Service Users and Experts in Finnish Mental Health Care Planning: Three Phases of Expansion and Inclusion

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Abstract

The article examines the roles of experts and service users in Finnish mental health care planning over the past fifty years. It analyses the expansion of mental health care as a societal question and suggests that the governing narrative of a clear-cut general medicalization and expert-drivenness needs to be reassessed. The analysis points out three distinct trends in terms of experts' and service users' roles. From the 1960s to the 1980s, mental health policy documents discussed the inclusion of a greater number of voluntary and healthier users of psychiatric treatment and practice. During the 1990s, the position of mental health care service users shifted from being a matter for specialists to being part of general and basic welfare services such as primary health care. The policy documents from this second phase also emphasize the need for professionals to refrain from taking expert positions. A third phase began in the 2000s highlighting the value of "user expertise" – a perspective embedding the idea of service users as the experts in mental health care. The views of expertise in the second and particularly the third phases contradict the traditional emphasis on the expertise of health care professionals.

KEYWORDS: Finland, medicalization, mental health policy, psychiatry, service users.

Introduction

In the past fifty years the number of Finns receiving hospital treatment for mental health problems has decreased tremendously, while the number using outpatient mental health services has increased even more dramatically. The number of psychiatric hospital beds has been reduced to one-sixth of its previous count: from nearly 20,000 in the mid-sixties and seventies (OSF 1994) to the current number of around 3,000 (OSF 2016). At the same time, other types of mental health service provision and use have multiplied, including the use of psycho-pharmaceuticals, especially prescriptions of so-called third generation antidepressants (Selective serotonin re-uptake inhibitors, SSRI). While there are no records of client's private out-of-pocket spending on mental health services, which is likely to be substantial, the

Finnish National Insurance Institution was reimbursing psychotherapy for 31 410 persons in 2016 and for psycho-pharmaceutical drugs for 789 000 persons in 2015 (NII 2017; Partio 2016). The corresponding numbers from previous decades show a different picture; in 1980, 589 people in Finland were compensated for psychotherapy (NII 2016). The use of psycho-pharmaceuticals has also accumulated in recent decennia. Since the 1990s, it started to grow particularly due to the growth of the use of antidepressants (Hautamäki, Helén & Kanula 2011; Saastamoinen 2016).

This article sheds light on these rather rapid developments in Finnish mental health policies. It explores how the positions of experts and service users have been articulated in the country's mental health policy planning documents from the 1960s to the 2010s. There is a long history of different experts and particularly medical expertise influencing policy-making in the Nordic welfare states (Lundqvist & Petersen 2010; concerning psychiatrists see Ludvigsen 2010). The objective of this article is to elaborate notions of experts' positions and influence. By distinguishing "psychiatrization", "medicalization" and "(psycho)pharmaceuticalization" as different trends, we provide evidence of simultaneous signs of a growing (psycho)pharmaceuticalization and yet a *de*psychiatrization during the studied period. Moreover, we will show that the often broadly employed notion of "medicalization" alone is not a sufficient descriptor of the developments, as the concept is able to encompass both trends, eclipsing the paradox of a simultaneous psycho-pharmaceuticalization and a depsychiatrization.

Mental health policies today typically express the view that mild, moderate, and partly under-diagnosed mental health problems are widespread and a burden on the economy primarily through the loss of working years. There is also a consensus in the current policies that these are problems to which societies should pay more attention, for example through mental health promotion and supply of primary care. This standpoint has been salient on the international level, pronounced for example by the European Commission (EC 2005; 2008 and the World Health Organization (WHO 2001; 2004; 2015). Furthermore, there has been an increased emphasis on psycho-pharmacological treatment (for example, Rose 2004; 2007) and service user empowerment (Beresford 2005; Hickey & Kipping 1998). Prescribing medical drugs for a broadening spectrum of mental health problems, often referred to as a general "pharmaceuticalization" trend (Williams, Martin & Gabe 2009), has been criticized for giving pharmaceutical companies influence over mental health policies' content and schemes (Abraham 2010a), and for causing unnecessary dependency on medical drugs among a large segment of the population (Abraham 2010b).

Generally speaking, the developments in Finnish mental health policies show great resemblance with those in other Western countries; the country has witnessed a general dehospitalization trend and an increased focus on prevention (Bergmark, Bejerholm & Markström 2017; Helén, Hämäläinen & Metteri 2011; cf. Conrad & Schneider 1992, 66–67). The main goals of the Finnish mental health policy of the last few decades have involved an expansion of the target group and a general dehospitalization or deinstitutionalization of mental health service users. A rather recently introduced angle is the widening of the conceptual scope from targeting the ill to promoting mental health in the population as a whole (for example, Helén, Hämäläinen & Metteri 2011; cf. Markström 2014).

The increased focus on a widespread prevalence of mental health problems and the simultaneous increase in the prescription of medical drugs in mental health policies and practices have been interpreted as strengthening the authority of certain experts, implying a "psychiatrization" (Rose

2006), a "medicalization" (Vilhelmsson, Svensson & Meeuwisse 2011) or a "pharmaceuticalization" (Hautamäki, Helén & Kanula 2011). This study shows that Finnish mental health policies, around the time of the turn of the new millennium, have had the paradoxical tendency of downplaying the expertise of professionals in medical and other health and social care while expanding the target group to include a larger part of the population as both likely and actual problem holders.

A clear-cut pharmaceuticalization of mental health governance in today's Finland concerns the increase in drug prescription, particularly antidepressant prescriptions, increasingly carried out by general practitioners, not only by psychiatric specialists (Hautamäki, Helén & Kanula 2011). The widespread use of antidepressants is a noticeable example of how a pharmaceuticalization of the societal problem of mental health can coincide with a depsychiatrization trend: the pharmaceuticalization of the treatment of depression has mainly been accomplished in the field of general practice, not in specialized psychiatric treatment. Olafsdottir (2011) has claimed that the pharmaceuticalization of mental health care within primary care might be less complex to grasp from a stakeholders' perspective. The trend is usually heavily stimulated by a pharmaceutical industry driven by commercial interests and technological imperatives. In addition, considering that a pharmaceuticalization of mental health care correlates with a policy emphasis on outpatient care, it seems to be logically intertwined with the dehospitalization trend. Advancements in antipsychotic medication have even been seen as a direct reason for diminishing the need for psychiatric hospital treatment (e.g. Shorter 1997).

In the next section we paint a backdrop of the scholarly discussion on the recent discussion of mental health care service users, after which we give an account of our analysis. At the end of the article, we draw conclusions regarding the implications of the role divisions between expertise positions during the studied time period.

Changing Perceptions of Mental Health Service Users

A central circumstance for understanding mental health policy developments concerns the ways in which the people perceived as needing the services are viewed and enounced in policies. Psychiatric dehospitalization was influenced by the social equality and egalitarian movement of the 1960s, particularly "social psychiatry", which demanded respect for the agency of those suffering from mental health problems and thereby shifting the attention away from the ill individual to the societal structures. Such claims arose in many countries simultaneously and are today, especially in Anglo-American contexts, blended into the so-called "service user/ survivor movement".

"User involvement" generally touches on the participation of service users in decision-making:

> The term "service user/survivor movement" refers to the work of individuals who advocate for their personal and collective rights within the context of discrimination faced as a result of having experienced mental health difficulties and/ or being diagnosed as having a mental illness (Wallcraft & Bryant 2003, 3).

A pioneer country for the service user movement has been the UK, where the first organization of service user groups can be dated to the 1970s when groups critical of psychiatry began to form collaborations between service users and experts (Wallcraft & Bryant 2003, 3). In the late 1980s, the movement in the UK was heavily influenced by the rise of the survivor movement in the U.S. (ibid.). The service user movement has since been integrated as an almost self-evident component into the official healthcare systems in several countries (Tritter et al. 2010).

By shifting and sharing power in decision-making through the inclusion of service users, the users are seen to be empowered with greater influence over decisions that affect them (Hickey & Kipping 1998, 84). While there are various modes, levels and areas of user involvement, the claims of its importance can basically be boiled down to a usefulness of an inside perspective on the part of those concerned and an ethical respect for the integrity and agency of people with mental health problems (e.g. Fox 2008; Tait & Lester 2005).

The user involvement's emphasis on experience and influence over one's own destiny has often been seen as contrary to a medicalized and positivist framing of "true knowledge" or outsider-experts' assumptions of the nature of the problems (Borg, Karlsson & Kim 2009). User involvement has been viewed on an historical continuum whereby the use of power in psychiatry has been criticized (Hopton 2006). An important conceptualization at the heart of user movements has been that mental health problems should be seen as disabilities among other (physical) disabilities (for example, Beresford 2005).

In Finland the service users' movement is rather recent and has especially been developed in the 2000s in projects within the service user organisation known as the Central Association of Mental Health (Salo 2011). The mental health policy programme MIND (in Finnish, *Mieli 2009*) was the first to raise "user expertise" concept to the policy level (MSAH 2009; MSAH 2010). The developments that preceded this development will be accounted for in the analysis section.

Data and Methods

This study takes influence from approaches employed in the tradition of governmentality studies (methodologically, see Bacchi 2009). The theoretical point of departure is that understandings of problems fluctuate historically and that these understandings are intertwined with policy interventions and their adherent power allocation. The data is analysed as representative of the governmental rationality of the time, and who produces the text is seen as of secondary importance. We performed a qualitative document analysis looking for problem formulations and their implications for subjectivities in different times. A corpus of the most significant policy documents concerning the development of mental health policy in Finland were sampled from a period that spans from the 1960s up until the present. During this time, the Ministry for Social Affairs and Health and the organizations under its auspices, such as the National Institute for Health and Welfare, have produced numerous publications on mental health policy. Furthermore, the legislation concerning mental health care has been amended several times; around such efforts there is a great deal of documentation of the ways in which mental health questions have been viewed at different times. We chose to sample documents that would include comprehensive aims to reform the country's mental health policy as a whole (cf. Bergmark, Bejerholm & Markström 2017), ending up with 12 documents consisting of committee memoranda, law proposals, mental health policy planning documents and assessments of mental health policy programmes. The analysed documents are presented in detail in Table 1.

We analysed the documents for i) ways in which mental health has been outlined as a problem, ii) who is seen as the target group of the policies, and iii) how expertise in mental health policies is viewed and articulated.

As the material under study consists of documents which define problems and envision their solutions, we asked what is viewed as possible,

TABLE I. The documents (N=12) analysed in the study. Title, background and length in pages.

ABBREVIATION	TITLE	BACKGROUND AND AIM	LENGTH IN PAGES
CR1964	Committee Report 1964	Report from a committee appointed for renewing the Mental Illness Act from 1953.	73
GP1976	Government proposal 1976	Government bill for changing the contents of the Mental Illness Act.	24
NBoH 1977	National Board of Health working group memorandum 1977	Memorandum of a task force appointed to renew Finnish psychiatric health care.	73
CR 1984	Committee Report	Committee report reviewing the history, current situation and the ideal future of mental health in Finland, including a proposal for a new mental health care work act.	Parts I and II altogether 706
GP 1989	Government proposal 1989	Government bill suggesting a new Mental Health Act.	30
Taipale 1996	Meaningful Life report	A one-person committee report by Vappu Taipale regarding the situation of mental health care after the 1990s recession.	72
MSAH 2002	From Structures to substance, from words to actions! Mental health in primary services – Swallow	End report from a programme suggesting education in mental health work for all social and health care frontline workers.	93
MSAH 2003	Meaningful Life! programme 2003	End report from the Meaningful Life programme attempting to solve the problems generated during the recession.	137
Motion 2004	National Mental Health Programme	A parliamentary motion suggesting a programme to ensure that everyone in Finland would get the mental health treatment they need.	1
MSAH 2009 (original) MSAH 2010 (English translation)	‘MIND 2009 [Mieli 2009]. Plan for mental health and Substance abuse work 2009–2015.	National policy programme intended to renew mental health care according to the needs of the Finnish population. Includes a suggestion to merge mental health and substance abuse care.	46
NIHW 2015	Plan for Mental Health and Substance Abuse Work 2009–2015. How to proceed from here?	Final report of the MIND programme	380
MSAH 2016	Plan for mental health and substance abuse work for 2009–2015. Final assessment of the plan and proposals of the steering group	Assessment report containing the assessment of the steering group of the programme as well as the assessment of outside experts.	111
		Total:	1,745

inevitable or contingent in view of actors' roles and their abilities to contribute to a solution to the problems (see Roberts et al. 2010; Sulkunen & Törrönen 1997). This procedure helped us place the discourses in their ideal historical political context, and it helped us to separate three main phases in the policy developments. These phases will be accounted for in the analysis section.

The analysis was conducted by reading the documents and identifying the basic problem definitions and their adherent key subjectivities (see also Alanko & Marklund 2013). In the second phase, the excerpts discussing expertise were selected for closer analysis. The procedure was to some degree similar to that of "coding" used in grounded theory and computer assisted text analysis, but analysing the data without a rigid coding system allowed us to take into account the variations between and within the documents and grasp the main rationale within a certain document and time period.

Analysis: Three Phases of Expansion and Inclusion

The policy documents from the *first* phase (1960s–1980s) were intended to replace the country's extensive hospital treatment with a combination of substantial support for former hospital patients and comprehensive public health work (Alanko & Marklund 2013; Korkeila 1998; Lehtinen & Taipale 2001). In the *second* phase, the 1990s, Finnish mental health care entered a complex stage: the long ongoing process of dehospitalization was affected by the general economic recession (see for example Alanko & Outinen 2016). At the same time, the health administration system was reformed, the autonomy of local municipalities increased significantly and the administration of psychiatry was merged with other health care administration (see Hämäläinen & Metteri 2011; Kröger 2011; Kärkkäinen 2004). The *third* phase began in the 2000s when policies continued to emphasize previous priorities but, as a novelty, "user experts" were called in to solve the perceived problems of mental health care. Each of these three phases involves distinct formulations of the problems and the roles of experts and users.

Broadening the Usership

During the first phase, from circa 1960 up to the 1980s, the scope of Finnish mental health care was actively broadened to include anyone suffering from mental health problems, not only the severely ill. The understanding of the "problem" was that mental health care focused too much on mental illness and that people outside the psychiatric hospitals could also be in need of mental health care. This first phase concurred with an era of a generally expansive welfare policy (e.g. Hellman, Monni & Alanko 2017; Julkunen 2001).

In 1964 a committee appointed to renew the 1953 Mental Illness Act presented a report recommending that the names and the focus of mental health legislation and mental health care be reorientated from an emphasis on illness to an emphasis on health. These suggestions were seen as inevitable in order for the system to keep psychiatric hospital treatment at a minimum and redistribute resources to serve a wider group of citizens. The idea was to include the treatment of milder conditions and concerns, not only "mental illnesses" proper. In the committee statement, the definition of mental health care is expanded to encompass a larger part of the population, with a less specialized and less separated care and treatment system envisioned:

> There is no reason for seeing mental health illnesses in another position than other illnesses. Instead of a Mental Illness Act, it is suggested that the law should be named the Mental Health Act, which is a more accurate description in line both with current concepts of prevention and treatment

> in this area, and with the aim of broadening the jurisdiction of the law. (CR 1964, 3.)

While the potential service user group was expanding, the treatment expertise would remain the same: the focus was still strictly on the kinds of treatment driven and implemented by the psychiatric profession. The committee pointed out that recently, a growing numbers of people had voluntarily sought mental health treatment in psychiatric hospitals, and it emphasized the importance of guaranteeing these people a position equal to that of any other citizen. In addition, it actively emphasized avoiding exposing the new group of voluntary help seekers to involuntary treatment. (CR 1964, 13–14.)

The suggestions by the 1964 committee were not enacted. Nevertheless, the content was reiterated in the subsequent mental health care initiatives, where a common aim after the 1960s was that everyone in need of mental health treatment would be cared for, not *only* those perceived to be severely ill (GP1976; NBOH 1977; CR 1984). In the government bill from 1976, a core group identified for care intervention was once more the growing number of people who would voluntarily seek help for mental health care in psychiatric hospitals, as opposed to the earlier patient population, the great majority of whom were treated involuntarily. The improvement of psychiatric patients' legal protection became a core aspect in this phase of Finnish mental health policies.

> When voluntary care seeking has increased, it has been considered important to change the regulations so that the position of psychiatric patients, when admitted to the hospital, when discharged and during hospital treatment, would be as similar as possible as other in-patients. (GP 85/1976, 1.)

The definition of mental health care also broadened to include "all the cure methods of modern psychiatry" (GP 1976, 3), and the service provision was to respond to seekers' own perception of having a mental health problem in need of treatment.

In the initiatives discussed above, the understanding of the problems was expanding within a psychiatric framework. Issues that had previously been perceived as non-medical were presented as concerns of the psychiatric profession and the psychiatric health care sector. However, and in contrast to accounts of medicalization in which subordination is considered due to the strengthened position of medical experts' control (see e.g. Castel, Castel & Lovell 1984; Rose 2006; Vilhelmsson, Svensson & Meeuwisse 2011), the initiative was seen to represent and originate from the citizens who sought treatment. The expansion of the focus of psychiatry was hence primarily justified as a way of liberating people from the kind of troubles, which had not yet reached the threshold of treatment.

A memorandum by the National Board of Health in 1977 broadens the understanding of the provision of mental health services to primary care, that is, general practice, and emphasizes the importance of the availability of these services for all citizens:

> The primary care services of psychiatric health care should, according to the Public Health Act, be organized for the residents of municipalities. To carry out these tasks, the personnel of municipal health services should include employees who have special psychiatric training, who would in cooperation with psychiatric health care be responsible for the prevention and primary care of psychiatric illnesses and disorders. (NBOH 1977, 21.)

What is typical of this phase was that, even though the document called for broadening the service usership and even the context of service provision (from the psychiatric department to primary care services), the expertise suitable for treating mental health problems would still be limited to psychiatry. The personnel treating mental health in primary care should include psychiatric specialists and act in co-operation with the field of psychiatry.

The committee report from 1984 introduced the concept of "mental health work", which extended care to the population as a whole and encompassed broader social circumstances. As to the treatment of mental health problems, the report runs through all the well-known areas of mental health: social, pharmaceutical and psychotherapeutic. Psychotherapy is emphasized, as its insufficient availability is mentioned various times. With regard to psychotherapy, the report places importance on therapeutic education among psychiatric experts and also emphasizes that those providing psychotherapy should have been through psychotherapy themselves. Moreover, the importance of psychotherapeutic expertise is further emphasized in mental health care planning: the report states that "*every mental health care planning group needs personnel that has received education in psychotherapy.*" (CR 1984, I, 266, original emphasis).

The broadened concept of mental health work included concrete suggestions in areas of overall social well-being, which did not seem to be directly mental health-related at all (CR 1984, GP 1989). Some definitions of relevant areas of work were, however, provided: it was explicitly stated, for example, that "the work of lawyers and construction engineers" should not be considered as mental health work (CR 1984, I, 43–44; also cited by Alanko & Marklund 2013).

To summarize, during the first phase of developments, the policy discourses typically emphasized the voluntary nature of seeking help, introducing a more active actor subject role than the previous more passive, medically-defined, and stigmatized patient who is examined and treated. Still, the treatment and care offered were rather strictly in the hands of the medical profession, which together with the suggestions of increasing service provision reflected an expansive welfare policy. The discourse thus contained elements of a "psychiatrization" in terms of expanding the group perceived to be in need of psychiatric treatment, but the labelling of conditions as an object for psychiatric interventions was combined with a view on the service user as autonomously seeking help, not only subjected to expert power.

Dismantling Exclusive Expertise

In the second phase, the problem was to begin with construed in terms of the challenge of taking care of the patients discharged during the early 1990s recession, which had coincided with administrative reforms in the welfare provision. However, the most prominent new angles in the policy documents concerned the questioning of traditional expertise and the desire to respond to the needs of mental health service users, now rephrased as "customers" (cf. Helén 2011). The circumstances were at first claimed to have led to an "uncontrolled downfall" of the service provision by Finnish mental health care (Taipale 1996). In the beginning of this phase, the documents articulated a frustration over a general austerity policy, within which budgets for psychiatric institutional care were cut and no compensation was arranged for adequate outpatient care. The availability of mental health care was seen as scant in relation to actual needs. Outpatient primary care was experienced as inadequate to care for patients who could after the rapid and massive hospital discharge be in a more difficult health state than those who had received outpatient treatment earlier. At the same time as resources were decreasing on the treatment side, the scope of mental health work continued to broaden to a range of issues, making an argument for a general mental health outlook on society as a whole.

In searching for solutions in the post-recession situation, the policies from this era typically suggested extremely abstract means such as the need for an overall "humanization" of society (MSAH 2003, 85). Unlike the outlook on the same issues in the previous phase where engineers and lawyers were not linked to mental health work, this inclusive grasp concerned even such areas as construction planning to "secure a good [mental] environment for all citizens" (MSAH 2003, 96), and "all branches of the public administration, associations and citizens themselves," who were presented as "responsible for the promotion of mental health and for the prevention of its malfunctions" (MSAH 2003, 90). During this time the mental health policy emphasized and strengthened an understanding of "the broadness of mental health [as a question]" (MSAH 2003, 86), and the circumstance that "a humane view is to be strengthened at all levels of society" was presented as a condition for maintaining good mental health and welfare as a whole (MSAH 2003, 91).

Another feature of the policy aims of this phase was a conscious effort to withdraw from what was perceived as the traditional dominance of expert positions in social and health care, but above all in psychiatry. In fact, an articulated aim was to "give up the expert power" and relate to mental health work as "dialogical." (MSAH 2003). An important objective envisioned in the policy goals from this era was concrete intervention in structural circumstances concerning occupational life, poverty, and problems of remote regions, but the solutions were more abstract such as "goodness, beauty, truth, and wisdom" (MSAH 2003, 99).

In contrast to the top-down framing of old professional expertise in medicine, healthcare, and psychiatry, which was still present during the previous phase, the new mental health care would call for "new expertise" (MSAH 2002, 46). The knowledge base was described as "not only scientific but also personal, aesthetic, ethical, intuitive and tacit knowledge based on the unique and unforeseen nature of encounters" (MSAH 2002, 54). In comparison, the old expertise position was seen as stemming from limited roles of professions and institutions:

> An obstacle to shifting to a customer-centred practice is partly related to the institutionalized praxis in organizational and sectorial social and health care… A customary way of understanding professionalism is to build walls around the kind of expected and conventional roles by the professional and the client, which do not contain elements of closeness and care-taking. (MSAH 2002, 54.)

The developments of the second phase can also be seen in view of austerity politics and neo-liberalist trends in the era of the postexpansive welfare state (see also Helén 2011; Julkunen 2001). Due to a down-prioritization of investments in public welfare structures, the system was oriented towards an emphasis on volunteer work and privatized resource provision (Hande & Kelly 2015; Jakobsen 2009, cited in Goodley, Lawthom & Runswick-Cole 2014; Leppo & Perälä 2017). The ambitions of the 1990s for the integration of different branches and professions in the promotion of mental health and the prevention of mental illness could also be seen in the light of economizing resources on mental health work, as no substantial additional resources were reserved for these purposes in the 1990s policies.

Rather, a call for a shift in values or a shift in perspective – in this case the promotion of abstract human values and humanism – as well as an increased burden of tasks on professionals already involved in the system are political strategies that can be seen as a means of change without investment in concrete action. An inability or an unwillingness to make structural investments when changing policies tends to orientate service users towards what Goodley, Lawthom and Runswick-Cole (2014) refer to as "ableism." In a system that promotes ableism, disabled people tend to find themselves in a position of the "able-disabled" (Mitchell 2014, 5), meaning that people who already have a vulnerable and weak point of departure are, in relation to those with better mental, physical, social or economic resources, required to have the same or greater degrees of abilities. This has also been a criticism of the kinds of user involvement that are not built on the organization of resourceful movements, but rather expects resourcefulness from the individual (e.g. Tritter et al. 2010, 169). These sorts of issues would be of great importance during the third phase of Finnish mental health policies.

Pursuing Service User Expertise

During the third phase, policy discourse came to highlight expertise originating from first-hand experience of mental health problems as opposed to medical or social service expertise. Both the second and third phases can thus be viewed as rather the opposite to traditional expert enhancement.

At the beginning of the third phase, the Finnish welfare policy had shifted to a "permanent austerity" (Hiilamo 2014) and mental health policy had shifted to a postdeinstitutionalist period where the dehospitalization was no longer the primary aim (cf. Bergmark, Bejerholm & Markström 2017; Markström 2014). The demand for mental health services was still estimated as higher than the supply. This was addressed in a parliamentary motion from 2004, which suggested a national mental health programme that would ensure that everyone in Finland would "receive the mental health services they need" (Motion 2004). The MIND-programme discussed below was set up as a response to the parliamentary motion.

The relationship between the experts and the service users was conceptualized in new terms in the early 2000s, when so-called "user experts" were actively called to participate in the planning and execution of mental health care. While the involvement of service users in policy and treatment work is by no means a new idea (see e.g. Laitila, Nikkonen & Pietilä 2011; Tait & Lester 2005), the National Plan for Mental Health and Substance Abuse Work in Finland, the so-called MIND plan from the year 2009 (MSAH 2009, MSAH 2010), was the first time that experience and user expert involvement was suggested in a Finnish mental health policy document.

The MIND plan, which is a joint strategy document for mental health and substance abuse work, especially emphasized expertise through experience in the evaluation and assessment of policies. Furthermore, one of the plan's eighteen proposals involves explicitly "Increasing client involvement by inclusion of user experts and peers in the planning, implementation and evaluation of mental health and substance abuse work" (MSAH 2010). While the MIND programme is mostly known for the at the time radical suggestion of merging mental health and substance abuse treatment (cf. Stenius et al. 2012), the introduction of user experts would be highlighted as one of its most successful achievements (MSAH 2016). In the programme's evaluation most of the other seventeen suggestions were considered inadequately implemented, partly due to administrative and partly to economic challenges, the experience expert training and consultation were seen as thriving and clear signs of an improvement of the position of the mental health care service user (ibid.).

In the MIND plan, the "real life experience narratives" were envisioned as opening up conventional expertise to the perspective of those who were ill and could provide a real-life, inside point of view on treatment and rehabilitation. In line with the international discussion at the time (cf. subchapter "Changing Perceptions of Mental Health Service Users") the user perspective was described as improving the understanding of the nature of treatment relationships, the content of services, its interaction, and the expectations of its functionality.

Referring to the results of an inquiry among the user experts, the final report presents a broad range of beneficiaries from active involvement of experience expertise including the professionals, the system, the service users themselves, and their fellow service users:

> For the professional helpers the experience-based service user experts can provide information and feedback on professional work from the grassroots level, and it can challenge and assess work and help methods [...] From the perspective of the user experts this perspective offers a possibility to alter the path of illness and the problems and turn the tough experiences of the past into a resource in life. The schooling of experience-based expertise and the activities that it implies can be an important stage in rehabilitation and continuation of life ahead.... The user expert may experience the feeling of being a useful member of society. (NIHW 2015, 240.)

The patient or the person being rehabilitated is also told to be able to gain appreciation for their experience and knowledge and the experience-based expertise is perceived to have brought "strength, light and joy" into the personal rehabilitation process (ibid.).

The positive imperatives surrounding the "giving back to society" by the rehabilitated with a personal experience narrative have been shown to be typical and also obligatory elements in residual welfare state cultures, such as the US, in which welfare and help structures are built around communities that depend on volunteers and engaged citizens (Hellman & Room 2015). A problem that may arise in a Nordic welfare state such as Finland is that the envisioned impact that the experience experts may have, or even want to have, is too naïve or unrealistic. First, if people are representing their own personal life narratives, then this group of people is bound to be a heterogeneous one, and the questions to be represented and driven must be carefully co-ordinated. Second, what is left unsaid is that the experience expertise applies in practice to people outside the labour market; a central challenge in organizing experience is how the "experts" should balance the sums they get from the expert activity with the income limits of disability pensions (e.g. NIHW 2015, 242). Due to the Finish dualized healthcare system (e.g. Vuorenkoski 2008) and particularly due to the system of allocating psychotherapy only to employable citizens (NII 2016b; Silfverberg 2016), the experience experts are excluded from significant parts of the Finnish health care system.

Third, it is also possible to look at the extreme promotion and appreciation of experience expertise as a sign of a great failure to make the ill or recovering people feel like "useful members of the society" or just appreciated in everyday life in the first place; the welfare system has thus failed in its universalist aims of a systematic and sensitive inclusion. Another critical view on the emphasis on experience experts concerns the above-mentioned aspect of the "able disabled", with the result that new demands and expectations are put on those who have already experienced much and may not have the resources to make the case expected of them.

Table II summarizes the results of our study. The analysis of problem definitions and role divisions shows that the scope has widened and become more inclusive over time. In each phase of developments, the emphasis given to service users has increased. Patients' freedom, the right to treatment and civil rights were insured; thereafter, outpatient treatment started to expand and hospital care gradually became a rarer option.

We found three stages in which the service user is distinguished through the articulation of aims of mental health policies in Finland. The aims, which are summarized in the middle row in Table II, involve a simultaneous general dismantling of traditional psychiatry expertise and a broadening of the perspective on mental health as a societal phenomenon.

Conclusions

Based on our inquiries we conclude that the strategies in the studied policy documents have not provided increasingly privileged influence positions to traditional psychiatric and medical expertise in the post welfare-state expansion era. While such trends might have occurred in different ways in other countries (Olafsdottir 2011) they were not salient in the visions of the mental health policy documents of this study.

The results contrast with earlier discussions on the power of psychiatry and/or the medical profession in mental health care and policies. Many studies in this area have either considered health promotion as increasing the well-being of all or they have criticized health promotion policies for "medicalizing" or "psychiatrizing" the issues in question. Based on our analysis, we suggest that the Finnish mental health policy has witnessed not only a broadening of its scope and its view on the people concerned, but it has also witnessed something of a de-professionalization or a de-expertization trend. This circumstance also contributes to a problematization of the narrative of a clear-cut strengthening of the position and the power of the medical profession, even in the context of a prominent pharmaceuticalization.

The results of our study reflect also general traits in Finnish welfare policies. A general "psychiatrization" among the whole population and concerning all methods of psychiatric treatment would in many ways conflict with the welfare policies practiced in Finland since the 1990s. On the other hand, the increasing pharmaceuticalization and the increase of the use of psychotherapy allocated on the basis of employability – while not directly perceivable in our data but very prominent in previous studies (e.g. Leppo & Perälä 2017; Partio 2016: Silfverberg 2016) – is congruent with welfare policies that de-emphasize the role of the state and aim at high employment and participation in occupational life.

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TABLE II. Views of problems, perspective shifts, experts and target groups in the three phases.

	BROADENING THE USERSHIP 1960 –	WIDENING OF EXPERTISE 1990 –	PURSUING USER EXPERTISE 2000–
VIEW OF MENTAL HEALTH PROBLEMS	A broader range of users to be treated within psychiatric treatment	Involving DIFFERENT SECTORS that were not typically considered directly linked with mental health issues	Integrating a perspective of the PEOPLE CONCERNED and EXPERIENCES of the subjects of treatment and policy
AIMS AND SCOPE	• focus shift from illness to health • orientation towards outpatient care • psychiatric treatment repertoire including psycho-therapeutic and pharmaceutical treatment. Emphasis on psychotherapy • an understanding of a broad need for services in the population	• the notion of mental illness fades from mental health planning • users perceived as customers • instead of adding service provision, the aim for a “humanization” of society, involving all sectors • a wide range of issues to be considered from the perspective of mental health • initiating the dismantling of exclusive expertise that “build walls between service provider and user”	• user and experience expertise to be integrated into treatment and policy • possibility to hear the users’ views on rehabilitation and care • aim of strengthening of client’s agency • user experts seen as a valuable source of information and a natural part of mental health policy and practice • neglecting the widespread use and possibly higher demand for mental health services • few people in inpatient care • outpatient service use widespread and prescription drug use common. • treatment and particularly psychotherapy according to employability and own resources
EXPERTS	The psychiatric profession	No specific experts articulated. Dismantling of rigorous professional positions. New sectors responsible for integrating mental health policies	Service users
SERVICE USERS/ WHO NEEDS SERVICES?	Various people, also those who are not severely ill.	Some of the users have been recently discharged due to the de-hospitalization.	Everyone and no-one. Users have become experts.
WELFARE POLICY	Expansionist	Postexpansionist	Permanent austerity

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