



European Monitoring Centre
for Drugs and Drug Addiction



knowledge for welfare and health

**2004 NATIONAL REPORT TO THE EMCDDA
by the Finnish National Focal Point, STAKES**

DRUGS IN FINLAND
**New Development, Trends and in-depth
information on selected issues**

REITOX

FOREWORD

The 2004 National Report to the EMCDDA by the Finnish National Focal Point is one of the national annual reports on the drug situation compiled by the National Focal Points in the REITOX network, co-ordinated by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). Based on the national reports, an annual report on the drug problem is drafted in the European Union and Norway. The national reports are compiled in accordance with the guidelines provided by the EMCDDA.

Compared with previous years, the present report has a clearer focus on recent developments in the drug situation. First, long-term developments are analysed briefly, and then the most recent developments and trends are looked at more thoroughly (part A). Finally, the report discusses three selected issues on drugs (part B). The long-term analysis is divided into two sections, the first one dealing with the drug situation as a whole and the second with anti-drug activities. Part A discusses the drug situation in another order. The chapters that describe the different aspects of the drug situation during the past year (drug experimentation, problem drug use, health problems, social problems, availability and supply of drugs) are linked with discussion on related societal interventions (preventive work, treatment, harm reduction, social rehabilitation, control). The selected issues discussed in part B are buprenorphine treatment and problem use of buprenorphine, alternatives to prison for drug-using offenders, and drugs and public nuisance.

It should be remembered that alcohol has long played a central role in Finnish substance abuse culture. Therefore it is still underlined in Finland that substance abuse behaviour should be looked at comprehensively in place of focusing on drugs alone. Nevertheless, this report will focus on drug use, drug-related harm and poly-drug use, all of which are approaches where alcohol has a minor role. This focus is justifiable as it is customary in Europe to deal with drugs separately from the abuse of legal substances and the problem use of alcohol. This division also applies to the REITOX data production. In addition, the level of drug experimentation, use and harm has not yet stabilised in Finland due to the short history of the phenomenon. Rapid changes in the drug situation, however, have led to increasing efforts since the late 1990s to address the situation by drafting a drug policy, launching anti-drug activities and developing drug research and related statistics.

The Finnish National Focal Point, which compiled *the 2004 National Report to the EMCDDA*, operates at the National Research and Development Centre for Welfare and Health (STAKES). On drafting the report, research data and comments from experts on different areas of the drug issue were made use of. We thank all experts for their comments. Special thanks are due to Professor Mikko Salaspuro (Helsinki University) and Senior Planning Officer Airi Partanen (STAKES), Ministerial Adviser Olavi Kaukonen (Ministry of Justice), and Ministerial Adviser Aarne Kinnunen (Ministry of Justice). They are the authors of chapters 12 to 14 on the selected issues in part B, respectively. Senior Planning Office Ari Virtanen at the Finnish National Focal Point was in charge of the compilation of the report as a whole.

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<p>Publication series and number Statistical Reports 2/2005</p>		
<p>Abstract In 1995–2001, all indicators (experimentation, problem use, health problems, morbidity, mortality, criminality and seizures) suggested that the drug situation was aggravating. As for 2001–2003, however, nearly all indicators show clear signs of a weakening of the trend. Problem use is the only exception as it increased slightly in 2001–2002. In the late 1990s, drug experimentation and harm increased particularly in the youngest age group (aged 15–24). On entering the 2000s, the trend seems to be evening out in this age group, too. However, the kind and stability of the change remains to be seen. At the core of anti-drug activities have been the establishment of drug prevention networks, addition of drug prevention sections in school curricula, enhancement of low-threshold treatment, investments in health counselling centres and youth workshops, development of drug treatment in prisons, and introduction of new control methods.</p> <p>According to the most recent data, those who had used drugs during the past year accounted for about 3% and problem users for about 0.5 % of the adult population (aged 15–64). Some 7% of schoolchildren (aged 15–16) had used drugs during the past year. The 15–24 age group had the highest level of both use (12%) and problem use (0.9–1.3%). The same age group also showed the highest figures in drug-related harm (drug-related diseases and deaths, or drug treatment clients), although there are some signs of evening out among those under 20. During the year, anti-drug activities have focussed on early intervention with young people at risk of exclusion; increasing the regional coverage of substitution treatment and health counselling units; referrals to treatment in the context of drug-user offences; care chains for those released from prison; and networking in street-level control and social work.</p> <p>In 2003, some 450 of about 600 patients in substitution treatment in Finland received buprenorphine treatment. There have been queues for buprenorphine treatment especially in the Greater Helsinki area. Buprenorphine treatment is strictly regulated in Finland, and it is not expected that the buprenorphine used for medical treatment will end up on illegal markets. However, buprenorphine is the most widely used injected opiate in the street. In 2003, buprenorphine was the primary drug of those entering treatment in 24% of the cases, and there were also about 40 overdoses related to its use.</p> <p>Since the late 1960s, Finnish judicial thinking and criminal policy have aimed at separating treatment and punishment. Special preventive measures have been taken into use only after drug crimes began to increase rapidly in the 1990s. Rehabilitative activities have been taken into use increasingly as part of the sanction system since 2000. It is possible to serve a part of community sanctions in the form of rehabilitation, and the number of intoxicant-free wards in prisons has also been increased considerably. A law on contractual treatment is in preparation, on the basis of which an offender with a substance abuse problem can be sentenced to intensified drug treatment in an institution outside prison.</p> <p>In Finland, public disturbances have traditionally been linked to alcohol use whereas drug-related disturbances have been fairly rare. The Finnish drug market is characterised by its secretive nature; the use and sale of drugs takes place in private residences. Custodies, violence and robberies are mainly related to alcohol use. The use of illegal drugs is prohibited by the Penal Code, which allows intervention in drug use whether it takes place in a public area or on private premises. The provisions of the Penal Code related to drug offences are implemented quite strictly.</p>		
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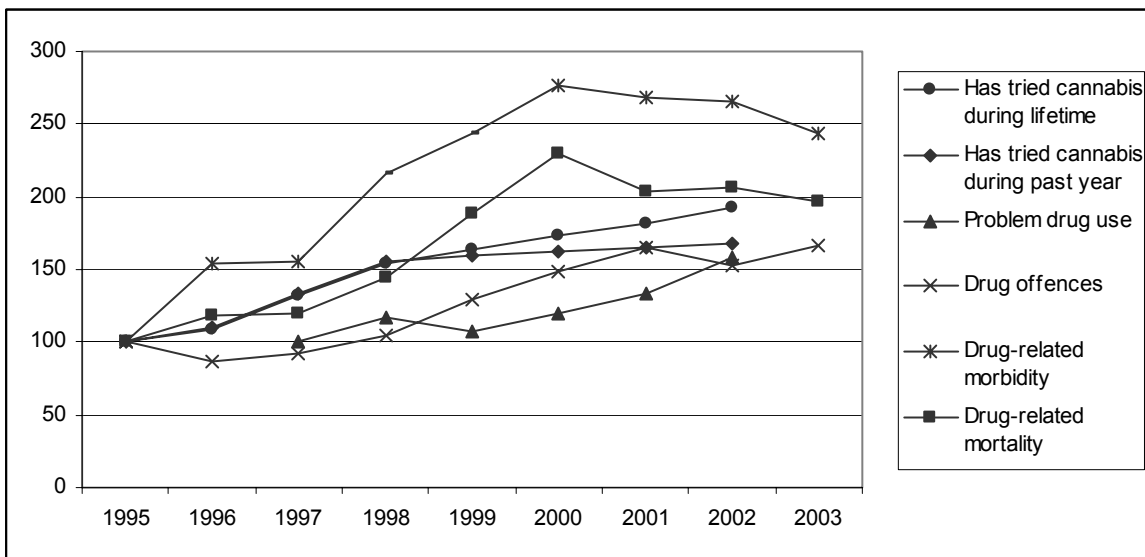
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LONG TERM DEVELOPMENT OF THE DRUG SITUATION AND ANTI-DRUG ACTIVITIES

DRUG SITUATION¹

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

Figure 1 Trends in drug use and drug-related harms 1995-2003 (1995 = 100)



Drug experimentation and use

Studies show that the drug trend of the 1990s was set in motion by men followed by women in the second half of the decade. The proportion of those having used drugs during the past year grew until the end of the 1990s after which the trend clearly levelled off.

¹ Based on Virtanen 2004, part II, sections 2 - 5. Updated data from part A, "new developments and trends". More specific information on the sources of the figures and tables in this chapter, see chapter 16, "Figures and Tables".

Figure 2a Percentage of men having tried drugs during their lifetime or in the past year (15–16-y.)

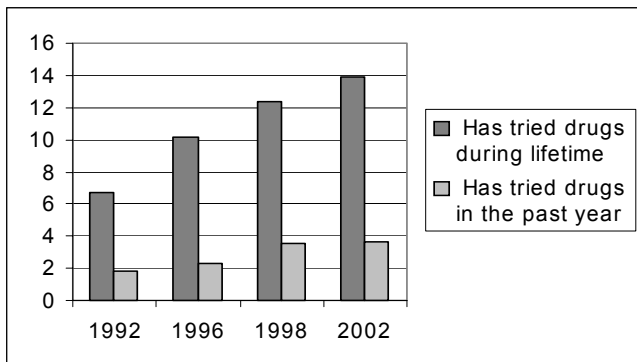


Fig .2b Percentage of women having tried drugs during their lifetime or in the past year (15–16-y.)

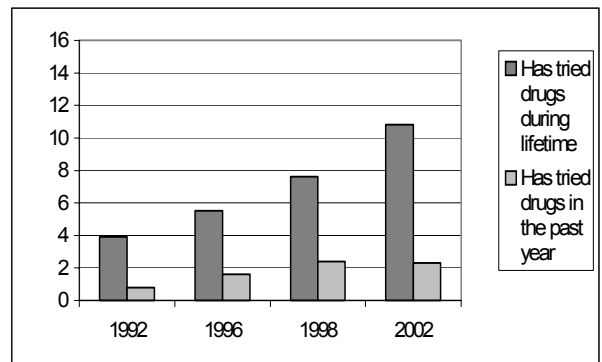


Figure 3a Percentage of boys having tried cannabis during their lifetime or in the past year (15–16-yo.)

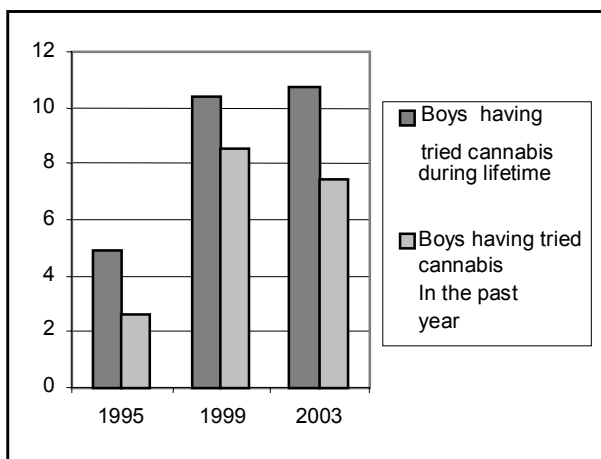
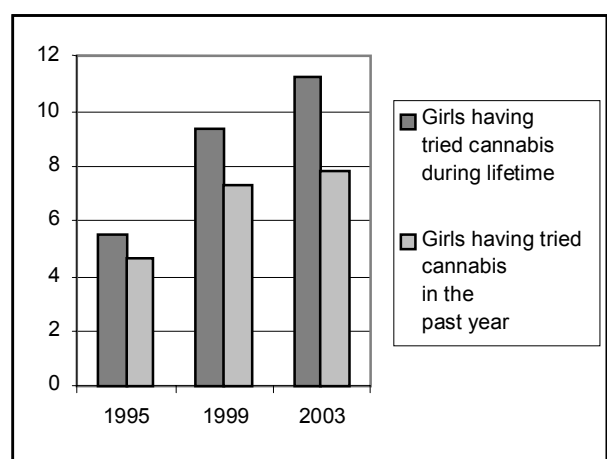


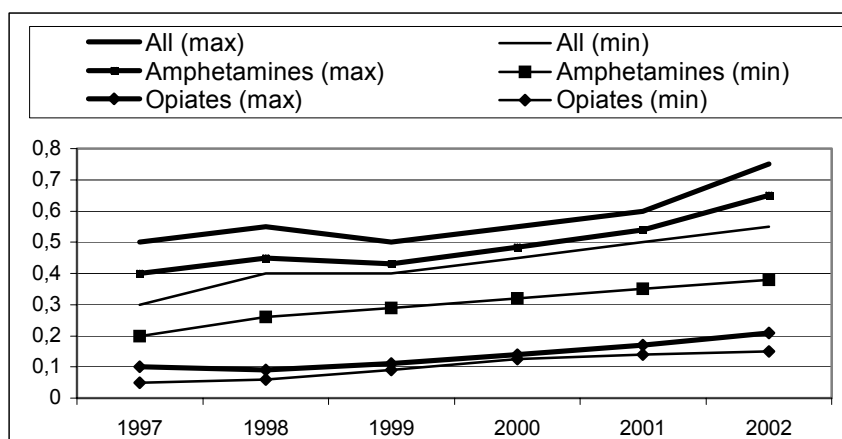
Fig. 3b Percentage of girls having tried cannabis during their lifetime or in the past year (15–16-yo.)



Problem drug use

The accumulation of detriment resulting from problem drug use seems to occur after a lag of 3 to 5 years from the commencement of use, which is often the time when problem users start to seek treatment. The growth of the number of problem users at the beginning of the 21st century would appear to be consistent with the recent estimate of the delayed effects of the trends in drug use on problem drug use.

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



The drug treatment information compiled from units providing specialised services for substance abusers helps in determining the development of a problem user's profile. The most significant change lately has been the problem use of buprenorphine, which during the past few years has replaced heroin almost completely.

Table 1 Substances used by clients entering treatment for the use of narcotics and pharmaceuticals (% of clientele) in 2000–2003

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

Drug-related health problems

With respect to drug-related health consequences, the delay in the rise of the user numbers can also be seen in drug-related deaths. However, the most common cause of drug-related death is death by poisoning, the number of which grows quickly whenever a new drug consignment enters the market or when the route of administration change (increase of drug injecting). However, the long-term development trend can be seen clearly in hospital treatment periods even though these figures do not give an accurate picture of the number of problem users because their treatment takes place to an

increasing degree in units providing specialised services for substance abusers. Lately the mental health problems suffered by problem drug users have also come to the fore.

Figure 5 Drug deaths according to different cause of death -criteria 1995–2002

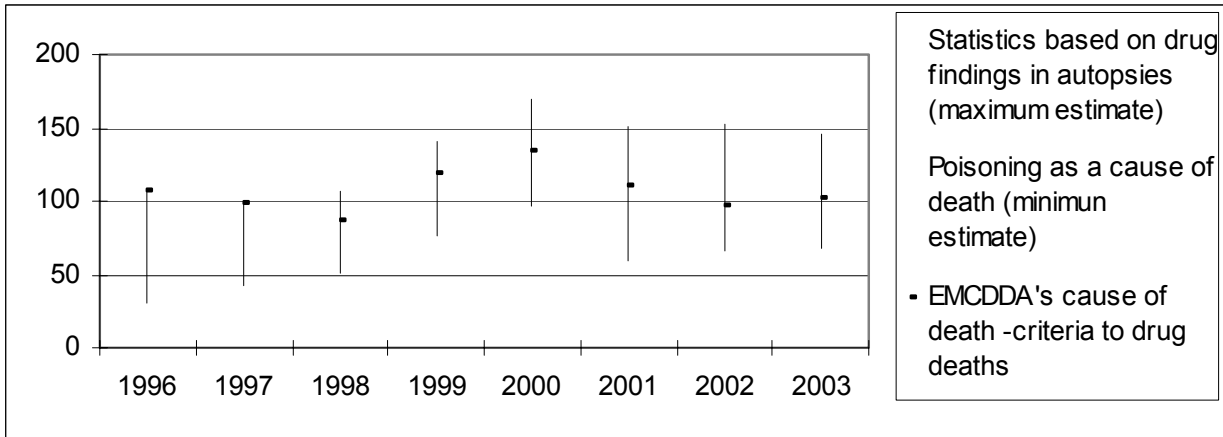


Figure 6 Hospital treatment periods related to narcotics and pharmaceuticals 1995–2003

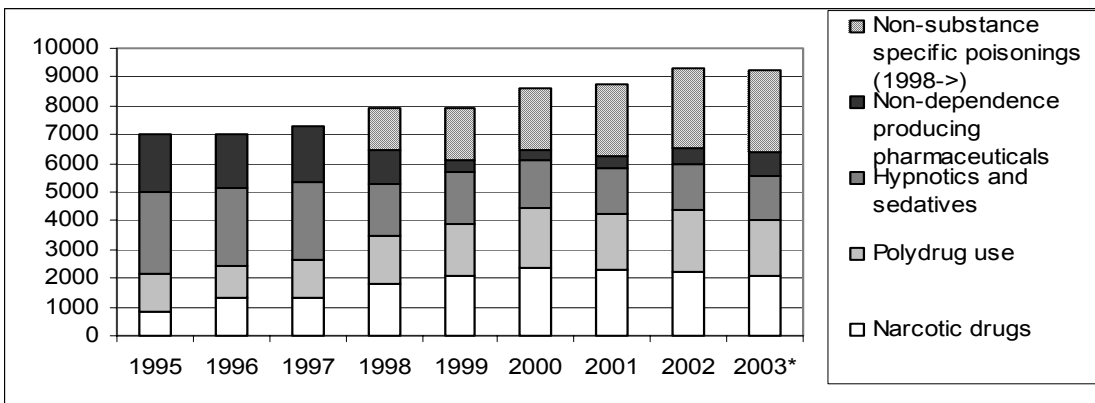
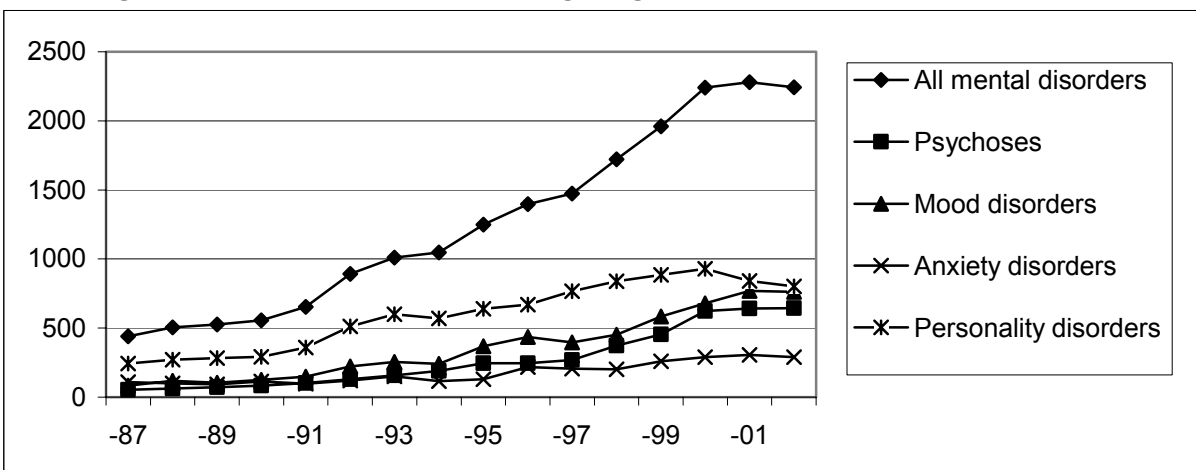


Figure 7 Mental disorder diagnoses co-occurring with drug diagnoses in 1987–2002 according to the hospital patient discharge register



Drug-related social problems

The most essential drug-related social problem is exclusion in its various forms. Problem drug users tend to have a lower level of education and are more often unemployed and/or homeless than the population in general. Another important variable that reflects social exclusion is drug-related crime, either directly through drug offences or indirectly through other offences (e.g. drunken driving). In Finland, the use of narcotics is a punishable offence; many offences are related to this particular type of offence and thus indirectly reflect the prevalence of drug use. A trend that mirrors exclusion better is the number of drug offences or aggravated drug offences, as these are connected both to regular problem drug use and to the supply of drugs through smuggling and distribution. The latter also correlates with the evolution in the number of people sentenced to imprisonment for drug offences. All the above-mentioned indicators grew at the end of the 1990s and stabilised at the beginning of the 21st century, thus mirroring the trend in drug experimentation (and many other drug-related detriments).

Table 2 Drug offences reported to the police and Customs in 1995–2003

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

Figure 8 Narcotics findings from people suspected of driving under the influence of drugs in road traffic 1995–2003

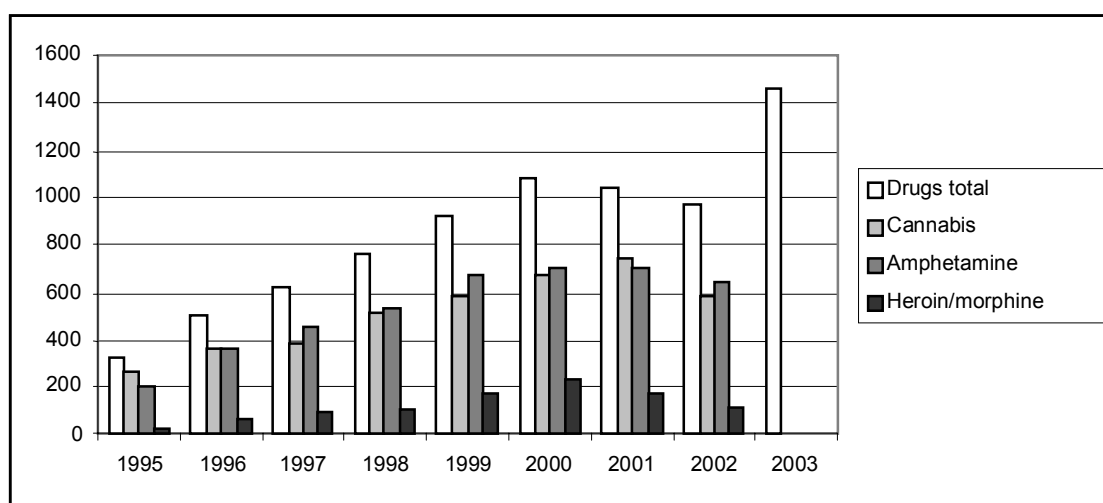
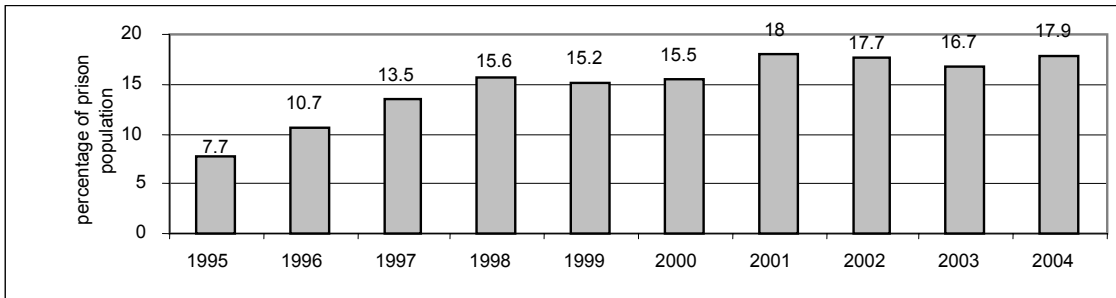


Figure 9 Percentage of prisoners with a drug offence as their principal offence in annual prison census 1995–2004



Drug markets

One reason for drug experimentation, drug use and problem drug use is the state of drug markets. It becomes evident in relation to the prevalence of supply which is reflected in the number of drug seizures and in citizens' personal experiences of having been offered drugs. These indicators also showed growth towards the end of the 1990s and a levelling off at the turn of the 21st century.

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

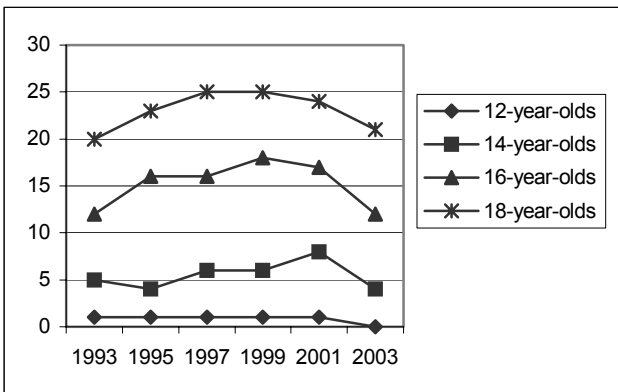


Figure 10b Drug offers to girls (%) in the past year

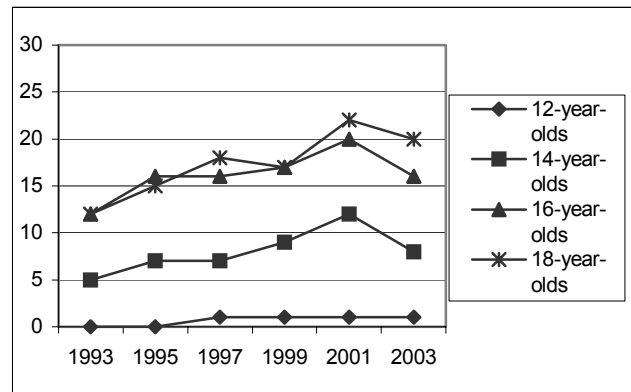


Figure 11a Drug offers to men (%) in the past year

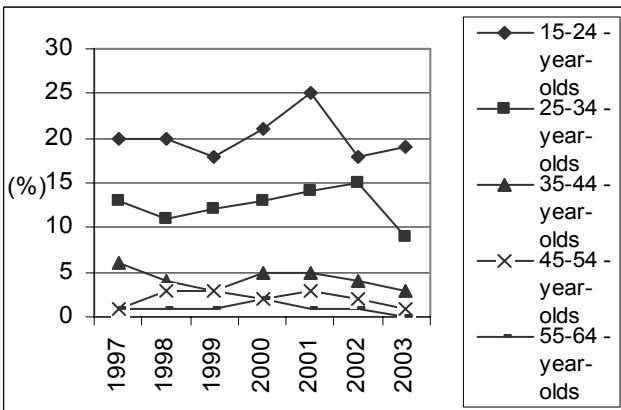


Fig. 11b Drug offers to women (%) in the past year

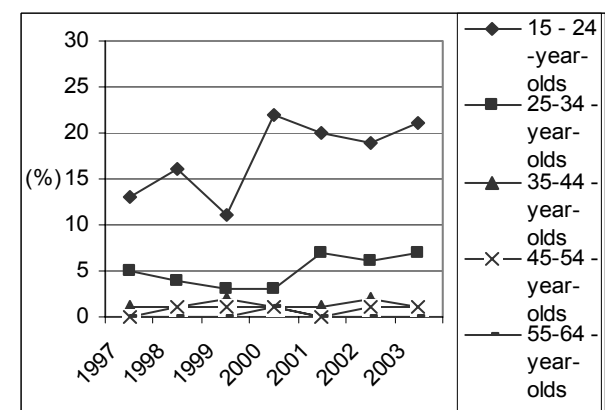


Table 3 Drugs recorded as seized by the police and Customs in 1995–2003

	1995	1996	1997	1998	1999	2000	2001	2002	2003
Hashish	147.51	99.44	197.66	160.97	492.32	196.54	589.6	482.3	423
Marijuana	4.27	3.51	12.15	8.01	18.17	13.82	16.1	32	45
Amphetamines	20.12	22.14	22.2	24.78	71.26	79.56	137.3	129.2	114.6
Cocaine	0.07	0.07	0.12	1.99	1.7	38.58	6.5	0.4	1.1
Khat*	68.11	264.5	249.01	103.94	374.1	348.41	664.5	1,039	1,879
Heroin	16.12	6.45	2.4	1.97	2.88	6.03	7.5	3.1	1.6
Subutex (tablets)	-	-	223	1,175	2,898	12,951	38,200	18,700	37,284
Ecstasy (tablets)	3,750	1,011	3,062	3,320	17,665	87,393	81,228	45,065	35,216
LSD (tablets)	500	41	323	301	50	2,355	1,026	4,679	1,460

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

Table 4 Number of seizures recorded by the police and Customs in 1995–2003

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

ANTI-DRUG ACTIVITIES²

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

² Based on Virtanen 2004, part I and part III, sections 9 - 12, 16.

Drug legislation

The Narcotics Act (1289/1993) prescribes the main principles of drug control based on international conventions. The related Narcotics Decree (1603/1993) lays down provisions for the export and import of drugs. The administrative decision by the Ministry of Social Affairs and Health (1709/1993) defines narcotics and the substances used in their manufacture. Drug legislation has subsequently been amended to comply with EU control regulations on precursors and the changes made in the drug Schedules of the United Nations. Drug offences are specified in the Penal Code (1303/1993), whereby they are categorised as drug offence, preparation or abetment of a drug offence (maximum sentence 2 years' imprisonment) or as aggravated drug offence (1–10 years' imprisonment). In 2001, an amendment was made to the Penal Code (654/2001) which introduced the drug-user offence (maximum sentence ½ years' imprisonment).

In 1997, the Ministry of Social Affairs and Health issued an order on the substitution and maintenance treatment of opiate addicts. Subsequently the legislation has been revised and a Decree on Substitution and Maintenance Treatment 289/2002 has been issued. Drugs are also present in e.g. the Act on Preventing and Clearing Money Laundering, the Act on Drunken Driving, The Act on Enforcement of Punishments, as well as in the Coercive Measures Act, the Police Act, the Temperance Work Act, the Act on Welfare for Substance Abusers, the Child Welfare Act and the Primary Health Care Act.

Drug policy

The Finnish Government issued a decision in principle on 5 October 2000 to enhance drug policy based on the first Finnish drug strategy from 1997. The objective was to reduce both the supply and demand of drugs and to arrest the growth of drug use and related crime. The Government set up a drug policy co-ordination group to co-ordinate, implement and monitor the national drug policy programme. The group had representation from the relevant Ministries and agencies. The co-ordination group was also given the task of preparing a Government decision in principle to enhance drug policies for 2001–2003 (2000). The Government was informed about the action plan on 5 February 2002.

With respect to drug strategy, the report of the committee for preventing drug use among young people was published in 2000, and the report of the working group on drug treatment in 2001. In addition, the police have produced an anti-drug strategy for 2003–2006 (2002) and the Prison

Administration its Intoxicant strategy strategy, Sections I–III (1999, 2000, 2001), emphasising control and the reduction of demand. The Customs have also produced a drug strategy for 2002–2005 and a joint drug strategy (PTR) has been drawn up by the police, the Customs and the Border Guard.

The Programme of the Finnish Government lead by Matti Vanhanen (2003) states the following with respect to drugs: (1) The Government will prepare a drug policy action plan for 2004–2007, (2) preventive substance abuse and drug work will be reinforced, (3) drug policy based on a total ban on drugs will be intensified in order to prevent the use and the proliferation of drugs and to reduce drug-related crime, and (4) a cross-sectoral programme on internal security will be drawn up in order to increase public security. The action plan was completed at the beginning of 2004.

Preventive work

The target and action plan for social and health services for 2000–2003 (1999), which was approved by the Government, proposed, among other things, setting up a municipal contact person network for substance abuse work. The contact person is in charge of the co-ordination of municipal substance abuse prevention together with the social and health services, schools and organisations. The contact person also co-ordinates the municipal or regional substance abuse strategy.

The reform of the school curriculum supports the qualitative development of health and legal education in school and the establishment of co-operative models between home and school and other important actors in the field. Parliament has passed a law (453/2001) whereby primary education will include a new subject, health education. Correspondingly, another amendment has made health education, which was formerly taught in conjunction with physical education, a separate subject in upper secondary and vocational schools. Substance abuse questions are key aspects of this new subject. A large-scale national post-graduate drug training programme for teachers was set in motion in 2001. The programme is implemented in close co-operation with local drug prevention authorities and organisations.

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

The focus of prevention has been on young people and improving their life-management skills, young people's participation through activation and the use of new media in anti-drug work. Telematic services in drug prevention have been introduced especially for the young: drug information services, virtual discussion forums and anonymous self-testing services for assessing one's own substance abuse. The first nationwide drug information campaign was implemented in 2001–2003. The campaign also included an extensive follow-up study.

Drug treatment

According to the Act on Welfare for Substance Abusers, municipalities must provide substance abuse services that are in accordance with the needs of the municipalities both in their content and in coverage. Substances included are alcohol, substitutes, pharmaceuticals and drugs. The social and health care sector must develop public services to meet the needs of substance abuse services and provide services that are intended specifically for substance abusers, when needed. The units providing specialised services for substance abusers include outpatient clinics (A-Clinics, youth centres), short-term inpatient care (detoxification units), rehabilitation units and support services (day centres and support housing) and peer support activities. A quality framework for substance abuse services has been created for the development work. In addition to the units providing specialised services for substance abusers, increasing numbers of substance abusers are treated within primary social and health care services, including social welfare offices and child welfare services, mental health clinics, health centre clinics and wards, hospitals and mental hospitals.

The treatment policy emphasises developing low-threshold services and related training. The aim is to get drug abusers to enter the treatment system as early as possible. The Finnish system also emphasises that drug treatment as such is often insufficient and so the substance abuser should be assisted in solving problems related to subsistence, habitation and employment. Both the traditional drug-free treatment and substitution and maintenance treatment, which are new in the Finnish system, have been used in the actual drug treatment. Investments have been made especially in the development of treatment practices for the latter along with the new legislation on the subject. In 2002–2003, the Government invested 15 million euros in the regional development of the drug treatment system on the basis of the proposals made by the working group that dealt with the matter.

Reduction of health problems

A central method in preventing drug-related health problems is outreach work that covers the everyday living environment and combats problem use and related problems where they appear. In

Finland, the target group for outreach work has traditionally been small, mainly young people in big cities on Friday nights.

The HIV epidemic that began in 1998 among drug users brought to the public eye the importance of preventing communicable diseases spread by intravenous drug use. The operating model of health counselling centres for drug users, which started as a trial in Helsinki in 1999, formed a good basis for expanding the operation elsewhere in Finland. Drug users can exchange used syringes and needles for clean ones at health counselling centres. An essential part of the operation is health counselling on drug-related communicable diseases and other serious risks related to drug use, such as overdoses and sexually transmitted infections. Health counselling centre services are free of charge for clients and the clients can visit the centres anonymously.

Drug-related psychiatric co-morbidity has increased fourfold since the beginning of the 1990s. Reports and statements related to the drug policy or developing the treatment system were issued especially in the latter part of the 1990s, but they have focused primarily on preventing drug problems or the medical treatment of drug-dependency, not on patients with multiple problems related to mental disorders (co-morbidity). There has been discussion on whether the expertise on the treatment of patients with drug-dependency and other mental disorders should be concentrated in specialised units. The prevention of other drug-related health problems (deaths, accidents) has been included especially in traffic safety campaigns.

Reduction of social problems

Multiprofessional co-operation between authorities has been emphasised in after-care adjustment activities. This includes social rehabilitation, employment and supported housing services. Education authorities are often involved in the care of young problem users. The planning of education and vocational guidance are automatically included in the treatment process. However, the educational system does not include much training that directs young people to a normal working career and is adapted to the problem user's abilities. In addition, not enough employers employ these young people, and they are not very useful if the employment threshold is too high. One example of employment activities is youth workshops. In Finland, financially supported housing for substance abusers can be arranged within municipal social services. Housing service units for substance abusers are part of the Finnish substance abuse services. They are meant for substance abusers that need daily support for independent living. There are also rehabilitation services available in some housing service units.

The anti-drug strategy for the police for 2003-2006 (2002) emphasises that a drug user met in connection with police control activities and investigation shall always be provided treatment referral and that appropriate treatment should be a real alternative to penal sanction for a problem drug user.

The Prison Service has prepared various substance abuse services for inmates in prisons and for drug users released from prisons in co-operation with the relevant organisations. The alcohol and drug programmes of prisons enable an individual rehabilitation continuum from the evaluation of rehabilitation needs to integrating the person released from prison to society. Nowadays, there are rehabilitation programmes as well as contractual wards supporting an intoxicant-free lifestyle in almost all prison institutions. Rehabilitation programmes are also available in open institutions. If the inmate started opiate treatment (methadone or buprenorphine) before entering prison, the treatment can be continued in prison in co-operation with the treatment unit where it was started.

Furthermore, proposals have been made on the use of juvenile punishment as an instrument for treatment referral. Juvenile punishment consists of youth service (work programmes and unpaid work) and control. Community service is an alternative sanction for adults. Substance abusers, however, cannot usually be sentenced to community service because they are not necessarily able to do it. Therefore, a new sanction called contractual treatment, which can be served in the form of substance abuse treatment, has been proposed for offenders with substance abuse problems. It would enable sentencing offenders to treatment as punishment for a crime. Contractual treatment would be intended for persons whose problem use of alcohol or drugs has considerably contributed to their crimes.

Drug control

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

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

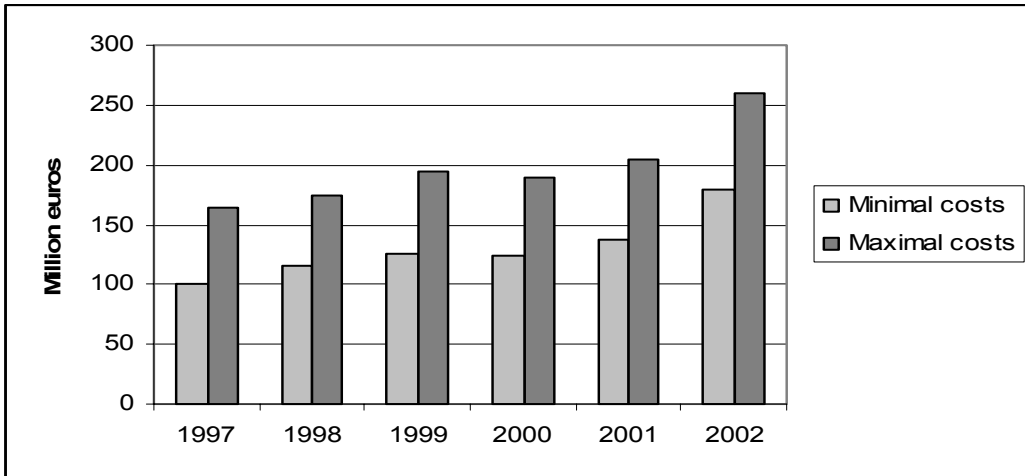
A central part of preventing organised professional crime is the amendments to legislation that aim at increasing control authority and methods. At the beginning of 2001, the police was given new, more extensive authority for fictitious purchases and undercover operations. The authority to intercept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

The increasing participation in international co-operation (e.g. in the neighbouring areas) and the new European Schengen and customs data systems have also provided the authorities new connections for controlling drug crime and money laundering and information for combating internationally organised professional crime.

Drug-related costs

Drug-related costs consist of the costs related to the abuse of drugs and pharmaceuticals and the detriment caused to health (hospitals etc.), social welfare (substance abuse services etc.) and crime control (the police, prisons etc.) as well as the resources of preventive work and research. The costs have grown considerably since the mid-1990s with the increase of drug use and problem drug use, but they are still much lower than alcohol-related costs. (Yearbook of Alcohol and Drug Statistics 2004)

Figure 12 Costs of the harms caused by drugs (minimum–maximum) in Finland in 1997–2002



PART A. NEW DEVELOPMENTS AND TRENDS

1. Drug policy and legislation at the beginning of the 21st century³

National strategies and action programmes, drug-related legislation, national resources to intensify drug policy and public opinion concerning such policy provide the guidelines for drug policy. This section examines these issues within the context of the five themes. The policy is applicable to drug prevention, treatment, the prevention of health related harms and social consequences as well as to control measures.

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

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

³ See Virtanen 2004, sections 1, 8, 15 and 19.

13. Continuing Finnish support for the work against drugs in neighbouring areas and within the framework of development co-operation.
14. Developing a knowledge basis and research regarding drugs.

The amendments to drug legislation during the past year dealt with:

- (1) The Act on the Protection of Privacy in Working Life, including restrictions to drug testing in working life, according to which, testing in working life should be based on an anti-drug strategy that has been drawn up in collaboration at the work place, and a job applicant or employee should provide the employer with a drug test certificate if the nature of the work is such that the use of drugs could cause bodily harm or damage or if the employee is suspected of being under the influence of drugs.
- (2) Amendment to the Communicable Diseases Decree, which increases the responsibility of the communicable diseases specialist at a health centre to provide health counselling for intravenous drug users and to exchange needles and syringes.
- (3) Amendments to the Coercive Measures Act and Customs Act which gives the authorities greater powers for technical observation and telecommunications monitoring.

The separate costs of the drug policy action programme 2004–2007 for the year 2004 are the same as the costs for the last year of the 2001–2003 programme. The largest changes can be seen in the treatment sector, which will no longer benefit from the temporary appropriation of the annual EUR 7.5 million and the treatment measures initiated with this funding will in the future have to be funded directly by municipalities. In addition, the investments by the Ministry of Foreign Affairs in drug prevention in neighbouring areas will be increased by EUR 0.4 million.

The extent of the drug debate in Parliament has not changed much over the past 2 years. However, compared with the previous three years there has been a drop in the number of speeches focusing on drugs. This is probably a sign of the normalisation of the drug phenomenon in Finnish society. Drug-related speeches focusing on control dominated somewhat, but they were fairly well balanced with speeches emphasising preventive work and treatment. The special themes that came up concerned the drug phenomenon in a broader sense as a part of international co-operation or Finnish drug policy. Surveys concerning drug prevention showed control measures and preventive work were the central themes of public opinion, whereas severe penalties and drug treatment were considered as less effective measures.

1.1 Drug policy⁴

1.1.1 Preventive work

Drug policy actions in 2004

The general principles of the Drug Policy Action Programme 2004 - 2007 (2004) are being adhered to; moreover, the following special projects are being carried out:

- The network of municipal drug prevention contact persons is being divided into a general information network and a special development network in accordance with each development project.
- The Neuvoa-antavat portal on drug prevention established for drug and alcohol policy decision-makers, experts, and others interested in the field is being consolidated and a new online learning environment is being added to it.
- The bases and related principles of the new curriculum for primary education (e.g. the prevention of tobacco, alcohol and drug consumption) were finalised at the beginning of the year and they were partly introduced in schools during the autumn.
- The project to develop drug prevention in youth workshops is being continued.
- The network of community trainers is beginning a national training project in workshops.
- The drug information campaign is continuing on the basis of the result evaluation for 2001–2003.

In research and follow-up:

- The evaluation report on the nationwide drug information campaign is being published.
- The results of the ESPAD survey are being published.
- The results of the school health study 2004 are being published.

1.1.2 Drug treatment

Drug policy actions in 2004

The general principles of the Drug Policy Action Programme 2004–2007 (2004) are being adhered to; moreover, the following special projects are being carried out:

- A quality evaluation form based on the quality framework for substance abuse services is being prepared for use by municipalities.

⁴ See <http://annualreport.emcdda.eu.int/en/home-en.html>

- The treatment unit database is being improved to better serve the quality framework for substance abuse services.
- Special funding from the Ministry of Social Affairs and Health is being targeted at developing the prevention of drug-related communicable diseases and drug treatment information and support services, and at training health care personnel treating opiate addicts and personnel involved in detoxification, substitution and maintenance treatment.

In research and follow-up:

- A report is being drafted on the use of the EUR 15.1 million granted for the treatment of problem users in 2002–2003.
- A literature survey is being carried out on research-based treatment methods and based on these the effectiveness of treatment will be evaluated.
- The number of problem users in 2002 is being estimated and reported.
- The results of the census of intoxicant-related cases, substance abusers met during one day in all social and health care services in 2003 are being reported.

1.1.3 Reduction of drug-related health problems

Drug policy actions in 2004

The general principles of the Drug Policy Action Programme 2004–2007 (2004) are being adhered to; moreover, the following special projects are being carried out:

- The Conference of the International Society for Addiction Medicine will be held in Helsinki.
- In line with the amendment to the Communicable Diseases Decree, efforts are being made to prevent drug-related communicable diseases.

In research and follow-up:

- An intermediary report is being produced on the study on risk behaviour among intravenous drug users.

Health 2015 public health programme (2001)

The Government Resolution on the Health 2015 public health programme outlines the targets for Finland's national health policy for the next fifteen years. Health 2015 is a cross-sectoral co-operation programme that focuses on health promotion and not so much on developing the health care system.

The foundation for the strategy is provided by the Health for All programme of the World Health Organisation. According to Health 2015, public health is largely determined by factors outside health care: lifestyles, living environment, quality of products, and factors promoting and factors endangering community health. The strategy presents eight targets for public health and 36 statements concerning lines of action. Several targets concern drug use and related problems indirectly but two targets refer to drugs directly:

- Health problems associated with alcohol and drug use among young people will be dealt with appropriately and they will not exceed the level of the early 90s.
- There will be co-operation in municipalities throughout the country between various authorities, organisations, schools, business and industry, parents and young people themselves aimed at reducing drinking and experimenting with drugs, and properly dealing with social and health problems related to the use of alcohol and drugs.

1.1.4 Reduction of drug-related social problems

Drug policy actions in 2004

The general principles of the Drug Policy Action Programme 2004–2007 (2004) are being adhered to; moreover, the following special projects are being carried out:

- The police are increasing the dissemination of drug-related information to key players.
- A drug addict encountered in connection with police control activities and investigation will be counselled on treatment options and if necessary, he or she will be referred for treatment pursuant with the agreed procedures for each police district.
- A proposal is being prepared to establish appropriate treatment as a valid option to punitive measures in all types of punishment.
- The Prison Service's substance abuse service network and rehabilitation continuum is being secured in collaboration with the Probation Service, the prisoner's municipality of residence and other actors.
- In connection with the physical examination of a convicted person, his or her substance abuse will be evaluated and if necessary detoxification treatment will be started and the need for substance abuse services will be determined.
- In prisons, health counselling for drug users is being intensified and the threshold is being lowered for HIV testing and seeking counselling.
- The Government proposal and its related legislation concerning trials in contractual treatment will be submitted to Parliament.

- The introduction of juvenile punishment as a regular punishment from the beginning of 2005 is being prepared.

In research and follow-up:

- The implementation of the law on zero tolerance for drunken driving is being examined.
- The assessment and development study of the alcohol and drug free ward in the Helsinki prison is being completed.

National plan of action to combat poverty and social exclusion 2003–2005 (2003)

The national plan of action for 2003–2005 was based on the decisions by the Nice European Council of December 2000 on preparing national plans of action as part of the EU Member States' political co-operation in the field of social protection. With respect to drugs, the plans are:

- The Government will draw up an action plan on drug abuse for the period of 2004–2007.
- The objective programmes and action plans of various ministries will support anti-drug measures.
- More drug issues will be included in the basic training and continuing education of teachers.
- Sufficient resources for basic youth work will be secured and preventive substance abuse work will be increased.
- Drug users will be provided with sufficient treatment.
- Measures to alleviate the negative effects of drug use will be expanded.
- According to a Government decision in principle, drug control based on a complete ban on their distribution and use will be enhanced.
- A cross-sectoral programme on internal security will be drawn up in order to increase public security and to reduce drug-related crime, violent crime and recidivism in particular.

1.1.5 Law enforcement

Drug policy actions in 2004

The general principles of the Drug Policy Action Programme 2004–2007 (2004) are being adhered to; moreover, the following special projects are being carried out:

- The Ministry of Social Affairs and Health is appointing a working group on drug precursors comprised of the responsible authorities for 2004–2007 in order to enhance control of the substances used to manufacture drugs.
- The formation of regional intelligence and criminal analysis units is underway.

- By profiling seized drugs, attempts are being made to identify the countries where the drugs are manufactured and from where they are imported into Finland.
- Police field trainers specialised in street-level drug control are training police officers involved in basic investigation or order supervision.
- Proposals are being prepared on the following: (1) assisting the authorities in solving another serious offence would be grounds for more lenient sentencing, and (2) improving witness protection and protection of the parties involved in a criminal process.
- The possibilities for the following amendments are being examined: (1) the maximum sentence for an aggravated drug offence would be changed from 10 years to 12 years, (2) leading an organised crime group would be grounds for more severe sentencing, and (3) the reward for a tip-off would be exempt of taxation.
- The Amendment to the Criminal Investigations and Coercive Measures Act to intensify the prevention of professional and organised crime came into force at the beginning of the year.
- The seizure of hidden assets and criminal proceeds is being intensified by the amendment to the Execution Act that entered into force on 1 March.
- The proposal to enforce the UN Convention on Mutual Assistance in Criminal Matters will be ratified during the year.
- Proposals are being made during the year to enforce the European Convention on Mutual Assistance in Criminal Matters and the Framework Decision on the execution in the European Union of orders freezing property or evidence. In addition, the Council Framework Decision on the European arrest warrant is being enforced, and the Convention on Mutual Assistance and Co-operation between Customs Administrations (Naples II) is being ratified.
- Co-operation between Estonia and Finland is being increased in order to ensure a smooth legal process from pre-trial investigation to the enforcement of sentences.
- The Customs is increasing the use of drug dogs in the busiest traffic areas and other risk areas.
- The Customs is considering placing a new intermediary in an area that is significant in terms of drug crime.
- Together with the Ministry of Finance, the Customs is preparing proposals for ensuring that it has sufficient authority to combat serious drug crime.

In research and follow-up:

- The police data system (Patja) is being developed to produce key drug offence parameters.
- The specific study on punishment for drug-user offence is still underway.

1.2. Drug legislation⁵

Drug legislation consists of the Narcotics Act and Decree as well as the laws mentioned directly in the Narcotics legislation (e.g. articles on drug offences mentioned in the Penal Code), and the legislation that refers indirectly to the drug issues.

1.2.1 Narcotics Act

In 2003, a Decree was issued on the amendment (1231/2003) to Section 2, as stated in Decree 201/2001, of the Decision of the Ministry of Social Affairs and Health on drugs and substances used in their manufacture (1707/1993), in accordance with which the following substances were transferred from Schedule II to Schedule I of the UN Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances: acetic anhydride and potassium permanganate.

According to the Drug Policy Action Programme 2004–2007 (2004) the Ministry of Social Affairs and Health is appointing a working group on drug legislation amendments in order to prepare a proposal on reforming Finnish drug legislation so that it is consistent with Community legislation by the end of the year.

1.2.2 Other drug-related legislation

1.2.2.1 Preventive drug work

The amendment to the Basic Education Act (477/2003) regulated curricula and pupil and student welfare services. According to the amendment, the curriculum shall be drawn up in co-operation with the authorities responsible for municipal social welfare and health care services. The organiser of education shall also determine how the co-operation between school and home and the pupil welfare services in accordance with the curriculum are organised. In addition, pupils are entitled to pupil welfare services, which are conditional upon participation in education, free of charge. Pupil welfare services refer to activities that promote, maintain and improve the conditions for good learning, and the good mental and physical health and the social welfare of pupils. Pupil welfare encompasses pupil welfare in accordance with the curriculum approved by the organiser of education as well as pupil welfare services, including the school health care referred to in the Primary Health Care Act

⁵ See European Legal Database on Drugs, <http://eldd.emcdda.eu.int/>

(66/1972) and the support for child upbringing referred to in the Child Welfare Act (683/1983). Similar amendments have been made to the General Upper Secondary Schools Act (478/2003), the Vocational Education and Training Act (479/2003) and the Vocational Adult Education Act (480/2003).

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

At the recruitment stage, an employer can only ask the person who has been chosen for the job for a drug test certificate. The employer has the right to use the information on the certificate if the job calls for precision, reliability, independent consideration or alertness. Furthermore, it is required that the employee concerned works in a job where performance under the influence of, or dependent on, drugs could endanger life or health or result in considerable damage. The interests to be protected are life, health, occupational safety, traffic safety, information security, State security, environment, trade and professional secrets and the employer's property.

The employee is obliged to provide a drug test certificate during the period of employment, if there is just cause to suspect that he or she is working under the influence of drugs or if the employer has just cause to suspect that the employee is addicted to drugs. A further requirement is that drug testing is necessary in order to evaluate the working or functional capacity of the employee and that the employee works in a job specified in the recruitment passage above. The interests to be protected are the same as at the recruitment stage, but the criteria are much stricter. The employer can also set the employee a reasonable deadline for providing the certificate.

The jobs for which a drug test certificate is requested or required should be determined in co-operation at the workplace. In addition, the employer is obliged to draw up in co-operation with personnel an anti-drug programme for the workplace, including the general objectives and practices to be followed in order to prevent drug use as well as to provide information on the drug treatment units or care methods available to drug abusers.

1.2.2.2 Drug treatment

The Decree of the Ministry of Social Affairs and Health on prescription of medicines (726/2003) regulates that the prescriber can only prescribe an actual narcotic with a verified narcotic prescription form. The identification of the patient has to be marked on the prescription. Narcotics listed in Schedule IV in the UN's Single Convention on Drugs of 1961 and Schedule I in the Convention on

Psychotropic Substances cannot be prescribed. Narcotic prescription forms must be kept in a locked place in each workspace. In an institution, the number of the narcotic prescription form, the patient's name and identity code and the prescriber's name should be recorded in each workspace. The prescriber should also keep a separate record of narcotic prescriptions. Dentists have the right to prescribe at a single time a maximum of 10 doses of medicines categorised as actual narcotics. In the experiment on electronic prescriptions by the Ministry of Social Affairs and Health (771/2003), narcotics are not included in electronically prescribed medicines.

1.2.2.3 Reduction of drug-related health problems

The Government Decree on the amendment to the Communicable Disease Act (1383/2003) states that the municipal institution responsible for the prevention of communicable diseases and the health centre's communicable disease specialist should, in addition to the tasks set out in the Communicable Disease Act, carry out the prevention of communicable diseases in the health centre's area of operation, including health counselling for injecting drug users and needle and syringe exchange as required by the prevention of communicable diseases.

The amendment to the Road Traffic Act (113/2004) regulates the physician's duty to report a vehicle driver's medical condition concerning his or her right to drive to a competent police authority. The guidelines for implementation issued by the Ministry of Social Affairs and Health state that the physician's report can only include such information as concerns the person's health requirements for a driving licence and the additional measures suggested by the physician to more precisely evaluate the patient's health or its effects on his or her driving ability. Before the report is issued, the patient must be informed about the physician's duty to report and the effects of health on driving ability. A driving licence may not be granted or renewed to an applicant or to a driver who is addicted to psychopharmaceuticals or who, even if not addicted to such a substance, abuses them regularly. The Ministry of Social Affairs and Health issued the guidelines for implementation of the physician's duty to report on 26 August 2004.

1.2.2.4 Prevention of drug-related social problems

No new drug-related legislation concerning this area was issued during the year.

1.2.2.5. Drug control and reduction of the supply of drugs

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

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

According to the Act on Extradition between Finland and other Member States of the European Union (1286/2003), a person can be extradited for prosecution or the enforcement of a custodial sentence from Finland to another Member State of the European Union or vice versa, if the maximum penalty provided for the extraditable offence is at least four months' imprisonment according to the law of the Member State that made the extradition request, and if the offence, when committed under similar circumstances in Finland, is considered a criminal offence under Finnish law. Irrespective of whether the extraditable offence is a criminal offence under Finnish law, extradition is granted if the offence is an offence related to sale of narcotic or psychotropic substances under the law of the Member State that made the extradition request and the maximum penalty for the offence is at least three years' imprisonment according to the law of the Member State. The Act also regulates extradition in connection with imprisonment.

The Act on the amendment of the Customs Act (774/2003) states that technical observation can be conducted on condition that the person, based on his or her behaviour or otherwise, can be reasonably suspected of committing a customs offence for which the maximum penalty is at least four years' imprisonment, or a drug offence that can be considered a customs offence. In addition, a

Customs Official has the right to monitor personal subscriber lines or temporarily close such lines, if a person, based on his or her behaviour or otherwise, can be reasonably suspected of committing a customs offence for which the minimum penalty is four months' imprisonment, or a drug offence that can be considered a customs offence.

The Act on the Processing of Personal Data by the Police (761/2003) regulates that the data system of suspects can include information on persons who can be reasonably suspected of committing or having committed an offence for which the penalty may be imprisonment, or a contributory offence for which the penalty may be more than six months' imprisonment, or especially a drug-user offence for which the maximum sentence is six months.

1.3 Drug-related costs

The abuse of drugs and pharmaceuticals causes society harm-related costs of approximately EUR 160–220 billion annually, including the costs of police and emergency services, justice and prison systems, damage to property, social services, health care, pensions and research and prevention. As regards public funds for anti-drug activity, special project appropriations for 2004 can be specified for different administrative sectors and compared with the costs of the Government Decision in Principle to Enhance Drug Policy 2001–2003 (2000; follow up report 2003).

According to the budget proposal for 2004, the separate costs generated by the Drug Policy Action Programme 2004–2007 correspond to the costs of the last year of the previous drug policy action programme (2003). The biggest changes can be seen in the treatment sector, which will no longer benefit from the temporary appropriation of EUR 7.5 million granted for 2002–2003 and the treatment measures initiated with this funding will in the future have to be funded directly by municipalities. In addition, the investments of the Ministry of Foreign Affairs in drug prevention in neighbouring areas will increase by EUR 0.4 million. The operating costs of the police and the Customs reflect the overall costs of their anti-drug activities as opposed to the additional appropriations presented in the previous action programme; thus, the figures are not comparable with the previous years' figures.

Table 5 Estimated resources of Action Plans for More Efficient Drug Policies 2001–2003, 2004–2007 (EUR million)

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

1.4 Opinions on drug issues

During 2003, drugs were mentioned in 145 of the 9,000 speeches given in plenary sessions of the Finnish Parliament. Speeches on drugs evenly covered various drug policy activities, preventive work, treatment, crime control and drug policy in general. The most discussed issue was drug crime (49 speeches), the central themes being police resources, the authority of the police and Customs, safety programmes and Customs drug dogs. Speeches on prevention dealt with preventive work in

general (9), drug testing (9) and young people and families with children (12). Speeches concerning drug addicts covered the topics of treatment (8), young people's treatment and mental problems (10), drug treatment in prisons and follow-up treatment (9) and social problems (9). In addition, general speeches were given on the relationship between alcohol and drug policy activities (9), the drug policy action programme (10) and international co-operation on drug issues (11). The speeches given in Parliament reflect the programmes and laws proposed by the Government, such as the budget and the proposed amendments to the Coercive Measures Act, Customs Act, the Act on the Protection of Privacy in Working Life (drug tests) and the tax reduction on alcoholic beverages.

The number of speeches on drugs in Parliament decreased from 1 July 2002–1 July 2003 to the period of 1 July 2003–1 July 2004 by 6 per cent; thus, the extent of the debate has not altered much in the past two years. However, twice as many speeches on drugs were given in 1999–2000, 2000–2001 and 2001–2002. The decrease since then can be seen as a reflection of the normalisation of the drug phenomenon in Finnish society and of the decline in drug-related legislative activity, which was of high importance in previous years when drugs were a fairly new phenomenon in Finland and anti-drug measures had to be developed rapidly in order to control the situation.

The 2003 study into the health behaviour of adults measured public opinion on the importance of various drug policy activities (Jallinoja 2003). The opinions of 15–24-year-olds differed most from the opinion of the public in general. According to the survey, very important anti-drug measures were preventive work among children and young people (89% of 15–64-year-old respondents/69% of young respondents), Customs border control (81%/72%), drug education (80%/63%), police activities (77%/68%), treatment of drug abusers (61%/60%), and severe punishments (60%/65%). Especially the attitudes of 15–24-year-old males towards anti-drug work emphasized control measures at the expense of preventive work and especially treatment (45%).

The results of the 2002 population survey on drug use were consistent with those of the study into the health behaviour of adults with the exception that in the drug survey, fewer people found severe punishments a very important anti-drug measure (46%). Of the new anti-drug measures, the most unanimous approval was given to the new police rights (telecommunications interception, infiltration into criminal groups and fictitious purchasing), and as regards drug testing, the number of those who strongly approved of it was clearly larger than the number of those who somewhat approved. A distinct majority also approved of health counselling and substitution treatment, but with these activities, opinions were more uncertain as the number of people who somewhat approved was significantly higher than of those who strongly approved. Researchers interpreted this to mean that the public was not as affected by questions concerning the protection of privacy and legal protection in principle as they were by concrete problems caused by unconventional anti-drug measures such

as health counselling for drug users and the related exchange of syringes and needles if, for example, this took place in the vicinity of children's day care centres. (Hakkarainen et al. 2004)

2 Drug experimentation and use⁶

According to the 2002 survey, some 12% of adults had used cannabis at least once during their lifetime and about 3% during the past year. Use during lifetime has increased from 1998 but use during the past year has remained almost the same (Hakkarainen et al. 2003). According to school surveys, 11% of 15–16-year-olds had tried an illegal substance during their lifetime, 7.5% during the past year. At the end of the 1990s, school students' experimentation almost doubled but since then, the number of experiments has remained more or less the same. Thus, the trend in experimental use seems to be similar with both adults and school students.

In terms of public opinion, drugs are quite unanimously seen as a serious national problem. Compared with the situation in the 1990s, the general concern about drugs has increased but at the same time, people have become less worried about the risks involved in experimenting with cannabis and more concerned about the risks of drinking and smoking.

2.1. Drug use in the general population⁷

The extent of the trend in experimenting with drugs and young people's exposure to drugs were evaluated indirectly in 2003 in studies into the health behaviour of young people and adults by enquiring whether the respondent knew somebody who had used narcotic substances during the past year.

Acquaintances having tried drugs were clearly more common in cities and among 15–24-year-olds. In this age group, women had more acquaintances who had experimented with drugs than men did. Regionally the differences were not significant (16–22%). Due to their age, many students knew people that had experimented with drugs. The number was also higher among those who were unemployed or otherwise excluded from working life. (Jallinoja 2004)⁸

⁶ See Virtanen 2004, sections 2.1 and 2.2..

⁷ See "data library" or "statistical bulletin" in <http://annualreport.emcdda.eu.int/en/home-en.html>

⁸ **The study into the health behaviour of adults** comprised a random sample of 5,000 Finns aged 15–64. The response percentage was 67% (65% in 2002): 60% (58%) for men and 73% (72%) for women. (Helakorpi et al. 2003; Jallinoja et al. 2003, 2004).

Figure 13a Acquaintances having tried drugs (%) / 15–64-year-old men 1996–2003

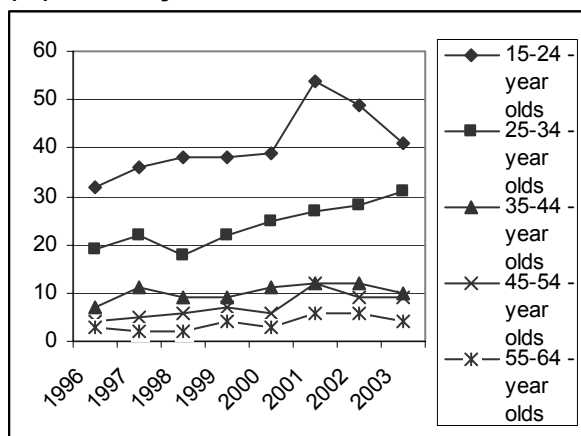
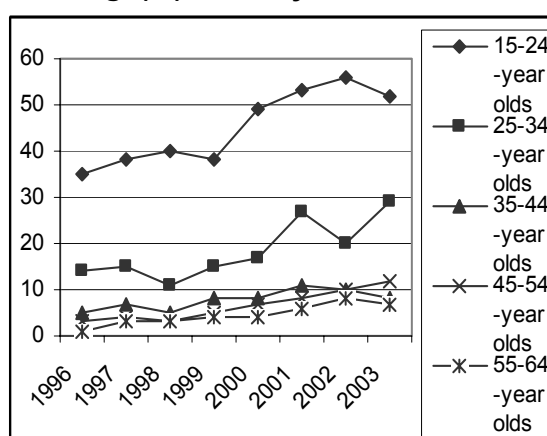


Figure 13b Acquaintances having tried drugs (%) / 15–64-year-old women 1996–2003



2.2 Drug use in schools⁹

Experiments with drugs and trends in drug use among young people are investigated every four years in national school surveys (ESPAD, HBSC) that are also part of European comparison surveys¹⁰ and regional school health surveys conducted every two years.¹¹

According to the ESPAD survey (Ahlström et al. 2003), 11% of 15–16-year-olds had experimented with an illegal drug sometime in their life whereas in 1999, the corresponding figure was 10%. The amount of experimentation nearly doubled between 1995 and 1999 but since then, there has been no significant growth. Experimentation with illegal drugs usually involved cannabis, and only a few girls around Finland had experimented with ecstasy. 7.5% of those surveyed had experimented with some illegal drug during the past year and 2.5% during the past month. WHO's 2002 school health study (HBSC 2003) gave almost the same result: 10% of 15-year-olds had experimented with cannabis sometime in their life and 7.5% during the past year. Two and a half per cent of the respondents were regular users and 0.5% heavy users.

School health surveys (Luopa et. al 2003, 2004) suggest that the number of those who have experimented with drugs sometime during their lifetime has either remained the same or even

⁹ See "data library" or "statistical bulletin" in <http://annualreport.emcdda.eu.int/en/home-en.html>

¹⁰ The latest of these surveys was the 2003 ESPAD survey which involved 3,321 pupils in 8th and 9th grade in secondary school in 200 schools. Data was collected with the same compilation method as in the 1995 and 1999 surveys. The response percentage was 92% in 2003.(Ahlström et al. 2003). See also EMCDDA's Annual Report 2004 web site, Standard Table 2. WHO's health behaviour study (HBSC) was conducted in Finland in 2002. The sample of 15-year-olds consisted of 1,745 pupils (see HBSC 2003).

¹¹ The school health survey was filled in by the 8th and 9th grades in secondary school in the municipalities (and their schools) that attended the survey voluntarily. Surveys are conducted every two years in the Provinces of Western Finland and Oulu (the last time was in 2003) and every two years in the other provinces, i.e. Southern Finland, Eastern Finland and Lapland (the last time was in 2002). The compared data included answers from the municipalities that attended both school surveys. The data consisted of 47,054 (2003) and 53,524 (2002) replies gathered from the 57,546 (2003) and 67,698 (2002) 8th and 9th grade pupils in the corresponding areas (Luopa et al, 2003, 2004).

decreased over the past two years. Surveys indicate an increase only in Eastern Finland for those provinces (including the most eastern province of Southern Finland, South Karelia) where the experimentation level has previously been quite low and where there is a medium-sized city of 50,000–100,000 inhabitants. The highest experimentation levels (11–14%) are found in Southern Finland and the Province of Lapland. For the latter, however, tourism is probably the biggest cause of the high experimentation level. The lowest experimentation level is in Ostrobothnia and Kainuu (4%).

2.3 Drug use among specific groups

According to a study, the central factor affecting the self-image of underage patients in drug treatment is drug use or drug-free living.¹² These young people may see themselves as drug users, former drug users, willing to quit drugs or incapable of quitting drugs. They see drug-free living as part of normal life. A typical feature in their stories was organising life and issues related to substance use with the help of clear boundaries. They formed the boundaries by separating ordinary life and the drug life outside it. In their stories, the young patients crossed the boundary back and forth without attaching permanently to the other side. One reason for this might be that the treatment of the underage patients had been started regardless of their own will. Those drug users who sought treatment voluntarily had to emphasise more their desire to become clean to enter treatment, and therefore they could not cross the boundary as easily.

2.4 Attitudes to drugs and drug users

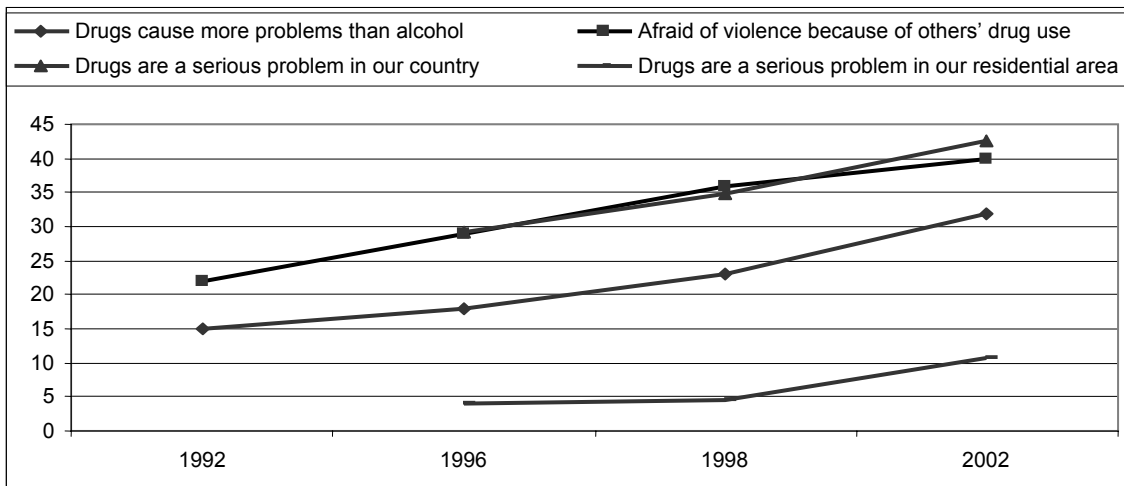
There is fairly general agreement among the population that drugs are a serious problem nationally. Only one in ten people considered drugs a minor problem or hardly a problem at all. Evaluations on the drug situation closer to their own world were clearly more moderate: about half the respondents thought that the drug problem in their own residential area was a minor problem or hardly a problem at all. People clearly saw fewer drug problems in rural population centres and built-up areas and

¹² The study deals with the views of 17 underage patients in drug treatment units on their life and substance use. Discourse analysis was used and the study focused on the meanings drug use had for the young people and the kinds of self-image the interviews revealed. (Virokannas 2004)

elsewhere in the countryside than in cities. However, the situation was different when people were asked about their views on the drug problem throughout country.

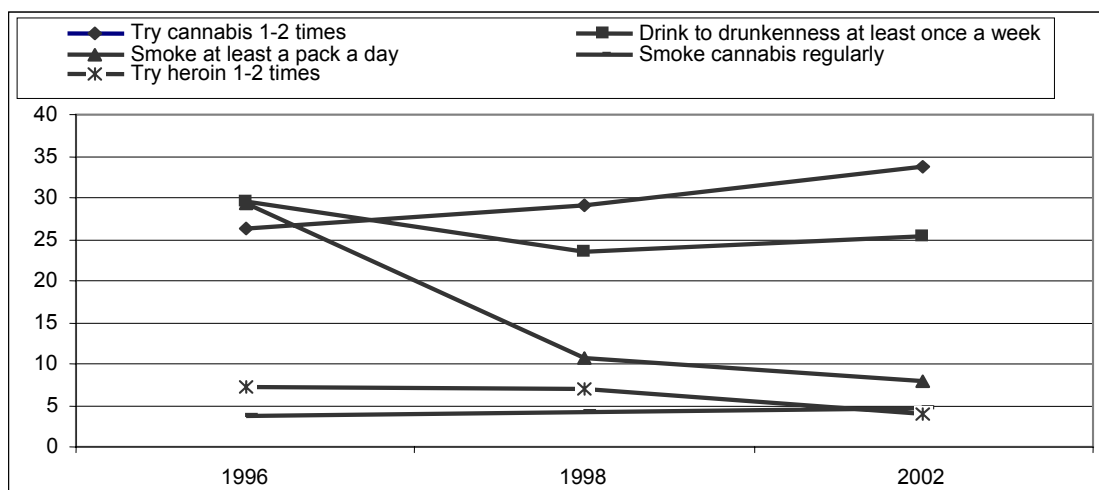
Women seemed to be more concerned about the drug problem and their concern increased with age. The responses showed that a large percentage of Finns (40%) suffer from social insecurity due to drug use; mostly, however, in Greater Helsinki and other cities where drug problems were seen to concern the respondents' own residential areas. (Hakkarainen et al. 2004)

Figure 14 Views on the drug problem



When evaluating the risks of different drugs, people separate cannabis from other drugs. According to the survey, one-third of the population considered cannabis experimentation at most a minor risk, whereas the corresponding figure was 11% for ecstasy, 8% for amphetamines and 4% for heroin. The views on risks clearly became tougher with age. Over half the youngest age group rated the risks of cannabis as minor. 40% of the respondents who knew drug users personally thought that cannabis experimentation was only a minor risk; among people who did not know any drug users, the percentage of those who rated the risks of cannabis as minor was half that. There were more negative attitudes towards smoking at least a pack of cigarettes a day (at most a minor risk 8%) and towards drinking to drunkenness on a weekly basis (25%) than there were towards experimenting with cannabis. However, the percentage of those who considered regular use of cannabis at most a minor risk was even smaller (5%).

Figure 15 Percentage of those (%) who consider it a minor risk if you...



Comparing the situation in 2002 with the earlier situation shows that the population's concern over drugs has increased with respect to drug problems, drug-related social insecurity, regional drug-related problems and the extent of the drug problem in relation to the alcohol problem. The same applies to the risks of regularly smoking cannabis and experimenting with heroin. However, concern for the risks of experimenting with cannabis has decreased when compared with the 1990s, while concern for the risks of drinking to drunkenness and smoking has increased. Researchers explain the change of attitudes towards cannabis as a generation phenomenon.

3 Preventive drug work¹³

The Basic Education Act, General Upper Education Act, Vocational Education and Training Act and Vocational Adult Education Act have been amended to emphasise a pupil's or student's right to pupil and student welfare services and to oblige educational institutions to prepare a curriculum with recorded strategies, for instance, for crises, school bullying and prevention and treatment of substance use.

Early intervention is emphasised in case of young people who face exclusion risk is emphasised because, for example, young people attending comprehensive school are still "under the eye" of the school and, due to being underage, easy to reach. The natural contact between schools and homes is in many situations the best way to ensure early intervention in young people's problems. Creating multi-administrative local cooperation would make it possible to ensure that young people facing exclusion risk get the support and services they need early enough.

¹³ See Virtanen 2004, section 9.

3.1 General prevention¹⁴

The Basic Education Act, General Upper Education Act, Vocational Education and Training Act and Vocational Adult Education Act and the relevant decrees have been amended.¹⁵ The central amendments concern teaching in primary education, a pupil's/student's right to pupil/student welfare services, and the authority and obligation to prepare for the curriculum the objectives for developing co-operation between homes and schools/educational institutions as well as pupil/student welfare services and for preparing a safety plan in co-operation between education and social welfare and health care authorities.

The National Board of Education has decided on a new curriculum for grades 1–9 in comprehensive school and for upper secondary schools. All comprehensive schools must adopt the new curriculum by 1 August 2006. Pupil and student welfare services and co-operation between homes and school is now recorded in the curriculum for the first time. Early intervention in problems is emphasised in pupil and student welfare services. Taking care of pupils' welfare also requires co-operation between the educational system and different administrative sectors. Strategies for the prevention and treatment of, for example, crises, school bullying and substance use should be recorded in the local curriculum.

The final report of the cross-administrative working group on social exclusion (2003) states that drug use is more and more evident in various harm statistics and treatment services. To prevent the problem, teacher training is going to be renewed so that it will be easier for them to recognise the problems of pupils, including drug use. The next step is extensive programmes and activities provided, for example, by youth workshops. Supporting civic activities, such as national youth organisations, youth work organisations and youth service organisations, can also be seen as part of basic preventive work. Other methods to achieve the goal of preventing substance use include making it easier to enter treatment and increasing professional skills in the treatment of drug problems.

In 2003, a report was published on the argumentation used in preventive drug work today by three non-governmental anti-drug organisations.¹⁶ Three central argumentation forms can be found in the education texts of the organisations. The basic message of the rational style of education is based on reason: it is "not sensible" to use drugs. In principle, this type of argumentation should be founded on fact-based analysis of the advantages and disadvantages of drug use. However, rational statements

¹⁴ See <http://annualreport.emcdda.eu.int/en/home-en.html>

¹⁵ See Section 1.2.2.1.

¹⁶ The data of the study comprises of texts from the Elämä On Parasta Huumetta (Life is the Best Drug) Association, Free from Drugs Association and Youth Against Drugs (YAD) Association. The texts include public education material that was published in 2001 and 2002 or, according to the associations, actively used during that time; a total of 228 texts dealing with drugs. (Majava 2003; 2004)

on the harmful consequences of drug use are not always sufficient counterarguments for the adventurous reasons for using drugs. The basic message of moral argumentation is that drug use is against the community values and therefore wrong. Drug users and "law-abiding people" are set against each other. Problems are caused by the fact that this type of drug education is based on a certain value system that the target audience does not necessarily share. The central message of drug education based on the universal principle of justice is that drug use is ethically unsound because it harms others. However, there is no desire to exclude drug users from the society. The problem is that drug education reaches its limits in a situation where the drug user does not see himself causing harm to others.

According to the researcher, the question arises whether the organisations only want to concentrate on preventing first-time experiments. As drug use is becoming more and more common, focusing on a problem framework emphasising the harm from drugs may create credibility problems for drug education also in terms of prevention of first experiments. Discussing the pleasure of intoxication and the meaning of use contexts along with the health effects of drug use is one way to develop drug education so that it does not underestimate the knowledge basis and intelligence of the target audience.

The KLAARI project on preventive work conducted in Helsinki aims at creating safety nets for young people to increase their well-being and reduce substance abuse. Safety nets are created by developing the multi-professional and cross-administrative co-operation networks in preventive drug work among young people in the seven social and health service districts of the city. The co-operation networks also include relevant organisations and parents of young people. The operation emphasises expertise but, according to an evaluation based on employee interviews, the different, even contradictory views of the organisations and experts concerning preventive work were considered a problem for the realisation of the project.¹⁷ There has also been a contradiction in the project between the common goals set for multi-professional co-operation and the different goals appearing in practical work. Flexible decentralisation of activities and partnership projects do not necessarily guarantee the quality of projects either. In practice, all "relevant" actors have been supported without knowing exactly how the projects have achieved their goals. As a condition for continuing the project, a proposal has been made to enhance project co-ordination and create more (political) guidelines based on research data to streamline the operation. (cf. Rantala 2004a)

¹⁷ The study involved interviews with central officials of the national drug policy (2), project co-ordinators (11) and co-operation network workers.

A report on the material in the most extensive virtual discussion forum in Finland, Sauna, dealing with drugs and other substances¹⁸ was issued in 2003 (Roine 2004a, 2004b). Five central approaches were found in the themes and message chains in the forum: (1) drug use is considered either an extremely good or bad experience, (2) controllability of drug use becomes an ideal, (3) drug use is seen as the individual's own choice, (4) acceptability of drug use is justified by comparing it, for example, with the use of alcohol, or (5) people in the forum indicate that they are experts in the field and thus qualified to give advice to others by referring to exact research-based information. According to the people in the Sauna forum, it is acceptable to go for extreme intoxication experiences but it should be done in a controlled way. They draw a strict line between themselves and those drug users that they classify as drug addicts. Drug education based on restrictive drug policy, which aims at getting the drug user to quit drugs altogether, does not reach these people, because they do not see drug use causing them any particular problems. According to the study, people participating in the Sauna discussion could be reached with drug education that would offer neutral information and guide drug users towards more controlled and safe drug use. (Roine 2004a)

3.2 Selective prevention¹⁹

The working group on active social policy proposed in its 1999 memo a rehabilitation trial for young people facing exclusion risk. 18 projects around Finland participated in the national rehabilitation trial in 2001–2003. Young people who had dropped out or were in danger of dropping out of comprehensive school, upper secondary school or vocational training were chosen for the projects.²⁰ In addition to difficulties with school attendance and studies, the young people could have other problems that increase the risk of social exclusion, such as alcohol or drug problems, but the project only dealt with them indirectly. (Suikkanen et al. 2004; Linnakangas et al. 2004)

According to the project results, two out of three young people had had their life situation improved significantly due to intervention in problems. Intervention was possible because young people attending comprehensive school are still “under the eye” of the school and, due to being underage, easy to reach. The natural contact between schools and homes is in many situations the best way to ensure early intervention in young people's problems. In addition to the “partnership” of school and home, cross-sectoral co-operation to support young people facing exclusion risk is also important. Multiprofessional co-operation requires guidelines that co-ordinate the activities of different interest groups and a person who co-ordinates the co-operation between different services. The starting point

¹⁸ The report dealt with 426 messages sent to Sauna in January–March 2002, which were selected from 27 message chains starting from the latest themes

¹⁹ See "data library" or "statistical bulletin" in <http://annualreport.emcdda.eu.int/en/home-en.html>

²⁰ Projects involved 576 persons in the age group of 15–17 years who had a rehabilitation plan prepared. Some 8% of the participants dropped the project.

should be that there is a collaborative group in every municipality including persons who either deal with young people in their work or are familiar with rehabilitation issues. The problems of the young people would be dealt with in co-operation as early as possible, and the task of the group would be to ensure that the young people facing exclusion risk get the support and services they need.

4 Problem drug use²¹

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

In 2003, the main drugs used by drug treatment clients of substance abuse services were opiates (31% of the cases, of which buprenorphine accounted for 24%), amphetamines and other stimulants (28%), mixing alcohol with drugs (19%), cannabis (16%) and hypnotics and sedatives (6%). The share of buprenorphine in particular has grown in the last three years. Nearly three out of four drug treatment clients had injected drugs at least once during lifetime. Two per cent of the tested clients were HIV-positive, 55% hepatitis C positive and 11% hepatitis B positive.

4.1 Estimates of the number of problem users²²

Statistical estimates on the prevalence of problem drug use have been made nationally since 1997 and regionally since 1998 with the help of register information reflecting drug-related harms. Problem use has been defined as the use of amphetamines and opiates or their derivatives as they appear in different registers.

According to the statistical estimate based on four registers²³, there were some 16,000–21,000 amphetamine and opiate problem users in the entire country in 2002; they are estimated to account

²¹ See Virtanen 2004, sections 2.3 and 3.1.

²² See "data library" or "statistical bulletin" in <http://annualreport.emcdda.eu.int/en/home-en.html>

²³ **The estimates of problem drug users** are based on the statistical capture-recapture method in which the samples from the same group are used to assess statistically the size of the entire target population. The samples were defined based on the interventions directed by society at the target population (amphetamine and opiate users). The interventions employed by the system included amphetamine or opiate diagnoses recorded in hospitals, penal action for drug offences involving the use or possession of amphetamines or opiates, arrest for driving under the influence of amphetamines or opiates and hepatitis C cases recorded in the infectious disease register due to intravenous drug use. The estimate intervals are based on 95-per cent confidence intervals of the estimates. Different log-linear models were applied to

for 0.6–0.7% of the 15–55-year-olds. The number of problem users, especially opiate users, has increased distinctly since 1999 even though the number of cases noted in the registers fell between 2001 and 2002.

Table 6 Development of the number of amphetamine and opiate users in Finland in 1997–2002

	1997	1998	1999	2001	2002
Overall estimate	9,400–14,700*	11,500– 16,400	11,100– 14,000	13,700– 17,500	16,100– 21,100
Opiate users*	1,500–3,300	1,800–2,700	2,500–3,300	3,900–4,900	4,200–5,900
Amphetamine users*	6,800–11,600	7,600– 13,000	8,300– 12,400	10,100– 15,400	10,900– 18,500
Register findings	2,138	3,206	3,865	4,515	4,097

* = Estimates are based on information from three registers

The majority of the problem users, 70–75%, consisted of amphetamine users; in 2002, they accounted for 0.4–0.6% of the 15–55-year-olds in Finland. Opiate users were estimated to account for 0.15–0.20% of the population. According to the study, about 80–85% of amphetamine users and 75% of opiate users were men. Gender distribution has remained approximately the same since 1999. In 2002, 40–45% of the users in both groups were 15–25-year-olds. The share of the youngest problem users has varied between 40 and 50% since 1999. In 1999, the rest of the problem users were divided evenly into the two other age groups studied, 26–35-year-olds and 36–55-year-olds, for both drugs. After 1999, the age structure of opiate users has not changed much, whereas the number of amphetamine users has increased especially in the age group of 26–35-year-olds, the share of whom was in 2002 already as big as the share of the youngest age group (45%).

Table 7 Development of the population share (%) of amphetamine and opiate problem users in Finland in 1998–2002

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

different subgroups so the sum of the subgroups differs from the overall estimate. (Partanen P. et al. 1999, 2000, 2001, 2004). See also <http://annualreport.emcdda.eu.int/en/home-en.html> .

In a 2002 population study, 0.6% of the 15–55-year-olds (0.9% of men) said that they had used amphetamine during the past year; for 15–24-year-olds, the figure was 2.1%. As for opiates, the population study showed that 0.1% of 15–55-year-olds had used them during the past year, the equivalent figures being 0.2% for men and 0.2% for 15–24-year-olds. (Partanen P. et al. 2004)

The population study and register-based estimates of problem users give a surprisingly similar picture of the situation. The results differ mainly for young people. When it comes to amphetamine use, register-based estimates probably do not cover occasional, other than intravenous drug use of young people, which does not easily come to control authorities' knowledge, as well as population studies (Salasuo 2004). For opiates, register-based estimation seems to reach the target group better than population studies. This is not surprising since drug users with multiple problems, as opiate users often are, are easily underrated in population samples. (Hakkarainen et. al. 2003)

Some 60–70% of all problem users were from Southern Finland and 30–40% from Greater Helsinki. In the Greater Helsinki area, the problem users were slightly older than elsewhere in Finland. The number of problem users seems to have grown fastest in the age group of 26–35-year-olds and outside the Greater Helsinki area. In addition, the proportionally biggest increase seems to concern the use of opiates.

Table 8 Development of the population share (%) of the problem use of amphetamines and opiates by region in 1998–2002

	1998	1999	2001	2002
Finland	0.4–0.55	0.4–0.5	0.5–0.6	0.55–0.75
Greater Helsinki	0.75–1.05	0.7–0.95	0.85–1.15	0.9–1.35
Southern Finland	0.5–0.85	0.55–0.7	0.7–0.9	0.85–1.25
Western Finland	0.25–0.4	0.2–0.3	0.4–0.55	0.4–0.6
East and North Finland	0.1–0.2	0.2–0.4	0.2–0.3	0.3–0.5

* = Due to a small number of cases, Eastern and Northern Finland were estimated as a whole

4.2 Clients in drug treatment²⁴

In 2003, all social and health service units took part in a one-day census of intoxicant-related cases, which examined all the cases related to substance abuse in each unit during the day in question. The results indicate that 44 per cent of the clients in outpatient care and 47 per cent of the clients in

²⁴ See "data library" or "statistical bulletin" in <http://annualreport.emcdda.eu.int/en/home-en.html>

inpatient care in the units providing specialised services for substance abusers had used pharmaceuticals or drugs (the figures for drugs were 35% and 39%). The results have changed significantly from 1999 when the share of drug treatment clients was just under 20% in substance abuse outpatient care and about 30% in inpatient care. (Metso 2004)

According to the coverage survey of drug treatment information system ²⁵ conducted in 2004, which estimated the number of people entering drug treatment, the shares of drug users were about half of the figures above: 18% in substance abuse outpatient care and 27% in inpatient care. The latter estimate reflects, however, the problem drug use related to substance abuse better than the census of intoxicant-related cases. Based on the figures in the annual statistics of substance abuse services (for which there is no substance-specific client classification), the number of drug treatment clients can be estimated to be 12,000 using the percentages of the coverage survey. (Statistical Yearbook on Social Welfare and Health Care 2003. Vismanen 2004) The statistical estimate is very close to the number of drug abuse clients in substance abuse services (11,200) reached by the coverage survey.

When estimating the number of treatment service users, it should also be taken into consideration that about 6,500 patients with drug or pharmaceutical diagnoses are treated in hospital wards every year. In addition, according to the census of intoxicant-related cases the number of drug treatment clients in outpatient health care services (hospitals, mental hospitals, health centres and mental health clinics) a day is about half of the number of clients in substance abuse outpatient units within the same period. The share of drug clients among the alcohol and drug treatment clients in outpatient health care services was 23% according to the same survey.

The drug treatment information system, which is voluntary and anonymous for substance abuse units, collects information on clients who have entered drug treatment for the abuse of pharmaceuticals or narcotics. The results for 2003 are based on the data collected from 165 units and 5,754 drug treatment patients. (Partanen A. 2004) As the coverage report of drug treatment information system covered some 11,200 drug treatment clients in substance abuse units, the system can be estimated to reach roughly half of all drug treatment clients in substance abuse units. According to the coverage report, Southern Finland had the smallest drug treatment information coverage (49%), of which 44% was in Helsinki; the figure for Western Finland was 67%, for Eastern Finland 71% and for Northern Finland 79%.

²⁵ For the coverage survey of the drug treatment information system, all the 551 units of substance abuse services were sent a survey regarding their alcohol and drug treatment clients. 324 of the units responded and 260 units said that they provide treatment especially for drug users. The number of units participating also in the treatment demand information system (all of 164 units) was 122. Overall, the units (units of substance abuse services as well as substance abuse units in health care and prisons) reported about 75,000 alcohol and drug treatment clients, of which 17,850, i.e. almost a quarter, were drug clients. (Vismanen 2004)

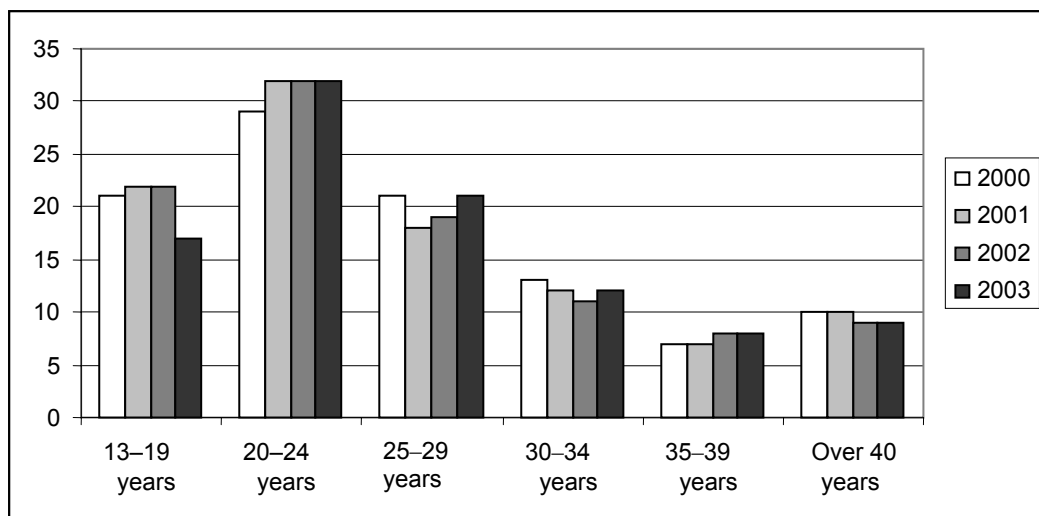
The profiles of drug treatment clients in the information system and in the census are quite similar regarding substance abuse units. On the other hand, in the census, the profiles of the clients of substance abuse units and the recorded clients of corresponding substance abuse units match as far as information on both is available. (Vismanen 2004) Thus, the results of drug treatment data collection can be evaluated to reflect quite well the drug treatment clients in substance abuse services: both the census of intoxicant-related cases and drug treatment information system included younger, single, unemployed and homeless drug treatment clients as compared to the clients in the census on the average.

There are, however, also differences between these two data collection methods. In the drug treatment information system, the drug treatment clients in outpatient and inpatient care are systematically five years younger than were the drug treatment clients in the census. The difference can be explained by the fact that youth centre clients are emphasised in the drug treatment information system. It can also be estimated based on the census that abusers of pharmaceuticals that are a little older on the average are underrepresented in the drug treatment information system, although the difference is only about 4–6 per cent. In the census, drug treatment clients are eight years younger on average than are the census clients in general. (Metso 2004)

According to the 2003 drug treatment information system, the drug treatment clients' backgrounds and life situations were similar to those of the clients in the previous year. The drug treatment clients were mainly men (71%), young adults (mean age 26.8 years) and single. Their educational level was low, and unemployment was common (60%). Every ninth client (11%) was homeless. The majority of the drug treatment clients had received drug treatment before, and one-fifth (19%) entered drug treatment for the first time. (Partanen A. 2004)

The mean age of the clients participating in data collection was 26.8 years. Men were on average 1.8 years older than women were. The clients of inpatient treatment units specialising in drug treatment (6.6% of all clients) were the youngest, with the mean age of 23.0 years. In substance abuse outpatient units, the mean age of clients (43.9% of all clients) was 26.0 years, in outpatient treatment units specialised in drug treatment (19.7%) 26.8 years, in substance abuser inpatient care (27.6%) 28.6 years and in prison health care (2.0%) 30.5 years.

Figure 16 Development of the age distribution of clients in drug treatment 2000–2003



The share of those entering treatment for opiate use had grown since 2003. In 2003, opiates (31%) were the primary problem substance of those entering drug treatment more often than stimulants were (28%). Within the category of opiates, there were more of those entering treatment for problem use of buprenorphine (24%) than in the previous year. Other primary problem substances leading to entering drug treatment included mixed use of drugs and alcohol (19%) and cannabis (16%). Sedatives (6 %) or other drugs were rarely identified as the primary problem substance. Polydrug use was common; almost two out of three clients had used at least three substances. If the three most used substances in drug treatment are counted in, the result is almost the same as in the census of intoxicant-related cases; except for heroin, which is three times more common in the census than in the drug treatment information system.

The primary substance of those entering drug treatment for the first time (1,064) was cannabis (29%), although it was also common to enter treatment for the use of stimulants (26%) and opiates (15%) or mixed use of drugs and alcohol (23%). The percentage of those entering treatment for the first time for the use of buprenorphine, which belongs to the category of opiates, was 13. The use of sedatives (5%) or other drugs (1%) was rarely the reason for entering treatment for the first time.

Almost three out of four (74%) drug clients in services for substance abusers had injected drugs at least once during lifetime. Nearly two-thirds (60%) of those who had injected drugs had done it during the past month. The most common way to use opiates was injecting (87%). Injecting buprenorphine (90%) was almost as common as injecting heroin (94%). Stimulants were also injected by 79 per cent of their users.

4.3 Problem drug use and users according to other studies

The first detoxification, substitution and maintenance treatments with buprenorphine or methadone were introduced in Finland in the 1990s. A practical problem has been the patients' concurrent use and injection of buprenorphine. Even if the patients stop using other opiates, they may continue the injection of buprenorphine for years after treatment has begun.

According to a study²⁶, those who inject drugs actively explain their use by the fact that injecting is more effective and cheaper than using drugs in other ways. If a patient's medication is adequate, he or she should not have a pharmacological reason for using more drugs. The beliefs regarding the effectiveness of a substance are indeed central in the needle addiction phenomenon. These beliefs among users stem from the times of active use and the immediate feeling of pleasure caused by drug use and especially injecting use. Injection also involved all kinds of rituals that regulated among other things the activities before injection, the type of music that was played in the background and what was done to needles and syringes after injection. Injection is seen as a form of social activity and a way to belong to a group. Breaking free from injecting drug use can be very hard for a patient in substitution treatment if he/she continues to socialise with active or injecting drug users.

The study emphasised that injection itself is a form of addiction. Injection can be seen as a functional concurrent addiction. It cannot occur unless the person is or has been addicted to a substance causing physical addiction and injected it. Quitting injection seems to require a completely new social network for the patient, which does not include other drug addicts.

5. Drug treatment²⁷

The monitoring of the use of the State's temporary appropriation for drug treatment revealed that the money has been used to expand the operations of treatment units, to establish new units and to create new work practices. It is, however, uncertain whether municipalities will be able to continue these development activities and their funding once the funds provided by the State run out.

²⁶ The material for the study into drug users' experiences on injection and its compulsiveness (Harju 2004) consisted of interviews of 12 persons. Those interviewed were patients of two outpatient substitution treatment units in Helsinki. The material was analysed using the grounded theory method.

²⁷ See Virtanen 2004, section 11.

According to a study made in Helsinki, the alcohol and drug treatment service system is fractured and built on the treatment needs of alcohol abusers. New resources are urgently needed in the treatment of substance abusers with mental health problems, in creating comprehensive treatment programmes for children and young people, and in organising treatment for opiate addicts. The waiting time for opiate addicts' buprenorphine substitution treatment in Helsinki can be as long as 2 years. Even though persons on the waiting list are put in contact with care staff, the most essential problem is that there are not enough substitution treatment places. In other parts of the country, the waiting lists are not quite as long.

5.1 Drug treatment systems²⁸

Treatment systems and their evaluation

The State budgets for 2002 and 2003 included temporary appropriations for the development of drug treatment in Finland. A total of EUR 7,570,000 was granted each year. The appropriations were distributed by State Provincial Offices to drug treatment development projects in municipalities and federations of municipalities. The funding was meant to help launch projects that would later be funded by municipalities themselves.

In 2004, a study was published which examined the use of 2002 State subsidy (Villikka 2003). According to the study, the money has been used to expand treatment units and establish new ones. New curative action and work practices were also developed. Resources were targeted especially at intensifying treatment and rehabilitation, improving the service referral system and increasing treatment for opiate addicts. The majority of the projects aimed at improving care for severely drug-dependent clients. Some of the projects focused on increasing treatment of young people, substance-using mothers, substance-using families and dual diagnosis patients.

The overall service system and the continuity of treatment were developed by the networking of various interest groups, and the personnel of social and health services were given training in how to handle and treat drug abusers. In most opinions, the essential problem with the appropriation was its temporary nature. According to the study, it is uncertain whether municipalities will be able to continue the initiated development activities with their own funding. (Villikka 2004)

In Helsinki, the coverage and efficiency of the local substance abuse services and organisations were assessed.²⁹ The following points and goals were brought up in the evaluations:

²⁸ See <http://annualreport.emcdda.eu.int/en/home-en.html>

- The substance abuse service system has been built on the treatment needs of alcohol abusers.
- The treatment system is fractured.
- The organisation of the substance abuse services has weaknesses in various practices, in the division and co-ordination of work between the city's own and outsourced services and in the use of existing treatment services.
- The treatment of drug addicts requires long inpatient periods, which diminishes the resources reserved for the care of alcohol abusers.
- Drug addicts need more low-threshold services.
- The statistical information system of substance abuse services requires modification, which would allow the assessment of care continuums, treatment demand, targeting of resources and scaling of treatment
- Treatment requires increasingly specialised competence and more and more knowledge on health care.
- In Helsinki, resources are most urgently needed in the treatment of substance abusers with mental health problems, in building comprehensive treatment programmes for children and young people, in referring young adults to treatment, in providing detoxification treatment to drug abusers and in organising adequate treatment for opiate addicts.

In Tampere, an assessment has been made on the role in the local service system of the low-threshold unit (Matala) open around the clock.³⁰ The primary task of the unit, opened in 2002, was to motivate and refer clients to treatment. In addition, the unit was supposed to develop treatment practices for clients who are incapable of quitting drugs, but still need services. The idea was that the concentration of drug treatment clients in one place would untangle care chains and reduce queues.

According to the assessment, the Matala unit was successful at reaching 18–25-year-old drug addicts and polydrug users, who had previously only had contact with health counselling and social services. The most sought-after services were health care and medical services. The Matala unit gathered a large amount of users in need of support and treatment services in one place and

²⁹ In the Helsinki project, the client feedback data was collected from various types of service units meant for different client groups and having different work practices. Data was collected between 1 November 2002 and 31 December 2002. The respondents included 107 outpatient clients and 177 inpatient clients. In addition, 25 specialists and co-operation partners of substance abuse services were interviewed in autumn 2002 and spring 2003. Questions on the treatment system were also answered by 7 outpatient unit directors and a third of senior social workers. (Törmä et al. 2004)

³⁰ The assessment of the Tampere low-threshold unit was made by presenting a questionnaire to the staff (to the entire staff before the commencement of the activities and a year after), to clients (86 out of all 572 clients responded) and interest groups (the questionnaire was sent to 52 representatives of various interest groups, the response percentage was 60%) a year after activities were started.

increased the demand for detoxification and rehabilitation services. Matala proved successful in reaching new clients and motivating them, in concentrating care need assessments in one place and in developing care continuums. According to interest groups, care chains became organised as the activities stabilised, but queues did not get shorter because clients usually also needed other social and health services. Especially the volume of the clientele resulted in the decline in efficiency and quality of services. It was also noted, that the personnel had insufficient skills for handling the clients' mental health issues. With a larger staff, less clients and more help from other substance abuse services the unit could have performed even better. (Kekki 2004)

Training system for drug treatment

Training in substance abuse work is provided by various parties and the competition for training places has increased. The challenge is to co-ordinate the training and secure its contents, methods and quality. The Transdrug project (2001–2003) supported by EU's Leonardo da Vinci programme and co-ordinated by the A-Clinic Foundation created *A Trainer's Tool Kit* handbook (Montonen ed. 2003). Within the project, experiences of Finnish co-operation partners were compiled in a collection of articles called *Perspectives on Addiction Training in Finland* (Montonen et al. 2003). In addition to these, an updated version of the book *Päihdelääketiede Addictive Medicine*] (Salaspuro et al. ed. 2003) was published for people working in the medical and social sectors.

Treatment systems for special groups

Services for immigrants are still limited, but there has also been some decrease in their need. For example, the language skills of Russian immigrants have improved and as a result their social networks have expanded and they have better access to services in Finnish.

It is stated in *Health and well-being by evidence-based treatment - The national target and action plan 2004 - 2007* (2004) that its target concerning drugs is to reduce drug use among young people and to organise a multiprofessional treatment and follow-up system for mothers with alcohol and drug problems and their children.

In a local treatment and cooperation practices programme in Riihimäki, drug-using pregnant women are informed of their possibilities for getting help and support to protect the child. At the same time, they are motivated to participate in a treatment programme in order to stop using drugs. The aim of the treatment programme is that the mother always deals with the same public health nurse, physician, substance abuse worker and social worker. The necessary laboratory and maternity clinic

visits are programmed to support more frequent child welfare clinic visits. If the mother refuses contact, a child welfare report is made once the child is born. In the hospital, the child is monitored for a week to detect any withdrawal symptoms and to see how the parents react to the child. After the mother has returned home, a child welfare clinic worker will visit the family home. In the beginning, the family will have frequent appointments at the child welfare clinic and the future will be based on the well-being and development of the child and the situation of the family. (Koskivuori et al. 2004)

5.2 Drug treatment in general – emphasis on drug-free treatment³¹

The same treatment models are used in drug-free treatment for drug abusers as in the treatment of alcoholics, for example, cognitive behavioural therapy, group therapy, family and network therapy, the so-called Minnesota model, other community models and various individual measures, such as acupuncture etc. According to meta-analyses of international methods for treating alcoholism, various specific psychosocial treatment methods based on a clear structure are fairly successful. However, there exists no scientific proof that a specific treatment method would suit a certain patient group better than another group. In the early stages of a substance abuse problem, any treatment seems to produce the same outcome as extensive treatment, whereas a person with a more severe problem and related social problems (homelessness, psychological problems) benefits from extensive treatment. (Salaspuro 2003)

During the past year, so-called extended family treatment (PYY) targeted at drug-using families was evaluated. Extended family treatment signifies a treatment process for drug-using families that consists of a rehabilitation phase (3–6 months) followed by family rehabilitation (3–10 months), outpatient rehabilitation (3–6 months) and finally, after about six months, an interval phase. Community, systemic and solution-centred approaches to substance abuse and family treatment are applied in extended family treatment.³² According to the results of the evaluation, the set goals, i.e. a drug-free life, parenting and learning life management skills, were achieved especially by those who had strong treatment motivation even though they had big problems in their lives. The community approach and learning its internal rules had helped the clients strengthen their self-esteem as parents. On the other hand, parents often realized only after the fact that there should have been more focus on the situation of the child during treatment (Rask et al. 2003)

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

³² In connection with the evaluation in Greater Helsinki 13 people who had gone through the treatment before October 2002 were interviewed (one of them had dropped out of treatment). In addition to this, in the spring of 2003, a postal questionnaire was sent to the parties that had referred the patients to treatment, 12 of whom responded. In addition, the staff of the institution was interviewed both individually and as a group.

5.3 Substitution and maintenance treatment³³

In 2003, an estimated 600 people were undergoing medical substitution and maintenance treatment. 428 of them were receiving buprenorphine treatment (Buprenorphine Treatment Today 2004)

A survey commissioned by the Ministry of Social Affairs and Health examined opiate addicts' access to treatment in the Greater Helsinki area and three other cities in Finland. In particular, the waiting lists for treatment with buprenorphine and methadone were studied³⁴. The results showed that opiate addicts in Greater Helsinki may have to wait for access to substitution treatment at worst almost two years, although there are not that many clients on the waiting list. In June 2003, the waiting list consisted of 41 patients, of whom the first client had been on the list since October 2001. In Greater Helsinki, the patients are mostly waiting for access to buprenorphine treatment. The clients are provided contact with care staff while being on the waiting list, so that they are not totally left without services. There are waiting lists for treatment elsewhere in the country as well. In August 2003, the waiting list in Tampere consisted of fifteen and in Oulu of six persons. At the moment, Turku is the only city that can provide fairly rapid access to treatment.

In Greater Helsinki, the most essential problem related to waiting lists appears to be that new places for starting substitution treatment are not released fast enough. In order to shorten waiting times, more treatment places should be created in outpatient care, both within services for substance abusers and in primary health care units. The 2003 state subsidy for drug treatment enabled an increase of about 15–20 places in Vantaa and as much as 50 in Helsinki. In the Greater Helsinki area, the City of Espoo did not receive the subsidy, and therefore could not increase its capacity as planned. The evaluation concludes that creating additional capacity does not necessarily facilitate the situation in the long term unless those who have received treatment for a long time can be moved from specialised care to continued care within primary services. It would also be necessary to scale treatment to a greater extent.

According to another study, the situation is similar in the drug addiction clinic at Kuopio University Hospital. Providing substitution treatment in a specialised clinic uses up the entire treatment capacity and new patients have to wait for a long time for care need assessment and treatment. This is why established treatments should be transferred to primary health care. The follow-up study of the 55

³³ See <http://annualreport.emcdda.eu.int/en/home-en.html>

³⁴ For the study, 11 people were interviewed in person in Greater Helsinki and 7 people by telephone in Oulu, Tampere and Turku from 2 June–22 August 2003. The interviewees work in substance abuse services. These and the State Provincial Office of Southern Finland also provided substance abuse services -related documents to be used as material in the study. (Villikka 2003)

patients who came to the clinic between 1 February 2001 and 1 February 2002 showed that the number of patients that dropped out of treatment was quite high (25%). This reflects how difficult it is for substance abuse patients to commit themselves to sustained care. The first year of treatment is usually spent trying to control a chaotic situation and get accustomed to the treatment. A favourable result of the study was however that a year after treatment had begun the number of injecting drug users was down by more than a half. (Aira et al. 2004)

6. Drug-related health problems³⁵

In 2003, there were 146 drug-related deaths in Finland according to preliminary information on forensic chemical findings. What makes the 2002–2003 situation special is that the number of heroin deaths has remained low since 2001, whereas buprenorphine has become the most common opiate finding in drug death cases, which reflects the strong increase in buprenorphine use also seen in drug treatment information.

Mental health problems are also prevalent among injecting drug users. Problems associated with injecting drug use were also common. In 2003, the number of HIV cases caused by injecting drug use decreased for the fourth year in a row. In addition, the number of hepatitis cases declined.

6.1. Drug-related deaths and mortality of drug users³⁶

In 2003, there were 146 drug-related deaths in Finland according to preliminary information on forensic chemical findings. Defined by the primary cause of death (poisonings) according to the EMCDDA criteria for special mortality registers (the register of autopsies in Finland), the number was 67 (Vuori 2004). These different estimates provide the limit values for the number of drug-related deaths in Finland. Estimated by the EMCDDA criteria for general mortality registers, which will be used for international comparisons in the future, the number of drug-related deaths (101) would be between the above-mentioned limit values (Huohvanainen 2004). According to the registers, the share of 15-24 - year-olds ranged between 25 % and 40 % in 2003

³⁵ See Virtanen 2004, sections 3.2 - 3.4. and 21.

³⁶ See "data library" or "statistical bulletin" in <http://annualreport.emcdda.eu.int/en/home-en.html> . Definitions see <http://www.emcdda.eu.int/?nnodeid=1419>

For opiates, the classification of chemical findings is not comparable with previous years because buprenorphine, which has become an increasingly common opiate finding, is not detectable in the opiate screening test. However, the numbers of amphetamine and cannabis findings are comparable to previous years' statistics: amphetamine was found in 51 cases, cannabis in 82 cases and opiates, according to very preliminary information, in 61 cases. The number of heroin deaths related to opiate findings continued to remain low during 2002–2003 (4 cases in 2003). This is consistent with the continuous decline in heroin deaths that started in 2001. Instead, the number of buprenorphine-related drug death cases (44 cases according to very preliminary information) has increased rapidly. Buprenorphine was the most common opiate finding in forensic autopsies - mostly in combination with benzodiazepines, sedatives or alcohol. (Vuori 2004)

6.2 Drug-related infectious diseases³⁷

HIV

In 2003, 132 cases of HIV infections were reported (131 cases in 2002). In cases where the means of transmission was reported, infections contracted by injecting drug use accounted for 21% (23 cases) showing a decline for the fourth year in a row. Thus, the number of HIV infections contracted by injecting drug use was at the same level as the year preceding the 1999 HIV epidemic that was associated with injecting drug use. Approximately half of the cases belong to the age group 20–34-year-olds. However, as a result of the 1999 epidemic, half of the HIV deaths in 2003 (a total of 10) were initially related to injecting drug use. (Infectious Diseases in Finland 2003). According to drug treatment data collection for 2003, of all the tested clients in drug treatment about 2% were HIV positive. Among injecting drug users, the percentage was 3%.³⁸ (Partanen A. 2004)

Hepatitis C

In 2003, a total of 1,262 hepatitis C cases were diagnosed in half of which the means of transmission was reported. 90% of the cases are estimated to have been contracted by injecting drug use. The number of hepatitis C cases declined by 10% compared to the previous year. The most significant decrease could be seen among 15–19-year-olds, the number of cases having dropped by 30%. Of those infected, 55% belonged to the age group 20–34-year-olds. (Infectious Diseases in Finland 2003).

³⁷ See "data library" or "statistical bulletin" in <http://annualreport.emcdda.eu.int/en/home-en.html>

³⁸ More than three fourth of drug treatment clients have been tested for HIV, hepatitis B and hepatitis C and two thirds for hepatitis A. About one-fifth of the data on infectious diseases is lacking, which may distort the result. (Partanen A. 2004)

According to drug treatment data collection in 2003, 55% of all tested drug treatment clients had hepatitis C. Among injecting drug users, 62% were infected with hepatitis C. (Partanen A. 2004)

Hepatitis B

In 2003, 369 hepatitis B cases were reported, showing a decline of 10% over the previous year. The majority of cases were found among 25–34-year-olds. According to drug treatment data collection in 2003, 11% of all tested drug treatment clients had hepatitis B. Among those who had injected drugs sometime in their life, almost two thirds had received at least one shot against hepatitis B and almost half of them had received all three shots. This explains partly the low prevalence of hepatitis B among drug treatment clients. (Partanen A. 2004)

Hepatitis A

The rapid rise in hepatitis A cases that started in 2002 in Greater Helsinki area among injecting drug users slowed down significantly in 2003, the number of cases being 242. The numbers were the highest among 20–29-year-olds (40% of the cases), which reflected the ongoing epidemic among injecting drug users. In Finland, the hepatitis A shot has been recommended for injecting drug users but so far, it has not been included in the national vaccination programme. This will change at the beginning of 2005, because the hepatitis A vaccination will be included in the vaccination programme for injecting drug users (which already includes the hepatitis B shot). According to drug treatment data collection in 2003, 6% of drug treatment clients were infected with hepatitis A.

6.3 Other drug-related morbidity³⁹

According to a 2003 study, the inpatient admissions of patients suffering simultaneously from drug addiction and other mental disorders have grown five-fold between 1987 and 2002. At the same time, the number of psychiatric inpatient beds has been cut sharply. Thus, the share of drug treatment clients' inpatient periods has increased in relation to the total amount of psychiatric treatment periods (Pirkola et al. 2004)

³⁹ See "data library" or "statistical bulletin" in <http://annualreport.emcdda.eu.int/en/home-en.html>

In a study on risk behaviour among drug users⁴⁰, other drug-related health problems among drug users were examined. During the six months prior to the interviews, 41% of the respondents had suffered from mental problems and 29% had experienced a psychosis. Many had had problems associated with injecting: shivers (43%), paresthesia (43%), angiitis (23%) and abscesses (16%). In addition, approximately half the respondents had bad teeth, a third had breathing difficulties and a fourth suffered from chest pain. About one out of ten had had problems related to overdosing. (Partanen, A. et al. 2004b)

6.4 Other drug-related health problems and their consequences

In 2003, pharmaceuticals and drugs were found in 2,577 drunken driving cases (1,663 cases in 2002). Among these, drugs were found in 1,467 cases (1,266). In February 2003, the regulations regarding drunken driving were amended by introducing so-called zero tolerance for drugs. Partly due to this, drug findings in traffic increased by more than 50%. On the other hand, the legislative amendment made it easier for the police to start pre-trial investigations when someone was suspected of driving under the influence of drugs in road traffic. According to the 2003 data, cannabis accounted for 25.5% of the findings (60% the year before), amphetamine 81.8% (66.7%) and heroin 2% (12%). The zero tolerance partly explains the changes in substance-specific percentages: according to the new act, sentencing now only requires evidence of one drug, so in cases of polydrug use, if one drug is found, others are not looked for (for example buprenorphine, which is categorised as a pharmaceutical substance, is only looked for if an actual drug is not found). In addition, substances are now analysed only based on blood tests, which decreased cannabis findings as cannabis can be detected in blood for only a short period, whereas in urine it stays longer.

7. Prevention of drug-related health problems⁴¹

Blood-transmitted diseases are a major health problem caused by injection. Therefore, prevention and treatment of infectious diseases is an essential part of drug treatment. In 2003, there were health counselling centres that exchanged needles to prevent infectious diseases in 21 localities, mainly in cities with over 50,000 inhabitants. The number of clients in health counselling centres and syringes and needles exchanged has grown by more than half in two years. During the same period, the

⁴⁰ The study included 494 initial interviews which were conducted between 12 September 2000–15 May 2002 in three health counselling centres engaging in needle exchange (Helsinki, Tampere, Turku) and the Helsinki-based drug clinic Kurvi which is open around the clock. Of these 354 participated in the follow-up group. Follow-up interviews continued until the end of 2003, but the report on them has not been finished yet.

⁴¹ See Virtanen 2004, section 11.

number of syringes and needles sold by pharmacists has increased by over 10 per cent. Syringes and needles will also be exchanged in primary health care according to the amendment to the Communicable Diseases Decree.

Another major drug-related problem is mental problems caused by drug use. Treatment of drug-related mental problems is still deficient in Finland, because the clients' support networks and follow-up care after treatment are insufficient. Training in the field is also considered inadequate.

7.1 Prevention of drug-related deaths⁴²

Some training concerning drug-related deaths is provided as part of the basic training in social welfare and health care. There are no special projects in progress at the moment. Prevention of drug-related deaths is also carried out as part of the work related to accidents and traffic safety.

7.2 Prevention and treatment of drug-related infectious diseases⁴³

Prevention of drug-related infectious diseases is provided by

1. specialised services within social services and health care
2. substance abuse services – especially health counselling centres (by needle and syringe exchange)
3. pharmacists selling syringes and needles
4. primary health care services according to the new Communicable Diseases Decree⁴⁴

University hospitals with other central, regional and psychiatric hospitals in the area are in charge of the treatment of HIV infected patients. The treatment of HIV infection is concentrated in the department of internal medicine. The biggest hospitals are specialised in infectious and communicable diseases. Visits associated with diagnosing, examining and treating HIV infection and the treatment of the infected person in a health care treatment unit are free of charge. Medicines prescribed for the patient are also free of charge. (HIV Handbook)

For hepatitis B vaccination, Finland follows a selective vaccination policy. All pregnant women are screened for hepatitis in maternity clinics, and the newborn children of hepatitis B infected mothers

⁴² See <http://annualreport.emcdda.eu.int/en/home-en.html>

⁴³ See <http://annualreport.emcdda.eu.int/en/home-en.html>

⁴⁴ See Section 1.2.2.

are protected by vaccination right after birth. People in high-risk professions, such as health care and social workers and police, are recommended to get a vaccination at the expense of the employer. Moreover, the sexual partners and family members of hepatitis B infected persons as well as injecting drug users and prostitutes are provided a vaccination free of charge. (Karvonen 2003)

Medicines used to treat chronic hepatitis B and C have many side effects, and therefore the patient should have high treatment motivation. Before the treatment is started, former substance abusers are usually required to prove that they have been clean from all drugs and alcohol for at least a year. Hepatitis C treatment can, however, be given in collaboration with the detoxification unit during detoxification, if it has been found to work well.

In 2003, there were health counselling centres that exchanged syringes and needles in 21 localities, mainly in cities of over 50,000 inhabitants. The number of clients in health counselling centres (9,586) was approximately the same as in the previous year and over 10% bigger than in 2001, whereas the number of visits (94,000) and the number of syringes and needles exchanged (1,430,000) had grown by 30% from the previous year and by more than half from 2001. (Partanen A. 2004b) In 2003, 86% of pharmacists reported to be ready to sell syringes and needles to drug users. This figure had grown by 14% since 2001, when the study was conducted the previous time. The greatest increase was seen in small municipalities that had no health counselling centres. The number of syringes and needles sold by pharmacists (486,000) had grown by some 14 per cent since 2001. According to the data for 2003, about half the pharmacists selling needles and syringes also receive them, even though the majority of pharmacists are in favour of transferring reception to health counselling centres. The support of the pharmacist network to health counselling of injecting drug users is particularly important for those drug users who have no access to health counselling centres. (Partanen A. 2004b)

According to the new Communicable Diseases Decree, health centres are given a new responsibility of preventing infectious diseases, including health counselling for drug users and, if needed, exchange of syringes and needles. Related to the new decree, training on prevention of drug-related infectious diseases is started by hospital districts in the autumn of 2004.

Finland is one of the founding partners of the Northern Dimension Partnership in Public Health and Social Wellbeing established on 27 November 2003. The overall objective of the partnership programme is to promote sustainable development and improve human health and social wellbeing in the Northern Dimension area. The programme aims at preventing the major public health problems within the area, including communicable diseases, such as HIV, tuberculosis and sexually transmitted infections, and drug use. The partnership programme of public health and social

wellbeing has been transferred under the EU's Second Northern Dimension Act 2004–2006. Finland also funds joint projects in Russia, for instance in St. Petersburg, to prevent infectious diseases, such as HIV and tuberculosis. (Press release of Ministry of Social Affairs and Health 311/2003)

7.3 Prevention and treatment of co-morbidity⁴⁵

Drug-related mental problems are common according to all drug treatment surveys. The treatment of drug and mental problems is carried out in practice within substance abuse services or through service counsellors. Substance abuse service workers, however, consider the training in the field partly inadequate. For the time being, there is no treatment system focusing on dual diagnosis in Finland.

7.4 Prevention and treatment of other health problems

Prevention of other health problems is related to, among others, traffic safety and accident campaigns. The new amendment to legislation concerning a physician's duty to issue a report to the police concerning a vehicle driver's right to drive can also be considered a preventive measure against accidental substance-related deaths.⁴⁶

8. Drug-related social problems⁴⁷

Problem drug users are a socially excluded group: according to drug treatment data collection in 2003, 60% of drug treatment clients were unemployed, two thirds had primary level education only and 11% could be classified as homeless. As drug use is punishable under criminal law, many users are also in a vicious cycle of crime and prison.

The number of registered drug offences has grown by 8% from 2003. Especially the number of drug-user offences has risen, whereas the number of aggravated drug offences has remained more or less the same. 46 per cent of prison inmates suffered from morbid drug use or drug addiction. For the past three years, 18% of prison inmates have been incarcerated for a drug offence.

⁴⁵ See <http://annualreport.emcdda.eu.int/en/home-en.html>

⁴⁶ See Section 12.2. and for traffic safety: <http://www.health.fi/index.php?page=kampanjat>;
http://www.health.fi/index_en.php

⁴⁷ See Virtanen 2004, section 4.

8.1 Social exclusion

Drug treatment data collection in 2003 reveals the same facts as do studies on risk behaviour among drug users, injecting drug users and HIV infected drug users: drug users are a socially excluded group. 60 per cent of drug treatment clients were unemployed. Two thirds had primary level education only, and one in ten had dropped out of primary education. One in four had secondary level education. Approximately 11% of clients could be classified as homeless. About a fifth were married or co-habiting, half of these with a partner who also had substance abuse problems. One in four had children under the age of 18. Two thirds of the children lived elsewhere, and in 25% of these cases child protection services were involved. (Partanen A. 2004)

8.2 Drug-related crime⁴⁸

In 2003 a total of 15,058 drug offences were reported to the police. Of these, 60% (ca. = 9,084) were drug-user offences, 5% (742) aggravated drug offences, 35% (5,202) drug offences, and 0.3% (30) concerned preparation and abetment of drug offences. Compared to 2002, the number of registered drug offences grew by 8 per cent. The increase has mainly taken place in drug-user offences, whereas the number of aggravated drug offences has remained more or less the same. The strongest increase of drug offences has taken place in the Province of Southern Finland, where also the number of registered aggravated drug offences grew compared to the previous year. Drug offences have also increased significantly in the Province of Oulu.

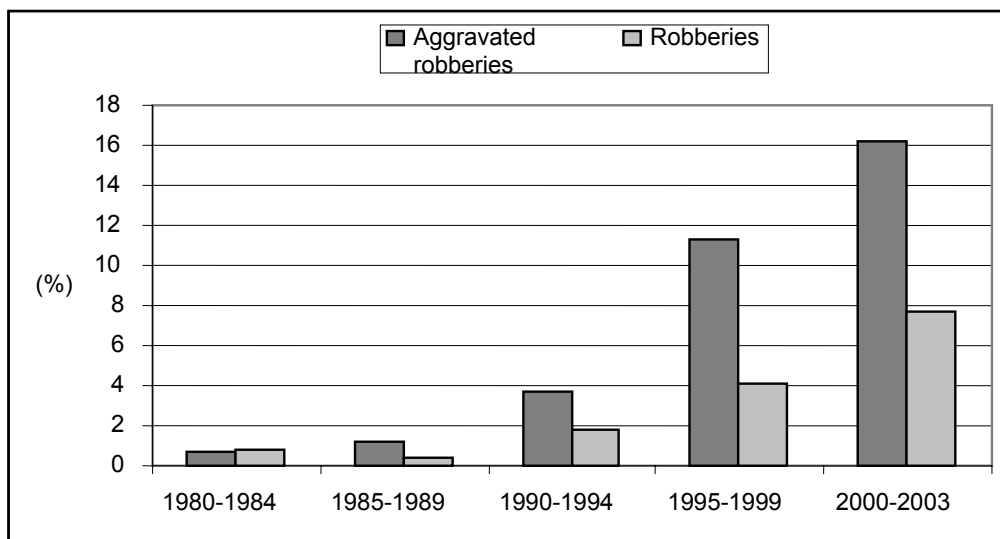
In 2003, the courts of first instance passed 7,130 sentences for drug offences (8,581 in 2002). In 3,309 (4,284) cases the principal offence was a drug offence. A fine was imposed in 62 per cent of the cases. The prosecutor also imposed 4,151 fines (3,103 in 2002) without court proceedings for drug-user offences. In total, the number of people punished for drug offences was almost the same as in the previous year. In 2002, the number of persons convicted of drug offences as the principal offence declined by 30% compared to 2001, and the same trend continued in 2003. The decrease was mainly due to fines imposed for drug-user offences through summary penal proceedings, which if the litigant agrees, are left to the prosecutor's discretion and do not go to courts of first instance at all. (Niskanen 2004). In addition, in 2002 the courts of first instance passed sentences for 1,232 drug-user offences, the prosecutor made the decision to waive charges in 900 cases, and penalties were waived in District Courts in about a hundred cases. (Kainulainen 2004) According to preliminary information for 2003, 655 sentences were imposed for drug-user offences.

⁴⁸ See "data library" or "statistical bulletin" in <http://annualreport.emcdda.eu.int/en/home-en.html>

Sanctions imposed for drug offences as the principal offence were divided in 1993–2002 as follows: a fine was imposed in 70% of the cases, an unconditional sentence of imprisonment in 18% of the cases and a suspended sentence in 10% of the cases. In 2002, the average sentence for an aggravated drug offence was 3 years and 3 months in prison and in case of suspended sentences, 1 year and 4 months. A few suspended sentences were imposed for drug offences, and their average length was 4 months. In total, the share of prisoners with drug offence as the principal offence was 18% of the entire prison population in 2002. (Kainulainen 2004)

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

Figure 17 Suspects (%) in solved robberies who were under the influence of drugs at the time of the offence



A study on repeated offences examined prison data for 1998–2001 for principal offences based on annual prison population surveys.⁴⁹ The results showed that 25.5% of those convicted to prison for

⁴⁹ The prison population survey is conducted annually on 1 May in all prisons and the principal offence is the offence for which the sentence is the longest.

drug offences (26% for all offences) are back in prison within a year, 38% within two years (42%) and 41.5% (47%) within three years. However, the new offence has not necessarily been a drug offence. The number of drug offence recidivists declines by age: 50% of 18–20-year-olds are back in prison within a year (within three years 75%), 30% of 21–29-year-olds (51%), 23% of 30–39-year-olds (36%), and 13% of 40–49-year-olds (29%). Of all those convicted of homicide as the principal offence, about one fifth were resentenced to unconditional imprisonment during the three year period studied, whereas of persons convicted of theft as the principal offence 60% were resentenced during the same time period. (Hypen 2004)

8.3 Drug use in prisons⁵⁰

A working group appointed to develop prison health care (2002) reported that 46 per cent of inmates suffered from morbid drug use or drug addiction. In 2004, 17.9% of prison inmates were incarcerated for a drug offence, and the number among remand prisoners was 23%. The open institutions of the prison services⁵¹ are drug-free and inmates are tested for drugs and pharmaceuticals. In 2003, some 90% of all inmates in open institutions were tested for drugs. 10.7% of all tested inmates gave verified positive test results. The results showed that of all tested inmates in open institutions, 1.6% used amphetamines, 0.9% used cannabis, 0.8% buprenorphine and 0.3% heroin. Other findings were benzodiatsepams (4.5%) or other intoxicating pharmaceutical substances (2.4%). However, some of the buprenorphine findings may be related to ongoing substitution treatment. (Muiluvuori 2004)

8.4 Social costs of drug consumption

The estimated direct costs of drug consumption and related harms for 2002 were as follows: enforcement and crime control EUR 54–67 million (EUR 41–54 million in 2001), damage to property EUR 28–65 million (19–42 million), social services EUR 53–58 million (45–50 million), health care and pensions EUR 24–48 million (22–44 million) and research and prevention EUR 21 million (12–15 million). The overall costs rose from EUR 138–204 in 2001 to EUR 181–260 million in 2002. (Yearbook of Alcohol and Drug Statistics 2004)

⁵⁰ See "data library" or "statistical bulletin" in <http://annualreport.emcdda.eu.int/en/home-en.html>

⁵¹ In 2003 open institutions (18 in total) had 2,920 inmates, and all prisons (in addition to open institutions 30 prisons, 16 closed institutions and 2 hospital units) had 10,070 inmates.

9. Prevention of drug-related social problems⁵²

According to the law, there is an obligation to multi-professional hearings and referral to treatment for minors related to drug-user offence to prevent exclusion. However, demand for referral to treatment has been limited, because treatment is not a tempting enough alternative to a fine, which is the usual sanction for a drug-user offence. Co-operation is also hindered by different operational cultures: the police see drug users as criminals who are themselves responsible for their situation, while social workers emphasise the fact that drug use is a result of many social problems and often uncontrollable for the users.

The Prison Service emphasises the connection of substance abuse work done in prisons and other actors in society and securing the inmates' possibilities to receive after-care after release to reduce recidivism. After release, the health and suitability for the employment market of those who have been in the vicious cycle of prison life is poor and their biggest problems cannot always be solved by networking on the local level. The central issues are also part of general criminal policy and social welfare and health care policy: who is primarily in charge of prevention of social exclusion and how the transfer from treatment and rehabilitation programmes to follow-up care is arranged so that the person suffering from a drug problem will not return to social interventions.

9.1 Social rehabilitation⁵³

According to the law on rehabilitative employment activities (189/2001), rehabilitative employment activities are meant for the long-term unemployed to improve their possibilities to find employment. Another goal of rehabilitative employment activities is to improve the life-management skills of the person participating in the activities. (The memorandum of the Steering Group on Rehabilitative Work, 2004) The law obliges municipalities and employment offices to arrange co-operatively client-specific service packages. However, it is not expedient to start rehabilitative employment activities if the client has an acute substance abuse problem, but the client should be directed primarily to substance abuse services. On the other hand, being a client of substance abuse services is not an obstacle to rehabilitative employment activities. However, possible substance abuse during rehabilitative employment will be dealt with immediately, and solutions for substance abuse services and rehabilitative employment to support each other in an appropriate way will be sought. If substance abuse continues, the rehabilitative activities will be discontinued.

⁵² See Virtanen 2004, section 12.

⁵³ See <http://annualreport.emcdda.eu.int/en/home-en.html>

The Deaconess Institute in Helsinki conducted a project on drug treatment for people who have been excluded from services (2003). The client criteria consisted of a drug problem and at least one diagnosed mental problem or a psychological symptom that negatively affects the patient's life, or social exclusion, which manifests as lack of life-management skills, problems in social situations or non-commitment to treatment. Project participants were chosen from the Helsinki-based low threshold drug addiction treatment clinic, Kurvi,⁵⁴ which operates 24 hours a day. The clients of the project formed a heterogeneous target group but they were all socially deprived. 12% of the clients had an HIV infection, while the corresponding figure for the basic group was 2%. The primary substance of the clients was amphetamine (43%), 12% of them were homeless, and suicide attempts were common – nearly half the group had attempted suicide at some point.

43% of the clients in the project continued with follow-up treatment, either in outpatient or inpatient care. However, the treatment and rehabilitation process was not long lasting for many of the clients, as most of them returned to the Kurvi clinic from follow-up care after a few weeks or months. It seems that follow-up care after psychiatric inpatient care or substance abuse services is insufficient, since the client is often left to manage by himself without any support and soon he seeks specialised services again. However, the clients need treatment and they gain from it because they repeatedly return to treatment. Many current treatment services are too demanding for some drug users. The conclusions of the study propose that instead of an intensive and complex treatment system, more compact treatment would be sufficient at the beginning in order to evaluate the client's mental state and medication needs. After that, the treatment could continue within housing services that support the clients' physical and psychosocial recovery or in a rehabilitation home type unit that would not be unconditionally intoxicant-free.

9.2 Prevention of drug-related crime⁵⁵

Police barometers conducted every other year are used to examine the views of over 15-year-old Finns on the operating environment of the police and the quality of policing.⁵⁶ The latest Policy barometer (2004) found that 60% of respondents considered the control of drug users as one of the police's responsibilities. According to the barometer, the most important measure that improves public order and safety is influencing young people's attitudes on drug use. Investigating and detecting drug offences is deemed the second most important task of the police. The sale and use of

⁵⁴ In 2003, Kurvi had 1,299 clients, and 93 of them met the criteria of the project, which was checked in connection with the evaluation of treatment need.

⁵⁵ See <http://annualreport.emcdda.eu.int/en/home-en.html>

⁵⁶ For the police barometer, 1000 Finns were interviewed in their homes between 31 November and 4 December 2003.

drugs were seen as the most alarming social phenomenon. According to the barometer, the police have been increasingly successful in solving drug-related offences, especially in the Greater Helsinki area.

The 3-year project "Future and security: scanning the changing environment of the police" was launched in the spring of 2003 in Western Finland. The aim was to develop a foresight programme for monitoring the development of the operating environment of the police and the entire security branch and for creating an operating model that supports development. The preliminary study of the programme revealed that the factors that caused the most insecurity were drug and other substance abuse, social exclusion, the growth in international crime, cutbacks in police positions and appropriations and the weakening of a community approach in society. Factors that increase security included preserving the welfare state, combating unemployment, preventive alcohol and drug policy, community approach and responsible child rearing. Preventive action and co-operation with interest groups were seen as more effective measures for the police than was mere reactive action. These also diminish the citizens' need to acquire services from private security companies. (Kahila 2004)

In 2001, a drug-user offence was introduced. In the case of juvenile offenders, sentencing for a drug-user offence includes the possibility of a personal multiprofessional hearing. A juvenile punishment will be introduced for under 18-year-old offenders at the beginning of 2005. Moreover, the Ministry of Justice appointed a working group in October 2003 to prepare a reform of the legislation on criminal sanctions for juvenile offenders. The aim is to support young people's crime free life by connecting the activities of social services and the criminal justice system even more tightly together. (Ministry of Justice, press release 6 March 2003)

A study was conducted on the collaboration between the Tampere police department and the adjoined social outpatient clinic Paussi regarding persons suspected of drug offences. The study examined the referral to treatment of problem drug users stipulated in the law on drug-user offence and the multiprofessional hearings for minors having committed a drug-user offence as an alternative to a fine.⁵⁷

The study showed that the majority of those suspected of drug-user offences were socially excluded to some degree, i.e. homeless, unemployed or trapped in a cycle of crime. More than half of them were also suspected of some other offence. Paussi employees were also familiar with many of them already through child welfare services or crimes committed as minors. Social workers hoped to

⁵⁷ The material consisted of 255 pre-trial investigation records, the interviews of 12 police officers, 5 social workers and 1 prosecutor as well as interviews of ten 10 outpatients. In addition, a survey was sent to 260 police officers, 60% of whom responded. (Kekki 2004b)

improve the quantity and quality of child welfare support and thus wished to be involved in the hearings of minors. In practice, treatment referral by the police meant that police officers inform the suspects about Paussi or bring them there. Once the suspect has arrived to Paussi, the social welfare and health care professionals refer him/her to treatment. The police had also told the suspects that seeking treatment would affect the consideration of charges. Treatment referrals have however been infrequent. Reasons for this are: suspects do not consider the police to be an authority to whom they should admit drug addiction or need for treatment, entering treatment is not a sufficiently attractive alternative to being fined, the police do not see themselves as convincing treatment counsellors, and rapid access to treatment cannot be guaranteed due to lack of resources.

In a study on the co-operation of the police and social workers, clear differences could be seen between the two groups in the profiling of drug users, which can cause severe problems⁵⁸ in co-operation. The police saw drugs as illegal and users as criminals who were personally responsible for their own situation. The police emphasised the damage that drugs can cause to society and other citizens thus stressing the importance on intervening with the prohibited behaviour. On the other hand, social workers considered drug use a result of various social problems and often out of the user's control. Drug users need help and support in order to solve their problems. The point that both parties agreed on is a drug policy based on a total ban on drugs. There exists, however, little communication between the two groups and those interviewed hoped that co-operation and communication would increase. So far, this has been hindered by strict boundaries between administrative sectors and lack of resources.

A report on the need to develop prison health care (2003) stated that the health care needs in prisons have increased due to the inmates' substance abuse problems, poor health and working capacity but also the rise in the number of inmates. According to the study, 46% of inmates suffer from morbid drug use or drug addiction. Under Finnish law, prison health care must be organised so that inmates have equal opportunities with the rest of the population to improve their health and prevent illness and access to sufficient health care services. To correct the situation it is suggested that substance abuse issues are addressed immediately when the inmate is incarcerated. This would allow early intervention of severe substance abuse problems that are exceedingly common among remand prisoners.

According to the intoxicant strategy for the prison administration for 2004–2006, more and more efforts should be made in society to prevent social exclusion since exclusion is seen to increase

⁵⁸ For the study, police officers and social workers were interviewed in Helsinki and Turku in the spring of 2001. 9 group interviews were held for 35 field workers, who were not specialised in drug cases. (Andérsen 2003)

crime and the number of prisoners. The strategy proposal underlines the importance of substance abuse work conducted in prisons in co-operation with the rest of society and especially third sector parties. The inmate's possibilities to receive follow-up care after being released from prison will be secured. Placing an inmate undergoing medical treatment into a drug-free institution, contractual ward or other unit will be made easier, and a curative approach is taken if a prisoner in rehabilitation relapses. (Press release of the Criminal Sanctions Agency 23 June 2004)

In 2003, almost all prison institutions had rehabilitation programmes and contractual wards that support a drug-free lifestyle. Rehabilitation programmes are usually based on cognitive behavioural theory, various forms of group therapy and community treatment models. 873 inmates participated in rehabilitation programmes and 1,646 in treatment motivation or relapse treatment. The inmate entering a programme and/or contractual ward must agree to be tested for drugs and other pharmaceuticals when asked. Almost all closed institutions have intoxicant-free contractual wards. Those entering an open institution must commit to a drug-free life.⁵⁹

The Probation Service is responsible for supervising those released on probation and the consequences of their actions, for example in community service units. According to Probation Service guidelines, the problem use of alcohol, pharmaceuticals or drugs is a contributing factor in recidivism and the objective of the enforcement of sentences is to reduce recidivism. For this reason, the client's substance abuse is always evaluated at the beginning of the client relationship. A client who is found to be under the influence of drugs is removed from the premises of the unit but the continuation of the client relationship is taken care of. The actual substance abuse workers are appointed from local co-operation authorities. (Press release of the Criminal Sanctions Agency 7 September 2004)

The activities and treatment programmes of the drug-free ward in the Helsinki prison were evaluated from December 2002 to April 2003.⁶⁰ The results showed that rehabilitation is demanding and also vulnerable in a prison environment. Employees find it difficult to concentrate in developing the activities of one ward in addition to their other tasks and inmates find it hard to break free from the prison and prisoner culture. From the rehabilitation point of view, the nature of the ward and the contents of the treatment programme are not clearly structured nor do the resources of the ward meet with all the quality requirements for substance abuse services. The external framework and professional skills needed for developing cognitive community treatment in the ward do exist, but the

⁵⁹ Ks. <http://www.vankeinhoito.fi/4829.htm>

⁶⁰ The study included a one-month period of participatory observation targeted at the ward's work team and community meetings. In addition, 3 group interviews were held among inmates, a feedback discussion with researchers and inmates and 11 individual interviews of inmates. The work team's substance abuse counsellors (2) and prison guards (2) were interviewed individually. (Tourunen et al. 2004)

work itself requires a commitment to long-term efforts from the work team and a commitment to securing conditions of activity from the prison and the Criminal Sanctions Agency. (Tourunen et al. 2004)

According to a study on social activities aiming at anchoring persons released from prison to society⁶¹, the prisoners' poor health, short sentences and their excessive amount in relation to places in institutions are important hindrances to the implementation of individual rehabilitative treatment. On the other hand, released prisoners are easily excluded from primary services due to prejudice and lack of resources. The work capacity and health of those trapped in a cycle of prison is usually poor. Local-level networking as a means to solve serious social problems does more to support problems in social structures than solve them, as the most grave problems cannot be solved by local-level networks. The essential questions pertain to criminal policy: who should go to prison, with what type of punishments and what legislative reforms are needed to reduce the number of prisoners. This is a challenge also for social and health services, because the less they invest in socially excluded people the more these people become the responsibility of judicial and law enforcement authorities. Improving the life of people with a criminal background will also increase the sense of security among citizens and overall savings for society. Furthermore, it is a question of human rights.

10. Drug markets⁶²

The number of seizures of hashish and amphetamine increased clearly at the end of the 1990s, but a slight decline can be seen in both drugs since 2001. The same applies to ecstasy. The number of heroin seizures has decreased systematically since 2001, whereas the number of seizures of buprenorphine (Subutex®), which is used for substitution treatment, on illegal drug markets has increased significantly. The number of offers of drugs to individuals also decreased from the previous year, especially for young men. In drug supply, organised crime groups led from Estonia have had an important role in the smuggling of almost all drugs to Finland. In 2003, the importance of their role in spreading drugs in Finland somewhat diminished.

⁶¹ The material consists of public documents from the "Co-operation for crime-free life" project, the results of the network training workshops organised by the Criminal Sanctions Agency in Tampere, interviews of specialists, authorities and the third sector (25) and the accounts of two persons with a criminal background undergoing rehabilitation. (Rantala 2004b)

⁶² See Virtanen 2004, section 5.

10.1 Availability and supply of drugs⁶³

Since drug crime is international, the intensification of law enforcement co-operation and seizure of drugs destined for Finland already outside Finnish borders have been introduced as an aim in drug strategies. In 2003, approximately the same amount of drugs destined for Finland has been seized abroad (for instance, ecstasy in Germany and Sweden) as in Finland. Seizures abroad are usually directed at international crime groups, and the destination of the drugs seized cannot always be detected indisputably. (Hietaniemi 2004)

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

Correspondingly, the role of Finnish crime groups grows, which may close the ranks of Finnish professional crime that is typically loosely structured and unestablished and, due to growing national competition, increase violence related to organised crime, which is already evident in the weapons and military explosives confiscated from crime groups. The significance of economic crime as an important financing means for organised crime also grows. (Hietaniemi 2004)

In addition to the direct sea connection between Finland and Estonia, smuggling takes place from Estonia via Sweden and the Åland Islands as well as via Haparanda and Tornio to Finland. Amphetamines and buprenorphine are smuggled via Estonia and Russia, and the first signs of the transfer of sorting and packing of synthetic drugs to Finland have emerged this year with the discovery of a Rohypnol factory. In addition, smuggling routes from Russia to Finland through the eastern frontier and Murmansk are noteworthy, the latter especially for smuggling doping substances to Northern Finland and Norway. (Hietaniemi 2004)

The adults' health behaviour survey in 1993–2003 asked who had been offered drugs for free or on sale during the past year. According to the survey, the number of drug offers has levelled off during the 21st century, and it is highest in the age group of 15–24 years (19 % to males and 21 % to females). In the older age groups, men were made more offers than women. A notable difference

⁶³ See "data library" or "statistical bulletin" in <http://annualreport.emcdda.eu.int/en/home-en.html>

compared to the previous year is the drastic decrease in the drug offers made to 25–34-year-old men (15 % in 2002 but only 9 % in 2003), and the number of drug offers to men is beginning to approach the corresponding figure for women in this age group too (6 % in 2002 and 7 % in 2003). Thus, the disparity of sexes in drug offers is declining. The offers for older age groups were rare (3 % to 35-44-year-old man and 1 % to women in the same age group - after that under 1 %)

10.2 Drug seizures⁶⁴

For the past three years, the trend of drug seizures has stabilised the same way as the trend of drug supply indicated by population surveys. The number of seizures of hashish and amphetamine grew distinctly at the end of the 1990s. In 2003, drug seizures involved 423 kilograms of hashish, 45 kilograms of marijuana and 114.6 kilograms of amphetamine. The amount of marijuana seized is clearly on the increase but there seems to be a slight decline in the other drugs from the previous year, and this decline is more evident when examining the data for 2001. Heroin seizures have decreased systematically since 2001. In 2003, 1.6 kilograms of heroin was seized. Due to the decline in heroin availability, the buprenorphine Subutex®, which is used for substitution treatment, has gained ground on the illegal drug markets. The Customs and the police seized a total of 37,284 Subutex tablets in 2003, which is substantially more than in the previous year but at the same level as in 2001. Ecstasy seizures involved 35,216 tablets, which is about one-fifth less than in the previous year and over half less than in 2001. Despite occasional large seizures, cocaine is rare in Finland: 1.1 kilograms seized in 2003. The same applies to LSD tablets (1,460 in 2003). (Hietaniemi 2004; Kainulainen et al. 2004)

There is, however, a lot of random variation in the kilograms of the drugs seized, and they cannot be used as such for evaluating the prevalence and temporal variation of drug use. The reliability of evaluating temporal variability can be increased by examining the number of seizures. In 2003, there were 2,796 hashish seizures and 1,712 marijuana seizures. The total number of these has not changed much from the previous year, but there is a clear decline as compared to 2001. For cannabis, a notable feature is the 1,170 seizures of cannabis plants (8,801 plants / 20.4 kilograms), and the number of these seizures is on the increase compared to previous years. The number of amphetamine seizures was 3,678, and there has not been much change during the past three years. There were only 90 seizures of heroin and their number has decreased by 80% since 2001, whereas there were 1,008 seizures of Subutex®, which shows a clear increase compared to the two previous years. The number of ecstasy seizures was 316, which is almost at the same level as the previous year but distinctly less

⁶⁴ See "data library" or "statistical bulletin" in <http://annualreport.emcdda.eu.int/en/home-en.html>

than in 2001. The number of seizures of LSD (20) and cocaine (49) has remained almost the same since 1999. (Hietaniemi 2004; Kainulainen et al. 2004)

10.3 Price and purity of drugs⁶⁵

The purity of seized drug consignments is tested at the Crime Laboratory of the National Bureau of Investigation. The average purity of amphetamine has been around 50 per cent annually through the entire 1990s. The purity of heroin has varied more drastically than the purity of amphetamine throughout years, though the number of tested heroin consignments has decreased significantly from previous years. The prices of the substances have also varied according to availability, which is evident especially for heroin. (UNDCP / Annual Reports Questionnaire 2003)

In 2003, the average purity of amphetamine in street trade was 35% (range between 2.8%–98%) and the corresponding figure was 17% for metamphetamine (2.2%–36%), 6% for white heroin (2.7%–31%) and 70% for cocaine (59%–74%). In wholesale, substances were on average purer. The average purity of amphetamine in wholesale was 60%, the corresponding figure being 33% for metamphetamine, 7% for white heroin and 80% for cocaine. The average price per gram in street trade in 2003 was EUR 10 for hashish, EUR 200 for white heroin, EUR 25 for amphetamine, EUR 135 for cocaine and EUR 16 for ecstasy tablets.

11. Drug-related law enforcement activities⁶⁶

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

Directions on implementing legal sanctions for drug user offences require that the prosecutor and the competent authorities agree on the procedure for treatment referral related to decisions to waive sanctions. However, the system does not function so well yet, because there have not been many decisions made to waive charges based on the person seeking treatment that prevents social exclusion.

⁶⁵ See "data library" or "statistical bulletin" in <http://annualreport.emcdda.eu.int/en/home-en.html>

⁶⁶ See Virtanen 2004, section 16.

11.1 Drug control system

In the last few years, drug crime investigation has focused on the prevention, detection and investigation of professional organised drug crime. Combating drug supply has made it possible to investigate the operations of organised drug syndicates. Seizure-centred drug crime investigation can be considered a central investigation method for very dangerous drugs. The problem with seizure-centred drug crime investigation is, however, that less attention has been paid to reducing drug demand. Drug control in the street has also been improved by increasing the number of police officers who are not experts in the demanding drug crime investigation. According to local level studies, efficient perpetrator-specific drug crime prevention targeted at drug users and sellers and use of coercive measures can also reduce other crime in the area and thus increase the sense of safety of the inhabitants. This requires, however, networking and co-operation of the police and other authorities.

11.2 Judicial system

The implementation of the new drug-user offence has been followed closely in the Office of the Prosecutor-General. According to the Office, the amendment to the law on drug-user offence has not really changed the prosecutor's workflow. The police supreme command and the Prosecutor-General have agreed that in these situations the police do not automatically fine. This ensures that the prosecutor considers the possibility to waive sanctions for every person seeking treatment.

Almost all prosecutorial units have created a procedure for treatment referral in co-operation with the police, representatives of substance abuse services and other social welfare and health care services. Still, only 150 decisions to waive charges based on the person seeking treatment have been made in two years, even though some 7,000 drug-user offences have been reported every year. However, the prosecutors are ready to make the decision to waive charges based on the person seeking treatment almost without exception, whenever the requirements for the application of the provision are met. (Metsäpelto 2003)

Possible treatment referral procedures often take place in practice before the case is brought to the prosecutor, by either the police or social welfare and health care authorities. If a drug user is caught and shows reluctance to seek treatment, neither the police nor the prosecutor have the possibility to motivate the drug user to treatment or evaluate his or her need for treatment. It would be important that the drug user could be directed to care need assessment as soon as the authorities find out about his or her drug use. One solution might be a social worker on duty at the police station, to whom the drug user could be directed.

11.3 Monitoring methods and technical equipment

In 2003, interception of telecommunications was targeted at 414 persons (427 in 2002). The courts granted 1,840 authorisations for telecommunications interception (1,468 in 2002). The increase is due to the fact that some of the suspects have been using several subscriber lines. The average duration of telecommunications interception was 25 days. Telecommunications interception has had an important role especially in solving aggravated drug offences. The number of persons whose telecommunications have been monitored was 1,025 in 2003 (1,082 in 2002). In 2003, the courts granted a total of 1,948 authorisations for telecommunications monitoring (2,215). The average duration of monitoring was 3 months. Undercover operations and fictitious purchasing were used mainly in investigating aggravated drug offences. In 2002, undercover operations were used only in a few cases involving in total under 10 suspects. In 2003, the numbers went up slightly but still remained low. In 2002, the police used fictitious purchases in 10 cases involving in total under 20 suspects. In 2003, the numbers came down. (Kainulainen et al. 2004)

As a means to develop drug control in road traffic the police started testing drivers' saliva samples for drugs in the Greater Helsinki area and in Tampere in May 2004. The experimental use of saliva testing devices pertain to the Rosita 2 project, which is a joint project of the European Union and the USA aimed at assessing the reliability and usability of roadside testing equipment. The project will be carried out in teams consisting of researchers and police officers by 31 December 2005.

11.4 Intelligence and information systems

According to the final report on the Status of Crime Investigation project (2003), crime intelligence and related operative crime analysis is not sufficiently perceived as basic activity of crime prevention. Intelligence operations are targeted mainly at drug crime, even though they should be targeted at all forms of professional or organised crime. Not enough attention has been paid to the laundering of criminal proceeds through legitimate companies. This problem has been recognised now and more resources are allocated for the purpose.

With respect to information systems, the report states that after the introduction of the drug-user offence there have been problems in compiling statistics on the numbers of drug offences, which hampers the planning of control measures. The summary penalties issued for drug-user offences do not contain sufficient information on the quantity and purity of the seized narcotic substance, on whether the suspect is a first-time offender, whether the suspected offence has been detected in

street supervision etc. As regards aggravated drug offences, there has been a change in recording practice. As of 2002, an aggravated drug offence committed by several persons is recorded as one offence, whereas before in cases concerning the same drug consignment, the offences of each accomplice were recorded separately if his/her role in the crime was a separate offence.

PART B - SELECTED ISSUES

Every Member State produces updated information on national drug policy, the drug situation and anti-drug activities as well as summaries of drug topics agreed in advance in the form of articles for the European Union drug report. The topics in 2004 were (1) buprenorphine treatment and problem use, (2) alternatives to prisons for drug-dependent offenders, and (3) drugs and the related disturbances.

12 Buprenorphine, treatment, problem use and prescription practices ⁶⁷

In 2003, some 450 of about 600 opiate-dependent substitution treatment patients received buprenorphine treatment. There have been long queues for buprenorphine treatment especially in the Greater Helsinki area. Buprenorphine treatment is strictly regulated in Finland, and it is not expected that the buprenorphine used for medical treatment will end up on illegal markets. However, buprenorphine is a widely used injected opiate in the street in Finland. Buprenorphine (24%) was a much more common primary opiate of those entering treatment than heroin (3%) in 2003. There were also about 40 overdoses related to buprenorphine use in Finland in 2003. Buprenorphine used in the street has been brought to Finland especially from France and Estonia.

12.1. Buprenorphine treatment

In Finland, the use of buprenorphine in substitution treatment is legal and it is increasingly used for that purpose. Sales of buprenorphine started in Finland under a special licence in October 1997 and it was registered by substitution treatment indication in 1999. The use of buprenorphine and methadone in detoxification, substitution and maintenance treatment is regulated by decree (289/2002). The decree does not apply to the use of pharmaceuticals containing buprenorphine or methadone as complementary treatment for opiate addicts during somatic illness in a situation where the withdrawal symptoms worsen the patient's clinical condition or make his or her treatment more difficult.

⁶⁷ The authors of this section are Mikko Salaspuro, professor of Addiction Medicine from Helsinki University, and Airi Partanen, senior planning officer from the STAKES. See also <http://annualreport.emcdda.eu.int/en/home-en.html> available by Autumn 2005

According to the decree, opiate-dependency is defined by the ICD-10 criteria (F11.2x). Three or more of the six addiction criteria must have occurred simultaneously for a month during the past 12 months or repeatedly if the periods are shorter than a month. Detoxification refers to treatment that lasts a maximum of a month and aims at curing opiate-dependency using pharmaceuticals containing buprenorphine or methadone. Respectively, substitution treatment refers to rehabilitative treatment that aims at drug-free living and lasts over a month and maintenance treatment means treatment that lasts over a month and focuses on reducing harm and improving the quality of a patient's life.

According to the decree, substitution treatment can only be started for an opiate-dependent patient that has not been cured of opiate addiction by using scientifically proven and commonly accepted treatment and methods. The decree does not place restrictions for substitution treatment in terms of the number of treatments, the length of the history of opiate use, the age of the patient, possible pregnancy or other simultaneous illnesses. In practice, the criteria for entering treatment vary considerably from locality to locality in Finland.

According to the decree, the assessment of detoxification, substitution or maintenance treatment need is conducted and the treatment is started in a central hospital, in another corresponding hospital designated for this purpose or in a unit that has a doctor in charge of the treatment, staff specialised in the treatment and appropriate premises. The majority of care need assessments are still made in practice on a specialised level, which restricts the availability of treatment.

After treatment has started, it can continue in a health centre, substance abuse service unit or health care unit of prison administration with adequate facilities. According to the decree, substitution treatment must be transferred to be provided as near the patient's residence as possible. The health care unit providing treatment must have a separately appointed doctor in charge of the treatment who must be notified to the State Provincial Office, and the State Provincial Office must further notify the National Authority of Medicolegal Affairs.

Moreover, the treatment of an opiate-dependent person must be based on a treatment plan that defines the medical treatment as well as the patient's other medical or psychosocial treatment and its follow-up. Only the doctor in charge of the treatment in the health care unit or another doctor appointed by him can prescribe Buprenorphine. Medical treatment can be provided and medicine handed over to the patient only under the supervision of the health care unit. A patient showing co-operation can be given an amount of medicine that is equivalent to a maximum of eight daily doses at the health care unit. However, medicine cannot be prescribed to be administered in a pharmacy.

In Finland, the staff that evaluates the need for substitution treatment and provides treatment is required to have appropriate training. Training sessions that last 1-4 days have been arranged for this purpose. Official training has been provided mainly by substance abuse service experts. Furthermore, evidence based treatment recommendation is being prepared, including recommendations for substance abuse treatment as well as detoxification and substitution treatment for opiate addicts.

The majority of the opiate-dependent patients have used buprenorphine intravenously as some kind of “self-treatment” for 2–3 years before entering official treatment. Compared with those in methadone treatment, buprenorphine treatment patients are somewhat younger. In some localities, patients are transferred to methadone treatment if buprenorphine treatment fails. Some 460 of 600 opiate substitution treatment patients received buprenorphine treatment in Finland in 2003. People have had to queue for buprenorphine treatment especially in the Greater Helsinki area.

Table 9 Development of buprenorphine sales in Finland since 1997

Year	Number of patients
1997	25 patients
1998	60 patients
1999	100 patients
2000	150 patients
2001	250 patients
2002	330 patients
2003	430 patients
2004	460 patients

The A-Clinic Foundation implemented a development project for detoxification using buprenorphine on 1 January 1998–30 June 2000, with a related evaluation study (Baas et al. 2002)⁶⁸ finished in 2002. According to the study, buprenorphine was found an effective method in terms of the patient’s commitment to treatment and it was also an effective medicine in curing heroin addiction and preventing heroin use. The concurrent abuse of buprenorphine during treatment was, however, a common problem.

At the moment, there is a study on the effects of long-term use of buprenorphine, methadone and benzodiazepams on patients’ cognitive abilities being conducted in Finland. Furthermore, a study investigating the effectiveness and costs of buprenorphine treatment provided exclusively in outpatient care is being launched. A double-blind study to investigate the possible side effects of buprenorphine-naloxone preparation is also being planned.

⁶⁸ See also Virtanen 2003, pp. 122–123.

12.2. Problem use of buprenorphine

Data on the problem use of buprenorphine is available in the 2003 census of intoxicant-related (alcohol, solvent, pharmaceutical and drug -related) cases in all social welfare and health care services (Metso et al. 2004) and in the drug treatment information system concerning the patients in substance abuse services that entered treatment specifically for drug use (Partanen A. 2004). There is no data available in population surveys.

Alcohol was still the most commonly used substance according to the census of intoxicant-related cases (Metso et al. 2004). An illegal drug was related to every fourth substance abuse case in social and health services. Of all substance abuse cases in social and health services in 2003, there were nearly as many cases related to heroin (8%) as buprenorphine (7%) (Nuorvala et al. 2004). The cases related to buprenorphine or heroin in social and health services were mainly in the age group of 20–29-year-olds. Every fourth person in this age group had used buprenorphine (28%) or heroin (27%). Under 20-year-olds had used buprenorphine (12%) more than heroin (6%). In the older age groups, opiates were mentioned less frequently than in the younger groups, and heroin was mentioned more often than buprenorphine.

Buprenorphine (24%) was clearly the more common opiate as the primary substance leading to entering treatment than heroin (3%) was among the patients of substance abuse services in 2003 (Partanen, A. 2004). Opiates (31%) were also the most common primary substances of those entering treatment. The situation of these two opiates has reversed since 2000, when heroin (20%) was the much more common primary substance of those entering treatment than buprenorphine (7%) (Partanen A. et al. 2004a).

Injection was the primary route of administration for 90 per cent, sniffing for 5 per cent and oral use for 5 percent of those entering treatment primarily for buprenorphine use (Partanen A. 2004). According to an interview survey conducted in health counselling centres for intravenous drug users in Helsinki, Turku and Tampere in 2000–2002, the majority of the respondents had injected buprenorphine sometime during their lifetime but only half of them had used it orally or sniffed it (Partanen A. et al. 2004).

The secondary substance (2–5 substance) of those who had entered treatment primarily for buprenorphine use was most often sedatives (56%), stimulants (55%) or cannabis (54%). Other opiates (22%) or alcohol (19%) were less common as secondary substances. 17 per cent of the patients mentioned heroin as the secondary substance.

The buprenorphine used in substance abuse treatment is not expected to enter illegal markets in Finland because the substitution treatment for opiate addicts is strictly regulated. Finnish drug users previously went to France for buprenorphine treatment because of the low-threshold treatment model there, and some of this buprenorphine ended in illegal markets. Import from France was replaced by import from Estonia due the amendment to the decree on importation of personal pharmaceuticals (1088/2002) in 2003. The decree was related to signing the Schengen Agreement; Estonia has not yet signed the Agreement. In 2003, a two weeks' dose of Subutex could be bought in a pharmacy with prescriptions written in Estonia and brought to Finland. In 2004, a proposal was made to make the decree more stringent by giving the right to write a prescription only to mental hospitals.

The problem use of buprenorphine has increased quickly as it has become more available. The amount of buprenorphine seized started to grow at the end of the 1990s. In addition to availability, the low price has increased its use. According to an interview survey conducted in the Greater Helsinki area in 2004 (Malin et al. 2004), the price of an 8 mg Subutex tablet in the street was 30–35 euros. According to the same survey, the price of heroin was estimated to be 60–350 euros/gram and the price of amphetamine was estimated to be 25 euros/gram.

Table 10 The number of buprenorphine tablets seized, the number of seizures and the percentage (%) of people entering treatment for buprenorphine use in 1997–2003.

	1997	1998	1999	2000	2001	2002	2003
Temgesic seizures (0.2-0.4 mg tablets)	19,617	4,771	9,156	857	n.a.	n.a.	n.a.
Subutex seizures (4-8 mg tablets)	223	1,175	2,898	12,951	38,200	18,700	37,284
Substance seizures (number)	n.a.	n.a.	n.a.	n.a.	727	741	1,008
Buprenorphine users in drug treatment (%)	n.a.	2.1	4.9	6.9	11.6	19.7	24.0

According to a study on social and health risks (Partanen A. et al. 2004), buprenorphine use seems to have increased among drug users since 1996, i.e. long before the heroin supply diminished in 2001. Since then, buprenorphine use seems to have replaced the use of heroin, which diminished on the markets. However, there is evidence that buprenorphine may also be the first injected opiate, especially for young drug users.

In 2003, 53 per cent of the opiate addicts in substitution or maintenance treatment had entered treatment primarily for their problem use of buprenorphine. The same year, 76 per cent of those entering substitution or maintenance treatment primarily for buprenorphine use had used buprenorphine during the month preceding the interview. Only 26 per cent of those previously in

substitution or maintenance treatment had used buprenorphine during the past month. It seems that the abuse of buprenorphine decreases during treatment. Twelve per cent of those who injected buprenorphine received medical treatment intended for opiate addicts.

Among drug users who had entered treatment, those whose primary substance was buprenorphine were slightly younger (26.2 years) than on average (26.8 years). Despite that, they had started the use of the primary substance later (at the age of 21.3) than users of other substances (18.0), and they entered treatment considerably sooner (3.3 years) after starting regular use of the substance than users of other substances on average (5.6 years). The main route of administering buprenorphine use is injection (90% of the users), but those entering treatment primarily for buprenorphine use had started injecting drugs earlier than drug users on average and considerably earlier (at the age of 18.3) than actual buprenorphine use. Otherwise buprenorphine users do not differ much from the other drug users entering treatment.

According to the findings at health counselling centres, the injecting use of buprenorphine had caused skin and vascular infections due to the additives in buprenorphine tablets. Intravenous use of buprenorphine is thought to have caused failing eyesight in some drug users due to stoppage of capillary circulation in the eye ground. It has been found that buprenorphine, sedatives and alcohol are increasingly related to death by overdose. Buprenorphine-related deaths did not occur until in 2003, when their number was estimated to be over 40.

Counselling related to buprenorphine use is available at drug treatment units and especially at health counselling centres exchanging syringes and needles, which provide counselling on how to avoid problems related to injecting buprenorphine, e.g. the importance of the use of filter when injecting buprenorphine. Avoiding an overdose is also an important issue in health counselling. The A-Clinic Foundation has published information on problems related to injecting buprenorphine on their website⁶⁹.

The abuse of buprenorphine was investigated in a study on social and health risks conducted in 2000–2003 (Partanen A. et al. 2004) and in a theme interview study conducted by the A-Clinic Foundation in 2004 (Malin et al. 2004). The theme interview data is still being analysed and the results will be published in one of the Finnish journals on substance use in 2005. Information on buprenorphine abuse is also provided by the annual drug treatment information system (Partanen A. 2004) and the census of intoxicant-related cases conducted every fourth year (Metso et al. 2004).

⁶⁹ See http://www.paihdelinkki.fi/tietopankki/400_huumelinja/index.html

13. Alternatives to prison for drug-using offenders⁷⁰

Since the latter part of the 1960s, Finnish judicial thinking and criminal policy have aimed at separating treatment and punishment but at the same time, it has been thought that the penal system should not unreasonably emphasise unconditional sentences of imprisonment. Special preventive measures have been taken into use only after drug crimes began to increase rapidly in the 1990s. Reducing recidivism became the main objective of criminal policy. Substance abuse problems are the main factor promoting a criminal lifestyle.

Since 2001, a more lenient penalty has been provided for drug use and the possession of small amounts of drugs than for actual drug offences. The prosecutor, the police or the court can waive sanctions if the offence is considered insignificant as a whole. The possibility to use alternative sanctions is related to the use of general penal sanctions. Rehabilitative activities have been taken into use increasingly as part of the sanction system since 2000. It is possible to serve a part of community sanctions in the form of rehabilitation, and the number of drug-free wards in prisons has also been increased considerably. A part of imprisonment can also be served in a substance abuse service unit. The new law on imprisonment that will come into force in 2006 specifies the rights of a prisoner concerning social and health services. A law on contractual treatment is in preparation, on the basis of which an offender with a substance abuse problem can be sentenced to intensified drug treatment in an institution outside prison.

13.1 Political and structural guidelines

Since the 1960s, Finnish criminal policy has been characterised by neoclassical judicial thinking, according to which penal sanctions for a crime must be uniform for everyone. At the same time, sanctions have been increasingly set in their social context, i.e. punishment should be both rational and humane and it should not emphasise unreasonably unconditional imprisonment. However, there has been firm belief in sanctions as effective deterrents. While it has been thought that a crime should be regularly followed by punishment, treatment and punishment have been separated from each other (Lappi-Seppälä 2000).

The criminal policy worked as intended for a long time: the number of prisoners decreased rapidly and consistently from the 1970s until the end of the 1990s. It was only after the number of prisoners

⁷⁰ The author of this section is Olavi Kaukonen, special adviser from the Ministry of Justice, Criminal Policy Department. See also <http://annualreport.emcdda.eu.int/en/home-en.html> available by Autumn 2005

and drug offences began to increase fairly quickly that special preventive measures were planned and used.

The current Government made a decision in principle on drug policy (2004) that is binding on all administrative sectors for the years 2004–2007. It aims at combating current problems related to the drug policy that require a solution to the co-operation between different authorities. The document commits various ministries to reach a common goal, reducing drug problems. Drug-user offences are sanctioned by the administrative sectors of the Ministry of Interior (the police, which is in charge of investigating crimes and pre-trial investigation) and the Ministry of Justice (the prosecutor, courts and enforcement of punishment).

Within the administrative sector of the Ministry of Interior, the alternative sanctions related to substance abuse problems concern primarily the drug-user offence and the related possibility of hearings for minors and treatment referral (see the section on legislation). The issue has also been recorded on anti-drug strategy for the police for 2003–2006 (2002)

The administrative sector of the Ministry of Justice aims at increasing the handling of substance abuse problems and the rehabilitation of offenders both quantitatively and qualitatively in accordance with the resolution so that the adjustment of offenders with substance abuse problems in society would become easier and recidivism, which is often related to substance abuse problems, would diminish. The Criminal Sanctions Agency, which is in charge of the enforcement of punishments under the Ministry of Justice, has created its own substance abuse strategy to guide anti-drug work as well as anti-intoxicant work in general within the prison administration. However, the same general principles are applied both to offenders who use drugs and to other offenders.

13.2. Legislation

Since 1994, drug offences have been dealt with under the amended Penal Code (1993/1304). Since 1 September 2001, drug use and the possession or acquisition of small amounts of drugs for personal consumption has been considered a drug-user offence, for which the most common sanction is a fine.

The police have fairly wide pre-trial investigation authority in Finland (Kinnunen et al. 2002). For a long time, the police, the prosecutor and the court have had the possibility to waive sanctions if the crime is considered insignificant, the offender is a minor or the sanction would be unreasonable considering the offender's situation. This possibility, however, has been used quite rarely and waiving

charges in particular does not seem to be established as part of the penal system, even though the Prosecutor General has repeatedly stressed the use of this alternative in his guidelines to prosecutors, especially for drug offences (Kainulainen 2002).

According to the law, charges or penalty can be waived in the case of a drug-user offence if the offence can be considered insignificant considering the amount or quality of the drug, situation of use or other circumstances. Sanctions for a drug-user offence can also be waived if the offender has sought treatment approved by the Ministry of Social Affairs and Health. Treatment shall be provided based on the Decree of the Ministry of Social Affairs and Health (2002) in accordance with the client's needs either in outpatient or inpatient care.

The development is also in accordance with the wishes of Parliament: there was a lot of discussion during the passage of the Narcotics Act of 1972 on whether a drug user should be punished at all. The Government proposal did not include criminalisation, and the issue was voted on repeatedly at different stages of the procedure for passing the law (Hakkarainen 1992). Finally, drug use was criminalised. When developing the legislation later, the Parliamentary Legal Affairs Committee emphasised in their statements that control and sanctions should be applied to aggravated and professional drug crime above all and that drug addicts should be guaranteed the possibility of getting treatment and rehabilitation.

There has not been much public debate on drug policy in Finland. According to survey results, people's attitudes to drugs are quite severe. For example, only 10% of Finns would legalise the use of cannabis. For other drugs, the corresponding figure is 2%. Young people have, however, a more lenient attitude to drugs; about half of 15–24-year-olds would allow the use of cannabis. (Hakkarainen 2004).

13.3 Penal sanctions

There are no specialised courts for drug offences in Finland. The court possibilities to impose alternative punishments are related to the use of general penal sanctions. These include a fine, a suspended sentence, an unconditional sentence of imprisonment and community sanctions. Community sanctions, especially community service, are the only real options to imprisonment.

Community service is a penalty imposed in place of unconditional imprisonment and it includes regular unsalaried and supervised work (The Act on Community Service 1055/1996). The court can

sentence an offender to community service instead of a maximum of eight months' imprisonment. A maximum of ten hours of community service can be served by participating in action programmes that reduce recidivism or in rehabilitation, mainly in outpatient care.

It should be pointed out, however, that community service is part of the general penal system, not a penalty designed specifically for drug users. Strong substance addiction is rather an exclusive than a supporting factor for an alternative sanction. The sanction is still imposed mainly on substance abusers: in 2003, about 60% of those sentenced to community service had drunken driving as the main offence. Overall, offenders have been sentenced to community service about 3,500 times.

In 2005, a juvenile punishment, which has been imposed only in some parts of the country by virtue of the act on the experimental introduction of juvenile punishment (1058/1996), will be introduced in the entire country. Under 18-year-old offenders can be sentenced to juvenile punishment, if a fine is considered insufficient considering the severity of the offence and the circumstances related to the offence, there are no weighty reasons for unconditional sentence of imprisonment, and when juvenile punishment is considered justified in order to prevent new offences and to promote the offender's social recovery. However, juvenile punishment was used quite rarely during the trial period. In 2003, only 23 juvenile punishments were imposed on offenders.

All offenders that have been sentenced to community service or juvenile punishment as well as those sentenced to a suspended sentence or put on probation after imprisonment have the opportunity to use the public social and health services that are normally free of charge for the client and paid by the municipality. Services intended specifically for substance abusers (both outpatient and inpatient rehabilitation) are available practically throughout the country.

In addition to the fact that an offender sentenced to sanctions outside prison can use public substance abuse services, the obligation to participate in a programme aiming at solving substance abuse problems or in rehabilitation can be included, in addition to unsalaried work, in community service and juvenile punishment.

Legislation and the penal system started to react to the increase of drug problems only at the end of the 1990s, and there are few real alternatives to prison for drug-dependent offenders. Rehabilitative measures, however, have increasingly been included in the penal sanctions that are currently used.

13.4 Rehabilitation as part of the enforcement of sentences

Even though it is possible to direct the afore-mentioned treatment referral interventions to drug users during pre-trial investigation and consideration of charges, the majority of the alternatives for the judicial administration are available only upon the enforcement of sentences. The Criminal Sanctions Agency, which operates under the Ministry of Justice and is divided into the Prison Service and the Probation Service (enforcement of community sanctions), is in charge of the enforcement of sentences.

In recent years, intoxicant-free wards have been established in prisons and several rehabilitation programmes have been started in accordance with the intoxicant strategy of the prison administration. The State covers in full all the costs for the social and health rehabilitation the offender needs in prison.

The Act on Enforcement of Punishments (amendment 364/1999) also enables placing an offender outside prison during his sentence. An offender with a substance abuse problem or one who can be expected to have problems coping at liberty and can be considered reliable can be placed for a fixed term in an institution outside prison or a similar unit where he can participate in rehabilitation or other target-oriented activities reinforcing his operational abilities.

The use of rehabilitation outside prison started in 2000. Overall, rehabilitation outside prison has been imposed, mainly for reasons of costs, relatively rarely, about 40 times a year. More than half the institutional placements have lasted less than 3 months. The total duration of a client's rehabilitation in practice has been longer because rehabilitation had usually begun in prison and for many offenders, rehabilitation continues after imprisonment at the expense of municipal social services (Karsikas 2004). Sometimes, nearly the whole term of short imprisonment is considered the fixed term of institutional placement regulated by law but usually the placement is done at the end of the imprisonment term (Karsikas et al. 2004). The decision to use rehabilitation outside prison, an external rehabilitation unit and the length and content of rehabilitation is made by the prison, but the use of special funds on institutional placements is decided by the Criminal Sanctions Agency.

In figures, about half of the drug users entering prison participated at least in informative and motivating sessions.⁷¹ About one-fourth of them participated in rehabilitation in prison and only about one per cent was referred to drug treatment outside prison in 2003.

Nowadays, rehabilitation programmes emphasise above all cognitive behavioural approaches and continuity of rehabilitation: the objective of having various forms of rehabilitation is that the rehabilitation started in prison or outside prison would continue after release.

Rehabilitation in prison takes place at the prisoner's request on intoxicant-free wards that have their own structural plans. Separate rehabilitation programmes are also arranged. The implementation of programmes is usually handled partly by prison guards and partly by instructors with special training in substance abuse.

Opiate-dependent inmates that started substitution treatment before the enforcement of sentence continue the treatment as part of prison health care. New assessments of the need for substitution treatment and decisions to start treatment have not been made in prison health care so far; instead, medical detoxification has been provided increasingly on inpatient wards.

13.5 Evaluation and development needs

Special acceptance guidelines for action plans with criteria have been issued for rehabilitation in prisons or outside prisons. Rehabilitation is also supervised and evaluated by a group of experts appointed by the Criminal Sanctions Agency that has representatives of university research, prison administration, substance abuse services and prison staff training (Järvinen et al. 2001).

Alternative sanctions for drug-dependent offenders have so far been used infrequently in proportion to need. The history of rehabilitation outside prison is also short in Finland and this option has been used rarely; so far, there is no fully reliable follow-up or comparison information available on the effectiveness of the activities. There is, however, a statistical study being prepared on the follow-up and effectiveness of rehabilitation especially in terms of reducing recidivism.

Substance abuse problems are common in prisons, and social recovery after release seems to have been easier and there seems to be less recidivism for those offenders released from prison that have managed to overcome their substance abuse problem one way or another (Hypen 2004). Therefore,

⁷¹ The rough estimate of the number of inmates with drug problems (3,500) is the result of calculating 46% of all inmates in prisons in 2003 (7,654) in accordance with the study on case histories in prison health care. However, according to an estimate by the Prison Service, as many as 80% of inmates have a drug problem.

rehabilitation programmes should be expanded and the number of substitution treatment programmes should be increased in prisons.

There are also other reforms of legislation being prepared. The Ministry of Justice is currently preparing a law on testing contractual treatment. The main target group of this sanction would be offenders that cannot be sentenced to community service due to their substance abuse problem but for whom imprisonment – often due to reasons related to their substance abuse problems – does not have the desired effect. An alternative is intensified drug treatment outside prison. The reform has been planned following the Swedish model and their experiences on contractual treatment.

The prison system is also to be reformed. The Government made a proposal on the new Imprisonment Act to the Parliament in 2004. According to the proposal, the main objective of the Prison Service is to increase prisoners' readiness for crime-free life and improve their life-management skills and adjustment to society. Individual planning of the content of the imprisonment process will be emphasised and prisoners' right to social and health services will be defined more specifically than before. The amendment will increase the use of substance abuse interventions and programmes and activities promoting social recovery.

14. Drugs and public nuisance⁷²

In Finland, public disturbances have traditionally been linked to alcohol use whereas drug-related disturbances have been fairly rare. The Finnish drug market is characterised by its secretive nature; to a large extent the use and sale of drugs takes place in private residences. Custodies, violence and robberies are mainly related to alcohol use and not so much to drugs. The most significant drug-related public disturbances are experienced in blocks of flats where one flat is used for dealing drugs. Despite the infrequency of drug-related disturbances, an important number of Finnish citizens suffer from social insecurity due to drug use. Drug problems are extensively discussed in the media, and it is possible that some of the mental patients and alcoholics demonstrating aggressive behaviour on the streets are confused for drug addicts. The use of illegal drugs is prohibited by the Penal Code, which allows intervention in drug use whether it takes place in a public area or on private premises. The provisions of the Penal Code related to drug offences are implemented quite strictly. The police may easily intervene in drug use taking place in public places. Imposing punishments for even petty drug offences is seen as having a preventive effect on drug use. In Finland, the prevention of drug-

⁷² The author of this section is Aarne Kinnunen, special adviser from the Ministry of Justice, Criminal Policy Department. See also <http://annualreport.emcdda.eu.int/en/home-en.html> available by Autumn 2005

related disturbances has been focused on extensively both at the state and local levels. However, there is no clear indicator for monitoring and assessing the prevention of drug-related public disturbances.

14.1 Definitions

According to social scientists, the drug problem was defined as a medical problem in Finland in the early 1990s, as a youth problem in the 1960s and 1970s and as an organised crime problem and public health problem (infectious diseases) as of the 1990s (Hakkarainen 1999). Drug-related public disturbances are not that common in Finland. Public disturbances have traditionally been linked to the use of alcohol. The typically Finnish practise of drinking to drunkenness is closely connected with drunken arrests, robberies, assaults and even homicides.

The infrequency of drug-related disturbances is partly explained by the fact that drug use is not as prevalent in Finland as it is in many other countries. Public reaction to drugs and drug use is negative and for example, drug use on streets is largely frowned upon. Drug legislation is also strict. Drug use has been criminalised and the police implement the ban on use actively (Kinnunen et al. 2002). The Finnish drug market is characterised by its secretive nature. By international comparisons, a special feature of the Finnish drug market is that there are no open drug parks or market places and selling drugs on the street is fairly uncommon. The drug market is hidden in private residences. On the other hand, alcohol use in public places leads to an annual toll of 100,000 arrests for drunkenness, i.e. custodies. Drug use that results in custodies has not been studied but the phenomenon is presumed to be rare. In 2002, 56 cases in which public order and safety had been disturbed by a drug user were reported to the Helsinki police. These cases usually involved intravenous use on the street, sleeping on the street, going through rubbish bins or behaving in a threatening way. (Kekki 2004b.) The mixed use of alcohol and drugs clearly causes more problems than drug use alone.

Drug-related violence in Finland typically takes place within the drug market and the drug-trade culture. Violence may be used when collecting debts or in connection with other disputes. A special feature of the illegal drug market is that the victim of such violence cannot turn to the police to get help. The drug culture is marked by a strong sense of masculine pride, thus wrongdoings are avenged with violence and shameful loss of face is avoided by maintaining a threat of violence. The violent traits of the drug market are however rarely targeted at the main population, as only 2% of all assaults (which amount to an annual total of 30,000) have been committed under the influence of drugs or pharmaceuticals, whereas alcohol was involved in 71% of the cases (Lehti et al. 2004, p. . 205).

Robberies committed by drug dealers are fairly common in many big cities of the world. These types of robberies are however quite rare in Finland. The most typical drug-related acquisitive crimes are stealing from a car (e.g. mobile phones, music electronics, laptop computers), shoplifting or commercial burglaries. Of all solved robberies (some 2000 annually), those committed under the influence of drugs or pharmaceuticals accounted for 9%, whereas alcohol was present in 43% of the cases. (Lehti et al. 2004, p. 250-251).

According to data from the drug laboratory of the National Public Health Institute in Finland, 2,931 persons were suspected of driving under the influence of drugs in road traffic in 2003 (In 2002, investigated cases amounted to 1,850 and in 2001 to 1,844). In 2003, the number of suspected drug cases rose by 58 per cent over the previous year. The rise is explained by the introduction of the so-called zero tolerance for drugs as of February 2003. The amendment stipulates that the driver of a motor vehicle is sentenced for drunken driving if there is a narcotic drug or its metabolic in his or her blood during or after driving.

Despite the infrequency of drug-related disturbances in Finland, a large number of Finnish citizens experience social insecurity due to drug use. According to a 2003 population survey, some 40% of the population reported being scared of assault by someone involved with drug use. This experience is more prevalent among women than it is among men. Young people tend to be more frightened of drug-related violence than older age groups. When examined by place of residence, there was clearly more insecurity in the Greater Helsinki area and cities, i.e. areas that have more drug problems and where the prevalence of drug use, according to indicators, is higher. (Hakkarainen et al. 2004) Drug problems are widely reported in the media and it is possible that some of the mental patients and alcoholics demonstrating aggressive behaviour on the street are confused for drug users.

Perhaps the most common drug-related disturbances are experienced in blocks of flats where there is a flat used for dealing drugs. (Kinnunen et al. 2004) As the drug problem has become more prevalent, these "drug houses" have become a more common phenomenon especially in bigger cities. In the last years, the districts of the Greater Helsinki area have begun to differentiate as regards their socioeconomic status, and so-called poverty pockets can be found in different areas. This is not indicative of large-scale polarisation, instead, poverty pockets can be found sporadically around the Greater Helsinki area. (Vaattovaara 1998) These pockets of poverty or "black spots" comprise of an individual building or at most a block of buildings that are situated here and there within the entire district. Their frequency is rising slowly (Vaattovaara et al. 2002, p. 281). These poverty pockets are usually marked by a strong culture of substance abuse, sometimes also involving drugs.

The prevalence of drug-related disturbances in citizens' own living areas have been mapped out with population studies and ethnographic interview studies. According to population studies, the proportion of those who deemed drugs an important problem in their own living area grew strongly between 1998 and 2002. The share of those who have experienced problems was approximately 11 per cent in the 2002 study. The percentage is typically much higher in cities than it is in rural areas. (Hakkarainen et al. 2004). People living in the neighbourhood of drug houses were interviewed for the ethnographic study conducted by Kinnunen et al. (Kinnunen et al 2004). According to many inhabitants, disturbances caused by drugs had become much more visible over the past few years in the target areas. Many of those interviewed said that they had encountered needles and syringes for the intravenous use of drugs while moving around the neighbourhood. Many also reported having seen people "that were clearly using something other than alcohol" in the streets of the area. These people were deemed unpredictable and dangerous. Drug users were often suspected of crime and disturbances in the area. The interviews revealed that people involved with drugs were suspected of almost any obscure incident in the area, such as offences against property, burglaries or vandalism. However, people's estimates on the numbers of drug users varied: some thought that users could be found in "every building in the area" whereas some thought there were only a few users in the area. The estimates differed partly according to where the interviewed person lived. Residents of owner-occupied housing reported having encountered drug users only occasionally, e.g. in public transport or shopping centres, whereas residents in city rental housing areas reported having seen them in the close neighbourhood. Residents in the city rental housing areas and owner-occupied housing areas had very different views on what was considered harmful behaviour. Those living in the rental housing areas were used to a more "lively" environment, including the heavy use of alcohol and drugs, the presence of ethnic minorities and disturbances caused by family disputes. (Kinnunen et al. 2004)

Certain special features related to drug use, such as the situation of the children of drug-using parents, are of special concern to the authorities. Activities to detect and react to such problems have been intensified to some extent. In addition, people in professions that involve meeting drug-users feel that intoxicated users and those suffering from withdrawal symptoms pose a threat to occupational safety. Within some sectors, such as the police, social work, hospitals' outpatient clinics and pharmacies, the skills and competence to deal with aggressive drug users have been improved.

One phenomenon related to public disturbances, which has generated much discussion, are needles and syringes found in parks and children's playgrounds. Many pharmacies have refused to sell syringes and needles to drug users for fear of disturbances. The A-Clinic Foundation, which is involved in substance abuse work, has increased health counselling and needle exchange for intravenous drug users in big cities. At the moment, there are 29 health counselling units in 21

localities in Finland. On the other hand, the new units have met with strong opposition from local residents. It is feared that needle exchange units will increase drug-related disturbances in residential areas. The amendment to the Communicable Diseases Decree introduced at the beginning of 2004 gave health centres the legal responsibility of preventing the spread of drug-related infectious diseases.

14.2. Measures taken to prevent drug-related public nuisance

Public disturbances in Finland have not been linked to drug use in particular. Problems pertaining to the maintenance of order are mainly connected to alcohol use and over the past years, attention has been paid to other factors such as street prostitution and its effects on public order.

The new Public Order Act came into force in Finland in October 2003. Before this, municipalities and cities enforced their own order regulations, which could differ greatly from each other. The Public Order Act states that “using intoxicating substances in public places in built-up areas and on public transport is forbidden”. Intoxicating substances include both alcohol and drugs. Alcohol, however, can be used in parks if this does not bother others.

The use of illegal substances is prohibited by the Penal Code (Chapter 50), meaning that it is possible to intervene in drug use, whether it takes place in a public place or in a private residence. Drug-related regulations of the Penal Code are enforced quite strictly. The police may easily intervene in drug use in public places. Exposed cases of drug use have usually led to pre-trial investigation, prosecution and court hearings. Imposing punishment for even a petty drug offence is seen to have a preventive effect on drug use. (Kinnunen et al. 2002.)

Even though drug-related public disturbances are not very common in Finland, precautionary measures have been taken. Examples from abroad have given cause for this. The open drug markets in large European cities have especially raised concern in Finland.

National drug strategies and action plans drafted in collaboration by various authorities (Drug Strategy 1997; Government decision in principle on drug policy, 1998) have deemed it important to ban drug use and sale in public places. The police have been put in charge of supervising this. In addition, attempts are made to prevent the emergence of the kinds of restaurants, clubs or cafés where drugs would be used openly. These activities aim at preventing new youth groups from being recruited to the drug market. Another underlying thought is that joining the drug use culture may be the start of a more serious career in crime.

During the past years, the Finnish police have emphasised in their own strategies the importance of street-level supervision in order to detect import organisations and wholesale in addition to influencing attitudes on drugs. According to the police anti-drug strategy (2002), local police must organise sufficient and efficient street supervision in order to prevent the sale and use of drugs, to obstruct the propagation of the drug culture and to reduce the recruitment of new users. It has been deemed important that local drug distribution channels cannot function undisturbed and that encounters between dealers and users are made more difficult.

During the past years, police resources and working hours have been increasingly targeted at the prevention of street-level drug sale and distribution. According to the Government decision in principle on more efficient drug policies (2000), additional appropriations were allocated to street supervision amounting to more than 60 man-years in the whole country. (Anti-drug Strategy of the Police for 2003–2006, 2002).

In addition to drug prevention, police activities have been increased to reduce drinking in the street and youth disturbances. There have been experiments in so-called zero tolerance. The most publicised project was the “To the sauna at five and to the slammer at six” project carried out in Tampere during 1999–2000. In the project, the Tampere police aided by additional staff supervised public drinking and related disturbances typical for young people on Friday and Saturday nights in the city centre. The threshold for intervention was kept low: almost 1,200 fines were given. The follow-up treatment for the intoxicated young people took place in a substance abuse and social clinic.

The evaluation report on the zero tolerance approach (Korander et al. 2002) deemed that the main goal, i.e. calming down the streets of the Tampere city centre at the weekends, was achieved. However, one result of the intensified patrolling was that disturbances by young people increased in the suburbs, where insecurity grew according to population surveys. In addition, the writers saw that laying the responsibility for safety and substance abuse problems on the shoulders of the police makes for a short-sighted social policy. An interactive and confidential relationship between young people and adults is an essential element when striving for change in the alcohol and drug culture and a safer future. The trial fulfilled the wishes of Tampere citizens in that it made the city centre more pleasant and improved safety at the weekends (Korander et al. 2002).

After the National Crime Prevention Programme approved by the Finnish Government in 1999 (Working Together for a Safe Society 1999), various authorities have jointly drafted municipal safety plans. Almost all municipalities now fall within the sphere of either regional or local safety plans. Maintaining order in the streets has been included in many cities' safety plans.

In September 2004, the Finnish Government approved a decision in principle on a programme for internal security. The programme suggests enhancing preventive activities for reducing crime, disturbances and accidents. Especially important goals are reducing offences, increasing the risk of apprehension and reducing recidivism in drug-related crime, violent offences and economic crime as well as in mass offences. (A Safer Community – internal security programme, 2004). In addition, a national violence prevention project is being prepared and due to be completed by the end of 2004.

Many cities have drawn up their own substance abuse strategies. These often emphasise the increase of street-level supervision. Intoxicant-free alternatives are offered to young people's drinking in public, such as cafés that are open at nights. The strategies of many cities also address drugs. For example, the Drug Strategy of the City of Helsinki (2000) outlines that the drug culture should not be seen in the cityscape and that residential areas marred by drug culture should not be formed. According to the strategy, "a successful drug strategy can be implemented through regional co-operation of social, health and youth services, the police and other authorities together with non-governmental organisations."

14.3. Indicators of work against drug-related disturbances

There are no clear indicators for monitoring work against drug-related disturbances in Finland. Indicators reflecting drug-related detriment are morbidity, crime and drug deaths. Indeed, there is extensive statistical information on the prevalence of drug use, drug crime and drug-related health consequences but the connection of these phenomena to public disturbances or the fruitfulness of the work against them is unclear. Closing down restaurants and denying licenses to serve alcohol usually has to do with serious alcohol-related disturbances or violations of alcohol legislation concerning the sale of alcohol and not so much with the sale or use of drugs in restaurants.

The citizens' experiences on being a victim of violence and their fear of violence are measured by victim surveys, but these studies do not separate the role of drug use in violent behaviour. The prevalence of violent crime can be monitored with the help of administrative registers, such as police and justice statistics. The intoxication of an offender is recorded by the police, but drug intoxication is more difficult to detect than alcohol intoxication is. The Finnish police maintain a special Street Security Index, which, however, does not directly describe drug-related disturbances. The Street

Security Index indicates the weighted number of robberies, aggravated robberies, aggravated assaults, assaults and petty assaults, damages to property, aggravated damages to property, drunken driving and traffic drunkenness in relation to the size of the population. However, there is no regularly used indicator that would allow the estimation of, e.g. the effect of the amount of street supervision on the development of the Street Security Index.

A few specific studies have assessed the fruitfulness of activities against drug-related disturbances. Police operations to prevent drug-related disturbances in residential buildings have been evaluated in the Greater Helsinki area (Kinnunen et al. 2004). In Tampere, an evaluation was conducted on the co-operation of the police and social services to prevent the exclusion of young drug users (Kekki 2004a). Alcohol-related disturbances have been assessed in a more structured way; an example of this being the evaluation report of the zero tolerance project to clean the streets of Tampere city centre (Korander et al. 2002). An evaluation has been conducted on local-level preventive substance abuse work in two districts in the Greater Helsinki area (Holmila 2002). The study on substance abuse and the control of public spaces (Törrönen 2004) addressed the control of public spaces especially as a moral issue, which is continuously linked to young people. Intoxicant-related disturbances on the streets cause conflicts between adults and young people. Dealing with the problem also brings up another question: how best to combine the freedom of the individual and the good of the community?

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CHANGES IN DRUG LEGISLATION

Basic Education Act. Perusopetuslain muutos (477/2003)

General Upper Secondary School Act. Lukiolain muutos (478/2003)

Vocational Education and Training Act. Ammatillisesta koulutuksesta säädetyn lain muutos (479/2003)

Vocational Adult Education Act. Ammatillisesta aikuiskoulutuksesta säädetyn lain muutos (480/2003)

Decree on prescription of medicines. Asetus lääkkeiden määräämisestä (726/2003)

Customs Act. Tullilain muutos (774/2003)

Act on the Processing of Personal Data by the Police. Laki henkilötietojen käsittelemistä poliisitoimessa (761/2003)

Amendment to the decree on drugs and substances used in their manufacture. Huumausaineita ja niiden valmistuksessa käytettävistä aineista annetun asetuksen muutos (1231/2003)

Act on Extradition between Finland and other Member States of the European Union. Laki rikoksen johdosta tapahtuvasta luovuttamisesta Suomen ja EU:n muiden jäsenvaltioiden välillä (1286/2003)

Decree on the amendment to the Communicable Disease Act. Tartuntatautiasetuksen muutos (1383/2003)

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

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

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

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

Laki nuorisorangaistuksen kokeilemisestä (1058/1996)

Laki rangaistusten täytäntöönpanosta (muutos 364/1999)

Laki yhdyskuntapalvelusta (1055/1996)

Päihdehuoltolaki (41/1986)

Sosiaali- ja terveysministeriön asetus hyväksyttävässä hoidosta huumausainerikoksissa (290/2002)

Rikoslaki (1304/1993)

Vankeinhoitoasetus (700/1999)

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