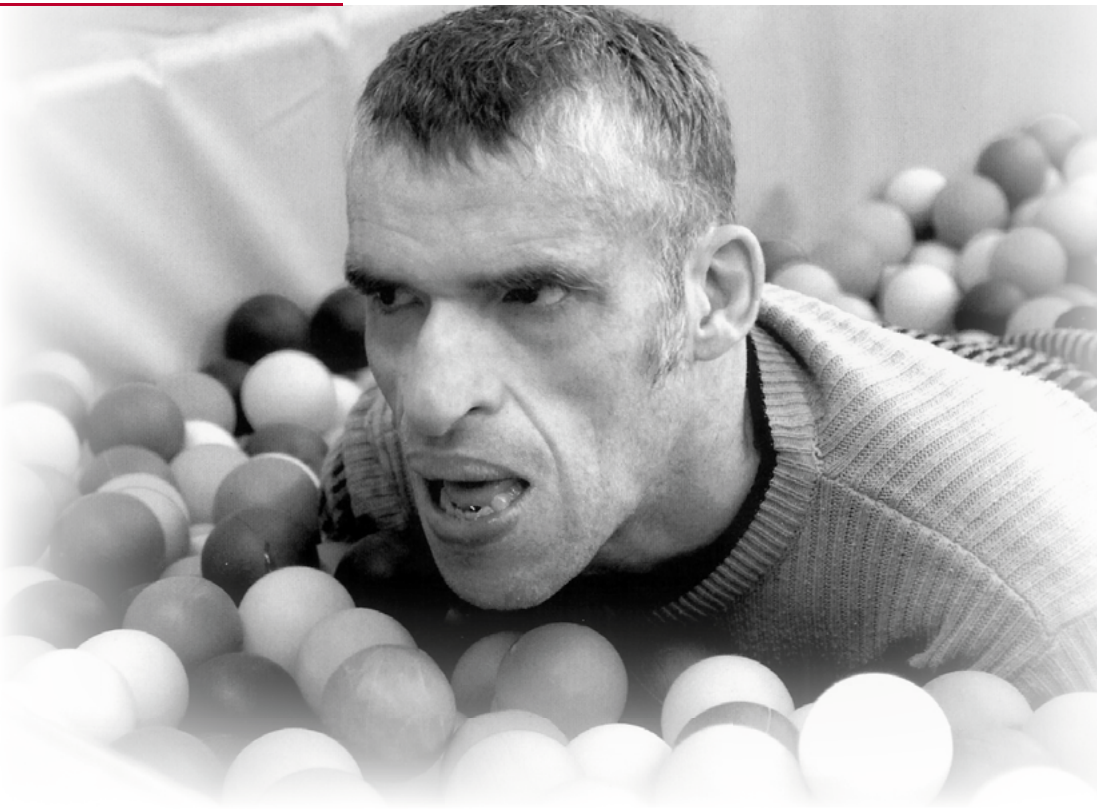
Finland



Care Work with People with Disabilities

Helsinki City College of Social and Health Care

Education and Culture DG
Lifelong Learning Programme

This Handbook for Students has been produced within Leonardo da Vinci -programme as a pilot project **"Learning Materials for Social and Health Care Students' Foreign Placements / ETM II"** (FI-06-B-P-PP-160 704) during 2006–2008. This publication has been funded by the European Commission. The Commission accepts no responsibility for the contents of the publication.

Care Work with People with Disabilities in Finland

Content

Introduction

Dear Student

A Very Warm Welcome to Finland.

◆ *We are delighted you have chosen to come here for your practical placement and hope that you will have a worthwhile and interesting time in Finland /with us / here.*

The purpose of this booklet is to give you an overview of and insight into care work with the disabled people in Finland.

This is a very interesting area to work in, with new initiatives and opportunities developing all the time. For this booklet, every effort has been made to provide you with up-to-date information. However, during your placement you may well learn about and be introduced to new legislation, policy and practices, implemented since this booklet was produced.

This booklet contains much useful information, which you can familiarise yourself with prior to your visit. In addition, we hope that this booklet will be a useful work of reference to you during your placement. We have included a case study of Niko that will give you practical comprehension of care work with people with disabilities.

We wish you a pleasant and enjoyable stay in Finland and hope your practical placement is successful.

More official version:

Our land, our land, our fatherland
Sound loud, O name of worth!
No mount that meets the heaven's band
No hidden vale, no wavewashed strand.
Is loved, as is our native North,
Our own forefathers' earth.
Translation from the Swedish version by Clement Burbank Shaw

Promoting the Status and Social Inclusion of People with Disabilities within EU

1. Rights, Status and Social Inclusion of People with Disabilities in the European Union

1.1. The United Nations

Universal Declaration of Human Rights

In 1948 The General Assembly of **the United Nations** proclaimed "**The Universal Declaration of Human Rights**" which is the most fundamental document that also defines the rights of people with disabilities.

All human beings are born free and equal in dignity, *without a distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status. Furthermore, no distinction shall be made on the basis of the political, jurisdictional or international status of the country or territory which a person belongs to, whether it is independent, trust, non-self-governing or under any other limitation of sovereignty."*

In 1971 United Nations' General Assembly issued "**The Declaration on the Rights of Mentally Retarded Persons**" and in 1975 the "**Rights of Disabled Persons**". Both declarations included normalisation and integration as the guidelines. The aim put forward in these declarations is that of guaranteeing all people equal possibilities of participating in social life. *Disabled persons, whatever the origin, nature and seriousness of their handicaps and disabilities, have the same fundamental rights as their fellow-citizens of the same age, which implies first and foremost the right to enjoy a decent life, as normal and full as possible." (Rights of Disabled People 1975)*

Furthermore, the **Rights of Disabled People** argues for their right to necessary services and social protection *"…disabled persons are entitled to the measures designed to enable them to become as self-reliant as possible… and …have the right to medical, psychological and functional treatment, including prosthetic and orthopedic appliances, to medical and social rehabilitation, education, vocational training and rehabilitation, aid, counselling, placement services and other services which will*

enable them to develop their capabilities and skills to the maximum and will hasten the processes of their social integration or reintegration….
…have the right to economic and social security and to a decent level of living. They have the right, according to their capabilities, to secure and retain employment…"
The position of people with disabilities was kept in public awareness by several means. The UN proclaimed 1976 as the ***International Year of Disabled Persons***, calling for an action plan at all levels, from international to regional, for the purpose of promoting the equalisation of opportunities, rehabilitation and the prevention of disabilities.

World Programme of Action Concerning Disabled Persons

After the International Year of Disabled Persons more extensive and specified development took place. The General Assembly formulated the **World Programme of Action Concerning Disabled Persons (1982)** to promote their rights and position in societies on a global level. The programme's agenda was more detailed and focussed. It included a broader approach with expressions such as the"*full participation*" of disabled people in social life and the development of "*equality*," i.e. equal opportunities in a broad sense as well. The programme also defined key concepts such as "impairment", "disability" and "handicap" – and prevention as the strategic objective. Rehabilitation was also defined in a clearer way – as a set of services that function as measures in the facilitation of the disabled persons' full participation and equality. This action plan also put emphasis on education and employment, as well as on removing barriers that often manifest themselves as negative approaches to and attitudes towards this question.

The United Nations' World Programme of Action Concerning Disabled Persons was an action plan for Governments. To provide time for putting the Programme of Action into effect, the UN proclaimed the **United Nations Decade of Disabled Persons 1983-1992**. Governments could implement the Programme within ten years.

At the end of the Decade of Disabled Persons in 1992, the General Assembly proclaimed the 3rd of December as the **International Day of Disabled Persons**. To enhance public awareness the Day has varying themes on issues that are relevant to people with disabilities. **In 2007 the theme was "Decent work for persons with disabilities".**

1.2. The European Union and People with Disabilities

◆ **The European Union** recognises the United Nations' rules on the Equalisation of Persons with Disabilities as the basis for the development of disability policy in Europe.
In 2003 the Commission stressed its belief that the *"emphasis on the rights based approach to disability should be reflected in the evolution of an international human rights standard relating specifically to disability"*.

The EU has specific legal grounds upon which to act in respect to advancing disability rights. Article 13 of the EC Treaties enables the Community to combat discrimination on the grounds of disability. Articles 21 and 26 of the Charter set out the rights of people with disabilities. Article 26, in particular, recognizes *"the right of persons with disabilities to benefit from measures designed to ensure their independence, social and occupational integration and participation in the life of the community"* as a fundamental right.

The European Union Disability Strategy stresses the need for a renewed approach, focusing upon the identification and removal of various barriers that prevent disabled people from achieving the equality of opportunity and full participation in all aspects of social life. However, the primary responsibility for action rests with the Member States. The Community Disability Strategy focuses on

- strengthening the co-operation between and within the Member States
- increasing the participation of people with disabilities
- mainstreaming Disability in Policy Formulation

A boy called Niko,
who is later diagnosed with both an intermediate cerebral palsy and a mild mental deficiency, is born into a Finnish family Nieminen. In the future, Niko will need a wheelchair to move about and his speech is slightly difficult to understand for those unaccustomed to it. Niko's parents are worried about the future of their son. What kind of possibilities does he have for a meaningful and full life, and how will he cope in this society when he is an adult?

2. The Concept of Disability and Most Common Client Groups

2.1 Definitions

◆ The word "disability" can mean various things. It can refer to physical or mental disorders, it can mean an impairment caused by illness or accident, or it can be congenital. Current definitions of disability focus on the **limitations of functional capacity**. These limitations, in turn, are dependent on both the type and the degree of the disability, as well as the problems caused by the surrounding society. Thus, for instance, for a person using a wheelchair the question of accessibility is very different in an environment with several obstacles, in comparison to an environment that has been built as accessible as possible.

According to Finland's *Services and Assistance for the Disabled Act*, people with **long-term or permanent limitations of functional capacity and difficulties in coping with everyday situations in their own environment** are defined as **disabled**. In other words, disability defined in the Act includes mental deficiencies and, for example, severe mental disorders, delays in development, learning difficulties or linguistic disorders in addition to physical handicaps. The relevant question is the existence of long-term limitations in functional capacity, not the medical diagnosis.

According to Finland's *Special Care for the Mentally Handicapped Act*, **a person, whose development or mental functional capacity has been hindered or disturbed due to congenital illness or one acquired during developmental age, a defect or a handicap, and who cannot receive the services he needs through any other act/decree** is considered **mentally deficient**. The traditional criteria for mental deficiency have been low IQ (below 70), social coping skills below that of one's age level and the onset of both criteria before the age of 18.

As is the case with defining disability in general, definitions of mental deficiency nowadays focus on the limitations of functional capacity as defined by the AAMR (the American Association for Mentally Retarded). Thus, **mental retardation** refers to the interaction between mental and adaptive skills (related to adaptive behaviour) and the environment. Therefore, the more the society takes into account the needs of different people, the less mental retardation is an obstacle to daily coping.

The effects of mental deficiency vary greatly between individuals. The

mentally retarded are often divided into four categories based on their need of help and support.

A mild retardation can manifest itself, for example, as difficulties in learning. Children who are mildly retarded need experiences of success as well as support in building up their self-esteem, because they understand their difference and often have experiences of being worse than the others. They also need support and guidance for becoming as independent as possible before reaching adulthood.

People with **intermediate mental retardation** have significant delays in their development in childhood. When supported, most of them learn to cope fairly independently with their daily chores. The amount of support members of this group need in adulthood varies greatly between different people.

Severe mental retardations create a permanent need of support and guidance. Most people with severe mental disorders have trouble communicating. Through long-term well-planned rehabilitation they can learn to cope with their daily chores relatively independently.

Those with **profound mental retardation** are completely dependent on others. They have severe problems with communication and accessibility, difficulties in taking care of their personal functions and controlling their bladder and bowel movements. They can learn some simple tasks and daily functions, but they need constant care.

Mental deficiencies are commonly associated with additional handicaps that affect the need for support. These additional handicaps include mobility disorders, sensory disabilities and different neurological and linguistic disorders.

2.2 Common Client Groups in Practical Nursing

◆ Due to their training Finnish practical nurses can work with both the physically disabled and the mentally deficient. Thus, the number and variety of different forms of disability the nurses encounter in their work is great. Because even a short introduction of them all is not possible or meaningful in the scope of this guide, the following description lists only some of the most common disabilities that practical nurses face at work and during their practical training periods.

The different types of mental retardation were discussed in the previous chapter. The estimated number of mentally deficient people in Finland is 30.000, and these people form the most common client group for practical nurses geared towards working with the disabled.

The single greatest source for mental deficiency, extra chromosome 21, causes **Down syndrome**. Annually, about 60-70 Finnish children are born and diagnosed with this syndrome. Most people are familiar with the common external features: stunted growth, oblique eye fissures, tendency for a protruding tongue and the wide nasal bridge. Down syndrome is often associated with heart defects and physical abnormalities as well as the rapid aging of the body. Even though the degree of mental retardation of most people with Down syndrome is mild or intermediate during their childhood and adolescence, their cognitive abilities start deteriorating around 45-50 years of age, which makes the degree of the deficiency more severe.

Autism, in turn, is a neurobiological disorder of the central nervous system that manifests itself as problems in behaviour and interactive situations. Autism has very different symptoms and we can talk about autism as a spectrum disorder which includes, for example, autism of early childhood, **Asperger's syndrome** and **Rett syndrome**. According to estimations there are around 10.000 autistic people in Finland, only a quarter of whom are female, because the occurrence of autism is more prevalent in males. Around 70% of autistic people have been diagnosed as mentally deficient.

Typical features associated with autism include the absence of reciprocation in social situations, problems in producing and understanding speech and interpreting gestures and facial features, stereotypical movements, getting stuck in one function and deviant reactions to sensory stimuli. The functional capacity of an autistic child can be significantly strengthened through early rehabilitation. Some of the evaluation and rehabilitation methods used in day care and schools will be discussed in chapters 5.3.2 and 5.3.3.

Practical nurses working in schools and day care often meet children who are diagnosed with or suspected to suffer from **ADHD**. It means Attention-Deficit/Hyperactivity Disorder. ADHD is not associated with subnormal intelligence, but it often comes with learning problems and susceptibility to psychic problems. Attention-deficit disorder is one of the most common neuropsychological disorders in children and the most common cause of problems at school in addition to dyslexia. It occurs in an estimated 6% of Finnish boys and 4% of girls.

Typical features of ADHD include over-activity, low control of impulses and the inability to direct and maintain attention. Problems with motor functions are common as well as difficulties in perception, and through them problems with reading and writing as well as mathematics. Behavioural dysfunctions associated with the syndrome cause problems in relationships and easily lead to being

labelled mean or a troublemaker. Consistent and calm guidance and support of self-esteem are important factors when working with children suffering from ADHD.

A great imbalance between linguistic and non-linguistic skills is called **dysphasia**, and it refers to specific difficulties in one's linguistic development. Features characteristic of dysphasia include severe pronunciation difficulties and mix-ups in sounds. Around 7.000 people in Finland are estimated to suffer from dysphasia, in other words 1-3% in every cohort. The estimated number of people suffering from severe difficulties with reading, **dyslexia**, is 100.000. Dyslexia is mostly passed down in families or inherited, whereas the causes for dysphasia are more diverse and can often remain unsolved.

Because spoken and written language are essential means of communication and learning in our culture, problems in producing and understanding language make it more difficult for a person to cope in life, even if his intellectual/cognitive abilities would be completely normal. An early diagnosis and rehabilitation is therefore extremely important. In addition to speech therapy a child may benefit from occupational therapy, and musical therapy may strengthen the willingness and ability to communicate, and neuropsychological rehabilitation facilitates learning problems. The AAC-methods introduced in chapter 4.4 can also be an asset in communication.

Cerebral palsy is a physical or an occupational disability that is caused by brain damage acquired during pregnancy, birth or very early childhood. It is the most common physical disability in children. There are a total of 6.500 people with CP in Finland.

Cerebral palsy is defined as damage to the centres responsible for movement and posture and the connections between them in a developing brain, that has been induced during pregnancy or in early childhood (before age 3). The degree of disability varies greatly with this syndrome. CP is commonly divided into three categories:

1. Spastic forms with hypertonia in the lower limbs (diplegia), limbs on one side (hemiplegia) or in all limbs (tetraplegia).
2. Dyskinetic forms, where the muscle tone alters from hypertonia to hypotonia in all muscles (dystonic tetraplegia) or so that there are quick involuntary motions in the body (athetoic CP).
3. Ataxic forms, where problems with balance and poor motion control are common.

About 80% of people with CP have secondary conditions. The most common is speech impairment. Problems in controlling motions of the

mouth and throat make it more difficult for a child to learn how to eat and drink. Dysfunctions in sensing posture make the development and control of movement more difficult. In addition, one can have visual or auditory perception disorders, astigmatism and cataracts. Problems with the co-operation between the different senses are also common. Around 30% of people with CP have epilepsy. A quarter of people with CP have a severe and a quarter a mild mental deficiency. Communication problems and lack of stimuli due to physical and occupational difficulties may also aggravate and slow down children's learning and development.

3. The Status and Rights of the Disabled in Finland

◆ The society's attitude towards and sense of responsibility for the disabled has varied in different eras. Towards the end of the nineteenth century those in need of help, the sick, the poor, the old and the disabled, had been taken care of mostly by their families. The church and private charities also played an important role, especially when there were no suitable family members. However, the assistance received by a disabled person was often random and based on volunteering.

Since the end of the eighteenth century it was the municipalities' responsibility to take care of the poor living in their district, but for those unable to take care of themselves, this most often meant the possibility of living in common poorhouses. In return for food and a place to stay people who had to turn to the municipality for help were subordinated to discipline and control. If a person could not support himself he could even be refused the right to vote and he had to submit himself to the mercy of the municipality's poor relief.

3.1 The Beginning of Systematic Development

◆ General relief work began to develop and differentiate towards the end of the nineteenth century. Asylums were founded for the mentally ill, and cities built common hospitals and special schools for the disabled. Different individuals with their unique needs began to be singled out from what used to be considered a uniform mass of people. It was also realized that, with the right treatment and education, it was possible for many of the disabled to carry out meaningful jobs and to earn their living. At the same time, organizational activities expanded and were structured, and through organizations for the disabled the voice of the disabled people was heard for the first time in societal decision making.

The care of the *severely mentally* disabled began to concentrate in large central institutions throughout Finland. The point of departure for this trend was the desire to help families living in difficult conditions by providing the disabled with expert care and special services that homes could not offer. The goals were partially met, but at the same time the severely disabled

were separated from their families and the rest of the society. **A central institution system** was created in Finland, with districts consisting of several municipalities, which all built their own central institutions. Because non-institutional social care did not develop simultaneously and as quickly, disabled people who were mostly in need of mere educational and work-related activities were also taken into the institutions. In addition to living quarters the institutions provided a possibility of attending school, working and spending leisure time. Simultaneously, the inhabitants were kept out of sight.

3.2 The Era of Rehabilitation and Non-Institutional Social Care

◆ Finland developed into relatively institution-centred country in other respects as well. The intensive development of non-institutional social care began only in the 1970s. Nowadays, the aim is to have public services that are comprehensive enough to meet the needs of different client groups. Services are provided in the clients' homes when possible, and if care outside home is necessary, small home-like units are favoured. Institutional care is always the last resort. However, the district division of the care for the mentally disabled that was created when building the central institutions still stands, because municipalities often have populations so small that it makes sense to combine forces with others when providing services. Expert knowledge in the field is also largely focused in the districts branches.

During the Second World War Finland fought two wars against the Soviet Union between 1939 and 1945. As a result, the country suddenly had over 90.000 people who were permanently disabled. The state had to develop **rehabilitation** intensively, and renew the care for the disabled. In **1946** the Welfare of the Disabled Act came into effect, and guaranteed those with different *physical disabilities* the right to receive state provided medical care, education and occupational training as well as sheltered working environments. It was the first national act that dealt specifically with the care of the disabled.

The Services and Assistance for the Disabled Act that regulates the responsibilities for treatment of the physically handicapped even today came into effect in **1978**. It shifted the focus of development to non-institutional care. Municipalities are responsible for organizing services, and these services are often carried out by Finland's 16 districts for the organisation of special care. The city of Helsinki forms its own district, while the rest of the districts consist of several municipalities.

Some of the central goals of international disability policy have for long included **normalization** and **integration**, also here in Finland. In 1971 the United Nations General Assembly approved the Declaration of the Rights of Mentally Retarded Persons and in 1975 Declaration of the Rights of Disabled Persons. Both declarations include the notions of normalization and integration. This policy aims at equality and equal opportunities of participation for all citizens.

Normalization means that the services provided by public social and health care meet the needs of all client groups and are primary. These services should not stigmatize clients, patronizing attitude is to be avoided and the autonomy of the client should be respected as much as possible.

Integration in turn means making normalization possible in practice so that the disabled can live among other people and have access to services provided by the society.

Later, towards the end of the twentieth century, **inclusion** was added to the aims of the disability policy. It means enhancing integration in a way that gives the disabled the right and the possibility to use the same services used by non-disabled people of the same age. This requires living among others in the same communities, going to the same schools and workplaces.

The effective acts in Finland concerning the special welfare for the disabled, the **Social Welfare Act** (from **1984**) and the **Services and Assistance for the Disabled Act** (which took effect in **1988** abolishing the Welfare of the Disabled Act), are in accordance with the disability policy, highlight the primary nature of the public services and non-institutional care. During the making of this guide the combination and renewal the Act on Special Care for the Mentally Handicapped and the **Services and Assistance for the Disabled Act** is in progress in Finland. The new law will take effect in 2008 or 2009.

3.3 Towards Equality and Empowerment

◆ Finland has accepted UN's Standard Rules on the Equalization of Opportunities for Persons with Disabilities in 1993. The national disability policy program "Towards a Society for All" is based on them. The program emphasizes the removal of barriers which generate inequality (physical, attitudinal and communicational) in our society. Developmental challenges named in the program for the 21st century include

- removing barriers to participation, encouraging activity and independence
- equal treatment of different groups of the disabled

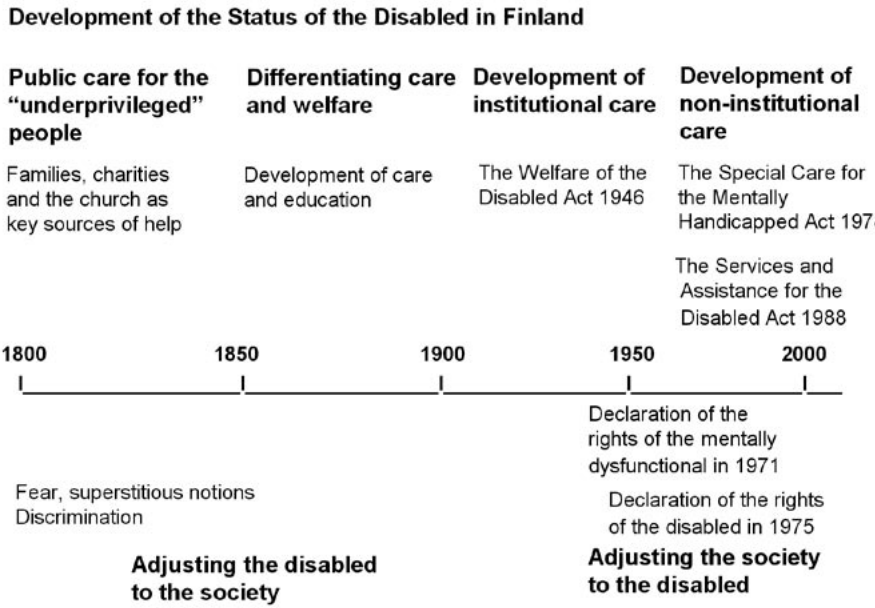
- maintenance and promotion of functional capacity and working ability of the disabled and
- supporting independent living of the severely disabled

In Finland the themes of the European Year of the People with Disabilities 2003 were indiscrimination and participation. They reflect the now central goal of international disability policy, **empowerment**. It means listening to the voice of the disabled, when dealing with matters related to their lives both at the level of society and in their personal lives.

International women with disabilities- seminar at "Little Parliament" in Helsinki, 12.3.2008.

Until now it has probably been best mediated through organizations for the disabled. There are dozens of them in Finland. A good example of a step towards empowerment is the national organization for the Finnish Mentally Deficient Me Itse ry (We Ourselves ra) founded in 1999. The board of directors includes nine disabled members and the disabled decide on the aims and action of the group themselves. This kind of action is ground-breaking, because the mentally deficient have been a category of disabled whose concerns have usually been voiced only by other people.

Supporting the independence and **enabling the autonomy of the decision making** of the disabled are challenges in practical disability care. Both the practical nurses and others working with disabled people should assist their clients when help is needed, but at the same time be careful of not suppressing the clients' initiative and independence, and not working according to their personal understanding, but trying to find out and take into account the clients' wishes and opinions. This may be a particular challenge with a mentally deficient client. Nobody wants to be a passive object of action and decision making. Everybody has the right to the lead role in their own lives and opportunities for deciding for themselves whenever they are capable of making such choices. Regardless of one's handicap one has the right to be treated with dignity and respect for human rights.



4. Recognition and Consideration of the Needs of the Disabled

◆ Because disability includes limitations of functional capacity, rehabilitation services are provided as a means of reducing and alleviating them. To be able to provide the best possible care and most useful services for everybody according to their needs, the point of departure for planning these services has to be the mapping of needs created by disability.

4.1 Early Support

◆ Providing initial information on becoming disabled or on the birth of a disabled child is highly important, and health care personnel have been and still are trained to do that. However, this guide excludes the topic, because students will not have to deal with such situations during their practical training period.

Nevertheless, it is worthwhile to remember to listen to the disabled client or the parents of a disabled child by giving them time to talk about their perceptions and considering them the experts of their own situations. Regrettably often recently disabled

people and those close to them, or the parents of a disabled child have been assumed to be going through the different stages of their crisis, and therefore to be ”difficult” clients, when they have actually been in need of justified help and services in a demanding and tough situation. Similarly, the parents' concern about their child has not always been taken seriously, and the situation has been merely monitored for an unnecessarily long time. Yet, parents often notice possible developmental delays or changes in their children earlier than the attending personnel, because they interact daily with their children and know them better than any non-family people.

Nowadays the significance of early support is well understood, as well as the need to pay attention to the family and the loved ones and to support them. However, in practice these matters are not always remembered well enough.

4.2 Evaluation Methods

◆ The rehabilitee's **functional capacity** forms the basis of the rehabilitation plan, because the purpose of the plan is to outline measures required for supporting this capacity.

Functional capacity means the ability to manage daily life and the ability to respond to challenges set by the surroundings. It can be divided into physical, psychological, social and mental management. Several aspects affect functional capacity in addition to personal characteristics and state of health, such as the surrounding circumstances, social relations, financial situation and life management skills.

Because functional capacity is a multifaceted and highly individual matter, several different means have been developed to measure it. It is important that the rehabilitees themselves as well as those close to them participate in the evaluation process, and that the chosen means are suitable for every individual in question.

WHO's wide classification of functional capacity **ICF** (International Classification of Functioning) evaluates body functions, functional capacity and the possibilities of participation. It was developed for describing health and functional capacity in a multifaceted way and to create and enable a shared language and terminology for the representatives of different fields of work.

For example, when school-aged children with CP are being assessed, their school performance is evaluated not merely from the point of view of reaching educational aims, but also from the point of view of autonomy, i.e. how well they can move, dress and eat without help, what their social

skills and speech production are like etc. In addition, attention is paid to the parents' financial situation, time management, interests and hobbies, as well as support from the society or the lack there of, and the possibilities of acquiring implements.

Chapters 5.3.2 and 5.3.3 deal with some common means of measuring functional capacity and rehabilitation plans related to the work of a practical nurse taking care of the disabled.

4.3 Rehabilitation Plan

◆ The purpose of the rehabilitation plan is to guarantee as good a service combination as possible from the perspective of the rehabilitee, and to make sure that everyone participating in the rehabilitation process agrees on the aims. The plan is made in the organization where the rehabilitation begins, and its execution is evaluated at least every half a year. The evaluation takes place in the organization whose services the rehabilitee uses at the time of the assessment, but it is recommended and meant to be carried out together with the organization where the rehabilitation began.

Even though the rehabilitation plans vary in different organizations, their contents are essentially similar to each other. The plans are made in writing and they include:

- the rehabilitee's personal and background information
- functional capacity in its different forms, resources and the emphasis of the rehabilitation
- aims of the rehabilitation
- execution and means of rehabilitation (what, what kind of schedule, who is responsible and how)
- finances or social security during rehabilitation
- other required services
- evaluation
- follow-up, monitoring
- line-up of the rehabilitation group and division of responsibility among experts
- contact person or person in charge
- rehabilitation plan's period of validity
- persons involved in making the plan
- signatures

(Suvikas et al., Kuntouttava lähihoito, 2006)

For an example of a rehabilitation plan, see the appendices (Appendix 1)

Some of the most important laws and acts that require a written rehabilitation plan and define the rehabilitation process include:

- Rehabilitation Allowances Act (611/1991)?
- Act on Cooperation in Respect of Client Services (604/91)
- Act on Rehabilitation Services Provided by the National Pensions Institution (610/1991)
- Special Care for the Mentally Handicapped Persons Act (519/1977) 1978
- Act on the Status and Rights of Social Welfare Clients (812/2000)

- Medical Rehabilitation Decree (1015/91)
- Decree on Services and Assistance for the Disabled (759/1987)

Plans similar to rehabilitation plans have different titles in different organizations. Social services department most often talks about a service plan and healthcare about a treatment plan. In day care it can be a pre-school education plan (see chapter 5.3.2), and at school children are provided with personal plans concerning the arrangement of education, HOJKS, when necessary (chapter 5.3.3).

The clients' **resources** and their operational environment (home, school, working place, social relations) form the basis of a rehabilitation plan. It is very important to hold the rehabilitees in a central role and to see them as active agents in the whole rehabilitation process. In this matter the rehabilitees and those close to them can be supported by taking their wishes and opinions into account, by encouraging them into being initiative and active and by providing them with information on various options for help and support.

Practical nurses support rehabilitation by working according to the aims of the rehabilitation plan in everyday situations. Therefore, they need to know the aims and means, and to understand their own role in the process reaching these aims.

4.4 AAC-Methods and Plain Language

◆ It has been estimated that there are about 20 000 people in Finland who cannot use speech as their means of communication. All types of disabilities described in chapter 2.2. of this guide may include problems of producing speech to a varying degree. Also, adults' ability to communicate may decrease significantly due to, for example, brain injury.

Different AAC-methods (augmentative and alternative communication) have been developed for those suffering from communication problems to support their speech or to substitute it. The need for various methods arises from the diversity and differences of the users' needs.

AAC-methods can be a permanent means of communication for those, who understand speech well, but cannot produce it themselves. For example, CP-handicapped who cannot speak because they cannot control their speech organs, but understand everything they hear, benefit from these methods. Another option is to use the AAC-methods for **enhancing speech and promoting its understanding**. For example, a child whose language development has been delayed, but who is expected to learn to speak, benefits from the AAC-methods. In a similar manner, methods supporting

speech can be used in situations, in which it is difficult for people to express themselves, even though they have learnt to speak. The third option is that the AAC-methods **replace speech** altogether. A typical example of this would be autistic persons, who speak very little or not at all.

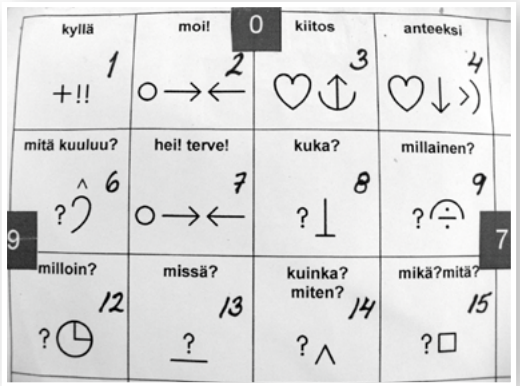
The most "natural" AAC-method is **gesturing**, which people also normally use to highlight or to demonstrate their message. Even the blink of an eye can be interpreted as speech when accompanied by and ABC-board or computer.

Using signs has proved to be a successful method of communication with disabled and dysfatic children. Using signs is easier than speaking, and sings can be made easier according to individual needs, if somebody suffers from motoric dysfunctions which make signing difficult. The use of signs slows down the speaker's rhythm of speech and simplifies the message, which further makes it easier for the listener to understand it.

Graphic symbols and systems of symbols use pictures / images as messages. Images are easy to perceive and eye contact, facial expressions and gestures strengthen the message conveyed by the images. Images can be made into various picture books and communication boards. These books and boards can consist of material **collected by oneself** (drawings, photos, pictures cut from papers and magazines), and they can be used to name the surrounding spaces and objects, for example. The most common r**eady-made systems of symbols** include the black and white, easily understandable **pictogram-images, PCS** (Picture Communication Symbols) **pictures**, with black and white or coloured expressive images, with their meaning written next to them, as well as **Bliss-language**, which consists of visual symbols. The use of Bliss-language requires literacy and the ability to use symbols. The most commonly used system of symbols of the above mentioned is perhaps the PCS pictures, because the number of pictures included in this system is very high, the pictures are available as computer soft ware, they are easy to edit with computers, and drawing them is easy.


KUUROJEN LIITTO r.y.
A
B
C
D
E
F
G
H
I
J
K
L
M
N
O
P
Q
R
S
T
U
V
W
X
Y
Z
Å
Ä
Ö

Pictos



PCS-icons:
maanantai = Monday
aamupiiri = morning meeting
ruokailu = eating
välitunti = break
musiikin kuuntelu = listening music
rentoutua = to relax
välipala = snack
piha = yard
taksi = taxi
koti = home

Bliss-symbols:
kyllä = yes
moi! = hello!
kiitos = thank you
anteeksi = excuse me
mitä kuuluu = how are you doing?
hei! terve! = hi!
Kuka = who?
millainen? = what kind of …?
milloin? = when?
missä? = where?
kuinka? miten? = how?
mikä? mitä = what?

Communicator

In **object communication** the means of communication consist of familiar objects, which can be used to arrange for example time and the course of events. A spoon may mean the beginning of a meal / lunch break, and a glove may mean going outdoors. This method is used in communicating with the deaf-blind and people with severe disabilities.

Contextual messages include visual (images), tactile objects or sings that can be otherwise perceived through senses, and the purpose of these messages is to organize time and space and help to outline locations. For example, a picture on the door of a closet or a drawer can be used to indicate what they contain.

Communicators or speech machines have been developed for different purposes. They can be used every now and then or regularly. Some of them contain pre-taped messages that can be printed or listened to by pressing a button. It is important to notice that the vocabulary or the messages should be chosen according to the users' needs of communication; this helps them to participate in matters concerning them, and simultaneously motivates them use the device.

Computers are multifaceted means of communication. They can be used for creating individual programs for communication and writing. In addition, they can be used as an additional means of making studying and work easier, as well as for playing and spending leisure time. Computers can also be used for managing the environment and communicating electronically. For example, for the severely paralysed individuals there are devices, which help them to control the computer through any voluntary action (such as thinking), without having to use hands.

Plain language means language that is simple both in form and content. It has been estimated that about 4–5 % of children and young people as well as 2–3 % adults in Finland (altogether 150 000–300 000 people) need it. What they have in common is problems with reading comprehension, low level of literacy, and difficulties in concentrating. Groups suffering from these problems include the mentally deficient, people born deaf, people with reading and writing disorders, people suffering from aphasia, some of the elderly and people learning Finnish language.

Books and magazines written in plain language are easier to read because of their simple structure and language. The Ministry of Education committee working with the question concerning plain language examines the books and grants the accepted books a plain language logo. The website of the Finnish Association on Intellectual and Developmental Disabilities includes a list of books written in plain language.

Niko was examined

soon after he was born, due to the parents' concern and observations, which they talked about in the maternity and child welfare clinic. Because there were two older children in the family, both Niko's mother and father noticed relatively soon that their baby's reflexes were not quite normal and he was stiffer than his older siblings. Because there had been some problems during Niko's delivery and it had been difficult, the parents began to suspect that everything was not quite alright.

Luckily, the public nurse in the child welfare clinic took the parents' concern seriously, and Niko was admitted to a closer examination. Neurological examination and all the special tests and examinations relevant for the diagnosis were carried out in the nearby hospital. After Niko was diagnosed with CP, a rehabilitation plan was made for him. A rehabilitation team and Niko's parents were together responsible for making a successful plan for him. In addition to a paediatrician, the rehabilitation team consisted of a nurse, a rehabilitation councelor, physio-, speech and action therapists.

Early rehabilitation aims at activating children's development in a holistic way. It is the best means of guaranteeing that abnormal motions do not become too dominating over the years. In addition to neuropsychological rehabilitation, the key methods in Niko's rehabilitation include physio-, speech and occupational therapy.

The parents enrolled themselves into a course on adjustment training, organized by Finland's CP Association ra (Suomen CP Liitto ry), which gave them an opportunity to gain information and meet other parents of small CP-children, and share their experiences and feelings with them. Also Niko's siblings were offered action suitable for children of their age, while the parents attended their course, and they too received information on their baby brother's disability, and had a chance to meet siblings of other children with CP.

5. Service System for the Disabled

5.1 Service Providers

◆ The Finnish social and health care system is based on public sector, i.e. services provided by the state or the municipalities. **The municipalities** provide and fund most of the services, approximately 65 %. **The state** supports these services by funding about 25 % of the costs as state subsidiaries, and the customers thus pay only 10 % of the costs of the services.

Legislation ensures all Finnish citizens have the basic right to economic and social welfare and education. The municipalities have the primary responsibility for providing basic services for all, but they can provide some of the services in collaboration with other municipalities or purchase the services from private service providers such as various organizations for the disabled. In particular, services and assistance for the disabled are often mainly organized by the **special care districts**, formed by several municipalities.

From the 1990s onwards several new private enterprises have emerged in the field of social welfare sector, providing various welfare services such as home care, housing and transportation services. In health care services provided by private doctors and so forth, as well as private health care centres, have traditionally had a significant role together with public services. **Private service providers** both complement services provided by the municipality, and offer services as well as their expertise in the services the municipalities are obliged to take care of.

In particular, various **organizations for the disabled** have traditionally had an important role as providers of services and support. There are dozens of national organizations for the disabled in Finland, with varying amount of members, and thus with varying extent of action. They all share the notion of looking after the interests of their members, and supporting them in diverse ways. The key activities of the organizations for the disabled include organizing various courses on rehabilitation and adjustment, as well as providing peer support for the members of their target groups. Peer support includes services for providing support persons and support families as well as various means of support for the families of the disabled. In addition, several organizations have begun to offer housing services to municipalities to purchase (chapter 5.2.2.).

Sources of support and services for the disabled:

Public services = municipalities and state

Basic care:
- health care centres and other basic health care services
- home care
- support for home care
- housing services
- day care
- schools

Special services:
- special health care services
- support for special needs children in day care
- support for special needs children at school
- services for the disabled
- services for the mentally disabled

Family, next of kin and friends
- moral support
- social relations
- practical assistance

Private service providers
- cleaning, catering etc. servicesbought by the client fromthe private sector
- private health care

Organisations
- dissemination of information, supervision of interest
- courses on rehabilitation and adjustment
- peer support
- development of the required services
- housing services provided by the organization

In other words, the disabled usually receive the support and services they need from various sources. Family and friends offer emotional support, and in many cases also concrete help in addition to social relations. Organizations may prove useful in finding peer support and, for example, training for adjusting to the situation. Private service providers can be used for assisting in cleaning and household chores, among other things, and the municipality offers statutory social and welfare services.

5.2 General Welfare Services

◆ Services provided by the public sector can be divided into general basic services and special services.

5.2.1 Health care

The general health care services are provided by **health centres**. In addition to services offered by doctors and other health care personnel these centres serve as maternity and children's welfare clinics, provide home care, school health care and health care for workers, as well as dental care and medical rehabilitation, and they often also rent medical means / technical devices of assistance. Municipalities can have their own health centres, or they can have a shared centre with another or several other municipalities. Some municipalities purchase most of their health care services from private service providers.

Health centres have health care branches and wards for bed care. In addition to doctors, nurses, specialized nurses and practical nurses also physiotherapists, occupational and speech therapists, laboratory and x-ray nurses, psychologists, social workers and nutritional therapists work in health centres.

Health care services – like social welfare services – are provided on the basis of the notion of each district being responsible for a certain part of the population. This means that the municipality has been divided into districts according to the population and the area the people live in, and every health and social centre is responsible for providing services for people living in a particular district.

5.2.2 Social Welfare Services

Common social services include social work (guidance, providing information, discussing problems, last resort-income support), family guidance and guidance on raising children, home care, housing services, formal / institutional care, family care and support for informal care. Those perhaps closest and most significant to the disabled include home care, support for informal care and housing services. Day care is also included in the general social services, but since this guide book focuses on children in need of special care, those questions will be discussed in the next chapter together with special services.

Social services at home mean assistance and care provided in the customers' home to make them cope with everyday tasks. It includes the following support services: meals, cleaning, bathing, transportation and clothing, for example. In several municipalities services at home are combined with health care provided at home, in which case the appropriate term is **home care**.

Care-giver's allowance includes a payment for the care as well as services provided to ensure the informal home care of the disabled, the elderly and the sick. The allowance depends on the degree of the required care and assistance. The amount of the allowance, as well as the required supporting services (usually home care services), are defined in the care and service agreement plan between the care-giver and the municipality.

Housing services are provided for people, who need help and assistance in their living, but do not need institutional care. Most common groups in need of this kind of service include the elderly, the disabled, the mentally disabled and the substance abusers. Personnel of the home care and health care provided at home often work in the municipalities' housing services units, but these units may also have their own personnel.

In addition to municipalities, housing services are provided by organizations, foundations and private enterprises. ASPA, a housing services foundation founded in 1995 by 13 organizations for the disabled is perhaps the most significant new provider of housing services. It purchases ordinary apartments, and rents them to the disabled. The required support services are most often provided by hiring personnel to the housing services unit.

5.3. Special Services

5.3.1 Special Health Care Services

The municipalities are also obliged to organize special health care for their residents. For that purpose the state has been divided into 20 health care districts in a way similar to that of the special care for the disabled. In addition, the autonomous province of Åland forms its own district. Every municipality belongs to some of these districts. The purpose of the district is to provide and organize special health care services to all the people living in the district.

Every health care district has **a central hospital** and **local hospitals**. Five of the central hospitals are university hospitals, providing special health care. Excluding emergency cases, special health care services are available only through an admission note written by a doctor. In areas with special health care units (central hospital or university hospital) also the services of a physical therapist are available. All university hospitals have **a genetics clinic**, where people can have genetics counselling, for example when there is a suspicion of a severe genetic disorder. In addition, this kind of counselling is provided by the Family Federation's Department of Medical Genetics, which serves the whole country.

5.3.2 Day Care

A Special Needs Child in Day Care

The **rehabilitation** of children suffering form long-term illnesses, disability or otherwise in need of special care is supposed to start as early as possible. Although home is the most important environment for children to grow up in, the responsibility of children's rehabilitation cannot be left to the parents only. In addition to families and children's welfare clinics, day care centres and schools are key actors of recognizing the children's needs as early as possible, and they are also responsible for supporting the development of the children as well as for making rehabilitation a part of the children's everyday lives.

According to the principles of normalcy and integration, **normal day care and general school** are always primary options, if they can respond to the needs of the child in question. If children are in need of extensive care, they can be placed into so-called double space, which means that the size of the group is smaller than usually. These children can also have their own assistant, if the amount of required assistance is high enough. If there is one or more children in need of special care in the day care centre, it has to be taken into account in either the number of children or that of the personnel participating in taking care of or educating the children, unless the centre has a special assistant for the child / children in question.

The personnel in charge of day care centre consists of pre-school teachers or social workers responsible for raising up and educating the children, children's nurses or practical nurses as well as the personnel working in the kitchen, cleaning and taking care of other assisting tasks.

Children can also be taken care of in **integrated groups**, which in addition to special needs children also include so called support children, i.e. children with no special needs themselves. A special pre-school teacher always works in these kinds of groups.

The third option is placing special needs children into **special groups**, in which all the children require special support and care. These children may have only certain kinds of special needs, for example linguistic disorders, but it is very common for these children to have various kinds of special needs simultaneously.

Both integrated and special groups mainly function in day care centres, and in their action they follow the general goals and guidelines of day care and national pre-school education. This action is supported by the **special personnel**, who in their work support both the staff and the children.

These workers include special day care teachers, speech, occupational and physical therapists. When necessary, also the services provided by psychologists, child guidance and family welfare clinics are available.

Children's need of special care and education must be based on a statement / advisory opinion given by a special doctor or an expert (e.g. psychologist or speech therapist). Children in need of special care will be made an individual action and rehabilitation plan, and experts, parents and day care personnel all participate in making this plan.

The plan includes a description of the children's overall situation, their strengths and needs of support. Similarly, the goals of the children's care and rehabilitation, agreed on together, are included in the plan, and the execution of tasks, which aim at reaching the set goals, is regularly monitored. The goals must be set in a way which allows monitoring the progress of the children.

It is of vital significance that the goals of the plan and the means for reaching these goals can be detected in the everyday work of the personnel. This way rehabilitation is a natural part of the children's daily lives. Practical nurses, like all other people working with these children, must therefore know the goals of the rehabilitation and work closely with the parents and each other to reach the set goals. The required practical instructions and advice can be obtained from the special personnel of day care centre, when necessary.

Rehabilitation Methods Used in Day Care

The above described means and methods of evaluation and monitoring of special pre-school education are simultaneously also **methods of rehabilitation**. What follows next is a short description of some common methods used in day care.

Portage – pre-school education program is, according to its title, a program that progresses gradually, step by step, and can be used at home and at school, for example when teaching mentally disabled children. In this program different parts of the children's progress of development are supported and evaluated regularly (e.g. social development, language development, motor skills, independence). The evaluation is summed up into a form in the Steps-folder. This evaluation helps to outline the children's abnormal or delayed progress of development. This method includes models, which give advice on how to act with the children and how to follow the progress of their development.

The steps-method was further developed into a **Little-Portage** model for 0-3-year-old multi-disabled children, a method that can be used also

in the rehabilitation of older children. It underlines the significance of family as the rehabilitator of the children, as well as the importance of the interaction between parents and children. The purpose of this method is to support parents in their task of bringing up their children, and to find the strengths of the family together with all the family members. The rehabilitation will begin as soon as possible, and the family will be supported all the time, and the personnel taking care of the child will be educated, and counselled when necessary.

The **Day Care Portage** is meant for children aged 2-6. This program includes a handbook, a personal follow-up form, a group follow-up form, a summing up form as well as counselling tips. The personal follow-up form is meant for the personnel as a collaborative device for working together with the parents, and the group follow-up form is used by the day care personnel for evaluating and planning the action of the group of children.

Varsu is a method of early evaluation and planning for children younger than 3 years of age, and the disabled children aged 3-6, as well as for children whose development is at risk of being delayed. The key element of this method is parents' participation in both the evaluation and the whole process of rehabilitation. The aim of the method is to make the children's and the family's resources and needs compatible. The children's occupational / operative skills will be evaluated in their own environment. These skills include fine and gross motor skills, independence, cognitive development, and social and communicational development. Each of these areas includes a series of tasks, i.e. partial and main goals. The ways of action will be planned in such a manner that they support reaching the goals. The practice is based on everyday situations.

The **Fox-test** is a method for evaluating the development of speech and language. It is meant for children younger than 3 years of age, but it is also suitable for assessing children suffering from delays in the development of language, language disorders, the disabled and bilingual children.

The test material consists of images related to the children's world of experience, including pictures of objects, toys in a bag and a story of a Fox. Attention is paid, among other things, to the listening comprehension of the children, their pronunciation, and the comprehensibility of their speech, naming, the length of the utterances, and the mastery of colours and numbers. Day care centres, children's welfare clinics and speech therapists use this test.

5.3.3 Education

Special Needs Children at School

According to the principle of integration and inclusion the disabled children go to school like the non-disabled children: when possible, in their local school in a group participating in general teaching. When necessary, the obstacles of access need to be removed, and the children will be appointed a personal assistant as well as all the means of assistance they need. They also have the right to special education and part-time special education. The teaching can be differentiated depending on the needs caused by a particular disability, for example through individual counselling and by providing learning material suitable for every child in question.

If the disability is severe, and normal / general education does not meet the needs of the children, it is possible to choose a special school, planned according to the needs of children suffering from a particular disorder. For example, there are three state schools for children suffering from motor / physical disorders in Finland, and there are 13 special schools for children with hearing disability. For children with visual disorders, there is one Finnish-language and one Swedish-language special school. These schools also serve as centres of services and development. They develop methods and teaching materials suitable for education and rehabilitation, and they also consult and educate municipal educational and teaching personnel and parents.

A prolonged basic education applies to children, who due to disability or illness are not assumed to reach the set goals of basic education within nine years. Their basic education begins a year earlier than that of the others (the year when they reach six years of age), and lasts for eleven years instead of the normal nine years.

Special education becomes an option, if children due to their disability, illness, delay of development, emotional disorder or some other reason cannot be given education in any other way. Before a decision on the need of special education is made, the children and their possibilities of learning will be evaluated by psychological, medical o social experts, and negotiated with their parents / care-givers. The decision on moving somebody to special education is made by the chief education officer.

All children admitted or moved to special education must be made personal plans concerning the arrangement of their education (HOJKS). The purpose of this plan is to **individualize** teaching in a manner, which allows the personnel to take into account the children's age and learning abilities. The written HOJKS-plan must include:

- description of the students learning abilities and strengths as well as a description of the special needs of education
- both long and short term aims of education
- annual weekly hours of the student's subjects included in the study-plan
- a list of subjects, in which the students' studying differs from the education outlined in the curriculum for basic education
- goals and central contents of the subjects, in which the student has a personal study-plan
- principles of monitoring and evaluating the progress of the students
- description of the required interpretation and assisting services, other services related to teaching and taking care of students, means of communication, as well as means of assistance and teaching / learning materials
- description of the organization of the students' teaching either in connection with other teaching or in a special group
- a list of people who are responsible for arranging the required teaching and assisting services
- principles for monitoring the execution of the required assisting services

The principles of basic education 2004, Ministry of Education

HOJKS can include a decision on whether the students participate in basic education or need an individualized plan for some, several or even all subjects to be studied. If the subject in question has not been individualized, the evaluation will be based on the set goals of basic education. Individualized subjects can be evaluated verbally on all levels of education.

If organizing education according to the set goals for subjects of basic education is difficult or impossible due to the disability or illness of the students, teaching must be arranged on the basis of their **functional capacity**. The areas of functional capacity include motor skills, language and communication, social skills, everyday survival skills and cognitive skills. In the study plan these areas of action will be further divided into sub-areas. Thus, for example, a mentally disabled child's day may include feeling the body, practicing fine motor skills, learning self-control and interactive skills as well as stimulating senses. The evaluation must be based on the individual goals set in HOJKS and it must describe the progress of the student based on the different areas of action. The evaluation must also take into account the obstacles caused by the disability and illness.

The special needs of the students will be taken into account in the size of the teaching group. A group of special needs students may include ten children the most. The size of the group may be exceeded temporarily, if there is

a good ground for that, but exceeding the limit must not jeopardize reaching the set learning goals.

A group of students of prolonged basic education may include eight children the most, and a group of students with an individualized study plan arranged according to different areas of action may include six children the most. If there are students of either of the above groups (prolonged basic education, individualized study plan) in groups of general basic education, the size of the group must not exceed 20 students.

According to the report by the Ministry of Education about 6% of students in basic education receive special education. More than a third of them study according to an individualized study plan, 23% have individualized plans for some subjects and 43% have individualized plans for all the subjects. The most common cause for moving a student into special education is delayed development. Two thirds of the students in special education are boys.

Rehabilitation Methods Used in Teaching

As day care, also schools use various methods of rehabilitation. The most common methods used in **teaching autistic children** are the Lovaas method of early education and TEACCH-program. Autistic children are entitled to prolonged basic education, and they will be made personal plans concerning the arrangement of their education, HOJKS.

The Lovaas method of early education is based on psychology of learning and behavioural therapy. It aims at strengthening positive characteristics of behaviour with rewards. The rehabilitation is planned in close collaboration with parents, nurses, teachers and therapists, because consistency and shared goals are important.

The program includes concrete methods for learning different things. Difficult things are divided into small units, to be learnt separately. The teacher must be active and show example, sometimes by holding hand. The method includes a six phase (steps) program, which begins with preparing to learn and ends with expanding the world view and world of experiences.

TEACHH-program (Treatment and Education of Autistic and Communication Handicapped Children) is a method of rehabilitation, which covers all the phases of life, and has proved to be useful in the rehabilitation of other than autistic children, too. The program is widely used in the United States and Europe. This program underlines the importance of parents in being responsible and carrying out their children's rehabilitation.

The central element of the TEACCH-method is **structured teaching**. It means structurally clear teaching, in which time, space, action and the people related to action have been organized in such a manner that autistic children understand it. A whole day program is planned for the child, with separate moments of action. It is important that the structure is gradually made more flexible based on the development of the child.

Structuring time means that certain things and actions always take place in their own time, and will be organized according to a carefully planned daily or weekly schedule. These actions are demonstrated with the help of series of images or verbal instructions in such a manner that the autistic children can follow the instructions themselves and act according to the instructions themselves. For example, when a certain task has been carried out, children can turn the card in question upside down, and continue working according to the instruction of the next image card.

Daily program Thursday = torstai
pestä kädet = wash hands
levätä = to rest
välipala = snack
leikkiä = to play
piha = yard
tyttökerho = girls' club

Structuring space means that all objects and materials to be used have their own place. **Structuring people** means that the same people always participate in the same situations. On the other hand, the children will gradually be taught to be more flexible in this respect.

Structuring actions means units of tasks the children carry out independently. In Finland this is called **koriopetus** (basket teaching). This title comes from the idea of organizing tasks in their order of performance into baskets or boxes, and children are then taught to work with them independently. Each basket includes the task and all the means necessary for completing the task. When children complete the task in one basket, they move the basket next to the other baskets of completed tasks, and move on to work with the next task. The contents of the tasks will be developed as the children progress in their development. However, the basket tasks only compose one part of teaching that considers practicing communication and interactive skills important.

Developing communication skills is one of the central goals of the method. These skills will be enhanced with speech therapy and images. An individually suitable method of communication will be searched for everybody (the methods will be introduced in chapter 4.4.).

TEACCH-method also includes **practicing self-control**. The practice aims at controlling the children's problematic behaviour, practicing social skills and promoting the ability to live and function as independently as possible later on.

The teaching of the most severely disabled consists of various teaching and rehabilitation methods. They are used according to the area specific teaching, for example, for perceiving the body and stimulating the senses.

KKK-programs (also named as knills after those who developed the method) consist of practices of feeling the body, communication and contact. They are suitable, for example, for the mentally disabled and autistic children. The program includes a handbook, four music cassettes, and forms of evaluation. Each program consists of sounds, rhythm and melodies, which are used for developing the ability to focus on and participate in interaction. For the severely physically disabled there is an application with more time for carrying out the required tasks.

Basal stimulation is based on the idea that the most severely disabled do not get enough stimuli from their environment and thus become easily isolated from their environment and other people. The method makes it possible to give severely disabled people opportunities to feel their own body and movements and to get into interaction with their environment. Different sensory experiences can be produced both in daily situations of basic care, as well as in situations particularly organized for this purpose. Examples of basal stimulation include producing sense of motion, massage with different materials, producing sense of vibration, rhythm and enhancing communication and interaction.

Snoezelen method resembles basal stimulation, because it is also based on providing sensory experiences in daily situations. This method offers these sensory experiences and new experiences in a particular space built for this purpose. Different materials providing sensory experiences will be installed in the ceiling, on the walls and the floor of this space. The goal is to reach a balance between action and relaxation, as well as a suitable level of alertness for learning. This method suits people of all ages.

There are other similar methods. **Lilli Nielsen's methods** provide different situations of communication and contact for the severely disabled.

This method has been developed by a Danish special needs teacher while working with visually disabled children.

Touching stimulation is based on ordinary techniques of massage, which aim both at relaxing and activating the disabled. In addition, the method aims at increasing the level of receptiveness towards the sense of touching, communication and feeling one's body.

Adolfsson's method is based on songs, with themes such as feeling one's body, recognizing one's own name, expressing emotions and sensing time and the environment. This method is meant for teaching the multi-disabled and mentally disabled.

Sherborne-method supports the overall development of moving. The goal is to teach children to feel their body and to create interaction with the help of physical experiences. This method offers feelings of success, because it contains no competition or wrong performances.

Because the scope of this guide book does not allow us to mention all the possible methods of rehabilitation, not even by merely naming them, students would do well by familiarizing themselves more thoroughly with the particular method that will be used in the work place they will complete their training period in.

Upper Secondary Education

Young people and adults in need of special care have several possibilities of gaining means for independent living and working, as well as for getting upper secondary education after basic education. In addition to providing students with professional skills, **vocational special education** gives students assets for overall development in different fields of life: work, home, immediate environment and spending leisure-time.

Vocational special education is organized either in general vocational institutions or in special vocational institutions. The vocational special institutions also serve as **centres** of special education. They provide information on and counselling for recognizing learning difficulties as well as planning and executing special education, among other things. There are altogether 13 special vocational institutions and they are all national, which means that students from all over Finland can apply to them. Three of them have specialized in the education of the mentally disabled, one in the education of the visually impaired and two in the education of children with hearing disorders. The other institutions have students from various groups of the disabled.

Most vocational special education focuses on catering and home

economics. The rate of employment after school has also been highest among those who have chosen this field of education. In addition, special vocational education is offered in the fields of technology and transportation, forestry, metalwork and construction work, clothing, woodwork as well as social and health care services.

Those in vocational special education are entitled to all the assistance they need in order to be able to complete their education, including personal assistants, student health care services and required means of assistance. In addition, they can be provided with study material, weekly visits home, full boarding in student hall of residence or other available housing as well as personal equipment for work, free of charge. They will be made personal plans concerning the arrangement of their education (HOJKS), and their teaching must be individualized in the same manner as in basic education. HOJKS always also includes the students personal study plan (HOPS), which includes (in writing) for example special arrangements concerning teaching, a plan for learning at work, as well as a list of all previous studies which will be accepted as part of the education.

Before special needs students apply for vocational education or for a job, they can be provided with preliminary **training and rehabilitating teaching and counselling**. This kind of training aims at giving students assets for managing their lives independently, as well as means for their future education or work, and it also strengthens their self-esteem and everyday skills. It always includes professional rehabilitation and study counselling.

Forms of preliminary and rehabilitative teaching and counselling include: **Training I**, which prepares students for vocational basic education and **Training II**, which prepares students for work and independent life and is meant for **the severely disabled**.

Personal goals of two students at Haavikko Training and Adult Education Centre (Haavikon opetus- ja aikuiskasvatuskeskus)

5.3.4 Care for the Disabled

The Act on Special Care for the Mentally Handicapped requires Finnish municipalities to organize the following services for the disabled, among other things:

- research, studies and tests that cover the medical, psychological and social examinations as well as the planning of individualized care and services
- guidance and counselling, also for the families
- work and housing services
- individual care and treatment, as well as guidance and counselling

Finland is divided into 16 districts for the organisation of special care for mentally handi-capped people. Capital city Helsinki forms one district alone, other districts include several municipalities.
Receiving services provided by special care requires making a **written plan for a special care program**. The general services are primary, and special care complements them, if general services are not sufficient enough or do not meet the needs of the clients. About two thirds of Finland's approximately 30 000 (0,6% of the population) disabled receive services provided on the basis of the Services and Assistance for the Disabled Act. During writing this guide (year 2008) the Services and Assistance for the Disabled Act and the Act on Special Care for the Mentally Handicapped are in the process of being combined and reformed.

Guidance and counselling

The basic health care of the mentally disabled children is provided by the health centres and children's welfare clinics, but with questions concerning disabilities people can turn to **the clinic for the disabled**. The personnel there assist in defining the need for special care, carry out necessary tests and examinations, monitor the clients' situation and provide support and counselling for the families of the disabled and, for example, for the personnel providing the accommodation.

The counsellor of non-institutional care supports families with disabled children and acts as a contact person for finding suitable services and coordinating the action. The counsellor makes house calls, monitors the development of the children, the execution of the special care plan and counsels the teaching of everyday skills. The work of the counsellor also includes supporting those living in service accommodation or going through their training period of independent living.

Housing

While the amount of institutional care for the disabled has decreased, small homelike housing units have become more popular. There are hundreds of these kinds of accommodation units and group homes available all around Finland. The goal of this action is to make it possible for the disabled to live in their own home community even after they move away from their childhood homes.

The disabled in need of extensive care have been built **service accommodation units**, with personnel working there all day and night. Those in need of less care can live in **guided accommodation units**, with no supervision during nights. **Supported accommodation** units serve best the most independent disabled, who can manage in their own apartment if assistance is available on demand. Supported accommodation units can be located near guided accommodation or service accommodation units, which makes it easy for the otherwise independent mentally disabled to turn to personnel for help when they need it.

Moving away from home or moving into a more independent form of accommodation can require some **practice of living**. An opportunity for this kind of practice can be arranged during a rehabilitation period in an institution or in a separate housing unit meant for this kind of training.

A small number of the mentally disabled lives in **family care**, other than their childhood home. Family care can be arranged in private homes or in group family care with hired personnel. **Short term** family care can be arranged for the purpose of supporting the families of the mentally disabled, in particular. The parents have an opportunity to relax and rest, and can focus more of their attention on the other children of the family during these regular short term periods of family care outside home.

Institutional care is meant for the most severely mentally disabled only. There are about 20 central institutions of special care with about 2700 inhabitants. These institutions function as the local centres of expertise and counselling in their own area, and they also provide non-institutional care and rehabilitation. The Decree on Social Services requires that the environment in institutional care is homelike, stimulating, allows for privacy, is safe and provides rehabilitation, as well as promotes independence and functional capacity. At the moment – in 2008 – institutional care is undergoing decentralization. The aim of this process is that only 500 most severely disabled people will stay in institutional care, and the rest of the disabled people will move into smaller housing units and communities.

The housing services for the mentally disabled in 2007

Assisted accommodation	*Guided accommodation*	*Supported accommodation*	*Family care*	*Institutional care*	*Inhabitants total*
4,850	2,100	1,200–1,300	1,150	2,600	12,000

Source: Kehitysvammaisten yksilöllinen asuminen. Pitkäaikaisesta laitosasumisesta kohti yksilöllisempiä asumisratkaisuja. Toim. Markku Niemelä ja Krista Brandt. Helsinki 2008. STM selvityksiä 2007:73.

Day care

Day care offers the young and older mentally disabled meaningful action, an opportunity to practice their everyday skills, practice working and gain social contacts. Although most of the mentally disabled children are in general day care, the special day care centres can also offer day or evening care for children, whose care cannot be arranged in the context of general day care services due to their disability, or who due to their age no longer wish to go to family care for pre-school children after school, for example.

The focus of day care services is on rehabilitation: either on maintaining or improving the functional capacity of the clients. The daily program includes practicing everyday skills, stimulating action and communication and practicing other social skills. For those less severely disabled day care can also provide and opportunity to practice more demanding tasks for work, or more independent living.

Work activities and supporting employment

Work activities are primarily rehabilitative in nature, and do not aim at productivity. The traditional activities for the disabled include handicraft, hobby crafts, as well as different assembling tasks performed for outsider orders. Those participating in working activities receive a small amount of money, which does not diminish the amount of their disability allowance / invalidity benefits. In recent years the scope of these activities has broadened and expanded outside work centres.

Non-institutional working activities have become more common since the late 1980s. These activities mean assistive work outside work centres in general work places, for which the disabled will be paid a small amount of money instead of actual wages. This also means that they do not have employment contracts, and thus are not employed in the actual sense of the word. More than half of these jobs are provided by the public sector, often in service centres for the elderly or in day care. The required tasks include working in the kitchen, cleaning, storing and maintenance. The working hours vary, and the disabled can work part of the day or week in non-institutional working activities and the rest in work centres.

CP-Liitto's day and work activity unit in Helsinki

Subcontracted working at Työkeskus Aula

Supported employment began in 1996, and has rapidly expanded into different areas of Finland.
It aims at finding suitable jobs for mildly disabled people in the general labour market. Instructors and counsellors working in the work centres search for suitable jobs for the mentally disabled interested in this kind of action, and contact employers of different fields. When a possible job is found the employers will guide and counsel the mentally disabled in the required tasks, and help to create a job description, in which the required tasks are compatible with the functional capacity of the person in question. In addition, the weekly working hours are agreed on based on both the needs of the employer and the expectations of the mentally disabled. The employer supports and assists the mentally disabled, but the amount of support and assistance will gradually decrease, when the disabled become more familiar with their work and the related matters. The disabled will be paid a certain amount of salary depending on the quality of the tasks and the amount of time spent on carrying them out (hourly wages). This also means that the disabled are actually employed. If necessary, the wages and possible pensions / benefits / allowances are combined to make sure that the employees can make the ends meet.

5.3.5 The Services and Assistance for the Disabled Act

The Services and Assistance for the Disabled Act aims at promoting equal treatment and the possibilities of the disabled to participate in all fields of life, according to the goals of the international disability policy. It obliges municipalities to develop the living conditions of the disabled, to prevent the emergence of inequality and disadvantage, and to remove obstacles and limitations of action, as well as to provide the statutory services.

According to legislation, social services provided by the municipality are divided into two categories: general services for all the disabled and statutory services the severely disabled have an undeniable right to.

The difference between services provided within the categories of general and undeniable, statutory services is that social services can deny a disabled person general services, it the funds for this particular purpose

General services meant for all the disabled include:

- rehabilitation and councelling
- adjustment / adaptation training
- personal assistant
- guidance and service in providing assistive devices (half of the expenses will be covered)
- covering the additional nutritional and clothing expenses caused by disability

Statutory services the **severely disabled** have an **undeniable right** to include:

- transportation services
- interpretation services
- day care
- service accommodation
- home modifications and required assistive devices and equipment

have been exceeded during the year in question. In comparison, services provided under the heading statutory, undeniable rights must be taken care of by the municipality independent of the available funding, if the client fulfils the criteria of the severely disabled.
In addition to disability, the criteria take into account the circumstances. Thus, two disabled with similar disorders may receive different responses to their applications for transportation services. If one of them lives in a distant area, with poor public transportation or difficulties in using it or the distance between home and the closest bus station is too long, this person may be given permission to use transportation services. Another person may be denied these services based on the fact that public transportation is easily available, and easy to use (e.g. busses with floors low enough).

The decree related to the Services and Assistance for the Disabled Act requires making a **service plan** to ensure the availability and continuity of services for the disabled. The purpose of the plan is to construct an overall picture of the clients' needs and life situations, as well as to map possible services simultaneously. It is particularly important to make this plan when the disabled in question is a child, a young person or a severely disabled, in need of services provided within several different systems.

Legislation Related to Working with Special Needs People or the Disabled:

- *The Services and Assistance for the Disabled Act (380/1987)*
- *The Special Care for the Mentally Handicapped Act 1978*
- *Act on the Status and Rights of Social Welfare Clients (812/2000)*
- *Social Welfare Act (710/1982)*
- *Children's Day Care Act (36/1973)*
- *Primary Health Care Act (66/1972)*
- *Basic Education Act (628/1998)*

Niko can use

all the services provided by the general welfare system, according to his needs. Since he is diagnosed with a mild mental disorder at the age of two, he and his parents are also eligible to use services provided by the child welfare clinic for the disabled. A special care programme will be made for him, and his parents will be advised on the rehabilitation of children. Niko's special care programme will be drafted together with his parents, and the task begins with mapping Niko's personal needs and making plans on meeting those needs. The earlier plan, drafted right after Niko was diagnosed with CP, will be taken into account as a part of the whole situation. The out-patient care councelor advises Niko's parents and monitors the child's development as well as assists the family with looking for and receiving the suitable services.

Niko is eligible for temporary home care or services at home at certain, agreed on intervals, for example for the purpose of supporting the parents' coping or for providing the parents with more time for their other two children.

After Niko's mother has returned to her work, Niko has been admitted to day care in a nearby day care centre. He is in a normal group of children, but because he needs constant care and assistance, he will be provided with a personal assistant, at least in the beginning. However, the whole personnel of the day care centre participate in taking care of him, and therefore they all familiarize themselves with Niko's rehabilitation plan, and act according to it. The main goal of Niko's rehabilitation is enhancing his independence and communication skills.

According to the Services and Assistance for the Disabled Act Niko has a subjective right to make certain alterations at home, by the time he starts using the wheelchair.

He gets the wheelchair free of charge from the health care centre. In addition, when Niko reaches the age at which children start moving about independently, without their parents, he is eligible to use the transportation services for the disabled during his leisure time. In addition, he has a subjective right to interpretation and translation services for the disabled, arranged by the municipal authorities, if his speech is too unclear for the others to understand, and he needs an interpreter to make himself understood.
According to the above Act, a car is one of the assistive gadgets and devices that Niko can purchase at a reasonable price, and then receive half of its price as a reimbursement, provided the car is necessary for transporting Niko, his wheelchair and other assistive devices he might need. In addition, he is eligible to a personal assistant, when he becomes old enough to move about without his parents, and needs the assistant for coping with his hobbies and leisure time activities.

Niko and his family have a right to rehabilitation and adaptation training when necessary, and, for example, when their life-situations change. According to the Services and Assistance for the Disabled Act, municipalities are responsible for arranging this kind of support as part of their welfare services. The social worker that is responsible for decision-making concerning these services is also responsible for making the service plan.

As part of his medical rehabilitation, Niko can be given pictogram-image cards to ease his communication with the others. In addition, medical rehabilitation includes other assistive means of communication, such as computers.

6. Working with the Disabled

◆ This chapter describes work places where people studying to become practical nurses – especially exchange students coming from abroad – can complete their training period. The text focuses mainly on general questions that students need to take into account in their work. These descriptions are complemented by two descriptions of a day at work. These descriptions have been provided by typical work places where exchange students are most likely to be located in.

Always when working with the disabled one must remember the important ethical principles:

- **respecting individuality and human life**
- **fair and equal treatment**
- **remembering autonomy and supporting independence**

Professional work always includes **aims and plans**. Therefore, also students need to familiarize themselves with their clients' care, bringing up, educational and service plans, to be able to work according to the set goals and as a part of a team. Discussions with one's own counsellor and other employees also help in outlining how working situations in practice can promote the execution and realization of matters that are important to the clients.

6.1 Day Care Centres

◆ Practical nurses, like other day care personnel, have knowledge on the normal growth and development of children, based on their education. It is their task to discuss the observed need for rehabilitation or support together with the parents, especially if the parents themselves have not noticed the problem. Very often parents share the same concern, or the child is already being examined, diagnosed or in the process of being diagnosed, and rehabilitation plan is already in the making.

Rehabilitation in day care is closely tied to the everyday life of the children. Special needs children can participate in day care, although they would otherwise not need day care due to their parents work, for example. When possible, physical and occupational therapy is arranged during day care, to ensure that the daily or weekly program of the child and the family would not become too heavy.

The personnel in the day care are counselled by rehabilitation experts, and they apply the given instructions in their daily work. For example, the therapists can make series of images or written instructions concerning the handling of the child, or the supporting of physical growth and communication.

Example case

When Niko enters day care, he already has a rehabilitation plan, which will be checked, if necessary, together with the experts, parents and the day care personnel. He can be provided with an evaluation and a rehabilitation plan that seems suitable for him, and this plan will be followed in day care (chapter 5.3.2.). All those working with children must know the goals of Niko's rehabilitation plan, as well as the means for reaching the set goals.

The day care personnel are given the same instructions concerning the posture in which Niko is to be fed and the feeding technique that were given to Niko's parents. Eating practices the coordination of mouth and throat, and this practice serves the purpose of learning to produce speech. The kitchen personnel must know the nutritional therapist's instructions to ensure Niko receives a sufficient amount of nutrition. The composition of food as well as the cutlery must be taken into account, too.

The instructions provided by physical and occupational therapists are important for the right managing and support of the children's physical development. With daily routines of getting dressed, care and play the day care personnel can thus promote Niko's rehabilitation. In addition, closeness and touching indicate acceptance and help Niko to understand his own body.

The parents take Niko to a speech therapist, but in addition to following the therapist's instructions and practicing speech in various everyday situations, the day care personnel decide to make use of image communication cards, which the parents then decide to use at home too, to support Niko's (development of) communication.

It is particularly important to pay attention to the fact that Niko can participate in as many actions in the day care as possible, and play with other children as much as possible. In addition, he is offered opportunities to touch objects and materials, which he could not reach himself from his wheelchair. Niko's positive self image is supported, and if other children shun him or tease him because of his disability, interventions into the situation will be made immediately. Niko will be provided as many opportunities as possible for free play and interaction with other children. His self-confidence will be supported and he is allowed to do himself all the things that he can. Personal assistive gadgets and perhaps computer aided rehabilitation will support his independence and the development of his playing.

The personnel has regular discussions with the parents concerning the shared outlines of Niko's care and education, as well as his progress, and the parents' expertise concerning their own child is respected in these encounters.

6.2 Schools

◆ At school practical nurses most often work taking care of the tasks of personnel assisting students in special classes. The assistant is supposed to work with the teacher, guiding students in completing the given tasks and making sure that they concentrate on their tasks and that the class room is peaceful. The aim is to guide students in a way which simultaneously supports the student's autonomy and independence.

The assisting person can either work for the whole group or a particular student, as his or her personal assistant. There can be several assisting persons working in one class room to help the teacher with the whole group, or in a group of severely disabled children every child can have his or her personal assistant. The teacher is responsible for executing the education according to the curriculum and the students' personal plans concerning the arrangement of their education (HOJKS), the assisting person guides the children in their work and ensures that the overall goals of the rehabilitation plan will be met.

Team work skills are important. In addition to the student / students and the teacher as well as other people who might be working in the classroom, the assistant can function as a contact person between the parents and the possible experts in therapy.

In the group of **the severely disabled** the role of the assisting persons is very important. In addition to helping students in the learning situations, they assist the students in eating, getting dressed, in going to the toilet and in other daily activities. They also act as the students' interpreters, and therefore it is very important that they notice the children's attempts to express themselves. In addition to knowing the contents of the arrangement concerning the student's education, the assisting person should know the student's ways of communicating and manage the possible assistive gadgets. Because several adults work together in the group of the severely disabled children, the significance of interactive working skills is highlighted.

Example case

The prolonged basic education applies to Niko, and the planning of matters related to his education will therefore start when he is five years old. His school starts during the year he becomes six years old. The pre-school is taken care of in day care, and it aims at supporting his preparedness for school.

At school Niko will be made his personal HOJKS. His education will be arranged in the group of special needs children. His teaching will be individualized at least in some subjects. For example, his physical disability will be taken into account in physical education, handicraft, art education and the set goals. If Niko has a chance of completing some subjects according to the general curriculum, it will also be mentioned in his plan, and depending on the school he is in, he can even participate in the general education of that particular subject in an ordinary class. Individualized curriculum will be mentioned in Niko's certificate, but it does not prevent him from applying to upper secondary education after he has completed his basic education.

When he has completed his compulsory education, Niko can apply to further education that meets his needs and interests. If necessary, Niko's vocational education can be preceded by preliminary education and training that aims at enhancing his learning skills and his skills of managing everyday life. He will be made a personal study and rehabilitation plan HOJKS, which aims at providing him with an opportunity to study according to his own abilities and capabilities. Niko will go to the preliminary training from home by a wheelchair accessible cab. In addition, according to the Services and Assistance for the Disabled Act, he is entitled to 18 one-way trips a month during his leisure time. He can also have a personal assistant for a few hours a week while attending leisure time activities.

6.3 Institutional Care

◆ Most of the mentally deficient people who live in institutions are severely disabled, and have additional disorders and possibly also behavioural disorders. Although work in these institutions is mostly basic nursing, all action is related to rehabilitation. As pointed out in the chapter on institutional care (5.3.3.), the institution must be homelike and stimulating. It is also the responsibility of the institution to provide the clients with rehabilitation, nursing and care that correspond to their age and condition. The goal is to take into account everybody's

individual, personal needs and to ensure their overall well-being.

In addition, in their own region the institutions can function as centres of development for the care of the disabled, and provide temporary care and various kinds of rehabilitation for the disabled.

In practice, individuality and privacy manifest themselves in the care plans and the set goals, but also, in the fact that most clients living in the institutions either have a room of their own or they share the room with another disabled, i.e. there are two people in one room the most. The rooms will be decorated according to the taste of the client, for example by taking colour preferences into account, and by using personal items and belongings.
The provided care is based on the so called model of responsible nurse, which means that every client has been named a nurse who is responsible for the client, and takes care of him and his matters in particular. The responsible nurse also keeps in rtouch with the client's family and functions as the co-operator in taking care of the client's matters.

In everyday care, particular attention is paid to communication with the clients. They will be told what is going to happen next and they will be encouraged to reciprocity. Friendly and positive treatment and a warm touch are means of nonverbal communication, which convey approval and respect to the clients. In particular, when working with clients who cannot speak, the significance of nonverbal communication and body language is highlighted. The care personnel must pay attention to what these means tell about the client and also, they must remember that on their part, body language communicates much more forcefully than verbal language.
A rough or a hasty way of taking care of the client, as well as tense appearance, has a negative impact on the whole interaction.

Because mere existence is not enough as the whole content of anybody's life, the personnel is also responsible for creating opportunities for gaining various experiences and doing meaningful things, even when the client is severely disabled. As much as possible, the clients will be given a chance to participate in the everyday activities and events outside the ward, and the clients' senses will be provided with stimuli.

A description of a day at work in Sofianlehto

Main entrance of Sofianlehto: Sofianlehto's central institution is the Helsinki district centre for the care of the disabled.

Sofianlehto offers around-the-clock rehabilitation and care for the disabled of all ages, if the services provided by non-institutional care and support are not sufficient enough. Sofianlehto includes different housing units and a day care centre. The housing environment provided is as individual, homelike and comfortable as possible.

Sofianlehto offers annually an interesting and challenging place for the training period for students of nursing and social services. There are trained work place councelors, work place councelor teachers and supervisors in Sofianlehto.

The personnel of Sofianlehto includes nurses specialized in working with the disabled, the mentally disabled, the retarded, mental health, basic nursing, practical nursing, general nursing, councelors for the disabled as well as Barchelors of Social Sciences. In addition, the personnel collaborate closely with a doctor, a psychologist, a social worker as well as a physical, occupational and speech therapist.

The housing units in Sofianlehto are profiled, and every one of them has its own characteristics. The course of the day may vary greatly depending on which kind of unit one works in. The different housing options include units for children, young people, adults, the elderly, mental health, the autistic and temporary units. However, the special characteristic of working with the mentally disabled as well as certain principles of nursing and caring show in the everyday life of every unit. The care plans are based on Roper-Logan-Tierney model, and nursing is based on the notion of accountable nursing.

The personnel work in three shifts, and every shift begins with a verbal (spoken) report, which informs the next shift about the events of the previous shift. In addition, the electronic Effica system is also used for writing down daily events, as well as for making and archiving care and rehabilitation plans. The working hours of the shifts vary form one unit to another, depending on the needs of the clients.

Every inhabitant has a named care-giver, and a substitute for him / her, who is accountable and mainly responsible for all the matters concerning the various fields of life of the client in question. This particular care-giver ensures and coordinates the managing and execution of all the matters agreed on in the client's care and rehabilitation plan. This care-giver is responsible for monitoring the client's health, the execution of medical measures, assisting in keeping in touch with the relatives, making the care and rehabilitation plans as well as the evaluation. In addition, this care-giver assists the clients in purchasing clothing, decorating their rooms, participating in their leisure-time hobbies and everything else that is a part of the clients' everyday lives.

Interactive skills as well as different alternative means of communication are an integral part of daily work. The alternative means of communication used here include picto-grams, PCS-images, weekly tables, photographs, assisting signs, sign language and plain language. It is important for the clients to be heard and understood. Not all clients can speak, or their speech may be minimal or mere sounds and gestures. In such a case the clients can use a PCS-image to show that they want to listen to music, for example. From the care-givers this requires good professional skills and the ability to interpret the clients' wishes.

Weekly program of a resident at Sofianlehto

The typical day at work focuses on basic nursing, which means assisting the clients in washing up, getting dressed, choosing clothes, wearing make up, doing hair, shaving and cutting nails, among other things. While providing basic care the care-givers pay attention to their clients' condition of skin, special functions, as well as other matters related to well-being. All the everyday activities support the clients and their efforts of taking care of all the everyday routines by themselves as much as they can, and not doing things or making choices for them or on their behalf. For example, the clients are offered the opportunity to make choices concerning clothing "would you like to wear this red or that blue shirt". The clients are assisted in getting dressed according to their age, as well in expressing their gender. This includes perfumes, jewellery and other accessories.

Meals, assisting during meals and guidance are also part of everyday work. During meals the clients' autonomy

and independence is supported as much as possible. The clients are given options to choose from, for example, "would you like to have milk or sour milk". In addition, alternative means of communication are made use of during meals. The clients can, for example, point at an image of the dish or the drink they want to have.

Some of the clients are completely dependent on help. Different, individual cutlery is often used when assisting them during meals. The meal situations will be practiced together with the care-givers, and an example meal situation is used for teaching purposes. During example meals the care-givers eat together with the clients, and simultaneously guide and council the clients. The clients will also be taken to restaurants to eat, according to their preferences, or to cafes and for an ice-cream outdoors during summers.

Some of the clients go to work in Sofianlehto or outside for day care and work activities. The personnel will take them there, and fetch them back, if necessary. When attending events outside the housing unit, the clients usually use invalid taxes. The personnel also daily assist the clients in their efforts of participating in hobbies and leisure time activities. One important form of leisure time activities is going outdoors. In addition, the clients will be offered opportunities to listen to music, watch TV, read magazines or do hobby crafts. The clients can also participate in small everyday household chores. For example, some clients will take out the trash, wash the dishes and water the flowers together with the care-givers. In addition, outdoor trips to zoos, amusement parks, movies, exhibitions, farmer's markets and other places according to the preferences of the clients are arranged. Car rides are also pleasant for the clients.

Sofianlehto celebrates the Independence Day, the First of May, the Midsummer and Sofia's day in a traditional manner. This means enjoying a good meal, program, music and meeting friends and family. Religious holidays, such as Christmas, will be celebrated in the housing unit with dignity and respecting the traditions. Also spiritual needs will be taken into account. Once a month Sofianlehto arranges church services headed by its own minister for the disabled.

The everyday work also includes sharing the clients' life in all its phases. The joys and sorrows of life will be experienced together. Festivals and birthdays are important, and they will be celebrated together with the clients and their families. The named care-giver is responsible for organizing for example the clients' birthday parties together with them. The treats will be selected and prepared together with the clients. Baking and participating in cooking is important for the clients. By participating in these activities the clients gain experiences of succeeding

as well as various sensory experiences by “tasting, smelling and feeling”.

Work in institutions for the disabled is challenging and sometimes includes difficult matters. Facing death, illnesses or challenging behaviour form part of the everyday sometimes. However, working in the institutions for the disabled is mainly pleasant, nice and offers an opportunity to make use of all the skills that you have acquired in your studies and lives. Collaboration with the clients’ families is part of the work almost daily.

Most of the clients are severely disabled and need much help and assistance. This sets the ethical requirements of the work on a high level. The clients must be encountered as subjects, and not merely as objects of treatment and care. Sofianlehto is an up-to-date unit, friendly towards students and we wish the students heartily welcome to work with us.

6.4 Day and work activity centres

◆ The goal of day care and different activities is to provide the clients with meaningful content and social relationships in their everyday lives. The clients participate in the daily activities according to their interests and care plans, for example on particular days of the week. The personnel will have to plan the program so that it is as interesting as possible, includes enough variation, and forms of action that suit the clients.

The action may include being together, going outdoors, making trips outside the centre, suitable forms of physical training, and practicing everyday skills (for example, baking and running errands) or using creative methods (hobby crafts, drawing, handicrafts). It is important to remember, that the care-giver is in the role of an assistant and the actual actors and agents are the clients themselves.

Shared activities at CP-liitto’s day and work activity unit

When guiding the client, it is important to keep the instructions clear and accurate, proceed peacefully and divide the action into smaller parts, which help the client to understand what is expected of him.

Important advice also for personnel! (odota = wait)

The central goals of daily and work activities include promoting participation and enhancing the clients' everyday life management skills. The disabled are easily marginalized in the society, and become bystanders, unless their possibilities for participating in the everyday life of the society according to their own age level and abilities are somehow supported. During the last decades the goals of integration and inclusion have begun to manifest themselves in the disability care; instead of functioning separately, the disabled have begun to orient themselves towards the society and to participate in its different events and activities.

In the field of work this change shows best in the fact that out-patient work and supported employment (chapter 5.3.3.) have become more common. People have realized that there are several tasks that the mentally disabled can manage, and that the disabled see themselves as useful members of the society when taking care of these tasks. One of the central tasks of the activity centres is to prepare the clients to further education and working life.

In addition to providing the clients with actual instruction and guidance, the counsellors also serve their clients by encouraging and activating them and by acting as role models and partners of the interaction.

Helsinki short term (temporary) home and workshop Lyhty ra or LYHTY RA

Helsingin lyhytaikaiskoti- ja työpaja Lyhty ra, later Lyhty, is a non-profit association, which provides living-, education and work activity services for adults with learning disabilities. Lyhty is located in Helsinki, Finland, and was founded in 1993. Lyhty provides services for approximately 100 individuals plus their families. Lyhty owns four buildings and houses. The employees consist of 60 professionals, who provide service around the clock. Furthermore Lyhty is co-operating with civil servants and exchange programmes and thus volunteers. The service philosophy of Lyhty was originally based on nursing philosophies, but nowadays the association is creating their own mix of philosophy and service trough research.

In addition to housing services, Lyhty provides learning and work services. The clients of day care are

mostly mentally disabled adults. The workshops and learning units mainly function during weekdays and daytime, for example between 9am and 4pm. The working hours are flexible, according to the clients' needs. The counsellors and teachers include graphic designers, gardeners, florists, carpenters, home economics teachers, health care nurses and nurses. In addition, students and people completing their civil service provide an important asset.

Everybody attending the workshops, learning units and special workshops (to be described later in this guide) will be made their own personal work and study plan, as well as a plan of expected development at work. When necessary, a service plan will also be made in collaboration with all the necessary parties. In addition to day care activities, this service aims at enhancing the clients' skills in their overall management of life, learning and the promotion of healthy lifestyle. All the clients have their own nurses, whom they meet from time to time to discuss questions concerning their health.

Six clients work in the **arts and handicrafts workshop Luovilla**, guided by a graphic designer. International flavour and cultural influences are brought in by volunteer workers coming from different countries. Clients in Luovilla are interested in arts and handicrafts, and it is their task to come up with ideas, execute them, and to market their products and works. All the clients develop their own series of products based on their own strengths and interests. The brands and brochures develop, and CV:s improve over time. The aim of this activity is to build professional identity and create quality art and works of art, which can be sold and displayed among professionals. The products and works are made for sale and exhibitions.

Lyhty's arts and handicrafts workshop Luovilla, Mikko Pulliainen weaving paper carpet

In **LATO outdoors workshop** all the clients search for their own strengths, and practice creating aesthetic environment through their own work. Developing in various activities, work and skills makes the clients feel useful, and it increases their desire to learn new things and enhances the development of their understanding about themselves and the surrounding world. The outdoors

workshop activities include taking care of the yard through various tasks typical of different seasons: chopping up firewood, clearing the snow from the yard, planting, mowing the lawn, raking the leaves etc. The daily work also includes theoretical studies, courses and visits to communities and enterprises of the field. In addition, LATO provides information and experiences of the environment to all the clients.

Music workshop supports the clients' orientation towards various tasks in music, and gives them an opportunity of practice completing clear, useful and professional tasks. Music is approached holistically from the point of view of playing, motion, dance, using one's voice as well as processing information. The music workshop sells program packages, built according to the wishes of the buyers' orders. These packages can consist of concerts, musicals, karaoke and DJ-services, for example.

Lyhty's music workshop: Sami Helle on bass playing by figure notes

Learning unit Lamppu offers young clients an opportunity to complement the skills and knowledge acquired in basic school, as well as a possibility of enhancing the skills required in everyday life. Through guided learning, based on activities and doing (hands-on learning), the young clients improve their own possibilities of managing their everyday skills, being positioned in working life and gaining upper secondary education as well as functioning as full members of their society. The teaching provided by Lamppu is based on the idea of providing students with experiences, and thus gaining and reaching for experiences of the surrounding world.

Special jobs are meant for those, who can manage independent working. The tasks and job descriptions of special workers are built for each individual personally. During their working hours special workers are supported by a professional care-giver, who guides them and develops their work in collaboration with them.

The example shift begins in Art and Textile workshop Luovilla at 9am. Welcome! The counsellor, the student and the clients change a few words, and discuss the tasks and the goals of the day. Some of the clients begin their independent work, and the student makes sure that their clothing and the required tools are suitable for the task at hand. A wish for an exhibition of one's own has been recorded in a

study plan of one of the clients. This particular client and the student pay a visit to the potential exhibition site, and take photographs of it. They plan the route to this site so that the daily walk is taken care of simultaneously. The counsellor looks after the needs of the other clients. The counsellor discusses a new idea by one of the clients, as well as the execution of it with the person in question, and soon after calls the personnel of the hall of residence of another client to discuss the observed changes in the client's vision with them.

Today we shall have lunch in the nearby cafeteria. The student walks to the cafeteria with one of the clients, encouraging him to learn safe manners and traffic rules by providing an example of how to move about in traffic. If necessary, the student advises the client in practicing hygienic manners. When taking food the student encourages the clients' to choose dishes that suit their individual nutritional plans. Giving a good example of table manners and discussion the student participates in the activities at the lunch table.

In the afternoon the student discusses the quality of some textile works and finishes them together with the client, who planned and made these works. At the same time, the student advices the client, who is planning her own exhibition, and became inspired by the morning visit to the exhibition site, and began to materialize her ideas by drawing and painting. The student advises the client on choosing materials and organizing the work place in the best possible way from the point of view of ergonomics. Quite unnoticeably the student puts on the clients favourite piece of music, and lures her to move and dance to the rhythm of the music in between working.

The weather is beautiful and the coffee made by one of the clients will be enjoyed outdoors admiring the garden taken care of by volunteers the previous day, during an event organized by the clients working in the LATO workshop. The student makes remarks about the environment and encourages the clients to do that too, in addition to which the student takes care of tidying up and decorating the environment together with the clients of the workshop. At the end of the day the student makes preparation for next day's visit to the Design museum by searching for information on the current exhibition in the Internet. She familiarizes herself with the material, and makes preparations for next morning's discussions on the themes of the exhibition. The counsellor and the student discuss the course of day and the following day's arrangements briefly. The day ends at 4pm.

6.5 Housing Units

◆ Work at various institutional housing units for the disabled (chapter 5.3.3.) consist mostly of taking care of the

everyday routines together with the clients, to the extent that it is possible, but above all it is about living together and mutual interaction. The clients' rhythm of life is usually relatively similar to the daily and weekly rhythm of other people of the same age. During daytime the clients go to school, work or to their daily activities, and their leisure time activities tend to take place during the weekends.

Based on the principles of integration and normalization the housing units for the disabled are usually located in general housing areas, and are as much home-like as possible, small units. All the clients have rooms of their own, if they wish to have one. However, sharing a flat or a room is also an option, if the clients feel like living together and can support one another and keep company to each other this way.

The personnel working at the housing units support the clients in their everyday routines, just like the personnel at work centres, day care centres and adult education. The clients will be assisted in and advised on cooking, running errands outside home, using money and other skills relevant in managing everyday life as an adult. The personnel can also support the clients' communication with their families and relatives, for example, by organizing birthday parties or events meant for the whole housing unit, and the clients' families and friends can be invited to these events.

Most housing units apply the model of the responsible nurse, which has been discussed earlier in connection with institutional care.

Based on the principle of supporting the clients' independence, their life is limited as little as possible. However, in some cases intervention may turn out to be necessary. For example, excessive use of money which can later on cause problems to the clients themselves, calls for intervention. Similarly, the personnel may have to remind the clients about the need to follow the principles that have been agreed on together. The housing unit is the clients' shared home, and therefore, for example, rules concerning smoking have to be agreed on together, taking into account questions of health and general safety. Sometimes crossing the boundaries of independence causes ethical problems, and it is difficult to decide what the right way of managing the situation would be. In such a case, it is useful to discuss the question with the whole work community, and bear in mind the ethical principles concerning care work and nursing.

The clients will be treated according to their age level, and their adulthood will be supported when necessary. In addition, they will be encouraged to participate in activities and social life outside their home, for example, by introducing them to different hobbies and providing information on various events, among other things.

In the housing units for the physically handicapped or disabled the role of the personnel is different. The personnel mostly act as "technical support" and perform tasks according to the wishes of their clients. The clients are completely independent in their decision-making, and live in their own, separate apartments. This work requires flexibility and the ability to respond to the clients' different needs.

Sometimes, however, the personnel's principle of supporting independence can contradict the clients' expectations. The clients may think that because they are in the role of the employer, their demands have to be followed and fulfilled by the employee. In such a situation, the question has to be thoroughly discussed and the personnel have to explain why they expect the clients to participate in the activities that they are able to perform.

A Working Day in Lyhty Ry; Housing Unit

In the housing service Lyhty (introduced in the previous chapter) provides care to adults with learning disabilities (from mild to severe disabilities) around the clock, in other words three shifts a day. The shifts are arranged according to the clients and therefore they differ from unit to unit. Approximately, the morning-shift starts at 7 am., and ends at 2.30 pm., and the evening-shift might be from 2 pm. - 10 pm, and the night-shift from 10 pm. to 8.30 am. The team consists of one or two employees a shift, mainly of representatives of the nursing profession, physiotherapists and also other professions. To describe the daily work tasks we refer to the mode of fluctuation and the mental conceptualisation/ types of knowledge discussed by Jaana Venkula, or reflect on the tasks on the basis of Yura & Walsh and their approach to nursing through a hierarchy of needs.

The next shift starts at 2 pm. Welcome! As in every shift, we start with a verbal report, covering the most accurate information about the client and the work (team, Lyhty as association, network). Additionally, the written report has to be read to get more concrete information in the form of 'silent reporting'. Through this practice we assure the continuity of the client's well being within the approach of primary nursing.

The clients might be at the work or in day activity centres at the time. Based on the report, the environment, the co-workers and the long-term plans the worker prioritizes the tasks that need to be done during that shift. Usually, this plan has to be kept flexible, because

the clients and their needs are the primary focus of the day's structure and work plan. Examples of action might include taking care of the aesthetic environment, developing and updating documents, and preparing the meal according to individual nutrition plans and the ability of the clients, etc… By then, the clients start to arrive from their work. One task is to share information (verbal or/and via written messages) about the day to guarantee the continuity of the care and the co-operation between the work and day centres. Depending on the clients (and thus the units), different kinds of support are needed. In general, the aim is to give room to the clients to use their own strength and to be as active as possible. This is carried out by respecting the values and the dreams of the clients, and by offering them opportunities, especially when assistance is needed. Returning to the moment when clients arrive from their work, this approach includes their decision-making concerning e.g. eating, planning their free-time, and eventually preparing for the next day or any other happening or future-dream, exercise, privacy, etc... Depending on the clients' skills, the support varies from verbal interaction to concrete actions such as feeding, washing, assistance in moving, assistance in experiencing life through all the senses, etc... While being at home, household tasks are naturally present and the clients participate in taking care of them as much as they can. From the personnels' perspective, this demands knowledge about the clients and their abilities, communication with the clients and insight into their well-being and strengths.

In the evening (or any other daytime) routines concerning hygiene and going to sleep are supported. Therefore, the clients' routines always originate in their history and momentary situation. The aim is to keep up routines in their lives and to create new healthy ones. Intensive work with families is necessary for the purpose of offering trustful support and for creating a trustful home environment.

The care is provided according to the principles of primary nursing. In general, this means that the same people support the client everyday. This way the service can reach the ideals of individuality, continuity of care, and responsibility in providing the care, accountability, and quality of service. The primary nurse is responsible for the planning of the care. The care plan ensures the amount and quality of the support. The team works according to the care plan to ensure that the validity and effectiveness of the care can be rearched, studied and the service developed accordingly.

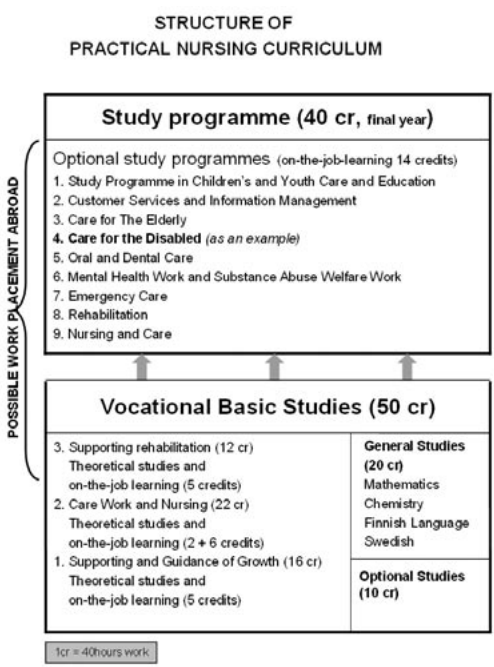
Niko has become
of age. He has continued his studies after the preliminary education in a special needs vocational institution. During his studies he has lived in a dorm (student housing unit). His personal assistant has helped him for several hours a day. After his graduation and training period, Niko has moved into an assisted housing unit. He has found himself a job that he is qualified for and interested in, and the social welfare covers his travelling costs, according to the Services and Assistance for the Disabled Act.

Niko is enthusiastic about the sports activities organized by the Organization for the Disabled, and has joined the wheelchair basketball team. While doing so, he has made some new friends.

Niko's parents and siblings visit him often, but by now they trust him and believe that he can manage by himself, without their continuous help. They have noticed that Niko has a chance of meaningful life of his own, and becoming independent, just like all the other young people.

7. Vocational Education / Training

◆ The structure of a practical nursing curriculum is presented in the diagram below. Each vocational basic study module also includes a work placement learning period. After completing the three vocational basic study modules, the student must choose one of the study programmes, each of which is worth 40 credits.



The duration of practical nurse studies is three years (120 credits). The qualification includes vocational basic studies (50 cr), general studies (20 cr), optional studies (10 cr) and a study programme (40 cr).

The study programme is carried out at the final stage of the studies and the included courses yield more specialised expertise in one sector of the study programme. The student can choose one of the following options:
children's and youth care and education, customer service and information management, care for the elderly, care for the disabled, oral and dental care, mental health work and substance abuse welfare work, rehabilitation or emergency care.

A practical nurse has various tasks in changing environments of social and health care services.
Practical nurses work, e.g. in day care centres, schools, old people's home, health centres, client's home, hospitals, and institutions for the mentally disabled.

The themes and included subjects of the Care Work for the Disabled study programme at Helsinki City College of Social and Health Care:

I Care Work for the Disabled in Society and Ethics (4 cr)

- Special education (1 cr)
- First aid II (0,5 cr)
- Social policy (1 cr)
- Entrepreneurship and labour market legislation (0,5 cr)
- Command of special work occasions (0,5cr)

II Encountering People with Disabilities (10 cr)

- Swedish (1 cr)
- Communication methods (1,5 cr)
- Special education (1,75 cr)
- Nursing (1,25 cr)
- Anatomy and physiology (0,75 cr)
- Psychology (1 cr)
- Social policy (0,5 cr)
- Finnish language/plain language (0,5 cr)
- Home economics (0,5 cr)
- Visual arts (0,75 cr)
- Music (0,5 cr)

III Individual Care Work with People with Disabilities (26 cr)

- Practical training (7 cr)
- Social policy (0,5 cr)
- Special education (0,5 cr)
- Psychology (1,75 cr)
- Home economics (1 cr)
- Physiotherapy (0,5 cr)
- Nursing (1 cr)
- Finnish language / plain language as group activity (0,25 cr)
- Visual arts (0,75 cr)
- Music (0,5 cr)
- Physical education (1 cr)
- Guiding people with mental/ intellectual disability (2,25 cr) (includes visual arts, physical education, music and Finnish language)
- Senior thesis (1,5 cr) (Finnish language, IT)
- Practical training (7 cr)

(1 cr = 40 hrs work for a student)

7.1 General Goals of the Practical Nursing Curriculum

◆ The essential qualifications required within social and health care professions include social and interaction skills, especially the ability to support the clients' own resources and functional capability. A social and health care professional can work with a diverse range of people from different age groups and backgrounds. Professionals must also be able to respect people's different cultural background and values, as well as take them into consideration in the everyday work. Other essential skills and abilities include high professional ethics and tolerance, as well as interactive and problem solving skills in a balanced combination with practical caring and upbringing skills.

When practical nurses work with promoting people's health and well-being, one fundamental requirement is that they have a good understanding of the dependencies between people and their social and physical environment and the society as a whole. A practical nurse must also be aware of the increasing demands arising from the economical and ecological reality. New technologies also set certain qualification requirements, as well as the increasing multi-professional cooperation and team work within social and health care.

Meta-cognitive skills (learning-to-learn skills), understanding learning as a lifelong process, as well as the continuous development of one's own professionalism and work are essential core skills for all modern professionals, and life-long learning is the only way to respond to the renewing and constantly changing challenges of care work. Extensive professional competence also includes the ability to plan work processes from a holistic perspective, and basic knowledge of administrative and entrepreneurial skills. Due to the rapidly increasing migration between societies both by workers and client groups, multicultural skills and competencies become more and more important as a part of care and nursing work.

A practical nurse has solid knowledge of the social and health service system, and always acts according to the professional ethics and norms that orient the work in the field. Practical nurses are able to work both individually and as members of multi-professional team, acknowledging both the resources they can offer to the work and the limitations of their own competence. Practical nurses appreciate their own profession and strive to develop the work with a client-oriented and service-oriented approach.

Care workers in the field of social and health care services are capable of and willing to take care of their own professional capacity. They are always able to justify their own actions, and know when and where to seek assistance in making decisions when necessary.

7.2 Description of the Practical Nursing Profession and Core Competence

◆ Within the field of social and health care, practical nurses working in basic care carry out their tasks both in the homes of the client and in different care and service units in the sector. Practical nurses take care of people of different ages and cultural backgrounds and in various life situations, by supporting their growth and development, by promoting their health and social welfare, and by treating illnesses.

The work of a practical nurse means helping and assisting people in various situations that concern their health, functional ability, well-being and coping in different crisis situations. Practical nurses always recognise the autonomy of the clients over their own lives and support their individual initiative that arises from their daily needs, aims, resources and possibilities.

In situations where clients do not have the strength and/or the resources to manage on their own, assisting them may require intervention and carrying out tasks on behalf of the clients. Also

- and in particular - in these situations the promotion of the clients' autonomy, integrity and independence is of great importance.

Practical nurses actively motivate the clients to self-care and to utilizing their own internal resources. Practical nurses' work is regulated by the legislation, norms and professional ethics of the social and health care sector.

Practical nurses participate in the planning, implementation and evaluation of their work as responsible actors in cooperation with the clients and their social network, experts and multi-professional teams. The practical nurses are able to recognise different alternative ways of acting and assisting the client, and of choosing the most expedient, sensible and client-centred way of working. Practical nurses assist the client in recognising both the various resources and threats and obstacles that are relevant to their coping with the everyday life.

Practical nurses guide and support the mental and social growth and development of the individual clients and client groups. Similarly, practical nurses assist the client in creating, maintaining and developing human relationships. Practical nurses assist the clients in caring for their own basic needs in different life situations and in removing obstacles that are caused by illness, impairment or other shortage of resources that have an effect on the clients' ability to manage in the everyday life. Practical nurses assist and encourage the client to act towards reaching their own goals of achieving, maintaining, and promoting autonomous command of their own life, functional ability and working ability. Practical nurses also guide the client in matters related to the appropriate social and health care services for their needs, as well as for social, cultural and recreational activities.

The work of a practical nurse in care work and nursing, as well as in supporting and proving guidance of growth, development and rehabilitation is based on a multidisciplinary scientific work. The broad knowledge basis of a practical nurse and the theoretical professional acquisition is visible in all the activities and their justification. The work of a practical nurse demands interactive skills, the sensitivity to make careful observations and the ability to identify different situations and problems, as well as evaluation and problem-solving skills. Decision making is based on careful and well-grounded ethical consideration.

Professional interaction is based on encountering different people as equal individuals. In order to make confidential and genuine interaction with the clients possible, practical nurses always try to set themselves in the place of the client and make interpretations of the client's situation and experiences from that perspective.

Practical nurses are bound by the clause of confidentiality. They have no right to discuss the client's affairs with outsiders.

Practical nurses are able to identify the most essential factors that have an impact on their own professional growth and development. Practical nurses constantly evaluate and develop the working methods and approaches at their working unit, and assess their significance to quality of services. Moreover, practical nurses are active participants in the society and strive to improve especially the living conditions of their clients.

As the basic vocational qualification of the social and health care field, practical nursing is carefully designed to be a broad-based and multidisciplinary qualification. A registered practical nurse is fully qualified to perform basic care work duties in the many different and changing working environments of the social and health care field.

7.3 Study Programme in "Care Work for the Disabled"

◆ The extent of the Care Work for the Disabled study programme is 40 credits (or study weeks).

According to the curriculum of the Study Programme in Care Work for the Disabled, a qualified practical nurse is expected to have the following skills:

- respects the clients' rights to self-determination and engages them in the decision-making concerning the treatment, education and rehabilitation, functions in a client-focused manner, complying with the principles of occupational ethics;
- draws up treatment and service plans, assessing individual client's needs for help and ability to cope with daily activities;
- guides and supports clients in individual or group accommodation and assists them in issues related to eating, nutrition, postural and kinesiotherapy and household management;
- uses creative expression skills, such as linguistic and visual expression, music and physical exercise, in support of a meaningful everyday life, and organises guided leisure activities;
- exploits knowledge of forms and causes of disability, additional impairments and diseases;
- guides clients in the acquisition and use of aids and uses communication methods supporting and compensating for speech;
- applies acquired knowledge of learning difficulties and special education and supports children, young people and adults in learning;
- supports disabled people in finding placements or in coping in supported and guided work;
- cares for, educates and guides children and young people of different ages;
- doses and administers drugs in accordance with instructions

(p.o., rect., inhalation, s.c. and i.m. injections), is familiar with drug groups, drug forms, drug administration methods and national legislation governing pharmacotherapy, and is able to guide clients in issues related to pharmacotherapy;

- systematically implements basic nursing and care for clients of different ages at institutions and in home care;
- commands the essential nursing and care skills (assistance in personal hygiene and bed baths, eating, drinking, excreting, moving about, skin care, foot and oral care, etc.) and is able to administer first aid;
- assists clients in coping with maintaining the cleanliness and pleasantness of their homes and attends to household management (cleaning, looking after clothing and laundry, cooking, including special dietary requirements, such as a
- diabetic diet, etc.) when clients are unable to do so for themselves;
- supports the physical, psychological, social and educational rehabilitation of clients, guides clients in the use and acquisition of aids and independently applies ergonomically correct working methods;
- is able to command the foundations of social and health care occupations in society, the essential legislation and the national service system and acts in accordance with the field's basic values and the principles of occupational ethics.

8. Working with the Disabled as a Profession

◆ In Finland there is a shortage of practical nurses who have specialized in working with people with special needs and disabilities, thus the employment situation is excellent.

Especially in the greater Helsinki area and Southern Finland there is a great demand for qualified practical nurses working with the mentally disabled. When the extensive education of practical nurses began in Finland in the 1990s, the distinct education of nurses and counsellors working with the mentally disabled was terminated. Currently, a decision has been made to launch a special vocational education for nurses working with the mentally disabled. However, the impact of this education will manifest itself in the working life only after several years.

For practical nurses at the very beginning of their career, the monthly salary is about 1600€ a month (in 2007). Their salary increases gradually, according to their years of working. In addition, evening, night and weekend work supplements are paid for shift work.

The average monthly salary of a practical nurse working in the municipal sector, where most of them work, is roughly 2000€ a month.

Job announcement of English School looking for school assistant (Helsingin Sanomat 6.4.2008)

The work can be carried out in day shifts or three shifts. In service housing and institutions practical nurses work in three shifts, in day care centres they mostly work in two day shifts, and in schools and action centres they work in one day shift only. The nature of the work differs depending on whether the practical nurses work with the physically disabled or the mentally disabled or children, young people and the elderly.

Applicants have to have vocational education according to legislation and those one employed after selection process have to also present doctor's statement on their health condition. They also have to present **Legal Register Centre's** *criminal records extract* as they are to work with vulnerable clients like children.

Due to the wide scope of work practical nurses specialized in working with people with special needs and disabilities have a good chance of becoming employed in the sector that best suits their own interests.

According to the **Act on Health Care Professionals** (564/1994) and **Decree** (564/1994), practical nurses have to register with the National Board of Medicolegal Affairs. The board grants the right to practice a profession in the field of health care. The official and permanent vacancies within public sector have to be filled by qualified (registered) professionals. People who have not been registered can be employed on a temporary basis.


24

KIRKKONUMMI
KYRKSLÄTT

7 LASTENTARHANOPETTAJAA

7 LASTENTARHANOPETTAJAA

LASTENTARHANOPETTAJAA

10 LASTENHOITAJAA

2 LASTENHOITAJAA

LASTENHOITAJAA

4 RYHMÄPERHEPÄIVÄHOITAJAA

4 PÄIVÄKOTIAPULAISTA

PÄIVÄKOTIAPULAISTA

PÄIVÄKOTIAPULAISTA

RAVITSEMISTYÖNTEKIJÄÄ

RAVITSEMISTYÖNTEKIJÄÄ

2 LASTENTARHANOPETTAJAA

LASTENTARHANOPETTAJAN

LASTENTARHANOPETTAJAN

LASTENTARHANOPETTAJAN

LASTENHOITAJAN

LASTENHOITAJAN

PÄIVÄKOTIAPULAISEN

LASTENHOITAJAN

KOLMIPERHEHOITAJAA

PERHEPÄIVÄHOITAJIA

LASTENTARHANOPETTAJAA

LASTENHOITAJAA

2 ERITYISLASTEN RYHMÄAVUSTAJAA

KOULUPSYKOLOGIA

KOULUKURAATTORIA

2 LASTENTARHANOPETTAJAA

LASTENTARHANOPETTAJA

2 LASTENTARHANOPETTAA

Job announcement in Helsingin Sanomat on 30.03.2008: Municipality of Kirkkonummi is looking social and health care professionals. Municipality is willing employ two assistants to work with children with special needs.
In addition municipality is also looking for temporarily employed staff for similar duties.

9. Bibliography / References

Helsingin kaupungin ammatillisen koulutuksen opetussuunnitelma. Tutkintokohtainen osa, sosiaali- ja terveysalan perustutkinto, lähihoitaja. Helsingin sosiaali- ja terveysalan oppilaitos 31.5.2006

Helsingin Sanomat 23. 2. 2007. Rinnekodin kuurosokeat vammaiset totuttelevat uusiin hoitajiin.

Helsingin Sanomat 30.3. ja 6.4.2008, job announcements

Ihalainen J., Kettunen T. 2006. Turvaverkko vai trampoliini. WSOY, Helsinki

Kaski M. (toim.), Manninen A., Mölsä P, Pihko H. 2001. Kehitysvammaisuus. WSOY, Helsinki

Kehitysvammaisten yksilöllinen asuminen. Pitkäaikaisesta laitosasumisesta kohti yksilöllisempiä asumisratkaisuja. Toim. Markku Niemelä ja Krista Brandt. Helsinki 2008. STM selvityksiä 2007:73.

Malm M., Matero M., Repo M., Talvela E-L. 2006. Esteistä mahdollisuuksiin. Vammaistyön perusteet. WSOY, Helsinki

Suvikas A., Laurell L., Nordman P. 2006.Kuntouttava lähihoito. Edita, Helsinki
www.superliitto.fi

Appendix:

Individual Service- and Support Plan

Model Form

The Finnish Association for Persons with Intellectual Disabilities
2005

==========

Service- and Support Plan – Instructions on How to Draw up the Plan

Individual service plan is drawn up together with the person and her/his family / or friends together with authorities and professional chosen by her/him // family // and close ones. Individual service plan consists of the following sections:

1. Description of recent situation

Sections 1-2 of the form are to provide general description of the person's recent (life) situation and services and supporting measures available to her/him. When describing the situation, e.g. rehabilitation plan and other similar plans can be utilised.

2. Need for services and support

Sections 3-4 are to map out the person's / family's need for services and support and to evaluate the appropriateness and sufficiency of services and support received at the moment together with the person's / family's satisfaction and need for change in recent service provision.

3. Summary of service and supportive measures

The third section of the sheet is for documenting precisely the necessary service and supportive measures and persons responsible for applying for them (last page of the form).
Each area of services and supportive measures is to be presented on a separate page, thus the page should be copied to the necessary extent.
Documenting on each page is to cover:
1) exact definition of those forms of service and supportive measures that respond to needs
2) the description of the measures to be taken to achieve the goals
3) norms and regulations defining the services and supportive measures and possible fees to be paid

4) definition of contact persons / responsible for obtaining services
5) when the evaluation of activities and implementation of the plan is to be evaluated
6) signatures

Service- and Support Plan Form

Date:_____

Person's name_____ ID-number:_____

Address:_____

Telephone:_____

Primary next of kind /
trustee:_____

Contact
information:_____

Drawn up by:

Name: **contact information**

Contact person:

_____ _____

Other participating persons:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Other plans concerning client / family:

E.g. rehabilitation plan, decision on family/parent care support, plan on day care, personal curriculum/syllabus, special care plan

1. Person and her/his recent life situation
(E.g. day care, schooling, studying, work, accommodation, leisure time, managing with the activities of daily life etc.)

2. Services and supportive measures used by the person

3. Person's needs for services and support
In this section the documentation is to include the person's and her/his next kin's wishes for services and supportive measures and changes both in the need for services and additions for the existing service and support measure forms.

3.1. Social security, income security and financial support
National Insurance Institution's benefits, wages/work income, sufficiency of the income, updating of the benefits.

3.2. Social services, services according to, e.g., the Social Welfare Services Act (day care services, support and services according to the Services and Assistance for the Disabled Act)
(e.g. day care, adaptation training, other possible courses and training provided by social welfare), services according to the Services and Assistance for the Disabled Act as transportation services, interpretation services, personal assistant, home modifications; and functionality, sufficiency of and satisfaction with the existing services and the need for adjusting these.

3.3. Special care services (EHO) (services according to the Act on Special Care for Mentally Handicapped Persons)
(e.g. support for upbringing and rehabilitation, housing, work/day activities, rehabilitation periods, mental health services, short term care, day care, pupils' morning – and afternoon care, need for support person etc., and functionality, sufficiency of and satisfaction with the existing services and the need for adjusting these. EHO's validity period. Evaluation and adjustment.

3.4. Health and rehabilitation services
E.g. services relating to person's health status, as health centre, child welfare clinic, family doctor, need for rehabilitation plan, medical rehabilitation, medical appliances and equipment, therapies, oral and dental care, medication, other health services; functionality, sufficiency of and satisfaction with the existing services and the need for adjusting these according to changes in situation.

3.5. Schooling and education
E.g. choice of school, support with schooling, guidance to further education, other education and course activities, strengthening of different areas relating to functional ability and skills, and functionality, sufficiency of and satisfaction with the existing services and the need for adjusting these according to changes in situation.

3.6. Participation in activities within community
E.g. supporting relationships, hobbies and other leisure time activities, for example transportation services support, escort service, need for personal assistant; person's own

wishes and plans, and functionality, sufficiency of and satisfaction with the existing services and the need for adjusting these according to changes in situation.

4. Services and support needs of the family / custodians
E.g. support for informal care, short-term care, home service, home nursing, adaptation training, support according to Disability Decree as home modifications, home services, guidance and counselling, contact person, taking siblings into account, wishes and plans of family, and functionality, sufficiency of and satisfaction with the existing services and the need for adjusting these according to changes in the situation.

5. Other needs for services and support presented by person her/himself and/or one's close relatives and friends
E.g. person's future hopes and wishes.

SUMMARY ON SERVICES AND SUPPORTIVE MEASURES

( ) Social security
( ) Social services, housing, work
( ) Special care services
( ) Health and rehabilitation services
( ) Schooling, education
( ) Participation in activities within community
( ) Services and support needs of family / custodians
( ) Other needs for services and support

Form of support, extent, duration and aim, norm, contact person/person or party in charge

Signatures, date when the plan is to be evaluated, distribution of the plan

Date:
Person/next of kin:
Contact person / person in charge:
Date of evaluation:
Distribution:

Notes

Notes

Notes

Notes

Notes

Acknowledgements

This Handbook has been produced by Mrs. Marjo Repo, who offers grateful thanks to the following for their guidance, support, donation of appropriate materials and proof reading for accuracy of this package of information.

Mrs. Christiane Schiemer and Mrs. Kirsi Alastalo at Lyhty Foundation
Mr. Sami Helle and Mr. Mikko Pulliainen at Lyhty Foundation
Lyhty Foundation
Mrs. Minna Miettinen at Suomen CP-liitto ry
Mrs. Heidi Kosunen and Mrs. Marja Piirainen at Sofianlehto-Institution
Helsinki City College of Social and Health Care -colleagues Mrs. Kaisa Koponen and Mrs. Pirjo Myllyaho
Haavikon opetus- ja aikuiskasvatuskeskus / Haavikko Training and Adult Education Centre
The Finnish Association for Persons with Intellectual Disabilities
Aula-työkoti Helsinki, Aula-työkotien Kannatusyhdistys

Peer evaluation: (for all packages)
Diaconie College
Omnia – The Joint Authority of Education in Espoo Region
The Finnish Union of Practical Nurses
Vaasa Vocational Institute

Mrs. Tuija Modinos Grandmaster Tmi for translation
Graphic Design Rhinoceros Ltd for layout
Mr. Frans Wagemakers for cover photo

All materials of the project are downloadable for free from partner colleges' websites:

www.hesote.edu.hel.fi
www.davinci.nl
www.ttk.ee
www.kbs-pflege.de
www.kellebeek.nl
www.vitaliscollege.nl
www.linkoping.se/birgitta
www.stevenson.ac.uk
www.oszee.de
www.dundeecoll.ac.uk/?about_us/european_projects.xml