlets are only allowed to sell alcoholic beverages between 09.00 and 21.00. Advertising mild alcoholic beverages is basically allowed. However, advertising for alcoholic beverages must be restrained and conservative and must not be designed to attract 'weak consumer groups' such as heavy drinkers or young people. It is inappropriate to depict the intoxicating properties or plentiful consumption of alcoholic beverages in a positive light, or to give a misleading impression of the properties or effects of alcohol. (National Supervisory Authority for Welfare and Health 2010.)

There are a number of legislative provisions governing the marketing and sale of alcoholic beverages in licensed restaurants and also smoking in such premises. The Regional State Administrative Agencies supervise retail sales of alcoholic beverages, licensed restaurants and advertising and promotion for alcoholic beverages in their regions. The National Supervisory Authority for Welfare and Health (Valvira) is authorised to carry out supervision nationwide. (National Supervisory Authority for Welfare and Health 2010.) The sale and delivery of tobacco products to persons under 18 years of age is prohibited. The advertising of tobacco products in Finland is prohibited. As of the beginning of 2012, tobacco brands may

²⁵ ALCOHOLIC BEVERAGES

Ethyl alcohol content, % by volume	Product group	Tax
<i>Beer</i>		
– over 0.5 but no more than 2.8	11.	EUR 0.04 per centilitre of ethyl alcohol
– over 2.8	12.	EUR 0.299 per centilitre of ethyl alcohol
<i>Wine and other alcoholic beverages produced by fermentation</i>		
– over 1.2 but no more than 2.8	21.	EUR 0.11 per litre of alcoholic beverage
– over 2.8 but no more than 5.5	22.	EUR 1.59 per litre of alcoholic beverage
– over 5.5 but no more than 8	23.	EUR 2.24 per litre of alcoholic beverage
– over 8 but no more than 15	24.	EUR 3.12 per litre of alcoholic beverage
<i>Wine</i>		
– over 15 but no more than 18	25.	EUR 3.12 per litre of alcoholic beverage
<i>Intermediate products</i>		
– over 1.2 but no more than 15	31.	EUR 3.79 per litre of alcoholic beverage
– over 15 but no more than 22	32.	EUR 6.25 per litre of alcoholic beverage
<i>Ethyl alcohol</i>		
Products under CN code 2208:		
– over 1.2 but no more than 2.8	41.	EUR 0.04 per centilitre of ethyl alcohol
– over 2.8	45.	EUR 0.434 per centilitre of ethyl alcohol
Others	46.	EUR 0.434 per centilitre of ethyl alcohol

not be displayed to retail customers even at point of sale. Smoking is banned in all public indoor spaces. Many workplaces have declared themselves non-smoking workplaces.²⁶

3.3 General substance abuse prevention

Youth work and policy

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

Preventiimi, a national knowledge centre for youth substance abuse prevention, has published support materials for high-quality substance abuse education. In its guide, preventive substance abuse work with young people is considered to include social empowering, general prevention and risk prevention. The purpose of general prevention is to provide young people with current information on various intoxicants and the risks caused by their use. In addition to health risks, these include problems that substance abuse may cause in relationships with friends, in school work and in families. How these matters are discussed and from what perspectives, and which examples are used, should be as closely related to the young people's own experiences as possible. Simply dishing out information is not necessarily enough. Efforts should also be made to ensure that the young people can process the information given to them and that the understanding they gain is relevant for their world. (Pylkkänen et al. 2009.)

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

Preventiimi, which is administered by HUMAK University of Applied Sciences, also provides professionals with continuing education in substance abuse prevention for young people. Preventiimi is one of the national youth service and development centres designated by the Ministry of Education and Culture in a resolution adopted in 2010. Preventiimi provides training in substance abuse prevention for youth work professionals and others involved with young people, networking with local authorities and NGOs. The Preventiimi centre has developed and provided training in substance abuse prevention aimed at young people. Its projects also support prevention at schools, and it has produced a variety of materials. Support for projects aimed at young immigrants has been increased. Several hundred young people have participated in the international youth education programme Avartti, which is intended for all young

²⁶ TOBACCO PRODUCTS

Product	Product group	EUR/unit	% of retail price
Cigarettes	1.	22.50/1,000 pcs	52,0
-- Minimum tax on cigarettes	1A.	146.00/1,000 pcs	–
Cigars and cigarillos	2.	–	27,0
Pipe and cigarette tobacco	3.	13.50/kg	48,0
Fine-cut tobacco for self-rolled cigarettes	4.	16.50/kg	52,0
-- Minimum tax on fine-cut tobacco for self-rolled cigarettes	4A.	87.50/kg	–
Cigarette paper	5.	–	60,0
Other product containing tobacco	6.	–	60,0

people. The website of Preventiimi, a knowledge centre for youth substance abuse prevention, is at www.preventiimi.fi.

General substance abuse prevention at school

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

Substance abuse prevention at schools consists of:

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

According to a recent evaluation study, both teachers and pupils in Finland are highly motivated to engage in the health education subject: teachers and pupils alike feel that there is much discussion in health education classes, and a notable percentage of pupils discuss the topics with their friends and parents after the classes. A qualification in health education is being required from teachers after a transition period, as of the beginning of 2012. (Aira 2010.)

Because substance abuse education is integrated into the school curriculum, school-based drug prevention programmes play a secondary role in Finland's drug strategy. Schools may decide for themselves whether to implement such programmes, and they are not systematically monitored. In 2008, two thirds of all upper-level comprehensive schools held health theme days, and more than one in ten held health theme weeks. (Aira 2010.) The police have cooperated closely with schools in anti-drug efforts and have appointed a liaison officer for each school. School resource officers and community policing have enabled the police to establish a close co-operation. The police have published information locally and nationwide on drug-related crime, designer drugs, drug offences under investigation and their backgrounds. The information published is preventive in nature and specifically targeted at adolescents who are susceptible to experimenting with drugs.

3.4 Selective substance abuse prevention

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

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

In surveys for the promotion of health and wellbeing at upper secondary schools and vocational education institutions,²⁷ respondents were asked what the procedure was when drug use was suspected. In all, the number of cases of drug use reported was very low, though notably higher at vocational education institutions (n=29) than at upper secondary schools (n=13). Generally, the procedure was for a teacher, group leader or headmaster to talk to the student in question. Vocational education institutions are markedly more active in referring students to student health care in these cases and also in contacting the parents in the case of a student aged under 18 and/or child welfare services and/or the police. (Rimpelä et al. 2009b; Väyrynen et al. 2009.)

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

As of 1 January 2012, the Association for Healthy Lifestyles, the Terveys-Hälsan association and the Life is the Best Drug association merged into the EHYT association for substance abuse prevention. The creation of EHYT as an umbrella organisation established a single solid platform for a broad-based approach to substance abuse prevention. In the field of drug prevention work, this led to the setting up of a joint drug prevention working group organised by the coordination unit of EHYT. The working group began its work in 2011. Improving cooperation in the field of drug prevention work is the key task of the working group, which is an open network whose members currently include an expert member from the National Institute for Health and Welfare, the Elämäni Sankari association, Free from Drugs, YAD Youth Against Drugs, Music Against Drugs, the Omaisiet huumetyön tukena [Families supporting drug prevention work] association, the Stop Huumeille [Stop drugs] association, the A Clinic Foundation, the Finnish Red Cross, the Nykterhetsförbundet Hälsa och Trafik temperance league and the Finnish Blue Ribbon, in addition to an expert member from the National Institute for Health and Welfare.

Free from Drugs is a national volunteer organisation for preventive and corrective substance abuse work founded in 1984. The *Avaa silmäsi* [Open your eyes] campaign co-organised with the Finnish Parents' League reached thousands of parents and guardians nationwide, warning them against the proliferation of cannabis. In 2011, the *avaasilmasi* website recorded 16,000 visitors. The professional unit of the association, the Family Support Centre, engages in family-oriented drug prevention work and serves as a low-threshold service centre in the Greater Helsinki area and nationwide.

YAD Youth Against Drugs is a national substance abuse prevention association. Founded in 1988, it relies on volunteer action by adolescents and young adults. Up-to-date drug use prevention and supporting materials with informative and emotive content are key elements in the operations of the association, which are based on peer influence. A new departure in recent years is the Street Team, a low-threshold volunteer task force with online guidance, offering opportunities for participating in substance abuse prevention regardless of time or place. In 2011, the association offered activities and employment for drug use rehabilitees, and there are plans for recruiting recovering drug users as experiential experts in substance abuse prevention.

Music Against Drugs is a substance abuse prevention association that promotes the health and social wellbeing of children and adolescents. In 2011, the association organised Music Against Drugs events at four locations in Finland, featuring a variety of substance abuse prevention methods.

In 2011, the *A Clinic Foundation* continued to provide health and social guidance related to drug use, outreach work, peer support services, substitution treatment, detoxification treatment, therapeutic work at A Clinics and youth stations, institutional rehabilitation with both non-medical and medication-supported

²⁷ A largely coherent survey was conducted in 2008 among all upper secondary schools (n=416) and institutions with vocational upper secondary qualification programmes (n=192). The response rate was 90% for upper secondary schools and 84% for the other institutions.

approaches, and community therapy. Drugs were featured in a large number of studies, student theses and development project, such as the Huuko project, which has been running since 2001. In 2011, the project involved networking actors involved in substance abuse and mental health services, enhancing their expertise and disseminating good practices. Drugs were also prominently featured in the publicity and online services of the A Clinic Foundation. The *Päihdelinkki* online service, launched in 1996, reaches an average of 82,000 individual visitors each month. Discussing all types of intoxicants and addictions, this is a service that provides both citizens and professionals with information, tests, peer support and advisory services. The services of the A Clinic Foundation are being developed in cooperation with clients and partners.

3.5 Targeted substance abuse prevention

Targeted substance abuse prevention aimed at young people often takes place in sheltered youth homes, rehabilitation units for young people and workshops. Substance abuse treatment and rehabilitation for young people is also a form of risk prevention, being aimed at discouraging them from returning to an intoxicant-favouring lifestyle. (Pylkkänen et al. 2009.)

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

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

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

Health counselling centres²⁸ engage in risk group prevention. Local authorities and NGOs also perform outreach work to find individuals not covered by services, such as school dropouts or drug users who do not use the services of the health counselling centres. Targeted information about the risks of drug use is also provided by NGOs in various relevant environments such as rock festivals or techno music events. (See e.g. Finnish Red Cross 2010; YAD 2011.)

²⁸ See chapter 7. Responses to health correlates and consequences.

3.6 National and local media campaigns

Traffic and waterway safety campaigns are organised annually, focusing on all substance abuse. A general intoxicant education campaign is also conducted during the annual substance abuse prevention week (week 45). Each year during the week, two regional radio stations (Radio Auran Aallot and Radio Melodia) conduct an anti-drug campaign in co-operation with the education authorities, the Turku Customs, the Free from Drugs NGO and corporate sponsors.

4 Problem drug use

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

According to the 2010 data from the Drug Treatment Information System, opiates were the major primary problem substance of clients entering drug treatment (representing 59% of all drug treatment clients of the substance abuse services), followed by stimulants (13%), cannabis (10%), alcohol (11%) and pharmaceuticals (6%). These results reflect the provision of treatment, since substitution treatment is so far available only to opiate users. Buprenorphine was the primary problem substance for as much as one third of the clientele. Although among the drug users with the most severe problems there are persons who use both amphetamines and opioids, the hard core of Finnish drug use consists of combined use featuring both polydrug use of opioid-based painkillers and sedatives (benzodiazepines) on the one hand and alcohol and cannabis on the other.

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

4.1 Prevalence and incidence estimates of problem drug use

Estimates on the prevalence of problem drug use based on administrative statistics have been made since 1997.²⁹ According to these estimates, out of the population aged 15 to 54, there were some 14,500 to 19,100 amphetamine and opiate problem users in the entire country in 2005. (Partanen et al. 2007.)

The number of problem users of amphetamines and opiates³⁰ increased noticeably between 1999 and 2002. Since then, the proportion of problem users of amphetamines and opiates seems to have stabilised. The majority of problem users, 75% to 80%, consisted of amphetamine users, and they accounted for 0.4% to 0.7% of the population aged 15 to 54 in Finland in 2005. The estimated proportion of problem users of opiates was 0.13% to 0.18% of the population. The percentage of women was 20% to 30% in both substance groups. While the proportion of young people aged 15 to 24 was about 25% to 35%, they were no longer the largest user group, the age group 25 to 34 having already exceeded the younger age group's percentage. (Partanen et al. 2007.)

²⁹ The estimates of problem drug users are based on the statistical capture-recapture method in which the samples from the same group are used to assess statistically the size of the entire target population. The samples were defined based on the interventions directed by society at the target population (amphetamine and opiate users). The interventions employed in the system included amphetamine or opiate diagnoses recorded in hospitals, penal action for drug offences involving the use or possession of amphetamines or opiates, arrest for driving under the influence of amphetamines or opiates and hepatitis C cases recorded in the infectious diseases register due to intravenous drug use. The estimate intervals are based on 95% confidence intervals of the estimates. Different log-linear models were applied to different subgroups, so the sum of the subgroups differs from the overall estimate. (Partanen et al. 2004; 2007.)

³⁰ According to the national definition used in the study, 'problem use' refers to the use of amphetamines and opiates which is so extensive that it causes social or health problems for the user. Furthermore, the authorities have had to intervene in one way or another, and this has been recorded in administrative registers. The intention was to produce a new estimate in 2010 using the 2008 data, but in analysing the register data it was found that because of a change in the register systems, the results were no longer compatible with earlier studies. New estimates of the number of problem users were therefore postponed by two years while the basis for retrieving data is re-evaluated.

Table 4. Development of the percentage in the population (%) of amphetamine and opiate problem users in Finland in 1998–2005.

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

Source: Partanen et al. 2004; 2007.

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

4.2 Problem drug use in a wider context

Finland's second wave of drug use, at the turn of the 2000s, manifested itself for instance in deaths from heroin overdose. In the statistics on drug-related deaths, which indirectly reflect the incidence of problem drug use, buprenorphine has been more common than heroin since 2002. The number of buprenorphine findings in forensic post-mortem examinations rose year on year throughout the 2000s, from fewer than 10 in 2000 to 156 in 2010. On the other hand, the number of cannabis and amphetamine findings increased by 50% over the same period, to more than 100 findings per year. By contrast, the number of deaths caused by either heroin or cocaine were restricted to a few cases every year during the same period. (Vuori et al. 2006; Vuori et al. 2011.)³¹

The increase in the percentage of treatment periods related to pharmaceutical opioids can be clearly seen in medical care statistics. In the information collected from drug-related treatment, 74% of the clients reported problem use of pharmaceutical opioids.

³¹ See chapter 6.2. Drug-related deaths and mortality of drug users.

In the 2000s, the average number of treatment days related to drug use³² has slightly decreased, but the percentage of those treatment days related to opiate use has doubled. The number of treatment days classified as substitution treatment is showing a clear upward trend; the number of treatment periods related to other opiate use varies considerably year on year but is not showing a clear upward trend.

The absolute number of hospital days per year related to other drugs has decreased, but their percentage has remained fairly stable. An exception to this may be found in the percentage of treatment days related to stimulants (amphetamine and cocaine); this figure has slightly decreased over the past decade.³³

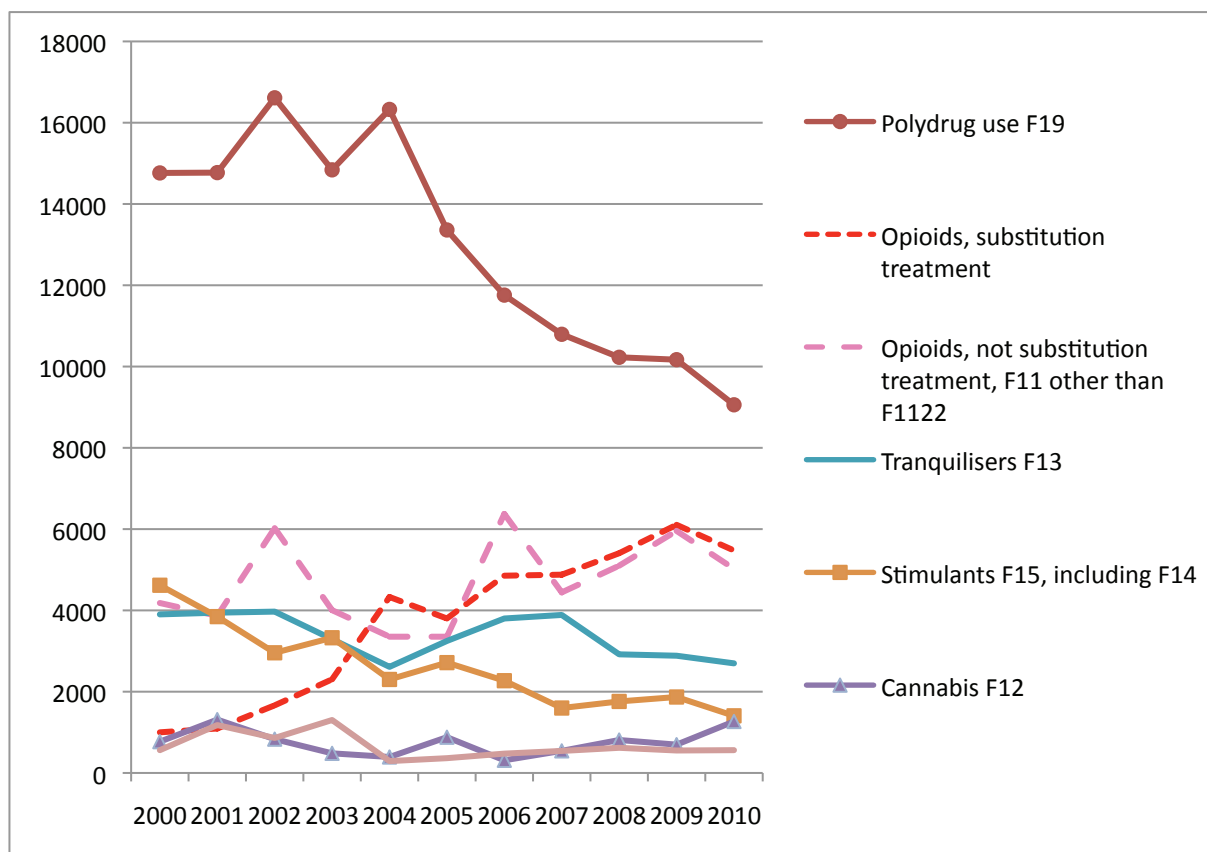


Figure 5. Treatment days at hospital, 2000–2010 analysed by the drug indicated in the primary diagnosis

Sources: Institutional health care. SVT, THL.

According to a study of morbidity statistics,³⁴ the incidence of behavioural disorders and organic brain syndrome caused by drug use, controlled for age, was 16.5 in 10,000 among men and 8.1 in 10,000 among women in 2009. The incidence was thus about twice as high among men as among women. The absolute numbers were 4,141 men and 2,071 women. The age-controlled incidence of behavioural disorders and

³² This includes all cases where 24-hour treatment is given in the health care system and the principal diagnosis is F11–F16, F18 or F19 (ICD-10). Poisonings are excluded. However, it should be noted that hospital treatment constitutes only part of all drug-related treatment given. Other types of treatment, such as outpatient care or institutional care provided by the social services, is more rehabilitative in nature and does not rely on medication as heavily. It is therefore only natural that a higher percentage of opiate use may be found in clients of drug-related treatment provided by health care than in that provided by the social services.

³³ Stimulants accounted for 14% of treatment days per year on average between 2000 and 2011, and 6% between 2009 and 2010.

³⁴ In this study, data from the care registers for health care and social welfare and from the statistics on disability benefits provided by the Social Insurance Institution (Kela) were combined. The study covered all drug treatment diagnoses – F11 through F16, F18 and F19. The focus was on hospitals in the health care system, because social welfare institutions seldom use ICD-10 codes, and outpatient substance abuse services were not included in the study.

organic brain syndrome caused by drug use increased by almost 25% among both men and women between 2005 and 2009 (Gissler et al. 2012).

The above findings notwithstanding, it is unclear by how much problem drug use actually increased in the 2000s, if at all. It is also unclear whether the percentage of opiate use out of all drug use has increased. The number of clients in substitution treatment has multiplied many times over, and both problem users and health care professionals are very well aware of the treatment available for opiate addiction. On the other hand, opiate problem users are more likely to seek out substance abuse services than users of other drugs. Opiate use is often an indicator of a clear need for treatment: users have typically used several kinds of drugs for years, often intravenously. Also, opiate withdrawal symptoms are easier to treat medically than withdrawal symptoms from other drugs. Indeed, it is a good thing that more treatment for opiate use is now available. What is not clear is whether drug users' access to treatment has become more difficult at the same time. (Forsell 2012a.)

Information collecting from drug-related treatment

In the annual survey for collecting information from drug-related treatment conducted by the National Institute for Health and Welfare,³⁵ the drug user clients were mainly men (67%) and mainly aged 20 to 35 (67%). Their educational attainment was low, and most of them were unemployed (61%). One out of ten clients (10%) was homeless, and 77% of the clients had used intravenous drugs at some point in their life. (Forsell 2012a.)

Opiates were the primary problem drug for 59% of the clients covered by the information collection. Overall, 74% of drug user clients had a history of opiate problem use. In recent years, nearly all of the opiate use recorded in Finland has involved synthetic, pharmaceutical opioids. Two of these, buprenorphine and methadone, are used both as intoxicants and as detoxification or substitution treatment medication. Substitution treatment medication is typically taken under a physician's supervision and orally, while drug use is typically intravenous and involves the use of other drugs too. (Forsell 2012a.)

Buprenorphine is by far the most common single opiate also in drug use (accounting for at least 74% of all opiate use). Other substances were occasionally reported as being used:³⁶ heroin and other poppy derivatives (9%), tramadol (4%), oxycodone (4%), codein preparations (3%) and phentanyl (1%). There was less intoxicant use of methadone (1%) than of a combined preparation of buprenorphine and naloxone (5%). (Forsell 2012a.)

Of those who reported that buprenorphine was their primary problem drug, no fewer than 86% used this substance mainly intravenously; 69% of them had used it intravenously in the previous month, and 44% used it on a daily basis. (Forsell 2012a.)

The percentage of clients whose primary problem drugs are opiates has been increasing since 2002 (Figure 5). However, as noted above, it is not clear whether opiate use has actually increased in the past decade. Opiate problem users are more likely to seek out substance abuse services than users of other drugs, and the number of clients in substitution treatment has multiplied many times over in the past ten years. (Forsell 2012a.)

³⁵The statistical report on drug user clients of substance abuse services is based on data from a separate round of information collection on drug-related treatment. In 2011, 74 units providing drug-related treatment participated in the information collecting, submitting data on 2,527 clients. Information collecting is not compulsory for the units involved, and no client identification data are submitted. The data collected cover an estimated one third of the drug-related treatment provided in Finland. The figures reported here include clients who continue in treatment, which means that the material has a broader coverage than specified in the treatment demand indicator (TDI) protocol of the EMCDDA. Finland's TDI figures may be found at <http://www.emcdda.europa.eu/themes/key-indicators/tdi>.

³⁶In the information-collecting process, clients are asked which drugs led them to seek treatment. A treatment relationship may last several years (especially with substitution treatment clients), and thus at the time of the inquiry the client may no longer be using the drug that initially caused him/her to seek treatment. For instance, 7% of substitution treatment clients reported that their primary problem drug was heroin, yet 69% of these clients had not used heroin during the previous month and indeed may not have done so for years. Regular, continuous use of heroin was practically non-existent in Finland in 2011.

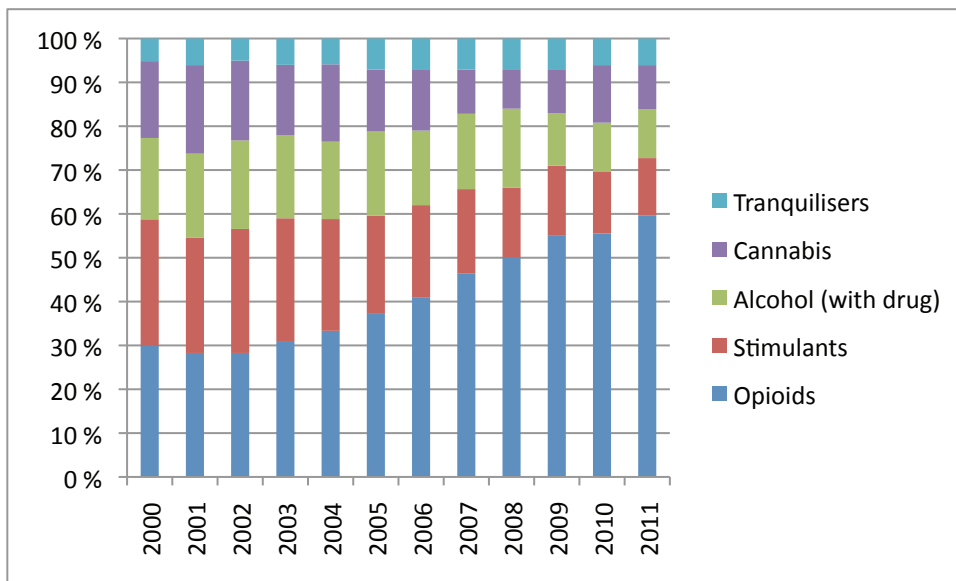


Figure 6. Primary substances used by clients entering treatment for the use of narcotics and pharmaceuticals (% of clientele) in 2000–2011.

Sources: Drug Treatment Information System, THL.

Polydrug use was very common. More than half (57%) of the clients seeking substance abuse treatment reported that they had a problem use history with at least three intoxicants. The average number of problem drugs reported was 3.2 for those clients who used opiates but were not in substitution treatment, 2.8 for those undergoing opiate substitution treatment, and 2.3 for those who did not report opiate abuse.

Tranquilisers were reported as secondary drugs far more often than as primary drugs. Pharmaceutical abuse comprised benzodiazepine abuse in 90% of the cases, with barbiturates (sleeping medicines) accounting for 9% and pregabalin for less than 2%. (Forsell 2012a.)

Stimulant use mainly comprised amphetamine use; there were some reports of secondary drug use of cocaine (7% of all stimulants) and ecstasy (6% of all stimulants). Although methamphetamine and MDPV had become more common on the drug market, they were not significant problem drugs, both having an incidence of 2%. (Forsell 2012a.)

Of the clients who sought treatment primarily for stimulant problem use, only one out of ten (10%) used a stimulant on a daily basis; 45% had not used stimulants in the previous month. By contrast, of the clients who sought treatment primarily for tranquiliser problem use, the majority used such drugs on a daily basis (57%), and only one out of five (16%) had not used them in the previous month. The principal mode of use was intravenous for stimulants (76%) and oral for tranquilisers (91%). (Forsell 2012a.)

Among the drug users seeking treatment who were not opiate problem users, cannabis was the most common drug leading the clients to seek treatment (31%). The percentage of cannabis as a primary cause for seeking treatment was considerably elevated in the youngest age groups. In fact, it was the most common problem drug reported as a cause for seeking treatment in the age group of under 20 (41%). Out of all clients who named cannabis as their primary drug, nearly half (42%) also had an alcohol problem. On the other hand, one out of three (31%) reported no other problem intoxicants. (Forsell 2012a.)

4.3 Data on problem drug use from non-treatment sources

In late 2009, a study was conducted on the substances used by drug users in Helsinki, how they used them and where they obtained them.³⁷ The criterion for inclusion in the study was that the interviewees had to be active users; however, persons who had not been actively using drugs for up to a month were also accepted. Out of the 100 people interviewed, 71 were men and 29 women; 23 of the interviewees were in substitution treatment, 20 of them men. The average age of the interviewees was about 29 years. However, more than two thirds of the women were under 28 years of age, as compared with less than a third of the men. The substitution treatment patients included in the study were on average older than the other interviewees (average age about 32 years). More than half of the interviewees were not in a steady relationship at the time of the interview. (Tammi et al. 2011.)

The interviewees were seriously disadvantaged. The majority (79%) of them were unemployed at the time of the interview, three fourths of them had only completed comprehensive school, and the highest educational attainment among them was vocational education or upper secondary school. More than half of the interviewees had a place to live, whether own or rented, but one in four lived in a shelter or were completely homeless. Three out of four respondents named social security as their principal source of income, and nearly one in six named drug trading or other illegal activities; by comparison, no one's principal source of income was begging or prostitution. Two out of every three interviewees had had trouble with the police more than once in the preceding year. (Tammi et al. 2011.)

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

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

³⁷ The study was a structured interview study whose participants (100) were recruited at the end of 2009 through anonymous health counselling centres intended for drug users (needle and syringe exchange points) (67), through peer support interviews in user networks (20) and through two outpatient clinics providing harm-reducing substitution treatment (15). The interviewees were instructed to approach women and immigrants in particular to gain a representative sample. The interviews lasted between 30 and 60 minutes. Two of the interviews were eventually discarded because of reliability issues. Only statistically significant differences were analysed; the tests used were the Fisher exact test, Chi test, and t-test in variance analysis. This study forms part of the European Quaf2 project. (Tammi et al. 2011.)

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

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

A register study³⁸ showed that the most common substances found in the blood and urine samples of intoxicated drivers were benzodiazepines and amphetamines. The study also showed that polydrug use was common in cases of suspected driving while intoxicated. It was considered important for intoxicated drivers to be referred to treatment and rehabilitation as an alternative to being convicted and sentenced, because being caught for driving while intoxicated would be a good opportunity for reaching out to substance abusers and referring them to treatment. (Karjalainen 2010.)

How the problem use of drugs is addressed is influenced by conceptions of problem use in society at large. Shifts in the discussion and scope of substance abuse and of addiction in general in the press between 1968 and 2006 has been analysed on the basis of articles published in Finland's leading daily newspaper.³⁹ The findings show that four trends may be identified over the 40-year period: an increasing number of articles on the topic, the expansion of discussion of the phenomenon from alcohol use to various other kinds of divergent behaviour, the mainstreaming of a previously marginal phenomenon, and a shift from social models explaining the phenomenon to personal histories. Over the period examined, the number of articles in this area per year would seem to have doubled. As recently as in the 1970s and 1980s, the phenomenon was identified with a specific group of people who had problems with a specific behavioural pattern, usually related to a specific substance (alcohol or drugs). The problems were seen as functions of the social status of these groups and not discussed as wider phenomena. From the 1990s onwards, however, addiction has been identified in highly diverse areas (work, gaming, TV, Internet use, eating disorders, etc.), and today a large percentage of the population could be described as being addicted to something. As the problem is seen to affect an increasing percentage of the population, it is becoming less of an anomaly and more of a mainstream phenomenon. At the same time, the identification of problems with a specific social status has decreased, and addiction is now seen largely as a personal problem; this is also reflected in the treatment of addiction, particularly in the medicalisation of treatment. (Hellman 2009; Hellman 2010.)

In a joint Nordic study, the harm caused by illegal drug use to family members and friends was studied in the Nordic countries by asking respondents about personal experiences of drug users among their family and friends, the harm caused by them and the willingness of the respondents to help drug users close to them.⁴⁰ The study showed that respondents in Helsinki differed from those in the other Nordic capitals in

³⁸ The study concerned cases between 1977 and 2007 of drivers apprehended by the police and suspected of driving while intoxicated (total number of suspects during the period: 31,963).

³⁹ The study examines articles published in the Helsingin Sanomat newspaper, the concept of 'addiction' referring to any discussion of a problematic or repeated behaviour over which the individual has little or no control, or to specific concepts such as 'alcoholism', 'problem use', 'bulimia', etc., and the treatment of same. The articles were selected from the same period of three weeks in even-numbered years. In all, 200 articles were found between the years 1968 and 2006. Analysed by decade, the number of articles varied as follows: 49 articles in 1968–1978, 26 in 1980–1988, 63 in 1990–1998, and 62 in 2000–2006. The material was analysed using the content analysis method. The daily circulation of Helsingin Sanomat has been between 400,000 and 500,000 since the 1990s. (Hellman 2009.)

⁴⁰ The study was conducted using a representative sample of 3,092 persons in the capital cities of the Nordic countries. The persons selected were over the age of 18 and were contacted by e-mail and asked to respond anonymously to an online questionnaire with 34 questions. The

that they had fewer personal experiences of drug users in their proximity than the other respondents. In Helsinki, 45% of respondents had had concerns about the drug use of someone personally known to them (12% within the previous year), whereas the figure in the other Nordic capitals was 56% to 67% (22% to 28%). The researchers explained this difference by referring to Finland's relatively brief history of drug use (compared to Denmark in particular), lower number of users of hard drugs (compared to Denmark and Norway) and shorter history of hard drug use (compared to all other Nordic countries). Similarly, fewer respondents in Helsinki had been personally acquainted with someone receiving treatment for substance abuse, but the difference between Helsinki and the other Nordic capitals was no longer significant in responses concerning personal acquaintance with someone receiving treatment within the previous year. (Melberg et al. 2011.)

There were also clear differences between Helsinki and the other Nordic capitals as to how serious the drug problem overall was considered by people who knew problem drug users personally. In Helsinki, 30% of respondents had experienced a fear of violence because of drug use by a person close to them in their lifetime (9% during the previous year), whereas the figures in the other Nordic countries were 20% to 23% (5% to 7%). Correspondingly, in Helsinki 11% of respondents had had to call in the police because of drug use (3% during the previous year), whereas the figures in the other Nordic countries were 4% to 6% (1% during the previous year). The researchers explain this difference too by the fact that this problem set is unfamiliar in Helsinki and that, on the other hand, Finland's drug policy is traditionally control-oriented, which is reflected in how citizens act. However, there were no great differences between the countries as regards how large a percentage of those personally acquainted with problem users had attempted to get those problem users to seek treatment. (Melberg et al. 2011.)

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

response rate was slightly over 50%. The group of participants did not significantly differ from the general population in terms of gender, age or educational attainment, at least not in the case of Helsinki. Cross-referencing and logistical regression analysis were used. (Melberg et al. 2011.)

5 Drug-related treatment services

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

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

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

A quality framework for substance abuse services (Ministry of Social Affairs and Health 2002) and Current Care guidelines (Duodecim 2006) for the treatment of drug abusers have been created in order to develop substance abuse work. The development policy for drug treatment services emphasises developing low-threshold services and related training.

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

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

5.1 Strategy and treatment systems

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

Treatment services

In Finland, services for substance abusers are provided within both social welfare and health care. Specialised services for substance abusers are mainly provided under social welfare. Outpatient treatment within these specialised services is free of charge for the client, whereas inpatient treatment generally requires a payment guarantee from the social welfare office of the client's home municipality.

The practical difficulty in substance abuse treatment is that the clients' problems and the availability of services do not necessarily meet. Some of the largest obstacles to receiving treatment are waiting times, the lack of knowledge and skills and negative attitudes towards substance abusers within the primary services and the physical distance of the treatment units within specialised services. One possible solution particularly for drug users is service guidance, a more personal counselling service for drug problem users (see also section 8.2 Social rehabilitation).

Outpatient substance abuse services

Drug users are offered specialist outpatient care services at A Clinics and youth centres. The services offered may include a survey of mental and somatic state, counselling, individual therapy, family therapy, group therapy, networking, outpatient detoxification or substitution treatment, depending on the client's needs. The care is undertaken according to a treatment plan drawn up together with the client and his/her support network. (Korteniemi 2011.)

Institutional detoxification or withdrawal treatment

Detoxification or withdrawal treatment is 24h institutional care. The length of the treatment period is determined according to the care needs of the client. The purpose of this treatment is to break the vicious circle of substance abuse, to treat withdrawal symptoms and to plan for further treatment. Once the client's physical health has improved, rehabilitative discussions are begun. (Korteniemi 2011.)

Rehabilitative institutional care

Rehabilitative institutional care in substance abuse services is long-term 24h institutional care. Rehabilitative institutional care forms part of a client's overall rehabilitation programme and is part of the treatment plan. Institutional care is intended as a treatment period to support outpatient care in the case of clients for whom outpatient care or institutional detoxification are not sufficient or feasible, or whose rehabilitation requires them to be removed from their normal living environment for a while. The length of the treatment period is individually determined. The content of the rehabilitation is also determined individually, according to the treatment ideology of the facility in question and the methods used. (Korteniemi 2011.)

Rehabilitative housing services

The purpose of housing services is to provide safe accommodation for the client, to support him/her in leading an intoxicant-free life and to guide him/her to the use of services. Rehabilitative housing services include sheltered housing with 24h assistance, sheltered housing, supported housing (near a sheltered home where help is available) and assisted housing (hour-based guidance). Forms of assistance may include guidance and counselling in everyday matters, setting limits, charting and strengthening the client's social networks, and providing health care services. Housing services are covered in the service and rehabilitation plan drawn up for the client. (Korteniemi 2011.)

Specialist medical care for drug users

Drug use treatment, which aims at ending or reducing drug use or abuse of pharmaceuticals or their harmful effects, is also provided at hospitals.

Somatic illnesses whose underlying causes include drug use are treated both at emergency clinics and in inpatient care. Drug-related poisoning, for instance, may be treated at an emergency clinic, or the client may need to be admitted for a few days of observation in an inpatient ward. Primary and secondary diagnoses are recorded for patients in health care, and a given patient may have a primary diagnosis of poisoning and a secondary diagnosis of polydrug use.

Drug use treatment proper is given at psychiatry outpatient clinics and wards. Clients may seek treatment at a specialist medical care substance abuse clinic through an A Clinic or a psychiatric emergency clinic, for instance. Substance abuse clinics conduct assessments of substitution treatment needs, among other things, if the client also has a psychiatric illness.

General social welfare and health care services

Drug use treatment given at health centres include discussions with a substance abuse nurse, substitution treatment, withdrawal treatment and treatment of somatic illnesses. Social welfare services and child welfare services offer discussion therapy and referral to treatment.

Low-threshold services

The point in low-threshold services is to explain to clients that they may easily seek out services intended for them without fear of consequences. The concept has broadened from syringe and needle exchange points to a wider range of services intended for the disadvantaged, such as shelters, day centres and night cafés. (Törmä 2009. See also the chapter Clinical research, Study on low-threshold operations.)

Treatment methods

A quality framework for substance abuse services (Ministry of Social Affairs and Health 2002) and Current Care guidelines (Duodecim 2006) for the treatment of drug abusers have been created in order to develop substance abuse work. A new Current Care guideline will be published in autumn 2012. The recommendations have been augmented with anthology articles updating clinical studies published in professional journals: on the treatment of clients suspected of using designer drugs (Lapatto-Reiniluoto et al. 2011), on encountering substance abusers at an emergency clinic (Salaspuro 2009), on encountering cannabis users in primary health care (Tacke et al. 2011), on developing treatment for pregnant women with substance abuse problems (Pajulo 2011), on opioid substitution treatment for young people (Mikkonen et al. 2010), and on ADHD and intoxicants (Niemelä et al. 2010). The Guide for Nurses was revised for teaching purposes in 2010 with updated articles on how to identify substance abusers, how to treat drug poisonings and withdrawal, how to refer intravenous drug users to treatment, and the co-occurrence of substance abuse and mental health problems (Mustajoki et al. eds. 2010).

Treatment of opioid addicts

The opiate addiction treatment with the best proven track record is medical substitution treatment. (Duodecim 2006.)

Substitution treatment may be given to opioid addict clients who have not been able to quit through other types of detoxification treatment. The aim of medical substitution treatment for opioid addicts is rehabilitation and abstinence or the reduction of harmful impacts, and in any case improving the client's quality of life.

There are nearly 2,000 substitution treatment clients in Finland. Subuxone, a combination preparation containing buprenorphine and naloxone, accounts for about 60% of the treatment and methadone for the remaining 40%. The use of buprenorphine only, i.e. Subutex, in substitution treatment is limited to a number of isolated cases according to the surveys. (MSD 2010.) A new study on the volume of substitution treatment will be published near the end of 2012.

Substitution treatment is preceded by a treatment needs assessment, which may be conducted in either outpatient or institutional care. In most cases, the treatment needs assessment is conducted or the treatment begun at a specialist unit such as an addiction psychiatry ward at a hospital, after which the actual course of treatment is provided by substance abuse outpatient services (e.g. an A Clinic) or a health centre. The time limits imposed by the treatment guarantee apply to medical substitution treatment (for non-urgent cases,

assessment of treatment needs within 3 days and access to treatment within 3 months and, for specialist medical care, assessment of treatment needs within 3 weeks and access to treatment within 6 months).

In order to improve the availability of medical treatment, a new Decree on substitution treatment was issued at the beginning of 2008. The aim in amending the Decree was the appropriate scaling of treatment (demanding patients being allocated to specialist medical care, others to the primary level; long-term care at a level which enables a normal life for the patient and is cost-efficient for the system). The Decree also enabled pharmacies to distribute substitution treatment medication containing buprenorphine and naloxone. (Ministry of Social Affairs and Health 2009e.) However, pharmacy contracts proved to be problematic from the viewpoint of the customer's personal data protection, as the contracts were deemed to constitute a sensitive personal data file, the use of which was not approved by the Data Protection Board until autumn 2010, and even then only in conjunction with a patient's individual treatment and detoxification plans. (Laine 2010.)

The pharmaceutical preparation containing buprenorphine and naloxone is subject to limited basic reimbursement, and the client must apply for a Kela refund entitlement. The Kela reimbursement is 42% of the cost of the medication. Even after the reimbursement, the client is paying nearly EUR 5,000 per year. However, if the client receives the medication at the place of treatment, it is free of charge.

Of the substitution treatment clients in the largest municipalities (n = 1,010), 20% were health centre clients and 5% were pharmacy distribution clients (Korteniemi 2011.)

Treatments for other drug users

The Current Care guideline includes care for the use of other drugs. (Duodecim 2006.)

Non-medical treatment and short-term detoxification are available for amphetamine problem users. Some amphetamine problem users undergo occasional treatment periods for amphetamine psychoses at hospital psychiatric wards.

There are scarcely any specialised treatment programmes for those who seek treatment because of cannabis use.

Organisation of services

The provision of services for substance abusers currently takes multiple forms: it can form part of a municipality's own operations or co-operation with the major provider of services for substance abusers. Moreover, it can also be arranged within a federation of municipalities or foundation for treating substance abusers or through purchase agreements with other organisations or private companies. For instance, according to 2008 data among A Clinics (n=75) providing outpatient substance abuser services for adults, 61 were municipal and 14 were maintained by the A Clinic Foundation. In all, the A Clinic Foundation has concluded agreements with approximately a hundred municipalities for the provision of substance abuser services. There are three federations of municipalities providing substance abuser services, each with from 24 to 71 member municipalities. Providers of institutional, detoxification and rehabilitation units most often include foundations, NGOs or private service providers. (Kekki & Partanen 2008.)

Riikka Perälä has studied the ways in which local authorities organise their social welfare and health care services through a case study involving co-operation between local authorities and Christian substance abuse service NGOs.⁴¹ Co-operation is based on business models rather than partnership. In the customer-provider model used in competitive tendering, the actual clients cannot influence the content of the service, and cost consciousness often trumps quality in developing services. Although the new service culture is hoped to increase networking, to strengthen the civic society and to shape services to match citizens' needs

⁴¹ The material for the study consists of themed interviews with 20 local government officials and representatives of Christian substance abuse service organisations collaborating with the local authorities, conducted in autumn 2008. There were 8 local authorities involved, 5 large (population more than 100,000) and 3 medium-sized; civil servants responsible for liaison with NGOs were interviewed, as were 12 persons responsible for the operations of various service points run by the NGOs involved. (Perälä 2010.)

better, the reality as outlined in the study is very different – albeit there are in fact some examples of successful cooperation. (Perälä 2010.)

Development of treatment services

In a study evaluating the treatment of drug addiction in Finland and its backgrounds, it was noted that five fundamental changes have taken place in forms of treatment and their underlying assumptions over the past 50 years.⁴² The study shows that drug addiction treatment can be divided into five phases: the psychiatric phase in the late 1960s; the social therapy phase in the early 1970s; the decline of drug treatment between 1975 and 1986; the drug treatment derived from the social therapy outpatient care tradition after 1986; and the expansion of specialist drug treatment since the late 1990s. The shifts in treatment methods were above all about changes in therapeutic reasoning: as drug addiction came to be regarded not as a personality aberration but as a problem manifesting itself in interaction, thinking and actions, the focus shifted from searching for the causes of drug addiction to seeking successful solutions. The technologies geared towards discipline and the patient's acknowledgement of his/her (alcohol) addiction were replaced by communal technologies and self-control techniques. Obedience and social conformity were joined by an emphasis on active client participation as the scope of drug addiction broadened from considering only the personality of the individual to an understanding of the client's family and its internal interaction and from there to considering entire population groups (e.g. youth rebellion). The author of the study notes that a solution-oriented approach gradually took centre stage in family therapy and therapeutic communities. In all, treatment in the 1970s, 1980s and 1990s was characterised by a trend towards voluntary and active participation by clients. Nevertheless, the problems of dropping out of treatment persisted; entering the 1990s, drug users could not identify with the forms of treatment available. (Selin 2010a; 2011a; 2011b.)

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

By 2002, as substitution treatment and maintenance treatment became generally accepted, medical treatment of opioid addicts had completely changed in its approaches, highlighting the medical side. The causes of addiction were eventually sidelined, and the emphasis was now on promoting a self-image conducive to self-control techniques and abstinence. Instead of eliminating the client's own thoughts and mental problems, cognitive and behavioural therapy seeks to replace harmful habits and skills with new, better skills that prevent the client from relapsing. The purpose of such a change is to highlight the match between drug treatments and the hopes and desires of potential clients with drug problems. At the same time, opiate addiction as a specifically defined somatic illness has become easier to control, and clients are more likely to stick with the treatment. However, substitution treatment does not in and of itself forfeit the control inherent in treatment or a transition towards an ethically sustainable way of providing treatment: substitution treatment too makes use of social control techniques to control and normalise the body. At the

⁴² The study was based on articles collected from five periodicals (Tiimi, Suomen lääkirilehti, Aikakauskirja Duodecim, Alkoholipolitiikka/Yhteiskuntapolitiikka, Sosiaalilääketieteellinen aikakauskirja), all of which except Tiimi also publish refereed articles. The articles span five decades, from 1965 to 2005. Detailed analysis involved articles on treatment methods, treatment problems and proposed measures. The texts were analysed in the light of the research framework of the analytics of power developed by Michel Foucault. (Selin 2010a; 2011a; 2011b.)

same time, the treatment system requires clients to conform to its logic and to behave more predictably and to be more patient – which may require a drug addict to display precisely the kind of active initiative the lack of which led him/her to need treatment in the first place. (Selin 2010a; 2011a; 2011b.)

Institutional control of drug-related harm

In a study on institutional substance abuse treatment and substance abuse control, data on substance abuse clients of the social welfare and health care services, the police and the prison administration from between 1985 and 2006 were compared.⁴³ Up until the recession of the early 1990s, the volume of rehabilitative social welfare and the number of treatment days in institutional care increased year on year as the welfare state and the social sector were built up. The focus was on softer values in treatment, not so much on coercive measures. However, following the recession the number of beds in institutional substance abuse treatment was drastically cut, the number of treatment days reduced and control increased; this was also partly due to the general increase in the use of drugs. By the mid-2000s, the number of related prison sentences issued has grown particularly because of extended sentences for drug-related crimes, drunk driving and violent crime. In 1985, prison inmates with a substance abuse background accounted for 45% of the prison population, but this figure had risen to 84% by 2006. It would thus appear that institutional control of drug-related harm has increased the most in prisons, where control and rehabilitation are strictest and days stayed are the most expensive. This would seem to dovetail with Finland's two-track interpretation of drug policy, whereby drug users are subjected to increasingly strict control while a low-threshold service network (excluded from the study referred to here) is being set up for drug users. (Obstbaum et al. 2011.)

Clinical research

Several studies on rehabilitation have been published in recent years: on community rehabilitation (Prättö et al. 2009), on peer group support in Narcotics Anonymous (Kotovirta 2009), on the involvement of the rehabilitee (Mattila-Aalto 2009) and on the results of substitution treatment (Vorma et al. 2009).

Study on low-threshold operations

In her dissertation, Riikka Perälä explored what kind of help is available to drug users at health counselling centres and how effective these are in controlling drug-related problems.⁴⁴ Users considered the operations of health counselling centres to be client-oriented. They treated their clients with respect and saw the person beyond the stereotypes associated with drug use and drug users. The employees were motivated and willing to help drug users with a wide variety of problems. The client-oriented approach had a clearly positive impact on the everyday lives and life management skills of drug users. This, in turn, helped the users commit to the work done at the centre and to be more receptive to the suggestions made by the employees. (Perälä 2012.)

⁴³ The study was based on inpatient treatment days for drug-related illnesses in the case of health care; on detoxification, rehabilitation and housing services treatment days in substance abuse special services in the case of social services; on statistics on taking into custody in the case of the police; and on health studies and interviews conducted in prisons in 1985 (n=1,099), 1992 (n=325) and 2006 (n=711). (Obstbaum et al. 2011; Joukamaa et al. 2010; see also sections 5.3 and 9.4.)

⁴⁴ The material for the study was collected at one health counselling centre in southern Finland between 2003 and 2007 using an ethnographic research method. The bulk of the material consists of observation notes made at and around the centre (about 200 pages in all) and themed interviews with clients (n = 19 and n = 20).

Drug users felt that they received the help and support they needed at health counselling centres. By contrast, the clients of health counselling centres felt that the majority of the mainstream service and treatment practices were controlling rather than supportive in nature.

The author felt that “the care dimension focusing on human contact and interaction has been sidelined in the discussion on substance abuse service policy. Many users turn to public services for something to balance their harsh life experiences and are discouraged – yet again – when they are met with a cool detachment.” (Perälä 2012.)

A more social approach should be highlighted in planning and developing policy to reduce the harmful impacts of drug use. Even though drug use involves serious addiction and sometimes criminal activities, drug use is also often just a symptom of much broader psychological, social and societal problems. Employees at health counselling centres felt that clients came to them or ended up with them because they could not get help for their problems anywhere else. As a result, health counselling centres are overworked with trying to explore and solve complex problems with multiple underlying causes. (Perälä 2012.)

Role of substance abuse counsellors in treatment

The effectiveness of substance abuse treatment has been studied from the perspective of what are known as common factors.⁴⁵

In this study, the impact of common factors in treatment on the effectiveness of outpatient substance abuse treatment was examined. The aim was to explore how the relationship between client and therapist, the therapist’s actions and the expectations and conceptions of the client affect the outcome of the treatment. (Kuusisto & Saarnio 2012.)

A follow-up study showed that the relationship between client and therapist, the work of the therapist and the client’s expectations are all significant factors for the effectiveness of treatment as measured by continuity of treatment, the number of sober days after the treatment, and satisfaction with the treatment received. The project demonstrated that common factors are interlinked and have combined impacts in addition to their individual impacts. (Kuusisto & Saarnio 2012.)

The principal findings emerging were that a well-functioning relationship between client and therapist and positive expectations on the part of the client were highly significant contributing factors in the effectiveness of treatment. The study also showed that there are differences between therapists that have a bearing on the effectiveness of the treatment they provide. Contextual factors combine with the treatment methods used to create the treatment environment perceived by the client. (Kuusisto & Saarnio 2012.)

5.2 Characteristics of treated clients

In the annual survey for collecting information from drug-related treatment conducted by the National Institute for Health and Welfare,⁴⁶ the findings on the backgrounds and life situations of drug user clients were found to be much similar to findings in earlier years. The percentage of women out of all drug user clients was 33%, but this figure was 40% in the age group of under 29. By contrast, women accounted for a smaller percentage of older age groups of clients and of clients in opiate substitution treatment.

⁴⁵ The follow-up study involved outpatient substance abuse treatment units (n = 7) in southern and western Finland. The clients (n = 327; 111 women and 216 men) comprised an unselected comprehensive sample of the new clients entering the clinics during the period in question. The study was conducted in the course of the clinics’ normal activities. The material was analysed using independent sample means testing and various regression analysis models. The therapist impact factor was analysed using intraclass correlation.

⁴⁶ The statistical report on drug user clients of substance abuse services is based on data from a separate round of information collection on drug-related treatment. In 2011, 74 units providing drug-related treatment participated in the information collecting, submitting data on 2,527 clients. Information collecting is not compulsory for the units involved, and no client identification data are submitted. The data collected cover an estimated one third of the drug-related treatment provided in Finland. The figures reported here include clients who continue in treatment, which means that the material has a broader coverage than specified in the treatment demand indicator (TDI) protocol of the EMCDDA. Finland’s TDI figures may be found at <http://www.emcdda.europa.eu/themes/key-indicators/tdi>.

Life situation

The average age of the drug user clients was about 31 years, median 29 years. The men were on average more than two years older than the women. Clients from Uusimaa were the oldest, and those from more predominantly rural regions were the youngest. Clients in 24h institutional care were younger (median age 28 years) than those in outpatient care (median age 30 years). The clients in substitution treatment for opioid addiction were by far the oldest (median age 33 years; age range 20 to 62 years). (Forsell 2012.)

Of the clients, 22% of the men and 39% of the women were married or cohabiting. Of those who were married or cohabiting, 69% had another problem substance user in the same household, women more commonly (79%) than men (41%). Children under the age of 18 were reported by 39% of the clients. Only 29% of the parents lived in the same household with their child or children, and 25% had had their children placed in care by child welfare services. Of the clients under the age of 20, half (52%) were still living with their parents. (Forsell 2012a.)

The clients' educational attainment was low, and most of them were unemployed (61%). One out of ten clients (10%) was homeless, although only 5% of substitution treatment clients were homeless, while the figure among other opiate problem users was 13%. This is probably due to two causes: the effectiveness of substitution treatment and the 'apartment first' principle. (Forsell 2012a.)

Intoxicants used

Polydrug use was very common. Use of at least three problem drugs was reported for 57% of the clients. Opiates were among the top three problem drugs with 78% of the clients, followed by stimulants at 47%, cannabis at 44%, tranquillisers at 40% and alcohol at 30%. (Figure 7.) The percentage of opiate users among drug users seeking treatment increased significantly in the 2000s. Opiate problem users are more likely to seek out substance abuse services than users of other drugs. (Forsell 2012a.)

Intravenous drugs had been used at some point in their life by 77% of the clients. Intravenous drug use during the previous month was reported by 69% of those whose primary problem drug was buprenorphine (35% of all treatment periods). (Forsell 2012a.)

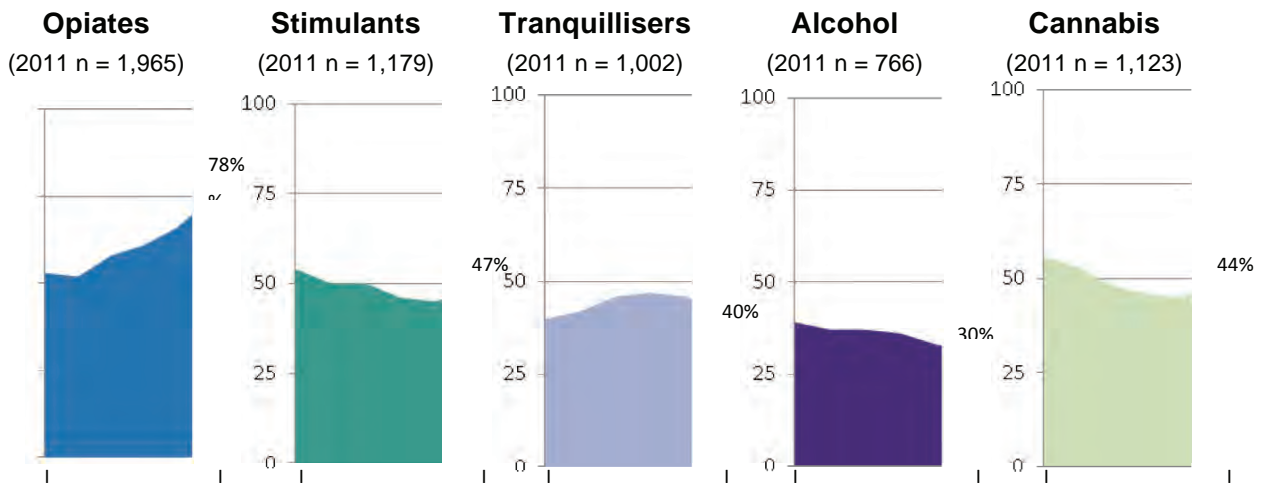


Figure 7. Problem drugs (primary, secondary and tertiary) leading drug users to seek treatment in 2005–2011, % of clients (n = 2,527).

Source: Forsell 2012a.

Treatment

Among the clients, 12% were seeking treatment because of drug use for the first time. About half of the clients (49%) had previously received treatment for drug use but began a new treatment period in 2011. The treatment relationship had lasted more than one year for 34% of the clients and more than two years for 19% of the clients. Opiate substitution treatment had lasted less than a year for 44% of substitution treatment clients, more than five years for 15% of them and more than 10 years for 1% of them. (Forsell 2012a.)

Out of all clients, 67% were in outpatient care and 33% in institutional care. Out of substitution treatment clients, 79% were in outpatient care and 21% were undergoing a period of institutional care. Institutional care, particularly rehabilitative institutional care, was more common among those clients who were not opiate users. The percentages of problem users of tranquillisers and alcohol were somewhat higher in institutional care than in outpatient care. (Forsell 2012a.)

At least 22% of the clients were undergoing opiate substitution treatment: out of these 52% were receiving a buprenorphine-naloxine combination (Suboxone), 38% were receiving methadone and 10% were receiving buprenorphine (Subutex or Temgesic). (Forsell 2012a.)

Intravenous drugs had been used at some point in their life by 77% of the clients. Intravenous drug use during the previous month was reported by 69% of those whose primary problem drug was buprenorphine (35% of all treatment periods). (Forsell 2012a.)

5.3 Client trends in substance and drug treatment

As discussed above, the Finnish substance abuse service system is heterogeneous; both social welfare and health care services must be taken into account. The numbers of cases of drug-related treatment have been estimated using general care statistics and three separate studies conducted by the National Institute for Health and Welfare. The *substance abuse census* is conducted during one day and collects information concerning clients who used the services of social welfare or health care units due to an injury caused by substance abuse or while intoxicated. This census, implemented at four-year intervals, enables an estimate to be made as to how large a percentage of all clients of social welfare and health care services are substance abusers. *Collecting of information on drug-related treatment* is a voluntary, continuous system of information collecting at treatment units for compiling anonymous, individual information on clients

undergoing drug-related treatment (see section 5.2 for clientele). A *coverage survey* was used to estimate the overall volume of drug-related treatment by treatment unit and by region for 2003 and 2008.

Substance abuse census

The most recent published results of the substance abuse census date from 2007. The results of the most recent census, conducted in 2011, will be published late in 2012. The census is conducted during one day and collects information concerning clients who used the services of social welfare or health care units due to an injury caused by substance abuse or while intoxicated. This census is carried out every four years and, since 1995, in a format allowing comparison. The percentage of drug users among all clients included in the census of intoxicant-related cases was 11% in 1995, 16% in 1999, 27% in 2003 and 24% in 2007. (Nuorvala et al. 2008a.)⁴⁷

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

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

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

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

⁴⁷ Intoxicant-related visits refer to visits which either directly or indirectly involve intoxicants. The data were based on reports made by service unit personnel. The most recent census was carried out on 9 October 2007, when intoxicant-related cases reached a record high of 12,045.

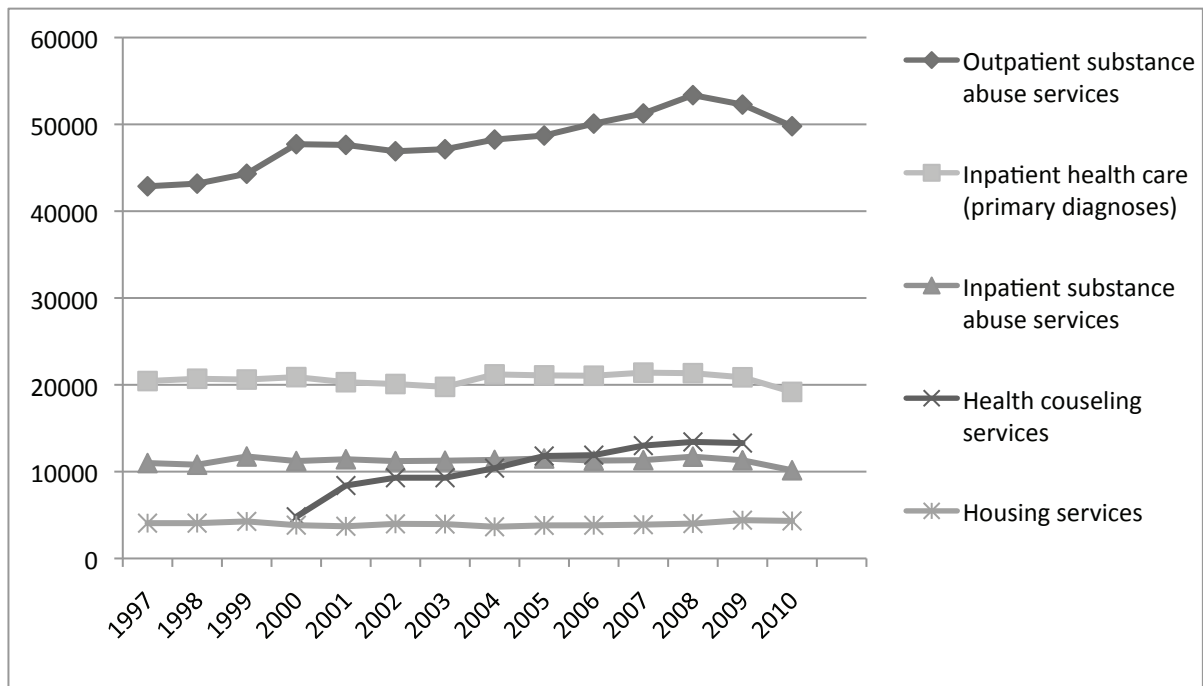


Figure 8. Intoxicant-related clients in social welfare and health care services 1996–2010.

Source: Yearbook of Alcohol and Drug Statistics 2011.

Coverage survey

In 2009, about 60% of the substance abuse service units that received the drug treatment coverage survey responded.⁴⁸ The reported number of clients in drug-related treatment was 12,807, or 18% of all substance abuse service clients. In considering this figure, we should note that the survey was not targeted accurately, nor were responses comprehensive. On the other hand, there was no provision for eliminating overlapping client relationships in the survey. A similar survey was conducted regarding clientele for 2004. At that time, 324 units responded, reporting 75,018 substance abuse service clients and 17,825 (24%) drug user clients. The coverage of the Drug Treatment Information System compared to the domain of clients in drug-related treatment was the same in both surveys (32%). This would seem to indicate that the decrease in client numbers observed is an actual trend and not due to the decreased number of units returning information. (Väänänen 2011.)

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

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

⁴⁸ The survey was relatively comprehensive with regard to specialised substance abuse services, but not so much with regard to health care outpatient services, for instance at municipal health centres. There was no provision for eliminating overlapping client relationships in the survey. Nevertheless, nearly two out of three treatment units responded, and the overall number of clients corresponds quite well to the annual number of substance abuse service clients obtained by combining data from other separate registers (cf. Figure 5).

specialised drug-related treatment were the unit's right to provide medical treatment for opiate addicts (43%) and a treatment programme dedicated to drug users (38%). Just under 20% of the units had a specialised ward for drug-related treatment. (Väänänen 2011.)

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

6 Health correlates and consequences

The number of HIV infections caused by intravenous drug use and hepatitis C, B and A cases recorded in the National Infectious Diseases Register has clearly declined over the past decade. Hepatitis A and B vaccinations for intravenous drug users have played an important role in reducing the spread of drug-related infectious diseases. Under the national vaccination programme, intravenous drug users and their sexual partners and people living in the same household are given vaccinations for both hepatitis A and B free of charge.

Health counselling centres have proved to be a cost-effective way of reducing adverse health impacts of drug use. The health and social welfare counselling centres provide health advisory services and a variety of support measures to help clients manage their own wellbeing. In addition to receiving advice, clients may exchange their needles and syringes for clean, disposable ones; receive vaccinations for hepatitis A and B; be tested for HIV and hepatitis; be treated for cuts and mild skin infections; and receive guidance and support for seeking other treatment or for managing everyday affairs.⁴⁹

The number of drug-related deaths grew along with other detriments at the turn of the millennium as a consequence of increased drug use in the 1990s. In the early 2000s, the number of deaths remained at this higher level. Drug findings in forensic toxicology investigations continue to increase, and new designer drugs are already beginning to be seen here too.

The increase in drug-related deaths have to do with polydrug use becoming common, with the fact that young drug users are risk-prone and inexperienced, with pharmaceuticals being used for intoxication and with mental health problems. It would be particularly important for users to be aware of the dangers of combined use, particularly with opioids, benzodiazepines and alcohol. In deaths related to combined use, victims typically die in their sleep, especially if buprenorphine, benzodiazepine and alcohol are involved.

6.1 Drug-related infectious diseases

More than 64% of the drug user clients of substance abuse service units submitting information to the drug use treatment information system had at some time in their lives taken all three tests: HIV, hepatitis B and hepatitis C: 70% had taken an HIV test, 66% a hepatitis B test and 75% a hepatitis C test. Of those who had at some time used intravenous drugs and who had taken an HIV test and received a test result (n = 1,551), about 2% came up HIV-positive, while of those who had at some time used intravenous drugs and who had taken a hepatitis C test and received a test result (n = 1,688), 73% tested positive for hepatitis C. The similar figures for hepatitis A and B were about 3% and about 5%, respectively.

The percentage of users positive for hepatitis C correlated with the length of intravenous drug use, calculated as the difference between the user's current age and the age at which he/she began using intravenous drugs. The percentage of users who had taken a hepatitis C test also correlated with the calculated length of intravenous drug use. These figures include both tests reported by the clients themselves and confirmed test results (test taken at the unit itself or confirmed for instance in the referral document). There were no significant differences between the positive HIV and hepatitis C test results reported by clients themselves and confirmed test results.

Of those who had used intravenous drugs at some time in their lives, more than half (52%) had received at least one dose of hepatitis B vaccine, and 39% had received all three doses.

⁴⁹ For more on the health counselling centres, see chapter 7.

HIV

According to the HIV infection statistics maintained by the National Institute for Welfare and Health, 176 new HIV infections were reported in 2011 (187 in 2010). Between 2001 and 2011, the annual number of HIV infections has increased by about 50, due to the rise in sexually transmitted HIV infections. The number of intravenous infections, by contrast, has remained low: in 2011, only 9 infections caused by intravenous drug use were reported, which is only 5% of the reported total (4% in 2010).⁵⁰ (Jaakkola et al. 2012.)

In addition to the passive monitoring enabled by the National Infectious Diseases Register, the National Institute for Health and Welfare has been co-ordinating prevalence surveys conducted approximately once a year.⁵¹ These surveys have aimed to assess the prevalence of infections also among those intravenous drug users who do not seek diagnostic testing. According to the survey results, the prevalence of HIV among intravenous drug users has remained, in spite of the epidemic of the early 2000s, at some 1% to 2%, which by international standards is very low. (Arponen et al. 2008.)

Hepatitis C

In 2011, the number of new hepatitis C infections reported was 1,160. This was 28 more than in 2010. However, because it is difficult to distinguish acute HCV infections from those contracted years ago, trends in case numbers must be viewed with caution. The mode of transmission reported was intravenous drug use in about half of the cases (600). The incidence of HCV among intravenous drug users is so high (80%) that bringing it down is a slow process that will take a decade at least even in the best case where risks are brought under immediate control. The number of unclear cases has decreased slightly but remains high (35% in 2011). (Jaakkola et al. 2012.)

The number of annual cases in the age groups 15 to 19 and 20–24 has remained fairly stable. This may be a sign that health counselling for intravenous drug users and the related preventive work has decreased the risk of infection most effectively in younger age groups and that hepatitis C is now more typically contracted at a later age, after prolonged intravenous drug use. The highest number of infections per capita were reported in the hospital districts of South Karelia, North Ostrobothnia and Helsinki and Uusimaa. (Jaakkola et al. 2012.)

⁵⁰ HIV and AIDS statistics reports compiled by the National Institute for Health and Welfare: <http://www.ktl.fi/ttr/gen/rpt/hivsuo.html>.

⁵¹ The survey has been conducted on a total of eight occasions between 1998 and 2009. The survey is usually arranged at several health counselling centres over a period of about two weeks. The respondents were clients of health counselling centres, numbering between 150 and 700. The respondents fill in an anonymous risk questionnaire and give a saliva sample, which is analysed for hepatitis C and HIV antibodies. Both the form and the sample bear the same anonymous participant number, enabling the comparison of individual risk factors against the antibody result. The test is not a diagnosis and, due to the anonymity observed, the results cannot be returned to participants. This fact is emphasised to the participants and it is also essential in terms of the survey's representativeness, since it enables participation by those who do not necessarily wish to learn of their infection. All clients of the health counselling centres are encouraged to participate in the study regardless of their HIV or HCV status.

Table 5. Hepatitis C according to physicians' reports, arranged by means of transmission, 2001–2011.

	2001	2003	2005	2007	2008	2009	2010	2011
Injection drugs	822	627	621	416	508	433	596	600
Sexual exposure	42	46	61	63	68	65	73	86
Perinatal	3	1	5	4	9	9	10	11
Blood products*	19	22	24	17	15	1	9	7
Other	31	34	35	23	31	26	38	39
Not identified	574	533	497	634	513	527	406	417
Total	1492	1264	1244	1157	1144	1061	1132	1160

Source: Jaakkola et al. 2012.

*) Since 2000, no HCV infections transmitted via the transfusion of Finnish blood components have been reported.

Hepatitis B

The number of acute hepatitis B cases recorded in the National Infectious Diseases Register has shown a significant decline over the past decade. Altogether there were 24 new infections in 2011, and the means of transmission was identified in 14 cases; in all of these, the infection had been contracted through sexual intercourse. (Jaakkola et al. 2012.)

Hepatitis A

In 2011, the number of new hepatitis A cases reported totalled 14. In 7 of the cases, the infection was reported as having been acquired through food or water. One infection was acquired in Finland and 9 abroad; in 4 cases, the country of acquisition was not specified. During the past few years, the number of infections has remained low. The prevalence has remained low owing to the vaccination of risk groups. Intravenous drug users, their sexual partners and persons living in the same household have had access to hepatitis A vaccination free of charge under the national vaccination programme since 2005. Seeking a hepatitis A vaccination is also common among those who are planning to travel abroad. (Jaakkola 2012.)

Follow-up study of HIV strains among intravenous drug users

Skar et al. conducted a detailed study⁵² of HIV epidemics among intravenous drug users in Stockholm and Helsinki, using both molecular epidemiology and epidemiology data. In summer 2006, the number of HIV infections among intravenous drug users in Stockholm began to spike, and the epidemic persisted until the end of 2007 with a total of more than 70 new cases. Prior to this, some 20 cases of HIV infection through intravenous drug use had been recorded in the Stockholm area annually since the early 1990s. In western Europe, HIV epidemics among intravenous drug users are principally caused by the HIV-1 B subtype. Of the infections among intravenous drug users in Sweden in 2001–2002, 85% were of the B subtype, and the majority of these had been contracted in Sweden; however, a handful of cases were reported as having been contracted in Finland. Finland experienced an HIV epidemic among intravenous drug users beginning in

⁵² Materials and methods: The material for the study consisted of 74 cases of HIV infection associated with intravenous drug use, diagnosed in the Stockholm area between 2004 and 2007. The following data were obtained from patient records: year of diagnosis, age, gender, principal drug, housing conditions, CD cell count and virus burden. A blood sample was also taken from patients for a HIV-1 V3 loop sequence. The V3 sequences were analysed using phylogenetic and phylodynamic methods. Also, 83 V3 sequences obtained from HIV-positive intravenous drug users in Helsinki between 1998 and 2007 were added to the analysis. Statistical analyses were used to compare virus counts and CD4 counts among the infected patients. (Skar et al. 2011.)

1998. This epidemic was caused by the HIV-1 recombinant subtype CRF01-AE, which is common in Southeast Asia. (Skar et al. 2011.)

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

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

6.2 Drug-related deaths and mortality of drug users

Drug-related death cases in Finland can be analysed using three different types of statistics: chemical findings, causes of death and poisoning. Since the number of chemical findings is based on positive drug findings in forensic autopsies, the drug itself is not necessarily always the direct cause or a major indirect cause of death. In Finland, all cases involving an unclear or doubtful cause of death are examined for drugs. Statistics by cause of death are kept based on the EMCDDA protocol,⁵³ under which drug-related deaths include cases of intentional and unintentional poisoning (i.e. overdosing) and mental health disturbances due to drug use. In Finland, the causes of death statistics are produced by Statistics Finland. A separate report was compiled for cases of accidental poisoning in 2007. Table 9 shows a summary of the three different ways of analysing drug-related deaths for 2007. The table shows that analysing the deaths by cause of death produces a bias towards the older age groups.

In Figure 8, the trend in drug-related deaths is illustrated on the basis of causes of death and drug findings. In these drug-related death statistics, changes occurring since 2000 are highly consistent. An exception to this rule arises in the sharp increase in the number of findings in 2007 and in the number of entries in the National Cause of Death Register in the following year.

⁵³ Data are extracted from the national cause of death statistics on the basis of WHO ICD-10 codes. The protocol is available as a PDF document at: <http://www.emcdda.europa.eu/?nnodeid=1419>.

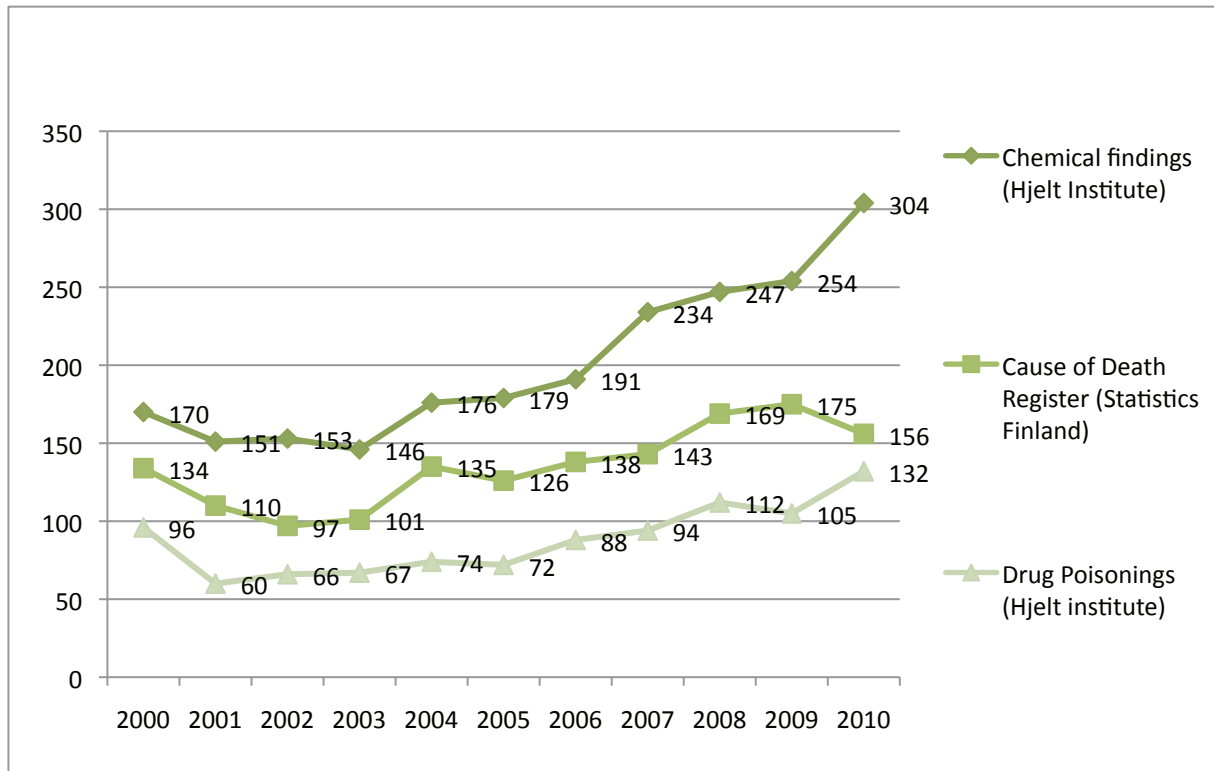


Figure 9. The number of drug-related deaths based on causes of death and drug findings in 2000–2010.

Source: Hjelt Institute and Statistics Finland 2012.

Drug findings in forensic toxicology investigations continue to increase, the number of chemical findings increasing by 14 on the previous year in 2008, by 8 in 2009 and by 48 in 2010. Growth has been strongest in findings of buprenorphine and the amphetamine group (Table 6). (Vuori et al. 2012.)

Intoxicant use of buprenorphine caused 46 deaths by poisoning in 2010. In deaths from poisoning caused by buprenorphine abuse, the substance was generally either injected or inhaled. In a typical case, the victim was also under the influence of alcohol and benzodiazepine and died in his/her sleep. After buprenorphine, the highest numbers of drug-related deaths were attributed to tramadol (26 cases), fentanyl (16), methadone (15), codeine (7) and oxycodone (5). Heroin and morphine were found in one case each. (Vuori et al. 2012.)

The statistics for the amphetamine group include MDPV, which is used like and as a substitute for amphetamine; this was the most commonly found designer drug in forensic investigations. Between 2008 and 2010, there were fewer than ten findings of ecstasy per year. By contrast, methamphetamine was a clearly more common finding between 2008 and 2010, being found in 11, 17 and 18 fatalities in those years, respectively. The finding of several amphetamine groups present at the same time is typical of amphetamine findings. (Vuori et al. 2012.)

In 2010, new designer drugs detected in samples from deceased persons included one case each of methylone, mCPP, 4-fluoromethamphetamine, 3-fluoromethamphetamine and desoxypipradrol (2-DPMP) and two cases of mephedrone.⁵⁴ (Vuori et al. 2012.)

⁵⁴ Among designer drugs, MDPV was classified as a narcotic drug in Finland in 2011, and methylone, mCPP and 2-DPMP in 2012.

The year 2009 produced a spike in the number of GHB findings, the drug being found in 11 subjects as opposed to only one finding in the previous year and three in the following year. (Vuori et al. 2012.)

In 2010, cannabis findings were accompanied by findings of amphetamine in 38% of the cases and buprenorphine in 45% of the cases. Alcohol was also found in one third of the cases, and simultaneous finding of benzodiazepines was also common. Findings of pregabalin have become common since 2007, and in 2010 pregabalin was found in 65 drug user fatalities. The findings indicate that intoxicant use of pregabalin is often linked with opioid abuse. (Vuori et al. 2012.)

Of those who die of pharmaceutical poisoning (including drugs), a little over 60% are men. Suicide accounted for 43% to 47% of deaths from pharmaceutical poisoning between 2008 and 2011, the percentage varying by pharmaceutical substance group. In cases where the finding was a beta blocker, an anti-depressant, an anti-psychotic medication or a sleeping medication, the percentage of suicides was higher. Only one out of four deaths from opioid poisoning was a suicide, and these tended to involve codein and tramadol. Buprenorphin is commonly abused, but deaths from buprenorphin poisoning are rarely suicides; in 2008 and 2009, none of them were.

Table 6. Drug findings in forensic toxicology investigations of cause of death, 2006–2010.*

	2006	2007	2008	2009	2010
Heroin	2 (2)	1 (1)	3 (3)	3 (3)	2 (1)
Buprenorphine	88 (28)	97 (35)	104 (34)	111 (34)	156 (46)
Cannabinoids	99	94	93	119	116
Amphetamines	64 (10)	94 (9)	73 (9)	94 (12)	113 (10)
Methadone	21 (3)	26 (16)	33 (16)	34 (18)	34 (15)
Cocaine	1 (0)	3 (0)	3 (0)	4 (0)	4 (1)
Gamma	6 (5)	2 (1)	1 (1)	11 (6)	3 (2)
Total	191	234	248	256	304

* The number in parentheses is the number of cases where the substance was the principal finding in a case of death from poisoning. The data on intoxicant use of pharmaceuticals are derived from background information provided by a forensic physician or from the death certificate.

** Gammahydroxybutyrate or similar lactone.

*** Includes other pharmaceuticals used as intoxicants besides the ones listed.

Source: Vuori et al. 2012.

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

A Nordic research team reviewed all of the positive drug findings for 2007 in attempting to describe what Nordic drug-related deaths are like and what the substances are that cause them and in what proportion.⁵⁵ In the case of Finland, the findings showed that the number of drug-related deaths per 100,000 inhabitants in 2007 was 4.02. In the Nordic countries in general, the place of death was in the capital city area in 29% to 35% of the cases in 2007, while the corresponding figure in 1991 had been between 53% and 75%. In Finland, about 15% of those who died from drugs in 2007 were women. The largest number of fatalities

⁵⁵This was the fifth study of this kind conducted in the Nordic countries over the past 23 years. The material for the study was obtained from forensic autopsies and toxicology analyses in the five Nordic countries (Finland, Sweden, Norway, Denmark, Iceland). These data were compared to similar data from 1991, 1997 and 2002. For the purposes of the study, a 'drug user' was someone who, according to police records or an autopsy report, had been using substances listed in Schedule I or Schedule II of the UN Single Convention on Narcotic Drugs (1961) or in Schedule III or Schedule IV of the UN Convention on Psychotropic Substances (1971). The causes of death determined the principal toxic agent and, in cases involving polydrug use, the substance with the highest levels, being most probably the substance that caused death.

was found in the 25 to 29 age group. The average age of persons dying from drugs in Finland increased from 2002 to 2007. The number of fatalities in the 20 to 29 and the 25 to 34 age groups also increased. (Simonsen et al. 2011.)

Considered by drug classification, class I substances such as cocaine, fentanyl, heroin/morphine, ketobemidone, methadone, oxycodone, etc., caused 40% of all drug-related deaths. Of class II substances (amphetamine, methamphetamine, MDMA, etc.), amphetamine in particular caused a number of deaths (7%). The number of fatalities from heroin and morphine had dropped to almost nil by 2007. On the other hand, Finland had higher percentages than any other Nordic country of fatalities caused by class III substances (benzodiazepine, buprenorphine, meprobamate, zolpidem, etc.) (35%) and by class IV substances (other drugs and poisons, including ethanol and carbon monoxide) (17%). The drug most commonly found was buprenorphine, and drug-related deaths ascribed to buprenorphine increased from 16 cases in 2002 to 32 cases in 2007, accounting at that point for 25% of all drug-related deaths. Methadone fatalities were not previously analysed in the statistics, but in 2007 methadone was listed as the cause of death in 16 cases. This indicates that the methadone used in opioid substitution treatment is finding its way onto the illegal market. Tramadol fatalities increased from 9 cases in 2002 to 14 cases in 2007. Combined use was common in all the Nordic countries; in Finland, a typical scenario was using ethanol and several (5 on average) other substances simultaneously. (Simonsen et al. 2011.)

Study on drug-related deaths

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

In 2007, one in six (17%) of all deaths of young adults (aged 15 to 34) were drug-related. Accidental poisoning from drug use or polydrug use accounted for about one in ten (8% to 11%)⁵⁶ of all deaths of persons aged 15 to 34. The most significant causes of death in this age group in 2007 were disease (29%), suicide (27%) and road traffic accidents (17%). By contrast, alcohol poisoning accounted for only 3% of deaths in this age group. In examining the larger age group of 15 to 44, we find that drugs were involved in 11% of all deaths, accidental drug poisoning being the cause of death in 5% to 7% of cases.⁵⁷

A study by Piispa⁵⁸ on drug-related deaths in 2007 explored the backgrounds of and events leading to these deaths, the contributing substances and how they were used. The study clearly shows how common polydrug use is, how risk-prone and inexperienced young drug users are, how pharmaceuticals are used for intoxication and how mental health problems are relevant in this context. Ignorance of the dangers of combined use was particularly apparent in cases of opioid, benzodiazepine and alcohol use among young people. (Piispa 2010.)

⁵⁶ The figure is 8% according to the National Cause of Death Register maintained by Statistics Finland (2008) and 11% according to Salasuo et al. (2009).

⁵⁷ The figure is 5% according to the National Cause of Death Register maintained by Statistics Finland (2008) and 7% according to Salasuo et al. (2009).

⁵⁸ The study material consisted of the cause of death documents for 2007 where traces of drugs were found in the deceased in a forensic autopsy. The research approach was material-oriented qualitative research as per Glaser & Strauss 1967 and Charmaz 2006.

Driving while intoxicated in Finland 1977–2007

According to a register study,⁵⁹ driving while intoxicated seems to have become more common, as over the past three decades the number of cases of driving while intoxicated reported to the police has multiplied by a factor of 18. The most common substances found in the blood and urine samples of intoxicated drivers were benzodiazepines and amphetamines. Polydrug use was also very common. (Karjalainen 2011.)

An exploration of the social background of intoxicated drivers showed that being socially disadvantaged correlated with driving while intoxicated.⁶⁰ Because being socially disadvantaged correlates with substance abuse more generally, narrowing the gaps between socio-economic groups would be beneficial both in reducing and preventing drug use in general and in curbing driving while intoxicated in particular. Intoxicant use is often begun at an early age, and the majority of intoxicated drivers are young; therefore substance abuse prevention and early intervention with young people are crucially important. (Karjalainen 2011.)

A study⁶¹ shows that over a five-year monitoring period mortality among persons suspected of driving while intoxicated was almost ten times higher than among sober drivers. A particularly high risk – 15 to 25 times that of the general population – was noted among those suspected of driving while intoxicated who were found to have been using two or more intoxicants simultaneously on the occasion of their first offence (drugs / pharmaceuticals impairing driving ability / alcohol). The most common causes of death among those suspected of driving while intoxicated were suicide, accidental overdose of drugs or pharmaceuticals and alcohol-related diseases or accidental alcohol poisoning. Two thirds of those who were killed driving while intoxicated were intoxicated at the time of their death, as opposed to one fifth of the control population. The significance of intoxication as a contributing cause of death was elevated in cases where the primary cause of death was a traffic accident or homicide. (Karjalainen 2011.)

The widespread use of benzodiazepines among those suspected of driving while intoxicated was one of the key findings of the study. The study showed that benzodiazepine users had a higher risk of premature death than amphetamine users and that combined use of benzodiazepines and other drugs or alcohol was very common. Although it was not recorded why the drivers had taken benzodiazepines, it seems likely that most cases involved substance abuse; therefore more attention should be paid to the intoxicant use of legal pharmaceuticals. (Karjalainen 2011.)

The study also showed that polydrug use was common in cases of suspected driving while intoxicated. It was considered important for intoxicated drivers to be referred to treatment and rehabilitation as an alternative to being convicted and sentenced, because being caught for driving while intoxicated would be a good opportunity for reaching out to substance abusers and referring them to treatment. (Karjalainen 2011.)

⁵⁹ The study concerned cases between 1977 and 2007 of drivers apprehended by the police and suspected of driving while intoxicated (total number of suspects during the period: 31,963).

⁶⁰ The social backgrounds of persons suspected by the police of drinking while intoxicated, between 1993 and 2006 (n=5,859), were compared to those of a control group representing a balanced sample of the population (n=74,809). The relevance of social background factors as predictors of driving while intoxicated was evaluated using logistical regression.

⁶¹ The study included drivers apprehended by the police and suspected of driving while intoxicated, between 1993 and 2006 (n=5,832); their mortality was compared against the mortality of the Finnish population in general. The mortality was assessed using the Kaplan-Meier method and Cox regression.

7 Responses to health correlates and consequences

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

Low-threshold services in particular have been essential in preventing and reducing infectious diseases spread by intravenous drug use. There are separate health and social security counselling centres for drug users at about 35 locations in Finland.

According to the quality recommendations for substance abuse services, substance abusers with serious mental health problems tend to fall through the cracks between substance abuse services and mental health services in the present service system. The quality recommendations stipulate that a client should primarily be provided with help at that social welfare or health care unit at which he/she seeks help. Municipalities must also have a clearly agreed division of duties in substance abuse services. In particular, the principal responsibility for treatment of substance abusers with mental health problems must be defined.

The health counselling centre concept has proved to be a good way to make contact with drug users. The guidance and advice provided at health counselling centres is driven by clients' needs. Goals are set according to clients' wishes and abilities. The primary goal is to prevent the transmission of infectious diseases through intravenous drug use by encouraging users to employ practices as hygienic as possible. If a client expresses a desire to cut down or quit drug use, various alternatives for attaining this goal will be discussed. Information collected anonymously indicates that the health counselling centres had some 11,500 clients in 2011. There were about 85,000 visits recorded, and 309 syringes and needles per client were exchanged on average. The most visits were to the health counselling centres in Helsinki (about 8,350), Vantaa (about 900), Turku (about 890), Espoo (about 825) and Tampere (about 568).

The treatment and prevention of infectious diseases related to drug use is provided within primary health care services, specialised services within health care and substance abuse services, health counselling centres and pharmacies that sell syringes and needles. HIV infected patients are treated at university hospitals and at central, regional and psychiatric hospitals in the area. Under the Communicable Disease Decree of 2003, municipalities must, within their health centres' operating areas, conduct prevention work against infectious diseases, including the dissemination of information on infectious diseases and health counselling. The scope of the Act encompasses health counselling for intravenous drug users, and exchanging syringes and needles where necessary. Free hepatitis A and B vaccinations have been included in the vaccination programme for intravenous drug users. Pharmacies play an important role in exchanging syringes and needles in areas where there are no health counselling centres.

In 2011, 3.5 million items of injection equipment were exchanged at health counselling centres.⁶² The most recent survey on needles and syringes sold at pharmacies was conducted in 2003. At that time, pharmacies sold 600,000 needles/syringes per year.

⁶² Needles and syringes.

The websites of the health and social security counselling centres⁶³ provide information on their location, on harm reduction, on field work and on peer support activities. The websites also give access to a materials databank with information for instance on infectious diseases, various drugs, health counselling, sexual health and first aid in an overdose emergency. (A Clinic Foundation 2012.)

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

Information for drug users on what to do in an emergency situation and how to prevent death from overdoses is provided in connection with all health counselling. However, the increase of drug-related deaths has also been taken into account by the authorities,⁶⁴ and there is concern about the combined use of opioids, benzodiazepines and alcohol, which was evident in the findings of a study⁶⁵ published in spring 2011. Combined use seemed to be a central part of the drug culture of the disadvantaged in Helsinki. Combined use of opioids, benzodiazepines and/or alcohol is the cause of a significant percentage of drug-related deaths in Finland. The study concluded that users should be informed of the risks of combined use to prevent drug-related deaths. Also, attention should be paid to intoxicant use of pharmaceuticals and the development of prescription practices to curb such use should be explored. (Tammi et al. 2011.)

Information on drugs is available on a 24/7 basis from third-sector helplines, for instance. Helplines are anonymous and free of charge for the caller. Information on drugs and the risks related to drug use is also distributed by the A Clinic Foundation, the Life is the Best Drug association and the rapid drug communications ring NOPSA maintained by the Deaconess Institute in Helsinki. NOPSA communicates with various target groups as needed. NOSA publishes information on the *Päihdelinkki* and *Vinkki* websites (www.paihdelinkki.fi, www.vinkki.info), uses the *Mobiilivinkki*® SMS service (free number 18182) and drafts press bulletins. (A Clinic Foundation 2012.)

Janne Liisanantti studied the prognosis of a patient with acute pharmaceutical poisoning and factors affecting the prognosis in his doctoral dissertation. His specific focus was on risk factors for prolonged treatment periods and repeated treatment periods and on long-term prognoses for patients with poisoning.⁶⁶ (Liisanantti 2012.)

For acute pharmaceutical poisoning treated in hospital, the prognosis was good; even patients requiring intensive care only required a short treatment period in hospital. Mortality during the treatment period was 1.6% to 2.3% for patients requiring intensive care. In complicated cases of poisoning requiring intensive care, aspiration pneumonia caused by the inhalation of stomach contents was found to be a common complication, leading to an extended period of intensive care. Securing the airways by intubation prior to admission to hospital reduced the risk of aspiration pneumonia. Other risk factors for prolonging intensive care included respiratory failure, kidney failure and low blood platelet count on admission. (Liisanantti 2012.)

Both young and adult patients were found to have quite a lot of repeat visits because of poisonings (7% to 21%). Young people in particular logged repeat visits, as occurrences of poisoning are associated with impulsive behaviour in their case. In a long-term follow-up covering 14 years on average, 30.4% of patients hospitalised for poisoning died. The percentage in the control group, controlled for age and gender, was

⁶³ Website (in Finnish): <http://toimipaikka.a-klinikka.fi/vinkki/>.

⁶⁴ Measures include publications on drug-related deaths; a seminar on drug deaths organised by the Ministry of Social Affairs and Health in 2008; and a seminar on work to reduce drug-related harm, organised by the Deaconess Institute of Helsinki in May 2011.

⁶⁵ In this study, 100 drug users in Helsinki were interviewed concerning which drugs they use, how they use them and how they obtain them; a European structured interview was used, translated into Finnish. This study formed part of the Second Multi-City Study on Quantities and Financing of Illicit Drug Consumption, or Quaf2. (Tammi et al. 2011.)

⁶⁶ The study domain consisted of patients with pharmaceutical poisoning treated at Oulu University Hospital between 1985 and 2006, and patients with pharmaceutical poisoning treated at Finnish intensive care units between 1998 and 2004.

13.6%. Patients with poisoning commonly died from cardiovascular disease. Injuries, poisonings and suicides were also more common in the study domain than in the control group. (Liisanantti 2012.)

The study indicated that patients with acute poisoning have a good prognosis while they are in hospital but that their long-term mortality rate is more than twice that of the control group. Respiratory disorders in particular are risk factors for prolonging treatment periods. Mortality from preventable causes such as suicide and cardiovascular disease was notably high in the long-term follow-up. (Liisanantti 2012.)

7.2 Prevention and treatment of drug-related infectious diseases

Almost two out of three (64%) of the drug user clients of substance abuse services had at some time in their lives taken all three tests: HIV, hepatitis B and hepatitis C. About 2% of the drug user clients of substance abuse services⁶⁷ who had at some time used drugs intravenously were HIV positive, while 75% tested positive for hepatitis C, 3% for hepatitis A and about 5% for hepatitis B. Based on the data available in the drug treatment information system, of those drug treatment clients who had used drugs intravenously at some point in their lives, more than half (52%) had received at least one of the vaccine doses for hepatitis B. A total of 39% had received all three vaccine doses.⁶⁸ (Forsell 2012a.)

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

Table 7. Activities of health counselling centres 2001–2011.

	2001	2003	2005	2007	2009	2010	2011
Health counselling centres	18	24	~26	<30	<30	<30	<30
Clients	8,400	9,300	11,800	12,600	13,291	14,193	11,432
Visits	44,500	70,600	80,500	90,000	79,735	83,450	84,586
Needles and syringes per client	113	150	161	190	233	242	309
Exchanged syringes or needles	950,500	1.4 million	1.8 million	2.4 million	3.1 million	3.4 million	3.5 million

Source: THL 2012.

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

⁶⁷ Self-notified testing and result (n=1,583).

⁶⁸ These percentages are lower than in the previous year's report, because they have been calculated from figures that include the missing data (18%–30%).

7.3 Study on the social management of the drug problem in Finland

In her doctoral dissertation, Riikka Perälä studied policy and practices for reducing drug-related harm.⁶⁹ The study points out that when working with drug users, better attention should be paid in the future to the concrete consequences of the multiple problems associated with drug use, such as a compulsive pace of life resulting from attempts to control problems and the emotional stress caused by drug use. (Perälä 2012.)

The study showed that drug users try to put their life back on track in a number of ways: by seeking training, by trying to find accommodation or a place to stay the night, to enter treatment or to gain various benefits. Obtaining drugs involves routines of its own, and drug users describe these as very similar to work. Many drug users would like to have help in life management. (Perälä 2012.)

Drug users considered that the ways in which the service systems try to help them are problematic. Many users had tried to seek help for their problems through services and treatment but had been discouraged by the bureaucracy and chilly attitudes they had encountered. Perälä notes that the human interaction dimension of treatment has been neglected in the discussion on how to develop substance abuse services, and during the period examined only the practices of the harm-reduction policy seemed to have succeeded in achieving a client-oriented approach in providing services. Drug users felt that they were treated like human beings at the health counselling centres, which they said was in itself a remarkable improvement over other services. (Perälä 2012.)

According to Perälä, the Finnish harm-reduction policy has successfully incorporated prevention of the harmful social and health impacts related to drug use, and efforts should be made to retain this feature of the policy. In Finland, harm reduction and treatment are not considered separate disciplines. Referral to services is a key component of harm reduction in Finland, and service professionals also emphasised the importance of treatment as the principal means for controlling drug problems. (Perälä 2012.)

⁶⁹ The material for the study was collected at one health counselling centre in southern Finland between 2003 and 2007 using an ethnographic research method. The material mostly consisted of observation notes and themed interviews with employees and clients.

8 Social correlates and social reintegration

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

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

The Finnish Constitution guarantees citizens universal rights to basic services. The Social Welfare Act is binding upon Finnish local authorities, stipulating the statutory duties that must be carried out at the municipal level. The Social Welfare Act provides for social services, income support, granting social credit, social security benefits and guidance and advisory services for their use, development of social conditions and elimination of social problems. (Ministry of Social Affairs and Health 2011c.) Universal basic services are complemented by special services for specific groups, such as substance abuse services and child welfare services. Preventive child welfare work is undertaken in family services, but also in substance abuse services for adult users, by investigating whether children involved have a need for care and support.

8.1 Social exclusion and drug use

The drug information system provides information annually on the socio-demographic situation of drug treatment clients and reveals that the situation has remained surprisingly unchanged for years. The clients' educational attainment was low, and most of them were unemployed (61%). One out of ten clients (10%) was homeless, although only 5% of substitution treatment clients were homeless, while the figure among other opiate problem users was 13%. This is probably due to two causes: the effectiveness of substitution treatment and the 'apartment first' principle. Of the clients, 22% of the men and 39% of the women were married or cohabiting. Of those who were married or cohabiting, 69% had another problem substance user in the same household, women more commonly (79%) than men (41%). Children under the age of 18 were reported by 39% of the clients. Only 29% of the parents lived in the same household with their child or children, and 25% had had their children placed in care by child welfare services. Of the clients under the age of 20, half (52%) were still living with their parents. (Forsell 2012a.)

8.2 Social rehabilitation

The purpose of social rehabilitation is to support the re-entry into society of persons severely affected by social exclusion through enhancement of their social functional capacity and their ability for social interaction. According to the Act on rehabilitative employment activities (189/2001), such activities are meant for the long-term unemployed, in order to improve their possibilities of finding employment. The Act obliges municipalities and employment offices to co-operate in providing client-specific service packages. However, it is not expedient to start rehabilitative employment activities if the client has an acute substance abuse problem; instead, the client should be directed primarily to substance abuse services.

Social work is aimed at strengthening the resources of citizens who need help and to support the self-reliance and coping of individuals, families and communities. The goal is to prevent social exclusion and to resolve social problems, thereby maintaining and promoting the wellbeing and social safety of citizens and communities.

In individual social work, social workers guide and counsel their clients, work through their problems with them and organise other support measures through official networks to maintain and improve the safety and coping of the individual and the family.

Community work is for preventing the emergence of social problems in communities and for reinforcing potential for involvement and participation of residents in the development of their communities. In community work, social workers and other social welfare professionals help individuals and groups contribute to the wellbeing of their communities and to network with community members, officials in various administrative sectors, NGOs and other parties. (Ministry of Social Affairs and Health 2011d.)

Homelessness and the programme to reduce long-term homelessness

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

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

The Ministry of the Environment's programme to reduce long-term homelessness 2008–2011 will be continued in the period 2012–2015 as outlined in the Government Programme. The purpose of the programme is to eliminate long-term homelessness by 2015, to reduce the risk of long-term homelessness by boosting the use of social rented housing for reducing homelessness and by enhancing measures to prevent people from becoming homeless in the first place. By 2015, some 1,000 apartments, supported housing apartments or treatment beds for the long-term homeless will be assigned in the Greater Helsinki area – 750 in Helsinki and 250 in Espoo and Vantaa combined. The aim is similarly to create at least 250 apartments, supported housing apartments or treatment beds in Tampere, Turku, Lahti, Kuopio, Joensuu, Oulu and Jyväskylä by 2015.

Social guarantee for young people

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

The training guarantee will form part of the social guarantee for young people. Everyone completing comprehensive school will be guaranteed a further placement at an upper secondary school, in vocational education, in apprenticeship training, at a workshop, in rehabilitation or elsewhere. Comprehensive education lays the groundwork for the employment of young people. However, just completing comprehensive school is not enough; a secondary-level qualification is in practice a necessity for finding employment or for entering further studies. Some young people drop out at every stage of the education

and training system. Some do not study further at all after comprehensive school, and some of those who do never complete a qualification. The result is that there are some 100,000 young adults (aged 25 to 34) in Finland who have no post-comprehensive qualification or degree of any kind.

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

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

The Government has set aside an annual appropriation of EUR 60 million for implementing the social guarantee. The first report of the working group presents solutions for allocating these funds and other proposals for implementing the social guarantee. With these solutions, implementation of the social guarantee for young people may begin in 2013.

The working group divided the task into two parts. Firstly, it must be ensured that the service network works as it should with regard to young people entering the sphere of the social guarantee. The aim is to create a system where all young people have a realistic chance of finding employment, training or other activities. These measures will create a situation where the number of young people who are socially excluded or at risk of social exclusion will no longer be increased by younger age groups.

Another focus area is to take care of the 110,000 young people who have no post-comprehensive education and who are thus at risk of social exclusion. Bringing them onto a stable employment path will be effected by increasing the supply of training so that by 2016 a 'normal situation' will have been attained: the youth service network is working and there is no longer an extensive number of young adults marginalised from society. This, however, cannot be achieved with the EUR 60 million per year reserved for implementing the social guarantee.

Cultural added value to preventing drug use

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

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

Social disadvantage as described in research

Being socially disadvantaged and being likely to turn to crime show a positive correlation: the weaker a family's financial standing is, the more likely it is that an adolescent in that family has committed criminal offences and been subject to violence. A survey among Finnish-speaking pupils in the 9th grade of comprehensive school (aged 15–16)⁷⁰ showed that the probability of experimenting with cannabis is the higher the worse off the family is. Of the young people who described the financial situation of their family as very good, only 5% reported that they had used cannabis during the current year. Similarly, of the young people who described the financial situation of their family as extremely poor, 14% reported that they had used cannabis during the current year. Cannabis use was also the more probable the less support and control the young person's parents provided (4% of young people under strong control, 9% of those under weak control). (Kivivuori et al. 2009.)

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

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

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

⁷⁰ In 2008, 5,826 young people responded to a questionnaire about self-declared crime. The sample space consisted of all pupils in the ninth grade (aged 15 to 16) in Finnish-language schools in Finland. The National Research Institute of Legal Policy conducts a survey on youth crime at regular intervals. The questionnaire contains questions regarding 21 forbidden or criminal acts. For each, the respondents are asked whether they have ever committed such an act in their lives, and if so, whether they have committed that act less than one year prior to the survey.

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

9.1 Drug-related crime

Documented drug-related crime surged in the 1990s. Crime accompanying drug use, such as crime against property and driving under the influence of drugs, also increased in the 1990s. This growth levelled off after 2000. The statistical increase in cases of driving while intoxicated was boosted by the zero tolerance approach with regard to drugs and driving, adopted in 2003. In the past few years, documented drug-related crime has again been on the increase. In 2011, more than 20,000 drug-related offences were recorded. The number of drug-related offences has increased each year. In 2008, the statistics only showed the offences reported to the police, but as of 2009 Statistics Finland changed its information base to include offences investigated by the Customs as well. This change may in fact explain part of the growth in the number of crimes, as it is observed later in the report that no corresponding growth in sanctions for drug-related crimes was found. (Kainulainen 2012a.)

According to the police, Finnish professional crime has typically been loosely structured, but is now closing ranks and becoming more disciplined. Major drug-related crimes investigated in Finland clearly show that the drug trade is professional and largely handled by organised crime groups. Criminal motorcycle gangs in particular hold a strong position in the drug trade in Finland and have close and functioning relations to groups abroad, particularly organised crime in Estonia. The prominent role played by organised crime groups in Finnish drug crime can be seen, for instance, in the more frequent presence of weapons, particularly gas sprays, as well as in the larger amounts of cash seized in the context of narcotics offences. Organised criminal groups have extended their domain from the traditional drug trade and property crime to financial crime and fraud, as organised crime seeks to generate rapid profits and increase its influence in the legal economy and in society at large. (National Bureau of Investigation 2012.)

In 2011, the number of seizures of cannabis products in Finland was, once more, higher than ever, according to statistics compiled by the police and Customs. The amount of hashish seized was the highest ever, and the amount of marijuana seized was the second highest per year on record. The number of cannabis plants seized (about 16,400) was also higher than ever in 2011. The number of seized cannabis plants doubled from 2007, which was probably due to the increased popularity of home growing and the fact that seeds are easy to buy over the Internet, and also due to the authorities becoming more effective at combating home growing. Home growing is still a minor activity in Finland, but the cases discovered have shown that cultivation is becoming more professional. A number of expertly set up cultivation facilities with more than 500 plants have been discovered in Finland. In Finland as elsewhere in Europe, criminal motorcycle gangs have taken up cultivation of cannabis. (National Bureau of Investigation 2012.)

A worrying amount of new designer drugs continue to be found on the market. Designer drugs are a new threat that has joined the ranks of outlawed narcotics. Designer drugs may be lethal, as the substances used and their levels in new drugs vary greatly, and there is no past user experience to rely on. Users also order batches of designer drugs for their own use over the Internet, as is shown by the considerable increase in the number of parcels containing designer drugs sent by post. Designer drugs have cut into the market share of other drugs, including amphetamine, seizures of which in 2011 were considerably less than in previous years. The percentage of methamphetamine on the amphetamine market and in the seizure statistics of the authorities has clearly increased. The volumes of seizures of narcotic pharmaceuticals have also been on the increase in recent years. (National Bureau of Investigation 2012.)

Narcotics offences

In 2011, some 12,100 cases of unlawful use of narcotics were recorded, about 59% of all documented drug-related crime. There were about 7,200 cases of basic narcotics offences (35%). One of the factors explaining the increase in narcotics offences is that home growing of cannabis is becoming more popular. There were about 1,000 cases of aggravated narcotics offences in 2011, about 5% of all narcotics offences and slightly fewer than in 2010. This was, however, the second largest annual total over the past ten years. Preparation or abetting of narcotics offences appears only rarely as a documented offence. (Statistics Finland 2012; National Bureau of Investigation 2012.)

The police and the other PTR authorities⁷¹ have stepped up their combating of serious crime. The focus in investigating drug-related crime is on the recovery of criminal gains, which has resulted in a weakening of the operating potential of drug-related crime.

Table 8. Drug-related crime reported to the police in 2004 and 2007–2008, and drug-related crime reported to the police, Customs and Border Guard in 2009–2011.*

	2004	2007	2008	2009	2010	2011
Narcotics offences total	14,486	15,448	15,482	18,524	19,724	20,394
Narcotics offence	4,672	4,206	4,835	6,274	6,444	7,226
Unlawful use of narcotics	9,217	10,333	9,823	11,257	12,158	12,093
Aggravated narcotics offence	582	883	789	922	1,083	1,036
Preparation or abetment of narcotics offences	15	26	35	71	39	39

*The compilation of statistics changed as of 2009. The statistics for 2009–2011 include crimes reported to the Customs and Border Guard. This accounts for a 5% to 6% increase in the volume of drug-related crime.
Source: Statistics Finland.

In 2011, there were 20,394 suspects in narcotics offence cases. (Statistics Finland 2012.) Of course, the same persons may commit several narcotics offences in the course of a year. In 2011, the police suspected a total of 6,197 individual persons of narcotics offences. The number of individual persons suspected of aggravated narcotics offences was 687. Compared with 2007, the number of individual persons suspected of narcotics offences overall had increased by 42% by 2011, and the number of individual persons suspected of aggravated narcotics offences by 28%. (National Bureau of Investigation 2012.)

Drug-related crime has robust international connections. The percentage of suspects of foreign origin in aggravated narcotics offences has increased remarkably in recent years. In 2011, no fewer than 24% of people suspected of committing aggravated narcotic offences were foreigners. This figure was 35% in 2010 and 27% in 2009. The largest groups of suspects were Estonians and Russians/Russians living in Estonia. The number of Estonian suspects in particular increased notably in 2010. The nationality distribution of suspects has continued to diversify. The people suspected of aggravated narcotics offences in 2011 included Nigerians but also a growing number of Iraqis, Moroccans, Dutch and Lithuanians. On the Finnish market, Finnish criminals generally manage the reception and distribution of drugs in Finland, while foreigners are engaged in import and smuggling. (National Bureau of Investigation 2012.) The

⁷¹ PTR is the Finnish acronym for police, Customs and the Border Guard.

internationalisation of drug-related crime has brought added challenges particularly to the uncovering and pre-trial investigation of aggravated narcotics offences, for instance because of interpreting requirements.

In 2011, the authorities confiscated about EUR 1.2 million in cash (about EUR 1.1 million in 2010 and about EUR 990,000 in 2009) in connection with investigating narcotics and doping offences, which illustrates the volume of this area of crime. Other forms of payment such as stolen property are also used in the drug trade. (National Bureau of Investigation 2012.)

Narcotics convictions

Narcotics offenders are generally sentenced to a fine. In 2010, somewhat over 4,000 offenders were fined in summary penal proceedings, as compared with about 4,400 offenders fined in district courts. The total number of offenders fined for narcotics offences was about 8,400. Nearly 5,300 offenders were sentenced to imprisonment for narcotics offences, more than half of them (n=3,431) to unconditional imprisonment. Charges were waived by the prosecutor for about 500 persons, and 50 persons were acquitted by a district court. There have been no significant changes in sanction practices in recent years. (Kainulainen 2012b.)

The usual consequence of unlawful use of narcotics (Penal Code, chapter 50 section 2a) is a summary fine, 15 day-fines on average. Between 2006 and 2010, in cases where the unlawful use of narcotics was the principal offence the sanction was a fine issued by summary penal order or imposed by a court in 95% of the cases. Alternatives to punishment remain a little-used option, but prison sentences are even more rare. In 2010, fines were issued by summary penal order in just over 4,000 cases and imposed by a court in almost 500 cases, while charges were waived in about 300 cases and punishment was waived in fewer than 20 cases. (Kainulainen 2012b.)

Between 2000 and 2010, the average number of day-fines in sanctions imposed for basic narcotics offences (Penal Code, chapter 50 section 1) was between 27 and 38. After the amendment regarding the unlawful use of narcotics, the average fine increased slightly, as in many cases minor narcotics offences are now handled in summary penal proceedings and never brought to court. In 2010, the average fine for a narcotics offence was 38 day-fines. (Kainulainen 2012b.)

Sanctions for narcotics offences (Penal Code, chapter 50 section 1) include prison sentences. If the same person is sentenced for several offences at once, the average sanction is usually more severe. In cases where only one offence is cited in the sentence, the average sanction for both conditional and unconditional imprisonment has been about four months. In 2010, the average sentences for unconditional and conditional imprisonment were 3.8 months and 3.9 months, respectively. (Kainulainen 2012b.)

For aggravated narcotics offences (Penal Code, chapter 50 section 2), the choice of punishment is in practice between unconditional and conditional imprisonment. An unconditional prison sentence is generally imposed for an aggravated narcotics offence; conditional imprisonment is considerably more rare. The average length of unconditional prison sentences has varied over the years; in 2010 it was about 2 years and 7 months (31.5 months). The average for conditional prison sentences has remained at about 1 year and 3 months for several years. Sometimes the sentences imposed for aggravated narcotics offences are quite long. (Kainulainen 2007; Kainulainen 2012b.)

Sanction tables are often used for consistency of punishment for narcotics offences. There has been inconsistency in sentences imposed by courts for home growing of cannabis. In order to harmonise prosecution practices, the narcotics prosecution team has drafted a recommendation to estimate the volume of the harvest gained from cannabis plants. The average yield of one plant is estimated at 25 grammes. The recommendation notes that a prosecutor could demand imprisonment for growing more than 10 plants and a fine if there are fewer plants. (Hakkarainen et al. 2011; Prosecutor General's Office 10 June 2010.)

Driving while intoxicated

In 2010, the total number of cases of driving while intoxicated decreased by 10% on the previous year. However, the number of cases involving drugs (3,125) and polydrug use (693) remained steady, and the percentage of cases involving alcohol thus decreased. In 2010, the cause of driving while intoxicated was

alcohol use in 82% of the cases, drug use in 15%, and polydrug use in 3%. (Statistics Finland 2012.) In 2011, drugs and pharmaceuticals were tested for in 4,166 cases of driving while intoxicated. The most frequently detected substances were benzodiazepines (78%), amphetamines (59%) and cannabis (40%). (National Bureau of Investigation 2012.)

A register study published in 2009⁷² assessed the manifestation of, and trends in, driving under the influence of drugs or pharmaceuticals in Finland between 1977 and 2007. During this period, driving under the influence of drugs or pharmaceuticals increased by a factor of 18. Of all suspects during the monitoring period, a total of 89.6% were men, but the annual percentage of women increased slightly. Women accounted for 6.9% of suspects in 1977 and 10.3% in 2007. This trend has statistical significance. The most frequently detected substances were benzodiazepines (75.7%), amphetamines (46%), cannabis (27.7%) and opioids (13.8%). The most frequent narcotic substances, amphetamines and cannabis, began to appear during the late 1980s, and the number of drug use cases began to grow as Finland adopted a zero tolerance approach to drugs and driving in 2003. (Ojaniemi et al. 2009.)

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

Other drug-related crime

During recent years, the annual number of robberies involving a break-in in order to obtain narcotic pharmaceuticals has remained steady (106). Between 2005 and 2007, however, the number of such offences per year was a third lower. The increase in burglaries is probably due to the reduced availability of Subutex. (National Bureau of Investigation 2012.)

In certain categories of crime the perpetrators are intoxicated in a large percentage of cases, but alcohol use is far more common than drug use or polydrug use. Out of all cases of all types of assault (assault, petty assault and aggravated assault), 56% were committed under the influence of alcohol but only 0.4% under the influence of other substances and 1% under the influence of both alcohol and other substances. The comparable figures are 31%, 3% and 4% for all robberies; 11%, 2% and 1% for theft offences (petty theft, theft, aggravated theft); and 22%, 9% and 3% for stealing a motor vehicle for temporary use. (Statistics Finland 2012.)

Money laundering offences in Finland are mainly associated with drug-related or financial crime. In 2011, the most common types of offence in data submitted for pre-trial investigation were dishonesty of a debtor, narcotics offence and fraud. Between 1994 and 2011, of all the cases where data on suspicious business actions were submitted for pre-trial investigation, about half involved financial crime, 9% involved narcotics offences and 8% involved money laundering. Money laundering based on corporate ownership structures, dealing in receipts and the grey economy undertaken by organised crime groups has become more common. In recent years, well above half of all reported cases of money laundering in Finland have involved the transborder movement of funds, usually from Finland to abroad. There are relatively few professional criminals in Finland specialising in money laundering, which is usually undertaken by persons in criminals' immediate circle of acquaintances. (National Bureau of Investigation 2012.)

⁷² The study was conducted as register-based research, including all cases of driving under the influence of drugs or pharmaceuticals (n=31,963) in Finland between 1977 and 2007. All toxicological analyses were conducted on blood and/or urine in the same laboratory (alcohol and drug laboratory of the National Institute for Health and Welfare, formerly under the National Public Health Institute).

The Financial Intelligence Unit of the National Bureau of Investigation has compiled a report⁷³ on Finnish money laundering cases for the period 1994 to 2010. Of the 96 judgments issued, 46 involved a narcotics offence as a predicate offence. In the remaining cases, the predicate offence was a financial offence. With respect to the rest of the cases, other predicate offences included hormones trade, doping offences, alcohol smuggling, bank robbery, appropriation, means of payment fraud, fraud or usury. The most common sentence included in the study was conditional imprisonment. Of unconditional prison sentences, nearly all were joint sentences involving several offences – chiefly narcotics offences. (National Bureau of Investigation 2012.)

Study on conceptions of habitual crime held by drug users and the police

Tuula Kekki (2012) conducted a study on conceptions of habitual crime held by drug users and the police, exploring habitual crime from the perspective of a criminal lifestyle and identity on the one hand and from the perspective of law enforcement on the other. The domain of the study concerned drug users whose use is regular and who continuously engage in criminal activities.⁷⁴ (Kekki 2012.)

The study analyses the motives and feasibility of criminal offences and changes in the behaviour of criminals over time. The study indicates that drug users commit a wide variety of crimes. No specialisation or professionalisation as such was found in the history of criminal activities of drug users. Financial reasons were not the only motivation for committing crimes; unlawful means were also used to attain immaterial benefits such as thrills and peer acceptance. The study material strongly indicated that the persons studied considered the criminal culture an attractive way of life. They were not interested in a conventional lifestyle, and they also became estranged from such a lifestyle as they acquired a criminal identity. They were more interested in identifying with a criminal peer group and gaining the respect of that group. Habitual criminals who use drugs are typically willing to take risks and are unwilling or unable to comprehend the consequences of their actions. However, lifestyle preferences notwithstanding, living and acting according to the rules and customs of the chosen sub-culture did not always produce contentment. (Kekki 2012.)

Secondly, the study examines ways in which the police see the significance of combating drug-related crime for the individual drug user on the one hand and for the social harm caused by criminal actions on the other. Because of the professional orientation of the police, there is a solid statutory foundation for their enforcement activities: all drug-related activities are criminal, so the police have the authority to intervene in them. The police also see drug-related crime as a harmful, immoral and undesirable pursuit, the discouraging of which is strongly supported by the majority of the population. Materials describing police operations show that enforcement was focused on known drug users, which is largely due to the fact that drug users often commit accompanying crimes too. In police rhetoric, controlling the use of drugs is largely about maintaining public order and safety. The police feel that they have very little potential in addressing individual offenders, whereas overall surveillance of drug users is significant for 'keeping the peace'. (Kekki 2012.)

⁷³ The study data included judgments issued by District Courts and Courts of Appeal. The collecting of cases began with the year 1994, when money laundering was criminalised in Finland. The dataset covers nearly all cases between 1994 and 2002 and contains some judgments from the years 2003 to 2010. A challenge in data collection lay in the fact that, until 2003, no essential elements required were specifically defined for money laundering crimes; instead, these were punished as receiving offences.

⁷⁴ The material for the study consists of interviews with police officers and drug users, a survey conducted at the Tampere Police Department and three different sets of pre-trial investigation records and notices of investigation.

9.2 Alternatives to prison

Referral for treatment, and reprimand

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

The amendment to the Penal Code concerning unlawful use of narcotics introduced the possibility of alternative penal sanctions. The focus was on two special groups: underage offenders should be reprimanded instead of imposing a fine on them, and problem drug users should be referred to treatment. A multi-professional reprimand is considered a more efficient sanction for young offenders than a fine. Treatment referral reduces the social exclusion of problem users as well as drug-related crime. According to studies and surveys, referral to treatment in particular has seldom been used. (Kainulainen 2009; Kainulainen 2012b.)

According to data collected by the Prosecutor General's office, in 2010 treatment was cited in 38 decisions to waive charges. Half of these decisions were made in Lapland. According to a survey made in 2009 of decisions to waive charges, of those seeking treatment 70% were men and 30% were women. One in five were underaged (n=6). In 43% of the cases, the offence only involved mild drugs. In 33% of the cases, a pharmaceutical classified as a drug was discovered. A further 10% of the cases cited only hard drugs (amphetamines). The remaining 13% involved combinations of various drugs. Subutex or Suboxene was mentioned in nearly one out of every three cases. (Kainulainen 2012b.)

An offender who sought treatment and whose charges were waived might be indicted with only a petty narcotics offence such as one-off drug use. In some of the cases, the offender had been using drugs for some months; in some cases, for a few years. In nearly all cases, the type of offence was unlawful use of narcotics. In a handful of cases, the offender had also committed another offence such as forgery, petty firearms offence or unlawful possession of alcohol. The materials also included some cases of a narcotics offence involving the growing of cannabis or the transfer of drugs. (Kainulainen 2012b.)

The Prosecutor General recommends that prosecutors arrange a reprimand session for 15–17-year-olds who have been arrested for unlawful use of narcotics for the first time. The young offender, his/her guardian, a representative of the social welfare authorities and the police participate in the session. (Prosecutor General 2006:1.) The young offender is informed of the criminal and reprehensible nature of drug use as comprehensively as possible, the offender's life situation is examined and appropriate further measures are decided. After the session, the prosecutor may decide to waive charges. If the young offender does not attend, or if it is determined in some other way at the session that waiving charges is not a feasible option, this course of action may be abandoned. A fine may then be imposed on the young offender. (Kainulainen 2009.)

According to data compiled by the Prosecutor General, 161 young offenders were reprimanded in 2010. The majority of these cases (61%) was in southwestern Finland. According to a survey conducted in 2009, in a typical case the reprimanded young offender was guilty of experimenting with cannabis on a small number of occasions. He/she was offered the substance personally or was reported to be responsible for acquiring it. Only a few cases involved a young offender with a longer history of cannabis use, and even then the longest period of use recorded was two years. Some cases involved not unlawful use of narcotics but a narcotics offence, because the young offender had distributed a small amount of drugs to another person or kept drugs in his possession with intent to distribute. (Kainulainen 2012b.)

A reprimand session might be attended by the parents, a social worker, a foster home representative or a police officer in addition to the young offender. In some cases it was mentioned that an official had not

attended a session despite being invited. The prosecutor's decision sometimes included a description of how the young offender behaved at the reprimand session. Support from the young offender's family or child welfare services helped convince the prosecutor of the appropriateness of this approach. (Kainulainen 2012b.)

The Prosecutor General has also compiled data on reprimands and referrals to treatment in 2011. The number of reprimands in 2011 was 154, 7 fewer than in 2010. Similarly, there were 38 referrals to treatment in 2010 and only 23 in 2011.

Table 9. Reprimands and referrals to treatment by prosecution unit, 2010–2011.

Prosecution unit	Reprimand		Referral to treatment	
	2010	2011	2010	2011
Helsinki	4	22	2	-
Länsi-Uusimaa		3	-	-
Itä-Uusimaa	13	15	-	-
Kanta-Häme	4	29	-	-
Salpausselkä	7	3	1	-
Western Finland	98	48	13	13
Pirkanmaa	2	7	3	-
Pohjanmaa	4	10	-	-
Central Finland	2	2	-	-
Eastern Finland	19	8	-	5
Oulu	7	7	-	-
Lapland	1	-	19	5
Total	161	154	38	23

Source: Office of the Prosecutor General (2012).

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

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

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

9.3 Drug use and problem drug use in prisons

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

There are 28 prisons in Finland, all very different in their size, operating culture, structures and traditions. In some prisons there are scarcely any findings of indicators of drug use during prison sentences, while in others the results of surveys, seizures and drug tests indicate that drug use is fairly common. In a closed setting like a prison, drug use involves not only the usual adverse effects but also debt recovery and coercion to commit narcotics offences, which is why many prisoners wish to spend their time in prison completely isolated from other prisoners. Intoxicant monitoring will thus be paid more attention in the future. (Tanhua et al. 2011.)

The results of intoxicant tests are documented comprehensively in the prisoner information system. Therefore drug tests may be regarded as the primary source for drug use by prisoners while in prison. In 2010, more than 19,500 drug tests were performed on urine. Just under 1,500 of these were sent to a laboratory for confirmation and further tox screening; 727 findings were confirmed. The substances most commonly found were benzodiazepine, buprenorphine and amphetamine. (Tanhua et al. 2011.)

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

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

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

Prisoners discovered to be dealing in intoxicants or otherwise committing narcotics offences while in prison are isolated from the rest of the prison population if necessary to prevent disruptions. For them too, the ultimate aim is to break the cycle of drug-related crime and to foster an intoxicant-free lifestyle. Local cooperation agreements between the prison and the police determine what the consequences of a drug discovery will be: a disciplinary matter within the prison or a referral to a police investigation. (Tanhua et al. 2011.)

Table 10. Drugs discovered in prisons, 2008–2010.

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

Source: Criminal Sanctions Agency 2011.

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

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

9.4 Prison health

Finland has a comprehensive prisoner information system including data on risk assessments and needs assessments, drug tests conducted while in prison, participation in substance abuse rehabilitation and drug-related disciplinary measures. Relatively few studies have been conducted in Finland focusing only on intoxicant use among prisoners, and even those that do exist do not always distinguish between drug use and alcohol use. (Tanhua et al. 2011.)

There are not enough research data or statistics available on drug detoxifications performed or harm-reducing measures undertaken during prison sentences. We do not know how many drug users overdose immediately after being released from prison. The drug test system is not foolproof, since prisoners may only be tested when intoxicant use is suspected or when certain permits are involved. Also, it is sometimes very difficult to detect intoxication clinically. The percentage of prisoners participating in group-form substance abuse rehabilitation programmes is quite small. (Tanhua et al. 2011.)

Prisoner health

The state of health of clients of the Finnish criminal sanctions system was studied in 2006. The sample consisted of some 600 prisoners and some 100 clients of community sanctions offices. The study methods

used were questionnaires, interviews conducted by nurses, psychiatric interviews, laboratory tests and a medical examination. Intoxicant addiction was ten times as prevalent among prison inmates as in the general population. The most commonly used intoxicant was alcohol, as is the case in the Finnish population in general.

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

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

Nearly half (42%) of all prisoners⁷⁵ had hepatitis C; 9% had hepatitis A and 8% had hepatitis B. An HIV infection was found in 1.0% of prisoners. (Joukamaa 2010.) The number of hepatitis and HIV tests conducted, as a percentage of the prisoner population, has remained stable, as has the number of positive results.

Responses to drug-related health issues in prisons

The Health Care Unit of the Criminal Sanctions Agency is responsible for the health care of remand prisoners and convicts during their time in prison. The administrative sector of the Ministry of Justice is currently exploring the transfer of prison health care to the general health care system. Nearly 200 health care professionals work at prisons and at the two prison hospitals. Health care personnel do not participate in the actual substance abuse rehabilitation undertaken during a period of imprisonment; this is managed by specially trained personnel at prisons such as substance abuse treatment instructors, psychologists and social workers. (Tanhua et al. 2011.)

Under the Communicable Diseases Act, the central government is responsible for preventing the spread of communicable diseases in prisons. It is the duty of health care personnel to ensure that prisoners are instructed on how to protect themselves particularly against diseases transmitted by blood contact or sexual contact and to prevent their spreading. Communicable disease prevention is undertaken in prisons through health education and by ensuring opportunities for protection. The hygiene package issued to each prisoner contains instructions on condom use and on the cleaning and disposal of injection syringes and needles, and also a personal hygiene kit. (Tanhua et al. 2011.)

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

⁷⁵ The prisoners were examined between 2005 and 2007.

prison admission have been continued. In 2010, there was an average of 50 prisoners each day receiving substitution treatment. (Tanhua et al. 2011.)

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

The personnel of the Health Care Unit make an important contribution to substance abuse work in providing substance abuse treatment. This is particularly important when a prisoner is admitted. The need for detoxification and withdrawal treatment is assessed by surveying the prisoner's substance abuse situation prior to being imprisoned. Substance abuse treatment provided by health care services consists of the treatment of substance-related illnesses and substance-related psychiatric treatment, and substitution treatment for opioid addicts. (Tanhua et al. 2011.)

At the Assessment Centre, a prison sentence plan is drawn up for the prisoner listing the points that the prisoner should address during his/her imprisonment. In drawing up the plan, the Assessment Centre will take the prisoner's substance abuse rehabilitation needs and the severity of his/her substance abuse problem into account, and this will influence prisoner placement. For about one prisoner in four, principally for those with a prison sentence of more than six months, the prison sentence plan is drawn up using a risk and needs assessment based on a face-to-face interview. (Tanhua et al. 2011.)

Substance abuse rehabilitation in prison consists of a substance abuse rehabilitation needs assessment, substance abuse rehabilitation guidance, motivational instruction, relapse treatment, group-format rehabilitation programmes of varying intensity, personal therapy, the possibility of placement in an external substance abuse treatment facility, release training and networking services after release. Various forms of substance abuse rehabilitation are available in nearly all closed prisons. Some of the open prisons specialise in substance abuse rehabilitation. The rehabilitation is mainly undertaken by rehabilitative prison personnel: psychologists, instructors and social workers. There are some 50 instructors specifically engaged for substance abuse work in prisons. The Health Care Unit participates in substance abuse rehabilitation for prisoners only to a very limited extent due to a lack of human resources. (Tanhua et al. 2011.)

The motivation and effectiveness programmes used in prisons must be approved through an accreditation procedure. The preference is for international programmes with research findings to back up their effectiveness. In addition to group sessions, one-on-one discussions are held with prisoners for whom group work is not suitable; they can discuss substance abuse issues in confidence by appointment. One-on-one discussions are also often used as an extension of group sessions. Peer groups in prison (NA and AA groups) and KRIS-Finland are important contributors to abstinence from substance abuse. (Tanhua et al. 2011.)

According to data from the prisoner information system, 340 prisoners in 2010 entered a substance abuse rehabilitation programme that is accredited or accepted as a good practice. There are no substance abuse rehabilitation programmes in prisons specifically aimed only at drug users. (Tanhua et al. 2011.)

Quality of services

The Central Administration of the Criminal Sanctions Agency is responsible for monitoring attainment of the substance abuse work goals through performance management, inspections and external audits. Internal Inspection is a key actor in substance abuse work quality control, monitoring the implementation of substance abuse work as required by law, for instance concerning the goals entered in the prison sentence plans. In addition to monitoring through inspections, quality management and evaluation, special reports and research findings are used to support the steering of substance abuse work. (Tanhua et al. 2011.)

Under the Act on Welfare for Substance Abusers (41/1986), local authorities are responsible for providing substance abuse services. The Criminal Sanctions Agency is not a rehabilitation institution as referred to in the rehabilitation legislation, and the primary task of a prison is not to rehabilitate but to execute punishments. Finland's prison legislation emphasises the preventing of recidivism and providing prisoners with the faculties they need to lead a crime-free lifestyle. Because a substance abuse problem is one of the key individual factors perpetuating a criminal lifestyle, a period in prison is a good time to stop and think about intoxicants. (Tanhua et al. 2011.)

In co-operation with the relevant organisations, the Prison Service has prepared various alcohol and drug programmes for inmates in prisons and for drug users released from prisons. In the future, prisons will aim to focus on activities requiring special expertise in criminal behaviour. Substance abuse rehabilitation that requires no particular familiarity with the criminal sanctions client in question can be outsourced where the expertise is available, i.e. from substance abuse service providers outside the prison. The aim in substance abuse rehabilitation is to employ methods that are effective, of high quality and reasonably comprehensive. In particular, methods in use outside prisons are increasingly being taken into prisons, since in the current economic situation it makes no sense to maintain parallel systems. The quality of outsourced services will also be particularly addressed in the future. (Tanhua et al. 2011.)

Special attention has been paid to the quality of the Criminal Sanctions Agency's own substance abuse rehabilitation programmes. All motivation and effectiveness programmes to be deployed in the criminal sanctions sector must be approved in an accreditation procedure before widespread introduction. Also, the aim is to provide each programme with an individual quality standard. (Tanhua et al. 2011.)

The structural decisions taken when the Health Care Unit was set up on 1 October 2006 have in some ways complicated cooperation between the unit and prison personnel. The administrative sector of the Ministry of Justice is currently exploring the transfer of prison health care to the general health care system. The Criminal Sanctions Agency is currently developing client assessment procedures and their tools. Client assessment will become a process lasting the duration of the sanction and including expert statements, initial evaluations by the convicts themselves, interim reports during the sanction and a final report as the sanction concludes. (Tanhua et al. 2011.)

9.5 Reintegration of drug users after release from prison

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

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

Osaava ohjaus (Skillful Guidance) 2010–2013 is a project run by the Probation Foundation with the aim of creating a multi-professional cooperation and expertise exchange model to reach out to adults at risk

of social exclusion. The project also offers training for professionals. The project has received ESF funding and is being run jointly with other actors. (Probation Foundation Finland 2012.)

Since 1999, the Regional Prison of Southern Finland and City of Helsinki Social Services Department have been engaging in rehabilitation work for prisoners with substance abuse problems (Kuva); prisoners enter the system when they are transferred to open prison and continue with the same contact persons as during their imprisonment. Selected prisoners participate in work rehabilitation provided by the City and therapeutic outpatient rehabilitation provided by A Clinic substance abuse services. Financial matters and debts can be settled with the execution authorities and debt counselling. Prisoners also have peer support group meetings. The aim is for prisoners to become accustomed to working regularly while still in the open prison and to continue working in the same job immediately after their release. The majority of participants have no permanent place to live and are clients of the municipal social services for the homeless. By the end of 2010, 121 prisoners had entered rehabilitation, of whom seven have participated in work rehabilitation after their release. More than half of them were released under Kuva. (Probation Foundation Finland 2012.)

10 Drug markets

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

In drug supply in Finland, organised crime groups from Estonia have played an important role – at the beginning of the 21st century in terms of smuggling and importing drugs and later on as collaborators with Finnish crime groups, supplying drug consignments for distribution and delivery. Estonian criminals continue to be major players in cross-border drug-related crime in the Finnish context, but criminals from Finland and other countries have been increasing their activities. The group of foreign players importing drugs in Finland has become more diverse and the role of Lithuania in particular in the Finnish drug trade is clearly strengthening. (National Bureau of Investigation 2012.)

On the one hand, the drug market appears organised and professional. On the other hand, the market is made up of several levels, where upper-level importers and wholesalers, mid-level distributors and low-level street dealers operate in different ways. Research shows that drug dealing in Helsinki, whether we consider the very top or the very bottom of the pyramid, is a far from rational pursuit. The undertakings are not very systematic; they are more a reaction to intoxicant addiction(s) and other problems. (Perälä 2011.)⁷⁶

The drugs on the Finnish market are mostly cannabis products, particularly home-grown marijuana or hashish; amphetamines and ecstasy and other synthetic drugs; the substitution treatment preparation, Subutex; and many pharmaceuticals classified as narcotic substances, particularly benzodiazepines. The number of marijuana and cannabis plant seizures has grown in the 2000s, which indicates that the fairly small-scale cultivation of drugs partly intended for sale has become more common. Hashish is smuggled from central Europe via Finland to Russia, which explains the large volume of hashish seizures in 2011. Designer drugs are increasing in popularity in Finland, partly displacing substances such as MDMA and amphetamines, seizures of which decreased. Cocaine has grown slightly in popularity on the Finnish market in the past few years, but it remains rather a marginal drug. The volume of heroin on the market remains low. The intoxicant use of Subutex, by contrast, remains high. (National Bureau of Investigation 2012.)

10.1 Availability and supply of drugs

No truly open drug market, such as those found in some major cities in Europe, exists in Finland; most of the sale and use of illegal drugs takes place in private homes. (Kinnunen 2008.) Home growing of cannabis has increased considerably in Finland, and this is reflected in the volume of seizures. The number of seized cannabis plants has doubled since 2007, which is probably due to the increased popularity of home growing and the fact that seeds are easy to buy over the Internet, and also due to the authorities becoming more effective at combating home growing. Although home growing mainly involves small-scale operations, it is becoming increasingly professional in nature. A number of expertly set up cultivation facilities with more

⁷⁶ The study material was mostly collected through ethnographical field work, including observations and interviews. Interviews with officials and minutes of pre-trial investigations concerning aggravated drug crimes are also included. The study takes a constructionist viewpoint, according to which language shapes reality. Therefore people evince differing conceptions of reality in their speech.

than 500 plants have been discovered in Finland. In Finland as elsewhere in Europe, criminal motorcycle gangs have taken up cultivation of cannabis. (National Bureau of Investigation 2012.)

Cases of home-grown cannabis in Finland usually involve cultivation for the grower's own use, with cultures of no more than 20 plants. In the five most severe sentences imposed by a district court for home growing in 2002 and 2003, the average number of plants involved in the offence was 11, the median being 6. The largest culture consisted of 130 plants. (Kainulainen 2006; Kainulainen 2011.) A study conducted among home growers of cannabis⁷⁷ supported this, noting that the overwhelming majority of respondents were growing 1 to 5 plants at a time. These findings show that domestic production has increased in significance and that marijuana has surpassed hashish as the leading cannabis product. Using marijuana grown by the user himself/herself or obtained from a grower known to the user is now more common than buying marijuana on the market. (Hakkarainen et al. 2011a.)

Most growers order their seeds (chemically treated seeds that produce pistillate plants) over the Internet, are given them by people they know, or obtain them from their own cultivation. Detailed growing instructions may also be found online. Also, the sale of equipment (which in itself is legal) required for home growing at certain shops favoured by home growers helps. The majority of home growing cases occur in major cities. The flower of a cannabis plant of a high-quality variant and grown under favourable circumstances can have a THC content of more than 10%. In the street trade, a cannabis flower is more valuable than low-grade hashish. (National Bureau of Investigation 2012.)

No websites selling drug-like substances aimed specifically at the Finnish market have been detected. However, people are increasingly ordering cannabis seeds, designer drugs, medicines and GBL online from abroad in small quantities for their personal use. GBL or 'lakka'⁷⁸ in particular is ordered by mail and express cargo from the Netherlands, the UK and Poland, but also imported from Germany via Estonia. The foreign companies selling these substances clearly state on their websites that the stuff they are selling is 100% GBL, which metabolises into GHB or 'gamma' in the body. The substance is sent to customers in plastic bottles whose labels indicate that they contain cleaning agents, for instance. Users also order batches of designer drugs for their own use over the Internet, as is shown by the considerable increase in the number of parcels containing designer drugs sent by post. (National Bureau of Investigation 2012.)

Import and the drug market

Drug-related crime has robust international connections. In recent years, 24% to 35% of those suspected of aggravated narcotics offences in Finland have been foreigners. The largest groups of suspects were Estonians and Russians or Russians living in Estonia. On the Finnish market, Finnish criminals generally manage the reception and distribution of drugs in Finland, while foreigners are engaged in import and smuggling. As in several earlier years, foreigners accounted for about 7% of suspects in all drug-related crimes in 2011. (National Bureau of Investigation 2012.)

Drugs are imported to Finland by land concealed in cars, vans and trucks. Couriers carry drugs concealed in their clothes and luggage and, increasingly, within their bodies. Drugs are also imported by sea in cargo ships, fast ferries and private yachts. Drugs also arrive by air, although the number of large batches of drugs brought in with tourist traffic by air has decreased due to tighter security screening of both passengers and luggage. Instead, larger quantities are flown in by air cargo and through courier companies. In most cases, imported drugs are transferred via a cache, the seller hiding the stuff and then drawing a map or making a note of the GPS coordinates of the location. Cache maps are tradeable commodities on the criminal market. (National Bureau of Investigation 2012; Perälä 2011.)

⁷⁷ For this study, 38 Finnish home growers of cannabis were interviewed in 2008, an anonymous online survey with 65 questions was targeted at Finnish home growers of cannabis (1,298 responses being received, of which 1,054 from growers) in 2009, and population survey materials analysed for hashish and marijuana use were examined.

⁷⁸ Gamma-butyrolactone (GBL), known in colloquial Finnish as 'lakka', is a substance governed by the Medicines Act and used as a cleaning agent and industrial chemical.

The majority of drugs are smuggled onto the Finnish market through various routes, particularly from the south and west. According to the police, most of the amphetamines on the Finnish market today come from western Europe, being smuggled in through Estonia or Lithuania. Currently, amphetamine and metamphetamine are also produced in Lithuania and trafficked to the Finnish markets by Estonian dealers. Today, amphetamine import is highly systematic and on a large scale. The usual scheme sees the Estonian dealers cache the amphetamine, with the Finns buying a map using which they retrieve the product. (National Bureau of Investigation 2012.)

The drug culture in Russia is becoming more Western, and the use of amphetamine, ecstasy, hashish and cocaine in particular is increasing. Increased surveillance along heroin smuggling routes and overdose fatalities from 3-methylfentanyl have led to heroin being replaced by cheaper and more easily obtainable substances on the Russian market. Synthetic drugs have also eaten into the market share of heroin in Russia, and the sharp increase in the demand for amphetamines has led to a number of illegal amphetamine laboratories being set up in St Petersburg and the Leningrad Oblast. Amphetamine can be manufactured from a number of precursors that are freely available, and the quality of amphetamines on the drug market is highly variable. Amphetamine production growth in Russia is also of some relevance for the Finnish drug market. International amphetamine comparisons indicate that amphetamine originating on the Russian market has been found in both Estonia and Finland. (National Bureau of Investigation 2012.)

Hashish, in turn, originates in Morocco, passing first through Spain, the Netherlands or Germany and then by sea, through Scandinavia or the Baltic countries. Hashish smuggling from central Europe via Finland to Russia has increased. Customs regularly seize major batches of hashish professionally concealed mainly in luxury cars. Hashish smuggling within the bodies of couriers has also become more common. Customs have found in criminal investigations that smuggling of khat is also an organised business involving large sums of money. Most khat seizures are made from airline passengers arriving from the UK, but the use of airmail and overnight courier services has increased in recent years. Khat is also smuggled into Finland concealed among legitimate cargo for instance in refrigerated transport. (National Bureau of Investigation 2012.)

Russia has been a significant route, especially for smuggling heroin, but heroin also reaches Finland via other routes. The lack of treatment services and the decreased supply of Subutex on the illegal market may increase the demand for heroin. In addition, Finland is a potential route for the international smuggling of heroin from Russia to elsewhere in Europe. The threat of drug smuggling via the Nordic countries (including Finland) to Russia is also a point to consider, as drugs are being smuggled through the northeastern corner of the EU to Russia in particular, especially by Lithuanian criminal groups active in international cocaine trafficking. Potential smuggling of designer drugs via Finland to Russia should also be given special focus. (National Bureau of Investigation 2012.)

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

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

The lower level is made up of gramme dealers and users. A batch of drugs may be resold one gramme or one pill or one 'fix' at a time. All of the lower-level actors themselves use the drugs they sell, their sales are small in volume, and there are considerably more actors on the lower level than on the other levels. The

operations here are often quite brutal. Drug use brings a measure of uncertainty to the running of the system and erodes trust between actors. Everyday life becomes chaos as verbal agreements fail to be honoured. By contrast, the authorities have become very good at controlling this level with tactical means. (Perälä 2011.)

Smuggling of pharmaceuticals classified as drugs

Using intoxicating pharmaceuticals as drugs is very common among Finnish substance abusers. Acquiring intoxicating pharmaceuticals is done particularly by exploiting the lack of centralised monitoring of the dispensing of pharmaceuticals: prescriptions are obtained from several physicians, and the pharmaceuticals thus obtained are both sold on the illegal market and used by the users themselves. Pharmaceutical products are also obtained from abroad, typically by ordering them online from a variety of countries. More than 90% of the pharmaceuticals of foreign origin arrive by mail; the largest volumes of seizures have been made from postal deliveries originating in the UK, India, Thailand and Turkey. The Schengen enlargement has boosted the importance of smuggling on the illegal market in intoxicating pharmaceuticals, and smuggling particularly from the Baltic states to Finland has increased. With the end of 'legal drug tourism', smuggling drugs within the body has become more common in the traffic between Finland and Estonia. There is a lively tourist trade in pharmaceuticals in Estonia; substantial quantities of benzodiazepines are imported from Estonia to Finland, mainly by ship passengers. In autumn 2011, a batch of nearly 20,000 tablets of a clonazepam preparation (a benzodiazepine) was smuggled into Finland concealed in a car tyre. Drug tourism to the Far East is also becoming more common, and many airline passengers bring back intoxicating pharmaceuticals from Thailand, for instance. (National Bureau of Investigation 2012; Finnish Customs 2012.)

The import routes for Subutex have been realigned after Estonia and Latvia joined the Schengen zone. Subutex is now often smuggled from France to Finland via the northern route, through Sweden. Buprenorphin has gained more ground in Sweden and Norway, and smuggling from these countries to Finland has increased, as is shown by the seizure of large batches of Subutex en route to Finland in Sweden. Northern Finland has become a significant market area for Subutex, which has now become a problem drug in the northern reaches of the country too. Another emerging area for sourcing Subutex is the UK, which lies outside the Schengen zone. Also, Subutex is available on prescription in Lithuania. The potential offshoring of Subutex production to the Far East will probably increase online sales, in particular. (National Bureau of Investigation 2012; Finnish Customs 2012.)

Drug production facilities

No synthetic drugs production facilities have been discovered in Finland. Overall, during recent years, only a handful of small facilities for the precipitation of amphetamine sulphate have been found. These have been procuring the necessary chemicals by ordering them from players in the chemistry field or by stealing them from research institutes or workplaces in the chemistry sector. Thus, combating illegal activities is also highly dependent on the alertness of the sector's players. Trade in the precursors required for drug production is often associated with legal business operations, but some legally transported chemicals may also end up in the production of drugs in Finland's neighbouring areas. In terms of the trade in precursors, Finland occupies a high-risk position: there are illegal drug production facilities in Russia and in all the Baltic states, and Finland engages in trade in chemicals or through transport of precursors with all these countries. No significant precursor seizures have been conducted in Finland. Precursor seizures are an effective means of preventing drug production and rendering it more difficult. (National Bureau of Investigation 2012.) In 2010, the Customs authorities seized ephedrine in tablet form. The users were fitness activists and had no intent of manufacturing drugs. (Finnish Customs 2011.)

In May 2010, the police made a unique discovery in Helsinki, including nearly 60 kg of mCPP, a substantial number of Bromo-Dragonfly blotters and a tablet-making machine. Often marketed as a substitute for ecstasy, mCPP is a designer drug which was classified as a narcotic drug in Finland on 12 March 2012. The police estimate that the quantity of mCPP seized would have been sufficient for about

800,000 tablets. A substantial number of Bromo-Dragonfly blotters, considered highly dangerous, was discovered in the same raid. Bromo-Dragonfly, which resembles LSD, was also classified a narcotic drug in Finland on 12 March 2012. (National Bureau of Investigation 2012.) Experts estimate that in the near future drug manufacturing may spread to Finland from countries that already have illegal drug production facilities.

10.2 Narcotics seizures

Data on drug seizures indicate that the situation prevailing on the Finnish drug market is fairly stable. Criminal cases concerning cannabis cultivation and narcotic pharmaceuticals have become more common in 2011. The number of designer drug discoveries, types of designer drug and types of intoxicating herbal product have all continued to increase, and the increasing popularity of ordering designer drugs online is apparent in the work of the Customs authorities in particular. In 2011, the Customs found 85 different kinds of designer drug, of which 42 had never been seen before. The number of intoxicating herbal products discovered was 13. In all, the Customs Laboratory discovered 10.4 kg of designer drugs. Those most common on the drug market are GBL or 'lakka', synthetic cannabinoids, methylone and methiopropamine. A new Act that entered into force on 12 March 2012 classified the following designer drugs as narcotic drugs: JWH-018, JWH-073, JWH-081, 2-DPMP, mCPP, methylone and Bromo Dragonfly. Last year, Customs seized more than 300 batches of the aforementioned seven designer drug types combined. (National Bureau of Investigation 2012; Finnish Customs 2012.)

Table 11. Drugs recorded as seized by the police and Customs in 2004–2011 (kg).

	2004	2005	2006	2007	2008	2009	2010	2011
Hashish	467.4	430.6	282.7	360	47	440	250	860
Marijuana	25.8	43.4	32.9	36	56	100	80	97
Cannabis plants (pcs)	7,840	9,460	7,510	7,600	14,000	12,500	15,000	16,400
Cannabis plants (kg)*	41.7	43.3	36.2	87	41	45	31	42
Amphetamines + Methamphetamines**	108.6	116.6	129	152	130+17	110+5	113+39	71+28
MDPV						4	9.5	2.4
Cocaine	1.1	1.2	6.5	4	3	2.8	4.2	3.5
Khat	2,118	2,562	3,283	3,300	2,250	3,300	4,700	5,800
Heroin	0.2	52.4	0.2	0.4	0.2	2	0.4	1
Subutex (tablets)	32,970	24,478	22,979	20,600	12,000	17,000	15,000	31,700
Ecstasy (tablets)	23,243	52,210	39,185	83,000	34,000	15,100	27,000	17,800
LSD (doses)	195	452	171	2,138	3,082	620	790	1260
Bromo Dragonfly (pcs)						1,200	7,600	1,100
GBL+GHB** (litres)			24	91	150+9	84+2	37+5	930+2.5

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

** = Combined until 2007, separate from 2008.

Source: National Bureau of Investigation 2012.

Table 12. Number of drug seizures recorded by the police and Customs in 2002–2011.

	2002	2004	2006	2007	2008	2009	2010	2011
Hashish	3,012	2,626	2,599	1,900	1,500	1,940	1,933	1,829
Marijuana	1,275	2,067	2,269	2,400	3,000	3,700	4,018	4,281
Cannabis plants	923	1,406	1,378	1,900	2,100	2,650	2,716	3,187
Amphetamines + Methamphetamines	3,399	3,392	3,101	2,990	2,900+120	2,910+125	3,154+199	3,157+90
Cocaine	45	65	82	92	107	102	126	81
Heroin	145	45	25	20	25	26	9	3
Subutex	741	844	840	800	850	940	1,126	1,276
Ecstasy	329	328	297	340	250	190	229	300
LSD	10	21	15	50	73	52	73	92
GBL+GHB			54	184	170+80	112+28	69+40	182+45
Khat			180	199	130	220	227	237

Source: National Bureau of Investigation 2012.

In 2011, the number of seizures of **cannabis products** in Finland was, once more, higher than ever. The number of **cannabis plants** seized (about 16,400) was also higher than ever: the number of seized cannabis plants had more than doubled since 2007. The amount of **marijuana** seized was the second highest per year on record, about 97 kg. This figure has nearly tripled since 2007. The growth is explained by factors such as a small number of exceptionally large seizures from smuggling undertaken by foreign parties from the Netherlands to Finland. In 2011, the amount of **hashish** seized was a record-breaking 860 kg. Most of this was on its way to Russia; the hashish seized was discovered by Customs in caches professionally concealed mainly in luxury cars. Hashish smuggling within the bodies of couriers has also become more common. The volumes of seizures of the most popular imported drugs are crucially affected by the results of investigative operations focusing on large-scale smuggling. The largest individual seizures of hashish in 2011 were an exceptionally large batch (about 210 kg) smuggled into Finland by ship concealed in two vehicles and two seizures of about 90 kg each made at the Vaalimaa border checkpoint in vehicles en route from Finland to Russia. (National Bureau of Investigation 2012.)

In the category of synthetic drugs, seizures of **amphetamines** totalled about 71 kg in 2011, clearly less than in previous years. In the largest individual seizure of amphetamines, a 6 kg batch was discovered in a cache in the ground. The two next largest seizures both involved batches of about 2 kg, one discovered in the residence of a suspect and another in a cache in the ground near the residence of the suspect. Shortages in amphetamine supply are continuing to be filled with **metamphetamine**, the percentage of which on the Finnish drug market and smuggling has continue to grow as is the case elsewhere in the Nordic countries and in the Baltic states. In 2011, the amount of confiscated metamphetamine was 28 kg. The largest single seizure was an outdoor cache of nearly 16 kg of methamphetamine. Another major outdoor cache with 8 kg of methamphetamine was discovered by Customs. (National Bureau of Investigation 2012.)

Alongside and among amphetamine on the market there are increasing amounts of methylenedioxypropylvalerone (**MDPV**), seizures of which in 2011 were lower than in previous years, totalling only 2.4 kg. The market share of MDPV has declined because of its poor reputation and because it was classified as a narcotic drug as of 28 June 2010. (National Bureau of Investigation 2012.)

The quantity of **ecstasy** seized in Finland per year again decreased in 2011, to less than 20,000 tablets, which is considerably lower than the peak annual figures of more than 80,000 tablets in the 2000s. Seizures

of **mCPP** (chlorophenylpiperazine, classified as a narcotic drug in Finland as of 12 March 2012), marketed as an alternative to ecstasy, were also low, only 60 tablets. (National Bureau of Investigation 2012.)

LSD seizures in 2011 increased slightly from the previous years to 1,260 blotters; seizures of **Bromo Dragonfly** (classified as a narcotic drug in Finland as of 12 March 2012) amounted to 1,100 blotters. (National Bureau of Investigation 2012.)

Cocaine has grown slightly in popularity on the Finnish market in the past few years, but it remains rather a marginal drug: only about 3.5 kg of cocaine was seized in 2011, in fewer than 100 items. (National Bureau of Investigation 2012.)

The amount of seized **heroin** in Finland plummeted at the beginning of the 21st century. The volume of heroin on the market remains low. Seizures in 2011 totalled about 1 kg. (National Bureau of Investigation 2012.)

Heroin has largely been replaced by the buprenorphine preparation **Subutex**, seizures of which increased considerably in 2011 to 31,700 tablets, the largest number in five years. The quantity seized of **other pharmaceuticals classified as narcotic drugs** (mainly benzodiazepines and some opiates) was double the annual average in recent years, some 243,000 tablets. (National Bureau of Investigation 2012.)

In 2011, Customs tracked down a large-scale and systematic operation for importing and distributing **GBL** in southwestern Finland. A Finnish man was suspected of ordering 1,000 litres of GBL from a Chinese pharmaceutical company. A total of 860 litres were seized, making this the largest single seizure of GBL in Finland to date. The substance was intended for the drug market in the Greater Helsinki area, and the batch would have been worth more than EUR 1 million on the street. The total volume of seizures of GBL in 2011 was a record-breaking 930 litres. (National Bureau of Investigation 2012.)

The volume of seizures of **khat**, a drug favoured by Finnish residents of Somalian extraction, continued to rise to 5,800 kg in 2011, the highest figure recorded since the arrival of the substance in Finland. (National Bureau of Investigation 2012.)

10.3 Price and purity of drugs

Street prices of drugs remained fairly stable in 2011. Cannabis prices remained at previous year's level, a gramme of cannabis costing EUR 13–20 on the street. The typical street price for hashish was EUR 6–15 per gramme, slightly lower than in previous years. In Lapland, the price was higher, about EUR 20 per gramme. Amphetamines typically sold for just over EUR 20 per gramme on average, the range being from EUR 15–25 in the Greater Helsinki area to as much as EUR 40–50 in northern Finland. Methamphetamine prices were at about the same level. Heroin cost about EUR 120 per gramme and cocaine EUR 60–100 per gramme in 2011. An ecstasy tablet cost EUR 12–20 each and LSD blotters cost EUR 10–20 each for end users in 2011. (National Bureau of Investigation 2012.)

A tablet of Subutex will cost the user EUR 25–40 in the Greater Helsinki area and as much as EUR 100–160 in northern Finland. The price depends on the quantity bought. The street price of MDPV is reported to be around EUR 60–80 per gramme, although street prices as low as EUR 25–40 have been discovered in cases investigated by Airport Customs. A 0.5-litre bottle of GBL costs about EUR 60 when ordered online; the street price in Finland is EUR 1 to 20 per millilitre depending on the concentration. The price for intoxicating pharmaceuticals on the illegal market is EUR 1–3 per tablet nationwide, although benzodiazepines may sell for anything up to EUR 5 per tablet. (National Bureau of Investigation 2012.) A single dose of khat is 150 to 250 grammes and costs about EUR 25 when fresh. (Perälä 2011.)

Finnish street prices for drugs vary greatly depending on the sales location: in Helsinki and the Greater Helsinki area, prices are clearly lower in general than in regional centres. A study conducted in the spring of 2011 suggests that, in regional centres, the price of amphetamines, popular among hard drug users, may be well be double that of Helsinki. Hashish and Subutex are also clearly more expensive outside the Helsinki area. Unlike the prices of smuggled drugs, cannabis prices do not show regional variation. Indeed, in regional centres cannabis may even be cheaper than in Helsinki. However, under special conditions, such

as when drugs are smuggled into a prison, prices may be very high on a case-by-case basis. (National Bureau of Investigation 2012.)

Laboratory tests at the Forensic Laboratory of the National Bureau of Investigation or the Customs Laboratory are conducted to establish whether samples obtained in the course of an investigation or in a seizure contain substances or preparations classified as narcotic drugs, pharmaceutical substances or doping substances, or new unclassified intoxicating substances, i.e. designer drugs. The Forensic Laboratory also investigates the illegal manufacture of narcotic drugs. Drug batches are compared to establish whether two (or more) batches were manufactured at the same laboratory or come from the same original batch. Such comparisons are frequently performed between batches of amphetamines in particular. Routine analyses of concentrations of seized drugs are only conducted for amphetamine and methamphetamine if the seized quantity exceeds 10 grammes or, for heroin and cocaine, 2 grammes. On request, concentrations of cannabis plants and marijuana are analysed for consignments exceeding 150 grammes. In other respects, concentrations are not analysed. (National Bureau of Investigation 2012.)

No significant changes were found in the average concentrations of drug samples during 2011. The average concentration of amphetamines has continued to decrease (2007: 29% by weight; 2011: 18% by weight). Average concentrations are about 30% by weight for cocaine and metamphetamine. What all drugs have in common is that there are huge variations in concentration. (National Bureau of Investigation 2012.)

B. SELECTED ISSUES

11 Institutional care for drug users in Finland

The purpose of this chapter is to discuss trends and the current situation in institutional drug use treatment in Finland as illustrated by a variety of materials – treatment statistics, documents, strategies and previous studies on the treatment. Specialised drug use treatment in Finland dates back to the early 1970s, at which time the treatment of people with drug problems was transferred from psychiatric care to social services together with other substance abuse care. At the time, some of the care facilities specialising in substance abuse care took responsibility for drug user care too (Kuussaari 2006). In the following decades, trends in drug use treatment and also in the institutional care for drug users in Finland have followed shifts in treatment philosophies, drug policy, welfare policy and the funding and structures of services. Key determinants of treatment have included central and local government, which provide funding for services and also maintain care facilities of their own, and in particular the NGOs providing substance abuse services specialising in drug use treatment. Drug use treatment has also been determined from time to time by drug users' family members, the drug users themselves, and certain individual persons and experts in the public eye.

11.1 History of institutional care, and legislation and recommendations on care

The history of drug use treatment in Finland is an under-researched area. Also, there have not been very many clinical studies exploring drug use treatment methods in Finland (Selin 2011c; Kaukonen 2005). The paucity of research may be partly due to the fact that Finland did not really acquire a drug use treatment system separate from the treatment of alcohol problems until the 1990s; prior to that, drug use will have been subsumed in the broader history of substance abuse services (Kaukonen 2002).

Generally, care provided for drug users in Finland has been analysed into various phases in previous studies, touching on trends in institutional care along the way. In their article *Finland: Drug Treatment at the Margins* (1998), Aarne Kinnunen and Juhani Lehto identify four phases in drug care from the early 1960s to the mid-1990s: 1) the psychiatric care phase (late 1960s to early 1970s); 2) the social therapy phase (early 1970s); 3) the separate drug use treatment decline phase (1975 to 1986); and 4) the pluralist phase (1987 to 1996). Olavi Kaukonen (2002) later augmented Kinnunen and Lehto's analysis by identifying a drug use treatment expansion phase from the mid-1990s onwards, influenced by significant changes in the drug use situation and drug policy in Finland towards the end of the decade. The following is a review of institutional care for drug users in light of the aforementioned phases.

1970s to 1990s

At the psychiatric phase of drug use treatment (late 1960s to early 1970s), drug problems were principally defined as medical problems, and responsibility for treatment for drug users rested with the health care system. Institutional care was provided primarily at psychiatric hospitals. No prior research exists concerning the contents and practices of drug use treatment applied during this phase, but it may be assumed that it involved psychiatric care practices typical for the era, such as various combinations of therapy and medication. In the mid-1970s, an experimental methadone treatment programme for people with chronic opiate addiction was begun in psychiatric medical care (Ahokas, Kajesalo & Holopainen 1998). The use of coercive measures was more common during the psychiatric care phase than it is now. This was due not so much to principles of psychiatric care as to principles of social order. According to the then valid Act on the Care of Abusers of Intoxicating Substances and Vagrants Act, "abusers of

intoxicating substances” – not differentiated by the substance(s) used – could be committed to a sanatorium or an institution if this was considered necessary because the patient was dangerous, a burden to society or in need of social assistance. Also, persons suffering from psychosis and severe withdrawal symptoms could be put in psychiatric care pursuant to the Mental Illness Act. At the turn of the 1960s–1970s, psychiatric hospitals treated up to 900 drug users in inpatient care each year (Kinnunen & Lehto 1998).

In the social therapy phase of drug use treatment (early 1970s), a move was made to shift drug use treatment away from psychiatric care, together with the treatment of problem users of alcohol. According to Kinnunen and Lehto (1998), the motivating force behind this was the deinstitutionalisation trend that had arrived in Finland through international influences in the late 1960s; one of the aims of this trend was to move certain groups of patients out of psychiatric hospitals who did not belong there, such as those with chronic substance abuse problems. As a result, the treatment of both drug problems and alcohol problems was transferred from general social services to the gradually emerging specialised substance abuse services, and social workers became a key professional group in drug use treatment and more generally in substance abuse services (Kinnunen & Lehto 1998). In terms of institutional care, responsibility for drug use treatment was transferred to two care facilities with a tradition of specialising in substance abuse problems: the Järvenpää Social Hospital and the A Home in Mikkeli (Kinnunen & Lehto 1998; see also Kuussaari 2006). Both facilities received funding from the central government specifically earmarked for drug use treatment.

What was remarkable in the social therapy phase compared with practices in the preceding decades was the emphasis on voluntary treatment and outpatient care for substance abusers, as outlined in two key reports on drug policy published in 1969 and 1971. These principles are still alive and well. The reports also stressed how similar alcohol problems and drug problems are; it was feared that creating special services just for drug users would enhance their sense of a separate identity and thereby the drug culture. (Kuussaari 2006; Hakkarainen 1999). This practice too can still be detected in the practices of care institutions, even though the treatment of patients with alcohol problems and those with drug problems have gradually become differentiated, particularly since the 1990s.

In the separate drug use treatment decline phase (1975–1986), the professional identity and practices of drug use treatment declined, and dedicated drug use treatment wards began to lose clients. (Kuussaari 2006; Kinnunen & Lehto 1998). According to Kinnunen and Lehto (1998), there were three key factors behind this decline. Firstly, it was becoming increasingly rare to encounter clients who only had drug problems. For instance, many young people who sought treatment had experimented with drugs, but their main problem was with alcohol. In other words, demand for specialised drug use treatment shrank. This strong downward trend can also be seen in the statistics on drug experimentation and use after the middle of the 1970s (Kontula 1996). Secondly, the decline was facilitated by the principle of the essential similarity of alcohol and drug problems based on the aforementioned committee reports, which in turn influenced the ongoing reform of substance abuse legislation. There was a reluctance to single out drug use and related problems in this process, and it was therefore considered that substance abuse problems of whatever kind could be treated at the same locations. There was thus seen to be no need for separate drug use treatment units. The third change that significantly contributed to the reduction in drug use treatment capacity was in the funding of care facilities. With the major Finnish administrative reform known as VALTAVA in the 1980s, local authorities were charged with added responsibilities in providing services, and the central government no longer provided funding ‘earmarked’ for drug use treatment; instead, local authorities were required to arrange their funding themselves. For NGOs, this reform involved a transfer to performance-based funding, which meant that it was not worthwhile to maintain empty beds for drug users, who by that time were rarely encountered in treatment situations (e.g. Ahonen 1999).

However, after the mid-1980s the number of beds for drug use treatment began to increase again. Kinnunen and Lehto (1998) describe the phase beginning at this time as the pluralist phase, referring particularly to the diversification that began to emerge in drug use treatment services in the 1980s. At that time, new players entered the field of drug use treatment, and new treatment ideologies emerged alongside the traditional social therapeutic approach (see also Kuussaari 2006; Kaukonen 2002). For instance, three

new institutional care facilities were founded that have been specialising in drug use treatment ever since: the Hietalinna Community, the Kisko Clinic and the Drug Detoxification Unit at Helsinki University Central Hospital (HUCS).

This change, too, was enabled by several factors. Firstly, a new Act on Welfare for Substance Abusers entered into force in 1986; this Act emphasised the similarity of alcohol and drug problems. As a reaction to the new Act, parents of children suffering from drug problems began a public campaign to gain more beds for drug user treatment and particularly an enhancement to measures aimed at young drug users. They asserted that treating drug problems specifically required measures different from those used to address alcohol problems. Families' organisations played an active role for instance in establishing the HUCS Drug Detoxification Unit. At the same time, a more general public debate was being conducted on drug policy and drug use treatment in Finland. Kinnunen and Lehto (1998) note that in the 1980s drug policy became a more important area in national politics because of international trends, and it was now considered essential for various authorities to allocate more resources to dealing with drug problems. Increasingly, a broader drug policy reform was called for in public, including a reform of drug use treatment. All of the above led, as Kinnunen and Lehto describe, to a paradoxical situation where the number of drug use treatment beds was being increased even though the newly minted Act on Welfare for Substance Abusers insisted that alcohol abuse treatment and drug use treatment should not be considered or provided for separately, and even though drug use and related problems had not grown by very much at all (Kinnunen & Lehto 1998; Hakkarainen & Kuussaari 1996).

According to Kristiina Kuussaari (2006), the number of new drug use treatment units began to increase at this point due to yet another change in the central government's funding practices. Because of a 1987 amendment to the Decree on the Finnish Slot Machine Association, which has a monopoly on gaming machines in Finland, it was possible to allocate funds from the Association to NGOs. This enabled NGOs providing substance abuse services to improve their expertise in drug use treatment even if local authorities, which were otherwise responsible for funding these services, would not invest in it (see also Kaukonen 2002). Indeed, international comparisons (Klingeman et al. 1992) show that at the end of the 1980s Finland had one of the world's most comprehensive networks in specialist substance abuse services in the world relative to population and the level of drug use. Another key feature of Finnish substance abuse services at this time was the predominance of institutional care.

Kinnunen and Lehto's survey extends up to the year 1996. After that, major changes occurred in Finnish drug policy and drug use treatment, leading to a proliferation of the number of specialist drug use treatment units in the 2000s. The following is a discussion of trends in this period, described by Olavi Kaukonen (2002) as the expansive phase of drug use treatment, drawing on earlier analyses of changes in drug use treatment prompted by the second wave of drug use.

2000s

At the expansive phase of drug use treatment, specialist services increased in volume and diversity. At this time, the drug use treatment system was being developed as a consistent whole, and continuity of treatment was addressed through networking and training, with a view to increasing the capabilities of social welfare and health care professionals in particular in how to encounter and treat clients with drug problems. This trend was fuelled by a sharp increase in drug use with the arrival of the 'second wave' of drug use in Finland in the 1990s, particularly in the use of opiates. The harmful impacts of increasing drug use prompted a need for a reform of Finnish drug policy and drug use treatment, as can be seen in a substantial increase in the number of reports, documents, regulations and action plans produced between the 1990s and the 2000s (Hakkarainen & Tigerstedt 2002). In terminology, this change is reflected in the transition from general substance abuse services towards specialist drug use treatment (Kaukonen 2002; see also Weckroth 2006).

The central government allocated more than EUR 15 million to the development of drug use treatment in its budgets for 2002 and 2003; these funds were used both to augment the operations of existing

treatment facilities and to set up completely new units (Kaukonen 2005). Funds were allocated specifically to the development of opiate substitution treatment and low-threshold health counselling centres for intravenous drug users, the latter being intended to reach the most disadvantaged drug users (Kaukonen 2005; see also Villikka 2004).

Key documents governing drug use treatment in this period were the Report by the Finnish Drug Policy Committee (1997) and the related Government Resolution (1998), both of which highlighted the need for developing drug use treatment and a more diverse drug policy. Also, several memoranda on care for problem users were published, discussing issues related to the development of opiate substitution treatment in particular (Hakkarainen & Tigerstedt 2002). According to Pekka Hakkarainen and Christoffer Tigerstedt (op.cit), many of these documents show a 'medical-liberal' outlook focusing on pharmaceutical treatments.

What is interesting from the perspective of institutional treatment is that the development of institutional drug use treatment was not separately discussed at this point. On the other hand, a 're-psychiatrisation' of drug use treatment occurred in the 2000s, as witness the increasing number of clients at addiction psychiatry inpatient wards (Kaukonen 2005).

Despite the proliferation of drug use treatment units, drug use treatment was the focus of critical discussion as well, even in this expansive phase. NGOs and treatment units subscribing to the social therapeutic approach, and also certain scientists researching substance abuse services, particularly criticised the dominance of substitution treatment in various drug use treatment strategies, as it was feared that this would eclipse discussion of the psychosocial issues related to drug use and lead to an unduly narrow definition and treatment of drug problems. Uncontrolled spreading of substitution treatment was also seen as a threat, leading in the long term to chronic drug use problems.

In short, the development of drug use treatment in Finland may be described as a transition from generic control and treatment of substance abuse problems towards more specialised drug use treatment. Another major trend has been the transition from the social therapeutic approach originating in the 1970s to more medically oriented forms of drug use treatment (Selin 2011c; Tammi 2007; Kuussaari 2006). This can be considered to have influenced the development of institutional care too, as rehabilitative institutional care has had to yield to outpatient substitution treatment in the first decade of the present century.

At the level of legislation and strategies, drug use treatment like all substance abuse services has become more client-oriented in terms of content; at the same time, the legislation has become broader, allowing more leeway for local negotiation and discretion as far as the providing of the services is concerned (Kaukonen 2005).

11.2 Legislation, key strategies and recommendations underlying institutional care

In Finland, the responsibility for providing drug use treatment, as with all social and health services, rests with local authorities. The Act on Welfare for Substance Abusers (14/1986) requires municipalities to ensure that the provision of substance abuse services meets local needs as regards content and scope. The goal is to prevent and reduce problem use of intoxicants and related social and security issues. The Act is complemented by the Decree on Welfare for Substance Abusers (653/1986), which contains more detailed provisions for instance on providing substance abuse services, drawing up rehabilitation plans, official appointment procedures, treatment of clients under 18 years of age and isolation of clients.

The Act on Welfare for Substance Abusers also allows for a client to be committed to involuntary treatment pursuant to the Mental Health Act, the Act on Welfare for Substance Abusers or the Child Welfare Act. Involuntary treatment is indicated when a substance abuser client is unable to make informed decisions because of his/her illness or intoxicant addiction. Traditionally, this provision has been invoked only very rarely in Finland. However, there is currently a lively public debate on increasing the commitment to involuntary treatment of pregnant substance abusers, and a Government bill is being prepared to this effect.

Other principal legislation relevant for the providing of substance abuse services include the Communicable Diseases Act (583/1986), the Decree of the Ministry of Social Affairs and Health on the detoxification and substitution treatment of opioid addicts (33/2008) and the Act on the Rehabilitation Benefits and Rehabilitation Allowance Benefits of the Social Insurance Institution of Finland (566/2005). The implementation of substance abuse services is provided for in concrete terms in the Act on Health Care Professionals (559/1994) and the Decree on Qualification Requirements for Social Welfare Personnel (804/1992), both of which govern substance abuse services employees, and also in the Act on the Status and Rights of Social Welfare Clients (812/2000) and the Act on the Status and Rights of Patients (785/1992). In 2005, a treatment guarantee was introduced in Finland in amendments to the Public Health Act and the Act on Specialist Medical Care, specifying maximum waiting periods for access to non-urgent examinations and treatment. In the area of drug use treatment, the treatment guarantee covers opioid substitution treatment, to which a client must be provided access within six months of seeking treatment (for further information on acts and decrees, see also Kekki & Partanen 2008).

Principal strategies and recommendations underlying the providing of drug use treatment include the 'Quality recommendations for substance abuse services' published by the Ministry of Social Affairs and Health (2002) and the Current Care guidelines for drug abusers drawn up by Duodecim and the Finnish Society of Addiction Medicine (2006). The national plan for mental health and substance abuse work (MIELI), published in 2009, outlines the key principles and focus areas for mental health and substance abuse work up to 2015. What is interesting in the MIELI plan from the perspective of institutional care is an emphasis on outpatient care and the explicitly stated aim of reducing the need for institutional care in both mental health services and substance abuse services. These recommendations will be discussed below in section 3.

11.2.1 Funding of institutional care and various means of funding

In Finland, liability for funding institutional care rests with local government. Where a local authority does not provide statutory services itself, it may outsource them through competitive tendering, augment its own services by entering into strategic partnership agreements with the third sector, or set up a joint authority with other municipalities, a hospital district, third-sector NGOs and/or the private sector. At the moment, the most common means for funding institutional care is the purchaser-provider model, where a local authority buys the services it needs from a private service provider, an NGO or a private care enterprise. In 2010, more than 60% of all substance abuse services were provided by NGOs or private service providers.

Some local authorities still have care facilities of their own, and in some municipalities substance abuse services have been converted into foundations. For instance, there is a substance abuse service foundation in operation in the Jyväskylä area in central Finland and another in the Kuopio area in eastern Finland; local authorities sign annual purchase agreements with these foundations or issue guarantees of payment for their clients. The principal aim in setting up substance abuse service foundations is to bring together substance abuse service professionals in a single organisation for better coordination of services (see also Inkeroinen & Partanen 2006).

In recent years, funding of substance abuse services in municipalities has been governed mainly by the Act on Public Contracts (348/2007), which requires local authorities to subject all outsourced services to competitive tendering. Some people feel that this has undermined the resources available for substance abuse services, as local authorities have only considered the financial aspects of tenders submitted. Increasing competitive tendering is also considered to erode the volume of institutional care, as local authorities seek to cut costs (for more on this debate, see Perälä 2010; Kekki & Partanen 2008). Indeed, local government politicians are considered to exercise a huge influence on the content of substance abuse services provided to citizens. (Ministry of Finance 2008; Kaukonen 2005.)

11.3 Organisation of drug use treatment and availability of institutional care

Institutional care for drug users in Finland is largely a social service. Only addiction psychiatry wards and detoxification treatment beds at health centres fall within the domain of health care. Social welfare services on the one hand and health care services on the other are governed by different legislation, and the statistics on these operations are also compiled in differing ways.

11.3.1 Recent developments in institutional care in the light of statistics: number of treatment units, treatment days and clients treated

In 2012, there are between 70 and 80 facilities providing 24h treatment for substance abusers.⁷⁹ The number of rehabilitation institutions has somewhat decreased in recent years. (Forsell 2012b.)

In 2010, there were an estimated⁸⁰ 2,000 to 3,000 individual clients in institutional care because of drug use: 1,000 to 2,400 clients in social welfare institutions and 700 to 1,700 clients at hospitals in the health care system (treatment periods longer than one week). The number of social welfare rehabilitation clients in particular has been decreasing since 2006 (by 10% to 25%). (Forsell 2012b.) At the same time, however, both the number of clients in residential substance abuse services and the number of treatment days have increased (by 10% to 25%). (Yearbook of Alcohol and Drug Statistics 2011, National Institute for Health and Welfare.)

In the annual survey for collecting information from drug-related treatment conducted by the National Institute for Health and Welfare, 66% of clients in institutional care were men, about the same percentage as in outpatient care. The average age of clients was 30 years. Clients in institutional care are on the whole somewhat younger than those in outpatient care. No fewer than 17% of the clients in institutional care were homeless (vs. 8% in outpatient care), and only 4% of them had a job (11% ditto). Supported housing is not included in this survey. (Forsell 2012a.)

According to the survey for collecting information from drug-related treatment, opiates were the reason for seeking treatment for half (49%) of the clients in institutional care. The percentages of problem users of stimulants (18%), tranquillisers (8%) and alcohol (17%) were somewhat higher in institutional care than in outpatient care, and 78% of the clients in institutional care had used intravenous drugs at some point in their life. Problem users of opiates and cannabis were more common among clients in inpatient care in health care services (treatment periods lasting more than one week), while problem users of stimulants were more common in institutional care in social welfare services⁸¹ (Forsell 2012a; 2012b).

11.3.2 Forms of institutional rehabilitation

Substance abuse service facilities in Finland offer detoxification, short-term care intervals and long-term rehabilitation. Drug users with severe mental health problems are treated in addiction psychiatry wards. Supported housing has become more common in recent years. It is a sort of combination of outpatient care and institutional care, with clients living in their own apartments or rooms but participating in day-centre activities integrated with the housing facility.

⁷⁹ This estimate is based on TOPI, the Register of Institutions in Social Welfare and Health Care maintained by the National Institute for Health and Welfare. The majority of institutions in the TOPI register are in the social welfare sector, because health centres and hospitals are entered as single entities, not analysed by specialisation. Comparison over time is difficult because practices have changed. In actuality, the number of substance abuse rehabilitation institutions has decreased by a dozen since 2006.

⁸⁰ The estimate was obtained by comparing data on substance abuse clients in the statistics on 'Finances and activities of municipalities and joint municipal boards', in the Care Registers for Social Welfare and Health Care, and in the information from drug-related treatment compiled by the National Institute for Health and Welfare. The number of drug user clients was calculated by using a coefficient based on the census of intoxicant-related cases conducted by the National Institute for Health and Welfare.

⁸¹ The estimate was obtained by comparing data in the Care Register for Health Care and in the information from drug-related treatment compiled by the National Institute for Health and Welfare. Comparing the data from the former to data from the latter is rather difficult, because alcohol problems are not included in the health care statistics, and on the other hand the 'combined use' diagnosis, F 19, is rather common.

In most cases, rehabilitation for problem users of alcohol on the one hand and drugs on the other is not separated; services at rehabilitation facilities are aimed at both groups. Within these institutions, however, functions may be differentiated. Also, some rehabilitation facilities specialise in drug use treatment, while others do not accept drug users as clients at all. There are also beds and wards exclusively for men, women, families or adolescents.

Treatment of drug addiction or drug problems begins with a course of detoxification. Detoxification treatment is provided at inpatient wards at municipal health centres, at detoxification centres specialising in withdrawal treatment, and at major rehabilitation facilities. The size of these units varies from a couple of beds to a couple of dozen beds. Especially at detoxification centres and rehabilitation facilities, the detoxification treatment includes rehabilitative elements in addition to the detoxification proper. In health care services there are addiction psychiatry wards at major central hospitals, where dual-diagnosis patients are often treated and assessments of treatment needs are conducted.

After a course of detoxification, the client may seek entry to institutional rehabilitation by applying for a payment guarantee from the social services office of his/her home municipality. Having been through detoxification is often a requirement for being admitted to rehabilitation. Rehabilitation facilities in Finland vary in size from small institutions with a dozen beds to major hospitals with almost 100 beds. The larger facilities are sub-divided into wards.

Rehabilitation is followed by post-rehabilitation, typically in outpatient care or supported housing.

Typical forms of treatment

Institutional withdrawal treatment almost always involves medication and 24h monitoring. Other methods used include rest, monitoring of physical condition, one-on-one and group therapy sessions, and planning of further treatment. Detoxification is based on a treatment plan, which is drawn up following an investigation of the severity of the intoxicant problem and an interview with the client. Many treatment facilities also employ a care agreement that determines the progress of detoxification: how long it will be, what medication will be administered and what examinations carried out, and what the rules of the treatment facility are concerning outdoor exercise, visitors, personal items and confiscation of intoxicating substances.

No separate study has been conducted on detoxification treatment for drug users, although detoxification and withdrawal treatment have been discussed at a general level in some theses and reports (Lampela 2010; Mikkilä 2010; Makkonen 2005). Teija Makkonen's report from 2005 also outlines a number of development proposals. One of the flaws and development needs highlighted is the lack of integration of detoxification with other substance abuse rehabilitation services, which according to Makkonen is a challenge due to the fragmented nature of the substance abuse service system. The quantity and quality of detoxification services varies from one municipality to another, and it is difficult to obtain a comprehensive overview of the state of detoxification in the country as a whole.

Institutional rehabilitation is traditionally set up as a variety of therapeutic communities that often apply the 12-step programme and community treatment principles. The operations of the Kisko Clinic of the Kalliola Settlement Youth Association founded in 1986 and the Mikkeli Community founded in 1998, for instance, are based on these principles. The operations of the Kisko Clinic have been registered as a brand; the concept combines the ideals of the Daytop therapeutic community model, the NA programme, social rehabilitation, and individual and group therapy according to the transactional analysis framework. The work of the Mikkeli Community is based on community treatment, combined with the NA programme and cognitive and creative methods. Both facilities have a non-medicinal approach.

The work of the Kisko Clinic and the Mikkeli Community have been studied previously. (Selin 2010b; Heikkilä 2004; Kylmälä 2001; see also Hakkarainen & Kuussaari 1996.) Jani Selin (2010b) noted the ritual dimensions of community treatment in both these communities in his research, the purpose of the treatment being to 'normalise' the clients into becoming upstanding citizens and decent members of the community once again. Heikkilä highlights the "stressful" nature of the treatment at the Kisko Clinic, which he

describes as both an advantage and a disadvantage. The disadvantage is that many clients drop out of the treatment programme, but the advantage is that those who do go through with it generally achieve good results. Indeed, Heikkilä notes that the Kisko Clinic is suitable for drug users who are themselves motivated to make a change in their lives.

There is also a number of small communities around Finland operating on the ‘halfway house’ principle, combining the 12-step programme with community treatment on a small scale. Many of these also rely on strong peer support, and some employees have a history of substance abuse themselves.

Numerous rehabilitation facilities combine various models of psychosocial rehabilitation in their work. Therapeutic combinations are typical for instance of the services provided by the A Clinic Foundation, a national substance abuse service organisation. Rehabilitation facilities supervised by the A Clinic Foundation include: the Hietalinna Community, which relies on community therapy without medication; Järvenpää Social Hospital, which combines multi-professional treatment with medication and various forms of psychosocial rehabilitation; and the A Home in Kankaanpää, which relies on the ‘ASTA work’ concept, combining various forms of individual, pair and group therapy with recreation, manual skills and job assignments. These rehabilitation programmes often employ a client-oriented approach.

Organisations with a Christian background have traditionally played a key role in Finnish substance abuse rehabilitation. Seukkala, a rehabilitation home owned by a private association, is a currently active facility with a Christian orientation. The work done at Seukkala combines the principles of community treatment with Christian ethics (see also Asikainen et al. 2004). The Karismakoti facility operates on the same principle but is for men only. Clients usually have the option not to attend the spiritual functions at rehabilitation facilities with a Christian orientation. However, the Christian faith often has a strong presence at such facilities, and this is clearly indicated in their presentation. In recent years, the use of facilities with a Christian orientation in substance abuse rehabilitation has decreased. It has been suggested that this is due to a lack of trained personnel (see e.g. Perälä 2010).

Rehabilitation facilities and programmes based on the cognitive framework have become more common in the 2000s. Some of them market themselves as an alternative to community treatment in particular. Another type of service that has increased in popularity is supported housing. This is a service typically intended for long-term substance abusers, combining accommodation with low-threshold psychosocial support services. Post-rehabilitation services may also be provided in the context of supported housing. Some treatment programmes and substance abuse service NGOs have their own sheltered housing, admission to which may be gained with a payment guarantee from the local authority.

There are dedicated treatment facilities for women only and adolescents only in Finland. There are also separate rehabilitation services for pregnant women and for mothers and families with substance abuse problems. The latter are provided particularly by the nationwide Federation of Mother and Child Homes and Shelters. The treatment principles at rehabilitation facilities for women and adolescents usually follow the diverse approaches described above, but there is also a specific focus on womanhood or parenthood in the case of women and on regularity of lifestyle, healthy diet and self-care in the case of adolescents.

Health care services have addiction psychiatry wards intended for drug users with severe mental health problems. The Department of Addiction Psychiatry of the Hospital District of Helsinki and Uusimaa, for instance, provides psychosis treatment, detoxification in severe cases, evaluation periods, care intervals to support outpatient care, and initiation periods for substitution treatment. Treatment periods vary from a few weeks to a few months, depending on the client’s needs.

Combinations of treatments and services

Finnish institutional rehabilitation typically combines various forms of individual and group activities with the principles of community treatment. Group therapies often rely on the 12-step programme or occupational therapy, while individual therapies tend to involve various form of cognitive or social therapy. Facilities also offer opportunities for various leisure activities and in some cases also employment activities. In community treatment, clients are coached in responsible behaviour towards themselves and their

community and to commit to the rules of the community. In facilities with a Christian orientation, spiritual activities and pastoral therapy form an essential part of the treatment (cf. the previous section).

Rehabilitation facilities typically offer health care services, for instance for controlling clients' medication. Major facilities also have their own detoxification wards, from which clients are transferred to rehabilitation. The services of a social worker are often also available. Personnel often include professionals specialising in substance abuse services and mental health care, with training in social and behavioural sciences (e.g. social workers, psychologists, occupational therapists) or in health care (e.g. physicians, nurses, psychiatric nurses, physiotherapists). Smaller facilities often have personnel trained in substance abuse services and mental health care and a nurse, for instance.

Substitution treatment in institutional rehabilitation

Some facilities in Finland have integrated substitution treatment into their care programmes, particularly substitution treatment initiation periods. Sometimes substitution treatment clients are transferred to institutional care if they exhibit too much additional substance use in outpatient care. Substitution treatment at institutions is provided pursuant to the relevant Decree of the Ministry of Social Affairs and Health. Clients also participate in other activities at the institutions, such as community treatment as described above, individual or group therapy, or occupational therapy.

There is one prior study on the providing of substitution treatment in institutional care (Weckroth 2006). An extensive study on the provision of substitution treatment in Finland was commissioned by the Ministry of Social Affairs and Health last year but has not yet been published. This study was intended to explore which parties currently provide substitution treatment in Finland and how many of them there are. At the moment, it is not known exactly who all the service providers are.

Post-rehabilitation and care pathways

Extended periods of rehabilitation always involve the drawing up of a treatment plan and visits to post-rehabilitation facilities. Some institutions and some types of treatment have their own post-rehabilitation programmes or supported housing services. No comprehensive study has been conducted on post-rehabilitation or its effectiveness in Finland.

11.4 Quality control of institutional care

The key recommendations underlying substance abuse services and drug use treatment were discussed in section 11.2. There is no current study on the quality of drug use treatment, nor indeed of substance abuse services in general. However, the current state and arrangements in substance abuse services have been touched upon in various articles and reports (Ministry of Social Affairs and Health 2012a; Kekki & Partanen 2008). Flaws identified in the providing of services include the fragmented nature of the service system and the resulting difficulty in coordinating and monitoring services; also, it has been considered that services rely too heavily on outpatient care.

National and local recommendations

The purpose of the quality recommendations for substance abuse services (2003) is to support the planning, providing and development of substance abuse services by local authorities. These recommendations are based on the key legislation governing substance abuse services, discussed in section 11.2. The quality recommendations cover both general principles in providing substance abuse services and more detailed recommendations for instance regarding the number of employees at treatment units or accommodation arrangements. The following is a brief discussion of the recommendations.

Firstly, the quality recommendations require services to be provided in such a manner that the fundamental rights, human rights and legal protection of the client are safeguarded. The need for help, support and treatment by the client and by people close to him/her is considered the basic principle in

substance abuse treatment and services. The treatment itself is based on respect of self-determination, support for the client's own initiative, and confidentiality. The client's participation in the planning and content of his/her treatment and related decision must also be ensured, and the physical and mental health of the client, the social situation and the need for support must be taken into account. An individual rehabilitation plan must be drawn up for each client.

There are concrete recommendations for substance abuse services for instance regarding institutional accommodation. In institutional, group or dormitory-type sheltered housing, the target standard is to provide clients with a private room with a floor area of at least 15 sq.m. The minimum floor area for a room with twin occupancy is 20 sq.m. The accommodation may be smaller in short-term institutional care such as detoxification. The client's right to privacy must be taken into account when designing and building a treatment facility.

The personnel numbers require 0.8 employees with social welfare or health care qualifications per client in 24h detoxification and withdrawal treatment. For some client groups, such as underage children, drug users and multidrug users, clients with mental problems or intoxicated clients, the requirement may be 1.5 qualified employees per client. The personnel requirement for a rehabilitation facility is 0.5 employees with social welfare or health care qualifications per rehabilitation client. A sufficient number of personnel not involved with client work (administration, cleaning, catering, etc.) must also be present.

Personnel qualifications must comply with the Decree on the Professional Qualifications of Social Welfare Personnel and the Act on Health Care Professionals. Also, in general social welfare and health care services and in specialist substance abuse services it must be ensured that employees have sufficient professional expertise acquired through basic, further and continuing education for the early identification of substance abuse problems, care needs assessment and high-quality professional treatment and rehabilitation of substance abuse clients.

Quality assessment forms for substance abuse treatment units have been prepared on the basis of the recommendations; local authorities, for instance, can assess the quality of the substance abuse services they use with these forms. Quality assessment forms invite units to describe the basic features of their operations: what kind of treatment they provide, how clients are admitted to the unit, and how much care personnel the unit has and of what kind.

No research has been done in Finland on how well the quality recommendations are followed. There are great differences between municipalities, and it is difficult to gain an overall impression of the situation.

The purpose of the Current Care guideline on the treatment of drug abusers is to provide information to clarify treatment of drug problems, to improve cross-discipline co-operation, to promote networking and to influence attitudes. This guideline was drawn up by a working group appointed by the Finnish Medical Society Duodecim and the Finnish Society of Addiction Medicine, consisting mainly of physicians. The guideline notes among other things that various psychosocial methods are the foundation of drug use treatment but that there is no scientific evidence of their efficacy. For opioid addiction, medication is considered an effective treatment.

In addition to national recommendations, there are also substance abuse strategies drawn up locally by local authorities themselves. Some of these may be found in the *Neuvoa Antavat* online service of the National Institute for Health and Welfare. According to the quality recommendations, each local authority must have a substance abuse strategy forming part of the municipal health and wellbeing strategy. The strategy must determine how the local authority intends to prevent the emergence of harmful impacts of substance abuse, how substance abuse services are provided and how the division of duties between social welfare and health care in substance abuse services is managed. A local authority may prepare its substance abuse strategy together with other local authorities.

Some local authorities have only entered the title of their strategy in the online service, or a note to the effect that there is a strategy. Some strategies are regional, jointly drawn up by several municipalities. There are also some regional substance abuse service development centres, planning and monitoring substance abuse services and policy in a given region.

Monitoring and quality assessment of institutional care

Finnish public services are highly fragmented, and it is very difficult to monitor how substance abuse services are provided in municipalities (Stenius et al. 2009). This applies to institutional care for drug users too. Service quality control is also diffuse.

Principal responsibility for quality control and monitoring of services rests with the local authorities, which under the Act on Welfare for Substance Abusers have responsibility for organising these services. Quality control may be undertaken for instance by the social workers responsible for outsourcing the services, or any municipal officials or committees formed of same. Various regional government bodies also supervise the providing of services together with the National Supervisory Authority for Welfare and Health.

Finland also has an Ombudsman for Substance Abusers, overseeing clients' interests in issues related to substance abuse services and policy. Clients may file a complaint with the Ombudsman for instance if they have been poorly treated in the services or have had difficulty accessing the services.

Today, the quality of substance abuse services is often monitored in the context of competitive tendering. In the tendering process, the quality level of services is often predetermined in the call for tenders, and only service providers fulfilling specific procurement criteria are invited to the tendering process. Service providers that do not fulfil the criteria listed in the call for tenders are excluded from tendering. In Finland, outsourced services are usually put to tender by local authorities, municipal federations or hospital districts. Service users generally do not make procurement decisions or engage in competitive tendering themselves.

Some NGOs and local authorities still have traditional partnerships based on negotiation and involving a commitment for development of services according to mutually agreed goals.

11.5 Conclusions and discussion

The present chapter is a discussion of the current state of institutional care for drug users in Finland. The discussion reveals that there is very little scientific information available on this. There is a clear need for a study of institutional care. Gaining new research findings would be important especially considering that the use of institutional care has been decreasing in recent years, as local authorities seek to cut costs in substance abuse services and invest in cost-effective and proven forms of treatment such as substitution treatment.

Also, some quite critical public comments have been made about the state of drug use treatment in recent years, and there has been some civic activism demanding the upholding of institutional treatment. One of the issues is how favouring outpatient care has influenced the social status of drug users. One of the threats identified is that substance abuse problems may become chronic in the absence of sufficient psychosocial rehabilitation.

Another often-mentioned flaw, which is referred to in this chapter too, is the fragmented nature of Finnish substance abuse services. This makes it difficult to gain an overall impression of the state of substance abuse services, to assess the quality of services or to ensure the equality of citizens in the system. For instance, municipal service policies have a great impact on the substance abuse services produced in their respective municipalities and the availability of those services. Secondly, substance abuse services are frequently outsourced to private service providers, which aggravates fragmentation and further complicates monitoring of the services. In a qualitative study on the providing of substance abuse services, representatives of both local authorities and NGOs considered it difficult to monitor and maintain quality in substance abuse services under current circumstances: municipal officials felt quality assessment to be difficult because of the large number of service providers and a lack of resources for monitoring, while NGOs felt that local authorities are pushing service providers' revenues down by focusing only on what the services cost. (Perälä 2010.)

On the other hand, the diversity of the Finnish substance abuse service system may be seen as a strength, as witness the client-oriented approach of rehabilitation facilities and the wide range of options available.

But because institutions largely operate according to their own principles, coordinating functions between institutions is often difficult. Because of their heterogeneous nature, it is also difficult to establish exactly what kind of treatment they provide on a day-to-day basis, and which types of rehabilitation work and which ones do not.

12 The drug situation in Helsinki

12.1 Functions and responsibilities of large cities in drug policy

Finnish local authorities have autonomy, and they are required by law to provide residents with certain statutory basic services, the most important of which involve social welfare and health care services, education and culture, and the environment and infrastructure. Local authorities are authorised to levy taxes; basic services are financed out of municipal taxes, central government transfers and service fees charged from clients.

Finnish local government rests on the principles of publicity and transparency. The importance of direct influence and involvement by local residents is stressed in the Local Government Act, and local residents have the right to submit initiatives concerning matters in their municipality. Local authorities inform local residents about matters in progress, plans, decisions made and their impacts.

The highest decision-making body in local government is the municipal council, elected in local elections with universal suffrage every four years. [Hereinafter, for ‘municipal’, read also ‘town’ or ‘city’.] The municipal council is responsible for the operations and finances of the municipality. The municipal council appoints the municipal board, whose job is to prepare decisions for the municipal council to make and to execute those decisions once made. The municipal manager and his/her deputy are subordinate to the municipal board.

The municipal council also appoints the committees responsible for organising the services that the local authority is required to provide. It is not mandatory to have executive committees for these services, but in practice every municipality has committees consisting of elected officials managing social welfare and health care services, for instance.

Under the Act on Welfare for Substance Abusers, local authorities are responsible for substance abuse services as part of social welfare and health care services. Specialist substance abuse services include outpatient care, short-term institutional care, long-term rehabilitation and support services. In addition to specialist substance abuse services, substance abusers are also treated under basic social welfare services and primary health care, and in specialist medical care.

Under the Temperance Work Act, preventive substance abuse work is the responsibility of local authorities. Most local authorities have designated a coordinator for substance abuse prevention, and many major cities have a dedicated unit for this purpose.

Municipal substance abuse strategies

The purpose of municipal substance abuse strategies is to create a substance abuse policy aimed at reducing substance abuse and related harm. A municipal substance abuse strategy outlines the policies and focus areas of the local authority’s substance abuse work. One of the most important goals of these strategies is to improve cooperation and networking among authorities. Substance abuse strategies generally cover both alcohol and illegal drugs. The origin of municipal substance abuse strategies may be traced back to the publication *Kunnallisen sosiaali- ja terveydenhuollon tavoitteet* (Objectives of municipal social welfare and health care, Ministry of Social Affairs and Health 1998), where local authorities were encouraged to draw up substance abuse strategies. (Romppanen 2005).

According to the database of municipal substance abuse strategies maintained by the National Institute for Health and Welfare, 82 out of the 336 municipalities in Finland in 2012 have a substance abuse strategy in place. (*Neuvoa antavat* website of the National Institute for Health and Welfare.) At the national level, efforts to reduce drug use and related harm are governed by a Government Resolution.

Substance abuse services in major cities in Finland

Substance abuse services provided in Finland's six largest cities (Helsinki, Espoo, Tampere, Vantaa, Oulu, Turku) and their costs are compared in the annual *Kuusikko* report. In addition to cost comparisons, the report discusses how these cities organise their substance abuse services and how they are prioritised. In 2010, the cities' substance abuse services included outpatient services such as A Clinics, youth stations, substitution treatment, health counselling, housing services and institutional care. Primary health care, substance abuse services in social welfare for adults and specialist medical care are excluded. (Korteniemi 2011.)

The six largest cities in Finland differ from one another in their organisation of substance abuse services and their definition of the various types of service. Generally, it may be noted that substantial structural changes have occurred and continue to occur in substance abuse services in all these cities. The aim in structural reform in all six cities is to shift the focus towards outpatient services. (Korteniemi 2011.)

The overall costs of substance abuse services at the City of Helsinki Social Services Department in 2010 were EUR 32.4 million under the narrow definition and EUR 50.7 million under the broad definition.⁸² Costs under the broad definition break down as follows: institutional services 23.2%, housing services 42.0%, substitution treatment in outpatient care 8.8%, outpatient care without substitution treatment 26.0%. (Korteniemi 2011.)⁸³

In Helsinki, the substance abuse prevention unit for children and adolescents, Klaari Helsinki, is subordinate to the Youth Department, while the substance abuse prevention unit for adults is subordinate to the Social Services Department. These units cooperate with other City departments, NGOs and substance abuse prevention units in other cities in the Greater Helsinki area. There are also various independent projects engaged in substance abuse prevention.

12.2 Case study: Helsinki, the capital city

The City of Helsinki prepared a drug strategy in 2000. According to this document, Helsinki applies a restrictive drug strategy aiming at reducing both drug use and related harm. Intoxication-oriented behaviour and easy access to drugs are considered particular threats for adolescents. General types of harm related to illegal drugs cited in the strategy include drug-related deaths, the spreading of serious communicable diseases, the proliferation of crime and insecurity, and problems related to social exclusion. Basically, the strategy follows on the same lines as Helsinki's first ever drug strategy (1997), while focusing more closely on clarification of concrete practical goals and means. The strategy defines specific goals for various administrative sectors. (City of Helsinki 2000.)

Particular goals named in the strategy include ensuring equal treatment of drug users as clients of social welfare and health care services, providing low-threshold treatment facilities, outreach work and a service framework with a variety of alternatives.

The strategy also notes the special status of Helsinki as Finland's largest city: generally, new services intended for problem users are introduced in Helsinki for the first time in Finland. The strategy stipulates that Helsinki must be actively engaged in research and development with neighbouring municipalities, with

⁸² Clients of substance abuse services often have multiple problems. A need for housing services may be seen as being caused variously by homelessness, a substance abuse problem or a mental health problem. The substance abuse service budget in Helsinki covers only part of the housing services most of whose clients have a substance abuse problem. Under the broad definition, the overall costs include services most of whose clients have a substance abuse problem. The Homeless Support Unit of the City of Helsinki Social Services Department is responsible for providing housing services for homeless adults. Forms of assisted housing include service centres, sheltered housing, communal supported housing or other types of supported housing.

⁸³ This figure does not include services outsourced by the Health Centre from other providers, such as the Helsinki Deaconess Institute HIV-positive service centre, health counselling centres (*Vinkki* services and the mobile health counselling centre of the Helsinki Deaconess Institute), substitution treatment at health stations, or services outsourced from Helsinki University Hospital.

NGOs and with the central government while monitoring national and international agreements concerning drugs. (City of Helsinki 2000.)

The Plan for Mental Health and Substance Abuse Work published by the Ministry of Social Affairs and Health in 2009 outlines mental health and substance abuse services at the national level, compiling proposals for improving these services by 2015. The plan focuses on strengthening the status of the client, promoting mental health and an intoxicant-free lifestyle, preventing problems and harm, and providing mental health and substance abuse services for all age groups with an emphasis on basic and outpatient services. Key points in the development of the service system include the low-threshold one-stop-shop principle and the setting up of combined mental health and substance abuse outpatient care units. (Ministry of Social Affairs and Health 2009b.)

Pursuant to the Plan, the substance abuse services provided by the City of Helsinki focus on flexibly combining treatment for mental health and substance abuse problems, improving the status of the client and providing mental health and substance abuse services specifically for children and adolescents on the one hand and for the elderly on the other. In the overall plan for substance abuse services, the City provides service assessment and the basic service framework, augmented by outsourced services based on special needs and alternative treatment programmes. Clients are assisted as early as possible through a flexible and comprehensive network of outpatient services. (Fabritius 2011.)

In practice, Helsinki pursues both a harm-reduction policy and a recovery policy in parallel. The purpose of this is to ensure sufficient and appropriate services for problem drug users at various stages of drug use or recovery.

Extent of problem drug use

Problem drug use in Finland has been assessed every few years since 1997 in statistical surveys; however, the first findings on problem drug use in the Greater Helsinki area date from 1995. The material for the study comes from drug-related data in the Hospital Discharge Register, the reported offences register, the intoxication register and the hepatitis C register. In the study, a 'problem drug user' is defined as a person whose use of opiates or amphetamines has led to action being taken by the authorities. (Partanen et al. 2007.)

In 2005, it was estimated that there were between 14,500 and 19,100 problem drug users in Finland, some 50% to 60% of them from Southern Finland and more than half of them from the Greater Helsinki area.

In 2005, there were an estimated 5,100 to 8,200 problem users of amphetamines and opiates in the Greater Helsinki area, accounting for 0.9% to 1.4% of the population aged 15 to 54. Out of these, an estimated 4,000 to 6,000 (70% to 75% of all problem users) were amphetamine users, accounting for 0.7% to 1.0% of the population aged 15 to 54. The number of problem users of opiates was estimated at 1,300 to 2,400, accounting for 0.2% to 0.4% of the population aged 15 to 54. (Partanen et al. 2007.)

In terms of gender distribution, it was estimated that in 2005 men accounted for 75% to 85% of problem drug users in the Greater Helsinki area. Towards the end of the 1990s, about 40% of problem users of amphetamines and clearly more than 40% of problem users of opiates were aged 15 to 24. Thereafter, the percentage of users aged 15 to 24 has decreased markedly for both substance groups (to 20%–25% in 2007) while the percentage of users aged 25 to 34 has increased. There have been no major changes in the percentage of users aged 35 to 54. The aging trend among Finnish drug users is most evident in the Greater Helsinki area. (Partanen et al. 2007.)

Only very limited quantitative data allowing for generalisation are available on which substances drug users in Helsinki use and in what ways. Problem drug use in the Greater Helsinki area was studied in a

survey where 100 drug users in Helsinki were interviewed.⁸⁴ Out of the 100 people interviewed, 71 were men and 29 women. The age range was 19 to 47, the average age of the interviewees being 29.4 years (median 28.5 years). The survey revealed that the interviewees were disadvantaged in a number of ways and were living on the margins of society.⁸⁵ Their educational attainment was low, and the majority of them (79 out of 100) were unemployed. More than half of the interviewees were not in a steady relationship at the time of the interview. More than half of the interviewees had a place to live, whether own or rented, but one out of four lived in a shelter or were completely homeless. Three out of four interviewees reported that their main source of income was social security. (Tammi et al. 2011.)

The study material from interviews with 100 drug users indicates that buprenorphine and amphetamines were the most frequently used illegal drugs at the time, although the use of benzodiazepines and various pharmaceutical opioids was also common. Buprenorphine-naloxone combination (Suboxone) and pure buprenorphine (Subutex) were used almost exclusively intravenously when used for intoxication purposes. Intoxicant use of Suboxone appeared to be particularly popular among young users. Heroin and cocaine use were rare. (Tammi et al. 2011.)

From the perspective of the care system, the assumed distinction between the groups of amphetamine users on the one hand and opioid users on the other is reinforced by the fact that there is a specific treatment available for opioid addiction, viz. medical opioid substitution treatment. In studies and surveys too, amphetamine and opioid users are typically described as two distinct groups. By contrast, the study discussed here indicates that although there are users who principally use amphetamines only or opioids only, the hard core of the drug sub-culture in Helsinki involves combined use featuring both polydrug use of opioid-based pharmaceuticals and benzodiazepines on the one hand and alcohol and cannabis on the other. The study also reinforces the findings that a substantial percentage of opioid addicts also have a benzodiazepine addiction and that alcohol use is common among opioid addicts. (Tammi et al. 2011.)

In 2010, clients who sought entry to the City of Helsinki substance abuse services reported their principal intoxicant as follows: alcohol 66.8%, buprenorphine 7.9%, tranquillisers 6.1%, cannabis 5.3%, amphetamines 5.5% (Korteniemi 2011.)

12.3 The drug situation in Helsinki

The size of the population in the area comprising Helsinki and its surrounding municipalities makes the area special in terms of drug use and the drug trade. Helsinki-Vantaa Airport and the Port of Helsinki handle a large volume of international traffic. Helsinki is the nexus of Finland's drug trade, and the principal market is also in the Greater Helsinki area. Hence, the key players in the drug trade are in this area. No truly open drug market exists in Finland; most of the sale and use of illegal drugs takes place in private homes, although a minor trade in cannabis may sometimes be observed in public parks or in restaurants in Helsinki in the summer. The major items on the drug market in Helsinki are amphetamines, cannabis and the buprenorphine preparation Subutex. (Kinnunen 2008; Perälä 2011; National Bureau of Investigation 2012.)

The street price of drugs is affected by many factors, one of them being the location where the particular batch of drugs is sold. In Finland, street prices of drugs are typically higher in the rest of the country than in

⁸⁴ Drug users in the Greater Helsinki areas were studied in the context of the European Quaf2 project; 100 drug users in Helsinki were interviewed using a structured interview form. The interviewees were recruited through anonymous health counselling centres, their network of acquaintances or on entry into the service system. The study involved exploring the drug users' life situation; analysing the frequency of use, mode of use and manner of procurement of drugs and psychoactive pharmaceuticals; and studying to what extent the groups of amphetamine and opioid users were distinguishable from each other. It was also considered whether users tended to combine opioid, benzodiazepine and alcohol use.

⁸⁵ Describing someone as 'disadvantaged' generally refers to various shortcomings in wellbeing such as unemployment, poverty, housing problems, family or other social problems, health issues, poor social skills and educational attainment, and marginalisation from participation and involvement in society at large.

the Greater Helsinki area. Amphetamines, hashish and Subutex are as a rule much more expensive outside the Greater Helsinki area. By contrast, unlike the prices of smuggled drugs, cannabis prices do not show regional variation because home growing has become more common. (Perälä 2011; National Bureau of Investigation 2012.)

Jussi Perälä has made an ethnographic study of the drug market in Helsinki in the early 2000s. His study demonstrates that drug dealing in Helsinki is a far from rational pursuit; it is more a reaction to intoxicant addiction(s) and other problems. Operations also differ depending on whether the dealing involves just one drug or several. Selling and using Subutex is very different from using cannabis that the user grows himself. Dealing in Subutex yields the highest return on investment, while dealing in cannabis is the least profitable. (Perälä 2011.)

Players on the drug market may be roughly analysed into upper, middle and lower level players. The upper level handles imports, the middle level handles wholesale dealing, and the lower level handles retail dealing. Typically, the players on the various levels also use the products they deal in. Several ethnic minorities are involved in the drug market in the Helsinki area in addition to native Finns. The largest group of foreign origin is Estonians, who are major players particularly in the import of amphetamines. Other prominent minorities include Russians and immigrants from Africa and Asia. (Perälä 2011.)

An increase in the online ordering of designer drugs and intoxicating herbal products has been noted by the Customs authorities. There are no research findings on problem use of designer drugs in Helsinki in particular, but the entry to market of designer drugs has been noticed in practice in the work of health counselling centres and detoxification units. No designer drug production facilities have been discovered in Finland. (National Bureau of Investigation 2012.) Finland does not have ‘smart shop’ dealerships of the kind found in some other European countries.

The police undertake home searches, street surveillance and traffic surveillance, and also engages in forensic investigation and screening at points of entry, for instance at major festivals. Efforts are made to influence the demand for drugs through substance abuse prevention, information distribution and public education.

Low-threshold services for problem drug users

Helsinki has four low-threshold health and social welfare counselling centres maintained on local government funds (*Vinkki* services, A Clinic Foundation) and a mobile health counselling centre (Helsinki Deaconess Centre), whose services are primarily intended for intravenous drug users. The purpose of the service is to reduce harm related to intoxicants and intoxicant use and to prevent the spread of infectious diseases. The health and social welfare counselling centres provide information on social welfare and health care services and offer needle and syringe exchange services, peer support and outreach field work. Clients are guaranteed anonymity at the health and social welfare counselling centres. The counselling centres also produce data on the local and regional drug situation. HIV-positive drug users have access to low-threshold substitution treatment, needle and syringe exchange and day centre services from the relevant NGO.

Drug users may seek entry to the City outpatient care services without an appointment; clients may then be further referred to detoxification or rehabilitative institutional care. Case management is also available for drug addicts.

Substitution treatment for opiate addicts is provided on a low-threshold principle. However, starting treatment requires undergoing an assessment period in outpatient services.

Helsinki University Hospital has a special clinic for pregnant women with substance abuse problems where clients may go at their own initiative or on referral from a physician or a public health nurse. The clinic provides information on how alcohol and drugs affect the foetus and on the progress of pregnancy while encouraging an intoxicant-free lifestyle. When a client is admitted, a survey on intoxicant use is conducted and a tox screen taken. The goals of the clinic for pregnant women with substance abuse problems are: discontinued or decreased substance use (referral to substance rehabilitation); diagnosis and

treatment of diseases and nutritional disorders that may pose a threat to the pregnancy; detection of substance abuse related development and growth disorders in the foetus; evaluation of the mother's capacity to take care of the baby, assessment of the need for child protection; evaluation of the possibilities for successful continuation of the pregnancy; and supporting the parents' growth into parenthood. (HUS 2008.)

The Helsinki Deaconess Institute provides low-threshold services at day centres and in a mobile unit. The Institute also provides specialist services for HIV-positive drug users on the low-threshold principle together with the Clinic for Infectious Diseases at Helsinki University Hospital and the City of Helsinki Social Services Department. The service framework includes day centre services and home care services. The services are free of charge for clients, being financed by the City of Helsinki Health Centre and the Cities of Espoo and Vantaa. (Helsinki Deaconess Institute 2012.)

12.4 Current issues in Helsinki

Substance abuse services in Helsinki underwent a structural change throughout the 2000s, the strategic objective being to reduce the need for institutional care through a diverse range of outpatient services. The City of Helsinki Social Services Department and Health Department will be merged in 2013, and this change will have an effect on substance abuse services. Psychiatric and substance abuse services will be combined into a single administrative entity. The purpose behind this is to improve parallel treatment of mental health and substance abuse problems and to reduce the risk of clients 'falling between the cracks'. The change will involve the reorganisation of large service systems and is thus a demanding management task.

The City of Helsinki has developed new service outsourcing models and engaged in closer cooperation with service providers and peer support providers. The substance abuse service system is being developed on a more networked and interactive basis. Efforts are being made to involve clients more closely in the development and implementation of the services. Support for clients will be built up of peer support, appropriately targeted treatment and care management.

Although investments have been made in recent years to reduce long-term homelessness in Helsinki, the housing situation remains difficult, and this complicates the implementation of individual substance abuse rehabilitation programmes in many cases.

Services will continue to be provided under both the harm-reduction and the recovery-promotion model. These two models are considered parallel, not mutually exclusive.

Proactive prevention of social exclusion is a major challenge for all administrative sectors.

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