Mental health ethics

YOU AND I HAVE A MORAL
RESPONSIBILITY

Ministry of Social Affairs and Health

*The National Advisory Board
on Social Welfare and Health Care Ethics
ETENE*

Mental health ethics
– you and I have a moral responsibility

Foreword

Mental health is a resource, and each of us must strive to preserve it. Communality and a personal feeling of relevance are conducive to mental health. There is a lot of information on mental health promotion available in various studies, surveys and reports, but it is ethically problematic that the availability of mental health services is even less than adequate in some parts of Finland. Although the situation has improved, even today services are not available as our basic and human rights would require.

This report prepared by the National Advisory Board on Social Welfare and Health Care Ethics ETENE is intended for ordinary citizens, for social welfare and health care professionals, and for political elected officials and decision-makers. The purpose of this report is to safeguard the rights of mental health patients and clients and their families, to help them participate in society and to improve their status. ETENE is thus contributing to a public debate about the values on which mental health promotion is based, about the requirements for the users of those services to lead a life of human dignity, about the right to self-determination and about equal and human treatment. We hope that this report will contribute to a discussion of what is sound mental health promotion.

Access to treatment is a common problem for mental health patients. Economic recessions have worsened the situation, but even without them psychiatric care has been under-resourced in many places for a long time. This is paradoxical, because in the European context we have a relatively high number of mental health professionals. So what is wrong when a person seeking care for mental health problems is treated differently from a person suspecting that he or she may have cancer? In 2009, we read the shocking news that the treatment queue for children's mental health services in a particular area was to be shut down for a fixed term. Mental health patients and their families are worried about how patients can cope after a course of treatment. Does the service system have sufficient resources to ensure that a mental health patient receives adequate care and supervision at the recovery stage?

Data protection of mental health patients is a current ethical issue. Does society unnecessarily stigmatise people who have had mental health problems at some point in their lives? There has also been public debate on taking children into care, on school violence and domestic violence, and on tangentially related subjects such as gun law reform, dismissals and layoffs, and increasing mental health problems among the elderly.

This report emerged from discussions and expert hearings engaged in by ETENE. The ETENE summer seminar on 27 August 2009 (www.etene.org/dokumentit) featured the mental health of children and adolescents, with expert guest speakers. The seminar was part of the preparation for this report. The seminar emphasised a child's right to receive care and to be considered as a person in his or her own right, not just as a future adult.

The report was prepared by a working group that included docent Ritva Halila, psychologist Pirkko Lahti, rehabilitation planner Markku Lehto, forensic psychiatrist Hanna Putkonen, dentist Heikki Vuorela and general secretary Aira Pihlainen. We would like to thank all the people and bodies that contributed.

Sound mental health promotion

Ethically sound mental health promotion fulfils the following principles:

- *A safe and healthy living environment helps the mental health of people of all ages.*

- *Mental health promotion helps people cope with their lives and everyday activities and participate in society as independently as possible.*

- *Smooth, appropriate and safe mental health promotion is part of the overall care for people.*

- *Citizens can promptly and flexibly receive the mental health services they need, specific to their condition and symptoms.*

- *A confidential, permanent and continuous care relationship ensures that mental health sufferers will not carry the stigma of their condition as they recover or after they have recovered.*

- *Respect for humanity and self-determination is the foundation of all care and services provided in mental health promotion. Restrictive measures are only used when the law allows, and even then as a last resort if all other care measures fail.*

- *Family and friends can participate in the care according to their abilities and resources if the patient allows them to.*

- *A good job offers an employee the opportunity to use his/her professional skills and improve himself/herself. A good workplace is a joy to work at.*

- *Expert mental health professionals provide appropriate guidance and information. Working conditions are conducive to employees coping at work.*

Contents

ETENE proposals for action

General proposals:

- Mental health promotion is based on a person's health, human value and resources, not the diagnoses of his or her illnesses. Regardless of whether a person is in outpatient treatment or institutionalised, he or she must have a dedicated physician and nurse to whom he or she can turn easily and quickly when help is needed. Treatment relationships must be made to last as long as possible through working arrangements.
- MComprehensive care of a patient with mental health problems requires effective support measures and cooperation between the social welfare and health care sector on the one hand and the education and employment authorities on the other. In order to recover from an illness, a patient needs a decent place to live and a sufficient livelihood. Work, studying and hobbies generate not only close human relationships but also meaningful content in life.
- When a person needs help because of a mental health problem, he or she must be admitted to triage and treatment on the same principles as for any other illness, urgent or not.
- Opportunities for patients and mental health care clients to participate in decisions concerning their own care must be improved. Cooperation groups must be set up for psychiatric care to discuss problems encountered by the patient in the care unit. It is important to hear and listen to people and to address any shortcomings, errors, negligence or infringement of rights.
- In psychiatric hospital care, patients must be given enough space and quiet, preferably a private room, as this is conducive to recovery. There must be sufficient personnel at psychiatric hospital wards so that the patients receive good care and the employees can cope at work.
- Any protective and restrictive measures that infringe on the right to self-determination must only be undertaken to safeguard the patient's or client's safety, to carry out care measures or, in extreme cases, as a protective precaution. Before any protective or restrictive measures are undertaken, it must be considered what hazard or harm their use may pose to the patient or client. The basic prin-

ciple should be to aim at reducing the need for and the use of restrictive measures.

- The prevalence of outpatient care must be taken into account in the content of regional mental health promotion plans. The primary requirement is to make sure that the patient can participate in the planning of his or her treatment when transferred to outpatient care. Mental health promotion must be planned as part of basic health care, where mental health expertise is available.
- The number, training and expertise of social welfare and health care professionals must be determined so as to ensure that they are in balance with the need and supply of services.

Specific proposals:

- The focus in the mental health of children and adolescents must be on prevention. The foundation for mental health is laid in the safe environment of early childhood. Early identification of and intervention in disturbances must be paid particular attention to at child care clinics, day care centres and schools and help provided. Home visits help survey the problem points in the life of a child, an adolescent and a family.
- Services with a low threshold of access must be provided for young people. Appropriate treatment must be available without delay. Schools must have access to the expertise of mental health professionals.
- Young people beginning an independent life must be supported in transitions in their lives such as when they move away from home or away from their home community, or they change schools. Special attention must be given to young people who cannot get a place to study or a job after leaving school.
- Working conditions and terms of employment for the working-age population must be arranged so that they are conducive to coping at work, well-being at work and the sustaining or improving of mental health. The working-age population must have the same access as all other population groups to mental health services in case of troubled life situations. Parenthood must be supported in the working-age population. The parents of children and adolescents must be able to harmonise work and leisure time while also taking care of the well-being of their families.

- After retirement and in old age, various support measures must be available to sustain a meaningful life, to prevent loneliness and to promote participation.

Mental health legislation and instructions

The national plan for mental health and substance abuse work adopted by the Ministry of Social Affairs and Health and extending to 2015 contains the stated targets of strengthening the status of clients of mental health services, promoting mental health and abstinence from intoxicating substances, increasing peer support, preventing problems and adverse effects while enhancing treatment, and providing basic care and outpatient care services on the one-stop-shop principle. The measures proposed for attaining these targets include mental health and substance abuse training, recommendations, coordination of actions, increasing of resources and updating of the relevant legislation.

A wide variety of services is needed for treating mental health problems. In 2006, more than 2 million outpatient visits were recorded in psychiatric specialist care, and about 30,000 patients were in institutional care. Mental health care is also provided at health centres, at private health care units and in occupational health care.

Mental health care services are used the most by adolescents and adults of working age. Nearly half of the families requiring mental health services considered that getting help was problematic in one way or another. The more trouble people have, the more difficult they feel it is to get help. Mental health problems are one of the most frequent causes for disability pensions.

Social welfare and health care services are provided pursuant to general and specific provisions in legislation, to international human rights conventions and to other official instructions. Finland's Constitution (731/1999) states that all citizens are entitled to equality, privacy and integrity, and to access to adequate social and health services. Under the Act on the Status and Rights of Patients (785/1992), citizens have a right to good quality care.

The Mental Health Act (1116/1990) contains provisions on the providing of mental health services, on cooperation between hospitals, outpatient care and social services, and on the control and supervision of

services. Provisions on housing, income, child welfare and special child welfare in particular also have an impact on mental health. The safety, health, growing up and well-being of citizens are also addressed in provisions concerning day care and various stages of education.

The treatment of mental health and mental illness is based on respect for human dignity, the right to self-determination and fairness and the principle of voluntary treatment. Measures may be taken against the will of the patient only in cases specifically provided for by law. By international comparison, measures restricting the freedom of the individual are used relatively frequently in health care, and there is great regional variation.

Patient or client?

The social welfare sector and the health care sector differ from one another not only in their range of services but also in the way in which services are provided and how they operate. Health care focuses on health vs. illness, while social services focus on well-being. Health care has patients; social services have clients. The term 'patient' emphasises the care aspect and the responsibility of the personnel providing the care, even if the patient's right to self-determination has received increasing focus in recent decades. The term 'client', by contrast, places the two parties on an equal footing and emphasises the client's power to decide. In mental health care, both terms are used. Persons who are ill are patients, but in social services and rehabilitation they are known as clients. The concepts of 'patient' and 'client' cannot be distinguished from one another in mental health promotion as easily as in other areas of social welfare and health care.

The group of 'mental health patients' cannot be unequivocally delimited by any uniform criteria. In mental health promotion, there are no precise boundaries between promoting mental health, sustaining mental health, preventing mental illness and providing treatment. A specific measure may constitute treatment of an illness for one person but may prevent mental health problems from arising in the first place for another. Sometimes the purpose of mental health promotion is to maintain health and prevent illness, sometimes to treat illness. Treatment is very much a process and a continuum. However, because of the uneven availability of

services, this continuum is interrupted in many cases, and it may well be that no one has an overall view of the situation of a particular individual patient. In order to ensure continuity of good treatment, boundaries between organisations should be eliminated in the system.

The mental health sector is also where people turn to in case of crisis. In such cases, a few appointments may be sufficient to allow the client to continue his or her everyday life on his or her own. A brief course of treatment in a case like this prevents illness and helps people cope.

The provision of housing services also helps the recovery of mental health patients. Patients who are hospitalised or in long-term institutional rehabilitation must have an address and a home to return to when they are discharged. An enjoyable, peaceful and safe environment helps mental health recovery at all stages. Even in institutional treatment, providing a patient with a private room is conducive to recovery. Many psychiatric hospitals are traditionally located in places of great scenic beauty. This should be taken into account when re-evaluating the use of hospital buildings and providing treatment services. For all its problems, the trend from institutional care to outpatient care is a good thing. However, those patients who actually need long-term hospitalisation cannot be abandoned.

Mental health and its care at the various stages in life

A safe childhood – a unique stage in life

A safe childhood includes the right to be a child. The framework for growth and development is partly laid out even before the child is born. A child needs a socially, psychologically and financially safe environment built by adults, but also the genuine presence of his or her caregivers and the care and nurture consistent with his or her age and development. The child's parents and caregivers are primarily responsible for building that environment. Day care, school, various volunteer organisations and the public social services and health care system are available to help them. It is important for the child's growth and development that the child feels important and accepted, is loved and listened to, is spent time with and is cared for. The child needs safe, interactive and permanent human rela-

tionships in order to learn to identify, process and express his or her own feelings. Childhood lays the foundation for confidence in the child's own abilities and trust in the surrounding world, and also for the capacity for empathy and sympathy.

Some life situations are a serious threat to normal growth and development. Family crises always affect the well-being of children. If a child's parents work long hours, they have very little time together. Periods of unemployment or layoffs, or the threat thereof, are also reflected in the lives of children. If the parents fall seriously ill, their ability to bear responsibility for the well-being of their children is impaired. The child's own physical and mental resources and limitations to growth and development can also jeopardise healthy mental growth. Violence of any kind in the living environment is a threat to the child's growth and development. Therefore domestic violence and bullying at school always requires intervention. At day care centres and at school, groups must be small enough to allow for each child and their special needs to be taken into account.

If a family does not have the resources to sustain a child's growth and development, society must provide help. Child care clinics, day care centres and schools must identify problems and intervene in them as early as possible. The personnel in basic health care, specialist medical care and child welfare services have the expertise and the skill to consider children as individuals and to identify any threats to their well-being. Knowledge of the special features of multicultural families is part of good professional competence.

Adults must under all circumstances take responsibility for the well-being of their children and give them the time and security they need. It is important for mental development that children are allowed to be children and not required to take greater responsibility for themselves or their immediate environment than their age and developmental abilities allow.

Adolescence – the road to self-awareness and community membership

Adolescence, or puberty, is a transition from being a child to being an adult. An adolescent distances him- or herself from the immediate home environment, seeks out new social contexts and explores the boundaries of his or her independent existence. Significant physical changes also happen. Emotions fluctuate strongly and rapidly, combined with insecu-

rity and variability in mental resources. Adolescents are not always able to manage their lives and their emotions because of the physical, mental and social changes they are undergoing simultaneously. They need the support of adults – even when they specifically protest against it. Home, school and hobbies are important growth environments for adolescents. A safe home and the well-being of the parents form a good foundation for growing up. Society supports adolescents and their parents.

School has a substantial impact on the growth and development of adolescents. Schools are mirrors of society, and teachers have a responsibility not only in teaching skills and conveying knowledge but also in managing the development of their pupils and the atmosphere in the classroom. At school, teachers are always role models of adulthood, whether they want to be or not. A safe school has an atmosphere of respect, discussion and listening. Adolescents are encouraged to participate and to express themselves and their feelings. Adults at school can support their growth and intervene if an adolescent is showing symptoms of aberrant behaviour. In a safe school, the pupils and teachers form a community with no fear of bullying. Young people are also allowed to participate in other activities in society and to find positive building blocks for their lives. The exclusion of young people, whether self-imposed or imposed by others, must be prevented. Sometimes special measures are needed for this, such as activities and training customised for adolescents.

We know quite a lot about mental health problems in young people. They manifest themselves as disruptive behaviour and malaise in boys, and in some girls, too. In such cases, adolescents may be restless and push the boundaries of appropriate or even legal behaviour. Girls often focus their bad feelings on themselves and their own bodies, and the incidence of eating disorders and depression is higher among girls than boys. Both extrovert and introvert symptoms must be taken seriously, and early intervention is necessary to prevent problems from accumulating. Adolescents are best helped in their growth environments. All too often problems are only addressed when the situation has escalated to the point where specialist medical care is needed together with institutional treatment where waiting lists are long and distances may be great.

Violence among young people has prompted public debate. Causes for such violence have been sought in mental health, youth sub-cultures, the Internet, bullying at school, families, schools, the previous recession, the Finnish psyche, and almost anything else one might care to name. Some mental health problems evinced by young people, particularly

behavioural disorders, intoxicant abuse, neuropsychiatric problems and psychoses, involve a decreased ability to manage anger and a propensity towards violent behaviour. However, a psychiatric disorder cannot in itself explain violent behaviour; the majority of adolescent psychiatry patients are not violent. There is thus no call for generalising young people requiring psychiatric care as instigators of violence or for transferring the stigma of mental illness to their adult life.

Mental health problems and violent behaviour among young people clearly demonstrate divisions in society: while the majority of young people are doing fine, some of them are doing worse than ever and accumulating an increasing load of problems. Investing in the well-being of children and adolescents is investing in the future. Safeguarding the well-being and treatment of children and adolescents is an ethical choice that society must make.

The working-age population – members of a human community

To lead a balanced life, a person needs a social community. Human contact and respect for the individual at work are conducive to mental health. Doing brings meaning to life. This statement is intentionally vague: 'doing' does not necessarily have to mean paid employment. Indeed, people of working age have a variety of roles, some in working life and others in family life, volunteer activities, hobbies and associations.

Two out of three Finns consider their mental state and mood to be good. One in ten consider them poor. Five per cent of the population consider both their mental and physical health to be poor. More than half of the working-age population feels overstressed sometimes; one in five feels overstressed often. One in ten Finns suffer from an accumulation of misfortune, physical and mental illness, social exclusion and poverty. Accumulating misfortunes often lead to exclusion. Unemployment is also an exclusion risk.

Working life has changed significantly in the past decades. Few people now spend their entire working careers at the same workplace. Competition has become tighter both in society at large and within workplace communities and between individuals. Companies now operate on the terms of the international market economy, and organisations freely transfer labour from one location and country to another. Rapid reorganisations and changes of ownership foster uncertainty and inse-

curity among employees. It is challenging to work in a team and a workplace community where one's colleagues change every so often. People specialise and drift apart as their jobs diverge. Individual employees no longer have an overall view of their workplace or their role in it. The hectic working pace jeopardises creativity and flexibility, which are also required by the constantly shifting demands of working life.

The running and managing of project-oriented workplace communities can become difficult when employees commit only to projects rather than to the work of the workplace community as a whole or the company as a whole. The workplace community becomes increasingly splintered with the focus on the 'here and now'. Tendered contracts and the competition and urgency which they require are exhausting and stressful for employees. In contract and project work, there is no room for taking leave or being off sick. Humanity and dignity are of little value in a quarterly economy. Can the employees accept the values of the workplace?

Working together, training and instruction contribute to employee well-being. Well-being comes from appreciation, correctly proportioned job tasks, opportunities to develop at work and a feeling of community at the workplace. Workplace culture should allow for more than just highly trained, highly energetic and high-performance employees. Change and development require acceptance of the fact that people are different. People must be allowed to plan their own work and to feel in control of their lives. Immigrants and minority members must also be able to adapt to a new workplace environment, though without compromising their own cultural backgrounds.

Employees must be encouraged to look after their health and well-being. A healthy lifestyle is easy in theory but not so easy in practice: an employee must get enough sleep and have a clear daily rhythm, and he or she must also have exercise, food and contact with other people on a daily basis. Well-being also requires human relationships outside the workplace, although the need and the requirements for these vary by individual. There are nuclear families, stepfamilies and people who live alone. Many people who are at work have not only children but elderly family members to look after. Family is an important resource of mental strength for many but can also turn into a burden on mental health.

An increasing number of people of working age drop out of employment for reasons of mental health, often combined with somatic illnesses. The consumption of alcohol in the working-age population has increased. When we combine mental health problems with excess alcohol

use and violence, we have an undesirable aspect of Finnishness that is known even internationally: Finland is statistically the most violent country in Western Europe.

The working-age population and violence

A typical Finnish homicide is a case of spur-of-the-moment manslaughter in an altercation between socially excluded men who are drunk. People who commit violent crimes commonly suffer from intoxicant abuse and personality disorders. However, only about 5% to 10% of violent crime is related to psychotic conditions. All sorts of reasons have been put forth for Finnish violence: biochemical, psychodynamic, behaviouristic, social, cultural, sociological and political. Although violence cannot be explained simply as an aberration of the mind, nor can it be ignored in a discussion of mental health.

The suicide rate in Finland has gone down since 1990. Studies have shown that there is a strong correlation between this and the increased use of anti-depressants. Suicides have decreased particularly in those areas where treatment of depression has been improved through a wider range of outpatient services. However, the suicide rate in Finland is still high compared with many other Western countries. According to the cause-of-death statistics compiled by Statistics Finland, 244 women and 751 men committed suicide in 2007. Out of these, 817 were of working age. A well-functioning mental health treatment network is needed to further reduce the suicide rate.

In regrettably many cases, alcohol is a contributing cause of death for both women and men of working age. Substance abuse increases the incidence of violence and suicide. Substance abuse is a central topic in the ethics of mental health, because intoxicants have a major impact on mental health. Substance abuse problems have increased in recent decades. Heavy drinking is a common feature of Finnish culture. Changing drinking habits from binge drinking to moderation requires an attitude shift. The health care sector and substance abuse services cannot achieve this by themselves; a comprehensive public debate is needed. Substance abuse problems and exclusion and certain personality disorders are associated with violence in Finland. If a person develops a psychosis, the risk of violent behaviour increases slightly but can be further increased if he or she also has a substance abuse problem. It may be difficult to analyse specifically what the correlation is between mental health problems and violence, because mental health problems often afflict those who are ex-

posed to violence in their lives anyway. Indeed, problem clusters pose a particularly great challenge for care systems. However, there is absolutely no case for tarring all mental health patients with the same brush as far as violence is concerned. Good mental health services reduce the risk of violent behaviour by patients.

Protecting life is an important ethical principle. Recently, there has been discussion of Finnish gun legislation and how it relates to violence. There is a remarkably high number of guns and gun permits in Finland per capita. Those whose hobby involves guns have strongly lobbied for their right to engage in these pursuits. However, is the right to possess a gun such an important value, ethically speaking, that it could not be limited? Simply curtailing the number of guns in circulation has been proven to reduce both the suicide rate and the homicide rate. Stricter gun legislation has also been shown to limit the number of suicides and homicides.

Somatic illnesses of mental health patients

Mental health patients are more prone to somatic illnesses than the rest of the population and die at an earlier age on average. For instance, depression patients have a higher incidence of cardiovascular disease, lung cancer, cerebral circulation problems, diabetes and asthma. Schizophrenics also have a higher incidence of cardiovascular disease, pulmonary disease and cancer. They are two or even three times more likely to die of a somatic disease than other people of the same age. Diagnosis and treatment of somatic illnesses in schizophrenia patients varies in different parts of the country. The health differential between schizophrenia patients and the rest of the population is increasing. Diagnosing and estimating the severity of a somatic illness in a mental health patient is sometimes difficult, and treatment varies in different parts of the country. The health differential between mental health patients and the rest of the population is increasing.

Hospitalised psychiatric patients have poor oral health and a higher than average need for oral hygiene treatment. Modern oral health care is rare in hospitals. Outpatient treatments lose their teeth and wear false teeth more commonly than the rest of the population. Poor oral health is often due to home care problems: mental health patients do not necessarily have the energy to take care of themselves or their teeth. They may also be afraid of going to the dentist or may not afford it. The socio-economic situation and the treatment of mental health problems and other

illnesses are related in many ways to oral health. Oral health is reflected in the individual's functional capacity and well-being and is also an important interaction factor. The prevention of dental and oral diseases should be focused on in oral health for mental health patients.

Many mental health patients get little exercise, have an unbalanced diet, and smoke and drink heavily. It may be more difficult for them to obtain information and preventive treatment than for the rest of the population. It is possible to improve the working and functional capacity of mental health patients through targeted health-promoting measures. Family members and the psychiatric treatment team must support the patient whenever enhanced treatment programmes are introduced at the institution or care home or in home care, or whenever attention is called to a healthy lifestyle. The patient does not always have the initiative to live a healthy life. The seriously ill and their families in particular need special measures in order to be able to change their lifestyle and to improve their health and well-being.

The somatic health of a mental health patient must be examined carefully. The patient may have difficulty in negotiating the complicated service systems of the social welfare and health care sector and may be incapable of describing his or her symptoms to family members or care personnel. Schizophrenia patients in particular may have difficulty identifying pain, which may delay seeking of treatment. Often the problem may be in attitudes: patients are not always believed and examined even if they report their symptoms. A confidential, consistent care relationship and sufficient time for medical examinations are essential for good quality overall treatment of patients.

A healthy life after retirement

Retirees continue to lead an active life after they are no longer working. They travel, engage in hobbies, do work, care for their grandchildren and realise their dreams. However, not everyone can find content in their lives after they retire from work: many are lonely, ill and poor.

The baby boom generation is now retiring, which is an added challenge to mental health promotion. Many people remain just as alert and positive beyond the age of 65 as they did in working life. However, physical and mental performance, alertness and mood decline with age, particularly beyond the age of 75.

Consumption of alcohol has increased among retirees, women in-

cluded. Loneliness, depression and other mental health problems may increase alcohol consumption. Alcohol, in turn, may exacerbate depression, cause confusion, provoke aggression and contribute to memory problems. People who start to drink on a daily basis suffer a loss of psychosocial functional capacity. Health risks increase with age. An elderly person on multiple prescription medications may not realise that alcohol and drugs may have unpredictable combined effects.

Old age – the right to life with dignity

For the purposes of this report, 'old people' is understood to refer to people aged 85 and above. Old age is part of a natural life span, yet in today's Finland, where youth is idolised, old age and the elderly are not sufficiently appreciated. There are frequent complaints about old people getting in the way and being a burden and an expense on society, and that old age is a problem. Human dignity, however, is indivisible and independent of age; it does not need to be earned. It is the duty of society to ensure that the elderly receive sufficient care and treatment.

Half of old people consider their well-being to be good or fair. Old people who live alone are susceptible to stress, which may be due to a decline in their alertness, mood, physical health and functional capacity. Almost half of all old people consider social welfare and health care services to be inadequate, and one in five feel they receive poor service.

Old people have the same mental health problems as younger people. Old people also have more difficulties coping with everyday life due to the decline of their physical health and functional capacity, and to illness. The lack and loss of family and friends affect the mental health of old people. Mood disorders, anxiety disorders, psychoses and organic mental disorders are particularly common. Old people do not use mental health services very much, which may be partly due to their symptoms being erroneously ascribed to ageing.

Ageing inevitably involves loss and letting go. Grief is a perfectly healthy reaction when the health and functional capacity of an old person or someone close to him or her deteriorates significantly and there are no family or friends to provide support. The difficulty of adapting to age-related changes involves the risk of depression. Depression in old people is often not diagnosed or given sufficient treatment. Old people are more prone to mild depression but less prone to severe depression than younger people. Old people who are widow(er)s, seriously ill or in

poor physical condition have the greatest risk of depression. There are troubling signs that the suicide rate among old people is increasing. Serious organic illness, loneliness, isolation, the narrowing of life, and alcohol and substance abuse all increase the risk of suicide. Social networks and a variety of hobbies help in keeping life meaningful for old people and contribute to their well-being. The care and treatment provided should support their self-esteem and respect the resources they still have. An empathetic approach and unhurried listening to problems are particularly important in services for the elderly.

Every year, more than 13,000 Finns develop a cognitive disorder. The need for institutional care can be delayed by providing appropriate and comprehensive treatment for cognitive disorder patients. Family members are important partners to health care professionals in this. Supporting family members is a critical part of preventive mental health promotion, as informal carers are prone to exhaustion. Some dementia patients may develop aggressive behaviour, which may be related to depression. An old person who behaves aggressively is a problem for the health care system and difficult to place. This is why dementia patients are sometimes committed to psychiatric institutions. Prisoners who have dementia or who are ageing need to be provided for in the health care system so that they can receive the treatment they need. Cognitive disorder patients are discussed in more detail in the ETENE publication Old age and ethics of care.

Not a lot of resources are allocated to diagnosing mental health problems in old people or providing mental health services for them. More training in geriatric psychiatry and services for old people are urgently needed, as the number of old people is increasing rapidly.

The service users' perspective

Users of services and their family members expect health care personnel to show a human approach, respect for dignity, commitment to their work and promotion of changes that support good treatment. Human-oriented care is based on the needs, expectations and goals of the client. The client must be seen as a complete personality; interest must be taken in him or her and his or her well-being cared for. Respect means hearing and listening to the service users and their family members and actively

asking them for their opinions, giving space to different ideas without value judgements, encouraging clients to seek individual solutions, treating everyone equitably regardless of their personal characteristics or social status, and accepting and respecting people as they are.

When clients' experiences and views are taken into account in the planning, provision and evaluation of services, personnel will experience more diversity in their jobs, too. It is important for successful treatment to believe that it is possible for the service user to be rehabilitated. This confidence can be increased by informing the service user of the right to rehabilitate at his or her own rate and in his or her own way and by creating the right circumstances to enable change. Service users must be encouraged to live their lives so that they feel that their rehabilitation is significant not only for themselves but for their community and for society at large.

The role of family members in mental health promotion must be strengthened and supported. If the patient so allows, they must be given relevant information on treatment decisions in order to ensure that the treatment is followed through; however, they must not be burdened with additional responsibility for the patient's care. This will also encourage family members to improve their own lives and well-being, since they too are at risk of falling ill if stressed with treatment responsibility to too great an extent.

Service users must be given more opportunities to participate in their own treatment. This requires more freedom for service users, better availability of information and the right to participate in decision-making concerning the patient's own treatment. Patients must have the possibility to request a second medical opinion if they so desire or to file an objection or a complaint pursuant to the Act on the Status and Rights of Patients. By default, the patient him- or herself, supported by family members or other people close to him or her, must participate in decision-making concerning his or her own treatment. In case of an underage child or adolescent, the patient's legal guardians must also participate as provided for in the aforementioned Act.

The service user may sign a power of attorney whereby another person may manage his or her matters on his or her behalf in case illness or other reason renders him or her not competent to do so. The patient must list which matters the power of attorney covers. The patient may authorise another person to represent him or her for instance in matters relating to finances or to health care. A power of attorney must be

confirmed by the local register office. A power of attorney does not, however, negate the patient's right to self-determination provided for in the aforementioned Act. While the person authorised by power of attorney is the patient's legal representative, his or her role is always secondary to the patient him- or herself. A local register office can assign a legal representative if a patient has not signed a power of attorney. This may be one way of protecting the well-being and rights of a patient whose capacity to manage his or her own matters has been materially impaired.

Civic activities

Many non-governmental organisations have actively developed volunteer and support services in response to requests for help. The third sector has also been active in providing information on problems that patients/clients have experienced with regard to care, drugs, lack of support, income and housing, with special reference to functions that maintain and promote mental health. In recent years, NGOs have also introduced various care functions, even though under current legislation local authorities are responsible for public social and health services.

A support volunteer is a peer who can help and support a mental health patient and even in some cases provide a role model. In a crisis, people need understanding and an opportunity to process their situation. Support volunteer work is complementary to treatment. The public health care system and the third sector should cooperate seamlessly in helping patients/clients.

NGOs have also noted that when health care personnel consult a patient expert while still in training, they find it easier to understand patients. Known as experiential expertise, this is drawn upon in several medical and nursing programmes at universities and at universities of applied sciences.

Third-sector activities have their own special ethical features. A volunteer worker may be a rehabilitee him- or herself, and generally has no training in social welfare or health care. Indeed, the ethical foundation of volunteer work and the importance of ethically sustainable practices must be emphasised when selecting and training volunteers. In job training provided by professionals, volunteers are coached and their activities evaluated, and ground rules are drawn up. Feedback from clients and other volunteers is important for keeping volunteer support on a sound

basis. Close cooperation between professionals and volunteers means security for patients/rehabilitees.

Peer workers supporting mental health rehabilitation

A peer worker is a mental health rehabilitee with personal experience of a mental health disruption and/or crisis. Volunteering for support work provides help for other people with the same problems and demonstrates that rehabilitation is possible. Peer workers complement public health care through their experiential knowledge. They may be under contract and be paid a fee for their volunteer work. What is important in peer work is to meet, listen to, hear, respect and encourage rehabilitees.

The peer worker life story model is an approach allowing other rehabilitees to identify with a role model. Indeed, a peer worker may bring up matters that even professionals have difficulty discussing. Drawing on one's own experiences to support others often helps the rehabilitation of the peer workers themselves.

A peer worker is seen more as a fellow rehabilitee than a 'ready-made' model of rehabilitation or a new life. The strengths of peer work are in the support and understanding that people who have had similar experiences can provide one another. Support is not just limited to talking about shared problems or illnesses; the rehabilitee may also share other things, feelings and experiences with the peer worker. This is an empowering experience of communality.

Trained peer workers are expected to understand and commit to the concept of confidentiality. Peer workers do not offer treatment or therapy and never give direct advice. A peer worker must be aware of his or her own functional capacity and its limits, and must also receive job training and other professional support.

Identifying and acknowledging peer expertise is a major factor in understanding the situation of a person who is ill and has undergone a crisis and that of his or her family members. Combining peer expertise with professional expertise reinforces the effects of treatment and rehabilitation. It also helps rehabilitees value their own experiences. Peer workers do not compete with the expertise of professionals; instead, they complement the help provided by professionals with their own experiential knowledge. Cooperation between professionals and peer workers and the participation of peer workers in the rehabilitation process require joint training, joint meetings and sharing of experiences.

The work of both peer workers and professionals is guided by the same ethical principles, most importantly a human approach, respect for human dignity, promotion of health, and confidentiality. Human health can be promoted when we believe that everyone has the chance to be rehabilitated.

Towards mental well-being!

Many good ideas and suggestions have been brought forth in the mental health sector that have nevertheless not been translated into reality. There are many reasons for this; ETENE would like to draw attention to the following:

1. Political will and resources are not uniformly oriented towards change.

2. Major shifts in mental health promotion, such as the trend from institutional care to outpatient care, happened at a time of great financial trouble in Finnish society. In the absence of resources, the good principles underlying these shifts have not been implemented to their full extent. It was left undefined what exactly constitutes good care for mental health patients and what exactly are the requirements for ensuring a sufficient level of care. A lack of money is frequently cited when funds are requested to solve glaring problems in mental health promotion. Access to sufficient resources is also hampered by the fact that people with mental health problems are not a powerful lobby.

3. Because mental health promotion has not been provided with sufficient public resources, NGOs have augmented support and care through volunteers. Volunteers may play a significant role in the well-being, rehabilitation and recovery of mental health patients. However, the ultimate responsibility for mental health promotion lies with the public health care system and must not be left for volunteer organisations to cope with.

4. In public debate and political decision-making, mental health patients are represented as a substantial cost to society and as a uniform group of people. In actual care work, by contrast, patients are analysed and treatment provided differently by group or even by individual.

5. Life has become more unpredictable. The number of personal crises has thus increased, and more help is needed to cope with unexpected situations. The need for rapid response may leach resources from those who need long-term care and even erode interest in improving their treatment.

6. Mental health promotion represents a challenge for all areas of society, not just the social welfare and health care sectors. Therefore, all decisions should be evaluated with a view to how they affect the mental well-being of the population as a whole.

Despite all the challenges described above, ETENE believes in the potential of good mental health promotion, which is the responsibility of us all. It is a responsibility that requires all of us to look after the well-being of people close to us as well as ourselves. Mental well-being is important for all of us at all stages of our lives – in childhood, in adolescence, in working life, in retirement and in old age.

> Indeed, the foundation of mental health is the same as the foundation of a happy life:
>
> **A good life and mental health are not characterised by the absence of problems but by the ability to deal with problems.**

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