Depression scorecard: Finland

This scorecard report was produced by The Health Policy Partnership as part of the Words to Actions initiative. Words to Actions began in 2018 with a report from nine mental health organisations across Europe. The idea for the depression scorecard came from collaborative discussions between The Health Policy Partnership and Janssen Pharmaceutica NV, and the scorecards were developed as a follow-on but separate activity. The authors had full control over the content of this report. All Words to Actions materials were initiated and funded by Janssen Pharmaceutica NV. For full details, please see wordstoaction.eu/about. No experts involved in this work, other than The Health Policy Partnership, were paid for their time.

The Health Policy Partnership

About this scorecard

The depression scorecard is a tool that aims to support the assessment of national-level performance in key aspects of policy, delivery and care for people with depression. The framework that underpins the scorecard was developed based on an international literature review and consultation with an expert advisory group.

The scorecard framework was applied initially by The Health Policy Partnership, in collaboration with experts, to four countries: Belgium, France, Italy and Romania, with national-level findings summarised in individual scorecard reports. In the next phase of work, reports were developed for Finland and Germany, and the assessment framework was made available for independent researchers to prepare scorecards for their own countries.

This scorecard focuses on Finland.

Author and contributor details

The research and drafting of this depression scorecard report were led by Catherine Whicher and Jody Tate of The Health Policy Partnership. We are grateful to members of the Depression Scorecard Advisory Group, who volunteered their time to provide the guidance and feedback that shaped the original assessment framework:

- Julian Beezhold, European Psychiatric Association
- Liesbeth Borgermans, University of Ghent
- Doina Cozman, Romanian Association of Psychiatry and Psychotherapy
- Massimo Di Giannantonio, Italian Society of Psychiatry
- Kevin Jones, European Federation of Associations of Families of People with Mental Illness (EUFAMI)
- Raluca Nica, Global Alliance of Mental Illness Advocacy Networks-Europe (GAMIAN-Europe)

We are also grateful to the national experts who provided valuable insights on the situation in Finland:

- Janne Jalava, Mielenterveyden keskusliitto (Finnish Central Association for Mental Health)
- Jukka Kärkkäinen, Suomen Psykiatriyhdistys ja Terveyden ja hyvinvoinnin laitos (Finnish Psychiatric Association and Finnish Institute for Health and Welfare)
- Oskari Korhonen, Mielenterveyden keskusliitto
- Riikka Mettälä, Mielenterveyden keskusliitto
- Vaula Ollonen, FinFami

About The Health Policy Partnership

The Health Policy Partnership (HPP) is an independent research organisation, working with partners across the health spectrum to drive the policy and system changes that will improve people's health.

Please cite this document as:

The Health Policy Partnership. 2022. *Depression scorecard: Finland*. London: The Health Policy Partnership.

Contents

Depression: why it matters

Depression is the most common mental health condition affecting people today.[1] It is a distinct, diagnosable mood disorder not to be confused with normal feelings of sadness.[2] Anyone can develop depression, and if a person is also experiencing another illness, addiction, poverty, unemployment or a personal loss, risk of depression increases.[2] Depression can range in severity and persistence.[2]

Best practice is to manage the condition as early as possible, while the person is still well enough to be fully engaged in their recovery and before treatment-resistant depression sets in.[3] Yet stigma associated with depression may prevent people from seeking and receiving the care they need, and exacerbate suffering.[4]

Depression has a devastating impact on the lives of those affected, their families and carers, and societies and economies more broadly.

In 2018, approximately 500
people with depression died by suicide in Finland[12*]

5.6%
of Finland's health spending is on mental health, compared with 4% in the EU overall[13‡]

5-7%
of people in Finland are living with depression[12*]

€11.14 billion
cost of mental health (direct and indirect) in Finland[14§]

5.3%
cost of mental health to Finland's GDP (direct and indirect)[14§]

Finland has 24 psychiatrists
per 100,000 inhabitants, compared with an EU average of 17[14§]

*Most recent data available ‡Data from 2017 §Data from 2015

The condition is associated with numerous negative outcomes throughout a person's life, including poorer academic performance, reduced earnings, other chronic illnesses, diminished quality of life and a higher chance of premature death.[5] [6] Depression is also the leading cause of suicide[7] – as many as 15% of people with untreated depression may die by suicide.[1] Up to 60% of all deaths by suicide worldwide are associated with depression.[8]

The COVID-19 pandemic has exacerbated the already significant crisis of depression. Demand for mental health services has soared while availability of in-person care has been constrained.[9] It is estimated that the pandemic was responsible for an additional 53.2 million cases of depression in 2020.[10]

Despite a growing understanding of depression and how best to support people living with the condition, global prevalence has risen nearly every year since 1990.[11]

Depression in Finland

The burden of depression and depression-related suicide in Finland is significant. The Finnish Medical Society (Duodecim) estimates that, in any given year, 5–7% of people in the country are living with depression.[12] One survey of people with chronic conditions found depression and anxiety disorders were second only to Parkinson's disease in terms of the perceived loss of quality of life.[15] Depression is also the single greatest risk factor for suicide: two thirds of deaths by suicide in Finland can be linked to the condition, in most instances where the person was not receiving appropriate treatment.[12] While the number of deaths by suicide has halved since 1990,[16] they remain a leading cause of preventable deaths.[17]

The organisation and funding of health services in Finland is in the midst of a generational change. By 2023, the last of a series of legislative changes will be passed to reorganise how healthcare is delivered, moving responsibility from municipalities to 22 new 'wellbeing services counties'.[18] Financing of care will also shift from municipalities to the federal level, while some funding will remain tied to service use at the municipality level.[18] Implementing these legislative changes, which were first proposed more than a decade ago, should help address some of the biggest identified weaknesses of the system: inequities in all aspects of care between the regions, linked to disparities in funding and service provision.[17] However, Finland will maintain its three-stream primary health system, which separates provision into occupational (for those in employment),

student (for those in education) and social (for all other people) services. The differences between these streams may mean some challenges and inequities persist. It is not yet clear whether the changes will have any impact on waiting times, which are a significant contributor to reported unmet needs for care in Finland and are higher than the EU average.[17]

Mental health care is also in flux, driven by the increased demand for and raised profile of mental health services following the onset of the COVID-19 pandemic. A historical lack of coordination between primary and secondary care has led to challenges in delivering mental health care.[17] To address this, the *National Mental Health Strategy and Programme for Suicide Prevention 2020–2030* aims to strengthen the availability of psychotherapies and psychosocial treatments, with a focus on structural and collaborative integration of primary and secondary care.[16 19]

Duodecim has also recently updated its depression care recommendations,[12] which are considered robust and comprehensive.[20] Meanwhile, a new legislative motion proposes reforming the Mental Health Act to secure 'immediate' access to therapy for anyone seeking help from their first visit to a health centre.[21] If passed, this would help to address the problem of waiting times.

Poor mental health comes at a high cost for Finland. Direct and indirect costs associated with mental illness are among the highest of the Organisation for Economic Co-operation and Development (OECD) countries.[16] Sickness benefits and disability pensions related to depression have doubled since the late 1990s,[12] and more than half of all disability pensions are related to mental illness.[16] If the Finnish health system could help just 15% of people with mental illness to recover before needing to retire with a disability pension, it is estimated that the country's GDP could rise by up to 0.5%.[16]

Assessing depression management: the scorecard

This scorecard was developed to highlight to policymakers where change is most needed to improve the management of depression in Finland. It is our hope that this document may galvanise policymakers to work in close partnership with all stakeholders to reverse the course of depression in Finland, taking a comprehensive and preventive approach to address depression in all its complexity.

The scorecard focuses on four key areas, identified as priorities for improvement:

1

Joined-up and comprehensive depression services

Integrated care – that is, a patient-centred system that supports the person with depression throughout their lifetime and with continuity across the health system – is essential to delivering adequate support and treatment. Integrating mental health services into wider health and social care services is convenient and can increase treatment rates, improve comprehensiveness of care and reduce overall costs.[22]

2

Data to drive improvements in depression care

Collecting and analysing robust and up-to-date data on depression is essential for ensuring the right services are available for everyone who needs them. Monitoring patient outcomes helps to identify and inform good practice, and may give hope to service users that their mental health can improve.[22] Data on services can support clinicians, policymakers and people with depression to better understand what treatment options are available and accessible. More transparent data will also facilitate shared learning across all domains of depression care. New digital tools may have the potential to facilitate documentation for transparency and research purposes while retaining the anonymity of the user.[22]

3

Engaging and empowering people with depression

It is essential that people with depression – along with their families, friends and carers – are actively empowered to participate in depression care plans at all stages. Empowerment involves a person gaining information and control over their own life as well as their capacity to act on what they find important, which in turn will allow them to more optimally manage their depression.[23] Peer support, whereby a person who has previously experienced depression offers empathy and hope to others in the same position, can assist both people with depression and their peer supporter in their recovery.[24] Social systems, patient advocacy groups and other civil society organisations with access to underserved communities are critical in ensuring that mental health services reach everyone, including those who have 'slipped through the net.'[22]

4

Harnessing technology to improve access to depression care

Digital platforms such as those which facilitate remote therapy sessions and online prescription requests, as well as other depression-focused software, smartphone applications and virtual platforms, can allow greater choices of treatment for people with depression while supporting them to take more control of self-managing their condition. While virtual sessions cannot replace in-person therapy, they may be a flexible option to support people with depression between regularly scheduled visits. Health and social services may also use digital tools to facilitate data collection and monitor care.[25] [26] In addition, people with depression may find it helpful to use digital tools to connect with others and reduce feelings of isolation.[27]

Summary scorecard for Finland

Joined-up and comprehensive depression services

Is depression included in either the national health plan or a specific plan for mental health?

Is there a government lead on mental health, with cross-ministerial responsibility to support a 'mental health in all plans' approach?

Is collaboration between primary care and mental health services supported and incentivised/encouraged/facilitated?

Are there guidelines on depression care developed jointly by primary care and psychiatry?

Is a range of therapeutic options reimbursed and available to people with depression, such as psychotherapy, counselling and cognitive behavioural therapy?

Are depression services available and tailored for at-risk groups?

- Young people
- Older people
- People in the workplace
- Homeless people

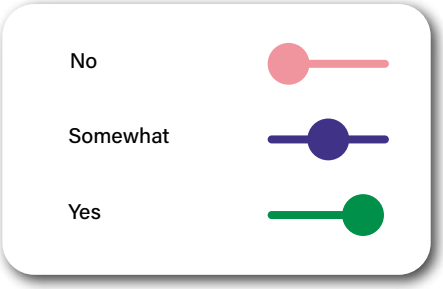



Data to drive improvements in depression care

Are data on people with depression systematically collected by the health system?

Are data on mental health services being used for planning?

Are patient-reported outcomes being measured systematically?



Engaging and empowering people with depression

Do guidelines or care pathways for depression recognise the importance of patient empowerment?

Were patient and carer representatives involved in the most recent national plan or strategy covering depression?

Is peer support recommended in depression care guidelines?

Do guidelines on depression recognise the role of families and carers in making decisions on the planning and delivery of care?

Do carers have access to financial aid to help them support their loved ones with depression?

Are peer support roles reimbursed?

Are there national associations advocating for the rights of:

- people living with depression?
- carers of people living with depression?

Harnessing technology to improve access to care for people with depression

Can patients access depression support remotely (via telephone or the internet) in addition to services delivered face-to-face?

Do professional societies or guidelines recommend the use of remote services alongside face-to-face services?

Is remote support for depression reimbursed?

Are people with depression able to use telephone or online platforms that allow them to renew their prescriptions from home?

Joined-up and comprehensive depression services

Variability in referral pathways and poor coordination between primary and secondary services hinder access to care for people with depression

Primary and outpatient mental health care is currently coordinated and funded at the municipal level, whereas specialist psychiatric clinics and psychiatric hospitals are organised separately.[28] Primary care is considered suitable to treat most cases of depression, especially when the condition is in the early stages.[12 29] Primary care physicians diagnose around 25–40% of patients during the first visit, with diagnostic rates improving if the consultation lasts at least 15 minutes or if the physician has a history of treating that person. To access specialist psychiatric care, a person must receive a referral, although municipalities have different referral pathways; this results in more limited access in some areas.[29] Although coordination between primary and specialist services is encouraged,[12] in practice it is variable. Some areas have robust connections and communicate very effectively,[20] while others identify a lack of coordination as an ongoing issue.[17] This is likely due, at least in part, to the variability in service organisation between the municipalities currently delivering care. The result is a system where the standard of care a person with depression receives is highly dependent on where they happen to live in the country.

Delivery of primary healthcare in Finland is divided into three streams with varying access to mental health specialists, which contributes to inequities in care

A person seeking healthcare will be served by the occupational healthcare stream if they are in employment, the student healthcare stream if they are in education, or otherwise the social healthcare stream (sometimes called the community healthcare stream).[17] These streams of primary care are separate and involve different healthcare practitioners. The balance of mental health professionals available to users varies from one stream to the next, with some people having greater access to psychiatrists and others being more likely to see a psychologist or psychiatric nurse.[20] Unsurprisingly, inequalities in service delivery are a challenge.[17] For example, referrals from the occupational healthcare stream to psychiatrists are typically much more efficient, with people being seen in as little as two weeks, whereas waiting times from the student or social healthcare streams may be many weeks longer.[20]

A reorganisation of Finland's health system aims to reduce geographical disparities and centralise financing, though the three primary care streams will remain

The Finnish government is in the midst of reorganising the coordination of primary care: by 2023, planning and management will shift from the country's municipalities, of which there are more than 200, to 22 'wellbeing services counties'.[18] Financing of care will also shift from municipalities to the federal level, although some funding will remain tied to service use at the municipal level.[18] These changes were first proposed more than a decade ago, and their implementation should help address some of the biggest identified weaknesses of the system: inequities in care between the regions linked to disparities in funding and service provision.[17] However, because Finland will maintain its three-stream primary health system, some challenges and inequities may persist.

A 'mental health in all policies' approach has been recommended in the latest mental health strategy but has yet to be implemented

The Finnish Institute for Health and Welfare (Terveyden ja hyvinvoinnin laitos, THL) supports a 'health in all policies' approach. The approach, which is also recommended by the *National Mental Health Strategy and Programme for Suicide Prevention 2020–2030*, recognises the impact that decisions in other sectors, such as education, employment and infrastructure, may have on health.[19 30] So far, there is no indication that initiatives from the health sector have been systematically taken up by other areas, and there is no governmental lead working to integrate these policies across different sectors.

Comprehensive care guidelines and a range of therapeutic options are available for people with depression, but differences in reimbursement rules and a shortage of specialists mean people may not be able to access care when they need it

In addition to robust, detailed and recently updated care recommendations for depression,[12 20] Duodecim also offers specialist clinical guidance covering different domains and types of depression, such as chronic depression, seasonal affective disorder, and the relationship between depression and addiction.[31] A range of treatments are available, including psychotherapies and psychological rehabilitation.[28 29] Kela, Finland's social insurance institution, only provides reimbursement for psychotherapy for people aged between 16 and 67 years, whose ability to work or study has been affected by their illness.[28 29] Even those who qualify, or who are able to pay 'out of pocket', may struggle owing to the general shortage of psychiatrists, psychotherapists and other mental health professionals relative to demand.[20 29] Waiting times are a significant problem for Finland's health sector and are a major cause of the country's unmet care needs.[17 20] It might be 7–12 months from the time a person seeks help before they can receive rehabilitative psychotherapy through Kela.[21] The COVID-19 pandemic exacerbated these challenges; while remote care was able to support some continuity of care, it seems that generally services were weakened and waiting times extended.[32]

A significant proportion of people with depression may not be accessing any care

Several studies in the early 2000s estimated that fewer than half of people with depression in Finland may be actively seeking care from the health system to try to manage their condition;[33-35] as of 2020, this may be as high as 76% for young adults.[16] Barriers, such as stigma and needing a certain severity of illness to access expert care, may be keeping thousands away, especially people with milder forms of depression.[20] Private insurers for health, home, loan or travel insurance may disqualify a person with mental illness (or a history of mental illness) from being insured, leading people to further delay seeking help.[36] These barriers are worrying because delaying care increases the risk of developing more severe depression.[3] Even when people are able to access quality care, lack of timely follow-up remains a challenge.[20 37] One expert interviewed for this scorecard report believes the challenge lies both in the frequency of appointments (which should be every two weeks) and in their duration (they are often rushed).[20] Failures in follow-up may contribute to the identified challenges among people with depression in adherence to pharmacological and psychological therapies.[20 37]

Owing to the three-stream system of primary care, some of those who are most at risk of depression may be least likely to receive timely care

Despite the working population having greater and more timely access to mental health care than students or those in the social healthcare stream, some 4,000 take early retirement because of depression every year – equating to ten people per day.[38] In addition to taking a significant economic toll,[16] this also compromises the continuity of care of these individuals, who must transition from the occupational healthcare stream to the social healthcare stream for their primary care. The longer delays to accessing specialist care through the social healthcare stream reduce the likelihood of achieving remission and returning to work. The government is launching programmes to try to facilitate employment for those who have experienced mental illness and keep people well enough to stay in work.[39] However, until disparities of care between the occupational and other healthcare streams are addressed, these challenges are likely to persist (**Case study 1**).

Case study 1. The therapy guarantee, a proposed reform to the Mental Health Act

A change to the Mental Health Act has been proposed in a citizens' initiative to secure 'immediate' access to treatment for people who seek help.[21] This reform would secure access to mental health treatment for people with financial need, including those not eligible under current Kela guidelines.[21] The new law would require that a person be assessed by the third weekday from the date they first sought help at a health centre, with treatment being initiated within four weeks.[21] The bill has received strong support from civil society organisations, including FinFami (an organisation that supports informal carers).[40]

Data to drive improvements in depression care

THL collects a comprehensive range of data related to mental health and depression, which are used to guide decisions on care

Finland has a long history of data collection and, alongside Sweden, shares the distinction of keeping the most extensive continuous data series in the world; the two countries have been recording data on suicide since 1751.[41] Today, digital services including the Patient Data Repository (Potilastiedon arkisto) are managed by Kanta, which holds the national electronic patient records and is jointly managed by THL and other governmental bodies.[17] THL also manages population-level statistics through the Sotkanet platform, which includes a comprehensive set of mental health indicators. These cover service use, symptoms and outcomes, and include depression-specific indicators, such as reimbursements for antidepressants and self-reported incidence of depression.[42]

Data collected are used to inform the Evidence-Based Medicine electronic Decision Support (EBMEDS) system.[43] EBMEDS proposes treatments and links clinicians to treatment recommendations, as well as offering warnings and reminders specific to each patient.[43] Additional data are collected by the municipal regions of care and civil society organisations, such as the Finnish Central Association for Mental Health (Mielenterveyden keskusliitto, MTKL), which collects data on service users' attitudes to and experiences with mental health care.[29]

Depression care recommendations specify criteria for evaluating the quality of care delivered in primary and specialist care

A working group set up by Duodecim has developed the most recent care recommendations for depression, including a detailed list of data that should be collected and analysed to assess whether quality care is being delivered. At both the primary and specialist care levels, this includes data on the epidemiology of depression, treatment planning and progress, and patient-reported outcomes.[12] While these data may be extremely valuable to inform care decisions and service planning, it is not clear whether they are being systematically collected or used.

While there is support for collection and use of data, more could be done to integrate findings into service planning

The National Mental Health Strategy noted that decision-makers should use the 'most suitable indicators' to guide healthcare management and planning (**Case study 2**).[19] Yet there is no specific indication in the strategy of what kinds of data were used to inform the ten-year programme, and there is a feeling that more could be done to make use of the data already collected by THL and others.[20]

Case study 2. A digital database of evidence-based approaches promoting mental wellbeing

One ambition of the *National Mental Health Strategy and Programme for Suicide Prevention 2020–2030* is the establishment of a digital database compiling all approaches to the promotion of mental wellbeing and prevention of mental illness.[19] This database will create a repository of evidence-based interventions, which could be used to inform individual- and population-level decision-making. Centralising information for the preventive aspects of mental health should: facilitate planning by clinicians and mental health programmers working to improve mental wellness; direct funding towards mental health programming more efficiently; and alleviate the burden of mental illness.

Engaging and empowering people with depression

Shared decision-making between the person with depression and their healthcare team is recognised as a priority in Finland, but the role of carers is less emphasised

Recommendations for depression care are explicit that the person seeking care should be an active decision-maker and be fully informed of their options for managing their depression.[12] One expert interviewed for this report stated that, while the situation is improving, there is much more to be done to fully empower people with depression and other mental illnesses in making decisions about their healthcare.[32] One survey of people with mental illnesses in Finland found that they wished to be actively involved in decision-making on care and treatment, and felt that 'better care planning and coordination' would help them achieve that.[44] Meanwhile, the National Mental Health Strategy stresses the importance of including family and carers in plans related to preventing suicide.[19 41] The strategy also notes that services should consider the family of the person with depression both as a resource and as individuals in need of support themselves.[19] Conversations with carers offer an important opportunity to better understand the needs and wellbeing of the family as a whole.[45]

Peer support and experts by experience are promoted as part of treating depression, though delivery of these services is informal and primarily coordinated by non-governmental organisations

Peer support means involving people who have lived experience of depression in delivering support, such as group therapy or individual counselling, to those who are currently experiencing a similar illness. Duodecim considers it 'obvious' that peer support should be promoted as part of treating depression.[12] The National Mental Health Strategy also recommends increasing the involvement of people with lived experience of depression (experts by experience) within the health system.[19 41] At present, nearly all delivery of peer support is managed by non-governmental organisations, such as the MTKL and FinFami.[29 40] There are concerns that the absence of formal criteria recognising peer support workers and experts by experience may restrict the inclusion of skilled support as formal roles open up.[29]

Organisations representing people with depression and their carers have been included in the development of federal legislation and mental health reforms, as well as on-the-ground programmes and support

The MTKL is the largest association advocating for people with mental illness, and is often consulted when legislation related to mental health is under discussion.[29] Among a number of activities, it provides training, legal advice, financial support and surveys such as the Mental Health Barometer (Mielenterveysbarometri).[29 46] For carers and families of people with mental illness, the FinFami national association and its local chapters are the primary sources of information and practical support, including peer support, counselling, tools to assess and deliver support for carers, and guidance for carers and clinicians.[29 40 45-50] These organisations are also consulted in the development of related services, predominantly at the legislative level.

Carers for people with mental health conditions are not recognised as requiring support to the same extent as carers for people with physical illness

While organisations like the MTKL and FinFami offer counselling and support, the public sector is less responsive to the needs of those impacted by mental illness.[29] People who are unable to work because of mental illness can apply for a sickness allowance or disability pension,[51] and families facing significant financial hardship can apply for social assistance.[52] It is generally recognised that carers for people with mental illness do not receive the same recognition of need or support as carers for people with physical illness.[29 40] But carers for people with depression may be just as likely to need to reduce their working hours and make other concessions in order to support their loved one. Broader support, as well as flexible work arrangements, for every carer in this position – rather than only those who are already incurring severe financial strain – would help to alleviate the burden of caring and lower the risk of the carer developing depression themselves owing to the stress of their role.

Harnessing technology to improve access to care

Finland has become a global leader in digitalisation and eHealth, which put the healthcare system in a good position to handle disruptions caused by COVID-19

The federal government has invested heavily in eHealth and digitalising its services.[17] Finland ranks second in Europe and third globally on the 2021 Digital Quality of Life Index, which measures criteria such as internet affordability, internet quality, electronic security and electronic government.[53] As the COVID-19 pandemic impacted health systems and forced care delivery to move online, the country's history of innovation and digitalisation has paid dividends in helping to secure continuity of care.[9] Electronic prescriptions have been mandatory since 2017, and Kanta offers a dedicated service for a person's prescription history.[54] This supports clear communication between healthcare practitioners, pharmacists and patients, and reduces the risk of overlapping or incompatible medications.[54]

The use of telemedicine and digital tools is promoted to help treat mild and moderate depression, while research continues to explore new ways to harness digital technologies for care

Telemedicine, which had already been in use for many years, expanded considerably during the COVID-19 pandemic.[29] Duodecim recommends the use of internet-assisted therapies for mild and moderate depression, while noting that severe or psychotic depression must be treated in person.[12] Research is now exploring the applications of digital tools to help treat depression on a large scale. Innovations draw from a vast array of sources; for example, a research team at Aalto University is developing a computer game that could be used in the treatment of mild and moderate depression.[55] These technologies are of interest as they could be cost-effective and alleviate pressures on the demand for in-person and specialist care, allowing a system with limited capacity to concentrate its efforts on the most challenging and advanced cases of depression.

Data security is a sensitive topic in Finland and must remain a priority in all aspects of digital health

In 2020, the confidential records of more than 13,500 private psychotherapy patients in Finland were released on the dark web.[56 57] Clients who had used the services of Vastaamo, a company which ran 25 therapy centres across the country, found that the details of their sessions had not been properly secured when many began receiving blackmail threats.[58 59] When the hack came to the attention of authorities, it became one of the largest criminal cases in Finland's history.[56] The Ministry of Social Affairs and Health intervened to provide dedicated support to those affected by the security breach.[60 61] Fortunately, after an initial period of shock, fear and concern, confidence seems to have grown in regard to using digital therapies as part of depression care.[20] This incident underscores the imperative of keeping personal data secure and private within all digital and eHealth tools.

Conclusion and recommendations

> ‘Finland has some of the best standards of care for depression in the world, but we are reaching fewer than half of the people in need. Fundamentally, we need to direct more resources towards mental health, especially for primary care centres and care in the early stages of depression. This will allow many more people with depression to access this good care, and receive timely treatment and frequent follow-up until they are in remission.’
>
> **Jukka Kärkkäinen, Suomen Psykiatriyhdistys ja Terveyden ha hyvinvoinnin laitos**

Finland offers world-class depression care, but fewer than half of those in need may be receiving it

The country’s history of data collection and a long-standing prioritisation of reducing the burden of depression has led to robust depression care guidelines and a strong, digitalised repository of information related to mental health care. However, with three distinct streams of primary care and waiting times that may stretch to months, weaknesses remain. The Finnish government must ensure that every person seeking help for depression receives timely and appropriate care, regardless of which healthcare stream they use. Each person with depression should have regular contact with their treating physician until they are in remission, to accelerate recovery and improve adherence to therapies.

A spirit of innovation will remain key to closing the gaps in care

Increasing resources for mental health will be essential to address the burden of depression. The inclusion of digital therapies may help to contain costs, increase efficiencies and provide more people with a guideline-recommended standard of care. Rapid access to treatment is also likely to reduce the incidence of more challenging forms of depression, which in turn may alleviate the strain on specialist psychiatric services.

Priority recommendations

Joined-up and comprehensive depression services

- Ensure the current changes to the structure of healthcare support greater consistency between regions in terms of timely access to care and better coordination between primary and specialist care.
- Improve access to specialist care for users of the social and student healthcare streams of primary care, reducing waiting times and lowering thresholds for referrals.
- Appoint a government lead to ensure a 'mental health in all policies' approach is integrated across public sector decision-making.
- Consider setting a standard of consultations with a psychiatrist every two weeks for people with depression who require specialist care.

Data to drive improvements in depression care

- Implement the proposed digital database on evidence-based approaches to depression care, and ensure these data are accessible and comparable across the country.
- Standardise collection and use of the quality care indicators laid out in the depression care recommendations to evaluate and improve primary and specialist care of depression.

Engaging and empowering people with depression

- Develop formal roles for peer support and experts by experience in mental health care settings.
- Offer financial and practical support to all carers of people with depression, to relieve the pressures of caring.
- Include patient advocacy groups and associations representing families and carers in the working groups developing depression care policies and programmes at the health system level, to ensure their valuable expertise is captured in the planning phase.

Harnessing technology to improve access to depression care

- Continue to support digitalisation of healthcare, including remote consultations for people with mild or moderate depression, while ensuring access to in-person care for people with severe depression.

References

1. Centre for Suicide Prevention. 2015. *Depression and suicide prevention: resource toolkit.* Calgary: CSP
2. World Health Organization. 2017. *Depression and Other Common Mental Disorders Global Health Estimates.* Geneva: WHO
3. Kraus C, Kadriu B, Lanzenberger R, *et al.* 2019. Prognosis and improved outcomes in major depression: a review. *Transl Psychiatry* 9(1): 127
4. Tavormina MG, Tavormina R, Nemoianni E, *et al.* 2015. Aquestionnaire to assess social stigma. *Psychiatr Danub* 27 (Suppl 1): S328-31
5. Linder A, Gerdtham U-G, Trygg N, *et al.* 2019. Inequalities in the economic consequences of depression and anxiety in Europe: a systematic scoping review. *Eur J Public Health* 30(4): 767-77
6. Cuijpers P, Vogelzangs N, Twisk J, *et al.* 2014. Comprehensive Meta-Analysis of Excess Mortality in Depression in the General Community Versus Patients With Specific Illnesses. *Am J Psychiatry* 171(4): 453-62
7. World Health Organization Europe. Depression. Available from: https://www.euro.who.int/en/health-topics/noncommunicable-diseases/mental-health/areas-of-work/depression [Accessed 11/06/20]
8. Ng CWM, How CH, Ng YP. 2017. Depression in primary care: assessing suicide risk. *Singapore Med J* 58(2): 72-77
9. OECD/European Union. 2020. *Health at a Glance: Europe 2020: State of Health in the EU Cycle.* Paris: OECD Publishing
10. Santomauro DF, Mantilla Herrera AM, Shadid J, *et al.* 2021. Global prevalence and burden of depressive and anxiety disorders in 204 countries and territories in 2020 due to the COVID-19 pandemic. *The Lancet*: 10.1016/s0140-6736(21)02143-7
11. Global Health Data Exchange. 2021. Prevalence of depression 1990–2019. Available from: http://ghdx.healthdata.org/gbd-results-tool?params=gbd-api-2019-permalink/341b859ab54f6e55e3ecb852c0dec59d [Accessed 22/11/21]
12. Duodecim. 2021. Depression: current care recommendation. Available from: https://www.kaypahoito.fi/hoi50023?tab=suositus [Accessed 22/09/21]
13. World Health Organization. 2017. *Mental Health Atlas Member State Profile: Finland.* Geneva: WHO
14. OECD/European Union. 2018. *Health at a Glance: Europe 2018.* Paris: OECD Publishing
15. Saarni SI, Härkänen T, Sintonen H, *et al.* 2006. The impact of 29 chronic conditions on health-related quality of life: a general population survey in Finland using 15D and EQ-5D. *Qual Life Res* 15(8): 1403-14
16. Pirkola S. 2020. Editorial: The broad, collaborative New Mental Health Strategy in Finland. *Psychiatria Fennica* 51: 8-9
17. OECD & European Observatory on Health Systems and Policies. 2019. *State of Health in the EU: Finland Country Health Profile.* Paris: OECD
18. Ministry of Finance, Ministry of Social Affairs and Health, Ministry of the Interior. 2021. *Government proposal for health and social services reform and related legislation adopted by Parliament.* Helsinki: Government of Finland
19. Ministry of Social Affairs and Health. 2020. *National Mental health Strategy and Programme for Suicide Prevention 2020–2030.* Helsinki: Ministry of Social Affairs and Health
20. Kärkkäinen J. 2021. Interview with Catherine Whicher at The Health Policy Partnership [Teleconference]. 28/09/21
21. Mielenterveyspooli. 2021. Immediate access to therapy. Available from: https://mielenterveyspooli.fi/terapiatakuu/immediate-access-to-therapy/ [Accessed 15/11/21]
22. Beezhold J, Destrebecq F, grosse Holftorth M, *et al.* 2018. *A sustainable approach to depression: moving from words to actions.* London: The Health Policy Partnership
23. European Patients Forum. 2015. *EPF Background Brief: Patient Empowerment.* Brussels: EPF
24. Repper J, Carter T. 2011. A review of the literature on peer support in mental health services. *J Ment Health* 20(4): 392-411
25. European Commission. 2018. Tackling depression with digital tools. [Updated 04/06/18]. Available from: https://ec.europa.eu/research-and-innovation/en/projects/success-stories/all/tackling-depression-digital-tools [Accessed 06/11/20]
26. Hallgren KA, Bauer AM, Atkins DC. 2017. Digital technology and clinical decision making in depression treatment: Current findings and future opportunities. *Depress Anxiety* 34(6): 494-501
27. Prescott J, Hanley T, Ujhelyi K. 2017. Peer Communication in Online Mental Health Forums for Young People: Directional and Nondirectional Support. *JMIR Ment Health* 4(3): e29-e29

28. Ministry of Social Affairs and Health. 2021. Mental health services. Available from: https://stm.fi/en/mental-health-services [Accessed 22/11/21]

29. Jalava J, Korhonen O, Mettälä R. 2021. Interview with Catherine Whicher at The Health Policy Partnership [Written]. 12/11/21

30. Finnish Institute for Health and Welfare (THL). 2021. Health in all policies. Available from: https://thl.fi/en/web/management-of-health-and-wellbeing-promotion/management-of-wellbeing/practices/health-in-all-policies [Accessed 29/11/21]

31. Duodecim. 2021. Evidence-based medicine guidelines. Available from: https://www.terveysportti.fi/dtk/ebmg/home [Accessed 07/10/21]

32. Kärkkäinen J. 2022. Personal communication by email: 06/04/22

33. Hämäläinen J, Isometsä E, Sihvo S, *et al.* 2009. Treatment of major depressive disorder in the Finnish general population. *Depress Anxiety* 26(11): 1049-59

34. Hämäläinen J, Isometsä E, Sihvo S, *et al.* 2008. Use of health services for major depressive and anxiety disorders in Finland. *Depress Anxiety* 25(1): 27-37

35. Hämäläinen J, Isometsä E, Laukkala T, *et al.* 2004. Use of health services for major depressive episode in Finland. *J Affect Disord* 79(1-3): 105-12

36. Korhonen O. 2021. Personal communication by email: 13/12/21

37. Vuorilehto MS, Melartin TK, Riihimäki K, *et al.* 2016. Pharmacological and psychosocial treatment of depression in primary care: Low intensity and poor adherence and continuity. *J Affect Disord* 202: 145-52

38. Finnish Centre for Pensions (Eläketurvakeskus). 2021. Number of new disability pension recipients decreased in 2020. Available from: https://www.etk.fi/en/topical-issues/number-of-new-disability-pension-recipients-decreased-in-2020/ [Accessed 12/04/22]

39. Ministry of Social Affairs and Health. 2020. Mental health is valuable capital at workplaces. Available from: https://stm.fi/en/-/mielenterveys-on-tyopaikkojen-arvokkainta-paaomaa [Accessed 21/09/21]

40. Ollonen V. 2021. Interview with Catherine Whicher at The Health Policy Partnership [Teleconference]. 05/11/21

41. Partonen T. 2020. A new national suicide prevention programme in Finland. *Psychiatria Fennica* 51: 10-15

42. Finnish Institute for Health and Welfare (THL). 2021. Sotkanet: mental health data. Available from: https://sotkanet.fi/sotkanet/en/haku?g=199 [Accessed 22/11/21]

43. Duodecim. 2021. The Evidence-Based Medicine Electronic Decision Support (EBMEDS). Available from: https://www.duodecim.fi/english/products/ebmeds/ [Accessed 22/11/21]

44. Laitila M, Nummelin J, Kortteisto T, *et al.* 2018. Service users' views regarding user involvement in mental health services: A qualitative study. *Arch Psychiatr Nurs* 32(5): 695-701

45. Ollonen V. 2021. Personal communication by email: 09/12/21

46. Finnish Central Association for Mental Health. 2021. Home page. Available from: https://www.mtkl.fi/ [Accessed 23/11/21]

47. FinFami. 2021. Home page. Available from: https://finfami.fi [Accessed 23/11/21]

48. FinFami Varsinais-Suomen. 2021. Ask a young person. Available from: https://www.vsfinfami.fi/kysy-nuorelta/tietoa-ja-tyokaluja/ [Accessed 16/11/21]

49. FinFami Pirkanmaa. 2021. Pay attention to relatives model. Available from: https://www.finfamipirkanmaa.fi/huomioi-omaiset-malli/ [Accessed 16/11/21]

50. FinFami Pirkanmaa. 2021. Risk mapping tool for professionals. Available from: https://www.finfamipirkanmaa.fi/oppaat-ja-materiaalit/riskikartoitustyokalu-ammattilaisille/ [Accessed 16/11/21]

51. Kela. 2021. Disability pension and rehabilitation subsidy. Available from: https://www.kela.fi/web/en/disability-pension-and-rehabilitation-subsidy [Accessed 23/11/21]

52. Kela. 2021. Social assistance. Available from: https://www.kela.fi/web/en/social-assistance [Accessed 23/11/21]

53. Surfshark. 2021. 2021 Digital Quality of Life Index. Available from: https://surfshark.com/dql2021?country=FI [Accessed 22/09/21]

54. Peltoniemi T, Suomi R, Peura S, *et al.* 2021. Electronic prescription as a driver for digitalization in Finnish pharmacies. *BMC Health Serv Res* 21(1): 1017

55. DF Report. 2021. Computer game to treat depression being made [online]. *Daily Finland.* Available from: https://www.dailyfinland.fi/health/19732/Computer-game-to-treat-depression-being-made [Accessed 22/09/21]

56. Helsinki Times. 2020. HS: Vastaamo hacking could turn into largest criminal case in Finnish history [online]. *Helsinki Times.* Available from: https://www.helsinkitimes.fi/finland/finland-news/domestic/18243-hs-vastaamo-hacking-could-turn-into-largest-criminal-case-in-finnish-history.html [Accessed 22/09/21]

57. AFP in Helsinki. 2020. 'Shocking' hack of psychotherapy records in Finland affects thousands. *The Guardian*. Available from: https://www.theguardian.com/world/2020/oct/26/tens-of-thousands-psychotherapy-records-hacked-in-finland

58. WIRED Magazine. 2020. A dying man, a therapist and the ransomraid that shook the world. Available from: https://www.wired.co.uk/article/finland-mental-health-data-breach-vastaamo [Accessed 22/09/21]

59. WIRED Magazine. 2021. They told their therapists everything. Hackers leaked it all. Available from: https://www.wired.com/story/vastaamo-psychotherapy-patients-hack-data-breach/ [Accessed 22/09/21]

60. Ministry of Social Affairs and Health. 2020. People need help quickly in times of crisis. Available from: https://stm.fi/en/-/people-need-help-quickly-in-times-of-crisis [Accessed 22/09/21]

61. Ministry of Social Affairs and Health. 2020. Where to get help for victims of recent data breach at Psychotherapy Centre Vastaamo — a list of key organisations providing help. Available from: https://stm.fi/-/mista-apua-vastaamo-tietomurron-uhreille-lista-tarkeimmista-avuntarjoajista?languageId=en_US [Accessed 22/09/21]

For more information about this scorecard, please contact
Jody Tate, Director of Research at The Health Policy Partnership
jody.tate@hpolicy.com

The Health Policy Partnership
68–69 St Martin's Lane
London WC2N 4JS
United Kingdom

The Health Policy Partnership

CP-359630