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Challenges of Accessibility: Finnish Substance Abuse Services Perspective

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Abstract

This empirical legal study explores the challenges to access in Finnish healthcare and social welfare services, focusing particularly on substance abuse care. Despite the guarantees of the legal framework for services based on individual needs, in practice, many clients face significant barriers. Using the combination of legal-dogmatic analysis and qualitative analysis of the interviews of 21 substance abuse professionals, the study identifies five key dimensions of accessibility: institutional, informational, economic, physical, and experiential. The findings of the research reveal systemic problems such as fragmented service provision, regional disparities, insufficient resources, and the stigmatization of clients. These barriers often prevent individuals from receiving timely and appropriate care, undermining the realization of their legal rights. The study concludes that, while Finnish legislation supports equitable access to services, its implementation frequently falls short. The need for reforms that better align service delivery with client needs and legal obligations is evident.

Keywords

accessibility; healthcare; social law; social welfare services; social welfare; substance abuse care

1. Introduction

In this empirical legal study, we are interested in the accessibility of public welfare services in Finland. These services may be available, but this does not mean that they are accessible to everyone who needs them. Possible obstacles to accessibility can weaken the effectiveness of the services. The full benefits of welfare services are not realized if people cannot access them for one reason or another.

Our focus is on healthcare and social welfare services, and especially on substance abuse care. In Finland, the goal of combining healthcare and social services coherently has been on the agenda of legislators for some time. The Finnish authorities have a constitutional obligation to organize adequate healthcare and social services, and people have a right to the services based on their needs. The aim is to support, care for, and rehabilitate individuals with a substance abuse problem so that it is possible for them to act as full members of society. This will ensure that they will be able to fully exercise their other fundamental rights. Reforms have been made to improve the availability and effectiveness of services (Finnish Government, 2022a, pp. 66–67).

Access to substance abuse services is challenging, and substance dependence causes significant social and health problems. In Finland, substance abuse services are inadequate, and there are major regional disparities. Only one-third of those in need receive the services they are entitled to (Finnish Government, 2016, p. 29). One of the biggest challenges of the healthcare and social care system is reaching those clients who need services and whose threshold for applying is the highest. The same clients have the greatest need for services due to multiple problems and perceived inferiority. It is a kind of vicious cycle because, as the need for help increases, the contact threshold for services also increases, along with the depth of the problems (Leemann & Hämäläinen, 2016, p. 591).

Our focus is on substance abuse services because they are an illustrative example of a Finnish welfare service at the intersection of healthcare and social welfare. However, the issue of accessibility has a wider impact and can also be examined on a more general level. We refer to accessibility as a person's ability to access healthcare and social services regardless of physical, psychological, financial, or other personal limitations. The challenges of accessibility cannot necessarily be defined clearly and exhaustively as being based on individual factors. However, it is problematic if there is no effort to investigate the barriers to accessibility and thereby react to them. The research question is therefore: What kind of obstacles can there be when it comes to accessing substance abuse services?

This study belongs to the body of empirical legal research. In addition to legal information, interview data is utilized in this research. In empirical legal research, the researcher has a legal understanding of the phenomenon under study upon which to build an empirical examination. The legal dogmatic analysis acts as a kind of lens through which the interview data is examined. In empirical legal research, the line between theory and empiricism may not be clear. This is because there is a constant dialogue between legal knowledge and empirical observations (van den Bos, 2020, pp. 5–6). Empirical legal research can be of particular value if empirical findings are connected to legal dogmatic analysis by reflecting on them from a normative perspective (Ansems & van den Bos, 2022, p. 219). This study is based on both legal dogmatic information about legislation and qualitative interview data. The observations produced are discussed especially in Section 5, but to some extent also in Section 4.

This study is mainly based on Vanjusov's (2022) doctoral thesis, which is the first doctoral thesis in law on substance abuse services and their accessibility. Previously, Maite San Giorgi has looked at access to health services as a human rights issue (San Giorgi, 2012), but Vanjusov's study takes a more practical approach, focusing on access to services. Access to services is a crucial issue with a significant human rights and fundamental rights dimension, as it may essentially be a question of the right to life (see, e.g., Magwood et al., 2020). One of the key aspects of the study is accessibility categorization (Vanjusov, 2022, pp. 70), which makes use of various classifications presented in previous studies (Fradgley et al., 2015; Goddard &

Smith, 2001; Levesque et al., 2013; Penchansky & Thomas, 1981; Rodriguez Santana et al., 2021; Saurman, 2016; Tanner et al., 2020).

Vanjusov's thesis was published in Finnish; our goal is to bring its key results to the attention of an international audience. Saurula's contribution to this article was particularly in the legislative parts, as well as in summarizing Vanjusov's dissertation research.

2. Research Layout

Legal dogmatic research is about interpreting the existing law, which requires an understanding of the internal rules and principles of justice, and the internal system of justice. The purpose of a legal dogmatic approach is to describe and interpret existing law and thereby make justified recommendations for its interpretation and systematization (Smits, 2017, pp. 210–213). The aim is to create interpretations of legal issues that are challenging or to produce information to support, for example, empirical examination by posing a legislative framework within which it is meaningful to examine the topic.

Legal dogmatic analysis is bound to a world of "shoulds": Such analysis cannot provide an answer to how legislation is applied in practice, for example, in social services. This requires observations based on empirical data. Empirical legal research combines the two perspectives of legislation and practice. This allows us to gain information on, for example, how well the objectives set by the legislator, which influence the background of the legislation, are achieved (Vanjusov, 2022, p. 40). This study aims to examine, on one hand, how an individual's right to access the substance abuse services they need is safeguarded in Finnish legislation and, on the other hand, what possible challenges may be involved in its equal implementation in practice; the purpose is to provide information on possible obstacles so that they can be tackled.

The data utilized was collected by conducting semi-structured interviews with substance abuse workers in healthcare and social services. In qualitative research, attention should be paid to the selection of informants and interviewees in interviews to include people from whom the best information about the topic can be obtained (Brinkmann & Kvale, 2018, Chapter 5). The empirical part of this study hypothesized that the realization of a client's rights in substance abuse services is largely dependent on how the public authorities carry out their responsibility for organizing social welfare and healthcare services. Based on this setting, the key knowledge interest of the interviews was to obtain information on, first, how substance abuse services are implemented in legislation and available for clients, and second, how a client's autonomy and involvement are taken into account when implementing those/said services (Vanjusov, 2022, p. 54).

The data is described in Figure 1. The semi-structured interviews proceeded within the framework of the prepared themes but flexibly, without a strict route of progression. The interviews, which were recorded with the permission of the interviewees, were initially transcribed (Brinkmann & Kvale, 2018, Chapters 5 and 8). The views and the experiences described by the interviewees were essential, not how they related to them. The purpose was to obtain information on the practices that exist in social welfare and healthcare, and in substance abuse services in particular. The data consisted of 21 interviews by Vanjusov of various actors in the field of Finnish substance abuse care. Finnish substance abuse treatment has traditionally been based on the major role of the care-providing organizations, which is also reflected in the fact that representatives of these organizations can be interviewed at all (Vanjusov, 2022, pp. 54–55).

Data

- N = 21 interviews. The interviewer was Vanjusov.
- Data was collected in 2016–2018.
- 16 of the semi-structured interviews were individual interviews and five were group interviews. There were three interviewees in one group interview and two in each of the other four groups. Therefore 26 people were interviewed in total.
- The interviewees were nurses, doctors, social counsellors, social workers, and substance abuse rehabilitation experts. They represent both private and public sectors.
- Some of the interviewees had been substance abusers in the past and were, thus, experience experts.

Figure 1. Description of the research data.

Content analysis was the method used to analyze the interview data. This method involves the researcher attempting to condense and generally describe the phenomenon under study. The purpose of the theming phase is to combine and summarize the reduced data by looking for similarities and differences in codes: The data was first thematized and coded for issues related to accessibility (Brinkmann & Kvale, 2018, Chapter 9). Thematic coding and categorization of the data in practice meant splitting the data into parts and putting the parts back together again to find various themes within the data (Gibbs, 2007, Chapter 4). The aim was to examine how accessibility to services appears in the dialogue of healthcare and social welfare professionals. Other dimensions of the data were not considered in this analysis.

The method of analysis used can be called abductive or theory-directed. In abductive analysis, results are formed on the basis of both the data and the theoretical framework (Brinkmann & Kvale, 2018, Chapter 9). The theoretical framework was the information produced through the method of legal dogmatism, which guided not only the construction of research questions and interview themes, but also the analysis of the data. On the other hand, the interview data also guided us in determining how to conceptualize the themed data and divide the legal information into categories. Thus, there was a constant interplay between the interview data and legal analysis during the research process (Vanjusov, 2022, p. 58).

It is the ethical responsibility of the researcher to carry out the research in such a way that it does not cause harm to the participants (Guillemin & Gillam, 2004, p. 274). That this principle was followed is evident in this study, for example, in the anonymization of the data so that the interviewees cannot be identified from the research reporting. The research interviews did not collect any sensitive information covered by privacy protection rules. Some of the interviewees brought up their substance abuse background on their own initiative, but they were not specifically asked about this issue. The interviewees participated in the study as employees of the organization they represented, rather than as individuals.

Clients were not interviewed. However, we believe that substance abuse workers are able to talk about structural problems that may be difficult for clients to identify or even notice. This was a conscious delineation: The interview data collection was intended to focus on examining the client’s position explicitly through different substance abuse service actors. It can be difficult to get analytical information from active substance abusers on a more extensive basis, as active use can make it difficult to commit to interviews on the one hand and, on the other hand, it can be difficult to modify the views presented in the interview in such a way that the interview statements are perceived as not necessarily being very reliable. As an interviewer, Vanjusov also found it ethically challenging to use a person as an informant who would not necessarily participate in research without active substance use problems or give information that they were willing to give during problematic substance use (Vanjusov, 2022, p. 61). In an ethically sustainable way, interviewing clients would have required the creation of a confidential relationship with informants (Müller et al., 2022, pp. 66–68). The data collection, which extended all across Finland, did not provide any opportunities for that.

3. The Legislative and Theoretical Framework of the Research

3.1. The Obligation of Public Authorities to Make Services Available

The legal starting point and empirical hypothesis of this study is as follows: Substance abuse services are available when they are organized according to the legislation concerning substance abuse care. However, this does not guarantee that they are accessible. It is a question of how legislation is implemented in practice. In Finland, the public authorities have an obligation to organize adequate healthcare and social services for everyone. In practice, regional actors are responsible for fulfilling this obligation. These regional authorities are called wellbeing services counties and are not only responsible for healthcare and social services but also, for example, fire departments (Finnish Government, 2021b). With the 2021 service system reform, the responsibility for establishing healthcare and social welfare was transferred from individual municipalities to wellbeing services counties covering larger geographical areas (Finnish Government, 2021a). The object of the reform was to improve equality, joint functionality, and cost-effectiveness. Services must be implemented as locally accessible integrated service packages and according to clients' individual and client groups' regional needs.

The Finnish regulation of substance abuse services was also reformed a few years ago. The aim of the reform was also to clarify healthcare and social welfare service activities, specifically the role of both social welfare and healthcare in mental health, substance abuse, and addiction work and treatment (Finnish Government, 2022a, pp. 66–67). The reform can mainly be described as a fine-tuning of the legislative system, as it did not bring significant changes to the contents of the regulation itself, despite the more clearly defined goal setting.

The central legal principle of Finnish social law is the principle of need, which manifests itself at three different levels. First, at the national level, the state must ensure that legislation supports the needs of the whole country in terms of the service system. Secondly, at the regional level, the wellbeing services counties must ensure that their provision of services meets the actual needs of the region. Thirdly, at the client level, individuals have the right to healthcare and social welfare services based on their individually assessed needs (Tuori & Kotkas, 2023, pp. 205–206). Thus, the right to services can be described as needs-based. In the case of substance abuse services, need must be assessed either in terms of healthcare or social services. However, "need" is not a clearly definable concept (Goddard & Smith, 2001, pp. 1150–1151). Legally, the concept of need can be linked to, for example, the action-ready thinking created by Sen (2004, pp. 332–337), according to whom the equitable distribution of resources does not guarantee justice; instead, attention must be paid to which resources will make it possible to help the individual (Sen, 2002, pp. 337–338).

The needs of clients of substance abuse care services are often extensive and diverse. The treatment of problematic substance use has been somewhat medicalized with the categorization of substance dependence as a disease, although the person can be seen as a biopsychosocial entity, which, for their part, requires multidisciplinary cooperation in responding to service needs (Poikonen & Kekoni, 2019, pp. 69, 78). The Finnish legislation obliges wellbeing services counties to recognize clients who have multiple or overlapping service needs (Finnish Government, 2021a). The most vulnerable segment of clients has several overlapping needs for services because of their decreased functional capacity. Counties must recognize these client groups and define their service packages in detail. At the same time, clients can have the need for substance or mental rehabilitation, but also social support, and there may be causality or interdependency between overlapping needs. Unmet health service needs can produce social welfare needs: for example, income support, support services in housing arrangements, or housekeeping assistance.

Finnish legislation does not provide rigid settings for service integration, and practical solutions can be highly fluid. This allows the organization of services in a way that best serves the wellbeing services counties, as long as such services are implemented in the form of service packages and serve the clients' best interests (Finnish Government, 2020, p. 677; see also Finnish Government, 1992, 2000). These fluid conditions allow true service development on a regional basis. The Finnish Institute on Health and Welfare has divided these service functions into social welfare functions and healthcare functions, which are legally important concepts, for example, when using client data.

Finnish healthcare and social services are divided into divisions as shown in Figure 2. Some integrated divisions have shared management responsibilities (grey units) within the service package organization, and these integrated service packages must also meet each client's overlapping individual needs in both administrative sectors (Finnish Government, 2022b, p. 5). These pre-defined packages must be supplemented with auxiliary services according to the needs of clients and their families (Finnish Government, 2020, pp. 390, 677; see also Finnish Government, 2021a).

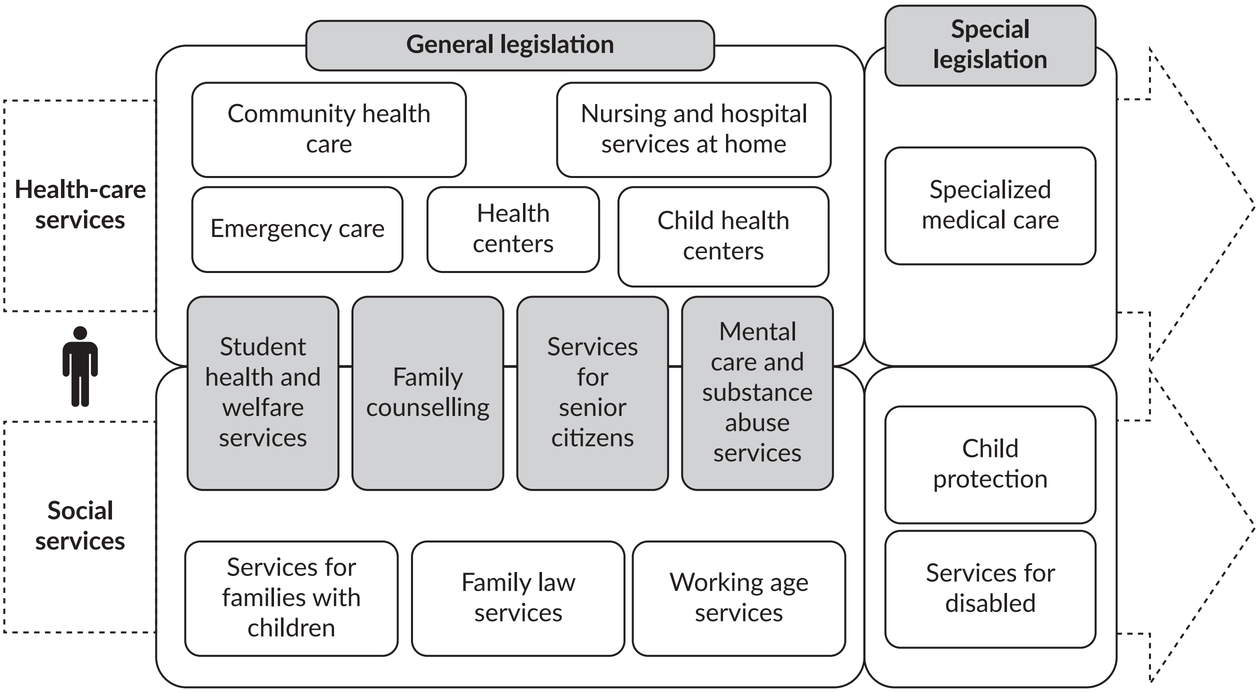


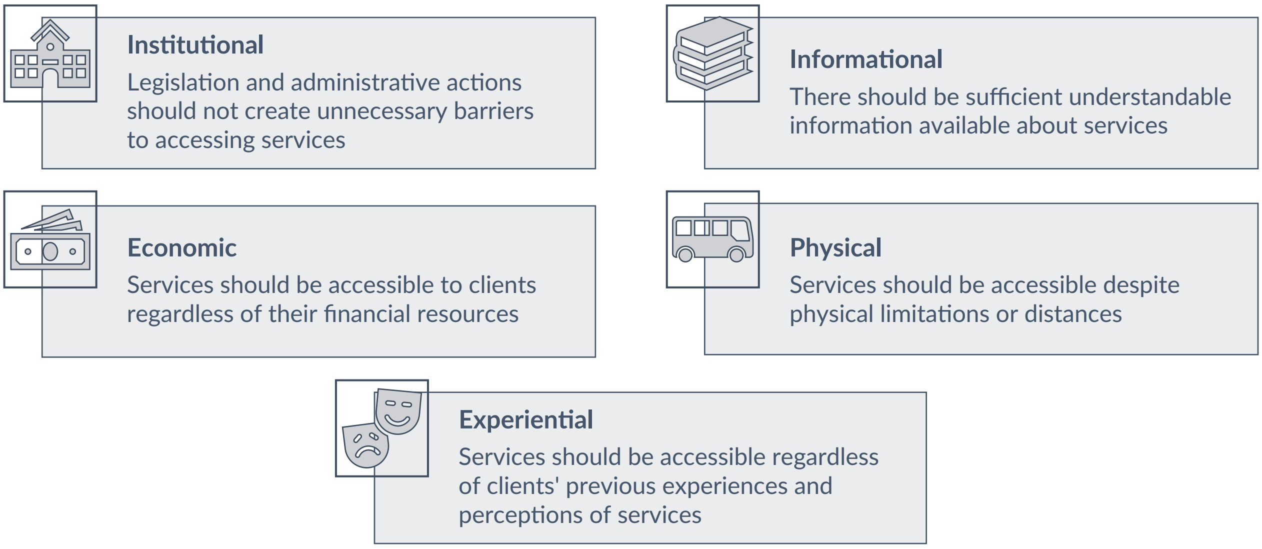
Figure 2. Finnish healthcare and social welfare services divisions (Finnish Government, 2010, 2014, 2022a, 2023).

3.2. Accessibility as a Theoretical Framework

Accessibility has been categorized in different ways in research, and the concept has been used particularly in studies related to health services. For example, Penchansky and Thomas (1981) examine access to health services from the perspective of consumer satisfaction. As Penchansky and Thomas were based in the United States, their context focuses on private health service markets, unlike the primarily public service provision in Finland; their categorization better reflects the consumerism of market-based health services (Penchansky & Thomas, 1981, pp. 128–129).

In our legal research, naturally, we especially sought support from legal sources. The term "accessibility" is used in Finnish healthcare and social service legislation and its legislative drafts (e.g., Finnish Government, 2020, p. 150) mainly as a complement to availability, but its content is not explicitly defined and thus remains vague. Since accessibility is not given a clear legal definition in the legislation, its interpretation is always context-dependent. However, the categorization of accessibility used in our study is supported by the definition provided by the UN Committee on Economic, Social, and Cultural Rights regarding what should be considered to effectively realize the right to health. According to the Committee, every individual's right to health is linked to a dignified life.

Also according to the Committee, member states must consider the following dimensions of the right to health when organizing healthcare, taking into account the individual circumstances of the state in question: (a) availability, referring to the existence of services; (b) accessibility; (c) acceptability, referring to the respectfulness, ethics, and professionalism of services; and (d) quality, referring to the adequacy of staff competence and the appropriateness of infrastructure (e.g., facilities, equipment, and medicines). The Committee defines what should be considered for the right to health to be implemented effectively and divides accessibility into four different overlapping dimensions: equal access, informational accessibility, economic accessibility, and physical accessibility (UN Committee on Economic, Social and Cultural Rights, 2000, pp. 1, 3–5). As can be seen in Figure 3, our study's division of accessibility into dimensions is more detailed.



Institutional
Legislation and administrative actions should not create unnecessary barriers to accessing services

Informational
There should be sufficient understandable information available about services

Economic
Services should be accessible to clients regardless of their financial resources

Physical
Services should be accessible despite physical limitations or distances

Experiential
Services should be accessible regardless of clients' previous experiences and perceptions of services

Figure 3. Division of accessibility. Source: Vanjusov (2022, p. 70).

Accessibility can also be divided into five different dimensions: institutional, informational, economic, physical, and experiential. The cross-cutting and unifying theme of these dimensions is equal access to healthcare and social services. Comprehensive consideration of accessibility is the implementation of equality, because the idea is to secure the opportunity for all individuals to access the services necessary for their needs to be satisfied. In addition, equality should also be seen as the goal of accessibility: That is, one should look at accessibility in a versatile way in the context of welfare services, especially healthcare and social services. When examining the accessibility of healthcare and social services, it is essential to examine the implementation of the services as a whole. It is not enough that the services are accessible in a form that does not meet a client's needs. In this case, quality factors should also be considered: for example, sufficient human resources and respect for the integrity of clients (Vanjusov, 2022, pp. 69–72).

On the one hand, this classification of accessibility dimensions can be seen as a theoretical framework for our research, but on the other hand, it is also partly the result of our research. It builds on a legal-dogmatic analysis of existing law, but is also supported by findings from empirical data. We now turn to our key findings from the empirical research data. In line with the empirical legal research approach, our research also engages in a dialogue with existing legal-dogmatic findings. Our results are presented through a breakdown of the five dimensions of accessibility. Our aim was to address the challenges related to the accessibility of welfare services, which on one hand are connected to legislation and on the other to how regulations are applied in healthcare and social welfare in Finland. Above all, our goal was to make practical observations and touch upon social phenomena related to legislation.

Below, we present and analyze the interview data through the different dimensions of accessibility. As this is an empirical legal study, our analysis is conducted through a legislative lens.

4. Accessibility of Healthcare and Social Care Services

4.1. Institutional Accessibility

Institutional accessibility refers to the fact that the organization and operations of the authorities should not cause obstacles to service access. In terms of institutional accessibility, it is essential that the authorities comply with general procedural regulations and that clients receive the services to which they are entitled based on their need for services under general or special legislation. Please note the importance of the practical implementation of the responsibility for organizing substance abuse services. Equal accessibility requires investigation into potential challenges within service organization. Figure 4 illustrates the key institutional accessibility challenges that emerged from the data (Vanjusov, 2022, pp. 103–104, 112, 130).

Finnish substance abuse services have in the past been organized in diverse ways, which could, on one hand, lead to inconsistency in services, but, on the other, large operating units have been seen to enable the development, quality, and specialization of services. However, a great deal of regional variation can, in practice, lead to regional inequality. Vanjusov's interviews raised the hope that reform in the organization of Finnish healthcare and social services could change this situation and promote equality. However, regional variation is also justified to some extent, as regional needs should determine the organization of services, and the needs of different regions may vary (Vanjusov, 2022, pp. 104–106).

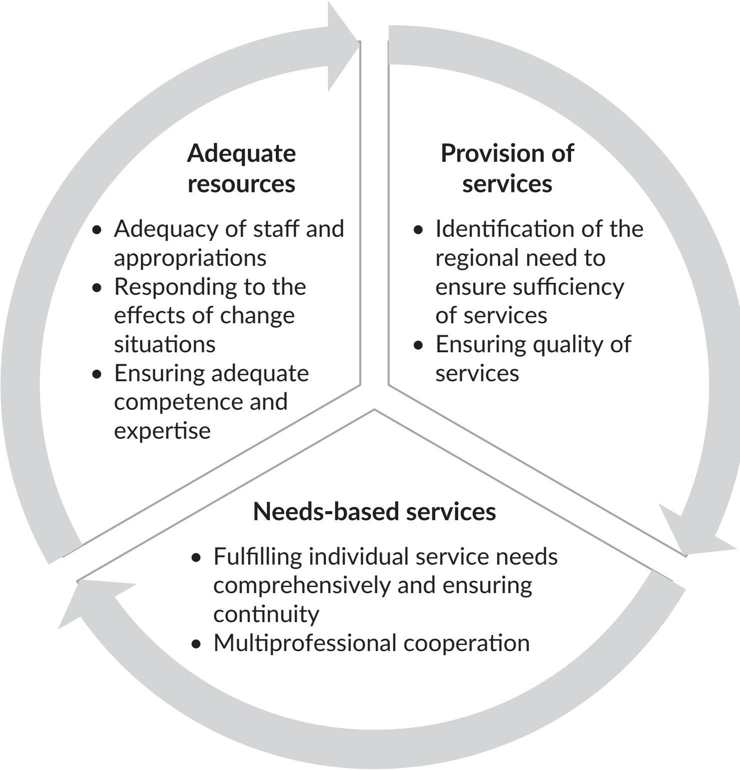


Figure 4. Challenges of institutional accessibility.

Substance abuse services should be organized so that people can apply for services on their own initiative, with a low application threshold. The system does not necessarily react flexibly enough to client needs. When a client is motivated to access substance abuse services, it should be possible for the system to respond quickly and flexibly. However, this is not necessarily what happens, and this can dissuade clients from seeking services. A person suffering from substance abuse problems cannot necessarily wait: Their expressed desire to seek treatment should be responded to as quickly as possible. Being placed on a waiting list can have a deterrent effect, as one interviewee describes: “It’s possible that there will be a date that you can get in two weeks. That way, your motivation will have time to change many times along the way” (Vanjusov, 2022, p. 112).

Each client has a statutory right to have their need for substance abuse services assessed both on social grounds and on medical grounds. Simply accessing a substitution treatment or other single point-based service does not necessarily mean that a client’s needs will actually be met as required by law. In this case, the authorities cannot acknowledge their responsibility for organizing services by only responding to one part of the package of service needs. The key challenge in the substance abuse sector is apparently the comprehensiveness of responding to service needs and securing service continuums. On the other hand, the policies made by the authorities leave room to take individual needs into account (Vanjusov, 2022, pp. 111, 117–118).

Problematic substance use is a multifaceted phenomenon: Such a client’s service needs cannot be met by the expertise of a single professional sector alone. People working in the field of substance abuse care see multiprofessional cooperation as something that improves their work as well as fulfills clients’ interests, as shown in the following quote:

> This multiprofessional collaboration, as it improves and grows. Then comes the new kind of know-how—learning from each other's work—and there's going to be a whole new way of operating, which is really the client. It is helpful that neither side, nor any sector, can help or act on its own, but can work together in the right way. (Social worker, interview 11)

Also apparent from the data was the workers' concern that healthcare and social welfare services have gone in the direction of viewing the client more and more as a consumer who can select and demand services and, if necessary, complain about the quality of services. In substance abuse treatment, the client's role as a quality supervisor might be too challenging. A substance abuse service client may not have the ability to act in the role of a consumer and monitor the quality of service. Several interviewees believed this to be too challenging for vulnerable and operationally limited clients (Vanjusov, 2022, pp. 111, 115, 117–118).

4.2. Informational Accessibility

Securing informational accessibility of services requires that the authorities communicate sufficiently, comprehensibly, flexibly, and in a timely manner about their services, both within the organization and to clients. Informative accessibility includes not only communication that considers different needs, but also basing the organization of healthcare and social services on sufficient knowledge and expertise. In addition to client involvement and the sharing of understandable and sufficient information, informative accessibility is linked with the authorities' activities being based on sufficient knowledge. Figure 5 illustrates the key informational accessibility challenges that emerged from the data (Vanjusov, 2022, p. 141).

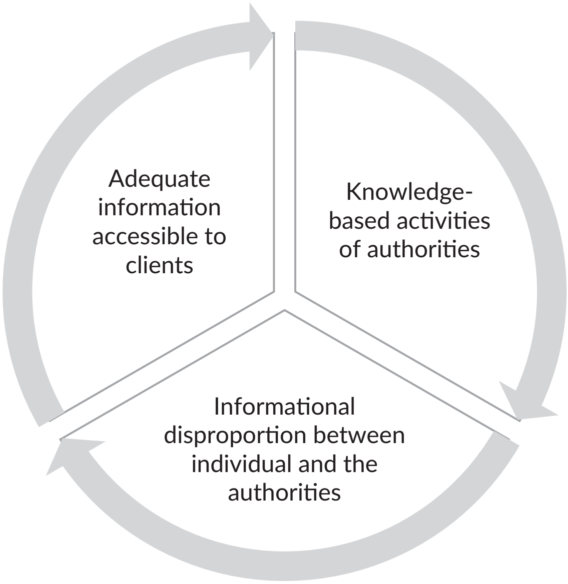


Figure 5. Challenges of informational accessibility.

Wellbeing services counties are obliged to provide information on their activities and services (Finnish Government, 1999). Accessibility can be related, on one hand, to the form of information required, or, on the other, to the ability of clients to access and understand the information. If clients are to apply for self-assessed services, the authorities must provide information about the services that are effectively accessible to clients, and such information must be in a form that allows clients to obtain it and understand its contents. Professionals working with clients must ensure that the clients truly understand the consequences of the information they are given and of their own choices (Vanjusov, 2022, pp. 152–153, 158). A quote from an interviewee illustrates this:

> The employee should make it clear to the client what it means when you choose this way, that you won't get anything. Now it's kind of a dismissive feeling. It leaves a bit of a feeling of being left behind. Yeah, he chose all by himself, his opinion was listened to, and he's not interested. It feels like these underprivileged [people] are being cheated out of the choice. (Expert working in care-providing organization, interview 14)

There can be great differences in people's information-seeking abilities and opportunities. It should be noted that the client may not realize what they do not understand or may not be willing to admit their incomprehension. The process of interaction between clients and social workers, doctors, or nurses is essential for collecting the information needed in the service process. The authorities must base their decisions on adequate information about the client's situation. Substance addiction can involve a variety of different challenges and service needs, the identification of which can be challenging and require long-term work (Vanjusov, 2022, pp. 146–148, 159).

In addition to knowledge gained from professional know-how, the necessary information is gleaned from each individual client, also information about their situation. The data producers are the clients themselves, but also the authorities and other parties in clients' lives, such as those close to the clients. Information from other actors may be needed to make an assessment of service needs. It is important to support clients by providing sufficient information, but it is also important to take into account that clients may not be able to articulate what they need. The interviews highlighted the responsibility of professionals in making the assessment (Vanjusov, 2022, pp. 159–160).

The importance of long-term and systematic action emerged from the research data. Too much and constant change can lead to a lack of communication, and clients may not get the services they need. What makes counselling and guidance complicated is that the decision-making processes of the service system may stray far from individual clients. The employee dealing with a client does not necessarily make the decisions in their specific case (Vanjusov, 2022, pp. 152–153, 158).

Problematic substance use is a medical and social challenge of its own that should be addressed in the way it requires. Our data created an image of a disease discourse in which the disease itself is identified, but treated with a rather paternalistic approach. That is, the status of substance abuse is recognized, but not necessarily its nature, i.e., what follows from it. Our research data showed that different forms of substance abuse services are provided based on different ideologies, especially in large cities. The ideologies of service providers regarding substance abuse and rehabilitation vary. For example, some are in favor of medical rehabilitation, and some are strongly opposed to it. The field can be described as diverse and uneven. The desire to provide necessary services is common, but there are great differences in the means that are employed (Vanjusov, 2022, pp. 142–143, 147, 156).

Assessment of the need for treatment in healthcare should be based on medically acceptable criteria. Unambiguous research results on differences in the effectiveness of various treatments are a challenge to find. On the other hand, the choices available may not even be justified. The implementation of substitution treatment in only one of the two possible treatment options serves as an example of a policy crafted by the authorities that is not necessarily based on anything at all, and choices made are not necessarily justified by either worker or client. This perception is supported by a quote from an interviewee who was a doctor:

> In opioid substitution therapy, it has been said that we only offer methadone, not buprenorphine, although there are basically two different drugs for that, and the reason is, I don't know, politics? I think that's an extreme example. (Doctor, interview 21)

According to the law, both drugs can be used in the treatment of diagnosed opioid addiction. The doctor in the previous quote does not know why methadone was chosen as the standard of care in his field, but another doctor interviewed unequivocally attributed the reasons behind favoring methadone to money. Money and the need to save resources came up several times in the interviews and were generally perceived as decisive factors in decision-making, rather than the needs of clients (Vanjusov, 2022, pp. 143–144, 158).

4.3. Physical and Economic Accessibility

Physical accessibility means that individual physical limitations and needs must be considered to a sufficient degree. Services should be accessible regardless of limitations caused by, for example, problems with physical mobility or long distances. The spaces used in the provision of services must be accessible. Accessibility can be defined socio-geographically to cover spatial, physical relationships and distances in outdoor space, but accessibility can also be considered in indoor spaces. Barriers to service access can arise from the locations where the services are provided and to what degree client financial resources are required for their use. Economic accessibility means that services should also be accessible to clients who lack financial resources to pay not only service fees but also travel expenses. Figure 6 illustrates the key physical and economic accessibility challenges that emerged from the data (Vanjusov, 2022, pp. 165–167).

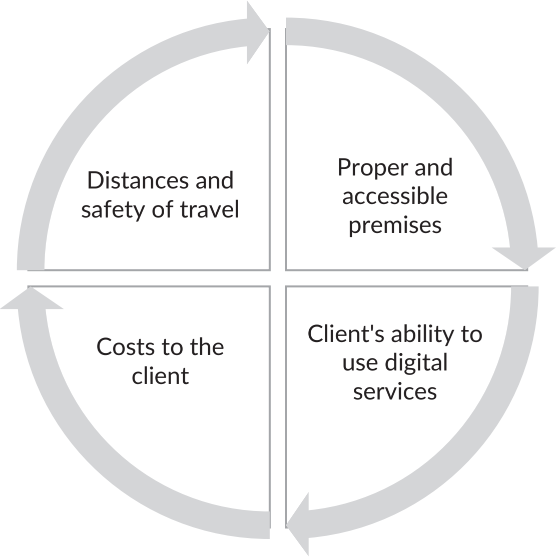


Figure 6. Challenges of physical and economic accessibility.

On a national level, the physical accessibility of services across Finland is greatly unequal. In sparsely populated areas, access to services and social contacts can be a significant distance away. The concentration of services in cities in wellbeing services counties may lead to not all services being available to all clients. Some substance abuse services may require the client to visit a treatment facility, for example, once a day. This can affect the accessibility of services, such as in the following interviewee example:

> We can't even start providing patients with [medical replacement treatment] here, because it means the patient has to come here once a day. It's unreasonable to expect them to make it here every day if they live a hundred kilometers away. (Doctor, interview 24)

On the other hand, physical accessibility is not just a question of sparsely populated areas. Service may be too far away from a client's point of view. Travel to another district can be regarded as a burden, no matter how "local" it is. Travel burden is one factor of spatial accessibility that can be influenced by considering the location of service points (e.g., Bachhuber et al., 2025; Cantor et al., 2021). Of course, it is natural that services are more diverse in large cities because the volume of needs there is different from that in rural areas. It emerged from the interview data that substance abuse rehabilitees may actually move to the Helsinki Metropolitan Area in search of better services (Vanjusov, 2022, pp. 167–169).

Physical accessibility is also connected with safety and security. For example, having to travel for services may involve safety problems for clients. The provision of substance abuse services requires the assessment and consideration of various risks in order to comprehensively ensure the safety of clients and others (Holst Jensen et al., 2014, p. 32; Vanjusov et al., 2021, pp. 204–205).

Accessibility includes non-physical accessibility: that is, the ability to access services, information, or people remotely through digital services. With the development of our information society, the hope was that remote work and remote services would reduce the necessity for physical movement. Electronic services can be fast and smooth, and can also have effects that promote equality and support independent living at home for many people who otherwise need institutional care. However, a decrease in both social interaction and beneficial exercise could be considered a threat, especially for the elderly and people with reduced mobility (Vanjusov, 2022, pp. 173–174).

Digital services can also become an economic barrier. It may not be financially possible for clients to obtain the necessary equipment or an internet connection. On the other hand, the practice of active substance use can also often result in phones being lost, and people may not respond to calls from substance abuse workers or other authorities. For example, when visiting a primary care doctor, a client may not want to highlight their problematic use of drugs, their financial situation, or other social support needs, making it difficult to determine what the client needs in terms of comprehensive care and support. A lack of money can also weaken treatment adherence. The following interviewee quote describes the effects of economic factors:

> Well, at least in the case of those with substance abuse problems, there is a lot of that money problem, of course, and you can already see in it how it can be difficult to commit to those treatments, whether there is enough money to buy those drugs or something like that, to get rehabilitation. (Doctor, interview 19)

It has been reported that user fees remain an important issue for many households in Finland (OECD, 2023, p. 14). Financial aspects must be taken into account when planning a patient's treatment and its continuation. Can a client actually afford the drugs prescribed? Can a client go to another location if travel is required? A client's living conditions may also be affecting their well-being and health (Vanjusov, 2022, pp. 175–176).

4.4. Experiential Accessibility

The four dimensions of accessibility mentioned above were clear categories, but the experiential side emerged later. The data revealed aspects that did not quite fit into any of the other categories but were united by the subjective perspective of the individual and thus by their experiential nature. When experientialism is perceived as a dimension, the entirety takes better account of the various factors affecting accessibility. Experiential accessibility concerns the meaningfulness of the service experience and the preconceptions clients have about the services. It can be an image created by logical thinking or an emotional reaction. Figure 7 illustrates the key experiential accessibility challenges that emerged from the data (Vanjusov, 2022, pp. 71, 181–182).

Figure 7. Challenges of physical and economic accessibility.

Some services may actually be inaccessible to a client due to the reputation of the service, the client's previous experience with the service, or the stigma associated with substance dependence and substance abuse care. Clients may feel undeserving of the services because they do not perceive themselves to be problematic substance users or for other related reasons. Clients may also be subject to expectations that they are unable to meet (Vanjusov, 2022, p. 182).

A significant factor in the accessibility of substance abuse services is the prevailing attitudes in society. The following interviewee quote illustrates this: "That is not a central perspective from the authorities' point of view, that substance abuse aspect, unfortunately." During elections, additional resources are promised to whatever group is perceived to be the most attractive to voters, such as children and the elderly, rather than to substance abuse services. Substance abuse and substance abuse services are still subject to stigma (Vanjusov, 2022, pp. 184, 213–214). Stigma is a mechanism that marginalizes the non-existent and the non-acceptable. When individuals are stigmatized, they often begin to see themselves as deviant in a negative way. A cycle is created in which the stigmatized individuals see themselves as the same as—and are generally seen through the perspective of—their negative quality. Stigma and prejudice can lead to understatement and poor service, for example (Goffman, 1963, pp. 11–13).

Stigma can have a significant impact on the substance abuse services provided to clients. The shame that a person feels about their situation can lead them to not seek services. People who use drugs problematically can also be the worst judges of themselves. Clients can be ashamed of their condition and feel that they do not deserve to receive anything from anywhere or anyone. Experts "by experience" who have already been rehabilitated may also carry a self-maintained stigma about their past. One interviewee described stigmatizing himself in many situations, especially if things came up that were not familiar to him but were mundane to others (Vanjusov, 2022, pp. 186–187).

In addition to stigma and shame, client preconceptions about services can be a barrier to accessibility. These preconceptions may be based on clients' or other people's own previous experiences of services. Misconceptions or gossip can also play a role. These preconceptions may lead clients to believe that they will not get the services they need or that they will not be treated well. The interviews revealed the importance that clients attach to the experience of being heard, which can be a crucial factor in building a successful client relationship and a starting point for rehabilitation. Clients may express appreciation of the fact that, for the first time, they were treated as equals and genuinely listened to (Vanjusov, 2022, pp. 191–197).

They may also have expectations that they may not be able to meet because of their capacity to function or lack thereof. They are expected to play a certain role and get value for the services provided to them. It could be, for example, the pursuit of a certain ideal of normality that is defined by service providers (see Kuusisto et al., 2023). However, not fitting into the stereotypical role of a client of substance misuse services can be a problem. Clients have very different needs, and one type of service does not fit all. Addiction also includes the possibility of relapse, but the substance misuse system does not seem to properly take this into account (Vanjusov, 2022, pp. 186–189).

5. Discussion

In summary, it can be stated that the same types of themes were repeated in different dimensions of accessibility as cutting-edge themes. In practice, the content of services seemed to be dictated more by available resources than the individual needs of the client. The organization of services is characterized by fragmentation, short-sightedness, and pacing, which leads to various potentials being wasted. A more efficient use of resources would benefit both clients and the system. The reality of the substance abuse service system also frustrates substance abuse professionals (Vanjusov, 2022, p. 203). The accessibility challenges are depicted in Figure 8.

The interview data tells two different stories about the accessibility of substance abuse services. On one hand, it describes various barriers to accessing services and, on the other, the factors that should be considered from the perspective of the characteristics of the substance abuse care client group in order to make the accessibility of substance abuse services a reality in practice. There can be challenges to clients' obtaining the services they need. For example, the system can inadvertently create obstacles, or the

Institutional

Lack of resources
Suboptimal dimensioning of services
Long waiting times
The misconception that “one size fits all”
Services provided don’t fullfill the client’s actual needs
Constant changes and their effects

Informational

There is not enough information about the available services
The information provided should be understandable
Shortcomings in the coverage and format of information sharing
Making decisions without enough information about a client’s actual situation and needs

Financial/economic

Client and user fees
Cost of transportation and other travel expences
Cost of medication, aids or devices
Cost of telephone and internet

Physical

Physical distance to the services
Problems with safe travel to the services
Facilities not being physically accessible for everyone
Use of digital services requires skills and devices

Experiental

Reputation of the services
Previous experiences
Possible stigma related to use of the services
Shame and other emotions related to the need for help

Figure 8. Accessibility challenges. Source: Vanjusov (2022, p. 205).

individual’s functional capacity can cause difficulties in accessing services because the system does not sufficiently consider individual needs and circumstances (Vanjusov, 2022, p. 204). These results are very similar to those of a Belgian study on access to mental health services for problematic substance users, for example. The fragmentation of services, genuine encounters and listening, attention to individual needs, and stigma are also highlighted in that study. The researchers stress that people with substance use disorders should not be seen as a particularly challenging client group, but as part of a diverse group of service users (De Ruysscher et al., 2024).

The Finnish legislation emphasizes needs, but, in practice, the needs of clients and the substance abuse services provided do not necessarily match each other. Individuals may have rights laid out in legislation, but these remain empty promises if these rights are not realized in practice. Assessing an individual's need for services or treatment and providing services are goal-oriented activities intended in the best interests of the client. This requires sufficient, long-term substance abuse services that meet clients' service needs in a timely and diverse manner. However, it seems that activities regarding substance abuse treatment may focus on the needs of the system more than the needs of clients. The resources available and administrative arrangements determine how and what decisions are made. This can result in clients' need for services not being met and their right to services that fulfill their needs not being respected. As Virokannas points out, the Finnish service system should be reformed to take better account of the individual needs of clients. The problems are more institutional than individual (Virokannas, 2020, pp. 493–494).

These service needs require simultaneous, overlapping, or consecutive assessment from both social welfare services and healthcare services. Multidisciplinary assessment of clients' service needs is an essential part of healthcare and social welfare service integration. Both healthcare and social services have their own purview of legislation, which means that both administrative domains handle their own statutory assessments: assessment of the need for social welfare services, and assessment of the need for healthcare services (Finnish Government, 2010, 2014). These assessments are required to make use of multidisciplinary information when available. The exchange of data between administrations is regulated by the Finnish Act on Processing Client Data in Healthcare and Social Welfare (Finnish Government, 2023). An important part of integration is the collaborative distribution of administrative responsibilities based on client needs. This is the basis for intra-administrative assessment, which usually requires multidisciplinary information to achieve adequate quality.

Coordination and collaboration between social services and health services have been called for in previous studies (e.g., Kosonen & Kuusisto, 2023; Virokannas, 2020), and the same theme is strongly present in our research data. The delicate point within healthcare and social welfare integration is whether the professionals have the ability or knowledge to assess whether a client needs services from another administrative sector. Healthcare professionals are obliged to report it when a client is in obvious need of social welfare services (Finnish Government, 2010, 2014). On the other hand, social welfare professionals have a responsibility to inform healthcare services, for example, if clients require additional healthcare services (Finnish Government, 2014). The remaining question is whether these professionals have enough knowledge of each other's services and jurisdiction to fulfill this responsibility. Barriers to accessibility can also arise from an experiential point of view: this could be a matter of misunderstanding or outdated information, and comprehensive information could make a significant difference. Barriers to accessibility can also arise from an experiential point of view: a matter of misunderstanding or outdated information, for example, when comprehensive information could make a significant difference (Notley et al., 2012, p. 46). Information should be provided within the organization, but also, of course, to clients.

The dimensions of accessibility presented above are based on those presented in Vanjusov's doctoral dissertation. Once we re-analyzed the data, we discovered a new and different angle of entry. Based on the interview data, we concluded that social relationships can have a significant effect on accessibility. An individual's social relationships affect how well they get information, help, support, and encouragement in seeking services and accessing services physically and financially. It can be a question of encouragement and reducing stigma, as well as sharing information in a way that the individual understands. These relationships can involve a person's family, friends, and/or other personal contacts and relations from private-sector organizations, or even in the healthcare and social care sectors in the past. In other words, it is about existing social contacts that make it easier to attach to the system and understand its requirements. Thus, relational accessibility intersects all the dimensions of accessibility outlined above.

Previous research on relational accessibility differs from our perspective in terms of focus and definition. The topic has been approached from the perspective of, for example, the relationship between nature and man (Forleo & Palmieri, 2018), social geography and the continuity of the care relationship (Locatelli et al., 2014). The relational definitions of accessibility differ significantly from one another in different fields of research. It is not always necessarily even a question of human relationships and interactions, but instead human choices in terms of nature, environment, and movement. In our review, the focus is explicitly on the impact of interactive relationships between people and the help and support they provide. Our analysis indicated that an individual's relationships have a positive effect on access to public healthcare and social welfare services; conversely, it is more difficult for those who do not have social networks to access services. This puts clients in an unequal position relative to others. An individual has the right to receive healthcare and social services without having a social support network. We did not conduct an in-depth analysis of the impact of relationships on the accessibility of services in this context. However, we feel that it is an essential aspect that should be explored further, allowing us to define the concept of relational accessibility more precisely.

Good practices related to relational accessibility emerged from the interview data. Former addicts with previous client experience can act as experience experts in the system and thus lower the barrier between the system and client, and the system can use the knowledge these experts acquired on the client perspective to improve the design and implementation of services and in communicating about them. Based on their own experiences, such experts can offer peer support and understanding to clients. Peer support has been identified as a means of improving accessibility in previous research (e.g., Parkes et al., 2022). One Finnish social welfare organization has a scheme in which former substance abusers are trained as support persons for substance abuse rehabilitees who have difficulty dealing with the authorities. These support people advise and help in very concrete ways: for example, they can accompany clients when they go to meetings with healthcare and social support staff. Their activities are based on volunteerism. It is an innovative way to provide actual assistance to individuals at risk of social exclusion (Muikku, 2018). At the same time, however, it must be said that it is worrying if and when a client needs a "system interpreter" to be able to deal with public services.

6. Conclusion

In welfare states, vulnerability and problems leading to inequality are mainly handled through social welfare systems (see Kildal & Kuhnle, 2005). This includes economic support, social care, and healthcare. In this study, we focused on healthcare and social services. The main problem is that individuals have a legal right to the services they need, but, in practice, decisions seem to be made on the basis of economic factors rather than client needs. The most significant problem in achieving equal accessibility to appropriate services is the semblance of protecting clients' rights: that there may be an ostensible effort to implement client rights, but not in a way that sufficiently respects individual needs. Formally, the solutions may appear to meet legislative requirements, but may not withstand closer examination and do not take equality aspects into account. The aim seems to be to meet minimum requirements rather than to implement a genuine individual assessment.

The Finnish system seems to be, at least in places, insensitive to what comprehensive treatment of problematic substance use requires from a service package. It is generally acknowledged that substance addiction has the status of a disease, but its nature is not accepted as part of the structure of the substance abuse service system. The voice of the client and the "expertise of experience" can be heard at the strategic level, but their actual significance remains minor. Clients with impaired functional capacity and vulnerability end up in a position where they are expected to comply with various demands, but, at the same time, due to the root causes of their service needs, they are unable to fulfill them. A cycle is created in which the system rejects a client whose needs it should meet so that underlying problems do not worsen, and rejection can, in turn, affect the client in such a way that their shame deepens and they may not feel entitled to welfare services. In addition, the question arises whether the system requires existing relational support from the client to access its services. Can a lonely person not be covered by services in the same way as a person with a social support network?

The problems of accessibility in the light of this study seem to be less about the legislation than about how the legislation is implemented in practice. The data used in this study is ten years old. It seems, though, that similar challenges are still occurring in Finnish healthcare and social welfare (Mäenpää et al., 2025). At this time, wellbeing services counties are struggling to meet their legal obligations and keep their finances balanced. However, it is worth remembering that timely access to services can save on costs by preventing problems and service needs from increasing (Kaukonen, 2005, p. 312). Wellbeing services counties should build their service palette according to genuine regional needs. Accessibility should be considered when organizing such services so that everyone has an equal opportunity to have their rights respected and their needs fulfilled. To ensure that potential clients can actually obtain the services they need, accessibility of services should be considered in different dimensions. Ultimately, the issue is equality.

The purpose of this article was to bring the results of Vanjusov's dissertation to the reach of an international audience. The key contribution of the research was outlining the concept of accessibility in a legal context. We hope to see more research on equal access to healthcare and social welfare. In the Finnish context alone, we need more information on how we can effectively ensure equal access to services and rights.

Conflict of Interests

The authors declare no conflict of interests.

Data Availability

The data of this study is not publicly available due to ethical reasons.

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