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Pauliina Patana

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Finland

Pauliina Patana

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ABSTRACT

As part of a wider project on mental health in OECD countries, a series of descriptive profiles have been prepared, intended to provide descriptive, easily comprehensible, highly informative accounts of the mental health systems of OECD countries. These profiles, entitled ‘Mental Health Analysis Profiles’ (MHAPs), will be able to inform discussion and reflection and provide an introduction to and a synthesised account of mental health in a given country. Each MHAP follows the same template, and whilst the MHAPs are stand-alone profiles, loose cross-country comparison using the MHAPs is possible and encouraged.

Mental health disorders comprise one of the highest burdens of disease in Finland. The share of disability pensions granted due to mental disorders is high and while the rates of suicide have decreased in recent years, they are still above the OECD average. Consequently, tackling mental ill health is a government priority for Finland. The mental health system has undergone a number of reforms in recent years, and several innovative initiatives have been introduced. Whilst a number of challenges remain, the evolution of the mental health system has been promising, and holds lessons for other OECD countries.

RÉSUMÉ

Lancée dans le cadre d’un projet plus vaste consacré à la santé mentale dans les pays de l’OCDE, la série de profils « Santé mentale : profils d’analyse » (*Mental Health Analysis Profiles* - MHAP) vise à décrire de manière simple et détaillée les systèmes de santé mentale des pays de l’OCDE. Ces profils, qui étayeront les examens et les réflexions qui seront menés, feront le point sur la situation d’un pays donné dans le domaine de la santé mentale. Les profils MHAP sont indépendants les uns des autres mais suivent le même modèle : il est donc possible, et recommandé, de les utiliser pour procéder à des comparaisons entre pays.

En Finlande, les troubles de la santé mentale représentent l’une des charges les plus lourdes pour le système de santé. La proportion de pensions d’invalidité versées au titre de troubles mentaux est élevée et bien qu’il ait diminué ces dernières années, le taux de suicide reste supérieur à la moyenne de l’OCDE. C’est pourquoi les pouvoirs publics finlandais ont fait de la santé mentale une priorité. Plusieurs réformes ont été menées dans le système de santé mentale au cours des dernières années, avec le lancement de plusieurs initiatives novatrices. Des problèmes persistent mais l’évolution du système de santé mentale est encourageante et pourrait inspirer d’autres pays de l’OCDE.

LIST OF ACRONYMS

FAMH: the Finnish Association for Mental Health

HUCH: Helsinki University Central Hospital

MSAH: The Ministry of Social Affairs and Health

RAY: The Slot Machine Association

THL: The National Institute for Health and Welfare

KELA: The Social Insurance Institution

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INTRODUCTION

1. This report is part of a series of descriptive profiles – Mental Health Analysis Profiles (MHAPs), produced by the OECD to give key insights into the mental health systems of select OECD countries. Following a set framework, these profiles give a detailed introduction to the history, mental health needs, and organisation and payment of care in select mental health systems. Countries have been selected so as to give an overview of different ways of approaching mental health care system organisation across the OECD.
2. Mental health services have undergone a comprehensive organisational and structural reform in the past thirty years in Finland. Nonetheless, the transition from hospital-based services towards more community-based care is still a work in progress. The current government is committed to promoting mental health: in 2009, “The National Plan for Mental Health and Substance Abuse Work 2009-2015” was established. The national mental health strategy sets ambitious goals for tackling mental ill health and substance abuse and paves the way for further development of early intervention and prevention. It also enhances efforts to promote good mental health and focuses on the development of outpatient services alongside a move towards a “socially sustainable welfare society”.
3. Universality and equitable access to services are the core principles of the Finnish health system, and good mental health care should be available to the whole population. The delivery of such services is, however, made more challenging by a highly decentralised system, where central government stewardship is somewhat weak, and where municipalities are in charge of organisation and delivery of health and mental health services.
4. Cultures of mental health care also differ between regions: variations can be noted, for instance, in lengths of stay, use of coercive measures and involuntary admissions across the country. Furthermore, different channels of delivery for services - public, private and occupational health care - , contribute to inequalities in access to treatment, which has been a growing concern amongst policy-makers in recent years. As well as the wide-spread regional differences in the availability and supply of mental health services across the country, there are observable differences in access to mental health services across different socio-demographic groups. In response to these disparities, one of the main items on the political agenda in Finland at the moment is the reform of the municipality, the health care and the social welfare structure.

1. MENTAL HEALTH HISTORY, LEGISLATION AND HUMAN RIGHTS

1.1. History and development of the mental health system

5. The Finnish mental health system can trace its development back to the 1600s when Finland was under Swedish rule. In the 1600s, a hospital for both lepers and the mentally ill was established on the island of Seili, outside the city of Turku in the southwest of Finland. For a long time, the church held responsibility for treating the mentally ill. In 1755, the hospital on Seili started exclusively treating patients suffering from mental illnesses and as a result became the first state mental hospital (Hyvönen, 2008).

6. The development of mental health services at a national level started only under Russian imperial ordinance. The first mental health regulation came into effect in 1840, and established state responsibility for the organisation of treatment for the mentally ill. At this time, no one could seek treatment voluntarily, and mental health care was available only through involuntary admission to a hospital. An imperial decree established in 1889 was the first step towards municipalities taking responsibility for treating individuals with mental disorders.

7. Given the high costs of the treatment of mental illness coupled with limited resources, in the 1920s the State encouraged municipalities to build regional mental hospitals by offering subsidies: this gradually led to the establishment of a large mental hospital network. Furthermore, the first Mental Health Act (1938) included a clause obliging municipalities to bear a share of the costs related to mental health care. In 1952, the Act was amended to shift all responsibility for treatment of mental disorders to the municipalities, with only criminals and dangerous and “difficult-to-treat patients” remaining under the responsibility of the State. Moreover, the amended Act created a nation-wide system of mental hospital districts while non-institutional alternative or complementary forms of care remained marginal. Another partial reform of the Act in 1978 gave the patient the right to appeal the order for treatment.

8. Whilst some industrialised Western countries started deinstitutionalisation in the 1950s, the construction of mental hospitals continued in Finland until the 1970s (Tuori, 2011). In fact, for local authorities, efficient care was considered to be equivalent to an abundant number of psychiatric beds. Large municipal psychiatric institutions were subsidised by the State, which guaranteed funding for the municipalities (Hyvönen, 2008).

9. Deinstitutionalisation in Finland started in the 1970s, facilitated by the introduction of antipsychotic drugs in 1952, the development of community care in the 1980s, and a gradual change in public attitudes (Oksanen, 2011). All of these factors created favourable conditions for deinstitutionalisation and the development of outpatient and housing services, which had until then remained modest. A national development programme focusing on research, rehabilitation and the treatment of schizophrenia was carried out between 1981 and 1988. This programme had two main aims: to develop care for patients newly diagnosed with schizophrenia and to improve rehabilitation for long-term inpatients (Tuori, 2011). Deinstitutionalisation of hospitals also created a market for private supported housing (Oksanen, 2011).

10. Before the downsizing of hospitals began in Finland, the number of psychiatric beds was relatively high when compared with other European countries, with bed numbers second only to Ireland in

1978 (Tuori, 2011; McDaid *et al.*, 2005). Some evidence also shows that the large number of beds appears to have led to a relatively widespread use of involuntary care in Finland (Hakkarainen, 1989).

11. Since the 1980s, the number of psychiatric beds has declined: between 1990 and 2003, hospitals reduced their beds by 50%, with bed numbers falling to approach the European average of 1 bed per 1 000 inhabitants (Harjajärvi *et al.*, 2006). Altogether, the number of psychiatric beds in Finland has dropped by four-fifths, from 20 000 in 1980 to 4026 (0.75 per 1 000 population) in 2010 (Tuori, 2011; OECD Health Data, 2012). The current national plan for mental health and substance abuse aims to further reduce the number of beds to a total of 3 000 (0.55 per 1 000 population) (Moring *et al.*, 2011).

12. Until the 1990s, psychiatric hospitals had different organisational structures to general hospitals and were separate from them. Psychiatric hospitals were divided into so-called “A” and “B” hospitals. “A” hospitals treated both acute and long-term patients, whereas “B” hospitals were mainly reserved for long-term patients, whilst also taking care of mentally handicapped and geropsychiatric patients (Tuori, 2011).

13. The 1990s saw major reforms in the organisation of mental health services that were enshrined by legislative acts (see section 1.2). For instance, the Act of Specialised Care, which came into force in 1991, merged psychiatric services with other secondary health care services. In parallel, long-term patients were moved and beds were transferred from psychiatric hospitals to housing services, and a number of psychiatric institutions and hospitals were closed. Finally, a significant proportion of the administration of mental-health services was transferred from secondary care in a hospital district to primary care in a municipality. Indeed, the deinstitutionalisation of mental health services overlapped with the transfer of main responsibility for services from hospital districts to individual municipalities. Decentralisation left the State with responsibility for defining general policy objectives and “information steering”, while municipalities were put in charge of detailed planning, policy implementation and delivery of health services (Vuorenkoski *et al.*, 2008).

14. In the context of deinstitutionalisation, the further development of mental health care aimed in particular to reduce long-term care, to develop outpatient and user-oriented services as well as to highlight the importance of early intervention and prevention. However, the country experienced a severe economic recession in the early 1990s, which had a major impact on mental health services. As financial resources were cut, the growth of outpatient services was not sufficient to meet the needs deinstitutionalisation had created (Kärkkäinen, 2004).

15. The new outpatient and community care approaches required the development of new working methods, such as home treatment teams, which remained neglected. The lack of a ring-fenced budget for mental health meant that the additional resources freed up by the reduction of psychiatric beds were directed to other fields of health care (Nenonen, 2001; Pylkkänen, 2000).

16. Within the past 30 years, the organisation of mental health services in Finland has undergone significant structural and organisational reforms. The number of outpatient services has significantly increased even though the system still remains somewhat hospital-oriented. Psychiatric beds have been increasingly integrated into general hospitals, and the number of separate psychiatric hospitals has fallen. The average length of stay has radically decreased, whilst the number of patients in psychiatric care has remained stable within the past 30 years at around 30 000 patients (Tuori, 2011). On the other hand, the proportion of elderly people, mentally handicapped persons and those suffering from minor mental disorders being treated in hospitals has considerably decreased, which implies an increase in the severity threshold for admittance and treatment for inpatient psychiatric care (*ibid.*).

17. The reform of mental health services is still in progress and, together with planned municipality reform, forms part of a large-scale reform of social and health care services that ranks high on the political

agenda in Finland (Vorma, 2011). While the prevalence of mental disorders has not increased, work incapability related to these problems has, and this has resulted in increased awareness of the burden of mental disorders upon individuals and the society.

18. In 2009, a national plan for work on mental health and substance abuse for the period 2009-2015 (MIELI) was launched, setting guidelines for the further joint development of mental health and substance abuse services over the period (Ministry of Social Affairs and Health, 2010a). The National Development Programme for Social Welfare and Health Care (KASTE) is a central development tool in the implementation of the MIELI plan at a regional level. The current Government, in place since June 2011, has committed to developing mental health services in the framework of the MIELI plan and in accordance with the Mental Health Act (see section 3.1).

1.2. Mental health legislation

19. The Constitutional Act (L 731/1999 6 §, 19 §) guarantees all Finnish citizens, regardless of their state of health or domicile, the right to access social and health care services (VTV, 2009). Municipalities have the responsibility of providing health and mental health services as defined in the Primary Health Care Act and the Act of Specialised Care (although these Acts will be replaced in the future by another Act as part of the reform, see page 8). Separate legislations – the Mental Health Act, Social Welfare Act and Health Care Act – further describe the scope of these services. In addition, given that the decree on the planning and state subsidy of social and health care also gives municipalities freedom with regard to how to organise its services, the Act on Private Health Care (L 152/1990), the Act on the Supervision of Private Social Services (L 603/1996) and the Occupational Health Care Act (L 1383/2001) also have an impact on mental health services (Pirkola and Sohlman, 2005).

20. In 1991, the Mental Health Act (L 1116/1990) and the Mental Health Decree (A 1247/1990) came into force, establishing a new framework for mental health services in the context of deinstitutionalisation, which dismantled the formerly separate hospital districts while prioritising the development of outpatient services. The Mental Health Act outlines “the concepts, content, supervision, provision obligation and principles of provision of mental health work” (Pirkola and Sohlman, 2005). The Act also defines different aspects of mental health care, which include the enhancement of the psychological well-being, performance, and personal growth of individuals as well as the prevention, treatment and alleviation of mental health illnesses and disorders. In addition, mental health care services in a larger context also include social and health care services. Satisfactory living conditions, which help to prevent the deterioration of mental health disorders, also form an integral part of mental health services.

21. Outpatient services are prioritised in the Mental Health Act. The Act also states that municipalities or municipality federations (which must belong to one of the 21 hospital districts) must organise their mental health services in order to correspond to the needs of the local authority concerned. Municipalities within a hospital district are also obliged to cooperate and coordinate services, in particular between the health centres, municipal social care, and specialised services provided within the district, in order to form a well-functioning ensemble of mental health services. The organisation of support and housing services on the other hand belong to the social services.

22. Moreover, the Mental Health Act defines the use of forensic assessments of individuals accused of crime (see Section 4.3). Regulations regarding the use of involuntary treatment and coercive measures are also included. Under the Act, involuntary psychiatric hospital care can be imposed only on patients who are psychotic and a danger to themselves or other people’s health or safety, and only when all other forms of mental health services are deemed to be insufficient. The involuntary hospital care of minors must be organised in child and adolescent care units.

23. The Mental Health Act was amended in 2001 (1423/2001). There were two additions: the first one is a clause dealing with discharges of forensic patients under the surveillance of the hospital district care unit (18a) (see section 4.3). The second is a chapter that clarifies the way in which patients' civil rights could be limited during involuntary care and assessment (4a). The decree on Mental Health has also been amended (1282/2000) with regard to child and adolescent mental health services (2a), to lay out maximum time limits "for the evaluation of referrals and provision of care, coordination of care units, outpatient support services and regional cooperation" (Pirkola and Sohlman, 2005).
24. The Social Care Act (L 710/1982) prioritises outpatient service organisation while emphasising clients' independence. The scope of central municipal social services includes social work, home and housing services. This might also include services for the severely disabled, care support for family members or rehabilitative work activities.
25. Social work includes steering, guidance and support work carried out by professionals. Home services are provided to people who have difficulties performing independently and who need help due to a sickness or a disability.
26. Housing services are involved in organising supported housing for people who, for specific pre-defined reasons, need help with accommodation or day-to-day living. At present, the Social Care Act is also under review, and a proposal for a reformed Act should be presented to the Parliament in spring 2014. Substance abuse services organised by social services will be regulated by the new Social Care Act.
27. As part of the ongoing reform of the social welfare and health care structure, some changes in the legislation on service provision have already been made. For instance, mental health services previously outlined in the Primary Health Care Act and in the Act of Specialised Care are now further defined in the new Health Care Act, which came into force in May 2011. Moreover, once the planned Act regarding the governance, funding, development and supervision of social welfare and health care services comes into effect in coming years, the Primary Health Care Act and the Act of Specialised Care will no longer be effective.
28. With regard to primary care, local authorities must provide mental health services according to the needs of their residents as part of their primary care in health centres (Pirkola and Sohlman, 2005). Specialised care, on the other hand, refers to specialised health services for prevention, assessment, examination, treatment and medical rehabilitation and, in order to provide these services, each municipality has to belong to a hospital district's joint municipal board.
29. The new Health Care Act was introduced in order to expand user choice in the municipal sector. This takes place in two steps: since May 2012 patients have had access to non-emergency health care outside their municipality under special circumstances (*e.g.* if they reside in another municipality on a regular or long-term basis). From 2014, patients will have the right to choose their health centre and hospital from all such units in the country. The main objectives are to empower patients, to ensure equal access to services, and to improve the quality of care and co-ordination between primary and secondary health care as well as between social and health services (Mäntyranta *et al.*, 2011). Before the new Health Care Act, virtually no user choice was available within the public health sector, although many patients had a choice between public care, and occupational care and private care (OECD, 2012a).
30. The new Health Care Act increases choice for mental health service users as well. A patient using primary care services has the right to choose the health care unit for treatment, which may be changed once a year. Municipal psychiatric care provided by a specialist is considered as secondary care, and if equivalent-level specialist psychiatric services provided by both municipalities and hospital districts are available within a given area (see section 3.1) then the patient may choose between these two providers at

the time the referral is made. If the treatment has started as involuntary treatment but then continues as voluntary, the patient cannot choose (or change) the care delivery setting within a period of inpatient care. According to the Act, “any treatment of an individual of less than 23 years of age deemed necessary on the basis of the assessment of the need for treatment shall begin within three months of the need for treatment having been ascertained, taking into consideration the urgency of the case, unless otherwise required on medical, therapeutic, or other comparable grounds.”

Detainment, restraint and seclusion rates

31. Only public institutions, under certain conditions, may use seclusion, detainment and restraint (Mental Health Act, 1990). The Mental Health Act is explicit about the conditions under which coercive measures may be used: seclusion and restraint may be used only for involuntarily admitted patients (see section 1.2). Involuntary treatment is to a certain extent “commonly” used in Finland: in 2010, 31% of all new patients arriving in psychiatric specialised inpatient care were admitted involuntarily (THL, 2012b). Involuntary admissions among children and adolescents also increased between 1995 and 2004 (Tuori and Kiikkala, 2004).

32. The rates of coercive measures in Finland, which have previously been high compared to European countries (Salize, 2002), have gradually decreased since 2005, and today are around average in comparison with other Western European countries (Keski-Valkama, 2010). It should be noted, however, that the higher rates may be due to more accurate recording of coercive measures in Finland (*ibid*).

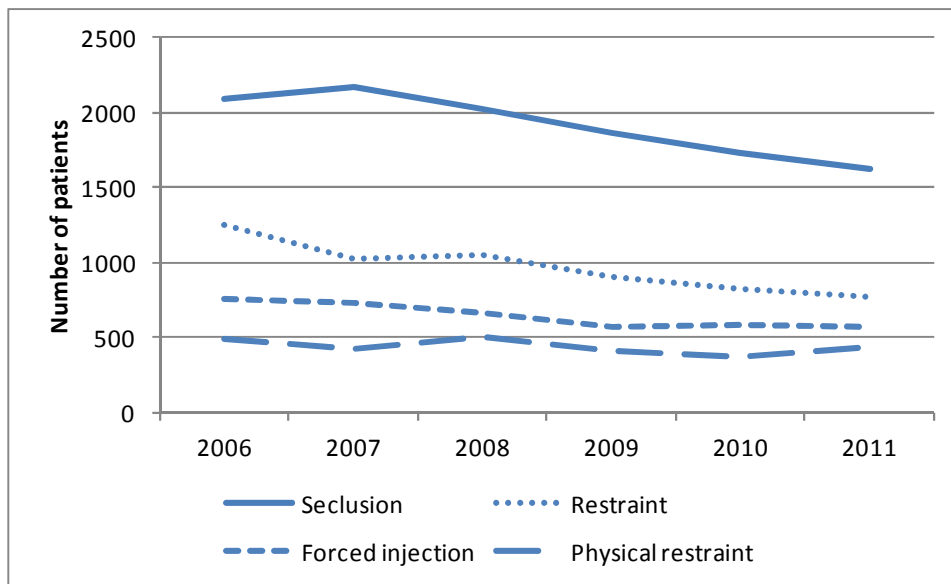
33. Although the use of coercive measures in Finland has decreased over the past five years, they are nonetheless more commonly used than in any other Nordic country except Norway, where legislation on involuntary care is much looser (Keski-Valkama, 2010). Hence, one of the objectives of the national plan for mental health and substance abuse work (MIELI) is to decrease the use of involuntary care (including coercive measures) by 40% by 2015. To achieve this, the MIELI plan states that, “the Ministry of Social Affairs and Health should produce a draft for a Government proposal for a common framework act containing provisions regarding limitation of the right of self-determination and submit a proposal for a statute concerning second opinions by external experts regarding admission to involuntary treatment in a psychiatric hospital. A national programme to reduce the use of coercive measures in psychiatric hospital treatment should also be implemented” (Ministry of Social Affairs and Health, 2009b).

34. Given that the organisation of health and mental health services is decentralised, and leaves municipalities in charge of supply and delivery (see section 3.1), significant variations in practice can be noted across the nation. Coercive measures are no exception, as their use may vary greatly between hospital districts (Tuori *et al.*, 2006). There are, for instance, regional variations in terms of the duration of seclusion or restraint between patients who are admitted for the first time or readmitted, and between genders (coercion is however more commonly experienced among men). This implies “that the use of involuntary care is determined by the culture of care rather than on medical grounds” (Tuori, 2002; Tuori and Kiikkala, 2004; Tuori *et al.*, 2006). Indeed, the differences cannot be explained simply by regional variations in the prevalence of mental illness and severe mental disorders (see section 2.1) – they could partly be explained by local, organisational and administrative differences between units (Korkeila, 2006).

35. Between 2004 and 2009, there were over 10 000 patients in involuntary psychiatric hospital care on an annual basis: 9 582 patients were involuntarily treated in 2009 (192 patients per 100 000 population) (Moring *et al.*, 2011). Of the total patient population in psychiatric hospital care, on average 33% were at some point involuntarily treated. Coercive measures are experienced annually by around 3100 patients (average for 2004 to 2009) *i.e.* 59 patients per 100 000 patients in psychiatric hospital care. Of all patients in psychiatric hospital care, approximately 10% experienced coercive measures between 2004 and 2009 (*ibid*).

36. In 2011, 31% of patients experienced involuntary treatment, which accounted for 8 376 admissions. Coercive measures were experienced by 3394 patients. Out of these patients, 6.2% had been *secluded* and 2.9% *physically restrained*, while *compulsory injections* were used on 2.2% of the patients¹ and 1.7% were *held involuntarily*, as shown in Figure 1 below (THL, 2013). Figure 1 also illustrates a modest decrease in the trend since 2005.

Figure 1. The use of coercive measures in Finland between 2006- 2011



Source: National Institute for Health and Welfare (THL) (2013).

37. The Nordic Council of Ministers has appointed an expert forum for further Nordic co-operation in the field of mental health. In 2010, the experts outlined six priority themes, which include reducing the need for coercion and developing treatment forms that provide alternatives to coercion (Nordic Council of Ministers, 2011a). The forum aims to further enforce Nordic cooperation in this area by facilitating the exchange of ideas on “alternatives to coercion, consequences of coercion and descriptions of the use of coercion in psychiatric care” (Herberts and Wahlbeck, 2011). In June 2011, the Nordic network had its first conference on the topic in Vaasa, Finland, which focused on exchanging experiences and enhancing Nordic cooperation within this area.

38. In addition, the Ministry of Social Affairs and Health appointed a working group in 2010, which aims to revise the legislation regarding health and social service patients’ self-determination and restrictions. One of the main areas included relates to measures limiting patients’ self-determination in psychiatric as well as somatic care. The working group’s mandate ends in February 2014 after which it presents its proposals for revision of the legislation. The National Institute of Health and Welfare (THL) has also set up a working group to develop a national programme to reduce the coercive measures in psychiatric treatment, which should be presented around fall 2015. Several hospitals have also established their own programmes to reduce coercion in psychiatric treatment.

¹ Compulsory injections refer to a care procedure carried out without the consent of a psychotic/aggressive/agitated patient. Chemical restraint is forbidden.

2. POPULATION CHARACTERISTICS

2.1 Prevalence of mental ill health across the population

39. It has been estimated that around 15 to 20% of Finns have suffered from a diagnosable mental disorder within the last year (Lehtinen *et al.*, 1990; Pirkola and Lönnqvist, 2002; Pirkola *et al.*, 2005), a rate that is comparable to other Western countries. However, in terms of Finnish public health, mental health and substance abuse problems represent one of the main disease burdens in Finland. These problems altogether accounted for 44.5% (or 116 482 Finns) of disability pensions in 2008. Therefore, the national plan for mental health and substance abuse for 2009-2015 aims to develop a strategy for substance abuse and mental health together, as these two strongly overlap in Finland (Partanen *et al.*, 2010).

Mild to moderate mental health disorders

40. The Health 2000 survey indicated that 6.5% of Finnish adults had experienced *depression* during the past year. Depressive periods are more prevalent among young adults, women, and single and unemployed persons (Pirkola *et al.*, 2005). The prevalence of depressive disorders was 6.4% among the employed and 11.9% among the unemployed (Honkonen *et al.*, 2007). In Finland, following a pattern similar to that seen in other OECD countries, the risk of developing depression is three times higher when unemployed (OECD, 2012b). Depression experienced within the past year is also more common in the north of Finland than in the south. The prevalence of seasonal mood disorder is estimated at around 2.6%, with no regional variations reported (Pirkola *et al.*, 2005; Grimaldi *et al.*, 2009).

41. The lifetime prevalence of depression is significantly more common than depression experienced within the past year. Among young adults (age group 20-35), the lifetime prevalence of depressive periods is 18%, and is much more prevalent among women (24%) than men (11%) (Suvisaari *et al.*, 2009).

42. Comorbidity between depression and *anxiety disorders* is quite common (Saarni *et al.*, 2007). The most common anxiety disorders are found to be panic disorder, social anxiety disorder and generalised anxiety disorder. The Health 2000 survey found that during the past year 4% of the adult population had suffered from anxiety disorders, which are also more common among women and people who are single, divorced or unemployed (Pirkola, 2005). The lifetime prevalence of anxiety disorder was 17% for women and 8% for men, and 13% for young adults (and is less common among the more highly educated) (Suvisaari *et al.*, 2009).

43. A condition called “burnout” is also recognised in Finland. Burnout is a chronic stress syndrome that develops gradually as a consequence of a prolonged stress situation at work and most frequently affects middle-aged women from lower socio-economic groups in less well paid occupations. Severe burnout is relatively rare, with a total population prevalence rate of around 2.5%, however burnout symptoms are relatively common at 25% (Ahola *et al.*, 2004; Ahola *et al.*, 2006). Nonetheless, burnout is considered a psychological state, not a psychiatric disorder (Ahola *et al.*, 2005).

44. Eating disorders occur predominantly among girls in puberty and among young women. The most prevalent eating disorders are anorexia nervosa (life-time incidence rate 2.2%) and bulimia nervosa (life-time incidence rate 2.3%) (Keski-Rahkonen *et al.*, 2009). The prevalence of eating disorders among men is one-tenth of the female rate (Raevuori *et al.*, 2009).

Psychoses and severe mental health disorders

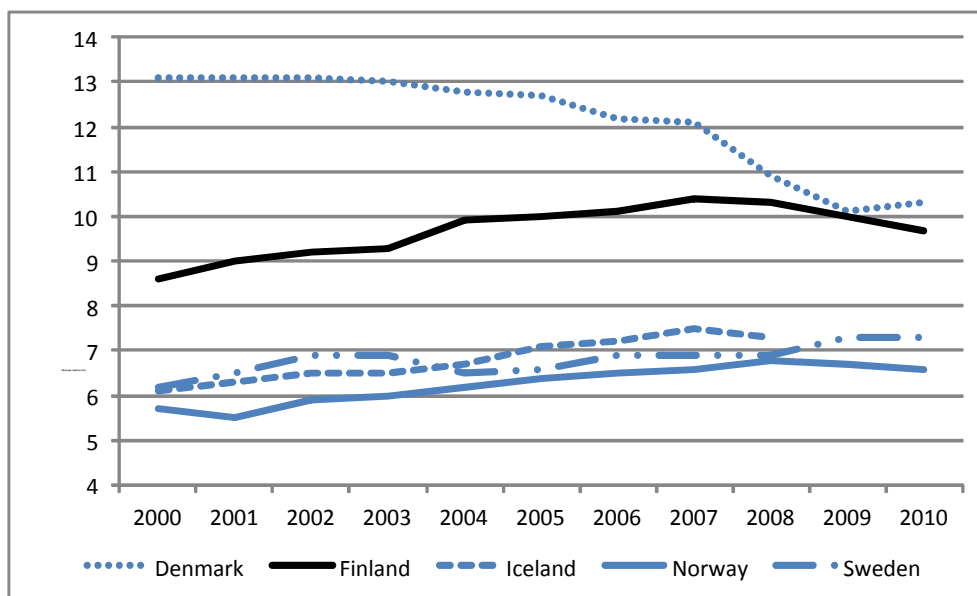
45. The lifetime prevalence of Type I Bipolar Disorder is below 0.5% in Finland (Perälä *et al.*, 2007), and the incidence of Type II Bipolar disorder is unknown. Further research as part of the Health 2000 study also found that among 19-34 year-olds, the prevalence of Type I Bipolar Disorder was 0.53%, and the prevalence was 0.72% for Type II (the rate for unspecified: 0.61%).

46. The lifetime prevalence of *psychoses* is estimated at 3-3.5% (Perälä *et al.*, 2007). The most common form of psychosis is schizophrenia, with a prevalence rate of 1% (*ibid*). There are clear regional differences in terms of incidence and prevalence; psychoses are more prevalent in northern and eastern Finland and less common in the South West and West. The prevalence rate across the population in northern Finland is three times higher than the prevalence of schizophrenia across the population in western and south-western Finland. There are no significant gender differences in the prevalence of schizophrenia. Nonetheless, psychoses triggered by substance abuse are more common among men, whereas schizoaffective disorder is more common among women. Most of the people diagnosed with psychosis are on disability pension (Perälä *et al.*, 2007). The prevalence of psychoses in Finland is relatively high in international comparisons, which could possibly be explained by the relatively high level of specific research in Finland.

Substance abuse

47. Alcohol consumption in Finland increased in the 2000s, alongside an increase in the number of alcohol-related deaths and diseases (Partanen *et al.*, 2010). However, after peaking in 2007, alcohol consumption has started to decrease, although it remains far above the other Nordic countries, with the exception of Denmark (THL, 2011) (Figure 2).

Figure 2. Alcohol consumption in the Nordic countries, 2000-2010, annual litres per capita



Source: OECD Health data, 2012.²

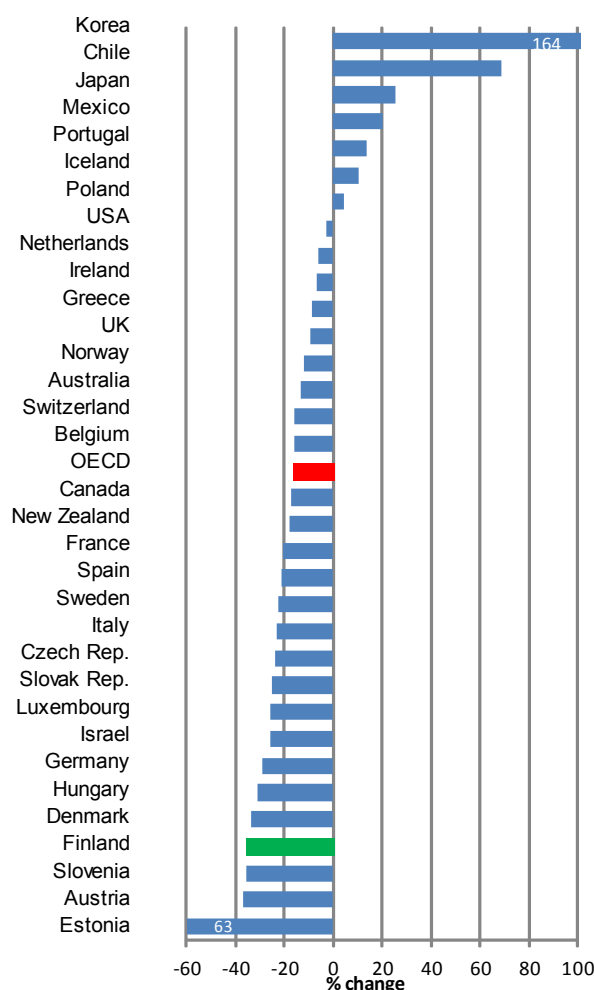
²

Recent trends on alcohol consumption in Finland: National Institute for Health and Welfare (2011) "National Statistics on Alcohol and Drugs" <http://www.thl.fi/thl-client/pdfs/0f25bf0a-ad0c-4294-9e44-5ac2cf5fe544>

48. *Substance abuse* (alcohol abuse and dependency in particular) is the most common mental health disorder among men. According to the Health 2000 survey, 6.5% of men and 1.4% of women had a problem with alcohol addiction during the past year (4% across the whole population). Furthermore, these problems are more prevalent among young adults and people who are divorced, single or unemployed. A study on lifetime substance abuse among young adults showed that 21% of men and 7% of women have had substance abuse problems at some point during their lives, with alcohol abuse or dependency accounting for 20% for men and 6% for women. The prevalence of non-alcohol substance abuse among men was 7% and among women 2%. Besides alcohol, other substance abuse remains relatively low in Finland, with the most common being cannabis (prevalence rates are 3% for men and 1% for women). Other substance abuse is almost always linked to alcohol abuse or dependency. Substance abuse among young adults is strongly linked to unemployment and to low levels of education (Latvala *et al.*, 2009; Suvisaari *et al.*, 2009).

2.2 Suicide

49. Suicide rates in Finland have fallen significantly across the past 20 years, especially amongst men, who commit suicide almost four times more than women (OECD, 2012a). Despite the 36% decrease between 1995 and 2010, Finland figures among the countries with the highest suicide rates in international comparisons. In 2009, with 1032 suicides registered, the suicide rate per 100 000 inhabitants was 29 for male and 10 for women, with the rate for the total population reaching 19.3 (Värnik, 2012).

Figure 3. Change in suicide rates, 1995-2010 or latest available year

Source: OECD Health Data, 2012. Information on data for Israel: <http://dx.doi.org/10.1787/888932315602>.

50. Since the 1980s, consecutive governments have taken the high rates of suicide in Finland seriously by implementing large-scale national prevention programmes. These strategies have had apparent success in reducing suicide rates, also having a positive impact on society (Wahlbeck *et al.*, 2011).

51. The national suicide prevention programme launched in the late 1980s had four phases: research, developing a national strategy, followed by implementation, and finally evaluation. A study project on suicide was carried out in 1987, and was followed by a suicide prevention programme, which was implemented over a ten-year period between 1986 and 1996 (Upanne *et al.*, 1999).

52. The main aims of the programme were to develop the means to prevent suicide and to reduce the suicide rate by a fifth by 1995 compared to the rate registered at the beginning of the programme. The project was carried out through cross-sector collaboration, which included different service sectors and key domains. The findings of this study, which indicated in particular that the risk of suicide was particularly high among young men aged 15 to 29, led to the establishment of a “Time Out! Aikalisä! Elämä raitelleen” – initiative (Time Out! Back on the track) that targets men in this age group. This initiative has shown

positive results and is in place in over a hundred municipalities, reaching approximately 60% of men in the target age group (Stengård *et al.*, 2009).

53. The high prevalence of suicide among young adults (aged 15-34) remains a major obstacle. Within this group, suicide concentrated in particular cohorts *i.e.* young men and lower socio-economic groups, accounts for 40% of male mortality rates, which is higher than in the other Nordic countries (Ministry of Social Affairs and Health 2006).

54. A study on socioeconomic differences in suicide mortality by sex in Finland in 1971-2000 found large and persistent socioeconomic differences in suicide mortality. Indeed, suicide among male and female (25-year-olds and older) manual workers was 2.3 and 1.3 times higher respectively than among upper non-manual workers, and the largest differences could be found among those in their early thirties (Mäki and Martikainen, 2007).

55. There is also a strong link between alcohol consumption and suicide in Finland: between 2000 and 2006, more than one of every four people who committed suicide were under the influence of alcohol. Among young adults (15 to 24 year-olds) the proportion was even higher: half of all young men and one-third of all young women who committed suicide did so under the influence of alcohol (Impinen *et al.*, 2008).

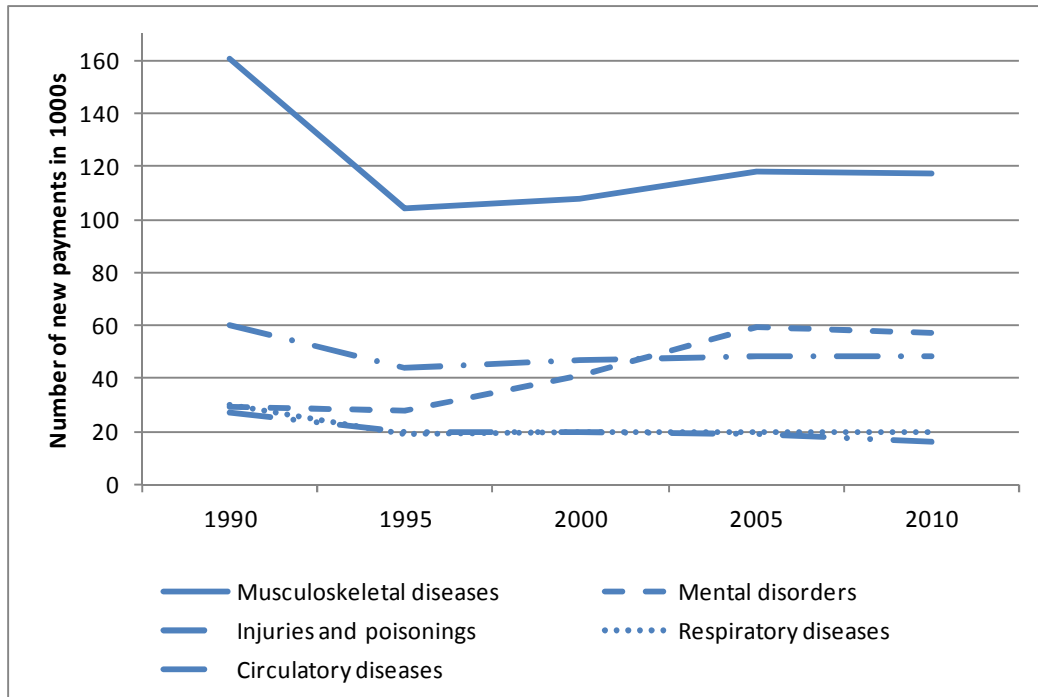
56. A nationwide survey of Finnish adult community mental health service units was conducted between 1 September 2004 and 31 March 2005 to assess the relationship between mental health services (using the European service mapping schedule) and the suicide rate in Finland (Pirkola *et al.*, 2009). The survey found that well-developed mental health services (*i.e.* a wide variety of outpatient services, more commonly used outpatient services over inpatient services, and 24h-emergency services, etc.) were associated with decreased suicide rates.

2.3 Other indicators

Work disability

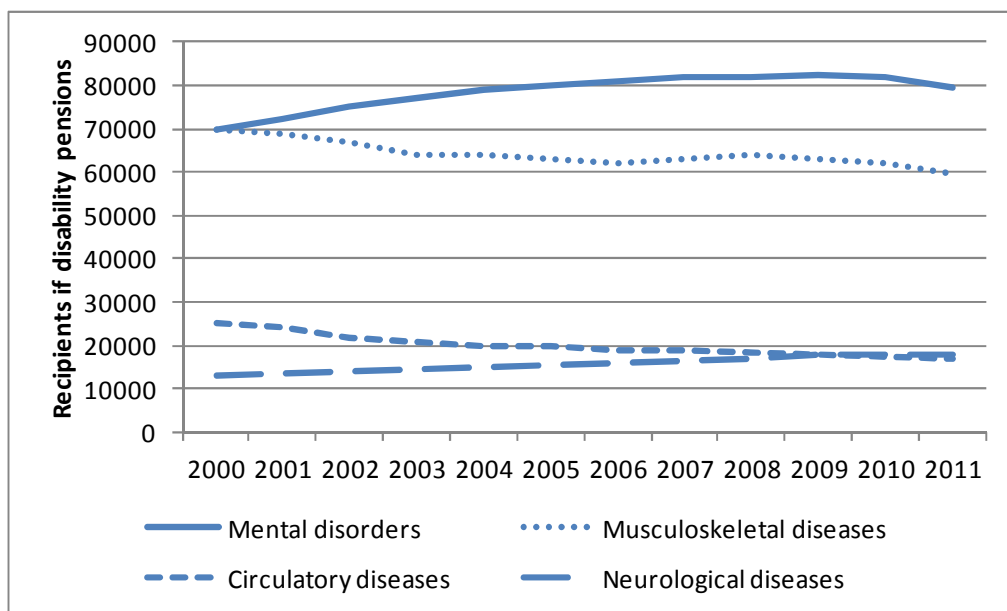
57. The share of disability benefit claims due to mental health disorders has increased over the past two decades in almost all OECD countries (OECD, 2012b). Finland is no exception, as mental disorders, particularly depressive disorders, have accounted for an increasing share of disability pensions since the late 1990s (Figure 4). People receiving disability pensions due to mental disorders represent the greatest share of all recipients of disability pensions (Figure 5). In 2010, 33% of new disability pensions were granted due to mental and behavioural disorders. In 2009, musculoskeletal or mental disorders accounted for two-thirds of the more than 25 000 people (or 0.7% of the working age population) retiring on disability pensions (OECD, 2012a).

Figure 4. New payment of sickness allowance by selected diagnostic categories, 1990 – 2010



Source: Social Insurance Institution, 2011,

Figure 5. Recipients of disability pension by diagnostic group, 2000 – 2011

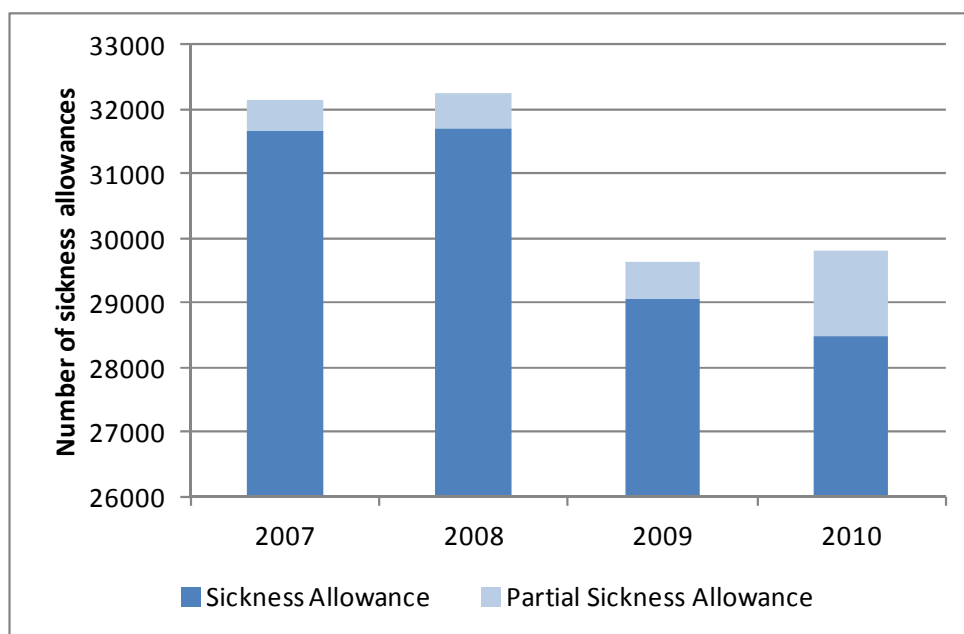


Source: Finnish Centre for Pensions, 2012

58. Although depression-related disability has been declining since 2008 (Figure 6), the economic cost of work-disability due to depression is still high in Finland. In 2010, depression-related sickness

allowance days and work disability pensions amounted to €639 million. Of this total, disability pension payments by work pension schemes amounted to €444 million (69%), the Social Insurance Institution paid €79 million (12%) in disability pensions, while sickness benefit costs were €116 million (18%) (Ministry of Social Affairs and Health, 2011b).

Figure 6. Sickness or partial sickness allowance spells beginning due to depression



Source: Ministry of Social Affairs and Health, 2011b.

Comorbidity between substance abuse and mental health disorders

59. Comorbidity between substance (primarily alcohol) abuse and mental health disorders is relatively common. For instance, 14% of people diagnosed with bipolar disorder were found to also have a problem with alcohol abuse (Mantere *et al.*, 2006). Moreover, 10-30% of people suffering from depression have been found also to have been addicted to alcohol or other substances (Melartin *et al.*, 2002). The Health 2000 survey revealed that 15% of those suffering from mood or anxiety disorders had a substance abuse problem. Finally, evidence from a survey carried out in 2007 on substance abuse visits in health and social care services indicates that 48% of people with substance abuse problems were suffering from depression or other mental health disorders (Nuorvala *et al.*, 2007).

3. POLICY AND GOVERNANCE

3.1 Governance and organisation of the health system

60. The health care system in Finland is an integrated public health care system comparable to those of the other Nordic countries, the United Kingdom and southern Europe. Finnish health care services are mainly publicly delivered and funded by tax revenues collected from municipalities and the State. The Finnish health care system is highly decentralised, and service provision is based on residential catchment areas. There is a system of funding that combines taxation and national health insurance. Universality and the equal right to health services are the core principles of the Finnish health care system. There are three different health care systems in place that receive public funding: municipal, private, and occupational health care (*occupational health care is provided to employees*), between which the scope, user-fees and waiting times vary greatly. Primary care is delivered through all of these three different channels (OECD, 2012a).

61. The Ministry of Social Affairs and Health (MSAH) is responsible for the planning, steering and monitoring of health care and social services. The MSAH steers the development and management of health and social policies through guidelines and targets set in the National Development Programme for Social Welfare and Health Care (KASTE programme). Its main objectives are to decrease health and social welfare inequalities, to improve health and welfare and to improve service quality and effectiveness. The KASTE programmes are adopted every four years – the current programme was renewed by the Government in January 2012, and to some extent it continues the work carried out by the previous programme for 2008-2011. In order to facilitate implementation and to reach the targets set in the KASTE programme, the government subsidises (regional) projects for the development of social welfare and health care. Altogether, €70 million has been reserved for these projects for 2012-2015 (Partanen *et al.*, 2010). In addition, together with other funding bodies, the Ministry of Social Affairs and Health coordinates project funding for municipalities, federations of municipalities, associations and firms.

62. Municipalities at a local level are in charge of the organisation of *primary health care and specialised medical care*. Municipal social and health care services must cover prevention, early detection, appropriate care and rehabilitation. Municipalities, which are responsible for the planning and provision of health care services, are obliged to provide primary care services in a health centre (Health Care Act). Given that the median size of municipalities is approximately 5 000-6 000 residents, it is common that smaller ones in rural areas form federations of municipalities and run a common health centre – consequently, in 2011 there were 162 health centres for 336 municipalities in Finland (Vorma, 2011).

63. Municipal health centres are the main providers of primary health care, covering over 70% of outpatient physician consultations and 95% of inpatient care periods (Vuorenkoski *et al.*, 2008). Municipal primary health care provides mainly outpatient services and includes, for example, consultations by general practitioners and public health nurses; health counselling, preventive work and vaccinations; oral/dental health care; maternity and child health clinics; school health care and home nursing; and laboratory and imaging services. Health centres have a limited capacity for inpatient services, which mainly consist of long-term care for elderly individuals with chronic diseases.

64. With regard to the provision of services, local authorities have a choice between producing the services themselves and purchasing them from private providers. Whereas municipal health centres are

responsible mainly for the provision of primary health care, *specialized medical care* is provided by the 21 hospital districts (20 if the autonomous island of Åland is excluded), which each have one central hospital and a number of smaller hospitals. Each municipality must belong to a joint municipality board of a hospital district. Access to specialised medical care is based on a doctor's referral and provided primarily in the 15 central hospitals and 5 university hospitals. Specialised medical care includes inpatient care, outpatient treatments and day surgery (Vuorenkoski *et al.*, 2008).

65. In addition, employers provide *occupational health services* (OHS) for their employees, which account for a substantial amount of primary care services, as about one-third of the population have access to these services. Altogether, 92% of wage earners (1.9 million) are covered by occupational health services. The Occupational Health Care Act requires companies to provide preventive care to their employees. Employers often offer additional services such as access to a GP; over 90% of employees have access to these additional services (Kauppinen *et al.*, 2009; Ikonen, 2012). Physician visits for around half of the working population occur in occupational health care (Vuorenkoski *et al.*, 2008). Employers pay the cost of the OHS, and the Social Insurance Institution (KELA) reimburses annually about 50% of the total costs. The reimbursement (KELA) is financed by the employers (73%) and self-employed and employees (27%). Thus, the employees' share of total OHS costs is 13%; the employers pay the rest. There is no contribution to the OHS from taxation.

66. Private services, which are mainly available in the biggest cities, complement public health care services, and their costs are partly reimbursed under the national health insurance system. In fact, 30-40% of the charges of private doctors and dentists and of treatments prescribed by private doctors are reimbursed, while clients pay the remainder. Private insurance is mainly used to supplement the reimbursement rate of the NHI. Private service units mainly provide outpatient treatments, and there are only a few private hospitals in Finland (Vuorenkoski *et al.*, 2008). A relatively small proportion of the population have voluntary private coverage: 375 000 children and 237 000 adults were covered by voluntary health insurance in 2005 (*ibid.*). However, the share of private insurance has been slightly increasing in recent years.

67. The Social Insurance Institution (Kansaneläkelaitos, KELA) is an institution under public law and operates under the oversight of the Finnish Parliament. KELA is in charge of providing National Health Insurance to Finnish citizens. The Institution, founded in 1937, was initially in charge of providing national pensions but today guarantees universal social protection, covering fields ranging from education, pensions, unemployment, the home and family to retirement and health.

68. The National Health Insurance (NHI) scheme is part of the Finnish social security system. Some of the expenses it covers under the Sickness Insurance Act include: a share of private doctors' fees; a share of the costs of examinations and treatments prescribed by a private doctor; a share of the fees of private dentists and of the costs of examinations prescribed by them; a share of medication costs and a share of illness-related transportation costs. Sickness Allowance is intended to compensate for loss of earnings during a period of incapacity for work, but a 10-day waiting period must normally be completed before any sickness allowance is paid. If a person is paid a wage or salary while on sick leave, the sickness allowance is paid to the employer. There is also a possibility of obtaining a partial sickness allowance. The maximum period of sickness allowance is 300 working days (Melart, 2011).

69. The reform of the municipalities and the social and health care structure undertaken by the current government aims to reduce the number of municipalities significantly. At the moment, smaller municipalities have difficulty in maintaining health centres and recruiting personnel (in sparsely populated areas in particular), and this reform should ensure the efficient provision of health care services in the merged municipalities (Vorma, 2011).

3.2. Governance and organisation of the mental health system

70. Mental health services are organised as part of health services and the Ministry of Social Affairs and Health is in charge of “information steering”, planning and monitoring. As governmental steering for health is relatively weak, the Ministry of Social Affairs and Health has guided and supported service development through “Quality recommendations for Mental Health Services” (Ministry of Social Affairs and Health, 2002) and “Development recommendation regarding housing services for mental health rehabilitees” (Ministry of Social Affairs and Health, 2007). The 12 quality recommendations are directed at helping decision-makers and mental health professionals to provide high quality services. They are, however, not legally binding.

71. Since the dismantling of separate mental hospital districts in the early 1990s, the municipalities have been in charge of organising mental health services as determined in the Mental Health Act. They can choose to outsource mental health services to their hospital district or other providers or to provide these services as part of their basic or specialised psychiatric services (Pirkola and Sohlman, 2005).

72. The municipalities must provide preventive mental health care and appropriate mental health services in health centres, while taking into account the particular needs of their residents. These services may be delivered by municipalities or be purchased from private service producers or organisations. The scope and supply of services must be sufficient, and must take into consideration for instance the age and mother tongue of the patient.³ Municipalities also have other requirements with regard to mental health care, such as providing housing and rehabilitation services. Regarding mental health care, social services need to be delivered in accordance with the Social Care Act (710/1982). There are for instance housing services targeted at patients in mental health rehabilitation.

73. Outpatient care, voluntary enrolment and patient independence are the priorities in treating mental health disorders (Mental Health Act). When insufficient, these services are followed by psychiatric outpatient and/or hospital care, and urgent psychiatric treatment is made available to everyone in need. Referral is, however, needed in order to access specialised services such as psychiatric wards and clinics.

74. Due to the multitude of actors and a relatively broad legislation, variations in the supply and delivery of services can be noted between municipalities in health as well as in mental health care. While some municipalities have very well-structured and comprehensive services, others face difficulties in meeting care needs (see section 4.1).

3.3. Current mental health strategy and recent mental health policy

Current government programme

75. The current six-party coalition government, in place since 21 June 2011, has set goals with regard to mental health in its government programme. A particular focus is on early intervention and prevention of mental health problems. By revising the Mental Health Act, “the availability of low-threshold mental health services will be enhanced. Reinforcement of the development programme for mental health and substance abuse services (MIELI) will continue alongside the embedding of practices created as part of the project to prevent depression and reduce incapacity for work caused by depression (Masto).” In addition, the government has pledged to invest in mental health care and welfare services for substance abusers (Government, 2011).

³ Swedish is the second official language in Finland; the Sami language also has a minority language status in Lapland.

76. The government has also recognised the overlap between mental ill health and incapacity for work and has committed to promoting the prevention and treatment of mental health problems: more work opportunities will be provided for those who are partially capable of working, and focus will be shifted to preventing incapacity to work, with special attention to mental health problems (Government, 2011).

The National Plan for Mental Health and Substance Abuse Work 2009-2015

77. Following a parliament motion, the Ministry of Social Affairs and Health set up a steering group, which established a national plan for mental health and substance abuse work between 2007 and 2009. The National Plan for Mental Health and Substance Abuse Work 2009-2015 was published in February 2009, after which the National Institute for Health and Welfare (THL) was given the responsibility of preparing the implementation plan. The plan consists of 18 propositions regarding the joint development of mental health and substance abuse work until 2015. Four main areas were identified: “strengthening the status of service users; investing in prevention and promotion; organising mental health and substance abuse services into a well-functioning set of services; and developing steering tools” (Moring et al., 2011). For the first time, mental health and substance abuse work are aligned under the same strategy (for more details see Moring et al, 2011).

78. The National Plan was established as a response to rising concerns in the field of mental health and substance abuse. Mental health problems increasingly lead to incapacity to work, and the indirect costs of mental health problems, such as those associated with lost labour input and cuts in productivity, are high (OECD, 2012b). Furthermore, it was seen as important to develop promotion and prevention in outpatient services in a context of prevailing inpatient care and to break existing borders between services. Other concerns taken into account in the plan included the relatively common use of involuntary treatment and coercive measures. Finally, one of the aims in putting together the National Plan was to develop the uncoordinated private sector and to solve both the difficulties of recruiting doctors in the public sector and geographical differences in service provision (Moring *et al.*, 2011).

79. A progress review and actions to be intensified in regard to implementation of the National Plan were published in 2012. In sum, the report finds that the development of mental health and substance abuse services has, for the most part, progressed in accordance with the Plan's proposals. Developing some key areas have already come a long way, including the establishment of mental health and substance abuse prevention strategies at the municipal level. While achieving the goals set out in Plan will require some effort, they are seen as relevant and feasible to achieve by 2015 (Ministry of Social Affairs and Health, 2012b).

The National Development Programme for Health and Social Welfare 2012-2015

80. The National Development Programme for Health and Social Welfare 2012-2015 (KASTE) is a strategic steering tool that aims to manage and develop social and health policies. The KASTE programme identifies principal social and health policy targets, main areas for development activities, any projects related to legislation, and monitoring, guidelines and recommendations that positively contribute to the realisation of the programme. The KASTE programme enhances national, regional and local cooperation for the implementation of the reform. The implementation of the KASTE programme is to a large extent carried out through regional development projects – municipalities and joint municipal boards for social welfare and health care can apply for discretionary government transfers for developing and implementing good practices.

81. Mental health is not one of the main themes of the current KASTE programme, renewed by the government on 2 January 2012. Nonetheless, good mental health service development overlaps with all of the identified areas of action and with the main goals: “improving the opportunities of risk groups for

inclusion, well-being and health; reforming services for children, young people and families with children; reforming the structure and content of services for older people; reforming the service structure and basic public services; adjusting the information and information systems so as to support clients and professionals; and supporting the restructuring of services and well-being at work by means of management” (Partanen *et al.*, 2010).

82. The current KASTE programme highlights that mental health and substance abuse services are to be developed in accordance with the national plan for mental health and substance abuse work 2009-2015 (MIELI), and the regional projects under the KASTE programme are a central tool in the implementation of the MIELI plan. The joint development of substance abuse and mental health services as well as the cooperation of social and health services is considered vital in order to achieve easily accessible, flexible and integrated services where mental health and substance abuse problems are treated.

83. Under the previous KASTE programme 2008-2011, five comprehensive regional project entities for the development of mental health and substance abuse work were launched, which altogether received €17.3 million of state funding (Ministry of Social Affairs and Health, 2012a). Mental health and substance abuse projects in northern and central Finland (Väli-Suomi) began in 2009 and were followed by similar projects in western and southern Finland in 2010. National coordination and cooperation between these projects enables wider regional and national dissemination and implementation of best practices.

84. As stated above, implementation of the national plan has been carried out mainly under the regional KASTE projects for mental health and substance abuse work, which today cover almost the entire country and take into account the specific needs of the area concerned. Four extensive regional programmes have already been implemented, including *Tervein Mielin Pohjois-Suomessa* (Healthy mind) in northern Finland, *Välittäjä 2009* (Carer 2009) in central Finland, *Länsi 2012* (West 2012) in western Finland and *Mielen avain* (Key to the mind) in southern Finland. In addition to these programmes, central and eastern Finland have conceived an *Arjen mieli* (Everyday mind) programme, which received a positive funding decision in 2011 (Partanen *et al.*, 2011).

85. *Tervein mielin Pohjois-Suomessa* is a part of a longer development action in the five most northern hospital districts in Finland. It uses the experience drawn from the Pohjanmaa project (2005-2014) and the Lapland mental health and substance abuse projects (see section 3.4). The current project highlights continuing regional development in compliance with the KASTE programme and the national MIELI plan.

86. *The Välittäjä 2009* consists of four sub-projects involving the Vaasa and Southern Ostrobothnia hospital districts, the city of Tampere and the substance abuse care of the Häme federation of municipalities. It aims to strengthen mental health and substance abuse work in primary care by increasing user participation and developing preventive mental health and substance abuse work and seamless service chains from primary to specialised health care and by establishing regional mental health and substance abuse plans (Kuosmanen *et al.*, 2010; Partanen *et al.*, 2010).

87. The *Mielen avain* project in southern Finland is the MSAH’s KASTE project for 2010-2013, and received government funding of €7.5 million in March 2010. 37 municipalities are included in the project. The targeted area is rather heterogeneous, and includes big cities such as Helsinki and Vantaa and several smaller towns and rural municipalities. In addition, several municipal mergers have been carried out in the area, which also contains new co-operation districts for social and health care – this explains the need for the development of a mental health and substance abuse work strategy and the development of service structure.

88. The main objectives of the *Mielen avain* project are to enhance Finnish mental health in the south and to prevent substance abuse as well as to improve access to care for individuals already experiencing problems. Actions in primary and outpatient care and a low threshold/one-door principle for care are emphasised, and all municipalities involved in the project have adopted a “care guarantee”. This guarantee ensures that every resident who feels ill (or has a detected need for help) will receive help in the municipal mental health and substance abuse service network within three days, following a one-door principle and where the help was first sought (Partanen *et al.*, 2010).

89. The *Länsi 2012* projects, carried out between March 2010 and October 2012 and followed by the *Länsi 2013* project, concentrate on developing mental health and substance abuse work in *Satakunta and the south-western regions*, which include approximately 537 000 inhabitants. The project aims to implement and further develop operating models founded on best practices and evidence in mental health work. Emphasis is given to reinforcing expertise at the primary care level in health and social care as well as developing and rooting regional mental health and substance abuse plans in guidance tools for planning. Concrete development actions of the project are carried out through pilots that involve all participating municipalities.

90. The *Arjen Mieli project* in central and eastern Finland, which ended in Fall 2013, focused on information, and indeed several regional indicators were collected to identify the type and scope of mental health and substance abuse services offered. For instance, care periods and the number of patients in psychiatric inpatient care are longer in northern and southern regions of Savo, and the number of disability pensions due to mental illnesses has been on the rise within the past years in central and eastern Finland, with the exception of southern Savo (Partanen *et al.*, 2010).

3.4 Mental health initiatives

The Masto project to prevent depression and depression-related work disability

91. In Finland, the number of people retiring due to depression almost doubled after the mid-1990s, in part reflecting changes in the living, working and psychosocial environment. However, during the past four years, depression-related work disability has been declining, mainly due to cooperation between different actors and the dissemination of best practices (Honkonen *et al.*, 2012).

92. The Masto project (2008-2011) was launched in 2007 by the Ministry of Social Affairs and Health in order to prevent depression and to reduce depression-related work disability in Finland. The project involved key administrative sectors, social partners and non-profit associations. It was targeted at people both in and out of work. Its main themes included the promotion of well-being at work and mental health, various activities to prevent depression, the early recognition and treatment of depression, and the rehabilitation and return to work of people recovering from depression. The project was carried out through a variety of activities, such as communications, regional events, training, expert working meetings, conferences and studies as well as proposals for legislative change. The action plan comprised 20 sub-projects and measures (Ministry of Social Affairs and Health, 2011b).

93. In practice, the project aimed at promoting well-being at work by taking up mental health themes in the training organised for occupational health and safety personnel and workplace supervisors. Effective methods of early support of work ability were also explored for sole entrepreneurs and farmers. An important component of the project was to develop good practices for occupational health services and, associated with this, to promote cooperation between the workplaces, occupational health services and psychiatry (Honkonen, 2011).

94. Another important element was to support the treatment of the initial phases of depression by primary care services. The Masto Project drew attention to the early recognition and active treatment of depression at health care centres. Initiatives included appropriate medication and better access to psychosocial support and time-limited psychotherapy in the public sector.

95. The Masto project also included a nationwide tour that helped to reach management, managers and occupational safety and health personnel and provided information on the manifestation of depression and its impact on working life. Early support and practices supporting the return to work were also introduced in workplaces. The MastDo campaign (Dec 2010 – Feb 2011), on the other hand, informed workplaces about concrete methods to help people to remain at work and to return to work after sick leave (e.g. part-time sickness leave, work trials). The campaign encouraged workplaces to agree on joint rules of the game for tackling work ability problems early and for increasing work-life flexibility, in particular for those who are able to work part-time. The website provided informational material and instructions for employers, managers and employees (see www.mastdo.fi).

96. In parallel with the project, changes in legislation regarding mental disorders and employment were made: partial sickness allowance was introduced and has been used in Finland since early 2007 to help people to return to working life. Amended legislation that came into force at the beginning of 2010 has speeded up and simplified the use of part-time sickness benefit. Furthermore, the laws on rehabilitative psychotherapy were also amended. As of 2011, rehabilitative psychotherapy was transferred to the organisational sphere of the Social Insurance Institution of Finland to support continuing in working life, and the need for legislative change was featured in the action plan for the Masto project (Honkonen, 2011).

97. In the final report of the Masto project (Ministry of Social Affairs and Health, 2011b), the steering group put forward proposals for further measures, including that the Ministry of Social Affairs and Health takes responsibility of their implementation, while also assessing the need for further work.

Regional mental health initiatives

98. The development of preventive mental health care has been slow, as the main centre of attention has focused on the development of services and structures, and the treatment of mental disorders still prevails over prevention. Indeed, mental health services focus mainly on individuals who have already fallen ill or have symptoms, even though the Mental Health Act (L 1116/1990) prioritises prevention. However, in the 2000s, more focus shifted towards prevention, mostly through different projects targeting specific groups or regions. On the other hand, these projects have remained relatively short and limited, which has made achieving real change in outcomes related to mental health more difficult.

99. Apart from the national suicide prevention programme between 1986 and 1996, initiatives targeting mental health disorders have been carried out mostly on a regional level (due to the decentralisation of the organisation and supply of services). In recent years, three relatively extensive projects have been carried out: *Pohjanmaa* (Ostrobothnia), *Sateenvarjo* (Umbrella) and mental health and substance abuse projects in Lapland (for the latter, see section 4.5 ii). These three projects have worked closely together since 2005 and have later been integrated under the KASTE programme (Kuosmanen *et al.*, 2010).

100. The *Sateenvarjo* project was carried out between 2005 and 2009 as a cooperative effort of the cities of Helsinki and Vantaa and the Uusimaa hospital district, which aimed to develop mental health and substance abuse work in the region. Funded by the MSAH, its principal target was to develop new operating models for the early detection and care of the most common disorders. The main areas of action included: the recognition and detection of depression in well-baby clinics among families with children; the prevention of severe depression in school health care; the development of a triangle model for the

treatment of depression (depression nurses) in health centres; and the reinforcement of mental health and substance abuse work as home care. New operating models were created: for instance, common mental disorders are detected and treated at an earlier stage, and care is now more systematic. These models also unite actors across different sectors and organisations in order to create and maintain efficient care processes. The city of Vantaa continued this effort in 2010 by constructing a mental health and substance abuse centre after the project ended (Kuusmanen *et al.*, 2010; Partanen *et al.*, 2010).

101. Moreover, the *Pohjanmaa* (Ostrobothnia) project was also launched in 2005 for a total duration of 10 years. *Pohjanmaa* is a wide-scale project involving the city of Vaasa, Southern and Central Ostrobothnia's hospital districts, the Ministry of Social Affairs and Health and the Ostrobothnia social centre of excellence (*Pohjanmaan maakuntien sosiaalialan osaamiskeskus*). The Pohjanmaa project's aim was to develop a well-functioning regional example of mental health and substance abuse work. Its goals are supporting municipalities "mental health and substance abuse work; promoting prevention and early detection and help; providing tools for care and services chains; developing rehabilitation; increasing well-being at work and remaining in the workplace; promoting the creation of networks and educational and research cooperation; and, finally, distributing the latest information on mental health and substance abuse work".

102. From November 2009, the Pohjanmaa project was aligned with the region's national KASTE development programme, resulting in some changes in organisation and funding. The targeted area was divided, and central Ostrobothnia is now part of the *Tervein mielin Pohjois- Suomessa* project, and Ostrobothnia and southern Ostrobothnia part of the *Välittäjä* project in central Finland (Partanen *et al.*, 2010).

103. Finally, as an example of projects targeted at specific groups, special concern has been given to the problem of the exclusion of adolescents in national social and health policy programmes. Young men are reached, for instance, via the Time Out initiative (see section 1.2). Also, children and adolescents whose parents suffer from mental health disorders or substance abuse form a particular risk group within preventive mental health. Hence, the *Toimiva lapsi ja perhe-methods* (Functional child and family) were created to develop preventive work to help families with these risk factors (Partanen *et al.*, 2010).

3.5. Monitoring and good practice guidelines in health and mental health services

104. As stated in the Mental Health Act, the MSAH is responsible for general planning, monitoring and supervision. Regional State Administrative Agencies at a regional level and local authorities at a municipal level have a legally binding obligation to monitor the health and welfare of their residents.

VALVIRA

105. The National Supervisory Authority for Welfare and Health (Valvira) is a centralised body operating under the Ministry of Social Affairs and Health. Valvira's mission is to supervise and provide guidance to health and social care services, alcohol administration authorities and environmental health bodies and to manage related licensing activities. Valvira's goal is to protect Finnish citizens and their right to a life environment that promotes their health and welfare and to assure their access to social and health care services that are both safe and adequate. Valvira's authority and responsibilities in these areas are defined by a range of legislation, orders, recommendations and guidance.

106. Valvira guides the six Regional State Administrative Agencies and local authorities in the above-mentioned areas, while promoting uniform guidance on licensing and supervision practices nationwide at a regional and local level. Valvira and the Regional State Administrative Agencies carry out their supervisory duties on the basis of jointly agreed supervision programmes. Social care facilities are

managed by the appropriate Regional State Administrative Agencies (determined by location), and Valvira ensures that the guidance the Agencies provide is coherent throughout the country. Valvira shares responsibility with the Regional State Agencies with regard to social care complaints, which are processed primarily in the appropriate Regional State Administrative Agency but may be referred to Valvira if the complaint requires an evaluation of a nursing unit. Valvira has many responsibilities in the field of healthcare, for instance maintaining a register of healthcare professionals (Terhikki), handling patient complaints in terms of severe treatment injuries and granting permission for abortion in special cases.

107. Valvira is in charge of monitoring access to care, which has improved since the introduction of time limits in 2005. As a result, waiting times for non-urgent care have decreased in the past few years. Municipalities or municipality federations are obliged to publish data on waiting times per operating unit, and if the time limits on access to care are exceeded the supervising authority may order the municipalities to pay a fine.

Current Care – evidence-based national guidelines

108. Current Care (Käypähoito) produces evidence-based national clinical practice guidelines for care in support of health care decision-making and for the benefit of the patient. These guidelines are produced by the Medical Society Duodecim in association with various medical specialist societies. Current Care and the Finnish Medical Society Duodecim are founding members of Guidelines International Network (G-I-N).

109. Current Care includes 101 guidelines at the moment, which are publicly available on the internet (www.kaypahoito.fi.) These guidelines aim to support doctors' work and form a basis for compiling regional care programmes. They are applied to medical practice in Finland in order to improve the quality of care and to reduce inconsistencies between treatment practices. Patient versions of the guidelines and educational material for professionals are also produced by Current Care. Several guidelines are updated every three years. Patient material, web learning for professionals, criteria for elective care, house rules, treatment chains and electronic decision-making tools are actively implemented (Laukkala, 2011).

110. The Current care open access electronic website is the main channel of access to the guidelines, which are also published in the journal *Duodecim*. Current Care has four levels of evidence; strong research-based evidence, moderate research-based evidence, limited evidence and no research-based evidence. Even though the clinical guidelines are comprehensive and easily accessible, they seem to be under-utilised, especially in primary care. This could however be partly explained by the fact that the use of guidelines is not tied to provider payment.

111. For mental health, psychiatric guidelines exist for Attention-deficit hyperactivity disorder (ADHD, children and adolescents); Bipolar affective disorder; Borderline personality disorder; Depression; Eating disorders (Children and adolescents); Insomnia; Post-traumatic stress disorder; Schizophrenia; Smoking, nicotine addiction and interventions for cessation; Treatment of alcohol abuse and Treatment of substance abusers.

Information systems and registers

112. National health registers, such as the treatment register HILMO, produce information on population health and care. HILMO is a statutory tool, with providers obliged to register data on public and private hospital care, day surgery procedures and public specialised outpatient care. Since 2011, primary outpatient care has also been included in the register. The *Sotkanet* database (operating under the National Institute of Health and Welfare – THL), on the other hand, collects information and data on social welfare and health in Finland.

113. The nationwide registers are currently limited in that they produce information only on people in treatment. In fact, legislation obliges municipalities to monitor the state and welfare of their inhabitants, but surveys targeting perceived health, welfare and the need for services have so far been carried out at a national level (with no possibility of obtaining municipal information). The THL has however launched an ATH-survey (*Alueellinen terveysterveys- ja hyvinvointitutkimus*: Regional health and welfare survey) that collects regional information on health and welfare in Finland. The project started in 2010 in the city of Turku, northern Ostrobothnia and the region of Kainuu, reaching 31 000 over 20-year-olds, and the project is currently expanding (for further detail see Ministry of Social Affairs and Health, 2013b).

SOTKANet

114. The SOTKANet indicator bank (www.sotkanet.fi) is THL's information service and contains key data related to the populations' health and welfare from 1990 onwards. It covers all Finnish municipalities and is broken down by the current number of municipalities. For example, SOTKANet enables users to search for indicator data for different geographical areas in absolute numbers or percentages. The data is accompanied by descriptions providing "information on the data content, interpretations, data sources, years covered, and possible restrictions" (SOTKANet). The SOTKANet data is gathered from the welfare and health data sources of THL and other agencies.

115. For mental health, SOTKANet contains 79 indicators divided into 7 different sub-groups: use of psychiatric hospital services; outpatient care visits related to mental health; health behaviour and psychic symptoms; sickness allowance related to mental disorders; use of special refunds on medicines; mortality; and involuntary care (SOTKANet).

Outcomes and quality indicators

116. Finland has proven its interest in mental health by actively participating in international initiatives in this field. For instance, Finland took part in the third Nordic Council's health indicator project, launched in 2007, which gathered a very comprehensive set of quality indicators in mental health across the Nordic countries (Nordic Council of Ministers, 2011b). Moreover, a broad collection of national indicators is available in the SOTKANet indicator database. 79 different indicators for mental health are available on the website, covering the use of: psychiatric services; outpatient visits for mental health reasons; health behaviour and psychic symptoms; sickness allowance; the use of special refunds on medicines; mortality; and involuntary care.

117. Finns are also active in the EU-funded REFINEMENT project, which analyses the effect of financing systems on mental health services. The project's aim is to identify financing systems that promote a high quality in mental health care (for further detail see European Commission, 2013). Finland participates in the "Mental health systems in OECD countries" project and is one of the ten countries currently involved in the OECD "Benchmarking club", which, as a part of the OECD mental health project, is in the process of defining mental health quality indicators across OECD countries (DELSA/HEA 2010:34). This project draws from the existing OECD Health Care Quality Indicator project, where the number of indicators for mental health remains limited. Existing mental health indicators under the HCQI project include age-standardised suicide rates and rates on readmissions to the same hospital for schizophrenia and bipolar disorders.

118. With regard to outcomes, the large decrease in suicide rates indicate that efficient measures, such as the suicide prevention programme, have achieved success in tackling mental health-related problems in Finland (see section 2.1). Moreover, a recent Nordic study conducted in Denmark, Sweden and Finland shows that the gap between the life expectancies of individuals suffering from mental health disorders and those in the general population has slightly narrowed. Despite this positive development, men suffering

from mental disorders still die 20 years earlier and women 15 years earlier than the general population. The aim of this study was to examine whether the recent mental health system reforms have had an impact on the life expectancy of individuals with mental health disorders. Whilst people with mental health disorders are twice as likely to die from somatic diseases (*i.e.* cardiovascular or cancer), the study shows that between 1987 and 2006 their life expectancy increased. The increase in life expectancy in Sweden was slightly more modest than in the other two countries, which could partly be explained by the vigorous implementation of national suicide prevention programmes in Finland and Denmark (Wahlbeck *et al.*, 2011).

119. Despite the fact that health inequalities in Finland have been widening, life expectancy between patients with mental disorders and the general population has decreased by approximately two years among men and five years among women between 1987 and 2006. These outcomes imply that recent mental health policy appears to have been effective at least in part, without neglecting the need for further development (Wahlbeck *et al.*, 2011).

120. During the past four years, depression-related work disability has been declining in Finland. The Masto project (see section 3.5), coordinated by the MSAH, has promoted measures underpinning the cooperation of different actors and the dissemination of best practices at the national level. Effective measures have included incorporating mental health aspects into legislation and national policies, national programmes, occupational health and safety, and corporate management strategies (Honkonen, 2011).

3.6. User involvement: consumer associations, family associations and other NGOs

121. There is no legislation on user involvement in Finland, and mental health services have previously been designed in a somewhat homogeneous way, partly due to the lack of user participation. Hence, one of the four main areas of the current mental health plan is *to strengthen the status of users* (Wahlbeck, 2011). Five sub-propositions are included for further development of user involvement. Individuals with mental health and substance abuse problems should have equal access to services and be treated equally to all other service users.

122. Moreover, client involvement should be increased by the inclusion of user experts and peers in the planning, implementation and evaluation of mental health and substance abuse work. Reducing the use of coercive measures in psychiatric hospital treatment through a national programme is also included. A final aim is to increase the safety of patients and staff (Moring *et al.*, 2011). Work is underway to improve the inclusion of users in the planning of services. For instance, one of the components of the Pohjanmaa project was to train service users, salaried by hospital districts, to lead peer groups (Kuosmanen *et al.*, 2010).

123. Finland has a number of influential mental health associations. For instance, the Finnish Central Association For Mental Health supports advocates and promotes the rights of people living with and recovering from mental health problems. It has 21 000 members and 173 local chapters, and hence operates at both the national and local levels. The Central Association for Mental Health provides dozens of rehabilitation courses (annually) and rehabilitation counselling services at the Propelli information and guidance centres located in Helsinki, Kuopio and Turku as well as in municipalities offering supported housing (Jyväskylä, Rovaniemi, Vantaa). In addition, the Association provides legal and social advice, supported education and training, information and skills to facilitate a return to working life, advice on apartment renovation, supported holiday opportunities for individuals and families, discounted travel, etc. The association has especially been thriving due to its stand of abandoning the use of coercive measures and involuntary care (Aalto, 2011).

124. The National Family Association promoting Mental Health in Finland was founded in 1991. It supports family associations and advocates the interests of the family members of patients with mental disorders at a national level. This association develops family work in cooperation with other organisations working in the mental health sector. The National Association does nationwide work affecting public opinion by distributing information, and it coordinates between family associations by acting as a link between member associations. At a regional level, the Association provides a meeting place for families and relatives, who share similar, often difficult experiences as regards mental health disorders.

125. The member associations also collaborate with municipalities while advocating the interests of their members. Activities include study, discussion and support groups, courses on rehabilitation and personal adjustment, recreational and hobby activities, subsidised apartments and work, seminars and public occasions, education, information and publication activities. A nationwide development project for the improvement of the well-being of care-givers was coordinated by the National Family Association during 2005-2009.

126. Furthermore, the Finnish Association for Mental Health is an NGO that, founded in 1897, is the oldest voluntary mental health organisation in the world. While its initial purpose was to provide assistance to recovering patients released from mental institutions, the FAMH's objective today is to promote good mental health by stimulating interaction between individuals and communities by encouraging people to act locally.

127. The FAMH collects and disseminates information on mental health to serve planning and decision-making, proposes initiatives and publishes reports, and publishes books and journals. As a non-governmental organisation, the FAMH organises volunteer activities in Finnish society and trains professionals and volunteers. The FAMH also provides expert services and training, sells journals and guidebooks and produces brochures and promotional material. Through its co-operative networks the FAMH offers support and raises awareness about mental health issues throughout Finnish society. As a developer and producer of services, the FAMH responds to social challenges by employing new models to promote mental health and provides help and assistance in crises.

128. A major part of the activity of FAMH and other mental health associations is financed by the Finnish Slot Machine Association (RAY), which was set up by various organisations for the purpose of raising funds. The Slot Machine Association's grants are applied for annually. Ministries, local governments and parishes provide some funds as well. For financing, the FAMH also collects membership fees, accepts grants and donations and organises fund-raising.

4. ORGANISATION AND DELIVERY OF SERVICES

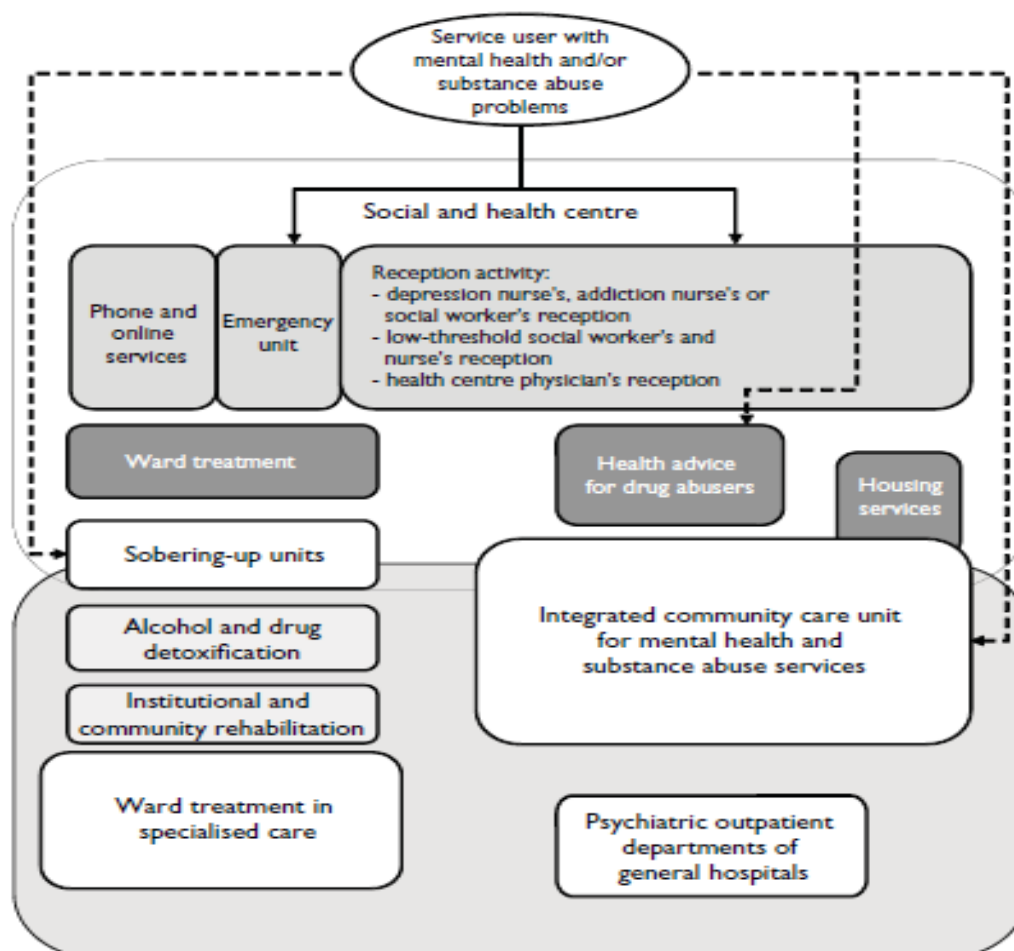
4.1. Adult mental health

129. National population surveys indicate that only a proportion of citizens suffering from mental illness are in the scope of psychiatric care. Whilst access to care seems to have improved, the majority of people with depression disorders, for instance, remain outside care. According to the Health 2000 survey, among those suffering from depression, 34% had been in care between 2000 and 2001 (Hämäläinen *et al.*, 2008).

130. The availability of mental health care services also varies regionally. Differences in access to discretionary psychotherapy, for instance, were fourfold in 2002 (Wahlbeck, 2005), and there is a lack of availability of psychotherapeutic treatment in primary and specialist care (Korkeila, 2012). Moreover, difficulties in recruitment also vary regionally, which creates regional disparities in the supply of services, and regional disparities equally exist as regards to time limits for the guarantee of care. The majority of hospital districts are able to guarantee access to care within the time limits, but quality deficits in the care provided may occur (Tuori, 2002).

131. In line with current mental health policy, services have been and are still being developed to increase the role of primary care and outpatient mental health services, to help drive a move away from the prevailing inpatient care (Figure 7). The MIELI plan also sets out the need for greater integration of primary, secondary and tertiary care, which is also a central part of the social welfare and health care reform (Moring *et al.*, 2011). Moreover, there has been relatively little coordination between health and social services on mental health, even though both are provided by municipalities. However, this can be partly explained by the existence of separate budgets.

Figure 7. Redesigned services, MIELI 2009 plan



Source: The Ministry of Social Affairs and Health, 2011b.

Primary Care

132. Municipal health centres provide services for individuals experiencing mental health problems. Mental health care can also be provided in occupational health services. The proportion of people consulting a primary care provider (GP) for mental health problems is, however, much lower than in a number of EU countries (Figure 8). Hence, one of the stated aims of the current mental health strategy is to integrate mental health services into primary care (Partanen *et al.*, 2010). Some notable progress has been made in the area of web-based projects. The innovative web-based project (Mielenterveystalo⁴) to improve the dissemination of information on primary care developed at Helsinki University Central Hospital (HUCH), for example is being gradually expanded into a national service. In addition, other web-based therapies and self-help programmes are being developed as part of the KASTE programmes.

133. Primary care is almost exclusively provided by municipalities (occupational health excluded). In 2011, there were in total 2.4 million outpatient mental health visits (0.44 visits per capita). Out of these,

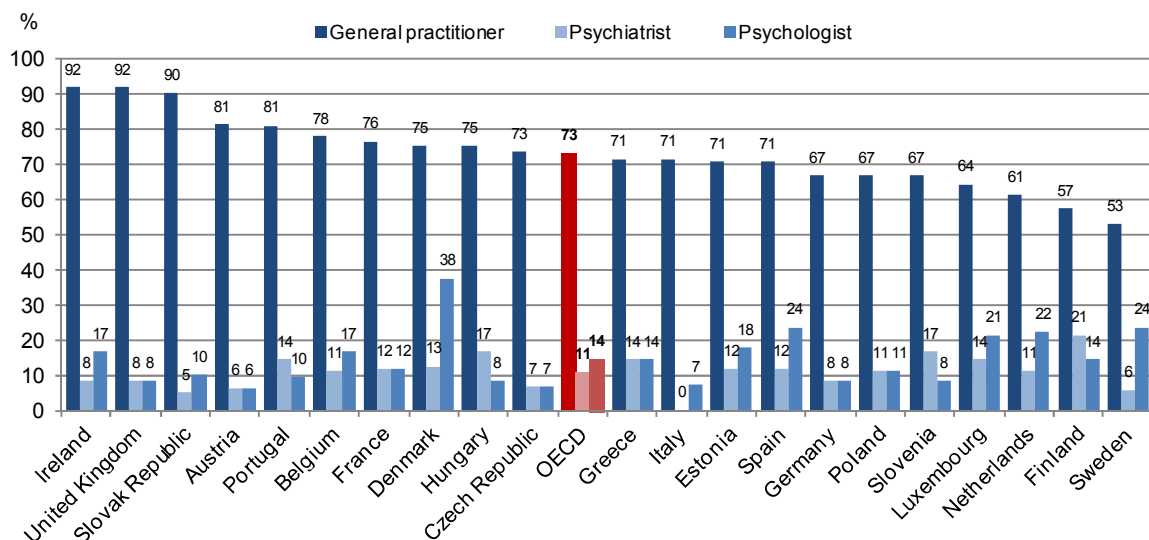
⁴ <https://www.mielenterveystalo.fi>, available in Finnish and Swedish

28% took place within primary health care, and more specifically 11% of the visits took place with a physician and 12% with other practitioners (THL, 2012b).

134. Licensed physicians are in charge of making decisions regarding medical examinations, diagnosis, and treatment (Act on Health Care Professionals). Primary health care doctors are authorised to prescribe or to continue the prescription of psychopharmacologic medicines, which primary care nurses are not authorised to do. On the other hand, these nurses are able to map the symptoms, give instructions to patients, offer psychosocial support, monitor the treatment and medication and recovery, and coordinate care and collaboration with other professionals involved in a patient's primary care treatment. As for primary health care professionals, it is unclear whether they have acquired official training on mental health in the past five years. Guidelines on management and treatment are, however, available in the majority of primary health care clinics (Vorma, 2011).

135. Figure 8 below shows the type of providers consulted for mental health problems in 2010. The majority of people seeking consultation due to mental health problems in Finland consulted a GP (57%), while 21% consulted a psychiatrist and only 14% a psychologist (OECD, 2011). The underdevelopment of mental health services within primary care has led to a low threshold for admittance to secondary care. Moreover, some conditions (such as mild to moderate depression and anxiety) treated in specialised services in Finland are similar to those that would be treated in primary health care in other countries. Secondary care services may therefore face problems with developing a sufficient focus on treating severe mental health disorders. In addition, individuals may be incited to use specialist outpatient services, free of charge to the patient, whereas in primary care an out-of-pocket fee applies (Wahlbeck, 2011). However, general practitioners act as gatekeepers to specialist services, which cannot be accessed directly.

Figure 8. Type of provider(s) consulted for mental health problems, selected EU countries, 2010



Source: OECD, Health at a glance, 2011.

136. Several health stations or centres have started to use a depression nurse model. A survey conducted in 2008 in all health centres indicated that 78% of all health centres had a depression or a psychiatric nurse, and 61% of centres had adopted a uniform practice for the screening of depression (Partanen *et al.*, 2010). However, it is not clear whether these nurses are following the clinical guidelines. A physician assesses the patient and plans the medication, tests and any necessary sick leave and refers the patient to the nurse, who plans, coordinates, implements and assesses care and medication.

Primary care provided in occupational health services

137. Occupational health services (OHS) account for a substantial amount of primary care; over 90% of the working population in Finland (1.9 million) have access to OHS (Kauppinen *et al.*, 2009; Ikonen, 2012). The main focus of occupational health services in Finland is promotion of the health and work ability of employees and prevention of work-related diseases (Ministry of Social Affairs and Health, 2011a). There is potential for greater focus on mental health promotion as well as prevention and early intervention related to stress, burnout, depression and other common mental health problems (including alcohol problems) of the working age population.

138. In many cases, the scope of occupational health care contracts might not cover psychiatrists' consultations for employees or consultations of occupational health psychologists (or these are limited in number), which means that doctors in occupational health may need to refer patients to primary or specialised care. Thus, it is considered essential to develop better cooperation between various actors. On the other hand, as municipal services are very fragmented, they might not be well-known in occupational health. This concern has also risen in social care – there is uncertainty about whether to refer mental health or substance abuse patients to primary or specialised care.

139. As depression and other common mental health problems are a major cause of disability (Ahola *et al.*, 2011), the potentially increased role of the occupational health system (in collaboration with work places and primary and specialised care) has been noted in promoting well-being at work and improving effective treatment and rehabilitation. The Masto project carried out between 2008 and 2011 aimed to prevent depression and to reduce depression-related work disability in Finland (see section 3.4). The project promoted in particular measures underpinning the cooperation of different actors and the dissemination of best practices at a national level (Honkonen, in Moring *et al.*, pp. 171-173). The success of well-timed and needs-based support for work ability requires that the occupational health services coordinate the implementation of any necessary measures at the workplace, in primary health care, and in specialised medical care (Ministry of Social Affairs and Health, 2011a).

140. Under the occupational health system, employers may negotiate quality targets with providers as they have an incentive to keep employees healthy in order to keep costs down, but such agreements appear to vary between employers and are not standardised. However, there are no national quality-related or “pay-for-performance” schemes in public health care whereby providers can be rewarded or penalised according to their performance on a range of quality indicators or metrics.

141. The parallel system of primary care provided by the occupational health system is likely dealing with lower severity patients as they are still in employment. This implies that the public primary health care system is probably dealing with more severe cases and, in fact, over 60% of anxiety and mood disorders are treated mainly in specialist care (Hämäläinen *et al.*, 2008). As many suffering from mental disorders are not eligible for (free) occupational health services, access to care is limited, for instance due to the limited supply of low-threshold acute services in primary care and user fees for public health care (Wahlbeck, 2011).

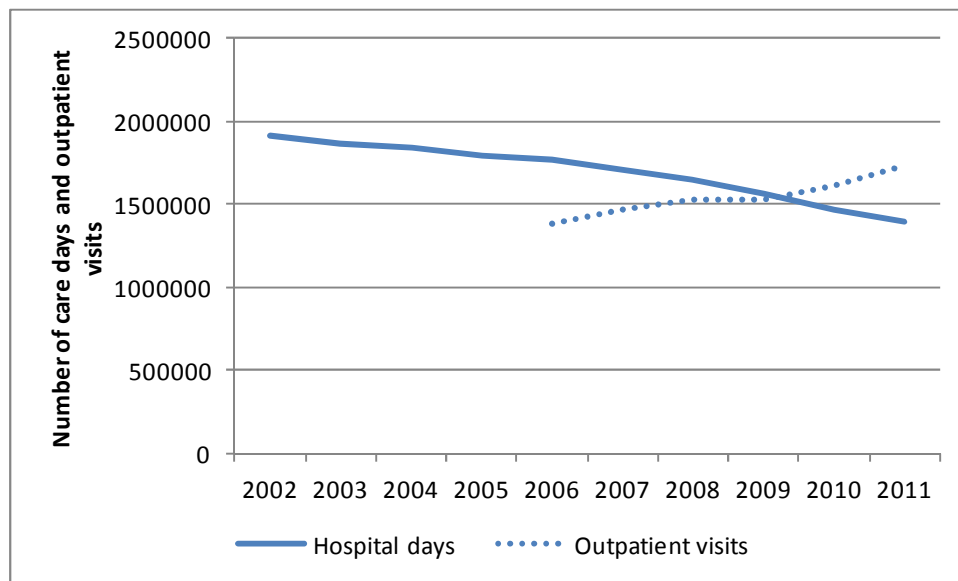
Secondary and tertiary care*Secondary specialised outpatient care*

142. Of the total of 2 262 816 outpatient mental health visits in 2010, visits in specialised care for mental health accounted for 69%, from which adult psychiatry accounted for 53%, adolescent psychiatry for 9% and child psychiatry for 7%. All in all, almost 155 000 patients used specialist psychiatric services in 2010 (THL, 2011). As regards the increase in outpatient visits, depression diagnoses (ICD code F32 and

F33) accounted for 32%, while outpatient visits related to schizophrenia (F20) seem to have slightly decreased, yet visits for schizoaffective disorders (F25) have increased by the same amount (THL, 2012b).

143. The number of periods of care has also decreased by 26% between 2002 and 2011, from 51 698 to 41 224, while outpatient visits, on the other hand, increased by 20% between 2006 and 2011 (THL, 2013). The changes in hospital days and outpatient visits between 2002 and 2011 is illustrated in Figure 9. below.

Figure 9. Psychiatric specialist medical care, 2002- 2011



Notes: Outpatient visits in specialist care have been recorded since 1998, but the figures have been comparable from 2006.

Source: Psychiatric specialist medical care 2011, THL, 2013.

Intermediate services/Community care

144. Between institutional care and outpatient care, there are intermediate services that aim to support outpatient care and rehabilitation. These include housing services, work activities and day care/nursing and are organised by hospital districts, municipalities and private providers, which contract directly with the municipalities in accordance with legislation. A wide range of outpatient services for *long-term psychiatric patients* exists, including rehabilitation and residential homes, sheltered housing, day-care centres and day hospitals. Due to the fragmented service provision system, there is regional variation among the providers of these services, so nation-wide data on them is not systematically available. The services can be provided by municipal health or social services, NGOs, the private sector or specialised psychiatric hospitals.

145. The *WHO Regional Office for Europe: Policies and Practices for Mental Health in Europe* (2008) indicates that in terms of access to assertive outreach in Finland, in practice only a minor proportion of people with mental health disorders (1-20%) had access to assertive outreach. Community-based early intervention and rehabilitation services in practice were available to the same proportion of people. Whilst access to community-based crisis day care was available to 21-50% patients in practice, in practice only 1-20% had access to round-the-clock crisis services or to home treatment.

146. Salaries in health services are higher than in social care, which appears to contribute to quality differentials. As outlined above, out-of-hours services and 24/7 -home treatment teams remain fairly

underdeveloped compared, for instance, to Sweden, which could partly explain the relatively high readmission rates for mental health disorders in Finland (Korkeila, 2012).

Housing services

147. In 2010, housing services were used by 7212 service users, a total that has increased steadily from 3095 service users⁵ in 2000. Three different service providers can be identified: municipal social care, municipal health care and private providers. Whilst municipal health care had merely 159 users and social health care 509 users, the private sector's dominance is clearly visible, with 6544 users (THL, 2011).

148. Supported housing may take different forms: rehabilitation homes encourage learning skills for independent living, nursing homes are targeted for severely ill individuals, and there is also supported living in the community. In 2010, there were 482 community residential facilities (Vorma, 2011).

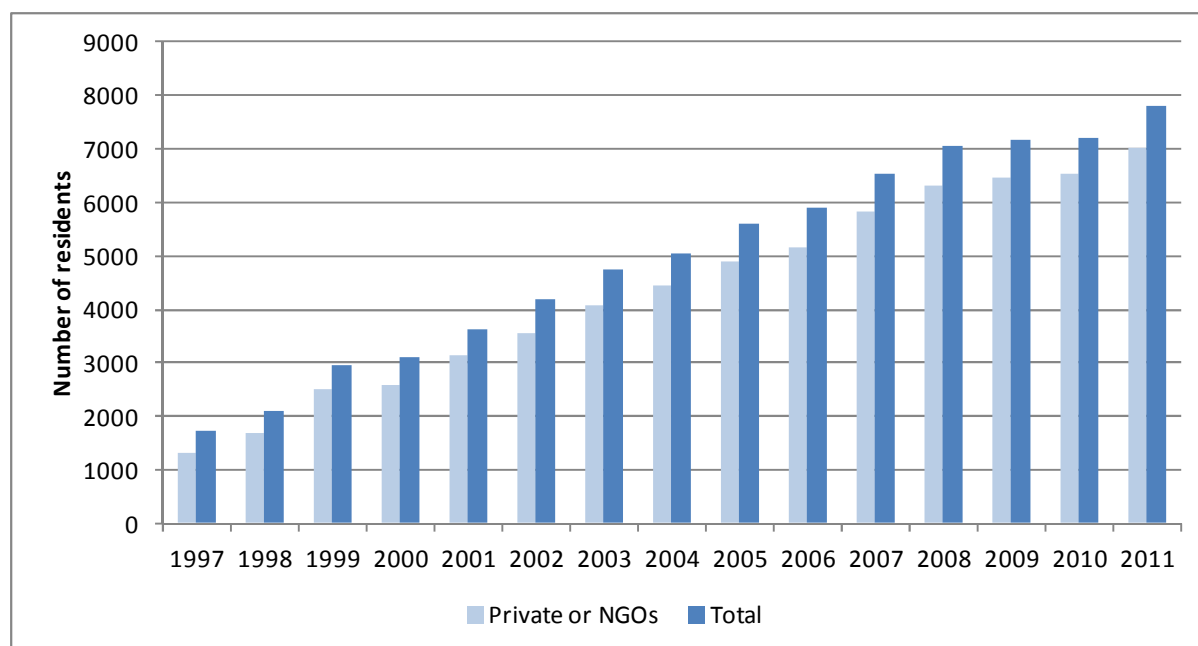
149. Private housing services are a central part of mental health services for severe mental health patients. Providing supervised or supported housing services has enabled patients to live outside institutions and has helped to reduce hospital care admissions. National and regional quality criteria have also been established in order to survey these services (see section 3.2). Inspections are carried out by municipalities and regional state authorities, and the quality of these services vary as municipalities have difficulty in regulating these services due to a lack of financial incentives to support active rehabilitation (Wahlbeck, 2011).

150. Transferring long-term patients with dementia or intellectual disabilities to non-psychiatric treatment facilities has facilitated the downsizing of psychiatric bed capacity. The downsizing of psychiatric hospital care has, however, created new challenges, as long-term patients have moved from psychiatric hospitals to housing services, in particular supported living, community-based nursing and rehabilitation homes. In 2009, these housing services had 4 070 rehabilitation customers who had been using the services continuously for over two years, out of a total of 7 160 mental health rehabilitation patients (Tuori, 2011).

151. Service users and researchers who have evaluated these services have noted significant shortcomings in these services. Indeed, the shift towards independent living and developing rehabilitative services has not taken place on a sufficient scale, which has exposed these housing services to the risk of becoming, functionally, the former "B" hospitals. In fact, regulating housing services for people with severe mental health disorders is problematic, given that the municipalities do not offer any financial incentives to support the active rehabilitation and social inclusion of the resident. On the contrary, the longer the stays are in these residences, the more money the (mostly private) providers of these services receive from the municipalities, giving them no incentive at all for rehabilitation. This has led to a rapid increase in private housing facilities and beds in private rehabilitation homes, while the proportion of other providers has remained stable, as is shown in Figure 10 below (Wahlbeck, 2011).

152. In October 2011, the Ministry of the Environment (in charge of housing, land use and building) set up a steering group to investigate the housing and living conditions of mental health rehabilitation patients. The findings were published in March 2012 and included proposals for further action and development (YM 2012:10). Drawing on this report, the Ministry of the Environment, in cooperation with other actors in the field, adopted a strategy for the development of housing for mental health rehabilitation patients between 2012 and 2015. This project will be carried out as part of the implementation of the MIELI plan.

⁵ Numbers of users at the end of the year, not annual totals.

Figure 10. Number of residents in homes for people with mental health needs, 1997-2011

Source: Sotkanet, Finnish Statistics and Indicator Bank 2013.

Rehabilitative psychotherapy

153. Rehabilitative psychotherapy is made available within the scope of private services and became a mandated activity at the beginning of 2011 (Melart, 2011). In terms of the socio-economic background of users of these services, it appears that 85% of them are women, and that access to psychotherapy is most commonly good or relatively good for people from higher socioeconomic groups (degree holders from university or polytechnics), which is similar to the situation in Sweden (Korkeila, 2012). There are significant regional inequalities in access to these services: psychotherapeutic services are especially concentrated in the university hospital areas (with the exception of Tampere), with very good access to these services in particular in Turku and Helsinki compared to other areas (Korkeila, 2012).

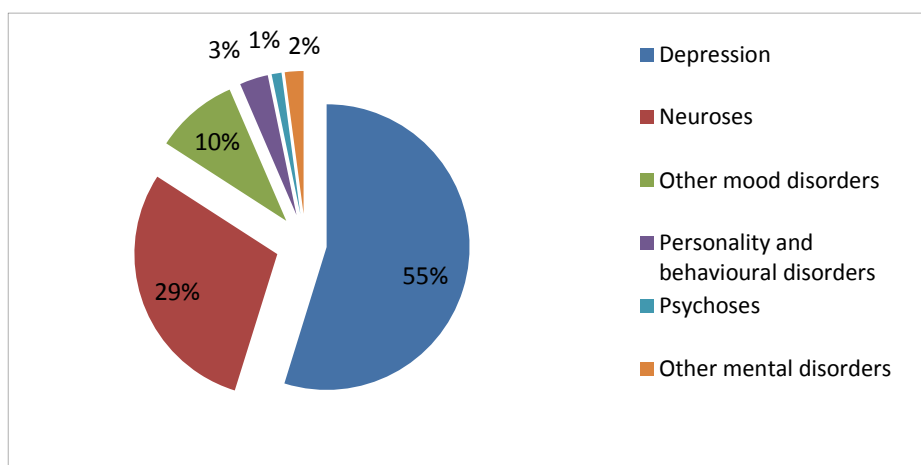
154. The Social Insurance Institution (KELA) is the largest provider of funding for rehabilitation services for working age adults. Services purchased by KELA for people participating in mental health rehabilitation include: rehabilitative psychotherapy; group rehabilitation services with a focus on mental health; vocational rehabilitation; rehabilitation for persons with severe disabilities and rehabilitation provided as part of development programmes implemented on a discretionary basis. KELA has provided compensation (a share of fees is reimbursed either directly or retrospectively) for the cost of psychotherapy on a discretionary basis since 1968, and compensation for psychotherapy as part of rehabilitation services for persons with severe disabilities has been provided since 1991. Psychotherapy services provided by KELA are now one of the most important types of mental health rehabilitation (Melart, 2011). In addition, hospital districts also use resources for medical rehabilitation to cover the rehabilitative psychotherapy of patients who do not fall within the scope of the services provided by KELA (Vorma, 2011).

155. To be eligible for rehabilitative psychotherapy, a person's work or study ability has to be impaired due to a mental health disorder, a consistent relationship between the person and a therapist in an established practice must exist, a health care unit responsible for providing treatment must evaluate the client's need and outlook for rehabilitation, and a written rehabilitation plan incorporating a psychiatrist's

statement must be made. Finally, the main goal is to support or improve the ability to work or study. Rehabilitative psychotherapy is not reimbursed for children (*i.e.* under age 16). Rehabilitative psychotherapy is granted for a period of 1 to 3 years, one year at a time, and there may be up to 80 visits per year, or 200 visits per three years. Entitlement may be renewed on special grounds if the last course of treatment was completed at least 5 years earlier. In order to be covered, rehabilitative psychotherapy must be medically justified and evidence-based. The forms of therapy covered include: individual therapy, group therapy, family therapy, relationship psychotherapy, art therapy and music therapy (for young people only). KELA also covers family consultations in connection with the therapy of a young person aged 16–25 (Melart, 2011).

156. With regard to rehabilitative psychotherapy provided on a discretionary basis, in 2010, out of the total number of 15 967 diagnoses, 54.2% suffered from depression, 29% from neuroses, 9.3% from other mood disorders, 3.2% from personality and behavioural disorders, 1.1% from psychoses and 2.1% from other mental disorders, as illustrated in Figure 11. The number of recipients of rehabilitative psychotherapy services provided through KELA has grown from slightly over 4 000 people in 1992 to around 16 000 in 2012 (child psychotherapy has been provided by the public health care system since 2004) (Melart, 2011).

Figure 11. Psychotherapy clients in 2010 by diagnostic category – Rehabilitation services provided on a discretionary basis



Source: Melart, P. (Medical Advisor), Presentation and personal interview, 25 October 2011, the Social Insurance Institution

Secondary inpatient care

157. There are only two state-owned mental hospitals in Finland. These two, Niuvanniemi and Vanha Vaasa hospitals, provide mental health examinations and treatment for criminals waived prosecution for mental health disorders and other patients whose care might raise dangers or be particularly complex (see section 4.3) (Vuorenkoski *et al.*, 2008). On the other hand, the majority of psychiatric beds belong to the municipal hospital districts in Finland. Psychiatric units in hospitals provide psychiatric inpatient care, and about half of these units are located within general hospitals and the other half in separate hospitals, which are however an integrated part of the general hospitals. The number of psychiatric beds in hospitals has fallen to 3 600, which includes 400–450 beds in the two state-owned psychiatric hospitals (Suvisaari and Moring, 2011; OECD health data, 2012).

158. In 2011, there were 28 528 patients in psychiatric inpatient care, accounting for almost 1.4 million inpatient care days. Between 2001 and 2011, the number of inpatient care days has decreased by 27%. Altogether these accounted for 41 224 care episodes (inpatient care between admission and

discharge). The majority of men in inpatient care were treated for schizophrenia, whilst women were most commonly diagnosed with depression. The average length of care period, 32 days in 2011, has decreased since 2000 by 8 days. The longest periods of care can be noted among patients diagnosed with schizophrenia (average 61 days in 2011) and the shortest among patients diagnosed with mood disorders (24 days in 2011) (THL,2013).

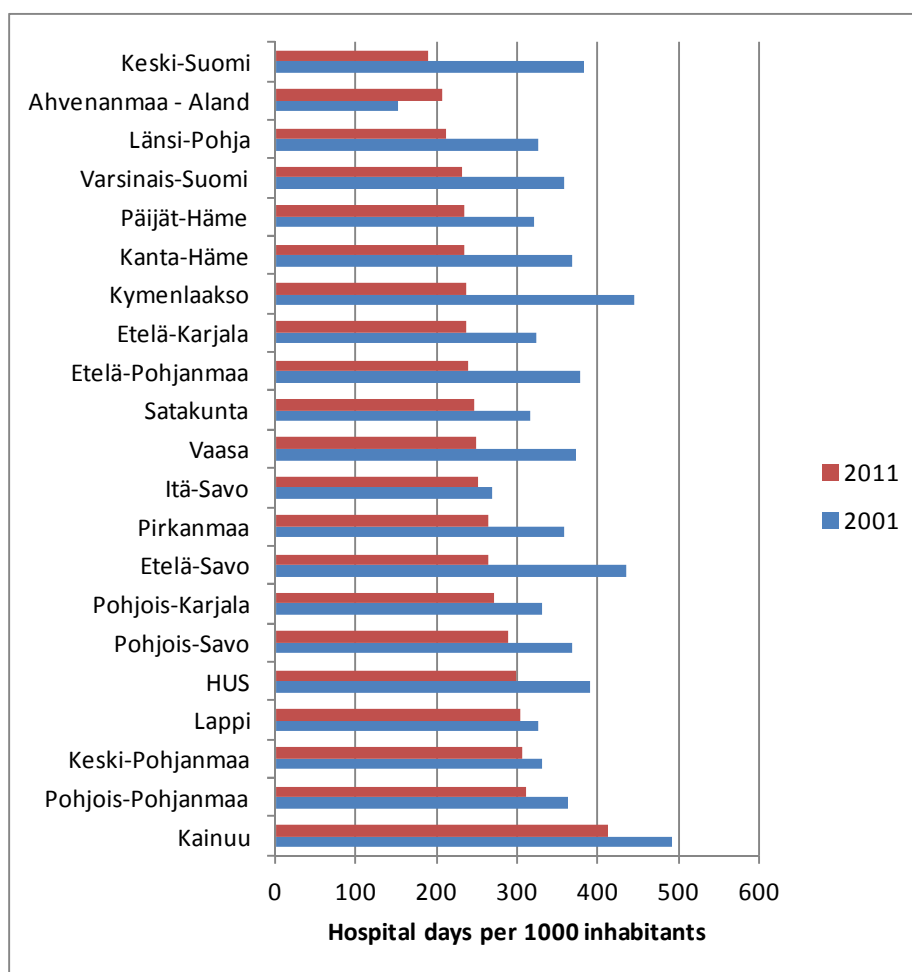
159. In 2011, 73,5% of care episodes were shorter than 30 days, implying that the mean length of a care episode is higher due to longer periods of care. 2.6% of all patients (944 patients) had been in continuous care for over a year (THL, 2013). In 2009, the number of patients in constant hospital care for over two years reached 465 – many of these patients were forensic psychiatry patients treated in Niuvanniemi and Vanha Vaasa hospitals (THL, 2012b).

160. Men and women are equally represented in inpatient care, but there are differences between age groups. For those aged 14 years and under and those aged 25-59 years, the majority of patients are men, whereas the proportion of women is higher in the 15-25 age group (THL, 2013).

161. In 2011, 39% of patients treated had not been admitted to psychiatric inpatient care before. After being treated, 75% of the patients returned to their homes or a comparable setting, while the remaining 25% were moved to another institutional care setting, including hospitals, health centres, elderly homes or other rehabilitation homes (THL, 2013).

162. Care days within hospital districts also vary. Figure 12 shows the variations in inpatient care days per 1000 inhabitants between different hospital districts in 2001 and 2011. In 2011, the highest number of care days were in the hospital districts of Kainuu, Pohjois-Pohjanmaa and Keski-Pohjanmaa, whilst the least were detected in the hospital district of Åland and Keski-Suomi. This figure also illustrates that since 2001 inpatient care days have decreased in all hospital districts, except for Åland.

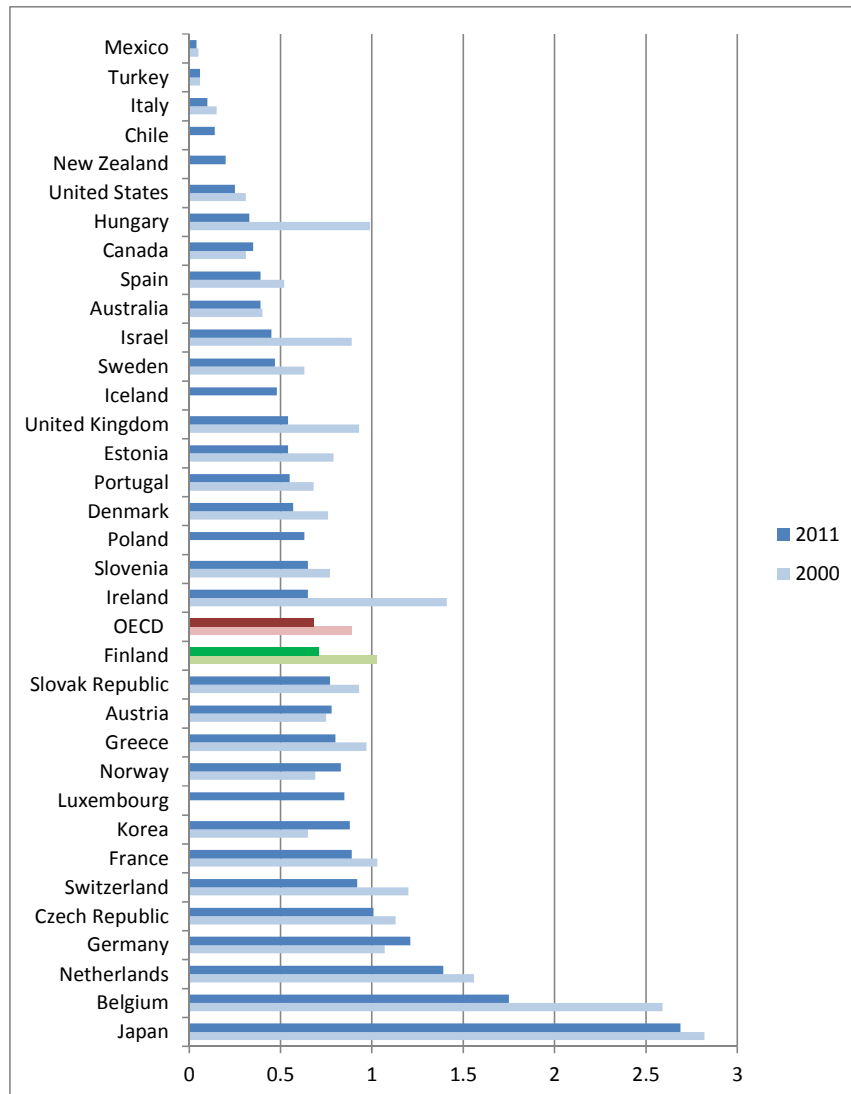
Figure 12. Inpatient care (hospital days) per 1000 inhabitants within the specialty of psychiatry, broken down between hospital districts in 2001 and 2011



Source: Psychiatric specialist medical care 2011, THL, 2013; Psychiatric specialist medical care 2010, THL, 2012b.

Psychiatric beds

163. Even though Finland has followed the trend of deinstitutionalisation seen in other Western European countries by considerably reducing hospital-based care and beds since the 1990s, the number of psychiatric beds in Finland is still higher than in some other Nordic countries *i.e.* Denmark and Sweden. However, in 2010 the number of psychiatric beds in Finland was below the OECD average, whereas in 1995 it was clearly above it (Figure 13) (OECD Health data, 2013).

Figure 13. Psychiatric beds per 1000 population, 1995 and 2010

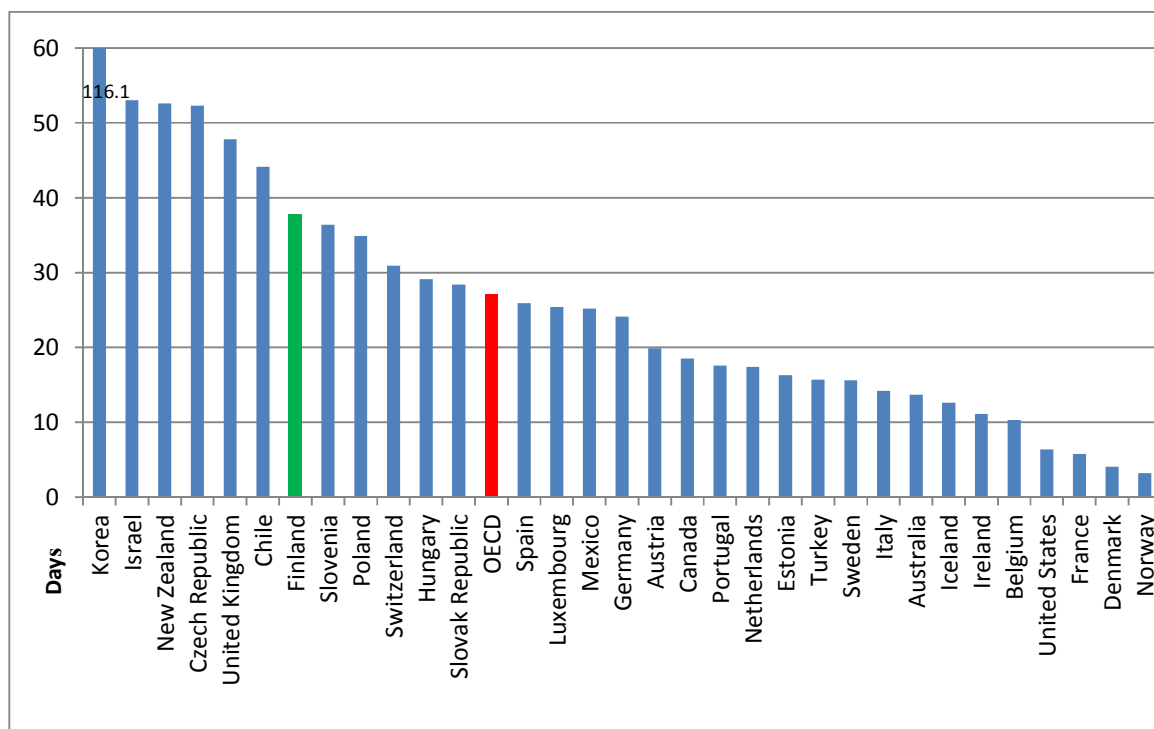
Source: OECD Health statistics, 2013

164. Mental health services remain predominantly hospital-based in Finland, despite the fact that the Mental Health Act (L 1116/1990) prioritises outpatient care as the preferred form of care. Long-term psychiatric care (greater than 1 year) is also much more common in Finland than in other Nordic countries. This can be explained by the underdevelopment of outpatient care rather than the development of hospital institutions (Tuori *et al.*, 2007; Sakharova *et al.*, 2007) and partly by the fact that the treatment of forensic patients is recorded in psychiatric inpatient statistics (Vorma, 2011). While 82% of patients in 2010 had been in long-term care in mental hospitals for less than a year, 11% were treated between 1 to 5 years and the remaining 7% for more than 5 years (THL, 2012b).

165. The average length of stay (ALoS) for *mental and behavioural disorders (dementia included)* in Finland is relatively long compared to the majority of OECD countries (Figure 14). By contrast, other Nordic countries, such as Denmark and Norway, have the lowest ALoS. Sweden and Iceland also exhibit levels below the OECD average (OECD health data, 2012). However, this could be partly explained by the fact that municipalities have faced difficulties in receiving discharged patients from hospitals – indeed, the

municipality is in charge of both hospital and housing services, but these are organised by two different bodies, as housing is under social services. Moreover, the fact that the relatively long periods of treatment of forensic patients are recorded in psychiatric inpatient care statistics, as they are treated in the mental health system and not prisons, also partly explains the long average length of stay (Vorma, 2011).

Figure 14. Average length of stay for mental disorders, 2011 (or nearest year available)



Notes: Data for Australia, Belgium, Canada, Chile, Denmark, Ireland, Norway, Sweden, Turkey, United States refers to 2010. For Iceland, data refers to 2009 (break in series)

Source: OECD Health Statistics, 2013.

166. In general, waiting times for non-urgent mental health care are relatively short, with the exceptions of tertiary care for eating disorders and neurodevelopmental neuropsychiatric disorders (ADHD among adults, etc.). However, there is pressure with respect to intra-treatment waiting times (psychotherapy, housing, scheduling an appointment) (Vorma, 2011).

4.2 Child and adolescent mental health

167. With regards to mental health problems among children and adolescents, well-baby clinics, schools and day-care centres have a central role in prevention, early detection and support. Unlike most other European countries, in Finland child and adolescent psychiatry are separate specialties. The age limit for child psychiatry is 13, and adolescent services treat young people up to 23 years of age (Repokari *et al.*, 2011). Waiting times are usually shorter for adolescent services than for adult services. The transition from adolescent to adult services can be difficult and may result in some discontinuities in treatment, but in general this is not a major issue in Finland (Repokari *et al.*, 2011).

168. Finland has a number of laws that enshrine the importance of child and maternal health. The Child Welfare Act (417/2007) defines a three-dimensional responsibility for guaranteeing children's rights. A clause on preventive support was added to the legislation in 2008. Preventive work refers to different

municipal services and action to improve children's and adolescents' welfare, when they are not using child protection services. Preventive child protection refers to support provided in education, youth work, day care and well-baby clinics as well as within other social or welfare services (adult services included) (Moring *et al.*, 2011).

169. Preventive mental health, included in the activities of child welfare clinics, school health care, student health care and health education in schools, reaches virtually all age groups up to adulthood⁶ (the Government Decree on Maternity and Child Welfare Clinics, Schools and Student Health Care and Preventive Oral Health Care). Universal preventive measures in child welfare clinics for mothers and children require that general practitioners see all children/families, without exception. Every family has at least 15 appointments in child welfare clinics, at least 5 of which are with a doctor (others are with a nurse). Of these, 3 appointments include wider examinations of the family's health and well-being. In school health care, pupils in elementary school have 9 health checkups, 3 including family well-being and medical examinations. Early detection, prevention and support guidance are also part of student health care (Ministry of Social Affairs and Health, 2009a).

170. Child welfare clinics cover 96.6% of children, although follow-up of somatic health and development has prevailed over mental health issues. A new decree that came into force in 2011 requires extensive follow-ups with health care professionals at 4 months, 18 months and 4 years: this includes interviews with the parents and examination of the family's well-being, whenever necessary (Santalahti *et al.*, 2011). Extensive follow-up covers both parents and the child, who are met by a community health nurse and a doctor; the follow-ups focus on the family's well-being and life situation and the child's development, health and well-being. The aim is to improve the use of previous investigations and information and enable earlier therapeutic interventions.

171. There appears to be a lack of expertise and interventions in the field of child psychiatry in primary care, although primary health care is gradually expanding its role in child mental health care. Specialised health care has played a dominant role in child psychiatry, and there is a need for planning, agreements and consultation to further define the role of primary care (Santalahti *et al.*, 2011). It is important to tackle mental health problems among children and adolescents, however, given that involuntary admissions of the latter have increased and that the number of admitted patients exceeds the number of those discharged from care (THL, 2012b). A significant proportion of care is still hospital-based, even though many hospital districts are trying to strengthen outpatient services for children and adolescents.

172. The number of children and adolescents using specialised psychiatric services has increased in recent years, in both outpatient and hospital care (Moring *et al.*, 2011). For instance, care periods for adolescents increased from slightly over 1500 in 2001 to approximately 2700 in 2010. The number of children and adolescents using outpatient services increased by 38% between 2006 and 2010 (THL, 2012b). In outpatient care, boys account for the majority of patients aged 7 to 14, while two-thirds of those aged 15 to 20 are female. In 2009, there were 4 885 patients under age 20 in inpatient care, of whom 54% were girls. Involuntary psychiatric care for over 15 year-olds has also increased in the past ten years (THL, 2012b), as has the use of antidepressant and antipsychotic medication in the treatment of children and adolescents (Autti-Rämö *et al.*, 2009).

173. Confusion has arisen in recent years on the respective roles of health care and social care in child mental health services. Co-operation between different services has, however, been improving, although there is no consistent patient pathway in the organisation of care, and there seems to be a lack of early

⁶ Some children and adolescents who are not in the education system do not fall within the scope of these preventive mental health services.

intervention in community services. In child and youth mental health services, many investigations and follow-up appointments do not result in therapeutic interventions (Santalahti *et al.*, 2011). The early identification of mental health problems does not therefore necessarily translate into early intervention. Children at risk of mental health problems are identified early, but there may often be long delays in treatment.

174. When an economic recession hit the country in the 1990s, school health care was downsized. Investment declined during the recession and has not fully returned to its previous levels (STAKES, 2002). There is little information on trends in children's mental health disorders, but a recent survey has nonetheless found that depression seems to be increasing among 8-year-old girls (Santalahti *et al.*, 2005), which merits further investigation (Sourander *et al.*, 2004; Sourander *et al.*, 2008). There has also been an increase in the numbers of children taken into care, and more families are living in poverty (Moring *et al.*, 2011). Further development of alternative therapies and interventions is seen as important for achieving more family-focused development, where parents and families are more involved in treatment, and for outpatient care to prevail over hospital-based care (Santalahti *et al.*, 2011).

175. Mental health is included in health education, which is a compulsory subject for upper levels in schools. By 2012, teachers were required to complete two years of training in order to teach health education, which includes "providing mental health skills" as an integral part.⁷ If a student is identified as having mental health problems, he or she is sent to a psychologist or social worker or a doctor or nurse in the schools (Decree 380/2009 on well-baby clinics, school and student health care and preventive dental health care).

176. Moreover, a large-scale programme on bullying, funded by the Ministry of Education, has been developed in the University of Turku. This *Kiva* school programme, which aims to prevent and decrease bullying in schools, has been implemented increasingly since its launch in 2006. The programme consists of *general measures*, where information is disseminated through various means with proactive material (assessment of the school environment, classes, online games, booklets for parents, etc.), and *targeted measures* (discussion with the teacher and the school team), which is applied once bullying is detected.⁸ An initial evaluation of the *Kiva* School programme showed that the programme has, for instance, reduced "self- and peer-reported bullying and victimisation" (Kärnä, 2011). The programme received the European Crime Prevention Award in 2009.

4.3 Forensic mental health

177. Violent crimes and homicides are a problem in Finland. Annual mortality due to violence is about 3 per 100 000; this rate has persisted for more than a century and is much higher than in most European countries, *i.e.* the rate of violent deaths is triple the European average. Ninety percent of crimes involve a substance abuse problem, and more than 80% the heavy influence of alcohol (Suvisaari and Moring, 2011).

178. Forensic mental health services are mainly run by the State (within the administration of the MSAH) and are not the responsibility of the municipalities. Few offenders are treated in mainstream mental health services, and outpatient and community care for forensic patients remain marginal (Wahlbeck, 2011). One of the aims of the current review of the Mental Health Act (L 1116/1990) is to develop outpatient forensic services in order to expand involuntary outpatient treatment (community treatment orders) just for forensic patients, which should lead to shorter hospital stays.

⁷ Until July 2012, teachers specialised in certain other subjects were allowed to teach health education.

⁸ For further details, see the website of the programme: <http://www.kivakoulu.fi/>

179. THL coordinates the forensic psychiatric examinations in Finland, and the board of forensic psychiatric issues at THL makes the decisions and commitments to psychiatric treatment after examination. A court orders the forensic psychiatric examination (which must be completed within two months, with a possible extension of another two months), during which the accused can be detained in the hospital against their will. A court forwards the documents to THL, which decides where the forensic examination will be carried out. Regarding ethnicity, the share of non-Finnish nationals is insignificant (Suvisaari and Moring, 2011). According to the legislation, offenders (of foreign nationality) considered criminally irresponsible are sent to their respective countries to be treated.

180. There are about 120-130 examinations per year, which are carried out by the two State mental hospitals (for further details on the Niuvaniemi State hospital, see the box below), university forensic psychiatry clinics in Helsinki (Kellokoski) Tampere and Oulu and in psychiatric hospitals for prisoners (units in Turku and Vantaa) (Suvisaari and Moring 2011).

181. Most forensic mental health examinations involve cases of homicide. After examination, the accused is held to be either responsible or irresponsible or has a diminished responsibility. In case of irresponsibility, the need for treatment is determined by the board in the THL, not as in most countries in the criminal court. If conditions are met, the THL orders the person into involuntary care, for which conditions are the same as for (non-forensic) involuntary care in psychiatric hospitals, and a minor (see Section 1.2) can also be ordered into treatment in a psychiatric hospital. In 2010, there were 123 examinations, of which 31 were held irresponsible. The same year, 23 patients were committed to involuntary treatment at a State mental hospital (25 in 2009), whereas 7 were committed to a municipal hospital and only 1 person to special care for the mentally handicapped (Suvisaari and Moring, 2011). Municipal hospitals usually treat less dangerous patients.

Box 1. Niuvanniemi Hospital

Niuvanniemi hospital opened in 1885, with 120 beds, 60 for men and 60 for women. The hospital is in charge of providing high-quality specialised forensic psychiatric services and mental examinations for the needs of the whole country. It also provides training and development for forensic psychiatry personnel. The hospital has 284 beds for adult patients and 12 for patients under age 18. Since 1983, the hospital has also functioned as the Forensic Psychiatric Clinic of the University of Eastern Finland, providing basic, further and complementary education in forensic psychiatry and conducting research in health science. The average duration of mental examinations is 56 days. Niuvanniemi can, as a state hospital, admit individuals suffering from mental illnesses and mental disorders whose treatment is particularly difficult, following a request of behalf of the hospital districts.

182. Forensic psychiatric examinations are costly, as they may take up to 2 months. These examinations are paid by the State, and there are no cost-containment procedures. Total costs came to almost 3 million euros in 2009, for 120 examinations, or about €24 970 each. The costs of forensic psychiatric treatment, on the other hand, are paid by the municipalities, which are determined by the place of domicile in the population register.

183. Forensic psychiatric patients are treated within the public health system; in August 2012, there were 428 forensic patients in Finland, with average treatment duration of 7-8 years, usually beginning in one of the State mental hospitals (Suvisaari and Moring, 2011). After hospital treatment and prior to the final discharge, the patient can be released from the hospital under the supervision of the psychiatric unit of the hospital district, for a maximum period of six months, for which the THL makes the decisions (Mental Health Act 1990). Admission decisions and decisions to discontinue treatment or discharge the patient are made by the THL.

184. On the recommendation of a hospital or a hospital district, persons who are suffering from mental illnesses or disorders and are particularly difficult or dangerous can be admitted to a state mental hospital. The number of forensic psychiatric patients has not increased, but beds are also being used for patients from acute psychiatry with challenging behaviour. Hence, the increased pressure on beds arises mostly from the increase in this group rather than from the purely forensic patient group (Suvisaari and Moring, 2011).

185. Prisons have their own mental health services. Psychoses in prisons, *i.e.* reactive or drug-induced psychoses, are common. Among prisoners who are diagnosed with schizophrenia, three-quarters receive their first diagnosis in a prison mental hospital. The majority of those diagnosed are men, with a mean age that is triple that of the general population. There are 40 beds in Turku and 14 in Vantaa in mixed and separate units for about 3 600 prisoners, which means that there is one bed for every 65 prisoners (15 times the number of beds per inhabitant in communal psychiatric hospitals in Finland). The average duration of treatment is 32 days (Suvisaari and Moring, 2011). Prison and probation services belong to the administrative services of the Ministry of Justice.

4.4 Access to mental health services – minorities and excluded groups

Elderly people

186. Despite a rapidly ageing population in Finland, old-age psychiatry is underdeveloped. The specialty of old-age psychiatry was disbanded in the late 1990s as a result of EU age discrimination legislation and a need to reduce the number of psychiatric specialties. This has had a detrimental impact on old-age mental health services, given that there are no new specialists in psychogeriatrics graduating, and at present there are no plans to re-introduce old age psychiatry as a specialty (Korkeila, 2011). Several supported proposals to reintroduce old-age psychiatry as a main specialty or subspecialty have been submitted, but these plans have not been put into practice (Saarela, 2011). At present, some schools offer a geriatric psychiatry CME (Continuing medical education) programme, which has not proven to be very attractive. However, the University of Helsinki has recently invited applications for a new professorship in old age psychiatry (*ibid*).

187. In Finland, dementia is often diagnosed by neurologists, but geriatricians or GPs are usually the doctors providing treatment and care management for dementia patients. There are, unfortunately, only a few geriatric psychiatry outpatient teams and ward units in different parts of the country.

188. Mental health services for older people appear to involve a real challenge due to the rapidly ageing population and the lack of old-age psychiatrists. In other countries, such as the UK, the retention of specialist old age services has been seen as critical in tackling age discrimination within services.

189. At the moment, Finland is preparing a national agenda for memory disorders, following the conclusions of the Council of the European Union. In addition to this, the current Government programme established and *Act on Supporting the Functional Capacity of the Older Population and on Social and Health Services for Older Persons* (980/2012) to ensure the rights of older persons to social welfare and health care according to their needs will be introduced as part of the overall reform of health and social welfare and health care reform.

Rural population

190. Distances are great in Finland and the country is sparsely populated, especially in the furthest northern region of Lapland, where in 2012 the population density was 1.98 inhabitants per sq.km, compared to 170.9 inhabitants per sq.km in the Helsinki-Uusimaa district (Statistics Finland, 2012). This creates additional challenges in terms of the availability and supply of services. The hospital district of

Lapland comprises the 15 northernmost municipalities of Finland; in 2008 these accounted for only 118 377 inhabitants whereas, in terms of surface, this area covers one-fourth of Finland. Furthermore, Lapland's population and birth rates are decreasing while morbidity is relatively high. Health inequalities between different age groups are higher in Lapland than on average in Finland, and these inequalities are also increasing (Kuosmanen *et al.*, 2010).

191. Nationally funded projects have enabled the long-term development of Lapland's mental health and substance abuse services. These programmes have targeted the competence and coping of mental health care personnel while enhancing the network between service providers and employees and cross-sector work. The objectives have been to diversify and enable better access to services while applying care and rehabilitation methods based on best practise to Lapland's particular circumstances while relying on the existing service infrastructure. Today, these projects are continuing to develop and operate under the regional KASTE project, *Tervein Mielin Pohjois-Suomessa* (see section 3.4).

192. The Finnish Mental Health Association imported the "depression school" model to Finland, which has been adapted to national circumstances in an effort to enhance self-care and prevent depression. It was first introduced in the region of Lapland when services were developed there for the prevention of mental health disorders. Given the great distances in Lapland, participation in different forms of therapies or group treatments is difficult. In 2008, the depression school was launched in a video conference (VC) format in the Lapland hospital district, where the first "multi-point" depression schools in VC format were also piloted (Kuosmanen *et al.*, 2010).

4.5 Human resources and education

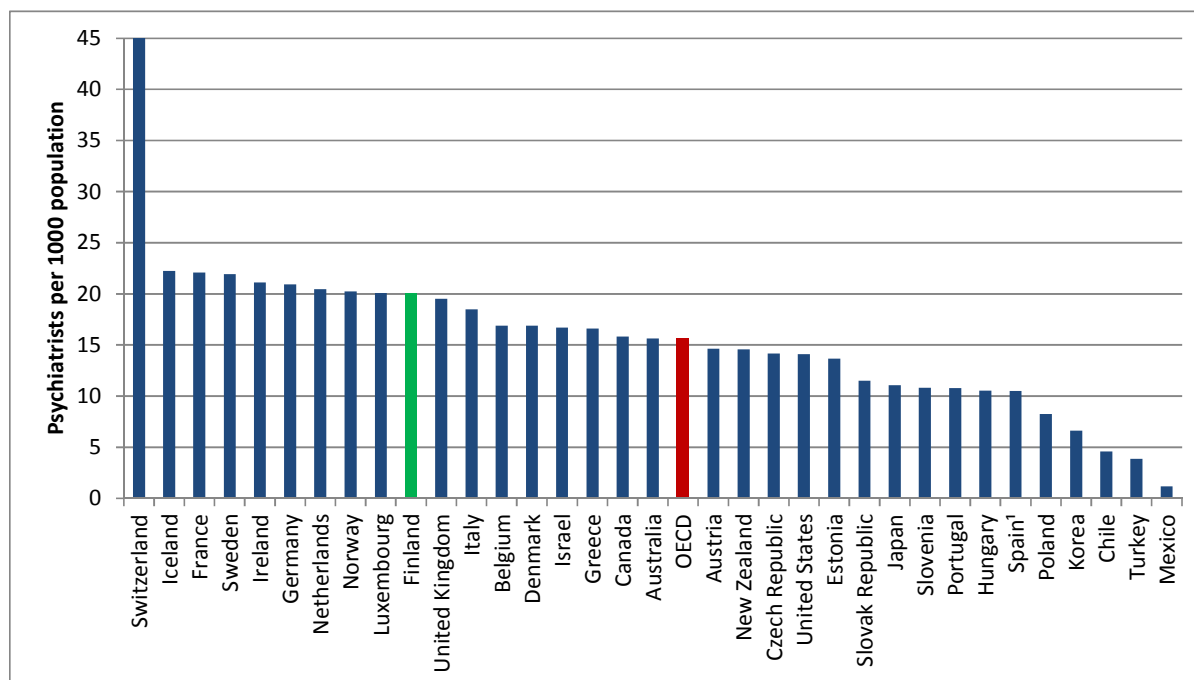
193. Many different professional categories provide mental health services, including GPs, psychiatrists, psychologists, psychiatric nurses, public and occupational health nurses, occupational therapeutics and social workers (Pirkola and Sohlman, 2005). VALVIRA is in charge of granting licenses and also manages the central register of health care professionals, entitled Terhikki, which "contains data on the right to practice a profession of over 300 000 health care professionals" (Pirkola and Sohlman, 2005). The Finnish Medical Society's data on physicians in 2011 indicates that 47% out of 24 502 licensed physicians were specialised. In terms of specialisation, 2% were child psychiatrists (of which 90% are female), 1.3% adolescent psychiatrists, 0.4% specialised in forensic psychiatry and 9.2% in general psychiatry (Finnish Medical Society, 2011).

194. In addition, it is possible to perform a two-year training programme for Addiction Medicine Special Competence authorised by the Finnish Medical Association. According to estimates on the shortages of specialists in terms of unfulfilled positions exist for 2025, adolescent psychiatry is the most threatened, with an estimated shortage of 14.9%. The shortage for general psychiatry in 2025 is estimated at 10.2% (Finnish Medical Society, 2011). Placement is a major difficulty and varies between regions – psychiatrists are concentrated in the Helsinki University Hospital area and in southern Finland in general (Korkeila, 2011).

195. In terms of human resources, Finland has a relatively high number of psychiatrists per 1000 population compared to other OECD countries, as illustrated in Figure 15. Compared to the Nordic countries, however, Finland has the second lowest number of psychiatrists (OECD health data, 2013). The relatively high proportion of psychiatrists relates to the fact that not only has Finland invested in mental health but also that primary care has a relatively small role in treating mental health problems. The number

of practicing physicians (per 1 000 population) is also much higher in other Nordic countries,⁹ implying there is more pressure on specialist services in Finland (Korkeila, 2012; OECD health data, 2013).

Figure 15. Psychiatrists per 1000 population, 2010



Notes: 1. In Spain, the number of psychiatrists only includes those working in hospital.

Source: OECD, Health Statistics, 2013.

196. Moreover, the number of nurses working in mental health care in Finland, 163 per 100 000, was the highest in comparison with other European WHO member countries (WHO, 2008). The number of practical mental nurses¹⁰ in specialised health care has decreased slightly since 2000, from 5.8 nurses per 10 000 people to 5.1 in 2007 (Sotkanet, 2012). The decrease in practical mental health nurses can, however, be explained by their replacement with psychiatric nurses with longer training, which is in line with the plans to upgrade the quality of services.

197. In order to obtain a degree of Licentiate in Medicine and to become a licensed physician, 6 years of basic medical training must be completed. Specialist training in all four fields of psychiatry lasts for a duration of 6 years, which includes training in health centres and university/teaching hospitals (Vallimies-Patomäki, 2011).

198. Nursing education is offered in 23 polytechnics and can lead to a Polytechnic Bachelor or Master degree. Professional specialisations and other adult education possibilities also exist. A matriculation certificate, a vocational qualification or corresponding foreign studies are required for entry. Completion of

⁹ In 2009 (or latest available year), there were 2.72 practising physicians per 1000 population in Finland, compared to 3.48 in Denmark, 3.66 in Iceland, 4 in Norway and 3.73 in Sweden.

¹⁰ Based on the municipal codes for public servants, practical mental nurses are classified as belonging to the occupational category practical mental nurses, in accordance with the classification of occupations by Statistics Finland. More information on the classification of occupations is available on Statistics Finland's website (in Finnish): http://www.tilastokeskus.fi/tk/tt/luokitukset/index_henkilo_keh.html.

a Bachelor degree requires around 3.5 years of full-time study, and a Master another 1-1.5 years. Professional specialisation is usually obtained in parallel with employment (Vallimies-Patomäki, 2011).

199. Following the recommendations of the Ministry of Social Affairs and Health, the Finnish Nurses Association and the Masto project in 2010, postgraduate training in mental health nursing was developed. This training is accessible after obtaining a Bachelor's degree in nursing, a nursing diploma or after two years of work experience in the field of mental health. It comprises depression as a mental disorder; identification of the symptoms; a target-oriented process of care and medication; interactive and therapeutic methods, assessment of the recovery; counselling, support of the patient's commitment, cultural aspects; cooperation in patient care, coordination of care; searching and using evidence, consultation with a physician; supervision of work, self-coping and service system and care models. After training, a nurse is qualified to consult with patients experiencing mild and moderate depression and can work with a personal physician in a health centre and in collaboration with a psychiatrist (Vallimies-Patomäki, 2011).

5. MENTAL HEALTH CARE FINANCING AND EXPENDITURE

5.1. Financing of mental health services

200. Mental health services are funded through different channels, including the State, municipalities and Social Insurance Institution (KELA). Both municipal and private services receive public funding, but in different forms. Public funding for private services refers to reimbursement for private mental health care by National Health Insurance, whilst in the public sector the NHI finances municipal health care. There are, however, some overlapping areas, in particular municipal purchases from private providers.

201. The system of financing mental health services was reformed in the 1990s, in parallel with the governance reorganisation (Vuorenkoski *et al.*, 2008). However, the overlap of the economic recession with the governance reform resulted in cuts in resources for psychiatry, which had a considerable impact on the development of mental health services (see section 1.1).

State subsidies

202. In 1991, a new act relevant to state subsidies was established, and in 1993 the former retrospective and earmarked payment system (rolling five-year plans for costs) was replaced by a new system. Before 1993, the central government used the retrospective payment of actual costs incurred to finance its share of services. In order to “improve cost-control, enhance efficiency, empower municipalities and reduce state regulation”, this system was changed to non-earmarked block grants (Vuorenkoski *et al.*, 2008). Currently, the state subsidies are prospective and (mainly sociodemographic) needs-based capitated payments, which are made to municipalities instead of service providers. These are calculated by taking into account the population (age structure and morbidity) of the municipality as well as its location (Vuorenkoski *et al.*, 2008). Furthermore, a revenue equalisation scheme ensures that grants are redistributed between municipalities with varying abilities to raise revenues. In 2008, the State budget estimation had allocated 5 billion euros for these discretionary grants on social and health care (www.stm.fi). However, for mental health, the state grants are not earmarked.

203. There is no specific state grant for social and health care: each municipality receives one non-earmarked grant. The state grant includes health and social care, education and other municipal functions. While calculating these grants, health and social care expenditure is, however, taken into consideration. Hence, a part of the state grant is implicitly allocated to social and health care, even though it is not earmarked (Vorma, 2011).

204. In order to facilitate implementation and to reach the targets set in the KASTE programme, the government subsidises (regional) projects for the development of social welfare and health care services. In total, €70 million has been reserved for these projects for 2012-2015 (www.stm.fi). For 2008-2011, €104.2 million was appointed for these state grants in the budget (Partanen *et al.*, 2010). In addition to this, together with other funding bodies, the Ministry of Social Affairs and Health coordinates project funding for municipalities, federations of municipalities, associations and firms.

205. In 2004, government funding was granted for 250 development projects, 82 of which were mental health and substance abuse projects (33% of total), receiving a total of €13.9 million of funding (VTV, 2009). State funding required that several municipalities and hospital districts were involved in the

implementation of the project. Resources have been targeted particularly to children and adolescents, and between 2000 and 2007, €14.7 million was granted for the development of child and adolescent psychiatry. In 2009, €3.2 million was added to the development of adolescent mental health services (VTV, 2009).

Municipal and private mental health services

206. Tax revenues collected by the state and municipalities form the majority of funding for primary care mental health services, while the municipal health service fees for patients are relatively small (in some exceptional cases, there are none). Municipal health centres constitute the only option for the unemployed and lower socio-economic classes, who are not able to access occupational care or to afford costly private services.

207. Mental health services are funded with municipal taxes, user fees, calculated state subsidies for social and health care, and possible discretionary financial grants. Approximately 60% of municipal health services are financed by the municipalities themselves, 34% are financed by the State and the remaining 6% by clients in the form of user fees.

208. Customers pay a fee for hospital-based municipal health care, which is relative to a person's ability to pay. The fees are different for short and long-term hospital care. In mental health care, the share of user fees is lower, and some mental health services are provided free of charge. The daily fee for inpatient care is also lower in mental health care than in somatic care. Outpatient care in specialised care units, on the other hand, is primarily free of charge for customers. Hence, outpatient psychiatric care constitutes an exception in municipal health care (Law on service fees in health and social care 734/1992), where service fees are collected. It is interesting to note that, as there is a service fee in primary care, individuals might be incentivised to seek specialist outpatient care, since it is free at the point of use (Wahlbeck, 2011), instead of following treatment in primary care .

209. From 1993, the municipalities have been able to purchase their services from private providers – this remained somewhat marginal in the beginning, as there was a larger incentive to buy specialised services from the hospital districts, given that the municipalities were already obliged to belong to one. Purchasing services from private providers has only increased in more recent years. These purchases consist mostly of housing services, and, to a smaller extent, rehabilitative psychotherapy.

210. Private services also receive public funding. Even though the client must bear the large majority of the costs, around one-third is reimbursed by the KELA. In addition, psychotherapy, mainly offered by private psychotherapists, has been organised by the KELA since the amendment of the legislation in 2011. The KELA usually covers the majority of the costs (see section 5.2.i.).

Occupational health services

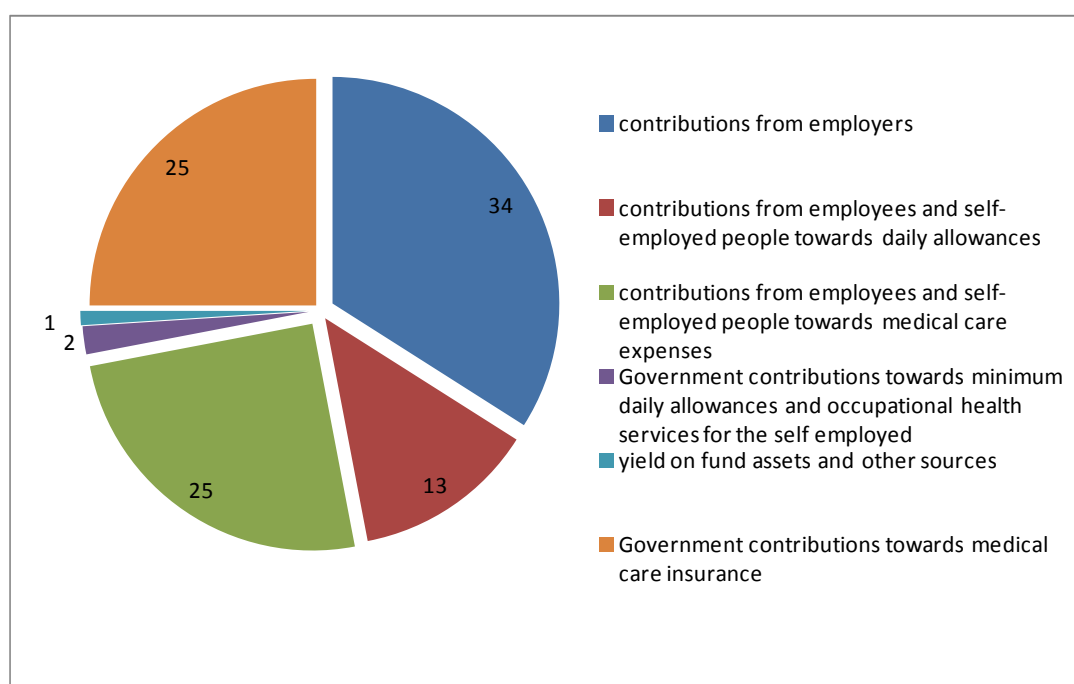
211. Employers pay the cost of occupational health services (OHS), while the KELA annually reimburses about 50% of the total costs (Alila, 2011). The majority of the KELA reimbursement is financed by employers (73%), with entrepreneurs and employees contributing the remainder (27%). Thus, the employees' share of the total costs of OHS is 13%, and the employers pay the rest (87%), with some small contributions from the State. Occupational health services are free of charge at the point of use for employees.

The Social Insurance Institution

212. The KELA's operations are financed with statutory contributions from the insured and from employers and with financing from the public sector. State funding covers approximately 67% of expenditure, 27% comes from contribution revenue from employers and the insured, and 5% comes from

payments by municipalities. The total expenditure of the KELA amounted to €12.6 billion in 2010, of which the majority (€11 billion) went towards benefits (Melart, 2011). The reimbursements for private services, pharmaceuticals and occupational health care are covered by the National Health Insurance, whose funding differs from the KELA average. The different sources of the National Health Insurance income and their proportions are illustrated in figure 16 below.

Figure 16. Total National Health Insurance Income



Source: Melart, P. (Medical Advisor), Presentation and personal interview, 25 October

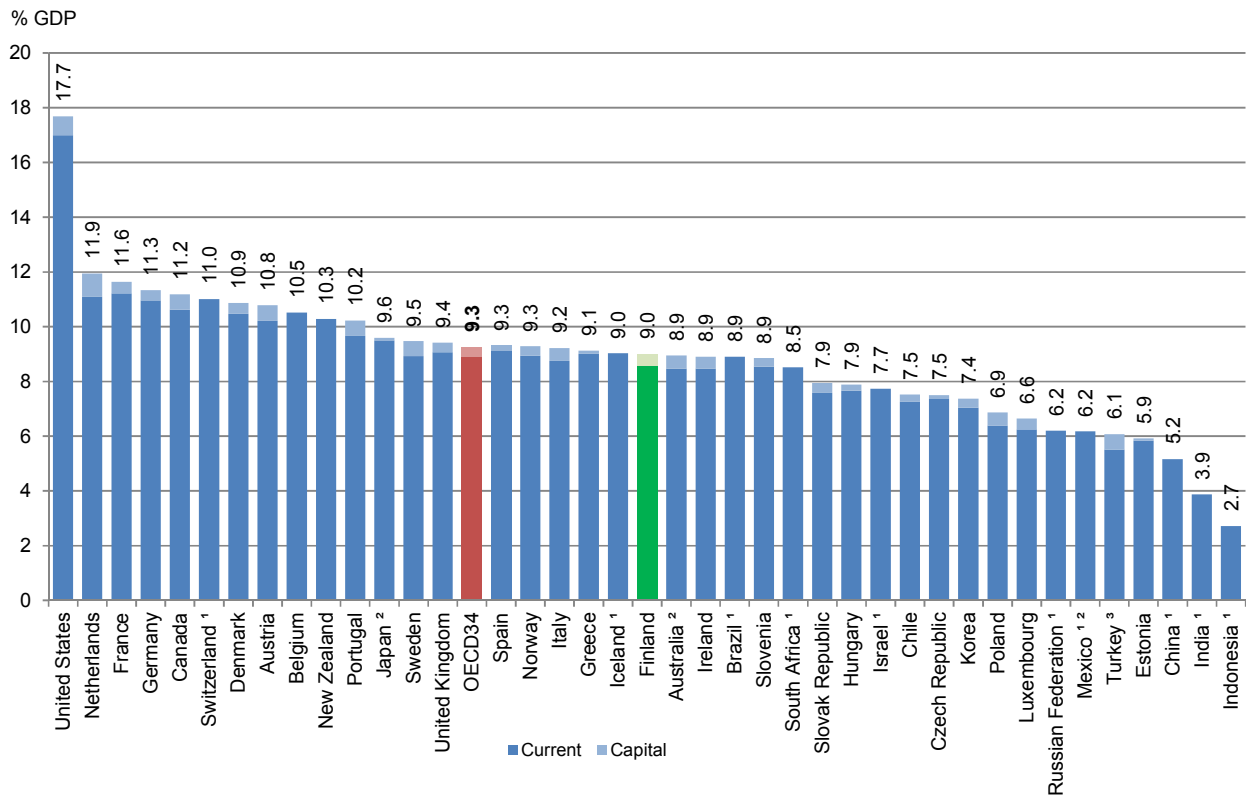
The Slot Machine Association

213. The Slot Machine Association (RAY) finances mental health services by supporting associations' investment and development projects on a discretionary basis. One of the Association's main objectives between 2008 and 2011 was to deal with major public health issues, such as mental health and substance abuse problems. €90 million was targeted for these projects and grants over that period. Another major issue was to prevent the development of social and economic isolation, and grants were directed towards the early detection and prevention of deprivation and isolation. Targeted groups included in particular those suffering from mental health or substance abuse problems or their families and those whose performance has deteriorated due to long-term unemployment, sickness or a handicap. €88 million was directed towards decreasing deprivation in the 2008 RAY budget (VTV, 2009).

5.2. Mental health care expenditure

214. With regard to overall health expenditure, Finland spends less than OECD countries on average, accounting for 8.9% of GDP in 2011 (Figure 17). Health care outcomes are nonetheless relatively good, in particular given the low levels of spending. The Finnish health system also enjoys a high level of satisfaction among the country's inhabitants (OECD, 2012a).

Figure 17. Total health expenditure as a share of GDP, 2011 (or nearest year)



Notes: 1. Total expenditure only. 2. Data refers to 2010. 3. Data refers to 2008. Information on data for Israel: <http://dx.doi.org/10.1787/888932315602>.

Source: OECD Health statistics 2013

215. However, the overall expenditure on mental health remains low compared to its burden on society. Expenditure on mental health care in municipal health services accounted for only 4.5% of total health expenditure in 2010 (THL, 2012a). Expenditure on outpatient mental health services in primary and secondary care and day treatment has clearly increased within the past decade, whilst the estimated share of psychiatric specialised care in total health expenditure has decreased (Table I).

Table 1. Expenditure on mental health care in municipal health services, 2000-2010**Millions of euro, 2010 prices**

	2000	2005	2010
Mental health outpatient treatment in primary care	52.1	79.3	131.8
Specialised psychiatric inpatient treatment	482.1	475.4	397.4
1. Long-term (>180 days)	149.3	112	82
2. Other inpatient treatment (>180 days)	332.8	363.4	315.5
Specialised psychiatric outpatient and day treatment	129.3	152.3	200.8
Other specialised psychiatric treatment	5.8	7.5	6.2
Total	669.3	714.5	736.3
Percentage of total health care expenditure	5.5%	4.8%	4.5%

Source: National Institute of Health and Welfare (2012) Health Expenditure and Financing 2010

216. Reimbursement of private psychiatric services by the NHI amounted to €17.2 million in 2009. In the same year, expenditure on rehabilitative psychotherapy covered by the KELA was reduced to €23.4 million.

Out-of-pocket fees in mental health services

217. Whilst outpatient care in a psychiatric care unit is free at the point of use, the out-of-pocket fee for inpatient care in a psychiatric hospital was €15.1 per day of care in 2012. There is a maximum limit of seven daily fees per year regarding children and adolescents under age 18 in inpatient care. A doctor's visit in primary care cost €13.8 in 2012. This fee may be collected a maximum of three times per year by one health care centre. There is a payment cap for health care, which means that there is a maximum amount a patient will pay for municipal health services annually (pharmaceuticals excluded): in 2012, this amount was set at €636 (www.stm.fi). However, this cap does not apply to long-term hospital patients (over 3 months), when an income-related client fee applies. This fee can rise up to a maximum of 85% of monthly net income. If the person being treated in a hospital has a higher income than his or her spouse, the maximum share is 42.5% of their combined monthly net income. The patient must, however, be left with no less than €99 (2012-2013) to spend per month.

218. Out-of-pocket fees in private services are high, and the customer usually bears around 60-70% of the costs. The remaining 30%-40% of the costs, however, are reimbursed by the Social Insurance Institution. The reimbursement rate may be supplemented by private insurance (Vuorenkoski *et al.*, 2008). The client's fee burden varies: on average the KELA covers the majority of costs under certain conditions, especially for children and adolescents. Out-of-pocket payments for clients account for €200 to €400 per year for young adults (16-25), for once-a-week therapy, while for adults aged 25-64 the annual costs for once-a-week therapy vary from €800 to €1600 (Melart, 2011).

219. In public inpatient care, the medicines patients receive are not charged separately. Medicines prescribed in outpatient care are paid by the patients but partly reimbursed by National Health Insurance. The KELA reimburses psychopharmaceuticals, with three reimbursement categories: the Basic Refund Category (42%), the Higher Special Refund Category (72%) or total (100%) reimbursement. Pharmaceuticals used in the treatment of psychosis and some other severe mental health disorders are

100% reimbursable (with a copayment of €3 per purchase), while other pharmaceuticals related to mental health disorders are reimbursed at a rate of 42%. Over-the-counter (OTC) medicines are not reimbursed. The right to these refunds depends on the patient's diagnosis and criteria that has been separately determined (Pirkola, Sohlman, 2005). The right to a special refund is granted on the basis of a diagnosis and description of the disease in accordance with separately agreed criteria. The annual payment cap for reimbursable products will be €610 in 2014 (www.stm.fi). Medicines exceeding the cap will be reimbursed with a patient co-payment of €1.5 per prescription medicine (Alila, 2011).

Spending on human resources

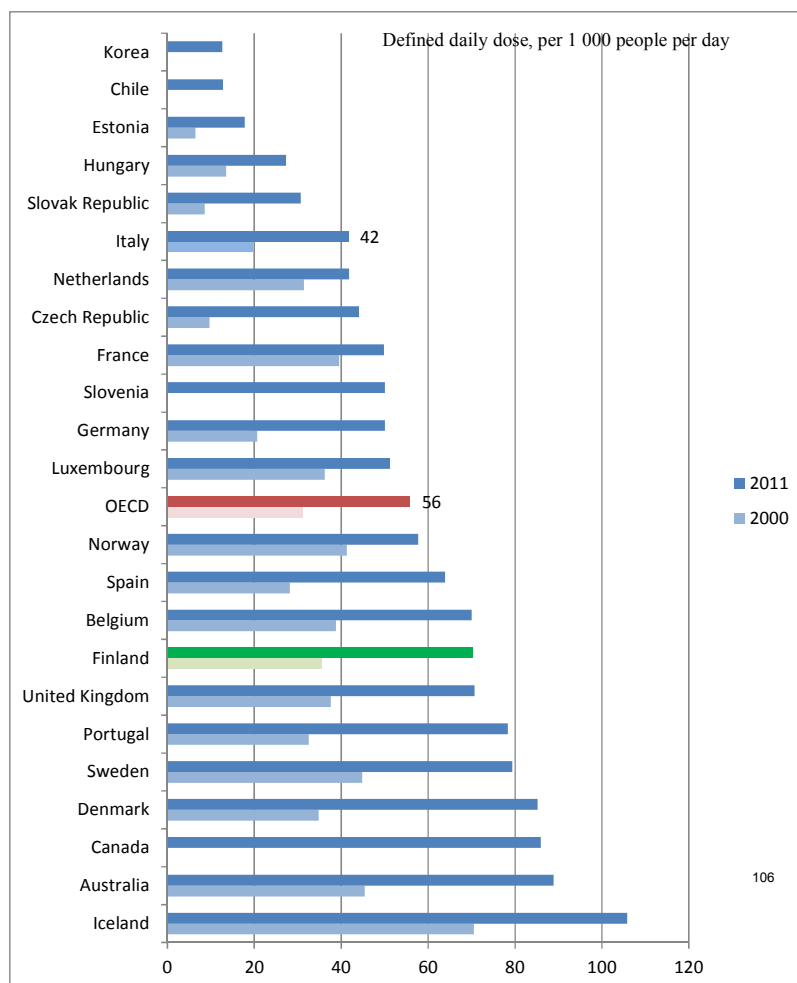
220. OECD data on doctors' remuneration from 2009 indicates that salaried specialists in Finland are paid 2.6 times more than the average wage. The salary of specialists rose at an annual rate of 3.7% between 2000 and 2009. General practitioners' wages are 1.8 times the average national wage and experienced a more modest growth rate of 1.9% over that same period (OECD, 2011). As for the remuneration of hospital nurses, this is on a par with the national annual wage (OECD, 2011). Wages in health services are higher than wages in social services, which contributes to quality differentials.

221. With regard to private practices, the mean appointment fee is €93 – on average, full-time private physicians have 25 appointments a week and part-time physicians 5 appointments (Ministry of Social Affairs and Health, 2009). Specialists working in publicly funded hospitals are allowed to work in privately funded hospitals or in private practice as well, conditional on the permission of the hospital's board. Private patients pay a fee for service.

Use of pharmaceuticals

222. Data on the use of psychopharmaceuticals is collected by the KELA (medicines in the Special Refund category), pharmacies (prescription data and wholesale trade in medicinal products) and the Finnish Medicines Agency (consumption data based on pharmaceutical wholesalers' sales to pharmacies and hospitals). These statistics indicate that the consumption of pharmaceuticals measured in defined daily doses (DDDs)¹¹ has significantly increased over the past few decades. This trend can be partly explained by the arrival of “new, easy-to-use, multipurpose anti-depressants (particularly selective serotonin reuptake inhibitors) to the market, the expansion of their purpose of use to other disorders than depressive conditions, and clearly longer treatment periods” (Pirkola and Sohlman, 2005). OECD data also indicate (Figure 18) that in terms of the use of anti-depressants, the average of defined daily doses per 1000 people in Finland (66.4) was above the OECD average of 52.5.

¹¹ The defined daily dose (DDD) is the assumed average maintenance dose per day for a drug used for its main indication in adults. DDDs are assigned to each active ingredient(s) in a given therapeutic class by international expert consensus (OECD, Health at a Glance, 2011).

Figure 18. Use of anti-depressants in OECD countries

Source: OECD Health Statistics 2013, <http://dx.doi.org/10.1787/health-data-en>

223. All prescription medicines for which a price has been approved by the Pharmaceuticals Pricing Board are entitled to a basic refund (see section 5.2.i) (Pirkola and Sohlman, 2005). Finland has a generic substitution system in place (introduced in 2003) that obliges pharmacies to change a medicine prescribed by a doctor to a cheaper corresponding product when applicable. In addition, a reference pricing system was introduced in 2009.

224. With regard to outpatient pharmaceuticals reimbursed from the NHI, in 2009 antipsychotics accounted for €89.5 million and antidepressants for €49.6 million (KELA), representing 5.3% and 2.9% of total outpatient pharmaceuticals reimbursed from the NHI (THL, 2012b).

5.3 Provider payment mechanisms

Hospital performance and DRGs

225. Overall, hospital performance appears to be relatively good in Finland (Kittelsen *et al.*, 2008). For instance, in a cross-country analysis on cost efficiency in university hospitals in the Nordic countries, Finland had the highest average cost efficiency in the patient care production models (including operating

costs and patient care outputs) and in the teaching and research models (including costs for teaching and research as well as teaching and research outputs) (Medin *et al.*, 2010). However, even though federations of municipalities own the hospitals, the municipalities have little access to information on hospital performance, which affects their negotiating powers and their ability to bargain with hospitals. Several factors explain this, including the large number of municipalities, which means that each one may not have expertise in negotiating with providers; the capacity of municipalities; the lack of financial incentives on quality; and the dearth of good information on individual hospital performance (Wahlbeck, 2011).

226. The NordDRG classification system is used to measure hospital inpatient and short-term therapy (where length of stay is less than two days) cases. The 2011 version of the system contains a Major Diagnostic Category (MDC) for “Mental diseases and disorders”, which contains 30 mental health Diagnosis Related Groups (DRG). Each DRG mental health category is assigned on the basis of the principal diagnosis recorded. Moreover, a case is assigned to the psychiatric rehabilitation DRG if the length of stay exceeds 28 days. If the length of stay is more than 90 days, it is assigned to the psychiatric long-term care DRG. However, there is little or no evaluation of the effect of the mental health DRGs on volume or cost control or length of stay.

227. Although the NordDRG system contains mental health items, these are not yet used by the Finnish hospital districts when charging the municipalities. The DRG system is currently used as a provider-payment mechanism only for somatic care. Psychiatric outpatient services are usually charged on a fee-for-services basis (number of psychiatric consultations, etc.), whilst psychiatric inpatient care is charged according to the number of hospital days.

6. DISCUSSION, INNOVATIVE PRACTICES, AND CONCLUSION

6.1. Discussion and key messages

228. Inequalities in access to health care services, mental health included, remain a major obstacle. In addition to regional variations in the supply and delivery of mental health services, two factors go a long way towards explaining these inequalities. First, a part of the population, notably the unemployed and the elderly, cannot access occupational health services. Furthermore, as the out-of-pocket fees in private psychiatric services are somewhat substantial, these services are accessible only to people from higher socio-economic groups (Wahlbeck, 2011).

229. There is scope for the further development of forensic psychiatry. The forensic psychiatric care system has not been deinstitutionalised and remains hospital-based. Moreover, providing forensic psychiatric care primarily in two remotely located state hospitals limits coordination with other mental health services. There could also be better purchaser control in the provision of forensic services: patients are sent to forensic psychiatric treatment by the State, but their treatment is paid by the municipalities.¹² However, work is underway to mainstream forensic psychiatry into other mental health services and to remove barriers to discharging patients into the community. In order to address this situation, a legislative proposal regarding the community-based care of forensic patients is being prepared (Moring *et al.*, 2011). Prior to the final discharge, a patient may also be released from the hospital under the supervision of the psychiatric unit of the hospital district (Mental Health Act).

230. The fairly limited outpatient services, poorly regulated housing services and the under-developed role of primary care all increase pressure on specialist secondary services. High rates of unplanned readmission due to schizophrenia and bipolar disorders in Finland compared to other OECD countries can be partly explained by the underdevelopment of outpatient services for individuals with severe mental health disorders. However, given the more accurate recording of this data in Finland, there is limited comparability between countries other than the Nordic countries (Korkeila, 2011).

231. Despite its shortcomings, outpatient care for mental health disorders in Finland can be considered well-developed compared to a number of other countries where mental health services are entirely hospital-based (Korkeila, 2011; Vilela and Moro, 2009). The level of education of the personnel working in mental health is high, even though there are difficulties in recruiting personnel in rural areas and there will likely be a shortage of psychiatrists in the near future. A wide range of services are available across the country, which is facilitated by the use of innovative e-health approaches in more remote areas. Finland is very advanced in research and records comprehensive data compared to other countries, and the number of homeless psychiatric patients is also very low (Korkeila, 2011).

6.2. Ongoing mental health agenda – next wave of the agenda

232. As stated in the current government programme, (see section 3.3), the Mental Health Act (L 1116/1990) will be reviewed in order to make low-threshold mental health services more widely available and the MIELI plan will be reinforced. Practices created as part of the Masto project will be

¹² The State orders the treatment for the first six months. The extension of treatment after this period is negotiated with the hospital districts. “Difficult-to-treat” patients are sent to State psychiatric hospitals.

embedded including: the promotion of mental health and well-being at work; the prevention of depression; and early intervention for work ability and the return to work. These practices will be implemented via the Finnish Institute of Occupational Health (FIOH), labour unions, non-profit associations and the National Institute for Health and Welfare (THL) (Ministry of Social Affairs and Health, 2011b).

233. The relatively common use of involuntary admission in psychiatric care is a central issue on the current agenda. Not only is this part of current mental health strategy, but involuntary admission is also being addressed at a regional level in the Nordic countries. Some progress can already be noted with regard to the use of coercive measures, which has been gradually declining since 2005 in Finland (see section 1.2.).

234. The planned reform of social and health care with the restructuring of the municipalities will have significant consequences on the organisation and supply of services. These reforms are currently under intensive debate, and although the outcome remains to be seen, the main objectives have been clearly underlined. Reducing the number of municipalities aims to create larger, economically robust municipalities, and should be implemented by 2015. Consequently, this reform should decrease inequalities in the delivery and supply of social and health services within the country and “improve the balance between primary and specialised care” (OECD, 2012a).¹³

235. Since May 2011, the new Health Care Act has paved the way for enhanced access by expanding user choice in health care services (OECD, 2012a; Vormaa, 2011). Given that mental health services are an integrated part of social and health services, the reform should also improve the coordination of and access to mental health care.

6.3. Outstanding and innovative initiatives: best practice examples

- Child welfare clinics and school health care
- Clinical guidelines (Current Care) and comprehensive database (SOTKANet)
- Mental health as part of health education in schools
- Depression nurses in primary care

¹³ For further information on the proposed reforms of the social and health care system, see p. 99 of OECD Economic Surveys, Finland 2012.

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