1 Paradigms of disability services in Finland

Timo Saloviita

Three paradigms of disability services will be presented, and the birth and development of each paradigm will be followed in Finland. These paradigms are institutional care, rehabilitation and support. They are connected to the economic development of the country and correspond to the industrial and post-industrial phases of society. It will be shown that an important division within the disability field has occurred between those with physical disabilities and those with mental disabilities. Both groups have progressed or are progressing through the three paradigms but within different time frames.

If we compare the ways in which disability services have been arranged at different times we can obtain an understanding of how disabling conditions have been perceived and interpreted over the course of history. A historical comparison of disability services reveals both periods of smooth development and also periods of change. Changes in the conceptualisation of disability are relatively rare and seem to be associated with economic changes in society as a whole. The divisions between agrarian, industrial and post-industrial society have their counterparts in the service models for people with disabilities.

The traditional, agrarian society had its own varied forms of care. In Finland, the development of relief for the poor at the beginning of the 19th century was politically accepted in an 1852 statute on the care of the crippled (Karisto, Takala & Haapola, 1988). While this statute confirmed an undifferentiated system of care developed during the early 19th century, it recognised and listed a variety of crippling conditions which could entitle a person to receive outside help from his or her local municipality. The insane and mentally challenged were listed separately from those with physical disabilities. The main form of assistance for those in need of constant care was through a filing system in which a few accommodations, or "farmhouses", were responsible for the care of a designated person, a "cripple from the file". The person could also be rotated between houses or sold by auction to a house offering the lowest bid for his or her maintenance for the upcoming year. This auction system, while obviously economically sound to start off with, developed into a source of debasement and humiliation for people in need. It attracted much public criticism and had the unfortunate important consequence of debasing reliance on foster care and giving the future implementation of institutional care more of a human face (Karisto *et al.*, 1988).

At the end of the 19th century, the disability-service system descended into a sort of financial crisis due to increasing costs. It was replaced through a new statute in 1879, which established a new service model obtained from England: a workhouse system. If a person wanted welfare relief, he had to go into a workhouse where he lost his freedom and was subjugated to hard work and strict discipline. The intention was to raise the threshold for asking for outside help and in this way lower the costs of welfare relief.

The number of municipal workhouses in Finland rose to around two to three hundred facilities at the beginning of the 20th century. During this period, more and more people incapable of performing work were placed there. As a result, the names of the workhouses were changed to "Houses for the Crippled" and later to "Municipal Homes". When a more specialised institutional system developed, these houses slowly changed into care homes, mainly intended for the elderly. At the present time they are referred to as "Homes for the Elderly".

Workhouses were the first form of institution, in the wider implementation of the service philosophy, which can be referred to as a paradigm for institutional care. The concept of institutional care was introduced as a cure for the rising expenses of early welfare relief. Proponents of institutional care later saw it as a cheaper alternative to other forms of service. Originally, it was seen as cost efficient because the mere threat of institutionalisation was thought to be a deterrent to asking for help. Besides being an economic solution, the institution was seen as a more humane alternative to the evils of the auction block and foster care that were motivated mostly by financial gain.

Differentiation of disability services and the major division within the disability field

Separate legislation for people with disabilities began to develop in the late 19th century. An important principle of classification was, at first, the source or origin of the impairment (Harjula, 1996). When disability originated as the result of an "honourable" cause, it was regarded as an appropriate basis for support. A work-related accident, for instance, was an honourable way to become disabled. Legislation on industrial-accident insurance brought about the concept of "invalidism" in the Finnish language. The term was borrowed from German social-welfare legislation of the 19th century (Stone, 1984). Another honourable source of disabilities was being wounded as a result of war heroism. Subsistence for disabled soldiers of the Finnish Civil War of 1917–1918 was secured through separate legislation. This legislation ensured that disabled veterans, who fought for the "Whites", or the winning side, did not need to seek help from ordinary welfare assistance. After the Second World War, this legislation was widened to guarantee subsistence and rehabilitation for over one hundred thousand disabled soldiers (Ranta-Knuuttila, 1996).

The development of legislation on the subsistence and rehabilitation of disabled war veterans led to a discrepancy between the benefits afforded to disabled veterans, on the one hand, and those allotted to disabled civilians, on the other. As a result, a law on the care of people with invalidism was enacted in 1946 (Harjula, 1996). There was a heated debate surrounding the question of who the disabled people were who would be entitled to receive the benefits afforded by this law. As a result of this discussion, the concept of "social acceptability" was introduced. A person was considered to be socially acceptable if he or she was an able-bodied member of society before the loss of the ability to work. On this basis, both disabled war veterans and disabled civilians opposed the widening of the concept of invalidism to include children with inborn developmental disorders. Through compromise, children with physical disabilities were finally accepted into the sphere of those eligible for benefits afforded by the law.

In conjunction with the enactment of the Invalidism Law in 1946, the field of disabilities was divided into two large classes. On one side were the "socially acceptable" disabled, called invalids. They were entitled to the benefits of the Invalidism Law. Their disability was physical in character and originated either from an inborn physical disorder or from accident or disease in adulthood. They also had to be of working age or younger. On the other side were those disabled who were not "socially acceptable". These were people with mental disabilities, either intellectually disabled or mentally ill. The foundational memorandum of the Invalidism Law was reticent about the reasons why this group was left out. It only referred to "reasons of expediency" without further explanation (Government Announcement, 62/1946). According to Harjula (1996), the Invalidism Law made a distinction that was not based on any objective division between those who would possibly be able to work in the future and those who would not. The division was made on the basis of cultural images of varying disabilities. On one side were the people with disabilities who were seen as full human beings. When a disability was physical, it was easy to make a distinction between a person and his or her disabling condition. On the other side were those whose humanity hung in the balance. Their disability was not about their bodies but their minds. Because their minds were disabled, their status as full human beings was questioned. Negative cultural images of people with mental disabilities were enhanced on the basis of eugenics theories and the eugenics movement of the late 19th century. This movement saw intellectual disability and mental illness as indices of the degeneration of the human race. The human race could be protected through the segregation and sterilisation of people with mental disabilities. Even the sterilisation law enacted in Finland in 1935 was not revoked until as late as 1970.

The growth of the institutional model for people with mental disability

It seems that, internationally, constructing institutions for people with mental disabilities is associated with the industrialisation and urbanisation of individual countries. When family units move from the country into towns, and people go to work in factories instead of working for the family farm, the ability of families to rear their disabled members is weakened. During the first part of the 20th century, Finland was an economy dominated by agriculture. Most people lived in the countryside. In this environment the tenets of the eugenics movement on the need to segregate mentally disabled people in institutions did not strike a chord. Institutions were not needed because mentally disabled family members did not prevent the mainly farming-based economy from functioning. Even if many Finnish professionals promoted the construction of institutions according to international models, the need for institutions was not seen among politicians. On the contrary, such plans would have been criticised as inhumane and expensive (Harjula, 1996, p. 150).

This way of thinking altered when Finland began to change into an industrial society. An industrial society developed late in Finland by international standards, but the development was rapid. The customary view is that the change to an industrialised society began during the Second World War, in the 1940s (Karisto *et al.*, 1988). During the 1960s the population working in industrial workplaces already superseded in number the population working in agriculture (Suomen Tilastollinen Vuosikirja, 1982). The government first became interested in constructing institutions during the 1940s. At that time the first committee reports on this topic were published. However, first the war and then economic hardships, including war indemnities, delayed the realisation of such plans. Nevertheless, legislation was finally ready in the 50s. In 1958, the Law on Mental Deficiency was enacted. It guaranteed generous state grants for the building and maintenance of institutions for people with mental deficiency. A similar law for people with mental illness was enacted in 1952. On the basis of these laws a network of mental institutions was built during the 60s and 70s. The original aim was to institutionalise 0.2% of the Finnish population into hospitals for people with mental deficiency. This aim was not achieved. The peak in intellectual disability services was attained in 1983 when the rate of institutionalisation was 0.12%, or 5,900 people (Saloviita, 1992). The rate was, however, higher than what was ever achieved in the US where the highest rate of institutionalisation, attained in the 60s, was 0.10% (Lakin, Bruininks & Sigford, 1981).

Governmental reports, which formulated legislation on institutional care, did not contain many arguments to justify this service model. For the most part, institutions were circularly justified on the basis of a need for institutional care. Institutions had become a matter of course and were not in need of any specific justification. A child-welfare committee in 1943 presented a few additional arguments for following the Danish centralised model, instead of the more decentralised Swedish model. It was argued that institutions should be large, as in Denmark, because this made it possible to classify residents into separate wards according to their diagnoses; it would also be cheaper to build a few larger institutions than many smaller ones (Komiteanmietintö, 1947).

The rehabilitation paradigm

The industrial phase of Finnish society lasted a very short time. During the 1960s, Finnish society developed from an industrial to a post-industrial service society, as measured by the people employed in different forms of industry. This change was also characterised by an upheaval in cultural values. Traditional values were superseded by value pluralism. The ironic side of this development was that while the comprehensive building of an institution-based service system for deviant people had at last begun, society had changed so that these institutions were no longer really needed. Society had become more tolerant towards deviancy, and new ideas were beginning to emerge about the types of care needed for people with various mental disabilities. It was not easy, however, to stop the process that had begun. The construction of institutions continued until 1979, after which remaining construction plans were finally frozen.

When millions of disabled soldiers returned home from the Second World War, it was understandable that a new definition of disabilities was needed. During the 50s, the International Labour Organisation of the United Nations (ILO) launched the concept of "rehabilitation" for disabled people. Disability was no longer seen as static but as a condition that could be improved through professional effort. The main idea was the return of disabled people into the mainstream of society as full members and as part of the active work force through the process of rehabilitation. This idea was contained in the Finnish Law on Invalidism in 1946. However, during the 40s and 50s this emerging rehabilitation paradigm was reserved mainly for people with physical disabilities.

It was not until the societal change from an industrial to a post-industrial society occurred that the idea of integrating people with mental disabilities into their communities was accepted. The turning point was the report of the rehabilitation committee published in 1966 (Komiteanmietintö, 1966). Soon after this, changes in legislation took place which guaranteed state grants for the development of open-care services for people with mental disabilities. These new services included the establishment of group homes, training schools, sheltered workshops, day-care centres, the provision of family-care subsidies and many other options. This legislation came into force in 1970. There was a clear cutting edge to the new service paradigm.

According to the rehabilitation paradigm, there was to be a continuum of services from more restricted services to less restricted services until an ordinary community was at last achieved. A disabled person was put on this ladder in a proper step-by-step sequence. The service steps were ordered to rehabilitate the person. The care services were therefore entitled to remove an individual from society and place him or her on this ladder on the basis of this desired effect, i.e. rehabilitation. It was in the individual's vested interest.

The extension of the rehabilitation model to include people with mental disabilities was a big step forward in their lives. The number of children who were institutionalised began to drop immediately in 1970 after the first parts of the new legislation came into force. During the 70s, a new law on mental retardation was enacted which confirmed the new service model (Laki, 1977). Similar changes were made in the same year to the law on mental illness (change 521/1977).

The rehabilitation paradigm was easy to adopt because it also included the institutions as the lowest step in the model. It simply interpreted the institutions in a new way. They were supposed to be no longer places of segregation but, rather, places of rehabilitation. The rehabilitation paradigm is currently the ruling philosophy of disability services in Finland. However, during the 80s new developments began to occur which led to the emergence of a completely new service paradigm.

The support paradigm

While the rehabilitation paradigm was mainly introduced by the ILO, the roots of the new support paradigm can be found in community-based rehabilitation model of the World Health Organisation, presented for the first time in 1978 in Alma Ata (Lysack & Kaufert, 1994). This model, originally planned for the conditions of developing countries, was based on the idea of helping disabled people in their own communities. The Western model of disability services, which was dominated by various professionals and based on the idea of moving people with disabilities into separate buildings to be served by staff, was not realistic in the context of developing countries. During the United Nations Decade of Disabled Persons (1983–1992) much work was done to develop a new understanding of disability services that would bring the rights of disabled people to the forefront in the spirit of "equality and full participation". These rights included the right to be part of a local community and receive the necessary supports there in contrast to being removed to separate disability services. The closing document of the decade, "Standard Rules on the Equalization of Opportunities for Persons with Disabilities" (1993), presented these ideas in a concise form.

The main idea of the new service paradigm was the right of every individual to belong to his or her own community instantly, without the need to first prepare for it through some rehabilitation process outside the community. This traditional form of service philosophy is often referred to as the "readiness model". The primary focus of the services was no longer rehabilitation but human rights and equality for the person with disabilities. Taylor (1988) presented a thorough critique of the old rehabilitation model, which is known in US legislation as the "principle of the least restrictive environment" (Taylor, 1988). He argued that the consequence of the rehabilitation model was to justify institutions and other special environments that separated people with disabilities from ordinary life. This was done in the name of their rehabilitation. Smull and Bellamy (1991) outlined five shifts which were part of the new paradigm: (1) shifting the view of disability from an emphasis on individual limitations to a focus on environmental constraints; (2) shifting the emphasis on the public role of providing community readiness programmes to guaranteeing access and providing support; (3) shifting from assessment and diagnosis to choice-based approaches; (4) shifting service location from separate programmes to integrated settings, and (5) shifting the service strategy from formal to informal supports.

In Finland the new way of thinking about disability services entered the field through the Disability Service Act that was passed in 1987 (Act 759/1987) and came into force step-by-step between 1988 and 1994. The change in focus was evident in the first paragraph of the law where the attention was directed to environmental constraints which should be removed so that people with disabilities could become equal members of society. The new law brought with it many important new services, such as the right to acquire personal assistants, interpreters, independent housing with services, and transportation. The Disability Act superseded the old Invalidism Law. Unlike the Invalidism Law, the new law was written to be non-discriminatory. It covered, in principle, both people with physical disabilities and people with mental disabilities. In practice, however, people with mental disabilities have found it difficult to obtain services through this law. The continued existence of separate laws for these groups has made it easy to knock back their attempts to receive (better) services through the Disability Act.

An important concept in the new service paradigm was the concept of "support". Support should not be understood in the old way simply as any service the person with disabilities can receive. Instead, the concept of support is connected to the interests and causes of the individual. "Support" is identified with those resources and strategies that promote the chosen lifestyle of the individual. It is easy to see that the popular implementation of the concept of support in the Finnish disability field rarely follows this rule. On the contrary, new concepts in the support paradigm are typically interpreted within the context of the old paradigm. In this assimilation process, the value basis of the support paradigm is lost and the new service forms, detached from their value base, are seen as just another model of service (Saloviita, 2000).

The concepts of supported housing, supported education and supported employment are some derivatives of the support paradigm. While the Disability Act of 1987 provided a basis for developing services in this direction, the support model has, thus far, mainly been applied to people with physical disabilities. Both major disability groups have gone through the shifting phases of disability services but at different rates. Negative cultural images of people with mental disabilities have prevented them from benefiting from service reforms over the same time period as people with physical disabilities. Currently, all three service paradigms, institutional, rehabilitative, and support based, seem to exist side by side in Finland. However, the institutional model continues its existence only as a relic of the past, as the meaning of mental institutions has been reinterpreted from the perspective of the ruling rehabilitation paradigm. In the same way, there is a tendency to interpret the new support-based services as just another instance of the rehabilitation paradigm. Therefore, many aspects of the support paradigm, such as supported employment (Saloviita, 2000) or inclusive education, must fight for their independence against attempts to distort them from the position of the old scheme.

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Editors:

Anders Gustavsson *is Professor at the Department of Education, Stockholm University, Sweden.*

Johans Sandvin *is Professor at the Department of Social Science, Bodø University College.*

Rannveig Traustadóttir *is Professor in the Faculty of Social Science, University of Iceland.*

Jan Tøssebro *is Professor in the Department of Social Work and Health Science at the Norwegian University of Science and Technology in Trondheim.*

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