EPA GAINING EXPERİENCE PROGRAMME REPORT
On the observership visit at the University of Helsinki and Helsinki Central Hospital, Helsinki, Finland
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REPORT:

Thanks to the EPA Gaining Experience Programme that I had a very interesting, fulfilling and enriching observership experience of four weeks at the University of Helsinki and Helsinki Central Hospital in Finland under the supervision of Dr Tanja Svirskis. The colleagues and professionals I met were very friendly, helpful, informing and collaborative and I felt welcomed by every one of them.

Dr Tanja Svirskis did her best to develop a programme which would fit my clinical interests and also give me a broader perspective of the psychiatric care and medical education in Finland. She facilitated contact and communications with other colleagues from different Units and was always available and helpful in case of any inquiry throughout my visit and made my experience useful, pleasant and enriching.

At first, I spent two weeks at the Adolescent Psychiatry units; mainly outpatient policlinics and for a shorter time adolescent psychiatry wards. In Finland, there are four Psychiatry specialities; Child Psychiatry, Adolescent Psychiatry, Adult Psychiatry and Forensic Psychiatry. There are also subspecialties. It's one of the rare countries where Child and Adolescent Psychiatry are separate specialities and have separate residency programs. Also, there are two official languages in Finland; Finnish and Swedish. There are also Swedish speaking teams at work in addition to Finnish. At the Adolescent Psychiatry outpatient unit at the Pasila District, my supervisor was Dr Henna Haravuori. She and her colleagues were quite helpful, informing and welcoming. They even provided me a private room which was very hospitable. I joined several patient and family meetings at the outpatient policlinics, and they did translations before and after the meetings. Helsinki University Adolescent Psychiatry Unit takes care of adolescents between the ages 13 up to 18. Resident psychiatrists have meetings for 3 to almost 4 patients a day in adolescent psychiatry and appointment time is 45-60 minutes per patient. Parents often come together. After meetings with patients at least 15 minutes is needed for the so-called 'paper work' which includes writing anamneses, reports, treatment goals, achievements and plans for each patient at a computerized program. Since there is a very good recording system, statistics in many fields can be obtained. Sometimes videocalls or visiting of homes and institutions are part of the work. Total treatment and follow-ups of patients usually takes between 3-12 months in general. For autistic patients there are rehabilitative and some several programs at the same time. For Attention Deficit Hyperactivity Disorder (ADHD) patients sometimes mindfulness therapies or neuropsychiatric rehabilitation combined learning treatments are provided. Since there is integration between private and public services, the health system in Finland covers over the half of private psychotherapeutic treatments of private offices for patients. The hospital also pays some amount for such treatments. For adolescent psychiatry, this private sector fills the gaps for rehabilitation. About 3 of 5 adolescent-psychiatry beds are closed throughout the country, and daily care, outpatient policlinics and ambulatory interventions are increased within the last ten years. In the adolescent and adult psychiatry units it was amazing to see the team work of colleagues. Teams were usually composed of a psychiatrist, a psychiatric nurse, a psychologist, a social worker and sometimes occupational workers. Nurses are very important elements of the team as they can start and arrange patient meetings, appointments, do treatment follow-ups, apply scales and inform the doctor regularly after their visits. They also record their reports after visits to the computer system separately. If nurses or psychologists are specifically trained, they can even apply psychotherapies and clinical diagnostic interviews like K-SADS. So patients are not interviewed every time by psychiatrists, but especially followed up by psychiatric nurses, trained social workers or psychologists and when there is a need for treatment evaluation or a serious

condition occurs are seen with the doctor. When a serious condition like suicidality or a psychotic condition is apparent the patient is seen with the doctor from the start.

In the adolescent psychiatry unit, I also had meetings with Dr Minna Nikula and Dr Marko Muukka, and they were quite helpful, friendly and informative as well as all other colleagues. In Finland, every school has a nurse, a school doctor and a school psychologist. They make the first assessment and visits with the young and his/her family. At first, mainly nurses at schools evaluate the young people, and the team tries to solve the problems within the school environment as far as possible. School psychologists mainly check for learning problems but also for psychological problems. If there is a serious condition the nurse informs and refers the young to the school doctor and if the doctor also thinks that a serious condition is present he/she refers the young through an electronic referral system to the adolescent psychiatrist with a detailed report. All these electronic referrals are checked every day by the Pasila Adolescent Psychiatry Unit by a specific adolescent psychiatrist who only does these first evaluations and interviews together with his team including K-SADS interviews, parent meetings, and meetings with the young. The nurse arranges the first appointment date of these referrals and sends a post to the young and his/her parents which states the appointment date and includes the forms to be filled in by patient and parents and to be brought to the appointment. The first assessments and evaluations usually take 3-5 visits and afterwards the action and treatment plan is generated. And then the treatment plan is usually realized by a different doctor and his/her team at the unit. The patient can be started medication or referred to psychotherapy protocols which are applied by different teams. Also if there is mainly substance abuse comorbidity, patients are treated by another team. Trained nurses, social workers and psychologists may apply K-SADS interview for adolescents in 2-3 meetings approximately 45 minutes each. They also apply self-report scales like Beck-Depression Inventory etc. Then they write, discuss and inform the diagnosis report with the doctor at the first evaluations. It was amazing to see that this clarification of work definition for every team member in psychiatry and working as teams makes the wiser use of resources and increases the effectiveness of treatment.

In Finland, within the last four years, referrals from primary care to adolescent psychiatry specialists has increased dramatically like 30-40 %. Therefore now the Helsinki University Adolescent Psychiatry Unit goals to strengthen the primary care (like school doctors, nurses) by providing them information, trainings in consultation and evaluation, behavioral therapy based counselling trainings for school nurses and psychologists to let them provide early and immediate intervention for the young people and so that to decrease the referrals to the specialists.

Regarding psychiatric wards for adolescents in Helsinki and Uusimaan Hospital District, the number of beds is currently 46 which were over 100 beds ten years ago. There are two acute wards, one of them is for first episode psychosis and conduct disorders mainly, and the other is for affective disorders. In acute wards, smoking is not allowed, and adolescent patients are given nicotine chewing gums up to 6 times a day when needed. One other ward is for very severe, aggressive patients of 8-17 years of age. There are also two other wards for evaluation and treatment. About half of the referrals to the wards are done by general practitioners (GPs), and GPs always have a contact psychiatrist on duty whom they can easily reach day and night. The number of beds was reduced as the outpatient policlinics took more responsibility that they started to treat some severe patients in their units. Also, basic psychiatric problems are being evaluated and intervened at the primary care level, and there is a strong connection between primary care physicians and psychiatry in Finland as well.

It was also interesting to learn that transgender adolescents in Finland have the right to change their sexes with the law. Usually, these treatments start at the age of 16. Two major clinics one in Helsinki and the other in Tampere are responsible for these assessments. The young transgenders referred to the Helsinki clinic are first assessed and then monitored by a team of a psychologist and a nurse for at least 6-12 months. At the first evaluation, an appointment to the young and the parents are given, and the patient history and evaluation information are collected. The family and the patient are listened carefully, and all information is recorded. They are provided guidance and support at the same time. After the young is followed up at least 6-12 months,

and it is documented that the young person physically, socially and psychologically expresses his/her sexual identity with consistency during this time an appointment with the adolescent psychiatrist is made and the first (initial) diagnosis is reported by the team. With this report, the person can make an application for changing his/her name, and hormone treatments can also be started. Afterwards, under this new process a new follow-up period of about one year starts, and at the end of this year, the young are referred to the Tampere clinic to have the diagnosis approved and to have a second opinion. If Tampere clinic approves the same diagnosis, this time the young have the right to change his/her sex in the identity card officially and also social security number changes and the young are then able to apply for surgeries.

In our meeting with Prof. Dr Mauri Marttunen, he informed me about the residency training in psychiatry and the psychiatric care in Finland. In Finland, there are four psychiatry specialities; child psychiatry, adolescent psychiatry, adult psychiatry and forensic psychiatry. Each takes six years. Common tracks for all there four specialities are; six months of acute general psychiatry, nine months of one of these four specialities (whichever the resident wants) and nine months of general practition (primary care) practice. These common tracks take two years in total. After this two years the resident decides and starts his/her main residency branch; for example 'adult psychiatry'. Specifically for adolescent psychiatry, the residents need to spend one year at the acute ward and one year at the acute adolescent outpatient clinic. The last two years of residency may be spent at some subspecialty units like eating disorders or neuropsychiatry clinic or gender identity clinic or rehabilitation for early psychosis unit or substance abuse clinic or consultation-liaison unit. These are tertiary clinics. Nowadays in Finland, new rules for the application procedures for residencies are being planned. During applications, previous medical experiences, academic properties, motivation and reference letters and some other conditions will be taken into considerence in the near future for many residencies. It was amazing to learn that every two years each resident has the right to participate in an international congress and the university covers the expenses for this participation.

In Finland, the prevalence of depression is assumed to be almost the same in Western or Southern European countries. Suicide rates in Finland have declined clearly (about 50%) since 1990. One reason for this is the National Suicide Prevention Program they implemented, and the other reason is the improvements in the treatment of depression during the last 25-30 years. There's a national help number for emergencies like suicidality with which people can be referred to professional help. During the last 15 years, the rates of alcohol use and smoking have also declined in the country.

During my experience at the adolescent psychiatry unit, it was amazing to learn the strong involvement of primary care physicians in evaluations, treatments and referrals and also to see the great team work done at the unit. I made a presentation to my colleagues at the adolescent psychiatry units about our work in Turkey, my research about evaluations in liver transplantation patients and also about the Gaining Experience Programme of EPA. Later at another session, I repeated the same presentation for my colleagues at the adult psychiatry units as well.

Helsinki University Central Hospital (HUS) is located in Töölö in Helsinki. Besides major HUS Hospitals in Helsinki, HUS also has several affiliated hospitals and psychiatry units throughout the three main cities in Finland which are close to Helsinki. There are 22 hospitals within HUS and HUS is responsible for the specialized medical care for almost 1.6 million people within the Uusimaa region. In the central hospital, I had meetings with several doctors in the units of Adult Psychiatry. In our meeting with Prof Dr Suoma Saarni, she informed me about the 'Psychotherapy Quality Registry Report' which is a new project to start this year. This project will be applied in five main universities throughout Finland and will be a tool for quality control in psychotherapies which will be integrated into medical records and gets data from patients, psychotherapists and health care unit. Within this project, some evaluation forms and assessment tools (scales) will be required to be filled in both by the patients and by the therapists at the beginning, at the end or in the middle of the psychotherapy. Thus the effect of the therapy, commitment and the applicability of therapy methods will be monitored and measured.

I was also informed about internet psychotherapies which are part of the Finnish public health care system. They're internet delivered and cognitive-behavioural based therapies done by trained psychologists or nurses. It's a national service for mild and moderate mood and anxiety disorders and free of charge to patients. It's funded with tax money, and municipalities pay the therapy bills. It was found to be cheaper compared to face to face therapies and cost-effective. For internet psychotherapies, there should be a referral from a doctor because they're usually for mild to moderate cases and not for severe cases. The patient can access therapy anywhere regardless of his/her place of residence. Patients have these therapies once a week for up to 3-4 months. Once the therapist is identified, the therapist informs, directs and answers the questions of the patient like a coach. Also, the therapist identifies and challenges the thoughts, gives feedback and exposure training and behavioural activation by using CBT techniques. Every therapist can have up to 40 patients. As a new treatment option for primary care in psychiatry, it was amazing to learn about internet psychotherapies as it also provides accurate, scientific, true and easy to reach information for patients with psychiatric problems. More information can be reached via the web site link: www.mielenterveystalo.fi.

It was a very interesting experience to work with Dr Johanna von Knorring and her lovely team. It was the acute evaluation and treatment ward at the 9th floor of the Psychiatry centre of HUS. In this ward, not only acute psychotic patients but also international patients like refugees and patients who are health workers and referred for differential diagnosis and treatment were treated. It was very interesting for me to see that there was a specific ward for patients who are also health workers. I think it is really necessary to make them feel confident as health workers may have specific needs for privacy. At this ward, international patients were being treated with the help of an appointed translator when needed. I could attend several patient visits and meetings and also of some English speaking international patients. It was really interesting to evaluate and discuss these patients with my colleagues altogether as a team where there were psychiatry nurses, social workers and psychologists as well. The duration of hospitalizations might be longer compared to other acute wards because detailed evaluations for differential diagnosis and specific decisions are made in this closed ward. For example, it is a really tough decision from several points of view to report that the health worker-patient (nurse, doctor etc.) can no longer do his/her job since they usually depend on their work for a living. In some health worker patients who were referred after malpractice, comorbidity of substance abuse and personality disorders along with other psychiatric disorders might be observed.

It was really interesting to learn about the teaching, training skills and techniques both for undergraduates and postgraduates in our meetings with Dr Tanja Svirskis. She was always quite polite, helpful, facilitating and informing as a supervisor during my observership period. In medical education at Helsinki University ' problem-based learning' and 'active learning' techniques are being used for medical students where there are fewer lectures but more researching and active learning facilities. Also recently 'simulation training' technique is started to be implemented under the supervision of Dr Tanja Svirskis in psychiatry training where there is a trained actor who knows the disease and plays his role very good and so that lets the trainee do throughout evaluation, examination and history taking without missing important points. In 'simulation training' each clinical encounter is followed by debriefing for 15-20 minutes where the patient and the audience has active roles in giving feedback which offers a possibility to learn and strengthen clinical skills. It seems a well-accepted and feasible method of learning in both specialist training in psychiatry and in continuing professional development of general practitioners, physicians in occupational medicine and psychiatrists. Also in Finland evaluation and feedback forms for both trainees (for example; Mini-Clinical Evaluation Exercise (CEX)-F1 Version) and supervisors (Clinical teacher's self-evaluation form, mini-Peer assessment Tool-F1 Version) are suggested and encouraged to be implemented. I especially learned the importance of giving 'high-quality feedback' in training and medical practice where the true medical expert is not only a professional but also a scholar, health advocate, manager, collaborator and a communicator.

In the Neuromodulation Unit, the team was doing an amazing job. About 10-15 Electroconvulsive therapies were being done per day, usually three days a week. The team of ECT is mainly composed of an anesthesiologist, a nurse, an anesthesiology nurse and a nurse for the recovery room. In the transcranial

magnetic stimulation unit, they are doing researches regarding the optimization of the target region in the brain for better outcomes.

It was also interesting to meet with Dr Venla Lehti who works at the outpatient and consultation unit for immigrants and deaf people. They are using Cultural Formulation Interview (CFI) of DSM-V which is translated to their language and when needed with the help of translators to the language of the immigrant patients during evaluations. This interview tool is quite helpful and also has supplements according to religion, sex etc. They were trying to help for the specific needs of immigrants as well as helping them have easier contact with other psychiatric units.

In our meeting with Dr Katinka Tuiska, it was interesting to learn about the evaluation, assessment and transition procedures of transgender individuals. After an examination period of about 12 months, a real-life test period of another minimum 12 months is needed for these individuals. At the real-life test period hormone therapy and some other applications are started, and the person leads a normal life in the desired gender role. After these periods medical statements of gender reassignment for genital reconstruction surgery are reported, and they are referred to the transsexual outpatient clinic of Tampere University Hospital, and also a gynaecologist's statement of the lack of reproductive ability is needed. After this second opinion and evaluation at the Tampere University Hospital which gives similar statement reports, genital or chest surgery and legal confirmation of gender are initiated. This year over 400 application was made to their institution at HUS. Also during the last ten years, the amounts of applications for these procedures rose from 40 at the beginning to 800 per year in Finland.

In my fourth and last week in Finland, I had meetings and observations with Dr Boris Karpov at Jorvi Hospital, and I also visited the Tikkurila Hospital Psychosis Outpatient Policlinics and met with Dr Max Franzen and Dr Nina Markkula. We had patient interviews and evaluations together with colleagues as well. It was also very interesting to visit The Consultation-Liaison Unit at the Meliahti Hospital and to meet with Dr Salla Koponen and her team. In my last day, I visited the psychiatric wards and the rehabilitation unit of Kellokoski Hospital, and it was very interesting to see this historical hospital area which gave impressions about the traditional way of psychiatric care and also about the new way of treatment approaches. In this hospital area, I had meetings with Dr Victor Volkov and Dr Ilia Kirilkin.

In Jorvi Hospital there are four wards; 1 for acute psychotic disorders, 1 for psychosis rehabilitation, 1 for mood disorders and 1 for acute psychiatric (general) conditions. In each ward about 12-15 beds are present. There are occupational therapists, psychologists, social workers and diet (nutrition) therapists in each ward. There's a neuromodulation unit as well where ECTs, TMS and ketamine infusion therapy are performed.

In Finland, there are also supported living facilities like house care treatments which are provided by the primary care and by the municipalities for patients with low support systems or who need special care at homes. This is called housing rehabilitation where the patients are monitored and trained, and when they're better, they're referred to less supported houses.

Newly discharged psychotic patients are referred to outpatient policlinics like the ones at Tikkurila Hospital and are followed up by teams. Teams consist of a psychiatric nurse, a social worker, an occupational therapist, a physiotherapist and a psychologist. They're followed up once a week at least for the first month. It was amazing to see that the psychiatric nurses are the basic and key elements of the treatment follow-ups. During these follow-ups when there's a new problem with the patient the nurse and the psychiatrist sees the patient always together. Otherwise, the basic and routine follow-ups are carried out by the nurses. Psychologists apply scales, interviews and cognitive evaluations and recommend for cognitive rehabilitation when needed. Cognitive rehabilitation is a game like programme which helps for cognitive problems like memory, attention etc. and may be applied by some nurses, psychologists and occupational therapists. Occupational therapists help and evaluate the functionality of patients. By their functionality assessment

reports the doctor can write a statement so that the patient is funded by the government till he/she can fit working again. The doctor also reports the treatment plan, medications and recommendations for part-time trained working for suitable patients. Apart from hospital care there're also support teams who check once a week at patients' homes and assesses his/her functionality for their basic personal care capacity and this support is provided by the city.

In means of consultation-liaison psychiatry (CLP) services there are four responsible psychiatrists and a resident, one psychologist, and four psychiatric nurses for the Helsinki University Hospitals in Helsinki city. The nurses in Finland are usually very good-trained, and they also make quite long medical records. The nurses usually do the treatment follow-ups and interviews at outpatient clinics and CLP services and consult the doctor when needed. They apply inventories like BDI (Beck Depression Inventory) etc. as well. Nurses usually do the first evaluations and interviews for initial patients at least two times and collect and record basic information. At the third visit, the patient is usually being evaluated together with the doctor. For simple situations sometimes only the psychiatric nurse follows up and does the patient interviews. In some units and cases (suicidality or acute psychosis) at the first evaluation doctor may be present from the start. In such difficult cases, psychiatrist is informed and taken into treatment in early stages. At the CLP unit mainly patients who have functional somatic symptoms are being evaluated and treated. Patients who have dementia are being evaluated not by the CLP unit but by the Geriatric Psychiatry outpatient Unit. CLP unit also evaluates the suicidal cases at the emergency units. These cases are first evaluated necessarily by the doctors, not by the nurses. And if there is a psychotic condition in the suicidal attempt the patient must be referred to psychiatric wards for mandatory hospitalization according to the Finnish legislation.

At the Kellokoski Hospital area, it was very interesting to see and learn about the psychiatric wards for chronical psychotic patients, forensic psychiatric patients and the rehabilitation units. In this historical hospital area, it was very interesting to see the intersection between newer treatment approaches and still impressing traditional traces of psychiatric care.

In conclusion, the EPA Gaining Experience Program was a great opportunity which fulfilled my expectations with real life and professional experiences. It helped me learn and familiarize with the National Health System in Finland and Europe. This observership gave me the stimuli and opportunity to improve my clinical and teaching skills and gave me new ideas for better ways of psychiatric care. It was great to meet all those amazing colleagues and be able to build new professional relationships that may be bases for new collaborations and international projects.

I would like to express my gratitude to those who made all this possible: the EPA ECPC for providing the opportunity and for their sincere efforts to make me participate in this Program; very special thanks to Dr. Tanja Svirskis who was always so kind and friendly, informing and supportive and did her best contribution to make my observership very efficient, diverse and useful. Also special thanks to all my other colleagues I met during those unforgettable four weeks in Finland who were always very friendly, informative, collaborative and welcoming.