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EMCDDA  
by the Finnish National Focal Point, STAKES

**FINLAND**

**DRUG SITUATION 2007**  
New Developments, Trends and in-depth  
information on selected issues

**REITOX**

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## FOREWORD

*Finland – Drug Situation 2007* is one of the national annual reports compiled by the National Focal Points in the European Information Network on Drugs and Drug Addiction (REITOX) which is co-ordinated by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). The national reports form the basis for the EMCDDA's annual report *The state of the drugs problem in Europe*. The national reports are compiled in accordance with the guidelines provided by the EMCDDA.

The present report consists of two parts. Part A discusses recent developments and research data from 2006 and early 2007. The sections that describe the drug situation during the past year (drug experimentation, problem drug use, health and social correlates and consequences, availability and supply of drugs) are linked with discussion on related societal interventions (prevention, treatment, harm reduction, social rehabilitation and control). Each section begins with background information on the subject and the latest data is discussed in the subsections. Part B discusses three selected issues relating to drugs. These issues, chosen according to the EMCDDA guidelines, are (1) Public expenditure (2) Drug use and social deprivation among Finnish youth, and (3) Drug-related research in Finland. The length of the sections in the report depends on the amount of data available on each subject area.

Research data and comments from experts on different areas of the drug issue were used in drafting the report. We thank all the experts for their comments. Special thanks are due to Senior Researcher Tuija Hietaniemi (National Bureau of Investigation). The report is based on last year's report.

Planning Officer Jouni Vihmo (STAKES) wrote Section 11 'Public expenditure' and Researcher Riikka Perälä (Finnish Foundation for Alcohol Studies) wrote Section 12 'Drug use and social deprivation among Finnish youth' of part B. We thank them warmly.

The report was compiled and the remaining sections written by Sanna Rönkä and Ari Virtanen at the Finnish National Focal Point, which operates at STAKES.

The report has been approved by the editorial board of STAKES Information as well as the working group on international co-operation on drug issues.

Helsinki, December 2007

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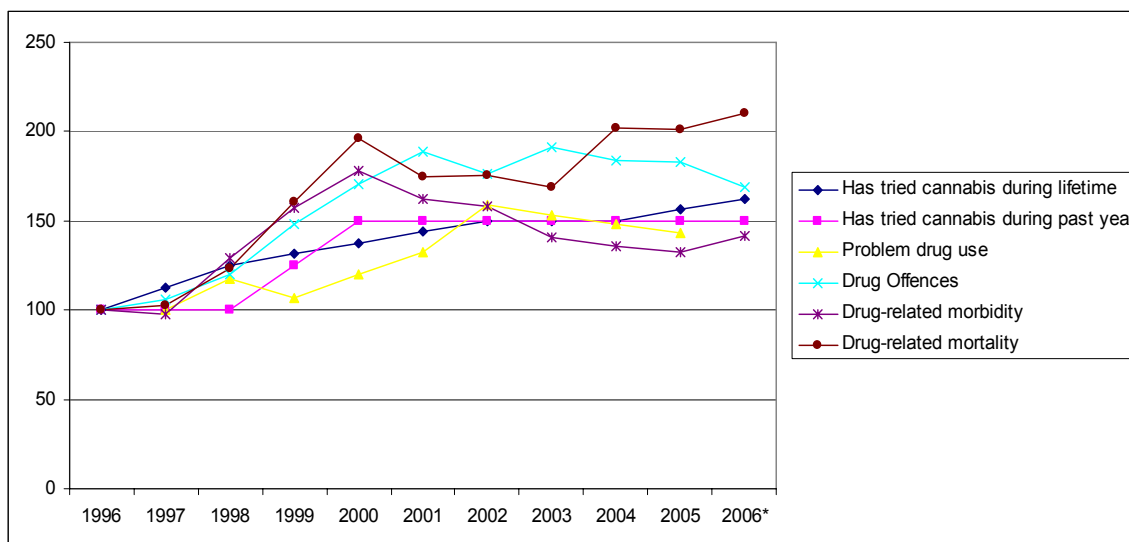
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<p>In 1995–2001, all indicators (experimentation, problem use, health detriments, morbidity, mortality, criminality and seizures) suggested that the drug situation was aggravating. However, in 2001–2006 this trend showed clear signs of weakening. According to the 2006 population survey, 13% of 15–69-year-olds had experimented with cannabis sometime in their life. The level was nearly the same as in the 2002 survey and three percentage points higher than in 1998.</p> <p>The number of problem drug users is estimated in Finland based on the number of problem users of amphetamines and opiates, which was 14,500–19,100 in 2005; this accounts for 0.5–0.7% of 15–54-year-olds among the entire population. Nearly four fifths of problem drug users used amphetamines. The proportion of men was 80%. The majority of problem drug users belonged to the 25–34-year age group.</p> <p>The numbers of hepatitis C, B and A cases and HIV infections among intravenous drug users have either decreased or remained at a low level. Buprenorphine is becoming the most common finding in drug-related deaths by poisoning. The victims of buprenorphine-related deaths have been mainly young people. Especially low-threshold treatment services play an important role in preventing and reducing infectious diseases related to drug use. Developing peer group activities, among other things, has reduced the spread of infectious diseases related to intravenous drug use.</p> <p>The harm associated with drug use cost the public sector 180 million euros in fiscal year 2005. The state paid 107 million euros and municipalities 73 million euros of the overall expenditure. Harm reduction and enforcement of safety and order comprised approximately 70 per cent of the expenditure. Noticeably lower funds were spent on drug treatment and the prevention of harm.</p> <p>Young Finns have a stable living environment in the sense that we do not have residential areas characterised by an accumulation of social problems. The worrying aspects include the rising number of child welfare cases and the fairly high number of children living in unstable conditions. Child welfare measures are often taken due to parental substance abuse, which can increase a young person's risk of developing substance abuse problems in adulthood. The increase of mental health problems among young people is also worrying because it has been seen that these problems are linked to drug experimentation.</p> <p>The measures taken in Finland are not primarily directed at risk groups. Instead, it is believed that drug prevention is linked to the comprehensive improvement of the living conditions of children and young people. Within the service system, the provision of emotional support, for instance, should be developed.</p> <p>Greater emphasis was first placed on drug-related research in the 1990s along with increased experimentation and use of drugs and their related harm. During the past 10 years, the specification for drug-related research has changed from a more general approach and setting up the basic indicators for monitoring the drug situation to more detailed proposals for measures that are based on the development of the drug situation. The Academy of Finland is financing drug-related research to the sum of 5.5 million euros through its Intoxicants and Addiction programme for the years 2007–2010.</p>			
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## SUMMARY

In 1995–2001, all indicators (experimentation, problem use, health detriments, morbidity, mortality, criminality and seizures) suggested that the drug situation was aggravating. However, in 2001–2006 this trend showed clear signs of weakening (Figure 1).

Figure 1. Trends in drug use and drug-related harm 1996-2006 (1996=100)



\*) preliminary data

Sources: Alcohol and Drug Studies, STAKES; Partanen et al. (2007); National Bureau of Investigation; Hospital patient discharge register, STAKES; Department of Forensic Medicine, University of Helsinki.

### 1. National policies and context

The Drug Policy Action Programme 2004–2007 was implemented within the drug policy. The final report of the programme stated that the development of the drug situation stabilised during the Government's term of office. The quality framework presented in the programme for substance abuse prevention and treatment was implemented, co-operation between the authorities increased, a crime prevention unit to combat serious crime was established, drug prevention in prisons was improved and investment was made into drug research (Ministry of Social Affairs and Health 2007).

According to a study that examined Finnish drug policy from a larger perspective, minimising harm (substitution treatment etc.) combined with punitive prohibition policy (harsher sentences etc.) forms a two-track drug policy typical for Finland (Tammi 2007).

## 2. Drug use in the population

According to the 2006 population survey, 13% of 15–69-year-olds had experimented with cannabis sometime in their life. The level was nearly the same as in the 2002 survey and three percentage points higher than in 1998. Among women the percentage was 12% and among men 16%. The proportion of 15–34-year-olds (22%) remained the same in 2002 and 2004. However, changes have taken place within the latter age group: between 2002 and 2006, the proportion of 15–24-year-olds decreased by 6 percentage points, whereas the proportion of 25–34-year-olds grew by the same amount. Thus, it seems as if cannabis has lost some of its significance as part of youth culture, whereas the generation that experimented with drugs at the turn of the millennium seems to continue using drugs at an increasing rate (Hakkarainen et al. 2007).

## 3. Prevention

Quality criteria have been determined for substance abuse prevention. Anti-drug organisations operate under a joint drug programme. Special drug prevention programmes have been carried out at the local level in order to reach immigrants.

Publicly funded substance abuse prevention requires that it is effective. The methods employed in substance abuse prevention are generally divided into the more known and established means (often internationally used) and those developed by organisations themselves. One study has shown that approximately 70 per cent of organisations are considered to pay sufficient attention to evaluating the effectiveness of substance abuse prevention, and only 40 per cent are considered to use systematic methodology in their evaluations.

## 4. Problem drug use

The number of problem drug users is estimated in Finland based on the number of problem users of amphetamines and opiates, which was 14,500–19,100 in 2005; this accounts for 0.5–0.7% of 15–54-year-olds among the entire population. Nearly four fifths of problem drug users used amphetamines. The proportion of men was 80%. The majority of problem drug users belonged to the 25–34-year age group.

Drug treatment clients are mainly men, young adults and single people. Opiates, stimulants, cannabis and the combined use of alcohol and drugs were the primary problem substances of the clients entering drug treatment. The proportion of buprenorphine as the primary substance of those entering treatment has increased the most.

## 5. Drug-related treatment

Buprenorphine was the most common pharmaceutical used in the medical treatment for opiate addiction. Treatment periods at substance abuse treatment units have become longer as the physical condition of clients has worsened and polydrug use has become more common. The availability of treatment and waiting times vary considerably between different localities.

## 6. Health correlates and consequences

The numbers of hepatitis C, B and A cases and HIV infections among intravenous drug users have either decreased or remained at a low level. Buprenorphine is becoming the most common finding in drug-related deaths by poisoning. There were

several cases at music festivals in the summer of 2006 where the combined use of GHB or GBL and alcohol had caused such things as delirium and unconsciousness. The information gathered by drug researchers from various sources shows that the use of these substances has become more prevalent.

#### 7. Responses to health correlates and consequences

Especially low-threshold treatment services play an important role in preventing and reducing infectious diseases related to drug use. Developing peer group activities, among other things, has reduced the spread of infectious diseases related to intravenous drug use.

#### 8. Social correlates and consequences

Problem drug users are usually socially marginalised and feel that they have no prospects in life. 62% of drug treatment clients were unemployed and 11% were homeless in 2006. The number of drug offences known to the police dropped by 7% when compared with the previous year. According to preliminary results, 90% of male inmates suffer from some type of substance addiction and 65 per cent of female inmates suffer from drug addiction.

#### 9. Responses to social correlates and consequences

Various projects and models related to social reintegration are ongoing. For example, the social welfare office for the homeless in Helsinki offers a form of housing support referred to as *Asso's* social housing management. The model offers residents support by helping them with outstanding rent payments, preventing them from losing their home, and reducing the harm caused by substance abuse and mental health problems.

In prisons, drug users are provided with substance abuse rehabilitation and opiate treatment. Of alternative penal sanctions, drug users' treatment referral has been rarely used and users have mainly been fined. Finland's first association for drug abusers, *Lumme*, was established in October 2005.

#### 10. Drug markets

The drugs on the Finnish market are mostly cannabis products, synthetic drugs such as amphetamines and ecstasy, buprenorphine and, above all, benzodiazepines. Heroin is still fairly rare in Finland. There were no significant changes in drug seizures in 2006. According to the latest assessment, the proportion of seized cannabis (2004: 493 kg + 7,840 cannabis plants) is 10–25 per cent of the cannabis available on the market, when previously it has been assessed at 5–10%.

#### 11. Public expenditures

The harm associated with drug use cost the public sector 180 million euros in fiscal year 2005. The state paid 107 million euros and municipalities 73 million euros of the overall expenditure. Harm reduction and enforcement of safety and order comprised approximately 70 per cent of the expenditure. Noticeably lower funds were spent on drug treatment and the prevention of harm.

## 12. Drug use and social deprivation among Finnish youth

Young Finns have a stable living environment in the sense that we do not have residential areas characterised by an accumulation of social problems. The worrying aspects include the rising number of child welfare cases and the fairly high number of children living in unstable conditions. Child welfare measures are often taken due to parental substance abuse, which can increase a young person's risk of developing substance abuse problems in adulthood. The increase of mental health problems among young people is also worrying because it has been seen that these problems are linked to drug experimentation.

The measures taken in Finland are not primarily directed at risk groups. Instead, it is believed that drug prevention is linked to the comprehensive improvement of the living conditions of children and young people. Within the service system, the provision of emotional support, for instance, should be developed.

## 13. Drug-related research in Finland

Greater emphasis was first placed on drug-related research in the 1990s along with increased experimentation and use of drugs and their related harm. During the past 10 years, the specification for drug-related research has changed from a more general approach and setting up the basic indicators for monitoring the drug situation to more detailed proposals for measures that are based on the development of the drug situation. The Academy of Finland is financing drug-related research to the sum of 5.5 million euros through its Intoxicants and Addiction programme for the years 2007–2010.

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## A. NEW DEVELOPMENTS AND TRENDS

### 1 National policies and context

Anti-drug activities are largely based on long-term choices in policy and the societal structures that steer those choices. The structures for drug prevention are shaped through drug legislation, the strategies that steer drug policy and action plans. Anti-drug activities (prevention, treatment, reduction of drug-related harm, drug control) become concrete in the implementation of legislation, strategies and action plans.

Many of the national approaches and activities are related to international systems and agreements regarding drug policy. The resources allocated for the activities also play an important role in their implementation.

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).

The amendment to Section 11 of the Basic Education Act (453/2001) introduced a new subject, health education, to primary education. In 2003, the legislation related to education obligated the National Board of Education to define together with the National Research and Development Centre for Welfare and Health (STAKES) the central principles for pupil and student welfare services and the educational objectives to be applied to the national curriculum. Educational institutions were obligated to apply them together with social welfare and health care authorities to the local curricula to prevent and treat substance abuse. (477,478,479/2003.)

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

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

telecommunications monitoring and technical surveillance, and the amendment to the Police Act (21/2001), which regulates undercover operations and fictitious purchases.

The Finnish Government issued a resolution on 5 October 2000 to intensify 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 prepared an action programme to intensify drug policy for 2001–2003 (2003). In line with the Programme of the Finnish Government lead by Matti Vanhanen, the co-ordination group drafted a drug policy action programme for 2004–2007 (2004), which was approved by the Finnish Government by a resolution at the beginning of 2004.

The objectives of the 2004–2007 programme are as follows: in terms of administration, the programme aims at strengthening the co-ordination of drug policy at the national level and at revising Finnish drug legislation by taking into account relevant amendments to Community legislation and the increasingly rapid entry onto the market of substances thus far not covered by drug control. The aim within drug prevention is to develop new methods, strengthen local co-operation between the authorities and support the reinforcement of the role of non-governmental organisations. Pupil and student welfare services aim at strengthening multi-professional and local co-operation in order to prevent social exclusion among young drug users. In the realm of treatment, the aim is to secure access to appropriate services in order to treat drug abuse, to improve skills related to the prevention and treatment of drug problems and to increase the use of treatments within the context of penal sanctions. In order to reduce drug supply, the aim is to increase the collaboration of the police, Customs, Border Guard, prosecutor and private security branch and to intensify co-operation among the competent authorities with respect to drug precursors. Other objectives are to promote international action to prevent the use and spread of drugs and to continue supporting the work against drugs in neighbouring areas and within the framework of development co-operation. (Ministry of Social Affairs and Health 2004.) A new drug policy co-operation programme for 2008–2011 was prepared in 2007. The Finnish Government issued a resolution on co-operation in November 2007. The new programme is mostly in accordance with the 2004–2007 programme.

With respect to the drug strategy of 1997, the report of the committee for preventing drug use among young people was published in 2000, and the report of the working group on drug treatment in 2001. In addition, the police have produced an anti-drug strategy (2002) for 2003–2006 and the Prison Service (2002) drew up its substance abuse strategy (Sections I–III), which has subsequently been supplemented by a new strategy for 2005–2006. 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.

Other drug strategies include the national plan of action to combat poverty and social exclusion 2003–2005, which calls for more effective drug prevention measures, sufficient treatment for drug users and the expansion of measures to alleviate the negative effects of drug use. The Health 2015 public health programme (2001) sets as one of its goals the appropriate treatment of the health problems associated with alcohol and drug use. In addition, a cross-sectoral programme on internal security

2005–2015 has been drawn up in order to increase public security (Ministry of the Interior 2004).

## **1.1 Legal framework**

### **1.1.1 The new Narcotics Act**

In the spring of 2006, the Government submitted to Parliament a proposal for the new Narcotics Act and certain Acts associated with it. By the fall of 2006, Parliament was still processing the proposal. Due to Parliament's delay in processing the Government's proposal, it became void at the end of 2006 when the Government's term of office ended. Reforms to the Act were postponed until the beginning of the year 2007 when the new Government would set its guidelines.

The objective of the new Narcotics Act was to strengthen drug control, but it does not aim to change national drug policy. The Act aims to prevent the illegal import of drugs into Finland, the illegal export of drugs from Finland as well as the manufacture, distribution and use of drugs. Concerning drug precursors, the Act was to comply with the European Communities' intra and extra-Community trade regulations on precursors. The Act did not suggest essential changes to existing principles and methods; it only proposed some specifications.

### **1.1.2 Legislation related to demand reduction**

#### *Prevention*

Drug testing in accordance with the Occupational Health Care Act (1383/2001) is dealt with in the Government Decree on drug testing (218/2005). The Decree aims at ensuring that drug testing is conducted in line with good occupational health care practices and laboratory quality standards, taking into account the integrity and protection of the privacy of the persons tested as well as their other fundamental rights. Together with central organisations for employees and employers, the Ministry of Social Affairs and Health has headed preparations for guidelines for testing (Ministry of Social Affairs and Health 2006a).

Amendments (760/2004, 456/2007) to the Occupational Health Care Act state that employers must have a written substance abuse programme, which contains the general goals of the workplace and practices to be abided by to prevent substance abuse and to help substance abusers in seeking treatment, before requiring a job applicant to take a test. Before approval, the employer and employees together should discuss the duties in the order of co-operative procedure. Additionally, a positive test result should be confirmed in the above-mentioned quality controlled laboratories. (334/2007)

#### *Drug-related treatment*

Government Decree 719/2007 stipulates that a maximum of €3,500,000 of state subsidies shall be granted to Social and Welfare Centres of Expertise and to municipalities and federations of municipalities for the development of services for substance abusers to cover costs for treatment and for improving treatment. Regional need for subsidies in treating substance abuse and the development of co-operation among authorities as part of the national structural reformation of municipalities and

services determine how the subsidies are distributed. Funding programmes pay special attention to female substance abusers and those with mental health problems.

The Child Welfare Act (583/2007) to take effect at the beginning of 2008 emphasises the ability of adults, who receive services for substance abuse and mental health problems, in taking care of and supporting children under their care. A child should be taken into care by social welfare authorities, and substitute care should be organised for him/her if the child is deprived of care to the extent that it seriously endangers his/her health or development, or if the child seriously endangers his/her own health or development by abusing substances, committing an offence considered to be more than a minor offence, or behaving in other similar ways. If taking into care can be considered beneficial to the child, a specific care plan is made, which states the goals of substitute care and especially how support and assistance will be arranged for the child, his/her parents and guardians and which may contain guidelines for special care in breaking the vicious circle of substance abuse or crime.

Substances that a child, who has been put into residential care, may use to intoxicate himself/herself and objects that the child may use to injure himself/herself or others must be taken away from the child. The child may be temporarily forbidden to leave the area of the institution or the institution itself, if it is in the best interest of the child. Once the child has been placed in substitute care, he/she should receive aftercare if the placement has continuously lasted at least six months. If a young person does not receive enough income or allowances after his/her placement period ends, the municipality must arrange for such funds to assist the young person in seeking a place to live, education and in other ways to help him/her become independent.

According to the Act (566/2005) and Decree (646/2005) on rehabilitation benefits and rehabilitation allowances granted by the Social Insurance Institution of Finland, a rehabilitation patient is entitled to rehabilitation allowance if rehabilitation is necessary to remain in, return to or enter working life. A rehabilitation patient is only entitled to rehabilitation allowance if rehabilitation takes place in a substance abuse rehabilitation unit approved by the Social Insurance Institution of Finland and rehabilitation is based on a treatment or rehabilitation plan. According to the refined version of the Act (902/2005), the rehabilitation unit providing substance abuse rehabilitation services must possess a licence, obtained from the State Provincial Office responsible for the supervision of such units, which grants the right to provide health and social welfare services. Additionally, the rehabilitation unit should have the appropriate facilities, equipment, and staff needed to carry out substance abuse rehabilitation. Discretionary compensation for maintenance and other costs can be paid during rehabilitation, and discretionary rehabilitative assistance can be paid after rehabilitation if it is necessary for the employment of the rehabilitation patient.

Decree 993/2006 set forth by the Ministry of Social Affairs and Health lays down the provisions for statements rendered by a referring physician and for the decisions made by a physician taking a substance abuser into treatment, as stated in the Act on Welfare for Substance Abusers, in the event the person is forced into treatment due to health endangerment.

In accordance with the Government Decree on medicinal products with reimbursement status granted on special grounds and diseases regarded as severe on medical grounds (616/2005), naltrexone used in the treatment of opiate addiction is now subject to basic reimbursement. Amendment 22/2006 to the Medicines Act states that the right to import pharmaceuticals that contain substances categorised as narcotic drugs can be forbidden or limited.

### *Responses to health and social correlates and consequences*

The amendment to the Public Order Act (582/2005) prohibits the consumption of intoxicating substances in public places in built-up areas, at checkpoints and on public transport. The prohibition does not concern drinking alcohol in parks or similar areas if it does not unreasonably hinder others from using that area for its intended purpose. As drug use is an offence under the Penal Code, the use of drugs is always forbidden in places set out in the Public Order Act. Amendment 533/2007 defines more precisely the fines for misdemeanours related to breaches of the peace, and the right of the police and Border Guard officers to confiscate and dispose of intoxicating substances. Amendment 848/2006 pertaining to the handling of intoxicated persons emphasises that an intoxicated person should not be taken to a public detoxification centre or substance abuse unit if his/her behaviour can be considered to endanger the safety of others. In such situation the person must be taken into police custody. (841/2006).

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

An inmate can be ordered to give a blood or saliva sample or take a breath test if there is cause to suspect that he or she is under the influence of alcohol or other intoxicating substance. A frisk or physical examination can be conducted if an inmate is suspected of possessing prohibited substances (for instance drugs) and if he or she is suspected of a drug-user offence or a crime for which the maximum penalty is more than six months. According to the amendment to the Coercive Measures Act (769/2005), a remand prisoner's communication with another person can be restricted during pre-trial investigation if there is just cause to suspect that the communication may endanger the purpose of the pre-trial detention.

According to the Detention Act (768/2005), a remand prisoner's incoming letter, postal item or message can be copied if it is evident, e.g. from reading such mail, that it is likely to contain plans for or information on a drug user offence. A remand prisoner's phone call can be recorded if it is evident, e.g. from listening to the phone call, that it is likely to contain plans for or information on a drug-user offence. A physical examination can be conducted on a remand prisoner if there is justifiable cause to suspect the remand prisoner of a drug-user offence. A remand prisoner can

be placed in solitary confinement if it is deemed necessary in order to prevent continuous use of intoxicating substances or a drug offence.

However, Amendments 265–266/2007 to the Act on Imprisonment and Detention Act pose tougher restrictions on inmates such that their criminal background, behaviour during imprisonment, suspicious postal delivery or the sender of such post are sufficient grounds for opening and checking a letter or other postal delivery and the contents therein without reading it, appealing to the possibility that the letter or postal delivery may contain forbidden substances or objects. Similar grounds may be used to read a letter if there is reason to believe it will help in preventing or solving a crime, preventing a threat to the order of the prison, or protecting the safety of an inmate or other person.

### **1.1.3 Legislation related to supply reduction**

The Introduction of the EU Framework Decision 2004/757/YOS states that by virtue of subsidiarity European Union action should focus on the most serious types of drug offences. The exclusion of actions pertaining to personal consumption from the scope of this Framework Decision does not constitute a Council guideline on how Member States should deal with these cases in their national legislation.

Amendment 928/2006 to Section 50 of the Penal Code regarding drugs and the related Decree 1014/2006 defined an act abetting an aggravated drug offence by a member of organised crime when the drug in question is considered an extremely dangerous drug, the drug consignment is large, or the act is committed to pursuit significant financial advantage. If the act abetting a drug offence can be considered aggravated when assessing the overall situation, the perpetrator should be sentenced to a minimum of four (4) months and a maximum of six (6) years in prison. The same amendment defines the cultivation and transportation of drugs, as well as consigning someone to transport drugs and attempting to abet a drug offence as being drug offences. Additionally, the sentences concerning legal persons are applied to legal persons having committed a drug offence or aggravated drug offence or participated in the preparation of such offence.

According to the amendment to the Police Act concerning information acquisition (525/2005), technical audio surveillance and technical visual surveillance in prisons requires that the person, based on his or her behaviour or otherwise, can be reasonably suspected of committing an offence, such as a drug-related offence. On similar grounds and to prevent direct threat to life or health, telecommunications monitoring can be targeted at a telecommunication subscription, telecommunication address, or telecommunication terminal used or presumably used by the person. Such subscription or terminal can be temporarily closed and permission can be granted to receive information on those mobile stations from which specific information is entered through a base station close to a specific location to a telecommunication system. The requirement for undercover operations is still an aggravated drug offence and the requirement for fictitious purchasing is that it is necessary to detect an offence for which the maximum penalty is at least 2 years' imprisonment (for instance drug offence).

#### **1.1.4 Legislation related to international co-operation**

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

#### **1.1.5 Legislation related to drug research**

No new information available.

### **1.2 Institutional framework, strategies and policies**

#### *Guidelines and co-ordination of drug policy in 2006*

The Drug Policy Action Programme 2004–2007, which was approved during Prime Minister Matti Vanhanen's first term of office (2004–2007), presents three different visions regarding the development of the drug situation by the year 2007: a rising, stable or decreasing trend in development (Ministry of Social Affairs and Health 2004).

The programme's 14 objectives relate to the co-ordination of drug policy, co-operation among authorities in different parts of administration, the availability of drug treatment services in various situations, the increase of expertise, the development of methods to use in substance abuse work, diversifying penal procedures, the development of local co-operation with non-governmental organisations, the development of drug legislation, the increase of international activities and co-operation with neighbouring areas, and investment in drug research. The programme's final report was presented in the spring of 2007 (Ministry of Social Affairs and Health 2007a)<sup>1</sup>.

The resolution of Prime Minister Matti Vanhanen's second Government, which took office in March 2007, concerning co-operation on the drug policy for 2008–2011 was drafted in the summer of 2007, and initially it comprises the same general goal pertaining to the prevention of the use and distribution of drugs as the previous programme, i.e. the financial, social and individual detriments and costs caused by drug use and prevention be kept as minor as possible. The specific details of the programme are, for the most part, the same as in the previous programme. (Finnish Government 2007).

The programme proposes that (1) the drug policy co-ordination group continue its work and that it reports regularly to the Government about the drug situation, (2) the status of substance abuse prevention be consolidated in the structural reformation of municipalities and services, and that early intervention be established as part of the realm of health and welfare services, (3) the prevention of drug-related crime be targeted especially toward international crime, but at the same time guidance for treatment provided by police be developed, (4) drug treatment services be developed

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<sup>1</sup> Cf. more detail on the next page "Implementation of drug policy".



according to the general principles of health care by fairly offering people the services they need, (5) the substance abuse rehabilitation of inmates and their adjustment into society be improved by planning their sentence term on an individual basis, by increasing the relative number of inmates placed in open institutions and by developing post-care for released inmates.

In addition, (6) active participation in the planning and implementation of the EU's common foreign policy will continue, and there will be participation in co-operation with the United Nations, the European Commission and neighbouring regions, and furthermore (7) long-term investigative monitoring of the drug situation will continue, drug research and training for researchers will be promoted, and the Academy of Finland's Intoxicants and Addiction research programme will be implemented in 2007–2010.

### *Implementation of drug policy*

The final report (Ministry of Social Affairs and Health 2007a) for the Drug Policy Action Programme of Prime Minister Matti Vanhanen's first term of office (2004–2007) states that the results obtained during the term in question clearly indicate a stable trend in development.

According to estimations in the scenario of moderate development of the programme's initial part, a slight increase in those who occasionally experiment with drugs could still be included in the model if the situation remains the same or improves in relation to use on a more regular basis and problem drug use and its adverse effects. It is essential that no changes occur in those who recruit as regular drug abusers. As regards problem drug use and the harm associated with it, society's trends in well-being, especially the employment situation and opportunities in education, should promote positive expectations for the future. The scenario suggests the stabilisation of the judicial and societal conditions in the areas around Tallinn and St Petersburg as a prerequisite in impeding the availability of drugs. According to the scenario, Estonia's EU membership favours this view on development.

However, the scenario's estimates concerning the link between a decrease in drug use and the development of negative attitudes toward the use of alcohol and binge drinking do not seem to be materialising, and even if the scenario of moderate development did materialise, it is difficult to say whether or not stability would be permanent because the drug markets and culture can change quickly.

Fourteen different sets of measures were presented for establishing the direction of development suggested in the programme. Estimates for the year 2007 considered how well the measures succeeded. Estimates stated that (1) the drug policy co-ordination group has established its position, (2) the Ministry of Social Affairs and Health has appointed a team comprising authorities for overseeing drug precursors, (3) forms of co-operation have been developed among various professionals involved in the welfare of pupils and students to prevent the abuse of drugs and other intoxicants and (4) among social welfare, the police, and prosecutors in helping drug abusers obtain treatment. Furthermore, municipalities have compiled safety plans across administrations and joint criminal analysis units have been established for the police, Customs and Border Guard to intensify procedures in preventing serious crime.

(5) A quality framework for substance abuse services has been drawn up and the execution of it has been monitored. Substance abuse services are improved in 2007

due to additional funding amounting to 3.5 million euros. Various organisations have prompted the compilation of the Current Care guidelines for the treatment of drug abusers. Furthermore, decrees have been enacted concerning the responsibility of municipalities in offering health counselling. (6) Attention has also been given to the substance abuse rehabilitation of inmates and helping them adapt to society, in connection with both juvenile punishments and community sanctions. (7) Quality criteria for substance abuse prevention have been established and opportunities for training for work in the field of substance abuse have been checked into. (8) Comprehensive education has advanced in this area in the form of health education, and (9) co-operation among authorities in substance abuse work on the local level has been promoted by creating a municipal-specific contact person network in preventing substance abuse.

(10) Finland's Slot Machine Association has sponsored non-governmental organisations for substance abuse with 25 million euros a year as well as with 2 million euros for the promotion of health. (11) Drug legislation concerning criminal justice and the Medicines Act has been revised, but the complete revision of the Narcotics Act as stated in the Drug Policy Action Programme in Finland 2004–2007, which would involve the implementation of all of the changes in Community legislation, has not taken place.

(12) As regards international co-operation, Finland has emphasised the role of multi-national organisations and actively participated in drug policy collaboration with the EU, the UN, the Council of Europe, and the Nordic Council of Ministers. However, Finland's EU Presidency of the Council in the latter half of the year 2006 posed a particular challenge to the country with regard to international drug policy collaboration.

Significant actions concerning drug policy during Finland's EU presidency included executing the EU Drugs Action Plan 2005–2008, preparing for the 50<sup>th</sup> conference of the UN Commission on Narcotic Drugs (CND) held in spring 2007, and organising tripartite dialogues between the US, Russia, Latin America, the Caribbean, and the Ukraine.

During its presidency, Finland led the EU's Horizontal Working Party on Drugs and placed particular emphasis on co-operation with Russia. European non-governmental organisations were invited to attend a conference for national drug authorities in EU countries.

Finland took advantage of co-operation with the Council of Europe Pompidou Group during the country's EU presidency and in so doing emphasised the full utilisation of the expertise in European institutions. The aims of the *Moving Forward Together* conference on drug abuse held in Turku included improving co-operation between social welfare and health authorities and the police, making work among drug authorities more effective, as well as expanding co-operation with the EU's eastern neighbours. One outcome of the conference involved the establishment of a European network of cities, which was approved in the Council of Europe's ministerial conference 28 November 2006 as part of the Pompidou Groups's new work programme.

Finland also made contributions to unifying EU activities in the UN Commission on Narcotic Drugs (CND) during its EU presidency. A resolution supporting activities in the laboratory of the United Nations Office on Drugs and Crime (UNODC) was prepared for the CND's next conference. The aim is to strengthen the drug control infrastructure in developing countries.

(13) Support for work against drugs with regard to neighbouring area and developmental co-operation continued with the UNODC's 2-year follow-up project concerning the drug situation in northwest Russia. Finland funded the project, which was launched in 2006.

(14) The Academy of Finland's three-year, 5.5-million-euro Intoxicants and Addiction research programme has advanced drug research.

A framework for drug policy 2008–2011 has been created on the basis of this follow-up report and on the mentioned scenario of moderate development. The guidelines set forth by the Government emphasise the continuation of sustained, grass-roots work and a unified approach to drug policy where actions, geared toward reducing the supply and demand of drugs, are in balance and compatible with each other.

### *Evaluation of drug policy*

According to the dissertation of Tuukka Tammi (2007), two different views on the drug issue collided within the 1997 Drug Policy Committee in Finland; the police authorities advocated a drug-free society and insisted on policies of strict control but the social welfare, health and criminal policy alliance was in favour of harm reduction. The Committee produced the first national drug strategy in 1997. The general objective of harm reduction was not solely based on public health concerns. The ideological roots of the concept can be traced back to the tradition of a rational and humane criminal policy that was first adopted in the 1960s and 1970s according to which criminal and social policy primarily aims at minimising social harm.

According to the study, minimising harm has not created a threat to drug prohibition policy; rather, it has become a part of it. Minimising harm through the establishment of syringe and needle exchange points (health counselling centres) and extended substitution treatment has meant new, specialised services founded upon medicine and the added effort of medical professionals in the treatment of drug-related problems. Penal control of drug use has at the same time become more effective. Therefore, minimising harm has not meant a step toward more liberal drug policy, nor has it debilitated the traditional policy based on complete drug prohibition. Instead, minimising harm combined with punitive prohibition policy forms a new type of two-track paradigm for drug policy. (Tammi 2007).

Models for substance abuse work in cities have been examined in the Helsinki area by assessing residents' opinions about the nature of the drug and alcohol problem and models for solving the problem in which the activities of day centres for drug users (Törmä & Huotari 2005b; Forssèn 2005), health counselling centres (Törmä & Huotari 2005a; Perälä 2007a, 2007b) and models for social housing management (Haapanen 2004) were analysed.

Of those interviewed in the study depicting the opinions of city residents, 72% did not feel substance abusers posed any problems to them. However, they emphasised the damage substance abusers cause to the area's general image and safety.<sup>2</sup> A clear majority suggested significantly increasing the number of security guards and policemen as a way to reduce the safety risks and risk of harm. A third of the respondents mentioned only drug users as the source of certain harm and one-fifth

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<sup>2</sup> The study involved a street poll of fifty-three people spending time in a shopping centre. Additionally, 11 entrepreneurs in the area were interviewed.

mentioned only alcoholics as the source. However, 60% of the respondents did not associate harm with any of the service units. (Törmä et al. 2007).

According to estimates, models involving institutionalised drug treatment no longer satisfy the demands of the present multifaceted alcohol and drug culture; rather, treatment must actively connect with the client. Evaluative research suggests that services be developed to allow clients with the weakest resources to receive basic services at units which have a low threshold. Satisfying basic needs by offering enough safe, protective places to rest during the day as well is one way to reduce disorder. Finding a place for substance abusers, who do not have a permanent place of residence, to stay is one of the basic requirements in reducing intoxicant-related disorder. Staggering support according to the client's resources and history of residency is important with regard to living on his/her own. Considering geographical location is also important in planning substance abuse services, for example in the immediate vicinity of areas where the risk of contracting HIV is high. People with the most serious substance abuse and mental health problems do not seek out even low-threshold services. Outreach work should be developed for these people possibly with the support of peer groups.

### 1.3 Budget and public expenditure

#### *Costs of the harm caused by drugs*

In 2005, the costs related to the abuse of drugs and pharmaceuticals amounted to 200–300 million euros in direct costs and 400–800 million euros in indirect costs (Table 1). Social costs and the costs of crime control accounted for the largest portion of the direct costs. The largest portion of indirect costs came from the value of life lost due to premature death.

*Table 1. Costs of the harm caused by drugs by main group in 2004 and 2005, EUR million*

	2004		2005	
	Min	Max	Min	Max
<b>Direct costs</b>	<b>191</b>	<b>272</b>	<b>190</b>	<b>274</b>
<i>Health care costs</i>	33	63	24	54
<i>Social costs</i>	63	69	66	71
<i>Crime control</i>	51	65	53	69
<i>Property damage, research, substance abuse prevention</i>	44	75	47	80
<b>Indirect costs</b>	<b>367</b>	<b>803</b>	<b>363</b>	<b>796</b>
<i>Production losses</i>	61	102	58	97
<i>Value of life lost due to premature death<sup>3</sup></i>	306	701	305	699
<b>Total</b>	<b>558</b>	<b>1,075</b>	<b>553</b>	<b>1,070</b>

Sources: Yearbook of Alcohol and Drug Statistics 2006 and 2007, STAKES.

<sup>3</sup> The value of life lost is calculated so that it equals the alternative costs that would accumulate if the person became completely disabled and would have to be institutionalised for the rest of his/her life.

## 1.4 Social and cultural context

### *Attitudes to drugs and drug use*

According to the 2006 Youth Barometer<sup>4</sup>, 23 per cent of men and 14 per cent of women agree or somewhat agree that it is acceptable to use mild drugs, such as cannabis products. Younger men have tougher attitudes towards mild drugs: 18 per cent of 15–19-year-old men found the use of mild drugs acceptable, whereas the corresponding figure for 20–25-year-old men was 27 per cent. There were no differences between different age groups among women. (Myllyniemi 2006.) The differences between the attitudes of men in different age groups reflect the results of studies on drug use: it would appear that the young generation born at the end of the 1980s is less interested in experimenting with drugs than the older age groups are (see Section 2).

According to the Health Behaviour Survey among the Finnish Adult Population<sup>5</sup> (Helakorpi et al. 2007, Piispa et al. 2007), 78 per cent of Finns considered in spring 2006 drug use to be a serious or very serious problem, whereas the corresponding figure was 90 per cent five years ago. A clear indication of more lenient views is also the fact that the proportion of those who consider drug use a very serious problem (38%) dropped by 20 percentage points between 2001 and 2006. The changing trend was also shown in the health behaviour survey when assessing the future development of the level of drug use. In 2006, thirty-eight per cent considered that drug use would remain at the current level; in 2001, the corresponding figure was only 11%. This change reflects the stabilisation of the drug situation. However, the changes in Finns' opinions do not mean that drug use is culturally acceptable, as four out of five respondents still considered drug use a very serious or serious problem.

In the spring 2006 survey, the proportion of women who considered drugs a serious problem came to 81%; the corresponding figure for men was 74%. The influence of age on opinions is also evident: the older the respondent, the more serious he or she considered the drug situation. Correspondingly, 92% of pensioners and only 57% per cent of students considered drug use a very serious or serious problem. The number of those who consider drug use a very serious problem has dropped in the 2000s (58% in 2001, 38% in 2006) but now the downward trend seems to have stopped.

### *Attitudes to problem drug users*

A survey was carried out in January 2007 concerning the attitudes of Finns toward drug addicts<sup>6</sup>. Results indicated that the majority of Finns would be willing to help a close relative or friend who was a drug addict. Eighty-one per cent of the respondents answered 'agree' or 'somewhat agree'. More than half of the respondents also felt that employers should take part in organising treatment for an employee with a drug problem. In addition to the desire to help, most of the respondents (87%) felt that drug

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<sup>4</sup> For the Youth Barometer, 1,900 persons aged 15–29 were interviewed in March 2006. The samples were randomly chosen from the population register. Quotas were determined for gender, region, language and age so that their proportion of the material corresponded with the proportion of variables in the basic group.

<sup>5</sup> Data for the 2006 study included a nationally representative random sample of 5,000 Finns 15–64 years of age, which was obtained from the population register. The questionnaire was mailed out in April 2006. Those who did not respond to the questionnaire were sent three new questionnaires if necessary. A total of 3,255 people responded to the questionnaire.

<sup>6</sup> Schering-Plough Oy carried out a survey, which examined the attitudes of Finns toward drug abusers. Data was gathered through phone interviews in January 2007. There were 500 respondents to the questionnaire, which represented the typical Finn in terms of age, sex, and place of domicile.

addiction can be cured. Seventy-three per cent thought that society should allocate more resources for treating people with drug problems. Drug abuse is seen as a societal problem as only a third (32%) of the respondents felt that drug addiction is completely the fault of the drug user. However, reasons for using drugs were usually seen as deriving from the individual himself/herself. Despite the desire to help and positive attitudes toward treatment, Finns react rather dubiously to drug users. Respondents felt that drug users spread infectious diseases (80%), and, in addition, drug users are also seen as frightening (66%) and unreliable (78%). (Sormunen 2007).

## 2 Drug use in the population

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

Studies show that the trend in drug experimentation of the 1990s was set in motion by men, followed by women in the second half of the decade. The proportion of those having tried drugs during the past year grew until the end of the 1990s, after which the trend clearly levelled off. The same phenomenon can be observed among young people. It would appear that the young generation born at the end of the 1980s is less interested in experimenting with drugs than the older age groups. Nonetheless, drug experimentation and use are still more prevalent than at the beginning of the 1990s. (Hakkarainen & Metso 2006.)

According to the 2006 population survey, 13% of 15–69-year-olds had experimented with cannabis sometime in their life. The level was nearly the same as in the 2002 survey and three percentage points higher than in 1998. The percentage was 12% among women and 16% among men.

According to the 2003 ESPAD survey, 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 (Ahlström et al. 2004).

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

### 2.1 Drug use in the general population

According to the 2006 population survey, 13% of 15–69-year-olds had experimented with cannabis sometime in their life.<sup>7</sup> The level was nearly the same as in the 2002 survey and three percentage points higher than in 1998. The percentage was 12% among women and 16% among men. The proportion of 15–34-year-olds (22%) remained the same in 2002 and 2006. However, changes have taken place within the latter age group: between 2002 and 2006, the proportion of 15–24-year-olds decreased by 6 percentage points whereas the proportion of 25–34-year-olds grew by the same amount. Thus, it seems as if cannabis has lost some of its significance as part of youth culture whereas the generation that experimented with drugs at the turn

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<sup>7</sup> The target group of the study comprised 15–69-year-old Finns, among whom a random sample of 5,500 people was chosen using the Finnish Population Information System. The inhabitants of Åland, people living in institutions and those devoid of a permanent home were excluded from the study. Half of the sample consisted of 15–34-year-olds. The aim of the oversampling was to focus the study on the most active population group in terms of drug use. In the analysis, the oversampling of young people was balanced by weighting. 3,029 people answered the postal questionnaire.



of the millennium seems to continue using drugs at an increasing rate. (Hakkarainen & Metso 2007.)

Three per cent had tried cannabis during the past year, which corresponded to the 1998 and 2002 survey results. The largest increase was seen among 25–34-year-old men: the proportion of experimenters doubled between 2002 and 2006. One per cent of adults had used cannabis during the past month: 4% of the 15–24 age group and 3% of the 25–34 age group. The percentages for men were somewhat higher than they were for women.

*Table 2. Lifetime and 12-month prevalence of cannabis use by age group (%)*

	1992	1996	1998	2002	2004	2006
<b>Lifetime prevalence</b>						
All	5	8	10	12	12	13
15–24	12**	14*	19	25	18	19
25–34	10	16	19	19	22	25
35–44	4	8	8	11	13	16
45–69	1	2	3	4	5	6
<b>12-month prevalence</b>						
All	1	2	3	3	3	3
15–24	6**	9*	10	11	8	9
25–34	2	3	3	4	5	7
35–44	0	1	0	1	2	2
45–69	0	0	0	0	0	1

\*\*18–24 yrs    \*16–24 yrs

Source: Kontula & Koskela 1992; Kontula 1997; Drug and alcohol surveys 1998, 2002, 2004, 2006, Stakes.

For drugs other than cannabis, the percentages of those having experimented with drugs during their lifetime varied from 2% for amphetamines to 0.6% for opiates. One point five per cent had experimented with ecstasy and 1.0% with cocaine. The group that had experimented the most with amphetamines (9%), ecstasy (5%) and cocaine (3%) were 25–34-year-old men. For all substances and among all age groups, fewer than 2% reported having tried a substance during the past year, and only a few individuals reported having tried a substance during the past month. (Hakkarainen & Metso 2007.)

Cocaine use in Finland can be regarded as a relatively minor problem. With respect to stimulants, amphetamines and ecstasy dominate the market. They cost considerably less and they are more readily available. Therefore, the use of cocaine is confined to the exclusive recreational use of a very small number. Crack cocaine has not been encountered at all in Finland. (Salasuo 2006b.)

Hypnotics, sedatives and analgesics had been used for non-medicinal purposes by 7% of the respondents during their lifetime, by 3% during the past year and by 2%

during the past month. Age and gender differences were not significant in the case of pharmaceuticals. (Hakkarainen & Metso 2007.)

According to the results of the annual Health Behaviour Survey among the Finnish Adult Population<sup>8</sup> for 2006, 14% of both men and women know someone who had experimented with drugs during the past year. For men the percentage was 13% and for women 15%. The percentage was higher (around 25%) in the younger age group of 15–34-year-olds, and about 10% of this age group had been offered drugs.

According to earlier health behaviour surveys, the proportion of people who knew someone who had experimented with drugs grew between 1996 and 2001 among all respondents from 12 to 20 per cent. In the two youngest age groups, the proportion grew from a third to more than 50%. However, since 2001 these proportions have decreased, and at an accelerated rate in 2005 and 2006. The proportion of 15–24-year-olds who knew someone who had experimented with drugs was lower than in 1996–1997. The same decrease was seen among 25–34-year-olds in 2006.

According to the 2005 health behaviour survey, acquaintances having experimented with drugs were clearly more common in cities. Regionally, people from Southern Finland (the region of Uusimaa) and big cities knew more drug users than people elsewhere. Three per cent of respondents knew more than five users but in the youngest age group, the percentages were 9% for men and 11% for women. (Natunen et al. 2006.)

The results confirm that the drug situation in Finland is calming down, most evidently among urban youth, who are the most influenced by developments in the culture of drug use. The new drug experimenters came from the age groups that were young at the end of the 1990s. As the results are similar elsewhere, the status of drugs seems to change along with the fluctuating trends in youth culture.

## 2.2 Drug use in the school and youth population

According to the ESPAD survey of school pupils<sup>9</sup> (Ahlström et al. 2004), 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. According to ESPAD results, 7.5% of 15–16-year-olds had experimented with some illegal drug during the past year, and 2.5% during the past month.

According to School Health Promotion Studies<sup>10</sup>, drug experimentations have not increased in the 2000s. In 2004–2005, six per cent of 15–16-year-olds had

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<sup>8</sup> The Health Behaviour Survey among the Finnish Adult Population comprised a random sample of 5,000 Finns aged 15–64. In the 2006 survey (the results of the 2005 survey are shown in parenthesis), the response percentage was 65% (66%); 58% (59%) for men and 73% (73%) for women. (Piispa et al. 2007; Natunen et al. 2006.)

<sup>9</sup> The latest of these surveys was the 2003 ESPAD survey, which involved 200 schools and 3,321 pupils in 9th grade of secondary school. Data was collected with the same compilation method as in the 1995 and 1999 surveys. The response percentage was 92% in 2003. (Ahlström et al. 2003).

<sup>10</sup> For the School Health Promotion Study the data are gathered in the same municipalities every two years using the same questionnaire at the same time of year. The survey is directed at 8th and 9th graders in secondary schools and 1st and 2nd graders in upper secondary schools. From 1996–2006 almost 400 municipalities have participated in the study, and 46,000–82,000 pupils have filled in the questionnaire annually. The combination of the data from two consecutive years reveals the situation for the whole country. (Luopa et al. 2006b.)

experimented with drugs sometime in their life, whereas at the turn of the century the corresponding figure was 9%. Experimentation with illegal drugs also decreased among 17–19-year-olds: 13% in the 2004–2005 study compared with 15% in the 2000–2001 and 2002–2003 studies. Boys had experimented with illegal drugs more than girls had. In the older age groups, the prevalence of drug experimentation varied significantly by region. (Luopa et al. 2006a.)

The data for the 2006 School Health Promotion Study were gathered in three provinces. According to the results, 6% of 15–16-year-olds and 12% of 17–19-year-olds had used marijuana or hashish sometime in their life. The proportion of those who had used the said drugs at least 5 times was approximately 2–3% in all other age groups except for boys in the 2nd grade of upper secondary school, among whom the proportion was 5%. In the case of other drugs, the proportions in all age groups remained at one per cent. (Luopa et al. 2006b.)

The results of the study indicated that wellbeing had generally increased among young people. Their living conditions and school environment had improved or remained stable. Compared to the situation eight years ago, health symptoms (fatigue, depression, headache, neck ache etc.) have increased considerably but with the exception for an increase in fatigue, the negative developments have not continued over the past few years. The past few years have also seen a positive trend in substance abuse: cigarette smoking and drug experimentation have decreased and abstinence has gained popularity.

### **2.3 Drug use among specific groups**

The situation among conscripts has been monitored systematically by conducting surveys since 1968. In the 2005 survey, 20% of the respondents reported having tried some drug, most often cannabis. In the same year, 0.7% of conscripts discontinued their military service for health reasons based on a drug diagnosis. In 2002–2004, a random sample of five per cent of the salaried personnel of the detachments was tested. According to the results, drugs (amphetamine) were detected in only one test out of 2000. The results may have been partly affected by the fact that information concerning the test was released in advance, which to some degree may have led to the internal selection by the target group. However, drug use appears to be extremely rare among Defence Force personnel or people who pursue a military career, at least compared to the results from many other countries. (Meririnne et al. 2007.)

The study by Obstbaum (2006) compared criminal behaviour between Finnish-speaking and Swedish-speaking young people<sup>11</sup>. Young people aged 15–16 years were asked among other things about the use of marijuana and hashish, the use of pharmaceuticals for intoxicating purposes and the use of other drugs. The results revealed that the use of marijuana or hashish was more common among Finnish-speaking young people. Around 7% of those who had used marijuana or hashish had financed it by illegal means.

According to a survey conducted in Åland, only 5% of its inhabitants had used cannabis sometime in their life.<sup>12</sup> The figure has gone down from 8% in 2001. The result is clearly lower than the estimated proportion of people who have tried cannabis

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<sup>11</sup> In the spring of 2004, the National Research Institute of Legal Policy carried out a questionnaire survey on criminal behaviour to which 5,142 Finnish-speaking and 1,137 Swedish-speaking 9th graders responded.

<sup>12</sup> The study was conducted in August 2005. Questionnaires were sent to 609 randomly chosen 18–69-year-olds registered as domiciled in Åland on 5.8.2005. The response percentage was 70%.

in Finland in general and corresponds to the differences in the total consumption of alcohol. In continental Finland, the total consumption of alcohol per inhabitant is twice as high as it is in Åland. Young people reported more instances of cannabis use than older people did. The use of cannabis also correlated with a person's total consumption of alcohol and to a lesser degree with cigarette smoking. On the other hand, there were no significant gender differences in cannabis use. (Lilja & Jordas 2006.)

### 3 Prevention

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

In municipal substance abuse strategies, preventive substance abuse work is usually seen as a continuum including prevention, early intervention and treatment (Romppanen 2005). According to a new concept definition, substance abuse work is divided into preventive and corrective substance abuse work. Municipal substance abuse strategies usually address intoxicating substances as a whole, without making a distinction between drugs and alcohol.

Quality criteria have been determined for substance abuse prevention (STAKES 2006). The criteria are qualitative and suited to the prevention and reduction of harm related to substance abuse<sup>13</sup>. The practical implementation of the quality criteria is considered a central tool in improving the quality of substance abuse prevention. The quality criteria do not separate drug prevention from other substance abuse prevention.

Publicly funded substance abuse prevention requires that it is effective. The methods employed in substance abuse prevention are generally divided into the more known and established means (often internationally used) and those developed by organisations themselves. One study has shown that approximately 70 per cent of organisations are considered to pay sufficient attention to evaluating the effectiveness of substance abuse prevention, and only 40 per cent are considered to use systematic methodology in their evaluations.

School curricula regulate health education as a separate subject. Substance abuse questions are key aspects of this subject. School curricula and pupil and student welfare services should also include drug prevention. For example, strategies for the prevention and treatment of substance abuse should be included in the local curriculum.

Furthermore, substance abuse prevention targeted at young people is carried out in workshops that have been created to activate young unemployed people. Youth workshops are a form of early intervention, and they aim at preventing the exclusion of young people from education.

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

Anti-drug organisations operate under a joint drug programme<sup>14</sup>. The organisations aim to promote discussion and provide information on drugs and drug use as well as

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<sup>13</sup> Criteria: focus of the work, target group, degree of effectiveness, knowledge base, values, realistic objectives, compatibility of the objectives with other strategies, operational models, resources, monitoring and evaluation, balance in the different subsections and relationship to the original situation.

<sup>14</sup> Organisations' drug programme 2006–2008, see Section 1.

on the causes and consequences of drug use. In addition, the organisations attempt to influence people's attitudes, organise peer support activities and provide post-care for substance abuse patients.

Drug prevention measures for private individuals include drug information services, virtual discussion forums and self-testing services for evaluating one's own substance abuse. Web-based expert forums have been developed for dissemination of information and training of professionals.

### 3.1 Universal prevention

Since 1992, the Finnish Centre for Health Promotion has conducted a Health Barometer survey with municipal and organisation managers on the effort to promote health and its related expectations for the future. In the 2007 survey<sup>15</sup>, substance abuse prevention was considered to be of great significance in the near future. In the opinion of the municipal health managers, the most important active content in the promotion of health was to promote non-smoking and healthy nutrition as well as substance abuse prevention; the answers given by the municipal managers were to promote traffic safety and working ability as well as to raise the level of exercise. (Parviainen et al. 2007.)

The respondents from the municipalities forecast that in the near future, greater significance will be placed on the promotion of working ability, substance abuse prevention and an increased level of exercise. According to those responding from organisations, the most important active content at the moment is to support social networks, prevent marginalisation and to reinforce the factors that support mental health. (Parviainen et al. 2007.)

A thesis published in 2007 studied the way in which drug and alcohol education projects had received funding in Finland between the years 1992–2001 and how they had changed during the research period<sup>16</sup>. The study focused on funding applications by drug and alcohol education projects. The sample consists of the 97 projects funded by the Ministry of Social Affairs and Health and Finland's Slot Machine Association RAY in 1992, 1995, 1998 and 2001.<sup>17</sup> The project plans were also scored in accordance with EMCDDA's objectives for a good (drug) education project. The project practices were not studied; rather, they were examined on the rhetorical basis of their funding application plans. (Hippi 2007.)

The role played by organisations in implementing drug and alcohol education projects has become increasingly important. This reflects the general change underway in social policy, which is seen in the fact that various services are being privatised and purchased from a third sector party. The trend financially for increasingly larger projects is equally as clear as the amplified role of Finland's Slot Machine Association in funding drug and alcohol education projects. All these factors are in line with the

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<sup>15</sup> The survey interviewed 100 municipal health managers, 100 municipal managers, 60 local branch managers of the Finnish Centre for Health Promotion and 60 managers of local branches of YTY, The Cooperative Association of the Social and Health Sectors.

<sup>16</sup> In 2006, Finland's Slot Machine Association RAY granted approximately 12 million euros for substance abuse prevention.

<sup>17</sup> Of the projects, 59% were applications by organisations and 41% were by the public sector. Some of the projects involved activities that focused on augmenting the necessary preparedness of professionals in the sector when encountering clients with drug and intoxicant problems.

objectives of the substance abuse policy as is the fact that as a target group, emphasis is being placed on young people. (Hippi 2007.)

The way in which the intervention process has an effect and earlier experiences of the way in which the planned intervention was realised were barely handled at all, and there was also scanty information on the extent of the problem and the need for evaluation resources. Although alcohol continues to be the largest substance abuse problem in Finland, the projects focused on intoxicants in general. For instance, the mixed use of alcohol and pharmaceuticals had hardly been raised as a separate project. There was also more informed knowledge about drugs, which probably reflects the increased discussion concerning the use of drugs and perhaps the general spread of their use. (Hippi 2007.)

In the conclusion, the researcher recommends a change to project funding in that the decision to grant funding would include the possibility and obligation to conduct a study, or at least to produce a report, on the extent and quality of the harm caused by intoxicants in the target area. This should be done before the start of a project as well as at the end of the project. Thus, it would be possible to gain at least indicative information on the effectiveness of a project. When planning projects, it would be worthwhile utilising the guidelines issued by EMCDDA concerning the characteristics of a good project. This would provide the ready framework for a good drug and alcohol education project, and individuals involved in implementing a project would not need to think about the specific elements of projects. (Hippi 2007.)

The activities of organisations receiving funding were evaluated in 2007 using the European Quality Award model.<sup>18</sup> The model is divided into six parts: (1) Operational Principles and Strategy (according to quality criteria for substance abuse prevention: the focus of work generally and more specifically at various levels of implementation and for predetermined groups); (2) Implementation and Organisation of Activities (ensuring the knowledge base of the work, determining values and selection of the method of implementation); (3) Fruitfulness (the objective in relation to the focus of substance abuse prevention, monitoring and evaluation, balance in the factors underlying quality and results in relation to the initial situation); (4) Expertise (evaluating and utilising the expertise of personnel); (5) Partnerships and Resources (objective-driven co-operation and determination of the required resources); (6) Leadership (the fruitfulness of the planning implementation and organisation of activities). (Wennberg et al. 2007.)

Overall, the role of substance abuse prevention in relation to the other activities of organisations is considered very clear. Among the organisations that have carried out corrective work in substance abuse, a few of those replying found their role somewhat unclear. The provision of information as well as training and consulting are indisputably the leading forms of the work being undertaken. Other methods that were employed were peer support activities, counselling centres, telephone and email counselling, interactive network services, intervention, games, network co-operation, courses and contacting risk groups and substance abusers (early intervention). (Wennberg et al. 2007.)

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<sup>18</sup> The materials used in the evaluation included interviews with representatives of organisations as well as with officials from the Ministry of Social Affairs and Health, analyses of annual reports from organisations and documents relating to the working methods employed in substance abuse prevention, an electronic questionnaire and intensive case studies of those materials as well as other supplementary documentation. The evaluation involved a questionnaire that combined self-assessment and data collection; the questionnaire was forwarded to the contact persons of the organisations. A request was made to forward the questionnaire to those people who were responsible for or who implemented substance abuse prevention in the organisation in question. A total of 53 people responded to the questionnaire. An interactive course on the results was arranged at the end of the evaluation process.

Publicly funded substance abuse prevention requires that it is effective. The methods employed in substance abuse prevention are generally divided into the more known and established means (often internationally used) and those developed by organisations themselves. In practice, it is only possible to find research and evaluation data on the effectiveness of the original model when evaluating the more known and established methods. Approximately 70 per cent of the respondents considered that the organisations paid sufficient attention to evaluating the effectiveness of substance abuse prevention. However, only 42% of the respondents used systematic methodology in their evaluations. (Wennberg et al. 2007.)

A survey on substance abuse prevention in the Province of Southern Finland in January 2007 involved all the 86 municipalities in the province. The survey was based on the national alcohol programme 2004–2007, which provides municipalities with guidelines on local substance abuse prevention and services. Through partnership agreements with the various parties involved in substance abuse prevention in the alcohol programme, the municipalities undertake to update their substance abuse strategy and draft a concrete plan of action for the alcohol programme for the near future. The partners in the alcohol programme are committed to setting clearly defined objectives for the work to reduce the harm caused by alcohol as well as to monitoring the fruitfulness of that work. The partners work in their own sectors and in line with their own resources to reduce the harm caused by alcohol. Regional co-ordination is through the State Provincial Office. (State Provincial Office of Southern Finland 2007.)

A total of 64 replies were received<sup>19</sup>, and the municipalities not responding to the questionnaire were often small. Of those municipalities responding to the questionnaire, 39 had a substance abuse working group where in most cases, the represented parties were the social and health, youth and education services and the police. The cultural office was seldom involved. A total of 32 municipalities had drawn up a municipal substance abuse strategy or programme. Fourteen municipalities were planning a strategy and the same number were updating their strategy during 2007. The majority of the municipalities, 33 altogether, had included substance abuse prevention in the job descriptions of some officials. Seventeen municipalities had either permanent or part-time staff working in substance abuse prevention. (State Provincial Office of Southern Finland 2007.)

Based on the questionnaire, only 14 of the 63 municipalities that responded to the questionnaire appeared to pay particular attention to substance abuse prevention in their political decision-making and allocation of resources. The conclusion states that only the long-term plans presented in the programme could provide the vision for a municipality's substance abuse prevention and the opportunity to commit municipalities to substance abuse prevention. (State Provincial Office of Southern Finland 2007.)

It is recommended that an organisation draw up a programme for substance abuse prevention and treatment guidance at the workplace. The programme should describe an organisation's objectives, ballpark rules, content, measures and distribution of duties on issues related to substance abuse. Its objective should be an intoxicant-free working life, and it can be incorporated into the occupational safety programme.

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<sup>19</sup> The survey involved the use of a questionnaire that included questions about the municipal substance abuse working group, the substance abuse strategy and the resources for substance abuse prevention. The questionnaire was addressed to the social and basic security managers in the municipalities of the Province of Southern Finland. The final response rate amounted to 74%.



According to the Occupational Health Care Act, an employer is legally required to draft a substance abuse programme if employees are given drug tests at the workplace. The aim of the programme is to give an employee the ability to regulate his or her substance use to a reasonable, risk-free level. At the same time, an employee should not need to suffer from the use of substances by other employees. As far as the employer is concerned, an intoxicant-free working life will ensure uninterrupted production, and hangovers and tiredness will not result in financial losses.

A questionnaire in 2007 studied the way in which actors working in substance abuse prevention had used the quality criteria that were drawn up in 2006 and whether these criteria had become available to the parties involved<sup>20</sup>. In addition, the questionnaire aimed to provide information that would lead to further development of the criteria. A total of 87% of the respondents were familiar with the quality criteria guide and 54% had used it. The majority of the respondents stated that the lack of time was the reason they had not utilised the criteria. With respect to education, some of the lecturers did not include substance abuse prevention in their teaching at that time and therefore, they had not utilised the quality criteria. For many, the matter was completely new. (Hemmilä 2007.)

The majority of the respondents thought that the quality criteria served as a tool when an idea was developed into a project or way of working. Most were also of the opinion that the quality criteria helped them to see the big picture in substance abuse prevention. The answers also brought forth the fact that the quality criteria made it easier to regularly monitor and self-assess the work of substance abuse prevention. (Hemmilä 2007.)

Although the quality criteria were proven necessary and applicable, some respondents felt that the criteria were poorly explained and too broad in scope. There was uncertainty concerning the applicability of the criteria, and the criteria were not used in full so therefore, a more concise guide and more accurate evaluation indicators would have been sufficient for some of the respondents. Based on the responses, training related to the quality criteria should be continued. The criteria would be easier to apply and understand if there were practical examples of situations where the quality criteria had been applied. In addition, more attention should be paid to marketing the criteria. (Hemmilä 2007.)

The Ministry of Education and the Ministry of Social Affairs and Health set up a group on 5 September 2005 to develop training in substance abuse prevention and treatment. The final report of the working group stated that the amount of training in substance abuse and the content of that training varied from one educational establishment to another and at different levels of education. This depended on whether schools, colleges and universities had a teacher interested in the subject, whether there was a teacher responsible for substance abuse prevention and whether the establishment conducted its own research into substance abuse. The results of the working group led to a proposal for a minimum content of training in substance abuse. (Ministry of Education 2007.)

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<sup>20</sup> The questionnaire was sent in December 2006 to the contact persons in municipalities (approx. 400) and provinces dealing with substance abuse prevention, the organisations listed by the Finnish Centre for Health Promotion that carry out substance abuse prevention work, substance abuse prevention teachers' networks, Social and Welfare Centres of Expertise and those involved in the quality criteria working group. The questionnaire was sent to 543 email addresses. There were 128 (23.5%) responses, of which 70.3% (n=90) stated that they worked in the municipal sector, 17.2% (n=22) in organisations and 10.2% (n=13) in some other job.

The proposal by the working group recommends that the obligation for training in substance abuse prevention should apply to all educational fields in which employees in the social and health sector graduate. It is also important that everyone qualifying in youth work, education and teaching or becoming a deacon or police officer receive the necessary basic preparedness for substance abuse prevention as part of his or her training. In order to ensure the quality and comprehensive and systematic nature of training in substance abuse prevention, it is necessary to specify clearly defined learning objectives for qualifications and professions. Courses should take an equal approach to substance abuse prevention and mental health work, and make this approach apparent in the curriculum and teaching. Those working in the above-mentioned fields should be offered a sufficient amount of good quality further and continuing education to supplement, maintain and strengthen their expertise in substance abuse prevention. Educational programmes in the hotel, restaurant and grocery trades as well as in the security and traffic sectors must also offer substance abuse training that responds to the needs of each profession. An educational establishment should also have an up-to-date drug and alcohol strategy to ensure that the institution's substance abuse culture develops alongside teaching substance abuse prevention. (Ministry of Education 2007.)

### **3.2 Selective/indicated prevention**

Over the past few years, focused or selective substance abuse projects have produced a wide range of materials that can be applied in substance abuse prevention. These materials have been put together on the Finnish Centre for Health Promotion's website. Based on the project descriptions on the website, Researcher Jaana Lähteenmaa<sup>21</sup> (2005) carried out a study of the preventative projects targeted at young people.

The projects were divided based on two key dimensions: the first was the effective means employed by the programmes all the way from manipulation through to dialogue and the second was the understanding of the projects about youth culture, in which the interpretations extended from the unidimensional, according to which drugs constituted a constant threat to young people, to multidimensional, where the relationship to drugs did not form a singular but a more multiformatted picture of drugs. Traditional educational campaigns were generally based on the communication and monologue of one indisputable statement of truth whereas projects based on independent development and learning were often grounded in genuine interaction between all the parties involved. Correspondingly, projects that had embraced the concept of the multidimensional youth culture had taken selective and focused means to generate effectiveness in line with the different target communities. The means for generating an impact were the same for all forms of preventative work that see youth culture as a single entity. (Lähteenmaa 2005.)

Examples of campaigns involving a singular truth and the adoption of a uniform youth culture were campaigns based on different shock techniques, the "say no" campaigns. The Internet chat pages where experimenters, users and professionals met or various theatrical or performance presentations were examples of projects that focused on substance abuse prevention through a manifold concept of drugs and good interaction. In turn, selective substance abuse prevention focusing on risk groups was based more on traditional educational methods. Community programmes

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<sup>21</sup> A total of 36 projects by various actors were taken from the Finnish Centre for Health Promotion's 2003–2004 catalogue of substance abuse prevention materials.

focusing on independent development on the one hand and education on the other hand were located between these two operational models. (Lähteenmaa 2005.)

According to Lähteenmaa, it was extremely difficult to evaluate the effectiveness of, or even to compare, the above-mentioned methods. Many projects were based on the concept that drugs were the enemy, one that was very distant from the normal lives of people and one that had to be stopped at any cost. She states that the projects often appeared to have a negative understanding of young people. She resorts to the positive value world of the temperance society in Finland at the beginning of the 1900s in order to give a new perspective on substance abuse prevention that would emphasise for young people the opportunity to set the world on a better course and not take the attitude that young people are a problem. (Lähteenmaa 2005.)

Focused local substance abuse prevention projects are implemented for many different groups, including families, non-heterosexuals, the disabled and immigrants.

The non-heterosexual and transgendered JoinUs project concentrated on issues related to multireasonal marginalisation. The project was launched in January 2005 and its point of departure was the observation that marginalisation can be the result of being transgendered or having a non-heterosexual identity combined with HIV or substance addiction. The objective of the project was to improve the work capability of people under threat of marginalisation and to provide support in their search for a place in employment or education. (JoinUs project 2007.)

The VAPA Substance Abuse Service Development Project for the Disabled (2001–2004) analysed disabled people's access to care as well as social and health care workers' skills in interacting with disabled substance abusers (Hintsala 2006). Based on an evaluation carried out for disabled housing service units, it was possible to standardise practices in situations where the use of intoxicants had earlier been the source of ambiguity. A similar project was carried out with the visually impaired. Based on interviews, it was found that the primary problem of a visually impaired substance abuse patient was intoxicants and not the impairment itself. Rehabilitation called for intervention in a visually impaired person's substance abuse in much the same way as with anyone else that had a substance abuse problem. A particular condition was that a visually impaired person received information and material in a suitable format and that he or she became familiar with a unit's facilities and treatment programmes. (Klingast 2006.)

Experiential alcohol and drug education methods, including plays and so called experience routes, have been used in Finland for some ten years. Experience routes are like exhibitions that young people walk through watching demonstrations on drugs, for example. The experiential alcohol and drug education methods currently used aim at teaching young people correct behaviour, but they do not often encourage critical and individual thinking. (Rantala et al. 2005, 2006.)

## 4 Problem drug use

The number of problem drug users is estimated in Finland based on the number of problem users of amphetamines and opiates, which came to 14,500–19,100 in 2005; this accounts for 0.6–0.7% of 15–55-year-olds among the entire population. Nearly four fifths of problem drug users used amphetamines. The proportion of men was 80%. The majority of problem drug users belonged to the 25–34-year age group.

According to the 2006 results of the drug treatment information system, among all drug treatment clients of substance abuse services, opiates were the primary problem substance of clients entering drug treatment (41%), followed by stimulants (21%), the combined use of drugs and alcohol (17%), cannabis (14%) and sedatives (7%). Buprenorphine was the primary problem substance for 31% of the clientele.

The mean age of the clients was 28.0 years. Men were on average 2.5 years older than women were. The clients were mainly men (69%), young adults and single. They had a low level of education, and unemployment was common (62%). Every ninth client (11%) was homeless. The majority of the drug treatment clients had received substance abuse treatment before.

According to all studies, alcohol is clearly the primary problem substance in Finland, and there is a fairly short history of problem drug use. The central factors of problem drug use in Finland are the relatively young age of users, and consequently a relatively short history of drug use, as well as the central role of buprenorphine in intravenous use. Despite their short history of drug use, the users are socially excluded and they are often polydrug users, which can be explained by the fact that many problem drug users have a history of alcohol abuse. Mental health problems related to alcohol abuse (such as delirium) also promote problem drug use.

### 4.1 Problem drug use according to statistical estimates

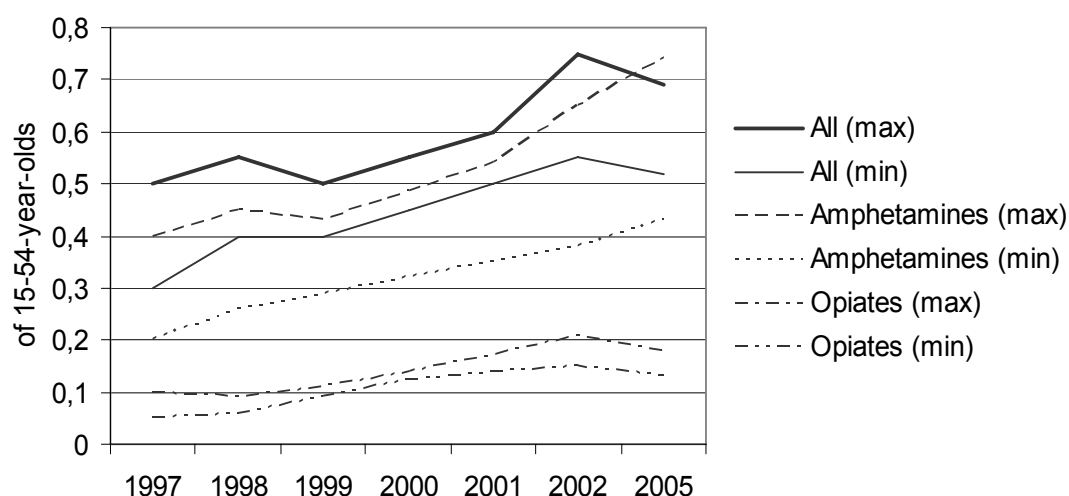
The number of problem users of amphetamines and opiates increased noticeably between 1999 and 2002. Since then, the proportion of problem users of amphetamines and opiates seems to have stabilised. According to statistical estimates, problem users of amphetamines and opiates<sup>22</sup> accounted for 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% of the population (Table 4). In 2005, the corresponding figure was 0.5–0.7% of 15–54-year-olds. Amphetamine users accounted for 0.4–0.7% and opiate users for 0.1–0.2% of the population. (Partanen et al. 2007.)

The accumulation of detriment leading to problem drug use seems to occur after a lag of 3 to 5 years from the commencement of use (Virtanen 2004). Thus, the sharp increase in drug experimentation at the end of the 1990s seems to have led to the growth in the number of problem users at the beginning of the 2000s and correspondingly, the stabilisation of experimentation at the beginning of the 2000s seems to have affected the latest estimates on the number of problem users (Figure 2).

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<sup>22</sup> According to the national definition used in the study, problem use refers to the use of amphetamines and opiates to such an extent that it causes social or health problems to the user. Furthermore, the authorities have had to intervene in one way or another and this has been recorded in administrative registers.

Figure 2. Percentage of problem drug users among 15–54-year-olds 1997–2005



Source: Partanen et al. 2004, 2007.

Statistical estimates on the prevalence of problem drug use<sup>23</sup> based on administrative statistics have been made since 1997. According to these estimates, out of the 15–54-year-old population, there were some 14,500–19,100 amphetamine and opiate problem users in the entire country in 2005 (Table 3).

Table 3. Development of the number of amphetamine and opiate users in Finland in 1997–2005

	1997*	1998	1999	2001	2002	2005
Overall estimate	9,400– 14,700	11,500– 16,400	11,100– 14,000	13,700– 17,500	16,100– 21,100	14,500– 19,100
Opiate users *	1,500– 3,300	1,800– 2,700	2,500– 3,300	3,900– 4,900	4,200– 5,900	3,700– 4,900
Amphetamine users *	6,800– 11,600	7,600– 13,000	8,300– 12,400	10,100– 15,400	10,900– 18,500	12,000– 22,000

\* = Estimates are based on information from three registers.

Source: Partanen et al. 2004, 2007.

<sup>23</sup> 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 diseases register due to intravenous drug use. The estimate intervals are based on 95-per cent confidence intervals of the estimates. Different log-linear models were applied to different subgroups so the sum of the subgroups differs from the overall estimate. (Partanen P. et al. 2004, 2007.)

Since the estimates of problem users are based on administrative registers in Finland, a user may have been included in a register due to the activity of the authorities. When making international comparisons, it should also be kept in mind that the estimated number of problem users in Finland is based on a fairly wide definition of problem use, especially concerning amphetamine, and the estimate may also include occasional users. However, temporal comparisons of problem users involve a degree of methodological uncertainty because changes have taken place during a short period of time and at the same time, the service system of society has undergone great change. (Virtanen 2004). For example, the substance abuse service system has been strongly developed in the 2000s, which may have reduced the number of people entering hospital care; the increased number of health counselling centres has reduced the occurrence of infectious diseases; the registration procedure for cases of driving while intoxicated has become stricter, which has increased the proportion of drug use in the register of cases of driving while intoxicated; and the introduction of a "drug-user offence" has indirectly affected the way the police record different substances in their register. (Partanen et al. 2007.)

The majority of problem users, 75–80%, consisted of amphetamine users, and they accounted for 0.4–0.7% of 15–54-year-olds in Finland in 2005. The estimated proportion of problem users of opiates was 0.13–0.18% of the population. The proportion of women was 20–30% in both substance groups. The proportion of 15–24-year-olds came to 25–35%. Some 50–60% of all problem users were from Southern Finland and more than half of them from the Greater Helsinki area. The proportion of women among problem users seems to be on the constant decline everywhere in Finland, possibly excluding the Greater Helsinki area. The aging trend among users is most evident in the Greater Helsinki area. (Partanen et al. 2007.)

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

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

Source: Partanen et al. 2004, 2007.

According to the data from 2005, the upward trend in the number of problem users in Southern Finland has stopped, and the number of problem users has even dropped outside the Greater Helsinki area in Southern Finland. Problem use was clearly on the increase at the turn of the millennium, but now it seems that problem use has spread

less in the satellite municipalities of the Greater Helsinki area than was assumed based on data from 2002. If the problem use phenomenon follows the trend evident in Southern Finland, the regional estimates on the extent of problem use (excluding the Greater Helsinki area) will probably decrease rather than increase in a few years' time. Thus, the drug problem as well as specialised treatment services (substitution treatment, health counselling) would centre in the Greater Helsinki area and possibly some other large cities. (Partanen et al. 2007.) The evidence for the concentration of treatment services can already be seen in the numbers of clients in health counselling centres (Yearbook of Alcohol and Drug Statistics 2006, 25).

According to the censuses of intoxicant-related cases<sup>24</sup>, the proportion of cannabis users doubled to 20 per cent and the proportion of amphetamine users trebled to 18 per cent between 1995 and 2003 among substance abuse clients in social and health service units. Opiate use increased clearly between 1999 and 2003. Of the intoxicants used, the proportion of opiates was 5% in 1999 and 12% in 2003. In 2003, 27% of all the clients of substance abuse services had used some illicit drug; the corresponding figure in the previous census in 1999 was 16%. In the 2003 census, about a fifth of the clients had used drugs intravenously. (Nuorvala et al. 2004.)

Drug treatment clients are relatively young. According to the census of intoxicant-related cases, of all the intoxicant-related cases in social and health service units, drugs were involved in 63% of the cases of under 20-year-olds, in 75% of the cases of 20–29-year-olds, and in 40% of the cases of 30–39-year-olds. The mean age of all the clients was 44 years. (Nuorvala et al. 2004).

Forty-four per cent of the clients in outpatient care and 47 per cent of the clients in inpatient care in the units providing specialised services for substance abusers had used pharmaceuticals or drugs in 2003. The corresponding figures for drugs were 35% and 40% whereas in 1999, the proportion of drug treatment clients was just under 20% in substance abuse outpatient care and about 30% in inpatient care. (Metso 2004.)

According to the 2006 drug treatment information compiled from units providing specialised services for substance abusers, buprenorphine was the primary problem substance of clients entering drug treatment. In only a few years, buprenorphine has replaced heroin almost completely as the main problem substance and the problem use of buprenorphine is now more common than the problem use of stimulants. (Kuussaari & Ruuth 2007.)

According to the drug treatment information system, the drug treatment clients in outpatient and inpatient care are systematically five years younger than the drug treatment clients in the census. The difference can partly be explained by the fact that based on the census, slightly older abusers of pharmaceuticals seem to be underrepresented in the drug treatment information system. (Vismanen 2004.)

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<sup>24</sup> The census of intoxicant-related cases is conducted to count the number of clients of substance abuse services within one day every four years in all social and health service units. The most recent census was carried out in 2003.

## 4.2 Profile of clients in treatment

According to the 2006 results of the drug treatment information system<sup>25</sup>, the drug treatment clients were mainly men (69%), young adults and single. They had a low level of education, and unemployment was common (62%). Every ninth client (11%) was homeless. The majority of the drug treatment clients had received substance abuse treatment before, and one seventh (14%) entered drug treatment for the first time in 2006. (Kuussaari & Ruuth 2007.)

The mean age of the drug treatment clients was 28.0 years (compared with 27.6 and 27.3 in the previous years). Men were on average 2.5 years older than women were (3 years in 2005). The clients of substance abuse outpatient units and inpatient drug treatment units were the youngest, with the mean age of 26 years. In outpatient drug treatment units and substance abuse inpatient care, the mean age was 30 years (29 years in 2005) and in prison health care 31 years. Of all the clients of substance abuse services, 9 % were in inpatient units and 25% in outpatient units specialised in drug treatment. Thirty-seven per cent were in general substance abuse outpatient units and 25% in inpatient units. (Kuussaari & Ruuth 2007.)

Among all drug treatment clients of substance abuse services, opiates were the primary problem substance of the clients entering drug treatment (41%), followed by stimulants (21%), the combined use of drugs and alcohol (17%), cannabis (14%) and sedatives (7%). Buprenorphine was the primary problem substance of 31% of the clientele (Table 5). Almost two out of three clients had used at least three substances. (Kuussaari & Ruuth 2007). The proportion of buprenorphine as the primary substance of those entering treatment has increased the most. Buprenorphine is already the primary substance for almost a third of drug treatment clients.

Three out of four (78%) drug clients in services for substance abusers had injected drugs sometime in their life; 59% of them had injected drugs during the past month and one in six (19%) had shared needles and syringes. Opiates were most commonly used intravenously (83%). The intravenous use of buprenorphine (88%) was slightly more common than the intravenous use of heroin (82%). Stimulants were also injected by 81 per cent of their users. (Kuussaari & Ruuth 2007.)

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<sup>25</sup> The results are based on data gathered from 133 units (161 in 2005) and 4,855 (5,499) drug treatment clients. The data collection is voluntary for the participating units. A coverage survey conducted in 2004 (Vismanen 2004) estimated that in 2003 the drug treatment information system covered about half of all drug treatment clients in the units providing specialised services for substance abusers.



Table 5. Substances used by clients entering treatment for the use of narcotics and pharmaceuticals (% of clientele) in 2000–2006

Substance category	Primary problem substance						
	2000	2001	2002	2003	2004	2005	2006
<b>Opiates</b>	29	28	28	31	37	37	41
-heroin	20	13	6	3	2	2	2
-buprenorphine	7	12	20	24	29	29	31
<b>Stimulants</b>	28	26	28	28	22	22	21
<b>Cannabis</b>	17	20	18	16	14	14	13
<b>Alcohol and drug</b>	18	19	20	19	19	19	17
<b>Sedatives</b>	5	6	5	6	7	7	7

Source: Drug treatment information system, STAKES.

The most common single substance of those clients entering drug treatment for the first time (n=655) was cannabis (30%). Other common primary problem substances were stimulants (19%), opiates (19%) and the combined use of alcohol and drugs (25%). The proportion of clients entering treatment for the first time due to buprenorphine use (15%) was at the same level as in the previous year. (Kuussaari & Ruuth 2007.)

There were no great changes in the treatment information of drug users when compared with the previous year. The most significant change was probably the decreased number of units involved in voluntary data collection and the decreased number of clients. In particular, the reported number of new drug users dropped from 884 clients in the previous year to 655 clients. Although the results may not be as generalisable as the results of the previous year, the change in the number of new clients did reflect another change in the data – the fact that clients were slightly older. There was also a change in the estimates on the numbers of problem users. The third notable change was the increased role of cannabis as the primary substance of new clients.

### 4.3 Main characteristics and patterns of use from non-treatment sources

Several separate studies in recent years have examined problem drug use. The studies have focused on the position of alcohol, the intravenous use of buprenorphine and mental disorders.

In his dissertation (2006)<sup>26</sup>, Peter Andersson studied the connection between heroin use and psychological vulnerability that stems from childhood. According to the study, domestic violence has detrimental effects on the care environment of the family.

<sup>26</sup> The dissertation was based on a case-control study with a test group of 81 people (aged 38± 5 years) who had been diagnosed with a drug-related behavioural disorder (heroin use) and a control group of 81 people with no such diagnosis. The groups were also homogenised on the basis of gender and age.

Insensitivity related to feelings of rejection in childhood enhances the child's feelings of insecurity, lowers his or her self-esteem and makes it more difficult for the child to deal with his or her problems. This turned out to be a risk factor behind the onset of heroin use. Correspondingly, a warm atmosphere in the childhood home has the opposite effect. According to the results of the study, people with high self-esteem had a 17 times (odds ratio) lower risk of starting to use heroin than did people in the test group consisting of heroin users. Correspondingly, a pathological and compulsive breakdown in self-confidence in relation to oneself and to others turned out to be 40 times more common among heroin users than among the control group. The risk factors for drug use also include experiences of failure at school. According to the researcher, these results support the statement that the atmosphere at home has a crucial influence on children's mental health and on the accumulation of such protective factors that improve a child's ability to resist drug use.

A survey of all conscripts born in 1981 examined binge drinking and the related psycho-pathological phenomena. The study also provided data on drug use. Eighty-five per cent of the respondents reported that they had consumed alcohol to become drunk during the past 6 months. Six per cent of them said that they had used some drugs, and almost half of this group were drunk every week. Risk behaviour, juvenile delinquency and self-destruction seemed to be connected with young people's regular and weekly binge drinking; this also concerns those who had experimented with drugs. Those who consumed alcohol and smoked cigarettes regularly also had a clearly more positive attitude towards drugs. (Niemelä et al. 2006.)<sup>27</sup>

The Kuopio Military Province Headquarters arranges a medical re-examination for service personnel who suspend their military service<sup>28</sup>. Mental and behavioural disorders are the biggest ICD category in the re-examinations (roughly 55% of the cases). Within this category, the most significant change between 1993 and 2003 was the increase of mental and behavioural disorders due to alcohol and drug use (F10–F19): in 1993, these cases accounted for 2.2%, in 1999 for 10.1% and in 2002 for 27.2%. In 2003, the percentage dropped to 20.7%. The percentages related to alcohol have declined continuously, while those related to drugs have increased. Alongside cannabis and amphetamines, it is not uncommon for those summoned for re-examination to use hard drugs, and there seems to be an increasing prevalence of substances used in combination. (Koskinen & Puustinen 2005.)

A two-day study conducted on patients on the emergency and internal medicine ward at Peijas Hospital in Vantaa revealed that 18 per cent of the cases had entered treatment due to substance abuse.<sup>29</sup> The study criteria for the cases of substance abuse included the certainty of addiction and a related illness or finding based on an examination. The case histories of the 41 patients who participated in the study had several notes on substance addiction, often from a long period of time. Almost all patients suffered from alcohol addiction, 10 per cent used both alcohol and other substances and only 5 per cent were intravenous drug users. Thus, substance addiction was in almost all cases alcohol addiction, which is typical for the Finnish substance abuse culture. The users in this study had particularly severe problems, which are demonstrated by the fact that a fourth of the patients died within six months

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<sup>27</sup> The sample consisted of 2,306 18-year-old boys who entered the military service in 1999.

<sup>28</sup> Re-examinations are mainly arranged to determine fitness for service of those who had to suspend their military service, conscripts who failed to respond to their call-up and reservists who fell ill. The situation of those summoned for re-examination was monitored from 1993–2003 according to the ICD category. The information was based on required medical certificates. The number of re-examinations totalled 335 in 2003 (202 in 1993).

<sup>29</sup> The data was collected at two separate times, in March 2005 and July 2005. The sample consisted of 41 substance abuse patients.

from entering treatment. After the six-month follow-up period, only 2 of the patients had probably not used intoxicants and 7 had been unable to use intoxicants due to their inpatient care. According to the study, it seemed that a great amount of health care and social service resources were put into the treatment of severely addicted patients, but the result was poor in terms of their life expectancy, functional ability and abstinence. (Pohjola-Sintonen et al. 2006.)

The addiction psychiatry outpatient clinic at Tampere University Central Hospital carried out a study on 34 clients who came to the assessment for substitution treatment between 1 July 2000 and 30 April 2002 and were transferred to opioid substitution or maintenance treatment after the assessment. This study also revealed the chain of substance use that led to problem drug use. The clients had started to use alcohol at the age of 12 on average, and younger clients had started to use other substances at an earlier age than older clients did: the younger clients had started to use cannabis and sedatives at the age of 14 (older clients at the age of 15) and amphetamines and opiates at the age of 16 (older clients at the age of 22). Nineteen of the clients had hepatitis C and 22 had at least two mental or substance abuse disorders. (Veide et al. 2007.)<sup>30</sup> (See Section 5.3.)

Health counselling centres in Helsinki collected information on their clients' drug use with a voluntary anonymous questionnaire during two weeks in 2005. About 30 per cent of the clients responded. According to the results, their mean age was 27.8 years. One fourth were women and they were on average 1.5 years younger than the men were. The clients had used opiates intravenously for an average of 7.3 years; the most common period of use was 4 years. The intravenous use of buprenorphine had lasted a considerably shorter period of time, 4.2 years. Only 3% of the respondents were in maintenance treatment. (Alho et al. 2006.)<sup>31</sup>

Nearly three out of four respondents said that buprenorphine was the most common drug that they used intravenously and one in four mentioned amphetamine or methamphetamine. However, only 28% used buprenorphine alone; the others could be classified as polydrug users. In 55 per cent of the cases, polydrug use included amphetamine or methamphetamine. About a fourth of the respondents mentioned the use of benzodiazepines together with buprenorphine. Two out of three had used buprenorphine and naloxone intravenously. Only 20% of them considered the use of buprenorphine and naloxone similar to the use of buprenorphine alone, but two out of three still continued their use. (Alho et al. 2006.)

The survey sample was estimated to cover 5–10% of all intravenous drug users in the Greater Helsinki area. Therefore, the results are only indicative. The survey also examined the prices of individual doses; the street price of buprenorphine-naloxone combination tablets was half of the street price of buprenorphine tablets, which partly explains the continuous intravenous use of buprenorphine and naloxone. The result does not necessarily provide evidence for the assumed agonistic effects of combination tablets although the price difference of the substances and the selected users in the survey sample who were used to intravenous use may be factors that have greater impact on the results. (Alho et al. 2006.)

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<sup>30</sup> The study was conducted at the time when the first Decree on substitution and maintenance treatment was issued in Finland. All clients who passed the assessment were admitted to the Tampere substitution treatment clinic until the places were filled.

<sup>31</sup> 589 questionnaires were distributed during the survey; 176 of them were returned. However, the response percentage is probably higher as the clients visit the units anonymously and therefore the same client may have visited the unit several times during the survey period.

The results above are supported by an assessment on the mobile health counselling unit<sup>32</sup>. According to the assessment, about a third of the clients who visited the unit were women and the mean age of the clients came to 31.7 years. The majority of new clients were 20–29 years old. The majority of those interviewed used buprenorphine intravenously and had started the intravenous use of drugs within two years of starting their use. However, approximately three out of four of the clients monitored had not shared needles and syringes during the month preceding their visit to the unit. Some 5 per cent of the clients had acute need for follow-up care. (Törmä & Huotari 2005a.)

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<sup>32</sup> The operation started at the end of 2003 and in 2004, the unit had 700 clients, in total 2,350 client visits. The material of the study consisted of survey forms on 212 new clients, who had not used health counselling services during the month preceding their visit. In addition, theme interviews were conducted on 20 clients. Interviews were also conducted on the personnel of the unit, other service providers and pharmacists and police officers operating in the neighbourhood. (Törmä & Huotari 2005a.)

## 5 Drug-related 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. All substances that are used for intoxication are considered intoxicants: alcohol, substitutes, pharmaceuticals and drugs. The social and health care sector must develop primary 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 supported housing) and peer support activities.

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

A quality framework for substance abuse services and Current Care guidelines for the treatment of substance abusers have been created in order to develop substance abuse work. The development policy for drug treatment services emphasises developing low-threshold services and related training. The first health counselling centre intended for the exchange of needles and syringes was set up in Finland in 1997, and substitution and maintenance treatment was introduced as an official part of substance abuse services in 2000. As far as possible, the most difficult-to-treat patients (dual or triple diagnosis patients) are treated centrally in units providing specialised services. The intention is to get drug abusers to enter the treatment system as early as possible.

In Finland, municipalities are in charge of organising social and health services, but local government lacks monitoring systems that would help identify client group specific welfare deficits and service needs. In particular, the most socially marginalised substance abuse patients face a high risk of being excluded from the service network. The number of clients in substance abuse services has not grown consistently, but the treatment periods have become longer, as the physical condition of clients is increasingly poor and polydrug use is becoming increasingly common. (Kaukonen 2005.)

After the turn of the century, the drug treatment situation has stabilised; for example, health counselling and the position of medical treatment have become firmly established. Substitution and maintenance treatment for opiate addicts is increasingly being transferred to health centres. The substance abuse service system faces a new challenge because resources have to be divided between treatment of the harm caused by increased alcohol consumption and drug treatment.

## 5.1 Treatment systems

### *Availability of treatment services*

According to the 2004 evaluation of basic municipal services, 24-hour detoxification for drug addicts was usually arranged in rehabilitation units, detoxification units or specialised health care services within municipalities<sup>33</sup>. One third of municipalities reported that they do not provide outpatient detoxification treatment for drug users and one fourth had no inpatient detoxification systems. Thirty per cent of municipalities have a system for needle and syringe exchange, but only 10 per cent provide these services within the municipality. Two thirds of municipalities had agreed to provide substitution and maintenance treatment for opiate addicts. Almost half of the municipalities reported that they have no need for substitution treatment. (Ministry of the Interior 2005.) Consequently, in several municipalities there was no guarantee that a problem drug user would be admitted to treatment.

Kuussaari (2006) writes that there is a lot of uncertainty among drug treatment workers regarding the treatment system. The workers do not always know where and how drug users are treated in their own municipality. The uncertainty may also reflect the change that the drug treatment system is currently going through.

Substance abuse services in Helsinki include primary social and health services (social welfare offices, health centres, family centres), emergency services (emergency social services, drug clinics and hospitals), specialised services provided by the Social Services Department (A-clinics, youth centres, detoxification units, rehabilitation centres) and by the Health Department (addiction psychiatry, health counselling centres, specialised services for HIV positive people). Furthermore, the service system includes other specialised services (service housing, daily activities, substitution and maintenance treatment for opioid addicts) and targeted services (for immigrants, disabled people, prison inmates, pregnant women). (Fabritius 2007.)

In Helsinki, a problem drug user can be admitted for detoxification treatment within a couple of days, at the most within two weeks, and can be admitted to an emergency ward immediately. There are 400 clients receiving substitution or maintenance treatment for opioid addiction at the moment, but there should be places for at least 450 clients, and opioid users have to wait more than six months before being admitted for treatment. It is estimated that approximately 7,000 clients visit the health counselling centres annually. (Fabritius 2007.)

As more and more drug users receive medical treatment, substance abuse problems, which previously were considered social problems, are now seen as medical problems and are increasingly handled by the health care services. This view is supported by a study on social work within substance abuse services, which showed that those working within substance abuse services were concerned that as the co-operation between social services and health care increased, social work was increasingly being defined and interpreted based on the objectives of health care. (Laitila-Ukkola 2005.)

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<sup>33</sup> It is worth noting that two thirds of the 432 Finnish municipalities are small municipalities of less than 7,000 inhabitants, comprising in total less than a fifth of the Finnish population. Only 5% of these municipalities have A-clinics or similar units. According to the quality framework for substance abuse services, it is not expedient to organise specialised services for substance abusers locally in municipalities of less than 20,000 inhabitants. Instead, they should be organised through, for example, regional co-operation. It has also been estimated that specialised services for drug abusers should be organised alone only by municipalities of more than 100,000 inhabitants. (Inkeroinen et al. 2006.)

### *Developing services for the severely problematic substance abusers*

The essential aim of substance abuse treatment is for the clients' problems and the availability of services to meet. Some of the largest obstacles to receiving treatment were waiting times, the lack of knowledge and skills and negative attitudes towards substance abusers within the primary services and the physical distance of the treatment units within specialised services. Getting the severely problematic substance abusers into treatment usually requires bringing low-threshold services to the clients. Many severely socially excluded clients would benefit from less goal-oriented treatment plans and supported housing services. (Ministry of the Interior 2005; Mäkelä et al. 2005.)

According to a study by Sanna Väyrynen (2007), getting caught up in drugs causes women in particular to feel disconnected from themselves, their own gender and the dominant culture.<sup>34</sup> The drug scene is fairly male-dominated, as only about a fifth of users are women. The proportion of women in outpatient and inpatient rehabilitation is also smaller than that of men: approximately a third of new clients are women. A woman who gets caught up in drugs often lives among drug-using men, and sometimes on their terms.

The physical violence or abuse taking place within the drug scene makes the women feel ashamed and becomes part of their sexual identity. This poses a challenge for society to develop rehabilitation methods and units that cater for the special needs of women. In order to conquer the feelings of shame and of being stigmatised, the young women need comprehensive support and the right kind of encouraging atmosphere both in the service system and in their everyday social networks. (Väyrynen 2007.)

The special problems of pregnant substance-abusing women have been studied at the Department of Obstetrics and Gynaecology of the Helsinki University Central Hospital (HUCH) since 1983. In August 2002, an enhanced care model was introduced, in which the hospital's maternity clinic has a drugs, alcohol and pharmaceuticals clinic and a special care team, which handles the treatment of the substance abuse patients. By the end of November 2005, 312 pregnant drug abusers had been treated. The patients come to the clinic every 1 to 4 weeks to visit their personal nurse and physician who monitor their pregnancy and give them psychosocial support for quitting drugs and reorganising the fundamentals of their life. (Halmesmäki et al. 2007.) (See also Section 7.4.)

A study dealing with the treatment at the clinic stated that the shame the pregnant women or mothers feel over their substance abuse problems and fear of the child welfare authorities may prevent them from seeking proper help.<sup>35</sup> For this reason, the treatment should be made easily accessible. Many patients have also felt that being

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<sup>34</sup> The study is based on interviews with fifteen 17–27-year-old young women who had used drugs. All the women in the study had been in outpatient or inpatient rehabilitation (or both) for drug use.

<sup>35</sup> Thirty-two per cent of the substance abuse patients had also used drugs intravenously during the pregnancy. The primary substance of abuse was opiates or amphetamine for 43% of the patients, and 105 (33%) patients only used opiates. Twenty-nine of them (28%) had been in buprenorphine or methadone substitution treatment or buprenorphine detoxification in another treatment unit before becoming pregnant. Twenty-two (21%) women started buprenorphine substitution or detoxification treatment at the clinic. Forty-seven per cent of the patients had hepatitis C.

treated in a somatic treatment unit is less stigmatising than having to seek help from a substance abuse or psychiatric unit. (Halmesmäki et al. 2007)

When the women first come to the clinic, the stage of their pregnancy is checked and their physical, psychological and social risk factors are evaluated using a comprehensive, structured interview. If the pregnancy is unwanted, the woman's substance abuse problem is extensive and her life situation is especially difficult or her psychological and physical health is poor, she is presented with the option to terminate her pregnancy. Through a motivational interview, the patient is encouraged to pursue an intoxicant-free lifestyle and to seek substance abuse treatment. Substance abuse treatment is discussed and the condition of the foetus is monitored during visits with the midwife. The patients can participate in voluntary ultrasound screenings during the 12–13 and 18–20 weeks of pregnancy. After this, the pregnancy is monitored individually according to medical needs at least every four weeks during a visit with the physician and weekly when visiting the nurse. (Halmesmäki et al. 2007.)

According to the study, the pregnancies and the births mainly went well, but the newborn had several withdrawal symptoms that extended their stay at the hospital. The patients were assessed in terms of their need for child welfare interventions. On average, only one in ten babies could be discharged without support measures. Half of the babies were discharged with the help of support interventions in community care, 11% were placed outside the home, 4% were taken into care and one child was given up for adoption. (Halmesmäki et al. 2007.)

The best treatment results were achieved by combining pregnancy monitoring and substance abuse treatment, which allowed early contact with child welfare authorities and facilitated the referral for follow-up treatment. The post-natal check-up and birth control were already planned at the hospital. The patient group is very mobile: they move around frequently and their maternity clinic may change a couple of times during the pregnancy. They may spend time in prison or seek substance abuse treatment at another locality, so it is important to co-ordinate the pregnancy monitoring in one place. Thus, it is also easier to monitor the patients' medication. (Halmesmäki et al. 2007.)

The extent and the models of family-centred substance abuse work in Finland were evaluated in 2006 (Mäkelä et al. 2006). The largest organisation providing treatment and rehabilitation, the A-Clinic Foundation, encountered some 30,000 substance abuse clients and their family members. Out of all counselling sessions, joint counselling sessions accounted for 6 per cent and group counselling sessions accounted for 15 per cent. The majority of the clients lacked the central points of reference in life: family, relationships, work and education as well as goals and objectives in life. More than 60 per cent of the service users live alone, outside of families or working life.

The questionnaires sent to the units yielded 22 responses and 25 descriptions of the models of family-centred work that were used in the units. The action plans of fourteen units had mentions of family therapy, family work, family orientation, substance abuse problems of women or mothers or the child's point of view. According to the responses, 13 units had personnel with specialised education. The brochures of several units also mentioned family work. However, only three of the units cited family work as one of its focus areas for 2006 and only three of the purchased service agreements made between the units and municipalities mentioned family work: family counselling services, family therapy as a treatment method and



family meetings for a young person undergoing inpatient treatment. (Mäkelä et al. 2006.)

The study examined the starting points and development goals of family-centred work. Four suggestions were made for short-term goals: (1) All those who enter treatment should be asked whether they have underage children, and the children should be taken into consideration when planning treatment; (2) The initial data gathered on the client should include data on the client's family structure, a family tree and/or a network map, if possible; (3) At least one family meeting should be arranged for a client with a family, if possible; (4) The possibilities to provide education and job guidance in family-centred work and to produce related support material should be examined. (Mäkelä et al. 2006.)

According to Törmä and Huotari (2005b), the most socially marginalised substance abusers are not suitable clients for treatment in units providing specialised care for alcoholics, drug addicts or mental health patients. Some of the clients do not use other services at all; others are major users of services who fluctuate between substance abuse rehabilitation, prison, health care clinics and the street. The most problematic are the so-called dual-diagnosis patients who are clearly in need of psychiatric services but do not have access to them because of their substance use. Thus, the patients' mental health problems are left untreated and they continue self-medicating with drugs and sedatives.

Because the most problematic clients are unable to commit to normal treatment or its requirements, they would benefit from less goal-oriented treatment plans and supported housing services. Linking the entire treatment chain so that a patient could advance in the treatment system according to his or her own abilities and needs would be of great use to clients with multiple problems. There is also a need for services for female clients as they are often especially troubled clients in male dominated treatment units and many of them have been forced to prostitute themselves in order to finance their drug habit. Increasing numbers of young people are facing social exclusion as a result of being "recycled" in the service system and not having a real chance to commit to treatment. (Törmä & Huotari 2005b.)

The Vinkki health counselling centre in Helsinki has provided peer group activities for drug-using clients since 2001. Peer group activities are implemented on three levels: peer support, snowball training<sup>36</sup> (peer education) and so-called Helpers (peer work). The Helpers participate in snowball training and after this, they are assigned individually tailored tasks that they carry out at the health counselling centre or among networks of drug users. Helpers are not required to live a drug and alcohol free lifestyle. Helpers provide health counselling and clean needles and syringes for other drug users, teach them how to dispose of needles and syringes safely, and hand out brochures on risk behaviour. (Malin 2006.)<sup>37</sup>

The drug users encountered by the Helpers were usually afraid of the authorities. The Helpers acted as communicators between drug users and the authorities, and they provided information on life in the social networks of drug users. The experiences gained by the Helpers have shown that peer group activities should be developed for drug users who have a family and are afraid of the child welfare authorities. Peer group activities could also offer a way to reach those young drug users who so far have not become clients of health counselling centres. (Malin 2006.)

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<sup>36</sup> In the snowball method, drug users are recruited to help other users at the local level. Clients of Vinkki are trained as tutors who disseminate health counselling information to their networks of friends and acquaintances. (Malin 2006.)

<sup>37</sup> The article by Malin (2006) is based on theme interviews with six Helpers.

The post-rehabilitation provided by substance abuse services is a support measure for those who are recovering from serious substance addiction. First and foremost, it aims at social and vocational rehabilitation.

A study of the post-rehabilitation provided by substance abuse services was carried out on one unit. The average age of the clients in the study was 32 (age structure: 19–50-year-olds) and two thirds of the clients were men.<sup>38</sup> (Jauhiainen 2006). The majority (71%) of the clients lived alone. Thirty-seven per cent of the clients had dependent children and in the case of one fourth, the child or children lived with them.

Typically the clients at the unit had started the substance abuse that led to addiction at the age of 14. Many had started by experimenting with alcohol at an even earlier age. Their substance use was characterised by polydrug use, which is common in Finland. Before entering rehabilitation, the clients' primary substances of addiction were amphetamines, heroin and/or alcohol. On average, the clients had abused substances regularly for 16 years and they had been sober for a year. (Jauhiainen 2006.)

The highest level of education achieved by approximately 70% of the clients was comprehensive school or unfinished comprehensive school. About a fifth had gained a vocational qualification after comprehensive school and approximately 10% had passed their matriculation examination. The clients had a fragmented work history and they had very little work experience compared to other people of the same age. When entering rehabilitation, the clients had usually been excluded from working life for many years. Twenty-one per cent of the clients were homeless and 24% lived in a supported housing or housing service unit. Initially, the clients were usually treated in A-clinics or units providing substitution treatment or they were in inpatient rehabilitation. (Jauhiainen 2006.)

As their rehabilitation progressed, homeless clients were provided with supported accommodation. The actual intensive post-rehabilitation usually started when the clients transferred from inpatient rehabilitation to independent living. During the follow-up period, the unemployment among the clients decreased (65 -> 29%) and the number of clients receiving vocational education increased (11 -> 35%). However, the clients' subsistence did not change in the same ratio to that which they had invested in work and education. The majority of the clients in the study managed to stay sober during the follow-up period. (Jauhiainen 2006.)

## 5.2 Drug-free treatment

The Children and Adolescents' Substance Abuse Outpatient Clinic in Turku<sup>39</sup> deploys a structured individual brief intervention programme that consists of an evaluation visit as well as 12 actual visits.<sup>40</sup> The treatment programme aims at dealing with the

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<sup>38</sup> The material for the follow-up study consisted of 140 substance abuse clients at a post-rehabilitation unit who entered treatment between 2003 and 2005.

<sup>39</sup> The Children and Adolescents' Substance Abuse Outpatient Clinic was founded in 2003. The project also aimed at separating the treatment of underage substance abusers from other substance abuse treatment, so that when seeking treatment young people would not come into contact with adults who have used drugs for a long time and who deal drugs.

<sup>40</sup> The evaluation visit and the final visit of the intervention programme are intended for both the young client and his or her parents, and in the middle of the programme the parents visit without their child, but the other visits are for the young person alone. In 2004, 127 young people came to the outpatient clinic and 33 of them underwent the intervention (during the evaluation visit 18 of them admitted to having used or tried cannabis). Boys accounted for two thirds of the clients, and the mean age of all the clients was 15.5 years. During the year, seven young clients were discovered to use drugs intravenously. (Jonsson 2005.)

young person's life situation comprehensively, and the young client is encouraged to join a treatment programme and to reduce or stop substance abuse. The programme provides the client with health counselling on risk behaviour related to substance abuse. Drug screening tests are conducted randomly or when necessary. The young person is taught to recognise the dangerous and problematic situations related to substance use and he or she is encouraged to find alternative activities. During the intervention, the young person sets personal goals regarding substance use, and the realisation of these goals is discussed analytically with the client in an encouraging atmosphere. After the actual treatment programme is over, the client is scheduled for follow-up visits in 1, 3, 5 and 12 months. (Jonsson 2005.)

Of those young people who came to the outpatient clinic and underwent the intervention in 2004, the majority had reduced their substance use when their situation in the month preceding the final visit was compared with their situation in the month preceding the evaluation visit. The comparison of the data of the final visit and the data of the follow-up visits showed that substance use did not decrease after the intervention was over. The feedback young people and their parents gave on the intervention programme was mainly positive. (Jonsson 2005.)

The Kisko unit of Kalliola Clinics provides community treatment for drug addicts who have a long and extensive history of substance abuse.<sup>41</sup> Patients are encouraged to pursue a substance-free life style and lifelong growth. The follow-up study showed that Kisko has a certain status among drug users. One interviewee said that he had enjoyed the treatment at Kisko "which is often likened to a concentration camp", whereas another patient who had dropped out of treatment said that he was disappointed with himself "for not having graduated from the drug addicts' university". Even though the interviewees also talked about the softer sides of the treatment at Kisko, its reputation as a "tough place" seemed to boost the patients' self-esteem. In the appraisal of Kisko's operations, the feedback on the treatment was positive. (Heikkilä 2005.)

According to a study on the significance of community education in the rehabilitation of drug addicts suffering from severe substance addiction (Hännikäinen-Uutela 2004), the identity and self-esteem of the drug addicts developed within the social context formed by other similar drug addicts<sup>42</sup>. Interaction with the external social environment stopped as the person joined a drug circle. Drugs could be seen a tool for socialisation when the normal development of an individual's identity was prevented or he/she had an unusually high need for attention and suffered from low self-esteem.

When drug rehabilitation based on community education replaced drug use as a tool for socialisation, the model provided by the peer group strengthened the addict's awareness of the need for changes in attitude and behaviour. Sobriety, socialisation and real life were the main goals of drug rehabilitation based on community education. This provided the foundation for the operational concept of the community, according to which the individuals had to participate in all the activities of the

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<sup>41</sup> The Kisko Unit of Kalliola Clinics is a treatment unit providing community treatment for drug addicts over 18. The entire staff (10) and 15 patients were interviewed for the study. Ten people who had finished the treatment and five who had dropped out were also interviewed.

<sup>42</sup> By the end of 1999, 15 women and 28 men entered the community, i.e. a total of 43 pupils. 32 pupils left rehabilitation. The researcher examined the life trajectory and the childhood socialisation processes of all the pupils, and in the case of the 11 pupils who remained in treatment the researcher also examined the socialisation process in community education. A follow-up study is under way dealing with the pupils' situation 1–5 years after leaving the community.

community and commit to different roles and to taking responsibility for themselves and their actions. By emphasising that the individual is always responsible for his/her own actions and him/herself, community education also focused on the individuality of the drug addict. The aim was that the internalisation of the new attitudes, values and operational models would continue after the client left the community. (Hännikäinen-Uutela 2004.)

Ruisniemi (2006) has studied the change in the self-image of a person recovering from substance addiction in community treatment<sup>43</sup>. According to the study, the community was consciously used to promote change and the peer group was considered important. The 12-step programme was the central recovery model in the community, and those in rehabilitation committed themselves to attend regular AA and NA group meetings. According to the study, the interviewees' self-image seemed to have become more flexible and their attitudes towards other people had changed. They felt that community feedback and activities had helped them to change.

Ulla Knuuti (2007) studied on a more general level the lifestyle and recovery of people who had stopped using drugs.<sup>44</sup> Drug use that had continued for years had usually caused multiple health problems and problems with work, education, income, living and relationships. The effect of the past on the present was evident in all aspects of life. There were various competing explanations for the changes taking place in an individual recovering from drug addiction. Those who currently had a contact to care for them felt that the contact supported them. Family and significant others had an important role in the maintenance of sobriety. Peer groups also had a large impact on the life of the interviewees.

The study also showed how the social atmosphere and political decisions did not always support rehabilitation. Those belonging to the mainstream population often had a low tolerance for differences. A former drug user encountered disrespect and distrust. The path to becoming an equal citizen is long. Various bodies in society do not always understand the problems related to drug addiction and do not always favour the culture of recovery. (Knuuti 2007.)

The study showed that a drug addict needs a sufficient distance from acute drug use for recovery to begin, but living without drugs in itself does not mean that the person has truly recovered. The basis for truly content sobriety is for the person to be freed from the internalised feelings of being different. An optimistic view of the future and a recovery culture that maintains and supports the new way of life are thus emphasised as the central factors that prepare the person for normal everyday life. (Knuuti 2007.)

### **5.3 Medically assisted treatment**

According to the drug treatment information system in 2006, one fourth of those who had sought treatment for opiate addiction received medical outpatient or inpatient treatment. The proportion remained roughly the same as in the year before but was clearly bigger than in 2004 (19%). According to the information system, buprenorphine (70%) was more common in the medical treatment of opiate addiction than methadone (26%). However, within one year the proportion of methadone had almost doubled from the year before. Sixty-one per cent of the buprenorphine used in

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<sup>43</sup> The material consisted of interviews with ten patients that were conducted at the beginning and end of a one-year community rehabilitation period as well as 1–2 years after the rehabilitation. (Ruisniemi 2006.)

<sup>44</sup> Thirty-two people with a serious drug past were interviewed for the study. At the time of the study, they had been free from illegal drugs for at least a year.

treatment contained naloxone in addition to buprenorphine. (Kuussaari & Ruuth 2007.)

It was estimated that approximately 1,000 clients were in substitution or maintenance treatment in Finland, 450 of whom used a combined preparation of buprenorphine and naloxone as a substitute medication, 150 used buprenorphine and 530 used methadone. Overall, it was estimated that 13% of the clients undergoing treatment programmes were in substitution treatment and that the waiting time for admission to substitution treatment was approximately 6–12 months. (Alho 2007.)

In August 2006, the Ministry of Social Affairs and Health conducted a study on the availability of 24-hour detoxification services.<sup>45</sup> The study dealt with the situation in the largest cities and urban municipalities and thus cannot be generalised for the whole country. In the units that were studied, a drug user could generally be admitted to detoxification within one to three weeks. The duration of the treatment periods varied in the units from 24 hours to four weeks. Most respondents had not observed any changes in waiting times or client numbers. However, almost all reported that the physical condition of the clients had deteriorated in the past few years. The composition of the clientele had remained the same in most localities. (Renko & Vuorinen 2006.)

Vorma et al. (2005) studied substitution treatment, how well patients remained in treatment, substance abuse during treatment, social rehabilitation, and psychiatric co-morbidity at the addiction psychiatry unit of the Helsinki University Central Hospital (HUCH).<sup>46</sup> Patients committed to treatment well; 94% remained in treatment after one year of starting the treatment. During the study, opiate abuse declined to the extent that out of the patients who had received treatment for at least a year and a half, 75% had not used additional opiates during the past year. Almost all the patients were polydrug users at the time they started treatment but during the treatment, other substance addictions also decreased clearly. During the follow-up study, part of the patients returned to active working life, but more patients were granted sick leave or disability pension. During the treatment, the patients were medically assessed and therefore were able to apply for appropriate subsistence support.

According to a study on the conditions for the treatment of clients who were admitted for opioid substitution and maintenance treatment between 2000 and 2002 in units outside the Greater Helsinki area, the clients typically had multiple problems. (Veide et al. 2007.)<sup>47</sup> During the period of evaluation there were 34 clients, 7 of whom were excluded from the study due to insufficient data. Eighteen of the clients were under 25 years old, 15 were unmarried and 13 had no vocational education. All the clients received social assistance and were in debt, 15 were awaiting trial. Their level of education was poor, and their lives involved unemployment, debt and criminal activity. Besides mental health problems, they frequently experienced somatic symptoms, and many had attempted suicide and had hepatitis C. The most common opioid they had used was buprenorphine, and polydrug use was common. Seventy per cent of the patients remained in substitution and maintenance treatment during the one year

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<sup>45</sup> The study was based on telephone interviews with 15 inpatient detoxification units in ten largest cities (with over 75,000 inhabitants) in Finland. The results are not based on official statistics, but rather on information received from the appointment books at the time of the study and on the subjective views of the interviewees on the changes in demand.

<sup>46</sup> The study included all the patients who started opioid substitution treatment in 2000–2002 at the HUCH Outpatient Department for Opioid Addiction. 70 new treatment periods were started during the study. One person started the treatment twice during the study period. The retroactive study was based on case histories. All the patients in the study received methadone treatment. (Vorma et al. 2005)

<sup>47</sup> Cp. Section 4.2.

follow-up period. The factors predicting that a patient would remain in treatment were a higher age, female gender, a higher level of education and good treatment motivation.

The municipality of Nurmijärvi, which is located in Southern Finland and has a population of 35,000, carried out a study on substitution treatment in primary health care, i.e. at the local health centre.<sup>48</sup> The central conclusion of the study was that it is possible to treat opiate addicts at health centres with substitute medication and psychosocial support, but the treatment must be based on sufficient expertise and resources. An effective security system must also be in place in order to prevent burglary and theft, even though opiate addicts seldom caused disturbance to the staff or other patients at the health centre. (Halmeaho & Nuorvala 2005).

A trial was also conducted on the transfer of substitution treatment to a day centre for homeless people. The trial resulted in similar observations and conclusions as in the health centre study. An important requirement for the work is strict rules within which each patient is treated individually. Despite the client-oriented approach, a client cannot decide on the content of his/her treatment, for example on the number of screenings or the level of medication, because ultimately the personnel is in charge of the treatment. (Forssén 2005).

There is a need to develop the psychosocial rehabilitation system for patients in substitution treatment (Makkonen 2005)<sup>49</sup>. With the OHJAT project, the A-Clinic Foundation has studied the psychosocial rehabilitation of clients in substitution treatment in the Greater Helsinki area and the factors that prevent or support psychosocial rehabilitation<sup>50</sup> (Harju-Koskelin 2006). The biggest challenge in the psychosocial rehabilitation of patients in substitution treatment was employment, as 80% of the clients were long-term unemployed. Some of them were also in debt or were involved in criminal activity. Many clients had still not completely left the criminal lifestyle behind them, and 40% of those interviewed had committed offences<sup>51</sup> during the treatment period.

According to Malin, Holopainen & Tourunen, the experiences of buprenorphine users themselves should be taken into account more when planning buprenorphine substitution treatment. (Malin et al. 2006.)<sup>52</sup> By involving users in the planning and by recognising their expertise in issues related to the use of buprenorphine, new doors could be opened in substitution treatment.

So far, Western societies have dealt with substance addiction as a question of morality and will. (Weckroth 2006.)<sup>53</sup> Recovery is thus characterised by a struggle against one's own compulsive cravings with the help of a moral community. Addiction

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<sup>48</sup> The Nurmijärvi health centre began administering substitution treatment in 1998 and by spring 2002, the centre had treated thirteen opiate addicts. By spring 2004, thirty patients had received treatment. The appraisal of the operation was based on 27 interviews with key people in the municipality. The material was collected in 2003–2004. (Halmeaho & Nuorvala 2005.)

<sup>49</sup> The report evaluated the current state and development needs of detoxification treatment in Southern Savonia and North Karelia.

<sup>50</sup> The study was conducted through bi-annual interviews with clients who had received substitution treatment in substitution treatment units in the Greater Helsinki area from six months to a year. Data was also gathered through questionnaires. Sixty clients in opiate substitution treatment participated in the study.

<sup>51</sup> When subjects were asked about criminal activity, drug-user offences were excluded from the data.

<sup>52</sup> The study by Malin et al. (2006) was based on interviews with twelve problem users of buprenorphine. The theme interviews were conducted at the Vinkki health counselling centre in Helsinki and at the Järvenpää Addiction Hospital.

<sup>53</sup> The study was based on an ethnographic research approach and included discussion groups held for the clients of a drug treatment unit once a month, participating observation of the activity, and theme interviews with the entire nursing staff (10) and 10 clients in 2001–2002.

has been called an illness, but it has not been given a similar judicial or social status as other lifestyle-related health problems, such as cardiovascular diseases. The ideology behind the substitution treatment of opiate users is an attempt to redefine substance addiction as a neurobiological condition and to put drug addicts on an equal standing with other health service users. Substitution treatment and its related medicalisation signify an attempt to define substance addiction treatment as the treatment of an individual's health problem.

Substitution treatment units often use the classification of "drug users' world" and "normal people's world". Figuratively the methods employed in a treatment programme, such as substitute medication, promise to transfer clients from the drug world to the normal world. This classification may however prolong a client's journey to sobriety by emphasising the marginalisation of drug users. However, substitution treatment does challenge old thought patterns and it forces the actors providing drug treatment to find new ways of working. (Weckroth 2006.)

Since the interviews in the Weckroth study were limited to 2001 and 2002, the majority of clients had started their opiate use with heroin. The interviews indicated that the use of buprenorphine was for them especially problematic because of its dual nature of being used both in treatment and as a substance of abuse. The differences between the various treatment methods used in the same treatment unit were reflected in the different goals of the clients. Those clients receiving substitution treatment felt that the treatment had a positive effect on withdrawal symptoms and this encouraged a change in lifestyle, whereas those in detoxification treatment felt that medical treatment had a negative effect on one's life management skills and the ability to change one's lifestyle. The differences in the client's goals were also reflected in their views on harm reduction versus the prevention of drug use.<sup>54</sup> (Weckroth 2007.) This same dichotomy can also be seen in Finnish drug policy.<sup>55</sup>

Substitution treatment is usually linked with the treatment of opiate users. There is no specific detoxification or substitution medication for amphetamine addicts. In 2004, a clinical study on the treatment of amphetamine addiction "*Aripiprazole and methylphenidate in the treatment of amphetamine addiction: a randomised, placebo-controlled double-blind study*" was launched". (Tiihonen et al. 2006.)<sup>56</sup> The study is the first study on amphetamine in the world that was conducted with a placebo as a so-called randomised study. The target group was individuals living in the Greater Helsinki area who had used amphetamines intravenously for more than 10 years. According to the 2005 intermediary analysis of the study results on 50 patients, methylphenidate seemed to work well in reducing amphetamine use. The comparison of methylphenidate and a placebo in the treatment of amphetamine addiction is on-going.

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<sup>54</sup> The material of this additional study consisted of 10 theme interviews with clients from the material used in Weckroth's primary study. (Weckroth 2006.)

<sup>55</sup> Cp. section 1.2. Institutional framework, strategies and policies

<sup>56</sup> The study was a collaborative effort of the Deaconess Institute, the Department of Psychiatry of the Hospital District of Helsinki and Uusimaa, the Department of Forensic Psychiatry at the University of Kuopio, the Department of Forensic Medicine at the University of Helsinki and the National Public Health Institute. The Department of Psychiatry of the Turku University Hospital will also participate in the follow-up study.

## 6 Health correlates and consequences

The number of hepatitis C, B and A cases recorded in the infectious diseases register has clearly declined over the past decade. Health counselling centres have played an important role in reducing the spread of drug-related infectious diseases.

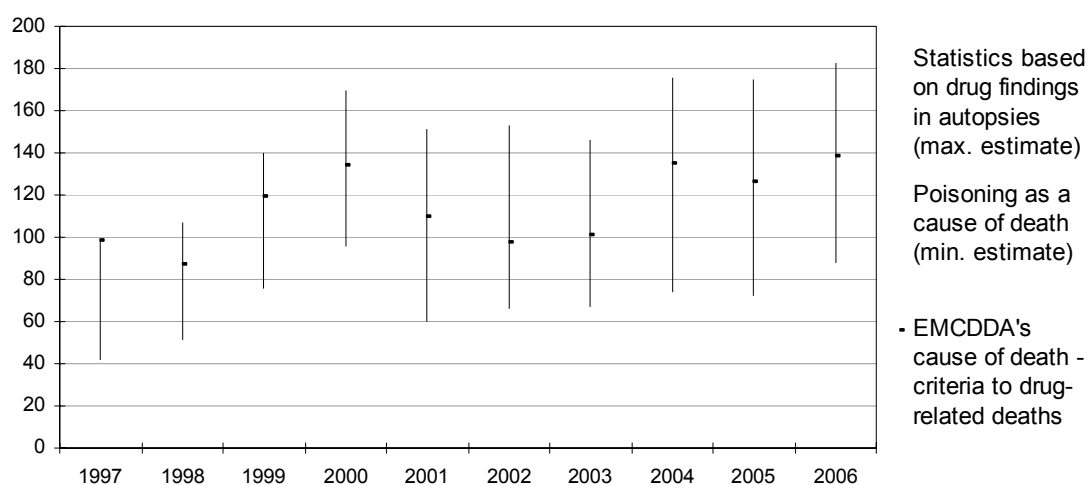
Drug-related psychiatric co-morbidity has increased fourfold since the beginning of the 1990s. The treatment of co-occurring drug and mental health problems is carried out in practice within substance abuse services. Substance abuse services still have insufficient resources for treating so-called dual diagnosis patients, who are often excluded from psychiatric services due to their substance abuse problem. The prevention of other drug-related health consequences, such as deaths and accidents, has been included for example in traffic safety campaigns.

Buprenorphine abuse has increased substantially in Finland in the 2000s. Buprenorphine is also becoming the most common finding in drug-related deaths by poisoning.

### 6.1. Drug-related deaths and mortality of drug users

The number of drug-related deaths grew along with other detriments at the turn of the millennium (Figure 3), which was a consequence of the increased drug use in the 1990s. In the 2000s, the number of drug-related deaths has varied annually but overall, their number has remained at the higher level they reached after the rise without showing clear signs of decline or increase. Drug-related deaths follow fairly consistently the trends in drug use, especially the trends in the use of injected drugs. Quick changes in the methods of use (intravenous use gains popularity, heroin disappears from the market) or new substances that enter the market can affect the number of deaths by poisoning fairly quickly.

Figure 3. Drug-related deaths according to different criteria 1995–2006.





Source: Statistics Finland; Department of Forensic Medicine, University of Helsinki

Drug-related deaths can be examined based on cause of death and chemical findings in forensic autopsies. According to information on forensic chemical findings, there were 183 (174 in 2005) drug-related deaths in Finland in 2006. Amphetamine was found in 64 (64) cases and cannabis in 99 (71) cases. The number of heroin and cocaine deaths has remained very low. In 2006, there were two heroin findings and one cocaine finding. Opioids were found in 30 (36) cases. Buprenorphine, which has become an increasingly common opiate finding, is not detectable in the opiate screening test, but it was found in 88 (83) cases. The proportion of other opioids – tramadol, oxycodone and fentanyl – in drug findings has also increased. (Department of Forensic Medicine 2007.)

The victims of buprenorphine-related deaths have been mainly young people. In 2002, two thirds of the victims were under 25 years old, and in 2003–2004 one third belonged to this age group. Typically, young people who have died of buprenorphine poisoning have first consumed alcohol and/or benzodiazepines and have then injected buprenorphine and gone to sleep or passed out without ever waking up again. (Vuori et al. 2006.)

There was one finding of gamma-hydroxybutyrate (GHB) both in 2003 and 2004; in both cases, the poisoning caused by the substance was also the cause of death. In the 2003 case, the victim had synthesised the GHB himself and in the latter case, the cause of death was gamma-butyrolactone (GBL), which is a prodrug of GHB. (Vuori 2006.) (See also Subsection 6.4.) In 2006, GHB was found in five cases; four of these were deaths by poisoning. No detailed information is available on the circumstances of the cases. (Vuori 2007)

Table 6. Drug findings in connection with forensic examinations, 2000–2004\*

	2000	2001	2002	2003	2004
Total	171	152	153	147	176
Heroin	63 (60)	26 (25)	6 (4)	4 (4)	0
Buprenorphine	7 (3)	10 (2)	22 (13)	73 (33)	73 (36)
Cannabinoids	62	62	70	82	80
Amphetamines	77 (11)	84 (10)	61 (16)	51 (5)	52 (8)
Cocaine	1 (1)	1 (1)	2 (2)	1 (0)	3 (2)

\*) The cause of death can be other than poisoning. The figures in parenthesis represent the number of cases where a drug has been the primary cause of death by poisoning.

Source: Vuori et al. 2006.

## 6.2 Drug-related infectious diseases

### HIV

According to the HIV infection statistics maintained by the National Public Health Institute, 194 new HIV infections (140 in 2005) were reported in 2006. The number of

infections contracted through intravenous drug use accounted for 5% of cases where the means of transmission was reported, showing a decline from the previous year (11% in 2005). According to the 2006 results of the drug treatment information system, two per cent of those who had used drugs intravenously and had taken an HIV test and received their test results (n=2,872) were HIV positive as reported by the clients themselves (Kuussaari & Ruuth 2007).

The number of drug users with chronic HIV viremia in Finland has been estimated at 250–300. HIV infection causes chronic viremia in almost all cases. The number of HIV cases related to the HIV epidemic that began at the end of the 1990s has so far remained below 250 in the Greater Helsinki area, and the prevalence of these cases in the area is also low (under 5%) among drug users. (Ristola 2006.)

According to a recent study<sup>57</sup>, HIV positive intravenous drug users who live in the Greater Helsinki area (Helsinki, Espoo and Vantaa) are marginalised both socially and regionally. There was an HIV epidemic among intravenous drug users in the Greater Helsinki area in 1998, but the epidemic took a downward turn in 2000. All the areas outside the centre of Helsinki, where users said that they had spent time or used drugs at the time of the HIV diagnosis, were areas in which men had the lowest rate of employment (less than 70%). The HIV infections of the intravenous drug users were concentrated in areas described as poverty areas. The conclusion drawn from the study was that when HIV prevalence is low, preventative measures should be targeted especially at socially marginalised drug users who practice risk behaviour and spend their time outside the city centre. (Kivelä et al. 2007.)

### *Hepatitis C*

In 2006, a total of 1,175 hepatitis C cases were diagnosed (1,243 in 2005). In approximately 55% of these cases the means of transmission was reported (National Public Health Institute 2007) and of these cases, four fifths were contracted through intravenous drug use. According to the 2006 results of the drug treatment information system, 67 per cent of those who had used drugs intravenously and had been tested for hepatitis C and received their test results (n=3,011) had hepatitis C as reported by the clients themselves. (Kuussaari & Ruuth 2007.) According the assessment of Ristola (2006), there are more than 15,000 drug users with chronic hepatitis C viremia in Finland.

Hepatitis C has been most prevalent within the Hospital District of Helsinki and Uusimaa (HUS). In 2004, the number of hepatitis C cases within the HUS district had declined by 48% when compared to the number in 1997. It seems that the decline is partly due to the introduction of health counselling because from 1997 to 2004, both the number of clients and the number of syringes and needles exchanged multiplied at health counselling centres. Pharmacies also have an important role in ensuring the availability of clean needles and syringes.

In Finland, hepatitis C started to spread on a larger scale in the 1990s. However, its health consequences and burden to the health care system will not be fully revealed until after 2010, as it takes years for cirrhosis of the liver due to hepatitis C to develop (Ristola 2006). The results of the treatment for hepatitis C have improved over the past few years and in most cases, a lasting treatment result can be achieved (Färkkilä 2005).

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<sup>57</sup> The material for the study consisted of HIV positive drug addicts who visited the clinic of infectious diseases at Helsinki University Central Hospital at least once between 1998 and 2003. Of the 213 clients, interview data on 176 (82.6%) clients was available for the study. The data related to drug use, sources of income, living conditions, education, employment, substance abuse treatment and imprisonment. The clients were also asked to name a maximum of four areas where they had spent time or used drugs at the time their HIV infection was diagnosed.

According to pharmaceutical consumption statistics, a couple of hundred patients receive treatment for hepatitis C each year in Finland and according to Ristola (2006), a health economic analysis should be conducted on whether the treatments should be available for more people with hepatitis C.

### *Hepatitis B*

The number of acute hepatitis B cases recorded in the infectious diseases register has shown a significant decline over the past decade. In 2006, 37 cases were reported. The means of transmission was reported in more than half of the hepatitis B cases, and infections contracted through intravenous drug use had decreased the most (4 cases in 2006). (National Public Health Institute 2007). The number of drug users with chronic hepatitis B viremia in Finland is estimated at 300–500 (Ristola 2006).

The decline in the number of hepatitis B cases is partly due to the vaccinations provided for intravenous drug users at health counselling centres and an effective needle and syringe exchange programme (e.g. Leino 2005). According to the 2006 results of the drug treatment information system, two thirds of those who had injected drugs sometime in their life had received at least one injection against hepatitis B (Kuussaari & Ruuth 2007).

### *Hepatitis A*

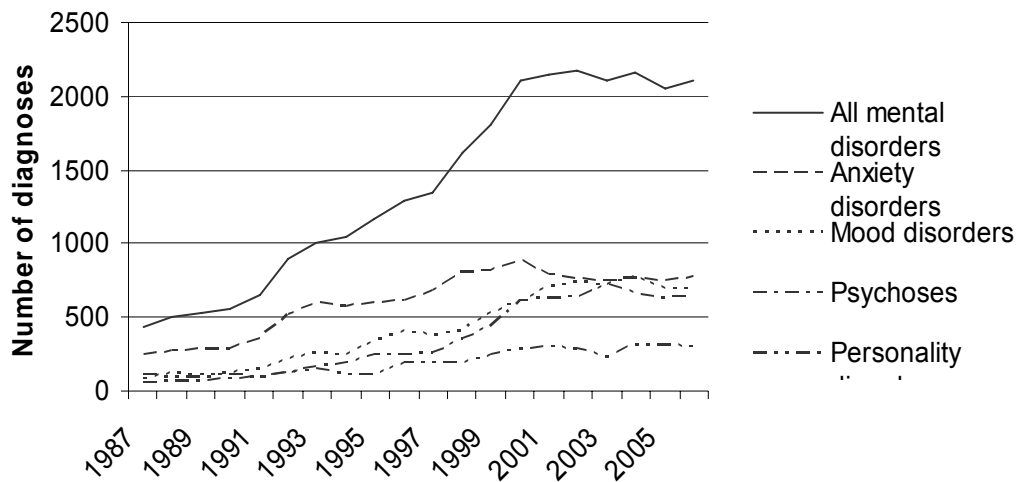
According to the infectious diseases register maintained by the National Public Health Institute, there were 26 hepatitis A cases in Finland in 2006, i.e. the same number as in 2005. Eleven of the cases were contracted abroad, seven in Finland, and one in either Finland or Norway. The means of transmission was not reported in seven of the cases.

The year 2004 showed a downward turn in the hepatitis A epidemic that had started among intravenous drug users in the Greater Helsinki area and had caused a rapid rise in new infections (393 cases were diagnosed in 2002 and 243 in 2003). Since the beginning of 2005, the hepatitis A vaccination has been included in the national vaccination programme for intravenous drug users.

## **6.3 Psychiatric co-morbidity (dual diagnosis)**

Figure 4 shows the number of mental disorder diagnoses co-occurring with drug diagnoses. The number of all psychiatric disorder diagnoses grew throughout the 1990s, but the trend has levelled off in the 2000s.

Figure 4. Mental disorder diagnoses co-occurring with drug diagnoses in 1987–2006 according to the hospital patient discharge register.



Source: Hospital patient discharge register, STAKES

#### 6.4 Other drug-related health correlates and consequences

Several overdoses due to the combined use of GHB (gamma-hydroxybutyrate) and alcohol were reported in the summer of 2006. There were several cases at summer events and festivals where the combined use of GHB or GBL (gamma-butyrolactone) and alcohol had caused such things as delirium and unconsciousness. The GHB sold in Finland is illegally manufactured, impure and its strength varies. GBL, which is a prodrug of GHB, is used as an industrial chemical in detergents and thinners. The information gathered by drug researchers from various sources shows that the problems have become more prevalent. The overdose cases indicate that as the substances have become more common, those young people who do not have enough information on the substances and their combined effects and risks have started to experiment with them. The A-Clinic Foundation reported on the issue and risks involved in July 2006.

The Riski study on risk behaviour among intravenous drug users also asked the interviewees about their health. Only one in ten respondents said that drug use had not caused them any health problems during the past six months. Two out of five had experienced paresthesia, shivers, problems with their teeth and mental health problems. Almost every third had experienced psychosis or delirium. One third of the respondents had experienced shortness of breath and exhaustion that had lasted more than a week. One fourth had experienced night sweats, angitis, chest pain or fevers exceeding 38°C that lasted more than a week. Almost one fifth cited anaphylactic reactions or a severe cough. Other cited health problems, such as abscesses, were rare. Of the rarest cited health problems, the most serious were myocarditis (2%) and pneumonia (4%). (Partanen et al. 2006.)

## 7 Responses to health correlates and consequences

The treatment and prevention of infectious diseases related to drug use is carried out within primary health care services, specialised services within health care and substance abuse services, health counselling centres and pharmacies that sell syringes and needles. HIV infected patients are treated in university hospitals and the central, regional and psychiatric hospitals in the area.

Low-threshold services in particular have been essential in preventing and reducing infectious diseases spread by intravenous drug use. 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 infectious diseases and other serious risks related to drug use, such as overdoses and sexually transmitted infections. Health counselling centre services are free of charge for clients and the clients can visit the centres anonymously.

Pharmacies have an important role in exchanging syringes and needles in areas where there are no health counselling centres. Since 2004, health centres have had a new responsibility of preventing infectious diseases, including health counselling for drug users and, if needed, the exchange of syringes and needles. Free hepatitis A and B vaccinations have been included in the vaccination programme for intravenous drug users.

### 7.1 Prevention of drug-related deaths

No special projects to prevent drug-related deaths are currently underway. Some training concerning drug-related deaths is provided as part of the basic training in social welfare and health care – in emergency care training, for example. Prevention of drug-related deaths is also carried out as part of health counselling related to infectious diseases and in problem user peer group activities. To prevent overdosing, awareness has been raised on the importance of correct dosage and calling for help in time. The issue is also dealt with in drug treatment units, when necessary.

### 7.2 Prevention and treatment of drug-related infectious diseases

At the beginning of 2005, the National Public Health Institute in Finland recommended a new vaccination programme. For the first time, the hepatitis A vaccination was included in the general vaccination programme. This decision was made based on the hepatitis A epidemics of the past few years among intravenous drug users and their circle of acquaintances. Isolated cases where the hepatitis A infection had been contracted abroad have not caused epidemics and therefore, the only target groups for the hepatitis A vaccination sited in the general vaccination programme are intravenous drug users and their contacts as well as patients with haemophilia. (National Public Health Institute 2005.)

The vaccination programme also recommends the hepatitis B vaccination for specific risk groups, including intravenous drug users, their sex partners and people living in the same household. It is deemed especially important that the newborn babies of parents who use drugs intravenously are vaccinated. The means to reduce hepatitis C infections among drug users are to reduce intravenous drug use or to reduce risk

behaviour related to intravenous drug use. Infectious diseases related to drug use are usually contracted by problem drug users. Thus, according to Ristola (2005), Finland cannot in the coming years afford to cut down operations that aim to prevent infectious diseases related to drug use.

In 2006 there were health counselling centres that exchange needles and syringes in approximately 36 localities, mainly in cities with over 50,000 inhabitants. The centres also provide counselling on health issues, small-scale health care, testing and vaccination services and case management. The health counselling centre statistics for 2006 are not fully complete at the time this report is published<sup>58</sup>. As 75% of the centres had provided their statistics and the remaining 25% only included two health counselling centres that dealt with a large volume, the data could be compared with the 2005 statistics in order to outline the trend. According to available data, it appears as if the number of clients increased in 2006 by 25% when compared with the previous year. The number of visits seemed to have dropped slightly from the previous year. The rise in the number of exchanged syringes and needles seemed to continue; it was up by a fifth compared with 2005. (Anturiverkosto 2007.)

The Riski study<sup>59</sup> (Partanen et al. 2006) examined risk behaviour among intravenous drug users between 2000 and 2003. The most common form of risk behaviour among the interviewees was sharing dirty needles and syringes. One fifth had used dirty needles and syringes during the past month, three quarters during their lifetime. Sharing needles and syringes was less common among the clients of health counselling centres than it was among non-clients. Risk behaviour was also quite common in all types of sexual contact. More than one in four had had a sexually transmitted disease sometime in their life. Only a small proportion of the interviewees said that they had received safe sex counselling at health counselling centres.

Risk behaviour and long-term intravenous drug use could be seen in the high prevalence of hepatitis C among the interviewees. According to the results of the saliva tests given to the follow-up group, 52% had hepatitis C and 3% had HIV. Among those who had used drugs intravenously for less than a year, only one sixth had hepatitis C whereas among those who had used drugs intravenously for more than six years, three quarters had hepatitis C. Thus, the critical time for preventing infections is very early on, when the person has just started intravenous drug use. (Partanen et al. 2006.)

It is estimated that a couple of hundred Russian-speaking drug users who are at a high risk of infectious disease live in Finland. A special drug prevention project directed at Russian-speaking immigrants was launched in autumn 2002. Within the project, the so-called snowball operation based on peer work was implemented among drug users in Helsinki. Substance abuse workers trained intravenous drug users to recognise the risks of infectious diseases as a result of intravenous drug use and to tell other drug users how to prevent those risks. The project specifically aimed at taking the immigrants' language and cultural differences into consideration. The Helsinki-based Russian language snowball project trained 11 drug users who helped

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<sup>58</sup> The Anturiverkosto network, set up by the A-Clinic Foundation, the National Public Health Institute, the Research and Development Centre for Welfare and Health (STAKES) and the health counselling centres, is responsible for gathering information on health counselling centres. In 2007, the network introduced a web-based data collection system but the system has experienced a few technical problems causing delays in data collection.

<sup>59</sup> For the Riski study, a total of 493 preliminary interviews were conducted in three localities between 2000 and 2003. Sixty-six percent of the interviews were carried out at health counselling centres and 63% in Helsinki. Follow-up interviews were conducted every six months after 0.5–1.5 years. But participants began to disappear: 177 participants were available for interviews after six months and only 82 were available after 1.5 years. For some, the follow-up continued after this for up to three years.

to reach 28 Russian-speaking and 81 bilingual or Finnish-speaking drug users. The snowball operation was able to contact ninety per cent of them for the first time. A similar project was carried out in Russia, and the results revealed the need for and possibilities of peer work among drug addicts in St. Petersburg. Another aim was to reach out to HIV positive drug addicts in the Tallinn area, Lithuania and prisons in Estonia, and to offer them assistance. The future challenges for this type of neighbouring area projects are to define a common value base for drug treatment and to develop the co-ordination of substance abuse prevention, solutions for securing resources, networking and project work. (Puro 2005a; Puro & Tuori 2006.)

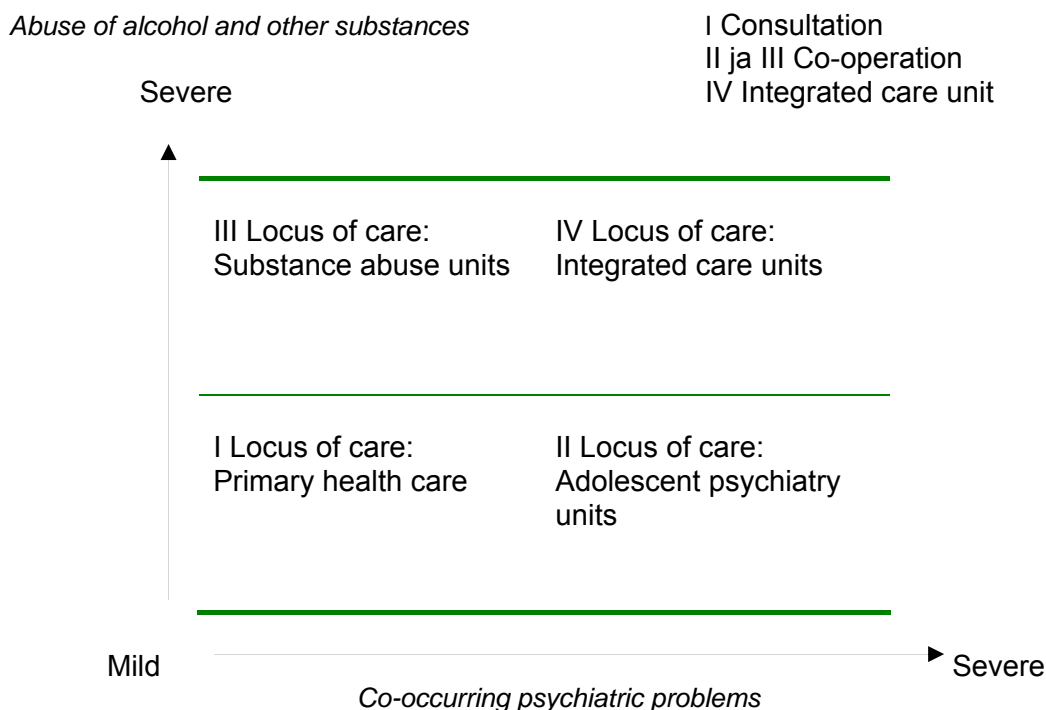
### **7.3 Interventions related to psychiatric co-morbidity**

One interesting result of the follow-up study on intravenous drug users was that the users' mental health problems decreased during the follow-up period in 2000–2003. It seems that being a client of a health counselling centre reduced the occurrence of mental health problems because at the centres, users undergoing difficulties in life receive conversational support and referrals for follow-up services. (Partanen et al. 2006.) (See more on the study in Subsection 7.2.)

The publication series "Tietoa nuorten kanssa työskenteleville aikuisille" (*Knowledge for adults working with young people*) by the National Public Health Institute includes a guidebook on the assessment and treatment of young people's substance abuse disorders and co-occurring mental health disorders. The starting point is that "after a comprehensive assessment, treatment measures are targeted at both disorders and the young person's development phase and the special characteristics of the substance abuse problem and the co-occurring psychiatric problem are taken into consideration in the treatment". Within psychosocial treatment, good results have been achieved by combining motivational techniques and/or cognitive-behavioural treatment with family-centred or community-oriented care. When prescribing medication for co-occurring mental health problems, physicians must consider the combined toxic effects of the medication and the patient's substance of abuse and assess the risk of abuse of the medication. Medical treatment must always be combined with psychosocial treatment. (Pirkola et al. 2007.)

The treatment of young dual diagnosis patients requires intensive co-operation between the social and health services as well as the clear division of their responsibilities in order to give the young person adequate treatment.

Figure 5. Care responsibility and co-operation between care providers in relation to the severity of disorders.



Source: Pirkola et al. 2007

The first care contact is usually established within primary health care (section I) such as school or student health care or health centres. In sections II and III the main responsibility lies with units of substance abuse services or the A-Clinic Foundation (youth centres, A-Clinics, inpatient units) which fall under the administration of social services or units of specialised health care services (adolescent psychiatry clinics, adolescent psychiatry wards), which should co-operate seamlessly. For severely symptomatic patients, there should be new types of units (section IV) combining expertise in substance abuse treatment and adolescent psychiatry, so that the units could provide young dual diagnosis patients with integrated treatment interventions. Combining knowledge on adolescent development and disorders with expertise in substance abuse treatment would be efficient and cost-effective and it would meet the needs of the young person. (Pirkola et al. 2007.)

#### 7.4 Interventions related to other health correlates and consequences

The September 2004 amendment to the Road Traffic Act stipulated that a physician has a duty to report to the police authority, without being bound by professional secrecy, if there have been permanent changes in a patient's health that have rendered him or her unfit to drive. The only information the physician is allowed to report to the police is that the health requirements for a driving licence are not met. Any related additional measures may also be reported.



The application guidelines for the duty to report define strict criteria that have to be met before the physician can report a patient unfit to drive due to substance abuse. The medical certificate may not be sent to the police authority without the patient's consent unless these strict criteria are met. The application guidelines emphasise that the decision usually requires additional tests and that the assessment should be made separately for each individual and taking into consideration the type of their driving license. According to the guidelines, the criteria for the duty to report are met when substance abuse has caused permanent changes in the patient's health, thus affecting his or her abilities to function, perceive, judge and react. The criteria for the duty to report are also met if neuropsychological tests show that substance abuse has clearly weakened the patient's functional ability or if the patient's behaviour has, due to severe addiction or substance abuse, changed permanently, an example of this being that he or she repeatedly drives under the influence. (Seppä 2005.)

A pivotal question in assessing a substance abuse patient's fitness to drive is whether the substance abuse disorder can be diagnosed as a permanent condition. There is no simple test for the assessment of a substance abuse patient's fitness to drive, and the assessment is particularly difficult when the patient has a dual diagnosis. Especially those in opiate substitution treatment often have other co-occurring psychiatric disorders. Another difficult group of patients is those who repeatedly seek treatment within emergency services without committing to long-term treatment: a physician is not entitled to report patients to the police authority based on isolated encounters. Even though the decisions concerning driving fitness have to be made on a case-by-case basis, some guidelines are needed that could be applied to drug-addicted patients in substitution treatment and in other long-term rehabilitation programmes. (Seppä 2005.)

The Department of Obstetrics and Gynaecology of the Helsinki University Central Hospital (HUCH) has introduced an enhanced care model in which a special care team handles the treatment of substance abuse patients. Between August 2002 and the end of November 2005, 312 pregnant drug abusers were treated. Thirty-two per cent of the patients also used drugs intravenously during pregnancy. The pregnancies and the births mainly went well. For the most part, the newborn were healthy and the number of anomalies did not exceed the normal average. None of the newborn needed intensive care. The biggest problems were the newborn's withdrawal symptoms, which extended their stay in the hospital. Half of the babies were discharged with the help of support interventions in community care, 21% went on to a substance abuse treatment unit with their mothers, 11% were discharged without support measures, 11% were placed outside the home, 4% were taken into care and one child was given up for adoption. The newborn who had been exposed to drugs in the womb were referred for growth and development monitoring. The mother was also referred for follow-up care. (Halmesmäki et al. 2007.) (See also Section 5.1)

The care model has yielded good results. The treatment of substance-abusing women carried out as teamwork is focused and systematic and at its best, it generates a good degree of trust with the patient. Combining pregnancy monitoring and substance abuse treatment facilitates the referral of mother and child for follow-up treatment. (Halmesmäki et al. 2007.)

According to the ethnographic study by Riikka Perälä (2007b)<sup>60</sup>, health counselling centres are often seen merely as places where needles and syringes are exchanged, when in fact the centres' workers feel that other aspects of their work are more important. They see needle and syringe exchange as an opportunity to establish contact with a client and to get the client to use the available services. For some

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<sup>60</sup> For information on the material and methodology of the study, see footnote 61.

clients, health counselling centres are places where they can take a break from the drug world and do ordinary things; they spend their time in the centres eating, talking, reading magazines and using the Internet. For the long-term homeless, the centres provide a homely environment to relax, sleep and wash.

## 8 Social correlates and consequences

The 2006 results of the drug treatment information system revealed the same facts as do many other studies on problem drug users' risk behaviour, substitution treatment and HIV infections: problem drug users are socially marginalised or on the brink of marginalisation. In 2006, 62% of drug treatment clients were unemployed and 11% were homeless and the clients had a low level of education. (Kuussaari & Ruuth 2007.) As drug use is punishable under criminal law, many clients are also in a vicious cycle of crime and prison.

There was no big change in the number of drug offences. In 2006, there were 14,286 drug offences known to the police (13,317 reports of an offence, see Table 6). Of these, 61% (n = 9,285) were drug-user offences, 4% aggravated drug offences and 35% other drug offences. The number of drug offences dropped by 7% when compared with the previous year. (National Bureau of Investigation 2007.)

*Table 7. Drug offences reported by the police and Customs in 1999–2006.*

	1999	2000	2001	2002	2003	2004	2005	2006
Drug offences in total	11,647	13,445	14,869	13,857	15,058	14,486	14,425	13,317
Drug offence	10,701	12,687	12,092	5,821	5,202	4,672	4,589	4,168
Drug-user offence			1,899	7,240	9,084	9,217	9,248	8,480
Aggravated drug offence	958	741	859	760	742	582	561	657
Preparation or abetment of drug offences	15	17	19	36	30	15	27	12

Source: Statistics Finland

### 8.1 Social exclusion

Riikka Perälä (2007) has studied<sup>61</sup> drug users' interpretations of their problems and the social and health care interventions designed to address those problems. In the light of the material, intravenous drug users appear to be a heterogeneous group which divides into subgroups based on whether the users see themselves as part of the so-called normal or abnormal population. From the point of view of treatment and services, it is worth noting that users speak of their drug use as only one part of their daily programme, which consists of handling multiple simultaneous problems and is characterised by a fast "work rhythm". This usually leads to an oppressive rat race type of existence, and many

<sup>61</sup> The study is based on ethnographic observation and interview material collected at health counselling centres for intravenous drug users between 2003 and 2006. This summarised article is based on the observation material (1,200 pages of field notes) and client interviews (n=20). A constructionist research approach is applied and the analysis builds upon interpretative frameworks and repertoires identified in the material.

users would need help to break away from it. Another essential aspect is the users' sense of having no prospects in life. Many feel that they have failed completely in life, and their experiences with strict control measures seem unfair to them, as if they are being kicked when they are already down. Hence, they easily feel resentment towards society and its institutions, which should be taken into consideration in the development of treatment and services. (Perälä 2007a.)

Problem drug users are a socially marginalised group. Sixty-two per cent of drug treatment clients were unemployed and the clients' level of education was low. For two thirds, the highest level of education achieved was comprehensive school and six per cent had dropped out of comprehensive school. Eleven per cent of the clients were homeless. About a fifth was married or cohabiting, half of these with a partner who also had substance abuse problems. One in three had children under the age of 18. Three fourths of the children did not live with their parents. (Kuussaari & Ruuth 2007.)

No studies have been conducted in Finland on the extent of drug use among socially marginalised people but it is estimated that the majority of homeless people have substance abuse problems.

## 8.2 Drug-related crime

In 2006, the number of drug offences recorded by the police (13,317) dropped by 8 per cent when compared with the previous year. Of all drug offences, the number of drug-user offences (8,480) has decreased and the number of aggravated drug offences (657) has increased from the previous year. The proportion of drug-user offences is 64%, the proportion of aggravated drug offences is 5% and the proportion of other drug offences is 31%. In 2006, 8,500 people were suspected of drug-user offences, 4,200 were suspected of drug offences and 560 were suspected of aggravated drug offences. (Statistics Finland 2007.) The number of aggravated drug offences has decreased in the long term: by a quarter between 2001 and 2006. (Kainulainen 2007b)

Overall, the police suspected 13,500 people of different drug offences. Women accounted for 16% (2,139) of all suspects. One fifth of the suspects were less than 21 years old. There were slightly fewer than 500 15–17-year-olds, and among them one fifth were girls (n=101). Underage people were usually suspected of drug-user offences. Four per cent of all those suspected of drug offences were foreigners (483 persons). Usually they were suspected of drug-user offences; 72 foreigners were suspected of aggravated drug offences. (Statistics Finland 2007; Kainulainen 2007.)

The number of robberies of pharmacies and other locations where intoxicating pharmaceuticals are stored (72) remained at the level of the previous year, which indicates that demand and supply are stable on the drug market (National Bureau of Investigation 2007).

The differences between the criminal behaviour of Finnish and Swedish-speaking young people were examined in a separate study by extending the sample to cover Swedish-speaking pupils<sup>62</sup>. The use of marijuana or hashish is 2.8 percentage points more common among Finnish-speaking boys and girls. Between the two language groups, there are no differences in the use of other drugs or in financing drug use by illegal means. The study strengthens the image of Swedish-speaking Finns as a

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<sup>62</sup> 5,142 Finnish-speaking pupils and 1,137 Swedish-speaking pupils.

positively deviating minority<sup>63</sup> in that the smaller rate of criminal activity among Swedish-speaking Finns is explained by their having a stronger sense of community. (Obstbaum 2006.)

In 2005, two per cent of assaults were committed under the influence of drugs and 66 per cent under the influence of alcohol. The proportion of violent offences committed under the influence of drugs<sup>64</sup> has grown since the 1990s, especially robbery offences. A tenth of detected robberies and a sixth of aggravated robberies in 2005 were committed under the influence of drugs. Despite this, the presence of alcohol in robbery offences is still much more common (45%) than that of drugs. (Lehti & Sirén 2006.) In 2006, 37 per cent of the people suspected of stealing a motor vehicle for temporary use were under the influence of alcohol and/or other intoxicant (Sirén & Hinkkanen 2007).

In 2006, drugs were found in 11 per cent and polydrug use in 3 per cent of all cases of driving while intoxicated. The proportion of drug use in cases of driving while intoxicated grew by three percentage points over the previous year. The cases of driving while intoxicated are divided into cases of driving while intoxicated and cases of driving while seriously intoxicated. In the cases of driving while intoxicated, the proportion of drug and polydrug use was 26% and in the cases of driving while seriously intoxicated only 5%. (Niemi 2007.) According to data provided by the alcohol and drug laboratory at the National Public Health Institute, the most common actual drugs found in cases of driving while intoxicated were amphetamine (82%) and cannabis (35%) in 2006. A total of 4,025 suspected cases of driving under the influence of drugs or pharmaceuticals were examined and actual drugs were found in 70 per cent of the cases. (National Public Health Institute 2007.)

### 8.3 Drug use in prison

In 2006<sup>65</sup>, 15.2% of prison inmates were incarcerated for a drug offence compared with 16.1% the year before.

Eight hundred and four (825 in 2004) drug findings were verified in the 17,632 (15,360) tests for drugs and pharmaceuticals conducted in prisons in 2005. The most common findings were benzodiazepine, cannabis, buprenorphine and amphetamine. Medical use accounted for about a third of the findings. During the year, 40 (49) patients entered prison whose opioid treatment continued in prison. A total of 1,073 (1,170) HIV tests were conducted, which revealed two new HIV infections, i.e. only 0.19% of those tested. (Probation Service & Prison Service 2006.)

According to preliminary results of the study on the health, working capacity and treatment needs of the clients of the criminal sanctions system<sup>66</sup>, 90% of male inmates and 60% of those performing community service suffer from substance addiction. Seventy per cent of inmates serving a life sentence and 55% of other groups suffer from alcoholism. Sixty-five per cent of female inmates suffer from drug addiction (the most common substances of abuse are amphetamine and opioids) as

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<sup>63</sup> According to the population register, 5.5 per cent of Finns spoke Swedish as their first language in 2004.

<sup>64</sup> Here, persons under the influence of drugs include those under the influence of drugs or pharmaceuticals and those under the influence of both drugs and alcohol.

<sup>65</sup> The census is conducted on 1 May.

<sup>66</sup> The study sample consisted of 700 persons (male and female inmates, default prisoners, inmates serving a life sentence, inmates held in preventive detention and offenders performing community service). The actual research report with a description of the applied methodology has not yet been released.

do 20% of community service clients. On average, 70% of the clients have a personality disorder (80% of inmates serving a life sentence, 40% of community service clients) and 50% have an antisocial personality disorder (60% of male inmates, 40% of community service clients). In all groups, 50% have hepatitis C and various somatic illnesses. According to an expert estimate, 90% of the clients in the study need some form of medical treatment. (Criminal Sanctions Agency 2007.)

## 9 Responses to social correlates and consequences

Multi-professional 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 of young people. However, the educational system does not include much training leading to a normal working career that would be adapted to the problem user's abilities. In addition, not enough employers employ these young people. One example of employment activities is youth workshops. In Finland, financially supported housing for substance abusers can be arranged within municipal social services. Housing service units for substance abusers are part of the Finnish substance abuse services. They are meant for substance abusers that need daily support for independent living.

According to the Act on rehabilitative employment activities (189/2001), rehabilitative employment activities are meant for the long-term unemployed to improve their possibilities to find employment. The Act 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; instead, the client should be directed primarily to substance abuse services.

According to Act 878/1995, prison health care must be organised so that inmates have equal opportunities with the rest of the population to improve their health and prevent illness. They must also have access to sufficient health care services. Substance abuse work in prisons is based on the intoxicant strategy for the prison administration for 2005–2006 drawn up in 2004.

Prison health care provides inmates with information on the effects of intoxicants, health risks related to substance abuse and treatment programmes available in prison as well as outside prison after release. Withdrawal symptoms that accompany quitting substance use are usually treated in prison in line with the instructions given by the prison physician. If an inmate suffers from severe withdrawal symptoms, he or she can be placed in a prison hospital or hospital care outside prison. It is also possible to provide detoxification, substitution and maintenance treatment with opioid medication in prisons. (Probation Service & Prison Service 2006.)

In co-operation with the relevant organisations, the Prison Service has prepared various alcohol and drug programmes for inmates in prisons and for drug users released from prisons. 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. Alcohol and drug programmes are usually based on the cognitive-behavioural theory. Community treatment programmes are also implemented in prisons. Prisons aim at close co-operation with substance abuse services outside prison, and in some prisons substance abuse services are outsourced. Inmates have the possibility to participate in AA and NA groups. (Probation Service & Prison Service 2006.)

Those sentenced to over two years' imprisonment are first placed in the assessment and placement unit within their own municipality, where a personal risk and service need assessment is made. The risk and service need assessment considers the

factors related to the inmate's life situation and personality that sustain criminal behaviour. Special attention is paid to inmates' substance abuse. Based on the assessment, a preliminary plan for the term of sentence is drawn up in the assessment and placement unit, and the plan is specified and updated in placement institutions. The aim is to enable systematic use of the sentence term to improve the inmate's capability to cope after release without committing crimes. (Probation Service & Prison Service 2006.)

The new Act on Imprisonment requires that a plan based on risk and needs assessment be made for the duration of an inmate's sentence, not only for those who are serving a sentence of over two years, but also for all those inmates who will be released on supervised probation. Additionally, a plan for the duration of an inmate's sentence, which fulfils minimum requirements and which is based on written material, shall be made for admitted inmates sentenced to unconditional imprisonment. The plan also includes a release plan compiled well in advance before an inmate is released and a surveillance plan compiled by the Probation Service for inmates who will be released on supervised probation (Criminal Sanctions Agency 2007).

Important hindrances to anchoring persons released from prison into society and implementing personalised rehabilitation are the inmates' poor health, short sentences and their excessive number in relation to places in prison institutions<sup>67</sup>. Released inmates are easily excluded from primary services due to lack of resources as well as prejudice: municipalities do not believe in their ability to recover and some services do not even want to acknowledge these people as valid clients. Various organisations offer services that enable a released inmate to get support for different problems under the same roof, but this type of activity is hampered by the short-term nature and insecurity of municipal and State funding. (Rantala 2005.)

A work group formed by the Ministry of Justice investigated how drug treatment could be made more effective for those serving community sanctions. The group completed its report, *Päihdekuntoutus ja yhdyskuntaseuraamukset* (2006: 19) (*Drug Rehabilitation and Community Sanctions*), in October 2006. The group proposed that drug rehabilitation be incorporated into the enforcement of all community sanctions if necessary. This requires closer, systematic, and client-specific collaboration with the Probation Service and municipal social welfare and health care.

The amendment to the Penal Code concerning drug-user offences (654–657/2001) introduced the possibility of alternative penal sanctions. The focus was on two special groups: underage offenders should be referred to a multi-professional hearing instead of imposing a fine on them, and problem drug users should be referred to treatment. A multi-professional hearing is considered a more efficient sanction for young offenders than a fine. Treatment referral reduces the social exclusion of problem users as well as drug-related crime.

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<sup>67</sup> The material consists of public documents from the "Co-operation for crime-free life" project, the results of the network training workshops organised by the Criminal Sanctions Agency in Tampere, interviews with specialists, authorities and the third sector (25) and the accounts of two persons with a criminal background undergoing rehabilitation. (Rantala 2004.)



## 9.1 Social reintegration

The basis for Törmä's (2007) evaluative research on the City of Helsinki's substance abuse work<sup>68</sup> was to find practices that would improve the status of problem drug users and their quality of life and with which it would be possible to reduce the harm experienced by the environment around them. Three case studies were investigated<sup>69</sup>: a model for day centres for substance abusers, a service model for health counselling of drug users, and a service model for social housing management. Törmä compared various models in Helsinki and the immediate vicinity.

The social welfare office for the homeless in Helsinki offers a form of housing support referred to as *Asso's* social housing management. The model offers residents support by helping them with outstanding rent payments, preventing them from losing their home, and reducing harm caused by substance abuse and mental health problems. It resembles the A-Clinic Foundation's supported housing model, for example, in that the superintendent lives in the same building and is therefore constantly available, although he/she may not always be doing superintendent duties. Working alone, however, can become too much of a burden. With supported housing, leases are bound to agreements concerning treatment and support. However, with *Asso* residency is permanent and drug rehabilitation a separate function. The *Asso* model utilises a network of co-operation and chiefly strives to direct clients to the services of other bodies. Supported housing chiefly involves work with clients with its own staff. The success of the social housing management model depends on how well the city's system of services works. From the point of view of offering opportunities to take residence somewhere and reducing harm caused by substance abuse, the model is a promising one, and for some residents it is the only opportunity they have to live independently. (Törmä et al. 2007).

The study indicates that low-threshold units and work out in the field are crucial in urban substance abuse work. Day shelters that are able to satisfy basic needs, such as rest and nutrition, should be available, and substance abusers who lack a permanent place to live should be offered a place of residence. There have been positive experiences in outreach work in the form of peer work for those living in subcultures and those with serious problems. Due to the diversity typical of the urban environment, services should be tailored to suit various needs. Client-oriented co-operation among various bodies, e.g. a pair work model where an employee of basic services and an employee of specialised services work together with the client, helps people with multiple problems. Because of Helsinki's geographical location, new drugs and new ways of using drugs quickly find their way into the city. Contributions to preventive action against the adverse effects of drug abuse should be made, even if the situation seems to be good, because of the serious HIV situation in the neighbouring areas. (Törmä et al. 2007).

Finland's first association for drug abusers, *Lumme*, was established in October 2005 and it was registered in the Associations Registry in April 2006. There are approximately 70–80 members, half of which are drug users and half close friends/relatives of users and professionals in the field of substance abuse. The association's activities concentrate on supporting and providing consultation to drug addicts. Support involves, for example, helping out with issues in various offices and

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<sup>68</sup> Data for the study comprises interviews with staff in organisations offering the services (14 interviews in total), and visits to the places in question (8 places).

<sup>69</sup> This report concentrates on housing services. Activities in day centres and health counselling centres have been discussed in earlier reports (see <http://www.stakes.fi/FI/tilastot/aiheittain/arkisto/paihteet.htm>).

at the physician's office. The association distributes syringes and condoms and offers health counselling about infectious diseases, as well as advises on the importance of taking tests for infectious diseases and practising safe sex. *Lumme* is also a voice for those who, for one reason or another, do not take advantage of the services offered by health counselling centres. The members of the association have also cleaned up a couple of places where drug abusers inject themselves. (Soimula 2007).

In 2003–2005, the Ministry of Social Affairs and Health and the Ministry of Education co-ordinated a national project to develop substance abuse prevention at youth workshops. The method developed by the project for the workshops was communal training. The aim of communal training is that the workshops develop communal operating models for preventing and dealing with substance abuse problems. Communal training helped with clarifying the workshop rules for substance use, developing activities and committing workshop participants to the activities. Communal training also increased communal responsibility and solidarity and lowered the threshold for intervention. (Ministry of Social Affairs and Health 2006.)

## 9.2 Prevention of drug-related crime

### *Assistance to drug users in prison*

In 2006, 881 (987 in 2005) inmates with substance abuse problems participated in rehabilitation programmes and in addition short counselling sessions and motivational interviews were offered. A total of 246 inmates took part in programmes to minimise recidivism, and 541 inmates partook in other types of social rehabilitation. Moreover, 50 inmates were admitted to external institutions for substance abuse treatment or other institutions for rehabilitation. A lack of trained counsellors has made it difficult to organise programmes. However, the time inmates use for participating in activities and alcohol and drug programmes during working hours on a daily basis has increased from 5.6% to 6.8%. (Criminal Sanctions Agency 2007).

In 2006, the reported number of drug confiscations in prisons had decreased from the previous year. Due to stricter control (e.g. drug detector dogs) and the growing number of intoxicant-free wards and intoxicant tests conducted in them, the amount and use of intoxicants in prisons have remained constant and even declined in the long term. These factors have increased the risk of being caught. The consequences of losing the opportunity for treatment in an open institution and permission to leave the premises effectively prevented the use of intoxicants. (Criminal Sanctions Agency 2007).

Riitta Granfelt (2007) has investigated an alcohol and drug programme that prepares female inmates in Vanaja prison for life outside the prison<sup>70</sup>. The loosely structured drug rehabilitation model works well although it is still being developed. Basic conditions for quality rehabilitation include the counsellor's social skills and the knowledge of the influence of the cognitive framework. Female inmates suffer from numerous mental health problems and fear associated with social interaction. Group rehabilitation is not suitable for everyone and therefore work with the individual must also be available. A multi-professional approach is also important to be able to treat the intertwining problems associated with drugs and mental health.

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<sup>70</sup> The study was conducted using an ethnographic approach, i.e. participant observation (during 5 months in two courses of the alcohol and drug programme that prepares female inmates for life outside prison) as well as interviews with female inmates and prison staff (15 inmates and about 20 representatives of staff).

Work with clients in preparing them for life outside prison, the creation of co-operating networks, and the development of systematic rehabilitation continua are not the responsibility of anyone at the moment. Since female inmates with a history of substance abuse have numerous socio-economic problems and problems with family relationships associated with being released from prison, the outcome of alcohol and drug programmes should be included as part of the release plan. Furthermore, it is important that the sick and most marginalised also receive rehabilitation. (Granfelt 2007).

The Probation Foundation Finland has an on-going project called *TERVE 2005–2008* involving health education and peer support for inmates who are drug users. The purpose of the project is to reduce the amount of infectious diseases as well as other health and social risks and harm arising from the use of drugs and to increase security. Peer activity is being introduced as a new method of working. The goal is to create operations models for prison staff, health counselling and treatment guidance based on peer support, as well as to generate a training programme and guidebook for realising the models. (Probation Foundation Finland 2007).

Throughout the course of the project, individual days of training and courses in health education and peer support have been organised. In spring 2007, the YLE Teksti-TV teletext service presented preventive material about the adverse effects of using drugs for inmates and prison staff for a period of two months. Topics in the series of articles included viral hepatitis, HIV, alternatives to using needles, drugs and mental health, overdose and first-aid, advice on health issues, and peer activities. (Probation Foundation Finland 2007).

#### *Alternative sanctions*

The Prosecutor General's instructions for prosecutors in autumn 2002 (Prosecutor General 2002), which were updated in autumn 2006 (Prosecutor General 2006), recommend that prosecutors arrange a hearing for 15–17-year-olds who have been arrested for committing a drug-user offence for the first time. The young offender, his or her guardian, a representative of the social welfare authorities and the police participate in the hearing where the young offender is informed of the criminal and reprehensible nature of drug use as comprehensively as possible, the offender's life situation is examined and appropriate further measures are decided. After the hearing, the prosecutor can decide to waive charges.

A recent study (Kainulainen 2006a) examined the changes in the practices of waiving charges. The data on the decisions to waive charges for 2001–2003 included 243 cases in which a hearing was arranged for the offender whose charges were waived. This accounts for 18 per cent of all decisions. The young person was usually guilty of trying a mild drug or other minor drug use. Eighty per cent of the cases were boys and 20 per cent were girls.

According to information gathered from prosecutors by the Office of the Prosecutor General, the hearing procedure was used some 47 times in 2006 and the prosecutor almost always decided to waive charges after a hearing (Office of the Prosecutor General 2007).

According to a separate study on hearings<sup>71</sup> (Rönkä 2006), the authorities use different discourses when talking to young people about drugs. They talk about the health and social consequences of drug use, its immoral and illegal nature and the way in which drug use hinders young people from integrating into society. The young offenders themselves talk very little in the hearings. They mainly respond briefly to the prosecutor's questions or agree with the authorities' comments. Social workers also did not speak much in the examined hearings, and drug education was mainly provided by the prosecutor and the police. The drug education on health and social consequences given by the authorities was one-dimensional.

The Prosecutor General's instructions for prosecutors (VKS 2002:3) encourage prosecutors to agree on appropriate treatment referral procedures in their own localities. Especially problem drug users should not be fined for a drug-user offence until the offender's willingness to seek treatment has been examined. In October 2006, the Prosecutor General updated the guidelines and issued instructions whereby in minor cases the police should confiscate the substance, give an oral warning and waive most charges. (Prosecutor General 2006).

The guidelines were updated due to the observations made in a study on sanction practices (Kainulainen 2006). Some decisions to waive charges based on the person seeking treatment were made right after the introduction of the amendment to the Penal Code concerning drug-user offences. The data on the decisions to waive charges in 2001–2003 included 178 mentions about treatment; this corresponds to 13% of all decisions. Seventy per cent of the cases were men and 30 per cent were women. Treatment focused on minors; almost half the cases were 15–17-year-olds. Those whose charges were waived were typically guilty of drug use or the possession of drugs for personal consumption. Almost half the cases involved mild drugs, (Kainulainen 2006.) The sanctions system had thus been made more stringent although it was not the intention of the legislators.

According to a survey conducted among prosecutors by the Office of the Prosecutor General, there were 35 decisions in 2006 to waive charges based on the person seeking treatment (Office of the Prosecutor General 2007).

#### *A drug control project carried out by the police in the Greater Helsinki area*

A drug control project targeted at districts known for drug problems was implemented in the Greater Helsinki area in 1999–2001. The aim of the project was to reduce drug sales and drug-related crime in the dwellings in the area. The project also aimed at reducing the insecurity and disturbance caused by trading in drugs as well as at creating new co-operation practices between the police and other authorities. The project was carried out through extensive drug raids and intensified control in restaurants and on the streets in busy areas. In addition, intensified road traffic control focusing on drugs was carried out in some areas. (Kinnunen et al. 2005.)

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<sup>71</sup> The data consists of the observations on 12 hearings between October 2003 and May 2004. The hearings were held in Southern Finland.

An evaluation study<sup>72</sup> (Kinnunen et al. 2007) examined the realisation of the project's objectives: the project did not succeed well in increasing the residents' sense of security in that they failed to notice the raids, and the police paid no attention to those residents who showed interest and would have liked to provide further information about the disturbance in the area. When the news of the police raids spread among the traders, the drug market went deeper underground. The raids reduced drug sales because the traders thought the police operations had intensified for a longer period of time than they actually were, which curbed the activity of some drug users and traders on the market.

The effect of the raids on the amount of crime reported to the police is difficult to evaluate based on statistics, but one possible interpretation is that the results were poor during the initial stage of the project but in time, the operation became more efficient and crime decreased in the districts. There was no significant intensification of co-operation with other authorities. Drug users were not directed to social and health care services; the police took a pessimistic view on drug treatment because they considered the users "lost causes". In terms of improving co-operation, the police also considered it a problem that social workers were only available during office hours. (Kinnunen et al. 2007.)

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<sup>72</sup> The material was collected in 2000–2001 and it consisted of ethnographic observation of police operations in 5 localities, observation of hearings (20), interviews with police officers, arrested persons, social workers, building managers and residents (a total of 70 interviews), survey forms on the drug raids (22), a sample of reports of an offence (138) and statistics on offences reported to the police in 16 areas before and after the drug raids in 1999–2000. The methodical basis of the study was qualitative evaluation research.

## 10 Drug markets

The drugs on the Finnish market are mostly cannabis products, synthetic drugs such as amphetamines and ecstasy, the buprenorphine preparation Subutex® and especially benzodiazepines. Heroin is still fairly rare in Finland. Among cannabis products, the number of marijuana and cannabis plant seizures has grown in the 2000s, which indicates that the fairly small-scale cultivation of drugs that are partly intended for sale has become more common. The number of seizures of synthetic drugs has remained fairly constant, except for the changes that are due to the phasing of the investigation of large complex crimes. The amount of seized heroin plummeted after 2001 and at the same time, seizures of Subutex® tablets started to increase. The number of Subutex® seizures has also dropped since 2005. (National Bureau of Investigation 2007.)

*Table 8. Drugs recorded as seized by the police and Customs in 2000–2006 (kg)*

	2000	2001	2002	2003	2004	2005	2006
Hashish	196.5	566.6	482	423.1	467.4	430.6	282.7
Marijuana	13.8	13.7	32	45.3	25.8	43.4	32.9
Amphetamines	78.3	149.7	129.2	114.6	108.6	116.6	129
Cocaine	38.6	7.3	0.4	1.1	1.1	1.2	6.5
Khat	348	624	1,039	1,879	2,118	2,562	3,283
Heroin	6.0	7.9	3.1	1.6	0.2	52.4	0.2
Subutex (tablets)	12,951	38,200	18,700	37,284	32,970	24,478	22,979
Ecstasy (tablets)	87,393	82,900	45,100	35,216	23,243	52,210	39,185
LSD (doses)	2,355	95	4,629	1,461	195	452	171

Source: National Bureau of Investigation

*Table 9. Number of drug seizures recorded by the police and Customs in 1998–2006*

	1998	1999	2000	2001	2002	2003	2004	2005
Hashish	1,997	2,259	2,482	4,011	3,012	2,796	2,626	2,408
Marijuana	382	463	663	1,223	1,275	1,712	2,067	2,305
Amphetamines	1,641	1,956	2,369	3,778	3,399	3,687	3,392	3,732
Cocaine	24	49	40	55	45	49	65	79
Heroine	210	342	437	558	145	90	45	58
Subutex	-	-	-	727	741	1,008	844	777
Ecstasy	57	159	393	465	329	316	328	363
LSD	-	15	34	14	10	20	21	17

Source: National Bureau of Investigation

In drug supply in Finland, organised crime groups led from Estonia have had an important role – at the beginning of the 21st century especially in smuggling and importing drugs and later on also as collaborators of Finnish crime groups, supplying drug consignments for distribution. In recent years, the role of Finnish crime groups in the distribution of drugs in Finland as well as in the acquisition of drugs from abroad has increased, but the Estonian collaborators of Finnish crime groups around Europe

are still the main suppliers of drugs to Finland. (National Bureau of Investigation 2006.)

### **10.1 Availability and supply of drugs**

The import of drugs is an international crime and in recent years, 15–30% of those suspected of aggravated drug offences in Finland have been foreigners. In 2006, their proportion decreased from 28% in the previous year to 14%. Among foreigners suspected of aggravated drug offences, the largest groups in 2006 consisted of Estonians (41%) and Russians (14%). (National Bureau of Investigation 2007.) Organised crime groups led from Estonia play an important role in acquiring drugs from abroad and smuggling almost all drugs to Finland.

At the same time, the role of Finnish criminals in smuggling and trafficking drugs has strengthened. Finnish criminals also participate in the acquisition of drugs from abroad and distribute them in Finland. This has closed the ranks of Finnish professional crime, which is typically loosely structured, and made it more disciplined. Readiness to use violence within organised drug crime is evident in the growing number of guns and ammunition confiscated during drug crime investigation. Organised drug crime groups have also expanded their activities to economic crime and fraud, which is used as a means of financing drug crime. (National Bureau of Investigation 2007.)

The majority of drugs are smuggled onto the Finnish market through various routes from south and west. About 90% of the amphetamines on the Finnish market come from Estonia or via Estonia, mainly from Lithuania, whereas hashish comes from Morocco via Spain and either Scandinavia or the Baltic countries. Russia is a significant route especially for smuggling heroin. The lack of treatment services and the decreased supply of Subutex on illegal markets may increase the demand for heroin. In addition, Finland is a potential route for the international smuggling of heroin from Russia to elsewhere in Europe. The popularity and supply of cocaine seem to have taken an upward swing since 2006, but cocaine is still quite rare on the Finnish drug market. (National Bureau of Investigation 2007.)

A recent study (Hakkarainen et al. 2006.) evaluated the amount of cannabis on the Finnish market based on demand. The study estimated the total number of cannabis users on the basis of population survey results, and an estimated number of those problem users who are underrepresented in population surveys was added to this figure. The amount of cannabis used was estimated by using the results of qualitative studies. Users were divided into five groups according to the models of cannabis use: experimenters, occasional users, active occasional users, weekly users and daily users. The amount of cannabis used annually by each group was estimated based on the frequency of use. When estimated this way, there were 106,200 cannabis users in Finland in 2004 and they used 1,700–4,250 kg of cannabis during the year. This exceeded the common assessment that the proportion of seized cannabis (2004: 493 kg + 7,840 cannabis plants) was 5–10% of the cannabis available on the market. According to this study, a more accurate estimate would be 10–25 per cent.

Since 1997, the annual Health Behaviour Survey among the Finnish Adult Population has asked people if they have been offered drugs during the past year. The number of drug offers increased in the youngest age groups until the turn of the century; since then, the figure decreased from 25 per cent to 13 per cent among 15–24-year-old men between 2001 and 2006. The upward trend in the 1990s and the downward trend

in the 2000s are also evident among young women. According to the latest survey, the number of drug offers among 15–24-year-old women dropped from 18% to 11% between 2005 and 2006. Among 25–34-year-olds, the proportion of those who had been offered drugs is larger than before. This indicates that those who belonged to the younger age group during the upward trend have reached this upper age group. (Piispa et al. 2007.)

## **10.2 Drug seizures**

There were no significant changes in drug seizures in 2006 (National Bureau of Investigation 2007). Hashish seizures dropped in kilograms (283 kg in 2006) and increased in number (2,599 in 2006) from the previous year. Marijuana seizures also dropped in kilograms (33 kg), as did the number of cannabis plants seized (7,510 plants + 36 kg) and the number of cannabis plant seizures (1,378), but the number of marijuana seizures (2,269 in 2006) continued to grow slightly. (National Bureau of Investigation 2007.)

In the long term, the amount of seized drugs has taken a downward swing. The decrease was preceded by the multiplication of seizures in the 1990s, although the starting level in Finland was low. Now the amounts of almost all drugs on the market are on the decline compared with the peak years, with one exception: increasing amounts of cannabis plants have been seized in the 2000s apart from 2006. (Kainulainen 2007b.)

Amphetamine seizures increased slightly in kilograms (129 kg), but the number of seizures (3,101) dropped. Ecstasy seizures declined (39,185 tablets, 297 seizures) when compared with the previous year. Cocaine seizures (6.5 kg, 82 seizures) grew; this clearly indicates that cocaine is gradually becoming increasingly popular in Finland. Khat seizures have grown throughout the 2000s. A total of 3,283 kg of khat was seized in 2006. (National Bureau of Investigation 2007.)

The amount of seized heroin plummeted at the beginning of the 21st century (2004: 0.2 kg). In 2005, a single seizure on the Russian border essentially increased the total amount of seized heroin. In 2006, the amount of seized heroin (0.24 kg) returned to the previous low level. (National Bureau of Investigation 2007.)

The amount of the seized buprenorphine preparation Subutex® continued to decline (22,979 tablets, 840 seizures). (National Bureau of Investigation 2007.) Large Subutex® consignments are smuggled into Finland from France, and smaller amounts are brought mainly against prescription primarily from Estonia. It has been noted in Estonia that besides Subutex, some physicians prescribe Finnish drug addicts sedatives that are classified as narcotic drugs in Finland and favoured by polydrug users. (Finnish Customs 2006). Other pharmaceuticals classified as narcotic drugs (mainly benzodiazepines and some opiates) were seized somewhat less than in the previous year, but the number of seizures increased slightly (74,924 tablets, 3,525 seizures) (National Bureau of Investigation 2007).

## **10.3 Price and purity of drugs**

The laboratory identification of drugs and the testing of the purity of drug consignments take place at the Crime Laboratory of the National Bureau of Investigation or at the Customs Laboratory.



The Crime Laboratory of the National Bureau of Investigation examined amphetamine seized in street trade (0.5–10 g) between September 2005 and March 2006. A total of 304 samples were analysed. The range of the purity of amphetamine was 0–99.1 per cent, the average purity being 24 per cent and the median value 23 per cent. The average purity has dropped significantly compared with the figures in 1993, when the average purity was 30 per cent and the median value 32 per cent. When examined by region, the purity of amphetamine was highest in the Greater Helsinki area and lowest in Eastern Finland. The size of the test sample was not related to its purity. (National Bureau of Investigation 2006.)

There were no significant changes in the prices of drugs in 2006. In 2006, the average street price per gram was EUR 6–12 for hashish, EUR 60–120 for white heroin, EUR 15–25 for amphetamine, EUR 60–100 for cocaine and EUR 12–20 for ecstasy tablets. However, the price may significantly differ from the average level in different circumstances: Subutex is particularly tempting to sell. In Estonian pharmacies, Subutex (8 mg tablet) costs about 6 euros, and its street price may come to EUR 30–40 on illegal markets in Southern Finland and EUR 80–120 in Northern Finland, and in prisons, where the substance is very popular among drug-addicted inmates, its price may be as high as EUR 130–150. (National Bureau of Investigation 2007.)

## B. SELECTED ISSUES

### 11 Public expenditures

#### 11.1 Introduction

The primary purpose of this section is to provide a reliable estimate of the direct public expenditure incurred by drug use in Finland in the fiscal year 2005. Private expenditure and the indirect expenditure associated with social problems are not included. The calculation framework complies with the internationally used and generally accepted cost-of-illness (COI) calculation category.

The expenditure presented in the report is based on the calculation framework established in Finland (Hein & Salomaa 1998), in accordance with which the calculated costs of the harm caused by drugs have been reported in the Yearbook of Alcohol and Drug Statistics published by STAKES since 1998. The calculated expenditure corresponds to the costs presented in the Yearbook in those respects where they are included in both calculation frameworks.

The second purpose is to ascertain which problems associated with drug use cost the most, who ultimately covers the costs, the types of activities for which resources are allocated and the ratios of financial resources used for different programmes. When the structure of the expenditure incurred by drug use is known, it is possible to evaluate whether the structure of expenditure reflects decision-making.

The methodologies applied in the expenditure calculations include the analysis of state and municipal sector budgets, the utilisation of various statistics and registers and a review of the year-end reports of ministries, various authorities and organisations. Interviews, expert statements and separate studies are also necessary for the calculations.

#### *The background to the cost calculations*

An estimate of the costs of the harm incurred by substance abuse is included in the so-called COI category (Single et al. 2003). The calculations have been developed to provide information about the actual and potential resources that are lost at the level of the national economy owing to some national disease. Combining epidemiological and economic data makes it possible to compare the social resources spent on various national diseases.

Above all, the current situation can be compared with a hypothetical diametrically opposite world situation where there is no disease and therefore no costs incurred by disease. The background to this way of thinking is the concept of alternative costs and scanty resources. If there were no disease, for what other purposes could the lost resources or funds be used? One could equally study the costs that would not be generated in a world where there are no intoxicating substances.

Costs can be divided into direct and indirect costs. Direct costs comprise the functions of the health care and substance abuse services or public safety. Indirect costs refer to losses in production or costs incurred by intangible harm (suffering, pain etc.). Costs can be examined from the perspective of all social actors. In this instance, the

total expenditure is called social costs. Social costs comprise public spending, private expenditure and external influences. Costs can also be examined from the perspective of only a single actor, such as the public sector.

COI calculations essentially examine the allocation of resources with the objective of exerting an influence on decision-making and general debate. The calculations are not perfect evaluations of economic effects and neither are they cost benefit analyses. Irrespective of whether the focus of study are national diseases or intoxicating substances, the purpose of the calculations is to produce financial information on the way in which the phenomenon that is the focal point of the study burdens social resources as well as to facilitate decision-making on the allocation of resources. On this basis, it can be said that COI calculations are a part of national economic research and that they should be made in compliance with the way of thinking typical for national economics.

### *Why are calculations made?*

The health and social problems caused by substance abuse are indisputable, and the effects of the problems are widely seen in society. One aspect of drug and alcohol policy in practice should be to take into consideration the economic perspective of the problems associated with substance abuse.

Carefully constructed and precisely reported cost calculations serve different parties. Decision-making without assessing economic effects is not prudent. In a world of scanty resources, introducing the cost perspective into decision-making forces one to give due consideration to the effectiveness and economic efficiency of activities. Different activities can be targeted to where they will have the greatest effect.

Progressing from cost calculations to cost benefit analyses facilitates a comparison of the effectiveness of different activities. This provides decision-makers with the opportunity to choose the most effective combination of different activities in terms of reducing problems while an understanding of costs and their structure makes it possible to evaluate whether actual expenditure corresponds to decision-making.

Presenting expenditure also provides the public and decision-makers with the opportunity to understand the dimensions of matters. The necessary large amount of background work that goes into making cost calculations also reveals shortcomings in current working practices, both in research and in compiling statistics.

There are several problems involved with evaluating the problems stemming from drug use and their extent. Differentiating the problems associated with drug use from problems due to other factors is problematic in many cases. Moreover, it may be difficult to decide whether drugs are the primary or secondary cause for the origin of a problem.

It is not possible to maintain statistics on all drug-related problems. Where statistics are missing, expert statements are used to provide information for expenditure concerning the number and extent of problems. In such instances, the accuracy of an assessment on the amount of the cost item in question depends on the accuracy of the original expert statement.

### *Expenditure classifications*

The level and division of costs are partially an outcome of political decisions. Consequently, besides evaluating the financial amount of the costs of drug use, it is also important to examine the structure of the costs. In order to elicit the information contained in the cost structures, the expenditure is divided into four classifications.

Firstly, the calculations are classified in accordance with the UN Statistics Division's international Classification of the Functions of Government (COFOG). In the classification, the various functions within the public sector are classified according to their costs. Included are the largest, and from the perspective of society, the most interesting cost items. Secondly, the expenditure within the public sector is classified according to whether the final payer is the state or the municipal sector. The study also takes revenue transfers within the public sector into consideration.

Thirdly, the costs are classified according to their purposes (Reuter 2006). Purposes of use are prevention programmes<sup>73</sup>, drug-treatment programmes, programmes that enforce safety and order and harm-reduction programmes<sup>74</sup> (Appendix 1).

Fourthly, the costs are classified according to whether the expenditure was labelled beforehand at the time of budgeting especially as expenditure allocated for anti-drug activities or whether an expenditure item was un-labelled, specifically a cost type item of expenditure such as health care activities where it is not possible to choose the number of drug cases and therefore it is impossible to actually plan expenditure beforehand.

The above-mentioned classifications are more informative in terms of the expenditure that is subject to decision-making because classifying expenditure of this nature indicates the purposes for which society wants to allocate resources.

### *Public expenditure*

Public expenditure in this instance refers to state and municipal expenditure. The planning of public expenditure is a key aspect of a well-organised functioning administration. The use of public funds should correspond to the wishes of citizens and political will. When viewed from this perspective, the public sector budget is not a list of expenditure and revenue; rather, it is a document of the political and moral choices made by society.

This report only deals with the direct costs incurred by the public sector. The total amount of expenditure incurred by society is larger when indirect costs are included (see, for example, the Yearbook of Alcohol and Drug Statistics 2007).

The cost items used in the calculation are year-end report information, in other words, only the actual cost items are included for the year under review. In Finland, the state participates in financing municipal expenditure through the transfer of revenue. Consequently, municipalities as producers of health care services are not the sole payers of the service. Municipalities bear around 75 per cent of public sector health service costs. The remainder is paid by the state administration.

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<sup>73</sup> Prevention programmes also include drug-related research.

<sup>74</sup> Reduction of harm in this instance refers to Reuter's (2006) definition, which in addition to substitution and maintenance treatment and needle exchange programmes, is based on broader prevention of harm and subsequent minimisation of harm, such as social assistance and health care.

In some instances, it is impossible to make a precise breakdown with regard to the end payer; for instance, from the perspective of cost calculations, it is difficult to resolve projects jointly funded by several actors. The most essential point is that no expenditure is calculated several times.

#### *What is not included?*

When examining the expenditure by public administration, private sector expenditure is intentionally omitted from the review. Drawing the line between the public and private sectors can be problematic in some instances. Private sector expenditure may fall onto the shoulders of consumers to pay, for instance as raised insurance payments. There is expenditure for which it is difficult to unequivocally indicate the end payer. It is extremely likely that some costs fall via something on the shoulders of society and taxpayers. The extent of the costs also depends on political and moral choices. In a society of endless needs, the needs are generally at least as great as the reserved resources. This means that in a world of scanty resources, costs are usually generated roughly to the same amount as available funds. The expenditure could be unequal if resources were flexible directly in line with needs. What would be the costs if all drug users were able to get into detoxification immediately if they so wished? What would be the costs if drug legislation were to become stringent to the extreme?

#### *The costs of the harm caused by drug use incurred by the public sector in 2005*

The harm associated with drug use cost the public sector an estimated 180 million euros in fiscal year 2005. When taking into consideration the revenue transfers paid to municipalities by the state<sup>75</sup>, the state paid 107 million euros and municipalities 73 million euros. The calculated costs are itemised in detail in Tables 11 and 12.

When calculated per capita, the harm caused by drug use in Finland amounted to 34 euros in fiscal year 2005. In ratio to the gross national product, the costs accounted for 0.11 per cent.

The costs accounted for 0.23 per cent of all public sector expenditures and for 1.8 per cent of the social budget (the budget of the administrative sector of the Ministry of Social Affairs and Health). When calculated per problem drug user, the harm related to drug use cost 10,719 euros.

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<sup>75</sup> The calculated proportions of the costs covered by state revenue transfers are based on the report *Alkoholihaittojen yhteiskunnalliset kustannukset 2003 (The Social Costs of Alcohol-related Harm)* (Mellin et al. 2006).

Figure 6. Cost distribution between the state and municipalities.

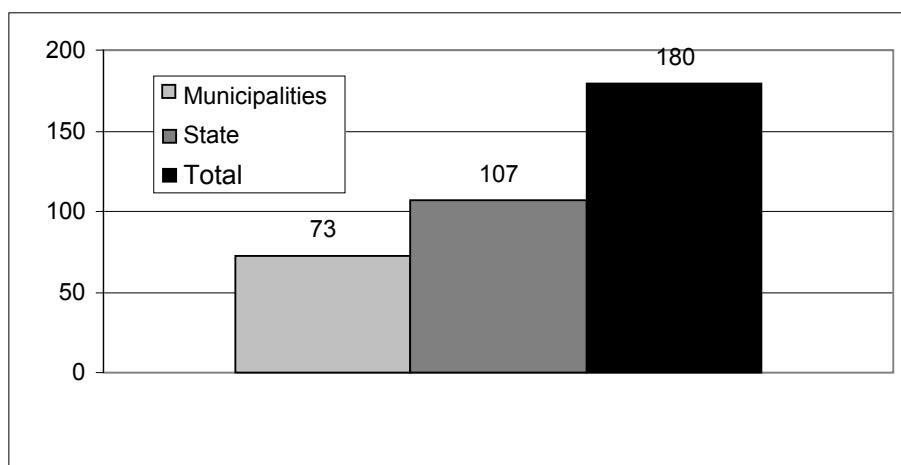


Table 10. The costs of the harm related to drug use, 2005.

Costs, total, million euros	180
Costs per capita, euros	34
Costs per problem drug user <sup>76</sup> (PDU), euros	10,719
Costs in ratio to GNP	0.11%
Costs per public expenditure	0.23%
Costs per social budget	1.8%
Costs per public sector research and development activities	32%
77	

Sources: State Treasury, Statistics Finland.

#### *Division of costs according to purpose*

The calculated costs in this report are divided according to purpose (Table 9) (Reuter 2006). When taking into consideration total costs, the public sector used the most funds on reducing the social and health problems caused by drug use (69 mill. euros).

Almost the same amount of funds were spent on enforcing safety and order (60 mill. euros), of which policing and enforcement clearly constituted the largest expenditure items. Noticeably lower funds were used on substance abuse treatment<sup>78</sup> (38 mill. euros) and the prevention of harm (12 mill. euros).

<sup>76</sup> Average of the minimum and maximum estimates of the number of problem drug users.

<sup>77</sup> Public sector research and development budget 2005, excluding the university sector.

<sup>78</sup> Includes measures to prevent infectious diseases, health counselling centres and substitution and maintenance treatment.

Table 9 also shows the upper and lower limits of the costs used in the calculation. The largest range is in the costs to reduce harm, which is due to the calculation method for health care expenditures and pension costs. Statistics on treatment periods and pensions are maintained in accordance with the International Classification of Diseases (ICD-10). In both instances, the minimum comprises cases where drug-related morbidity was the primary diagnosis. The maximum comprises cases where drug-related morbidity was the primary or a secondary diagnosis.

Figure 7. Expense distribution according to purpose.

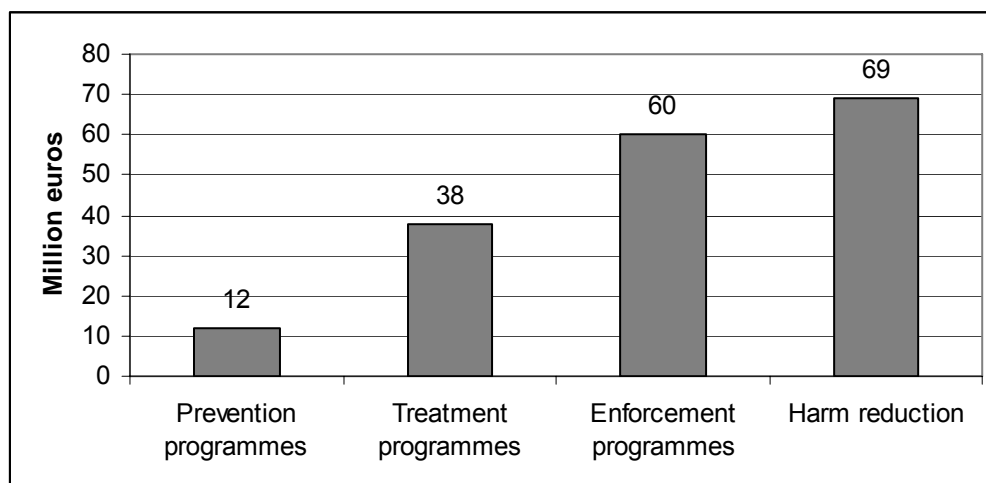


Table 11. Costs according to purpose and upper and lower limits

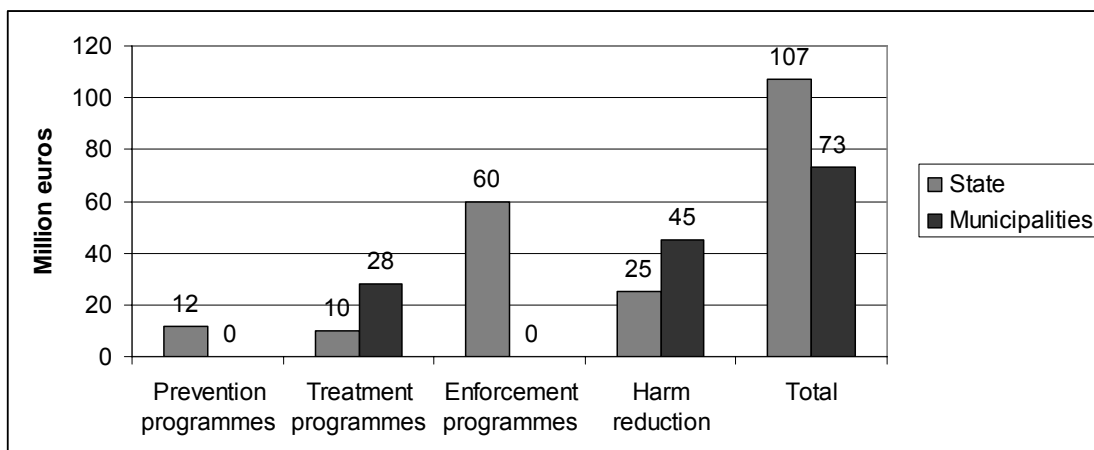
Category	Cost, million euros	Min	Max	Basic estimate per capita	Per problem drug user
Prevention programmes	12 (7%)	12	12	2	707
Treatment programmes	38 (21%)	38	38	7	2,269
Enforcement programmes	60 (33%)	53	68	11	3,600
Harm reduction programmes	69 (39%)	52	86	13	4,143
Costs, min – max	180	155	204	34	10,719

#### Who foots the bill?

If the division of work between the state and municipalities is evaluated based on the payer of costs, the harm caused by drug use quantitatively affects several state actors (Table 11). Roughly viewed, the state is responsible for enforcing order and safety and the major part of research and prevention.

Municipalities are responsible for activities related to health care and social services (Figure 8); through revenue transfers, the state contributes around one quarter towards the costs of these services. If the division of work is evaluated purely on financial criteria, it appears that the municipalities do not participate in prevention work. Prevention work is also carried out within the municipal sector but in this calculation, it does not show as an independent item.

Figure 8. Division of work between the state and municipalities



#### International comparison

The costs of drug-related harm in different countries are difficult to find, and neither is comparing countries from various demographic and economic starting points problem-free. In conducting international comparisons, the estimated expenditures should be made comparable by weighting them based on the size of the population and economy (Kopp 2003).

Table 10 presents the estimated costs of harm related to drug use for four other countries besides Finland. The figures here have not been adjusted to be directly comparable and the estimated costs for Sweden, the best closest comparison target, are from 2002.

However, it can be said that when compared internationally, the costs of the drug-related harm encountered by the public sector are low in Finland. It can be assumed that this is due to there being fewer drug users in Finland than in the countries in the comparison. Finland is also not a significant transit country for drugs unlike several Central European countries, for instance.



Table 12. International comparison

	Finland (2005)	Sweden (2002)	Netherlands (2002)	Luxembourg <sup>79</sup> (2005)	United States <sup>80</sup> (2002)
<b>Costs</b>	180	744	2,186	38–40	
<b>Percentage of GNP</b>	0.11	0.3	0.47	0.13–0.14	0.42
<b>Percentage of public expenditure</b>	0.23	0.61	1.6	0.54–0.57	1.30
<b>Per capita</b>	34	82	137	83–88	150
<b>Costs per problem drug user</b>	10,719	-	-	13,571–16,000	-
<b>Drug treatment per problem user, euros</b>	2,269	7,600	9,200	-	1,500
<b>Order and safety per problem user, euros</b>	3,600	17,000	55,000	-	8,000

Sources: Reuter 2006, Origer 2005, Ramstedt 2006.

## 11.2 Labelled drug-related expenditures

Labelled drug-related expenditures subject to decision-making amounted to an estimated 8 million euros in fiscal year 2005 (Figure 9).

There is little documentation on public labelled drug-related expenditures. Most of the budgeted expenditure is allocated directly to various authorities and institutions without more precise budgetary itemisation concerning its purpose. If expenditure is itemised at the time of budgeting, the more precise itemisations rarely end up in the actual year-end report. Financing for different projects and policy programmes may also be divided over several years and several actors are frequently involved.

In most instances, the expenditure is labelled for “substance abuse work”. In this instance, the expenditure has to be separated into alcohol or drug related expenditure. It may be difficult to make expenditure-item-specific separations between drugs and alcohol. Roughly viewed, it can be said that only the authorities and institutions carrying out anti-drug activities are in a position to differentiate the labelled drug-related expenditures. In this calculation, the expenditures by the Ministry of Social Affairs and Health and STAKES may be classified within this category. STAKES’ expenditure also includes funds allocated for international co-operation, such as the money reserved for Reitox co-operation.

Substance abuse work in Finland involves an internationally unusual arrangement. In Finland, gaming is organised through the monopoly activities of Finland’s Slot Machine Association (Raha-automaattiyhdistys [RAY]). The funds it raises through its gaming operations are used for diverse activities related to public health, sports and well-being. RAY is the single largest supporter of substance abuse work and it has

<sup>79</sup> Advance information.

<sup>80</sup> Only the expenses for the central administration.

numerous funding targets. The assets are included under public sector expenditure and they are administered through the budget of the Ministry of Social Affairs and Health.

The amount of funding annually labelled by RAY for anti-drug activities is available from RAY's funding register. The amount of funding can in no way be classified under one category because there are several funding targets related to anti-drug activities as well as organisations carrying out anti-drug activities that receive support. The funding distributed by Finland's Slot Machine Association can be classified as money labelled especially for anti-drug activities but because the amount of funding is included as a combined amount, all the projects are reported here as one expenditure item labelled for anti-drug activities. This serves to explain why in Finland there appears to be less earmarked money labelled purely for anti-drug activities.

It would be possible to obtain the detailed expenditure generated by the problems associated with drug use by increasing co-operation between the authorities and by focusing greater effort on budgeting, where expenditure items that are the foci of general interest are reported in greater detail.

### **11.3 Un-labelled drug-related expenditures**

In fiscal year 2005, drug use generated various un-labelled expenditures payable from the public budget, which are not subject to decision-making, totalling 172 million euros (Figure 9).

It is difficult to anticipate precisely all the expenditure caused by drug use. Consequently, the majority of expenditure associated with drug use is of the kind that cannot be budgeted precisely beforehand so accordingly, it cannot be labelled as drug-related. Most authorities are unable to determine the number of drug cases. The expenditure incurred by the different authorities and actors depends directly on the number of drug cases annually.

It is impossible to determine the number of drug users using public health care services. The proportion of drug-related expenditure within health care depends directly on the number of drug cases. In Finland, STAKES maintains statistics of all treatment periods and inpatient days in accordance with the International Classification of Diseases (ICD-10). Based on the classification, inpatient days arising from drug-related morbidity can be calculated separately according to diagnosis. Drug-related expenditure can be calculated subsequently when the number of inpatient days arising from drug-related morbidity and the average cost of an inpatient day are known.

The evaluation of health care expenditure can be considered as a process where by starting out from individual cases, one builds up the entire picture (*bottom-up*), whereas an assessment of the expenditures incurred by the police and the judicial system starts out from overall expenditure (*top-down*). In these instances, the proportion of expenditure arising from drug use depends on the proportion of drug cases in the workload. The proportion of drug cases in the workload has to be assessed based on expert statements because there are no actual statistics on the workload generated by drug cases.

When weighing up the validity of expenditure based on expert estimates, the aim has been to ensure their accuracy by giving upper and lower limits to expenditure proportions. The proportions of expenditure are considered to be normally divided,

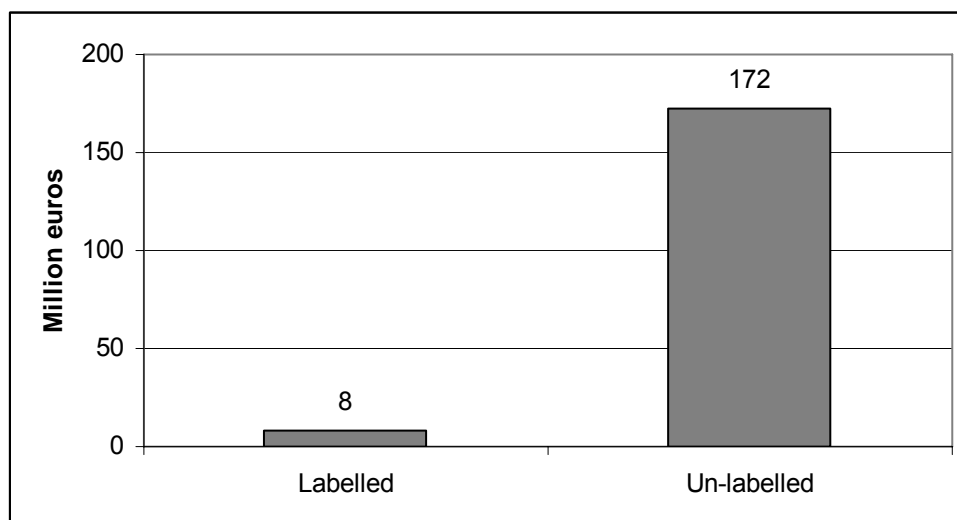
whereupon the true costs most likely fall between minimum and maximum, amounting to their mean value.

*In the light of decision-making*

Expenditure is classified according to whether the expenditure item is a labelled drug-related expenditure or an un-labelled drug-related expenditure payable from the public sector budget. The key difference is that the first-mentioned expenditure is expenditure subject to decision-making that is possible to plan beforehand and that is labelled purely for anti-drug activities. The latter expenditure is either of the type where overall expenditure depends on the annual number of drug cases, which is impossible to know precisely beforehand, or else it is expenditure that is generally allocated for “substance abuse work.”

When working according to this grouping, it is impossible to plan beforehand the greater portion (Figure 9) of drug-related expenditures or single out as a labelled drug-related expense. This being the case, it can be said that although it is possible to estimate the amount of expenditure generated by drug use and the final payer is known, there are causal relationship areas from the perspective of expenditure that are not the targets of the systematic compilation of statistics and research and neither of systematic decision-making.

*Figure 9. Labelled vs. unlabelled drug-related expenditures.*



#### **11.4 Earlier Finnish research**

Finland has long traditions of compiling statistics regarding the use of intoxicating substances and the harm caused by intoxicants. The economic evaluation of the harm caused by the use of intoxicants has also been considered important.

Hein and Salomaa’s (1998) report “Päihteiden käytön haittakustannukset vuosina 1994–1995” (*The Costs of the Harm from the Use of Intoxicating Substances 1994–1995*) can be considered as the first comprehensive Finnish study of the costs of the harm caused by the use of intoxicating substances. The study also evaluated the

indirect costs caused by the use of intoxicants, such as production losses and the financial value of lost life as well as the expenditure incurred by the private sector.

In Finland, the harm-related costs caused by the use of intoxicating substances are evaluated separately for alcohol and drugs in the Yearbook of Alcohol and Drug Statistics (Official Statistics of Finland) published annually by STAKES. The annual costs have been reported using the same calculation framework since 1998, and the calculation framework complies with the most essential aspects of Hein and Salomaa's study.

The latest Finnish study concerning the expenditure generated by the use of intoxicating substances was conducted in 2005 (Mellin et al. 2006). The study focuses on the harm-related costs caused by the use of alcohol, but the same framework can also be used when assessing drug-related expenditure.

## **11.5 Summary**

The health and social problems resulting from the use of intoxicating substances are indisputable and the effects of the harm are widely seen in society. Taking the economic perspective of the harm caused by the use of intoxicants into consideration should be one aspect of the drug and alcohol policy.

There are several problems involved with evaluating the problems stemming from drug use and their extent. In many cases, differentiating the problems associated with drug use from the problems caused by other factors is problematic and it may be difficult to decide whether drugs are the primary or secondary cause of the origin to a problem.

Drug use cost the public sector 180 million euros in fiscal year 2005. The state paid 107 million euros of the overall expenditure and municipalities paid 73 million euros. The harm caused by drug use also quantitatively affects several state actors.

When taking into consideration the total cost, the public sector used the most funds on reducing the problems caused by drug use (69 mill. euros). Nearly the same amount of funds was used to enforce safety and order (60 mill. euros). Noticeably lower funds were spent on drug treatment (38 mill. euros) and the prevention of harm (12 mill. euros).

When calculated per capita, the harm caused by drug use amounted to 34 euros. In ratio to gross national product, the costs accounted for 0.11 per cent. When calculated per problem drug user, the harm related to drug use cost 10,719 euros. Comparing different countries from various demographic and economic starting points is not problem-free but when compared internationally, the costs of drug-related harm are low in Finland. The state paid more of the costs stemming from drug use than the municipalities. The state administration is responsible for enforcing order and safety and the major part of research and prevention. The municipal sector is responsible for the activities related to health care and social services.

Expenditures are classified according to whether the expenditure item is a labelled drug-related expenditure or an un-labelled drug-related expenditure payable from the public sector budget. When working according to this grouping, drug-related expenditures are frequently of the type that are impossible to either plan precisely beforehand or single out as labelled drug-related expenses. This being the case, it can be said that there do exist causal relationship areas from the perspective of

expenditures, which are not the targets of the systematic compilation of statistics and research and neither necessarily of systematic decision-making.

Table 13. Harm-related costs from drug use incurred by the state.

COFOG	Authority	Reuter's	Budget expenditures total	Harm-related costs associated with drug use	Labelled
03. PUBLIC ORDER AND SAFETY	03.1 POLICING				
	Policing	Enforcement	575.4	16.1	
	Customs control	Enforcement	130.3	4.7	
	03.2 FIRE AND RESCUE SERVICES				
	Fire and rescue services	Enforcement	62.3	2.2	
	03.3 JURIDICIAL SYSTEM				
	District Court	Enforcement	127.7	1.7	
	Court of Appeal	Enforcement	34.4	0.9	
	Supreme Court	Enforcement	7.2	0.1	
	Legal aid	Enforcement	21.2	0.2	
	Enforcement Office	Enforcement	80.4	0.8	
	System of prosecution	Enforcement	30.9	1	
	03.4 PRISON SYSTEM				
	Prison Service	Enforcement	188.9	31.6	
	Open institution work	Enforcement	5.9	1	
	03.5 RESEARCH AND DEVELOPMENT RELATED TO PUBLIC ORDER AND SAFETY				
	National Research Institute of Legal Policy	Prevention	1.1	0.03	
	The European Institute for Crime Prevention and Control	Prevention	0.5	0.01	
	03.6 PUBLIC ORDER NOT ELSEWHERE CLASSIFIED				
	Ministry of Justice	Prevention	79.3	0.6	
Certain paid compensations	Harm reduction	10.1*	0.09		
07. HEALTH CARE	07.5.0 RESEARCH AND DEVELOPMENT IN THE HEALTH CARE SECTION				
	National Research and Development Centre for Welfare and Health (STAKES)	Prevention	22.9	0.6	Yes
	National Public Health Institute	Prevention	34.3	1.2	
	Finnish Foundation for Alcohol Studies	Prevention	0.5	0.2	
	07.6 HEALTH CARE NOT ELSEWHERE CLASSIFIED				
	Ministry of Social Affairs and Health	Prevention	70.1	2	Yes
	Finland's Slot Machine Association	Prevention	305	5.4	Yes
	Finland's Slot Machine Association	Prevention	305	1.8	
10. SOCIAL SECURITY	10.1.1 ILLNESS (IS)				
	Sickness allowance	Harm reduction		0.9	
	10.1.2 DISABILITY				
	Disability pension	Harm reduction		8.2	
REVENUE TRANSFERS TO MUNICIPALITIES				25.4	
COSTS, TOTAL				107	

\*) Certain paid compensations, with the exception of aid in maintaining Sámi culture and self-administration.

Table 14. Harm-related costs from drug use incurred by municipalities and state revenue transfers to municipalities\*.

	Authority/Institute	Reuter's	Costs to municipalities	Costs to the state
7. HEALTH CARE	07.2 OUTPATIENT SERVICES	Harm reduction	7	2.5
	07.3 HOSPITAL SERVICES, i.e. INPATIENT TREATMENT	Harm reduction	15.3	5.1
10. SOCIAL SECURITY	10.4.0 FAMILY AND CHILDREN (IS)	Harm reduction	18.3	6.4
	10.7.0 SOCIAL EXCLUSION NOT ELSEWHERE CLASSIFIED (IS)			
	Substance abuse services	Drug treatment	28.1	9.9
	Social assistance	Harm reduction	4.3	1.4
COSTS, TOTAL			73	25.4
COSTS TO MUNICIPALITIES			73	

\*) The calculated proportions of the costs covered by state revenue transfers are based on the report Alkoholihaittojen yhteiskunnalliset kustannukset 2003 (*The Social Costs of Alcohol-related Harm*) (Mellin et al. 2006).

## Annex 1. Categorization of expenditures by policy domain and goals

	<b>Targeted policy</b>	<b>Broad policy</b>
Prevention	School drug prevention programmes	School discipline
	Mass media campaigns	General delinquency prevention
	Reducing access for youth through policing	Improved public housing
Treatment	Methadone maintenance	Psychiatric services
	Counselling, therapeutic communities, etc.	
	Coerced abstinence through probation/parole supervision	
Enforcement		
(1) Supply reduction	(1) Trafficker/dealer arrest, corrections	General criminal enforcement
(2) Demand reduction	(2) Buyer's arrest	
Harm reduction		
(1) Preventing harms occurring	(1) NEP, low threshold methadone, responsible use messages	(1) Social assistance for addicts
(2) Ameliorating bad consequences	(2) Health care for infected addicts	(2) General health care

Source: Reuter 2006.



## **Annex 2. Labelled drug-related expenditures**

### **07.5 RESEARCH AND DEVELOPMENT IN THE HEALTH CARE SECTOR**

#### **07.5.0 Research and development in the health care sector**

STAKES' expenditure is available from STAKES' internal budgeting. Drug-related expenditure is itemised according to project for the calculation.

### **07.6 HEALTH CARE NOT ELSEWHERE CLASSIFIED**

#### **07.6.0 Health care not elsewhere classified**

##### *Ministry of Social Affairs and Health*

The Ministry of Social Affairs and Health expenditure for anti-drug activities is available in a separate report from the Ministry's information diffusion system.

##### *Finland's Slot Machine Association RAY*

The amount of funding granted by Finland's Slot Machine Association RAY for anti-drug activities is available from RAY's funding register. Only the funding labelled for anti-drug activities has been gathered as a separate report from the funding.

RAY also grants funding for "substance abuse work." In these cases, the funds allocated for alcohol and drug work have to be itemised. This funding amount is reported as un-labelled expenditure in Annex 2.

## **Annex 3. Un-labelled drug-related expenditures**

### **3.1.1 PUBLIC ORDER AND SAFETY (03.)**

#### **03.1 Policing**

The drug-related expenditure by the police and Customs is based on the actual expenditure by the police and Customs, which fall under the Ministry of the Interior's administration, during the review year as well on the evaluations of police and Customs experts on the proportion of the drug-related workload of the police and Customs.

#### **03.2 FIRE AND RESCUE SERVICES**

The expenditure by the rescue services is based on the actual expenditure of the rescue services, which fall under the Ministry of the Interior's administration, during the review year as well on the evaluation of a rescue service expert on the proportion of the drug-related workload of the rescue services.

#### **03.3 JUDICIAL SYSTEM**

Judicial system expenditure is based on the actual expenditure of the judicial system, which falls under the Ministry of Justice's administration, during the review year. Information is provided separately on the overall expenditure for each court instance. The proportion of criminal cases in the workload is also ascertained for each court instance. Drug-related expenditure is based on the proportion of the drug-related workload in the total amount of work related to criminal cases. For the time being, the varying lengths of hearings for offences cannot be taken into consideration.

The expenditure by legal aid offices, the prosecution and enforcement offices, which fall under the Ministry of Justice's administration, is based on the actual expenditure during the review year as well as on expert statements.

#### **03.4 PRISON SYSTEM**

The expenditure from the enforcement of punishment, i.e. of the prison system and open institutions, is based on the actual expenditure by the Prison Service, which falls under the Ministry of Justice's administration, during the review year. The proportion of drug-related expenditure is obtained as an expert assessment from the Ministry of Justice.

#### **03.5 RESEARCH AND DEVELOPMENT RELATED TO PUBLIC ORDER AND SAFETY**

The expenditures by the National Research Institute of Legal Policy and the European Institute for Crime Prevention and Control are based on the actual expenditures during the review year as well as on an expert statement from the Ministry of Justice.

#### **03.60 PUBLIC ORDER AND SAFETY NOT ELSEWHERE CLASSIFIED**

##### *Ministry of Justice*

The expenditure by the Ministry of Justice is based on the actual expenditure during the review year as well as on an expert statement from the Ministry of Justice.

##### *Certain paid compensations*

Certain paid compensations refer to compensation for crime damage, compensation payable to wrongfully imprisoned and convicted people as well as Ministry of Justice

subsidies for communities that work in crime prevention and take care of victims of crime. The expenditures incurred by drug-use are available based on an expert statement.

## **07. HEALTH CARE**

### **07.2 OUTPATIENT SERVICES**

Within outpatient services, statistics are maintained only for specialised health care visits according to diagnosis. The involvement of drugs in health centre, mental health clinic and home nursing visits is available by utilising the results of a census of intoxicant-related cases. The census of intoxicant-related cases records all visits that have occurred throughout the country on one day where the patient is believed to be a problem user of intoxicating substances, or where the patient seeks help while intoxicated or for an intoxicant-related problem.

Organising health care services is the responsibility of the municipalities. However, the state participates in financing health care services through revenue transfers. Municipalities cover around 74 per cent of the costs of health care services and the state covers around 26 per cent of the costs.

### **07.3 HOSPITAL SERVICES, i.e. INPATIENT TREATMENT**

Hospital inpatient days related to drug use are available from the Finnish Care Register (Hilmo) maintained by STAKES. Inpatient days related to drug use are entered in accordance with the International Classification of Diseases (ICD-10) and they can be gathered separately from the Register according to primary and secondary diagnosis. Inpatient expenditure is based on the number and average cost of inpatient days.

Organising health care services is the responsibility of municipalities. However, the state participates in financing health care services through revenue transfers. Municipalities cover around 74 per cent of the costs of health care services and the state covers around 26 per cent of the costs.

### **07.5 RESEARCH AND DEVELOPMENT IN THE HEALTH CARE SECTOR**

#### **07.5.0 Research and development in the health care sector**

The expenditure by the National Public Health Institute is based on the actual expenditure during the review year as well as on an expert statement from the National Public Health Institute.

The expenditure by the Finnish Foundation for Alcohol Studies is based on the actual expenditure during the review year as well as on STAKES' internal budgeting.

### **07.6 HEALTH CARE NOT ELSEWHERE CLASSIFIED**

#### **07.6.0 Health care not elsewhere classified**

##### *Finland's Slot Machine Association RAY*

The amount of funding granted by Finland's Slot Machine Association RAY for anti-drug activities is available from RAY's funding register. Only the funding labelled for anti-drug activities, which is reported as labelled expenditures, has been gathered from the funding as a separate report.

RAY also grants funding for "substance abuse work." In these cases, the funds allocated for alcohol and drug work have to be itemised. This funding is reported separately as un-labelled expenditures.

## **10. SOCIAL SECURITY**

## 10.1 ILLNESS AND DISABILITY

### 10.1.1 Illness (IS)

The Social Insurance Institution of Finland maintains statistics on sickness allowances paid for drug-related morbidity as in accordance with the ICD-10 codes. Also included are sickness allowances paid by the Social Insurance Institution of Finland where a person has been paid sickness allowance for injury, poisoning or accidents. Separate statistics for drug-related accidents or poisonings are not maintained in this payment category. An estimate of the drug-related proportion can be obtained from the census of intoxicant-related cases by assuming that the involvement of intoxicating substances among sickness allowance recipients corresponds to the involvement of intoxicants among outpatient visits.

*Table 15. Drug-related sickness allowances paid by the Social Insurance Institution of Finland 2002–2005, thousand euros<sup>81</sup>*

2005	890
2004	1,445
2003	1,644
2002	1,531

Sources: Social Insurance Institution of Finland. Finnish Centre for Pensions

### 10.1.2 Disability

The Social Insurance Institution of Finland and the Finnish Centre for Pensions maintain statistics based on the International Classification of Diseases (ICD-10) on the disability pensions paid due to drug use.

Statistics on pensions are maintained according to whether drug morbidity was the primary or secondary diagnosis in the grounds for granting a pension. The employment pension expenditure given in this report, which is paid due to drug use, is based on the average value of the paid primary and secondary diagnosis drug-related pensions granted by the Social Insurance Institution of Finland and the Finnish Centre for Pensions (Table 14).

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<sup>81</sup> Sickness allowance paid due to the use of drugs is recorded statistically in accordance with the ICD-10 code. Also included are sickness allowances paid due to poisoning and various external reasons. The proportion of drugs in the above-mentioned expenses is estimated through a separate study.

Table 16. Pensions, drug-related morbidity as a primary or secondary illness, 2002–2005, thousand euros.

Year	Mental and behavioural disorders	Organic mental disorders	Drug dependency	States of intoxication	Poisonings and other drug-related morbidity	Total
2005	7,001	174	982	36	146	8,338
2004	5,624	192	1,024	37	136	7,014
2003	4,461	191	1,049	41	134	5,876
2002	3,190	228	1,076	45	157	4,695

Sources: Social Insurance Institution of Finland. Finnish Centre for Pensions

## 10.4. FAMILY AND CHILDREN

### 10.4.0 Family and children (IS)

Child protection expenditure comprises the inpatient treatment for children and young people for which the municipalities are responsible. The annual expenditure is based on statistics maintained by Statistics Finland for the finances and activities of municipalities. No comprehensive statistics are maintained on the reasons for taking children and young people into care, and it is frequently difficult to pinpoint a single reason for taking children into care. The proportion of drug-related cases in child protection is obtained by estimating the proportion of all intoxicant-related cases in child protection and from these cases, only the child protection cases related to drugs and pharmaceuticals.

## 10.7 SOCIAL EXCLUSION NOT ELSEWHERE CLASSIFIED

### 10.7.0 Social exclusion not elsewhere classified (IS)

#### *Social assistance*

Municipalities have a statutory obligation to grant social assistance according to the terms and conditions prescribed by law. Municipalities can also grant discretionary preventative social assistance. The annual social assistance expenditure is available from the social protection expenditure statistics maintained by STAKES. The proportion of drug-related expenditure is obtained by first estimating the proportion of all intoxicant-related cases from social assistance expenditure and by using the census of intoxicant-related cases to separate the proportion of drug-related cases from this grouping.

#### *Substance abuse services*

Substance abuse service expenditure comprises the general social welfare and health care services and units providing specialised services for substance abusers paid for by municipalities. Substance abuse service expenditure is obtained from the social protection expenditure statistics compiled annually by STAKES. Expenditure includes A-Clinic and youth centre activities, supported housing unit and housing services for substance abusers, detoxification and rehabilitation services and other substance abuse care and temperance work. The proportion of drugs in substance abuse service expenditure is estimated by using the census of intoxicant-related cases.

## 12. Drug use and social deprivation among Finnish youth

The risk of becoming involved with illegal drugs and suffering related consequences varies among young people. Previous studies have shown (see e.g. McCrystal et al. 2006; Feliti 2003) that there is a link between an unstable living environment and problematic substance use. This has been confirmed by statistical data on drug use among young people in some countries, which have shown that drug use and experimentation are more prevalent among those young people who have various social problems than they are among those who do not have social problems, at least not on the same scale (see e.g. Smit et al. 2002; Korf et al. 1999). Thirdly, serious drug problems are often considered to be linked to institutional discrimination against certain population groups within countries (see e.g. Allaste 2006).

This article discusses the connections between drug problems and social deprivation especially among children and young people in Finland. First, I attempt to form a picture of the cause and effect factors between drug use among young people and their living conditions and social context based on previous Finnish studies. Secondly, I review Finnish statistical surveys and reports to discover the current living conditions of young Finns and the way in which these might make them vulnerable to problems related to drug experimentation and use. Thirdly, I examine how Finnish authorities and legislation have addressed the problems related to social deprivation and drug use among young people.

The questions I address in this article are partly based on the need highlighted by the EMCDDA for further investigation of the links between drug use and social deprivation within the EU countries. Analysing the social factors that make people vulnerable to drug use helps to predict problems and target substance abuse prevention more accurately.

### **12.1 Previous studies on the connections between social deprivation and drug use in Finland**

In Finland, there has been little research on the connections between drug use and any preceding social problems or “risk factors”; for example, no targeted data collections among different youth or risk groups have been carried out. Nor is there any systematic data collection on the social background of drug users or on any other environmental factors that may push people to drug use.

However, studies and surveys among clients of drug treatment units in Finland have alluded that drug use is often connected to various factors characteristic of social deprivation such as a low level of education, an early onset of drug experimentation and poor social networks (Harju-Koskelin 2007; Partanen et al. 2006; Baas and Leiman 1999). This result has also been confirmed by studies into the backgrounds of people sentenced for drug offences (Kinnunen 2001). However, no follow-up or longitudinal studies have been conducted on the subject.

Qualitative studies have revealed some information on the social deprivation of drug users. In her dissertation based on theme interviews (N=32) with people who have stopped using drugs, Ulla Knuuti (2007) highlights the problematic background of

some of the interviewees, which often included parental substance abuse and children being taken into care.

In an article by Riikka Perälä (2007) on problem drug users' own interpretations of their problems, the backgrounds of the interviewees (N=20) revealed parental alcohol, drug and psychiatric problems and cases where the children had been taken into care at an early age, "abandoned" by their parents and left in a relative's care or placed in reform school. The interviewees' pasts also included juvenile delinquency and professional criminal activity carried out by parents or other close family members with the participation of the young person. Some of the interviewees said that their lives had involved interventions by youth and/or social workers from a very early age. Perälä recruited her interviewees from among the clients of Finnish health counselling centres that run the needle and syringe exchange programme.

Pekka Hakkarainen (2002) highlights the problematic social context of drug use in his article on drug-related deaths in the coastal city of Turku. Drug-related deaths clearly increased in Turku at the end of the 1990s, and they were also discussed in the media. In his article, Hakkarainen combines data from register material compiled by different authorities, based on which he has been able to outline the "drug careers" and life events of the deceased.

Hakkarainen deals with eleven drug-related deaths. Nine of the victims were less than 25 years old, which in itself can be seen as an indicator of a downward spiral of exclusion that had begun at an early age. The victims had a very low level of education. Half of them had no vocational education and the majority had an unsettled occupational and financial situation at the time of their death. One of the victims was registered as homeless.

He mentions separately a group of young heroin-using men in Turku to which some of the victims belonged. In addition to substance abuse, the young men in the group were involved in criminal activity and their lives were extremely chaotic and uncontrolled. According to Hakkarainen, the drug-related deaths in Turku reflect the worldwide pattern of drug use being linked to social deprivation.

In all the Finnish studies there is, however, a clear lack of scientific research data on how different social problems are connected to drug use: do the problems precede drug use or do they result from drug use? A study by researcher Mirjam Kalland and her research group on the life events of children who had been taken into care between 1991 and 1997 revealed that the children had a higher risk of mortality than did children who had not been taken into care and that the most important reason for the elevated risk was the children's self-destructive behaviour. The most common cause of death was related to substance abuse, and the young people were at the highest mortality risk at the time they started becoming independent (Kalland et al. 2001). This indicates that there are important links among the Finnish population between substance abuse and an unstable childhood or adolescent environment.

Next, I discuss current developments in the living conditions of Finnish children and young people. At the end of the section, I will analyse the possible connections between these figures and young people's drug use and experimentation.

## 12.2. Living conditions of Finnish children and young people in the 2000s

Studies on the living conditions of children and young people carried out in recent years have highlighted a polarisation trend among children and young people. The majority of children and young people are doing very well, but some of them are doing poorly and have accumulated problems (see e.g. Rimpelä et al. 2006). Studies on the living conditions of young people in Finland have revealed the following negative developments: increased use of antidepressants among teenagers and young adults – especially girls and young women; a decrease in the gender differences related to substance use, i.e. the drinking patterns among girls have started to resemble the drinking patterns of boys who traditionally drink more; increased need for social assistance among both genders; single parenthood among young women and related problems; and crime among boys and young men<sup>82</sup> (Karvonen et al. 2006).

Other factors cited by researchers demonstrating the deteriorated living conditions of children and young people are problems that children and young people are having in their family and other close relations and the increase in child welfare measures (Rimpelä et al. 2006; see also the review of literature, Häggman-Laitila and Pietilä 2005). Researchers have also brought up offences committed by young people and problems among ethnic minorities (from a conversation, e.g. Honkatukia and Kivivuori 2006).

Next, I examine the situation more closely in the light of various recent studies and reports on the living conditions of children and young people. I concentrate especially on figures that indicate ailments among children and young people.

### *Children in families at risk*

According to a survey conducted under the “Lasinen lapsuus” (*Fragile childhood*) project carried out by the A-Clinic Foundation, one in ten Finns has grown up in a home where parental abuse of alcohol or other substances has caused problems or detriment. The result is based on the respondents’ subjective assessment on substance abuse in their childhood home and its effects on their own life. The material represents the entire Finnish population over the age of 15 with the exception of Åland. The sample consists of 473 men (weighted = 485) and 532 women (weighted = 520), i.e. a total of 1,005 people (Peltoniemi 2005). Overall, there are 5.3 million inhabitants in Finland and about half a million families with children.

Some of the consequences of having lived in a substance-using family cited in the survey were low self-esteem, timidity, nervousness, aggressiveness, difficulties in trusting people, feelings of insecurity and powerlessness and difficulties in relationships. Fourteen per cent of the respondents also cited their own substance abuse problem (Peltoniemi 2005).

Based on the population survey material gathered under the STAKES PAKKA project (local alcohol policy) in 2004 and 2006, it has been estimated that in Finland at least 70,000 children live in families where the parents use alcohol excessively (Holmila et al.). This figure is based on the respondents’ own assessments of the amounts they

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<sup>82</sup> The *Nuorten elinolot* yearbook on the living conditions of young people aims to compile the research and statistical data available on young people. The publication is a collaborative effort of the Advisory Council for Youth Affairs, the Finnish Youth Research Network and the National Research and Development Centre for Welfare and Health (STAKES). The yearbook has been published since 2000 and in addition to the general data on the living conditions of young people, it each year highlights some selected issues such as young people as consumers or young people’s living conditions in different parts of Finland. The latest yearbook (2005) focused on gender.



drink and the related detriment and the number of dependent children they reported in the survey.

As far as is known, there are no homeless children or children living on the street in Finland as there are in some other European countries and in the neighbouring areas of Finland. The environment in which Finnish children grow up is also stable in the sense that problems with health or well-being among young people do not seem to be linked to the size or location of their place of domicile (Paju 2004).

#### *Child welfare measures*

In Finland, child welfare measures are divided into 1) support interventions in community care, 2) placements, which mean that the child is placed outside the home to be brought up and cared for either through support interventions in community care or taking the child into care, and 3) aftercare, which takes place after the termination of the placement. In 2006, 15,626 children were placed outside their homes in Finland. The total number of placed children has grown 2–5 per cent annually in recent years and it increased by 2 per cent between 2005 and 2006. A total of 59,069 children and young people were the subject of child welfare interventions in community care in 2006. This number has remained essentially unchanged compared to 2005 (Stakes 2007).

Of the children placed outside the home, 38% were in foster care and 49% in residential care in 2006. Sixteen per cent were placed elsewhere. This figure consisted of young people living in supported housing (the largest group) and children and young people in different hospitals and similar institutions. Of those in residential care, 34% were placed in professional family homes or such like. The proportion of placements in foster homes out of all placements has decreased steadily whereas the proportion of placements in residential care has increased (Stakes 2007).

Some research has been conducted in Finland on the reasons behind the placements of children and young people. According to a study by Annika Myllärniemi, which was based on a questionnaire survey carried out among child welfare workers in the Greater Helsinki area, care orders issued by the municipal social services in the Greater Helsinki area and interviews with head social workers and social workers working in child welfare services, the most common reason for a child under 12 being taken into care was parental substance abuse, most often that of the mother. In the case of adolescents, the most common reason was the unruly behaviour and maladjustment of the young person. Problems tended to accumulate in that, according to the assessment of the social workers, the children's lives involved approximately 6.4 such risk factors that warranted placement (Myllärniemi 2005).

A study by Alpo Heikkinen (2006), which was based on child welfare statistics in the Greater Helsinki Area and interviews with experts in community child welfare interventions revealed that the most common reasons behind a young person being taken into care were problems with social interaction and the young person's own substance abuse. The interviews disclosed factors related to parenting problems and the disintegration of families. Mental health problems suffered by some young people were also seen as a catalyst for substance abuse. Some general developments cited were the lack of parenting and the increasingly liberal attitudes towards intoxicants in society.

### *Education and employment of young people*

In Finland, very few young people – approximately 300 annually – do not finish comprehensive school. More than 90 per cent of young Finns pursue further education after completing their compulsory education. According to the statistical yearbook on the living conditions of young people, in 2004 thirteen percent of 17–24-year-old men and 9 per cent of women of the same age were excluded from education (Karvonen et al. 2006).

It is estimated that in Finland more than one in ten in each age group have problems with school (Lavikainen et al. 2006). Around eight per cent of comprehensive school pupils currently receive special needs education, and the number has been growing especially during the 2000s. Part of the increase can be explained by changes in the compilation of statistics. However, participation in special needs education has also grown due to the increased awareness of various diagnoses such as ADHD and Asperger's syndrome. Current legislation also offers improved opportunities to provide special needs education to a child or young person (Jahnukainen 2006).

There are more boys in special needs education than there are girls, and boys in general tend to have more problems with school and they also drop out of school more often than girls do (see the above work; see also Karvonen et al. 2006).

The combination of a low level of education and unemployment especially seems to increase the prevalence of various problems (Vanttaja and Järvinen 2006). In 2005, 11.4 per cent of 15–24-year-old Finns were unemployed; 12.4 percent of women and 13 per cent of men (www.sotkanet.fi; Karvonen et al. 2006).

### *Use of cigarettes, alcohol and drugs among young people*

Various surveys monitor the use of alcohol, drugs and cigarettes among young people in Finland. The most prominent are the Adolescent Health and Lifestyle Survey, the European School Survey Project on Alcohol and Other Drugs (ESPAD), the School Health Promotion Study and the WHO's Global School-based Student Health Survey (GSHS). Mikko Salasuo reported comprehensively on the results of these studies regarding the use of alcohol, drugs and cigarettes among Finnish youth in the 2006 national report on the Finnish drug situation (Salasuo 2006a). These results are the most recent available in Finland. Next, I briefly go over some of the results and bring forth some complementary figures.

According to the Adolescent Health and Lifestyle Survey, 22 per cent of 14–18-year-old boys and 23 per cent of girls of the same age smoked cigarettes daily in 2005. The figures are same as in 1979, which were the lowest ever recorded in Finland. The onset of experimenting with cigarette smoking shifted to a later age during 2003–2005, and young people's attitudes towards cigarette smoking have become tougher. (For more information on the survey results, see Rimpelä et al. 2005).

The Adolescent Health and Lifestyle Survey also indicated that binge drinking has decreased among young people. Among 12-year-olds, binge drinking is very rare. Among 14-year-olds, 7 per cent of boys and 4 per cent of girls reported that they consumed alcohol to become very drunk once a month or more often. Among 14–16-year-olds, binge drinking has become rarer (Rimpelä et al. 2005).

According to the latest data, drug use and experimentation also seem to have decreased among young people. For example, the 2005 School Health Promotion Study indicated that drug experimentation among 16–18-year-olds has decreased to

the same level as in 1997. Overall, 7 per cent of boys and 6 per cent of the entire age group said that they had experimented with drugs in 2005. Cannabis was the most common drug experimented with.

The latest ESPAD survey results are from 2003. At that time, 7.5 per cent of 15–16-year-olds in Finland had experimented with an illegal drug during the past year. Cannabis was the most common illegal drug the young people had experimented with, and 11 per cent of 15–16-year-olds had tried it. Three per cent had tried other drugs, the most prevalent of which were amphetamine and ecstasy.

The combined use of alcohol and pharmaceuticals is more common in Finland than in the other ESPAD countries. In 2003, seventeen per cent of 15–16-year-olds had mixed alcohol with pharmaceuticals, compared to 9 per cent in other ESPAD countries.

Overall, it appears as if the intoxicant situation among young people in Finland has taken a positive turn over the past few years. Use and experimentation with all intoxicants seems to have levelled out or even decreased. Jaana Lähteenmaa deems it significant that the number of abstinent young people has grown for several years, and the onset of experimenting with intoxicants has shifted to a later age (Lähteenmaa 2007).

#### *Young people in substance abuse and psychiatric treatment*

Out of all clients of substance abuse services, three per cent were under 19 years of age in 2005 (n=333). The primary substance of abuse for which 15–19-year-olds had sought treatment was cannabis (36%) followed by alcohol (16%) (Official Statistics of Finland; Social security 2006).

Approximately 11% of drug treatment clients of substance abuse services were under 20 years of age in 2006. According to the drug treatment information system, there are isolated or only a few cases of young people less than 15 years old entering treatment annually. In Finland, information on drug treatment clients is gathered through the drug treatment information system maintained by STAKES. Substance abuse units can voluntarily participate by filling in a statistical form that gathers data on their clients. In 2006, 131 units filled in the form, providing information on 4,865 clients. In 2005, the corresponding figures were 161 and 5,499 (Kuussaari and Ruuth 2007).

The drug treatment information system provides some information on the social backgrounds of drug treatment clients. Next, I review data on clients less than 20 years of age. Fifty-nine percent of them were men and the majority were unmarried. The highest level of education achieved was comprehensive school (76%) and more than a fifth were still in comprehensive school. The majority (61%) categorised themselves as students and one third were unemployed. Four percent were employed. Half of them lived with their parents (50%), approximately a fourth (23%) lived on their own, and less than a fifth (16%) were in inpatient units. Four per cent were homeless. Forty per cent had been referred for treatment by child welfare services, and 16 percent had sought treatment at the request of their parents. Fourteen per cent of the clients had sought treatment on their own.

The primary problem substance among the clients was cannabis (41%), followed by alcohol (22%), stimulants (16%) and opiates (14%). Almost all opiate users used buprenorphine. One per cent mentioned that they used “another” opiate, but none used heroin. Forty per cent had taken drugs intravenously sometime in their life. The

majority (61%) were in outpatient care and approximately one fifth of them were undergoing a period of evaluation before substitution treatment. The majority (19%) of those in inpatient care were in detoxification units.

Drug users often have mental health problems, either preceding or following drug use. It is estimated that more than half of the young people with a diagnosed substance abuse problem have co-occurring mental health problems. Usually, mental health problems precede drug use (Pirkola et al. 2007). In Finland, 4.9% of 0–17-year-olds had received hospital treatment for mental health problems in 2005 ([www.sotkanet.fi](http://www.sotkanet.fi)).

### *Crimes committed by young people*

The proportion of young age groups among those suspected of committing an offence under the Penal Code has slightly decreased in Finland in the 2000s. In 2005, young people less than 20 years of age comprised more than a fifth of those who had committed such an offence. The proportion of 15–17-year-olds was 6.6 per cent of those who had committed an offence and the proportion of under 15-year-olds was 2.6 per cent. There were 395,286 suspects. Men comprised the majority of those who had committed an offence and their proportion was clearly larger than that of girls especially in younger age groups (see also Karvonen et al. 2005).

In his article, Janne Kivivuori uses various sources of information to examine the development of juvenile delinquency by types of crime, and he highlights the following trends. Violence among young age groups increased at the turn of the millennium but after that, it has remained stable or even declined slightly. In 2004–2005, a total of 3,941 assaults committed by under 17-year-olds were recorded in statistics. In Finland, violence among young people is strongly related to alcohol (Kivivuori 2006).

The main trend in property offences has taken a downward swing. The number of robbery offences as well as acts of vandalism committed by young people recorded in statistics has decreased. Overall, young Finns are more law-abiding today than they were ten years ago. This is also evident in young people's attitudes, which have become tougher towards offences committed by young people (see the above work).

Based on register data from the police and social workers, a follow-up study on offences committed by children and young people less than 15 years of age in the Greater Helsinki area revealed the following features of crime among very young people. The offences committed by children are minor, usually petty thefts, and recidivism in those cases is rare. There is usually a very problematic family situation and difficult childhood behind serious and continuous criminal behaviour and as many as 70 per cent of recidivists had been involved with the child welfare services before their first offence. Boys start committing offences at a younger age than girls do (Savolainen et al. 2007).

The drug offences committed by young people are usually drug-user offences. In 2005, the police suspected 15,400 people of drug offences. Less than a fifth of them were under 21 years old. The number of 15–17-year-olds totalled 721 (Kainulainen 2006).

### *Substance abuse and crime among young people belonging to foreign and ethnic minorities*

At the end of 2005, 121,700 foreign nationals resided in Finland permanently, which amounts to 2.3% of the entire population. The largest groups of foreigners are Russian and Estonian. Another visible foreign minority group are Somalis. There is

also a visible Roma minority of approximately 10,000 people in Finland. The Roma are Finnish citizens.

Drug-related problems in Finland are strongly associated with young people originating from the former Soviet Union. The most common drugs used by them are heroin and buprenorphine. The problems were at their worst at the end of the 1990s but now the situation seems to have improved (Puro 2003).

Among other foreign and ethnic minorities, the use of opiates and sedatives by young Roma, the use of opiates by people of Asian origin and the use of khat by young Somalis has attracted attention from time to time. However, no exact figures on these phenomena are available.

People of foreign origin or ethnic minorities are rarely encountered in treatment units. However, the data collection systems only record the nationality of the client and therefore, the statistics do not show representatives of ethnic minorities who are Finnish citizens.

Juhani Iivari has studied offences committed by immigrants between 1997 and 2001 (Iivari 2007). The study also includes information on offences committed by young people and it is based on statistics of the principal offences committed by sentenced immigrants, offences committed by immigrants reported to the police and interviews with sentenced immigrants.

In 2001, immigrants committed a total of 2,686 offences. Young people (15–20-year-olds) committed about 30 per cent of these offences, the most typical of which related to property and violence. Drug offences comprised 13 per cent of the offences.

#### *Summary and considerations based on the statistical data*

It is believed that the risk of someone developing drug and other substance abuse problems is at its highest when the person is biologically susceptible to addiction and when environmental factors promote drug use. I mentioned above some of the environmental factors that may contribute to the development of substance abuse problems in young people.

The downward trend in the use of intoxicants (alcohol, drugs and cigarettes) among young people is a positive phenomenon. Especially in the 1990s, there was concern about the continuously increasing rate of drug use among young people but this concern is not reinforced by statistics, at least not at the moment. This in itself is a positive factor, but it can also be significant in terms of the offences committed by young people in that the decline in substance abuse is also seen to decrease violence (Kivivuori 2006). Furthermore, the attitudes of young people towards substance abuse and offences committed by young people have become tougher, which provides a good foundation for the prevention of substance abuse among young people.

Young Finns have a stable living environment in the sense that we do not have “slums” characterised by an accumulation of social problems. There is also little segregation between residential areas, although some negative developments have been noted. However, these problems are local and often relate to a specific building or staircase (Kortteinen ym. 2006).

Considering future substance abuse and drug problems, the worrying aspects include the rising number of child welfare cases and the fairly high number of children living in unstable conditions. As in other countries, it has been noted in Finland that there is a

connection between the need for child protection and drug problems, and that mortality among those who have been taken into care is higher than among those who have not been taken into care (Kalland et al. 2001). What makes the situation even more alarming is the fact that child welfare measures are often taken due to parental substance abuse, which can also increase a young person's risk of developing substance abuse problems in adulthood. The increase of mental health problems among young people is also worrying because it has been seen that these problems are linked to drug experimentation.

However, there is currently little information on what the growing figures actually indicate. Have the problems become worse or have the activities of the authorities become more efficient? Lying in the background may also be the changed practices in the way problems are determined; for example, the use of various medical diagnoses in determining the problems of children and young people has become more common, but this does not indicate that the problems have become worse (Hoikkala 2006). There are also problems in community child welfare interventions: the division of responsibilities between the authorities is unclear and the measures taken are often inadequate, thus prolonging the problems (Heikkinen 2006).

Those who have a low level of education and who have experienced early unemployment are considered to have, with respect to their education, a poor social prognosis (Vanttaja & Järvinen 2006). In the context of drug problems, this scenario is supported by the low level of education and high unemployment among drug abusers.

However, there is not much long-term follow-up information on the way in which exclusion from education and employment in youth affects an individual's later life. According to Markku Vanttaja (2005), who has studied school dropouts, those school dropouts whose parents were socio-economically disadvantaged were more likely to be excluded from education and employment as adults. Problems with school can also lead to other problems, as has been shown in previous studies, but here too, interpretation of the phenomena is influenced by the way the problems are defined. For example, the increase of special needs education in Finland is not necessarily an indication of growing problems but of the fact that more and more young people receive help early on.

The problems of ethnic groups in Finland are similar to those in other European countries: they have most problems with integration into society, which is further hampered by the lack of language skills and education. According to Juhani Iivari (2006), crime among immigrants in Finland is linked to their high unemployment rate and low income. Other problems behind crime include their lack of Finnish skills and their related isolation from the dominant culture. Their experience of racism also plays a role. Their problems may originate from before their immigration. For example, those who have come to Finland as refugees may have had hard experiences in refugee camps from which they later suffer. Moreover, refugees often have a very low level of education, which increases their problems. Iivari concludes that the offences committed by immigrants in Finland are the result of the combination of failed integration, unemployment and lack of money.

### **12.3 Measures focused on social deprivation and drug problems among children and young people in Finland**

#### *Preventative measures for large target groups*

In Finland, various family policy measures aim at providing children and young people with a safe environment for their development. The purpose of these measures is to guarantee equality between families through different forms of financial support and welfare services for all families with children. The welfare services for families with children include maternity and child health clinics, child dental care and school health care (Ministry of Social Affairs and Health 2006c). Some proposals have been made in Finland in recent years to further improve the position of children and young people and to prevent their problems.

A new Child Welfare Act will come into force in Finland at the beginning of 2008. The new Act will lower the threshold for issuing a child protection report and it will expand the duty to report; besides social and health care workers, schools, the police and church workers, those who have the duty to report will include youth service workers and private sector service providers. A report will have to be issued whenever there is cause to examine the need for child protection. Furthermore, community child welfare interventions will become more systematic and resources will be increased when the Act comes into force. As for placement decisions, the objective of the Act is for the child primarily to be placed in his or her network of significant others rather than outside his or her home (Bulletins of the Ministry of Social Affairs and Health; Ministry of Social Affairs and Health 2006c).

The first Ombudsman for Children was appointed in Finland in 2005. The Ombudsman's task is to promote the rights and interests of children in Finnish society. So far, the Ombudsman for Children has raised such things as the problems related to substance-using families.

Based on a Parliament resolution in 2001, health education, which is taught at every grade level, was included in the school curricula in Finland. The health education curriculum also includes providing information related to substance abuse prevention. Schools can also use alcohol and drug programmes provided by external parties. For example, the websites of various organisations in the field nowadays include a lot of educational material and information on substance abuse issues specifically designed for young people. In the 2000s, the organisations have also carried out many drug-related campaigns that have aimed to increase young people's knowledge on drugs and the related harms (Virtanen 2005).

The quality criteria for substance abuse prevention were determined in Finland in 2005. The criteria can be applied to the prevention and reduction of all substance abuse and related detrimental effects (STAKES 2006).

Work to prevent problems of young people is also carried out within youth work provided by the municipalities in Finland. Youth work focuses on supporting youth workshops and afternoon playschools for children, but it also includes work to prevent substance abuse. There is a special appropriation reserved for this work in Finland. The appropriation has been used to support various projects and programmes that aim at reducing substance abuse (Ministry of Social Affairs and Health 2005).

With respect to foreigners and ethnic minorities, a proposal for monitoring discrimination was prepared in Finland this year (Ministry of Labour 2007). According to the proposal, it is important to examine the position of foreign and ethnic minorities in public services and to involve representatives of minority groups in monitoring and reporting discrimination.

### *Risk group interventions*

In Finland, the so-called families at risk are often clients of child welfare and/or the social services (see e.g. Känkänen and Laaksonen 2006). School health care is also responsible for identifying pupils at risk of illness or at other risk and for providing them and their families with special guidance. This also applies to substance abuse problems.

The target group for specialised youth work consists of young people who are socially excluded or at risk of exclusion and need support from adults. Municipalities carry out various specialised youth work projects that often include street level outreach work or support activities and workshops directed at young people. In its latest report, the National Audit Office of Finland noted the role of youth workshops in preventing the social exclusion of young people (Kaljärvi et al. 2007). According to the report, the workshops were a good example of multiprofessional co-operation with young people who were at risk of social exclusion. Participation in the workshops improved the life management skills of young people and often led to their further education. The workshops were most beneficial for those young people who had no upper secondary education.

There are also anti-drug organisations that work with young people in Finland. The organisations carry out various prevention projects and provide consultation on substance abuse issues by phone or online.

Various research and development projects directed at specific risk groups have also improved the position of children and young people. In 2001–2004, the Ministry of Social Affairs and Health co-ordinated the Early Intervention project, Varpu, which aimed at providing the authorities and other actors with tools to help them tackle the problems of children, young people and families with children as well as to support them (see e.g. Eriksson and Arnkil 2005). The Development Programme for Child Welfare is being implemented in Finland in 2003–2007. The programme aims at securing the long-term welfare of children and young people and safeguarding the environment for their development in co-operation with municipalities, organisations and private service providers (Känkänen and Laaksonen 2006).

Finnish legislation also aims at preventing the development of problems among young people. A characteristic feature of the measures directed at underage offenders is the so-called care model, which defines involvement in criminal activities as a symptom of personal problems or problems related to the environment in which a young person is raised. In addition, the so-called principle of the mildest sufficient measure is observed for young people in Finland. Social services play a central role in implementing penal sanctions and underage offenders are often clients of child welfare services (Savolainen et al. 2007). Juvenile punishment was introduced in Finland at the beginning of 2005. Juvenile punishment includes programmes to improve social competence as well as various support measures and guidance that can be related to substance abuse.



A new provision concerning minor drug offences was introduced into the Penal Code in 2001. The amendment focused on young people less than 18 years of age and drug users in need of treatment. In these cases, the authorities were advised to arrange a hearing instead of summary penal proceedings.

Within substance abuse prevention, the idea of two-way education has been developed in Finland. Two-way education is based on communication and co-operation between researchers in the field and substance-using young people and consequently, on early recognition of changes in the alcohol and drug culture (Seppälä and Mikkola 2004; Seppälä 2003).

#### *Special measures for young people with drug problems*

In Finland, a young person with drug problems is referred for treatment whenever possible and there are special treatment units for young people less than 18 years of age but as the data on young drug clients in services for substance abusers show, the majority of them are treated in outpatient units. Many of those who enter treatment have undergone various interventions by the authorities before the treatment, which is shown by the fact that 40 per cent of young clients enter substance abuse treatment through child welfare services.

The social and health counselling provided for intravenous drug users, which also includes needle and syringe exchange, is also available to young clients. They are referred from the counselling centres to other services. The clients can visit the centres anonymously, and the operation is based on the needs of each client. Furthermore, outreach work is used to reach young drug users.

In recent years, special attention has been paid to substance-using mothers, some of whom are very young. There are, for example, mother-and-child homes for substance-abusing pregnant women that combine child welfare services and rehabilitation. Currently, mother-and-child homes are involved in a project funded by the Finnish Slot Machine Association that focuses on the development of treatment for substance-abusing pregnant women. There are also specialised maternity clinics for substance-abusing pregnant women in Finland. The majority of the clients are drug users. The operation is based on medical supervision of pregnancy combined with the perspectives of substance abuse and social and child welfare work.

Nowadays substance abuse services include more and more substance abuse prevention for ethnic groups, which is often directed at problem users. This development is shown by the increased number of workers with an immigrant background especially in various substance abuse prevention projects (Puro 2003). There are also services directed entirely at specific population groups and educational and information material is produced in the languages of various population groups.

#### **12.4 Summary and considerations**

The connection between drug use and social deprivation has not been studied much in Finland. Moreover, the measures taken are not primarily directed at so-called risk groups, even though this happens to some extent. It is believed that drug prevention is linked to the comprehensive improvement of the living conditions of children and young people.

Recently, concerns about the risks and threats of the social exclusion of young people have been expressed in public. For example, the National Audit Office of Finland stated that the measures taken to help socially excluded young people are too sporadic and funding is too fragmented (Kaljärvi et al. 2007). Youth researchers have also criticised the fragmented funding as well as the project-oriented approach and the lack of sustainable structures in youth work (Lähteenmaa 2006).

Currently, the measures directed at drug use among young people are oriented towards medicine; for example, many young people receive substitution treatment, which reflects a more general development that has meant growth in the role of medicine to control drug problems in Finland (Tammi 2007). However, as it is clear that drug use is also influenced by social and environmental factors, studies should be made into how these factors could be better taken into consideration in drug treatment or when working with young people who have problems. For example, at present many drug users feel that they do not get enough emotional support within the service system (Perälä 2007a). The positive results from youth workshops show that interventions to support young people's activities could be carried out in the future as part of their substance abuse or other such treatment.

## 13 Drug-related research in Finland

Due to the central position occupied by alcohol in Finnish alcohol and drug culture, drug-related research in Finland has a relatively brief tradition when compared with research into alcohol. Greater emphasis was first placed on drug-related research and statistical recording in the 1990s along with increased experimentation and use of drugs and their related harm.

### 13.1 Research structures

#### *Drug-related research in national policy*

Several points in the key Finnish drug policy document of recent years – the 1997 *drug strategy* – refer to the importance of research knowledge. From the perspective of substance abuse prevention, the strategy calls for research that will enhance the educational knowledge base. With respect to drug treatment, it calls for projects to develop treatment and their scientific evaluation.

The first *action programme for 1991–2001* relating to the strategy called for research projects to develop education, prevent the spread of infectious diseases and get problem users to become firmly involved with the service system. The objective was also to focus research on monitoring the drug situation and on evaluating the measures taken for the drug policy.

Research themes are proposed in a separate subsection; the subsection lists 26 targets for research that relate to the prevalence of drug use and problem drug use, users of different substances and methods of use, values related to drugs, attitudes and drug cultures, research into drug-related infectious diseases, morbidity and death, as well as research into drug treatment, drug-related criminal activity and the activities of the authorities.

The *action programme to intensify drug policy for 2001–2003* listed two concrete measures that both related to research into drug prevention. The report section reviewed the ongoing research and follow-up projects that related to anti-drug campaigns, drug treatment, infectious diseases, population surveys and crime.

The objective set by *the drug policy action programme for 2004–2007* is research into the use of drugs and the image associated with use, the results of use at different levels, the user service system and treatment, drug-related crime and the possibilities to intervene in crime. An additional objective is to analyse and evaluate dialogue on the drug policy and reinforce the drug-related information and expertise base. Besides applied research, it mentions the need for “advanced” research and suggests that a proposal be drawn up and submitted to the Academy of Finland to launch a drug-related research programme.

*The Finnish Government's resolution concerning co-operation on the drug policy for 2008–2011* proposes as its objectives that researcher training and research into drug use, drug markets, the treatment of drug users, and methods of combating drug-related problems is furthered and the international co-operation of Finnish researchers is promoted. In addition, citizens' opinions on drugs, drug use and their related harm should be monitored regularly.

The specification for drug-related research has changed from a more general approach and setting up the basic indicators for monitoring the drug situation to more detailed proposals for measures that are based on the development of the drug situation. The social sciences, infectious disease epidemiology, forensic science, education and criminology/sociology of law/law all play a key role. However, the documents fail to mention explicitly research themes relating to medical science or psychology/psychiatry. According to evaluations, official documentation refers to the importance of research more in connection with drug policy than with alcohol policy.

Limited research funding sets restrictions on drug-related research. Out of all the research undertaken, the proportion of drug-related research is reasonable when taking into consideration the extent of the drug problem in Finland.

No external scientific evaluation has been carried out on the Finnish drug policy that could be used to specify in greater detail the proportion of research conducted within the drug policy.

#### *Relationship research – policy*

Research occupies a key position in the national drug policy, and it relates not only to the use of drugs, the harm resulting from their use and the study of services but also to evaluating policy and measures. In the latest drug policy action programme for 2004–2007, the matter was argued as follows: "Research knowledge and expertise on drug-related matters are indispensable in order to effectively plan, evaluate, develop and implement the Finnish drug policy."

A committee report (1997:11), which brought together expert articles ordered by the Drug Policy Committee in order to support its work, was appended to the 1997 drug strategy under the title "Background materials for consideration by the Drug Policy Committee". The publication included nine articles based on research data as well as reports from three fields of administration. Moreover, the recommended measures in all three drug policy action programmes were based on research knowledge.

The work of the drug policy co-ordination group, which co-ordinates the drug policy assisted by the action programme, emphasises research. For instance, the co-ordination group during the 2004–2007 administrative period includes researcher representation from the National Research and Development Centre for Welfare and Health (STAKES) and the National Public Health Institute. Moreover, the co-ordination group regularly listens to the latest findings of researchers engaged in drug-related research, and the research data can thus have a direct impact on guiding policy.

#### *Main national structures for drug-related research*

Research relating to monitoring the drug situation as per the drug policy action programmes is conducted at three different institutes: the National Research and Development Centre for Welfare and Health (STAKES) and the National Public Health Institute, both of which fall under the auspices of the Ministry of Social Affairs and Health, and the National Research Institute on Legal Policy, which falls under the administrative responsibility of the Ministry of Justice. Funding for the drug-related research at the institutes falls within the framework of the state budget as part of the total funding for each institute. Moreover, it is possible to apply to the ministries for separate research funding, such as to the Ministry of Social Affairs and Health for a

grant to promote health<sup>83</sup> or to the Ministry of Justice for research and development funding (TUKE).

The Finnish Foundation for Alcohol Studies, A-Clinic Foundation, Helsinki Deaconess Institute, drug-related organisations and Social and Welfare Centres of Expertise also carry out drug-related research.

Of the foundations, the Finnish Foundation for Alcohol Studies grants money for drug-related research in particular. It is also possible to apply for drug-related research funding from the many foundations that are involved in financing research. The Academy of Finland is financing drug-related research to the sum of 5.5 million euros through its Intoxicants and Addiction programme for the years 2007–2010.

The Nordic Centre for Alcohol and Drug Research (NAD), whose office is located in Helsinki, is also a significant player. NAD promotes and supports research co-operation in the social sciences that focuses on the issues of drugs and alcohol. The National Research and Development Centre for Welfare and Health (STAKES) hosts the monthly Seula drug research seminar that brings together from throughout the country drug researchers involved in social science research.

### 13.2 Main recent studies and publications

#### *Main recent studies since 2000*

##### **Research into Problem Use**

In 1997, the National Research and Development Centre for Welfare and Health (STAKES), the National Public Health Institute and the Ministry of the Interior launched a joint project to evaluate the extent of problem drug use. By applying the capture-recapture method, it was possible to statistically estimate the number of users through registry data that describes drug-related harm. The project defined problem use as the use of amphetamines and opiates or their derivatives. The first evaluation in 1995 only included the Greater Helsinki area. Data has been collated from throughout the country since 1997, and it has been possible to examine the data regionally since 1998. According to the latest evaluation, there are approximately 14,500–19,000 problem drug users throughout the country.

The project has been jointly funded by all the participating parties, and the budget for each study has amounted to approximately 13,500 euros.

#### *Publications:*

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<sup>83</sup> Not, however, for basic research.

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### **Research into drugs and alcohol**

STAKES' alcohol and drug research group studies the changes in the prevalence and patterns of use of alcohol and drugs. The research series focuses on alcohol and drugs in alternate years. The surveys were implemented in 2002, 2004 and 2006. The next survey will be conducted in 2010. The target group is 15–69-year-old Finns. The material is collected by sending a questionnaire to a sample chosen randomly from the population register.

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Hakkarainen, P. & Metso, L. (2001). Onko huumeiden käytön yleistymisen taittumassa? Vuoden 2000 huumeikyselyn tulokset. (Is the increase of drug use slowing down? Results of the 2000 drug survey.) *Yhteiskuntapolitiikka* 66 (3), 277–283.

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### **Drug-related dissertations**

In relation to the extent of Finnish science, the 2000s have seen the publication of a significant number of social science dissertations on drug-related issues.

Elina Virokannas (2004): Normaalin rajan molemmilla puolilla. Tutkimus huumehoitoyksikön nuorten identiteettien rakentumisesta (On the Verge of Normality. A Study into the Construction of Identity of Young People in a Drug Treatment Unit). Tutkimuksia 144. Helsinki: STAKES.

Mikko Salasuo (2004): Huumeet ajankuvana. Huumeiden viihdekäytön kulttuurinen ilmeneminen Suomessa (Drugs – A Description of the Times. The Cultural Manifestation of Recreational Drug Use in Finland). Tutkimuksia 149. Helsinki: STAKES.

Kristiina Kuussaari (2006): Näkemysten kirjo, sirpaloitunut tieto. Terveystieteiden, sosiaalitoimen ja nuorisotoimen työntekijöiden käsityksiä huumeiden käyttäjien hoitopalvelujärjestelmästä (The Spectrum of Opinions, Splintered Knowledge. The Conceptions of Workers in Health Care, Social Welfare and Youth Work on the Treatment Service System for Drug Users). Tutkimuksia 155. Helsinki: STAKES.

Antti Weckroth (2006): Valta ja merkitysten tuottaminen korvaushoidossa. Etnografinen tutkimus huumehoitolaitoksesta (Power and Creating Meaning in Substitution Treatment. Ethnographic Study on a Drug Treatment Unit). Alkoholitutkimussäätiön julkaisuja 47. Helsinki: Finnish Foundation for Alcohol Studies.

Tuukka Tammi (2007): Medicalising Prohibition. Harm Reduction in Finnish and International Drug Policy. Research Report 161. Helsinki: STAKES.

Ulla Knuuti (2007): Matkalla marginaalista valtavirtaan. Huumeiden käytön lopettaneiden elämäntapa ja toipuminen (On a Journey from Marginal to Mainstream? The Lifestyle and Recovery of Former Drug Users). Yhteiskuntapolitiikan laitoksen tutkimuksia 1/2007. Helsinki: Department of Social Policy, University of Helsinki

Sanna Väyrynen (2007): Usvametsän neidot. Tutkimus nuorten naisten elämästä huumeekuvioissa (Maids of the Misty Forest. A Study of the Lives of Young Women on the Drug Scene). Acta Universitatis Lapponiensis 118. Rovaniemi: University of Lapland.

Taru Kekoni (2007): Kannabiksen käyttö, yhteiskunnallinen reagointi ja siihen vastaaminen. Kannabisaktivistien näkökulma (The Use of Cannabis, Societal Reaction and Responses to It: The Perspective of Cannabis Activists). Acta Universitatis Tamperensis 1281. Tampere: University of Tampere.

### **A study into the medical treatment of amphetamine addicts**

There is no special detoxification or substitution treatment for amphetamine addicts. From 2003–2005, the Helsinki Deaconess Institute, in co-operation with the Department of Psychiatry and the Department of Forensic Medicine at the University of Helsinki, the Department of Forensic Psychiatry at the University of Kuopio and the National Public Health Institute, conducted a study on the medical treatment of amphetamine addicts: "Aripiprazole and methylphenidate in the treatment of amphetamine addiction: a randomised, placebo-controlled double-blind study".

Preliminary results of the study show that methylphenidate looks promising in reducing the use of amphetamines. Based on these results, research into the use of methylphenidate in the treatment of amphetamine addiction will continue as a multicentre study.

Publication: Tiihonen J, Kuoppasalmi K, Föhr J, Tuomola P, Kuikanmäki O, Vormaa H, Sokero P, Haukka J, Meririnne E: "A Comparison of Aripiprazole, Methylphenidate and Placebo for Amphetamine Dependence". [American Journal of Psychiatry](#)

### **Intoxicants and addiction 2007–2010 (Academy of Finland)**

Only two projects in the Intoxicants and Addiction research programme focus on drugs, both of which are in the natural sciences. In addition to these, five projects have the general theme of intoxicants or addictions. The funding for these seven projects is divided between the Universities of Tampere, Helsinki and Kuopio, the National Public Health Institute and the Finnish Foundation for Alcohol Studies. The projects receiving funding are

Koski-Jännes Anja, University of Tampere, €456,260

Process and outcome of initial motivational interviews with substance abusers

Kaprio Jaakko, University of Helsinki, €441,280

Predictors, neuropsychological correlates, and consequences of cannabis and alcohol use among Finnish young adults. A twin and population approach

Lillsunde Pirjo, National Public Health Institute, €415,190

The life course of DUI\* offenders (\*Driving under influence of alcohol and/or drugs)

Saarnio Pekka, University of Tampere, €548,580

Effectiveness of substance abuse treatment in light of common factors

Tiihonen Jari, University of Kuopio, €244,590 (Consortium Co-ordinator)

Effectiveness of pharmacological treatments of drug dependence

Kauhanen Jussi, University of Kuopio, €233,160

Natural course of drug addiction, and risk factors for various health outcomes among illegal drug users in Finland: epidemiologic follow-up study

Sulkunen Pekka, University of Helsinki, €224,470 (Consortium Co-ordinator)

In addition, the Ministry of Social Affairs and Health funds game addiction research to the sum of €200,000

Koski-Jännes Anja, University of Tampere, €423,330

Poikolainen Kari, Finnish Foundation for Alcohol Studies, €157,950

Theories of addiction and images of addictive behaviours

### *Peer-reviewed scientific journals (in international scientific journals in 2006)*

Kantojärvi, L., Läksy, L., Herva, A. & Järvelin, M-R. (2006). Co-occurrence of personality disorders with mood, anxiety, and substance use disorders in a young adult population. Journal of Personality Disorders 20 (1), 102-112.

Meririnne, E., Kajos, M., Kankaanpää, A. & Seppälä, T. (2006). Rewarding Properties of 1-Benzylpiperazine, a New Drug of Abuse, in Rats. Basic & Clinical Pharmacology & Toxicology 98 (4), 346–350.

Steentoft, A., Teige, B., Holmgren, P., Vuori, E., Kristinsson, J., Hansen, A.C., Ceder, G., Wethe, G. & Rollmann, D. (2006). Fatal poisoning in Nordic drug addicts in 2002 Forensic Science International 160 (2-3), 148-156.



### 13.3 Collection and dissemination of research results

#### *Information flows*

The Finnish National Focal Point in the European Information Network on Drugs and Drug Addiction (REITOX), which is co-ordinated by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), is located at the National Research and Development Centre for Welfare and Health (STAKES). The National Focal Point puts together the annual report on the drug situation in Finland, which collates the key drug statistics and research knowledge from the preceding year. A network, whose members represent the organisations producing the key drug statistics and applied research knowledge, contribute to the work of the National Focal Point.

The drug situation report is published online in English and Finnish. Earlier, a press conference was arranged in connection with publication but since then STAKES has cut back on the number of press conferences it arranges and consequently, information concerning the publication is given to the media through a press release. The publication of the report is well received by the press, as is all news concerning intoxicants in Finland. In addition to its good media visibility, the publication is also available on the STAKES website.

Within the National Focal Point's sphere of activities, STAKES has three of EMCDDA's five key indicators that describe the drug situation: drug treatment, prevalence of use among the population (both adult substance abuse research and the school pupil ESPAD) and problem use; the first is part of the collation of statistics by the intoxicant team and the latter two are research projects by the alcohol and drug research group. The research results are not only summarised in the drug situation report; they are also released in national publications.

The National Focal Point has representation on the so-called Anturiverkosto network (*sensor network*) of STAKES, the National Public Health Institute and the A-Clinic Foundation. The network produces statistical data and reports concerning health counselling. In addition, the personnel at the National Focal Point participate in the Seula drug research seminar arranged by STAKES.

In other research fields, the role of the National Focal Point in drug research is limited to monitoring research data. Its connections to the field of drug research are good but due to inadequate resources, the National Focal Point's initiatives to launch or co-ordinate new projects have been minimal.

#### *National scientific journals that publish drug-related research*

No national scientific journals in Finland focus purely on drugs and intoxicants.

#### ***Scientific journals that publish drug-related research***

##### **Aikakauskirja Duodecim**

- medical science
- national
- referee: yes
- abstract languages: no abstracts

**Janus**

- social policy and social work
- national
- referee: yes
- abstract languages: Finnish and English

**NAT (Nordisk alkohol- & narkotikatidskrift, Nordic Studies on Alcohol and Drugs)**

- alcohol and drug-related themes in the Scandinavian languages
- international, primarily Nordic contributions
- referee: yes
- abstract languages: English, Finnish

**Oikeus**

- sociology of law
- national
- referee: yes
- abstract languages: English

**Sosiologia**

- sociological research
- national
- referee: yes
- abstract languages: Finnish

**Suomen Lääkärilehti (Finnish Medical Journal)**

- medicine
- national
- referee: yes
- abstract languages: English

**Yhteiskuntapolitiikka**

- social and health themes
- primarily national contributions
- articles reviewed by referees
- abstract languages: English (in the articles section)

*Other journals that publish drug-related research***Dialogi**

Dialogi deals with social welfare and health and it comes out eight times a year. It is distributed free of charge to workplaces in the social welfare and health sector. The magazine is published by the National Research and Development Centre for Welfare and Health (STAKES) and it has a circulation of 28,000.

**Socius**

Socius deals with social and health policy and it comes out four times a year. It is distributed free of charge to the Ministry of Social Affairs and Health's interest groups, such as decision-makers and employees working in state administration and municipal social and health services as well as to organisations in the sector. The journal has a circulation of approximately 9,000.

### **Kansanterveys**

Kansanterveys conveys the latest news on health research to those working in health care. Nine issues of the magazine came out in 2007.

### **Sosiaaliturva**

Sosiaaliturva (Social Security) is published by the Huoltaja Foundation and it is an independent professional magazine in the field of social welfare. Its readers work in municipalities, state administration, organisations and social service enterprises. There were 19 issues of Sosiaaliturva in 2007. Two issues of the magazine are released as a double issue.

### **Tiimi**

Tiimi is published by the A-Clinic Foundation and the magazine is primarily for professionals working in substance abuse treatment and prevention. It comes out six times a year.

### *Other means of dissemination*

Drug-related research knowledge is disseminated in Finland through various Internet portals and journal websites.

#### *Internet portals*

[neuvoa-antavat.stakes.fi](http://neuvoa-antavat.stakes.fi)

[www.paihdelinkki.fi](http://www.paihdelinkki.fi)

#### *Scientific journal websites*

[yp.stakes.fi](http://yp.stakes.fi)

[nat.stakes.fi](http://nat.stakes.fi)

[www.ktl.fi/kansanterveyslehti](http://www.ktl.fi/kansanterveyslehti)

[www.a-klinikka.fi/tiimi](http://www.a-klinikka.fi/tiimi)

Alkoholi- ja huumeutkijain seura ry (The Association of Alcohol and Drug Researchers) has arranged seminars on the following themes during the 2000s:

- The Psycho-social Rehabilitation of a Drug-addicted Patient
- Young People's Substance Abuse and its Control
- Harm Reduction in the Finnish Drug Policy
- The Current State of Substance Abuse Services
- Programmes As a Tool of Drug and Alcohol Policy
- How to Relate to Evidence Based Medicine in Substance Abuse Treatment?
- When is Drug Testing Necessary?
- Drugs in the News: The Roles of Correspondents, Researchers and the Authorities

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