Care Work with Mental Health and Substance Misuse Clients in Sweden

Content

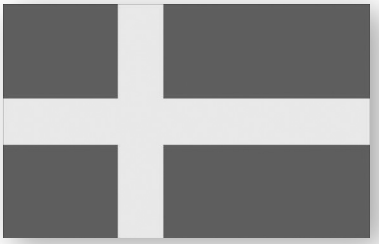
1. Introduction

Dear Student

◆ *Welcome to Sweden! We are very pleased to have you here doing your practical study placement and hope it proves to be a productive and pleasant experience for you.*

Sweden is located in northern Europe on the Scandinavian peninsular. The closest neighbours are Norway, Finland and Denmark. Sweden is a constitutional monarchy with a central government appointed by the Riksdag which is the country's highest decision-making body. The population of Sweden is 1.9 million and the capital city is called Stockholm.

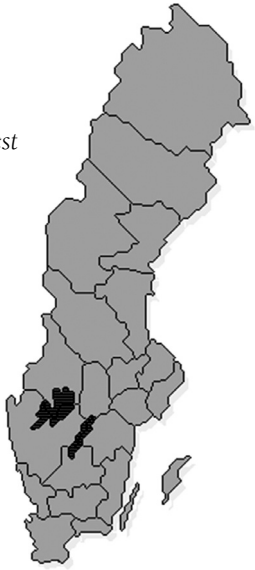
Stockholm and the Royal Palace



The Swedish flag

Source: www.FreeDigitalPhotos.net

Sweden is an oblong country (1 571 930 km.) divided into 21 counties which all contain a number of municipalities. The largest municipalities are also the cities of Stockholm, Gothenburg and Malmö. Sweden celebrates its National Day on 6 June. The currency is Swedish kronor.



Sweden

Sweden attracts many tourist, not least to admire the beautiful countryside. According to the right to roam free (allemansrätten) all have the right to access certain public or privately owned Swedish land to enjoy the countryside, pick berries etc so long as they do not damage or harm anything nor pick wild flowers that are protected. Access is not permitted to private areas. There are wild animals such as the king of the forest, the moose roaming the Swedish woodland.

Moose

Source: www.FreeDigitalPhotos.net

Woodland and meadows

Source: www.Fotofinnaren.se

In the north of Sweden there are mountains suitable for downhill ski-ing during the winter months and through the summer there are a number of beautiful rambling paths. The Svealand coastline is famous for its fantastic beauty and to the south and inland there are two large clean, fresh water lakes. The southern most county in Sweden is called Skåne and the Öresund Bridge connects mainland Sweden with the continent.

The purpose of this handbook is to give you an overall view and understanding of the care, support and help which is available for those individuals who are experiencing mental health problems including those individuals who do so as a direct result of substance misuse.

The pack has not made specific reference to children's mental health service provision because it is unlikely that a work placement would be available in this special area. It must be remembered that with any care provision it is constantly evolving to meet the needs of the individual. Changes also occur in response to government targets and initiatives to support health in its widest sense. Mental health and the promotion of mental health for the Swedish people are seen as a priority of the Swedish Government and as a result many new initiatives are being implemented throughout the country. Whilst every effort has been made to include up to date information which is accurate at the time of publication you may be introduced to new initiatives as a direct result of legislation and policy which has taken place since publication of this booklet.

A case of a family has been included in the text. This case will illustrate the type of service provision available for this family in Sweden.

Depending on where your placement is you may be working with individuals at hospital wards or in the community. This booklet does contain a lot of information and it is hoped you will use it as an information guide prior to coming to Sweden and to provide additional information when you are undertaking your experience. The contents page will allow you to locate the information you require with greater ease.

A glossary of terms in relation to Mental Health and Substance misuse has been included to provide additional information for any terms which you may require additional clarification with.

We hope you enjoy your visit to Sweden and that this booklet assists in your learning experience.

Meet the family!

Family Svensson lives in a three bedroom rental apartment in a large block of flats. The area where they live is some five kilometres from the city centre and is crowded with families who have many children. The number of unemployed people is quite high in the area and the average level of education is quite low.

The family members are four: mother Maria, 33 years, father Lars, 34 years, son Johan, 16 years and daughter Anna, 9 years).The parents were very young when they got married.

The mother of the family had no chance to educate herself because of getting pregnant so young. Nowadays she is working as a home help worker. She has suffered from depression for the last five years and been occasionally on sick-leave, but just now she is back at work.

The father worked as a bus-driver until last year when he lost his job. He has been drinking quite heavily over the last couple of years which was one of the reasons why he was fired. Now he is unemployed and he has not succeeded in getting a new job.

Son of the family is still studying in secondary school. Due to lack of motivation he has missed lessons and is not getting his studies completed according to set timetables – with the result that there is the threat of dropping out of school entirely. Recently he has been skipping lessons even more than before and he has also started to experiment with drugs.

The daughter of the family is in primary school. She is shy and slightly isolated but gets quite good grades. The mother of the family is worried especially about the son but she also feels herself too exhausted to find any solution to the situation. She and her husband do not have any relatives near by because they have moved to the area seven years ago from (the) countryside.

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. History and Development

3.1 History and Development - Mental Health Care

3.1.1 Outlook

In Sweden mental health has been described in old texts. In some of the texts one can deduce various currents that have left their mark on psychiatric care. Designations of the sick have changed over the years from possessed, insane, mad, crazy, idiot and mentally ill to mentally sick, mentally disturbed and functionally impaired. Illnesses in the 1980's comprised of fury, melancholy, insanity, oppression, feeble-mindedness, stupidity and general confusion. Hospitals have been called everything from hospital, asylums, madhouses and mental hospitals to psychiatric clinics.

The wonderful disease model involving the belief that a person who was beset by evil spirits, which one tried to remove through banishment, witchcraft and punishment, was fashionable during ancient times and the medieval ages. Parallel to this theory was a medicinal disease model originating in Hippocrates and describing psychiatric diagnoses which, even today, have the same name (mania, melancholy, paranoia).

Care of the sick took place in the home and with the arrival of the medieval times even in hospital. During the 17th and 18th centuries the process of locking people up in the sanatoriums and asylums began. It was believed that the "nutters" could be treated through fosterage, work and various surprise treatments which would "awaken" the patients: trapdoors, ants in sacks, drop treatments on a shaved head, surprise showers etc.

"Idiotic coffin" for transports of patients. Picture from Hospitalsmuseum, Vadstena, Sweden.
Source: Maria Andersson, Norrköping

From the middle of the 19th century more was understood and it was asserted that the patient was mentally sick. Answers were sought in natural sciences and it became more obvious that mental illness was a disturbance in the brain and genes played an important role. Treatments were aimed at removing the evil through various

"Long bath" and "Keeping chair". Pictures from Hospitalsmuseum, Vadstena, Sweden. *Source: Maria Andersson, Norrköping*

methods: vomiting, diarrhoea, leeches, irritant creams, open wound in the neck which would produce a good flow of puss, revolving chair, needles in the body etc.

The natural science way of looking at things, even though this field was still in its infancy, involved criticising the treatments, which more often were similar to punishment.

One of the first reform movements, which originated from France, introduced non-violent principles and a more humane view. However, Sweden was, in the main, more impressed by Germany during that time which focused more on a division of psycho-somatic. After the Second World War Sweden was more influenced by the USA.

"Swinging chair", model and "Swinging chair", natural size. Pictures from Hospitalsmuseum, Vadstena, Sweden. *Source: Maria Andersson, Norrköping*

3.1.2 Laws and Hospitals

In 1858 the first legislation relating to psychiatric care came into force in Sweden. At about this time special hospitals were being built which would later be called mental hospitals. In 1900 there existed 14 such places with accommodation for 1400. The 20th century brought with it great expansion and at most there were 35 large hospitals. The last of these was introduced in the 1970's.

Mental hospitals were small communities within the existing community and the personnel lived together with the patients within the hospital grounds. The intention was to supervise the sick and not, initially, to treat them. This was because there were no proper care methods.

There were various types of wards: care, worried and storm wards. There were reclining wards which involved the patients lying in bed for a number of weeks at the beginning of their care. If they behaved themselves they could, after a while, be permitted to go to exercise pavilions. Later they could leave the ward and work in the various self-supporting units within the hospital. Work was an important aspect of the treatment.

To use force was strictly forbidden and only permitted when prescribed by a doctor. Despite this, strait-jackets,

Single room, Vadstena hospitalsmuseum, Sweden.
Source: Maria Andersson, Norrköping

"Force sweater" and Force tools. Pictures from Hospitalsmuseum, Vadstena, Sweden.
Source: Maria Andersson, Norrköping

covers with straps and special clothes which prevented the patients from harming themselves, were common. Restraining patients in warm baths and administering large doses of tranquillizers were some of the few treatments that were available.

3.1.3 Care Personnel

Those who worked with psychiatric care when it was in its infancy, at mental hospitals in Sweden, came, in the main, from the working classes and this type of work was an alternative to the factories or farming. The personnel, who were without training, were called "attendants". Working conditions were terrible with long days and bad pay.

At the beginning of the 20th century training for the care personnel was slowly introduced at various hospitals. The senior consultant was responsible for its planning and the subsequent examinations. At Lunds hospital the "lower attendants" were given, for example, 14 hours of training which included 4 hours of mental care.

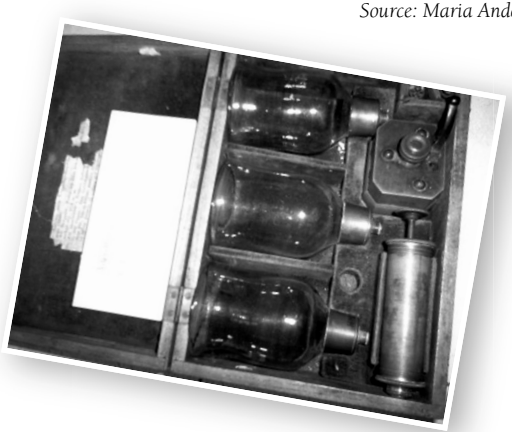
In 1931 the first regulated training for care personnel was introduced on instruction from the National Board of Health & Welfare and would include 15 hours of practical training and 30 hours of theory. In order to be qualified as an ordinary care worker it was necessary to have 4 years of good service record. To gain a position as a principal care worker it was necessary to have undergone a higher theory course involving 50 hours or a proper nurses training which included psychiatrics as well as a years' service.

3.1.4 Treatments

The 1930's saw a whole new range of treatments: insulin, malaria medication, medication induced fever and ECT treatments which replaced other methods such as bath restraining treatments. However, the major changes came about through the so-called

Insulin tools and Medications. Pictures from Hospitalsmuseum, Vadstena, Sweden.

Source: Maria Andersson, Norrköping



psycho pharmaceutical revolution which took place in the middle of the 1950's. Thanks to these new medications it was at last possible to provide qualitative treatments and the patients got better. '

Pharmaceutical preparations such as Hibernal and other so-called narcoleptics affected the patients in ways so that they began to react, live, talk, read, become optimistic and believe in a future. They would be granted leave, work training and in many case allowed to leave. The 1950's and '60's in Sweden are characterised by financial commitment and a revival of the mental hospitals. Large psychiatric clinics were established at hospitals and new, specialised personnel categories were introduced.

3.1.5 "The New Psychiatry"

Psychiatry in Sweden has progressed through a number of major changes to its organisation, the way it is viewed and the treatments given during the latter part of the 20th century. It has formed a part of medical science.

The term "new psychiatry" arrived in the 1960's and is characterised by a new perspective. It came about as part of the massive criticism in the 1960's and '70's from the users, experts, sociologists as well as promoters of the psychodynamic trend. Psychiatry was criticised for being passive-inducing and inflicting institutional harm. The aim was to be part of the society, respect and a dignified life and a more normal existence.

During this period many chronically sick were moved to care homes. Many pointed out that discussion was preferable to medication, de-medicationalisation, no mental hospitals, no forceful actions and the need for reintroduction in society.

Through research a new rating scale has been introduced, new diagnostics and evidence-based treatment methods as well as scientific and biological knowledge about, amongst other things, the importance of transmitters in psychiatric disturbances.

Responsibility for psychiatric care moved in 1967 from the State to the County Council. In the 1980's sectors were introduced as well as an increase in non-institutional care.

3.1.6 Psychiatric Reforms

With the introduction of the Psychiatric Reform in 1995, the municipality's responsibility expanded to include people with psychiatric functional impairments whose medicinal care from the County Council was completed. Institutional care places within psychiatry were dramatically reduced (1967:27,000 – 2003:6,000) therefore the patients were moved from the hospitals to different types of accommodation.

The municipalities were given the responsibility for housing and employment. The result of the Psychiatric Reform is still being discussed in Sweden today. The goal of this reform was to improve the living situation for the psychiatric functionally impaired, brought with it improved welfare and a stronger position for the psychiatric functionally impaired and their relatives.

3.2 History and Development – Substance Misuse

3.2.1 Alcohol

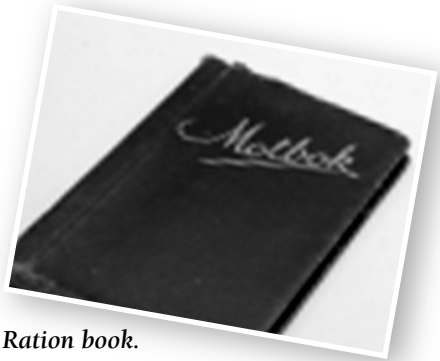
In Sweden, as in other parts of the world, people have throughout the ages and within all culture intoxicated themselves using alcohol and other substances. The reasons given are usually associated with a need to escape as well as a change in experience and performance.

Our Nordic ancestors drank a type of beer called mead. In the mediaeval times around the 15th century, it was discovered that one could produce vodka from corn. This led to a successive increase in drinking amongst the Swedes and reached its peak in the 19th century. This was a major problem and a serious threat to the development of a modern state. During this century, alcohol was often given as a pay benefit and commonly used as a means to cope with the terrible working and difficult living conditions.

The greatest increase in suicides in the history of Sweden occurred during the 18th century and the end of the 19th. Alcohol misuse, poverty and over-crowding were the main reasons for this.

The advance of the temperance movement at the end of the 19th century argued against the "boozing". Opinions grew strong resulting in a drop in alcohol misuse at the beginning of the 20th century. With the arrival of authoritative social care legislation, temperance committees and a rationing system were introduced.

A ration book was brought into operation in 1919 as part of the regulations for the sale of liquor. This involved greater control and restriction of the purchase of alcohol. A referendum was held in 1922 to



Ration book.
Source: www.Fotofinnaren.se

introduce a total ban on alcohol in Sweden. The referendum voted down and instead the ration book remained in operation until it was abolished in 1954 by a parliamentary decision.

At the same time the Systembolaget AB (Swedish alcohol retailing monopoly) was formed. Through an agreement with the State, the monopoly had the sole right to sell liquor, wine and strong beer in accordance with the legislation relating to the sale of alcohol. With the abolition of the ration book alcohol consumption increased considerably, not least of all amongst women in Sweden. Since then Swedes have, on average, been placed in the middle of the European league.

During the 1960's a medium-strong beer was introduced as a drink for young people and sold in the supermarkets. Combined misuse which involves a combination of medium-strong beer and magnecyl (a painkiller) occurred during the 1960's and '70's. Medium-strong beer was thus removed from the market as a significant increase in alcohol consumption amongst the young was noted.

Today light beer and cider with a maximum alcohol level of 3.5% is sold in the stores, the remainder is sold through Systembolaget which has a monopoly. To purchase beer, cider (and tobacco) it is necessary to be 18 years of age which is also the age limit to purchase alcohol in restaurants. To shop at Systembolaget it is a requirement that the purchaser is 20 years of age. Products that have been developed and marketed for younger people include alco pop and strong cider, both of which are available at Systembolaget.

Illegally produced alcohol, home-distilling, occurs mostly in the countryside. It is believed to have reduced since Sweden became a member of the EU in 1995 as customs actions changed due to reduced border controls. Since then illegal private importation and pure smuggling of narcotics, tobacco, beer, wine and liquor has increased in Sweden. Studies show that Swedes have a much more liberal attitude towards alcohol than was the case at the beginning of the 1980's. In 1990, according to official statistics, each Swede consumed almost 6 litres of pure alcohol per year.

3.2.2 Drugs

Narcotics misuse is a relatively new phenomenon in Sweden, even if it is believed that the Vikings were said to use fly agaric (fly mushroom). Also those living in the medieval times used domestic herbs such as henbane and bitter-sweet to intoxicate themselves.

During the 1920's the country was struck by a temporary wave of cocaine which remained until the National Board of Health & Welfare intervened in 1931. The first narcotic legislation was introduced in 1930. In 1942

amphetamine was classed as a narcotic in Sweden. In the 1950's amphetamine became a problem. However it was not until the 1960's that illegal narcotic misuse became widespread first involving amphetamine and a little later, during the hippy era hash and LSD.

Also during the 1950's thinner, solutions and glue sniffing occurred amongst young people. That dramatically increased during the 1970's when the major sniffing wave arrived.

An attempt to provide free narcotics to abusers was started in Sweden in 1965 but was rescinded by the Attorney General in 1967. Abuse increased dramatically during this period and in 12 months the number of injecting addicts in Stockholm doubled.

Illegal opiate abuse really took off with the introduction of pure morphine around 1970. Since 1974 pure morphine has been totally replaced by heroin which has since become the dominant drug of abuse. In 1977 it was calculated there were approximately 2000 heroin addicts in Sweden, two years later the number of addicts using heavy drugs was estimated at 10-14,000 and in 1992 the figure was 14-20,000.

By the beginning of the 1980's narcotics misuse was on the decline but this trend has now turned and over the last few years misuse is once more on the increase. At the end of the 1980's the drug kat was introduced in Sweden and since the beginning of the 1990's, ecstasy has increased.

Source: www.freephotosbank.com

4. Present Situation and Future Challenges

4.1 Present Situation and Future Challenges – Mental Health Care

4.1.1 Present Situation

Mental ill-health has increased in Sweden over the last 15 years. Since 1997 there has been a marked increase in the number of people absent from work through mental illness. Statistical studies point towards a dominance of symptoms such as tiredness, sleep problems, worry, anxiety, nervousness and depressions whilst increases in more difficult mental illnesses such as schizophrenia and psychoses have not been noted.

Most common mental ill-health in Sweden

- **tiredness**
- **sleep problems**
- **worry**
- **stress**
- **anxiety**
- **nervousness**
- **depressions**

Self-reported uneasiness, worry and anxiety dropped during the 1980's only to increase again during the 1990's. Mental ill-health in the form of depressions, anxiety and stress are the single largest reasons for ill-health (24%) amongst Swedish women and constitute one third of all sick absenteeism.

For men, mental ill-health comes in second place (19%) and is responsible for one fifth of all sick absenteeism. It is estimated that about 1.2 million Swedes between the ages of 18 and 64 have mental problems. 210,000 suffer from long-term mental illnesses.

4.1.2 Adults

It is above all young women aged between 15-24 that are the most ill. Since 1986-87 medication to this group has trebled and the use of anti-depressants has increased six-fold. There are many factors responsible for this but changes in society with an increased individualisation and professionalizing during the 1990's is seen as being of importance. Demands and stress has increased, there are many difficult decisions to make, take initiative and get involved whilst at the same time tolerance and failure have "decreased" in society. Some researchers claim that there has also occurred a shift in symptoms towards a greater acceptance for mental diagnoses.

Worry, anxiety, women, 16–84 years, 1980–2005

	2004-05		1996-97		1988-89		1980-81	
	% 16-84 år	stv 16-84 år	% 16-84 år	stv 16-84 år	% 16-84 år	stv 16-84 år	% 16-84 år	stv 16-84 år
Kvinnor 16-84 år	23,4	23,4	20,0	20,0	16,3	16,6	19,8	20,1
ÅLDER								
16-24 år	29,9	29,9	18,7	18,7	8,8	8,8	12,6	12,6
25-34 år	24,5	24,5	17,1	17,1	9,8	9,8	12,7	12,7
35-44 år	22,6	22,6	19,0	19,0	12,6	12,6	15,7	15,7
45-54 år	20,7	20,7	18,6	18,6	16,6	16,6	19,4	19,4
55-64 år	20,9	20,9	20,4	20,4	20,8	20,8	25,3	25,3
65-74 år	23,7	23,7	22,0	22,0	23,1	23,1	30,5	30,5
75-84 år	22,8	22,8	28,0	28,0	31,3	31,3	31,4	31,4
85- år	21,8	21,8	..	..	..	..	..	..

Worry, anxiety, men, 16–84 years, 1980–2005

	2004-05		1996-97		1988-89		1980-81	
	% 16-84 år	stv 16-84 år	% 16-84 år	stv 16-84 år	% 16-84 år	stv 16-84 år	% 16-84 år	stv 16-84 år
Män 16-84 år	13,3	13,3	10,8	10,7	7,7	7,9	9,7	9,9
ÅLDER								
16-24 år	13,3	13,3	10,5	10,5	3,8	3,8	5,4	5,4
25-34 år	13,3	13,3	11,6	11,6	7,8	7,8	9,3	9,3
35-44 år	15,2	15,2	11,0	11,0	7,4	7,4	8,3	8,3
45-54 år	13,2	13,2	11,6	11,6	7,8	7,8	9,9	9,9
55-64 år	13,8	13,8	10,0	10,0	9,0	9,0	11,5	11,5
65-74 år	9,7	9,7	10,0	10,0	8,6	8,6	11,4	11,4
75-84 år	12,0	12,0	9,3	9,3	14,3	14,3	18,2	18,2
85- år	10,0	10,0	..	..	..	..	..	..

Source: www.Statistiskacentralbyrån.se

The 2006 Public Health Questionnaire showed that men but above all women in large urban areas have greater problems with mental health than those living in the countryside in Sweden. This also shows a connection between increased sick absenteeism and increased alcohol consumption, social-economic conditions, stress, offensive behaviour, lack of influence and participation. Factors in the Swedish working life which lead to mental pressure are highlighted as being central in this case.

About 1,500 Swedes commit suicide every year. However, the figure is probably higher as there is thought to be a large number undetected which may include unexplained accidents. Five hundred of these people suffer from schizophrenia or deep depressions and suicide is also common amongst abusers. The number of men who commit suicide is higher than women especially in the north of Sweden. Suicides are also increasing amongst young people and women. The latter category is dominates in the major

cities. The reasons given for suicide are lack of alternatives, loneliness, abandonment and existential pain.

4.1.3 Children and Teenagers

Even amongst children and young people mental ill-health has increased over the last 10 years. Girls dominate in this group and are treated for nervous problems, stomach ache, headache, anxiety, depression and self-destructive behaviour. Boys show, to a larger extent, anti-social behaviour.

Psychological ill-health in children and young people is judged to be a serious health problem in Sweden today. It is an important research area as well receiving special attention from the municipalities, county councils and the government. Factors such as environment during childhood are of especial interest in these studies.

Most of the resources devoted to this area are of a general nature covering organisation, availability and content. Examples of this are pre-natal care, child health care, pre-school child day care, schools, school health care, day care for school children and also youth medical care.

Selected activities for children in danger or in need of extra support is provided by the child and adolescent psychiatric clinics as well as the municipal department of social services.

There is probably a connection between the reduction in pre-school child care and schools which took place during the 1990's and the increase in the number of visits to the child and adolescent psychiatric clinics. A further problem is the lack of coordination and cooperation between the various parties involved in this field regarding preventative support. Research points to the importance of parental support, personnel, number of teachers and competence as well as particular pedagogical activities to deal and prevent abuse, psycho-social hindrances to work as well as psychological ill-health in adulthood.

During the period 1987-1996 the number of teenagers aged between 13-17 years treated in hospital for suicide tendencies increased. During the latter half of the 1990's suicide figures in general within the Swedish population have decreased however this is not the case for women.

4.2 Present Situation and Future Challenges of Substance Misuse

Some of the largest problems facing Swedish society and the medical care system are alcohol and drug abuse. Other associated substances are medicines and liquor for example alcohol, solvents, narcotics and tobacco.

Source: www.Fotofinnaren.se

4.2.1 Medicines

Certain **medicines** are habit-forming and contain narcotics. Today about 1 million Swedes take habit-forming substances. 600,000 use medicine that is dangerous in traffic and of these 150,000 have driving licenses.

Benzodiazepines of the type Sobril, Valium, Rohypnol are by far the most common and classed as narcotics by the Medical Products Agency. These compounds are an internationally acceptable standard product for the treatment of anxiety, concern and sleep problems and were introduced in Sweden during the 1960's. Women and people over the age of 65 are the largest users. Benzodiazepines can be habit-forming even if given in therapeutic doses and it is not uncommon for abuse problems to occur in association with prescribed treatment.

Combination abuse with medication and alcohol and/or narcotics is becoming more common not least amongst women. A study from 1995 has shown that 25% of those with alcohol problems also use tranquillisers. There is a youth-trend in Sweden to experiment by mixing alcohol and prescription-free pain killers which contain acetylsalicylic acid, paracetamol, codeine or dexopropoxifen. In a study, 21% of the girls and 10% of the boys in the last year of compulsory school have admitted to using these substances to intensify and prolong the intoxicating affect in this way. This also occurs amongst older, serious addicts. The sleeping tablet, Rohypnol is becoming more evident within the criminal fraternity in Sweden.

4.2.2 Alcohol

Alcohol consumption in Sweden is on the increase and becoming a noticeable threat to public health. This has been classed as one of the top priorities of the National Institute of Public Health. Spirits, wine and beer are the most common intoxicating substances in the country.

Almost 10% of the adults in Sweden are teetotal. More than 90% of the adult Swedish population has more or less regular drinking habits. The majority have a positive attitude to moderate amounts whilst intoxication and alcohol problems have a negative connotation, especially amongst women. Alcohol consumption, as in the case of the problems relating to it, is very biased within the population.

The proportion of major consumers, those who drink quantities of alcohol which lead to somatic or psychiatric damage was assessed in 2004 to be about 300,000. The number of heavy misuers is calculated at about 75,000. Approximately 200,000 Swedish children and young people live in a home where one or both parent has or have had alcohol and/or drug problems.

After several years of decreasing alcohol consumption levels the figures are on their way up again after membership in the EU in 1995 and are now the highest in the last 100 years. At present, on average every Swede over the age of 15 years is consuming about 10 litres of pure alcohol every year. During 2006 a small decline in general consumption was noted (equal to about one serving of vodka). A more liberal view since the 1980's, fewer alcohol-free zones and increased pressure from outside with extensive smuggling, private purchasing and domestic production are usually given as explanations.

Source: www.Fotofinnaren.se

Source: www.FreeDigitalPhotos.net

Alcohol consumption

Alcohol consumption in Sweden over the years: total and type of alcohol (in litres of pure alcohol (100%) per inhabitant 15 years and older)
Spirits, Wine, Strong beer, Medium strong beer

Alkoholkonsumtionen i Sverige under olika år: totalt och per dryckesslag (i antal liter ren [100 %] alkohol per invånare 15 år och äldre).

Typ av dryck	1976	1989	1990	1993	1995	1996	1998	2000	2001	2002	2003	2004	2005
Sprit	---	3,0	2,9	2,9	2,7	2,7	2,5	2,3	2,5	2,6	2,6	2,8	2,6
Vin	---	2,3	2,4	2,2	2,2	2,3	2,6	3,0	3,4	3,8	3,9	3,9	3,9
Starköl	---	1,3	1,3	1,3	1,6	1,7	1,8	2,1	2,4	2,7	2,9	3,1	3,0
Folköl	---	1,2	1,2	1,3	1,3	1,3	1,2	1,0	0,9	0,8	0,8	0,7	0,7
Totalt *	8,8	7,7	7,8	7,7	7,8	8,0	8,1	8,4	9,1	9,9	10,2	10,5	10,2

Källor: Kühlhorn, m.fl. 2000; Kühlhorn 2001; Leifman & Trolldal 2002; Leifman 2003; Norström 1997; Leifman & Gustafsson 2003; Gustafsson & Trolldal 2004.
Den totala konsumtionen beräknas utifrån den registrerade alkoholkonsumtionen samt utifrån skattningar av oregistrerad konsumtion.

The total consumption is calculated on the amount of registered alcohol consumed combined with the estimated amount of unregistered consumption.
Source: Centrum för socialvetenskaplig alkohol- och drogforskning, www.sorad.se

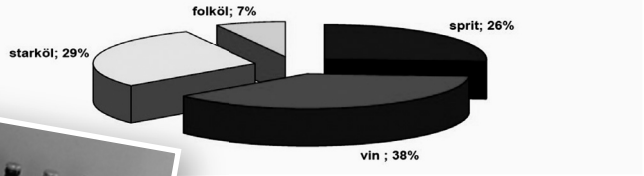
In 2007 the figure was 10.3 litres.

Source: www.Fotofinnaren.se

Alcohol consumption

The total alcohol consumption depicting the various types of alcohol during 2005
Medium strong beer: 7%; Spirits: 26%; Wine: 38%; Strong beer: 29%

Den totala alkoholkonsumtionens fördelning på olika alkoholslag under år 2005.



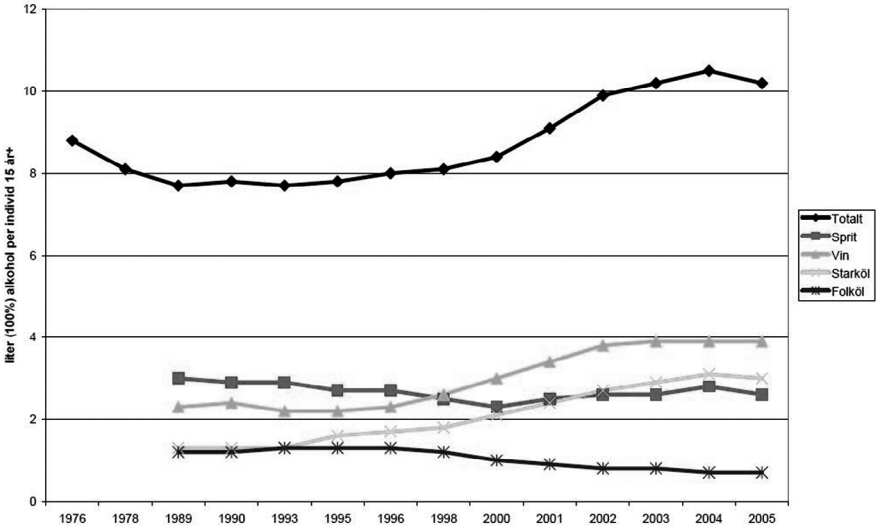
Source: Centrum för socialvetenskaplig alkohol- och drogforskning, www.sorad.se

The proportion of school children using alcohol frequently has dramatically increased, especially involving home-distilling and smuggle sprits with an increase in the number requiring acute alcohol detoxification. During the first

Alcohol consumption

Development of the total amount of alcohol consumed as well as the total consumption of spirits, wine and strong beer in the population 15 years and older.

Utvecklingen av den totala alkoholkonsumtionen samt den totala konsumtionen av sprit, vin och starköl i befolkningen 15 år och äldre. Liter 100% alkohol.



Source: Centrum för socialvetenskaplig alkohol- och drogforskning, www.sorad.se

months of 2008 the home-distlling dramatically decreased in Sweden, probably because of more own import and smuggling.

The social harm in the form of family tragedies, assault, drink-driving is great:

- alcohol is present in at least 75% of violent crimes
- 20-30% of those drivers killed in car accidents are under the influence of alcohol
- 8 out of 10 who die by drowning have alcohol in their bodies
- a noticeable increase in the number of alcohol-related injuries
- 20% of those seeking emergency care are related to alcohol misuse
- 40% within psychiatry are related to alcohol misuse

Almost 6,000 people a year in Sweden die due to alcohol; this is 3-5 times higher than compared with the population as a whole. Mortality amongst younger heavy drinkers has also increased. About 3% of these are suicides and a further 10-15% of

deaths are a direct cause of alcohol's toxic effects, above all cirrhosis of the liver and oesophagus cancer. Ill-health figures are also high with early retirement and low work activity rate.

Source:
www.FreeDigitalPhotos.net

Brain damage relating to social function such as Wernicke-Korsakoffs syndrome and alcohol dements is apparent in about 10% of alcohol-dependent people. Over a number of years institutional care for addicts and compulsory institutional care has reduced in Sweden and the variety of municipal non-institutional care forms has instead increased.

4.2.3 Drugs

Of a total of approximately 240 narcotic-classed substances specified in the Medical Products Agency's narcotics regulations about 30 are misused.

Hash is the most common narcotic amongst young Swedes. The drug is often the way in to misuse of other narcotics and is evident in combination misuse. There is broad, hidden cannabis abuse amongst older, socially established people with families and jobs.

Amphetamine is the second commonest narcotic substance after hash. Curious, young people sometimes drink amphetamine mixed with beer and soft drinks. It has shown that the risk of moving on to injecting the drug is great.

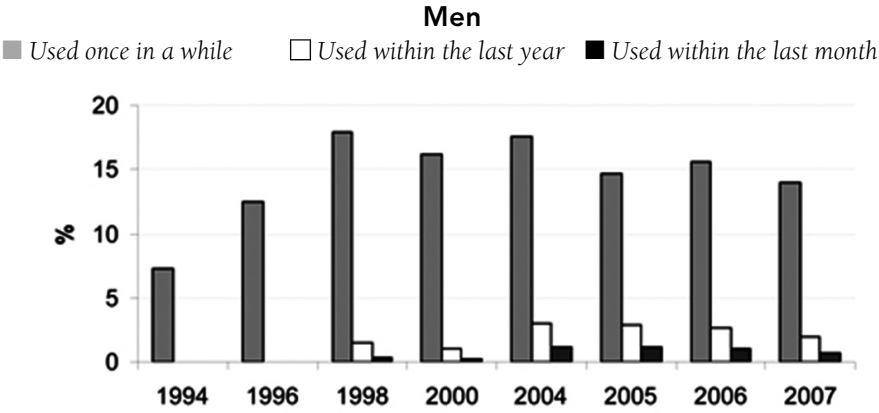
Cocaine is expensive and the spread of this drug is still limited but confiscation is on the increase. Transit traffic through Sweden does occur. The largest confiscation of cocaine was 243 kg by the Swedish customs in 1999.

LSD has undergone a renaissance over the last few years and is available throughout the country. LSD, amphetamine, cannabis and ecstasy are all classed as narcotics, having progressed from being an important part of the rave culture it is now the day party drug for a wide circle and evident throughout the country.

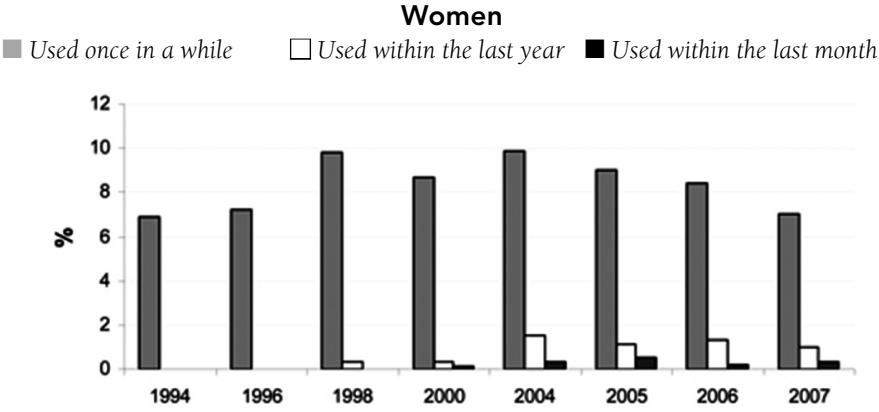
Ecstasy began to spread through the country in the 1970's.

Party drugs in Sweden:
- Amphetamine
- Cannabis
- LSD
- Ecstasy

Experience of cannabis among adults, men and females, 1994-2007



Cannabis use (%) 1994-2007 amongst men 16-64 years (18-64 years in 2004). 1994 and 1996 no questions relating to use during the previous month or year were asked.

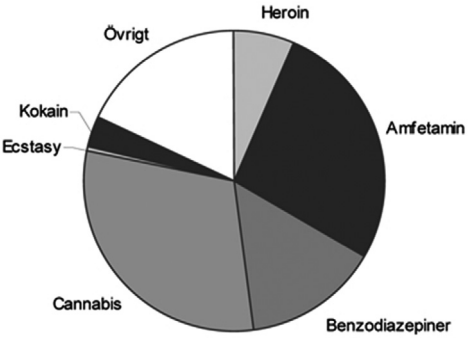


Cannabis use (%) 1994-2007 amongst women 16-64 years (18-64 years in 2004). 1994 and 1996 no questions relating to use during the previous month or year were asked.

Source: Statens folkhälsoinstitut, www.fhi.se

Dominating type of drug used by those in care for the first time. Also depicts the total number of people in care for drug abuse in 2006

Heroin, Amphetamine, Benzodiazepines, Cannabis, Ecstasy, Cocaine, Others



Source: Statens folkhälsoinstitut, www.fhi.se

A new wave of **opium and heroin** misuse has occurred amongst young people over the last few years. Brown, smoke heroin dominates the Swedish opiate market with heroin and crack being less common.

The party and sex drug **GHB** appeared at the beginning of the 1990's as the new in-drug in Sweden. It soon became an accelerating problem with the death of many young people. The substance was sold in health shops until 1990 but after its narcotic classification in 2000 misuse dropped off. Despite this confiscation still occurs. GHB is also used in doping circles together with anabolic steroids, methandienone and somatropin to improve the physical and psychological performance.

The number of school children who have tried narcotics has dropped over the last five years in Sweden. Amongst adults there is a still an extensive misuse of, in the main, cannabis but also the supply of amphetamine has increased. Cocaine misuse is not so widespread but it is very serious and destructive. The supply as well as variety has increased during the 1990's and new drugs appear successively.

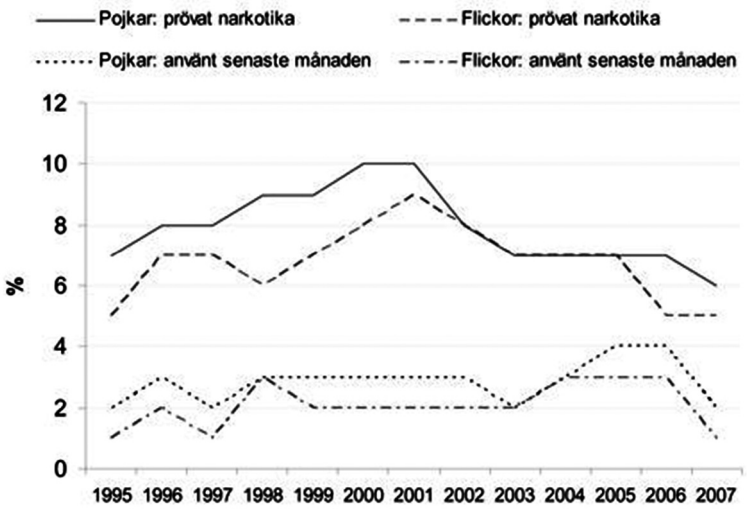
At the end of the 1980's the drug **Kat** appeared on the Swedish market. It was classed as a narcotic in 1989. The leaf from the plant Catha edulis is the most popular. These leaves are chewed which often results in the characteristic discolouring of the teeth. The stimulating affect is similar to that provided by amphetamines. This drug is addictive if used over longer periods and can result in serious social disorders. This is still abused but mostly within a limited group of immigrants from East Africa but a major confiscation occurred in 2006 amounting to 6 tons.

The latest in line is **Dragon-Fly** which has been classed as a narcotic in Sweden since 1 May 2007. Ecstasy as well as other hallucinogenic drugs has become more common and the supply of heroin is abundant. The number of heavy drug addicts is calculated at about 25,00 today.

After a stabilisation in the 1980's attitudes in Sweden appear to have

Use of narcotics amongst school children

Boys who have tested narcotics
Boys who have used narcotics within the last month
Girls who have tested narcotics
Girls who have used narcotics within the last month



Number of school children in the last year of compulsory school (aged 15-16 years) who have at some time tried and used narcotics during the last month during 1995-2007.

Source: Statens folkhälsoinstitut, www.fhi.se

changed. Confiscations by the customs and police have increased as has narcotic-related deaths. It is thought that large amounts enter the country via the former East European countries. There is an over-representation of drug addicts amongst the criminal and crime against property is dominant. Criminality is a care problem as the psycho-social care needs collide with sanctions.

Source: hittabilden.se

Sniffing is a method of intoxication often associated with young teenagers in Sweden. The reason, it is said, is the difficulty in accessing alcohol and narcotics. Over the last ten years it has shown, however, that this type of abuse remains even when the person gets older.

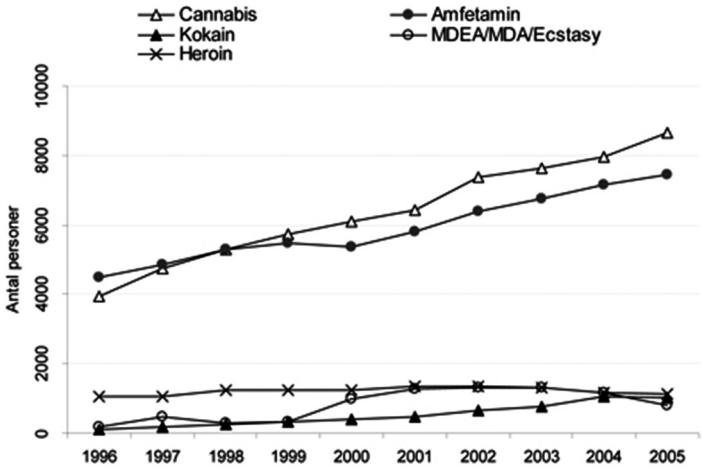
Sniffing solvents and "boffing" gases comes and goes. The signs indicate that it has once more become a common youth problem involving both physical as well as psychological dependency. Besides previously known substances (acetone, benzene, trichloroethylene, turpentine, and aerosols containing propellants) misuse of lighter-gas such as butane and propane also occurs.

A number of teenagers died during the 1990's after having inhaled these gases. About a fourth of all last year compulsory school pupils have sniffed at some time. The illegal handling is difficult to control as the substances are sold legally in stores. Regulations state, however, that they should be stored in such as way as to hinder or prohibit their use by intoxication.

Narcotic crime

Narcotic crimes, number of convicted persons per type of narcotic 1996-2005

Number of people – Cannabis; Cocaine; Heroin; Amphetamine; MDEA/MDA/Ecstasy



Number of convicted persons per type of narcotic 1996-2005

Source: Statens folkhälsoinstitut, www.fhi.se

In 2007 the number of crimes in Sweden associated with narcotics was 73,000. This is a 7% increase since 2006 and the economy is thought to be the main cause. Half of these crimes are associated with personal use.

4.2.4 Smoking

Smoking is diminishing in Sweden. Despite this about 8,000 people die annually due to smoking. Almost 500 Swedish teenagers begin smoking every week, most of them are girls. 80% of them continue to smoke into adulthood.

In 1999 36% of girls and 30% of boys in the last year of compulsory school smoked. If snuff is included in these figures, tobacco use is equal between the sexes in this group. A major study was carried out amongst school children in Stockholm in 1998 which showed that every other young smoker has also tested cannabis but only 7% of non-smokers.

Since 1997 it is prohibited to sell tobacco to people less than 18 years of age and restrictions are also in place regarding tobacco advertising. In 2000, 19% of all adult men and women in Sweden smoked. A few years ago more women than men in Sweden smoked, this is a unique world wide situation. Middle-aged and older women continue to smoke and based on this there is an increase in chronic lung illnesses as well as an increase in the number of deaths due to lung cancer.

The National Institute of Public Health has initiated four goals in an effort to reduce smoking in Sweden:

- The aim is to work towards achieving the following goals by 2014:
- all children will experience a smoke-free start to their lives
- halve the number of young people under 18 years of age who start smoking or using snuff
- halve the number of people who belong in the groups that smoke the most
- no one should experience passive smoking

Source: www.Fotofinnaren.se

4.3 Interaction between Mental Health and Substance Misuse

4.3.1 Double Diagnosis

Misusers run a higher risk of suffering from mental illness and a higher number of mentally ill misuse various types of intoxicating substances. Mental ill-health can be the primary problem or the secondary. Patients suffering from combination illnesses, so-called "double diagnosis" has become a greater problem in Sweden.

Studies show that there are a large number of addict patients who suffer from anxiety, depression and sleep problems. It is calculated that about 40% of all those with alcohol problems and 70% with drug problems also have mental ill-health symptoms. Studies from the beginning of the 1980's showed that the more difficult mental problems addict patients had, the worse the prognosis. Psychoses and manic depressant diagnoses are overrepresented in these groups as are people with personality disorders.

The majority diagnosed with double diagnosis is also combination misusers and misuse anything that is available, for example, drugs, benzodiazepines, solvents, alcohol. They quite often show chaotic misuse behaviour. Every day on average 11 people die in Sweden due to mental ill-health or abuse or a combination.

4.3.2 Treatment Double Diagnosis

For those suffering from double diagnosis it is important that help is given to cover the whole situation. Problems related to treating double diagnosis are to be found amongst the shared responsibility and diverse competencies of the health care, medical care and the social services coupled with the lack of coordination between them and other groups within society. Various care providers are often unaware of the existence of each other which aggravates and compounds this difficult problem.

Follow-ups in Sweden show that people with mental disorders are seldom treated within the misuse and addict care environment. Patients with psychotic problems are normally cared for in a treatment care home under the auspices of psychiatry and receive help for their problems. People with personality disorders are usually to be found within the abuse and addict care environment and do not always receive adequate help and to a higher extent self medicate for their mental problems.

Today's care or treatment is inefficient and requires a coordinated and integrated approach through formalised cooperation between psychiatry, abuse and addict care and the social services.

Plans to cooperate with clear goals and care are necessary. An attempt to improve and develop custodial care forms in cooperation has occurred and a project run by the National Board of Health and Welfare between 1995 and 1997 is one example.

The double diagnosis groups are also a high priority group within the national guidelines for misuse and addict care which the National Board of Health and Welfare presented at the beginning of 2007. Enligt dessa riktlinjer ska personer med blandmissbruk, psykisk störning eller social instabilitet remitteras till specialist för ytterligare bedömning. Detta är extra viktigt eftersom studier visat att många blir av med sina psykiska symtom som ångest, depression och oro vid avgiftning.

4.4 Preventive Work

4.4.1 Preventive Work – Future Challenges – Mental Health Illness

A study carried out by the National Board of Health & Welfare in 2000 showed, however, that there are still failings, especially in work-related social and psychiatric rehabilitation. Despite the Psychiatric Reform of 1995, it is clear that there is a substantial increase in absenteeism due to illness. This is often related to psychiatric ill-health as well as an increase in the number of young people in this category.

In combination with a number of high-profile violent crimes associated with psychiatric ill-health it has led to a psychiatric study (2002-2006). The result became a decision to greater investment in psychiatric care with cooperation and joint efforts, greater availability, an increase in the type of care forms. A clear tendency within Swedish psychiatry is that institutionalised care is shrinking whilst non-institutionalised care is growing.

The Swedish society also has to spend more money to the corner stones:

- non-institutionalised care with special conditions
- increased resources
- increase in competencies within care and social care
- preventative work
- rehabilitation

The general health condition amongst the Swedish population, public health, shall be promoted through 11 national objectives which have been set up. Included in these objectives is mental ill-health as well as the use of tobacco and alcohol. According to the public health objective number 6, by year 2020 the psycho-social well-being of people shall have improved and there should exist an extensive and varied care system which is available for all who suffer from mental health problems.

Included are also two sub-objectives. The first applies to the occurrence of mental problems and the health-hazard they represent. These will be reduced considerably and people will be better equipped to cope with stress in various life situations. The second involves suicide frequencies with the aim of reducing them by at least a third. A substantial reduction should be seen in those countries and sections of population that at present has the highest number of suicides.

The National Board of Health and Welfare has been working since 2004/2005 to devise common principles to ensure good and equal care and treatment provided by the County Councils and municipal social services. These five main principles are:

- preventive actions on group levels
- appropriate care of care seeker
- support and care at initial stage
- provision of care at uncomplicated stage
- treatment and support when cases are complicated or at a serious stage

At year end 2008 it is hoped that a presentation of national principles for the treatment of depression and anxiety illness as well as schizophrenia and other similar schizophrenia illnesses will be possible. These principles will form the basis for local care plans. As far as treatment for schizophrenia is concerned the various psycho-social methods used shall be investigated and lead to recommended common principles.

4.4.2 Preventive Work – Future Challenges – Substance Misuse

The National Board of Health and Welfare presented in 2007 national guidelines for the care of misuse and addicts in Sweden. The background being that the number of abusers has increased in the last ten years whilst care facilities have decreased and treatment methods have not always been based on science. Quality has been eroded as has competence and there exists major regional quality discrepancies.

Misuse care is an area with a variety of currents, for example, various types of "fashionable" therapies. The intention of these new guidelines drawn up by the National Board of Health and Welfare is to find a common ground for preventative better cooperation and an agreement between the medical services and the social services whereby they function as a unit with a common leadership.

The social services have costs the care of abusers in the region of SEK 4.5 billion annually and the figure for the County Council is somewhat higher. These figures added to the costs incurred by regional social insurance offices, treatment of offenders, decline in work etc the cost is in the region of SEK 100 billion.

National directives in order to reduce deficiencies in the care provided to abusers in Sweden (2007)

Detection and preventive activities
Brief advice provided by primary care, A&E departments as well as psychiatric centres and also by Company Health Care providers is an effective method to reduce alcohol consumption by patients in the initial stages of alcohol addiction. A contributing factor is it provides health care personnel with the opportunity of discussing with the patient the situation before the problem has reached a more serious somatic, psychological or social level. In this way it is possible to detect a problem at an early stage and also initiate a dialogue which the patient regards as being respectful.

Two discussion techniques used that have produced good results are FRAMES and MI FRAMES which are based on providing advice and require a basic knowledge of alcohol. MI aims at supporting the patients own reflections regarding their motive to certain behavioural patterns and require a long training process.

A further method used to identify and influence alcohol consumption, a method which has proved successful in Sweden, is screening with feedback. This method is based on the use of biological markers in association with a questionnaire and requires repeat visits which include tests and regular dialogue with the patient. Throughout the screenings it is not only possible to identify alcohol habits that are in a risk zone but also serious alcohol problems. For these people access to suitable treatment must, of course, exist.

It is of course important that the identification and assessment of the problem is carried out in an effective and time-saving manner. This is especially important as time available for each individual patient is limited. Such a sound method for those persons within the risk zone category is called AUDIT.

Assessment instrument and documentation
To detect and assess the level of alcohol and narcotic problem associated with an individual requires various forms of assessment instruments. There are, in principle, two types: the first is a biological test (a marker) and the other a scientific behavioural questionnaire. The biological tests are mainly used to clarify if a problem exists at all. The scientific behavioural questionnaire aims to clarify the nature of the problem and its level.

A number of biological markers fulfil the experts' requirements. To identify a recent completed consumption of alcohol one of the following can be used: EtG, EtS or 5-HTOL. In the case of long-term usage CDT or GT can be used (preferably in combination)

as well as ASAT, ALAT and MCV. To assess the level of the alcohol problem a combination of CDT and GT can be used.

To identify narcotics a urine test is the norm. This can take the form of a fast test which always require verification if narcotics is detected. A safer test result is achieved using the normal urine test as long as it is conducted according to instructions provided by the National Board of Health and Welfare.

AUDIT and MAST are two psychological test methods used to detect alcohol and is regarded as having adequate quality to be used in regular day to day operations and is capable of identifying an alcohol problem. AUDIT is recommended initial with DUDIT being the only established test to be used to identify narcotic usage.

To assess the level of the alcohol problem AVI-R is a tool used within specialist health care. The principles discussed also provide the opportunity of using AUDIT for this assessment. A similar test for narcotics is called DUDIT-E

Investigation, documentation and follow-up
Once the initial identification and assessment of the level of the problem has been carried out an instrument is needed to decide the type of activity, treatment plan and follow-up of the individual's situation and needs.

Many of the assessment instruments used to assess the type of treatment required by a patient can also be used to develop operations and quality. This normally requires relatively extensive training.

Those instruments which meet the requirements of, amongst other things, authenticity include: ASI and DOK. For young patients ADAD or Euro-ADAD quality tested instruments can be used. As a complement to, mainly, ASI, MAPS can be used.

The principles promote the importance of complete documentation of all activities, both in the way they are administered and their results.

Psychosocial treatment and pharmaceutical treatment for alcohol problems

Abstinence treatment
This treatment initially begins with methods to reduce symptoms of, for example, sweats, worry and cramps which can occur as a result of cessation of alcohol consumption. The treatments used in the implementation of abstinence are well developed.

The foremost treatment used for all types of abstinence symptoms is the administration of Benzodiazepines which are most effective. Even clometiazol and beta-receptor antagonists have documented effects on so-called unspecific symptoms such as

sweats and shakes but have little or no effect on delirium tremens or cramps. In the case of abstinence symptoms the use of thiamine (vitamin B1) should always be administered to prevent brain damage.

Pharmaceutical treatment
Within research relating to neurological addiction much progress has been made over the last few years which has led to the introduction of new pharmaceuticals which have considerably improved the treatment of alcohol related problems.

These are mainly acamprosat and naltrexone which have proved effective especially when combined with medicinal advice. Such medical treatment can successfully be provided together with psycho-social treatments. Disulfiram has also shown to give good results when administered under supervision.

Psycho-social treatments
A number of psycho-social treatment methods have proved effective. All these methods are characterised by their aim to change or work-through the individual's problem behaviour. They are aimed at dealing with the individual's abuse as well as other problems which may have existed prior to the alcohol problems, or as a consequence of the abuse. This is mainly used in the treatment of psychologically disturbed abusers.

Rehabilitation outside the health care system
Research into self-healing of alcohol and/or narcotic abusers shows that a considerable majority of people do succeed in overcoming their problems without care or treatment. These experiences and the knowledge gained from these studies all point to a number of important principles relating to treatment.

Long-term
One result gained through knowledge sharing of the long-term treatment of abusers is that participation in self-help groups and a stable social network are important to achieve positive development.

Psycho-social treatment and pharmaceutical treatments for narcotic abuse

Abstinence treatment
For those people involved in a period of intensive narcotic abuse it is often necessary to introduce abstinence treatment. The aim is to alleviate the psychological and physiological reactions which usually occur but also to prepare and motivate the patient to continue with the treatment.

Today there is a lack of specific pharmaceutical methods in the case of abstinence treatment for such narcotics as amphetamine, cocaine, cannabis and hallucinogens. In general, established principles to alleviate abstinence

symptoms such as worry and agitation (excitement or elation) are usually used. Treatments using benzodiazepines or anti-psychotic medicine can also be administered.

Cannabis
In the treatment of cannabis abuse it is important that the personnel have experience in cognitive functions and can identify a reduction in these functions.

Treatment of cannabis abuse should always involve immediate abstinence and the use of psycho-social treatments especially cognitive behavioural therapeutic methods and techniques which have proved successful in the case of other addictions. Cannabis abuse often involves young people, therefore support activities for the abusers' family and close associates should be considered.

Hallucinogens
Hallucinogens are popular party drugs. These include for example ecstasy, LSD and mescaline as well as other preparations which give an hallucinogenic experience such as GHB and ketals. Despite the popularity of these preparations little research into them has been conducted. One reason for this is they are often used together with other drug abuse and are regarded as a complementary drug and attract little interest.

Central Stimulants
Included in this category are amphetamines and cocaine. Studies have mainly been concentrated to cocaine abuse however they are also thought to be applicable to other central stimulants. One of the most effective pharmaceutical treatments is the use of disulfiram. In the case of psycho-social treatments, cognitive behavioural therapeutic methods or techniques are at present the most effective.

Opiates
The National Board of Health and Welfare has previously presented a review of current knowledge as well as instructions and general advice for so-called pharmaceutical assisted treatment. The review of current knowledge presents predominately positive effects of, in the main, the use of methadone and subutex, especially when the treatment is integrated with psycho-social treatment.

Even psycho-social treatments alone have proved to be effective to combat opiate abuse. A number of methods have been used. To attract the abuser to remain involved in treatment for abuse, psychotherapy does appear to be more effective than other psycho-social methods.

Long-term
Within the framework of the role of the expert and the treatment of narcotic abuse, studies have also been carried out to assess the long-term affects of

narcotic abuse. These studies have taken into consideration that the majority of people who have tested narcotics have become free of them on their own without professional help. The area which has attracted most interest is the self-healing process and the way in which this can contribute to the development of professional treatments operations.

Social support activities
Social support activities over and above treatment methods are thought to have a great influence on the rehabilitation of narcotic abusers. When experts have studied research literature some areas have attracted much attention such as the role of the family, work rehabilitation and accommodation support. Reports point out that the family, under certain conditions, can be an important factor if the abuser is to stop or reduce their usage of narcotics. It is therefore important that the care sector assist those family members who function as a support during rehabilitation.

Family Svensson

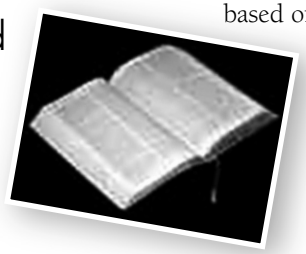
The family represents public health and community problems in Sweden relating to drugs and mental ill-health in the 21st century. The mother Marias long-term depression and the daughter Anna's introverted behaviour are, in combination with anxiety, worry, stress, sleep problems, psycho-somatic symptoms in the form of stomach ache and head ache as well as self-destructive behaviour, usual. These problems are on the increase and overrepresented amongst young girls and women in the active age group. The girls turn their problems inward whilst the boys, as is the case with the son in this family, often behave anti-socially.

The social problems of various types of drug abuse in the form of family tragedies, economic problems, unemployment and offences against the law exist in family Svensson. It has gone so far that resignation and hopelessness have taken away from the family the initiative to take charge and do something with their lives.

Anna's isolation, the son Johan's increasing truancy and growing abuse are dangerous signals that the family cannot cope and are in need of professional help.

5. Legislation and Policy

5.1 Legislation and Policy in Mental Health Care



5.1.1 Tradition of Compulsory Care

The Swedish society has throughout time assumed the right to lock up the mentally ill to provide care and Sweden has been well-known, in earlier times, for the relatively high number held in care without consent .1858 saw the arrival of the first regulations covering psychiatric care in hospitals. Included in these regulations were matters relating to compulsory care.

Not until the beginning of the 1930's was a regulation in place allowing voluntary care at mental hospitals. A change of direction during the latter half of the 20th century led to the number of people in compulsory care being reduced and in 1966 regulations relating to compulsory care were introduced – Act on Compulsory Psychiatric Care (LSPV, 1966).

5.1.2 Voluntary Care Today, HSL, 1982

Today people are usually treated within psychiatry under the **Health and Medical Services Act (HSL)**. This is an all-embracing act and is based on voluntary actions. All compulsory measures are forbidden and the patient has the right to leave the medical centre whenever he chooses.

According to HSL the *aim is*

- *good health and care on equal terms for the whole population*
- *good quality care which*
- meets the care-receivers requirements of safety in the care establishment and the treatment
- is designed and given in consultation with the patient
- is easy accessible care
- is based on respect for the patient's self-determination and integrity
- promotes good contacts between patient and the health and medical personnel
- informs the patient or his relatives on the state of health and of the treatments that are available.

5.1.3 Compulsory Care Today, LPT, 1992

The **Compulsory Mental Care Act (LPT)** came into force in 1992 and replaced the Act on Compulsory Psychiatric Care (LSPV, 1966). This was a complement to HSL in regard to psychiatric care relating to compulsion and other restrictions.

The intention of this Act is to provide care on a voluntary basis after in-patient treatment has been provided. The person in question must be informed of his legal rights. In order for LPT to be implemented three conditions must be met at the same time. The person must:

- be suffering from a serious mental disorder that it is deemed there is danger he will hurt himself or others,
- has to refuses care of lacks the ability to express this and due to his psychological condition and personal circumstances
- has an indispensable need for care which cannot be provided in any other way other than through 24 hour care in a care establishment.

A mental certificate (no more than 4 days old) drawn up after being examined by a licensed doctor will be the basis for a decision on invoking LPT. Within 24 hours the Chief Medical Officer at the psychiatric clinic will determine if the compulsory care order is warranted which initially runs for 4 weeks.

If a further period of compulsory care time is needed over and above the initial four weeks, the Chief Medical Officers can seek an extension from the County Administrative Court. This care period can be extended to four months, followed by a maximum of 6 months at a time. If the application for extension is rejected the care period ceases immediately.

5.1.4 Care Instead of Prison, LRV,1992

Forensic Psychiatric Care Act (LRV) was brought into operation in 1992 and is applicable when psychiatric care has been associated with deprivation of liberty or other restraint to those who based on a court decision:

- *granted psychiatric care*
- *arrested*
- *held in custody*
- *admitted to a unit for forensic psychiatric study*
- *admitted to or is to be sent to a correctional facility*
- *suffering serious mental disorders*
- *after having taken into consideration the mental state and personal circumstances need psychiatric institutional in-patient care*
- *refuse this care or lack the capability of expressing an opinion.*

Care is provided at specific forensic psychiatric clinics managed by the County Council. The care ceases when the person in question no longer suffers from a serious mental disorder. Another reason for this is if the consideration taken to his mental state and personal circumstances no longer warrant the need for institutional in-patient care.

5.1.5 Community Care, SOL, 2002

Legislation relating to the actions of those people who suffer from mental

disorders or impairments expects these people to be active and capable of taking initiative. It assumes that the person can plan, make decisions, seek help when needed and understand as well as take responsibility for his actions.

The Social Services Act (SOL) (1982, 1998) 2002 is an overall Act based on voluntary participation and sometimes refers to people with mental impairments. The Act is based on a comprehensive view and belief in the individual's ability to affect his own situation.

This Act regulates the responsibility of the municipality's regarding people

- with mental impairments
- who have difficulties in looking after themselves
- who should be given the opportunity of participating in society and live as others, for example, meaningful employment and housing.

It is usual that people with serious mental disorders and impairments are unable to cope on their own without support, help and guidance. Due to these situations an addition has been made to SOL. This indicates the responsibility of the municipality to arrange for visiting, investigating, supporting and motivating operations, they shall also be cognisant with the group's living conditions as well as coordinating with other authorities.

5.1.6 Particular Support in the Community, LSS, 1994

The Act concerning **Support and Service for Persons with Certain Functional Impairments (LSS)**, 1994, is an Act of Rights and will guarantee that those with the most serious impairments will be provided with a good standard of living.

It contains conditions relating to *actions for particular support to people with permanent mental impairments which result in major difficulties in their daily lives and therefore are in need of extensive support or service.*

The actions the individual has the right to expect include advice, personal support, guidance/companion service, help from a caseworker, short-term accommodation outside the home as well as housing particularly adapted and providing service for an adult.

5.1.7 Psychiatric Reform, 1995

A psychiatric study conducted at the beginning of the 1990's showed that people with psychiatric impairments were the most neglected group requiring support within Swedish society. This resulted in the **Psychiatric Reform** in 1995 which was based on the rights, elderly psychiatric delegation and rehabilitation perspectives. The basic idea was to provide better welfare and improve the position for these

groups and their relatives within the Swedish society.

According to this reform people with mental disorders:

- *shall have the same rights and responsibilities as others*
- *shall be offered actions according to individual requirements and needs based on their own choices and priorities*
- *shall be given access to necessary actions within the local community*
- *shall be given support regarding independence, integrity and individual welfare*. With the introduction of this reform, responsibility was divided between two main authorities: County Council and the Municipality.

5.2 Legislation and Policy in Substance Misuse Care

5.2.1 Three Laws Become One

At the beginning of the 20th century Sweden gained its first real social welfare legislation. This divided the various social problems into areas which resulted in three laws: an **Act on the treatment of inebriates in 1913 (Alkoholistlag)**, Poor Law in 1918 (Fattigvårdslag) and Child Welfare Law in 1924 (Barnavårdslag).

In the 1950's new legislation was introduced amongst them were the **Law on Temperance, 1994 (Nyktrhetsvårdslag)**. The old ways of thinking regarding anti-social problems still permeated the authoritative spirit. Actions were characterised by a Big Brother attitude, force, punishment, admonition and warnings.

Discussions about democracy during the 1960's and 1970's involved a new way of thinking and view of people. This was based on developing more individual solutions with less involvement in detail. Focus became coordination, an overall view, preventative methods and service. This three-pronged organisation with its various committees and administrators appeared to be forced and irrational. The needs that were regulated in the different legislation was often to be found within the families. ***För att få en helhetssyn slogs därför lagarna ihop till en enda, SOL.***

5.2.2 Social Services Act, SOL, (1982, 1998) 2002

As a part of this discussion and the Government's social report (1967), the **Social Services Act (SOL)** came into force in 1982. It was reworked in 1998 and was replaced in 2002 with new social legislation. The law stated that the social services individual and family care units were responsible for providing support and treatment to individuals and families. It could be related to economic problems, problems with children and young

people, misuse and other social problems:
"The municipalities are ultimately responsible for those living within the municipality have the support and help they need" (SOL § 3).

According to the Social Services Act it is the municipalities who bear main responsibility for the treatment of people with alcohol and drug problems:

"The Social Welfare Board shall actively work towards providing the individual with the help and care he requires to be free of his abuse. The Board shall, together with the individual, plan the help and care and scrupulously follow-up these plans."
This is a coherent and goal oriented basic Act allowing for great individual freedom for each municipality to formulate as they will. It is based on the overall view and belief that the individual is capable and takes into consideration freedom, democracy, solidarity, self determination and responsibility. SOL proceeds from the need of the individual and providing that person with a reasonable living standard. The act places great importance on preventative and community improving work, rehabilitation and treatment development.

In 1998 SOL underwent a reformation to adapt it to the changes that had taken place in society with objectives and goals that were more suitable to the time. The foundation and the objectives are the same. The difference is a new way of thinking, incorporated to test and adapt means and working methods to suit the actual situation.

5.2.3 Support Laws to SOL

SOL does not contain any compulsory actions and work within the social services is based on voluntarism and agreement. There however does exist occasions when the social services must use compulsory actions. As a support to SOL there are a number of additional Acts.

In the case of children and young people it is possible to use the **Compulsory Care of Young Persons Act, 1990 (LVU)** to invoke compulsory measures for those under 18 years and if necessary care cannot be given voluntarily. This can involve maltreatment, misuse, inappropriate exploitation, lack of care and home conditions that involve risk for physical and mental health and development.

In regard to abuse, the **Compulsory Care of Alcohol and Drug Abusers, 1988 (LVM)**, can be used to provide treatment against the will of the individual. People shall be over 20 years of age and in need of treatment to get away from the addiction. This is used by them as a result of their misuse of alcohol, drugs or solvents and subjects their physical and mental health for obvious danger and they are in turn likely to harm themselves or others.

The Compulsory Care of Intoxicated Persons, 2001 (LOB) allows for the involuntary care of an intoxicated person who is not able to care for himself or is a danger to him or others. After sobering up in a special unit for a period of no more than 24 hours or in a police cell for a maximum period of 8 hours the person in question should be informed of available help and motivated to seek such help and support.

Persons with abuse problems as well as mental ill-health can be taken into care against their will according to the **Compulsory Mental Care Act, 1992 (LPT)**. In such cases a doctor's certificate is necessary at the time of compulsory care.

5.2.4 The Traffic Offences Act, TBL

The Traffic Offences Act, 1951 (TBL) regulates drink-driving as well as other drugs. A person who is driving a motor-driven vehicle has been drinking and is recorded to have at least 0.2 permille in their blood or 0.1 milligram/litre exhaling breath, or has narcotic substances in their blood is breaking the law. He will be deemed as being under the influence and is not capable of driving in a safe manner.

He will be sentenced to a fine or prison for a maximum of 6 months and his driving licence will be rescinded for a period of 1-12 months. If in the case of a serious drink-driving offence the prison time can be for a maximum of 2 years and the driving licence taken away for 12-36 months.

5.2.5 Narcotics

Sweden has embraced all of the **United Nation's narcotic conventions from the 1960's** onwards. Narcotics in Sweden are therefore only to be used for medicinal or scientific purposes and all criminal dealings are to be fought. National stringent legislation and regulations were implemented during the second half of the 1990's.

The Criminal Code Relating to Narcotic Drugs 1968, regulates the punishment for criminal actions which today, after some additions, involves:

- possession
- use
- handling of
- transfer
- production
- storage
- acquisition
- process
- packaging
- transport
- sale

All narcotics are listed on the **Medical Products Agency's narcotics register** and are therefore deemed to be narcotics in the legal sense. Legislation relating to narcotic-classed substances in Sweden states that it is illegal to

- *use, purchase or in any way at all possess narcotics*
- *to sell, exchange, lend or give as a present*
- *cultivate or process narcotics in any other way.*

Narcotics are not to be repackaged, transported or stored. Further it is not permitted to arrange contact between purchaser and seller or assist in the transfer of payment between purchaser and seller.

The punishment for narcotics offences depends on the seriousness of the crime. For insignificant narcotic offences a court of law can sentence the offender to a fine or prison not exceeding 6 months. More serious crimes will always involve a custodial sentence, normally for a maximum of three years. If a crime is considered serious the sentence will always mean prison for a minimum of two years with a maximum of 10.

Family Svensson

The Social Services Act (SOL) is intended to provide support and treatment for the individual and the family in regard to economic problems, problems with children and young people, abuse and other social problems is relevant in the case of family Svensson.

According to the Swedish Education Act, the school's personnel are responsible to report suspicions of child mistreatment to the municipality's social services. The pupil's council comprising of a school nurse and welfare officer work together with teachers and mentors in these case and should, in this situation, contact the social services for an investigation into the family circumstances. If it is judged the child requires care the school or the social services will contact the Child and Adolescent Psychiatry (BUP) within the boundaries of Health and Medical Services Act (HSL).

Others Acts which can be involved in this area are also Compulsory Care of Young Persons Act (LVU), The Compulsory Care of Alcohol and Drug Abusers (LFV), The Compulsory Care of Intoxicated Persons (LOB) as well as The Criminal Code Relating to Narcotic Drugs.

6. Service Provision

6.1 Service Provision for Mental Health Clients

6.1.1 The National Board of Health and Welfare

The National Board of Health and Welfare has supervisory responsibility for all psychiatric care relating to standardisation, development and supervision of health care as well as the social services. The work contains follow-ups and reports of the results of the psychiatric reform as well as the national plan of action for health care.

6.1.2 The County Council

The County Council is responsible for all psychiatric disorder emergency care. Included in this is responsibility for and availability of general psychiatric institutional in-patient care places as well as units with under-specialities including misuse, psycho geriatric, and forensic psychiatry.

Employed at the psychiatric clinics are psychiatrists, nurses, mental attendants, occupational therapists, welfare officers, psychologists, physiotherapists and medical secretaries with responsibility for specialist psychiatric care for adults living in the community.

The goal of the daily operations is to, based on the individual's rehabilitation plan, be meaningful, structured and function as preparation for work training. The day care operations cooperate with the out-patient care clinics, the recreational operations and housing support.

6.1.3 Child and Adolescent Psychiatry, BUP

Child and Adolescent Psychiatry (BUP) has both consultant organisations as well as institutional in-patient care for young people up to 18 years of age. The psychiatric institutional in-patient care places are often connected to the somatic hospitals. When a person has completed his medical treatment provided by the County Council responsibility for any continued treatment or care is passed to the initial municipality.

6.1.4 Mobile Team

Mobile emergency teams, who are on duty 24 hours a day and comprise of a doctor and nurse, replace the psychiatric clinic's emergency services but do not exist in all County Councils. The teams are given assignments by out-patient medical services, family doctor, police, and social services or directly from the patient or his relatives.

6.1.5 Out-patient Care

Out-patient care forms are run on the same lines as primary care, psychiatric clinics, day care, crises team, consultancies and psycho therapy. Out-patient care forms work together with the institutional in-patient care centre at the nearest psychiatric clinic, the social services, the regional social insurance office and the local employment office.

The semi-out-patient care forms, which are the responsibility of the municipalities, include treatment homes, group housing with 24-hour care, training apartments, own housing with assistance from the home-help organisation as well as support to the relatives.

The home-care teams comprise of nurses and attendants whose responsibilities are to give support to the patients in their own home. So-called self-help. These are people who already have contact with the out-patient system but require extra psychiatric support in the form of help to self-help in the home. This is available in certain Swedish municipalities. Housing support works closely with the out-patient care system as well as the day care and school-aged child care organisations. Those municipalities who do not have a particular housing support system the responsibility lies with the home-help organisation.

6.1.6 Hobby Occupation

Organisations responsible for hobby occupations can either be arranged by the municipality or voluntary organisations, for example IFS and RSMH (Swedish National Association for Social and Mental Health).

6.1.7 Personal Representative, PO

For a person with mental impairments to receive communal support which leads to an independent life with as little professional help as possible, the opportunity exists to apply for a support person, a Personal Representative (PO). The County Administrative Board is the supervising authority for this operation.

A personal representative shall be a personal support and amongst other things provide crises support, visiting operations, devise an individual plan with the customer, coordinate actions, guarantee continuity and make use of all resources. Those who can make use of these services are people with serous and permanent mental impairments who are also in need of help.

6.1.8 Trustee

If a person, with or without mental impairments is not able to manage his economy or in any other way has difficulties functioning in society, they can receive the help of a Trustee. This

person is responsible for taking care of his customer's person, to see that he is well cared for, administer his property and safeguard his interests.

6.1.9 Primary Care

Primary care (care centres) diagnose and treat patients with anxiety conditions , depression, crises, psycho somatic conditions, mental ill health related to somatic illnesses as well as age-related mental symptoms.

6.1.10 Voluntary Organisations

A number of voluntary organisations in Sweden work at improving the situation for those with mental disorders, for example:

- Riksförbundet för social och mental hälsa – The Swedish Association for Social and Mental Health
- IFS Intresseförbundet för personer med schizofreni och liknande psykoser – an interest association for people with schizophrenia and similar psychoses
- Fountain House
- Stödföreningen för drabbade av Panikångest och Social fobi – a support association for those suffering from panic attacks and social phobias,
- Stadsmission – The Stockholm City Mission
- Röda Korset – Red Cross

6.2 Service Provision for Substance Misuse Clients

6.2.1 The National Board of Health and Welfare

The National Board of Health and Welfare monitors the care of abusers within the healthcare system. It also compiles information about the County Council's monitoring of the work carried out by the social services. The National Board of Health and Welfare compiles official statistics on this area, it maps the activities of the abusers as well as works with developing processes aimed at guidelines, quality indicators and the gathering of know-how.

The aim of these national directives governing the care of the abuser and addict is to develop and improve knowledge, methods and techniques. These directives shall be used as guidance by both the social services as well as within the healthcare sector.

In the last few years the National Board of Health and Welfare has, for the first time, devised national directives in order to reduce deficiencies in the care provided to abusers in Sweden. These directives are also intended to even out the major regional differences in quality (4:4:2)

6.2.2 The Social Services Act, SOL

SOL – The Social Services Act – states that the social services shall work towards preventing and discouraging the misuse of alcohol and other addictive forming substances within the population. They should provide the inhabitants of the municipality with information relating to various types of drugs, their harmful effects and the legislation relating to this area. The social services shall also provide information about the opportunities available for support and help as well as organise operations to seek out those that have not yet sought help themselves.

In general the main care of abusers in Sweden is based on out-patient and institutional in-patient care. This can be on a voluntary or compulsory basis.

6.2.3 Out-patient Care

Out-patient care comprises of out-patient team within the social services called institutional homes for care or housing (HVB). These institutions are privately-owned and run on behalf of the municipalities and the County Council. The operations are based on various work methods and treatment philosophies: treatment programmes, work, training, recreational activities, social training, environmental therapy, group discussions, and individual psychotherapy.

6.2.4 Institutional In-patient Care

Some abusers are treated at mental clinics or drug addiction clinics. There are also many abusers within correctional facilities. The social efforts regarding different types of misuse are similar: practical help with economy or other assistance, support discussions or dialogue treatments, caseworkers, a support family, or placing in an appointed family home or treatment centre.

6.2.5 Voluntary Organisations

A number of voluntary organisations in Sweden work at improving the situation for abusers, for example: Frälsningsarmén – The Salvation Army, Sällskapet Länkarna – The Link Society, Röda korset - Red Cross, Stadsmissionen – The Stockholm City Mission, Anonyma Alkoholister - AA, Alkoholproblematikers riksorganisation (ALRO) – The Swedish Alcoholic Problematics Association, RIA, LP Stiftelsen – LP Foundation. Verdandi, RFHL – National Association for Aid to Drug Abusers and FMN – National Swedish Parents Anti-Narcotics Association.

6.3 Service Provision for Dual Diagnosis Clients

Population studies show that people with alcohol or narcotic problems have a clear increased risk to suffer psychological illnesses and personality disorders. The most obvious diagnosis is depressions and anxiety illnesses. This category of people is very diverse and displays a wide variety of symptoms and problems. What they do have in common today is they receive inadequate help and treatment, in some way due to where responsibility for this group lays which in turn impedes both diagnoses of their condition as well as continuity in their treatment.

6.3.1 Identification and Assessment

Identification and assessment is a problem today as the principle representative often lacks routines to diagnose and assess both the abuse and the psychological illnesses or disorders. It is therefore important that this takes place.

One solution would be to allow the health care sector to create a system which would include both strategies as well as the competencies which would make use of the screening and risk assessment instruments which have been developed. In this way such methods such as AUDIT, which was mentioned earlier, can be used in a wide area. This test can also provide information on suicidal tendencies, aggression and level of dangerous behaviour.

6.3.2 Treatment

Today there is no treatment for abstinence or any other specific treatment for people suffering from both abuse and other, mainly, psychiatric illnesses. Therefore, in general, such methods which have shown to be effective on people who do not suffer from psychiatric illness should be used.

Treatment for depression and anxiety should, of course, involve anti-depressants or buspiron, however these treatments do not have any known affect on abuse or addictions. There is a case for early testing of preventative methods which includes brief advice for those people assessed to have minor problems.

An important conclusion regarding all treatment of this category of people is that treatment should be coordinated. Experience from such teams or units where the treatment of both the condition and the incorporation of social activities has proved good.

Family Svensson

The efforts that can be employed in the case of the family could include economic or other assistance. Dialogue treatments individually or in the form of family therapy are also needed. The family will be informed and the efforts employed will lead to upholding their rights. Basically the family must be seen as a resource despite their problems and providing them with the support so that they can make use of their own functions. Decisions for care and help are made together with the family as far as are possible.

Maria requires treatment for her depression the Health and Medical Services Act (HSL) as well as support, relief and help to build up a functioning network which can be in the form of, for example, a support family (the Social Services Act (SOL)).

The Lars should be informed and motivated to accept treatment for his misuse which could be either out-patient or institutional in-patient care. If he does not agree to voluntary care then compulsory care in accordance with Compulsory Care of Alcohol and Drug Abusers (LVM)) can be invoked.

The parents are guardians of their children until they reach their majority at the age of 18. Any decisions regarding actions for their children are taken together with the mother and father. If this is not possible then the Compulsory Care of Young Persons Act (LVU) can force children under the age of 18 years to accept treatment if there exists abuse or deficiencies in care and home conditions which could prove harmful to their psychological and physical health and development. In these situations the children can be taken into care and placed in an appointed family home, a temporary appointed family home or a treatment centre.

7. Working with Clients

7.1 Principles of Working with Clients

The central functions of the social services and the health care organisations are to promote and maintain good health, functional abilities, quality of life and welfare. Included are also preventative measures, treatment of illnesses and suffering as well as rehabilitation efforts.

Treatment within the Swedish psychiatric and misuse care sectors can be out-patient or institutional in-patient, voluntary or compulsory. Over the latter years there has been a reduction in the amount of institutional in-patient treatment and an increase in out-patient.

The work shall be conducted in agreement with the receiver and based on the individual's needs and the relationship between the care attendant and the client. Common to all professional categories within the social services and the health carers is the requirement for broad knowledge and capability as well as good and well-thought-out basic values.

The personnel must be able to visualise the whole picture and able to make fast decisions as well as solve problems in critical situations – to identify, judge and act in an adequate manner. They must also have the ability to reflect, evaluate and develop their own as well as that of others professional roles. They must be able to work with different types of people and function in strong and close cooperation.

Official Secrets Act 1980 and Lag om yrkesverksamhet på hälso- och sjukvårdens område, 1995 applies to all those working within healthcare in the public sector and within the social services. Legislation regulating secrecy and professional secrecy is in place to protect the patient. Personnel are not permitted to interfere with details relating to the condition of the patient or other personal conditions. An offence against this legilsation is punishable by a fine or prison.

7.2 Multidisciplinary Team

Psychiatric nurse
- a member of the psychiatric team together with doctors, psychologists, counsellors, psysiotherapists, occupational therapists and carers

Psychiatrist
- a doctor with special training in qualified psychiatric

Carer/auxiliary nurse
- works with caring, helping and supporting people within the psychiatric care sector on a psychiatric ward or an out-patients clinic
- work with mentally functionally impaired people within the municipal operations at a group home or day centre
- provide support and service in the home, called accommodation support or carer
- activate and support people so that they may become part of society's daily activities

Treatment assistant /social educationalist
- work together with people who have various social problems: destructive home environment for children, ill-treatment, abusive treatment, substance abuse

Social welfare officer / field worker / social assistant
- provide help and support to people and families who have problems: economic, substance abuse, unemployment, problems within the family hold dialogue and provide support to help the person/family find solutions to the problems

Psychologist
- motivate people and try to improve their life situation and help them discover resources and needs
- provide support to other professional categories
- have taken part in basic training for psychotherapists

Counsellor
- help people to find solutions to their problems and support people in various living situations

Occupational therapist
- train people so that they may function in every day life after an illness or an accident and also help those cope with birth defects

Personal assistant
- provide support to people with functional disabilities and help disabled people or people with a mental deficiency
- support people so that they can live their lives as they would like to

Personal representative
- work with individuals suffering from psychological functional difficulties and give them support in their meetings with care, support and service providers such as authorities and institutions
- most often employed by the municipality but works with private organisations

Recreation leader
- usually works with young people but also elderly people
- support and coach in common and safe environments, activate and arrange visits

Family guidance officer
- work with couples who are experiencing conflict and problems in their relationship
- give advice and information and make it possible for people to find solutions themselves

Benefit assessor
- investigate an individuals' need for help and support from the municipality home service, personal assistant or special accommodation
- imployed by the municipal care and welfare department

7.2.1 Mental Health Care

Besides **care attendants**, the psychiatric care centres also include **psychiatric nurses, psychiatrists, aid administrators, social workers, occupational therapists and physiotherapists**.

Psychotherapists can involve welfare officers, psychologists, psychiatrists, psychiatric nurses or mental attendants and work for the County Council, Municipality, various organisations or in the private sector. Every individual psychotherapist bases his treatment on for example, psycho analysis, behavioural modification, cognitive theory or transactional analysis.

The majority of Swedish municipalities have a psychiatric coordinator and access to a Personal Representative, Trustee, Mobile team as well as voluntary organisations.

7.2.2 Substance Misuse

Abuse care institutions, run by County Council's, municipalities, various organisations, and foundations or under private ownership, can incorporate different types of treatment philosophies. Working within the municipalities social services are **social workers** who are graduated from a school of social works and public administration.

Attendants and **auxiliary nurses** within the misuse care sector operate within the home care sector, housing with special services, day care centres or treatment centres. There areas of work include providing support and help to the misuser and their family, to see their basic needs are met, stimulate participation in activities, and healthcare information, inform, observe and communicate any changes to care needs.

Health and medical staff are also to be found in staff at the County Council units for sobering up, detoxification and abstinence care. Employed the municipalities to work with practical aspects with the clients are also **social educationalists** and **treatment assistants**. Specific **field assistants** work with seeking out and preventative operations aimed especially at young people.

The personnel working in the treatment centres are often referred to as **dependence therapists** specialising in care and treatment with social training, environmental therapy, work, training, recreational activities, group discussions and individual conversation. A close, working relationship also exists with the police, employment office, regional social insurance office and voluntary organisations.

7.3 Ethical Codes and Communication

Care ethics are associated with how one is treated in the care sector and the situation that exists when people meet. This is the core of all care and treatment.
Swedish legislation is based on a humanitarian view of people, to be subjective, where the patient is a participating resource, a person who can, wants to and should take responsibility for his actions.

The Psychiatric Reform of 1995 stressed the family, client and user perspective which means a shift of power from the employee to the person with the physical impairment. Operations within the mental and abuse care sectors shall be permeated by value which shall be mirrored in the daily work. Respect for life and empathic treatment, equality, justice, autonomy and responsibility shall be the basis.

Included in the ethical principles are the unimportance of a persons position, situation in life, gender, age, religion, culture, background, race, conviction and opinions, and a respect for the integrity of the client/patient/user, personal values, philosophy and the right to make a decision. The work shall involve informing and meeting the rights of the individual. Care shall take place in accordance with the individual as far as possible.

Sometime it is necessary for the provider of care to assume the role of decision-maker. This is strictly regulated and is prescribed in the legislation for the protection and the security of the patient and may only occur if a lack of respect for integrity does not take place.

Communication comprises of intellectual, emotional as well as social. Conversation, which can be supportive, relieving, motivational or investigational, is used as a tool which is affected by the social correlation and the relationship between people.

Within Swedish psychiatry and misuse care the same empathic principles apply as for other forms of care. It is important to create a functioning cooperation on the level of each individual. This also requires a need to be keenly aware and vigilant of everything one says or does as the people a care worker is helping are vulnerable.

It is important to talk *with* and not *to* a person. Clear communication with an involved and participating patient who understands what is being said is one of the cornerstones of the Swedish healthcare system. Conscious and well-thought-out treatment is the basis for mutual cooperation, built on respect, loyalty, involvement and interest. The foundation is to create security, to

have a positive attitude, to be plain, clear and honest and to set up realistic boundaries.

7.4 Working Methods

7.4.1 Working Methods - Mental Health

The work of an attendant in a psychiatric clinic is to accompany a patient and provide support during activities, examinations and treatments.

This work is often conducted by pairs or in groups. Caseworkers who have special responsibility for one or more receivers provide greater continuity for the receiver and deeper contact with the personnel. A caseworker helps with the physical needs as well as providing help and support in the home. This person is also responsible for providing the receiver with information as well as therapeutic conversations and documentation. Even when the receiver has been discharged, in long-term care, the caseworker remains.

The investigation into mental ill-health uses a number of different screenings, classifications and risk assessment instruments. The most common instrument for the classification of mental illness in Sweden is DSM IV (Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition) and ICD (International Classification of Diseases). The condition is coded based on specific criteria which provide support and advice when diagnosing.

There are a large number of psychotherapy forms which are used more or less frequently depending upon actual currents within psychiatric care. These can be divided into three groups:

- structured dialogue
- emotional liberation methods
- behavioural direction methods

Examples of therapy forms are psycho-analysis, transactional analysis, gestalt therapy, picture therapy, hypnosis to name but a few. These can be used as support, insight or promoting the discussion and shall take place either individually or in a group.

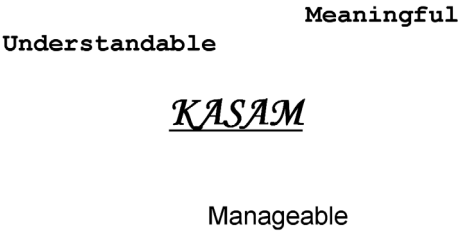
All, however, have the same goal, to create free, harmonious people who dare to take responsibility for their lives. Often the treatment involves strengthening a patient's self-esteem and helping them to control their feelings. Besides psycho therapy there are also a number of other methods that made use of medicines and various type of specialised treatments such as ETC and light therapy.

One method used within psychiatric rehabilitation is the Boston model. The aim of this method is to make use of the person's inner resources and opportunities. The model covers goal, development planning, skills upgrading and application. Included also are club operations such as Fountain House

which strives to involve the users resources and provide a meaningful occupation and probably the most important aspect of all is to help people to be seen and give them a feeling of being needed.

The municipal psychiatric care is based on supporting all forms and in all types of social networks. The municipality is responsibility for accommodation and accommodation support based on providing help and support according to legislation SOL and LSS. The municipality is also responsible for seeing that the user is provided with meaningful occupation and leisure activities. Also and, when necessary, the municipality should see that the user is given work that is suitable to their needs. Included in the responsibilities of the municipality is to provide rehabilitation to help overcome hindrances and regain a life and existence that is as meaningful as possible.

Regardless if the care is provided by personnel employed by the County Council or the municipality it is their responsibility to see that they cooperate with the user on an individual level with a comprehensive perspective. The aim is to help the individual regain control over his life. This is achieved in many ways including improving and training basic social competencies by using the programme ESL (An independent life). The training is carried out in groups and deals with everyday situations. Environmental therapy is aimed at adapting the users' organisational surrounding and contents to fit in with the need for change and development. One method used for functionally impaired people and which has shown to work is the KASAM model (devised by Aaron Antonovsky). This is based on persons' needs to experience that life has some meaning, that it is in some way understandable and that situations are manageable sufficiently well.



Care activities within psychiatry can involve supporting a person, providing direction and hope. The aim is to help them develop or maintain the level of functionality they already have and to train experiences of every day life. It is important to cooperate to increase insight and understanding of the problem.

The individual shall receive care based on their own particular needs and to achieve this an individual care plan (IVP) is drawn up. This is conducted in cooperation with the individual and their family. The plan should describe the individual's situation based on an overall view of the person. It

should contain goals, sub goals and assessments.

Psychiatry VIPS is a specific care programme for psychiatric care and is based on the care process route and is structured using tracking words. These words guide the way in which everything is documented and where information about the individual can be found. Only information relating to the way in which care is provided regarding a specific situation should be documented (appendix VIPS)

7.4.2 Working Methods – Substance Misuse

An attendant within the psychiatric care field is responsible for nursing and has a close and daily contact with the receiver. The areas of work include providing support and help to abusers and their families, to see their basic needs are met, stimulate participation in activities, inform, observe and communicate any changes to care needs, give advice, provide healthcare information and seek presumptive patients.

Care within the abuse care sector follows a number of differing stages for sobering up, abstinence care, investigation, rehabilitation and after care. Often care begins in an addict clinic run by the County Council to be followed by a municipal-run treatment centre. The next stage is after care and long-term follow-up by a caseworker.

Care and treatment focus on drug addiction but also on a number of social and somatic and mental problems which occur due to abuse. Treatment is handled in the main by social treatment institutions, sometimes by a treating doctor and to a much lesser degree by psychiatric care providers.

Regardless of whether a person is given care and treatment as a day patient or institutional care. Regardless of whether the treatment, such as detoxification, is provided by the County Council or in a collective/treatment home where the individual receives training to lead a drug-free life, regardless of whether this is a private care home or owned by the municipality, all treatment is based on the same or similar corner stones. Treatment activities always focus on drug use/dependency.

- Abstinence/detoxification
- Pharmaceutical treatment/blocking medicines
- Motivational treatment
- CBT based relapse prevention

Individual adapted treatments require a broad understanding and assessment of the problem, requirements and resources. This presupposes that the personnel are competent in a various areas. Previous treatment methods must be taken into consideration, as must the individuals' motivation and personality. It is important the individual participates and that together a reasonable treatment goal can be devised.

The use of biological markers and behavioural methodology is used as an aid in the diagnostic work. To increase motivational treatment, which focuses amongst other things on advice and discussion based on cognitive theory is an important part and aims at changing behaviour and thoughts relating to misuse and thus prevent relapse.

Included in the assessment work is the internationally established ASI (Addiction Severity Index) for adults and ADAD (Adolescent Drug Abuse Diagnosis) for young people.

The functional method that has been promoted for cognitive therapy is the Minnesota model with its twelve stages including psychodynamic treatment based on development theories of objective relationships. It has also be pointed out, over and above this, the importance of focusing on social support actions for the family, work and housing.

Also recommended are famous pharmaceuticals which work against alcoholism and drug addiction. These national directives promote: *increased cooperation between municipality and county council, to specialise operations, level out municipal differences based on size, tax support and the pressure on the care sector and to work towards creating a functioning unit and combined management for the care sector and social services.*

Criticism of misuse care is based on the major deficiencies and extensive differences in resources, competences and choice of therapies by the Swedish municipalities – the scientific level is too uneven. This has since led to national directives from the Board of Health and Welfare, 2007. This covers some 50 points which are intended to promote similar qualitative and national conformity.

There are a number of voluntary organisations which also provide care and treatment over and above that provided by the public sector. They all have in common the methods which combine social efforts as well as social support, psycho-social advice, activities aimed at developing or promoting social competence, psychological and medicinal treatment. Central to all these treatments is prevention, the early discovery through seeking operations and to provide information.

8. A Day in the Life of the Personnel and Residents Perspective

8.1 Presentation of Nybro Group Housing, Vis Vitalis Omsorg AB

Nybro is municipal-owned group housing in Linköping for people with physical impairments. Operations began in May 2002 and are run and managed by Vis Vitalis Omsorg i Linköping AB which is a company owned by Jan-Erik Antonsson (occupational therapist), Göran Almkvist (social worker) and Peter Rimås (social worker).

Nybro is located on an old farm in the beautiful Landeryd oak landscape which is one of Linköpings finest natural areas. In days gone by the farm was exemption accommodation for Harvestad Farm which lies close by.

There are 9 Vis Vitalis treatment personnel at Nybro who are trained mental attendants, auxiliary nurses and treatment assistants. There is also a nurse who is responsible. This person has fixed work hours at Nybro but can be contacted 24 hours a day.

The staff works to a 9-week schedule which they have decided on themselves. There is staff on duty 24 hours a day with 3 personnel during the day, two in the evening, at weekends and sleep duty. There is always a member of staff who is ready and can be reached 24 hours a day for consultation or personnel back-up.

There is also an older, renovated building with two apartments in the grounds of Nybro as well as a larger, newly built house containing five apartments, a common room comprising of a kitchen, dining room and living room. The large building was built specifically for group housing.

The farm also has an old building which the personnel together with the residents have renovated so that it can be used for daily activities. Today this building houses the hobby group and the woodwork group. The residents have also been involved in doing-up an old barracks which will be used for the impending horse activities this spring and will also function as a kennel for the dogs owned by the personnel.

Nybro group housing accommodates 7 people all with physical impairments. The diagnoses are schizophrenia, schizoaffective syndrome, affections disturbances, learning disability and depressions. Those living at Nybro have a long history of illness, the majority became ill in their youth or early adult life.

Linköping Municiaplity's specification of requirements for Nybro Group Housing requires Vis Vitalis to provide daily activities amounting to 5 hours per day. These daily activities are to include, besides standard work activities, even exercise activities, daily routines in communal rooms, a kitchen day, meetings with caseworkers, care of their apartments including any outdoor activities as well as a certain amount of help with personal hygiene.

8.1.1 A Day at Nybro from the Personnel Perspective

We always begin the day by reporting on the situation at Nybro. How the residents are feeling mentally and somatically and if there is a need to change some medication? We also plan the days activities according to the schedule, various activities etc. Afterwards we all sit down together to eat breakfast in the dining room with the residents and personnel.

Afterwards we watch the news on the television together and plan the day. We call this our morning assembly and have existed since day one and is an important part of the operations. During the day there are a number of work activities such as handing out the medication prescribed to the residents, the ADL training, various daily activities held here at Nybro and also the activities taking place outside the group housing.

All the residents at Nybro have two caseworkers who have the opportunity of getting to know the residents better and thereby providing them with the support actions they require. Just being around, providing support and motivation is a large and important part of our work. We provide five hours of daily activities, Monday to Friday. At the weekends the residents can suggest their own activities, for example, excursions or just to take life easy. We write shopping lists and buy the food once a week and together with the residents we look after the two cats, Selma and Sally who live at Nybro.

8.1.2 A Day at Nybro from the Residents Perspective

Communal breakfast in the dinning room after having received help with the morning tasks for example, help to get up and get going in the morning. Morning assembly after the news (see above) when we each talk about the weekly schedule or what has been planned for the day.

Then those who are involved in activities outside Nybro leave, for example, to the municipal swimming pool or the music group whilst others stay at home and participate in other activities which can include Outside/garden activities which is the responsibility of the personnel. Much of the time at Nybro for the residents is spent in ADL training which often

comprises of cleaning and washing in the apartment.

Every resident has his own kitchen day where he helps with kitchen activities such as preparing the meals during that day. Sometimes a resident will make a trip to visit a friend or family or receive a visitor. To sit together with a neighbour or member of staff in the communal areas is much appreciated. Once a month a residents meeting is held which allows the opportunity to give opinions and views and the staff members that participate can inform the residents about any changes that have been discussed at the personnel meetings.

Every Thursday during the winter period there is always an evening activity. These are usually suggestions made by the residents. Every Tuesday during the summer there is also an excursion; the destinations have also been suggested by the residents. Sometime we have activities together with other organisations within Vis Vitalis and/or with other group housing in Linköping.

8.1.3 Activities during the Week and Other Daily Activities within Vis Vitalis

Activities during the week

Monday
Floorball at Missionskyrka
We are 13 active players of all ages and from various parts of Linköping, who have different backgrounds and problems and who meet once a week to exercise.

Excursion
1-4 people travel to different places, which are known to the participants. These excursions could be to the woods, get to know horses and see places they remember from their childhood.

Tuesday
"The Tuesday Group" involving various forms of exercise and movement.
We are 7-8 participants who meet at different places throughout Linköping and exercise, talk, and, in general, have a nice time which ends with coffee and fruit. We have over the years tried, amongst other things, badminton, bowling, spinning, swimming, climbing, tennis, ice-skating and rambles to many beautiful places in the Linköping area. Sometimes we visit places like Kolmården, Tinnerös oak landscape or take a bicycle tour. On suitable occasions we even visit a restaurant.

Wednesday
Outside/garden activities at Nybro
In the mornings we are only a few and in the afternoons we are 7-9 who work with gardening, snow clearance, sawing logs, walks, cultivating etc. For external guests there is a changing room and lunch can be ordered. These activities are, of course, dictated by the weather and any begun or ongoing operations

which can be continued at other suitable times throughout the week.

Thursday

Music activities at Skylten

We are 6 who belong to a band called "SÅNÅRA". We have been practising since 2004 and have, amongst other things, given concerts. The music we choose is based on the wishes of the band members and we adapt the arrangements of every song to suit the person singing and to the instruments each band member plays.

Building operations at Nybro

Three or four work with new constructions as well as service and renovation of existing buildings. Painting, sawing, roof maintenance, casting, woodwork, plastering and purchase of material are all recurring activities. If there are larger projects, then more Nybro residents and even external guests take part. Tools and machines are adapted to suit the residents and their usage.

Hobbies at Nybro

Four to seven work in our woodwork department creating everything from bead boards, sanding butter knives, building bird nesting boxes and flower boxes to embroidery, working with polymer clay and renovating, sanding and varnishing chairs and tables. We order semi-manufactured and mount and sell or use the objects in Nybros operations. Personal ideas and suggestions are willingly accepted as we want as many as possible to find something that they are interested in and find fun and stimulating.

Friday

Purchasing trips

On Fridays the residents at Nybro are invited to a shopping trip to the ICA store in Sturefors to buy personal things for their apartment. Staff is available to give assistance if required. Sturefors has a relatively small store making it easy to find things and reasonable prices.

Water gymnastics

Three to five people from Nybro travel to Hjulsbrobadet (municipal swimming pool) to participate in water gymnastics arranged by another housing group.

Other daily activities

Caseworker time

Every resident at Nybro has two caseworkers. Together with these people, the residents can plan and structure their days and their daily activities, shopping trips, cleaning their apartment, visiting family, bank errands, devising an "individual development plan", taking part in excursions, playing games, visiting the doctor or participating in individual and more personal discussions.

Apartments

Those living at Nybro look after their own apartments as much as possible themselves. The caseworkers or other personnel support and help them if

needed; this varies from apartment to apartment. Some require help to get going, others need help with their washing, others have specific times every day when they need to see what should be done, some have written instructions which they follow and other take care of their apartments without assistance.

Gardening
Nybro has a large, communal garden which offers many opportunities for various kinds of gardening activities. Watering flowers, mowing the lawn, cutting the trees, raking the gravel paths, weeding, picking fruits and berries are just a few of the activities that need to be done in the garden if everything is to grow properly. If there is time, interest and energy there are always activities to do in the garden. Besides the communal garden each resident has his own little area which he takes care of and decides about the planting himself.

Horses
In April, two Iceland horses will arrive at Nybro. These will provide opportunities for activities spread throughout the day which is positive for those that are tired after the morning's activities and are a little more active during the evenings. The horses need to be fed, watered, brushed and, of course, ridden and exercised. First of all the fields have to be fenced in using posts and fencing, then they need to be continuously checked to see that the horses do not get out and there has to be pasture for them.

8.1.4 Working Methods

Every resident has his own individual weekly schedule and an individual development plan which has been devised together with the caseworker. The schedule is adapted according to personal preferences and abilities. The individual development plan is based on a work method called Ett Självständigt Liv (ESL) – An Independent Life – and involves short term goals which have been decided on by the resident together with the caseworker and takes into account need and preference.

It can be that the resident has difficulty in attending various activities not due to a lack of interest but perhaps because of worry, fatigue and insecurity and maybe due to a fear of trying something new. The plan will be to take into account the resident's ability, concerns and problems and then look at suggestions and actions. This is then reviewed regularly. Frequent follow-ups give a better result. Also included in the development plan is a long term goal.

Working with the An Independent Life (ESL) method and the individual development plan and weekly schedule makes it easier for the personnel to support and motivate when problems occur. It is the preferences and needs of

the resident that forms the basis of the goals that have been planned.

To achieve continual improvements of our organisation we have two staff meetings every month and two planning days every year. During these occasions we discuss any possible changes to the resident's requirements, the coming terms activities and any changes that affect the company and its employees. Every year each member of staff takes part in a Personnel and Development discussion together with Jan-Erik Antonsson, the Manager. We have taken part in various training courses and coaching courses over the years. The An Independent Life (ESL) training forms the basis of our work method at Nybro.

8.2 Presentation of the Psychiatric Clinic

The Psychiatric clinic in Linköping is located in the hospital grounds and is part of the local medical care centre. The University Hospital in Linköping comprises of about 10 different centres. The local medical care centre is the largest with over 2,000 employees and with many different activities. During the summer it is planned to divide the centre into two to allow for a more comprehensive view of the operations.

There are about 200 people working with the psychiatric clinic in Linköping from various professional categories: attendants, psychologists, social workers, occupational therapists, psychiatrists, nurses and many more. A large number of the staff have worked here for many years and have much experience in people with serious mental illnesses.

The centre has two institutional in-patient wards each providing accommodation for 14. Ward 37 takes care of patients with serious depressions, young people with personality disorders and sometimes people with eating disorders. The care time is on average about 14 days with many of the patients returning at regular intervals. The Ward also takes care of people who are in the middle of a crisis and require support and discussion over a limited period of time and then do not require further treatment.

Ward 38 treats patients with psychotic illnesses such as schizophrenia with a long treatment time. The Ward employs a contact person system which in practice means that a person is chosen to have more contact with a particular patient and is responsible for that persons care time. This can involve everything from helping to pay the bills to activating the patient and helping him to create as dignified a life as possible. Many patients with psychotic illnesses are in need of lifelong medication and require regular control checks.

The centre also has 3 out-patient consultancies which help the patients when they are not admitted to the clinic. The personnel make home-visits; accompany the patients on shopping trips, hold support discussions and even therapeutic discussions as well as seeing that the patients take their medication. The out-patient consultancies are divided into geographic regions based on where in the municipality a person lives, this does not however apply to the psychosis consultancy which has responsibility for all patients suffering from psychotic illnesses.

The clinic also has a Dialektiskt Beteendeteam (DBT) – a Dialectical Behaviour Therapy Team – who is responsible for helping young self-destructive people to leave as normal a life as possible. DBT is a year long training course where the patient is taught how to handle his impulses etc.

Various examinations are carried out to assess whether the patient is suffering from, for example ADHD, Aspbergers syndrome or Damp.

This centre also provides daycare which includes group cookery classes and occupational therapy as well as body awareness groups.

8.2.1 Psychiatric Case Study with Treatment Plan

A summons arrives at the social welfare office from Ward 37 which is at the psychiatric clinic at the hospital regarding a treatment plan.

This treatment plan concerns a patient by the name of Tomas Andersson who is 43 years old.The Needs Assessment administrator at the social welfare office contacts the nurse on Ward 37 to book a time.

Treatment plan for Tomas Andersson

At a treatment plan meeting the intention is to plan the type of care and support a patient requires after being discharged from the hospital. Those participating in the meeting play a key role in maintaining a good treatment chain. They can be nurses, doctors, Needs Assessment administrators, family personnel from the daycare centre and of course the patient himself. The choice of participants is dependent upon the type of care required after discharge.

Tomas has been on this Ward for 6 months. During the treatment planning meeting the Needs Assessment administrator must find out about his social situation, health, actual needs and what type of help Tomas is asking for.

Tomas moved from Luleå to Linköping when he was 23 years old when he began studying at the university. After a few years he became ill with a psychotic condition and was unable to continue with his studies. He was admitted to the psychiatric clinic where

he was eventually diagnosed with schizophrenia. He was given medication and after a long hospital stay he was eventually discharged and moved back home. Tomas tried to begin his studies again men could not continue with his training. He was signed off sick again and subsequently awarded a disability pension.

At the beginning he was in contact with the daycare centre at the psychiatric clinic. After a few years Tomas wished to try coping on his own which included taking care of his medication. He had no job and no social network and became more and more isolated.

The reason for his return to the hospital was a neighbour had complained to the landlord that Tomas had been causing disturbances. He was behaving strangely, was loud and suspicious of the neighbours, his apartment balcony was also very messy. The landlord was also critical of Tomas as he had failed to pay his rent for a number of months. Personnel from the daycare centre made a home visit to see how Tomas was doing and realised the situation immediately therefore re-admitting Tomas to hospital.

Tomas is now taking his medicine again and feels much better. He does not want to live alone and is applying for group housing. He wants help with his medication, requires support in his everyday life – with his hygiene, cooking and taking care of the home. He needs contact with personnel and other residents if he is not to isolate himself again.

The Needs Assessment administrator has received the summons. The administrator writes a report describing Tomas's background, social situation, and state of health, reason for the latest admittance and also the reasons for Tomas's need for group housing for the physically impaired. The Needs Assessment administrator makes a decision and hands over his report together with the decision to the person responsible for housing placements at the social welfare office. A copy of the report will also be sent to Tomas as well as the contact person at Ward 37 confirming a place in group housing as soon as a place becomes available.

8.3 Addiction Care in Linköping

8.3.1 Addiction Care at TNE, University Hospital, Linköping

Tillnyktringsenheten (TNE) - Sobering up centre is what its name claims to be, a centre for sobering up. This is the first step towards detoxification and treatment. There are many ways of coming here. A person can seek help himself, come with a relative, a workmate, through various voluntary organisations, social services, through

other departments within the hospital or in the company of the police: The Compulsory Care of Intoxicated Persons (LOB).

On arrival a person's exhaling breath will be tested to assess the alcohol level as will his pulse and blood pressure. The person is searched and his belongings stored in a safe place, his shoes and shoelaces will be removed as will his belt and anything that he can harm himself with or perhaps use to take his own life.

The staff will also try to find out if the person has any illnesses and takes medication. If the person is suspected of using drugs other than alcohol, a urine sample will be taken and a quick test will be conducted. During the time the patient is admitted to the TNE centre he will be checked at regular intervals: to see if he feels well, has not vomited and is breathing without problem.

When the patient is sober the staff will try to discuss with him how he can be helped to remain sober. Perhaps it's enough with detoxification help from the out-patient clinic which means the patient will visit the clinic or centre every day to collect his medicine and have a talk. Patients can also receive discussion contact at our daycare. Sometimes admission to the Detoxification Ward is needed. The patient is not always ready to deal with the situation at that moment and would rather go home. It is very difficult to try to help someone using voluntary methods if they are not interested.

Those who are admitted to the Detoxification Ward are those who suffer greatly from abstinence, suffer somatic deterioration and/or have previously had delirious tremors and/or cramps. These apply, in the main, to those patients with alcohol problems or indulge in combined abuse. A further indication for admitting a patient is a date has been set for him to live in a treatment centre and this is directly connected to the treatment. This can apply to both alcohol as well as drug abuse and can involve voluntary treatment or treatment according to Compulsory Care of Alcohol and Drug Abusers (LVM).

To work on a ward that provides treatment for addiction is slightly different to working on a somatic Ward. In this case it is mainly to do with motivational discussions and communicating about the future and not so much traditional care. Of course many patients have somatic problems with cardiovascular diseases, lung problems and diabetes's for example. If the situation warrants it, the patient can be send to the discipline that is better able to treat the particular problem. We try to motivate the patients into coping with their freedom from drugs once ward treatment is over. Help comes in various forms including care at a treatment centre, discussion contact,

daycare combined with Antabuse or Campral and Alcoholics Anonymous (AA meetings).

Drug abuse patients are seldom if even admitted to a ward if they have not been allocated after care of if they are first-timers. To be admitted to a treatment centre they first have to be "clean" from certain drugs.

Patients dependent on tablets or abuse pain killers or tranquilisers are often admitted for periods as they are susceptible to abstinence problems, otherwise treatment is administered through the out-patient system by specially trained nurses.

Treatment for alcohol abstinence is based on reducing the risk of delirium and cramps helping the patient to sleep and eat normally. Tranquillisers are often administered in the form of benzodiazepines but are rapidly downscaled, B vitamin injections and some for of sleeping medication. An uncomplicated method of treatment usually takes 4-5 days.

The police can arrive at any time, day or night, with people they want to us to take a blood sample from. These samples can be related to suspected drink-driving offences or from people who are affected by drugs.

Nearly all doctor certificates which are required by the social services and relate to Compulsory Care of Alcohol and Drug Abusers (LVM) originate from the Ward.

8.3.2 Addiction Care at St Larsmottagningen, Linköping

At this out-patient surgery there are both personnel employed by the County Council as well as staff employed by the municipality. There is a treatment team who can quickly and efficiently arrange for places at a treatment centre. A home, run according to the Minnesota model, Sensus, is located in Linköping. We have frequent and close ties with this home.

The surgery is responsible for administering and following-up of methadone and Subutex treatments to opiate abusers.

The out-patient clinic for adolescent drug abusers receives patients wishing to give a urine sample and for discussions.

Once a week an out-patient surgery, staffed with a doctor and a nurse, is held for drug addicts. People can visit this surgery without making an appointment and receive help.

Family support is an important part of the work also has a surgery.

The information officer at the clinic makes frequent visits to the schools in

the Municipality giving information about drugs.

In 2005, Landeryds Ängar in Linköping was started as providing accommodation for abusers with psychiatric problems. This home is run jointly by the Municipality and the County Council. Those who live in this housing always have the opportunity of a place at a Sobering up centre (TNE) or detoxification ward.

We cooperate and have contact with a large number of people associated with the patients. They are family, employer, social services, psychiatry, somatic healthcare, The Stockholm City Mission, treatment centres, police and many others. Both men and women from all walks of life and social classes and of all ages suffer from abuse and addiction problems. In other words this is a very varied job with many dimensions in the daily routines.

9. Vocational Education

9.1 The Swedish School System

The Swedish public school system comprises compulsory school and various types of voluntary schooling. Compulsory school includes compulsory basic school (for children with impaired sight, hearing or speech), and compulsory school for mentally handicapped. Voluntary schools comprise upper secondary school, municipal adult education and education for mentally handicapped adults.

9.1.1 Costs

Tuition in the state school is free. Neither pupils nor their parents usually incur any costs for teaching materials, school meals, health care, school transport, etc.

9.1.2 Responsibility and Control

Curricula, national objectives and guidelines for state schooling in Sweden are defined by parliament (Riksdag) and the government. The national budget includes grants to the municipalities for their various functions.

9.1.3 Upper Secondary School

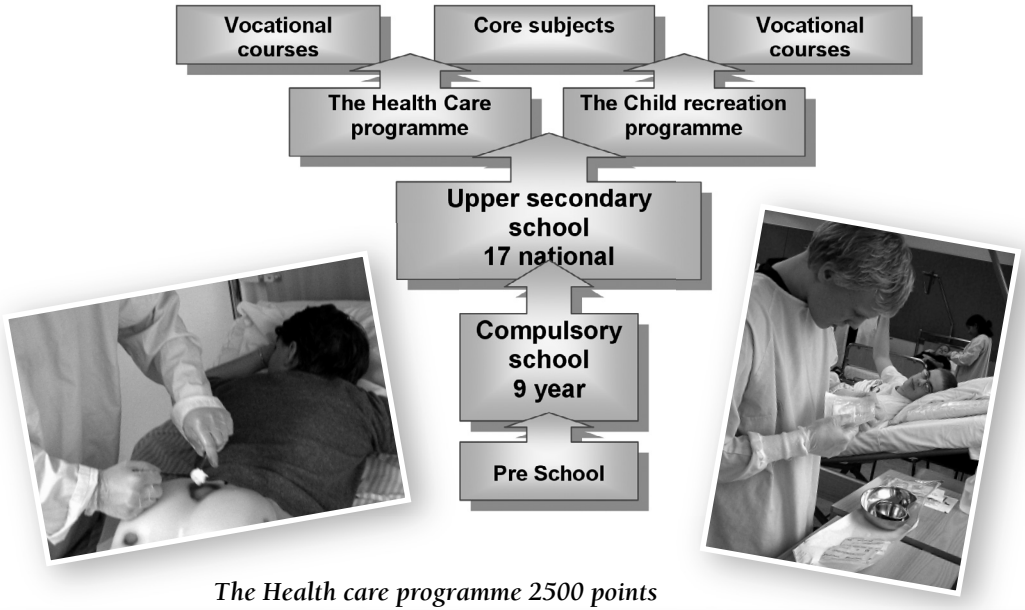
Almost all the pupils attending compulsory basic school continue directly to upper secondary school, and almost all of them complete their upper secondary schooling within three years (1993).

Upper secondary school is divided into 17 three-year national programmes, all of which are intended to provide a broad-based education and confer general eligibility for further studies in higher education and confer general eligibility for further studies in higher education. In addition to the national programmes there are also specially designed and individual programmes.

9.2 Adult Education

Young persons are entitled to enter upper secondary school up to the age of twenty. After this they can choose between various forms of municipal adult education. This comprises regular adult education (komvux). The komvux programmes comprise both basic adult education corresponding to compulsory basic school and voluntary education corresponding to the courses offer by upper secondary school.

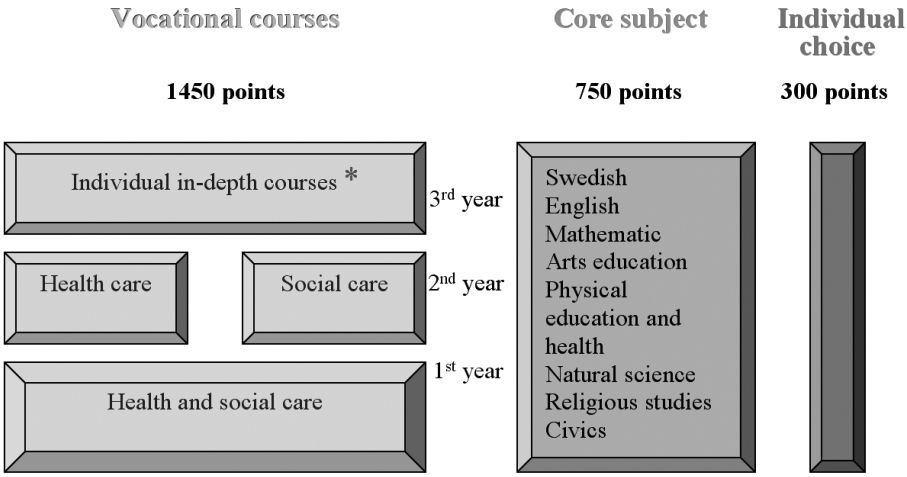
9.3 The Health Care Programme, 2500 points



The Health care programme 2500 points

The Health Care programme is designed to give students basic vocational training in health care and nursing (somatic and psychiatric), social welfare. By specialisation, students will gain competence corresponding to the requirements needed to work in these areas.

School will aim to give students an education that, on completion, enables them to give service, treatment and care, based on an overall view, and in witch the approach used is to release and develop the resources of person in need of care, with respect for their independence, integrity and background.



Vocational training is a part of all vocational courses

* **Individual in-depth courses**
Psychiatry
Nursing
Mentally handicapped /disabilities
Care of children and young people
Social Psychiatry
Social care
International co-operation

Today nurse training has been stipulated by the Government and Parliament and takes place within upper secondary school or within municipal adult education facilities. Completion of the Health Care Programme including Individual Choice Courses in psychiatry or courses especially adapted to psychiatry is required for almost all positions.

The attendant can work in a psychiatric clinic, at an out-patient surgery, as a personal representative or housing support administrator. There are also a number of titles this person can hold: mental attendant, field attendant, housing support administrator, social rehabilitator, or habilitation personnel. Modern psychiatry and abuse care requires the role of the personnel/ attendant/nurse to change to keep pace with changes in society.

9.4 Course Goals

9.4.1 Course Psychiatry

The theoretical training is intended to provide the students with the following:

- knowledge in order to participate in psychiatric care and provide treatment and rehabilitation.
- knowledge of the various services, support, care and rehabilitation that is provided by the community.
- in-depth knowledge of care planning, provision, evaluation and documentation
- acquire basic conversational skills
- in-depth knowledge of mental disorders
- insight into the correlation between mental health and ill-health from a developmental psychological perspective
- a developed understanding of the interaction between people and society
- an understanding of the importance of a therapeutic manner and the importance of empathy in care work
- knowledge and understanding of current legislation application to the patient
- an understanding of specific ethical problems within the field of psychiatric care

The student will acquire the following skills from work-place training

- training through participation in psychiatric care, treatment and rehabilitation.
- an understanding of the importance of involving the patients' own resources
- understanding human behaviour and the correlation between earlier experiences
- understanding the role of people in society and the importance of relationships for mental health/ill-health
- an understanding of the impact one's attitude has on the individual
- training in applying conversational skills with patients
- an understanding of the importance of good working cooperation between the various personnel categories both within as well as outside the team
- knowledge of speaking on behalf of a patient and awareness of the resources available within the societal network
- an understanding of the application of legislation relating to practical care as well as the various ethical aspects relating to compulsory institutional care
- training in the participation of individual care planning and documentation
- knowledge of the meaning of guidance/supervision

9.4.2 Course Social Treatments

The student will acquire the following skills from work-place training:

- knowledge of the various social treatment methods available for the care of abusers as well as social and treatment of offenders

- experience of social treatments and an understanding of social pedagogic treatments
- knowledge of the various organisations providing social treatments
- an understanding of the pedagogical meaning of conversations and dialogue associated with social treatments

9.4.3 Course Social Psychiatry

The student will acquire the following skills from work-place training:

- ability to understand and communicate with people suffering from mental disorders
- participate in needs assessments as well as planning and follow-ups relating to social psychiatric organisations
- knowledge of the interplay between the patient and society including the relatives and carers
- knowledge of current and relevant legislation within this field

10. References/ Bibliography

Andersson-Höglund Inger & Hedman-Ahlström Britt, Psykiatri, Bonniers, 2: uppl., 2000

Andersson-Höglund Inger & Hedman-Ahlström Britt, Socialpsykiatri, Bonnier Utbildning AB, 2002

Consolidated Version Of The Treaty Establishing The European Community (29.12.2006 EN Official Journal of the European Union C 321 E) http://europa.eu.int/eur-lex/en/treaties/dat/C_2002325EN.003301.html

Cullberg Johan, Dynamisk psykiatri, Natur och Kultur, 2000

Glant Heléne, Ny i Psykiatrin, Förlagshuset Gothia, 1998

Green Paper. Improving the mental health of the population: Towards a strategy on mental health for the European Union © European Communities, 2005.

The European Commission was together with the Ministry of Social Affairs and Health of Finland and the Council of Europe, a co-operating partner in the organisation of the WHO Europe Ministerial Conference on Mental Health "Facing the Challenges, Building Solutions", Helsinki, 12 -15 January 2005.

Grunewald Karl, Psykiska handikapp-möjligheter och rättigheter, Liber AB, 1997

Göthson Eva & Karlström Elisabeth, Socialt arbete-socialt behandlingsarbete, Liber, 2000

Hartelius Jonas, Narkotika, dopningsmedel och hälsofarliga varor, 5:e uppl., 2001

Heilig Markus, Beroendetillstånd, Studentlitteratur, 2004

Holmquist-Carlsson Ingrid & Zettergren Margaretha, Grunder i psykiatrisk omvårdnad, Natur och Kultur, 1993

Sahlqvist Lena & Wiberg Erland & Arvidsson Kenneth, Vård och omsorg, Utbildningslitteratur, 2002

Sigling Inga-Lisa, Socialpsykiatri, Liber, 2003

WHO Europe Ministerial Conference on Mental Health

Wiberg Erland, Social omsorg, Utbildningslitteratur AB, 2:a uppl., 1999

Åsberg Marie & Herlofson Jörgen, Psykiatri 91, Pilgrim Press, 1991

Consolidated Version of the Treaty Establishing the European Community (29.12.2006 EN Official Journal of the European Union C 321 E) http://europa.eu.int/eur-lex/en/treaties/dat/C_2002325EN.003301.html

Internet addresses

www.arbetslivsinstitutet.se (arbetslivsinstitutet)

www.bo.se (barnombudsmannen)

www.can.se (centralförbundet för alkohol- och narkotikaupplysning)

www.drogfritt.nu

www.drugnews.nu

www.drugnews.se

www.drugsmart.com

www.fhi.se (folkhälsoinstitutet)

www.Fotofinnaren.se

www.FreeDigitalPhotos.net

www.freephotosbank.com

www.frialankarna.se

www.hittabilden.se

www.ki.se (nationellt och Stockholms läns landstings centrum för suicidforskning och prevention av psykisk ohälsa)

www.lankarna.nu

www.mpa.se (läkemedelsverket)

www.nymedicin.com

www.police.se (rikspolisstyrelsen)

www.skl.se (svenska kommuner och landsting)

www.socialstyrelsen.se (socialstyrelsen)

www.sorad.se (centrum för socialvetenskaplig alkohol- och drogforskning)

www.statistiskacentralbyrån.se

www.sv.wikipedia.org

www.vardguiden.se

Andersson Maria, Norrköping (foton från Vadstena Hospitalsmuseum)

11. Glossary

The National Board of Health and Welfare (Socialstyrelsen)
A Swedish authority responsible for medical care and all varities of health care

The County Council (Landsting)
A regional political division of the country
responsible for issues relating to health and medical care, public transport, cultural and regional development. The County Council Executive Board is the highest decision making authority

Municipality (Kommun)
A territorially limited area involving self government
Legal representative within public law
Obligatory membership
Has authority under public law including taxation rights, the right to imposes charges and fees, the right to issue local regulations, certain authoritative rights

12. Appendix

Model psychiatri – VIPS

The overall goals for nursing care:
Well-being
Integrity
Prevention
Safety

This is a model for nursing care documentation in the patients records using a search term – aimed especially at psychiatric care. Devised by Anna Björkdahl.

Care history	Care status	Care diagnosis	Care goal
Care actions	Care result	Care epicrisis	Care message

Care history:
Reason for contact
Health record
Care experience
Known risks
Care in progress
Aid contribution
Hypersensitivity
Social background
Lifestyle

General information:
Informant
Close relative
Information
Temporary information
Head of planning
Rounds
Daily notes

Care status:
Communication

Knowledge/development
Breathing/circulation
Nutrition
Elimination
Skin/tissue
Sore
Activity
Sleep
Pain/sensory impression
Sexuality/reproduction
Psychosocial
Emotional
Social/economic
Abuse
Legal
Spiritual/cultural
Well-being
Composite status
Pharmaceuticals

Medicinal information:

Medicinal assessment

Care actions:

Planned-completed
Participation
Information/teaching
Support
Environment
Care
Advanced care
Training
Observation/surveillance
Special care
Wound care
Managing pharmaceuticals
Coordination
Coordinated ward planning
Discharge planning

Notes

Notes