Country Profile "FINLAND"

Suicide and Suicide Prevention: Key Facts and National Priorities

Author(s):	Lead author: *Pia Solin* Co-authors: *Timo Partonen*
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Contents

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Introduction

The EU-Co-funded "Joint Action on Implementation of Best Practices in the area of Mental Health", short **JA ImpleMENTAL** has a duration of 3 years, lasting from October 2021 to September 2024. Detailed information can be found at the project's website JA ImpleMENTAL ja-implemental.eu. It aims to promote and improve mental health structures, services, capacity and outcomes in participating countries in 2 specific areas:

- mental health reform (promoting community health services)
- suicide prevention.

Two national best practices - mental health reform in Belgium and the Austrian suicide prevention programme SUPRA - serve as best practice examples. Selected components of these should be prioritised and implemented over the course of the JA in 14 i.e. 17 participating EU-countries. JA ImpleMENTAL comprises 6 Work Packages (WPs), 4 horizontal WPS and one for each best practice. **WP6 on suicide prevention** aims to support improvement in knowledge and quality of suicide prevention services. Defined elements of SUPRA should be transferred and pilot implemented at national/regional level, suicide prevention strategies in participating countries developed, i.e., revised.

The present country profile is one of the major deliverables of the JA, presenting national priorities for suicide prevention embedded in contextually relevant facts. It summarizes results of the national Situation- and Needs Assessment (SANA), lists lessons learned, recommendations and prioritized measures for suicide prevention. It includes challenges and opportunities as well as outlining next steps necessary to scale-up i.e. promote national/regional suicide prevention activities. The country profile is a basis for strategy formulation, for decision-making and a declaration of commitment to suicide prevention.

1 Context

1.1 Country, Health and Social System

Finland is a republic Nordic country in Northern Europe, which covers an area of 338,455 square kilometres with 5,563,970 inhabitants (see Table 1 next page). Helsinki is the capital and largest city. The vast majority of the population are ethnic Finns. Finnish and Swedish are the official languages.

The Finnish health system in Finland was restructured in the beginning of 2023. This new structure health care was organized by 22 Wellbeing Service Counties (WBSC), which are governed by democratically elected councils and are financed from the state budget. Municipalities, which were responsible for organizing health care and social services until the end of 2022, remain responsible for public health functions (e.g., environmental health and health protection). For health promotion and well-being programmes, municipalities collaborate with the WBSC's. The WBSC's are responsible for organizing primary and secondary health care as well as social and rescue services for their residents. The WBSC's belong to one of five collaborative areas, which are organized around five university hospitals. Legislation and general policy guidelines are prepared at the national level by the Ministry of Social Affairs and Health (MSAH). The new health system structure aims to strengthen the strategic role of the central government including steering the WBSCs in how they organize services through recommendations, and supporting collaboration between the counties through collaborative area agreements (2).

Table 1: Population, 2022, by age (5-year) and sex (1).

	Sex		
Age group	**male**	**female**	**total**
<19	587 083	561 205	1 148 288
20–64	1 592 601	1 528 570	3 121 171
65+	573 793	720 718	1 294 511
Total	**2 753 477**	**2 810 493**	**5 563 970**

Healthy life expectancy at birth is 78 (80 for females and 76.1 for males), and 18.3 at age 65 (3). A total of 15.6% of the population is at risk of poverty and social exclusion (4). Income inequality in 2022, expressed as the Gini coefficient, was 26.6 (5), and total healthcare expenditure relative to GDP is 9.61% (6).

Finland's healthcare and social welfare system is founded on public healthcare and social welfare services supported by government funds. According to the Constitution of Finland, the public authorities shall guarantee for everyone adequate social, health and medical services. Alongside the public sector, private companies provide services. Finland also has an extensive network of non-governmental healthcare and social welfare organisations that provide services both free of charge and for a fee.

1.2 Mental Health System

Finland has National Mental Health Strategy and Suicide Prevention Agenda 2020–2030 which are based on long-term preparations and broad-based collaboration. The strategy has five priority areas: mental health as capital, mental health of children and young people, mental health rights, services and mental health management. Suicide prevention agenda, which is included in the strategy has 36 measures in the areas of 1) awareness raising, 2) impacting the means of suicide, 3) early intervention, 4) supporting risk groups, 5) developing care options, 6) increasing media competence, and 7) strengthening knowledge basis and research (7).

The government's total expenditure on mental health was 6.3% of (as % of total public health expenditure) in 2020 (atlas). The total expenditure on mental hospitals was 84.9% (as % of total government mental health expenditure). The number of mental health workers per 100,000 population has increased from 99.2 in 2014 to 222.17 in 2020. The total number of admissions in mental hospitals was 499. There was 86 involuntary admissions. There is a follow-up for more than 75% of people with mental health condition discharged from hospital in the last year (discharged persons seen within a month). Finland has a dedicated authority for undertaking regular inspections on mental health legislation. It also responds to complaints and reports its findings at least once a year (8).

The care and treatment of persons with mental health conditions (psychosis, bipolar disorder, depression) is included in national health insurance or reimbursement schemes in Finland. Persons with mental health conditions pay at least 20% towards the cost of services or medicines. Number of community-based mental health facilities is 8.33 per 100,000 population (8). In Finland, 7.4% of people reported unmet mental health care needs due to financial reasons (9).

There are 41 mental health outpatient facilities attached to a hospital and 309 Community-based/non-hospital mental health outpatient facility. Furthermore, there are 36 outpatient facilities specifically for children and adolescents (8). Mental health inpatient care facilities, number of beds and hospital admissions can be found in Table 2.

The information about the main forms of government social support available for persons with severe mental health conditions is not collected in Finland.

Table 2: Facilities, number of beds and hospital admissions related to mental health, latest available year (8).

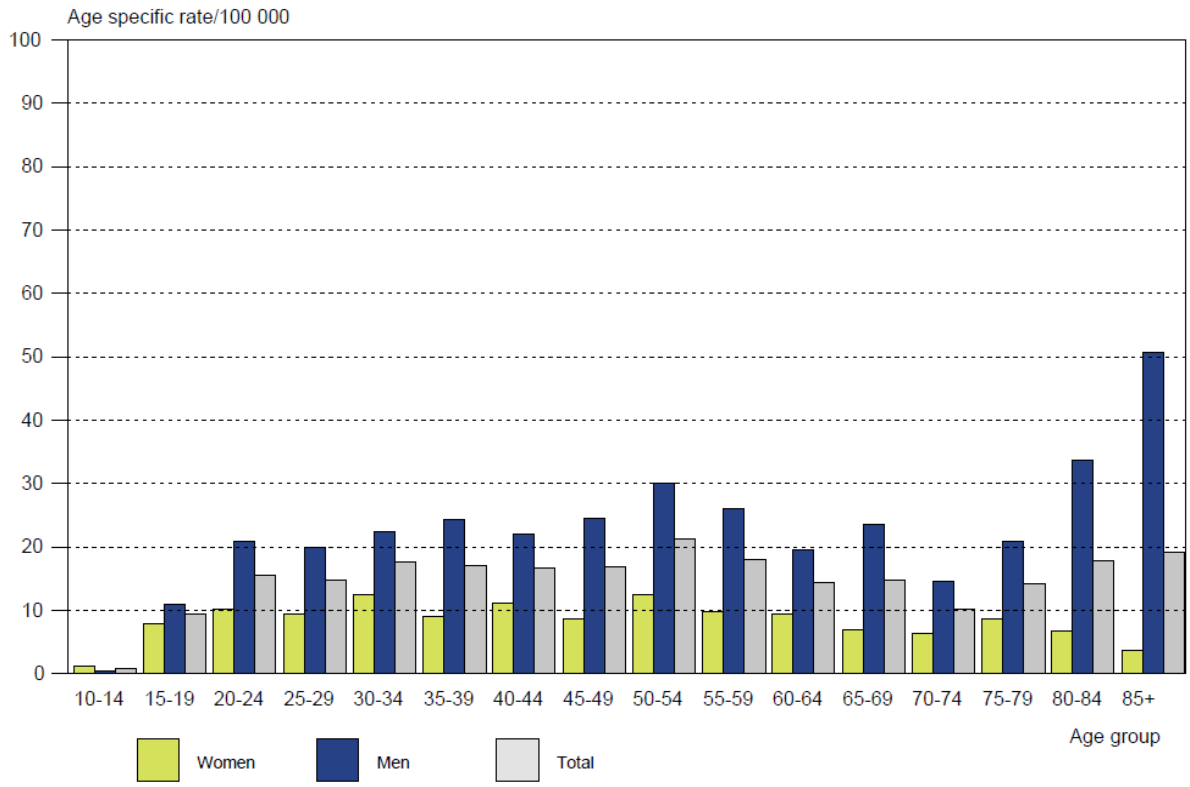
Indicator at national level		number	rate per 100,000 adult/minor population
Mental health hospitals	Facilities	3	-
	Beds	-	8.06
	Admissions	-	9.02
Psychiatric wards/units in general hospitals	Wards/units	31	-
	Beds	-	39.75
	Admissions	-	567.03
Mental health inpatient facilities specifically for children and adolescents	Facilities	24	-
	Beds	-	26.74
	Admissions	-	467.10

2 Suicide and Suicide Prevention

2.1 Situation Analysis (SA)

Statistics on suicide mortality have been compiled in Finland since 1751. Statistics Finland, as an independently acting government agency in the administrative sector of the Ministry of Finance, produces the Official Statistics of Finland on causes of death and releases the annual data in December. The sources of statistics data are the record on deaths obtained from the national Population Information System and death certificates written by medical doctors. The current situation of suicide mortality in Finland is presented by age groups and sex (see Figure 1 opposite page).

Figure 1: Suicide rate, 2021, by age groups and sex (10).

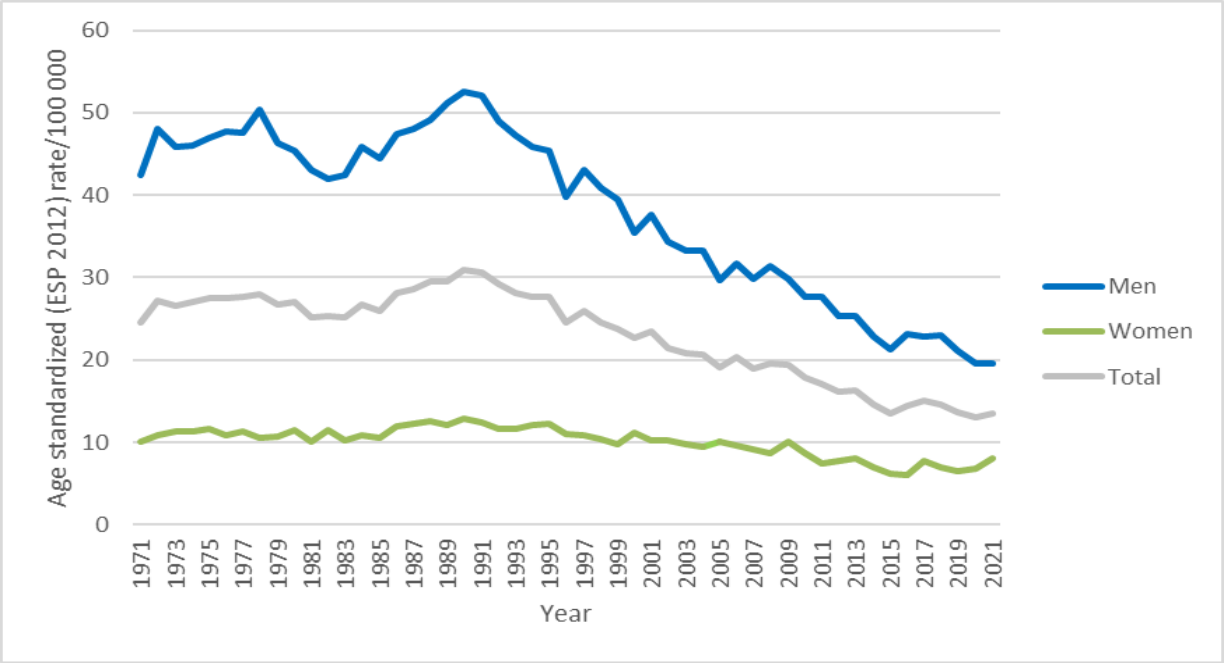


Deaths due to suicide as well as those being suspected as suicides are subject to the cause of death investigation by police together with independently acting medical professionals of forensic medicine and sourced from the Forensic Medicine Unit of the Finnish Institute for Health and Welfare, the national legal authority which is in charge of guiding and monitoring the official cause of death investigations as well as carrying out forensic autopsies conducted by medical doctors as specialists in forensic medicine and with analysis of forensic toxicology samples, and verifies death certificates in Finland.

Furthermore, statistical data, including suicide mortality rates are available per region and by age group from the Sotkanet Indicator Bank which offers key population welfare and health data on all municipalities of Finland, and the Potential Years of Life Lost (PYLL) index are available from the Welfare Compass provided by the Finnish Institute for Health and Welfare, although there is a delay in publishing the data on current situation. All these data are based on the Official Statistics of Finland.

Suicide rates have decreased more than by half since 1990 (see Figure 2 next page). The turn to this positive trend occurred during the first national Suicide Prevention Project in 1986–1996 (12).

Figure 2: Suicide deaths trend, 1971–2021, by sex (11).



Currently, from 2016 to 2021, the number of deaths due to suicide was significantly decreased among men, whereas there was no statistical change among women (10). Hanging has thus far been the most common method of suicide every year, as it was in 2021 (see Table 3 below). Among women aged 20 to 79 years, hanging was second to self-poisoning by prescription medicines as the most common method of suicide.

There is no official data about hospitalization due to self-harm or the most common methods of self-harm with or without a suicidal intent.

Table 3: Most common methods of suicide: 2021, by age group and sex (13).

Sex/Age	0–19 y	20–39 y	40–59 y	60–79 y	80+ y
Women	1. hanging (71%) 2. railway (14%) 3. firearms (7%)	1. poisoning (35%) 2. hanging (28%) 3. high place (17%)	1. poisoning (44%) 2. hanging (29%) 3. drowning (8%)	1. poisoning (57%) 2. hanging (17%) 3. drowning (13%)	1. hanging (36%) 1. poisoning (36%) 3. high place (18%)
Men	1. hanging (61%) 2. high place (11%) 3. firearms (6%)	1. hanging (46%) 2. firearms (13%) 2. high place (13%)	1. hanging (34%) 2. firearms (23%) 3. poisoning (20%)	1. hanging (37%) 2. firearms (30%) 3. poisoning (15%)	1. hanging (52%) 2. firearms (20%) 3. poisoning (8%)
All	1. hanging (66%) 2. railway (9%) 3. firearms (6%)	1. hanging (40%) 2. poisoning (18%) 3. high place (14%)	1. hanging (33%) 2. poisoning (27%) 3. firearms (17%)	1. hanging (31%) 2. poisoning (28%) 3. firearms (21%)	1. hanging (49%) 2. firearms (16%) 3. poisoning (13%)

Group 1. Men aged 90–99 years.

Group 2. Women aged 30–39 years.

Group 3. Youth aged 20–24 years.

Group 4. Those with previous suicide attempt.

Group 5. Family members bereaved by suicide.

Box 1: Groups most vulnerable to suicide (7,10)

The national Mental Health Strategy and Programme for Suicide Prevention 2020–2030 (7) are based on long-term preparations and broad-based collaboration (7). The separate, goal-oriented suicide prevention programme contains 36 measures in areas of 1) awareness raising, 2) impacting the means of suicide, 3) early intervention, 4) supporting risk groups, 5) developing care options, 6) increasing media competence, and 7) strengthening knowledge basis and research. There were three proposals for the indicators: 1) real-time monitoring of suicide mortality and means of suicide in different population groups and geographical regions are followed up via the information system within forensic medicine, 2) healthcare registers are used to establish number of suicide attempts and means of suicide in different population groups and different geographical regions, and 3) healthcare quality registers are used to monitor the number of patients (by diagnosis) receiving outpatient services within 7 days of being discharged from a hospital. Currently, the first indicator is in use by the Finnish Institute for Health and Welfare, whereas the latter two indicators are under planning.

Moreover, there are five regional projects being funded by the Ministry of Social Affairs and Health for 2021–2023 that are implementing the actions as written in the national Programme for Suicide Prevention in their grass-roots activity. The regional projects develop their best practices and upload them as products to Innokylä, which is an open online environment for sharing of knowledge and co-creation, operated by the Ministry of Social Affairs and Health, the Finnish Institute for Health and Welfare, SOSTE Finnish Federation for Social Affairs and Health ry which acts as the umbrella for more than 240 members of non-governmental organisations in social affairs and healthcare, and the Association of Finnish Municipalities ry. This approach connects programme goals with implementation and ensures that the objectives remain active, and that information and data are collected systematically and in a timely manner.

There are service administrators for voluntary telephone and online help which are members of the national Advisory Board on Ethical Principles for Telephone and Online Helping. Non-governmental organisation Mannerheim League for Child Welfare ry provides the national helplines for parents as well as children and adolescents. Non-governmental organisation MIELI Mental Health Finland ry provides the national online crisis hotline (Crisis Helpline), which operates in Finnish on 24/7/365 basis and in several other languages in less hours, and has a network of crisis centres operated by local associations. Non-governmental organisation Surunauha ry supports those who have lost their loved one to suicide and provides online support via telephone, message board, and peer-group chats.

Some universities have included suicide prevention training in specialized studies for their medical students, which was provided by the Finnish Institute for Health and Welfare. In addition, the Finnish Institute for Health and Welfare gave suicide prevention training for over 2000 social and health care professionals during 2018–2019. Having completed this action, the Finnish Institute for Health and Welfare developed an online suicide prevention training course, which is targeted to professionals working in the social affairs and healthcare but available to anyone free of charge, and furthermore Police University College and Finnish Institute for Health and Welfare co-created an online suicide

prevention training course for police officers and students. Non-governmental organisation MIELI Mental Health Finland ry also provides suicide prevention training courses to professional groups as well as to interested citizens with a fee.

2.2 Needs Assessment (NA)

Needs assessment and SWOT analysis (see Table 4 below) based on it showed several strenths and weaknesses in current Finnish suicide prevention as well as in future. One of the major strengths is the current National mental health strategy and suicide prevention programme, which was launched 2020. Thus the political will as well as allocated resources were available to develop new and promote current suicide prevention activities more thoroughly. Actors and professionals in the areas of mental health and suicide prevention are very motivated to collaborate towards suicide prevention actions.

Due to Finnish parliamentary election in April 2023, the mental health focal points, including suicide prevention, for next 4 years are still in process. Scarse financial situation may lead to situation that other societal issues may be prioritized. Effective suicide prevention actions as well as decisionmaking in favour of them, needs research and real-time monitoring of the issue.

Table 4: SWOT analysis.

Factor	Contents					
Strengths	1. National mental health strategy and suicide prevention programme 2020–2030	2. Close collaboration with the Ministry of Social Affairs and Health and non-governmental organisations	3. National coordinating network for suicide prevention work	4. Annual release on the official national statistics on causes of death	5. Regional suicide prevention projects funded by the national suicide prevention programme	6. Interest and motivation on suicide prevention among different professsions
Weaknesses	1. Relatively short period for implementation by the regional suicide prevention projects	2. Staff turnover	3. Missing data on suicide attempts	4. Missing data on emergency medicine reports	5. Shortage of collaboration across administrative sectors	6. Fragmentation of computerized medical records systems
Opportunities	1. Nordic ministerial working group for mental health	2. Collaboration with Nordic countries	3. EU Joint Action ImpleMENTAL and other international suicide projects	4. Well-known stakeholders	5. Active mental health non governmental organisations	6. Building up data lakes for real-time monitoring
Threats	1. Loss of support to suicide prevention and mental health promotion	2. Inadequate resources for research and development	3. Negative attitudes against mental health issues	4. Loss of key actors and champions in suicide prevention	5. Collapse of social welfare and health care	6. Strengthening of positive attitudes to violence and suicide

3 Reflection on SANA results

In order to improve the current situation among the vulnerable groups (see Box 1 on page 6), it is necessary to:

- have real-time data, for example, on emergency medicine reports
- provide information and increase knowledge about suicide prevention for gate keeper professions (for example, provide training for emergency care personnel)
- enhance collaboration with family members bereaved by suicide (see Box 2 below).

Success factors/facilitators

- national Mental Health Strategy and Suicide Prevention Programme
- JA ImpleMENTAL outputs and deliverables
- existing networks and partners for multisectoral collaboration
- interest of professionals and work force outside health care
- utilising existing channels, actions and outputs and up-scaling them (not re-inventing the wheel)
- involvement of people with lived experience.

Barriers

- changes in prioritization of societal issues
- uncertain allocation of resources
- stigma.

Box 2: Prioritized measures for implementation according to the SUPRA columns

Column 2: People at risk of suicide and risk groups are supported or treated as needed and strategic and

Column 4: Awareness and knowledge of suicidality and about coping with psychosocial crises are widespread among the general population)

- Focused suicide prevention training for new professional groups

Column 6: Suicide prevention is quality-assured on the basis of scientific expertise

- Research on the background factors of recent suicides.

QUICK WINS

Column 4: Awareness and knowledge of suicidality and about coping with psychosocial crises are widespread among the general population)

Quick win 1: Update current online training course of suicide prevention.

Column 6: Suicide prevention is quality-assured on the basis of scientific expertise

Quick win 2: Build up the current sources of data to a data lake for use.

4 Next steps

Finland had a parliamentary elections in April 2023, and currently a new government is about to be formed. Due to this, the governmental priorities in suicide prevention and mental health issues for the next 4 years are yet to be decided.

Taking this momentary uncertainty into consideration, proceeding with quick wins in the mean time allows taking actions in suicide prevention. Continuation of suicide prevention training for social and health care personnel and police officers and providing training to new professions, such as emergency care personnel, is carried on. Building up the current sources of data to a data lake is also important.

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Corresponding authors

Chief specialist Pia Solin

pia.solin@thl.fi

Research professor Timo Partonen

timo.partonen@thl.fi

Mental Health Team, Equality Unit, Department of Public Health and Welfare, Finnish Institute for Health and Welfare (THL)