

# The development of mental health services in Finland between 1980-2000

In Finland, health services are funded out of tax revenue and provided by local municipalities, as are also primary and secondary education and social welfare services. Earlier the delivery of mental health services and the services for other patient groups were separated. According to the Public Health Act, community health centres are primarily responsible for health care. Each health centre has a number of health care teams working under the guidance of a general physician and providing preventive, therapeutic and rehabilitative care. The network of community health centres forms the primary level of the health care system.

According to the idea of stepwise health care system, the municipal general hospitals and university central hospitals provided specialised health care services. The country was divided into 21 central hospital districts. Hospitals with their outpatient clinics form the secondary level of the health care system (specialised health care services). Five of the central hospitals also serve as university hospitals.

Mental health care was organised separately and independently of general hospitals. According to the Mental Health Act of 1952, the country was divided into 21 mental health districts. Each district had to have one or more mental hospitals and these also provided outpatient care. The Mental Health Act of 1978, which amended the 1952 Act, expanded the system to include outpatient clinics, night and day hospitals, hostels, sheltered workshops and other forms of rehabilitation.

The Finnish mental health system has changed dramatically during the last ten years. During the sixties and seventies, psychiatric hospital care developed very strongly so that in 1980 Finland had 20,036 inpatient beds in psychiatric care. The population of Finland was under 5 million people, so that Finland had 4.2 beds per 1,000 inhabitants. For instance, Sweden had only 3.2 per 1,000 inhabitants and Norway 1.9.

According to the idea of de-institutionalisation, the mental health system in Finland began to reduce the number of psychiatric hospital beds since the beginning of the 1980s. (Table 1). One of the

*Table 1. Beds in psychiatric in-patient care 1980-1994*

TIME	Beds	Beds per
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<b>31,12</b>		<b>1000 inhabitants</b>
1980	20 036	4,2
1985	17 143	3,5
1990	12 336	2,5
1991	10 570	2,1
1992	9 730	1,9
1994	7 708	1,5

problems in Finnish mental health care was that large numbers of inpatients were long-stay patients.

In the 1970s, about 70% of the patients were long-stay patients (Hakkarainen 1989). At the beginning of 1980, the mental health organisation began actively to develop the rehabilitation system for long-stay patients, especially schizophrenics. As a consequence of this, the proportion of long-stay patients in hospital population decreased. On the other hand, outpatient care was also developed, so that the mean of inpatient days for new patients could be reduced. Earlier it had been a problem, because the new patients remained inpatients for long periods. In 1990, Finland had 12,336 beds in psychiatric inpatient care (Table 1). The number of vacancies in inpatient care has been reduced and part of them has been moved to outpatient care. A total of over 3,000 vacancies in psychiatric care had been reduced in ten years (Table 2).

*Table 2. Vacancies in psychiatric care 1982-1994*

<b>Year</b>	<b>Vacancies</b>
1982	13 142
1992	12 013
1994	10 269

At the beginning of the 1990s, the Finnish society was faced with a severe economic recession with a record-high unemployment rate. At the same time, mental health legislation was being amended. The previously independent mental health districts were dismantled and psychiatric care was introduced to general hospitals and outpatients services to outpatient clinics in general hospitals.

The aim of the de-institutionalisation of mental health systems at the beginning of the 1980s was to devolve resources to outpatient care. As a result of the recession, the specialised health care sector was forced to reduce its costs by 13%, which in practice meant cutting mental health resources. As it was, the society had no resources to develop outpatient care as was planned. At the beginning of 2000,

outpatient services have been again reorganised under general health centres in primary health care.

Figure 1 shows the reduction of beds in psychiatric inpatient care, occurred also at the beginning of the 1990s. Although there were fewer beds in the psychiatric hospitals, the rate of patient admission did not decrease. According to the study of Korkeila et al (1998), there was a significant increase in re-admissions to the psychiatric hospitals and particularly in multiple (three or more) re-admissions among new inpatients at the beginning of 1990s.

Although it is very difficult to estimate the mean of inpatient days, the figures in Table 3 indicate that the mean of inpatient days of discharged patients has decreased. The indicator takes into account the episodes of care of discharged patients. In any case, the episodes of care in 1997 have been one month shorter than in 1994.

*Table 3. The mean of in-patient days of discharged patients in psychiatric care 1994-1*

<b>Year</b>	<b>Mean of in-patient days</b>
1994	87
1995	62
1996	67
1997	51

The greatest group among psychiatric hospital patients are schizophrenics; depressed patients also form a big group. One Finnish follow-up study has so far addressed the effects of the rapid reduction of psychiatric beds. The purpose of the follow-up was to examine the living conditions of discharged schizophrenia patients, and to assess their use of and need for health and welfare services and other supportive services. (Salokangas et al 2000). The patient population under study consisted of patients discharged in 1982, 1986, 1990 and 1994. It was found, that by the beginning of the 1990s the discharged schizophrenia patients were increasingly very long-term mentally ill, more disabled and with fewer social contacts than in previous years. The significant increase in the number of discharged patients in poor condition presents a great challenge for community care. Psychiatric inpatients also appear to be more seriously disturbed psychologically, somatically and functionally than previously. Unfortunately, there is no information available on other patients.

The number of outpatient visits has increased; especially child and youth psychiatric care have been developed. On the other hand, it is very difficult to supply the right figures concerning outpatient visits, because we have so many ways to organise the outpatient services, clinics in general

hospitals  
and health centres in primary care.

The patient population in psychiatric inpatient care has changed very much during the last ten years. Earlier the long-stay patients were the biggest group and the rehabilitation of these patients was the main task for many years. Today the treatment episodes are shorter, the readmission rate is high and the patients come to the inpatient care in poorer condition than previously. On the other hand, outpatient care has to bear the responsibility for patients that are more seriously disturbed than before. In this situation, the working conditions and possible burn-out among the working staff need special attention.

Further research is needed into psychiatric inpatient treatment so that it should meet the needs of a changing patient structure and the requirement of shortening care periods. Psychiatric community care should be developed more actively to take account of continuing treatment for long-term patients and also for other patients.

#### References

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