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Integrating mental health services: the Finnish experience

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Abstract

The aim of this paper is to give a short description of the most important developments of mental health services in Finland during the 1990s, examine their influences on the organisation and provision of services, and describe shortly some national efforts to handle the new situation. The Finnish mental health service system experienced profound changes in the beginning of the 1990s. These included the integration of mental health services, being earlier under own separate administration, with other specialised health services, decentralisation of the financing of health services, and de-institutionalisation of the services. The same time Finland underwent the deepest economic recession in Western Europe, which resulted in cut-offs especially in the mental health budgets.

Conducting extensive national research and development programmes in the field of mental health has been one typically Finnish way of supporting the mental health service development. The first of these national programmes was the Schizophrenia Project 1981–97, whose main aims were to decrease the incidence of new long-term patients and the prevalence of old long-stay patients by developing an integrated treatment model. The Suicide Prevention Project 1986–96 aimed at raising awareness of this special problem and decreasing by 20% the proportionally high suicide rate in Finland. The National Depression Programme 1994–98 focused at this clearly increasing public health concern by several research and development project targeted both to the general population and specifically to children, primary care and specialised services. The latest, still on-going Meaningful Life Programme 1998–2003 which main aim is, by multi-sectoral co-operation, to improve the quality of life for people suffering from or living with the threat of mental disorders. Furthermore, the government launched in 1999 a new Goal and Action Programme for Social Welfare and Health Care 2000–2003, in which mental health has been chosen as one of the eight priority areas.

Keywords

mental health, integration of mental health services, decentralisation, de-institutionalisation, R&D programmes

Finland joined the European Union in 1995. This vast country with an area of 330,000 km² and a 1000 km border with Russia is populated by only 5 million inhabitants. It is characterised by a homogeneous culture, a strange language, a melancholic mentality, and implementation of the Nordic welfare state model. Finns are most keen on modern technology, and the number of Internet connections and the mobile phone usage are some of the highest in the world. Most of the Finnish mental health services are public, and the main part of financing is based on general taxation.

In the beginning of the 1990s, some important developments took place in the Finnish health care system and in the society in general, which had profound influence on the mental health services of the country [16]. The most important of these developments were the following:

- the former, administratively separate, mental health service system was integrated with the somatic health care by renewing the health care legislation
- the health care system, including its financing, was radically decentralised by moving the responsibility of arranging and purchasing health care services to the 450 municipalities alone
- the state gave up almost all administrative control over the provision of health and social services
- a radical decrease in the number of psychiatric hospital beds has taken place during the 1990s
- the National Research and Development Centre for Welfare and Health, STAKES, was founded to support the municipalities with the means of development activities and guidance by information
- Finland encountered the deepest economic recession of the western European countries, the unemployment rate rising by the mid 1990s up to 20%; the funding of health services had to be cut down.

The aim of this paper is to give a short description of the most important developments of mental health services in Finland during the 1990s, examine their influences on the organisation and provision of services, and describe shortly some national efforts to handle the new situation.

Integration of mental health services

Before 1991 the specialised mental health services were administered in Finland totally separately from

the other health services. For this purpose the country was divided into Mental Health Districts, composed by federations of municipalities. At this time, the Finnish mental health service system was not only separate from other health sectors, it was also distant from the community/municipal primary health care because of its hospital-centredness.

However, due to the new health legislation in the beginning of the 1990s, radical changes happened. The most important laws in this respect were the Mental Health Act, the Specialised Health Care Act, the Public Health Act, the Social Welfare Act and the Law on Patient's Rights. According to the Specialised Health Care Act the former Mental Health Districts were dissolved, and psychiatric and somatic specialised health care were merged into new administrative units, called Health Care Districts. Membership in some of the 22 Health Care Districts is obligatory for every municipality.

A new broad definition of mental health work, defined by the Mental Health Act, opened the way for better integration between mental health services and the different components of the health and social service system. This definition is as follows:

> 'Mental health work refers to promotion of the individual's psychological well-being, functional capacity and personal growth, as well as prevention, cure and alleviation of severe and other mental disorders. It includes also development of the living conditions of the population so that they prevent contraction of mental disorders, enhance mental health work and support the organisation of mental health services.'

The Finnish mental health legislation very strongly underlines co-operation and synergy between sectors. The legislation includes explicit requirements on joint work between specialised and primary health care as well as between health care and social welfare services to create a functional mental health service system. On the other hand the new Law on Patient's Rights as well as the Mental Health Act ensure stronger participation of the patient and the inclusion of his/her family in the treatment process.

For the moment, the models and degree of co-operation between primary health care and social welfare services vary between the different municipalities. In some municipalities (the social welfare and primary health care) services are joined both at administrative as well as at the practical level. In other municipalities they still work separately from each other, although, especially during the 1990s, there has been an increasing tendency to seek stronger integration.

Decentralisation of the financing

The Finnish health care is mainly public and financed by taxes collected both by the state and the municipalities (http://www.vn.fi/stm/english/). A new law on state subsidy was passed in 1993 in Finland. This meant a radical change in the financial system of the health care. Earlier the state subsidy, which was about half of the total health care costs, went directly to the public health care providers according to their running costs. After the reform, the responsibility to provide or purchase the needed (primary and specialised) health services to the population was given solely to the municipalities. The municipalities have also a right to levy income taxes, which is the basis of their incomes. After 1993 the state subsidy is a block grant, calculated according to a per capita basis, and goes to the municipalities without any earmark. This means that the municipalities can use the funds according to their best views. In principle the subsidy can also be used for other purposes (e.g. to build streets, schools or sport facilities) than health care. The rationale behind this is that the health care decisions should be made as close to the people as possible, and that the municipalities, anyhow, should know best the needs of their population.

This radical reform changed Finland into a country with perhaps the most decentralised health care financing system in the world. As stated above, the financial units are the municipalities, of which there are a total of 450, half of them having less than 6000 inhabitants. The biggest municipality is Helsinki with half a million people, but the smallest municipalities have only a few hundred people. Despite this, every municipality has the responsibility to provide all the services to its inhabitants, including social welfare services, basic education and all health care (the most specialised care included). The municipalities can meet this responsibility by organising the care themselves or by purchasing it from Health Care Districts, other municipalities or private care providers. The private sector has some importance in providing psychotherapy (mainly in the bigger towns) on one hand, and supportive housing services on the other. Out-patient visits to the private sector are also partly paid by the national sickness insurance scheme.

The de-institutionalisation process

Traditionally, the Finnish mental health care system has been based on hospitals, and the de-institutionalisation process started later than in many other developed countries. In the beginning of the 1980s

Finland still had about 20,000 psychiatric beds, almost all situated in more than 100 separate psychiatric hospitals. This meant 4.2 psychiatric beds per 1000 inhabitants [16]. During the last 20 years there has been a radical and planned change in the structure of mental health services in Finland: the psychiatric hospital beds have decreased from 20,000 to 6000. Furthermore, more and more beds are placed in general hospitals as small units of intensive psychiatric care. At the same time the community care facilities have increased all over the country, as was nationally planned.

The de-institutionalisation of psychiatric services has been possible by developing the out-patient care and community based mental health services [20]. This development has also been part of the integration of mental health services, especially with the primary care and social welfare services. An increasing tendency, which has supported the integration of mental health services, has been the transferral of psychiatric out-patient care from the specialised health care to the health centres as an activity of primary care.

According to assessments, the de-institutionalisation process was in balance during the 1980s when the decrease in the number of psychiatric beds was compensated for by increasing the outpatient resources and by developing community-based care [21]. For example, the personnel in outpatient care doubled from 1982 to 1992 from 2.6 to 5.1 persons per 10,000 population.

However, the economic recession in the beginning of 1990s seriously hampered this positive development, and the psychiatric care faced a crisis in Finland: despite the fact that the number of psychiatric beds continued to decrease, the personnel in outpatient care decreased between 1992 and 1995. Thereafter, it again slightly increased but in 1999 is still under the level reached in 1992 [22]. As the number of psychiatric beds decreased radically during the same time, the total resources in specialised psychiatric health care decreased by about 30% during the 1990s.

In the evaluation, made of the Finnish de-institutionalisation process during the early 1990s [8–10], it was, however, concluded that, in spite of the rapid de-institutionalisation of the psychiatric hospital services in Finland, the situation is satisfactory. The strain on the psychiatric community care has increased dramatically, but the users of the services are mostly satisfied with the accessibility of the services [11]. However, the primary care doctors seem to have problems with the co-operation with psychiatric services. The out-patient-oriented care of a de-institutionalised psychiatric service system perhaps requires more activity on the part of the GP than it did before. Therefore, for the services as a whole, good relationship between specialised psychiatric services and primary health care are essential. It has also been shown that the burnout of the psychiatric personnel, as well as other health and social care personnel, is an increasing problem in Finland [6, 7].

The role of the national programmes

Conducting extensive national research and development programmes in the field of mental health has been typical for the Finnish mental health service development. The main goal of these programmes has been to support the service providers, mainly the municipalities, to develop and improve the services so that they better meet the needs and requirements of the population, the communities and the society. The main national programmes in the field of mental health, the Schizophrenia Project, the Suicide Prevention Project, the Depression Programme, and, most recently, the still on-going Meaningful Life Programme, will be shortly described in the following.

The National Schizophrenia Project 1981–1987

The basis for the National Schizophrenia Project in the 1980s was the high number of long-stay schizophrenic patients in the Finnish mental hospitals [3,19]. This nation-wide publicly financed project had as its main goals to develop the treatment and rehabilitation of patients suffering from schizophrenia, and especially, to decrease the incidence of new long-stay patients and the prevalence of old long-stay patients in psychiatric hospitals by 50% over a 10-year period, starting in 1982.

The project had both research and development characteristics. The main strategy was extensive and intensive co-operation with the Mental Health Districts, responsible for providing the needed services at that time. An important effort of the project was to launch to the whole country a comprehensive treatment model that put great emphasis on the integrative approach, with a particular focus on the psychosocial modes of treatment [2]. The main features of the model were patient and family participation, psychotherapeutic basic attitude, teamwork and the need-adapted treatment approach. One specific element in this model was the establishment of multidisciplinary psychosis teams to provide intensive first-aid care in all cases of psychosis in the community.

The 10-year evaluation of the National Schizophrenia Project was conducted in 1992 [21]. It showed that the aims of the project were fully achieved. The number of new long-stay schizophrenic patients in psychiatric hospitals had decreased by 60% between 1982 and 1992, and the number of old long-stay patients even more, by 68%. Both the treatment of schizophrenic patients and the structure of mental health services had changed greatly during and still after the implementation of the project. Psychosocial treatment methods in particular had developed due to nation-wide training of mental health personnel. The major innovation of the project, the public acute psychosis teams [2], were serving more than 50% of the psychiatric catchment areas of the country. The overall conclusion from the evaluation was that it is possible to conduct successfully nation-wide projects to develop the treatment of schizophrenic patients and the psychiatric practices across a whole country. It is clear that the project was the major facilitator in making possible the rapid de-institutionalisation process, described above.

The National Suicide Prevention Project 1986–1996

The background for starting the National Suicide Prevention Project was the high Finnish suicide rate, which in the 1980s was considered to be the second highest in the world (33 annual suicides per 100,000 inhabitants in 1986). This theme had been the focus of health policy discussion in Finland since the early 1970s. In 1985 the National Board of Health formulated the first directive goals for the prevention of suicide:

- to draw attention to this theme as a complex problem
- to launch a development process in the entire country
- to integrate the project into the public service system; and
- to bring about activities that would affect especially health services.

A specific goal to reduce the Finnish suicide rate by 20% during the next 10 years was set for the project. The project, which was mainly financed by the Ministry of Social Affairs and Health, was also included in the national health policy programme based on the WHO 'Health for all 2000' programme [15].

The project started with a research phase, co-ordinated by the National Institute of Public Health and conducted mainly by regional expert groups. An extensive psychological autopsy study was conducted with all suicides (n = 1397) during one year (1987–88) [13]. Based on the experiences, gained from the research phase, a national target and action strategy was developed [17, 23], and an extensive implementation phase, co-ordinated by the National Research and Development Centre for Welfare and Health, followed.

During the implementation phase a multi-sectoral co-operation was developed with at least 30 different organisations and agencies, including health and social services at local, municipal, regional and national level, police, church, the defence forces, Ministry of Education, Ministry of Labour and different civil society organisations (CSOs). Furthermore, an implementation network of about 1100 strategically important contact persons was established. The project team developed a co-operative process model that was implemented under real-life circumstances in community-based settings. The project developed its own information channels, leaflets, etc. and trained journalists in issues of mental health, family crises and suicide [23].

The Finnish suicide rate still increased during the first years of the project to a peak in 1990, followed by a reduction of 20% between 1991 and 1996 during the implementation phase, and finally dropping to 9% below the initial level. This happened despite the economic recession, which was as its deepest during these same years. The external evaluation of the project, made by an international peer group [14], concluded that

> 'the implementation was successful in putting suicide prevention on the social agenda and at large in promoting development in the chosen areas. It may already have contributed to the reversal of the increasing trend in suicide rates. It gave experiences of an interactive participating working model and produced practical models and guidebooks for suicide preventive work. In these respects the project has been both purposeful and appropriate and has produced good results.'

The National Depression Programme 1994–1998 'KEEP YOUR CHIN UP!'

In the beginning of the 1990s depression came more and more into the foreground in the public health discussions in Finland. One reason was that the Suicide Prevention Project could clearly show the strong association between depression and suicide [4]. There were also clear signs that the occurrence of depression among the population was increasing in Finland. For example the use of anti-depressive drugs increased rapidly as well as the number of disability pensions due to depression. One major

reason for this increase was considered to be the deep economic recession Finland encountered in the beginning of the 1990s.

The project was focusing on four areas, namely public in general, children and adolescents, primary health and social services, and specialised services. In all these areas both research and development actions were conducted. Depression was approached as a broad concept, and special emphasis was laid on awareness raising and multi-sectoral co-operation in defeating depression [12]. In addition to specific R&D projects training courses for health and social welfare professionals were provided, public campaigns were conducted and self-help groups of people suffering from depression were established [1, 5–7].

From the internal evaluation of the KEEP YOUR CHIN UP! project it is evident that the project has contributed to the clearly increased public awareness of depression during the 1990s. For example depression has been a regular theme in the mass media. Health professionals are also nowadays providing more attention to depression than earlier.

The Meaningful Life Programme 1998–2003

One practical example of increasing multi-sectoral co-operation in the area of mental health work in Finland is the newly established development programme called ‘Meaningful Life!’. This nation-wide programme, the aim of which is to improve the quality of life for people suffering from or living with the threat of mental disorders, operates both at the national, regional and local levels. It really has a multi-sectoral approach as almost all ministries have participants in its steering group, such as Ministry of Environment, Ministry of Education, Ministry of Labour, Ministry of Defence, Ministry of Interior, Ministry of Finances, as well as many important public actors, the social partners, and all relevant mental health CSOs.

The programme deals with the fact that mental health is not only a matter for social welfare and health authorities. It is much more, and often the role of these authorities may be just marginal. People, and of course also people with mental health problems, need homes, education, work, free-time activities and so on. Therefore, the Meaningful Life! programme has been set up to invite all actors and stakeholders.

The Meaningful Life Programme is a pure development project where the main emphasis is on local level. Its main activities have included the evaluation of the Finnish mental health services, enhancement and support of different local activities, training of the professionals in different sectors on mental health issues, awareness raising by public campaigns etc. The programme has its network based on voluntary persons interested in mental health work. It has a web site in Finnish and its own information and publication activities.

The new governmental strategy

One effort by the government to strengthen its guidance of the municipalities by information is the new governmental Goal and Action Programme for Social Welfare and Health Care 2000–2003, launched in 1999 (English translation available on request from the Ministry of Social Affairs and Health). Mental health has been chosen as one of the eight priority areas in this strategy document. The most important actions, suggested by the document in the field of mental health are the following:

- every municipality has to establish a plan for seamless and comprehensive mental health care in which special emphasis should be laid on mental health promotion and prevention of mental ill-health, including prevention of suicides
- quality criteria for local and regional mental health work must be developed
- special emphasis should be laid on the mental health care for children and young people
- the municipalities have to develop 24-hour service homes for the severely mentally ill, responding to 0.2 places per 1000 population
- the municipalities and CSOs are encouraged to develop tele-psychiatric facilities and telematic counselling services.

For a successful realisation of these targets, a special emphasis is needed on multi-sectoral co-operation, as well as an integrated mental health service system in every municipality and at regional level.

The actual discussion in Finland for the moment is whether the governmental guidance by information is enough to ensure the needed development of mental health services or whether some return to the earlier normative guidance is needed. One sign of this dilemma is that the Parliament of Finland decided at the end of 1999 to provide an ear-marked extra budget of 70 million FIM (€12 M) for the year 2000 for the development of mental health services for children and young people. A corresponding amount of money is included in the 2001 state budget, too.

Conclusions

A special challenge for Finland has been to develop integrated mental health services in a vast but sparse-

ly populated country under the conditions of extreme decentralisation of decision making in health care. Decentralisation has created a situation, where the public services may be differently organised and provided for the population, and their costs and quality differ from one municipality to another [18]. This has also meant clear regional differences in the use of mental health services [10]. However, the decentralisation has its strengths too: the local decision-makers know best the local circumstances and the needs of the population. One sign of success of the Finnish system is that there have not been homeless schizophrenic patients in the streets in Finland as there are in many other countries.

A tendency towards increasing integration and co-operation between sectors has taken place in Finland during the 1990s. The co-operation between the health and social welfare sectors has the longest tradition, but in recent years the role of education and employment sectors has become increasingly prominent as well. SCOs are also developing rapidly in the field of mental health, although the users' and carers' organisations are still rather weak in comparison with other organisations within the health area. However, their local activities of arranging events, fund raising and campaigns, and even providing services purchased by the municipalities are of utmost importance.

At national level, the co-operation between sectors and ministries has slowly grown in importance. The different sectors have realised their own opportunities and responsibilities in the field of mental health by internalising the concept of positive mental health. For instance, the Ministry of Environment has started to study within their health impact assessment procedure also the dimension of mental health, and the Ministry of Defence has developed, in co-operation with the National Suicide Prevention Project, a crisis intervention programme for the Finnish conscription army.

Real integration means that all the participants can join the activities with their own ideas and targets, and that real added value will be gained. The experience so far has taught that it takes time, there will be backlashes as well success stories, and that many different working methods are needed for the best possible outcome.

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Further reading

For more information:

http://www.stakes.fi/english/search/index.html
(search the STAKES website; look for 'mental health')

http://www.vn.fi/stm/english (look for publications)