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Linnaranta, Outi

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OUTI LINNARANTA, KLAUS RANTA, MAURI MARTTUNEN, TERHI AALTO-SETÄLÄ, MIIA STÅHLE, JAANA SUVISAARI, HELENA VORMA

A NATIONAL IMPLEMENTATION OF INTERPERSONAL COUNSELLING, ADOLESCENT VERSION (IPC-A) IN FINLAND

ABSTRACT

Depression is one of the most common psychiatric disorders among adolescents and young adults. Interpersonal counselling, adolescent version (IPC-A) is a short method to treat depression of adolescents in 3 to 8 sessions in primary healthcare. IPC-A has been selected in a participatory project for national implementation in Finland, starting 2020. By the end of 2022, the estimated need to treat 7000 depressed adolescents per year in primary care will be targeted by training about 1600 professionals in providing IPC-A. In preparation for implementation of this strategy, the Finnish Ministry of Social Affairs and Health funded a project in 2016-2017. The first step was selection of evidence-based interventions that would be suitable for national implementation in primary care. The government then funded a pilot study using IPC-A intervention in one city. The pilot had the goal of constructing a national implementation model for further testing within adolescent mental health services. As the results were encouraging, IPC-A was then chosen as the first intervention to test for nationwide implementation of short interventions in primary care. Five university clinics coordinated subsequent national training and local implementation. The Finnish Institute for Health and Welfare (THL) and Itla Children's Foundation provided implementation support for local project teams. While the training is still ongoing, the successes and limitations of the implementation process will be explored from the perspective of national coordination and support of implementation.

KEY WORDS: MENTAL HEALTH, INTERVENTION, SCHOOL, ADOLESCENT, INTERPERSONAL, IMPLEMENTATION, STRATEGY, EVIDENCE BASED

1. AN INCREASING NEED FOR TREATMENT AMONG YOUNG PEOPLE IN FINLAND

Being a period of intense biological, psychological and social changes, youth is a critical period for individual growth, as well as for learning and internalization of knowledge and skills that support and maintain mental health. Accordingly, compromised mental health at a young age can endanger transition towards adulthood. While mental disorders are common, prevalent in 20–25 per cent of young people (1), a psychiatric diagnosis increases the risk for social exclusion and low educational attainment by adulthood (2). In Finland, information on the actual need for treatment for mental health among young people is limited.

Most visits with mental health as the reported reason for the visit to healthcare take place in primary healthcare (*Table 1*). The school health and welfare services (SHWS) are free of charge in Finland. The focus of SHWS has been in promotion and prevention. Surveys have shown that professionals especially consider the number of psychologists at school to be insufficient (3). Information on waiting lists, from register and survey data from professionals, show that specialized services have been overwhelmed by an increasing number of adolescents referred for both diagnostic evaluation and treatment.

The medical records for public healthcare are digital in Finland. From digital medical records, it is possible to define visits that have been done for evaluation or treatment of mental health problems. This consists of information on diagnosis or reason for visit, and to some extent, an operational code for the content of visit. The information is collected in national registers that can be used to describe the number of adolescents who received mental health services in public healthcare. It is to be noted that this information is still an underestimate due to missing data and because it does not cover all visits to mental health services; most importantly, information from services provided in social services and private healthcare is missing. However, it provides some idea about the minimal proportion of adolescents in contact with healthcare due to mental health problems. A recent report describes the use of public healthcare services for mental health among young people in 2020 (4).

Table 1. Proportion of young people with at least one mental health-related visit to public healthcare services in 2020. Adapted from Forsell 2022 (4.)

Proportion of the age group with at least one mental health-related visit to public healthcare services in 2020	7–12-y	13–17-y	18–22-y
Primary care only	4.3 %	6.9 %	10.3 %
Specialized services only	3.2 %	4.7 %	4.1 %
Both primary care and specialized services	1.0 %	2.8 %	3.6 %
Total	8.5 %	14.4 %	18.0 %

The number of both adolescents and visits is larger in primary healthcare than in specialized psychiatric services (4). Accordingly, the quality of primary care mental health services is essential for the overall quality of mental health services. The total number of young people and the total number of visits for mental health have increased over several years now, in both primary care and specialized services, the increase being more prominent in primary care settings.

The median number of visits per client in primary care was 2 (4). Thus, typically, the number of visits was sufficient only for a short evaluation. Those adolescents who need treatment were referred to specialized care, where the waiting time may even be several months (5).

Several other sources of information show that the demand for youth psychosocial services has steadily increased. In Finland, the proportion of youths aged 16 to 24 years who receive rehabilitation psychotherapy, financially subsidized by the Social Insurance Institution, has increased 2.5-fold from 2012 to 2021 (http://sotkanet.fi info 3872). During the same period, psychiatric outpatient visits have increased 1.5-fold among those aged 13 to 17 years (http://sotkanet.fi info 2484). This is interpreted to result from an increased perceived need and also from a targeted lowered threshold to seek treatment.

Moreover, despite the declining trend of suicide rates of young people in Finland (Source: Causes of death, Statistics Finland), the suicide rates are still high internationally (6). Among the causes of death for young people aged 15 to 24, the share of suicides (n = 99) was over one third in 2021. While suicide has always an individual, multifactorial background, the quality of services should be a priority when aiming at decreasing suicide rates.

2. MENTAL HEALTH STRATEGY: AIMS FOR IMPROVING CARE

The Finnish Mental Health Strategy 2020-2030 (7) has a strong focus on young people. The strategy proposes a comprehensive approach to face the increased need for psychiatric services and insufficient resources with methods to provide timely and high-quality services for mental health.

The Mental Health Strategy 2020-2030 presents several initiatives for increasing positive mental health and mental health literacy of young people and people interacting with young people. Individual level, structural and political level promotion of mental health, as well as reduction of the risk for compromised mental health and substance abuse, are seen as an essential basis for the current and future mental health of young people.

The key problems identified in the Finnish mental health services for the young include a need for faster access to care without organizational thresholds and waiting lists, a need for efficient use of existing resources for high-quality care, and a need for professionals to provide psychosocial interventions in primary care (7). Reaching these aims would strengthen the ability to prevent chronic and more complex mental health problems, and provide specialized care for those who have a severe mental disorder.

Accordingly, a strong strategic emphasis, implemented as part of the ongoing Finnish national health and social services reform, is on provision of short evidence-based (EB), low-threshold interventions in primary care (7). The target was set to start with the most common clinical problems. For young people, these are depression and anxiety (8,9).

3. THE PROCESS OF SELECTING IPC-A FOR NATIONAL IMPLEMENTATION

During 2016-2017, the Helsinki University Hospital, THL and the City of Espoo conducted a pilot project with Klaus Ranta and Mauri Marttunen as the project leaders. The knowledge and report (10) from this pilot study served as the basis for preparation of a national implementation.

The project team included experts and professionals in youth mental health services, in both primary care and specialized care, and stakeholders. The methods included reviews of literature, group discussions and interviews. After selecting the most promising interventions based on the reviews, one intervention was to be tested in a pilot study, including collection of qualitative and quantitative data for feasibility and efficacy.

The project team evaluated certain predetermined factors to identify a suitable intervention for national implementation. The factors evaluated included: a) incidence of mental health disorders in adolescence, b) implementation context, i.e., the school as the operational environment for implementation, c) literature review of previous knowledge of clinical interventions for adolescents on suitability, efficacy and success in implementation, and d) experiences from prior Finnish projects and stakeholders in implementing other primary level mental health interventions for adolescents (10).

a. *Incidence* of mental health disorders in adolescence. Based on available epidemiological data and data on actual service use, anxiety and depressive disorders were the two most prevalent mental health disorders with the highest incidence in adolescents (8,9).

b. *Implementation context:* The school as the operational environment for implementation had an impact on selection of the intervention. Selection was further explored in an analysis of how the services work at primary care and in specialized services, what the principal tasks of primary care services are and what are the possibilities for collaboration. The school health and welfare service leaders and the project lead reviewed these factors in a series of discussions. The identified important factors included estimated and available time resources of staff with other tasks, profile of work, basic knowledge and skills in mental health work of the professional groups working in school health and welfare services, and length of intervention compared to time available. The results favoured implementing brief, individual-based interventions requiring no lengthy theoretical training.

c. *Literature review* of previous knowledge of clinical interventions for adolescents on suitability, efficacy and success in implementation. Evidence on effectiveness of clinical interventions favoured testing either cognitive behavioural therapy (CBT) or interpersonal psychotherapy (IPT) for adolescents. Only a limited number of brief CBT/IPT-based interventions suitable for the school context were available. The length of interventions was estimated to be optimally not more than 6-8 meetings.

d. *Experiences from prior Finnish projects of implementing other primary level mental health interventions for adolescents.*

During the preliminary phase and first phase of the development project 2016-2017, experiences from prior Finnish projects implementing mental health programmes were collected informally (KR, MM). Only few interventions had previously been implemented for adolescents in Finland; commonly failures appeared to be in the maintenance phase of knowledge and skills, preventing large-scale use.

Professional support and supervision were seen as important factors for maintenance of skills. This meant that the intervention to be selected was favoured if experts with experience of using CBT or IPT in a longer format were available. Experiences of prior implementation projects suggested that being able to support an intervention by professionals with experience in public health services would be especially important, providing supervisory knowledge about the setting and practical obstacles in the public sector, in addition to theoretical and practical tips for using the intervention at individual level.

In preparation for a need for supervisors in a larger implementation project, the longer version of interpersonal psychotherapy, IPT-A, had been implemented in specialized services at several university clinics in Finland in 2018 and 2019. These therapists were already clinically competent and familiar with the interpersonal model through IPT-A. Thus, they could be recruited to supervise the IPC-A trainees, and simultaneously be trained for the shorter IPC-A version of interpersonal therapy.

The identified reasons for unsuccessful implementation, based on the previous literature and informal inquiries, included discontinuity, lack of planned, sustained support and supervision for practical use, and unclear target groups for the intervention. Furthermore, evaluation of factors that would have an impact on success of the implementation process in a school environment had previously been limited.

The project team concluded that most factors favoured selecting IPC-A as a short intervention, suitable for the time available and the profile of professionals, and of potential help for a large proportion of adolescents presenting with depressive symptoms at school health services. There was a sufficient existing pool of therapists that could rapidly be trained to work as supervisors within public healthcare. The training was short and the overall time commitment for training and supervision was considered realistic for professionals. The critical risk was that only one person in Finland had an accreditation to train IPC-A. This was ameliorated by important support from international centres for IPC-A training.

The options for the pilot implementation model included: a) using public primary healthcare services and specialized services, with support for implementation, b) using private sector agents, or c) using third sector organizations. After consideration, it became clear that for generalizable results for a national implementation, the pilot should be done in a public health care setting.

This was deemed the most realistic for maintenance of knowledge after the project funding period.

4. IPC-A, EVIDENCE FOR FEASIBILITY AND EFFICACY

IPC-A is a brief, individual-based intervention (3–8 sessions) focusing on interpersonal relations as a factor of resilience in depressive symptoms. IPC-A is a shorter form of IPT for youths, developed by prof. Myrna Weissman and team (11). The evidence for efficacy of IPT has been well shown in several well-designed RCTs that were specifically designed for evidence in adolescents (for reviews, see (12–14)). IPC-A was developed to take into account age-specific needs and features. Previous trials of IPT for adults and older people have proposed that shortening of IPT does not necessarily decrease efficacy (15).

Suitability of IPC-A to a school setting was piloted in Finland in one city, Espoo (16). Espoo is a city of 295 000 inhabitants with an average high socio-economic status in the capital area of Finland. In the Finnish pilot study, the schools were cluster randomized.

A comparison group of active treatment (Brief Psychosocial Support, BPS) was chosen (16). To deliver BPS, the school health and welfare workers were instructed to assess, repeatedly monitor and target symptoms of depression, in addition to using their routine skills to support students coping with symptoms of depression, and to limit the BPS to six sessions over 6–12 weeks. BPS was delivered with the same frequency and session duration as IPC-A. Thus, BPS represented an enhanced, more intensive and more focused version of the routine counselling provided by professionals working in the Finnish SHWS (10,16).

The sample size remained modest (total 55 adolescents) but was sufficient for a pilot trial. Qualitative interviews (10,17,18,19) showed positive results for feasibility of IPC-A, which is consistent with international studies (11,20,21). Adolescents and counsellors in both groups were satisfied with the treatment, and 89% of the adolescents with IPC-A completed the treatments and follow-ups. A trend indicated greater baseline symptom severity among adolescents treated in the schools providing IPC-A. While no statistical significance was reached between treatments (16), the results for efficacy remained inconclusive.

Overall, because evidence from large RCTs specifically for young people is lacking, selection of IPC-A for a national, large-scale implementation was not in line with the strictly defined EB implementation guidelines. Therefore, while there was a common agreement on the immediate need to try a novel approach of short interventions in primary care, the large-scale national implementation of IPC-A before more evidence had been accumulated was criticized by some. Others stressed relevance of the other selection criteria and of the pilot in public primary healthcare in Finland, and saw the overall evidence for feasibility and knowledge about efficiency for short forms of IPT as sufficient.

Immediately after the pilot phase, in years 2018 and 2019, both IPT and IPC-A training was available in a less organized format than the current nationwide training. While experiences from the training were not systematically evaluated, we sought information from these professionals when starting the nationwide implementation process. More than 200 professionals had already been trained in the use of IPC-A in Finland by the end of 2020, initiated at local, personnel or organization level.

A major part of those who had organized training in 2016 to 2019 reported that the interventions were not in use. Two major reasons for that appeared. First, they reported that it was almost impossible to identify suitable adolescents for interventions, i.e., "pure" mild or moderate depression, without any anxiety, social or family issues, or substance use. This was clarified in new instructions allowing broader inclusion and stressing the option of integrating different forms of support. Second, no sufficient mentoring or other support for professionals was provided after the training, despite the fact that several had simultaneously been trained in IPT to provide supervision for IPC-A experts. Overall, this information provided further support for the need for sufficient local and national support for trainees and their supervisors. This would include coordination and follow-up of supervision. In addition to new training, the previously trained professionals were provided shorter booster trainings and the same mentoring as the new trainees.

5. ESTIMATING THE NEED FOR TRAINING

The number of the target population for treatment had to be first estimated based on incidence of depression. Optimally, incidence would describe the onset of new episodes fulfilling the inclusion criteria for the specific treatment. General population incidence studies are very rare, as they require a prospective design where a study sample representative of the general population is examined twice, 12 months apart.

We used the information from the Netherlands Mental Health Survey and Incidence Study (NEMESIS), which is a high-quality study. NEMESIS provides gender- and age-specific data on the incidence of common mental disorders (22). Moreover, prevalence findings from NEMESIS (23) are consistent with previous Finnish studies.

According to NEMESIS, the incidence of major depressive disorder in the age group 18-24 years is 0.84% in men and 3.11% in women, and the incidence of anxiety disorders is 1.62% in men and 5.42% in women (22). Based on these findings, we roughly estimated that the incidence of depressive disorders would be 2%. We used this estimate and the number of adolescents aged 13-18 years in Finland (n = 356 000) to calculate the number of adolescents aged 13-18 years who would potentially need an intervention to treat depression in primary care. This means that roughly 7000 adolescents would benefit from IPC intervention in primary care.

6. NATIONWIDE IMPLEMENTATION OF THE MENTAL HEALTH STRATEGY FOR YOUTH MENTAL HEALTH

The Finnish ministry for social affairs and health in 2020 initiated funding for the implementation of the social and health services reform, and a major part of the funding was dedicated to implementing the Mental Health Strategy, most importantly, the strategic goal of improving the quality of mental healthcare services. It was obligatory for each hospital district receiving the funding to start an implementation process of EB interventions to treat young people. Accordingly, THL would monitor the success and maintenance of the training, as well as the interventions.

The municipalities were free to choose professionals to be trained for IPC-A. The professionals to be trained were those who were locally estimated to be the most likely to reach adolescents with low threshold in their position, had own interest to attend training, and had sufficient basic knowledge and skills necessary to provide the interventions. No formal or nationwide criteria for selection were applied.

The subvention of 43 million euros from the ministry in 2020 covered the coordination of training and the support for implementation in five university clinics, and training of professionals in 21 future wellbeing services counties. They decided to train a total of 1600 professionals in IPC-A by the end of 2022. It turned out that support of implementation, including follow-up and communication, was resource intensive for the university clinics. This is why an additional funding of 10 million euros was provided in December 2021 for the five university clinics to compensate for building sustainable resources for collaboration.

The university clinics have hired project teams for local coordination and support of implementation. This has varied from 0.5 full-time (FT) personnel to 3FT personnel per university clinic. It has commonly been reported that the personnel for the project teams was underestimated in the applications for funding, while previous experience about importance of communication and tools and interaction at follow-up were lacking.

The realistic estimated costs of training for the employer were clarified during the implementation process. The costs should take into account the time and thus, salary needed for a trainee for two days of initial training, two additional half-days of training within a year, bi-weekly group mentoring for 12 months and other events for trained personnel, e.g., for learning evaluation methods or to support implementation. Furthermore, for the professional, getting prepared for sessions, analyzing and reporting sessions, and identifying suitable young people for interventions was expected to take extra time.

7. THE ROLE OF THE FINNISH INSTITUTE FOR HEALTH AND WELFARE

THL has provided input in networking the stakeholders and professionals, and coordinating the creation of guidelines for professionals, with the aim of confirming efficacy and safety of treatment. Follow-up of success in implementation and integration of the therapists into the primary care services is the main task of THL.

Temporary solutions for follow-up. While the digital medical files did not provide uniform components for follow-up, we encouraged the report of finding temporary solutions from all professionals who received the IPC-A training. It was also necessary to list the number of adolescents who were provided treatment, whether trainees started to use the intervention, the overall number of treated adolescents, as well as symptom profiles at intake and end of treatment. The data had to be collected as a separate survey, completed by therapists and summarized by university clinics. This information was then disseminated by inviting all districts to present their results at 6-month meetings. Simultaneously, a process of creating common structures for follow-up was coordinated at THL.

Number and equal access to interventions. THL has advanced use of national register data for follow-up of interventions. A specific IPC-A operational code for use in medical files was created in 2021. After implementation of the IPC-A operational code in medical files, it will be possible to monitor number of overall and per patient IPC-A sessions as well as geographic distribution of use.

Follow-up of trainees. A professional ID for professionals is in use in healthcare services in Finland. This enables evaluating individual level performance of trainees using the intervention after training. In the future, thanks to personal identification numbers of patients, it will become possible to combine information from different registers. This will enable identification of the number and some characteristics of adolescents receiving IPC-A, as well as their outcome: hospitalizations, use of psychotropic medication or rehabilitation psychotherapy, or need for child welfare services.

Psychometric measures. We stressed the importance of having one nationally accepted measure, Patient Health Questionnaire (PHQ-9) for depressive symptoms, to compare symptom level at intake and efficacy of treatment (24). Originally, the university clinics had selected three different scales, not comparable at intake or after treatment. We are working towards structured methods of integrating symptom measurement to local medical files and from there, into the national level register. This would confirm robust information to estimate equal and appropriate access to interventions, as well as real-life efficacy and cost-effectiveness of IPC-A and training.

Networking stakeholders and project teams. THL formed a network of project managers and people in response for the services. Initially, checklists were created for pathways to care, for integration to other services, and for inclusion and follow-up of patients. At 6-month meetings, stakeholders and project managers described the status of implementation, any problems encountered and successful practical solutions to those problems. One to two months before the meeting, THL sent a survey to collect information on the number of professionals trained in IPC-A as well as number of adolescents that received treatment. This information was collected as a survey from university clinics and from each hospital district. Furthermore, open field questions and invited presentations identified and confirmed dissemination of the best practical innovations for training and implementation and encouraged interaction to find practical solutions.

8. CURRENT STATUS OF IMPLEMENTATION

The data provided here is previously unpublished and based on the information collected through the university clinics. By the end of 2021, the number of professionals trained in IPC-A was 1013, which is 62% of the total aim/goal of 1600 professionals by the end of 2022. Overall, it seems that the target number for training will be reached. Regional differences in the number of therapists were large, varying from 374 trained therapists in Eastern Finland to

Table 2. Number of IPC-A professionals trained and treatments provided based on the report from the five university clinics

District of Finland	Number of IPC-A professionals trained (2020 to end of 2021)	Number of professionals to be trained in 2022	% trained of the overall goal by end of 2022	Number of adolescents treated (end of 2021)	Ratio between professionals trained and adolescents treated (by end of 2021)
Southern	189	185	50.5	352	1.86
Eastern	374	150	71.4	700	1.87
Northern	200	80	71.4	358	1.79
Central	200	150	57.1	213	1.07
Western	50	102	32.9	29	0.58

50 in Western Finland (*Table 2*). While the training was ongoing, more than 1600 adolescents had initiated IPC-A treatment by the end of 2021, which is 26% of the originally estimated need for treatment.

Government grants do not cover the costs of scientific evaluation of the implementation process, effectiveness or cost-effectiveness of IPC-A. However, THL and distinct project teams have collected feedback, mostly unstructured, from professionals of the project teams, supervisors, IPC-A professionals, adolescents and their families. The overall view is positive from all informants. They uniformly confirm that IPC-A fits well the school environment.

Based on the comments, there seem to be differences between professionals in how they describe the utility of the structured intervention and training for IPC-A. A psychologist might feel that their professional training had already provided them with tools to help adolescents, or that a major part of their time is allocated for psychological testing and preventive work. On the other hand, school social workers were more likely to report that their training was a very useful way to complement their professional training, and IPC-A provided a structured method to give effective support for the adolescents they met in their work. The optimal profile of professionals to be trained is worth considering in the future. For conclusions, follow-up of the ability of professionals to use IPC-A and maintain their skills in the school setting will be essential.

9. CONCLUSIONS AND FUTURE STEPS

With the experiences from more than 1000 professionals, working in rural and urban areas representing all of Finland, it seems that IPC-A is suitable for use in primary care. It is still unclear whether the training will be transferred into actual interventions in all areas. So far, the average number of adolescents treated does not reach the estimate of 4-5 treatments per year per professional. Given that the training is ongoing, a critical follow-up and support for using the skills is necessary.

In the future, resources for confirming the continuity of the implementation will be essential. Repeated and consistent communication about the aims of training will be necessary to maintain the knowledge and motivation. Interaction between different implementation teams about the model for the practical phases of treatment can facilitate rapid progress. Collection of information concerning trainees, the number of adolescents treated per trainee, as well as real-life efficacy of interventions is necessary. Given the magnitude of investment, evaluation of the factors affecting feasibility and cost-effectiveness of IPC-A in real-life settings across regions and in subgroups of youths would be important. Finally, knowledge about theory, facilitators and barriers to implementation is needed both from project teams as well as leaders to strengthen the likelihood of success in maintaining the skills and knowledge from training (25). Evaluation of feasibility should include participation of youths and professionals.

The ongoing programme will not be sufficient to provide equal access to EB interventions for all young people with wellbeing issues and prevalent mental health conditions. Accordingly, the implementation project of IPC-A would provide essential information in efforts to produce a general model suitable for Finland to provide mental health services in primary care. Over the years, the aim has to be to provide suitable EB methods to treat all groups of adolescents, e.g., the increasing proportion of youths with multicultural or minority background, or adolescents with multimorbid conditions and in need of social services.

The overall goal of the mental health strategy is to improve efficacy of mental health services by using EB interventions. Several international guidelines (Grade, SPR, Blueprints) list explicit criteria for EB interventions (25). Similar criteria are used in the Finnish treatment guidelines that are created and updated by Duodecim, the Finnish medical association. In creating the Finnish treatment guidelines, classification of methods with strong or moderate evidence for efficacy is performed by an expert panel based on a systematic review and updated once sufficient novel data is available. To confirm efficacy, it seems important to confirm reliability of EB interventions by using national frameworks and follow-up structures, especially when it comes to use of governmental funding.

Despite a uniform international definition, the concept of EB interventions has proven controversial among stakeholders in Finland. The fact that the selection of IPC-A was made on broader criteria, as described above, but is not a strictly defined EB intervention has caused confusion. Currently, the university clinics are selecting training for future interventions to target other problems such as anxiety. The representatives of university clinics seem to consider EB to refer to the knowledge base that can be summarized from efficient components of actual EB treatments. For practical reasons, they want to adapt a loose definition for the efficacy of future interventions, allowing modifications

to the content and changes to accredited training. In their view, if the method to be developed has sufficient evidence for a background theory (such as CBT), and consists of components that commonly are included in the manuals of efficient interventions (such as exposure to anxiety provoking triggers), the intervention may be considered as being EB. This would allow development of "own" interventions, free from restrictions of accreditations, licences for use or other costs. This is clearly against international definitions of EB intervention.

For efficacy, the priority should be to use EB interventions where they exist. Where modifications are necessary due to some specific needs of the target group or context of use, the process should optimally be transparent and evaluated by a scientific process. This includes a peer review of protocol including literature for previous knowledge, reasons for edits and a manual for content. Additionally, the general characteristics of EB interventions apply, e.g., providing accredited training, describing content in a manual, confirming efficacy with psychometric measures at individual and group level, and aiming at final evidence for efficacy in RCTs.

It is relatively cheap to create interventions and provide short training. Critically evaluating efficacy and feasibility, maintaining fidelity to the method by providing supervision, providing booster training and supporting implementation is resource intensive. This knowledge has implications for funding. Conflicts of interest should be transparent. Accordingly, we would recommend creating explicit guidelines for selection of interventions, support of implementation and target number of patients to be treated per trainee, as it comes from use of public funding. A good example of guidelines for implementation of EB interventions is from Norway, the Ungsinn criteria (25,26).

Contributions

Outi Linnaranta, MD, PhD, started in June 2020 as a coordinator of the implementation of the Finnish Mental Health Strategy 2020-2030. As a chief physician at THL, she has contributed to planning the national support for implementation and evaluation of success in implementation (Sections 7 and 8). She has coordinated collection of information on the national implementation, written the original manuscript and interviewed other contributors.

Klaus Ranta, MD, PhD, was the principal investigator in the IPC pilot study and responsible for coordinating the original plan for national implementation. He made a major contribution to the selection of IPC-A and to planning the training programme (Sections 3 to 5). He was a member of the expert group for the preparation of the Mental Health Strategy (Section 2 and 6). Dr. Ranta worked at the Helsinki University Hospital as the Head of Adolescent psychiatry until December 2020. Currently, he works as a researcher at the University of Tampere.

Mauri Marttunen, MD, PhD, is a professor emeritus of adolescent psychiatry. The knowledge on epidemiology of adolescent mental health and services for adolescents in Finland is mainly collected under his leadership, and he has been a key person in training professionals as well as serving the ministry over decades. He was in leadership of the pilot study and contributed to the planning of the national implementation (Sections 3 to 5).

Terhi Aalto-Setälä, MD, PhD, and *Miia Ståhle*, MSocSc, work at THL and with Outi Linnaranta, they contributed to the national support for implementation in 2020-2023 (Sections 7 and 8).

Jaana Suvisaari, MD, PhD, is a research professor at THL. She conducted the estimation of incidence, and has written the corresponding section of the text (Section 5). She was a member of the expert group for the preparation of the Mental Health Strategy (Section 2).

Helena Vorma, MD, PhD, is a senior ministerial adviser in medical affairs/mental health at the Ministry of Social Affairs and Health. Over the years, she has made a major contribution as a medical advisor in building the legal basis and guidelines for organizing mental health services, as well as writing the National Mental Health Strategy and building structures for the funding of the National Mental Health Strategy (Sections 2 and 6).

All co-authors have accepted the final manuscript for publication.

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