Finland

General Information

Finland is a country with an approximate area of 338 thousand sq. km. (UNO, 2001). Its population is 5.216 million, and the sex ratio (men per hundred women) is 96 (UNO, 2004). The proportion of population under the age of 15 years is 17% (UNO, 2004), and the proportion of population above the age of 60 years is 20% (WHO, 2004). The literacy rate is 99% for men and 99% for women (UNESCO/MoH, 2004).

The country is a high income group country (based on World Bank 2004 criteria). The proportion of health budget to GDP is 7%. The per capita total expenditure on health is 1845 international $, and the per capita government expenditure on health is 1395 international $ (WHO, 2004).

The main language(s) used in the country is (are) Finnish and Swedish. The largest ethnic group(s) is (are) Finn. The largest religious group(s) is (are) Lutheran Christian (five-sixths), and the other religious group(s) are (is) Orthodox Christian.

The life expectancy at birth is 74.8 years for males and 81.5 years for females (WHO, 2004). The healthy life expectancy at birth is 69 years for males and 74 years for females (WHO, 2004).

Epidemiology

There is substantial epidemiological data on mental illnesses in Finland in internationally accessible literature. No attempt was made to include this information here.

Mental Health Resources

Mental Health Policy

A mental health policy is present. The policy was initially formulated in 1993.

The components of the policy are advocacy, promotion, prevention, treatment and rehabilitation. Finland has a health policy document (Health 2015) where mental health is included as an integrated component (a specific mental health policy paper is not there). In health policy, the main priorities are basic services and outpatient services. The Ministry of Social Affairs and Health produced quality guidelines for mental health services in 2001 and is working on quality guidelines for supportive housing regarding people with mental health problems.

Substance Abuse Policy

A substance abuse policy is present. The policy was initially formulated in 1997. The substance abuse policy is known as Drug Strategy. The Government has adopted a Drug Policy Action Programme for the period 2004-2007. An Alcohol Programme was formulated in 2004.

National Mental Health Programme

A national mental health programme is present. The programme was formulated in 1999.

Finland was the first country in the world to adopt a comprehensive national suicide prevention programme (in 1992).

National Therapeutic Drug Policy/Essential List of Drugs

A national therapeutic drug policy/essential list of drugs is absent.

Mental Health Legislation

There is a Mental Health Act. An amendment was made in 1997 regarding involuntary treatment of persons with criminal records and in 2000 regarding coercive actions. The other laws are Specialized Health Care Act, Public Health Act, Social Welfare Act and The Law of Patient's Rights. In Finland, there are two national laws that deal with the forensic psychiatric services: the Penal Code (1889, amended 2003) and the Mental Health Act (1990) with the Mental Health Decree (1990). While the Mental Health Act defines when and how patients can be committed into mental hospitals involuntarily, according to the Finnish Law, the courts decide if a forensic psychiatric evaluation should be conducted. In many cases of violent acts, the court asks the National Authority of Medicolegal Affairs to arrange for an evaluation.

The latest legislation was enacted in 1990.

Mental Health Financing

There are budget allocations for mental health.

Details about expenditure on mental health are not available.

The primary sources of mental health financing in descending order are tax based, social insurance, out of pocket expenditure by the patient or family and private insurances.

One special feature of the Finnish health care system, since the state subsidy reform in 1993, is that its financing is much decentralized. The financial units are the municipalities which total 450, with an average size of 6000 people. The biggest municipality is Helsinki, with half a million people, but the smallest have only a few hundred inhabitants. Despite this, every municipality has the responsibility to provide all health care, including the most specialized, to their inhabitants, either by organizing this themselves or by buying it from health care districts, other municipalities or private providers. The municipalities have the right to collect their own taxes. The other part of the needed money comes to municipalities as a state subsidy, but without any specific earmarking for health. This has led to increasing regional and local differences in the provision of mental health care, e.g. the differences between health care districts in the annual prevalence of hospital treated patients was twofold in 2002. The differences between municipalities were even greater. The same is true for the numbers of outpatient personnel: the difference between the districts was three-fold in this respect in 1999.

The country has disability benefits for persons with mental disorders.

Mental Health Facilities

Mental health is a part of primary health care system. Actual treatment of severe mental disorders is available at the primary level. Mainly, emergency treatment of severe mental disorders is available at the primary level.

Regular training of primary care professionals is not carried out in the field of mental health. Mental health is a part of basic training for physicians and nurses, however, systematic further education is not provided to primary care workers in mental health.

There are community care facilities for patients with mental disorders. Mental health services are primarily organized as community-based outpatient services. According to available data, the deinstitutionalization process was in the balance during the 1980s. The decrease in the number of psychiatric beds was compensated for by increasing outpatient resources and by developing community-based care, e.g. the personnel in outpatient care doubled from 1982 to 1992. The main problem in implementing community care is the scarcity of supporting services for long-term patients living in general communities. There is a need for more supported housing, day centres, support persons and guided leisure activities; patients' families also need more help and support. In recent years, there has in fact been a slight increase in these services. Extramural rehabilitative facilities used to be provided mainly by the public health sector and a few semi-private foundations. In the 1990s, a large number of private complimentary services were founded, and now they provide nearly 90% of all extramural residential services. Currently, nearly as many patients stay in such facilities as in psychiatric hospitals. However, the standard of care in such facilities is variable as the control of authorities over such institutions is weak.

Psychiatric Beds and Professionals

Total psychiatric beds per 10 000 population	10
Psychiatric beds in mental hospitals per 10 000 population	0
Psychiatric beds in general hospitals per 10 000 population	9
Psychiatric beds in other settings per 10 000 population	1
Number of psychiatrists per 100 000 population	22
Number of neurosurgeons per 100 000 population	1
Number of psychiatric nurses per 100 000 population	180
Number of neurologists per 100 000 population	4
Number of psychologists per 100 000 population	79
Number of social workers per 100 000 population	150

Mental health services are organized around the concept of catchment areas, which are currently governed by health care districts (HCD). Roughly two-fifths of psychiatric services, mostly outpatient care, has been moved administratively to primary care in many districts. Most psychiatric wards belong to the administration of general hospitals. Other settings include state hospital beds for forensic psychiatry, prisoners, military psychiatric wards, psychiatric wards in primary care and in private hospitals. Traditionally, the mental health care system has been hospital-centred, and the deinstitutionalization process started later than in

many other developed countries. At the beginning of the 1980s, Finland still had about 20 000 psychiatric beds, almost all situated in separate psychiatric hospitals. A specific feature of the Finnish situation, however, was that there never were really big hospitals; beds are spread between 60 hospitals located all over the country, and no hospital has more than 300 beds. During the last two decades, a substantial (75%) reduction in the number of beds in psychiatric institutions has occurred. The 1990 Mental Health Act forbade the treatment of minors in the same wards as adults, so the Health Care districts had to build separate units for adolescents run by adolescent psychiatrists. Hospital services for adolescents and children are separated, though they may be provided together with outpatient services. The Finnish mental health care system is characterized by teamwork (usual outpatient team comprises of psychiatrist, psychologist, psychiatric nurses and social worker). One prerequisite for this cooperation is the high standard of training among all personnel, so that all staff groups can participate in this cooperation on an equal basis. For instance, many nurses have received formal training in psychotherapy, especially family therapy. At the municipality level, local mental health work is often organized on a multidisciplinary basis. Currently there is a shortfall of psychiatrists by about one-third of the requirement, despite the intensified programme for training of psychiatrists since 1980s. Four psychiatric specialities are recognized: general psychiatry, child psychiatry, adolescent psychiatry and forensic psychiatry. About one-fifth of psychiatrists work as private practitioners only and one-third of psychiatrists working in the public sector have part-time private practice.

Non-Governmental Organizations

NGOs are involved with mental health in the country. They are mainly involved in advocacy, promotion, prevention, treatment and rehabilitation. The Finnish Mental Health Association is the world's oldest NGO in the mental health field.

Information Gathering System

There is mental health reporting system in the country. The Ministry of Social Affairs and Health biannually sends a social and health report to the parliament and mental health is incorporated in it.

The country has data collection system or epidemiological study on mental health. A large national epidemiological health examination study (Health 2000) was conducted in 2000. A central finding was that the prevalence of mental disorders is at present the same as twenty years before. Finland has a care register for institutional social and health care, including mental health, for service data collection.

Programmes for Special Population

The country has specific programmes for mental health for refugees, disaster affected population, elderly and children.

The Finnish National Schizophrenia Project, which was carried out in the 1980s, recommended that ‘acute psychosis’ teams should be established in every catchment area. Their task would be to take care of new psychotic patients in the area by active initial intervention which, whenever possible, includes family participation. The 10-year follow-up of the Project, focusing on the year 1992, verified that most of the catchment areas had established these multi-disciplinary teams. In the last few years, the Government has allocated special resources for the development of services for children and adolescents. Financing of psychotherapy for children and adolescents has also increased. Specialized outpatient departments and a few wards in mental hospitals have been created for substance abuse patients. In the last few years, the Government has allocated funds for expanding such services and extending it also to primary care. There is still, however, a shortage of rehabilitative services for chronic drug users. For forensic patients, who are judged to be not criminally responsible and in need of treatment, hospitalization usually starts at either of the

two state mental hospitals. After discharge the patient is under supervision for the initial 6 months and is assessed regularly at a municipal psychiatric centre, since there are no specific forensic psychiatric outpatient treatment facilities in Finland. After this period he has no other obligations to the judicial system and can continue treatment, if required, as any other psychiatric patient.

Therapeutic Drugs

The following therapeutic drugs are generally available at the primary health care level of the country: carbamazepine, ethosuximide, phenytoin sodium, sodium valproate, amitriptyline, chlorpromazine, diazepam, fluphenazine, haloperidol, lithium, biperiden, carbidopa, levodopa.

Fluphenazine is available only as a decanoate injection. Medicines for outpatients are dispensed from private pharmacies and not by the Government or institutions.

Other Information

Social welfare and health care are integrated at the national and provincial levels. At the national level, the Ministry of Social Affairs and Health has the highest administrative responsibility, and STAKES (National Research and Development Centre for Welfare and Health) is the active agent in the field of research and development activities. In every provincial administration, there is a Department for Social Affairs and Health. At municipal level, the models and degree of cooperation vary. In some, the social welfare and primary health care services are joined both at the administrative as well as at the practical level. In others, they still work separately from each other, although there has been, especially during the 1990s, an increasing tendency to achieve stronger integration. One practical example of increasing multi-sectoral cooperation in the area of mental health work has been the development programme called 'Meaningful Life'. This nation-wide programme from 1998-2002, the aim of which was to improve the quality of life for people suffering from mental disorders or their consequences, operated at national, regional and local levels. It has a genuinely multi-sectoral approach, as almost all ministries are participating in its steering group. The main target areas in the field of mental health promotion have been: enhancement of the value and visibility of mental health; development of mental health indicators; promotion of mental health in children and adolescents; in old age; in relation to working life and employment policy and the use of telematics in mental health promotion and substance abuse prevention. Mental health and its promotion have been stressed both in the new health strategy ‘Health for 2015’, as well in the governmental Goal and Action Plan for Social Welfare and Health Care 2004-2007. A national project to secure the future of health care services started in 2002 and a national development project for social services started in 2003. Both projects are financed and coordinated by the Ministry of Social Affairs and Health. The main priority is regional development of mental health work.

Additional Sources of Information

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