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National Mental Health Strategy and Programme for Suicide Prevention 2020–2030

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National Mental Health Strategy and Programme for Suicide Prevention 2020–2030

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Abstract

The National Mental Health Strategy and Programme for Suicide Prevention 2020–2030 are based on long-term preparations and broad-based collaboration. The starting point is the comprehensive approach of mental health in society and its different sectors and levels.

The strategy recognises the importance of mental health in a changing world. Mental health is seen as a resource that can be supported. It is possible to effectively prevent and manage mental disorders and reduce discrimination and stigmatisation associated with mental disorders. Mental disorders are a public health challenge, and therefore the availability of mental health services (and addiction services) must be brought to the same level of other health and social services. The strategy provides guidelines for decision-making and for targeting activities and resources. Extensive collaboration is necessary to achieve the objectives.

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. Monitoring of progress should use both existing indicators and new indicators.

The objectives of the strategy will first be implemented by increasing the availability of preventive services and therapies at the basic level and by improving the cooperation structures necessary for maintaining these services. Other measures aim to improve employment-oriented mental health services, raise the level of mental health competence in municipalities and step up suicide prevention efforts.

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Tiivistelmä

Kansallinen mielenterveysstrategia ja itsemurhien ehkäisyohjelma vuosille 2020-2030 perustuu pitkäaikaiseen valmisteluun ja laaja-alaiseen yhteistyöhön. Lähtökohtana on mielenterveyden kokonaisvaltainen huomioiminen yhteiskunnassa ja sen eri toimialoilla ja tasoilla.

Mielenterveysstrategia tunnistaa mielenterveyden merkityksen muuttuvassa maailmassa. Mielenterveys nähdään voimavaraksi, jota voidaan tukea. Mielenterveyden häiriöitä voidaan ehkäistä ja hoitaa tehokkaasti ja niihin liittyvää syrjintää ja leimaamista vähentää. Koska mielenterveyden häiriöt ovat kansanterveydellinen haaste, palvelujen (mukaan lukien päihdepalvelut) saatavuus tulee saattaa muiden sosiaali- ja terveyspalvelujen tasolle. Strategia antaa suuntaviivat päätöksenteolle sekä toiminnan ja voimavarojen suuntaamiselle. Laaja yhteistyö on tarpeellista sen tavoitteiden saavuttamiseksi.

Strategiassa on viisi sisällöllistä painopistettä: mielenterveys pääomana, lasten ja nuorten mielenterveys, mielenterveysoikeudet, palvelut ja mielenterveysjohtaminen. Seurantaan ehdotetaan sekä olemassa olevia että kehitettäviä mittareita.

Strategian tavoitteita toteutetaan aluksi lisäämällä ehkäisevien ja hoitopalveluiden saatavuutta perustasolla sekä näiden ylläpitämiseksi tarvittavaa yhteistyörakennetta. Lisäksi parannetaan työelämään kuntouttavia mielenterveyspalveluja, mielenterveys-osaamista kunnissa ja itsemurhien ehkäisyä.

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Referat

Den nationella strategin för psykisk hälsa och det nationella programmet för suicidprevention 2020–2030 bygger på en lång beredning och ett brett samarbete. Utgångsläget är att den psykiska hälsan bör beaktas på ett övergripande sätt på olika sektorer och nivåer i samhället.

Strategin identifierar den psykiska hälsans betydelse i en föränderlig värld, där den psykiska hälsan betraktas som en resurs som kan stödas. Psykiatriska tillstånd kan förebyggas och behandlas effektivt, och den diskriminering och stigmatisering som är förknippad med dem minskas. Eftersom psykisk ohälsa är en utmaning för folkhälsan bör tillgången till vård (inkl. missbrukarvård) förbättras så att den motsvarar nivån i övriga social- och hälsotjänster. Strategin ger riktlinjer för beslutsfattandet och inriktningen av verksamheten och resurserna. För att nå målen i strategin krävs ett omfattande samarbete.

Strategin innehåller fem prioriteringar: psykisk hälsa som en resurs, barns och ungas psykiska hälsa, rätt till psykisk hälsa, tjänster och ledarskap i psykisk hälsa. För uppföljningen föreslås både befintliga och nya indikatorer.

Inledningsvis genomförs strategin genom att öka tillgången till förebyggande tjänster och vård på basnivå samt en samarbetsstruktur till stöd för dem. Dessutom utvecklas rehabiliterande mentalvårdstjänster, kompetensen inom psykisk hälsa i kommunerna samt suicidpreventionen.

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TO THE READER

Goal-oriented planning is vital for collaboration in a society where different interests are competing for attention and mutual resources.

Mental health promotion must be taken on several different levels using multidisciplinary approaches. A broad approach is needed in order to meet diverse needs ranging from mental health promotion for the entire population to the urgent treatment of severe mental health disorders. Mutually accepted values and principles are needed to facilitate action planning. The Mental Health Strategy provides guidelines for concrete decisions.

Several Western countries have formulated mental health strategies which tend to share similar characteristics and emphasise similar issues. These strategies are built on mutually accepted values such as fairness and helping those in vulnerable situations. Finland has carried out strategic planning also in the past for example by preparing and implementing the Plan for Mental Health and Substance Abuse Work (Mieli) for the period 2009–2015. The Mental Health Strategy 2020–2030 is its successor.

The Mieli plan had four areas of focus: strengthening of service-users status, mental health promotion and preventing of mental health difficulties, developing and organising mental health and substance abuse services, and developing steering measures. An external review established that each focus was valid, and that the programme was beneficial. Promoting the rights of people with mental health difficulties was evaluated to have progressed to a certain degree, and efforts to integrate mental health and substance abuse services was progressing in some parts. The review found that there was still work to be done with regard to mental health promotion and prevention of mental health difficulties, and development of the service system was found to have been overshadowed by the social welfare and healthcare reform. Overall, the Mieli plan was successful in mobilising the service system in a meaningful way. Nonetheless, the question of how to continue planning mental health actions in a goal-oriented manner remained unanswered.

As the world is changing, people's needs are also shifting with future prospects inevitably affecting population wellbeing. As attitudes towards mental health difficulties have improved, more people are seeking treatment. Service planning must reflect this change and be built on this new premise. Potential increases in societal inequality may also be considered to be a mental health concern.

The Mental Health Strategy 2020–2030 does not provide ready-made answers to challenges faced by the mental health sector. Instead it supports goal-oriented planning carried out under the programme. The strategy's principles and focal areas provide support in different contexts such as political decision-making and development work. The strategy translates the spirit of the Mieli Plan into principles guided by a desire to safeguard everyone's right to wellbeing, and the right to effective support services for people with mental health difficulties who may be in a weaker position in society.

This Mental Health Strategy includes focal areas for mental health work up until the year 2030. It also contains a separate, goal-oriented suicide prevention programme. National indicators for monitoring the implementation of the strategy have also been established enabling evaluation of the effectiveness of the strategy and intensifying certain areas if necessary.

The Mental Health Strategy also guides the development of substance abuse services. Actions relating to intoxicants will be integrated into alcohol, tobacco, drug and gambling policy, and will be used to complement the Action Plan on Alcohol, Tobacco, Drugs and Gambling. The Action Plan on Alcohol, Tobacco, Drugs and Gambling, which is valid until 2025, supports the statutory work conducted in municipalities and regions.

Helsinki, 11 February 2020

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1 Why does Finland need a mental health strategy?

1.1 Mental health as part of public health and wellbeing

The significance of mental health for society has grown recently. Considerable societal changes underlie this development including: advancement of technology, urbanisation and increased movement between countries, diversification of values and lifestyles. The significance of education and continuous learning has gained prominence in working life, and an increasing number of people experience cognitive burdening and stress in their work environments. As our environment changes, positive mental health is an increasingly important resource. Positive mental health supports a balance in life and facilitates activity in different contexts and communities. Different areas of life enable and compel individual choices which result in skills such as mental flexibility, adaptability, learning new things, and the ability to make independent decisions. These skills have taken a whole new meaning today.

The overall picture of public health has changed in the past few decades. While considerable improvements can be seen in physical health and life expectancy, such positive trends cannot be seen in terms of mental health. Mental health disorders (including substance abuse issues) are considerable public health challenges. Up to half of the population may suffer from mental health difficulties at some point in their lives, and nearly half of disability pensions are caused by mental health disorders. Despite there being no increase in mental health disorders and despite increased understanding about their treatment, mental health disorders continue to impede a growing number of people's functional ability. Substance abuse also causes premature deaths. Furthermore, treatment options and other mental health services have not been developed at a comparable rate to treatment

and services for somatic illnesses. Bringing mental health services (including substance abuse or behavioural addiction treatment services) to a similar level as other health services requires collaboration and joined up resources.

86% of Finnish people assess their mental wellbeing as at least moderate.
(Koponen et al. 2018)

Nearly 20% of Finnish people experience a mental disorder.
(OECD/EU, IHME 2018)

The lifetime risk for developing mental illness is nearly 50%.
(Kessler et al. 2007, Suvisaari et al. 2009)

Around 30% of adults exceed the limit set for problematic alcohol consumption.
(Sotkanet, 2018)

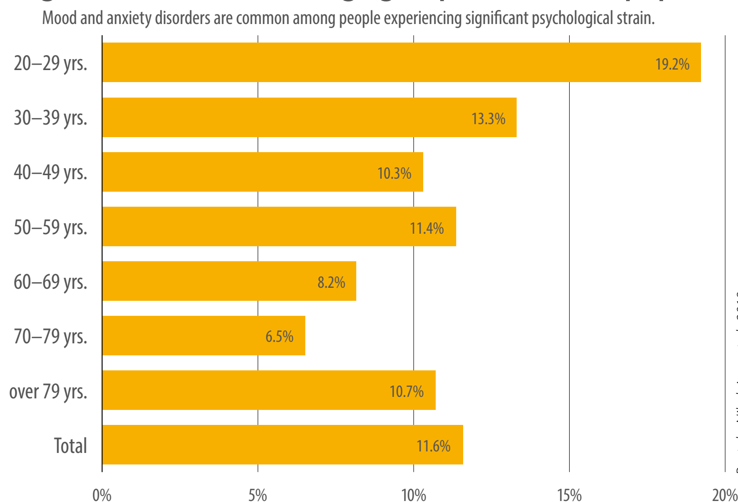
Around 3% of Finns have a gambling problem.
(Cantell et al. 2019)

Mental health can be seen to encompass two perspectives: On one hand, good mental health acts as a resource supporting functional capacity and quality of life. On the other hand, we have mental health disorders and symptoms. Genetic factors, one’s daily surroundings and the environment impact on both perspectives.

Mental health is influenced by sectors outside of health and social welfare. Socioeconomic factors, such as education, professional status and income are all connected to mental health. People from the lowest socioeconomic income quintile experience nearly two times higher psychological strain compared to those in the highest income quintile. Families in living in poor socioeconomic circumstances have a higher risk of depression and young people in this socioeconomic group are

more likely to experiment with substance use which in turn is linked to increased risk of mental health difficulties and lower educational attainment. The negative impact of social inequality on physical and mental health is largely avoidable.

Psychological strain in different age groups of the adult population (%)



Mental illness and substance abuse carry a strong risk of discrimination and social exclusion. While our fundamental rights safeguard equal rights for all people to essential services, in practice these are not implemented equally. Therefore, action against discrimination and stigma is crucial.

Mental health is a key aspect of wellbeing and impacts a variety of sectors both socially and financially. The financial implications of mental ill health consist of direct costs relating to treatment of mental health disorders, as well as indirect costs relating to the impact of lost profitability.

A mental health strategy is needed in order to guide long term mental health policy and its implementation. Collaboration is needed in many different areas. Firstly, different administrative branches including the public, private and third sector as well as other non-governmental actors must collaborate and work towards a shared aim. Secondly, there is a need for building bridges between mental health promotion, prevention of mental health difficulties and between treatment, care and rehabilitation. Third, achieving results will require closer collaboration between

somatic medicine and psychiatry, between occupational healthcare, primary healthcare and specialised medical care and between health and social welfare services. The strategic development of work on mental health and related services covers economic aspects, fairness and effectiveness.

1.2 What is meant by mental health, mental wellbeing, mental illnesses? Concepts used in the Mental Health Strategy

Mental health is a state of wellbeing in which an individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community (WHO, 2014). Mental health has a strong impact on physical health and lays a vital foundation for general wellbeing and functional capacity.

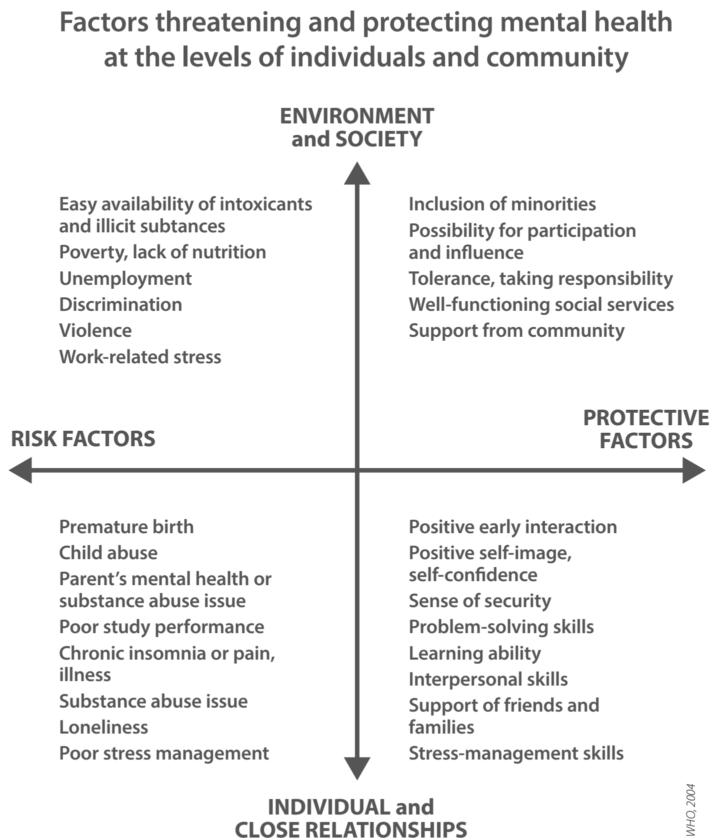
Mental health is not a static characteristic, but rather a fluid aspect which shifts and changes over the life course. A variety of social, economic, biological and environmental factors impact our mental health. Mental health resources increase in favourable conditions and are depleted in unfavourable or adverse circumstances. Aspects such as work and well-functioning healthcare services act as a protective factor for mental health. Mental health skills can also be developed, for example coping and problem-solving skills.

Good mental health includes many things, such as being able to engage in interpersonal relationships and meaningful activities, having problem solving abilities, resilience and self-confidence. During times of mental distress these abilities may suffer, and symptoms of mental health disorders may appear. Disorders due to substance use or addictive behaviours shift ones focus onto compulsiveness. A person’s mental health can decline temporarily or for a long period. Mental health symptoms may not always indicate a disorder but can be a temporary reaction to particular life circumstances.

Mental or **psychological wellbeing** refers to an individual’s subjective experience of his or her wellbeing. The term mental wellbeing is often used in similar ways as

mental health. While mental wellbeing is often connected with good mental health and psychological functional capacity, a person with a mental health disorder may also experience mental wellbeing. Even severe mental illness does not necessarily prevent a person from experiencing wellbeing or enjoying a good quality of life as long as the person's fundamental needs are taken care of, and human rights are guaranteed in an equitable way.

Mental or psychological functional capacity refers to the individual's resources which allow him or her to cope with adversities in daily life as well as times of crises. Psychological functional capacity includes emotions, thought processes, perception, assessment ability and problem solving, among other things. Cognitive functions, which are concerned with thinking and the processing of information, are core mental functions.



Mental illness refers to conditions that cause suffering and harm to a person's functional capacity. The duration and severity of the condition is used as the basis for setting a diagnosis for a mental health disorder. Substance use disorders, and behavioural addiction are also included in the diagnostic category of mental health disorders. Mental illnesses often include changes in the way a person thinks and feels, his or her cognitive functions, behaviour and/or interpersonal relationships. Symptoms may cause moderate difficulty and a reduction of functional capacity, or considerable suffering and decline in a person's functional capacity and quality of life. The majority of symptoms and mental health disorders, including substance abuse and substance use disorder, can be successfully treated.

Mental health literacy refers to the knowledge and understanding of mental health as a resource, and as an integral part of overall health. It also refers to an understanding of the various protective factors and risk factors to mental health and how to make improvements to it. Mental health literacy includes identifying and understanding the attitudes and beliefs related to mental health. It also includes knowledge and understanding of mental health disorders and related treatment options and mental health services. Mental health literacy also includes an understanding of substance abuse and of the protective factors for individuals and the wider community. It also refers to an understanding of the risk factors in relation to how intoxicants may endanger health and wellbeing, and of what services are available. Mental health literacy also includes an understanding of the societal impact of mental health as a whole.

Mental health skills comprise emotional awareness and interpersonal skills, flexibility to cope with life crises, the ability to regulate strain and stress and being able to form meaningful relationships with other people. They also refer to the ability to control and regulate impulses which could lead to substance misuse or other destructive behaviours. Mental health skills also include life skills such as identifying mental resources in oneself and others and making use of these to create a balance between work, studies, rest and leisure time. Mental health skills also help us to address our own mental health and facilitate the ability for identifying and assessing periods of time when one's own mental health resources may be low, and when professional help may be needed.

2 Mental health policy guidelines

The Mental Health Strategy has five focus areas:

1. mental health as human capital,
2. mental health for children and young people,
3. mental health as a right,
4. appropriate, broad-based mental health services,
5. mental health management.

This strategy is based on the general assumption that mental health is an integral part of health, also impacting socioeconomic wellbeing. The foundation for mental health is laid during childhood and adolescence. In this context, mental health as a right refers to action against prejudice, intolerance and stigma. It also assumes good mental health to be a fundamental right that everyone is equally entitled to. This is particularly important in relation to fundamental rights for people with mental health disorders. Services in relation to mental health disorders including other societal actions impacting on mental health must be extensively developed, and the present strategy is particularly focused on managing these actions as a whole.

2.1 Mental health as human capital

Mental health is one of the most important things in a person's life, affecting health and wellbeing, interpersonal relationships, studies, work, and the entire life-course. Good mental health strengthens trust, reciprocity and a sense of belonging in society. Productivity is closely tied to the mental health of the workforce. High levels of good mental health in the population will support success in Finland as a whole.

Mental health is a form of capital for individuals, families, communities and society as a whole which can be looked after and invested in

- at all life stages,
- during studies and at work,
- in everyday circumstances, communities and recreational activities,
- in connection with societal and environmental changes.
- In addition to a public health perspective, specific attention is given to minorities including different language and cultural groups.

Justification of the guideline

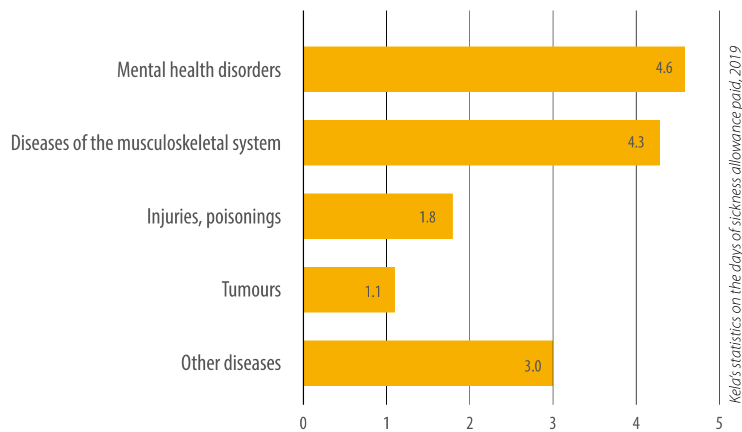
Mental health as a human capital refers to the significance and meaning of mental health for individuals, communities and society as a whole. Good mental health improves opportunities for positive interpersonal relationships and success in studies and at work. Work is an essential part of wellbeing and an important part of many peoples' lives.

Good mental health manifest itself as general wellbeing and reduced levels of strain on families, communities and the entire society. A significant share of sickness absences and disability pensions is currently caused by mental illness. Population mental health impacts working life productivity.

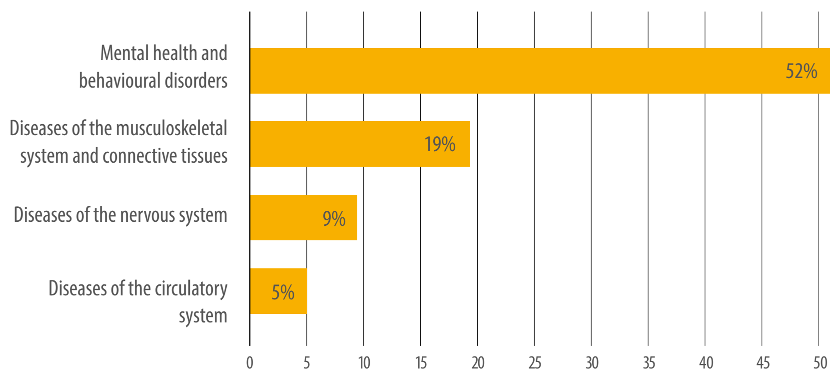
Mental health promotion strengthens resources which support a well-functioning daily life and facilitate solutions to obstacles or crises in life. Mental health can be promoted through actions which lie outside of the health and social care context. Mental health can for example be promoted by supporting healthy development in early childhood education and schools, via family policy actions, by promoting access to work and wellbeing at work, via access to recreation and physical activity, via hobbies, culture and social activities, and through access to safe surroundings.

Older adults can make valuable contributions to the community. Municipalities and non-governmental organisations play a significant role in mental health promotion. Mental health promotion and supporting mental health at every level is an investment which pays itself back in mental and material returns.

Days of sickness allowance paid in 2018 (per mill. days)



Share of disease groups causing disability of total disability pensions



Official Statistics of Finland: Statistical yearbook of pensioners in Finland 2019

Proposals for accomplishing goals of the guideline

1. Identifying the professionals, networks, people and communities for whom mental health literacy and skill development would be particularly useful and increase competence in these groups. This is particularly important for professional groups who are in close interaction with others.
2. Increasing mental health literacy and skills in early childhood education, in schools and educational institutions, and through specific projects and curriculum development.
3. Improving mental health literacy and skills in the workplace via training and programmes supporting leadership and periods of transitions. The wellbeing of employees is the most important asset for organisations, and mental health is an essential part of this. Improving ways of identifying undue burden and occupational burnout in employees is needed as is the preparation of an operational programme for good mental health in working life.
4. Increasing mental health literacy and skills in services for older adults via additional training and programmes. Older adults will be included in these actions making use of their existing resources and experience.
5. Improving communal wellbeing in residential areas. Increasing activities that reduce loneliness, encourage togetherness, and support people to engage in activities together. These may include libraries, schools, service homes, residential or neighbourhood activities, community organisations, culture and the arts, and social media. Meaningful activities and the feelings of inclusion are well known factors of mental wellbeing.
6. Unique risks in related to digitalisation will be identified (such as online bullying), and opportunities will be taken advantage of (such as peer support, social inclusion). Within social media, mental health promotion can for instance mean increasing moderation for identifying and removing harmful content.
7. Ensuring that the non-governmental organisations and voluntary activities which support positive mental health are provided with statutory and financial support.
8. Ensuring statutory and financial support for municipalities and other public agents across sectors, to enable mental health promotion and harm reduction in terms of substance abuse and behavioural addictions.
9. Actively intervening in all forms of discrimination, and promoting a sense of togetherness in neighbourhoods and other communities as part of municipal and county health and wellbeing promotion initiatives.
10. Launching research and development actions investigating how mental health as a resource can be looked after in the context of societal and environmental changes.

2.2 Developing positive mental health in the daily lives of children and young people

The environments in which children and young people grow significantly influence their mental health. Good mental health in children and young people is supported when society

- creates secure conditions for family-life and in other formative environments also during societal change,
- ensures that each child has equal opportunities for self-esteem, mental health skills, learning and feelings of achievements,
- gives each child equal opportunities for engaging in safe recreational activities which promotes their development,
- safeguards the rights of vulnerable children and young people and those in challenging life circumstances
- reduces childhood poverty in families
- reduces social exclusion of children and young people.

Justification of the guideline

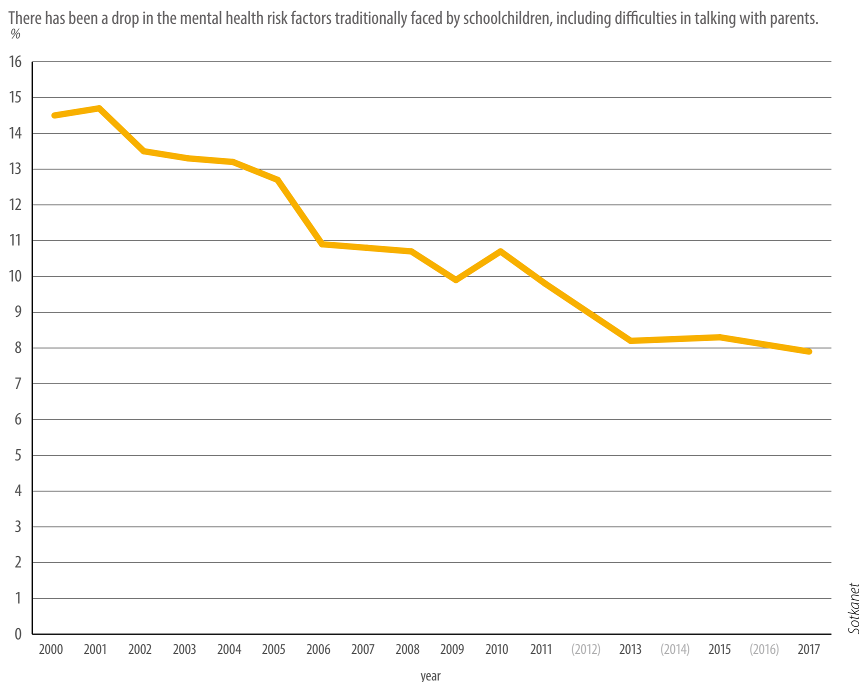
Mental health promotion for children and young people is linked to the National Strategy for Children currently under preparation. The purpose of the National Strategy for Children is to create a child and family friendly vision for Finland which extends over several administrative sectors and over several governmental periods.

Much of the foundation for mental health is laid during a childhood and younger years. Under optimal circumstances, development and learning environments support mental health, allowing children to develop their mental resources. Children and young people may have considerably different premises for growth and development, also in terms of mental health. Disparities in the circumstances which children and young people grow up in have become more pronounced as social inequality increases, and difficulties accumulate and transfer across generations. In order to effectively support the mental health of children and young people in their daily lives, it is important to recognise the significance of childhood throughout the life-course.

The family plays a huge role both on the health and development of children and young people. The family also plays a large part in how the individual copes later

in life. Supportive factors include adequate care and a sense of security, positive early interaction and parents' wellbeing, and financial security. Grandparents and other close adults may be beneficial for a child's development and the family's wellbeing. Opportunities for balancing work and family also affect families' and children's wellbeing.

Difficulties talking to parents,
% of pupils in grades 8 and 9



The need for significant mental health resources is heightened at the point when the young person is becoming independent. This is when the young person needs the necessary skills in order to deal with the uncertainty related to their future, such as those connected to studies and the labour market. Young people have to make choices related to their studies at an increasingly young age. At the same time, the amount of face-to-face educational instruction and specialised teaching has been cut in many learning environments. This freedom for making individual choices requires the capacity for self-direction. In order to develop positive mental health, it is vital that young people have opportunities for forming safe relationships with peers and avoiding traumatic experiences once they start engaging in activities outside their immediate family to a larger extent. Global events, such as climate change create new causes of anxiety and a sense of uncertainty.

Around one out of four young people aged 12–18 in Finland had experienced harm cause by adult alcohol consumption in the home.
(Takala & Ilva, 2012)

Mental health risk factors are 2–5 times more common among disabled children and young people, among children and young people placed in care, children and young people of foreign origin, and LGBTI children and young people in comparison to others.
(Halme et al. 2017; Ikonen et al. 2017; Kanste et al. 2017; Luopa et al. 2017)

Around 30% per cent of parents experience at least moderate levels of depression when expecting a child.

(Korja et al. 2018)

Many mental illnesses develop during childhood and adolescence. Mental health disorders are among the most common health-related problems for school aged pupils and during later studies. Risk factors include loneliness, bullying, discrimination, substance use, and academic stress. Poverty reduces the entire family's wellbeing as well as the mental health of children and young people. Abuse and violence is a risk factor for positive mental development. Young people's capacity for coping varies individually, and it is important to identify any support needs at an early stage.

The number of young people in current generations is clearly smaller than their preceding generations. As Finland's dependency ratio is weakening, more and more people are needed in the labour market. In a rapidly ageing society, it is important to also pay attention to equality between generations, and the status and opportunities of the younger generations in society. Levels of wellbeing and functional capacity in children and young people will define our future.

Proposals for accomplishing goals of the guidelines

1. Structures for the development, implementation, maintenance and restoration of practical help for families will be created via legislative processes if necessary in order to reduce poverty in families, create benefits and support parenting.
2. Introducing age appropriate support for children and young people in their local environments, such as early childhood education and care, school or study environments, child health clinics, and other social and healthcare services. Particular attention will be paid to minorities, and specific cultural and language groups. Mental health support for both parents already during pregnancy stage including relationship support.
3. Developing mental health skills and good self-esteem in children and young people is supported by good practice and investment in mental health training and developing positive cultures in early education, as well as primary and secondary education.
4. Developing a more family friendly working life. For example, families and significant others of children under statutory school age need more flexible working conditions, and children under the age of 12 need more versatile options for safe afternoon activities.
5. Creating structures for wide-ranging collaboration between different administrative sectors, organisations and citizens to develop a shared foundation and mutually accepted values supporting positive mental health for children and young people. Identifying necessary factors for cooperation and agreeing structured models for collaboration such as those agreed in line with the local alcohol policy model.
6. Ensuring that children and young people get versatile opportunities for engaging in recreational activities based on their interests, via legislative and quality regulation where necessary.
7. Systematically supporting inclusion of children and young people in their peer groups and protecting them against bullying, substance use and other forms of risky behaviours within peer groups and on social media. Supporting children's and families' competence in the digital environment. Preventing social exclusion and supporting young people during points of transition in their lives, including changes to the school and studying environment, education choices, and transition into working life.
8. Ensuring sufficient available resources and coordinated collaboration for maternity and child health clinics, pupil and student welfare services, and primary health and social services for children and young people to carry out mental

health support. Furthermore, in addition to preventive work, brief interventions should be available for people in difficult life situations or crisis.
9. Supporting children and young people under psychological strain for example, children and young people whose close relatives may experiencing psychological strain, those in otherwise vulnerable positions or life circumstances, and those who are vulnerable due to their cultural or societal position.

2.3 Mental health rights

The implementation of mental health rights protects everyone's mental health. Mental health services must pay particular attention to the implementation of mental health right which may include

- being accepted and not discriminated against,
- respect for human dignity, and fundamental and human rights,
- equal rights to housing, studies, work, subsistence and social inclusion,
- the right to decide what things support coping with daily life and receiving support in line with these,
- the right to civic engagement, to be part of the decision-making process, and action as peer and expert-by-experience,
- the right to good and effective care when necessary,
- the right and opportunity to use Finland's national languages and other languages spoken in Finland, and obtaining sufficient interpretation and translation services when using mental health services.

In order to achieve these mental health rights, work is needed to combat prejudice, discriminative views and polarisation.

Justification of the guideline

Mental health rights is founded on universal human rights and the fundamental rights under the Constitution of Finland, based on principles of equality of all, language rights, the right to work and education, the right to an adequate standard of living which safeguards housing, subsistence, health and wellbeing, and the right to social security and adequate health services. Fundamental and human rights

safeguard societal conditions which promote mental health and protects against risk factors of mental health disorders. Mental health rights fosters protective factors and reduces risk factors. These mental health rights cover the entire population as well as those living in vulnerable or difficult circumstances.

Fundamental rights are not implemented in an equal manner for all. People with mental health disorders are likely to experience discrimination, stigma and prejudice. These are encountered in social interactions, at work, in studies, in housing and within services. Many people with a mental health disorders do not seek treatment due to a fear of stigma or discrimination. Particular attention should be paid to groups who are vulnerable due to their cultural or societal status. The right to high-quality and evidence-based treatment which meets the need of the client must also be perceived as a fundamental mental health right.

The life expectancy of people with psychotic disorders is 15–20 vuotta years shorter than that of the general population. The most significant causes of death include cardiovascular diseases and cancer.
(Tiihonen et al. 2009; Nordentoft et al. 2013; Keinänen et al. 2018)

The life expectancy of people who have been hospitalised for a substance abuse disorder is over 20 vuotta years shorter than that of the general population.
(Westman et al. 2015)

Around 38,000 psychiatric hospitalisations occurred in 2017. 10,000 of these were involuntary.
(A statistical report on psychiatric specialised medical care by the Finnish Institute of Health and Welfare, 2018)

Mental Health Barometer

23% would not like to live next door to a person with a mental illness, 62% would not like to live next door to an alcoholic, and 81% would not like to live next door to a drug user.

47% of those who have personally experienced a mental health disorder feel that they have been stigmatised because of their mental illness.

60% of mental health professionals feel that a mental illness causes stigma.
(Mental Health Barometer 2019)

The right to free will, self-determination and bodily integrity are also fundamental rights. People with mental health disorders often struggle to achieve autonomy in decision-making. Psychiatric care may include involuntary treatment under specific legislation. Well-functioning services which have been approved by service-users reduce the need for involuntary care measures.

A noteworthy positive development is the reduction in stigma surrounding mental health disorders which is evident from the increase in open and constructive public discussions around mental health, and increased help-seeking from mental health services.

Proposals for accomplishing goals of the guidelines

1. Reforming the legislation on self-determination and involuntary treatment to ensure that it safeguards the right to self-determination within services for people with mental health disorders.
2. Launching a national programme against discrimination and stigma related to mental health and substance abuse disorders. Implementing an anti-discrimination development and monitoring programme which also safeguards language rights.
3. Monitoring and researching discrimination also within quality monitoring systems used in social welfare and healthcare and imposing sanction if discrimination occurs.
4. Updating quality criteria and establishing a quality register for monitoring housing services and other support services used by people with mental health and substance abuse disorders.
5. Continuation of the existing programme for reducing the use of involuntary treatment and coercive measures within psychiatric care and strengthening the national network for reduced use of coercion.
6. Establishing actions safeguarding rights for people with mental health or substance use disorders to participate in work and studies according to ability. Expanding and establishing operative models which strengthen capacity for participation in education and working life as well as increase inclusion in the workforce.
7. Planning measures for reducing the effects of poverty and inequality for individuals and families.
8. Taking measures against incompetent and harmful consequences of pseudo-medicine or alternative medicine with the help of legislative action.

2.4 Broad-based services that meet people's needs

Services meet people's needs when they ensure that

- they are client-driven, age and developmentally appropriate and perceived as suitable by service users.
- they are accessible, effective, of high-quality and available in a timely manner,
- they are flexible, compatible and support continuity,
- they promote rehabilitation,
- they follow the equality principle: service planning paying particular attention to population groups at risk inequality
- they take the client's family and other relations into account both as a resource and as people in need of support,
- staff maintain competence and wellbeing at work,
- they prioritise the physical health of people with mental health or substance use disorders in the same manner as rest of the population.

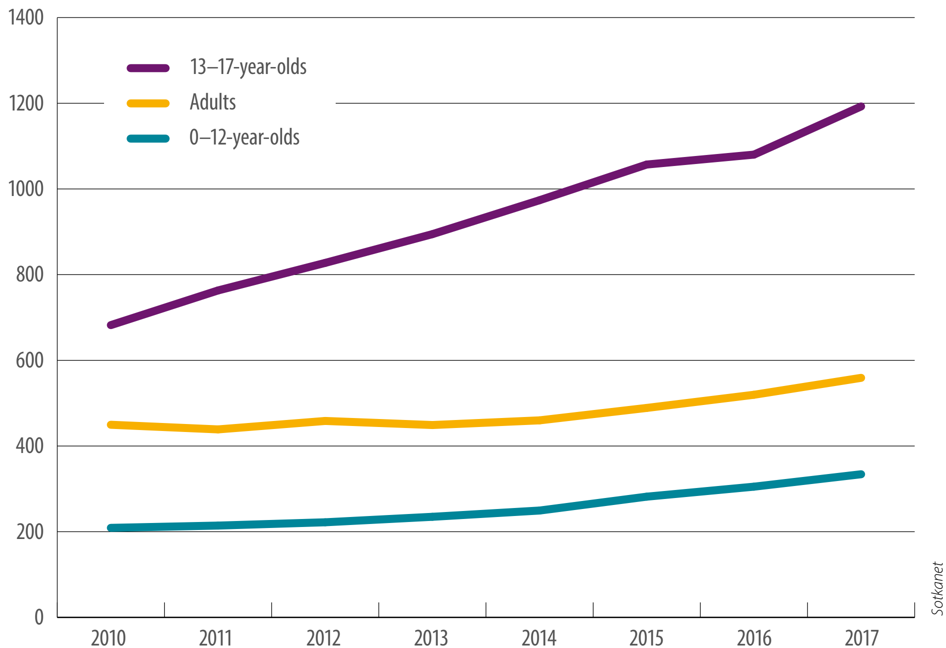
Justification of the guideline

The treatment of mental illness has increased annually over the past decade although it has been argued that the threshold for gaining access to psychiatric treatment remains high. Regional differences in the timely access to treatment, and the availability of versatile outpatient services continues to exist, and it has been difficult to access treatment within the time set by legislation. The availability of evidence-based psychological treatments has been relatively poor and treatment options have not been coordinated or maintained in a longstanding or continued manner according regional population need. Mental health as something which concerns everyone has not always been recognised in primary healthcare and has therefore been delegated to specific workers. In many regions, work in relation to substance abuse continues to be isolated from other areas of healthcare, and is inconsistently organised.

The services are fragmented and service providers have failed to harmonise their activities or agree on a division of duties, reducing the availability and allocation of services.

International trends in mental health service development leans towards more collaborative approaches. This trend involves more client or patient driven approaches and providing services according to individual need, instead of on the basis of what is available. Harmonised and coordinated services are efficient and versatile. Case management can increase service use at the right time and appropriate level.

Outpatient appointments in mental health care in the 2010s per 1,000 people of the same age



Generally, people with mental health disorders should receive timely access to treatment. Treatment is most effective when assessment and primary care is provided as part overall primary healthcare, taking place in the same location such as social and healthcare centres. Services should also be available for children and young people in their usual primary care setting and occupational wellbeing should be monitored in collaboration with occupational healthcare services. Support and guidance should be provided by specialised mental health in an accessible and flexible manner. Similarly,

psychiatric inpatient care should be provided in connection with other hospital treatment, treating all issues at the same time. For example, in relation to substance abuse, merely treating the addiction will typically not suffice on its own, attention is also required to mental health and somatic health.

Of individuals with suicidal ideation, 49% of 20–54-year-olds, 26% of 55–74-year-olds and 11% of 75-year-olds and older seek help.
(Pentala-Nikulainen et al. 2018)

76% of young adults with major depressive disorder are in receipt of treatment.
(Kasteenpohja et al. 2015)

The social and healthcare sector and the service system as a whole must be quick to respond to all types of needs ranging from early stages to severe, sudden and complex difficulties. People with mental health disorders are more likely to have comorbid illnesses which will need higher levels of support in comparison to the general population, particularly in the case of severe illness. Currently somatic healthcare, social welfare services, as well as housing and employment services are lacking for this population group. People with substance use disorder will need particular attention in order to ameliorate accumulating social problems which are common in this context. Mental illness may reduce the ability to access available services and advocate for one's own interests, services must therefore be adapted to be versatile and easily accessible. This accessibility can also be ensured through digital services, particularly in remote regions. The stigma surrounding mental health disorders especially substance use disorder makes service availability, their level of client-orientation and quality particularly important. Services will fail if they are not accessible, or if they are not accessed due to misconceptions, prejudice or stigma, including self-stigma.

It is relatively common for a mental disorder and substance use disorder to occur simultaneously. For example, around 10–30% of people with depression have a substance use disorder.
(Kessler et al. 1996; Melartin et al. 2002)

Around 50% of clients using substance abuse services also had a mental health disorder.
(Kuussaari & Hirschovits-Gerz, 2016)

It is common to have a somatic and mental illness at the same time. 20–40% of the patients in primary healthcare and somatic patients in hospitals have some mental disorder.
(Räsänen et al. 2019)

Housing services have around 7,500 residents with mental health difficulties.

Housing services have around 6,000 residents with substance abuse issues.
(Sotkanet, 2018)

Less than half of those hospitalised for mood disorders during adolescence or younger years are employed after the age of 25.
(Hakulinen et al. 2019)

Examples of groups in which mental health disorders are more common:

1 **Of homeless people who had spent one night in a shelter, 80–90%** had some form of mental disorder, **80%** had a substance use disorder, and over **10%** had a psychotic disorder.

(Stenius-Ayoade, 2019)

2 Nearly **80% of prisoners** have some form of mental disorder, most commonly substance use disorder or a personality disorder.

(Joukamaa et al. 2010)

3 **Of the young people excluded from** education and working life for several years, **60%** had been prescribed antipsychotic medication.

(Aaltonen et al. 2015)

4 Nearly **40% of adult asylum seekers who had recently arrived in Finland** experience significant symptoms of depression and anxiety.

(Skogberg et al. 2019)

Proposals for accomplishing goals of the guidelines

1. Legislative reform around mental health and substance abuse services will make particular attention possible to the optimal use of resources, their sufficiency, allocation and coordination.
2. Increased resources for mental health services in primary health and social care including resources for capacity building for workers. Developing collaboration and guidelines to help for specialised services to support primary services.

Harmonising services through concrete collaboration between primary healthcare providers and specialised services.
3. Including client-based perspectives in planning, implementing and evaluation of services. For example by making use of experts-by-experience and client experiences. Adaptation of actions delivered by different service providers taking clients individual situations into account by way of joint planning. When making arrangements on the services provided to an individual client, Taking into account clients wishes and what clients determine as important.
4. Launching a development programme for promoting physical health and ensuring somatic healthcare for people with mental and substance abuse disorders. This programme also covering oral health care.
5. Improving the access to psychosocial interventions and organising their provision regionally as appropriate. This involves university hospitals districts, and centres of excellence coordinating evidence-based care for the most demanding services for children and young people and disseminating evidence-based psychosocial interventions in a coordinated collaboration across regions, and ensuring that the needs of sparsely populated areas are met.
6. Support social welfare services to provide services which support mental health in a timely manner. These services include social work and social counselling, family work, home services, social rehabilitation, housing advice, and supported living. Ensuring that social assistance benefit is granted as necessary for the purpose of promoting social security and preventing social exclusion.
7. Utilising evidence-based approaches in promotion and preventative work within social and healthcare services and assessing their effectiveness in Finland.
8. Developing accessible and versatile services which can be provided in the context of the clients' everyday surroundings, particularly for people who are difficult to reach, at risk of social exclusion, or groups who are vulnerable due to their cultural or social status. Outreach services will be used to reach those who are particularly difficult to reach.
9. Compiling and introducing operative models which have proven to be effective in a variety of environments, including early childhood education and care, schools, workplaces and supported housing.
10. Accounting for quality, continuity and coordination of services in legislation concerning procurements. Continuity and rehabilitative features particularly accentuated in housing and support for daily living.

2.5 Good mental health management

Leadership should take all aspects of mental health into account. Mental health action is led and managed in a systematic manner across administrative sectors.

- Leadership adapts organisations and their activities towards topical issues and economic actualities affecting mental health preparing them for future challenges.
- Management is based on current knowledge and technology.
- The availability of knowledge from topical and preventative research is safeguarded.
- The most suitable indicators are used to inform leadership and management.
- The Mental Health Strategy is regularly evaluated and focal points are reformulated as necessary.

Justification of the guideline

The ultimate goal of leadership for mental health is to create mental health and wellbeing, and promote human values. Mental wellbeing lies in the core of an individual's wellbeing which contributes towards a stable society and stable economy. The latter in turn, further increases opportunities for improved wellbeing. The concept of the economy of wellbeing can be used to describe the relation between the economy and people's wellbeing.

Good mental health leadership is part of social and healthcare management. This guideline uses the term "leadership for mental health" as the transformation of society and public health has made it necessary to introduce mental health as a strategic area of focus for health and wellbeing, and for the development of social and healthcare services. Leadership for mental health is also linked to knowledge management, as work encompassed in the strategy is not possible without knowledge and competence. In the present strategy, the promotion of mental health as part of human resources management is included in the section "mental health as human capital".

Leadership for mental health is needed at the national, regional and municipal level as well as in social welfare and healthcare organisations. Leadership for mental

health different sectors and administrative branches as mental health is part of all policy areas. This 'Mental health in all policies' approach emphasises the significance of mental health as part of general health. This approach systematically accounts for mental health impacts in all decision-making across all sectors, seeking common interests and avoiding harmful mental health impacts. Mental health impact assessment is a way of accounting for mental health in all decision-making all administrative sectors and throughout all levels of decision-making.

Leadership for mental health includes updating legislation, guidance and quality control on a national level relying on a solid base of contemporary knowledge. Leadership in mental health also means implementing the Mental Health Strategy and monitoring results.

No municipality or county is doing well unless its inhabitants have good health and wellbeing. Long term actions for mental health promotion requires determined and goal-oriented action based on effective interventions, research, and sufficient resources. Awareness of population health, wellbeing, and mental health as well as an understanding of the capacity of the service system underpins the strategic work.

Actions implemented in the service system must be harmonised and encompass wider collaborative networks. Leadership builds on multidisciplinary impacts, including wellbeing impacts. Leadership for mental health also examines substance abuse and addiction related issues from a broader perspective including preventative actions, harm prevention, treatment and rehabilitation.

Competent and knowledge driven leadership which makes use of different digital solutions is an important part of managing mental health. Leadership for mental health is promoted via developing the knowledge base further, as well as making use of improved and more accessible resources which include technical solutions.

Proposals for accomplishing goals of the guidelines

1. Strengthening collaborative structures in various administrative branches and organisations and within the Government and central government, counties and municipalities in fostering work on mental health. Agreement of collaborative management practice.
2. Agreeing on the measures, indicators and tools for assessing the impact of societal decisions on mental health.
3. Establishing a digital information centre for effective mental health promotion and prevention of mental health problems.
4. Enhancing management training and assessment of mental health actions as part of training modules for management and evaluation.
5. Creating clear operative models for the division of duties in relation to available services in different sectors, stipulating collaboration and identification of essential resources, cost accountability and compensation mechanisms in this context. Drawing up models for shared activities between different administrative branches and describing different roles of stakeholders, division of costs, and management of activities.
6. Developing the knowledge base and making it more accessible in order to better assess actual need for services instead of monitoring and assessing the use of services. This necessitates knowledge of the prevalence of mental health symptoms, mental health disorders, and predisposing factors among the general population, on a regional level and in specific groups. Research and register data on the costs, quality and outcomes of services will improve the steering of services based on content. Data collection will utilise the quality registers. Performance tools will be developed for assessing service sufficiency. Needs assessment in terms of incidence and prevalence of mental disorders among children and young people and the ageing population will be identified in service planning and adaption for population groups.
7. Effectiveness and impact assessment directs service system development and selection of appropriate actions.
8. The Strategic Research Council prepares a research programme supporting the implementation of the Mental Health Strategy.
9. Monitoring implementation of the Mental Health Strategy using a specific set of indicators.

3 Measures, monitoring and expenditure

3.1 Measures planned for the period 2020–2022

The Ministry of Social Affairs and Health will implement the proposals of the Mental Health Strategy as of 2020. During the period 2020–2022, implementation focus on the development of services, launching the Programme for Suicide Prevention, and increasing mental health literacy in people's daily environments as part of more extensive health and wellbeing promotion initiatives. A further aim is to amend the legislation concerning mental health and substance abuse services, and prepare legislation concerning the right to self-determination. The Finnish Institute for Health and Welfare will plan the implementation and coordination of the Programme for Suicide Prevention.

Services will be developed as part of the Future Health and Social Services Centres programme. The aim is for evidence-based, early-intervention approaches to be in use within primary health care services by 2022, treating common mental health difficulties in different age groups. This also applies to early intervention for substance abuse disorders, interventions for people who are at risk for suicide, and interventions carried out in student welfare services. A collaborative structure with specialised services must be developed for upholding these interventions, identifying disorders, and supporting care and treatment. The implementation of mental health services as part of regular services at primary health and social services centres also enables the development of models for implementing social welfare services, and supports the provision of equitable somatic health care for people with mental disorders.

The service system also requires cooperation with other authorities, organisations and municipal agencies. In the period 2020–2022, the aim is to test the research-based Individual Placement and Support (IPS) model of supported employment. This model involves implementing job search and support as part of healthcare services. The purpose is to implement the model in Finland through pilot initiatives.

The aim is to develop collaboration between municipalities, different sectors and administrations via increased mental health literacy. This collaborative structure also serves to support projects and capacity building initiatives within municipal and non-governmental organisations

3.2 Monitoring and proposals for indicators

A number of indicators are proposed for the implementation of the Mental Health Strategy and related policies. Most of them are already available, but some would have to be separately constructed.

Table 1. Ehdotukset seurantamittareiksi

Focus area	Theme	Indicator	Data source	Inquiries
Mental health as human capital	Mental wellbeing	Positive mental wellbeing: The Warwick-Edinburgh mental well-being scale (WEMWBS). Average values for different age groups: pupils in grades 4 and 5; pupils in grades 8 and 9; students in years 1 and 2 in vocational education and training (VET) institutions, students in grades 1 and 2 in upper secondary schools; 20–64-year-olds, 65 years old or older; 75 years old or older	FinSote, School Health Promotion Study (average indicator values for different age groups)	More information about indicator: Appelqvist-Schmidlechner et al. 2016 The indicator is also suitable for following the focus area “Construction of mental health in the daily lives of children and young people”.
	Loneliness in different age groups	Feels lonely (%), pupils in grades 4 and 5 Feels lonely (%), pupils in grades 8 and 9 Feels lonely (%), students in years 1 and 2 in VET institutions Feels lonely (%), students in 1 and 2 in upper seconda-ry schools Share of respondents who feel lonely (%), 20–64-year-olds Share of respondents who feel lonely (%), 65 years old or older Share of respondents who feel lonely (%), 75 years old or older	Sotkanet 4816 Sotkanet 4712, KUVA Sotkanet 4713 Sotkanet 4714 Sotkanet 4285, KUVA Sotkanet 4286 Sotkanet 4287	Mental health background factor The indicator is also suitable for following the focus area “Construction of mental health in the daily lives of children and young people”.
	Occupational burnout	Occupational burnout	Occupational burnout (TTL), Working Life Barometer (Ministry of Employment and the Economy) The quality of work life survey (Statistics Finland), Working life barometer (Ministry of Employment and the Economy)	More information about indicator: Schaufeli et al. 2019
	Mental wellbeing at work	Work engagement	The quality of work life survey (Statistics Finland), Working life barometer (Ministry of Employment and the Economy)	More information about indicator: Schaufeli et al. 2019

Focus area	Theme	Indicator	Data source	Inquiries
Construction of mental health in the daily lives of children and young people	Symptoms of mental health problems in young people	Moderate or severe anxiety (%), grade 8 and 9 pupils Moderate or severe anxiety (%), students in years 1 and 2 in VET institutions Moderate or severe anxiety (%), students in 1 and 2 in upper secondary schools	Sotkanet 328, KUVA Sotkanet 346 Sotkanet 337	Indicator used in the School Health Promotion Study, GAD 7 indicator More information about indicator: Spitzer et al. 2006
	Substance use and use of tobacco products and gambling among young people	Worrying substance use or tobacco and nicotine products use or gambling (%), pupils in grades 8 and 9 Worrying substance use or tobacco and nicotine products use or gambling (%), students in years 1 and 2 in upper secondary school Worrying substance use or tobacco and nicotine products use or gambling (%), students in years 1 and 2 in VET institutions	Sotkanet 5362 Sotkanet 5363 Sotkanet 5364	School Health Promotion Study This joint indicator creates a general picture of the risky behaviour of young people on different levels of education related to substance abuse issues or other addictions. Separate indicators on the different forms of risky behaviour included in the joint indicator are also available in Sotkanet.
	Under-18-year-olds in small-income households	At-risk-of-poverty-rate for children	Sotkanet 228; KUVA	Mental health background factor
	Severe bullying	Bullied at school at least once per week (%), grade 4 and 5 pupils Bullied at school at least once per week (%), grade 8 and 9 pupils Bullied at school at least once per week (%), students in years 1 and 2 in VET institutions Bullied at school at least once per week (%), students in years 1 and 2 in upper secondary schools	Sotkanet 4834 Sotkanet 1514; KUVA Sotkanet 3928 Sotkanet 3913	Mental health background factor Based on a question in the School Health Promotion Study
	Unstable living environment	Children aged 0–17 placed in care repeatedly / 10,000 persons of same age	Sotkanet 1079; KUVA	Mental health background factor

Focus area	Theme	Indicator	Data source	Inquiries
Mental health rights	The use of coercion in psychiatric inpatient care	Coercive measures in psychiatric inpatient care (% of total psychiatric inpatients)	Sotkanet 3205	
	Participation in working life	Participation in working life (share of paid employment/ earnings of total income) in all members of population documented to have mental health issues (outpatient care, inpatient care periods, sickness absences, medication purchases)	The state of work ability in Finland; Mental vulnerability in Finland, TTL	Also measures the functionality of the society beyond the scope of the social and healthcare system (labour market). Formed by joining register data for the monitoring of the Mental Health Strategy.
	Experience of discrimination	Experience of stigma due to illness (%) Share of Finns who would not like to live next door to a drug user (%) alcoholic (%) person with mental difficul-ties (%) The share of Finns who feel uncomfortable and scared when encountering per-sons with mental health issues (%)	Mental Health Barometer	Collected on both mental health and intoxicants.
	Non-discrimination programme in a service organisation	Does the organisation have a non-discrimination programme? Has the programme been included in the organisation's quality programme?		A new indicator to be developed, possibly implemented as a separate survey
	Excess mortality among schizophrenia patients	FIGURE: **Indicator will be completed in the period 2020–2023	KUVA	A new indicator to be developed, based on the data in the Care Register for Health Care and causes of death statistics

Focus area	Theme	Indicator	Data source	Inquiries
Broad-based services that meet people's needs	Strengthening the mental health services carried out in health centres	Questions included in a survey for the Medical Directors at health centres on capacity building training on mental health and substance use, collaborative models with psychiatry and substance abuse units and the functionality of these models, and treatment chains	Survey for the medical directors at health centres	A new indicator to be developed The indicator is also suitable for monitoring the focus area "Good mental health management".
	Client experience	To be developed	Data collected from the clients of the service system on client experiences	A national indicator to be developed as part of the implementation of the Mental Health Strategy The indicator is also suitable for monitoring the focus area "Mental health rights".
	The functionality of the treatment chain after inpatient treatment	The first outpatient care visit within a week since discharge from psychiatric hospital (percentage)	Care Register for Health Care	A national indicator developed as part of the implementation of the Mental Health Strategy The indicator is also suitable for monitoring the focus area "Mental health rights".
	Referring a patient to involuntary treatment	Involuntary referrals for observation in psychiatric inpatient care for those aged at least 18 / 1,000 persons of same age Involuntary referrals for observation in psychiatric inpatient care for those aged 0–17 / 1,000 persons of same age	Sotkanet 3083; KUVA Sotkanet 3058; KUVA	The data includes patients who were referred to involuntary psychiatric treatment based on a referral for observation (form M1) or who were referred from one hospital to another during involuntary psychiatric treatment. The indicator describes the functionality of the voluntary service system. The indicator is also suitable for monitoring the focus area "Mental health rights".
	Differences in smoking and alcohol use by gender and level of education	Excessive alcohol use (AUDIT-C) (%). Share of persons who smoke daily (%)	Finsote; terveytemme.fi	Finsote survey; results by gender and level of education published in the terveytemme.fi portal

Focus area	Theme	Indicator	Data source	Inquiries
Good mental health management				An assessment practice can also be considered in addition to the indicators.
	Mental health impact assessment	To be developed	Proposed to be included in the TEA-viisari indicator	A proposal for an indicator
	Services and need	The number of services in relation to the needs among the population		A new proposal for developing a national indicator, requires supplementing the knowledge base
	The coverage of services	Mental health service use by people reporting suicidal ideation (%)	Finsote; terveytemme.fi	The indicator is based on the questions in the Finsote study concerning suicidal ideation and the use of mental health services. The indicator is also suitable for monitoring the focus area “Mental health rights”.
	The management of networks transcending	What municipal agencies are involved in working groups for promoting wellbeing and health? Which sectors are represented in the working group for promoting wellbeing and health?	TEA-viisari	
	The wellbeing at work	Wellbeing at work	Mental wellbeing among personnel in the social welfare and healthcare sector	More information about indicator: Karasek, 1979; 1990

3.3 Financial impacts and costs

The disease burden caused by mental disorders is mostly caused by a decline in work ability and functional capacity. Mental disorders typically develop when people are young, which can cause difficulties in education, employment and the social network. This contributes to significant indirect costs.

Based on the OECD’s latest report (Health at a glance: Europe 2018) the direct and indirect costs on mental health in Finland are among the highest in the OECD nations.

The financial impact of increased treatment of mental disorders has been investigated internationally. A study led by the WHO evaluated the financial impact of increased treatment of depression and anxiety in 36 countries. The study concluded that the benefits of expanding the treatment exceed the costs by 2.3–3.0 times in terms of financial benefits, and 3.3–5.7 times if this value included benefits of health improvement (Chisholm et al. 2016).

A project by the Finnish Government's analysis, assessment and research activities calculated sickness allowance periods related to mental health issues as reducing gross domestic product by 0.3–0.4 per cent in Finland. If a 10–15 per cent reduction in disability pension retirement (for mental health reasons) was achieved, Finland's gross domestic product would grow by 0.3–0.5 per cent. The research concluded that investing in mental health promotion, enabling people with partial work ability to return to the labour market and developing mental health services can significantly reduce indirect costs, such as those related to productivity. (Wahlbeck et al. 2017.)

In the United Kingdom, assessments have been made on the financial benefits of mental health interventions, proving them to be cost effective. Interventions which promote mental health, prevent mental disorders, as well as early interventions produce financial savings to both social and healthcare sectors, as well as society as a whole. Interventions aimed at children and young people are particularly profitable as the benefits can also be measured in terms of finance benefits relating to higher levels of education and better placement in the working life. On the other hand, if behavioural problems beginning in childhood continue in a negative spiral, these present the most extensive costs in relation to social exclusion. As the service and cost structures in different countries vary, assessments of potential cost savings cannot directly be applied to other countries. (Knapp et al. 2011.)

An estimate of the direct and indirect costs caused by mental health issues (including substance abuse issues) in Finland and EU member countries in 2015.
(OECD/ EU, 2018)

			EU 28	Finland
Total costs		EUR mill.	607,074	11,140
		% of GDP	4.10%	5.32%
Direct costs	Costs caused by health care expenditure	EUR mill.	194,139	2,576
		% of GDP	1.31%	1.23%
	Costs caused by social benefits	EUR mill.	169,939	3,884
		% of GDP	1.15%	1.85%
Indirect costs	Costs incurred in the labour market	EUR mill.	242,995	4,681
		% of GDP	1.64%	2.23%

The number of people benefiting from mental health interventions can be assessed based on factors such as the annual incidence of disorders. Estimates indicate 2.7% of the adult population will develop depression and 2.9% will develop anxiety disorder each year (Bijl et al. 2002). Even after taking the comorbidity of the two disorders into consideration, and the fact that not all individuals seek help, the annual number of people receiving care would exceed 100,000.

Table 2. Examples of the costs of measures taken in accordance with the Mental Health Strategy.

Measure	Description	Target groups	Projected costs
Training initiatives for mental health promotion	Educating mental health promotion course leaders to provide training for various target groups	Population groups of different kinds, different age groups, professional groups	Course leader training around EUR 1,500/person
Preventive and therapeutic interventions in the social and healthcare service system and the related organisations such as school environments	Making arrangements for the implementation and coordination of interventions, and maintaining competence in used methods Improving the availability of brief psychotherapy	Social and healthcare clients and the related service system	Costs of a single intervention around EUR 500–2,000 per person Costs of the structure maintaining the interventions: a centre of excellence around EUR 500,000/year Costs of brief psychotherapy EUR 700–2,200 /period of psychotherapy
A digital database of actions for mental health promotion and prevention of mental health problems	Compiling evidence-based approaches in a database	Municipalities	EUR 120,000–200,000 / year (EUR 200,000/year in the establishment stage)
Targeted programmes for social and healthcare, other areas of the service system, or elsewhere in society	Activities carried out under the programme: data collection, selecting target groups, formulating messages for each target group, raising awareness in target groups, establishing the work in the regular activities by the target groups, monitoring results. Anti-discrimination programmes, development programmes for improving physical health, anti-stigma programmes	Municipalities, communities and the entire society	Modelling and maintaining the programme, for instance EUR 200,000 /year and EUR 500,000 / year in project funding.

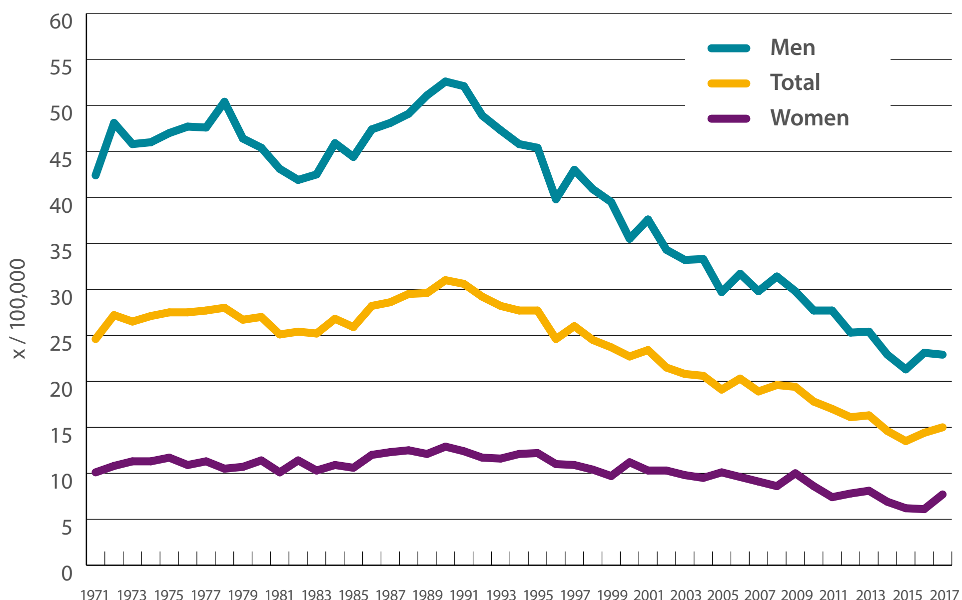
4 Programme for suicide prevention

The prevention of suicides requires improvements to existing actions and developing new approaches.

- General awareness-raising. Suicide attempts should not be thought of as attention seeking, nor should people who have attempted suicide be labelled or reproached for their actions.
- Restricting access to common means of suicide should be emphasised.
- Low-threshold crisis support must be available in all areas of country. Information about these services should be adequately provided so all residents are aware of where to find services in their local area, and how to access them.
- Access to treatment will be enhanced by prioritising treatment for people at risk of suicide, and providing increased support for bereaved friends and family. Early intervention for people in crises or difficult life circumstances may prevent further suicides.
- Suicide risk related to substance abuse will be prioritised on the same level as other population groups at increased risk of suicide.
- Improvements in responsible coverage of suicide by the media may play an important part in suicide prevention. Reporting positive survivor stories may encourage people to seek help.
- Developing EU legislation in order to limit destructive social media content, including content which may promote suicide on social media, videos, television series and film.
- Up-to-date data is needed for different age groups and risk groups in relation to suicide mortality, suicide attempts, access to treatment, quality of care, and early intervention.

Statistics on suicide mortality have been compiled in Finland since 1751. Suicide rates have dropped by half since 1990 (figure 1). This positive trend occurred during the National Suicide Prevention Project (1986–1996) (Statistics Finland, 2017; Upanne et al. 1999; Hakanen et al. 1999) which found that the majority of people who had died by suicide (88%) had other concurrent illnesses, the most common of these were depression (59%), serious physical illness (46%), substance abuse disorder (43%) and various personality disorders (31%) (Henriksson et al. 1993).

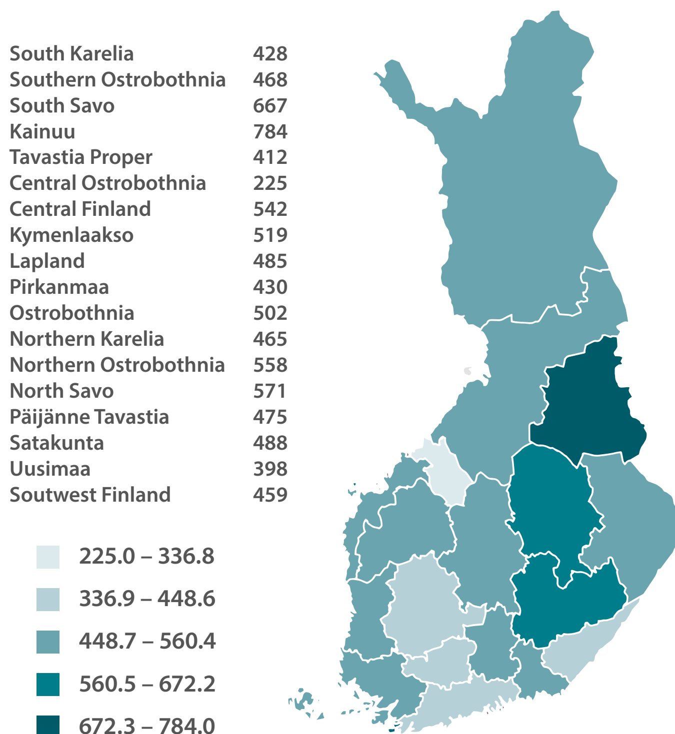
Figure 1. **Suicide mortality in Finland 1971-2017. Age standardised suicide mortality per 100,000 population. Age standardisation was calculated by Statistics Finland using the age distribution of the Eurostat European Standard Population (ESP2012). Age-standardised mortality rates are only comparable when calculated using the same standard population.**



The positive downward trend cannot be expected to continue in Finland without specific measures preventing further suicides (Holopainen et al. 2014; 2015). Moreover, suicide mortality can be expected to gradually increase due to population growth, and may include sudden spike in numbers if the suicide prevention measures lose their effectiveness.

Finland's suicide mortality rates have been characterised by considerable regional differences as well as differences between men and women (Partonen et al. 2003; Statistics Finland, 2018). This is also apparent in the potential years of life lost (PYLL) due to suicide mortality (figure 2). A high regional PYLL index represents a large loss of of potential years of life due to suicide before the age of 80. This indicates that suicide mortality is higher among younger people in that particular region. The National Action Plan for Promoting Safety among Children and Young People (thl.fi/lastenturvallisuusohjelma) takes this into account by including ten action points for preventing suicides. This action plan aims to significantly reduce suicide mortality among young people by 2025 (Korpilahti, 2018). A separate plan has also been prepared for preventing suicides among the Sámi people (Sami National Competence Centre & Saami Council, 2017).

Figure 2. **Potential Years of Life Lost due to suicide in Finland from 2015–2017. The Potential Years of Life Lost (PYLL) index represents the number of potential years of life lost due to suicide before the age of 80 per 100,000 population. The age limit of 80 years represents the average life expectancy among Finnish people. (Sotkanet)**



Based on the most recent data, 810 people died by suicide in the year 2018 and the suicide mortality rate was 14.6 suicides per 100,000 population. The average age of suicide mortality was 50 years of age for women, and 48 years of age for men. In the same year, a total of 99 people under the age of 25, and 203 people over the age of 65 died by suicide.

There is limited information on potential changes in means of suicide and their underlying causes in the years following the National Suicide Prevention Project. Furthermore, knowledge is limited to specific regions (Lahti et al. 2014), individual means of suicide (Lapatto-Reiniluoto et al. 2013), or particular population groups (Laukkala et al. 2014).

Justification of the suicide prevention programme

Mortality trends in different socioeconomic groups indicate significant levels inequality. Suicides contribute to approximately 10 percent of life expectancy variation in different socioeconomic groups. Reasons behind this variation include mental disorders as well as various socioeconomic and health related difficulties. Comorbidity, being affected by more than one mental disorder at the same time (for example substance use disorder or anxiety disorder in addition to depression) is also common, and makes mental disorders a leading risk factor for suicide.

Statistical data, including the Potential Years of Life Lost (PYLL) index are easily available from the Welfare Compass provided by the Finnish Institute for Health and Welfare (www.terveytemme.fi/avainindikaattorit/index.html), and suicide mortality rates are available per region and by age group from the Sotkanet database (sotkanet.fi/sotkanet/fi/haku), although there is a delay in publishing the data. Despite the availability of this data, it may not necessarily reach professionals within the social welfare and primary healthcare sector. In order to direct suicide prevention actions more precisely, up-to-date data is needed not only in relation to the age and regional distribution of suicides, but also including data on the means of suicide.

Policies which promote mental health and reduce mental health inequalities are also likely to prevent suicides. The following section outlines proposals for suicide prevention actions. Furthermore, potential indicators evaluating the implementation and effectiveness of these actions will be built on available data.

Proposals for reaching the goals of the programme

Awareness Raising

Increasing awareness of suicide and suicidal ideation through societal discourse facilitates access to appropriate and equitable support and services. At the same time, the aim is to support a sense of community and a feeling of mutual responsibility. Every one of us can support those at risk of suicide with compassion and without condemnation. In order for this to be possible, we need to address common prejudices surrounding mental health disorders as well as substance use disorders as both of these are significantly associated with suicide. Key professionals for this task include youth workers, coaches, school psychologists, social workers, reception centre and parish staff, guards, police officers, debt counsellors, enforcement authorities, paramedics, emergency rescue workers, prison guards, journalists, supervisors and so on.

Measure 1: Providing systematic information on mental health promotion and suicide prevention measures to the general public.

Measure 2: Continued collaboration with the Ministry of the Interior and the Internal Security Strategy in providing suicide prevention training for different front-line professionals.

Impacting the means of suicide

Suicide risk can be reduced by influencing access to common means of suicide. It is therefore important to research common means of suicide and reduce their accessibility. For example, misuse of prescription medicines can be restricted through community pharmacy agreements.

Measure 3: Accounting for suicide risk in relation to traffic safety regulations.

Measure 4: Accounting for suicide risk within city and environmental planning including bridges and buildings, and transport infrastructure design for example train tracks and crossings.

Measure 5: Taking suicide risk into account within interior design solutions, particularly in hospitals, child protection institutions, reception centres and penal institutions.

Measure 6: Developing regulations on the availability and storage of toxic substances.

Measure 7: Developing regulation on availability, prescription and home storage of medications, with particular attention to risk of substance misuse.

Measure 8: Developing regulation concerning the availability and storage of firearms.

Early intervention

People under culminating financial distress or experiencing feelings of hopelessness and/or social or material marginalisation are in need of better support. Face-to-face meetings are often the best way to support people at risk of suicide.

Measure 9: Expanding telephone helplines to include support in languages other than Finnish and supporting existing helpline-workers to develop their competency.

Measure 10: Establishing a 24-hour online chat support service to which social media platforms are obliged to refer users at risk of suicide.

Measure 11: Strengthening low-threshold mental health and substance abuse services in primary healthcare and other local services, such as educational settings.

Supporting risk groups

Suicide risk is highest for those who have expressed suicidal thoughts or made previous suicide attempts. The treatment need for other risk groups must be assessed and opportunities to engage in peer support should be safeguarded. Peer support may be a suitable form of case management. Suicide risk assessment and treatment planning must be made in an equitable way for everyone, also in the context of substance abuse.

Measure 12: Increased support for people at high risk of suicide and for families bereaved by suicide.

Measure 13: Developing culturally sensitive suicide prevention programmes and emergency support which take into account different cultural and language groups including indigenous people, LGBT and other minority groups, victims of violence and others in critical situations, those affected by negative asylum decisions, prisoners, people living in poverty or under debt collection orders, people with disabilities, people suffering from chronic pain and long-term illness, substance abuse, or people with problematic gaming or gambling issues.

Measure 14: Training local opinion leaders for example in schools and within the defence force, with the purpose of mental health promotion and suicide prevention in these contexts.

Measure 15: Increasing the use of effective suicide prevention interventions within youth work.

Measure 16: Developing online outreach functions in order to reach risk groups online and encourage them to seek help.

Measure 17: Strengthening mental health promotion at work, particularly for work communities in crises or at risk of sudden changes, for example in connection with bankruptcy or redundancies.

Measure 18: Arranging accessible services for older adults. This could be achieved through new socially orientated residential options developing a sense of community, by developing face-to-face support and improving online and telephone-based support..

Developing care options

Ensuring access to adequate, timely, and evidence-based care. High-quality competencies will be developed for healthcare professionals, including access to evidence-based suicide prevention models for addressing and assessing suicide risk. Healthcare professionals will be supported by sufficient levels of consultation and supervision. Emergency and front-line professionals play a key role in this context, as do General Practitioners and occupational health physicians who have an important role in identifying people at risk of suicide.

Measure 19: Continued collaboration with the Ministry of Social Affairs and Health in organising suicide prevention training for social and healthcare professionals.

Measure 20: Developing evidence-based care models for people at risk of suicide, particularly in relation to new electronic approaches. Consolidating care approaches which follow the Current Care Guidelines for preventing suicides and treating people who have attempted suicides.

Measure 21: Enhancing collaboration between care providers to ensure people at risk of suicide receive seamless and continued care despite care provider changes.

Measure 22: Providing people at immediate risk of suicide with urgent psychiatric consultation to assess treatment need and developing a treatment plan which includes safety planning if necessary. In the case of children or young people, support for older siblings, parents and other friends and family will be accounted for. In the case of parents, children's support needs will be accounted for.

Measure 23: Strengthening collaboration between experts-by-experience, community organisations, early intervention and healthcare agencies.

Measure 24: Facilitating a high-quality management system for a compassionate care culture.

Increasing media competence

Media actions have been found to impact suicide mortality both negatively and positively. In line with this, recommendations on how suicides should be reported to a large audience have been developed in collaboration with media professionals.

Measure 25: With professionals in the media industry, planning and organising training on reporting news about suicides and the content of the provided information.

Measure 26: Obligatory supervisory measures for social media platforms will be imposed, including obligations for identifying harmful content which promotes suicide, content which indicate suicidal thoughts or intentions, as well as developing a steering system for those at risk of suicide.

Strengthening knowledge basis and research

In order to be able to target suicide prevention actions more precisely, we need access to up-to-date data on age and regional distribution of suicides, as well as means of suicides. In order to find new ways to prevent suicide, we also need further research on underlying causes of suicide and the effectiveness of suicide prevention measures.

Measure 27: The Ministry of Social Affairs and Health implements a national plan for suicide prevention for each governmental period, committing all stakeholders and administrations to suicide prevention actions.

Measure 28: Including the suicide prevention programme in all municipal and/or regional health and wellbeing plans (such as a mental health and/or substance abuse programmes and plans).

Measure 29: Providing research funding for new, digital solutions for suicide prevention.

Measure 30: Extending accident and incident investigations to include a so-called 'psychological autopsy' in the event of suicides. Initially this will be implemented in relation to young people who have died by suicide, eventually covering all suicides which have occurred during treatment or within a month of discharge.

Measure 31: The Finnish Institute for Health and Welfare launches a national suicide register for the purpose of monitoring and assessing the quality of suicide prevention actions, and enabling suicide research.

Measure 32: Bringing together national multidisciplinary competency in suicide research in order to strengthen and improve its effectiveness.

Measure 33: Allocating and resourcing the responsibility for coordination, monitoring and assessment of the national suicide prevention programme to a specific and task-appropriate organisation.

Measure 34: Implementing early intervention through community organisations for instance via the Suicide Prevention Centre at Mental Health Finland (Mieli).

Measure 35: Establishing permanence for community organisations and other actors engaging in suicide prevention through support from the Funding Centre for Social Welfare and Health Organisations as well as support from municipalities and regions.

Measure 36: Presenting national research funders with an interdisciplinary suicide prevention research programme.

Monitoring of the suicide prevention programme and proposals for indicators

A considerable part of the operational programme for suicide prevention comprises of a comprehensive network of service units which are in close collaborative contact with national networks. This approach connects programme goals with implementation, and ensures that objectives remain active and that information and data are collected systematically and in a timely manner.

Proposal 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.

Proposal 2: Healthcare registers are used to establish number of suicide attempts and means of suicide in different population groups and different geographical regions.

Proposal 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.

Appendix

Preparing the Mental Health Strategy

An extensive group of experts, including specialists in the service system and mental health organisations, was responsible for preparing the content of the Mental Health Strategy. The task of the group of experts was to prepare a strategy covering the following areas:

- creating opportunities for mental wellbeing for everyone, and good everyday environments,
- activities and services preventing mental health difficulties ,
- encourage participation and providing people with opportunities for influence and agency in matters concerning what services they need,
- providing all age groups with well-functioning services, with particular emphasis on services for children and young people, the entities formed by services, and points of transition,
- creating impacts within decision-making.

The Mental Health Strategy supports the implementation of mental health and substance abuse legislation. A special focus area of the strategy is the developing mental health for children and young people and cross-administrative collaboration. The strategy will be integrated into other strategic steering by the Ministry of Social Affairs and Health over its entire duration.

The group of experts held thirteen meetings and two workshops in the period between 21 September 2018 and 13 December 2019. The steering group met four times in the period between 21 August 2018 and 13 December 2019. The suicide prevention programme was prepared by the suicide prevention network of the Finnish Institute for Health and Welfare.

The group of experts organised consultations with stakeholders on the focal areas suggested for the Mental Health Strategy in the spring of 2019. Consultations were implemented as two online surveys as well as hearings and workshops organised for various stakeholders. The questionnaire was available at the Otakantaa.fi website from 8 April 2019 to 5 May 2019. A total of 661 responses were received. The Webropol questionnaire aimed at experts and professionals was available

from 5 April 2019 to 31 May 2019. A total of 129 responses were received. A total of nine consultations were organised in the period between 8 April and 27 May 2019. A wide group of representatives of organisations and the authorities as well as representatives of mental health and substance abuse services participated in the events. 16 written statements or other forms of written feedback were also received. In total, the study received feedback on 806 issues. The draft of the Mental Health Strategy and Programme for Suicide Prevention was submitted for comments from 1 to 28 October 2019. In total, 162 different agents submitted their opinions.

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Deputy chair

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References

Mental Health Strategy

Aaltonen S, Berg P, Ikäheimo S. Nuoret luukulla – Kolme näkökulmaa syrjäytymiseen ja nuorten asemaan palvelujärjestelmässä. Tutkimuksesta tiiviisti [Research in brief] 3/2015. Helsinki: Finnish Institute for Health and Welfare, 2015. http://urn.fi/URN:ISBN:978-952-302-442-7

Appelqvist-Schmidlechner K, Tuisku K, Tamminen N, Nordling E, Solin P. Mitä on positiivinen mielenterveys ja kuinka sitä mitataan? Suomen Lääkärilehti 2016; 24: 1759–1764.

Bijl RV, De Graaf R, Ravelli A, Smit F, Vollebergh WA. Gender and age-specific first incidence of DSM-III-R psychiatric disorders in the general population. Results from the Netherlands Mental Health Survey and Incidence Study (NEMESIS). Social Psychiatry and Psychiatric Epidemiology 2002; 37(8): 372–379.

Cantell M, Castrén S, Fabritius J, Järvinen-Tassopoulos J, Keinänen J, Kesänen M, Koskela T, Laitakari S, Leinonen S, Mikkola J, Murto A, Mustalampi S, Mykkänen A, Rydman E, Salonen A, Selin J, Suominen S, Tukia J, Tulirinta T. Suomalaisen rahapelaamisen tilannekatsaus 2017. 2nd revised edition. Helsinki: Finnish Institute for Health and Welfare, 2019. http://urn.fi/URN:ISBN:978-952-343-291-8

Chisholm D, Sweeny K, Sheehan P, Rasmussen B, Smit F, Cuijpers P, Saxena S. Scaling-up treatment of depression and anxiety: a global return on investment analysis. The Lancet Psychiatry 2016; 3(5): 415-424.

Hakulinen C, Elovainio M, Arffman M, Lumme S, Pirkola S, Keskimäki I, Manderbacka K, Böckerman P. Mental disorders and long-term labour market outcomes: nationwide cohort study of 2 055 720 individuals. Acta Psychiatrica Scandinavica 2019; 4: 371–381.

Halme N, Kanste O, Klemetti R, Kuusio H, Rajala R, Seppänen J. Ulkomaista syntyperää olevien nuorten hyvinvointi Kouluterveyskyselyssä vuonna 2017. Tutkimuksesta tiiviisti [Research in brief] 26/2017. Helsinki: Finnish Institute for Health and Welfare, 2017. http://urn.fi/URN:ISBN:978-952-302-910-1

Ikonen R, Hietamäki J, Laakso R, Heino T, Seppänen J, Halme, N. Sijoitettujen lasten ja nuorten hyvinvointi: Kouluterveyskyselyn tuloksia. Tutkimuksesta tiiviisti [Research in brief] 21/2017. Helsinki: Finnish Institute for Health and Welfare, 2017 http://urn.fi/URN:ISBN:978-952-302-903-3

Joukamaa M. and working group. Health, working capacity and need for treatment of criminal sanction clients. Perustulosraportti [Report on basic results] 2010:1. Publications by the Criminal Sanctions Agency, 2010. https://www.rikosseuraamus.fi

Kanste O, Sainio P, Halme N, Nurmi-Koikkalainen, P. Toimintarajoitteisten nuorten hyvinvointi ja avun saaminen – Toteutuuko yhdenvertaisuus? Kouluterveyskyselyn tuloksia. Tutkimuksesta tiiviisti [Research in brief] 24/2017. Helsinki: Finnish Institute for Health and Welfare, 2017. http://urn.fi/URN:ISBN:978-952-302-838-8

Karasek RA. Job Demands, Job Decision Latitude, and Mental Strain: Implications for Job Redesign. Administrative Science Quarterly 1979; 24: 285–308.

Karasek R & Theorel T. Healthy work: Stress, Productivity, and the Reconstruction of Working Life. New York: Basic Books, 1990.

Kasteenpohja T, Marttunen M, Aalto-Setälä T, Perälä J, Saarni SI, Suvisaari J. Treatment received and treatment adequacy of deppressive disorders among young adults in Finland. BMC Psychiatry 2015; 15: 47.

Keinänen J, Mantere O, Markkula N, Partti K, Perälä J, Saarni SI, Härkänen T, Suvisaari J. Mortality in people with psychotic disorders in Finland: A population-based 13-year follow-up study. Schizophrenia Research 2018; 192: 113–118.

Kessler RC, Angermeyer M, Anthony JC, DE Graaf R, Demyttenaere K, Gasquet I, DE Girolamo G, Gluzman S, Gureje O, Haro JM, Kawakami N, Karam A, Levinson D, Medina Mora ME, Oakley Browne MA, Posada-Villa J, Stein DJ, Adley Tsang CH, Aguilar-Gaxiola S, Alonso J, Lee S, Heeringa S, Pennell BE, Berglund P, Gruber MJ, Petukhova M, Chatterji S, Ustün TB. Lifetime prevalence and age-of-onset distributions of mental disorders in the World Health Organization's World Mental Health Survey Initiative. World Psychiatry. 2007; 6: 168–76.

Kessler RC, Nelson CB, McGonagle KA ym. Comorbidity of DSM-III-R major depressive disorder in the general population: results from the US National Comorbidity Survey. The British Journal of Psychiatry 1996: 17–30.

Knapp M, McDaid D, Parsonage M (toim.). Mental health promotion and mental illness prevention: The economic case. London: Department of Health, 2011.

Koponen P, Borodulin K, Lundqvist A, Sääksjärvi K, Koskinen S (eds.) Terveys, toimintakyky ja hyvinvointi Suomessa. Fin Terveys 2017 -tutkimus. Report 4/2018. Helsinki: Finnish Institute for Health and Welfare, 2018. http://urn.fi/URN:ISBN:978-952-343-105-8

Korja R, Nolvi S, Kataja E-L, Scheinin N, Junttila N, Lahtinen H, Saarni S, Karlsson L & Karlsson H. The courses of maternal and paternal depressive and anxiety symptoms during the prenatal period in the FinnBrain Birth Cohort study. Plos One 2018; 13(12): e0207856: 2.

Kuussaari K & Hirschovits-Gerz T. Co-occurrence of substance use related and mental health problems in the Finnish social and health care system. Scandinavian Journal of Public Health 2016; 44: 202–209.

Luopa P, Kanste O, Klemetti, R. Toisella asteella opiskelevien sateenkaarinuorten hyvinvointi 2017: Kouluterveyskyselyn tuloksia. Tutkimuksesta tiiviisti [Research in brief] 25/2017. Helsinki: Finnish Institute for Health and Welfare, 2017. http://urn.fi/URN:ISBN:978-952-302-909-5

Melartin TK, Rytsälä HJ, Leskelä US ym. Current comorbidity of psychiatric disorders among DSM-IV major depressive disorder patients in psychiatric care in the Vantaa Depression Study. Journal of Clinical Psychiatry 2002; 63: 126–34.

Mental Health Barometer 2019. Finnish Central Association for Mental Health. https://www.mtkl.fi

Nordentoft M, Wahlbeck K, Hällgren J, Westman J, Osby U, Alinaghizadeh H, Gissler M, Laursen TM. Excess mortality, causes of death and life expectancy in 270,770 patients with recent onset of mental disorders in Denmark, Finland and Sweden. PLoS One 2013; 8 (1): e55176.

OECD/EU. Health at a Glance: Europe 2018: State of Health in the EU Cycle. Paris: OECD Publishing 2018; 28. https://doi.org/10.1787/health_glance_eur-2018-en

OECD/EU. Health at a Glance: Europe 2018. More than one in six people in EU countries have a mental health problem. IHME (The Institute for Health Metrics and Evaluation). http://dx.doi.org/10.1787/888933833920

Official Statistics of Finland (OSF): Statistics on Pensioners in Finland 2018. Työkyvyttömyyseläkkeensaajat sairauspääryhmän mukaan 31.12.2018. Eläketurvakeskuksen tilastoja 9/2019. Eläketurvakeskus ja Kansaneläkelaitos, 2019. Last accessed on: 16 July 2019. https://www.etk.fi

Pentala-Nikulainen O, Koskela T, Parikka S, Kilpeläinen H, Koskenniemi T, Aalto A-M, Muuri A, Koskinen S & Lounamaa A. Kansallisen terveys-, hyvinvointi ja palvelututkimus FinSoten perustulokset 2017-2018. Finnish Institute for Health and Welfare, 2018 Online publication. http://www.terveytemme.fi

Pocket statistics 2019. Helsinki: Social Insurance Institution of Finland, 2019. http://urn.fi/URN:NBN:fi-fe2019061019680

Psychiatric specialist medical care 2017. Statistics report 33/2018. Helsinki: Finnish Institute for Health and Welfare, 2018. http://urn.fi/URN:NBN:fi-fe2018101037957

Räsänen S, Läksy K, Leppävuori A. Mielenterveyshäiriöiden yleisyys, luokittelu ja diagnostiikka. In: Pesonen T, Aalberg V, Leppävuori A, Räsänen S, Viheriälä L. (eds.). Yleissairaalapsykiatria. Duodecim 2019: 340–345.

Schaufeli W, De Witte H, Desart S. Burnout assessment tool (BAT). KU Leuven, Belgium: Unpublished internal report, 2019.

Schaufeli W, Shimazy A, Hakanen J, Salanova M, De Witte H. An ultra-short measure for work engagement. The UWES-3 validation across five countries. European Journal of Psychological Assessment 2019; 35(4), 57–591.

Skogberg N, Mustonen K-L, Koponen P, Tiittala P, Lilja E, Omar A-A-H, Snellman O, E Castenada A (eds.) Turvapaikanhakijoiden terveys ja hyvinvointi – Tutkimus Suomeen vuonna 2018 tulleista turvapaikanhakijoista. Report 12/2019. Helsinki:

Sotkanet database for statistics and indicators. Finnish Institute for Health and Welfare. Difficult to talk to parents, as % of all pupils in 8th and 9th year of comprehensive school. Kouluterveyskysely. Info indicator 329. Last accessed on 10 December 2019. https://sotkanet.fi

Sotkanet database for statistics and indicators. Finnish Institute for Health and Welfare. Persons who drink too much alcohol (AUDIT-C) (%). Info indicator 4411. Last accessed on 10 December 2019. https://sotkanet.fi

Sotkanet database for statistics and indicators. Finnish Institute for Health and Welfare. Psychiatric rehabilitation homes, clients on 31 Dec, total. Info indicator 2869. Last accessed on 10 December 2019. https://sotkanet.fi

Sotkanet database for statistics and indicators. Finnish Institute for Health and Welfare. The housing services of substance abuse services/ 1000 residents. Info indicator 1272. Last accessed on 10 December 2019. https://sotkanet.fi

Sotkanet database for statistics and indicators. Finnish Institute for Health and Welfare. Mental health outpatient visits in the 2010s per 1000 persons of the same age. Last accessed on 11 December 2019. info ind. 3075, info ind. 2483, indo ind. 2484. Finnish Institute for Health and Welfare, 2019.
http://urn.fi/URN:ISBN:978-952-343-351-9

Spitzer RL, Kroenke K, Williams JB, Löwe B. A brief measure for assessing generalized anxiety disorder: the GAD-7. Archives of Internal Medicine 2006; 166(10): 1092–7.

Stenius-Ayoade A. Housing, health and service use of The Homeless in Helsinki, Finland. Helsingin yliopisto DSHealth Doctoral Thesis Series 2019; 29: 69, 76.
http://urn.fi/URN:ISBN:978-951-51-5178-0

Suvisaari J, Aalto-Setälä T, Tuulio-Henriksson A, Härkänen T, Saarni SI, Perälä J, Schreck M, Castaneda A, Hintikka J, Kestilä L, Lähteenmäki S, Latvala A, Koskinen S, Marttunen M, Aro H, Lönnqvist J. 2009. Mental disorders in young adulthood. Psychological Medicine 2009; 39(2): 287–99.

Takala J & Ilva M. Mikä suojaa nuorta aikuisten alkoholinkäytön aiheuttamilta haitoilta? Yhteiskuntapolitiikka-YP 77 2012; 2: 176–185. http://urn.fi/URN:NBN:fi-fe201209117923

Tiihonen J, Lönnqvist J, Wahlbeck K, Klaukka T, Niskanen L, Tanskanen A, Haukka J. 11-year follow-up of mortality in patients with schizophrenia: a population-based cohort study (FIN11 study). Lancet 2009; 22; 374(9690):620–7.

Wahlbeck K, Hietala O, Kuosmanen L, Mc Daid, D, Mikkonen J, Parkkonen J, Reini K, Salovuori S, Tourunen J. Effective mental health and substance abuse services. Publications of the Government´s analysis, assessment and research activities 2017:89. Prime Minister's Office, 2017. http://urn.fi/URN:ISBN:978-952-287-501-3

Westman J, Wahlbeck K, Laursen TM, Gissler M, Nordentoft M, Hällgren J, Arffman M, Ösby U. Mortality and life expectancy of people with alcohol use disorder in Denmark, Finland and Sweden. Acta Psychiatrica Scandinavica 2015; 131(4): 297–306.

WHO. Prevention of Mental Disorders. Effective interventions and policy options. Department of Mental Health and Substance Abuse in collaboration with the Prevention Research Centre of the Universities of Nijmegen and Maastricht: A Report of the World Health Organization, 2004.

WHO. Mental health: Strengthening Our Response. 2014. https://www.who.int/news-room/fact-sheets/detail/mental-health-strengthening-our-response

Further reading

Partanen A, Moring J, Bergman V, Karjalainen J, Kesänen M, Markkula J, Marttunen M, Mustalampi S, Nordling E, Partonen T, Santalahti P, Solin P, Tuulos T, Wuorio S. Plan for Mental Health and Substance Abuse Work 2009–2015: What will happen next? Working paper 20/2015. Helsinki: Finnish Institute for Health and Welfare, 2015. http://urn.fi/URN:ISBN:978-952-302-538-7

The Action plan for preventive work in substance abuse and addictions. Reducing the adverse effects of alcohol, drugs, gambling and smoking. Ministry of Social Affairs and Health publication 2015:19 http://urn.fi/URN:ISBN:978-952-00-3746-8

Plan for Promoting Mental Health Work and the Social Work with Substance Abusers. Proposals for development of mental health work and the social work with substance abusers 2015. Ministry of Social Affairs and Health publication 2012:24. http://urn.fi/URN:ISBN:978-952-00-3382-8

Fancourt D & Finn S. What is the evidence on the role of the arts in improving health and well-being? A scoping review. Health Evidence Network (HEN): synthesis report 67. Copenhagen: WHO Regional Office for Europe, 2019.

Mental Health ATLAS 2017. World Health Organization. https://www.who.int/mental_health/evidence/atlas/mental_health_atlas_2017/en/

Plan for mental health and substance abuse work. Proposals of the Mieli 2009 working group to develop mental health and substance abuse work until 2015. Reports of the Ministry of Social Affairs and Health 2009:3. http://urn.fi/URN:ISBN:978-952-00-2768-1

Plan for mental health and substance abuse work 2009–2015. Final assessment of the plan and proposals of the steering group. Reports and memorandums of the Ministry of Social Affairs and Health 2016:3. http://urn.fi/URN:ISBN:978-952-00-3694-2

Mäkelä P, Härkönen J, Lintonen T, Tigerstedt C, Warpenius K. Näin Suomi juo – Suomalaisten muuttuvat alkoholinkäyttötavat. Teema 29/2018. Helsinki: Finnish Institute for Health and Welfare, 2018. http://urn.fi/URN:ISBN:978-952-343-146-1

Reports published as part of the Mental Health Strategy

Raivio H & Appelqvist – Schmidlechner. IPS –Sijoita ja valmenna! –toimintamallin soveltamisen mahdollisuudet suomessa. Working paper 23/2019. Helsinki: Finnish Institute for Health and Welfare, 2019. http://urn.fi/URN:ISBN:978-952-343-377-9

Partonen T, Eklin A, Grainger M, Kauppila R, Suvisaari J, Virtanen A. Deaths from suicide in Finland 2016–2018: Study in forensic medicine. Report 3/2020. Helsinki: Finnish Institute for Health and Welfare, 2020. http://urn.fi/URN:ISBN:978-952-343-446-2

Kurki-Kangas L. Review of the national mental health strategies of principal reference countries. Reports and Memorandums of the Ministry of Social Affairs and Health 2019:17. http://urn.fi/URN:ISBN:978-952-00-4047-5

Programme fo Suicide Prevention

Hakanen J, Upanne M. Itsemurhien ehkäisyn käytännöt Suomessa. Itsemurhien ehkäisyprojektin seuranta ja arviointi. Reports 228. Helsinki: Stakes, 1999.

Henriksson MM, Aro HM, Marttunen MJ, Heikkinen ME, Isometsä ET, Kuoppasalmi KI, Lönnqvist JK. Mental disorders and comorbidity in suicide. Am J Psychiatry 1993; 150: 935–940.

Holopainen J, Helama S, Partonen T. Finnish suicide mortality from 1950 to 2009 in a European comparison Duodecim 2014; 130: 1536–1544.

Holopainen J, Helama S, Partonen T. Itsemurhakuolleisuuden muutokset ikääntyvässä Euroopassa. Suom Lääkäril 2015; 70: 1983–1989.

Korpilahti U, ed. National Action Plan for Safety Promotion among Children and Youth – Target and Action Plan 2018–2025: part I. Working paper 11/2018, Helsinki: Finnish Institute for Health and Welfare, 2018

Lahti A, Harju A, Hakko H, Riala K, Räsänen P. Suicide in children and young adolescents: a 25-year database on suicides from Northern Finland. J Psychiatr Res 2014; 58: 123-128.

Lapatto-Reiniluoto O, Vuori E, Hoppu K, Ojanperä I. Fatal poisonings in Finland during the years 2004–2009. Hum Exp Toxicol 2013; 32: 600–605.

Laukkala T, Partonen T, Marttunen M, Henriksson M. Suicides among military conscripts between 1991–2007 in Finland: a descriptive replication study. Nord J Psychiatry 2014; 68: 270–274.

Partonen T, Haukka J, Lönnqvist J. Itsemurhakuolleisuus Suomessa vuosina 1979–2001. Duodecim 2003; 119: 1827–1834.

Saamelaisten kansallinen osaamiskeskus – psyykkinen terveys- ja päihdehuolto & Saamelaisneuvosto: Norjassa, Ruotsissa ja Suomessa asuvien saamelaisten itsemurhien ehkäisysuunnitelma. Kárášjohka/Kaarasjoki: SANKS, 2017.

Official Statistics of Finland (OSF): Causes of death. Statistics Finland 2018. Last accessed on: 23 May 2018. Available at: www.terveytemme.fi/avainindikaattorit/terveydentila/maakunnat_html/atlas.html

Official Statistics of Finland (OSF): Causes of death [online publication]. Helsinki: Statistics Finland, 2017. ISSN=1799-5051. http://www.stat.fi/til/ksyyt/2017/ksyyt_2017_2018-12-17_tie_001_fi.html

Sotkanet database for statistics and indicators. Finnish Institute for Health and Welfare. Potential years of life lost (PYLL) due to suicide at ages 0-80 per 100,000 inhabitants Info indicator 3960. https://sotkanet.fi/sotkanet/fi/metadata/indicators/3960

Upanne M, Hakanen J, Rautava M. Voiko itsemurhan ehkäistä? Itsemurhien ehkäisyprojekti Suomessa 1992–96: toteutus ja arviointi. Reports 227. Helsinki: Stakes, 1999.

In accordance with its government programme, Prime Minister Marin's Government publishes the National Mental Health Strategy and Programme for Suicide Prevention 2020–2030 and launches its implementation. This publication provides information about the background and goals of the Mental Health Strategy, publishes the focus areas of mental health work until 2030, and describes the measures launched in the period 2020–2022 and related monitoring activities. The Mental Health Strategy also contains a separate, goal-oriented suicide prevention programme.

The Mental Health Strategy and Programme for Suicide Prevention has been drawn up via extensive collaboration with stakeholders and are based on a comprehensive approach to mental health. The implementation of the strategy engages a wide range of operators.

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