

# Care Work with Mental Health and Substance Misuse Clients in Finland

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# 1. Introduction

## Dear Student

◆ *Welcome to Finland! We are pleased that you have chosen our country in which to take part in international on-the-job learning and that you have come to find out about our social welfare and health services and the work involved.*

*So what kind of country have you come to? Finland is a large country with a small population. In area, it is the eighth largest in Europe, but in fact it is the most sparsely populated country in the EU. There are just 5.3 million of us Finns here, mostly living in the south.*

*Finland became an independent country in 1917. Before this it had been part of Imperial Russia and before that it had been ruled over by the Swedish monarchs. Now Finland is a democratic republic, a modern welfare state and it has been a Member State of the EU since 1995.*

*Finland has two official languages: most of the population speak Finnish, with a minority (5.5%) speaking Swedish. Foreigners in Finland can normally get by very well with English, which most Finns have studied at school. And although we are supposed to be quiet and shy, we are friendly and helpful – at least when we start to get to know you.*

*How will this book benefit you? It is intended as familiarisation and study material for all foreign students doing a period of on-the-job learning here in different units involved in mental health and substance abuse work in connection with studies that correspond to Finnish Practical Nurse Education courses. The book describes substance abuse and mental health work in Finland, the services offered, the law and the practical work that is done.*

*The focus in the book is on substance abuse and mental health work for adults in the most common working environments from the point of view of the practical*



nurse. It mainly restricts itself to matters connected with the core content of the professional knowledge and skills of a qualified practical nurse. So there is little here in the way of child or youth psychiatry, for example.

The descriptions of the work units are an attempt above all to depict environments which are suitable as on-the-job learning places for foreign exchange students.

As information and knowledge in this sector quickly goes out of date, the book avoids information that is likely to change rapidly (e.g. precise figures) and tries merely to present the main trends. Please notice that concepts “intoxicants abuse”, “substance misuse”, “intoxicants misuse” all refer to same phenomena.

# 1. Historical Overview

## 1.1. History of Mental Health Work

### 1.1.1. No Humane Treatment for the Mentally Ill

There is no doubt that mental disorders have existed through the ages. As a concept, mental health is new. Mental illness as a concept, however, goes back a very long way. Views of mental disorders and attitudes to them have varied from one culture to another and in different periods of history.

In early cultures and communities people tended to think in terms of magical powers. The **spirits in nature and those of the dead** had great importance in perceptions of the world. These were also a way to try and explain human behaviour and the driving force behind it. In those days mental illness was thought to be the work of evil spirits. Shamans and sorcerers were respected members of the community who could communicate with the spirit world and drive the evil spirits away with spells and natural herbs.

In the Middle Ages the church had an important role in society. At that time religion pervaded everything: even mental illness was thought to be **caused by the Devil**. The clergy considered it their duty to help the mentally ill and attempt to exorcise the Devil

within them with prayers and spells. Furthermore, the church believed it had a duty to take care of the mentally ill and the disadvantaged and founded asylums for those in society who were worst off. Finland is known to have had at least two so-called rooms of the Holy Ghost for this purpose.

In addition to providing care, the Church and the clergy saw it as their task to root out heresy in society. This, among other things, led to the mass persecution of witches, with huge numbers of innocent people accused of witchcraft being condemned to death. Among those who lost their lives in this way were many who today would be thought to be suffering from mental health problems.

As people began to view the world more scientifically, their ideas of mental illness tended to be grounded more in biology and medicine. They began to regard mental illness as a **medical disease**, even if they had no proper ways of treating it. Mental illness was seen as incurable, but patients obviously needed a place of shelter where they could be kept. For this purpose asylums or infirmaries were founded, these later becoming mental hospitals.

The first infirmary was founded on the island of Seili by order of the then King of Sweden–Finland. It provided

treatment for lepers and the mentally ill. After leprosy was eradicated in Finland at the end of the 18<sup>th</sup> century, the place was just used to **keep the mentally ill**. The treatment there, as in other similar institutions of the time, was inhumane, with patients being kept in chains and cold and hot baths being used to calm down boisterous patients.

A doctor or barber surgeon did not make diagnoses of the mentally ill and the treatment they received cannot be considered to have been proper care. Apart from baths and chains, the methods used did not really go beyond prayer, punishment and isolation. Mental illness was largely thought of as animal behaviour, and an animal could only be treated like an animal. So the sick were locked up in small cells which, in the case of Kruunupyy Infirmary, for example, were not even heated in the winter. For that reason mental patients had to be allowed to warm up for a while in the morning. Many had no hope of rehabilitation, let alone recovery. When patients went to infirmaries such as that on the island of Seili they took along their coffins with them.

Not until a century later did a **more humane** approach to care begin to spread to Europe and Finland. The mentally ill were to be treated decently

and no longer kept in chains. And so the treatment of mentally ill patients and their living conditions began to improve.

### 1.1.2. The Beginnings of the Modern Hospital Service

Towards the end of the 19<sup>th</sup> century there was a dramatic increase in the number of places in mental hospitals. Lapinlahti Hospital was founded in 1841, and then **other hospitals began to appear**. During that same decade, an imperial decree on mental health care was issued, according to which the mentally ill had to undergo trial treatment for two months. If patients recovered they were discharged; if not, they remained where they were or were transferred somewhere else for treatment. This meant that proper wards for mentally ill patients had to open in hospitals in different parts of Finland.

As improvements were made to the hospital service **knowledge relating to mental illness grew**, thanks to people like Bleuler and Freud. It gave rise to healthy feeling of optimism and experiments and development in new forms of care. However, it was several decades before more effective and medically sound approaches to treatment and cure were arrived at in the care of the mentally ill.

An imperial decree issued in 1889 stated that the local authorities

(municipalities) had to take care of the poor and mentally ill. In addition to mental hospital wards they began to **open wards for mentally ill patients in communal rest homes (alms houses)**. Even up to the 1930s conditions for patients in wards for the mentally ill were very austere: they were isolated institutions in which hot and cold baths, straitjackets, occupational therapy, insulin, electric shock treatment and lobotomy were used as treatment methods.

### 1.1.3. Therapies and Non-Institutional Care Become Established

It was not until the 1950s that the possibilities of more effective treatment of mental illness presented themselves in the form of **psychiatric drugs**. Medical treatment with these had the effect of calming patients down and it became possible to talk to them properly. The new medication and an increase in psychological knowledge made it possible to develop different therapeutic methods.

In the 1960s various **psychotherapeutic methods** began to take shape and eventually became firmly established in psychiatry. The trend has continued ever since.

In the 1970s treatment was still very hospital-centred. The wards were large and institution-like and patients easily fell into a hospital routine.

However, from the beginning of the 1980s care and treatment practices radically changed and **non-institutional care started to be developed** to take the place of the services offered by hospitals.

Non-institutional care also meant a change in the lives of patients and their families. Instead of staying in hospitals, patients began to live among others, maintaining contact with their relatives, homes and society. At the same time this meant in less institutionalisation. With non-institutional care, the number of those receiving psychiatric care in hospitals and clinics gradually fell from around 20,000 to the present figure of some 6,000.

At the same time the importance of the **family and network-centred approach** began to be emphasised in mental health work. Greater attention was paid to the importance of a client's relatives, family and home and an effort was made to include relatives in the process of care and rehabilitation.

In the period 1981-1987 a large-scale '**schizophrenia project**' was carried out in Finland and with it new and successful models of treatment were established, mainly in the care and rehabilitation of schizophrenic patients. The aim of the nationwide schizophrenia project was to explore and promote the possibility of allowing schizophrenia sufferers to live as non-institutionalised members of society.

The project had two objectives: to develop the primary care of schizophrenic clients and to diversify and improve approaches to the further treatment of schizophrenia and rehabilitation. When the project ended, multi-professional work groups were set up around Finland - so-called psychosis teams – who, as non-institutional care actors, began to assume responsibility for studying the potential for primary care for schizophrenia and initiating programmes of treatment.

In the 1990s, new legislation was also introduced in the form of the **Mental Health Act**, which laid down new rules for mental health work and highlighted the importance of preventive action.

Under the Act, local authorities were obliged to organise statutory basic services in mental health work, either in the form of procured services or producing them themselves, and be responsible for preventive work in their own area. The Act also laid down provisions concerning the conditions on which treatment could be given against a patient's will and how that treatment should be administered.

As approaches that stressed the importance of prevention, non-institutional care and the notion of networks took off, **forms of peer support** aimed at social reinforcement began to gain a foothold and develop. Different associations, organisations and other actors started to provide more and more opportunities for peer support work. Divorce groups for those who have been through divorce, peer groups for sufferers of various mental health disorders (including action for those suffering from panic attacks and depression), and patient associations with a robust and diverse range of activities have become ever more important actors in the system of services that support mental health work.



*Status of a person suffering from mental problems during different times*



## 1.2. History of Substance Abuse and Substance Abuse Work

### 1.2.1. A Nation of Beer Drinkers

People have always used intoxicants. In Finland the use of spirits and beer brewing are firmly entrenched in our culture. Beer in Finland is a tradition. Since olden days beer has been drunk at parties and celebrations and in very early times it was also associated with different religious rituals.

In the 16<sup>th</sup> century Finnish beer was held in high regard by the ruling Swedish Court. Finland actually sometimes paid its taxes to Sweden in beer. Beer also started to become more common in the everyday lives of townfolk, partly owing to the fact that soldiers were paid in beer. Beer was mainly regarded as being more a form of sustenance, rather than alcohol. Nevertheless, even back then drinking to excess was looked down upon.

Drinking among the common people did not really become a cause for concern among the urban intelligentsia until strong, cheap spirits began to take over from beer. The more organized and complex Finnish society became, the more **general harm was caused by people's heavy drinking**. By the 17<sup>th</sup> and 18<sup>th</sup> centuries both the religious

and secular powers thought it best to start restricting alcohol consumption. In their sermons the clergy warned of the dangers of the immoderate enjoyment of spirits.

During the reign of King Gustav III of Sweden–Finland, they tried to introduce laws to ban the use of spirits among minors. Similar laws were passed for the peasantry, although they inevitably led to the production of moonshine, rather than any drop in consumption.

When Finland was under Russian control even the Tsar thought it advisable to do something about the use of spirits in Finland purely and simply to get drunk. Prohibition acts were passed and jail sentences imposed on the common people – though again it did not do a lot of good. At the same time the clergy contributed to the drive for temperance by continually warning their parishioners of the dangers of drinking too much. But religious ideals about abstinence and the temperance movements which sprung up among the common people seemed to bear more fruit. For example, the association called ‘The Friends of Temperance’ started up and it founded a sanatorium for alcoholics in 1888.

### 1.2.2. From Prohibition to Care for Alcoholics

In the early 1900s the Finns consumed the least alcohol per head of population

in Europe. This was mainly due to the restrictive laws on alcohol and, in particular, the temperance movement. The latter had succeeded in cutting the consumption of spirits mainly in rural areas. Despite this, excessive drinking was felt to be a serious problem in society.

In 1917, when Finland became independent, there began a wave of prohibition in western countries. Similarly in Finland, a **Prohibition Act** that related to the nation as a whole was introduced and it remained in force from 1919 to 1932. Nevertheless, the consumption of spirits continued, made possible by an efficient network of smugglers and distributors of illegal alcohol.

When the Prohibition Act was repealed in 1932, that same year Oy Alkoholiliiike Ab, the present Alko, was founded, which had a monopoly on the sales of alcohol. It was around then that the first proper **Act on Alcoholism** was passed. It came in in 1936. Under the Act, the treatment of alcoholics became a social duty comparable with looking after the poor, with the state mainly assuming responsibility for it. The measures recommended under the Act included abstinence monitoring, warnings and institutional care for alcoholics lasting 1–4 years. People could seek institutional care voluntarily, but in most cases it was a question of compulsory care. The sanatorium founded earlier on by the Friends of

Temperance was taken over by the state and renamed the ‘Institution for Curing Alcoholics’.

Even though the use of alcohol among women was strongly disapproved of at the time, the Act on Alcoholism also mentioned female alcoholics, even though the Vagrancy Act of 1936 mainly applied to them. Special wards were reserved for them in institutions for women with other problems not relating to substance abuse. For children there was the Child Welfare Act.

The use of alcohol in Finland has long been highly regulated and has only been liberalised very gradually. In 1969 low alcohol became available to buy in food shops. The purpose of this change was to try and lighten the use of intoxicants among Finns, with people opting for weaker alcoholic drinks rather than strong liquor. At the same time, however, various laws were brought in to try and restrict the serving of alcohol. For example, alcohol could not be served in restaurants/pubs without a sandwich or a meal.

In the 1960s **drugs began to find their way into Finland**, and now there were new clients for substance abuse care. The first drug users were mainly morphine addicts, although cannabis also started being used. The following decade also saw the spread of other narcotics to the country. Because there were still no specific services

at the time for drug users, it became something of a challenge to develop them in substance abuse care over the years to come.

Nowadays drug use has become more common with such phenomena as internationalisation and cultural changes. The consumption of alcohol per head of population has increased steadily in Finland, with the major social and economic problems that result from such a situation. The habit of mixed drug use has become more common. The problems of users of intoxicants have reached crisis point as use has become more widespread and has increased. Furthermore, the problems associated with intoxicants and mental health are more and more frequently occurring simultaneously, which is a huge challenge for the development of the service system.

### 1.2.3. Development of Proper Substance Abuse Care

After the war, towards the end of the 1940s, care and treatment for alcoholics began to develop properly. At first the work was very **institutionalised and based on control**. In 1948 an alcoholics' reception centre was opened. It was run by psychiatrists to serve as a centre for the treatment of alcoholics and complementing the normal care service provided for them with physical and psychological medical research to be

able to develop treatment methods and cures for patients with intoxicant problems. At present the centre is located in the Järvenpää Social Hospital.

In the 1950s the drug Antabus, still known today, was launched. If taken at the same time as alcohol it causes unpleasant feelings and thus makes it easier for people with alcohol problems to control their drinking. The AA (Alcoholics Anonymous) also became established in Finland.

In the 1950s the Finnish A-Clinic Foundation was also started. Today it still significantly contributes to the provision of outpatient services for substance abuse. The A-clinics and their multiprofessional care teams were an addition to general social services. They set up different kinds of discussion-based or functional meetings for individuals and groups and provided medical assistance and support for substance abusers and their families. A-clinics also offered its employees vocational training courses. Their clients consisted mostly of alcohol and drug users or mixed users.

In the 1960s, with the entry into force of the PAVI Act, the **emphasis started to be put on people seeking help voluntarily**, even if the initiative still came from the authorities. At the time the client was mostly seen as a passive object of care. Under the Act there was a shift of focus from control to care and rehabilitation.

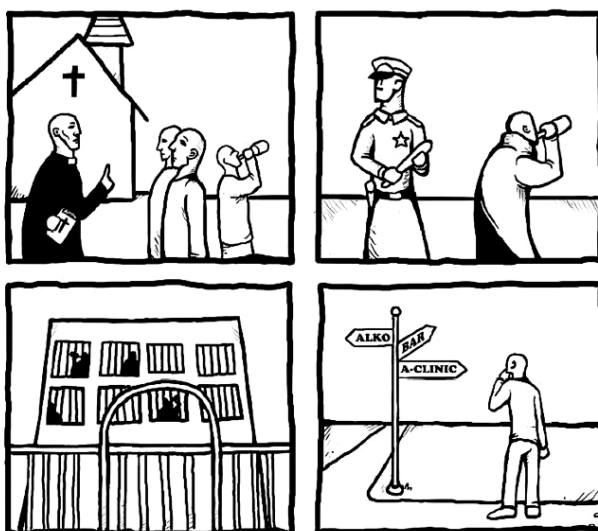
In the 1970s the authority-based approach began to be called into question. **Care services increased** and diversified and detox units and nursing homes, for example, were opened. A network of youth clinics for young clients was set up in association with the A-Clinic Foundation. The work of **voluntary and self-help organisations** also increased and became established. Support groups based on the AA model also helped drug users and the families of substance abusers.

The 1980s saw the launch of the Myllyhoito (literally 'Mill Care') models, based on the Minnesota project but adapted to the situation in Finland. Its approach to care and the nursing units it opened became the responsibility of the Mill Care Association founded in 1983.

During the 1980s and 1990s a **networked service system** started to be built. A new development too was the work of the social welfare and health care services acting with shared responsibility. In 1986 the new Act on Social Work with Intoxicant Abusers was passed, highlighting, as it did, the importance of preventive work

and a client-centred approach. The emphasis was on cooperation and the client's expertise in his/her own affairs.

In the early 1990s, with the increase in drugs-related problems, Finland passed its Narcotics Act. The basis of this and the Act on Social Work with Intoxicant Abusers was an overall ban on drugs, which meant criminalisation of the manufacture, supply and use of all substances regarded as narcotics. In the early 2000s attitudes towards drugs have started to become more liberal in many European countries, so in Finland too, despite the legislation based on total prohibition, we began to see the need to develop advisory and health services for drug users to lower the risks and damage caused by drug use.



*Ali K.*

*Attitudes towards alcohol misuse during different times*

## 2. The European Union's Policy on Mental Health And Intoxicant Misuse

◆ *Public health is a major concern within European Union. Therefore health reducing and damaging factors have already been recognised when establishing The European Community. Thus the basis for European level co-operation and promotion of mental health and initiatives and measures to reduce health damages related to intoxicants lays with The Treaty establishing The European Community (in paragraphs 1-2, article 152 dealing with public health):*

**“Community policies and activities complement and support national policies that aim to improve public health and prevent illnesses and diseases. These policies and activities include actions in both prevention and reduction of drugs-related health damage. Member States are encouraged to co-operate to reach stated goals. The Commission will support such efforts via different policies, initiatives and programmes.” (a)**

**Extract of the Article 152 of the Amsterdam Treaty:**

“A high level of human health protection shall be ensured in the definition and implementation of all Community policies and activities. Community action, which shall complement national policies, shall be

directed towards improving public health, preventing human illness and disease, and obviating sources of danger to human health. Such action shall cover the fight against the major health scourges, by promoting research into their causes, their transmission and their prevention, as well as health information and education. The Community shall complement the Member States' action in reducing drugs-related health damage, including information and prevention.”

The need for common programmes and policies promoting mental health derives from challenging situation. Approximately 25% of EU's population suffers from some form of mental ill health, most common ones being anxiety disorders and depression. Mental ill health on social level causes also significant economic and social losses, causes far too often stigmatisation and discrimination for people suffering from them. Furthermore their human rights and dignity are neither respected in acceptable manner. Thus Commission outlined launching of common strategy on mental health called **Green Paper: “Promoting the mental health of the population. Towards a strategy on mental health for the EU”**.

**Importance of mental health in Green Paper is crystallised in following key lines:**

- ◆ good mental health is a resource for individuals and society – without it nor individuals or society as a whole can be considered well-being. Ill mental health prevents individuals to fulfill their intellectual and emotional potential to full and reducing quality of life – resulting also on social level to lesser social and economical welfare. Mental and physical health are also inter-related: e.g. depression is a risk factor for heart diseases.
- ◆ Ill mental health has significant economic and social effects: mental disorders are a leading cause of early retirement and disability pensions – and depression is expected to be the second most common cause of disability in the developed world by year 2020. Unfortunately social exclusion, stigmatisation and discrimination of the mentally ill are still a reality within the Member States.
- ◆ Currently, in the European Union app. 58,000 citizens die from suicide every year and there seems to be close connection to mental health as up to 90% of suicide cases are preceded by a history of mental ill health, often depression.

**In accordance to Green Paper WHO European Ministerial Conference on Mental Health (Helsinki 2005) announce following priorities:**

It is necessary to build on the platform of reform and modernization in the WHO European Region, learn from our shared experiences and be aware of the unique characteristics of individual countries. We believe that the main priorities for the next decade are to:

- a) foster awareness of the importance of mental well-being;
- b) collectively tackle stigma, discrimination and inequality, and empower and support people with mental health problems and their families to be actively engaged in this process;
- c) design and implement comprehensive, integrated and efficient mental health systems that cover promotion, prevention, treatment and rehabilitation, care and recovery;
- d) address the need for a competent workforce, effective in all these areas;
- e) recognize the experience and knowledge of service users and carers as an important basis for planning and developing mental health services.

*(WHO European Ministerial Conference on Mental Health. Facing the Challenges, Building Solutions Helsinki, Finland, 12–15 January 2005)*

**The EU-Public Health Programme 2003-2008** constitutes the current instrument for action at Community level in the field of mental health and includes Green Paper's strategic aims. Member States outline their national policies in accordance of EU-level strategies and policies.

The Council of European Union set in 2005 “**EU Drugs Action Plan for years 2005-2008**”.

The drugs phenomenon was considered as one of major concerns of the citizens of Europe and as a major threat to the security and health of European society. The Action Plan was based on EU Drug Strategy (2005-2012).

From social and health care –viewpoint one of Strategy’s major aims is “to achieve a high level of health protection, well-being and social cohesion by complementing the Member States’ action in preventing and reducing drug use, dependence and drug-related harms to health and society.”

From social viewpoint emphasis is laid on prevention programmers: on reducing demand and also on improving methods of early detection of risk factors of potential intoxicant abusers. Furthermore one important result to be achieved in combating drug abuse is to “ensure the availability of and access to targeted and diversified treatment and rehabilitation programmes, referring to services and treatment available for people facing the problem.

## 3. Current State of Affairs and Future Challenges

### 3.1. Mental Health Work Today

#### 3.1.1. Mental Health Disorders Reach an Acute Stage

Everywhere in Europe the demands of society and work have grown. There are also more people at risk of exclusion in society than before. People with physical, psychological or social problems find it harder to take control of their everyday lives, and living in a world that has become far more complex is more arduous than ever.

In Finland this is conspicuous in the incidence of **social problems and psychological disorders**. The huge rise in alcohol consumption in recent years has in turn added to the number of substance abuse problems and the need for mental health services. Problems relating to family and children's welfare and the need for child protection have increased at the same time. Demand for mental health services manifestly exceeds supply and there is continually increasing pressure to develop completely new types of services. A growing number of projects have started or are already under way now in Finland with the specific aim of providing psychological and social support for families and children.

However, research suggests that the mental health of the Finns has not become worse as such: it is just that the **need for the services and their use** has increased in all age groups. In Finland the incidence of mental health disorders is about the same as in other western countries. Problems among mental health clients have nevertheless now reached critical proportions.

Mental health and substance abuse problems are also occurring more and more in clients at the same time. The increase in the use of alcohol among Finns has resulted in more and more mental health problems. Alcohol can be an attempt to forget problems such as anxiety and depression. On the other hand, the long-term use of intoxicants can have psychological symptoms and aggravate existing mental health problems.

The broad range of clients' problems and needs is reflected in the amount of both non-institutional and institutional care there is, which has led to overloading in care units. It has been economically impossible, however, to increase resources for services to the extent hoped for.

Various population studies have shown that a good fifth of the adult population exhibit mental health disorders in varying degrees. The number of disability pensions specifically due to mental health



problems has increased substantially. In 2003 they accounted for 33.3%. Now

mental health disorders are the main reason for granting disability pensions.

### 3.1.2. Mental Health Disorders in Adults

<b>Mood disorders</b>	<ul style="list-style-type: none"> <li>• Depression has become the new Finnish national disease.</li> <li>• Roughly a fifth of Finns at some stage of their life suffer from some degree of depression.</li> <li>• Depression sufferers are the second largest client group in institutional psychiatric care.</li> <li>• Depression is more common in women than men.</li> <li>• At present 5–6% of the population suffer from serious depression.</li> <li>• Some 4–9% of Finns have suffered from various states of depression in the last year.</li> </ul>
<b>Bipolar disorder</b>	<ul style="list-style-type: none"> <li>• Affects 1–2% of the population.</li> <li>• Significant need for services to treat the disorder.</li> </ul>
<b>Suicide</b>	<ul style="list-style-type: none"> <li>• Finland used to be known as a gloomy place – especially in terms of the male suicide rate. There were up to 1,500 suicides a year at one time.</li> <li>• A large-scale suicide research project was launched in the 1980s resulting in improved facilities for recognising the signs and providing care.</li> <li>• The proportion of men committing suicide is nevertheless still much greater than that for women: in 2002 men accounted for 824 of the total of 1,095 suicide cases in the country.</li> <li>• In statistics on the causes of death suicides are still prominent, particularly among men under the age of 35.</li> </ul>
<b>Anxiety disorders</b>	<ul style="list-style-type: none"> <li>• Some of the most common disorders in terms of numbers. Some of the most familiar anxiety disorders are panic attacks, fear of social situations, generalised anxiety disorder and various phobias.</li> <li>• One in ten Finns is thought to have various types of anxiety symptoms, with just a few per cent thought to suffer from more serious disorders.</li> <li>• Young people are the most likely to suffer from anxiety disorders.</li> <li>• The most common occurrence in this category is panic attacks.</li> </ul>
<b>Personality disorders</b>	<ul style="list-style-type: none"> <li>• Personality disorders are estimated to occur in around 5–15% of the population.</li> <li>• Virtually none of these sufferers seek help – especially since people with personality disorders do not necessarily perceive any need to do so.</li> </ul>
<b>Acute psychoses</b>	<ul style="list-style-type: none"> <li>• A few per cent of the population suffer from acute psychoses at some point in their life.</li> <li>• There has been a distinct rise in the number of cases of psychosis due to the use of intoxicants in recent years.</li> </ul>
<b>Schizophrenia</b>	<ul style="list-style-type: none"> <li>• Around 0.5–1.5% of Finns suffer from schizophrenia.</li> <li>• The largest group receiving institutional psychiatric care.</li> <li>• Around a third need a wide range of treatment and help in their lives, so they are significant as major users of services.</li> </ul>

### 3.1.3. Mental Health Disorders among the Elderly and Children

The incidence of mental health disorders among the elderly is the same as among younger people and there are no big differences in their occurrence. About a fifth of those over 75 are thought to have mental health disorders.

Mental health disorders among the older generation, however, call for more attention, care and special knowledge and skills. The elderly often have underlying physical conditions which pose their own challenges for diagnosing and treating mental health disorders, for example, as regards medication. Since physical factors like illness are closely related to mental health, professionals need to know how significant they are for the disorders to appear and their symptoms. Loneliness is also common among the elderly, and this places a strain on their well-being.

The need for services among dementia patients is already now very extensive and it has been estimated that it is still growing.

The number of **dementia** sufferers among the elderly has increased steadily, due to the fact that the disorder has become more prevalent as people live longer.

- ♦ At present 6.7% of people over the age of 65 exhibit dementia with medium severity.
- ♦ In 60% of these the cause of dementia is Alzheimer's disease and in 20-30% it is vascular dementia due to cerebral circulation problems.
- ♦ The need for services among dementia patients is already very great and is thought to be growing.

More than one fourth of **children** have psychiatric symptoms, of which almost a tenth have symptoms of severe disorders. Anxiety disorders and depression are the most common. Boys have more symptoms than the girls in childhood. During puberty, on the other hand, girls exhibit clearly more symptoms than boys.

### 3.1.4. Prevention of Mental Health Disorders

Because mental health in humans is part of general well-being, many social factors impact on it and make it possible. These include solutions in urban planning and living, with opportunities for education and training, employment and earning a livelihood. These may be either favourable or stressful factors as far as human mental health is concerned. One aim in the promotion of mental health is therefore to strengthen social factors favourable for mental health and reduce stressful factors and their effect.

Mental health work today is understood more and more to be an ingredient in general social policy. **The importance of promoting mental health** has been highlighted and has become more and more visible as one of the core aims of mental health work and social policy. All social decision-making aims to emphasise the importance of promoting mental health, and this is a growing phenomenon.

Because mental health work relies on networks, how well its promotion succeeds depends on how well cooperation between the various agencies works. Crucially important too for the promotion of mental health are a flexible and efficient system of crisis services and the early identification of disorders and problems.

Various **groups specialised in crisis services** have been set up locally, especially in the last few decades. Improvements to access to crisis services, their coverage and flexibility have been and still are key areas for development in mental health work. The function of these services is to provide immediate mental health assistance in different crisis situations. Clients and families are helped to cope with crises with support from outpatient services at home. It is also possible in crisis situations to combine short-term periods of treatment in hospital with outpatient services in a way that suits clients and their families best.

Municipal services aside, many organisations and agencies in the private sector have been actively developing and creating new forms of service, many of which aim to make cooperation more effective and improve prevention. What is needed, however, is a **more profound and comprehensive change to approaches and the service system** and effective cooperation. Set out below are the priorities for the development of preventive action in Finland.

*See table on page 20.*

There are many different **development projects** in health care and social services now in progress in Finland to try and improve mental health work and the prevention of mental disorders. Some key examples include:

The Ministry of Social Affairs and Health's Social and Health Care Objective and Action Programmes:

- ◆ set targets and development strategies for mental health work
- ◆ steer the work of the local authorities and those who deliver mental health services

The Meaningful Life Programme 1998 – 2002:

- ◆ has created a basis for the broad development and implementation of mental health work at national, district and local level
- ◆ the project's aim has been to give those receiving mental health

*Table: Stages of development in preventive work in mental health care*

<b>The aim for wider cooperation</b>	Mental health work needs to be approached as a form of cooperation between many different actors which relies on networking – as a component of general social policy.
<b>Promoting mental health as a principle</b>	The local authorities (municipalities), which are responsible for mental health work, should take more account of mental health factors in all social decision-making, be it employment, education and training, or housing policy.
<b>More effective cooperation</b>	Crucially important to mental health work is improved and more effective cooperation between different local authority sectors and actors, especially with regard to the harmonisation of social welfare and health care services and the development of cooperation between them.
<b>More psychosocial support for children and young people</b>	Guarantees of psychosocial support services for children and young people; more effective cooperation needed for the prevention of problems and mental health disorders, early identification and treatment.
<b>Systematic development</b>	According to current recommendations in mental health work, the local authorities should examine possible defects in mental health work and services in their area and draw up a comprehensive programme for mental health work in collaboration with different actors. The programme could meet the needs of people comprehensively and effectively.
<b>Flexibility as a principle</b>	People with the most serious mental health problems and their relatives need or would need flexible support and a wide range of services to help them cope; it is important that there is satisfactory and flexible cooperation with the agencies delivering services.

rehabilitation services a chance for a meaningful life and to help them cope in society and in the community

The current Welfare Programme:

- ♦ looks for ways to organise services so that they respond to today's changed needs more satisfactorily

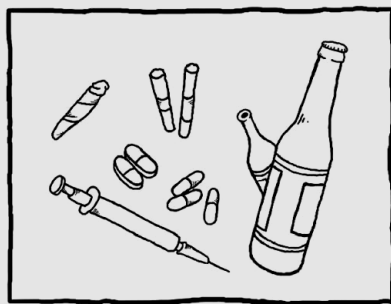
## 3.2. The Use of Intoxicants and Substance Abuse Work

### 3.2.1. Some Key Concepts

- ♦ Intoxicants (**substances**) means chemical substances or natural substances which, once in the body, cause intoxication or drunkenness and which are explicitly used to become intoxicated, as a stimulant or as a narcotic.
- ♦ In everyday language any narcotic or intoxicant is considered to be a drug, with the exception of alcohol and tobacco. Only substances which the Ministry of Social Affairs and Health defines as drugs in their decisions are drugs in the legal sense.
- ♦ In Finland **social intoxicants** are those which are permitted under the law, though with restrictions in place. They are alcohol and tobacco. There is nevertheless a growing number

of people in Finland for whom intoxication is a more important consideration than what intoxicants are used and how legal they are. The availability of substances, their cost and user environment determine what is taken at any one time.

- ♦ **Intoxicant dependency** means a state associated with the continued use of an intoxicant, characterised by a compulsive need to use the intoxicating substance and a weakened ability to control when use starts and ends and the amounts involved. Intoxicant dependency is associated with physical, social and psychological problems. Physical problems relate to health, social problems to difficulties in human relationships and at work, and psychological problems to mental health, emotions and the ability to reason. Thus, intoxicant dependency occurs in most areas of life, making it hard to cope on an everyday basis and causing problems for human relationships.



### 3.2.2. Alcohol Consumption

The use of intoxicants by Finns is mainly accounted for by alcohol. Its consumption has grown steadily and in 2006 it worked out at more than 10 litres of 100% alcohol per head of population. Almost half of the alcohol drunk is beer and more than one fourth strong alcohol beverages.

Affluence, the tax cuts on alcohol in 2004, and the abolition of limits on the amount of alcohol travellers can bring into the country have all contributed to the increase in consumption.

#### **Special features of alcohol consumption in Finland:**

- ◆ The consumption of alcohol among Finns is unevenly spread
- ◆ A small number of people drink most of the alcohol.
- ◆ Most Finns drink moderately or very little.
- ◆ 10% of Finns do not use alcohol at all.
- ◆ There are thought to be 250,000 – 500,000 heavy drinkers of alcohol (6–12% of the adult population).
- ◆ The one-tenth of the population who drink most consume around half of all the alcohol.
- ◆ The number of heavy consumers has risen and alcohol-related problems have clearly grown in number with increased consumption.

- ◆ It is mainly men who use alcohol.
- ◆ Today the proportion of women users has also increased, and they account for around a fourth of all consumption.

Over just one generation, Finnish **drinking habits** have likewise altered significantly. It has become common to drink several times a week, though it is still at weekends that most alcohol tends to be drunk. Alcohol consumption has become more common in public places and in connection with sports and cultural events. Attitudes towards drinking have softened. However, the Finnish drinking habit still means ‘drinking to get drunk’, which is contributing to the increase in alcohol dependency.

Population studies show that the likelihood of health and social problems related to the use of alcohol grows dramatically after a certain level of consumption. The harm caused by alcohol may either be due to heavy and continued drinking or binge drinking. In such cases the concept of **heavy consumption** applies.

#### **Upper limits for alcohol consumption:**

- ◆ The weekly upper limit for drinking alcohol is considered to be 24 units for men and 16 units for women.

- ◆ The upper limit for drinking at any one time is 7 units for men and 5 units for women.
- ◆ A fifth of men and around 10% of women reach or exceed these limits. There are estimated to be around half a million Finns in the risk group.

**Health problems** manifest themselves as alcohol-related illness, in terms of the costs of treatment and rehabilitation, and mortality. The increase in alcohol consumption has clearly resulted in a rise in the number of mental health problems. Alcohol is the main reason for premature deaths among Finnish men of working age. The causes of death include accidents, alcohol-related illness and poisoning. In 2005, 3,035 people died as a result of alcohol consumption in Finland. That was 203 more than in the previous year.

Apart from health problems alcohol causes significant **social problems**. The sharp rise in the use of alcohol is also reflected in family- and work-related problems. The rise in alcohol consumption is now conspicuous in terms of acute problems in families with children and in the increased need for family psychosocial services, e.g. putting children into care. Problems with intoxicants are also reflected in absenteeism from work and illness.

What is more, the increase in alcohol consumption is incurring increasing **costs for society** e.g. as a result of drunken driving and crimes and violence connected with intoxication caused by strong alcohol. It is also reflected in police work. In 2006 the number of times the police were called out to investigate disturbances in the home increased by more than 5% and the total number of assaults recorded was up by 1.6% compared to 2005.

### 3.2.3. Drug Use

Drug use has also **increased amongst Finns**, although in recent years it is thought to have declined slightly. Between 1995 and 2001 the drug situation in Finland got significantly worse, with an increase in the number of people trying out drugs and drug use generally. Part of the reason for this was the spread of the techno-culture and the use of recreational drugs to the country. The increase in use of the time is



seen today in the rise in intoxicant dependency and resultant problems. In recent years drug use has levelled off, however.

**Reasons for the increase in drug use:**

- ◆ Drugs are more easily available and cheaper.
- ◆ Studies show that young people are well disposed towards 'mild' drugs.
- ◆ Social changes in the 1990s had an impact on the drugs situation in Finland. Recession, higher unemployment and frailer national social support networks together with increased availability set the stage for a rise in the use of narcotics.
- ◆ Closer international ties, the opening up of borders and the deterioration in Finland's neighbouring regions with regard to drugs and crime have contributed to the situation as it is today.

The age group which uses drugs most and has most of the drug problems is the 15–24 year-olds. The average age of drug addicts receiving substance abuse care, however, is a bit higher at 26 (in 2006). Girls begin using drugs slightly earlier than boys, but they also tend to stop after reaching the age of 25 rather more quickly than boys. The number of schoolchildren experimenting with drugs hardly seems to have increased in the 2000s.

Fewer and fewer young people say they have tried cannabis. The number of those who have experimented with hard drugs is small and accordingly only a few individual young people have sought treatment.

**Drug use in Finland in 2005**

- ◆ Percentage of 15-64 year olds using drugs . . . . . 3  
– problem users . . . . . 0.5
- ◆ Percentage of 15-16 year olds using drugs . . . . . 7
- ◆ Percentage of 15-24 year olds using drugs . . . . . 12  
– problem users . . . . . 1

In Finland, as elsewhere in Europe, cannabis is the most common drug. 12% of Finns have tried it at some point. In the Helsinki Metropolitan Area, as is true of big cities generally, the use of drugs is more common, with about a fifth of the inhabitants having tried cannabis (2006). Fewer have experimented in rural areas, just a few per cent in fact.

The use of heroin would seem to be falling in Finland compared to previous years. Buprenorfine, a substitute drug for opiate addicts, has taken its place, but its problematic use has significantly increased this present decade. It has replaced heroin as the primary intoxicant and its problematic use can be compared to that for stimulants.



**Drug addicts receiving substance abuse care in 2005**

- ◆ Mainly males (71%)
- ◆ Young (average age 26), single adults
- ◆ Most excluded or at risk of exclusion
- ◆ Low standards of education and most are unemployed (82 %)
- ◆ One third are minors
- ◆ 12% homeless and in most cases older
- ◆ In general the youngest were still living at home
- ◆ Most were mixed users and most of these used three problem intoxicants
- ◆ The most common primary intoxicants among those coming in for treatment were opiates, with buprenorfine the one used most
- ◆ The substance abuse care client's profile is also the same for 2006

There are thought to be around 16,000-21,000 problem users of amphetamine or opiates in Finland. Three-quarters of them are intravenous users of drugs. The problems of intravenous users of drugs have worsened and in many local authorities it has been difficult to provide adequate care services for them.

About one fifth of drug addicts seek treatment. Most addicts live normal lives and go out to work. Many of them might spend most of their time sober. The reason they seek treatment is not really because of any intoxicant

problem but is most likely to be everyday problems, such as physical or psychological health problems, withdrawal symptoms, or problems relating to human relationships, home or work. They generally seek treatment unprompted.

The table below shows the numbers of those seeking substance abuse care in 2006 by primary intoxicant. (Report by the National Research and Development Centre for Welfare and Health [STAKES] on drug addicts receiving substance abuse care 2006.)

**Primary intoxicant used by clients seeking substance abuse care (percentage of all clients)**

<i>Primary problem intoxicant</i>	<i>2006</i>
◆ Opiates . . . . .	41%
– Buprenorfine . . . . .	31%
– Heroin. . . . .	2%
– Others. . . . .	8%
◆ Cannabis . . . . .	14%
◆ Stimulants . . . . .	21%
◆ Tranquilisers . . . . .	7%
◆ Drug in connection with use of alcohol. . . . .	17%

**3.2.4. Prevention as an Aim in Substance Abuse Work**

The aim of substance abuse work today is to prevent and to reduce the problematic use of intoxicants and the social and health problems they cause. It is also to promote the functional

<b>Preventive substance abuse work</b>	<ul style="list-style-type: none"> <li>• The aim is to prevent the problematic use of intoxicants and increase knowledge about intoxicants.</li> <li>• The main focus is on the young.</li> <li>• The main actors are child welfare clinics, schools, places of work and the media.</li> <li>• Many different projects on this in Finland.</li> <li>• More time devoted to intoxicant awareness in the school curriculum.</li> <li>• Workshops for young people where one key aim is the prevention of exclusion and the occurrence of intoxicant problems.</li> </ul>
<b>Early stage substance abuse work</b>	<ul style="list-style-type: none"> <li>• Tries to track down heavy users of intoxicants and reduce their use and the risks they cause.</li> <li>• The emphasis is on advice, guidance and support. Brief advisory sessions called mini interventions are a way to try to raise the issue of a client's use of intoxicants.</li> <li>• Such a brief advisory session might consist of three visits.</li> <li>• Alcohol use indicators, laboratory tests and a drinking diary may be used as aids.</li> <li>• Clients are told about the harm caused by intoxicants and are motivated to change their consumption habits. For example, they are helped to set targets and find alternative approaches to the problem.</li> <li>• It is mainly health centres, hospitals, the occupational health service, the student and school health care service, the social services and peer groups that are responsible for the work.</li> </ul>
<b>Corrective substance abuse work</b>	<ul style="list-style-type: none"> <li>• Concerns treatment and rehabilitation.</li> <li>• The aim is to provide care, treatment and rehabilitation for intoxicant dependency.</li> <li>• Special services are mainly involved, including A-clinics, youth clinics, rehabilitation centres, housing services and various peer groups for intoxicant abusers.</li> <li>• Various associations, private service providers and parish councils provide a diverse range of care and rehabilitation services.</li> </ul>

ability and safety of problematic users and their families. Another goal is to organise a comprehensive system of rehabilitation. The client's life situation needs to be examined holistically and he/she has to be helped to solve problems relating to livelihood, home and work.

Depending on the level of intoxicant use, substance abuse work can be divided into preventive work, early stage work and corrective work i.e. substance abuse care. Early stage work is also important in prevention: it attempts to identify an intoxicant use problem as early on as possible and so prevent any resultant harm as quickly as possible.

*See table on page 26.*

Prevention and the client's comprehensive treatment and rehabilitation also rely on steady **cooperation on an equal footing and reciprocal networking** among other municipal actors. The agencies of cooperation mentioned in the Act on Social Work with Intoxicant Abusers are the abstinence services, the housing and employment authorities, school and youth services and the police. Very effective cooperation at regional and local authority level above all allows for better preventive substance abuse work.

In the 2000s this type of work has come to be regarded more as a **component of the general promotion of health and**

**well-being.** Prevention of intoxicant-related problems is becoming more and more important and the aim is to introduce solutions and measures locally and nationally to pre-empt conditions and lifestyles that favour the use of intoxicants.

Various **recommendations and development programmes for substance abuse work** have been

drawn up to help professional groups, the authorities and NGOs to plan and evaluate preventive work:

- ◆ The Preventive Substance Abuse Work Quality Criteria (2006) provide guidance for the relevant actors in substance abuse work and its development.
- ◆ The Substance Abuse Services Quality Recommendations (2002) are intended to help the Ministry of Social Affairs and Health and the Association of Finnish Local and Regional Authorities try and increase the availability of intoxicant abuse services and improve their quality.
- ◆ Every two years the 'current care' recommendations are updated. These evaluate the effectiveness or otherwise of forms of care and treatment and make recommendations for procedures and approaches relating to substance abuse work.

### 3.3. The Co-Occurrence of Mental Health and Intoxicant Problems

◆ There is a clear two-way connection between mental health and intoxicant problems. Mental health problems may predispose someone to use intoxicants, where they are an attempt to relieve anxiety, depression or some other intolerable emotional experience. It is estimated that 30-50% of psychiatric patients in Europe have a problem with intoxicants.

The use of intoxicants, especially long-term, contributes to the start of mental health problems and aggravates symptoms. Depression and psychoses brought on by intoxicants are the commonest examples. The more intoxicants are used the more mental health problems result. Moreover, the use of intoxicants does not just affect the mental health of users but is also reflected in the psychological and social well-being of their families, thus compounding problems many times over in the user's environment.

The co-occurrence of intoxicant dependency and other mental health disorders is more common than was previously thought. The substantial increase in alcohol consumption among Finns has also contributed to this.

Simultaneously occurring mental health disorders and intoxicant dependency is called **dual diagnosis**. A study conducted in Finland suggests that the number of dual diagnosis patients in Finland went up fivefold in the period 1987-2002.

**Triple diagnosis** refers to a situation in which someone has a somatic illness in addition to these, e.g. a physical or sensory disability, a chronic illness or an infectious disease.

The most common mental health disorders associated with intoxicant dependency in order of prevalence:

- ◆ Personality disorders
- ◆ Anxiety disorders
- ◆ Mood disorders (especially depression)
- ◆ Psychotic disorders
- ◆ Eating disorders, ADHD, etc.

Dual and triple diagnosis patients in most cases need a wide range of services and the skills and expertise of a multiprofessional team. This poses a challenge for smooth cooperation among several professionals. There needs to be flexibility and continuity regarding services if treatment and rehabilitation is to be of a high standard. There is often also a need for services expressly planned for, and targeted at, this client group.

The most common reasons why dual diagnosis clients come for treatment:

- ◆ psychosis
- ◆ feeling suicidal
- ◆ violent tendencies

There are huge regional differences in Finland when it comes to services for people with mental health and substance abuse problems. Dual or triple diagnosis patients are often the most at risk. Services intended especially for them at present are insufficient to meet the need – and they are not evenly spread around the country. They are furthermore in danger of receiving worse standards of care or no care at all if cooperation between actors, the division of labour and the mutual sharing of responsibilities are unsatisfactory. There is a need in particular for a diverse range of psychosocial support services. There is also huge demand for substitution treatment and maintenance regimes for opiate addicts whose efficacy is scientifically proven.

The development of services and procedures relating to the treatment and rehabilitation of dual and triple diagnosis patients is indeed one of the most serious challenges to mental health work.

## 4. Legislation

This is a list of the main Finnish Acts of Parliament that create a basis for mental health work and intoxicant/substance abuse policy in the country. There are several relevant laws and they all in their own way control mental health work and substance abuse care:

- ◆ *Narcotics Act (1298/1993)*
- ◆ *Alcohol Act (1143/95)*
- ◆ *Decree of the Ministry of Social Affairs and Health on the Treatment of Opioid Addicts (289 / 2002)*
- ◆ *Act on Social Work with Intoxicant Abusers (41/1986)*
- ◆ *Abstinence Act (828/1982)*
- ◆ *Social Welfare Act (910/1982)*
- ◆ *Child Welfare Act (417/2007)*
- ◆ *Primary Health Care Act (66/1972)*
- ◆ *Occupational Health Care Act (743/1978)*
- ◆ *Act on Health Care Professional (559/1994)*
- ◆ *Act on the Status and Rights of Patients (785/1992)*
- ◆ *Mental Health Act (1116/1990)*
- ◆ *Penal Code of Finland (19.12.1889/39)*

### 4.1. The Law Relating To Mental Health Work

#### 4.1.1. Legislation Providing a Framework for Mental Health Work

**Mental health work** means promotion of the growth in people's psychological well-being, functional capacity and personality, and the prevention, cure and relief of mental illnesses and other mental health disorders as stated in the Mental Health Act (14.12.1990/116), in the Decree on Mental Health (21.12.1990/1247) and in its supplementary provisions (2001). Mental health work is regulated by several acts and decrees.

The main laws concerning health care are the **Primary Health Care Act, the Mental Health Act and the Decree on Mental Health Act with their supplementary provisions, the Act on Specialised Medical Care, and the Occupational Health Care Act**. They guide and control mental health work and the supply of services.

The corresponding laws on social welfare are the **Social Welfare Act and Health and the Act on Social Work with Intoxicant Abusers**.

**Legislation relating to rehabilitation** also provides a framework for mental

health and substance abuse work. It provides, among other things, for a plan of rehabilitation to be made for the client, a decision on rehabilitation to be made if necessary, and arrangements for the client's subsistence security via a rehabilitation allowance.

Likewise, the Occupational Safety Act guides and controls mental health work. It also contains provisions on the psychological well-being of employees.

The Act on the Status and Rights of Patients and the Act on the Status and Rights of Social Welfare Clients (the so-called **Patient** and **Client Acts**) safeguard the patient/client rights. These include the right to access to services, the protection of privacy, decisions relating to themselves and their care and treatment, access to information and equal treatment.

In addition to these laws there is a number of **national plans, recommendations and strategies**, which provide guidelines for mental health work and its development. They include the Social Welfare and Health Policy Strategies 2010, the Health 2015 public health programme and the quality recommendations for mental health services.

Legislation guiding mental health work stresses the importance of prevention and non-institutional care and the priority given them. In today's mental health work the aim is to concentrate

more and more on the prerequisites for mental health work, in other words the **promotion of mental health**. This means any action or activity which may improve the living conditions of the population by providing support for the sound mental health of people and communities, boosting factors that favour mental health and eliminating the impact of unfavourable factors. The project is, however, still so new that is not yet visible in practical mental health work to the extent hoped for.

The law states that mental health work is done for the sake of the social and physical environment as well as individuals, families and groups. Information and advice on mental health are ways to influence the social environment – the population and special needs groups. The law emphasises the importance of mental health work done with families. Families are seen as a key target group in mental health work and more effort should be put into providing support for them in society, in the shape of psychosocial services, for example.

#### **4.1.2. Key Content of the Mental Health Act**

It is important for anyone working in mental health to know the laws and norms that govern it. There are provisions not only on the organisation of mental health work as described above but on several practical matters that define and guide it. What follows

is the main content of the provisions in summarised form.

### **Harmonisation of mental health services:**

The agencies undertaking mental health work (primary health care, the social services and specialised medical care) must work together to ensure that mental health services function as a whole and that there is adequate care for clients as well as enough services, especially home care services and sheltered housing for purposes of rehabilitation.

### **Involuntary admission to care:**

Under the Act adults can be taken into psychiatric hospital against their will if all the following criteria are met:

- ◆ if someone is diagnosed to be mentally ill
- ◆ if someone is in need of care and treatment on account of mental illness and if they are not
- ◆ admitted to care it would essentially worsen their illness or would seriously jeopardise their health or safety or the health and safety of others
- ◆ if no other mental health services are suitable or they are inadequate

The Act also refers to putting minors into care against their

will. The criteria are the same as for adults except that instead of diagnosed mental illness the term serious mental disorder is used. Furthermore, a minor can only be compulsorily admitted to treatment in a psychiatric ward for minors.

### **Admission of patients against their will to observation and care, and observation in hospital:**

Patients may be admitted to care against their will after a doctor has examined them. If a doctor, for example one at a health centre, believes that the conditions for involuntary admission to care are probably met, he will make out a **referral for observation**. With minors, the doctor must always allow the parents or guardians an opportunity to have their say.

On arrival at the hospital ward the doctor on duty examines the patient and the referral. If the doctor thinks the conditions for treatment against the patient's will are probably met, the patient is admitted to the ward for a four-day period of **observation**.

**The decision on compulsory admission to care** is taken after the period of observation has ended by the senior physician in



charge of psychiatric care in writing with reference to the referral for observation, opinion on observation, and the patient's case history. In the case of minors, the decision must be submitted immediately for confirmation by the Provincial Court.

Patients can be kept in care against their will for not more than three months, after which another opinion on observation has to be issued. The right of people admitted for observation or care to determine their own affairs may only be restricted and he or she may only be constrained to the extent made necessary by the treatment of their illness and their or someone else's safety.

**Other legal provisions:**

**Care organized in a state mental hospital:** it is primarily those whose treatment is particularly dangerous or difficult who may be admitted to a state mental hospital.

**Involuntary mental examination and treatment of someone accused of a crime:** the Act describes procedures for admitting someone for an examination of their mental state, the examination stage and possible treatment thereafter. The

Act also lays down provisions on the admission to care of someone whose sentence has been waived and the special treatment of a mentally disabled person accused of a crime.

**Supervision of work:** A condition of providing mental health services is a viable system of work supervision.

The Act also describes the right to appeal, cases where the doctor is prevented, a health centre physician's obligation to act, the police's obligation, police assistance, and documents relating to care and treatment.

## 4.2. The Law Relating to Intoxicants and Substance Abuse Work

Finnish policy on substance abuse creates a basis for substance abuse care and the legislation that governs it. Policy on substance abuse can be divided into legislation on alcohol and legislation on drugs. Key aspects of the law are presented in this section.

### 4.2.1. Legislation on Alcohol

Alcohol is also an intoxicant that is permitted with restrictions. The aim of alcohol policy, and thus the

legislation on alcohol, is to control consumption and prevent and reduce the social, health and social harm done by the consumption of alcohol ('harm reduction policy').

Under the law, a product is said to be a substance containing alcohol if it has more than 2.8% by volume ethyl alcohol. If the content is no more than 22% by volume, it is a mild alcohol beverage. If it is higher than 22% it is a strong alcoholic beverage

The main instruments in alcohol policy are the laws which restrict and regulate the manufacture, import, sale and age restrictions on retail sales of alcohol. Under the law, alcohol can only be sold in licensed premises and making it available to anyone under the age of 18 is a criminal offence. The aim of the age restriction is mainly to protect young people from the risks relating to alcohol consumption. In addition to these provisions, tax on alcoholic beverages and information and education are ways for society to endeavour to implement alcohol policy.

#### 4.2.2. Legislation on Narcotics

Finnish policy on narcotics and the legislation relating to it are based on general socio-political measures, general national legislation and international

agreements. The guidelines on drug policy in EU and foreign and security policy are taken into account in policy on narcotics.

- ♦ complete prohibition of drugs
- ♦ general welfare policy
- ♦ harm reduction policy

##### Basic tenets of policy on narcotics

- ♦ a full ban on drugs
- ♦ general welfare policy
- ♦ harm reduction policy

Drug policy is built around three basic tenets. The first of these is the **complete ban on drugs**. In practice this means that serious drug-related crime, i.e. dealing and smuggling, and the use and possession of drugs are criminal offences in Finland. The basic premise here is that by declaring the use of drugs illegal one is strengthening negative attitudes towards drugs and reducing their use.

The second is the notion of **general welfare policy** and the emphasis on its importance. Investing time and money in services relating to substance abuse problems, alongside general welfare services, is regarded as being a component of the welfare policy. Thus, the basic premise here is that by promoting people's general welfare and living conditions drug-related problems can also be prevented.

The third and the most recent is harm reduction policy. This more liberal approach, one that is common now internationally, emphasises the importance of minimising the harm caused by drugs, by, for example, promoting low-risk ways of using drugs and by regulating the safety of the substances used. In the new Millennium, many European countries have moved towards harm reduction rather than the punishment of users. In practice this thinking in Finland is mainly at present reflected in the health information for drug users and the substitution treatment and maintenance regimes for addicts that are available.

These three basic tenets, mutually somewhat contradictory, form the basis of Finnish policy and legislation on narcotics. To implement the policy in practical terms, compromises are employed to try and interpret the view that advocates restriction and that which emphasises reduced harm at one and the same time. The implied contradiction, however, lies in whether the drug addict is seen as a criminal who should be punished (complete ban policy), or a risk user who should be receive support in all respects regardless of whether he or she continues to use drugs or not (harm reduction policy).

With the liberalisation of drug policy, many European countries are decriminalising the use of

cannabis, which is regarded as a mild drug. In Finland, a provision has been added to the Penal Code stating that someone accused of the criminal use of narcotics will not be charged or sentenced if they have sought treatment for their intoxicant problem.

However, the present interpretation of Finnish drug policy still puts the stress on banning drugs altogether. Accordingly, the aim of legislation on narcotics is the prevention and restriction of the spread of narcotics and their use and the reduction in the individual, social and financial harm caused by drugs and the prevention, care and control operations they give rise to.

The use of narcotics is mainly prevented by improving the living conditions of people and promoting their welfare. In addition, the supply of narcotics is restricted by actions on the part of the police, customs and border control authorities in that they continue to ensure there is a risk that people will get caught for drug crimes. The Ministry of Health and Social Affairs monitors the situation regarding substance abuse in Finland with respect also to drugs, keeps a list of substances which are classified as drugs, and implements the decisions of the government.

### 4.2.3. Legislation on Substance Abuse Care

The Act on Social Work with Intoxicant Abusers obliges **the local authorities** to organise and finance services as necessary for those with substance abuse problems and their families. It is their responsibility to monitor the problematic use of intoxicants in their area and to organise substance abuse care to meet the needs of the local people. The local authorities are mainly responsible for introducing substance abuse care services in collaboration with certain citizen and self-help organisations and religious communities.

Because problems with intoxicants concern the client and his/her family in every respect, causing a wide range of social and psychological harm, there is also a need for different kinds of services and forms of help. It is therefore crucial to care and rehabilitation how smooth **cooperation between the different service agencies** is. Accordingly, the development of cooperation has become a central priority in substance abuse care. It is also important to know the law on mental health work, child protection, etc. in substance abuse care – the services they deliver are often essential in the treatment and rehabilitation of substance abuse clients.

Local authority decision-making needs to focus more and more on the

prevention of intoxicant problems and to try and improve people's living conditions and way of life. The Act places an obligation on the various actors involved in substance abuse care - the social and health care services, the abstinence movement, the housing authorities, the employment authorities, the education department, the youth services and the police – to work together.

The Act also stresses the importance of **working with the client and his/her family** and the principles that are involved in that: voluntary involvement, freedom of choice, confidentiality and individual participation. In substance abuse care the voluntary involvement of the client and self-motivation are vital for rehabilitation.

But although the Act on Social Work with Intoxicant Abusers emphasises the importance of the client's voluntary involvement, it nevertheless also makes it possible for adults to be admitted to **care against their will**, when the criteria involved are endangered health or violence. When it is a case of endangered health it is the doctor who decides on admission. When violence is a factor it is mainly the director of social services or social secretary who makes the decision.

In either case, care can last five days at most, although when the reason is violence it may continue for 30 days. The Act also provides guidelines on consultation with the client, implementation of the decision, the organisation of care and treatment, its termination and appeal. In practice, the legislation on admission to care against a client's will is applied very rarely.

#### **Principles of substance abuse care**

- ◆ confidentiality
- ◆ seeking treatment independently
- ◆ support for coping independently
- ◆ support for families and relatives
- ◆ availability and flexibility of services
- ◆ priority for non-institutional care
- ◆ integrated system of services

Substance abuse care is guided by recommendations in addition to legal statutes. The most important are the joint recommendations for substance abuse services issued by the Ministry of Health and Social Affairs and the Association of Finnish Local and Regional Authorities. They provide guidelines and instructions for the planning, organisation and development of local authority services. According to the recommendations, the municipalities must have an established strategy for substance abuse which determines locally procured services. Its aim is to support the development of substance abuse work and employ common policies to unite the various agencies involved in the work. It must be based on the local authority's welfare programme and on a solid values and knowledge base and take account of special needs groups in addition to the population as a whole.

# 5. The Service System

## 5.1. Mental Health Work Services

What follows is a list of mental health services. This section primarily describes basic mental health services which mainly come under statutory and local authority health care. Besides health care services, clients often receive social welfare assistance organized by the local authority, e.g. income support and home care services. In addition, services run by various private organisations and communities are an important addition to the care and rehabilitation services that clients need. Similarly, occupational rehabilitation services, not dealt with in any detail in this section, are also of vital importance for those receiving mental health rehabilitative services and who are returning to work.

### Basic local authority health care services

**General services of health centres:** consultation with doctor/nurse/psychologist, hospital ward treatment, home medical care, provision of maternity and child welfare clinics, school and student health care, occupational health care, ambulance services, etc.

#### Services of mental health centres:

- ♦ **consultation:** services of a psychiatrist, state registered, practical or mental health nurses, crisis services: nurses, psychologists, social workers, occupational therapists
- ♦ **psychotherapy services:** individual, group and family therapy according to different trends in psychotherapy
- ♦ **rehabilitation services:** housing, (rehabilitation homes, sheltered housing), day centres, occupational activity services (work centres [sheltered workshops], sheltered work), rehabilitation courses and camps

### Special local authority health care services

#### Hospital district-based special mental health services

- ♦ **outpatient services:** emergency and outpatient services, day hospital services, mobile crisis services
- ♦ **institutional services:** open and closed psychiatric wards, rehabilitation wards

## Local authority social welfare services

- ◆ substance abuse care
- ◆ child protection
- ◆ care of the elderly
- ◆ care of the disabled
- ◆ home care

## Other services

Housing, care, rehabilitation, etc. services run by various organisations, the parish council and producers of private services

## The local authorities are responsible for mental health work

According to the law, **the local authorities** or the joint municipal authorities that comprise them have the main responsibility for organising social and health services and associated mental health services. They can produce these services themselves or deliver them in collaboration with other local authorities. They can also buy services from private producers in, for example, the private sector or from mental health organisations.

The law only obliges the local authorities to organise 'basic statutory services'. They might also decide

independently to produce and supply other services. The services provided are funded through local taxes, client fees and the municipal share of state funding.

Because the resources the local authorities have available to them vary greatly, there are obviously **considerable differences between them** with regard to the supply of services. In sparsely populated and poor municipalities or in municipalities in economic decline they are fewer and less balanced in scope, and limited simply to the basic services required by law. From the point of view of regional equality, better diversity of services and equality amongst the people are key challenges for developing the service system. Quality recommendations have been made for mental health work which aim to harmonise the quality of the service system among the local/joint municipal authorities.

In mental health work, as in the system of social and health services in general, **basic services** take priority. Accordingly, the majority of mental health work is done within the framework of these basic services. Depending on their duties, employees in basic services are educated and trained in the social welfare and health sector, but they also have the skills to meet and support mental health and substance abuse clients and their families. Some of them also have specialised training in mental health and substance abuse work. In addition, the greater use of professional

consultation services is a growing trend within different professional groups in a given municipality. After all, mental health and substance abuse problems are encountered everywhere in the social welfare and health sector today.

### **5.1.2. Primary Health Care Services as a Component of Mental Health Work**

Basic services in health care are provided by **health centres**, whose role in mental health work has continued to strengthen. The health centre is the primary supplier of mental health services. About a third of all health centre visits are thought to be related to mental health problems in one way or another.

Health centre employees are educated and trained to varying degrees in health care or social welfare. They are doctors, psychologists, public health nurses, specialised nurses, social workers, physiotherapists, laboratory or X-ray nurses and practical nurses.

#### **Health centre services:**

- ♦ General practitioners are responsible for diagnosing and treating the most common mental health problems.
- ♦ If necessary, doctors refer patients to specialised services in mental health work.
- ♦ Psychologists, public health nurses and specialised nurses are responsible for advising, guiding and treating patients.

#### **Maternity and child welfare clinics:**

- ♦ Employees in these clinics endeavour to recognise a client's psychological needs and bring up problems relating to mental health, intoxicants, etc.
- ♦ The clinics support mothers who need the service on account of substance abuse problems or for psychological problems.
- ♦ The employees point mothers, families with children or children who need additional support or help in the direction of care.

#### **School and student health care and occupational health care:**

- ♦ The most common functions are the identification of mental health and substance abuse problems and referring clients for care and treatment.

#### **Departmental treatment:**

- ♦ The different departments of health centres deal with the most common psychological disorders whose treatment does not require special psychiatric expertise.

#### **Mental health centres:**

- ♦ These are responsible for the supply of non-institutional mental health services. Mental health centre clients are normally referred there by a health centre.
- ♦ Mental health centres are involved in the investigation, treatment and rehabilitation of people with mental health problems.
- ♦ They employ a multiprofessional



team of mental health experts, which includes psychiatrists, psychologists, social workers, psychiatric nurses, practical nurses and occupational therapists.

- ◆ Mental health centres provide a range of services:
  - reception/surgery services
  - consultation and help in crises
  - psychotherapeutic services
  - different functional groups and support services for housing and rehabilitation, such as home care, activity services and work centres (sheltered workshops)

### 5.1.3. Specialised Mental Health Work Services

In Finland, **specialised mental health services** i.e. non-institutional and institutional services relating to specialised psychiatric care are organised regionally according to hospital district. It is the task of **hospital districts** to coordinate specialised medical care services in such a way that primary health care and specialised medical care services form a graduated, though flexible and viable, whole.

**Graduated treatment** aims at the possibility of treating a client effectively and as economically as possible, avoiding overlap and cutting the high costs of specialised care. It tries to ensure that a client's treatment initially starts and proceeds in primary health care, only moving on to specialised care if the health centre doctor thinks

that the client's state of health makes that particularly necessary.

There are usually **several hospitals** included in each specialised medical care (hospital) district. General hospitals usually have psychiatric wards in which to treat clients with mental health disorders. In addition to these, there are special psychiatric hospitals and outpatient clinics for non-institutional care. These are for clients requiring specialist care and treatment. University hospitals are responsible for more demanding specialised medical care - both somatic and psychiatric - in their local area.

There are **different types of wards** in hospitals: closed and open wards, admission and rehabilitation wards, and often also wards for different client groups, e.g. dual diagnosis wards, top security psychiatric wards, psychogeriatric wards, etc.



*Occupational therapy room at Porvoo Hospital, Helsinki and Uusimaa Hospital District*

### 5.1.4. Basic Social Welfare Services as a Component of Mental Health Work

Basic social welfare services are, besides health care, a crucial part of mental health work. Basic services provide the client with many kinds of guidance and support, e.g. in applying for social security and in the use of care and therapy services. Similarly, services such as home care, housing services and child protection are

taken care of via the social services. The social services provide financial support for mental health clients and arrange appropriations for special services relating to health and substance abuse care.

The key social service agencies involved in mental health work include those to do with home care, day care, care of the elderly, care of the disabled, substance abuse care and child protection.

Home care service	The home care service linked to health care visits at home. Its task is to ensure that clients and their families can cope in the home on an everyday basis, take care of themselves and function as part of the rehabilitative service system.
Day care	Day care supports the growth and development of children whose parents have mental health or substance abuse problems. At the same time it strengthens parenthood among the adults in the family and shores up the life of the family as a whole, especially if it is one that indulges in substance abuse.
Care of the elderly and of the disabled	Units dedicated to treating and caring for the elderly and disabled, which include, for example, dementia units and housing, care and rehabilitation institutions for the disabled, do a lot of corrective and rehabilitative mental health work in collaboration with mental health work specialists.
Substance abuse care	Substance abuse and mental health problems often manifest themselves at the same time. The following section (5.B.) presents more details on forms of substance abuse work and the services that relate to it.
Child protection	Child protection services include the financial support, day care and child welfare clinic services already referred to, but extend to child and family counselling, the use of support families, holiday activities and recreation, and family rehabilitation. The ultimate stage in child protection is custody, only resorted to when the child's development and health are seriously threatened and non-institutional support structures are not possible, appropriate or adequate.

### 5.1.5. Other Mental Health Services

In addition to the basic services mentioned in the law **private agencies, communities and organisations** may organise and deliver mental health services. For example, patient and relative organisations deliver many important services regionally and locally to help mental health clients and their families. Peer groups, recreational activities, rehabilitation units, holiday activities and rehabilitation courses are some of the forms this work takes.

Different communities, parishes and organisations deliver a wide range of services, from crisis services to therapy and course activities and various housing and day care services. For example, parishes in Finland have many mental health services to complement the service system.

National mental health organisations include the Finnish Association for Mental Health, which has founded regional crisis centres and which employ a number of voluntary workers work in addition to full-time professionals. In addition, the Finnish Central Association for Mental Health and the National Family Association promoting Mental Health in Finland deliver many different services via their local associations.

### 5.1.6. Services Form a Regional Whole

Like the social welfare and health care services, mental health services work on the basis of 'population-specific responsibility'. The population of a municipality is divided into population responsibility cells of 4,000-10,000 inhabitants, where health centres and social centres are responsible for mental health services. It is important for the organisation and use of services that primary health care, specialised medical care and the social services are jointly responsible for the planning and implementation of services. In addition, cooperation with the private service sector and voluntary organisations is necessary in order to guarantee a seamless service system. The '**regional population-specific psychiatric working model**' aims at close collaboration between the agencies doing mental health work for the integration of services to form as flexible a package as possible.

The work group representing the basic services of the region maps out and monitors the population's need for services and the changes required. This way services can be planned and delivered in the most appropriate way, with harmonisation of mental health work among the various actors involved. The quality recommendations for mental health work require the local authority to draw up a **general plan for mental health work** that involves the

various service agencies. The aim is for preventive, flexible and fast services in mental health work and continuity of care.

### 5.1.7. Mental Health Service Development Needs

Although there are numerous development projects in progress in mental health work there is still a need for a general change to the volume, content and quality of services and cooperation in the services network.

#### **Pressures for improvements to mental health work:**

- ◆ Developments in non-institutional care services have not made the progress that was hoped for, owing to fewer financial resources, among other things.
- ◆ The demand for services exceeds supply. Clients need more in the way of support to cope on an everyday basis and a wider range of services than is on offer at present.
- ◆ Clients' mental health problems have become more complex and acute, in addition to which increased alcohol consumption has resulted in more and more social problems and a greater need for services.
- ◆ The current service system is overloaded as regards both institutional and non-institutional care.

Because with the Finnish system the local authorities have a good deal of autonomy in the production of services, there are obviously huge **differences in the supply of services both regionally and locally**. For example, the situation can vary significantly from one local authority to another as regards housing services, day and occupational activities, and psychotherapeutic rehabilitation. In municipalities with sparse populations and few resources clients have less chance of receiving a wide range of services.

**Inequality** is also conspicuous by client group. The supply of mental health services is extremely unsatisfactory for some special needs groups, such as the intellectually disabled and language minorities. There is a clear dearth of places in care and rehabilitation for dual and multi diagnosis clients in particular.

Furthermore, non-institutional services at present do not properly cater for those with the most serious mental health disorder or give them a chance of a meaningful life. There is also to some extent a lack of **intermediate services**, like home care and sheltered housing and day and occupational activities. Similarly, there is a huge demand for around-the clock, flexible services that respond rapidly to clients' needs. Such services could strengthen clients' social skills and their ability to cope.

Mental health work today is in the throes of change and under pressure to

alter its ways. There is a **re-evaluation of the entire service system and forms of activity** going on and a desire to focus on services and activities that are more efficient and effective and to develop flexible and diverse psychosocial services. The priority in mental health work has tended to move towards more multi-actor, networked cooperation.

## 5.2. Substance Abuse Care and Related Services

### 5.2.1. Basic Substance Abuse Care Services

Finland has a very multilevel and diverse service system for people with intoxicant problems and their families. Services consist of general **basic social welfare and primary health services** and **services specialised** in substance abuse care. Basic services take priority and through them the client can be referred to specialised services if need be.

Under the Act on Social Work with Intoxicant Abusers, the **local authorities are responsible** for organising and financing these services according to need. However, they do not have to produce all the services themselves: they can purchase them from third sector actors – different organisations, parishes and private outfits.

Primary health care here refers to the **health centre services** described in connection with mental health work in a previous section: consultations with a doctor or nurse, maternity and child welfare clinics, school health care and occupational health care. One of its roles is to identify substance abuse problems in their early stages and refer clients to treatment. Another role it has is to support the rehabilitation of substance abusers and their families. Basic services can also provide detox treatment and withdrawal treatment and first aid and treatment for intoxicant-related illness and injury.

**Basic social welfare services** have also already been described in connection with mental health work in an earlier section. These services make it possible for substance abuse clients to receive guidance and support in many forms. The social services guide clients when they apply for social security and in the use of care and therapy services. Furthermore, services such as home care, housing, child protection and family rehabilitation are organised via the social services. The social services provide financial support for substance abuse clients and organise appropriations for special services relating to substance abuse care.

## 5.2.2. A-Clinics as Suppliers of Special Services

In addition to basic services there are special substance abuse care services and specialised medical care services within the framework of health care. Special services are either institutional or non-institutional. Non-institutional services may most usually be sought voluntarily; for institutional care a referral is required. The local authority or joint municipal authority must organise services in terms of their content and scope to correspond to the needs of the local population. Services must in the first place be offered in the form of non-institutional care and they should take full account of the needs of the client. It is the A-clinics and youth clinics that have main responsibility for delivering non-institutional substance abuse care services.

**The A-clinics** are the main agency delivering non-institutional substance abuse care services. They or their branch surgeries exist in virtually all the larger towns. The services are free, and no one needs a referral to have access to them. In the majority of cases clients come along of their own accord, but they can also be referred there by basic services in an emergency or by appointment. The employees at A-clinics make up a multiprofessional team normally consisting of nurses, social therapists, doctors and psychologists.

When clients come along to an A-clinic, first of all their use of intoxicants is looked at. Then the strength of their addiction, their physical and psychological state of health, and their social circumstances are examined. Their need for care is assessed. The most common forms of help are advice and guidance, detox treatment, special therapies, special treatments i.e. the 'soft' treatment options, and withdrawal treatment, substitution treatment and maintenance regimes.

### **Detox treatment**

The aim here is to break the long-term and heavy use of intoxicants. The client spends the evenings and nights at home. This kind of treatment is especially suitable when withdrawal symptoms do not warrant continued monitoring and round-the-clock care. The process consists of medical treatment for withdrawal symptoms and the drawing up of a plan for further care and treatment. The treatment period lasts between two and five days.

### **Therapy services**

Individual therapy helps clients to sort out their lives and develop problem-solving skills. It also supports them in changing and crisis situations. Therapy for couples and families attempts to examine

the family situation and find new ways of looking at what is often an inflammatory situation. Group therapy acts either as the sole form of treatment or as a support for individual therapy. It aims to strengthen a client's social skills. Therapy services also extend to network therapy, which involves the client's social network. Crisis therapy provides help for acute and immediate crisis situations.

### **Special treatments**

The 'soft' treatment options. The most common include acupuncture, acupressure, massage, and reflexology.

### **Withdrawal treatment, substitution treatment and maintenance regimes for opiate addicts**

This form of treatment began in Finland in the 1990s. The medications used were buprenorphine and methadone, which are still in use. In 2003 approximately 600 people were receiving substitute treatment and maintenance regimes, with most on buprenorphine. The need for care is assessed and treatment starts in hospital. Permission for treatment can also be

given to a health care or substance abuse care unit with a separately appointed doctor in charge of care and a staff familiar with how to commence treatment. Withdrawal treatment lasts one month at the most and is aimed at an intoxicant-free lifestyle.

Substitution treatment is a way to use medical therapy and psychosocial rehabilitation to achieve an intoxicant-free lifestyle and break free from the world of drugs, opting, instead, for work or study. The treatment consists of daily administrations of medication, meetings with a doctor or nurse, group visits, and weekly, random sample tests, i.e. samples taken under supervision, which reveal the presence of any other drugs and medications. The treatment usually lasts years.

**Youth clinics** offer services to those under the age of 25. The services are free and no referral is needed. They provide help for substance abuse and dependency problems and various kinds of crisis associated with youth.

### 5.2.3. Other Specialised Substance Abuse Services

Besides the most common services of the A-clinics described above, there is still a large number of other services for substance abuse clients, which are the responsibility of either the local authorities or private agencies and various organisations and associations. For example, within the Church and among private organisations there is a range of services for those addicted to drugs or alcohol. Organisations such as the Association for Healthy Lifestyles and the Free from Drugs Organisation are involved in many kinds of activity, including peer support.

#### **Drug and intoxicant stops**

for the young (under 18s or sometimes also under 25s) are one special service. In most cases the services are provided by the local authority but the work may also be carried out in partnership with regional associations or the A-clinic Foundation. The drug and intoxicant stops organise activities for young people in an attempt to break the cycle of intoxicant dependency, assess the need for treatment and provide further care.

**Health counselling points** were started in Finland in 1997, the first

opening in Helsinki. It is a service for drug users. The main area of focus is harm reduction. The aim is to lower the threshold for seeking treatment, and prevent and reduce the incidence of contagious disease, damage to health and death from overdosing. The services consists among other things of client-focused health advice, and changing syringes and needles.

**Day centres** for substance abuse clients are places where they can meet other people, engage in activities, eat, wash, wash clothes, read newspapers, etc. The units also provide guidance on social security and housing.

**Detox centres** provide round-the-clock detoxification treatment, with the purpose of terminating the use of intoxicants and creating opportunities for physical rehabilitation and solving social problems. The services offered are rest, medication to treat symptoms, monitoring clients' physical condition, individual and group discussion, and the organisation of further treatment. To be admitted to detox centres clients need to make a reservation and have a doctor's referral.



There are **overnight shelters** in the bigger towns and cities. They are places people can stay temporarily overnight, even if they are intoxicated. The service is an attempt to satisfy the basic needs of intoxicant addicts and point them in the direction of the additional services they need.

**Housing service units** are for substance abusers in rehab who need temporary or permanent accommodation and/or daily support and help. The units differ greatly. Some only provide accommodation, while some offer psychosocial rehabilitation for independent living, i.e. rehabilitative living plus various other services to promote rehabilitation. It is the client's local authority Office of Social Affairs that normally applies to housing services. The services are organised by the local authorities, joint municipal authorities, private organisations and religious communities and organisations. Charges are based on the social services' fees and charges regulation.

**Rehabilitation units** are available to clients if, after detox treatment, non-institutional care services are

inadequate or if clients need to stay away from their own living environment.

Rehabilitation units are maintained by the local authorities, joint municipal authorities, the A-Clinic Foundation, organisations specialised in substance abuse care, and religious communities and organisations. This kind of care is applied for by the social services, the primary health care services or A-clinics, and an appropriation is arranged for the client. Clients have to pay a nominal charge for the service, though if they are without means they may receive this in the form of income support. Some clients are paid a rehabilitation allowance for the relevant period by the Social Insurance Institution of Finland. The period of rehabilitation is normally between a couple of weeks and six months. The whole family can take part in the rehabilitation process (family rehabilitation).



*Canteen at Messi Day Centre for substance misusers*

## 5.2.4. Peer Support Services

The oldest form of peer support activity is the AA (Alcoholics Anonymous) groups. AA began in Finland in 1948. At present there are over 600 groups in Finland. The work is based on anonymity, open meetings, closed groups at homes, and support staff, i.e. sponsors. The scheme is based on a twelve-step recovery programme. AA does not accept funding from outside and does not charge any membership fees. It is politically, ideologically and religiously independent.

In the wake of the AA groups, other peer groups have evolved along the same principles of recovery and not just for alcohol problems.

**Al Anon** groups help family members of alcoholics who are still drinking or who have quit. **Alateen** groups are for the teenage children of alcoholic families. **NA** (Narcotics Anonymous) groups work in the same way as the AA, but are for drug addicts.

**A-guilds** are also based on peer support and are registered associations founded by A-clinic clients. They are often places for further treatment in addition to regular forms of basic care or following it. The work is voluntary and relies on mutual trust and a willingness to help. A-guild groups meet once or several times a week and organise leisure activities and recreation.

## 5.2.5. Dual and Multi Diagnosis Patient Care

Finland is seeing ever more dual and multi diagnosis patients. They normally receive services, as with mental health and/or substance abuse clients, from the places mentioned previously.

They have also had their own special services organised for them, at, for example, special care and rehabilitation units. There is nevertheless huge demand for both institutional and non-institutional services intended for them, and there is a need for more. The supply of services is thus still inadequate and regionally uneven. It is mainly the bigger cities and towns that offer them.

It is in the care and rehabilitation of dual and multi diagnosis in particular that expertise and services are needed just as much in health care as in the social services. In practice, though, there is not always seamless cooperation between the social welfare and health care services. Because of administrative fragmentation it can be inflexible or professional attitudes sometimes get in the way.

There have been efforts to make professionals more aware of mental health disorders and substance abuse problems so that dual and multi diagnosis clients can have access to quality care and rehabilitation in general services. This has made it easier

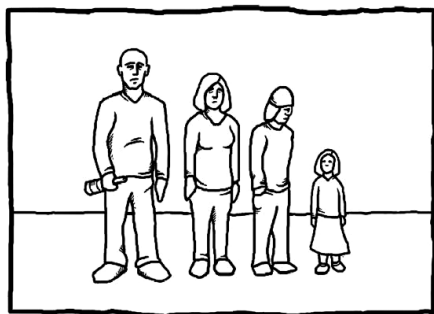
for employees in the social services and health care to deal with these sorts of patients and provide them with proper support and expertise.

### 5.3. Example of a Finnish Family in Receipt of Mental Health and Substance Abuse Services

#### The Suominen Family

The Suominen family consists of mum, 33, dad, 34, their son of 16 and daughter of 9. They live in the Helsinki area in a block of flats on a housing estate. They have no relations or support network nearby.

Mum works as a housekeeper and suffers from depression. Dad has been out of work for the last year because he drinks too much. He is still unemployed and is a heavy drinker.



*What Help Is There for the Family?*

Their son has started having difficulties at school: he plays truant and is failing in his studies. Now he has got in with a crowd that uses intoxicants. He has tried drugs several times – no one knows exactly what.

The daughter is shy and withdrawn, but is good at school.

As mentioned, mum goes out to work. She is tired out and depressed, but motivated to get help for her family.

Mrs Suominen has gone along to her GP because she sleeps badly and is exhausted and depressed. The doctor discusses her state of health, symptoms and the family situation with her. He gives her a 'depression test', which confirms his suspicions that her depression symptoms are becoming aggravated.

So doctor and mother agree that she should resume her depression medication, which she has not taken for a year. In addition, the doctor puts her on sick leave for two weeks and suggests she should see the depression care specialist at the health centre. After her period of sick leave mother could either continue with her visits to her GP at the health centre or see an occupational health specialist. In any case, he suggests she should talk about things with a nurse or psychologist at a mental health centre. After a week she gets an appointment with a psychiatric nurse. She also arranges to see her

occupational specialist in two weeks' time.

When she is speaking to the nurse at the mental health centre mother brings up the subject of her exhaustion and the family's financial difficulties. The nurse arranges an appointment with the social services to enable her to get home care and financial help.

A social worker explains how the family can apply for income support and home help. Income support for the family is arranged, but because of the demand there is no home help available. So they decide to do something about it themselves.

When she is talking to her own nurse mother mentions that she is worried about her husband's and son's substance abuse habits. The nurse reassures her that she is capable of looking after her family. She recommends her to bring the matter up with both of them. The nurse also tells her about the various service options available which might help and support the family in their situation.

The nurse gives mother brochures which describe different support and peer groups for clients with depression. Regional patient associations are active in cities and there are many types of service on offer: peer support groups, excursions and activity centre programmes. Mother thinks that she might well benefit from such services in the future.

A few weeks later, mother decides to bring up the matter of their use of intoxicants with her husband and son and suggests they seek help. But neither thinks it is a problem and are not inclined to get help. So she contacts her son's school nurse and school counsellor, who promise to discuss the matter with her son.

The following week a meeting is arranged at the school between her son, the school nurse, the school counsellor, his teacher and his mother. Despite her efforts, mother could not get her husband to attend. At the meeting they discuss the use of intoxicants and the risks and consequences of experimenting with drugs. The boy is offered a chance of support from the school counsellor, the nurse, the teacher or a psychologist.

After discussing the matter with her husband mother decides to get into touch with an A-clinic, because her husband does not seem to think his substance abuse habit is problematic. She books an appointment for herself and is able to talk to a substance abuse therapist about the situation. She receives information, advice on the service and support. She is also given the contact details of a peer group for the families of users of intoxicants, which she decides to go along to, mainly to help her cope herself.

She gives her husband the information pack on intoxicants drugs that she got

from the A-clinic, which includes a test on the risks of alcohol consumption and various brochures describing substance abuse services. She suggests again that her husband should go with her to the A-clinic or family guidance centre, so that they can talk about the problems the family is going through. The husband is reluctant, but two weeks later (and after his wife has strongly urged him to) he agrees, albeit rather half-heartedly, to go along to the family guidance centre with his wife.

## 6. Working with Mental Health and Substance Misuse Clients

### 6.1. Work with Clients Is Built on Trust and Cooperation

Rehabilitation following mental health and intoxicant problems stresses the importance of the active involvement of the clients and their families in the process. After all, it is the clients who are most aware of their situation, so they are usually the most competent parties to find solutions for themselves and their lives. Accordingly, the aims of care and rehabilitation have always to be planned together with clients and their families. When clients feel that they are the main protagonist and the one who has the power to influence their own rehabilitation they are better able to commit to working with others.

Because recovery from mental health and drug problems takes time and patience, it is important to establish motivation on the part of the client and maintain it. When motivated, the client commits to the aims and is able to make an effort to achieve them. Working together with one's relatives is also crucially important, because support from one's family and environment is the best way to aid recovery.

In most cases, mental health and substance abuse problems are associated with a range of problems. The clients' needs are all-encompassing and affect them and their families in all aspects of life. That is why mental health and substance abuse work calls for multiprofessional cooperation, in which clients are supported by a team consisting of various professionals.

The team often works closely with clients and their families. This is known as networked cooperation. Clients and their networks participate equally in the network from the time the initial situation is assessed up till when targets are set and the end of the client relationship.



*A room for family meetings*

## 6.2. Professionalism and Ethics in Work with Clients

### The general ethical principles of social welfare and health care:

- ◆ Respect for life and human values
- ◆ The right to determine one's own affairs
- ◆ Justice
- ◆ Equality
- ◆ Encouraging people to be self-motivating
- ◆ A good attitude to providing a service

The client relationship in mental health and substance abuse work always works on the assumption that there will be **respect for human values and the client's individuality**. The employee maintains a professional and respectful attitude towards the client, regardless of the latter's state of mind, behaviour, social status or history. Respect for clients is reflected in how one addresses and treats them, respect for their life values and opinions, all the time ensuring that their intimacy, privacy and self-respect are not deliberately violated.

The client's **right to determine his or her own affairs** is vitally important in mental health and substance abuse work. The client's right to an independent life and to make decisions that affect him or her independently

cannot be stressed too much in care and rehabilitation. Client relations aim for cooperation and balanced dialogue, which in turn allows the client to become more active and involved.

To enable clients to participate in the decisions taken on them, they and their families must be given sufficient information on their treatment and rehabilitation and be told the reasons why any solutions have been selected. The client's **right to information** is protected in the law (the Act on the Status and Rights of Patients and the Act on the Status and Rights of Social Welfare Clients - for health care and social welfare respectively).

During care and rehabilitation, the client's personal affairs generally have to be gone into. This means that it is essential to protect privacy and maintain **confidentiality** in the client relationship. Confidentiality may also be understood as the duty of employees to keep their promises and ensure that outsiders do not get information on clients' or their families' affairs which may be private and sensitive.

Confidentiality also naturally extends to the employee's **pledge of secrecy**, considered to be crucial to the client relationship. Information on clients can therefore only be passed on with their knowledge and consent. Legislation on social welfare and health care work has its own guidelines on pledges of secrecy among professionals.

Mental health and substance abuse work stresses the importance of clients' **voluntary admission to care, coping independently and being self-driven.** The latter objective is reflected in what is a rehabilitative approach, where the aim is to strengthen the client's own involvement, functional ability and resources, in order to avoid unnecessary work on the client's behalf and to ensure that the client does not try to get round taking decisions.

The aim of care and rehabilitation is to strengthen the client's functional ability physically, psychologically and socially. The aim is also to help the client cope as independently as possible in everyday situations - at home, home-like living accommodation units, at school and at work. Voluntary admission to care is justified in that the client's own motivation is crucial to rehabilitation following mental health and substance abuse problems. Clients have to be able to work hard for their rehabilitation and it will not be forthcoming if they are not motivated.

In extreme situations in both mental health and substance abuse work one has to resort to **taking clients into care against their will and sanctions of various kinds.** But this is for only very serious cases and only when softer treatment options are not viable (see previous sections on legislation on mental health and substance abuse work).

## Psychotherapeutic attitude

The relationship between client and employee in mental health and substance abuse work is goal-oriented and based on cooperation and mutual agreement. The main protagonist in the relationship is the client. The employee uses his or her professional skills, knowledge and personality to help the client achieve the goals set for the collaboration. The employee endeavours to establish and maintain trust and openness in the relationship, so that the client is able to say what he or she is thinking, express emotions and deal with them during the treatment and rehabilitation process.

**The psychotherapeutic attitude** of the employee is the main basis of such work and this is instilled in the early stage of training. It relies on the employee's capacity for empathy and sympathy and being able to understand the thoughts and feelings of another person. In the client relationship the employer exploits the emotions that are kindled in contact with the client more successfully to reach the world as the client experiences it.

Crucial to the psychotherapeutic attitude is the employer's effort to understand the client's feelings, thoughts and behaviour, and the factors that relate to them. Through discussion and by listening attentively to the verbal and non-verbal communication of clients, the employee can more successfully reach their



experiences and thus help them become more aware of their own thoughts, feelings and behaviour and the factors relating to them.

A key method in adopting a psychotherapeutic attitude is **active - or reflective - listening**. This embraces not only empathy and attentiveness but clarification and providing a frame of reference. Clarification means making what the client is thinking or saying more specific in connection with the matter in hand. The employee may ask more focused questions, repeat what the client says using his or her own words or ask the client to say more about something. By providing a frame of reference the employee tries to help clients see the connection between their behaviour, feelings and external events, possibly asking them to think about possible connections or tactfully expressing his or her own thoughts about them.

#### **Elements in the psychotherapeutic attitude:**

- ◆ Respect for the client and caring attitude
- ◆ Approving, understanding and encouraging attitude
- ◆ Allowing clients to express and share their feelings and thoughts
- ◆ Active listening
- ◆ Enabling the client's better self-understanding
- ◆ Communicating hope

## **6.3. Approaches in Mental Health and Substance Abuse Work**

Mental health and substance abuse problems are often linked to someone's environment as well as society as a whole. This is why these problems should be examined at several levels and from many points of view. Work with clients makes use of several approaches and methods with regard to care and treatment. Every approach has its advantages and limitations. In holistic care and rehabilitation they merge and thus complement one other - they are not in competition.

The most common approaches in mental health and substance abuse work take the following forms: the resources- and solutions-centred perspective, the family and network perspective, the cognitive perspective, the biological perspective and the psychodynamic perspective. In addition to these, community care and the Mill Care model of substance abuse care have a major role in substance abuse work in Finland.

<b>Resources- and solutions-centred perspective</b>	Focus on the future and searching for change and workable solutions, instead of dwelling on the past, the reasons for the behaviour and whose fault it is. Instead of concentrating on the problems, the aim is to highlight the clients' resources, coping strategies and success. This way they can be made more aware of their resources and discover ways to cope which will help them in everyday life despite mental health problems, or help control their use of intoxicants more successfully.
<b>Family and network perspective</b>	The aim here is to take account of the client's family, social network and life situation. Cooperation between client and family is established. The objective is to try and support and exploit a client's and his network's resources and boost reciprocal social support. In practice this comes about either in the form of different family and network therapy models or it is applied in different aspects of work with the client, e.g. as psychoeducation, i.e. support, guidance and advice for the family and relatives.
<b>Community care</b>	Applied in substance abuse care especially. Community care means the conscious use of the entire care community to achieve targets in treatment, rehabilitation and education. The community acts as a means of support, a source of feedback, and a means of achieving the client's rehab targets.
<b>Mill Care</b>	Mill Care is the Finnish equivalent of the Minnesota care model for American substance abuse patients. It sees substance addiction as an illness from which the patient can recover through rehab. Mill Care uses professional help, the AA's recovery programme and peer group support. It tries to motivate the client to break free from intoxicants and reinforce faith in the possibilities of recovery.
<b>Cognitive perspective</b>	Based on cognitive psychology, with reference to which different short- and long-term cognitive psychotherapies have been developed. The aim is to question ways of thinking and belief systems that sustain mental health problems or intoxicant dependency and find new means of coping and resources. The client is helped to establish images, beliefs and approaches that are linked to himself and are more favourable for change, and which support him more satisfactorily in rehab.
<b>Biological perspective</b>	The most commonly used biological treatment methods are psychiatric drugs to aid treatment and rehabilitation for mental health and substance abuse problems. As a result of modern research methods, drugs have been refined and precision drugs are being used more and more. These are more effective and have fewer side-effects. Other biological treatments used include electrotherapy, bright light or dawn simulation therapy and sleep deprivation.
<b>Psychodynamic perspective</b>	Based on psychoanalytical theory and psychoanalysis derived from it. Psychoanalytical theory has led to the development of various longer- or shorter-term forms of psychotherapy. The aim is to help the client to become aware of the psychological conflicts that lie behind his symptoms, thereby becoming symptom-free. The mental health employee's basic attitude – one which is understanding in the psychotherapeutic sense – is based on this perspective. Its essential ingredients are empathy and respect for the client.

## 7. Practical Work in Mental Health and Substance Abuse Units

Trained practical nurses work in education, care, and rehabilitation. Their training courses lead them to different sectors of social welfare and health care, e.g. day care, hospital care, work with the disabled, rehabilitation, mental health work, substance abuse work, and so on. A practical nurse works with clients of all ages and with different cultural backgrounds, promoting and aiding their social welfare and health and looking after the sick.

Practical nurses **work in a wide variety of environments**. These may be day care units, special needs schools, child welfare institutions, care homes, hospitals, home care environments, outpatient clinics, housing units and rehabilitation centres. Practical nurses involved in mental health and substance abuse mainly work with clients in non-institutional and institutional units.

The practical nurse is a professional who works in basic social welfare and health care as a member of a multisectoral team. The composition of such a **multiprofessional team** varies from one work unit to another. In day care centres and hospitals that team would include a wide range of professionals. Depending on the place of work the following social welfare and health care professionals would

make up these multiprofessional teams: doctors, psychologists, social workers, nurses of various kinds, physiotherapists, occupational therapists, speech therapists, and nutritional therapists. In units specialising in mental health and substance abuse work, the professionals also have specialised knowledge and skills in this area. For example, the doctor would be a psychiatrist, the state registered nurse a substance abuse care professional, or the practical nurse someone who specialised in mental health and substance abuse care early on in training.

Someone can only describe her/himself as a practical nurse if they are properly qualified, though others can engage in the tasks of a practical nurse, provided that they have adequate training in other areas, as well as experience and the right professional skills and knowledge.

The work of a practical nurse is regulated by health care legislation, certain norms and values and a set of professional ethics (Act on Health Care Professionals [559/94]; Decree on the National Authority for Medicolegal Affairs [1121/92]).

**Any professional in any sector, e.g. someone coming to Finland from**

abroad who wishes to become a health care employee, must be registered, i.e. apply for a license to the National Authority for Medicolegal Affairs to have the right to practise legitimately as a health care professional. The National Authority for Medicolegal Affairs is also the body that monitors the work of professional in the health care sector.

## 7.1. Working in a Mental Health Unit

Human Care Network Ltd. (HCN Oy) is a company which provides those in mental health rehabilitation programmes as well as the mildly mentally disabled with social rehabilitation and housing services.

Social rehabilitation involves indoor and day activities, trips and hiking/camping, organised in accordance with each client's needs. Housing services include sheltered housing, more independent living accommodation for those in rehab, and rehabilitative living accommodation for the mentally ill in rehab. There are 17 service units.

Residents have their own room at a centre. Sheltered housing works along the lines of community care. The staff are multiprofessional and committed to the ISO 9001 Quality Management System, surveyed by Lloyd's Register.

### A working day at the Berttas Sheltered Housing Unit

Berttas is a unit of HCN Oy in Helsinki. The place is a rehabilitative housing unit for mental health patients in rehab. It is located in a quiet area of detached houses in Konala, about 15 minutes away from the city centre. It is a spacious and light unit in a building with three floors.

Our clients are very diverse – men and women, young and old. What unites them, however, is various mental health problems. The commonest is some type of schizophrenia. Some are suffering from anxiety or bipolar disorder. Many also have a background of substance abuse. There are six staff, including practical nurses and one state registered nurse. A psychiatrist regularly visits the house.

There are 22 places for residents in our house. Everyone has their own room. There is also general living space and a sauna. The unit also has two annexes, with three places for residents in each of them. The accommodation is dedicated to independent, more autonomous living.

Our unit offers home-like living accommodation services for those in mental health rehabilitation programmes. Social rehabilitation is closely associated with the work. This mainly takes the form of weekday indoor activities around five hours. It is

important for those with mental health problems that the days are structured properly; the daily programme needs to keep very much to the same routine. Predictability and repetition of the familiar create a feeling of security. The residents engage in different work tasks that suit their level and skills, e.g. packing and assembling tasks. They are paid incentive money for the work they do.

The employees' job description is mainly to supervise, encourage and support the residents. Their everyday functions are in most cases restricted, and the staff offer advice and guidance to each in turn to be able to do what they have to do, e.g. to cook and clean, in matters of personal hygiene and doing their washing - in fact in anything that helps them lead a more independent and balanced life.

Social rehabilitation also takes the form of group and leisure activities. The groups might get together with a leader just to chat or do handicraft work, for example. Physical exercise groups, everyday skill improvement groups or recreational trips give residents' lives meaning and a sense of adventure.

The day passes in different ways. Sometimes the staff have a lot to do, e.g. assist or talk to various official agencies, deal with residents' personal matters, fill out forms, deal with property maintenance tasks or attend internal training sessions.

In addition to these duties, organising group or leisure sessions is an opportunity for staff to get closer to the rehab patients as people. It is essential to establish a feeling of security in their everyday lives and create a network of support that takes account of their needs. It is important to identify a client's resources and strengthen them and be able to create a basis for learning new skills and subjects.

Every day is unique. Our work at the home is very different from the clinical environment of a hospital, say. It is client-focused, so whatever is involved at any one time depends on each client's needs and the stage of their rehabilitation. It is challenging work, but it is also very rewarding. Every single moment in a patient's rehabilitative progress is worthy of attention. They all help the employee to remember that learning is a lifelong process.

## 7.2. Working in a Substance Abuse Unit

Messi is a day activity centre for substance abuse clients in Malmi. It comes under the work of the Helsinki North A-clinic. The staff include a head supervisor, two other supervisors, a caretaker, and two kitchen staff trainees.

The clients are people with substance abuse problems and their relatives living

in north Helsinki. They are men and women of different ages. There are also gambling addicts represented. In general the clients having anonymous dealings in the unit, except when in non-institutional rehabilitation programmes.

The activity centre is open from 9 am to 3 pm. Clients come along without an appointment to receive guidance, support and advice. There is a cafeteria during opening hours. People can eat there on Mondays, Wednesdays and Fridays from 11 am to 12.30 pm. Donated bread is given out free once a week.

Once a week there is a communal meeting – on ‘Theme Tuesday’. Every day the clients can take part in various activity groups. Sometimes trips are also organised. Some of the clients go there when they are in a non-institutional period of rehabilitation. Then they take part in different all-day activities organised by the unit lasting two weeks altogether.

The supervisor’s (e.g. practice nurse’s) job description at the unit is very broad and varied. It includes the following:

- ◆ Supervision of activity and discussion groups
- ◆ Supervising trips and visits
- ◆ Discussions with individuals
- ◆ Guidance on care and treatment where necessary
- ◆ Multiprofessional, networked cooperation

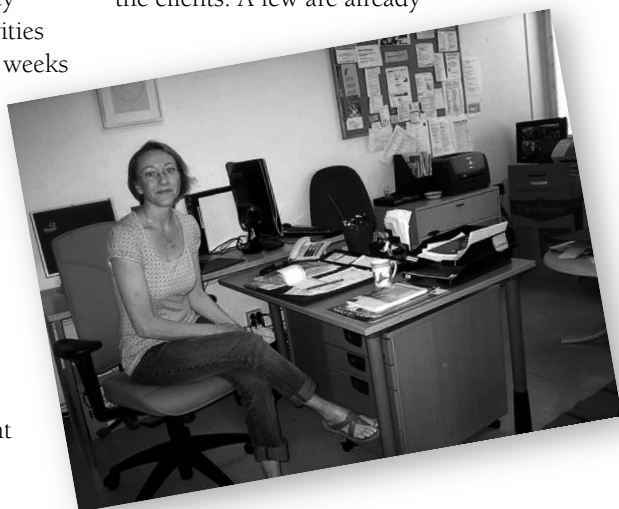
- ◆ Providing clients with information on the unit’s work
- ◆ Providing partners with information on the unit’s work

## **A working day at the Messi Activity Centre**

I am greeted by the smell of fresh coffee as I open the door of the Messi Activity centre, where I work. I clock in and say good morning to my colleagues who are already there – the head supervisor, the supervisor for non-institutional rehabilitation, the caretaker, and the two employees in the kitchen.

I write on the board the programme, menu and thought for the day. We hold a short meeting to discuss the week’s timetable and other business.

Then it is time to open the doors for the clients. A few are already



*Messi office*

waiting on the steps to be let in. We ask one another about the weekend. A client who has been away for a long time comes to talk about his problems. Together we sort out a pile of bills and some housing matters.

A visit to the garden is on the agenda today. Three clients and I walk there. A few clients are waiting for us there already. We pull up some weeds and pick some parsley and flowers to take back to Messi. We do not need to water the garden as it poured down at the weekend.

Lunch tastes good after being outside and walking. I help serve the food in the kitchen and talk to some clients about our forthcoming anniversary. Some of them persuade me to have some photos taken.

The phone rings. On the phone I give a client some guidance on how to apply for detox treatment. I hang up and it rings again. My partner from the Office of Social Affairs is asking about our meal days and says she is referring a client to our day centre.

I get a moment to see about the photos before the client arrives. I offer him coffee and describe our work, our monthly programme and the possibility of non-institutional rehabilitation. He is interested in the fitness centre, Nordic walking and relaxation. He is going to propose a self-help group for his housemates.

Group activities will not begin to get into full swing until a few weeks later, so my working day does not as yet involve a lot of group supervision.

I go to the A-clinic building next door to copy our monthly programme for tomorrow's Theme Tuesday communal meeting. I plan and produce a leaflet about our trip to a bowling hall for the notice board.

A client almost persuades me to play pool with him, but another client is in distress and wants to talk to me. The caretaker will play with him instead.

The clients gradually go home or wherever and it is time to shut up. We employees tidy up and get ready for the next day. Then it is time to go home. On my way I think about how different each day is.

## 8. Vocational Education of Practical Nurses in Finland

Finnish education system can be divided in five different levels. Compulsory schooling lasts from age of seven to age of sixteen and consists of lower and upper basic education. After completing basic education young person has to choose whether she or he is interested in upper secondary education or vocational education on level three. Most young people apply for upper secondary education preparing them for national matriculation examination. These young people are mainly looking for further education routes directly to universities (level 5) or polytechnic (level 4). Term “University of Applied Sciences” is also used instead of Polytechnic. Third option for those students that have completed their upper secondary general education studies is to apply for same level (3) vocational education. When choosing this option their vocational studies will last only two years in vocational schools.

After compulsory education an alternative route leading faster to working life and employment is to apply for level three vocational education. This will take three years of studies. While studying at vocational college on level three student is also able to study in upper secondary school and to prepare her/himself for matriculation exam; thus acquiring both

vocational qualification and completing upper secondary general education. After completing level three vocational qualification student can apply both to polytechnic or university.

Following diagram will describe the structure of Finnish education system: *page 65.*

**Basic vocational qualification of practical nursing is one of level three social and health care qualifications.**

In order to give an overall comprehension of this qualification 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 40 credits long. *Page 66.*

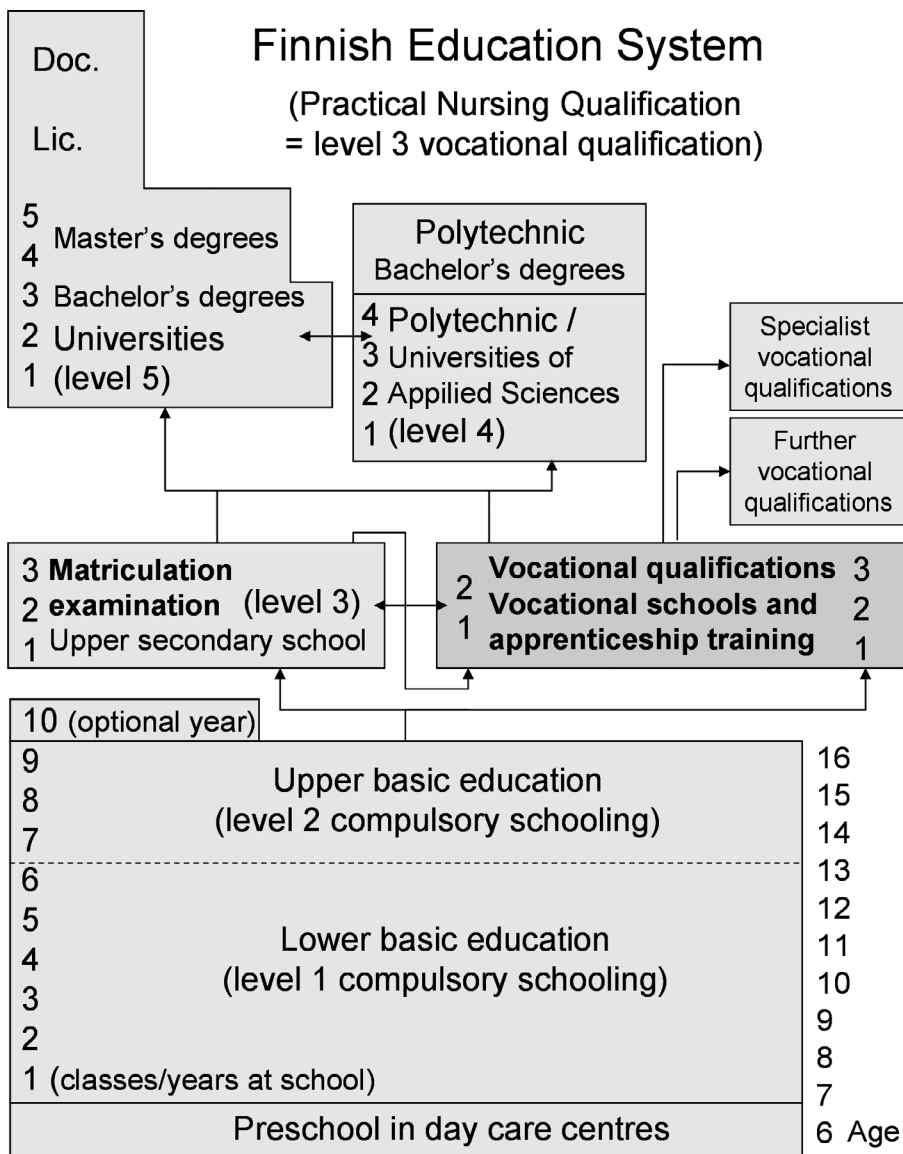
The **duration** of the practical nurse study course is three years (120 credits). For students who have matriculated it is two years. The course includes vocational basic studies (50 cr), general studies (20 cr), optional studies (10 cr) and a study programme (40 cr).

The **study programme** takes place in the final stage of the course and provides more specialised expertise in



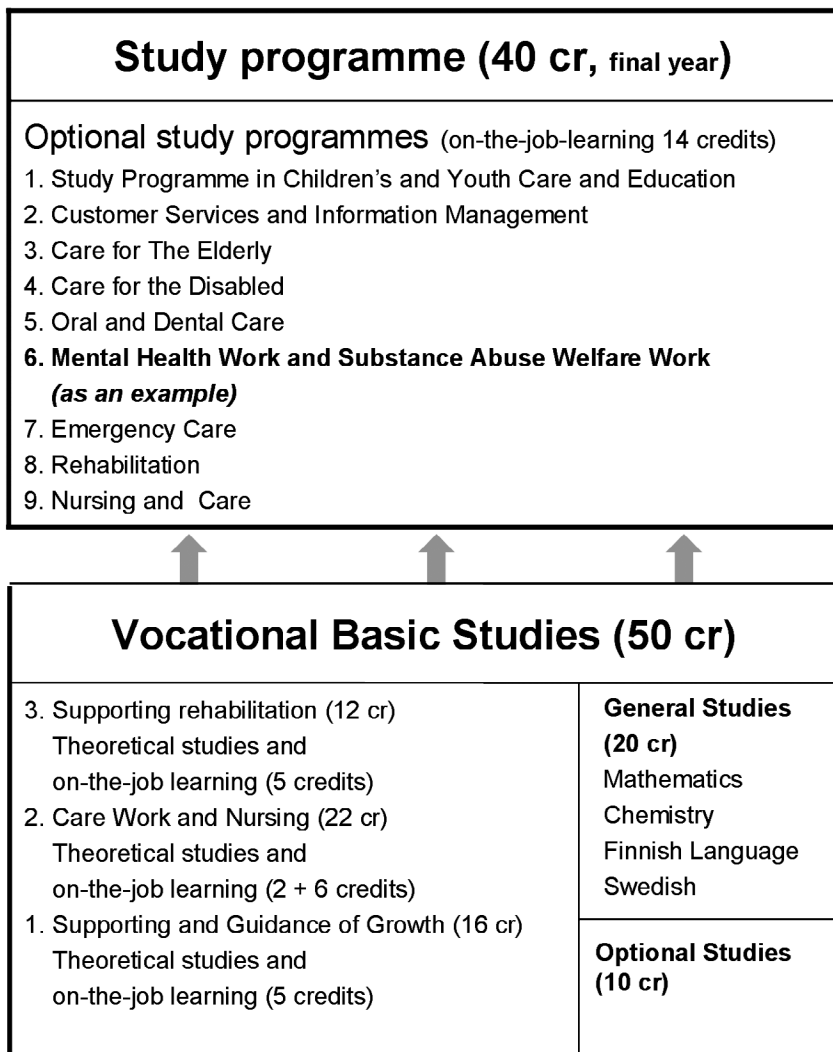
# Finnish Education System

(Practical Nursing Qualification  
= level 3 vocational qualification)



## STRUCTURE OF PRACTICAL NURSING CURRICULUM

POSSIBLE WORK PLACEMENT ABROAD



1 cr = 40hours work

one sector. The student can choose one of the following options: children's and youth care and education, client service and information management, care of the elderly, care of the disabled, oral and dental care, mental health work and substance abuse work, rehabilitation, emergency care or nursing and care.

A practical nurse has various tasks in the changing environment of social welfare and health care services. Practical nurse work takes place in a range of social and health care settings, e.g. in day care centres, schools, old people's homes, health centres, clients' homes, hospitals, and institutions for the mentally disabled.

## 8.1. General Goals of the Practical Nursing Syllabus

The essential qualifications required for social and health professional care are social and interactive skills, especially the ability to support clients' own resources and functional ability. A social welfare and health care professional can work with a range of people from different age groups and backgrounds. Professionals must also be able to respect people's different cultural backgrounds and values, and take them into account in everyday work. Other essential skills and abilities are a high standard of professional ethics and tolerance and a good balance of

interactive and problem-solving skills combined with practical care and educational skills.

When a practical nurse works with promoting people's health and well-being, one fundamental requirement is that he/she has a good understanding of the relationship between a someone and both his/her social and physical environment and society as a whole. A practical nurse must also be aware of the increasing economic and environmental pressures. New technologies also call for certain qualification requirements as well as increased multiprofessional cooperation and teamwork social welfare and health care.

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

A practical nurse has a sound knowledge of the social and health service system, and always acts in accordance with the professional ethics and norms that govern work in the field. A practical nurse is able to work both individually and as a member of a multiprofessional team, acknowledging both the resources he/she can offer and the limitations of his/her competence. A practical nurse appreciates his/her own profession and strives to develop the work with a client-oriented and service-oriented approach.

A care worker in the field of social welfare and health care services is able and willing to be responsible for his/her own professionalism. He/she is always able to justify his/her own actions, and knows when and where to seek assistance in making decisions, as and when necessary.

## 8.2. Description of the Practical Nursing Profession and Core Competence

A practical nurse works within the field of social welfare and health care in basic care work both in the homes of clients and in different care and service units in the sector. A practical nurse takes care of people of different ages and cultural backgrounds who are in various life situations by supporting their growth

and development, by promoting their health and social welfare, and by treating illness.

The work of a practical nurse means helping and assisting people in various situations that concern their health, functional ability, well-being and ability to cope in different crisis situations. A practical nurse always recognises the autonomy the clients have in their own lives and supports the individual initiative that arises from their daily needs, aims, resources and potential.

In situations where clients are not able and/or lack the resources to manage on their own, assistance may require intervention and carrying out tasks on their behalf. In addition and in particular, in these situations the promotion of the client's autonomy, integrity and independence is of great importance. A practical nurse actively motivates clients to look after themselves and use their own internal resources. A practical nurse's work is regulated by the legislation, norms and professional ethics of the social welfare and health care sector.

A practical nurse participates in the planning, implementation and evaluation of her/his work as a responsible actor in cooperation with clients and their social networks, with experts and with multiprofessional teams. He/she is able to recognise alternative ways to act and assist clients, and to choose the most expedient,

sensible and client-centred approach possible. A practical nurse assists clients in identifying both the various resources and threats and obstacles that are relevant to coping with everyday life.

A practical nurse guides and supports the mental and social growth and development of individual clients and client groups. In the same way, a practical nurse helps the client establish, maintain and develop human relationships. A practical nurse helps clients to take care of their own basic needs in different life situations and eliminate obstacles that are due to illness, impairment or other shortages of resources that have an effect on their ability to manage in everyday life. A practical nurse assists and encourages clients to act to achieve their own goals in taking responsibility for their own lives, maintaining and enhancing that responsibility, and in functional and work ability. A practical nurse also guides clients in matters relating to appropriate social welfare and health services and social, cultural and recreational activities.

The work of a practical nurse in care work and nursing, as well as supporting and guiding growth, development and rehabilitation has a multi/interdisciplinary scientific basis. The broad knowledge base of a practical nurse and the theoretical professionalism acquired are visible in all activities. 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-reasoned ethical considerations.

Professional interaction is based on seeing different people as equal individuals. In order to make confidential and genuine interaction with clients possible, a practical nurse always tries to put him/herself in the place of the client and interpret the client's situation and experiences from that perspective. A practical nurse is bound by confidentiality. He/she has no right to discuss the client's affairs with outsiders.

A practical nurse is able to identify the most crucial factors that impact on his/her own professional growth and development. A practical nurse constantly evaluates and develops working methods and approaches at his/her working unit, and assesses their significance for the quality of services. Moreover, a practical nurse is an active participant in society and strives to improve the living conditions of his/her clients, in particular.

A basic vocational qualification in the social welfare and health care field, practical nursing is carefully designed to be a broad-based and multidisciplinary course. A registered practical nurse is fully qualified to perform basic care

work duties in the many different and changing work environments in the field of social welfare and health care.

➤ *Helsinki City College of Social and Health Care, Malmi Centre, provides vocational education for practical nurses.*



## 8.3. Study Programme of Mental Health and Substance Abuse Work

The Study Programme in “Mental Health and Substance Abuse Welfare Work” is worth 40 credits (or study weeks). The **themes and subjects** of the Mental Health Work and Substance Abuse Welfare Work study programme are as follows:

### I Mental Health and Intoxicant Abuse Welfare Work (4 cr)

- ◆ Basics of mental health work (1.5 cr)
- ◆ Basics of substance abuse work (1 cr)
- ◆ Personality psychology (1 cr)
- ◆ Development of work and quality (1 cr)

### II Encountering mental health and intoxicant abuse clients (4 cr)

- ◆ Mental health problems and assistance (1 cr)
- ◆ Intoxicant abuse problems and assistance (1 cr)
- ◆ Crisis and catastrophe psychology (1 cr)
- ◆ Swedish language (1 cr)

### III Individual mental health work (22 cr)

- ◆ Fundamental assistance methods in mental health work (3.5 cr)
- ◆ Professional growth and maintenance of resources (1 cr)
- ◆ Medication in mental health and substance abuse work (1 cr)
- ◆ Clinical psychology (2 cr)
- ◆ Anatomy and physiology (1 cr)
- ◆ Music (0.5 cr)
- ◆ Visual arts (0.5 cr)
- ◆ Physical education (0.5 cr)
- ◆ Finnish (0.5 cr)
- ◆ Nutrition and home economics (1 cr)
- ◆ Social security for mental health and intoxicant abuse clients (0.5 cr)
- ◆ First aid II (0.5 cr)
- ◆ Entrepreneurship and labour market legislation (0.5 cr)
- ◆ Senior thesis (2.0 cr) (Finnish language, IT)
- ◆ Practical training (7 cr)

### IV Individual addiction care (10 cr)

- ◆ Principles and practices of addiction care (1.5 cr)

- ◆ Special issues relating to intoxicant abuse (1.5 cr)
- ◆ Practical training (7 cr)

The Study Programme in Mental Health and Substance Abuse Welfare Work states that a qualified practical nurse is expected to have the following skills:

- ◆ the ability to establish confidential care and support relationships with clients who have problems coping with everyday life due to mental health disorders or substance abuse
- ◆ the ability to use acquired knowledge of theories on human behaviour and personality structures in supporting their clients' resources, functional abilities, zest for life and social relationships
- ◆ recognises mental disorders, such as psychotic disorders, depression, anxiety, self-destructive behaviour, aggression, anorexia, bulimia and problems caused by substance dependency, and is able to apply his/her knowledge to care and rehabilitation work
- ◆ uses creative expression skills, such as linguistic and visual expression, music and physical exercise, in support of a meaningful everyday life and as an alternative to substance abuse
- ◆ is familiar with the care and service system in mental health and substance abuse work and is able to comply with statutes governing the field and the principles of occupational ethics; develops one's

own work and possesses the potential to function as an entrepreneur in the field

- ◆ is able to use both Finnish and Swedish at work
- ◆ provides care for, educates and guides children and young people of different ages
- ◆ 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 relating to pharmacotherapy
- ◆ systematically delivers basic nursing and care services for clients of different ages at institutions and in home care
- ◆ possesses 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 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 manage 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

- ◆ knows the basics of social welfare and health care occupations in society, basic legislation and the national service system, and acts in accordance with basic values in the field and the principles of occupational ethics

Those who have completed the Vocational Qualification in Social and Health Care Study Programme in Mental Health and Substance Abuse Welfare Work may function as Practical Nurses in mental health care/substance abuse work at psychiatric hospitals, day centres, psychogeriatric units, detoxification units, housing services and individual clients' homes.

## 8.4. The practical nurse at work

Practical nurses can work in a wide variety of social welfare and health care areas. Opportunities for employment depend on what sort of client group and area of work is involved.

As mental health and substance abuse problems are very common, practical nurses who have specialised in these fields are in great demand. There is also a need for expertise in home care and care of the elderly. There are also jobs available in units providing rehabilitative services in mental health and substance abuse work – in different

rehabilitation and group care homes, housing services, day care hospitals, home care and occupational activity services and work centres [sheltered workshops].

Practical nurses in specialised medical care work for psychiatric departments and substance abuse rehabilitation units. Practical nurses work in care and rehabilitation services for special needs groups (e.g. child and youth psychiatry) far less commonly.

Practical nurses start on rate of pay of an average of 1,600 – 1,700 euros a month. Pay depends on the employer organisation: there may be differences in the salaries of practical nurses doing the same work, depending on whether the employee is working for a private company or in the public sector.



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## Legislation

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*Alcohol Act (1143/95)*

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*Abstinence Act (828/1982)*

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*Child Welfare Act (417/2007)*

*Primary Health Care Act (66/1972)*

*Occupational Health Care Act (743/1978)*

*Act on Health Care Professional (559/1994)*

*Act on the Status and Rights of Patients (785/1992)*

*Mental Health Act (1116/1990)*

*Penal Code of Finland (19.12.1889/39)*

## Websites

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[www.stakes.fi](http://www.stakes.fi) – Sosiaali- ja terveystieteiden tutkimus- ja kehittämisskeskus (National Research and Development Centre for Welfare and Health)

[www.etene.org](http://www.etene.org) – Terveysthuollon eettinen neuvottelukunta (The National Advisory Board on Health Care Ethics)

[www.finlex.fi](http://www.finlex.fi) – suomalainen lainsäädäntö (Legislative Information Database)

[www.paihdelinkki.fi](http://www.paihdelinkki.fi) – päihdeasioiden tietopankki (Addictionlink)

[www.kaypahoito.fi](http://www.kaypahoito.fi) – käypähoitosuositukset, tietopankki (Finnish Current Care Guidelines Database)

[www.mtkl.fi](http://www.mtkl.fi) – Mielenterveyden keskusliitto (Finnish Central Association for Mental Health)

[www.tukinet.net](http://www.tukinet.net) – Mielenterveysaiheinen infosivusto (Mental health – related information site, only in Finnish)

# 10. Appendix:

## Structure of a Rehabilitation Plan

The content of a rehabilitation plan depends on the unit and organisation. Most commonly the plan includes the following:

### Assessing the need for rehabilitation

- ◆ Clinical information (description and nature of illness or disorder, the changes it has caused and medical damage)
- ◆ Details of earlier periods of treatment and rehabilitation and their results
- ◆ Description of physical, psychological and social functional ability (coping independently, need for help and support)
- ◆ Effect of illness/disorder on functional ability (functional harm)
- ◆ Social situation (home, interests, atmosphere at work, etc.)
- ◆ Resources: physical, psychological and social

### Goals of rehabilitation

- ☐ Partial and eventual goals (as regards functional and work ability, the home and work environment, different life situations)

### Measures to achieve goals

- ☐ Implementing agency, method of implementation, timing and financing
- ☐ Client and family guidance and advice
- ☐ Therapies (e.g. psycho-, physio- and occupational therapy)
- ☐ Rehabilitation periods, either institutional or non-institutional
- ☐ Other rehabilitative needs (e.g. rehabilitation guidance and supervision, adaptation training, ancillary services)
- ☐ special measures relating to vocational rehabilitation (vocational rehabilitation itself, changes in the work place)

## **Social security and social services**

- ☐ Benefits within the social security system (e.g. special medications for which the patient is wholly reimbursed, health insurance allowance or rehabilitation allowance/pension)
- ☐ Social services (benefits under the Act on Services for the Disabled, other forms of support)

## **Monitoring rehabilitation**

- ☐ Implementation
- ☐ Person(s) responsible
- ☐ Timetable

## **Other**

- ☐ Period for which rehabilitation plan is in effect
- ☐ People involved in drawing up the plan

# Notes

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